

Report One

Literature Review of Barriers to and Factors for Successful Return to Work

Nurses Return to Work in Hospitals Project

An Australian Nursing Federation (Victorian Branch) Project

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Abbreviations

CEO – Chief Executive Officer
 DHS – Department of Health Services
 GP - General Practitioners
 KPI - Key Performance Indicator
 NSW – New South Wales
 OH&S – Occupational Health and Safety
 OHSAS - Occupational Health and Safety Agency for HealthCare
 Pears Program - Prevention and Early Active Return to work Safely Program
 RTW – Return to Work
 SA - South Australia
 TCF - Textile Clothing and Footwear
 VWA - Victorian WorkCover Authority

Purpose

The purpose of this literature review is to assist in identifying the barriers to and factors for successful return to work (RTW) of injured and/or ill nurses. The review is of literature published since 1994 on RTW.

Method

The method utilised to conduct this review included:

1. Review of Australian workers' compensation jurisdictions, publications and international websites.¹
2. Identify studies relating to return to work of injured and/or ill nurses in Victoria, Australia and Internationally.
3. Identify studies in hospitals of return to work for injured and/or ill nurses.

1. RTW in Australia and Internationally.

Qualitative and quantitative research studies on the barriers and factors for successful RTW for injured and/or ill workers in general were identified, and are discussed below:

1. Australian research studies;
2. Australian Jurisdictions;
3. International research studies.²

1.1 RTW Research Studies in Australia

1.1.1 New South Wales

Common themes on the barriers and successes for RTW were identified by Kenny's research of injured workers, employers and rehabilitation providers and are discussed below (Kenny, 1995a; 1995b; 1998a; 1998b; 1998c).

Barriers identified from Kenny's research were:

¹ Electronic Databases - CINAHL, MEDLINE, COCHRANE DATABASE of SYSTEMATIC REVIEWS, EBM Reviews, Expanded Academic ASAP, Journals@OVID full text, PsycINFO, Proquest 5000. A general internet search was undertaken, and references of key documents were also scanned for relevant studies. The objective was to identify original research published in English. The key words searched by were: return to work, injury, workplace injuries, occupational injuries, injured nurses, injury management, disability management, workers compensation, rehabilitation, vocational rehabilitation and barriers. These key words were exploded and all word combinations were applied in the searches.

² Full details of research studied refer to Appendix 1.

- (i) The failure of employer's and insurance agents to disseminate information on the workers' compensation and RTW processes to the injured worker (Kenny, 1995a; 1995b).
- (ii) Problems with communication pathways in distributing information between injured workers and other key stakeholders (Kenny, 1995a; 1995b; 1998a).
- (iii) Polarisation between the injured worker and the employer on how best to manage the injury (Kenny, 1995b).
- (iv) Employers tendency to question the genuineness of injury, creates conflict and affects communication between the injured worker and their employer (Kenny, 1995b).
- (v) Injured workers alienation due to their employers' and co-workers' attitude towards them in the workplace (Kenny, 1995a).
- (vi) Lack of communication between the employer and injured workers treating doctor, particularly in determining suitable duties and timeframes for RTW (Kenny, 1995b).
- (vii) Lack of personal contact from the employer, insurance agent, and rehabilitation provider (Kenny, 1995a; 1998c).
- (viii) Lack of contact by the RTW coordinator (Kenny, 1995a).
- (ix) Employers' failure to:
 - (a) Offer suitable duties; and
 - (b) Make accommodations in the workplace to assist injured workers' RTW (Kenny, 1995a).
- (x) Injured workers' concern that rehabilitation providers had insufficient understanding of the workplace and their injury to advice on suitable RTW duties (Kenny, 1998b).
- (xi) Insurance Agents concern that rehabilitation provider's impact negatively on the RTW process through:
 - (a) Generic RTW plans; and
 - (b) Lack of ownership and/or responsibility for RTW (Kenny, 1998b).
- (xii) Rehabilitation providers concern that a barrier to RTW is identifying their primary client, as this differed with varying emphases placed on the injured worker, their employer and the insurance agent in the process of returning injured and/or ill workers to work (Kenny, 1998a).

Kenny's research identified predictors of successful RTW as proactive occupational health and safety work environments because of a perception by workers that employers who maintain safe workplaces are more likely to manage RTW well (Kenny, 1998c).

1.1.2 South Australia

Roberts-Yates (2004) research aims to identify from the injured workers' perspective practical considerations that need to be addressed in workers' compensation and rehabilitation.

Injured workers identified the barriers to RTW to be:

- (a) Process orientated case management which failed to consider the individual's circumstances;
- (b) A lack of focus and control in determining RTW goals and treatment;
- (c) Legalistic language which is perceived as confronting and antagonistic;
- (d) Legislation which was difficult to understand;
- (e) Information needs at each step of the process which are not met;
- (f) Changed relationship with their employer following a work caused injury;
- (g) The social stigma of having an injury caused by work, fear of loss of employment and diminished social status in the workplace (Roberts-Yates, 2004).

Injured workers identified the following factors for successful RTW:

- (a) Equal collaboration by all parties in the RTW process;
- (b) Knowledge of process - including rights and obligations;
- (c) Access to information, including diagnosis;
- (d) Constructive and timely communication;
- (e) Uninterrupted payment of financial entitlements;
- (f) An information package which outlines the RTW process distributed to all injured workers at the onset of injury;
- (g) Quality management of suitable duties for return to work;
- (h) Education of the workplace and wider community;
- (i) Managing the injury from a whole person perspective; and
- (j) Transparency in regard to dispute resolution (Roberts-Yates, 2004).

Roberts-Yates (2006) interviewed employers to obtain a practical understanding of an employer's viewpoint of the workers' compensation and rehabilitation process.

Employers identified that they:

- (a) Understand the importance of communication and, consideration of, social support factors for a successful RTW;
- (b) Believe the relationship with the injured worker pre-injury is an important determinant for successful RTW;
- (c) Perceive some workers' to be pain focused and lack the motivation to return to work;
- (d) On occasion small business resist meeting their RTW obligations as it is not cost

effective;

- (e) Believe RTW is dependent on the injured worker's personality;
- (f) Believe that self-esteem and motivation is an important determinant for successful RTW;
- (g) Support open discussion with injured workers' co-workers on requirements of RTW;
- (h) Feel frustrated at not being able to control claims costs, which can impact on the relationship and RTW of the injured worker;
- (i) Are concerned by the adversarial nature of the WorkCover process;
- (j) View medical practitioners as being biased towards the injured worker and focused solely on the injured worker's story; and
- (k) Believe that rehabilitation providers are constrained by the focus on monetary incentives and are only appointed when the claim becomes a serious problem.

Key solutions told to Roberts-Yates by employers related to:

- (a) Early intervention and step by step reporting procedures;
- (b) People orientated approach by management which reflects a culture of shared concern;
- (c) Ongoing open communication between employer and injured worker;
- (d) Timely diagnosis and early identification of treatment and ongoing communication with treating doctor;
- (e) Ergonomic support in the workplace;
- (f) Effective relationship management; and
- (g) Effective information sharing (Roberts-Yates, 2006).

The Working Women's Centre in South Australia undertook a project entitled *Gender, Workplace Injury and Return to Work: A South Australian Perspective* (2004).

Barriers identified from the injured workers' perspective related to:

- (a) The workers' compensation system;
- (b) Dissemination of information;
- (c) Lack of communication between stakeholders, which creates a feeling of isolation from the workplace and co-workers;
- (d) Psychosocial issues; and
- (e) Workplace issues.

Identified suggestions for improving RTW processes and outcomes from injured workers' perspectives related to:

- (a) Better communication and information dissemination;
- (b) Genuine acceptance that an injured worker is injured;
- (c) Qualified case managers and rehabilitation providers;
- (d) Better system for determining suitable duties;
- (e) Improved timeliness of response to injury and provision of adequate treatment;
- (f) Awareness that workplace bullying is common.

Employers considered the barriers to be:

- (a) System that favours an injured worker;
- (b) Difficulty in finding meaningful suitable duties;
- (c) Expense of providing supplementary assistance whilst workers' return to pre-injury role;
- (d) Role of general practitioners (GP's);
- (e) Lack of communication; and
- (f) Negative attitude of employees (Working Women's Centre, SA, 2006).

1.1.3 Victoria

Sdrinis (1995) undertook a research project to identify the barriers to effective rehabilitation and return to work of injured workers. Targeted industry areas were Finance, Textile Clothing and Footwear (TCF), and Food. A survey of employers and injured workers was undertaken.

Barriers identified included:

- (a) A lack of planning and coordination by employers for RTW;
- (b) A lack of understanding of principles of injury management;
- (c) A tendency to deal with rehabilitation and RTW in an ad hoc manner;
- (d) Failure to effectively provide suitable and/or alternative RTW duties, address the rehabilitative options for injured workers who cannot return to their normal duties, and/or provide offers of permanent alternative duties;
- (e) Tendency to view rehabilitation in a limited context focused on getting injured workers' back to work; and

(f) Lack of information, education and training in relation to RTW at all levels of organisations involved in the study (Sdrinis, 1995).

Calzoni's (1997) project aimed to give injured workers a voice through storytelling of their experiences of RTW.

Identified barriers related to:

- (a) Insufficient investment of time in RTW;
- (b) Inadequate coordination by RTW Coordinator;
- (c) Ad hoc approaches to RTW;
- (d) Lack of safe, sustainable, suitable and durable RTW duties;
- (e) Poor communication between injured worker and employer and co-workers;
- (f) Hostility from co-workers; and
- (g) Lack of dialogue on OH&S prevention.

Identified successes related to:

- (a) Employer openness to workplace redesign of injured workers' roles;
- (b) Open dialogue in the workplace on health and safety and rehabilitation; and
- (c) The positive impact of redesign on preventing further injuries (Calzoni, 1997).

1.2 RTW Outcomes in the State Jurisdictions

Each State and Commonwealth WorkCover site was accessed for publications on RTW of injured and/or ill workers and/or injured and/or ill nurses.

1.2.1 New South Wales

New South Wales (NSW) WorkCover commissioned a report on *Health, Return to Work, Social and Financial Outcomes associated with different compensation pathways in NSW: Quantitative Survey of Claimants* (PriceWaterhouse Coopers, 2003). The aim of the report was to identify the factors associated with (a) health outcomes; (b) RTW outcomes; (c) social outcomes; and (d) financial outcomes, following a workers compensation claim for a work related injury in NSW.

The Report identified that the health of injured workers' in NSW was (a) poorer than the national health average, and (b) adversely affected by the claims process and rehabilitation (PriceWaterhouse Coopers, 2003). It was reported that:

- (a) 60% of respondents had not returned to work or had returned only for a short period of time;
- (b) 57% of those who had returned to work were employed by a new employer with different duties;
- (c) Long term injured workers perceived there was a lack of commitment from rehabilitation providers/insurers/employers in assisting them to RTW;
- (d) Psychological distress increased likelihood of poor RTW outcomes, which influenced social contact and participation;
- (e) The RTW rate was lower than that reported elsewhere for NSW (Campbell et al, 2000 cited in PriceWaterhouse Coopers, 2003); and
- (f) 66% of injured workers' reported that they had some form of debt (PriceWaterhouse Coopers, 2003).

The report identified an evidence gap, as RTW was focused on the workers' compensation outcomes and there was little known about success or durability of RTW (PriceWaterhouse Coopers, 2003).

NSW WorkCover's (2004) pilot project on injury management involved non-insurer and insurer pilot groups with the objective of identifying best practice measures in injury management. The purpose of the pilots was to improve (a) workers' health outcomes; (b) return to work outcomes for injured workers; and (c) service usage and costs.

The project outlined the importance of:

- (a) Communication by insurance agents with workers and employers equally;
- (b) Successes in focusing on RTW;
- (c) Employer participation in RTW;
- (d) Monetary incentives to employers who report injuries early and who actively participate in the RTW process;
- (e) Provision of quality treatment;
- (f) A focus on injury management which reduces costs; and
- (g) Data integrity (NSW WorkCover, 2004).

NSW WorkCover (2007) consulted with stakeholders to review the three Guides for Management of Soft Tissue Injury. The report identified, in relation to RTW, there was a:

- (a) Minimal focus on RTW as the primary goal of recovery;

- (b) Lack of suitable RTW duties; and
- (c) Failure to identify and address workplace barriers (NSW WorkCover, 2007).

1.2.2 South Australia

WorkCover South Australia commissioned a report on *Barriers and facilitators to return to work: A literature review* (Foreman et al, 2006). The aim of the Report was to provide an overview of (a) the facilitators of, and barriers to RTW after injury, and (b) to identify a research agenda for WorkCover SA focused on the development of best practice guidelines for RTW.

The key findings of the Report were that:

- (a) Psychological characteristics of the individual and workplace factors should be addressed;
- (b) A coordinated approach that includes all stakeholders should be adopted;
- (c) Best practice guidelines on the management of work related injury should be incorporated in practice guidelines for medical practitioners; and
- (d) The focus of RTW may differ according to length of injury.

The Report concluded that for RTW to achieve optimal outcomes the following need to be addressed:

- (a) Systems level interventions (eg payment systems, regulation, education and social marketing, workforce development and training); and
- (b) Practice based intervention (eg. workplace involvement, treatment that addresses psychosocial variables, coordinated RTW planning).

1.2.3 Tasmania

WorkCover Tasmania (2007) has developed a RTW and Injury Management model. The proposed model aims to deliver “better health and return to work outcomes for injured workers’, with lower costs to employers and the workers’ compensation system” (WorkCover Tasmania, 2007: 4).

The seven principles that underpin the model are:

1. All parties, including the injured worker, should:
 - (a) View recovery and return to work as the prime goals following a work related injury;

- (b) Have a shared commitment to these goals; and
 - (c) Work together through cooperation, collaboration and consultation to achieve these goals.
- 2. Early intervention is critical – injury management should commence as soon as possible following injury regardless of determination of liability.
- 3. Where possible, the injury management process will focus on maintaining the relationship between the employer and worker.
- 4. The injury management process should be transparent, cost efficient and effective.
- 5. All parties, particularly the injured worker, the employer and the medical practitioners, should have access to information and support in order to clearly understand their roles, rights and responsibilities.
- 6. Injury management should be of a high standard to:
 - (a) Maintain the dignity and integrity of the injured worker; and
 - (b) Ensure that the injured worker is an active participant.
- 7. Effective injury management requires the timely, facilitated resolution of issues.³

The WorkCover Tasmania Board has approved the model and is currently seeking advice of the impact on the scheme and the cost of implementation, before a final decision is made.

1.2.4 Victoria

Klein and Associates (1996) undertook research on behalf of the Victorian WorkCover Authority (VWA) on employer and worker attitudes to return to work in the metropolitan small business sector. Focus groups were conducted with injured workers, employers, occupational rehabilitation providers and general practitioners.

This report identified, from the focus groups, a number of criticisms of the RTW process which related to:

- (a) The bureaucracy of the workers' compensation system;
- (b) Lack of clear guidance on the process to the injured worker;
- (c) Lack of sustainable and meaningful duties;
- (d) Inexperience and lack of medical knowledge among insurance case managers; and
- (e) Minimal prosecution of employers who are non-compliant in regard to RTW obligations.

The VWA commenced in 2005/06 discussions with medium and large sized employers on their

³ To access Return to Work and Injury Management Model go to <http://www.workcover.tas.gov.au/node/wrcreturntow.htm>

RTW performance. This was expanded in 2006/07 to include health and other industries. 100 employers participated in the discussions on RTW issues, including RTW outcomes. Insurance agents conducted most of these discussions (VWA, 2007).

Employers in the health sector reported that the barriers to RTW were:

- (a) Ageing workforce;
- (b) Specific skill base of injured workers;
- (c) Physical nature of work - for example, bed changing, lifting patients;
- (d) Emotional nature of work - for example, psych patients or palliative care;
- (e) Inadequate OH&S staff training;
- (f) Managers' lack of involvement with RTW process; and
- (g) Managers' poor understanding of obligations. (VWA, 2007: 10).

Employer recommendations for effective RTW strategies in the health sector included the provision of:

- (a) A library of suitable job descriptions;
- (b) Permanent pool of suitable duties;
- (c) Suitable duties across workplaces to assist with sustainable RTW;
- (d) A holistic approach to OH&S, RTW and general health and wellbeing of all employees; and
- (e) RTW KPI's in performance management plans of management (VWA, 2007: 10).

1.2.5 Western Australia

Workers Compensation and Rehabilitation Commission of Western Australia (1998) commissioned a report on *Management, Medical Intervention and Return to Work*. The objective of the Report was to:

- (a) Provide empirical evidence on the importance of collaboration and communication between an injured worker, their employer and medical practitioners, and
- (b) Document the impact proactive workplace based policies and practices can have in managing work related injuries.

The Report identified the importance of:

- (a) Proactive communication between employers and GP's to improve RTW outcomes;
- (b) Organisational characteristics/culture and the level of involvement by supervisors;
and
- (c) Frequent contact (WorkCover Western Australia, 1998).

1.3 International RTW research studies

The international studies outlined below were all undertaken in Canada.

Baril et al (2003) undertook a qualitative research project in three Canadian provinces which aimed to identify what impedes and/or facilitates the RTW process.

The research identified that the:

- (a) Injured workers' beliefs and attitudes about their injury, recovery and work were important in successful RTW programs;
- (b) Injured workers' perception of their employer's genuine interest in their wellbeing had a positive impact on RTW;
- (c) Employers who single-mindedly focused on cost containment and disputing claims, impacted negatively on the RTW program and motivation of injured workers to RTW;
- (d) Co-workers' perception of injured workers is important to the RTW outcome, including the negative psychosocial impacts;
- (e) Union involvement had a positive impact on RTW, especially where employers and unions shared the common goal of the workers' welfare and safe RTW;
- (f) Clearly defined supervisors' RTW responsibilities in performance management plans resulted in more constructive participation in the RTW process; and
- (g) Ergonomic definitions of available duties set up as a job bank of temporary assignments assists positively in the RTW of injured workers.

Baril et al (2003) also reported that in the companies where senior management valued and understood the advantages of RTW:

- (i) Injury prevention was considered a high priority;
- (ii) A participatory style of management was promoted, and
- (iii) A workplace culture increased the likelihood of RTW success.

Beardwood et al (2005) undertook a study of the perceptions and experiences of injured workers. The Study identified that:

- (a) The issue of legitimacy of injury is a major impediment to successful RTW, with a

constant need to prove the causal relationship between the injury and the workplace;

(b) Injured workers experienced coercion, overtly and covertly, through the threat of loss of benefits;

(c) There was a perception by injured workers of a lack of control over the management and treatment of their injury; and

(d) Limited input by injured workers into the RTW program, led to feelings of being forced to comply with the program due to fear of losing benefits.

Friesen et al (2001) undertook a study aimed at determining barriers and facilitators for return to work from a stakeholder perspective. The findings indicated that barriers for RTW related to delays in:

(a) Processing;

(b) Delivery of information;

(c) Treatment; and

(d) Ineffective communication among stakeholders.

Facilitators for successful RTW were identified as:

(a) Establishment of RTW programs in the workplace;

(b) Early communication and effective teamwork;

(c) Trust and credibility among stakeholders; and

(d) Union support and cooperation for RTW programs (Friesen et al, 2001).

Kirsch and McKee's (2003) quantitative study on the experiences of injured workers recommended:

(a) Involvement of injured workers in the development and monitoring of treatment and rehabilitation plans;

(b) A holistic approach to treatment and rehabilitation;

(c) Supportive work environments;

(d) Improved access to information on rights;

(e) Acceptance of the legitimacy of injured workers' claims;

(f) Sensitivity and accountability; and

(g) Increased employer responsibility in following the treating doctor's RTW restrictions and in applying RTW accommodations in the workplace (Kirsch and McKee, 2003).

2. RTW of injured and/or ill nurses.

Discussed below are studies on injured and/or ill nurses from Australia and Internationally. Only one study of nurses focused on their perspective of work caused injury and/or illness.

2.1 Buried But Not Dead

The only Australian research project on RTW of injured and/or ill nurses is *Buried But Not Dead: A survey of occupational illness and injury incurred by nurses in the Victorian health services industry* (Langford, 1996). This Report was based on a survey of the experience of injured and ill nurses following an injury and/or illness caused by work, and the impact of that injury on nurses.

The Survey aimed to examine:

- (a) The types of injuries and/or illnesses sustained by nurses in their work;
- (b) Stakeholders' treatment of nurses who have a work caused injury or illness;
- (c) The effect on the long term health of injured and ill nurses;
- (d) Effects of injury or illness on their income and work prospects, and
- (e) The types and effectiveness of treatment (Langford, 1996).

The Survey included:

- (a) How the injury and/or illness affected a nurse's RTW, particularly their ability to work, and to return to their pre-injury role.
- (b) The effectiveness of rehabilitation services; and
- (c) How recovery of nurses could be assisted more effectively (Langford, 1996).

Of the 170 respondents to the Survey:

- (a) 52% were unable to return to their pre-injury role or hours; and
- (b) Only 42% had contact with a rehabilitation provider despite long periods off work (Langford, 1996).

2.2 Australia

A number of reports on nurse recruitment and retention have been undertaken in Australia. These reports while not specifically focused on RTW provide information on work related injury and illness relating to the impact on nurses leaving the profession - for example, the physical nature of the work, stress, violence, harassment, and staffing levels (ACIRRT, 2004, 2002;

Bloch and Nowack, 2003; NSW Workforce Research Project, 2000; Tasmanian Workforce Planning Project, 2001; Victorian Nurse Recruitment and Retention Committee, 2001a).

2.2.1 New South Wales

The NSW Workforce Research Project (2000) for the NSW Health Department Nursing Branch, surveyed 10,089 nurses. The objectives of the Project were to:

- (a) Determine why nurses enrolled or registered in NSW were not working as nurses, and
- (b) Identify conditions and/or incentives required to encourage these nurses to return to nursing work.

The survey identified that 6.7% of respondents had left nursing due to health concerns and work related injuries (NSW Workforce Research Project, 2000).

There were also 98 telephone interviews. Nurses commented in those interviews that once they sustained an injury and/or illness there was:

- (a) A lack of support from management and colleagues;
- (b) A perception of abandonment;
- (c) A concern of diminished value as a nurse if unable to do nursing duties; and
- (d) Little or no assistance in finding alternative or modified duties (NSW Workforce Research Project, 2000).

2.2.2 Victoria

The Victorian Nurses Recruitment and Retention Committee (2001a) in May 2001 expressed concerns at the proportion of nurses responding to the various surveys that had left nursing because of injury and/or illness.⁴ The Committee reported that:

- (a) 17% of the registered cohort gave this as their principle reason for not working as a nurse;
- (b) The survey of registered nurses highlighted that many nurses leave the profession because of physical illness, such as back injury or as a result of psychological stress; and
- (c) The qualitative survey of registered non-working nurses showed that many injured nurses wished to RTW, but feel unable to do so because of:
 - (i) Lack of support from management and colleagues; and
 - (ii) The physically and mentally demanding nature of the work (DHS, 2001b;

⁴ Refer to www.dhs.vic.gov.au/pdps/pdfs/recruit.pdf

2001c).

The Victorian Government accepted the recommendation to “Explore the extent to which return to work programs for injured nurses have been implemented in public healthcare facilities in Victoria.” The Victorian Government undertook that the Department of Health Services (DHS) would conduct a survey of OH&S coordinators in 2001, with further action dependent on the results of the survey (DHS, 2001d).

Fellows Medlock & Associates P/L (2007) have undertaken a *Return to Work Review* for the Victorian Health Service Management Innovation Council. The objective was to review RTW practices within health services across Victoria, with particular focus on the effectiveness of current RTW practices and to identify best practice initiatives and strategies across the health sector (Fellows Medlock & Associates, 2007).

Face to face interviews with stakeholders on RTW practices in the health sector were conducted, and included CEO's, line managers, RTW coordinators and/or claims managers, human resources managers, and OH&S managers (Fellows Medlock & Associates, 2007).

The review reported barriers to RTW in health services as:

- (a) Workforce composition;
- (b) Difficulty in identifying suitable alternative duties, due to budget and staffing constraints;
- (c) Workplace culture;
- (d) Line managers had limited understanding and commitment for RTW;
- (e) Limited access to RTW policy and practices, including inability of staff to access the workplace intranet services;
- (f) Difficulty with establishing cooperative relationships with treating doctors;
- (g) Workplace stress;
- (h) Agents spend minimal time in the workplace restricting understanding of the nature of issues that impact on RTW;
- (i) Failure to identify psychological factors that affect RTW; and
- (j) A lack of careful assessment of the ergonomic design of equipment is leading to additional problems for RTW (Fellows Medlock & Associates, 2007).

The Review has reported on a “Good Practice Model” to assist the health sector improve the management of RTW, and includes:

- (a) "Appropriate and effective systems;
- (b) Competent and knowledgeable RTW staff and line management;
- (c) Early intervention and early RTW;
- (d) Active involvement from Boards and senior management in driving RTW performance;
- (e) A positive and supportive culture, that return's injured workers to their normal duties;
- (f) The individual worker's understanding and expectations of their medical condition, RTW and rehabilitation;
- (g) Consideration of psychosocial and environmental influences on a worker's rehabilitation;
- (h) Effective and timely communication and good teamwork between all stakeholders in the RTW process;
- (i) Different interventions according to the phase of injury and rehabilitation; and
- (j) Continuously improving systems, processes, skills and knowledge" (Fellows Medlock & Associates, 2007:i).

2.3 International

2.3.1 United Kingdom

The Royal College of Nursing (2006) survey on the wellbeing and working lives of nurses in the United Kingdom received 2, 813 responses. This survey is important in identifying the nature of injuries and issues that impact on the wellbeing and working lives of nurses. It does not address the RTW of injured and/or ill nurses.

2.3.2 Canada

The Occupational Health and Safety Agency for HealthCare in British Columbia (2004) reported on workplace injuries and illnesses in the Healthcare Sector across Canada. The objectives of the Report were to identify (a) patterns of injury and disease; (b) impact of nursing policy and practice changes on the incidence of injury and/or disease; and (c) data limitations (OHSAS, 2004). Data on time loss workers compensation claims, was collected from the Association of Workers Compensation Boards of Canada on each of the Provinces for a ten year period from 1992-2002.

The report recommended:

- (a) Inclusion of early intervention in RTW programs to assist the rehabilitation of injured

workers; and

(b) Preventative programs for musculoskeletal injuries, violence prevention programs and psychological stress (OHSASBC, 2004).

18, 676 Canadian nurses participated in the 2006 National Survey of the Work and Health of Nurses, of which:

- (a) 9% reported a work related injury in the past year;
- (b) One in three nurses reported pain or discomfort, aching or tingling serious enough to prevent them from carrying out their normal work activities;
- (c) Almost 20% reported pain which affected their ability to perform their job;
- (d) Nearly 1 in 10 reported that they were depressed due to their work in the past 12 months; and
- (e) 5% lodged a workers compensation claim with time loss (Health Canada, 2006).

The survey did not investigate whether injured and/or ill nurses were supported in their return to work and/or were able to return to nursing work (Health Canada, 2006).

2.3.3 United States of America

4, 826 nurses' across the USA, in 2001, participated in the American Nurses Association (2001) survey of the health and safety of nurses. The Survey identified that:

- (a) 40% of participants had been injured at work in the past year;
- (b) 80% did not feel safe in their working environment;
- (c) 48% had exacerbated their injury through work;
- (d) Approximately 30% of nurses who sustained an injury did not report their injuries because they:
 - (i) Didn't think the injury was significant;
 - (ii) Were too busy;
 - (iii) Feared retribution;
 - (iv) Were not encouraged to report the injury and seek treatment;
 - (v) Had no one to cover for them; and
 - (vi) Had no mechanism for reporting injuries.

3. Evidence of RTW Programs in Hospitals.

The objective of stage 3 of the Literature Review was to analyse research for hospitals that

had implemented a holistic approach to rehabilitation and RTW of injured and/or ill nurses, linked to OH&S prevention. International, but not Australian, hospital RTW programs were identified.

3.1 International

3.1.1 USA – John Hopkins Hospital and associated facilities

In 1992 John Hopkins Hospital and associated facilities in Baltimore, Maryland USA, implemented an integrated workers compensation claims management system to control the incidence and costs of work related injury and illness for nurses and other employees (Bernacki et al, 2000; Bernacki and Tsai, 2003). In the ten year period 1992 to 2002 the number of employees increased from 20,969 in 1992 to 39,063 in 2002. The study identified that the early return to work program implemented at John Hopkins Hospital was integral in controlling the duration of workers compensation claims and claims costs.

Pre-1992 the workers compensation management system at John Hopkins and associated facilities was limited to processing and payment of workers compensation claims. In 1991 it was decided to broaden the scope and adopt managed care strategies through the integration of workers compensation with health, safety and medical functions. The objective was to prevent environmental risks and reduce workers compensation claim costs (Bernacki et al, 2000; Bernacki and Tsai, 2003; Bernacki and Tsai, 1996; Green-McKenzie et al, 1998). This amalgamation brought a change to the philosophy regarding claims management.

The integrated workers compensation system adopted:

- (a) A non-adversarial approach to manage injuries, which encouraged early reporting, injured worker advocacy, and facilitation of care;
- (b) Preventative measures as primary strategies in managing claims;
- (c) A psychosocial approach to the management of injuries, with the objectives to:
 - (i) Build supportive relationships;
 - (ii) Be considerate; and
 - (iii) Tend to the psychological and emotional needs of the injured worker.
- (d) Provision to each injured worker up to date information on their current condition and prognosis;
- (e) Realistic return to work expectations was set;
- (f) Occupational physician and onsite nurses to coordinate the voluntary injury management process from:

- (i) Accident prevention to job-site evaluations to ergonomic assessments to RTW with monitoring until the claim is closed.
- (g) Weekly multidisciplinary case management group meetings to review claims; and
- (h) Monthly Workers Compensation claims management workshop, to formulate plans to manage each time loss claim with an emphasis on RTW (Bernacki and Tsai, 2003; Green-McKenzie et al, 1998).

Bernacki et al (1996, 2000,) and Bernacki and Tsai (2003) reported that:

- (a) A sophisticated real time database was created to:
 - (i) Enable all parties to input information; and
 - (ii) Access relevant information, for instance OH&S professionals had access to nature and mechanism of injury data.
- (b) A reduction in the number of time loss claims from 22 per 1000 employees to 6 per 1000 employees was achieved from 1992 to 2002;
- (c) Industrial Hygienists, in work environments where managers advised they could not provide suitable return to work duties, undertook worksite assessments and identified in 54% of cases suitable RTW duties for injured and/or ill workers (Bernacki et al, 1996, 2000).

Bernacki and Tsai (2003:513) believed that this reduction in time loss is “associated not only with the use of modified duties, but also with continuous assessment and improvement of work areas where injuries occur.” Bernacki et al (2000) concluded RTW programs that are early and well structured are:

- (a) Integral to reducing time loss and claims costs; and
- (b) Require participation from all parties - injured workers, supervisors, OH&S professionals and medical professionals.

3.1.2 British Columbia, Canada – PEARS Program

Yassi et al (2005) reported on an evidence based initiative to improve health and working conditions of healthcare workers in British Columbia, Canada. The healthcare workforce, healthcare employees, and unions, in 1999, entered into a partnership to develop the Occupational Health and Safety Agency for Healthcare (OHSAS) in British Columbia. An initiative of OHSAS is the Prevention and Early Active Return to work Safely (PEARS) Program.

The PEARS program is based on the integration of primary (prevention of injury) and secondary (prevention of impairment through early intervention) prevention measures in injury management. There are 20 PEARS Principles. The aim is for an integrated approach involving effective communication between stakeholders with a singular collaborative focus. Essential components include: “senior management participation and commitment to a culture

of safety; creating a participatory, supportive, work climate; and cooperation and trust between management and labor (unions) in injury prevention and facilitating the return to work process" (Davis et al, 2004:2).

The PEARS Program was piloted in 2002 on the 6,000 employees of Vancouver General Hospital. The hospital was chosen due to its well established musculoskeletal injury prevention team, and prevention of musculoskeletal injury to nurses was a primary focus of OHSAS. Davis et al (2004:3) advised that "the theory of the program proposed that primary prevention activities combined programmatically with on site intervention activities that had bi-partite support, would act synergistically to enhance injury prevention, as well as reduce disability."

362 registered nurses with musculoskeletal injuries volunteered to participate in the PEARS program. Early intervention activities as part of the PEARS program were offered onsite to injured workers and included:

- (a) Physiotherapy;
- (b) Review of work tasks, to identify improvements in work practises to prevent further injury – with advice and training given where appropriate;
- (c) Workplace assessment, modification and purchase of equipment where necessary;
- (d) Modified RTW with reduced hours and/or duties;
- (e) Onsite access to a doctor (OHSAS, 2004).

The first year's study found no reduction in the incidence of time loss musculoskeletal injuries. The study attributed this to the isolation of primary prevention from early intervention activities (Davis et al, 2004).

The goal was that once workplace modifications had been implemented there would be a focus on primary prevention. The research, however, identified that 95% of PEARS program participants received physiotherapy but only 16% had their workplace modified to accommodate their injury (Davis et al, 2004). Improved coordination of primary prevention and early intervention activities was identified as an area to be addressed in ensuring the effectiveness of the program.

The study concluded that the early intervention program appears to have been effective in returning injured nurses more promptly to their pre-injury role and in reducing time loss and compensation expenses but not in reducing the occurrence of time loss musculoskeletal injuries (Davis et al, 2004; Yassi et al 2005).

Concurrently a pilot was also undertaken for all employees at Royal Columbian Hospital, Vancouver. The objective of the study was to ascertain the influence of the PEARS program on incidence of:

- (a) Injuries reported;
- (b) Musculoskeletal injuries reported;
- (c) Time loss of musculoskeletal injuries;
- (d) Duration of all time loss injuries; and
- (e) Compensation and health care costs (Badii et al, 2006).

Participation in the program was voluntary and 216 participated in PEARS. In the first year there was an increase in time loss musculoskeletal injuries which was attributed to (a) increased reporting and (b) injured workers taking time off to recover from injury when in the past it was unlikely they would have (Badii et al, 2006). Badii et al (2006: 1163) believe the program has been effective in returning injured workers back to work in a shorter period of time, but note "more research is needed to identify the components that contributed to this reduction, ie physiotherapy, onsite physician consultation, ergonomic assessments, workplace modifications, the bipartite support for the program, and so on."

Research undertaken by Ouellette et al (2007) on the satisfaction with the PEARS program identified that:

- (a) 60% participated in the program due to the provision of free physiotherapy;
- (b) Only a low proportion of PEARS participants had their workplace assessed or modified despite the focus on workplace assessment and modification;
- (c) 44.5% didn't participate in the voluntary program as they perceived their injury as minor; and
- (d) 65% of participants who received workplace assessments and modifications reported that this was successful.

This research (Ouellette et al, 2007) reinforces Davis et al's (2004) conclusion that for the program to be more effective there needs to be improved coordination between primary prevention and early intervention. The PEARS program, however, is in its infancy and research is ongoing.

4. Objective of Literature Review

The objective of the *Literature Review* was to provide a review of published sources on RTW to assist to identify barriers to and factors for successful RTW of injured and/or ill nurses.

The *Literature Review* identified the limited sources on RTW of nurses specifically following work caused injury and/or illness. The Review also reports the experiences of injured and/or ill workers and is relevant to nurses.

The *Initial Report on Factors for and Barriers to Successful Return to Work* will outline more specifically the identified barriers and factors for successful RTW, with a more specific emphasis on RTW of nurses.⁵

The factors for and barriers to successful RTW of nurses also will be further explored in the Nurses Return to Work in Hospitals Project through:

- (a) Focus groups with injured and/or ill nurses;
- (b) Discussion with those who affect the RTW of injured and/or ill nurses; and
- (c) Pilot projects in Victorian Hospitals.

⁵ *Report 2 – Initial Report on Factors for and Barriers to Successful Return to Work* (Australian Nursing Federation (Victorian Branch), September 2007).

Appendix 1

Author(s) year	Purpose	Sample/Setting	Method/Analysis	Key Findings
Kenny (1995a)	Identify and determine barriers that hinder the reintegration of long term injured workers'.	12 injured workers'	Survey and interviews	Identified a number of barriers that impact on the RTW work process.
Kenny (1995b)	Identify the impact of employer-injured worker relationship on RTW.	49 injured workers and 23 employers	Survey and interviews	Four themes emerged: 1. Insufficient knowledge of rights and legislation; 2. Communication breakdown between injured worker and employer and other stakeholders; 3. Negative perception of injured workers by employers; 4. Structural and organisational difficulties with the provision of occupational rehabilitation.
Kenny (1998c)	The objective was to identify factors that predicted return to work.	407 injured workers	Survey	Employers that are pro-active in managing injuries, are informative and safe, ensures a better educated workforce in negotiating RTW.
Kenny (1998a)	The role of rehabilitation providers.	19 rehabilitation providers	Survey and Interview	Barriers related to identification of primary client, misconception of rehabilitation role, communication, and obstruction by stakeholders.
Kenny (1998b)	Key stakeholders' perception of rehabilitation providers.	49 injured workers, 23 employers, 9 general practioners and 14 insurance agents.	Survey and Interview	Key stakeholders verified rehabilitation providers' lack of knowledge of the workplace, provide stereotypical RTW plans and lack ownership or responsibility for RTW.
Roberts-Yates (2004)	Identify from injured workers' perspective practical considerations that need to be addressed in workers compensation and rehabilitation.	85 Injured workers	Interview	Barriers to and factors for successful RTW were identified.

Roberts-Yates (2006)	To obtain a practical understanding of an employer's viewpoint of the workers compensation and rehabilitation process.	40 employers	Interview	Barriers to and factors for successful RTW were identified.
Sdrinis (1995)	The aims of the project were to: 1. Identify problems and barriers to effective RTW; 2. Identify factors which positively contribute to the RTW outcome; and 3. To develop strategies that reduce and overcome barriers to RTW.	8 Employers and 33 injured workers	Survey and interview	The barriers identified: Lack of understanding and knowledge of RTW process; Failure to provide suitable RTW duties and address rehabilitative options for injured workers who cannot return to their pre-injury work; and a tendency to view rehabilitation in a limited context of getting back to work.
Klein and Associates (1996)	Employer and worker attitudes to return to work in the metropolitan small business sector.	Injured workers, employers, general practitioners and insurance agents	Focus Groups	A number of criticisms of the RTW process were identified.
Calzoni's (1997)	The project aimed to give injured workers a voice through storytelling of their experiences of RTW.	Injured workers	Stories	Enable injured workers to communicate their thoughts and feelings about their injuries and RTW.
Working Women's Centre (2004)	The project aimed to explore the following issues: experience of workplace injury and rehabilitation, does this differ for men and women, what hindered and/or helped during rehabilitation and RTW, do statistics consider psychosocial aspect of workplace injury and gender differences, and to identify best practice strategies to assist rehabilitation and RTW.	123 Injured workers, 9 employers, rehabilitation coordinators, 20 health and safety representatives, unions, insurance agents.	Survey and interview	Identified barriers and factors to RTW from injured workers and employers perspectives.
Victorian WorkCover Authority (2007)	The objective of identifying barriers to RTW and to make recommendations for effective RTW strategies.	100 Employers	Interview	Health sector employers identified barriers to RTW and made recommendations for improvements.

Baril et al (2003)	Aimed to identify what the participants of RTW regarded as the most effective strategies in returning injured workers with musculoskeletal injuries to work, and what impedes and / or facilitates the RTW process.	Injured Workers, employers, union, OHS representatives, and healthcare providers.	Surveys, one on one Interviews, focus groups	Common themes emerged: Importance of trust; communication and labour relations in the failure and/or success of RTW of injured workers.
Beardwood et al (2005)	Undertook a study aimed at determining barriers and facilitators for return to work from a stakeholder perspective.	17 injured workers	Survey and Interview	Themes emerged relating to: genuineness of injury; lack of involvement in RTW process; lack of control over management of injury and treatment.
Friesen et al (2001)	The purpose of the study was to determine barriers and facilitators for RTW.	55 Key Stakeholders	Individual interviews and focus groups	Perceived barriers: delivery of information or treatment; and ineffective communication among stakeholders. Perceived facilitators: RTW programs in the workplace; effective communication and teamwork; and trust.
Kirsch and McKee's (2003)	Study was on the needs and experiences of injured workers to develop strategies for change.	50 injured workers	2 day Workshop	Findings indicated many experience undue financial, emotional and physical hardship. Strategy is to empower workers and create a more supportive RTW climate.
Langford (1996)	A survey of occupational illness and injury incurred by nurses in the Victorian health services industry.	170 injured and/or ill nurses	Survey	Identified types of injuries sustained by nurses in their work and the impact on their long term health, future income and work prospects.

NSW Workforce Research Project (2000)	The Project aimed to determine why enrolled or registered nurses in NSW were not working as nurses and to identify the conditions and/or incentives required to encourage these nurses to return to the nursing profession.	10,089 nurses	Survey and Telephone interviews (98)	6.7% of nurses had left nursing due to health concerns and work related injuries. Nurses commented in the telephone interviews when they sustained an injury/illness there was a: (i) Lack of support from management and colleagues; (ii) A perception of abandonment; (iii) A concern of diminished value as a nurse; and (iv) Little or no assistance in finding alternative or modified duties.
Nurse Recruitment and Retention Committee Final Report (2001b, 2001c)	A quantitative and qualitative survey of the attitudes, beliefs and behaviour of registered nurses in Victoria who are currently not working in the nursing profession.	2,089 nurses	Survey	17% of registered nurses were not looking for nursing work due to injury/illness. Nurses reported barriers to returning to the nursing profession: (i) Work caused injuries/illness perceived to be a result of poor working conditions; (ii) A lack of support from management when injury/illness occurs; (iii) Nurses often feel unable to RTW due to lack of alternative duties; and (iv) Injured/ill nurses want to work but feel the inflexibility of the workplace and their employers are barriers to gaining suitable employment.
Fellows Medlock & Associates (2007)	The objective was to review RTW practices within health services across Victoria.	Key stakeholders	Face to face interviews	Identified barriers to RTW and factors for successful RTW. Developed good practice model on RTW for health sector.
The Royal College of Nursing (2006)	Wellbeing and working lives of nurses in the United Kingdom	2,813 nurses	Survey	Identified issues that impact on the wellbeing and working lives of nurses.

Occupational Health & Safety Agency for HealthCare in British Columbia (2004)	The objectives of the report were to identify (a) patterns of injury and disease; (b) nursing policy and practice changes that may have impacted on and/or causally affected the incidence of injury and/or disease; and (c) data limitations.	18,676 nurses	Survey	The report recommended: Inclusion of RTW programs of intervention in the rehabilitation of injured nurses; and preventative programs for musculoskeletal, violence prevention and psychological stress.
American Nurses Association (2001)	Health and safety of nurses.	4,826 nurses	Survey	The survey identified: a reluctance to report incidents; many felt their workplaces were unsafe, many had sustained injuries and then re-aggravated due to the nature of their work.
Bernacki and Tsai (1996)	3 years' experience in identifying and abating workplace hazards and medically managing workers compensation cases utilising an integrated managed care program.	All employees who sustained work caused injury.	Data from John Hopkins Self-Insured Workers Compensation Program.	Results indicate that environmental risk management and medical care management can be integrated with positive results in reducing injury and associated costs.
Green-McKenzie et al (1998)	Comparing before and after the implementation of the integrated managed care program at John Hopkins Hospital with particular focus on quality of care.	All employees who sustained work caused injury for the period 1990-1993.	Data from John Hopkins Self-Insured Workers Compensation Program.	Concluded that managed care can reduce claims costs, but that it was difficult to determine if this affected quality of care as they were unable to directly examine this.
Bernacki et al (2000)	Reported on facilitators of successful RTW.	All employees who sustained work caused injury.	Data sourced from Occupational Safety and Health Administration, John Hopkins Hospital.	It was concluded that for RTW to be effective this must include participation from the injured worker, supervisor, medical providers, and safety professionals. Getting RTW right is integral to control the length of time loss and costs associated with work caused injury or illness.

Bernacki and Tsai (2003)	10 years experience of an integrated managed care program at John Hopkins Hospital and associated facilities.	All employees who sustained work caused injury 1992 - 2002.	Data sourced from Occupational Safety and Health Administration, John Hopkins Hospital.	The data suggests that an integrated managed care program reduces the cost of workers compensation.
Davis et al 2004	Healthcare workers are at a high risk for musculoskeletal injuries. A program was developed to decrease injuries and associated time loss.	362 registered nurses at Vancouver Hospital, Canada	Data sourced from OH&S Department Vancouver Hospital.	Study identified no reduction in incidence of injury, but concluded program more effective at returning injured workers to work earlier.
Badii et al 2006	Objective of study is to investigate effectiveness an integrated workplace based program to reduce musculoskeletal injury and time loss.	216 employees at Royal Columbian Hospital, Vancouver, Canada	Comparison of data 3 years pre-program with 1 year of data during program.	It was concluded that time loss injuries increased, but duration of RTW decreased which led to a reduction in claims costs.
Oullette et al (2007)	A study of utilisation and satisfaction with PEARS program to determine further development directions of the program.	335 injured healthcare workers	Survey	It was identified non-participation in program related to perception of injury as minor. PEARS participants accessed more services than non-participants.

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