

# Workability

Injured, ill and disabled nurses can return to work

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1

# Workability

*Injured, ill and disabled nurses can return to work*

## **Foreword by the RCN General Secretary Christine Hancock**

Nurses are a very precious asset to the health of the nation. The health and well being of nurses as individuals, and of the nursing workforce as a whole is crucial to the delivery of high quality care. This was a founding principle of the Royal College of Nursing in 1916 and has underpinned our work ever since.

Our *Working Well* campaign aims to improve the physical environment in which nurses work, and to assist nurses to fulfil their career aspirations. A vital part of this campaign is to look at those nurses who are not working because of injury or illness – some of which may have actually been caused by their work – or disability. With good strategies for rehabilitation, many of these nurses could return to work. Good practice in rehabilitation need not be expensive; sometimes it is just a matter of common sense and making the best use of local resources.

This pack gives practical suggestions that occupational health nurses, managers, and health and safety representatives can use to develop good local practice in rehabilitation. Nurses who are ill, injured or disabled will also find it a useful source of information.

We cannot afford to waste the skills and knowledge of a single nurse, if we can avoid it. Through campaigning and good local policies, the success stories that we have used to illustrate this information pack can be repeated many times over to help ill, injured and disabled nurses back to work.



Christine Hancock  
General Secretary

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## Workability – what’s in it for my organisation?

### The advantages of having a positive approach to rehabilitation

#### Reducing the financial cost of sickness absence

Illness and work-related injury have direct and indirect costs for employers and employees.

Direct and indirect costs to the employer include:

- ◆ occupational sick pay
- ◆ replacement staff costs (agency fees, training)
- ◆ management time (investigation, managing sickness absence)
- ◆ compensation and damages
- ◆ insurance and legal costs
- ◆ loss of skilled and committed staff
- ◆ reduced commitment and productivity, low morale.

Costs to the employee include:

- ◆ loss of physical or mental health and fitness
- ◆ loss of social and psychological well-being
- ◆ actual financial loss
- ◆ potential future financial loss.

#### How much does all this cost?

There is no one reliable estimate for the cost of sickness absence. West (1998) drew together a range of figures from different studies, adjusted for inflation that reflected the NHS workforce in England. These included:

- ◆ sickness among nurses (England) £90.5 million annually

- ◆ back injuries (all NHS staff, England) £73.5 million annually, plus replacement staff costs of £52.5 million annually
- ◆ accident-related early retirements (NHS, England) £71 million annually.

These figures are an obvious argument for interventions to prevent work-related accidents and illness. But they also suggest that early, workplace-focussed rehabilitation programmes could reduce the costs of ill-health retirement, permanent replacement of staff, and long-term sickness absence.

Early intervention and planned rehabilitation programmes, particularly in cases of musculo-skeletal injury and stress-related illness, have been shown to reduce the length of sickness absence and diminish the likelihood of subsequent “relapse” (Malcolm, 1993; Haig et al, 1990).

#### Other benefits

Occupational rehabilitation is the process of assisting a person back into the workplace as soon as possible, at the highest possible level of function.

It’s a managed, multi-disciplinary process. It demands that occupational health staff, personnel specialists, managers, employees and their representatives work together to establish a realistic local policy, and to monitor its implementation. This can build team-working skills and give a real sense of achievement.

The development and implementation of a rehabilitation strategy can also demonstrate that the employer is committed to fairness at work for ill, injured and disabled employees. This has value for existing employees, and can also be effective when recruiting to new or vacant posts.

If there is no consistent rehabilitation policy, it is easy for misunderstandings to occur between the different groups involved. For example, the employer has a statutory role in meeting the requirements of the Disability Discrimination Act 1995, and the occupational health staff have a responsibility to maintain confidentiality. However, an employee may feel unsupported by her manager, and the safety representative may believe that wider issues of prevention of work-related illness are ignored.

The process of establishing a policy allows conflicts to be resolved and for a common understanding and shared responsibility. However, the occupational health

department should have the overall responsibility for the policy.

In summary, the employer benefits from:

- ◆ effective use of resources
- ◆ demonstrating a commitment to staff
- ◆ reduced sickness absence costs
- ◆ learning about an enabling, rather than disabling culture
- ◆ enhanced performance skills and productivity
- ◆ reduced risk of litigation
- ◆ improved staff awareness of the causes of work-related illness and injury.

### The principles of rehabilitation

- 1 Maintaining an ill, injured or disabled employee in meaningful work at the maximum level of functioning is the primary goal in:
  - ◆ the same job
  - ◆ the same job with reasonable adjustments
  - ◆ a new job with the same employer.
- 2 Commitment by all parties is essential.
- 3 Rehabilitation should begin as early as possible (subject to medical opinion).
- 4 The employee must play an active, empowered role in the process.
- 5 Information should be treated confidentially and only used for the purpose for which it was supplied.
- 6 No employee should suffer financial disadvantage when in a rehabilitation programme - for example, by loss of shift enhancements.
- 7 Rehabilitation is most effective when linked to a work-based occupational health and safety programme.
- 8 An individual's rehabilitation programme must be monitored by the occupational health service and reviewed at regular intervals by all involved.
- 9 An individual's programme should not be based on diagnosis alone, but on an individual assessment of capability.

### What services may be required?

- ◆ physiotherapy
- ◆ occupational therapy
- ◆ counselling services
- ◆ job design/ergonomic assessment
- ◆ workplace assessment
- ◆ provision to make reasonable adjustments under the Disability Discrimination Act
- ◆ phased or gradual re-introduction to work
- ◆ access to specialist advice from the Department of Employment, disability advisers, and specialist groups concerned with particular medical conditions or disabilities
- ◆ access to other specialist NHS services such as diagnostic, orthopaedic, mental health and others if the employer does not provide these, or if the employee prefers not to use in-house services for reasons of confidentiality
- ◆ advice on grants, welfare benefits and retraining opportunities.

### How to go about it?

The first step is to gain the commitment of all interested parties:

- ◆ occupational health staff
- ◆ personnel specialists
- ◆ managers in key organisational roles
- ◆ health and safety representatives
- ◆ employees and their representatives.

Then identify the elements of your policy:

- ◆ overall philosophy of the organisation
- ◆ aims and objectives
- ◆ eligibility criteria
- ◆ confidentiality and security of information
- ◆ mechanisms for resolving disputes in the application of the policy
- ◆ accountability of each of the parties involved
- ◆ budgetary and resource responsibilities.

Then assess employee and organisational needs:

- ◆ sickness absence – what is the current cost locally?

- ◆ what types of ill health and sickness absence are the most problematic?
- ◆ what are you already doing in this area? How effective is it? How well has it been evaluated? Could it be built upon?
- ◆ what resources are there locally outside the organisation that can offer financial help, advice, information?
- ◆ what are the gaps in your provision?
- ◆ from this, can you prioritise the demands?
- ◆ what are the financial and other resources needed to meet the demands?
- ◆ can your staff deliver what is required? In particular, can your occupational health staff meet the demands from their existing resources, or will additional training or finance be needed?

Once this information has been collected and analysed, it should be possible to draw up an overall rehabilitation strategy and define the elements of a rehabilitation programme for an individual employee.

### How might this work in practice for an individual employee?

This is an outline of the process, indicating the key actions necessary at each stage and the allocation of responsibility.

- 1 Initiation of the process  
*occupational health staff give information to employee and obtain consent to consult appropriate manager*
- 2 Assessment of suitability to participate  
*employee agrees to participate and is assessed as suitable by occupational health staff*
- 3 Assessment of individual abilities  
*occupational health staff in conjunction with specialist advisers if needed*
- 4 Assessment of current post and its demands  
*employee, line manager and occupational health staff*
- 5 Is job modification or redeployment needed?  
*all parties, including personnel staff, to discuss and agree*
- 6 Identification of action needed and agreed goals  
*all parties*
- 7 Monitoring and review  
*all parties to agree a time span and frequency of review*
- 8 Evaluation

### In summary

Effective, planned rehabilitation strategies have financial and organisational benefits for the employer, and financial and psychological benefits for the employee.

Rehabilitation is a managed process requiring commitment from all parties. Early intervention, individual assessment and maximising an employee's level of function in meaningful work are essential to the process.

It is important that a realistic policy is agreed, implemented and reviewed at local level.

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## What must employers do by law?

### The Disability Discrimination Act 1995

The key purpose of this law is to prevent discrimination and disadvantage to those with a disability. An employee who believes that the employer has breached the provisions of the Act may complain to an Employment Tribunal.

This is a summary of the main provisions of the Act that relate to employment.

Nursing students are not counted as employees in the Act, but the RCN believes that the same framework should be used in recruitment to nurse education programmes or if a student becomes disabled during training.

The Department for Education and Employment has published a *Code of Practice for Employers on the Implementation of the Act*.

#### Why is this relevant to rehabilitation?

An employer must not treat a disabled person, whether already in employment or seeking employment, less favourably than someone who is not disabled.

If there are any physical features of the premises or the job, which could cause a substantial disadvantage to a disabled person, the employer must make reasonable adjustment to allow that person to do the job.

Reasonable adjustments could include making alterations to premises, allocating job duties differently, redeployment to another job, acquiring or modifying equipment, additional training, allowing time for rehabilitation, assessment or treatment.

The cost, effectiveness, or difficulty of making adaptations can be taken into account when deciding whether adaptations can reasonably be carried out.

#### What does the term disability cover?

The Disability Discrimination Act defines a disabled person as somebody with a physical or mental

impairment that has substantial and long-term effects on normal day-to-day activities. For example, mobility, manual dexterity, physical co-ordination, continence, speech, hearing, eyesight, memory, ability to concentrate/learn/understand, ability to lift, carry or move everyday objects.

#### What does substantial mean?

Unfortunately, the Disability Discrimination Act does not define this other than to rule out minor or trivial effects. If an application has to go to Employment Tribunal, the individual circumstances will be considered, taking into account such factors as:

- ◆ time taken to carry out an activity
- ◆ the way in which it is carried out
- ◆ the cumulative effects of minor impairments such as fatigue when walking
- ◆ how far the person can control the impact of the impairment. For example, a person with depression may be able to cope with normal stress in everyday life, but may not be able to manage more severe pressures
- ◆ the impact of the environment such as humidity, temperature, time of day or night.

#### What does long-term mean?

An adverse effect is long-term if it:

- ◆ has lasted at least 12 months
- ◆ is likely to last at least 12 months
- ◆ is likely to last for the rest of the life of the person affected.

A sporadic effect may still be long-term. For example, epilepsy, and cyclical mental health problems. Therefore, employers must consider the causes of sickness absence when assessing whether they have a responsibility to an employee under the Act.

#### What about progressive conditions?

Cancer, multiple sclerosis, and HIV infection, among others, fall into the definition of disability once sufficiently advanced to affect ability to carry out normal day-to-day activities (see above).

#### In what ways might an employer be guilty of discrimination?

Discrimination can occur in two ways:

- ◆ where an employer treats a disabled person less

favourably than a non-disabled person because of the disability. For example, an employer would be guilty of discrimination for dismissing someone because of sickness absence resulting from a disability, when action against non-disabled employees with comparable sickness absence records is not taken

- ◆ if an employer fails to comply with the duty to make reasonable adjustments to the job to allow a disabled person to undertake the work, and cannot show that this was justified.

### What are reasonable adjustments, and must an employer make them regardless of cost?

The employer has a duty to make the adjustment where the physical features of the workplace, working hours or shift patterns cause a substantial disadvantage to a disabled person compared with a non-disabled person. In practice, modifications will not need to be extensive or expensive, but the employer can take into account factors such as:

- ◆ how effective will the adjustment be – will it actually allow the person to do the job?
- ◆ how practicable is it to make the adjustment?
- ◆ the financial costs and the extent of disruption to the employer's activity
- ◆ the availability of financial or other assistance.

As a guide, the employer should consider what it would cost to recruit a replacement, and spend at least this amount on adjustments to retain a disabled person.

### Is discrimination ever justified?

Yes, if the employer can show that it was both material to the circumstances and substantial. For example, it might be lawful not to appoint a nurse to a community nursing post covering a large rural area if the nurse cannot drive because of poor eyesight. But if the same nurse applies for a post as a practice nurse, the job modifications could be more easily made, and failure to make them could be unlawful.

### So can a disabled employee ever be fairly dismissed?

Yes, if the employer can show that they acted reasonably and followed a fair procedure before deciding to dismiss. For example:

- ◆ was there adequate consultation with, and explanation to the employee?

- ◆ did the employer take all steps to find out the extent of the disability, from medical reports if necessary and independent medical advice, if the employee requests it?
- ◆ was suitable alternative employment or redeployment considered?

### What should an employer do when recruiting to a post?

It is unlawful for an employer to discriminate against a disabled person by refusing to offer employment, or in relation to the terms of employment offered.

Employers should ensure that job descriptions and person specifications do not contain any unnecessary or marginal requirements, which could be seen as discriminatory. Blanket health exclusions are undesirable unless they can be justified. For example, to exclude all people with epilepsy from being appointed.

Finally, employers should ensure that disabled applicants are able to access application forms and information about the post, for example by providing large print, Braille or Typetext information, to make informal visits, and to have interviews conducted in an accessible venue.

### Do aggrieved employees have to take their complaint to an Employment Tribunal?

Obviously this is the right of employees who feel that they have been discriminated against. It may also be needed if there are doubts as to whether the circumstances of a case fall with the provisions of the Act.

However, going to tribunal should be the last resort, and the majority of difficulties should be resolved locally by discussion and negotiation between employer and employee, and with personnel and union help if needed.

As employers become more aware of their responsibilities, and employees of their rights under the Act, more and more disabled people can be retained in meaningful employment, making full use of their skills, training and experience, by imaginative adaptations to the job and the workplace. It is a mistake to think that the often very physically demanding nature of nursing makes it impossible to modify a job, or that the costs of modifications will be prohibitive. As the case studies and examples of good practice in Sections 4 and 5 of this pack will show, imaginative adaptations and approaches can retain nurses in a variety of work situations.

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## The Disability Discrimination Act in practice

### Case studies showing how the act can be used

It is important to note that these are actual cases and used either with the permission of the nurse concerned or with details changed to preserve confidentiality.

#### CASE 1

A health visitor in Scotland who had bi-polar disorder, a mental health problem, had responded well to treatment and was stabilised on medication. However, when she applied for a new job and was successful at interview, the job offer was withdrawn following occupational health assessment when she disclosed her condition. The occupational health doctor concerned had not contacted her consultant, who would have confirmed that she was fit and well.

The health visitor complained to Employment Tribunal. It was agreed that she did have a disability under the terms of the Act, and the tribunal decided that she had been discriminated against, and that she should be paid compensation.

#### Learning points:

- ◆ the Disability Discrimination Act covers mental health problems
- ◆ employers must treat job applicants fairly
- ◆ occupational health doctors must consider all available evidence when assessing fitness for a post, not just diagnosis alone.

#### CASE 2

An E grade nurse applying for a job was not appointed because she had in the past suffered from the eating disorder bulimia nervosa. She was frank and open about her illness when assessed by the occupational health department, and gave permission for her medical records to be disclosed to them. However, the prospective employer decided not to wait for this, and

rejected her application on the grounds that she had a severe personality disorder.

The nurse complained to Employment Tribunal, which had first to decide whether bulimia nervosa was a disability within the terms of the Act, and then as to whether discrimination had occurred. The application was successful and the NHS trust concerned offered the nurse compensation.

#### Learning points:

- ◆ eating disorders can come within the terms of the Act
- ◆ the guidance in the *Clothier Report*, issued following the case of Beverly Allitt, has been interpreted as requiring a two-year treatment-free period following a diagnosis of eating disorder. This is not so, and each case should be considered using all the evidence available.

We have included this case because, although the nurse concerned was not a student, this is an area of concern for many students or prospective students of nursing.

#### CASE 3

A nurse working in an accident and emergency unit had suffered two or three whiplash injuries in car accidents. Her employer agreed to make reasonable adjustments to enable her to continue in her present job. The employer altered her work hours so that she could avoid the busiest part of the shift, changed her work days, and arranged for her to have less contact with the more challenging patients.

#### Learning points:

- ◆ quite simple adjustments may help a nurse to keep her job – think laterally!
- ◆ adjustments need not cost a lot of money or cause major inconvenience to the employer
- ◆ discussion and negotiation can work, and should always be tried before making a complaint to an Employment Tribunal.

#### CASE 4

A nurse who had worked on a high dependency ward for many years developed back problems. Her NHS trust had a policy that committed them to consider rehabilitation and redeployment possibilities. A post in outpatients, a ward clerk position, and modifying her current post to allow her to continue were all examined by the trust. None of these proved completely suitable,

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and after a trial period, the nurse accepted a post in a day surgery unit.

### Learning points:

- ◆ successful redeployment and adaptations may take some time to achieve
- ◆ a trial period in a new post is often useful
- ◆ skills and experience gained over many years need not be wasted.

## It worked for us

### Employers and nurses share their positive examples of rehabilitation

#### Latex sensitivity

*Example taken from the occupational health department of a university:*

A student nurse had Type 1 latex sensitisation. After 18 months of her course she became severely affected, suffering asthma and anaphylaxis. She thought she might have to give up her chosen career, but the occupational health department negotiated with her employer to provide latex-free gloves in the student's clinical placement areas. This reduced the environmental exposure to the harmful latex protein which, when concentrated in glove powder, becomes an airborne hazard.

The occupational health department kept the situation under review and is prepared to explain the rationale for providing latex-free products to staff in the clinical areas.

The student remains healthy, has successfully completed a variety of clinical placements, and is looking forward to qualifying shortly as a nurse.

#### A multi-faceted approach

*Example taken from Alexandra Healthcare NHS Trust, Redditch:*

The trust's occupational health (OH) department advises line managers on getting staff back to work. This includes changing the hours worked, adjustments to equipment in the working environment, additional training and risk assessments. OH also co-ordinates physiotherapy, reflexology, aromatherapy and counselling services as well as commissioning specialist medical reports. Redeployment is taken seriously. OH is also aware of the local agencies that can provide information and advice such as the Disability Employment Advisers attached to Job Centres. All the agencies are notified of vacancies in the trust.

## Early access to specialist assessment and treatment

*Example from Huddersfield NHS Trust:*

The occupational health department ensures that staff members receive early physiotherapy treatment if needed, and will try to bring forward other specialist medical appointments. The department has made reciprocal arrangements with other local NHS trusts for mental health services if a staff member does not want to use the in-house services.

*Example from Birmingham Heartlands and Solihull NHS Trust:*

The trust offers fast-track referral to in-house physiotherapy services.

## Adaptations to the workplace

*Example from a specialist community mental health nurse:*

“I work in an old clinic building with three flights of stairs and no lift. Since I can’t climb stairs, all the case notes and resources I need have been relocated at the right height in a ground floor storeroom next to the office I share with three other staff. I have a trolley that I load with what I need, and push it to my adapted car for home visits, meetings and talks to community groups. The front doors to the clinic open automatically with a swipecard.”

Her manager explained: “It took quite a bit of organising – moving staff and offices around, putting in new shelving and so on. We had advice from a local disability resource centre, and obtained a grant to pay for adapting some of the doors within the building. But it has been worth it. We have been able to keep a very valuable and experienced member of staff in the job she loves and is good at. Incidentally the adaptations have benefited all staff, and the building is now more secure and pleasant to work in.

## Using outside help and advice

*Example from Huddersfield NHS Trust:*

A nurse who was unable to write for long periods of time following surgery. She was offered a Dictaphone and secretarial support, but had problems visualising what her dictated notes would look like. The disability adviser at the Employment Service suggested a laptop with voice-control operation. This has been successful. The Employment Service met a large part of the cost for this work.

The trust found that it was not getting many job applications from disabled people, and addressed this by an employer participation scheme. This resulted in more than 20 people with disabilities taking work experience placements with the trust. Its biggest impact has been that there is now awareness that the trust is definitely willing to employ people with disabilities. We have also widened the areas where they can work, and more and more managers are becoming involved with the scheme.

## Support from colleagues

*Example from an occupational health nurse working in Wales:*

“I have a hearing impairment, and I was worried that my colleagues would find me a nuisance or a burden. For example, there are certain work areas of the factory where I find it extremely difficult to hear, and I have had to ask other people to take over these duties. In fact, they’ve all been very helpful and supportive, and they say that in fact teamwork has improved since I came back to work.”

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# Drawing up and implementing a model rehabilitation policy –

## *information for managers and occupational health staff*

Managers, occupational health staff and safety representatives can use this section as a framework for planning and implementing a rehabilitation policy for their area.

Occupational rehabilitation is the process of assisting a person back into the workplace following injury or illness whether this is work-related or not. The process should aim to restore the person to the highest possible level of function as soon as it is appropriate. It is a strategy to maximise an individual's potential to return to pre-injury and physical, social, psychological, educational and vocational status, emphasising a multidisciplinary approach to needs assessment.

The rehabilitation process involves early intervention with adequate, appropriate and timely services based on the individual's assessed needs. The services should aim to maintain an ill or injured employee in employment, or return them to suitable employment.

### **Benefits of rehabilitation programmes for employers**

Work-related injuries result in direct and indirect costs for employers, and employees. Costs to employers include:

- ◆ sickness absence costs
- ◆ compensation and damages costs
- ◆ training costs for replacement staff
- ◆ loss of skilled and loyal staff members
- ◆ costs of accident investigation
- ◆ insurance costs
- ◆ legal costs

- ◆ management time needed to investigate claims, and sickness absence
- ◆ lost care workers' time (productivity loss)
- ◆ reduced commitment and employee morale.

Cost to the employee include:

- ◆ loss of physical or mental health and fitness
- ◆ loss of social and psychological well-being
- ◆ financial loss
- ◆ impact on future employability.

Early intervention and a workplace focus for rehabilitation are recognised as effective in reducing many of the economic and human costs associated with occupational and non-occupational ill health, disease and disability.

It is important for occupational health and personnel staff, managers and employees to work together both in assessing the needs of the employee and implementing a rehabilitation programme.

This approach to rehabilitation will involve early reporting of injury and illness and a co-ordinated response from management involving all relevant parties. The responsibility for rehabilitation planning and interventions should be located in the occupational health department with a clear communication strategy with all relevant parties.

### **Working in partnership and communicating**

It is easy for misunderstandings to occur between the different groups involved in the rehabilitation of employees. For example, the employer has a statutory role in meeting the requirements of the Disability Discrimination Act 1995. The occupational health department has a responsibility to maintain confidentiality. The employee's GP or medical advisers may have a major contribution to make to the rehabilitation plan. The employee may feel unsupported by the employer.

The key to reducing communication problems is to have a clear and agreed rehabilitation policy that outlines everyone's responsibility - including the responsibility to communicate with all of those involved in the rehabilitation process.

Rehabilitation services may include:

- ◆ physiotherapy or occupational therapy

- ◆ education or counselling on ways of coping and adjusting to injury or illness
- ◆ job or ergonomic analysis
- ◆ health and work capacity assessment
- ◆ workplace assessment
- ◆ reasonable adjustments under the Disability Discrimination Act 1995
- ◆ phased or graded re-introduction back to work
- ◆ work hardening or conditioning programmes
- ◆ liaison with other specialist NHS services
- ◆ obtaining advice from external bodies (such as the Employment Service disability advisers or specialist groups such as the National Society for Epilepsy)
- ◆ a facility to ensure the employee does not lose pay or benefits during a phased return to work.

### Principles of rehabilitation

- 1 Maintenance at work or early return to work is in the best interests of employees who have suffered a work injury or disease, and this should be the primary goal.
- 2 Commitment by all parties to the rehabilitation process is essential for successful outcomes.
- 3 Rehabilitation should occur at the earliest possible time depending on medical judgement.
- 4 Rehabilitation interventions should:
  - ◆ maintain the dignity of the employee
  - ◆ ensure that employees play an active role in the process.
- 5 Consultation between the employer and employee (and their representatives) should occur at all stages of the rehabilitation process.
- 6 Information should be treated confidentially, with sensitivity and only used for the purpose for which it was supplied.
- 7 Return-to-work programmes should aim to return the employee to work in:
  - ◆ the same job
  - ◆ the same job with reasonable adjustments made to it
  - ◆ a new job with the same employer.
- 8 Work assigned through the rehabilitation process should be meaningful to the employee.
- 9 No injured or ill employee should suffer financial disadvantage by participating in a return-to-work or rehabilitation programme.
- 10 Rehabilitation is most effective when linked to a work-based occupational health and safety programme.
- 11 The occupational health department should provide regular progress reports to all relevant parties while maintaining client health and medical confidentiality.

### Rehabilitation policy development

The development of a rehabilitation policy demonstrates a commitment to fairness at work for ill, injured or disabled employees. The document should be agreed collaboratively with employer and employee representatives, and the occupational health department.

The policy should be tailored to the requirements of the workplace and should include:

- ◆ policy philosophy and the aims and objectives
- ◆ commitment to all parties to the principles of rehabilitation, and an overt statement of partnership and a communications strategy
- ◆ eligibility criteria and how injured and disabled employees are to be assisted
- ◆ a statement on confidentiality and security of information collected through the rehabilitation process
- ◆ mechanisms for adequate resolutions of disputes
- ◆ accountability of all parties working towards successful outcomes
- ◆ budgetary and resource commitments.

### What to do next

After establishing a commitment to introduce a rehabilitation policy, organisations should undertake a comprehensive assessment of employees' needs, and prioritise actions according to available resources. This assessment should include :

- ◆ identification of current costs associated with sickness absence
- ◆ identification of suitability of existing rehabilitation services
- ◆ identification of evaluation data showing effective

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- practices already undertaken by the organisation
- ◆ identification of the prioritised needs of employees
  - ◆ identification of available resources and an assessment of additional resources needed
  - ◆ identification of support mechanisms that exist in the health service, or other organisations that could be used by the organisation. For example, counselling services, RCN Nurseline, Employment Service disability advisers, and specialist charities and patient groups
  - ◆ ensuring that the occupational health department is able to deliver the programme competently (some further training of occupational health staff may be needed).

## Prevention is better than cure

### A standard for successful health and safety management

#### Introduction

This standard provides a framework for improving the organisation's health and safety arrangements and performance. It identifies the structures that should be in place, the processes that should take place, and the outcomes that should be achieved as a result. It can be modified to reflect local situations, but should be audited so that continuous improvement can be implemented. Some of the measures that can be used to audit the standard are shown below.

#### Auditing the standard

Areas for audit could include:

- ◆ records of accidents, illness and other untoward events that have resulted in damage to property and equipment
- ◆ costs of these events
- ◆ sickness absence records broken down into absence as result of accidents and ill health
- ◆ implementation of policy measured through compliance with safety standards, and achievement of objectives in performance review
- ◆ occupational health referrals
- ◆ staff turnover, ill health retirements
- ◆ cost of NHS injury benefit payments, negligence claims
- ◆ any enforcement measures taken by the Health & Safety Executive
- ◆ staff surveys through questionnaire or focus group for example on stress
- ◆ committee structures for managing clinical and non-clinical risk
- ◆ frequency and content of safety committee meetings
- ◆ number of training programmes, numbers of staff attending, outstanding training needs.

## STANDARD

**Standard statement: the organisation has its health and safety risks under control and improves its injury and ill health record.**

Structure	Process	Outcome
1 Written safety policies that are up to date and communicated to staff.	1 Regular safety committee meetings held, agendas and minutes circulated to appropriate staff.	1 Staff understand the organisation's commitment to their well being.
2 Safety policy that covers staff, patients, visitors and others in contact with the services provided.	2 Risk assessment made of all hazards in the workplace, and account taken of circumstances such as pregnant staff.	2 There is active and visible support from senior management.
3 Safety policy that identifies designated director as accountable to the board for health and safety matters.	3 Safe systems of work are in place with written instructions. For example, safe disposal of sharps.	3 There is recognition that accidents, ill health and incidents result from failings in management control, and are not necessarily the fault of careless employees.
4 Safety policy contains recognition that good health and safety performance contributes to service delivery objectives.	4 Control measures implemented.	4 Accidents to staff and patients minimised.
5 Departmental policies specific to local situations exist that reflect the overall policy.	5 Health and safety information circulated to staff who need to know.	5 Staff more confident in the workplace.
6 Access to competent advice. For example, risk manager, health and safety officer.	6 Staff are trained in general health and safety and on specific hazards such as manual handling.	6 Reduced costs from absenteeism, occupational sick pay, injury benefit, and litigation.
7 Occupational health service providing full range of services. Level of risk analysed and action plans made.	7 Performance review considers health and safety matters.	7 Compliance with all health and safety legislation.
8 Consultation/negotiation machinery in place, involvement of TU safety reps in all health and safety matters.	8 Managers monitor health of staff and refer to occupational health where appropriate.	8 Accidents analysed to remove causation and not apportion blame.
9 Regular analysis and feedback of accident statistics. Good reporting procedures including HSE RIDDOR reports. <i>Reporting of injuries, diseases and dangerous occurrences</i> regulations (1995)	9 Safety representatives given paid time off for duties and training.	9 Line managers accountable for health and safety in their areas.
10 All managers trained in health and safety.	10 Information on hazards, risks and controls is given to employees, temporary staff and contractors	10 Safety culture exists that involves all staff in prevention of accidents and promotion of good health.
11 Health and safety integrated into risk management strategy as part of clinical governance.	11 Team briefings include health and safety topics	
12 Performance standards set and measured.	12 All staff report all accidents	
13 System for dissemination of information from external bodies in place. For example, Medical Devices Agency (MDA), Health & Safety Executive.	13 Accident statistics are analysed and data input into risk assessment	
14 Safety committee with representation from management and TU safety reps.		

## 8

# Sources of information and advice

All the organisations listed below operate throughout the UK unless otherwise specified. We have not included postal addresses for those organisations that operate mainly through telephone or helpline services.

## 1. The RCN:

### RCN Direct

24-hour information and advice for RCN members  
0345 726 100

### Nurseline

0208 681 4030

Information and advice for all nurses and midwives, provided through the RCN. Career information and advice on grant aid and benefits.

### RCN Work-Injured Nurses Group (WING)

0208 649 9536

Advice, information and support for work-injured, ill or disabled nurses.

RCN website: [www.rcn.org.uk](http://www.rcn.org.uk)

## 2. Employment

### Employers' Forum on Disability

60 Gainsford Street  
London SE1 2NY  
0207 403 3020

### The Employment Service

0845 6060234

Website: [www.employmentservice.gov.uk](http://www.employmentservice.gov.uk)

### Disability Services Teams

Contact through local Job Centres

## 3. Accessibility – information on adaptations to the workplace, access audits and equipment

### Centre for Accessible Environments

60 Gainsford Street  
London SE1 2NY  
0207 357 8182

E-mail: [cae@globalnet.co.uk](mailto:cae@globalnet.co.uk)

### Disabled Living Foundation Helpline

0870 603 9177

## 4. General Information and Advice

**DIAL UK** – Disablement Information and Advice Lines  
01302 310123

**Disability Action Advice and Information Service**  
(Northern Ireland)

01232 322504

### Disability Information Scotland

01506 433468

## 5. Occupational health and safety

### Institution of Occupational Safety and Health

0116 257 3100

Website: [www.iosh.co.uk](http://www.iosh.co.uk)

### The Health and Safety Executive

0541 545500

E-mail: [public.enquiries@hse.gov.uk](mailto:public.enquiries@hse.gov.uk)

Website: [www.hse.gov.uk](http://www.hse.gov.uk)

### The Faculty of Occupational Medicine

020 7317 5890

Website: [www.facocmed.ac.uk](http://www.facocmed.ac.uk)

**Association of NHS Occupational Physicians (ANHOPS)**

0721 607 3420

## 6. Helplines and patient support groups

### The Telephone Helplines Association

0207 242 0555

Website: [www.helplines.org.uk](http://www.helplines.org.uk)

A directory of general and specialist helplines

### Latex Allergy Group

PO Box 36  
Cheltenham, Gloucestershire  
GL52 4WY  
07071 225 838

## 9

## Glossary and references

**BackCare** (formerly the National Back Pain Association)

020 8977 5474

**ME Association**

01375 361013

**ME Association Northern Ireland**

01230 439831

**National Society for Epilepsy**

01494 601400

**Epilepsy Association of Scotland**

0141 427 4911

**Epilepsy Helpline** (British Epilepsy Association)

0800 30 90 30

**British Dyslexia Association**

0118 966 8271

**Headway** (rehabilitation after head injury)

0115 924 0800

**MIND** (England and Wales)

0345 660 163

**Mental Health information service (Northern Ireland)**

01232 237937

**Scottish Association for Mental Health**

0141 568 7000

**Trauma Aftercare Trust**

01242 890306

### 7. Students

**Skill** (National Bureau for Students with Disabilities)

Information line 0800 328 5050

**Educational Grants Advisory Service**

0207 927 3513

**Alteration of shift patterns** – Temporary or permanent change of shifts. For example, no night work, working only on day shifts, or not working alternating early and late shifts.

**Health assessment** – Matching employees to the work proposed, by ensuring that they are placed in work compatible with their physical and psychological capabilities, taking into account health needs of the employee.

**Modified duties** - Temporary change in the requirements of the job until full normal work can be resumed. For example, not taking charge of a shift, or delegating some duties to another member of staff.

**Phased return to work** – Gradual re-introduction to contracted hours (ideally with no loss of pay) or previous shift patterns over a period of time. For example, reduction of hours or days worked per week, supernumerary status, or changes to shift pattern.

**Redeployment** – Move to an alternative job on a temporary or permanent basis.

**Risk assessment** – “The employer must make an assessment of risks to the health and safety of employees whilst at work... to enable the identification of actions necessary to comply with the requirements of any relevant statutory provision.” UK Government, *Management of Health and Safety at Work Regulations*, 1992. HSE Books.

**Screening** – A better term is health surveillance, defined as: A process involving a range of techniques used to detect early signs of work-related ill health among workers exposed to certain health risks; and subsequently acting on the results.” *Health Surveillance at Work*. HSE 1999, HSE Books

**Short-term alternative work** – Temporary redeployment.

## References

- AUSTRALIAN NATIONAL OCCUPATIONAL HEALTH AND SAFETY COMMISSION (1999) *Guidance Note for the Best Practice – Rehabilitation Management of Occupational Injuries and Disease*, Commonwealth of Australia.  
View at: [www.worksafe.gov.au](http://www.worksafe.gov.au)
- DFEE (1999) *Code of Practice for Employers on the Implementation of the Act*, ISBN 0-11-27 1055-7
- DYCK, D (1996) Managed Rehabilitative Care *American Association of Occupational Health Nurses Journal*, 44,1,18-27.
- SCOTT PARKER, S (1997) *Putting Disability in the Picture*.  
MacWhinnie, L (1998) *Counselling at Work*, Association for Counselling at Work, London
- WEST, P (1998) *The costs of ill health among NHS Workers*. In Williams, S., Michie, S., and Pattani, S. *Improving the health of the NHS workforce*. The Nuffield Trust
- WILLIAMS, S, MICHIE, S AND PATTANI, S. (1998) *Improving the Health of the NHS Workforce*, The Nuffield Trust, London
- WORLD HEALTH ORGANISATION (1980) *The International Classification of Impairments, Disabilities and Handicap*, WHO Geneva

Injured, ill and  
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020 7409 3333

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