

CONDUCTING SURVEYS FOR INVESTIGATIONS

Introduction

The most important source of information on workplace hazards is our members. In fact, they may be the only source of information on workplace hazards since management may not document incidents (or near misses). In addition, conducting regular surveys may also enable the local union to evaluate workplace hazard prevention measures, and educate members at the same time. This document will provide some guidance on conducting a survey in your workplace, and provides an example of some of the survey questions you may wish to use.

Preparing to do the survey

A survey can be carried out solely by the union, but it is easier to carry out if you have the employer's support. With the employer on board, distribution, filling out the surveys, and collection can be done on work time which will improve the chances of participation.¹ However, the following conditions should be met before you proceed with a *joint* survey with the employer:

- The employer and the union have a full and agreed-upon understanding that the purpose of the survey is to identify hazards that may cause injury or illness.
- The employer and the union agree on the questions being asked.
- Union volunteers will distribute and collect the survey on work time.
- The survey design and implementation will ensure that participants are not identified, and their individual responses are kept confidential.
- The employer will not receive any of the hard copies of the survey or raw data, only summarized results so that individual worker confidentiality can be further assured.
- Results of the survey will be shared with all employees.

If the above conditions are not met, or the employer does not support the idea of a survey, then the local should proceed with its own survey. This survey would need to be done outside of work hours, requiring more time to ensure that everyone has a chance to complete the survey. The union health and safety committee or the union executive can develop the survey and distribution plans.

Once the survey is developed and approved, the health and safety committee should develop a letter explaining the purpose of the survey, and provide contact info for members who have questions. If the survey is being done in collaboration with the employer, ensure that the letter contains information about the time available to complete the survey at work.

¹ Locals considering doing a survey in an online format should contact their regional health and safety representative who can provide support for the process.

Developing the survey

When developing the survey, consider the list of possible hazards that are present in your workplace. A number of sample surveys have been provided at the end of this document.

Information can be collected either through a written questionnaire distributed to workers or through one-on-one interviews (oral surveys). A written survey may be appropriate if the union wants personal or sensitive information, since the form won't identify the individual. For example, a worker may be reluctant to voice to a union representative fears about a co-worker, but may be more willing to describe the problem in an anonymous questionnaire. One-on-one interviews can be very useful for organizing the membership as it gets people talking about their jobs and working conditions, and introduces union leaders to the rank and file members. Oral surveys are also a way to involve members who have difficulty with written questions due to literacy challenges or because English or French is not their mother tongue. If a number of members have another mother tongue, consider translating the survey and recruiting survey distribution and interviewer volunteers fluent in those languages.

Maximizing participation

Have individual health and safety committee members take responsibility for distributing the survey to specific areas, departments or units. To ensure that people actually fill out the form, limit the response time to a few days. Have the same person who distributed the forms collect the completed surveys.

Prior to introducing a survey into the workplace, whether the employer is involved or not, it is a good idea to have a special union meeting to describe the purpose of the survey, how results will be used, confidentiality, etc. It is recommended that you engage your CUPE servicing representative or health and safety specialist when developing the survey as well.

Confidentiality

For the purposes of investigations, most surveys will take the form of symptom surveys. It is important that members feel comfortable that their personal data will be protected, and that only those who have the absolute need to know will have access to the raw data. Any data released on the results should be presented as a collection, and should not allow for any identification of individual members.

Results

Once the surveys have been collected and the results tabulated, the health and safety committee or the local should have a special meeting to discuss the results. Using the survey, pinpoint problem areas, causes and factors that increase the risk of violence and use the meeting to start to plan for ways the union can work to fix any issues that have been found in the survey.

A note about Demographic and Occupation Information

Demographic profiles (answers grouped by age, gender, etc.) allow us to see patterns in workplace hazards that we might miss otherwise. Given that many workplace hazards can affect workers differently, these patterns are very important.

Some members are reluctant to answer questions about their identity and occupation, especially in small work places where the information can identify the respondent (e.g. there is only one person in the worksite under 35) or expose them to discrimination (e.g. homophobia). For very small workplaces or locals, where demographic or occupationally related questions could easily identify members, it is If you are running an electronic survey, place them at the end of the survey, and explain why the local is collecting the information, and make them optional. On tip is that you should consider using ranges where applicable.

Demographic and occupational questions include (but are not limited to):

What is your job Title: _____

What is your age?

- 19-25
- 26-35
- 36-45
- 56-65
- 65+

How many years of experience do you have in your current position?

- 0-5
- 6-10
- 11-15
- 16-20
- 21-25
- 25+

What is your primary gender identity?

- Female
- Male
- Transgender
- Transsexual
- Intersex
- Two-spirit
- FTM (female-to-male)
- MTF (male-to-female)
- Gender non-conforming/Genderqueer/ Androgynous
- Other, please specify _____

Do you consider yourself: (Mark more than one or specify, if applicable)

- White
- Chinese
- Black
- Filipino
- Latin American
- Arab
- Korean
- Japanese
- West Asian (e.g., Iranian, Afghan, etc.)
- South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.)
- Aboriginal/Indigenous/First Nations/Métis
- Other, please specify _____

Are you an Aboriginal person, that is, First Nations (North American Indian), Métis or Inuk (Inuit)?

Note: First Nations (North American Indian) includes Status and Non-Status Indians.

- No, not an Aboriginal person
- Yes, First Nations (North American Indian)
- Yes, Métis
- Yes, Inuk (Inuit)

Do you consider yourself a ... (Please check all that apply.)

- Person with a physical disability
- Person with a learning disability
- Person with a mental health challenge
- Person with low vision/vision disability
- Person who is hard of hearing
- Person who is Culturally Deaf
- Person with a disability not listed above, please describe ...

Does a physical condition or mental condition or health problem reduce the amount or the kind of activity you can do at work?

- Yes, sometimes
- Yes, often
- No

Do you consider yourself ... (Please check all that apply.)

- Heterosexual
- Lesbian
- Bisexual
- Gay
- Queer
- Two-spirited
- Other, please specify _____

Sample Worker Discomfort Survey (source <https://www.iwh.on.ca>)

Date ___/___/___ Job Name _____ Department _____

Shift _____ Hours worked _____ Years _____ Months _____
 Time on THIS job _____

Other jobs you have done in the last year (for more than two weeks) **Note:** If more than two jobs, only include those you worked on the most.

Site _____ Dept _____ Job Name _____ Months _____ Weeks _____
 Time on THIS job _____

Site _____ Dept _____ Job Name _____ Months _____ Weeks _____
 Time on THIS job _____

1. Have you had pain or discomfort during the last year that you feel is job-related?

Yes No (if NO, Stop here)

2. If YES, please rate the level of discomfort over the last MONTH by checking off the appropriate box using the scale of 0 to 10, with 0 being no discomfort and 10 being the worst discomfort experienced.

No Discomfort ↓ 0	1	2	3	4	5	6	7	8	9	10 ↓ Worst Discomfort Ever		No Discomfort ↓ 0	1	2	3	4	5	6	7	8	9	10 ↓ Worst Discomfort Ever													
□ □ □ □ □ □ □ □ □ □ □											Neck	□ □ □ □ □ □ □ □ □ □ □											Upper Back												
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□ □ □ □ □ □ □ □ □ □ □											Left Hip/ Thigh/ Buttock	□ □ □ □ □ □ □ □ □ □ □											Right Hip/ Thigh/ Buttock												
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Sample Stress Survey (source <http://www.usdaw.org.uk>)

	Never	Sometimes	Often
1. Do you ever suffer from any of the following?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion or nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeplessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neckache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 2. Do any of the following cause problems for you at work?			
Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor/inadequate lighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overcrowding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor ventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dust or fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor maintenance of equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 3. Do you find any of the following cause problems?			
Shiftwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate break times/mealtimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsocial hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Very heavy workload	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unfair distribution of work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repetitive/boring work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meeting deadlines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job insecurity, ex. threat of redundancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Under-utilisation of skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Sometimes	Often
4. Regarding working relationships, do any of the following cause you problems?			
Poor relations with supervisor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor relations with workmates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harassment and/or discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impersonal treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of communication from management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working with the public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How much control do you feel you have over your job? Do you feel:			
You are able to plan your own work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You can participate in decision making for your own job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You have some control over the pace/content of your work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You have no control at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you feel you:			
Are underpaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are undervalued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive appreciation for good work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How do you feel about your job in general? (Check one)			
I am completely happy and enjoy my job		<input type="checkbox"/>	
I sometimes feel dissatisfied but generally enjoy my job		<input type="checkbox"/>	
Most of the time I do not enjoy my work		<input type="checkbox"/>	
I have no interest at all in my work		<input type="checkbox"/>	
8. If you feel you are under stress, please tick which you feel is the main contributory factor:			
Problems at work		<input type="checkbox"/>	
Problems at home		<input type="checkbox"/>	

9. Please list below what you feel are:

(a) The main causes of stress in your job

(b) The effects that these have on other workers and yourself

(c) The steps you think could be taken to ease the situation

Sample Air Quality Survey

Some employees have complained of the working conditions that exist at their workplace. To help isolate the problem, your union is asking you to fill out the following survey. Answers will be kept confidential, and only the group data in full will be shared with your employer.

		Frequency	Does the condition only occur at your workplace, and get better when you leave?
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes: Do you ever have any of the following symptoms:	<input type="checkbox"/> Blurring	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Aching	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Running	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Redness	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digestive Tract: Do you experience any of the following symptoms:	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Sick Feeling	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No

		Frequency	Does the condition only occur at your workplace, and get better when you leave?
Respiratory Tract: Do you experience any of the following symptoms:	<input type="checkbox"/> Breathlessness	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Dry nose	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Congestion	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Running Nose	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Sore Nose	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Bleeding from the nose	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Dry Throat	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Coughing	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin: Do You experience the following symptoms?	<input type="checkbox"/> Sweating	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Rashes	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No

		Frequency	Does the condition only occur at your workplace, and get better when you leave?
Legs: Do you experience of the following symptoms:	<input type="checkbox"/> Weakness in Legs	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Aching Legs	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back: Do you experience any of the following symptoms	<input type="checkbox"/> Back Pains	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Back Aches	<input type="checkbox"/> Rare <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally	<input type="checkbox"/> Yes <input type="checkbox"/> No

What is your work area and occupation?

What percentage of your work week is spent at this workplace?

0-20% 20-40% 40-60% 60-80% 80-100%

Do you have any other symptoms that may be related to your job?

Do you have any comments about your working conditions?

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