Promotion and Support of Implementation of Directive 2010/32/EU on the prevention of sharps injuries in the hospital and health care sector

Final Report, 15 November 2013

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On behalf of

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1 Introduction

This document provides the final report of the joint EPSU-HOSPEEM project on the Implementation of Directive 2010/32/EU on the prevention of sharps injuries in the hospital and healthcare sector, realised with the support of the European Commission. Further information on the final conference to disseminate the findings of the project can be found on http://www.epsu.org/a/9543.

1.1 Background of the project: Directive 2010/32/EU on prevention of sharps injuries in the hospital and health care sector

In July 2009, the European sectoral social partner organisations – the European Public Services Union (EPSU) and the European Hospital and Healthcare Employers' Association (HOSPEEM) signed a framework agreement on the prevention of sharps injuries in the hospital and healthcare sector. The social partners requested the Commission to submit the agreement to Council for a decision, in accordance with Article 155(2) TFEU. On the 26 October 2009, the European Commission issued a proposal for a Council Directive containing the full social partner agreement (and the explanations provided by the social partners to a Council Working Party) as an annex. On 11 February 2010 the European Parliament supported the proposed Directive in a resolution and on 8 March 2010 the Council reached political agreement on its adoption. The Directive was published in the Official Journal as Council Directive 2010/32/EU on the 1st June 2010 (L134/66). Member States were required to implement the Directive by 11th May 2013.

During the process of adopting the Directive EPSU and HOSPEEM appeared in front of a Working Group of the Social Council. They afterwards elaborated a "Joint clarification of the Framework agreement on prevention from sharp injuries in the hospital and healthcare sector" that in case of doubt how to interpret the stipulations of the Directive has to be read in parallel to the EU legislation (see http://www.epsu.org/a/6261).

The Directive aims to achieve the safest possible working environment for employees in the sector and protect workers at risk, as well as patients, including prevention of injuries to workers caused by all types of sharp medical objects (including needle sticks). The Directive proposes the setting up of an integrated approach to assessing and preventing risks as well as to training and informing workers.

Clause 11 of the agreement concerning its implementation stipulates that the interpretation of the framework agreement could be referred by the Commission to the signatory parties, i.e. EPSU and HOSPEEM, for them to give their opinion. The European sectoral social partners also included the possibility to review its application five years after the date of the Council decision, if requested by one of the parties to the agreement - an option which also supports the idea of an early and timely follow-up to allow for an informed decision making at a later stage. Finally, there is a formal obligation by the European and national sectoral partners to engage in and stay involved in appropriate follow-up activities including awareness-raising, monitoring and assessing the implementation process, participation in relevant committees and bodies responsible for the transposition.

Having in mind the deadline for the transposition of the Directive, this project aimed:

a) To gather information on the transposition and implementation of the Directive at the national level;

b) To gather and exchange information about existing guidance and toolkits at the national and local level to help with the implementation of the agreement at the organisational level;

c) To learn about the practical issues being raised at the organisational level in the implementation of the agreement; how to deal with these issues and to learn from good practice.

1.2 Project methodology

This report summarises the findings of the different methodological aspects of this project, which included:

- A survey of the member organisations of EPSU and HOSPEEM
- Three regional seminars held in Dublin on 31 January 2013 (see http://www.epsu.org/a/9264 for a report and all presentations from this event); in Rome on 7 March 2013 (see http://www.epsu.org/a/9393) and in Vienna on 16 April 2013 (see http://www.epsu.org/a/9396)
- A closing conference held in Barcelona on 20 June 2013 (see http://www.epsu.org/a/9543)
- Verification of draft final report information by member of EPSU and HOSPEEM between July – September 2013.

1.3 Structure of the report

This report is structured as follows:

- Section 2 summarises what is currently known about the level and reporting of sharps injuries in the different EU countries and assesses the extent to which this will aid – or indeed complicate – the assessment of any progress made in the prevention of sharps injuries resulting from the implementation of the Directive.
- Section 3 provides an overview of the status and nature of transposition of the Directive at Member State level as of 1 September 2013. It also analyses the extent to which national legislation had to be amended to take account of the requirements of Directive 2010/32/EU. Furthermore, it assesses transposition processes and in particular the extent to which national social partner organisations and other relevant stakeholders were involved in discussions and decisions on the precise nature of transposition and subsequent implementation.
- Section 4 presents information on existing guidance which is already available at Member State level and how this can be used to support the implementation of the principles contained in the Directive at organisational level. This section also seeks to provide an overview of the challenges for implementation within individual health care settings and how these might be overcome.
- Annex I delivers a brief country-by-country overview on all of the above aspects for ease of reference.
- Finally, Annex II contains the English version of the survey instrument circulated to member organisations of EPSU and HOSPEEM in December 2012.

In reading this report, it should be borne in mind that it is the 28 EU Member States which need to transpose the Directive. The same is true, in principle, for the countries of the EEA which have special arrangements with the EU, which applies to Norway. Additional countries such as Belarus, Kosovo, Serbia and the Ukraine were involved in the project though attendance at events. However, they are not required to implement the Directive. In presenting the information, details on the EU28 are therefore presented first, followed by information on the participating EEA countries and finally non-EU and non-EEA countries.

2 Sharps injuries: a significant risk in the health care sector, but one which is hard to quantify

2.1 Estimates of the number of sharps injuries

There are 21 million workers active in the hospital and healthcare sector in Europe.[1] It is estimated that 1 million needle-stick injuries occur annually.[2] Another estimate[3] based on studies performed using different methods places the number of needlestick injuries (NSI) per health care worker between 0.1 and 0.64 per year. The paper argues that, taking these figures into account, the number of NSI alone could be in the range between 800,000 and 5,120,000 per year, but considers the figure of 600,000 reported injuries and 600,000 unreported injuries to be a more realistic estimate. The number of other accidents with medical sharps is not known because they are even less likely to be recorded.

It is not just medical professionals who are at risk. While hospital nurses and doctors working in acute medical situations are identified as being at highest risk (with junior staff often suffering proportionately the highest number of sharps injuries), many other workers have the potential to sustain – and do indeed - sustain such injuries, including nurses working in the home care sector and ancillary staff, for example cleaners, waste managers or laundry staff. A particularly issue identified is that ancillary staff are often not afforded the same protections, particularly where such services are contracted out and/or delivered by temporary or agency work staff. Albeit not covered by the Directive, the potential risk of sustaining sharps injuries can also transcend the immediate health care sector and can affect, for example, social workers (working with drug addicts for example), or general waste management workers.

The data presented in Table 2.1 summarises evidence on the number of sharps injuries recorded at national or organisational level, as presented at the regional seminars and closing conference of the project. When looking at these data, it is important to bear in mind that the number of incidences reported depends on the method of data collection. Survey-based results tend to show a significantly higher number of sharps injuries than results-based on official data for many reasons which will be further discussed in section 2.3 below.

2.2 Key risks arising from sharps injuries

The main risks of infection relate to patients carrying HIV, Hepatitis B and Hepatitis C. The level of potential risk associated with exposure to patients carrying such infections varies from country to country. In Austria, for example, it was noted that the level of such infections in the patient population is relatively low and therefore the risk of contracting such infections as a result of a sharps injury is considered to be relatively minimal (indeed no such infections resulting from sharps injuries have been reported among health care staff).

Other factors also affect the potential risk associated with infection, particularly in relation to Hepatitis B. In many countries, health care staff are routinely vaccinated against Hepatitis B on entering the profession. Unless there are proven counter-indications against such vaccinations at the individual level, such vaccination programmes are often compulsory, and significantly reduce the risk of infection. Obviously no such vaccinations are available to protect against infection with HIV or Hepatitis C, but these are also less widespread in the patient population.

It is notable that budgetary factors are playing a role in this important area. It was noted by a Romanian representative of EPSU, that a vaccination programme against Hepatitis B which had been available to health care staff is currently not assured for budgetary reasons (such

[1] Data from the Eurofound Report, 'Employment and industrial relations in the healthcare sector, February 2011, Dublin, accessed at: http://www.eurofound.europa.eu/eiro/studies/tn1008022s/index.htm
[2] Estimate comes from the European Agency for Health and Safety at Work.
[3] De Carli, G, Raboud, C; *The burden of disease of needlestick injuries in Europe*; in Working together to improve health worker safety; Hospital pharmacy Europe, special supplement, 2013

inoculations have to be updated every 5 years) and is now only available to those in areas where the risk of infection is considered to be high.

Even where a serious blood-borne infection is not acquired, nurses and healthcare workers can be subjected to many months of mental anguish and uncertainty as they await the results of their follow-up tests.

Table 2.1 Selected information on the number of sharps injuries in different European countries

Country	Data	Source
Austria[4]	Reduction of NSI injuries from 334 in 2009 to 275 in 2012. 30% of these injuries are considered to have been preventable.	Data gathered at organisational level[5]
Czech Republic	83% of nurses had experienced a sharps injury at some point in their career.[6] Transmission of an infectious diseases resulted in around 2.5% of cases (mainly hepatitis). In 95% of cases, this infection was subsequently recognised as an occupational illness. Most injuries occurred during the preparatory stages for using a medical sharp, followed by incidents during the storage or disposal of sharps equipment in a waste container. Every fifth sharps injury occurred during blood collection. The vast majority of workers responding to the survey considered the injury to be their own fault. In just over half of cases, stress was considered to be an important factor in the causation of the injury.	Research commissioned by the Czech Association of Nurses (based on a poll of around 1,400 nurses carried out in 2009 and 2010).
Ireland[7]	2000 NSI between 1996-2012; no resulting blood-borne infections	Data gathered at organisational level[8]
Italy	Approximately 100,000 sharps injuries per annum. It is estimated that around 70% of injuries go unreported. The general risk of exposure is greatest among nurses, doctors and cleaners in general surgery and surgical specialities, whereas the incidence of high risk exposure is most significant in general medicine and medical specialities (particularly among nurses). The risk factors for cleaners are significant, given that such exposures are largely related to inadequate disposal of needles and sharp instruments.	Information from research studies[9]
Lithuania	A survey of nurses found an average rate of injury of 1.72 per worker. Only ten percent of the injuries declared in the survey (1,139) were reported.	Survey carried out by the Lithuanian trade union of healthcare employees[10]
Netherlands	Between 13,000-16,000 reported blood exposures per annum.	Data held by National Hepatitis Centre[11]

[4] Information pertains to Salzburger Landeskliniken only (as presented at the Vienna seminar).
[5] See presentation R. Waclawiczek, Vienna seminar, http://www.epsu.org/a/9396
[6] It is important to note that such surveys can draw more responses from individuals affected by the problem which is being investigated.
[7] Information pertains to Beaumont Hospital Dublin only (as presented at the Dublin seminar).
[8] See presentation by B. Hayes, Dublin seminar, http://www.epsu.org/a/9264
[9] See presentation by G. De Carli, Rome seminar, http://www.epsu.org/a/9393
[10] See presentation at Dublin seminar, http://www.epsu.org/a/9264

Country	Data	Source
Poland	Approximately 28,000 sharps injuries reported per annum; around 3,000 of these develop blood borne infections	Official register of occupational injuries
Spain	Approximately 100,000 sharps injuries per annum. It is estimated that around 70% of injuries go unreported. The general risk of exposure is greatest among nurses, doctors and cleaners in general surgery and surgical specialities, whereas the incidence of high risk exposure is most significant in general medicine and medical specialities (particularly among nurses).	Information from research studies[12]
UK	5,822 occupational exposures to blood or other high-risk body fluids were reported since 1997 in England, Wales and Northern Ireland. From 2002 to 2011, 4,381 incidents have been reported from 172 centres (increasing from 276 in 2002 to 541 in 2011), nearly three-quarters (72%, 3,140/4,381) of reported injuries between 2002 and 2011 were percutaneous injuries. In suffering an injury from a contaminated needle, the risk of transmission of infections is 1 in 3 healthcare workers for hepatitis B, 1 in 30 for hepatitis C, and 1 in 300 for HIV.[13]	Official register of occupational injuries

Source: Summary by ICF GHK (2013) from presentations provided at three regional seminars of the project 'Promotion and Support of Implementation of Directive 2010/32/EU managed by EPSU and HOSPEEM with the support of the European Commission

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[11] See presentation by P. van Wijk, Dublin seminar; http://www.epsu.org/a/9264
[12] See presentation by C. Mazón, Rome seminar, http://www.epsu.org/a/9393
[13] Data retrieved from the Health Protection Agency (2012) Eye of the Needle Report.

2.3 Reasons for under-reporting and the lack of reliable and comparable data

The lack of reliable data at national level is an important issue in relation to any potential efforts to assess the impact of the implementation of the Directive on the incidence of sharps injuries. Any data that are gathered are generally only collected and aggregated at the organisational level and are not often reported to a centralised database. Many organisations/facilities have their own internal reporting system of sharps injuries in place, and/or adhere to reporting in CIRS (Clinical Incident Reporting System) as part of their own risk management.[14]

However, the lack of national aggregation is not the only, nor the most significant complicating factor.

Firstly, it is important to take account of national reporting requirements and provisions regarding the recognition of occupational injuries. Although in most countries there are workplace-level requirements to report occupational accidents, these are only reported to the national level where they are associated with absences from work of more than three consecutive days[15] to be recognised as occupational diseases, which is only the case in relation to a minority of sharps injuries. Similarly, in some countries illnesses and infections (or indeed psychological trauma) sustained as a result of a sharps injury are not recognised as occupational illnesses and are therefore not reported to national authorities (e.g. the relevant health and safety at work/occupational disease bodies).

Secondly, under-reporting is a very significant issue, with estimates suggesting that only half of sharps injuries sustained are reported. There are a number of reasons for this:

- Staff blame themselves for sustaining an injury or they fear to be blamed by others;
- They do not see a reason to report an injury if the perceived (or the real) risk of infection is low;
- Processes of reporting are bureaucratic or time consuming (e.g. in some cases blood tests cannot be taken at the same hospital, which can mean that even where this would be vital, early prophylaxis cannot be delivered);
- Staff are discouraged from reporting injuries because they consider that nothing will change;
- Some staff (e.g. ancillary staff, see section 2.1 above) are not aware of associated risks and the processes for reporting.

Although the most significant concern relates to under-reporting of injuries, it was also mentioned that in some cases incidents are reported which could not (and did not) lead to injury, let alone infection. Further awareness raising was therefore considered to be needed regarding situations involving sharps injuries which cannot carry the risk of infection (e.g. where there is no contact with blood or other bodily fluids).

Some injuries are attributed to patients being distressed and restless and moving about during procedures. Such situations are more likely to require additional staff or calmer environments (or reduced stress among staff) to manage them.

Independent studies show that the majority of these injuries can be avoided using a combination of training, safer working practices and, if based on the outcome of a risk assessment, medical technology incorporating safety features, e.g. needles with automatic protective sheaths.[16] This mixed approach is indeed the one taken by the social partner framework agreement negotiated by EPSU and HOSPEEM.

[14] In the Vienna hospital association, a lot of experience is being gained through the project '*Erfahrungsdrehscheibe*'.
[15] In general, the 3 day limit applies, although in some countries, reporting is required after one day of absence.
[16] For example Van der Molen et al (2012) Interventions to prevent needle stick injuries among health care workers, Work ; 2012, Vol. 41, p1969-1971, 3p

3 Status of Transposition of Directive 2010/32/EU

The project timetable spanned the critical transposition phase of Directive 2010/32/EU and was therefore able to map – more or less in real time – the transposition of the legislation at Member State level. This section presents the information accurate as of 1 September 2013 regarding the status of national transposition, the nature and processes of transposition as well as the level of change required in national legislation and regulation to seek to reach conformity with the requirements of the Directive.

Figure 3.1 below demonstrates the current status of transposition, highlighting 4 different situations:

- Three countries considering that they did not require any change in their legislation to meet the requirements of Directive 2010/32/EU (marked in shaded green): Belgium, Denmark and Latvia.
- 14 EU countries as well as Norway and Belarus (in the latter transposition is not required) having transposed the Directive by 1 September 2013 (marked in green): Austria, Bulgaria, Croatia, Czech Republic, Finland, France, Germany, Greece, Hungary, Lithuania, Netherlands, Romania, Sweden and the United Kingdom.
- Eight countries whose transposition is almost complete (marked in orange): Cyprus[17], Estonia, Ireland, Italy, Malta, Poland, Portugal and Spain.
- No information was available on the status of transposition in Luxembourg, Slovakia and Slovenia.

It is not uncommon for countries requiring some additional months beyond the transposition deadline to finalise their legislative process, so the fact that at least 11 EU countries had not completed their transposition process at the time of writing is not unusual and cannot be seen as a feature of any difficulties or a lack of commitment in transposition EU legislation arising from social partner agreements.

3.1 Nature and process of transposition

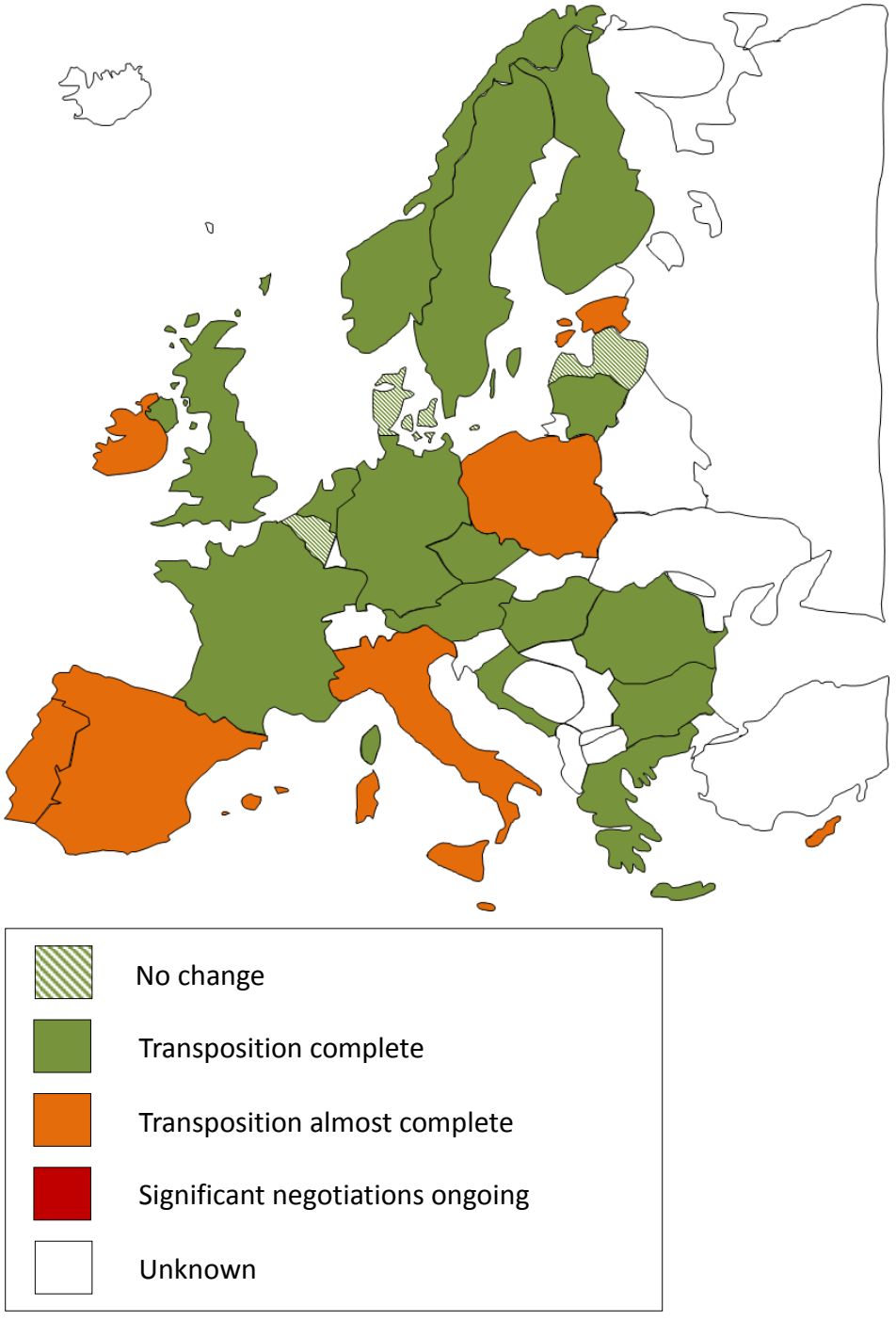
With the exception of those EU countries where no changes to existing legislation were considered to be necessary, all Member States where transposition is complete chose to amend existing laws and regulations to achieve this. Table 3.1 below summarises the relevant legislative acts and, where available provides links to the relevant texts. Only few countries and social partners are currently considering the possibility to supplement this legislation with collective agreements, with guidance and codes of practice the more likely route to provide additional practical guidelines on implementation.

Social partner involvement in transposition processes was ensured in most of the countries that responded to the survey[18], although the process of involvement and consultation was different from country to country. Although processes were largely in line with existing industrial relations traditions and methods of tripartite consultation and concertation in different countries, it is worth noting that sectoral social partners were more involved that would otherwise have been the case, had they not been the original authors of the framework agreement. As in most processes of consultation not all stakeholders felt that all their views were necessarily taken into account in the final draft of the legislation, but on the whole, the level of involvement was considered to be satisfactory.

[17] Not shown on the map.

[18] 28 responses were received from 21 countries. From the trade union side, responses were received from Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Hungary, Lithuania, the Netherlands, Poland, Romania, Spain, Sweden, the UK, Belarus and the Ukraine. From the employer side, responses came from Denmark, Estonia, Finland, France, Ireland, Italy, Latvia, Lithuania, the Netherlands, Sweden and the UK.

Figure 3.1 Status of transposition of Directive 2010/32/EU as of 1 July 2013 in EU28 and Norway



Source: ICF GHK (2013) on the basis of responses received to survey of EPSU and HOSPEEM members carried out as part of project 'Promotion and Support of Implementation of Directive 2010/32/EU' managed by EPSU and HOSPEEM with the support of the European Commission.

In the majority of countries the Ministry of Employment and Social Affairs or the Ministry of Health took the lead in transposition, but in some countries specific health and safety authorities were also given charge of the transposition brief. In a few countries, survey responses highlighted a number of organisations which social partners considered should have been involved or better consulted. These tended to be specialist professional organisations or specific employers' organisations (e.g. for private hospitals).

Table 3.1 Transposition legislation (or legislation in force) at Member State level

Country	Title of legislation	Date of entry into force	Weblink
Austria	Nadelstichverordnung (NastV) (*Needlestick Regulation*)	3.1.2013	http://www.ris.bka.gv.at/Dokumente/BgblAuth/BGBLA_2013_II_16/BGBLA_2013_II_16.pdf
Belgium	Arrêté royal modifiant l'arrêté royal du 4 août 1996 concernant la protection des travailleurs contre les risques liés à l'exposition à des agents biologiques au travail, en vue de la prévention des blessures par objets tranchants dans le secteur hospitalier et sanitaire (*Royal decree amending royal decree of 4 August 1996 on protection of workers against risk of exposure from biological agents at work, to prevent sharps injuries in health care sector*)	17.4.2013	http://staatsbladclip.zita.be/moniteur/lois/2013/05/03/loi-2013202242-Print.html
Bulgaria	Национальная програма по безопасным и здравословным условиям труда (*National programme on safe and healthy working conditions*)		
Croatia	'*Pravilnik o načinu provođenja mjera zaštite radi sprječavanja nastanka ozljeda oštrim predmetima*' - Ordinance on safety measures to prevent sharp injuries; "Narodne novine", nr. 84/13	2013	http://www.propisi.hr/print.php?id=12450
Czech Republic	Most relevant existing texts 432/2003 Criteria for categorisation of work in relation to risk factors in the working environment 262/2006 Labour Code 309/2006 Accompanying law to Labour Code (risk assessment) 537/2006 Vaccination against communicable diseases for health care workers 372/2011 Act on Medical Care 373/2011 Act on Specific Health Services	Most recent amendments in 2011	
Denmark	Existing legislation on health and safety and biological agents	No change to existing legislation	

Country	Title of legislation	Date of entry into force	Weblink
Finland	Government decree on the prevention of Sharps Injuries in the hospital sector 317/2013 (*Valtioneuvoston asetus terävien instrumenttien aiheuttamien tapaturmien ehkäisemisestä terveydenhuoltoalalla 317/2013*)	8.5.2013	http://www.finlex.fi/fi/laki/alkup/2013/20130317
France	Decree No 2013-607 on the protection against biological risks (*décret n° 2013-607 du 9 juillet 2013 relatif à la protection contre les risques biologiques auxquels sont soumis certains travailleurs susceptibles d'être en contact avec des objets perforants et modifiant les dispositions relatives à la protection des travailleurs intervenant en milieu hyperbare*)[19]	9.7. 2013	http://legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000027689086&categorieLien=id
Germany	Verordnung zur Neufassung der Verordnung über Sicherheit und Gesundheitsschutz bei Tätigkeiten mit Biologischen Arbeitsstoffen und zur Änderung der Gefahrstoffverordnung (Biostoffverordnung) (*Regulation on Biological Agents*)	Agreed by Cabinet 24.4.2013, final approval due July 2013	http://www.bmas.de/SharedDocs/Downloads/DE/PDF-Meldungen/neufassung-biostoffverordnung.pdf;jsessionid=35EE1C2EBB9DC997C987B6FC1A2BEAF0?__blob=publicationFile
	Verordnung zur Arbeitsmedizinischen Vorsorge (*Regulation on occupational health prevention*) TRBA 250 für Gesundheitsdienst (*technical regulation for health sector*)	Unchanged as a result of 2010/32/EU	http://www.gesetze-im-internet.de/bundesrecht/arbmedvv/gesamt.pdf http://www.baua.de/cae/servlet/contentblob/672990/publicationFile/47827/TRBA-250.pdf http://www.baua.de/cae/servlet/contentblob/666126/publicationFile/
	TRBA 400 für Gefährdungsbeurteilung einschließlich psychischer Gefährdungen (*technical regulation for risk assessment*)	Unchanged as a result of 2010/32/EU, but to be revised in December 2013 Most recent amendment 13.9.2012	
Greece	Presidential Decree 6/2013, Φ.Ε.Κ.:15/Α`/21.1.2013	21.1.2013	http://www.elinyae.gr/el/lib_file_upload/15a_13.1359100961546.pdf
Hungary	Decree of the Minister of Human Resources 51/2013. (VII. 15.) '*EMMI rendelet az egészségügyi szolgáltatás keretében*	16.7. 2013	http://njt.hu/cgi_bin/njt_doc.cgi?docid=161942.245337

[19] In addition to existing legislation in force in France, mentioned in footnote 25 on p.22 below.

Country	Title of legislation	Date of entry into force	Weblink
	használt, éles vagy hegyes munkaeszközök által okozott sérülések megelőzésére, az ilyen eszközök használatából eredő kockázatok kezelésére, valamint az egészségügyi tevékenységet végző személyek tájékoztatására és képzésére vonatkozó követelményekről'		
Ireland	Although agreement was reached between the social partners and the health and safety authority on the text for the transposed legislation, the Irish Government have not as of 15th November transposed the directive into Irish law. Safety, Health and Welfare at Work (Prevention of Sharps Injuries in the Healthcare Sector) Regulations, 2013		http://www.hsa.ie/eng/Your_Industry/Healthcare_Sector/Biological_Agents_/Sharps_/Directive_on_Sharps_/guide_to_the_proposed_regulations.pdf
Latvia	Existing legislation on health and safety and biological agents	No change to existing legislation	
Lithuania	Order of the Minister of Social Security and Labour, Minister of Health, Minister of Education and Science of the Republic of Lithuania, No A1-157/V-501, regarding the special regulation to implement the Directive on the prevention from sharps injuries in the hospital and healthcare sector	16.3. 2012	http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=420536&p_query=&p_tr2=2
	Order of the Minister of Health Nr. V-946 '*Lietuvos Higienos norma HN 47-1:2012 „Sveikatos priežiūros įstaigos. Infekcijų kontrolės reikalavima*i' (renewed Hygiene Norm No 47 "Health care institutions. Infection control requirements")	19.10. 2012	http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=435637&p_query=&p_tr2=2
Netherlands	Wijziging van het Arbeidsomstandighedenbesluit in verband met opname van regels uit de Beleidsregels Arbeidsomstandighedenwetgeving (*Amendment of health and safety act*) Amendment of Articles 4.97 and 9.3	1.1.2012	http://www.ggznederland.nl/werk-en-opleiding/staatsblad-2011-399.pdf
Romania	Romanian Government Decision No 243 on the Minimum Safety and Health Prevention from Sharps Injuries in the Hospital and Healthcare Sector, pursuant to Art. 108 of the Romanian Constitution and Art. 51 on the Health and Safety at Work Act 319/2006 as amended	8.5.2013	http://www.mmuncii.ro/nou/images/Documente/Legislatie/HG243-2013.pdf
Sweden	Ändringsföreskrifterna (AFS 2012:7) om mikrobiologiska arbetsmiljörisker - smitta, toxinpåverkan, överkänslighet	7.12.2012	http://www.av.se/dokument/afs/afs2012_07.pdf

Country	Title of legislation	Date of entry into force	Weblink
	(AFS 2005:1) (*Amendment of legislation on microbiological hazards in the workplace*)		
UK	Health and Safety (Sharps instruments in healthcare) Regulations 2013	18.3.2013	http://www.legislation.gov.uk/uksi/2013/645/made HSE Guidance: http://www.hse.gov.uk/pubns/hsis7.pdf
	EEA Countries		
Norway	Amendment of Work Environment Act	21.6.2013	http://www.arbeidstilsynet.no/lov.html?tid=78120

3.2 Level of change required to existing legislation

A significant body of EU occupational safety and health (OSH) legislation already exists, which is also referenced in Directive 2010/32/EU. Most relevant here are Directive 89/391/EC (the EU framework directive on the introduction of measures to encourage improvements in the safety and health of workers at work[20]) and Directive 2000/54/EC on the protection of workers from risks related to exposure to biological agents.[21]

As these Directives have already been transposed at Member State level for a number of years, a framework of protection is already in place to which the new Directive adds further specificity and – in some countries – new requirements.

Figure 3.2 below shows the level of change required in Member State legislation on the basis of survey responses received.

The following picture emerges:

- Five countries consider that no changes were needed to their legislation: Belgium, Denmark and Latvia. In addition, answers received from the Czech Republic and Poland also indicated the need for no (or only very minor) changes.
- Five EU countries only saw the need for low level changes, including Estonia, France, Italy, Lithuania, the Netherlands. In the EEA, Norway also made limited changes and outside the EU28 and EEA, Belarus, a country which is not required to implement the Directive, also indicated that only minor changes were required to meet the standard set by the Directive.
- Ten countries including Austria, Croatia, Germany, Greece, Finland, Ireland, Portugal, Spain, Sweden and the UK, and as well as and considered the changes to their legislation to be moderate (medium level).
- Only the Ukraine indicated the requirement for more significant legislative alterations to meet the requirements of the Directive (which they do not need to implement).

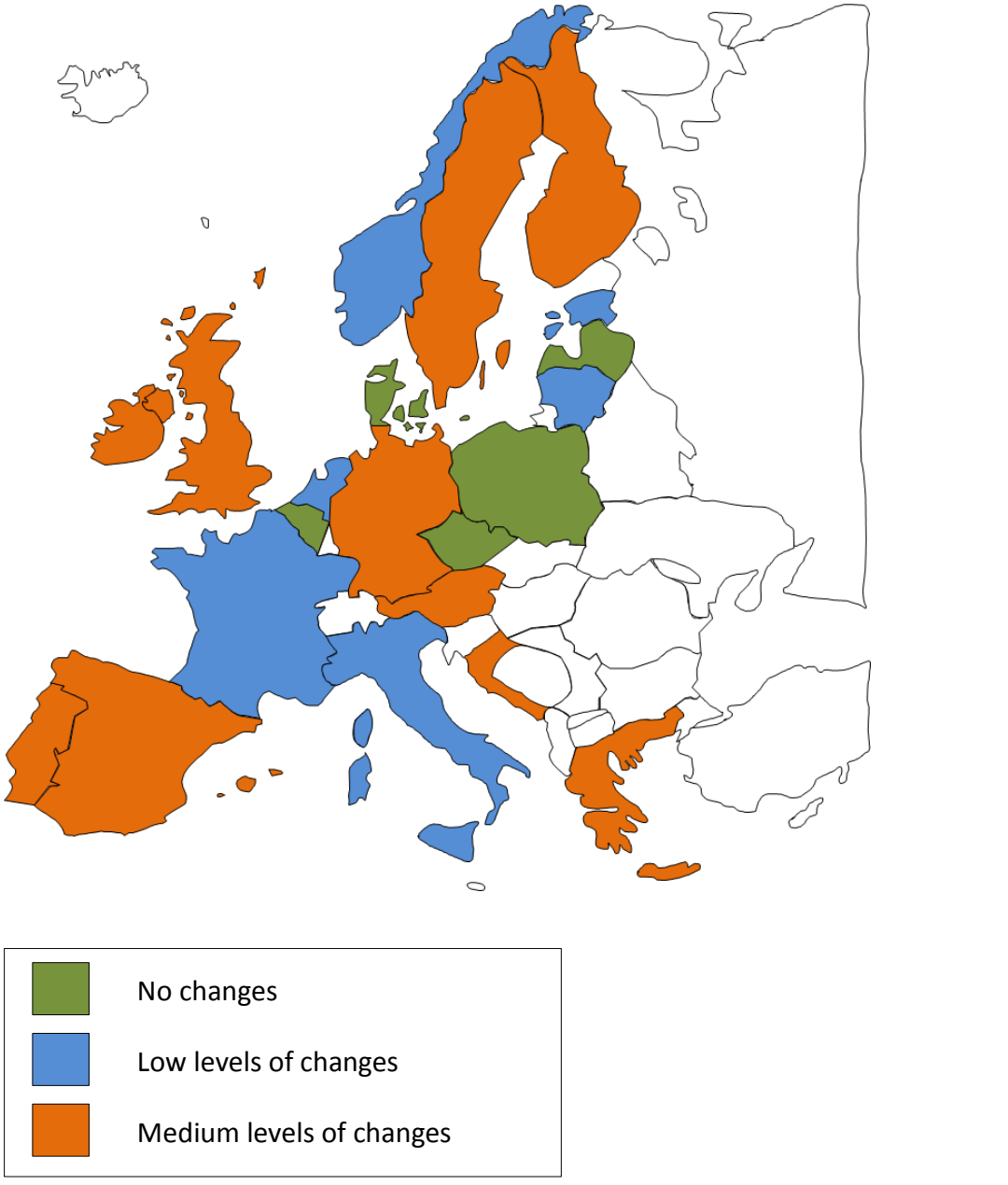
The main alterations to existing legislative texts revolve around issues such as the ban on recapping, requirements for more specific risk assessment and the provision of preventative vaccinations. The more widespread introduction of safety-engineered devices was also considered to be a likely consequence of the new legislation in a number of countries (albeit based on risk assessment).

The cost of such new equipment was considered to be a potential challenge in some countries, particularly in smaller Member States with significant budgetary restrictions, who are often not able to benefit from greater economies of scale when purchasing medical devices. The issue of challenges to implementation will be discussed in further detail in the following section.

Different interpretations applied regarding the scope of application of the Directive (which staff are covered) were also considered to be a potential issue.

[20] See http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31989L0391:EN:HTML
[21] See http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32000L0054:en:NOT

Figure 3.2 Level of change required to existing legislation in the EU28 and Norway



Source: ICF GHK (2013) on the basis of responses received to survey of EPSU and HOSPEEM members carried out as part of project 'Promotion and Support of Implementation of Directive 2010/32/EU' managed by EPSU and HOSPEEM with the support of the European Commission.

4 Existing Guidance and Challenges for Implementation

The majority of countries already have existing guidance on the prevention of sharps injuries and most countries where such guidance is not yet available plan it issue it as part of the transposition and implementation of the Directive. For example, in Finland, the negotiating parties agreed on publishing a guide book that will we published by the end of the year at the webpages of Finnish Institute of Occupational Health.

As part of the survey regarding the transposition of the Directive, samples of such guidance or codes of practice were gathered and these have been made available on the project website http://www.epsu.org/r/629 on page http://www.epsu.org/a/9157. At transnational level, existing guidance includes material prepared by the European Agency for Safety and Health (EU-OHSA)[22], the European Biosafety Network[23] and the World Health Organisation (WHO)[24]. The table below presents examples of guidance gathered from various EU Member states.

Table 4.1 Existing guidance on the prevention of sharps injuries

Country	Title of guidance and author	Weblink
Belgium	Prévention des Blessures Par Objets Tranchants ; CSC SP	http://www.epsu.org/IMG/pdf/B-Prevention-Blessures-Objets-Tranchants-CSC-SP.pdf
Cyprus	Central Committee : Hospital Infections : Instructions for management of contaminated sharps, Ministry of Health Hospital Infection Control : Guidelines for the management of waste ; General Hospital Nicosia Office	http://www.epsu.org/IMG/pdf/CY-MoH-CC-HI-Instructions-management-contaminated-sharp.pdf http://www.epsu.org/IMG/pdf/CY-MoH-CC-HI-Instructions-management-contaminated-sharp.pdf
Denmark	Stikboksen.dk - et ressourcested om stikskader på sygehuse; Branchearbejdsmiljørådet Social & Sundhed	http://stikboksen.dk/
Finland	Do not let a needlestick get you by surprise : Accident Hazard ; Tehy	http://www.epsu.org/IMG/pdf/Finnish_study_on_needlestick_injuries_-_Tehy.pdf
Germany	Website 'Safe Hospital' Model Project 'STOP Needlestick'	http://www.sicheres-krankenhaus.de/ http://www.stopnadelstich.de/Home.html
Greece	Various campaigns and training seminars for the staff by the Ministry of Health or/and Hospital Administrations or/and the Committees for Hospital Infection or/and Hellenic Institute for Health and Safety at Work "Greek and international experience on accidents at work and diseases of the hospital workers. Guidance for the assessment and prevention of occupational risks", *Makropoulos Vassilis, 2007*	http://www.elinyae.gr/el/lib_file_upload/Ellhnik%20Diethn%20Empeiria%205.1191576532627.pdf
Hungary	Prevention of blood- and bodily fluid-borne viral diseases during health care ; National Centre for Epidemiology	http://www.epsu.org/IMG/pdf/H-KJ-Ver-Es-Valadek-2003.pdf

[22] https://osha.europa.eu/en/sector/healthcare/prevention-sharp-injuries-workplace
[23] http://europeanbiosafetynetwork.eu/
[24] http://www.who.int/occupational_health/activities/4policyl.pdf

Country	Title of guidance and author	Weblink
Italy	Azienda Ospedaliera "Maggiore Della Carità", Novara : Disposizioni in merito alle contaminazioni con materiale biologico a seguito di infortunio	http://www.epsu.org/IMG/pdf/I-AOU-Maggiore-della-Carita-di-Novara-Info-.pdf
The Netherlands	Ziekenhuisen : Accidenteel Bloedcontact ; Werkgroup Infectiepreventie	http://www.epsu.org/IMG/pdf/Report-Dutch-WG-Prevention-Sharps-Injuries.pdf
Spain	FSP UGT : Manual de Uso (and various awareness raising posters)	http://www.epsu.org/IMG/pdf/FSP-UGT-ManuelDeUso.pdf http://www.epsu.org/IMG/pdf/FSP-UGT-Poster-NoSeDeclaranLosAccidentes-Enfermera.pdf http://www.epsu.org/IMG/pdf/FSP-UGT-Poster-NoSeDeclaranLosAccidentes-Enfermero.pdf http://www.epsu.org/IMG/pdf/FSP-UGT-Poster-3-NoDejesQueJuegenConTuSalud.pdf
Sweden	Project on prevention of needlestick injuries (project report from which guidance with arise	http://www.epsu.org/IMG/pdf/S-Project-Reduction-Sharps-Injuries-Sweden-Description_Summary.pdf
United Kingdom	Joint social partners' guidance on prevention of needlestick injuries Advice on prevention of sharps injuries; NHS Employers Sharps Safety: RCN Guidance	http://www.epsu.org/IMG/pdf/GB-Joint-SP-Guidance-Needlestick-Injury.pdf http://www.nhsemployers.org/Aboutus/Publications/Documents/Needlestick%20injury.pdf http://www.epsu.org/IMG/pdf/GB-RCN-Sharps-Safety-Guidance-Implementation-Dir-2010-32-EU.pdf

Source: Submissions by members of EPSU and HOSPEEM for project 'Promotion and Support of Implementation of Directive 2010/32/EU' managed by EPSU and HOSPEEM with the support of the European Commission.

4.2 Key challenges and good practice in overcoming them

The following elements below are at the centre of good practice in implementing the spirit of the Directive at national level and overcoming challenges to implementation:

Data gathering and reporting

There is clear evidence of under-reporting of sharps injuries. The reasons for this can be structural, e.g.

- The recognition of sharps injury as an occupational injury
- Which incidents have to be reported at which level (for example, only those that lead to more than 3 days of absence from work)?

Reasons can also be organisational, e.g.

- Are there transparent and unbureaucratic processes of reporting for all workers who can potentially sustain sharps injuries (including sub-contracted ancillary workers)?
- Are clear processes in place to monitor the incidence of sharps injuries at organisational level and to take appropriate actions?

Finally, there are also personal reasons for under-reporting as a result of

- Lack of awareness of risk or processes of reporting
- Blaming oneself for the accident or fear of being blamed

All these factors can be overcome by instituting clear guidance and processes ensuring that all incidents are reported (first at organisational and then at central level); accompanying this with training and awareness raising; ensuring that reporting processes

are simple but effective and support (and where required prophylactic treatment) are rapidly available; commitment exists at the highest level, as well as through line management structures to tackle potential risk factors in consultation with employee representatives; a no-blame culture clearly prevails in all health care settings; and information gathered is used at the organisational and national level to regularly review progress and make any required changes.

Risk assessment and prevention

The need for any changes in working processes and procedures is best assessed through a process of regular risk assessment in all different settings. Employee representatives should be involved in such risk assessment, which must focus on prevention wherever feasible. This does not always necessarily mean the introduction of safety engineered devices, but can require changes in working practices. Working at speed and in stressful situations (sometimes with insufficient staffing levels), for example, has also been identified as an important cause of sharps injuries. In the context of budgetary restrictions the most effective and efficient ways need to be found to prevent risk factors at workplace level.

Use of safety engineered devices

Safety engineered devices can plan a role in prevention, as demonstrated by the evidence in the workshops and closing conference of the project. However, it was similarly recognised that the introduction of such devices is not always necessarily the best and only way to prevent risks. Similarly, not all devices are of equal quality and cannot be used for all types of interventions to be performed, and thus their introduction can even be counterproductive. The following were therefore recommended:

- Safety engineered devices should be developed with the assistance of practitioners
- Manufacturers should be responsible for providing training, and it is good practice to require this as part of procurement processes
- The wholesale introduction of new devices should be preceded by transparent and robust trial processes
- In order to ensure the effective and efficient use of such devices, procurement processes and systems may need to be adapted to ensure the appropriate equipment is made available
- Effective ways to achieve economies of scale in ordering new products should be explored (where possible) beyond the level of a single organisation.

Annex 1 – Country by Country Overview

This Annex summarises briefly the information presented by representatives of EPSU affiliates, HOSPEEM members or other experts (medical staff, researchers, representatives of national ministries) for the countries participating in the regional seminars in relation to the national transposition of the legislation, existing guidance and possible challenges to implementation. This information is taken from the reports of the regional workshops.

Austria

Austria is one of the four Member States in which the Directive has already been transposed into national legislation, through the so-called 'needlestick regulation' (*Nadelstichverordnung, NastV*). The regulation was published on 3 January 2013 and enters into force on 11 May 2013. It makes specific reference to the Directive and to EPSU and HOSPEEM as the negotiating parties behind the framework agreement. The regulation covers health care sector workers and makes specific reference to the fact that any ancillary staff (for example in sub-contractors supplying laundry facilities) must also be informed and covered by its provisions.

Overall, the number of sharps injuries in Austria – and more specifically, the resulting number of occupational infections – were considered to be rather low by a speaker from the hospital association of Salzburg (*Salzburger Landesklinken, SALK*). This was partly due to the relatively low underlying level of Hepatitis and HIV infections in the patient population in Austria.

Using the example of SALK, it was demonstrated that many measures aimed at preventing sharps injuries have already been in place for a number of years. These include:

- Risk assessment to establish existing risk levels and to take relevant steps to prevent or eliminate these;
- Hepatitis B inoculation;
- Training and awareness raising;
- Internal reporting procedures;
- Introduction of safety engineered devices where appropriate.

At SALK, a number of safety engineered devices were introduced since 2008 including gripper micros, safety butterflies (both in 2008), safety lancets (2010), safety system for blood tests (2011) and safety venflon (2012). In each case, the process of sourcing and commissioning is time-consuming, involving a group of experts, call for tenders and relevant training during the introduction of new equipment. It is particularly important to note that at SALK the purchasing department and the department for occupational medicine work closely together: only devices which have been tried and tested by the department for occupational medicine are being ordered for use within SALK.

In 2011 there were 277 needlestick injuries reported at SALK of which 73 occurred during disposal. According to the statistics on where and how the injuries occurred, it is considered that 30% of these are preventable. Since 2009, SALK has seen a reduction of needlestick injuries from 334 to 275 in 2012. However, when looking at the different safety engineered devices, it is important to note that not all are equally effective in reducing incidents of sharps injuries: for example, following the introduction of the use of the safety butterfly, the number of injuries in fact increased. This is partly the result of staff finding it more difficult to work with such equipment (or getting used to it), but also demonstrates that some of the causes of such injuries are difficult to prevent with safety engineered devices alone. In fact, many "safety devices" available at present are found not to be usable for the intended treatment to be performed. Thus they rather pose a risk for causing unnecessary injuries and potential infections.

In relation to sharps (rather than needlesticks) it can prove more difficult to replace these types of instruments and to manage injuries. While it is possible to source retractable scalpels, it is found that most injuries occur during surgical procedures themselves which cannot be prevented with safety engineered devices.

On the whole, it was considered that the most effective steps to prevent occupational injuries and illnesses arising from contact with medical sharps are:

- Hepatitis B inoculation
- Wearing of personal protective equipment (gloves etc.)
- Skin protective creams when performing operations involving presence of blood
- Sharps disposal containers within ready reach
- Training and the presence of well trained staff in high risk procedures
- Whenever possible, reducing time pressure when performing the procedure

In terms of costs associated with the 277 needlestick injuries arising in 2011, these are considered to include around 45,000 Euros for laboratory testing of patient and staff blood samples; an additional 100,000 Euros for safety engineered devices and around 10,000 Euros associated with the cost of additional disposal containers. Nothing is known about the additional cost of the increased waste arising from safety devices. In this context it is notable that there have not been any contaminations associated with needlestick injuries since 1994.

Belgium

As in most countries, in Belgium there is some pre-existing legislation relevant to the provisions of the Directive and implementation of its provisions was done via an amendment of the Royal Decree on exposure to biological agents. A draft text for this amendment was proposed by the cross-industry social partners on their own initiative, not involving the sectoral social partners signatories of the HOSPEEM-EPSU Framework Agreement on the prevention from sharp injuries in the hospital and healthcare sector of July 2009 transposed into Directive 201/32/EU. This is being questioned by the sectoral social partners in Belgium as the cross-industry social partners are not signatories to the European Framework Agreement. Furthermore the sectoral social partners were not involved in the transposition of the Directive, which only the cross-sectoral social partners participated in.

However, in principle the changes proposed are relatively minor and primarily serve to cover not only directly employed health care sector workers, but also workers of sub-contractors at risk of exposure to sharps injuries. Greater responsibility for workers to take care of their health and safety (according to the individual level of training/qualification and pursuant the instructions given at a specific workplace by the employer) and to pursue relevant training, as well as the notification of sharps injuries at central level is also foreseen by the amended legislation. The use of safety-engineered instruments is not an absolute obligation, but where they are available, they have to be used.

Further to the European directive, Belgium has adapted its legislation regarding the protection of workers against work hazards related to their exposure to bacteriological agents, in view of the prevention of sharp injuries in the health sector.

The employer provides the workers with adequate training on the guidelines and procedures related to the injuries and/or infection by medical sharps, with a particular emphasis on the adequate use of medical sharps and their appropriate disposal after use. In this context, recapping is forbidden. Other arrangements are made for emergency care, notification and follow-up.

If an accident occurs after recapping, the worker can be sanctioned for failing to respect safety instructions. As a result, injured workers tend to no longer report accidents. If legislation on work-related accidents does not reconsider the notion of (professional) mistakes, the afore-mentioned Royal Decree places, de facto, the responsibility on the workers who hurts herself/himself when disregarding safety instructions.

We consider that this is a negative effect, not intended during the discussions that took place in the framework of the European social dialogue which led to the transposition of the Directive.

Bulgaria

The Directive has already been transposed under the participation of the social partners. Alongside this, a National Programme for the Safety and Health in the Workplace is being implemented to achieve a reduction in the number of occupational illnesses and workplace injuries and making provisions for legislative, organisational and technical preventive measures to maintain safe and healthy working conditions. It operates based on annual work programmes of the Healthy Working Conditions and Workplace Safety Strategy. This aims a clear reduction of occupational injuries and illnesses.

As outlined in the Framework Agreement, the first step in the prevention of sharps injuries is risk assessment. In Bulgaria guidance is in place is which allows risk to be assessed into different categories, with high risk areas of work being singled out for priority treatment in order to make effective use of scarce resources. As many organisations in Bulgaria are currently experiencing frequent re-organisations, it is important to repeat such risk assessments in time a re-organisation of work and work places takes place. The speaker underlined that when managing occupational risks, particular attention should be paid to introducing an effective risk monitoring and assessment system.

This is followed by the drawing up of prevention measures which need to be outlined in a plan at organisational level.

Trade unions and employees should be involved both in risk assessment and prevention planning. The risk assessment is organised as a multi-step procedure. In Bulgaria the recommendation is that workers should be involved in this risk assessment process through Working Conditions Committees on the level of the relevant healthcare institution. These committees in addition have the duty to i.a. receive information about the way in which the risk assessment process is organised and participate in the identification of persons performing the relevant tasks, report changes which have occurred at their workplace or work together with their employer to maintain the safety of the working environment. The speaker also presented possible measures to reduce the risk of injuries with medical sharps to occur, e.g. based on an Action Plan, and steps jointly agreed and implemented by employers and employees to underpin a general prevention strategy such as training programmes or the proper use of containers for used sharps.

When an accident takes places, it is important to report causation and effect clearly to allow for the planning of improved processes where required. This can only take place of there is a no-blame culture, all accidents are reported and steps are seen to be taken to address any risks identified.

Staff is further protected through preventative inoculation against Hepatitis B. The speaker presented the trade union's demand to offer immunisation free of charge for all workers and students involved in the provision of medical care and related activities in the workplace.

A seminar of various stakeholders from the employees' bench to help promoting the implementation of the directive took place on 24 November 2012 in Sofia.

Croatia

Upon accession to the European Union in July 2013, Croatia was required to implement the EU legislative acquis. The Sharps Directive was transposed in 2013 via an Ordinance on safety measures to prevent sharps injuries (see Table 3.1 above). It is possible that this legislation will in future be supplemented with more detailed provisions laid down in collective agreement. At present the relevant trade unions consider that implementing legislation is not sufficiently clear in relation to sanctions which would be applied for non-implementation. A lack of resources could also lead to limitations regarding the introduction of safety engineered devices on the basis of risk assessment. In relation to this, it is considered to be of relevance that the Croatian health insurance funds (responsible for resourcing health care) were not involved in the implementation of the Directive. Reporting such incidents and injuries is also currently considered to be incomplete.

Prevention measures currently in place include the following:

- HBV vaccination for pupils, students and healthcare workers – available and obligatory for all
- Injuries reporting systems in all healthcare institutions in place
- Procedures in case of injuries in all healthcare institutions
- Sharps Containers in majority of institutions, but very often very law quality
- Gloves usage, and not significant use of needleless devices and safety needles and cannulas
- Posters for raising awareness
- Education of employees about the risks and protective measures

Cyprus

A bill to transpose the Directive has been submitted to parliament. This would amend existing legislation.

Guidance on the prevention of sharps injuries already exists. It has been uploaded to the webpage (http://www.epsu.org/a/9157) showcasing available guidance, training material, films, etc, as for a range of other countries.

Czech Republic

The Czech Republic has transposed the Directive through existing legislation contained in the Labour Code which was most recently amended in 2006. In addition, the year 2011 saw the introduction of new Occupational Safety and Health Regulations for health care workers (372/2011 and 373/2011). A further amendment in the area of OSH, relevant to the transposition of the Directive comes into force in 2013 (79/2013). The law on hazardous waste already stipulates that medical sharps have to be disposed of in a safe manner.

Transposition was the responsibility of the Ministries of Labour, Health and the Environment.

In relation to the implementation at the organisational level, the first step is always risk assessment, with specific assessments being carried out in different workplaces/activities and for different categories of staff. It is important that such assessments, a responsibility of the employer according to the Czech Employment Code, are (to be) regularly updated to take account of changing work practices and staffing. This regulation stipulates that priority should be given to technical and collective measures, to be supplemented on the individual level by the use of protective equipment and modifications in the working arrangements. There is also a comprehensive set of provisions on information and awareness raising on identified risks and measures that need to be provided by the employer.

All accidents at work have to be documented at workplace level (with clear duties to report for worker and employer), but only accidents and injuries leading to an absence of more than 3 working days are reported at the national level. In future more data will need to be reported to the national level.

Health care staff receives mandatory inoculation against Hepatitis B, which they cannot refuse (otherwise they would be considered to be ‘unfit to work’ and not be covered by insurance). Staff also receive every two years (in areas with higher risks) or every 3 to 5 years (depending on the age) a medical check up with the cost for these covered by the employer.

In some areas, the use of safety-engineered devices has been widespread for some time (for example pre-filled needles etc). However, injuries continue to occur and high workloads and associated stress factors play an important role here.

Denmark

In Denmark no changes were considered to be needed to existing legislation in order to transpose the Directive. Key legislation is based on risk assessment and enhanced by collective agreement. Precise implementation and preventative measures are determined (on the basis of risk assessment) at the local level with strong processes for communication and learning from good practice between organisations.

Estonia

Although Estonia has not yet completed its transposition of the Directive, the level of changes to existing legislation required are considered to be limited. Considering is therefore being given to transposition via further guidance rather than legislative changes. Social partner organisations have been fully consulted in this process. No major challenges are foreseen to implementation.

Finland

The Finnish tripartite Advisory Committee in the Ministry of Social Affairs and Health decided to set up a sub-committee in early 2011 to work on the implementation of the Directive and to assess which national regulations would need to be amended in order to propose amendments. The sub-committee was composed of various stakeholders such as social partners, municipal authorities, and safety device producer organization. The task was quite complex as in Finland there are already 17 regulations that address parts of the principles of the Directive. In the beginning of the assessment it seemed that most of the principles were already applied in Finland and no substantial amendment needed to be made. When the chair of the committee provided the first draft of a decree to the committee the employers remained opposed to the proposal. Negotiations completed in May 2013 with the adoption of revised legislation.

The most debated issues were: risk assessment and elimination of risk of sharps injuries, providing for safe working procedures – here it was discussed what are safe devices and safe working standards at this moment not much experience exists; place technically safe waste bins for sharps, vaccination free of charge for affected workers; and finally reporting and follow-up after injuries occurred. The debate concerned also the scope of the Directive on how to practically implement standards for the health care sector, nursing homes and social work sector – as it was not clear what can be also considered as a sharp instrument (for example acupuncture needles) and what is a safe waste bin for example in home care.

France

In France, the transposition of the Directive took place on 9 July 2013 through Decree No 2013-607 on the protection against biological risks (décret n° 2013-607 du 9 juillet 2013 relatif à la protection contre les risques biologiques auxquels sont soumis certains travailleurs susceptibles d'être en contact avec des objets perforants et modifiant les dispositions relatives à la protection des travailleurs intervenant en milieu hyperbare). This Decree integrated Article R.4424-11 into the Labour Code, completing the current provisions on the measures to prevent biological hazards. The law covers 1.2 million employees in the health care sector, both in public and private sector institutions. The Decree refers to a joint order of the ministers of Labour and Health in order to adapt the protection of workers who might come into contact with medical sharps as well as the terms of use of medical sharps. This joint order will also specify which categories of establishments are covered by these rules, the obligations to provide information and training to staff, as well as the obligations for the employers to provide immediate care.

Trade unions in the sector would be keen to see the application of the law expanded to cover not only hospitals but also clinics and health care workers working in patients' homes.

French health care establishments have already had to comply with a comprehensive set of regulations regarding the prevention of accidental exposure to blood and iatrogenic infections.

Among these regulations, we find the Labour Code, the Public Health Code and various regulations applying to the hospital sector[25]. This also covers the issue of prevention (for example in relation to the vaccination of health care staff and the disposal of sharps).

[25] E.g. Décret No 94-353 of 1994 on the protection of workers from exposure to biological agents ; it modifies the Labour Code; Circulare DGS/SH/DRT No 98/228 of 1998 on recommendations on anti-retroviral treatments

The monitoring of the incidence of sharps injuries with blood exposure is the responsibility of a National Surveillance Institute established in 1998 (e.g. monitoring of risk of HIV, Hep B or C infection).

A committee has been established with the goal of reducing the risk of sharps injuries (*Réseau RAISIN*). This body was responsible for a 5 year action plan 2009-2013 with the goal of achieving a 25% reduction in exposures per 100 beds. Around 16,000 incidents with a risk of exposure to blood borne infections are reported per day, and this is bearing in mind that approximately 70% of such incidents are not reported.

In order to address the situation of under-reporting, it is suggested by the trade union representative presenting the case of France that reporting should be made mandatory.

In practice, hospital managers are responsible for establishing a prevention strategy and trade unions play an important role here in influencing and ensuring the implementation and monitoring of such strategies. Such strategies include steps towards prevention (including the introduction of safety engineered devices in high risk areas), steps for reporting, treatment, and – where necessary – compensation of affected staff.

The trade unions have particularly supported the use of a single document (in French: *document unique*) at organisational level which includes the initial risk assessment, the prevention plan and strategy for reducing and managing risks, as well as reporting and follow up actions. This process also includes a regular process of assessment of the level of reduction achieved in sharps injuries and the next steps required to improve the existing prevention policy.

Germany

Germany has also completed its discussions about the implementation of the Directive, with relevant legislation and regulations due to come into force in July 2013. Transposition via amendments of the legislation on biological agents (*Biostoffverordnung*), in itself part of the transposition of EU legislation (Directive 2000/54/EC) and the regulation on prevention in occupational health (*Verordnung zur arbeitsmedizinischen Vorsorge*) which relates to preventative injections for (medical) staff. In addition, there are a number of specific technical regulations such as TRBA 2508 for the health care sector and TRBA 4009 on risk assessment. TRBA 250 (technical regulation for the healthcare sector) is to be revised in December 2013.

In Germany, the social partners and the relevant ministries, in particular the Federal Ministry of Labour and Social Affairs (*Bundesministerium für Arbeit und Sozialordnung*, BMAS), collaborated closely in the transposition of the Directive and welcomed its integrated approach with a strong emphasis on risk assessment and prevention, training and reporting to help improve processes.

In addition, a pilot project has been carried out to assess practice at organisational level and how this can best be improved. The project *STOP Nadelstich* (Security through training, organisation and selection of products (to prevent needlestick injuries) involved one hospital, four surgeries and one ambulance service.

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following exposure to risk of transmission of HIV; Circulaire DGS/DH No 98/249 of 1998 on the prevention of the transmission infectious agents through blood or other biological liquids in a health care establishment; Circulaire DH/SL20DGS/VS3 No 554 of 1998 on the collection of sharps; Circulaire interministérielle DGS/RI2/DHOS/DGT/DSS no 2008-91 du 13 mars 2008 relative aux recommandations de prise en charge des personnes exposées à un risque de transmission du virus de l'immunodéficience humaine (VIH); Circulaire 2009/272 du 26 août 2009 : Programme national de prévention des infections nosocomiales 2009/2013 avec un objectif de réduction de 25% du taux d'incidence des AES/100 lits en 2012 (Données de référence AES RAISIN 2008); Circulaire DGS/VS 2/DH/DRT n°99-680 du 8 décembre 1999 relative aux recommandations à mettre en œuvre devant un risque de transmission du VHB et du VHC par le sang et les liquides biologiques; Décret n° 94-352 du 4 mai 1994 relatif à la protection des travailleurs contre les risques de leur exposition à des agents biologiques et modifiant le code du travail.

The project began with 'data collection' on current procedures and levels of injury, which involved project staff to understand as well as to observe existing procedures. At this stage, many shortcomings were identified. There followed an 'intervention' stage during which different types of services were offered including:

- Training
- e-learning
- Sample case (containing different types of safety engineered devices to be tried with instructions)
- Practical aids (such as a small memo-card on safe processes which can be carried in a pocket)

Subsequently, processes and results were again assessed and observed and these showed significant improvement in practices among direct health care staff. However, gaps in implementation were also evidence among sub-contracted staff in laundries, cleaning and catering services in particular, where a significant number of sharps injuries occurred. The pilot project sought to involve relevant staff but this proved not to be possible as the relevant sub-contracted employers refused to co-operate in the project.

Apart from the involvement of all affected staff, the key lessons drawn for different stakeholders were as follows:

- All existing procedures should be reviewed on a regular basis and all staff should be aware of what to do in case of an injury occurring.
- Employers should be encouraged to involve staff in the development of relevant processes as well as the selection of safety engineered devices where they are deemed to be appropriate. In addition, all staff should be involved, including those who might be worked in contracted out services.
- The recommendation was also made the industry – in co-operation with healthcare professionals – needs to develop more suitable tools, provide better training and thus increase the acceptance of such devices.

A representative of ver.di speaking at the conference identified the following deficits when it comes to the implementation of safe processes at work:

- Information deficits
- Lack of awareness of the issue
- Lack of attentiveness in carrying out work processes
- Incorrect use of sharps equipment
- Cost issues
- High work load/stress

Implementation at the organisational level will therefore be the real test of the success of the Directive.

He also presented the webpage "*Sicheres Krankenhaus*" ("Save Hospital"), built up by the Occupational Accident Insurance Fund in North-Rhine Westphalia (*Unfallkasse Nordrhein-Westfalen*) and the (*Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege, bgw*). It is still "under construction" and contains information on occupational safety and health in hospitals, also covering the topic of prevention from injuries with medical sharps.

Greece

The Directive was transposed in Greece in January 2013, via Presidential Decree. Prior to this, there was no legislative framework on sharps injuries apart from some provisions under the "measures for medical waste management" so in that sense, the level of change is quite significant. However, most of the provisions of the Directive were already practiced across the health care sector, by means of good practice and guidelines (from training seminars and campaigns provided by the ministry of health, hospital administrations, council for the health and safety in the workplace, and others). The implementation of the Directive will point out the actual changes needed such as ensuring the necessary working environment with the appropriate equipment.

The organisations involved in the process were the Ministry of Labour and Social Security, the Ministry of Health and Social Solidarity, the Ministry of Finance, the Ministry of Development, Competitiveness and Shipping as well as, the Council of Health and Safety for Workers.

However, Trade Unions and Employers organisations (in the health care sector) were not involved.

Hungary

The majority of the provisions foreseen in the Directive are already implemented in Hungary. The main issue relates to enforcement which proves difficult both for budgetary reasons but also as a result of shortcomings on the part of hospital management. Not many safety engineered devices are in use in Hungary, however, protection from Hepatitis B infection is ensured as since 1993 every exposed worker in the health care sector has to be vaccinated and since 1999 all over 15 year olds are inoculated.

The transposition of the Directive required the co-operation of the ministries responsible for public health and for occupational safety and health. The decree that completes the national implementation is in force since 16 July 2013.[26] Guidance has been elaborated by the National Centre for Epidemiology addressing themes like vaccination, post-exposure prophylaxis, prevention, assessing the probability of transmission, disinfection, waste treatment, and prohibiting recapping in 2003.

Ireland

Early in 2012, the Irish Health and Safety Authority (HAS) launched a stakeholder consultation on its draft Safety, Health and Welfare at Work (Prevention from Sharps Injuries in the Hospital and Healthcare Sector) Regulations. The impact assessment of the Irish HSA states the following: *The impact of transposing the Directive through the proposed new Regulations is expected to be minimal given that many of the obligations already exist in principles expounded in the Safety Health and Welfare at Work Act 2005 and the Safety Health and Welfare at Work (Biological Agents) Regulations 1994 and amended Regulations. The proposed new Regulations apply the same principles specifically to the issue of sharps injuries but are more explicit with regard to certain obligations such as the preparation of a risk assessment for sharps, switching to safety engineered devices, information and training on new devices and a ban on the practice of recapping sharps. The analysis concludes as many of the obligations are already in existence most healthcare employers will only need to extend existing practices to those areas where changes have not yet been implemented*.

Although agreement was reached between the social partners and the health and safety authority on the text for the transposed legislation, the Irish Government have not as of yet, transposed the directive into Irish law. Currently there is no time line for transposition. The Irish Congress of Trade Unions continue to lobby for immediate transposition. The text refers to all employees working in the hospital and health care sector. This includes self-employed and unpaid interns. The risk assessment should be carried out by the employer in consultation with the employees. The employer should take into account in the assessment available technologies reducing risks, work organisation in place and the experience of the employees. If risks are assessed the employer has the duty to eliminate or reduce them by preventive procedures, prohibition of recapping, training, awareness raising, procedures if injuries occur, provision of safety devices and provide for safe transportation of sharps devices at the workplace.

[26] Decree of the Minister of Human Resources 51/2013. (VII. 15.) '*EMMI rendelet az egészségügyi szolgáltatás keretében használt, éles vagy hegyes munkaeszközök által okozott sérülések megelőzésére, az ilyen eszközök használatából eredő kockázatok kezelésére, valamint az egészségügyi tevékenységet végző személyek tájékoztatására és képzésére vonatkozó követelményekről*', available at: http://njt.hu/cgi_bin/njt_doc.cgi?docid=161942.245337

The employer will have a general duty to provide training. Employees need to report any incident to the employer, while the employer has the duty to report incidences that result in employee absences of more than 3 days and those that present a high risk of contamination to the national Authority.

Free vaccination should be provided to workers that are exposed to high risks.

In case an accident occurs employers have to ensure counselling.

The Irish trade union ICTU is quite satisfied with the draft, finding that the provision of free vaccination for workers is a step forward, as well as the risk assessment in consultation with employees. There were, however concerns regarding interpretations on the provisions on recapping, having in mind the clinical reality and the practicability of the procedure and rules spelled out in the directive. Furthermore, trade unions are more generally worried about the impact of budget cuts in the health care sector on the implementation of the provisions of the legislation.

The presentation by an occupational physician from a local Irish hospital demonstrated that hospitals keep reports on sharps injuries and already apply prevention measures and procedures. Internal research showed however that even if good health and safety procedures are in place, injuries still occur simply because tasks requiring the use of sharps are inherently unsafe. Safe systems of work are not always adhered to in situations where training is suboptimal or supervision is inadequate. Where safety engineered devices are provided, resistance to new technologies can be an obstacle to safer practice. Furthermore, purchase and procurement departments are sometimes bound by contracts which don't allow for a change of product. Sometimes stock is not replaced in clinical units particularly if they are new or non-stock items and new products are not always displayed and stored where they are most likely to be used. It was remarked that safety devices are not guaranteed to ensure a safe procedure and there is a growing body of evidence showing that accidents do occur during their use when training is inadequate.

Italy

In Italy, many of the provisions of the Directive are already covered by existing legislative decrees. However, some amendments are required to fill some gaps highlighted by the EU framework agreement and subsequent Directive.

Legislative Decree 81 provides for the elimination of risk in line with risk assessment. It includes provision for the use of safety engineered devices.

New provisions will be added to chapter 10 of legislative degree 81 to ensure that its provisions also cover medical students. Furthermore, Article 286 on risk assessment will be amended to ensure that the risk of exposure to blood borne infections is taken into account.

The new draft legislation is complete, but the current political situation arising from the lack of an overall majority to form a new government (as a result of the general election that took place at the end of February 2013) brings an inevitable delay in the debate and passage of the amended law through parliament.

In practice, the implementation of safer work processes and equipment has been ongoing since the 1980s, with increasing awareness of the risk of HIV and Hep B and C infection (as the rate of such infections has grown in the patient population). Over the years, there has been a ban on recapping, the mandatory introduction of sharps containers, the introduction of personal protective equipment, enhanced awareness raising and training, and from the mid-to late 1990s, the increasing introduction of safety engineered devices.

Guidelines have been developed for risk assessment and procedures for recording have been improved and in some cases simplified.

Faster testing for exposure and better prophylaxis and treatment for affected workers has also helped to reduce significant health risks posed to workers suffering sharps injuries.

Since all these measures have been introduced there has been a significant reduction in the rate of injuries suffered, particularly where safety engineered devices have been used and safe containers for sharps collection have been made readily available.

The Italian experience shows that an integrated approach is to most effective way to work towards a sustainable reduction of sharps injuries. It was argued that the Directive has brought an important step forward towards ensuring the implementation of such an integrated approach.

Latvia

No (significant) changes to existing legislation are considered to be needed in Latvia to implement the Directive. Financial restrictions on hospitals, however, are considered to present a potential obstacle to full implementation of the standards required.

Lithuania

In Lithuania, the Directive was transposed through an Order of the Minister of Social Security and Labour, Minister of Health, Minister of Education and Science of the Republic of Lithuania (No A1-157/V-210/V-501 regarding the provisions approval of the Prevention from sharp injuries in the hospital and healthcare sector) March 16, 2012, and order of the Health Minister (No v-946 of 10 October 2012) (see Table 3.1 above). The extent to which this order changes the existing legislative situation was limited.

Even prior to passing the relevant order, health and safety regulation already required risk assessment and the undertaking of relevant preventative steps within a no-blame culture (see http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=453359). Safety engineered devices are to be deployed where required on the basis of risk assessment (see http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=435935) and a ban on recapping was already in place from 2001 (see http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=140647&p_query=&p_tr2=2). Employers are required to provide relevant training and monitoring should be in place (see

http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=435637&p_query=&p_tr2=2).

All relevant parties were involved in the transpositions process, including the social partners. One of the main challenges is considered to be linked to implementation and the reporting of sharps injuries. A survey of 12 health care institutions carried out by the Lithuanian Trade Union of Healthcare Employees found an incidence of 1.72 sharps injuries per annum among the individuals participating in the survey. Among these, between 10-15% are not reported, resulting not only in a distortion of the official statistics but also in a lack of support and (potentially necessary) prophylactic treatment for affected workers. Despite existing provisions, trade union representatives consider that training available on safety measures and the prevention of sharps injuries is currently insufficient.

Malta

The Ministry of Health in Malta will be responsible for the implementation of the Directive.

One of the concerns expressed by the trade unions is over the coverage of the Directive which could be widened in order not only to cover the health care sector. The example of postal workers was given, as there have been incidents of injuries resulting from drug users disposing of needles into letterboxes.

The Netherlands

As mentioned above the Netherlands has already implemented the Directive by amending the national Health and Safety law (Arbo) through two new articles: obliging hospitals to switch to safety needle systems and by the ban of recapping.[27] In addition to legislation the Guidelines for the prevention of needle stick injuries apply. However the scope of the

[27] Besluit 399 van 22 augustus 2011, houdende wijziging van het Arbeidsomstandighedenbesluit in verband met opname van regels uit de Beleidsregels Arbeidsomstandighedenwetgeving

Guidelines is more restrictive as the Directive since it applies only to the hospital sector. It is left to the hospitals to implement the necessary procedures and the spirit of the Directive. The national Labour Inspectorate will carry out controls from 2014 onwards. The main elements of the Guidelines state that employers have to provide for safe working conditions, need to introduce safety devices wherever possible without costs playing a predominant role.

A report published 2008 by the National Hepatitis Centre recommended that hospitals should focus on information and training to reduce costs for new purchases and use available devices as much and for as long as possible as reconversion of needle sticks does represent quite an important cost. Furthermore it was recommended to establish a health and safety committee at hospital level involving management, workers and their representatives in order to establish a safe environment in which workers would feel as well safe. This has the benefit that working environments will cause less insecurity and stressful situations.

Poland

In Poland there are an estimated 700,000 individuals in the potential patient population carrying infectious diseases such as Hep A, Hep B and HIV/AIDS. When assessing the risk to health care staff it is important to bear in mind that in Poland nurses are entitled to perform tasks which only doctors and other specialists are allowed to carry out in other EU countries. Similarly, it should be noted that cleaning and laundry staff are also at risk, but as such services are increasingly outsourced, it is becoming more difficult to prevent risk and monitor injuries. Around 28,000 sharps injuries are reported per annum and of these injured staff around 3,000 develop infections. It is estimated that the actual number is higher as many incidents are not reported.

The government only opened a dialogue with the social partners in the transposition of the Directive in December 2012. In the first draft text not all staff is covered (e.g. trainees and temporary workers were excluded). A conference to discuss the situation and the implementation of the Directive was subsequently held and the social partners received a revised draft of the implementing legislation on 5 April 2013. This draft covers all health care workers and provides that employers must ensure safe working conditions. The discussions on a final text are ongoing.

Romania

The Directive was transposed in Romania in May 2013. However, the health care sector faces significant challenges as a result of budgetary cuts. This includes the cessation of mandatory inoculation of healthcare staff against Hepatitis B which is now only offered in areas considered at highest risk. All other healthcare workers have to pay to receive the injection.

Spain

In Spain the Directive was set to be implemented in line with the deadline of May 2013 via amending existing legislation, but this process is not yet complete.

Current legislation allows for the prioritisation of intervention and in particularly the introduction of safety engineered devices in areas where risk factors are greatest. Detailed research has been done to demonstrate in which areas of work, among which staff and qualification levels the risk of exposure is currently greatest.

The importance of involving professionals in the design of safety-engineered devices was underlined, as well as the fact that it should be a requirement for companies marketing such devices to offer training in their safe use. Without such training, it is often found that the risk of injury initially increases as health care workers are unaware how to use the new devices.

The Spanish experience shows that with use of safety engineered devices in high risk areas, it has been possible to reduce percutaneous injuries suffered by 41%.

Sweden

The Directive has been implemented in Sweden already via amending existing legislation. The country has started initiatives already in the late 90s to promote health and safe work environments, creation of Safe Communities, which included risk assessments also with regard to exposure of blood borne viruses. Nevertheless, the number of needle stick injuries has not significantly dropped (difficult to assess, as no national data is available and information is only gathered at organisational level). Therefore research is currently carried out to assess what needs to be done in practice to reduce the number of injuries.

A project was undertaken in Sweden to speak to employees that had reported a needle stick injury in order to find out when accidents occur, what kind of training was received and information was available prior the accident and what kind of steps were taken as follow-up of the accident. The outcome of the interviews was that most of the workers blamed themselves for the accident; had a rather poor knowledge on ban of recapping; the use of safety devices and safe working procedures existed; but incidents were poorly followed up by managers and were not discussed though often incidents lead to long term anxiety and fear.

The project furthermore organised workshops with national stakeholders to determine best practices and develop measures that should be included in a strategy. The main challenges that were identified: environment – how to reduce plastic waste from safety devices; how to use safe waste bins correctly; how to balance costs for products and safe work procedures; how does patient react to safety procedures – should be as well good for the patient; finally how to implement organisational responsibilities for procurement of safety devices, reporting and follow- up. In order to answer these questions staff working routines, organisational structures and education aspects will further be studied and researched.

The project will be finalised end of 2013.

United Kingdom

The United Kingdom has national working groups that promote safe working policies with regard to needlestick injuries such as the Safer Needle Network. Reporting is in place in most of the hospitals, ensured via specific software (EPInet) that is to guarantee in the future standardised reporting. The UK Health Protection Agency publishes every 2 to 4 years the “Eye of a needle” report on surveillance of significant occupational exposures to blood-borne viruses for healthcare workers. Nevertheless, Some of the rules in place are more of a generic nature. For example, employers are already required to undertake risk assessments to assess the risks to the health and safety of their employees. However, the Directive goes further and requires a risk assessment specifically for sharps injuries and requiring certain elements to be considered in that risk assessment. The Directive will have a similar impact in relation to safe practices, information sharing, training and reporting.

The starkest change in UK law will be the immediate banning of the practice of recapping or re-sheathing needles. Whilst this is a practice that is frowned upon in the healthcare sector, it is not, yet, specifically outlawed. It is anticipated that national guidance, including the NHS Handbook and Department of Health Guidance, will be updated to reflect the more specific standards set out in the Directive.

The starkest change in UK law will be the immediate banning of the practice of recapping or re-sheathing needles, unless the employer’s risk assessment has identified that recapping is itself required to prevent a risk (e.g. to reduce the risk of contamination of sterile preparations). In these limited cases, appropriate devices to control the risk of injury to employees must be provided. It is anticipated that national guidance, including the NHS Handbook and Department of Health Guidance, will be updated to reflect the more specific standards set out in the Directive.

At the end of 2012 the Health and Safety Executive (HSE, body that regulates health and safety at the workplace) launched a stakeholder consultation on the proposed draft regulations to implement the Directive. The draft had been developed after an inspection campaign by the HSE in 21 hospitals and a study to evaluate the effectiveness of safety

devices. The inspection report concluded that in the majority of hospitals policies were in place to reduce employee's exposure to blood borne viruses however only in a minority of hospitals all staff were aware of risks and their responsibilities. The HSE has inspection powers and in October 2010 prosecuted an NHS trust after a healthcare worker contracted the Hepatitis C virus after injuring herself on a needle used to take blood from an infected patient. The hospital was fined £12,500 plus £9,000 costs. The study to evaluate the effectiveness of safety devices concluded that their use reduces incidents of sharps injuries when combined with training and safe workplace policies.

Following discussions with stakeholders the UK Regulations were adopted in May 2013. Whilst a number of concerns were taken on board by the HSE, the Trade Unions found the scope of the regulations unsatisfactory. Specifically that the regulations did not cover those working in social care or those who did not have a healthcare employer e.g. some prison nurses. Trade Unions were also concerned that the burden of reporting responsibilities fell onto employees with no new requirement on employers to report all sharps injuries to the regulator.

Social partners are currently working with the Safer Needles Network to update existing national guidelines to support the implementation of the regulations.

EEA countries

Norway

Norway faces a rather specific situation as all blood samples are taken by bio-medical scientists. There is a risk of the issue being overlooked as the prevalence of such injuries is not very high. According to the most recent data, there were 200 reported cases of sharps injuries in 2011, with an estimated 150 cases not reported.

According to a recent study, 50% of these accidents were caused by inattentiveness, but safety engineered devices could have prevented the injury. Currently such devices are primarily used in blood sampling (90% of such procedures use these devices), but in other procedures, safety engineered devices are only used in 5% of cases.

Norway will transpose the EU Directive in full, and public hearing is currently being organised by the Norwegian Labour Inspection Authority, with responses requested by 28th April.

Changes suggested to existing legislation are relatively limited and mainly relate to:

- Strengthening the duty to perform risk assessment
- Training of staff to include information on the risk from sharps injuries
- Safety containers to be made available to collect sharps
- Ban on recapping

The Norwegian transposing legislation is currently not proposed to go as far as the Swedish text. In cases where risks factors are identified the Swedish legislation requires the use of safety-engineered devices. In Norway, the legislation does not currently foresee requiring the use of such devices.

Non-EU countries

Of the non-EU countries presenting the at Vienna workshop, Belarus, Kosovo and the Ukraine, the latter has a well developed system of legislation on risk assessment and prevention in place.

In Belarus this arises from legislation on health protection and prevention of infectious diseases as well as regulations on the use of personal protective equipment. This legislation provides for preventative inoculations against Hep B for all health care workers in training. There are detailed provisions for reporting of work accidents that also apply to injuries with medical sharps. Training on risks with biological agents is part of the study programme or of professional training programmes of a range of health care professions (doctors, nurses, paramedics). However, according to the speaker of the main health care worker trade union, improvements are possible, including the greater involvement of employees in risk

assessment and prevention planning as well as the greater use of safety engineered devices.

A short description of some features relevant for the topic was given by the colleagues from Kosovo and the Ukraine.

Annex 2 – Questionnaire to members of EPSU and HOSPEEM

Promotion and support of Implementation of Directive 2010/32/EU on the prevention from sharps injuries in the hospital and health sector

Draft Survey of EPSU and HOSPEEM Members

Your details

1. Name

Organisation (name and indicate employer or trade union)

Employer

Trade union

Country

Contact details (telephone and email)

Transposition of Directive 2010/32/EU on prevention of sharps injuries in hospital and health care sector

2. Has the Directive been transposed yet in your country (please tick as appropriate and elaborate below)?

Yes

No

If yes, please provide legislative reference and link to the relevant text

If no, please indicate when transposition is likely to be completed.

3. What form is the transposition taking (please tick as appropriate)?

Legislation only

Legislation and collective agreement

Collective agreement only

Other form of transposition (please specify)

Please comment on whether you consider the form the transposition has taken/is taking to be appropriate?

Please describe any issues which arose or are likely to arise during the transposition of the Directive

4. Please comment on the level of change in provisions require as a result of the Directive compared to the previous position in national legislation (please tick as appropriate)?

None

Low

Moderate

Significant

Please comment on the changes required summarising the main changes needed

5. Do you foresee any challenges to implementation?

Yes
No

If yes, please indicate the nature of these likely obstacles?

<u>Organisations involved in the transposition of the Directive</u>

6. Who was responsible for transposition of the Directive in your country

7. : Which organisations were significantly involved during the transposition of the Directive in your country?

Ministry of Labour

Ministry of Health

Other Government Ministry (please specify)

Employers' organisation (cross-industry)

Trade union organisation (cross-industry)

Employers' organisation in health care sector

Trade union organisation in health care sector

Other organisations (please specify)

8. In your view, which organisation(s) were not involved in the transposition, which should have been involved?

Current practice and guidance on prevention of sharps injuries

9. Please describe current legal structures and systems in place in your country in relation to the prevention of sharps injuries? Please provide a link or attach any relevant documents.

How is prevention practiced at organisational level. Please provide a link or attach any relevant documents.

10. Is there existing good practice guidance in your country on the prevention of sharps injuries in the health care sector (please tick and comment as appropriate)?

Yes

No

If yes, please provide information on the author of this guidance, the date of its publication as well as – where possible – a link or a copy of the document

If no, are there any plans to draft such guidance (yes/no)?

Yes

No

Who will be involved in its preparation?

Interest in active role in one of the regional seminars and/or the final conference of joint EPSU-HOSPEEM project

11. Would you or a relevant colleague be prepared to present your existing practice/guidance tool on the prevention of sharps injuries at a regional conference of the project

Yes

No

If yes, please provide contact information
