

VOLUME 1

**Overview of Best Practices**  
*in Occupational Health and Safety  
in the Healthcare Industry*



*Best Practices Guidelines for Occupational Health  
and Safety in the Healthcare Industry*

**Government  
of Alberta** ■



## CREDITS

This document has been developed by the Government of Alberta, with input from:

- » Alberta Employment and Immigration
- » Alberta Health Services
- » Alberta Continuing Care Safety Association
- » The Health Sciences Association of Alberta (HSAA)
- » United Nurses of Alberta
- » Alberta Union of Provincial Employees
- » Alberta Home Care and Support Association

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The information provided in this Guidance Document is solely for the user's information and convenience and, while thought to be accurate and functional, it is provided without warranty of any kind. If in doubt, please refer to the current edition of the *Occupational Health and Safety Act, Regulation and Code*. The Crown, its agents, employees or contractors will not be liable to you for any damages, direct or indirect, arising out of your use of the information contained in this Guidance Document.

This Guidance Document is current to May 2011. The law is constantly changing with new legislation, amendments to existing legislation, and decisions from the courts. It is important that you keep up with these changes and keep yourself informed of the current law.

This Guidance Document is for general information only and may be applicable to assist in establishing of a compliant health and safety system at your work site. However, it is critical that you evaluate your own unique circumstances to ensure that an appropriate program is established for your work site. It is strongly recommended that you consult relevant professionals (e.g. lawyers, health and safety professional and specialists) to assist in the development of your own program.

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Current to May 2011

# Section 1

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Introduction  
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Current to May 2017



Current to May 2011

## Section 1: Introduction<sup>1</sup>

This is the first volume in a series of best practice resource handbooks that describe methods for employers and workers in the healthcare industry to improve health and safety. The healthcare industry includes complex work environments, with a wide range of activities, personnel, tasks and hazards. This resource handbook is an over-arching discussion of occupational health and safety (OHS) in healthcare. This volume provides fundamental OHS information for the other four volumes in this series. Subsequent volumes of this series will address specific classes of hazards – biological, chemical, physical and psychological. Each of these volumes will build on the concepts presented in this document.

In 2007 the health services industries in Alberta accounted for 3,310 lost time claims (a claim rate of 3.37 per 100 FTEs), which resulted in 55,100 days of lost work, and over \$12,600,000 in compensation payments.



Did you know?

**Volume 1 - Overview of Best Practices in Occupational Health and Safety in the Healthcare Industry** highlights general health and safety issues in the healthcare environment by considering:

- » how current challenges in the healthcare industry impact OHS,
- » legislated roles and responsibilities for all workforce parties for ensuring the health and safety of the workplace,
- » strategies to effectively create and maintain safe and healthy work environments,
- » a framework for identifying and controlling hazards,
- » OHS management systems to help create and maintain safe and healthy work environments,
- » common elements of occupational health and safety programs, and,
- » the importance of worker participation in program development and implementation.

<sup>1</sup> All WCB data is from “Occupational Injuries and Diseases in Alberta; Lost-Time Claims, Disabling Injury Claims and Claim Rates; Health Services Industries 2003-2007”; Alberta Employment and Immigration, Summer 2008.

Other topics in this volume are OHS Committees, communication, performance measures, accountability and record keeping. The published literature utilized to provide information about practices widely considered effective in developing and improving OHS programs are detailed in Appendix 1.

## Resources

Consider these Alberta Occupational Health and Safety Resources for obtaining more information:



- » Alberta Employment and Immigration [www.worksafe.alberta.ca](http://www.worksafe.alberta.ca)
- » Alberta Continuing Care Safety Association
- » Your Occupational Health and Safety Committee
- » Your Occupational Health and Safety Department
- » Your Union Occupational Health and Safety Representative
- » Your Department Occupational Health and Safety Representative

Alberta Occupational Health and Safety Contact Centre  
1-866-415-8690 Edmonton 780-415-8690

The information included in this resource handbook is—to the best of our knowledge—current at the time of printing. The document is intended to serve as a guideline to all healthcare workplaces and provides information on legislated requirements, best practices, guidelines and strategies in workplace health & safety. While legislated requirements—the laws—are specifically identified, the rest provides general information rather than a definitive guide to specific practices or procedures. The laws for health and safety are **minimum requirements**. The best practices, tools, forms and list of resources are provided to assist in meeting or exceeding the minimum requirements in the healthcare industry. While this document provides guidelines, only you can (and must) identify the specific hazards and controls required for your workplace.

In Alberta, the requirements for health and safety are outlined in the *Occupational Health and Safety Act*, Regulation (OHS Regulation), and Code (OHS Code). The *Act*, Regulation, and Code are available for viewing or downloading on the Alberta Employment and Immigration (AEI), Workplace Health and Safety (WHS) website at [www.worksafely.org](http://www.worksafely.org). This document does not replace the *OHS Act*, Regulation, and Code and does not exempt you from your responsibilities under the legislation.

Official printed copies may be purchased from the Queen's Printer at [www.qp.alberta.ca](http://www.qp.alberta.ca) or:



Edmonton  
Main Floor, Park Plaza  
10611-98 Avenue  
Edmonton, Alberta  
T5K 2P7  
Phone: (780) 427-4952  
Fax: (780) 452-0668

## Resources

### Current Challenges in the Alberta Healthcare Industries

Social and healthcare-specific issues affect occupational health and safety in Alberta healthcare organizations. The challenges that arise from these issues are opportunities to improve workplace health and safety and create a culture of safety. While these issues and challenges are felt by many healthcare organizations across Canada, Alberta's newly restructured health care delivery model may provide the opportunity for all healthcare organizations in the province to work together in meeting these challenges in a coordinated way. These challenges include the following:

#### HEALTHCARE RESTRUCTURING

Restructuring of the healthcare delivery system is intended to improve the accessibility and delivery of healthcare services to Alberta residents. Opportunities to improve OHS may include sharing of OHS information and best practices among employers and improved coordination of resources and efforts to advance workplace health and safety. While there may be distinct needs in certain locations or facilities, there is also likely to be benefits in standardizing OHS processes and programs.

#### RESOURCES

Resources are necessary to ensure workplace health and safety including providing adequate levels of staffing, financial resources, and dedicated OHS staff. Staff shortages may lead to increased workloads and overtime, which may create an environment where incidents are more likely to occur and potentially affect patient care. A focus on effective use of staff, increased recruitment, retention and keeping workers healthy will help reduce staff shortages.

Financial resources are required to implement and maintain health and safety programs. Over the last few years, there has been a demonstrated need for healthcare organizations to invest in OHS. Examples of these investments include training, safety equipment, OHS information systems, programs to address OHS legislative changes, and participation in the Partnerships Program. In particular, additional patient/resident handling equipment and back injury prevention training programs were provided to reduce workplace injuries related to patient/resident handling.

The specialized nature of some OHS activities highlights the importance of hiring a variety of OHS professionals (e.g. nurses, physicians, safety specialists, occupational hygienists, disability managers, etc.) to effectively manage OHS.

### **RANGE OF TASKS**

Another challenge is the wide range of jobs present in the healthcare environment. In many ways, hospitals and resident care facilities can be viewed as small towns – employing a variety of medical professionals and skilled trades. This diversity of tasks requires skill and training to understand and control all potential hazards in the workplace. Training must be available for OHS Committees, workers and OHS staff to ensure that all hazards and controls are understood.

### **INFECTIOUS DISEASES**

Routine/Standard Practices are used for all patient/resident care activities to reduce workers' exposures to infectious diseases. With the forecasted pandemic influenza, worker safety is an issue for healthcare organizations as they plan for the potential impacts. Organizations are continuing to develop and refine risk assessment protocols and exposure prevention strategies. These protocols will require occupational health and safety professionals to work cooperatively with infection prevention and control professionals to ensure that both patients/residents and healthcare workers are not exposed to infectious diseases in the workplace.

### **DEALING WITH THE PUBLIC**

Healthcare workers are constantly interacting with the public, which has the potential for healthcare workers to come face to face with unexpected behaviours. As patients, residents and families deal with their health issues and the healthcare system, negative emotions may be directed towards healthcare workers. The potential for violence directed towards healthcare workers has been identified in many organizations, and programs are

in place to identify and control violent behaviour. In extreme situations, many healthcare organizations also offer employee assistance programs that provide critical incident de-briefing. Specific duties of healthcare workers (such as public health inspection, enforcement activities and decision making that controls access to programs and services) may trigger abusive behaviour and put the workers at greater risk. While specific patient populations are recognized as potentially more susceptible to violent behaviour such as psychiatric, geriatric, or in the emergency room, disruptive behaviour can occur in any individual (patient, resident, family member, member of the public, co-worker, etc.). Under-reporting of abusive incidents is likely, as some level of abuse is frequently accepted as part of the job by some healthcare workers. When incidents are unreported, opportunities to identify the cause of the incident and methods to implement controls are lost.

### CULTURE OF SAFETY

Attitudes towards safety have evolved significantly in recent years. In some healthcare organizations, the focus on patient safety has included worker safety, as the safety of patients has been correlated with the safety of workers.<sup>2</sup> In other organizations, this connection has not been made and worker safety remains as a “nice to do” rather than a “must do”. Creating a safety culture is a challenge for many healthcare organizations as they focus on the immediate crises without the time to consider long-term solutions. A clear understanding of what constitutes a culture of safety and participation in the OHS program by all levels of employees in the organization are essential in developing a culture of safety.

### DEMOGRAPHIC CHANGES

An aging population in our communities means an increased demand for healthcare services. As the “baby boomers” become a larger segment of the population, both patients and workers are impacted. The aging workforce is more susceptible to health and safety risks on the job and as the ‘boomers’ retire, the shortage of skilled and experienced healthcare workers leads to increased workloads for those remaining. Trends also demonstrate increased obesity in the general population which increases the risk to workers who provide care to these patients/residents.

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<sup>2</sup> *Keeping Patients Safe - Transforming the Work Environment of Nurses*; Committee on the Work Environment for Nurses and Patient Safety; Ann Page, editor; Institute of Medicine; The National Academies Press; 2004.

As Alberta's population increases, the occupancy rate in many hospitals has also increased, leading to bed shortages and the need to triage patients carefully and manage available beds. At times, bed shortages may lead to mixed patient populations on hospital units, such as surgical patients admitted in medical units. This in turn makes patient care more difficult as staff must become familiar with the care plans for a variety of conditions. In addition, as hospitals struggle with bed shortages, acutely ill patients may be moved into long-term care facilities.

### CULTURAL DIVERSITY

Healthcare organizations must consider the cultural and language diversity of both workers and patients/residents to ensure adequate communication as Alberta workplaces include employees from diverse cultural backgrounds. This often requires specific attention to training programs to overcome communication barriers.

### CONTRACTED SERVICES

A number of third party services are used in Alberta's healthcare workplaces which may impact OHS in organizations. Whether the third party services are construction-related, care providers or administrative, the healthcare organization's health and safety program must address OHS requirements for contractors.

### Status of OHS Losses in Healthcare

Worker injuries have resulted in high costs for the organizations, physical as well as emotional impacts on workers, and have aggravated the already substantial shortage of trained and experienced healthcare workers. Healthcare organizations and all employees would like to see this situation improve.

#### Did you know?

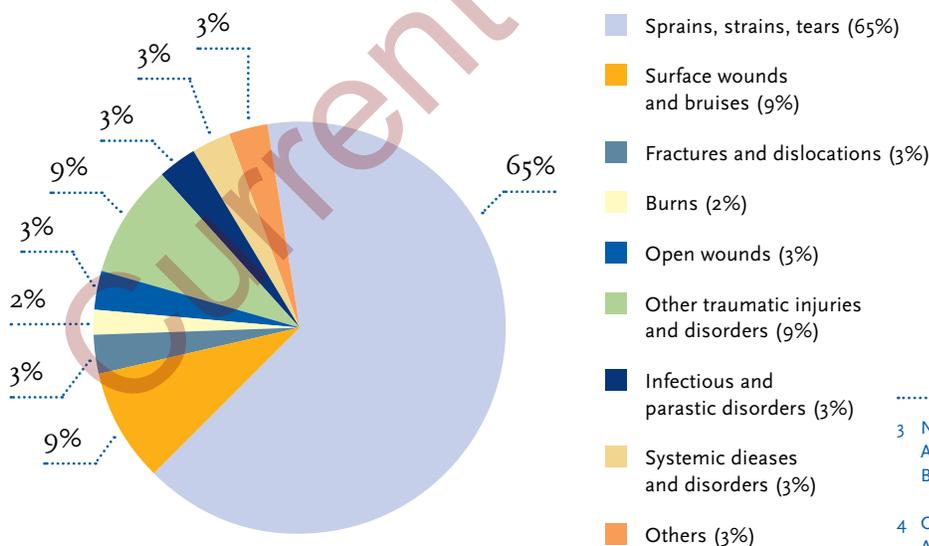
The average lost-time claim rate for all employers in Alberta in 2007 was 2.12 claims per 100 workers. Alberta health industries had an average lost-time claim rate of 3.37, which is approximately 59% higher than the all-industry provincial average.



According to data compiled by the Association of Workers' Compensation Boards of Canada<sup>3</sup>, only British Columbia and Alberta experienced a steady increase in the number of accepted time-loss injuries in the health and social service industries over the three-year period of 2004-2006. In 2007 in Alberta, lost-time claims decreased by 11%. However, this was still 59% higher than the provincial average lost-time claim rate<sup>4</sup>. Compensation payments for Workers' Compensation Board (WCB) claims in the healthcare industries in 2007 totalled over \$12,600,000. This figure does not include medical costs, rehabilitation costs, and other benefits paid to employees or their families. A limitation of this data is the varied reporting processes used by different employers (e.g., the reporting of needle stick injuries that do not require medical follow-up, the reporting of injuries that result in informal modified work for a short time, etc.).

A recent focus has been on disabling injuries, which includes injuries that result in modified work (even with no time lost) plus lost-time injuries. This figure more adequately reflects the impact of workplace incidents on employees and highlights the importance of preventing injuries rather than relying on modified work to reduce costs. In 2007, the disabling injury rate in the healthcare industry was 4.28 disabling injuries per 100 workers. This means that almost 1 out of every 23 workers per year experienced an injury that affected the worker's ability to perform all tasks of their job. The following chart illustrates the nature of disabling injuries in the health services Industries in 2007.

### Nature of Disabling Injuries



<sup>3</sup> National Work Injury Statistics Program; Association of Workers' Compensation Boards of Canada; [www.awcbc.org](http://www.awcbc.org)

<sup>4</sup> Occupational Injuries and Diseases in Alberta: Lost-Time Claims, Disabling Injury Claims and Claim Rates – Health Service Industries 2003-2007; Alberta Employment and Immigration – Work Safe Alberta, Summer 2008.

## Lost-Time Claim Data

Work-related employee injury or illness losses result in both financial losses and non-financial losses. Financial losses include WCB costs, property damage, etc. Examples of non-financial losses include staff shortages caused by lost time, overtime work for other workers, decreases in productivity by limiting work in modified work situations, administrative time for dealing with incidents and claims management, decreases in employee morale of both injured employees and their co-workers, and non-quantifiable impacts to the injured worker in pain and inconvenience.

The WCB Health Services Industries rating group includes a variety of employers, numbers and types of staff employed, nature of work, and types of hazards present. The lost-time claim rates for 2007 reflect this variation<sup>3</sup>:

### Lost-Time Claim Rate\* for the Health Services Industries – Alberta (2005 - 2007)

|   | 2005 | 2006 | 2007 |
|---|------|------|------|
| Health Services (overall)                             | 3.89 | 3.97 | 3.37 |
| Hospitals and Acute Care Centres (82100)              | 3.48 | 3.48 | 2.96 |
| Home Support Services (82704)                         | 4.08 | 4.33 | 3.13 |
| Health Units (Community Health Services) – (82705)    | 1.50 | 1.85 | 2.00 |
| Supply of Medical Personnel (82710)                   | 1.57 | 0.92 | 1.15 |
| Rehabilitation Services for the Disadvantaged (82806) | 4.68 | 3.82 | 3.35 |
| Long Term Care Facilities (82808)                     | 6.10 | 7.09 | 5.68 |

\* Lost Time Claim (LTC) rate is the number of claims that resulted in time lost from work per 100 full time equivalents (FTEs).

<sup>3</sup> National Work Injury Statistics Program; Association of Workers' Compensation Boards of Canada; [www.awcbc.org](http://www.awcbc.org)

From this data, it is clear that most sub-sectors made strides in reducing the lost-time injury rates over the past 3 years. Long-term care facilities continue to have higher lost time injury rates than other healthcare organizations. This is likely due to higher needs of residents for more extensive physical support. As the worker population ages, it is not surprising that approximately 45% of lost-time injuries in both 2006 and 2007 occurred to workers 45 years old or older.

In 2007, sprains, strains and tears accounted for 66% of all lost-time claims. Thirty-five percent of these occurred to employees in “assisting occupations in support of health services.” Approximately 20% occurred to nurse supervisors and registered nurses, and 11% to technical and related occupations in health.

The types of incidents leading to lost-time claims implicated a variety of hazards. Almost 58% were classified as “bodily reaction or exertion.” Falls accounted for over 13% of the claims. Physical contact with objects or equipment was listed in 10% of the claims and exposure to harmful substances (chemical or biological) was identified in almost 7% of claims. Violence accounted for approximately 6% of the claims, and other events or exposures were involved in the remaining 6%. This information is important as we consider ways to control the various types of hazards present in the healthcare environment.

A limitation of WCB illness and injury data is that it may not reflect the full experience of organizations, as there may be under-reporting of some or all types of incidents. Sometimes employees do not want to go “on the record” of having an injury for a variety of reasons (e.g., fear of impacting their reputation, fear of being blamed for the incident, pressure to not report minor incident, believing the incident is “part of the territory” and accepting it as unavoidable, etc.). In addition, reporting procedures may be unclear or difficult to follow. Not only does under-reporting skew results, it also robs the organization of opportunities to identify hazards and develop appropriate controls to prevent further incidents. It is well acknowledged that investigation of “near miss” or “close call” incidents enables the organization to take preventive action to reduce risks. However, the reporting of this type of incident is not common in healthcare organizations in Alberta.

While we have good data that helps us understand the magnitude of losses, there is less data available to understand the causes of the incidents. The Health Authorities (the 9 Regional Health Authorities and the Alberta Cancer Board as they existed in 2007) of Alberta conducted a benchmarking project in 2007 to identify common performance metrics that may be used by all health authorities to measure both lagging and leading indicators. Lagging indicators measure “after the fact” statistics. The lagging indicators in the project included measurements of loss related to WCB claims, disability claims and sick time. Leading indicators measure the work done to reduce employee incidents and to ensure employee health and safety before injuries or illnesses occur.<sup>5</sup> Leading indicators measured Partnerships audit results, action plans incident investigations, job hazard analyses, respiratory fit testing, immunizations, inspections, OHS committee activities, wellness programs, and OHS staff activities.

## Resources

For detailed and up to date analysis of Occupational Injuries and Diseases in Alberta - Health Services Industries:



[www.employment.alberta.ca/documents/WHS/WHS-PUB-oid-health.pdf](http://www.employment.alberta.ca/documents/WHS/WHS-PUB-oid-health.pdf)

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<sup>5</sup> *OHS Performance Measures: Data Collection, Analysis and Reporting Guidelines*; Shematek GM and Barbour J; GMS & Associates, Ltd. 2007 ISBN 978-0-9808941-0-3

# Section 2

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Roles and Responsibilities – Workplace Health & Safety  
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Current to May 2011



Current to May 2011

## SECTION 2: Roles and Responsibilities – Workplace Health & Safety

In Alberta, the requirements for workplace health and safety are outlined in the *Occupational Health and Safety Act (OHS Act)*<sup>6</sup>, Regulation (OHS Regulation)<sup>7</sup> and Code (OHS Code)<sup>8</sup>.

The *OHS Act* authorizes the government to make workplace health and safety regulations and codes. The *Act* also outlines basic duties and obligations of employers and workers. The OHS Regulation largely details government policy and administrative matters. The contents of the *OHS Act* and OHS Regulation apply to all workplaces in Alberta that fall under provincial jurisdiction. A third piece of legislation, the OHS Code, outlines technical safety standards that employers and workers must follow. Some portions of the OHS Code apply to all workplaces within provincial jurisdiction; examples include performing hazard assessments and provision of first aid. Other parts of the OHS Code are specific to certain industries and activities such as diving operations, forestry, oil and gas wells, and mining.

Employers must be knowledgeable of their responsibilities for workplace health and safety as detailed in the *OHS Act*, Regulation and Code. For many health and safety topics, employers must develop and maintain written procedures, plans and Codes of Practice. Workers need to be aware of their health and safety responsibilities and programs such as orientation, training and in-services can help achieve this.

The OHS Code Explanation Guide<sup>9</sup> provides clarification of technical topics that are contained in the Code and assists in compliance efforts. Extensive background information is also provided for some topics to assist in explaining the requirements of the Code.



### Did you know?

6 Government of Alberta, *Occupational Health and Safety Act Revised Statutes of Alberta* 2000, May 24, 2006

7 Government of Alberta, *Occupational Health and Safety Regulation Alberta Regulation* 62/2003, 2003

8 Government of Alberta, *Occupational Health and Safety Code*, 2009

9 Government of Alberta, *Occupational Health and Safety Code Explanation Guide*, 2009

The OHS Code consists of 41 parts that are outlined in the following table. The most common parts of the Code applying to healthcare are **highlighted in light blue** and are discussed in more detail in one of the Best Practice documents in this series.

| Part # | Title  | Part # | Title   |
|--------|--|--------|---|
| 1      | Definitions and General Application                                | 22     | <b>Safeguards</b>   |
| 2      | <b>Hazard Assessment, Elimination and Control</b>                  | 23     | Scaffolds and Temporary Work Platforms                    |
| 3      | Specification and Certifications                                   | 24     | Toilets and Washing Facilities                            |
| 4      | <b>Chemical Hazards, Biological Hazards and Harmful Substances</b> | 25     | <b>Tools, Equipment and Machinery</b>                     |
| 5      | <b>Confined Spaces</b>   | 26     | <b>Ventilation Systems</b>                                |
| 6      | Cranes, Hoists and Lifting devices                                 | 27     | <b>Violence</b>   |
| 7      | <b>Emergency Preparedness and Response</b>                         | 28     | <b>Working Alone</b>                                      |
| 8      | Entrances, Walkways, Stairways and Ladders                         | 29     | <b>WHMIS</b>  |
| 9      | <b>Fall Protection</b>   | 30     | Demolition  |
| 10     | Fire and Explosion Hazards   | 31     | <b>Diving Operations</b>                                  |
| 11     | <b>First Aid</b>   | 32     | Excavating and Tunnelling                                 |
| 12     | General Safety Precautions   | 33     | Explosives  |
| 13     | Joint Work Site Health and Safety Committee                        | 34     | Forestry  |
| 14     | <b>Lifting and Handling Loads</b>                                  | 35     | <b>Health Care and Industries with Biological Hazards</b> |
| 15     | Managing the Control of Hazardous Energy                           | 36     | Mining  |
| 16     | <b>Noise Exposure</b>  | 37     | Oil and Gas Wells   |
| 17     | Overhead Power Lines   | 38     | Residential Roofing – Expired                             |
| 18     | <b>Personal Protective Equipment</b>                               | 39     | Tree Care Operations                                      |
| 19     | Powered Mobile Equipment   | 40     | Utility Workers – Electrical                              |
| 20     | <b>Radiation Exposure</b>  | 41     | Work Requiring Rope Access                                |
| 21     | Rigging  |        |   |

The Alberta *Occupational Health and Safety Act*, Regulation, Code and Explanation Guide can be viewed on the Alberta Government website at:

[www.employment.alberta.ca/ohs-legislation](http://www.employment.alberta.ca/ohs-legislation)

Official printed versions of the *Act*, Regulation, Code and Explanation Guide can also be obtained through the Queen's Printer at:

[www.qp.alberta.ca](http://www.qp.alberta.ca)

Or by calling 780-427-4952



## Resources

Not all requirements under the *OHS Act*, Regulations and Code are discussed in this resource. This is not a definitive guide to the legislation and does not exempt readers from their responsibilities under applicable legislation. In case of inconsistency between this resource and the occupational health and safety legislation or any other legislation, the legislation will always prevail.



## Focus

Current to May 2011

## General Responsibilities of Employers and Workers

Employers are responsible for ensuring the health and safety of all workers on their work site. This not only includes their own workers but workers of other employers that are working at the worksite. Ensuring the health and safety of workers of other employers (contractors) at the work site may not be easy. The health and safety of a contractor's workers is a shared responsibility between the contractor and the employer of the worksite. Organizations that use contractors must have an understanding of the Prime Contractor requirements of the Alberta OHS legislation, and a contractor health and safety program in place that outlines roles, responsibilities, communications, hazard assessments, etc.

### Did you know?

In Canada, there are important similarities in OHS legislation in each jurisdiction (provincial and federal). Similarities relate to the basic elements of the OHS legislation such as the following:

- » Rights and responsibilities of employees;
- » Responsibilities of employers;
- » Responsibilities of supervisors.

*The details of the legislation in each jurisdiction vary including how the legislation is enforced.*



### Legislated Requirements

Employers must ensure, as far as reasonably practicable, that they protect the health and safety of:

- » their employees,
- » employees of other employers that may be present at a work site.

Workers must:

- » take reasonable care to protect the health and safety of themselves and other workers,
- » cooperate with their employer to protect the health and safety of themselves and other workers.

Reference: *OHS Act*, Section 2



The Government of Alberta's Employer's Guide to the *Occupational Health and Safety Act*<sup>10</sup> includes discussion of the following employer responsibilities:

- » Identification, communication and control of workplace hazards
- » Maintenance of equipment in safe working order
- » Proper labelling and storage of chemicals
- » Development and enforcement of safe work practices
- » Provision of Material Safety Data Sheets and proper labels for controlled substances
- » Training of workers
- » Implementation of appropriate protective measures

The Government of Alberta's Worker's Guide to the *Occupational Health and Safety Act*<sup>11</sup> includes discussion of the following worker rights and responsibilities:

- » The right to know about the hazards and controls in the workplace
- » The responsibility to participate in training and apply knowledge to the job
- » The right to access the employer's safe work procedures or codes of practice
- » The responsibility to follow health and safety rules
- » The responsibility to report unsafe situations and refuse to perform work that puts the worker or co-workers in imminent danger

### WHO IS COVERED UNDER THE ALBERTA OCCUPATIONAL HEALTH AND SAFETY ACT, REGULATION AND CODE?



Every occupation, employment, business, calling or pursuit, over which the Legislature has jurisdiction, except:

1. Farming or ranching specified in the regulations, and
2. Work in, to or around a private dwelling or any land used in connection with the dwelling that is performed by an occupant or owner who lives in the private dwelling or household servant of the occupant of owner.

OHS Act, Section 1

### Legislated Requirements

10 Employer's Guide – *Occupational Health and Safety Act*; The Government of Alberta,, revised 2007

11 Worker's Guide – *Occupational Health and Safety Act*; The Government of Alberta, revised 2007

It makes sense...

Some employers think their health and safety responsibility only covers workers who are covered by Workers' Compensation Board accounts. Many employers do not include volunteers, physicians, students, or contractors in their health and safety program (in terms of participation or enforcement of safety rules). However, from a best practice perspective, as well as an ethical perspective, all individuals who provide services in an organization should be included in the health and safety program. This means that hazard assessments should be completed, incidents reported and investigated, and training should take place for those providing services, regardless of their official "employee" status. The organization's health and safety policies, rules and responsibilities should be communicated to all these individuals and they should be held accountable for complying with them. Remember, even if someone is not covered by WCB, employers are still required to comply with OHS legislation.



### Serious Injuries and Incidents

Employers must report serious injuries and incidents to Occupational Health and Safety as soon as possible. The types of reportable incidents are detailed in the *OHS Act*. Occupational Health and Safety's contact line for reporting serious incidents or injuries anywhere in Alberta is **1-866-415-8690**. When workers are injured in workplace incidents, workers and employers must follow the *Workers' Compensation Act* regarding the filing of claims.

## SERIOUS INJURIES AND ACCIDENTS



Employers must report to Government of Alberta, Occupational Health and Safety:

- » An injury or accident that results in death,
- » An injury or accident that results in a worker being admitted to a hospital for more than 2 days,
- » An unplanned or uncontrolled explosion, fire or flood that causes a serious injury or that has the potential of causing a serious injury,
- » The collapse or upset of a crane, derrick or hoist, or
- » The collapse or failure of any component of a building or structure necessary for the structural integrity of the building or structure.

### Legislated Requirements

Reference *OHS Act*, Section 18

### Imminent Danger<sup>12</sup>

“Imminent danger” refers to any danger that a worker would not normally face in their tasks or any dangerous conditions under which a worker wouldn’t normally carry out their work. Workers must refuse to perform any task they believe would put them or their fellow workers in imminent danger.

If a worker refuses work due to imminent danger, the employer must protect other workers exposed to the hazard and undertake an investigation into the cause of the work refusal. The investigation must be documented and actions taken to rectify the cause of the work refusal. If the worker is not satisfied with the employer’s actions, the worker may take the matter to Alberta Occupational Health and Safety for an OHS Officer to investigate.

<sup>12</sup> Taken in part from the *Employer’s Guide – Occupational Health and Safety Act*; Government of Alberta, revised 2007

Employers need to inform workers of their right and duty to refuse work that they believe presents imminent danger. For most healthcare organizations, educating employees about these responsibilities is achieved by including information on imminent danger in orientations that are provided to newly hired employees. Similarly, management personnel need to be aware of imminent danger provisions and what procedure to follow if a worker refuses work due to imminent danger. Employers should have procedures in place before imminent danger is ever reported by a worker. These procedures should identify the steps to follow and who should be involved in the investigation, communications, and follow-up. Workers cannot be disciplined or dismissed because they refused to perform a task they believed posed imminent danger.

As a best practice, the Joint Workplace Health and Safety Committee should be informed of imminent danger work refusals for their participation, review and consideration.

## Legislated Requirements

### IMMINENT DANGER



Workers must refuse to perform any task they believe would put them or their fellow workers in imminent danger.

A worker who refuses work due to imminent danger must inform their employer. The employer must:

- » Investigate and take action to eliminate the imminent danger,
- » Ensure that no other workers are similarly exposed to imminent danger,
- » Prepare a written record of the worker's notification, the investigation, action taken, and,
- » Give the worker a copy of the written record.

Reference *OHS Act*, Section 35

### Penalties and Fines

The *OHS Act* contains significant penalties that include fines or imprisonment for contraventions. Both corporations and individuals can be prosecuted in Alberta courts. Typically, prosecutions under the *Act* have resulted from serious workplace injuries and fatalities.

## OFFENCES



A person who contravenes this *Act*, the regulations or an adopted Code or violates an order made under this *Act* or the regulations or an acceptance issued under this *Act* is guilty of an offence and liable.

- » For a first offence,
  - i. to a fine of not more than \$500,000 and in the case of a continuing offence, to a further fine of not more than \$30,000 for each day during which the offence continues after the first day, or part of a day, or
  - ii. to imprisonment for a term not exceeding 6 months, or to both fines and imprisonment, and
- » For a 2nd or subsequent offence,
  - i. to a fine of not more than \$1,000,000 and in the case of a continuing offence, to a further fine of not more than \$60,000 for each day, or part of a day, during which the offence continues after the first day, or
  - ii. to imprisonment for a term not exceeding 12 months, or to both fines and imprisonment.
- » A person who fails to comply with an order is guilty of an offence and liable to a fine of not more than \$1,000,000 or imprisonment for a term not exceeding 12 months or to both fines and imprisonment.
- » A person who knowingly makes any false statement or knowingly gives false information to an officer or a peace officer engaged in an inspection or investigation is guilty of an offence and liable to a fine of not more than \$1,000 or to imprisonment for a term not exceeding 6 months or to both fines and imprisonment.
- » A prosecution under this *Act* may be commenced within 2 years after the commission of the alleged offence, but not afterwards.

Reference: *OHS Act*, Section 41

Legislated Requirements

## Role of Government of Alberta OHS Officers

Alberta Government OHS Officers enforce the *OHS Act*, Regulation and Code in Alberta workplaces. Officers work with employers to ensure compliance with legislative requirements. Officers may provide information to assist employers in understanding and applying legislative requirements to their workplaces.

The Occupational Health and Safety division of the Alberta Government operates a 24-hour contact line where employers and workers can obtain health and safety information, report serious incidents or concerns regarding their workplaces. When a worker contacts Occupational Health and Safety, an OHS Officer may complete a follow-up that may include contacting the worker, employer and/or inspecting the worksite.

### Resources

Alberta Occupational Health and Safety Contact Centre  
1-866-415-8690 Edmonton 780-415-8690



### WORKSITE INSPECTIONS

An Officer may inspect a worksite for the purposes of identifying workplace hazards, because of a reported concern, or because of a serious injury or incident.

Officers may, or may not, inform an employer of a workplace inspection before their visits. Regardless if advance notification of a site visit is given or not, legislation requires the employer's participation with the Officer in the inspection. An employer must allow the Officer onto the work premises for inspection.

If an Officer tours the physical worksite, the employer should appoint a management representative to escort the Officer through the premises to facilitate the inspection and to respond to any enquiries. The Officer may also request that the worker who reported the concern or a labour representative also participate in the inspection.

Alberta OHS legislation empowers OHS Officers with significant authority on worksites. An Officer may enter work premises to perform inspections. Officers may also request and review health and safety documentation, interview workers, take measurements, seize equipment, take photographs and stop work at the work site to protect the health and safety of workers or to preserve investigative evidence.

## INSPECTION



An Officer may:

- » at any reasonable hour enter into or on any work site and inspect that work site,
- » require the production of any records, books, plans or other documents that relate to the health and safety of workers and may examine them, make copies of them or remove them temporarily for the purpose of making copies,
- » inspect, seize or take samples of any material, product, tool, appliance or equipment being produced, used or found in or on the work site that is being inspected,
- » make tests and take photographs or recordings in respect of any work site,
- » interview and obtain statements from persons at the work site.

Legislated Requirements

## STOP WORK ORDER

When an Officer believes that the work is unsafe or unhealthy at a work site, the Officer may write an order for the person responsible for the work

- » to stop the work that is specific in the order, and,
- » to take measures to ensure that the work will be carried out in a healthy and safe manner.

Reference: *OHS Act*, Section 9

The *Alberta OHS Act* authorizes OHS Officers to enter any work site at any reasonable hour to perform an inspection. Not allowing an Officer access to the work site is a contravention of the *Act*.



DID YOU KNOW?

## Criminal Code of Canada

While Occupational Health and Safety legislation is under provincial jurisdiction, the Criminal Code of Canada, Section 217.1, covers criminal liability of organizations related to OHS. Initially proposed as Bill C-45, this amendment to the Criminal Code came into effect on March 31, 2004. The impetus for introducing the bill came from the explosion at the Westray coal mine that claimed 26 lives in Nova Scotia on May 9, 1992. The Westray mining disaster inquiry revealed difficulties in holding organizations criminally responsible for negligence associated with workplace OHS.

One of the major changes brought on by Section 217.1 was the reference to “organizations” rather than corporations.<sup>13</sup> This amendment defines an “organization” as:

- » “a public body, a body corporate, a society, a company”
- » “a firm, a partnership, a trade union or an association of persons created for a common purpose.”

Section 217.1 ensures that senior managers cannot use the argument that they have delegated responsibility for OHS and are distant from OHS activities and issues. This section defines a “senior officer” as one who has an important role in:

- » Setting policy, or
- » Managing an important part of the organization.

Section 217.1 of the Criminal Code addresses negligent acts or omissions, and requires that senior officers have departed markedly from the standard of care. This section creates a legal responsibility for those who direct others in their work to take reasonable steps to prevent bodily harm to anyone. The criminal negligence aspect includes “wanton or reckless disregard” of safety considerations.

In an article published by Cassels, Brock & Blackwell LLP<sup>14</sup>, the impacts of the amendment on the healthcare industry were discussed.

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<sup>13</sup> This section has used the following reference extensively. *Criminal Liability of Organizations: A Plain Language Guide to Bill C-45*; Department of Justice Canada.

<sup>14</sup> Quoted with permission from Cassels Brock Lawyers; Complete article can be accessed at [www.casselsbrock.com/index.cfm?cm=Doc&ce=details&primaryKey=723](http://www.casselsbrock.com/index.cfm?cm=Doc&ce=details&primaryKey=723)

*“Of utmost concern for the healthcare industry is that amendments may make it possible for the Crown to prosecute a hospital and its directors, officers, physicians and employees for criminal negligence, where a person suffers bodily harm or death relating to circumstances where the hospital knew (or ought to have known) that there was a danger to a patient and they showed “wanton and reckless disregard” for the patient’s safety. This potential criminal liability stems from the explicit duty established for those who undertake a task, or have the authority to direct how another person performs a task, to take reasonable steps to prevent bodily harm to any person arising from the work.”*

In addition to directors, managers and supervisors, workers in positions where they supervise or direct the work of others (even temporarily) are implicated in this liability.

## **The Internal Responsibility System**

The Internal Responsibility System (IRS) is a fundamental principal underlying occupational health and safety legislation in every jurisdiction in Canada. The foundation of the IRS is that everyone in the workplace (employers, supervisors and workers) is responsible for his or her own safety as well as the safety of co-workers. The IRS requires a partnership between the employer and employees to establish a safe and healthy workplace. The basic concept is that solutions to health & safety issues in the workplace often come from workers themselves. For example, every worker who sees a health and safety problem such as a hazard in the workplace has a duty to report the situation to management. If a hazard has been identified, the employer and supervisor have a duty to look at the problem and eliminate any hazard that could injure workers. An important tool in implementing an effective internal responsibility system is the Occupational Health and Safety Committee (discussed later in this document).

## EMPLOYEE RIGHTS AND THE IRS

A basic tenet of the IRS is that workers are partners in an effective health and safety program and that each employee has basic rights and responsibilities. The key rights of all workers include the following:

1. **THE RIGHT TO PARTICIPATE** – workers have the right to take part in efforts to keep the workplace healthy and safe. An example of a specific legal requirement for workers to participate under the Alberta OHS legislation is the requirement for workers to participate in hazard assessments, if reasonably practicable (AB OHS Code, Part 2,8(1)(2)).
2. **THE RIGHT TO KNOW** – workers have the right to know the hazards related to their job. Employers must provide adequate information to ensure that workers can perform their work in a safe and healthy manner. An example of this is the WHMIS requirement to train workers who work with or near controlled products (AB OHS Code, Part 2, 8(2)).
3. **THE RIGHT TO REFUSE UNSAFE WORK** – workers must refuse to perform any job they believe would put them or their fellow workers in imminent danger (AB OHS Act, Section 35).

## Roles and Responsibilities

The IRS requires that workers within an organization take an active role in health and safety and be direct participants in the health and safety program. This suggests that senior managers, members of the board of directors, managers, supervisors and workers all have responsibility for the health and safety program in their company. Each person plays a different role in the IRS system corresponding to his or her function in the organization and realm of control. Workers fulfill their responsibilities under the IRS through individual activities as well as co-operatively with other employees.

There are also stakeholders that act as “contributive participants” to the IRS. Inside an organization, the members of the OHS Committee, health and safety staff members and unions have a contributive responsibility for health and safety in their organization. There are also contributive participants to the IRS from outside the organization including Safe Workplace Associations (e.g. Continuing Care Safety Association), Alberta Employment and Immigration and suppliers. The following table, taken from a report written by the Ontario Ministry of Labour, summarizes the participants in the IRS in Ontario.

**TABLE A: Participants with Direct Responsibility in the IRS and Those with a Contributive Role<sup>15</sup>**

| PARTICIPANTS IN INTERNAL RESPONSIBILITY SYSTEM  |   |
|---|---|
| Direct Participants   | Contributive Participants   |
| <ul style="list-style-type: none"> <li>» Members of Board of Directors</li> <li>» Executives</li> <li>» Managers</li> <li>» Supervisors</li> <li>» Workers</li> </ul> | INTERNAL <ul style="list-style-type: none"> <li>» Joint OHS Committee</li> <li>» Health and Safety Staff</li> <li>» Engineers</li> <li>» Other Staff</li> <li>» Union(s)</li> </ul>                       |
|   | EXTERNAL <ul style="list-style-type: none"> <li>» Union(s)</li> <li>» Safe Workplace Association</li> <li>» Workers' Centre</li> <li>» Ministry of Labour</li> <li>» WSIB</li> <li>» Suppliers</li> </ul> |

### EFFECTIVENESS OF THE IRS

An effective IRS is a critical strategy to implement a successful health and safety program that reduces the risk of occupational injuries and illnesses. A well run IRS is also an important due diligence tool to establish compliance with occupational health and safety legislative requirements. The Ontario Ministry of Labour summarized key factors in establishing the IRS in the following 12 points.

<sup>15</sup> Ontario Ministry of Labour – The Internal Responsibility System in Ontario Mines; Final Report: The trial audit and recommendations. [www.labour.gov.on.ca/english/hs/pdf/syn\\_minirs.pdf](http://www.labour.gov.on.ca/english/hs/pdf/syn_minirs.pdf)

## Keys to a Successful Internal Responsibility System<sup>16</sup>



### Focus

1. Everyone must have a sincere wish to prevent incidents and illnesses;
2. Everyone must accept that incidents and illnesses have causes that can be eliminated or greatly reduced;
3. Everyone must accept that risk can be continually reduced, so that the time between incidents and illnesses get longer and longer;
4. Everyone must accept that health and safety is an essential part of doing his or her work (health and safety is not an extra, it is part of doing the job);
5. Every person must have a clear understanding of what he/she is responsible for; what he/she can do to change matters; and when things must be done;
6. Every person must be regularly asked to explain what they have done to ensure health and safety on the job and in the workplace;
7. Everyone must have a clear understanding of their own skill, ability and limitations, and should have the capacity to carry out their responsibilities;
8. Everyone must attempt to avoid conflict when trying to reduce risk;
9. As an individual, each person must go beyond just complying with health and safety rules and standards, and strive to improve work processes to reduce risk;
10. When an individual cannot reduce risk by him/herself, then they must cooperate with others to go beyond just complying with health and safety rules and standards, and strive to improve work processes to reduce risk;
11. Everyone must understand the IRS process, believe in it, and take steps to make it effective at all levels in the organization; and
12. No one should be fearful of reprisals when using IRS processes.

<sup>16</sup> Ontario Ministry of Labour – The Internal Responsibility System in Ontario Mines; Final Report: The trial audit and recommendations.  
[www.labour.gov.on.ca/english/hs/pdf/syn\\_minirs.pdf](http://www.labour.gov.on.ca/english/hs/pdf/syn_minirs.pdf)

## Due Diligence

### WHAT IS DUE DILIGENCE?

Employers must take all reasonably practicable steps to protect the health and safety of their employees, as well as employees of other employers that may be present at a work site. Similarly, all workers must take reasonable care to protect the health and safety of themselves, their coworkers and workers of other employers at the work site. These requirements are detailed in Section 2 of the Alberta *Occupational Health and Safety Act*, which is commonly referred to as the “General Duty Clause”.

Employers must ensure, as far as reasonably practicable, that they protect the health and safety of:

- » their employees,
- » employees of other employers that may be present at a work site.

Workers must:

- » take reasonable care to protect the health and safety of themselves and other workers,
- » cooperate with their employer to protect the health and safety of themselves and other workers.

Reference: *OHS Act, Section 2*

If a workplace incident or injury were to occur, an employer, or individuals working for that employer, could be found to be in contravention of the *Occupational Health and Safety Act* (Act, Regulations and Code) and be subject to prosecution that could include fines and/or imprisonment. Due diligence is a legal defence in which an employer or person charged under occupational health and safety legislation may exercise to demonstrate that all reasonably practicable steps to protect workers' health and safety were taken and therefore be acquitted of the offence.



Legislated Requirements

Due diligence is the level of judgement, care, prudence, determination, and activity that a person would reasonably be expected to do under particular circumstances. Applied to occupational health and safety, due diligence means that employers shall take all reasonable precautions, under the particular circumstances, to prevent injuries or incidents in the workplace<sup>17</sup>. Being duly diligent does not just happen on its own. An employer must actively plan, act, document and measure their health and safety program and activities to effectively demonstrate due diligence and apply it as a legal defence.

### Example

A nursing aide is seriously injured because of a violent attack from a patient who had not previously demonstrated any aggressive characteristics or tendencies. The employer successfully demonstrated due diligence by having established a comprehensive corporate occupational health and safety program and a workplace violence prevention program that identifies, assesses and controls workplace hazards, by having provided employees with workplace violence prevention training and by maintaining documentation related to these programs.



### Did you know?

Due diligence is a standard by which employers demonstrate that all reasonable steps have been taken to protect the health and safety of their employees. It is used as a legal defence in the event of prosecution.



### REASONABLENESS

The premise of due diligence is based upon taking all reasonable steps in the circumstances to protect workers' health and safety. However, 'reasonable' is a subjective term, so how are one's actions determined to be reasonable or not?

<sup>17</sup> CCOHS - OSH Answers: OH&S Legislation in Canada – Due Diligence; [www.ccohs.ca/oshanswers/legisl/diligence.html](http://www.ccohs.ca/oshanswers/legisl/diligence.html)

Ignorance of workplace hazards and the preventative measures is clearly not considered reasonable and is unacceptable when applying the due diligence defence. Some measures by which an individual's or an organization's actions could be 'tested' as being reasonable are outlined in the chart below.

|   |   |
|---|---|
| <b>Compliance:</b>                        | Were the actions that have been taken compliant with requirements of OHS legislation? |
| <b>Industry Practice:</b>                 | Were the actions taken consistent with current industry best practices?               |
| <b>Corporate Policies and Procedures:</b> | Were the actions taken consistent with corporate policies and work procedures?        |
| <b>Reasonable person test:</b>            | Would a reasonable person have taken similar actions in the circumstances?            |
| <b>Peers:</b>                             | Would most of one's peers have taken similar actions in the circumstances?            |

A particular action could be determined to be reasonable if it is successfully stands up to these 'tests'.

#### **DEMONSTRATING DUE DILIGENCE**

An organization may develop and implement an occupational health and safety management system to help meet the standard of due diligence. The Alberta Partnerships in Health and Safety program outlines eight standard elements of an occupational health & safety program that should be included in an organization's OHS management system (OHSMS). Documentation must demonstrate that the system is functioning and all records related to the program are retained. This includes assessments, training records, procedures, documented enforcement, etc. The OHSMS must be regularly reviewed and monitored for effectiveness.

OHS audits measure an organization’s OHSMS against an approved standard and provide opportunities to improve the OHS program. As OHS program auditing is routinely performed by many organizations, it is considered an industry best practice in healthcare. Healthcare organizations that perform regular OHS audits may find it easier to demonstrate due diligence if there is a serious workplace injury or incident.

The Canadian Centre for Occupational Health and Safety (CCOHS)<sup>18</sup> has developed the following due diligence checklist that can assist in evaluating an organization’s OH&S program in meeting the due diligence standard. Negative responses to any of the questions may suggest that the standard of due diligence may not have been met.

<sup>18</sup> CCOHS - OSH Answers: OH&S Legislation in Canada – Due Diligence; [www.ccohs.ca/oshanswers/legisl/diligence.html](http://www.ccohs.ca/oshanswers/legisl/diligence.html)

| Due Diligence Checklist  |   |
|--------------------------|---|
| How well are we doing?   |   |
| <input type="checkbox"/> | Do you know and understand your safety and health responsibilities?   |
| <input type="checkbox"/> | Do you have definite procedures in place to identify and control hazards?   |
| <input type="checkbox"/> | Have you integrated safety into all aspects of your work?   |
| <input type="checkbox"/> | Do you set objectives for safety and health just as you do for quality, production, and sales?  |
| <input type="checkbox"/> | Have you committed appropriate resources to safety and health?  |
| <input type="checkbox"/> | Have you explained safety and health responsibilities to all employees and made sure they understand them?  |
| <input type="checkbox"/> | Have workers been trained to work safely and use proper protective equipment?   |
| <input type="checkbox"/> | Is there a hazard reporting procedure in place that encourages workers to report all unsafe conditions and unsafe practices to their supervisors? |
| <input type="checkbox"/> | Are managers, supervisors, and workers held accountable for safety and health just as they are held accountable for quality?                      |
| <input type="checkbox"/> | Is safety a factor when acquiring new equipment or changing a process?  |
| <input type="checkbox"/> | Do you keep records of your program activities and improvements?  |
| <input type="checkbox"/> | Do you keep records of the training each employee has received?   |
| <input type="checkbox"/> | Do your records show you take disciplinary action when an employee violates safety procedures?  |
| <input type="checkbox"/> | Do you review your occupational health and safety program at least once a year and make improvements as needed?                                   |

# Section 3

Occupational Health & Safety Management Systems

Current to May 2011



Current to May 2011

## Section 3: Occupational Health & Safety Management Systems

### Definition and History

Over the past twenty years, the development and implementation of occupational health and safety management systems (OHSMS) has become widespread. Occupational health and safety was one of the last organizational functions to utilize a management system to provide for clear roles and responsibilities and accountabilities, utilize worker participation, and monitor the activities and progress of the organization. Finance, quality control, human resources, patient safety and risk management, etc. have all utilized management systems to ensure that the functions were performed properly and persons responsible held accountable. One likely reason occupational health and safety was slow in adopting a management system approach was the focus on patient care and the basic prevailing attitude that workers were responsible for their own safety. As the organization's role in ensuring health and safety was often not understood or acknowledged, OHS took a while to be reflected in organizational policies and systems. A well-implemented OHSMS focuses the organization on prevention of workplace injuries and illness, rather than on the more traditional approach of reacting to health and safety incidents. To effectively prevent workplace injuries and illness, a management system uses the approach of continuous improvement. It has clearly defined responsibilities, worker participation and a focus on risk management through the proactive identification of hazards and controls.

In Alberta, the *Partnerships in Injury Reduction* initiative was one of the first OHSMS developed in Canada to assist employers in designing effective health and safety systems. The Alberta Government Occupational Health and Safety website<sup>19</sup> outlines the underlying beliefs that act as principles for the *Partnerships* program:

“First established in 1989, Partnerships in Injury Reduction (*Partnerships*) was developed with the belief that:

*when employers and workers build effective health and safety management systems in their own workplaces, the human and financial costs of workplace injuries and illness will be reduced.*

<sup>19</sup> [www.employment.alberta.ca/documents/WHS/WHS-PS-InfoSheet1.pdf](http://www.employment.alberta.ca/documents/WHS/WHS-PS-InfoSheet1.pdf)

*more can be achieved by working together than by working alone*

*corporate leaders in the province can be proactive in creating a climate where employers and workers work together to ensure a healthier and safer work culture, ultimately leading to greater industry self reliance and less government intervention.”*

Other early efforts at defining management systems to improve occupational health and safety included the International Loss Control Institutes “Five Star” program in the 1980s, and the British Standards Institute BS8800 in 1999 that was the basis for OHSAS 18001. More recent OHSMS standards have been established in the US and Canada by standardization organizations. In Canada, the Canadian Standards Association (CSA) released its standard Z1000-06<sup>20</sup> in 2006. In the United States, the American National Standards Institute introduced ANSI Z-10. In all of the OHSMS standards, the standards are not legislated, but rather are voluntary. However, it is well acknowledged that voluntary standards often form the basis for “best practices” and are cited by various jurisdictions as required by their legislation.

## Models of Systems

Most management systems contain similar themes. These include:

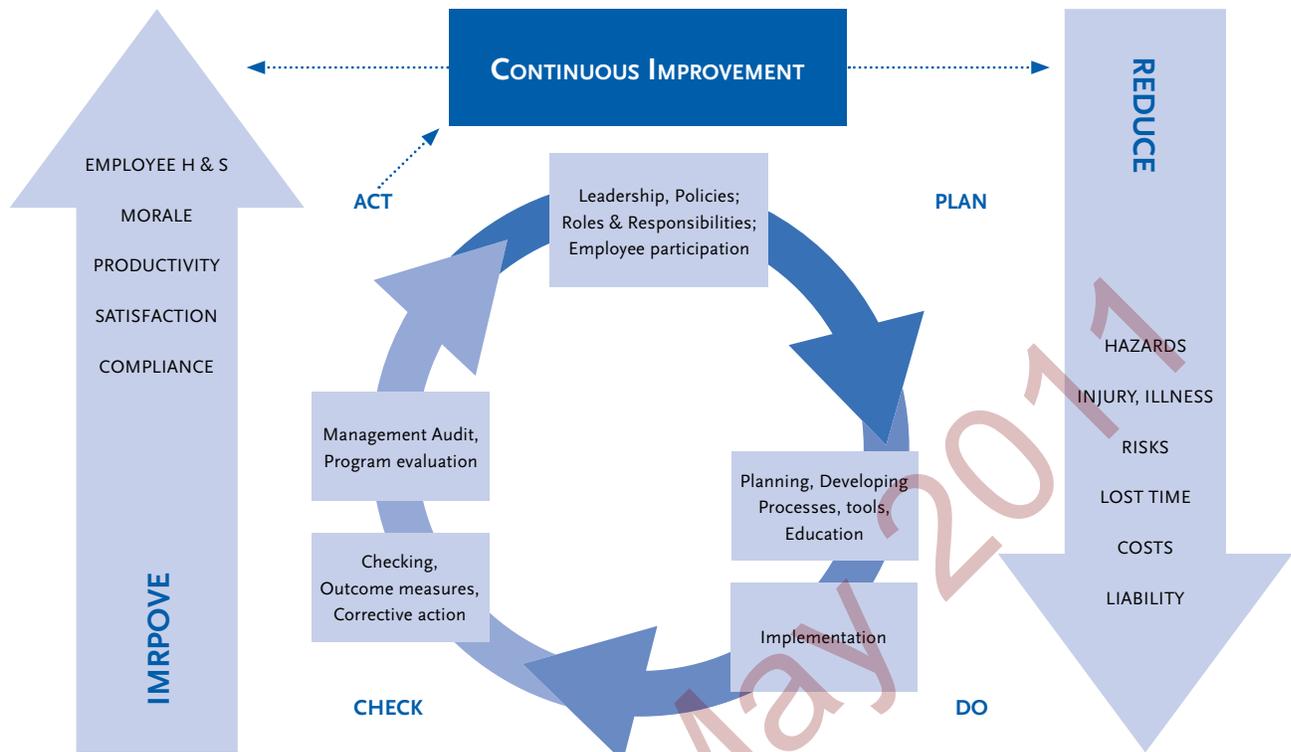
- » Management commitment and leadership
- » Written policies and procedures
- » Roles, responsibilities and accountabilities
- » Worker participation
- » Training
- » Measurement of performance and outcomes
- » Identification of required action to ensure continuous improvement

Some OHSMS focus on the basic continuous improvement cycle which includes planning what needs to be done (PLAN), doing what has been planned (DO), assessing the work done (CHECK) and performing the work recommended to improve the system (ACT). The following diagram represents activities in each part of the cycle.

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<sup>20</sup> Additional information about Z1000-06 can be found on the CSA website at [www.csa.ca/products/occupational/Default.asp?articleID=8880&language=english](http://www.csa.ca/products/occupational/Default.asp?articleID=8880&language=english)

## OHSMS Cycle (adapted from ANSIZ10-2005)



Most systems include the same basic elements. In Alberta, details of each element are outlined in the Partnerships in Injury Reduction Program. This enables accurate and consistent auditing of the systems, and provides a detailed blueprint of the components of a good OHSMS. In this next section, the elements of the Partnerships in Injury Reduction OHSMS system standards are reviewed.

Full details of the Partnerships in Injury Reduction Program are available on the Alberta Government Occupational Health and Safety website at:

[www.employment.alberta.ca/ohs-partnerships](http://www.employment.alberta.ca/ohs-partnerships).



### Resources

### Program Elements

The program elements currently found in the Partnerships in Injury Reduction OHSMS standards include

- » Management leadership and commitment
- » Hazard identification and assessment
- » Hazard control

- » Workplace inspections
- » Worker competency and qualifications
- » Emergency response
- » Incident reporting and investigation
- » Program administration

Each of these elements contains several common themes. These include

- » The requirement for documented policies and procedures
- » Roles, responsibilities and accountabilities for all workplace parties
- » Standardized forms
- » Worker participation
- » Training related to the processes
- » Follow-up processes to ensure proper completion of tasks and correction of deficiencies
- » Communication and reporting processes

### Did you know?

Detailed questions to help evaluate your organization's occupational health and safety management system are found in the Partnerships in Injury Reduction audit instrument.



Each of the common elements of a health and safety management system is described below. Where checklists are provided, they have been adapted from the Partnerships audit protocol.

#### ELEMENT 1 - MANAGEMENT LEADERSHIP AND COMMITMENT<sup>21,22</sup>

Management must have visible and genuine commitment to worker health and safety as this commitment is a fundamental factor that affects the success of an OHS management system. Ways to demonstrate management commitment to occupational health and safety include the following:

- » Having a current written OH&S policy that clearly states management commitment, indicates compliance to OHS legislation as a minimum standard, identifies organizational goals and objectives regarding health and safety, outlines OHS roles and responsibilities for all workplace parties, and is well communicated throughout the organization. The policy should be signed by the senior administrator, reviewed, and updated regularly.

<sup>21</sup> Adapted from information in *Health, Safety and Environmental Management Systems Auditing*; G. Shematek, P. Lineen, P. MacLean; LexisNexis Canada, Inc. 2006; Chapter 2, Section 3 "Components of an Occupational Health and Safety Management System". Used with permission of the authors.

<sup>22</sup> Adapted from material in *Building and Effective Health and Safety Management System*, Partnerships in Health and Safety, Alberta Human Resources and Employment

- » Ensuring the provision and communication of written safe work practices to all applicable staff.
- » Enforcing all safety policies, procedures, and rules.
- » Establishing a “safety culture” that embodies good health and safety values and beliefs. Examples of these values/beliefs are
  - All incidents are preventable
  - Health and safety performance is a line responsibility, with all workplace parties held accountable for their safety responsibilities
  - Working safely is a condition of employment
  - All employees are fully engaged in safety
  - All incident investigations are directed towards identifying root cause
  - All workplace parties intervene when they observe an unsafe condition or behaviour
  - All incidents are ultimately the failure of leadership
- » Developing and communicating the strategic direction and organizational plan for improving health and safety.
- » Ensuring that health and safety issues are discussed regularly at the management table.
- » Communicating the importance of health and safety from the senior executive and through all levels of management.
- » Encouraging and enabling worker participation in all aspects of the health and safety program.
- » Including OHS on all performance appraisals and recognizing workers who contribute significantly to improving health and safety.
- » Providing adequate resources, including OHS expertise, equipment and materials, and time for training and worker involvement.
- » Ensuring a proactive approach through processes that identify and correct hazards before the cause incident.

| Element 1 – Management Leadership and Commitment - Components of an effective system   | Yes?                     | No?                      | Required follow up (what should be done) |
|--|--------------------------|--------------------------|--|
| Is there an OHS policy that meets the standard?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are safe working procedures for all tasks developed and communicated?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are all health and safety policies, procedures and rules enforced?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Do we have a “safety culture” that places a high value on worker health and safety?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is senior management committed to OHS by including OHS goals and objectives in organizational planning and performance measures/ performance appraisals? | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are workers invited and encouraged to participate in the health and safety program?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are adequate resources provided to enable safe work?   | <input type="checkbox"/> | <input type="checkbox"/> |  |

## ELEMENT 2 - HAZARD IDENTIFICATION AND ASSESSMENT

One of the key activities in a good OHS management system is the proactive identification and assessment of hazards. Though this often requires much effort on the part of many people in the organization, it provides the greatest reward as it enables control of a hazard before it becomes a significant issue. Some organizations perform hazard assessments only for “high risk” jobs. However, to derive the best benefit of the hazard identification and assessment process, it should be a systematic process that looks at all jobs/tasks in the organization. An inventory of positions/jobs/tasks is necessary to ensure that all hazards are identified. Assessment of the hazards assists in classifying hazards by risk level that helps to address high priority hazards promptly. Key features of hazard identification and assessment process include:

- » Inclusion of all types of hazards – biological, chemical, physical, and psychological
- » Classification of each hazard as to its
  - frequency of occurrence (numbers of people exposed to the hazard or how often they are exposed),
  - severity potential (how severe the consequences would be if exposure were to occur), and
  - probability of occurrence (how often the hazard is likely to lead to exposure).

- » Numerical values for each of these factors are given and either added or multiplied together to determine a risk level.
- » Participation of workers who actually perform the jobs/tasks to ensure accuracy of identification and assessment.

There is a difference between job hazard assessments (JHAs) and Job Physical Demands Analyses (JDAs, PDAs, or JPDA). The Job Physical Demands Analyses concentrate on the physical demands of the work and are often used in the return to work process for injured/ill workers or in the placement of new hires. The JHAs however identify all classes of hazard that may affect workers as they perform their jobs.

All hazard assessments should be reviewed periodically to ensure that any new or changed processes are reflected in the JHA.

| Element 2 – Hazard Identification and Assessment – Components of an effective system                                      | Yes?                     | No?                      | Required follow up (what should be done) |
|---|--------------------------|--------------------------|--|
| Has an inventory been taken of all jobs in the organization?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are health and safety hazards identified for all jobs listed in the inventory?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Have health and safety hazards been evaluated for risk and prioritized based on risk?                                     | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are workers actively involved in the hazard identification and control process?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Do workers have access to the hazard assessment records?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is training provided for those conducting the hazard identification and assessment process?                               | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are the hazard identification and assessment records reviewed periodically or when changes are made to the jobs/tasks?    | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are the results of the hazard identification and assessment records communicated to all workers who perform the job/task? | <input type="checkbox"/> | <input type="checkbox"/> |  |

## HAZARD ASSESSMENT & CONTROL – HERE ARE THE STEPS



### Focus

**Step 1:** List types of work and work-related activities

**Step 2:** Identify the hazard(s)

**Step 3:** Assess the hazard(s)

**Step 4:** Implement controls

**Step 5:** Communicate the information to workers and provide training

**Step 6:** Evaluate the effectiveness of controls

### ELEMENT 3 - HAZARD CONTROL

Identifying hazards and assessing the risks associated with each hazard is only the first step in the proactive process of managing health and safety risks. Once the hazards are identified and assessed, it is critical to control the hazards to reduce the potential of worker exposure. The OHS Code requires a “hierarchy of controls” in selecting controls for workplace hazards. The hierarchy implies that some controls should be preferentially used over others. The most effective control is the elimination of the hazard altogether, something not always possible in healthcare. The hierarchy of controls includes (in order of preference) the following, with examples frequently found in healthcare organizations:

1. Complete elimination of the hazard
2. Engineering controls or controls at the source of the hazard;  
Examples include
  - a. Patient lifting and transport devices; lifting equipment for non-patient lifting or transfer tasks
  - b. Ventilation, including negative pressure rooms, air changes per hour, etc.
  - c. Local exhaust ventilation such as chemical fume hoods and biological safety cabinets in laboratories or shops
  - d. Machine guarding on machines in the laboratory, kitchen or maintenance areas
  - e. Security systems
  - f. Safety engineered needlestick prevention devices
  - g. Sharps containers

- h. Substitution of products for less dangerous ones
  - i. Ergonomic design of facilities and furniture
3. Administrative or procedural controls
- a. Infection prevention policies and procedures
  - b. OHS policies and procedures
  - c. No Unsafe Lift policy
  - d. Immunizations and occupational health programs
  - e. Orientation and training
  - f. Purchasing processes
  - g. Job rotation
  - h. Limiting time spent when potentially exposed to a hazard
  - i. Monitoring of worker exposures (industrial hygiene program)
  - j. Preventive maintenance of facilities and equipment
  - k. Hazard reporting processes
  - l. Separate lunchroom and break facilities
  - m. Enforcement of policies and rules
  - n. Housekeeping practices
4. Personal protection (e.g. PPE) or controls aimed directly at the worker.
- a. Gloves of various types and sizes
  - b. Protective clothing (gowns, lab coats, coveralls, uniforms, etc.)
  - c. Eye protection (face shields, safety glasses, goggles, full face respirators, etc., as appropriate to hazard)
  - d. Hearing protection (muffs, ear plugs)
  - e. Respiratory protection (respirators, masks for affected workers)
  - f. Footwear

Sometimes several controls are used simultaneously to offer adequate protection to workers. In healthcare, biological hazards may pose a significant hazard, as the nature of the work often involves very close contact with patients or their bodily fluids. The nature of the patient's illness or infectious disease status may be unknown and workers sometimes neglect their own safety concerns to provide services promptly. For this reason, a systematic hazard identification, assessment and control process will make the use of controls more "automatic" for workers, as they will be familiar with best control practices.

When developing a hazard identification, assessment and control process, be sure to:

- » Start with an inventory of all jobs and related tasks.
- » Create one hazard identification, assessment and control record for each job or task on your inventory.
- » Provide training for those creating the job hazard assessments (JHAs) to ensure consistency in evaluating risk.
- » Involve workers who actually perform the jobs/tasks in the process.
- » Respect the hierarchy of controls - elimination of the hazard, followed by engineering, followed by administrative, and followed by personal controls. Where hazards are not completely known, utilize the highest level of control in keeping with the best practice principles of precautionary prevention.
- » Ensure that managers and workers understand that the use of controls is not “optional”. Enforce the use of controls.
- » Review and update the JHAs on a periodic basis and when there are changes to processes, equipment, procedures or materials.
- » Use your JHAs for training purposes, orientation of new workers, worker placement, to assist in determining modified work options, and to identify OHS improvement objectives and actions.

| Element 3 – Hazard Control -<br>Components of an effective system                                | Yes?                     | No?                      | Required follow up<br>(what should be done) |
|--|--------------------------|--------------------------|---|
| Are workers actively involved in creating the Job Hazard Assessments (JHAs)?                     | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Is training provided for those creating the JHAs?  | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Is the hierarchy of controls respected?  | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Have actions been identified for improving controls, with accountabilities and timelines listed? | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Are the JHAs reviewed periodically or when changes are made to the jobs/tasks?                   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Are the results of the JHAs communicated to all workers who perform the job/task?                | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Are new workers made aware of the JHAs?  | <input type="checkbox"/> | <input type="checkbox"/> |   |

The following forms are examples that can be used for the process. Directions for completion of the form are provided.



## Hazard Assessment & Control – Instructions for Example 1 (previous page)

A Hazard Assessment & Control Record is prepared for every occupation to document hazards, risks and controls that are used to protect workers. It is most effective to have the hazard assessment and control record completed by a small group that includes workers who actually perform the tasks. They should list the major tasks of the position, then identify specific hazards, assess the risks using the chart below, then identify controls currently in place as well as controls that are recommended to reduce risk further,

### HAZARDS

| Physical                      | Chemical                    | Biological  | Psychological      |
|-------------------------------|-----------------------------|-------------|--------------------|
| Slip, Trip                    | Compressed Gas              | Blood       | Work conditions    |
| Struck by                     | Combustibles/<br>Flammables | Body fluids | Violence           |
| Caught in                     | Oxidizers                   | Virus       | Critical incidents |
| Mechanical                    | Irritants                   | Bacteria    | Fatigue            |
| Falls                         | Toxics                      | Mould       |                    |
| Repetitive motion             | Corrosives                  |             |                    |
| Improper work position        | Dangerously reactive        |             |                    |
| Lifting                       | Dust, mist, fume            |             |                    |
| Heat or cold stress           | Or, list specific chemical  |             |                    |
| Noise                         |                             |             |                    |
| Fire                          |                             |             |                    |
| Electrical                    |                             |             |                    |
| Radiation                     |                             |             |                    |
| Non-ionizing radiation        |                             |             |                    |
| Vibration                     |                             |             |                    |
| Pressure                      |                             |             |                    |
| Violence                      |                             |             |                    |
| Awkward or forceful positions |                             |             |                    |

### RISK FACTORS

| Value | Probability   |
|-------|---|
| 1     | Improbable, not likely to result in injury                          |
| 2     | Remote, not likely to happen, but may occur greater than five years |
| 3     | Occasional, will happen every 1 to 5 years                          |
| 4     | Probable, expected to happen at least once per year                 |

| Value | Severity  |
|-------|---|
| 1     | Minor, first aid injury   |
| 2     | Marginal, medical aid injury, minor illness                       |
| 3     | Critical, lost time injury/illness, temporary disability          |
| 4     | Catastrophic, death, serious injury/illness, permanent disability |

| Value | Frequency                 |
|-------|---------------------------|
| 1     | Several times per year    |
| 2     | Monthly                   |
| 3     | Weekly                    |
| 4     | One or more times per day |

### Risk

| Calculated Risk Value | Risk Classification |
|-----------------------|---------------------|
| 3 – 6                 | Low                 |
| 7 – 9                 | Medium              |
| 10 – 12               | High                |

## Hazard Assessment and Control Sheet – Example 2

- » List all identified hazards.
- » Identify the controls that are in place—engineering, administrative, PPE, or a combination—for each hazard.

| Job or Task | Potential or Existing Hazard | Hazard Risk Assessment | Controls in Place |                |     | Follow-up Action Required | Date and Person Responsible |
|-------------|------------------------------|------------------------|-------------------|----------------|-----|---------------------------|-----------------------------|
|             |                              |                        | Engineering       | Administrative | PPE |                           |                             |
|             |                              |                        |                   |                |     |                           |                             |
|             |                              |                        |                   |                |     |                           |                             |
|             |                              |                        |                   |                |     |                           |                             |
|             |                              |                        |                   |                |     |                           |                             |
|             |                              |                        |                   |                |     |                           |                             |

List potential or existing hazards here.

Identify controls that are in place. If you wish you may identify them by type of control.

Identify if there is any follow-up action required, such as more training or PPE.

Fill in name of person who is responsible for implementing controls.

### Did you know?

The Alberta Occupational Health and Safety Code requires all employers to identify, assess and control all workplace hazards, utilizing the hierarchy of controls, involving workers in the process, and documenting the results.



#### ELEMENT 4 - WORKPLACE INSPECTIONS

Another activity that proactively identifies workplace hazards is the workplace inspection. Workplace inspections are regular tours to identify if the controls are working or any hazards that have not been identified previously. Often the inspections are the responsibility of the manager or supervisor. This is sometimes delegated to a small group of workers with the supervisor. In some organizations, the OHS Committee conducts the inspections. In many organizations, OHS Committees review inspection reports. There is a good reason for managers to be responsible for the inspections and for workers of the area to participate. The workers are most familiar with the work environment and readily see when things are amiss. Managers are responsible for implementing corrective action and this occurs more readily if the manager “signs off” on the completed inspection report.

Key steps in developing the inspection process include:

- » Develop and communicate a workplace inspection policy that identifies responsibilities and accountabilities as well as frequency of inspections. The policy should include a prioritization of hazards, and a path of follow-up to ensure the correction of hazardous conditions.
- » With workers of the area, develop or customize a checklist that covers all workplace conditions and hazards.
- » Provide training for all those who will be conducting inspections.
- » Determine the frequency of the inspections needed by consulting the policy for the minimum number required and increasing the frequency in high hazard areas.
- » Ensure that the inspection forms utilize a hazard classification system and correction timeframe; ensure that follow-up occurs.
- » Document all inspection findings and maintain records.

A checklist is usually used to prompt the inspections to look at certain processes, facilities and equipment. Though there may be some items on the checklist that are common to all areas (such as fire prevention equipment, etc.), most departments will need to create their own specific checklist or modify a generic checklist to make it applicable in their own areas. An example of a general healthcare workplace inspection checklist is provided in Appendix 2.

| Element 4 – Workplace Inspections - Components of an effective system                          | Yes?                     | No?                      | Required follow up (what should be done) |
|--|--------------------------|--------------------------|--|
| Is there a policy requiring regular workplace inspections in all areas/ departments?           | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Does the policy include a definition of roles, responsibilities and accountabilities?          | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Does the policy require inspections at a specific frequency?                                   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is an inspection checklist/form used?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Do workers play a meaningful role in inspections?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is training provided for those who conduct inspections?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| When deficiencies are identified, are they classified according to risk?                       | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are corrective actions identified?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are accountabilities and timeframes established for corrective action?                         | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is there a mechanism to ensure that corrective action is performed?                            | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are inspection reports provided to and reviewed by at least the next level of management?      | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is there a process to report hazards?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Does the process include timely correction of hazards?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is there preventative maintenance on equipment to identify and correct any potential problems? | <input type="checkbox"/> | <input type="checkbox"/> |  |

#### ELEMENT 5 - WORKER COMPETENCY AND QUALIFICATIONS

Choosing qualified workers and providing a good orientation for them are the responsibility of the employer. These are the first steps in the initiation of the new worker to the safety culture of the organization. Processes should be in place to select workers who are well qualified for their positions. This implies they understand basic safe work procedures related to their profession or tasks. Where possible, interviews of candidates should contain questions that will provide the interviewers with a sense of the candidate's attention to safety. When checking references, the employer should specifically ask if the candidate works safely and follows safety rules.

To emphasize the value and importance of safety, an orientation program that covers essential health and safety program information should be mandatory for all new workers before they are permitted to work alone at their job. In some healthcare organizations, workload challenges lead to orientation being “optional.” If the organizational orientation program is provided only periodically (monthly, biweekly, etc.), the job-specific orientation provided to the new worker must contain critical safety elements.

**Focus**

**WHAT SHOULD BE INCLUDED IN NEW HIRE ORIENTATIONS?**

- » OH&S policies, roles and responsibilities of all workplace parties
- » Rights and responsibilities of all employees (including the right to refuse work that poses imminent danger)
- » Emergency response procedures
- » How to report hazards and incidents
- » Critical safety rules and enforcement

Once staff are oriented to the workplace and the specific job, employers must provide on-going training to maintain employee competency and currency. The healthcare environment changes continually and safety procedures must be updated regularly. While some types of training have regulated “refresher” requirements (such as Transportation of Dangerous Goods (TDG), First Aid and CPR), organizations must consider other training that would benefit by refresher courses. In particular, managers and supervisors should be required to attend update sessions on their roles and responsibilities related to managing occupational health and safety. Where specific hazards are common (such as musculoskeletal injuries related to lifting and transferring of patients), periodic refresher training should be provided.

**Focus**

**AN IMPORTANT POINT TO CONSIDER**

To address staff shortages, there is an increase in recruitment of skilled workers from across the country as well as from outside Canada. To ensure the safety of all workers, attention must be given to language and cultural differences in developing and delivering health and safety training.

| Element 5 – Worker Competency and Qualifications - Components of an effective system                                | Yes?                     | No?                      | Required follow up (what should be done) |
|---|--------------------------|--------------------------|--|
| Have qualifications and competency requirements been defined for each position?                                     | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Does the selection process require verification of qualifications, competence, and reference checking?              | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is there an orientation program that is required for all new hires prior to their commencing their work?            | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is there a job-specific orientation provided for all new or transferred staff?                                      | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are training requirements established for all positions? Do they include safety aspects related to the job?         | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are supervisors and managers oriented to their specific responsibilities related to occupational health and safety? | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are training records maintained and reviewed to ensure that employee training is up to date?                        | <input type="checkbox"/> | <input type="checkbox"/> |  |
| When new equipment or procedures are introduced, do all impacted workers receive appropriate training?              | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Do training programs include an assessment of competency or comprehension?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are training needs reviewed on a regular basis?   | <input type="checkbox"/> | <input type="checkbox"/> |  |

The Alberta Occupational Health and Safety Regulation defines a competent worker as one who is “adequately qualified, suitably trained and with sufficient experience to perform work without supervision or with only a minimal degree of supervision.”



*Alberta OHS Regulation, Section 1(g)*

### Legislated Requirements

## ELEMENT 6 - EMERGENCY RESPONSE PLANS

While a good health and safety management system works to prevent work-related injuries and illness, reducing the impact of emergencies also reduces organizational losses. In emergencies, an effective response minimizes danger to workers as well as to patients and visitors. An emergency response management system requires consideration of all potential emergencies that may occur in the organization. The plan must cover the development, communication and training of appropriate responses for each type of emergency.

## WHAT ARE POTENTIAL EMERGENCIES THAT MAY OCCUR IN/TO YOUR ORGANIZATION?



### Focus

- » Fires
- » Explosions
- » Chemical spills
- » Biological Spills
- » Bomb threats
- » Violence
- » Power failures
- » Information systems failures
- » Severe weather
- » Floods
- » Infectious disease emergencies
- » Ventilation failures
- » Others

To develop effective emergency response plans, management must review hypothetical impacts of the emergency. Who will be affected? What processes will be impacted? Then management must develop contingency plans to minimize those impacts. Communication, clear direction, and employee awareness of response procedures are critical in reducing health and safety risks.

Communication protocols must include mechanisms to alert all appropriate staff to the emergency. (This often includes a detailed “fan-out” list, with responsibilities for calling groups of employees designated to various levels of staff.) Communication also refers to contacting and alerting individuals to the on-going status of the emergency. Clear direction is required to enable a consistent message to all employees. Large healthcare organizations often use an incident command system to coordinate communications and activities throughout an emergency. Smaller organizations may designate a responsible position or committee to act as “directors” in the emergency activities. Communication includes the protocols used to communicate with outside organizations or authorities. These may include Police, Fire Department, EMS Services, Municipalities, Alberta Health Services, and various government organizations.

Being prepared for emergencies means more than having a written process available for each emergency. Employees must be aware of the procedures (there is often insufficient time to consult manuals once an emergency occurs), and practice their responses. A health and safety management system provides for regular drills (either simulated emergencies or tabletop discussions) for any anticipated emergencies. Records of responses to both drills and actual events are reviewed for improvement possibilities.

| Element 6 – Emergency Response Plans - Components of an effective system   | Yes?                     | No?                      | Required follow up (what should be done) |
|--|--------------------------|--------------------------|--|
| Have potential emergency situations been identified?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are there written emergency response procedures for each situation?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Do the plans include information about communication, procedures, responsibilities, and direction?                                       | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are managers and workers aware of their roles in emergency response situations?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are regular drills conducted for various types of emergencies to provide employees with an opportunity to “practice” their responses?    | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are drills conducted on all shifts to ensure that all workers can practice their responses?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are all employees trained in all facets of emergency response that for which they are responsible?                                       | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are reports of emergencies and drills kept and reviewed to identify opportunities to improve responses?                                  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are first aid requirements met (provision of required first aid services, supplies, facilities as per the OHS Code, Part 11, First Aid)? | <input type="checkbox"/> | <input type="checkbox"/> |  |

### ELEMENT 7 - INCIDENT REPORTING AND INVESTIGATION

An incident can lead to losses or potential losses for the organization. An effective occupational health and safety management system learns from these incidents or potential incidents by determining factors that led to the incident and correcting them. As the attention to patient safety has escalated in recent years, this process of incident reporting and review has become a critical feature in improving patient safety and reducing medical errors and organizational liability. Theoretically, if underlying causes of incidents are eliminated, incidents should not happen again. The same principles should be applied to OHS incidents.

For this process to be effective, all incidents should be investigated. The “near miss” incidents provide an opportunity to identify and correct a situation that has resulted in a “close call” but no injury or loss. Yet workers often do not report these incidents. Once incidents are reported, the investigation should focus on identifying root causes of the incident. This implies looking at what features of the management system may have contributed to the incident. The goal of the investigation is to correct underlying problems that may lead to future similar incidents to other workers.

#### WHY DO WORKERS NOT REPORT INCIDENTS OR “CLOSE CALLS”?

- » They are afraid they will be blamed for the incident or that it will appear on their personnel record.
- » They believed the incident was “part of the job” and a normal, expected occurrence.
- » They are too busy to report the incident.
- » They believe the manager/supervisor is too busy to discuss it.
- » They are not seriously injured and do not want to “make mountains out of mole hills.”
- » They thought the incident was their own fault and it would not occur again if they just paid attention more.
- » They do not want to fill out forms or do not have time to fill them out.
- » They do not believe the causes will be corrected, based on previous experience.
- » They cannot find the proper forms.
- » They do not know the incident reporting process.
- » They do not understand the importance of reporting incidents from a prevention perspective.

#### Focus



Incident investigation skills are required for the investigation process to yield the expected benefits. Frequently those responsible for incident investigations in healthcare have received insufficient training in root cause analysis or are too “busy” to conduct thorough investigations. They may be held accountable for conducting the investigation but not for the quality of the investigation. This has led to a superficial identification of immediate causes of incidents, with corrective action usually at the worker level rather than the system level. This may be a reason healthcare incident profiles and rates have not changed significantly over the years.

| Element 7 – Incident reporting and investigation - Components of an effective system   | Yes?                     | No?                      | Required follow up (what should be done) |
|--|--------------------------|--------------------------|--|
| Is there a requirement and a process for all incidents (including near misses) to be reported?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is there a standard form used for incident reporting that promotes root cause identification?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Do all supervisors and managers understand the importance of incident reporting and investigation and communicate that this is a valuable prevention tool? | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Do workers understand the importance of reporting all incidents and report all types of incidents?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are supervisors held accountable for conducting and documenting quality incident investigations that focus on root cause analysis?                         | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are corrective actions identified in the investigations implemented promptly?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are workers involved in the investigation process and made aware of results of the investigation and follow-up actions?                                    | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are those responsible for investigations provided with effective training that includes examples and opportunities to practice the skills?                 | <input type="checkbox"/> | <input type="checkbox"/> |  |

## ELEMENT 8 - PROGRAM ADMINISTRATION

An occupational health and safety management system is part of the overall management system of the organization. To be comprehensive, the management system must address workers, management, visitors, patients, and contractors. Management has oversight to ensure that all aspects of the system are running effectively and according to design. This includes maintaining a connection to and awareness of OHS issues. To ensure the system meets its goals and objectives, this must include ongoing system surveillance. Reviewing activities, outcomes, and continual improvement efforts are part of the system surveillance. Worker involvement ensures relevance and worker participation. Attention to worker health and safety concerns builds trust and cooperation. Maintaining and analyzing both leading and lagging indicators shifts the focus from a reactive to a proactive approach to injury prevention. Regular program auditing enables an objective assessment of program strengths and areas for improvement.

| Element 8 – Program administration - Components of an effective system  | Yes?                     | No?                      | Required follow up (what should be done) |
|---|--------------------------|--------------------------|--|
| Is there a mechanism to obtain and provide follow-up to worker suggestions, concerns, and issues?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Does the health and safety management system include addressing health and safety issues related to all levels of staff, visitors, and contractors? | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Does management participate in health and safety meetings and activities?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are OHS records and statistics kept?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Does OHS performance data include trend analysis and both leading and lagging indicators?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Is the OHSMS audited regularly, with action plans developed and implemented to incorporate recommendations made in the audit?                       | <input type="checkbox"/> | <input type="checkbox"/> |  |

# Section 4

.....  
Joint Occupational Health & Safety Committees  
.....

Current to May 2017



Current to May 2011

## Section 4: Joint Occupational Health & Safety Committees

The formation of a joint management-worker Occupational Health and Safety Committee (referred to here as an OHS Committee) is a major avenue used by many employers to facilitate a cooperative approach to workplace safety.

In Alberta, the establishment of a joint health and safety committee is voluntary, unless specifically required by the Minister of Employment and Immigration or required by collective agreement. An OH&S Officer may request an employer to establish a committee voluntarily based on the following criteria<sup>23</sup>

- » Repeated violations of the *OHS Act* or regulations;
- » Non-compliance with orders to correct safety hazards;
- » Repeated substantive worker complaints within a brief period of time;
- » Lost-time claim rate exceeding the industry average; and
- » Poor communication between the employer and worker on health and safety matters.



Did you know?

### Why Establish an OHS Committee?

An OHS Committee can be an effective forum for management and workers to work together to ensure and improve health and safety in the workplace. When workers and management have the same health and safety goals, the cooperative atmosphere assists in promoting and improving health and safety. Most healthcare organizations in Alberta have OHS Committees, as this is a requirement in some collective agreements. While the collective agreements specify the entitlement of union members to participate in OHS Committees, the employer is responsible for making sure that the committees are established and are effective.

<sup>23</sup> Alberta Occupational Health and Safety Code 2009 Explanation Guide, Part 13

The OHS Committee does not remove the legal responsibility of the employer to provide a safe and healthy work environment, nor does it provide a mechanism to bypass the normal chain of command in an organization. The OHS Committee is not responsible for issuing policies, but may have a role in reviewing policy drafts in some organizations. In establishing the committee, the roles and responsibilities of the committee should be well defined and documented.

When an OHS Committee is effective, there is greater likelihood that a safety culture is developed in an organization. An effective committee can monitor the internal responsibility system by reviewing outcomes of health and safety processes. It also helps to develop and promote organizational values related to health and safety.

### Establishing/Re-establishing an OHS Committee

These guidelines may assist an organization in establishing an OHS Committee. In addition, they will be useful in helping established committees become more effective.

Consider the following steps in establishing/re-establishing an OHS Committee:

- » Identify the purpose of the committee
- » Determine committee membership
- » Determine committee reporting structure
- » Define roles and responsibilities, powers and authorities
- » Create a terms of reference

#### Focus

#### THE PURPOSE OF THE OHS COMMITTEE

Clearly document the purpose of the committee. This will help keep everyone on track. It may become necessary to ask “Does this activity/discussion/action contribute to the stated purpose of this committee?” if discussion strays from the purpose. The purpose is often written in a policy or committee charter, and usually appears as the first statement on the committee’s Terms of Reference.

This OHS Committee provides a formal forum for management and workers to work together in a non-adversarial effort to promote health and safety in the workplace. The committee evaluates the status of health and safety system development and implementation, reviews outcome measures, and makes recommendations to the employer regarding health and safety issues.



This OHS Committee is established to promote a healthy and safe work environment by making health and safety activities an important part of the organization's culture. The committee discusses health and safety issues affecting workers, identifies problems in program implementation and suggests solutions. The goal of the committee is to reduce the risk of workplace injuries and illnesses.

The purpose of this OHS Committee is to engage all levels of staff in health and safety activities, to promote awareness of OHS responsibilities for all workers, and to provide a forum for management and workers to better control health and safety risks and create a safe work culture in the organization.

It makes sense...

The successful committee fits into the structure of the organization, and does not become a separate entity with parallel processes to those already established in the organization. For example, the committee is not usually the first recipient of a hazard report, as it is commonly the responsibility of local management to receive and act on reports of hazards in their work areas. The committee only receives reports of hazards that have not been properly dealt with through established channels, or that cross several departments that warrant a more coordinated response.

#### **DETERMINING COMMITTEE MEMBERSHIP**

Once the committee has a defined purpose, committee members who can support the purpose should be selected. To be effective, equal numbers of workers and management are recommended. A committee made up mostly worker representatives risks becoming a sounding board for issues, but one that may have insufficient management support or participation necessary to resolve issues. With a majority of management representatives, there may be insufficient input of employee concerns or perspectives in dealing with issues. In this case, the worker representatives may be seen as “token” representatives that have little impact on committee decisions.

Ideally, members should include:

- » Senior management
- » Middle management and supervisors
- » Workers representing various departments and shifts
- » Ex-officio members who can serve as committee resources such as a facilities manager, the OHS manager, a representative from Security Services, etc.

Ex officio members are usually non-voting members who can provide specialized knowledge or input on issues and can provide some immediate follow up to recommendations relevant to their areas of responsibility. An OHS manager will also be able to provide regular reports on the functioning of the OHS management system and OHS statistics.

The management team should choose management members. They should be committed to attending meetings, actively participating, and bringing forward issues raised to the management team. Workers should choose worker representatives. This occurs in a process defined either by the union, or through a general selection/volunteer process for non-unionized workers. For an effective committee, the criteria for member selection (management and worker representatives) should include being currently employed in the organization, having an interest in health and safety matters, a willingness to work cooperatively in a management-worker forum, and a willingness and ability to dedicate the required time and energy for committee work.

Ideally, OHS committees have between 6 and 12 members, often with each member having a designated alternate to attend if the member is unavailable. Having less than six members may result in cancelled meetings, while having more than 12-14 members makes the meetings more “informational” and less active.

The length of term as a committee member should be considered. Having members remain on the committee for terms of 1-3 years allows for a balance of experience and new ideas. To promote greater involvement in health and safety, both worker representatives and management representatives should rotate and not remain as committee members indefinitely. It is important to ensure that all memberships do not rotate

at the same time, as staggering them will provide sufficient “more experienced” members to act as mentors for the newer members. Note that the group represented on the committee may determine the length of committee membership.

In many committees, management and worker co-chairs are chosen to manage the meetings and coordinate committee activities.

#### **DETERMINING THE REPORTING STRUCTURE**

To reduce the likelihood of issues being “stalled,” the committee should have a specific reporting process or escalation procedure. Some committees require management response to specific issues within an allotted timeframe. Often the management representatives on the committee are responsible for bringing forward committee issues to the management table for decisions. In other cases, a specific member of the senior management team is designated as the OHS Committee “sponsor” and is the link between the committee and the senior management table. The committee and senior management should agree upon any structure chosen jointly. Each party must adhere to any timeframes or guidelines.

#### **ROLES AND RESPONSIBILITIES**

One of the most variable aspects of committees is their designated roles, responsibilities, powers and authorities. These are often based on size and complexity of the organization, with some smaller facilities sometimes giving committees responsibilities for managing and conducting certain health and safety program functions. In larger organizations, the committee does not have the time and resources to take on this type of work – it primarily operates as an “overseer” of the health and safety system. It ensures nothing “falls through the cracks” by not being addressed promptly, or by not being reported to the appropriate place. Coordinating the implementation of health and safety programs in larger organizations is usually a support function with qualified health and safety professionals.

**DEPENDING UPON THE SIZE OF THE ORGANIZATION AND THE COMMITTEE'S TERMS OF REFERENCE, EXAMPLES OF TYPICAL COMMITTEE FUNCTIONS MAY INCLUDE:**



**Example**

- » Review of the OHS policies and programs
- » Act as departmental “safety representatives” to ensure departmental implementation of health and safety programs and processes such as WHMIS inventory management, OHS training, workplace inspections, etc.
- » Monitor the effectiveness of health and safety improvements
- » Identify cross-department or system-wide health and safety issues, review concerns and make recommendations for improvements
- » Review and monitor effectiveness of OHS training programs
- » Review OHS statistics related to injuries, illnesses and incidents to identify trends and suggest corrective action
- » Work with management and with health and safety staff to improve procedures and rules related to health and safety
- » Participate in safety promotion and safety awareness programs
- » Periodically review departmental health and safety activities and issues for all departments in the organization
- » Discuss and bring to senior management OHS issues that are unresolved at the local department level through the regular management process
- » Provide input as requested on new program development
- » Participate in the hazard assessment, evaluation and control process
- » Evaluate and recommend training programs
- » Evaluate and recommend equipment
- » Promotion of health and safety throughout the organization, including safety recognition programs
- » Others, as defined and agreed upon.

A good committee has the critical job of keeping the organization focused on injury prevention. In some cases, there may not be agreement about the interpretation of information, the actions required, or the resolution of issues. In this case, it is important that all opinions and views are respected and that constructive dissent is valued. Constructive dissent enables considerations of diverse opinions and enables better decision making, as all views are considered. With an emphasis on cooperation, an effective committee helps create a sense of teamwork and improves organizational morale.

The functions of the committee should be well discussed, clearly written, understood, and formally accepted by all workplace parties.

### CREATING A TERMS OF REFERENCE

A “Terms of Reference” document provides clear definitions of the OHS Committee’s structure, function and operations. It provides the blueprint from which the committee is built and maintained.

The following items should be included in the OHS Committee’s Terms of Reference:

- » Committee purpose (including reporting structure)
- » Membership structure (how many members, selection of members, alternates, terms of office, co-chairs, etc.)
- » Functions and activities of the committee (roles, responsibilities, powers, authorities, etc.)
- » Meetings, quorum (how many meetings, how often, required quorum for meeting to take place, location and time of meetings, length of meetings, special meetings, meeting rules/etiquette, etc.)
- » Minutes (who provides secretary services, agendas)
- » Follow-up/closure (identification of follow-up action, next steps, etc; assignment of responsibilities related to follow up)
- » Communication (distribution of minutes, committee information boards, etc.)
- » How committee effectiveness will be measured.



Focus

## Did you know?

In many Alberta healthcare organizations, the requirement for an Occupational Health and Safety Committee and the parameters of its set-up and activities are agreed upon by management and unions in the collective agreement. All workers and employers are required to abide by the terms of this agreement.



In an article in *The Synergist*<sup>24</sup>, Jerome E. Spear outlined ten key success factors for effective safety committees. These factors include:

1. Having a clear direction (knowing the purpose)
2. Identifying common performance goals (expected outcomes)
3. Having a clear definition of roles (of committee chairs, members)
4. Performing actual functions as a committee (rather than as individuals)
5. Visible management support and commitment
6. Mutual responsibility and group accountability
7. Having authority to manage the work
8. Having the right number of people with the right skills on the committee
9. Having sufficient basic resources/tools to perform functions
10. Having interdependence and trust.

What can be done about a long-standing committee that is ineffective?

It may be time to admit that the committee is not effective and find ways to diagnose and treat the problems. Where the committee is very ineffective, it may sometimes be necessary to abolish the existing committee and start over.

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<sup>24</sup> Spear, Jerome E., *10 Success Factors for Effective Safety Committees*, *The Synergist*, March 2008.

## STARTING OVER OR REVITALIZING AN OHS COMMITTEE (THAT IS INEFFECTIVE)

The first step to improving OHS Committee effectiveness is to admit that the current committee is not as effective as it should be. Review the minutes of the committee meetings, looking particularly at:

- » Attendance of management representatives
- » Attendance of worker representatives
- » Starting and end times of meetings
- » Structure and control of agenda
- » Meeting etiquette and dynamics
- » Identification of issues, recommendations, follow up actions
- » Completion/sign off of items
- » Recurrence of issues on agendas

If any of these items are issues in your committee, it may be time for a revitalization of the committee. Where possible, have the current committee members identify these issues.

- » Review the current Terms of Reference. In particular, answer the following questions:
  - » Do we have a clear purpose statement that defines our direction and ensures we keep “on track”?
  - » Do we have clearly defined responsibilities as a committee? Do we have agreement on responsibilities and how we will accomplish them? What are the committee’s responsibilities? What is it NOT responsible for? To whom does the committee escalate issues?

- » Is the membership of the committee appropriate? Are major/high hazard areas represented? Have we ensured enough turnover to keep fresh ideas coming and avoid having the same people on the committee for extended periods? Is there an attendance requirement for committee members (are they removed from the committee if they miss many meetings)? Do members have alternates to ensure quorum if they cannot attend a meeting? Are the administrative aspects of the committee well defined and handled (e.g. setting the agenda, managing the meeting, taking minutes, producing and disseminating the minutes, etc.)?
- » Are the committee co-chairs effective in ensuring cooperation, smooth running of the meetings, and sharing responsibilities?
- » Is there follow-up to items discussed, with actions and timeframes defined? Are items “closed off” in an appropriate time, or left to return on subsequent agendas?
- » How does the committee communicate – to the organization and to members? How do representatives report to those they represent? How are minutes provided and to whom?
- » Does the committee periodically evaluate its effectiveness and suggest ways to improve its performance?

Answering these questions will direct committee members to the necessary improvements. The committee members will likely need to be open-minded and willing to try new things to make the committee more effective. This may mean resigning from the committee and encouraging new volunteers or representatives to step up. It may require a renewed commitment by senior management to support an effective committee.

A beneficial approach may be to provide an OHS Committee workshop for the current or newly formed or modified committee. This workshop should highlight the importance of OHS in the workplace, and the importance of an effective OHS Committee. The following is an example of an OHS Committee Workshop agenda.

#### OHS COMMITTEE WORKSHOP AGENDA



- » Welcome by Senior Management / CEO
- » Introductions
- » OHS legislation overview
- » OHS Committee Terms of Reference (including purpose, functions, membership, minutes, etc.)
- » Discussion of resources (including courses) available for committee members
- » Committee dynamics (rules of order, committee etiquette, etc.)
- » Work plan for coming year – goals and objectives (interactive group work)

Example

#### THE PERSONAL ELEMENT

The following tips for members can contribute to the success of your OHS Committee:

- » Come to the meetings prepared (read the agenda and do the required reading/homework before the meeting)
- » Arrive on time
- » Respect the opinions of other members (listen, do not interrupt); encourage all members to participate
- » Hold one meeting at a time (avoid mini-meetings on the side)
- » Avoid personal attacks; try to find a middle ground if there are opposing ideas
- » Volunteer ideas

- » Participate in out-of-meeting committee work
- » When you agree to do something, do it
- » End the meeting on time
- » Periodically evaluate meetings
- » Provide leadership by communicating and promoting health and safety in the workplace.

### Resources

Guides on Joint OHS Committees are available from the Alberta Government Occupational Health and Safety website:



[employment.alberta.ca/documents/WHS/WHS-PUB\\_l1003.pdf](https://employment.alberta.ca/documents/WHS/WHS-PUB_l1003.pdf) is the members guide, and [employment.alberta.ca/documents/WHS/WHS-PUB\\_l1005.pdf](https://employment.alberta.ca/documents/WHS/WHS-PUB_l1005.pdf) is the employer's guide.

Current to May 2014

# Section 5

Communication

Current to May 2017

# 5



Current to May 2011

## Section 5: Communication

An employer must ensure that workers affected by the hazards identified in a hazard assessment are informed of the hazards and the methods used to control or eliminate the hazards.



The employer must ensure that a worker who may be exposed to a harmful substance at a work site is informed of the health hazards associated with exposure to that substance.

OHS Code Part 2, Section 8 and Part 4, Section 21

### Legislated Requirements

To meet all organizational objectives, communication has been consistently identified as a key factor. Whether speaking about patient care, financial management, organizational growth and structure or occupational health and safety management, success hinges on timely and effective communication. Throughout these best practice modules, communication issues are emphasized. Communication should be considered broadly – various levels and types of communication are important in ensuring the health and safety of patients, workers, visitors, contractors and third parties impacted by organizational activities. In healthcare, examples of communication requirements include the following:

Orientation, including a discussion of rights and responsibilities of all workplace parties

- » Initial and refresher training
- » Health and safety policies and procedures
- » Hazard assessments and required controls
- » Equipment use and maintenance
- » Emergency response including equipment and procedures
- » Health and safety performance objectives
- » Information available about patients that may affect worker safety (e.g. lifting and transferring requirements, isolation status, etc.)
- » Information about emerging hazards

- » Actual emergency situations
- » Environmental issues
- » Outcomes of health and safety activities and experience
- » Communication between facilities

*The two words “information” and “communication” are often used interchangeably, but they signify quite different things. Information is giving out; communication is getting through.*

*-Sydney J. Harris, American journalist, author (1917-1986)*

For communication about health and safety to be effective, values about health and safety should be consistent and shared among those in an organization. Communication should be an open and two-way process. By presenting a willingness to hear what is being said, asking questions for clarification and by giving the “benefit of doubt”, trust is built and common goals are promoted. The OHS Committee can be an effective vehicle to enhance communication in an organization by its role as a joint forum for discussion.

Current to May 2011

# Section 6

Performance Measures

Current to May 2017



Current to May 2011

## Section 6: Performance Measures<sup>25</sup>

### Purpose of OHS metrics

Healthcare organizations must track meaningful occupational health and safety data, analyze the data and encourage the development and implementation of action plans to improve performance and prevent losses to the organization. It is useful to understand where performance data can be found, how to interpret it and how to display it effectively. Most importantly, interpretation should lead to action plans to improve health and safety performance.

Performance measures allow organizations to benchmark their progress with similar organizations. The benchmarking process in health and safety is described by Christopher A. Janicak in “Safety Metrics: Tools and Techniques for Measuring Safety Performance”<sup>26</sup>

*Best practices in benchmarking can be set...by posing four fundamental performance questions:*

- » *Are we performing better than we ever have?*
- » *Are we performing better than other... business units in the company?*
- » *Are we performing better than our competitors?*
- » *Are there any other industries that are performing well and from whom we can learn?*

Benchmarking extends beyond how one organization, or employer, compares with another using OHS statistics. By analyzing benchmarking data collectively, healthcare organizations can identify trends and implement successful programs. A key aspect of the benchmarking process is the development of action plans and effective follow-up on agreed upon improvements.

### Leading and lagging Indicators

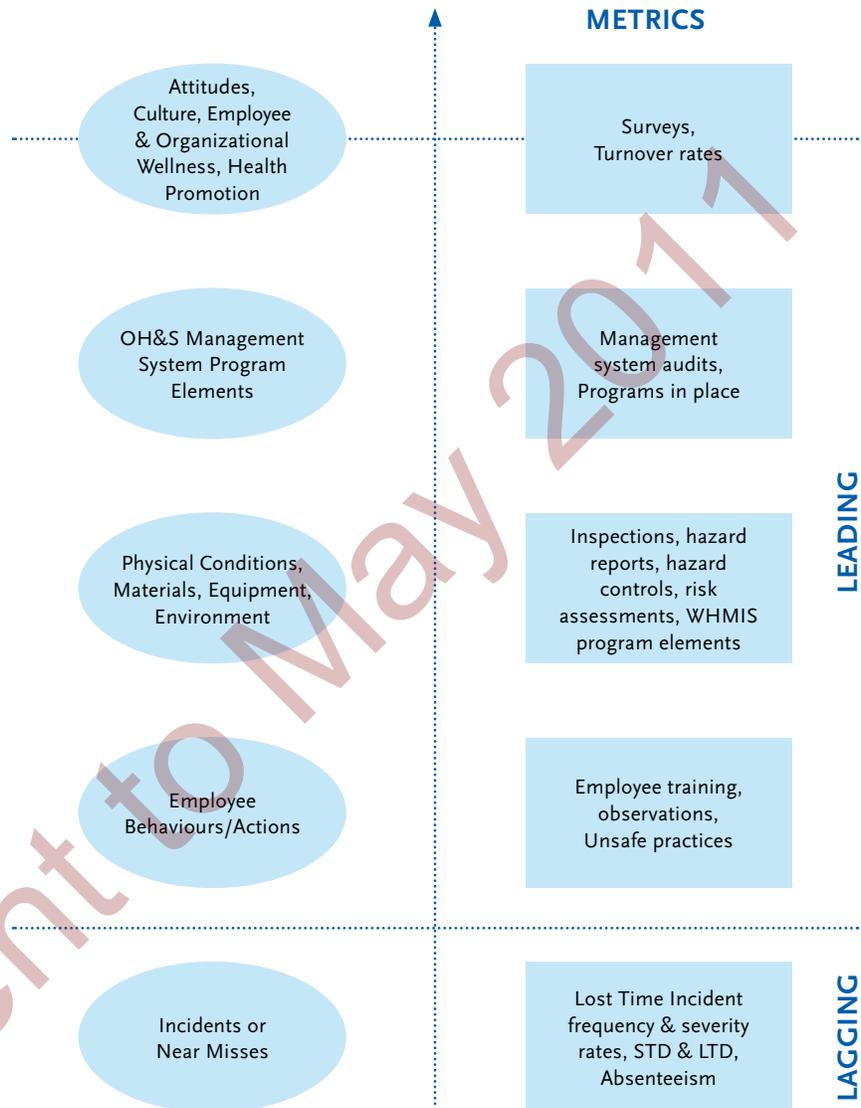
For decades, employers have measured the success of their health and safety programs by measuring its failure. They measured losses that occurred because of NOT having effective programs in place. These are called “lagging indicators” as they are measured “after the fact”. Data that demonstrates what proactive work has been done to prevent or eliminate injuries are considered “leading indicators.” These are sometimes called “process indicators”. Usually this work involves setting and enforcing policies and procedures, assessing all jobs for risks,

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<sup>25</sup> This section has been reproduced with modifications from *OHS Data Collection, Analysis and Reporting Guidelines*, GMS & Associates, Ltd. 2007 with permission of the author.

<sup>26</sup> Janicak, Christopher A., *Safety Metrics – Tools and Techniques for Measuring Safety Performance*, Government Institutes, 2003, ISBN 0-86587-947-8.

prescribing control measures, assessing hazards, training and orienting workers, investigating all incidents, preparing for emergencies, and setting up systems to ensure the program is maintained. The time continuum of performance measures can be depicted in the following diagram:



To obtain a clear picture of the status of occupational health and safety, it is important to look at BOTH leading and lagging indicators. Traditional indicators measured by health care organizations include:

#### LAGGING INDICATORS

- » Lost time frequency rate
- » Lost time severity rate
- » Cost per claim

- » Average duration of claim
- » Number of new claims
- » Average sick days per FTE
- » Insurance premium rates
- » Number of workplace health & safety citations

#### LEADING INDICATORS

- » Partnerships audit results
- » Inspections completed
- » Numbers of staff trained
- » Number of immunizations given
- » Percentage of incident investigations completed which identified root causes
- » Percentage of required hazard assessments completed
- » Effectiveness of OHS Committees
- » Percent of follow-up on corrective action completed
- » Results of staff surveys

Traditionally, healthcare management has measured lagging indicators, as these are usually better defined and linked directly to cost data.

OHS staff are sometimes challenged to “prove” that leading indicators are a good predictor of the status of health and safety. Many of the leading indicators require accountability at the operational level for activities, and there may be a reluctance to accept this level of responsibility as being necessary for OHS progress.

Research has indicated a trend to using leading indicators as a proactive approach to measure health and safety program success. In the European Process Safety Centre’s book “Safety Performance Measurement”<sup>27</sup>, limitations with measuring outputs such as the lagging indicators listed above are presented. For example, injury rates may be low, which makes measurement difficult and inadequate for providing feedback for continuous improvement. Second, very serious injuries may have a low

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<sup>27</sup> *Safety Performance Measurement*, Edited by Jacques van Steen for the European Process Safety Centre; Gulf Publishing Company, 1996, ISBN 0 85295 382 8

probability of occurring; however, absence of these serious incidents is not an adequate measure of good safety management. This book also identifies the three major components that proactively ensure safety by providing:

- » *“Plant and equipment which is “fit for the purpose” of reducing the risks from identified hazards as far as is reasonably practicable;*
- » *Systems and procedures to operate and maintain that equipment in a satisfactory manner and manage all associates activities;*
- » *People who are competent, through knowledge, skills, and attitudes to operate the plant and equipment and to implement the systems and procedures.”*

While more industries and companies are starting to report positive performance (leading) indicators, many are still reporting only lagging indicators. The most effective approach to measuring performance should be balanced, using indicators of systems, management activities, and processes as well as outcomes.

### **Challenges related to OHS metrics development and implementation**

Healthcare organizations face several challenges in developing and implementing meaningful OHS data collection and reporting processes. One requirement is good data tracking capabilities. In some organizations, information systems used to collect and track employee data (such as Human Resources (HR) and payroll systems) do not include parameters important for collecting and analyzing OHS data.

Another limitation is the unavailability of relevant data related to incidents causes. While many organizations require investigation of incidents, the level of root cause analysis is often poor, making the determination of cause and development of corrective action difficult. We cannot expect to reduce injuries and illnesses without understanding and correcting root causes.

OHS professionals require time to collect, analyze and report on OHS performance metrics. While information systems greatly aid the process, time is still required to ensure that the data is reported in a meaningful manner. Determining what to report and who should receive the reports is a challenge for many organizations. It is essential to streamline OHS reporting to make it significant and drive improvement efforts.

## Creation and distribution of OHS metrics

Choices must be made about what data to collect and report on. OHS staff must understand the full scope of data that is available and to choose specific reports to generate depending on the organization's needs. The CEO and Senior Management Teams receive volumes of information about all aspects of the operations and it is sometimes difficult to understand the importance of it all. To ensure that data is provided that will assist in decision-making, it is important to provide data that is relevant to organization.

The purpose and desired contents of data that is collected and reported on should reflect the needs of the various stakeholders within the organization.

An overview of performance data is required by senior management to:

- » Track trends
- » Be alert to problems
- » Benchmark best practices
- » Review comparative analyses
- » Identify weak performers
- » Determine priorities
- » Evaluate the value of OH&S departments

OHS and HR professionals may require a more detailed collection and analysis of information to:

- » Identify issues or areas to target
- » Prepare business cases
- » Select options
- » Show impacts of change/program implementation/actions

Frontline managers control the immediate work environment and are greatly impacted by worker illness and injury. These supervisors and managers require specific data (lagging and leading indicators) in order to:

- » See patterns in worker absence or incidents
- » Identify hazards that have or could result in injury
- » Ensure that all of their OHS responsibilities have been carried out
- » Identify the impacts of modified work
- » Determine priorities

With the increased use of OHS and HR information systems, a multitude of data, information and reports are now possible. Could there be too much of a good thing? Information overload is often accompanied by widespread disregard of the data. With systems able to crunch numbers and provide statistical analysis of almost everything, the challenge quickly becomes providing "meaningful reports." These should be brief, include explanations of the information, be targeted to the appropriate level, provide trends, and lead to decisions and actions.

### Healthcare benchmarking project

In 2007, the Alberta Health Authorities (then 9 Health Regions plus the Alberta Cancer Board) undertook a project to provide a consistent framework for collecting, analyzing and reporting on OHS performance metrics. The purpose of the project was to enable better benchmarking between the participating healthcare organizations so that the organizations would be able to share successful strategies to improve health and safety. The project consisted of four phases. Phase 1 included a literature review of best practices in data collection, analysis and reporting. Phase 2 involved the development of a questionnaire to assist in assessing the status and capabilities of the various organizations in obtaining and reporting on data. Phase 3 resulted in the development of guidelines and templates for consistent collecting, analyzing and reporting. Phase 4 included the completion of the templates by each organization.

Of the 10 health authorities (health regions plus the Alberta Cancer Board) existing in 2007, 9 provided results of the benchmarking exercise<sup>28</sup>.

Most of these organizations reported that they either completed, or partially completed, the development and reporting of lagging indicators.

Other findings of the project included:

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<sup>28</sup> *Occupational Health and Safety Benchmarking Project – Final Report*; GMS & Associates, Ltd. December 2007

- » Root cause analysis of incidents was being done in 34% of the organizations.
- » Four of the reporting organizations participated in the Partnerships in Health and Safety program.
- » Five required incident investigations for all incidents.
- » Five had completed job hazard assessments for all positions.
- » Several collected data on some of the leading indicators.

Following the completion of the project, many of the participating organizations have worked to improve their data collection and reporting capabilities.

Details of the project results can be found in the **OHS Data Collection, Analysis and Reporting Guidelines**<sup>29</sup>.

## Secondary benefits of good OHS performance

It is often assumed that the major driver for improving OHS performance is cost reduction. While it is clear that reducing workplace injuries reduces Workers' Compensation costs, there are many other benefits of improved OHS performance. These include:

- » **Improved patient safety**

Studies have indicated that nurses' work environments affect patient safety. In *Keeping Patients Safe: Transforming the Work Environment of Nurses*<sup>30</sup>, the work environment consisted of organizational management practices, workforce deployment practices, work design, and organizational culture. In recent years, greater attention has been placed on medical errors that affect patient health and safety. A systems approach must look at the connection between the work that is done, the work environment, and the causes of errors.

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<sup>29</sup> **OHS Data Collection, Analysis and Reporting Guidelines**, GMS & Associates, Ltd. 2007

<sup>30</sup> **Keeping Patients Safe – Transforming the Work Environment of Nurses**, Institute of Medicine of the National Academies, The national Academies Press, Washington DC, 2004.

» ***Increased recruitment and retention of skilled workers***

Providing a work environment that values worker health, safety and wellness is far more likely to attract and retain skilled workers. With a shift towards employers who provide a better “work life balance”, employers with high injury rates and poor working conditions cannot successfully compete for workers in a tight labour market. In addition, workers who work in environments they consider unsafe are more likely to seek employment elsewhere. For the healthcare industry as a whole, it would become increasingly difficult to be “an industry of choice” if working conditions are seen to be unsafe and lead to high numbers of injuries.

» ***Keeping workers at work***

Employee absenteeism and disability seriously affect staffing numbers in healthcare organizations. In addition to the costs associated with the absences, replacement workers are difficult to find, leading to the need for increased overtime and heavier workloads for those workers who are present. Good OHS performance translates into less absence from the job and reduces the need for overtime work.

» ***Improved morale***

When an organization demonstrates its value of worker health and safety by steadily improving its OHS performance, workers respond with higher levels of dedication and improved morale. Workers are more likely to participate in programs when they can trust the employer’s intent to improve health and safety.

# Section 7

Accountability

Current to May 2011



Current to May 2011

## Section 7: Accountability<sup>31</sup>

In many non-healthcare industries, the role of OHS practitioners has changed considerably over the past 20 years. It has evolved from that of being “the safety police” to being effective contributors to the success of the organization. In healthcare, this change has been more gradual. Occupational health and safety has only recently encompassed workplace safety, risk and environmental issues in healthcare. Traditionally OHS played a role in infection control, occupational health monitoring, and disability management. In recent years, safety specialists, occupational hygienists, occupational health physicians, ergonomists, and environmental technicians work in a team with occupational health nurses and disability case managers in healthcare facilities. This group of specialists provides the expertise to develop effective programs, track the status of programs, mentor and coach frontline supervisors and managers and provide advice to senior management. OHS specialists are generally considered support staff and provide the expertise to develop programs and best practices. They do not have line responsibilities or control of frontline staff functions.

The most effective implementation and on-going management of a good health and safety system relies on frontline managers and supervisors. Frontline managers and supervisors should be held accountable to senior management for their management of OHS at the operational level. OHS specialists can provide valuable support for managers by ensuring that they understand reports of OHS performance measures and indicators. Workers and unions also contribute to improved health and safety through participation in many aspects of OHS programs and by increasing awareness of OHS issues.

The late Dan Petersen, an influential health & safety theorist and management consultant, explored accountability for safety in several of his publications. In “Safety by Objectives”<sup>32</sup>, he identified several key principles to guide safety efforts. Among them are two key principles that relate to accountability:

*“Safety should be managed like any other company function. Management should direct the safety effort by setting achievable goals, by planning, organizing, and controlling to achieve them.*

*The key to effective line safety performance is management procedures that fix accountability....When line managers are held accountable, they will accept*

<sup>31</sup> Adapted from **OHS Data Collection, Analysis and Reporting Guidelines**, CMS & Associates, Ltd. 2007.

<sup>32</sup> **Safety by Objectives – What Gets Measured and Rewarded Gets Done**, Dan Petersen, 1996, Van Nostrand Reinhold, ISBN0-442-02179-8. Reprinted with permission of John Wiley & Sons.

*the given responsibility. If they are not held accountable, they will not, in most cases, accept responsibility. They will place their efforts on those things that management is measuring: on production, quality, cost, or wherever the current management pressure is.”*

According to Dr. Petersen, safety staff should be involved in all aspects of program development, from analysis of the safety climate to making the business case to senior management. Safety staff work on an on-going basis as technical consultants and resources, called in by line management for special projects or issues. The safety staff track and report on outcome measures and performance for the line managers and provide all levels of management with the information they need to make decisions.

Line supervisors and managers, according to Dr. Petersen, should be accountable for the performance of workers in all aspects of the work and this accountability should include safety. It is critical that senior management ensure that supervisors and managers are accountable for performing the activities that ensure safety in their work areas – for both patient safety and worker safety.

In addition to supervisor and management accountability, workers must also be held accountable for safety performance. Responsibilities should be outlined and need to be communicated to all workers. These responsibilities usually include the reporting of all incidents and hazards to supervisory staff, following all safety rules and guidelines, working safety so as to not endanger their own health and safety or that of co-workers, and participating as requested in all aspects of the health and safety program. The organization must ensure that all workers are capable of carrying out their responsibilities by providing the resources necessary and ensuring that communication is clear.

### **Safety cultures**

The term “safety culture” is used to indicate the overall value placed on occupational health and safety as demonstrated through communications, actions and outcomes of the activities of all workplace parties. In recent years, healthcare organizations strive to demonstrate a culture of patient safety by taking steps to identify and control risks that could impact the health, safety and wellbeing of patients. Much of this effort has been directed towards risk identification and control, error reporting, root cause analysis, and continual improvement efforts. While there is a belief and ethical obligation that patient safety is a priority in healthcare organizations, worker safety should not take a backseat. “Safety culture”

in some organizations needs to be extended to equally include worker health and safety in a move towards best OHS practices.

Over the past 15 years, the concept of the “safety culture” of an organization has been studied extensively. Levels of safety culture have been correlated to safety performance and affect many aspects of organizational health. Employees usually have a sense of the importance of worker safety to an organization and respond accordingly. In a 1993 article<sup>33</sup>, Larry Henson identified the following major attributes of various levels of safety culture in an organization:

| Characteristic                               | Poor Safety Culture  | Average/Traditional Safety Culture                             | World Class Safety Culture  |
|--|--|--|---|
| <b>Perception of Incidents</b>               | Incidents accepted as part of doing business                         | Incidents excused away   | Incidents not tolerated   |
| <b>Relationship between work and safety</b>  | Safety seen to conflict with work                                    | Safety programs seen as a necessary evil                       | Safety and quality and effectiveness seen as linked   |
| <b>Safety responsibility</b>                 | Up to workers to work safely; little or no management accountability | Safety department is responsible                               | Responsibilities clearly defined and accepted by all workforce parties                                |
| <b>Management involvement in OHS program</b> | Not involved; no line accountability                                 | Pays “lip service” to safety; inconsistent line accountability | Involved and participating; line accountability is standard practice                                  |
| <b>Worker involvement</b>                    | Receive direction; provides no input                                 | Ineffective OHS Committee; superficial involvement             | Active “true” participation of workers in all aspects of safety program                               |
| <b>Problem solving</b>                       | Reactive; short-term solutions                                       | Fix symptoms, not underlying causes                            | Seeks solutions to root causes  |
| <b>Monitoring/outcome measures</b>           | WCB reports/external compliance reports                              | Mostly lagging indicators; little trend analysis               | Monitors and reports on both leading and lagging indicators; provides trend analysis and action plans |
| <b>Worker relations climate</b>              | Labour vs. management  | Superficial cooperation  | True and effective collaboration  |

An organization can evolve its safety culture over time. This is sometimes prompted by a health and safety crisis (good examples of this are the changes in safety culture as result of the emergence of HIV-AIDS and SARS). Other drivers of change include leadership changes and escalating costs related to health and safety. In the healthcare environment, employee recruitment and retention also drive changes to safety culture.

<sup>33</sup> Modified from “Safety Management: A Call for (R)evolution”, Larry Hansen, Professional Safety (ASSE) March 1993.

## STEPS TO IMPROVE THE SAFETY CULTURE OF YOUR ORGANIZATION:



### Focus

- » Evaluate the status of your safety culture. Use a perception survey and analyze the results to determine areas to focus attention on. Identify the differences between the perceived culture and the culture that your organization would like to have. Identify concrete activities that can move the organization to an improved safety culture.
- » Enlist leaders/supporters at each level of the organization to become “champions”. Choose people who can work together constructively to move the program forward.
- » Identify and communicate the benefits of an improved safety culture (improved patient care, financial, employee morale, improved trust, etc.). Show the links between a good safety culture and the organization’s values, mission and goals.
- » Develop a “culture evolution plan” with planned objectives, timelines, and measurable outcomes.
- » Review and revise accountabilities for health and safety for all levels in the organization; determine how these accountabilities will be evaluated and how success will be measured.
- » Review the organization’s culture on a regular basis for continual improvement opportunities.

In a good safety culture, all levels of staff understand their health and safety responsibilities. This implies that they perceive a morale and ethical obligation to act in the best interests of the health and safety of all workers. Being accountable for health and safety activities implies that there are consequences for not assuming these responsibilities. An accountability framework provides proof that the organization takes these health and safety responsibilities seriously, provides mechanisms to assess performance, and holds individuals accountable for outcomes. Responsibilities for specific health and safety functions may be delegated, but accountability for the outcomes cannot be delegated.

The following perception survey may be modified to include aspects that are important to your organization and be used to obtain a baseline assessment of the perceived culture of safety in the organization. When a survey such as this is used, it is sometimes evident that various levels of staff have different perceptions of the organization's culture. Repeating the survey periodically will assist in evaluating progress in improving the safety culture

### Employee Perception Survey<sup>34</sup> – (Example)

Studies have shown that the perception of how safety is valued, viewed, and practiced in a workplace vary greatly. A safety culture is one in which doing things safely is part of every job or task; it is one that values the health and safety of the worker. Several indicators help describe the perception of safety in our company. Please take the time to fill out this anonymous questionnaire and send it to \_\_\_\_\_.

Please respond to the following statements, indicating if they are true: A - all the time; S - sometimes; N - never.

#### CIRCLE THE RESPONSE YOU FEEL DESCRIBES YOUR PERCEPTION:

|   |       |  |       |
|---|-------|--|-------|
| 1. In this organization, safety is a high priority.   | A S N | 14. There are opportunities for people to participate in safety programs.  | A S N |
| 2. The amount of work we do here sometimes makes it hard to do things safely.   | A S N | 15. Most people I work with participate in safety programs.                | A S N |
| 3. My supervisor stresses safety.   | A S N | 16. If I see a co-worker doing something unsafe, I tell them.              | A S N |
| 4. I work safely.   | A S N | 17. My supervisor tells me if I am doing things unsafely.                  | A S N |
| 5. My co-workers work safely.   | A S N | 18. I was given safety training when I first started working here.         | A S N |
| 6. I can shut down a machine, or not perform a task, if it is unsafe.   | A S N | 19. I have been trained in WHMIS.  | A S N |
| 7. The senior administrators are concerned about safety.  | A S N | 20. I receive safety training regularly.                                   | A S N |
| 8. My supervisor talks to us about safety issues.   | A S N | 21. I feel that safety training is good in this organization.              | A S N |
| 9. If I report a safety problem, something is done about it.  | A S N | 22. We have a strong safety committee in this organization.                | A S N |
| 10. Safety is discussed at my performance evaluation.   | A S N | 23. If I make a suggestion to the safety committee, they will take action. | A S N |
| 11. Material Safety Data Sheets are available for me to look at.  | A S N | 24. I have participated in workplace inspections.                          | A S N |
| 12. There is good follow-up on safety suggestions   | A S N | 25. I have been able to contribute to the safety program here.             | A S N |
| 13. I talk about safety with my co-workers.   | A S N | 26. I have some good ideas about how to improve safety here.               | A S N |
| <b>I am a (circle one):</b> <b>Supervisor/Manager</b> <b>Senior Manager</b> <b>Full time worker</b> <b>Part-time worker</b> |       |  |       |

<sup>34</sup> From Spotlight On Safety; Gene Marie Shematek; Journal of the Canadian Society of Medical Laboratory Science; 2001.

## Tools for Accountability

Health and safety policies and procedures should include specific responsibilities for managers, supervisors and workers. A reporting system must be developed and used to track what is being done to meet these responsibilities, and there should be repercussions for poor performance. Without accountability, it is difficult to monitor and improve safety performance.

### PERFORMANCE APPRAISALS

To ensure that OHS accountabilities are accepted and acted upon, performance appraisals for all levels of staff should include OHS responsibilities consistent with each position. In some organizations, performance appraisals may already include health and safety. However, the OHS portion of the appraisals is often very general and includes such criteria as “the worker follows all safe work procedures”, without mention of any specific responsibilities. This is also the case for supervisors and managers, who often have specific responsibilities detailed in policies and procedures but lack accountability for completion of their responsibilities. For each responsibility, measurement parameters should be identified and used to assess performance. The organization should customize performance reviews to be consistent with assigned accountabilities, and use these reviews to assist in the development of learning objectives and in meeting corporate safety goals. Examples of OHS performance measurements that may be included in supervisor, manager and worker reviews are provided in Appendix 3.

### ALIGNING WITH ORGANIZATION OBJECTIVES

Most organizations have a strategic plan that helps direct organizational activities, decision-making, and outcome measurement. With specific goals and objectives, an organization determines how best to allocate budget dollars and human resources. The strategic planning process can consider a long-term or short-term horizon or both. The process can follow a well-established format (such as the Balanced Scorecard approach<sup>35</sup>) or be developed in-house. The strategic plan identifies measurable goals, objectives, actions to support these goals and objectives, and includes the designation of accountabilities and timelines for meeting these objectives.

35 “The balanced scorecard is a strategic planning and management system that is used extensively in business and industry, government, and nonprofit organizations worldwide to align business activities to the vision and strategy of the organization, improve internal and external communications, and monitor organization performance against strategic goals. It was originated by Drs. Robert Kaplan (Harvard Business School) and David Norton as a performance measurement framework that added strategic non-financial performance measures to traditional financial metrics to give managers and executives a more ‘balanced’ view of organizational performance.” from [www.balancedscorecard.org/BSCResources/AbouttheBalancedScorecard/tabid/55/Default.aspx](http://www.balancedscorecard.org/BSCResources/AbouttheBalancedScorecard/tabid/55/Default.aspx)

Occupational health and safety objectives seldom include a connection to the organization's overall goals and objectives. Without this essential tie-in, it is difficult to gain the support and resources needed to achieve these OHS objectives. It is not difficult to link most OHS objectives to those of the organization as a whole. For example, an OHS objective may be to "obtain the Certificate of Recognition". This takes the dedication of considerable resources to develop and implement the necessary programs and processes. However, the objective supports most organization's overall goals by improving health and safety, which in turn reduces employee injuries and illness – leading to more availability of staff, lower injury costs, etc.

#### HOW TO DEVELOP OCCUPATIONAL HEALTH AND SAFETY OBJECTIVES TO SUPPORT ORGANIZATIONAL OBJECTIVES

1. Find the organizational objectives by reviewing written documents, website information, or speaking to members of senior management.
2. List each objective and consider how workplace health and safety affects the objective. It may have patient safety, financial, recruitment, staff retention, or public perception impacts, or a variety of other influences that support organizational objectives.
3. Identify what actions are required to meet the OHS objective, determine accountabilities and timeframes for conducting the activities.
4. Determine criteria with which to measure the status of each action at periodic performance assessment intervals.

Focus

#### OHS COMMITTEE OBJECTIVES AND PERFORMANCE

Another opportunity to monitor accountability exists for the OHS Committee in setting annual objectives that support the organization's overall goals. Each year, the OHS Committee should determine specific activities it will embark upon. It should consider the desired outcomes, who will be involved, and how to measure success. Regular reports of the status of the activities will help the committee keep on track and ensure that it has value for the organization. An annual report of the OHS Committee's performance in meeting its objectives should be provided to senior management.

### DEPARTMENTAL REPORT CARDS – (EXAMPLE)

Some organizations have found departmental “report cards” to be valuable tools to strengthen awareness and accountability. These reports provide department details of both leading and lagging indicators and often include a comparison between the current and previous reporting periods to show trends. When provided on a quarterly or semi-annual basis, these reports can provide valuable feedback to departmental management about health and safety performance.

| XYZ Department  |    |    |    |    |
|---|----|----|----|----|
| Parameter   | Q1 | Q2 | Q3 | Q4 |
| Lagging Indicators  |    |    |    |    |
| WCB time lost injuries  |    |    |    |    |
| Average length of time loss injury  |    |    |    |    |
| Cost of injuries  |    |    |    |    |
| Average sick time use (shifts or hours per FTE)                           |    |    |    |    |
| Total days lost due to sick time use                                      |    |    |    |    |
| Total cost of sick time use   |    |    |    |    |
| Number of new disability claims   |    |    |    |    |
| Leading Indicators  |    |    |    |    |
| % of new employees who attended orientation within 2 weeks                |    |    |    |    |
| % of required workplace inspections conducted                             |    |    |    |    |
| % of incidents investigated to determine root cause and corrective action |    |    |    |    |
| Number of employees who received specific training (list type)            |    |    |    |    |
| Number of meetings in which safety was discussed                          |    |    |    |    |
| Number and type of emergency response drills conducted                    |    |    |    |    |

## The importance of enforcement<sup>36</sup>

As discussed previously, legislation holds the employer responsible for ensuring a healthy and safe work environment. Employers cannot delegate this responsibility to a committee or to an individual or department. Managers ensure that safe work procedures are followed, that safety equipment is purchased, and that training is provided. Managers make the budgetary decisions. Managers also determine what rules and policies they enforce. Permitting safety hazards to exist (whether physical hazards or unsafe work procedures) is a management decision. Remaining silent on safety issues implies acceptance of the status quo.

The job of a supervisor or manager can be complex and demanding. It includes managing tight budgets, dealing with multiple personality types in staff, ensuring quality control for outcomes, meeting difficult deadlines and timeframes, keeping up to date with technical, administrative and management issues, AND ensuring the health and safety of all staff. Safety staff and OHS committees can assist the manager by providing information and advice, but ultimately the manager is accountable for setting and enforcing rules. Managers are sometimes reluctant to enforce safety rules; workers often believe that the risk is not high enough to warrant specific precautions and will argue the issue with management. Some managers themselves are sometimes not convinced of the value of certain safety precautions or rules, and do not want to “police” workers on practices they do not believe are critical. Some managers believe that safety precautions are common sense and the workers should be trying to protect themselves. These reasons (and probably many more) factor into enforcement decisions. A good guide for safety rules is that if management is not prepared to enforce a rule (with disciplinary action) then they should get rid of the rule. There is no value in giving conflicting messages to workers with “real” enforced rules and “lip service” un-enforced rules.

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<sup>36</sup> Modified from “*Spotlight On Safety*”;  
Gene Marie Shematek, Canadian Society  
of Medical Laboratory Science; 2005.

**THE REPERCUSSIONS OF NOT ENFORCING SAFETY RULES  
ARE MANY AND SERIOUS.**



**Focus**

- » Un-enforced rules are quickly assumed to be unimportant by most workers, and encourage widespread disregard for the rules.
- » Those workers who follow the rules are sometimes seen in a negative light by those who do not.
- » Supervisors, managers and senior executives can be held morally and criminally negligent should an incident occur which could have been prevented.
- » Workers who do not follow safety rules may cause injury or illness to themselves or to co-workers.

If supervisors and managers do not heed their moral and legal responsibilities for safety, the workplace becomes a more dangerous environment. Supervisors and managers should assess their own behaviours related to health and safety. They should ensure that they understand and support the safe working procedures and safety rules, communicate and train staff to work safely, and visibly enforce safety rules. In addition, valuable information can be obtained when supervisors and managers investigate and determine the root causes of non-compliance. These causes may reveal inconsistencies, impracticalities or unforeseen deficiencies of safety rules.

All workers are responsible for following safety rules and safe work practices, wearing the appropriate protective equipment, reporting all safety hazards and incidents to their supervisors and cooperating in creating and maintaining a safe work environment. Peer pressure to work safely is sometimes a stronger motivator to improve safety behaviour.

The accountability to ensure a healthy and safe work environment rests with the employer, but all levels of workers and management have roles and responsibilities that must be fulfilled.

# Section 8

Record Keeping

Current to May 2011



Current to May 2011

## Section 8: Record Keeping

Many types of OHS records need to be retained for legal and organizational purposes. Legal requirements for maintaining some records exist and are detailed in OHS legislation. Examples of records that must be retained include medical records of health assessments, first aid records, incident investigations, and industrial hygiene monitoring results.

In addition to the legal requirements for retaining OHS records, organizations may demonstrate due diligence by detailing the work the organization has done to ensure the health and safety of workers.

Perhaps the most important reason to maintain records is to provide information to identify critical issues in the OHS management system that may need to be addressed.

### Practical aspects

From a practical perspective, record keeping frequently presents challenges. The organization must have a process to determine what records it will maintain, who will maintain them, how they will be maintained, and who can have access to them. If records are maintained electronically, proper security measures must be in place to protect the information and appropriate back-up processes must be in place to ensure the records are not lost.

### Types of records and length of record maintenance

OHS records that are most often maintained in healthcare organizations include:

- » Employee health (including immunization records, communicable disease status, audiometric testing results)
- » Health assessments (30 years if related to asbestos, coal, silica)
- » Orientation and on-the-job training
- » Inspections
- » Near misses
- » Incident investigations
- » Serious injury or incident reports (2 years)
- » Emergency response plans and drills
- » Industrial hygiene monitoring of hazards

- » All OHS training
- » First aid training
- » First aid incidents (3 years)
- » Air monitoring results (3 years)
- » Hazard assessments
- » Fit-testing for respirators
- » Audiometric testing (10 years)
- » PPE training and provision
- » OHS Committee minutes
- » Codes of Practice (respiratory, confined space entry)

OHS records should be maintained for a reasonable length of time. In some cases (where indicated), these are prescribed by legislation. In others, the length of record maintenance likely will be determined by the reason the records are kept. In most cases, records are kept for at least three years, but in some cases (particularly those involving medical issues) as long as 30 years.

### Accessibility of records

Who has access to records kept by an organization? In most cases, OHS records that do not contain personal medical information are maintained at the departmental level or centralized in an OHS Department. OHS staff, auditors, departmental management and staff often access these.

Only authorized personnel may access medical information in employee health records. This includes occupational health and safety professionals, but does not include operational management or the Human Resources department. Access to relevant employee health information may include third parties who provide disability management services or return to work professionals (this may be limited to medical information specific to the placement process) or the Government of Alberta's Director of Medical Services when required. In general, employees have access to their own employee health files.

# Useful References

Current to May 2017



Current to May 2011

## Useful References

### Glossary

**Benchmarking:** As it relates to OHS, comparison of occupational health and safety statistics and performance data with standards and measurements from other organizations.

**Biohazardous material:** Blood, body fluids, or body substances that contain biological organisms known or suspected to cause disease in humans, or any material contaminated with such organisms.

**Certificate of Recognition:** The certificate that is given to employers who develop health and safety programs that meet standards established by the Government of Alberta. Certificates are issued by Alberta Employment and Immigration and are co-signed by Certifying Partners through the Partnerships in Injury Reduction program.

**Competent worker:** An adequately qualified, experienced and suitably trained worker that requires minimal supervision.

**Contractor:** A person or business who provides services or materials through a contract or an agreement.

**Disabling Injuries:** Work-related injuries or illnesses that result in lost time or, if not resulting in lost time, require a modification of work (tasks or schedules) for a period of time.

**Employer:** A person or business that employs one or more workers.

**Employee:** Any person working for a company or organization that is paid by that organization. This is usually interpreted to include both management and non-management personnel.

**Hazard:** A situation, condition or thing that may be dangerous to the safety or health of workers.

**Imminent danger:** Any danger that a worker would not normally face in their job or any dangerous conditions under which a worker wouldn't normally carry out their work.

**Incident:** Any occurrence that has the potential to cause injury or illness. This includes "near miss" incidents.

**Lagging indicators:** Data that measures losses that have occurred. Examples include the number of incidents that have occurred, the average duration of injuries and lost time injuries and cost data related to incidents. Often considered “reactive data.”

**Leading indicators:** Data that demonstrates proactive work that has been done to prevent or eliminate workplace injuries. Examples include OHS program audit results, number of incident investigation performed, hazard assessments completed and inspections performed. Often considered “proactive data.”

**Lost Time Claim Rate:** The number of claims that resulted in time lost from work per 100 full time workers per year. Full time workers are often expressed as full-time equivalent workers (FTEs) to reflect total hours worked by both full and part-time workers.

**Lost Time Injury:** An injury or illness accepted by WCB that causes a worker to miss work beyond the day of the injury.

**Musculoskeletal injury (work-related):** an injury to a worker of the muscles, tendons, ligaments, joints, nerves, blood vessels or related soft tissues that are caused or aggravated by work and includes overexertion injuries and overuse injuries.

**OHS metrics:** Measurements of occupational health and safety activities and outcomes.

**Partnerships in Injury Reduction:** An Alberta Government program that promotes health and safety through partnerships with safety associations, industry groups, education institutes and labour organizations. Partnerships provides the framework for certifying health and safety programs and achieving and maintaining the Certificate of Recognition.

**Prime Contractor:** The chief contractor for a project who has an agreement with the owner and has responsibility for the project’s completion. The prime contractor may employ one or more subcontractors. If there is no agreement, the owner is the prime contractor.

**Worker:** A person engaged in an occupation.

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Current to May 2011

## Appendix 2 - Sample Healthcare General Workplace Inspection Checklist

| Date:   |     | Department / Area: |     |                 |  |                |
|---|-----|--------------------|-----|-----------------|--|----------------|
| Inspected by:   |     | Reviewed by:       |     |                 |  |                |
|   | Yes | No                 | N/A | Risk<br>(H,M,L) | Action<br>(include name of individual responsible and timelines) | Date Corrected |
| Are all work areas clean and orderly?   |     |                    |     |                 |  |                |
| Are doorways, aisles, hallways and stairwells free of materials and obstructions that could pose a tripping or evacuation hazard? |     |                    |     |                 |  |                |
| Are floor surfaces smooth, even and free of cracks or defects that could cause a trip or fall?                                    |     |                    |     |                 |  |                |
| Is lighting adequate?   |     |                    |     |                 |  |                |
| Is ventilation adequate?  |     |                    |     |                 |  |                |
| Are ceiling tiles in place; no evidence of significant leaks or mould?  |     |                    |     |                 |  |                |
| <b>Offices</b>  |     |                    |     |                 |  |                |
| Are filing cabinet drawers kept closed when not in use?   |     |                    |     |                 |  |                |
| Are filing cabinet drawers properly loaded from the bottom, and do not pose a tipping hazard?                                     |     |                    |     |                 |  |                |
| Are computer workstations configured in a manner to minimize ergonomic injury?  |     |                    |     |                 |  |                |

|   | Yes | No | N/A | Risk (H,M,L) | Action (include name of individual responsible and timelines) | Date Corrected |
|---|-----|----|-----|--------------|---|----------------|
| Are the chairs used for computer workstations adjustable?   |     |    |     |              |   |                |
| <b>Clinical Areas</b>   |     |    |     |              |   |                |
| Are biological specimen containers tightly closed and shipped appropriately?                      |     |    |     |              |   |                |
| Are sharps containers available and not overfilled?   |     |    |     |              |   |                |
| Is personal protective equipment available and ready for use? i.e. eye protection and gloves.     |     |    |     |              |   |                |
| Have chemical containers been closed when not in immediate use?                                   |     |    |     |              |   |                |
| Are all chemicals stored at levels below eye level?   |     |    |     |              |   |                |
| Are there sufficient numbers of staff scheduled to work to ensure safety?                         |     |    |     |              |   |                |
| Are waterless hand cleaners available where required?   |     |    |     |              |   |                |
| Is there good communication about the current lifting/transferring requirements for each patient? |     |    |     |              |   |                |
| Are there appropriate containers available for disposal of biohazardous waste?                    |     |    |     |              |   |                |
| Are there sufficient numbers of patient lifting devices and slings?                               |     |    |     |              |   |                |

|   | Yes | No | N/A | Risk (H,M,L) | Action (include name of individual responsible and timelines) | Date Corrected |
|---|-----|----|-----|--------------|---|----------------|
| Are beds, wheelchairs, patient lifting and transfer devices and other equipment functioning properly? |     |    |     |              |   |                |
| Are mercury spill clean up kits available for areas where mercury blood pressure cuffs are used?      |     |    |     |              |   |                |
| <b>Material Handling and Storage</b>  |     |    |     |              |   |                |
| Are storage shelves capable of supporting the intended load?  |     |    |     |              |   |                |
| Are storage shelves secure and not able to tip?   |     |    |     |              |   |                |
| Are heavy items stored at optimal lifting heights (between shoulder and knees)?                       |     |    |     |              |   |                |
| Are carts available to move heavy items and materials?  |     |    |     |              |   |                |
| <b>Security</b>   |     |    |     |              |   |                |
| Are areas locked as required and do security devices (alarms and locks) work properly?                |     |    |     |              |   |                |
| <b>Emergency Response</b>   |     |    |     |              |   |                |
| Are emergency evacuation routes posted?   |     |    |     |              |   |                |
| Are emergency phones numbers readily accessible?  |     |    |     |              |   |                |
| Are the names of first aiders posted?   |     |    |     |              |   |                |
| Are adequate first aid supplies available?  |     |    |     |              |   |                |

Current to May 2017

|   | Yes | No | N/A | Risk (H,M,L) | Action (include name of individual responsible and timelines) | Date Corrected |
|---|-----|----|-----|--------------|---|----------------|
| <b>Fire</b>   |     |    |     |              |   |                |
| Are fire exits marked and signs illuminated?  |     |    |     |              |   |                |
| Are fire extinguishers, hoses and alarm pull stations clearly marked and free of obstructions?                              |     |    |     |              |   |                |
| Have fire extinguishers been inspected and bear inspection tags?  |     |    |     |              |   |                |
| In areas with fire sprinklers, are materials stored at least 18 inches from sprinkler heads?                                |     |    |     |              |   |                |
| <b>Electrical</b>   |     |    |     |              |   |                |
| Are electrical cords in good condition and free of damage and defects (including not frayed and grounding prongs in place)? |     |    |     |              |   |                |
| Are there enough electrical outlets/power bars to ensure they are not overloaded?   |     |    |     |              |   |                |
| Are power bars connected to directly to an electrical outlet?   |     |    |     |              |   |                |
| Is the area around electrical panels free of obstructions?  |     |    |     |              |   |                |
| Are electrical appliances CSA approved?   |     |    |     |              |   |                |
| <b>WHMIS</b>  |     |    |     |              |   |                |
| Is the WHMIS inventory current?   |     |    |     |              |   |                |
| Is the binder of WHMIS MSDSs present and all MSDSs less than three years old?   |     |    |     |              |   |                |

Current to May 2017

|  | Yes | No | N/A | Risk (H,M,L) | Action (include name of individual responsible and timelines) | Date Corrected |
|--|-----|----|-----|--------------|---|----------------|
| Are all WHMIS products labelled with WHMIS supplier or workplace labels?   |     |    |     |              |   |                |
| <b>Documentation and Training</b>  |     |    |     |              |   |                |
| Are emergency response procedures available in the department?   |     |    |     |              |   |                |
| Are previous workplace inspections retained by the department and have deficiencies identified during previous inspections been rectified? |     |    |     |              |   |                |
| Are Job Hazard Assessments retained by the department and are employees knowledgeable of their contents?                                   |     |    |     |              |   |                |
| Have employees received WHMIS training?  |     |    |     |              |   |                |
| If employees work alone, are employees aware of working alone procedures and guidelines?   |     |    |     |              |   |                |
| If there is a potential for violence, have employees received violence prevention awareness information?                                   |     |    |     |              |   |                |
| Have employees that manually handle and lift heavy items or work at computer workstations received ergonomic awareness information?        |     |    |     |              |   |                |
| <b>Other</b>   |     |    |     |              |   |                |
|  |     |    |     |              |   |                |
|  |     |    |     |              |   |                |
|  |     |    |     |              |   |                |

Current to May 2017

## Instructions:

1. Complete the inspection as a team.
2. Document deficiencies and assign a risk level as (H) High, (M) Medium or (L) Low.
3. Report deficiencies to department management.
4. Take action to correct deficiencies as follows:

| Risk   | Criteria                              | Recommended Timeline to Correct Deficiencies |
|--------|---------------------------------------|--|
| High   | Likely to result in serious injury    | Correct immediately within one day           |
| Medium | May result in injury                  | Correct within one week                      |
| Low    | Could possibly result in minor injury | Complete within one month                    |

Current to May 2011

## Appendix 3 - Examples of Performance Expectations / Assessment Criteria

| Managers, Supervisors  |   |   |  |  |               |
|--|---|---|--|--|---------------|
| Expectation  | Poor  | Fair, needs improvement   | Good   | Excellent  | Justification |
| Show leadership and commitment to health and safety; Participate in OHS activities   | <input type="checkbox"/> No documented evidence of OHS leadership activities      | <input type="checkbox"/> Tours work area and addresses OHS issues; communicates importance of OHS                           | <input type="checkbox"/> Enforces safety rules, policies; leads by example; tours of areas; responds to hazard reports                       | <input type="checkbox"/> Communicates clear expectations about safety and safety performance; written communication about safety   |               |
| Ensure that the inspection process is well implemented   | <input type="checkbox"/> No evidence of regular inspections conducted             | <input type="checkbox"/> 50% or less of required inspections conducted; corrective action not always taken in timely manner | <input type="checkbox"/> All required inspections conducted; corrective action identified and accountabilities defined                       | <input type="checkbox"/> All required inspections conducted; corrective action identified and accountabilities defined; corrections done in timely manner; sign off          |               |
| Implement the hazard assessment and controls process   | <input type="checkbox"/> No evidence of hazard assessment and controls documented | <input type="checkbox"/> Process is implemented; less than 50% completed; employee participation evident                    | <input type="checkbox"/> Greater than 75% job hazard assessments completed; employee participation evident; most (>75%) controls implemented | <input type="checkbox"/> Greater than 95% jobs with JHAs completed; employee participation evident; controls documented and implemented; plans in place to improve controls. |               |
| Ensure the orientation of all new workers to safety rules, practices and procedures in place in the specific workplace and to the organization's safety program and policies | <input type="checkbox"/> No evidence of adequate orientation                      | <input type="checkbox"/> Informal process; not fully documented; some employees not receiving orientation                   | <input type="checkbox"/> Documented processes; most employees received orientation; sign-off sheets used                                     | <input type="checkbox"/> Documented processes; all employees received orientation; sign-off sheets used; competency assessed   |               |

| Managers, Supervisors  |  |   |   |   |   |
|--|--|---|---|---|---|
| Expectation  | Poor   | Fair, needs improvement   | Good  | Excellent   | Justification                           |
| Ensure appropriate job specific safety training for all employees                                  | <input type="checkbox"/><br>No evidence of department specific safety requirements or process to ensure training | <input type="checkbox"/><br>Requires employees to obtain training, but does not make it mandatory ; poor training records                 | <input type="checkbox"/><br>Supports training initiatives; has training requirements identified and enforced. Requires the maintenance of good training records | <input type="checkbox"/><br>Supports training initiatives; has training requirements identified and enforced. Requires good training records; supports and encourages additional safety training                                |   |
| Ensure the investigation all work-related incidents, with root cause identification and follow-up. | <input type="checkbox"/><br>No evidence of follow-up to incident reports   | <input type="checkbox"/><br>Most Incident reports completed; No follow up to poor quality investigations that do not determine root cause | <input type="checkbox"/><br>All incident reports completed; root cause analysis done; corrective action identified; reviews all incident reports                | <input type="checkbox"/><br>All incident reports completed; root cause analysis done; corrective action identified and completed; employees involved in investigation; communication about results occurs; sign-off of reports. | Not applicable if no reported incidents |

## Performance Expectations/Assessment

| Workers   |   |   |   |   |                   |
|---|---|---|---|---|-------------------|
| Expectation   | Poor  | Fair, needs improvement   | Good  | Excellent   | Justification     |
| Attend OHS orientation and training programs  | <input type="checkbox"/><br>Did not attend any orientation or training                                | <input type="checkbox"/><br>Attended orientation; did not take specific training courses that would be useful           | <input type="checkbox"/><br>Attended site-specific orientation, took topic-specific safety courses  | <input type="checkbox"/><br>Seeks additional training and attends optional sessions   | For new employees |
| Is aware of workplace hazards and controls; reports unsafe conditions and incidents | <input type="checkbox"/><br>No evidence of awareness of OHS hazards and controls                      | <input type="checkbox"/><br>Has reviewed the job hazard assessment; does not report unsafe conditions or incidents      | <input type="checkbox"/><br>Participated in or reviewed the job hazard assessment; reports unsafe conditions and incidents; takes part in workplace inspections | <input type="checkbox"/><br>Actively participates in identifying and controlling hazards; takes responsibility for informing others of hazards; locks out defective processes, etc. |                   |
| Uses controls to reduce the risk of injury  | <input type="checkbox"/><br>Rarely uses controls that have been identified                            | <input type="checkbox"/><br>Uses some controls, but not all; or uses controls sporadically                              | <input type="checkbox"/><br>Consistent use of required controls   | <input type="checkbox"/><br>Consistent use of required and optional controls  |                   |
| Participates in health and safety activities  | <input type="checkbox"/><br>No evidence of participation in departmental health and safety activities | <input type="checkbox"/><br>Limited evidence of participation; attendance at departmental meetings where OHS is a topic | <input type="checkbox"/><br>Participates in inspections process; hazard assessments;  | <input type="checkbox"/><br>Member of OHS Committee; takes responsibility for aspects of safety program (training others, WHMIS inventory, etc.)                                    |                   |

Current to May 2011

