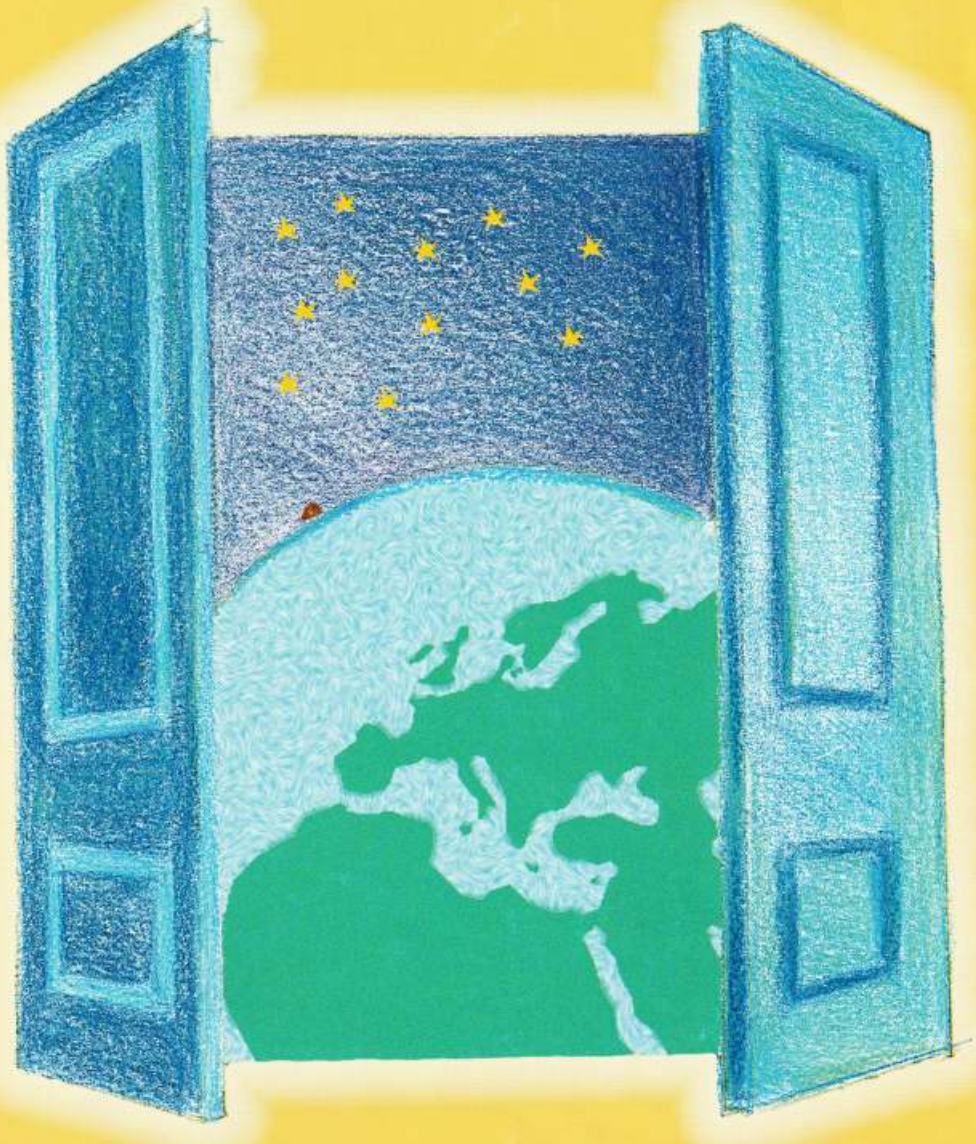
Federation of Occupational Health Nurses within the European Union

Occupational Health in the European Union



This is FOHNEU.....

It is most appropriate that the first FOHNEU Journal should appear this year. 1995 has been a time of reconciliation and remembrance for the sacrifices of an earlier European generation. It is now the task of a new generation to take forward the cause of unity among the nations of Europe.

The formation of the Federation of Occupational Health Nurses within the European Union (FOHNEU), representing as it does some 45.000 nurses in Member States, is the culmination of a decade of striving to bring closer together those whose concern is the health and safety of people in the workplace.
Since the first International Occupational Health Nursing (OHN) Conference in 1986 in Edinburgh, and a number of other events the past decade has been characterised by the growing desire of OHN's to work more closer together. In 1993 the decision at Windsor, England, to form FOHNEU marked the formal beginning of this European movement.
Subsequently FOHNEU's recognition by the European Commission (CEC) together with funding for a programme of action; encouragement from Euro-Members of Parliament and Commissioners, including the office of Jacques Santer President of the CEC, clearly shows that significant progress has been made. More recently FOHNEU has become a Specialist Group of the PCN (the Standing Committee of Nurses in the EU) further demonstration what has been achieved in just over two years.

The report to DG V of the CEC, on FOHNEU's first action programme, draws attention to the specialist Common Core Curriculum presently being considered by ACTN (the Advisory Committee on Nurse training). This could provide a mechanism for basic OHN education and training in most Member States and in other European countries. The PCN put particular emphasis on the latter in its concern for a "Wider Platform for Nurses in Europe".

The first major European OHN Congress, to take place in September 1997 in Brussels, will give further confirmation of FOHNEU's developing significance. The fundamental aim of the Federation is to contribute to improving the health care of people at work. The information shared about conditions of work and the extent to which Europe's nurses can and are playing a part in raising standards will be the ultimate measure of our success.

Frances Baker
President of FOHNEU

Editorial

In 1992 the Dutch Association of Occupational Health Nursing contacted their colleagues in other European countries and produced a magazine with contributions from 12 different nations. In their own words "we want you to get interested in what goes on beyond your own borders".

Before and during that time Europe's occupational health nurses were already meeting to discuss how they could network, co-operate, support and learn from each other in developing quality, cost effective health care for workers within the European Union. Since then progress has been rapid. In 1993 the Federation of Occupational Health Nurses within the European Union (FOHNEU) was formed and is now the main representative body for approximately 45.000 occupational health nurses. It has a constitution, an executive consisting of president, vice-president, secretary and treasurer and all but one Member State has joined. There is a planned programme of work, with financial support from the European Commission.

Now we are delighted to introduce the first FOHNEU Journal. In it we give you a flavour of some of the developments in various countries; topical issues, such as health promotion in the workplace; articles on how individual Member States are implementing EU Directives; and the driving forces influencing health and safety practices and provisions now and in the future.

All articles have been written in English by the occupational health nurse, for many it is not their native language.

Mirjam de Groot - The Netherlands
Charles McK. Graham - United Kingdom

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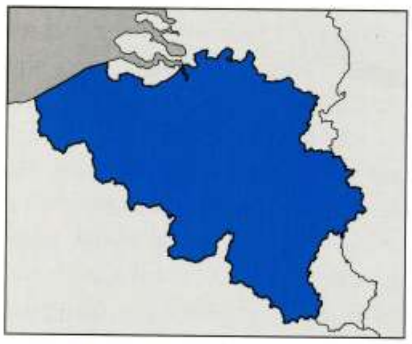


Job evaluation according to physical burden in Belgium

1 Introduction

Problem definition

A fifty-year-old mechanical fitter has worked for 25 years in an oil refinery. Because of the fact that he has suffered from back pathology, the company's medical officer prescribed job modification in order to spare his back.

As a first stage the employee got alternative work in the central workshop. He asked for an interview with the director of the personnel department and complained that this alternative job was still affecting his back and he therefore asked for another job change.
The personnel director asked the medical officer to evaluate the complaint and the situation of the employee.

Contribution of the company's occupational health nurse

The medical officer discussed the problem with the occupational health nurse and asked him to make a job analysis of the employee's job.
Based on the recent text of a law (K.B. of 12.08.1993 concerning the manual handling of loads) the job analysis was discussed in the Medical service. The opinions of the medical officer and the occupational health nurse were taken into consideration.

Methodology

- Consultation of the above mentioned law.
- Evaluating the objective measurement standards, such as the NIOSH-formula.
- Making an appointment with the employee and the head of the central workshop.
- Judging the function description of a mechanical fitter in the workshop.
- Announcing the job analysis.

2 Job analysis

2.1 Job content

2.1.1 Adjusting of valves (levelling and smoothing)
The employee performs this job daily, during a variable period. He uses an abrasive disc and grinding compound. This job demands rotation of the pelvis and the back.

2.1.2 Bundle work (Removing and replacing of tubes)

2.1.3 Using a pneumatic hammer
He sometimes uses a pneumatic hammer (weight 19 kg) while squatting on the ground in order to fasten or loosen nuts.

2.1.4 Test bench for valves
Pushing and pulling, using the fixing bar of the bench in order to fasten or loosen the valve.

2.1.5 Testing of the steam hoses
The rolled hoses, each weighing 17 kg, must be carried to and put on the test bench and must be stacked afterwards.

2.1.6 Manipulating of blind and test flanges
The flanges, each weighing maximum 25 kg, are put on a shelf at a height of 1,40 m.

2.2 Appliances

- Central loading platform, limited in space
- Two mobile hoisting winches
- Various working tables with different heights
- Small transportation carts
- Levers

3 Summary and conclusion

- We can conclude that one can speak of a relative effect on the back, because no weights of more than 25 kg must be handled.
- In consequence as no formal standard exists to list the risks for back injuries the NIOSH formula cannot be used as a guideline to estimate the risks associated with lifting.
- In order to make the job suitable for this employee the following ergonomic measures must be taken:

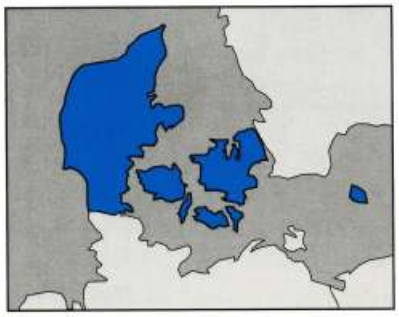
Propositions

- The impact wrench can be replaced by a more modern, lighter model. A suspension system combined with a balance can be provided.
- For the transport of the valves and other heavier pieces, a pallet cart with vertical lifting can be bought.
- The flange standard is now placed at shoulder height, but can be put lower to about 75 cm above ground level.
- For the heavier adaptation work as well as bundle work, electrical devices can be bought.

Note

The K.B. prescribes that the other working conditions must also be guarded. In consequence, when a high noise level is noticed, it is recommended that ear protection be worn. The other parameters were OK, for example the employees involved can more or less control their own work rhythm.

G. van de Vel
Occupational Health Nurse
Fina Refinery Antwerp - Belgium



The creative workshop a pedagogical method of health promotion in Denmark

During several years the Occupational Service of the Danish Asphalt Industry has used a pedagogical method called "the Creative Workshop"

When working with health promotion it is necessary that the persons having problems in their work environment themselves make an effort to improve their own work situation.
This is ensured by the creative workshop where the participants have influence on creating their own working environment. Thus opening the possibility of health promotion. the method can:
- make problems visible
- make participants responsible
- make participants active.

What then is the creative workshop ?
A group of 18 to 20 persons decide on a subject which everyone finds important to deal with. The workshop is devided into three main phases.

In phase 1 - **Criticism** - you look back on the problems which are to be criticized. You then chose to work with the most urgent problems.
The purpose is to critically assess the present situation, e.g. what causes a stain on me, what displeases me. No monologues, only catchwords are to be listed.

In phase 2 - **Imagination** - you deal with chosen problems from phase 1. Here you try to think untraditionally without being hampered by existing limits, obstacles and standards.
The purpose is to change the criticism into positive suggestions. Be open to changes, use your imagination, do not criticise other peoples ideas. Write in short sentences.

In phase 3 - **Strategy** - you assess the possibility of implementation of the suggestions made in phase 2. The purpose is to agree upon a plan of action containing time-limits and persons responsible for the solution of problems.

The creative workshop involves all participants, both employees and employer, and everyone takes part on the same terms, which I think is necessary in order to solve the working environment problems.

My part as an occupational health nurse was to:
- ensure entirety of the method
- keep the aspect of health promotion in view
- give guidelines in the handling of materials
- teach
- ensure a holistic approach
- write down the plan of actions agreed upon.

The following is a description of a team of 20 persons working with epoxy. Due to great routine combined with hard physical work they had a large income.
No one paid any special attention to the working environment. When mixing materials and substances no protective equipment was used, and there was a risk of direct contact with health hazardous substances. Several men had shown signs of exposure to health hazardous substances.

Instructions were insufficient and the workers had only a few product safety data sheets available. Some of the men had worked 2-3 years before they attended the obligatory epoxy course.

Our first meeting lasted 8 hours, and the following annual meetings lasted 4 hours. An occupational health nurse, a chemical engineer and a physiotherapist from the Occupational Health Service took part in the first meeting. As a result of this meeting the problems were listed and a plan of action was decided upon.

At the annual meetings we assessed to see to what extent the plan of action was carried out. Problems from

phase 1 -Criticism- were dealt with and new problems presented. The management was good at indicating what it would be possible to implement before the next meeting.

Some problems were solved at the first meeting, others shortly after, e.g. the missing truck lift, knee-protection when working on the knees, gloves, working clothes and protective clothing.

In the time between the meetings we visited the sites in order to discuss the results with the workers. We found that all epoxy-workers and their employers were active in improving the working environment. For example they were involved in testing protective clothing, and I arranged that different types of disposable suits were tested until we found the most suitable.

Don't eat at the workplace

At one meeting I showed the workers how to wash their hands - everyone found it amusing - but did it. Afterwards I told them about the structure and function of our skin.

In order to sort out the selection of hand cleansers and hand lotions I contacted several suppliers of skin-care proucts and ended up with 1-2 products good enough to be used. At the same time I found 1-2 types of gloves resistant to the hazardous substances.

In connection with the problems of handling the chemical substances I told the workers about the structure and function of our lungs and about the use of respiratory protective equipment. Afterwards the workers worked in groups with the product data safety sheets. During this group work the workers asked that the data sheets be more concrete in order to be able to see precisely what type of protective equipment should be used in a certain situation.

The creative workshop has served its purpose. We have had positive feedback and the participants have gained knowledge of:

- **their health**
- **skin care**
- **protective equipment**
- **product safety data sheets**
- **their responsibility in solving mutual problems jointly**
- **use of their safety team**
- **ventilation systems etc.**

Bodil Bertelsen - Denmark

Workplace survey in Finland

Introduction

The occupational health services in Finland are based on the Occupational Health Care act which came into force in the beginning of 1979. The OH Care Act obligies all employers to organize OH services for all their employees. OH services are one component of preventive health care with the focus on eliminating workrelated health hazards and on preventing harmful impact of work and work environment on employees health.

The employers may, in addition to the obligatory measures defined by the act, also offer voluntary services to their workers. Through the national sickness insurance the employers are reimbursed for 50% of the costs of OH services. The employer can organize the OH services in different ways; establish an OH unit alone or together with other employees or buy the services from a private clinic or a municipal health centre.

The act also defines the personnel carrying out the OH services; as a minimum they are usually carried out by an OH nurse and a physician. The work of the OH nurse in Finland is very independent, naturally working in colla-

boration with the employer, the employees and the safety personnel. This article describes the workplace survey as it functions as a good base when planning health examinations, giving recommendations, suggesting corrective action and different projects at the workplace.

Occupational Hygiene

This area covers ergonomics as well as physical stress factors in the work environment such as noise, lighting, ventilation, temperature and draught, also including chemical exposures and biological health hazards. The OH nurse may and does a lot of workplace surveys on her own using different equipement for monitoring noise, light and temperature. In Finland the ventilation is especially problematic because of the cold winters and warm summers. When the OH nurse has identified the hygienic health hazards at work she gives, when possible, recommendations of how to eliminate or minimise the health hazards. When necessary, the needs of personal protection equipment is also taken into consideration and the OH nurse has a key role in advising the workers how and when to use them.

Physical Health Hazards

During the workplace survey the physical health hazards caused by work are identified as well. Difficult working positions, heavy loads and working methods are notified. By collecting data about locomotor work injuries, diseases and absenteeism the OH nurse gets a good picture of the appearance of physical health hazards at work. The OH nurse may for instance teach how to handle heavy loads and how to plan work breaks in order to decrease physical stress.

Psyco-social Health Hazards

The workplace survey also brings up different psycosocial stress factors in the work environment. The agestructure of the workers, responsibilities at work, working hours are examples of factors that have an impact on the workers health and working ability.
The OH nurse collects data by interviewing the workers; psycological stress affects, however, vary individually. The Finnish workplaces are at the moment undergoing big changes which naturally affect the workers; they feel more insecure at the moment. The OH nurse's role is to support both management and workers by stressing the importancy of an openminded and constant dialogue between management and personnel.

Sociology has become an important part in occupational health. By using different questionnaires the OH nurse estimates the phsycological climate and interpersonal relations at the workplace.

All the collected data is documented by the OH nurse and summarized in a report including suggestions and recommendations for corrective actions. The report is handled in a joint meeting where employers, workers and safety personnel are represented. Plans for further actions and responsabilities are agreed on as well as the schedule for follow-up surveys.

Gegen Streß

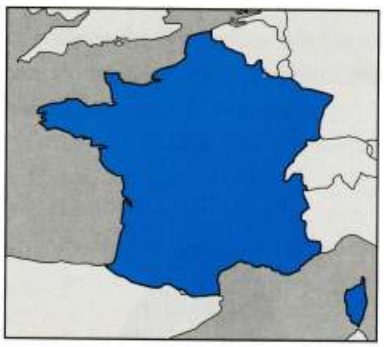
Λιγότερη ένταση και άγχος

Less stress

Le bien-être

A thorough and well performed workplace survey sets a good base for all the activities of the OH nurse. It also helps us all to reach our mutual goal; a healthy, happy and productive worker in a healthy and safe workplace.

Mailis Jaavamo
Anne Boström
The Finnish Association Of
Occupational Health Nurses



Occupational Health Inter-university Diploma Course, (D.I.U.S.T.) Nurse qualification in France

Being responsible for coordinating the teaching of the occupational health interuniversity diploma course, nurse qualification, I feel it is my duty to inform and share with you our enthousiasm.

In actual fact, since january 1995, an occupational health university course is availiable for Occupational Health. Nurses in three universities in France : Lille, Rouen, and Strasbourg.

Composed of modules, the teaching is identical in the three universities and can be achieved in one or two years.

There are six modules lasting 39 hours each, 32 hours are theoretical and 7 hours are allocated to tutorial and practical courses. Each module is taught in each university and lasts one whole week.

Some of the teaching is done by distance learning. In fact national and international experts write courses for each module. These are polycopied and sent to the students in the three universities some time before the begining of each module, thus assuring homogenity and interactive teaching.

Interveners are regional or national experts having practical experience in specific fields. This method is geared towards achieving lively and interactive teaching. The educational aspect is founded on expertise and theoretical grounds.

A three months practical training period is compulsory. This may be done in one's own firm, although students are greatly encouraged to spend at least eight days in another company. The objectives are determined with the course tutor ; they may be discussed with the Occupational Health Physician, and a written report must be presented.

A national assembly of all students, presented as a seminar is organised during the study period.

Each module includes a double validation, to verify knowledge on one hand through short questions and a short dissertation of five to ten pages on the other hand to demonstrate capacity to apply knwoledge. A final dissertation of 30 to 40 pages applying knowledge and objectives to the firm is compulsory to obtain the diploma.

This work is done with the help of a tutor who may be the occupational health physician. A second tutor can be an experienced occupational health nurse or the national course coordinator herself. One strongly hopes that occupational health nurses being trained to day will be future tutors.

The double tutoring O.H.Nurse-O.H.Physician is organised so as to help and support the student, to develop a stronger work relationship and ultimate closer collaboration whilst leaving a certain amount of independance to the nurse.

Studies are organised so as the students get to know and understand first, module one, the working environment, the company, the legal and organisational structure of occupational health, social protection and some sociology. Then in the second module, the student discovers work health equation, identification and measure of health hazards as well as work physiology.
In the third module, work psychology, work related pathology and the external environment.
The fourth and fifth modules are specially centred on occupational health practice , work man adaptation, epidemiology, communication, medical surveillance and so on.
The sixth module is a proficiency course, the student can choose two subjects he wishes to improve.

To register for the diploma course, the nurse must be state registered and hold the occupational first aid instructor's certificate.

It seems essential to offer working professionals specialised education. The occupational health nurse must be an efficient and trained collaborator. One does hope that the diploma will be recognised by national and international authorities so that the French occupational health nurse be accepted and recognised as such, but also for her contribution to maintaining and promoting Man's health at work.

For the first time in France, a specialised and complete training course for occupational health nurse exists and aims at official acknowledgement. The final objective being the occupational health nurse's competence and know how.

We already have the collaboration of international authorities such as W.H.O and I.L.O.

This training course which is also accessible to french speaking occupational health nurses should help to stimulate the building-up of the team occupational health physician/occupational health nurse, technician/engineer,hygienist, of which the occupational health nurse must be the permanent link.

During the first session at each university, students and teachers have been able to enjoy an evening together tasting regional wine and dishes. This evening reinforces the link between students and interveners and gives them a unique opportunity to know each other better.

"To work together it is essential to learn to know each other better".

Half way through the first year, the evaluation of this course seems positive. The 55 students are satisfied with the education contents, the high quality teaching, as well as excellent teachers.

They find the work load important, but armed with enthusiasm and solidarity of the regional groups they should certainly all get their diploma, considering they found the third module already easier than the first two !

May one take this special opportunity to thank all those who have have contributed towards the realisation of this project : The three universities, occupational health professors, occupational health nurse colleagues, occupational health physicians, interveners as well as authors of the various polycopies without forgetting those who have brought financial support

Janine Fanchette
Course coordinator
France

Occupational health nursing in Germany

The Industrial Safety Act (Framework Legislation), passed in 1973, forms the basis for comprehensive technically and medically orientated industrial protection for employees in Germany.
With this Act the legislation body sets out industrial protection practice in legal standards which had already existed and functioned for decades in large undertakings, but with the intention of simultaneously bringing all employees into the fold.
The Act (Industrial Safety Act - ASiG) targets the employer as the person responsible, the latter being obliged to employ qualified specialists and occupational physicians who must freely advise and support him in all questions of safety and health protection within and for the benefit of his company, in their respective specialist fields.
The following are required to participate in complying with the Act: the employer, the employees (works council/ staff committee), occupational safety staff and occupational physicians.

Whilst technically orientated industrial protection is predominantly established within the company itself (operational proximity) it is supported by an external sector-specific technical service provided by the professional associations, the most frequent organisational forms of occupational medical care are;

1 an occupational medical service within the company which employs a full-time occupational health physician specialising in occupational medicine, together with assisting staff;
2 an industry-wide occupational medical service (external centres) supported by the widest spectrum of different agencies, which offers its services to employees;
3 a part-time occupational physician (commissioned by the hour), who must nevertheless specialise in occupational medicine.

Over a period of some years now, item 2 has increasingly become the favoured option, and is already the most frequently encountered form of occupational medical care. As an association we regret this development because of the loss of relationship at the primary level of "company/employee", and because of the emphasis of the EU on comprehensive health protection at the workplace, as has been practised to date in Germany in the sense of a classical model based on technical specialists using technical methods of accident prevention and prevention of occupational diseases.

The doctor carries the responsibility as manager of and contact for the occupational medical service. His job scope and area of responsibility, his specialist training requirements and his further development training are governed by the law.

Important tasks are:

1 giving advice to the employer and the works council/ staff committee, as well as to the persons responsible for industrial protection and health care;
2 monitoring the operation of industrial protection, health care and accident prevention measures in the company; organising first aid; visiting work stations;
3 carrying out examinations and occupational medical assessments, and giving advice to employees;
4 providing everyone in the company with explanations and information on all questions involving industrial protection and health care.

Around 11.000 occupational physicians are currently employed in Germany. Current knowledge indicates that between two and five medical assistants are available to the doctor, depending on the nature and size of the company. The latter are responsible for their own work and are to some extent independent, though they are supervised by the doctor in the specialism in question, who has overall responsibility for them. Their job scope (which is certainly more complex in large companies) extends from administrative and documentation work to assisting with all medical tasks (examinations), to using technical diagnostic equipment independently, and to the provision of first aid, medical care and advice to workers, depending on each occasion on the size of the company and the available medical equipment.
Having reduced the chaos of former occupations, fictitious job titles and staff with training functions, the range of people involved consists of nurses, consulting room assistants (more in external centres), medical technicians and lifesaving first aid attendants. In our estimation the proportion of qualified nursing staff in companies - including the figures for the newly formed German states - amount to around 50 - 60%.

After the coming into force of the Industrial Safety Act (ASiG) in 1974 and after taking stock of the unsatisfactory work situation of employees, our association was founded in the same year. Our main thrust was directed towards further and continuing training, since the abundance of new tasks could not be properly managed with only self-acquired knowledge. At the same time the national nursing associations showed little interest in occupational medicine, which meant that we were establishing an independent organisation. This path was without doubt more difficult than affiliating ourselves to another specialist group. We chose it because problems specific to the work situation arise in practice and no-one will take this work on board if we do not do it ourselves. Our success has shown this view to be correct, having regard also to the EU requirements in this field which have the objective of "prophylaxis for the responsible citizen in the world of work".

Because of the plethora of regulations and laws in this area, the qualified nursing staff, who have a broadly based qualification in nursing and curative skills (oriented towards the patient), are insufficiently qualified to be able to deal with specific tasks which arise. Problems which call for specialist knowledge in workplace assessment, work technology, work rhythms, ergonomics, toxicology or other work factors, are more than doctors' assistants can cope with in the area of occupational medicine. There is a lack of specifically orientated further occupational medical training. Even the (new) German Nursing Care Act does not once mention the term occupational medicine in it's curriculum.

Our aim of legally standardised further training in occupational medicine has not yet been achieved, but we have been able to successfully call into question the term "assisting personnel" used by the legislators in the Industrial Safety Act, and have also been successful in establishing the concept of "occupational medical assistance".

For over 15 years we have been training staff using a "publicly recognized" 160 hour study plan in occupational medicine and law. As an association and for the benefit of our members we also award the association "Specialist Tittle -Occupational Medical Assistant- VAF e.v." on the basis of 288 hours of further training and wide ranging criteria.
The greatest impediment to all our efforts is the lack of a central contact point in Germany. "Not-responsible" is the key phrase to all levels in the jungle of ministerial and institutional "areas of competence". This situation is caused on the one hand by the federal system of the Federal Republic of Germany with it's federal states and their own legislative responsibilities in education and further training, and on the other hand by a regulatory and institutional system within the structure of industrial protection legislation which is not readily comprehensible to the individual.

Unlike the rest of Europe (for example in the Netherlands where the central work inspection authority has primary responsibility), German industrial protection legislation derives from a historical situation governed by decentralized structures. The unique "dual system" (state and professional associations (employer/employee)) functions under the principle of subsidiarity, which dictates that the state (legislature) only takes on board those tasks which cannot be dealt with at subsidiary levels and in respect of which the helpful additional element of self-responsibility is conceded, this process involving a multitude of institutions (employers, employees, federal institutes, professional associations, medical practitioner associations, health and safety at work services, in-house accident insurers, health insurance companies etc.), all of which establish specialist priorities with a

wealth of individual provisions - particularly in their own fields. Because of regulatory activities and the double enactment of legislation, this structured juxtaposition of competing legislative authorities leads on the one hand to effectively rapid and outstanding results in part, but on the other hand - each having regard to it's own sovereignty and with little co-ordination - to fragmentation of the whole, with almost 200 individual provisions which are comprehensible only to specialists and which create passivity amongst those involved.

The accident prevention provisions of the professional associations are thus sector-specific and therefore close to the company, but do not however constitute blanket coverage. Apart from the nursing sector, there is thus no standardised federal regulation for the further training of "curative assistants" and to this extend no central contact point. The structure of Federal German accident insurance business with diverse public accident insurance schemes in federal states and large cities thus for example also serves to hamper the assessment of epidemiological developments in the health service.

The introduction of European directives and standards in Germany calls for changes to all these individual provisions and regulations. A summary of individual laws and the production of a clear national legislative basis to which everyone can orientate themselves has twice been sought on the basis of the "basic law of European industrial protection" (EU Framework Directive 89/391/EEC of 12.6.89) and in the form of an Industrial Protection Framework Act (ASRG), and has been overdue since 1992. We hope that the current quest for new requirement profiles for occupational safety (technology) does not end with the adoption of partial areas of classic occupational and environmental medicine. The German Company for Occupational Medicine is needed.

In a law of 29.7.94, Germany has approved Article no 161 of the International Labour Organisation (ILO) Convention concerning occupational medical services. If the occupational health teams, other than doctors are to be integrated into the job scope of Art. 5, regular further training is required.
It is worth recording the concluding observation of an investigation carried out by the "European Foundation for the Improvement of Living and Working Conditions", Ireland:

"There are few Regulations which relate to occupational health services, in consequence provision is limited. The number of people employed in these services is small whilst appreciation of the problem of "company health promotion" is limited and continues to concentrate more and more on traditional health and safety questions. Further development in this context is to a large extent dependent on the readiness of governments, health services and occupational health establishments to take action".

In other words. for as long as we are employed in the company health service, we are also called upon to play a part. Health and safety questions are here and now and not in health insurance companies and external circles.

Hans Schwertner
Chairman VAF e.v.
Düsseldorf - Germany

Preventive health screening in Greece

According to the Greek legislation (Presidential Decree No. 351/89), the professional responsibilities of the Health Visitors are defined. Because of their education, theoretical as well as practical, Health Visitors are the only branch of health professionals who are entitled to work together with the occupational health physician, in the Occupational Health Services.

Despite the fact that the general principles of the Health Visitors' work are defined in the aforementioned Presidential Decree, there are still several areas that are only vaguely described so that those working in this field many times have to function according to the needs of the moment.

Under such conditions and because of the fact that there is no clearly defined work role for the Health Visitor in the field of occupational health, our framework of activities has been expanded within the lines given to us by some enlightened occupational physicians who collaborated in the past with health visitors. We thus inherited their experience.

Based on that substantial material, in association with the freedom we gained from some employers for new ideas our work today is not much inferior to that of our colleagues in the advanced countries of the European Union, especially those with a history of occupational health services.

The **health screening of workers** is in three categories:

A Pre-employment examinations
B Follow up
C Research of work and working conditions.

A Pre-employment Examination All those who are about to be employed go through a health interview. Before this examination by the occupational health physician, the candidate undergoes a series of tests and the results are recorded by the Health Visitor (occupational health nurse) on a certain form. The health interview includes:

- Personal, family and professional history
- Habits (smoking, alcohol consumption, sports, etc.)
- Blood pressure measurement
- Visual acuity, stereoscopic vision examination and chromatopsy test
- Urine examination
- Chest X-ray (referral to special centre)

In relation to the nature of the work he is going to be employed in, the candidate is submitted to some more specialised tests, performed by the Health Visitor, or he is sent to a special private or state centre.

per example:

a People who are to be employed in environments with high noise levels undergo an audiometric examination
b People who are to be employed as drivers or handlers of elevating machines are submitted to lumbar spine X-rays in collaboration with specialised centres
c People who are going to work in an environment with dust-enzymes or lanuginous materials are submitted to spirometrical tests while particular care is given to those liable to respiratory, dermatological or allergic problems.

After the candidate has gone through all the aforementioned examinations, the occupational health nurse fixes the appointment with the occupational health physician for the clinical examination during which she assists - if necessary -in the evaluation of the results and they decide whether the candidate is employable in that particular post or is to be diverted to another job in accordance, always, with the consensus of the personnel manager.

B Follow-up Examination The Follow-up examination takes place once a year or even more frequently (it depends on the nature and the heaviness of the work). All employed people are submitted to clinical examinations. Before the clinical examination takes place, the same preliminary tests as in the case of pre-employment examination are performed, except chest x-ray and lumbar spine x-ray, which are performed regularly every four or five years.

The occupational health nurse follows up the absentee because of sickness or accident and takes care in order to pass clinical examination all those who return to work after a common illness or a professional accident or disease. Also she insures that people returning from a journey to countries of Latin America, Asia or Africa, are submitted to a medical inspection.

Both pre-employment and follow-up examinations which deal with work and exposure to certain professional

dangers, are the concern of the Health Services. We in Greece are also concerned with prevention in its most widest sense. The care for all tests included in this effort is undertaken by the occupational health nurse, who collaborates either with state or private agencies especially in the following tests:

- Haematology tests, such as glucose, urea, uric acid, cholesterol, triglycerides, total lipids, HDL, LDL, creatine, etc.
- Haemoccult test in men and women (after the age of 40)
- Pap test, breast examination
- Mammography (in women of over 40 years of age)

The occupational health nurse collaborates not only with the occupational health physician but also with specialists of other medical branches when it is necessary, in order to channel people who suffer to the proper agency.

C Research The objective of this research is to get and to keep the ratio between work load and individual strength in balance. research information is gathered in areas like, for example, noise, climate, lighting, and ergonomics.

The functions of the occupational health nurse include: health education, treatment, rehabilitation and the management of the Occupational Health Department.

In conclusion it should be said that the aforementioned model of work is in place in only a limited number of Greek enterprises and is the result of private initiatives.

Kiki Velitzelou - Greece

The occupational health nurse in Ireland

The Republic of Ireland has a population of 5,5 million. There is a large agricultural sector and a growing modern industrial base.

Health Surveillance - the Nurses' Contribution

This article describes the type of health surveillance carried out in an industry that uses high Heat/high Pressure technology together with chemical processes to produce industrial diamond which acts as a superabrasive. The major part of the surveillance is regular health screening for various indicators (described below).

Screening Process

The process of health screening has three main phases:

1 Pre-employment
2 Regular screening - including statutory requirements
3 Exit Medical.

It is on a regular screening that this article concentrates.

The policy of the organisation is to divide employees into different age groups and to provide screening at different intervals for the different groups as follows:

- age 45 and over - every year
- age 38 - 45 - every two years
- age 31 - 38 - every three years
- age under 31 - every four years

In addition employees deemed to be high risk will be screened for that risk annually e.g. noise and dust.

Employees are screened by the Occupational Health Department and this screening is divided into two parts. First is the Biometric screening. This is initiated and carried out by the occupational health nurse and consists of:

- **Audiometry**. This is carried out as a matter of policy on all employees but is a statutory requirement for employees who work in areas where noise levels are 85 dB or over.
- **Vision testing, using Visionaire** - statutory requirement for V.D.U. operators
- **Spirometry**
- **Blood profile which includes:**
  Haematologist
  Biochemical
  Hepatic
  Renal, Lipid profile screening
- **ECG**

The second part of the screening is carried out by the occupational health physician. This consists of detailed medical examination which includes past medical, family, social and work history, a questionnaire review of the body systems over the previous 12 months and a full physical examination.

The results of the screening are used to:

a Identify if there are any adverse findings linked to the workplace.

b As a basis for discussion with each employee by both the doctor and the nurse.

Any abnormal non-occupational findings, such as elevated blood pressure readings are referred to the individuals family doctor with the employees permission, together with the results of all revelant tests.

The Occupational Health Unit

The screening is done on site in a purpose built medical centre. This is staffed by one full time occupational health nurse and by an occupational health physician who attends six hours per week. The analysis on the bloods are carried out at an outside accredited laboratory. The workforce numbers 400 of which 100 are staff while 300 are employed in production and maintenance. The average age is 40.

Health Surveillance leads to Health Promotion

In this organisation the role of the occupational health nurse is multi-facited and the various elements are not easily separated as the above would imply. For example while discussing the screening results this provides an opportunity for the nurse to engage in health promotion with the individual employee. It is normal for this discussion to go beyond strict occupational health issues and into life-style concerns. Thus issues such as smoking, diet, alcohol are discussed. Advice and practical help are offered where appropriate. Issues such as stress whether generated in the home or workplace are discussed and counselling provided either by the nurse or by an outside agency through an Employee Assistance Programme

In addition there is a health and safety education role both by the provision of formal training courses to employees and by regular plant tours. These tours are invaluable in that they provide the opportunity to talk to employees in their own environment, observe them at work and see hazards to which they are exposed. It is also an ideal opportunity to advise them of the importance of observing health and safety regulations e.g. wearing appropriate personal protection equipment. The informal contacts made on such tours do much to develop communications and trust between the employee and the occupational health nurse.

Results of the Screening and Conclusion

The results of the screening over the last 14 years (when the medical unit was set up) is that mainly life-style issues are being identified. Why this is so requires further study. But it is believed to result from preventive measures (including health education) of which the screening process itself is a vital part.

Mary McGee - Ireland

Medical examinations for individual sensitivity

Occupational health nursing in Italy

It is rather difficult to describe the function of the Italian OHN, as we operate at many different levels; in the public sector working in hospital and in private companies working in factories and other organisations.

The OHN qualification does not exist, and the speciality is not officially recognised, by any nursing or medical board. It is left to the individual nurse employed either in the industrial or the public sector to motivate and create a role for herself.

I work as part of a team of three nurses and four doctors in a hospital for the prevention of industrial illness.

Attending the Congress of the OHN at Le Mans was a very small step forward for Italy. In 1993 I was able with the help of professor Gambini, head of my department, to develop a training course to bring nurses working in OH up to date. Unfortunately only nurses employed in the public sector were able to attend this training which took place at my hospital in Novara.

This training course is officially recognized by the state and by the regional health service.

On the strength of this course another training section was organised at a hospital in Cremona, based on the same lines as ours, but with a different prospectus.

For the very first time, my colleagues and I have been able to educate the doctors in the skills which we can offer.

As a result of this course we now accompany the doctors and visit various factories to evaluate risks on the different tasks.

We try to keep up to date with the new legislation and inform all employees, that we come in contact with. We encourage health screening, and educate workers on risk monitoring.

Recently we have started a training course in ergonomics and lifting, for nurses working in general hospitals to prevent back and muscular injuries. We are continuing to try and develop new projects.

The meetings with my European colleagues are motivating me to continue to strive.

The road to an efficient OHN group in Italy is hard and lonely, but I hope that at least, I may be remembered for my efforts.

Gabriella Pecchi - Italy

What's new in Luxemburg

The new law will be the occasion to put a legal view on the existing system in Occupational Health and Safety.

Since June 1994, there is a new law about Occupational Health and Safety. Luxemburg was the last country in the European Union without a specific law on Occupational Health and Safety matters.

Since the 1st of January 1995 the new law is in application. Some companies did not wait for the new law before organizing their own internal Occupational Health and Safety policies.

Companies have the choice of three possibilities:
1 buying into a private Occupational Health organisation
2 creating an inhouse Occupational Health Service
3 becoming affiliated to a Group Occupational Health system.

The problem for occupational health nurses is that nowhere in the new law is there any mention of their function or their responsibilities.

We must be vigilant, we must take our future into our own hands. We need the help and the experience of our European colleagues. We are a small group, working on our own. We need to work together for our future and the future of our colleagues.

We have little time to gain experience. We think it is important to define objectives after looking at the activities of colleagues in other countries.

The first priority is to define what we are, what we want and of what we are capable. What kind of organisation do we want and need and what role do we need to defend in the Occupational Health System ?

We cannot find a definitive answer, but it is evident that we have our own specialities and our own skills. We are not doctors.

It is true that this article is not scientific, but the manner of our reflection can be scientific. We are on the first step of a great adventure. We will collect the maximum of information, at which point we can say thank you FOHNEU.

The next step will be to build a framework. This framework must help us to get to the essence and to avoid being sidetracked.

We must prove that we are able to work in a multidisciplinary team rather than on our own vision. We hope to be working within the Hanasaari model.

Do not leave us alone !!!!

Jacques Rothier - Luxemburg

Implementation of the display screen equipment directive in The Netherlands

The role of Dutch occupational health nurses may be summarised as follows:

a Assessment of occupational health risks taking into consideration the demands of the job, potential health risks and the physical and mental capacity of the individual.
b Research into the working environment and early detection of occupational ill health trend or effects.
c Health promotion and health education.
d Advice and consultation with managers, other occupational health practitioners and workers.
e Health surveillance, health screening and, where appropriate, medical examinations.

It is evident that not all of these tasks can be performed by the occupational health nurse alone. Developments in The Netherlands means that there is an integrated, multidisciplinary team approval in delivering the most cost-effective occupational health care.

The occupational health nurse (OHN) is more and more involved in prevention, advising managers, co-ordinating company health and safety policies and ensuring that European Union health and safety directives are implemented. One such directive is the Display Screen Equipment Directive.
The Netherlands has the resolution "Working with VDU's". These minimum requirements are what will be used in this article to make an inventory and map out the health and safety hazards for VDU workers.

The approach to this problem is structural.

1 During the first meeting between management and the working-conditions co-ordinator an implementation plan from start to finish of the project is discussed - health and safety hazards involved, involvement of which OH specialists, assessment of needs, reporting and evaluation.

2 All management involved in the project receive information from OHN and OHP concerning implementation, planning and the consequences of possible future investment to acquire optimal working conditions.

3 The OHN informs all employees of the coming project and a questionnaire is given to all who work with VDU's for more than two hours a day.

4 With the information obtained through the questionnaire a visit is made by the OHN to each individual VDU-worker at his place of work. With the help of a checklist an inventory is made of all hazards.

The summing up of the possible hazards will be very compact as the length of this article is limited.

Concerning hazards:

4.1 The work-environment

- Working space
  - The workplace dimensions available must be sufficient to make body movements possible.
- Lighting
  - Light must be between 200 and 1000 Lux
  - Annoying reflection should be avoided by using the right screen light.
  - The brightness proportion between workplace environment - VDU screen background and the text must be correct.
  - Windows must have appropriate sunshades.
  - A VDU should never be placed in front or near a window.
- Noise
  - Attention disturbing noises should be avoided (ex. talking).
  - Printers should be kept in a different room.
- Climate
  - There are many complaints in offices, such as too dry, draughty, too hot or too cold.
  - It is necessary to check that the workroom can be properly ventilated and that the temperature can be regulated for individual offices.

4.2 Workplace set-up

- VDU
  - Check that the screen is straight in front of the worker and at eye height.
- Furniture & Accessories
  - Chair: height - backrest - armrest all adjustable, a safe construction with 5 wheels.
- Worktable
  - Required measurements (120 x 80 cm), adjustable height, footrest.
  - Available document holder
  - Good work posture.

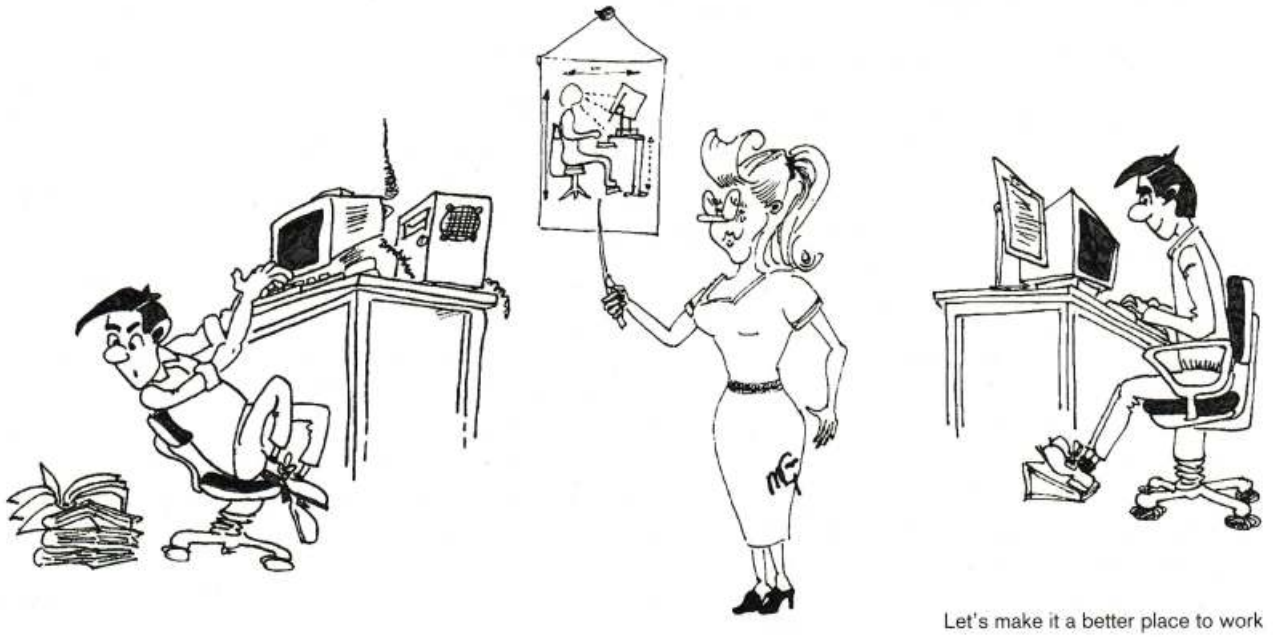
- Checklist for possible neck, back, wrist, fingers or eye complaints.

During the survey the individual employee is informed on how to adjust his workplace set-up to a maximal comfortable position, and that it is advisable to have a short break every 1,5 to 2 hours.

5 A short briefing to management by the OHN follows, giving a summary of survey findings and questionnaire responses.

My experience shows that VDU workplaces frequently do not fulfil the legal requirements. But with a little financial input and good OHNursing advice many hazards can be corrected and healthy and safe working conditions ensured.

With this preventive approach procedures are carried out in such a way that maximum results are achieved.



Let's make it a better place to work

6 Employees are invited for a periodic eye-examination attuned to VDU requirements. These results are discussed with the OHP and when necessary referral to specialists can follow.

7 The concept report is discussed by the OH Team (OHP, OHN, Safety & Hygienist).
After discussion of the final report between management and the co-ordinator, a plan of implementation for resolving the problems is put together and approved. Here it is essential to fix dates within which this must be accomplished, which resources are needed, etc.. etc..

8 The OHN then informs all involved employees on the results of the project and future plans for problem-solving. She will finish her counselling with a video presentation concerning the VDU workplace and work posture.

9 Follow-up of the implementation is required.

10 Evaluation by the OHTeam involved in the project provides quality assurance.

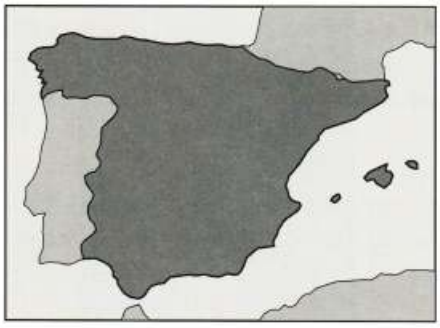
Plan-check-evaluate. The OHN can take care of all the activities involved. If necessary she can consult other members of the OH Team.

Finally

It goes without saying that appropriate education and training is needed if the OHN is to carry out this project independently. Her degree of competence must be maintained at a high level.

In the Netherlands OHN certification came into effect in 1993. The many training courses for OHNurses are evaluated against certification requirements. This way we hope to a guarantee that all trained OHNurses have obtained qualified competence.

Mirjam de Groot
Occupational Health Services GGD ZZL - The Netherlands



Occupational health nursing in Spain

Spain is at the moment implementing the EC Directive of 1989 on occupational health risks.

There are 165.000 nurses in Spain (but these are not occupational health specialists). 83% of nurses are employed in public health occupations and some 70% of them work in hospitals. It is here where the working conditions of nurses have caused the most criticism and where there are high levels of absenteeism.

In Spain there is no specialised occupational health service but there is the officially recognised title of Nursing Technical Assistant (ATS) which was established in 1959. Integration of occupational health nursing in multi-disciplinary professional teams is an established fact but the law to institutionalise this is still to be passed through Parliament.

Spain consists of autonomous regions and within the National Health System (SNS) there are important regional variations. Thus regional governments in areas like Catalonia, Galatia, Andalucia and the Basque Country have their own administration whereas areas like Catabria, Asturia (both in northern Spain) and Madrid are still administered by the central Government on health matters.

Since January 1994 a multi-disciplinary team including three nurses has been carrying out research into the work of nurses who are doing occupational health work.

At present we have three specialist occupational health institutes - in Navarra, Valencia and the Basque Country.

There is a central committee for occupational health as well as for occupational health hygiene. Safety committees with representatives from employers and the trade unions are also a feature of Spanish Health and Safety Organisation.

Isabel Esquiroz Ayesa - Spain

Occupational health nursing in Sweden

In Sweden the Occupational Health Services were built up very quickly from 1970 to the mid 80's. Almost all workers were covered by OH services. Since 1985 however, the general economic situation has changed dramatically.

The OH system was built up partly with economic support from the government. In 1992 the government decided to withdraw its support. This meant that financial income suddenly fell by 30%. The OH services now have to handle their own economic situation just like other companies. Consequently the number of employees in the OH business has decreased from 10.000 to 7.000 over the past three years.

The effect of this in the OH company I work for, called Vårgårdahälsan, is that the number of OH practitioners employed has changed:

	1992	1995
OH nurse	1	1
OH physician	0,4	0,3
physiotherapist	1	0,4
safety engineer	1	0,2
secretary	1	0,8
social scientist	-	0,2

We have as clients 26 different companies with between 10 and 360 employees and the local council with 700 people in 10 different departments. The total number we serve is 1800.

As an occupational health nurse I visit every company and municipal department at least once a month to discuss the general problems with the managers, visit the workshops alone or with the foremen and talk with the workers to identify early warning signals and hazards.

When one of "my" companies has a technical/medical problem I am contacted. Together with the safety engineer, the physiotherapist or the social scientist we visit the workplace and I make a proposal to the company on how to solve the problem.

Every day I get a number of visits and phone calls from workers and employees in "my" companies for medical treatment and counselling in personal matters connected with their work. Of course, as a professional, I am obliged to observe confidentiality.

In my office I do medical check-ups and questionnaires for all the people in a company. The results form a basis for the planning of preventive health care projects such as health promotion, company organisation and working environment projects.

An important task is rehabilitation to allow people to return to normal work. In Sweden the company is obliged by law to draw up a rehabilitation plan for each worker who has had more than four weeks sick leave. I am the co-ordinator between the person involved, the company, the social authorities and my fellow practitioners.

I am also responsible for the planning and education of industrial first aid in the companies.
Altogether it makes a full time job!

Birgitta Oberger
Vårgårdahälsan - Sweden

Occupational health nursing in the United Kingdom

Wales, Scotland, Northern Ireland and England are the four countries within the United Kingdom. While each has its own distinctive culture they all share the same health and safety laws and a similar nursing education system.

Even though there are no legal duties on employers to provide occupational health services in the UK, occupational health nurses have been employed within the four countries for over a hundred years. Today they are increasingly taking a leadership role and often the occupational health nurse manages a multi-disciplinery team of nurses, doctor, hygienist and safety engineer. Prevention is a key role for the occupational health nurse and health education with positive health promotion is one aspect of this. What follows is a description of an intervention programme to improve workers health.

The introduction of a smoking/no smoking policy in the workplace

Expert opinion has, for a considerable time, been in agreement that smoking is by far the most significant course of preventable illness. In Scotland, which has one of the highest incidences in the Western world of smoking related illness, a workplace policy on smoking is thus of particular relevance. In the United Kingdom 60% of the adult population are non-smokers and their interests have to be considered, as well as those of the minority who still smoke, and a balance has to be created between the two groups.

There is also increasing concern at the possible harmful effects of passive smoking. Consequently smoking may not just be a habit which can irritate or annoy others in the vicinity of the smoker, but may also be harming their health. The argument for having a policy could therefore be summarised as "whether people smoke or not is a personal choice, but where people smoke is of public concern".

As with so much in the realm of health promotion the occupational health nurse had a significant part to play in a policy whose aims were to:

1 Improve the workplace environment by reducing the amount of smoking
2 Assist smokers who wish to stop by providing them with guidance and practical assistance.

Initial steps included making places where food was served or consumed no-smoking areas; the sale of tobacco on company premises ceased; smoking was prohibited on all lifts; smoking was discouraged at meetings.

Employees were also given the opportunity to consider how the policy could be further implemented in their own work locations. Possible options were:

- smoking totally banned
- smoking restricted to specific times of the day
- smoking restricted to particular parts of the working area if this was possible

- smoking discouraged by displaying signs etc. but not specifically forbidden.

After a 12 month period, using the technique of a random sample questionnaire, the views of employees on the effectiveness of the policy and their opinion on the need for possible changes were obtained. The subsequent conclusion was that the existing policy was ineffective and that stronger measures needed to be adopted. Added impetus had come from a variety of scientific documents such as the Fourth Report of the Independent Scientific Committee on "Smoking and Health" which highlighted the particular hazard of side-stream smoking; and wider initiatives such as the 1989 EEC resolution inviting member states to ban smoking in public places. Moreover a report entitled "Passive Smoking" published by the Imperial Cancer Research Fund in 1991, concluded that passive smoking was a proven hazard and that employees should respond quickly to the scientific evidence rather than wait for the inevitable claims likely to occur under the existing Health & Safety Legislation.

HELPING YOU TO GIVE UP SMOKING

A management decision was taken in consultation with the trade unions to introduce a "No Smoking Policy" affecting all company employees in Scotland. Under the policy which would be monitored and introduced on a phased basis over a 12 month period, smoking would be prohibited on all the regions' premises except for designated smoking areas. It was recognised that some employees would have difficulty in altering their smoking habits or indeed trying to stop smoking. In both situations the contribution of the occupational health nurses would be essential.

In the lead up period, health education materials were distributed, and in this second phase the momentum gathered pace. A poster with a strong Scottish flavour "Going, Going, Gone', devised by the occupational health nurses, was displayed in all work locations. Individual and group counselling sessions were organised and delivered in company time. During these sessions information was given on the effects of smoking on health and how to go about stopping. A variety of teaching methods were adopted including video presentation. Any employee seeking assistance was given a copy of GASP, a cartoon illustrated booklet in diary form. This was intended to form the basis of a cessation programme and aimed at taking people through the various stages of stopping. Any employee requiring information, advice or assistance was able to obtain it by contacting their local occupational health nurse who was the designated person to be approached if help was needed.

At the counselling sessions strategies were discussed, either individually or in groups, about how best to achieve reduction or cessation of smoking. Health checks were offered with weight, blood pressure, and lung function being recorded and monitored on subsequent occasions. Each session lasted 1/2 hr and group size was limited to 6 members. These meetings provided an opportunity for the sharing of coping mechanisms together with other strategic hints and ideas.

In addition to the counselling sessions, courses of NICORETTE chewing gum were made available where appropriate, the cost being met by the company. Acupuncture therapy was also provided, when requested, by a member of the occupational health nursing team.

During the year when the NO SMOKING at work policy was being phased in, support from the occupational health team was on-going. All employees who had sought help were followed up at 3,6 and 12 month intervals. One year later, analysis of results demonstrated that 60% of this group has substantially reduced their intake of tobacco and 13% had completely given up smoking. A potentially controversial policy reconciling the needs of smokers and non-smokers, had been successfully introduced in a constructive manner, through the significant involvement of the occupational health nursing team.

Frances T.J.Baker - United Kingdom

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EURO NEWS - An overview of Health and Safety within the European Union

The European Commission (CEC) published a consultative document (The "General Framework for Action") in November 1993 setting out the CEC strategy for health and safety at work from 1994 to the year 2000. It was recognised that an important stage had been reached with the adoption of a large number of health and safety Directives between 1987 and 1994. The consultative exercise was to allow Community institutions, Member States and Social Partners (employers, unions etc.) to express their views and concerns on these directives and proposals for future action. These views were taken into account by the CEC when it drew up the Fourth Action Programme.

The objective of the CEC's policy in health and safety at work, over the last 30 years, has been to reduce to a minimum both occupational diseases and work accidents. Statistics from the Member States show that even today accidents and occupational diseases are still too high. Each year there are 10 million sufferers out of a Community workforce of over 120 millios. The money paid out in 1991, as a direct consequence, was estimated at 26.000 million ecus. This sum does not take into account the indirect costs such as lost time, increased administrative costs or damage to equipment. There are therefore strong economic as well as human factors to be considered in seeking to make the workplace a healthier and safer environment.

It is now recognised and accepted that there is a need to ensure a correct and consistent implementation of the large amount of Community health and safety legislation introduced over the past few years. There must be adequate controls and monitoring procedures. Some Directives need to be updated, extended or amended in the light of new knowledge, to remedy shortcomings or to fit into the CEC's own future work. The period up to the year 2000 will be one of consolidation and rationalisation. The Commission's 4th Action Programme, agreed by the European commissioners and published in the Official Journal of the European Community, is set out in eleven separate "Actions" under three broad headings: **1 non-legislative measures; 2 existing and new legislative measures** and **3 health and safety in other EC policies.** Occupational health and safety practitioners are encouraged to obtain copies to see how their own action plans, to secure healthier and safer working environment, fit in with the CEC's Programme.

The European Council's Regulation establishing a European Agency for Health and Safety at work was formally adopted on 18 July 1994. The objectives of the Agency are to promote improvements in health and safety at work by raising awareness and improving the availability of health and safety information. It will supply the Community institutions, Member States and those involved in the field of health and safety at work, with technical, scientific and economic information. It will assess the impact of health and safety legislation on enterprises, especially small and medium sized companies and encourage the exchange of experts between Member States. The Agency's work will also include setting up a network to provide and disseminate relevant information within the European Union, and to co-operate with other countries and organisations. This Agency will have a key role to play in Community health and safety matters in the future.

Attention is also drawn to another institution with which some readers may not be familiar. The European Foundation for the Improvement of Living and Working Conditions is based in Dublin, Ireland and is funded by the European Union. Foundation news bulletins are produced regularly and give details of its work including publications. Recently it has produced two prototype bulletins antitled "euro Review- on research in health and safety at work" and is seeking readers opinion on them.

Finally I would mention "Janus" a quartely European Commission publication giving news and views on health and safety issues across the Community. It is available on subscription and published in most EU languages.

It will be interesting to see how the work of the Foundation, the new Agency, and the CEC's Advisory Committee on occupational health and safety develops in the coming months and years. Details on how to contact the Foundation or subscribe to Janus are given in the list of correspondance addresses.

Charles McK. Graham - United Kingdom

Nursing news

FOHNEU/EUROHNET

There has been some confusion amongst occupational health nurses (OHNS) as to the distinctions between FOHNEU and EUROHNET, and suggestions that they might be duplicating each others efforts.

FOHNEU is an OHN organisation which comprises representatives of national associations from each Member State of the European Union.

EUROHNET is a peer group network of occupational health nursing teachers and others concerned with education, training and general professional development of occupational health nurses.
Membership is on an individual basis, members do not represent particular organisations. At the moment EUROHNET has 36 members from 12 European countries most of whom are OHNS. In countries outwith the European Union where there is no OHN educational provision members of EUROHNET who are not currently teaching nurses have a particular interest in offering appropriate assistance. In this context EUROHNET aims to offer support to practising and prospective OHN teachers; to enable members to help and support each other; to enable members to exchange ideas on training initiatives and related matters and learn from each others programmes and experiences; and to support the development of occupational health nursing qualifications in wider Europe. EUROHNET organises workshops and other meetings and publishes a Newsletter twice a year. It is affiliated to the Scientific Committee on Education and Training of the International Commission on Occupational Health (ICOH).

There will be areas of overlap between the work of the two organisations but both are seeking to advance the professional development of OHNS and co-operate where possible. A dialogue between the two groups has been established.

Kitta Rossi (EUROHNET), Mirjam de Groot (FOHNEU)

The International Commission on Occupational Health

The International Commission on Occupational Health (ICOH) is an organisation whose aims are to foster the scientific progress, knowledge and development of occupational health and safety in all its aspects. It was founded in 1906 and today is the world's leading international scientific society in the field of occupational health with a membership of 1.600 professionals from 79 countries. The ICOH is recognised by the United Nations as a Non-Governmental Organisation (NGO) and has a close working relationship in particular with ILO, WHO, UNEP, CEC, and ISSA. Its official languages are English and French. The most visible activities of ICOH are the triennial World Congresses on Occupational Health, which are usually attended by some 2.500 participants. ICOH has 27 Scientific Committees one of which is the Scientific Committee on Occupational Health Nursing and additionally ICOH issues a **Bilingual Quarterly Newsletter** which contains congress reports, reviews of publications, a list of coming events, information on research and education, and other relevant announcements.

The Scientific Committee on Occupational Health Nursing

The Scientific Committee on Occupational Health Nursing (SCOHN) was established during the 1966 ICOH meeting in Vienna and has made major contributions to the practice of occupational health nursing internationally through:

- meetings which share and discuss aspects of occupational health nursing management, practice, education and research;
- publication of documents relating to occupational health nursing;
- research into issues relating to occupational health nursing practice and education.

Seminars and meetings organized by SCOHN have taken place at each triennial congress and have also been held in UK ('69), Bulgaria ('71), USA ('80), UK ('82), Sweden ('86), Nigeria ('88), Wales ('91), and Jamaica ('95).

There has been a nurse member of the ICOH board continuously since 1972 and SCOHN has published 8 reports/proceedings in the Series: (1) The Nurses' Contribution to the Health of the Worker, as follows (2) Edu-

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On behalf of SCOHN, Kitta Rossi - Finland

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Message from commissioner Padraig Flynn to the federation of occupational health nurses within the European Union

I would like to wish your Federation every success on the occasion of your Luxembourg meeting. There is clear scope for improving the effectiveness of occupational health care through closer links between practitioners in the various Member States in the EU. Your meeting will further encourage these closer links.

Occupational health nurses play the key role in the delivery of safety and health care in the workplace. They are the interface between workers and the necessity to ensure the application of high health and safety standards. Without their dedication and commitment, the effectiveness of the standards implemented by the Commission and the Member States would be severely compromised. Occupational health nurses also have first hand experience of how our legislation is functioning in the workplace. They are first to spot new and emerging occupational and health care problems.

The foundation of the Federation has ensured that this valuable expertise and experience can be shared with a wider audience of safety and health care professionals. The Commission can only encourage such developments and I would like therefore to convey my appreciation of your invaluable work.

FOHNEU congress 1997

Greetings from the Netherlands and Belgium national associations of occupational health nurses. We want to tell you about an exciting event in the future. Our national associations are very proud and honoured that our bid to host the first FOHNEU Congress has been successful. The other venues that were considered were Denmark and Spain. It will be held in the beautiful city of Brussels on 10, 11 and 12 September 1997. We look forward to welcoming you there when there will be opportunity to discuss international professional developments; to look at new ideas and strategies in the delivery of quality, cost effective workplace health care. The emphasis during the conference will be on networking and future co-operation so please put the dates in your diaries and come and join us. There will be further announcements and information in the health and safety press and at other conferences.

Rob van Soest, Chairman of the Dutch Association of Occupational Health Nurses,
Geert Sambaer, Chairman of the Belgian Association of Occupational Health Nurses

Colophon

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Editors
Charles Graham
Mirjam de Groot

Editorial assistant
Frances Baker
Pina van Dorpe
Janine Fanchette
René Kolhoop

Translators
Marja Bakker
Betty van Dorpe
Josette Moresi
Barbara Seggewiss
Colette Verboven

Front cover
Julie Staun

Illustrators
Raymond Stijns
Peter Koomen

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FOHNEU secretariat
Frances Baker
Lothian Occupational Health
Research Project
26/28 Albany Street
Edinburgh EH1 3 QH
Scotland
United Kingdom

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