

June 29, 2007

WorkSafeBC  
Prevention Policy & Regulation Review Department  
Policy and Research Division  
P.O. Box 5350 Station Terminal  
Vancouver, BC V6B 5L5

*Via Mail & E-mail: (Regquery@worksafebc.com)*

**Attention: Anne Burch, Director,  
Prevention Policy and Regulation Review**

**Re: Proposed Amendments to Part 3, Part 4 and Part 30 of the Regulation**

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### **Introduction**

The British Columbia Nurses' Union represents 26,000 workers, mostly Registered Nurses employed throughout the province, in all types of healthcare settings. Nurses deal with demanding situations every day in less than perfect workplaces. The BCNU strives to prevent occupational injury and disease by supporting ongoing Regulation Review with the development of Regulations that protect the health and safety of BC workers.

### **Issue**

This submission is in response to the proposed amendments to Part 3, Part 4 and to Part 30 of the Regulation.

### **Submission**

#### ***Part 3: Rights and Responsibilities***

The BCNU agrees that first aid should be covered by Regulation. However, as stated in our earlier submission, we have concerns about the ratings on the assigned hazard rating list which is found in the current guidelines.

As we understand the proposed Regulation, Employers are either required to provide first aid services based on their assessment of the level of risk at their worksite or the assigned hazard rating list. Healthcare has the second highest number of compensable injuries amongst classification groups, yet nursing homes, clinics and hospitals are all listed as low risk on the assigned hazard rating list. It is our view that these ratings do not reflect the level of risk that nurses face in their workplaces. It is therefore our recommendation that the "Assigned Hazard Rating List" be reviewed and updated in consultation with stakeholders.

***Part 4: Working Alone in Isolation***

Many of our members are required to work alone or in isolation. It is especially common for community nurses who perform the majority of their work in client's homes or doing community outreach and for nurses who are working in small hospitals and community health care centers. We therefore support the proposed changes to the Regulation which require Employers to identify hazards to workers before they are assigned to work alone or in isolation and to take measures to eliminate or minimize the risk of the hazard to the lowest level practicable.

We suggest that the Board clarify what is meant in section 4.20.1 where it states that "to work alone or in isolation means to work in circumstances where assistance would not be readily available to the worker." In the proposed Regulation, the term "readily available" is not clearly defined and could be interpreted to include situations in which support is only available by telephone or other similar mechanism. It is our view that even if support by telephone or other similar means is available it does not constitute having assistance "readily available." We urge the Board to clearly define readily available to include only situations in which another worker is physically present and able to respond in the event of an emergency or if a worker is injured or in ill health.

The Regulation also requires that the Employer must implement a written procedure for checking the well-being of a worker assigned to work alone or in isolation. We submit that the Regulation needs to go further. It is our position that the Regulation should stipulate that the Employer is responsible for providing any necessary equipment, such as cell phones and/or satellite phones for workers to conduct a check in procedure or call for help in the case of an emergency. It is our understanding that many Employers do not provide this type of equipment to nurses who are required to work alone and instead rely on the nurses to provide their own equipment. This clearly should be the responsibility of the Employer and not fall to individual workers.

***Part 30: Laboratories***

**30.9 Airflow Monitoring**

The addition of the word 'immediately' in this section addresses the concern that we raised in our earlier submission.

Respectfully submitted,

Lara Acheson  
Coordinator, Occupational Health & Safety  
**BRITISH COLUMBIA NURSES' UNION**

c: D. McPherson, President, BCNU  
Provincial OH&S Committee Representatives, BCNU (Via E-mail)

LA/lp cope: 15/#62049

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**Attention: Anne Burch, Director,  
Prevention Policy and Regulation Review**

**Re: Proposed Amendments to Part 5 and Part 6 of the Regulation**

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### **Introduction**

The British Columbia Nurses' Union represents 26,000 workers, mostly Registered Nurses employed throughout the province, in all types of healthcare settings. Nurses deal with demanding situations every day in less than perfect workplaces. The BCNU strives to prevent occupational injury and disease by supporting ongoing Regulation Review with the development of Regulations that protect the health and safety of BC workers.

### **Issue**

This submission is in response to the proposed amendments to Part 6 and consequential amendments to Part 5 of the Regulation.

The Board's stated intent of the proposed amendments is to emphasize that the scope of the regulation is not limited to blood-borne or body fluid-borne pathogens. The amendments provide definitions for adverse health effects and infectious agents. The Board has proposed that the definition of an infectious agent be linked to a classification system. The classification system is based on the biosafety containment classification system developed by the Communicable Diseases Branch of the World Health Organization (WHO), the Office of Laboratory Security of the Public Health Agency of Canada (OLS-PHAC), and the US Department of Health and Human Services, Centers for Disease Control and Prevention (DHHS-CDC).

## **Submission**

Healthcare workers put the health and safety of their patients ahead of their own. It is essential that healthcare workers feel confident that when they go to work to care for the public, they will be provided with the necessary level of protection. This is true whether the worker is providing care to a patient with seasonal influenza (Risk Group 1 Agent) or some other emerging infectious disease or providing care during the next flu pandemic.

The Regulation as drafted specifically excludes agents in Risk Group 1. The reason for this is that “these agents are common to the general community and of low morbidity... [and] are unlikely to cause occupational disease, posing little or no risk to a worker.” While that statement may be true in the case of workers outside of healthcare, we disagree that the same premise accurately reflects the situation in a healthcare setting. For example, often, when one patient becomes infected with the flu in a long term care setting, the facility will experience an outbreak and healthcare workers will also become infected. For that reason, it is our view that the Regulatory requirements should also apply to Group 1 agents in healthcare settings.

Often when a person enters the healthcare system with signs of infection, it is unclear as to the etiology and diagnosis of the presenting complaint. There will always be a window of time in which it cannot be determined with absolute certainty the level of protection that is necessary to ensure worker safety. This is due to time delays between diagnostic tests and procedures and their results. Accordingly, until the etiology and diagnosis of the presenting complaint are determined, it may be difficult to determine the required level of protection to prevent exposure to the worker. During this period of uncertainty, healthcare workers must be provided with the highest possible level of protection.

Once the etiology and diagnosis of the complaint are determined, a decision can be made to either maintain the level of precaution or to reduce it based on scientific knowledge about the mode of transmission of the infectious agent. In the case of new and emerging infectious agents where there is no clear and unequivocal science about transmission, workers must be given the highest level of protection until certainty is attained. The precautionary principle must be the basis for any decisions related to the level of protection afforded to a worker.

To illustrate this point, we draw on a recent example of SARS. Initially, no one knew anything about the origins of SARS, how it was transmitted, its course or its death rate. However, “instead of working from the worst-case scenario that SARS might be spread through airborne transmission and scaling back containment measures as more was learned, the report found that officials waited for ‘scientific certainty’.” This resulted in the deaths of 2 nurses and one doctor. Healthcare workers made up almost half of the cases of SARS in Ontario.

We cannot allow that to happen in BC. To ensure that it doesn't, BCNU urges WorkSafe BC enshrine the precautionary principle into the Regulation. It is our position that the precautionary principle should be specifically referenced and explained in the Regulation.

The BCNU disagrees with the definition of adverse health effect as references in Sections 5.1 and 6.33. A more appropriate definition of adverse health effect is “a change in body function or cell structure that might lead to disease or health problems.”

We urge WorkSafe to go beyond the proposed requirements of 6.34 (e). It is our view that the Board must require Employers to not only provide “a description of the personal protective equipment designed to eliminate or minimize occupational exposure” but also require that the Employer provide sufficient and appropriate personal protective equipment to protect all healthcare workers who have a risk of exposure. At the present time, our members have advised us of circumstances in which there are insufficient PPEs available for workers at their worksite. For example we have been advised of units which do not have a sufficient supply of masks to complete a shift. In our view, the only way to ensure that there is an adequate supply of equipment at a worksite is to include a requirement in the Regulation.

Section 6.34 (f) states that the Employer must have “a program to inform workers about the contents of the exposure control plan and to provide them with adequate education, training and supervision to work with and in proximity to, an infectious agent or infectious material.” At this time there are several healthcare employers which have not completed required fit testing nor provided education about infectious agents. In addition, some Employers are prioritizing fit testing based on the perceived level of risk. In these days of “hallway” nursing and units receiving “off-service patients,” it is our view that all patient care areas should be treated as high risk. To ensure that there are clear parameters to determine whether an employer is in compliance with the Regulation, we submit that the Regulation should provide clear direction about the frequency of the training and education and supervision required.

With respect to Section 6.39, we disagree with the proposed amendments. We suggest that the section be revised to state “an employer must offer vaccination against hepatitis B virus to all workers who *may be* at risk of occupational exposure to that virus.” [emphasis added] It is our view that the current Regulation provides a higher level of protection to workers than the proposed Regulation does.

As stated in our earlier submission, it is often difficult for nurses to be granted leave from work to seek medical attention due to workload and patient care issues. It is our view that Section 6.40 Medical Evaluation, should be revised as follows:

If a worker may have been exposed to an infectious agent, the Employer must advise the worker to seek immediate medical evaluation and ensure that the worker is able to immediately access such attention.

We must also emphasize that in order to ensure that healthcare workers are protected from infectious agents the Board must immediately set in motion a vigorous program of Board inspections and enforcement. As it stands now, despite regulatory requirements around fit testing, many Employers are not in compliance. We submit that regular inspections and enforcement are the cornerstones to ensuring that healthcare workers are protected and ready to handle infectious disease outbreaks.

## **Conclusion**

In closing, we urge the Board to adopt a regulation which is based on the precautionary principle. Coupled with required availability of PPF, clear parameters for education and training as well as a vigorous inspection and enforcement program, we believe that healthcare workers will be protected from contracting infectious diseases through their work.

Respectfully submitted,

Lara Acheson  
Coordinator, Occupational Health & Safety  
**BRITISH COLUMBIA NURSES' UNION**

c: D. McPherson, President, BCNU  
Provincial OH&S Committee Representatives, BCNU (Via E-mail)

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