NEW ZEALAND NURSES ORGANISATION

Exposure Draft Health and Safety at Work (General Risk and Workplace Management) Regulations 2015

Submission to the Ministry of Business, Innovation and Employment

Date: 15 May 2015

Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 46,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

INTRODUCTION

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Exposure Draft of the Health and Safety at Work (General Risk and workplace Management) Regulations.

2. We have consulted with our health and safety representatives, other unions and the New Zealand Council of Trade Unions, te Kauae Kaimahi (CTU) and support their submissions.

3. This submission is informed by the evidence and our experience NZNO has accumulated over many years in relation to health and safety issues raised by NZNO members, including members of Colleges and Sections who may be exposed to specific risks associated with their speciality area of practice.

4. Health is one of the largest areas of employment and was one of the six high-risk sectors for which ACC established a 'safer industry' group to reduce accident and injury. Occupational health and safety is a consistent subject of discussion amongst health workers and this submission is also informed by discussion with practitioners across a range of disciplines, though we note with concern that many were unaware of this consultation, including regulatory agencies and professional practitioners' associations.

5. The 2013 *Forum on Carcinogens in the Workplace*, jointly hosted by the Cancer Society of New Zealand and the Centre for Public Health Research, Massey University, highlighted the significant systemic gaps

in New Zealand's capacity to recognise or mitigate established occupational health risks, much less proactively identify and address new risks.

6. It was hoped that these regulations would establish a robust regime for effective workplace monitoring but they fall well short of offering New Zealand workers the protections to health and safety guaranteed to workers in comparable jurisdictions such as Canada, Australia and the United Kingdom.

7. Accordingly, while we acknowledge some improvement in the regulatory protections offered for the health and safety of workers, we reiterate the concerns we have expressed many times since the Report *of the Independent Taskforce on Workplace Health and Safety (*2013) over fundamental omissions relating to mandated worker involvement at all levels of the regulatory regime, and provision for a proactive and comprehensive occupational health surveillance scheme.

8. Both gaps are evident in these regulations which fail to provide for workers' access to their own risk exposure information, or put in place a practical, robust 21st century surveillance scheme to assure workers health and safety in the long as well as the short term.

9. In addition to the above, we discuss and make recommendations in relation to:

    - the interpretation of occupational health professional;
    - the hierarchy of controls to risk management;
    - PCBU duties in relation to the provision of facilities and access to first aid;
    - Worker representatives' (i.e. Union) and ability to review control measures;
    - employee rights/protections in relation to sickness at work and the provision of personal protective equipment;
    - minimum age restrictions;
    - retaining accommodation standards; and
    - access to, and protection of, occupational health information.

10. The key recommendations of the Taskforce should be implemented in full.

DISCUSSION

Regulation 3 Interpretation

***"Occupational health professional** means a registered medical practitioner, a nurse practitioner, a registered nurse, or an occupational hygienist, with experience in health monitoring."*

11. In general the scopes of practice of regulated health practitioners, including doctors and nurses, do not encompass the level of expertise, training and experience in occupational health required for the supervision of systematic surveillance of hazardous workplaces and health monitoring.

12. We believe strong clinical oversight is essential and recommend that the necessary education, training and qualifications framework for occupational health professionals is discussed with, and agreed to, by the respective authorities responsible for regulating health practitioners under the Health Practitioners Competence Assurance Act, 2003 (HPCAA) i.e. the medical, nursing, and other Councils.

13. We recognise that there is a shortage of appropriately qualified OH personnel, and we also understand that the Ministry is working with the Health and Safety Association of New Zealand (HASANZ) to develop something akin to a licensing authority for practising OH professionals. It is imperative that this authority is not confused with, and does not undermine, the robust regulation of health practitioners.

14. The OH workforce comprises many roles outside the regulated health workforce - ergonomists and hygienists, for example; but overall responsibility for OH surveillance, which may involve sensitive/intrusive testing, requires clinical guidance and oversight by a regulated health practitioner. The interpretation should include this distinction and the regulations must be clear about when clinical supervision is required. Eg OH monitoring may be carried out by a competent person under the supervision of a regulated health practitioner with appropriate occupational health training.

Part 1 General Requirements

15. Part one of the regulations establishes risk management processes but implies rather than articulates the crucial first step which is the duty to eliminate risk. This obligation should be explicit.

16. The 'hierarchy of control measures' is qualified by clause 6 (3) "the PCBU must *"minimise risks by,,,, doing 1 or more of the following*" as it treats the risk management processes of substitution/ isolation/ engineering as equivalent, rather than the hierarchical controls needed

to respond to increasing levels of risk. This is very clear with the current process where there is a duty first to eliminate, then to reduce, and then to monitor risk. A clear hierarchy of control measures should be explicit.

17. As representatives of workers, with particular regard for their health and safety as evidenced by the health and safety clauses in all our collective agreements, NZNO understands very well the importance of being able to initiate action/investigation in relation to worker safety. Indeed, we work proactively with some employers in constantly reviewing health and safety, in order to prevent and minimise risk and this has been very effective.

18. We anticipated the regulations would facilitate such interactions rather than undermine them, and be consistent with section 20 (1)(2) of the Health and Employment Relations Act 2000 giving union representatives access to workplaces specifically for health and safety purposes.

19. This is an essential aspect of balancing the relative power of employers and employees. Union have the research, policy and legal expertise to support, educate and inform members about health and safety issues, and the professional and industrial expertise to respond to any concerns. A robust OHS regime is dependent on people being well informed and able to facilitate best practice.

20. The regulations must include the right of unions to request a review of control measures if members are at risk under any of the circumstances outlined in Regulation 8(2).

21. With regard to duties in respect of unwell workers (cl 11), the decision to stay or leave work rightfully belongs to the person concerned and is affirmed by s 18 of the Bill of Rights Act 1990. Employers are not qualified to make decisions with respect to health and citizens' rights with respect to decisions are implicit in s 11 and s 27 of the aforementioned Act.

22. We have a number of issues in respect to workplace facilities, specifically that they:

    - include explicit provision for rest and meal breaks as per the, admittedly nebulous and equivocal, provisions in Part 6D s 69ZD(1) of the Employment Relations Act 2000 obliging employers to ensure employees have a reasonable opportunity for rest refreshment and attention to personal matters;

    - are *conveniently* accessible;

    - are adequate and appropriate for the workforce i.e. gender, size, type(s) of work;

- ensure that access to sick bay facilities/ first aid is appropriate and on hand (eg it is not appropriate to assume that being next door to a health centre qualifies as having an accessible first aid facility);

- ensure workers have access to a secure place to store personal effects if they have to be separated from them.

23. Accordingly we recommend:

    - amending regulation 12(1)(d) to refer to “eating and rest break facilities”;

    - inserting “conveniently” before “accessible” in reg 12(2)(b);

    - adding “facilities provided in accordance with regulation 13(1)” to regulation 12;

    - reword regulation 12(3)(d) to have regard for the number of workers and characteristics of the workforce; and

    - adding a regulation providing for workers to have access to appropriate secure storage if their work requires them to be separated from their personal effects.

24. Further, we note that the regulations in relation to facilities do not apply to accommodation and indeed that the limited provisions for accommodation standards that applied to recognised seasonal employees (RSE) have been removed altogether.

25. We understand that the rationale for this is that accommodation standards for workers would be more appropriately dealt with under anticipated housing regulations and that Immigration New Zealand intends to retain the accommodation requirements for RSE under that scheme.

26. Again we are astonished that the opportunity to improve health and safety standards for workers has been abandoned in favour of removing whatever weak protections for one small group of vulnerable workers existed!

27. Employer provided accommodation has never been restricted to workers on the RSE programme and the recognition that current regulations for rental accommodation are so entirely inadequate as to warrant a significant review *should* have prompted the inclusion of explicit standards for accommodation for workers.

28. As we have pointed out before with regard to health and safety reform, the complex factors impacting on health at work seem to take a very secondary role compared with the more easily identified safety issues.

29. Housing is fundamental to health as numerous studies including the seminal work of Philippa Howden-Chapman and her colleagues have shown. There is every reason for these regulations to ensure adequate standards of accommodation where accommodation is linked with employment.

30. Accommodation is provided in some instances to nurses, particularly in aged residential care and in rural locations, and to nursing students, including migrant nurses in enrolled in Competence Assessment Programmes.

31. In this context, we note that there has been some discussion in relation to the Pacer Plus agreement between Australia, New Zealand and the Pacific Islands about extending the RSE scheme beyond the agricultural sector to other areas of work including into aged care[1].

32. There are already considerable the concerns about the current inequitable and poor conditions of work in this sector[2], and the continued reliance on immigration in lieu of workforce planning to address nursing skills shortages. It is not acceptable to rely on anticipated reviews of other regulation to ensure standards for worker accommodation sometime in the future or rely on the assurances of another department that it will retain some protections for some vulnerable workers.

33. Standards for accommodation when accommodation is part of the conditions of employment conditions must be covered by health and safety regulations.

34. The provisions for employees to "genuinely and voluntarily "choose their own protective clothing are supported in principle but we note that there is considerably more pressure on employees to provide personal protective equipment (PPE) and that that is a barrier to being compensated for 'consumables' associated with the job.

35. We suggest robust provision is made to protect workers from coercion and exploitation with regard to the provision of PPE.

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[1] E.g. http://www.radionz.co.nz/international/pacific-news/246682/pacific-wants-extended-labour-mobility
http://pang.org.fj/health-implications-of-pacer-plus-for-pacific-island-countries/

[2] Eg Judy MacGregor. 2012. *Caring Counts* Human Rights Commission: Wellington http://www.hrc.co.nz/your-rights/employment-opportunities/our-work/caring-counts/ and the New Zealand Aged Care Workforce Survey 2014, Auckland University of Technology http://www.hrc.co.nz/files/2614/3019/0144/NZ_Aged_Care_Workforce_Survey_report.pdf

Part 3 duties relating to young persons at workplace

36. New Zealand law is inconsistent with regard to minimum age restrictions and this can and does cause confusion.

37. In accordance with international conventions, we regard young persons as those under 18 years of age.

38. We note that convention 138 of the International Labour Organisation establishes the minimum age restrictions for hazardous work as 18 years of age with provision for this to be extended down to 16 years of age "under strict conditions".

39. We recommend that the regulations are amended in accordance with C138.

Part 4 Duties relating to monitoring.

40. We understand that, in addition to the general requirements, new health and safety at work legislation will apply to only 18 specified risks, six of which will be enacted immediately and 12 of which will follow. (We also understand and commend WorkSafe New Zealand's intention to review all health and safety codes to ensure that they are fit for purpose.)

41. We reiterate our urgent request that cytotoxic medicines (anti neoplastics) be identified as hazardous substances and covered under Hazardous Substances and New Organisms (HSNO) Regulations, as per our written and oral submissions to the Transport and Industrial Relations committee on the Health and Safety Reform Bill and subsequently to the Ministry of Business, Innovation & Employment (MBIE) on their consultation document *Developing Regulations to support the new Health and Safety at Work Act.*

42. We also record our extreme disappointment that, despite the ostensible 'reform' of health and safety regulations, they are still narrowly predicated on the traditional management of risks associated with hazardous substances and ignore the risks associated with hazardous conditions of work and the potential to monitor and improve them.

43. Modern health and safety regulation should be consistent with modern working conditions and, notwithstanding new Zealand's appalling record in relation to preventable accidents and injury in the deregulated primary industry sector, the vast majority of workers are not exposed hazardous substances or machinery but are, or may be, affected by workplace stress, workloads, shift work, new technologies etc.

44. While we welcome clarity around the responsibility for health monitoring by PCBUs, including the assumption of shared duties and shared costs where there are several PCBUs, we again note that duty

is restricted to identifiable disease, the reasonable likelihood of disease, and availability of valid techniques for testing. We note that under such conditions, even the risk of exposure to asbestos wouldn't qualify!

45. To develop and implement new regulations that ignore the conditions of work that most workers face is ludicrous and regressive. We urge the Ministry to live up to its name and implement innovative, evidence based regulation to protect and improve health and safety at work.

46. At the very least we recommend the regulations refer to ACC legislation where Schedule A – O identifies a range of occupational health risks/ hazards including noise, zoonotic disease, fumes, lifting, cosmic radiation, leptospirosis etc.

47. In general we suggest that there need to tighter regulations/guidance for monitoring workplace health and safety, specifically in regard to the regularity of testing, who does them, how they are done and how such information is recorded, stored and accessed.

48. We have earlier outlined the need to ensure supervision by an appropriately certified and regulated health practitioner, and we support moves to develop and accredit an occupational health workforce.

49. This is particularly important where monitoring exposure to risk and health impact involves individual testing which can be invasive/sensitive and which certainly involves very secure understanding about rights with regard to health and health information.

50. The regulations are quite inadequate with regard to the latter: they ensure employees may be subject to health monitoring, but fail to protect their rights, particularly around access to, and protection of the privacy of their own health information. There are robust and widely accepted protocols around health information as established in the Health Information Privacy Code 1994[3] and regulated health practitioner codes of conduct.

51. This is particularly concerning given the potential for workplace monitoring to be extended to socially sensitive areas such as drug testing, for instance, and well recorded instances of inappropriate

[3] https://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/HIPC-1994-incl.-amendments-revised-commentary-edit.pdf

access and misuse of employee's health information by employers and insurance companies.

52. While provision is made to report workers' exposure to hazards to regulators (not health providers!) and employers are unrealistically expected to retain information for 30 – 40 years, there are no provisions for the workers' concerned to access the information. This is not only a breach of human rights and the health information code, it significantly reduces the value of the data.

53. This is a complex area requiring coherent and integrated regulation. We recommend that it is developed in consultation with the RAs, the Health and Disability Commissioner, the Privacy Commissioner, Human rights Commission.

54. With regard to safeguards around information being passed on to the regulator and other PCBU's, we suggest that the non-identifying mandatory notification for sexually transmitted infections proposed in the Health (Protection) Amendment bill may be useful.

55. However, it is self-evident that without a national repository for such information that can be connected to health information, the regulations are purely bureaucratic and, we suggest, are unlikely to be monitored or complied with.

56. Finally, we strongly urge you to consider adopting a robust system of health surveillance, such as the UK model, which facilitates researchers' access to both health and occupational health data to improve health outcomes.

SUMMARY OF RECOMMENDATIONS

57. In conclusion NZNO recommends that you:

- amend the interpretation of occupational health professional as indicated;
- ensure supervision is tied to regulated health practitioners under the HPCAA;
- consult with relevant responsible authorities under the HPCAA over occupational health certification for regulated helath practitioners and ensure this is consistent with HASNA certification;
- clarify the hierarchy of risk control processes by ensuring that the first duty is to eliminate risks to health and safety as far as is reasonably practical; minimisation of risk follows;
- amend reg 12(1)(d) to refer to "eating and rest break facilities";

- insert “conveniently” before “accessible” in reg 12(2)(b);
- add “facilities provided in accordance with regulation 13(1)” to reg 12;
- reword regulation 12(3)(d) to have regard for the number of workers and characteristics of the workforce; and
- add a regulation providing for workers to have access to appropriate secure storage if their work requires them to be separated from their personal effects.
- amend minimum age restrictions to comply with ILO C138 i.e. minimum age restrictions apply to young persons under 18 years of age , with provision to extend down to 16 years;
- add accommodation to the provisions for appropriate facilities to ensure that where accommodation is linked with employment the health of workers, and particularly vulnerable workers is protected; and
- add cytotoxic medicines (anti neoplastics) to the list of hazardous substances covered by HSNO;
- extend the range of occupational health risks/ hazards eg using ACC legislation where Schedule A – O identifies a range of including noise, zoonotic disease, fumes, lifting, cosmic radiation, leptospirosis etc.;
- broaden the recognition of risks hazardous to health beyond those of hazardous substances to include hazardous conditions of work;
- ensure appropriate and ethical provisions for the collection, access and use of health monitoring data, including protections for the privacy of and access to individual’s personal health and safety at work information; and
- implement a robust, comprehensive and user friendly health surveillance scheme.

58. NZNO values the opportunity to provide feedback on the development of health and safety regulations and would be happy to discuss any aspect of the above.

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