Follow-up on the Directive 2010/32/EU on the prevention from sharps injuries in the hospital and healthcare sector

Sectoral Social Dialogue Committee for the Hospital Sector

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List of Abbreviations

Acronym	Name	English Translation
ADEDY	Ανώτατης Διοίκησης Ενώσεων Δημοσίων Υπαλλήλων	Civil Servants' Confederation
ARAN	Agenzia per la rappresentanza Negoziale delle Pubbliche Amministrazioni	National Agency for Representation of Public Administrations in Collective Bargaining/Social Dialogue
BGW	Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege	Employers' Liability Insurance Association for Health Service and Welfare Work
CFDT	Confédération Française Démocratique de Travail	French Democratic Confederation of Labour/French Democratic Trade Union Confederation
ČAS	Česká Asociace Sester	Czech Nurse Association
CNSST	La Comisión Nacional de Seguridad y Salud en el Trabajo	National Institute of Hygiene and the National Committee for Occupational Health and Safety
EC	European Commission	
EEA	European Economic Area	
EHA	Eesti Haiglate Liit	Estonian Hospital Association
EPSU	European Federation of Public Service Unions	
ESP	European Social Partners	
EU	European Union	
EU-OSHA	European Agency for Health and Safety at Work	
FEHAP	Fédération des établissements hospitaliers et d'aide à la personne privés non lucratifs	Federation of non-profit private hospitals and personal care institutions
FeSP-UGT	Federación de empleados de servicios públicos de UGT	Federation of Public Service Employees of UGT
FIASO	Federazione Italiana Aziende Sanitarie e Ospedaliere	The Italian Federation of Healthcare and Hospitals
HOSPEEM	European Hospital and Healthcare Employers' Association	
HSE	Health Service Executive	
INAIL	Istituto nazionale Assicurazione Infortuni sul Lavoro	National Institute for Accident Insurance at Work
KT	Kuntatyönantajat	Commission for Local Authority/Government Employers
LSADPS	Lietuvos sveikatos apsaugos darbuotojų profesinė sąjunga	Lithuanian Trade Union of Health Care Employees
MS	Member State(s)	
NAHCO	Nacionalinė sveikatos priežiūros įstaigų asociacija	Lithuanian National Association of Healthcare Organizations
NHS	National Health Service	
NIMS	The National Incident Management System	
NITO	Norges Ingeniør- og Teknologorganisasjon	Norwegian Society of Engineers and Technologists
NSF	Norsk Sykepleierforbund	Norwegian Nurses Organisation

NSI	Needlestick Injuries	
NUMGE	Fagforbundet	Norwegian Union of Municipal and General Employees
NUPH	Националното сдружение на частните болници	National Union of Private Hospitals
OSH	Occupational safety and health	
OSZSP ČR	Odborový svaz zdravotnictví a sociální péče České Republiky	Trade Union of Health and Welfare of the Czech Republic
PASYDY	Παγκυπρια Συντεχνια Δημοσίων Υπαλλήλων	Pancyprian Public Servants' Trade Union
POUPZ	Profesní a odborová unie zdravotnických pracovníků	Professional and Trade Union of Health Workers
RCN	Royal College of Nursing	Royal College of Nursing
SALAR	Sveriges Kommuner och Landsting	Swedish Association of Local Authorities and Regions
SCA	State Claims Agency	
SED	Safety-engineered devices	
SETCa-BBTK	Syndicat des employés, techniciens et cadres de la FGTB/ Bond van bedienden, technici en kaderleden van het ABVV	Trade Union for the employees, technicians and managers of the FGTB/ABVV
SZZSZS	Sindikat zaposlenih u zdravstvu i socijalnoj zaštiti Srbije	Trade Union of Health and Social Care of Serbia
TRBA	Technische Regel für Biologische Arbeitsstoffe im Gesundheitswesen und in der Wohlfahrtspflege	Technical Regulation for Biological Agents in Health Services and in Welfare Services
Ver.di	Vereinte Dienstleistungsgewerkschaft	United Private and Public Services Union
VKA	Vereinigung der Kommunalen Arbeitgeber	Association of Local Government Employers
WHO	World Health Organisation	

Introduction

The prevention from sharp injuries has become a high priority topic in the field of Health and Safety at Work, in particular for the hospital and healthcare sector across the European Economic Area. Therefore, the European Social Partners (ESP) for the hospital and healthcare sector, the European Hospital and Healthcare Employers' Association (HOSPEEM), representing employers and the European Federation of Public Services Unions (EPSU), in early 2009 decided to negotiate on the issue. They succeeded in signing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector[1] on 17 July 2009.

The Council of the European Union, positively reacting to the joint request of HOSPEEM and EPSU to transpose their Framework Agreement into European legislation, on 10 May 2010 adopted the Directive 2010/32/EU (henceforth called the Directive) implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU (1).

Aim

In their joint Work Programme 2017-2019[2], HOSPEEM-EPSU committed for a second time to follow-up on the Directive with the primary aim to monitor the national implementation more than four years after the Directive has been officially put in place.

The first follow-up activities were framed and guided by the joint project on the "Promotion and support of the implementation of Directive 2010/32/EU on the prevention of sharps injuries in the hospital and healthcare sector" in 2012 and 2013. The Final Report of 15 November 2013[3] was based on a HOSPEEM-EPSU affiliates survey, which included 25 country reports on the implementation of the Directive, three regional seminars in Dublin, Rome and Vienna and a conference in Barcelona on 20 June 2013. It also comprised a section on key challenges to be addressed either by the national governments, social partners, public institutes or agencies or other relevant actors in the field of occupational safety and health (OSH).

Methodology

The qualitative research used for this enquiry was a semi-structured survey. It was framed by a concept note addressed to the HOSPEEM members and EPSU affiliates, which was disseminated one month prior to the launch of the survey for comments and revision. The survey was addressed to all EPSU affiliates organising workers in health and social services in the EEA (i.e. 65 Trade Unions) and to 14 HOSPEEM members in the countries of the European Economic Area (EEA). The survey targeted national Social Partners that are Members of HOSPEEM or EPSU in the EEA countries, i.e. the sample size is limited. HOSPEEM and EPSU approached their national member organisations respectively with the request to fill in the online questionnaire. It investigated areas where the implementation and use of the

[1] The Framework Agreement (available in EN, FR, DE, ES, SV and RU) can be accessed on the EPSU webpage and on the HOSPEEM webpage.
[2] The Work Programme (available in EN. FR, DE, ES, SV and RU) can be accessed on the EPSU webpage and on the HOSPEEM webpage.
[3] ICF GHK (2013): Promotion and Support of Directive 2010/32/EU on the prevention of sharps injuries in the hospital and healthcare sector. Final Report 15 November 2013. The document (available in EN, FR, DE, ES and PL) can be accessed on the EPSU webpage together with documents of the Final Conference on 20 June 2013 in Barcelona and on the HOSPEEM webpage.

Directive has been proven beneficial in the prevention of sharps injuries in the hospital and healthcare sector and indicated potentially or still existing problems with its implementation or use or issues linked to the regulatory framework for OSH in place in a given European Union Member State (EU MS).

The ESP collected the input through an online survey between the 14 December 2017 and 20 March 2018. Whereas EPSU affiliates were offered to answer the survey in their native language (English, French, German, Italian, Portuguese and Spanish), HOSPEEM members were asked to answer in English. While the national Social Partners for the hospital and healthcare sector were invited to fill in the survey first hand, they were also encouraged to obtain more detailed information, such as from a sample of hospitals or from national agencies or observatories having data and evidence on the issue if they considered this feasible and appropriate. Furthermore, employers' organisation and trade unions from each Member State were invited to provide a joint response. HOSPEEM members and EPSU affiliates could also share supporting documents (e.g. national regulations linked to the implementation of Directive, relevant information or training material) they themselves or other organisations (ministries; health and safety agencies; social security organisations responsible for accidents at work and occupational diseases, etc.) had produced, in their national language or in English.

If the answer was given in a language other than English, the EPSU Secretariat commissioned a translation of the responses into English to facilitate the analysis based on one common language.

Results

As displayed in **Figure 1**, the ESP received 29 responses (9 HOSPEEM[4], 16 EPSU and 3 joint responses and 1 not affiliated to either of the ESP[5]). In total 12 HOSPEEM members, 21 EPSU affiliates and 3 organisations[6] not affiliated to either of the ESP from 22 countries (20 EU MS plus Norway and Serbia) replied. The country with the most responses recorded (n = 4) was Norway. Countries from where two answers were received are Denmark, Finland, Germany and Lithuania. Joint answers were received from three countries, the Netherlands, Norway (with in addition to separate answers from 3 trade unions) and Sweden. For the other 13 EU MS[7], the analysis is based on this one reply, either from the Trade Union or the Employers' side.

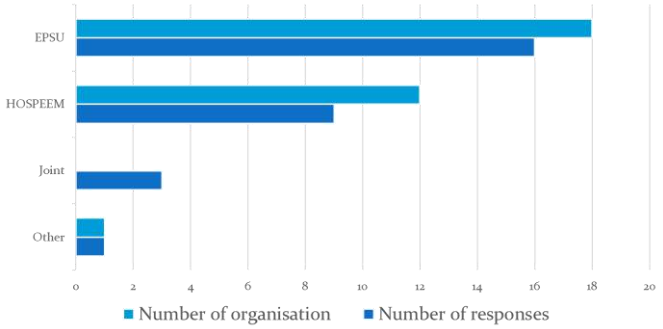


Figure 1 *Number of organisations and number of responses*

The analysis of the responses the ESP identified among others the different

[4] HSE, Employers' informed the Secretariats that the Irish Trade Unions are aware of contents and agreeable for same to be forwarded.
[5] This reply was received from the Hungarian Nurse Organisation. For the purpose of the in-depth analysis this reply was excluded from the analysis but is internally taken up by EPSU. The same holds for a reply to question 6 by EPSU's Serbian affiliate Sindikat zaposlenih u zdravstvu i socijalnoj zaštiti Srbije (SZZSZS) [Trade Union of Health and Social Care of Serbia].
[6] Česká Asociace Sester (ČAS) [Czech Nurse Association], Profesní a odborová unie zdravotnických pracovníků (POUZP) [Professional and Trade Union of Health Workers, Czech Republic] and Hungarian Nurse Organisation.
[7] Austria, Bulgaria, Cyprus, Czech Republic, Estonia, France, Greece, Hungary, Ireland, Italy, Latvia, Spain and the United Kingdom

principles of the Directive (**Box 1**) areas where the implementation and use of the Directive been proven beneficial in the prevention of sharps injuries in the hospital and healthcare sector and areas where potential or actual still existing problems with the implementation or use of the Directive can be recorded.

Box 1 *Six principles of the Directive*

Principles of the Directive is the introduction to the six principles then elaborated on more in detail, namely:

- *Clause 5: Risk assessment*
- *Clause 6: Elimination, prevention and protection*
- *Clause 7: information and awareness-raising*
- *Clause 8: Training*
- *Clause 9: Reporting*
- *Clause 10: Response and follow-up*

Awareness of the effectiveness of the Directive in the national and/or local setting

The following section describes the awareness of the effectiveness of the Directive in the national and/or local setting by analysing the awareness and the information from the Social Partners. It also analyses, when available, the evidence and assessment by national governments or competent authorities on the effect of the reduction of risk of health workers resulting from the implementation of the Directive.

Out of 28 replies received from organisations being affiliated to either HOSPEEM or EPSU, 23 respondents were aware of an effect of the Directive in the reduction of risks of health workers resulting from the Directive's implementation in their country, of which 15 respondents are affiliated to EPSU and 5 to HOSPEEM. The same reply was also given by all three joint responses jointly prepared by national trade unions and employers' organisations (the Netherlands, Norway and Sweden) – see **Figure 2**. It is noteworthy that this question only reflects the respondents' awareness of an effect and not the knowledge of an actual concrete effect.

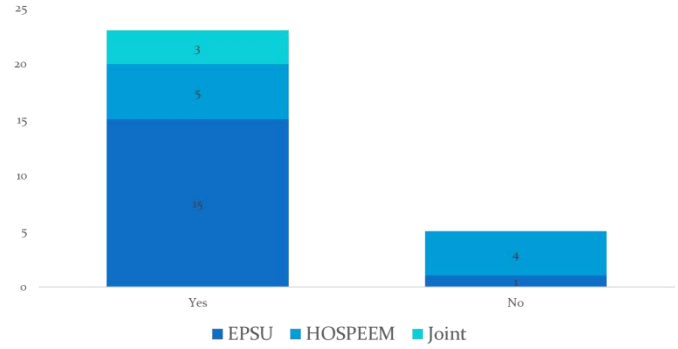


Figure 2 *Number of respondents' awareness of the effectiveness of the Directive in the national and/or local setting*

Participants who were not aware of any effect include both Danish Social Partners, whereas the **Danish Nurses Organisation, Trade Union**, reported that "*it is [im]possible to say anything certain about the impact of the Directive in Denmark. We [are unaware] of the number of sharps injuries - neither before or after the implementation. The injuries are registered primarily internally at the individual workplaces. Only if there is a sickness absence in connection with the injury, it will be reported as an occupational injury.* The **Danish Region, Employers'**, reported that *"the directive and the implementation probably made a contribution to more awareness. [However,] statistic information specific [to] injuries due to sharps is not available on a national level*. **EHA, Employers', Estonia**, noted that "*Hospitals are required to collect data about injuries and infections inflicted by sharp objects during [the] provision of healthcare services. It is mandatory for employees to give this information to hospitals*

quality services immediately and the hospital then sends this notification to the Health Board. There is a national infectious disease database (created in 2005, on national level 2009). Unfortunately, they do not have a report concentrating on sharps injuries to healthcare personnel."

When being asked about the provision of information on the effect of the implementation of the Directive in the national or local setting, 9 respondents mentioned the increase of purchase of safety devices by the hospital employers or the use of safety devices by healthcare staff, such as the "*Procurement of blood sampling equipment.*", **Norwegian Social Partners**. National Social Partners were often not able to identify concrete evidence for change associated with the transposition of the Directive (n = 6). The **Swedish Social Partners** noted that "*it [is] difficult to determine an effect that can be associated with the Directive, in part, because the reporting frequency for relevant injuries was initially low and remains low*." For those who did identify concrete changes and direct transposition of the Directive (n = 6) reported that *"A comparison of the number of incidents before and after the directive (national transposition) shows a small (where great importance was attached to accident prevention even before transposition) to significant reduction in accidents."*, **YOUNION, Trade Union, Austria**, and that "*Needlestick injuries fell steadily from 159 in 2007 to 109 in 2014 and to 95 in 2016*.[8]", **Ver.di, Trade Union, Germany**. The methodology of how the data is collected differed among the respondents: Whereas it was mentioned by **LSDASP, Trade Union, Lithuania**, "*each medical institution has a registry of sharp injuries*.", **EHA, Employers', Estonia**, noted that "*Hospitals are required to collect data about injuries and infections inflicted by sharp objects during [the] provision of healthcare services. It is mandatory for employees to give this information to hospitals quality services immediately and the hospital then sends this notification to the Health Board*." The most important direct effect of the Directive is the same for Ireland, as reported by HSE: "*The National Incident Management System (NIMS) was introduced in 2015 by the State Claims Agency (SCA). This requires all incidents to be reported through a national centralised system and will ultimately improve the quality of incident data collected*[9]*. The HSE has long been proactive in encouraging staff to report all incidents – also all "near misses" and incidents, even those that do not result in harm – and this is enshrined in the Corporate Safety Statement, Sharps Policy and Incident Management Framework and Guidance. The number of incidents reported through the National Incident Management System appears to have gradually reduced in the years since the introduction of the Sharps legislation", from 572 in 2012 to 408 in 2017* **(HSE, Employers', Ireland). Ver.di, Trade Union, Germany**, explained that "*A report on injuries and the reasons for them to happen is being produced in the hospitals at least once a year*". It is noteworthy that respondents equally mentioned awareness raising or the launch of awareness raising campaigns as well as increased training (n = 5), as the **SETCa-BBTK, Trade Union, Belgium**, reported that "*the 2010 Directive has risen the awareness around the health risks of sharp and needlestick injuries. In several hospitals, sensibilisation campaigns were launched*". **Tehy, Trade Union, Finland**, underlined that *"the directive and national legislation have increased awareness and improved the risk assessment of sharp injuries at workplaces. Also, reporting mechanisms have improved in some workplaces.*" Regarding increased training, **PASYDY, Trade Union, Cyprus**, explained that "*for the public sector, there has been [an] education of infection control nurses and all other healthcare professionals."* As displayed in **Figure 3**, most respondents reported

[8] This data refers to the case study of one hospital in Germany.

[9] The NIMS includes information on who was involved in the incident, the problem/cause (exposure to needlestick and sharp part", the date of the incident and if it was harmful ("adverse effect), i.e. lead to an infection, or if it leads to no harm, if it was a near miss or a dangerous occurrence or a complaint.

that they are unaware of the availability of reports or assessments by national governments or national authorities (n = 18). Countries that indicated that reports have been made available are, France[10], Germany (Trade Union and Employers[11] separately), Greece[12], the Netherlands[13] (joint response) and the United Kingdom[14].

ARAN, Employers', Italy, acknowledged the absence of a report, however, noted that available data on accidents at work from the National Institute for Accident Insurance at Work (INAIL) for the hospital setting show a decrease in the number of accidents reported per year[15]. "*It is not possible to enucleate needle and sharps injuries within these accidents and therefore to ascribe this decrease to the effects of the implementation of the Directive, though data seem suggestive as a decrease can be observed following 2014, year of the final transposition of the directive*." This was also observed by **FeSP-UGT, Trade Union, Spain**, "*sharps instruments [injuries] are included under the "Contact with unspecified sharp, pointed or hard instruments" section*" but explained that "The *Autonomous Community of Madrid pioneered the obligatory use of products with safety devices, established by Order 827/2005*[16]." The German Social Partners shared detailed information about follow-up studies ran in 2014 and 2017: *"In all 3 settings [i.e. hospitals, doctors' surgeries and care facilities] about half of the NSI did not occur during the invasive procedure, but during the subsequent disposal of the instruments. 30 % of all NSI were caused by needles for subcutaneous injections; in care facilities, the proportion was above 50%*[17]", **VKA, Employers', Germany**, explains. **Ver.di, Trade Union, Germany**, informs that *"despite improved statutory regulation, needlestick injuries and cuts are among the most frequent causes of accidents in the health sector. […] Colleagues in the hospitals note that steps are being taken to reduce risk [and that] stress in*

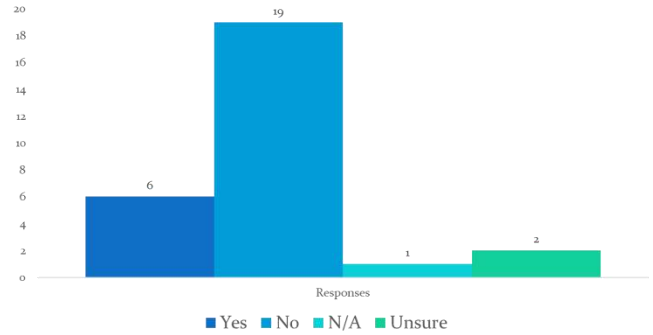


Figure 3 *Number of respondents reporting on their awareness of the availability of reports or assessments by national governments or national authorities*

[10] Surveillance nationale des accidents exposants au sang chez les soignants : réseau AES-Raisin 2015 [National Surveillance of Accidents Exposing to Blood in Caregivers: AES-Raisin Network] (available in FR) retrieved 17 April 2018

[11] Unfallmeldungen zu Nadelstichverletzungen bei Beschäftigten in Krankenhäusern, Arztpraxen und Pflegeeinrichtungen [Workers' Compensation Claims for Needlestick Injuries Among Healthcare Personnel in Hospitals, Doctors' Surgeries and Nursing Institutions] retrieved on 17 April 2018

[12] In process of allocating the report KEELPNO (Hellenic Center for Disease Control & Prevention)

[13] Werkdruk, Agressie en Geweld in Zorg & Welzijn 2014 [Work pressure, Aggression and Violence in Care & Welfare] (available in NL) retrieved on 17 April 2018

[14] Report on the post implementation review (PIR) of the Health and Safety Sharps Instruments in Healthcare) Regulations 2013 HSE 17 53 retrieved on 17 April 2018

[15] Banca Dati Statistica: Sezione: Q Sanita' e assistenza sociale Divisione: Q 86 Assistenza sanitaria Gruppo: Q 861 Servizi ospedalieri Classe: Q 8610 Servizi ospedalieri [Section: Q Health and Social Assistance Division: Q 86 Healthcare Group: Q 861 Hospital Services Class: Q 8610 Hospital Services]

[16] Enfermería "está en peligro": la mitad de hospitales no tiene bioseguridad [Nursing "is in danger": half of hospitals do not have biosecurity] (available in ES), describing a study that was carried out to monitor Order 827/2005, retrieved on 17 April 2018

[17] Quoting from a study to investigate whether hospitals, doctors' surgeries and care facilities differ with respect to the causes of needlestick injuries (NSI) and to collect data on availability and implementation of safety-engineered devices (SED) in these healthcare settings workplaces.

the workplace continues to be the prime risk factor for injury[18]". **Tehy, Trade Union, Finland**, explained that "*[between 2014-2015, Southern Finland] Inspectors of Occupational Safety and Health supervised the prevention of accidental injury from needle stick and other sharp instruments in the healthcare sector. Every third of audited workplaces was deficient in the safe use of sharp instruments.*" **OSZSP ČR, Trade Union, Czech Republic**, expressed the concern that "*reports can only be requested on an individual basis. However, the results are not relevant as [the] survey shows that only about 50% of injuries are reported.*"

Legal transposition

This section analyses the issues relating to the awareness of problems perceived (or not) in relation to the transposition of the Directive into national legal systems, about relevant documentation issued to conclude this transposition as well as on the involvement (or not) of the sectoral Social Partners to overcome complications or problems in this context.

Regarding national social partners' involvement in the legal transposition of the Directive, 5 respondents explicitly answered in the affirmative.

Overall, the majority of respondents (n = 16) were not aware of any problems concerning the transposition of the Directive into national law. Out of these 16 respondents, 3 were joint responses, 6 came from EPSU affiliates and 7 from HOSPEEM members. It is noteworthy that 10 EPSU affiliates expressed the awareness of problems, whereas only 2 HOSPEEM members did so (**Figure 4**).

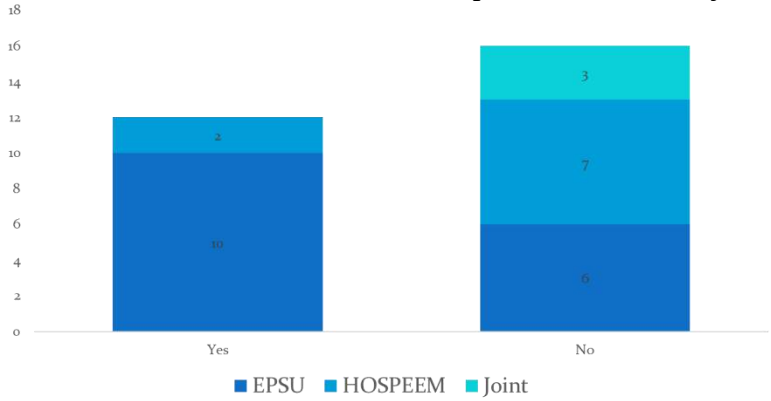


Figure 4 *Number of respondents' awareness of problems perceived in relation to the transposition of the Directive into national legal system*

Of those national Social Partners, who reported concrete problems in the legal transposition, respondents noted that the transposition of the Directive penetrated many different pieces of national legislation making it impossible for the Social Partner "*to cover all of [them] Our organization has therefore developed a methodological guidance that has been extended to partner organisations to healthcare facilities. However, this guidance does not have any legal weight, it is only a recommendation. The Ministry of Health's interest in this issue is scant and there is no interest in cooperation. Our organization has held a number of meetings with representatives of the ministry, these talks lasted for more than two years, without much success.*", **OSZSP ČR, Trade Union, Czech Republic**. Furthermore, **FeSP-UGT, Trade Union, Spain**, noted that "*Social Partners were not involved in drafting the order, but they did apply pressure to transpose the directive. [...] Social Partners worked with the Ministry of Employment and Social Security on transposing the directive. The Spanish regulations are more restrictive than the directive, in favour of protecting workers in Spain. The trade union [FeSP-UGT] was involved as a social partner, advocating that the directive should be*

[18] Concretely: 1) Injuries are better recorded, leading to an increased number of incidents reported; 2) Technical and organisational risk minimisation measures are being implemented; 3) Guides and training measures helped to raise the awareness of staff and managers. 4) A report on injuries and their reasons is being produced in the hospitals at least once a year, which, however, does not always imply that counter-measures are taken.

transposed by royal decree in accordance with legislation from the law on preventing occupational risks", but eventually the "format" maintained was a ministerial order." The **Norwegian Social Partners** and **PASYDY, Trade Union, Cyprus**, reported a delay in the legal transposition.

In general, the national Social Partners gave a positive outline regarding the legal transposition in their home country and as a rule, reported a "copy-paste approach" from the Directive. The **Norwegian Social Partners** noted that they "*were in dialogue [with] the government about this legislation and gave [their] opinion and also answered a public hearing and [that they] were very happy with the result of the new legislation.*" **NAHCO, Employers', Lithuania**, explained how their Minister of Social Security and Labour initiated through an order a Working Group including representatives of Ministries, healthcare employers' organizations and trade unions. "*The following implemented law [...] was approved by the general order of the Ministries of Social Security and Labour, of Education and Science, of Health.*" **OSZSP ČR, Trade Union, Czech Republic**, observed that "*OSH inspectors check the injury by the sharp objects. First during checking Safety Risks Analysis. It's about injury by an injection needle or other medical supplies. Second, the employer is obliged to send the employee to taking blood plus to send this information to the Hygienic Station. In case of the positive findings employer should have to proceed as a work accident.*". **ARAN, Employers', Italy** noted that *"[The legislation] represent more a reminder to health employers than new concepts, as most preventative actions and measures were already included in existing laws […], with the exception of the adoption of safety-engineered devices. The Directive […] appl[ies] to all workers who operate in the workplace concerned by health activities […], including trainees, apprentices, temporary workers, students […] and subcontractors.*" **Ver.di, Trade Union, Germany**, noted that "*A particularly important feature of [Ordinance on Biological Substances and Technical Regulations 250/BioStoffV] is that it significantly strengthens the importance of carrying out a risk assessment*. **VKA, Employers', Germany**, supplemented that "*anyone who deliberately endangers the life or health of an employee through an act listed in § 20 is punishable under Section 26 of the Occupational Health and Safety Act*[19] *(excerpt from § 21 Criminal offences - BioStoffV)*".

Table 1 below provides an overview of documentation shared by HOSPEEM members and EPSU affiliates on the national transposition of the Directive.

[19] Ordinance on Safety and Health Protection at Workplaces Involving Biological Agents (BioStoffV)

Table 1 *Overview on the national transposition of the Directive*

Country	Member organisation	Document name	Date of publication/ last amendments/ entry into force
Austria	YOUNION	Verordnung der Bundesregierung zum Schutz der Bediensteten vor Verletzungen durch scharfe oder spitze medizinische Instrumente (Nadelstichverordnung Bund – B-NastV)	March 2015
Belgium	SETCa-BBTK	Royal Decree of 17 April of 2013[20]	April 2013
Bulgaria	NUPH	НАРЕДБА № 3 от 8 май 2013 г. за утвърждаването на медицински стандарт по превенция и контрол на вътреболничните инфекции	May 2013
Cyprus	PASYDY	Οι Περί Ασφάλειας και Υγείας στην Εργασία Κανονισμοί.	January 2014
Czech Republic	OSZSP ČR	O řešení situací spojených s poraněním ostrými předměty ve zdravotnictiví a prevenci jejich vzniku	
Denmark	Danish Regions Danish Nurses Organization	Bekendtgørelse om biologiske agenser og arbejdsmiljø	May 2013
Estonia	EHA	Bioloogilistest ohuteguritest mõjutatud töökeskkonna töötervishoiu ja tööohutuse nõuded	May 2013
Finland	KT TEHY	Valtioneuvoston asetus työntekijöiden suojelemiseksi biologisista tekijöistä aiheutuvilta vaaroilta/Statsrådets förordning om skydd för arbetstagare mot risker som orsakas av biologiska agenser[21]	August 2013/December 2017
Germany	Ver.di	TRBA 250 Biologische Arbeitsstoffe im Gesundheitswesen und in der Wohlfahrtspflege	October 2016
	VKA	Verordnung über Sicherheit und Gesundheitsschutz bei Tätigkeiten mit Biologischen Arbeitsstoffen	March 2013

[20] The Directive was added to the Belgian codex on health and safety at work.

[21] This Regulation shall enter into force on 1 January 2018. This Regulation repeals the Government Decree on the Protection of Workers from the Risk of Exposure to Biological Agents at Work (1155/1993) and the Government Council's Prevention of Accidents Due to Sharp Instruments in Health and Safety Healthcare (317/2013) of 5 August 2013.

Country	Member organisation	Document name	Date of publication/ last amendments/ entry into force
Greece	ADEDY	Πρόληψη τραυματισμών που προκαλούνται από αιχμηρά αντικείμενα στο νοσοκομειακό και υγειονομικό τομέα σε συμμόρφωση με την οδηγία 2010/32/ΕΕ του Συμβουλίου της 10ης Μαΐου 2010 (ΕΕ L 134/66)	January 2013
Italy	ARAN FIASO IRCCS Spallanzani	DECRETO LEGISLATIVO 19 febbraio 2014, n. 19 Attuazione della direttiva 2010/32/UE che attua l'accordo quadro, concluso da HOSPEEM e FSESP, in materia di prevenzione delle ferite da taglio o da punta nel settore ospedaliero e sanitario. (14G00031) (GU Serie Generale n.57 del 10-03-2014)	March 2014
Lithuania	NAHCO LSDASP	Regulations for the prevention of acute injuries in the healthcare sector	May 2013
Netherlands	NVZ FNU NU9 CNU FBZ	Arbeidsomstandighedenbesluit, Artikel 4.97	January 2012
Norway	NUMGE NSF Spekter NITO	Forskrift om utførelse av arbeid	December 2017
Romania	SANITAS Federation	HG 243/2013 privind cerintele minime de securitate si sanatate in munca pentru prevenirea ranirilor provocate de obiecte ascutite in activitatile din sectorul spitalicesc si cel al asistentei medicale. Hotarare nr. 243/2013	May 2013
Spain	FeSP-UGT	Orden ESS/1451/2013, de 29 de julio, por la que se establecen disposiciones para la prevención de lesiones causadas por instrumentos cortantes y punzantes en el sector sanitario y hospitalario	July 2013
Sweden	SALAR Kommunal Vision Vårdförbundet	Mikrobiologiska arbetsmiljörisker - smitta, toxinpåverkan, överkänslighet	March 2014
United Kingdom	UNISON	Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 Guidance for employers and employees	March 2013

Practical transposition

Moving towards the practical transposition of the Directive in the hospital or healthcare setting, national Social Partners were asked on their awareness of (concrete) problems, taking into consideration as main "points of reference" the principles set out the in the Directive. They were also asked to share any information they had (if any) on how the involvement of the national Social Partners had been of assistance to overcome problems occurred with the practical transposition.

The majority (n = 19) of national Social Partners were aware of problems in the practical transposition of the Directive. Out of the 19 respondents, 4 were associated with HOSPEEM, 14 represented EPSU member organisations and 1 joint response (**Figure 5**). 9 respondents were not aware of problems with the practical transposition of the Directive. **HSE, Employers', Ireland**, informed that no specific problems were brought to their attention, but "*that information and awareness raising, training and reporting are always challenges in an organisation of such scale and complexity*".

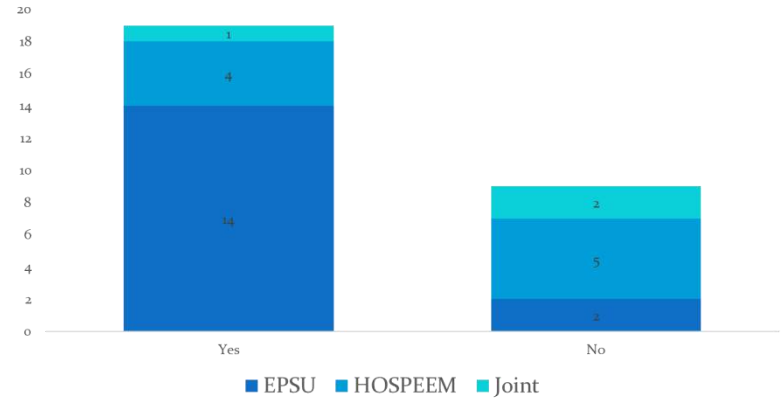


Figure 5 *Respondents' awareness of problems in the practical transposition of the Directive*

To allow for an in-depth analysis of the practical problems encountered by national Social Partners, the Secretariats clustered the answers around the six principles of the Directive (**Box 1**).

When looking into the order of importance of problems or improvements linked to the transposition of the Directive into the national regulatory frameworks and/or the actual application of its key principles included in the six Clauses, the principle most often mentioned by respondents was *Clause 6: Elimination, prevention and protection*, in total 12 times (by EPSU 8 times, by HOSPEEM members 3 times and in one joint reply). Scoring second was *Clause 9: Reporting*, mentioned 7 times (by EPSU affiliates 6 times, 1 time by a HOSPEEM member), third *Clause 7: Information and awareness-raising*, referred to 6 times (by 4 EPSU affiliates and 2 HOSPEEM members). On the fourth-place ranked *Clause 5: Risk assessment* and *Clause 8: Training*, mentioned 3 times respectively (and in both cases by EPSU affiliates only). None of the respondents indicated a challenge or positive change with regard to *Clause 10: Response and follow-up* (**Figure 6**). As **RCN, Trade Union, UK**, remarks that this result might be due to a different understanding of this sixth clause of the Directive by the respondents to the online survey and due to its interrelatedness with the principle *Reporting*: "*In the UK we have*

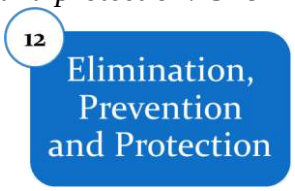
Figure 6 *Respondents' reported order of importance of problems or improvements linked to the transposition of the Directive*

appropriate follow-up following an incident in terms of a medical checks of the individual, but follow-up of the root causes of the incident is very poor, i.e. an investigation into how it happened covered by clause 10 is lacking by employers." And adds, referring to the answers by Ver.di and NNO under **Reporting** below: " *How can one report on the main causes (locally and nationally) if no local investigation of the incident as required under clause 10 has been done?*"

In the following section, concrete illustrations for the challenges and difficulties reported to the national Social Partners are given, again by referring to the six key principles.

Elimination, prevention and protection

Different aspects were raised by the respondents in relation to *Clause 6 Elimination, prevention and protection*: One first problem is linked to the lack of sufficient financial resources for the purchase of safety-engineered devices, mentioned by organisations from Greece, Italy and Spain: *"In some cases shortage of necessary medical supplies due to the austerity measures and cuts"* (**ADEDY, Trade Union, Greece**). **ARAN, Employer, Italy**, reported that *"The adoption of medical devices incorporating safety-engineered protection mechanisms is suboptimal*", first due to a lack of economic resources, as reported by 39% of the hospital directors and 44% of the nurses enquired. Another is linked to the fact that older products are used alongside newer products: *"Not all sharps instruments that are currently used in health centres have the same level of protection for avoiding accidents"* (**FeSP-UGT, Trade Union, Spain**). In their joint reply, the **Norwegian Social Partners** stated that *"We know that equipment with safety mechanisms is in use in many settings - with adequate training. But we also know that hospitals are still buying equipment without safety mechanisms, which indicates that such equipment is still in use. We have no information on the situation in the healthcare sector […]."* Similarly, the **OSZSP ČR and ČAS, Trade Unions, Czech Republic**, highlighted that the *"Ministry of Health not willing to cover higher costs for better products, the decision to use safety devices (or not) is left to each healthcare facility, which has to bear the costs."* **Tehy, Trade Union, Finland**, reported that the National Institute of Health and Welfare operates a categorisation of "at-risk groups" and "not at-risk groups" in relation to health and safety hazards. This has the consequence that certain professions or students of professions do not get a free vaccination against Hepatitis B as a preventive measure in the context of injuries with medical sharps as they are classified as not-at-risk groups.



A second challenge mentioned is linked to the workforce. **ARAN, Employers', Italy**, reported that the second main obstacle for the suboptimal adoption of medical devices incorporating safety-engineered protection mechanisms is that hospital staff has difficulties in accepting changes or new rules, *"68% of interviewed nurses reported at least one incorrect behaviour in manipulating or eliminating used needles and sharps.*" For **Germany** both social partners indicated particular challenges for handling medical sharps in their disposal for doctors. On the contrary, **LSADSP, Trade Union, Lithuania**, informed that often there is a *"shift of blame on workers in case of injury and following investigations rather than an analysis of the reasons causing the injury or accident"*. **UNISON, Trade Union, UK**, highlighted the insufficient protection or preventive measures for those workers involved the safe disposal of medical sharps: *"It could be the focus on [the] implementation of safety devices has led to employers being less vigorous re[garding] disposal of sharps. There is evidence that although there is [a] decline in injuries to clinical staff, there has not been a corresponding decline in injuries to cleaning and housekeeping staff. UNISON personal injury data suggest these injuries are being caused by failure to dispose of non-safety devices."* **SETCa-BBTK, Trade Union, Belgium**,

highlighted that "some hospitals have tried to put the prevention principles into practice [with] experimenting with safety butterfly needles [and] the safe removal of used needles, introducing needle boxes or needle plateaus."

Reporting

Seven respondents[22] indicated deficits regarding *Clause 9: Reporting*. **PASYDY, Trade Union, Cyprus**, informed that there is no collection of data at the national level yet. There have, however, also been positive developments as *"all [healthcare facilities] had developed policies for incidence reporting regarding sharps injuries in their attempt to implement the directive".* And it is not least *"in their attempt to secure accreditation based on ISO standards for their hospitals [that] they are trying to implement the clauses 4 to 10 of the Directive."* **POUZP, Trade Union, Czech Republic**, added that a uniform reporting system for injuries with medical sharps is lacking. **Ver.di, Trade Union, Germany**, deplored the absence of a uniform system of assessment, evaluation and reporting of injuries with medical sharps across the country: *"As a result of Germany's federal structure, the results have to be laboriously collated."* The **Norwegian Nurse Organisation, Trade Union, Norway**, recalled the problem of underreporting. They base their insight on feedback received from a sample of hospitals. The three Norwegian trade unions[23] expressed their concern about the system of registration, reporting and follow-up to injuries with medical sharps as well as the need of training in the local settings in a letter to their government. They deplore that neither a substantial improvement of the reporting system(s) in place has taken place nor an action plan to address the issues mentioned has been developed to date by the national government. **FeSP-UGT, Trade Union, Spain**, pointed to a problem originating in austerity policies and the subsequent underfunding of the healthcare system: *"Owing to the crisis in Spain […], there has been a rise in temporary contracts, meaning that healthcare workers are contracted to provide nursing care for short periods of time. As a result, accidents may not be registered by staff for fear of losing their jobs."*

Information and awareness-raising

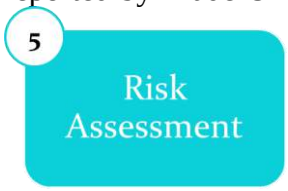
In regard to *Clause 7: Information and awareness-raising* the six respondents[24] that further elaborated on this point saw positive effects stemming from the implementation of the Directive. For **OSZSP ČR and ČAS, Trade Union, Czech Republic**, underlined that the implementation of the Directive allowed them *"to make [the] Ministry of Health aware of modern safety devices, their benefits and costs."* In their joint reply, the **Swedish Social Partners** in the hospital sector underlined that they are conscious *"of [the] fact that practical transposition of the Directive requires continued vigilance in areas such as education, training, purchasing, monitoring, safety routines, employee compliance with established routines and staffing in order to prevent or minimise risks of sharps injuries."* In the reply submitted by **CFDT Santé Services Sociaux, Trade Union, France**, colleagues informed about only few problems and highlighted the improvements that resulted from the provisions of the Directive: *"The staff representative bodies, and essentially in the Health, Safety and Working Conditions Committee, must ensure that the single document is up to date as part of risk prevention. During nursing training, time is spent on the provision of information*

[22] Six EPSU Members and one HOSPEEM Member
[23] NUMGE, NSF and NITO
[24] Four EPSU Members and one joint reply from the Swedish Social Partners

on [the] prevention of accidents with exposure to blood." Other improvements are that staff now better respects procedures, that the disposal of products used has improved and that health and safety at work services monitor the serological results of accidents at work, with serological tests are carried out, even though those declarations of accidents at work are not done in a completely systematic manner. **HSE, Employers, Ireland**, informed that *"in 2016 following a period of consultation with all key stakeholders, including Unions, the Health Service Executive approved and published a Policy on the Prevention of Sharps Injuries. The purpose of the Policy is to inform all HSE Managers (Responsible Persons) and employees of the key issues to address when developing safe work practices for the prevention of sharps injuries. Under this Policy, HSE is committed to eliminating or reducing the risk of exposure. […] The National Health and Safety Function has developed a number of resources to support managers in implementing the policy*[25].

Risk assessment

Deficits and challenges in relation to risk assessment, as further elaborated on in *Clause 5*, are reported by Trade Unions from five countries. **SETCa-BBTK, Trade Union, Belgium**, saw

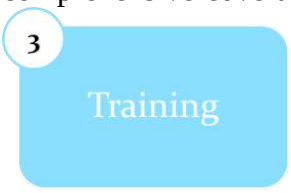


the *"need to have more comprehensive approach when implementing and using the Directive, by taking into account the concrete working conditions and work environment (i.e. problems with understaffing, […], voluntary overtime […]linked to (higher) risks of injuries with medical sharps.*" The reply also explained that it is an important shortcoming of [this specific] EU legislation that it is not sufficiently taking account of concrete working conditions and the work environment: *"Accidents are often related to work stress and excessive working hours.* The **Swedish Trade Unions (Kommunal, Vårdförbundet and Vision)** underline that *"a successful implementation of the Directive is also linked to good working conditions with adequate staffing. Stress is a major risk for non-compliance when handling sharp instruments and needles regardless of information and training".* **Ver.di, Trade Union, Germany**, reported on problems in connection with risk assessments at the workplace level: *"Risk assessments are being performed, but associated measures are not being adequately implemented. Another aspect is the inadequate supervision by monitoring bodies – both [commerce] inspectorates and accident insurance organisations, which are the bodies that need to provide [a] more detailed specification of the disclosure requirements associated with risk assessments."* **Tehy, Trade Union, Finland**, explained that the *"assessment of workers at risk is not (systematically) done by employers at enterprise-institutional level."* This is also because public authorities here see the role of the National Institute of Health and Welfare. The **FeSP-UGT Trade Union, Spain**, stated that *"occupational risk assessments are carried out in most health centres, but there is usually a delay in implementing preventive and corrective measures.*" **LSDASP, Trade Union, Lithuania**, identified the general need to strengthen the work of the Health and Safety Committees in the healthcare sector.

[25] The documents can be retrieved from **Table 2**

Training

Regarding *Clause 8: Training*, the contributions highlighted problems due to the non-comprehensive coverage of training programmes by all categories of staff potentially at risk.



One contribution focused on positive effects regarding training. **YOUNION, Trade Union, Austria**, referred to that *"problems arise with staff who are not permanently employed, such as trainees, students and interns, because they do not receive sufficient training."* A similar case was reported by the **Norwegian Nurse Organisation** in view of part-time staff only working on weekends and nights having difficulties to get any training. Finally, the **Spanish FeSP-UGT** highlighted that *"new employees are not given training prior to using safety devices, which is usually the most common cause of accidents."* More generally, **LSADSP, Trade Union, Lithuania**, highlighted the need for training *"both for employees and for employers in order to change their attitude."* A positive effect was reported by **PASYDY, Trade Union, Cyprus**, that *"ongoing training and building of awareness amongst healthcare workers in the public hospitals"* is in place. The provision of training and relevant information to the workers to improve the prevention of and protection from injuries with medical sharps is also partly done in the private sector by *"some directors of private hospitals and employers"*.

The form of involvement of social partners

Furthermore, HOSPEEM members and EPSU affiliates were asked whether they have been involved in the promotion of the practical transposition of Directive 2010/32/EU and if yes, which role they played and what was the impact or effect of their involvement.

16 respondents gave a positive affirmation whereas 9 respondents replied negatively; three respondents abstained from answering (**Figure 7**). This involvement often occurred in relation to the aspect of information and awareness raising on the occupational risks related to injuries and infections by medical sharps and how they could be best prevented or dealt with in case of an injury, both towards governments and public authorities, but also at the workplace level. National social partners also had meetings with governmental bodies to inform them about the Directive and to learn about planned activities with the aim to give more effect to the provisions of the Directive, as reported in answers from Cyprus, the Czech Republic and Norway.

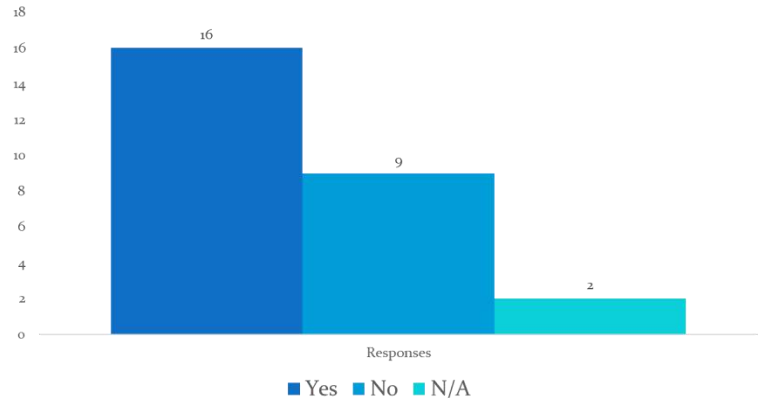


Figure 7 *Respondents' awareness of involvement of other stakeholders in promoting practical transposition of the Directive along with social partners*

The **Spanish trade union FeSP-UGT** informed that "*after the Directive was issued, information sessions were held, with UGT involved in the organisational elements*." This involvement concerned the aspects of "elimination, prevention and protection", "training" and "reporting": *"Most health centres have working protocols to follow, including behaviour and monitoring protocols in the event of biological accidents. Most health centres have been given specific instructions on prohibiting the recapping of needles. […] We are also aware that verbal instructions were*

given regarding the Directive, for example, not to cap needles, and the use of prepared containers for disposing of sharps was insisted upon – these specialist containers already existed prior to the transposition of the Directive. In terms of implementing these measures, we are only referring to the public health sector; we do not have as much information on the private health sector." In the case of Germany, in accordance with the national structure of the occupational health and safety system, the inspectorates for economic activities (Gewerbeaufsichtsämter) were also involved in the implementation.

Recent follow-up

The section on recent follow-up concentrated on the national Social Partners' awareness of recent (or planned) follow-up initiatives in their respective Member State with the intention to showcase better effect to the provisions of the Directive.

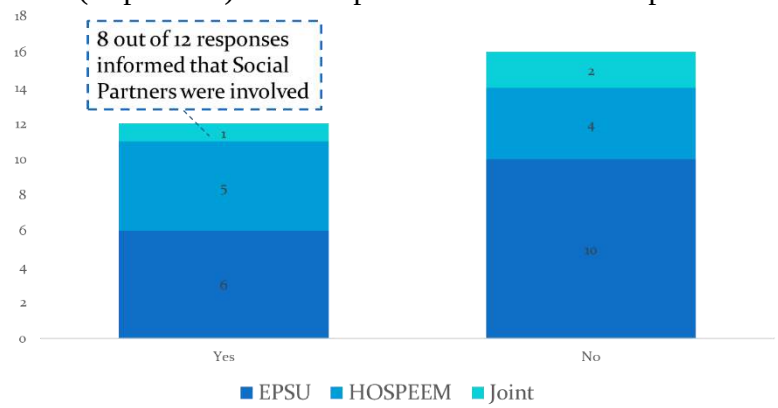


Figure 8 *Respondents' awareness of recent (or planned) follow-up initiatives*

The majority (n = 16) of national Social Partners were unaware of any follow-up initiatives. Out of the 16 responses, 4 were associated with HOSPEEM, 10 represented EPSU and 2 joint responses. Of those being aware (n = 12), 8 reported to having been involved in the initiatives (**Figure 8**).

Respondents were welcome to share documents on their recent follow-up. **Table 2** provides an overview of the documents gathered. It has to be noted that the below-mentioned documents merely constitute a snapshot provided by the respondents and does not cover the entirety of the projects within the respective Member State.

Table 2 *Documents on national recent follow-up*

Country	Member organisation	Documents / Websites
Cyprus	PASYDY	Training and Awareness Raising of the Sharps Directive
France	CFDT	Mise en Œuvre de la Directive 2010/32/UE en France
	Santé publique France	Surveillance of occupational blood and body fluids exposures in French healthcare facilities in 2015
Germany	Ver.di	Vermeidung von Nadelstichverletzungen in der Arztpraxis – Was muss der Praxisinhaber beachten?
	Ver.di / VKA / BGW	Risiko Nadelstich Infektionen wirksam vorbeugen
	DGUV	DGUV Information 207-024
	VKA / BGW	Fragebogen zur Analyse von Unfällen mit Blutkontakt
	VKA / BGW info	Unfälle mit Blutkontakt erfassen
Ireland	HSE	HSE survey results regarding the implementation of Directive 2010/32/EU – prevention from sharp injuries in the hospital and healthcare sector, presented to HOSPEEM (March 2016)

		Policy on the Prevention of Sharps Injuries (August 2016)
		Fast Fact Sharps Policy
		Fast Fact Safe Use & Disposal of Sharps
Spain	FeSP- UGT	FSP-UGT presenta su campaña divulgativa de la UE sobre prevención de lesiones con objetos cortopunzantes
	FeSP- UGT / redacción médica	Enfermería "está en peligro": la mitad de los hospitales no tiene bioseguridad
	FeSP- UGT / Comunidad de Madrid, Consejería de Sanidad, Dirección General de Salud Pública33	Vigilancia de accidentes biológicos en la Comunidad de Madrid Ano 2016
Sweden	SALAR Kommunal Vision Vårdförbundet	Sharp and safe[26]
	Kommunal Vision Vårdförbundet	Report "A zero-tolerance vision for blood-borne infection caused by sharps in healthcare
	Svenska Miljöinstitutet	Report "Stick and cuts in health care - Prevention of injury and infection due to sharp instrument
United Kingdom	UNISON	Report on the post-implementation review (PIR) of the Health and Safety Sharps Instruments in Healthcare) Regulations 2013 HSE 17 53
		UNISON response to the Health & Safety Executive (HSE) post-implementation review of the Sharps Regulations.
	RCN	Post Implementation Review – The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

In addition to providing relevant documents and websites, the different **Swedish Social Partners** informed the ESP that "*in 2013, the three Trade Union organisations […] surveyed their members regarding the extent to which their work tasks entailed risks associated with the use and exposure to medical sharps. The major findings were that [the] members proposed that the use of safe products would have the greatest impact on safety. They also noted the importance of purchasing safe, functional products, and the necessity of education, training, risk assessments, personal safety equipment and of adapting work routines to new, safer products including safe disposal following use*." The **Austrian Trade Union YOUNION** emphasised that, not least as an effect of Directive, "*there are training, informational events, training and many other initiatives, where brochures and other information material are provided. These measures are organised or published by the social partners*" and that *"compulsory training sessions for the entire staff are and have been organised regularly. In many institutions, these training sessions are held upon commencement of service."* The **Latvian Hospital Association, Employers', Latvia**, deplored that their government does not pay sufficient attention to this health and safety hazard.

[26] Web-based material in Swedish devoted to the topic of preventing injuries from medical sharps.

Course of action

The European Social Partners were able to identify five recurring areas for future activities to improve the prevention and make more effective the protection from sharps injuries in the hospital and healthcare sector on different levels within the national contexts respectively (**Figure 9**).

Figure 9 *Recurring areas for future activities*

Standardisation of registration, reporting and follow-up systems of injuries with medical sharps

The setting up or improvement of information systems that provide standardised procedures and/or formats for the registration, reporting and follow-up to injuries resulting from medical sharps across one country, – as laid down in *Clause 9: Reporting and Clause 10: Response and Follow up* of the Directive – was the most recurring area for future action (n = 11) for the national Social Partners.

Respondents, such as the **Swedish Social Partners**, noted that "*better incident reporting systems locally, nationally and internationally*" should be introduced which is in line with **OSZSP ČR, Trade Union, Czech Republic**, who saw "*the unification of the system of reporting injuries by sharp objects [as another priority]*."

EHA, Employers', Estonia, would like to "*collect [...] and analys[e] data about the effects of the Directive on the national level.*" **Ver.di, Trade Union, Germany**, noted that "*there should be a standard system of assessment/evaluation. Because of Germany's federal structure, the results have to be laboriously collated. A national register might perhaps be useful here*." **FeSP-UGT, Trade Union, Spain**, highlighted the need for "*the government [to] establish monitoring mechanisms to verify the presence of safety equipment, in accordance with the Directive, and that the equipment does not pose any risks in itself.*" Lastly, **KT, Employers', Finland**, would like to go one step further and encourage "*the reporting of accidents caused by medical sharps [...] and then [use it] for "preventive work.*"

Appropriate training and education of healthcare professionals on policies and procedures associated with sharps injuries

Training and education of healthcare professionals as laid down in *Clause 8: Training*, was the to the same extent as a key area identified for future action (n = 11) for the national Social Partners.

VKA, Employers', Germany, identified "*early suitable briefing and education of all apprentices and employees"* as a crucial element for training. The **Norwegian Social Partners** expressed the need "*[for] a better system of training (should be a national standard for all health personnel)*". **HSE, Employers', Ireland,** stated a possible consideration was to the *"development of learning and education resources, such as e-learning (e.g. to be delivered as part of blended learning approach), which can be tailored for local implementation by healthcare organisations across member states"*. **NUPH, Employers', Bulgaria**, gave a concrete example on the necessity of training in areas or for tasks where the risk of injuries is higher, such as in "*surgical wards and emergency care, as well as [for] workers working over*

8 hours and young workers below the age of 24 and for those with little experience[27]." It was also noted from **ADEDY, Trade Union, Greece**, that "*funding and the provision of the appropriate training [for] the workers of the health sector*" is an issue where future action is needed. The "*importance of understanding occupational risks in employee training, as well as how to prevent them*" was emphasised by **FeSP-UGT, Trade Union, Spain**, too.

Information and awareness-raising measures on institutional and political level

The implementation of awareness-raising measures on various levels, as laid down in *Clause 7: Information and awareness-raising* has been mentioned by multiple respondents (n = 9), coming from the Social Partners, governmental institutions and hospitals in general.

PASYDY, Trade Union, Cyprus, as well as **ARAN, Employers' Italy**, stressed the need to initiate joint actions to the extent that "*Social partners have to take initiatives to use their pressure to promote the implementation of the directive and of all safety measures to reduce exposure to risks of sharps injuries. They also have to initiate joint actions with other bodies and services to raise awareness and information*." and that *"A European awareness raising campaign to be promoted in all Member countries by Ministries of Health could have a greater impact if supported by social partners*." **The Swedish Social Partners** highlighted the *"development of information and targeted marketing to various actors who influence training, purchasing, use and disposal of medical sharps.*" as another approach to raise awareness on the reduction of injuries inflicted from medical sharps. **VKA, Employers', Germany**, referred specifically to the need to "*consolidate threat awareness of disposing of cannulas*", which is much in line with **CFDT Santé Services Sociaux, Trade Union, France**, who would like to see awareness-raising measures "*related to the waste chain"*. This demand is also echoed by **UNISON, Trade Union, United Kingdom** when proposing a stronger focus on the preventive action for workers exposed to risks from unsafe disposal of waste.

Transition and access to medical devices incorporating sharps protection mechanisms

The elimination of unsafe procedures, i.e. the safe disposing of sharp medical instruments and contaminated waste, the unnecessary use of medical sharps, as well as the transition to safe sharps protection mechanism and devices was reported by 5 participating national Social Partners. This aspect to focus further action by social partners on in the future insofar ranks fourth. As expressed by **FeSP-UGT, Trade Union, Spain**, the involvement of Social Partners in "*selecting safety devices"* and equally importantly the verification of *"presence of safety equipment"* by the government should be introduced. Similar responses were received by the **Norwegian Social Partners**, who called for "*[better systems] to influence the procurement of safety equipment.*" Focusing on the transition, **UNISON, Trade Union, United Kingdom**, indicated that further "*thought could be given to transition from non-safety to safety devices*" and also recalled the importance of "*remaining vigilant in the disposal of sharps*" during the transition period. **HSE, Employers', Ireland,** supports this last point by suggesting *"a greater promotion, at national level, of the need for safe disposal and waste handling."* They also encourage a *"continued development by manufacturers of safety-engineered solutions and needle-free systems and the continued development of safe(r) hardware disposal solutions"* and support *"a greater promotion, at national level, of the benefits of safety-engineered protection systems" and their use.*

[27] Less than 4 years of work experience.

Implementation of risk assessment initiatives

Fifthly, risk assessment, as laid down in *Clause 5: Risk assessment* and the implementation thereof on a national level was explicitly mentioned by three respondents.

Ver.di, Trade Union, Germany, called for the strengthening of the "*implementation of risk assessments*" and that the responsible "*monitoring institutions also need to call for risk assessments to be based on a standard*." **PASYDY, Trade Union, Cyprus**, reported that "*a successful risk assessment program requires the collaboration between both employers' and employees*." The Trade Union stressed in particular "*that the presence of nurses in [risk assessment] programs (e.g. as part of safety committees) is paramount for the success of a risk assessment plan since they are those who know better the nature of the work. Therefore, risk assessment programs should be developed, implemented and be assessed regularly, especially when major changes occur, in order to achieve a reduction of sharps injuries*." **HSE, Employers', Ireland,** suggests considering *"a greater promotion, at national level, of the benefits of risk assessment (by all categories – clinical and non-clinical – of employees)".*

Other noteworthy further actions proposed or demanded included "*the need for overall adherence to the Directive*" (**Tehy, Trade Union, Finland**), the launch of a "*mandatory annual report [...] at European level, which would also be signed by both the government and the representatives of trade unions and representative employers at national level*" (**SANITAS Federation, Trade Union, Romania**) as well as the introduction of a "*no blame culture*", whereby "*reporting of sharp injuries [...] should be seen by both employers and employees as an opportunity to improve the system that allowed such an incidence to occur.*" Moreover, "*the no blame culture allows both the employers and employees to discuss and perceive new ideas and concepts on how to create a safer environment under a mutual understanding and respect, without the fear of punishment or humiliation.*" Taking it one step further, **CFDT Santé Services Sociaux, Trade Union, France**, would like to see the establishment of a "*European Observatory*." to facilitate a better monitoring of the effects of action taken and of still existing problems. The same Trade Union also suggests to "*extend the scope of the Directive to cover home care, self-employed registered nurses and the activities related to the waste chain.*"

Additional information provided by the national Social Partners

The information provided below has been reported by the national Social Partners, however, are not directly linked to the Clauses of the Directive.

Sanitas, Trade Union, Romania, noted that in Romania, apart from the translation from English into Romanian and the formal transposition of the Directive into national legislation, no concrete action in relation to the six principles could be observed up to date. Meaning that the Clauses laid down in the Directive exist on paper but have no real-life effect in hospitals and/or other healthcare institutions. Romania is the only country out of the 20 EU countries covered by the survey for which such a difference between theory and practice has been explicitly reported on.

The **Swedish Social Partners** informed that partly due to commitments made in the social partner agreement concluded to transpose Directive 2010/32/EU, *"the Swedish social partners have encouraged the funding of two research and development projects […] which led to the creation of a web-based informational training material "Vasst och säkert" / "Sharp and safe" [and] the development of a web-based incident reporting system that is being adapted to the hospital and healthcare sector [...] to improve incident reporting and [to] reduce the hypothesized degree of underreporting."* They also shared the information that used the ILO

World Day for Safety and Health at Work 2016 to present the cooperation and the *"joint efforts prior to and including the writing of the HOSPEEM-EPSU agreement, the transposition to a Directive and later to Swedish provisions and our subsequent joint activities […]."*

NUPH, Employers', Bulgaria, saw a need for a *"more widespread discussion with various actors in the healthcare system […] on the issues of prevention of injuries with sharp items in the healthcare sector and hospitals".* Actors to be included are *"employers and trade unions, the Ministry of Health, medical specialists of all specialities, importers and distributors of medical devices, lawyers and others."*

Ver.di, Trade Union, Germany, initiated multiple possible action points important in their view to improve the effectiveness of the Directive. For the German context three proposals are made: 1) Improve the passing on of information on sharps injuries by the occupational doctor/occupational health service not only to the managing director of a healthcare institution, but also to employee representatives, and this in a structured format. 2) *"The manufacturers of medical products and their product information should be reviewed, and obligations imposed"*; and 3) Ver.di sees a need for a common standard for training and workers' instruction and proposes to ask the EC *"to produce an implementation guideline on risk assessment that in particular includes follow-up activities in an action plan".* **FeSP-UGT, Trade Union, Spain**, elaborates on four points in the "outlook section". 1.) The importance of *"continuous training for staff […] on how to prevent biological risks […] and how to use new safety devices correctly."*; 2.) The need for *"public authorities to be involved in developing regulations and monitoring compliance"* to allow the setting up of better health and safety conditions for healthcare workers; 3.) The key role of having *"sufficient staff with permanent contracts to ensure work is carried out correctly"*. 4.) *"It should be the prevention services, the National Institute of Hygiene and the National Committee for Occupational Health and Safety (CNSST) [to] make the recommendations for the characteristics of safety devices. These recommendations should then be followed by procurement centres across the country. It will be particularly important to ensure monitoring in health centres that provide private healthcare."*

Discussion

As the aims of this survey were to explore on the one hand areas where the implementation and use of the Directive been proven beneficial in the prevention of sharps injuries and to illustrate still existing problems, this section will critically discuss the major findings and reflects them in the light of the findings presented above.

To enrich the discussion below, HOSPEEM and EPSU Secretariats recalled key insights from the final report compiled in **Box 2** below at the end of the first joint follow-up activity.

Box 2 *Reflecting on the first joint follow-up project*

Recalling insights from the project to effectively follow-up to the Directive can be considered as useful for at least three reasons: firstly, they are still valid; secondly, they may serve as a starting point for the renewed assessment of the effects of the Directive and thirdly, they help to identify issues or fields for future action by HOSPEEM and EPSU or other relevant actors.

The Final Report contains a systematic presentation of key risks arising from sharps injuries and of the main reasons for under-reporting. It is clearly established that the "main risks of infection relate to patients carrying HIV, Hepatitis B and Hepatitis C" (2). Research with health workers affected revealed that 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." (2)

The Final Report also stated that "the lack of reliable data at [the] 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." "The lack of national aggregation is not the only, nor the most significant complicating factor […]. 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 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." (2) It is also noteworthy to recall that member organisations of the ESP had underlined that "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." (2)

Going beyond the aspect of (under-)reporting, HOSPEEM and EPSU in 2013 had shared the view that the majority of injuries from medical sharps "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." (2) This mixed approach was also negotiated by the ESP in the Framework Agreement and is contained in the Directive. It offers the starting points for joint action to address still existing problems by the social partners.

Question 2 on the effects and possible problems with the legal transposition of the Directive can be contextualised by the results of the first survey done with EPSU and HOSPEEM members in 2012 and 2013. Back then it was reported that in five countries no changes were needed in the national legislation and in five only minor changes had to be operated whereas organisations from 10 EU MS had informed about medium-level changes. No EU MS had reported important adaptations. The first survey done around five years ago had also documented that guidance on the prevention of sharp injuries existed for quite a number of EU MS (2) or was being elaborated. This is again illustrated by the table included in this report (2). To this add – on a transnational level – information and/or training material e.g. prepared by the European Agency for Safety and Health (3) or issued by the World Health Organisation (WHO) (4). The lack of guidance, issued by national social partners themselves or by other key actors, was not identified as a problem in a single reply to the current survey.

Awareness of the effectiveness of the Directive in the national and/or local setting

The Social Partners identified problems hindering the uptake of information and reporting of sharps injuries. Whereas respondents noted that the reporting of concrete sharp injuries is operated at the level of a hospital/healthcare institution, many respondents noted that those systems vary from hospital to hospital (i.e. reports kept on hospital level, shared with insurance companies, shared with national health board or compiled in annual reports), that their use often is time intensive and sometimes outdated. It needs to be further investigated whether a more centralised approach on national or EU-wide level with as little as possible additional administrative burden would facilitate better reporting of injuries with medical sharps and then, in turn, would help to improve preventive action and the effectiveness of measures to eliminate or at least reduce their causes. This is also due to the fact that robust data are needed to be able to assess the effects of regulations and of concrete preventive or curative actions should injuries or infections with medical sharps occur. In this context, it has to be considered that most national Social Partners reported that there are no reports available allowing for conclusions on the decrease of sharps injuries and the implementation of the Directive, except for the publication of annual reports and statistics from competent institutions. If annual reports or

statistics are available, injuries with medical sharps are listed among other categories of incidents.

Furthermore, respondents remarked that, even though the overall purchase and use of safety devices have increased, more could be done. In particular, it was noted that the mixture of safety and non-safety devices can be confusing for the staff. Improved training on the proper use of safety-engineered devices and how to differentiate devices could defuse this situation.

Legal transposition

Since OSH itself is a comprehensive and multifaceted topic, penetrating many different layers of legislation and agreements on numerous levels within a Member State, national Social Partners reported challenges in successfully integrating themselves into the dialogue on governmental level. In certain Member States, pressure had to be applied to the authorities, leading to a varying extent of success. Some activities resulted in consultations and meetings at the respective Ministries, however, leading to no concrete outcome, whereas other Social Partners reported the establishment of designated Working Groups. A potential explanation for this phenomenon is the political agenda setting of the respective government, however, this has to be further investigated. In general, most respondents reported a "copy-paste" approach, where either the entire Directive was transposed into national legislation or parts of it, which have previously been identified as missing.

Practical transposition

Out of the 27 national Social Partners who replied to the online survey 19 indicated impacts they attributed to the practical transposition of stipulations of the Directive. Most of the issues reported indicated still existing problems. Most of the problems reported are linked to deficits regarding the elimination, prevention and protection of risks from injuries and/or infections from medical sharps. The second most important category and potential field of action for the future is linked to deficits when it comes to the reporting of injuries and/or the systems for reporting in place. Problems linked to *Clause 5: Risk assessment* and *Clause 8: Training* rank third and were only reported by trade unions.

Several respondents, both from the Employers' and from the Trade Union side, however, also informed about improvements brought about by provisions of the Directive, in particular, due to improved preventive measures, a higher level of awareness about the risks and as a consequence of improved information and training measures.

Some of the issues identified by the national Social Partners might be of nature for allowing "countermeasures" by social partners:

Firstly, improve the reporting, documentation and reporting systems for injuries and/or infections with medical sharps with as little as possible administrative burden, starting with the level of the hospitals/healthcare institutions and going up from there to the national level.

Secondly, when it comes to professional groups facing a risk of an injury and/or infection with medical sharps several replies highlight still existing deficits with regard to the safe disposal of non-safety-engineered devices that in turn imply the need to critically assess measures or provisions for non-clinical/-medical staff in hospitals and other healthcare facilities.

Thirdly, two replies explicitly mention a non-compliance with new or existing rules for the elimination of used needles and other medical sharps or incorrect behaviour as the cause for

injuries and/or infections, one focusing on doctors, the other on nurses. It, however, cannot be said exactly what is behind actual errors in handling used needles or other medical sharps.

Fourthly, the Directive already calls for putting in place a "no-blame culture". In the cases where fears of healthcare staff to report injuries with medical sharps and to embark on investigations on reasons causing injuries and/or infections are mentioned in the replies by Social Partners, the provisions of the Directive, if applied, should already allow an improvement of the situation as Clause 4 Principles, Point 11 reads: "Promote a 'no blame' culture. Incident reporting procedure should focus on systemic factors rather than on individual mistakes. Systematic reporting must be considered as [an] accepted procedure." Fifthly, Trade Unions report deficits with regard to certain categories of workers (non-permanently employed staff such as trainees, students or interns; newly employed workers; temporary agency staff; part-time staff only working at weekends or at night) when it comes to either the access to training and/or the actual provision of information on the risks and training to prevent or reduce them, excluded due to national regulation or procedures.

Finally Trade Unions put an emphasis on deficits with regard to the extent to which risk assessments are done, to the insufficient use of insights gained from risks assessments to improve the prevention or reduction of OSH hazards stemming from medical sharps or to the insufficient involvement of workers' representatives or competent institutions at the workplace, such as health and safety committees.

The lack of economic resources to provide safe medical sharps in the quality or quantity needed was nearly exclusively mentioned by respondents from Southern, Central or Eastern Europe and a systematic approach to set up uniform systems for the reporting of injuries with medical sharps in a country, however, evolve from the answers as two fields for future action that would increase the positive effect of the Directive. In both cases, a political commitment and investment by governments and/or other public authorities active in the field of OSH would be needed to be able to achieve progress.

It could be considered as encouraging that 16 out of the 27 respondents said they were involved in at least one aspect of the practical transposition of the Directive. This mostly happened with regard to *Clause 7 Information and awareness raising* on how the occupational risks related to injuries and infections by medical sharps could be best prevented or dealt with in case of an injury. Practically speaking social partners either issued own guidance and/or did own campaigns or they were consulted upon the contents of information material produced by governments, government agencies or other public authorities in the field of OSH.

Recent follow-up

Only about a third of the respondents indicated that they had knowledge about recently done or soon planned activities by governments, government agencies or other public authorities in the field of OSH and slightly more than a quarter of the respondents informed that they have been or are being involved in such initiatives. National Social Partners from Cyprus, France, Germany, Spain, Sweden and the United Kingdom – both from employers' organisations and from trade unions – share related documents (listed in **Table 2**). When asked about recently done or soon planned activities by governmental bodies in the field of OSH to improve the prevention or reduction of injuries with medical sharps the replies revealed a positive impact of the Directive when it comes to initiatives linked to *Clause 7 Information and awareness raising* and to *Clause 8 Training*.

Course of action

Following the respondents' identification of the five recurring areas, standardisation of registration, reporting and follow-up systems of injuries with medical sharps primarily highlighted the need for a structured centralised system that, desirably, to a certain extent and time, would become interoperable on a European level. It has to be further investigated whether a bottom-up or top-down approach would be more applicable for implementing such as system while respecting the responsibilities of the Member States in relation to the "organisation and delivery of health services" (5). On the one hand, creating bottom-up approach, including the concerns of the healthcare staff – those who are ultimately affected by medical sharps injuries – can be easily taken into consideration for the practical implementation, whereas a common, minimum set of standard reporting data, established through a European Framework (top-down) needs to be set in place, to ensure interoperability, knowledge exchange and comparability of the collected data, consequently allowing for improved monitoring across the EEA.

Secondly, appropriate and continuous training for healthcare staff, specifically targeted on preventive measures, needs to be made available, irrespectively on the nature of their relation to the healthcare facility. A particular focus, however, needs to be on the training and education of underrepresented groups (such as: trainees, students or interns; newly employed workers; temporary agency staff; part-time staff only working at weekends or at night), who are in fact one of the main groups in contact with medical sharps and consequently suffering from sharps injuries. To take due account of the subsidiarity of each Member States, the funding of the said training needs to be arranged on national level or would need to be requested by national Social Partners or institutions from dedicated European funds. On the same level, the provision and dissemination of information and awareness-raising campaigns was mentioned as a way forward. Joint Social Partner initiatives, also together with other bodies, a European awareness-raising campaign and where decided additional national campaigns were identified as actions that could be implemented. Nevertheless, the key to successful awareness raising is the identification and sharing of best practices, not only within a Member State but also across the EEA. Then Best practices can be presented and exchanged among participants of the European Sectoral Social Dialogue.

Elimination of unsafe procedures and the availability of those devices is yet another key factor in reducing injuries resulting from medical sharps. Taking into consideration the respondents concerns, to achieve the greatest positive effect, healthcare staff from all levels have to be involved in selecting the devices that work for them, as they are the ones using the devices. If healthcare workers are included in the dialogue, they would subsequently feel a greater sense of ownership and responsibility. The same applies to the implementation of risk assessment programmes, which requires both collaborations between employers and employees and regular evaluations by all parties involved.

If all of the above would be taken into consideration, annual reports of medical sharps injuries could be conducted on a national level and consolidated into a European report by relevant European agencies, permitting an improved monitoring on all levels, consequently creating a systematic approach for follow-up and identification of trends and patterns.

Strengths and limitations

The following sub-section highlights the survey's strength and limitations that the European Social Partners encountered during the process.

Firstly, one of the major strength of this enquiry is the approach used to initiate the survey: building on their "ownership" of the Framework Agreement that was transposed into the Directive the national and ESP endeavoured to monitor its implementation in the Member States without external support to start with. Secondly, the outcomes of and insights from the survey as presented in this report are expected to provide further guidance to the European institutions and other relevant stakeholders that are involved in the assessment and evaluation of the present Directive.

The survey targeted national Social Partners that are Members of HOSPEEM or EPSU in the EEA countries, i.e. the sample size is limited. EU or EEA countries that could not be included in the survey because both European Social Partner organisations currently have no (active) national member organisation there are Iceland, Liechtenstein, Hungary and Slovenia. EU MS for which it is not possible to obtain an input although either EPSU or HOSPEEM have a national member organisation are Ireland, Malta, Poland and Slovakia. The Serbian EPSU affiliate only responded to question five[28]. It is noteworthy that responses of one Trade Union or one Employer organisation per country do not necessarily in a comprehensive manner reflect the actual situation of the country in question, limiting the representativity of the outcome of the survey. Furthermore, the lack of available, reliable as well as comparable data from national statistics – e.g. from accident insurance agencies or national health and safety institutions – before and after the survey, limited the conclusions that can be drawn from the analysis on the implementation and use of the Directive and the opportunity to find potential patterns. As reported by many national Social Partners, data on sharps injuries were neither systematically collected prior to the transposition of the Directive into national law nor after the transposition. In order to allow for comparable data, concrete steps to set up uniform and ideally interoperable nation-wide reporting systems would be needed.

Another potential limitation was the approach used to collect the data. Although the ESP have consulted the national Social Partners prior to the publication of the survey over a period of 2 weeks, the ESP, in retrospect could have elaborated on e.g. question 4. This question was limited to a yes / no answer, however, if the ESP would have included a follow-up question on specificities on the national Social Partner involvements in follow-up activities instead of limiting the respondents to a binary response and merely enabling them to upload relevant documents, this could have helped investigating potential patterns of involvement and also identifying best practices to be shared with other national Social Partners for added-value. Additionally, it must be noted that the collection and compilation of the data or of relevant information could not always be conducted first hand by representatives of national member organisations of HOSPEEM and EPSU[29]. In some countries, national employers' organisations are not responsible for the data collection consequently having limited to no access to it.

Lastly, the ESP identified period for collecting and language barriers as potential limitations of the survey. As already described in the methodology section, the survey was available to the national Social Partners over a limited period. Even though all members and affiliates were made aware of the survey, some organisations did not fill in the survey. It needs to be further investigated whether the survey's length of availability impacted the number of responses. Albeit the national Social Partners were given the possibility to answer the survey in their

[28] Serbia currently has the status of a candidate country for the EU.

[29] It was mentioned during the Working Group meeting of the Sectoral Social Dialogue Committee on 4 April 2018 that data and information were also acquired from e.g. social insurances or national agencies working in the field of OSH not only by the Social Partners directly

mother tongue, it has to be acknowledged that either the respondents or the translators were to some extent limited in answering the questions (in particular HOSPEEM members) if this had to be done in English or had the additional hurdle that they needed to translate answers from a draft reply done in the official language of the country into English.

Conclusions and starting points for future (joint) activities and recommendations

The ESP recognised that the adoption and implementation of the Directive were more rapid, and the compliance considered has been more effective when they are involved from the very beginning, creating a sense of ownership. Therefore, practising grassroots level implementation in the field of OSH can be seen as a major justification for the success in the formulation and the support of the implementation. The involvement of the national and the ESP in three regional seminars in 2013 focusing on the implementation of the Directive can be seen as another value-added to the implementation of the Directive.

The Final Report of the first joint project set out key challenges regarding an effective implementation of the Directive that together with the insights from the present survey can serve to identify starting points to propose future joint action by the national and European social partners and recommendations addressed to other EU-level stakeholders.

A general request by HOSPEEM and EPSU to the EC is to conduct their own assessment of the implementation of Directive 2010/32/EU and to elaborate on an implementation report, indicating improvements and still existing problems and how they could be addressed by the EC, national authorities and/or by other relevant stakeholders.

Table 3 summarises possible joint actions and recommendations based on progress and concerns as reported by HOSPEEM members and EPSU affiliates. The ESP would like to stress that the possible joint actions and recommendations as laid out below may have a different relevance for the various countries. EPSU and HOSPEEM and NSPs as well as other relevant stakeholder are invited to engage, discuss and follow-up with further actions.

Table 3 *Possible joint actions and recommendations*

Clauses	Possible joint action points for NSP or ESP	Recommendations to national bodies within EU MS	Recommendations to European institutions
Elimination, prevention and protection	Work with relevant regulatory bodies by sharing the experiences of employers' and trade union representatives and make suggestions based upon their experiences respectively when it comes to the development and/or design of appropriate medical devices, with the aim to prevent and reduce injuries to medical staff. Invite the relevant regulatory bodies to share this information with producers of safety-engineered devices.	Provide sufficient funding for the purchase of quality, safety-engineered medical devices as part of a broader strategy to prevent and reduce OSH hazards and as part of the health budgets[30]	Continue to share information on relevant websites, information and training materials, research, etc. that support a better elimination, prevention and protection against the risk of injuries with medical sharps. For EU-OSHA to consider input received from the ESP in the hospital and healthcare sector for its future work and to put a strong focus on the sector in future Healthy Workplace Campaigns.
	Promote and establish a "no blame culture" in case of injuries and/or infections with medical sharps in all healthcare settings within the context of national legal obligations.	Focus on workers involved in the safe disposal of medical sharps and strengthen for this group relevant prevention measures, to be agreed and implemented by the social partners while respecting the diversity of healthcare settings.	
	Cf. below under "Risk assessment"	Support more uniform procurement rules for medical devices/material to effectively eliminate the risk of injuries with medical sharps and to prevent and protect the workforce and the patients, while respecting national competencies.	
Reporting	Explore opportunities to share knowledge from national reporting procedures and reporting systems – ideally integrated into existing reporting systems on health and safety hazards – on injuries with medical sharps with as little as possible administrative burden that contains	Review national regulation on the recognition of occupational injuries: Would changes in this regard help to reduce the number of under-reported cases?	Support exchange of experience to improve a good and consistent national data basis on the incidence of injuries with medical sharps and on their main causes that ideally could be made in the future more comparable across countries.

[30] This recommendation builds on the insight that we will achieve best results by working together for sound healthy and safe work environments, for the health and safety of the workforce and for the patient safety and on efficient provision of services.

	evidence-based information on their causes motivated by the aim to improve future preventive and protective measures.		
	Promote and establish a “no blame culture” in case of injuries and/or infections with medical sharps in all healthcare settings within the context of national legal obligations.	National governments to provide sufficient investment to build up and/or improve comprehensive systems of reporting for the OSH risks of injuries with medical sharps	
		National governments to elaborate and put into place a comprehensive reporting system with as little as possible additional administrative burden covering all categories of health workers to produce national comparable data which allow for an aggregation at national level and to support sharing of experience at European level.	
Information and awareness raising	Continue with information work and awareness raising as to the risks in relation to injuries with medical sharps, especially towards newly recruited workers.	Support the Social Partners and public authorities in the dissemination and sharing of good practice across the Member States regarding awareness raising as to the risk in relation to medical sharps injuries.	Support national and European social partners with guidance (6) particularly on awareness raising, while respecting national settings.
Risk assessment	Include the risks of exposure to injuries with medical sharps into risk assessment at the level of hospital/health institution.		Support national and European social partners with guidance (6) and adapted EU-level materials on the scope of risk assessment and the effective use and implementation of its results.
	Include into the risk assessment and the analysis of work processes and situations aspects on the concrete handling of the devices by individual health workers/professionals and on organisational and social factors affecting the health and safety of workers and patients.		
	Include publicly available and objective evidence in regard to which (types of) medical devices are effective to achieve the best possible prevention and protection from injuries with medical sharps.		
	Put also a focus on workers involved in the safe disposal of medical sharps, on patient safety and on efficient provision of services.		

	Fully involve existing OSH committees and representatives of the management and of the workers and/or trade unions into such risk assessments.		
Training	Inform all staff about training possibilities, entitlements and responsibilities as well as work with all staff (potentially) exposed to risks due to infections and injuries with medical sharps within the context of national legal obligations. This also covers the use (or non-use) of appropriate equipment, medical devices, etc.	National governments to give sufficient financial support for training measures to prevent and reduce risks of injuries with medical sharps, preferably within a broader setting of CPD (on OSH-related topics).	EU-OSHA (and WHO): Continue to elaborate and promote training material and tools to support a better elimination, prevention and protection against the risk of injuries with medical sharps. For EU-OSHA to consider input received from the ESP in the hospital/healthcare sector for its future work and to put a focus in the sector in future Healthy Workplace Campaigns.
	Put also a focus on workers involved in the safe disposal of medical sharps, on patient safety and on efficient provision of services.		
	Train staff potentially exposed to injuries with medical sharps, initially and in view of updates needed to stay fit for practice.		

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Annex

Annex 1: Questionnaire

Question 1: Effectivity of the directive in the national/ local setting

Are you aware of the effect of the directive in the reduction of risks of health workers resulting from the directive's implementation in your country?

YES / NO

a. Can you provide us with information on the effect of the implementation of the directive in your national/local setting?
   You may indicate any relevant data on the effect on the frequency of injuries, infections, adoption of general and specific preventive measures.

b. Are there reports/assessments by national governments or competent authorities (i.e. healthcare Inspectorate) to provide evidence on the results or effects of the implementation of the directive?

Question 2: Legal transposition

Are you aware of problems concerning the transposition of the Directive 2010/32/EU on the prevention from sharps injuries in the hospital and healthcare sector into your national legal system?

YES / NO

a. Do you have any factual evidence how the transposition has been carried out in your Member State? Did the transposition result in new pieces of national legislation or regulations or was it operated by amending existing national legislation/regulations?
You may include relevant legal documents to support the transposition.

b. If there is/are (a) problem(s) in the legal transposition, what are these problems? Have the national Social Partners been involved? If yes, has their involvement been of assistance to overcome the(se) problem(s)? If no: Why not?

Question 3: Practical transposition

Are you aware of problems in the practical transposition of the Directive 2010/32/EU on the prevention from sharps injuries in the hospital and healthcare sector into the hospital setting?

YES / NO

a. If yes, we would welcome more detailed information by referring to the principles set out in the directive (principles; risk assessment; elimination of dangerous practices, prevention and protection; information and awareness-raising; training; reporting; response and follow-up – set out in clause 4 to 10)

b. If there is/are (a) problem(s) in the practical transposition, what is/are the(se) problem(s) (please refer to one of the clauses 4 to 10) and how has the involvement of the national Social Partners been of assistance to overcome the(se) problem(s)?

c. Have other stakeholders (e.g. professional or scientific groups, work insurance groups etc.) been involved in promoting the practical transposition of the Directive along with the national Social Partners?

Question 4: Recent follow-up

Are you aware of recent (or planned) follow-up initiatives in your Member State to give better effect to the provisions of the directive (e.g. awareness raising campaigns; elaboration of information or training material; provision of training; data collection, etc.)?

YES / NO

a. If yes, have the Social Partners (or employers or trade unions) be involved in the initiative(s)?

b. Relevant documents: Please upload here any documents that might be of interest for the analysis in view of effects for management and/or the workers

Question 5: Course of action

What is for you the most important area/issue covered by the Directive 2010/32/EU on the prevention from sharps injuries in the hospital and healthcare sector where future targeted action by Social Partners could support a more effective prevention and reduction of risks on a national level?

Question 6: Space for additional comments