OHNAI SUMMER 2017 NEWSLETTER

Welcome Letter

Dear Members,

I hope you are all well, and as you by now are all aware in January I was nominated by Niamh and the committee as the OHNAI President for 2017.

We have had a very busy first half of the year with all the committee working tirelessly behind the scenes meeting and communicating regularly. We have been busy what with arranging the *At Work Partnership Study Day* in May and planning ahead for our autumn event.

The feedback from both the Work Partnership team and those of you who attended the *Mental Health at Work Study Day* was excellent. We had 44 in attendance and it was a fantastic informative day from start to finish. A huge thanks to Monica, Annmarie, Edel, Liz, Daragh, Breege and Elaine for all your efforts, the management and staff of the Aisling Hotel and of course our specialist speakers from the *At Work Partnership*.

Further news is that as current President I represented the Association at the 45th board meeting of *The Federation of Occupational Health Nurses of the European Union* (FOHNEU) in Stockholm last month. This event was attended by Occupational Health Nurses of EU member states which included Finland, the Netherlands, Sweden, Hungary, Germany, Slovenia, Denmark, Belgium, Finland and of course Ireland. It was an excellent forum for all representatives to share evidence-based best practice in the field of Occupational Health and Safety within their respective jurisdictions.

A new FOHNEU Declaration was agreed and adopted and plans are now in place for the 7th Congress in Budapest Hungary 2019. It was a fantastic experience and I look forward to informing you further at our AGM later in the year.

The OHNAI continues to be involved with the planning and preparation of the ICOH Congress Dublin 2018. We have been offered an opportunity for a member to speak at the Occupational Health Nurses special speaker session. The closing date for submission of the abstract is 31st July. I would urge all members to put themselves forward for this wonderful opportunity to showcase Irish Occupational Health Nursing at this prestigious event. The chosen speaker will have 20 minutes to present; the theme for the Special Session is 'Future Occupational Health Nursing Roles.' Susan Randolph is the current chair of SCOHN and abstracts must be submitted to her by July 30, 2017. She can be reached on her email susan.randolph@unc.edu.

We are going from strength to strength as an organisations and trust you as members benefit from your membership and the services we as a voluntary committee are striving to provide for you.

As always we would welcome any suggestions you may have no matter how small. You are welcome to contact myself or any of the committee members, or alternatively use our new Facebook page to highlight any suggestions and to share any evidence-based best practice advice to our members .

I trust you will enjoy this summer newsletter and I hope you will find it both interesting and informative.

Kind regards,

Mary Doran

OHNAI President

CASE MANAGEMENT APPROACH

SOME ADVICE FOR OCCUPATIONAL HEALTH NURSES/MANAGERS

Eileen Holland

Case management is a process of planning, coordinating, managing and reviewing the care of an individual.

The overall aim is to establish cost effective and effective methods of co–ordinating services in order to enhance the quality of life.

The primary aim of case management is to deliver quality health care in an uninterrupted process, avert fragmented care that would delay return to work. It would also supplement the employee's quality of life minimising cost to the company.

Rogers (2003) stipulates that Occupational Health Nurses/Managers coordinate and manage the health care requirements from start of occupational and non-occupational injuries/illness until a safe transitional, modified, or full duty return to work is achieved. Haag & Kalina (2002) encourage the concept of case management as positive highlighting a number of key benefits for employee and employer.

Some of the benefits for the employee to include the provision of financial security, strengthen positive self-image, promoting of regular contact between employee and coworkers. This re enforces the key element of going to work in conjunction with a sense of positive health and well -being.

The Faculty of Occupational Medicine UK (2005) supports the health and well- being concept by outlining that activity of 'going to work' is paramount in achieving economic independence, prosperity and personal satisfaction.

Assisting people to stay at work or return to work is an integral part of the therapeutic process undertaken by OH.

Some benefits of the case management approach for employers include; reduce claims costs, maintains productivity, enhances communication and good will among workers.

Although the overall process of case management is beneficial it is not without its pitfalls. Wallace (2009) highlights concern if roles within the overall process overlap and if open chain of communication amongst all departments involved is not consistent, this leads to inefficiency in the workplace.

One of the key findings from the literature was; the huge challenge of an aging workforce and its demands that require innovation in health promotion activities. Such as reducing work related and occupational diseases, reduction impairments arising from diseases and finally supporting disabled workers/ enhancing work ability (Ilmarinen, 2006) This is a huge challenge observed due to the change of traditional seated work areas to a more active role within a large multinational company.

Wallace (2009) recognises another key element in relation to successful case management by affirming that return to work programmes are most effective when there is engagement with all parties involved in the process and this thus yields a positive outcome for both employee and employer.

Franche, Cullen, Clarke, Irvin, Sinclair, & Frank, (2005) support this viewpoint by highlighting the importance of good communication amongst the key stakeholders within any work organisation employers, managers employees, General Practitioners' in working in close collaboration with the occupational health team to manage absence of long term sickness.

Nice (2009) outline a key element with successful case management by advising that proactive procedures conducted by organisations in the management of sickness absence that organisations

(Cont...)

need to ensure they implement sickness absence policies, trigger points for management action and return to work interviews are crucial for effective case management.

MacEachen, Kosny, Stahl, O Hagan, Redgrift, Sanford, Carrasco, Tompa & Mahood (2015) all highlight an integral component to ensure effective case management. Regular contact with employees through sickness absence is viewed as an imperative strategy in relaying to staff that they are valued and supported in the workplace.

SOME OTHER GOOD SOURCES IF GUIDANCE FOR OCCUPATIONAL HEALTH NURSES

www.rtwknowledge.org

What works at work? Hill, Lucy, Tyers & James 2007

Is work good for your health and Well Being? Waddell & Burton 2006 (very useful for return to work plan)

www.kendallburton.com

www.tsoshop.co.uk

Ilmarienj. Work ability-editorial. Scand J work Environ Health 2009:35:1-5

ABOUT US

P&A Medical Limited has been offering medical equipment and calibration services to the Occupational Health industry for 30 years, operating in, and serving over 1,800 blue chip companies on the UK mainland. After three decades of experience we are now offering the same products and services to the Occupational Health industry in Ireland

We are an independent, family operated company offering the full range of medical screening equipment available in today's marketplace. Being independent, you can be sure you'll receive unbiased advice from our sales team.

The Directors of P&A Medical would like to thank you for considering our sales and calibration services in 2017 and beyond.

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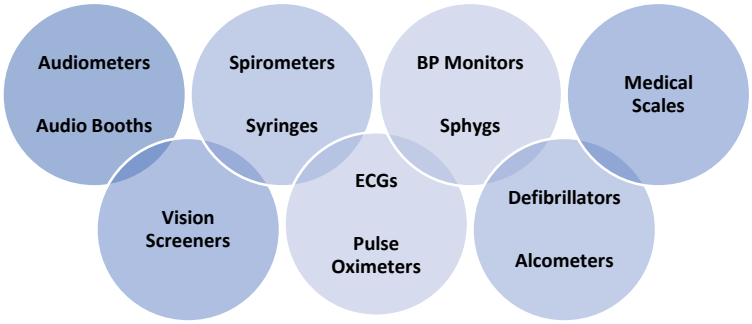
As an ISO9001 approved company, our performance is annually audited to reassure customers of our continued high standards. We are continually improving and expanding our services to better meet the needs of our customers.

WHAT WE CALIBRATE & SERVICE



AND MORE…

WHAT IS A CALIBRATION?

A calibration is an evaluation and investigation into the inaccuracies of your medical equipment. A variety of factors may affect what measurements your equipment reads therefore part of the calibration process is to investigate the reasons behind the inaccuracies. For example, the equipment could have a fault, or not be kept in an optimal environment. Before continuing the calibration or making any adjustments it is imperative that these reasons for the inaccuracies are addressed.

Calibrations should be completed using measurement equipment that is, itself, calibrated to British Standard required intervals. In other words, a valid calibration is completed using measurement equipment that is proven to be more accurate than the measurement capability of the equipment being calibrated. A calibration should *never* be completed using equipment not kept within British standards.

Documentation of your equipment's measurements should be recorded on an official calibration certificate and made available to you at any time. A calibration includes documentation of the entire measurement range of your equipment, not a single reading. At P&A, we offer hard copies of your certificates which we leave with your equipment. Digital copies are available through the P&A customer portal at www. pandamed.co.uk. Completion of any calibration, along with your calibration certificates, is a guarantee of the future accuracy of your machine (typically one year).

All P&A Medical equipment is calibrated to UKAS standards and proof can be provided at any time should you require it. The United Kingdom Accreditation Service (UKAS) is the only national accreditation service for the United Kingdom recognised by the UK government.

For more information on UKAS, please visit www.ukas.com/about/our-role.

BEST SELLING PRODUCTS!

Oscilla USB 330 Screening Audiometer

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The Oscilla USB 330 is a PC-based screening audiometer with a built-in patient response button.

- -10dB to 110dB in 5dB increments
- Features 20dB automatic test
- Functions to test manually
- Hughson Westlake automatic test
- Includes Audioconsole software
- Noise-excluding headset

Oscilla SM 930 Screening Audiometer

€1,575

The Oscilla SM930 automatic screening audiometer is equipped with a host of features, making it extremely advanced and at the same time focusing on ease of use.

- -10dB to 110dB in 5dB increments
- Built-in memory for 100 measurements
- Features 20dB automatic test
- Hughson Westlake automatic test
- Includes Audioconsole software
- Noise-excluding headset

Carefusion Microlab Mk8 Spirometer

€1,375

The highly portable MicroLab™ Mk8 spirometer can be used in physician offices or for bedside spirometry testing. The MicroLab can be connected to Carefusion Spirometry PC software, allowing trending, reporting and data sharing with your Electronic Health Record (EHR).

- Optional pulse oximetry module
- Fully compliant to ATS/ERS 2005
- 2,000 patient memory

Carefusion Spiro USB

€1,125

The Spiro USB plugs directly into the USB port of your PC, without the need for any additional docking station or data uploading. All you need is a Laptop or Notebook and the Spiro USB becomes a highly portable spirometer.

- Easy setup: plug in, launch exam, blow into Spiro USB to view results
- Features incentive spirometry and pre- and post-bronchodilator testing
- Fully compliant to ATS/ERS 2005

P&A'S PRICE MATCH PROMISE

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…AND MORE!

LONG TERM ABSENTEEISM

Terence O'Sullivan, TJOS Solicitors

Employee absences can have a devastating impact on any workplace. When long term absenteeism is thrown into the mix, it isn't difficult for a plethora of problems to arise.

Communication between employer and employee is an absolute necessity when it comes to a healthy work environment. This applies to everyday scenarios, but also to instances of long term absence. An efficient company should have standard sick leave protocol in place which requires frequent communication between absentee and employer.

In such instances, an employer retains the absolute right to refer an employee for medical examination. An employee is not legally bound to attend, but failure to comply may result in further action. There is an element of pressure involved when a formal referral to an occupational health services is made. Employees often feel compelled to attend because they fear a negative consequence if they don't comply.

An occupational health professional may be called in and in this case, asked to verify an employee's reason for absence and decide on whether it is justified or not. If an occupational health professional does not deem an employee's absence as excusable, this may call into question the genuineness of the illness, and the employee's dedication to their company. It is in situations like these that an employee may feel it is their job to 'convince' the health professional that their absence is justifiable on medical grounds. This can lead to an employee wanting their illness shown 'in the best light', which can mean the over-exaggeration of symptoms or even an unwillingness to enter into an honest discussion about factors which may play a significant part in their absence.

The concern is that placing a health professional in the position of having to verify the reason for absence on behalf of the employer can change the nature of the doctor–patient, nurse–patient relationship, which raises various ethical issues. Technical and ethical guidance on this matter has been published by the International Labour Organisation which states that "occupational health professionals should not be required by the employer to verify the reasons for absence from work". This is largely in order to protect the delicate relationship between a health professional and patient, which ensures open and truthful communication between the two.

The issue of dismissing an employee who is absent due to long term illness has always been a difficult one. For example, an employee has been missing from work for 14 months following a road traffic accident (RTA). During this 14 month period, the employer has made multiple attempts to contact the employee and ascertain the length of the absence. The employee has given no further explanation aside from the fact that he has been in an accident, and therefore the employer has no medical details of his condition. The employer has received one medical report during this period of absence. This medical report does not state any reason for which the employee has failed to contact the employer. Had the employer decided to dismiss the employee in this case, it may well have been justified. There was a lack of communication on the employee's side, and periodically furnishing vague medical reports is not sufficient explanation for an absence of this length.

Contrary to this, an actual case was taken by the Employment Appeals Tribunal on the 24th of September, 2007. In this case, Adrienne O'Brien was employed by Dunnes Stores for some 17 years, and was dismissed following a 16 month absence on sick leave. Ms. O'Brien attended a number of meetings with her employer regarding her illness and estimated return date. She was informed that if she didn't return to work by a certain date, she was to be dismissed. The dismissal was found unjust as no consideration had been given to the idea of re-integration supported by a medical opinion.

In more simple terms, Ms. O'Brien should have been given the opportunity to return to work part-time, or to do work suited to her ability level. It's easy to sympathise with both sides: on one hand, the employer was understandably concerned about an employee absence. The position is being held open for an unforeseeable amount of time, and there are plenty of ambitious and willing prospect employees. On the other hand, Ms. O'Brien had been a loyal, well-performing employee for quite some time. (Law Society of Ireland, Employment Law, 2011)

Dealing with long term absenteeism can be difficult in this regard, and every aspect of the scenario must be reviewed. Many employees are anxious to return to work as there is no reintegration scheme in place, and they fear they may have been rendered incapable. Altered working hours must always be considered, as many employees absent on long term sick leave are perfectly able to return to work, just not to resume their normal responsibilities. Dismissing an employee on the basis of long term absence can be difficult for all parties involved, and every possible option should be considered before the dismissal of a loyal employee, such as Ms. O'Brien.

In actuality, the Unfair Dismissals Acts describe a dismissal as justified if it is "wholly or mainly from the capability, competence or qualifications of the employee to perform work of the kind which he was employed by the employer to do". Employees can be dismissed on grounds of capability, and when it comes to illness, it becomes extremely important to distinguish between the types of absence:

(i) Long term illness and

(ii) Persistent, frequent short term absences.

Persistent, short term absences can be filed as a misconduct issue as there is no underlying medical issue which governs the absences. Absence related to a long term illness may qualify as a disability and in cases like this, the unfair dismissals legislation cannot be viewed without consideration to any potential obligations under the Employment Equality Acts, mainly to make reasonable accommodation in order to assist the person with a disability in returning to work.

It is clear that managing absenteeism in the workplace is a difficult task, which becomes even more complex when long term illness is considered. Reintegration schemes and altered working times are both valid options, and open communication is an essential. An efficient workplace should run smoothly, and a standard procedure for long term absenteeism can help. Above all else, the relationship between an occupational health professional and an employee should mirror that of any doctor and patient. All parties involved should exhibit openness and adaptability, and working together this way is key to solving any difficult situation.

Terence O'Sullivan,

TJOS Solicitors

Check out our website: www.tjos.ie

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MANAGEMENT OF OCCUPATIONAL BLOOD EXPOSURES (OBE'S) IN THE WORKPLACE

Dr Fiona Kevitt, Consultant and Accredited Specialist in Occupational Medicine

Occupational Blood Exposures (OBEs) encompass injuries from contaminated sharps (venepuncture needles, suture needles, scalpels, etc) as well as human bites and splashes to the eyes and mouth from contaminated body fluids, i.e. contaminated with blood. The main concern is in relation to the risk of infection with a blood borne virus (BBV), typically Hepatitis B, Hepatitis C and HIV.

OBE's typically occur in the healthcare setting, but can also occur in other settings, for example homeless services, city or county council sector, emergency services (Gardaí, Paramedics, Firefighters etc) or the social care setting, to name a few.

The most important aspect of OBE management in the workplace is prevention.

Elimination of the hazard is the first step in minimising the associated risk. In the case of OBE, the only way to eliminate the risk is by vaccination, and the only BBV against which there is an effective vaccination is Hepatitis B. Hepatitis B is however, the most virulent of the 3 main BBVs, with approximately a 1 in 3 chance of transmission from an infected source blood. This is compared with 1 in 30 for Hepatitis C and 1 in 300 for HIV. All healthcare workers and workers in settings where there is a risk of OBEs should be offered and encouraged to avail of the Hepatitis B vaccine, unless there is a contraindication to receiving it.

SUBSTITUTION:

This is not really an option in this case, as the risk is from the patients/clients/service users etc.

ENGINEERING CONTROLS:

Particularly relevant in the healthcare setting, where safety devices are now commonplace, if not

ubiquitous. Safety devices are engineered so that after the sharp has been in the patient, it retracts or can be covered with a safety cap, thus eliminating the risk of exposure to blood. They can be more cumbersome to use and there has been resistance among some healthcare professionals to their introduction, but the advantages far outweigh the drawbacks.

ADMINISTRATIVE CONTROLS:

In the healthcare setting this involves educating staff on the appropriate and safe use and disposal of sharps, and in other settings may include techniques in management of violence and aggression.

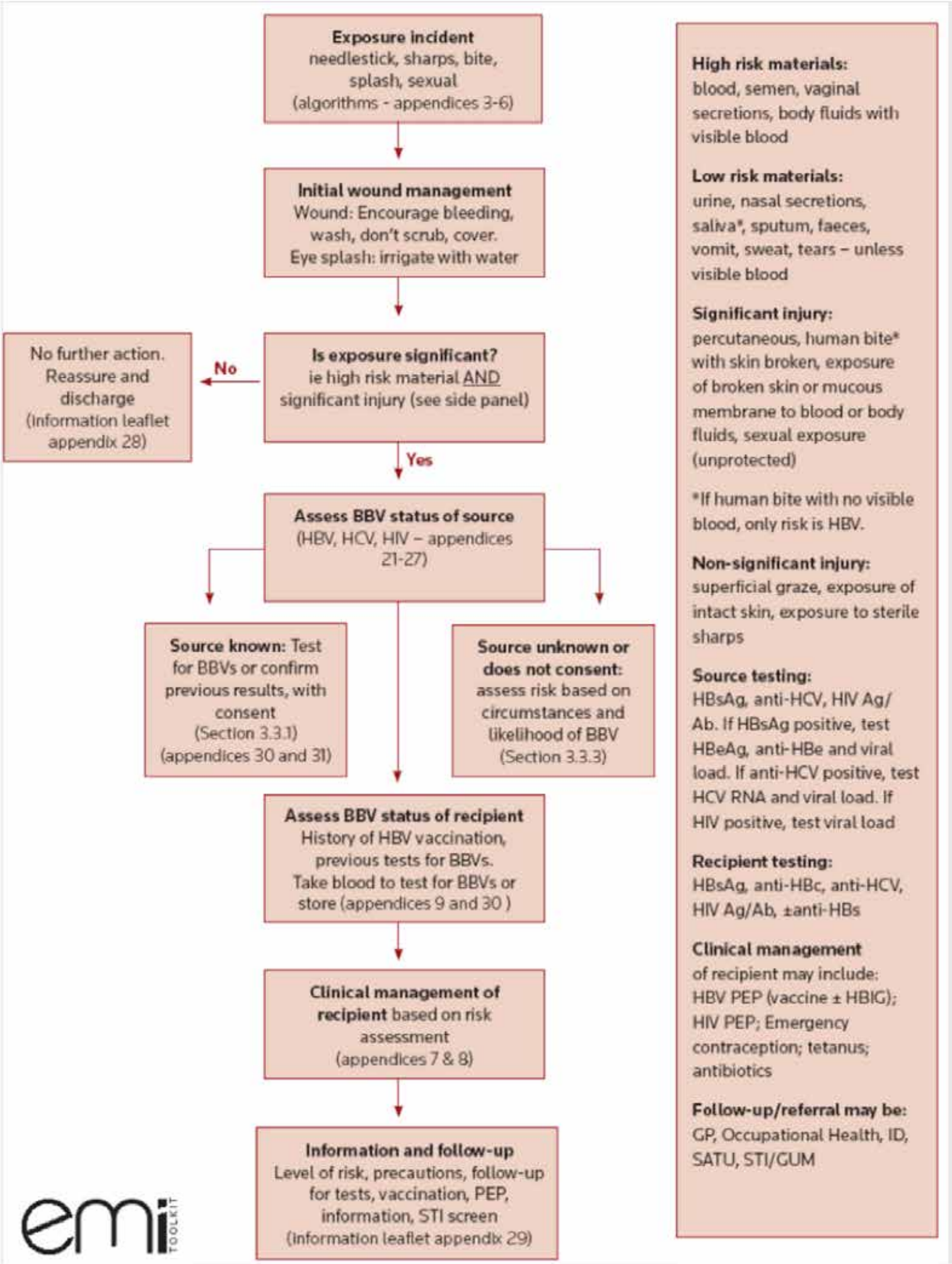
PPE:

The final bastion of prevention, but as is often the case in many of the above workplace settings, becomes the first line of prevention rather than the last. In the healthcare and other settings, this involves 'double gloving' with high risk patients, and the use of gowns and goggles/eye protection where there is a risk of blood or contaminated fluid splashes. If an employee has any broken skin or wounds, these should be covered.

(cont...)

MANAGEMENT OF AN OBE:

EMI guidelines Toolkit 2012, revised 2016



MANAGEMENT OF AN OBE:

The previous flow chart, taken from the EMI guidelines Toolkit 2012, revised 2016, http://www.hpsc.ie/a-z/EMIToolkit/EMIToolkit.pdf summarises the steps.

Depending on your organisation, you may manage the case entirely within your Occupational Health Department, you may involve your local infectious diseases team, and/or you may involve the local emergency department. The key is to act promptly, as the window for post exposure prophylaxis (PEP) is 72 hours for HIV, and the earlier this is started the better. If in any doubt, contact the local infectious diseases (ID) team for further guidance. It is beyond the scope of this article to cover every possible case, and it is strongly recommended that you consult the EMI Guidelines Toolkit, but a basic outline is provided here:

LOW RISK INJURY, LOW RISK SOURCE –

Reassure and discharge, no further follow up required.

HIGH RISK INJURY, HIGH RISK SOURCE –

1. Source bloods for Hep B, Hep C and HIV (as per chart above)
2. Recipient bloods for storage and check Hep B immunity status (if unknown, test blood)
3. Depending on risk assessment, refer recipient to ID, or ED if out of hours, for PEP.
4. Follow up recipient bloods at 6 weeks and 3 months.
5. If on PEP, final bloods at 4 months (i.e. 3 months post completion of PEP).

The EMI Guidelines Toolkit provides a very useful patient management form which will guide you through the whole process.

WHY ONE SIZE DOES NOT FIT ALL

Jan Mulligan

Would you wear the same sized T-shirt as your 3 year old child? Use a kettle to cook boil-in-the-bag rice or paint a wall with a shaving brush? No? Well, that's because it is makes more sense to select the right clothing or tool for the purpose and needs of the individual. That's where Ergonomics comes in.

Ergonomics, also known as human factors, is the scientific discipline that seeks to understand and improve our interactions with the world around us. By developing and applying knowledge and techniques, from disciplines such as human biology, psychology, engineering and design, Ergonomics aims to make our lives simpler and safer by taking account of human characteristics across work, leisure and other aspects of daily life. Armed with this knowledge we seek to understand how a product, system or workplace can be designed to suit the people who need to use it, rather than expecting the users to adapt to the design and face uncomfortable, stressful or potentially dangerous interactions. For existing situations we look to improve those interactions and remove any barriers that may exist; including those relating to medical conditions and disabilities.

Where standard provision does not meet the need, adjustments or specialist adaptations may be required. In order to identify suitable solutions for an individual or situation a good starting point is 'first spend no money'. Most adjustments are low-cost or even free; coming from a change in process or set-up or by utilising existing items for another purpose.

EVERYDAY TASKS: WRITING

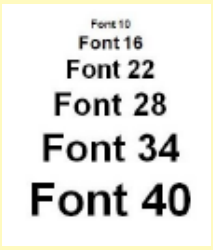
Let's consider an everyday task such as handwriting. Without a second thought, most of us will pick up the first pen or pencil that comes to hand and start to write. For someone with Repetitive Strain Injury (RSI), arthritis or a condition such as Parkinson's it's not that simple. The physical act of writing might cause discomfort or pain, or a reduction in control may result in illegible writing or an inability to write.

How one holds a pen may contribute to local symptoms. For example, too much force can cause joint pain, cramps, fatigue, or muscle weakness. Use of a felt tip, gel, rollerball or fountain pen may help with writing difficulties; the freer flowing ink produces less resistance on the page and requires less pressure to operate; the same is true of pencils. If the pen is too small or too large, the grip required will not be natural and writing for longer periods may be uncomfortable. Where an individual holds the pen tightly, use of a pen with a thicker barrel may help. A quick and easy solution might be to use pen/pencil grips; these are attached to standard pens/pencils to make them thicker and easier to hold and control. As with all adaptations, pen/pencil grips come in a wide variety of sizes, styles and materials and it may take some time before a suitable solution can be identified.

SPECIFIC LEARNING DIFFICULTIES: READING

Specific Learning Difficulties (or SpLDs) are neurological and affect the way information is learned and processed. SpLD is an umbrella term which covers a

range of frequently co-occurring difficulties, more commonly referred to as: dyslexia, dyspraxia (DCD), dyscalculia, and attention deficit disorder (ADD)/ attention deficit hyperactivity disorder (ADHD). Access to print is a common difficulty experienced and taking the low cost/no cost approach first, we would consider the use of font styles (note the shape of the letter A in each style shown below), font point sizes (size may matter!), and use of colour (both for the font itself and the background or paper it is printed on).

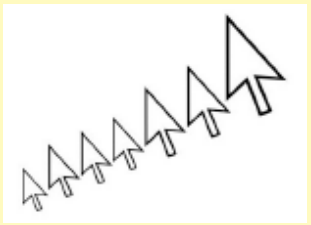


Top Tip: A quick way to change the paper colour without spending a fortune on paper or ink is to pop the sheet of white paper into a coloured plastic wallet (open on two sides for ease of access), e.g. blue, green, yellow, pink tints.

- Even if you do not have a SpLD you may find reading through a coloured folder to be more relaxing on your eyes compared to the starkness of a white sheet.

COMPUTER ACCESS: MAKING IT EASIER

Whether you are working on a Windows or Apple computer, built in accessibility features are available to make life easier. For example, did you know that you can change the size and colour of your on-screen mouse pointer to make it easier to see (or find!)? Or perform keyboard commands (hotkeys) as a sequence of keys (instead of needing to perform the finger gymnastics required to press the keys at the same time)? You can even have on-screen text read out to you, which may give your eyes a rest or help to provide meaning and context for emails and documents.



Links:

• Windows: https://www.microsoft.com/en-us/Accessibility/windows

• MAC: https://www.apple.com/uk/accessibility/mac/

TRY BEFORE YOU BUY

Once free and low cost solutions have been ruled out, we move on to specialist items. However tempting it may be to introduce an ergonomic split keyboard, fancy mouse, voice/speech recognition, or an all-singing-all-dancing Star Trek-inspired chair, avoid costly mistakes by allowing the intended user the chance to try things out and compare products before making a purchase.

Top Tip: A good supplier will provide equipment on a loan basis or via a sale-or-return service; some will even visit to demonstrate a selection of products (don't forget to check if such services are free-of-charge, or attract hidden costs, e.g. visit fee, cost of returning any unwanted products).

- Alternatively, commission an on-site assessment of need. These should consider the individual's declared difficulties, their environment and tasks, and include a trial of potential solutions (from low to high tech); i.e. adjusting the existing provision and trial of new solutions.

NEVER ASSUME

Ergonomics celebrates individuality and with individuality comes differences. Within the average office 5% won't be able to read 10 point font without straining their eyes, 10% will be left handed, 15% will have dyslexia or other SpLD, and 19% will have a long-term illness or disability (which may be hidden). Within the wider population, 1 in 4 of us will

experience some kind of mental health problem over the course of a year. This means that what will work for me may not work for you. Until the individual has had the chance to try a solution and compare it to others, she or he (and you) cannot know how effective (or not) it will be.

Jan Mulligan is a Chartered Ergonomist and Disability Consultant. Whilst the majority of her clients are in London and the South East of England, Jan works with companies and individuals throughout the UK.

Jan's consultancy is Greenleafe Ergonomics: www. greenleafe.co.uk

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.

SOCIAL COLUMN

We would like to send out our huge congratulations to one of our OHNAI Committee members, **Ciara** on the recent birth of her twins.

Jisc mail Is an online forum which discusses OH practice and research. It has over 1000 subscribers from different countries (including Irish nurses). It's entirely free and the link to subscribe is:

https://www.jiscmail.ac.uk/cgi-bin/webadmin?A0=OCC-HEALTH

Picture from the FOHNEU Conference in Stockholm with our OHNAI President Mary Doran

ICOH

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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

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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

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