Ontario

Occupational Health and Safety Branch

Health Care Sector Plan

2011-2012

Safe At Work Ontario

Enforcement > Compliance > Partnership >

Ministry of Labour

ISSN 1923 -6239 (Online) I June 2011

Contents

Introduction

Safe At Work Ontario is the Ministry of Labour (MOL) strategy for enforcing the Occupational Health and Safety Act (OHSA) and its regulations. As part of *Safe At Work Ontario*, MOL develops annual sector-specific enforcement plans that focus on hazards and outline what inspectors will be looking for during an inspection. Ontario's health care workers are on the front lines protecting patients, residents and clients every day. This Health Care Sector Plan outlines the ministry's strategy to protect Ontario's health care workers from occupational injury and illness.

On November 1, 2010, Ontario launched a new provincial toll-free number – 1-877-202-0008 – to report workplace health and safety incidents or unsafe work practices. Anyone, anywhere in Ontario, may call to report a workplace health and safety incident, critical injury, fatality or work refusal, or with general inquiries. The number operates 24 hours a day, seven days a week.

In 2010, the Ministry of Health and Long-Term Care (MOHLTC) Long-Term Care Homes Act, 2007 (LTCHA) repealed and replaced the Homes for the Aged and Rest Homes Act, the Nursing Homes Act, and the Charitable Institutions Act on July 1, 2010. The application sections of both the Health Care and Residential Facilities Regulation (O. Reg. 67/93) and the Needle Safety Regulation (O. Reg. 474/07) under the OHSA have been amended to reflect this change. These regulations continue to apply to facilities that were previously captured by one of the repealed statutes above if the facility now meets the definition of long-term care home under the LTCHA.

In 2011, as part of the regular review and update process for Occupational Exposure Limits (OELs) for biological or chemical agents, the MOL proposes to introduce new or revised OELs every year.

Please refer to the e-laws website to download a copy of the OHSA and its regulations: www.e-laws.gov.on.ca/navigation?file=browseStatutes&reset=yes&menu=browse&lang=en.

You are encouraged to familiarize yourself with all of this plan's contents and to share copies freely with others in your workplace.

Sector plans for other MOL programs may be downloaded from: www.labour.gov.on.ca/english/hs/sawo/sectorplans/index.php.

The health care sector

The health care sector in Ontario is diverse and complex. The table below shows a steady increase in the number of registered health care premises: there was an increase of 1,482 health care premises, or approximately 26 per cent over the previous five years. From 2006 to 2010, there was an increase of about 14 per cent in the number of registered workers in health care.

Sector size	2006	2007	2008	2009	2010
Registered premises	5,792	6,079	6,429	6,765	7,274
Registered workers	480,871	492,967	512,566	529,524	550,464

Health care and community care services are provided in a variety of complex settings. There are seven settings covered by the ministry's Health Care Health and Safety Program:

Long-term care homes
Long-Term Care Homes (LTCH) are government funded and regulated by the MOHLTC under the Long-Term Care Homes Act S.O. 2007, which came into force July 1, 2010. In general, long-term care homes offer higher levels of personal care and support (such as 24-hour nursing services or personal support) than typically are offered either by retirement homes or supportive housing.

Homes for residential care (e.g., retirement homes)
Retirement homes provide residential services to individuals who are generally able to care for themselves; however, a variety of levels of care and services is often available. Staff of these operations include nursing staff, personal support workers, and support service staff such as housekeepers and kitchen staff. Government passed the Retirement Homes Act (RHA) 2010, to be administered by the Ontario Senior's Secretariat, Ministry of Tourism and Culture. The RHA will come into force pending the completion and approval of associated regulations currently under development (current as of December 2010).

Hospitals
Hospitals are the largest employer of workers in the health care sector. Their activities include diagnosis and short-term treatment for patients with a wide range of diseases and injuries. Hospitals vary in the types of services they offer. These include, but are not limited to: general hospitals, rehabilitation hospitals, extended care hospitals, psychiatric hospitals, addiction hospitals, outpost hospitals, paediatric and other specialty hospitals.

Nursing services
Nursing services include agencies providing temporary or long-term professional health services (including nursing and medical), other health care services (such as non-professional physical and personal care of clients) and home support services (such as homemaking). Health care personnel whose business activities fall into this group may include: dental technicians and hygienists, physiotherapists, health care aides and providers, home care aides and workers, home support workers, and homemakers.

Group homes
Group homes are for residents who require care or support. Residents may have decreased physical or cognitive ability and require supervision and assistance with daily living, or they may require other types of support related to emotional or social well being.

Treatment clinics and specialized services
Treatment clinics and specialized services include: drug and alcohol treatment centres, public health, Community Care Access Centres, community clinics, skills development programs, and child care settings. Activities include continual assessment and rehabilitative treatment for non-institutional patients whose physical or mental condition is expected to improve.

Professional offices and agencies
Professional offices and agencies include, but are not limited to: doctors' offices, dental offices, other allied health professional offices, and laboratories and specimen collection centres in the community setting. Activities include the private practice of medicine or a specialty of medicine — in individual or group practice — by registered physicians and surgeons.

***Note*: Emergency Medical Services (EMS)**
EMS workers and employers should refer to the Transportation sub-sector of the *Industrial Health and Safety Program Sector Plan* for the MOL *Safe At Work Ontario* strategy for EMS: (http://www.labour.gov.on.ca/english/hs/sawo/sectorplans/2011/industrial/industrial_27.php). EMS is supported by the Public Services Health & Safety Association (PSHSA).

Ministry of Labour compliance focus in health care for 2011-2012

Ministry of Labour health care sector initiatives for 2011-2012

MOL's Health Care Unit will focus on increasing workplace compliance with the requirements of the OHSA and its regulations. Below is a brief overview of recent and future partnership strategies aimed at assisting health care workplaces with achieving compliance with key occupational health and safety requirements.

Needle safety

The Needle Safety Regulation mandates use of safety-engineered needles or needleless devices to replace hollow-bore needles to protect workers from needlestick injuries and blood borne infectious diseases. It applies to hospitals, long-term care homes, laboratories and specimen collection centres, and designated psychiatric facilities for all applications requiring the use of a hollow-bore needle. It also applies to all other workplaces in which a worker is to do work requiring the use of a hollow-bore needle on a person for a therapeutic, preventative, palliative, diagnostic or cosmetic purpose.

MOL has partnered with PSHSA on the development of compliance tools for the Needle Safety Regulation.

Enforcement focus

Injury and illness trends

For the *Safe At Work Ontario* strategy in the health care sector, MOL's Health Care Unit obtained input from the WSIB and PSHSA to identify workplaces for proactive inspections by MOL inspectors.

Under the strategy, the occupational health and safety injury and illness record of a company is one of the many factors that MOL uses to select a workplace for inspection. Hazards (often inherent in the work) and the compliance history are other selection criteria.

In addition to proactive inspections and consultations under the *Safe At Work Ontario* strategy, MOL also conducts reactive investigations and carries out hazard-specific blitzes.

The injury trends and program enforcement activity data within the health care sector are summarized below.

The health care sector had an average lost-time injury (LTI) rate per 100 workers of 1.90 in 2009, a decrease from 2.01 per 100 workers in 2008 (PSHSA data 2010).

For the health care sector, MSDs not related to client handling (28 per cent) and MSDs related to client handling (21 per cent) accounted for nearly half of the LTIs. Among other causes of LTIs were slips and falls (16 per cent), exposures to hazardous biological, chemical and physical agents (12 per cent), contact with, or being struck by, objects (9 per cent), workplace violence (8 per cent) and motor vehicle accidents (2 per cent) (PSHSA data 2010).

WSIB LTI cost data show that the five most costly injuries in the health care sector in descending order are:

1. overexertion
2. falls on same level
3. bodily reaction
4. assaults, violent acts, harassment, and
5. repetitive motion.

The no-lost-time injury (NLTI) — a work-related injury that does not result in lost-time from work — rate in the health care sector was approximately 3.19 per 100 workers in 2009 and 3.26 in 2008 (PSHSA data 2010).

When reviewing occupational injury and illness data, MOL inspectors encourage workplaces to establish and promote a robust workplace health and safety culture. They also consider the contributing workplace hazards while conducting field visit activity to enforce the OHSA and its regulations (such as the Health Care and Residential Facilities Regulation and the Needle Safety Regulation).

The table below quantifies the health care program activity from 2006 to 2010 (MOL data 2010). A trend analysis shows the number of proactive visits, number of inspections, investigations and consultations and number of compliance orders issued. The investigation data ("events") are further broken down into the number of fatalities, critical injuries, work refusals, complaints and other incidents.

Program Activities	2006	2007	2008	2009	2010
Pro-active visits[1]	1,494	2,279	2,552	2,117	1,598
Workplace inspections	1,464	2,231	2,507	2,073	1,558
Workplace consultations	30	48	45	44	40
Workplace investigations[2]	830	964	1,191	1,266	1,364
Orders issued	3,067	4,530	4,517	3,855	3,197

Events	2006	2007	2008	2009	2010
Complaints	271	314	334	327	443
Work refusals	6	7	1	7	1
Fatalities	1	0	0	2	1
Critical injuries	59	65	78	102	101
Other incidents	90	87	134	513	208

Investigations have increased steadily from 830 in 2006 to 1,364 in 2010.

During the five-year period beginning in 2006, there were four work-related fatalities of health care sector workers, two occurring in 2009. The number of critical injuries to health care sector workers has increased 71 per cent from 2006 (59) to 2010 (101). These are reported injuries; some workplaces may not report all injuries that meet the definition of critical injury. Additionally, the increase may be due to the enhanced MOL focus on employer reporting of critical injuries as the OHSA requires.

Complaints increased from 271 in 2006, to 314 in 2007, to 334 in 2008, dropping to 327 in 2009, with a high of 443 in 2010.

During a workplace visit, a written order is one of the enforcement tools the MOL inspector may use. The three most frequently issued orders issued by MOL inspectors in health care in 2010 concerned:

1. failure to comply with the employer duty to take every precaution reasonable in the circumstances for the protection of workers

2. failure to comply with the employer duty to prepare and review at least annually a written occupational health and safety policy and develop and maintain a program to implement that policy, and

[1] Pro-active visits include inspections made under the *Safe At Work Ontario* strategy, and consultations.

[2] Investigations are reactive workplace visits, which include complaints, work refusals, fatalities, critical injuries and other incidents.

3. failure to comply with Material Safety Data Sheets (MSDS) for controlled products in the workplace. (Controlled products are also referred to as Workplace Hazardous Materials Information System [WHMIS] products).

In 2011-2012, MOL inspectors will continue to focus on health care sector-specific hazards while inspecting for compliance with the OHSA and its regulations and encouraging workplaces to foster the Internal Responsibility System (IRS) as part of the workplace's health and safety culture.

Special enforcement focus for 2011-2012

For 2011-2012, in addition to inspecting for compliance with all legislative requirements, MOL inspectors will focus on the following three specific areas: competent supervision, responsibilities of directors and officers of corporations, and effectiveness of the Joint Health and Safety Committee (JHSC) and Health and Safety Representative (HSR).

Workplace injuries and fatalities can usually be traced to a few root causes that may vary by sector. The Ministry of Labour also conducts proactive inspection blitzes on health care sector-specific hazards to raise awareness and increase compliance with occupational health and safety legislation.

For more information concerning competent supervision, responsibilities of directors and officers of corporations, effectiveness of the JHSC and HSR, and the Health Care Blitzes, please see the text below.

Competent supervision

Competent supervision is an important part of workplace safety culture and the Internal Responsibility System (IRS), both part of the ministry's enforcement focus this fiscal year. MOL inspectors will consider whether competent supervision is present in workplaces as an indicator of an effective IRS.

The OHSA defines a supervisor as a person who has charge of a workplace or authority over a worker. For example, a charge nurse may be a supervisor.

Under clause 25(2)(c) of the OHSA, when appointing a supervisor, an employer must appoint a competent person. The OHSA defines a competent person as someone who is qualified because of his/her knowledge, training, and experience to organize the work and its performance, is familiar with the OHSA and its regulations that apply to the work and has knowledge of any potential or actual danger to health or safety in the workplace.

The OHSA also sets out certain specific duties for workplace supervisors under section 27, including:

- advising a worker of any potential or actual health or safety dangers known by the supervisor
- taking every precaution reasonable in the circumstances for the protection of workers
- ensuring that a worker works in the manner, and with the protective devices, measures and procedures required by the OHSA and its regulations; and
- ensuring that a worker uses or wears the equipment, protective devices or clothing required by the employer.

Responsibilities of directors and officers of corporations:

Under section 32 of the OHSA, directors and officers of corporations shall take all reasonable care to ensure the corporation complies with:

- OHSA and its regulations
- orders and requirements of MOL inspectors and MOL directors, and
- orders of the Minister.

Effectiveness of Joint Health and Safety Committees and Health and Safety Representatives

Workplaces in which the number of workers regularly exceeds five and in which no Joint Health and Safety Committee (JHSC) is required must have a Health and Safety Representative (HSR), selected by the workers from those workers who do not exercise managerial functions at the workplace. The HSR must inspect the physical condition of the workplace monthly or, where this is not practical, inspect the physical condition of the workplace at least once a year and a part of the workplace in each month. An HSR has various discretionary powers, including the power to identify potential hazards to workers, and to make recommendations to the employer regarding those hazards.

JHSCs are required at workplaces that regularly employ 20 or more workers, other than a construction project to which a designated substance regulation applies, at a workplace where an order has been issued under section 33 of the OHSA (concerning toxic substances) or where the Minister requires a JHSC. A JHSC is composed of one or more representatives of the employer and of the workers. Other than in the circumstances specified in subsection 9(13), at least one employer member and one worker member are to be certified as JHSC members. Like an HSR, the committee has various discretionary powers, such as the power to identify sources of danger to workers and make recommendations to the employer. Unless otherwise ordered by an inspector, a worker member of the JHSC is to inspect the physical condition of the workplace monthly or, where this is not practical, to inspect the physical condition of the workplace at least once a year and a part of the workplace in each month. The JHSC is required to meet once every three months, maintain minutes of the meetings, and make the latter available to an inspector for examination and review.

You are encouraged to download the MOL Guide for Joint Health and Safety Committees and Representatives in the Workplace for additional information: http://www.labour.gov.on.ca/english/hs/pubs/jhsc/index.php.

Health care sector blitzes

Throughout the year, MOL will also conduct blitzes focusing on specific hazards to reduce injuries and illnesses in the health care sector. The blitzes will be announced during the year. You are encouraged to visit the Ministry's web site frequently for updated information: www.labour.gov.on.ca/english/hs/sawo/blitzes/index.php.

During these blitzes, all workplaces should evaluate their workplace specific policies, measures and procedures, and worker training related to the specific subject matter of the blitz. This may include (but is not limited to) reviewing and updating the health and safety policies and programs, risk assessments and implementation of control measures related to mitigating or eliminating the risk, and developing a continuous improvement plan to correct non-compliance.

Health and safety characteristics of the health care sector

The health care sector faces some challenges which may have significant impact on worker health and on LTI rates. These include, but are not limited to, increased care requirements resulting from the aging of Ontario's population, increased patient and resident needs, increased obesity rates, increased demand on community and health care services, globalization of occupational health and safety issues such as emerging infectious diseases, pandemics and other environmental health risks. In addition, employers face recruitment and retention challenges, an aging workforce, a shortage of skilled professional staff, and an increase in casual and part-time workforce.

These issues illustrate the importance of communicating occupational hazard information during the continuum of care and when patients, residents or clients are transferred between health care settings (such as a hospital, long-term care home and community-based health care). This includes communication of information such as precautions regarding risk of violence, infection transmission, MSDs, etc., with the particular patient, resident or client.

With Ontario's aging population, there is growing demand for long-term care and residential care services. The demand for long-term care admission may affect workers' injuries (such as MSDs) in retirement homes, because residents may be staying longer in residential care despite their need for a higher level of care.

The "aging-in-place" philosophy may increase demand for nursing and home support services in the community. More workers would be in uncontrolled environments — usually away from supervision — and in workplaces not typically built for, nor physically able to accommodate, many care activities. Such settings can adversely affect worker health and safety with respect to musculoskeletal disorders (MSDs), violence, and infection prevention and control, as staff are required to care for residents with more severe illnesses and, in some cases, decreased cognitive ability (i.e., dementia). In addition, these workers face greater potential for injury from motor vehicle accidents as they travel from one client to another.

Group home settings face challenges to provide services to clients. Like the health care sector as a whole, they must balance the provision of appropriate quality care to clients and families with the health and safety of staff providing that care. This is coupled with the challenge of providing staff with appropriate education, training and equipment to provide care safely and the need to maintain a home-like setting for clients.

Hospitals continue to face increased demand on services, providing quality care for complex health needs, while balancing the need for the protection of health care workers.

In an effort to ease the demand on acute care services there is also an increase in the use of community-based health care and treatment clinics, physician practices, and other health care services.

Health and safety hazards inherent in health care work

Risk assessment of health and safety hazards is the process of a qualitative and/or quantitative determination of the likelihood of adverse effects resulting from exposures to hazards. Risk assessment helps in identifying hazards, developing control programs and advising workplace parties of hazards. Measures and procedures for controlling hazards should be developed after assessing risks in consultation with the JHSC or HSR.

Workplace Safety and Insurance Board (WSIB) data show that the major hazards which continue to cause the greatest number of LTIs include musculoskeletal disorders (MSDs); contacting or being struck by objects; slips, trips and falls; exposures; workplace violence; and motor vehicle accidents. Construction, mechanical and other industrial hazards are also common to health care workplaces and must be considered and addressed appropriately. For more information, see the Major hazards and inspection focus table on page 11.

Musculoskeletal disorders

Musculoskeletal disorders (MSDs) are injuries and disorders of the musculoskeletal system. They may be caused or aggravated by various hazards or risk factors in the workplace. In 2009, MSDs continued to be the leading cause of injuries in the health care sector, accounting for 49 per cent of all injuries (4,085 LTI claims). MSDs resulting from lifting, transferring and repositioning patients/residents accounted for 21 per cent of the total LTIs in health care. MSDs from non-client-handling tasks accounted for 28 per cent of all LTIs in health care.

Slips, trips and falls

Slips, trips and falls account for the second highest proportion of injuries in health care, accounting for 16 per cent of LTIs in 2009. This resulted in 1,311 LTIs to workers in the health care sector.

Contact and struck-by-object injuries

Contact/struck-by-object injuries can involve issues such as material handling, machine guarding, lock out and tag out. Injuries to workers resulting from contact with, or being struck by, equipment, machinery, devices and other objects accounted for 9 per cent of LTIs in 2009 (733 injuries).

Workplace violence

Health care workers are at an increased risk of exposure to workplace violence owing to factors, such as working in the community and private residences, working alone, providing direct care to patients/residents with cognitive impairments, and working with the public. Violence accounted for 672 LTIs in health care in 2009, 8 per cent of all LTIs in the sector.

Exposures to hazardous biological, chemical and physical agents

Hazardous biological, chemical and physical agents associated with health care facilities include: fungal spores/mould, viruses, bacteria; nuisance dust, asbestos; laboratory chemicals; hazardous drugs such as anaesthetic gases and antineoplastic drugs; and sterilizing, disinfecting and cleaning chemicals. Exposure to these agents could occur during medical procedures such as laser treatment and/or routine activities such as housekeeping.

In 2009, 12 per cent of LTIs in health care resulted from exposure to biological, chemical and physical agents in the workplace (984 injuries).

Infectious diseases

Workers in the health care sector may develop disease through potential exposure to infectious materials, body substances, contaminated medical supplies/equipment and contaminated environments. Transmission of infectious diseases occurs through direct or indirect contact, droplet and airborne exposures.

Occupational infections in workers, acquired as a result of workplace exposures, meet the definition of occupational illnesses under the OHSA. The nature of the illness must be reported to the MOL, HSR or JHSC, and trade union (if any). In addition to isolated cases of worker infections, outbreaks of illnesses within workplaces that provide care or services to clients occur every year and often involve workers among those infected. Occupationally acquired infections represent a particular concern in the health care sector. They continue to occur frequently as part of common outbreaks of illnesses within workplaces in the sector.

Needle and sharps injuries

Needles and other sharps are sources of injuries and potential exposure to infectious agents. Employers are responsible for assessing the risk of sharps injuries to workers and implementing appropriate control measures, including the use of safety-engineered needles.

Transportation hazards (motor vehicle accidents)

Although this hazard represents a smaller portion of LTIs in the health care sector, it is significant in that it has resulted in work-related motor vehicle fatalities to workers. Motor vehicle accidents accounted for 2 per cent of LTIs in the health care sector in 2009 (PSHSA data 2010), resulting in about 154 LTIs.

Major hazards and inspection focus

As part of the *Safe At Work Ontario* strategy, MOL inspectors will give special focus to certain sector-specific workplace hazards. However, inspectors will continue to inspect for overall compliance with the OHSA and its regulations, such as the Health Care and Residential Facilities Regulation (Occupational Health and Safety Act - O. Reg. 67/93) and the Needle Safety Regulation (Occupational Health and Safety Act - O. Reg. 474/07).

Inspectors will emphasize the role of HSR and JHSC in addressing an organization's hazards and prevention efforts. Inspectors will use organizations' LTI history, field intelligence and information provided by workplace parties to inspect and pay attention to the presence of the following hazards:

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
Asbestos	The Regulation Respecting Asbestos on Construction Projects and in Buildings and Repair Operations, (O. Reg. 278/05) continues to be a focus, particularly in older health care facilities that may have asbestos-containing material (ACM). A MOL guide to the regulation is available at: A Guide to the Regulation Respecting Asbestos on Construction Projects and in Buildings and Repair Operations. An asbestos management program must be in place where ACM is present in a building and in other specified circumstances and required measures and procedures (e.g., for Type 1, Type 2 operations) must be followed by employers and workers when performing work in a Type 1, 2 or 3 operation involving ACM.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
Construction hazards	Construction (including renovations, maintenance, new construction and the installation of new equipment) in health care facilities is common. One common example is construction related to asbestos removal. Where a pre or post-construction risk assessment identifies worker exposure to construction hazards, workplaces to which the Health Care and Residential Facilities Regulation applies must have written measures and procedures in place to protect the health and safety of workers. Employers are required to review these measures and procedures at least annually. Consultation with the JHSC or HSR on developing those measures and procedures and in providing worker training and educational programs regarding the measures and procedures is required. Employers of workplaces not covered by the regulation are required under the OHSA to (1) provide information, supervision and instruction to workers to protect their health or safety and (2) to take every precaution reasonable in the circumstances for the protection of a worker. These duties would apply with respect to protecting workers from construction hazards. Worker protection should include hazard communication, including infection prevention and control measures and procedures during construction and renovation. It is also important to consider controls limiting interaction between construction work and health care staff, as well as controlling access and egress through construction areas. As an employer, the health care facility has the duty to ensure that the measures and procedures prescribed are carried out in the workplace as required by clause 25(1) (c) of the OHSA.
Contact and struck-by-objects	Employers are responsible for assessing the risk to workers and developing and implementing measures and procedures for their protection. Compliance with clause 25(2) (a) of the OHSA, requires workers to receive information, instruction and supervision regarding safe work practices and conditions.
Emergency preparedness and response	For workplaces under the Health Care and Residential Facilities Regulation, emergency preparedness and emergency response shall include development and implementation of written measures and procedures for the health and safety of workers, including training programs. The employer should conduct a risk assessment to develop emergency measures, procedures and training. Employers of workplaces not covered by the regulation are required under the OHSA to take every precaution reasonable in the circumstances to protect workers from hazards at all times, including during an emergency, and to provide information, instruction and supervision about the same.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
Exposures to hazardous biological, chemical and physical agents	Employers must minimize health care workers' exposure to hazardous agents including hazardous drugs by complying with all applicable regulatory requirements, including the following: • availability of Material Safety Data Sheets (MSDSs) (where applicable) • compliance with prescribed procedures for safe use, handling and storage of hazardous agents and specified gases and drugs, worker education and training • compliance with prescribed Personal Protective Equipment including training in use, care, selection and limitations • Respiratory Protection Program • emergency response procedures in the event of a worker's exposure to antineoplastic agents • proper maintenance of anaesthetic gas scavenging systems, including monthly inspection for leakage, and • availability of control measures such as biosafety cabinets for the preparation of antineoplastic agents. Inspections will focus on ensuring compliance with the OHSA and regulations, including the Workplace Hazardous Materials Information System (WHMIS) Regulation (Reg. 860), Designated Substances Regulation (O. Reg. 490/09), Control of Exposure to Biological or Chemical Agents Regulation (Reg. 833), and the Health Care and Residential Facilities Regulation (O. Reg. 67/93), which addresses anaesthetic gases and antineoplastic drugs in sections 96 and 97.
Infections and Infectious diseases	The focus is to ensure that measures and procedures for the prevention and control of infections and infectious diseases are in accordance with the OHSA, and sections 8, 9 and 10 of the Health Care and Residential Facilities Regulation for workplaces covered by the regulation. Workplaces in which the Health Care and Residential Facilities Regulation applies are required to have in place written measures and procedures to protect the health and safety of workers, including protection from exposure to infectious diseases. Employers are required to review these measures and procedures at least once a year. Consultation with JHSC or HSR on developing those measures and procedures and in providing worker training and educational programs in health and safety measures that are relevant to the worker's work is required. Employers must ensure where personal protective equipment (PPE) is required by either the employer or the regulation, workers are instructed and trained in its care, use and limitations before wearing or using it for the first time and at regular intervals thereafter. Workers shall participate in such instruction and training. PPE that is provided, worn or used shall be a proper fit. Respiratory Protection Programs should include, among other things, these PPE requirements.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
	Employers in workplaces not covered by the regulation are required under the OHSA to (1) provide information, supervision and instruction to workers to protect their health or safety and (2) to take every precaution reasonable in the circumstances for the protection of a worker. These duties would apply with respect to protecting workers from the hazard of infectious diseases. Whether or not the Health Care and Residential Facilities Regulation applies to the workplace, infection prevention and control measures, procedures and training should be developed following a thorough risk assessment.
Material handling equipment	For workplaces subject to the Regulation, various requirements relating to material handling equipment apply. For example, material handling equipment must be thoroughly examined by a competent person and clearly marked with the maximum rated load. No material handling equipment shall be loaded in excess of its maximum rated load. Workers must be trained in their use before operating. Employers must ensure compliance with the OHSA and its regulations, including clause 44(e) and sections 75 through 79 of the Health Care and Residential Facilities Regulation.
Mechanical and other industrial hazards	Common industrial-type hazards found in health care workplaces include, but are not limited to, machines, equipment, confined space and restricted spaces, falls related to working at height, and energy hazards requiring lock-out/tag-out systems in place including electrical, pneumatic, hydraulic or kinetic energy. Each requires hazard identification through a risk assessment so that the employer implements corrective action, including developing and implementing control measures, procedures, training and education. Identification of the hazard through a risk assessment will enable the employer to determine which hazard-specific regulatory requirements may apply.
Musculoskeletal disorders (MSDs) (non-client-handling)	Inspectors will emphasize the role of HSR and JHSC in addressing organizations' MSD hazards and prevention efforts as well as a specific focus on the safe stacking, maintenance and transportation of carts within dietary, housekeeping, and the maintenance departments. In addition, there will be an ongoing focus on laboratory workstations and the appropriate clearances for worker safety. Employers should be aware of their organization's MSDs injury record and the presence of MSD hazards. They must take appropriate action to protect workers from MSD hazards. This may include developing written measures and procedures, providing and maintaining equipment, and providing information, instruction and supervision on MSD hazards and the protective measures put in place.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
MSDs specific to client handling (lifting, transferring and re-positioning of patients/residents/clients)	Inspectors will emphasize the role of the HSR and JHSC in addressing an organization's MSD hazards and prevention efforts and will focus specifically on client handling. Inspectors will use an organization's MSD injury history, field intelligence and information provided by workplace parties to inspect for the presence of MSD hazards in direct patient/resident care. Client handling injuries contribute close to half of all MSDs in the health care sector. Employers and supervisors must be diligent in ensuring that staff have equipment available to assist them in moving clients and that they are trained in its use. Employers in consultation with JHSC or HSR must establish written measures and procedures including but not limited to: assessing clients' mobility status, communicating the acceptable client handling technique and how to perform the technique.
Needle and sharps safety	In Ontario, the Needle Safety Regulation mandates the use of safety-engineered needles or needleless systems to replace hollow-bore needles to protect health care workers from needle-stick injuries in hospitals and all long-term care homes, laboratories and specimen collection centres. The regulation was extended on July 1, 2010, to cover any worker using a hollow-bore needle on a person for therapeutic, preventative, palliative, diagnostic or cosmetic purposes. Workers are also at risk from other sharp medical devices such as scalpels, solid needles, medical instruments and other materials. Employers must ensure that appropriate controls are in place for the use, handling and disposal of all needles and sharps at a workplace.
New and young workers	Employers are required to provide all workers with training, instruction and supervision to protect their health and safety. Where there are new and young workers on the job, inspectors will pay special attention to health and safety measures to prevent injuries to this vulnerable group of workers. The MOL considers new workers to be those who, regardless of age, have been on the job for less than 6 months or who have been assigned to a new job and considers anyone between 14-24 years of age to be young workers. For employers in workplaces to which the Health Care and Residential Facilities Regulation applies, the education and training programs must be developed in consultation with the JHSC or HSR.
Reporting occupational injuries and illnesses	If workplace injuries or illnesses occur, the employer has the following duties under the OHSA to notify: • If a person, whether a worker or not, has been critically injured or killed at the workplace, the employer must immediately notify a MOL inspector, the Joint Health and Safety Committee or Health and Safety Representative and the union, if any. This notice must be by telephone or other direct means, such as by facsimile. Within 48 hours, the employer must also notify, in writing, a director of the Ministry of Labour, giving a written report of the circumstances of the occurrence and any information that is prescribed *[subsection 51(1)]*.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
	• If accident, explosion, fire or incident of workplace violence at a workplace occurs and a worker is disabled or requires medical attention, the employer must notify the Joint Health and Safety Committee or Health and Safety Representative and the union, if any, within four days of the occurrence. This notice must be in writing and must contain any prescribed information *[subsection 52(1)]*. If required by an inspector, this notice must also be given to a director of the Ministry of Labour. • If an employer is advised that a worker has an occupational illness or that a claim for an occupational illness has been filed with the Workplace Safety and Insurance Board, the employer must notify a director of the Ministry of Labour, the joint health and safety committee (or health and safety representative) and the union, if any, within four days of being advised. This notice must be in writing and must contain any prescribed information *[subsection 52(2)]*. The duty to notify applies not only to current workers but also to former ones *[subsection 52(3)]*. An occupational illness includes occupationally acquired infections of workers. • For workplaces covered by the Health Care and Residential Facilities Regulation, the written notice details required are outlined in section 5 of the regulation.
Slips, trips and falls	Employers are required to take every reasonable precaution in the circumstances to protect workers, provide information and instruction, and to ensure the workers properly use or wear the required equipment. To decrease potential for slip, trip and fall injuries, inspectors will focus on maintenance of work surfaces, general housekeeping, safe ladder use, etc. in accordance with sections 33 through 41 of the Health Care and Residential Facilities Regulation.
Transportation hazards (motor vehicle accidents)	Employers shall assess potential motor vehicle hazards and put in place appropriate measures and procedures in consultation with the JHSC or HSR and ensure worker training to reduce risk of motor vehicle accidents. Employers in consultation with the JHSC or HSR must establish measures and procedures for the maintenance of motor vehicles in accordance with sections 8 and 9 of the Health Care and Residential Facilities Regulation.
Ventilation maintenance and monitoring	A mechanical ventilation system is required to be inspected every six months by a person who is qualified by training and experience. The person must file the ventilation inspection report with the employer and the JHSC or HSR. Furthermore, regular and preventive maintenance of a mechanical ventilation system, such as a cooling tower, is required to prevent the proliferation or colonization of *Legionella* bacteria in the system. Ventilation is addressed in sections 19 and 20 of the Health Care and Residential Facilities Regulation, and additional guidance is available in the MOL's Ventilation Inspection and Report for Health Care and Residential Facilities.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
WHMIS	The WHMIS Regulation contains sections regarding the three core components of the WHMIS program: product labels, MSDSs, and worker education must be in place. In addition, section 42 of the OHSA requires instruction and training, consultation and periodic review of the training instruction. Additional requirements are provided under "Exposures to hazardous, biological, chemical, and physical agents" in this table.
Workplace safety culture and Internal Responsibility System	To promote a strong IRS, employers, when appointing supervisors, are required to ensure that they are a competent person, as defined by the OHSA. In addition, employers in specified circumstances are required to ensure that a JHSC is in place or that there is a HSR selected. A worker member of the JHSC or the HSR must conduct inspections of the workplace in accordance with the OHSA. The JHSC must meet at least every three months and have at least one worker member and one employer member certified by WSIB. Employers in workplaces governed by the Health Care and Residential Facilities Regulation must develop measures and procedures, training and education in consultation with the JHSC or HSR. The employer must put the measures and procedures in writing and review them at least annually, or more frequently if advised by JHSC or HSR, or if there are changes in circumstances that affect worker health and safety. Directors and officers of corporations have specific duties under the OHSA. MOL will concentrate on these aspects of the IRS and workplace safety culture.
Workplace violence and harassment	Employers are required to develop workplace violence and harassment policies and to have programs to implement them. Employers are also required to assess the risks of workplace violence, and take every precaution reasonable in the circumstances to protect workers from domestic violence that may enter the workplace. Employer, supervisor and worker duties that are respectively specified in sections 25, 27 and 28 apply to workplace violence as appropriate. The OHSA provides definitions for workplace violence and workplace harassment and specifies employer duties in respect of workplace violence and harassment. More information on the MOL's approach to workplace violence prevention and workplace harassment is available at: Workplace Violence and Harassment: Understanding the Law.

Summary and highlights

The MOL's Health Care Sector Plan is based on *Safe At Work Ontario,* the MOL's compliance strategy for occupational health and safety. Through proactive enforcement, *Safe At Work Ontario* provides a modern, flexible, compliance-based program. Ontario's health care sector faces a number of health and safety challenges and contributing risk factors as a result of an aging population, increased demand on health care services, and the emergence of multi-factor risks (such as during emergencies).

This sector plan contains a brief description of some of the main topics that an inspector may address in the workplace. While each workplace is unique and the circumstances presented to an inspector may result in a different inspection focus, this sector plan provides a general overview of the ministry's focus within health care.

A health and safety culture requires all workplace parties to pay constant, appropriate attention to workplace health and safety, in other words, to have a well-functioning internal responsibility system. Sustainable workplace health and safety culture needs a strong commitment by everyone to prevent injuries and illness and to reduce risk.

For further information contact:

- Ministry of Labour at www.labour.gov.on.ca/english/hs
- MOL New and Young Workers at *www.worksmartontario.gov.on.ca/scripts/default.asp*
- Public Services Health and Safety Association at www.healthandsafetyontario.ca/bundles/pshsa/index.html
- Workplace Safety and Insurance Board at www.wsib.on.ca
- Ministry of Health and Long-Term Care at www.health.gov.on.ca/en/default.aspx
- Ontario Agency for Health Protection and Promotion at www.oahpp.ca.
- Regional Infection Control Networks at *www.ricn.on.ca/homes1.php*