

Pre-employment Health Assessment for Nurses Policy

Version Control Sheet

VERSION	DATE OF REVIEW	IMPLEMENTED AND AUDITED BY	STATUS	COMMENTS
4	01/04/2024	Ann Kelly (Registered Manager)	Active	To be reviewed 01/04/2025

Purpose

This policy applies to all nurses being considered for agency work with Clinical24 Staffing Limited in Northern Ireland.

Statement

Clinical24 Staffing Limited is committed to ensuring the health and well-being of our nursing staff. This policy outlines the procedures for conducting a pre-employment health assessment for nurses joining our agency. The purpose of this assessment is to identify any health-related concerns, ensure the safety of our staff, and determine the suitable working environment based on their health status and vaccination history.

Procedure and Guidance

Pre-employment Health Assessment Process:

New Starter Medical Questionnaire

All nurses must complete a New Starter Medical Questionnaire, providing relevant information about their medical history, any ongoing medical conditions, disabilities, allergies, or other health-related concerns. This information is treated confidentially and safeguarded in accordance with data protection regulations.

Vaccination Record:

Nurses are required to provide a complete vaccination record, indicating their immunization history. The following vaccinations are required for nurses working in clinical environments in the UK: Hepatitis B, Measles, Mumps, Rubella, Varicella (Chickenpox), and Tuberculosis (TB), and HIV and Hepatitis C for nurses conducting exposure prone procedures (EPPs). Any missing vaccinations will be addressed in accordance with the recommended immunization schedule and occupational health guidelines.

Declaration of Medical Conditions

Nurses must declare any medical conditions or disabilities that may impact their ability to perform their duties or pose a potential risk to themselves or others in the workplace. This declaration allows Clinical24 Staffing Limited to evaluate the nurse's suitability for specific roles or placements.

Risk Assessment

Upon declaration of any medical conditions, the Registered Manager, in consultation with the nurse and occupational health professionals, will conduct a risk assessment. This assessment will determine the nurse's ability to safely perform their duties and identify any necessary adjustments or accommodations that may be required.

Occupational Health Assessment

Clinical24 Staffing Limited partners with Healthier Business to conduct occupational health assessments. Nurses will be referred to Healthier Business for a comprehensive assessment based on the information provided in the New Starter Medical Questionnaire and vaccination record.

Fitness to Work Certificate

Following the occupational health assessment, Healthier Business will provide a Fitness to Work Certificate which indicates the nurse's suitability for employment. This certificate may include recommendations or restrictions related to specific clinical environments or duties.

Work Location Determination

Based on the Fitness to Work Certificate, a nurse will be determined to work in one of the following areas:

- Exposure Prone Procedures (EPP): Nurses cleared to work in all clinical environments with higher infection risk, including areas such as A&E, intensive care units, or operating theatres.

- Non- Exposure Prone Procedures (Non-EPP): Nurses cleared to work in clinical environments with lower infection risk, such as general wards or outpatient departments.

- Not NHS Cleared: Nurses who have not met the necessary health requirements and are not eligible to work in clinical environments.

Compliance and Accountability

Clinical24 Staffing Limited ensures compliance with all relevant legislation, regulations, and best practices regarding pre-employment health assessments. The Registered Manager and occupational health professionals are responsible for implementing and adhering to this policy.

Review and Updates

This Pre-employment Health Assessment for Nurses Policy will be reviewed annually to ensure its effectiveness, relevance, and compliance with evolving regulations and guidelines.

Next Review

Reviewed by:	Ann Kelly
Title:	Registered Manager
Signed:	
Last Review Date:	01/04/2024
Actions:	Address Updated

Next Review Date: April 2025



**OCCUPATIONAL HEALTH MEDICAL QUESTIONNAIRE
 (NEW STARTER CLINICAL FORM)**



CONFIDENTIAL

Due to the nature of the role you have applied for we need to carry out an assessment of a new starter health questionnaire – even if you have been employed in UK health services before. The health of each candidate is considered individually and a decision regarding fitness for work in the prospective job role will be based on the functional effects of any underlying health condition/disability/impairment as well as health service requirements for fitness and immune status.

Before health clearance is given for employment you may be contacted by telephone from a clinician at Healthier Business UK Ltd, however you may also need to be seen by an occupational health advisor/specialist or physician, arrangements for face to face consultations will be arranged by your employer or agency. We may recommend adjustments or assistance following an assessment to enable you to carry out your proposed duties safely and effectively. Recommendations to your employer will be directed to essential information regarding your health and the hazards and risks of your employment and with due reference to other relevant statutory requirements and professional practice. Our aim is to promote and maintain the health of all individuals in the workplace: staff, service users and third parties. Your records will be retained electronically in accordance with best practice and the requirements of the General Data Protection Regulations. Your records will be held on file for the purposes of processing your request only and for no longer than is necessary, however your records may be subject to internal clinical audits. Your records may also be used to cross reference and ascertain your fitness should you register with other clients of Healthier Business UK Ltd.

Personal Information			
Title	Surname	First names	DOB
Home Tel:		Work Tel:	Mobile:
Home Address:		GP Address:	

Medical History		
All staff groups complete this section		
	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having, or waiting for treatment (including medication) or investigations at present?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you may need any adjustments or assistance to help you to do the job?	<input type="checkbox"/>	<input type="checkbox"/>

Medical History (continued)			
Have you suffered from any of the following?	Yes	No	Date
methicillin resistant staphylococcus aureus (MRSA)	<input type="checkbox"/>	<input type="checkbox"/>	
clostridium difficile (C-Diff)	<input type="checkbox"/>	<input type="checkbox"/>	

If you have indicated yes to any of the above questions you must provide further details in additional information section, failure to do so will result in the form being returned/rejected.

Additional Information
(If you have answered yes to any questions above please provide additional information below, including dates, treatment and details of condition)

Chicken Pox or Shingles		
Have you ever had chicken pox or shingles		
Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	

BBV (Blood Borne Virus)		
Have you ever <u>come into contact with</u> any BBV's? Including Needle Stick Injuries?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Tuberculosis		
Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2016)	Yes	No
Have you lived outside the UK or had an extended holiday outside the UK in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered YES to the above, please list all the countries that you have lived in/visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.		
Have you had a BCG vaccination in relation to Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes, please state when;	Date:	

Tuberculosis Continued		
Do you have any of the following	Yes	No
A cough which has lasted for more than 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained fever	<input type="checkbox"/>	<input type="checkbox"/>
Have you had tuberculosis (TB) or been in recent contact with open TB	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information
(If you have answered yes to any questions above please provide additional information below)

Immunisation History			
Have you had any of the following immunisations	Yes	No	Date
Triple vaccination as a child (Diphtheria / Tetanus / Whooping cough)	<input type="checkbox"/>	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>	
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B (If Yes is ticked please give dates below)	<input type="checkbox"/>	<input type="checkbox"/>	
Course:	1	2	3
Boosters:	1	2	3

Proof of Immunity (Please send the following)	
Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we strongly advise that you provide serology test result showing varicella immunity

Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result (Do not Self Declare)
Rubella, Measles & Mumps	Certificate of "two" MMR vaccinations or proof of a positive antibody for Rubella and Measles
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100iu/l or above
Proof of Immunity (Please send the following) EPP Candidates Only	
Hepatitis B Surface Antigen	Evidence of Hepatitis B Surface Antigen Test (Inc. 'e' antigen and DNA viral loads if applicable) Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a Hepatitis C antibody test (Inc. Hepatitis C RNA/PCR if applicable) Reports must be an identified validated sample. (IVS)
HIV	Evidence of a HIV I and II antibody test (Inc. DNA viral loads if applicable) Reports must be an identified validated sample. (IVS)

Exposure Prone Procedures		
Will your role involve Exposure Prone Procedures	Yes <input type="checkbox"/>	No <input type="checkbox"/>

UK General Data Protection Regulation (UK GDPR)
<p>All information supplied by you will be held in confidence by Healthier Business UK Ltd. Records will be retained electronically in accordance with best practice and the requirements of the General Data Protection Regulations at which time it may be subject to audit. Your data may also be cross referenced should you have registered with other clients of Healthier Business UK Ltd. Your personal data may be required to be seen by an occupational health advisor or physician; however it will not be shown, nor their contents shared with anyone - including Managers, Human Resources Advisors, GP's, Specialists or third party's - without your explicit consent. You have the right of erasure (the right to be forgotten), refusal of consent and withdrawal of consent without detriment (withdrawal of consent can be exercised at any stage of the process). The only exceptions to this may be a court order for release of records in a judicial dispute or where there is a public responsibility obligation.</p> <p>Further information regarding your rights under GDPR can be found on the following: https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/individual-rights/</p> <p>If you wish to have sight of our privacy policy, please send your request to support@hbcompliance.co.uk</p>

Consent		
<p>Consent is a process rather than a <u>one off</u> decision, for consent to be valid, it must be voluntary and informed. You have the right to withdraw your consent at any stage of the process, either verbally or in writing. Further information regarding consent is available on the 'Candidate Screening Leaflet'.</p>		
All staff groups complete this section	Yes	No
Do you consent to this questionnaire and your immunisation reports being assessed by an Occupational Health Advisor for the purpose of providing a Fitness to Work Certificate?	<input type="checkbox"/>	<input type="checkbox"/>
Do you consent to our Occupational Health Advisors speaking with you regarding any declaration you may have made relating to your medical history?	<input type="checkbox"/>	<input type="checkbox"/>
Do you consent to our Occupational Health Advisors making recommendations to your employer/agency to assist with your ability to carry out your perspective role?	<input type="checkbox"/>	<input type="checkbox"/>

Declaration		
<p>I will inform my employer if I am planning to or leave the UK for longer than a three-month period to enable a reassessment of my health to be conducted on my return. I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.</p>		
Name	Signature	Date



**OCCUPATIONAL HEALTH MEDICAL QUESTIONNAIRE
 (ANNUAL REVIEW FORM)**



CONFIDENTIAL

Before health clearance is given for employment you may be contacted by Healthier Business UK Ltd and may need to be seen by an occupational health advisor or physician with gained consent. We may recommend adjustments or assistance following an assessment to enable you to carry out your proposed duties safely and effectively. Recommendations to your employer will be directed to essential information regarding your health and the hazards and risks of your employment and with due reference to other relevant statutory requirements and professional practice. Our aim is to promote and maintain the health of all individuals in the workplace: staff, service users and third parties. Your record will be held on file for the purposes of processing your request and for no longer than is necessary. Your records may also be subject to internal clinical audits. Your records may also be used to cross reference and ascertain your fitness should you register with other clients of Healthier Business UK Ltd.

Personal Information			
Title: Mr, Mrs, Ms, Miss	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:		GP Address:	

Changes to your health	
Please ensure to tick one box only	
I confirm that I have reviewed my health questionnaire and there has been no changes to my health in the past year	<input type="checkbox"/>
I confirm that I have reviewed my health questionnaire and I have listed the changes below	<input type="checkbox"/>

Medical History		
Have you come into contact with any BBV's (Blood Borne Virus) since you were initially screened by Occupational Health including Needle Stick Injuries?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Medical History (continued)			
Have you suffered from any of the following?	Yes	No	Date
methicillin resistant staphylococcus aureus (MRSA)			
clostridium difficile (C-Diff)			

If you have indicated YES to any of the above questions you must provide further details in additional information section, failure to do so will result in the form being **returned/rejected**.

Additional Information
(If you have answered yes to any questions above please provide additional information below, including dates, treatment and details of condition)

Tuberculosis		
Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2016)	Yes	No
Have you lived outside the UK or had an extended holiday outside the UK in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
<p>If you answered YES to the above, please list all the countries that you have lived in/visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.</p>		
Have you had a BCG vaccination in relation to Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes, please state when	Date:	

Tuberculosis Signs & Symptoms		
Do you have any of the following	Yes	No
A cough which has lasted for more than 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained fever	<input type="checkbox"/>	<input type="checkbox"/>
Have you had tuberculosis (TB) or been in recent contact with open TB	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information (If you have answered yes to any questions above please provide additional information below)		

HEALTH ASSESSMENT		
<u>If your answer to any of these questions is YES or if you are currently taking any medication, please provide details in the space below</u>	Yes	No
Have you had any medical problem in the past which has prevented you from working at night?		
Are you diabetic?		
Are you subject to angina, or other heart problems which may affect your fitness?		
Are you suffering from any circulatory problems which affect your activities?		
Have you had duodenal or stomach ulcers in the past, or under treatment at present?		
Have you had any continuing bowel problem, for instance following major surgery?		
Do you have any chronic chest problem such as asthma, emphysema or bronchiectasis?		
Do you have any disability affecting mobility which will cause difficulties in arranging night work?		
Do you have any recurrent or continuing sleep disturbance requiring medical advice?		
Are you having specialist care requiring your attendance at hospital clinics for treatment?		
Do you have any other health problem which affects your fitness for night work?		
Are you taking any medication to a strict timetable?		

ADDITIONAL INFORMATION
Please give the names of any prescribed medications which you take regularly:

Please give any further details which you would like to bring to our attention
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All staff groups complete this section		
Do you consent to this questionnaire, and any supporting documentation, being assessed by an Occupational Health Advisor for the purpose of providing a Fitness to Work Certificate?	<input type="checkbox"/>	<input type="checkbox"/>
Do you consent to our Occupational Health Advisors speaking with you regarding any declaration you may have made relating to your medical history?	<input type="checkbox"/>	<input type="checkbox"/>
Do you consent to our Occupational Health Advisors making recommendations to your employer/agency to assist with your ability to carry out your perspective role?	<input type="checkbox"/>	<input type="checkbox"/>

Declaration		
<p>I will inform my employment agency if I am planning to or leave the UK for longer than a three-month period to enable a reassessment of my health to be conducted on my return.</p> <p>I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.</p>		
Name	Signature	Date



**OCCUPATIONAL HEALTH MEDICAL QUESTIONNAIRE
 (MATERNITY RISK ASSESSMENT FORM)
 (New and Expecting Mothers)**



CONFIDENTIAL

Personal Information			
Title	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:		GP Address:	

Expected Date of Delivery

Do you intend to breastfeed when you return to work?

Brief Summary of work processes (Including Number of hours and shift/patterns)

Working Conditions		
<u>If your answer to any of these questions is YES, please provide further information below</u>	Yes	No
Unusually stressful work	<input type="checkbox"/>	<input type="checkbox"/>
Working with VDUs	<input type="checkbox"/>	<input type="checkbox"/>
Manual Handling	<input type="checkbox"/>	<input type="checkbox"/>
Lone Working	<input type="checkbox"/>	<input type="checkbox"/>
Travelling (in the job)	<input type="checkbox"/>	<input type="checkbox"/>
Night work or Shift Patterns	<input type="checkbox"/>	<input type="checkbox"/>

Additional details (please provide additional information for any yes answer) It is also helpful if you provide further information about your working conditions (if you have answered yes to any questions please provide further details below)

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Exposure to External Agents		
<u>If your answer to any of these questions is YES, please provide further information below</u>	Yes	No
Awkward spaces and workstations	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to Biological Agents	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to Chemical Agents	<input type="checkbox"/>	<input type="checkbox"/>
Extremes of cold and heat	<input type="checkbox"/>	<input type="checkbox"/>
Ionising radiation (x-rays, exposure to radioactive materials/ therapy)	<input type="checkbox"/>	<input type="checkbox"/>
Non- Ionising radiation (MRI, ultrasound etc)	<input type="checkbox"/>	<input type="checkbox"/>
Noise	<input type="checkbox"/>	<input type="checkbox"/>
Periodic manual handling of loads	<input type="checkbox"/>	<input type="checkbox"/>
Physical fatigue e.g. standing >1½ hrs	<input type="checkbox"/>	<input type="checkbox"/>
Whole body vibration	<input type="checkbox"/>	<input type="checkbox"/>
Work Equipment and Use of Personal Protective Equipment (PPE)	<input type="checkbox"/>	<input type="checkbox"/>

Additional details
(If you have answered yes to any questions please provide further details below)

Exposure to external factors		
<u>If your answer to any of these questions is YES, please provide further information below</u>	Yes	No
Stressful situations (to be discussed with manager)	<input type="checkbox"/>	<input type="checkbox"/>

Additional details
(If you have answered yes to any questions please provide further details below)

Any other problems at time of assessment (to be completed by the candidate)		
<u>If your answer to any of these questions is YES, please provide further information below</u>	Yes	No
Backache	<input type="checkbox"/>	<input type="checkbox"/>
Swollen feet	<input type="checkbox"/>	<input type="checkbox"/>



Morning Sickness	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information
(If you have answered yes to any questions please provide further details below)

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If you wish to have sight of our privacy policy, please send your request to support@hbcompliance.co.uk

Consent		
Consent is a process rather than a one off decision, for consent to be valid, it must be voluntary and informed. You have the right to withdraw your consent at any stage of the process, either verbally or in writing. Further information regarding consent is available on the 'Candidate Screening Leaflet'.		
All staff groups complete this section		
Do you consent to this questionnaire, and any supporting documentation being assessed by an Occupational Health Advisor for the purpose of providing an assessment on your fitness to undertake your role?	<input type="checkbox"/>	<input type="checkbox"/>
Do you consent to our Occupational Health Advisors speaking with you regarding any declaration you may have made relating to your medical history?	<input type="checkbox"/>	<input type="checkbox"/>
Do you consent to our Occupational Health Advisors making recommendations to your employer/agency to assist with your ability to carry out your perspective role?	<input type="checkbox"/>	<input type="checkbox"/>

Employees Name:

Employees Signature:

Date:

Managers Name:

Managers Signature:

Date: