

Report 8

Nurses Return to Work in Hospitals - Pilot Program in 5 Victorian Hospitals.

An Australian Nursing Federation (Victorian Branch) Project

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Abbreviations

ANF (VB) – Australian Nursing Federation (Victorian Branch)

HR – Human Resources

OHS – Occupational Health and Safety

ORP – Occupational Rehabilitation Provider

RehabMoC – Rehabilitation Model of Care

RTW – Return to Work

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Purpose

As part of the Nurses Return to Work in Hospitals Project, it was proposed to undertake a Pilot Program with hospitals in Victoria.¹

The research phase of the Project assisted in identifying what to Pilot and included a:

- ◆ Literature Review of Barriers and Factors to Successful Return to Work;
- ◆ Analysis of Return to Work Data;
- ◆ Focus Groups with injured and/or ill nurses; and
- ◆ Discussions with key organisation who affect the Return to Work of Nurses (ANF (VB); 2007a, 2007b, 2007c, 2008a, 2008b).

The research identified the need for a shift towards a holistic approach to the management of workplace injury and/or illness, with the emphasis on rehabilitation with return to work as one component of this. The Project determined to develop a model to Pilot, known as the Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria, providing a holistic framework for the management of workplace injury and/or illness.

The objective, in developing the model, has been to focus on what works in Return to Work (RTW) that is to the benefit of the injured nurse and their employer.

Methodology

The methodology applied for the Pilot Program is based on Action Research, "which has dual aims of action and research":

- ◆ Action to bring about change in an organisation; and
- ◆ Research, where the participants and researcher are involved in the research process, and outcomes evolve from this (Dick, 1993:4).

In applying action research, this has enabled the Pilot Program to be responsive to qualitative and quantitative research in influencing change in Return to Work (Dick, 1993).

Where possible the Project has utilised participants own language.

Scope of Report

The Pilot Program Report will:

- ◆ Define Return to Work;

¹ Attachment 1 provides an overview of the Nurses Return to Work in Hospitals Project.

- ◆ Provide background to the Pilot Program;
- ◆ Outline the development of a Model to Pilot;
- ◆ Apply the Pilot Program in 5 Pilot Hospitals; and
- ◆ Undertake three case studies in the Pilot Hospitals.²

It is not within the scope of this report to provide recommendations, as this will be reported on in Nurses Return to Work in Hospitals Project Final Report in September 2009.

1. Defining Return to Work

There is a presumption that everyone understands what RTW means, but what is RTW? Defining RTW it could be considered is obvious. It simply means return to work and in this context following a work related compensated injury. However the extent to which there is a shared meaning is surprisingly small (Young et al, 2005).

Athansou (2005) and Calvey and Jansz (2005) advise that RTW is based on the medical model which focuses on the set timeframes for recovery from a particular injury, for instance 13 weeks, 26 weeks, 52 weeks, 130 weeks etc... RTW can be measured by a return to full time or part time employment, other than the pre-injury role (Joy, Lowy and Mansour, 2001). RTW is where an injured worker returns to any paid employment, regardless of employer (Commonwealth, 2003). It can be an injured workers desire and/or ability to do everything possible to RTW (Shaw and Hsuang, 2005). Krause et al (2001:465) describe RTW as "the duration or extent of an inability to work due to impaired health and functional limitations." RTW is the early return to the workplace without being fully recovered from the work caused injury, which means "workers are back in the workplace in some capacity, often modified, while they may still be undergoing treatment such as physiotherapy and/or taking medication" (MacEachen, 2006:257). Friesen et al (2001) define RTW as a complex process which requires:

- (a) An injured worker to recover from injury;
- (b) To be assessed by a treating GP for a capacity for work;
- (c) The insurance agent to pay for rehabilitation services where required; and
- (d) The employer to provide pre-injury role and/or alternative or modified duties and to keep a position available for 52 weeks from date of injury.

Therefore there are a number of ways to define RTW. This report will utilise the definition outlined at 1.3 of the Report.

² Please refer to the Evaluation Report: Nurses Return to Work in Hospitals Pilot Program for the evaluation findings of the Nurses Return to Work in Hospitals Pilot Program.

1.1 State Jurisdictions definition of RTW

The Victorian WorkCover Authority (2007) defines RTW as helping an injured worker get back to work or stay at work while they recover from an injury. WorkCover NSW (2009) defines injury management as ensuring the prompt, safe and durable return to work of an injured worker. Injury management is defined as ‘the management of workers’ injuries in a manner that is directed at enabling injured workers to return to work’ (WorkCover, 2001:5). WorkCover Tasmania (2009) explains the RTW process as ensuring that everything possible is done to enable the injured worker to return to the workforce as soon as possible and to minimise the physical, psychological, social, vocational and economic consequences of work injuries. QCOMP (2009) outlines that workplace rehabilitation means helping an injured worker back to safe and suitable work at the earliest possible time. WorkCover SA (2009) defines rehabilitation as an entitlement that is a managed process that aims to assist an injured worker to achieve the best practicable level of recovery following a work injury or illness, to return to safe, suitable employment as quickly as possible, and to reduce the impact of a serious work injury or illness.

Return to Work is therefore defined differently in each State. It can be defined as injury management, rehabilitation and/or return to work.

1.2 So, What is Return to Work?

For something that is considered quite simple it is evident that it is actually quite difficult to define RTW, which inadvertently leads to RTW being defined in an ambiguous manner. To focus solely on RTW is flawed, as this fails to acknowledge the number of phases that an injured nurse will go through as part of the rehabilitative process following a workplace injury and/or illness (Friesen et al, 2001; Young et al, 2005). In focusing on RTW this also takes focus away from the individual with the work related injury, therefore taking the human out of the process. As a consequence it is limiting to focus solely on RTW.

The *Nurses Return to Work in Hospitals Project* defines return to work as one component of Rehabilitation. RTW therefore means, in this context, return where possible to the pre-injury role following a workplace injury.

1.3 Defining Rehabilitation

The *Nurses Return to Work in Hospitals Project* defines rehabilitation as:

The restoration of the injured to their fullest physical, mental, social, vocational and economic capabilities, it begins from the moment of injury or disease and continues until the nurse returns to meaningful and productive employment.

To achieve maximum recovery rehabilitation should therefore include:

- (i) The physical, social and psychological rehabilitation of the injured and/or ill nurse and assistance in returning them to their work as nurses;
- (ii) A commitment to recovery and return to work from both the employer and injured nurse;
- (iii) Provision of meaningful, productive, safe and durable return to work of injured and/or ill nurses identified through consultation with the injured/ill nurse, their employer, treating doctor and other key stakeholders;
- (iv) Early identification of those injured and/or ill nurses who cannot or potentially will be unable to return to their pre-injury nursing role and assistance provided for training and re-skilling to achieve meaningful and productive alternative employment with potential to achieve similar income to that prior to injury/illness;
- (v) Strategies for long term injured nurses who will never return to work in any capacity and this must encompass quality of life to the maximum possible level; and
- (vi) The linking of rehabilitation with prevention of injury and/or illness to nurses in hospitals (ACTU, 2007).

This is the definition utilised for the Draft Rehabilitation Model of Care for injured and/or ill nurses in Victoria, to be discussed below.

1.4 What is the RTW Strategic Focus?

The Nurses Return to Work in Hospitals Project strategic focus is on the injured nurse. As outlined above the focus is on rehabilitation, with RTW as one component, and the integral relationships between the injured nurse, their NUM/ANUM, Medical Practitioner and RTW Coordinator, in achieving successful RTW.

The strategic focus at a macro level is on the system that is the framework for the management of workplace injury. A model has been developed for the management of workplace injury. At a micro level the Project has listened to nurses who have advised they want to remain in nursing, therefore our focus has been on:

1. Developing a Guide for identifying suitable RTW duties that are “real” nursing duties.³

³ Guide on Return to Duties and Guide on Nursing Roles and Employment Opportunities were developed outside of the Pilot Program but by the Nurses Return to Work in Hospitals Project, and will not be expanded upon in this report. For further information as to the development of these Guides refer to Report 6 *Examine the Feasibility of*

2. Developing a Brochure for Nurses on “What to do if injured?” (Attachment 2).
3. Training and educating nurses on rehabilitation and return to work (Appendix 2).
4. Developing an internal vocational rehabilitation process to be applied with the pre-injury employer where a nurse is unable to return to their pre-injury role (Appendix 3).
5. Developing material for Medical Practitioners on their role in rehabilitation and return to work (Appendix 4).
6. Developing a Guide to assist with career planning and identifying nursing roles and employment opportunities where an injured nurse is unable to return to their pre-injury role.⁴

Points 3, 4 and 5 will be expanded on below.

2. Background to the Pilot

In identifying what to Pilot, the Project drew on the research that had been undertaken to date, Reports 1 to 5. Injured nurses are/is the focal point of the Project. Therefore, it was necessary to ensure that the Pilot would meet their needs, and at the same time meet the needs of employers in improving RTW outcomes.

2.1 What to Pilot?

In determining what to Pilot we reviewed what Nurses had advised the Project in *Report 4 Experience of Injured and/or Ill Nurses in Victoria – Focus Groups* (sic):

- ♦ The negative experiences of their RTW plan, especially a lack of communication, documentation and coordination of the RTW plan by their employer.
- ♦ In a number of cases a RTW plan was developed which identified modified or alternative duties, but the employer did not implement it in the workplace.
- ♦ Their RTW plan was not suitable for a nurse as the duties they were being asked to engage in were non-nursing duties, such as administrative duties, answering phones, filing, hanging residents clothes, etc.
- ♦ Lack of understanding of the impact of the injury or illness on the individual and their family, compounded by the failure to incorporate this into the RTW plan.
- ♦ Should have full involvement in the development and implementation of their RTW Plan.
- ♦ Should be informed of their rights.
- ♦ RTW duties should involve meaningful nursing duties whether or not this is outside the injured/ill nurses’ pre-injury workplace.

Catalogue of Return to Work Duties and Employment Opportunities to support RTW Planning (ANF, 2008b).

⁴ Op cit.

- ◆ Alternative duties should be nursing duties focused on what an injured and/or ill nurse can do rather than what they cannot do.
- ◆ A RTW Coordinator should understand the cause, nature and mechanism of injury and/or illness and be empathetic to the needs of injured and/or ill nurses.
- ◆ Should be assisted to RTW as a nurse, whether in their pre-injury role or in an alternative role, and recognised early in their pre-injury workplace.
- ◆ Participants believed that if there was a need for retraining, the injured nurse should be allowed to focus on an area of interest, which could assist in improving quality within their workplace and enable nurses to remain in a nursing role (ANF, 2007d).

It was also necessary to draw upon research that identifies what works in RTW, and *Report 2 Initial Report on Factors for and Barriers to Successful Return to Work* (ANF, 2007b) provides synopses of factors for successful RTW, which are outlined below:

(a) Positive and continual communication between injured workers and their employers and other stakeholders (Baril et al, 2003; Bernacki and Tsai, 2003; Fellows Medlock & Associates, 2007; Friesen et al 2001; Kenny, 1998b; Klein and Associates, 1997; Roberts-Yates 2006, 2004; WorkCover NSW, 2004; WorkCover WA, 1998; Working Women's Centre SA 2004).

(b) Proactive occupational health & safety (OH&S) work environments (Bernacki and Tsai, 2003; Calzoni, 1997; Davis et al, 2006; Friesen et al 2001; Kenny, 1998c; Roberts-Yates 2006; WorkCover WA, 1998; Working Women's Centre SA 2004).

(c) A work centred approach to recovery from injury and/or illness – with RTW as the primary goal (Bernacki and Tsai, 2003; Davis et al, 2006; NSW WorkCover, 2007).

(d) Recognition of genuineness of injury (Baril et al, 2003; Beardwood et al, 2005; Kenny, 1995b; Roberts-Yates, 2004; Working Women's Centre SA, 2004).

(e) Psychosocial approach to the management of injuries (Bernacki and Tsai, 2003; Fellows Medlock & Associates, 2007; Foreman et al 2006; PriceWaterhouse Coopers, 2003; Roberts-Yates, 2004; Working Women's Centre SA, 2004).

(f) Sustainable, safe, meaningful and durable RTW duties (Bernacki and Tsai, 2003; Calzoni, 1997; Kenny, 1998c, 1995b; Klein and Associates, 1997; Roberts-Yates 2006, 2004; Working Women's Centre SA 2004).

(g) Collaboration between injured workers, their employers and other key stakeholders in the RTW process (Foreman et al 2006; Roberts-Yates, 2004; WorkCover NSW, 2004; WorkCover WA, 1998).

(h) Knowledge of process, rights and obligations (Kenny, 1998c; Roberts-Yates, 2004).

(i) Access to information (Bernacki and Tsai, 2003; Fellows Medlock & Associates, 2007; Kenny 1995a; Kirsh and McKee, 2003; Roberts-Yates, 2004; Working Women's Centre SA 2004).

(j) A people orientated approach by management, based on shared concern (Bernacki et al, 1996, 2000; Bernacki and Tsai, 2003; Fellows Medlock & Associates, 2007; Foreman et al, 2006; Robert-Yates, 2004).

(k) Redesign in the workplace of injured workers' roles (Calzoni, 1997; Kenny, 1995a).

(l) Injured workers' involvement in the development and monitoring of treatment and rehabilitation plans (Beardwood et al, 2005; Kenny, 1998c; Kirsch and McKee, 2003; Robert-Yates, 2004).

(m) Early intervention (Baril et al, 2003; Badii et al, 2006; Bernacki et al, 1996, 2000; Bernacki and Tsai, 2003, Davis et al 2004; Fellows Medlock & Associates, 2007; Roberts-Yates, 2006).

(n) Education of the workplace and wider community (Roberts-Yates, 2004; Sdrinis, 1995).

(o) Different interventions according to the phase of injury and rehabilitation (Fellows Medlock & Associates, 2007).

(p) Competent and knowledgeable RTW staff and line management (Fellows Medlock & Associates, 2007).

(q) Active involvement from Boards and senior management in driving RTW performance (Fellows Medlock & Associates, 2007).

(r) A holistic approach to OH&S, RTW and general health and wellbeing of all employees (VWA, 2007).

The objective in developing a system for the management of workplace injury was to focus on factors for successful RTW rather than on the barriers. The following sources were utilised to provide a framework for developing a system for the management of workplace injury:

- John Hopkins Hospital – Integrated Workers Compensation System.
- Good Practice Model - Victorian Health Services Management Innovation Council.

- Seven Principles for successful Return to Work – Institute for Health and Work (Canada).
- PEARS Principles – Prevention and Early Active RTW Safely – Occupational Health and Safety Agency British Columbia (Canada).
- Return to Work and Injury management Model – WorkCover Tasmania Board (ANF (VB), 2007a).

These sources will be expanded on below.

2.1.1 John Hopkins Hospital – Integrated Workers Compensation System

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).

2.1.2 Good Practice Model – Victorian Health Services Management Innovation Council (Department of Human Services)

A Good Practice model for RTW management put forward in the *Return to Work Review* comprises:

- (a) Commitment to RTW, identified as a core management outcome in the organisation's business plan;
- (b) Clear definition and communication of RTW responsibilities and accountabilities across the health service;

- (c) Consultation with OH&S Committees and OH&S Representatives and communication with managers and employers;
- (d) Training, with specific programs developed for management, RTW and claims management employees and for employees in general;
- (e) Risk management program, for injury prevention and rapid response to injuries;
- (f) RTW management based on early intervention, RTW planning, suitable employment and stakeholder engagement;
- (g) Performance monitoring and reporting; and
- (h) Continuous improvement through auditing, analysis of performance information, feedback from stakeholders and benchmarking against other health services (Fellows Medlock & Associates, 2007).⁵

2.1.3 Seven Principles for successful Return to Work – Institute for Health and Work (Canada)

The Seven Principles for successful Return to Work were developed from a systematic review of the literature on quantitative and qualitative studies on return to work (Franche et al, 2005; MacEachen et al, 2006).

The Seven Principles:

1. The workplace has a strong commitment to health and safety which is demonstrated by the behaviours of the workplace parties.
2. The employer makes an offer of modified work (also known as work accommodation) to injured/ill workers so they can return early and safely to work activities suitable to their abilities.
3. RTW planners ensure that the plan supports the returning worker without disadvantaging co-workers and supervisors.
4. Supervisors are trained in work disability prevention and included in RTW planning.
5. The employer makes an early and considerate contact with injured/ill workers.
6. Someone has the responsibility to coordinate RTW.
7. Employers and health care providers communicate with each other about the workplace demands as needed, and with the worker's consent.

2.1.4 Pears Program – Occupational Health and Safety Agency British Columbia (Canada)

The PEARS (Prevention and Early Active Return-to-Work Safely) 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

⁵For further detail of the RTW Good Practice Model refer to pages 17-24.
<http://www.health.vic.gov.au/managementinnovation/return-to-work.pdf>

PEARS Principles.⁶ The aim is for an integrated approach involving effective communication between stakeholders with a singular collaborative focus (Davis et al, 2004; Ouellette et al, 2007; OHSABC, 2006; Yassi et al 2005).

The following PEARs Principles were utilised in developing the model:

1. Preventing disability must be integrated with preventing injury and illness.
2. PEARs should offer a comprehensive approach to post injury/illness intervention, addressing all risk factors – organisational, environmental and individual. The workplace must always be considered in the assessment.
3. All modified work assignments must be meaningful.
4. PEARs should be recognized as a resource for the larger health and safety culture/environment and should build on previous experience within the workplace.
5. PEARs must be based on research and best practice which include effective communication strategies with all stakeholder groups.
6. There must be recognition of, and respect for existing worker relationships with their family physician and all other relevant healthcare providers.
7. PEARs must be entirely voluntary.
8. PEARs must be designed for rapid intervention.
12. Both employer and union representatives must be involved in all stages of the design and implementation of PEARs.
20. PEARs will ensure that all processes, communication, evaluation, record keeping, and record storage respect the worker's right to confidentiality and privacy and are fully compliant with provisions of Freedom of Information.

2.1.5 Return to Work and Injury Management Model – WorkCover 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.

⁶ For further information www.ohsah.bc.ca

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.⁷

The WorkCover Tasmania Board has approved the model. The expectation is that the model will be ratified in legislation at the end of 2009 (WorkCover Tasmania, 2009).

2.2 Developing a model to Pilot

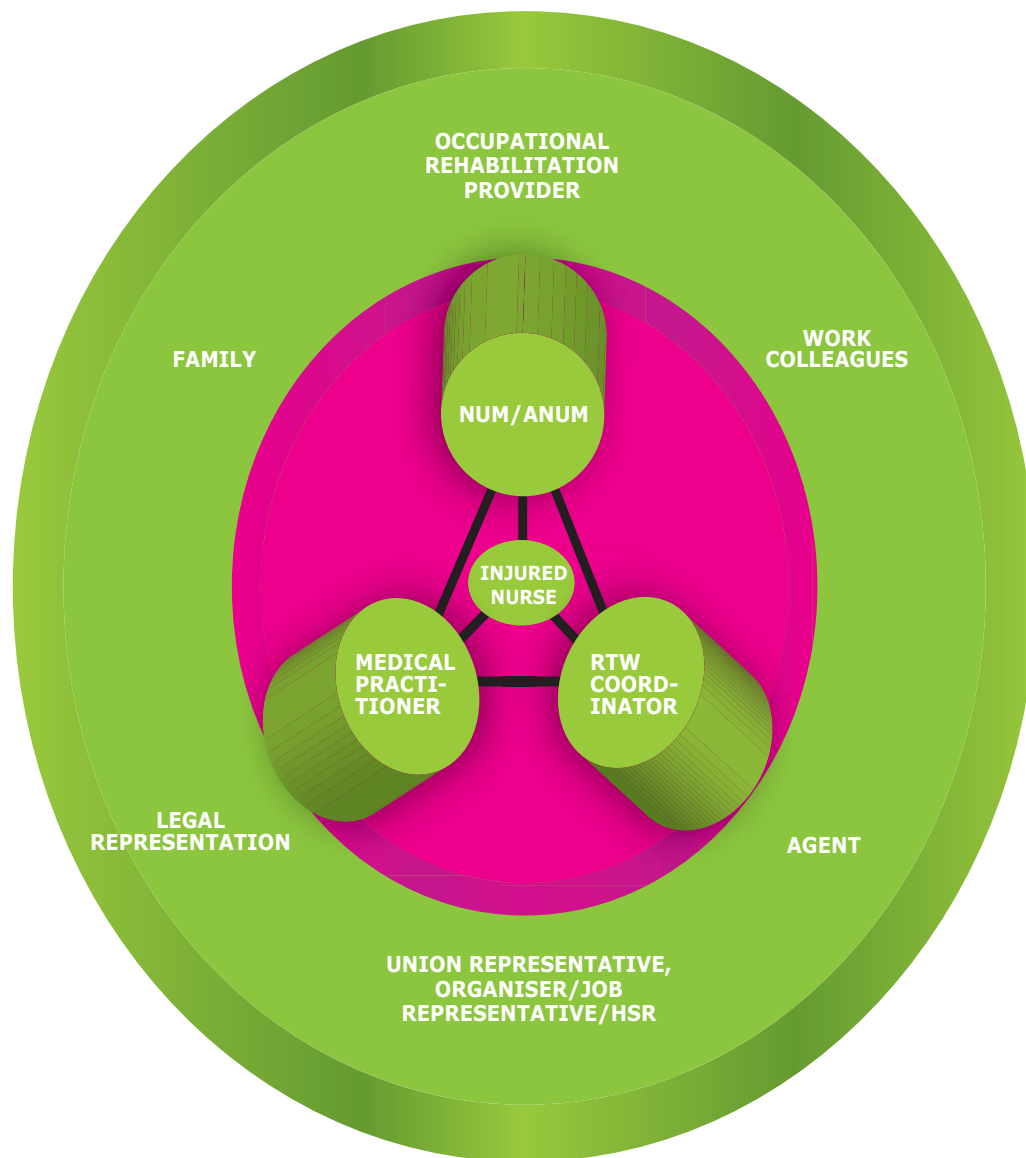
So, what to Pilot to improve RTW for injured nurses? It was identified to improve RTW focus should be at a systems level, that is the framework for the management of workplace injury and/or illness. This in turn led to the development of a model. The above sources provided the content and direction for developing the model.

It is a behavioural model. Why? Simply because how we behave in return to work affects the RTW of an injured nurse. The focus of the model is therefore on the injured nurse, and on the primary stakeholders involved in their rehabilitation and how these relationships are interconnected and play a crucial role in successful RTW (ANF, 2007b). The model identifies that where we get these relationships right, this leads to successful rehabilitation and RTW outcomes for all concerned parties.

The model therefore limits the number of parties involved in the process. Where there are a number of parties involved this leads to a multitude of expectations, which in turn takes the focus away from the injured nurse. Diagram 3 outlines the relationships, with the injured nurse as the centre focus, and defines the primary stakeholders as working together, it does acknowledge the secondary stakeholders as there will be times when it is necessary for them to become involved.

⁷ To access Return to Work and Injury Management Model go to <http://www.workcover.tas.gov.au/node/wrcreturntow.htm>

Diagram 1 Nurses Return to Work in Hospitals Project Strategic Focus of RTW



The emphasis is on rehabilitation and applying this as a model of care, as this reflects nursing practice as nurses' work to a model of care. The objective therefore was to look at the management of injury/illness from a holistic perspective by shifting the emphasis to rehabilitation with RTW as one component of this.

Furthermore it can be argued there is only a limited legislative framework, incorporated within the *Accident Compensation Act 1985*, covering certain specific duties and requirements of employers and injured workers in relation to rehabilitation and return to work in Victoria.

Whilst there are Guidelines for Employers, *Helping Injured Workers get back to work: The Return to Work Guide for Victorian Employers*, these guidelines are limited in nature to matters relating to specified obligations of employers under the return to work provisions of the legislation (VWA, 2005b). The model therefore provides a strategic focus for the management of workplace injury at a macro and micro level.

3. Draft Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria (Draft RehabMoC)

The Draft Rehabilitation Model of Care for Injured and/or ill Nurses in Victoria provides a comprehensive model for rehabilitation and return to work of injured nurses based on a holistic, multi-faceted approach, and is targeted towards employers, nurses and others who participate and/or play a role in the rehabilitation and return to work of injured and/or ill nurses.

The draft RehabMoC aims to deliver better health, rehabilitation and return to work outcomes for injured and/or ill nurses and their employers.

The draft RehabMoC is underpinned by the following principles:

- A non-adversarial approach to manage injuries which encourages early reporting, injured worker advocacy, and facilitation of care.
- Preventative measures applied through policy and practice to prevent injury in the workplace.
- A psychosocial approach to the management of injuries, with the objective to:
 - i. Build supportive relationships;
 - ii. Is considerate;
 - iii. Tends to psychological and emotional needs of injured workers.
- Early intervention is critical. Rehabilitation should commence as soon as possible following injury regardless of determination of liability.
- All parties, including the worker, should:
 - i. View recovery and return to work as the primary goals following a workplace injury and/or illness.
 - ii. Have a shared commitment to these goals; and
 - iii. Work together through co-operation, collaboration and consultation to achieve these goals.
- Rehabilitation will include maintenance of the relationship between the employer and the injured nurse.
- Recognition of the differing phases of rehabilitation.
- Support for long term injured nurses to promote the recovery and restoration of their functional capabilities, return to work and/or employability and/or quality of life, to the maximum possible level.

- All parties, particularly the injured nurse, their employer and medical practitioner should have access to information and support in order to clearly understand their roles, rights and responsibilities.
- Provision of sustainable, safe, meaningful and durable duties.
- Competent, knowledgeable and authoritative return to work coordinator and line management.
- Active involvement from Boards and senior management, particularly in:
 - i. Awareness raising regarding injury and consequence of injury;
 - ii. Adopting fair, equitable and non-discriminatory policies that support injured and/or ill workers.
 - iii. Budget appropriately.
- Continuous evaluation and improvement.

Refer to Appendix 1 for a Copy of the Draft Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria (ANF (VB), 2008c).

4. Pilot Program

Having developed the Draft Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria, for the Nurses Return to Work in Hospitals Pilot Program, it was then necessary to determine which hospitals would be invited to participate in the Pilot Program. The RTW Steering Committee and ANF Industrial Organisers were asked to identify hospitals that had a good reputation with their management of RTW and would be willing to apply learning's in RTW.

In February 2008 seven hospitals were invited to participate in the Pilot:

- Three Public Metropolitan;
- One Private Metropolitan; and
- Three Regional.

Of the original seven hospitals, three declined to participate, one public, one private and one regional hospital. The Project was approached by a private metropolitan hospital asking to participate in the project, which was agreed. As of June 2008, five hospitals agreed to participate in the Pilot Program:

- Two Public Metropolitan – Royal Melbourne and St Vincents Public;
- One Private Metropolitan - HealtheCare; and
- Two Regional – Ballarat Health and Echuca Regional Health.

4.1 Pre-Pilot Program Workshop

In May 2008 a workshop was held with the pilot hospitals. The pilot hospitals were provided with the Draft Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria (Appendix 1), 2 weeks prior to the workshop. The objective of the Workshop was to explain the Pilot Program, to fine tune the Model and to assist hospitals identify what they will pilot for the Pilot Program. The Hospitals at the workshop agreed to pilot the draft RehabMoC. It was also agreed to have follow up consultations at each of the pilot hospitals and for the Project to provide Guidelines for the Pilot Hospitals on the Pilot Program (Attachment 1).

4.1.1 Methodology of the Pilot Program

The methodology applied to the Pilot Program was based on qualitative and quantitative research methods.

Qualitative analysis includes:

- Workshops;
- Focus Groups; and
- Case Studies.

Quantitative analysis includes:

- A Gap Analysis to identify rehabilitation and return to work practices compared to the Draft Rehabilitation Model of Care which will assist in setting benchmarks for the Pilot Program.
- Independent evaluation of the Pilot Program.

It is important to note the Project allowed for flexibility in how the model would be applied in the workplace.

4.1.2 Initial Meetings with Pilot Hospitals

Initial meetings with the pilot hospitals took place between June 2008 and July 2008, and the objective was to go through the guidelines for the pilot hospitals and to organise initial workshop dates. The guidelines cover:

- Goals and Objectives of the Pilot Program.
- What is involved in participating in the Pilot Program?
- What is the difference between employer's legislative obligations for RTW and the Draft Rehabilitation Model of Care?

- How will the Pilot Program be evaluated? (Attachment 3)

Issues identified by the Pilot Hospitals with the original draft RehabMoC:

1. Provisional liability – wouldn't be able to apply due to financial reasons.⁸
2. Two plans (rehabilitation management plan and return to work plan) – advised they wouldn't utilise both due to time constraints and/or the plans didn't fit their current system.

4.2 Pilot Program July to September 2008

In July 2008 the Pilot Hospitals were provided Draft 2 of the Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria (Appendix 1).

The Pilot Program started in July 2008 and concluded March 2009. The implementation phase of the Pilot Program included:

- ♦ Workshop with NUM/ANUMS at each Pilot Hospital.
- ♦ Workshop with Job Representatives/HSR's at each Pilot Hospital.
- ♦ Focus Groups with injured nurses from Pilot Hospitals.
- ♦ Workshop with RTW Coordinators.

4.2.1 Workshops

Workshops at each pilot hospital were conducted in July/August/September 2008. The timing of workshops was negotiated with each pilot hospital. The workshops were for an hour and provided a general overview of the Project and outline of the Draft Rehabilitation Model of Care, and discussion of return to work practices within their Hospital.

The objective of the workshop was to determine understanding and knowledge of rehabilitation and return to work. It was also to determine why the following key elements of the draft RehabMoC are important in rehabilitation and return to work:

1. A Shared Commitment to Rehabilitation and return to work.
2. Access to information and support.
3. Early Intervention.

⁸ Provisional Liability incorporates the following strategies:

- Encourage the employer to make provisional payments of reasonable medical, rehabilitation and other compensable expenses on receiving the injured and/or ill workers claim for compensation.
- Weekly compensation payments are capped at 12 weeks and provisional payments of medical, rehabilitation and other compensable expenses are capped at \$5000.00.
- Payments cease where genuine dispute is determined at Conciliation.

4. Effective communication, consultation, consideration and planning.
5. Timely and appropriate medical management.
6. Early sustainable, safe, meaningful and durable RTW.

Diagram 5 outlines when the Workshops occurred and how many attended.

Diagram 2

Pilot Hospital Workshops

Date	Pilot Hospital	Attendee's	Number
21 July 2008	Hospital C	NUM/ANUMS	7
22 July 2008	Hospital C	Job Representatives/HSR	6
24 July 2008	Hospital D	NUM/ANUMS	0
24 July 2008	Hospital D	Job Representatives/HSR	0
30 July 2008	Hospital D	NUM/ANUMS	10
30 July 2008	Hospital D	Job Representatives/HSR	4
28 July 2008	Hospital B	NUM/ANUMS	9
29 July 2009	Hospital B	Job Representatives/HSR	2
12 August 2008	Hospital C	NUM/ANUM/HSR	16
25 August 2008	Hospital A	NUM/ANUMS	13
26 August 2008	Hospital A	Job Representatives/HSR	0
4 September 2008	Hospital E	NUM/ANUMS	3
4 September 2008	Hospital E	Job Representatives/HSR	0

NUM/ANUM's attendance at the workshops was high, whilst attendance by Job Representatives and HSRs was disappointing. One reason could be that they do not see this as part of their role. Those who did attend commented that their roles should not be broadened to incorporate RTW. Others commented that there is no framework for RTW in the workplace and there is a lack of awareness of roles, whilst others had only been in their HSR roles for less than a week, and there was a need for educating them in rehabilitation and return to work in general.

NUM/ANUM's who attended the workshops demonstrated their knowledge and understanding of rehabilitation and return to work. Rehabilitation is looking at the whole person and the impact of injury on recovery from physical and emotional perspective.

RTW is planning and identifying duties. There was however a lack of understanding of rehabilitation and return to work's interconnectedness.

There was acknowledgement by participants of the importance in rehabilitation and return to work of (sic):

1. A Shared Commitment to Rehabilitation and return to work
 - It is the only way it can work;
 - Working together, not working against each other, if things are integrated it works better;
 - It is the whole organisations responsibility.
2. Access to information and support
 - ♦ The process falls apart if they don't;
 - ♦ Both employee and employer need information to understand their roles and expectation.
3. Early Intervention
 - ♦ Sooner you start, sooner you finish, sooner get back to work;
 - ♦ Sooner start rehabilitation, sooner get a positive result and back to work, doesn't become an aggravated injury.
4. Effective communication, consultation, consideration and planning
 - ♦ Without all those it wouldn't work, everyone needs to be on the same page.
5. Timely and appropriate medical management
6. Early sustainable, safe, meaningful and durable RTW
 - ♦ Because your aim is to get them as close to what they were doing before.
 - ♦ Self esteem of the injured worker.
 - ♦ Effective rehabilitation to avoid future and further injuries or aggravations. Productive most important, as don't want to be non productive or a burden.
 - ♦ Handover was considered unimportant – that kind of attitude is devastating – if your put in an area that you're not used to it puts more stresses and takes injury backwards.
 - ♦ Staff need to identify injury. More about the culture in different departments.
 - ♦ Very few nurses work in isolation, team driven. If you feel isolated then it takes the process backwards.

- ♦ You get them back, you keep them. Retention. So people don't fester and become more debilitated because they feel disregarded and a failure.

4.2.2 Workshop RTW Coordinators

RTW Coordinators participated in a 1 day workshop on the draft RehabMoC, which was held on Thursday 31 July 2008. The objective was to provide:

- Background to the development of the draft RehabMoc;
- Application of draft RehabMoC in the Workplace; and
- Discussion of Rehabilitation and RTW – to gain RTW Coordinators' perspectives.

The RTW coordinators reinforced the barriers and factors for RTW, and it was felt it was important to gain their perspective. In regard to nurses they identified that (sic):

- ♦ Nurses tend to think they will be ok, self diagnose and they leave it rather than report or access treatment.
- ♦ If the injury and/or illness is not bad enough its ok, they won't report niggles.
- ♦ Where they report incidents they don't like to put in WorkCover claims due to the perceived stigma and would rather take sick leave.
- ♦ Emergency Department worst to report violence and aggression but the most common areas of damage.
- ♦ Casuals very reluctant to report injuries.

They identified the following barriers (sic):

- Inability of GPs to sign off on certain procedures, i.e MRI, which impacts on early diagnosis as the injured worker has to be referred to a specialist.
- Lack of access to GPs.
- Lack of understanding by GPs of their role in RTW.
- Perception and attitudes of NUM's towards injured nurses, they question are they genuinely injured, do we want them back here?
- Management education of workers compensation and return to work.
- NUM turnover – lose relationships that have been created, lack of communication, repeat offenders.
- Attitude of NUMs towards RTW duties,
- Lack of recognition of RTW coordinator by high level management.
- Dual role, in workers compensation and RTW Coordinator, is compromising – pressure, impacts on leave.
- Agents lack of understanding of injury and/or illness, which leads to delays in treatment.

- Agents are not maintaining relationships and are ineffective communicators.
- How Agents treat workers has a negative effect.
- Change of Agent case manages is dysfunctional to the management of the claim.

4.2.3 Focus Groups Injured and/or Ill Nurses

The Project undertook four focus groups (2 metropolitan and 2 regional) with injured and/or ill nurses from the Pilot Hospitals, initially to explain the project and gain their perspectives of return to work. Twelve nurses participated in the focus groups.

The expectation was that Pilot Hospitals would encourage nurses who currently have time loss injury/illness, have long term claims and those who are currently participating in return to work, to participate in the focus groups. The pilot hospitals invited their nurses to participate with a letter from the ANF encouraging them to also participate and asking for their permission to participate in the focus groups (Attachment 4).

There was a consensus from focus group participants of the need for education on “their rights and responsibilities in workers compensation and RTW, on what happens from the incident onwards and what to expect and what will eventuate.” Some advised there was no follow up proceeding the reporting of the incident. There was consensus that their NUMs were supportive in the workplace, but from their perspective they still felt worthless at times.

Nurses advised their medication had hindered their ability “to go to work and function” – and they weren’t given parameters by medical practitioners in regard to managing their medication. There was consensus that their “doctors were not very clear, supportive or attentive to evidence, nor listened to them to diagnose them properly, nor provided timeframe for recovery, nor told what to expect with recovery”. One nurse advised their GP was very reluctant to encourage lodgement of a Workers Compensation claim, and they had to push due to it being work related because their GP wanted to protect them from lodging a workers compensation claim.

Nurses advised the culture of their work environment has had an impact on their rehabilitation and RTW, “even when it comes down to breaks during a shift – some places culturally it is ensured that they must take breaks other workplaces it is not enforced due to inadequate number of staff.” Culturally the nurses acknowledged in some workplaces it is easier to communicate and discuss injury or illness than others. One nurse advised “I had to fight for the workplace to communicate with me and to make them listen when I wasn’t coping with my RTW duties”.

One of the nurses advised that she was reluctant to lodge a claim due to the stigma of WorkCover - “You don’t want to have to put this on your CV to hinder you from future

employment. You don't want to be labelled as an aging nurse - that makes you a liability, the nursing culture is not one to whinge and complain but to get on with it. There is a perceived shame in lodging a claim. Low confidence to raise the issue of injury, don't want to rock the boat, so you blame injury on personal incidents and get used to the pain and tolerate it".

Nurses advised their personal lives were affected by their Rehabilitation and RTW - one stated "I live alone, and my friends are all at work, I needed to go back early even to answer the phone to have contact. I wasn't made aware of many aspects that affect you, psychologically I needed to be back at work but physically I needed to heal." Whilst some felt they were ready to go back to work and were prevented, others felt they were pushed back to work too early.

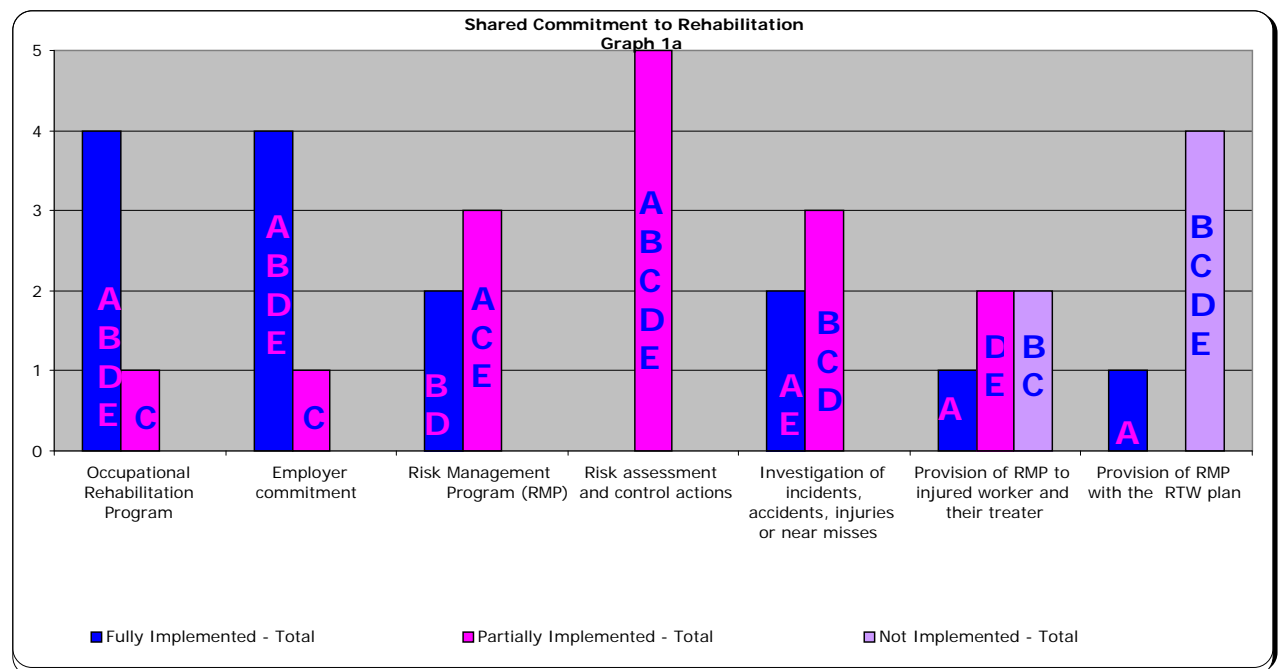
4.2.4 Gap Analysis

The objective of the Gap Analysis was to identify the gap between RTW practices based on legislative obligations defined in *Accident Compensation Act 1985* (the "Act") and the draft RehabMoC. The Guidelines for the Pilot Hospitals includes the Gap Analysis questions and comparison (Attachment 3). Following the Gap Analysis, participating Pilot Program hospitals were able to develop their own benchmarks, utilising the draft RehabMoC, for improvement in Rehabilitation and Return to Work.

The information obtained from the Gap Analysis has been graphed and summarised below.⁹ The 5 pilot hospitals have been identified as Hospitals A, B, C, D and E.

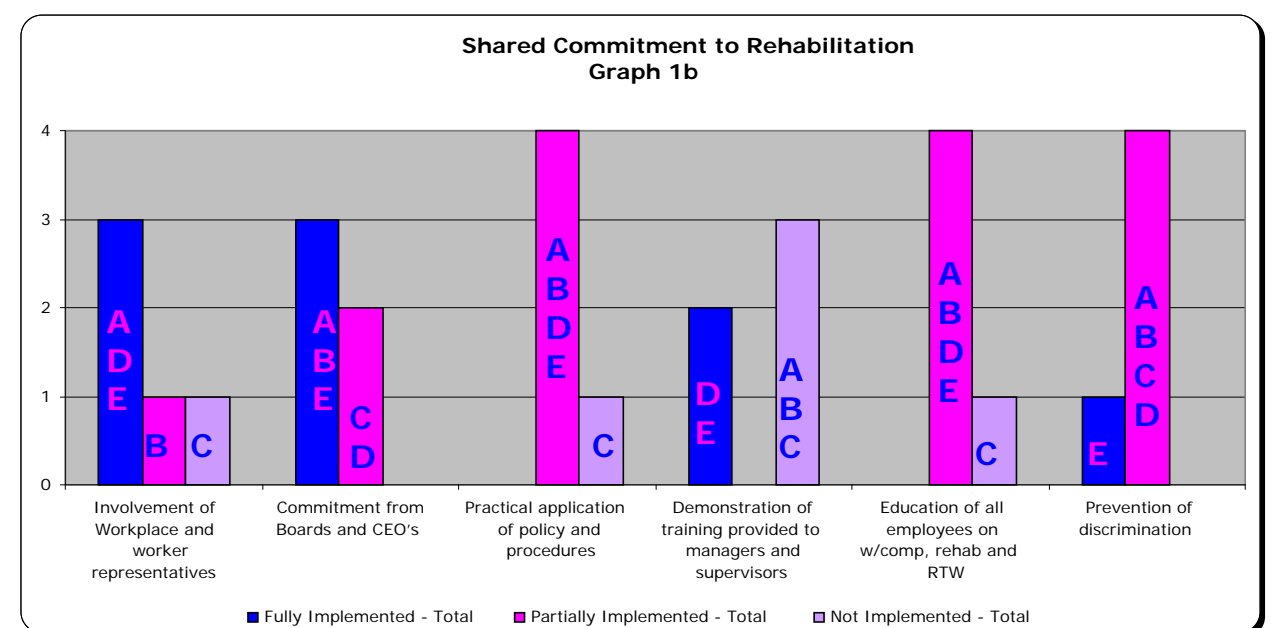
⁹ The y axis of the Graphs represents the total number of hospitals. The x axis represents questions asked in the gap analysis.

Graph 1a Shared Commitment to Rehabilitation



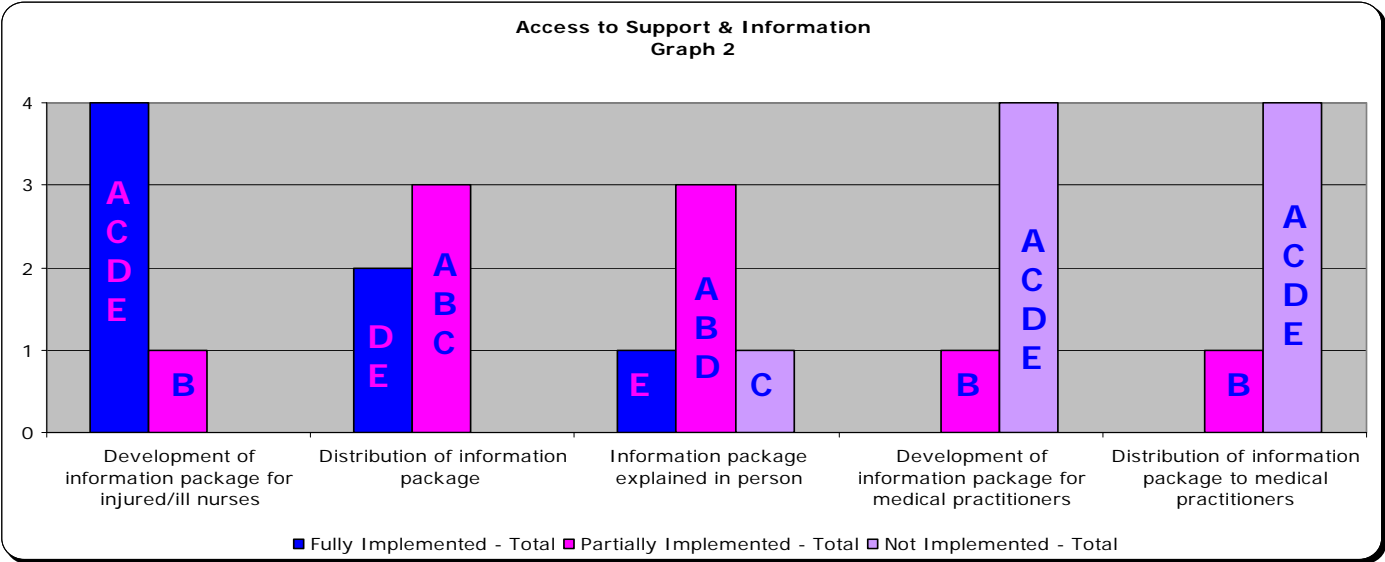
As identified in Graph 1a Hospital C is meeting in part their legislative obligations for developing and implementing their occupational rehabilitation program, whilst the other hospitals are fully meeting their obligations. It was identified in the initial discussion that Hospital C was currently revising their policies and practices for rehabilitation and return to work. For each of the Pilot Hospitals it was noted that risk management is weighted towards business and clinical risk, and that particular policy is based on the *Occupational Health and Safety Act* and the "Act".

Graph 1b Shared Commitment to Rehabilitation



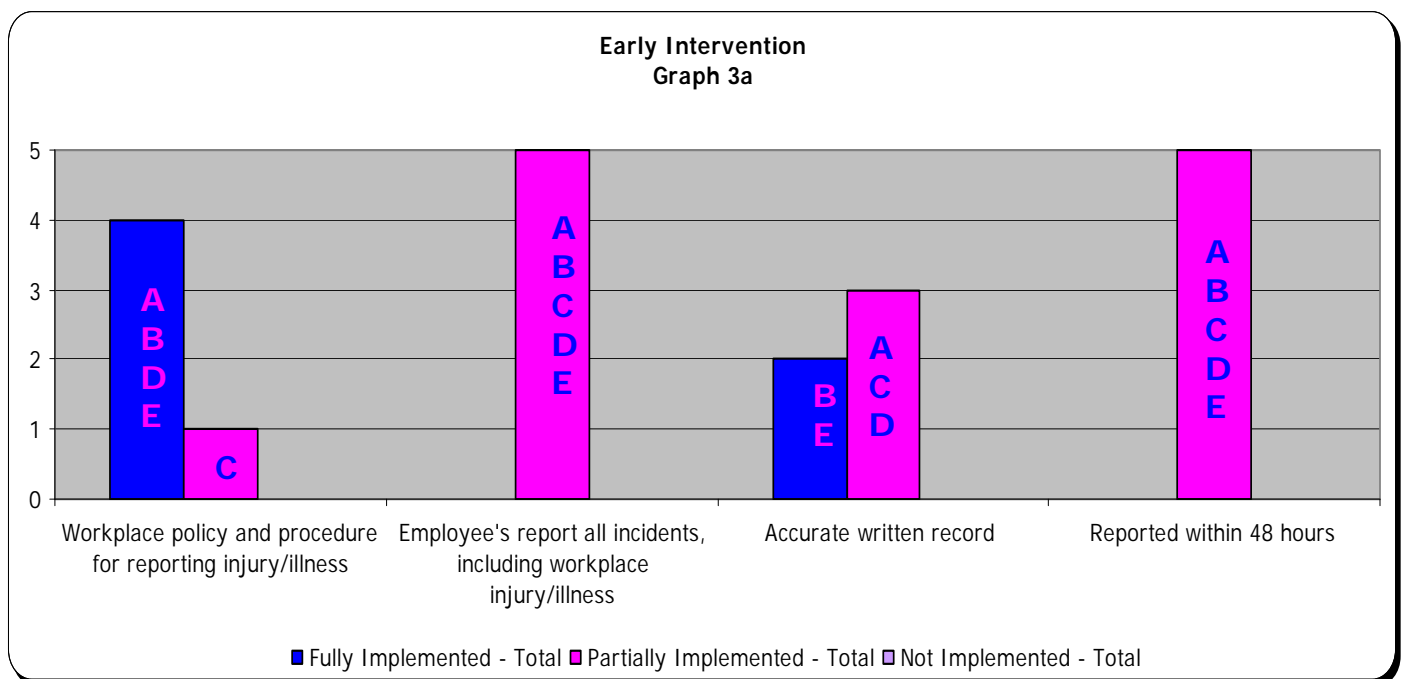
Graph 1b highlights that there is no training for managers on their roles and responsibilities in workers compensation, rehabilitation and return to work at Hospitals A, B and C. Graph 1b also highlights that there is only partial education of the whole workforce in workers compensation, rehabilitation and return to work. The Draft RehabMoC promotes training of the whole workforce in understanding roles and responsibilities in workers compensation, rehabilitation and return to work, and on educating of the consequence of injury and/or illness. Hospital E advised that they have developed and apply training for managers/supervisors on workers compensation, rehabilitation and return to work (Graph 1b). However there is no specific training for the whole workforce on workers compensation, rehabilitation and return to work (Graph 1b).

Graph 2 Access to Support and Information



Graph 2 highlights that Hospital A has developed an information packages for injured workers, but only partially implements this in terms of distribution and explanation in person. No information packages have been developed for medical practitioners on their roles and responsibilities in workers compensation, rehabilitation and return to work. Hospital B has developed in part information packages for injured workers and medical practitioners, and only partially implements this in terms of distribution and explanation in person (Graph 2). Hospital C has developed an information package for injured/ill nurses, but not for medical practitioners. Hospitals D and E do not develop or distribute information to medical practitioners. From discussions it was identified Hospital D and E have tried to engage Medical Practitioners without success. However they believe that this is the role of the regulator to educate medical practitioners of their roles and responsibilities and is out of their control (Graph 2). The draft RehabMoC highlights that medical practitioners are a primary stakeholder, and that it is imperative to the model to develop relationships with medical practitioners.

Graph 3a Early Intervention



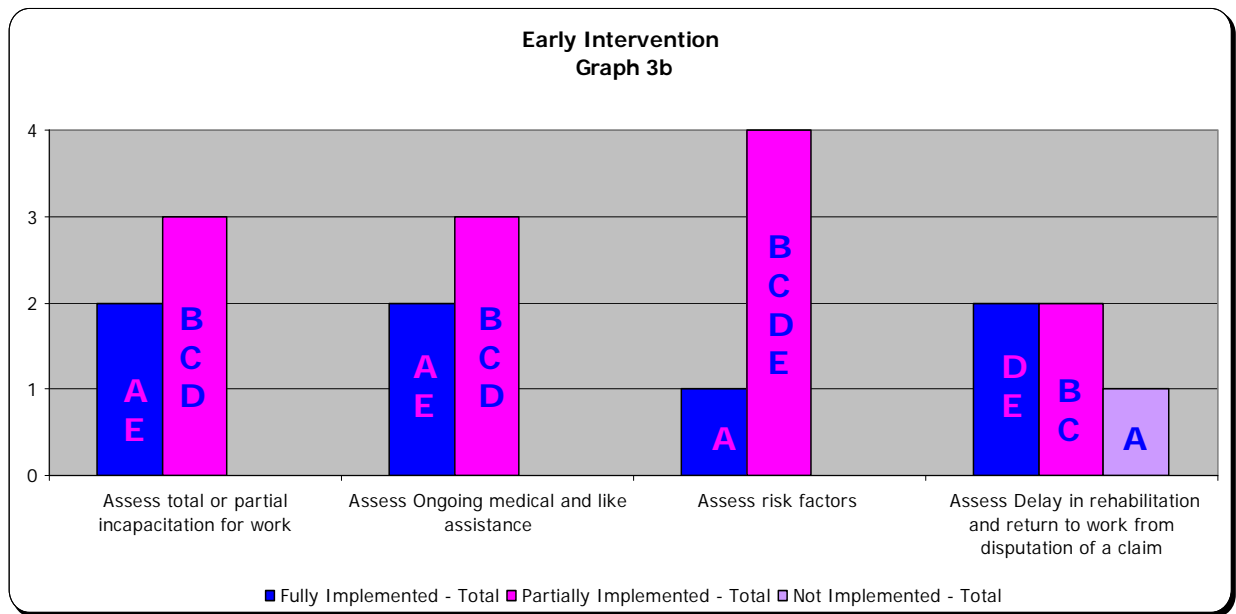
One of the issues identified by Hospital D is whilst they have developed RTW policy and procedures, and educates management in the workplace, practical application is out of their control and is an identified system failure. From the Gap Analysis with Hospital D we are able to highlight this system failure. It is also important to note that from research on RTW that this is an identified barrier to successful RTW. Below is an example identified from Hospital D's Gap Analysis:

1. Hospital D has fully implemented policy and procedure relating to RTW and Incident Reporting, for example the Occupational Rehabilitation Program (Graph 1a);
2. Graph 1a identifies that investigation of incidents is only partially implemented - from discussion this is due to those incidents that are not reported;
3. Graphs 1b and 3a identify that incident reporting policy and procedures are only partially implemented, for instance where incidents are not reported and/or not reported within timeframes;
4. This impacts on the advisement of entitlements for workers compensation, rehabilitation and RTW (Graph 3c); and
5. Further impacts on RTW planning from the date of injury (Graph 4g).

Hospital D acknowledged this system failure when they were undertaking the Gap Analysis. Hospital D was the only Pilot Hospital to recognise this. Whilst the other hospitals advised that reporting is fully implemented, this was revised to partially based on the acknowledged system failure. The draft RehabMoC provides a solution to this system

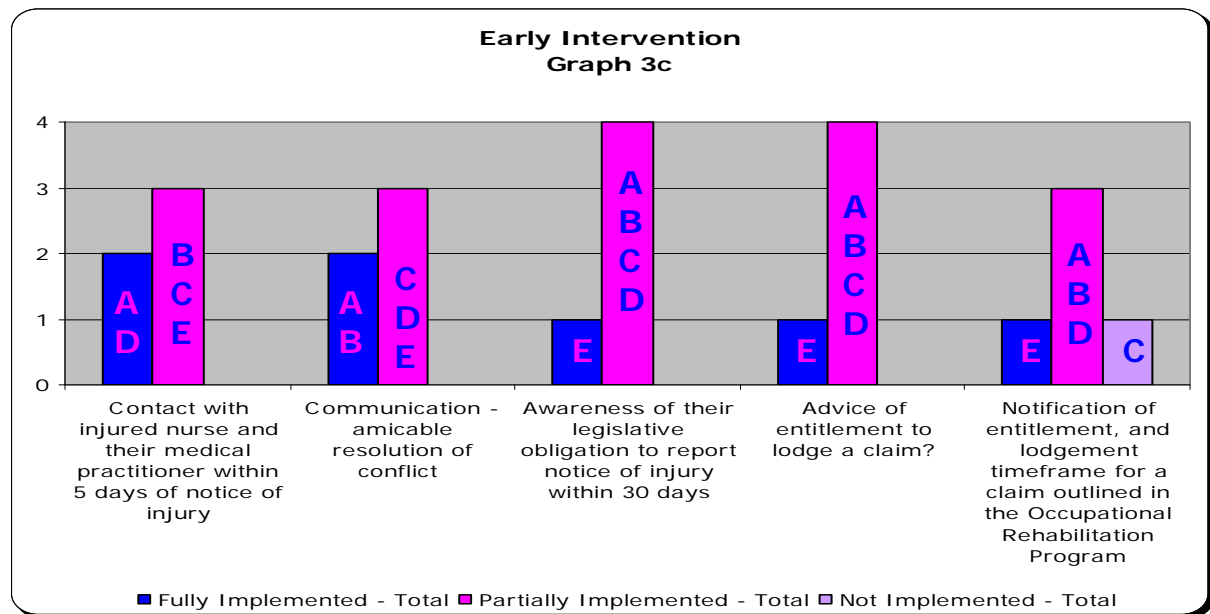
failure through the education of the whole workforce on workers compensation, rehabilitation and return to work, and consequence of injury and/or illness.

Graph 3b Early Intervention



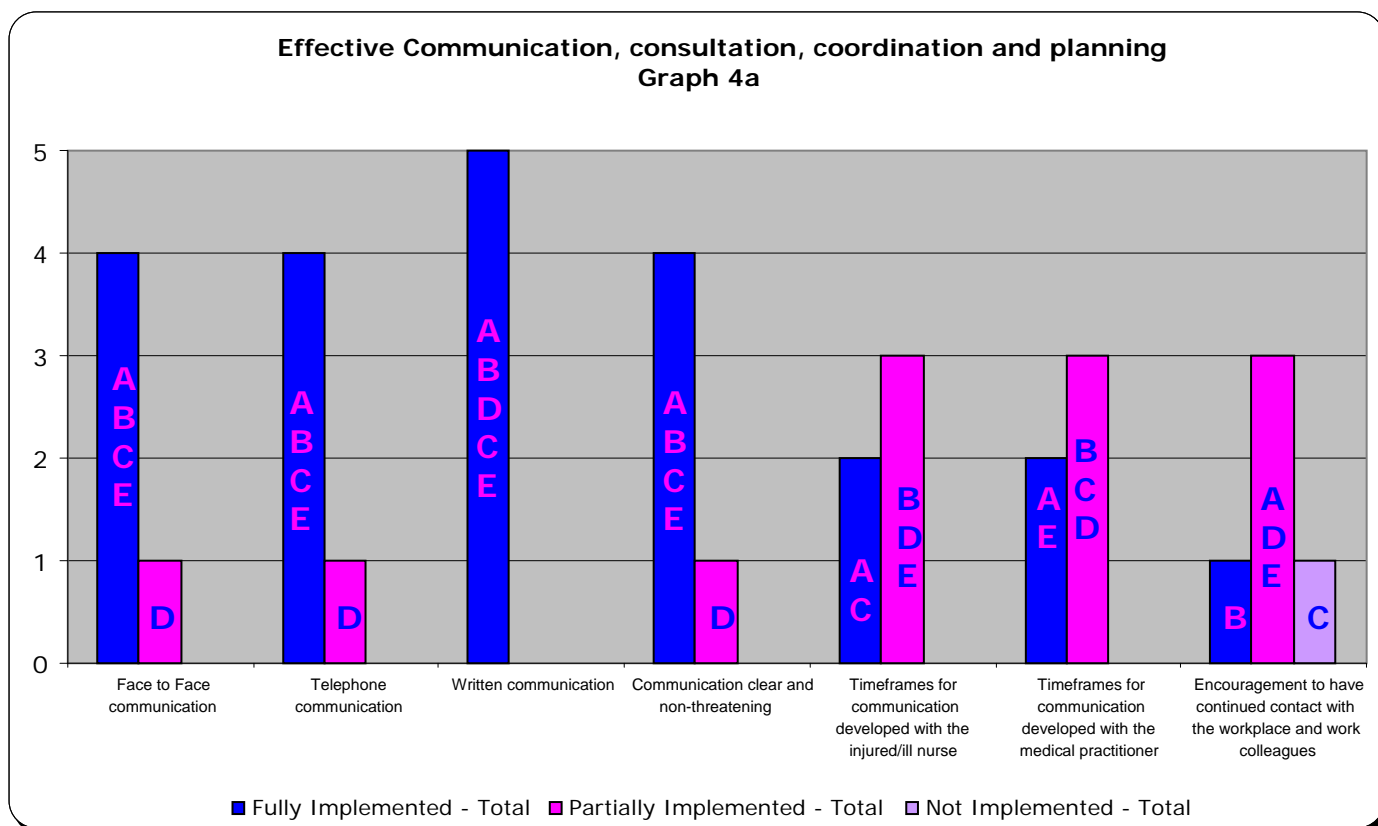
Graph 3b highlights that Hospital A is the only hospital that fully implements assessment of risk factors as part of Early Intervention.

Graph 3c Early Intervention



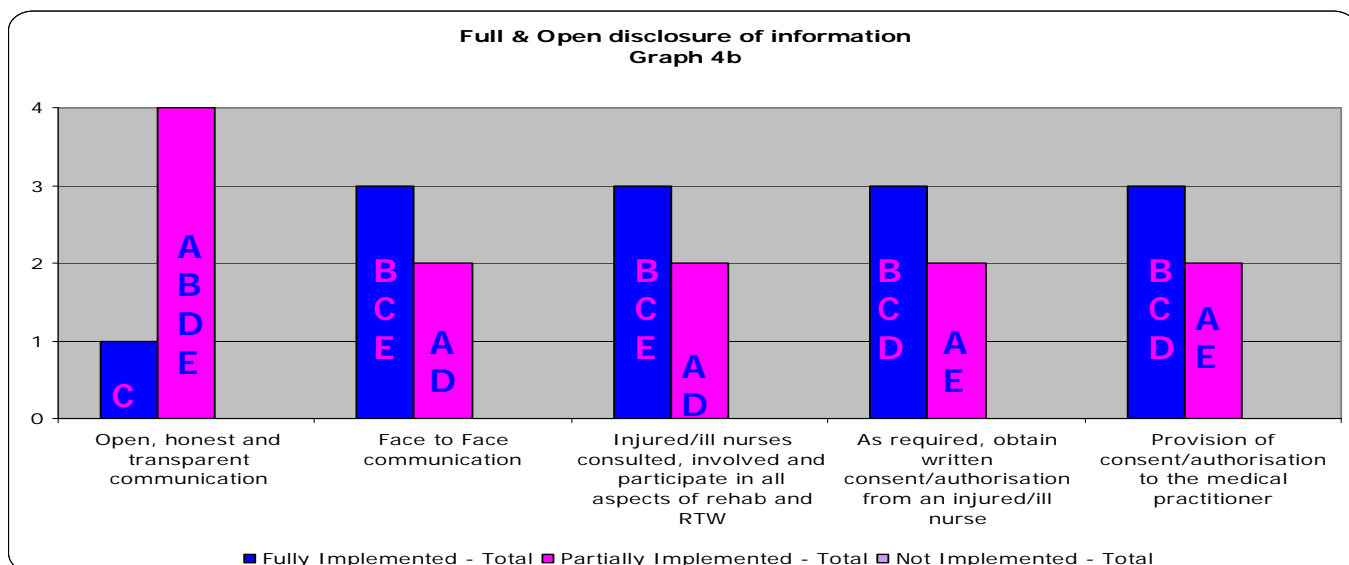
Graph 3c highlights that Hospital E is the only hospital that fully implements advising injured nurses of their legislative obligation to report notice of injury, advice of entitlement to lodge a claim and outline this in their occupational rehabilitation program.

Graph 4a Effective Communication, consultation, coordination and planning



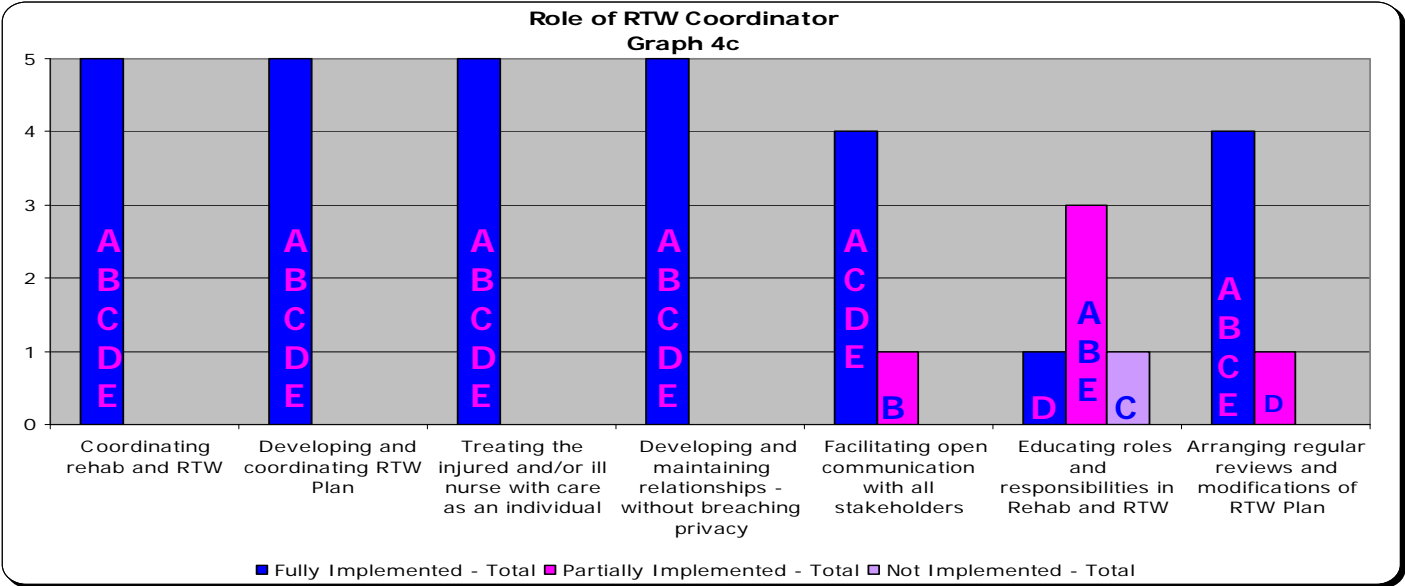
Graph 4a highlights once an injury and/or illness occurs pilot hospitals are fully implementing effective communication, consultation, coordination and planning. Hospital D advised they cannot fully advise this is implemented due to circumstances where they are unable to contact the worker.

Graph 4b Full and Open disclosure of Information



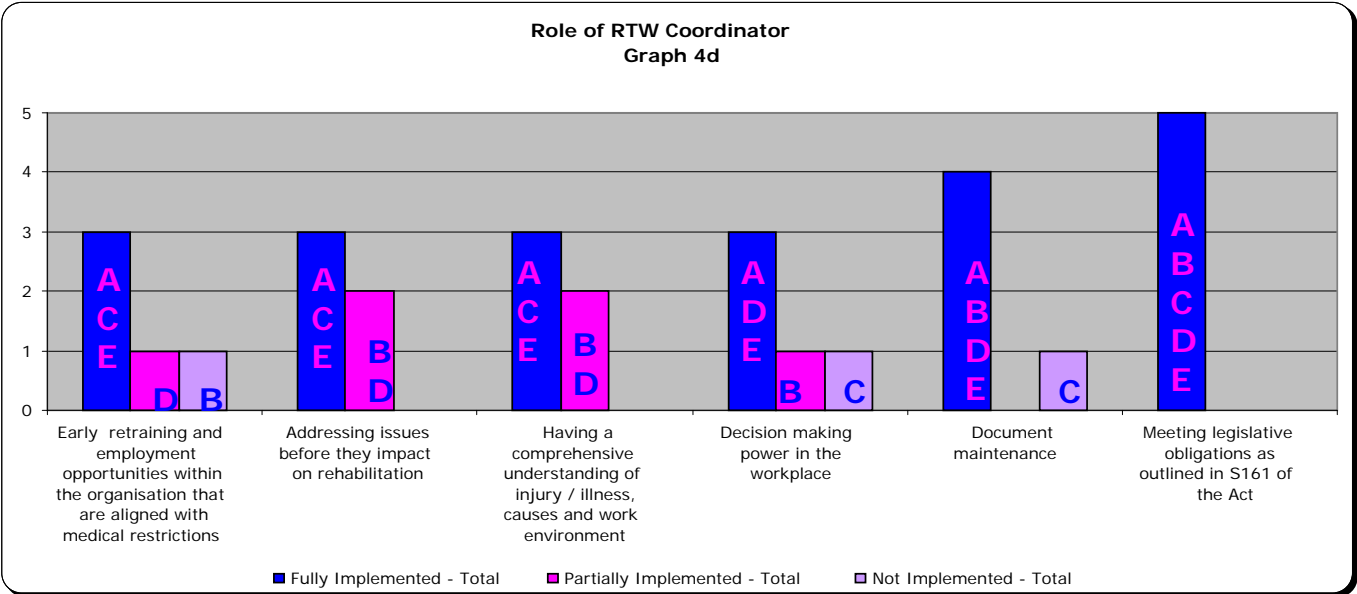
Graph 4b highlights that full and open disclosure of information is only partially applied by the Pilot Hospitals. The draft RehabMoC highlights the importance of transparency in regard to information provided to injured/ill nurses, to ensure this information should be provided in person as this ensures understanding on the part of the injured/ill nurse.

Graph 4c Role of RTW Coordinator



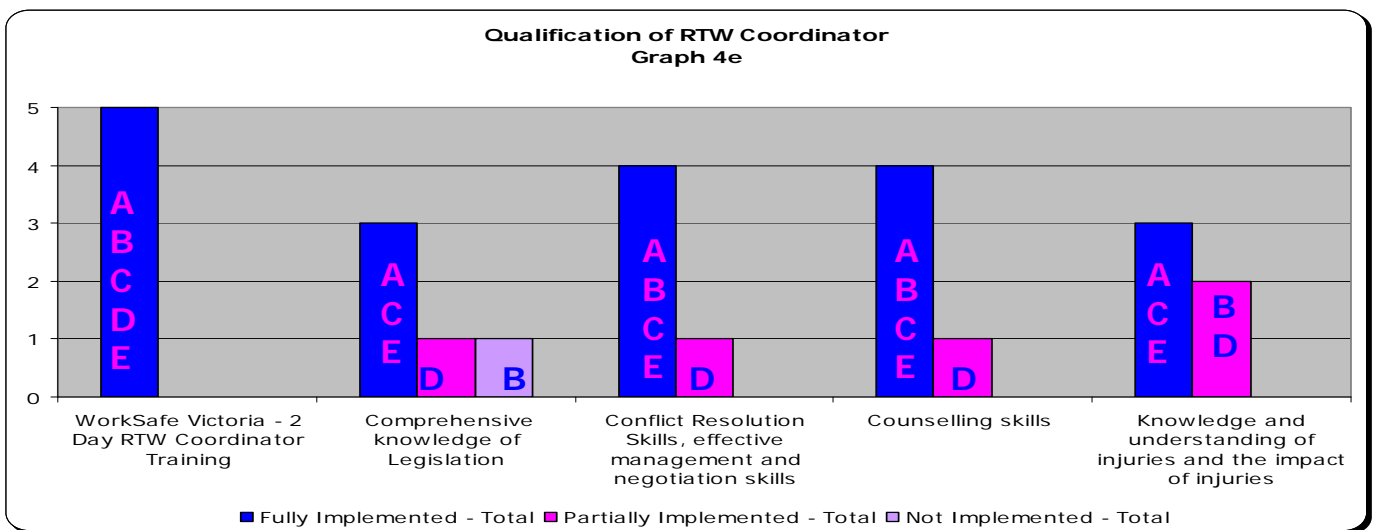
Graph 4c highlights that RTW coordinators are only partially educating injured/ill nurses on their roles and responsibilities in rehabilitation and return to work.

Graph 4d Role of RTW Coordinator



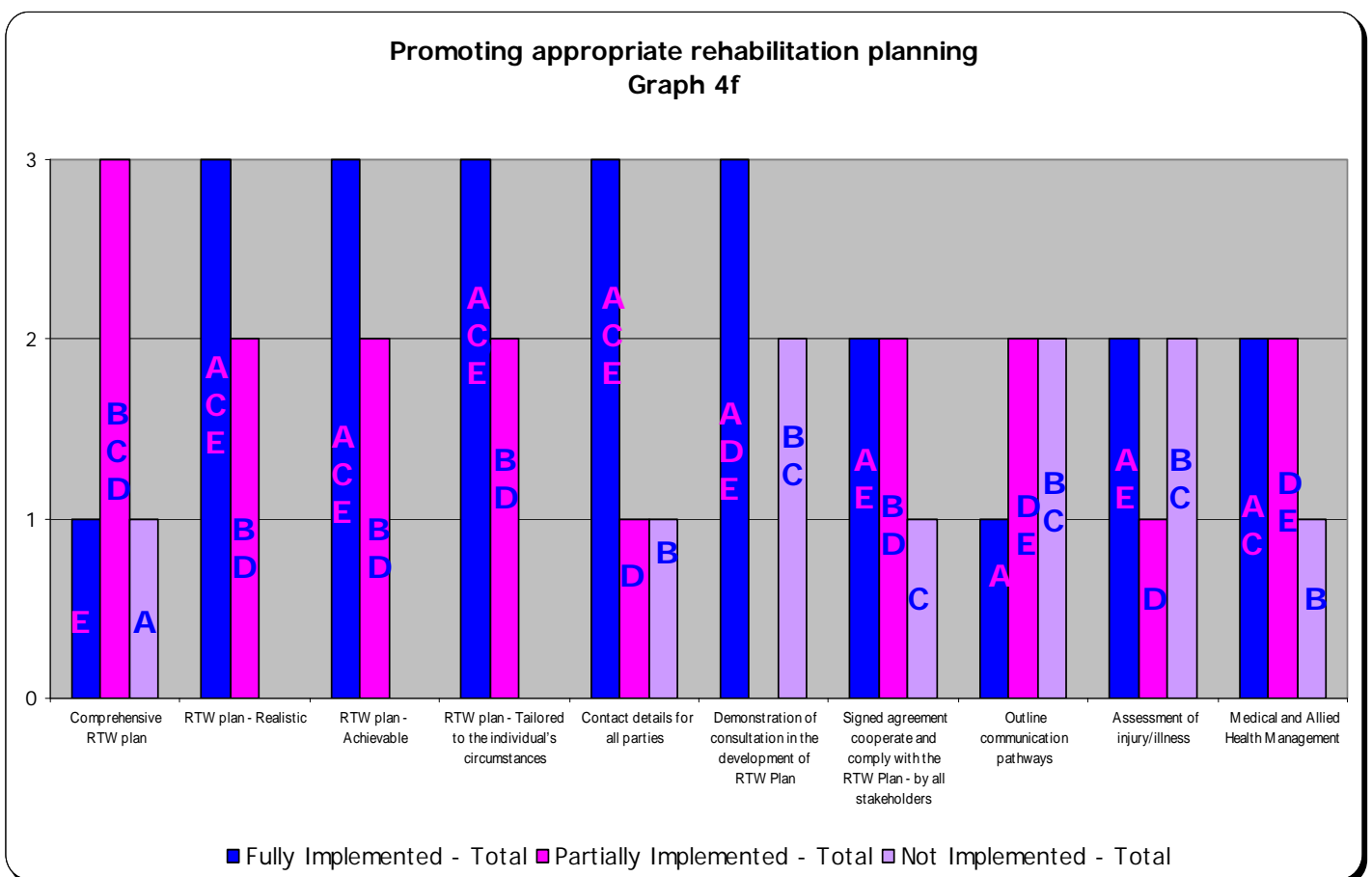
Graph 4d highlights that all pilot hospitals are meeting their legislative obligations for RTW.

Graph 4e Qualification of RTW Coordinator



Graph 4e shows that all of the RTW Coordinators from each of the pilot hospitals have undertaken the WorkSafe 2 day RTW Coordinator Training. Hospital B advised they do not have a comprehensive knowledge of the legislation nor of injuries and their impact.

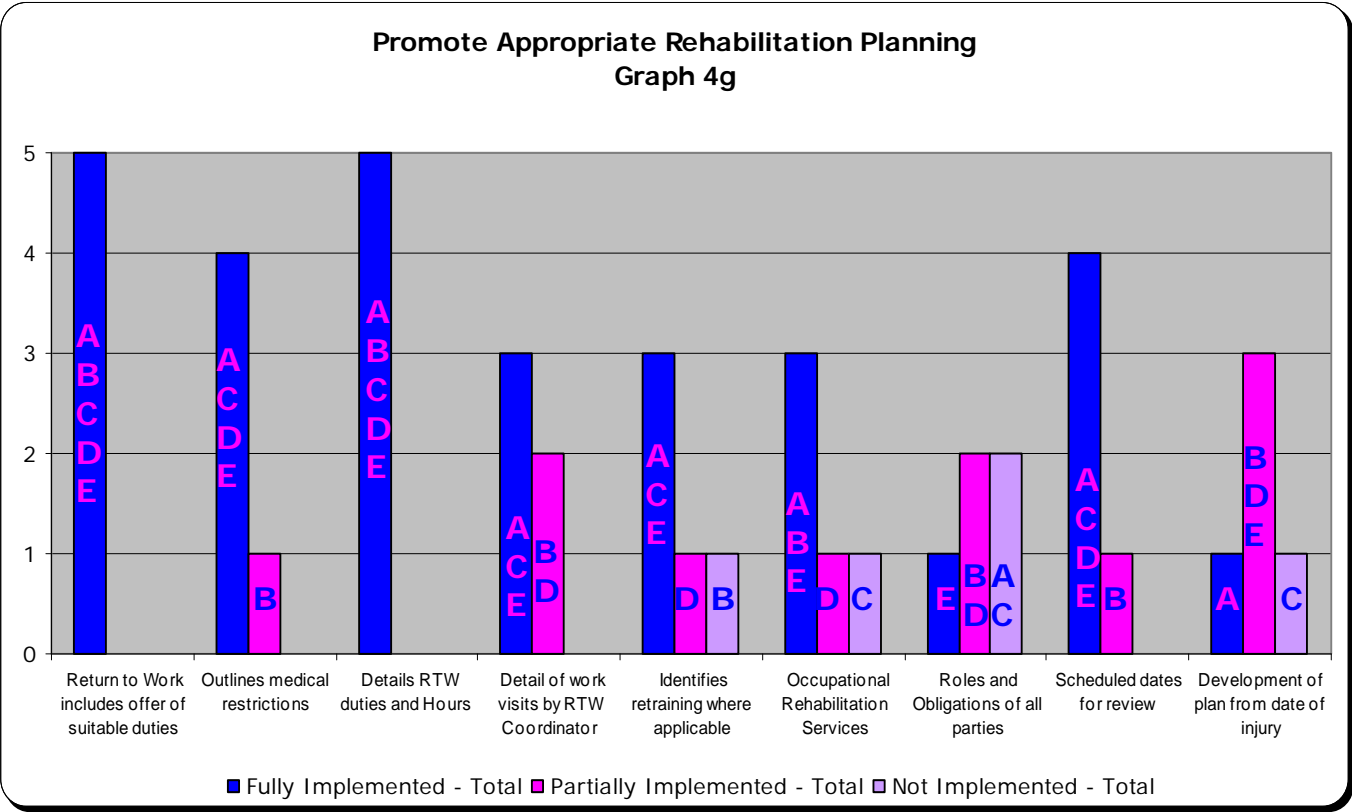
Graph 4f Promoting appropriate rehabilitation planning



Hospital A does not have a comprehensive RTW plan. From discussions with Hospital A there have been modifications to their current RTW plan to incorporate those outlined in the draft RehabMoC (Graph 4f). Graph 4f highlights that Hospitals B and C are not outlining in the RTW plan that there has been consultation nor communication pathways.

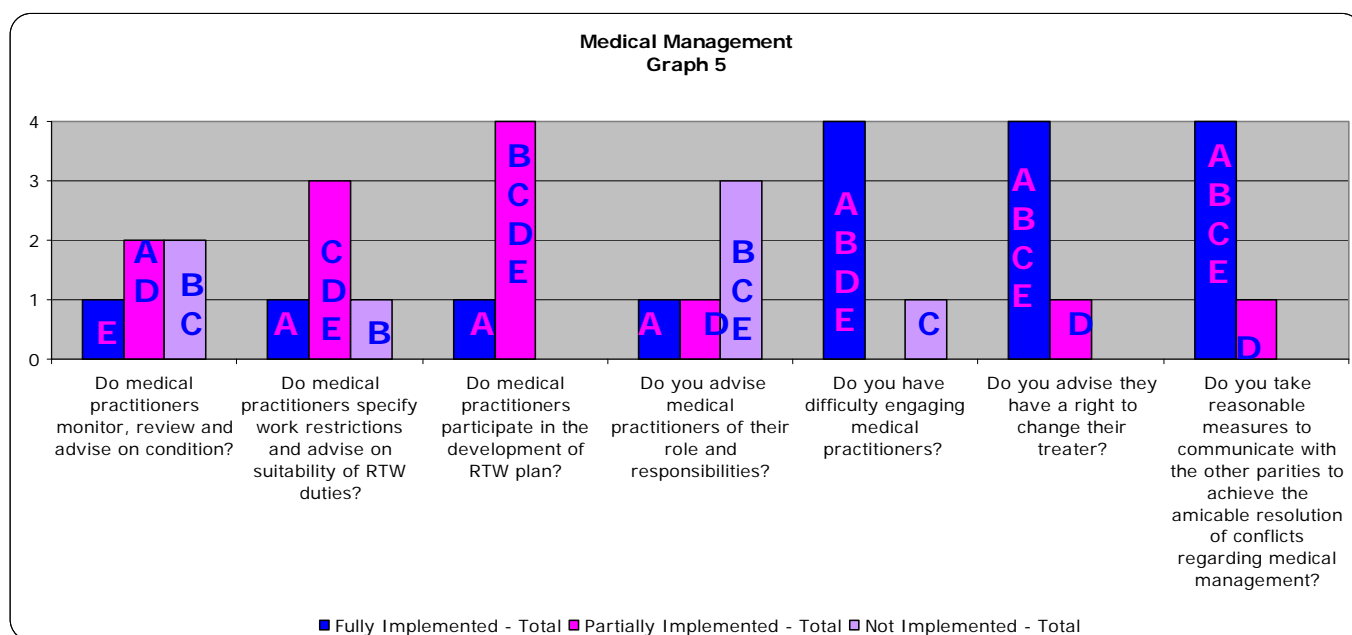
The Draft RehabMoC promotes appropriate rehabilitation planning, particularly the involvement of the injured/ill nurse in the development of their RTW plan and for the plan to be tailored to the individual – Graph 4f and 4g highlights that this is partially implemented by Hospital D. Graph 4g highlights that Hospital E only partially implements the development of RTW plan from the date of injury. Hospital E advised that this was not due to determination of liability but was dependant on other factors for instance notice of injury and/or that a claim was lodged from the date of injury.

Graph 4g Appropriate Rehabilitation Planning



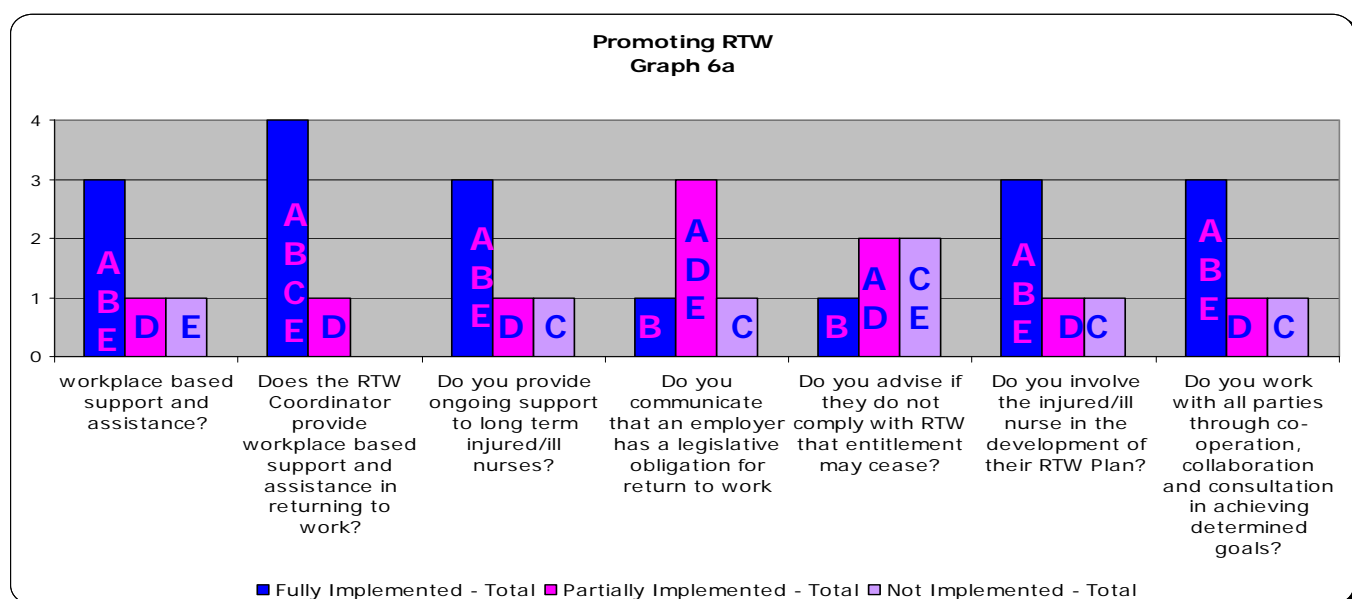
Graph 4g highlights that Hospitals B, D and E only partially implement the development of RTW plan from the date of injury. Hospital D and E advised that this was not due to determination of liability but was dependant on other factors for instance notice of injury and/or that a claim was lodged from the date of injury.

Graph 5 Medical Management



Graph 5 highlights that Hospitals A, B, D and E have difficulty in engaging medical practitioners. Hospital C is the only pilot hospital that does not have difficulty with engaging medical practitioners.¹⁰

Graph 6a Promoting RTW

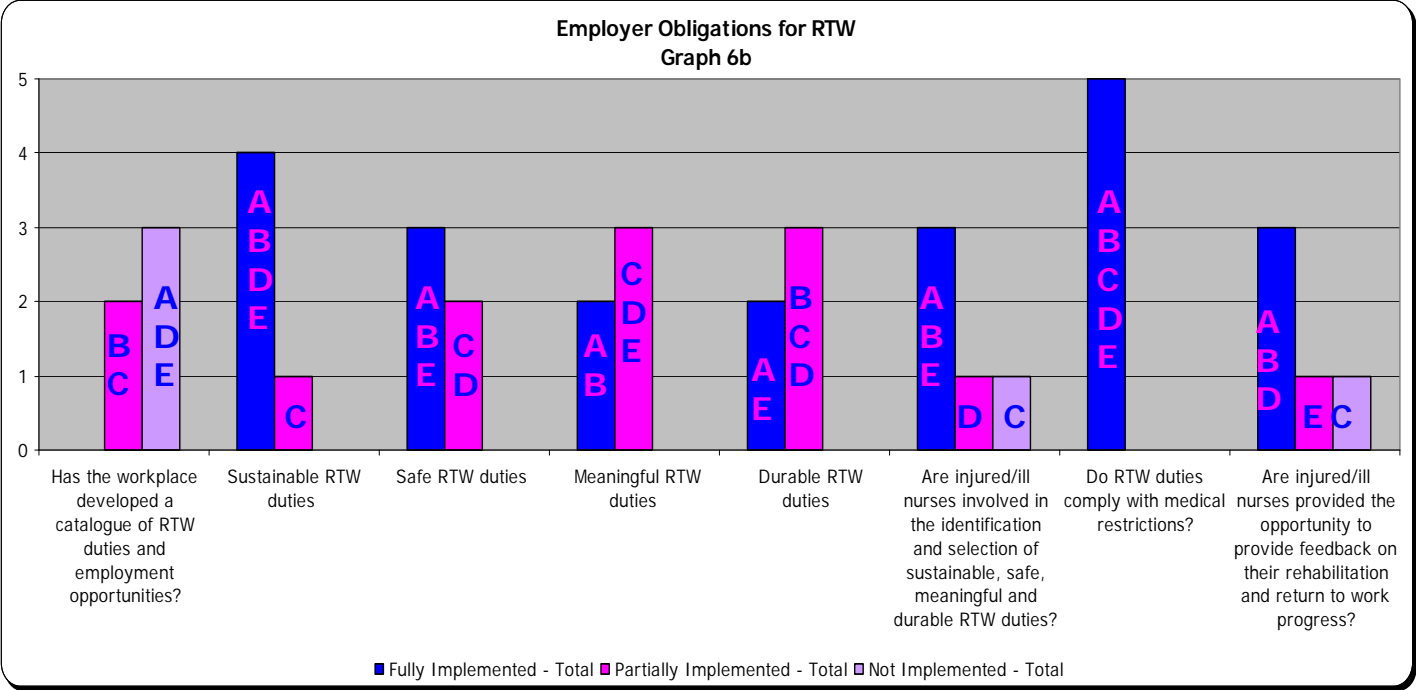


Graph 6a highlights that communication of employer and injured worker obligations for RTW are only partially implemented by Hospital A, D and E. From discussions this was identified as being on an as needs basis. Hospital C does not communicate legislative obligation. Graph 6a indicates that there is no workplace based support and assistance for injured/ill nurses in returning to work. Hospital C does not communicate the legislative

¹⁰ Note that "not implemented" in this instance means "no" and "fully implemented" means "yes".

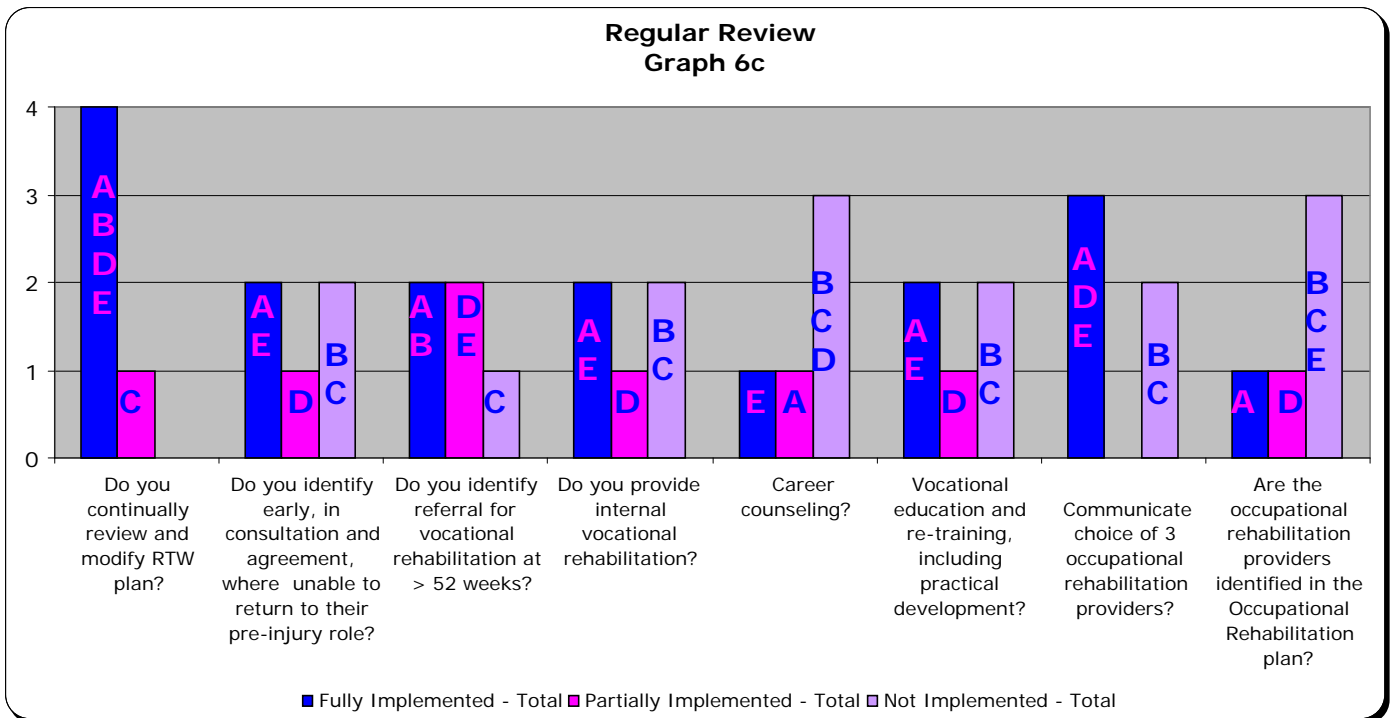
obligations of the employer or the injured/ill nurse’s obligations in return to work. The draft RehabMoC promotes that all key stakeholders work together in achieving determined goals for rehabilitation.

Graph 6b Employer Obligations for RTW



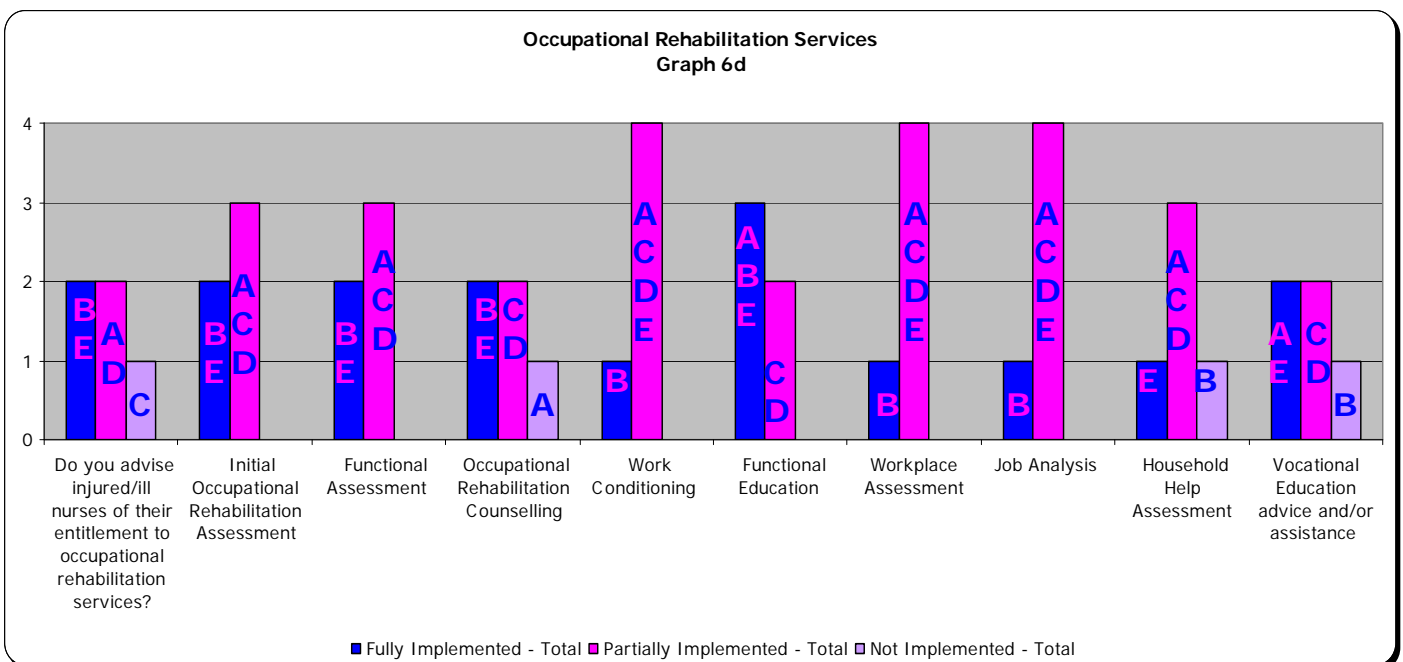
Graph 6b highlights that Hospitals B and C have in part developed a catalogue of RTW duties and employment opportunities. Hospital E acknowledged that as they do not request feedback specifically on whether RTW duties are meaningful, they believe they only partially implement meaningful duties (Graph 6b).

Graph 6c Regular Review



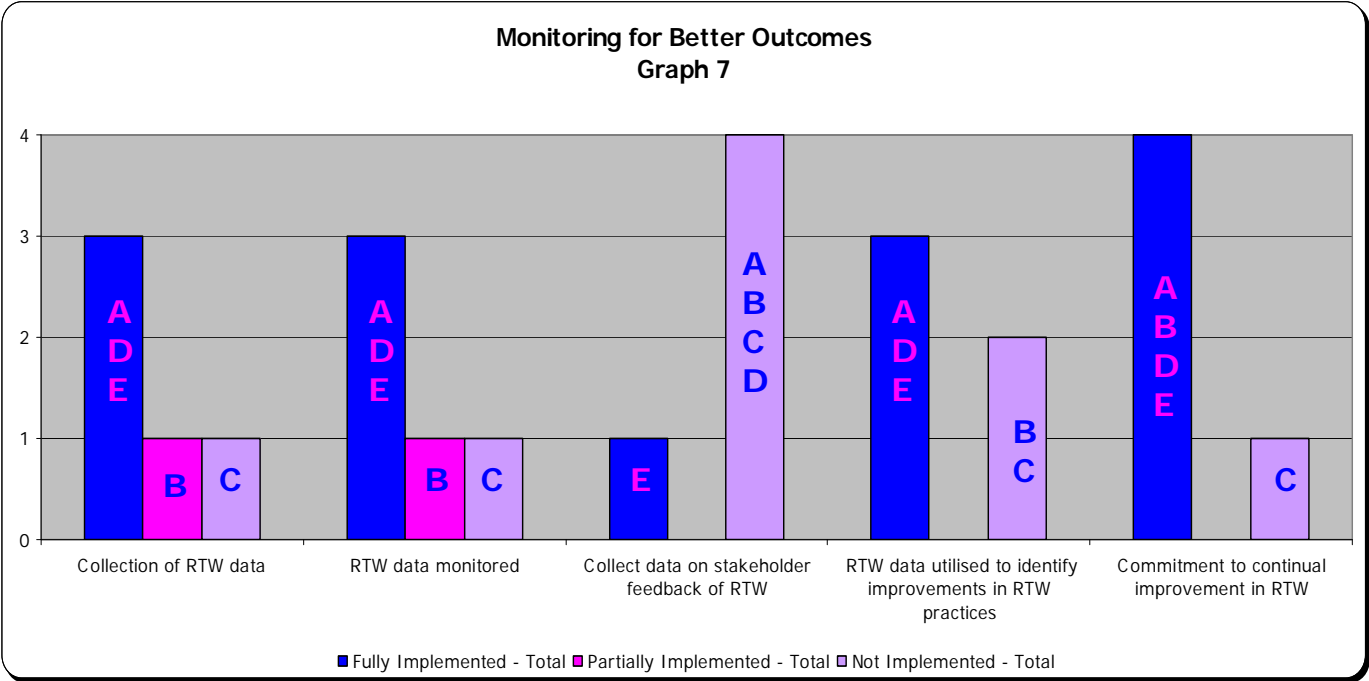
Graph 6c highlights that Hospitals B, C and E Occupational Rehabilitation Program do not outline the choice of 3 Occupational Rehabilitation Providers. S158 of the Accident Compensation Act outlines that the Occupational Rehabilitation Program needs to outline at least one occupational rehabilitation provider (S158(1)(a)(iii)). Hospital A and E fully implements the provision of Internal Vocational Rehabilitation (IVR), Hospital D partially implements IVR and Hospital B and C do not implement IVR.

Graph 6d Occupational Rehabilitation Services



Graph 6d highlights that Hospitals B and E advise injured/ill nurses of their entitlements to occupational rehabilitation services, whilst Hospitals A and D do this in part. Hospital C does not implement this. From discussions with Hospitals A and D this is advised on an as needs basis. This highlights that communication of information needs to be more open, honest and transparent in regard to entitlements.

Graph 7 Monitoring for Better Outcomes



Graph 7 highlights that Hospital C does not implement monitoring for better outcomes. Hospital E fully implements collection of data on stakeholder feedback, whilst Hospitals A, B, C and D do not implement this.

4.2.5 Monitoring of Pilot Program

The Project always envisaged that Pilot Hospitals would monitor and review the implementation of the pilot program through monthly meetings and for this to be an added agenda item for review of workers compensation and return to work. However each of the Hospitals advised that there is currently no review through meetings specifically of workers compensation and return to work and that this was unlikely to occur.

The Project also encouraged the development and participation in establishing a network for pilot hospitals RTW Coordinators, envisaging a monthly teleconference and/or meeting to allow for an opportunity to discuss any issues and sharing of improvements in rehabilitation and return to work. However in reality this was not feasible due to allocation of time, as the RTW Coordinators advised they were time deficient. As a

substitute two workshops were held with the pilot hospitals over the duration of the Pilot Program.

4.2.6 Workshop November 2008

A workshop was held in Bendigo for the Pilot Hospitals on 13 November 2008. The objective of the workshop was for participants:

- ♦ To hear of the outcomes of Bendigo's Health RTW Fund Project, which lead to considerable discussion from participants.
- ♦ To be provided an overview of the findings that had been undertaken in the pilot hospitals from the Workshops, Focus Groups and Gap Analysis.
- ♦ To introduce to the pilot hospitals to Robyn Dale from Urcot, Urcot are evaluating the Pilot Program.

It was also an opportunity to receive some feedback from the pilot hospitals on the Pilot Program, and the following questions were asked and responses received (sic):

How are the pilot hospitals applying the Model in the workplace?

- Working towards implementing the Model;
- Strategy to be completed tomorrow after gathering information from today's seminar;
- Working on information packs;
- Consolidating with offer of suitable employment;
- No hidden agendas – total transparency;
- Weekly monitoring.

What has been the benefit?

- Filling the gaps in return to work;
- Networking/shared ideas.

What hasn't worked?

- Communication of ideas and implementation needs to be encouraged between ANUM, NUM and RTW Co-ordinator;
- Workshops and focus groups – lack of interest from nurses;
- Disappointed by lack of response/interest by injured nurses, Job Representatives.

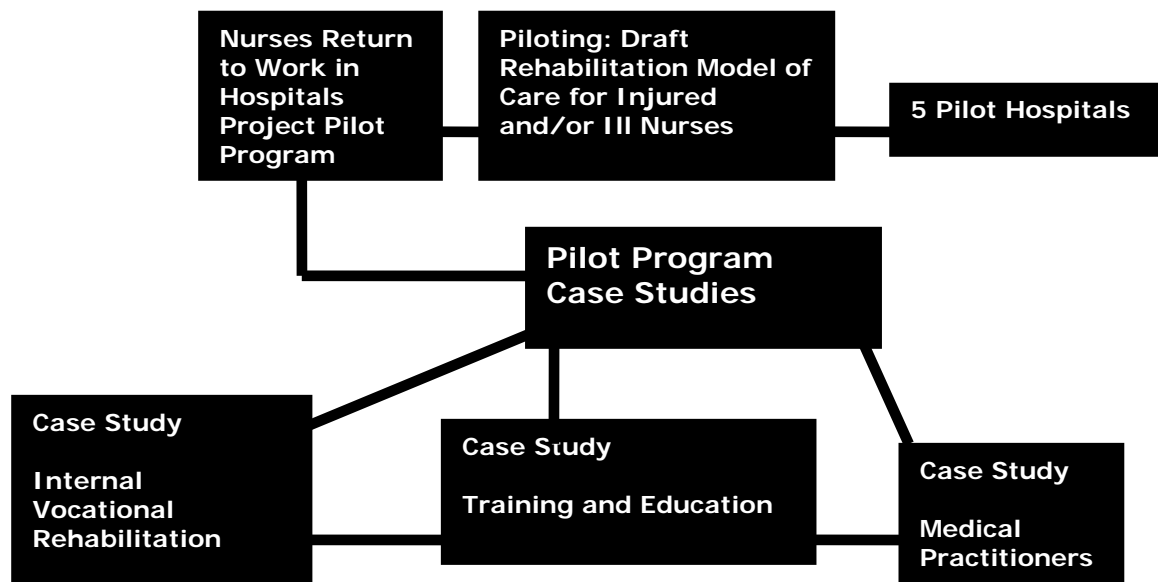
Identified issues with the Pilot Program

- How to support processes;
- Produced support materials/marketing tools;
- WorkSafe complacency;
- Get greater recognition of the benefits of RTW in the wider workforce;
- Dispel the stigma surrounding workers claims and the reporting of injuries.

4.3 Pilot Program Case Studies October 2008 to March 2009

The Project determined that the qualitative and quantitative data from the workshops, focus groups and gap analysis would drive the Case Study component of the Pilot Program.

Diagram 5 Flowchart of Pilot Program



Three Case Studies were identified to be undertaken as part of the Pilot Program on:

1. Developing and applying training and education in three of the Pilot Hospitals (Appendix 2).
2. Develop and apply internal vocational rehabilitation in three of the Pilot Hospitals (Appendix 3).
3. Develop tools for Medical Practitioners on their roles and responsibilities for return to work to be undertaken with one of the Pilot Hospitals (Appendix 4).¹¹

¹¹ Case Study in this context is defined as a research approach using qualitative and quantitative data about a subject and/or subjects, (subject is defined as the area of study), and involves the collection of data through observation, interviews and the collection of documentary evidence. This data will then be presented in a report format.

The Case Study outcomes are reported on in Appendix 2, 3 and 4. A brief description of each Case Study is provided below.

4.3.1 Case Study Training and Education

It was identified from the Workshops/Focus Groups and Gap Analysis that there was a need for training and education in three of the Pilot Hospitals. The Project determined to undertake a Case Study on Training and Education, with the objective to educate of the roles and responsibilities NUM/ANUMs and nurses in general have in rehabilitation and return to work. The practical application of the training sessions reinforced the identified need for training in rehabilitation and return to work. Participants advised they found the workshops to be clear and very informative.

4.3.2 Case Study Internal Vocational Rehabilitation

Report 6 *Examine Feasibility of a Catalogue of Return to Work in Duties and Employment Opportunities to Support Return to Work Planning*, of the Nurses Return to Work in Hospitals recommended the development and application of Internal Vocational Rehabilitation (IVR). The Gap Analysis, Graph 6c, identifies that Hospitals A and E fully implement IVR and Hospital D partially implements IVR.

The Project determined to get a good understanding of the Policies and Procedures for IVR that are applied by the Pilot Hospitals, and to learn from injured nurses of their experiences of IVR. In undertaking this research the objective was to develop an Internal Vocational Rehabilitation approach.

4.3.3 Case Study Medical Practitioners

From discussions with Pilot Hospitals and through the Gap Analysis the difficulty with engaging medical practitioners in rehabilitation and return to work was identified. Hospital A asked the Project to develop resource tools for medical practitioners on their role in rehabilitation and return to work, on the role of a nurse, and to trial an addendum to the medical certificate with a focus on RTW.

4.3.4 Workshop May 2009

A final Workshop for the Pilot Hospitals was held in Melbourne on 27 May 2009. The objective of the Workshop was:

- ◆ To provide an overview of the Pilot Program Report and the structure of the Report, and to formalise how Hospitals want to be identified in the Report.
- ◆ To provide an overview of the evaluation findings,

- ◆ To provide pilot hospitals with the opportunity to provide feedback and validate the evaluation findings.¹²

4.4 Evaluation of Pilot Program

The Project engaged URCOT in October 2008 to undertake the Evaluation of the Pilot Program.

The objective of the Evaluation was to determine the following:

1. Whether the Draft Rehabilitation Model of Care is a workable and effective model, to facilitate:
 - a. communication between all parties;
 - b. recovery from work-related injury;
 - c. Early, sustainable, meaningful and durable return to work duties; and
 - d. Prompt resolution and minimisation of disputes.
2. In what way was the Pilot been useful?
3. What were the learnings from the Pilot Program?
4. Has attitudinal change occurred? If so, how have attitudes changed?

Please refer to the Evaluation Report: Nurses Return to Work in Hospitals Pilot Program for the evaluation findings of the Nurses Return to Work in Hospitals Pilot Program.

5. Conclusion

The Nurses Return to Work in Hospitals Projects Pilot Program objective was to focus on what works in RTW that is to the benefit of the injured nurse and their employer.

The Project strategy for the Pilot Program at the macro level was focused on the development of the Draft RehabMoC to provide a framework for the management of injury, and at the micro level was focused on the development of usable resources driven by injured nurse analysis. These strategies have led to the development of practical, useful and relevant tools for the management of workplace injury for the benefit of injured nurses and their employers.

It was identified from the start it was not going to be feasible to have quantifiable evidence that the Pilot Program would lead to a decrease in claims costs, firstly due to the timeframes for the Pilot Program (9 months is not a large enough period to test the draft

¹² This will be reported on in Evaluation Report: Nurses Return to Work in Hospitals Project Pilot Program.

RehabMoC) and secondly unable to drive the Model as the Project Team was not physically located in the workplace. However, of importance has been the resources that have been developed as part of the Pilot Program and Project as a whole, as the Pilot Hospitals are utilising these tools in their Hospitals as they recognise the practical value.¹³ This you could say is the success of the Pilot Program and Project, and this is measurable in the potential future benefits to injured nurses in these hospitals.

The ANF (VB) would like to thank the Pilot Hospitals for their participation in the Project, and to also thank those nurses who participated and who have driven the direction of the Project and Pilot Program.

¹³ Resource Tools –

1. Developing a Guide for identifying suitable RTW duties that are “real” nursing duties.
2. Developing a Brochure for Nurses on “What to do if injured?” (Attachment 2).
3. Training and educating nurses on rehabilitation and return to work (Appendix 2).
4. Developing an internal vocational rehabilitation process to be applied with the pre-injury employer where a nurse is unable to return to their pre-injury role (Appendix 3).
5. Developing material for Medical Practitioners on their role in rehabilitation and return to work (Appendix 4).
6. Developing a Guide to assist with career planning and identifying nursing roles and employment opportunities where an injured nurse is unable to return to their pre-injury role.

Attachment 3

Pilot Program Guidelines for Pilot Hospitals

These guidelines will outline:

1. The Goal and Objectives of the Pilot Program.
Pilot Program.
Methodology.
2. What is involved in participating in the Pilot Program?
July/August 2008.
March 2009.
May 2009.
3. How the Pilot will be evaluated.
 - 3.1 Policy documents to be requested.
 - 3.2 Data to be requested, for the periods 2004-05; 2005-06; 2006-07; 2007-08 (Financial Year).
 - 3.3 Gap Analysis.
 - 3.4 Evaluation.
4. Outline of employer Legislative Obligations for rehabilitation and return to work, and the Draft Rehabilitation Model of Care.

1. Goal and Objectives of the Pilot Program

The purpose of the Pilot Program is to assist hospitals to improve opportunities for injured and ill nurses in Victoria to successfully return to work and to influence change of their rehabilitation and return to work policies and practices through the implementation of the draft Rehabilitation Model of Care (RehabMoC).

The objectives of the Project, which the Pilot program is an important part, are to:

- Improve rehabilitation and return to work outcomes for injured and ill nurses.
- Reduce the human and financial costs of injury and illness to nurses.
- Reduce the loss of skilled nurses and the associated costs of nurse shortages, recruitment and training.
- Promote recruitment and retention of injured and ill nurses.

The envisaged benefits for the hospital sector in participating in the Pilot Program are:

- Reduce the human and financial cost of workplace injury and/or illness.
- Improve rehabilitation and return to work outcomes.
- Learn from the Project and influence change in rehabilitation and return to work.
- Identify gaps in current practices and processes for return to work.

- Participate in return to work networks with other pilot hospitals.

1.1 Pilot Program

Proposed Pilot scope:

- Implementation and evaluation of Draft Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria.

Research undertaken to date for the Nurses Return to Work in Hospitals Project led to the development of a Draft Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria.

The Draft Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria provides a framework for improving and streamlining the management of workplace injury and illness. It can be argued that there is only limited legislative framework, incorporated within the *Accident Compensation Act 1985*, covering certain specific duties and requirements of employers and injured workers in relation to rehabilitation and return to work in Victoria.

Whilst there are Guidelines for Employers, *Helping Injured Workers get back to work: The Return to Work Guide for Victorian Employers*, these guidelines are limited in nature to matters relating to specified obligations of employers under the return to work provisions of the legislation.

The Draft Rehabilitation Model of Care for Injured and/or ill Nurses in Victoria provides a comprehensive model for rehabilitation and return to work of injured nurses based on a holistic, multi-faceted approach, targeted towards employers, nurses and others who participate and/or play a role in the rehabilitation and return to work of injured and/or ill nurses.

The Model is intended to facilitate:

- Communication between all parties;
- Recovery from work-related injury;
- Early, safe and sustainable return to work;
- Prompt resolution and minimisation of disputes.

Pilot Hospitals should have received a copy of the Draft Rehabilitation Model of Care for Injured and/or Ill Nurses. Copies are available from the RTW Project Officer.

1.2 Methodology

Qualitative and quantitative analysis of the implementation and application of the Draft Rehabilitation Model of Care will be undertaken for the Pilot Program.

Qualitative analysis will include:

- Workshops;
- Focus Groups; and
- Case Studies.

Quantitative analysis will include:

- A Gap Analysis to identify rehabilitation and return to work practices compared to the Draft Rehabilitation Model of Care which will assist in setting benchmarks for the Pilot Program.
- Evaluation of the Pilot Program.

2. What is involved in participating in the Pilot Program?

- In participating in the Pilot Program Pilot Hospitals will need to work with the ANF (VB), RTW Project Officer, in implementing the Pilot Program in their Hospitals for the period July 2008 to March 2009.
- Identify an employee who would be the appropriate ongoing contact for the Pilot Program, and who will liaise with the RTW Project Officer.
- Assist the Pilot Program Evaluation.

We envisage that Pilot Hospitals will:

- Understand issues involved and commit to, achieving long term change.
- Have senior management commitment to the Pilot Program.
- Encourage and support injured and ill nurses' involvement in the Pilot Program.
- Promote the Pilot Program.
- Encourage and support relevant staff involvement in the Pilot Program.
- Promote the reporting of all incidents.
- Allow access to de-identified workers compensation and return to work data, as outlined below.

We would envisage that Pilot Hospitals will monitor and review the implementation of the pilot program through monthly meetings. Where there is in place review of workers compensation and return to work, we would envisage this to be included as an agenda item. We would encourage the appointment of an injured and/or ill nurse representative and ANF OHS Representative to attend and participate in the monthly meetings. We would

envisage that for the first 3 months of the Project the RTW Project Officer will attend these meetings, to allow for the opportunity to provide assistance to each pilot hospital.

We would encourage the development and participation in establishing a network for pilot hospitals RTW Coordinators, this could be through a monthly teleconference and/or meeting to allow for an opportunity to discuss any issues and sharing of improvements in rehabilitation and return to work.

Outlined below are key timeframes that at this stage need to be implemented for the Pilot Program. More specific timeframes will be defined through consultation with Pilot Hospitals (Refer to attachment 1 for timeline template).

2.1 July/August 2008

Pilot Hospitals have advised they would not be able to apply provisional payments as outlined in the Draft Model. Each Pilot Hospital is provided with the opportunity to formalise their current practices in regard to this, and to provide the RTW Project Officer with a paragraph outlining this practice by the 7 July 2008.

An updated Draft of the Draft Rehabilitation Model of Care will be provided to Hospitals by the 31 July 2008. Changes include:

- Formalising the rehabilitation management plan and return to work plan into one plan;
- Separate overview pages on rights and responsibilities for injured and/or ill nurses and medical practitioners.

The ANF (VB) envisages that workshops at each Pilot Hospital will be conducted in July/August 2008. The timing of workshops will be negotiated with each Pilot Hospital. We envisage the following staff would attend the workshops NUM, ANUM's, Human Resources, RTW coordinator, ANF Job Representatives, OHS representatives, and injured and/or ill nurses. The workshop will be for 1 hour and will provide a general overview of the Project and outline the Draft Rehabilitation Model of Care, and discussion of return to work practices.

We envisage undertaking two focus groups with injured and/or ill nurses initially to explain the project and gain their perspectives of return to work and to then follow up with them as part of the evaluation process for the Pilot Program. We expect Pilot Hospitals will encourage nurses who currently have time loss injury/illness, have long term claims and those who are currently participating in return to work, to take part in the focus groups. We would also like to ask their permission to participate in the focus groups, and are currently developing a consent form.

A Gap Analysis of return to work practices compared to Draft Rehabilitation Model of Care will be undertaken, details of this will be provided below.

RTW Coordinators to participate in 1 day training for implementing the Draft Rehabilitation Model of Care, which will be provided by ANF (VB). The training will be held on the 31 July 2008, more detailed information on the training day will be provided to RTW Coordinators by the 1 July 2008.

2.2 March 2009

Evaluation of the Pilot Program, to be outlined below.

2.3 June 2009

Workshop for Pilot Hospitals on the evaluation of the Pilot Program.

3. Evaluation of Pilot Program

All data requested is to be de-identified in accordance with the *Information Privacy Act 2000*. All information and data provided will be treated as confidential, and will only be published in aggregate de-identified form in any documentation for the Nurses Return to Work in Hospitals Project.

3.1 Policy documents to be requested:

- Copy of the current Occupational Rehabilitation Program and Risk Management Program.
- Copy of the current return to work policy.
- Copy of the current workers compensation policy.

3.2 Data to be requested, for the periods 2004-05; 2005-06; 2006-07; 2007-08 (Financial Year):

- Total number of time loss and medical and like claims for each financial year for Nurses.
- Nature of injury/illness.
- Mechanism of Injury/Illness.
- Causation of Injury/illness.
- Claim continuance rates for nurses (13, 26, 52, 104 and >104 weeks).
- Number of injured nurses who are currently working and are engaged in the same and/or similar duties to those they had before the injury/illness.

- Number of injured nurses who are currently working and have had a change in duties.
- Number of injured nurses who are currently working and have had a change in employer.
- Types of rehabilitation services (for example, Vocational Rehabilitation, Vocational Counseling, Vocational Assessment, Job Seeking Assistance) provided to injured nurses and the point that this service is provided.
- Number of nurses whose employment is terminated at > 52 weeks where they have no capacity for work, where they have a partial capacity for work, where they have full capacity for work in an alternate role.
- Number of nurses whose claims are terminated at >104 weeks where they have no capacity for work, or have a partial capacity for work.
- Impact on RTW of physical injuries developing secondary injuries?
- Estimated cost impact on premium for an average claim, for a musculoskeletal injury, and for a psychological illness.

3.3 Gap Analysis

The Gap Analysis should be undertaken at each Pilot Hospital. The objective of the Gap Analysis is to identify the gap between RTW practices and the Draft Rehabilitation Model of Care (Refer to Attachment 2 to access the Gap Analysis).

We envisage that the identified contact for the Pilot Program in your hospital will work with the RTW Project Officer in undertaking the Gap Analysis. The Gap Analysis will be undertaken at the beginning of the Project and again at the end for ongoing evaluation the, initial analysis will provide a benchmark for the Pilot Hospitals.

3.4 Evaluation

We are currently selecting an evaluator for the Pilot Program. We will be able to provide you with more details regarding the evaluation after consultation with the evaluator.

4. Outline of employer Legislative Obligations for RTW and the Draft Rehabilitation Model of Care

Attachment 3 outlines an employer's legislative obligations for return to work and the Draft Rehabilitation Model of Care.

Timeframe	Date	Description	Who to Attend	Location	Time
July/August 2008	TBC	Workshop - provide overview of Nurses Return to Work in Hospitals Project, overview of Draft Rehabilitation Model of Care, and discussion of barriers and factors for successful RTW.	NUM/ANUM, Management, HR	Boardroom	1 Hour
	TBC	Workshop - provide overview of Nurses Return to Work in Hospitals Project, overview of Draft Rehabilitation Model of Care, and discussion of barriers and factors for successful RTW.	Job Representatives, OHS Representatives	Boardroom	1 Hour
	21.08.08	Focus Group - provide overview of of Nurses Return to Work in Hospitals Project, overview of Draft Rehabilitation Model of Care, and their perspective of rehabilitation and return to work.	Injured/III Nurses	TBC - offsite for injured/ill nurses from each pilot hospital.	2 Hour
	31-Jul-08	Draft Rehabilitation Model of Care - Training	RTW Coordinators	TBA	1 Day
	TBC	GAP Analysis	Hospital nominee/RTW Project Officer	TBC	TBA
Ongoing	TBC	Consultative committee, meeting in workplace on Pilot Program	Management and employee representatives	TBC	TBC - 1 hour monthly meeting
	TBC	Teleconference and/or meeting	RTW Coordinators/RTW Project Officer	TBC	TBC -1 hour monthly meeting
April-June 2009	TBC	Evaluation of Pilot Program - Quantitative	TBC	TBC	TBC
		Focus Group - Evaluation	NUM/ANUM, Management, HR	TBC	2 Hour
		Focus Group - Evaluation	RTW Coordinators	TBC	2 Hour
		Focus Group - Evaluation	Injured/III Nurses	TBC	2 hour
Jun-09	TBC	Workshop Program - Evaluation Outcomes	Pilot Hospitals	TBC	1 Day

Attachment 2 Gap Analysis

Pilot Hospital

Item	Analysis		
1. Shared Commitment of Rehabilitation			
Occupational Rehabilitation Program and Risk Management Program			
1. Occupational Rehabilitation Program	2	1	0
a. Employer commitment to the management of workplace injury/illness	2	1	0
2. Risk Management Program	2	1	0
a. Risk assessment and control actions following injury, with timelines	2	1	0
b. Investigation of incidents, accidents, injuries or near misses to identify their cause(s) and adopt preventative measures to minimise risk in the workplace	2	1	0
c. Provision of risk management program to injured worker and their treater to demonstrate that ongoing risk has been identified and minimised	2	1	0
d. Provision of risk management program with the rehabilitation management plan (currently return to work plan)	2	1	0
3. Occupational Rehabilitation Program and Risk Management Program which includes:			
(a) Involvement of Workplace and worker representatives	2	1	0
(b) Commitment from Boards and CEO's to the Programs	2	1	0
(c) Practical application of policy and procedures	2	1	0
Promoting supportive Workplaces			
Demonstration of training provided to managers and supervisors on workers compensation and rehabilitation	2	1	0
Education of all employees on workers compensation, rehabilitation and return to work, and consequence of injury and/or illness as part of induction	2	1	0
Prevention discrimination as a result of reporting workplace injury/illness or lodging a workers compensation claim	2	1	0
2. Access to support and information			
1. Development of information package for injured/ill nurses	2	1	0
2. Distribution of information package to injured/ill nurses	2	1	0
3. Information package explained in person to injured/ill nurse	2	1	0
4. Development of information package for medical practitioners	2	1	0
5. Distribution of information package to medical practitioners	2	1	0
3. Early Intervention			
Early notification of Injury			
1. Workplace policy and procedure for reporting injury/illness	2	1	0
2. Employee reported all incidents, including workplace injury/illness	2	1	0
3. Accurate written record of all notified incidents and accidents and workplace injury/illness	2	1	0
4. Reported workplace injury/illness within 48 hours of the incident/accident	2	1	0
Encouraging parties to take appropriate action following notification of injury/illness			
1. In accordance with the Occupational Rehabilitation Program an employer should identify:			
(a) Injury/illness likely result in total or partial incapacitation for work	2	1	0
(b) Ongoing medical and like assistance	2	1	0
(c) Any risk factors that could lead to the injury becoming a long term injury/illness	2	1	0
(d) Delay in rehabilitation and return to work from disputation of a claim	2	1	0

2 = yes 1 = yes in part 0 = no

(e) Contact with injured nurse and their medical practitioner within 5 days of notice of injury	2	1	0
2. Communication between parties to achieve the amicable resolution of conflict regarding the workers compensation claim and/or rehabilitation and return to work	2	1	0
Promoting early lodgement and reporting claims for workers compensation			
1. Injured/ill nurses awareness of their legislative obligation to report their notice of injury within 30 days from becoming aware of injury/illness?	2	1	0
2. Advice to injured/ill nurses their of entitlement to lodge a workers compensation claim?	2	1	0
3. Notification of injury/illness, entitlement to lodge a workers compensation claim, and lodgement timeframe for a claim outlined in the Occupational Rehabilitation Program	2	1	0
4. Effective communication, consultation, coordination and planning			
Encouraging clear, timely and non-threatening communication			
1. Face to Face communication	2	1	0
2. Telephone communication	2	1	0
3. Written communication	2	1	0
4. Communication clear and non-threatening?	2	1	0
5. Timeframes for communication developed with the injured/ill nurse	2	1	0
6. Timeframes for communication developed with the injured/ill nurse's medical practitioner	2	1	0
7. Encouragement of injured nurses with time loss injury/illness to have continued contact with the workplace and work colleagues, including:	2	1	0
(a) Workplace social activities (observing any medical restrictions)	2	1	0
(b) Workplace communication	2	1	0
Promoting full and open disclosure of relevant information			
1. Open, honest and transparent communication	2	1	0
2. Face to Face communication	2	1	0
4. Injured/ill nurses consulted, involved and participate in all aspects of their treatment and rehabilitation including RTW	2	1	0
5. As required, obtain written consent/authorisation from an injured/ill nurse	2	1	0
6. Provision of consent/authorisation to the medical practitioner	2	1	0
Role of RTW Coordinator			
RTW Coordinator responsibilities include:			
(a) Coordinating rehabilitation and return to work	2	1	0
(b) Developing and coordinating the rehabilitation management plan (currently RTW Plan)	2	1	0
(c) Treating the injured and/or ill nurse with care as an individual	2	1	0
(d) Developing and maintaining relationships with the injured and/or ill nurse, their NUM/ANUM, and treating medical practitioners – without breaching privacy	2	1	0
(e) Facilitating open communication with the injured and/or ill nurses, their NUM/ANUM, and treating medical practitioners, and other relevant parties	2	1	0
(f) Educating injured and/or ill nurses, their NUM/ANUM, and treating medical practitioners of the rehabilitation process and their roles and responsibilities	2	1	0
(g) Arranging regular reviews and modifications of the Rehabilitation Management Plan and RTW Plan, including practical review in the work environment to see how injured and/or ill nurses are managing their injury and/or illness	2	1	0

2 = yes 1 = yes in part 0 = no

and RTW			
(h) Where appropriate identifying early with the injured and/or ill nurse retraining and employment opportunities within the organisation that are aligned with medical restrictions	2	1	0
(i) Addressing issues before they impact on the rehabilitation of the injured and/or ill nurse	2	1	0
(j) Having a comprehensive understanding of the injured nurse's injury and/or illness, its causes and of the work environment	2	1	0
(k) Decision making power in the workplace	2	1	0
(l) Document maintenance	2	1	0
(m) Meeting legislative obligations for RTW Coordinator duties as outlined in S161 of the Act	2	1	0
Qualifications of RTW Coordinator			
1. WorkSafe Victoria - 2 Day RTW Coordinator Training	2	1	0
2. Other RTW Coordinator Training incorporating:	2	1	0
(a) Comprehensive knowledge of Legislation, including detailed understanding of practical application of workers compensation and RTW	2	1	0
(b) Conflict Resolution Skills, effective management and negotiation skills	2	1	0
(c) Counselling skills	2	1	0
(d) Knowledge and understanding of injuries and the impact of injuries	2	1	0
Promoting appropriate rehabilitation planning – Rehabilitation Management Plan			
1. Comprehensive rehabilitation management plan for coordinating and managing the treatment, rehabilitation and return to work of each injured and/or ill nurse	2	1	0
2. If so, is the rehabilitation management plan:	2	1	0
(a) Realistic	2	1	0
(b) Achievable	2	1	0
(c) Tailored to the individual's circumstances	2	1	0
3. Rehabilitation management plan (currently RTW Plan), includes:	2	1	0
(a) Contact details for all parties	2	1	0
(b) Demonstration of consultation with the injured nurse, NUM/ANUM, treating Medical Practitioner in the development of Rehabilitation Management Plan	2	1	0
(c) Signed agreement by the injured nurse, NUM/ANUM, treating Medical Practitioner and RTW Coordinator to cooperate and comply with the Rehabilitation Management Plan	2	1	0
(d) Outline communication pathways	2	1	0
(e) Assessment of injury/illness	2	1	0
(f) Medical and Allied Health Management	2	1	0
(g) Return to Work includes offer of suitable duties	2	1	0
(h) Outlines medical restrictions (in accordance with the medical certificate)	2	1	0
(i) Details RTW duties and Hours	2	1	0
(j) Detail of work visits by RTW Coordinator	2	1	0
(k) Identify retraining where applicable	2	1	0
(l) Occupational Rehabilitation Services	2	1	0
(m) Roles and Obligations of all parties	2	1	0
(n) Scheduled dates for review	2	1	0
4. Development of rehabilitation management plan from date of injury	2	1	0
5. Timely and appropriate medical management			
1. Do medical practitioners monitor, review and advise on the injured/ill nurse's condition?	2	1	0
2. Do medical practitioners specify work restrictions and advise on	2	1	0

2 = yes 1 = yes in part 0 = no

suitability of return to work duties?			
3. Do medical practitioners participate in the development of the rehabilitation management plan (currently return to work plan)?	2	1	0
4. Do you advise medical practitioners of their role and responsibility for rehabilitation and return to work?	2	1	0
5. Do you have difficulty engaging medical practitioners for rehabilitation and return to work?	2	1	0
6. Do you advise injured/ill nurses that if they are not happy with their current medical practitioner, that they have a right to change their treater?	2	1	0
7. Do you take reasonable measures to communicate with the other parties to achieve the amicable resolution of conflicts regarding medical management?	2	1	0
6. Early, sustainable, safe, durable and meaningful return to work			
Promoting return to work			
1. Is workplace based support and assistance provided to the injured/ill nurse in returning to work?	2	1	0
2. Does the RTW Coordinator provide workplace based support and assistance to the injured/ill nurse in returning to work?	2	1	0
3. Do you provide ongoing support to long term injured/ill nurses?	2	1	0
4. Do you communicate that an employer has a legislative obligation for return to work	2	1	0
5. Do you advise the injured/ill nurse that if they do not comply with return to work that entitlement may cease?	2	1	0
6. Do you involve the injured/ill nurse in the development of their rehabilitation management plan (currently RTW plan)?	2	1	0
7. In rehabilitation and return to work planning do you work with all parties through co-operation, collaboration and consultation in achieving determined goals for rehabilitation of the individual injured/ill nurse?	2	1	0
Employer obligations for rehabilitation and return to work			
1. Has the workplace developed a catalogue of RTW duties and employment opportunities?	2	1	0
2. In identifying RTW duties are they:			
(a) Sustainable RTW duties – to determine capabilities of injured/ill nurse to undertake duties, and that the duties can be accommodated in the workplace	2	1	0
(b) Safe RTW duties – assess the risk of further injury and/or recurrence	2	1	0
(c) Meaningful RTW duties – of value to the injured nurse and employer	2	1	0
(d) Durable RTW duties – long term focused	2	1	0
3. Are injured/ill nurses involved in the identification and selection of sustainable, safe, meaningful and durable RTW duties?	2	1	0
4. Do RTW duties comply with medical restrictions?	2	1	0
5. Are injured/ill nurses provided the opportunity to provide feedback on their rehabilitation and return to work progress?	2	1	0
Regular review of work capacity			
1. Do you continually review and modify the rehabilitation management plan (currently return to work plan)?	2	1	0
2. Do you identify early, in consultation and agreement with injured/ill nurses, NUM, and treating medical practitioner, where an injured/ill nurse is unable to return to their pre-injury role?	2	1	0
3. Do you identify referral for vocational rehabilitation at > 52 weeks, when obligation to re-employ ceases?	2	1	0
4. Do you provide internal vocational rehabilitation?	2	1	0
5. Does internal vocational rehabilitation include:	2	1	0
(a) Career counseling?	2	1	0
(b) Vocational education and re-training, including practical development?	2	1	0

2 = yes 1 = yes in part 0 = no

Appropriate referral to occupational rehabilitation			
1. Does the Occupational Rehabilitation Program communicate to injured/ill nurses that they have a choice of 3 occupational rehabilitation providers?	2	1	0
2. Are the occupational rehabilitation providers identified in the Occupational Rehabilitation plan?	2	1	0
3. At what stage are occupational rehabilitation providers selected to assist rehabilitation and return to work of injured/ill nurses from date of injury:			
(a) 0 to 5 days	2	1	0
(b) 5 to 10 days	2	1	0
(c) 10 to 20 days	2	1	0
(d) 20 to 30 days	2	1	0
(e) > 30 days	2	1	0
4. Do you advise injured/ill nurses of their entitlement to occupational rehabilitation services?	2	1	0
5. Do you advise injured/ill nurses of the occupational rehabilitation services that are available including?	2	1	0
(a) Initial Occupational Rehabilitation Assessment – an assessment of current medical status and employment status to determine specific occupational rehabilitation needs	2	1	0
(b) Functional Assessment – measurement of physiological functioning capacity to identify work capabilities	2	1	0
(c) Occupational Rehabilitation Counselling	2	1	0
(d) Work Conditioning – specific individualised program of simulated or actual work activities that are structured and graded to progressively increase physical capacity, tolerance, stamina, endurance and productivity	2	1	0
(e) Functional Education – education of recommended physical activities to strengthen body and mind to avoid re-injury	2	1	0
(f) Workplace Assessment – identification of suitable employment in workplace and/or modifications in the workplace	2	1	0
(g) Job Analysis – assessment of transferable skills and abilities to determine suitable employment opportunities with pre-injury employer	2	1	0
(h) Household Help Assessment – to assess ability to carry out basic, routine, common household tasks which they have identified as having difficulty completing and where appropriate recommending external household help services where independence cannot be maintained	2	1	0
(i) Vocational Education advice and/or assistance – identification of vocational education needs and employment goals	2	1	0
7. Monitoring for better long term outcomes			
1. Collection of RTW data	2	1	0
2. RTW data monitored	2	1	0
3. Collect data on stakeholder feedback of RTW	2	1	0
4. RTW data utilised to identify improvements in RTW practices	2	1	0
5. Commitment to continual improvement in RTW	2	1	0

2 = yes 1 = yes in part 0 = no

Attachment 3

Outlines the difference between an employer's Legislative Obligations for RTW and the Draft Rehabilitation Model of Care¹⁴

Difference between an employers legislative obligations for return to work and the Draft Rehabilitation Model of Care			
	1. Shared commitment of Rehabilitation	2. Access to information and Support	3. Early Intervention
Employer Legislative Obligations for return to work	<p>Basic system and legal compliance:</p> <ul style="list-style-type: none"> • S156, S158 and S159 outlines an employer must develop and maintain an Occupational Rehabilitation Program and Risk Management Program. 	<p>Basic system and legal compliance:</p> <ul style="list-style-type: none"> • As outlined in Occupational Rehabilitation Program and Risk Management Program. 	<p>Basic system and legal compliance:</p> <ul style="list-style-type: none"> • Incident register, S101. • An injured worker must notify of injury/illness within 30 days of becoming aware of an injury or illness, S102.
Rehabilitation Model of Care (adds to legislative obligations)	<p>Encourages employers to provide supportive workplaces through:</p> <ul style="list-style-type: none"> • A commitment to providing training and information on workers compensation and rehabilitation for managers and supervisors. • A commitment to educating all employees on workers compensation, rehabilitation and return to work, and consequence of injury and/or illness as part of the induction process and ongoing bi-annually. • Preventing discrimination (including perception of discrimination) – promote and encourage cultural change of reporting injury and/or illness and workers compensation. 	<p>Encourages employers to:</p> <ul style="list-style-type: none"> • Develop information packages for injured and/or ill workers and their medical practitioners on workers compensation and rehabilitation. • To be transparent in the delivery of information provided to injured and/or ill workers. • To provide information in person to ensure understanding and clarification of information provided. <p>This information to be provided from the date of injury and/or notification of injury.</p>	<p>The RehabMoC¹⁵ acknowledges and reinforces the importance of commencing rehabilitation and the RTW process as soon as possible following an injury by:</p> <ul style="list-style-type: none"> • Promoting early notification of injury (within 48 hours of injury); • Encouraging parties to take appropriate action following notification of injury i.e. risk minimisation; • Promoting early lodgement and reporting of claims for workers compensation; • Promoting and/or encouraging the provisional payment of medical and rehabilitation expenses (and endorsing the provisional payment of weekly compensation payments up to 12 weeks of weekly compensation payments and a maximum of \$5000 in medical and rehabilitation expenses.

¹⁴ Refer to Appendix 1.

¹⁵ RehabMOC – Draft Rehabilitation Model of care

Difference between an employers legislative obligations for return to work and the Draft Rehabilitation Model of Care				
	4. Effective communication, consultation, consideration and planning	5. Timely and appropriate medical management	6. Early, sustainable, safe, meaningful and durable return to work	7. Monitoring for better long term outcomes
Employer Legislative Obligations for return to work	<p>Basic system and legal compliance:</p> <ul style="list-style-type: none"> As outlined in Occupational Rehabilitation Program and Risk Management Program. S161 outlines role of the RTW Coordinator 	<p>Treating Medical Practitioner –</p> <ul style="list-style-type: none"> To provide a workers compensation medical certificate, to outline diagnosis/prognosis, duration of incapacity and/or outline current work capacity, outline medical restrictions. <p>(This is not an employer's legislative obligation).</p>	<p>Basic system and legal compliance:</p> <ul style="list-style-type: none"> Appoint a RTW Coordinator, S161. Prepare a RTW Plan, S160. Provide employment which is the same or equivalent to the pre-injury role with the pre-injury employer, up to 52 weeks, S155A. Provide an offer of suitable employment, S155A. 	<p>There are no legislative obligations under the Act, WorkSafe Victoria provides guidance and encourages employers to have regular reviews with their Agent.</p>
Rehabilitation Model of Care (adds to legislative obligations)	<p>RehabMOC aims to improve communication, coordination and planning by:</p> <ul style="list-style-type: none"> Encouraging clear, timely and non-threatening communication; Promoting full and open disclosure of relevant information; and Promoting appropriate rehabilitation planning – Rehabilitation Management/Return to Work Plan. <p>Encourage that RTW coordinator role expanded to include:</p> <ul style="list-style-type: none"> Coordinating rehabilitation and return to work. Developing and coordinating the rehabilitation management plans (RehabMP) and return to work plans (RTWPlan), which are individual plans. Treating the injured and/or ill nurse with care as an individual. Developing and maintaining 	<p>RehabMOC aims to influence medical practitioners participation in rehabilitation and return to work:</p> <ul style="list-style-type: none"> Providing diagnosis, primary medical care and coordination of medical treatment (including referral to and coordination of specialist care as appropriate); Completing workers compensation medical certificates; Monitoring, reviewing and advising on the injured nurses condition and treatment; Specifying work restrictions and advising on suitability of duties offered by the employer; and Participating in the development of the Rehabilitation Management Plan and RTW Plan. Maintain communication channels 	<p>RehabMOC aims to improve rehabilitation and return to work outcomes by:</p> <ul style="list-style-type: none"> Advocating continued worker contact/involvement with the workplace following injury; Acknowledging genuineness of injury and/or illness; Developing individualised Rehabilitation Management Plans and Return to Work Plans; Promoting workplace-based coordination of return to work; Encouraging appropriate consideration of retraining and redeployment options; Encouraging the employer to meet legislative obligations with respect to rehabilitation and return to work; Explaining to injured and/or ill nurses the process, their rights 	<p>Regular monitoring and evaluation is essential to ensure that the Draft Rehabilitation Model of Care is meeting its objectives. It allows any problem areas, or opportunities for improvement to be identified and addressed accordingly. The Model facilitates this process by:</p> <ul style="list-style-type: none"> Requiring collection of relevant data; and Through the development of review and evaluation mechanisms.

	<p>relationships with the injured and/or ill nurse, their NUM/ANUM, and treating medical practitioners – but should not breach privacy.</p> <ul style="list-style-type: none"> • Facilitating open communication with the injured and/or ill nurses, their NUM/ANUM, and treating medical practitioners, and other relevant parties. • Educating injured and/or ill nurses, their NUM/ANUM, and treating medical practitioners of the rehabilitation process and their roles and responsibilities. • Arranging regular reviews and modifications of the Rehabilitation Management Plan and RTW Plan, including practical review in the work environment to see how injured and/or ill nurses are managing their injury and/or illness and RTW. • Where appropriate identifying early with the injured and/or ill nurse retraining and employment opportunities within the organisation that are aligned with medical restrictions. • Addressing issues before they impact on the rehabilitation of the injured and/or ill nurse. • Having a comprehensive understanding of the injured nurse's injury and/or illness, its causes and of the work environment. • Decision making power in the workplace. • Maintaining documentation. • Duties outlined in S161 of the Act. 	<p>with the injured worker and employer. Development of information package for medical Practitioners.</p>	<p>and obligations with respect to rehabilitation and return to work;</p> <ul style="list-style-type: none"> • Requiring regular review of Rehabilitation Management Plan; • Encouraging early and appropriate referral to occupational rehabilitation providers; • Promoting minimisation and appropriate resolution of disputes about rehabilitation and return to work. 	
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Attachment 4

Dear Colleague

RE: NURSES RETURN TO WORK IN HOSPITALS PROJECT – FOCUS GROUP

The Australian Nursing Federation (Victorian Branch) invites you to participate in Focus Groups for the Nurses Return to Work in Hospitals Project being held on ... at the Jasper Hotel.

Injured and ill nurses who want to return to their profession are often prevented from doing this due to poor rehabilitation and return to work practices. The Focus Groups are an important part of the ANF (Vic Branch) three year Nurses Return to Work in Hospitals Project for injured and ill nurses. The project has the support of the Injured Nurses Support Group (INSG) and of the Victorian Hospitals' Industrial Association (VHIA). The Nurses Return to Work in Hospitals Project is also supported by your employer who has agreed to participate in the Project's Pilot Program, which includes the Focus Groups.

The objective of the Focus Groups is to gain an understanding from injured and/or ill nurse's perspective of rehabilitation and return to work. Julia Suban, Nurses Return to Work in Hospitals Project – Project Officer, will facilitate the Focus Groups, and will provide an overview of the Project and of the Project Pilot Program.

Please find enclosed:

1. Nurses Return to Work in Hospitals brochure; and
2. Return to Work Focus Groups for injured and/or ill Nurses brochure, which includes the registration form.
3. Permission form.
4. Claim for reimbursement form.

If you can assist our Project, by participating in one of the Focus Groups, please complete the attached registration form and place it in the reply paid envelope and send to us **by no later than 1 August 2008**.

Once you have registered, a confirmation letter will be sent to you. Lunch will provided on the day, and we will reimburse you for travel expenses.

Thank you for helping the ANF (Vic Branch) Project to make a difference.

Yours sincerely,

Lisa Fitzpatrick
SECRETARY, ANF (VIC BRANCH)

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