The Challenge !

Congress Delegate Book

The Federation of Occupational Health Nurses within the European Union

The 4th International FOHNEU Congress on Occupational Health

19th- 21st September, 2007

New Connaught Rooms
61-65 Great Queen Street

WELCOME TO THE FOHNEU CONGRESS

A warm welcome to all occupational health nurses and to those whose responsibilities include workplace health and safety issues. This congress builds on the experiences and successes of the last three held in Brussels, Strasbourg and Helsinki.

Working life is in continuous transition. Keeping pace with the changes and the impacts on health, safety and well being at work is *The Challenge* facing all OH professionals. The programme at this Congress will focus on central issues reflecting the current changes at the workplace.

The 4th FOHNEU Congress aims to bring together occupational health professionals from the UK, EU and internationally to share research papers, to network and to enjoy the company of like minded colleagues. The congress also provides companies the opportunity to exhibit their brands and to meet delegates with purchasing and influencing powers.

Thank you for joining us at the OH event of the year hosted by FOHNEU and the UK Partners RCN OH Managers Forum, RCN OHN Scotland and RCN SOHN Northern Ireland. The FOHNEU Congress is also sponsored by Mid Downs OH Group.

On behalf of the Congress Organising Committee we warmly welcome you to London.

Julie Staun Denmark
FOHNEU President

Bernie Jackson UK
FOHNEU Vice President

For more Information on FOHNEU go to:
www.fohneu.org

WEDNESDAY 19th SEPTEMBER

11.00 Registration and Coffee

12.00 Lunch

OPENING CEREMONY

Session chaired by Julie Staun (Denmark) and Bernie Jackson (United Kingdom)

13.30 - 13.45 **Welcome to the UK, Ms. Bernie Jackson**

Chair RCN OH European Group, United Kingdom

13.45 - 14.00 **Welcome to the 4th FOHNEU Congress, Ms. Julie Staun**

President, FOHNEU

14.00 - 14.30 **Dr. F.J. Alvarez Hidalgo**

Unit "Health, Safety and Hygiene at Work" - DG EMPL.F.4, European Commission

14.30 - 15.00 **Mr. Geoffrey Podger**

Chief Executive Health and Safety Executive, United Kingdom

15.00 - 15.30 **Ms. Annette Kennedy**

President, European Federation of Nurses Associations EFN

15.30 - 16.15 **TEA/COFFEE/EXHIBITION**

16.15 - 16.45 **Professor Dame Betty Kershaw FRCN**

Emeritus Dean, the School of Nursing and Midwifery, the University of Sheffield, United Kingdom

16.45 - 17.15 **Ms. Zinta Podniece**

European Agency for Safety and Health at Work, Bilbao, Spain

17.15 - 17.45 **Professor Dame Carol Black**

National Director for Health & Work, UK Government

17.45 - 18.15 **Questions to the panel (all speakers)**

18.30 - 20.30 **CONGRESS RECEPTION - GRAND HALL**

THURSDAY 20th SEPTEMBER

GRAND HALL

09.00 - 10.15 **Session 1**

Workplace Health Promotion

Session chaired by Lynda Spear (United Kingdom) and Panayota Sourtzi (Greece)

Health Promotion Needs of the Ageing Workforce
Ms. Paula Naumanen, RN, PhD, the Finnish Institute of Occupational Health, Finland

Health Promoted Workplaces
Ms. Lotta Dellve, RN, PhD, Sweden

Health Promotion at Workplaces
Dr. Paul Fleming, Associate Dean, Faculty of Life and Health Sciences University of Ulster, North Ireland

YORK SUITE

09.00 - 10.15

HOHNEU Special Session

Launching of the EU Project HOHNEU
A Master Degree in Occupational Health Nursing: HOHNEU - a European Perspective

Harmonising Occupational Health Nursing in the European Union (HOHNEU) is an ambitious three year Leonardo Da Vinci project. It was built on the vision of the OH nurses across Europe who were represented by FOHNEU and some dedicated OH nursing lecturers at Sheffield University.

10.15 - 10.45 Tea/Coffee/Exhibition

GRAND HALL

10.45 - 12.15

Evidence Based Practice

Session chaired by Lynda Spear (United Kingdom) and Panayota Sourtzi (Greece)

Using Champions to Transform Clinical Performance
Caroline Cliff**,** Clinical Quality Assurance Manager, Atos Healthcare, United Kingdom

The Value of Standardising Health Programmes to Ensure Occupational Health Service Outcomes in a Global Corporation
Karen Linn, Health Services Manager, Johnson & Johnson Europe, Middle East & Africa Region

The MARATHON Project - Developing the Hotel and Restaurant Sector and its Occupational Health Services
Aira Ylä-Outinen, OHN, The Institute of Occupational Health, Finland

Factors Influencing the Ability of Irish Occupational Health Nurses to Provide Primary Care in a Changing Workplace
Patricia English, RGN, H Dip OHN, RNT, BSc, MSc, Department of Defence/University College Cork
Cork Ireland

Flexibility in the Work Environment throughout the Life Span - A Safeguard against Work-Life Conflict
Annette Wethje, Consultant, MPH, Denmark

YORK SUITE

10.45 - 12.15

HOHNEU Special Session (continued)

The aim of the project was to develop a Master Degree in Occupational Health which would be accessible to OH nurses across Europe in whichever country or clinical practice environment they were.

To ensure that the Master programme truly represented the reality of OH Nursing in the different countries in the Union, seven partners consisting of FOHNEU, the Danish Society of OHN, the University College, Nursing Studies, Maribor, Slovenia, the Irish Nurses Organisation, the Jagiellonian University Krakow, Poland, Swiss Occidental Leonardo, Switzerland and the University of Sheffield collaborated to develop the programme and make it available online through the Internet.

The Master programme will be launched at the FOHNEU Congress in London and samples of the online programme will be available to view.

Project team members will also be at the Congress to answer questions about the HOHNEU project and to recruit candidates to the programme which is expected to commence in **September 2008**.

12.15 - 13.30 Lunch and Exhibition

GRAND HALL

13.30 - 15.00 **Session 2**

Working Conditions and Psychosocial Risk Factors

Session chaired by Agatha Lyons (United Kingdom) and Una Feeney (Ireland)

European Barometer of Working Conditions
Jean-Michel Miller, Research Manager, Working Conditions Unit. European Foundation for the Improvement of Living and Working Conditions, Dublin, Ireland

Psychosocial Risk Factors
Robert (Bobby) Zachariae, Professor, MSc, MDSci, Psycho-oncology Research Unit, Aarhus University Hospital and Aarhus University, Denmark

YORK SUITE

13.30 - 15.00 **Session 3**

Special Session Sponsored by Mid Downs OH Group UK

Session chaired by Wendy Stimson (United Kingdom) and Eeva Himmanen (Finland)

Stress & Depression in the Workplace
Dr. Jeremy Broadhead MA(Oxon) MPhil MBBS FRCPsych, Consultant Psychiatrist and Medical Director, The Priory Hospital Hayes Grove Kent, United Kingdom

Bully for Occupational Health - Why OH Practitioners must know the Legal Framework relating to Bullying at Work
Joan Joan Lewis MCIPD MA (Law and Employment Relations) Legal Consultant in Employment Law and Human Resource Management, United Kingdom

15.00 – 15.30 Tea/Coffee/Exhibition

15.30 - 17.30

Education, Research and Professional Development

Session chaired by Agatha Lyons (United Kingdom) and Una Feeney (Ireland)

Specialty Recognition (Certification) in USA and Canada
Brian Verrall, RN, MSc, Executive Director, Ontario OHN Association, Canada

Assessment of Critical Thinking in Post-Registration Nurses Undertaking Specialist Practice Education for Public Health Nurse Practice
Fiona Begbie, Lecturer in OH, The Robert Gordon University, Aberdeen, Scotland, United Kingdom

Current Status of Occupational Health Nursing Education and Practice in EU Countries
Panayota Sourtzi, Associate Professor, University of Athens, Greece

The Education of Occupational Health Nurses in Finland - plans for the future
Maria Rautio, PhD, Med, Head of Development, Finnish Institute of Occupational Health, Finland

"Making Sense of Models for the Profession"
Mo McBain, MSc, OHN, The Robert Gordon University, Aberdeen, Scotland, United Kingdom

The New OH Service in the Netherlands
Marja Bakker, Manager, OHN, the Netherlands - presented by Susan Kamerling, the Netherlands

Evaluating the Appropriateness of e-Learning in Occupational Health Education
Professor Peter Kokol, Faculty of Health Sciences, University of Maribor, Slovenia

Nurse Externship Program
Brian Verrall, RN, MSc, Executive Director, Ontario OHN Association, Canada

15.30 - 17.30 **Session 4**

Free Paper Session

Session chaired by Christina Butterworth (United KIngdom) and Susan Pierrot (France)

The Study of Fatigue at a fly in/ fly out. Minerals Extraction and Processing Operation in remote North Queensland
Anthony Carter, Dr., BappSc, GradDipEpi, MMSc, DR PH, School of Public Health and Tropical Medicine, James Cook University, Australia

Being Healthy at Construction Site CD
Kirsi Tamminen, RN, OHN, District OH Services of Jyväskylä and Marjatta Peurala, OHN, PHN, MSc, The Institution of Occupational Health, Finland

Thoughts on Investigating a Suspected Occupational Skin Problem
Chris Packham, EnviroDerm Services, United Kingdom

Review of the Noise Sources in the Hospital Setting. Causes, Results and Recommendations
Anna St. Korompeli, RN, MSc-Public Health, PhD candidate, University of Athens, Greece

Lipoatrophia Semicircularis
Maria de Meersman, OHN**,** KBC Bank en Verzekeringen, Brussels, Belgium

Airway Hypersensitivity in Female Hairdressers
Kerstin K. Diab, OHN Educator, Doctoral candidate, Department of Occupational and Environmental Medicine, Lund, Sweden

Pneumoconiosis in Coalminers in Asturias (Spain)
Esperanza Alonso Jimenez, Spain

20.00 - Congress Dinner

FRIDAY 21st SEPTEMBER

GRAND HALL

09.00 - 10.30 **Session 5**

Managing Absenteeism

Session chaired by Mo McBain (United Kingdom) and Dirk Vermeulen (Belgium)

Managing Sickness Absence
Mary MacFadzean, Director, MMC Absence and Health Management Ltd., United Kingdom

Workload and Work Capacity
Frank van Dijk, Professor, Coronel Institute, Academic Medical Centre, the Netherlands

Implementing Case Management on a Global Basis
Sharon Kemerer, PN, MSN, COHN-S/CM, Corporate Director, USA

YORK SUITE

09.00 - 10.30 **Session 6**

Health Risk Management and Work Related Rehabilitation

Session chaired by Anne Boström (Finland) and Annika Claesson (Sweden)

Health Risk Management
Christina Butterworth, Health Risk Manager BG Group and Caroline Minshell, Segment OH Advisor, E and P, BP International, United Kingdom

Managing Musculo Skeletal Disorders (MSD's) in the Workplace
Grahame Brown, Occupational Health Physician, Birmingham Orthopaedic Hospital, United Kingdom

Work Related MSD's in Europe - good practices and prevention
Zinta Podniece, Project Manager, European Agency for Safety and Health at Work, Bilbao, Spain

10.30 - 11.00 Tea/Coffee/Exhibition

11.00 - 12.30

Managing Absenteeism and Rehabilitation

Session chaired by Mo McBain (United Kingdom) and Dirk Vermeulen (Belgium)

Using Case Management to Address long-term Absence
Helen Stokes, Occupational Health Advisor, Atos Healthcare, United Kingdom

The Role of OHN in Managing Absenteeism in the Netherlands
Susan Kamerling, OHN, Achmea Arbo, the Netherlands

Absenteeism in the Printing Industry: A Greek Case Study
Aikaterini Michaliou, RN, BSc, MSc, Department of Public Health Faculty of Nursing, University of Athens, Greece

An Evaluation of the Effectiveness of Occupational Rehabilitation Programmes in the Management of long-term Sickness Absence
Angela Higgins, RGN, SCPHM, BSc. Hons MBA, OH Department, United Hospitals Trust, Northern Ireland, United Kingdom

Returning the Incapacitated Worker to Work or the Disability Benefit Route - A South African perspective
Sonja Kruger, President of the South African Occupational Health Nursing Practitioners

11.00 - 12.15

Research Development and Methods

Session chaired by Anne Boström (Finland) and Annika Claesson (Sweden)

The Content of Electronic Documentation of Health Check-ups
Leena Uronen, MNSc, Mehiläinen OH Services, Finland

Occupational Health Nursing in Scotland: Scope of practice and future continuing professional development
Mo McBain, MSc, OHN, The Robert Gordon University Aberdeen, Scotland, United Kingdom

Privacy and Dual Loyalties in Occupational Health Practice
Anne Heikkinen, MNSc, RN, PhD(c), University of Turku, Department of Nursing Science, Finland

Auditing the Management of long-term Absence - moving to peer review
Judy Cook, General Manager Health Services Delivery, British Airways, United Kingdom

Promotion of School Community Staff´s Occupational Well-being in Co-operation with Occupational Health Nurses
Terhi Saaranen, PhD., University of Kuopio, Department of Nursing Science, Finland

Participatory Teams in the Intervention Study "Healthy Workplaces in the Hospital Sector"
Christine Wolff, OHN, Denmark

12.30 - 13.30 Lunch and Exhibition

FRIDAY 21st SEPTEMBER

GRAND HALL

13.30 - 15.00

13.30

Future Perspectives in Occupational Health

PROFESSOR JORMA RANTANEN, FINLAND
President of the International Commission on Occupational Health (ICOH)

14.15

BEST POSTER PRIZE

CLOSING CEREMONY

Session chaired by Julie Staun (Denmark) and Bernie Jackson (United Kingdom)

NOTES:

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KEYNOTE SPEAKERS

Dr. Francisco Jesús Alvarez Hidalgo is Principal Administrator at the European Commission, Unit "Health, Safety and Hygiene at Work", at the Directorate General “Employment, Social Affairs and Equal Opportunities” in Luxembourg. Dr. Alvarez is an occupational physician, and has also worked as a director of several public hospitals in Spain

SUMMARY

Occupational illness and accidents at work are a heavy burden on both workers and employers in Europe. Every year there are 4 million accidents at work which represent enormous economic costs for the European economy. A considerable share of these costs falls upon social security systems and public finances. Improving the health and safety of workers is key to the EU's Growth and Jobs agenda.

Despite major advances over the past five years, there is still considerable room for improvement. The costs of accidents at work and work-related ill health do not fall equally on all players. Loss of income due to absence from work costs European workers around EUR 1 billion a year. Employers face costs linked to sick pay, replacement of absent workers and loss of productivity – many of which are not covered by insurance.

Small and medium-sized enterprises are particularly exposed, accounting for 82% of all occupational injuries and 90% of all fatal accidents. Sectors such as construction, agriculture, transport and health all present higher than average risks of accidents at work, while young workers, migrants, older workers and those with insecure working conditions are disproportionately affected.

Specific illnesses are on the rise, including musculoskeletal diseases – such as back pain, joint injuries and repetitive strain injuries – and illnesses caused by psychological strain.
The European Commission adopted in February 2007 the Community Strategy on Health and Safety at Work 2007-2012.The new strategy for 2007-2012 aims to achieve an overall 25% reduction of occupational accidents and diseases in the EU. It sets out a series of actions at European and national levels in the following main areas:

- Improving and simplifying existing legislation and enhancing its implementation in practice through non-binding instruments such as exchange of good practices, awareness-raising campaigns and better information and training
- Defining and implementing national strategies adjusted to the specific context of each Member State. These strategies should target the sectors and companies most affected and fix national targets for reducing occupational accidents and illness
- Mainstreaming of health and safety at work in other national and European policy areas (education, public health, research) and finding new synergies
- Better identifying and assessing potential new risks through more research, exchange of knowledge and practical application of results

Geoffrey Podger took up office as the Chief Executive of the Health and Safety Executive on 28 November 2005. He was previously Executive Director of European Food Standards Agency. Prior to that, Mr Podger was Chief Executive of the UK Food Standards Agency, which was established in April 2000 to bring about increased transparency and consumer involvement in food safety and related matters. Mr Podger has been a UK civil servant since graduating from Oxford University in 1974. He has been mainly concerned with public health matters and has worked extensively for the Department of Health in London. He was awarded the CB in 2003.

Annette Kennedy, RGN, RM, RNT, Dip in Management, BNS, MSc. is currently Director of Professional Development for the Irish Nurses Organisation, which involves the provision of continuing education and library and information services and advice to all members. Annette is a registered nurse and midwife with a Bachelor's degree in Nurse Education from University College Dublin and a Master's in Public Sector Analysis from Trinity College Dublin. Annette and her colleagues have developed one of the most comprehensive professional nursing and midwifery information portals in the world entitled "Nurse2Nurse" (www.nurse2nurse.com)

In Ireland, Annette works with a variety of national organisations, including the Department of Health and Children, Nursing Policy Divisions, Irish Nursing Regulatory Body and a host of other voluntary and statutory bodies in relation to nursing and midwifery policy.

Annette is continually involved in workforce planning at National, European and International levels aimed at addressing the continent-wide shortage of nurses. She is an active participant in International Council of Nurses (ICN) programmes and is a member of the ICN Credentialing Forum, International Centre of Nurse Migration Strategic Advisory Group, European Forum of Nursing Midwifery Associations and the World Health Organization (WHO). In 2004, she was selected as a member of Rho Chi Chapter, Sigma Theta Tau International, Honor Society of Nursing.

Annette is currently President of the European Federation of Nurses Associations (EFN), an independent organisation consisting of Nursing Associations in over 30 European countries, representing over six million nurses.

Zinta Podniece is a project manager with the European Agency for Safety and Health at Work and is dealing with work-related musculoskeletal disorders, which is a theme of the European Campaign for Safety and Health at Work in 2007. She is a medical doctor specialised in public and occupational health. Zinta has obtained an extensive experience on this subject both at national and international level. Amongst others, she was responsible for the development of Public Health Strategy and HIV/AIDS prevention programme in Latvia, and was in charge of the European Health Portal and health systems file at the DG SANCO of the European Commission.

SUMMARY

Musculoskeletal disorders (MSDs) are the most common work-related health problem in Europe, affecting millions of European workers in all employment sectors. Across the EU27, 25% of workers suffer from backache and 23% report muscular pains.[1]

MSDs are caused mainly by manual handling, heavy physical work, awkward and static postures, repetition of movements and vibration. The risk of MSDs can increase with the pace of work, low job satisfaction, high job demands, job stress and working in cold environment. MSDs are the biggest cause of absence from work in most Member States, while in some, 40% of the costs of workers' compensation are caused by MSDs. They reduce company profitability and add to the social costs of the government. The cost to the state can be up to 1.6% of the gross domestic product (GDP).[2]

Many problems can be prevented or greatly reduced through employers complying with existing safety and health law and following good practice. However, there are specific actions that have to be taken if MSDs are to be tackled effectively. Lighten the Load is the European Agency for Safety and Health at Work's 2007 campaign to tackle MSDs in the workplace. It is backed by the EU Presidencies of Germany and Portugal in 2007, the European Parliament, the European Commission and the European social partners. The campaign culminates in the European Week of Safety and Health at Work from 22 to 26 October 2007.

The European MSDs Campaign seeks to promote an integrated management approach to tackle MSDs, embracing both elements - prevention of MSDs and the retention, rehabilitation and reintegration of workers who already suffer from MSDs. In support of this campaign the Agency has been producing a number of informative materials such as a good practice website, 'MSDs: prevention report' and 'MSDs: back-to-work report'. They include information on the effectiveness of interventions at the workplace, an overview of policy initiatives regarding MSDs prevention in Europe and at international level, and the case studies illustrating practical solutions on how to improve the working conditions.

The good practice awards are an important feature of the campaign. These recognise companies and organisations that have made outstanding contributions to tackling MSDs. Organisations and individuals are encouraged to get involved in the campaign, organise their own events for the European Week, and help ensure that MSDs blight fewer lives.

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[1] European Foundation for the Improvement of Living and Working Conditions. 4th European Working Conditions Survey, 2007. Available at http://www.eurofound.europa.eu/pubdocs/2006/98/en/2/ef0698en.pdf

[2] Asian-Pacific Newsletter on Occupational Health and Safety. Vol.7, nr.1, p. 5. March 2000

Carol M. Black, DBE, FRCP, FMedSci., National Director for Health and Work is the Government's first National Director for Health and Work. She is also the Chairman of the Academy of Medical Royal Colleges, Chairman of the Nuffield Trust, and maintains a deep interest in both the clinical and research aspects of connective tissue diseases.

As National Director for Health and Work, Carol heads up the Government's 'Health Work Wellbeing' strategy; a joint initiative across government to improve the health and well-being of working age people.

SUMMARY

Health Work Wellbeing: The Challenge Ahead

The key note address will cover why an holistic approach to Occupational Health (OH) is needed; the barriers between what has been seen as ‘Occupational Health’, ‘Absence Management’ and ‘Public Health’ need to be removed ensuring that OH is truly focused on keeping employees healthy and in work.

Interaction between OH, Employers and General Practionors is also key area that needs to be focused on. As it currently stands the ‘system’ is not set up to support GPs to support people top stay in and return to work.

To improve the health of the working age population we need people to work in partnership. In creating the Health Work and Well-Being Strategy we have already joined together in partnership the Department for Work and Pensions, Department of Health and the Health and Safety Executive as well as the devolved administrations. To achieve a real difference, this partnership needs to continue across employers, primary care, occupational health, public health and the large number of other parties which are involved in the relationship between health and work.

What might this mean for the occupational health practitioner? I would suggest; opportunity, challenge, changes in practice and new horizons.

Paula Naumanen is a specialized researcher, PhD at the Finnish Institute of Occupational Health
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SUMMARY

Health Promotion Needs of the Ageing Workforce

Workforce is ageing quite rapidly in European countries and this will set more challenges to the future working life. In the same time, short term employment contracts, continuous changes and global competition in various branches and lengthening working career put more challenges for ageing employees' well-being, as well as their professional competence and effectiveness. Balancing work and other areas of life is perceived to be quite difficult in these days and needs more inputs from ageing workers themselves and their workplaces, with the support of other co-partners, respectively.

This presentation will describe the health needs of the ageing workers, how their well-being can be maintained and promoted, and what the expected outcomes of the health promotion are. Presented facts are based on different study results focusing on ageing employees, entrepreneurs, occupational health professionals and other rural co-partners. This theme will be examined from the different points of views, and the same facts can be applied to younger workforce as well. Some recommendations will be given for the future health promotion and successful ageing for ageing workers themselves, workplaces, occupational health professionals, and society.

Good working life is an important prerequisite to successful ageing during work career. That will also reflect positively to the quality of the retirement life.

Paul Fleming MSc PhD is Associate Dean of the Faculty of Life and Health Sciences at the University of Ulster in Northern Ireland, United Kingdom, where he has worked since 1992. He was the founding Course Director of the University's masters programme in Health Promotion and Population Health. His professional background is as a Health Promotion Specialist and Post-Primary School Teacher, having held posts in both the United Kingdom and Papua New Guinea.

With regard to workplace health, his interest is centred on the workplace as a health promoting setting. In this context he has researched and published on workplace issues such as tobacco control, prevention of violence, health information dissemination and men's health. He has also published several ground-breaking papers on reflective practice in workplace health promotion, is co-author of Impacting Health at Work and is Editor of the Journal of Environmental Health Research. His most recent publication is a chapter on work as a social determinant of health in Scriven and Garman's Public Health: Social Context and Action. Other health promotion interests include Relationships and Sexuality Education, cancer prevention education and mental health promotion; he has served on a number of government policy reviews and acted as consultant to a wide range of health promotion initiatives in the public sector.

SUMMARY

The workplace has been recognised by the World Health Organisation as a key setting for health promotion. Its readily accessible population, the ability to monitor key elements of health status and the fact that the majority of the population spend a significant proportion of their lives at work make it an important arena for health promotion. Health Promoting Workplaces are developed through a combination of health improvement activities aimed at the physical and work-culture environments and in the individual health choices made by employees. While the development of Health Promoting Workplaces has been a clear focus for international, national and local initiatives, the unique needs of health promoters, such as Occupational Health Nurses, in being able to reflect on their work, have not been fully addressed. This presentation explores the potential for enhancing the Health Promoting Workplace through the use of a Reflective Typology which focuses on the work of individuals and teams engaged in health promotion facilitation. The Typology focuses on the person as health promotion facilitator, the context within which health promotion is planned and the process by which initiatives are delivered. The presentation applies the Typology to a specific workplace research initiative in relation to violence prevention.

Jean-Michel Miller is a research manager currently working on the European Working Conditions Observatory, the Foundation's web-based monitoring tool on quality of work and employment in the EU. Michel also works on quality of work indicators, and is involved in the transversal project looking at labour market mobility and access to social rights for migrants. Before joining the Foundation, he worked for the European Trade Union Confederation in Brussels, and for the Parliament in his native Luxembourg.

Robert Zachariae has a BA in political science, an MA in psychology, and a doctoral degree (MDSci) in medicine. He has been visiting associate professor at Harvard Medical School, Boston, and research fellow at Memorial Sloan Kettering Cancer Center, New York, and is currently professor of Health Psychology at the University of Aarhus, Denmark, and adjunct professor at Department of Oncological Sciences, Mount Sinai School of Medicine, New York. His research career has focused on different aspects of mind-body-research, including stress, psychoneuro immunology, and in recent years on psychosocial cancer research.

SUMMARY

Psychosocial Risk and Stress Factors at Work

Research in work-related stress has identified several risk factors that are associated with negative health outcomes such as increased risk of a number of diseases, including coronary heart disease, infections, and gastrointestinal and muscoloskeletal disorders. Some of the most extensively investigated work-related risk factors include high job-demands in combination with low perceived control, imbalance between effort and perceived rewards, and low levels of social support. There are, however, conflicting findings, and the associations may be confounded and moderated by other factors, including individual differences in coping, hostility, and conscientiousness. In recent years, there has also been a growing interest in exploring the possible protective effects of “positive” psychological factors. Such factors include positive job-related qualities such as meaningful tasks and aesthetic surroundings, as well as individual factors such as optimism and self-efficacy. Increasing demands on the workforce continues to raise new challenges to identify protective factors in organizations and help employees develop their individual strengths.

Dr. Jeremy Broadhead, MA (Oxon) MPhil MBBS FRCPsych has been a consultant psychiatrist and medical director with the Priory Hospital group, the largest independent provider of psychiatric care in Europe, since returning from New Zealand in 2002. He is an emeritus consultant of the Bethlem & Maudsley NHS Trust, South London (1995-1998), where he trained and worked for 15 years. During this time he had research and teaching roles at the Institute of Psychiatry and developed services for mentally ill mothers in the NHS. He has spent approaching ten years working overseas, as a Clinical Director for Mental Health Services in Auckland, New Zealand (1998-2002), and developing mental health services in Zimbabwe and Pakistan. Clinically he specialises in the assessment and treatment of mood and anxiety disorders, both common consequences of unmanaged stress, and addictions, especially to alcohol. He teaches about mental health to different professional groups. He has published approximately 20 peer refereed scientific papers, on the treatment and causation of depression and anxiety.

SUMMARY

Work, stress, anxiety and depression

A level of pressure is necessary for people to function optimally. It is good people management to ascertain what that level is. No one can endlessly manage more and more demand to achieve targets and deadlines with impunity.

Particularly noxious stresses are those involving difficulties with colleagues, for example, harassment or bullying.

Where the limit to what we can endure lies depends on a combination of personality, our brain's biology, the stresses upon us and the supports around us. When that limit is reached symptoms of excessive stress begin to manifest. If the limit is exceeded by a greater degree actual brain changes occur which manifest as psychiatric illness, usually an anxiety disorder or depression.

This talk discusses these phenomena and how they can be prevented, detected and managed in the workplace.

Joan Lewis MCIPD MA (Law & Employment Relations)
A summary of the key legislative issues will be provided along with practical tips 7 examples of case law.

Joan is a qualified legal consultant in employment law and human resource management. She is licensed by the General Council of the Bar under the BarDirect scheme in employment matters. As well as undertaking cases 7 assignments for clients, Joan is a regular writer and lecturer on employment law and related occupational health 7 disability discrimination issues. She is co-author with Greta Thornbury on a best selling text book." EMPLOYMENT LAW & OCCUPATIONAL HEALTH: A Practical Handbook" ISBN 1405149728 - Blackwell 2006

Mary McFadzean is currently the Director of MMC Absence and Health Management Ltd. She is passionate for business to become really engaged in the idea of "single focus" absence management where HR, managers and occupational health specialists don't work in silos but really share their skills and knowledge across the piece. This approach led to significant savings in absence costs at HBOS, the last organisation she worked at before leaving to set up her own company.

Mary has 8 years experience in occupational health roles and 5 years at HBOS within an HR capacity. Many of her roles have been at a senior level where she has developed strategies for absence management both for the private and public sectors. Mary has also been successful in securing funding from the British Occupational Health Research Organisation to study the factors which account for de-motivation and stress in employees within contact centres. She is keen to see the effective implementation of the HSE standards on stress and has designed an e-learning toolkit to help organisations address the problem.

Over the past five years Mary has spoken at many conferences on absence management. She has spoken at the CIPD conference as-well as being invited to Helsinki to speak at the conference for the Federation of Occupational Health Nurses in Europe. She is published in the regular Human Resources and Occupational Health press and is the lead on absence management and rehabilitation for the Royal College of Nursing's Occupational Health Manager's Forum.

Mary is married with 2 children and has a Diploma in Occupational Health and a Master's Degree in Public Health and Health Economics.

SUMMARY

Managing Absenteeism-Sharing the Solution

Within the last 20 years we have seen a gradual increase in sickness absence rates across all parts of Europe with the UK having the second largest level of absence.

There are a number of factors relating to high levels of absence, not least the lack of funding to support employers getting people back into work. However the complexity of absence has meant that there are a number of factors to consider.

It is now becoming increasingly clear that sickness absence is based upon medical as-well as non-medical problems i.e. domestic/social difficulties, and yet, in the UK at least, up until recently, the management of sickness absence and rehabilitation has largely been based upon a "medical model" which has meant that the employee has been treated for the symptoms of absence as opposed to the cause. This reliance on the medical model approach to managing absence and rehabilitation has meant that companies have found it difficult to engage in the rehabilitation process and take real ownership on behalf of their employees.

The whole process of managing absence needs to be considered carefully if companies are to be successful in helping their employees back into work.

Firstly, the Management Information systems that capture sickness absence data need to be as efficient and as reliable as they possibly can be. As importantly, the policy that shapes an organisation's approach to absence needs to clearly state people's roles and responsibilities, including those of the employee.

Occupational Health professionals need to be used for their skills, not their availability. At present many OH professionals are under-utilised and de-skilled as they attempt to see all employees on long term sick, with little or no support from the rest of the business.

HR and managers need to develop an understanding of the underlying causes of absence so they can assist employees at the start of a problem/period of absence. They also need to improve their confidence in developing return to work plans and putting reasonable adjustments into place to support all employees, not just those who are disabled. In this respect Occupational Health professionals can be called upon in a consultative capacity when there are clear health issues to be tackled, including support in developing return to work plans.

Finally, the employee themselves needs to be committed to the returning to work and levels of motivation to do this need to be monitored.

Once the above is in-place an end-to- end process can be developed, within the organisation that ensures contact with the employee who is off sick, action within reasonable timeframes and a "key worker" or case manager who can ensure that the whole process of getting someone back into work is co-ordinated and well-run.

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He is committed with postgraduate education for occupational physicians. He is member of the Board of ICOH, active in the ICOH scientific committee on Health Services Research and Evaluation in OH and represents the institute as Collaborating Center in WHO. Special interests are mental health at work, chronic diseases and the maintenance of working capacity, quality of OHS, and evidence-based practice.

SUMMARY

The workload and capacity model and the WHO ICF model, benefits for occupational health care

Key words: occupational health, model, occupational diseases, work functioning

Using models in occupational health practice can aid the understanding of problems and solutions, showing 'which relevant factor is present and what can be done'. Models can guide multidisciplinary collaboration and sustain education. In this contribution the workload and capacity model and the WHO International Classification of Functioning, Disability and Health (ICF) model are explored for the usefulness in occupational health.

The main topics in occupational health care are the prevention of occupational and work-related diseases, and the control of consequences of diseases for work e.g. maintenance of work ability and prevention of sickness absence.

The cause-oriented *workload and capacity model* can be useful to illustrate how occupational or work-related diseases can develop for all kinds of occupational risk factors such as ergonomic factors, chemical substances, vibration or mental stressors. But also capacity or susceptibility aspects can be made visible such as genetic polymorphisms, pregnancy or coping skills. For a specific risk factor or disease, the model has to be transformed to a tailor-made version, developed in consultation with the various disciplines involved. The addition of relevant assessments and interventions can enhance the usefulness of the model substantially.

In the *ICF model* the factors that may influence participation in society are presented, in this case work participation. In this model focussing on the impact of a disease for participation, the disease is the starting point. As factors the severity of the disease and impairments of body functions are described. For 'activities' and 'participation', in this case work participation, capacities and actual performance are relevant. Personal characteristics are regarded as a contextual factor, e.g. illness perception and the ability to cope with the limitations in activities. The environment as a factor can include the social support of the supervisor and colleagues.

Both models can be applied for an overview of opportunities for assessments and monitoring, such as functional capacity evaluation or biological monitoring. Another application is to demonstrate the variety of possible interventions by occupational health professionals, such as the substitution of risk factors, stimulating concrete adaptations of the work, development of capacities by education and support of self-efficacy. Relevant activities can be a task of others such as technical experts and health care professionals who can be consulted.

References

Dijk FJH van, Dormolen M van, Kompier MAJ, Meijman TF. Revaluation of the model work load capacity (in Dutch) Tijdschrift voor Sociale Gezondheidszorg. 1990;68:3-10.

Heerkens Y, Engels J, Kuiper C, Van der Gulden J, Oostendorp R. The use of the ICF to describe work related factors influencing the health of employees. Disabil Rehabil. 2004;26:1060-6.

Hulshof CT, Verbeek JH, van Dijk FJ. Development and evaluation of an occupational health services programme on the prevention and control of effects of vibration. Occup Med (Lond). 1993;43 Suppl 1:S38-42.

Slebus FG, Sluiter JK, Kuijer PP, Willems JH, Frings-Dresen MH. Work-ability evaluation: A piece of cake or a hard nut to crack? Disabil Rehabil. 2007;29:1295-300.

Van der Beek AJ, Oort-Marburger D, Frings-Dresen MH. The relations between work demands and health complaints in lorry drivers. A model tested by means of LISREL.
Int Arch Occup Environ Health. 1994;66:179-84.

WHO. International Classification of Functioning, Disability and Health (ICF). Geneva: WHO, 2001 (http://www.who.int/classifications/icf/en/).

Caroline Minshell has been working in the field of occupational health since 1989. Having worked as the sole OH manager in a number of multi-national organisations she joined BP 9 years ago to lead a large OH team. She moved into an international role 2 years later and is now responsible for setting health strategy for part of the business, for 6 countries health management programmes and is involved in a number of projects. Resourcing, mentorship, development of tools and best practice documents and audit are part of her role. Her main project as lead, is capability on a global scale for all health professionals working in BP.

She is a member of the OHMF steering committee, chair of the Thames Valley Occupational Health Nurse group and member of Corporate Health and Performance (CHAP). She has presented at national and international conferences on health risk assessment and management and global emergency medical planning.

Christina Butterworth has worked in the Occupational Health field of practice for 18 years within various international, National and local organisations. Her present role is that of Health Risk Manager for BG Group, with responsibility for; developing and implementing health standards, providing strategic occupational health advice and auditing both medical facilities and BG businesses around the world. Prior to this appointment Christina has gained in depth experience and developed her skills in; health surveillance, absence management, health risk assessment, office ergonomics and travel health. She has presented at various national and international conferences on topics such as travel risk assessment, behaviour change and the RCN OH competencies. Christina is presently the Chair of the RCN OH Managers Forum and has helped to develop 2 RCN publications: 'Clinical supervision in the workplace - Guidance for Occupational Health Nurses' and 'Competencies: An integrated career and competency framework for Occupational Health'.

SUMMARY

Practical Magic

Health risk management may seem to be the realm of a few who hold the magic knowledge but there are practical techniques to build the necessary competence.

Health risk management underpins all health programmes and should be the first step in managing health. Without it, the health management programme falls down.

Unlike safety and environmental risks there are presently few tools to assist management in understanding health issues and determine risk priorities, let alone control the negative outcomes. There is a confusing array of issues to be considered, so it’s not surprising that they are often less than comfortable with the management of health. Like driving a car, you don’t just get in and drive. You need guidance and support to acquire the necessary skills, whilst also considering; other road users, third parties and the activity itself, to prevent risky outcomes like a collision.

You as OH practitioners can drive this process.

I am sure that many OH practitioners conduct risk assessments, such as manual handling and lifestyle but few of them have a documented health risk assessment for the WHOLE workplace. As OH practitioners we know the importance of the holistic approach, however very little is written about a structure or process to realise this for workplace health risks. Health risk management is a multidisciplinary process involving many individuals, particularly those who are involved in the work tasks being assessed. A considerable amount of data should be gathered to assist in the risk evaluation (such as health reports, environmental monitoring, analyses, health surveillance results, occupational illness and injury statistics, other risk assessments, employee records, task rotations). Risks should be prioritised, mitigations planned with assigned responsibilities, metrics set and the health plan monitored to a specified timeline.

We will demonstrate the simple process each of our organisations has employed with practical examples on their use, so that you can utilise these within your own organisations.

Dr. Grahame Brown works as a doctor specialising in musculo-skeletal, sport & exercise medicine. He is trained in occupational medicine and this additional expertise is valuable when advising on occupational rehabilitation. He is also trained in brief solution focussed counselling / psychotherapy from the Human Givens model, invaluable in the practice of integrated medicine. He has an NHS and private practice based in the West Midlands and consults for a wide range of industries nation wide. Grahambrown50@hotmail.com. *www.drgrahamebrown.co.uk*

SUMMARY

Regional pain problems, tiredness, worry causing physical symptoms are all common health complaints which so often have no clear organic basis for their existence but are very real to the sufferer. These complaints account for most of the long term and recurring sickness absence problems in the workplace and at least 70% of people who draw Incapacity Benefits. The traditional (at least the last century) bio-medical model of health care fails these patients most of the time and becomes part of the problem perpetuating their suffering. An out-line of a bio-psycho-social approach is put forward looking at known risk factors that perpetuate symptoms and disability and a problem solving approach for us all to help move these patients forward.

Intended learning outcomes

1. why the bio-medical model of health care doesn't work for common health complaints

2. develop the organising idea of an obstacles to recovery approach

3. identify one thing you can do differently when seeing your next client

References

1. Concepts of Rehabilitation for the Management of Common Health Complaints; Waddell & Burton 2004. TSO

Prof. Jorma Rantanen, MD, Ph.D, President of International Commission on Occupational Health, ICOH, since 2003. Until 2003 Director General of the Finnish Institute of Occupational Health and attached as an expert to WHO, ILO and EU. He participated in drafting of the ILO instruments on Occupational Health Services, the WHO Global Strategy on Occupational health for All and recently the WHO/ILO/ICOH Guideline for basic Occupational Health Services. He has over 30 years experience on programs for occupational health in developing countries in Africa, Asia and in Central and South America.

Specialist in occupational health service, in clinical occupational medicine, in toxicology research and in development of regulations for OHS in Finland and internationally.

Publications: about 450 research articles on several topics of occupational health.

ABSTRACTS
ORAL PRESENTATIONS

PNEUMOCONIOSIS IN COALMINERS IN ASTURIAS (SPAIN)

Alonso Jimenez; Esperanza

Introduction

The Principality of Asturias is a region with an important coal mining activity. Certain respiratory diseases like pneumoconiosis have been found to affect workers in this sector of the industry. Pneumoconiosis is a disease that presents few therapeutic treatments although it can be successfully avoided it by applying determined preventive measures. Hence, it is very important to deepen its knowledge. This study, leaded by Prevention Society of Ibermutuamur, shows data about incidence of pneumoconiosis cases between coalminers in Asturias and its relation to the working years in this industry and the health habits

Materials and Methods

Data referring to work histories, age, health habits, spyrometry and presence or absence of pneumoconiosis from 173 coalminers that belong to three different companies in Asturias were collected within a period of one year by the Prevention Society of Ibermutuamur.

Results

In this report the results obtained after the evaluation will be presented in percentages and statistics that indicate disease incidence and its association to different factors like age, health habits, previously plaques…with the objective to design a preventive strategy to combat this pathology in this group of risk. Further, we will propose a plan of activity that could be developed by the USB in terms of sanitary education and technical assistance in the companies in which the coalminers are working.

Conclusions

In terms of the results, health plans will be drawn up in order to try to avoid risks and to minimise the already established pathologies.

THE NEW OH SERVICE STRUCTURE IN THE NETHERLANDS

Ms. Marja Bakker, the Netherlands Presented by Susan Kamerling

Key words: is there place for an OHN in the new OH Service structure in the Netherlands

Due to recent European legislation, economical and political developments and the changing needs of employers and employees in the Netherlands, the OHN is working hard to redefine her position within the occupational health setting.

Since July 1st 2005, businesses will be given the opportunity to choose another form of expert support instead of the existing internal or external services provided by the Occupational Health Services. There is a stipulation that the employer and the employees council will have to reach an agreement concerning this alternative form of occupational health support. When a consensus has been successfully reached, the company can then arrange and implement the alternative form of support. The Dutch Law of the Working Conditions, has named this the “made-to-measure” regulation, made to order regulation. If an agreement cannot be reached then the existing support continues and the compulsory requirements attaining to the Occupational Health Service remains in force. This is the “safety-net” regulation.

This means two important changes. Firstly, a legal requirement that all businesses will need to employ a prevention co-ordinator. The Law of the Working Conditions stipulates also a contract with a registered Occupational Health Physician. The Occupational Health Physician plays an important role, providing support for employers and employees and policies regarding absenteeism due to sickness. Further advice and support can be obtained from registered Safety Engineer Experts, Occupational Industrial Hygienists and Work Organisation Specialists. The Occupational Health Nurse is not mentioned anymore.

The effect is that many Occupational Health Services have decided to terminate the contracts of the Occupational Health Nurses.

Aim

An overview of the new OH Service structure and the effects to the role and position of OHN´s in the Netherlands.

Objectives

- Understand the new legislation around the organisation of the Occupational Health Services.
- To give an overview about the changes of this new OH Service structure.
- The role and position of the Occupational Health Nurses.
- The effects of the changes for the Occupational Health Nurses.

References

- The decision of the EU court about the OH Service Structure, 2004
- The Law of the Working Conditions, 2005 and 2006
- The profile of the Prevention Co-ordinator, 2005
- The OH Professions Act, 2004

ASSESSMENT OF CRITICAL THINKING DISPOSITION IN POST-REGISTRATION NURSES UNDERTAKING SPECIALIST PRACTICE EDUCATION FOR PUBLIC HEALTH NURSING PRACTICE

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Rationale & Methods
To achieve the critical thinking outcomes required in post-registration nurse education attention to critical thinking disposition development is required. This requires assessment. This mixed method study assessed and explored critical thinking disposition in distance learning Specialist Community Public Health Nursing students. Survey data was gathered using The California Critical Thinking Disposition Inventory on-line and semi-structured interviews were used to gather qualitative data.

Findings
Survey findings revealed positive mean total scores, wide variation in scores, and 27% of participants with scores demonstrating ambivalence towards critical thinking. Mean scores for truth seeking and systematicity were ambivalent; all other mean scores were positive. Scores were lower than those reported in a North American meta-study (Facione & Facione 1997). Interview data suggests that participants found testing interesting and useful. Sociological factors, including primary and secondary socialisation and work culture, and psychological factors, including motivation and confidence, were identified as determinants of the disposition to question and think critically.

Implications
Findings suggest that developing critical thinking disposition requires critical thinking orientation, the use of frameworks to structure thinking, development of CT skills, structured feedback on critical thinking, and more opportunities for dialogue. Early introduction of research appraisal skills and confidence building interventions were also identified as potentially useful. Although quantitative data collection difficulties encountered in this study impose limitations on interpretation of data, the study demonstrates that both quantitative and qualitative CTD assessment is feasible and useful in educational needs assessment.

Findings raise questions about the CTD characteristics of SCPHN students and the requirements for effective DL for CT development. DL may offer fewer opportunities for dialogue and active co-operative learning. Although creative use of e-learning can address this, student confidence and competence to participate in on-line discussion needs to be developed. CT disposition development requires enculturation (Tishman et al 1992). This may be compromised in DL that lacks of face to face contact and exposure to Higher Education environments and/ or by exposure to practice cultures that are resistant to CT. Teaching and learning strategies must acknowledge and address these issues.

References
Facione, N & Facione, P 1997 Critical Thinking Assessment in Nursing Education Programs: An Aggregate Data Analysis. USA. California Academic Press.

Tishman, S., Jay, E and Perkins, D 1992 Teaching Thinking Dispositions: From Transmission to Enculturisation. Accessed On-line@
www.learnweb.harvard.edu/ALPS/thinking/docs/article2 (13.04.06)

THE STUDY OF OCCUPATIONAL FATIGUE AT A FLY IN / FLY OUT MINERALS EXTRACTION AND PROCESSING OPERATION IN REMOTE NORTH QUEENSLAND

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Introduction
The School of Public Health and Tropical Medicine at James Cook University conducted a prospective observational study of fatigue in staff working a 10 day/5 off/8 night/5 off roster of 12 hour shifts at a fly-in/fly-out minerals extraction and processing operation in remote northern Queensland, Australia. The aims of the study were to determine whether fatigue in staff increased: from the start compared to the finish of shift; with the number of consecutive shifts; and from day- compared to night-shift.

Methods
Data of sleep/wake patterns, cognitive processing reaction times and subjective ratings of fatigue were collected using sleep diaries, the Mackworth Clock test and the Swedish Occupational Fatigue Inventory respectively at the start and finish of each shift of the roster from August to November 2004.

Results
A total of 51 staff participated in the study. Cognitive processing reaction times, sleepiness and lack of energy scores were higher at the finish of the first four night-shifts compared to any other stage of the roster. The reaction times increased significantly at both the start and finish from the eighth day-shift onwards, and at the finish of the seventh night-shift. Reaction times and lack of motivation were highest during night-shift.

Conclusión
From the above results, a roster of more than eight consecutive shifts in combination with a disturbed diurnal rhythm and decreased motivation during night-shift are the primary contributors to fatigue in staff in this setting. The implications for changes to roster design, workplace environment, and organisational policies, procedures and practices will be discussed.

USING CHAMPIONS TO TRANSFORM CLINICAL PERFORMANCE

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The rate of change in occupational health has never been greater. The expectations of patients and managers are rising and they are increasingly likely to ask challenging questions about the evidence for our practice and the quality of our activities. The environmental context is also changing as there is increasing political emphasis on keeping people at work and increasing demands for 'professionalism'. Occupational health nurses are adapting to these changes but inevitably some will do this more easily and more enthusiastically than others.

This presentation describes the work of a "Shaping the Future" team. This team worked to change the debate from "it can't be done" to "how well can we do it" redefining the leadership capabilities of occupational health nurses, transforming engrained working practices, and raising morale. The presentation will focus on hard data that measures soft issues and provides compelling evidence of change. Data will be presented that demonstrate quantum changes in morale, professionalism, productivity, quality, and performance development. In addition data will be presented that shows that these changes are associated with improved customer satisfaction and improved health of the workforce.

Using a case study approach the presentation will address the simple steps occupational health nurses can make to change the care they give and support the development of their teams.

Reference

Kirk Helen, Preece Richard 'Looking at the whole picture'
Occupational Health, June 2006 Volume 58 No.6

AUDITING THE MANAGEMENT OF LONG TERM ABSENCE - MOVING TO PEER REVIEW

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During British Airway's recent business challenges and headcount cuts, the management of British Airways Health Services (BAHS) has needed to ensure that BAHS adds value to the airline.

The BAHS input to the management of attendance was identified as an important issue for audit. It was agreed to look at this to help ensure all practitioners work consistently and effectively and where necessary, to identify areas needing change or development.

A random sample of cases was audited, using agreed criteria. The aim was to identify in the management of long-term absence, if BAHS had either added value *or* not added value *or* destroyed value.

The audit was first conducted successfully during 2004 and all practitioners fully informed of the revealing and interesting results. The team's response was varied, ranging from optimism and acceptance to scepticism and negativity.

Noting these responses and again involving the team, it was decided to continue the audit but rather than repeating a management led approach, BAHS would introduce formal & regular peer review.

The goals of peer review were to

- Enhance the quality of client care.
- Ensure BAHS adds value to the business
- Involve the practitioners
- Provide personal growth and learning for the health professional team.
- Support the vision of a high quality and efficient occupational health service.

The purpose of this paper is to

- Provide information of why and how peer review is used by a large service
- Assist understanding of the advantages of these review methods
- Inform of the challenges
- Encourage utilisation of this type of audit

The paper is relevant to promoting good practice in occupational health and in many ways relates to each of the conference themes.

References

Cohen B, Berube R, Turrentine B 1996. A peer review programme for professional nurses. Journal of Nursing Staff Development. 12(1) January/February pp13-18

Gopee N 2001. The role of peer assessment & peer review in nursing. British Journal of Nursing 10(2) January pp115-121

Ontario Nurses' Association 2006. Position statement on peer review. Sept 2006http://www.ona.org/webfm_send/402?#

LIPOATROPHIA SEMICIRCULARIS OR LS IS A DISORDER CHARACTERIZED BY AN ATROPHY (I.E. DISAPPEARANCE, MELTING AWAY) OF THE SUBCUTANEOUS FATTY TISSUE

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The disappearance of the subcutaneous fatty tissue occurs in a semicircular zone, hence the name 'semicircularis'.

The subcutaneous fatty tissue disappears on the anterolateral side of the thigh at desk height. The lesion occurs 72 cm or 74 cm from the floor, measured on standing patients wearing shoes and this is the predominant desk height in all our administrative buildings.

The indentation can be on one or both legs and, in rare cases, there may be multiple indentations on each leg. Depending on their severity, indentations can be between 5 and 20 cm long, 1 to 3 cm wide and 1 to 5 mm deep.

In the early phase there are often symptoms involving the upper leg, such as tingling sensations, a feeling of heaviness or the tenderness of a bruise.

These symptoms disappear as soon as the indentation appears. After that, only the aesthetic damage remains. A small percentage of colleagues with LS suffer persistent local complaints.

The existence of LS is often linked to working constantly in a large, new or renovated office building. Normally, the first reports of LS emerge two to three months after moving in to an 'LS-sensitive' building. It is quite wrong, however, to suggest that LS only occurs in new or renovated office buildings. The phenomenon has also occurred in older buildings containing little or no computer equipment.

We had the opportunity to present this problem to delegates at the third FOHNEU congress in Helsinki three years ago.

The subject stimulated considerable discussion both during and after the congress, since only a handful of those present had heard of the condition, and no-one knew how to cure it.

Three years on, we still do not know for sure <u>what causes</u> this phenomenon, but by means of trial and error we have learned how to manage the condition. For the first time in more than 10 years, there have only been a handful of new LS cases reported during the last 12 months. Furthermore, it is also important to report that, thanks to the measures taken, the condition has either disappeared completely or improved significantly among a large number of our colleagues.

Current thinking on remedying the condition is focused on limiting ESD (Electrostatic Discharge) as much as possible.

FACTORS INFLUENCING THE ABILITY OF IRISH OCCUPATIONAL HEALTH NURSES TO PROVIDE PRIMARY CARE IN A CHANGING WORKPLACE USING A QUANTITATIVE APPROACH

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Consistent with best international practice the emphasis in today's Irish healthcare setting is on the development of primary care services, so that they become the cornerstone of care and preventative services (Department of Health and Children, 2001 & 2004). The workplace has been identified as one of the key primary care areas to promote the health of the working population (World Health Organisation, 2001). These changes have prompted debate among occupational health nurses, with questions being raised in particular about educational preparation, practices and ability to meet the occupational health educational needs of employees in the workplace. However, a review of the literature highlights a paucity of studies in relation to all aspects of occupational health nursing practice in Ireland.

The aim of this study was to identify the factors influencing occupational health nursing practice in Ireland and to establish Occupational Health Nurses' perception of their ability to meet the changing occupational health educational needs of employees in the workplace.

The objectives were

- To identify and describe, the factors influencing occupational health nursing practice and professional development in Ireland.
- To establish occupational health nurses' perception of their ability to meet the occupational health educational needs of employees in a changing workplace.
- To articulate the current practices employed by occupational health nurses in Ireland

The findings have been grouped into the following areas

- Factors influencing practice including, educational preparation for role of OHN in Ireland.
- Occupational Health Nurse perception of ability to meet the occupational health educational needs of employees in the workplace.
- Practices employed by Occupational Health Nurses in Ireland.
- Resources available, to support occupational health nursing practice, in Ireland.

Recommendations have been made in this study for occupational health nursing practice with regard to education, practice and research, if the Occupational Health Nurse is to meet the challenge of providing primary care in the workplace.

References

Department of Health and Children, (2001) Primary Care A New Direction Government Publications Dublin Ireland.
Department of Health and Children, (2004) Guidelines For Community Involvement in Health, Position Paper of the National Primary Care Steering Group Government Publications Dublin Ireland.
World Health Organisation, (2001) The Role of the Occupational Health Nurse in Workplace Health Management World Health Organisation European Centre for Environment and Health, Geneva.

PRIVACY AND DUAL LOYALTIES IN OCCUPATIONAL HEALTH PRACTICE

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Key words: privacy, occupational health care, dual loyalty, ethics, tripartite co-operation

An ethical dilemma is defined as a problem where there is a conflict between two or more values, where there are two or more 'right' courses of action. Ethical dilemmas around privacy issues are frequent occurrences in occupational health (OH) practice. Occupational health professionals (OHP) are often caught between the conflicting interests of employees who wish to maintain their privacy and employers who have a legitimate right to know. OHP must carefully balance these interests of both groups of clients, employees and employers.

The **aim** of this study was to analyse OHP' courses of action related to privacy in their position of dual loyalty. The postal inquiry, followed by a reminder card, was sent to randomly selected respondents in the winter of 2006. The overall response rate was 64%; 140 (77%) nurses and 94 (51%) physicians returned the questionnaire.

The **objectives** were:

- What courses of action do OHP adopt in ethically problematic situations related to privacy?
- Do nurses and physicians differ in their courses of action?
- What is the underlying knowledge base of the different courses of action?

The main **findings**:

- The most valid course of action in dealing with sensitive subjects such as drug and work community problems, sexual harassment and sick leaves in the dual loyalty position, is to rely on tripartite cooperation.
- There were statistically significant differences between nurses and physicians in relation to the courses of action adopted in the problematic situations of privacy.
- The most commonly used knowledge base in the choice of one's courses of action was work experience. Evidence-based decision-making remains as rare as it has been previously in Finnish OH.
- If professional independence and impartiality are maintained, OHP have every chance to succeed in the challenging task: maintaining privacy of their two groups of clients, employees and employers.

Recommendations:

- Ethics and ethical codes should be adopted as an integral part of basic professional training and education.
- OHP should be taught to apply research knowledge in their decision-making.

References

Martimo K-P, Antti-Poika M, Leino T et al. Ethical issues among Finnish occupational physicians and nurses. Occup Med 1998; 48: 375-80.

Higgins P, Orris P. Providing employer-arranged occupational medical care: conflicting interest. Occup Med 2002; 17: 601-606.

Mitchell CS. Confidentiality in occupational medicine. Occup Med 2002; 17: 617-623.

Heikkinen A, Launis V, Wainwright P et al. Privacy and occupational health services. J Med Ethics 2006; 32: 522-25

London L. Dual loyalties and the ethical and human rights obligations of occupational health professionals. Am J Ind Med 2005; 47: 322-32.

AN EVALUATION OF THE EFFECTIVENESS AND BARRIERS TO REHABILITATION PROGRAMME IN THE MANAGEMENT OF LONG-TERM SICKNESS ABSENCE, WITHIN THREE NORTHERN IRELAND NHS TRUSTS

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The author undertook primary research as part of the dissertation towards the Executive MBA at Queens University, Belfast from February - September 2006. The research dissertation received a prize for the best dissertation at distinction level and the results are due to be published in Occupational Health Journal and peer reviewed journals. The overall aim of the research was to assess the attitudes of both employees and senior managers within three neighbouring NHS Trusts in Northern Ireland, relating to the effectiveness and possible barriers to long-term sickness absence rehabilitation procedures.

Review of the academic literature highlighted the lack of empirical evidence, particularly in the UK and NHS, in relation to the effectiveness of rehabilitative return to work programmes in the management of long-term sickness absence (Ritchie et al 1999, Whitson and Edward 1990 and Wright 1997). The literature review also highlighted the lack of research surrounding employee attitudes towards rehabilitation return to work programmes (Butler et al 1995, Cunningham and James 2000, Evan and Walters 2003, Franche et al 2004, Kenny 1996, Krause et al 1998, Nice and Thornton 2004, Pransky et al 2005 and Whitson and Edwards 1990).

Therefore, the applicant carried out primary research which consisted of both an extensive quantitative employee postal survey (total survey sample - 660 employees) and a small number of qualitative semi-structured interviews with senior managers, across the three organisations. The results from the employee survey indicated that staff who received rehabilitative changes found them effective and the majority of respondents indicated that the rehabilitative changes did facilitate an earlier return to work. However there were significant differences in the attitudes expressed by employees and managers relating to the effectiveness of rehabilitation measures in facilitating an earlier return to work.

THE ROLE OF THE OCCUPATIONAL HEALTH NURSE IN MANAGING ABSENTEEISM IN THE NETHERLANDS

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In this presentation I do announce you:
- The Law of the Gatekeeper Improvement Act
- The reason for this new law
- The swing of the role of the OHN from prevention to reintegration
- The future for our occupational health nurses in the Netherlands

Since 2002, by the law of The Gatekeeper Improvement Act, employers and employees have also been responsible for the prevention of absenteeism and reintegration. It imposes a new set of rules, which employees, employers and the Occupational Health Service have to comply with in the case of absence through sickness, and is intended to stimulate employers and employees to start working on solutions as soon as possible in the case of protracted sickness.

The Gatekeeper Improvement Act sets out the steps the employer and employee must take to get the sick employee back to work again as soon as possible. The Act therefore places conditions on the work resumption process and this has tightened up the rights and obligations of employers and employees considerably.

The consequences of the implementation of The Gatekeeper Improvement Act are disastrous for the Occupational Health Nurses. Before the law was implemented we were working in occupational health as a prevention adviser and counsellor. After the implementation of this law, the Occupational Health Services decided to change the role and the tasks of many OHN´s. They were PUSHED in the role of managing absenteeism without the part of our prevention tasks.

After four years, absenteeism is decreasing and reintegration has a stimulated effect. But the result is that the OHN is not any longer useful for the task managing absenteeism. After 60 years, Occupational Health Nurses are not longer useful in Occupational Health Service in the Netherlands.

IMPLEMENTING CASE MANAGEMENT ON A GLOBAL BASIS

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Abstract
Case management can be defined in many ways but is generally considered to be the coordination of post-injury or illness care for the purpose of achieving the best outcomes for all parties. This is accomplished by providing the best care, in a timely manner, by the best-qualified provider for the injury or illness at hand. Best outcomes usually follow and include optimal physical recovery and the ability to return to work in a timely manner. The case management process includes thorough assessment of the injury/illness, open planning for optimal care delivery, implementation of the treatment plan and ongoing evaluation of the effectiveness of treatment and can be used for work-related and non-work related injuries and illnesses.

Case management has become an integral part of US-based occupational health systems, with specialty areas of nursing and professional certification being built up around this activity. However, implementing the same strategy globally has often met with skepticism, resistance and the claim of legal barriers. Many elements affect the ability to successfully implement case management, including company policies, work environment, attitudes and behaviors. By defining case management in its most basic elements, and then using a leading indicator model to further define this metric, Baxter has been able to successfully implement pro-active case management on a global basis. This presentation will illustrate how case management program implementation was coordinated globally and will address the challenges faced, strategies utilized, and tools that were developed to support facility-level implementation. Strategies for communication and dealing with cultural barriers will be discussed, along with multiple country-specific examples including the overall injury record outcomes.

References
Denniston, P.L. (Ed.) (2006). Official Disability Guidelines, 2004. (11th Ed.) Work-Loss Data Institute: Corpus Christi

Denton, V., and Leinart, N. (2004). Absence monitoring: A case management perspective. AAOHN Journal. 49

Dyck, Diane, (2000). Disability Management: Theory, Strategy and Industry Practice. (2nd Ed.) Butterworths: Toronto and Vancouver

EVALUATING THE APPROPRIATENESS OF ELEARNING IN OCCUPATIONAL HEALTH EDUCATION

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Momentarily it is not possible to study occupational health nursing in Slovenia. For that reason our participation in the European Leonardo project "Harmonizing the Occupational Health Nursing in the European Union -HOHNEU" is very important. An in its scope a master degree program in occupational health will be developed.

Regarding the fact that entire master degree program will be managed/carried out as distant eLearning program, we performed in a research study on attitudes and opinion regarding distance education in nursing among full time students at Faculty of Health Sciences University of Maribor.

The study showed that almost all students posses a computer and have an access to the World Wide Web (Internet) and that about two thirds of them use it for educational purposes. One third of the students had minimal or moderate knowledge about eLearning, but more then half of them would like to use it in combination with conventional lectures (so called blended learning). The main reason for using it is flexibility and that eLearning can be used everywhere at anytime.

To extend the findings encountered in the study above we performed a follow up experiment. We designed eLearning materials for a short 2 hours course in Research methods in Occupational Health Nursing. The course materials were first presented as a conventional lecture and after one week we performed a pre-test. The average score of the test was 41%. After the test the students had two hours to learn from the eCourse materials and after that we performed the post-test. The items for both the pre and post test were selected randomly from the same pool of items for each student individually. The average post-test score was 60% and the student-t test showed that the difference between pre and post test was significant ($p=0.00$). Students also answered to a questionnaire which showed that they were satisfied with the structure and appearance of the eCourse materials and that they like the eLearning experience and indicated that they would prefer having some of the theoretical subjects in occupational health nursing in the form of eLearning instead of classical lectures.

From the results and experiences collected through the both studies we can conclude that eLearning is an appropriate method for occupational health education but we also have to take into the consideration that nursing education requires some specific requirement which will be discussed in the full paper.

REVIEW OF THE NOISE SOURCES IN THE HOSPITAL SETTING. CAUSES, RESULTS AND RECOMMENDATIONS

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Background
The level of sound pollution in the intensive care units, operating theatres and recovery wards have exceeded the internationally recommended levels. The hospital equipment itself, as well as, conversations among the personnel constitute the main sources of sound pollution.

Aim
To produce an information booklet for patients and nursing personnel affected by the noise pollution.

Method
Literature studies and practical experience.

Results
The emergence of headaches and irritability, a delayed recovery, or sensitivity to pain, which are all signs very often observed at in-patients, are due to the various types of noise taking place in the interior of the hospital.

Conclusions
Taking precautions, such as using low alarm equipment, isolating highly noisy rooms and replacing noises with musical sounds, has proved helpful not only to the improvement of patients' recovery, but also to the quality of workplace

References
1. Biley FC. Effects of noise in hospitals.Br J Nurs.1994 Feb10-23;3(3):110-3
2. Moore MM, Ngugen D, Nolan SP, Robinson SP, Ryals B, Imbrie JZ, Spotnitz W. Interventions to reduce decibel levels on patient care units. Am Surg.1998 Sep;64(9):894-9
3. Tsiou C, Eftymiatos D, Theodossopoulou E, Notis P, Kiriakou K. Noise sources and levels in the Evgenidion Hospital intensive care unit. Intensive care Med 1998 24:845-7.
4. Topf M, Thompson S. Interactive relationships between hospital patients' noise-induced stress and other stress with sleep. Heart Lung 2001 Jul-Aug;30(4):237-43.

VARIATIONS IN NASAL REACTIVITY AND HEALTH-RELATED QUALITY OF LIFE IN FEMALE HAIRDRESSERS WITH WORK-RELATED NASAL SYMPTOMS

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Background: Hairdressers are exposed to several reactive chemicals and they have an increased incidence of nasal symptoms (1). We have earlier shown effects on nasal symptoms from persulphates in hairdressers. In a qualitative study hairdressers claimed to become less reactive to hair chemicals after a few weeks of holidays (2).

Objectives: We studied changes in nasal reactivity to persulphates and in healthrelated quality of life in hairdressers with hair bleach related nasal symptoms after holidays and again after one month of exposure.

Methods: Seventeen female hairdressers with hair-bleach related nasal symptoms without atopy (HS) and 20 without symptoms and atopy (HNS) participated. As a control group ten non exposed pollen allergic women (A) were employed. A medical examination including information about symptoms and relation to work, a skin prick test to common allergens and to persulphates was performed. After at least two weeks off work the hairdressers filled in questionnaires for quality of life (SF36, RQLQ) (3,4). The symptomatic hairdressers were also challenged with solutions of persulphate (0.001% and 0.01%). A nasal symptom score (NSS), and acoustic rhinometry (AR) were used as markers of effects. This procedure was repeated after one month of exposure. The controls filled in the questionnaires before the pollen season and after four weeks of rhinitis.

Results: The HS group increased significantly in nasal blockage after one month of exposure compared to the pre exposure situation shown both in symptoms and rhinometry. Their NSS increased significantly after the challenges both before and after exposure. However, no significant change was noticed in reactivity to persulphates, indicating a negative effect of the chemicals but no increase in reactivity to persulphates. The HS group as well as the A group had significantly lower specific quality of life (RQLQ) than the HNS group both before and after exposure. Quality of life decreased during the exposure and during the pollen season in hairdressers and atopics respectively in both ROLQ and SF36.

Conclusion: Symptomatic hairdressers increase in nasal symptoms and decrease in quality of life during exposure. However nasal reactivity to persulphates does not seem to increase during the month of exposure.

References:

1. Albin M, Rylander L, Mikoczy Z, Lillienberg L, Dahlman Höglund A, Brisman J, Torén K, Meding B, Kronholm Diab K, Nielsen J. 2002. The incidence of asthma in female Swedish hairdressers. Occup Environ Med 59:119-123.
2. Kronholm Diab K. Hur påverkar överkänslighet mot blekmedel kvinnliga frisörers hälsa och livskvalitet. Thesis for Bachelor Degree, Dept of Nursing, University of Lund. 2002.
3. Sullivan M, Karlsson J, Ware J. The Swedish SF-36 Health Survey-I. Evaluation of data quality, scaling assumptions, reliability and construct validity across general populations in Sweden. Soc Sci Med 1995;41:1349-1358.
4. Juniper EF, Guyatt GH. Development and testing of a new measure of health status for clinical trials in rhinoconjunctivitis. Clin Exper Allergy. 1991; 21: 77-83.

RETURNING THE INCAPACITATED WORKER TO WORK OR THE DISABILITY BENEFIT ROUTE - A SOUTH AFRICAN PERSPECTIVE

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ABSTRACT

Key words: impairment; incapacity; disability; disability management; functional capacity evaluation; return to work program.

Major changes in South African legislation in recent years highlight the rights of disabled people, particularly in the workplace. Employers are faced with the responsibility of accommodating employees with disabilities - even more so when the disability occurred as a result of an occupational injury or disease. Returning incapacitated workers to work has important benefits to both the employer and the employee. The various paths which a disability case may take depend on the intervention and management of the case by the employer. Which path any specific case will follow is determined by the particular circumstances of the case. A fundamental underlying principle, which applies to all disability situations, is that there must be an outcome, or in other words, anybody that enters into the disability management process must exit it, as people are not allowed to remain looping around or to sit statically inside the process indefinitely. The preferred outcome is always to have employees return to their normal duties as quickly as possible but if that option does not exist an application for disability benefits is the next step, often with dire consequences to the affected worker.

Aim

An overview of the importance of returning an incapacitated worker to work.

Objectives

Understanding the difference between impairment, incapacity and disability with specific reference to the workplace.
Identifying the forces that sabotage return to work
Understanding the benefits of returning to work.
Using members of the multi-disciplinary team.
Understanding disability management.
Overview of the duties of employers in terms of South African legislation.

References

South African Constitution.
Employment Equity Act No 55 of 1998 and Code of Good Practice on Key aspects of Disability in the Workplace.
Labour Relations Act No 66 of 1995.
Occupational Health and Safety Act No 85 of 1993.
Mines Health and Safety Act No 85 of 1993.
Compensation for Occupational Injuries and Diseases Act of 1993.
Demeter SL et al. Disability Evaluation. St Louis: Mosby. 1996.
Shrey DE, Lacarte M. Principles and Practices of Disability Management in industry. Boca Raton: CRC Press, 1995.

THE VALUE OF STANDARDIZING HEALTH PROGRAMS TO ENSURE OCCUPATIONAL HEALTH SERVICE OUTCOMES IN A GLOBAL CORPORATION

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Key words: value, OHN, auditing process, standardized health programs

Johnson & Johnson is a global health care corporation with more than 110,000 employees globally, representing more than 50 countries. The global distribution of operating companies therefore entails a wide variety of Occupational health services.

J&J has manufacturing capabilities in 11 European countries, and Sales and Marketing in another 9 countries. Health care service provision for manufacturing companies is mostly rendered on site, although in a limited number, an external provider will deliver service provision.

Service delivery in terms of nursing is carried out by nurses with a variety of educational backgrounds, varying from well qualified occupational health nurses, to emergency or medically qualified nurses. This is compounded by the fact that occupational health education is not available in all European countries. Having Johnson & Johnson representation in a number of European countries offers us a unique perspective on the regional variability of occupational health services in European countries.

The concern therefore exists that health service delivery may vary from country to country, and may be influenced by the educational level of the service provider. Consequently, in order to achieve the expected outcome in terms of the set corporate goals, certain procedures had to be put in place to ensure the required outcome.

The Corporation therefore developed the following to assist in the achievement of the above:

- Development of an extensive set of standards with associated guidance documents
- Regular auditing process performed by an external organization to measure adherence to the standards
- Provision of regional OH Advisors to provide support and expert guidance where required

The value of these processes is reflected in:

- OH audit results
- The achievement of Corporate goals
- In some countries, the provision of an OH service at a far higher standard than would be the norm for that country

"MAKING SENSE OF MODELS FOR THE PROFESSION"

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Historically we know from the literature that occupational health nurses (OHNs) have adapted models from general nursing and used them within occupational health settings (Thompson 1996). For years there has been the debate within the profession as to whether or not we actually need a model to guide and inform our practice. Chang (1994) surveyed OH nurses and asked this very question and discovered that 38% indicated the need for a model while 45% felt there was no such need and 16% did not respond. Clearly the profession was divided on this issue at the time and probably still are today. This same question has been asked in recent years with little response.

Aim

Give an overview on occupational health nursing models but the usefulness of two specific models.

Objectives

- Give delegates an appreciation that nursing stands on four great pillars (Wright 1990)
- Define what is meant by the terms "model" and "role" within nursing.
- Give delegates a range of OH nursing models.
- Distinguish between Chang's (1994) model and CeNPRaD's revised OH nursing model (McBain 2006)
- Apply model/s to specific working context.

Findings/conclusions

There is a wider array of models available these days, however the difficulty is in distinguishing between them and finding the best one for the specific purpose e.g. (Beattie 1991) for health promotion or Chang's (1994) for OH nursing practice or revised CeNPRaD OH nursing model (McBain 2006) which can be applied to practice, management, education and research.

The rational for proposing two specific OH nursing models are that both are underpinned by a sound research evidence base and involved a wide consultation with those in practice at the time. That is not to say that other models should not be considered only that there are fundamental differences between conceptual models and those which have emerged from a wide consultation process with those in practice at the time as well as a sound research evidence base. However the difficulty can be in appreciating the difference and it is up to each individual to decide which model best fits their purpose. So perhaps some of what has been delivered in this paper will help to make sense of what can be a daunting but illuminating subject.

References

- Chang P-J (1994) Factors Influencing Occupational Health Nursing Practice. A two part PhD Doctoral thesis. Kings College London. University of London.
- McBain M. (2006) This years' model. Occupational Health. March 2006
- Thompson. M (1986). Role enactment: A model for pre-retirement planning. Occupational Health Nursing. (1986) 34 (5): 221-227
- Wright . S. G (1990) Building and Using a Model for Nursing 2nd Edward Arnold. UK

OCCUPATIONAL HEALTH NURSING IN SCOTLAND: SCOPE OF PRACTICE AND FUTURE CONTINUING PROFESSIONAL DEVELOPMENT

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With the decline in manufacturing industries and the development of new businesses Scotland is has become integrated into Europe. Thus occupational health nursing as grown and expanded (Pickvance1996) and some have made moves towards primary and public health (Shipley 1996).Nursing for Health (SE 2001) addressed the concept of public health and how the nursing professions contribute towards it.

Aim - survey nurses working in occupational health settings across Scotland to identify their range and scope of practice and their perceived requirements for their future continuing professional development.

Objectives
- To identify the educational background and preparation of health nurses currently practicing in Scotland.
- To describe the range of job titles currently deployed.
- To articulate the scope of their professional practice.
- To explore the suitability of their educational preparation for practice.
- To identify the continuing professional development requirements.
- To identify areas for future practice and professional development.

Methodology
This was primarily a questionnaire survey which involved:
- A series of focus group interviews with the nurses themselves in order to help inform the content of the questionnaire.
- Review of the educational curricula from the main occupational health nursing programme providers in the UK in order to inform the questioning on educational preparation.
- A pre-pilot phase for validity and understanding of the questionnaire.
- A pilot study to test the sampling strategies, administrative process, questionnaire design and data handling procedures with a sample of occupational health nurses working in England.
- Administer, analyse and report on the main survey.

Conclusions
This project provided the first demographic and professional picture of nurses working in occupational health settings in Scotland. What emerged was a lack of uniformity, a great diversity and an inequity in working practices, role and professional status. Twenty two different recommendations emerged from this study and have been grouped into the following:

- Development of occupational health nursing practice.
- Development of primary care and public health aspects of the role.
- Development of education for students and existing practitioners.
- Development of research within occupational health nursing.

References

Pickvance. S (1996) Towards multidisciplinary prevention services. Occupational Health Review. Sep/Oct

Scottish Executive (2001) Nursing for Health. The effectiveness of public health nursing: a review of systematic reviews. SO Edinburgh

Shipley. P (1996) Occupational health outside the factory gate. Occupational Health Review. May/June pp10-13

ABSENTEEISM IN THE PRINTING INDUSTRY: A GREEK CASE STUDY

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Key words: printing industry, OHN, absenteeism, indicators

Occupational risks, that are present in a printing industry, are related to risks from mechanical equipment, exposure to chemicals, dust, noise, shift working, VDU work, high intensity work, etc. (1). Ooccupational accidents and diseases, that are the consequence of exposure to these risks, have been described in the literature and are most often related to injury of the fingers, musculoskeletal disorders, dermatitis, hearing loss, asthma and effects on the CNS (2,3).

The **aim** of this study was to estimate absence due to sickness for a number of 260 men and women working in a printing industry in Athens, for a period of one year, in 2003. Demographic and working conditions data were also collected.

The **objectives** were:

- To calculate indicators of absence, occupational accident frequency and severity.
- To calculate frequency distribution of absence spells, duration of absence days and absent workers for each diagnostic category.
- To examine the correlation between absence from work and demographic-working data.

Findings and recommendations
The results of this study revealed increased absence frequency of the workers in the specific industry, while the severity of absence was limited to a level that reflected satisfying working conditions. Musculosceletal and respiratory problems were the most frequent disease categories that resulted to employees' absence from work. As to occupational accidents, moderate frequency and low severity were observed at the particular industry, compared to other productive sectors mainly in Greece (4).

The examination of possible correlation between absence from work and demographic data, with the use of logistic regression, indicated that there was no association between absence and age, gender, specialty, sector of work, education, work experience and nationality of workers in the particular industry. Likewise, gender of workers did not have an effect on the duration of absence that occurred due to a health problem. On the contrary, there was a positive correlation between the duration of absence and the workers' age.

The limitations of this study are related to limited data for comparisons, because of the diversity of methods and indicators that are used by researchers as well as the small sample and the short study period used.

Monitoring of absenteeism can be used by employers, employees and OHS specialists as a non-specific tool to locate groups of workers at risk as well as the adoption of a common methodology to monitor it.

References

1. International Occupational Safety and Health Information Center. "International Hazard Datasheet- Printers" ILO/CIS, 2000.
2. Health and Safety Executive. "The printers Guide to Health and Safety" Crown, 1998.
3. Georgiadou E, Papadopoulos G, Komninos X et al, "Risk assessment of occupational hazards in the printing industry" 8th International Symposium ISSA, Research Section, Athens, 2003 [Greek].
4. IKA. "Annual Report on Occupational Accidents" Athens, 1996 [Greek].

THOUGHTS ON INVESTIGATING A SUSPECTED OCCUPATIONAL SKIN PROBLEM

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Given that:
We have our skin twenty-four hours each day, of which only eight or so will be spent at work
Chemicals that can contribute to skin problems exist outside the workplace as well as inside,
The most common form of occupational skin disease, irritant contact dermatitis, is mostly due to repeated exposures to many different chemicals,
Irritant and allergic contact dermatitis can occur simultaneously and may be difficult to differentiate,
Endogneous problems can also contribute to a skin problem, the investigation of a situation where a skin problem is suspected to be of occupational origin requires a comprehensive and careful approach. It will require an understanding of the working environment, the nature of any exposure and its significance as well as a medical diagnosis. The diagnosis must also reflect both occupational and non-occupational exposures.

Thus investigation of a skin problem in the workplace will generally require collaboration between occupational health practitioner, medical specialist (dermatologist) and the hygienist or safety specialist who can evaluate and assess the real workplace exposures. Unless this occurs the probability of an inaccurate diagnosis is significant.

The author will demonstrate a practical, structured approach, illustrated with case studies, that includes all the elements needed to reach a correct evaluation of the problem and will also propose ways in which the employee can then be kept at work.

THE EDUCATION OF OCCUPATIONAL HEALTH NURSES IN FINLAND – PLANS FOR THE FUTURE

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Key words; OHS, OHN, education, competence

The report done by Finnish institute of Occupational Health (FIOH) tells that there are about 2500 occupational health nurses (OHN) in Finland in 2004. Their number has increased year by year during last 4-5 years. They are working both in public and private sector in about 750 occupational health units which give services to enterprises, companies and their employees. Most of the time OHNs are working in multi-professional teams taking responsibility of health promotion and coordination of OHS.

The education of OHNs is based on the degree of public health nurse (240 sp). This education gives the basic competence to begin to work in OHS. Occupational health law requires supplementary education during two years working in OHS. OHN can get the education either in FIOH (10 sp) or in some of the numerous polytechnics (30sp). The main contents of these studies are occupational medicine, occupational health care, risk assessment, health promotion, legislation and labour protection, management and strategies, planning of occupational health service and work development. Until to today the education has given good competence to work as an OHN in OHS.

In the near future, changing working life demands new and more profound competence of the OHNs. In addition, lectures, leaders and researchers are needed in institutes, universities and in OHS. That is the reason why the universities (2-3), polytechnics (9) and FIOH have started the co-operation in Finland. We have got the main support from Ministry of Social and Health Care and Ministry of Education. We have to make a plan how to organize the higher education of OHNs in polytechnics and universities in corporation during 2007.

The plan is based on the analyses of the curricula in polytechnics and universities concerning management, preventive nursing science and health promotion. After that we try to specify the competence needed. We are going to take account also the xxxx European qualifications. We are taking advantage of strengths of all education producers in carrying out the education. Also the newest technology is going to use for instance virtual learning environment. The education is based on core processes of OHS. The main criteria are impressiveness and effectiveness of the OHS, needs of the clients, ethics, prevention and promotion and using evidence based methods. We planned to start the higher education of OHN in 2008. The target is to get about 300 - 500 OHNs, who have the higher education during next 10 years.

CURRENT STATUS OF OCCUPATIONAL HEALTH NURSING EDUCATION AND PRACTICE IN EU COUNTRIES

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Literature findings on the state of Occupational Health Nursing (OHN) show great discrepancies among countries within Europe and worldwide (Rossi 1987, Sourtzi 1993, Burgel et al 2005). The Federation of OHNs in the EU (FOHNEU) has developed and disseminated a model education curriculum – The Core Curriculum - but there is no evidence of its use until today (FOHNEU 1997).

The aim of this study was to find out the extent to which OHNs are educated and practise under statutory requirements within EU, as well as the extend to which the Core Curriculum developed by FOHNEU has been implemented so far.

A questionnaire was designed and sent out to country members of FOHNEU. The questionnaire was seeking information on education and practice, such as statutory requirements, description of existing courses regarding level, length and content, as well as information on practice regarding content and context.

The findings revealed that six countries have included some OH teaching in undergraduate curricula, either as a separate course, or as part of public/community health nursing. Ten of the countries that responded in the survey have established OHN specialisation, although courses offered vary both in length and content. Possibilities of postgraduate studies at master's or doctoral level exist in some countries. The Core Curriculum is not being used as such, but when analysing the content of specialist education some of the countries reported that have included most or some of its elements which are:

- Health Promotion in OH Nursing,
- The work of an OHN and interaction,
- Planning an OH Service,
- Administration and organisations aims,
- Evaluation and development of OHS.

Practice however in most of the countries has similarities, which is quite surprising considering the differences in education. It includes statutory requirements, but also public health nursing activities.

In conclusion, OHN practice is wide spread in EU, but education is not yet satisfactory for the role OHNs practise. The development of postgraduate specialisation programmes based on the Core Curriculum could be proposed for improving it. FOHNEU also is planning to continue surveying at frequent intervals the situation in EU countries, especially as EU is expanding.

References

Burgel B, Camp J, Lepping G (2005): The nurse's contribution to the health of the worker. Scientific Committee on Occupational Health Nursing. Working Party Report #10.
FOHNEU (1997): Core Curriculum for Occupational Health Nurses.
Rossi K (1987): Occupational Health Nursing world-wide. AAOHN Journal, 35, 505-9.
Sourtzi P (1993): Occupational Health Nursing in the European Community Countries: Education, Training and Practice. OCCUPATIONAL HEALTH, 45: 373-6.

USING CASE MANAGEMENT TO ADDRESS LONG TERM ABSENCE

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HM Prison Service regularly monitor their 300 longest absentees. In the first half of 2005 these employees consistently had a total absent of about 100000 days.

An OH nurse team was appointed to work with Prison Service to bring closure to the 300 longest cases using an active case management approach. The total absence of these cases when the pilot commenced was 98,925 days absence.

The principal measure was a reduction in the total duration of absence for the 300 longest absentees throughout HM Prison Service at the start and end of the project. (Naturally the employees in the start and end populations were different).

A case study approach was also used to provide qualitative data.

141 (47%) employees returned to work during the four months project compared to 40 who have been considered for Ill health retirement (and if not eligible termination of their contract).

The total absence duration was reduced by 11,945 days by intervening and bringing earlier closure. This equates to a non-cashable saving of over £1.4 million (after accounting for project costs).

The project has been extended to address medium term absenteeism and the model could be applied in any organisation to improve the case management of employees absent due to illness and get them back to work. Success will be dependent on close collaboration with managers and Human Resources.

PROMOTION OF SCHOOL COMMUNITY STAFF'S OCCUPATIONAL WELL-BEING IN CO-OPERATION WITH OCCUPATIONAL HEALTH NURSES

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Key words: occupational health, workplace health promotion, triangulation

This paper describes a research and development project of school staff members and occupational health nurses (2001-2004) in 12 comprehensive schools in Eastern Finland. The aim of this study was to describe school staff members' occupational well-being and activities aimed at maintaining their ability to work at the planning and beginning phases of the above-mentioned project. A further aim was to report on the outcomes of the action phase of the project. The study also sought to develop a theoretical basis for the promotion of school staff's occupational well-being by employing a structural equation model to empirically examine the functionality and structure of the theoretical *Content Model for the Promotion of School Community Staff's Occupational Well-being* in explaining school staff's well-being at work. The investigation, conducted during the years 2002-2004, implemented methodological and data triangulation. Based on the results in the planning phase of the project, the focus was on actions maintaining school staff members' individual and physical work ability. In the beginning phase of the project a quarter of the respondents reported dissatisfaction with the occupational well-being activities available in their working community. The two years of development saw a significant increase in the staff's satisfaction with activities aimed at maintaining their work ability. The structural equation model confirms the view that the *Content Model for the Promotion of School Community Staff's Occupational Well-being* is a useful framework in planning, implementing and evaluating development projects for school staff's occupational well-being. The results and the content model can also benefit occupational health nurses, school staff, occupational health service administration, school administration, researchers and educators in developing measures for the promotion of occupational well-being.

References:

Saaranen T., Tossavainen K., Turunen H. & Vertio H. 2006. Occupational wellbeing in a school community - staff's and occupational health nurses' evaluation. Teaching and Teacher Education 22(6), 740-752.

Saaranen T., Tossavainen K., Turunen H. & Naumanen P. 2006. Development of occupational wellbeing in the Finnish European Network of Health Promoting Schools. Health Education 106(2), 133-154.

Saaranen T., Tossavainen K., Turunen H., Kiviniemi V. & Vertio H. 2006. Occupational well-being of school staff members: a structural equation model. Health Education Research (in press).

BEING HEALTHY AT CONSTRUCTION SITE CD

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Background
Construction is very demanding for occupational health nurse for many reasons: workers suffer from occupational diseases, and most accidents happen in this field. The main reasons for the workers' early retirement are back problems. On the other hand the workers are conscious, and want information about the health risks of the work. One of the main duties of the OHN is to give information and guidance about these subjects. There is plenty of information about the building branch but lack of easy understandable information.

Aims
The aim was to make a simple educational multimedia CD program including the most important risk factors in the construction branch. It was meant to support the health examinations, and to serve as a tool for constructors' training.

Material and methods
The material was collected by video recording constructors' work during worksite visits.

This new educational CD program is easy to use not forgetting the humor in the learning process. It includes a short introduction to different professions in the construction field, the most common health risks and hazards. It also provides examples of work techniques and tools that can facilitate the work, and decrease the health risks.

Content: 1) Job descriptions (carpenter, construction worker, bricklayer, element fitter, plumber, electrician and building master) 2) Noise, vibration, bad lightning, heat and coldness/ layer dressing 3) Chemical, physical, biological and mental factors, 4) Welding, 5) Possible accident 6) Tips for better work conditions 7) Health examinations. CD also includes links which lead the user to the subject related internet pages.

The content of the programme was developed/ reviewed by an expert occupational health physician.

Conclusion
The program improves the health examinations, and serves as a tool in getting the information up to date among the occupational health professionals. The CD is a great visual educational instrument of vocational schools; a good tool for orientation of new workers as well as for occupational safety education.

THE CONTENT OF ELECTRONIC DOCUMENTATION OF HEALTH CHECK UPS

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Approximately one million health check ups are made every year in Finnish occupational health care. An immense amount of narrative and structured documentation is gathered from these check ups. Most of the data and information remains usable for only an individual nurse doing the health check up. Electronic documentation offers possibilities of further use of the information.

The purpose of this study was to describe the ideal content of an electronic documentation of health check done by occupational health nurses. The data were gathered using a two round Delphi method with purposefully chosen 17 expert panelists. The response rate for both Delphi rounds was 85%.

First Delphi round was an interview and second a questionnaire based on the results of the first round. Panelists were asked to identify an ideal content of documentation of a normal health check up and also to identify which information should be documented in numerical or structured form and which in narrative form.

Results indicate that numerical and structured form should be used when documenting Body mass index, results of measured indicators of wellbeing at work, physical education, eyesight, vital graph, vaccinations, sleep, and work ability. The following structured information needs additional narrative explanations: exposes, blood pressure, hearing and diabetes risk type. Free text should be used when documenting: working conditions, situation in life, family situation, leisure time, social life, managerial issues, vocational know-how, osteoporosis risk, gynecological issues, family illnesses, allergies, chronic illnesses, medications, job satisfaction, use of safety equipment, statement or estimate of the ability to work, and counseling. Consensus was not reached about how to document mental workload, stress, smoking, intoxicants, and nourishment.

A more systematic and structured body of documentation could add continuity and effectiveness to health check ups and add further use of gathered information also for other than individual purposes.

NURSE EXTERNSHIP PROGRAM

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The demographics of occupational health nursing in Ontario Canada are not looking good. The average age of the Occupational Health Nurse in Ontario is climbing exponentially, with the number of young graduate nurses entering the field not keeping up with the void being created by retiring experienced Occupational Health Nurses. It has been estimated that in 10 years in excess of 80% of today's practicing occupational health nurses will be retired. To investigate this phenomenon the Compensation Board of Ontario, in cooperation with the Council of Ontario University Programs in Nursing, joined forces to seek out the actual numbers. As a result of the less than favourable results, a partnership was formed between the Universities and the Compensation Board to develop a pilot nursing externship in workplaces as part of the university schools of nursing curriculum.

The key goals of the pilot program were to:

1. Create awareness among nursing students about their potential contributions to a healthy work environment and to ask the question that Hippocrates asked his patients many hundreds of years ago, "What do you do for a living",

2. Inspire students to consider a career in occupational health nursing.

Following the success of this pilot project, the administration of this project has been taken over by the Ontario Occupational Health Nurses Association, a group of 1100 Registered Nurses working in Occupational Health in Ontario, Canada. The plan is to develop a sustainability strategy for the future.

This paper will discuss the project, the format followed, the topics undertaken, and the successes of the program.

SPECIALTY RECOGNITION (CERTIFICATION) IN USA AND CANADA

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Specialty recognition in Occupational Health Nursing is different in Canada and USA than it is in other countries. In Canada we have developed an examination to determine eligibility for "certification" in the specialty of occupational health nursing. These examinations have been carefully designed by selected peer groups specifically charged with citing areas of expertise the candidate should have, specific knowledge in those areas of expertise, and then design specific questions regarding these areas. All of the examination design and implementation is supervised by a professional examination testing company. The examination is given yearly and its administration comes under the umbrella of the Canadian Nurses Association, which is also responsible for the examinations of candidates for 17 other nursing specialties. The certification credential is an important indicator to patients, employers, the public and professional licensing bodies that the certified nurse is qualified, competent and current in a nursing specialty. Certified nurses have met rigorous requirements to achieve this expert credential.

This paper will outline the steps taken to develop the examination and the criteria needed to qualify to write the exam. Comparisons will be made with the USA model.

This presentation will be of interest to countries developing their own levels of occupational health nurse expertise.

FLEXIBILITY IN THE WORK ENVIRONMENT THROUGHOUT THE LIFE SPAN – A SAFEGUARD AGAINST WORK-LIFE CONFLICT

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Key words: Work-life balance, working hours, stress, health risk.

Background: Attractive jobs are a much discussed topic! And work-life balance too! Opposed such conditions produce stressful work and life with health problems and absenteeism. Nurses have different needs e.g. when they are young or older and when they have children or not. How do we secure work-life balance throughout the life span?

Objective: The purpose of this paper is to clarify strains and resources in the nurses' working life which determinate work-life balance, low stress and health risk.

Methods: The paper builds on data from a follow-up study based on a questionnaire to 4559 nurses in Denmark. The study is being carried out in cooperation with the Danish Nurses' Organisation and The National Institute of Occupational Health.

Results: A stressful work environment is conditioned by an imbalance between work demands and resources. What factors in the psychosocial work environment ensure that the nurses are relaxed both at work and at home? Having influence on work organisation and flexibility of the working hours prevents work-family conflict, non-satisfied and stressed nurses. Satisfactory and healthy work environment includes appropriate time for lunch break, not working overtime and an optimal internal culture of the work place.

Conclusions: The manager can improve work-life balance by introducing flexible working hours, improved balance between demands and resources, high level of social support and adequate information. Healthy work environment throughout the life span of the nurses ensures low absenteeism and low job exit - in short "the good life-circle of the workplace".

References:

Wethje A, Borg V. The Nurses Work Environment, Job satisfaction and Health: ***Work-life balance***. Copenhagen: The Danish Nurses' Organisation and the National Institute of Occupational Health, 2003.

Wethje A, Borg V. The Nurses Work Environment, Job satisfaction and Health: ***Working hours and work environment***. Copenhagen: The Danish Nurses' Organisation and the National Institute of Occupational Health, 2005.

Wethje A, Bue R M. ***Stress among Danish Nurses***. Copenhagen: The Danish Nurses' Organisation, 2006.

PARTICIPATORY TEAMS IN THE INTERVENTION STUDY "HEALTHY WORK-PLACES IN THE HOSPITAL SECTOR"

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Key words: Participatory teams, workplace intervention study, health care workers

Introduction
In order to provide practical tools for the improvement of working condition at Danish hospitals, a governmental research program was initiated in 2002. As part of this program, the present intervention study was initiated in the psychiatric and orthopaedic ward at a Copenhagen University hospital. Previous studies have shown that the concept of local participatory teams has been a successful workplace intervention.

Objective
1) Evaluation of the establishment and functions of local participatory teams (to plan, initiate and implement intervention activities) 2) to decrease the prevalence of musculoskeletal complaints among the hospital staff 3) to increase the hospital staff ´s ability to cope with violence

Methods
Working environment problems were assessed in a validated questionnaire-based survey focusing on musculoskeletal- and psycho-social problems. Based on the survey, a controlled trial was conducted by assigning sub-units in the wards to either intervention or control groups. A follow-up questionnaire was applied after the intervention period.

Participatory teams were established in the 3 intervention sub-units. The teams´ major assignment was to decide 1) the appropriate intervention activities 2) how to initiate and implement the activities.

The research- group supported the teams by clarifying the relevant activities and assisting with practical issues.

Results/Conclusion
Low back prevalence decreased with 24% and sick-absence due to low-back pain decreased with 33 %. No significant changes were found in the psycho-social dimensions. However concerning ability to cope with workplace violence the intervention groups reported to be better prepared due to the training they had received as one of the intervention activities compared with the control groups.

To our knowledge this workplace intervention study using participatory teams as intervention method is the first to show significant positive health effects among hospital staff.

References:
- Kompier M.A.J.et al. Cases in stress prevention:The succes of a participative and stepwise approach Stress medicine 1998;14:155-168
- Winstanley S.et al. Aggression towards health care staff in a UK General Hospital: variation among professions and departments. Jr. Clin Nurses 2004;13(1):3-10
- Hignett S. Interventionstrategies to reduce musculoskeletal injuries associated with hand-ling patients:a systematic review. Occup Environ Med 2003;60(9):e6

THE MARATHON PROJECT - DEVELOPING THE HOTEL AND RESTAURANT SECTOR AND ITS OCCUPATIONAL HEALTH SERVICES

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Introduction

The threat of violence; exposure to cigarette smoke and noise; night work; irregular working hours; standing work; lifting, carrying and poor lighting are all typical aspects of work in the hotel and restaurant sector, and all pose health risks to workers. Based on these factors, the MARATHON project was launched in 2004: a two-year development project aimed at the hotel and restaurant sector and its occupational health services. Its target was to improve employee well-being, and the contents of the occupational health services.

Methods

The project consisted of joint seminars between eight companies and six occupational health service units, joint seminars between the occupational health services units themselves, and development activities centred on individual companies and occupational health service units. In seven companies, we performed risk assessments in co-operation with the personnel, with the occupational health services participating in the assessment groups' work. Specialists held ergonomics training courses in all the companies and courses on mental well-being development in three companies. In addition, wider-ranging development activities of the work community took place, focusing on changes and workplace atmosphere. Together with the occupational health services, we developed workplace interventions and health checks, and workload evaluations of shift work and physical work in different fields.

Results

During the project, in co-operation with the companies, occupational health services, and specialists, the aims and activities of the hotel and restaurant sectors occupational health services became more clearly defined. The project also produced new forms and a book on the contents of occupational health services in order to support workplace interventions and health check ups.

Conclusions

Occupational heath services still need further development in order to more effectively meet the needs and expectations of the hotel and restaurant sector, and in order to cover smaller workplaces and workers in more unusual jobs. Furthermore, the issue of well-being at work of the varying aged employees in this field presents challenges to both occupational health services and to the companies themselves.

ABSTRACTS
POSTER PRESENTATIONS

ASSOCIATION BETWEEN MEDITERRANEAN DIET AND CARDIOVASCULAR RISK

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Aims
To assess the cardiovascular risk, compliance with Mediterranean diet and the possible association between both.

Methods
An observational cross-section survey was set out in our centre. A randomised sample of workers aged 45-64 was taken. Variables analysed: demographic parameters, body mass index (BMI), cardiovascular risk, presence or absence of established cardiovascular disease, diabetes, smoking and alcohol consumption and exercise. An 14-item questionnaire on compliance with Mediterranean diet was passed.

Results
N: 61. Mean age: 55.6 ± 7.2 yr., 54.1% of women. 14.8% of diabetics, 8.2% with active cardiovascular disease, 14.8% of smokers, 44.3% stated to practice exercise. Mean BMI: 28.9 ± 5.7 Kg/m^2. Mean compliance with Mediterranean diet: 10 ± 1.4. Subjects with higher cardiovascular risk (those with cardiovascular disease and cardiovascular risk greater of 20% in 10 years) were less compliant with this diet than subjects with lower cardiovascular risk (9.56 ± 1.9; 9.6 ± 1.3 and 10.13 ± 1.4, respectively), even though these differences were not statistically significant. Differences were observed between compliance with diet and gender and BMI. Men consumed more alcohol and pulses and women more white flesh and confectionery. Butter, margarine and cream were more commonly eaten by subjects with BMI > 28 Kg/m^2.

Conclusions
The greater cardiovascular risk the poorer compliance was observed with Mediterranean diet. Subjects with active cardiovascular disease and higher BMI comply less with this diet, phenomenon that has to be taken into account by primary health professionals.

LIFESTYLE CHANGES RESULT IN WEIGHT LOSS AMONG OBESE PATIENTS

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Background
Obesity leads to a higher morbidity and mortality.

Aims
To assess the effectiveness of a systematic weight-decreasing health education program in overweight patients.

Methods
Intervention survey set out in primary care in which a random sample of subjects was taken considering body mass index (BMI) > 25, sedentarism and presence or absence of several cardiovascular risk factors. Variables analysed: weight, height, body mass index, systolic and diastolic blood pressure, dsylipidaemia, diabetes, smoking, high blood pressure, coronary heart disease, cardiovascular risk, counselling on lifestyle change and smoking, and prescribing of exercise. Patients were followed for 3 months with visits every two weeks.

Results
N=192 pts (female: 66.67%), drop-outs: 24 (4 pts with exercise contraindicated, 20 gave up follow-up). Mean age: 55.38 yr (range: 39-79). Coronary heart disease: 4.17%; high blood pressure: 87%, dyslipidaemia: 29.17%, diabetes: 41.67%, smokers: 16.67%. High cardiovascular risk by means Framingham chart (>20%): 25%. Overweight: 41.67%; mild obesity: 45.83%, severe obesity: 12.5%. Mean weight was decreased at the end of the survey in 2.23 Kg (range: 1.5-2.8). 30 pts lost 1-2% of initial weight (17.86%), 82 lost 2-4% (48.81%), and 54 lost 4-5.51% (32.14%). 12.5% of patients gave up smoking; mean decrease in blood pressure: 1.3 mm Hg, and 88.1% were adhered to follow-up.

Conclusions
Systematic health education on lifestyle changes is an effective way for achieving weight losses in patients diagnosed of overweight/obesity.

INFLUENCE OF ANTI-SMOKING LAW AND HIGH PRICES ON SMOKING HABIT

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Aims
To determine the influence of the anti-smoking law (ASL) and the increasing of tobacco's price on the smoking habit among smokers and ex-smokers.

Methods
An observational cross-section survey was set out in the primary care setting in which smokers aged 14 or more who attended our primary care centre in April 2006 were included. Variables analysed: demographical parameters, tests of Richmond and Fagerström, job, work time, places where smokers smoke. A questionnaire including knowledge, opinion and influence of ASL items was passed. A descriptive analysis was performed.

Results
N: 87. 54% male. Mean age: 39,1 yr., ex-smokers: 23%. The degree of dependence was mild in 48.7%, moderate in 32.9% and severe in 18.4%. Motivation scale: low in 68.4%, moderate in 21.1% and high in 10.5% -76.3% due to health concerns and 2.6% due to ASL-. Influence: 43.4% family and friends, 21.1% physician, 8% ASL and 5.7% high prices. 98% of inquired subjects knew about the ASL (57.9% were fully aware of that law and was greater among ex-smokers, $p<0.01$). 69.7% agreed with ASL, 56.5% for not disturbing non-smokers. Influence of ASL was not present in 51.7%, 16% gave up smoking, 19.5% stated to smoke less, 5.7% planned to give up, 6.9% changed the work time. 31.6% had difficulties to avoid smoking in the workplace, 44.7% had not, and 23.7% were allowed to smoke. Significant relationship was found with gender and agreement status. 15.8% smoked in forbidden places and 32.9% abandoned the workplace for smoking. Aid for giving up smoking: 61.5 any, 20.7% gum and sweets, 9.1% nicotine patches, 5.3% bupropion. Higher prices had no effect on 53.9% of all the subjects, 18.3% changed trademark, and 11.5% reduced consumption. A significant association was observed between smoking status with motivation, job, smoking place, awareness of ASL and higher prices.

Conclusions
More male subjects have difficulties to avoid smoking and are more prone to disagree with ASL. Health professionals in the primary care setting can offer our aid to make these subjects give up smoking.

GUIDELINES FOR ALCOHOL AND DRUG ABUSE PREVENTION PROGRAMMES IN FINNISH WORKPLACES

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The consumption of alcohol amongst the Finnish population has increased during the past 30 years. Only in 2004 the consumption increased by 10 % due to legislative changes. Finland hasn't had severe problems with drug abuse but especially in the late 1990s it seemed that also the use of drugs was increasing.

Prevention of abuse was set at high priority by the Finnish Health Authorities as well as by the representatives for working life. The high consumption was seen not only as a national health problem but also as a problem for the workplaces in terms of sickness absenteeism, increasing risks for accidents, low production and quality problems.

The Act on Protection of Privacy in Working Life came into force in 2004. The law was prepared in collaboration with the Ministry of Labour and the representatives for the employers and employees. The law lays down provisions on, amongst others, the performance of tests and examinations on employees including drug tests. The law also states that companies performing drug tests should have a programme for abuse prevention.

The group for Work Place Illicit Substance Abuse (representing both employers, employees and OH professionals) at The Centre for Occupational Safety decided to give out guidelines for the programmes.

The main guidelines are:

- The program shall be made in collaboration with the representatives of employers and employees
- Main emphasis is on prevention
- Part of the work ability and well-being policy at the companies
- General information about alcohol and drugs and their impact on health
- Education of key persons
- Instructions on how to manage abuse problems
- Access to care
- Impact on terms of employment

The Centre for Occupational Safety has published a guide for setting up the programmes and is providing courses for all the working life partners.

THE OCCUPATIONAL HEALTH NURSE AND THE MULTIDISCIPLINARY TEAM

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The role of the Occupational Health Nurse (OHN) is varied and varies according to her working environment.

The company based OHN is often the first line confidante when employees have worries especially when they are work related. He or she is often the initiator of a plan of action that is put into place using the skills and knowledge of other experts in prevention both within and external to the company.

In my particular environment the multidisciplinary team means working together with the Safety Group, health physics, department managers, the CHSCT and the company Welfare Officer, individuals who have been used to working independently .

At the request of the employees we carried out a study in the self-service workshop and a campaign to promote individual protection such as gloves and eye protection. The teamwork used in these actions was enriching and allowed us to be better integrated and known within the workplace and promoted an acceptance of our preventative actions. Communication of information whilst ensuring professional confidentiality is primordial in a successful common action.

Results presented in 2005 showed a decrease in the number of works accidents from 100 in 1997 to 37 in 2004.

Our teamwork is not limited to work related “problems” but also extends to public health issues. Our welfare officer together with members of the CHSCT, safety group and voluntary employees formed a working group n the subject of alcohol in the workplace. The result was a change to the company rules prohibiting alcohol within the workplace apart from organised and approved celebrations.

The OHN therefore has a unique place in the multidisciplinary team. She has a privileged contact with the workforce. Often a confident, she is also the one who picks up the alert on early signs of health problems and initiates action.

The positive results of teamwork benefit all;

For the **team** who work together and in doing so have a stronger voice when putting ideas in front of the management.

For the **workers** whose health risks are taken charge of by experts in all fields.

For the **company** gaining a healthier, satisfied workforce.

CONTINUING PROFESSIONAL EDUCATION AND OCCUPATIONAL HEALTH NURSE PROFESSIONAL PERFORMANCE

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Background
An important aim of continuing education for health professionals is to improve professional performance[1]. This study was designed to measure the impact of a one year undergraduate diploma, employing mixed educational methods, on occupational health (OH) nurses' knowledge base and professional performance in the workplace.

Methods
109 OH nurse diploma graduates received a piloted postal questionnaire. The 2003/4 diploma students received the original questionnaire at either 18 months (n=19) or 6 months (n=34) after graduation. The 2005 diploma students (n=56) received the augmented questionnaire 6 months after graduation. Students' self-reported knowledge and confidence in their ability to perform their OH role in the workplace and recognition of their enhanced clinical practice post-diploma were measured using a 4-point Likert scale and yes/no responses. The data were analysed using percentages.

Results
49 questionnaires were suitable for analysis (45% overall response rate). The majority of graduates (94%) reported feeling more knowledgeable in their OH work role. Furthermore, three quarters (76%) of 2005 graduates strongly agreed that they were more likely to search for evidence-based literature.

The graduates also stated that they were more confident in their OH work role (92%). 86% of 2005 graduates strongly agreed that they were more confident to lead and develop OH initiatives.

Workplace responsibilities and promotion in the workplace had increased by 47% and 22% respectively for the 6 month graduates, and risen by 91% and 64% respectively for the 18 month graduates.

Conclusion
This study suggests that post-diploma, the OH nurses considered that they were more knowledgeable, confident and self-directed practitioners that could expect to have an increasing influence on the delivery of OH services. Interactive course interventions may have the potential for long term positive impact on OH nurses' professional performance.

DO WE IMPROVE THE QUALITY OF LIFE IN CHONIC OBSTRUCTIVE PULMONARY DISEASE?

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Aims

To assess the improvement of perceived quality of life and spirometric values in patients with chronic obstructive pulmonary disease (COPD) by means of health education programs and lung rehabilitation.

Methods

Clinial trial set out in the primary care setting. Random sampling of two groups of 43 patients aged 45-79 yr. diagnosed of COPD stage I-II according to the Spanish Society of Family Medicine classification (alpha 0.05, beta 0.20, sensitiveness 0.7). Variables: demographic parameters, smoking, drugs taken, FEV_1, questionnaire score of quality of life for COPD that measures dyspnoea, breathlessness, emotional function and sickness dominion. Both questionnaire and spirometry were carried out in the first visit and at 12 and 24 months; health education and rehabilitation were only implemented in patients allocated to the intervention group.

Results

86 patients (65% male). Mean age of 66 yr. 46% of patients in the intervention group and 41% in the control group were initially smokers; at the end of the survey 33% and 39% continued smoking.

	Intervention group			Control group		
	Onset	12 months	24 months	Onset	12 months	24 months
Dyspnoea	3.26	4.02	4.31	2.67	2.73	3.10
Breathlessness	4.58	5.12	4.87	4.4	4.42	4.62
Emotional function	4.98	5.45	5.20	4.66	4.74	4.83
Sickness dominion	6.07	6.35	5.95	5.78	5.81	5.87
FEV_1	57.97%	57.09%	57.62%	66.26%	61.23%	62.15%

Conclusions

An improvement of quality of life was observed among patients allocated to the intervention group, with a lesser loss of FEV_1 even though the differences were not significant at 12 months and 24 months.

DO WE ASSESS THE OBSTRUCTIVE IMPAIRMENT OF THE SPIROMETRIC VALUES IN SMOKERS?

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Aims
To assess the obstructive impairment observed in spirometries performed in smokers without diagnosis of pulmonary obstructive pulmonary disease (COPD).

Methods
Cross-sectional descriptive survey carried out in primary care. Subjects: consecutive sampling of smokers >15 yr. without a diagnosis of COPD. Variables: age, gender, number of cigarretes/day (≤20, 21-30, >30 c/d), smoking status length, score of Fagerström test (moderate dependence if 4-7 and high if it was higher than 7), FEV_1 value (normal 80%, mild obstructive 79-70%, moderate-severe < 70%). Descriptive statistics was performed.

Results
62 smokers (63% male). Mean age of 45 yr. 37.7% with an obstructive pattern in the spirometry (26.3% mild, 11.4% moderate-severe). 9% of spirometries were impaired in subjects < 40 yr., 56% in patients aged 40-60 yr. (36% mild, 20% moderate-severe), and 72% in subjects elder than 60 yr. (45% mild, 27% moderate-severe) ($p<0.01$). 25% of spirometries were impaired in subjects who smoked ≤ 20 c/d, 44% in patients with smokers of 21-30 c/d, 81% in smokers of >30 c/d ($p<0.01$). No impairments were observed in smokers of less than 15 yr of smoking status, 33% (3.7% moderate-severe) in 15-30 years of smoking, 73% (36% moderate-severe) in patients of >30 yr. Of smoking status ($p<0.01$). 33% of spirometries were impaired if mild dependence, 37% in moderate and 50% in patients with high dependence.

Conclusions
A significant relationship between obstructive impairment of spirometries was observed with age, years of smoking, and the number of cigarretes per day, but not with dependence and gender.

"CAN INTERCULTURAL COMPETENCE BE USED AS A TOOL TO UNDERSTAND AND MAYBE IMPROVE THE PSYCHOSOCIAL WORKING ENVIRONMENT IN A MULTI-CULTURAL EU INSTITUTION?"

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Background
The EU institutions have developed into multicultural workplaces. The European Investment Bank has 1300 staff members from 25 different countries.

Problem statement
The psychosocial working environment is influenced by the many different cultural backgrounds, creating language problems, multicultural team working conflicts and misunderstandings. The intercultural contacts are part of the routine tasks of professionals and lack of knowledge of intercultural competence might influence the degree of success in the career/social life. The development of the knowledge society is raising demand for competences in the personal, public and professional spheres.

Search strategy
To understand what intercultural competence is, how it can be used and developed, I used the recommendation of the EU on key competences for lifelong learning, 2005, and an article "Cultural Competence" by Iben Jensen, a project made for the Danish Ministry of Teaching, 2005

Results and conclusion
To keep up with globalization, to change to the knowledge society, and to keep a good psychosocial working environment, you are in need of good personal and social competences. Intercultural competence can be used as a tool for a complex cultural understanding, where culture is not only seen as something you were born with, but something you experience and you create through your acting among other people. To have intercultural competence is to be aware of when and how culture is a part of the act and communication of other people. To develop intercultural competence is, in a time where "cultural catastrophes" have become more frequent than "natural catastrophes", a "must" for the future. It needs to be integrated as a part of the workers, managers and top managers' education.

Key words
Interculturel, competence, psychosocial, environment.

CERVICAL ACHES AMONG MULTI-FOCAL GLASSES WEARERS WHO WORK WITH COMPUTERS

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Aims
Because of the high rates of absenteeism due to cervical pain we carry out a study for assessing the actual situation of the workers of a petrochemical enterprise who use either computers or multi-focal lenses

Methods
The simple consisted of 49 workers out of the 103 people who work in this company. All of them use either computers or multi-focal lenses in their work. An specific guideline about musculoskeletical disorders published by the Health Ministry was beginning to use, reviews were done and assessment of the symptoms in all the workers was registered.

Results
Mean age of 51 yr. Cervical hyperextension was observed in 20 out of the 22 workers who are users of multi-focal lenses, and 17 of the former complained of pain in the cervical region, all of them with a height less than 165 cm. Nonetheless, the two workers who did not complain of aches were taller than 185 cm. Out of the 27 workers who worked with computers, 24 were asymptomatic and the other three presented similar symptoms to the previous group.

Conclusions
This survey highlights the importance of taking into account cervical aches in workers who use computers and multifocal lenses. Some proposals addressed to improve this fact have been shown to the company.

FUNCTIONAL OPHTHALMOLOGIC TESTS IN NURSING APPLIED IN PRIVATE COMPANIES

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Introduction
The functional ophthalmologic tests are important tools in the medical check- ups in order to monitor visual acuity, visual fatigue, stereoscopic vision, **foria** and chromatic vision of the workers. These kind of tests are very important in those employees that must drive, climb to high altitudes or work with computers during the workday.

Objetives
To make known of the activity in the field of the Ophthalmology by nurses working in private companies

Methodology
Exposition of working and professional activities with sanitary and associated protocols to the functional ophthalmologic test that corresponds

Results
Proceed with different test depending on the equipment and explanation of the protocol to follow according to the age and job position of the worker

Conclusions
To quantify the number of interactions of the nurses working in private companies with the field of the Ophthalmology within a period of one year.

INFLUENCE OF ROTATING SHIFT SYSTEM ON CORTISOL RESPONSE IN ICU NURSES

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Key words: shift work, plasma cortisol, SSI, nursing personnel.

Objective: The purpose of the present study was to examine the temporal changes in circadian rhythm of serum cortisol levels due to an irregular and rapid shift rotation system in relation to variables which are thought to modify an individual's response to shiftwork, such as, individual circumstances, personality variables and personal outcomes for the individual including, psychological health, sleep disturbances and social and domestic disruption.

Method: We studied 25 healthy nurses working in an Intensive Care Unit of a general hospital in Athens. A total number of six blood samples were collected from each subject, two from each shift. The blood samples were taken at the beginning and the end of each shift. Additionally, subjects completed the Standard Shiftwork Index questionnaire (1). The internal consistency of the questionnaire was sufficient with Cronbach-a coefficient ranged from 0.70 to 0.92. Correlations coefficients (r) were used to explore the association between cortisol concentrations and the scores on the SSI questionnaire.

Results: The proportion of female to male nurses was 12/13. The mean age of the sample was 35.4±5.0 years and range from 27 to 47 years. The work experience ranged from 3 to 20 years with a mean equal to 9.1± 4.2 years. 60% of the subjects were smokers and the mean BMI was 25.3±5.6, and range from 18.0 to 40.6. Concentrations of morning plasma cortisol was negatively correlated with BMI (r=-0.47, p=0.028) and the score on job satisfaction (r=-0.45, p=0.040). Concentrations of evening plasma cortisol was negatively correlated with the score on morningness (r=-0.64, p=0.002), the score on sleep disturbance between two consecutive night shifts (r=-0.47, p=0.032) and positively with the score on somatic anxiety (r=0.51, p=0.015). Concentrations of night plasma cortisol was positively correlated with the score on somatic anxiety (r=0.64, p=0.001) and the score on the work load in the morning shift (r=0.56, p=0.005), in contrast with the results of Munakata et al (2). The mean morning cortisol levels were higher to women compared to men (12.6±4.0 vs. 11.3±3.8) finding that is in accordance with Wüst et al (3). There was no significant association between age and smoking with cortisol levels, in accordance with the findings of Pruessner JC et al (4), or with the scores of variables of the SSI questionnaire.

Conclusion: The present data provide information on potential confounds which could facilitate investigations into the endocrine consequences of exposure to a rotating shift system.

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References

1. Barton J, Spelten E, Totterdell P, Smith L, Folkard S, Costa G. The Standard Shiftwork Index: a battery of questionnaires for assessing shiftwork-related problems. Work & Stress, 1995, 9, 14-30.
2. Munakata M et al. 'Influence of night shift work on psychologic state and cardiovascular and neuroendocrine responses in healthy nurses' Hypertens Res, 2001, 24(1), 25-31.
3. Wüst S, Wolf J, Hellhammer D, Federenko I, Schommer N, Kirschbaum C. The cortisol awakening response- normal values and confounds', Noise & Health, 2000, 7, 77-85.
4. Pruessner JC, Wolf O.T, Hellhammer DH, Buske-Kirschbaum A, Von Auer K, Kaspers F, Kirschbaum C. Free cortisol Levels after awakening: a reliable biological marker for the assessment of adrenocortical activity, Life Sciences, 1997, 61(26), 2539-2549.

NORDSAM

Poster produced by The Danish Society of Occupational Health Nurses (FaSA)
Abstract Jytte Kruckow

NORDSAM is a Nordic collaboration of Occupational Health Nurses from Denmark, Norway, Sweden and Finland.

NORDSAM was founded in 1976.

NORDSAM's purpose:

- to exchange knowledge and working experience through collaboration and personal contact
- to pass this on to the sphere of Occupational Health Nurses
  working to prevent occupational illness
  promote good health on the job
  create a safe and healthy working environment

NORDSAM's organisation:

- each country has one representative chosen by that country's association
- the representative leads his workteam
- the representative has a seat in NORDSAM's administration and they meet at least once a year
- each representative has a substitute
- NORDSAM's committee chooses a Chairman and a Secretary for a 3 year period
- NORDSAM's committee consists of one representative from each Nordic country with the right to vote. Norway on the other hand has two representatives, one from each organisation

NORDSAM's task:

- Pass on knowledge of the respective country's seminars and courses
- Give the members of the organisation in the Nordic countries the opportunity to participate in seminars and courses
- Exchange pamphlets and magazines
- Arrange Nordic Conference for Occupational Health Nurses

VISIONS FOR DEVELOPING EDUCATION AND TRAINING IN OCCUPATIONAL HEALTH

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Key words: occupational health service, education, training, questionnaire

The training programme fulfils the competence requirements for OHS practice in Finland (The Ministry of Social Affairs and Health, 2004) aiming to improve participant's own expertise in OHS by multidisciplinary content, the main areas comprising occupational medicine, occupational health care, occupational hygiene, ergonomics and occupational psychology. A participant writes also a diploma work in which he has to evaluate and develop some aspects of OHS activities.

The world of work is constantly undergoing changes and this challenges OHS in Finland (Rautio, 2004) and thus the training of professionals in OHS. The training is effective in raising the basic knowledge of OH & S (Melart & Meyer-Arnold, 2006). The **purpose** of this study was to evaluate the competence education and training at the Finnish Institute of Occupational Health.

The **objectives** were:

- To analyze the correspondence between needs of OHS units and substance of competence training
- To survey the effectiveness of training at workplaces
- To develop the competence training

The **findings and recommendations**:
The participants considered the education and training in OHS to be adequate with the working life. The respondents suggested focusing more on developing work organizations and on evaluating the consequences of the psychosocial load factors. The training must emphasize in future all the more the significance of the multidisciplinary co-operation. This could be implemented with reflective discussions. The superiors had noticed the professional self-confidence of the employees (participating this training) had evolved. The diploma work should address to current challenges in OHS unit. The superiors proposed they could contribute to planning and guiding the diploma work. The training leaders continue to dialogue with various actors in the working life to keep up to date with current and tomorrow's challenges.

References

Melart P, Meyer-Arnold M (2006) The effectiveness of training and education in occupational health. In: Proceedings. 28th International Congress on Occupational Health, Milan, Italy June 11-16, 2006.

The Ministry of Social Affairs and Health (2004) Qualifications required of occupational health care professionals and experts and instructions for further education in occupational health care issued by the Ministry of Social Affairs and Health. Handbooks 2004:10, Helsinki.

Rautio M (2004) Changing Work Life Challenges Occupational Health Care. Developing Methods through a self-reflective learning process. Diaconia polytechnic Publications, Series A, Studies 9. Helsinki.

EVALUATION AND DEVELOPMENT OF OCCUPATIONAL HEALTH SERVICE'S (OHS) ACTION PLANS FOR CLIENT ORGANIZATIONS

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Introduction
Research on occupational health actions plans is seldom found in literature. The Occupational Health Act (1383/2001) emphasizes co-operation between client organizations and occupational health in planning occupational health actions.

According to information gathered by The Social Insurance Institute (SII) action plans do not correspond with good occupational health practise guidelines (GOHP) thus presenting a reason to research the quality of action plans and the planning process.

Aims
The aims of this research are 1) to find out if the current action plans, and the processes involved correspond to the quality and criteria of good occupational health and 2) to find out if the action plans reflect the perceived needs of the employers and client organizations.

Data
The data was collected from a random sample of 300 action plans extracted from the register on companies and organizations by the SII. Additionally, a random sample of 18 occupational health service providers and their 18 occupational health client organizations from these 300 were interviewed. These 18 organizations and occupational health providers were sampled using criteria related to their size and geographical location.

Methods
Action plans were evaluated using criteria from the Occupational Health and Safety Act, Government Decree on the principals of good occupational health care practise (1484/2001), the Guidebook for GOHP and research publications on OHS.

The action plan processes were reviewed and evaluated by interviewing multidisciplinary teams in these 18 OH units and their 18 client organizations.

Results
To date 225 action plans have been evaluated. The results show a need for development in the content of action plans. For example, in measuring the effectiveness of occupational health services, concrete, well defined targets of action are needed.

Conclusion
In light of these preliminary results we can conclude that several proposals for improving the content of occupational health action plans are to be expected.

RISK ASSESSMENT IN GREEK HOSPITAL AREA

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Abstract
Risk assessment in hospitals that means the recognition and evaluation of workplace hazards, also entails the promotion of health of health care workers' and it is required by European and national legislation. In Greece, risk assessment in the hospital area is not yet common practice and wherever is applied there is no evidence that the methodology used is appropriate. Therefore the development of a methodology, specific for that special workplace would improve the implementation of legislation as well as the working conditions of health care workers (Sadhra & Rampal 1999, Hasselhorn et al 1999, Sandford 1997).

Method: A cross sectional study, using multiple triangulation, by different data sources and methods (observation, questionnaire, objective measurements) was designed and implementted in two hospitals in Athens (A) and Thessaloniki (B). Based on international and Greek bibliography, a tool was developed which consists of three parts:

1. Three Inspection Checklists for H&S Hazards (General, for Clinical Laboratory and for Operation Room),
2. A Hazard Identification and Action Record sheet, and
3. A Staff OH&Safety Questionnaire corresponding to the three inspection checklists.

Findings: 248 questionnaires were filled in hospital A (68,9%) and 199 questionnaires were filled in B (79,6%) by health care staff, while 27 checklists were filled in hospital A and 29 B by OH&S experts. In the inspected hospital departments - in both hospitals - measures of control and improvement were necessary for a number of hazards. There was agreement between health care staff and experts in most occasions, which demonstrates the value of staff participation in risk assessment. The perception of risk as reported by staff, was found to be influenced by the service in which they were employed, the years of working experience and the level of education. In addition, a need for training programmes for the staff in order to be appropriately informed on H&S issues was made apparent.

Conclusion: The major conclusion drawn, is that the enforcement of relevant legislation and the application of risk assessment studies in hospitals will improve the safety of workers and patients and the quality of services provided. The proposed methodology (as it is or in an improved version) could be a useful tool for use in any hospital department and task, as well as cooperation of specialists and employees, with the aim to improve the working conditions.

References:
Hasselhorn HM,Toomingas A, Lagerstrom M (editors). (1999): Occupational Health for Health Care Workers. A practical guide. Elsevier Science B.V.
Sadhra SS, Rampal GK (1999): Occupational Health. Risk assessment and Management.
Sandford M (1997): Checking your way to working safely. Austr. Nurs. J. July 5 (1): 15-24.
Sinclair W (1988): The hazards of hospital work.

RESULTS OF THE SURVEY "DO OCCUPATIONAL HEALTH NURSES WRITE AN ACTIVITY REPORT?"

Fabienne Varaigne

The survey was carried out by a working group within GIT (Groupement des Infirmièr(e)s du Travail), the French OHN Association.

Its aim was to support an oral presentation given by members of GIT at the 29th National Congress of Medicine and Health at Work, an event until this year seeing only presentations by OH physicians.

According to French law, the OH Physician must produce an annual report. Its contents not only show a statistical account of medical surveillance but also of preventative surveys and actions taking place over the year. The nurses' report is not required by law and as such is not written by all OHNs. The survey was carried out to evaluate the actual situation. By analysing how many OHNs ***did*** write a report and studying the reasons why some ***did not*** the GIT went on to deliver guidelines and methodology to help encourage those lacking a "savoir faire".

HOW DO I WRITE ONE? A SUMMARY OF CONTENTS

POSTER BY CATHERINE CHAZETTE

This poster is a summary of what should be included in the OHNs report.

SUPPORTING OCCUPATIONAL SKILLS IN CHANGING WORKING ENVIRONMENTS - A STUDY FROM THE PERSPECTIVE OF AGING EMPLOYEES

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Key words: support of professional competence, learning atmosphere, aging employees, occupational self-image, leadership

The **purpose** of the study was to describe the experiences of received support of aging employees and their work related self-image in changing working environments. Firstly, the aim was to discover how the support from organisations and leaders was verified. Secondly, the aim was to get answers how employees experienced themselves as workers and as learners in the current work context. Thirdly, the aim was to compare different knowledge information stages and company cultures and how they have influenced the experiences of professional competence development among aging employees. In addition the education- and career backgrounds were investigated to gain more understanding of their role in experiencing support and relation to the occupational self-image.

The **theoretical frame** of reference of this research is multidisciplinary. The theoretical part focuses on the meaning of work for human being from a sociological, late-modern perspective. On the other hand it examines the ageing process from a physiological and also from a perspective of age discrimination and life control. The occupational self-image and the strength of motivation has an effect on learning in working life which is crucial and firm part individual trajectories. According to the theoretical review company culture, leadership and especially the managers´ role as a creator of a learning atmosphere are increasingly critical for aging adults´ learning when the role of informal work-based learning is increasing.

The **empirical data** was collected with a questionnaire and interviews, which were carried out in May to October 2001. The data consists of 263 respondents of which further eight persons were interviewed. All respondents were over the age of 45 and represented all levels of their organisations in an IT-technology firm and a chemical industry plant.

The **central findings** in this research show that the aging adults have experienced that the employers do care about the development of their occupational skills. On the other hand there are fewer concrete activities to reveal this support. There is an obvious disproportion between the expressed aims and the realisation of the activities. Signs of age discrimination are few. The style of management has become more supporting for self directed activities which are seen to support adults learning.

Higher **education** and individual activity to seek possibilities to learn were encouraging the development of occupational skills. Age itself was not a crucial aspect when comparing the experiences among younger (45-54 years) and older (55-64 years) groups. Job satisfaction and professional self esteem seemed to be considerably strong. The individual characteristics were more important elements in developing occupational skills than the age. The degree of anxiety at work was low. In addition among the older group the strong feeling of coherence and the occupational self image were significant for supporting the professional competence. The motivation to learn was also stable. Among the seniors there was some slight evidence of declining motivation.

In the IT-firm the support was experienced stronger for aging employees than in the chemical industry plant. Those who had experienced support in the chemical industry plant had higher educational background than the others. In IT-firm they also experienced more support from the manager than in the chemical industry plant. The results show that it is more likely that the differences are caused mostly by the stage of information intensity and the character of company culture which is determined by the activities. IT-business demands constantly accommodation to changes and the chemical industry plant which is representing more traditional business field, where the atmosphere of learning is determined by the traditions of company culture, the changes are carried out slowly.

Reference:

Wiitakorpi, I. 2006. Ammatillisen osaamisen tukeminen muuttuvissa toimintaympäristöissä - Tutkimus ikääntyvien työntekijöiden näkökulmasta. Åbo Akademis Förlag - Åbo University Press. Åbo.

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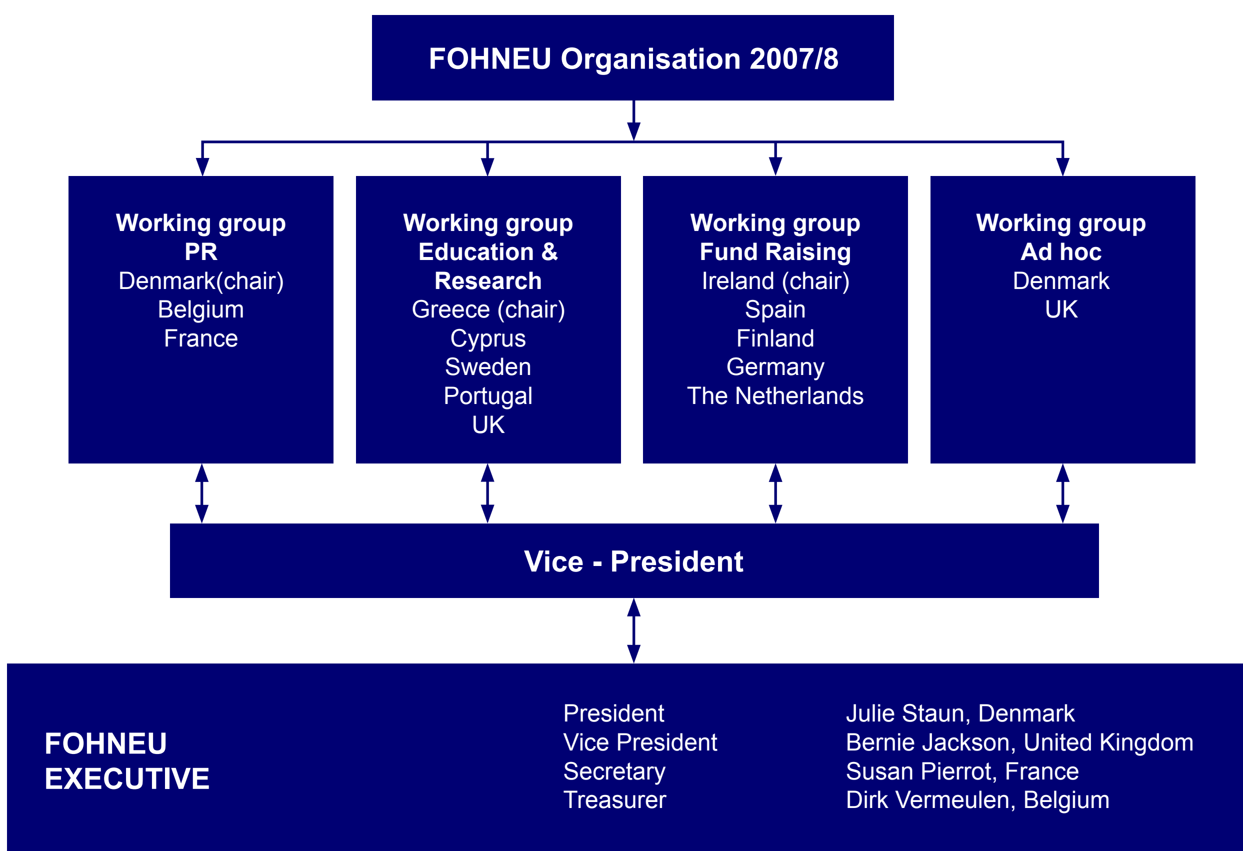

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