Engagement on Parts 1-5 of *The Occupational Health and Safety Regulations, 2020*

Submission of SEIU-West to the Ministry of Labour Relations & Workplace Safety

November 27, 2025

SEIU-West represents more than 15,000 workers across Saskatchewan. More than 13,000 are employees of the Saskatchewan Health Authority (SHA) and its affiliates, working in acute care, long-term care, home care, and community care settings, in dozens of roles such as continuing care assistants, licensed practical nurses, food and environmental services workers, medical lab and diagnostic technologists, maintenance staff, and clerical and administrative workers. We also represent about 2,000 workers in schools, community-based organizations, and light industry.

We prepared an online survey that was essentially a condensed version of the Topics for Consideration/Questions for Consideration portion of the Ministry's backgrounder. The survey was promoted to our members via website, email, and social media.

We received responses from 240 members, 90% of whom work for the SHA or an SHA affiliate. The respondents work in nearly 100 different workplaces in more than 40 different communities, in more than 60 different job classifications. Almost half of them have been a member of the Occupational Health Committee (OHC) in their workplace; 15 of them currently serve on an OHC.

Here are some of the OH&S issues commonly reported by key subsets of members:

- **Employees of SHA & affiliates**
    - Violence from patients/residents (dementia, drugs, mental health) and "Code White" situations.
    - The "normalization" of abuse. They feel they have fewer rights to safety than other industries because their "hazards" are people, many of whom are not in control of their actions.
    - Viewed as the most dangerous and least regulated environment.
- **School staff:**
    - Lack of protection against violence from students, echoing the healthcare sentiment that "care" roles are expected to endure abuse.
- **Saskatoon/urban workers:**
    - Weapons (guns/knives), gang activity, crystal meth/fentanyl crises, and personal safety in parking lots/transit.
    - "Hallway medicine" creating fire & trip/fall hazards and increasing the risk of violence.
- **Rural/remote workers:**
    - Travel safety (especially, winter driving), isolation, and lack of backup.
    - Incident response: a rural worker hits a panic button, police/security response time is too slow to help. "Calling 911" is not a valid safety plan in remote areas.
- **OHC members (current/past):**
    - Management often dominates meetings and investigations, ignores recommendations, or fails to schedule meetings (lack of quorum).

- Minutes are too often not posted.

Focusing on the themes the in the Ministry's backgrounder, here are our main concerns and recommendations.

A. Incident Reporting and Investigation Thresholds

Currently, the Regulations only require Ministry notification if hospitalization lasts 72+ hours, and investigation if it lasts 24+ hours. Members universally view this as dangerously high, allowing serious injuries and "near misses" to go unexamined. We therefore recommend:

- **Immediate Notification:** The employer must notify the Ministry immediately of **any** workplace incident resulting in admission to a hospital (regardless of duration) or any loss of consciousness.
- **Mandatory Investigation:** Investigations must be triggered for any injury requiring medical treatment beyond first aid, not just those requiring hospitalization.
- **"Near Miss" Protocol:** Mandate the reporting and investigation of high-risk "near misses" (e.g., weapons produced in a healthcare setting, failed equipment), even if no injury occurred.

B. Violence and Harassment

Respondents' top complaint regarding harassment was that investigations are "swept under the rug" because they are conducted by a manager who is often the alleged perpetrator of the harassment. We therefore recommend:

- **Third-Party Investigation Option:** Create a regulatory mechanism allowing workers to request an investigation by an **independent third party** (appointed by the Ministry) when the accused harasser is a member of management or when the internal process has failed to resolve the issue within 60 days.
- **Zero-Tolerance Reporting:** Mandate that **all** claims of physical violence (from patients, public, or staff) be reported to the OHC co-chairs within 24 hours, preventing "normalization" of abuse in healthcare.

C. Working Alone

The Regulations in their current state seem to suggest that a worker working alone is adequately protected so long as they have access to a cell phone. Members, especially those working in home care, report this is useless during an active attack or medical emergency. We therefore recommend:

- **Mandatory Monitoring:** Amend regulations to require an **active electronic monitoring system** (e.g., GPS-enabled lone worker apps with "man-down" alerts) for all home care and night-shift solo workers. A cell phone alone shall no longer constitute compliance.

- **Risk-Based Staffing (The "Two-Person Rule"):** Mandate a risk assessment prior to any home care placement. If a client has a known history of violence or substance abuse, regulations must require **two employees** be present.
- **Travel Safety:** Mandate strict check-in/check-out protocols for rural workers traveling between sites, with an automated escalation procedure if a check-in is missed.

D. The Occupational Health Committee (OHC)

OHCs were described as “powerless” and “management-dominated” by respondents who have served on them, and as “invisible” and “inaccessible” by those who have not. We therefore recommend:

- **Mandatory Visibility:** Employers must post OHC member names, photos, and direct contact info (not just a general email) in a high-traffic physical space and on the digital intranet.
- **Quorum & Scheduling:** Enforce penalties for employers who repeatedly fail to schedule meetings or release staff to attend, ensuring OHCs meet their quarterly obligations.
- **Scope of Plans:** Remove the "10 employee" minimum for detailed OH&S plans. High-risk industries (Healthcare, Construction, Education) must have detailed plans regardless of staff size.

E. Addressing Staffing as a Hazard

Members, particularly those working for the SHA and affiliates, overwhelmingly cite short-staffing as the root cause of injury (e.g. rushing, inability to team-lift, working alone in designated two-person zones). We therefore recommend:

- OH&S Regulations should formally recognize chronic understaffing as a workplace hazard.
- Mandate that OHCs have the authority to conduct "Workload Safety Reviews" when staffing levels fall below the baseline required for safe patient handling/safe operation. The workers, either through their OHC representatives or through a separate workload subcommittee of the OHC, must be involved in determining safe baseline staffing levels.