RIGHT TO REFUSE UNSAFE WORK - HR-XI-9

POLICY:

The Occupational Health & Safety Act gives workers "the right to refuse work or do particular work which he or she has reason to believe the work, or part of the work is unsafe."

Workers have the right to refuse work they believe would directly endanger the life, health or safety of another person. However, as stated in the Health and Safety Act, this right has limitations for certain workers which include OPTIONS NORTHWEST. Limitations apply to ... "a person employed in the operation of a residential group home or other facility for persons with behavioural or emotional problems, or a physical, mental or developmental disability."

PURPOSE:

1. To ensure that workers are aware of their rights.
2. To ensure compliance with the Health & Safety Act.
3. Provides the workplace parties with the opportunity to constructively resolve workplace Health and Safety concerns.

PROCEDURE:

1. In accordance with the Occupational Health and Safety Act, Section 43 (3), a worker may refuse to work or do particular work where he or she has reason to believe that:
   a) any equipment, machine, device or thing the worker is to use or operate is likely to endanger himself, herself or another worker;
   b) the physical condition of the workplace or work station or the part thereof in which he or she works or is to work is likely to endanger himself or herself.
   c) any equipment, machine, device or thing he or she is to use or operate or the physical condition of the work place or the part thereof in which he or she works or is to work is in contravention of this act or the regulations and such contravention is likely to endanger himself, herself, or another worker.
   d) workplace violence is likely to endanger the worker. NOTE: This right is limited for workers in which a danger to health or safety in inherent in the worker's work or a normal condition of employment.

2. Workers exercising their right must immediately report the unsafe condition to their supervisor/designate following the process outlined in the Flow Chart, (Appendix B), and must complete an Employee Incident Report (Appendix A). This form must be forwarded to the Coordinator, Health and Safety who will be responsible for following up with the area Health and Safety Representative or committee member to ensure an opportunity to make recommendations to the Executive Director. If a worker needs to leave the workplace due to a hazard, i.e. allergy, they must notify their supervisor immediately and follow the supervisors' instructions.

3. The Co-ordinator, Health and Safety shall work with all necessary individuals to ensure the required steps per the flow chart are completed.

4. The Coordinator, Health and Safety, will forward the incident form to the Executive Director for review, initialling, and/or recommendations. A copy will be kept in the office of the Coordinator, Health and Safety.

RECOMMENDED BY: Manager, Human Resources **APPENDICES:** 2

OPERATIONAL ACCOUNTABILITY: Administration, Finance, Human Resources, Supportive Living Services (all)

ORIGINAL POLICY DATE: January 1997

AUTHORIZED BY: Executive Director **SIGNATURE:**

POLICY: HR-XI-9
APPENDIX A

Employee Incident Report

Employee Information

Last Name
First Name
Date of Birth (DD/MM/YY)
Home Telephone No.
Work Telephone No.
Employee ID# / SIN
Address ______ City/Town ______ Province ______ Postal Code
Division/Dept./Unit
Occupation at time of injury
Check: ☐Full-time ☐Casual ☐Part-time ☐Student
Years of Experience
Was the employee on the job when the injury occurred? (check) ☐YES ☐NO

Date of Incident (DD/MM/YY)
Time of day ______ AM/PM
Date Reported (DD/MM/YY)
Time of day ______ AM/PM
To whom was the incident reported?
If report is delayed, please explain why.

Description of Incident

State the exact sequence of events leading up to the incident. Include an explanation of what the employee was doing.

Did the accident happen on the employer's premises?

What caused the injury/illness?

Identify the sizes, weights & types of equipment involved.

Type of Incident (check one–definitions on reverse)
1 ☐ Struck/Caught
2 ☐ Overexertion
3 ☐ Repetition
4 ☐ Fire/Explosion
5 ☐ Fall
6 ☐ Harmful Substances/Environmental
7 ☐ Assault
8 ☐ Slip/Trip
9 ☐ Motor Vehicle Incident

Witnesses

Names, positions, & phone numbers of witnesses or persons having knowledge of the incident.

Cause

Was the accident/illness:
1☐A Sudden, Specific Event/Occurrence? 2☐Gradually Occurring Over Time? 3☐An Occupational Disease? 4☐A Fatality?
Direct causes (check one – see reverse): 1☐Physical/Environmental 2☐Personal
Basic causes (check one – see reverse): 1☐Job factors 2☐Personal factors

Correction

Action(s) Taken	CORRECTED (check box)	PLANNED (check box)	Date (DD/MM/YY)
1.	☐	☐	
2.	☐	☐	
3.	☐	☐	
4.	☐	☐	
5.	☐	☐	
6.	☐	☐	
7.	☐	☐	

Examples of Actions:
1. Reinstruction of person involved
2. Reassignment of person
3. Order job safety analysis done
4. Improve personal protective equipment
5. Action to improve inspection
6. Equipment repair or replacement
7. Correction of congested area
8. Installation of guard or safety device
9. Actions to improve design/procedure
10. Check with manufacturer
11. Inform all department supervisors
12. Discipline of persons involved
13. Other

Injury

Describe the illness or injury, part of body involved and specify left or right side.

Are you aware of any prior similar or related problem, injury, or condition? If yes, please explain:

No injury (check one)
1☐Hazardous situation

Injury – No WSIB Claim (check one)
1☐First aid
2☐No aid

WSIB Claim Treatment Memorandum (check one)
1☐Health care (medical aid)
2☐Lost time

Occupational Health

Did employee seek medical attention? (check one) 1☐No 2☐Yes
Did employee visit health service? (check one) 1☐No 2☐Yes
Did employee visit emergency? (check one) 1☐No 2☐Yes
If Yes, ER Physician's Name
Tel.No.

Did employee visit family physician? (check one) 1☐No 2☐Yes
If Yes, Physician's Name
Tel.No.
Physician's Address

Will the employee undertake: (check one)
1☐Regular duties
2☐Modified duties
3☐Remain off work

Has the employee had a similar disability? (check one)
1☐Yes
2☐No
3☐Unknown

Check attachments to this report.
1☐Statements
2☐Photographs
3☐Treatment memo
4☐Other – specify

EMPLOYEE SIGNATURE Date
MANAGER SIGNATURE Date
OCC. HEALTH DEPT. SIGNATURE Date

This information is to be used for completion of WSIB Claim Form 7

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WORKER REFUSAL PROCESS