

# The importance of work and health in a neuromusculoskeletal assessment

**NICOLA SUCKLEY** MSc Physiotherapy PG Cert Occupational & Vocational Rehabilitation BSc (Hons) Sport Science MCSP HCPC ACPOHE Reg  
Occupational Health Physiotherapist

**HEATHER O'NEILL** MSc Health Ergonomics BSc (Hons) Physiotherapy MCSP HCPC ACPOHE Reg  
Occupational Health Physiotherapist

**KATHERINE ROBERTS** MSc Health Ergonomics BSc (Hons) Physiotherapy MCSP HCPC ACPOHE Reg  
Occupational Health Physiotherapist

**TRACEY ATKINSON** BSc (Hons) Physiotherapy Ad Cert Occupational Health MCSP HCPC ACPOHE Reg  
Occupational Health Physiotherapist



This article, based on a case study that was submitted as part of the Association of Chartered Physiotherapists in Occupational Health and Ergonomics' (ACPOHE) registered membership process, will help demonstrate specific considerations when dealing with the working age population in a private practice setting. It encourages focus on work factors, using "work" as an outcome measure. It will cover how to have specific work conversations, how to obtain consent from an occupational health perspective and how to apply a biopsychosocial approach, outcome measures and functional testing relevant to the patient's job role. This will inform an "evidence-based" approach, facilitate successful return to work and improve overall patient outcomes.

## LEARNING OUTCOMES TO SUPPORT PHYSIO FIRST QAP

- 1 Understand the importance of work factors in a biopsychosocial assessment.
- 2 Learn how the use of appropriate outcome measures and functional measurement testing can enhance your assessment, rehabilitation, and aid overall patient care.
- 3 Improve your knowledge on use of the Allied Health Professionals (AHP) Health and Work Report.

## Introduction

An occupational health (OH) physiotherapy service is designed to

assist with reducing absenteeism owing to musculoskeletal (MSK) conditions, and to support the health and functional rehabilitation of people within a workplace. It can be a service offered as part of a physiotherapy practice and be based on site within an organisation, or at an external premises. The benefits of occupational health physiotherapy are in maintaining the wellness and health of the workforce and providing a cost-effective solution to reduce absenteeism. Occupational health services should follow the guidelines and recommendations highlighted in the publication *Working for a healthier tomorrow* (Black 2008).

The case study that informs this article was completed for an electronics

engineer working in a logistics centre that sells and distributes electrical components. It illustrates the importance of clinical and functional assessment, treatment and management strategies, including use of the AHP Health and Work Report, and highlights the importance of incorporating work factors into the individual's overall management plan.

## Consent in occupational health practice

The context of occupational health and ergonomics clinical practice differs significantly from that of physiotherapists working in other areas as there are responsibilities to the employing organisation as well as to the

**“IT IS ESSENTIAL THAT AN OCCUPATIONAL HEALTH SERVICE ADDRESSES FACTORS THAT PROMOTE HEALTH AND WELLBEING IN THE WORKPLACE”**

patient. While employers are entitled to information about an individual’s fitness for work, they do not have access to any diagnoses or specific clinical details without the prior consent of their employee, and a genuine need to know.

It is advised that the General Medical Council (GMC) Guidelines (2020) should be referenced to when providing an occupational health report to the employing organisation. This states that the physiotherapist should offer to show or supply the employee with a copy of the report before it is sent to the employer. This gives the employee opportunity to correct any factual errors before the report is issued. Exceptions to this guidance include whether the employee has already indicated that they do not wish to see the report, or if disclosure would cause harm to a third party.

It is therefore important, beyond obtaining the patient’s consent for assessment and treatment, to gain additional written consent to release the reports to the company in line with both the GMC (2020) and CSP (2020) guidelines. The Data Protection Act (GovUK 2018) guidance must also be followed to safeguard sensitive information and the right for persons to be informed about how their data will be used and when it may be used for the decision-making process.

### Clinical assessment for occupational health factors

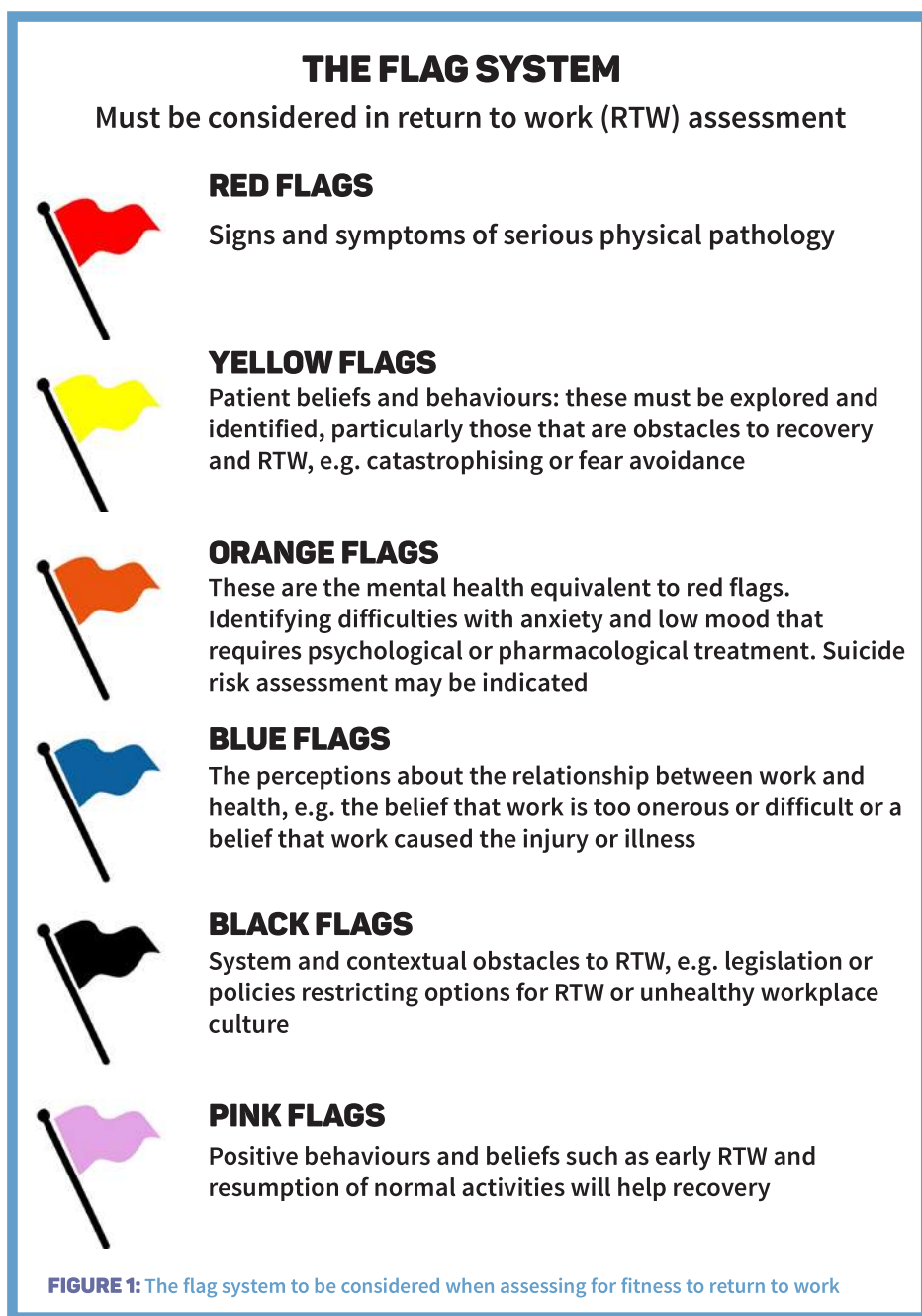
When carrying out a comprehensive biopsychosocial assessment it is essential in an occupational health service to address occupational factors to facilitate return to work and promote health and wellbeing in the workplace.

The “flag” system is frequently used in occupational health assessment (Kendall *et al* 2009), and these can also be used in

general practice. Flags can be divided into two distinct categories; clinical flags such as red flags that are common in general physiotherapy practice to identify serious pathology, and psychosocial flags with a range of colours to be considered as part of a return to work assessment, i.e. orange which are the mental health equivalent to red flags, yellow, blue, and black that indicate the potential obstacles to

recovery and the issues that are essential to identify when supporting the patient to return to work, and pink flags that identify positive behaviours and attitudes that are likely to assist an individual to successfully return to work (figure 1).

Research has demonstrated that employees’ representations of their pain, and social and occupational consequences, are significant prognostic factors when they result in psychosocial issues such as catastrophising, anxiety, fear, pain-related avoidance or dysfunctional behaviour (Roquelaure 2018; Vlaeyen & Linton 2000). ➔



To ensure that these psychosocial aspects are identified during assessment and addressed during rehabilitation, ACPOHE advocates the use of outcome measures that assess patient perceptions of pain, mood, function and work, in the form of standardised questionnaires, and has additionally developed a guideline on “psychological screening in functional capacity evaluation” with recommended screening tools for OH physiotherapists (ACPOHE 2016). This guide can be beneficial for all physiotherapists as it can be used to identify psychosocial factors that predict long-term disability as well as the readiness of the patient to return to work.

## The case study

Mr D had been absent from work for two weeks with right elbow pain and was referred by his manager for physiotherapy case management. The company was seeking help on how it could facilitate Mr D’s return to work without placing him under risk of further possible injury. Mr D’s initial assessment was taken on 3 November 2021.

## SUBJECTIVE ASSESSMENT

### History of present condition

Mr D, 42 years old, 190cm tall, weighs 95kg and is right-handed. He reported a 10-week history of right elbow pain localised to the outer side of the elbow and distally 2-3 inches into the forearm. He did not report any specific cause but rather an insidious onset which was progressively getting worse. Exacerbating factors were stated as any repetitive gripping or prolonged use of the right hand, for example DIY, writing and using a screwdriver at work. In the past two weeks Mr D had avoided using his right arm as he was fearful of exacerbating his injury further.

### Past medical history and drug history

Mr D was taking nonsteroidal anti-inflammatory medication to manage his pain. He did not report any other medical or drug history.

### Social

Mr D lived with his wife who was eight months pregnant, and his two children.

He had moved house three months previously and had been carrying out renovation work ever since. This work was done on his days off to be completed in time for the birth of his third child. Mr D reported that he was tired physically from the work he was doing at home and at work. Mr D used to go to the gym and play football but had not done any formal exercise for the past three years. He was keen to get back to regular exercise.

### Mood

Mr D reported that he felt “stressed” due to his injury. He was worried about his finances as he was off work, expecting a third child, and felt pressured to complete renovation work before his wife gave birth.

### Work

Mr D had been absent from work for two weeks due to his elbow pain. He worked a European shift pattern of four days in work and four days off, with each shift lasting 10 hours. He worked in an electrical testing room processing returns of electrical switches. His task mainly included repetitive use of a handheld screwdriver to release and re-screw multiple screws per shift. He reported that by lunchtime of every shift his pain was aggravated, but that it eased overnight with relative rest. He reported that he processed approximately 40 switch units per shift with the handheld screwdriver and believed that this activity was the cause of his pain. Mr D had been doing this work for more than five years.

Mr D reported his line manager to be supportive but felt his pain should be resolved before he returned to work.

## OUTCOME MEASURES

### Pain

The Visual Analogue Scale (VAS) is a validated, subjective measure for acute and chronic pain, and was chosen as a self-reported measure to determine pain severity (Younger *et al* 2009). Symptoms are marked on a 10cm line with no pain at 0cm and “worst pain” at 10cm. Mr D’s VAS score at assessment was 7/10.

### Mood

The Modified Zung Questionnaire is a useful, validated outcome measure for identifying changes in mood (Zung 1965). It is a 20-point self-rating scale and scores range from 25 to 100; 25-49 being normal range, 50-59 being mildly depressed, 60-69 moderately depressed, and 70-100 severely depressed. Mr D scored 52 indicating mild levels of low mood.

### Work

The Orebro MSD Screening Questionnaire is a validated outcome measure used to predict long-term disability and work absenteeism in working adults with acute and chronic MSK pain following soft tissue insult (Linton & Hallden 1998). A higher score indicates higher risk, i.e.  $\leq 105$  = low risk, 105-130 = moderate risk,  $\geq 130$  = high risk. Mr D scored 115 suggesting he was at moderate risk of not returning to work.

### Perceived function

QuickDASH is an evidence-based outcome measure that assesses, through a validated questionnaire, physical function and symptoms in people with disorders of the upper limb. It allows for improved time efficiency while still producing similar measurement properties to the full DASH outcome measure (Macdermid *et al* 2015). QuickDASH has been proven in studies to have excellent test and retest reliability and it also provides a way of measuring the success of physiotherapy intervention and treatment (Gummeson *et al* 2006; Franchignoni *et al* 2014).

Higher test scores indicate a greater level of disability and severity, while lower scores indicate a lower level of disability. Mr D scored 43/100 generally, and 63/100 for the work module, indicating that his elbow pain was providing a moderate level of disability and severity in general, but a slightly higher level of dysfunction and pain in the workplace.

## OBJECTIVE

### Observation

Initial observations noted that Mr D rubbed at his elbow and held it across his torso. Locally, there was slight erythema on the outside of the elbow joint.

### Range of movement

There was full active range of movement in the cervical spine, shoulders, elbows and wrists and hands.

### Resistance testing

There was reduced muscle power with right wrist extension, graded 4 out of 5 on the Oxford scale, otherwise Mr D had grade 5 muscle power throughout the upper limbs.

### Cervical spine / neurological screening

Upper limb neurological testing revealed normal myotomes, dermatomes and reflexes. Upper limb tension tests were negative and palpation of the cervical spine did not reveal any abnormalities.

### Special tests

Based on the subjective history and objective findings, special tests for lateral epicondylitis were also considered. In a systematic review of the literature (Zwerus *et al* 2018) that examined the diagnostic accuracy of clinical tests for common elbow conditions, only one article (Dorf *et al* 2007) met the inclusion criteria for lateral epicondylitis. Although none of the special tests described in table 1 were found to provide information on diagnostic accuracy, they were included as part of Mr D's assessment as they are considered useful in day-to-day physiotherapy practice, particularly when used in combination (Zwerus *et al* 2018). The results of all tests performed as described in table 1 were positive on

TEST	DESCRIPTION	POSITIVE TEST INDICATED BY
Cozen's	The subject is seated with their elbow extended, forearm maximally pronated, wrist radially abducted and hand held in a fist. The examiner then stabilises the elbow palpating the lateral epicondyle while the other hand is placed on the dorsum of the wrist. The examiner then resists the movement into dorsal flexion.	Pain over lateral epicondyle
Maudsley's	This involves resisted extension of the third digit of the hand while the assessor palpates the subject's lateral epicondyle.	Pain over lateral epicondyle
Mill's	The subject's elbow is extended, forearm pronated and the assessor passively moves the wrist into flexion while palpating the lateral epicondyle.	Pain over lateral epicondyle
Grip strength	The subject is seated with the shoulder adducted and neutrally rotated, elbow flexed at 90, forearm in neutral position, and wrist between 0 and 30 dorsiflexion and between 0-15 ulnar deviation. In this position they are instructed to squeeze the dynamometer as hard as possible for three successive trials with each hand. The mean grip-strength measurement of each hand is then recorded (ACPOHE 2016).	A change of 6kg between left and right sides is considered significant (Nitschke <i>et al</i> 1999).

**TABLE 1:** Details of clinical tests that should be considered for indications of lateral epicondylitis

Mr D's right side, indicated by pain being reproduced over the lateral epicondyle.

The grip strength test using a hand-held dynamometer was also included in Mr D's assessment as this was the only test identified in the systematic literature review (Zwerus *et al* 2018) that presented data on sensitivity (ranging from 78% to 85%) and specificity (ranging from 80% to 90%) and is also a more functional test.

Potential psychosocial and physical risk factors, and pink flags identified for Mr D's successful return to work are outlined in table 2, highlighting the importance of identifying and addressing psychosocial risk factors which adopt

a work focus. It was unlikely that Mr D would successfully return to his work if only the physical risk factors were treated.

### Functional objective assessment

In addition to physiotherapy assessment skills, functional tests can be used to enhance the therapist's clinical reasoning when assessing and making recommendations regarding the employee's ability to remain in or return to work. Standardised objective measurements are selected in relation to the employee's work activities / demands of their job, and their identified MSK condition, to assess their capability. ➔

PSYCHOSOCIAL RISK FACTORS	PHYSICAL RISK FACTORS	PINK FLAGS
Two-week absence from work and moderate risk of not returning to work indicated on Orebro	Repetitive twisting of screwdriver	Good relationship with line manager and eagerness to return to work
Moderate levels of pain perception indicated on VAS and DASH with an indication of higher levels of dysfunction and pain in the workplace	Some degree of force applied to re-screw	Keen to return to regular physical activity
Belief that work is the cause of injury	Potential awkward wrist postures with screwdriver and DIY tasks at home	
Belief that the injury needs to be fully resolved before returning to work	Inadequate rest periods to allow recovery	
Mild low mood indicated on Modified Zung questionnaire and reported financial concerns and personal pressures	Generally tired	
Pressure to continue to renovate home and lack of awareness of how this could be an aggravating factor		
Lack of structure physical activity / exercise		

**TABLE 2:** Multifactorial nature of risk factors



The employee's job demands can be identified, as advised by the ACPOHE's functional measurement toolkit (2016), from the job description, management referral or the employee themselves regarding the frequency and effort required with tasks at work. Functional tests can therefore assist the therapist to provide more specific, tailored advice and / or adjustments to the employer regarding the employee's work tasks. They can also be useful in providing base line measurements for goal centred rehabilitation with reassessment at appropriate intervals.

For Mr D's role at work, the following functional tests were selected (table 3) in relation to his reported condition and job demands:

1. Grip strength: Using the standardised testing protocol for the JAMAR hand dynamometer as described by Mathiowetz *et al* (1984), the subject is seated with the shoulder adducted and neutrally rotated, elbow flexed at 90, forearm in neutral position, and wrist between 0 and 30 dorsiflexion and between 0-15 ulnar deviation. In this position they are instructed to squeeze the dynamometer as hard as possible for three successive trials with each hand. The mean grip-strength measurement of each hand is then recorded (ACPOHE 2016). This test was relevant to both Mr D's reported condition and to his repetitive gripping of the screwdriver at work.
2. Six-minute walk test: Based on the standardised protocol recommended by the American Thoracic society (ACPOHE 2016), the subject is asked to walk as quickly as possible back and forth along a 30-metre corridor / walkway within a six-minute time period and to record the distance completed. The subject is also asked to estimate their level of effort during the six-minute walk using the rate of perceived exertion (RPE) scale that they are shown at the start and at the end of the test. This test was selected for Mr D as a general measure of fitness and based on the fact that he was required to stand for most of the

“STANDARDISED OBJECTIVE MEASUREMENTS ARE SELECTED TO ASSESS CAPABILITY IN RELATION TO THE EMPLOYEE'S WORK ACTIVITIES AND THEIR IDENTIFIED MSK CONDITION”

FUNCTIONAL ACTIVITY	WORK ACTIVITY	FUNCTIONAL TEST	RESULTS
Gripping	Almost continuous use of handheld screwdriver to release and re-screw (40 switch units per shift)	JAMAR hand dynamometer	Left 45.4kg Right 38.6kg
Standing / walking	Prolonged standing / being on feet throughout shift; no seated tasks	Six-minute walk test	520m

TABLE 3: Functional tests selected based on work activity

day, had reported feeling tired and did not exercise regularly.

### COMPARISON OF RESULTS TO NORMATIVE VALUES

As Mr D is right hand dominant, it would be anticipated that he would be stronger on his right than on his non-dominant, left side. However, the grip strength test showed a lower average result of 6.8kg on the right side compared to the left. Nitschke *et al* (1999) identified that a change of 6kg between sides is considered significant.

In addition, compared to normative values (Dodds *et al* 2014) of grip strength in males of a similar age (mean grip strength = 50.3kg), Mr D's results were within only a 10% range, revealing that he had some functional deficit in his right hand.

The reported range of distance covered by healthy adults undertaking the six-minute walk test is between 400m to 700m (Chetta *et al*, 2006) but the anticipated range can be calculated more specifically when gender, height, weight and age are taken into consideration by using the following formula (Enright & Sherrill 1997):

For men, the formula is  $(7.57 \times \text{height (cm)}) - (1.76 \times \text{weight (kg)}) - (5.02 \times \text{age}) - 309 = \text{expected metres}$   
Specifically for Mr D, therefore the calculation was:

$= (7.57 \times 190) 1438.3 - (1.76 \times 95) 167.2 - (5.02 \times 42) 210.84 - 309 = 751.26 \text{ metres.}$

Mr D's actual recorded distance, however, was just 520 metres, his heart rate rose to 125 beats per minute (70% of VO2 Max), and RPE was at 7/10, which indicated that the activity had been hard, and he had experienced visible shortness of breath.

### CLINICAL ASSESSMENT OUTCOME

Results from both the subjective and objective assessments, detailed in this article, led to a differential diagnosis of lateral epicondylitis, also known as tennis elbow. It is thought that lateral epicondylitis can affect a group of muscles including the extensor tendons of the wrist and forearm, supinator and, most commonly, the extensor carpi radialis brevis, resulting in pain with resisted wrist and middle finger extension (Vaquero-Picado *et al* 2016).

### PHYSIOTHERAPY TREATMENT AND MANAGEMENT

A significant amount of time was taken with Mr D to explain the multifactorial nature of his right elbow pain and how his own self-management could support his recovery. His belief that only work factors were contributing were particularly addressed so that he fully understood that the extra physical loading on to his right wrist involved in his home DIY activities and his high stress levels are also contributing factors to his pain. Mr D realised himself that the worry over losing his job was his main cause of stress and that completing the DIY before the new baby was born

was less important. He agreed that, for the next two weeks, he would stop any DIY that involved forceful or awkward wrist postures, and then only undertake such tasks for short periods at a time, and generally “pace” his DIY activities in the future. He also understood the importance of returning to his fitness activities and felt that playing football would be ideal in that it would also provide him with social support, which was likely to boost his mood and overall sense of wellbeing.

Further treatment and advice were provided in line with the NICE guidelines for management of tennis elbow (NICE 2020), including exercises for self-management to improve strength and flexibility, advice for pain and inflammation management, and manual therapy to assist with pain and function. Interestingly, Bisset *et al* (2006) suggest in their random control trial that, of patients who are advised to wait and see if tennis elbow settles itself, 83%-90% showed significant improvements. This is in contrast to other studies that have shown moderate evidence for immediate pain relief and improved grip strength with manual therapy techniques and exercise programmes (Vicenzino *et al* 2007).

## RECOMMENDATIONS FOLLOWING CLINICAL ASSESSMENT

A conversation with Mr D was initiated after the initial assessment to ensure “shared decision making” and that the patient was in agreement with all recommendations that would be made to his employer. It was decided that a period of four weeks of modified duties, where Mr D undertook no “main switch testing” would afford him the necessary time to settle his current acute symptoms and allow for a recommended workplace assessment by the occupational health physiotherapist to be undertaken. An AHP Health and Work Report was completed and a copy provided to Mr D to give to his employer ([http://www.ahpf.org.uk/AHP\\_Health\\_and\\_Work\\_Report.htm](http://www.ahpf.org.uk/AHP_Health_and_Work_Report.htm)).

## FOUR-WEEK FOLLOW-UP

A follow-up appointment was scheduled

SUBJECTIVE	OBJECTIVE	FUNCTIONAL
<b>Pain – VAS Score 3/10</b> Improvement from 7/10 at initial assessment	No erythema over elbow and no guarding of elbow (Improved)	<b>Jamar Maximal Grip Strength - Left 50.2kg</b> <b>Right 43.1kg</b> Improved from scores at initial assessment of Left 45.4kg and Right 38.6kg
<b>Mood – Zung Questionnaire Score 39</b> Improvement from 52 at initial assessment	Mild reduction muscle power right wrist extension (grade 4+ out of 5 on the Oxford scale) Improved from 4/5 at initial assessment	<b>6-minute Walk Test - 605m</b> Improved from 520m at initial assessment
<b>Work – Orebro Score 100</b> Improvement from 115 at initial assessment	Mill’s, Cozen’s and Maudsley’s test all mild exacerbation of lateral elbow pain (Improved)	
<b>Function – Quick Dash 30/100 (work component 50/100)</b> Improvement from 43/100 and 63/100 at initial assessment)		

**TABLE 4: Reassessment of subjective, objective and functional measures**

for 30 November 2021 at which Mr D reported a significant reduction in his symptoms and that, following a return to playing 5-a-side football, his mood had improved considerably, as had his overall fitness. He remained slightly anxious about returning to main switch testing activities at work and was fearful that his pain and loss of function would return. Subjective, objective and functional measurement tests were re-assessed (table 4).

The underlying causes of Mr D’s anxiety about returning to main switch testing was investigated further. He worried that long shift hours of this activity might contribute to his symptoms returning and that this would impact on his ability to care for his new baby. The progress that Mr D had already made was reinforced to him, along with the importance of “pacing” his upper limb activities and continuing his rehabilitation programme. Mr D admitted that he had made great progress and that seeing his objective improvements in the functional measurement tests was particularly motivating. Progression to a stretching and strengthening regime was advised, and the return to his normal work activities was discussed with him. It was decided that he could return to main switch testing but with limited hours on this task until a full workplace assessment had been undertaken. A new AHP Health and Work Report was

completed stating that Mr D should take a five-minute break from main switch testing after every 15 minutes of this activity to undertake stretching exercises, and that the total time spent on main switch testing must not:

- exceed two hours for the first two weeks
- exceed three hours in the following two weeks.

The importance of the workplace assessment being completed within the next four weeks was advised.

## Conclusion

Use of the biopsychosocial model of healthcare ensures that all elements affecting recovery are highlighted, assessed and addressed in pain management. In the case of Mr D, he made excellent improvements which were backed up by the subjective, objective and functional measurements and results on his right elbow pain. This also highlights the importance of knowing how to use these outcome measures, as well as being able to engage in an active conversation with the patient regarding their work tasks, and that this can be undertaken effectively when offering this option away from the patient’s place of work. Physiotherapists working in occupational health settings should consider the use of photographs or videos as a way to help understand ➤

more fully the employee / patient job role, and that the use of the AHP Health and Work Report facilitates communication with the employer to help advise on work modifications and return to work management strategies. For Mr D, a workplace assessment was recommended by the physiotherapist in the initial AHP Health and Work Report, and the assessment was undertaken by an occupational health specialist. The results and outcomes of this assessment can be seen in the article on p12.

## About the authors

### Nicola Suckley

Nicola is an Occupational Health Physiotherapist and the Managing Director of the Wellbeing and Rehabilitation Company. She has been working in the field of occupational health for more than 10 years, providing services to the public, private and corporate sectors. Nicola has designed, developed, and delivered national and international programmes on injury prevention and health promotion. She is passionate about developing occupational health physiotherapy and is the current Chair of ACPOHE, a committee member of IFPTOHE, and a Director of the Council for Work and Health in the UK.

### Heather O'Neill

Heather has worked as an Occupational Health Physiotherapist in a variety of settings, but mainly the NHS, since 1997. She currently leads a physiotherapy team as part of occupational health service provision for a large NHS Trust and local authority in North East England. She has been a member of the ACPOHE committee since 2013, and tutors on the ACPOHE education courses.

### Katherine Roberts

Kathy is an experienced physiotherapist specialising in occupational health and ergonomics and has worked in a variety of public, private and third sectors. She enjoys being based and entrenched within an organisation, especially when she can really have a positive influence on health and safety culture.

Kathy is a passionate educator and currently holds the position of Education Officer for ACPOHE. She has recently developed a new Learning and Development Hub in Work and Health and updated ACPOHE's course offerings into a new blended learning format.

### Tracey Atkinson

Tracey is an experienced Occupational Health Physiotherapist and has worked within this field for the past 26 years. She currently works as an Occupational Health Physiotherapy Service Manager and Clinical Governance lead. Tracey's role involves managing numerous contracts across a wide range of business sectors, clinicians, supporting on governance issues and SEQOHS accreditation.

Tracey joined the ACPOHE executive committee eight years ago as membership secretary and has been involved in the registered membership process over that time and, more recently, in the introduction of technical membership.

## CONTACT DETAILS

[admin@acpohe.org.uk](mailto:admin@acpohe.org.uk)  
<https://acpohe.csp.org.uk>

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## Additional resources

For more information about ACPOHE and details on how to increase your own knowledge on Assessment of Fitness for Work, or to undertake an Introduction to Occupational Health, please visit these links: [https://acpohe.csp.org.uk/event/new-assessment-fitness-work-course-affw-blended-learning-online-face-](https://acpohe.csp.org.uk/event/new-assessment-fitness-work-course-affw-blended-learning-online-face)

## face-study-day-200522

<https://acpohe.csp.org.uk/content/what-acpohe-courses-should-i-do>

For further information on completion of the AHP Health and Work Report, please visit the free guest access to the ACPOHE2p1 Learning and Development Hub: <https://acpohelms.co.uk/login.php>

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## ACPOHE courses 2022

ACPOHE regularly runs courses to enable all physiotherapists to gain the specialist knowledge required to practice in the field of occupational health. For advice on which courses might be most suitable for you, first look at the “What courses should I do” webpage <https://acpohe.csp.org.uk/content/what-acpohe-courses-should-i-do>

Course	Date	Cost	Notes
Occupational health essentials	Any time online	£250 members	Module 1 is free to CSP and ACPOHE members. Module 2 free to ACPOHE members
Vehicle ergonomics	Any time online	£150 members	New course. Online
Remote DSE assessment best practice	17 April / 7 July / 23 Nov	£50 members	New course. Online
Dealing with chronic pain cases in the workplace	6 May	£85 members	New course. Online
Office ergonomics (DSE) level 1	14 May / 17 Nov	£185 members	Online
Assessment for fitness for work	20 May	£200 members	New course. Online plus face-to-face study day
First contact practitioner work and health training workshop	23 May	Free	Online
Introduction to applied ergonomics	17 June	£250 members	Online

For more info and to book go to <https://acpohe.csp.org.uk/content/acpohe-courses> or contact our course administrator: [admin@acpohe.org.uk](mailto:admin@acpohe.org.uk).

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