Nurses with Disabilities’ Experience of Accommodation in the Workplace:

A Qualitative Study

BY

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THESIS

Submitted as partial fulfillment of the requirements
for the Doctor of Philosophy in Nursing Sciences
in the Graduate College of the
University of Illinois at Chicago, 2017

Chicago, Illinois

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ACKNOWLEDGMENTS

I would like to thank my dissertation committee, Dr. Teresa Savage (chair and advisor), Dr. Catherine Vincent, Dr. Linda Scott, Dr. Carol Gill, and Dr. Leslie Neal-Boylan for their support and guidance throughout this process. I would also like to acknowledge Dr. Beth Marks and Dr. Donna Carol Maheady for assistance with recruitment for this study and for their expertise in nursing and disability studies. Lastly, I would like to express my appreciation to the nurses with disabilities who participated in this study and shared their experiences to advance the science of nursing.

DD
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>DESCRIPTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTRODUCTION</td>
<td>.............................................................</td>
<td>1</td>
</tr>
<tr>
<td>A. Background</td>
<td>.........................................................</td>
<td>1</td>
</tr>
<tr>
<td>B. Statement of Problem</td>
<td>.........................................................</td>
<td>2</td>
</tr>
<tr>
<td>C. Purpose and Major Aims</td>
<td>.........................................................</td>
<td>3</td>
</tr>
<tr>
<td>D. Research Questions</td>
<td>.........................................................</td>
<td>3</td>
</tr>
<tr>
<td>E. Significance</td>
<td>.........................................................</td>
<td>3</td>
</tr>
<tr>
<td>F. Innovation</td>
<td>.........................................................</td>
<td>4</td>
</tr>
<tr>
<td>II. CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW</td>
<td>.............................................................</td>
<td>5</td>
</tr>
<tr>
<td>A. Conceptual Framework</td>
<td>.........................................................</td>
<td>5</td>
</tr>
<tr>
<td>B. Literature Review</td>
<td>.........................................................</td>
<td>5</td>
</tr>
<tr>
<td>III. METHODS</td>
<td>.............................................................</td>
<td>12</td>
</tr>
<tr>
<td>A. Design</td>
<td>.........................................................</td>
<td>12</td>
</tr>
<tr>
<td>B. Inclusion and Exclusion Criteria</td>
<td>.........................................................</td>
<td>14</td>
</tr>
<tr>
<td>C. Recruitment</td>
<td>.........................................................</td>
<td>15</td>
</tr>
<tr>
<td>D. Sample</td>
<td>.........................................................</td>
<td>16</td>
</tr>
<tr>
<td>E. Data Collection</td>
<td>.........................................................</td>
<td>16</td>
</tr>
<tr>
<td>1. Procedures to maximize data integrity</td>
<td>.........................................................</td>
<td>17</td>
</tr>
<tr>
<td>F. Data Analysis</td>
<td>.........................................................</td>
<td>18</td>
</tr>
<tr>
<td>G. Trustworthiness and Rigor</td>
<td>.........................................................</td>
<td>21</td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>.............................................................</td>
<td>24</td>
</tr>
<tr>
<td>A. Actual Experience and Process of Accommodation</td>
<td>.........................................................</td>
<td>24</td>
</tr>
<tr>
<td>1. Self-accommodation</td>
<td>.........................................................</td>
<td>24</td>
</tr>
<tr>
<td>2. Inevitable to request accommodation</td>
<td>.........................................................</td>
<td>26</td>
</tr>
<tr>
<td>3. Self-advocacy</td>
<td>.........................................................</td>
<td>28</td>
</tr>
<tr>
<td>4. Lack of process</td>
<td>.........................................................</td>
<td>29</td>
</tr>
<tr>
<td>5. Resistance to accommodation</td>
<td>.........................................................</td>
<td>31</td>
</tr>
<tr>
<td>6. Complaisance with accommodation</td>
<td>.........................................................</td>
<td>33</td>
</tr>
<tr>
<td>7. Disability identity</td>
<td>.........................................................</td>
<td>34</td>
</tr>
<tr>
<td>B. Ideal Experience and Process of Accommodation</td>
<td>.........................................................</td>
<td>37</td>
</tr>
<tr>
<td>1. Openness</td>
<td>.........................................................</td>
<td>37</td>
</tr>
<tr>
<td>2. Employer advocacy</td>
<td>.........................................................</td>
<td>39</td>
</tr>
<tr>
<td>3. Streamlined process</td>
<td>.........................................................</td>
<td>40</td>
</tr>
<tr>
<td>4. Employer accountability</td>
<td>.........................................................</td>
<td>42</td>
</tr>
<tr>
<td>C. Comparison of the Experiences of Nurses with Physical and/or Mental Disabilities</td>
<td>.........................................................</td>
<td>47</td>
</tr>
<tr>
<td>D. Teamwork as an Accommodation</td>
<td>.........................................................</td>
<td>49</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS (continued)

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>V. DISCUSSION</td>
<td>..........................................................51</td>
</tr>
<tr>
<td>A. Discussion of Findings</td>
<td>..........................................................51</td>
</tr>
<tr>
<td>B. Implications for Nursing</td>
<td>..........................................................60</td>
</tr>
<tr>
<td>C. Implications for Future Research</td>
<td>..........................................................62</td>
</tr>
<tr>
<td>D. Strengths and Limitations of the Study</td>
<td>..........................................................64</td>
</tr>
<tr>
<td>E. Conclusion</td>
<td>..........................................................65</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>..........................................................67</td>
</tr>
<tr>
<td>Appendix A</td>
<td>..........................................................68</td>
</tr>
<tr>
<td>Appendix B</td>
<td>..........................................................69</td>
</tr>
<tr>
<td>References</td>
<td>..........................................................77</td>
</tr>
<tr>
<td>VITA</td>
<td>..........................................................86</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Demographics of the Sample</td>
<td>71</td>
</tr>
<tr>
<td>II. Participants’ Disabilities</td>
<td>72</td>
</tr>
<tr>
<td>III. U.S. State Where RN Requested Accommodation</td>
<td>73</td>
</tr>
<tr>
<td>IV. Comparison of Actual and Ideal Process of Accommodation</td>
<td>74</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>FIGURE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1. International Classification of Functioning, Disability, and Health</td>
<td>75</td>
</tr>
<tr>
<td>Figure 2. Negotiated Interactive Process of Accommodation</td>
<td>76</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
</tr>
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<td>ANA</td>
<td>American Nurses Association</td>
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<td>ADAAA</td>
<td>Americans with Disabilities Act Amendments Act</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>ADN</td>
<td>Associates Degree in Nursing</td>
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<tr>
<td>BLS</td>
<td>Bureau of Labor Statistics</td>
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<tr>
<td>BSN</td>
<td>Bachelor of Science in Nursing</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CFS</td>
<td>Chronic Fatigue Syndrome</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disorder</td>
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<td>DNP</td>
<td>Doctor of Nursing Practice</td>
</tr>
<tr>
<td>EEOC</td>
<td>Equal Employment Opportunity Commission</td>
</tr>
<tr>
<td>FMLA</td>
<td>Family and Medical Leave Act</td>
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<tr>
<td>HR</td>
<td>Human Resources</td>
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<td>ICF</td>
<td>International Classification of Functioning, Disability and Health</td>
</tr>
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<td>IRB</td>
<td>Institutional Review Board</td>
</tr>
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<td>JAN</td>
<td>Job Accommodation Network</td>
</tr>
<tr>
<td>MSN</td>
<td>Master of Science of Nursing</td>
</tr>
<tr>
<td>NOND</td>
<td>National Organization of Nurses with Disabilities</td>
</tr>
<tr>
<td>NWD</td>
<td>Nurses with Disabilities</td>
</tr>
</tbody>
</table>
**LIST OF ABBREVIATIONS** (continued)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR</td>
<td>Operating Room</td>
</tr>
<tr>
<td>PhD</td>
<td>Doctor of Philosophy in Nursing</td>
</tr>
<tr>
<td>PI</td>
<td>Principal Investigator</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
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<td>PWD</td>
<td>Persons with Disabilities</td>
</tr>
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<td>RN</td>
<td>Registered Nurse</td>
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<td>SSDI</td>
<td>Social Security Disability Insurance</td>
</tr>
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<td>UIC</td>
<td>University of Illinois at Chicago</td>
</tr>
</tbody>
</table>
SUMMARY

A qualitative study of nurses with disabilities’ experience of accommodation was conducted using naturalistic inquiry and constant comparison. Interviews were conducted with 21 nurses with disabilities, physical and/or mental, who experienced accommodation in the workplace. Demographic data were collected on nurse, job, and disability characteristics. Data were collected via semi-structured interviews on the nurses’ experience and process of accommodation.

Nurses with disabilities were asked to describe their actual experience and process of accommodation and to describe what they thought was an ideal experience and process of accommodation in the workplace. In the actual experience and process, nurses often self-managed and provided their own accommodation (self-accommodation) in the workplace. Many nurses reported a lack of process for requesting accommodation, and did not actually obtain their requested accommodation from the employer. Instead, the employer provided the nurse with an accommodation that was based on factors such as cost, convenience, safety, and the ability of the nurse.

In an ideal experience and process of accommodation, nurses recommended the employer serve as an advocate for nurses with disabilities, the process of accommodation be a collaborative discussion and decision between the employer and nurse, and the employer be held accountable for providing accommodation in the workplace. Most nurses in the study believed the process of accommodation was unclear and untimely. Based on their own experiences, nurses offered several strategies on how to develop a more accessible and fluid process of accommodation in the workplace.
Nurses with various types of disabilities (physical and/or mental) reported similar experiences of accommodation. Most nurses with invisible physical and/or mental disabilities self-managed accommodation until they were forced to ask for an accommodation from their employer. Many nurses in this study changed jobs or were forced to resign because of the inability to perform the essential job functions, concerns of safety, difficulty with supervisors and human resources providing accommodation, and/or they felt stigmatized and discriminated against by employers (i.e., human resources, supervisors, and colleagues). Nurses sought new jobs where they could self-manage and self-accommodate with minimal employer involvement.

Nurses with disabilities identified several barriers and facilitators to accommodation in the workplace. Knowledge of the Americans with Disabilities Act, flexibility, creativity, and support from employers positively impacted the process of accommodation for nurses with disabilities. Nurses viewed teamwork as an informal type of accommodation and potential facilitator in the workplace for nurses with disabilities. Nurses defined accommodation as an interactive process and mutual responsibility between employers and themselves. They reported employers and nurses could be more forthcoming and knowledgeable on how to effectively address disability awareness and accommodation in the workplace.
I. INTRODUCTION

Background

Approximately 20% of U.S. adults have disabilities (Centers for Disease Control and Prevention [CDC], 2013). In 2012, the U.S. government estimated there were 74 million adults with disabilities (CDC, 2014). In 2015, 68% of adults with disabilities reported that they were striving to be employed (Kessler Foundation, 2015). In 2015, only 17.5% of persons with disabilities (PWD) were employed (U.S. Bureau of Labor Statistics [BLS], 2016). In 2015, the U.S. government spent an estimated $150 billion on Social Security Disability Insurance (Chantrill, 2016). Social Security Disability Insurance (SSDI) is a U.S. federal program that provides financial assistance to qualified unemployed PWD. Persons with mental disabilities were the largest group receiving SSDI in the U.S. in 2013 (McDowell & Fossey, 2015). In 2014, the U.S. government passed a law stating that all federal contractors and subcontractors must employ seven percent of PWD as employees (Office of Federal Contract Compliance Programs, 2013). It is a critical time to recruit, hire, and retain PWD as employees in the U.S.

In 2015, the number of employed Registered Nurses (RNs) in the U.S. was 2.75 million (BLS, 2016). The number of nurses with disabilities (NWD) in the U.S. nursing profession is unknown. From a prior study, approximately 14% of RNs who worked in hospital settings reported having disabilities (Matt, 2011). From these statistics, it can be extrapolated that there are a significant number of RNs with disabilities in the U.S. nursing workforce. It is important to consider how to accommodate and retain persons with various types of disabilities in the nursing workforce because employment rates are low for PWD in the U.S., and there is a predicted nursing shortage and projected need for an additional 1.13 million nurses by 2022 (ANA, 2014). Baby-boomer nurses (born from 1946 to 1964) who are a large segment of the nursing workforce...
are approaching retirement and are at risk of developing disabilities as they age (Barrett, 2016; McCulloh & Marks, 2015). This is an important consideration for the nursing profession because baby-boomer nurses may desire to work with a disability, and this may require employers to provide them with accommodation to remain employed. Furthermore, as baby-boomers age there may be an increased demand for nurses to care for an increased number of baby-boomers with disabilities in the population. In 2015, 47% of PWD were 65 years and older (BLS, 2016). It is a crucial time for the nursing profession to better understand disability and accommodation and its impact on the healthcare industry.

Statement of Problem

It is known that nurses with physical or sensory disabilities faced many barriers in the nursing workforce. For example, nurses with physical or sensory disabilities in the nursing workforce were reluctant to ask for accommodation (Matt, 2008; Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008a, 2008b, 2008c); employers did not provide accommodation (Neal-Boylan, Fennie, & Baldauf-Wager, 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c); and some of these nurses left the nursing profession due to discrimination (Neal-Boylan, 2012; Neal-Boylan, et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). It is unknown how NWD (physical and/or mental) experience accommodation or how they overcome barriers to requesting and obtaining accommodation in the workplace.

In a recent systematic review of workplace accommodation for PWD, researchers found the process of accommodation was rarely described in studies (Nevala, Pehkonen, Koskela, Ruusuvuori, & Anttila, 2015). In the nursing literature, most researchers reported on the barriers to accommodation for nurses with physical or sensory disabilities (Matt, 2008; Neal-Boylan, 2012, Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c), not specifically
on the process of accommodation for NWD. Research about the process of accommodation for NWD and PWD is scant in the literature.

**Purpose and Major Aims**

The purpose of this qualitative study was to describe the experience and process of accommodation in the workplace from the view of NWD. The Principal Investigator (PI) interviewed nurses with disabilities (physical and/or mental) who had experienced accommodation in the workplace. The major aims were to describe: (1) the experience of accommodation in the workplace from the view of NWD; (2) the process of accommodation in the workplace from the view of NWD; and (3) how to best facilitate an ideal process of accommodation in the workplace from the view of NWD.

**Research Questions**

The research questions were: What is the experience and process of accommodation in the workplace as perceived by NWD? How can NWD and employers best facilitate the process of accommodation? Are the experiences of RNs with physical and/or mental disabilities similar regarding accommodation? What are NWD views on teamwork as an accommodation?

**Significance**

A better understanding of how NWD describe the experience and process of accommodation in the workplace was needed to fill a gap in the current literature. This study is significant because a nursing shortage is predicted and employment rates are low for PWD. This study provides insight on how to facilitate the process of accommodation in the workplace and potentially retain NWD as employees in the nursing profession and healthcare industry. Nurses with disabilities can diversify the nursing profession which is comprised mostly of able-bodied
persons. The findings of the study offer insights into what barriers were encountered by NWD and provide a glimpse as to what NWD and employers can do to implement a process of accommodation in the workplace. Additionally, this study can provide the foundation for the development of a quantitative study design such as a survey(s) on accommodation for employers, NWD, and PWD in the nursing profession and healthcare industry.

**Innovation**

The novelty of this study is that it was the first qualitative study to describe the experience and process of accommodation from a sample of nurses with varying types of disabilities (physical and/or mental) who have experienced accommodation in the workplace. By using a purposive sampling strategy, the PI recruited a heterogeneous sample of nurses with disabilities and accommodation experiences from various regions and places of employment in the U.S. These findings can potentially aid employers and NWD to better communicate, educate, advocate, and develop policy and process of accommodation for NWD in the workplace. These findings filled a gap in the current research.
II. CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Conceptual Framework

A conceptual framework was not utilized *a priori* to guide this study. In naturalistic inquiry, there is no *a priori* commitment to any one theoretical view of target phenomena (Lincoln & Guba, 1985).

Literature Review

Disability and reasonable accommodation are complex phenomena that are not well understood by employers in the nursing workforce (Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). Disability is classified into two main categories: physical and mental (Americans with Disabilities Act [ADA], 1990). The ADA (1990) defines a person with a disability as having a physical or mental impairment that substantially limits one or more major life activities; has a record of the impairment; or is regarded as having an impairment. Persons with disabilities are the largest minority group in the U.S. (Garland-Thomson, 2016).

The United States has a long history of legislation to promote inclusion for PWD in employment. The Rehabilitation Act of 1973 prohibits discrimination of PWD who work for the federal government. The Rehabilitation Act of 1973 led to the enactment of Title I of the American with Disabilities Act (1990) which protects PWD from discrimination who work for employers with greater than 15 or more employees. The ADA Amendments Act (ADAAA, 2008) broadens the interpretation of the definition of disability in the ADA (1990). The purpose of the ADAAA (2008) is to make it easier for individuals to establish they have a disability. Under the ADAAA (2008) the term “substantially limits” is construed more broadly. An impairment that is episodic or in remission is considered a disability (if it does substantially limit a major life activity when active) such as a person with an impairment like cancer, diabetes, and
epilepsy (ADAAA, 2008). The term “major life activities” is also broadened to include “major bodily functions.” The legislation and definition of disability continue to evolve (Garland-Thomson, 2016).

In the U.S. research literature, most studies on disability in the nursing workforce included samples of nurses with either physical or sensory disabilities, not included were nurses with disabilities such as mental impairments. It is unknown how nurses with disabilities, physical and/or mental, experience accommodation in the workplace. It is known how nurses with physical or sensory disabilities experience disability in the workplace, for example, nurses with physical or sensory disabilities often hide their disabilities from employers (Neal-Boylan, 2014; Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008a, 2008b, 2008c), they were reluctant to ask for accommodation in the workplace (Matt, 2008; Neal-Boylan, 2014; Neal-Boylan, 2012; Neal-Boylan, et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c), and reported that employers and staff lacked knowledge of the ADA (Matt, 2008; Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). Supportive and unsupportive supervisors impacted career outcomes for nurses with physical or sensory disabilities in the nursing profession (Matt, 2008; Neal-Boylan, 2014; Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). Nurses reported that supervisors who were nurses with disabilities versus without disabilities were more empathetic toward disability in the workplace (Neal-Boylan, 2014). Supervisors who were non-nurses were more likely to support NWD in the workplace because they did not know or question the nurse’s role and what a nurse should do (Neal-Boylan, 2014). Disability discrimination (84%) and failure to accommodate (46%) were the top two categories of legal claims brought by nurses with physical or sensory disabilities within the years of 1990-2008.
These findings are troublesome and can be costly and detrimental to NWD, employers, nursing profession, healthcare industry, and U.S. government.

The hospital setting was reported as a difficult workplace environment for nurses with physical or sensory disabilities. It is known that nurses with physical or sensory disabilities employed in hospitals had trouble with the workload and lack of accommodation (Matt, 2008; Neal-Boylan, 2012; Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). The inability to manage the workload and lack of accommodation for nurses with disabilities led to reports of fatigue (Neal-Boylan & Guillett, 2008a, 2008b, 2008c), over-compensation (Matt, 2008; Neal-Boylan, 2012; Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c), and frustration by nurses (Neal-Boylan & Guillett, 2008a, 2008b, 2008c). Nurses with disabilities reported feeling stigmatized and rejected by staff in hospitals (Matt, 2008; Neal-Boylan, 2014; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). Nurses with disabilities who worked in hospitals were three times more likely to leave these jobs than NWD who worked in non-hospital settings (Neal-Boylan et al., 2011). Ultimately, many of these nurses with physical or sensory disabilities reported leaving the hospital setting or left the nursing profession entirely (Neal-Boylan, 2014; Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c).

It is unknown how NWD experience requesting and obtaining accommodation from employers in the workplace. Nurses with visible physical or sensory disabilities (disabilities that other persons can see upon meeting the person with a disability) such as those who use mobility devices (wheelchairs) or have amputations, were more likely to obtain accommodation and support in the workplace than those with invisible physical or sensory disabilities, such as persons with systemic lupus erythematosus or chronic pain (Neal-Boylan, 2012; Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). These findings are concerning because
many types of physical and mental disabilities are invisible (disabilities that other persons cannot see upon meeting the person with a disability) such as hearing impairments, visual impairments, heart conditions, chronic fatigue syndrome, seizure, depression, anxiety, bipolar, and autism.

Mental disabilities are becoming more prevalent in the U.S. such as depression, anxiety disorders, anorexia, traumatic brain injuries, attention-deficit disorder, autism, and dementia (Garland-Thomson, 2016). In 2013, persons with mental disabilities were the largest group receiving SSDI in the U.S. (McDowell & Fossey, 2015). To qualify for Social Security disability benefits, a person must have worked in jobs covered by Social Security; have a disability; and be unable to work for at least one year. There is minimal published research about nurses with mental disabilities in the U.S. nursing workforce. There is limited research about workplace accommodation for persons with mental disabilities in the U.S. (Nevala et al., 2015). In a literature review of workplace accommodation for persons with mental illness, researchers concluded that research on the implementation of workplace accommodation for this population was scarce and necessary (McDowell & Fossey, 2015). In a study conducted in Australia, researchers revealed that nurses with mental illness reported negative attitudes by colleagues, felt stigmatized, and recommended that staff obtain more education on mental illness such as mental health literacy and mental health first aid skills (Joyce, Hazelton, & McMillan, 2007). In New Zealand, nurses with mental illness preferred non-disclosure of their disability due to the fear of being stigmatized (Korzon, 2014). Nurses who have mental disabilities are an understudied population. By including nurses with various types of disabilities in this study, this PI can identify similarities and differences amongst nurses with physical and mental disabilities based on their experience of accommodation and gain a better understanding of accommodation.
Reasonable accommodation is a complex concept. The purpose of reasonable accommodation is to eliminate barriers for PWD in the workplace (EEOC, 2012). Accommodation in the workplace is a way of assuring equal employment opportunity for PWD (ADA, 1990). The U.S. government mandates that employers provide reasonable accommodation to qualified employees with disabilities to perform the essential functions of the job unless this would cause undue hardship to the employer (ADA, 1990). Per the U.S. Equal Employment Opportunity Commission (EEOC, 2010) which enforces Title I of the ADA, there are three categories of reasonable accommodation: modifications to the job application process, modifications to the work environment, and modifications that enable an employee with a disability to enjoy equal benefits and privileges of employment. The EEOC (2012) provides examples of workplace accommodations such as modifying the physical environment to be accessible, restructuring of job descriptions, providing qualified readers or interpreters, and reassignment to a different position in the facility. Employer-provided leave is also considered a reasonable accommodation under the ADA (EEOC, 2016). The person with a disability can request accommodation orally or in writing, and an employer may ask for reasonable documentation from a healthcare provider (EEOC, 2010). An employer cannot ask for documentation when both the disability and need for accommodation are obvious (EEOC, 2010). The EEOC policy on reasonable accommodation states that the process of requesting and providing accommodation is an interactive process between the employer and PWD and communication is a priority (EEOC, 2010). The employer determines if a request for accommodation is granted or denied and decides on a case-by-case whether a reasonable accommodation would cause undue hardship (EEOC, 2012).
It is unknown how employers are handling the process of requesting and providing accommodation for PWD in the workplace. Furthermore, it is unknown how NWD, physical and/or mental, are experiencing accommodation and more specifically, how NWD are experiencing the process of accommodation in the workplace. To request accommodation, a person must disclose his/her disability (McCulloh & Marks, 2015). From the prior studies, many nurses with physical or sensory disabilities hid their disability and were reluctant to ask for accommodation. There is limited research about the experience and process of accommodation for NWD in the literature.

There have been some studies on PWD and workplace accommodation in the literature. Providing accommodation in the workplace was positively correlated to job retention, job performance, and to improved attitudes and perceptions of disability by employers (Gold, Oire, Fabian, & Wewiorski, 2012). Providing accommodation was negatively correlated to employers’ perceptions of accommodation costs (Gold et al., 2012). Disclosing a disability and requesting accommodation required a mutual trust and respect between the employer and employee (Gold et al., 2012). In a systematic literature review, it was reported that the accommodation process was an interaction between the person with a disability, colleagues, and employers (Nevala et al., 2015). Assistance from colleagues was reported as an accommodation in studies of PWD (Nevala et al., 2015). Nevala et al. (2015) reported that a facilitator to workplace accommodation was a “flexible work organization” that included “job sharing, adaptations to work roles, and altered work requirements” (p. 443). The key facilitators to the workplace accommodation process for PWD were: employee communicated request to employer, supportive employer, and cooperation and trust between employer and employee (Nevala et al.,
It is important to describe the experience and process of accommodation for NWD; this can be beneficial not only for NWD but also for PWD in the workforce and healthcare industry.

Support from supervisors and colleagues was a common theme NWD attributed to their ability to accomplish workload in the workplace (Matt, 2008; Neal-Boylan, 2014; Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). Nurses with physical or sensory disabilities worked with certified nursing assistants and paired up with nurses to help with job tasks (Neal-Boylan & Guillett, 2008a, 2008c; Wood & Marshall, 2010). Feeling like being part of a team was reported as a facilitator in the hospital setting by NWD (Matt, 2008). Teamwork in the workplace is known to contribute to job satisfaction and to decrease turnover rates of nurses in hospital settings (Kalisch & Lee, 2011). Teamwork has been researched from nurses’ perspectives but not yet specifically from NWD perspectives.

In May 2012, the U.S. Labor Department’s Office of Disability Employment Policy and the National Organization of Nurses with Disabilities (NOND) signed an agreement to increase the hiring of PWD in the healthcare industry. Persons with disabilities can be an asset to the nursing profession. Retention and recruitment of all nurses in the healthcare industry and nursing profession is imperative. In prior studies, nurses with physical or sensory disabilities were reported as valuable employees by supervisors and colleagues (Kontosh, Fletcher, Frain, & Windland-Brown, 2007; Matt, 2008; Wood & Marshall, 2010), and attitudes of employees toward NWD were more positive with prior experience of working with NWD (Kontosh et al., 2007; Matt, 2011). Nurses with disabilities can potentially better serve patients with disabilities by providing culturally relevant care (Neal-Boylan, Marks, & McCulloh, 2015). This qualitative study is necessary to gain an in-depth understanding of the experience and process of accommodation as perceived by NWD (physical and/or mental) in the workplace.
III. METHODS

Design

Due to limited data on the experience and process of accommodation from the views of NWD in the literature, this preliminary study required further investigation by qualitative inquiry. The basic characteristics of qualitative inquiry are: natural setting, researcher as key instrument, participant meaning, induction, emergent design, and reflexivity (Creswell, 2014). Considering the definitions of disability and accommodation are highly contextual and vary amongst fields of interest, disability is a socially constructed concept (Caldwell, 2011; Greco & Vincent, 2011), and accommodation is embedded in social, historical, cultural and political constructs, the PI chose naturalistic inquiry as the qualitative approach. Naturalistic inquiry is dependent upon context (Erlandson, Harris, Skipper, & Allen, 1993). A researcher using naturalistic inquiry intends to grasp a common meaning of phenomena through shared constructions of human interactions from within natural contexts (Lincoln & Guba, 1985). Naturalistic inquiry is a suitable approach to better understand the context and phenomenon of accommodation in the workplace from views of NWD.

Naturalistic inquiry is rooted in the naturalist paradigm which is based on induction and constructed realities (Lincoln & Guba, 1985). The assumptions of naturalistic inquiry are natural context, no a priori commitment to theory, and the researcher has an interpretive role in the research process. In naturalistic inquiry, the researcher is mindful of fairness “to represent the multiple constructions of individuals” (Lincoln & Guba, 1985, p. 84). The PI approached this naturalistic inquiry through the lens of the researcher, and most importantly through the lens of the participants in the study. Participant meaning is important in naturalistic inquiry. The key design characteristics of naturalistic inquiry are: purposive sampling, natural setting, data
collection via interviews, thick description, authenticity, constant comparison, and data saturation (Erlandson et al., 1993). These design characteristics are described below.

Purposive sampling is a selection of participants who will best help the researcher describe the phenomena of interest. The goal of purposive sampling is to obtain cases that are information-rich for the purposes of the research (Sandelowski, 2000). Purposive sampling is guided by emerging insights, the research problem, and typical and divergent cases (Erlandson et al., 1993). There is no sample size recommended in naturalistic inquiry, more important is the quality of data and how the researcher arrived at sampling and analysis decisions to reach data saturation (Erlandson et al., 1993). Data saturation occurs when no new major themes or constructions are developed or when redundancy is reached (Erlandson et al., 1993).

The human instrument is the primary source of data collection in naturalistic inquiry (Lincoln & Guba, 1985). The interview is the main method of data collection (Erlandson et al., 1993). Interviewing is a dynamic interactive process (Erlandson et al., 1993). Interviews capture social processes, complex phenomena, and human interaction from a natural context (Strauss & Corbin, 1990). Interviews start with basic questions and then lead to open-ended semi-structured questions about issues that need further exploration (Erlandson et al., 1993). Lincoln and Guba (1985) suggest starting with broad icebreaker questions and then proceeding to more specific questions. In the interviewing process, the researcher probes by using reflection, clarification, and requests for examples and descriptions from participants (Jasper, 1994). Probes can be used to gather more information and the interviewer can use silence with neutral reinforcement (Erlandson et al., 1993).

Data collection, data analysis (constant comparison), purposive sampling, and design review continue until the researcher reaches data saturation (Erlandson et al., 1993). In constant
comparison, the researcher simultaneously codes and analyzes data. As each interview is completed, the researcher begins analysis and compares emerging themes with subsequent interview data until themes are saturated. The report is written to tell a story from the perspectives of the participants (authenticity) about their experience of the phenomena in their natural context. The researcher provides thick description in the report by using direct quotes from participants which further describe themes and context.

**Inclusion and Exclusion Criteria**

Purposive sampling is a method of selecting participants who fit the inclusion and exclusion criteria for the focus of the study (Lincoln & Guba, 1985). Inclusion criteria for the study included: (1) RN has a medical diagnosis provided by a licensed health care provider that supports the RN has a disability; (2) RN has disclosed his/her disability to the employer; (3) RN has requested and obtained accommodation for this disability while employed in the nursing workforce; (4) RN has worked with this disability in the nursing workforce at least part-time within the past eight years; (5) RN works or worked in the U.S.; (6) RN speaks and understands English; and (7) RN is 18 to 65+ years of age. The PI chose to include RNs who had worked in the nursing profession within the past eight years since the enactment of the ADAAA; ADAAA (2008) broadens the definition of disability. Registered nurses with mental disabilities were included in this study; persons with mental disabilities were the largest group receiving SSDI in the U.S. in 2013 (McDowell & Fossey, 2015). Registered nurses who self-report a type of impairment such as drug addiction or alcoholism were excluded; no participants reported drug addiction or alcoholism.
Recruitment

The PI obtained approval from the University of Illinois at Chicago (UIC) Institutional Review Board (IRB) prior to recruitment for this study. The recruitment approach was multifaceted. The PI recruited participants by advertising broadly using posted IRB-approved flyers on bulletin boards throughout the UIC medical campus. The IRB-approved email flyer was disseminated on the NOND Facebook website and listserv, and to the listserv of members of exceptionalnurse.com, minoritynurse.com, and Sigma Theta Tau. The IRB-approved email flyer was disseminated to the graduate students of UIC, the UIC College of Nursing listserv, and the UIC Disability and Human Development listserv. The IRB-approved recruitment flyer was posted at Access Living (disability advocacy organization) in Chicago, Illinois and was given to a contact from the Office of Equal Opportunity at Rush University in Chicago, Illinois. The PI also disseminated the IRB-approved recruitment flyer at an ADA symposium conference in Denver, Colorado. The PI ended recruitment when data saturation was reached.

As each participant responded and contacted the PI, the PI verified that he/she met the inclusion and exclusion criteria for the study. Eligibility was based upon self-report by each participant. If the participant was eligible, the PI asked for the participant’s name, address, phone number and email, and scheduled the telephone interview. The PI reviewed the elements of the informed consent form and answered any questions the participant had about the study and eligibility. Upon agreement to participate in the study, the PI mailed each participant the stamped self-addressed envelope with two copies of the informed consent; one consent to be signed and returned to the PI and the other to be kept by the participant. The PI informed each participant that an incentive of either a $20 Starbucks or Amazon gift card would be emailed by the PI after the interview was completed. At the end of the study, an additional $10 Starbucks or
Amazon gift card was sent to participants who reviewed the PI’s emailed findings and replied on whether they agreed with the PI’s summary of the findings (participant verification summary).

**Sample**

The PI interviewed a purposive sample of 21 RNs who met the inclusion criteria. The PI recruited a heterogeneous sample of nurses with various disabilities, ages, and places of employment. All the nurses were female, the mean age was 49.6 years, and most were Caucasian (n = 16). Participants varied in number of years as RN, number of years as RN with a disability, level of nursing degree, onset of disability occurring either before or after becoming a RN, and in work settings (Table I). Participants had various types of physical and mental disabilities (Table II), and came from various regions of the U.S. (Table III). The PI interviewed 27 participants; six interview transcripts were excluded and not used in the final sample and analysis (two nurses were excluded who did not return to work after long-term disability, one nurse who was newly diagnosed with a medical condition and did not yet need accommodation, one nurse who requested and did not obtain accommodation, and two nurses who did not request accommodation from employers). The PI was not able to determine eligibility of these participants until the interview was underway and after reviewing the interview transcripts with the dissertation chair, the mutual decision was made by the PI and dissertation chair to exclude these six nurses. There was one nurse who inquired about participating and met eligibility criteria but declined due to concerns of privacy.

**Data Collection**

The PI collected data using a demographic questionnaire (Appendix A) and a semi-structured interview protocol (Appendix B). The interview questions listed in the interview protocol were based on personal experience, the literature, and with input from the dissertation
committee members. The PI conducted all the telephone interviews (approximately 30-45 minutes per interview), and chose telephone interviews to include nurses from various regions of the U.S. All participants provided written informed consent. At the beginning of each interview, the PI reconfirmed each person’s willingness to participate in the study, and answered questions about the study and the consent form. A digital recorder was used to audiotape the telephone interviews. The interviews were transcribed verbatim by a transcriptionist (rev.com), and double-checked for accuracy by the PI. The PI notified the participant that he/she may email the PI if a new idea came to mind that was not captured during the interview. One nurse emailed additional comments about new experiences of accommodation that occurred in the workplace after the initial interview and these were added to the data and analysis.

**Procedures to maximize data integrity.** As an interviewer, it is important to be a good listener, be courteous, stay within the time frame, adhere to an interview protocol, and thank each participant for his or her time (Creswell, 2013). The PI used an interview protocol (Appendix B). Following Creswell’s recommendation (2014), an interview protocol contains the following: heading (date and interviewee number), instructions, icebreaker question(s), probes, a concluding statement, and a final thank-you.

The purpose of digitally recording the interviews and transcribing the data were to ensure descriptive validity, refer to interview data, and compare and analyze data. The audiotaped telephone interview data were uploaded to a secure digital file on the PI’s computer in the home. A confidentiality agreement obtained from rev.com (online transcription company) was sent to the IRB at UIC. The de-identified digital file data were sent to rev.com. The electronic transcription from rev.com was then uploaded to a password-protected Folder Lock file on the PI’s computer in the PI’s home, and the file(s) were encrypted. The computer did not leave the
PI’s home. The transcripts were double-checked for accuracy and corrected by the PI against the digital file. The PI explained to each participant that identifiable data disclosed in the interview would be removed from the transcripts by the PI. The audiotaped interviews will be deleted after the PI submits the completed dissertation thesis to UIC.

Data Analysis

The PI analyzed the demographic data from the questionnaire using descriptive statistics which included frequencies for categorical variables, and means and standard deviations for continuous variables. Interview data were analyzed using the method of constant comparison. Constant comparison is a method of processing data (Lincoln & Guba, 1985) by comparing data for similarities and differences (Corbin & Strauss, 2015). The elements of constant comparison are: simultaneously collect and analyze data, code and categorize data, write memos, reach thematic saturation, and gain theoretical sensitivity (Strauss & Corbin, 1998; 1990). It is important to mention that the PI is a RN with a disability who is educated in nursing and disability studies at the graduate level. The PI has previously requested accommodation in the workplace for a physical disability. Strauss and Corbin (1990) encourage researchers to gain theoretical sensitivity to effectively engage with the data. The elements of constant comparison applied by the PI in this analysis are discussed below.

Coding is a key analytical process in the constant comparative method (Strauss & Corbin, 1998; 1990). The coding process consists of an interplay of open, axial, and selective coding by the researcher (Strauss & Corbin, 1998; 1990). In this analysis, the PI first listened to each interview, read each transcript entirely, and then began open coding. Open coding is a procedure of analyzing data line-by-line to identify categories, properties, and dimensions (Strauss & Corbin, 1990). A category is a classification of concepts, properties are characteristics of
categories, and dimensions are the range of the property (Strauss & Corbin, 1990). After open coding, the PI began axial coding. Axial coding is a process to determine relationships amongst categories, properties and dimensions, and to code for context (Corbin & Strauss, 2015; Strauss & Corbin, 1990). Strauss and Corbin (1990) describe the characteristics of axial coding as the identification of causal conditions, strategies, context, intervening conditions, and consequences that surround categories. For example, in this analysis the PI identified “self-accommodation” as a theme. Self-accommodation is defined as NWD provide their own informal type of “self-accommodation” without a formal oral and/or written accommodation request from employers. The causal conditions of self-accommodation as reported by NWD were to avoid stigmatization by colleagues and employer, to maintain privacy and job security in the workplace, and because of a prior negative accommodation experience in the workplace. Nurses with disabilities developed intervening conditions to achieve self-accommodation in the workplace such as: use of sick-time employee benefits for time-off, assistance from supportive colleague with specific tasks, develop new way to accomplish job task, modify the workplace environment, purchase adaptive equipment independently, and work in lower-acuity settings. Self-accommodation by NWD in the workplace led to these consequences, either the nurse continued to self-accommodate or eventually had to request accommodation from an employer. This is an example of axial coding from this analysis.

Next, the researcher engages in selective coding, which is the selection of a phenomena around which all categories are related and integrated (Strauss & Corbin, 1990). Selective coding occurs when the researcher develops propositions that connect or describe the relationships between the categories. In this analysis, the PI identified the phenomena of the process of accommodation to depict relationships between emerging categories. The PI
separated the process of accommodation into an actual process and an ideal process and drew comparative visual diagrams on paper and white boards to assist with analysis. Visual diagrams are analytic tools used by the researcher to explain contexts and relationships of categories (Corbin & Strauss, 2015). The PI linked emerging categories into the actual process and ideal process diagrams. As analysis continued, the PI collapsed the most relevant, frequent, and explanatory saturated categories into themes. The PI either accepted or rejected these themes as the analysis continued, and the accepted themes were reconfirmed with subsequent participants. The analysis and sampling continued until no new themes were identified in subsequent interviews (thematic saturation).

During the entire process of this study, the PI kept memos to assist with analysis. Memos are written records of the researcher’s abstract thoughts from the analysis which aid with the development of theory (Strauss & Corbin, 1990). Corbin and Strauss (2015) provide strategies to keep memos organized and accessible: use dates, conceptual headings, keep a research journal (separate from memos), keep memos separate from interview transcripts, record thoughts, use white boards, write memos after each analytic session, and write summary memos periodically. The PI engaged in these strategies and referred to written memos often while transitioning from the descriptive analysis to the theoretical analysis. In the final step of analysis, the PI further synthesized memos in an inductive manner to describe, explain, and compare the relationships of themes from within the actual process and ideal process structures of accommodation. Last, the researcher can propose or hypothesize relationships among themes, find evidence in the literature that supports or rejects these hypotheses, and compare this theory to other theories that may have similar concepts and relationships (Glaser & Strauss, 1967). In the discussion section of this
report, the PI proposed a relationship amongst themes based on the actual process and ideal process of accommodation.

**Trustworthiness and Rigor**

In naturalistic inquiry, trustworthiness is achieved by examining credibility, transferability, dependability, and transparency (Lincoln, 1995; Lincoln & Guba, 1985). Credibility in the qualitative research process provides truth-value to the data and interpretations. Constant comparative analysis serves as a tool to maintain credibility by simultaneously collecting, analyzing and introducing emerging categories and themes in subsequent participant interviews. The PI used several strategies to establish credibility and rigor in the data analysis: peer review and feedback from the dissertation chair (investigator triangulation), two investigators (PI and Dr. Beth Marks) reviewed de-identified data independently and compared codes and themes (analyst triangulation; inter-coder reliability), a participant verification summary was emailed to all participants and they all agreed with the PI’s summary of the findings, themes from the PI’s analysis were confirmed with themes in the literature, and with applicable theory in the literature (theoretical triangulation).

In this study, the PI disclosed her disability to each participant at the start of each interview. To enhance credibility, the PI incorporated bracketing as a strategy to examine the role of the researcher. Bracketing requires the researcher to describe one’s experience and views with the phenomena and bracket these data prior to conducting interviews with participants (Creswell, 2013). This PI documented her perspective on the phenomena of disability and accommodation prior to and during phases of data collection and analysis. The PI kept an online diary. The diary is a reflexive journal where the researcher records notes about the self and the method (Lincoln & Guba, 1985). The PI documented her experience on the process of
accommodation in the workplace (barriers and facilitators), and her understanding of the concepts of disability, accommodation, and the ADA in the online diary. The PI recorded written thoughts and emotions, and emerging insights in the diary during the research process.

Transferability is how the results of the study can be applied to other situations and contexts. The researcher needs to be explicit on how the thought process led to the result (Maz, 2013). Transferability is established by using thick description. The PI provided demographic data from participants, data on the characteristics of the contextual settings, direct quotes from participants in the findings, and an understandable dissertation report for lay audiences and experts.

Dependability refers to the inquiry process being consistent, reliable, and replicable over time. The PI maximized dependability by using an interview protocol, digitally recorded the interviews, double-checked verbatim transcriptions, and established inter-coder reliability. The PI and dissertation committee chair and advisor (Dr. Teresa Savage) independently coded transcripts and agreed on coding and initial categories from six interview transcripts at the start of the analysis. Inter-coder reliability was determined by the PI and an outside member of the committee who is a nurse and disability expert (Dr. Beth Marks); two of the interview transcripts were not reviewed by Dr. Marks due to confidentiality concerns. To confirm inter-coder reliability, the PI and Dr. Marks first coded interview transcripts independently and then met in-person to reconcile these differences until inter-coder agreement reached 88%. Eighty-eight percent is acceptable, as Miles, Huberman, and Saldaña (2014) suggest that inter-coder agreement should aim to range between 85% to 90% during initial phases of analysis. Dr. Marks also reviewed and agreed with the PI’s final analysis of the findings and themes.
Transparency refers to the visibility of the research practices. Procedures and procedural decisions need to be stated clearly so that readers can conduct a similar study, and to aid readers in determining how well the researcher followed the stated procedures (Lincoln, 1995). The PI saved a paper trail of visual diagrams at different stages of the analysis which display how the themes from the data were constructed. The PI also kept an audit trail in the online diary with a record of methodological decisions that explain the rationale of procedural decisions. A researcher should keep an audit trail such as an explicit presentation or diagram of the results that accounts for methodological decisions, interpretations, and investigator biases (Whittemore, Chase, & Mandle, 2001). The results of the study are discussed in terms of contribution to the literature and advancing the science (Lincoln, 1995). The PI clearly stated procedures, findings, limitations, contribution to the literature, and how the research study advanced the science of nursing.
IV. RESULTS

The major aims of this study were to describe the experience of accommodation, the process of accommodation, and how to best facilitate an ideal process of accommodation in the workplace from the view of NWD. The nurses described their actual experience and process of accommodation, and were asked to describe an ideal experience and process of accommodation in the workplace. The PI identified 11 themes from the data on the actual and ideal experience and process of accommodation as reported by NWD. The PI found that nurses with physical and/or mental disabilities reported similar experiences of accommodation, and responses from participants about teamwork as an accommodation were slightly variable. The results are reported in further detail below.

Actual Experience and Process of Accommodation

Nurses were asked to describe their actual experience and process of requesting and obtaining accommodation in the workplace. The seven identified themes of the actual experience and process of accommodation were: self-accommodation, self-advocacy, inevitable to request accommodation, lack of process, resistance to accommodation, complaisance with accommodation, and disability identity. Each of these themes are discussed in more detail below.

Self-accommodation. Nurses used the term “‘self-accommodation” to describe when they provided themselves with their own informal type of accommodation without a formal oral and/or written accommodation request to their employers. Nurses feared that requesting accommodation from employers would threaten their chance of being hired or staying employed. Nurses provided examples of self-accommodation in the workplace such as: using sick-time from employers when the symptoms or the condition of the disability worsened, asking for
assistance from supportive colleagues, independently developing new ways to accomplish job tasks, modifying the workplace environment themselves, and by purchasing adaptive equipment on their own. Self-accommodation was described by a nurse with hearing loss employed in a school setting prior to requesting accommodation:

   I bought myself an amplified stethoscope. I was very self-sufficient and independent. I didn't want to ask people [employer] for anything that I could manage without asking. I moved my own chairs and tables around the classroom. I didn't ask anybody to arrange things for me. It was just easier for me to adapt than it is for them [employer] to accommodate.

Many nurses preferred informal self-accommodation without disclosure due to concerns of being stigmatized and loss of privacy. Nurses did not want to be “looked at differently or treated differently” or be perceived as “asking for too much or receiving special treatment” by employers, supervisors and/or colleagues. A nurse with Chronic Fatigue Syndrome (CFS) stated, “I think the stigma associated with an invisible disability is really a major player in people not asking for accommodation.” Stigmatization was a major reason why a nurse with vision loss quit her job to pursue self-accommodation in her current position after obtaining a less than reasonable accommodation in her prior position.

   I am pretty much now self-accommodating. I don't request anything. I'm in a new job now. I had to leave that [prior] job. It was very stressful and I was treated differently [after disclosing]. I know what programs I need and I can buy them myself.

Other nurses described self-accommodation as finding a different nursing job in their current or new workplace that was more compatible with their disability. Nurses returned to school or looked for nursing roles and workplaces where they could self-accommodate, work in
lower acuity settings, and/or feel valued as NWD. The acuity of patient care was posing a challenge for a nurse on a labor and delivery unit and she commented, “I left the patient care area because I didn't want to make an error or cause harm to any of the patients that I care for. I obtained my masters in nursing education and I became an instructor.” The lack of feeling valued by her employer was a concern for a new nurse with ADHD who had to quit her job due to difficulty with workload and performance. She remarked on what she was seeking from a new employer:

I guess finding some place [of employment] where you feel like they're [employer] going to care about you as an employee with a disability which I think is kind of hard sometimes. Investigating how much do they [employer] care about disability, employee evaluation and employee retention.

Many nurses in this study were either using self-accommodation in a new job because of a prior negative disability and/or accommodation experience or using self-accommodation in their present job until it became unmanageable without requesting an accommodation.

**Inevitable to request accommodation.** For many nurses, a request for accommodation from employers was inevitable because the disability became unmanageable in the workplace. For example, nurses stated the disability was interfering with their ability to perform the essential functions of the job, their strategy of self-accommodation was no longer sufficient, their disability could no longer be hidden, and/or when nurses were concerned about the disability affecting the care of patients. When a new computer software program caused the words to appear smaller on the computer screen at work, a nurse with a visual impairment described how she felt “forced” to disclose and request accommodation:
I didn't decide [to disclose], it just happened because I needed something [an accommodation] to do my job. I have a visual impairment and I couldn't see. I needed a larger screen to see [the words on the screen]. I requested a larger monitor and a program called Zoom Text which is an assistive software.

Nurses were required to disclose to supervisors and Human Resources (HR) to receive medical leave such as Family and Medical Leave Act (FMLA), short-term disability, and/or long-term disability employee insurance benefits. These requests for leave were often precipitated by events such as the symptoms or the condition of the nurse’s disability worsened. Disclosing was inevitable for a nurse who described how she could no longer perform at work because of her worsening depression and anxiety:

It was scary. Because I was at a stage where I didn't have a choice. I was so sick that I had to take time-off from work. And especially with it being a mental illness, it was hard for me to even put into words or explain to my boss because there were certainly parts of my illness that were very personal to me and I did not want to disclose. I guess for the fear of not having my job be secure. I know FMLA is in order but people talk and there are rumors. The FMLA protects your job but as far as your working environment, people might not understand my disability or be as welcoming back when I come back from time-off. Or they may feel differently; feel like I'm taking advantage or asking for special treatment because of my disability. So, that was scary for me when I disclosed.

Nurses also requested accommodation when they felt the disability was affecting their job performance. Two new nurses stated they waited too long to request accommodation in the workplace and both had to quit these jobs due to performance issues. A nurse with dyslexia, who chose to hide her disability because of a prior negative job experience, disclosed in a
meeting when she received a poorer job performance review from her supervisor than she expected. Nurses expressed that they waited to request accommodation because they were afraid, embarrassed, apprehensive, and concerned about how employers and colleagues would react to their disability and need for accommodation. Most nurses approached accommodation with a “reactive approach” by requesting accommodation when they encountered problems in the workplace.

**Self-advocacy.** Participants consistently reported “self-advocacy” (advocating for oneself) was important in the process of accommodation. Nurses educated themselves on the ADA and joined online disability organizations for knowledge and support. They mentioned advocacy organizations such as NOND, Job Accommodation Network (JAN), YES! program (dyslexia), ADD.org, (Attention Deficit Disorder Association), the Hearing Loss Association of America (hearing loss.org), and EEOC.gov. They also researched various types of accommodation available for persons with similar disabilities. A nurse with ADHD stated how and why she was a self-advocate, “I started doing more research, I joined organizations, and I kept advocating. Then my son was diagnosed with ADHD so it made me want to advocate even more. Now I openly disclose.”

Nurses collaborated with various professionals in departments such as information technology, occupational therapy, physical therapy and speech therapy to assist with accommodation requests. The unique accommodations nurses with Attention Deficit Hyperactivity Disorder (ADHD) mentioned were as follows: request the unit-secretary to provide hand-written sticky note messages to nurse, audio-record patient assessment and shift nurse-to-nurse report, use a timer in the workplace to stay-on-track, and use a private place to chart with fewer distractions. Nurses with hearing loss mentioned utilizing appropriate
technologies such as captioning, electronic documents, webinars, dragon computer software, and amplified wireless microphones. Many nurses exemplified self-advocacy by researching and developing a written list of accommodation options to present to their employers prior to pursuing an accommodation request from their employer. This nurse described her process of providing a written list to her employer:

I planned a list of things. I did some research. I went to the JAN website, and there is a big list [of accommodations] for people with disabilities. I went to them [HR/manager] and wrote down things that work for me and then we sort of went from there.

**Lack of process.** Most nurses reported there was “no process” in the workplace that described how to request accommodation. Nurses revealed it was difficult figuring out what to do and who to contact to initiate an accommodation request. They described procedures as “unclear, vague, and untimely.” Nurses often waited several months before obtaining accommodation; one nurse waited two years. They stated there were “loopholes” in communication and too many persons involved; nurses met with managers, supervisors, HR, occupational health, and primary healthcare providers at various stages from requesting to obtaining accommodation. Some nurses with visible disabilities, such as amputation and profound hearing loss, were uncertain as to why they needed documentation from a healthcare provider stating they had a disability. A nurse with a profound hearing loss who worked in a school setting shared her thoughts on the lack of process and obtaining a doctor’s note:

I just asked for a room that I can hear in and to do that I had to disclose that I had a disability. In fact, I went to the person who handles the students’ accommodations and this person told me I had to go through HR. I went to HR and they told me I needed a
note from my doctor which to me was absurd. I've been living with this for several years.

I had to have a doctor's note which I did get.

Depending on the type of disability and to determine the type of accommodation that was needed, nurses contacted persons within and outside of the workplace such as a rehabilitation case manager, long-term disability liaison, disability counselor, JAN, and NOND. Some nurses who experienced problems with obtaining accommodation followed the chain-of-command in the workplace to negotiate and mediate a reasonable accommodation. Others required involvement from the EEOC, lawyers, JAN, and NOND for support and legal advice. The Equal Employment Opportunity Commission was asked to be involved when an accommodation request was determined unreasonable by an employer due to safety concerns. The nurse spoke about this experience:

Originally HR had said, ‘This was a safety issue.’ The person from the EEOC said, ‘You can't have a safety issue unless you have somebody come in and evaluate her [NWD] for a safety issue. You [HR] can't just use that terminology [safety issue].’ I filed a charge against them [employer] for discrimination, ultimately got a lawyer and that continues to play out. It's turning into a big deal. For the EEOC to get involved, it's so helpful. If I did nothing else, I'll help the people [PWD] that come behind me.

Communication was ineffective because nurses were excluded from employer discussions and decisions about accommodation. For example, a nurse who requested to use a manual wheelchair on a hospital unit explained:

First, the manager was involved and then the Director of Nursing, and then it was Environmentalist Safety. But I know that it went above my manager, to her director, and then somewhere else to talk the logistics [of using my wheelchair on hospital unit]. It
then went to the top. It was somebody in our legal department that looked at this. It would have been nice to be able to get all those people together on one page, rather than piecing it all together and me not knowing what was going on.

Most nurses (n = 16) who worked in larger institutions such as universities and hospitals reported that procedures to request accommodation were “confusing and inefficient.” They had difficulty locating required forms for initiating a request and forms were lengthy and incomprehensible. Faculty members with disabilities in school settings reported students with disabilities had better access to accommodation resources than faculty members. Some nurses reported accommodation procedures were more difficult in the workplace than the school setting because a disability counselor and/or disability department worked and communicated directly with nursing students with disabilities. Two nurses new to the profession expressed that they did not feel they had the same type of support in the workplace as in school, and their supervisors and HR departments in the workplace were not as knowledgeable on disability or accommodation. Process, policy and procedures of accommodation were lacking in the workplace.

**Resistance to accommodation.** Nurses described employers as being “resistant” to providing accommodation. Nurses stated employers were more concerned about cost of accommodation, patient safety, and the nurses’ ability to do the essential functions of the job. A nurse with a vision impairment spoke about *not* obtaining the accommodation she requested due to cost:

First, it [accommodation] was difficult because the program [assistive computer software] was expensive and they [employer] didn't want to buy it, and I had to go through about four or five different channels to get it. And then I didn't get it. They [employer] ended
up contacting an IT [Information Technology] person to show me how to manually blow
up text on the computer, but it didn't work with all components on the computer, like the
internet.

Another nurse who tried to maintain her role in the operating room (OR) was denied by
her employer because of a lifting restriction (essential job function) and patient safety concern.
She discussed the interaction she had with her supervisor and HR about job-sharing with a
colleague as an accommodation in the OR:

I was answering the phone basically and coordinating movement of patients to the
operating room. At one point, I requested to be in charge three days a week because this
other girl and I were doing a job-share, so I could continue doing this [working in OR].
The next day my boss called me in with HR and said that I could be a staff [nurse] three
days a week but I couldn't be in charge because I couldn't bring patients back from the
waiting area.

Nurses were strongly encouraged by employers to relocate to a different job and/or
department that was more suited to their disability as an accommodation. Most nurses were
asked to relocate because they either acquired a disability while employed or their disability was
progressively worsening. A nurse who resumed work one-month after her first Chronic
Obstructive Pulmonary Disorder (COPD) exacerbation was told by HR, "Well, I don't know
what we can do. Have you thought about doing something different?" Her proposed resolution
of working from home with a 10-pound lifting restriction was met with indifference:

It was kind of a drawn-out process, and I think that was somewhat intentional on the part
of the company because there was some lack of understanding of the law [ADA] and of
what I needed. There was also a reluctance on their part to do it. Again, they wanted a note from the doctor. Essentially, I feel like I had to educate them on the ADA a little bit as part of the process.

Nurses described that employers often determined reasonable accommodation based upon what was best for the employer without consideration of the nurse’s strength, ability, and value as an employee.

**Complaisance with accommodation.** Some nurses were complaisant with an unreasonable accommodation provided by employers. Nurses “settled for less” due to concerns of job security and stigmatization. An employer did not set-up an accessible bathroom for a nurse who used a wheelchair and she explained why she just accepted it:

I did request that the larger bathroom down at the end of the hall would have been adapted better but that never was set-up. They [employer] put a grab bar in for me, but if anybody would have looked at that bathroom, they would have been cited on it [for not being ADA compliant]. I think maybe if I had been more open and expressed what I needed at the onset, I don't know, maybe all the years I just sort of dealt with it. I got complaisant. As an individual, you come to the point and decide, how much you're going to invest in this fight and whether it's worth it. You get to the point where you try not to make a lot of noise. You don't want to be looked upon as a troublemaker.

Excerpts from nurses that demonstrated complaisance included, "I did not have the energy; physical or mental energy to be assertive and stand up for myself. I think persons with disabilities need classes and scripts available for being assertive and empowered.” Another commented on being complaisant due to concerns of job security:
I guess there's a fine line of figuring out exactly what you need and then what is more beneficial, and you just kind of go with the bare minimum, because you are afraid that they're [employer] not going to want you anymore.

A nurse with hearing loss who was still using a voice telephone after several months in a hospital medical-surgical unit said, "We [employer and myself] are still working on the best option. If I had to pick, I would prefer everyone to text or page me. I don't like talking on the phone at all. It's hard for me to understand." Another with hearing loss who worked at a university stated, "I was an advocate for students who had hearing problems. I prompted the situation to accommodate students when they [employer] should have been doing that all along. I wasn't as assertive for myself, that's the deal." In hindsight, many of these nurses expressed they should have been less complaisant and more assertive.

**Disability identity.** Nurses with disabilities had varying perceptions of how they identified with disability, and this impacted the process of accommodation. Some nurses were apprehensive while others were more comfortable and assertive in the workplace. A few described themselves as being “lucky” or grateful to be employed. Different approaches to requesting accommodation were influenced by disability identity as described by this nurse with an amputation:

I think people need to learn to be more assertive when they need an accommodation. For example, when I asked, ‘Where's a restroom I can use?’ And the response was, 'Well, this building that's a block away.' And I think, ‘So I guess I won't drink throughout the day so I don't have to go to the bathroom.' That was stupid on my part. But I think when people have a disability, there are several schools of thought. Because of your disability, you don't want to be a burden, you don't want to have accommodations that are above and
beyond what you need. And there are other people that are much more aggressive to the point where they're assertive and aggressive in making sure they have their accommodations. And unfortunately, I was in the first group where I asked and I just accepted the answer and that was stupid.

Some of the nurses’ perceptions varied based on the number of years they worked with their disability. Over the course of her 10-year career as a nurse, she described how her attitude toward disclosure and accommodation changed:

When I first started [nursing] it was extremely difficult [to disclose]. Now I tell it to them [employer] and I don't care. I am who I am, and you [employer] either can accept me and try to accommodate me or you can't. Initially, in nursing school, it was slightly challenging. It was not challenging in my first job, but in a few subsequent jobs, I was very afraid [to disclose].

This nurse described how a person who is diagnosed with dyslexia at an older age may approach accommodation differently than someone who is diagnosed at a younger age:

The kids [with dyslexia] that have always been accommodated [in school] have just started graduating college. They were diagnosed when they were learning to read, they asked for accommodations, and they've been accommodated. The difference is, those new nurses know how to advocate for themselves. I graduated grammar school, was pulled out of reading classes, and nobody knew what was going on. I didn't even get my diagnosis until I was an adult.

Some participants expressed how being in the nursing profession affected their own view of disability. This nurse spoke about the challenges of identifying as a nurse with a disability:
The whole thing with nurses is a lot of us have a difficult time when we are the patient. When we're the ones with the difficulties, it is very hard to cross over into that world of sick people.

As her vision worsened, another participant spoke about what it was like when she first self-identified with disability and how others challenged the legitimacy of her being a nurse with a disability:

Disclosing my disability was for me personally very difficult. One, because it requires that you admit that you have a disability. So, disclosing it was very difficult for me and depressing because I had to deal with that. And then once I disclosed, some people asked, ‘Why are you a nurse? I mean, what can a blind nurse do?’

Disclosing may be associated with a negative image of a “professional” nurse per this participant:

I just decided that at this point in my career that I won't disclose because it makes things work better. Because like I said, as you disclose, people change and they start treating you different. And I don't want that. I want to be recognized as a high-quality nurse who is professional, who can get the job done and is excellent. And disclosing would disrupt that.

The expectation of nurses in the workplace also posed challenges for NWD. Participants reported the workload for a nurse with or without a disability was unrealistic. They used terms such as “superwoman syndrome, the sink or swim unit, and publish or perish” to describe nursing. Workplace conditions were described as too strenuous:

I didn't eat for those 12 hours; I didn't take my break. The turnover rate down there is horrific. I received a half-day of training and then they [employer] put me on the floor. I
was working sometimes 60 hours per week. I felt like even taking away the disability piece, they [employers] were asking too much of one person.

**Ideal Experience and Process of Accommodation**

Nurses were asked to describe an *ideal* experience and process for requesting and obtaining accommodation in the workplace based on their actual experience, and to describe how NWD and employers can best facilitate an ideal process of accommodation. The four identified themes were: openness, employer advocacy, streamlined process, and employer accountability. Each of these themes are discussed in further detail below.

**Openness.** Even with concerns of discrimination, nurses felt that it was important to be “open and honest” about their disability with employers, supervisors, and colleagues. They recommended that NWD disclose and request accommodation *after* the interview process, know the rights as an interviewee with a disability, and assess the job before requesting accommodation. As one participant simply stated, “You can’t get an accommodation unless you ask for one.” Nurses with visible disabilities (spinal cord injury and amputation) were open, but most nurses with invisible disabilities only disclosed to request accommodation. Two nurses with invisible disabilities (vision loss and hearing loss) who disclosed during the interview process and shortly after being hired, regretted their decisions because they were either not hired or forced to resign. Two new nurses with invisible disabilities (ADHD and dyslexia) who waited too long to request accommodation were forced to quit by employers due to performance issues. Two nurses (major depression/anxiety and spinal cord injury) who reported more positive seamless accommodation experiences had supportive supervisors and colleagues, and worked in departments with fewer employees. Being prepared and straightforward with an employer was advised by this nurse with a hearing loss from a school setting:
If you have a hidden disability, I think going to a supervisor and talking about it with the doctor's note in-hand might be the best way to go about it because otherwise you're just up against barriers and you might have to keep going back to fulfill whatever they [employer] ask you to fulfill.

For NWD to be open and honest, they proposed employers create a more welcoming and safe environment for NWD where they feel unthreatened to discuss accommodation. One nurse reiterated, “I guess the ideal process would be one where you felt comfortable asking for it.” Participants suggested that employers initiate and open the discussion on disability and accommodation with *all* employees. Being open and honest was a way to break down barriers for a nurse with hearing loss:

I prefer to disclose if I can, if I'm not threatened in some way. I think telling people is the best way to have understanding, otherwise you're hiding something and you're just putting up a barrier yourself. If you can disclose, I think it's probably the best way to get people to work with you.

Another nurse with hearing loss stated why it is important for her to disclose:

During those years, I learned a lot about advocating for myself. I learned that if I don't disclose I'm doing everybody a disservice. I tell people and I tell my classes. All my colleagues know because otherwise they don’t know how to communicate with me.

Disclosing sooner may have prevented this nurse with dyslexia from being forced to resign:

Once I did disclose, it wasn't like…let's see what we [employer and I] can do and have a conversation. It was kind of like, I disclosed a bomb and everybody went into recovery mode. If there's anything, I would have disclosed a lot earlier, and let them [employer] know what was going on so we could have worked at it from the beginning.
Employer advocacy. Nurses suggested that employers be more flexible and creative with accommodation requests and to consider NWD as valuable employees when making decisions on accommodation. Some NWD were unable to return to work in the same position after acquiring a disability. These nurses felt that they could have stayed employed in the same department with a different position if the supervisor and HR had advocated more for them or had been more flexible with essential job functions. This nurse provided an example of employer advocacy:

Not you [the employer] telling me what I can do, we [employer and myself] can work on this together rather than me individually trying to make it work. I think that would have made me feel like they wanted me and they're fighting for me rather than me having to fight to get what I want.

Nurses expressed that employers should be less resistant and objective when hiring and providing accommodation, and be more open to “trust” that NWD know their capabilities. Nurses were impacted by lifting as an essential job function in this study (two nurses were almost not hired, one was encouraged to relocate to a different department, and one sued her employer and transferred to another department). A lifting restriction (essential job function) and inaccurate job description almost prevented a nurse from being hired as a case manager. She thought her employer could have been more flexible and less objective when evaluating her for the physical requirements of the job:

The only problem I had was when occupational health looked at the requirements for my job title. They said they didn't match and that I had way too many restrictions. They [HR] should make case management a different requirement instead of the straight nursing [requirement]. It [case manager] should be considered sedentary. Yes, there are
restrictions I have but I feel I'm confident I can do this job. I think that there should be more flexibility based on how the person feels they can do the job. If you tell them [employer] you can do the job, ‘How can we [employer] help you do the job’ should be their question… not, ‘No, you can't do the job, you have too many restrictions.’

**Streamlined process.** Based on their actual experiences, NWD had suggestions on how to “streamline” the process of accommodation. They recommended employers and nurses document the entire process and suggested a “liaison” (exclusive of HR or a supervisor) to be designated to lead the process of accommodation. The “liaison” can coordinate meetings with the NWD and necessary “multidisciplinary team members” to determine the most reasonable accommodation. Ideally, the “liaison” would act as a “mediator” or “bridge” between the supervisor and NWD and should be knowledgeable on nursing, disability, and accommodation.

Many nurses suggested a “disability specialist” (i.e., universities) or a “nurse case manager.” Nurses also recommended being paired-up with a “mentor” to assist with the process such as another employee with a disability who is knowledgeable on the process. This nurse explained why she thought a “mentor” and liaison were necessary similar to how students receive accommodation in school settings:

I wasn't allowed to work with the same people who are experts in [providing] accommodation for students because I'm an employee; it should be the same for faculty. I had to go to the human resources person. She wasn't a specialist in accommodation, she was a specialist in keeping the institution from getting sued. You [NWD] need to have access to the [disability] specialist, whether you're a student or whether you're an employee. I need somebody to be an advocate. I need somebody to empower me and point out to me when I'm not standing up for myself. I think it would've been helpful to
have a mentor. At our college for disabled students, they [students] have their own [disability] department. They have their own mentors. They had their own case managers that follow them through and make sure they get the accommodation such as wide seats in class, someone taking notes for them, and extra time for exams. I think we need somebody [disability specialist / case manager] like that for employees.

Nurses offered suggestions on how to simplify and make procedures more “accessible” and “efficient” for requesting and obtaining accommodation. Below are the findings on how to “streamline” the process per NWD:

I think ideally there should be something in the employee handbook that doesn't state the whole law [ADA] but that gives a synopsis of… This is what employees need to do if they are disabled or if they become disabled during their employment here. Here's the form you need to fill out to get the process started.

Another nurse commented:

I guess large institutions have a lot of bureaucracy and so the fact that you [NWD] must go through HR is difficult. Here we have a Title IX coordinator who is also the person responsible for disability accommodations. This is new. I think having this person makes a difference because if you have a point person who knows how to do things, who knows the law, and probably the process is a lot smoother than just going to a HR department and just getting whoever is there to help you.

Another nurse reiterated:

There should be a clearly identified step-by-step process. It should be given to every employee, not just to those who have a disability because you never know when it [acquiring a disability] is going to happen. Some HRs have websites and the web
linkages need to be made that are very clear. Forms need to be very easy to fill out.

They [the forms] were worded in such way that even my physician had trouble figuring out what to put in some of the spaces.

Nurses also voiced that the process of requesting and obtaining accommodation should be a negotiation between the employer and employee. An ideal process was described as a “two-way conversation that allows brainstorming and bringing in outside resources.” A scenario of a negotiation between a supervisor and employee was exemplified by a participant:

I think you [NWD] should go to your supervisor and say, ‘I need an accommodation.’

The person [supervisor] should ask you what kind of accommodation you need and I think it should be a negotiation. It depends on the extent of whatever it is, whether it's the ideal accommodation or if it's something a little bit less, but it works in the end. I think the goal is to be able to do the job. It needs to be you and your supervisor and frankly I don't like having to go to another department like HR. I think it should be confined to you and your supervisor.

A “trial and error” approach to accommodation was also proposed:

I would tell someone [NWD] that go into the conversation with your employer with an open mind, start that conversation, and be flexible. Know that we [myself and employer] won't know exactly what is needed from the very beginning but have a little trial and error period.

**Employer accountability.** Participants voiced that employers need to be more accountable to employees and be held more “accountable” to comply with the ADA. Nurses advised that employers, supervisors, and employees receive more education on disability,
accommodation, the ADA, and cultural awareness in the workplace. Providing education to staff to promote disability awareness was this nurse’s graduate school project, she explained:

My hospital project was basically a hearing-impaired access program for the hospital to help people understand the needs of hard-of-hearing and deaf patients. I did this in-service to educate all the staff, whether it was nurses, therapists or physicians, about this program.

Nurses proposed employers engage in a more “proactive” approach versus “reactive” approach to disability and accommodation for NWD. Being proactive prior to taking leave for a known surgery may have been helpful for this nurse who stated:

I think most of the time employers don't think about accommodations until they must and so it's a reactive approach rather than a proactive approach. And there are a variety of reasons for that. You don't construct a work environment based upon potentially one person. Buildings have been in existence for 40, 50, and 60 years. You can't just tear them down and rebuild them. But I think if it was a more proactive [approach] before I left for the surgery ... It would have made me look at the policy and think, ‘I never thought of that. I never thought about where I’d go to the restroom. I never thought about some offices here that I can't even get into because the doors are too narrow. And don't ask me why they're narrow, but they're narrow.’ But it would have allowed me to think about what accommodations I need, rather than just showing up to work and going, ‘Well, I'll figure it out when I get here.’

Simple thoughtful gestures such as reserving a space at a table for a person using a wheelchair, or providing captioning for someone with hearing loss in a meeting were important for NWD. A simple gesture resonated with this nurse:
I just went to a conference that was the first one I've been to that had a sign when you walk through the door that said, ‘The first-row seats and tables are reserved for those who are physical, hearing, and vision impaired.’ For the first time, I didn't have to get there early and fight for a front row seat.

Nurses provided several examples from actual experiences that were indicative that accountability was lacking and education was necessary. A director pressured a nurse with a seizure disorder to sign paperwork:

The director stated, 'I want you to sign this paperwork saying that you'll never do floor work again.' I said 'No, I'm not going to do that.' The director said 'Yes, you are.' I said 'No, I'm not.' The director was pushing me hard. It made me very uncomfortable. At the point where, at that hospital, I'll never be able to work a floor job again. That's the part I miss, is working hands-on with patients.

A director and HR unexpectedly asked a nurse to attend impromptu meetings about accommodation:

It was individual meetings with usually me, the director of the unit, and human resources, always two against one, there would be nobody else in [meetings] on my side. It always felt like it was two against one. They wouldn't give me any warning ahead of time.

A nurse with a hearing loss felt discriminated against by her employer after requesting accommodation:

A few weeks after I started the job, it was at a clinic and I had to place high volumes of calls over the phone to the pharmacy, and I requested for accommodation for the phone. The director of HR wanted to know why I did not disclose on the application and I told the director that it is not mandatory for me to disclose. The director was upset. They
[director and HR] were going try to work with me and after a month they let me go; they said that it was for performance. I would advise [NWD] during disclosure to make sure you record, make sure you have copies of the email, and make sure that you document everything that happened between the employer. Because sadly I was discriminated against.

Another nurse felt discriminated against in the interview process:

I interviewed at a different hospital and was offered a position. I had disclosed at that interview and asked [about accommodation] when they offered the position. They were wishy-washy and eventually gave away my position without telling me, when I had asked over and over to sign the papers to be officially hired and have a conversation about these accommodations. When I interviewed at my current position, I did not disclose until after I signed the official papers. When applying for a job, most places state that if you disclose your disability, they won't use it against you… I don't believe that is true. I believe that organizations usually pick able-bodied people over those who have disabilities. In an ideal world, disabled people would not face discrimination in the application and interview process.

An employer provided a ramp that did not seem to be up to ADA standards nor safe:

The indoor ramp that connects the buildings; it’s so steep. I can’t remember what the grade is but I cannot walk up it with a walker. I can with the wheelchair. It’s hard work but I can. And this is where sometimes it’s frustrating.

Employers reduced two nurses work hours unknowingly which affected their insurance benefits; one of the nurses had been working at the hospital for over 20 years. These nurses expressed concerns that employers may have been trying to “force” them out of their jobs.
Nurses voiced that employers need to be more accountable and be held more accountable by the U.S. federal government. They reported employers need education to change their perspectives on how they approach hiring and accommodating NWD. Below are excerpts from NWD that described how employers can be more accountable:

I think if your HR person, it's not just your interviewer, but your HR person is fully versed in the ADA. The HR person knows what the definition of reasonable accommodation is and is not afraid to ask those personal questions like, 'What can we do for you to make you most successful at this job?' Not to be afraid to ask that and not wait for the employee because it's intimidating to reveal a private part of yourself to an employer.

Another nurse said:

I've read literature and it's the employer's job to let you know that you can request accommodation at any time, and they should give more opportunity during different times of your employment to let you know that it's okay to request them. Even having inserts about that for people and to let everybody [employees] know that workplace accommodations are normal and that the government says it's a legal responsibility that we [employer] must do.

Another stated:

Include the concept [of disability] in employee education. It would be nice if the university includes a module. You hear about how you should include all races, genders, and disabilities but there's nothing explicit. I know as part of the management training that I have had, it was very much explicit that employees and managers know what the
process is at our institution. I think continuing education related to each specific institution [on disability and accommodation] would be a great idea for everyone.

**Comparison of the Experiences of Nurses with Physical and/or Mental Disabilities**

In this study, more nurses had physical disabilities than mental disabilities (Table II). Overall, nurses with physical and/or mental disabilities had quite similar reports of the experience and process of accommodation; differences were more evident amongst nurses with visible and invisible physical and/or mental disabilities. The types of invisible mental disabilities reported by nurses in this study were: ADHD, dyslexia, major depressive disorder / generalized anxiety disorder, and Post-Traumatic Stress Disorder (PTSD). The types of visible physical disabilities in this study were: amputation, profound hearing loss, muscular dystrophy, neuropathy, and spinal cord injury. The types of invisible physical disabilities in this study were: chronic fatigue syndrome, chronic obstructive pulmonary disorder, hearing loss, heart condition, seizure, traumatic brain injury, and vision loss.

The common theme reported by nurses with invisible physical and/or mental disabilities was they felt *stigmatized*. Nurses were surprised at the difference in treatment by peers and supervisors before and after disclosure. They felt they were perceived in the workplace as being “lazy, slow, dumb, not a team player, crazy, and all in your head.” A nurse provided a vivid explanation on why she thought persons perceived her as “dumb”:

People who are hearing-impaired and wear hearing aids process slower. Because it's an artificial transmission, your brain responds slower. ‘No, you're not brain damaged,’ the [neurologist] said, ‘Your auditory processing is slower.’ Accommodation to me means that people should know that I'm not dumb and that's a big thing. People think I'm dumber and slower mentally and cognitively but it's just because of my hearing loss. The
other thing I've discovered is that some people who are hearing-impaired have noise sensitivity. The noise level is painful.

Nurses reported that employers and staff need to be more educated, sensitive, and supportive toward persons with invisible disabilities. These nurses want to be “treated the same” as other nurses with visible disabilities in the workplace. A nurse with Chronic Fatigue Syndrome (CFS) stated:

CFS is like an invisible disease and people usually just kind of roll their eyes and say, ‘Oh yeah, I was tired. Yeah I was tired!’ There's such stigma about it just being all in your head and that part was difficult. Because I was fearing what people would say and think about me.

Another nurse with traumatic brain injury stated, “I have to make my pitch again for invisible disability. People really need to be aware that it is just as devastating to people's lives as disabilities that you can see.” A nurse with hearing loss felt colleagues doubted her audible assessments:

I was confident I heard crackles in the lower lobes of a patient’s [lungs]. I asked another more experienced nurse to listen just to be sure. She said she didn't hear any crackles at all and what I heard must of been from my ‘fancy stethoscope.’ The tone in which the words ‘fancy stethoscope’ were delivered was with condescension.

Nurses with invisible disabilities described colleagues as being apprehensive and resistant toward less tangible accommodation requests because colleagues were unaware of their disabilities. Instead of requesting equipment or physical environmental modifications, these nurses requested accommodations such as flexible scheduling, modified training, concrete job descriptions, no floating to other units, switching to a unit with lower acuity and more structure,
an open-door policy to speak with the supervisor, and consistent patient assignments when working consecutive shifts. Colleagues were not pleased when a nurse with ADHD requested *not* to float because of her disability. She explained that colleagues perceived her as receiving “special treatment” because they were not aware that she had a disability:

> The me not floating thing had repercussions with other people because at that time other people were floating and people would get mad and wonder why I wasn't [floating]. Sometimes I would [float] just to make it not seem like I was getting special treatment.

Human Resources did not know how to respond to this nurse’s request for accommodation:

> I contacted HR about getting accommodations [for ADHD]. I sent them [HR] an email and my email was never answered. I gave them plenty of time to answer. I gave them like three weeks or something. Then HR emailed me back and said they hadn't known what to do with my email.

**Teamwork as an Accommodation**

Participants in this study were asked by the PI, “What are your thoughts on teamwork as an accommodation?” For example, in the hospital setting, instead of two nurses independently caring for three patients each; teamwork is defined as two nurses work interdependently to care for six patients and divide job tasks based on abilities accordingly. All the NWD in this study agreed that, disability or no disability, teamwork is essential and a hallmark of nursing. The idea of having a colleague to assist with job tasks, particularly as a method of self-accommodation, was mentioned by four nurses prior to introducing this interview question.

The responses from participants were variable in terms of teamwork as defined above as an accommodation. Many nurses thought of teamwork as an “informal” type of accommodation and agreement between colleagues. Some NWD reported they may have stayed employed in
hospital units if teamwork was an option as a type of accommodation. Nurses stated that their colleagues were willing to divide tasks based on abilities, but when supervisors and HR became involved, it was determined that this was a liability and/or safety issue. Supervisor and collegial support was viewed as an important facilitator by NWD. Two nurses who worked together in a school setting (one with a hearing loss; one without hearing loss) successfully divided job tasks by having the one nurse without hearing loss answer most of the telephone calls. “Team teaching” was also described as an accommodation in the classroom by a nurse with hearing loss:

I think team teaching is ideal for someone with a disability, especially hearing loss, because the other person hears what is going on that you might not hear. I think the best way to get accommodation is just to have colleagues who are willing to help.

Other nurses felt differently. Nurses with ADHD and dyslexia did not think teamwork would be a good strategy for them in the workplace because they felt “trust” could be an issue and it could be complicated dividing job tasks fairly. A newer nurse with ADHD described why she thought trust could be an issue with teamwork:

I think if it [teamwork] was structured and I knew what my task tasks were, and I wouldn't feel like I was going to be responsible for somebody else's part, then I think it [teamwork] would be okay. It's just a trust thing because if you're both responsible for somebody [patient] then you’re both responsible for them. I've just had people say I was supposed to do something and I was never told I was supposed to do it.

A nurse with hearing loss mentioned that she wanted to be “fully competent” in her job and teamwork could be used as a “temporary solution,” but she preferred a more reliable “long-term solution.” A few stated that cost may be an issue for employers due to the increased staffing needs for team members.
V. DISCUSSION

Discussion of Findings

The purpose of this qualitative study was to describe the experience and process of accommodation in the workplace from the view of NWD. There were several new findings, not in the research literature on NWD, that emerged from this study on the experience, process, and facilitation of accommodation in the workplace. The themes revealed by the PI and participants may differ from prior studies because the sample included NWD who worked in the nursing profession within the past eight years and requested and obtained accommodation while employed. The PI identified several new themes that NWD described relative to how they experienced accommodation, and how NWD perceived themselves and employers can best facilitate the process of accommodation. The new themes described from their actual experience and process of accommodation were self-accommodation, self-advocacy, inevitable to request accommodation, lack of process, complaisance with accommodation, and disability identity. The reconfirmed theme, resistance to accommodation, was found in this study and in other studies on NWD (Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). When nurses were asked to describe an ideal experience and process of accommodation based on their actual experience, the new themes described were openness, employer advocacy, streamlined process, and employer accountability. In this study, the actual process and ideal process of accommodation were described quite differently by NWD (Table IV). In the actual experience and process, many responsibilities were primarily handled by NWD (employee-focused), the approach was reactive, nurses hid disabilities, process was lacking, nurses were self-advocates, and often settled with less than reasonable accommodation or resorted to self-accommodation. In an ideal experience and process, NWD preferred an employer-focused proactive approach to
accommodation where nurses could be open, employers serve as advocates for NWD, the process be streamlined and negotiated, and the NWD obtain a reasonable accommodation from employers. These differences are discussed in further detail (new themes are italicized) below. The findings are confirmed with findings from the research literature, theory, and with comments from NWD from the participant verification summary.

In the actual experience and process of accommodation, many NWD reported on barriers to accommodation as echoed in earlier studies, especially those NWD employed in larger institutions such as hospitals and universities. In this study and in prior studies, nurses hid disabilities (Neal-Boylan, 2012; Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c), nurses waited to ask for accommodation (Matt, 2008; Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008a, 2008b, 2008c), and nurses reported narrower career trajectories in nursing (Neal-Boylan, 2012; Neal-Boylan, et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). In the actual process, many nurses first preferred or resorted to self-accommodation to hide their disability or because they had prior negative accommodation experiences in the workplace. Most nurses who decided or felt “forced” (inevitable to request accommodation) to request accommodation from employers reported there was a lack of process on how to request accommodation in the workplace, and many NWD ended up accepting what they described as less than reasonable accommodation from employers (complaisance with accommodation). Nurses reported they were complaisant or “settled for less” because they were afraid that employers would perceive them as being “troublemakers” or “too needy” if they acted “too assertive” or complained about the obtained accommodation. Fear was a similar negative emotion nurses with physical or sensory disabilities reported in earlier studies (Matt, 2008; Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008a).
In this study, NWD believed they were discriminated against and stigmatized by HR personnel, supervisors, and colleagues in various phases of accommodation. Nurses stated colleagues perceived them as receiving “favoritism and special treatment” because of obtaining accommodation. Nurses with physical or sensory disabilities have previously reported discrimination (Neal-Boylan & Guillett, 2008b, 2008c) and stigmatization (Matt, 2008; Neal-Boylan, 2014; Neal-Boylan & Guillett, 2008a, 2008b, 2008c) as barriers in the workplace. Nurses in this study with invisible disabilities believed stigmatization was problematic because colleagues lacked understanding of “invisible” disabilities and colleagues did not understand why NWD were receiving less tangible accommodations. It was reported previously that nurses with visible physical or sensory disabilities were treated differently than those with invisible physical or sensory disabilities (Neal-Boylan, 2012; Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). Several nurses changed jobs or contemplated looking for new jobs because they were treated differently by supervisors and colleagues after requesting or obtaining accommodation. These findings are troublesome because accommodation is not “special treatment” nor intended to increase barriers. Accommodation is a means to reduce barriers and to provide equal employment opportunity for persons with disabilities (EEOC, 2002).

Identifying as a nurse with a disability (disability identity) was challenging because of how NWD and their colleagues perceived disability and nursing. In this study, NWD reported of unfavorable working conditions and unrealistic expectations of a nurse. In prior studies, researchers described this phenomenon as nurse heroics, which is the culture of the nursing profession that requires nurses with or without disabilities to go above and beyond to accomplish job tasks in the workplace (Neal-Boylan & Guillett, 2008a, 2008b, 2008c). This phenomenon of
nurse heroics is known to negatively impact nurses with physical disabilities in the workplace (Neal-Boylan & Guillett, 2008a, 2008b, 2008c). In this study, nurses were also negatively impacted by these expectations.

In an ideal process of accommodation NWD believed openness and honesty were important although most nurses in the actual process were not open. Openness was reported as a facilitator to accommodation in prior studies of PWD (Nevala et al., 2015) and by nurse recruiters (Neal-Boylan & Guillett, 2008c). Fostering environments where NWD can feel safe disclosing and requesting accommodation is critical for larger institutions such as hospitals and schools. Nurses expressed that employers should be more open to “trust” that NWD know their own capabilities. Trust and respect were reported as facilitators in prior studies of PWD requesting accommodation (Gold et al., 2012; Nevala et al., 2015). Nurses reported employers were overly concerned that NWD were threats to patient safety, this concern for safety was evidenced in prior studies of NWD (Neal-Boylan, 2012; Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). There is no evidence in the literature stating NWD are less safe than nurses without disabilities. In this study, NWD reported they wanted to feel valued and trusted by employers. Nurses were aware of their capabilities and recognized when the disability was interfering with their ability to provide safe patient care. This self-awareness triggered these nurses to leave bedside nursing to pursue jobs in less-physically demanding settings. In a prior study, NWD reported knowing their own limitations (Neal-Boylan, 2014).

A more streamlined process in the workplace is necessary per NWD. All nurses concurred that user-friendly online and/or written policies and processes on disability and accommodation need to be transparent, visible, and accessible in the workplace. Nurses stated that interactions between employers and employees on discussion, decision, and action of
accommodation must be documented. The negotiation on a plan of implementation for accommodation should be an explicit agreement between a NWD and employer, and the effectiveness of the accommodation should be re-evaluated by employers and employees in regular intervals and/or if the disability worsens. Accommodation is an interactive process (EEOC, 2010; Nevala et al., 2015). Some nurses reported delays in responses from employers when requesting accommodation, and delays in obtaining accommodation. An unnecessary delay is equivalent to a denial, and therefore is a violation of the ADA per JAN (“JAN employees’ practical guide to requesting and negotiating reasonable accommodations under the Americans with Disabilities Act,” n.d.). Per JAN, if an employer denies a request for a reasonable accommodation, an employee should follow these steps: go up the chain-of-command, file a grievance with the employee union (if applicable), and file a complaint with the EEOC or state enforcing agency. Nurses must document these accommodation experiences and follow these steps if necessary to mediate a reasonable accommodation.

To further streamline the process, NWD also recommended a “liaison” and a “mentor” to assist with the process. A liaison would be educated on accommodation and the ADA, and serve as an advocate to lead and be present in meetings with employers and NWD to discuss and negotiate reasonable accommodation. A liaison can identify a mentor (PWD in workplace) who would provide additional support to NWD by building self-advocacy skills of NWD, and the mentor can assist nurses with navigating through the process of accommodation (if desired by employee). Many nurses in this study did most of the advocating on their own (self-advocacy) and relied on online organizations and outside resources for knowledge and support about accommodation instead of gaining support and guidance from within their organization (employer advocacy).
Nurses described *employer advocacy* as employers being more active, creative, and flexible with accommodation and less strict with essential job functions (i.e., lifting). Essential job functions are fundamental duties of the position. Employers do not have to eliminate essential job functions, but they *can* do so if they prefer (“JAN employees’ practical guide to requesting and negotiating reasonable accommodations under the Americans with Disabilities Act,” n.d.). A few nurses stated job descriptions were inaccurate and not available; this was reported in a prior study (Neal-Boylan, 2014). Nurses in this study feared that without government enforcement of the ADA, employers will not be held accountable and continue to discriminate NWD, hire able-bodied nurses, and be too rigid with their decisions on accommodation and essential functions. Employer flexibility was an important facilitator in previous studies of NWD (Neal-Boylan & Guillett, 2008a, 2008b, 2008c).

Nurses with disabilities expressed that employers should be more accountable (*employer accountability*). It was surprising in this study that NWD reported that employers lacked knowledge of the ADA, employers were discriminatory toward NWD, and staff were unprepared on how to handle requests for accommodation. The ADA was enacted in 1990. Lack of knowledge of the ADA was also evident in prior studies of NWD (Matt, 2008; Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). Employers and employees need more education on various types of disabilities, especially those that are invisible such as mental impairments. As noted earlier, mental disabilities are becoming more prevalent in the U.S. (Garland-Thomson, 2016). Interestingly, nurses with mental impairments (ADHD and dyslexia) suggested accommodations that could be beneficial for *all* nurses such as a private place to chart (minimize distraction and interruption; decrease liability), more concrete descriptions of job
requirements (decrease liability), and the use of sticky notes for phone messages (decrease liability).

The PI further confirmed these themes with a conceptual framework and theory. The International Classification of Functioning, Disability, and Health (ICF) conceptual framework (Figure 1), based on the biopsychosocial model, was used after analysis to verify the findings and enhance credibility of the findings (theoretical triangulation) (World Health Organization [WHO], 2001). Sandelowski (1993) recommends researchers use outside theoretical frameworks to validate findings. The ICF framework is a classification of functioning and disability. Functioning and disability are the outcomes of the interaction between an individual with a health condition and contextual factors (WHO, 2001). Contextual factors are environmental and personal factors. Environmental factors are considered individual and societal factors. Personal factors are considered demographics such as age, gender, education, etc. Functioning refers to the positive interaction between an individual with a health condition and contextual factors (WHO, 2013). Disability refers to the negative interaction between an individual with a health condition and contextual factors (WHO, 2013). Disability leads to activity limitation and participation restriction (WHO, 2013).

In this study, the process of accommodation was an interaction of a nurse with a health condition and contextual factors. The outcome of participation in this study was either the nurse obtained accommodation or did not obtain accommodation. There were several contextual factors that influenced accommodation. In the actual process of accommodation, NWD often self-managed accommodation and relied less on contextual factors such as HR, supervisors, institutions, and policy. In the actual process, the employer’s focus was more on the nurse’s impairment versus functioning and modifying the environment. Personal factors of the nurse
(age, years as nurse, years with disability, and type of disability), and the nurse’s own disability identity (individual contextual factor) also impacted whether accommodation was requested and obtained in the workplace. Historically in the nursing curricula, educators explained disability through the lens of the medical model of disability, which depicts disability as an individual’s abnormality or deficiency (Marks, 2000). In the medical model, the healthcare professional serves as an agent to cure or normalize the individual’s deficiency with an aim to promote independence (Marks, 2000). In this study, many NWD tried to independently self-manage accommodation, and the responsibility of accommodation was placed on the individual with the impairment (health condition) versus the employer. Instead of the environment being modified to the nurse’s health condition, the NWD made adaptations on their own to function in the workplace environment (i.e., purchasing equipment on their own, finding a new job, using sick-time, and relying on colleagues). The employer’s lack of involvement and resistance to accommodation led to disability, which refers to the negative interaction between an individual with a health condition and contextual factors.

In an ideal process, the interactions between the nurse and environment would be more open, collaborative, and positive. Functioning in the workplace would be the goal and this would be accomplished by the employer providing accommodation with less focus on the limitation(s) of the nurse with the health condition. The themes of openness, streamlined process, employer advocacy, and employer accountability were identified by NWD as potential factors that could positively impact obtaining accommodation. This is consistent with the social model of disability. In the social model of disability, disability is the result of an interaction between an individual and the environment; a condition imposed by society (Oliver, 2009). Disability is the lack of societal participation of an individual with an impairment which is the result of social
barriers, not from an individual’s embodied impairment (Oliver, 1998). In an ideal process, employers would create workplace environments where NWD are welcome and able to fully participate. A streamlined process and point person can aid to facilitate the process of accommodation to decrease social and environmental barriers so NWD can obtain reasonable accommodation in the workplace.

Last, to validate the findings of this study, participants were asked to review and comment on a summary of the PI’s findings (participant verification summary). The comments from the NWD were as follows:

These nurses make great suggestions about creating a NWD ‘friendly’ [workplace], and making the request for accommodation a simplified process (easy to navigate). I pulled out our Employee Handbook and it [requesting accommodation] is not mentioned at all.

Another nurse stated:

I cannot believe how badly some of my fellow NWD have been treated. I also cannot believe that more [NWD] do not engage attorneys and if nothing else to educate employers on their responsibilities. One expensive lawsuit usually does the trick.

Another commented about a streamlined process of requesting and obtaining accommodation:

I think that [requesting accommodation] is a huge hurdle for nurses with any [type of] disability. An accommodation [process] needs to be more streamlined and made clear on how one [NWD] is to go about getting an accommodation. It's such a ‘grey area.’

Interviewing and disclosing her disability while seeking a new nursing position has been a negative experience in most instances per this nurse with COPD:

Since we spoke during the data collection phase of your research, I have been searching for new jobs. I have been keeping an unscientific tally. For the positions in which I
choose to self-identify as disabled I have had zero percent further response from those applications; from the nurse positions in which they [employer] did not ask me to self-identify or where I chose not to self-identify, I have had approximately 70% further response from the employers. This is true whether I stated what my disability was or not.

Nurses with disabilities are breaking down barriers for other NWD by sharing these experiences. In this study, all nurses were self-advocates, some pursued legal action, and all persevered in the workplace despite facing many obstacles. Nurses found it was helpful to join and refer to disability organizations for knowledge, and supportive supervisors and colleagues were assets. Supervisor and collegial support is a known facilitator for NWD in the workplace (Matt, 2008; Neal-Boylan, 2012; Neal-Boylan et al., 2011; Neal-Boylan & Guillett, 2008a, 2008b, 2008c). Most nurses were very knowledgeable of the ADA and its terminology, some had to educate employers on the ADA, and many realized how their perceptions of disability changed over the years based on work experience, education, self-advocacy and self-awareness.

All nurses in this study provided innovative suggestions on various types of accommodation and how to develop an ideal process of requesting and obtaining accommodation in the workplace.

**Implications for Nursing**

The findings from this study have several implications for the nursing profession and healthcare industry. Policy, process, and procedures of accommodation need to be developed by employers and made readily available for employees. The Job Accommodation Network provides an online toolkit (http://prod.askjan.org/toolkit/) to assist with the process of accommodation, and provides a sample letter of request for accommodation that can be used by employers and employees. Employers should make the process of requesting accommodation more transparent and user-friendly for employees, and have websites with linkages to the ADA,
NOND, JAN, and EEOC. Documentation and analysis of accommodation by employers and retention of NWD in the workplace are critical.

Recruitment and retention of all nurses in the nursing profession and healthcare industry is imperative. Employers and nurses must consider how fostering innovative practices for NWD will reflect on their institution, the nursing profession, and on the care of their patients with disabilities. Nurses with disabilities may potentially better understand the needs of patients with disabilities because they have experienced disability. This may lead to improved care of patients and especially patients with disabilities. Recruitment and retention of NWD as employees may stimulate employers to create more accessible workplace environments for employees and patients. For example, it was reported by a nurse in this study that she had difficulty maneuvering her wheelchair in a hospital patient room because the room was small and crowded with equipment. This raises the concern of how patients with wheelchairs comfortably maneuver in hospital rooms. It can be beneficial for the nursing profession and healthcare industry to be more inclusive and diverse.

In this study, employers were not flexible with essential job functions. Employers must start documenting and analyzing the cost of accommodation in comparison to retention of and turnover rate costs of NWD. For example, it would be beneficial to document and analyze the cost of adding more mechanical lifts or hiring ancillary staff to assist with lifting in hospital settings versus terminating vested experienced nurses with lifting restrictions and hiring new employees. There were nearly 35,000 back injuries among nursing staff (RNs and nursing assistants) reported by the Bureau of Labor Statistics in 2013 (Zwerdling, 2015). The bedside RN turnover rate costs an average hospital approximately $5.2M - 8.1M annually, and only 51.5% of healthcare organizations have a formal retention strategy (NSI Nursing Solutions, 2016).
paradigm shift is critical for the nursing profession and healthcare industry. The goal of the American Nurses Association in 2017 is to create healthy and safe workplace environments.

Education on disability and accommodation in nursing school curricula and work settings is vital to diminish risks of stigmatization and discrimination associated with disability and accommodation. Employers need to be more forthcoming in presenting topics on disability and accommodation. They can offer Continuing Education Units on topics of disability, implement anti-stigma programs / videos in the workplace, incorporate guest speakers experienced in disability and accommodation, introduce these concepts in employee orientation and in annual education practice modules, and implement strategies to recruit and retain NWD. Colleges of nursing should offer more courses on disability, accommodation, the ADA, and theory about disability in nursing curricula (i.e., the social model of disability, Goffman’s theory of stigma, and the International Classification of Functioning, Disability, and Health conceptual framework). In addition, offering more interdisciplinary courses on disability (i.e., nursing school, medical school, physical therapy, occupational therapy, speech therapy, social work, education, psychology, and disability studies) may be another option to help change perspectives on disability through education. Presently, many universities have specific departments for students with disabilities, such as Disability Resource Centers, these larger healthcare organizations and institutions should also create these departments for their employees with disabilities. In the future, this may be a requirement for federal contractors and subcontractors who are currently required by law to employ seven percent of PWD in the workplace.

**Implications for Future Research**

This study has implications for future nursing research. Nurses with disabilities such as mental impairments are a population that needs further study. Inclusion criteria and recruitment
strategies may need to be broadened to be more inclusive such as including nurses with alcoholism and/or prescriptive drug addiction (i.e., pain killers and/or stimulants), and nurses and student nurses who *self-identify* as having a type of mental impairment versus requiring documentation from a healthcare provider. Although the nurses in this study sought accommodation in the workplace, there may be other nurses with mental disabilities in the population who do not self-identify as having a *disability* or request accommodation. In a prior study of employees with mental illness, many of these employees were unfamiliar with disability law and their right to request accommodation in the workplace (Granger, 2000). It is concerning that there were only five nurses with mental disabilities who contacted the PI to participate in this study. There is scarce published research about nurses with disabilities such as mental impairments in the U.S. nursing workforce. This phenomenon needs further exploration.

Delegation of an essential function (i.e., lifting requirement) by employers may help retain NWD in positions where they are most comfortable and experienced instead of narrowing their career trajectories. Employers are not *required* to eliminate an essential function of a job, but they *can* if they desire. Although in the case of Phelps v. Optima Health (2001), the court determined it was an unreasonable accommodation for a nurse with a lifting restriction to request a colleague to perform lifting (Neal-Boylan & Miller, 2015). This means that a colleague’s willingness cannot be guaranteed as an accommodation, but this task of lifting could be delegated by an employer to another employee or eliminated as an essential function. Per the EEOC (2008), essential functions are based upon: the employers’ judgment, if the function can be *delegated* to other available employees, if the position exists to perform the function, and the degree of skill needed to perform the function. To retain aging nurses, nurses with injuries, and NWD in the profession and in their preferred specialty, delegation, employer flexibility, essential
job functions, and teamwork may need to be further explored from employers’ perspectives, especially in hospital settings where there are high rates of turnover.

Lastly, development of a survey(s) on accommodation for employers and employees in the nursing profession and healthcare industry is needed to determine relationships between knowledge of, attitude toward, and experience with requests for accommodation. Based on the findings from this study, the PI proposes that the process of accommodation is an interactive process which is a negotiation between NWD and employer influenced by nurse factors such as disability identity, self-advocacy, openness and trust, and by employer factors such as employer advocacy (support; trust), employer flexibility (essential functions; delegation), and employer accountability which can potentially lead to accommodation of NWD in workplace (Figure 2). A streamlined process may lead to accommodation and retention of NWD (Figure 2). Understanding these relationships and which factors are most significant may lead to the development of interventions and strategies to aid in the recruitment and retention of NWD in the workplace.

Strengths and Limitations of this Study

In this qualitative inquiry, the heterogeneous sample strengthened the credibility of the findings. This is the first study in the U.S. research literature to include nurses with mental disabilities who discussed the experience of accommodation in the workplace, and the first to provide an inquiry on the process of accommodation. The PI engaged in a rigorous methodology and identified new themes about the process of accommodation. Presenting and disclosing as a researcher with a physical disability may have facilitated trust and enhanced comfort for the interviewee; the PI used bracketing and reflexivity as strategies to reduce bias. Nurses with disabilities were eager to participate in this study and share their experiences on the phenomena
of disability and accommodation. Many nurses reflected on their experiences and voiced that participating in this study encouraged them to think more openly and creatively about accommodation in the workplace.

Recall by participants is a limitation of this study. The PI gathered nurses with disabilities’ views, which may or may not reflect the actual events that occurred. The sample was small and not diverse in categories of gender and race; all participants were female and most were Caucasian. It was difficult recruiting nurses who had disabilities such as mental impairments. There were other NWD who inquired about participating in the study but were excluded because they did not obtain accommodation from their employers. Other NWD who did not participate may think and feel differently, such as those who may have tried and failed to get accommodation, those who did not even try, and/or those who were never hired or experienced outright discrimination and were fired. Presenting and disclosing as a researcher with a physical disability may have introduced bias; participants may have shared experiences differently in comparison to a PI without a disability. Excluding nurses with alcohol or substance abuse can also be considered a limitation; alcoholism or drug addiction (use of legal drugs) is considered a disability under ADA. It is important to gather data from employers, supervisors and colleagues on accommodation, but this was not feasible for the scope of this study.

**Conclusion**

In sum, employers need to implement a process of accommodation in the workplace. Nurses with disabilities need to feel empowered and safe to request accommodation in the workplace. Nurses must report disability discrimination and failure to accommodate to appropriate internal and external agencies so that employers are held accountable. As one nurse
stated after reading the summary, this study may “Prompt a standardized approach among the professional organizations toward individualized case management of persons with disabilities in the nursing profession.” A streamlined process of accommodation is necessary. It is a critical time to recruit, hire, and retain NWD in the healthcare industry.
## APPENDIX A

**STUDY DATE (MM/DD/YYYY):**

**Demographic Questionnaire.** The following questions are statements about you. Please answer each question. This will take approximately 15 minutes. This will be filled out by the PI.

<p>| | | |</p>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Age</td>
<td># in years</td>
</tr>
</tbody>
</table>
| 2 | Gender | 1. Male  
2. Female |
| 3 | Race/Ethnicity | 1. White  
2. Hispanic or Latino  
3. Black or African American  
4. Asian  
5. Other: ______________________ |
| 4 | Highest Degree in Nursing | 1. ADN (Associates Degree in Nursing)  
2. BSN (Bachelor of Science in Nursing)  
3. MSN (Master of Science in Nursing)  
4. DNP (Doctor of Nursing Practice)  
5. PhD (Doctor of Philosophy in Nursing)  
6. Other: ______________________ |
| 5 | Nurse experience | # of years |
| 6 | Medical Diagnosis pertaining to Disability |   |
| 7 | Category of Disability | 1. Physical  
2. Mental  
3. Other: __________ |
| 8 | Work Experience as RN with Disability | # of months and/or years |
| 9 | Within past eight years where RN experienced accommodation | Job Role(s): |
|   |   |   |
|   |   | Job Setting(s): |
|   |   | # of hours worked per week: |
|   |   | Months/Years at job(s): |
This interview will take approximately 45 minutes, and then will be followed with a 15-minute demographic questionnaire.

Again my name is Dawn, and I have a physical disability. I will be audio-taping each interview, and reviewing the data from each interview. I will remove any identifiable data from the transcripts such as names of colleagues and employers.

Are you ready to begin? Any final questions before we start?

*Icebreaker question.*

- What is your nursing specialty?

*Central questions.*

- Tell me about your job experience(s) as a nurse with a disability.

- Tell me about your job role(s) with an accommodation as a nurse.
  - What does accommodation mean to you?

- Tell me about disclosing your disability.
  - What was this experience like for you?
  - How did you decide to disclose?

- How would you describe your process of requesting accommodation in the workplace?
  - What type(s) of accommodation did you request?

- How would you describe your process of obtaining accommodation in the workplace?
  - What persons were involved in the process?
APPENDIX B (continued)

- What types of accommodation(s) would you recommend for yourself to continue working as a nurse in your current job?

- What types of accommodation(s) would you recommend for yourself to work as a nurse in a different job that you desire?

- Based on your experience, could the process of accommodation be improved and if so, how?

- How would you describe an ideal process for requesting and obtaining accommodation?

- What would you tell other persons with disabilities to do in order to facilitate the process of accommodation?

- What are your thoughts on teamwork (two or more nurses working together; divide job tasks based on abilities) as an accommodation?

A concluding statement: Please know that you may contact me if a new idea comes to mind that was not captured during the interview. If you know of other nurses with disabilities who may want to participate in the study, please have them contact me by phone or e-mail.

Final thank-you: Thank you very much for taking the time to participate in this interview. I greatly appreciate it. Please contact me within the next week if you think of something you would like to add.
TABLE I

Table 1

Demographics of the Sample (N = 21)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n (%)</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>16 (76.2)</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>3 (14.3)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2 (9.5)</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td>49.6 (12.2)</td>
</tr>
<tr>
<td>Years as RN</td>
<td></td>
<td>19.9 (16.1)</td>
</tr>
<tr>
<td>Years as RN with Disability</td>
<td></td>
<td>11.9 (12.2)</td>
</tr>
<tr>
<td>Onset of Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before RN</td>
<td>12 (57.1)</td>
<td></td>
</tr>
<tr>
<td>After RN</td>
<td>9 (42.3)</td>
<td></td>
</tr>
<tr>
<td>Category of Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>16 (76.2)</td>
<td></td>
</tr>
<tr>
<td>Mental</td>
<td>5 (23.8)</td>
<td></td>
</tr>
<tr>
<td>Highest Degree in Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADN</td>
<td>3 (14.3)</td>
<td></td>
</tr>
<tr>
<td>BSN</td>
<td>9 (42.3)</td>
<td></td>
</tr>
<tr>
<td>MSN</td>
<td>5 (23.8)</td>
<td></td>
</tr>
<tr>
<td>DNP</td>
<td>2 (9.5)</td>
<td></td>
</tr>
<tr>
<td>PhD</td>
<td>2 (9.5)</td>
<td></td>
</tr>
<tr>
<td>Work Setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>9 (42.9)</td>
<td></td>
</tr>
<tr>
<td>Academic institution</td>
<td>7 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>2 (9.5)</td>
<td></td>
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<tr>
<td>Clinic</td>
<td>2 (9.5)</td>
<td></td>
</tr>
<tr>
<td>Community / Home health</td>
<td>1 (4.8)</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE II

Table 2

*Participants’ Disabilities (N = 21)*

<table>
<thead>
<tr>
<th>Disability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical:</strong></td>
<td></td>
</tr>
<tr>
<td>Amputation</td>
<td></td>
</tr>
<tr>
<td>Chronic fatigue syndrome</td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary</td>
<td></td>
</tr>
<tr>
<td>disorder</td>
<td></td>
</tr>
<tr>
<td>Hearing loss</td>
<td></td>
</tr>
<tr>
<td>Heart condition</td>
<td></td>
</tr>
<tr>
<td>Muscular dystrophy</td>
<td></td>
</tr>
<tr>
<td>Neuropathy</td>
<td></td>
</tr>
<tr>
<td>Seizure</td>
<td></td>
</tr>
<tr>
<td>Spinal cord injury</td>
<td></td>
</tr>
<tr>
<td>Traumatic brain injury</td>
<td></td>
</tr>
<tr>
<td>Vision loss</td>
<td></td>
</tr>
<tr>
<td><strong>Mental:</strong></td>
<td></td>
</tr>
<tr>
<td>Attention deficit hyperactivity</td>
<td></td>
</tr>
<tr>
<td>disorder</td>
<td></td>
</tr>
<tr>
<td>Dyslexia</td>
<td></td>
</tr>
<tr>
<td>Major depressive /anxiety disorder</td>
<td></td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE III

**Table 3**

*U.S. State Where RN Requested Accommodation (N = 21)*

<table>
<thead>
<tr>
<th>State</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>2</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1</td>
</tr>
<tr>
<td>Illinois</td>
<td>5</td>
</tr>
<tr>
<td>Maine</td>
<td>1</td>
</tr>
<tr>
<td>Michigan</td>
<td>2</td>
</tr>
<tr>
<td>New York</td>
<td>1</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1</td>
</tr>
<tr>
<td>South Carolina</td>
<td>1</td>
</tr>
<tr>
<td>Texas</td>
<td>2</td>
</tr>
<tr>
<td>Virginia</td>
<td>1</td>
</tr>
<tr>
<td>Washington</td>
<td>1</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>3</td>
</tr>
</tbody>
</table>
### TABLE IV

Comparison of Actual and Ideal Process of Accommodation

<table>
<thead>
<tr>
<th>Process</th>
<th>Actual:</th>
<th>Ideal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee-focused</td>
<td>Reactive approach</td>
<td>Employer-focused</td>
</tr>
<tr>
<td>Reactive approach</td>
<td>Hide disability</td>
<td>Proactive approach</td>
</tr>
<tr>
<td>Hide disability</td>
<td>Self-advocacy</td>
<td>Open</td>
</tr>
<tr>
<td>Self-advocacy</td>
<td>Lack of process</td>
<td>Employer-advocacy</td>
</tr>
<tr>
<td>Lack of process</td>
<td>Less than reasonable accommodation</td>
<td>Streamlined process</td>
</tr>
<tr>
<td>Less than reasonable accommodation</td>
<td>Self-accommodation</td>
<td>Negotiate</td>
</tr>
<tr>
<td>Self-accommodation</td>
<td></td>
<td>Reasonable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>accommodation</td>
</tr>
</tbody>
</table>
Figure 1. The International Classification of Functioning, Disability, and Health (ICF) model is a multidimensional, interactive classification of functioning and disability. Functioning and disability (body functions and structure, activity, and participation) are the outcomes of the interaction between an individual with a health condition and contextual factors (personal and environmental factors) (World Health Organization, 2001).
Figure 2. The Negotiated Interactive Process of Accommodation which is a negotiation between NWD and employer mediated by nurse factors such as disability identity, self-advocacy, openness and trust, and by employer factors such as employer advocacy (support; trust), employer flexibility (essential functions; delegation), and employer accountability which can potentially lead to reasonable accommodation (RA) of NWD in workplace. A streamlined process may lead to accommodation and retention of NWD.

*RA = Reasonable Accommodation
References


doi: 10.1007/s10926-014-9512-y


VITA

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TEACHING:
  2012 Teaching Assistant, Human Development Across the Life Span
      University of Illinois at Chicago

HONORS:
  2016  Sanford-Brown College Lifetime Achievement Award
  2010  Inductee to the District 230 Foundation Legacy Hall
  2006  Certificate of Appreciation from Tripler Army Medical Center
  2005  ADVANCE Nurse: Advancement, Development, and Validation of Achievement in Nursing Clinical Excellence, Certificate of Completion, Children’s Memorial Hospital

PROFESSIONAL
MEMBERSHIP:
  American Case Management Association
  National Organization of Nurses with Disabilities
  Sigma Theta Tau

PROFESSIONAL
EXPERIENCE:
  2010-present CEO of 501(c)(3), America Against Malaria.org
      Non-profit organization, Chicago, IL

  2010-2015 Certified Case Manager (CCM)
      Lurie Children’s Hospital, Chicago, IL

  2007-2008 Staff Nurse, Pediatric Medical-Surgical
      Children’s Memorial Hospital, Chicago, IL

  2006-2008 Registry Nurse, Pediatric, NICU & Post-partum
      Saint Joseph Hospital, Chicago, IL

  2006 Travel Nurse, Rehabilitation
      Rehabilitation Institute of Chicago

  2005-2006 Travel Nurse, Pediatric Medical-Surgical
      Tripler Army Medical Center, Honolulu, HI

  2003-2005 Clinical Certified Transplant Nurse
      Children’s Memorial Hospital, Chicago, IL
2002-2003 Staff Nurse, Pediatric Outpatient Clinic
Dr. Thomas Moore’s Office, Shorewood, IL

2002 Staff Nurse, Pediatric Camp
Sanborn Western Camps, Western Springs, CO

2002 Staff Nurse, Pediatric Camp
Camp Matoaka, Springfield, ME

2001-2002 Travel Nurse, Club Med
Crested Butte, CO & San Carlos, Mexico

1999-2001 Staff Nurse, Adult Medical-Surgical
University of California San Diego Hospital

PROFESSIONAL / COMMUNITY SERVICES:

2009 Featured in article on malaria in *Chicago Tribune* titled Fight Against Malaria: Battle of Life and Death

2010 Keynote speaker for non-profit event for Clarke Cares Foundation regarding malaria prevention

2010 Keynote speaker for MBA students at DePaul University regarding malaria, nursing, and disability

2011 Keynote speaker for Pepsi Corporation on working with a disability and accommodations at the workplace

2011 Keynote speaker for undergraduate students regarding life experiences post malaria at Aurora University

2012 Guest speaker on Chicago television show *Windy City Live* to discuss life experience with malaria and disability

2013 Guest speaker for physical therapy students at University of Illinois at Chicago regarding amputations and prosthetics

2013 Author of *A Real-life Story of a Girl’s Struggle with Malaria*. Sent this children’s book to Ghana, Africa as CEO of America Against Malaria.org

2014 Guest speaker for middle school students at Liberty School in Orland Park, IL on malaria and amputations, and provided the children’s book to students
2015 Keynote speaker for undergraduate students regarding life experiences post malaria at Aurora University

2015 Keynote speaker at Skills for Life conference in Houston, TX on tips and tricks for travel for persons with amputations

2016 Author of *The Stories of Oko, Addea, and Ms. Victoria the Vector. Stop Malaria*. Sent this children’s book to Ghana, Africa as CEO of America Against Malaria.org

2016 Author of *Help, Educate, Protect, and Vaccinate*. Sent this children’s book to Ghana, Africa as CEO of America Against Malaria.org

2016 Initiated structure of an educational health clinic in Ghana, Africa as CEO of America Against Malaria.org