EVALUATION REPORT: NURSES RETURN TO WORK IN HOSPITALS PILOT PROGRAM

Prepared by URCOT

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- The nurses for sharing their stories, which at times was very difficult for them.

ABBREVIATIONS

ANF – Australian Nursing Federation (Victorian Branch)
ANUMs – Assistant Nurse Unit Managers
CEO – Chief Executive Officer
DON – Director of Nursing
IVR - Internal Vocational Rehabilitation
KPIs – Key Performance Indicators
NUMs – Nurse Unit Managers
OH&S – Occupational Health and Safety
RehabMoC - Draft Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria
RTW – Return to Work
NURSES RETURN TO WORK IN HOSPITALS PILOT PROGRAM
EVALUATION REPORT

Scope of Report

SECTION 1 - BACKGROUND

Over the past three years, the Victorian Branch of the Australian Nursing Federation (ANF) has led a major project, designed to facilitate a more effective and efficient return to work (RTW) of injured and/or ill nurses – The Nurses Return to Work in Hospitals Project. During this period, a number of reports have been produced including a literature review, preliminary data and focus groups on the experience of injured and/or ill nurses and their return to work, and from the perspectives of key stakeholder organisations who affect the return to work of injured and/or ill nurses.

This work culminated in the development of a Draft Rehabilitation Model of Care for Injured and/or Ill Nurses in Victoria (RehabMoC), which was proposed as the pilot for the Nurses Return to Work in Hospitals Project Pilot Program. Five hospitals in Metropolitan and rural/regional Victoria agreed to Pilot the draft RehabMoC. The draft RehabMoC provides a best practice approach to rehabilitation and return to work for Injured and/or ill Nurses in Victoria. The key features of the draft RehabMoC were:

a) clear open and transparent communication between all stakeholders;
b) return to work components of the rehabilitation of an injured nurse;
c) early, safe, sustainable meaningful and durable return to work duties; and
d) prompt resolution and minimisation of disputes.

There was also a high priority placed on the provision of comprehensive information and training, early intervention and timely and appropriate medical management. The draft RehabMoC also required a more regular collection of data by the hospitals to support ongoing monitoring and to enhance longer-term outcomes. The fundamental principle underpinning the draft RehabMoC is a shared commitment by all parties to the rehabilitation process.

The objectives of the Nurses Return to Work Project and of the Pilot Program were to:

- improve rehabilitation and RTW outcomes;
- reduce the human and financial costs;
- reduce the loss of skilled nurses; and
- promote recruitment and retention of injured and ill nurses

Essentially the intended outcome was to influence the rehabilitation of an injured and/or ill nurses rather than simply relying on RTW. Whilst the primary
focus was on improving rehabilitation it was intended that a bi product of the Pilot Program would be to affect cultural change in RTW practice.

The Nurses RTW in Hospitals Project retained URCOT to conduct an evaluation of the Pilot Project, drawing on a range of sources of data including hospital records and qualitative insights gathered by URCOT researchers. The purpose of the evaluation was to investigate and report on whether the Pilot Program had demonstrated that the draft RehabMoC was workable and effective in achieving its objectives, to report on specific learnings from the Pilot Program, and establish whether any attitudinal change had occurred in the stakeholder organisations during the Pilot Program. The evaluation process began in October 2008, and concluded in June 2009. This document is the Final Report of the evaluation of the Pilot Program, prepared for the Nurses RTW in Hospitals Project and other key stakeholders by URCOT.

SECTION 2 - THE PILOT PROGRAM

Five hospitals agreed to participate in the Pilot Program. These were:

- Healthe Care (The Valley Private; South Eastern Private);
- Melbourne Health;
- Ballarat Health;
- Echuca Regional Health; and
- St Vincent’s Public Hospital.

The participant hospitals represent a cross section of:

(i)   metropolitan/rural
(ii)  size – small/medium/large
(iii) private and public.

The potential breadth of the Pilot was extensive given the numbers of nursing staff which the participating hospitals employ\(^1\). As of the 2007/2008 Annual Reports and data from Human Resources Departments:

Healthe Care- Approximately 300 nurses of a total of approximately 500 staff
Melbourne Health-3285 nurses of a total staff of 7857
Ballarat Health-901 nurses of a total staff of 3196
Echuca Regional Health-238 nurses of a total staff of 489
St Vincent’s Public Hospital-Approximately 3000 nurses of a total of approximately 5500 staff\(^2\)

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\(^1\) These figures are actual numbers. This figures were more relevant that Full Time Equivalent (FTE) in this case because they offer a snapshot of how many individuals are employed. When the figures for FTE staff are calculated, given many staff at hospitals are part-time, the numbers alter drastically.

\(^2\) The figures for Melbourne Health, Ballarat Health and Echuca Regional Health were obtained through Annual Reports.
All of the participating hospitals were involved in the pilot implementation of the draft RehabMoC. As a result of an initial Gap Analysis, focus Groups and workshops, three case studies were identified. These were:

- Case study Training and Education for Nurse Unit Managers (NUMs) and Injured Nurses
- Case Study Internal Vocational Rehabilitation (IVR); and
- Case Study Development of Guidelines for Medical Practitioners.  

The Project’s RTW Project Officer supported the project implementation and monitoring of the Pilot Program. An external consultant was engaged to develop and conduct Case Study Training and Education. The RTW Project Officer undertook the Case Studies IVR and Medical Practitioners. As part of the implementation phase of the Pilot Program the RTW Project Officer undertook a Gap Analysis of the Hospitals’ practices based on Legislative Obligation for RTW and the draft RehabMoC at each of the Pilot Hospitals with the RTW Co-ordinator/OHS Manager.

In terms of the breadth of the evaluation, URCOT received a total of 100 completed pre and post pilot surveys which were analysed. A total of 28 NUM’s, ANUM’s and Human Resource personnel took part in the focus groups, eleven injured nurses and five RTW Co-ordinators. A total of seven RTW Co-ordinators took part in interviews, some more than once.

SECTION 3 - EVALUATION

The evaluation was to draw on:

- copies of the current Occupational Rehabilitation Programs and Risk Management programs at each hospital;
- copies of the current RTW policy at each hospital;
- copies of the hospitals’ current workers compensation policies;
- background data from the participating hospitals for the periods 2004-2008, covering a range of specific issues related to the number, nature, extent, of injuries and various aspects of the cost and duration of RTW experience;
- pre- and post-pilot surveys designed to measure staff attitudes/attitudinal changes to RTW of injured and/or ill nurses;
- interviews with the RTW Co-ordinators at each hospital;
- focus groups with injured and/or ill workers in each hospital, and with Nurse Unit Managers and Assistant Nurse Unit Managers (NUMs and ANUMs)
- Pre and post pilot implementation interviews and evaluation workshops with the RTW Co-ordinators of the pilot hospitals; and
- Modelling on premium impact/costs of successful/unsuccessful RTW in the pilot hospitals.

A detailed analysis can be found in the Report on Nurses Return to Work in Hospitals Project - Pilot Program in 5 Victorian Hospitals.
The objective of the evaluation was to report on whether the draft RehabMoC is a workable and effective model, to facilitate;

a) Communication between all parties,
b) Recovery from work related injury,
c) Early, safe, sustainable, meaningful and durable RTW, and
d) Prompt resolution and minimisation of disputes.

The intent during the investigations was to seek feedback on whether the Pilot had been useful, what the learnings had been from the Pilot and to establish whether attitudinal change had occurred and if so, in what way.

In addition, the RTW Project Officer undertook a Gap Analysis of the hospitals practices based on Legislative Obligation for RTW and the draft RehabMoC, at each of the pilot hospitals with the relevant contact in each hospital (in most cases the RTW Co-ordinator or OHS Manager).

As the Pilot Program proceeded, not all of the data requested could be collected from the hospitals. This reflected partly the specific arrangements for data collection in each hospital, and partly concerns by the hospitals in releasing data for public view. A lack of resources in the pilot hospitals also hindered some aspects of the pilot program’s implementation and evaluation. RTW Co-ordinators at some pilot hospitals lacked the time and resources needed. A period of unforeseen sick leave by one contact also affected attempts to access the data required. However, the pre- and post-pilot surveys were conducted, as well as the pre and post pilot interviews and focus groups. A post pilot evaluation workshop was also held on the 27th May to report on, and validate the findings of the evaluation. These constitute the key sources of data on which the evaluation is based.¹

¹ While the questions asked at the focus groups were framed around set questions aimed at eliciting information for the evaluation of the Pilot and the RehabMoc, other related issues were discussed depending on the interest of focus group participants.
SECTION 4 - SUMMARY OF FINDINGS

4.1 The draft Rehabilitation Model of Care (RehabMoC) represents a significant step forward in the management and support of injured or ill nurses rehabilitation and return to work.

4.2 Those that approached the Pilot Program holistically and had the opportunity to access the support and resources that the Pilot offered, and those hospitals in which there was active involvement by hospital staff in the Pilot, claimed the most success.

4.3 Survey results suggest that nurses have little knowledge or awareness about RTW, and that a significant proportion of nurses believe that workplace injury and/or illness and RTW and rehabilitation practices lead to increases in the workload of non-injured nurses.

4.4 Statistical data from hospitals was difficult to obtain. The reasons for this included

- inadequacy in the hospital systems which prevented access to the data;
- the difficulty and time investment required of disaggregating the data and distinguishing nurses from other workers;
- some statistical data sets requested are not kept by hospitals;
- changes in staff and management which meant data was not available; and
- reluctance amongst hospitals to release information.

4.5 The Gap Analysis revealed a consistent gap between RTW legislative obligations and the draft RehabMoC.

4.6 One of the clear implications of the Pilot is the importance of education.

4.7 RTW Co-ordinators spoke with high regard about the Pilot and the key stakeholders involved in undertaking the Pilot. All RTW Co-ordinators saw their participation as an opportunity; some to enhance their practice and procedures, others to build them.

4.8 The case study for Training and Education for Nurse Unit Managers (NUMs) and Injured Nurses was viewed as productive.

4.9 The case study for Development of Guidelines for Medical Practitioners is expected to be useful for some doctors. Whether the guidelines are adopted by doctors will depend on educational support that they receive during its introduction and the extent of the intervention by WorkSafe.
SECTION 5 - EVALUATION FINDINGS

The overwhelming evidence of the Pilot Program is that the draft RehabMoC represents a significant step forward in the management and support of injured or ill nurses return to work. Those that approached the Pilot holistically and had the opportunity to access the support and resources that the Pilot offered, specifically active involvement by hospital staff in the Pilot, claimed the most success. Where hospitals were in the development and consolidating phase of RTW initiatives, the Pilot was described as most successful.

The draft RehabMoC at this point in time has been applied by the Pilot Hospitals spasmodically. Key elements from the draft RehabMoC have been accepted and added to existing policy and practice in hospitals. It will however, take a much longer timeframe for implementation of the Rehabilitation Model of Care and then evaluation of it than has been possible in the Pilot Program in order for there to be a rigorous evaluation of attitudinal change.

Communication of RTW issues by the broader staff within the pilot hospitals is generally limited and this is a serious constraint on the potential value of providing a more effective environment for rehabilitation. The lack of communication about RTW issues, and more specifically the draft RehabMoC was evident in the focus groups:

‘I haven’t heard of it [draft RehabMoC]’

‘I think I have heard of it, but don’t know the specifics’

‘You really don’t know about RTW process until you are injured [and] even then it’s hard to figure out’

It is significant however, that at least one hospital claims that they have seen attitudinal change occur as a result of the application of elements of the draft RehabMoC and other pilot initiatives. The attitudinal dimension of this initiative cannot be underestimated, as nurses themselves struggle with many fears as part of the return to work process, and without the clear support of their work supervisors and their colleagues, the process is made much harder. It also serves to deter other nurses from reporting injury and therefore acts to inhibit early intervention and recovery.

Section 5.1 - This Report

The Final Report is organised so that the specific insights from each of the Gap Analysis, surveys, and the focus groups and interviews are summarised first, before more general observations are presented. The Report concludes with recommendations for the next phase in this work.
Section 5.2 - Gap Analysis

The Gap Analysis was conducted in mid 2008. The objective of the Gap analysis was to identify the gap between the legislative obligation for RTW and the draft RehabMoC.

A detailed template was prepared covering each specific element of the draft RehabMoC, as a framework for assessing how well the current hospital practices met the principles and expectations of the draft RehabMoC (see Attachment 2). The template was framed in terms of fully implemented, partially implemented and not implemented. This template was completed for each participating hospital by the hospital RTW Co-ordinator and the ANF Project Officer.

The Gap Analysis found that with the exception of one hospital who was ‘meeting in part’ their legislative obligations, all hospitals were meeting their legislative obligations for RTW. The Gap Analysis also clearly revealed that none of the five hospitals were meeting the expectations of the draft RehabMoC.

Given that the draft RehabMoC outlines a much more comprehensive description of the way in which the various elements of the return to work process should be conceived and implemented, it is not surprising that the gap analysis demonstrates that the hospitals are yet to achieve its full implementation. The Gap Analysis enabled a comprehensive understanding of where each of the pilot hospitals was positioned in relationship to the expectations of the draft RehabMoC. For the hospitals this Pilot provided the opportunity to build on the work that had been commenced in moving towards the draft RehabMoC.

A detailed analysis of the Gap analysis can be found in the Report on Nurses Return to Work in Hospitals - Pilot Program in 5 Victorian Hospitals.

Section 5.3 - The Evidence from the Surveys

‘there should be compulsory info sessions for nurses at all levels on this important subject to ensure an understanding of the process involved’.

‘We need to work really hard to change the culture and attitude among nursing staff towards injured/ill nurses returning to work. ...Nurses are often too quick to doubt and criticise their colleagues.’

‘...having an injury I would like more support, understanding from my co-workers and management, as often an injury is an ongoing problem,’

The pre- and post-Pilot surveys (see Attachment 1) were distributed online to 250 nurses (for the pre-Pilot) and to 700 (over two stages) for the post-Pilot.

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5 These findings are taken from the Nurses Return to Work in Hospitals Project- Report on Nurses Return to Work in Hospitals - Pilot Program in 5 Victorian Hospitals.
In each case, emails were sent to nurses at all levels (including Nurse Managers/Assistant Nurse Manager, Division 1 and 2 nurses) selected randomly from the ANF membership records at each of the participating hospitals (ensuring that the number invited from each site reflected the overall balance of nurses employed in these hospitals). The numbers of respondents were as follows.

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Pre-Pilot Respondents</th>
<th>Post-Pilot Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ballarat Health Services Base Hospital</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Echuca District Hospital</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>St Vincent’s Public Hospital</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>The Royal Melbourne Hospital</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Healthe Care (La Trobe Private)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>

Table 1: Respondents by site

The low number of respondents from Healthe Care means that no site-specific analysis can be taken of the responses from this hospital, although the overall sample is both relevant and representative. With respect to gender, the majority of respondents were female (86 per cent, pre-Pilot; 92 per cent, post-Pilot). There was some contrast, however, between the pre- and post-Pilot responses in relation to employment status:

<table>
<thead>
<tr>
<th></th>
<th>Full-time</th>
<th>Part-time</th>
<th>Casual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Pilot</strong></td>
<td>39%</td>
<td>57%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Post-Pilot</strong></td>
<td>59%</td>
<td>22.5%</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

Table 2: Respondents employment status

Overall, the surveys suggest that nurses have little knowledge of RTW, and that a significant proportion of nurses believe that workplace injury and/or illness and RTW practices lead to increases in the workloads of non-injured nurses.

*The support is there ‘on paper’ but there is very little in reality for seriously injured nurses*

*I never really think about it [RTW,] as nor my co-workers nor my self ever have been faced with this situation. I know that my NUM is not supportive even if I have a sick leave day*
In both surveys, approximately two thirds of the respondents indicated that they have had injuries in the past, which they have not reported, and that they have paid for their own medical expenses (even where they knew that their injury had occurred at work). The lack of knowledge about RTW and the perceived lack of unconditional support from their co-workers and managers were cited as reasons why the respondents would be unlikely to make a WorkCover claim if they became ill or injured at work in the future. These findings suggest that the workplace injuries continue to be underreported.

Approximately half of the respondents in both the pre and post pilot survey reported that they had little or no knowledge of their organisations’ RTW policies and procedures. We can also conclude that a significant number of nurses at each of the hospitals knew little or nothing about their rights and responsibilities in relation to RTW (or their employers’ obligations and rights). Only approximately two thirds of respondents in both the pre and post pilot survey thought that they understood the role of RTW Co-ordinator. The lack of change between the pre- and post-Pilot surveys might be explained by the limited direct involvement of nursing staff in the Pilot.

The lack of knowledge clearly concerned a number of nurses who made specific comments that ‘there should be compulsory info sessions for nurses at all levels on this important subject to ensure an understanding of the process involved’. Another nurse commented that there should be ‘increased channels of communication between managers and the co-workers of injured nurses’.

In the post-Pilot survey, almost one fifth indicated awareness of the Pilot. Ten per cent had participated in the Pilot, while a further 10 per cent thought that they might have participated. This participation was important as 30 per cent of the post-Pilot respondents reported that they now had a more positive approach to RTW.

...I have known several friends who have made a Worker’s Comp claim and have definitely had trouble even getting an interview for a different job. I know it’s wrong but it’s just the way it is....

Support is verbal only never backed up with actual help

[I] have experienced this[RTW] first hand and I am still getting a hard time and being bullied

Colleagues in my workplace recently have attempted RTW and their experience has been awful

The post-Pilot survey reinforced the findings of the pre-pilot survey regarding nurses’ unwillingness to make a WorkCover claim. Both surveys revealed that while approximately 70 per cent of nurses would definitely report a workplace injury/illness, only approximately 25 per cent would definitely make a claim. This is consistent with finding from both the pre and post pilot surveys
that over 80 per cent of respondents that the form of leave taken after an injury or illness was sick leave. The qualitative responses indicated that the reasons behind the hesitancy to claim included the perceived stigma attached to claimants and a belief that claims are only warranted for severe injuries/illnesses.

The survey data indicates that the Pilot has not had a great impact on the attitudes of nurses towards injury and its consequences, even though the data has revealed also that this is a critical feature of the RTW process.

_I do think that possibly my workload would be affected if someone call sick for example but I never found this problematic. That I just another obstacle to overcome that day and if the place is managed well probably another staff member like Bank or Agency can take the workload off your shoulders._

_I have to do certain jobs that they [injured nurses] can't or find difficult do_

Respondents answers suggested the role of supernumery staffing was not understood, and almost one quarter of respondents believed that their colleagues would question the legitimacy of their WorkCover claim. Non-managerial nurses indicated that their workload increased if a co-worker was undertaking RTW with light or restricted duties.

_The work they cannot do has to be shared amongst their colleagues_

One recurring theme related to light duties. The respondents felt that those on ‘light duties’ are still considered part of the team when it comes to rosters. As a result they feel that those on light duties increase the workload of others.

_I think as nurses we should be more understanding of work place injury. Thankfully the stigma involved with the same is slowly fading_

_[The] Stigma of a work cover claim is undesirable; Old attitudes of not wanting to look as though you were a trouble maker_

One sixth said the same about their managers, suggesting that it is perceived that the stigma attached to workplace injury is less prevalent within management. The majority of respondents in both surveys felt that management would support them if they became ill or injured as a result of a workplace incident, but remained somewhat uncertain about this. The perceived severity of injury was a critical factor that would influence decisions to report or not in the future.

There is little doubt from the survey responses that there is a significant ‘hidden’ cost in relation to workplace injury. Certainly the written comments

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6 Supernumery nurses are those whose shifts are in addition to regular staffing numbers. These nurses are not counted as rostered staff.
would indicate that nurses are concerned about reporting injury, concerned about the extra workload to colleagues and the non-injured workers are both concerned for their colleagues and also for the extra work this may entail. The qualitative responses also indicate that there is concern at least in terms of the stigma associated with being injured that while becoming less of an issue still sits there. The focus groups supported this with injured nurses saying that they ‘push’ themselves and ‘give themselves a talking to’ urging themselves to continue at work or working in the home when they feel pain.

One of the clear implications of the Pilot was the importance of education. This was reinforced strongly in some of the qualitative comments within the survey:

‘We need to work really hard to change the culture and attitude among nursing staff towards injured/ill nurses returning to work. Education is the key along with a supportive and proactive management team. Nurses are often too quick to doubt and criticise their colleagues.’

Other comments were that ‘more education should be given to co-workers on the disadvantage put to the worker returning. It is a hard thing for them as well’ and that there needed to be ‘more education of staff in [the] area they are coming in to, make sure staff are aware before they come that they know what they can and can’t do’. An injured worker added that, ‘having an injury I would like more support, understanding from my co-workers and management, as often an injury is an ongoing problem, for example back disk prolapse, and you are expected to cope’.

These comments might reflect some of the difficulties in implementing the education component of the Pilot Program. In some cases, the sessions were not conducted until relatively late in the Pilot timelines, meaning that any educative work in the hospitals had to be undertaken by the RTW Coordinators and OH&S staff, on top of their other workloads.

The training was highlighted as a need from the preliminary workshops, focus groups and Gap Analysis.\(^7\) Once the need for training was identified, the training material needed to be developed then implemented and time became a constraint in implementing this earlier, as there was some difficulty for hospitals in organising times and dates for training. There is little doubt that training earlier in the Pilot Program would have been beneficial.

**Section 5.4 - Focus Groups**

The intention of the focus groups was to obtain grounded data through which to evaluate the Pilot and the draft RehabMoC specifically. The focus groups provided in-depth data and demonstrated the full range of knowledge ranging from well versed in the Pilot to no knowledge at all. What was significant in the data from the nurses who had very little or no knowledge of the draft RehabMoC was that when describing their positive experiences, many times

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\(^7\) Refer to Report on Pilot Program in 5 Victorian Hospitals.
these experiences mirrored the draft RehabMoC. Conversely, the bad experiences they expressed often related to gaps the draft RehabMoC identified need to be addressed. Some of the participants in the focus groups referred to broad RTW and rehabilitation issues. Where relevant, the range of responses has been included in the focus group discussion because of the importance of the issues to the particular group and the potential they offered from the participants perspective of improving RTW experiences.

Section 5.5 - Interviews and Focus Group with RTW Co-ordinators

The RTW Co-ordinators spoke with high regard about the Pilot and the key stakeholders involved in undertaking the Pilot (see Attachment 4 for list of questions). All RTW Co-ordinators saw their participation as an opportunity; some to enhance their practice and procedures, others to build them. The RTW Co-ordinators felt supported by the RTW Project Officer throughout the Pilot and also by the consultants who were involved in the case studies.

While most hospitals thought that some cultural change had occurred as a result of the Pilot, one hospital in particular believed that significant positive cultural change had occurred as a result of the Pilot. This was corroborated by the nurses, the NUMs and ANUMs. Significantly this hospital was involved in three elements of the Pilot. One other hospital said that while cultural change had occurred in their hospital, the appointment of a new CEO and a requirement to report on KPIs relating to RTW was likely to be the reason.

One of the great benefits of the Pilot overall was the perceived cooperation of the ANF and WorkSafe. The RTW Co-ordinators believed that this cooperation held currency with senior managers which was of assistance and enabled greater results to be achieved. One Co-ordinator believed that much of the success of the Pilot in her hospital could be attributed to the role of the ANF because the nurses in her hospital had great respect for the ANF.

For some hospitals the Pilot offered a mechanism for engagement in RTW and rehabilitation that had not existed before. In its simplest form it required sign off from the CEO and as such raised it as an agenda item. This in turn served to raise the profile of injury and RTW. Support from the CEO and senior management was described as crucial to the success of RTW. This support varied from hospital to hospital. Where the support from the CEO was explicit and active, the RTW Co-ordinators felt that cultural change would occur. As one person said and others concurred, 'It needs to be led from the top'.

All hospitals thought that elements of the draft RehabMoC were valuable. Where the draft RehabMoC was most likely to be adopted in its entirety was in hospitals that were developing procedures and practices or substantially changing current ones. These hospitals could clearly see the benefits of the draft RehabMoC over and above the legislative requirements.

In the larger hospitals where processes and procedures had been in place for some time, the draft RehabMoC served to enhance existing policy. While the
draft RehabMoC was described as a good idea, one large hospital believes that they were applying the elements of the draft RehabMoC and have been for some time. In a sense they believed the draft RehabMoC worked as confirmation for their practices. In another larger hospital the draft RehabMoC served to give priority to collaboration in discussions about modified duties. Greater involvement from the worker enables them to take ownership of their RTW.

Overall RTW Co-ordinators said that the ethos of the draft RehabMoC was great. They said that the holistic approach was very useful. They acknowledged that the application of the draft RehabMoC depends on the injury. Each case was seen as unique and RTW Co-ordinators believed that each person needed to be treated differently. One Co-ordinator intends to use the draft RehabMoC to provide NUMs and ANUMs with additional information.

In terms of opportunities to refine the draft RehabMoC, they said that they would prefer the RTW plan in the draft RehabMoC to be written more simply. The RTW Co-ordinators were responding to the language used in the draft RehabMoC. They believed that the language was a little confusing. Another aspect of the language was that they thought that it assumes there will be a problem rather than the language being entirely ‘neutral. One Co-ordinator was concerned that language in the draft RehabMoC such as ‘the employer must...’ could be construed as confrontational as if the employer was the problem. It should be noted however that the use of the word ‘must’ was only used when there was a legislative obligation. The reason for this wording may not have been clearly understood by the Co-ordinator.

RTW Co-ordinators would have liked a step by step process to be articulated in their initial workshop in respect of the draft RehabMoC. Some felt confused about what to do immediately that they returned to the workplace. One of the RTW Co-ordinators said that the ‘step by step’ instructions could have looked like a checklist that outlined not just ‘what’ to do but ‘how’ to do it. They believed that milestones for implementation of the draft RehabMoC. This would have provided more concrete guidance in terms of what do by when. As this issue was raised during the evaluation of the Pilot, changes could not have been made retrospectively. However this concern is worth noting so that it can be addressed in future roll outs of the draft RehabMoC.

In terms of other information in the draft RehabMoC, RTW Co-ordinators expressed that they would have liked a clearer picture of what was required of them when the nurse initially reports the injury. A number of RTW Co-ordinators expressed some confusion at this aspect of the RTW. One suggested that a template of the process may have made this easier for them to understand. Other support could include standard letters to doctors, a standard authority form and standard privacy brochure.

The Internal Vocational Rehabilitation (IVR) case study was described as useful.
The case study for Training and Education for Nurse Unit Managers (NUMs) and Injured Nurses was viewed as productive. The RTW Co-ordinators believed that the tone was right and that the sessions were very informative. They reported that the participants were all interested and wanted more. In terms of what else they would have liked included, these ran to; information on the RTW plan, a little on the legislation, and something explaining minor and standard claims. In addition they believed that the NUMs and ANUMs needed to read the draft RehabMoC before they came to the training.

The Development of Guidelines for Medical Practitioners case study was straightforward and occurred without incident. RTW Co-ordinators said that they received greater cooperation from medical practitioners as they had more contact and developed relationships. They also said that this has taken some considerable work on their behalf and while acknowledging that some medical practitioners were knowledgeable about workplace injury, said many still are not. These medical practitioners often required educating and extra support. There were significant issues with medical practitioners so Co-ordinators welcomed this initiative.

One of the additional benefits of this Pilot has been the opportunity for RTW Co-ordinators to get together, to share ideas and discuss practices that work well for them. As one Co-ordinator said, this whole Pilot has caused me to sit down and think about my approach. Discussions between the RTW Co-ordinators were usually energetic and demonstrate generosity both in terms of their curiosity in terms of what is working elsewhere and also their preparedness to share resources.

Section 5.6 - Focus Groups with NUMs and ANUMs

The NUMs and ANUMs that were most familiar with the Pilot were, not surprisingly, those who had been actively involved with it. Those hospitals where they were involved in one of the case studies or in developing other supports for injured workers were aware of the Pilot and had read the draft RehabMoC. They also tended to be the most vocal in the focus groups. One hospital in particular sported the most attendees at the focus group and also the most knowledge of the Pilot (see Attachment 4 for list of focus group questions).

Those unfamiliar with the Pilot Program discussed instead their experiences with RTW.

Some NUMs were concerned that nurses were reluctant generally to report injury. They said that nurses would say ‘it’s just a twinge’. One nurse in particular said that she ‘didn’t want to be a burden’. It took an intervention by the Director of Nursing (DON) before this injury was reported. The NUMs and ANUMs were aware of the tendency of injured nurses to take sick leave rather than make a WorkCover claim. One of the reasons for taking sick leave apart from its simplicity is that leave still accrues when sick leave is taken as distinct from a claim under WorkCover. The focus group participants believed that it was important to communicate to nurses that early intervention offers a
greater chance of quick recovery and as such, is likely to have less, if any, impact on long term wages.

There was some concern expressed that when nurses wanted to return to work quickly, doctors’ would provide certificates that the nurse was fit to return to work with anti-inflammatory. Concerns were raised about some doctors’ lack of understanding of the impact of the injury and the consequences for the injured nurse, the team and the patient.

The perceived stigma attached to injury and RTW was seen to be a result of very few workers who participants felt, were in some way rorting the system with no intention of returning to work. Participants acknowledged that this was very rare but they believed that this stigma created by a few who were not genuine has affected the general attitude to injury and return to work. By far the bigger problem was nurses desperate to RTW early.

While NUMs and ANUMs were confident that nurses were familiar with their occupational health and safety (OH&S) obligations and rights, they were equally as confident that nurses remain reluctant to say no to consultants and allied health professionals. They did however acknowledge that ‘No Lift’ has been a very powerful policy and is understood by most people (except patients’ families), when it is brought to their attention.

Participants discussed the culture of the past when ‘ringing in sick was frowned upon’ and said that the stigma of being injured harks back to the ‘martyr’ culture when you were expected to come into work irrespective of how ill you were. They believed that the approach had changed so that now there was an expectation that nurses would stay home when they were ill. Interestingly, some participants believed that nurses under thirty years of age had fewer issues in terms of putting themselves at risk. This was attributed to the change in generations coupled with university based training.

The participants from the rural hospital said that it was more difficult in rural areas for injured nurses because ‘even if you go to the milkbar someone will see you’ and as such there is greater knowledge of what everyone does.

RTW Co-ordinators were the key resource for NUMs and ANUMs and were thought to be pivotal both in terms of advice and support for them in their support of the injured worker.

Where the hospital was most involved in the Pilot, the NUMs and ANUMs were aware of the need for cultural change. This is what they believed was happening. They acknowledged that there was some resistance to change and that sometimes it was a challenge ensuring that the list of ‘acceptable duties’ was adhered to but on the whole thought that the organisation was definitely moving. They saw small wins in terms of changes to attitudes when for example, an early intervention meant recovery from a back injury. Other nurses took hope from that example.
Each of the focus group participants was aware of the financial cost of work-related injury and were all focussed quite deliberately on early intervention to ensure that the claim is minor. One particular hospital has had sixty eight cases in the last eighteen months for a total cost of $7,000.00.

One of the struggles collectively for NUMs and ANUMs has been the amount of information relating to the injured nurse that can be shared. Some nurses do not want their co-workers told that they have an injury, others are happy for the information to be shared. Better outcomes were achieved when the whole team was aware of the duties the nurse could perform because the whole team could then support them.

When exploring the NUMs and ANUMs knowledge of RTW, they said that while they were aware of general information relating to injury and RTW, having an injured nurse on the ward sharpened your need for knowledge. Education was sought at the point that it was needed. Most relied on the RTW Co-ordinator for this knowledge.

Suggestions for dealing with some issues included: offering special leave with pay for very minor incidents; email the RTW policy to all workers; education to the team of the injured worker; information on the possibilities for better types of work for injured nurses; managers reporting injuries, and visible pamphlets/posters outlining injury and RTW.

**Section 5.7 - Focus Groups with Injured/Ill Workers**

*The injury changes everything*

The feedback from the nurses who attended the pre and post pilot focus groups was mixed in terms of both knowledge and experience although there were some consistent themes that emerged throughout the discussions (see Attachment 5 for focus group questions).

Most participants could not remember whether they had been involved in the Pilot Program. Some said that they had attended a focus group about eighteen months ago and they thought that it was related to RTW but were unsure whether it was part of the Pilot. Upon further prompting and explanation about what might have been discussed in these focus groups, they became clearer about their attendance. What drove them to attend the sessions was their desire to tell their story, contribute to the dialogue relating to RTW and have input into policy that will improve RTW for nurses.

Nurses from one hospital reported a positive change in the behaviour and attitudes in their hospital over the period of the Pilot Program. Significantly this group were from one of the hospitals that was very active in the Pilot. They had also observed a marked improvement in structure for reporting, information, and support since the recent appointment of a new RTW Co-ordinator. They felt more reassured with more open communication and
claimed an increased awareness of the RTW process. These nurses said that the provision of a list of duties for the ANUM and NUM was very helpful; having it attached to the information board in the ward enabled colleagues, ANUMs and NUMs to know the duties and this was seen as a very helpful activity. Nurses noted the much quicker intervention occurring now, with a clear RTW plan. They were appreciative of the clearer structure, which in turn meant they felt more cared for.

Some of the nurses believed that they could have returned to work earlier than they were permitted to return. As conversation continued it became clear that nurses who would have returned to work night shift could not do so because they would not have the same level of supervision that they would have had during ‘business hours’. Some nurses said that this has meant re-jigging domestic arrangements and partners’ working hours and as a result has caused disruption to households.

Most nurses were reluctant to make an initial WorkCover claim. Indeed there was reluctance to report at all. This reluctance was alleviated if the NUM or ANUM insisted on the incident being reported. Generally, nurses felt the stigma of being injured. Most believed it could not happen to them. Some had seen information about RTW or heard of other injured nurses returning to work but did not pay attention because they were convinced ‘it couldn’t happen’ to them. Many said that they did not want to be away from work and away from their colleagues and patients. Most of the focus group participants struggled with having time off work and were eager to RTW, some getting frustrated with both doctors and RTW Co-ordinators when either believed that nurses were attempting to RTW too early. Some did concede, however, that had they returned when they wanted to, they would have exacerbated the injury.

Some nurses believed that one of the toughest aspects of being injured was the attitudes from their colleagues. They were concerned that their colleagues would have to do more work and that they would be sceptical about the injury. This is supported in the survey data obtained. During the focus groups nurses talked about how much easier it would be if they had an injury that could be seen like a broken leg, all plastered up. Their injuries were unseen and as such they were frightened that their colleagues would see them as ‘malingering’. Some even ‘gave themselves a talking to’ telling themselves to ‘get better and be pain free -- stop being a wimp’, when in fact they were seriously injured. Nurses did not want to ‘be a burden’ on their colleagues or cause their managers undue work. The stigma associated with injury remains significant and continues to cause stress for a number of nurses.

Irrespective of the support received at work, the ease of returning to work and the extent of the injury, nurses articulated the disruption to domestic arrangements and domestic relationships. Activities such as collecting children from school, playing with children or doing the grocery shopping initially meant injured nurses needed help from someone or at a minimum meant reorganising arrangements often to the financial and emotional cost of the nurses. Asking nurses to get the children or the partner to help is easier
for some than others. It is not just the activity of helping but the fact that some of these tasks were enjoyed by the nurse and she saw them as part of her role.

Nurses also spoke of the consequence of the injury on their libido or the physical impossibility of sexual activity which was lamented by some, celebrated by another; nonetheless sex was yet another casualty of the injury which in turn affected domestic relationships.

In terms of other activities, some nurses felt guilty shopping during working hours as if they should be working. ‘What if someone from work sees me?’ despite the fact they were legitimately at home injured, others were worried about being seen at rehabilitation programs feeling as though they should be working. For some the effort to get to rehabilitation was onerous. Because driving was not an option due to the nature of the injury, public transport was the mode of travel. Jostling with other commuters and sitting or standing with rickety trams and trains caused pain for some nurses. Simple social occasions required considerable planning and were often avoided. This affected friendships. Going out to dinner was difficult as was going to the movies due to the requirement to sit for a prolonged period of time. As a thank you for participating in the focus groups movie tickets were offered to the nurses. One nurse became upset when these were offered saying that it was not be possible for her to go to the movies. When prompted about what might have been better for her, she struggled and her anger abated and turned to sadness as she said that she could not think of something that she could enjoy doing at the moment. These examples are offered by way of explaining the challenges faced by injured nurses rather than by way of complaint. They also illustrate how even the best of intentions, can offend.

Without exception, nurses spoke with some poignancy of the fear of the unknown after being injured. The tentacles of this fear were far reaching. Nurses were frightened of the injury itself; certainly the pain was significant, as was the ambiguity surrounding the injury. Doctors’ opinions were scary, particularly when they entailed the possibility of an operation. Then there was the scariness of the waiting, of the ambiguity in not knowing whether they would get better and when they would be pain free.

While medical practitioners were usually consistent in terms of diagnosis, the treatment tended to be different from doctor to doctor. The differences in opinion from medical practitioners were very significant in terms of decisions that nurses needed to make, such as whether they should have an operation or not. During one focus group the nurses were sharing information on treatment because they had felt unsure about what to do and who to trust when relying on information from medical practitioners. Most nurses had also sought remedies from alternative practitioners, with some success. The nurses were also fearful of being injured long term given the implications for their health and well-being and also the subsequent drop in pay.

Injury has an effect on the identity of the nurses; both their identity at work and their identity in their community including their home. Many spoke of their
loss of self-confidence and their apprehension of the future. Others articulated their depression and feelings of isolation. Specifically many of the women expressed that they felt a sense of disappointment in themselves when they were unable to continue activities that they considered central to their identity as a mother or partner. These women expressed a sense of guilt that they were unable to play with their children, complete household tasks or be intimate with their partner. While the effect on those aspects of identity relating to their roles as mother and partners were definitely the most upsetting for them, other aspects of their lives as women separate to their children and partners were very difficult for them to pursue. So much of their time and energy was required to do ‘ordinary things’ and also was required for rehabilitation that going out with friends (when pain was not too great) tended to be foregone due to exhaustion. Almost all injured nurses spoke with concern about feeling depressed and the damage to their self-esteem.

During the focus group at one hospital, concern was expressed that injured workers were not aware of their rights. Some were unsure whether they were entitled to help at home with tasks such as cleaning and babysitting. While some nurses were aware that they could get assistance with cleaning through WorkCover, a WorkCover registered cleaner was mandatory and they are not always available. One nurse paid for her own support rather than ask for it through work.

Some used their sick leave rather than make claims through WorkCover. Nurses at this hospital spoke of the delay in getting payment through insurance. While pay was made up by the insurance company, the delay in receiving the money meant that nurses were out of pocket for some time hence putting a strain on the family finances. They tended also to be more careful in purchasing household items, noting the ergonomics of furniture and whitegoods. One nurse said that she had to buy a new car because her injury meant she could not get in and out of the old car with ease and be confident that she would not exacerbate the injury.

A significant systems issue was evident in terms of the discussions that ensued relating to reluctance to make a claim is the fact that pay will be effected. Most had families and were financially committed in one way or another. Coupled with the extra cost in relation to the out of pocket expenses for the purchase of household goods, the injury adds an additional anxiety about losing pay. While there was misinformation relating to time periods, the nurses were aware that making a claim that required time away from work could mean a reduction in wages. Furthermore they claimed that taking sick leave still counted as service so other leave and entitlements could be accrued whereas time away from the workplace as a result of a making a WorkCover did not permit the accrual of other leave and entitlements.

The nurses at one hospital reported the benefits in attending pilates and massage classes offered by the hospital. They said that not only did these assist in alleviating pain and adding to their strength, they demonstrated that the hospital was interested in them. These nurses and others also said that they thought a rehabilitation consultant coming with nurses to support them
when they are returning to work would be very helpful. They believed this service would be very helpful in assisting them to do simple things more ergonomically. The nurses said that at one hospital this was happening and it was very helpful.

Some nurses could not resume duties in the ward they were working prior to the injury. Nurses that attended these focus groups were now working in different areas though still undertaking nursing duties such as education. All reported favourably on their current duties and also on the process of getting there. These nurses attributed the success to both the RTW Co-ordinators and the NUMs in the area they were now working. These nurses thought that having another nurse working alongside them acting as a ‘buddy’ would have assisted them in their RTW. Most of the nurses raised the idea of a ‘buddy’ system; some had heard of this idea through partners or friends in other industries.

The most significant indicator of the nurses feelings of well-being, worth and belonging and as a result, successful RTW, was inextricably linked to the level of support offered to them by their NUM and ANUM. The expression ‘I felt cared for’ was used repeatedly by injured nurses who felt that they had a good experience of RTW. The more knowledgeable of RTW process and practices the NUM and/or ANUM was, the more likely the nurse would be accepted on the ward amongst colleagues, supported during the RTW process and have meaningful work to do. The successful intervention in this process by the RTW Co-ordinator inspires confidence and support for both parties.

Nurses that attended the focus groups made suggestions as to what would have been helpful for their RTW. Some of these activities are taking place but not across hospitals in a consistent manner. These included:

- a support group for injured/ill nurses which would provide an opportunity just to talk with others or ‘just have a weep’;
- structured inclusive activities for nurses on leave, sessions with a psychologist; massage (happening in one hospital);
- consultant ergonomists available to assist with modification of duties when returning to work (happening in some hospitals); ‘buddying up’ with other nurses during the RTW process;
- sessions for all staff to enable them to understand the experiences of injured/ill nurses. They thought that peer education sessions for co-workers would be the most effective learning process.

In terms of advice they would offer co-workers, the response was ‘report!’; be conscientious with exercises, ask for support, learn about your rights, and most of all, stay positive.

It is clear from the focus groups with injured nurses that there is a need for a holistic approach to the management of workplace injury with an emphasis on rehabilitation, as outlined in the draft RehabMoC.
Section 5.8 - Data Obtained From the Hospitals

All bar one of the five hospitals involved in the Pilot supplied a copy of their current ‘Occupational Rehabilitation and Risk Management Program’. Each of the documents is similar in laying out the rights and responsibilities of the employer, the manager and the injured/iill worker. The primary focus of each of the documents was the process to be followed if a worker is injured/iill. This includes timelines relating to procedural and legislative requirements, including an explanation of payments to injured/iill workers.

The differences between the hospitals was not marked although one hospital was explicit in stating that Board members, and senior management have specific responsibilities including awareness raising and the adoption of fair policy and appropriate budgeting.

One hospital provided specific information relating to job assistance in relation to RTW. This specified that the original position would be kept for twelve months; external assistance would be provided for employees seeking work elsewhere; re-training and job seeking assistance would be provided; that as far as is practical assistance will be offered when returning to work after a non-work related injury, and that selection for permanent positions by injured employees would be based on merit. One of the hospitals has developed a handbook that is in plain language which the evaluators consider to be easy to understand and ‘user friendly’.

This aspect of the evaluation seemed to be the greatest struggle for the hospitals. Reasons for this ranged from inadequacy in the hospital systems which prevented access to the data, the difficulty and time investment required of disaggregating the data and distinguishing nurses from other workers, some statistical data sets requested are not kept by hospitals, changes in staff and management which meant data was not available, and reluctance to provide the information(see Attachment 6 for table of data requested from hospitals).

Data has been difficult to compare given the different information that has been received. No hospital could provide the ‘Estimated cost impact on premium for an average claim for a musculoskeletal injury and for a psychological injury.’ The evaluators have sought this information from WorkSafe who sought permission from the hospitals to release the data.

Section 5.9 - Case Study Evaluation: Training and Education for Nurse Unit Managers (NUMs) and Injured Nurses

After the training was conducted in each of the hospitals participants were asked to complete evaluation surveys. A total of thirty three participants responded across three hospitals. The feedback from all hospitals was positive. Participants offered feedback on how they would apply the training and the responses consistently said that they would report early, ensure communication channels were open, listen more intently and provide
information to, staff. Participants that commented reported greater knowledge as a result of the training. They said that the training was clear and informative. While all participants scored the sessions as useful or very useful, certainly some of the participants would like more training.
SECTION 6 - SUMMARY OF EVALUATION FINDINGS

The objectives of the Nurses Return to Work in Hospitals Project and of the Pilot Program were to:

1. improve rehabilitation and RTW outcomes;

Some of the RTW Co-ordinators said that the Pilot had directly affected better rehabilitation and RTW outcomes. Two hospitals said that the used the draft RehabMoC to effect change and certainly the NUMs and ANUMs in one of those hospitals supported this claim. In both hospitals the injured nurses said that there had been some change which dated to the period of the Pilot however it would be difficult to attribute this to the Pilot or draft RehabMoC alone.

2. reduce the human and financial costs

One hospital claims to have reduced both the human and financial costs over the life of the project. There is no data available from the other hospitals at this stage. There is however evidence that, at this stage the Pilot has been the catalyst for the adoption of more specific processes and procedures.

3. reduce the loss of skilled nurses

Certainly, with regard to reducing the loss of skilled workers and promoting the recruitment and retention of injured nurses, all respondents were eager to ensure that nurses remained not just working in the hospital system, but nursing. This was a primary objective of all of those interviewed as part of the evaluation process. It is too early to tell whether this has been delivered as a result of the Pilot. Some of the resources that have been developed as a result of the Pilot offer concrete opportunities to reduce the loss of skilled workers.

4. promote recruitment and retention of injured and ill nurses, and

While the resources that have been developed as a result of the Pilot are aimed at promoting the recruitment and retention of injured or ill nurses and certainly the RTW Co-ordinators and NUMs and ANUMs say they are focussed on ensuring this takes place, there is no substantial evidence that this has changed as a result of the Pilot.

5. affect cultural change in respect to RTW practice.

Certainly some hospitals believe that cultural change has been affected by the Pilot. Some RTW officers and NUMs and ANUMs have said that there has been change as a result of the Pilot. Some of the nurses said that had
observed some change in attitude but could not attribute this to any particular series of events. The fact that the Pilot was being conducted in the hospital and as a result there was greater activity, raised awareness of RTW and enabled RTW to be on the agenda. All agreed that this depended largely on the capacity and the desire of the CEO to drive the issue.

The feedback from the RTW Co-ordinators is that the Pilot is going some way to meeting the objectives listed above. As a result of some of the work developed as a result of the Pilot, some hospitals are claiming improved rehabilitation and RTW outcomes. This is in part as a result of the documentation as a result of the outcomes of the Pilot and partly other factors such as a result of the higher profile of RTW in some hospitals as a result of the Pilot, a change in staff and in part the sharing of ideas and resources.

**SECTION 7 - CONCLUSION**

There is little doubt that the specific resources that have been produced as a result of Pilot, either as part of the case studies or that have materialised as a result of perceived gaps have been roundly applauded. Feedback from the RTW officers was that each of them used elements from the draft RehabMoC and applied it to their practice.

Overall according to the qualitative data gathered, the Pilot was successful. All hospitals gained something from participating and applied various aspects of the draft RehabMoC to their practice. It also operated as a reflective device where hospitals could cross-check their practice against the draft RehabMoC. The draft RehabMoC in its entirety was undoubtedly more successful in hospitals that were developing practices and procedures for RTW or those that were significantly re-writing these processes.

The survey data indicated that both knowledge and outcomes of the Pilot were limited in terms of the broader nurse population at this stage which firstly indicates that general information and education regarding the Pilot would have been useful at the start of the Pilot and secondly it is likely to be too early for the outcomes to have filtered outwards.

What is troubling is that the surveys indicated that a significant proportion of nurses believe that workplace injury and/or illness and RTW practices lead to increases in the workloads of non-injured nurses. Some respondents believed that nurses attempting RTW in their hospital directly increased their own workload, while others articulated that they believed that the nurses attempting RTW ‘should be supernumery’. These findings may indicate that the respondents were not aware that nurses returning to work after injury are in fact supernumery, or perhaps alternatively, that injured nurses returning to work are not being declared supernumery in all cases. This may be resulting in more pressure being felt by non-injured nurses or indeed a perception that they will be doing more work when in fact this is not the case.
It appears that there is still a way to go for both nurses and their managers to be aware of their rights and responsibilities. There is a dilemma in relation to information given that both groups said that they did not pay much attention to the information until it was needed. This is problematic in the case of both groups. For injured nurses, when they are injured, they will be in pain and vulnerable and taking in new information is difficult during this time. For managers, ignorance may prevent them from noticing when a worker may be showing initial signs of injury or their attitude may prevent a nurse from the reporting an injury. This does however present challenges in terms of the timing of training and education. It also reinforces the need for a systemic framework for rehabilitation and return to work such as that provided by the draft RehabMoC.

Many nurses thought the financial cost of making a WorkCover claim was too great. The reluctance to report might be a significant barrier to the long term success of the draft RehabMoC. Fear of losing money was a determining factor in whether they reported the injury, made the claim and whether they admitted to the level of pain they were feeling. Even if the draft RehabMoC was fully implemented and understood, it would still not resolve this issue.

The data provides ample evidence demonstrating the far reaching effects of injury on the worker in terms of family, community and the workplace, and for the workplace in terms of the team and the organisation.

The effects of the injury on the psyche of the nurse cannot be overestimated. Significant changes to self-confidence and self-esteem result in a work related injury and this has a deleterious effect on the whole of life well-being of the injured nurse. As a direct result of the workplace injury and/or illness, nurses are often feel guilt in being unable to fulfil their roles as mothers/partners/friends.

The case studies of Training and Education NUMs and Injured Nurses, IVR and the Development of Guidelines for Medical Practitioners were all described as successful by the RTW Co-ordinators and some have been applied in the workplace.

The power of the project, funded by WorkSafe Victoria, cannot be overestimated. Comment was regularly made of the significance of the joint branding with both the Union and the regulator working together to support the Pilot.

This evaluation is limited in that it is too early to assess long term transfer of the Pilot to the workplace or long term cultural change.
SECTION 8 - RECOMMENDATIONS

These recommendations have emerged from the research undertaken during the evaluation. Each of the recommendations results from the analysis of the interviews, focus groups, survey data and supporting documents. In making these recommendations the evaluators have paid particular attention to the input received by the participants, as many have had personal experience with workplace injury and/illness, and as a result have the greatest understanding of how the experience of injured/ill nurses could be improved. The recommendations that have been framed from this input are as follows.

URCOT requests that as result of these findings the ANF recommends to WorkSafe8:

8.1 Hospitals establish, through the RTW Co-ordinators, facilitated peer support for injured workers. There is benefit in these meetings having an agenda and an orientation, which encourages injured workers to look to the future.

8.2 Hospitals develop a Key Performance Indicator (KPI) relating to RTW and rehabilitation outcomes, which is reported to the Board. One hospital is currently doing this and may be able to offer a template.

8.3 Hospitals ensure that information pertaining to their rights and responsibilities in relation to injury and RTW is formally included in all induction programs for nurses.

8.4 Hospitals consult with injured nurses who have made a successful return to work to identify which types of information were most useful. This will ensure that RTW and effective rehabilitation have the greatest chance of success.

8.5 Blogs are designed for NUMs and ANUMs to utilise as a means of creating a network of ideas in relationship to RTW that offer strategies that are working currently. These could include both the interpersonal and team aspects of RTW and would complement the work that has been undertaken relating to alternative nursing duties.

8.6 Further research be conducted into the impact of financial loss on the decision to report and/or make a WorkCover claim as this appears to be a barrier to early remedy of injury.

8.7 WorkSafe Victoria to recognise the need for a holistic approach to the management of workplace injury with the focus on the rehabilitation of an injured worker, with RTW seen as one component of their rehabilitation.

8 These recommendations will be expanded upon in the final project report.
8.8 WorkSafe Victoria, using the outcomes of this Pilot Program establishes the RehabMoC, with modifications, as Best Practice and adopts it as its preferred model.

8.9 WorkSafe Victoria support the implementation of the key features of the Pilot across all hospitals.

8.10 WorkSafe Victoria publishes the resources from the case studies for access by other hospitals and industries and that this is coupled with investment in implementation.

8.11 WorkSafe Victoria seek to ensure that hospitals maintain consistent data sets given the difficulty of both obtaining and comparing data sets.

8.12 WorkSafe Victoria publish and rewards Best Practice RTW for the hospital that demonstrates early intervention and recovery using the above data sets and feedback from injured nurses.

8.13 WorkSafe Victoria invest in a training and learning initiative designed to ensure learning about injury and RTW is integrated. This would need to include:

- education for Boards and CEOs relating to the financial costs including the effect on premiums as well as education exploring the effect of injury and RTW on nurses and their colleagues
- education for NUMs and ANUMs which extends and builds on the work undertaken in this project.
- train-the-trainer facilitation skills so peer education sessions can occur when a worker is injured and on RTW

8.14 WorkSafe Victoria use the case study Guidelines for Medical Practitioners and invest in a campaign with the intent of educating and supporting medical practitioners.

8.15 WorkSafe Victoria establish a project to explore the complexities of the effect of injury and RTW on workers, their families, communities and workplaces.

8.16 WorkSafe Victoria conduct an evaluation in twelve months time in order to assess the practical benefits and transfer of the key features of the Pilot into the workplace.

8.17 WorkSafe Victoria recognise the need for, and sponsor, early intervention and ongoing rehabilitation which may take various forms including yoga massage and palate to ensure psychological and physical health as a priority.
Attachment 1 (copy of pre and post pilot survey)

INTRODUCTION
NURSES RETURN TO WORK IN HOSPITALS PROJECT DRAFT
REHABILITATION MODEL OF CARE PRE PILOT SURVEY

PLEASE NOTE: This survey will take less than 8 minutes of your time. (Yes, we have tried it!)

This web based survey is designed to ascertain your views on nurses’ injury and illness and return to work (RTW) following a work related injury and/or illness.

All survey responses are anonymous and will be treated as CONFIDENTIAL. They will be analysed by Robyn Dale from URCOT, an independent research centre. Robyn can be contacted on (03) 9663 4555 or at robyn@urcot.org.au to answer any questions you may have.

No persons other than URCOT staff will have access to the individual survey responses.

The results of this survey, will be in thematic form only and will only be used to ascertain attitudes to illness, injury and RTW as pre pilot information.

The survey will be repeated post pilot to ascertain whether any change has occurred as a result of the pilot.

To return the completed survey all you need to do is click on 'done' and it will immediately return to us.

Please complete the survey by close of business Monday 22nd December, 2008.

Some Background

The ANF applied for funding for this project from the Victorian WorkCover Authority. They were successful and as a result have developed a model of care for rehabilitation and RTW for injured and ill nurses. The project is in the pilot phase and will soon be evaluated. The results from these surveys will provide baseline data for the evaluation.

Contact Information

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SURVEY QUESTIONS - PLEASE COMPLETE THE FOLLOWING

1. What is your current position?
   - 1. What is your current position?  Div 1
   - Div 2
   - ANUM
   - NUM
   Other (please specify)

2. What is your gender?
   - 2. What is your gender?  Male
   - Female

3. What is your age?
   - 3. What is your age?  Under 18
   - 18 - 20
   - 21 - 25
   - 26 - 30
   - 31 - 40
   - 41 - 50
   - 51 - 60
   - 61+

4. What is your current work status?
   - 4. What is your current work status?  Full time
   - Permanent Part time
   - Casual
   - Casual Agency
   Other (please specify)
5. If you were injured or became ill at work would you report it?
☐ 5. If you were injured or became ill at work would you report it?  Definitely yes
☐ Probably yes
☐ Possibly
☐ Probably Not
☐ No

If yes, who would be the first person you would report to?
☐ If yes, who would be the first person you would report to?  Co-worker
☐ Manager
☐ OH&S Co-ordinator
☐ Union/job representative
☐ RTW Co-ordinator
☐ OH&S representative
☐ Not sure

If probably not or no, why not? (You may select as many answer choices as you like.)
☐ If probably not or no, why not? (You may select as many answer choices as you like.)  Wouldn’t want to make a fuss
☐ Wouldn’t know how to go about reporting
☐ Wouldn’t want workplace to know I was injured
☐ Worried that I might lose my job
☐ Would be worried that people might consider I was wasting their time

Other (please specify)

6. Would you make a WorkCover claim?
☐ 6. Would you make a WorkCover claim?  Definitely yes
☐ Probably yes
☐ Possibly
☐ Probably Not
☐ No

Other (please specify)
If probably not or no, why not? (You may select as many answer choices as you like.)
- Wouldn’t want to make a fuss
- Wouldn’t know how to go about making a claim.
- Wouldn’t want workplace to know I was injured/ill
- Worried that I might lose my job
- Would be worried that people might think I was slacking off
- Stigma
- Fear of impact on future employment options

Other (please specify)

7. Do you understand the roles of the following people in terms of your health in the workplace?

<table>
<thead>
<tr>
<th>Role</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>☐</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>OH&amp;S Co-ordinator</td>
<td>☐</td>
<td>☐ No</td>
</tr>
<tr>
<td>Union/Job representative</td>
<td>☐</td>
<td>☐ No</td>
</tr>
<tr>
<td>RTW Co-ordinator</td>
<td>☐</td>
<td>☐ No</td>
</tr>
<tr>
<td>OH&amp;S representative</td>
<td>☐</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

8. Are you aware of your workplace's policies and procedures in relation to RTW?
- 8. Are you aware of your workplace's policies and procedures in relation to RTW?  Yes, I am very aware
- Yes, I have a basic understanding
- Not really, I know there is one but that's about it
- No, I have never heard of them

Other (please specify)
9. Are you aware of your own rights and responsibilities in relation to RTW?

☐ 9. Are you aware of your own rights and responsibilities in relation to RTW? Yes, I am very aware
☐ Yes, I have a basic understanding
☐ Not really, I know I have rights but that's about it
☐ No, I have never been made aware that I had these rights

Other (please specify)

10. Are you aware of your employer's rights and responsibilities if you are injured/become ill at the workplace?

☐ 10. Are you aware of your employer's rights and responsibilities if you are injured/become ill at the workplace? Yes, I am very aware
☐ Yes, I have a basic understanding
☐ Not really, I know my employer does have responsibilities but that's about it
☐ No, I have never been made aware of my employer's responsibilities

Other (please specify)

11. Do you believe that you would be supported by your manager if you were injured/became ill?

☐ 11. Do you believe that you would be supported by your manager if you were injured/became ill? Definitely yes
☐ Probably yes
☐ Possibly
☐ Probably Not
☐ No

Other (please specify)

If probably not or no, why not? (You may select as many answer choices as you like.)

☐ If probably not or no, why not? (You may select as many answer choices as you like.) They may be resentful of the increase in their workload
☐ They may think I was being weak
☐ They may think I was making up the injury/illness
12. Do you believe that you would be supported by your co-workers if you were injured/became ill?

☐ 12. Do you believe that you would be supported by your co-workers if you were injured/became ill?  Definitely yes
☐  Probably yes
☐  Possibly
☐  Probably Not
☐  No

If probably not or no, why not? (You may select as many answer choices as you like.)

☐ If probably not or no, why not? (You may select as many answer choices as you like.)  They may be resentful of the increase in their workload
☐ They may think I was being weak
☐ They may think I was making up the injury/illness
☐ They may worry about patients not getting adequate care
☐ They don’t seem interested in their co-workers

Other (please specify) __________________________

13. Do you believe overall that your employer/the hospital helps injured or ill workers return to work when the worker is able after their injury/illness?

☐ 13. Do you believe overall that your employer/the hospital helps injured or ill workers return to work when the worker is able after their injury/illness?  Yes
☐  Occasionally
☐  Not very often
☐  Don’t know
☐  No

14. What do you feel/think if a colleague goes on leave because they have become injured/ill at the
14. What do you feel/think if a colleague goes on leave because they have become injured/ill at the workplace? (You may select as many answer choices as you like.) I feel frustrated because I know I will be doing more work.

☐ I wonder if they are legitimate
☐ I wonder when they will be back at work
☐ I wonder if they will be on restricted duties when they return
☐ I feel concerned about them
☐ I would like to know how to support them
☐ I don’t really think about it at all
☐ I am grateful it’s not me.

Other (please specify)

15. Have you ever used your own sick leave, annual leave or another form of leave to deal with a workplace injury or illness?

☐ 15. Have you ever used your own sick leave, annual leave or another form of leave to deal with a workplace injury or illness? Always

☐ Often
☐ Sometimes
☐ Rarely
☐ Never
☐ Not Applicable - I've never been had a workplace injury/illness

If you have, which leave did you use? (You may select as many answer choices as you like.)

☐ If you have, which leave did you use? (You may select as many answer choices as you like.) Sick leave
☐ Annual/holiday leave
☐ Carer's leave
☐ Unpaid leave

Other (please specify)
16. Have you ever paid for your own medical treatment following a workplace injury/illness?
☐ 16. Have you ever paid for your own medical treatment following a workplace injury/illness?  Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never
☐ Not Applicable - I've never had a workplace injury/illness

17. How do you think your colleagues would respond if you went on workers compensation?

a) Co-workers would (You may select as many answer choices as you like.)

☐ 17. How do you think your colleagues would respond if you went on workers compensation?

a) Co-workers would (You may select as many answer choices as you like.)  Be frustrated that they have to take on extra work

☐ Wonder if I was legitimate
☐ Wonder when I would be back at work
☐ Wonder if I will be on restricted duties when I return
☐ Feel concern for me
☐ Would like to know how they could support me
☐ Not really think about it at all
☐ Be pleased it’s not them

Other (please specify)  

b) Manager would (You may select as many answer choices as you like.)

☐ b) Manager would (You may select as many answer choices as you like.)  Be frustrated if they have to take on extra work

☐ Wonder if I was legitimate
☐ Wonder when I would be back at work
☐ Wonder if I will be on restricted duties when I return
18. Is there an impact on you when a co-worker/s are on restricted duties/hours for illness or injury?
- 18. Is there an impact on you when a co-worker/s are on restricted duties/hours for illness or injury?  Definitely yes
- Probably yes
- Possibly
- Probably Not
- No

19. Do you feel extra pressure if a co-worker is on restricted duties/ hours for illness or injury?
- 19. Do you feel extra pressure if a co-worker is on restricted duties/ hours for illness or injury?  Definitely yes
- Probably yes
- Possibly
- Probably Not
- No

20. Does the time a co-worker is on restricted duties/hours impact on your workload?
- 20. Does the time a co-worker is on restricted duties/hours impact on your workload?  Definitely yes
- Probably yes
- Possibly
- Probably Not
- No
If yes, in what way?

21. What do you think could be done to improve the process for injured/ill nurses returning to work?

22. Is there anything else you would like to say?

Thank you for your time.

Robyn Dale and Karen Davies
URCOT
2/210 Lonsdale Street
Melbourne Vic 3000
(03) 9663 4555
INTRODUCTION

NURSES RETURN TO WORK IN HOSPITALS PROJECT DRAFT REHABILITATION MODEL OF CARE POST PILOT SURVEY

This survey will take less than 8 minutes of your time.

This web based survey is designed to ascertain your views on nurses’ injury and illness and return to work (RTW) following a work related injury and/or illness.

All survey responses are anonymous and will be treated as CONFIDENTIAL. They will be analysed by Robyn Dale from URCOT, an independent research centre. Robyn can be contacted on (03) 9663 4555 or at robyn@urcot.org.au to answer any questions you may have.

No persons other than URCOT staff will have access to the individual survey responses.

The results of this survey, will be in thematic form only and will only be used to ascertain attitudes to workplace illness and injury and RTW.

To return the completed survey all you need to do is click on 'done' and it will immediately return to us.

Please complete the survey by close of business Monday 18th of May, 2009

Some Background

The ANF (VB) received funding for the Nurses Return to Work in Hospitals Project from WorkSafe Victoria.

As part of the Project a pilot program in your hospital has been running since July 2008.

The results from this survey and a survey we conducted before the pilot took place will be used to evaluate the pilot program and impact on RTW of injured and ill nurses in your hospital.

Contact Information

Robyn Dale
URCOT
2/210 Lonsdale Street
Melbourne Vic. 3000
Phone: 03 9663 4555
Email: robyn@urcot.org.au
SURVEY QUESTIONS - PLEASE COMPLETE THE FOLLOWING

1. What is your current position?
☐ 1. What is your current position?  Div 1
☐ Div 2
☐ ANUM
☐ NUM
Other (please specify) 

2. What is your gender?
☐ 2. What is your gender?  Male
☐ Female

3. What is your age?
☐ 3. What is your age?  Under 18
☐ 18 - 20
☐ 21 - 25
☐ 26 - 30
☐ 31 - 40
☐ 41 - 50
☐ 51 - 60
☐ 61+

4. What is your current work status?
☐ 4. What is your current work status?  Full time
☐ Permanent Part time
☐ Casual
☐ Casual Agency
Other (please specify) 

5. If you were injured or became ill at work would you report it?
☐ 5. If you were injured or became ill at work would you report it?  Definitely yes
☐ Probably yes
☐ Possibly
Probable Not
No

If yes, who would be the first person you would report to?
- If yes, who would be the first person you would report to?  Co-worker
- Manager
- OH&S Co-ordinator
- Union/job representative
- RTW Co-ordinator
- OH&S representative
- Not sure

If probably not or no, why not? (You may select as many answer choices as you like.)
- If probably not or no, why not? (You may select as many answer choices as you like.)  Wouldn’t want to make a fuss
- Wouldn’t know how to go about reporting
- Wouldn’t want workplace to know I was injured
- Worried that I might lose my job
- Would be worried that people might consider I was wasting their time

Other (please specify)

6. Would you make a WorkCover claim?
- 6. Would you make a WorkCover claim?  Definitely yes
- Probably yes
- Possibly
- Probably Not
- No

Other (please specify)

If probably not or no, why not? (You may select as many answer choices as you like.)
- If probably not or no, why not? (You may select as many answer choices as you like.)  Wouldn’t want to make a fuss
- Wouldn’t know how to go about making a claim.
Wouldn’t want workplace to know I was injured/ill

Worried that I might lose my job

Would be worried that people might think I was slacking off

Stigma

Fear of impact on future employment options

Other (please specify)

7. Do you understand the roles of the following people in terms of your health in the workplace?

<table>
<thead>
<tr>
<th>Role</th>
<th>Yes</th>
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</tr>
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<td>OH&amp;S representative</td>
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<td>☐</td>
</tr>
</tbody>
</table>

8. Are you aware of your workplace’s policies and procedures in relation to RTW?

☐ 8. Are you aware of your workplace’s policies and procedures in relation to RTW?  Yes, I am very aware

☐  Yes, I have a basic understanding

☐  Not really, I know there is one but that’s about it

☐  No, I have never heard of them

Other (please specify)

9. Are you aware of your own rights and responsibilities in relation to RTW?

☐ 9. Are you aware of your own rights and responsibilities in relation to RTW?  Yes, I am very aware

☐  Yes, I have a basic understanding

☐  Not really, I know I have rights but that’s about it

☐  No, I have never been made aware that I had these rights
10. Are you aware of your employer's rights and responsibilities if you are injured and/or become ill at the workplace?

☐ 10. Are you aware of your employer's rights and responsibilities if you are injured and/or become ill at the workplace? Yes, I am very aware
☐ Yes, I have a basic understanding
☐ Not really, I know my employer does have responsibilities but that's about it
☐ No, I have never been made aware of my employer's responsibilities

11. Do you think that your knowledge of RTW has improved over the last six months?

☐ 11. Do you think that your knowledge of RTW has improved over the last six months? Yes, my knowledge has improved greatly
☐ Yes, my knowledge has improved a little
☐ No change at all
☐ Not sure
☐ Other (please specify)

If yes, why do you think your knowledge has improved?

☐ If yes, why do you think your knowledge has improved? I have attended a training session
☐ I have been given some written information
☐ I know someone that has attempted RTW
☐ I have attempted RTW
☐ My colleagues told me
☐ Other (please specify)

12. Do you believe that you would be supported by your manager if you were injured/became ill?

☐ 12. Do you believe that you would be supported by your manager if you were injured/became ill? Definitely yes
☐ Probably yes
If probably not or no, why not? (You may select as many answer choices as you like.)

- They may be resentful of the increase in their workload
- They may think I was being weak
- They may think I was making up the injury/illness
- They may worry about patients not getting adequate care
- They don’t seem interested in their workers

Other (please specify):

13. Do you believe that you would be supported by your co-workers if you were injured/became ill?

- Definitely yes
- Probably yes
- Possibly
- Probably Not
- No

If probably not or no, why not? (You may select as many answer choices as you like.)

- They may be resentful of the increase in their workload
- They may think I was being weak
- They may think I was making up the injury/illness
- They may worry about patients not getting adequate care
- They don’t seem interested in their co-workers

Other (please specify):
14. Do you believe overall that your employer/the hospital helps injured or ill workers return to work when the worker is able after their injury/illness?
☐ Yes
☐ Occasionally
☐ Not very often
☐ Don’t know
☐ No

15. What do you feel/think if a colleague goes on leave because they have become injured/ill at the workplace? (You may select as many answer choices as you like.)
☐ I feel frustrated because I know I will be doing more work.
☐ I wonder if they are legitimate
☐ I wonder when they will be back at work
☐ I wonder if they will be on restricted duties when they return
☐ I feel concerned about them
☐ I would like to know how to support them
☐ I don’t really think about it at all
☐ I am grateful it’s not me.
Other (please specify)

16. Have you ever used your own sick leave, annual leave or another form of leave to deal with a workplace injury or illness?
☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never
☐ Not Applicable - I've never been had a workplace injury/illness
If you have, which leave did you use? (You may select as many answer choices as you like.)

- ☐ If you have, which leave did you use? (You may select as many answer choices as you like.) Sick leave
- ☐ Annual/holiday leave
- ☐ Carer's leave
- ☐ Unpaid leave

Other (please specify)

17. Have you ever paid for your own medical treatment following a workplace injury/illness?

- ☐ 17. Have you ever paid for your own medical treatment following a workplace injury/illness? Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not Applicable - I've never had a workplace injury/illness

18. How do you think your colleagues would respond if you went on workers compensation?

a) Co-workers would (You may select as many answer choices as you like.)

- ☐ 18. How do you think your colleagues would respond if you went on workers compensation?

a) Co-workers would (You may select as many answer choices as you like.) Be frustrated that they have to take on extra work

- ☐ Wonder if I was legitimate
- ☐ Wonder when I would be back at work
- ☐ Wonder if I will be on restricted duties when I return
- ☐ Feel concern for me
- ☐ Would like to know how they could support me
- ☐ Not really think about it at all
- ☐ Be pleased it’s not them

Other (please specify)
b) Manager would (You may select as many answer choices as you like.)

☐ b) Manager would (You may select as many answer choices as you like.) Be frustrated if they have to take on extra work
☐ Wonder if I was legitimate
☐ Wonder when I would be back at work
☐ Wonder if I will be on restricted duties when I return
☐ Feel concern for me
☐ Would like to know how they could support me
☐ Not really think about it at all
☐ Be pleased it’s not them
Other (please specify)

19. Is there an impact on you when a co-worker/s are on restricted duties/hours for illness or injury?
☐ 19. Is there an impact on you when a co-worker/s are on restricted duties/hours for illness or injury? Definitely yes
☐ Probably yes
☐ Possibly
☐ Probably Not
☐ No

20. Do you feel extra pressure if a co-worker is on restricted duties/ hours for illness or injury?
☐ 20. Do you feel extra pressure if a co-worker is on restricted duties/ hours for illness or injury? Definitely yes
☐ Probably yes
☐ Possibly
☐ Probably Not
☐ No

21. Does the time a co-worker is on restricted duties/hours impact on your workload?
☐ 21. Does the time a co-worker is on restricted duties/hours impact on your workload? Definitely yes
☐ Probably yes
☐ Possibly
22. Are you aware that the ANF has been running a RTW Pilot Program in your hospital?
☐  22. Are you aware that the ANF has been running a RTW Pilot Program in your hospital?  Yes
☐  No

If yes, how did you hear about the pilot program?
(Choose as many as apply)
☐ If yes, how did you hear about the pilot program? (Choose as many as apply) Promotional Material
☐ Co-workers
☐ Manager
☐ Job/Union Representative
☐ OH&S Representative
☐ RTW Co-ordinator
☐ OH&S Co-ordinator
☐ Other (please specify)

If no, how would you expect to hear about initiatives such as this?
☐ If no, how would you expect to hear about initiatives such as this?  Promotional Material
☐ Co-workers
☐ Manager
☐ Job/Union Representative
☐ OH&S Representative
☐ RTW Co-ordinator
☐ OH&S Co-ordinator
☐ Other (please specify)
23. Did you participate in any of the aspects of this pilot program?

☐ Yes 23. Did you participate in any of the aspects of this pilot program? Yes
☐ No (go to question 26)  No (go to question 26)
☐ Not sure  Not sure

If yes, how were you involved?

☐ If yes, how were you involved? Focus groups  If yes, how were you involved? Focus groups
☐ Completed a survey  Completed a survey
☐ Attended a session with the ANF  Attended a session with the ANF
☐ Consultation with the RTW co-ordinator  Consultation with the RTW co-ordinator

Other (please specify)

Q.24 What did you learn from your participation in the Pilot Program?

Q.24 What did you learn from your participation in the Pilot Program?

Q.25 After participating in the pilot model, do you believe your attitude to RTW is...

☐ Q.25 After participating in the pilot model, do you believe your attitude to RTW is... More positive  Q.25 After participating in the pilot model, do you believe your attitude to RTW is... More positive
☐ More negative  More negative
☐ About the same  About the same

Other (please specify)

26. What else do you think could be done to improve the process for injured/iill nurses returning to work?

26. What else do you think could be done to improve the process for injured/iill nurses returning to work?
27. Is there anything else you would like to say?

Thank you for your time.

Robyn Dale and Karen Davies
URCOT
2/210 Lonsdale Street
Melbourne Vic 3000
(03) 9663 4555
Attachment 2 (Gap Analysis Template)

Pilot Hospital .................................................................

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

1. In accordance with the Occupational Rehabilitation Program an employer should identify:

<table>
<thead>
<tr>
<th>Description</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Injury/illness likely result in total or partial incapacitation for work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Ongoing medical and like assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Any risk factors that could lead to the injury becoming a long term injury/illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Delay in rehabilitation and return to work from disputation of a claim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) Contact with injured nurse and their medical practitioner within 5 days of notice of injury</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Communication between parties to achieve the amicable resolution of conflict regarding the workers compensation claim and/or rehabilitation and return to work

### 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. Advice to injured/ill nurses their of entitlement to lodge a workers compensation claim?

3. Notification of injury/illness, entitlement to lodge a workers compensation claim, and lodgement timeframe for a claim outlined in the Occupational Rehabilitation Program

#### 4. Effective communication, consultation, coordination and planning

**Encouraging clear, timely and non-threatening communication**

<table>
<thead>
<tr>
<th>Description</th>
<th>2</th>
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<th>0</th>
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</thead>
<tbody>
<tr>
<td>1. Face to Face communication</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Telephone communication</td>
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<td>3. Written communication</td>
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<td>4. Communication clear and non-threatening?</td>
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<tr>
<td>5. Timeframes for communication developed with the injured/ill nurse</td>
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<td>6. Timeframes for communication developed with the injured/ill nurse's medical practitioner</td>
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<tr>
<td>7. Encouragement of injured nurses with time loss injury/illness to have continued contact with the workplace and work colleagues, including:</td>
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<tr>
<td>(a) Workplace social activities (observing any medical restrictions)</td>
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<tr>
<td>(b) Workplace communication</td>
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</table>

**Promoting full and open disclosure of relevant information**

<table>
<thead>
<tr>
<th>Description</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td>1. Open, honest and transparent communication</td>
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<tr>
<td>2. Face to Face communication</td>
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<tr>
<td>4. Injured/ill nurses consulted, involved and participate in all aspects of their treatment and rehabilitation including RTW</td>
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<tr>
<td>5. As required, obtain written consent/authorisation from an injured/ill nurse</td>
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<tr>
<td>6. Provision of consent/authorisation to the medical practitioner</td>
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</table>

#### Role of RTW Coordinator
RTW Coordinator responsibilities include:

(a) Coordinating rehabilitation and return to work  
(b) Developing and coordinating the rehabilitation management plan (currently RTW Plan)  
(c) Treating the injured and/or ill nurse with care as an individual  
(d) Developing and maintaining relationships with the injured and/or ill nurse, their NUM/ANUM, and treating medical practitioners – without breaching privacy  
(e) Facilitating open communication with the injured and/or ill nurses, their NUM/ANUM, and treating medical practitioners, and other relevant parties  
(f) Educating injured and/or ill nurses, their NUM/ANUM, and treating medical practitioners of the rehabilitation process and their roles and responsibilities  
(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 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  
(i) Addressing issues before they impact on the rehabilitation of the injured and/or ill nurse  
(j) Having a comprehensive understanding of the injured nurse’s injury and/or illness, its causes and of the work environment  
(k) Decision making power in the workplace  
(l) Document maintenance  
(m) Meeting legislative obligations for RTW Coordinator duties as outlined in S161 of the Act

Qualifications of RTW Coordinator

1. WorkSafe Victoria - 2 Day RTW Coordinator Training  
2. Other RTW Coordinator Training incorporating:  
   (a) Comprehensive knowledge of Legislation, including detailed understanding of practical application of workers compensation and RTW  
   (b) Conflict Resolution Skills, effective management and negotiation skills  
   (c) Counselling skills  
   (d) Knowledge and understanding of injuries and the impact of injuries

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. If so, is the rehabilitation management plan:  
   (a) Realistic  
   (b) Achievable  
   (c) Tailored to the individual’s circumstances  
3. Rehabilitation management plan (currently RTW Plan),
includes:

| (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 suitability of return to work duties? | 2 1 0 |
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:
   
   (a) Career counseling?  2 1 0
   
   (b) Vocational education and re-training, including practical development?  2 1 0

**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

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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
## Attachment 3

Outlines the difference between an employers Legislative Obligations for RTW and the Draft Rehabilitation Model of Care

### Difference between an employers legislative obligations for return to work and the Draft Rehabilitation Model of Care[^9]

<table>
<thead>
<tr>
<th>Employer Legislative Obligations for return to work</th>
<th>Rehabilitation Model of Care (adds to legislative obligations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Shared commitment of Rehabilitation</td>
<td>Encourages employers to provide supportive workplaces through:</td>
</tr>
<tr>
<td></td>
<td>• A commitment to providing training and information on workers compensation and rehabilitation for managers and supervisors.</td>
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<tr>
<td></td>
<td>• 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.</td>
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<td></td>
<td>• Preventing discrimination (including perception of discrimination) – promote and encourage cultural change of reporting injury and/or illness and workers compensation.</td>
</tr>
<tr>
<td>2. Access to Information and Support</td>
<td>Encourages employers to:</td>
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<tr>
<td></td>
<td>• Develop information packages for injured and/or ill workers and their medical practitioners on workers compensation and rehabilitation.</td>
</tr>
<tr>
<td></td>
<td>• To be transparent in the delivery of information provided to injured and/or ill workers.</td>
</tr>
<tr>
<td></td>
<td>• To provide information in person to ensure understanding and clarification of information provided.</td>
</tr>
<tr>
<td></td>
<td>This information to be provided from the date of injury and/or notification of injury.</td>
</tr>
<tr>
<td>3. Early Intervention</td>
<td>The RehabMoC acknowledges and reinforces the importance of commencing rehabilitation and the RTW process as soon as possible following an injury by:</td>
</tr>
<tr>
<td></td>
<td>• Promoting early notification of injury (within 48 hours of injury);</td>
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<td></td>
<td>• Encouraging parties to take appropriate action following notification of injury i.e. risk minimisation;</td>
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<td></td>
<td>• Promoting early lodgement and reporting of claims for workers compensation;</td>
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<td></td>
<td>• Promoting and/or encouraging the provisional payment of medical and rehabilitation expenses (and endorsing the provisional payment of weekly compensation) up to 12 weeks of weekly compensation payments and a maximum of $5000 in medical and rehabilitation expenses.</td>
</tr>
</tbody>
</table>

[^9]: Refer to Appendix 1.

[^10]: RehabMOC – Draft Rehabilitation Model of care
### Difference between an employers legislative obligations for return to work and the Draft Rehabilitation Model of Care

<table>
<thead>
<tr>
<th>Employer Legislative Obligations for return to work</th>
<th>Rehabilitation Model of Care (adds to legislative obligations)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Effective communication, consultation, consideration and planning</strong></td>
<td><strong>RehabMOC aims to improve communication, coordination and planning by:</strong></td>
</tr>
<tr>
<td>Basic system and legal compliance:</td>
<td>Encouraging clear, timely and non-threatening communication;</td>
</tr>
<tr>
<td>- As outlined in Occupational Rehabilitation Program and Risk Management Program.</td>
<td>Promoting full and open disclosure of relevant information; and</td>
</tr>
<tr>
<td>- S161 outlines role of the RTW Coordinator</td>
<td>Promoting appropriate rehabilitation planning – Rehabilitation Management/Return to Work Plan. Encourage that RTW coordinator role expanded to include:</td>
</tr>
<tr>
<td></td>
<td>- Coordinating rehabilitation and return to work.</td>
</tr>
<tr>
<td></td>
<td>- Developing and coordinating the rehabilitation management plans (RehabMP) and return to work plans (RTWPlan), which are individual plans.</td>
</tr>
<tr>
<td></td>
<td>- Treating the injured and/or ill nurse with care as an individual.</td>
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<tr>
<td></td>
<td>- Developing and maintaining relationships with the injured and/or ill</td>
</tr>
<tr>
<td><strong>5. Timely and appropriate medical management</strong></td>
<td><strong>RehabMOC aims to influence medical practitioners participation in rehabilitation and return to work:</strong></td>
</tr>
<tr>
<td>Treating Medical Practitioner –</td>
<td>- Providing diagnosis, primary medical care and coordination of medical treatment (including referral to and coordination of specialist care as appropriate);</td>
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<tr>
<td>- To provide a workers compensation medical certificate, to outline diagnosis/prognosis, duration of incapacity and/or outline current work capacity, outline medical restrictions. (This is not an employer’s legislative obligation).</td>
<td>- Completing workers compensation medical certificates;</td>
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<td></td>
<td>- Monitoring, reviewing and advising on the injured nurses condition and treatment;</td>
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<td></td>
<td>- Specifying work restrictions and advising on suitability of duties offered by the employer; and</td>
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<tr>
<td></td>
<td>- Participating in the development of the Rehabilitation Management Plan and RTW Plan.</td>
</tr>
<tr>
<td><strong>6. Early, sustainable, safe, meaningful and durable return to work</strong></td>
<td><strong>RehabMOC aims to improve rehabilitation and return to work outcomes by:</strong></td>
</tr>
<tr>
<td>Basic system and legal compliance:</td>
<td>- Advocating continued worker contact/involvement with the workplace following injury;</td>
</tr>
<tr>
<td>- Appoint a RTW Coordinator, S161.</td>
<td>- Acknowledging genuineness of injury and/or illness;</td>
</tr>
<tr>
<td>- Prepare a RTW Plan, S160.</td>
<td>- Developing individualised Rehabilitation Management Plans and Return to Work Plans;</td>
</tr>
<tr>
<td>- Provide employment which is the same or equivalent to the pre-injury role with the pre-injury employer, up to 52 weeks, S155A.</td>
<td>- Promoting workplace-based coordination of return to work;</td>
</tr>
<tr>
<td>- Provide an offer of suitable employment, S155A.</td>
<td>- Encouraging appropriate consideration of retraining and redeployment options;</td>
</tr>
<tr>
<td></td>
<td>- Encouraging the employer to meet legislative obligations with respect to rehabilitation and return to work;</td>
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<tr>
<td></td>
<td>- Explaining to injured and/or ill nurses the process, their rights and</td>
</tr>
<tr>
<td><strong>7. Monitoring for better long term outcomes</strong></td>
<td>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:</td>
</tr>
<tr>
<td>There are no legislative obligations under the Act, WorkSafe Victoria provides guidance and encourages employers to have regular reviews with their Agent.</td>
<td>- Requiring collection of relevant data; and</td>
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<td></td>
<td>- Through the development of review and evaluation mechanisms.</td>
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</tbody>
</table>
| Relationships with the injured and/or ill nurse, their NUM/ANUM, and treating medical practitioners – but should not breach privacy.  
- 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.  
Development of information package for medical Practitioners. | Obligations with respect to rehabilitation and return to work;  
- 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. |
Appendix 1
Return to Work Legislative Obligations

S155A of the Act outlines where an employer is to re-employ worker:

(1) This section applies if-
(a) a worker receives an injury arising out of, or in the course of, employment with an employer; and
(b) the worker makes a claim for weekly payments in respect of the injury and either-
   (i) the claim is accepted; or
   (ii) a Conciliation Officer gives a direction that weekly payments are to be paid in relation to the claim; or
   (iii) a Conciliation Officer makes a recommendation that weekly payments be paid in relation to the claim and the recommendation is accepted by the employer or the Authority or the self-insurer (as the case maybe); or
   (iv) the claim is determined by a court in favour of the worker.

(2) If, within the period specified in subsection (3), the worker no longer has an incapacity for work or has a current work capacity, the employer must provide the worker-
   (a) if the worker no longer has an incapacity for work, with employment in a position which is the same as, or equivalent to, the position which the worker held before the injury; or
   (b) if the worker has a current work capacity, with suitable employment.

(3) The period-
   (a) starts on the day this section first applies in respect of the worker; and
   (b) includes any period or periods after that time during which the worker has an incapacity for work; and
   (c) does not include-
      (i) any period or periods after that time during which the worker does not have an incapacity for work; nor
      (ii) any of the following periods (if applicable)-
         (A) the period between when the Authority rejects a claim after it has been accepted by the employer and when weekly payments are resumed;
         (B) the period between when a direction of a Conciliation Officer that weekly payments are to be made is revoked and when weekly payments are resumed; and
       (d) ends as soon as the total of the period or periods described in paragraph (b) less any period described in paragraph (c)(ii) is equal to-
          (i) 12 months; or
          (ii) if the employer provided the worker with employment of the nature described in subsection (2)(a) or (2)(b) (as the case maybe) before the employer was required to do so by this section, 12 months less the period of that employment (or less the total of the periods of that employment, if there are more than one).

S155B of the Act outlines exemptions from S155A:

(1) An employer need not comply with section 155A if doing so would cause unjustifiable hardship to the employer.
(2) Relevant factors in determining whether compliance with section 155A would cause unjustifiable hardship to an employer include-
   (a) the nature of the benefit likely to accrue, or the detriment likely to be suffered, by any relevant person;
   (b) the effect on the worker of his or her incapacity for work;
   (c) the financial circumstances of the employer and the estimated cost to the employer of compliance;
   (d) the extent of previous efforts by the employer to rehabilitate the worker;
(e) the sustainability of the relevant work in the medium to longer term with regard to the worker’s injury;
(f) the length of service of the worker;
(g) the employer’s documented return to work policy;
(h) the potential for retraining the worker;
(i) the number of workers to which the employer has already extended suitable employment;
(j) the extent to which the injury that caused or materially contributes to the worker’s incapacity is related to the worker’s employment with the employer;
(k) the potential of the worker to obtain suitable employment elsewhere in the labour market if he or she is not provided with suitable employment by the employer.

S156 of the Act sets out Occupational rehabilitation and Risk Management Programs, which is what an employer must do to meet legislative obligations:
(1) An employer who has certified, or in respect of whom there has been assessed, a total amount of more than $1 000 000 of rateable remuneration for all workplaces of that employer for a financial year in accordance with the Accident Compensation (WorkCover Insurance) Act 1993 must within 3 months of the certification or assessment establish and maintain:
(a) an occupational rehabilitation program; and
(b) a risk management program-
in accordance with this Part.
(2) The employer of a worker who has an incapacity for work that was caused by, or that was materially contributed to by, an injury must-
(a) as soon as practicable but not later than 10 days after the relevant day-
(i) prepare a return to work plan in respect of the worker; and
(ii) nominate a return to work co-ordinator; and
(b) within 3 months after the relevant day establish and maintain-
(i) an occupational rehabilitation program; and
(ii) a risk management program- in accordance with this Part.

S159 of the Act outlines a risk management program:
A risk management program must provide for the steps to be taken after an injury has occurred in the workplace to, as far as is practicable, reduce the risk of subsequent injury of that kind.

An occupation rehabilitation program – S158 of the Act outlines:
(1) This must:
(a) Include-
   (i) A statement of the employer’s return to work policy; and
   (ii) The name of a return to work co-ordinator nominated by the employer; and
   (iii) The name of at least one approved provider of occupational rehabilitation services who will be available to provide services where reasonably necessary for the return to work and maintenance at work of an injured worker; and
(b) Provide for any additional matters specified by the Authority;
(c) Be developed by the employer in consultation with the workers of the employer; and
(d) Be in writing.
(2) Must be made available to all workers of the employer.

S160 of the Act outlines the content of a RTW plan:
(1) A return to work plan must –
(a) Include –
   (i) The name of the injured worker; and
   (ii) An estimate of the date that the injured worker should be fit to return to
work; and
(iii) An offer of suitable employment under section 155A; and
(iv) The steps to be taken to facilitate the worker’s return to work; and
(b) Specify any occupational rehabilitation services that are reasonably necessary for the return to work and the maintenance at work of the injured worker; and
(c) Be prepared in accordance with guidelines issued by the Authority for the purposes of this section.
(2) A return to work plan must be revised in accordance with guidelines issued by the authority for the purposes of this section.

An employer must nominate a RTW coordinator. **S161** of the Act provides that a RTW coordinator must:

(a) Assist injured workers, where prudent and practicable, remain at work or RTW as soon as possible after injury;
(b) Liaise with any parties providing occupational rehabilitation of, or medical or hospital services to, an injured worker;
(c) Monitor the progress of an injured worker’s capacity to return to work;
(d) Ensure that, where reasonably necessary, an injured worker is given access to occupational rehabilitation services in accordance with section 99 (3A);
(e) Take steps to as far as practicable prevent recurrence or aggravation of the relevant injury upon the worker’s return to work; and
(f) Assist in meeting the requirements of this Part.

**S162** of the Act outlines the Interview about Employment Opportunities:

(1) The Authority may require a worker who is receiving weekly payments to attend at an interview with a representative of the Authority for the purpose of ascertaining whether the workers’ opportunities for employment can be enhanced.
(2) Can be assisted by person/s for the purpose of assisting the worker to achieve the purpose of the interview.
INFORMATION TO BE SENT OUT REGARDING FOCUS GROUPS

To: NUM’s/ANUM’s

As you may know, the Australian Nurses Federation (ANF) Vic Branch has received funding from the Victorian WorkCover Authority to undertake a three-year Return to Work Project for nurses injured or who are ill through their work in hospitals.

Your hospital is one of the five hospitals that agreed to participate in the Pilot Program.

URCOT, a not for profit research centre has been contracted by the ANF (Vic Branch) to undertake an evaluation of the Nurses Return to Work in Hospitals Project Pilot Program.

You are invited to attend a focus group on XXX which is part of the process to evaluate the Pilot Program.

The focus group will run for an hour and time will be made at the conclusion for anyone in the group who would prefer to speak to the URCOT staff on a one-to-one basis.

We look forward to seeing you at the focus group.

Kind Regards

Robyn Dale / Karen Davies
URCOT
Ph: (03) 9663 4555
ANF FOCUS GROUP QUESTIONS

The aim of the focus group is to discuss/establish:

Whether the Draft Rehabilitation Model of Care (*RehabMoc*) is a workable and effective model and facilitates:

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

**Questions for discussion will include:**

Did you know your Hospital participated in a Pilot Program for the ANF (VB) Nurses Return to Work in Hospitals Project from July 2008 to March 2009?

Did you know that as part of the Pilot Program your Hospital was piloting a Rehabilitation Model of Care for Injured and/or Ill nurses? (for nurses)

(i) Has the Draft RehabMoc been piloted in the form as proposed by the ANF? (ii) Was the model easy to understand and implement?  
(iii) Were there sections of the model that you could not pilot? If so, why not? (iv) What was the best thing about the Draft RehabMoc?  
(v) What was the worst or most difficult (if any) aspect about the implementation of the Draft RehabMoc?  
(vi) Has your and/or your hospitals attitude/behaviour changed toward injured/ill nurses? If so, how? Evidence?

(vii) Were you happy with the support you received during the MOC pilot? (RTW officers)  
(viii) Were expectations by external parties (ANF/WorkSafe/Consultants reasonable? Comments

Have you participated in workshops/focus groups/case studies as part of the larger Pilot Program? If so what did you participate in? ie workshops/focus groups/case studies.
To: Injured/and or ill nurses (or nurses who have been through the RTW process)

URCOT, a not for profit research centre has been contracted by the ANF to undertake an evaluation of the Nurses Return to Work in Hospitals Project Pilot Program including the Draft Rehabilitation Model of Care for Injured and/or ill Nurses in Victoria, and other pilots and case studies which took place in your hospitals as part of the Pilot Program.

We are running a focus group for nurses who have ever experienced the RTW process to ascertain your point of view in relation to the Draft Rehabilitation Model of Care (RehabMoc) which was piloted in your hospital. URCOT has been retained to evaluate the Model.

Confidentiality is guaranteed.

The focus group will run for an hour and time will be made at the conclusion for anyone in the group who would prefer to speak to the URCOT staff on a one-to-one basis.

The focus group will be held on: XXXXX
Your participation is important to us.

Kind Regards

Robyn Dale / Karen Davies
URCOT
Ph: (03) 9663 4555
ANF FOCUS GROUP QUESTIONS – STAFF QUESTIONS

INJURED / ILL WORKERS (IF INVOLVED IN THE PILOT PROGRAM)

The aim of the focus group is to discuss/establish:

Whether the Draft Rehabilitation Model of Care (RehabMoc) is a workable and effective model and facilitates:

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

Questions for discussion will include:

Did you know your Hospital participated in a Pilot Program for the ANF (VB) Nurses Return to Work in Hospitals Project from July 2008 to March 2009?

If so, have you participated in workshops/focus groups/case studies as part of the larger Pilot Program? If so, what did you participate in?

Did you know that as part of the Pilot Program your Hospital was piloting a Rehabilitation Model of Care for Injured and/or Ill nurses? (for nurses)

Have you noticed any change (behaviour/attitude) in the way that the hospital is working with injured/ill nurses?

If yes, what might you attribute that to?

What has your experience been? (What worked well and what didn’t).

Were expectations by external parties (ANF/WorkSafe/Consultants reasonable? Comments.
Dear RTW Co-ordinator,

Re:  Nurses Return to Work in Hospitals Project and Evaluation of the Pilot Project: Draft Rehabilitation Model of Care for Injured and/or ill Nurses in Victoria Evaluation Phase

Thank you for your participation in the project so far. This document provides a refresher on the outcomes of the above project, an outline of the major phases as well as providing the plan for evaluating the pilot, the work for which is about to begin.

I have also attached a list of the information that we are asking the hospitals to provide. As I said at the workshop in Bendigo, I know some of the information may be difficult to get hold of. I promise I will be patient!

BACKGROUND

As you know, the Australian Nurses Federation (ANF) Vic Branch has received funding from the Victorian WorkCover Authority to undertake a three-year Return to Work Project for nurses injured or who are ill through their work in hospitals.

The overall aims of the three-year project in the hospital sector are to:

- Identify barriers to and factors for successful return to work
- Promote early and proactive return to work
- Achieve meaningful, productive, safe and durable return to work
- Identify strategies to support long-term injured nurses
- Promote a holistic approach to rehabilitation and return to work.

The project is currently underway and involves three phases, which include; A) identification of barriers to and factors for successful return to work B) return to work pilot programs with five pilot hospitals C) evaluation of programs in pilot hospitals.

As RTW coordinator at one of the five hospitals that agreed to participate in the Pilot Program (part of phase B) it was anticipated that your hospital would benefit from participating in the Pilot Program by:

- Reducing the human and financial cost of workplace injury and/or illness.
- Improving rehabilitation and return to work outcomes
- Learning from the Project and influencing change in rehabilitation and return to work.
- Identifying gaps in current practices and processes for return to work.
- Participating in return to work networks with the other pilot hospitals.
Research undertaken during the first phase of 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 Model provides a comprehensive plan for the 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.

We are now up to Phase C) of the Project which is Evaluation of Programs in Pilot Hospitals.

Evaluation of Programs in Pilot Hospitals

URCOT, a not for profit research centre has been engaged by the ANF to undertake the Evaluation of the Projects Pilot Program. The evaluation will be conducted by Robyn Dale, the URCOT Director, and supported by other URCOT staff.

The aims of the evaluation are to establish:

Whether the Draft Rehabilitation Model of Care is a workable and effective model to facilitate;
Communication between all parties
Recovery from work-related injury
Early, safe and sustainable return to work and
Prompt resolution and minimisation of disputes.

In what way has the Pilot been useful?
What have been the learnings from the Pilot Program?
Has attitudinal change occurred? If so, how have attitudes changed?

Methodology

URCOT will undertake a variety of activities for the evaluation of the project, these activities include the following:

Data Gathering and Analysis. URCOT will undertake an analysis of the data provided by the hospitals (see Attachment A for details).

Surveys. Conduct pre and post implementation attitudinal surveys for non-injured workers including NUM’s, ANUM’s, and RTW Coordinators.

Focus Groups. Run two focus groups at each of the pilot hospitals. One with NUM’s/ANUM’s, HR management, RTW Coordinators and the second with injured and/or ill nurses.

Case Studies. Case studies will be developed during the evaluation. These will enable hospitals to understand positive factors and identify barriers to
RTW and they will assist the development of new and helpful strategies for RTW.

**Workshops.** Undertake workshops where the preliminary evaluation findings will be discussed with yourselves and other stakeholders of the pilot hospitals.

**Statistical Comparison.** Model and compare the impact of premiums on both an MSD and a psychological injury where there is a) a successful RTW and b) no RTW

**Final Report.** Produce a final detailed report of the evaluation. The report will be disseminated to the ANF Vic Branch and pilot hospitals. URCOT will ensure that all relevant data is included.

Results will be published in aggregate form only. Data provided by individual pilot hospitals or facilities will not be individually identified or identifiable in published results.

Your role as a pilot hospital

The role of the RTW Coordinator during the evaluation phase of this project includes:

Initial meeting with Robyn Dale from URCOT to:
- Identify relevant personnel and arrange interviews/meetings. (URCOT will arrange them but will seek advice on timing etc);
- Identify personnel to be involved in each of the two focus groups (both focus groups will be held on the same day with the intention of providing some time and space for people who would prefer a one-on-one meeting with Robyn.), and
- Discuss with Robyn options for a venue, dates and times for the focus groups/interviews.

*Please Note:* Scheduling and location will be undertaken to ensure minimum disruption to work operations. For example, focus groups can be scheduled over handover times or other times suitable to the hospital.

Based on the list provided (see Attachment A) arrange for the delivery of the quantitative data to URCOT for analysis by the agreed date [insert date]. This will include both pre and post data.

**Timeframe**

The Evaluation of the Pilot Program will begin in earnest as soon as can be negotiated with each pilot hospital depending on the agreed timelines for the implementation of the Draft Rehabilitation Model of Care for Injured and/or ill Nurses in Victoria.

Work on the evaluation will need to take place both pre and post implementation of the Draft Rehabilitation Model to ensure that the final
evaluation report can be presented to the ANF Vic Branch by early June 2009. (Please see specific timeline attached – Attachment B).

We are very excited to be working with the hospitals and the ANF on this project and looking forward to working with you.

Kind Regards

Robyn Dale
URCOT
Attachment A

Data Requested From The Hospitals

Data that can be sent electronically would be helpful. URCOT is happy to provide confidentiality agreements if requested. Our contract with the ANF however does contain a confidentiality clause.

Some documents may include several items on the list below. Please do not feel you need to sort this information for me.

Policy Documents

It is requested that URCOT is provided a copy of the following policy documents

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

We would appreciate receiving the data below for the financial year periods 2004-05; 2005-06; 2006-07 & 2007-08. Please provide spreadsheets providing the:

- 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.
- Copies of climate surveys undertaken during the above mentioned periods.
- Sick leave statistics
- Current retention rates.

We thank you for providing this data.
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Who</th>
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<tbody>
<tr>
<td>November 2008</td>
<td></td>
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<tr>
<td>November 24th – 28th</td>
<td>Set up interviews with RTW coordinators</td>
<td>RD &amp; KD (URCOT)</td>
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<tr>
<td>November 26th –</td>
<td>Conduct interviews with RTW coordinators (1 hour)</td>
<td>RD (URCOT), JS, JS (ANF)</td>
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<td>December 5th</td>
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<td>December 20th</td>
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<tr>
<td>December 12th</td>
<td>Pre-Pilot survey to be distributed (150 distributed)</td>
<td>RD, KD (URCOT), ANF</td>
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<tr>
<td>December 22nd</td>
<td>Pre-Pilot surveys to be returned and analysed</td>
<td>RD, KD (URCOT)</td>
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<tr>
<td>December – April 2009</td>
<td>Analysis of quantitative data supplied by hospitals</td>
<td>BW, RD (URCOT)</td>
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<td>November – April 2009</td>
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<td>March 2009</td>
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<tr>
<td>March 2nd</td>
<td>Pre-Pilot survey analysis completed</td>
<td>RD &amp; KD</td>
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<tr>
<td>March 16th – 20th</td>
<td>Interviews and focus groups organised</td>
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<td>(see below)</td>
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<td>April 2009</td>
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<tr>
<td>April 20th – May 9th</td>
<td>Focus groups and interviews in hospitals (2 hours)</td>
<td>RD &amp; BW (URCOT)</td>
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<td></td>
<td>(i) NUM’s, ANUM’s, RTW Coordinators</td>
<td>RD &amp; BW (URCOT)</td>
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<td></td>
<td>(ii) injured / ill workers</td>
<td>RD &amp; BW (URCOT)</td>
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<tr>
<td>April 20th</td>
<td>Post-Pilot survey to be distributed (150 distributed)</td>
<td>RD &amp; KD</td>
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<td>May 2009</td>
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<td>May 15th</td>
<td>Draft Evaluation Report Quantitative completed</td>
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<td>May 25th – 27th</td>
<td>Half day workshop for hospitals – validation of evaluations findings</td>
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<td>June 2009</td>
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<td>June 1st</td>
<td>Draft Report to the ANF</td>
<td>RD(URCOT)</td>
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<td>June 10th</td>
<td>Final Evaluation Report</td>
<td>RD (URCOT)</td>
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