

Occupational Health and Safety Branch

# Health Care Sector Plan

---

*2009-2010*

**Safe At Work Ontario**  
Enforcement > Compliance > Partnership >

**Ministry of Labour**

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## Introduction

Introduced in the Spring of 2008, *Safe At Work Ontario* (SAWO) is the Ministry of Labour's occupational health and safety compliance strategy. *Safe At Work Ontario* seeks to improve the health and safety culture of workplaces leading to a reduction of injuries and avoidance of associated costs for employers, the Workplace Safety and Insurance Board (WSIB) and health care system. Through proactive enforcement, *Safe At Work Ontario* strives to provide a level playing field for compliant employers.

*Safe At Work Ontario* encourages stakeholder involvement in the planning process, introduces broader selection criteria to identify workplaces for proactive inspections and involves integrated planning with system partners. The focus of *Safe At Work Ontario* is to facilitate proactive enforcement of the Occupational Health and Safety Act (OHSA) on the top hazards in each sector and promote compliance and the development of a strong health and safety culture in the workplace.

*Safe At Work Ontario* has turned MOL's enforcement direction around, moving it from a traditional reactive, enforcement-based program to a modern, proactive, flexible, compliance-based program. It is innovative, transparent and inclusive of stakeholder concerns, while continuing to protect the public interest.

*Safe At Work Ontario* expands the factors that the MOL uses to identify a firm for a proactive inspection beyond the firm's injury history. Additional factors include regional information, compliance history and/or hazards inherent in the work or work processes. It includes hazard-based inspections, and actively engages health and safety system partners (such as the WSIB and health and safety associations) in building a safety culture in workplaces across the province. Under *Safe At Work Ontario*, the ministry aims to be into workplaces before injuries occur.

The level of engagement with the workplace depends on factors such as the employer's commitment to a strong health and safety culture and a well defined, suitable and sustainable Internal Responsibility System (IRS). Other factors affecting the level of engagement include the number of lost-time injuries (LTIs) and no-lost-time injuries (NLTIs), nature and extent of any past non-compliance identified, and corrective actions required of the employer to achieve compliance.

The *Safe At Work Ontario* strategy is administered through five specialized sector programs: construction, industrial, mining, health care, and specialized and professional services. Sector plans are developed on an annual basis for each program area. These documents outline the enforcement focus for each year and identify planned blitzes. They are posted on the ministry's web site to encourage voluntary compliance. The sector plans also provide basic information about each sector and a brief overview of health and safety hazards and non-compliance concerns.

The following is the Health Care sector plan for the 2009/10 year. Other sector plans can be found at: [www.labour.gov.on.ca](http://www.labour.gov.on.ca)

## The health care sector

The health care sector in Ontario is diverse and complex. There are 6,516 premises registered by the Ministry of Labour (MOL) and 516,180 workers representing both union and non-unionized workplaces. The health care sector experienced a growth of 24,553 job increases in 2007.

Health care and community care services are provided in a variety of complex settings including:

### **Nursing homes (long-term care facilities)**

Long term care facilities include extended care residential facilities where nursing and personal care is provided on a continuing basis, with medical and professional supervision.

### **Homes for residential care (retirement homes)**

Retirement homes provide residential services to seniors who are generally able to care for themselves. The staff of these operations include nursing staff, personal support workers, and support service staff such as housekeepers and kitchen staff.

### **Hospitals**

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

### **Nursing services**

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

### **Group home**

Group home settings provide care for residents who have decreased physical or cognitive ability and require supervision and assistance with activities of their daily living.

### **Treatment clinics and specialized services**

Treatment clinics and specialized services may include settings such as drug and alcohol treatment centers, public health and community clinics, etc. Activities include providing continual assessment and rehabilitative treatment for non-institutional patients whose physical or mental condition is expected to improve.

### **Professional offices and agencies**

Professional offices and agencies include but are not limited to doctors' offices, dental offices, other allied health professional offices and laboratories in the community setting. Activities included are registered physicians and surgeons primarily engaged in the private practice of medicine or a specialty of medicine, whether in individual or group practice.

## Health and safety characteristics of the health care sector

The health care sector has the fourth highest rate of lost-time injuries (LTIs) in Ontario, after transportation, forestry and farming. With an average lost-time injury rate (LTI per 100 workers) of 2.03 in 2007 (WSIB Data 2007), it ranks higher in lost-time injuries than other industrial sectors and the mining and construction sectors. Musculoskeletal disorders (MSDs) continue to be the highest injury area, accounting for 54% of the lost-time injuries in 2007, followed by slips, trips and falls at 17%. The lost-time injuries caused by violence/aggression are 8% in the health care sector, which is above the provincial lost-time injury rate of 3% (WSIB Data 2007).

The health care sector critical injuries were 59 in 2006, 65 in 2007 and 78 in 2008. For the same time period from 2006 to 2008 there was one work-related fatality under MOL jurisdiction that occurred in 2006 in the health care sector (MOL Data 2008).

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

In addition, as Ontario moves toward adopting an "aging-in-place" philosophy, where people are cared for longer in their own homes and communities, this will continue to have an impact on the potential for injuries in the health care sector.

With Ontario's aging population, there is growing demand for long-term care and residential care services. This can have an impact on staff health and safety in these settings in areas such as musculoskeletal disorders (MSDs), violence and aggression, and infection prevention and control, as staff are required to care with residents with increased illness severity and in some cases decreased cognitive ability (i.e. dementia). The demand for long-term care admission may impact injuries in retirement homes because residents may be staying longer in residential care services despite the need for them to be moved to higher level care settings.

The "aging-in-place" philosophy may result in an increased demand for nursing services in the community with a potential impact on injury in the areas of MSDs, and infection prevention and control. In addition, nursing services face greater potential for injury from motor vehicle accidents as they travel from one client to another.

Group home settings face increased challenges to provide services to clients who may have been previously cared for in institutional settings. As with the health care sector as a whole, they have to balance the provision of appropriate quality care to clients and families with the health and safety of staff. This is coupled with the challenge of providing staff with appropriate education, training and equipment to provide care safely and the need to maintain a home-like setting for clients.

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

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

## Health and safety hazards inherent in health care work

Health care workers continue to be impacted by a number of hazards. The health care sector critical injuries were 59 in 2006, 65 in 2007 and 78 in 2008. For the same time period from 2006 to 2008, there was one work-related fatality that occurred in 2006 in the health care sector (MOL Data 2008). In 2007, the lost-time injury rate (LTI per 100 workers) was 2.03 and the no-lost-time injury rate (NLTI per 100 workers) was 3.24 (WSIB data 2007).

Based on a review of WSIB data, the major hazards that continue to result in the greatest number of lost-time injuries (LTIs) are: musculoskeletal disorders (MSDs), slips trips and falls, contact and struck by object injuries, violence and aggression, exposure, and motor vehicle accidents.

### **Musculoskeletal disorders (MSDs)**

Musculoskeletal disorders (MSDs) are pains and strains caused or aggravated by work. MSDs continue to be the leading cause of injuries in the health care sector accounting for 54% of all injuries and over 4,802 lost-time injury (LTI) claims (WSIB Data 2007). MSD client handling injuries resulting from the lift, transfer and reposition of a patient/resident account for 24% of the total LTIs in health care. MSDs from non-client handling tasks account for 30% of all LTIs in health care.

### **Slips, trips and falls hazards**

Slips, trips and falls account for the second highest proportion of injuries in health care, accounting for 17% of lost-time injuries (WSIB Data 2007). This resulted in over 1,501 lost-time injuries to workers in the health care sector. Eighty-four per cent of the falls that occur are falls on the same level.

### **Contact and struck-by-object injuries**

Injuries to workers resulting from contact with, or being struck by, equipment, machinery, devices and other objects accounted for 10% of lost-time injuries in 2007.

### **Violence and aggression hazards**

Health care workers are at an increased risk of exposure to workplace violence and aggression due to a number of factors, including working in the community and private residences, working alone, providing direct care to patients/residents and working with the public. Violence and aggression accounted for over 696 lost-time injuries in health care in 2007 which represents 8% of all lost-time injuries in the sector.

### **Exposures to biological, chemical and physical agents**

In 2007, 7% of lost-time injuries in health care resulted from exposure to biological, chemical and physical agents in the workplace. Health care associated infections are included in the lost-time injury data for exposure. More information on health care associated infections is provided under Infection Prevention and Control.

### **Infection prevention and control**

Health care associated infections in health care workers, acquired as a result of workplace exposures, are occupational illnesses that must be reported to the Ministry of Labour. These are included in the lost-time injury data under the category of 'exposure'.

## Needle safety

Needle and other sharps injuries are sources of workplace exposures to potentially infectious agents. In 2007, there were over 1,700 reported sharp injuries to WSIB (lost-time and no lost-time). Devices most often involved in sharps injuries are hollow bore needles. In Ontario, the [Needle Safety Regulation](#) (O. Reg. 474/07) came into force September 1, 2008 for hospitals and April 1, 2009 for long-term care homes, designated psychiatric facilities, laboratories and specimen collection centers.

## Motor vehicle accidents

Motor vehicle accidents accounted for 2 per cent of lost-time injuries in the health care sector (WSIB Data 2007), resulting in approximately 183 lost-time injuries. Although this hazard represents a smaller portion of lost-time injuries, it is of great significance to address given that it has resulted in work-related motor vehicle fatalities.

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## Ministry of Labour's compliance focus in health care for 2009-2010

### Partnerships: a key success factor

The Ministry of Labour is one of several partners in the health and safety system in Ontario focused on preventing and reducing injuries and illnesses.

The Occupational Health and Safety System is composed of the Ministry of Labour (MOL), the [Workplace Safety & Insurance Board](#) (WSIB) and the [Health and Safety Associations](#) (HSAs). As with the previous strategy, the health and safety system partners focus on improving workplace health and safety practices through education, training, and enforcement of provincial legislation and regulations. The Ministry of Labour is responsible for enforcement of the [Occupational Health and Safety Act](#) and its regulations, the WSIB focuses on prevention and insurance, and the health care specific HSA, the [Ontario Safety Association for Community & Healthcare](#) (OSACH), provides education, training and consulting services.

The Health Care Program within the MOL works collaboratively with other partners within and outside the Ministry to improve health and safety in Ontario health care workplaces.

The Health Care Program will help improve the health and safety of health care workers in Ontario by working with its prevention partners such as WSIB and Ontario's Health and Safety Associations. Additional partnerships have been established with other stakeholders including other ministries, agencies, unions, employer associations, occupational health and safety and infection prevention and control professionals and consultants, educational institutions and community organizations.

Working together with our partners, the Health Care Program will help develop enforcement and compliance support tools for health care sector workplaces to ensure health care providers are better prepared for emergencies, including outbreaks of infectious diseases. In addition, the Health Care Program supports the Ontario Health Care Health and Safety Committee under Section 21 of the Occupational Health and Safety Act. The following is a brief description of the partners' focus:

The MOL and the Ontario Safety Association for Community & Healthcare (OSACH) have worked together on the implementation of the *Safe At Work Ontario* (SAWO) program and in the development of compliance support tools on needle safety, workplace violence prevention, and infection prevention and control. [www.osach.ca](http://www.osach.ca)

The Ontario Health Care Health and Safety Committee Under Section 21 of the Occupational Health and Safety Act is appointed by the Minister to advise and make recommendations to the Minister on matters relating to the occupational health and safety of health care workers.

With respect to the Ministry of Health and Long-Term Care and related agencies, the MOL is partnering with the MOHLTC on H1N1 Influenza preparedness and response, needle safety and the MOHLTC “Just Clean Your Hands” program. In addition, MOL participates in the MOHLTC Provincial Infectious Diseases Advisory Committee (PIDAC). [www.health.gov.on.ca](http://www.health.gov.on.ca)

### **Compliance: intervention based on need**

Some businesses require targeted and focused enforcement intervention up to and including prosecution to deter non-compliance. While these firms are not the majority of businesses in Ontario, the ministry will continue to pay particular attention to them.

### **MOL health care sector initiatives for 2009-2010**

The MOL health care program will be focusing on increasing workplace compliance with the statutory requirements surrounding musculoskeletal disorders (MSDs), infection prevention and control, and workplace violence prevention. Below is a brief overview of recent and future partnership strategies aimed at assisting health care workplaces with achieving compliance regarding these key issues.

#### **Musculoskeletal disorders (MSDs)**

In preparation for the April 2009 MSD blitz in long-term care and residential care workplaces, the MOL worked with the Ontario Safety Association for Community & Healthcare to develop education and compliance tools for use by stakeholders as well as to inform and advise them, specifically on requirements for safe measures and procedures for tasks associated with client handling.

#### **Infection prevention and control**

Health care providers are continually at risk from exposure to infectious diseases in the workplace. Employers covered by the [Health Care and Residential Facilities Regulation](#) are required to consult with the Joint Health and Safety Committee (JHSC) or health and safety representative (HSR) in developing written measures and procedures to protect the health and safety of workers from exposure to infectious diseases. Based on a risk assessment and in consultation with the JHSC or HSR, a hierarchy of controls should be implemented including: engineering controls, work practices, hygiene practices, administrative controls, personal protective equipment, and worker training.

For infectious diseases affecting workers (including the H1N1 influenza virus), MOL will continue to work closely with the [Ministry of Health and Long-Term Care](#) (MOHLTC), the [Ontario Agency for Health Protection and Promotion](#) (OAHPP), the [Regional Infection Control Networks](#) (RICNs), the [Ontario Safety Association for Community & Healthcare](#) (OSACH), and other health care stakeholders to ensure health care workers are protected from health care associated infectious diseases.

The MOL Health Care Program will continue to collaborate with the MOHLTC and the OAHPP on the development and posting of Important Health Notices and Clinical Guidance resources to protect health care workers and other workers from the H1N1 influenza A virus.

#### **Workplace violence prevention**

To assist health care workplaces with violence prevention strategies, the Ministry of Labour has partnered with the MOHLTC ([HealthForceOntario](#)) and OSACH to develop compliance tools, including education sessions and a DVD on Workplace Violence Prevention in Health and Community Care.

## The Internal Responsibility System – fostering a culture of safety

The Ministry of Labour has a primary responsibility to ensure that workplaces comply with Ontario's [Occupational Health and Safety Act](#) (OHSA) and related legislation. This means ensuring that a strong Internal Responsibility System (IRS) is in place. A strong IRS implies, in part, a well-functioning Joint Health and Safety Committee (JHSC), where required, that fosters a strong, sustainable culture of workplace health and safety.

A strong health and safety workplace culture consists of:

- **Competence** (appropriate knowledge and training, systems for responding to events, properly functioning JHSC and other IRS components),
- **Commitment** (demonstration by the employer of leadership on safety, appropriate policies and procedures to protect workers, low tolerance for poor health and safety practices, insistence upon full compliance), and
- **Capacity** (adequate resources for preventing injuries, a good system for obtaining assistance from HSAs and the WSIB).

A strong IRS produces a strong culture of health and safety. Strong leadership by senior executives and other managers sets the tone and establishes a corporate culture that nurtures the IRS. A health and safety culture requires all workplace parties to pay constant, appropriate attention to workplace health and safety.

A sustainable workplace health and safety culture needs a strong commitment by everyone to prevent injuries and illness and to reduce risk.

In health care, the development of a strong Internal Responsibility System that can support an organizational culture of health, safety and wellness is the cornerstone of improved staff and client health, safety and wellness and quality of care.

To ensure a strong IRS, MOL inspectors will look for evidence of competent supervision as per the Enforcement Focus outlined below.

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## Enforcement focus: focused enforcement to maximize impact

Under the *Safe At Work Ontario* strategy, the health and safety information of a company is only one of the many factors that will identify a firm for an MOL inspection. Hazards, often inherent in the work, such as those mentioned above are also considered when identifying workplaces for inspections.

For the *Safe At Work Ontario* strategy in the health care sector, the MOL Health Care Program used an integrated planning process with the WSIB and OSACH to identify approximately 900 workplaces representing a range of health care settings for proactive inspections by MOL inspectors, ergonomists and occupational hygienists. In addition, the MOL enforcement focus includes hazard specific blitzes (i.e. MSD blitz) and regional initiatives. Among the regional initiatives is a focus on health and safety in hospices in the Western region and retirement homes and hospitals in the Eastern region.

The health care sector critical injuries were 59 in 2006, 65 in 2007 and 78 in 2008. For the same time period from 2006 to 2008 there was one work-related fatality that occurred in 2006 in the health care

sector (MOL Data 2008). In 2007, the lost-time injury rate (LTI per 100 workers) was 2.03 and no-lost-time injury rate (NLTI per 100 workers) was 3.24 (WSIB Data 2007). When reviewing occupational injury and illness data, Ministry of Labour inspectors consider the workplace hazards contributing to the root cause while conducting field visit activity to enforce the Act and its regulations. A written order is one of the enforcement tools the MOL inspector may use.

The three most common orders issued by MOL inspectors in 2008-2009 included requirements for employers to: establish written measures and procedures in consultation with the joint health and safety committee or health and safety representative; conduct an annual review of the written measures and procedures; and in consultation with and in consideration of the recommendations of the JHSC or HSR develop, establish and provide training to workers.

In 2009-2010 inspectors will continue to focus on health care sector specific hazards while auditing compliance with the OHSa in general and encouraging workplaces to establish and enhance a robust workplace health and safety culture.

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## Special enforcement focus 2009-2010

### Supervisors

Competent supervision is an important part of workplace safety culture and the IRS, which are both part of the Ministry's enforcement focus this fiscal year. Inspectors will consider whether competent supervision is present in workplaces as an indicator of the IRS.

OHSa defines a supervisor as a person who has charge of a workplace or authority over a worker. As an example, a charge nurse may be a supervisor.

When appointing a supervisor, an employer must appoint a competent person (qualified because of knowledge, training, experience to organize the work and its performance, familiar with the OHSa and its regulations that apply to the work and has the knowledge of any potential or actual danger to health or safety in the workplace).

The OHSa also sets out certain specific duties for workplace supervisors:

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

### Health care blitzes

Blitzes are sector-based enforcement strategies with a focus to address specific hazards and reduce injuries and illness in health care settings. Please see the Compliance: Intervention Based on Need section for information regarding the MSD blitz.

To prepare for and then sustain health and safety in the identified blitz subject area, workplaces should focus on workplace specific policies, measures and procedures, and worker training. This may include (but is not limited to) a review and updating of the health and safety policies and programs, risk assessments and implementation of control measures to mitigate or eliminate the risk, and developing a continuous improvement plan to correct any identified gaps. The following sections provide additional detail on the specific hazards, causes of injuries/illnesses, and enforcement focus of the health care sector blitzes.

### **MSD blitz**

In 2009-2010, inspectors and ergonomists visiting health care workplaces proactively addressed the issue of MSDs through an MSD blitz in April 2009 and will continue with routine inspections for the rest of 2009-2010.

The MSD blitz focused on long-term care and residential care workplaces, specifically on tasks associated with resident lifting, transferring and repositioning as they pose risks to workers' backs and shoulders. Controls to minimize these risks are imperative to keeping health care workers safe and well. Inspections determined whether worker training occurred; if resident handling equipment was available and maintained; if residents' mobility status was communicated; and if supervisors were supervising client handling tasks.

### **MSD proactive visits**

The MOL ergonomists' proactive visits in support of Safe At Work Ontario for 2009-2010 will focus on hospitals and the measures, procedures and training they have in place to recognize and control MSD hazards. Nursing and support staff will be the focus of attention.

### **Hazardous chemical exposure blitz**

Beginning in September 2009 the MOL Health Care Program will be conducting a blitz on hazardous chemical exposures in health care workplaces. During the month-long blitz, the focus will be on worker training regarding hazardous chemical exposures in health care workplaces. Specifically, attention will be paid to chemicals used for cleaning by housekeeping staff; and cleaning and disinfecting chemicals (e.g. halogenated compounds) and detergents used in therapeutic pools and in laundry operations.

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## **Major hazards and inspection focus**

Ministry of Labour inspectors enforce the [Occupational Health and Safety Act](#) and its regulations at workplaces for Health Care and Residential Facilities sites across the province. As part of the *Safe At Work Ontario* strategy they will give special focus to certain sector specific and workplace hazards, however, they will continue to ensure overall compliance with the Act and its regulations. For example in the health care sector, MOL inspectors will focus on enforcement of the Occupational Health and Safety Act and its regulations, such as the [Regulation for Health Care and Residential Facilities](#) (O. Reg. 67/93) and the [Needle Safety Regulation](#) (O. Reg. 474/07).

In addition to general enforcement of the OHS Act and regulations inspectors will give special attention to the following this year:

Major hazards and key health and safety issues	MOL Health Care Health and Safety Program inspection focus
Asbestos	The <a href="#">Regulation Respecting Asbestos on Construction Projects and in Buildings and Repair Operations</a> , (O. Reg. 278/05) continues to be a focus, particularly in older health care facilities that may contain asbestos containing material (ACM).
Contact and struck-by-objects	<p>Contact/struck-by-objects could encompass issues such as material handling, machine guarding, lock out and tag out, etc.</p> <p>Employers are responsible for assessing the risk to workers and developing and implementing policies and programs for their protection. Workers should receive information, instruction and supervision regarding safe work practices and conditions.</p>
Exposures to chemical, biological and physical agent hazards	Continued focus on ensuring compliance with the OHSA and regulations including the <a href="#">WHMIS Regulation</a> (Regulation 860), Designated Substances Regulations, <a href="#">Control of Exposure to Biological or Chemical Agents Regulation</a> (Regulation 833), <a href="#">Health Care and Residential Facilities Regulation</a> (O. Reg. 67/93) and other legislation applicable to the workplace. The key areas of enforcement will be on material safety data sheets, safe use, handling and storage of chemicals, worker education and training, appropriate personal protective equipment, provision of eye wash stations, etc.
Emergency preparedness and response	Emergency preparedness and response plans should include measures and procedures for the health and safety of workers including training programs. The employer should conduct a hazard identification and risk assessment to develop emergency measures, procedures and training (for example, but not limited to influenza pandemic preparedness and response for health care workplaces).
Lifting devices and mobile equipment	Lifting equipment must be thoroughly examined by a competent person. Workers must be trained in their use before operating.
Motor vehicle accidents	Employers should assess the type of motor vehicle hazard and put in place measures and procedures in consultation with the Joint Health and Safety Committee (JHSC) or Health and Safety representative (HSR) and ensure worker training to reduce motor vehicle accidents. Employers are

Major hazards and key health and safety issues	MOL Health Care Health and Safety Program inspection focus
	responsible for the maintenance of company owned motor vehicles.
Musculoskeletal Disorders (MSDs)	Employers in consultation with the JHSC must: <ul style="list-style-type: none"> <li>• Ensure assistive devices are readily available;</li> <li>• Ensure proper equipment maintenance &amp; training; and</li> <li>• Ensure documented safe work procedures and ongoing inspection.</li> </ul>
MSDs specific to client handling	Workplaces must ensure that written measures, procedures and training are in place to recognize and prevent MSDs when conducting tasks of lifting, transferring and repositioning of clients.
Needle safety	In Ontario, the <a href="#">Needle Safety Regulation</a> (O Reg. 474/07) mandates the use of safety-engineered needles (SENs) or needleless systems to replace hollow-bore needles to protect health care workers from needle-stick injuries in hospitals and all long-term care homes, laboratories and specimen collection centres. The focus of the Ontario regulation is hollow-bore needles but employers must identify risks related to all sharps and take all reasonable precautions to protect workers from the hazard of injury by any sharp.
Reporting occupational illnesses	Health care associated infections in health care workers, acquired as a result of workplace exposures, are occupational illnesses that must be reported to the MOL in accordance with the OHSA, section 52 (2) and the applicable Regulations.
Slips/trips and falls	Employers are required to take every reasonable precaution to protect workers, provide information and instruction, and to ensure the workers properly use or wear the required equipment. To decrease potential for slip, trip and fall injuries there will be a heightened focus on maintenance of work surfaces, general housekeeping, safe ladder use, etc.
Ventilation maintenance and monitoring	A mechanical ventilation system is required to be inspected every six months by a competent person, and the report presented to the JHSC or Health and Safety Representative.
Workplace hazardous materials information system (WHMIS):	The three components of the WHMIS program: product labels, MSDSs, and worker education must be in place. Additional requirements are captured under “Exposures to chemical, biological and physical agent hazards” in this table.

Major hazards and key health and safety issues	MOL Health Care Health and Safety Program inspection focus
Workplace violence prevention	Health care workers experience a large number of injuries in the workplace. Violence prevention measures and procedures and worker training are required under the OHS Act, section 25 (2) (h) to take all reasonable care. More information on the MOL approach to workplace violence prevention is available at: <a href="http://www.labour.gov.on.ca">www.labour.gov.on.ca</a> .
Infection prevention and control	Workplaces are required to have in place written measures and procedures to protect workers from exposure to infectious diseases. Consultation with the joint health and safety committee (JHSC) or health and safety representative, and worker training are required. Infection prevention and control measures, procedures and training should be developed based on a risk assessment.
Risk assessment	Risk assessment is the process of a qualitative and/or quantitative determination of the likelihood of adverse effects resulting from exposures to hazards. Risk assessment helps to identify hazard(s), develop control programs and communicate hazards to workplace parties. Measures and procedures for hazard control should be developed based on a risk assessment conducted in consultation with the joint health and safety committee or health and safety representative.
Workplace safety culture and the IRS	To promote a strong IRS, employers, when appointing supervisors, are required to ensure the person is competent as defined by the OHS Act. In addition, employers are required to establish a JHSC or have a health and safety representative in place, to conduct inspections in accordance with the Act. The JHSC must meet at least quarterly and have at least one worker member and one employer member certified as JHSC members. MOL will focus on these aspects of IRS and workplace safety culture.

Workplace parties are also reminded that there are several hazard based regulations that may apply in the workplace and may impose requirements beyond those of the sector specific regulations. For additional advice on health care health and safety issues, contact the Ontario Safety Association for Community & Healthcare (OSACH) at [www.osach.ca](http://www.osach.ca).

## Summary and highlights

The Ministry of Labour's Health Care Sector Plan is based on *Safe At Work Ontario*, the MOL's compliance strategy for occupational health and safety. Through proactive enforcement, SAWO provides a modern, flexible, compliance based program. Ontario's health care sector faces a number of health and safety challenges and contributing risk factors as a result of an aging population, increased demand on health care services, and emergence of multi-factorial risks (pandemics, environmental health risks, etc). Some of the major contributors to higher than average lost-time injuries (LTI) in the health care sector include an aging workforce, and an increased demand for health care services.

The Ministry of Labour's Health Care Health and Safety Program will be continuing its enforcement and compliance focus on the following hazards: musculoskeletal disorders (MSDs), infection prevention and control and needle safety, workplace violence/aggression prevention, slips/trips/falls, and hazardous chemical exposures to promote compliance in these areas.

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

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

For further information contact:

Ontario Ministry of Labour (MOL) at [www.labour.gov.on.ca](http://www.labour.gov.on.ca)

Ontario Safety Association for Community & Healthcare (OSACH) at [www.osach.ca](http://www.osach.ca)

Workplace Safety & Insurance Board (WSIB) at [www.wsib.on.ca](http://www.wsib.on.ca)