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Barriers to retention of nurses with acquired disability: A scoping review

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The US Bureau of Labor Statistics (BLS) projects a 6% growth in the nursing workforce over the next decade. However, once nursing retirement and other departures from the workforce are taken into account, the BLS projects approximately 203,200 nursing vacancies per year through the year 2031.[1] Contributing factors include an aging workforce, with the potential for more than 1 million nurses to retire by 2030, combined with an increased need for healthcare access.[1] The added stressors of the pandemic created larger gaps and increased the rates of younger nurses who are considering leaving the profession.[1] Although there are a variety of reasons why nurses are leaving the profession, some of the identified contributors are related to disability, including personal illness, mental health, and work-related injuries.[2]

According to Dressner and Kissinger, the most common work-related injuries for RNs are musculoskeletal disorders.[3] Back injuries were the most prevalent type, accounting for over 44% of all nursing work-related injuries.[3] By increasing the retention of nurses who acquire disabilities, there's an opportunity to reduce the projected nursing shortage. In addition, because 25% of US adults have a disability, failing to include those with disabilities in the nursing workforce demonstrates a lack of diversity and representation.[4]

In the context of this scoping review, disability is defined as any impairment that causes bias, prejudice, or discrimination toward the individual. Types of disability include physical, cognitive, or intellectual; sensory; mental illness; and invisible disabilities. Not all individuals who fit into these categories self-identify as being disabled, and different types of disabilities may be supported by different accommodations depending on the role.

Very little is known about the lived experience of healthcare workers with disabilities. Only a moderate amount of information on disability within the healthcare profession has been published since the early 1990s, and most articles are case studies and personal accounts. These nonresearch publications are primarily focused on physicians, and often are published outside of the US. The limited literature might reflect that disabilities within the healthcare workforce are often hidden and surrounded by stigma. This view of disability may contribute to the lack of individuals with disabilities who remain within the nursing profession or advance their careers after acquiring a disability.[5-7]

Moreover, as the nursing workforce ages, the potential for injury and disability rises, further contributing to nursing shortages, which makes this topic even more timely and important.[8] The purpose of this scoping review was to identify the nature and extent of literature on ableist barriers that nurses in the healthcare workforce face after developing a disability that contributes to lower retention rates. The review included 11 articles focused on disability within the nursing profession, excluding those focused on nursing students in academic settings.

Methods: study design

Framework

The researchers used the JBI Scoping Review Framework (2020), which included the fol-

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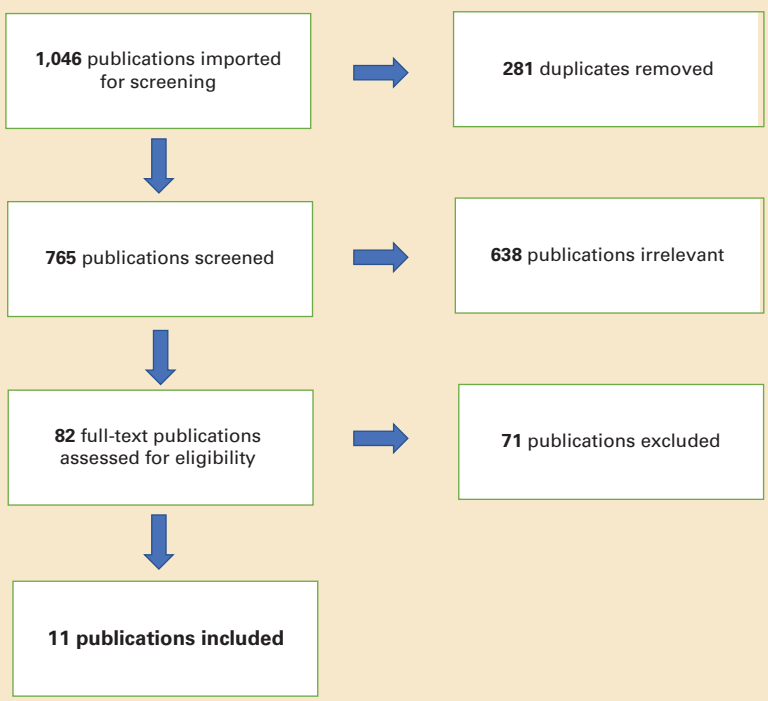
lowing steps: 1) identifying the research question; 2) identifying relevant literature; 3) article selection; 4) charting the data; and 5) collating, summarizing, and reporting information.[9]

Identifying the research question. The scoping review was guided by the following research question: What's known from the literature about how the development of disability impacts retention within the nursing profession?

Retrieving relevant studies. Covidence was used to manage the scoping review using the electronic databases of CINAHL and PubMed for articles published from January 1990 to October 2022. The following search and MeSH terms were used: (ableism [tiab] OR discriminat* OR social discrimination [MeSH] OR diversity [tiab] OR equality [tiab] OR social justice [MeSH] OR inclusion [tiab] OR inclusiv* OR social inclusion [MeSH] OR accessib* [tiab]). The search included peer-reviewed research and nonresearch articles.

Article selection and data abstraction. This search identified 1,046 references that were imported for screening, including 281 duplicates from the multiple databases. Title and abstract screening were completed on 765 publications, excluding 683. For the remaining 82, full-text eligibility was reviewed and 72 were excluded for the following reasons: setting (40), population (26), intervention (3), or indication/focus (2). As a result, 11 publications were included in the scoping review. See *Figure 1* for the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) diagram of this process.

Figure 1: PRISMA diagram depicting the literature review and inclusion process



Results

Table 1 shows the results of the three research studies and *Table 2* describes the nonresearch articles. Findings across all 11 articles are reported in sections specific to retention, structural or systemic barriers, individualized barriers, and internalized barriers.

Retention

Many contributing factors reduce the retention of nurses with disabilities, including aspects within the healthcare system as a whole and the attitudes and cultural norms within the nursing profession.[11,13] Common reasons for leaving the profession after a disability include unsupported concerns of patient safety, a mismatch between job expectations and realistic abilities, and lack of organizational or collegial support.[6-8,10,11] The literature describes the strengths that nurses with disabilities can bring to the healthcare environment, including improved empathy and advocacy for patients, unique healthcare expertise and experience, and exemplary critical thinking and problem-solving skills.[5,8,16] This scoping review examines the impact of the three primary ableist barriers that reduce the likelihood that nurses will return to and remain in the nursing profession after disability: structural or systemic barriers, individualized barriers, and internalized barriers.

Structural or systemic barriers

Structural or systemic barriers include the environment in which someone functions, both

Table 1: Research studies

Author(s) and year	Sample	Findings	Conclusions/recommendations
Gilworth et al., 2007[10]	• Nurses	• Mismatch of individual's functional (in)capacity and their work demand is work instability.	• Early interventions to prevent absence from work due to disability are effective, such as early-return-to-work programs. • Timely identification of work instability is key to reducing work-disability-related turnover.
Neal-Boylan et al., 2011[11]	• Nurses with sensory disability • Rehabilitation nurses	• Nurses with sensory disabilities often leave the profession due to the disability. • Healthcare workers are more likely to work through illness or injury, which may negatively impact disabilities.	• Increased work instability leads to decreased retention. • Nurse-Work Instability Scale (Nurse-WIS) has good internal consistency for sensory disabilities.
Wood and Marshall, 2010[12]	• Nurse leaders	• Nurse leaders often have initial concerns about the ability of employees with disabilities to perform job tasks, patient safety, and general acceptance by public and coworkers.	• Sharing experiences of effective recruitment and retention of individuals with disabilities may help dispel misconceptions. • Positive attitudes in hiring, advancing, and working with individuals with disabilities arise after lived experiences.

the physical surroundings as well as the organizational or environmental culture.[4] Healthcare is seen as a traditionally complex environment for making individualized changes and accommodations.[13] Universal design is a method of evaluating and updating physical environments so they're more inclusive for all individuals, which improves access for those with disabilities while simultaneously increasing ease for all users.[5] A proactive approach to improving the environment may reduce the risk of injury due to a previously poor design and create more opportunities for effective return-to-work programs after injury.[10,14]

An important aspect to keep in mind when reviewing structural barriers is that, despite the work that's been done during the past decade to shift the disability paradigm into a social model framework, disability is still typically seen from a medical model perspective, which places individuals with disabilities into a category of stigma, oppression, and otherness.[5,17] This framework identifies disability as an individual problem that requires fixing through medical intervention and leads to enculturated medical ableism, or assumptions made by healthcare professionals about the lives of those with disabilities that negatively impact the care they receive.[18]

The social model framework instead views disability through a lens of being a societal and human rights issue. The cultural shift happening in activist groups is growing but hasn't yet extended into the healthcare environment and culture.[17] Influencing these cultural aspects of the environment is more nuanced and often begins with individual experiences. The healthcare workforce is well positioned to lead this paradigm shift by identifying and addressing opportunities for increased inclusion.

Individualized barriers

Individualized barriers come in the form of those interacting and/or working directly with the individual with a disability, and the impact of the relationship, perspective, and engagement.[4] High-functioning teams that emphasize communication, critical thinking, and collaboration often focus on individual strengths within the team rather than an individual's physical limitations.[13] It's this shift from individualistic to team performance that creates a successful and safe environment for patient care.

Some key contributing factors affecting perceptions of a nurse's ability to function with disability include outdated job descriptions that may not accurately reflect

Table 2: Nonresearch Articles

Author(s) and year	Sample	Findings	Conclusions/recommendations
Davidson et al., 2016[13]	• Nurses	• Primary barriers include the practice setting, stereotypes/stigma, expectations, and exclusions. • The culture of nursing and healthcare doesn't support workers to request accommodations. • Lack of disclosure and appropriate accommodations is what leads to safety concerns.	• Team functioning is often more critical for a safe and successful environment than individual physical performance or capability. • Encouraging disability disclosure and accommodations creates a safer environment for patients.
Hassouneh and Mood, 2022[5]	• Nursing faculty	• Discrimination against individuals with disabilities creates health inequities and a history of exclusion from health professions. • Inaccessible environment is a contributing factor to this exclusion.	• Environments should strive to be equitable, flexible, intuitive, perceptive, safe, easy, and accessible.
James et al., 2018[14]	• Nurses with major workplace injury or illness	• Health and safety of the workplace is a key component to providing a return-to-work plan. • Individual knowledge of and involvement in the return-to-work process is important. • Organizational, industry, and system factors that impact retention after injury or illness include workforce composition, workplace culture, workplace stress, ergonomic design, recognition of psychological impact, ability to identify alternative responsibilities, and cooperation with treating providers.	• Increased retention for nursing profession and reduced costs for insurance companies through return-to-work programs • Return-to-work plan development should include the employee and medical practitioner. • Return-to-work programs should be outcome-based and should recognize existing skills and capabilities.
Matt et al., 2015[8]	• Aging nurses	• Challenges faced include vision and hearing changes and decreased strength, flexibility, bone mass, endurance, reaction time, and mental processing. • These factors can lead to an increased risk of injury.	• Accommodation through universal design is possible. • Enhanced expertise, experience, and presence among nurses with disabilities
Neal-Boylan, 2014[7]	• Nurses with physical and sensory disabilities	• Unnecessary and unrealistic expectations may still be present within job descriptions. • Discrimination is still present in hiring and retention.	• Nurse-heroics occur, where staff work above and beyond their strength and endurance. • Lack of visibility perpetuates inaccurate assumptions.
Neal-Boylan, 2012[6]	• Nurses with physical and/or sensory disabilities • Physicians	• Commonalities among health professionals with disabilities include: feeling pushed out of the profession or unable to perform job roles, and having reduced or altered career choices. • Healthcare workers may decide whether or not to disclose or discuss disability in workplace, which impacts patient safety and organizational culture.	• Increasing retention and job satisfaction includes accommodations or transitions into other fulfilling roles, addressing organizational culture including the attitudes of leaders and colleagues, flexibility and creativity in making modifications, and increased knowledge and awareness of disability.
Neal-Boylan, 2019[15]	• Nurses	• Individual needs for accommodations are variable.	• Supportive culture and willingness to accommodate individual needs • New perspective and ability to be creative is key.
Neal-Boylan and Miller, 2020[16]	• Nurses	• Physical expectations of roles may not be accurate or necessary. • Misconceptions and unfounded fears may stem from leaders' lack of understanding.	• Critical thinking, sound judgment, and compassion can improve leaders' ability to engage staff.

the reality of the work required, the culture of "nurse heroics" in which nurses consider it a point of pride to neglect personal care in order to care for others, and lack of past experiences working with individuals with disabilities.[7,8,12] The literature shows that the more experience and engagement someone has with individuals with disabilities, especially coworkers, the less likely they are to be concerned about a nurse's ability to compensate and use accommodations to ensure safety and make contributions to the team.[12]

Managers who either weren't nurses, and therefore didn't have a preconceived notion of what a nurse "should" be able to do, or who had a disability or chronic illness themselves were found to be much more supportive of nurses with disabilities and created a more positive and welcoming environment.[7,12] Moreover, managers who worked with an individual with a disability, whether or not accommodations were required, were typically pleased with job performance. Managers who had positive experiences were more likely to consider working with and promoting individuals with disabilities in the future.[12] This body of literature continues to support that perceptions about abilities can be misleading, but as individuals with disabilities are given opportunities to grow and develop, their contributions, creativity, and unique insights outweigh the unfounded concerns regarding safety or the reasonable accommodations that are needed to maintain a safe and appropriate work environment.[6,12,16]

Internalized barriers

Internalized barriers come directly from the nurses with disabilities regarding their own capabilities and concerns pertaining to patient safety, emotional impact of the disability, and the relationships in the workplace.[6] The University of Leeds developed a Nurse-Work Instability Scale (Nurse-WIS) to identify a mismatch between the demands of a job and the ability of the individual to meet those demands.[10] Findings showed as work instability increased without intervention, risk of leaving that position or nursing altogether increased.[10]

One way to address barriers is through legally required accommodations, but because of the stigma and exclusion that exists, many nurses hide their disabilities for as long as possible and avoid requesting accommodations that may single them out in their workplace.[13] It's this lack of disclosure and adequate accommodations that places patients at risk rather than the disability itself.[6,11-13] Nurses with disabilities must overcome the engrained culture of nurse heroics, recognize personal limitations, and be willing to find ways to compensate and/or accommodate for the limitations. Although this is often possible, colleagues are frequently unaccepting of the compensation methods even though they are safe, which reinforces the nurse's feelings of inadequacy and increases the likelihood that the nurse will leave the profession.[8]

A key component to addressing internalized barriers is recognizing strengths and identifying roles in the nursing profession that support those strengths and minimize the challenges of the disability.[19] Not all roles can accommodate all disabilities, but there are many options within the nursing profession that can provide alternatives to traditional direct care nursing roles. For example, roles such as case management, professional development, academia, or telehealth nursing may be less physically taxing, more easily accommodated, and allow the strengths and expertise of nurses with disabilities to continue supporting patients, leading to high-quality outcomes and contributing to the future of the nursing profession.[19]

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Implications for practice

Structural or systematic barriers are found within the physical and organizational or environmental culture and encompass a large set of barriers that reduce the likelihood that nurses will return to or remain in nursing after a disability.[20] Making changes to overcome these barriers within an organization may feel overwhelming, but the impact will exceed any investment. Providing opportunities for individuals who have experienced adversity to share their stories and perspectives with others and ensuring access to and support for advocacy groups within the organization are methods that can intersect and make this possible. When considering the physical structure of the environment, advocating for improved accessibility within the organization will not only benefit any nurses needing those accommodations but will also improve the experience for patients and families because everyone benefits from improved accessibility.[8]

Individualized barriers exist directly between colleagues; therefore, opportunities to address these barriers are at the front lines of care. First, unit leaders can update job descriptions to reflect the required roles and responsibilities for the job.[16] Unit leaders can have candid conversations with nurses with disabilities to understand their goals and strengths, then begin to discuss what's needed to achieve these goals.[5,6,15] Transparency and clear communication with the team regarding individual and team expectations is key to optimize team performance and ensure safe patient care.

In addition to general team communication, real-time communication may be needed. For example, a team may discuss and assign roles for an emergency response when starting a shift. Planning that focuses on the strengths of individuals and the responsibility of the team will optimize overall team performance.[13] Lastly, in addition to normalizing integration of a diverse nursing team, nurse leaders can emphasize the value, talent, and perspective that nurses with disabilities offer to patients, families, and the healthcare team.

To address internalized barriers, nurses who acquire a disability need support to cope with their new limitations and a mixture of creativity and flexibility as the right combination of accommodations are identified.[5,7] Organizational leaders can help nurses achieve realistic practice goals in the workplace setting, including redefining/refining role expectations and responsibilities to leverage their current skills and strengths.[14] Leaders can also create healthcare teams in which nurses with disabilities can contribute in their areas of expertise, assisting nurses to move forward and continue in the profession.[12] Ensuring that nurses have knowledge of and comfort in using all legal protections and employee-assistance programs available within the organization is also key to securing longevity and retention.

Positively influencing systemic/structural, individual, and internalized barriers provides the opportunity for greater culture change: from departmental, to organizational, to a shift toward the social model of disability within the healthcare environment. By encouraging disclosure, making individualized and creative accommodation plans, and supporting appropriate rest and self-care, departmental culture can begin to shift.[5,13] By sharing what has worked and the value that individuals with disabilities bring, organizational culture is impacted.[12] Finally, by addressing these barriers head-on, speaking up when injustices are seen, and ensuring that the voices of healthcare workers with disabilities are included and equal, healthcare can begin to shift away from the medical model and toward the social model of disability. This shift will benefit not only healthcare workers with disabilities but also the community of individuals with disabilities who face so many health disparities.[18]

Making changes to overcome barriers to retaining nurses with acquired disabilities may feel overwhelming, but the impact will exceed any investment.

Implications for nurse leaders

Several key implications for nursing management arise from the review findings. First, one must recognize one's own biases regarding professional norms and intentionally align behavior and leadership decisions with ethically sound practices intentionally including disability within diversity efforts.[13] Engaging nurses with disabilities in systemwide diversity, equity, and inclusion efforts gives a voice to another valuable and underrepresented segment of workplace.

Second, create a psychologically safe environment that encourages disclosure of disabilities to promote understanding of the abilities, needs, and goals of individuals with new disabilities.[13,15] An open dialogue with clear communication conveys compassion and promotes trust.

Third, connect with an expert in disability accommodations to gain a full understanding of options for nurses with disabilities, keeping in mind that nurses are needed and may find professional fulfillment in a variety of roles, including education, leadership, research, clinical care, and telehealth, among others.[13,16] Fostering an environment in which critical thinking, communication, and compassion are valued as much as physical abilities elevates the talent and contributions of nurses with disabilities.

Research and support

The most pressing finding from the scoping review is the dearth of research in this area. Although nonresearch publications provide compelling and important information, change must be evidence-based and guided by research findings. Based on the literature, leaders in healthcare have an opportunity to engage a population of nurses who are often marginalized.[6-8,11-13,16] Nurses with disabilities can practice safely in many different environments and offer unique perspectives to their team and patients. However, support from the organization, leaders, and coworkers must be present, along with an accepting culture and a willingness to provide reasonable accommodations.[15]

If these goals can be accomplished, nurses with disabilities will have the opportunity to stay in their chosen profession longer, contributing their expertise and unique skill set and perspective to improve patient care and outcomes and provide a richer and more diverse work environment.[8,16] The skill and knowledge retained has the potential to positively influence healthcare and improve patient outcomes, increase diversity and representation within the nursing profession, and provide support in the face of the current nursing shortage. Researchers must investigate the three branches of ableist barriers (structural/systemic, individualized, and internalized) to identify the priorities to improve retention of nurses with disability. NM

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