OHNAI SPRING 2017 NEWSLETTER

Welcome Letter

Dear Members,

It's hard to believe another year has gone by so fast and already the committee are working hard behind the scenes to meet new objectives for a new year.

I would like to take this opportunity to acknowledge all the hard work of the committee in achieving a highly successful year for the association. The OHNAI hosted two conferences and we received a huge amount of positive feedback about the high calibre of speakers and the relevant subject matter of presentation for both conferences. We also hosted the Jack Eustace Lecture and for those of you that were able to attend I think you'll agree we struck gold with our speaker, Professor Ian Roberston, who held our interest with his unique take on stress that gave way to a thought-provoking debate afterwards. In addition, we provided a study day on employment law and the day proved to be very informative.

As you may be aware a new committee role was developed last year to examine how the association can utilise social media for our advantage. I am pleased to inform you that significant progress has been made and the OHNAI now have our very own Facebook page. This will open up alternative avenues for networking and sharing of expertise knowledge among our profession. It will also raise the profile of the OHNAI at a national and international level. You will be informed shortly on how to become a 'friend' on our Facebook and full access will be given to paid members.

The OHNAI continues to be involved as a supporting organisation, in the planning and preparation of the ICOH Congress Dublin 29th April – 4th May 2018. Updates are communicated as appropriate.

At our November AGM, three new committee members were nominated to join the OHNAI team, Edel Casey, Mary Doran and Breege Bernie. I would like to welcome them and thank them for putting themselves forward to work on the committee and I hope they find it as rewarding as it is challenging. I would also like to thank Theresse Hodgins, Rose Curtis and Ciara McGowan for their invaluable contributions to the committee but who are no longer in a position to stay on committee this year. Also I'm unable to work on the committee this year and so Mary Doran has agreed to take on the President's role and I wish her every success with this. So there have been some changes to committee members but the goal will remain as always to maintain a functional and productive OHNAI.

The OHNAI really appreciates our members continued support and welcomes any feedback or suggestions you may have so please feel free to contact us at ohnai@gmail.com.

I like to remind you all that membership is due for renewal March 1st and it is very easy to renew membership via PayPal on the website.

Finally, on behalf of the OHNAI committee, I hope you enjoy this newsletter and I trust you will find it topical and interesting.

Kind regards,

Niamh Tuohy

PRESIDENT & SECRETARY 2016

AN OVERVIEW OF IRISH EMPLOYMENT LAW COURSE RUN BY LA TOUCHE TRAINING

Annemarie Howard, CNM Waterford Regional Hospital

I attended the La Touche Training day on Employment Law in July 2016. I found the day very informative and interactive. The following is a brief summary of the day and updated information on the Workplace Relations Commission.

The training is designed to provide you with an overview of the important issues arising within the employer/ employee relationship in Ireland. The course began by highlighting the sources of Irish employment law and the key players involved before moving on to discuss the various rights, duties and obligations arising within the employment relationship. The training also focused on areas of conflict, in particular; issues surrounding bullying and harassment, equal treatment and termination of employment. Finally the course outlines the potential venues for litigation and highlights the key changes to the employment landscape since the commencement of the Workplace Relation Act 2015. I am going to give a short synopsis on the Workplace Relations commission.

INFORMATION ON THE WORKPLACE RELATIONS COMMISSION.

In accordance with the Workplace Relations Act 2015 all complaints and disputes under employment, equality and equal status legislation which were presented after 30th September 2015 will be dealt with by the Workplace Relations Commission (WRC). This is an independent, statutory body which assumes the role and functions previously carried out by the National Employment Rights Authority (NERA), Equality Tribunal, Labour Relations Commission , Rights Commissioners Service and the first instance (Complaints and Referrals) functions of the Employment Appeals Tribunal.

THE WORKPLACE RELATIONS COMMISSION OFFERS A NUMBER OF CORE SERVICES:

- Advisory and information
- Conciliation and early resolution
- Adjudication
- Compliance and enforcement
- Inspection of employment rights compliance
- The processing of employment agency and protection of young persons (employment) licences.

The commission has a board consisting of a chairperson and eight ordinary members appointed by the Minister for Jobs, Enterprise and Innovation.

PHOTOS FROM THE OHNAI AUTUMN CONFERENCE IN THE AISLING HOTEL

Delegates chat to speakers

FAS stand at Annual Confernce

OHNAI president and speakers

KOS stand at Annual Conference

Kathleen Treanor
Consultant Ergonomist

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Kathleen Treanor, RGN OHN MSc in Health Ergonomics. MSc in Environmental Health Risk Management, MSc in Healthcare (Risk Management and Quality)

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WHY ARE IRISH OFFICES MOVING TO SIT-STAND WORKING?

James Kennedy, Senior Ergonomic Consultant, KOS Ergonomic Solutions.

Office based workers are sitting longer than ever before and sedentary behaviour is having a huge negative impact on our health. There is a growing body of research showing that a sedentary lifestyle is detrimental to our long-term health.

In the past, it was thought that if you get aerobic exercise at least a few times a week and watch your diet, you'll offset a sedentary lifestyle. However, according to James Kennedy, senior ergonomic consultant with KOS Ergonomics, "The research shows exercise alone is not the perfect antidote for prolonged sitting and there is increasing evidence that prolonged sedentary behaviour has a long lasting negative impact to our health and cannot be fully compensated by short periods of moderate to vigorous exercise". Health professionals and large companies are recognising this and are now looking to create more active work environments for employees. Kennedy noted "Companies, now understand that the human body is in conflict with technology, in a sense. Technology is eliminating the need for whole body movement completely in some roles. The human body needs a consistent moderate level of movements, for brain to perform optimally, for the body to function and recover adequately and while."

IRELAND IS PLAYING CATCH UP

Ergonomists and health care professionals have recognised the body's need for postural changes for many years. Kennedy states "I have always encouraged flexible workstation designs that support an easy transition from sitting to standing as one solution to the sedentary office environment. Sit-stand working has been the norm in Scandinavia since the 90's and it's only really in the last two years that I've seen it become the norm in the modern Irish workplace, which is great!". As a company, KOS Ergonomics have been promoting active working and postural variation since its inception and introduced sit-stand desks to Ireland originally over 16 years ago. Kennedy notes says "When we first introduced them to Ireland they were, novel and more expensive and only really bought by people with back injuries, the very tall, very small individuals and the very health conscious. However, in 2014, things seemed to change overnight and the increase in demand was huge. "It has been great for us as a company, as with the increase in demand,

our pricing has come down significantly also and for a single Danish made sit-stand desks for €699, where previously prices that low was unheard of."

WHY THE CHANGE TO SIT-STAND WORKING?
HEALTH RISKS OF SITTING:

Kennedy says "I believe this change has a lot to do people in the ergonomics and health community highlighting the health impact of sedentary behaviour but it was also majorly helped by health campaigns in the UK that were promoting active working and sit-stand workstations". In the ergonomics field, the focus has been traditionally on reducing the negative musculoskeletal impacts of prolonged sedentary work but recent research has shown there are far more risks than just musculoskeletal. It was reported in the British Journal of Sports Medicine that "prolonged bouts of sitting and lack of whole body muscular movement as being strongly associated with obesity, diabetes, heart disease, cancer, and an overall higher risk of death, irrespective of whether moderate to vigorous exercise is undertaken."

MUSCULOSKELETAL DISORDERS

While MSDs have traditionally been associated with physically strenuous occupations, there is increasing evidence that sedentary office work and other constrained sitting or standing postures are associated with a high incidence of MSDs, in particular, back complaints.

Prolonged sitting increases the deformative force on the discs of the spine due the loss of lumbar lordosis where the load on the discs in the lumbar spine increases significantly. Prolonged sitting is regularly associated with a high incidence of back complaints, as well as increased muscle loading of the neck and shoulder muscles when sitting with the forearms unsupported

Standing requires more effort compared to sitting. While standing, you tense your leg muscles, and engage the muscles of your back and shoulders; while often shifting from one foot to another. All of this requires energy usage. Prolonged standing increases the load on the lower limbs significantly and requires constant tension of the core to maintain an upright posture and can result in more musculoskeletal discomfort than sitting, particularly in the lower limbs.

There is no perfect position that it is recommended for the body to hold. Research shows that static standing is not the answer, nor is static sitting recommended. Each position has its positives and negatives. The research shows there are risk factors for both constrained standing and constrained sitting; it shows that varying work postures may be preferable. Changing between multiple postures allows for increased rest intervals for upper and lower limbs, and reduces the potential risks associated with the development of musculoskeletal disorders.

INCREASED RISK OF OBESITY

Research from James Levine, an endocrinologist at the Mayo Clinic, investigated why some office based workers put on extra weight, while others didn't. The researcher standardised participants' diet and eating habits and found that some participants gained weight, while others remained slim. Participants every subtle movement was tracked using sensors and the study found the participants who weren't gaining weight were standing up or walking around for an average of 2.25 hours per day, even though they were all working in similar sedentary, desk based roles.

Kennedy advises "our bodies are designed for movement and require it. Our increasing reliance on technology, results in a lot of the tasks we do day to day require no movement and this isn't beneficial for our physical or mental health. We need to look for opportunities to move regularly throughout the day and not doing so is linked to increasing the risk of obesity. A study undertaking in the University of Chester found that on average standing burns 50 calories more per hour than sitting.

INCREASED RISK OF TYPE 2 DIABETES AND OTHER METABOLIC PROBLEMS

Evidence from Levine's work and similar studies suggest prolonged sitting results in the cells in the body becoming less responsive to insulin. Sedentary behaviour also saw a sharp reduction in the activity of the enzyme lipoprotein lipase, which breaks down blood fats and helps the conversion to fuel for the muscles.

Studies have found that sitting for extended periods of time is correlated with reduced effectiveness in regulating levels of glucose in the blood stream, part of a condition known as metabolic syndrome that dramatically increases the chance of type 2 diabetes.

INCREASED RISK OF CARDIOVASCULAR DISEASE

A study carried out by Levine and his colleagues also found that adults who spend four or more hours per day sitting have a 125 percent increased risk of health problems, such as heart attacks, chest pain and other problems related to cardiovascular disease.

INCREASED RISK OF CANCER

There is evidence that cancers, in particular, breast and colon cancer appear to be influenced by a lack of physical activity also. In 2011, a study by Christine Friedenreich, an epidemiologist at Alberta Health Services-Cancer Care in Canada found that sedentary behaviour could be the cause of 49,000 cases of breast cancer and 43,000 cases of colon cancer per year in America. Her study also saw a correlation with excessive sitting and a significant amount of other cancers lung cancer (37,200 cases), prostate cancer (30,600 cases), endometrial cancer (12,000 cases) and ovarian cancer (1,800 cases).

CHANGE CULTURE, NOT ONLY THE ENVIRONMENT OR EQUIPMENT

The Irish workplace has not seen such a drastic change to the work environment since the PC became mainstream. Sit-stand desks are new to most people in Ireland and companies can make the mistake of assuming that they all perform the same and that they can fit exactly into a workspace designed for a fixed desk and that's not always true. Kennedy mentions that "On a few occasions, I've been brought in after companies have just purchased sit-stand desks and have got it terribly wrong. There are a lot more factors to consider than with a fixed desk; privacy, distraction of colleagues, accommodating the different height ranges, load capacity, noise, stability, cabling, acoustic and lighting issues, When companies choose sit-stand desks as the standard for all employees, clients will always ask our ergonomic consultants to consult with their architects/ designers, facilities department and health and safety departments to advise on what specification, layouts and configuration is most suitable for the range of employees, tasks and environment.

When a company is converted from fixed desks to sit-stand desks, it always goes hand in hand with an education program. You can provide employees with ability to incorporate more movement and postural variation into their working day but unless you educate them on the benefits and health impacts of doing so, it will not be as successful as it should be. Forming the habits is crucial in creating a more active work environment and with any successful cultural change, it needs to go hand in hand with an education.

EASE OF USE IS PARAMOUNT

Humans by nature are lazy and will avoid things that are complicated and difficult. That is why if the sit-stand desk is difficult to adjust, people are unlikely to change postures at all, let alone frequently, as is recommend. In the first few years, when we provided sit-stand desks, we had systems that were adjusted using a manual hand cranks. After analysing usage over many years in the work environment, we found that they were not being utilised fully, as the users found it difficult and time consuming to make the necessary adjustments, and users therefore typically didn't adjust it regularly or didn't adjust it at all. Workspaces need to be designed to make it as easy as possible to do the correct option otherwise it won't be done. The most effective adjustment systems currently on the market are those with electric motors.

RECOMMENDATIONS FOR SELECTING THE CORRECT SIT-STAND DESK.

- Choose electric motor desks over crank systems or counter balance systems. We find Linak or Bosch motors most reliable.
- If going with an electric sit-stand desk, ensure 100kg minimum dynamic load capacity. Light weight load capacity motors are far less reliable and often have a shorter life.
- Test the stability of the desk when it is at its highest, this is where it is least stable and can cause movement in parts which is most likely cause of breakage.
- Anti-collision sensors are recommended to reduce the risk of injury or damage.
- Ensure a suitable height range to accommodate potentially tall and short employees. The greater the height range the better. Ensure sit-stand desk has a minimum height adjustment range of 650mm. as required under BS EN 527-1: 2011.
- Ensure to source from a reputable supplier. All suppliers of sit-stand desks are required under law to be registered and comply with WEEE Waste Management regulations
- If you are introducing a number of sit-stand desks into the space, consult with your ergonomics team or an experienced ergonomic consultant for advice on set up and layouts.

BEST PRACTICE FOR SIT-STAND DESK USAGE:

- If you are introducing them to replace fixed height desk, this must be done in conjunction with an educational campaign.
- Variation is the key and regular postural change. The more frequent the change the better. Ideally there should be two postural changes per hour. Initially try to stand for at least 10 minutes per hour and try to increase this to 20-25 minutes per hour. Public Health England recommend desk based employees should aim to initially progress towards accumulating 2 hours per day of standing and light activity during working hours. This should eventually increase to a total accumulation of 4 hours per day or half their working day.
- Simply standing is insufficient. Movement is important to get blood circulation through the muscles. Encourage employees to look for reasons for short breaks away from the desk at least once an hour. The desk should only be one element of the active work environment.
- Raise desk to height where shoulders are relaxed and arms are at right angles, level with the desk
- Ensure enough slack in the cables and suitable cable management to reduce the risk of trip hazards.

Kennedy predicts that in the next 5-10 years all large companies in Ireland will be using sit-stand desks as standard. What is happening now in Ireland is very comparable to what happened in Scandinavia in the 90's, where physiotherapists, ergonomists and other occupational health professionals are really driving this forward. Technology is evolving at a much faster rate than the human body can adapt. As humans, we need to take control of our own health and not let technology eliminate movement from our daily lives. In most office jobs, the employee is most productive at their desk, when they have the ability to change from sitting to standing effortlessly without interrupting their work. Maximum oxygen is reaching the brain and productivity is at its highest. Employee health is protected and absenteeism is substantially reduced. The return on investment period is very short so most organisations do not see the cost as a barrier. The solution, isn't to sit all day in work and then head for a run or to the gym afterward, because evidence suggests that the negative impact of prolonged sitting cannot be countered by brief bouts of strenuous exercise. The solution is to incorporate variation into our day, standing, walking and other forms of light activity.

Sit or stand? – No, sit, stand and move!

James Kennedy works for KOS Ergonomics, Ireland's leading ergonomic solutions and equipment provider working with Ireland and UK's leading companies. He studied occupational ergonomics and occupational health and safety and he works with occupational health professionals advising on ergonomic design and helping them to determine the most appropriate ergonomic solutions and equipment to improve their work environment. He also assists companies in accommodating workers with musculoskeletal conditions or specific requirements.

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Since 1991, KOS Ergonomics have been helping Ireland's largest companies solve their ergonomic problems. Our ergonomic consultants work with occupational health professionals and internal ergonomic teams to advise on what is the most appropriate solutions for employees with MSDs to ensure the correct equipment is selected.

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HSE DUBLIN NORTH EAST OCCUPATIONAL HEALTH SERVICE - FIRST PUBLIC SECTOR OHS TO ACHIEVE SEQOHS QUALITY CERTIFICATION

Dr Peter Noone

Our 'Apple Challenge'

The SEQOHS (Safe Effective Quality Occupational Health Service) accreditation scheme is a stand-alone scheme managed by the Royal College of Physicians of London.

HSE DNE Occupational Health Service (OHS) is the 1st public service OHS to achieve quality certification and is the 2nd health service OHS to achieve accreditation on the island of Ireland after the Belfast Health & Social Care Trust OHS.

The OHS which covers the old North Eastern Health Board area was set up in 2001. In 2014-15 we realised that we needed to refocus our services on the needs of our service users and to re-examine our own working practices in light of the wider organisational change and macroeconomic environment.

We faced a number of challenges including how best to provide a high quality, cost efficient service, to support management cost pressures and recruitment challenges in maintaining services, advice to management on reasonable accommodation for persons with disability including alternative duties not causing disproportionate burden; providing information and training to management of the role of occupational health within the employment legal framework, providing ongoing appropriate learning and development for staff, and measurement of effectiveness of OHS.

Hence we embarked on our 'Apple Challenge':

- Approach service users with warm welcome
- Probe politely for all concerns
- Present a solution for the service user on the day
- Listen & resolve any issues or concerns
- End well & respectfully

Left to right: Breda Healy Admin. Aoife Carroll OHNA, Dr. Peter Noone, Consultant in Occupational Medicine, Grace Brady OHNA, Eileen O'Connor OHNA, Karen McCabe OHNA, Charity Craig OHNA, Martin McCoy Quality Co-ordinator, Wendy Duffy Admin.:

We would deliver this by;

a. Focusing on service users

b. Ensuring consistency of standards of our service

c. Identify any gaps in our Quality Management System

d. Review and agree all documented procedures

e. Improve staff communications internally and externally

This would translate in to a quality management system that is responsive to the changing needs of service users and is: capable & clear, organised, results focused, effective, efficient.

There were 6 domains which were shared out among each member of the clinical and administrative staff. These were:

- Business probity (business integrity and financial propriety)
- Information governance (adequacy and confidentiality of records)
- People (competency and supervision of occ. health staff) Facilities and equipment (safe, accessible and appropriate)

- Relationships with purchasers (fair dealing and customer focus)
- Relationships with workers (fair treatment, respect and involvement)

Each domain had a set of standards and sub-standards. We had to provide comments and extensive documentary evidence on how we were meeting each standard and substandard in each of the domains.

The benefits to date of SEQOHS implementation have been

- Greater focus on service user's needs,
- Greater occupational health team focus and cohesion
- Greater recognition and greater appreciation of team members roles and challenges
- A detailed review and updating of all our policies, procedures, protocols and guidelines
- Sharper focus on all our services
- It has addressed important gaps in our Quality Management Systems

This involved a lot of work in a department with limited resources and having faced significant budget cuts. However we did find it beneficial and our hard work with limited resources was acknowledged by our assessors.

As the first SEQOHS certified health service OHS we are delighted with the outcome of the recent audit. The team worked extremely hard over the last 12 months preparing for the audit. We have a great team and this is recognition of the high level of occupational health support that we provide - not only to our own HSE DNEstaff but also for the health science students at Dundalk Institute of Technology. We are very proud of how we have all pulled together to achieve our quality certification and that our 'apple' met the SEQOHS standards.

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- Functions to test manually
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- Includes Audioconsole software
- Noise-excluding headset

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- Features 20dB automatic test
- Hughson Westlake automatic test
- Includes Audioconsole software
- Noise-excluding headset

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Spiro USB

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- Easy setup: plug in, launch exam, blow into Spiro USB to view results
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- Fully compliant to ATS/ERS 2005

Keystone VS5 Vision Screener

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MIGRAINE IN THE WORKPLACE

Debbie Hutchinson, Communications Officer, The Migraine Association of Ireland.

On any given day in Ireland over 13,000 people are suffering from migraine.

Migraines are most prevalent among 30 – 40 year olds who consequently form a majority part of the Irish workforce. Migraine and chronic headache have been found to be the second most frequently identified cause of short-term absences (47%) for non-manual employees[1].

The cost of migraine to the Irish economy is a staggering €252 million a year and EU €26 billion. This is due to a combination of workdays lost and a reduction in productivity, totaling almost four days annually.

For those who suffer migraine, a debilitating neurological condition, the workplace can become an isolating and stressful environment where the sufferer can often feel their condition is misunderstood and stigmatised.

Migraine is much more than a headache. There are many different types of migraine and the headache is just one aspect of a disabling attack. Some migraine sufferers never suffer the actual headache but suffer the various other symptoms, such as dizziness, nausea, loss of vision, muscular weakness, slurred speech and confusion. To find out more about triggers, symptoms and types of migraine visit the website of the Migraine Association of Ireland (www.migraine.ie) which provides a comprehensive resource on the condition.

ALLOW RECOVERY TIME AND SPACE.

One of the most important accommodations an employer can make for a migraine sufferer is time and space to recover. Many people can return to work if they take their medications quickly and are allowed the chance to rest in a darkened room. If the migraine attack continues it is best to allow the employee to go home, rest and return to work the next day. By remaining at work the person is often exacerbating their attack which may cause it to linger for a longer period of time and if they stay in work they will be unable to work to any useful capacity while suffering an attack.

If the migraine attacks are more common and increasingly occurring in the workplace there may be a number of areas to investigate as possible workplace triggers for migraine attacks:

Lighting in the workplace: The link between light and headache was investigated through the work of Dr Andy Dowson, Director of Headache Services at King's College Hospital, London, and Alan Maine (European Institute of Health and Medical Sciences) who found that migraineurs are specifically sensitive to the red and blue parts of the spectrum, rather than the green middle part of the spectrum. Red light is prominent in strip lighting and many people feel that fluorescent lights can trigger an attack. If a member of staff feels that the fluorescent lights are triggering regular attacks then there are a number of options available to rectify the situation.

- **Fix the light**: A lot of fluorescent lights are flickering because the ballast is faulty. The ballast regulates the output of light and if it is irregular it can cause flickering. It is often cheaper to replace the light rather than the ballast if this is the problem.
- **Turn off the lights**: If you are in a work environment where a fluorescent light is over your desk then ask your employer and colleagues' permis-

sion to turn the lights off over your desk, even for a number of hours or all day if it does not affect other workers.

- **Diffuser:** Fitting a diffuser to the lights may solve the problem. They are relatively inexpensive and can be a good option in a smaller workspace with the co-operation of employers and colleagues.
- **Filters:** Filters for fluorescent lights are almost like shades over the lights. They can range from relatively cheap filters that can be fitted over the lights to more expensive professional filters. When ordering filters ask your supplier for a filter that filters out blue and red light

LED lighting has been hailed as an improvement for migraine sufferers as there is virtually no flicker emitted from LED lights, so it triggers fewer migraines in workers. Unfortunately not all LED lights are of the same quality and substandard LED lighting may actually be flickering at higher rates than expected. Employers should consult with a lighting specialist to check the flicker rate of LED's in their workplace

COMPUTER USAGE AND MIGRAINE TRIGGERS

In many cases it is the length of time on the computer that can trigger a migraine attack rather than the equipment itself. Often lengthy periods of monitor usage are combined with stressful conditions and unhealthy eating as employees struggle to reach deadlines during particularly busy work periods. Regular breaks and re-hydration are very important in preventing migraines and headaches. Dehydration is a particularly common migraine trigger. When you are choosing snacks for the workplace choose magnesium rich nuts and seeds. There is some medical evidence that migraine sufferers may be deficient in magnesium and Vitamin B2 and many doctors and consultants now prescribe a supplement to their migraine patients. Just a half cup of pumpkin seeds provides nearly 100 percent of the daily requirement for magnesium. Other nuts and seeds high in magnesium include almonds, sunflower seeds, Brazil nuts, cashews, pine nuts, flaxseed, and pecans.

If attacks are still occurring and seem to be directly related to time on the computer at work then making some equipment adaptations could improve the situation:

- **Antiglare Screens** – Antiglare screens are available for most sizes of screens and can also help with VDU flicker.
- **LED Backlighting:** Some migraine sufferers indicate sensitivity to LED backlighting on tablets and laptops. If the laptop is operating on battery power, then the display is flickered (as a power-saving measure). However, if the laptop is plugged in to AC power and the brightness is set to the maximum, then the LEDs are not flickered, but on constantly. Apple Tablets and iPhones have a Night Shift setting which reduces the blue light transmitted through the back light to a more agreeable yellow hint which can be more comfortable for the migraine sufferer.
- **Text display** can be adjusted to ensure that it is easy enough to read on screen or you may also benefit from colour contrasts that are easy on the eye.

Where workplace adaptations are not suitable or financially possible, or simply just not working then the migraine sufferer may need to employ some specialty aids and treatments to help improve their working life. There are two specific visual aids that migraine sufferers can use, the Migralens and Orthoscopic lenses. Ordinary tinted lenses do not prevent migraines.

The lenses of the Migra Lens absorb the red and blue light from sunlight, artificial lighting, television and computer screens and they can be worn by those with ordinary eyesight and those who wear prescription glasses. You can order Migra Lens at www.migralens.com.

Orthoscopics is a process of using colored lenses to correct Migraine and perception problems and there are a number of clinics in Ireland that can be found online.

LAW AND MIGRAINE IN THE WORKPLACE.

Under the Employment Equality Acts, 1998 to 2007, an employer has a duty to do all that is reasonable to accommodate the needs of a person with a disability. The main problem for migraine sufferers is having migraine recognized as a disability under the legislation. Irish law recognizes the effect the condition has on a person's life as being of greater importance than the condition itself. Therefore migraine is not automatically excluded or included as

a disability and employees can appeal to the Workplace Relations Committee if they feel their employer is not reasonably accommodating their disability.

The Migraine Association of Ireland regularly holds Free Health Professional Training Seminars throughout Ireland which are open to all Health Professionals, including Occupational Health Nurses. These events are publicised through our social media channels, at www.migraine.ie or you can sign up for our Health Professional Ezine by emailing deirdre@migraine.ie. We also hold a number of FREE information seminars for the General Public which are publicised through local media and online and are open to anyone to attend.

If you would like the MAI to present a seminar on migraine or provide an information stand in the workplace then contact Debbie Hutchinson at communications@migraine.ie.

1. (CBI, Pfizer. Healthy Returns? Absence and Workplace Health Survey 2011. P20.)

IMMUNISATION FOR HEALTH CARE WORKERS

IMMUNISATION GUIDELINES, 2013

Laura Ahearne - Occupational Health Nurse

In the Irish workforce, the largest at risk group to infectious agents during employment are Health Care Workers (HCWs). HCWs refers to those who have direct patient contact, both clinical and nonclinical staff.

ROLE OF IMMUNISATION:

- Protect the HCW- physically and psychologically
- Reduce HCWs ability to transmit to vulnerable patients
- Essential component in stopping the spread of infection
- Legal requirement

VACCINATIONS FOR HCWS

- Hep B
- Measles, Mumps, Rubella
- Varicella Zoster Virus (VZV)
- BCG
- Hep A
- Pertussis

HEPATITIS B VIRUS

- Hepatitis B virus (HBV) is a DNA virus and an important cause of serious liver disease including acute and chronic hepatitis, cirrhosis and primary hepatocellular carcinoma.
- Risk for infection through blood and bodily fluid.
- HBV can survive in the environment for 1 week or longer.

TRANSMISSION

Mainly occurs by percutaneous exposures e.g. needle stick injuries.

VACCINATION FOR HEP B

- Confirm Anti-HBs levels and Hep B core antibody .
- A course of Hepatitis B vaccination should be given if not previously vaccinated.
- The vaccine is 80 to 100% effective in preventing infection or clinical hepatitis in those who receive a complete course of vaccine.

Anti-HBs level	Action required
0 or <10 mIU/ml	Non responder. Test for anti-HBc*. If anti-HBc negative, repeat full course of hepatitis B vaccine (use a different brand). Recheck anti-HBs 2 months post completion and follow guidance above. If anti-HBs remains <10 mIU/ml, person is susceptible to HBV.
10-99 mIU/ml	Low response. If low level anti-HBs confirmed by 2 different assays, give booster dose if at increased risk (see page 12). There is no need to retest for anti-HBs.
100 mIU/ml or greater	Good response. No need for further vaccine or anti-HBs investigations.

Hepatitis B				
		Dose	Volume	Schedules (months unless stated)
Age 16 and older	Engerix B	20µg	1ml	0,1,6 0,1,2,12[1] 0,7,21 DAYS[2] + 12 months
	HBVAXPRO 10	10µg	1ml	0,1,6 0,1,2,12[1]
	HBVAXPRO40 (adult dialysis and pre-dialysis)	40µg	1ml	0,1,6
Age 15 years and older	Fendrix (renal insufficiency) (NOT NTERCHANGEABLE)	20µg	0.5ml	0,1,2,6

Hepatitis A and B				
		Dose HAV/HBV	Volume	Schedule (months)
Age 16 years and older	Twinrix	720IU/ 20µg	1ml	0,1,6 0,7,21 DAYS[2] + 12 months
Age 1-15 years	Twinrix	360IU/10µg	0.5ml	0,1,6
	Ambirix	720IU/ 20µg	1ml	0, 6-12[3]

[1]when rapid protection is required
[2]when very rapid protection is required
[3]to be used only when there is a low risk of hepatitis B infection and when completion of the two-dose vaccination course can be assured

- Between 90%-100% of vaccinated persons who develop anti-HBs concentrations ≥10 mIU/ml after a primary series are protected from significant HBV infection for at least 20 years and probably longer.

NON RESPONDERS

Up to 15% of adults have a poor or no response to 3 doses of vaccine. Poor response is associated with:

- Age over 40 years
- Male gender
- Obesity
- Smoking
- Alcoholics

FOLLOW UP FOR NON-RESPONDERS

1. Level of anti-HBs <10m IU/ml. 2 months after the third dose.
2. A repeated course of vaccination, preferably with an alternative hepatitis B vaccine, is recommended. This results in protective anti-HBs titres in 50 to 100% of previous non-responders.
3. If there is still no response (anti-HBs <10m IU/ml. 2 months after the third dose) of 2nd course: Administration of a course of a double dose (2mls) of combined hepatitis A and B vaccine (Twinrix) at 0,1 and 6 months is recommended as this can induce a protective anti-HBs response in >90% of non-responders.
4. If there is still no response (anti-HBs <10mIU/ml two months after the third dose) of 3rd course: A single dose of Fendrix should be offered and anti-HBs checked 2 months later.

MMR- MEASLES, MUMPS, RUBELLA

- Viral diseases.
- Measles: fever, cough, runny nose, red pinpoint rash that starts on face and spreads to rest of body. Can cause pneumonia and encephalitis with lung and brain inflammation.
- Mumps: swelling in glands just below the ears, giving the appearance of chipmunk cheeks.
- Rubella: facial rash, glands swelling behind the ears, Pregnant women who contract rubella in 1st trimester have 20% chance of child born with birth defects.

TRANSMISSION

Airborne or droplet infection.

MMR VACCINATION

- HCW born in Ireland since 1978 who do not have serological evidence of infection or documented evidence of 2 doses of MMR vaccine should be given 1 or 2 doses of MMR as required separated by at least 1 month so that a total of 2 doses are received.
- The vaccine contains live attenuated measles, mumps and rubella which are cultured separately and mixed before lyophilisation.
- Priorix
- MMr vaxPro

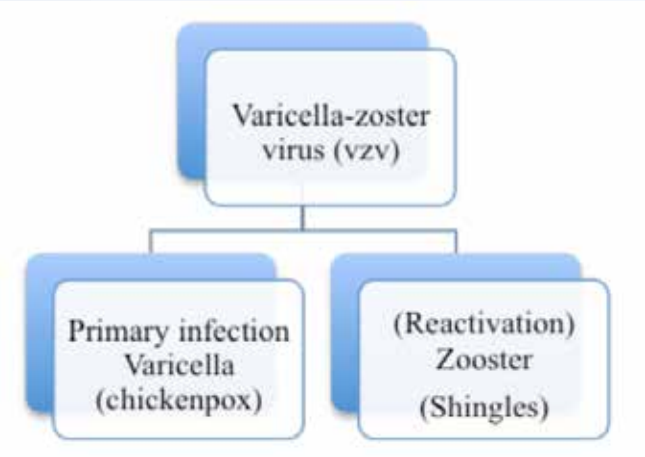
MEASLES: Approximately 95% of individuals develop immunity to measles after 1 dose of a measles containing vaccine. Two doses give protection in about 99% of people.

MUMPS: Mumps vaccine studies of the protective effect of a single dose of mumps-containing vaccine varies between 61% and 91%. Vaccine effectiveness after 2 doses is estimated to be around 88%.

RUBELLA: Satisfactory evidence of protection against rubella includes documentation of having received at least one dose of a rubella-containing vaccine or a positive antibody test for rubella. Over 95% of recipients are likely to develop lifelong immunity to rubella after a single dose of a rubella containing vaccine

- Laboratory investigation to determine vaccine response is not routinely recommended.
- MMR vaccine can be given to those who have a history of measles, mumps or rubella infection.

- MMR vaccine may be given at the same time as any other vaccine. There must be an interval of 4 weeks between the administration of any other live vaccines if they are not given at the same time.
- Scientific evidence confirms no association between the MMR vaccine and autism or inflammatory bowel disease.



VARICELLA- ZOSTER VIRUS (VZV)

- Varicella is typically a generalised, pruritic vesicular rash. A mild fever and malaise may occur, more commonly in adults. The rash usually starts on the head and progresses to the trunk and extremities, progressing from macules to papules rash to vesicular lesions that crust over as they dry.

TRANSMISSION

Mainly by direct contact with vesicular fluid, or by contact with fomites

VZV VACCINATION

- HCWs without proof of immunity or documented evidence of 2 doses of vaccine require vaccination follow up.
- Two doses, at least 4 weeks apart, are recommended
- Varicella zoster vaccine is a live attenuated viral vaccine.
- Vaccine efficacy is estimated to be approx 75% in those aged >13 years(HCWs).
- Immunity in most appears to be long lasting, probably lifelong.
- However, approximately 1% of vaccines per year have developed mild breakthrough infections.
- Post-vaccination serological testing is not recommended.
- Varivax

BCG

Bacteria: may infect any part of the body. However, the majority of cases involve the respiratory system.

TRANSMISSION

TB is primarily an airborne disease, transmitted by a person with respiratory TB through coughing, sneezing, speaking, laughing or spitting. Infected particles are inhaled during close contact (usually within 1 metre) and prolonged or repeated contact with an infected family member, friend, childminder, co-worker, or classmate.

BCG is indicated for HCWs aged <35 who are unvaccinated and are Tuberculin skin test (TST) or Interferon gamma release assay (IGRA) negative.

VACCINATION:

- Not all HCWs are at equal risk of TB. A risk assessment should be carried out to see if BCG is indicated for unvaccinated HCWs aged 35 and older who are TST negative, taking into account their country of origin and the nature of their work.
- BCG Vaccine SSI

HEP A

Virus (HAV) acute, usually mild and self-limiting disease of the liver but can result in illness usually lasts up to 2 months, characterised by fever, malaise, anorexia, nausea and jaundice.

Risk: HCWs e.g. paediatric hospital staff, workers who handle faeces as a diagnostic sample.

TRANSMISSION

Faecal-oral transmission

HEP A VACCINATION

Hepatitis A vaccines are available as either monovalent vaccines, or combined with either typhoid or hepatitis B vaccines.

Monovalent vaccines

Approximately 95% of subjects acquire protective levels of HAV antibodies within 4 weeks of one dose, and over 99% after the second dose. The duration of the vaccine induced immune response has been demonstrated to protect for at least 15 years. It is likely that at least 95% and 90% of subjects will remain seropositive (>15 mIU/ml) 30 and 40 years after vaccination, respectively.

Combined hepatitis A and hepatitis B (HBV) vaccine:

May be used when protection against both HAV and HBV is required.

HEP A SCHEDULES

Monovalent Hepatitis A:
Single dose of 0.5 or 1ml followed by a booster at 6-12 months.
(Havrix, Avaxim)

Combined Hepatitis A and Hepatitis B vaccine:
(product dependent)

Twinrix (Hep A and Hep B) consists of three doses of 0.5mls, the initial dose followed by a second dose at one month and a third six months after the first dose.

Viatim (Hep A and Typhoid) the schedule consists of two doses, the initial dose followed by a second dose between 6 and 12 months after the first dose.

Hepititus A Virus

Monovalent vaccines contain higher amounts of hepatitis A antigen and provide hepatitis A protection more quickly than Twinrix.

PERTUSSIS- WHOOPING COUGH

Highly infectious bacteria

TRANSMISSION:

Close contact via droplet infection from the respiratory tract of infected individuals.

A booster dose of Tdap is recommended for Health Care Workers who are in contact with infants, pregnant women and the immunocompromised.

VACCINATION:

- Low dose pertussis vaccines (ap) are recommended for children aged 10 years and older i.e HCWs
- Following both infection and vaccination immunity wanes, so that after 10 years, over 50% are susceptible to reinfection.
- A full course of vaccine confers protection in 75-90% of recipients. Immunity wanes with age, and is usually inadequate 8 -10 years after primary and booster vaccination. High vaccine uptake rates, including booster doses, are therefore very important in order to reduce the incidence of pertussis.
- Boostrix suspension for injection in pre-filled syringe

GENERAL IMMUNISATION INFORMATION

Interrupted immunisation courses:

- If an immunisation course is interrupted, it should be resumed as soon as possible. It is not necessary to repeat the course, regardless of the time interval from the previous incomplete course. The course should be completed with the same brand of vaccine if possible.

DRUGS OF ABUSE AND ALCOHOL SCREENING IN THE WORKPLACE

WITH MEDLAB PATHOLOGY (MLP)

Niamh Cosgrave, Director of Sales and Marketing, Medlab Pathology

Occupational Health is a dedicated division of medicine which aims to provide a safe working environment as well as promoting the wellbeing of employees in the workplace. Occupational health departments are critical to companies for the prevention of occupational injury and illness through hazard identification and control, in addition to ensuring that companies adhere to Occupational Health and Safety Regulations.

One very important component of safety in the workplace relates to Drug and Alcohol Screening. In conjunction with Alere Toxicology and our sister laboratory, The Doctor's Laboratory (TDL) in London, MLP can provide you with a first class service in this area covering:

- Provision of point of care (POC) drug screening kits and alcohol breathalysers
- Chain of Custody(COC)/Non-COC analysis for both drugs of abuse and alcohol
- Confirmatory testing on all initial screening results
- Comprehensive DOA training

DOA SPECIMEN COLLECTIONS IN THE WORKPLACE

Preparation is critical in taking a COC sample in the workplace. Key steps involved:

1. Preparation of specimen collection facilities:
    - Addition of colouring agent to the toilet bowl.
    - Awareness of any attempts to hide 'clean' urine containers or other substances in the area.
    - Removal of all potential sample contaminants.
    - Taping of taps to prevent unauthorised access to water that could intentionally dilute a sample.
2. Identification of donor with formal ID.

3. Ensure donor has no opportunity to introduce an adulterant or substitute specimen.
   - Empty pockets, remove coat and personal items.
4. Ensure that the donor's dignity is respected at all times.

POINT OF CARE KIT

The Drug Screen Test Cup for a urine sample (pictured below) is intended for screening for the presence of drugs and drug metabolites in urine. These user-friendly rapid screening devices come in a wide range formats and panel configurations. They provide initial screening results in only five minutes and so are ideal for screening employees in the workplace for pre-emplyment testing, random screening and post-accident incidents. Kits should be stored at room temperature and the minimum acceptable amount is 30ml. Full training on the use and reading of these POC kits is included in the training offered by MLP.

CHAIN OF CUSTODY

COC refers to the system of controls governing the entire urine collection, processing and storage of sample to ensure that a particular urine specimen originated from a particular individual and that the reported results relate, beyond doubt, to that specimen. COC requires attention to detail so that it is possible to prove that there has been no opportunity for the sample to be accidentally or maliciously adulterated. Sample collection should be undertaken by collectors who are well versed in the protocols of chain of custody. MLP's training will ensure that all staff involved in the process have undergone the appropriate training and are competent to collect a COC sample once completed.

Urinary creatinine is routinely measured during testing to verify the validity of the sample submitted. Creatinine levels below normal occur when the urine has been diluted, either directly or by drinking large amounts of water before providing the urine sample. Chain of custody containers, forms, seals and barcodes are provided by MLP on request. All COC, and non-COC, samples with positive findings will proceed to identification/confirmation by Gas Chromatography/Mass Spectrometry.

MEDICATIONS

When collection a sample for direct COC analysis or if sending an initial non-negative POC screening result to the laboratory for confirmatory testing any medications the donor may have taken need to be clearly stated and documented. These include any medicines prescribed by your doctor for regular or occasional use e.g. Antibiotics, sleeping pills, eye drops/inhalers, medications for foreign travel. Also important to state are any non-prescribed medicines for pain, allergies, coughs and colds (including inhalers) and travel sickness. Finally it is important to declare if the donor has had any injections or local anaesthetics from a doctor, dentist or hospital and the timeframe since it occurred.

For more information please contact MedLab Pathology on 1800 303 349 or sales@medlabpathology.ie

ICOH

FACULTY OF OCCUPATIONAL MEDICINE
ROYAL COLLEGE OF PHYSICIANS OF IRELAND

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Save the Date ICOH 2018 in Ireland
FIRST ANNOUNCEMENT

Occupational Health and Wellbeing: linking research to practice

Welcome

Céad Míle Fáilte/Welcome/Bienvenue

We would like to invite you to attend the **32nd ICOH Congress in Dublin, Ireland 29th April – 4th May 2018**. Our theme is Occupational Health and Wellbeing: linking research to practice. To deliver on this we will have an excellent blend of plenary, semi-plenary and parallel sessions on a range of the latest occupational health and safety topics. The Policy Forum will also discuss strategies to deal with future challenges in occupational health and safety from national and global perspectives. The Congress offers a unique opportunity to experience a truly global multi-disciplinary event where you can learn, discuss and share views with a wide range of expert OSH contributors and practitioners from across the world. Come to Dublin and benefit from the exchange of ideas and practice which contributes to advancing research, policy and interventions. Dublin is Ireland's capital city and is steeped in history and vibrant cultural diversity with a variety of activities and sights to enjoy. The conference will take place in the iconic Convention Centre Dublin and we look forward to welcoming you.

Dr Martin Hogan
Chair, National Organising Committee

Prof Ken Addley
Chair, National Scientific Committee

FOR QUERIES OR MORE INFORMATION

icoh2018.org

Twitter

Facebook

icoh2018@conferencepartners.ie

FOR QUERIES OR MORE INFORMATION

Call for Abstracts
6th February 2017

Registration Opening
6th February 2017

Close of Abstract Submission
16th June 2017

Notification of Acceptance
15th November 2017

End of Extra Early Registration
15th November 2017

Presenter Registration / Confirmation of Attendance
30th November 2017

End of Early Registration
25 January 2018

SUPPORTING ORGANISATIONS (as at May 2016)

Occupational Hygiene Society of Ireland
Irish Society of Toxicology
UCD Dublin
OHNAI Occupational Health Nurses Association of Ireland
iosh
HSA Health and Safety Authority
Irish Ergonomics Society
Ibec For Irish Business
GORDS
Failte Ireland
hseni Controlling Risk Together
conference partners

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ADVERTISING TYPE COSTING

❊ Newsletter (1/4 A4 page)	€32
❊ Newsletter (1/2 A4 page)	€65
❊ Newsletter (1 A4 page)	€130
❊ Newsletter (insert)	€100
❊ Conference stand (incl. lunch for one person)	€320
❊ Insertion of flyer in 'conference pack'	€100
❊ E-mail	€50
❊ E-mail and insert in 'job-box' in newsletter	€100
❊ Flyer (mail shot)	N/A
❊ OHNAI Website advertisement	€50

All cheques are to be made payable to:
OHNAI, PO Box. 5616, Dublin 8.

All payments must be received prior to the publishing/circulation of the advertisement.

NEWSLETTER ARTICLES

Newsletter articles are always welcome and very much appreciated. Topics can include anything from research, health promotion activities in your workplace, wellbeing, advertisements, posters etc.

There is a €100 paid for each published article greater than 200 words. Also any social news new births/ marriages etc. is welcome. Please forward anything you want submitted to: elaine@chi.ie

Thank you.

MEMBERSHIP

For any colleagues who still have to pay membership.
There are 2 payment methods:

1. Cheque payable to the OHNAI P.O. Box 5616 Dublin 8

2. Electronic Bank transfer – Allied Irish Bank, Main Street, Malahide.

Sort Code 93-25-23 | Account Number 46900-181

IBAN: IE46 AIBK 9325 2346 9001 81 | BIC: AIBKIED2D

We hope to soon have the facility on www.ohnai.ie to pay online with Paypal.
As soon as this is finalised we will update you. If you have any queries, please contact us via ohnaireland@gmail.com and a committee member will deal with your query.