

AN ACTIVITY ANALYSIS OF OCCUPATIONAL HEALTH NURSES' WORK IN THE UNITED KINGDOM

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ABSTRACT

This paper describes how occupational health nurses (in seventeen services) allocated their working time to fourteen activities in order to meet the objectives of occupational health nursing. For 20 days each participant recorded all time at work on charts, from which were calculated the percentage of time spent on each activity by the individuals and their services, between which there were wide variations in practice. The main difference between nurses inexperienced in occupational health and those specially trained, was that the latter attempted all the activities and spent less time on clerical duties. Most time was spent on employee suitability and least on rehabilitation/resettlement and formal health/hygiene education. This raises a question of the "right" apportionment of nursing time and of future changes in these patterns to meet the needs of workers.

Occupational health nurses perform certain activities in order to meet the objectives of occupational health, to keep the worker well and working: what the occupational health nurse does has frequently been discussed. What proportion of time is devoted to each activity has not previously been studied in the United Kingdom, although in 1967 Margaret Hardy had made a study in Ontario, Canada². Case loads, frequently compiled, though helpful, are not accurate as they only reveal part of the work of the occupational health nurse.

The (now) Nursing Scientific Committee⁴ states that the nurse's functions not in any order of priority, are (a) treatment of illness and injury occurring at work, including the development of plans for major emergencies (b) health supervision of the individual (14 different activities), (c) advice, health education and counselling, (d) supervision of health aspects of the environment and (e) administration.

The present study detailed 14 main activities: (1) personal (including meals), (2) employee suitability, (3) rehabilitation and resettlement, (4) sick and injured, (5) counselling, (6) employee protection (including immunization, shop visits, observation, first-aid boxes, environmental surveys, managerial consultation, research projects), (7) health and hygiene education, (8) sick visits, (9)

departmental administration, (10) visitors, (11) professional development, (12) committee work, (13) general practice work and (14) other.

It was not suggested that all of these should or would be done, but those that were, were recorded on a specially designed activity chart. With reference to no. 13, general practice work was included in this chart, not that it is part of the work of an occupational health service in the U.K. but because the study was first made in hospital occupational health services where sometimes a general practitioner may have so many of the staff on his "list" that he holds a clinic or branch surgery on hospital premises, often, though this is not encouraged, connected to or in the occupational health service premises. As will be known, in the U.K. the National Health Service provides personal general practitioner services to all individuals, who register with the physician of their choice. In occupational health services in industry and commerce, the occupational health doctor may, by coincidence, be the employee's general practitioner, but anyone needing more than immediate aid (in line with normal occupational health practice) would be referred to the doctor at his own practice.

The activity chart's size, shape and content was finalized after a pilot study in six services. The activities were printed across the top, and the time of day, from 8 a.m. to 8 p.m. was printed in five minutes intervals down each side¹. If a nurse started work at 8.30 a.m., went straight into the department to get it ready, she would put a cross under column 9 at 8.30 a.m. and when she finished, say 15 minutes later, would put another cross against 8.45 a.m. and join the two vertically, together*. These times were then counted, then added up for each activity, for each person and for the whole service. This enabled results to be obtained for all the services together, representative of occupational health services in the U.K., and also for services in hospital and also in industrial/commercial undertakings, as two groups.

Each nurse in seventeen services (11 hospitals and 6 representative industrial/commercial services) noted how duty time was spent. In all, some 4730 hours of work, undertaken by 36 people, were studied. This may seem a very small sample, but at the time when a self-administered questionnaire was sent to the 332 hospital groups (many with 6-12 hospitals in the group) then in the National Health Service, the 329 replies indicated that only 35 groups seemed to have an occupational health service, and eventually only 11 could undertake the extra work involved in a detailed study. The criteria determining those with a service were that not only was a purely treatment and medical examination services provided, but some emphasis on selecting the right person for the right job at interview or medical examination, was made, there was monitoring of the working environment, possibly some research into the causes of sickness absence, accidents and labour turnover³.

The industrial/commercial group was obtained from willing colleagues, and was selected to give a reasonable cover throughout England of typical undertakings, and consisted of a public utility undertaking, precision

*Copies of the chart are available, on request.

assembly/office work (2 units), heavy engineering/foundry, manufacture with a high trauma hazard and a scientific research and development undertaking.

In these services, it was found that most time was spent on employee suitability (23%), next sick and injured (19%), third, departmental administration (16%), fourth, employee protection (12%), fifth, personal time equally with items 10-14 combined (11%), seventh, counselling (5%), eighth, sick visits (2%), ninth rehabilitation and resettlement (1%), and lastly, formal health and hygiene education (0.8%),

The main difference between the hospital and the industrial/commercial groups were that the hospitals spent twice as much time on clerical work as the others. If we examine the activity on which occupational health nurses spent most of their time, i.e. employee suitability (23%), we find that the hospitals devoted 28% of all time on this and industry/commerce (13%). However, closer examination of the work done within the activity shows that the industrial/commercial group spent more time, 53% against 35%, on post-pre-employment interview and preparation for medical examination, than the hospitals, about the same, 12% against 11%, arranging investigations, 19% against 7% on periodic screening, i.e. all more than the hospitals did. What reverses these findings for the time on the whole activity, is that the hospitals spent 54% of time on clerical work, against 15% by the other group. There was also evidence that the individual nurse in the industrial/commercial group who was inexperienced or untrained in occupational health work, or had just left hospital or similar institutions, spent more of her time writing and recording than her colleagues.

Indeed, within the hospital group itself there is some evidence that the more occupational health experience and preparation the head nurse had (and she determines the organization of work within the service) the less time was spent on clerical work. Records are essential, but up-to-date labour saving methods must be adopted, as they apparently are in industry and commercial undertakings. It is not only a question of being aware of such methods, but we have to ask ourselves if doing the thing you have always done as a nurse (medical examinations and laborious handwriting,) is not a defence mechanism against tackling those tasks, such as employee protection (protective clothing, shop visits, environmental surveys, research projects and consultation with and advising management) and the personal involvement of counselling and listening to people, for which the nurse who has only worked in hospital wards, is unprepared. In both groups, the experienced occupational health nurses spread their time fairly evenly over all the activities except sick visiting and the general practitioner service, and in doing rather than writing about their work, though they made reports to management.

In both groups variations between the services occurred, but with the exception mentioned above, results between the two groups were remarkably close, and validated the use of such a small sample.

Occupational health nurses should ask themselves "what is the right proportion of time to spend on each activity in my workplace?" Is one activity,

say employee suitability, finding out if the man is fit for his job, any use without employee protection which enables the nurse to know the job for which the employee is being examined and what the physical, mental, manual skills and abilities are? Are records being compiled laboriously which could be provided by some other department which is already keeping statistics upon which the occupational health service could comment? Why is rehabilitation and resettlement given so little attention? Is it because we do not use imagination about the sort of jobs the disabled can do? It may not be inappropriate in this connection to remember all those very disabled people who still do worthwhile jobs, exemplified perhaps by Miss Elizabeth Twistington-Higgins, a trained ballet dancer, completely paralysed from neck down by poliomyelitis, who paints beautiful pictures (by mouth) and teaches ballet dancing, to regular classes, most successfully.

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