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December 1, 2006

FAX and Email

Policy and Regulation Development
WorkSafe BC
PO Box 5350, Station Terminal
Vancouver, BC
V6B 5L5**Re: Proposed Regulatory Amendments -- Part 6: Substance Specific Requirements**

Please accept this as the Health Employers' Association of British Columbia's (HEABC) submission with regard to the proposed amendments to Part 6 of the *Occupational Health and Safety Regulation*. HEABC represents a group of approximately 315 publicly funded health care employers who have approximately 100,000 employees. This includes the entire spectrum of health care employers from acute care, long term care, community, public, and mental health.

HEABC has reviewed the proposed changes to Part 6 and is providing the following feedback with regard to these proposed changes.

Increasing Regulation:

The provincial government's Regulatory Reform Policy, which is in place until December 31, 2008 targets a zero net increase in regulatory requirements. HEABC has a general concern that the Board is increasing regulatory burden in contravention of the government's directive mandating the contrary. The Policy requires that the Chair of the Board must ensure that proposed regulations are evaluated according to regulatory criteria set out in the Policy and in accordance with a Regulatory Criteria Checklist designed to ensure that all new regulations are results-based and contribute to a more competitive regulatory environment. Unfortunately, with the current proposed regulatory amendments, there is no evidence that the Board has complied with the government's Policy or completed the Checklist process. If it has done so, it has not been a transparent process.

Lack of Cost-Benefit Analysis:

Of serious concern to HEABC is that the Board has not completed a cost-benefit analysis with respect to the current proposed amendments and this is a requirement under the Policy. HEABC had requested that such a cost-benefit analysis be conducted; however, if there has been one completed, it has not been made public. Also, there has been no competitive analysis completed by the Board. The current proposed regulatory amendments are much broader than those required in other Canadian jurisdictions; yet, the Board has not addressed this as an issue within a competitive analysis framework, as required. Furthermore, the announcement of the proposed amendments has not provided sufficient time to complete full cost benefit analysis, much less appropriate consultation.

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Employer Consultations:

HEABC provided a detailed submission, as part of the regulatory review process, dated May 31, 2006 which supported the scope of proposed regulatory amendments pertaining to the requirement to use safety engineered devices when hollow-bore needles are used for vascular access. HEABC has repeatedly stated its support for the use of safety engineered devices and was able to provide its support for the May 2006 proposed changes to Part 6 after having had the opportunity to participate in a lengthy and detailed consultation process with representatives of WorkSafeBC.

The current proposed amendments to Part 6 were developed in the absence of any consultation with health care Employers. Section 228 of the *Workers' Compensation Act* mandates that the Board undertake a process of ongoing review and consultation on its regulations to ensure that they are consistent with current workplace practices, technological advances and other changes affecting occupational health and safety.

Unfortunately, the current amendments have been proposed in the absence of the above required consultation and this has resulted in a proposed *Regulation* which is technically substandard and does not accurately or comprehensively reflect current workplace practices, environment, or process.

Current Implementation Process:

As the Board is aware, each of the regional Health Authorities is currently implementing or has implemented safety engineered devices. The Health Authorities and HEABC have provided extensive submissions with respect to the complexity involved in the transition to safety engineered devices. The proposed amendments mandating a full scope transition to safety engineered devices by October 1, 2008 are not realistic or achievable. As noted by Fraser Health, in its submission, product evaluation, trials, and implementation will require at least 18 – 36 months. Vancouver Island Health Authority (VIHA) is also making submissions during the public hearing process and supports a 3 year phase in of the proposed amendments. The proposed timeline is not adequate to ensure appropriate selection, education, training and infrastructure support. Interior Health Authority has also provided a submission confirming the inadequacy of an October 1, 2008 timeline.

Implementation Timelines:

As Fraser Health has advised, in its submission, its own transition to safety engineered devices in 2004-2005 was the largest single change initiative which its supplier, BD, had attempted in Canada. A full scope implementation requirement of October 1, 2008 could result in shortages of devices. Had the Board completed proper consultation with health care employers, especially those which have transitioned to safety engineered devices, there would have been an opportunity for it to explore best practices and to determine the feasibility of the proposed *Regulation*.

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With respect to the increased scope of the proposed *Regulation*, the Board has not provided any data or evidence to support the need for an expanded regulatory requirement. The statistical data identifies that the greatest risk for a BBF exposure comes from arterial/venous access and there is *Regulation* in place to deal with this.

Definitions:

With respect to the definition of a medical sharp, the amendment defines this to mean a "needle device, scalpel, lancet, broken glass, broken capillary tube or any other medical device that can reasonably be expected to penetrate the skin or any other part of the body". As noted in VIHA's submission, the inclusion of "broken glass" as a medical sharp requires clarification and context. This is also supported by Interior Health Authority and Fraser Health.

The solution is to have the term "broken glass" removed from the *Regulation* as per the following:

1. Broken glass represents a cut or puncture risk and must be handled and disposed of appropriately regardless of the situation i.e. a medical or non-medical workplace.
2. Broken glass is not used in medical treatment but may occur as a result of a container or device being broken. Safety glass can also present injury risks.
3. Numerous medications are supplied in glass ampules that must be "broken" in order to access the medication. While their inclusion in the definition may be appropriate, it may represent significant consequences to the healthcare industry, medication manufactures, end users and ultimately the patients.
4. If the broken glass is contaminated with blood/ body fluids, then it requires special handling and disposal. This would include a glass vial or specimen/ suction container.
5. Under the proposed definition, glass from a broken window would need to be considered a medical sharp. As such it would be required to be put into an appropriate sharps container and be disposed of as a medical sharp. This would have a significant impact on all industries and result in global non-compliance / inability to comply.
6. The phrase "or any other part of the body" is misleading and may lead to confusion and inaccurate interpretation where items or devices are used in body cavities such as the mouth (e.g. toothbrush), ear canals (e.g. Q-tips), urethra (e.g. Foley catheters) etc. HEABC is assuming that there is no requirement for these devices to be safety-engineered; yet, the *Regulation* appears to mandate this.

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Definition of "Highest Level of Protection":

With regard to the language mandating the use of devices which provide the "highest level of protection", the Board has not provided a definition of this as there is no such definition. The amendment states that the Employer must make a determination of the highest level of protection available based upon information provided by manufacturers, independent testing or other reliable sources. The amendment completely ignores the need for clinical trialing as critical to the selection process. HEABC and the Health Authorities have spent considerable time, during the first regulatory amendment process with respect to Part 6, educating the Board as to the critical importance of clinical trialing and its complexity and yet this is ignored as a selection criteria. This is disappointing, especially as there is no scientific objective definition of "highest level of protection".

Safety engineered devices constitute new technology which is in a constant process of development. A *Regulation* which ignores that fact, prescribes a standard for which there is no definition, and which does not acknowledge the complexity of the selection process is one which will not provide maximum protection for health care workers and will not be feasible for Employers to comply with as it is not based in technological, organizational, or occupational health and safety reality.

HEABC supports VIHA's submission that while the employer must make the determination of the "highest level of protection", the proposed *Regulation* identifies the resources the employer is to use to make this determination. While manufacturers and independent testing agencies are worth looking at, they are not appropriate sources to base a final decision on. Information and claims by manufacturers, independent testing agencies or other "reliable sources" can be self-serving and may make false or inappropriate product claims.

The healthcare industry must be allowed to conduct clinical trials/ reviews and not be forced to rely solely on information and claims that may not be accurate or are misleading. Selection of medical equipment and devices must be based on clinical and medical appropriateness, not solely on testing by third parties who potentially have a vested interest in the outcomes. Identification of the need to move towards a safety device should be based on a risk assessment that balances the need to both protect the caregiver and which ensures the highest medical outcome for patients. WorkSafeBC must not implement *Regulation* that adversely affects patient or medical outcomes.

Clinical trials and evaluation by the employer and end users must be the determining factor to move towards safety engineered sharps or medical devices. There must be awareness that a particular engineered sharp or medical device may not be clinically appropriate or medically acceptable in all instances.

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While objective data is preferable, the reality is that there will be a degree of subjectivity in any engineered sharps or medical device trial and selection.

While cost should never be the primary motivator to select a particular engineered sharp or medical device, impact on other equipment and processes must be seriously considered in the process.

Interior Health Authority has also provided a submission outlining its concerns with the language pertaining to "highest level of protection" and HEABC supports the Health Authority's comments in this regard.

HFARC also supports the submissions of VIHA and Fraser Health which confirm that the requirement for the "highest level of protection" does not allow for clinical/procedural variables as follows:

1. Alternate terminology should be considered/used to support a shift from those conventional devices that, based on a risk assessment, are deemed to increase the risk of exposure.
2. Highest level of safety must be appropriately defined to shift the focus from technical sophistication of an engineered sharp or medical device to the process which involves determining the root cause and required interventions used to create the highest level of safety.
3. Statistical data and research supports the use of engineering controls in conjunction with other controls to manage risk.
4. It is misleading and negligent to make the assumption that any safety device will provide the highest level of safety in the absence of identifying the root cause of the risk. Reliance on the device sophistication negates the importance of safe work practices and evidence based clinical practices.
5. In addition, the reliance on the device sophistication does not take into account clinical appropriateness, medical acceptability, usability, end user issues, client based interactions or the environment in which these devices are to be used
6. A conventional device that is compatible with established safe work practices that reduce or eliminate identified risks could easily be considered the highest level of safety.
7. If the existing device and the work practice no longer maintain that level of safety, then intervention is warranted based on the identification of the root cause – is it the device or the work practice?

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8. In most cases a simpler intuitive device that is more end user friendly and/or task friendly provides the highest level of safety.
9. Devices for similar tasks that have different activation features may decrease the activation frequency due to confusion or frustration related to the various activation methods.

With respect to the definition of a safety engineered medical sharp, HEABC again supports the submissions of VIHA, Interior Health and Fraser Health that this definition is too narrow and focuses only on needleless or technically sophisticated devices as follows:

1. Failure to be representative of the wider range of devices within the body of the regulation is misleading and confusing to the target group the regulation is intended for.
2. Other safety needles also offer safer alternatives over conventional needles (e.g. integrated safety mechanism) and are more appropriate in a wider variety of applications.
3. Consideration must also be given to the current safety engineered needles and future devices that may come into use.
4. Despite the expanded explanation in the guidelines, numerous individuals are incorrectly drawing a correlation between technically sophisticated devices (e.g. retractable needle system) and the highest level of safety.

HEABC supports the submissions of VIHA and Fraser Health with respect to the proposed definition of "clinically appropriate" in that it needs to be concise and easily understood. In addition a definition of "medically acceptable" needs to be included for completeness as per the following:

1. The addition of "medically acceptable" and its definition will quantify and qualify the chosen product.
2. Promote selection through a process involving risk assessment and product trials and reviews.
3. Significantly reduce the likelihood of an inappropriate device being selected or an appropriate device being rejected due to personal bias.
4. Defining and determining Safety Engineered Needles (SEN's) and other Safety Engineered Devices (SED's) that are "clinically appropriate" is complex. It involves many aspects such as:

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- specific applications,
 - device acceptability,
 - acute versus emergent use,
 - willingness to explore SED's,
 - perception,
 - comfort,
 - safe work practices.
5. What may be deemed clinically appropriate for one medical procedure may not be for another task or situation.
6. There is a balance between subjective and objective clinical appropriateness of SED's. Some primary factors to consider for SED's include:
- Evidence based clinical standards
 - Suitable for task and acuity
 - Does not impede or compromise established clinical standards
 - Is acceptable to the end user (sufficient comfort/ proficiency level)
 - Use of / activation of safety feature compliments or supports safe work practices

HEABC supports VIHA's recommended definition for "medically acceptable" device:

Medically acceptable devices must:

- (a) be approved/certified for use in Canada through the appropriate regulatory body and*
- (b) facilitate meeting clinical standards and/or be used in accordance with the device's intended purpose.*

As stated in the beginning of this submission, HEABC has always been supportive of the adoption of safety engineered sharps devices. Unfortunately, the proposed amendments to Part 6 are poorly written and are inconsistent with best health and safety practice.

Stakeholder Submissions:

HEABC has had the opportunity to review the submission of the BC Nurses' Union with respect to the proposed amendments and would like to offer the following comments. The Union's submission is based on speculative and unsupported statements. Specifically, the Union is requesting an implementation date of July 2007 because in its view, "they could complete this process in a shorter time period". While this may be a belief, it is not substantiated by any of the Health Authorities. A comparison to Saskatchewan and Manitoba is not an appropriate comparison given the scope of implementation in British Columbia in comparison to Saskatchewan and Manitoba which are not comparable in size. We respectfully request that the Board rely on the submissions of the Health Authorities who have experience with

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transitioning to safety engineered devices and who can provide reliable opinions, based on fact, with respect to implementation timelines.

Tracking:

The union has repeatedly called for a separate tracking system to track sharps injuries. As HEABC and the Health Authorities have confirmed to the Board on many occasions, there are mechanisms currently in place to track sharps injuries. As the union correctly states, Fraser Health, Vancouver Island Health Authority and Vancouver Coastal Health use EPINet to track their sharps injuries and exposures. Northern Health Authority and Interior Health Authority track their sharps injuries through WHITE which is their workplace health incident tracking system. Provincial Health Services Authority tracks sharps injuries through its PeopleSoft system. Unfortunately, the union again provided incomplete information in this regard to the Board. There is no need for a separate mandated tracking system as these injuries are currently being tracked by Employers.

Worker Involvement in Selection:

The union has also repeatedly called for a regulatory requirement for the involvement of Joint Occupational Health and Safety Committees in the selection and evaluation of safety engineered medical sharps. HEABC and the Health Authorities have repeatedly stated that the appropriate level of worker consultation in the selection and evaluation process stems from clinical trialing. This is a very detailed and extensive process by which clinical staff, who will actually have to use the products, are provided with the opportunity to trial various devices. It is not appropriate for Joint Committees to be mandated to be involved in the selection and evaluation process as many of its members are non-clinical employees, have no clinical expertise, will never use a safety engineered sharp or a medical device of any kind, and are not involved in medical outcomes and patient experiences.

Such a mandatory consultation process with non-clinical employees would be nonsensical and potentially dangerous.

The union has provided very general statements that employees are not being involved in the clinical trialing process. This is incorrect. HEABC strongly urges the Board to make its decisions based on the factual information and experience of the Health Authorities.

There is further factually incorrect information contained in the union's submission which pertains to the statement that they have not identified any devices where safety engineered counterparts do not exist. This is patently incorrect. As HEABC and the Health Authority have advised repeatedly to WCB in previous consultation meetings, there are a wide variety of medical devices which do not have safety engineered counterparts.

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Finally, the union has provided very generalized and speculative statements with respect to the types of devices selected. As noted by both VIHA and Interior Health in their submissions, there is a great deal of emotion and misperception within the union stakeholder community about what types of devices should be used. This misperception should not be relied upon by the Board in developing regulatory requirements.

The BCNU states that research has shown that workers can be injured while activating safety devices. None of that research is documented. Furthermore, workers can be injured using any device, safety or not, if it is not properly used. There are incidents of workers being injured when using a retractable device because of lack of activation. There is also the issue that clinical trialing has not always resulted in nurses wanting to select a retractable device because its use can be more painful for a patient. The Board cannot be in the business of mandating which clinical equipment should be used, given the complexity of selection, preference, clinical trialing results, patient comfort, etc.

Submission:

HEABC urges the Board to retract the amendments and commence a true and meaningful consultation process with the health care industry to draft *Regulation* which is practical and which will actually ensure the highest level of protection for workers and which will be achievable for health care Employers. The current amendments will not achieve this end.

Enclosed is HEABC's May 31, 2006 submission which contains further details with respect to the complexity of the transition process. We would also be pleased to submit for the Board's consideration, Health Authority documentation pertaining to their clinical trialing processes which confirms the complexity and wide ranging scope of the clinical trialing process.

HEABC and the Health Authorities reiterate their invitation to WorkSafeBC staff and Board representatives to meet with us to discuss the current status of the transitioning to safety engineered devices and to review the issues and results associated with the transitions which are underway and which are planned as technology evolves.

We appreciate the opportunity to provide this submission and look forward to working with you on developing a more effective regulatory amendment to Part 6.

Original Signed



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/w Attachments

ATTACHMENT

May 31, 2006

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Re: Proposed Regulatory Amendments - Amended

Please accept this as the Health Employers' Association of British Columbia's (HEABC) submission with regard to the proposed amendments to Parts 5 and 6 of the *Occupational Health and Safety Regulation*. HEABC represents a group of approximately 315 publicly funded health care employers. This includes the entire spectrum of health care employers from acute care, long term care, community, public, and mental health.

Part 6: Substance Specific Requirements

HEABC has reviewed the changes to Part 6 and is supportive of the amendments as proposed. Specifically, we are supportive of the language which will mandate that workers use only safety-engineered needles with needless devices unless it is not safe or practicable to do so when hollow-bore needles are used for vascular access.

In taking this position, HEABC is aware that there is some controversy within health care with respect to the scope of the *Regulation* as it pertains to the use of safety-engineered needles. HEABC supports the proposed amendments to the *Regulation* with respect to the scope for several reasons.

First, it is important to recognize that all of the six regional Health Authorities have either implemented or are in the process of transitioning to safety engineered medical devices. The purpose of the amendments to Part 6 is to increase safety in the use of sharps and this is already occurring with respect to the transition to safety-engineered devices in British Columbia health care. During the consultation process between WorkSafe BC, health care unions, and employers, it has been confirmed that Fraser Health and Vancouver Island Health Authority are the first Health Authorities in Canada to transition to safe needle technology and the other four British Columbia Health Authorities are currently in the process of doing so. British Columbia, therefore, has the advantage of having a "made in BC" experience which is being developed for which there is an evaluative process and potential. The current transition to safety engineered devices is a good news story for British Columbia health care organizations and most importantly, for employees.

For example, Interior Health, with approximately 18,000 employees, has received senior executive approval to begin the transition to safety engineered devices. It has a regional steering committee comprised of union representatives, some of whom are on Joint Health and Safety Committees, purchasing, infection control, workplace health and safety, clinical managers, clinical educators, pharmacy, and public health. Interior Health has its current contract with BD for the purchase of its devices. To date, Interior Health has hosted a one day forum attended by clinical users to provide selection recommendations.

Selection criteria include items such as devices which provide a rigid cover that allows the hands to remain behind the needle, assurance that the safety feature is in effect before disassembly and remains in effect after disposal, that the device be simple and obvious in operation, and be cost effective. A further criterion is that features designed to protect healthcare personnel should not compromise patient care. Again, these are only some of the criteria. Once a selection decision is made, there will be a rollout plan which includes extensive training and locally based committees at each Health Service Delivery Area within Interior Health. It is expected that the rollout will be complete by early 2007.

Devices will cover infusion, injection, blood collection, and IV therapy. This includes hollow bores for venous and arterial access as well as for IM and subcutaneous procedures. The medical/surgical areas within the Health Authority are currently looking at safety scalpels and suture needles.

Vancouver Coastal Health is also transitioning to safety engineered devices throughout its Health Authority as well as Providence Health. This encompasses 25,000 employees. It is important to emphasize that many sites within the Health Authority, such as Lions Gate Hospital, are already using safety engineered devices.

The Health Authority has a steering committee with representatives from senior management, logistics, unions, clinical areas, equipment and supplies, frontline staff, health and wellness, and infection control. Vancouver Coastal Health is currently in the process of product selection. This has involved identifying all sharps in the system. There are over 1500 different types currently in use. The Health Authority put out an RFP stating that it is moving to safety engineered devices and asked suppliers to advise them of what types of safety devices they

have available. Vancouver Coastal's purchasing contracts are expiring in Spring, 2006 so the transition to safety engineered devices Health Authority-wide is timely. Vancouver Coastal's logistics team has completed a review of the available safety devices.

The Health Authority then held a 2-day product fair at the end of March 2006 and had over 150 frontline staff, educators, and managers participate. On the first day, companies demonstrated their safety products and on the second day, each product was evaluated using several criteria by each participant. This resulted in 8,000 evaluations. The evaluations were then entered into a data base to score the results. 50% of the weighting related to clinical efficacy and safety and 50% related to logistics such as availability, reliability, cost, etc. The next step in the selection process will involve clinical trialing by users and once a final selection is made, the negotiation of new contracts will commence. Implementation of the chosen product will then occur. Vancouver Coastal is focusing on its high risk areas, as are the other Health Authorities. The highest risk areas are those in which blood filled hollow bore needles are used. IM and subcutaneous devices are also part of the selection and implementation process which also includes safety scalpels, razors, and trochars.

Vancouver Island Health Authority, with approximately 16,000 employees, has also completed its transition to safety engineered devices. Its implementation process involved completing a risk assessment to identify the highest areas of risk. HCADC understands that Vancouver Island Health Authority has provided a submission with respect to this review and that it has provided details of its implementation to WorkSafeBC. Briefly, Vancouver Island Health Authority has converted its hollow bore devices as well as those pertaining to IM and subcutaneous procedures. It has converted its phlebotomy devices used for blood collection and is currently trialing other safety devices such as renal fistula access devices.

Fraser Health, with its 22,000 employees, is the first and largest Health Authority to transition to safety engineered devices. Like the other Health Authorities, Fraser Health completed a risk assessment to identify its areas of highest risk. Its contract for needles, syringes, IV catheters and spinal needles expired in December 2003. A task group was formed in April 2003 with participants from materials management, workplace health and safety, infection control, pharmacy, department of anesthesia, emergency department, nursing (hospital based IV teams, home IV teams, SCN, Preventative Health, and Home Care), and the laboratory. Clinical specifications were developed and approved in June 2003. The senior executive of the Health Authority issued its approval and in July, 2003 an RFP was issued.

In December 2003 safety devices were reviewed and trials were arranged. For example, IV team representatives from acute care and home care participated in a review of safety IV catheters. Representatives from acute care, home care, and preventative health reviewed the safety needles and syringes. Meetings were held with the department of anesthesia to review samples of IV catheters and safety needle and syringe combinations as well as evaluation forms. Further clinical trials occurred at multiple sites and in various types of clinical sites.

In April, 2004 Fraser Health announced its broad scale standardization with new needle stick prevention devices with engineered sharps protection. Implementation commenced with BD, the successful company, providing 22 educators to complete training of Fraser Health

employees. According to BD personnel, Fraser Health's implementation was the largest in its experience.

As part of its overall exposure control plan, Fraser Health is now reviewing available safety devices, as its other contracts expire, such as suture needles and scalpels. Phlebotomy is currently in a transition process to safety engineered devices. Fraser Health has converted hollow bore devices used for venous and arterial access as well as for IM and subcutaneous use. It is an ongoing process as contracts expire and technology is developed.

Northern Health and Provincial Health Services Authority are also in the process of transitioning to safety engineered devices and HEABC is happy to provide further details to WorkSafeBC.

All of the Health Authorities emphasize that the transition to safer sharps is part of an overall exposure control plan with respect to biohazardous materials and that the adoption of safer sharps alone, in the absence of exposure control plans, is insufficient to protect its workforce.

HEABC has provided this very brief synopsis of the Health Authority implementations in order to document their efforts and successes in transitioning to safety engineered devices. The transition, given the sizes of the Health Authorities and the complexity of the services they provide, is an enormous undertaking. Vancouver Coastal Health has provided its documentation and attached to this submission is a sample of the supporting documents used by the Health Authority in planning its transition. The intent of their attachment is to provide WorkSafeBC with a small example of the complexity, detail, and effort required to transition to safety engineered devices in a safe and responsible manner. HEABC would be pleased to provide further documentation, if required by WorkSafeBC.

It is important to recognize that safe needle technology is evolving and because health care is in the process of transitioning to the technology, a broad prescriptive *Regulation*, as requested by some stakeholders in health care, is premature and unnecessary and could have the effect of hampering the ability of health care organizations to avail themselves of developing technology or interfere with their current and ongoing progress in transitioning to safety-engineered needle devices. It is also important to note that there are situations for which their may not be safety-engineered devices manufactured and as such, a broad-based prescriptive *Regulation* would be unenforceable if a technology mandated by *Regulation* is not available.

The health care industry and its partners which include unions, WorkSafe BC, and OHSAA have an opportunity, with the current conversion to safe-needle technology, to evaluate the successes of the transition as well as to develop best practices for the implementation of this technology. A broad-based *Regulation* would put the "cart before the horse" as it would mandate the use of devices which may have not yet been fully evaluated for their efficacy in improving safety and reducing exposure to biohazardous substances for the health care workforce or which may not be available on the market. The proposed amendments to the *Regulation* will improve safety for health care workers and will not hinder health care organizations from implementing safety-engineered devices throughout their facilities.

It is also important to recognize that in developing a *Regulation* pertaining to the use of safety-engineered needle devices, that there are three parties to consider: the employer, the worker, and the patient. The use of any medical equipment involves a significant clinical decision-making component based on medical expertise and the needs of patients/residents/clients. Medical practitioners are responsible for providing care and HEABC does not support a *Regulation* which substantially interferes or hampers clinical decision-making. Ultimately, the responsibility for decision-making with respect to patient care rests with medical practitioners and their patients. The proposed amendments to the *Regulation* provide for enhanced safety to the health care workforce without interfering in clinical decision-making.

HEABC is also supportive of the proposed amendments as they allow for health care organizations to implement a selection process which involves representatives of all user groups within health care organizations. The experience of the Health Authorities which have transitioned to the devices is that there can be a variety of opinions among users as to what the most effective device is and which device(s) provides maximum protection. There are many factors to be considered including safety, usability, efficacy, functionality, patient safety, cost, and compatibility and the proposed amendments give clinical practitioners, who are the users, and decision-makers the opportunity to select devices based on the needs of all of the parties. This is critical as the transition to safety-engineered devices entails a significant change management component and the needs of the users must be considered. The proposed *Regulation* will not interfere with consultation with users and HEABC is supportive of this.

It is also important to recognize that the Health Authorities are very large organizations which are composed of previous Health Region and "stand alone" health care organizations. This means that there are a variety of purchasing contracts which have been negotiated with varying expiry dates. If the Board were to adopt a broad-based prescriptive *Regulation*, health care employers would potentially be in a situation where they would have to purchase safety engineered devices within their current contracts which could result in the adoption of technology which is not suitable to the needs of the users or patients or which does not provide a maximum safety benefit.

HEABC understands that there has been a request for the proposed amendments to include mandatory consultation with Joint Health and Safety Committees. HEABC is not supportive of this as the membership of Joint Health and Safety Committees (of which there are many in each Health Authority) includes non-clinical employees and management representatives who have no expertise or knowledge of needle technology and it would absolutely be inappropriate for the Board to require consultation on a clinical issue with non-clinical members of a Committee.

The Health Authorities are consulting with clinical users and this is clearly the appropriate form of consultation. This is not to suggest that there is no role for the Joint Occupational Health and Safety Committees; however, a requirement for this would be clearly inappropriate and more importantly, would not result in increased safety for the workforce. Also, from a logistical perspective, it would be impossible to consult with the numerous Joint Occupational Health and Safety Committees which exist in the Health Authorities. For example, Fraser Health has over 40 Committees and Vancouver Coastal has approximately 50 Committees.

HEABC recognizes that there are concerns within the worker community with respect to the scope of the proposed amendments. We do not believe that further *Regulation* is a way to address these concerns at this time as the industry is moving towards the adoption of safe-needle technology and it is very important to deal with factual information and not make decisions based on opinion, anecdote, or assumption in order to ensure the safety of the workforce.

HEABC believes that an evidence/knowledge/experience-based approach to implementing safety-engineered devices is the only way to ensure the highest standards of health and safety for health care workers and safety for patients and we encourage WorkSafeBC to consult and liaise with the Health Authorities who are happy to provide the facts regarding their implementations and transitions to safety engineered devices. The Health Authorities have transitioned to the safety engineered devices without the need of *Regulation* and they are continuing to do so and it is imperative that this be acknowledged so that decisions on *Regulation* can be made with the full facts and in the best interests of all stakeholders within the health care system. The goal is to improve the health and safety of health care workers and this is occurring with the transitions to safety engineered devices.

We have a huge advantage in British Columbia, given the scope of implementation to safe needle technology, to work together with our partners to develop best practices, share best practices and factual information about what is happening in the industry with respect to this issue and most importantly, to evaluate the successes and efficacy of the use of safety-engineered devices and to base future decisions on the results of evaluation. HEABC believes that it is the evaluation results along with developing technology which will drive future expansion and adoption of safe-needle technology and that this will ensure the highest level of safety for health care workers. Because British Columbia health care organizations are the first to implement safety engineered devices on such a large scale in Canada, we hope to serve as a best practice model for other jurisdictions.

We strongly encourage WorkSafe BC's Board of Directors to adopt the proposed *Regulation* and then liaise and work with the industry and unions in future to review progress in implementation and to monitor evaluation results. Given the implementations which are occurring, there is a real opportunity for all stakeholders to benefit and learn from the growing experience in British Columbia and we look forward to a positive collaboration with all of our partners, including WorkSafe BC.

HEABC is supportive of the implementation date of January 1, 2008. As WorkSafeBC is aware, the Health Authorities are large and complex organizations. Fraser Health is one of the largest Health Authorities in Canada. Given the size of the Health Authorities and the enormous change management issues involved in planning, selection, training, and implementation of safety engineered devices, a January 1, 2008 implementation date sets a realistic timeline for the proposed amendments to become effective and allows for a safe transition period. Given the change management implications associated with the transition to safety engineered devices, it is imperative that appropriate timelines for implementation be established and HEABC applauds WorkSafeBC for recognizing this by proposing January 1, 2008.

While there have been comparisons to other jurisdictions such as Saskatchewan and Manitoba, it is important to recognize that those jurisdictions are nowhere near as large as those in British Columbia and as such, comparison is not justified or helpful.

HEABC is aware that as per the May 26, 2005 public hearings, that there is a request for the *Regulation* to include a duplicate requirement for the logging of sharps incidents. HEABC does not feel this is necessary as there are current regulatory requirements for employers and workers and physicians to report injuries and exposures. There are also first aid reporting requirements. There is a protocol for workers who have sustained an exposure to attend emergency departments for assessment and this results in reporting. All of the Health Authorities, with one exception, use the EPINet system which logs, in detail, sharps incidents. The one Health Authority currently not using EPINet has indicated that it will be adopting the WHITE system which contains EPINet. There is no need for duplicate *Regulation* to again require reporting of sharps incidents. The requirement exists and health care has gone beyond the regulatory requirement in its use of EPINet.

There has also been a request made for a *Regulation* mandating a hierarchy of selection based on the devices which are most effective. As noted in this submission and during the consultation process, each Health Authority has developed detailed selection criteria which is based on the best scientific and medical processes. A *Regulation* mandating the selection of the most effective devices is illogical as there is no objective definition of the term "most effective". There are various opinions in the clinical community as to which are the most preferred or effective devices which is why the Health Authorities have used selection criteria and grading of devices based on best practice. There is simply no way to regulate the definition of "most effective". The Health Authorities, based on their clinical trialing and selection criteria are already determining what is the most effective device(s). HEABC does not support further *Regulation* for which there can be no definition or enforcement.

There has also been a request for a regulatory requirement to adopt a neutral space concept in operating rooms. HEABC agrees that the adoption of neutral space practices is beneficial but does not support *Regulation* pertaining to neutral space as it cannot be enforced and is not practicable as a regulatory requirement.

HEABC understands that a November 2005 OHSAA report on needlestick injuries was submitted at the May 26, 2006 public hearing. It is important to recognize that this report used data from Fraser Health and Vancouver Island Health Authority when they had completed or were close to the completion of their transitions to safety engineered devices. This affects the statistics presented. Also, the numbers used in the report are flat numbers. The report does not contain the rate of usage for various devices in determining risk of injury. The rates are currently being developed and once available, will provide a much more accurate analysis of the relationship between the use of certain devices during certain procedures and exposures or injuries.

While we are very supportive of the consultation methods adopted by the Board and have greatly appreciated the opportunity to meet with Board representatives, we would strongly recommend that the Board consult with the industry prior to the development of future

Regulation pertaining to safety engineered devices, if there is to be further consideration of such, so that all of the factual information can be considered and incorporated into *Regulation* in order to maximize health and safety outcomes for health care workers. Unfortunately, this did not occur with respect to the proposed amendments to Part 6 and we believe that this may have resulted in some of the current concerns being expressed by the stakeholder community during the consultation and public hearing process. We would also recommend that members of the Board of Directors attend all public hearings as they are the decision-makers with respect to regulatory change.

With respect to the current implementations which have occurred and which are occurring, HEABC would like to extend an invitation to WorkSafeBC representatives and to its Board of Directors to visit a Health Authority in order to have an opportunity to actually view the safety devices, the policies and procedures, the training programs, and the future direction plans in person in order to gain a true understanding of the large scope of the transition to safety engineered devices and its successes. Fraser Health has advised that it would be happy to participate in a demonstration of its devices at WorkSafeBC for interested parties. This invitation is being issued to provide an opportunity for WorkSafeBC and other stakeholders to get a clear picture of the progress occurring in the industry with respect to safety engineered devices. This has all occurred without benefit of *Regulation* and will be ongoing.

During the May 26, 2006 public hearing, one of the presenters demonstrated two types of safety syringes. These devices both have the same effect and are designed to have the same outcome; however, more importantly, it is critical for WorkSafeBC to recognize that these were only two devices and we welcome an opportunity to demonstrate all devices.

In summary, HEABC supports the proposed amendments to Part 6 and strongly recommends their adoption by the Board of Directors. In addition to this submission, HEABC endorses the recent submission provided at public hearing by Vancouver Island Health Authority.

Thank you for the opportunity to provide our submission with respect to these very important issues. We look forward to working with you in future with respect to the industry's progress in the area of safe needle technology and as well as on evaluation results.

Original signed


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