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REGISTERED NURSES' EXPERIENCES AND PERCEPTIONS OF PRACTISING WITH A DISABILITY

ABSTRACT

Aims: The aims of this study were to explore the perceptions and experiences of registered nurses (RNs) practising with a disability or impairment, and to describe the strategies they used to support their role as an RN.

Background: Despite the availability of anti-discrimination guidance, nurses practising with a disability or impairment described varying levels of understanding and support available to them from colleagues and managers.

Methods: A descriptive qualitative study allowed us to explore and describe RNs' experiences and perceptions of their interactions with colleagues and managers in clinical practice. This process uncovered what was important to the participants, including strategies they used to ensure they practised safely. Participants took part in a 60-90 minute interview that gathered their experiences and perceptions of working with a disability or impairment as defined by the RN. The semi-structured interview schedule, with one main question and prompt questions, enabled participants to share their individual stories. Thematic analysis was undertaken.

Participants: Ten RNs – nine female and one male – were selected purposively because they identified as living and working with a disability or impairment.

Findings: Four themes were identified. *Impairment or disability?* – Nurse participants preferred to articulate the impact of the disability or impairment on them, rather than defining those terms. *Telling others* captured the decision-making process they went through on whether to disclose their disability or impairment at work. Participants described fear or reluctance to disclose; this decision was also influenced by whether their disability or impairment was visible or invisible. *Getting support* pulled together some of the concerns nurses had about the lack of organisation-wide support. The perceived lack of support affected the nurse's desire to ask for help and often resulted in the nurse organising their own support resources. *Impact in the workplace* – The nurse participants had developed unique strategies to ensure they nursed safely.

Conclusion: For participants, the ability to define the impact of their disability or impairment on their working lives was more important to them than selecting a definition of "disability or impairment". All participants were committed to safe nursing practice. The degree of visibility of the disability or impairment influenced the nurse's willingness to disclose or ask for help. A visible disability was acute or obvious and a less visible disability reflected the post-acute, rehabilitative, or chronic stage. However, overall, because many of the nurses did not feel safe to disclose their disability or impairment, ask for help, or know where to go to access support, accommodations were not made for them in the workplace.

KEYWORDS

Nurse, disability, impairment, disclosure, accommodations

INTRODUCTION

Articles 24, 25 and 27 of the United Nations Convention on the Rights of Persons with a Disability specifically relate to people with disabilities having equitable access to the same resources as others and being able to realise their goals in education, health and employment (United Nations General Assembly, 2007). For nurses practising with a disability, the debate often focuses on their fitness to practise, and the consequences that the disability or impairment has for people wishing to join the nursing profession. This debate is accompanied by a discussion about workplaces making reasonable adjustments or accommodations, and the attitudes of others towards the health worker with a disability (Tee & Cowen, 2012; Griffiths et al., 2010; Storr et al., 2011; Tee et al., 2010; King, 2018).

A review of the literature related to nurses practising with a disability or impairment is timely, as nurse leaders and managers in New Zealand voice concerns over retaining nurses in the workforce in the context of a global shortage of nurses (Matt, 2008; Moloney et al., 2018; Neal-Boylan, 2013, 2019; Report from the National Nursing Organisations to Health Workforce New Zealand, 2014). The review of the literature that follows informs this research study, which is designed to explore the challenges experienced by nurses working with a disability or impairment, the support they would prefer and the strategies they employed at work to practise safely.

BACKGROUND AND LITERATURE REVIEW

Neal-Boylan and Miller (2016) found that many nurses with physical or sensory disabilities left the nursing workforce because they felt discriminated against, and unsupported by nursing colleagues or administrators. Nurse participants in that study were also worried that they themselves could have a negative impact on patient safety. Compounding these concerns, many of the nurses were also unaware of their disability employment rights.

Through a grounded theory study in the United States, Matt (2008) also explored the attitudes of nurse colleagues that did not meet the legislative requirements designed to mitigate employment discrimination. The aim was to identify themes related to the "disability climate" (p.1524), so policies could be designed that supported nurses practising with a disability. Matt's (2008) study identified the impact of an unfriendly environment and the support nurses with disabilities needed from leaders, managers, colleagues and peers to be accepted. This study provided an important snapshot in time, to show how nurse managers could contribute to creating a disability-friendly work environment.

A New Zealand study, which used a qualitative approach, identified the barriers that registered nurses (RNs) experienced due to their impairment, and the strategies they used to overcome them (Korzon, 2011). Seven participants were selected purposively and identified their disability – these included head injury, hepatitis C, fibromyalgia, anxiety, panic disorder and spinal injury. Some of the nurse participants had lived with their impairments from birth, while others had acquired them later. The sometimes disabling attitudes of managers and colleagues had the most impact on the RNs, often leaving them feeling pre-judged (Korzon, 2011). This prevented them from discussing their disability or impairment or asking for support. Korzon's study has contributed to the qualitative literature on RN colleagues whose attitudes "dis-able" nurses with disabilities.

Wood and Marshall (2010) used a study with an exploratory descriptive design to understand the attitudes and concerns of 219 nurse leaders who employed nurses with disabilities in the United States. The study explored the nurse managers' attitudes to work performance, concerns expressed by other staff, perceived abilities of nurses' disabilities, job performance and accommodations made in the workplace. The researchers found the job performance of nurses with disabilities was exceptional. Wood and Marshall (2010) also found a positive correlation between nurse managers' historical experiences of hiring a nurse with disabilities, and willingness to employ in the future. They concluded that further research on the effective recruitment and retention of nurses with disabilities was vital so experienced nurses could be retained, and their skills used.

Similarly, Neal-Boylan (2013) – in a qualitative exploratory study – explored workplace requirements in the United States. Job descriptions of RNs were correlated to the actual work carried out by nurses. Notably, it was found that nurses with disabilities did not generally receive a job description, did not disclose their disability, and therefore did not receive any accommodations in the workplace. Neil-Boylan concluded that nurses were often pre-judged because of their disability and did not feel valued, resulting in them leaving the nursing profession.

While there have been several studies on nursing students with disabilities (Ashcroft & Lutfiyya, 2013; King, 2018; Moodley & Mchunu, 2018; Tee et al., 2010; Tee & Cowen, 2012; Wray et al., 2013), there have been few on graduated nurses who acquired or developed a disability or impairment. Taking into account the global nursing shortage, an ageing nursing workforce (Moloney et al., 2018; Neal-Boylan, 2019; Report from the National Nursing Organisations to Health Workforce New Zealand, 2014), the cost of educating nurses, and legislation that specifically prohibits discriminatory behaviour, it is important to understand the issues and concerns for nurses practising with a disability or impairment.

METHOD

Aims

The aims of this study were to explore the perceptions and experiences of RNs with a disability or impairment and to describe the challenges they faced at work, and the strategies they used to support their role as a nurse.

Design

A qualitative descriptive design was selected to explore and describe nurse participants' experiences and perceptions to answer the research question: How do RNs who live and work with a disability or impairment negotiate their roles and responsibilities in their clinical practice settings? The design was informed by Sandelowski (2000, 2010) who explains that qualitative descriptive studies are useful for exploring and describing a phenomenon, rather than interpreting or penetrating the data.

Ethics

The nurse participants were assigned a pseudonym to ensure confidentiality. Ethical approval for project 1839 was granted by the Ara Human Ethics Committee in April 2019. Confidentiality, privacy and autonomy were maintained throughout the research process.

Table 1. Demographics and disability, impairment or health conditions of nurse participants

Gender	Female	9
	Male	1
	Gender diverse	0
Age	20-29 years	3
	30-39 years	1
	40-49 years	3
	50-59 years	2
	60-69 years	1
Ethnicity	New Zealand European	6
	New Zealander	4
	Māori	0
Disability or impairment	Hearing loss	3
	Autoimmune disease	1
	Chronic pain, neuropathy memory loss	1
	Dyslexia/dyscalculia	1
	Brain injury	1
	Traumatic injury/chronic pain	1
	Dyslexia	1
	Poor vision, back injury, rheumatoid arthritis	1

Notes: The disability, impairment or health condition is as described by the participant. These descriptions have been kept broad to enhance anonymity.

Table 2. Clinical practice settings of nurse participants and years of nursing experience

Workplace/clinical area		
	Medical/surgical	4
	Medical	3
	Community	1
	Primary health	1
	Mental health	1
Years of experience		
	< 1 year	2
	< 2 years	1
	< 3 years	1
	< 8 years	1
	25-28 years	3
	30-32 years	2

Note: All nurse participants were employed during the study.

Recruiting participants

Purposive sampling was used to recruit RN participants who met the inclusion criteria. Nurses were eligible to be included if they were registered as a nurse and identified as working with a disability or impairment. They could be employed in any clinical practice setting. A snowballing strategy was also used to recruit participants, whereby prospective participants shared information about the study with colleagues (Polit & Beck, 2012; Valerio et al., 2016).

Ten RNs who met the inclusion criteria were selected, nine female and one male. The demographic characteristics of the participants, including age, gender, ethnicity and type of disability or impairment, are presented in Table 1 (above). Their experience ranged from one to 32 years. Clinical practice settings and years of experience are presented in Table 2 (above, right).

Data collection

Interview questions were sent to participants two weeks before a scheduled face-to-face interview so they could prepare their responses. The main question was: *"Can you please tell me about your experiences of living with a disability or impairment and working as a nurse?"* This was followed by 11 prompt questions that were used as a guide to the information the nurse participant chose to share. The semi-structured interview schedule is provided as Table 3 (see following page). To maintain consistency, the lead researcher carried out every interview. The face-to-face interviews were audiotaped and transcribed verbatim by a professional transcriber. The interviewer wrote field notes and a reflective diary during and after each individual interview.

Data analysis

Braun and Clarke's (2006, 2012) data analysis process was used as a guide to analyse the data that emerged from the 60-90 minute interviews. The personal stories that emerged from the summary were checked by the other researchers and returned to the participants for comment, deletions, additions or changes. All participants responded to this request and changes were made to three interview summaries. To maintain consistency, the data analysis process was initially undertaken by the lead researcher, then discussed and reviewed with the co-authors.

Colour coding was used to firstly group the data into categories and subcategories, and then to group these into themes within each of the interviews, and between interviews. Verbatim quotes were used to support the themes. The three researchers met again to clarify the names of the themes, as well as their content, evidence and descriptions. The themes identified by the data analysis were: "Impairment or disability?", "Telling others", "Getting support," and "Impact in the workplace".

FINDINGS

Impairment or disability?

While a distinction between disability and impairment is made in government policy documents (Ministry of Social Development, 2016), for the participants in this study, the choice of a term or word such as disability or impairment was not a distinction they felt the need to make. Most of the participants bypassed the definition and described their condition through their diagnosis or the signs and symptoms they were experiencing.

Tammy: *"I have a chronic [auto immune disease[1]]".*

Garry: *"I have a brain injury".*

Pat: *"It's a disability but I don't think of it that way".*

While Jenny had never thought of her hearing loss as a disability,

1) Name of health condition has been kept broad to enhance anonymity.

she felt she was *"disabled without them [the hearing aids]. . . . But it never stopped me doing things".*

Participants believed it was important to capture the impact of the disability or impairment, rather than defining the terms.

> Cindy: *"It's either or neither. I'm not fussy about what you call it . . . They exist. It's real"*.

> Terry preferred the descriptor *"challenges or difficulty rather than using labels such a disability or impairment . . . Like if they asked me, 'Do I have any disabilities?' then I would have said, 'Well I don't define dyslexia as a disability'."*

> Emma felt her dyslexia was an impairment, not a disability. *"I just think differently. And because of how things are taught and tested, I'm impaired because of how I must respond."*

Table 3. Interview schedule

The semi-structured questionnaire that guided the interview, including the main question and prompt questions:

Before you come to the interview, you might like to consider some of the questions listed here. Please feel free to write on/beside the questions, bring notes with you or ask for clarification.

Demographic data

- What is your gender?
- What is your age?
- How would you describe your ethnicity?
- How long have you been registered?
- Are you currently employed?

Main question

Can you please tell me about your experiences of living with a disability or impairment and working as a nurse?

Prompt questions

- How would you describe or define your disability or impairment?
- Did you acquire your disability or impairment or was this something you have always lived with?
- Has living with your disability or impairment impacted on your role as a nurse in your workplace?
- Have you always disclosed your disability or impairment to your colleagues and managers? Have you ever hidden it in any way? If so, how?
- Have you ever asked for help for your disability or impairment at your workplace?
- Has a workplace or a colleague ever made any accommodations or adjustments for your disability or impairment?
- Can you describe a situation when a person or workplace facilitated and supported your success as a nurse working with a disability or impairment?
- Can you please describe an experience that illustrates some of the difficulties you may have had as a nurse working with a disability or impairment?
- Were you able to overcome the barriers you identify in the previous question? Please describe.
- What sort of support, strategies or enablers, if any, would you like to see in your workplace?
- What skills and attitudes do you think nurses and managers need to work safely and effectively with nurses with a disability or impairment?

Note: The semi-structured nature of the interview encouraged nurse participants to share the ideas, issues and concerns that were important to them and enabled them to describe their own story.

Telling others

The "Telling others" theme was informed by two subcategories which exemplified the process of disclosing. These subcategories were: "fear of disclosing", and whether the disability or impairment was "visible or invisible".

Fear of disclosing: The "fear of disclosing" subcategory captured the reluctance many of the participants felt in telling their colleagues and managers about their disability or impairment. Some were reluctant to disclose this information because they were worried it wouldn't be treated confidentially, or they weren't sure they could trust them with the information. For others, this reluctance was linked to their perception that there was a stigma attached to their disability or impairment.

Ellen and Emma did not want to disclose information about their health conditions to prospective managers or colleagues as they felt there was a lack of confidentiality.

> Ellen: *"I haven't really told a whole lot of colleagues. They know I was on treatment. One of them very explicitly asked: 'What problems do you have after treatment?' So, I told her because I trust her.. . . I haven't shared it with my manager. I think it's a trust issue. I don't want to be felt like I couldn't do my job. . . . And I guess that comes to part of the trust issue, that I wouldn't necessarily trust a whole lot of people to, you know, react to it well, or you know, not to be talking about me".*

> Emma: *"I don't know if my colleagues know. I've mentioned it to some of them . . . I honestly don't know if my boss knows whether I'm dyslexic . . . I would probably be more selective in who I approached about it though."*

The degree of stigma associated with the disability or impairment also influenced whether they disclosed.

> Cindy did not disclose any of her disabilities in her job application: *"I didn't disclose my disabilities because I thought that I wouldn't get the job. And I wouldn't have. They didn't ask in the application or the interview . . . I knew I wouldn't have a chance they'd employ me."*

> Fear of disclosing was echoed in Garry's interview. He was quite clear – if you disclosed, you were treated unfairly and

"discriminated against. . . . Because of my injury I've had to have a significant amount of time off work. You have to disclose that when you go for jobs. I just like don't get interviews! . . . As soon as they ask: 'Have you had any significant time off work?' I think that's a big tick box that says: 'Don't even bother with this person.' "

Tammy also felt there was a degree of unfairness: *"I still feel there's a lot of people that see [my autoimmune disease] and then just [write me off]. Because before that, I used to, you know, I applied for quite a few jobs and that, but I don't even get interviews nowadays. And I never had that. You know? . . . Cos I'm choosing jobs that I think I can do."*

Jenny believed that having a hearing impairment did come with stigma. *"I do [find that]. More than with poor sight. So, nobody thinks twice if somebody's wearing glasses. But if you can't hear what they're saying, people get a bit irritated. And I mean, I don't feel embarrassed. Because I'm old and I don't care now. But I used to feel embarrassed when I couldn't hear what people were saying, you know, before I had hearing aids. . . . I think I've got more confident about speaking up about it as I've got older."*

On the other hand, Pat believed there was no stigma associated with her hearing impairment. She was able to articulate her hearing impairment needs in meetings so she was not disadvantaged, and had the confidence to ask people to face her when they spoke to her so she could lip-read.

"And that kind of leads us to the next question about disclosing. Well it's my managers who found it, so that wasn't an issue. And I've never kept it hidden because there's no gain for me. It's easier for me because it's not an embarrassing thing to mention. I've not done anything stupid. I've not done anything unfortunate. It just is."

Invisible or visible? Disclosure was also dependant on whether the disability or impairment was visible or invisible. A visible disability or impairment was one where the signs and symptoms were overt or obvious, such as the need to use a hearing aid or walking stick, or if the nurse was in an acute stage of their condition. An invisible disability was one where the nurse was in a less acute, less obvious, chronic or rehabilitative stage. When the disability or impairment was overt or visible, this removed the need to re-explain, justify or re-tell their story.

Although Rebecca's experiences of support from management were glowing, her perception was that when her disability was visible, she did not feel guilt when asking for help or receiving it. However, when it became a rehabilitating and chronic situation (and was no longer as overt or visible), she felt a sense of guilt. This led to her re-explaining her condition and feeling the need to justify it more to her manager and others.

"It's interesting. And it's almost like I felt a little bit guilty [as now not so visible], I didn't get as much support as last time. And I wonder if it's the stigma of ACC and the stigma of chronic issues and the stigma of . . . you don't know how long they're going to go for versus 'I've had a traumatic injury, and actually, I can see that I'm improving' and people can see that you're improving".

Tammy described finding other people understanding of acute health issues, but it was the chronic, often unseen, ones that people struggled to see and understand.

"Well, I had some crutches – my mother had a broken ankle. That was my idea as well. I just felt more stable with it. And then I found that people were maybe well . . . a visual aid. Cos [an autoimmune condition] is pretty much an invisible thing. . . . But that's why I use the crutch more too, because people actually go, 'Okay. She may need a little bit of help.' Whereas before that, you didn't get any. Which is kind of funny."

Polly also talked about the visible versus invisible stages of a disability or impairment:

"Especially people with regional pain syndromes – and just back pain . . . I mean, just back pain, that is so disabling. And then the whole mental health stuff. It's nothing visible. I feel really sorry for people with those less visible conditions that you might be embarrassed of or ashamed of or just tired of, kind of thing."

Ellen confirmed this sentiment. *"Yeah. And I guess for me it's, because it's not a very visual thing, it's kind of a blessing and a curse. The fact that I can present as very – no problems at all. Like sometimes I will be sort of limping and things, but, you know, I don't use a crutch. You know, I don't have a very visible thing, or I haven't got a hearing aid. I haven't got, you know, anything that would really identify me as disabled. But then also if I did, I feel like people would be more understanding of my situation."*

Getting support

The "Getting support" theme captured the ideas expressed by the participants relating to organisation-wide help and support, the workplace making accommodations, and the nurse asking for help.

Organisation-wide help and support: Many small and medium-to-large organisations employ a health and safety officer or quality or privacy officer. However the participants in this study did not believe that an office or person existed for employees with a disability or impairment. This led nearly all participants to believe there was a lack of an overall point of contact or organisation-wide support.

Tammy had problem-solved the barriers she encountered each step of the way as her condition deteriorated. She pointed to the human resources (HR) department as a possible support but could not think of any office or person dedicated to supporting or advising employees with disabilities or impairments, although her (new) charge nurse had tried to help.

"I kind of get the feeling that it was just new for her [the charge nurse] and new for me. So we kind of didn't really know where to go from there. . . . But, I mean, you know, she's been trying to find me other work."

Pat could not think of any support offered that was an organisation-wide point of contact:

"I wouldn't know where to go other than occupational health, and to be honest I wouldn't consider it. They're not really set up to help in these situations."

Jenny suggested that the nurses' union could be approached for

support, but was not aware of any other organisation-wide support.

She added: *"There are some good managers . . . And you know they want to look after their nurses. It starts at the top."*

Garry described an immediate manager who was caring, helpful and supportive. He also noted that he had offered his services to senior management, to share his experiences of re-entering the workforce and working with a disability with other employees. However, the organisation had not returned his calls or responded to his offer. Although the organisation had a human resources (HR) division, overall he felt the quality of the information provided to him was variable, and sometimes conflicting. His perception was that there was not enough support for people with disabilities or impairments in his organisation.

The workplace making accommodations: The participants identified some missed opportunities for their workplace to make accommodations for nurses with a disability or impairment. This led to several of them seeking out their own resources and supports.

Sally and Cindy both spoke about their workplaces buying equipment that did not meet the needs of all users. Sally struggled with phones that were old, or not capable of having the volume turned up or down, even though they were newly installed – this was despite nurses with hearing impairments having worked there for several years.

Sally: *"And so, I really struggled with phones. I still really do if it's too noisy. I can't hear anything. And I'm still getting used to that and trying to figure out how it works and what phones work and how to turn them up and things. But they're aware that I won't use the phone unless I really have to . . . Yeah, they [the Cochlear Programme] give me ideas. But, like, all the things they've given me related to phones and stuff wouldn't work with the phones we have [at work] and they're all too old and I can't plug anything in or do anything."*

She was not aware of a specific support person or office within her organisation. Other than the ward suggesting she could get a badge saying, "I'm hard of hearing," which she did not find helpful, Sally had worked on solving her own problems. For example, she had organised her own personal stethoscope which was linked by Bluetooth technology to her cochlear implants. She believed this need to problem-solve for oneself was the same for all employees with a disability or impairment.

Sally: *"My whole Bluetooth thing is new. Before that, I just plugged it in. So, I have my own stethoscope and that is quite good. I can turn the volume up, so it worked out quite well for me . . . There was someone that was a midwife that I met through the Cochlear Implant Programme. And she used that one. Like, she said she'd spent years and years trying to find good ones. Like, she'd bought so many, and this one worked. And so I tried it. I was like, 'Yes, this one's good.' So, I got one. And yeah, it's been really good so far."*

Sally also identified a missed opportunity to help people with disabilities in her workplace. When she started the job, she was replacing someone with a similar impairment. Being able to talk to this outgoing staff member would have been beneficial for her.

"Yeah. Like even kinda finding people like you to feed off ideas. Because, like, before I even started, I was worried about the phones. And, I mean, I was talking to other people but, they had different jobs, so, circumstances were different. But it would have been kinda good to kinda feed ideas off people on how they cope."

Asking for help: Some participants said they were reluctant to ask for help and support.

Ellen did not ask for any help and therefore her workplace had not made any accommodations or adjustments. *"I guess I don't want to be seen as weak. And I don't want to be seen as not doing my dues."*

Terry felt the same. *"I avoid asking my charge nurse [for help] as I feel as though she will think I'm incompetent, it is the charge nurse specialist I go to for help."*

Emma was also hesitant to ask for help because of the experiences she had had. *"And I don't want to ask her . . . Yeah. I definitely know some of my colleagues know. I've mentioned it to some of them. . . . I don't think it's actually changed how they work with me one way or the other."*

She could not name any support services or department within her organisation who she could ask for help.

Conversely, Rebecca had found her manager not only supported her requests, but almost anticipated them. [My manager said]: *"Look, let me know if they pull that [support] out and you still need it. So, she was prepared to pay for taxis for me which is absolutely incredible."*

Cindy's experience differed to this. She described being in a new, purpose-built building that did not have sufficient natural light, which affected visibility. However she was keen to point out that this affected all the staff, not just her. She said support and help had been non-existent in her previous clinical workplace, but when she disclosed her dyslexia in her new workplace, she received extra computer training.

Impact in the workplace

The "Impact in the workplace" theme reflected some of the barriers the participants encountered and the strategies they used to keep themselves and their patients safe. Participants identified barriers such as:

- Phones that were old and lacked volume control.
- A perception of discriminatory thinking and stigma associated with some disabilities or impairments.
- A perception that there was a lack of confidentiality, which led to a lack of trust to disclose.
- Feelings of guilt about being unwell when it was not overt or obvious to others.
- Difficult and similar names of medications or products.
- Small print on medication labels.
- The time-consuming effects of constantly having to clarify information on the phone (when hearing-impaired).
- Lack of an overall organisational point of contact for people with disabilities or impairments.

Participants revealed their own unique ways of coping, via strate-

gies to keep themselves and their patients safe.

Terry always made a special effort to ask a senior RN to double-check her medication calculations to be as safe as possible. This was important to her.

> *"And it's like if we've got new medication to draw up or something that I'm not familiar with or don't feel that confident with, I'll always grab a senior nurse versus a junior one. . . . for them to educate me and make sure that I'm doing it right and we can have a thorough discussion in regard to what else we need to look for as well as reading the protocol and everything like that."*

Emma had taught herself to keep the label attached to dressing products and medications she was using, especially if they had similar names. This gave her confidence that the spelling and information she had documented about the dressing was correct.

> *"The dressing products, a lot of the names are quite similar. And I sometimes get them muddled. I know exactly what I mean, so I'll often describe it as well as saying the name. And when I'm doing one, I'll take the top bit of the packaging off, and I won't throw it away. I'll put it in my pocket. So, I've got the name written down."*

Rebecca had seen a physiotherapist, and educated herself on chronic pain.

> *"And the first thing that she [physiotherapist] does is educate you a little bit on chronic pain and that biopsychosocial element of it. And then I went on my phone and downloaded a number of apps where I could actually listen to people's stories and listen to some facts and information so that I had extra education on that. And that was actually quite a key changing point for me, actually understanding what I needed to do to get myself well. So, that whole education was a really good tool kit strategy for me in itself."*

Garry had learned not to accept night shifts, as the lack of sleep interfered with his ability to concentrate.

> *"I don't work night shift. My manager has made sure that I don't work night shift, because I said I think I will probably end up in hospital. Cos that's the reality of it, if I don't get decent sleep. So that's about knowing my limits and what I can and can't do."*

Tammy had learned that when she used her physical aids more, this acted as a cue to others around her. She also tried a range of shifts and non-nursing roles to see what was more suitable.

> *"The time that I actually said, 'I have [an autoimmune disease]' to my charge nurse was when I said, 'Look, I just can't do the shifts I'm doing now.' So, then I changed to nights for a while. . . . I knew I could do them okay. . . . I like the work, cos you have to think more when there's not as many people around. It's just the hours that are horrible. . . . And keep the safety going for the patients, but to not be so tiring on myself."*

> Cindy: *"I'm very fortunate in that, so far, I haven't made any drug errors or any administration errors, probably because of that. And I'm a bit pedantic. I've got a colleague who's a good nurse, but she likes to be fast and speedy at everything. And she did make a mistake purely because of rushing through and not double checking . . . "*

Sally purchased her own stethoscope that was the correct type for hearing impairment and used a Bluetooth connection to her new hearing aids. She also ensured she could see people's faces when they were talking so she could use her lip-reading skills.

> *"I was trying to listen to them, I was like, 'Oh, I can't understand.' But I was like, yeah, it would be the same for everyone. But then when I tried to, like, focus on their lip movements more, I just found I actually could get what they were saying."*

DISCUSSION

While government policy documents clarify the differences between disability and impairment (Ministry of Social Development, 2016), the nurse participants in this study were not interested in distinguishing the terms. They were more concerned about the impact of their disability or impairment on their roles than defining the terms.

Nearly all the participants chose not to disclose their disability or impairment at work, because they believed they would receive unfair treatment if they did. Such reluctance is not a new finding (Ashcroft & Lutfiyya, 2013; Korzon, 2011; Neal-Boylan 2013). However our study made new and detailed findings (although they are not intended for generalising) – that our participants feared that if they disclosed their disability at work it would not be kept confidential; that the degree of stigma attached to their disability influenced whether they would disclose it; and that the visibility or invisibility of their disability affected how colleagues treated them. If we are to retain experienced nurses in the workplace, these findings would benefit from further investigation and research.

Of note, the finding that the nurse's disability or impairment did not prevent them from carrying out their nursing roles and responsibilities, and that it was other people's attitudes towards their disability that affected their ability to do their job, is consistent with the social model of health recommended elsewhere (Ministry of Social Development, 2016; Oliver, 2013). Korzon (2011) also highlighted the disabling attitudes of others, which is in keeping with the intention and understanding of the social model of disability. That is, people may have impairments but are dis-abled by other's attitudes.
While Matt (2008) describes how managers can support and help nurses with disabilities or impairments and can play a crucial role in supporting them, two of the nurse participants in this study expressed a reluctance to tell their manager as they lacked sufficient trust to share this information. The decision not to disclose can result in the manager not being aware of the support the nurse needs and thus no accommodation is made for them.

None of the participants we interviewed believed their disability made them unsafe. Rather, they exhibited a strong desire to be very safe. Their strategies are evidence of this heightened awareness and responsiveness to patient safety. While the need to be "double-double" safe or "triple safe" is a new expression of this, the desire to work safely as a nurse has been identified by Neal-Boylan & Miller (2016) and Wood & Marshall (2010).

Participants in this study had developed professional strategies to address the barriers and challenges they experienced, and this information has added to the findings already available (Ashcroft & Lutfiyya, 2013; Korzon, 2011; Matt, 2008; Neal-Boylan 2013,

2016, 2019). While the fact that nurses who work with a disability or impairment experience challenges is not new, the detail in this study about the strategies used to overcome them has provided additional perspectives and evidence. The strategies they developed were unique to each nurse – they had developed these over time to suit their own particular challenges and their individual disability or impairment. Significantly, all the strategies developed by the nurses in this study cost little or nothing.

While some of the participants found there were some helpful and caring individuals in their organisations, there were no dedicated departments or persons charged with supporting, advising or helping nurses with disabilities or impairments. This meant that in some instances nurses had to organise their own resources, and opportunities were missed to prepare new staff to talk with an outgoing staff member with a similar disability or impairment. In addition, the equipment provided in some workplaces, while positively intentioned, did not meet the needs of the person working with a disability or impairment.

This study has provided unique individual insights and detailed experiences and perceptions of RNs who live and work with a disability or impairment. The United Nations Convention on the Rights of Persons with a Disability, Articles 24, 25 and 27 (United Nations General Assembly, 2007) explain that people with disabilities require equitable access to achieve their goals in education, health and employment. This is not consistent with the experience of several of the participants, who expressed a fear of disclosing, a reluctance to ask for help or approach some staff members, the perception that disclosure of the disability or impairment would lead to discrimination, a lack of organisation-wide support and missed opportunities to provide equipment that functioned for everyone. Addressing these challenges and barriers could help retain experienced RNs (Report from the National Nursing Organisations to Health workforce New Zealand, 2014).

IMPLICATIONS FOR PRACTICE AND RECOMMENDATIONS

We recommend organisations provide a dedicated staff member to ensure consistent advice and support is available to nurses working with a disability. This role could include dealing with requests for equipment and resources that meet nurses' needs and contribute to a disability-friendly environment, as identified in Matt's (2008) research.

The result of nurses not disclosing their disability or impairment is that accommodations cannot be made to help them (Neal-Boylan, 2013). Providing a designated resource person would address the findings in this study related to a lack of trust and confidentiality, reluctance to approach managers and the perception that disclosing their disability or impairment might disadvantage them. Further research is needed to explore what kind of support nurses with a disability or impairment need to practise well.

In this study, the participants all expressed a desire to be "very safe" nurses. The strategies they developed to be very safe and to overcome the barriers they experienced in clinical practice could be shared within this newly created resource role.

STRENGTHS AND LIMITATIONS

This is a small qualitative descriptive study, with 10 participants. The findings should be interpreted in this context and generalisation is not claimed. A strength of this study was the in-depth descriptions and the individual and unique stories generated. This has provided a detailed picture of the RNs' experiences and perceptions of working with a disability or impairment.

CONCLUSIONS

The nurse participants identified a number of barriers to them performing their job. However, none of them pointed to their disability, impairment or health condition as a barrier. Rather it was the reaction to their disability or impairment that was notable. Participants identified barriers such as phones that were old with non-adjustable volume, a perception of discriminatory thinking about disabilities, a fear of lack of confidentiality which led to a lack of trust to disclose, and a lack of an overall organisational point of contact for people with disabilities or impairments.

The number of nurses who disclosed their disability or impairment at work was low, because they felt it was not safe to do so. It is important to understand the barriers these nurses experience and the strategies needed to overcome them, given the global nursing shortage, the ageing nursing workforce, and legislation that specifically prohibits discrimination against those living and working with a disability. Addressing some of the findings in this study may help retain nurses who are dedicated to being safe practitioners.

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DECLARATION OF INTEREST

The authors declare there is no conflict of interest.

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