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November 27, 2006

WorkSafeBC
Workers' Compensation Board of British Columbia
Prevention Policy & Regulation Review Department
Policy and Research Division
PO Box 5350 Station Terminal
Vancouver BC V6B 5L5

Dear Sir:

Re: 2006 Proposed Amendments to the Occupational Health And Safety Regulation

Enclosed please find the submission concerning the 2006 Proposed Amendments to the Occupational Health and Safety Regulation on behalf of Interior Health's Needlestick Injury Prevention Advisory Committee.

Yours truly,



Lance Stone
Project Manager
Needlestick Injury Prevention Program

Enclosure

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Interior Health is committed to providing a safe and healthy work environment for all staff. As such, we welcome regulations that will assist in achieving that goal and are in process to implement devices that will greatly reduce needlestick occurrence. The information outlined below covers some of the concerns we have with the proposed Amendment to part 6 of the Regulation, dated October 12, 2006.

Part of the Oct 12, 2006 explanatory note reads, "The information available indicates that hollow bore needles for vascular access pose the greatest risk to workers' health, however, any stick or cut can require the same treatment as a stick from a hollow bore needle for vascular access. The physical and emotional trauma to workers can be severe."

It would appear that you are willing to strengthen the requirements due to common misunderstandings of the relative risk, in effect fostering that misunderstanding, versus working to heighten awareness.

Part of the July 31, 2006 explanatory note reads, "All time loss disease claims accepted by WorkSafeBC over a 10-year period (1995-2004) that resulted in a person contracting a disease from an infected person involved hollow-bore needles used to draw blood, which are intravascular hollow-bore needles (WorkSafeBC Statistical Services 2006).

From this, it clearly appears that the regulation requiring a safety engineered needle when a hollow-bore needle is used to access a vein or artery was evidence based. Unless WorkSafeBC has new, solid evidence (which has not been made public) it appears that the expansion of the scope of the regulation is neither science nor evidence based.

Despite the above, Interior Health recognizes the magnitude of the misperception of the risk and the difficulty in countering that misperception and as such, can accept the expanded scope of the proposed regulation; however, we do have concerns about the timelines and wording.

Regulations 6.36 (1.3) (a) and (b) provide exceptions to the requirements to use safety-engineered devices. We recommend the inclusion of an additional exemption, which could be worded as follows:

6.36 (1.3) (c) the safety-engineered needle or medical sharp has not been available long enough to have been adequately trialed and deemed clinically effective.

As regulations change and advances to needles and medical sharp technology continues, more safety engineered products will be marketed. Considerable time and usage is necessary to prove their value.

Our biggest concern is with 6.36 (1.4), which is proposed to read "If more than one type of safety-engineered hollow bore needle or safety-engineered medical sharp is available in commercial markets, the needle or sharp that provides the highest level of protection from accidental parenteral contact must be used".

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We believe 6.36 (1.4) should be deleted or significantly altered. "Highest level of protection", while clearly well-intended, is far too vague and subjective. There is clear indication that 'highest level of protection' is automatically assumed to be the most complex and technologically advanced, unless proven otherwise. If an easy to use and simple device eliminates the risk of accidental parenteral contact (post activation), that device should not be considered inferior and automatically discounted because there is a more technical device that also eliminates the risk of accidental parenteral contact (post activation). If the risk of the needlestick is readily and effectively eliminated, additional features should not be made mandatory. Eliminated is eliminated, whether the risk is eliminated once or multiple times over. Consider the following hypothetical example: an automobile airbag is proven to protect the occupants of an automobile in collisions up to 400 kmph. A new airbag is marketed which is speculated to protect the occupants in collisions exceeding 400 kmph. Would it be irresponsible of the employer to continue to provide the 'lesser' airbag? The same argument can be made for currently available retractable needles. There is zero real evidence to suggest that retractable is more effective than guarded devices; however, there are advocacy groups stating that we are doing a disservice and putting staff at risk by implementing guarded devices. Using another example, assume all healthcare facilities implemented retractable devices and after two years of use, had zero needlestick injuries. A new, voice activated retractable device is marketed that is far more sophisticated than the current retractables. Because these devices would require zero manual activation, does it suggest a 'higher level of safety' and therefore, would we be mandated to use them. We believe if the risk is eliminated, it is eliminated, regardless of how it is achieved.

We believe (1.4) could be kept if re-worded similarly: *'If more than one type of safety-engineered hollow bore needle or safety-engineered medical sharp is available in commercial markets, the product selection must be made by personnel knowledgeable of available products, the risks associated with needlestick injuries, higher risk procedures, the applications the products will be used with, clinical and medical indications and contra-indications. The ultimate selection must be made on the products' ability to eliminate the risk of accidental parenteral contact.*

6.36 (1.5) reads "For purposes of subsection (1.4), an employer must make a determination of the highest level of protection available based upon information provided by manufacturers, independent testing agencies or other reliable sources and, if that information is not available, based on other objective product evaluation criteria".

If (1.4) were deleted, current (1.5) would also be deleted. If (1.4) was modified as suggested above, (1.5) could be changed to read: *Post implementation surveys and data analysis must be utilized to determine the appropriateness of the product selections. Where concerns are noted, the process described in (1.4) must be repeated to ensure appropriate products are utilized.*

If (1.5) were left as is, it implies a continual need to prove the products implemented are as good as the claims of the manufacturers and independent testers of new products. Manufacturers will provide positive information about their products, and they will find 'independent' testers to provide further positive information. Consider the following: a multi-

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disciplinary selection committee completes a comprehensive evaluation and device X is implemented. No accidental parenteral contact is experienced following use of device X, and no problems are uncovered. Under those circumstances, is it prudent to continually measure your products against new products just because manufacturers claim they are superior and lobby groups consider the devices more 'technical' and therefore necessary? Recognizing the value of continued quality improvement, if a product clearly works and has stood the test of time, the onus should switch.

We also have a concern with some of the proposed definitions:

Definitions 6.33

"medical sharp" means 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;

We suggest removal of the term broken glass from the definition.

Broken glass is not used to provide care; rather, it presents a risk as a result of a container, vessel, window etc. being broken. Like any other hazard, broken glass must be handled in a safe manner. It presents a risk of a laceration or puncture, rarely a blood or body fluid exposure. The July 31, 2006 explanatory note reads "Needlestick injury means a cut or skin puncture from contact with a needle that has been used for the care or treatment of a person and the needle is no longer to be considered sterile as it has been in contact with blood or body fluids of a person". The qualifying phrase **is no longer to be considered sterile as it has been in contact with blood or body fluids of a person**, is key. Glass ampoules must be broken to extract medications, yet even lacerations from them do not present a risk of a blood or body fluid exposure, as the glass has not been in contact with the blood or body fluids of a person.

"safety-engineered needle" includes a self-sheathing needle device and a retractable needle system.

We suggest inclusion of the words "**integrated needle guard mechanism**", and reference to *G6.36(1.1)-1 draft August 22nd 2006*, in which advisable characteristics of safety-engineered devices are recommended.

The proposed definition limits the selection to self-sheathing or retractable devices only. This fosters the assumption and misperception that not only are more technical devices superior, they are the only ones that satisfy WorkSafeBC requirements.

With respect to the timelines, we do not believe an October 1 2008 deadline adequately permits an effective implementation of all hollow bore needles and other medical sharps. There are numerous facets of a conversion, such as evaluation, selection, budget consideration, contract procurement, education development and delivery, product changeover etc. An

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October 1 2008 deadline simply does not allow adequate time to responsibly make a change of this magnitude. Of considerable concern is that the prime users of the medical sharps are medical personnel, and as such, are not employees of the facilities. Getting their participation and endorsement greatly adds to the complexity and presents further challenges in meeting deadlines. We believe WorkSafeBC should liaise with the British Columbia Medical Advisory Committee to get their buy-in before passing regulations that greatly impacts their members.