ONTARIO LABOUR RELATIONS BOARD

Occupational Health and Safety Act

OLRB Case No: 0746-20-HS
Health and Safety - Appeal of Inspector's Order

United Food and Commercial Workers Canada, Local 175, Applicant v Hazel Farmer, Inspector, Maplewood Nursing Home, and A Director under the Occupational Health and Safety Act, Responding Parties

Ministry of Labour, Training and Skills Development F.V. No: 03226PKVR019

COVER LETTER

TO THE PARTIES LISTED ON APPENDIX A:

The Board is attaching the following document(s):

Decision - December 22, 2020

DATED: December 22, 2020

Catherine Gilbert
Registrar

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OLRB Case No: **0746-20-HS**

United Food and Commercial Workers Canada, Local 175, Applicant v Hazel Farmer, Inspector, **Maplewood Nursing Home**, and A Director under the *Occupational Health and Safety Act*, Responding Parties

Ministry of Labour F.V. No: **03226PKVR019**

BEFORE: C. Michael Mitchell, Vice-Chair

APPEARANCES: Brittany Ross-Fichtner for United Food and Commercial Workers Canada, Local 175; Melissa Keeshan for Maplewood Nursing Home; David McCaskill for A Director under the Occupational Health and Safety Act, and Ministry of Labour, Training & Skills Development

DECISION OF THE BOARD: December 22, 2020

1. This is an appeal of a refusal of an inspector to make an order under section 61(1) of the *Occupational Health and Safety Act,* R.S.O. 1990, c.O.1. ("the Act"). This appeal was filed on July 3, 2020. A consultation was held on November 25, 2020. Maplewood Nursing Home ("Maplewood" or the "Employer") is a long-term care home in Brighton, Ontario, operated by Omni Health Care.

2. This case is occurring in the context of the world-wide COVID-19 pandemic. In Ontario, a state of emergency was declared on March 17, 2020 under the *Emergency Management and Civil Protection Act. The Reopening Ontario (A Flexible Response to COVID-19) Act, 2020, S.O. 2020, c. 17* established a mechanism to continue previously issued emergency orders and most of these have been renewed and extended.

3. As of the time of the request for the installation of a plexiglass barrier in the nursing station, there was an outbreak of COVID-19 in this

workplace involving only one patient in early May 2020. However, there were confirmed cases of COVID-19 throughout Ontario and within the community. Although the science of the transmission of the virus is not settled, and there is still some controversy regarding airborne transmission, it is currently thought that the disease is mostly but perhaps not exclusively transmitted through large droplets generated when an infected person exhales, coughs, sneezes, laughs, or talks in close proximity to another person. The droplets may then be absorbed by others directly by absorbing the droplets or through touching surfaces which contain the virus and then touching the face.

4. The issue in this appeal is a narrow one and is whether an order should be made by the Board directing Maplewood Nursing Home ("Maplewood") to install a plexiglass barrier at the nursing station. While other matters were raised tangentially, the real issue is whether Maplewood is required to install this barrier pursuant to section 25(2)(h) of the Act which requires an employer to "take every precaution reasonable in the circumstances for the protection of a worker".

5. Notwithstanding that the inspector declined to make the order sought by the Union, the Director remained neutral in these proceedings and took no position on what the Board ought to do. It made no submissions.

6. The nursing home in Brighton, Ontario has approximately 49 beds, 41 residents and 59 employees. The nursing station is located at a vantage point where both hallways of the nursing home can be viewed by staff from the station. It has a 5 ft high countertop which is one foot deep. On the inside of the station directly below the countertop there is a built in desk with a phone, binders, trays, computers, and other paperwork needed for the operation of a nursing station. The countertop is angled and has sufficient length for three staff to sit or stand behind the counter physically distancing 3 metres apart. There are three office chairs in which different staff work throughout the day.

7. The concern expressed by staff in the appeal and at the consultation is related directly to the possible spread of the COVID-19 virus. The Union does not seek a permanent plexiglass barrier after the danger from the virus lifts, but only one which will be in place

temporarily. The plexiglass sought is not a floor to ceiling barrier but rather one like those now commonly installed in grocery stores, pharmacies, retail stores and physician offices to separate cashiers or counter staff or receptionists from customers.

8. The specific concern of the staff is that residents can and often do approach the counter. A great many of the residents are cognitively impaired and while at the time of the filing of the complaint with the Ministry of Labour in May residents were required to wear masks, many did not, or wore them improperly. By the time of the consultation, residents were not required to wear masks at all, not because the risk of the spread of the virus has abated, and indeed the opposite is true, but because given the extent of cognitive impairment and the physical condition of the residents, it is impractical. While some residents are in wheelchairs and others cannot reach the top of the counter, many can. When they approach the counter to socialize, watch, or seek something, they look down and exhale on the staff sitting below as they engage with them verbally or just stand and watch. They can, for example, touch the heads of staff, and one resident attempted to remove the mask of a staff person. Visitors are not supposed to approach the nursing station, but this does occur. From the photographs and information provided at the consultation, there is not a 2 meter distance between someone standing at the counter and someone working below them.

9. The nursing station is where the nurses and personal support workers ("PSWs") do the computer entry and other work that is required of them, mostly charting. At shift changes, the "report" function occurs at the station where important information on the state of the residents and concerns relevant to the incoming staff are transmitted orally. Currently, three staff sit or stand in the station itself during "report" while others, which could be up to 7 additional staff, stand in locations beyond the counter which are marked to maintain social distancing. The Employer describes the nursing station as the hub of the provision of care in the home - a characterization the Union disputes. The Union characterizes the nursing station as the place where administrative functions related to the provision of health care for the residents are performed.

10. Residents are sometimes brought to the area in front of the nursing station in their wheelchairs where they can be observed by the staff working there. The vantage point of the nursing station is such that one can see if someone is approaching the station from either of the two hallways. The staff say, however, that if they are engaged in charting, they may be unaware of an approach and not be conscious of the presence of a resident.

11. Residents move freely throughout the home (leaving aside rules which may apply when there is an outbreak of COVID-19). Maplewood has installed plexiglass barriers in the dining room between residents because the table are too small to allow for proper social distancing. Obviously, the residents eat without masks. The barriers are present to try to avoid the spread of droplets.

12. Staff are required to wear masks and goggles throughout the day except when on break. The health care staff wear masks and goggles when they are at the nursing station and gowns and gloves are available.

13. The staff who work at the nursing station provide patient care of various kinds during the course of their shifts to residents in their rooms and washrooms and interact with them throughout the home in the course of the day.

14. A COVID-19 outbreak was declared after a resident tested positive for COVID-19 on May 4, 2020. In early May 2020, Karen Vaughan, a nurse, expressed concern in an email to the administrator of the home, Ms. Corkery, that the Nurse's Station presented a hazard to workers of possible exposure to COVID-19 from residents who were not adhering to physical distancing practices and were either not wearing masks or not wearing masks properly when interacting with staff at the Nurse's Station. She asked the Employer to install a plexiglass barrier around the nursing station to minimize workers' potential exposure to COVID-19. There was no response to the email.

15. On the same day she received the email, the administrator forwarded it to the head office where Sarah Ferguson-McLaren, Director

of Operations for Omni's eastern region replied privately to the administrator the same day as follows:

> Lol – no. The staff are a far greater risk to the residents than the residents are to staff.

16. On May 25, 2020, a housekeeper at the home, Jane Melvin, on behalf of the Joint Health and Safety Committee, submitted a written "Report of Hazardous Working Condition or Practice" to Ms. Corkery. This document recommended that the Employer install a plexiglass barrier around the Nurses' Station to create a physical separation between residents and workers. The administrator discussed the matter with Ms. Melvin and wrote on the form that she would:

> "Will increase audits to monitor adherence to PPE @nurses (sic). Forwarded concern. No plexiglass. Staff are universal masking at all times. The residents are more at risk than staff".

17. A complaint was filed with the Ministry of Labour, Training and Skill Development ("the Ministry") by the Union. On June 4, 2020, an inspector for the Ministry conducted a field visit of the workplace via telephone. The Inspector's Report dated June 4, 2020 states:

> The workplace parties stated that the request for a plexiglass barrier by the Joint Health and Safety Committee was submitted recently to Corporate Office by the Management at the workplace with the request denied as there is Personal Protective Equipment (PPE) available for each worker and other measures and procedures which have been implemented for infection control…
>
> The workplace parties stated that residents are given masks to wear outside their rooms in the main areas of the workplace but that there have been instances where they are either not worn or are worn incorrectly by residents but masks and goggles are worn by all workers at all times through the main areas of the workplace. Gloves and gowns are additionally worn by workers when entering a resident's room. Gloves and gowns are also available for workers to wear any time

> they choose to do so, including at the Nurse's Station. Hand hygiene audits are performed continuously. The Nurse's Station has a counter which acts as a physical barrier between workers and residents. All residents are screened twice daily for COVID-19 and any suspect cases have tests sent for testing.

18. The controversy continued in the home with the Joint Health and Safety Committee continuing to ask the management and the inspector to provide the barrier or to make an order. On June 29, 2020 in an email to senior management, the administrator stated:

> I tried to explain to Hazel [the inspector]that it is not our staff at risk of developing COVID from residents but the other way around.

19. Maplewood indicates that it is unaware of other institutions placing a plexiglass barrier at a nursing station.

20. Both parties referred to the following extracts from Public Health Ontario ("PHO") and the Ministry of Health and Long Term Care:

> Public Health Ontario July 27, 2020.
>
> TECHNICAL BRIEF
>
> IPAC [Infection Prevention and Control] Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19
>
> 07/27/2020
>
> *Background*
>
> After four months of global clinical experience and updated scientific and epidemiological evidence, routes of transmission for COVID-19 reveal the following:

- COVID-19 cases and clusters demonstrate that **Droplet**/Contact transmission are the routes of transmission…

- **The majority of cases are linked to person-to-person transmission through close direct contact with someone who is positive for COVID-19.** The mechanism of transmission is likely through direct large aerosol droplets or indirect contact of contaminated surfaces.

- Aerosols are liquid droplets which can travel through the air. COVID-19 forms predominately large aerosol droplets which are unlikely to travel beyond two meters. **These aerosols can be generated by coughs and sneezes**….

Application of the Hierarchy of Hazard Controls

According to the U.S. Centers for Disease Control and Prevention's National Institute for Occupational Safety and Health (NIOSH), **the fundamental method for protecting workers is through the application of the hierarchy of hazard controls. The levels of control range from the highest levels considered most effective at reducing the risk of exposure (i.e., elimination and substitution) to the lowest or last level of control between the worker and the hazard (i.e., PPE).**

The application of the hierarchy of hazard controls is a recognized approach to containment of hazards and is fundamental to an occupational health and safety framework. An understanding of the strengths and limitations of each of the controls enables health care organizations to determine how the health care environment (e.g., infrastructure, equipment, processes and practices) increases or decreases a HCWs risk of infection from exposure to a pathogen within the health care setting.

Collaboration between IPAC, OHS and health care building engineers supports the comprehensive evaluation and implementation of measures to reduce the risk of HCWs exposure to pathogens.

Elimination and Substitution

Elimination and substitution are considered to be the most effective means in the hierarchy of controls, but are not often feasible or possible to implement, particularly in regard to infectious diseases in health care settings.

…

Engineering and Systems Control Measures

Engineering control measures reduce the risk of exposure to a pathogen or infected source hazard by implementing methods of isolation or ventilation. **Engineering controls reduce or eliminate exposure by isolating the hazard from the employee and by physically directing actions to reduce the opportunity for human error**.

Examples include dental dams in dentistry, **rigid barriers at the interface between the patient and the HCWs at reception and triage** and point of care sharps containers and alcohol-based hand rub….

Personal Protective Equipment (PPE)

Although the use of PPE controls are the most visible in the hierarchy of controls, **PPE controls is the last tier in the hierarchy and should not be relied on as a stand-alone primary prevention program**. **The PPE tier refers to the availability, support and appropriate use of physical barriers between the HCWs and an infectious agent/infected source to minimize exposure and prevent transmission.** Examples of PPE barriers include gloves, gowns, facial protection (including surgical masks and N95

respirators) and/or eye protection (including safety glasses, face shields or masks with visor attachments).

…

Public Health Ontario June 2020

Prevention and Management of COVID-19 in Long-Term Care and Retirement Homes Public Health Ontario:

Maintain physical distancing between all HCWs, other staff and between residents.

…

Ministry of Health COVID-19 Operational Requirements: Health Sector Restart Version 2 – June 15, 2020

Hierarchy of Hazard Controls

The application of the following hierarchy of hazard controls is a recognized approach to the containment of hazards, including health hazards, and is fundamental to occupational health and safety.

1. Elimination and Substitution

Elimination and substitution are considered to be the most effective means in the hierarchy of controls. However, they are often not feasible to implement within all health care settings.

- Examples include not having patients physically come into the office/clinic, telemedicine, etc.

2. Engineering and Systems Control Measures

These measures help reduce the risk of exposure to a pathogen or infected source hazard by implementing methods of isolation or ventilation. These measures work to reduce exposure by isolating the hazard from the worker and by

> **implementing physically distancing actions to reduce the opportunity for transmission**.
>
> - **Examples include physical barriers like plexiglass barriers for administrative staff. A plexiglass barrier can protect reception staff from sneezing/coughing patients.**
>
> [**emphasis added**]

21. *The Long-Term Care Homes Act, 2007* provides in section 1 as follows:

> The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs met.

22. Section 25(2)(h) of Act provides:

> Without limiting the strict duty imposed by subsection (1), an employer shall take every precaution reasonable in the circumstances for the protection of a worker.

23. In the COVID-19 Response Framework, *Keeping Ontario Safe and Open November 3, 2020,* amended November 13, 2020, the Government of Ontario indicated that:

> There are several risk factors that help drive transmission of COVID-19. **Close contact is the highest risk.**
>
> [emphasis in the original]

Submissions of the Union

24. The Union submitted that this was a simple case where the residents could not maintain physical distancing or masking and an

outbreak of COVID-19 had occurred. Staff could be infected directly from close contact with the residents, or the papers and equipment they use in performing their administrative functions could be contaminated. It was unrealistic to think there could be constant decontamination of paper, the telephone and computers, and other surfaces because of residents exhaling and talking at the counter. The Employer failed to take the request for protection of a plexiglass barrier seriously and the attitude of the senior administrators demonstrated belittlement of the concerns of staff. The installation of a plexiglass barrier temporarily is a solution in keeping with what has been done in many other industries during the pandemic such as in stores, pharmacies, and doctors' offices. The Employer position that PPE is available and used by staff throughout the performance of their duties is irrelevant because the use of protective measures is not mutually exclusive. Used together, a barrier and the use of PPE will increase the chances that spread of the virus can be stopped. The use of PPE is said by PHO to be a measure of last resort in the hierarchy of controls and not one barring the use of other measures. While the virus is typically brought into the workplace by staff or visitors, it can be spread by residents. The use of barriers is appropriate as the Employer itself has provided them in the dining room. The Union relies on the PHO documents above as providing examples of where the use of barriers is warranted and says they do not constitute an exclusive list. This proposed barrier is analogous to the use of barriers in administrative areas and reception, mentioned in the PHO documents. Here, the use is reasonable in all the circumstances having regard to the precautionary principle. The Union relied on *Inovata Foods Corp*, 2020 CanLII 49519 (ON LRB) and *Ste. Anne's Country Inn and Spa*, 2020, CanLII 64749 (ON LRB).

Employer Submissions

25. The Employer submitted it complied with all the requirements of the Ministry and PHO, and as such has upheld a high standard of safety. The Act does not require, and the Employer cannot provide the impossible which is an absolute guarantee of protection to staff. The outbreak at the home involved only one resident and the home was successful in containing it.

26. It is inherent in the provision of health care in the home that staff are in contact with residents providing care throughout their shifts and everywhere in the home. Staff always wear PPE (except on break) including at the nurses' station. The wearing of PPE puts staff at very little risk in their contact with residents. The nursing station is not an administrative area but a hub for patient care which the staff engage in throughout their shifts. Installing plexiglass does nothing to increase PPE which is the most important form of protection. The plexiglass will leave space at the top and the sides where infection can spread so it will not accomplish its purpose.

27. The institution is the home of the residents and placing a plexiglass barrier at the heart of their home will negatively impact the residents and their feeling of security and increase the possibility of feelings of isolation. Counsel asserted installing the plexiglass will be "horrible" for the residents in their home. The measure will have limited impact on protecting staff, in addition to the protection currently offered by PPE, and is likely to cause harm to residents. The measure would run contrary to the express purposes and intent of the Act governing the provision of care to residents which is to provide security and comfort to them in their home.

28. The PHO and Ministry of Health advisory documents provide examples of the need for plexiglass potentially in reception and administrative areas, but nowhere provide for such barriers in the nurses' station; the silence is persuasive as if those bodies intended a barrier to be present there, it would surely have been provided for.

29. The risk to staff is small because the duration of the interactions with residents at the nursing station is brief compared to bathing or toileting them. People who work in grocery or pharmacies or retail are exposed to far more people and therefore much greater risk than these staff to these few residents. There are a limited number of residents who can stand and reach over the counter as many cannot. Staff should be able to anticipate the arrival of the residents at the desk because of the views down the hallway and should not be taken by surprise. The counter acts a natural barrier to contact between the staff and residents.

30. Effecting "report" at the change of shifts will be very difficult with a plexiglass barrier and staff may have difficulty hearing and errors in patient care may occur as a result. Having "report" elsewhere as in the dining room would be riskier as residents are there more frequently.

31. All the surfaces in the nursing station need to be sanitized regardless of the presence of plexiglass and putting in plexiglass will likely lull staff into thinking the work surfaces at the nursing station do not need to be sanitized frequently and will also lull them into not wearing their masks. The plexiglass, if installed, would require constant cleaning and sanitizing and itself becomes a hazard as another potential source of infection.

32. The advice in the PHO June 2020 advisory document to maintain physical distancing between all HCWs, other staff and between residents, means between staff, as a group *inter se*, and between residents, as a group *inter se*; it is not intended to apply to residents and staff interacting with each other.

33. The cost of making this change was stated by the Employer not to be a factor.

34. The Employer relied on *Ontario (Ministry of Labour) v. Sheehan's Truck Centre Inc.*, 2011 ONCA 645 (CanLII); *Ontario Public Service Employees Union v. Ontario (Community and Social Services)*, 2008 CanLII 70515 (ON GSB); *Ontario (Labour) v. Quinton Steel (Wellington) Limited*, 2017 ONCA 1006 (CanLII); *Dunsmuir v. New Brunswick*, 2008 SCC 9 (CanLII), [2008] 1 SCR 190; *Royal Ottawa Health Care Group - Brockville Mental Health Centre,* [2015] O.O.H.S.A.D. No. 35; *Canadian Auto Workers, Local 222 (Re),* [1996] O.O.H.S.A.D. No. 15; *Walker (Re),* [1995] O.O.H.S.A.D. No. 54; *Oakville Assembly Complex Ford Motor Co. of Canada,* [2013] O.O.H.S.A.D. No. 16; *Toronto District School Board,* [2019] O.O.H.S.A.D. No. 17; *Xstrata Canada Corp.,* [2010] O.O.H.S.A.D. No. 44; *Timmins Police Services Board,* [1999] O.O.H.S.A.D. No. 296.

Union Reply

35. The Union responded to the Employer's concerns about the plexiglass being a sound barrier for "report" as speculative and unrealistic as the Union was asking for a barrier and not a wall. It essentially sought a divider. "Report" could still take place at the station or elsewhere if necessary. There was no reason to believe professional staff would have a false sense of security and not follow protocol or remove their masks or not sanitize the area. While the nursing home is the residents' home, it is also the employees' workplace and the alleged impact of the measure on residents together with the remaining Employer concerns were speculative. Staff having contact with residents in their rooms, washrooms and elsewhere in the home throughout a shift are events planned, evaluated, and adjusted for by staff in advance of the contact. Contact at the nursing station, on the other hand, is unanticipated and initiated by the residents when staff are engrossed in doing their administrative work and can take staff by surprise. The Employer distinction between administrative and patient care areas is artificial and unhelpful in assessing the risk to staff. If the plexiglass will become a hazard from potential contamination from residents, this is even more evidence as to the possibility of infection to staff in the absence of a barrier.

The Interpretation of Section 25(2)(h)

36. I have distilled the scope of section 25(2)(h) from the jurisprudence of the Courts and the Board to be that the Act is public welfare legislation and is to be broadly interpreted in accordance with its purposes. Section 25(2)(h), in particular, is sweeping in its scope and potentially goes beyond and in addition to any specific regulation because it is not possible to anticipate every circumstance in the wide variety of workplaces through Ontario. The purpose of the section is not to eliminate hazards but to take reasonable precautions to protect workers from them. A generous approach to interpretation of the Act in line with its purposes does not, however, justify a limitless interpretation of the provision. There cannot be a complete absence of risk and danger and the Act is not aimed at achieving an impossible standard of a risk-free workplace. Ultimately, what the Act requires is a balance between the risk of harm, and the ability to carry out necessary public and private

functions. It is not every precaution that must be taken but every reasonable one. This involves balancing what is to be gained in light of all the factors and circumstances including potentially the cost, the effect on efficiency, the severity and magnitude of the risk and the likelihood or frequency of its occurrence. And while it is not possible for all risk to be eliminated, it does not follow that the obligation of employers is to the minimum required in a regulation as there may be specific safety measures particular to a specific workplace that are required in addition to specific regulations: *R. v. Timminco Ltd./Timminco Ltée*, 2001 CanLII 3494 (ON CA), 54 O.R. (3d) 21; *Ontario (Ministry of Labour) v. Sheehan's Truck Centre Inc.*, 2011 ONCA 645 (CanLII), 107 O.R. (3d) 763; *Blue Mountain Resorts Ltd. v. Ontario (Ministry of Labour)*, 2013 ONCA 75 (CanLII), 114 O.R. (3d) 321; *Ontario (Labour) v. Quinton Steel (Wellington) Limited*, 2017 ONCA 1006 (CanLII); *Ontario Public Service Employees' Union v. Ontario (Ministry of Transportation)*, 2006 CanLII 10956 (ON LRB); *Glencore Canada Corporation*, 2015 CanLII 85298 (ON LRB); *Sgt. Mark Radke v. Ontario Provincial Police*, 2017 CanLII 56938 (ON LRB).

37. In the specific context of the COVID-19 pandemic, section 25(2)(h) gives effect to the precautionary principle that there is an obligation to take all reasonable measures in the circumstances to protect the health and safety of workers. In the context of an epidemic caused by a new and previously unknown virus, the precautionary principle was given voice to by Mr. Justice Campbell following the SARS crisis in Ontario and was as described by Justice Morgan in *Ontario Nurses Association v. Eatonville/Henley Place*, 2020 ONSC 2467 (CanLII) as follows:

> An important recommendation of the Commission of Inquiry chaired by Justice Archie Campbell in the wake of the SARS outbreak of 2003 – an outbreak of a virus related to COVID-19 - is that the precautionary principle is to be put into action in order to prevent unnecessary illness and death. As explained by Justice Campbell, this principle applies where health and safety are threatened even if it cannot be established with scientific certainty that there is a cause and effect relationship between the activity and the harm. The entire point is to take precautions against the as yet unknown.

See also: *Inovata Foods Corp. supra; Ste Anne's Country Inn and Spa, supra.*

Decision

38. While the Employer put all the arguments set out in paragraphs 25-32 before the Board at the consultation, what stands out in the reaction of the Employer to the request for the installation of a plexiglass barrier is the absence of many of these positions from the responses of management. Instead, starting at the time of the initial request and over 8 weeks until the time the Union filed this appeal and while the controversy continued in the Home, one finds the expression from Maplewood three times that the real risk at the Home is not to the staff from the residents but to the residents from the staff. This was expressed not only internally but to the Inspector and to the staff in writing in the response to the "Hazard Report".

39. In the Board's view, the comparative risk to the residents of infection from staff as compared to the risk to staff of infection from residents is not a criterion that the statute contemplates. In essence, this response constituted an unfortunate denigration of the concerns of the staff as the clear implication is that rather than concerning themselves with any risk to themselves from residents, staff should be concerned with the risk they themselves pose to the residents.

40. In terms of health and safety and the reasonableness of the proposed measure, this sentiment was an irrelevant consideration that is not in keeping with the duty of care that the Employer owes to the employees under the *Occupational Health and Safety Act* as expressed through section 25(2)(h) itself. It should not be necessary to state that the well being, and health and safety of the residents and the staff are both of the highest importance. Moreover, it should be obvious that the virus does not pick and choose among which groups it will spread and that people who live and work in the home are potentially at risk from all others who live, work and visit there. The virus represents an all too real lethal risk to both groups and their families. The reality that the COVID-19 crisis in long-term care homes in Ontario impacted on all

concerned was captured in the interim report of Ontario's Long-Term Care COVID-19 Commission dated October 23, 2020, which stated that:

> Many witnesses have shared heart-wrenching accounts of their experiences during the first wave of the pandemic that resulted in tragic loss of life, suffering and devastating impacts on residents, families, and staff.

41. The reality of the COVID-19 crisis is the potential spread of a dangerous virus by way of close contact from person to person, especially indoors. This is precisely why the precautionary measures to prevent the spread of the virus stress physical distancing and the use of PPE. This is precisely why the Ontario Government document dated November 3, 2020 states that there are several risk factors driving transmission of the virus but **"close contact is the highest risk."** (emphasis in the original).

42. As Ontario has experienced, the risk in long-term care homes is very significant. In this Home, the risk raised by the Union is that residents standing at the counter of the nursing station are in very close physical proximity to the staff sitting below them. The residents are unmasked, often cognitively impaired, able to reach down and touch the staff or exhale, laugh, and speak onto them or in their direction. Of course, the staff are masked and have goggles, but they are not necessarily gowned or gloved as they perform their administrative charting and other functions. There is no guarantee that the masks or goggles will be fully effective in blocking any virus. Nor, of course, is there any guarantee that the creation of a plexiglass barrier at the counter will stop the emission of virus which can go around the barrier or on top of it. The question simply is whether the installation of a plexiglass barrier is a reasonable precaution to take in these circumstances.

43. I find that the response of the Employer that this preventive measure is not reasonable because the staff are already wearing PPE, and that they provide direct care and have to be in direct contact with the residents throughout the day in any event, to be unconvincing evidence of the lack of reasonableness of this proposed precaution. Of course, there are risks inherent in the delivery of care to the residents and it is the core function of the staff to deliver such care. Of course

PHO and the Ministry do not require physical distancing while care and services are being provided to residents by staff, and of course, staff provide that care wearing the same masks and goggles (and gowns and gloves in the rooms) as they do while sitting at the nursing station. But that does not mean that it is not reasonable to try to protect staff and residents from the contact that takes place in other encounters in the home, or that therefore residents should be able to approach staff sitting at their workstations without masks and stand above them potentially spreading the virus.

44. The circumstance at the nursing station is not a situation like others where staff encounter residents outside the resident rooms and bathrooms in a hallway, or lounge or common area during their shift and naturally interact. Those encounters can be expected by staff and reacted to naturally while some physical distancing can perhaps be maintained. However, the encounters at the nursing station are not directed or anticipated by the staff themselves in the same way as when they administer care or medications to patients or interact with them in the hallway or lounge. Here, the staff are engaged in necessary administrative functions and the contact with residents is not incidental in those moments to patient care. The encounter constitutes an act by residents to draw close to staff to interact with them or to simply watch them while staff are engaged in other necessary tasks. In my view in such circumstances where there is such close physical contact, there is no masking by residents, and the virus is potentially dangerous to the health of all concerned and also potentially lethal, the erection of a barrier is a reasonable precaution.

45. Moreover, the fact that there is PPE being used by the staff to protect against the spread of infection does not obviate the advantage of additional forms of protection if they are also reasonable precautions in the circumstances. The use of preventative measures is not mutually exclusive as the Union pointed out and the IPAC document from July 27, 2020, does indicate the use of PPE is the lowest and last barrier between a worker and the hazard and not, as the Employer arguments suggest, the first and only preventive measure.

46. It would appear to be obvious that during the workday three staff are often sitting and working at the nursing station, masked and

with goggles, and they must maintain the required physical distance from each other. The wearing of masks and goggles by staff does not obviate the need for the staff to physically distance from each other. If a resident approaches the counter, is not masked and is in very close proximity to those same workers sitting and working at the nurses station, all the concerns about the spread of the virus that required the staff to physically distance from each other do not evaporate because it is a resident who approaches closely. Given that staff are required to be physically distanced from each other when they are masked and wearing goggles while working at the nursing station, in my view it is reasonable for there to be a barrier so that an unmasked resident cannot approach directly to the counter and interact with staff without any physical distancing.

47. The fact that the advisory documents from the Ministry and PHO mention specific barriers in nursing homes in reception and administrative areas does not mean that plexiglass or other barriers should not be considered elsewhere where appropriate. For example, the advisory documents are silent on barriers in the dining room but yet Maplewood has implemented them there because they are a precaution for the safety of residents. Just as the Ontario Court of Appeal made clear in *Quinton Steel, supra* that the obligation of an employer to conform to a specific regulation does not circumscribe or supplant the sweeping obligation of the employer to take every reasonable precaution in the circumstances for the protection of staff under section 25(2)(h), so too the substantive obligation of the Employer here is not dictated or circumscribed by the Ministry or PHO advisory documentation although they are highly influential and in some case likely dispositive.

48. Similarly, I do not find Maplewood's contention convincing that not many residents will stand at the counter because they can't rise from a wheelchair or are not tall enough to reach over it, or that if they can, the frequency of these events or the duration of the interactions means the risk is not serious. It is not denied that residents regularly approach the counter and interact with staff working there in some way and the inherent risk in those regular interactions cannot be dismissed as unimportant or not posing a significant risk of harm given the realities of this virus.

49. The possibility that "report" will be harder to hear because of the barrier is speculative. The barrier is unlikely to be so high as to make sound transmission ineffective. In any event, in the unlikely event that "report" is not manageable in the large group in this physical area once a barrier is installed, other options or areas can certainly be explored. While there was a discussion in the consultation about the suitability or lack thereof of alternatives, there was no evidence that any systematic effort has been made to canvass alternatives, assuming one is necessary.

50. I take seriously the objection of Maplewood that the installation of this barrier is an undesirable intrusion into the home of the residents. In that regard, I reviewed and have taken into account section 1 of the *Nursing Home Act* set out above. This is the home of the residents and that matters. Undoubtedly, all the consequences of the crisis caused by the pandemic and the threat that it poses to the residents of long-term care homes has an adverse impact on the security and feelings of isolation of the residents in their home. These new restrictions and changes from the pre-COVID-19 *status quo* include restrictions on visitors, the presence of barriers in the dining room, the fact that staff are wearing masks and goggles all the time and gowns and gloves as well in the residents' rooms. These are all changes that have been deemed necessary for reasons of safety and there was no decision not to implement them because this is the home of the residents. The installation of a barrier is one additional change, and it appears in comparison to the others to be significantly less pervasive and impactful and can likely be implemented with modest impact on the residents. Hopefully, all these measures are transient. At the end of the day, this concern is speculative and highly subjective and cannot weigh so heavily as to prevent the implementation of the protective measure.

51. Finally, the fact that the plexiglass will, like other surfaces, require disinfecting is not a reason not to install it if it is otherwise reasonable to do so. Cleaning is done three times a day and this will not add much work to what is already been done.

52. Maplewood is correct that there is no evidence the barrier will fully block any virus that may be present which can be transmitted

around and on top of it, or that the barrier will necessarily provide significant protection. In this regard, I have regard to the precautionary principle referred to above, which is that where health and safety are threatened, even if it cannot be established with scientific certainty that there is a cause and effect relationship between the activity and the harm, precautions that appear reasonable should be taken.

53. Maplewood relies heavily on *Ontario Public Service Employees Union v. Ontario (Community and Social Services),* 2008 CanLII 70515 (ON GSB). This was a public sector case where the Grievance Settlement Board ("GSB") interpreted the collective agreement but also OHSA, and in particular section 25(2)(h). The GSB declined to order that the employer install a plexiglass barrier in a new government office providing services under the Ontario Disability Support Program ("ODSP") to the public in Windsor, Ontario. The prior facility had such a barrier at the front counter separating clients from staff.

54. The facility serviced tens of thousands of clients. The Union sought the barrier to protect employees from violent physical contact, abusive language and/or the possibility of human bodily fluid exchange with clientele or the public. The Government proposed to implement numerous other safety measures as a part of a larger package of measures it said would provide a safe working environment without a plexiglass barrier. The Government said that the creation of the plexiglass barrier was inconsistent with the *Ontarians with Disabilities Act* and set an adversarial tone between clients and staff which fostered aggressive behaviors from clients. Its removal would reduce the anxiety and frustration levels in clients and the tendency for aggressive behavior.

55. The GSB did not consider that the threat of physical and imminent harm to the employees was proven. There were twenty-eight (28) incident reports of what was perceived to be threatening or disruptive behavior occurring in a period when 86,000 clients were served, the use of objectionable language would not be prevented by the barrier, there was no evidence that any ODSP employee in the Windsor Office had ever been physically assaulted by a client, and there was one unsuccessful attempt at assault. No employee had been spit

on by a client. There was one incident where there was some potential for the transmission of an infectious disease.

56. Maplewood submits that the GSB case is persuasive and highly relevant to the situation at Maplewood. It argues that the principles inherent in the *Long Term Care Homes Act, supra,* and particularly the principle that the institution is the home of the residents where they have to be able to live with dignity, security and comfort, is akin to the concerns regarding the vulnerability of the clients serviced under the *Ontarians with Disabilities Act.*

57. *Ontario (Community and Social Services), supra* was a case where a permanent barrier was sought in an ongoing government program where the erection of a barrier would have institutionalized a negative psychological barrier between the staff and the clients, creating anxiety and a tendency to aggressive behaviour. Most importantly there was in that case no persuasive evidence of an ongoing threat to employees. In Maplewood, the staff continue to perform critical care functions for the residents without any physical separation. What is sought is a temporary measure addressed to one physical area, where given the threat from the virus, there is unnecessary close contact between residents and staff putting both at risk. Most importantly, however, unlike that case where there was virtually no evidence of the spread of disease, here there is extant in Ontario an epidemic with the spread of a dangerous virus where new cases are raging and where far too many residents and health care workers have been infected and many have died precisely in long-term care homes such as this one. I reject entirely the Employer's submission that there is any equivalence in the two cases.

58. In my view having regard to all the circumstances, the installation of a plexiglass or similar barrier at the countertop of the nursing station in the Maplewood Nursing Home in Brighton, Ontario is a reasonable measure for the protection of the employees so long as the threat of the spread of the COVID-19 virus is present and I so order.

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