OPSEU/ONA

SUBMISSION TO JUSTICE CAMPBELL

REGARDING:

January 30, 2006 REQUEST for

ADDITIONAL SUBMISSIONS

MARCH 2006

*** This is a revised version of the submission submitted to the SARS Commission in March 2006. It has been revised and formatted for this website.**

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EXECUTIVE SUMMARY

Since the SARS crisis of 2003, Ontario Nurses' Association (ONA) and Ontario Public Service Employees Union (OPSEU) have provided lengthy submissions and recommendations to the SARS Commission. We have participated in a number of confidential interviews with the Commission as have our members, presented at a public hearing of the Commission in September and November, 2003, and submitted final recommendations in July 2004. During this time, we have also provided the Commission with additional updates and concerns we believed were relevant to the Commission's mandate.

This submission is provided in response to a specific request made by the Commission in January 2006 for further information concerning lessons learned from SARS, changes to the health and safety environment in health care since SARS, and possible legislative changes reflecting lessons learned from SARS. Although we welcome the Commission's request and the depth of its inquiry, there is one particular aspect of the Commission's request that both unions find troubling: a number of the questions put by the Commission in its letter to us, refer to the "unique needs and requirements" of the health care sector. At a recent meeting we had with Ministry of Labour (MOL) senior policy advisors, we (and SEIU representatives) also encountered references to the unique needs of the health care sector. In this submission, our unions argue that while health care workers do face unique health and safety hazards, so do workers in many other workplaces.

We are concerned about implications to our members and to health care workers in general, of being labelled "unique" in some way. We are concerned that the intent or implication of the label may be to somehow diminish the authority of the MOL over health and safety matters in the health care sector. We are opposed to such a change. It is the belief and experience of both unions that the general language of the *Occupational Health and Safety Act* and the more specific *Regulation for Health Care and Residential Facilities,* at least in theory, offers as much protection to our members as existing health and safety legislation does to workers in other sectors. And while we believe that the *Act* and the Health Care regulation should be amended in a number of areas, it remains our position that the largest barriers to improved health and safety in the health care sector are: failure to comply with the *Act* and its regulations; lack of health

care sector leadership commitment to occupational health and safety; lack of education about health and safety duties and obligations; and lack of enforcement of *OHSA*.

In the area of administration and enforcement of health and safety law, we believe that it may be appropriate to compare health care with the construction and mining sectors. All three areas face unique hazards, and all three also have a sector-specific regulation to address some of those specific hazards. However, both mining and construction have specific health and safety programs within the MOL with inspectors who have additional training and experience which allows them to carry out their enforcement activities more effectively. The health care sector unfortunately does not have a specific program, and it is our recommendation in this submission that one be created. We do not accept that there is anything so unique about health care that would require the sector's health and safety matters to be administered or enforced differently than those of any other sector.

This submission serves as a "report card" of sorts, reflecting the current understanding of the two unions on a number of events and factors which have affected the health and safety of our members since SARS. Additionally, this submission has given us the opportunity to probe more deeply into the application of the precautionary principle in the health care sector and into the relationship between, and powers of, the Ministry of Labour and the Ministry of Health and Long Term Care (MOHLTC).

Our careful consideration of the theory and application of the precautionary principle approach has led the unions to make a strong recommendation to the Commission that the precautionary principle should be codified into *OHSA* and its regulations. In the workplace, this would mean that workers would be supported by the *Act* when they request the implementation of precautionary measures to protect them, even if some cause-effect relationships have not been fully established. We believe that this approach will offer our members and all workers greater workplace protection and will be particularly useful when determining measures to protect workers from infectious diseases with uncertain routes of transmission.

The SARS crisis gave OPSEU and ONA our first serious experience with the sorts of problems and confusion that can arise when two separate provincial ministries have jurisdiction over the same issue. It was the first time that the unions became aware of the 1984 agreement between

MOL and the MOHLTC which could be applied during an infectious disease outbreak in a workplace. Since SARS, we have seen more examples of negative workplace health and safety effects in situations where it is not clear which ministry is to take the lead and which ministry has authority in workplace health and safety matters. These experiences have led us to make a number of recommendations requesting it to be made clear that in all cases, the MOL is the government body with the power and responsibility to investigate workplace health and safety concerns, to establish health and safety guidelines, standards and legislation, and to enforce such guidelines, standards and legislation.

Since SARS, the MOHLTC has opened up its consultative processes to unions and other stakeholders, which is a positive development. Both unions have been deeply involved in the Ministry's consultations, particularly with respect to the development of the Provincial Pandemic Influenza Plan and other infectious disease initiatives. However, this experience, as well as our experience with the 2005 Legionnaires' Disease outbreak in Toronto, has led both unions to have great concern about the Ministry's understanding of and commitment to occupational health and safety. Our concerns have given rise to a number of recommendations concerning the MOHLTC, requesting that the Ministry recognize its duties under the *Act*, its duty to demonstrate leadership in health and safety matters to employers and workers, that it recognize the authority of MOL, that it infuse all of its decisions and directives with health and safety principles and that it direct employers to adopt the precautionary principle in health and safety matters.

Both unions have also considered the role of the Provincial Infectious Diseases Advisory Committee (PIDAC). PIDAC exists as an advisory body to the Chief Medical Officer of Health "with respect to prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases." In its role as an infectious diseases advisor to the Ministry, it also provides advice regarding matters which affect worker health and safety. However, PIDAC's mandate contains only brief mention of occupational health and it is only very recently that it gained one member with specific expertise in occupational health. The unions believe that it is PIDAC's advice to the Chief Medical Officer of Health and to other senior members of the MOHLTC which is preventing the Ministry from giving further consideration to the unions' concerns about personal protective equipment in the case of pandemic influenza. We believe that the problem in part, may be the lack of occupational health and occupational hygiene

expertise on PIDAC. Consequently, we make recommendations to the Commission which we hope will remedy this problem.

Not included in these submissions are the unions' recommendations with respect to Bill 56, the *Emergency Management Statute Law Amendment Act, 2005*. Bill 56 contains proposed amendments to emergency management legislation, revised from Bill 138, which was addressed in the Commission's Second Interim Report. Both ONA and OPSEU will be preparing submissions in response to Bill 56 assuming the Bill will go to legislative committee hearings. One of our concerns is whether or not collective agreements would apply in an emergency. These submissions may deal with implications for health care worker health and safety and both unions would be pleased to forward their submissions to the Commission upon completion.

Although a tragedy for many, the SARS crisis in Ontario did provide a tremendous push to all workplace parties in the health care sector and to the provincial government, to finally turn their attention to health care health and safety matters. The looming influenza pandemic continues to keep health and safety matters in the forefront. Members of both of our unions have gained a much greater understanding of the importance of health and safety and of their rights under existing legislation, since SARS and in anticipation of a pandemic. It is clear to both of our unions that our members will be much less willing in the future to sacrifice their own safety and health at work if they believe that their employers are not taking all reasonable precautions to protect them.

Our previous submissions identified many problems that contributed to weak health and safety structures and systems in the sector. We believe that our previous recommendations, if implemented, would dramatically improve the health and safety climate in the sector. Our experiences since SARS, reflected in this submission, indicate that many of the problems we previously identified persist, despite efforts by many to make improvements. It is our hope that the Commission will consider these submissions and recommendations, in light of our previous ones and in light of our experiences over the past three years, and make its recommendations accordingly.

ONA/OPSEU

Response to SARS Commission correspondence dated January 30, 2006

1. General

a) Could more have been done during SARS to protect health care workers?

Ontario Nurses' Association (ONA) and Ontario Public Service Employees Union (OPSEU) have previously made lengthy submissions to the Commission, both written and in person in which we offered our analysis of what could have been done during SARS to better protect health care workers. If the Commission has identified a specific area or issue during SARS where you believe we may have more information, please advise us and we will be happy to provide you with any information we have which may be of use.

b) Could more have been done before SARS to prepare for health care worker safety?

SARS was an awakening for everyone. In our previous submissions to the Commission, we identified a number of areas where we believe much more could have been done or could have been in place which would have reduced the impact of SARS in Ontario and on health care workers in particular. We pointed to serious weaknesses in infection control programs and training, weaknesses in communication systems, and failures to comply with existing health and safety legislation, among other things. However, we believe it is useful to raise the following issues, given the knowledge we have gained since SARS:

i) OPSEU and ONA participated in the MOL's Health Care Health and Safety Action Group in 2004 along with representatives from the Ministry of Health and Long-Term Care (MOHLTC), Workplace Safety and Insurance Board (WSIB), various employer associations, safe workplace associations and other unions. At that table, it became very clear to us and to others, including the Minister himself, just how far behind health care health and safety is. One employer representative who originally came from industry and who now heads the occupational health and safety department of a large teaching hospital said at our April 2004 meeting that when he entered the health care sector, he felt like he had taken a step back in time. He advised the

meeting that he felt that hospitals' health and safety practices were the way they were in industry 20 years ago. The more our two unions have attempted in the three years since SARS to work with our members to help them develop effective health and safety systems in their workplaces, the more true that statement rings.

ii) We have outlined previously to the Commission, the problems arising from poorly functioning and non-existent Joint Health and Safety Committees (JHSCs). Arising from our analysis of the problems with JHSCs, we made a number of recommendations which we believe, if implemented will encourage the development of more effective health and safety systems. It continues to be our belief, based on our knowledge of the state of health and safety systems in health care pre-SARS, that the lack of effective JHSCs contributed to the chaos, anxiety and fear among health care workers (HCWs) during SARS. As we stated in earlier submissions, it is also our belief that had effective JHSCs and corresponding health and safety systems been in place, fewer HCWs may have contracted SARS.

In our previous submissions however, we may not have made clear enough our understanding of the part the MOL played or did not play, which we believe contributed to the problems arising from inadequate JHSCs. Previously, we understood that since the MOL had never made the health care sector a priority, it had failed to identify the serious weaknesses with health and safety systems in the sector. However, it is now our understanding that even when the Ministry does begin to focus efforts on the sector, it often fails to examine the content and implementation of health and safety program components.

iii) In the three years post-SARS, it has become even clearer to us that very few health care employers have ever really tried to properly use the internal responsibility system or to fully implement the 1993 *Regulation for Health Care and Residential Facilities*. This became more obvious when the Ministry of Labour launched its “acute care hospital blitz” wherein MOL inspectors visited, most if not all, acute care facilities in the province focusing their visits on certain requirements under the *Health Care Regulation* such as infection control programs and needlestick injuries. Although the two unions were not entirely satisfied with the content of the orders, the

program did reveal serious health and safety gaps throughout the hospital sector. It is our position, that if the MOL had chosen to focus some of its activities on the health care sector pre-SARS, in particular to ensure that employers were complying with the *Health Care Regulation* and the requirement under S.10 of the *Regulation* to have properly fitted personal protective equipment where necessary, some workplace-contracted SARS cases would have been prevented.

iv) The MOL should have had a separate Health Care health and safety program, prior to SARS. Given the experiences of our unions and membership since SARS, particularly the issues which have been revealed following the MOL acute care and long term care blitzes, we now believe that it is necessary for the MOL to create a separate Health Care health and safety program with its own dedicated health care inspectors. During SARS, if the Ministry had had inspectors who were more knowledgeable and aware of the particular hazards and culture of all components of the health care sector (acute, long term, community), they may have been able to play a more active and effective role, rather than choosing to defer to public health authorities in most cases. This proposal will be explored more fully in part 3 of our submission.

v) Despite the fact that WSIB maintains injury and illness statistics and so must have been aware that the health care sector had an extremely high incidence of injuries, and despite WSIB's mandated role to work to prevent workplace injuries and illnesses, it declined to take an active role in identifying health and safety problems in the sector pre-SARS. In 2000, WSIB did initiate its Safety Group Program, although hospitals did not participate until 2003. The Safety Group program was designed to provide employers with a network of firms who pool resources and share best practices and who help each other to develop and manage effective health and safety programs. Although the program may assist poor performers to improve their compliance with *OHSA*, we do not believe the financial incentives provided by the program are justified. We do not believe that employers should receive financial incentives (reduced WSIB premiums and financial rebates) for complying with the law -- something that they should have been doing all along.

Post-SARS, WSIB has taken small steps towards some prevention efforts. Through its funded safe workplace association, the Health Care Health and Safety Association (now renamed Ontario Safety Association for Community and Health Care (OSACH)) and through its continued expansion of the Hospital Safety Group program, it has begun to support some workplace safety efforts. Although not indicative of a shift to embrace a health and safety culture, and although work remains as outlined elsewhere in this submission, these efforts are helpful.

vi) Our final point concerns the role of the Ministry of Health and Long-Term Care (MOHLTC). Since SARS, both unions have had the opportunity to work with MOHLTC representatives on a number of initiatives such as the development of the provincial pandemic influenza plan and other infection control documents. Our role during the consultations has been to attempt to ensure that necessary occupational health and safety principles and controls are inserted into documents which will be used by employers and/or workers. Our experience throughout these consultations has been frustrating and troubling and we have come to the conclusion that the MOHLTC has very little understanding of the *OHSA* and the obligations and duties arising from the *Act*. The MOHLTC is a major funder of the health care sector; it also establishes policies, procedures and guidelines, such as the pandemic influenza plan, for the sector. The MOHLTC has great influence over hospitals and other facilities and is seen to be a leader within the sector. Given our experience over the three years post-SARS, we now believe that the Ministry's failure to understand the importance of health and safety and its failure to promote a health and safety culture in the sector pre-SARS, contributed to the problems our members had during SARS.

Recommendation:

- The Ministry must incorporate into its sector strategies, direction for inspectors to examine the content, quality and implementation of health and safety program components.
- The MOL should develop a separate Health Care health and safety program with inspectors who have special training in health care health and safety issues.

c) *What changes have been made since SARS to increase health care worker safety?*

The list below summarizes a number of activities involving the unions, safe workplace associations, MOHLTC and the MOL which we believe have had or will have positive impacts on health care worker health and safety. Although some of the activities or changes have not had concrete results, we believe they demonstrate an increased understanding of the importance of health and safety issues in the sector. (The list is in no particular order.)

- Minister of Labour's Health Care Health and Safety Action Group was established and met three times in 2004. Although we saw no specific outcomes that could be attributed to the meetings with the Minister, the meetings allowed the unions and other participants to raise with the Minister critical health and safety issues in a frank manner.
- Approximately 200 new MOL inspectors have been hired in the last two years.
- The MOL is in the process or has hired six inspectors to be specifically designated to the health care sector. The actual parameters of their role and responsibilities have not yet been announced.
- Health Care Health and Safety Association (HCHSA) has broadened its consultation process and is seeking union participation in all new program development.
- Increased cooperation between health care unions on health and safety matters
- ONA held a Health and Safety conference in June, 2005 and has developed materials for its membership to improve the functioning of the Internal Responsibility System (IRS) and in particular JHSCs.
- ONA has scheduled a June 2006, health and safety workshop to address the hazard of workplace violence.
- ONA negotiated significant province-wide (central hospital collective agreement) and local collective agreement health and safety language
- OPSEU through collective bargaining with the Ontario Hospital Association on behalf of hospitals included in the central collective agreement, has created a Joint Central Committee on Health and Safety (JCCHS) to address province-wide health and safety matters in the hospital sector. The JCCHS has the ability to make health and safety recommendations to the OHA's Health and Safety Advisory Committee.

- The unions, through the Ontario Federation of Labour Health and Safety Committee, now have been given paper copies of the MOL policy and procedure manual. However, our request to have the manual available online has not been granted.
- The MOL and WSIB appear to have developed a strategy to share workplace injury and illness information, which is informing the MOL targeted visits in the health care sector.
- The Public Health Agency of Canada was created in September 2004, following a recommendation in the report by the National Advisory Committee on SARS and Public Health. The Agency's stated mission is to promote and protect the health of Canadians through leadership, partnership, innovation and action in public health. The new agency has responsibility, among other things, for developing infection control and occupational health standards.
- In 2004, the MOHLTC announced $1 million to be invested in the recruitment of qualified Infection Control Practitioners (ICPs) for the hospital sector. Twenty-five ICPs were to be funded for fiscal year 2004/05. An additional $2 million was to be invested in creating regional infection control networks.
- Health care employers in acute care and long-term care for the most part appear to be complying with their regulatory obligations (and the CSA respirator program standard) to continue to perform respirator fit-testing at least every two years.
- The MOL sent inspectors to most, if not all Ontario acute care facilities and a number of long-term care facilities in 2004-05 to investigate compliance with certain parts of the *OHSA* and the *Health Care Regulation*.
- Organizational changes have been made to Ontario's public health system granting more authority to the Chief Medical Officer of Health, who is now an Assistant Deputy Minister.
- The MOHLTC has requested input from the health care unions and other stakeholders in a number of consultation processes such as the development of the provincial pandemic influenza plan and other infection control initiatives.
- MOHLTC has funded two specific health and safety programs in 2004-05: in acute and long term care funding was offered to purchase lifting devices; and in acute care only, one-time funding was offered to assist facilities in purchasing safety-engineered medical devices to reduce sharps injuries.

- In October, 2005, the WSIB released draft Early and Safe Return to Work Policies for stakeholder feedback. The draft policies are an improvement, but do not go far enough to protect worker health and safety. Reminding the WSIB that their priority mandate is to "promote health and safety in workplaces and to prevent and reduce the occurrence of workplace injuries and occupational diseases" (section 1 *WSIA),* ONA, with the OFL has responded that more attention must be paid to occupational health and safety principles and legislation in the decision-making process.
- At labour's urging, WSIB has involved the MOL Director of the Occupational Health and Safety Branch and the Ontario Federation of Labour in discussions regarding best practices to incorporate health and safety principles and legislative obligations into their decision- making processes.

d) *What more should be done to increase health care worker safety?*

ONA and OPSEU have provided lengthy submissions and recommendations previously to the Commission. This subsequent submission will provide further recommendations which we believe will provide the Commission with concrete ideas about what still can be done to increase health care worker health and safety.

e) What role is there, in health care worker safety, for the precautionary principle?

The utility and validity of the application of the "precautionary principle" to real-life situations has been the subject of much discussion and debate in the environmental and health and safety communities for years. The Commission now asks what role the principle has in health care worker health and safety. Before considering particular circumstances in health care, which the unions believe make the application of the precautionary principle critical, it is important to define the term and to situate it within a historical and scientific context.

A 2001 European Environment Agency paper describes the principle as "an overarching framework of thinking that governs the use of foresight in situations characterized by uncertainty and ignorance and where there are potentially large costs to both regulatory action and inaction…" (*Late Lessons from Early Warnings: the precautionary principle 1896-2000* http://reports.eea.eu.int/environmental_issue_report_2001_22/en).

Perhaps the most widely used summary of the "precautionary principle" is as follows:

> "When an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause-and-effect relationships are not fully established scientifically" (January 1998 *Wingspread Statement on the Precautionary Principle* http://www.johnsonfdn.org/conferences/precautionary/finpp.html).

Application of the principle therefore requires protective action in the absence of scientific certainty. It is based on the principle that people and the environment should not be exposed to hazards if exposure can be avoided. Advocates of this approach refer to precaution as the compass policy makers use to lead them when science is uncertain.

The European "Late Warnings" report furnishes compelling evidence of the need to adopt the precautionary principle in policies affecting human health and the environment. Using 14 separate cases, including asbestos, lead and polychlorinated biphenyls (PCB), the authors demonstrate how scientists and policy-makers illogically have argued that the absence of scientific proof of harm is in fact, synonymous with safety.

In commenting on a 1906 UK industrial disease inquiry involving asbestos, the European Agency points out:

"Dr. Murray's view that 'no evidence of harm' is the same as 'there is evidence of no harm' is an early example of a common fallacy that has inhibited the identification of many dangerous substances which were initially considered to be harmless ('false negatives')." (Page 53, *Late Lessons from Early Warnings: the precautionary principle 1896-2000*)

This approach towards asbestos resulted in decades of delays in protecting people and the environment, resulting in countless injuries and death.

Traditional science is not predisposed to action. A strict scientific approach strives to disprove theories, not to prove them, and seeks near-perfect evidence before accepting cause-and-effect relationships. Scientific disciplines are by necessity, often quite compartmentalized. In complex issues involving human health or the environment, dominance by narrowly-focused single disciplines, rather than by generalists who can employ a multidisciplinary approach may result in missing evidence relevant to a larger picture.

In cases where relevant science does exist, it must be transparent and readily shared with other disciplines, stakeholders and policy makers before it will be trusted by them, particularly when areas of uncertainty persist.

The examples presented in the European Environmental Agency document, demonstrate how special interest groups can and will hide behind the absence of absolute scientific proof that a substance is harmful and accordingly describe a substance as “safe”, when in reality the absence of absolute proof only denotes continued scientific uncertainty. In such situations, scientists and special interests cite quantitative and other analyses that look objective or scientific and discount knowledge that has been garnered through personal life experience or that has not been quantified.

The European study cites the telling example of Lucy Deane, a factory inspector who in 1898, documented asbestos work having “easily demonstrated danger to the health of workers and…ascertained cases of injury to bronchial tubes and lungs medically attributed to the employment of the sufferer.” (Page 53, *Late Lessons from Early Warnings: the precautionary principle 1896-2000*) This and other anecdotal “non-scientific” evidence of harm was ignored, and adequate measures to protect workers were not implemented for many more decades.

Industry and establishment spokespersons over the years have dismissed workers' health and safety concerns as exaggerated and often irrational unless an iron-clad scientific case had been made. However, the European agency paper paints compelling pictures of a history replete with examples which demonstrate that failing to take precautions when a hazard is suspected is really the irrational approach.

Some may argue that the precautionary principle approach ignores science. However, the unions argue that this approach advocates more science, not less, to better understand the hazards faced by people and the environment. We argue that the studies should be done and the evidence gathered; however, we believe that in cases where we know enough to postulate that an activity or a substance raises a threat to workers' health, action must be taken to protect workers even though some cause-effect relationships have not been definitively proved.

Despite the naysayers, the “precautionary principle” has been widely adopted internationally in policies and treaties. In 2001, the Canadian Supreme Court in 114957 Canada Ltée (Spraytech, Société d’arrosage) v. Hudson (town) recognized the “precautionary principle” as a tenet of international law respected in Canada. The court confirmed that in matters pertaining to protecting health, “Where there are threats of serious or irreversible damage, lack of full scientific certainty should not be used as a reason for postponing measures to prevent environmental degradation.”

Though not specifically set out, in our view, the precautionary principle is embodied in the Ontario *Occupational Health and Safety Act* in the general duties sections which require employers and supervisors to “take every precaution reasonable in the circumstances for the protection of a worker.” As discussed further below, this principle should be more explicitly set out in the legislation.

MINISTRY OF HEALTH AND LONG-TERM CARE

The unions’ experience since SARS has led to concern about MOHLTC’s use of “science” to formulate policy in matters of health care sector occupational health and safety. In particular, the Ministry’s current refusal to recommend respiratory protection other than surgical masks in its pandemic influenza plan for workers facing unknown or uncertain infectious disease cannot help but evoke the ghosts of lessons past. For instance, despite considerable international scientific uncertainty regarding the transmission route of SARS, the Ministry following the advice of the Provincial Infectious Diseases Advisory Committee (PIDAC), ultimately and unilaterally declared that SARS is droplet spread. At the March 30, 2005, Pandemic Influenza Steering Committee meeting, PIDAC dismissed additional evidence indicating that SARS may be airborne. As well, cast against the backdrop of considerable international (and local) evidence of airborne hazards associated with aerosol-generating procedures, the Ministry’s stubborn pronouncement that surgical masks offer sufficient protection to workers is worrisome.

Following, using the example of the current debate around appropriate respiratory protection, and in light of our discussion about the precautionary principle, we will examine the approach taken by the MOHLTC and its outcome to date:

- **Equating "no evidence of harm" with "evidence of no harm"** The MOHLTC has cited questionable SARS studies which find that there is no conclusive evidence that SARS is airborne, to argue that the evidence proves that SARS is not airborne
- **Compartmentalized science** The MOHLTC has failed to consider, let alone invite, the views of other disciplines regarding routes of transmission before making decisions regarding the hazards of and protections for infectious disease in the workplace. Only recently, after pressure from the unions did the MOHLTC invite a MOL health and safety expert to participate on the Provincial Infectious Diseases Advisory Committee (PIDAC).
- **Ignores other evidence** The MOHLTC has discounted the valuable anecdotal evidence of workers who battled SARS and of occupational health and safety experts in the health care sector as well as other experts around the world. For instance, Dr. Raymond Tellier, (MD MSc FRCPC CSPQ Microbiologist, Hospital for Sick Children, Senior Associate Scientist, Hospital for Sick Children, Associate Professor, University of Toronto) has recently conducted a literature review which strongly suggests that influenza A is airborne. Although the MOHLTC/PIDAC is aware of Dr. Tellier's work, there is no indication that it has considered this evidence.
- **Ignores evidence of failure of its own approach** The flawed response to the recent Legionnaires' outbreak (detailed in Part 2, 7 & 8 of this submission) provided evidence that the MOHLTC's approach to health care worker health and safety must be reconsidered. There is no evidence to date that the MOHLTC has heeded this evidence.
- **No transparency** The unions have repeatedly requested at Pandemic Steering Committee meetings, that the MOHLTC share the scientific evidence upon which it is making its decisions about protections against infectious disease. To date the MOHLTC has failed to provide any convincing scientific rationale for its decisions. Until recently, the MOHLTC seems to have been withholding information even from its own sister ministries. For example, it appears to the unions that the MOL representative involved in these discussions at the Pandemic Influenza Steering Committee and elsewhere is also ignorant of the science and rationale upon which the MOHLTC is basing its decisions. MOHLTC's current propensity for secrecy undermines trust and makes us reluctant to rely on "science" that is generated in such a closed environment.

- **Claims that workers are overreacting and irrational** MOHLTC and health care sector leaders have frequently suggested that calls for respiratory protection for health care workers facing unknown respiratory disease are generated by "overreaction," and "psychological effects" of SARS. Because the workers and their unions cannot offer conclusive proof of the risk of airborne transmission, we are judged as being irrational in our requests. The psychological effects of SARS among HCWs have been significant and must be acknowledged. But it is improper and irrational for the MOHLTC to cite this as reason to resist providing respiratory protection for health care workers. We believe it is irrational and contradictory for the MOHLTC to deny HCWs inside facilities access to respiratory protection, while on the other hand continuing to provide it for emergency services workers. It is irrational for the MOHLTC to operate under a façade of certainty when the world, scientific and policy-making community remain very uncertain about the issues surrounding transmission routes of SARS and various forms of influenza. Despite its clear decision, reputedly based on science, that respirators are not needed for health care workers, PIDAC itself recently publicly revealed its own uncertainty. At a presentation/debate held at the Hospital for Sick Children in Toronto on March 9, 2006, regarding "Influenza Transmission: Implications for Infection Control", a PIDAC member said, "Maybe in this next pandemic we will get a clear indication of how influenza is transmitted."
- **Regression in occupational health and safety** Post SARS stakeholders met with MOHLTC representatives to develop a febrile respiratory illness document (FRI) that in Section 3.3 highlighted the role of JHSCs and adopted a precautionary approach. The section stated: "When there is disagreement about appropriate infection control practices among those caring for a patient with FRI, staff should follow the practice of using the higher level of precautions until consensus has been reached." Despite protest from the unions, the MOHLTC has since changed this consensus document (and the OHPIP) to remove the clause quoted above. Only a few brief references to Joint Committees remain in the new document including a reference to JHSCs naming them incorrectly.

In our ever-changing world of public and occupational and environmental health and safety, the precautionary principle has been increasingly adopted by scientists, governments and courts around the world and here in Canada. When hazards and risks are known and the science is "certain," it is appropriate to adopt a risk assessment approach to protect against hazards.

However, when the science is still “uncertain” but when there is reason to believe that a hazard exists, we must integrate the precautionary principle into our risk assessments.

The unions believe that the behaviour and decisions made by the MOHLTC during and post-SARS, provide us with ample evidence of the need to expressly codify the precautionary principle into the *Occupational Health and Safety Act* and its regulations. This appears to be especially critical for the health care sector given its apparent propensity to ignore sound occupational health and safety principles. A legacy of codification of the precautionary principle in health care health and safety would honour those who suffered in the battle against SARS.

Recommendation:

- Expressly codify the precautionary principle into the *Occupational Health and Safety Act* and its regulations

f) Is there any room in Ontario for the integrated focus on occupational health and safety provided in the U.S. by the National Institute for Occupational Safety and Health (NIOSH) and in British Columbia by the Occupational Health and Safety Agency for Healthcare in BC (OHSAH)?

Both OPSEU and ONA welcome the question by the Commission about the possible need for an integrated focus on health and safety such as that provided by NIOSH in the U.S. or by OHSAH in B.C. Although neither union has a full understanding of the historical factors which led to the creation of NIOSH or OHSAH, or even to the creation of the Canadian Centre for Occupational Health and Safety (CCOHS), we recognize the importance of each of the three organizations to our work and others in the health and safety field. We also must comment on the invaluable role played by the Workers Health and Safety Centre in providing us with health and safety information and resources and in delivering health and safety training to large numbers of our members. Additionally, the Health Care Health and Safety Association has recently been producing documents and resources that are extremely useful to our membership. All of these organizations provide us with resources, research material and guidelines which we use in our daily work.

However, the fact that on any one issue, we routinely turn to all five of these organizations for different types of assistance, in itself reveals a structural weakness. We would welcome the existence of an Ontario-centred organization which could provide a more integrated focus on health care health and safety. However, without further consultation among ourselves and within the broader labour movement, we hesitate to examine each of the organizations listed above to determine where duplication and overlap occur or to make suggestions about how to better streamline and coordinate resources.

We recognize that there are large differences in history, factors that led to the creation of each organization, organizational structure, funding, reliance on political support, services offered, types of research performed, and classifications of staff retained by all of the organizations. Rather than examining and analysing each of them to determine which aspects of which one might be most useful to further the health and safety needs of Ontario's health care workers, we offer below a short list of factors which we believe are integral to the creation of an integrated resource:

- assured long-term funding not dependent on which provincial political party is in power or the success or failure of collective bargaining.
- the health and safety agency would have sufficient resources to stay abreast of health and safety developments in the health care sector in Canada and internationally.
- the health and safety agency would have the staff resources or other capacity to conduct research to reduce work-related injuries and illnesses.
- the health and safety agency would be governed by a bi-partite board of employer and union representatives. Representatives of the MOL and MOHLTC to sit as non-voting resources to the governing board.
- the health and safety agency would have the technical resources on staff to assist workplaces at the request of JHSC to analyse health and safety problems and to make recommendations to resolve problems.
- the health and safety agency would provide the expertise upon request to assist JHSC to create effective policies and programs.

While we do not believe this is an exhaustive list, we believe it contains most of the key aspects necessary to establish a provincial health care health and safety body to further the growth of health and safety initiatives in the health care sector.

Recommendation:

- That the Ontario Government create an occupational health and safety resource similar to NIOSH and OHSAH, ensuring this resource integrates the factors noted above.

2. Cooperation, Consultation, Communication and Coordination

a) *Are there any lessons from SARS about cooperation, consultation, communication and coordination in respect of health care worker occupational health and safety?*

The unions' experience during SARS clearly demonstrated to us the absence of a health and safety culture in the health care sector. Throughout the outbreak, failure among the key players to cooperate, consult, communicate and coordinate their efforts effectively was the norm, rather than the exception. SARS taught us that to protect our health care workers from similar harm in future emergencies, we must work to establish open, transparent, clear communication, and to ensure that there is clear direction, leadership, cooperation, consultation and coordination among all stakeholders in matters of health and safety. We believe that the recommendations we offered the Commission in our earlier submission, especially those recommendations found in the sections concerning the Provincial Operations Centre and Ministry of Labour Policies and Procedures speak directly to the themes raised in this question.

b) *Is there now an adequate level of cooperation, consultation, communication and coordination among separate organizations that deal with health care worker safety, for instance, the Ministry of Health and Long-Term Care, the hospital system, the public health system, the Ministry of Labour, health care work organizations, infection control departments and organizations, the Workplace Safety and Insurance Board and experts in the field of health care worker safety, such as occupational hygiene professionals and occupational health professionals?*

This question highlights the necessity of cooperation, consultation, communication and coordination among the separate organizations that deal with worker health and safety in order to build a health and safety system that works. In 2004, then-Minister of Labour Chris Bentley spoke to the Minister's Health Care Health and Safety Action Group about the need to develop a health and safety culture in the health care sector. The cultural shift envisioned by Minister Bentley depends, among other things, on real cooperation, consultation, communication and coordination between stakeholders.

The unions are extremely supportive of Minister Bentley's vision. We hope to witness a day when that culture exists, when it is understood and accepted within the health care sector that the MOL leads the province in establishing and enforcing occupational health and safety standards. We hope to see the MOHLTC fulfil its leadership role in the sector by modelling and advocating occupational health and safety behaviours to employers. WSIB would fully accept and promote its mandate to prevent workplace injuries and illnesses and take active steps to promote health and safety in the workplace. WSIB-funded safe work associations such as Health Care Health & Safety Association, Workers Health and Safety Centre and Occupational Health Clinics for Ontario Workers, will be invited by health care employers to support occupational health and safety efforts in their facilities. Employers will consult and support JHSCs who will work hand-in-hand with infection control departments to ensure that health care workers are protected from harm. The entire sector will welcome input from health and safety and occupational hygiene professionals to maintain current and effective protective measures. In such a culture, workers will be confident that their employers and the government regard their health and safety as a priority in the workplace.

Given the tragic lessons of SARS, and given the time that has passed and the extensive resources invested by numerous stakeholders into health and safety activities, one might think we would be closer to creating that seamless web of organizations necessary to ensure health care worker health and safety. Sadly the evidence suggests otherwise. Both of our unions have worked diligently on a number of fronts over the past three years, and although some progress has been made (see our response to Q.1.c.), we have developed increased concerns in other areas.

In particular, in our dealings with the MOHLTC over various infection control issues, communications strategies and pandemic influenza planning, we have found that some representatives of the Ministry appear to have adopted an adversarial attitude towards the unions as we promote the health and safety needs of our members. We have discovered important areas of conflict within the MOHLTC itself which we believe is having an impact on health care health and safety. We are also witnessing important disagreements between the MOHLTC and the MOL on issues concerning worker health and safety. This government discord cannot help but spill over to employers in the hospital system, public health, long-term care and community care systems. Our members are anything but confident that their

employers are mindful of their health and safety, and given the current situation, we are not at all confident that all of our members would report for duty in another crisis similar to SARS.

Following is a brief description of our experiences over the post-SARS years with some of the key players in our non-existent health care health and safety system. We hope that our description and analysis will indicate to the Commission some of the critical areas where cooperation, consultation, communication and coordination must be improved if we hope to be able to send our health care members into the next emergency situation with the knowledge that their employers are taking all reasonable precautions to protect their health and safety.

MINISTRY OF HEALTH AND LONG-TERM CARE (MOHLTC)

The state of occupational health and safety in Ontario health care facilities surprised Minister of Health George Smitherman in the early days of his portfolio. Speaking to an audience of nurses in May 2005, he revealed, “One of the things I was struck by …[was] the number of nurses that work in environments, hospital environments perhaps more particularly, that actually are unsafe…We have a lot of work to do on that.” Participants in the Minister of Labour’s Health Care Sector Health and Safety Action Group corroborated Smitherman’s conclusion. Minutes and notes from the three meetings outline numerous areas where participants confirmed to the Labour minister that serious health and safety problems exist.

Although historically, our unions and others have identified lack of enforcement of the *OHSA* by the MOL, as a critical factor contributing to inadequate health and safety conditions, recent experiences by OPSEU and ONA have led us to identify the MOHLTC as another part of the problem faced by our members. The MOHLTC develops legislation and sets standards and guidelines for various components of the health care system. It has been argued that in certain circumstances, including during SARS, the MOHLTC should be considered a “supervisor” within the definition of the *OHSA*, with all the attendant duties of that position. The court has demonstrated openness to that argument stating in a decision of August 22, 2005: "For the purposes of this motion I am not prepared to exclude the possibility that the Crown would be found at trial to be a supervisor to whom the statutory duties and standards applied." It is our belief that the MOHLTC should lead its sector by modelling and demanding adherence to occupational health and safety principles and the law. We have argued previously to the

Commission that you cannot properly attend to infection control measures for patients without ensuring that the workers who care for them are also protected. Similarly on a macro scale, the MOHLTC cannot place all of its attention on the patients/clients/residents who are cared for by the facilities it funds, without also attending to the workers who perform the work. While the Ministry appears to have accepted that argument in some instances and for example decided in 2004/05 to fund the purchase of patient-lifting devices in acute and long term care facilities to reduce back injuries, in other areas it has actively resisted inserting health and safety concepts and principles into the documents it produces.

Over the last two years, the unions have had substantive interactions with three main areas which are a part of, or linked to the Ministry -- the Emergency Management Unit (EMU), Provincial Infectious Disease Advisory Committee (PIDAC) and Public Health officials. We have been addressing issues and/or have been consulted on important areas such as the provincial pandemic influenza plan (OHPIP), the Febrile Respiratory Illness (FRI) document, several predecessor documents to FRI documents, various infection control documents, respiratory protection programs issues, and the Toronto Legionnaires' Disease outbreak. In each of these projects or events, our goal has been to ensure that our members and other HCWs are working, or will be working, in environments which are as safe as reasonably possible.

We have been working, for the most part, with many of the same players from the MOHLTC on each of these events or projects. Yet in every project in which we have participated our experience has been that in health and safety matters, we are starting at zero. It seems the Ministry cannot build on past achievements. Instead it waits for us to repeat the same basic principles, over and over, before incorporating even bits of them in any documents. A particularly remarkable example occurred when, despite months of meetings and discussions where the unions stressed the importance of writing workplace health and safety principles, such as consultation with JHSCs, and worker training, into the OHPIP document, the Ministry’s first draft of the plan was silent with respect to health and safety. After the unions raised the “oversight” at our first 2005 OHPIP steering committee meeting, the MOL’s Dr. Genesove led a last minute initiative to insert some occupational health and safety principles into the document.

The struggle to add occupational health and safety content into the OHPIP document would be comical were it not so serious. Subsequent to Dr. Genesove's contribution, made in consultation

with the unions, an Occupational Health and Safety appendix was added to OHPIP which was posted on the MOHLTC website at the end of June, 2005, as part of its larger OHPIP plan. To see entire June 27, 2005, version, go to Ontario Legislative Assembly Library at http://www.ontla.on.ca/library/repository/mon/11000/254032.pdf) In January 2006, the Ministry reposted the OHPIP on its website (still dated June 2005), ostensibly to include the updated FRI document. However, although it had advised the Pandemic Influenza Steering Committee, about the addition of the FRI document as an appendix, it neglected to advise us that it was removing altogether the Occupational Health and Safety appendix for which we had fought so hard. Only by chance did the unions stumble over the fact the appendix had been deleted. When the unions challenged the EMU (the Ministry body in charge of the OHPIP project) about the deletion, they reluctantly agreed to re-insert some health and safety content and suggested that the unions take on the task of writing it.

As ONA and OPSEU prepared this part of our submission, we discovered that within the week since we wrote an earlier draft of the paragraph, the OHPIP has again been revised. The original June 27, 2005 Appendix 6 health and safety material has been placed back into OHPIP joining the FRI document within the same appendix. The FRI document remains in the OHPIP, despite written assurances stating that it would be removed.

Another example of the failure of the Ministry to understand the importance of including health and safety content in its pandemic plans and the need to effectively consult with stakeholders, surfaced in October, 2005. At a Pandemic Influenza Steering Committee meeting, participants learned that a "*Guide to Influenza Pandemic Preparedness and Response in Long-term Care Homes*" had been produced which contained no occupational health and safety components. Neither union had been invited to provide input to the document. The unions insisted that the Ministry provide us with a draft for review. And despite our comprehensive recommendations, very little in the document was changed to reflect our input. Then, on December 5, 2005, the EMU wrote in response to our input that they were, "not sure they would ever meet the expectations of organized labour regarding health and safety…" Comments such as this have led us to believe that MOHLTC views occupational health and safety as a partisan issue, with occupational health and safety proponents as their adversaries.

A key problem area during the SARS crisis, identified by all of those who have commented, was communication among and between the workplace parties and government authorities. In our earlier submissions to you, OPSEU and ONA devoted a great deal of effort documenting communications problems and making recommendations to address them. Consequently, when the OHPIP Steering Committee established a Communications subcommittee to address communications issues during a pandemic influenza emergency, ONA eagerly chose to put a representative on the subcommittee. It was the unions' understanding and hope, that we would take the lessons learned from SARS and apply them to this plan. Critical for the unions was the development of a communication plan which would be able to effectively link HCWs to accurate, accessible information about pandemic influenza, changing workplace conditions, health and safety practices, infection control practices, availability of assistance with things such as child care and transportation, and more.

We have been extremely frustrated with the processes (or lack of them) and products/plan developed by the subcommittee under the guidance of EMU. To date, a few “products” have been produced through the subcommittee to raise public awareness of the possibility of a pandemic, but nothing of substance has been developed to ensure that HCWs will have access, in an emergency, to the information they need to work safely and to have access to the support they will need.

In Toronto, in September 2005, during the Legionnaires‘ Disease outbreak, we had a glimpse of how little progress has been made to improve communication networks. Although this was a small outbreak contained for the most part in one facility, workers were unable to get reliable, consistent information about what was going on and what they were supposed to do to work as safely as possible. The Report of the Expert Panel on the Legionnaires' Disease Outbreak in the City of Toronto (September/October 2005) comments in some detail on the failures of existing communications systems to keep contact information up to date, getting information to community providers and "ensuring information gets to front-line staff in a timely way." Knowing that current systems could not cope with this small, confined outbreak, makes our experiences with the Communications Subcommittee even more frustrating.

After a year of little progress in the Communications Subcommittee work, ONA again raised its concerns to the OHPIP steering committee and finally in February 2006 the MOHLTC hired a consultant to develop a crisis communication plan.

PROVINCIAL INFECTIOUS DISEASES ADVISORY COMMITTEE (PIDAC)

PIDAC was created by the MOHLTC to "advise the Chief Medical Officer of Health with respect to prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases." Advisory committee members are considered experts in infection control, infectious disease, medical microbiology, public health and epidemiology. Very recently, an occupational health and safety physician (the MOL's Dr. Genesove) was added to the committee, and we have been advised that an occupational hygienist is to be added as well. These additions were made following ONA's complaint to Dr. Basrur concerning the lack of occupational health and safety expertise on PIDAC. A careful reading of PIDAC's mandate and activities indicates that other than the recent addition of Dr. Genesove to its membership, it has little expertise and no clear direction to address infectious diseases from an occupational health perspective.

As a scientific resource, the PIDAC may provide valuable advice to the MOHLTC on infection control strategies. However, to date, our experience with PIDAC's contribution to the development of the FRI document referenced above and to the pandemic influenza plan, is that PIDAC representatives simply do not "get" basic occupational health and safety principles. Our experience has been that the MOHLTC relies heavily on the advice it receives from PIDAC and appears to use that advice to buttress its arguments against including what we consider to be reasonable health and safety guidance in its documents.

In the final section of our submission, in our responses to your query about the roles of the MOL and the MOHLTC in infectious disease outbreaks and during emergencies, as well as their roles in establishing and enforcing health and safety standards, we go into greater detail about our concerns with PIDAC and its possible negative effects on worker health and safety.

In this section of the paper devoted to the concepts of cooperation, consultation, communication and coordination, it is also useful to describe some of the problems we have encountered with PIDAC and its impact on MOHLTC. For example, the unions have repeatedly raised our concerns about the level of respiratory protection needed by workers during a pandemic influenza emergency, when performing or assisting with various procedures with patients that may result in airborne transmission of infectious diseases, when dealing with unknown infectious illnesses which may be airborne, and the requirement for respiratory protection programs in health care facilities. We have raised this issue repeatedly with the MOHLTC at the Pandemic Influenza Steering Committee verbally and in writing, as well as in correspondence to the Minister himself, advocating the inclusion of sound health and safety principles in the Ministry's guidance around this issue.

During the Fall of 2005, when it became clear to the unions at the Pandemic Influenza Steering Committee that MOHLTC in its pandemic influenza plan intended to take the position that surgical masks would provide adequate respiratory protection to workers, both unions began to request the scientific evidence on which the Ministry is relying.

At a November, 2005 Pandemic Influenza Steering Committee meeting both unions specifically requested to be provided with the written scientific rationale which supported changes to the OHPIP and to the FRI document which indicated that in all cases, with the exception of infectious pulmonary tuberculosis, surgical or procedure masks would provide adequate respiratory protection to HCWs. The unions were not insisting that HCWs be provided with N95 respirators in all cases when caring for those with respiratory illnesses; we were requesting the evidence to support what kind of respiratory protection was necessary in which situations. All of the research we had done was providing us with more evidence that influenza could be transmitted by the airborne route and that additionally, N95s should be worn while performing certain tasks considered to be “high-risk.”

The chairperson of the Pandemic Steering Committee committed that a major portion of the Steering Committee meeting in January 2006, would be devoted to the respiratory protection question. At that meeting, the Ministry of Labour representative presented a cross-jurisdictional analysis which indicated that in most other jurisdictions he surveyed, N95 respirators are recommended in situations where Ontario's pandemic influenza plan (and FRI document)

recommend the use of surgical masks. Several stakeholders in attendance expressed concern about the variance from international standards in our plan, and the Ministry of Labour indicated it would enforce the use of respiratory protection (N95 respirators) at least for aerosolizing procedures.

At that meeting, we expected to be presented with scientific evidence by the PIDAC representative to support the PIDAC/MOHLTC decision to recommend surgical masks in most situations. No new evidence was provided to the Steering Committee by the PIDAC representative despite the document provided by the MOL indicating Ontario is out of line with other major world players. The MOHLTC indicated that it had no plans to change its guidance contained in OHPIP and the FRI document. As previously noted, in January 2006, the EMU and the PIDAC revised and reposted the OHPIP document to remove the occupational health and safety appendix, replacing it with the FRI document which we had previously criticized for its general health and safety deficiencies, and in particular for its rejection of the need for respiratory protection for workers.

Following the January change to OHPIP, ONA communicated its concerns to the province's Chief Medical Officer of Health, Dr. Sheela Basrur. In particular, the union raised the issue that the FRI document did not properly belong inside the pandemic influenza plan, since its primary use was in non-outbreak conditions. Secondly, the union objected to the loss of the health and safety appendix. Dr. Basrur, in her response to ONA, February 16, 2006, agreed that the FRI document should be removed and that a health and safety document should be included within OHPIP. As noted above, the FRI document still remains in OHPIP although the original health and safety Appendix 6 has been put back.

Strangely, the only direction which remains in the OHPIP for the use of N95 respirators is for emergency services workers, a male-dominated workforce. We have been advised by the MOHLTC that EMS workers should have respiratory protection because “they regularly go into environments where the health risks are unknown”. The same rationale is repeated word-for-word in the Report of the Expert Panel on the Legionnaires’ Disease Outbreak. There is no similar acknowledgement that health care workers in facilities and in the community also may be in “environments where the health risks are unknown.” An arbitrary line is drawn at the health

care facility door as an unprotected female-dominated workforce receives patients delivered by the fully equipped emergency services workers.

As ONA said in a letter to Premier McGuinty, we believe that if PIDAC is challenging respirators for airborne hazards and respirator fit testing, it is exceeding the boundaries of its expertise. Occupational and industrial hygiene engineers and other experts, standard-setting bodies, other agencies and industrial unions must be consulted and their opinions, research and practices considered before respirators and fit testing are abandoned.

Our unions are approached regularly by members and non-OPSEU/ONA occupational hygiene community members, expressing frustration, concern and support as we continue to press for clear, responsible government direction to protect the health and safety of health care workers. Following are recent examples our unions have experienced which further demonstrate poor communication and failures to cooperate and coordinate as described above.

Legionnaires' Outbreak

The unions understand that the Public Health system relies on PIDAC for guidance on new and emerging infectious diseases. During the 2005 Legionnaire's outbreak at a long-term care facility in Toronto, the MOHLTC/PIDAC/Public Health in Toronto issued a Health Notice advising employers and workers to employ "droplet protection" measures to protect themselves from the unknown (at that time) illness. The Health Notice was based on guidance from the FRI document. Ultimately, the illness was identified as Legionnaires' Disease, an airborne illness against which droplet precautions offered no protection. At the same time as Public Health authorities were recommending that employers and workers follow guidance from the Health Notice, the Ministry of Labour was advising and at times ordering employers to provide respirator protection to their employees while the mode of disease transmission remained unidentified.

We have provided a more complete account later in this submission of the confusion, anxiety and possible risks to worker health and safety which arose as a result of this failure on the part of government authorities to cooperate and coordinate their efforts. We use this example later to argue against granting the MOHLTC an enhanced role in occupational health and safety

matters. However, we believe it is a useful example to cite here in this portion of our submission dealing with issues of communication, cooperation, consultation and coordination.

Thunder Bay Regional Hospital

Since SARS, the Ministry of Labour has required that health care facilities where there is a risk to workers of being exposed to an airborne infectious disease perform respirator fit-testing for workers at least every two years in accordance with the CSA respirator standard. Nevertheless, in part because of contradictory messages coming from some branches of the MOHLTC and from PIDAC members, respirator fit-testing programs continue to be questioned by some employers. In April, 2005, an employer representative on the JHSC who the unions understand is a PIDAC subcommittee member advised the Thunder Bay General Hospital JHSC that the hospital would no longer require workers to wear respirators, and therefore no more fit-testing would be done. This advice was given to the hospital JHSC and posted in the workplace, long before the MOHLTC and PIDAC publicly began to move away from requiring workers to use N95 respirators in certain circumstances. Two months later, at the June 2005, JHSC meeting, the employer reversed its opinion, now advising JHSC members that the MOL did not authorize the move away from respirators. Events such as this only contribute to worker confusion and mistrust of directions received by their employers.

Sunnybrook and Womens' College Hospital

Recently, without consultation with the JHSC (as required under section 9 (3) (b) of the Regulation *for Health Care and Residential Facilities*), Sunnybrook Hospital revised its respirator protection program by removing Stryker suits (a brand of personal protective equipment) from hospital units. The employer representative, a PIDAC member, relied on PIDAC having "identified the transmission of SARS as droplet and contact transmission," as the reason for removing Stryker suits. The employer representative gave no reason for effecting the change without first consulting with the JHSC as required by law. The Stryker suits used at Sunnybrook include powered air purifying respirators (PAPR), yet the Sunnybrook employer representative, advised the union in an email, "Although they could provide a barrier against droplets, they were not designed to protect against airborne transmission."

Not only do we not understand this statement about PAPRs, which are designed to protect against airborne hazards, it is perplexing that the employer representative reached such a conclusion about airborne transmissibility given the international scientific uncertainty about this issue. The employer representative/PIDAC member advised the union that the Stryker suits did not provide more protection than traditional PPE, without citing proof of that assertion. In fact during SARS, staff found that the cessation of nosocomial transmission of SARS actually coincided with the introduction of Stryker suits. Workers now have an increased level of comfort using them in circumstances when there is known or suspected airborne disease, when they lack scientific certainty about transmissibility, and when they perform high-risk respiratory procedures which can make a droplet-borne disease airborne. Union members are very disturbed by this latest controversy. The employer's response reveals lack of transparency and consultation (as required by the *OHSA),* lack of understanding of respiratory protection and occupational health and safety principles and law, disregard for contrary evidence, and overall regression in occupational health and safety. Events such as this only contribute to worker confusion and mistrust of directions received from their employers.

Ontario Hospital Association (OHA)

The OHA also is a victim of confusing advice about respiratory protection programs and fit-testing. On the OHA website, the Health and Safety Advisory Committee (HSAC), the body which provides health and safety advice to OHA members has had posted since July 2005, a document recommending that hospitals implement full respiratory protection programs in their facilities. Yet at an OHA Joint Industry Meeting with unions on February 9, 2006, an OHA spokesperson indicated that the OHA supports PIDAC's position on respiratory protection. At the same time as this comment was made, the original HSAC guidance to members remained up on the OHA website. When these contradictory messages were raised by OPSEU at a February 15, 2006, meeting of the Joint Central Committee on Health and Safety (JCCHS), the OHA representative acknowledged that the HSAC guidance was still posted, but that it was now under review.

The contradictory messages inevitably lead to confusion within and between hospitals, Public Health, and the community and long-term care sectors. The unions believe that the MOHLTC's actions and messages to date inhibit the creation of a health and safety culture in the sector.

MINISTRY OF LABOUR (MOL)

As we have argued above and as we demonstrate in our submissions in response to the Commission's questions about the roles of the MOL and MOHLTC at the end of this paper, the two ministries have taken contradictory positions at times on the critical issue of respiratory protection for HCWs. It is the unions' position, that on the Pandemic Steering Committee, the MOL has taken a more correct approach by determining its advice based on a careful reading of existing science and by considering decisions taken by world-renowned bodies such as the World Health Organization and the Centres for Disease Control.

We are unable to fault the MOL for failing to cooperate and coordinate its efforts with the MOHLTC around the issue of respiratory protection and respiratory protection programs. We believe it had made consistent efforts to consult on the issue and to communicate its position.

In other areas, the MOL has also made efforts and improvements. The Ministry has increased its efforts to consult with stakeholders such as the OFL Health and Safety Committee on a variety of health and safety initiatives. Senior Ministry staff are currently meeting with stakeholders to discuss possible initiatives regarding the critical issue of violence in the workplace. And it has been widely consulting stakeholders on the issue of ergonomics and workplace musculoskeletal injuries.

Although the unions would prefer to see more vigorous enforcement of the *Health Care Regulations* and to see the introduction of new regulations to address a variety of health care hazards such as ergonomics, violence and needlestick injuries, there is no doubt that there have been noticeable improvements in the Ministry's attempts to communicate its plans and to consult with stakeholders on the above initiatives. Because we are on the outside looking in, it is difficult for us to offer useful comments about its attempts to cooperate and coordinate its efforts with the MOHLTC. We have given examples of failures to cooperate and coordinate, and we have identified specific areas where we believe that the MOHLTC is at fault. However, we are unaware of what internal efforts there have been between the two ministries to arrive at agreements.

INFECTION CONTROL DEPARTMENTS AND OCCUPATIONAL HEALTH AND HYGIENE EXPERTS

The unions are able to provide only anecdotal evidence in terms of the levels of cooperation, consultation, communication and coordination among these various experts. We hope that the Commission will actively seek out information from the various associations and professional bodies to which these practitioners belong to assess what improvements, if any, there have been since SARS.

Our most recent experience involving these experts, as described throughout this submission, has centred on the issue of respiratory protection programs and types of respiratory protection offered to workers. We have observed that the approach employed by infection control practitioners and that of professionals with an occupational or industrial hygiene background is quite different. While those with a hygiene background appear to come to conclusions based on highly technical data and formulas based on factors such as particle sizes, density, velocity, air currents, protection factors of various respirators, relative humidity of air, etc., infection control practitioners appear to rely on their experience of the past to make predictions about the future.

The infection control experts appear to take the position that simply because the hygienists can demonstrate that airborne transmission is technically possible, does not necessarily mean that it will happen. We have also heard infection control experts advance the somewhat fatalistic theory that since it will be impossible to protect HCWs from contracting influenza in the community, it is pointless to attempt to protect them in the workplace. This approach appears consistent with the infection control expert opinion that since fit-testing N95 respirators is technically challenging, then it is pointless to attempt to fit-test them at all, or to even offer them to workers.

We have attached a number of emails from professionals with backgrounds in occupational hygiene and infection control as evidence of the varying approaches and the frustration within the professional community about the issue of respiratory protection. We believe that they demonstrate failures to consult and to coordinate among these practitioners and that they mirror the situation currently within and between the MOHLTC and the MOL.

CONCLUSIONS:

The level of cooperation, consultation, communication and coordination among separate organizations that deal with health care worker safety in the sector remains sadly lacking. Although we have seen attempts to address these concerns, the recent example of the Legionnaires' Disease outbreak in Toronto demonstrates just how much more work must be done. Although we disagree with a number of the recommendations arising from the Expert Panel report on the outbreak, we encourage the Commission to carefully consider the problems that the Expert Panel identified in its report.

Recommendations:

- more vigorous enforcement of the *Health Care Regulations* by the Ministry of Labour.
- amend PIDAC mandate and membership to ensure that it has adequate health and safety expertise and capacity to capably advise both MOHLTC and the MOL.
- amend the EMU mandate and mission to "write in" its obligations to include occupational health and safety principles and measures in its policies, procedures and documents that affect workers.
- create a health and safety audit process for the health care sector on a five-year trial basis to report annually to the provincial government on the state of health and safety in all sectors of health care.
- build in health and safety accountabilities in health care funding and contracts.
- senior staff at MOHLTC, PIDAC, Public Health and CEOs in health care to receive mandatory two-day health and safety training annually. Mandatory health and safety training would be part of the health and safety accountabilities recommended above.
- MOHLTC to be directed to:
    - Recognize its duties under the *OHSA* and the duties of those it funds; demonstrate leadership in health and safety to employers and workers; cooperate, consult, communicate and coordinate with MOL; and, recognize and seize opportunities to lead the health care sector to compliance with *OHSA* to create healthy and safe workplaces.

- Infuse decisions/directives/guidelines/alerts/notices etc with basic occupational health and safety principles.
- When possible, direct employers to adopt the precautionary principle in matters of worker health and safety.

3. Overall

a) Does the current system of occupational health and safety protections in Ontario meet the unique needs and requirements of the health care sector?

- *If not, please detail why?*
- *If not, what reforms are required?*

The system of occupational health and safety protections in Ontario is erected around an IRS that makes workplace health and safety the joint responsibility of management and workers. Since employers essentially control the conditions of work and how it is done, they have the greatest degree of responsibility for worker health and safety. This system establishes three fundamental workers' rights:

1. the right to know about hazards in the workplace.
2. to participate in health and safety decisions through joint worker-management health and safety committees.
3. and the right to refuse unsafe work.

The internal responsibility system has been tested for decades in a variety of sectors. While all sectors can claim unique needs and requirements, the IRS is a scheme intended to transcend differences and to work in all workplaces. Ideally, the IRS involves everyone, from the company chief executive officer to the worker. A major component of a functioning IRS is the existence of a continuous, unbroken chain of responsibility and accountability for health and safety throughout a workplace, linking workers to senior management. The unions believe that problems in the successful application of the IRS within the health care sector persist, not because of the unique needs and requirements of the sector, but because sector leadership commencing with the MOHLTC, extending down to employers has been largely ignorant of and at times actively resistant to, the adoption of a health and safety culture.

Workplace health and safety protection is established in a few key pieces of legislation, administered and enforced by a variety of bureaucratic agencies.

Health and Safety protection legislation

- The *OHSA (*and its regulations*)* is the principal piece of legislation in our system of occupational health and safety protections. The IRS is the implicit framework of this legislation. Our original submission contained suggestions for reforms of this *Act* and regulations to meet specific needs for the sector.
- Other legislation such as the *Criminal Code of Canada* and the *Workplace Safety and Insurance Act* also contain health and safety pieces that support our system of occupational health and safety protections.
- Specific to the health care sector, there are health and safety requirements contained in the *Hospital Management Regulation* of the *Public Hospitals Act.* Section 4 of the regulation requires a hospital to have occupational health and safety bylaws, and Section 7 allows for the appointment of one or more medical staff to advise the Joint Committee upon request of the JHSC. We were unable to locate similar provisions in either the *Health Promotion and Protection Act* or the *Long Term Care Act.*

Health and Safety Administration and Enforcement

<u>Ministry of Labour</u>

Administration

The Ministry of Labour Occupational Health and Safety Branch is organized around industry sectors (mining, construction, industrial). It is our position that the MOL should add a health sector division which would bring badly needed resources and expertise to the sector in an attempt to reduce injury rates in our workplaces. In the unions' previous recommendations to the Commission, we requested that the Ministry maintain a pool of inspectors and hygienists with special training and expertise in health and safety hazards in health care workplaces.

We are now of the opinion that not only are specially trained inspectors needed, but that an actual structural change within the Ministry is necessary to ensure that health care receives the

focus it requires. In a letter to the MOL dated October 13, 2005, regarding the Industrial Health and Safety Program Sector Plan 2004/2005, ONA made this suggestion, stating:

ONA strongly suggests that it is long past time for the Ministry of Labour (MOL) to establish a separate Health Care Health and Safety Program within the Occupational Health and Safety Branch. Disturbing indicators demonstrate this need:

- *The dismal state of health and safety in the health care sector*
- *The persistent high rate of accident/injury in the health care sector*
- *The lack of mature internal responsibility systems in the health care sector despite more than 25 years of legislation and enforcement*

Industrial Health and Safety Program health care sector strategies have not been working. The health and safety situation in the health care industry continues to deteriorate. Health care employers require focused attention from the Ministry of Labour if we are ever to see health and safety improvements in these workplaces.

Since ONA's letter to the Ministry, the MOL has initiated the hiring of six inspectors with health care backgrounds; however they will continue to function in the “industrial” sector without organizational focus on health care. This initiative, although promising will not be enough to meet the challenges presented within the health care sector.

ONA and OPSEU have also been taken aback by the lack of stakeholder involvement to inform the MOL in preparing its sector strategies. ONA addressed these concerns in its October 13, 2005, letter stating:

Your 2004/2005 Sector Plan once again claims to rely partly on “experience and knowledge of …health and safety system partners.” Yet in 2004, the MOL neglected to consult with ONA, which represents more than 50,000 workers in this industry. Instead, we approached the MOL. In 2005, again, no one from the MOL approached ONA for consultation. After requesting a copy of the last sector plan (2004/2005) at a meeting of the OFL, it was not until July 27, 2005 that we actually received a copy, only to be advised that the new 2005/2006 Plan is currently being finalized.

How can we be confident that our detailed review will even be given serious consideration and incorporated into the 2005/2006 Sector Plan when the MOL to date has only paid lip service to the consultation process? We would appreciate if you would provide us with some assurance that our feedback is valued and that from here forward we will be given a real opportunity to provide timely input into health and safety strategies in this area.

Despite raising our concerns for two years, the MOL continues to plow ahead developing their sector strategies without any meaningful input from worker stakeholders. Even as we write, the MOL is finalizing its 2006/2007 sector strategies, and although we have scheduled a meeting with MOL representatives to provide input, we are not confident, given the timing, that our input will have any real effect. In order to effect change, the MOL must consult with stakeholders prior to the development of the next fiscal year's sector plan and strategies.

Enforcement

At times leaders in the health care sector seem to consider themselves above the health and safety laws. In our first submission dated October 2003, on page 19, we referred to the influence a hospital believed it had to reduce worker health and safety precautions. The hospital's CEO stated in an email, that they had sent their own doctors to work with the Ministry of Health to revise these directives. Shortly after that email, on June 16, 2003, the directives were changed and precautions had been reduced. It appeared to the unions that the MOHLTC changed these directives and others with no input from the MOL, the body charged with establishing and enforcing standards of worker protection in the province.

In 2004, a MOL blitz of acute-care facilities revealed inconsistencies with regard to the Ministry's approach to targeted initiatives such as orders for the adoption of safety-engineered medical devices (SEMD). An early order requiring a hospital to introduce SEMDs was written with the assistance of the Ministry of Labour's Dr. Leon Genesove. The order was comprehensive and, as a result, the University Hospital Network will be a world leader for its implementation of needleless devices hospital-wide. Unfortunately, subsequent orders were not as wide-ranging and often ordered only risk assessments.

Two years later, few hospitals have converted to safer devices in any substantive way. The following excerpt from a 2004 memo, posted on the OHA's website page for its members

demonstrates how the health care sector leadership may have influenced the attitudes towards the enforcement process:

It goes without saying that in complying with these orders, there will likely be financial and practice implications for hospitals. As a result, the OHA has had discussions with the Ministry of Health and Long-Term Care (MOHLTC) to gather additional information and clarify how best to proceed in dealing with these directives.

The MOHLTC has indicated that they intend to strengthen their partnership with the Ministry of Labour and work collaboratively with them in assessing the financial and practical implications of taking steps to prevent needle stick injuries and enhancing the use of SEMDs. To better understand the financial impact of these orders, the MOHLTC may also be contacting individual hospitals for additional information.

We believe the Ministry of Labour has not effectively asserted its dominance in matters of health care sector health and safety. As we noted in our previous recommendations to the Commission, the MOL Policy Manual must be amended to clarify the role of MOL inspectors when enforcing the *OHSA* in the health care sector. Especially during an emergency and/or infectious disease outbreak, it must be made clear that the MOL sets and enforces occupational health and safety standards, and that while the MOHLTC may advise the MOL of its opinions during standard-setting, it must comply with the MOL's final decisions.

We believe that it also may be useful to give two other types of examples where the MOL defers to another authority. When a worker is involved in a motor vehicle accident during the course of his/her work, the accident investigation is completed by the police, often with no involvement by the MOL. While it is appropriate for police investigators with expertise in road conditions and the legislation which governs driving motor vehicles, to initiate the investigation, the MOL must also have a role, to investigate any workplace factors which may have contributed to the crash. It is not clear from the unions' experience that the MOL plays a consistent role in these investigations.

A similar situation often occurs following an assault or violent episode affecting a worker in a workplace. For example, following the recent murder of an ONA member at work by another worker, the MOL initially refused to indicate whether it would perform a fatality investigation.

While the event was undoubtedly a police matter, it was also a murder of one worker by another in a workplace where they both worked. Despite numerous calls and letters to the MOL by union members and the union itself, requesting the MOL to conduct a fatality investigation, the MOL has to date not initiated an investigation. Recently, senior staff at the Ministry indicated that they are still considering an investigation into workplace factors that may have been involved.

A protocol for the Policy Manual must be developed to clarify that regardless of the source or cause of a workplace critical injury/illness or death, if it occurs in the course of employment, the MOL must investigate to ensure compliance with the *OHSA* in all sectors and all kinds of workplaces.

Police Agencies

Police forces are expected to enforce the so-called "Bill C45" amendments to the *Criminal Code of Canada* which became law in 2004. Generally, it appears that police agencies are not entirely comfortable with enforcing this part of the *Criminal Code*. Nevertheless, we are aware of one investigation in the health care sector where the police are considering *Criminal Code* charges. Given the Ministry of Labour's reluctance to investigate workplace violence, especially in cases where the police are involved, ONA has asked the Attorney General to ensure that police agencies take a more active role investigating and enforcing all health and safety incidents around violence in health care workplaces.

Workplace Safety Insurance Board (WSIB)

The current system of occupational health and safety protections includes the Workplace Safety and Insurance Board. The WSIB's principal role is outlined in Section 1 of the *Workplace Safety and Insurance Act:*

1. *The purpose of this Act is to accomplish the following in a financially responsible and accountable manner:*
    1. *To promote health and safety in workplaces and to prevent and reduce the occurrence of workplace injuries and occupational disease*.

Elsewhere in our submissions, we have argued that the WSIB consistently has missed opportunities to use its legislation and expertise to promote safe and healthy workplaces.

However, we have also indicated to the Commission, that recently the unions have seen some small signs of interest in increased prevention efforts from within WSIB. We hope that the Board will build on those initiatives.

Ministry of Health and Long-Term Care (MOHLTC)

Within the current system of occupational health and safety, we argue throughout this submission that the MOHLTC should take a leadership role, encouraging all health care stakeholders to adopt a health and safety culture. We have demonstrated that in some circumstances it may be that the MOHLTC can be defined as a supervisor under *OHSA*. Whether or not the Ministry is prepared to accept this position, its actions and directions have substantial influence in the health care sector. The Ministry has many opportunities to encourage health and safety consciousness in the sector. For instance, the MOHLTC can infuse documents and directives with health and safety principles and build health and safety accountabilities into its funding arrangements similar to standard health and safety clauses employers impose on contractors. Yet as outlined elsewhere in this document, in our experience with the MOHLTC, it seems to have very little understanding of the *OHSA* and the obligations and duties arising from the *Act*, and thus has not led the sector in matters of health and safety.

Recommendations:

- The MOL should develop a separate Health Care Health and Safety program with inspectors who have special training in health care health and safety issues
- In order to effect change, the MOL must consult with stakeholders prior to the development of each fiscal year's sector plan and strategies.
- The Ministry of Labour Policy Manual must be amended to clarify the role of MOL inspectors when enforcing the *OHSA* in the health care sector. Especially during an emergency and/or infectious disease outbreak, it must be made clear that the MOL sets and enforces occupational health and safety standards, and that while the MOHLTC may advise the MOL of its opinions during standard-setting, it must comply with the MOL's final decisions

- A protocol for the Policy Manual must be developed to clarify that regardless of the source or cause of a workplace critical injury/illness or death, if it occurs in the course of employment, the MOL must investigate to ensure compliance with the *OHSA* in all sectors and all kinds of workplaces.

b) Does the Internal Responsibility System, a key element in Ontario's occupational health and safety protections, meet the unique needs and requirements of the health care sector?

- *If not, please detail why?*
- *If not, what reforms are required?*

The needs and requirements of the health care sector are not so unique that the sector should be excluded from the application of the Internal Responsibility System (IRS). Other emergency responders (police, fire) and shift workers, large institutions and professionals are all governed by *OHSA* and consequently are obliged to work for health and safety improvements within the IRS. Yet our experience tells us that the IRSs in health care facilities are for the most part weak or dysfunctional. We also understand that the IRS functions much more effectively in some industrial workplaces. The Minister of Labour's Health Care Health and Safety Action group did not challenge this conclusion as participants who had worked in industry also made this point.

Before examining problems which may be particular to building a functioning IRS within the health care system, it is important to briefly explore the underlying contradiction which hampers the advancement of a health and safety agenda within all workplaces governed by the IRS. Descriptions of high-functioning health and safety systems which rely on the IRS for the most part describe the workplace parties, employer and worker representatives, working in harmony to improve health and safety conditions. In the unions' experience, no matter what the sector, a highly functioning IRS is difficult to attain and is often maintained only as a result of consistent worker and/or union vigilance and activity.

The inherent adversarial nature between the workplace parties in most workplaces and the basic fact that the employer ultimately controls the workplace appear to be ignored in idealized descriptions of a functioning IRS. Consider the extremely simplified explanation of competing interests set out as follows: In general, employees are concerned about going home from work

at the end of their shift in the same condition as they arrived. If they identify a workplace hazard, whether the solution costs $5.00 or $500.00 is not a great concern to them. Workers simply want the hazard to be addressed. Employers, on the other hand, are concerned with producing a product as inexpensively as possible in order to make a profit. Or, in the non-profit, or public sector, employers are obliged to work within a budget set by another authority and to produce a mandated amount of products or services within that budget. It matters to them whether the “fix” for a health and safety hazard costs $5.00 or $500.00. Employers are aware that health and safety costs money. Certainly, in many instances, investment in health and safety will pay off to the employer in the long run, either in reduced absenteeism or increased productivity. However, it is key to consider that the pay-off is often in the long, not the short-term.

However, all workplaces, whether for-profit, non-profit, or public sector, are subject to the same competing forces as workers strive to achieve safer, healthier working conditions, and employers strive to keep their business functioning. In a system with little or no enforcement of health and safety standards, and where the workers are poorly trained and naïve about their rights, the employer experiences little pressure to develop the IRS in its workplace. It is our position then, that although the health care sector does face some unique hazards, there is no substantive difference between health care and any other sector which would mitigate against working toward improvements to the IRS.

There are a number of key factors, which although not entirely unique to health care, are of particular importance when considering the failure of the IRS in the sector:

- the failure to grasp basic occupational health and safety principles and to implement legislated health and safety roles, responsibilities and standards. These failures run throughout the sector from the MOHLTC to employers and supervisors and are reflected back by workers themselves. As we have stated in our earlier submissions, it was as if the health care sector hardly realized that the *OHSA* and regulations had anything to do with them, pre-SARS. Those attitudes have proven to be quite resistant to change.
- the serious shortage of employers, supervisors and workers who have been adequately trained to fulfil their roles and obligations under *OHSA* and its regulations.

- the apparent failure by MOHLTC and authorities within the health care sector to acknowledge the MOL as the government body which establishes and enforces health and safety standards
- the failure over the years of the MOL to regularly inspect health care workplaces to ensure that they were in compliance with the *OHSA* and its regulations. The absence of an MOL presence in the health sector contributed to the impression throughout the sector that the *Act* somehow did not apply to them

The *OHSA* establishes the critical role and responsibility held by the employer in the workplace. The employer must establish, implement and attend to the workplace health and safety program. There can be no functioning internal responsibility system until the employer takes this first step. The IRS therefore, can only begin to work when sector leaders, including senior Ministry of Health officials and facility CEOs, openly and genuinely commit to making it work and then follow through on that commitment. The challenge is to ensure that each individual in a position of authority within the health and safety system assumes their responsibilities personally.

In our previous submissions to the Commission, we drew your attention to the problem of supervisors who are not competent under the *OHSA* and we made recommendations to address this issue. Problems continue in this area that have a negative impact on the functioning of the IRS. We believe that in addition to our previous recommendations, it would be beneficial to ensure that supervisor job descriptions clearly establish health and safety responsibilities such as those identified by SafetyXChange an online community for health and safety professionals.

The unions recognize that there is also a great deal of education and training to be done among workers, whether unionized or not. Some improvements can be made in workplaces where workers understand their rights under *OHSA* and are not intimidated by their employers. However, meaningful system-wide change will take place only when employers begin to accept their responsibilities under *OHSA* and to work towards creating a bone fide IRS.

The unions also recognize that while the IRS is a significant feature of the legislation, it is only one tool. The MOL must also be directed to act assertively and to issue orders pertaining to

dysfunctional JHSCs and incompetent supervisors, as well as to investigate accidents and complaints with a view to prosecution.

Recommendations:

The unions believe that the following recommendations will assist to encourage the development of a functioning IRS:

- require senior staff of MOHLTC, PIDAC members, Medical Officers of Health and health care facility/program CEOS and Boards of Directors to participate in a two-day health and safety educational program which includes a module on liabilities and due diligence.
- include Health and safety criteria in all health care supervisor job descriptions.
- require senior managers to sign and review regularly occupational health and safety management plans.
- the voluntary occupational health and safety audit/benchmarking program offered by Health Care Health and Safety Association should become mandatory and linked to MOL inspections.
- require senior management to review all JHSC minutes.
- All health care facilities governed by a Board of Directors should be required to place health and safety first on the agenda of all Board meetings to address issues arising from JHSC minutes.
- require all members of the JHSC to receive Certification training.
- require HCWs to attend a 1-day mandatory health and safety training similar to the requirements under Workplace Hazardous Materials Information System (WHIMIS). This training must focus on the worker's right to know, to participate and to refuse unsafe work, highlight the employer's and supervisor's responsibilities, the health care regulation and the types of policies, measures and procedures every health care employer should have developed (section 9 Health Care and Residential Facilities), training requirements, JHSC powers and functions and the IRS.
- all management performance contracts within the health care sector, including MOHLTC senior officials, will contain a requirement to demonstrate that they have taken active steps to promote health and safety activities and the development of the IRS.

- the MOHLTC must be required to:
    - recognize its duties under the *Occupational Health and Safety Act,* demonstrate leadership in health and safety, work collaboratively with MOL when necessary and recognize and seize opportunities to lead the health care sector to compliance with legislation and standards to create healthy and safe workplaces.
    - recognize in its written policies that the MOL is the government body with the power and responsibility to establish health and safety legislation and to enforce it in the workplace.
    - infuse decisions/directives/guidelines/alerts/notices with basic occupational health and safety principles, including highlighting the need to involve JHSCs, conduct risk assessments where appropriate, and adopt the precautionary principle where appropriate.
    - where it has the ability, direct employers to adopt the precautionary principle and to comply with health and safety legislation and standards.
    - build health and safety accountabilities into funding relationships and contracts.
- The MOL must be required to:
    - act assertively and to issue orders pertaining to dysfunctional JHSCs and incompetent supervisors, as well as to investigate accidents and complaints with a view to prosecution.

These measures, designed to stimulate top-down leadership in health and safety, should encourage the development of a robust IRS within health care workplaces, especially those that have a direct relationship with MOHLTC.

c) *Do Joint Health and Safety Committees, a key element in Ontario's occupational health and safety protections, meet the unique needs and requirements of the health care sector?*
    - *If not, please detail why?*
    - *If not, what reforms are required?*

As expressed throughout this submission, the unions believe that the needs and requirements of the health care sector are not particularly unique in relation to Ontario's system of occupational health and safety protections. Yet our experience tells us that JHSCs across the sector are for the most part weak or dysfunctional. Members complain of committees that do not meet as often as they should, problems reaching quorum at meetings, health and safety concerns that spend months and years on agendas, and management that ignores JHSCs when establishing or revising components of health and safety programs such as infection control measures and respiratory protection. For instance, as described elsewhere, Sunnybrook Hospital recently unilaterally decided to remove powered air purifying respirators from its stock of personal protective equipment with no discussion with their JHSC. Another common complaint from JHSC members is that they are not replaced on their units while attending to JHSC business and so are reluctant to attend meetings, afraid that patient care or other duties will suffer in their absence.

The unions believe the widespread dysfunction of JHSCs in this sector is not a result of the unique needs and requirements of the health care sector, but rather a result of the uniquely successful resistance on the part of employers and other leaders to matters of occupational health and safety. The unique thing about this sector is that it has managed to evade occupational health and safety law and enforcement in a way that has not been possible in many other sectors, particularly those with similarly high levels of unionization.

The factors negatively affecting JHSCs stem from the same problems outlined throughout the document and in our previous submissions. Health care sector leadership from the MOHLTC, to CEOs, to managers, apparently are ignorant of their duties under occupational health and safety legislation; nor do they appear to understand their organizational and personal liabilities in matters of health and safety. Similarly, HCWs in many cases are ignorant of their rights under *OHSA*. This ignorance, coupled with lack of enforcement by the MOL, has rendered the sector's IRS largely dysfunctional.

It is impossible for us to determine, generally speaking, whether this apparent ignorance of the law and its intent, on the part of employers, is wilful or genuine. Notwithstanding the cause, it is the unions' position that the weaknesses in the health and safety system within the sector can be addressed only by first placing a focus on educating the sector's leadership. Elsewhere in

this submission (Q3 b.), we have made a recommendation that senior staff at MOHLTC, PIDAC, Public Health, CEOs and health care facility Boards of Directors receive annually mandatory two-day health and safety training. We believe it is critical to first train the health care sector leadership in occupational health and safety laws, principles and liabilities, and the value of the IRS and in particular the JHSC. This training should then cascade down throughout the sector. We believe that this recommendation would assist in the development of a functioning IRS sector-wide.

We also refer the Commission back to several recommendations the unions made in our July 2004, submission to you. Recommendations 3a, 3b, 3d, 3g, 3s and 4a, all addressed problems we had identified as contributing to poorly functioning JHSCs. The recommendations focused on the appointment of full-time worker health and safety representatives, ensuring supervisors were competent under *OHSA*, communication of health and safety matters to boards of directors, emergency meetings of JHSC when necessary, increased fines for breaches of *OHSA* and more certified committee members. We believe that each of these recommendations and those outlined in question 3 b of this submission, if implemented, would also help to develop a more effective health and safety system throughout the sector.

d) In detail, outline the lessons learned by your institution or organization from SARS regarding occupational health and safety.

Our previous submissions to the Commission arose from the lessons we learned during the SARS crisis in the province. All of the recommendations we previously made to the Commission were made in an attempt to address the problems our members experienced during SARS. Following is a short list of some of the most critical lessons we have learned and which continue to hamper the development of a health and safety culture in the sector.

- SARS awakened many of us to the fact that occupational health and safety in Ontario health care facilities is lagging decades behind the industrial sector. Health minister George Smitherman himself was surprised to learn this in the early days of his portfolio. Speaking to an audience of nurses in May 2005, he said, "One of the things I was struck by … [was] the number of nurses that work in environments, hospital environments perhaps more particularly, that actually are unsafe… We have a lot of work to do on that."

- Although historically, health care workers have tended to focus so completely on everyone else's care, they have failed to advocate for their own health and safety. Since SARS, it is the experience of both unions that their members' views on the importance of their own health and safety have changed. They tell us that they are no longer willing to put their lives at risk when they believe employers are not providing them with all available precautions for their health and safety.
- During and post-SARS, we learned most JHSCs throughout the sector are not functioning effectively, committee members are neither fully trained nor supported in their committee work, and even simple attempts to address health and safety issues continue to be met with resistance and delay.
- During and post-SARS, we learned of a disturbing and continuing disconnect between the MOHLTC and MOL in matters of health care health and safety. Instead of following Ministry of Labour direction, the MOHLTC at times has established standards at variance with those of the MOL, possibly creating more hazardous workplaces and generating unnecessary confusion and fear among workers. (Refer to submissions in Q7 & 8).
- The MOHLTC and health care sector leaders, during and post-SARS have demonstrated lack of knowledge of the *OHSA* and insufficient regard for worker health and safety. In developing guidelines and directives, they have tended to focus on patient health and safety to the exclusion of worker health and safety. The unions also have concerns that some decisions made by MOHLTC concerning health and safety have been negatively affected because of cost concerns.
- Given our experiences with the MOHLTC since SARS, we have learned that without active union involvement on committees charged with developing provincial standards and guidelines affecting worker health and safety, it is unlikely that the Ministry will proceed on its own to work toward promoting a health and safety culture.
- We have learned that there is a keen international debate about appropriate respiratory protection for HCWs facing risk of exposure to infectious diseases. The infection control and occupational health and safety communities continue to be at odds regarding this issue. Despite the ongoing debate, MOHLTC has chosen not to apply the precautionary principle, causing confusion and fear among health care workers who will be expected to respond in an emergency.

e) In detail, outline changes implemented by your institution or organization from SARS regarding occupational health and safety.

ONA IRS Education Initiative:

SARS deepened the unions' understanding of the deficits in the health care sector's IRS. Partly in response, ONA held its first ever health and safety workshop in June 2005 and developed valuable reference materials which have since been posted on the ONA website. The training and materials focused on strengthening JHSCs and stimulating health and safety activity in key areas:

1. infection control
2. respiratory protection
3. violence
4. needlesticks/sharps
5. lifting
6. air quality
7. supervisor competency

In recognition of the tendency for health and safety concerns to languish on JHSC agendas, at the workshop ONA recommended a three-point strategy for JHSCs to expedite resolution of health and safety concerns:

1. caucus with other worker members before meetings
2. draft and present written recommendations to the employer
3. call the MOL if the matter is not resolved

The training material included templates for written JHSC health and safety recommendations to employer that ONA has since shared with OPSEU, CUPE and SEIU.

OPSEU Member Education Initiatives

In 2003, in response to member requests, OPSEU developed and launched a basic occupational health and safety course for our members in the Developmental Service Sector. Although the union was well aware that there were serious problems with health and safety in

this sector, the SARS experience made this even clearer. These members, although covered by the Health Care regulation, have even fewer health and safety structures and protections than exist in the hospital sector.

In 2005, also in response to member requests, OPSEU further modified its basic occupational health and safety course for members who work in the long term care sector. It was clear from all of the reports OPSEU receives from these members that health and safety structures in this sector are also worse than those in the hospital sector.

Collective Agreement Language:

Largely in response to the occupational health and safety lessons learned from SARS, ONA developed and negotiated significant health and safety contract language across the province. Significant gains, including certification training for all ONA JHSC members, were made in the hospital central collective agreement, and efforts continue in local collective agreement negotiations.

In 2003, OPSEU negotiated a Letter of Understanding with the OHA, to create a provincial health and safety committee called the Joint Central Committee on Health and Safety (JCCHS). The purpose of the JCCHS is to gather information, discuss and make recommendations to the OHA's Health and Safety Advisory Committee on matters affecting the health and safety of OPSEU-represented employees in the workplace. The JCCHS has met quarterly since its first meeting in May 2004, and to date has focused its attention on recommendations concerning safety engineered medical devices, communications issues with JHSCs, WSIB injury information and is now initiating a survey of ergonomic injuries affecting sonographers.

Peer Review of Health and Safety Documents:

ONA and OPSEU have reviewed and critiqued many of HCHSA's new program documents primarily identifying where more JHSC involvement should be emphasized.

Minister of Labour Health Care Sector Health and Safety Action Group:

OPSEU and ONA participated fully in the Action Group and it was clear from the input of participants that *OHSA* enforcement was a problem throughout the health care sector, that JHSCs were not functioning, that workers in general do not understand their rights under the *Act*, and that many health care employers continue to resist meeting their legislated health and safety duties. Participants made several recommendations to the Minister including: the introduction of an ergonomics regulation; the introduction of a regulation mandating the use of safety-engineered medical devices similar to existing U.S. legislation; that more MOL inspectors be hired; that all HCWs workers in the province receive basic health and safety training (similar to a manner in which WHMIS was initially introduced); and that all JHSC members be certified.

Union collaboration:

In the latter part of 2004, OPSEU and ONA initiated bi-monthly meetings with the health and safety staff from the four health care unions, (OPSEU, ONA, SEIU and CUPE). Since that time we have continued to share information about health and safety issues, contract language, and JHSCs and to coordinate our efforts to attain functioning JHSCs in the workplaces where we jointly have members. For example, in June 2005, the four unions developed a joint statement to our JHSCs outlining their joint responsibilities. We have also made joint representations to the MOL, requesting the development of regulations to address mandating the use of safety-engineered medical devices, ergonomics and violence in the workplace.

Precautionary principle:

OPSEU and ONA continue to advise our members to apply the precautionary principle where appropriate, especially in the face of MOHLTC recommendations that do not appear to have scientific justification.

Meeting/communicating with MOHLTC:

Both ONA and OPSEU have devoted significant resources to participation in several MOHLTC committees reviewing and developing various infection control and pandemic influenza planning documents.

In November 2005, after expressing its concerns in writing, ONA met with the MOHLTC Deputy Minister, the Chief Medical Officer of Health and other MOHLTC officials to urge that the ministry:

- Work with the Ministry of Labour in matters of health care sector health and safety. ONA's identification of the interministerial disconnect was met with news that MOL physician Dr. Leon Genesove would join PIDAC, as would an occupational hygienist.
- Since the science is uncertain, adopt a precautionary principle approach to respiratory protection against diseases for which the route of transmission is unknown, or suspected or known to be airborne, and during high-risk respiratory procedures with FRI patients.

In follow-up correspondence and at a meeting January 23, 2006, ONA reiterated its concern that the MOHLTC was not calling for proper respiratory protection for health care workers although it was providing such protection for emergency services workers. ONA argued that the different approaches were confusing employers and workers and causing great anxiety among HCWs. Chief Medical Officer of Health Basrur acknowledged the conflict about this issue between the MOHLTC and the MOL, committed to taking steps to resolve this issue, and confirmed that she was acting to ensure MOHLTC documents and directions would reflect occupational health and safety principles.

Unfortunately the next day, MOHLTC staff conveyed a completely contrary message at the OHPIP steering committee meeting. The OHPIP chair announced that both the OHPIP and FRI documents would be changed to indicate that surgical masks only would be available to health care workers to protect against all but exposures to known airborne illnesses. The documents were changed accordingly. Again after OPSEU and ONA expressed concern, Dr. Basrur reiterated her commitment to health and safety and directed her staff to correct the error in the OHPIP.

As stated earlier, when ONA and OPSEU were preparing this part of our submission, we discovered that the OHPIP has again been revised. The original June 27, 2005, Appendix 6 health and safety material has been placed back into OHPIP joining the FRI document within the same appendix. The FRI document remains in the OHPIP, despite written assurances that it would be removed.

4. Occupational Health and Safety Act

a) *Does the* Act *meet the unique needs and requirements of the health care sector? If not please detail why?*
b) *Recommendations for new powers to address unique needs and requirements of the health care sector.*
c) *Recommendations for changes to current provisions to address unique needs and requirements of the health care sector*
d) *Recommendations for accountability measures and safeguards*

The Commission has asked a series of questions relating to the *Occupational Health and Safety Act.* The unions believe that we have addressed key areas in our previous submissions and ask that the Commission consider the recommendations we made concerning *OHSA* in our July 2004, recommendations document. (Recommendations 3a-s)

5. Regulation for Health Care Facilities (O.Reg.67/93)

a) *Does O.Reg. 67/93 meet the unique needs and requirements of the health care sector? If not, please detail why?*
b) *Recommendations for new powers to address unique needs and requirements of the health care sector*
c) *Recommendations for changes to current provisions to address unique needs and requirements of the health care sector*
d) *Recommendations for accountability measures and safeguards*

The Commission has asked a series of questions relating to the *Regulation for Health Care and Residential Facilities.* The unions believe we have addressed key areas in our previous submissions and ask that the Commission consider the recommendations we made concerning the Health Care regulation in our July 2004 document (Recommendations 4a-f).

We would also like to draw your attention to our earlier recommendation concerning the definition of Critical Injury (*Regulation 834)*. In that recommendation (Recommendation 4g in July 2004 document), we requested that the definition be amended to include *critical illnesses*.

We have no indication that the MOL is considering this recommendation and we request that you give it serious consideration as you prepare for your final report and recommendations considering health and safety matters.

6. Industrial Establishment Regulation (O.Reg.851)

a) Does O.Reg. 851 meet the unique needs and requirements of the health care sector? If not, please detail why?

b) Recommendations for new powers to address unique needs and requirements of community care workplaces covered by O. Reg. 851

c) Recommendations for changes to current provisions to address unique needs and requirements of community care workplaces covered by O. Reg. 851

d) Recommendations for accountability measures and safeguards

The Commission has asked whether O.Reg.851 meets the unique needs and requirements of the health care sector. We do not believe that the Industrial regulation does adequately meet the need of the HCWs who are covered by it. Currently, the largest group of HCWs not covered by the *Regulation for Health Care and Residential Facilities* and who consequently are covered by the Industrial regulation, are community health workers. In our July 2004, submission to you, we recommended that the Health Care regulation be amended at S.2(1) to add the following subsection:

13. Any location where a person is being observed, examined, diagnosed, or rehabilitated or is receiving care or treatment. (Recommendation 4b)

Our rationale remains the same as it was. Our experience during SARS was that community health workers were treated differently than HCWs inside facilities -- they received less information, had less health and safety training, and had less personal protective equipment. The industrial regulation provides no guidance specific to the hazards and working environments faced by HCWs who work in the community. There are numerous provisions in the Health Care regulation which could be directly applied to community health workers and if implemented would provide them with safer working conditions. For these reasons, we repeat

our previous recommendations that this group of workers be added into the Health Care regulation.

7 & 8: Ministry of Labour and Ministry of Health and Long-Term Care

7. Ministry of Labour

a) The role of the Ministry of Labour during an infectious disease outbreak

b) The role of the Ministry of Labour in establishing occupational health and safety standards and regulations

c) The role of the Ministry of Labour in enforcing occupational health and safety standards and regulations

d) The relationship between the Ministry of Labour, the Ministry of Health and Long-Term Care and public health units in respect of outbreak management, emergency planning and occupational health and safety generally

8. Ministry of Health and Long-Term Care

a) The relationship between the Ministry of Labour, the Ministry of Health and Long-Term Care and public health units in respect of outbreak management, emergency planning and occupational health and safety generally

b) The role of the Ministry of Health and Long-Term Care in establishing occupational health and safety standards and regulations

<u>Role of Ministry of Labour and Ministry of Health during an infectious disease outbreak</u>

Unlike our previous responses in this submission, we have chosen below to group together our responses to the Commission's questions about the Ministry of Labour and the Ministry of Health and Long-Term Care.

In our previous submissions to the SARS Commission, we made a number of recommendations regarding the role of the MOL and the MOHLTC during an infectious disease outbreak in a workplace, specifically in a health care workplace. We have commented earlier in this submission on progress by the MOL in addressing the issues raised by our recommendations. However, in light of recent events concerning possible infectious disease outbreaks, we would

like to draw your attention back to four of the recommendations we made in our July 2004, submissions to you and to take the opportunity to update these recommendations given our recent experiences.

We believe that a discussion of our previous recommendations and their revision in light of our experience since SARS will illuminate the questions asked by the Commission concerning the roles of the MOL and MOHLTC.

July 2004 ONA/OPSEU Recommendations

2.f. That the Ministry of Labour Policy Manual be amended to clarify the role of MOL inspectors when enforcing the OHSA in the health care sector, especially during an emergency situation, given the sometimes overlapping jurisdictions of MOL and MOHLTC.

2.g. Where agreements such as the 1984 MOL/MOHLTC agreement exist, all stakeholders must be made aware of the agreement and how it could affect worker health and safety. All such agreements that affect the normal role of the MOL inspectorate should become part of the MOL Policy Manual.

2.h. If the 1984 Agreement is still in force, it must be revised to clarify that regardless of which Ministry takes the lead in an outbreak investigation, that both ministries will continue to ensure that all applicable Acts are being enforced and that critical injuries and fatalities will continue to be investigated as per the OHSA by the MOL.

7.f. That in the future where the MOHLTC develops directives/standards affecting infection control procedures and/or worker health and safety measures and procedures, that this be done in consultation with the unions affected by such procedures.

Revisions to Recommendation 2.f.

While previously, we recommended that the role of the MOL during an infectious disease outbreak be clarified given the sometimes overlapping jurisdictions of MOL and MOHLTC, it is now our recommendation that the MOL, in consultation with MOHLTC and other experts should take the lead in investigating all infectious disease outbreaks that affect workers in a workplace and putting in place measures and procedures to protect them. The experience of the two unions since SARS, in particular our experience during the September 2005, Legionnaires' Disease outbreak at a Toronto long-term care facility has led us to revise our recommendation on this issue.

During the Legionnaires' outbreak, as residents and HCWs became ill and as residents were transferred to hospital, before the illness and its source and route of infection were identified, public heath officials and MOL inspectors took very different positions regarding personal protective equipment to be worn by HCWs who cared for these patients.

Public health officials relied on a document developed by the Provincial Infectious Diseases Advisory Committee (PIDAC) and released by the MOHLTC, “Preventing Febrile Respiratory Illnesses (September 2005)” (known as the FRI document) to govern their advice to HCWs and employers regarding respiratory protection. They relied on the guidance of the FRI document despite instructions in the preamble of the document that it is to be used in the control of "droplet spread respiratory illness ONLY." (p.ii) In the early days of the outbreak, it was not known what the illness was or how it was being transmitted. The FRI document also indicates that in the case of an "outbreak of febrile respiratory illness," "appropriate outbreak management procedures" (p.ii) are to be followed, suggesting that the FRI document is not to be used in an outbreak situation. Nevertheless, workers and employers were initially advised by Public Health authorities that surgical or procedure masks would provide adequate protection from the unknown illness. At the same time, MOL inspectors gave advice and wrote orders in some workplaces requiring workers to wear N95 respirators.

The report prepared by the Expert Panel on the Legionnaires’ Disease Outbreak (December 2005), documents the confusion these contradictory instructions caused among affected HCWs. The report notes that during the outbreak although Toronto Public Health initially did not agree that N95s were necessary, it decided eventually to recommend the use of N95s “for consistency” because of the position taken by the MOL. Some hospitals persisted in denying their staff access to N95s despite changed Public Health recommendations; other facilities distributed N95s from the beginning. The report also notes that a group of workers in one facility chose to stay away from work during the outbreak, presumably because of their health and safety concerns.

While OPSEU and ONA disagree with the Expert Panel’s conclusions and recommendations that are specific to the role of MOHLTC in a workplace infectious disease outbreak, we believe the description of the contradictory messages from representatives of the two ministries and the confusion and fear this engendered among workers is accurate.

We have taken the liberty of excerpting below lengthy portions of OPSEU's response to the report by the Expert Panel on Legionnaires' Disease which we believe summarizes our misgivings about a stronger role for the MOHLTC in matters of workers' health and safety and supports our recommendation that the role of the MOL be clarified and strengthened. Please consider that while OPSEU is specifically rebutting points in the Expert Panel report, all of these points have been expressed previously either verbally or in writing from PIDAC members. We include them here to deepen your understanding of our misgivings about enlarging the role for PIDAC and/or MOHLTC in worker health and safety matters.

OPSEU has participated for two years on the Pandemic Influenza Steering Committee and we have had input into various iterations of the provincial pandemic plan as well as the FRI document. We continue to be concerned that the MOHLTC and PIDAC are making critical decisions about HCWs health and safety, particularly around respiratory protection that are not well grounded in science or evidence. We, along with representatives from the Ontario Nurses' Association have raised those concerns repeatedly. We have asked for the scientific evidence that supports the use of surgical masks to protect workers from unknown respiratory illnesses and we are not in any way satisfied that the evidence provided to us is convincing. In fact, in other jurisdictions, scientists continue to recommend that workers be provided with N95 respirators to protect them from unknown respiratory illnesses that may be airborne. Consequently, we are extremely troubled to see the Expert Panel accepting the PIDAC opinion about respiratory protection especially if PIDAC has not provided any new evidence to support this opinion.

PIDAC and the Ministry of Health on occasion have stated that because fit-testing of N95s is not perfect, wearing an N95 does not guarantee protection against airborne exposure. They then argue that since a poorly fitted respirator offers inadequate protection, therefore, there is no point in using N95 respirators. This logic has always astounded us. Workers around the world in many workplace settings are obliged to rely on fit-tested respirators to protect them. No one in an industrial setting requiring respiratory protection suggests abandoning respiratory protection because of problems with fit-testing and/or finding properly fitting respirators. However, this argument is being advanced in health care settings. We believe this is the wrong approach. We should be analyzing the problems with current fit-testing programs and respirator choices and developing solutions, not just giving up.

We also take serious issue with the following points in the report:

- *On page 21, the document notes that EMS workers wear N95 masks because they "regularly go into environments where health risks are unknown. Their standard PPE is designed to protect them from toxins and chemical contaminants in the environment as well as infectious disease." We fail to understand why EMS workers require N95s "where health risks are unknown" when HCWs in hospitals and long-term care facilities who also face unknown health risks do not. We do not see any distinction between an unknown health risk in the community and one inside a workplace. Additionally, it is important to point out that an N95 respirator would not be adequate to protect an EMS worker from most airborne chemical hazards. Respiratory protection from airborne chemical hazards is*

usually provided by respirators fitted with filters appropriate to the particular chemical or by an air-supplied respirator.

- *On page 22, the report lists the "Risks of Inappropriate Use of Higher Level of Precautions." We do not accept that any of the factors on this list offer a compelling argument against accepting the precautionary principle and providing better respiratory protection. The first risk cited is that "personal protective equipment is uncomfortable and difficult to put on, so it is often misused or worn improperly." The work environment of a HCW is not known for its ease or comfort. It is our experience arising from SARS that most workers are prepared to accept a certain level of discomfort if they believe it may save their lives. We have seen no evidence to support the statement that because the equipment is uncomfortable or difficult to put on that it is <u>often</u> misused or worn improperly. Our experience during SARS was that workers had never been fit-tested, nor had they received prior training about putting on and wearing N95s and other new PPE – consequently, they made errors. However, the problem was lack of training and experience, problems which can be readily addressed.*

The next risk cited is that "errors are more common." We have no idea of what kind of errors are being referred to, or what evidence there is of these "errors."

Next, the report states that "workers tend to become over-confident in their equipment and neglect other key measures such as hand hygiene." It is OPSEU's experience that this is true in some instances, especially around the use of protective gloves and hand-washing. This has been documented in studies and anecdotally. However, no one has suggested that protective gloves should be abandoned because workers fail to wash their hands properly. The focus has been on developing guidelines on when gloves should be worn, what kind of gloves should be worn and ongoing training to ensure that workers wear gloves appropriately and practice good hand hygiene. Consequently, we do not find this a compelling argument to decide not to provide N95 respirators.

Another risk listed is that "health care providers experience health problems (eg., rashes, problems breathing)." In the early 1990s when HCWs began to develop latex allergies that were in some cases life-threatening, no one suggested that HCWs should no longer be provided with gloves to protect them from infectious agents. Once the allergy was better understood, scientists and manufacturers worked to develop alternative gloves that would not make HCWs sick. Within less than 10 years, it was rare to find a HCW who could not be accommodated back into her workplace using a non-latex or low protein latex glove. It is simply unacceptable for the Panel to suggest that because some PPE may cause health problems that workers should not be offered proper respiratory protection. Most workers will be able to find an appropriate N95 respirator that will not cause a rash. Some workers may need other accommodations.

The report states that "patient care may suffer." OPSEU does not know what evidence the Panel is using to support that statement. It is our position that in cases where workers are afraid of contracting an unknown illness and where they believe that their employer is not taking all reasonable precautions to protect them, it may have an effect on the quality of care they are able to deliver.

The final risk is that higher level precautions are "costly and uses supplies that may be required when the system is faced with diseases that require that level of protection." If we believed that N95 respirators were unjustified, we would accept that statement. However, since it is our

position that in cases where there is a risk of airborne infection, N95s should be used, we do not accept it.

In conclusion, OPSEU disagrees with some of the recommendations arising from this section of the report. Specifically, we are gravely concerned with Recommendation 3.2 that the MOHLTC be made responsible for establishing policies regarding infection prevention and control measures for HCWs. While it is entirely appropriate for the MOHLTC and its advisors to develop policies/procedures for patient infection prevention and control, it is not within their mandate or experience to ensure that the appropriate provisions of the Occupational Health and Safety Act and its regulations are in force in a workplace. It is the role of the Ministry of Labour to enforce the OHSA and to ensure that workers are being adequately protected. While the MOL may choose to consult and coordinate its decisions with the MOHLTC, it must have the ability to fulfill its mandate and function.

Despite the resources and expertise, the MOHLTC may have to investigate an infectious disease outbreak, it has become abundantly clear to both of our unions that the MOHLTC has been unable to expand its mission and mandate to include an understanding of occupational health and safety principles and a recognition of employers' obligations to ensure that the workers they employ work in safe and healthy working conditions. Earlier in our submissions to you, we described in great detail the problems that both unions have faced as we have sought to "write into" the provincial Pandemic Influenza Plan basic principles of occupational health and safety. While we have made small gains in that the Plan now recognizes that health care employers have obligations to protect their employees' health and safety, we have had to fight for every word that has been included. And as recently as February 2006, we learned that with no prior notification to the unions, the MOHLTC had removed the appendix from the Pandemic Plan which specifically addressed occupational health and safety matters. The unions challenged the MOHLTC on this issue and subsequently received a commitment that the health and safety appendix will be rewritten and inserted back into the plan. As noted earlier, when ONA and OPSEU prepared this part of our submission, we discovered that the OHPIP has again been revised. The original June 27, 2005, Appendix 6 health and safety material has been placed back into OHPIP joining the FRI document within the same appendix. The FRI document remains in the OHPIP, despite written assurances from Dr. Basrur in her February 16, 2006, letter to ONA stating that it would be removed.

In addition to our concerns about the approach taken by MOHLTC during pandemic influenza planning, PIDAC, the committee charged by the MOHLTC to "advise the Chief Medical Officer of Health with respect to prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases," has also contributed to our concerns. During the

last year, PIDAC has steadfastly refused to provide the unions (or the Pandemic Steering Committee) with scientific rationale for the decisions behind its advice to MOHLTC regarding worker respiratory protection during a pandemic. Additionally, PIDAC is the author of the Febrile Respiratory Illnesses (FRI) document which both unions believe fails to recommend adequate health and safety precautions. As well, PIDAC members have openly raised the cost of personal protection for health care workers as an argument to reject respiratory protection. And, they continue to cite the "respirators are uncomfortable" argument, despite recent reports from ONA members that suppliers are now finally fit-testing workers with models of N95 respirators that are greatly improved in comfort.

It is because of the experiences outlined above that we feel it is essential to revise our recommendation. The role of establishing occupational health and safety standards both during an outbreak and in general should belong to the Ministry of Labour. While the MOL may choose to draw on the expertise of MOHLTC on occasion, the MOL should always be the body to set health and safety standards and to enforce them. Our recommendation applies to other emergency situations which may have an impact on worker health and safety conditions as well. In an emergency, more than ever, the body most familiar with occupational health and safety principles and legislation should be the body in charge of ensuring standards are complied with. This position appears to be supported by the provincial government which is reported to have issued Orders in Council designating the MOL during an emergency to take the lead role within government around occupational health and safety.

<u>Recommendation 2.g.</u>

Since we provided you with our submissions more than a year ago, we have learned that subsequent to the 1984 MOL agreement with the Ministry of Health regarding infectious disease outbreaks, a very similar document was posted in the MOL Policy and Procedure Manual. We were unaware of this when we made our submissions in 2004. Apparently, the MOL was also unaware of its own document, since it referenced only the 1984 agreement in its public submissions to you. Dated June 1, 1998, policy 10.11, titled, "Suspected Outbreak of Infectious Disease," it sets out guidelines for the two ministries to follow in order to coordinate their responsibilities during an infectious disease outbreak in a workplace.

Most of the changes to the 1984 document found in the 1998 document reflect changes to the organizational structure of the MOL and are not substantive in nature. Ironically, since both unions were previously critical of the 1984 document and the way it was interpreted during SARS, we realize on examination of both policies that in one respect the 1984 policy was more protective of workers. The 1984 document, opens with a "Statement of Understanding," not found in the 1998 version, which contains the following statement: "4. prior to the issuing of orders under either status, the proposed control measures and their manner of enforcement will be discussed and coordinated between the Medical Officer of Health and the local Medical Consultant of the Ministry of Labour."

This statement requires the two ministries to coordinate their efforts and implies that they will come to an agreement about control measures and their manner of enforcement. Recent events during the Legionnaires' Disease outbreak in September 2005, which we detailed above demonstrate what can happen when there is a failure to come to such an agreement. Although we have now revised our previous recommendation to indicate that the MOL should always take the lead in a workplace infectious disease outbreak, we believe it is important to reinforce the intent of our previous recommendation 2.g. In any case where an agreement between the MOL and any other party departs from existing legal obligations, policies and practices, the agreement must be publicly available and communicated to affected stakeholders.

Recommendation 2.h.

As proposed above, we no longer believe that it is appropriate to allow the MOHLTC to take the lead in matters of occupational health and safety. While it may be appropriate in certain instances for the MOHLTC to be involved, especially to perform functions such as contact-tracing for which it is trained and equipped, it is our position that only the MOL has the role, objectivity, neutrality, legal mandate and the expertise to attend to occupational health and safety matters, even when the hazard is an infectious disease. If our revised Recommendation 2.f. is accepted, there is no longer a need for Recommendation 2.h.

Our experience first during SARS and more recently during the Legionnaires' outbreak has led us to this position. During the Legionnaires' outbreak, because both ministries were competing for the lead role in worker health and safety matters, it is our contention that the *OHSA* was not in all cases being enforced. The unions take the position that until the illness, its source and its

mode of transmission were known, workers should have been issued appropriate respiratory protection as a "reasonable precaution" under the *OHSA*. Intervention by Public Health authorities guided by PIDAC advice and documents led to workers being issued surgical masks only. Had the MOHLTC considered its obligations under the *OHSA* to take reasonable precautions, we believe that workers would have been issued N95 respirators.

Revision to Recommendation 7.f.

We would also like to substantially revise our previous recommendation to clarify that it should be the MOL in consultation with the MOHLTC and other experts which will develop standards and or directives concerning infection control measures and procedures for workers. Although it continues to be appropriate for the MOHLTC to develop infection control measures to protect patients, residents and/or clients, the MOHLTC should not have lead responsibility to ensure worker health and safety.

We have argued previously that infection control standards for patients cannot be separated from infection control standards for workers and we continue to believe this is the correct approach. However, as we have argued above, both unions now have grave reservations about the outcome should the MOHLTC begin to develop standards which affect worker health and safety. We have previously recognized that there may be infection control expertise within the MOHLTC which does not exist within the MOL giving rise to our previous recommendation. We believed that it would be acceptable to have the MOHLTC develop worker health and safety measures in some circumstances as long as they were done in consultation with the unions affected.

However, the latest controversies between scientists/physicians at the two ministries over influenza transmission during a pandemic, Legionnaires' Disease and appropriate personal protective equipment in both cases, has caused the two unions to question MOHLTC expertise, objectivity and commitment to worker health and safety. Because the MOHLTC and PIDAC have refused to provide us with the science to support their position on respiratory protection, choosing instead to defend their position with non-scientific arguments addressed above, we do not trust the MOHLTC/PIDAC to develop appropriate worker health and safety measures. It is now our position that this is properly the role of the MOL, the only ministry which has the ability to enforce the *OHSA*.

Recommendations:

- The MOL Policy and Procedures Manual must be amended to clarify that it will be the Ministry of Labour, in consultation with the MOHLTC and other experts, which will take the lead in investigating all infectious disease outbreaks that affect workers in a workplace.
- The MOL Policy and Procedures Manual must also be amended to clarify that it will be the MOL which will develop health and safety standards and/or directives concerning infection control measures and procedures for workers during an outbreak or other emergency and in general. Although it continues to be appropriate for the MOHLTC to develop infection control measures to protect patients, residents and/or clients, the MOHLTC should not have lead responsibility to ensure worker health and safety.

CONSOLIDATED RECOMMENDATIONS

Ministry of Labour

1. The Ministry must expressly codify the precautionary principle into the *Occupational Health and Safety Act* and its regulations (page 13)

2. The Ministry of Labour Policy and Procedures Manual must be amended to clarify that it will be the Ministry of Labour, in consultation with the MOHLTC and other experts, which will take the lead in investigating all infectious disease outbreaks that affect workers in a workplace. (page 59)

3. The Ministry of Labour Policy and Procedures Manual must also be amended to clarify that it will be the MOL which will develop health and safety standards and/or directives concerning infection control measures and procedures for workers during an outbreak or other emergency and in general. Although it continues to be appropriate for the MOHLTC to develop infection control measures to protect patients, residents and/or clients, the MOHLTC should not have lead responsibility to ensure worker health and safety (page 59)

4. The Ministry of Labour Policy and Procedures Manual must be amended to clarify the role of MOL inspectors when enforcing the OHSA in the health care sector. Especially during an emergency and/or infectious disease outbreak situation, it must be made clear that the MOL sets and enforces occupational health and safety standards, and that while the MOHLTC may advise the MOL of its opinions during standard-setting, it must comply with the MOL's final decisions (page 36)

5. The Ministry of Labour Policy and Procedures Manual must be amended to clarify that, regardless of the source or cause of a workplace critical injury/illness or death, if it occurs in the course of employment, the MOL must investigate to ensure compliance with the OHSA in all sectors and all kinds of workplaces (page 36)

6. The Ministry must incorporate into its Sector Strategies, direction for inspectors to examine the content, quality and implementation of health and safety program components. (page 4)

7. The MOL must be required to act assertively and to issue orders pertaining to dysfunctional Joint Health and Safety Committees, incompetent supervisors, and lack of compliance with the *Regulation for Health Care and Residential Facilities*, as well as to investigate accidents and complaints with a view to prosecution (page 29, 41)

8. The MOL should develop a separate Health Care health and safety program with inspectors who have special training in health care health and safety issues (page 4, 36)

9. In order to effect change, the MOL must consult with stakeholders prior to the development of the next fiscal year's sector plan and strategies (page 36)

10. Require all members of the JHSC to receive Certification training (page 40)

11. Require HCWs to attend a one-day mandatory health and safety training similar to the requirements under WHIMIS. This training must focus on the worker's right to know, to

participate and to refuse unsafe work, highlight employers' and supervisors' responsibilities, the Health Care regulation. (page 40)

Ministry of Health and Long Term Care

12. The MOHLTC must recognize its duties under the *Occupational Health and Safety Act* and the duties of those it funds; demonstrate leadership in health and safety to employers and workers; cooperate, consult, communicate and coordinate with MOL; and, recognize and seize opportunities to lead the health care sector to compliance with *OHSA* to create healthy and safe workplaces (page 29, 40)

13. Senior staff at MOHLTC, PIDAC, Public Health, CEOs and Boards of Directors in health care should receive mandatory two-day health and safety training annually including modules on liabilities and due diligence. Mandatory health and safety training would be part of the health and safety accountabilities recommended below. (page 29, 40)

14. The MOHLTC must recognize in its written policies that the MOL is the government body with the power and responsibility to establish health and safety legislation and to enforce it in the workplace (page 41)

15. The MOHLTC must amend Provincial Infectious Diseases Advisory Committee mandate and membership to ensure that it has adequate health and safety expertise and capacity to capably advise both MOHLTC and the MOL (page 29)

16. The MOHLTC must amend the Emergency Management Unit mandate and mission to 'write in' its obligations to include occupational health and safety principles and measures in its policies, procedures and documents that affect workers. (page 29)

17. The MOHLTC must ensure that all decisions, directives, guidelines, alerts, and notices that affect health care workers include basic occupational health and safety principles including highlighting the need to involve JHSCs, conduct risk assessments where appropriate, and adopt the precautionary principle where appropriate (page 29, 41)

18. The MOHLTC must direct employers, where it has the ability, to adopt the precautionary principle in matters of worker health and safety and to comply with health and safety legislation and standards (page 29, 41)

19. The MOHLTC should create a health and safety audit process for the health care sector on a five-year trial basis to report annually to the provincial government on the state of health and safety in all sectors of health care (page 29)

20. Build health and safety accountabilities into health care funding and contracts (page 29, 41)

Employers

21. The voluntary OHS audit/benchmarking program offered by Health Care Health and Safety Association should become mandatory and linked to MOL inspections (page 40)

22. All health care facilities governed by a Board of Directors should be required to place health and safety first on the agenda of all Board meetings to address issues arising from JHSC minutes (page 40)

23. All management performance contracts within the health care sector, including MOHLTC senior officials, should contain a requirement to demonstrate that managers have taken active steps to promote health and safety activities and the development of the IRS (page 40)

24. Require senior managers to sign and review regularly occupational health and safety management plans and to review all JHSC minutes regularly (page 40)

25. Include health and safety criteria as part of all Health Care Supervisor job descriptions (page 40)

Other Recommendations

26. That the Ontario Government create an occupational health and safety resource similar to NIOSH and OHSAH, ensuring this resource integrates the factors noted in our submission (page 14)

LHIN Recommendations

27. The government should use its ability to expand the health service provider definition in Bill 36 to include all critical components of health care, including public health, into the LHINs planning umbrella. (page 65)

28. A system of province-wide bargaining should be established to extend the hospital terms and conditions of employment to all health service providers. The government should establish by regulation that no integration decision or approval made either by a LHIN or the Ministry will alter the terms and conditions of employment of health service providers' employees, including a collective agreement, without union consent (where represented by a union), except as provided by the *Public Sector Labour Relations Act*. (page 65)

29. The Ontario government needs to establish consistent protocols to ensure public health's interface with the hospitals is seamless. (page 65)

Appendix A

Recommendations to SARS Commission regarding Health and Safety Issues

LHINS

On March 1, 2006, the Ontario government passed third reading of Bill 36 – the *Local Health System Integration Act, 2005*. The Bill now awaits Royal assent. ONA and OPSEU have serious concerns about the impact of Bill 36 and the Local Health Integration Networks (LHINs) it establishes, on the occupational health and safety of health care workers. ONA and OPSEU have both made extensive submissions to the Standing Committee on Social Policy with respect to Bill 36.

Integrating Public Health

As set out in the SARS Commission's First Interim Report, public health in Ontario has been neglected and marginalized for years: "The underlying problems of public health in Ontario have to do with a lack of resources, years of neglect, and lack of governmental priority" (p. 19). The First Interim Report also identified the "significant weaknesses in the links between public health and hospitals" as well as between public health and nurses, doctors, other health care workers and their unions (p. 14). All of these weaknesses had reverberations for the health and safety of health care workers (HCW). ONA and OPSEU are concerned that Bill 36 will exacerbate these problems.

In particular, the Bill's powers to fund and integrate health services apply only to "health service providers", as it defines that term. This definition excludes public health facilities/institutions. Accordingly, under this system, public health will remain on the outskirts of the health system, perpetuating the isolated position it has held for years. ONA and OPSEU believe that public health is an integral part of the health care system, which should be part of an integrated delivery system (and funded by the province). While the SARS Commission's Second Interim Report raises concerns about aligning public health with LHINS, in our view, the answer is not to exclude public health from Bill 36, but to ensure that health care integration is carried out with a mandate and intention of strengthening public health.

ONA and OPSEU recommend that the government use its ability to expand the health provider definition to include all critical components of health care, including public health, into the LHINs planning umbrella.

Underfunding and Fragmentation

In ONA's and OPSEU's view, Bill 36 is focused on financial expediency and cost-cutting more than patient care, or the welfare of health care workers. To date, the government has provided no assurance that the current level of funding or services will be maintained. It is a fundamental concern of ONA and OPSEU that the government will not provide sufficient funding for the maintenance of existing publicly-funded services, let alone the cost of restructuring and the additional costs to provide the profits for the burgeoning for-profit sector that this legislation encourages. ONA and OPSEU are further concerned that attempts will be made to fund this shortfall through cost cutting measures aimed at front line workers.

SARS has already shown that underfunding can contribute to a health emergency and, in particular, can have devastating effects on the occupational health and safety of health care workers. For example, during SARS, infection control departments did not have the resources to reach out to staff to ensure they were working safely. Underfunding also may have contributed to the lack of adequate advance training of staff in infection protocols and to the shortage of N95 masks. ONA and OPSEU are concerned that the cost cutting inherent in LHINs will encourage cutting corners with respect to health and safety, particularly as workplaces become fragmented from larger facilities which may have had appropriate health and safety systems and supplies in place. ONA and OPSEU are also concerned that the realities of collective bargaining in smaller, fragmented workplaces will inevitably lead to an undermining of terms and conditions of employment, including in relation to health and safety issues.

The need for public health to respond in a time of a crisis also requires some additional capacity within the system. For example, while additional public health workers were brought into Toronto to assist during the SARS crisis, there was not enough physical space for them to work out of. If costs are to be a paramount concern to the LHINs, we fear that such capacity will be early prey to a cost-cutting agenda.

ONA and OPSEU have accordingly made a number of recommendations regarding collective bargaining. In particular, we are proposing that a system of province-wide bargaining be established to extend the hospital terms and conditions of employment. ONA and OPSEU also recommend that, by regulation, no integration decision or approval made either by a LHIN or the Ministry will alter the terms and conditions of employment of health service providers' employees, including a collective agreement, without union consent (where represented by a union), except as provided by the *Public Sector Labour Relations Act*.

OPSEU and ONA are also concerned that the present boundaries of the LHINs may be an obstacle to coordinated response to any future pandemic. The City of Toronto, for example, is now broken into five different LHINs. The interface between public health and the hospitals reporting to five different LHINs structures could create a level of chaos within the system.

The Ontario government needs to address the need for consistent protocols to ensure public health's interface with the hospitals is a seamless one, especially in times of crisis.

Contracting Out

Bill 36 allows cabinet to order any public hospital to cease performing any non-clinical services which they choose to prescribe and to transfer it to any other person or entity (s. 33). ONA and OPSEU have real concerns that the government is specifically targeting "non-clinical services" for contracting out. Their concerns are heightened by the lack of a definition of non-clinical services" in Bill 36, which we are told will be determined by regulation at a later date.

Non-clinical services can be an important part of health and safety in health care facilities. For example, housekeeping and dietary staff play a critical role in infection control in hospitals. Furthermore, as we learned through the experience of HCWs during the SARS outbreak, the ability to prevent transmission from institution to institution is an important element of infection control.

Recommendations

- The government should use its ability to expand the health service provider definition in Bill 36 to include all critical components of health care, including public health, into the LHINs planning umbrella.

- A system of province-wide bargaining should be established to extend the hospital terms and conditions of employment to all health service providers. The government should establish by regulation that no integration decision or approval made either by a LHIN or the Ministry will alter the terms and conditions of employment of health service providers' employees, including a collective agreement, without union consent (where represented by a union), except as provided by the *Public Sector Labour Relations Act*.

- The Ontario government needs to establish consistent protocols to ensure public health's interface with the hospitals is seamless