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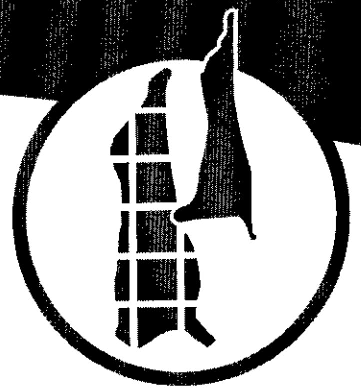

National best practice rehabilitation model RPDA.214

1998

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MEAT & LIVESTOCK
AUSTRALIA

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EXECUTIVE SUMMARY

The Meat Research Corporation has been actively working to support its member organisations to adopt OHS best practice principles. To facilitate this aim a number of projects have been identified to focus on specific issues, one of these being a national best practice model for rehabilitation in the meat industry.

The aim of this project was to design a model outlining the rehabilitation process from the initial incident or injury to return to work which incorporates the communication flow, roles and responsibilities of key stakeholders and the potential resources.

A review of the literature on the general elements of best practice, and best practice in rehabilitation was used to identify the principles underlying the best practice model. A framework for best practice extending beyond the actual rehabilitation process arose from this information. Key characteristics of the rehabilitation process and of the environment in which it occurs were identified.

Current rehabilitation practices in the meat industry were researched, initially through review of the Gill report and other literature. This project team conducted six site visits. A standard interview tool was used during interviews with key stakeholders at each site.

This information was used to develop the stages of the best practice rehabilitation model and to identify specific activities for each stage.

The key features of the rehabilitation model are that it:

- rehabilitation commences early, and the company encourages early reporting to facilitate early diagnosis and recommendations for early, safe return to work
- is workplace based
- is managed by a team comprising the injured employee, the treating doctor and treatment team, the company or district rehabilitation coordinator, the employees supervisor and an employee representative
- is coordinated by the rehabilitation coordinator
- is actively supported by the workers' compensation insurance company and the OHS Authority

- is a documented process
- is reviewed at regular intervals
- is measured against performance indicators
- is supported by consistent human resources strategies
- ensures staff are aware of and understood the process
- is one part of a proactive accident prevention strategy.

The next stage of the project involved consultation with key stakeholders on the model and the implementation plan. The comments were then incorporated into the model and implementation plan.

The final products of this project then include a strategic direction model, the rehabilitation process model, implementation plan and the accompanying report.

INTRODUCTION

The Meat Research Corporation contracted Niki Ellis and Associates to design a national best practice model for rehabilitation in the meat industry. This initiative is in line with the Meat Research Corporation's work to support its members to adopt OHS best practice principles. This project involved consultation with the OHS Network Committee, production sites and union delegates. This enabled the model to be evaluated by end users and thereby facilitate ease of incorporation into the industry.

The Meat Research Corporation covers close to 120 meat facilities, which have an average size of 300 employees with a range of 45 to 1000. The facilities are spread throughout Australia and a proportion of these are in rural areas with limited access to or choice of support facilities. The management teams tend to be small and frequently cover a number of roles. The employee pool includes an element of casual employees along with permanent.

The general practice and knowledge of rehabilitation is variable and the role of this project was to provide meat facilities with clear and practical guidelines that facilitate best practice in rehabilitation.

Specifically the objectives of the project were to:

- research rehabilitation practice within the industry and externally, and identify best practice principles
- design a best practice model of rehabilitation from the initial incident or injury to return to work, incorporating communication flow, the roles and responsibilities of key stakeholders, and the potential resources
- present this model to the stakeholder group and collect feedback on the model and refine the model to reflect this consultation and to facilitate application to the work environment
- design an implementation plan for the model.

METHODOLOGY

The project commenced with a literature review of the previous reports undertaken within the industry including the Gill Report, Barriers to Rehabilitation, and The Final Report of the NSW Workers' Compensation Inquiry. This was followed by research into rehabilitation best practice models within other industries, and State Government authority guidelines on rehabilitation.

Field research included site visits to large, medium and small meat facilities with varying levels of development of rehabilitation programs. Six sites were visited and interviews were conducted with general managers, human resource or personnel employees, the designated OHS employee and an employee who had participated in rehabilitation. OHS employees included workplace health and safety officers, registered and enrolled nurses and human resource employees.

A uniform interview tool was used to guide the researcher at the site visits. This included the following topics:

- opening questions
- management commitment
- consultation
- reporting
- rehabilitation procedures
- OHS/rehabilitation training
- planning and review
- uptake.

The interview tool is included at Appendix 3.

Niki Ellis and Associates then designed a draft model; implementation plan and report based on our research of best practice, with reference to gaps in rehabilitation identified during our field research.

Consultation on the model and the implementation plan then took place with the industry, including the sites visited, the OHS Network Group and union delegates.

ANALYSIS OF THE SITE VISIT RESEARCH IN RELATION TO BEST PRACTICE

Many models of best practice have been identified throughout industry. A description of nine best practice elements was obtained from the Australian Best Practice Demonstration Program. The Meat Research Corporation has also developed best practice elements for occupational health and safety. The two sets of elements contain similarities, as would be expected, and are cross-referenced below. These elements are referred to throughout the body of the report and form the basis of the model. Although we have used the Australian Best Practice Demonstration Project headings we have cross-referenced these to The Meat Research Corporation, elements.

Australian Best Practice Demonstration Program	Meat Research Corporation
Strategy	Management commitment
Structure	Integrated OHS systems Risk Management Approach
Measurement and control systems	Development of positive performance indicators
People Management	Training Communication
Employee empowerment	Employee participation
External relations	
Technology	
Process improvement	
Change leadership	

This section of the report discusses the findings in relation to the elements of best practice, which were evident at the sites visited. A detailed discussion of the findings of the site visits is at Appendix 2. The complete literature review is provided at Appendix 1.

Strategy/management commitment

Some evidence of a strategic approach to rehabilitation was apparent at all sites; for example, there were written policies, evidence of managerial commitment, use of consultative committees and the use of safety audits. One site's approach was clearly more strategic, linking the rehabilitation program outcomes with the achievement of business objectives. After approximately two to three years this site achieved a decrease in their workers' compensation premium and in the number of lost time injuries.

One site demonstrated a systematic approach to injury prevention by way of formalised hazard identification and control process, and a supervisor accident investigation process. A few sites did this in an ad hoc manner.

There was evidence of early intervention at some sites. It is a concern however that three of the six sites are holding back on commencing a formal program until claims are determined, or according to maximum legislative timeframes.

Some difficulties that adopting an early intervention rehabilitation can cause a small business was illustrated at one site. The costs associated with early reporting and increased workers' compensation claims are expected to take approximately two to three years to result in cost benefits by way of decreased workers' compensation premiums. This can be expected to occur earlier if accompanied by preventive OHS strategies.

Two companies provide chiropractor and physiotherapy consultations for employees. This approach has merit if integrated with an early intervention strategy to identify whether an injury exists and if treatment is required. A risk is that workers' compensation claims may be 'hidden'.

The nature of duties made available at most sites illustrated different approaches to identifying suitable duties. Some companies demonstrated a sound approach based on task analysis and identified the specific duties that would be suitable for specific injury types. However, other sites used what appeared to be a generic list of 'light duties' which would limit return to work options.

Table 1 over page identifies how the key features of a strategic approach were demonstrated at each site.

Table 1: Strategy

Site	Business plan	OHS/rehab objectives linked to Business Plan	Number of years program used	Training in OHS/rehab	Rehab in performance review	Documented accident investigation process	Rehab non-compensation as well	Documented system of risk management
1	yes	yes	2–3	Rehab coordinator – yes First aiders – yes WH&SO – yes OHS committee – yes Supervisors – yes Employers – yes	no	Unclear	Some	yes
2	no	no	Approx. 2	OHS committee – yes Rehab coordinator – RN	no	yes, by supervisors	no	yes
3	yes	no	Unknown	OHS/rehab induction for new employees	no	no	no	Ad hoc initiated by OHS rep not formal process
4	yes	no	>2yrs	WH&SO – yes OHS committee – yes Video on OHS for induction and explanation of rehab	no	no	Unknown	yes, every 2 weeks

Site	Business plan	OHS / rehab objectives linked to Business Plan	Number of years program used	Training in OHS / rehab	Rehab in performance review	Documented accident investigation process	Rehab non-compensation as well	Documented system of risk management
5	yes	no	Approx. 12 months	Rehab coordinator – RN – yes New employees OHS induction	no	yes by RN	yes	yes, ad hoc by RN
6	no	no	Unknown	TAFE certificate OHS modules Staff info session	no	no	yes – treatment services	yes – initiation by OHS rep not linked to formal process

Structure/integrated OHS systems

Many of the elements of best practice rehabilitation process model were evident at five of the six sites. The model incorporates the things that are working well and covers the gaps in rehabilitation identified during the field research.

Where team approaches to case management existed they were reported to be working well; difficulties in gaining support for proactive rehabilitation approaches were experienced by those who were not supported by a team.

The difficulties experienced by the smaller companies in regard to provision of alternative duties may indicate the need for a more cross industry cooperative approach to rehabilitation with other sites in their geographical areas. A professionally trained district rehabilitation coordinator may provide the kind of support they need.

Technology

The largest site demonstrated the use of technology in injury prevention. For example, technology has eliminated the manual lifting of carcasses which they report is considered a contributing factor to their decreasing lost time injuries and injury profile.

In general, it appears that explanation of accident causation is primarily focused on human factors – and the lack of accident investigation procedures in most sites has probably allowed this view to prevail.

The pressure of financial survival was a clear concern at many sites, especially the smaller ones. The short-term costs of improvements in technology may not be considered a viable option for some companies:

> *"The bosses don't understand that investment in maintenance will give a better product and be better for workers... rehabilitation won't work if maintenance problems aren't fixed."*

Only two companies had a formal process for documenting and prioritising maintenance requests and their completion.

People management/training/communication

The aspects of people management that were of particular note at the site visits were in relation to early intervention in injury management. Some sites had strategies in place to identify and manage other factors, apart from the injury, that could influence the success of the rehabilitation process. These included initiatives to provide rehabilitation for non-work-related injuries, for overall health and wellbeing, and communication with family members about the rehabilitation process.

With the exception of one site, training in rehabilitation and OHS is only provided to employees through induction. Most sites had a trained rehabilitation coordinator, first aid attendant and OHS representative. Some OHS committees had received training.

Some sites provide induction training to casual staff; however, two sites stated that they continue to use the 'gate recruitment' method for selecting casuals who may or may not have received training.

External relations

The key external stakeholders identified by those interviewed were the treating doctor and the insurance companies, and in some cases family members. All sites stated that relationships with local doctors had a significant effect on return to work outcomes. Some companies had established communication with local doctors and hospitals by inviting them to an orientation morning. Ongoing visits to the plant by local doctors are a constant reinforcement of this open communication forum.

However, one site noted that whilst the above approach has been part of their policy, communication channels have broken down when employees choose to see a doctor outside of the local area who is not familiar with the site.

Most companies, especially the domestic abattoirs, were interested in hearing about case studies examples of best practice in rehabilitation at other abattoirs. This was suggested as the most effective way to convince owners of the benefits of rehabilitation.

Change leadership

Examples of how this is demonstrated were found in the written rehabilitation policies, formal process of conducting and acting on recommendations of safety audits at some sites.

Whilst management commitment is stated, most of the sites did not follow this through with action by measuring or rewarding good performance in OHS and rehabilitation. However, one site supported training in OHS at TAFE and had arranged a presentation of certificates from the course. This was further supported by all staff being directed to attend and paid overtime for this.

Most sites provided management input at the site visits, which also demonstrated commitment to improvement in rehabilitation.

Employee empowerment and participation

The degree to which employees are consulted about health and safety, rehabilitation and changes to work processes was high in some cases, low in most. It appears that when formal consultation about OHS and rehabilitation does occur, this is with the OHS representative and/or the OHS committee. Two sites did not have an OHS committee. Other measures taken to make information available include via noticeboards and newsletters. Informal channels were the most common way of giving and receiving information.

Table 3 provides a summary overview of these best practice features.

Owners and managers stated that employees report OHS/rehabilitation issues to their supervisors, foremen and sometimes directly to them, but this process was not supported by documentation.

Of the staff interviewed, most appeared to know less about policies, available information and the process for raising OHS issues than expected.

Evaluation and continuous improvement

The most significant limitation of the programs reviewed was in relation to performance indicators.

All sites were monitoring their workers' compensation premium. Two sites have been provided with computer programs to monitor their workers' compensation experience.

While most sites were aware of their injury trends and had an opinion on whether their rehabilitation program was effective in returning people to work, there did not appear to be a formal method of gathering data for analysis of incidence occurrences, injury trends, rehabilitation performance and outcomes, to be able to demonstrate the benefits or otherwise of the OHS and rehabilitation program.

The inclusion of roles and responsibilities in OHS and rehabilitation in performance appraisals was not apparent at any of the sites visited.

Performance indicators for rehabilitation service providers had been identified and monitored informally, at one site.

Some companies demonstrated commitment to continuous improvement by regular review of rehabilitation plans and annual review of the rehabilitation policy.

Agreed performance indicators for rehabilitation outcomes are necessary in general to identify and evaluate improvements in the process, over duration. A broader approach could identify some short-term benefits for owners during the period between implementing the rehabilitation program and achieving premium savings.

Documentation of the rehabilitation process and activities is done well by some, poorly by others. One site expressed the opinion that their 'hands on' approach was working well and documentation of procedures would be a waste of time.

Table 2: Best practice features

Site	Time of rehab commencement	Formal process	Workplace based	Team approach	Documented RTW program	Rehab coordinator role clarity	Documented info for employees	Suitable duties	Structured review of rehab program
1	First aid required and unable to perform duties	yes	yes	yes HR manager WH&SO EN, first aid officer	yes	yes	yes	yes	yes
2	Receipt of doctor's certificate Formal program when insurer determines liability	yes	yes	no RN – first aid, rehab coordinator Providers for WC case	yes if off >20 days	yes	yes	yes	no
3	First aid worker not seen until RTW certificate	Yes	Yes	yes WC admin/rehab coordinator Supervisor/OHS manager, H&S rep	yes if off >20 days	yes	no	yes	no
4	Dr prescribes suitable duties	Yes	Yes	yes HR manager WH&SO EN, first aid officer	yes	yes	yes	yes	no
5	Injury report	Yes	Yes	no RN – rehab coordinator First aid, OHS manager, HR manager	yes	no	no	yes – some difficulty	yes by rehab coordinator
6	Injury requiring light duties or time off work	no	no	yes – but more trained WC & rehab manager CEO, OHS rep	yes if injury involves >10days off	no	no	yes – no formal register	no

THE MODEL

Niki Ellis and Associates have designed two models based on our research of best practice and field research analysis of rehabilitation in the meat industry.

The first model described is a strategic model for creating the business/workplace environment to support the best practice rehabilitation model.

The best practice model for the rehabilitation process in the meat industry outlines the recommended process for managing rehabilitation from the initial incident or injury to return to work.

Communication flows, the roles and responsibilities of key stakeholders, and the potential resources that can be used to meet the needs of the different meat facilities, are incorporated in both models.

Organisational strategic directions

The key principles for successful rehabilitation outcomes were presented in the literature review and expressed during interviews at the site visits. The themes, which featured most strongly throughout, were the need for genuine, demonstrated management commitment to occupational health and safety, rehabilitation and continuous improvement of work practices and the work environment.

Consultative people management and the extent to which occupational health and safety systems are integrated into the general running of the business demonstrate management commitment.

OHS and rehabilitation plans and polices will be developed for the organisation through a consultative process between management, staff and involved unions. Once developed, links between goals of these plans and those of the business plan are the initial way management commitment to OHS and rehabilitation can be made visible to the workforce.

People management

Some examples of people management initiatives, which demonstrated commitment to OHS and rehabilitation, include:

- involving employees in the development of the OHS and rehabilitation plans and policies

- providing rehabilitation support alternative duties, and gradual return to work plans for non-work-related injuries as well

- seeking employees' participation in identifying and addressing health and safety and rehabilitation issues

- providing information and training in formal and informal ways about general business information and specific OHS and rehabilitation issues

- providing information and training in formal and informal ways specifically about OHS and rehabilitation responsibilities and injury prevention

- involving employees in decision making about changes to work practices

- providing a clear and consistent message about management commitment to OHS, rehabilitation and workplace changes

- establishing and maintaining good relationships with key stakeholders which are external to the business; in relation to rehabilitation, this includes the local doctors and treatment providers and establishing good systems for communication about rehabilitation

- consulting with all stakeholders relevant to a rehabilitation case

- formalising the consultation processes used by including these in the rehabilitation policy.

Integrated OHS systems

Some examples of how the management of OHS issues are integrated with usual business systems include:

- the OHS impact of new technology is assessed and any hazards addressed

- the need for new technology to eliminate OHS hazards is assessed and provided

- systems for reporting accidents/incidents/hazards are in place

- systems for investigating and addressing accidents/incidents/hazards are in place

- hazard identification and assessment leads to control of hazards

- systems for monitoring accidents/incidents/hazards exist and are reviewed monthly and annually

- responsibilities for employees at all levels in the organisation are specific, clear and appropriate to their level

- employees are accountable for their performance of their OHS and rehabilitation responsibilities

- systems for monitoring OHS and rehabilitation are reviewed and improved on an ongoing basis

- the OHS system is regarded as a way to improve work practices and the work environment.

Structure of the rehabilitation program

The structure of the rehabilitation program should be developed in consultation with all employees and clearly outline how the organisation will assist an injured person, the expectations of the process and how the rehabilitation process will progress. The program must comply with legislative requirements and be documented in the form of a policy. The culture of the organisation should be considered when planning policy content, consultation about the policy development and communication about the policy.

The best practice rehabilitation process model provides more detail.

Review and evaluate

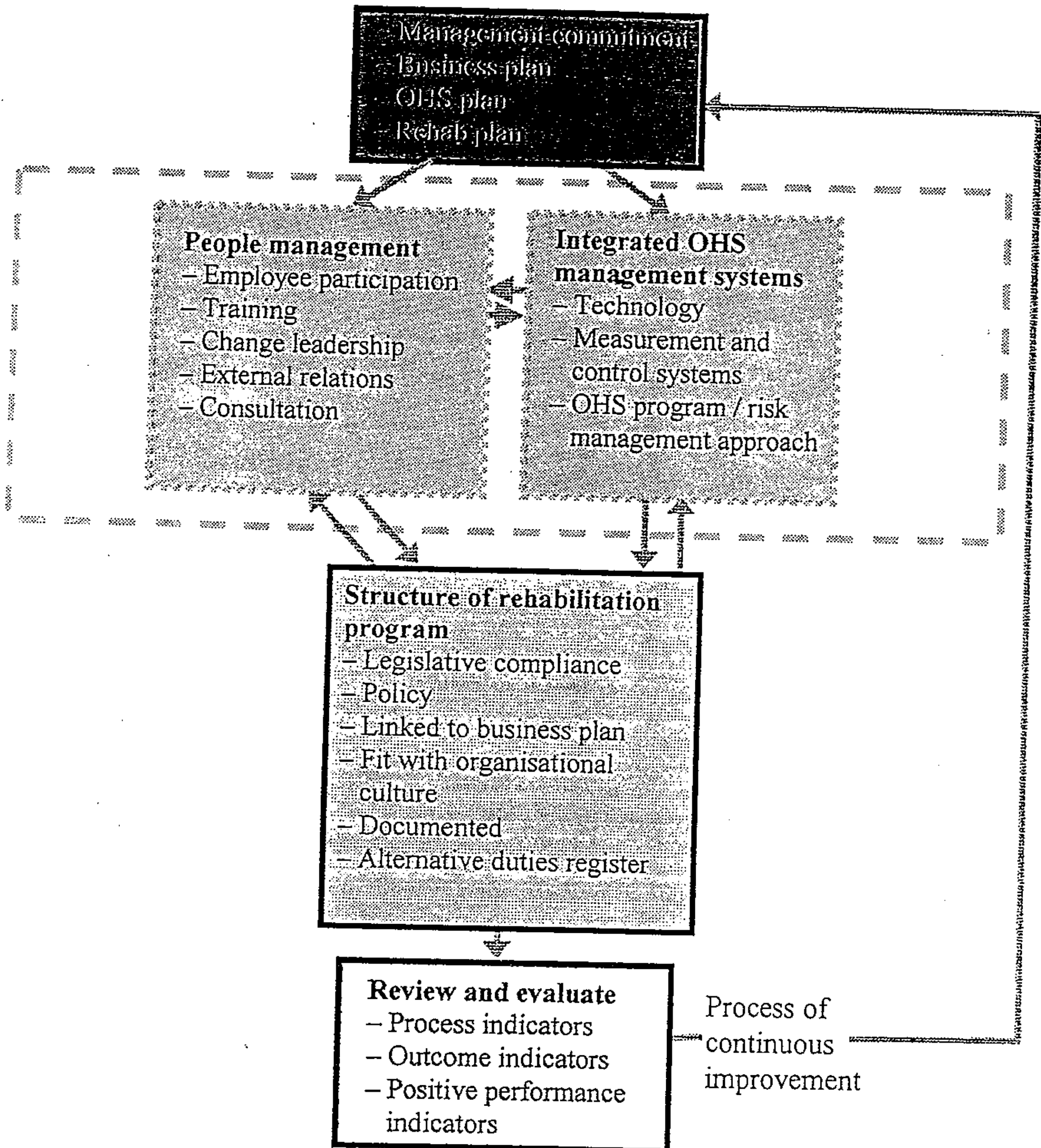
Review and evaluation of this entire approach to OHS and rehabilitation is essential for the process of continuous improvement. Positive performance indicators for both the OHS/rehabilitation process and OHS/rehabilitation outcomes should be developed and monitored at short and longer-term intervals. Indicators should be considered carefully. For example, a decrease in lost work time injuries is clearly an aim of a good OHS program; however, it has been shown that the measurement of these as an indicator of success can lead to under-reporting of accidents. Similarly, a decrease in the workers' compensation premium is another clear aim for good OHS management, but there are other factors related to the worker's compensation system that can affect premium calculations.

The measurement and evaluation of these indicators can demonstrate the benefits of good OHS and rehabilitation practice in relation to the achievement of business objectives.

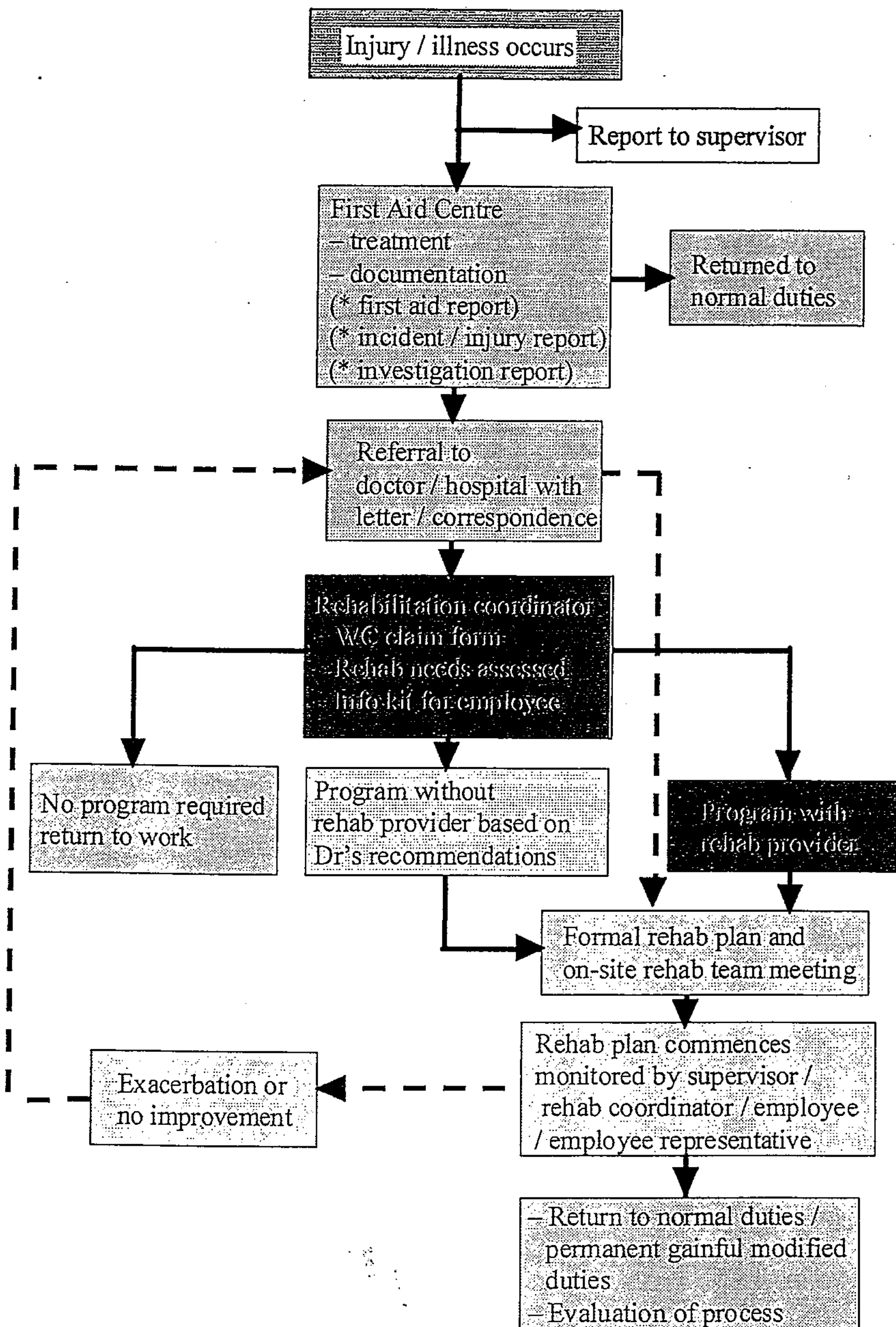
Some examples of positive performance indicators for OHS/rehabilitation include:

- number of hazard assessments performed
- positive outcomes for work practices from hazard assessments
- decrease in time between accident occurrence and reporting
- decrease in duration of time off work due to injury/illness
- decrease in duration of rehabilitation cases
- number of successful rehabilitation outcomes
- positive attitudes to safety in the workplace
- positive reinforcement by peers to rehabilitation plans
- decrease in workers' compensation premium or demonstration of the savings made by the OHS/rehabilitation program as compared to the workers' compensation premium without the program in place.

BEST PRACTICE MODEL FOR REHABILITATION IN THE MEAT INDUSTRY



REHABILITATION PROCESS MODEL



RECOMMENDATIONS: REHABILITATION PROCESS MODEL

First Aid Centres

At this stage, after assistance has been provided, the following documentation should be completed immediately.

Documentation

1. First aid report – by first aid officer and the injured employee.
2. Incident/injury report – by the injured employee or their representative.
3. Accident investigation report – by the injured employee's supervisor.
4. OHS Authority notification of serious injury – by the rehabilitation coordinator as prescribed by the relevant state legislation.

Referral to local doctor or hospital

As appropriate, the injured employee should be directed to be medically assessed. Indicators of the needs for assessment include:

- obvious signs of trauma, e.g. cuts, possible fractures, sprains
- symptoms which have been present for more than 24 hours, e.g. muscle spasm
- symptoms associated with long duration claims, e.g. overuse injuries, back injuries
- where the ability to work is impeded
- where the employee requests it.

Ideally, relationships with the local doctors/hospitals will have been established. Methods to maintain a good case management relationship with the treating doctor should be used; for example, a phone call to the doctor to reintroduce yourself before the employee's appointment to advise of the employer's support and to invite the doctor for a tour of the plant if this has not already occurred.

Documentation

- Injured employee to sign and take to the appointment an authority for the release of medical information in relation to this injury.
- A letter of introduction for the employee to take which outlines the site's policy and commitment to rehabilitation and safe, early return to work.
- A standard letter for the doctor to complete, outlining any specific restrictions for continuation at work with a review date and a request to contact you if the employee requires time off work to discuss rehabilitation needs.

Rehabilitation coordinator

The rehabilitation coordinator has the central role in organising communication amongst the stakeholders to assess general rehabilitation and return to work needs. It may be beneficial for the manager/supervisor to contact the injured employee also.

If the injury is work related or has been aggravated by a work process, a workers' compensation claim must be submitted.

An assessment of the need for a rehabilitation plan should occur, through consultation with all stakeholders within 48 hours of the injury occurring. The plan should be devised at the workplace with the injured employee present and an OHS representative if requested. If the injured employee cannot get to work, provision of transport may be an option. If this is impossible, the rehabilitation coordinator should go to them.

The rehabilitation coordinator should assess whether indicators of complex and high cost claims are present and a strategy progressed accordingly, for example referral to a specialist.

An information kit on rehabilitation should be supplied to the injured employee and their family.

Documentation

- Workers' compensation claim form.
- Rehabilitation needs assessment – checklist.
- Information for injured employees – OHS Authority and the site's documentation.

Formal rehabilitation plan

The best practice literature and experience has shown that early establishment of formal, documented rehabilitation plans results in the best rehabilitation outcomes. The various OHS authorities have set mandatory guidelines based on minimum requirements.

Documented and specific rehabilitation plans for the treatment and return to work plan should be devised for all injured employees who require modified or alternative duties and/or time off work.

An initial plan should be devised within 48 hours of the injury occurring in consultation with the injured employee and treating doctor and signed accordingly.

Review dates should feature in all plans, and delays on progress analysed.

A formal plan devised in consultation with the injured employee and treatment team is highly recommended for any injuries requiring more than two days off work and/or for those injuries which feature characteristics of long duration/high cost claims. An employee representative can be a valuable member of the team by providing peer or union support.

Return to work options should be based on the doctor/treatment team's recommendations for activity and be meaningful work tasks. Alternative duty registers will assist this process. Ideally, alternative duties should be identified through task analysis of available duties and assessment of their suitability for the injured employee.

The involvement of an injured employee in a return to work program should not place other employees at a disadvantage of risk of injury to themselves. The following hierarchy should be applied for return to work options:

- same job/same employer
- similar job/same employer
- new job/same employer.

If the above options are inappropriate or no position is available with original employer, the following hierarchy of options should be applied:

- same job/new employer
- similar job/new employer
- new job/new employer.

Documentation

- Initial rehabilitation plan – within 48 hours of injury.
- Revised rehabilitation plan – within one week of injury if required.
- Specific recommendations for return to work duties.

Monitoring rehabilitation plan

This process involves a team approach between the rehabilitation coordinator and relevant supervisors. The supervisor should conduct a daily informal review of progress. A formal weekly review of progress by the rehabilitation team should involve the rehabilitation coordinator, injured employee, their supervisor, employee representative and the treatment team.

Formal case reviews should occur as per the rehabilitation plan.

Documentation

- Weekly review report of rehabilitation plan.
- Case review report.

Exacerbation

Exacerbation of injuries may occur, often during periods of upgrading by way of hours or introduction of new tasks. If treatment is occurring this may be structured to support the upgrading. Exaberation should be investigated early and the plan modified as necessary. Modifications should also be documented.

Documentation

- Rehabilitation review report.
- Modification of rehabilitation plan, where necessary.

Return to usual duties/permanent alternative duties

The injured employee's progress should continue to be monitored at two weeks and again at four weeks after their return to permanent duties – whether these are their usual duties or an appropriate alternative.

The case closure report should be completed and signed by the rehabilitation team and the injured employee.

A review of the rehabilitation process should occur by the rehabilitation team and the following indicators considered:

- success rate of individual programs
- effect of reducing lost time
- positive outcomes and problems or issues of concern
- statistical information on the case, for example duration of claim, duration of time off work, costs of treatment
- new or proposed initiatives to improve/enhance existing program
- employee's satisfaction
- communication with external stakeholders
- changes to work practices that will prevent recurrence.

Some specific ways to evaluate rehabilitation providers where they are involved in a case include:

- were specific rehabilitation objectives stated and met?
- did the plan accurately reflect service provision and cost?
- was communication between the provider and the rehabilitation team and injured employee effective?
- were reports and recommendations on time and able to be understood?
- were the services justifiable in relation to provision and cost ?
- employee satisfaction.
- period between referral and contact with employee.

Documentation

- Case closure report.

Evaluation of the rehabilitation program

Formal evaluation of the rehabilitation program should occur annually based on data collected at least quarterly. Outcomes measured should be reflected in the site's overall business plan.

Positive performance indicators should be measured in addition to the effects on the workers' compensation premium. Indicators could include those measured at case closure with some additional broader indicators of rehabilitation outcomes which can then be used to review the rehabilitation process. For example:

- occurrence and duration of lost time injuries
- analysis of characteristics of actual long-term claims to identify specific factors at the enterprise and workplace level, e.g. type of injury, initial intervention
- the number of return to work outcomes as a percentage of cases referred to rehabilitation providers.

More performance indicators have been suggested in the previous section.

Documentation

- Rehabilitation program quarterly review report.

IMPLEMENTATION PLAN

Now a best practice rehabilitation model has been developed specifically for the meat industry the challenge is to implement it. The implementation strategies presented here were devised from the literature review and recommendations for uptake suggested at the site visits. The implementation plan will require leadership in order to sustain and activate these initiatives.

Strategy	Outcomes
1. Distribute the model for best practice by the meat industry Best Practice Committee with an extract of the report to owners/general managers, HR managers and rehabilitation coordinators.	Awareness of the model amongst key people in rehabilitation in the industry.
2. Present at Meat Industry HR Conference in September outcome integration into HR systems.	Rehabilitation coordinators have a guide for how to implement the model, and the tools with which to do this.
3. Develop case studies of sites that demonstrate best practice to present at travelling road show presentations to domestic abattoir owners.	Owners provided evidence of cost benefits of best practice rehabilitation model.
4. Provide an accompanying information kit for rehabilitation coordinators with relevant OHS authority guidelines, and examples of standard forms, checklists and positive performance indicators tailored to the meat industry.	Rehabilitation coordinators have a guide for how to implement the model, and the tools with which to do this.
5. Obtain support from State WorkCover authorities for the model and for sponsoring of a best practice demonstration project.	Employer attempts to improve rehabilitation processes are actively supported by OHS authorities.

Continued over

Strategy	Outcomes
6. Provide insurance companies with the model to obtain their support for the application of the model and incentives for employers who demonstrate best practice.	Insurance company active support in reducing the costs of workers' compensation.
7. Invite companies to participate in a best practice demonstration program.	Benchmarks for best practice identified. Continuous improvement of best practice model.
8. Publish the model and report extract in *WorkCover News, Country HR Update, Australian Meat Industry Bulletin, and QA–Quantum Leap.*	Public attention to meat industry commitment to best practice.
9. Investigate with WorkCover NSW a pilot for district rehabilitation coordinators for domestic abattoirs.	Support for domestic abattoirs to identify rehabilitation needs and suitable duties options for return to work.
10. Cooperative cross industry approach to return to work options.	Support for domestic abattoirs, reduce time off work.
11. Industry cooperative approach to hazard control, identifying improvements to technology.	Prevention of accident/incidents related to unsafe work practices or outdated technology.
12. Cooperative industry approach to task analysis to improve identification of alternative duties.	Early return to work options, meaningful jobs based on physical abilities, rather than restrictions.
13. Development of an OHS/rehabilitation training module for supervisors.	Supervisors able to take an active role in rehabilitation.
14. Development of an OHS/rehabilitation 'train the trainer' module for employees to conduct throughout their company.	Employees aware of their rights and responsibilities, taking an active role in injury prevention.

Continued

Strategy	Outcomes
15. Development of a standard 'Information kit' for all employees and specifically for injured employees and their families.	Employees aware of their rights and responsibilities in rehabilitation and have realistic expectations of the process.
16. Establishment of an OHS helpline for the industry.	Support for domestic abattoirs, unified approach to hazard and rehabilitation management.

CONCLUSION

Features of best practice already exist in most sites visited. There was, however, a lack of integrated approach with general business plan. There was also a lack of positive performance indicators, and a lack of annual and long-term monitoring and review of program benefits to the site.

The implementation plan is especially relevant for targeting domestic abattoir owners and sites that are geographically isolated. On the basis of the six sites visited, these groups are probably in the most need of support and direction with rehabilitation.

APPENDIX 1 – LITERATURE REVIEW

This literature review covers the following topics:

- review of injuries in the meat industry
- rehabilitation in the meat industry
- best practice
- best practice in occupational rehabilitation
- best practice in OHS
- integrated OHS and rehabilitation strategies
- evaluating rehabilitation programs

Review of injuries in the meat industry

A review of the Worksafe performance overviews of the meat products industry provides information on the types of injuries commonly featured in rehabilitation programs in this industry and the range of OHS issues relating to their incidence.

For the period 1992/93 and 1993/94, the meat products industry had a very high injury incident rate: five times the rate for all industry in Australia. In 1994/95 this increased to more than seven times. The main causes of injuries are sprains and strains, with shoulder injuries/diseases steadily increasing.

More than one-third of these injuries were related to activities involving muscular stress, of which half involved lifting, carrying, putting down or handling carcasses, offal and waste; others involved hitting objects with the body.

One-quarter of injuries involved the use of non-powered knives and resulted in open wounds, sprains, strains and muscle and soft tissue injuries. Recent analysis shows a reduction in the prevalence of open wounds.[1]

[1] NOHSC, Worksafe Austrialia, OHS.Performance overview Meat and Meat Product Manufacturing Industry Aust 1992/93, 1993/94, 1994/95.

A low proportion of injuries involved plant but questions were raised in the Worksafe report about whether the absence or under-utilisation of more technologically advanced plant might be contributing to the high rates of injury.

Rehabilitation in the meat industry

A review of 'Rehabilitation in the Meat Processing Industry' was undertaken by Gill (1997) for the Meat Research Corporation. Nine sites were visited and representatives interviewed about the way rehabilitation was managed in their site.

Overall, rehabilitation was considered an important issue, and management and employees demonstrated interest in improving the present arrangements. Many suggestions for overcoming the difficulties experienced in rehabilitation in the meat industry were suggested.

The key issues identified by this review relevant to this project are:

- injuries, workers' compensation and rehabilitation were considered important and topical
- awareness of legislation was evident, policies and procedures exist however, it was evident that many experienced difficulties with practical application
- recording of occurrences, number of cases kept manually
- reliance on insurance companies in relation to data sets on injury type
- majority familiar with return to work programs – concern by author that this confused with rehabilitation, rather than one part of the rehabilitation program, worker comments emphasized that return to work is good as long as it is safe
- some sites did not have a rehabilitation coordinator, and of those that exist, clarity of roles and level of experience and training varied; most in NSW were trained, some in Queensland were, none in Victoria had received formal training
- rehabilitation coordinator training is available in NSW and Queensland
- heavy reliance on doctors externally and OHS nurses internally
- majority consider health professionals lack adequate understanding of meat tasks

- communication difficulties experienced with doctors, insurance companies and OHS authorities
- rehabilitation providers used for difficult cases
- rehabilitation for non-compensable injuries is happening in some sites
- 'light duties' are running out and it's hard to get people off them
- some support for general fitness and injury prevention strategies exists
- there is a large amount of interest in more information (noting a significant amount of illiterate employees in some sites), a rehabilitation kit, and training packages on rehabilitation and developing networks.

Some of the factors which were identified as contributing to rehabilitation outcomes:

- level of consultation with employees
- follow up
- level of understanding about site and work processes by the site doctor
- attitudes to rehabilitation
- rehabilitation coordinator being on site and approachable.

Best practice

Best practice is a term used widely and is the goal for this rehabilitation initiative, so in order to apply the factors of best practice in rehabilitation, a search for best practice principles in general was required.

The 'Australian Best Practice Demonstration Program' concluded that best practice embraces all of an organisation's activities and processes and is characterised by:

> *A holistic, comprehensive, integrated and cooperative approach to the continuous improvement of all aspects of a site's operations – including leadership, planning, people, customers, suppliers, the production and supply of products and services, and the use of benchmarking as a learning tool. These practices, when effectively linked together, can be expected to lead to sustainable world class outcomes in productivity, quality customer service, flexibility, timeliness, innovation, cost and competitiveness.*[2]

The central ingredients of best practice are that best practice spans all aspects of the organisation's operations. It involves an integrated approach to changes in these activities; it requires cooperation between management and employees with the aim of achieving benefits for all stakeholders – 'customers, shareholders, managers and employees'[3]

The Australian best practice program documentation identified nine elements of a best practice approach:[4]

- strategy – a plan or direction for how all the activities, linked together will achieve the desired outcomes
- structure – how tasks are allocated, performed and reported
- technology – the use of and training in effective technology
- process improvement – activities to continuously improve products and services
- measurement and control systems – how the site collects and uses information about performance
- people management – a diverse range of issues which are part of managing current and future employees
- external relations – anyone outside the site which can improve value to the customer
- change leadership – those with key responsibilities in the change process
- employee empowerment – the degree to which employees can make decisions about how they work.

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[2] Rimmer, Macneil, Chenhall, Langfied-Smith, Watts, 1996, p20
[3] Rimmer et al., p21.
[4] Ibid, p48–55.

Considering that best practice is about how business activities and processes link together to achieve positive outcomes a review of the basic principles and activities of the rehabilitation process and how these are demonstrated in practice was used to construct the model for best practice in rehabilitation in the meat industry.

Best practice in occupational rehabilitation

In a *Guidance Note* issued by Worksafe Australia, occupational rehabilitation is defined as:

> *A managed process involving early intervention with appropriate, adequate and timely services based on assessed needs, and which is aimed at maintaining injured or ill employees in, or returning them to, suitable employment.*[5]

The key aims of the process of occupational rehabilitation are:

- achieving optimal physical and mental recovery
- safe, early return to suitable work
- reducing the human and economic costs of injuries to employees, employers and the community.

Fourteen principles of the rehabilitation process are also provided:

a) the prime goal should be the maintenance at work, or early and appropriate return to work (RTW)

b) commitment is required from all parties

c) the work place is usually the most effective place for rehabilitation

d) rehabilitation should occur at the earliest possible time consistent with medical judgment

e) employees should be active in process and their dignity maintained

f) consultations occur at all stages with all parties

g) all parties should be informed of their legislative entitlements and requirements under the relevant workers' compensation system

[5] NOHSC, Worksafe Australia Guidance *Note for Best Practice in Rehabilitation Management of Occupational Injuries and Disease*. 1995, p2.

h) information should be treated confidentially

i) all relevant rehabilitation expenses should be met by the agent responsible under legislation

j) RTW programs based on the hierarchy:
   - same job/same employer
   - similar job/same employer; or
   - new job/same employer

   If the above options are inappropriate or no position is available with original employer:
   - same job/new employer
   - similar job/new employer
   - new job/new employer.

k) work assigned through the rehabilitation process should be meaningful to employee

l) graduated return to full-time duties, permanent part-time or reduce hours should be considered in planning RTW programs

m) no injured employee to suffer financial disadvantage by RTW program

n) rehabilitation is most effective when linked to workplace based OHS programs.[6]

The benefits of maintaining injured workers at work or returning injured workers to suitable duties early, has been reported upon by many authors. It is therefore considered the primary goal of rehabilitation, and the focus for best practice approaches in rehabilitation. One of the key outcomes of workplace-based approaches is that workers see themselves as 'valued employees who remain attached to the workplace'. When this does not occur the environment is created which will see them attach to other stakeholders/steps in the process, for example 'treatment providers, lawyers, the benefits offered, the rhythm of incapacity or the pulse of an alternative lifestyle' and as a consequence lose the incentive to return to work.

Key factors for successful return to work outcomes were identified by the Return To Work Advisory Group's (RTWAG):[7]

- Doctor understanding the limitations of the workplace.

[6] NOHSC, Worksafe Australia, *Guidance Note for Best Practice in Rehabilitation Management of Occupational Injuries and Disease*, 1995, p4.
[7] *Review of International and Jurisdictional Best Practice in Return to Work* and by Kenny (1995) in her *Review of occupational rehabilitation in New South Wales.*

- Motivation of the injured worker.

- Site commitment to occupational health and safety. This includes training for employees in policies and procedures to assist return to work and for supervisors in work environment, early intervention, prevention and strategies for non-compensable issues which demonstrate that employers are acting in the spirit of the legislation.

- Positive employee perceptions of the quality and effectiveness of services and personnel providing these services.

Kenny identified seven key barriers to successful return to work:

1. inadequate level of knowledge amongst employers, rehabilitation coordinators, treating doctors and injured workers

2. inadequate employer compliance with legislation – possibly because they don't receive any direct benefit by way of reduced costs, fewer injuries or decreases in lost time from injuries as a result of the workplace safety and rehabilitation practices

3. poor individual case management due to conflict in expectations of the rehabilitation coordinators' role, inadequate allocation of time to case management, insufficient expertise and their absence in smaller workplaces

4. insufficient communication between stakeholders

5. difficulties in identification and provision of suitable duties and negative perceptions about suitable duties

6. polarising roles of doctors selected by injured workers and insurance doctors, which increase costs and may precipitate litigation

7. the perceived adversarial nature of the workers' compensation system, exacerbated by insurer-driven delays in payment, disputes and inadequate communication and information dissemination between insurer and injured worker[8].

Eight recommendations were proposed by Kenny to improve the rehabilitation process:

1. development of education programs for employers and workers about workers' compensation and rehabilitation process, rights and responsibilities

[8] *Review of Occupational Rehabilitation in New South Wales. NSW WorkCover Authority*, Kenny 1995, p7.

2. stricter surveillance of recidivist employers and penalties for repeated breaches

3. enhanced role for rehabilitation coordinators 'District rehabilitation coordinator' model for smaller workplaces; role conflict addressed at policy and structural level

4. selectively use case management approach, rehabilitation coordinator taking the role of central organiser

5. development of a coordinated, cooperative, industry-based approach to the identification and allocation of suitable duties; using trained 'District rehabilitation coordinators', a register of available suitable duties could be drawn up and allow injured workers to move between workplaces if nothing suitable at their own workplace at the time

6. training and accreditation of treating and insurance doctors, accountability procedures

7. reduction in use of insurance doctors, increased use of independent medical panels, earlier than dispute stage

8. user-friendly insurance practices, more direct contact between insurer and injured worker[9].

Specific recommendations for each stakeholder were suggested, primarily targeting the education needs of each group. A cooperative approach to suitable duties within industries is recommended with WorkCover providing some strategy to offset the costs.

[9] *Review of Occupational Rehahiliation in NSW.* NSW WorkCover Authority, Kenny, 1995. p7.

The *Inquiry into Workers' Compensation System in NSW* (1997) made further recommendations to improve the workers' compensation and injury management process:

- The formation of industry reference groups by 1 July 1998 comprising worker and employer representatives to investigate specific issues affecting their industry and, with the OHS Council, to examine the better performing NSW employers, and interstate and international best practice for the industry to develop practical guidance material for employers and workers. Their responsibilities will include developing benchmarks to identify poor performers and provide advice, identifying and maintaining a bank of suitable positions for return to work processes and providing practical vocational advice where retraining is required.

- Injury management should focus on early intervention and return to work within tight mandatory timeframes for claim reporting and for establishing injury management programs with active involvement from WorkCover and with disincentives for failure to comply built into system.[10]

Best practice in occupational rehabilitation

The RTWAG undertook an international (including Australia) review of best practice in return to work and suggest the following best practice principles for return to work:

- occupational rehabilitation and return to work strategies should be workplace based

- early intervention is a major requirement for those clients who need rehabilitation

- not all clients will benefit from, or need rehabilitation

- corporate commitment from the top is required for return to work strategies to be implemented effectively

- the organisational culture directly or implicitly affirms human resource management principles where early return to work is seen as a guiding corporate principle

- the site should become the driver for integrating the key stakeholders in the managed care and rehabilitation of the injured worker

[10] Grellman, *Inquiry into Workers' Compensation System in NSW*, 1997, pp 59, 60.

- accidents and injury need to be responded to regardless of cause and the issue of liability, and claims management, is a separate but related feature of a workers' compensation system

- feedback loops, including computerised information systems, should be provided to guide action at the employer and the individual level

- consultative and tripartite arrangements are vital in having integrated management of the operating systems.[11]

This report also suggests a 'Best practice script' for sites that are aiming to implement a best practice approach:

- *we value our staff in this agency, particularly when they are injured and need support as this is a particularly stressful time for them*

- *by and large the majority of staff do not want to 'rip off' the system, especially if agencies genuinely care for staff*

- *it's no good for staff to stay at home, as the peer support available at work has a great deal of recuperative value anyway*

- *we will manage the care, the return to work and the key stakeholders actively and from the outset*

- *we do not want injured workers to think – even for a minute – that we do not care of that we have forgotten them*

- *the claims management process is the last point at which to manage the re-entry process*

- *we will not be soft on staff (or doctors, providers) playing the system, but the model will not be premised on the fact that everyone is out to rort us*

- *if any barriers or ambivalence occur in any of the stakeholders we will act as a consultant or mediator in the process.*[12]

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[11] *Review of International and Jurisdictional Best Practice in Return to Work*.RTWAG, pg48.
[12] *Review of International Jursidictional Best Practice in Return to Work*, RTWAG, pp48,49.

Best practice in OHS

The fundamental position of best practice in OHS, in any best practice approach for rehabilitation, is reflected in the objectives of the NSW WorkCover system:[13]

- To prevent workplace injuries, diseases and illness through best OHS practices.
- When injuries occur, to medically rehabilitate the injured worker to the maximum medical improvement and, if necessary, provide vocational rehabilitation.
- To provide the maximum opportunity and incentive for injured workers to return to pre-injury or other employment.

Integrated OHS and rehabilitation strategies

The RWTAG referred to Du Pont's 'Zero Accidents perspective', which makes safety an area of line management accountability as an example of a best practice approach to safety and rehabilitation. In the US, they consistently have a rate of lost time injuries (LTI's) less than one-fifth of other sites in same industry, and maintain that all work injuries can be prevented. The Du Pont approach has been successfully applied to other industries.

A case study of a smaller site demonstrated the effect of focusing on early reporting to enable early intervention and RTW planning and accident prevention involving senior management, other employees, claims data and work practices analysis. Early reporting has a direct effect on reducing the costs of workers' compensation.

Some sites in Australia, the US and Canada have recognised that occupational rehabilitation and RWT are one feature of a broader human resource or industrial relations program and have eliminated the need for a determination of whether the injury is work-related prior to organising treatment. Treatment and services are provided for all injuries affecting work performance, so for those that are work related, the rehabilitation program is initiated at the same time as the workers' compensation process. This approach results in cost savings due to the determination process and improved workplace culture through minimising adversarial relationships associated with claims determination.

[13] Grellman, *Rehabilitation in the meat processing industry*, 1997, p 49.

It also provides greater potential for relationships with service providers and can result in cost effective and greater accountability of service providers and more timely access to services. For example, George Weston Ltd attributed savings of an estimated $20 million to their workers' compensation costs over three years in great part to this approach, and a few large Australian government and non-government sites have also achieved savings by using this approach.

A review of workplace-based rehabilitation services by McGeough (1997) cited studies that identified a number of other factors of in-house services that contributed to successful return to work outcomes. They included: early notification and early intervention, the maintenance of return to work expectations by management and employees, easier ability to coordinate services, knowledge of corporate structure and culture, and reduced lost work time by early allocation of suitable duties.

NOHSC, Worksafe (1995) recommend that the role of the team should be to support the coordinator in developing the appropriate rehabilitation and return to work strategy and with its implementation and administration.

Evaluating rehabilitation programs

NOHSC, Worksafe recommend a number of indicators for measuring the success of internal programs and rehabilitation providers, and to monitor injury trends to indicate appropriate rehabilitation strategies.

Performance indicators for internal programs include:

- success rate of individual programs
- affect of reducing lost time
- positive outcomes and problems or issues of concern
- provider performance
- statistical information on overall program
- new or proposed initiatives to improve/enhance existing program
- consumer satisfaction[14].

Some specific ways to evaluate rehabilitation providers include:

[14] NOHSC, Worksafe Australia Guidance Note for Best Practice Rehabilitation Management of Occupational Injuries and Disease. 1995, p33.

- are specific objectives stated and met?
- the number of return to work outcomes as percentage of cases referred
- whether plans accurately reflected service provision and cost
- effectiveness of communication between provider and employer
- reports and recommendations able to be understood?
- services justifiable re provision and cost
- employee satisfaction
- period between referral and contact with employee.[15]

Statistical indicators are useful to:

- identify priorities for preventing long duration claims
- identify the potential of result in a long duration claim
- assess prevention and rehabilitation strategies.[16]

Action that employers should take in regard to these include:

- early commencement of rehabilitation for potential long-term and high-cost claims
- analysis of characteristics of actual long-term claims to identify specific factors at the enterprise and workplace level
- request for reports from insurers on the characteristics and status of individual long-term claims to develop criteria for early intervention
- develop checklists based on identified criteria

[15] NOHSC, Worksafe Australia Guidance Note for Best Practice Rehabilitation Management of Occupational Injuries and Disease, 1995, p33.
[16] NOHSC, Worksafe Australia Guidance Note for Best Practice Rehabilitation Management of Occupational Injuries and Disease. 1995, p33

- use consultative committees to identify information, including: precise nature of injury, personal characteristics of injured worker, medical advice received, job requirements re appropriate rehabilitation interventions[17].

Calzoni (1997) emphasises the value of client satisfaction as an indicator to measure the success/failure or effectiveness of a rehabilitation program.

The literature has identified the broad elements of best practice and specific characteristics of a best practice approach to rehabilitation. Researchers have demonstrated barriers to rehabilitation programs, and positive features of programs. Practical recommendations on how to integrate best practice principles into the rehabilitation process have been suggested.

[17] NOHSC, Worksafe Australia Guidance Note for Best Practice Rehabilitation Management of Occupational Injuries and Disease. 1995, p37–8.

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APPENDIX 2 – SITE VISIT SUMMARY

Field research included site visits to large, medium and small facilities with varying levels of development of rehabilitation programs. Six sites were visited and interviews were conducted with general managers, human resource or personnel employees, the designated OHS employee and an employee who had participated in rehabilitation. OHS employees included workplace health and safety officers, registered and enrolled nurses and human resource employees.

An interview tool was used to guide the researcher at site visit and is given in full at Appendix 3.

The results of the interviews are presented with discussion about similarities and differences between sites.

Description of sites and OHS/rehabilitation programs

There was a wide variation between sites in terms of number of employees, the stage of development of their rehabilitation programs and the degree of success of their program in reducing the costs associated with workplace injuries. Five of the six sites had a formal rehabilitation program in place.

The type of work done was similar between sites. All were involved in slaughtering, labouring, engineering/maintenance and administration activities relevant to their size. The larger sites also included processing activities such as boning, slicing and packing.

Similarities in the type of injury experience were reported, with all but one reporting sprains/strains and overuse as their most common.[18]

The next most common injury reported was knife wounds, with one site adding that prior to a hygiene promotion initiated by management, infection was a common complication of these injuries.

Other injuries reported included hernias, contusions and back injuries. One site also reported that drug, alcohol and stress-related illnesses were a problem in their workforce.

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[18] This is related to their method of reporting injuries discussed later.

Those who commented on the causes of these injuries proposed a number of factors, which included:

- prolonged exposure to physical work, leading to an eventual 'wearing out'
- the physical environment, especially heat, poor ventilation, wet floors
- loss of concentration, distraction
- inadequate maintenance of equipment (knives, stun guns)
- kicks from animals (associated with killing methods)
- lack of experience/training of co-workers leading to unsafe conditions
- inadequate plant maintenance.

The three larger sites considered that their rehabilitation program was working well and one of these reported significant reductions in their workers' compensation premium and their lost time injury frequency rate (LTIFR). Another site had received favourable assessments by OHS Authorities but their workers' compensation premium had increased over the previous two years. One of the smaller sites acknowledged that they were behind the mark and were taking steps to establish a formalised program, which they believed would greatly assist their rehabilitation performance.

In another of the smaller sites a conflict in how the success of rehabilitation was being measured, created a significant conflict in opinion about how well the program was working. Whilst the owner acknowledged that everything was being done 'by the book', in his opinion the way the rehabilitation program was operating was creating more costs for his site than before it was established. The number of workers compensation claims has increased, and as a consequence their workers' compensation premium has increased steadily over the past 12 months.

In his opinion the rehabilitation program convinces people they can't do things. "The rehabilitation manager is causing injuries. Before he started, everyone with injuries was still at work now they're all off work."

In contrast, the rehabilitation manager has observed that early intervention is causing people to report injuries and seek treatment early, which is costing money in the short term. They believe this will bring savings in approximately three years and will prevent common law cases – to which the site has been open in the past.

One injured employee at the same site said he felt he was "held back" from returning to work and would have done so earlier. On reflection, he thought this approach assisted his recovery – he wasn't pushed too far too quickly and had a chance to heal.

Table 3 following describes the sites in terms of number of employees, types of work performed, the most common injuries experienced, current rehabilitation program was in place.

Table 3: Description of sites visited

Site No.	Number of employees	Work performed	Main injury types	Rehabilitation indicators	Formal rehabilitation program
1	600	Slaughtering, boning, slicing, packing, engineering / maintenance administration	1. Sprain / strains 2. Occupational overuse syndrome	↓ LTIFR's ↓ premium	Yes
2	420	As above plus overseas transport	1. Sprains / strains 2. Lacerations 3. Drug & alcohol related 4. Stress related	↑ premium	Yes
3	350	As above	1. Overuse injuries 2. Back injuries 3. Lacerations & infections		Yes
4	287	As above but no overseas transport	1. Knife wounds 2. sprains and strains 3. Hernias 4. Contusions	↑ premium annually WorkCover bonus points	Yes
5	64	Slaughtering Labourers Administration Maintenance	1. Sprains & strains 2. Occupational overuse syndrome	↑ premium	Yes
6	45	As above	1. Cuts 2. Strains 3. Hit by object	↑ premium	No

Perceived strengths and weaknesses

Strengths

Factors which stakeholders identified as good about their programs were:

Strategy/management commitment

- "the director is very supportive of people being at work – he'd find them something" [suitable duties]
- policies all in written form and available to staff – return to work is expected
- direct, dynamic and communicative approach to return to work
- return to work is supported by management/supervisors/fellow employees
- provides rehabilitation programs for injuries that are not work-related – to prevent work-related aggravation
- alternative duties identified through task analysis

People management

- in one site the rehabilitation coordinator involves wives in negotiating return to work plans as they are often running the household finances
- the union is consulted in the design of new work systems

Program structure

- early intervention and rehabilitation commences at the time of injury with immediate first aid and referral if necessary
- team approach between human resource manager, workplace health and safety officer, enrolled nurse and first aid officer
- allowing injured workers to continue to contribute to the business which increases self esteem
- in-house rehabilitation services – clinic attended by a doctor three days a week, and regular visits by physiotherapist
- rehabilitation programs have clear outcomes stated
- graduated return to work in real jobs

- the rehabilitation coordinator won't return people to work if there is a high risk of re-injury or aggravation – WC and non WC

External relations

- local doctors and hospitals are familiar with operations and are provided with an alternative duties register
- rehabilitation providers used on a needs basis and have a good insight into the nature of work done at site.

Results

- common law cases being prevented, decrease in LTIFR in plant with good relationship with local clinicians.

Weaknesses

Factors that stakeholders considered weaknesses were:

Strategy/planning/management commitment

- there is a lack of formal OHS strategy both annually and longer term
- OHS initiatives are not linked to business plan
- perceived lack of management commitment to plant maintenance in some sites, creating generally unsafe work conditions
- perception that in some case meaningless tasks are used as a rehabilitation deterant

Program structure

- uncertainty about the process, rights, responsibilities and entitlements while on rehabilitation
- in the past-people were brought back to work too early, which led to the exacerbation of injuries and has resulted in complex cases and common law claims

Strategy

- "the rehabilitation process is covering the legal and moral responsibilities, but not commercial needs of sites"
- "the site needs people to be productive"
- "directors don't understand rehabilitation and the requirement for employees to be fit to work before alternative duties can be arranged"
- short-term planning in the business in general ('What's brought in today, gets killed tomorrow and sold the next day')
- "bosses don't understand that investment in maintenance will yield a better product and be better for workers"

Program structure

- difficult to identify appropriate alternative duties
- the nature of injuries such as OOS, epicondylitis, body parts affected
- risk of infection
- "too much time is given off for less serious injuries"
- "people want to come back to work but held back by rehabilitation" stated in one site

External relations

- demographics of the workforce: "the problems are with rehabilitation is one part of a broader problem with the workforce – higher turnover, younger staff don't like the sort of work"
- misinformation to families by solicitors: "some have belief that they're automatically entitled to a pay-out or retraining"
- unsupportive attitude of some doctors and new hospital interns
- differing opinions of doctors
- "WorkCover lack of support and inconsistency, for example in relation to dodgy claims"
- "lack of understanding by doctors and employees about the costs of workers' compensation"

- "workers' compensation system gives no incentives for employers – the insurance premiums are high and then they go up further if you have claims"

Technology

- "in this business, aches and pains are part of work, to a certain point"
- high cost of redesigning workplace to meet ergonomic recommendations
- the nature of the work environment
- manual demands of work

Monitoring and control

- rehabilitation only measured by short term dollar costs
- adhoc way of monitoring the rehabilitation program and rehabilitation coordinator's performance

People management

- supervisors have difficulty with the parameters of rehabilitation: "they ask employees to go beyond rehabilitation restrictions at busy times"
- "the way people treat employees in smaller industries in general"
- no formal ways of appraising anyone on any aspect of work performance, other than trainees
- "when fellow workers feel the system is being abused"
- "lack of understanding about the intention of rehabilitation – there's a difference between being unfit and being uninterested in this type of work anymore"
- "lack of adherence to HR strategies resulting in 'deals' being done; for example, at one site an employee who no longer wished to be a foreman continued to be paid at this level"
- no worker/health and safety representative involvement in the design or monitoring of alternative duties
- no training for staff or supervisors in rehabilitation.

Suggestions

Description of current practice

Management commitment and resourcing

All interviewees reported that management commitment to rehabilitation existed. In all sites a designated supervisor and/or manager, often the Human Resources (HR) manager, held responsibility for overseeing rehabilitation. The largest site had the best-resourced rehabilitation team, comprising the HR manager, workplace health and safety officer, enrolled nurse and first aid officer. A visiting doctor and physiotherapist also supported this team.

The management of the smaller site without the formal rehabilitation program has a system of paying for employee treatments by a local chiropractor, which demonstrates to the employees an interest in their health and wellbeing. However, as yet, this is not integrated with broader injury prevention and management strategy and these cases are not reported as workers' compensation claims.

Another site has commenced a trial of on-site physiotherapy services, which they report has assisted in injury management of strain injuries.

No formal system of monitoring performance in carrying out rehabilitation roles exists in any of the sites.

The largest site has been monitoring the success in reducing LTIFRs with a package supplied by an insurance company.

Consultation and communication

The consultation process varied, occurring informally in most sites, and formally in some.

Two sites involved workers in the development of their rehabilitation policy, drafted initially by the HR Manager and then provided to management, employee representatives and the OHS committee for comment. Another site is planning to use this process shortly for review of the existing policy. These sites have the policy displayed as per the legislative requirements. One of the larger sites has a policy which is displayed, however, there was no formal process for consultation or promotion of the policy. Their health and safety representative had not seen it, but was aware that it existed. Another large site is currently reviewing their policy, seven years after its inception.

Three sites (two large, one small) have incorporated their rehabilitation policy and procedures into their induction program, and the largest site recently gave this training to all staff.

Three of the larger and one of the smaller sites have an OHS committee; the membership, training and level of interest is varied. Others rely on the monthly communication meetings, which cover the results of the QA audits, productivity and other staff matters, or in the case of the smallest site, the weekly informal communication meetings.

All have OHS representatives – most have received formal training. All sites report that OHS issues are raised verbally by staff to their foreman or safety representative.

Regular safety audits are occurring in two of the larger sites and involve participation by management and the OHS committee. The health and safety representative in the sites with no program has taken it upon themself to conduct monthly audits of the work area. However, there is no formal process for dealing with the issues their report identifies.

Four sites report that they give documented information to people on rehabilitation. There appears to be a questionable level of awareness amongst staff who have experienced the rehabilitation program. Some employees interviewed were not aware of the formal aspects of the program they simply followed instructions given to them. Two sites however, distribute a newsletter to all employees, which includes information about health and safety issues.

Reporting

All keep a register of injuries and accidents and incidents.

Three (two large, one small) use a standard accident/incident report form.

Two sites (one large, one small) have an accident/investigation form and procedure for reporting to management. One of these sites requires the supervisors to report on action taken to prevent reoccurrence. The general manager and rehabilitation coordinator then signs these off. In the other sites the rehabilitation coordinator initiates completing the form. This rehabilitation coordinator also compiles a monthly report of injury and near miss reports, for the directors, with a summary for the staff noticeboard.

Five sites have a designated first aid register. In one site this is reviewed by the health and safety representative, one site has their OHS committee chairperson review them, and in two sites the person with rehabilitation coordination responsibilities reviews these.

Four use a safety audit checklist; however, this is part of a formal reporting process in only two large sites, where this is reviewed by the OHS committee. In the other cases health and safety reps or the rehabilitation coordinator on an irregular basis uses them and issues are referred to management.

The two largest sites uses a maintenance request form on which requests are recorded, prioritised and signed off. The other sites make requests for maintenance verbally.

Rehabilitation procedures

The five sites with a rehabilitation program stated that rehabilitation begins 'when an injury occurs' and the person is unfit for their usual duties. Representatives of three sites specified that the receipt of a medical certificate and prescription of suitable duties began the rehabilitation process. A health and safety representative from one site stated that whilst some occasional contact with the worker is made, generally the 'injured worker is not seen by fellow workers until return to work'.

One large site requires the rehabilitation coordinator to wait for the insurance company to determine liability before a formal program is commenced. Another two sites adhere strictly to their OHS Authorities guidelines by initiating a formal program if the case involves more than 10 days off work (NSW) or 20 days off work (Victoria).

The smaller site with a rehabilitation program provides the program to employees with non-work-related injuries and includes ongoing personal contact with the injured worker and family during the period off work.

Standard rehabilitation plans were featured in all programs, with one having a specific plan for back injuries. Most manage rehabilitation in-house, one site uses a provider for all workers' compensation cases and two use a rehabilitation provider for 'difficult cases'. The site without a program uses rehabilitation providers on an 'as needs basis'.

Four sites, have a register or checklist that is provided to the treating doctors to assist in devising suitable duties. The sites, two of which had medical professional input, devised these.

The large site with the in-house rehabilitation team has the most developed alternative duties approach. There are two classifications of suitable duties:

1. Modified duties that could be part of the original job, with some restrictions.

2. Alternate duties are a different range of jobs used specifically for rehabilitation (tagging, making up boxes, stenciling).

One site's general manager expressed interest in designing a work area, specifically for rehabilitation cases, to keep these employees separate and prevent a 'workers' compensation culture' affecting the morale of other employees.

A process for monitoring return to work plans exists in the four sites with programs, the two with professional staff involvement emphasised daily monitoring of progress. Formal reviews occur weekly, every two or four weeks for individual cases, and one site does a quarterly case review. The small site mentioned that they have reviewed their claims twice a year with the insurance company.

One rehabilitation coordinator prepares a weekly summary 'Medical–in–Confidence' for Directors and relevant people about all rehabilitation cases. This covers: weekly progress, number of hours working, allowed duties, restricted duties, review date, who reviewed by, probable outcome, if long term/short-term case. All sites with programs have attempted to establish a good rapport with the local doctors by way of inviting them to visit the site, an orientation day and making appointments to discuss cases.

The main difficulties rehabilitation causes the meat industry are:

- Availability of duties is particularly an issue for the smaller sites. The type of tasks available as alternative duties include stenciling, tagging, boxing, stringing and yard activities. The requirement that tasks not be demeaning is difficult for some sites to achieve.

- Possibility of cross-infection to produce is an issue related to laceration injuries.

- Time demands – the meat industry is production driven. Time away from this had a direct effect on commercial outcomes.

- Nature of work structure – being a production line, an injury to a boner results in lost time and no work for two slicers and two packers, which affects production and can create hostility amongst co-workers.

- The effect of extended light duties on morale of other employees.

- Skills drain on other employees to cover the duties of those on suitable duties.

Suggestions for what would be helpful were given by many interviewees and targeted needs for more education/information and better rehabilitation procedures.

Education and information needs were identified for employees, owners and doctors. Specifically:

- information for injured workers to take with them to the doctor, and for their families
- regular information sessions, training in OHS and rehabilitation for staff
- education program for doctors which will encourage them to communicate with employers
- case studies of actual results for sites targeting directors/owners to explain the long-term benefits of a good program
- case studies of managing OOS injuries.

Suggestions for better procedures for work practices in regard to the rehabilitation process included:

- the development of safe work procedures, for example sharpening knives
- help in identifying suitable duties
- more practical and specific advice on work restrictions from doctors, for example at one site an employee with a cut finger was given a medical certificate restricting use of his entire arm
- practical guide to rehabilitation management in the meat industry
- early and active advice from the insurance companies.

Description of current practice

OHS / Rehabilitation training

All but one site had a process of induction training. Three sites are using Mintrac training indicating an acceptance for training and the role it can play in their organisation. One site extended this for all employees last year. Rehabilitation can be woven into this module by trainers.

The small site without a program is making an attempt in regard to OHS and rehabilitation through training. The local TAFE are providing the Certificate in Meat Processing course for interested staff. This is conducted at the local pub (saving 1-hour travelling). Management supports this by providing refreshments during the sessions. Management has arranged a function for the presentation of the certificates, which will be attended by all staff. They pay employees overtime to attend, in order to encourage more staff to do the course. They have also invited a speaker from the local OHS Authorities office to the function to present an information session.

Training of the major stakeholders in rehabilitation and OHS is inconsistent and reflects the approach to training in general within each site. Only one site reported that all staff and stakeholders in rehabilitation had had training. In the words of one interviewee, "we are in survival mode".

Most rehabilitation coordinators had received formal training, except for those in Victoria.

Rehabilitation coordinators seek advice and support from various sources including the National Meat Association, treating professionals, supervisors, OHS Authorities and some insurance companies. A Northeast OHS group exists in the Albury Wodonga area and specifically a Northeast Domestic Abattoir group was established in 1993 and is facilitated by Wodonga TAFE. WorkCover have also organised a Murray Region Safety and Rehabilitation Forum.

Planning and review

The six sites visited were at various stages of developing a formal business plan. Only one site had linked OHS to their overall business plan objectives. Two sites do not have a formal business plan; one of these is developing a business plan and is interested in including OHS/rehabilitation objectives.

The largest site reported an annual decrease in their workers' compensation premium and a significant decrease in LTIFRs. This site includes OHS in its business plan and includes rehabilitation in its strategic planning.

One site has an aim for 'zero accidents' but has no indicators or formal review of the program. OHS is mentioned in its business plan but there is no annual link back from the program. This site's workers' compensation premium is increasing, despite favourable assessments by OHS Authorities.

Another of the large sites uses early return to work and measures the average lost time for accidents, however, there is no formal review of the program or link between rehabilitation and the overall business plan. This site considers use of a best practice rehabilitation plan and formal documenting of procedures 'a wasteful use of resources'.

Workers' compensation premiums are the only indicator reviewed by the other site and the rehabilitation program had no links to the business plan.

In practical terms, rehabilitation is considered to the daily running of the business as all sites consider those on rehabilitation plans when rostering and planning work schedules. The use of casuals is common practice, the gate recruitment method is still used by some sites and apparently an induction process does occur for these employees.

No formal system of performance appraisal of OHS/rehabilitation roles and responsibilities was apparent at any of the sites.

Uptake

All but one site considered this project to be worthwhile but all expressed interest in the outcome. Support for a trial of the model exists, particularly from those struggling with rehabilitation. Ideas for uptake were suggested:

1. Need to target owners personally, road show presentations with emphasis on the cost savings in the longer term. Provide an overview of the process with a benchmark case example. Support with training

2. Best practice model for trial by those struggling with rehabilitation, which must be simple and flexible as they don't have much time to devote to rehabilitation.

3. Manual for rehabilitation coordinators with a step-by-step guide for how to manage the rehabilitation process in the meat industry, including checklists, case studies, forms and guidelines to follow, and should include minimum training requirements for rehabilitation coordinators.

4. Employee suggestions re brochure for injured workers.

5. TAFE run 'train the trainer' in OHS and rehabilitation along the lines of the existing 'Performance Assessor' courses.

Distribution of this research was suggested to be done through Margie Mahon, The NMA, TAFE, MRC Best Practice Committee and the associated Best Practice Program, OHS Authorities *News* or the Country Meat Association *HR Update*.

APPENDIX 3 – RESEARCH INTERVIEW TOOL

Background information for interviewers

On site visits the following questions are to be answered through observation, collection of documentation, and also through interviews with managers and employees.

During your visit you will need to meet with:

- Area manager
- HR manager
- Person with responsibility for rehab
- Any dedicated OHS personnel
- A range of employees

It will be difficult to be prescriptive about whom to question about what, as the areas will differ, but please check that you have covered all the areas identified in the tool. Each area of questions shows a guide for who, they should be directed at.

If you come across any documentary evidence or examples please collect copies wherever possible.

At the end of the day your report should list the people you saw and summarise the issues you discussed. The report should include a description of the facilities you visited and the major issues you observed through sight and conversation.

Interview tool

The interview tool/script is provided for you to follow as you consider appropriate to the various interviewees. Some of the questions should be asked of all, others might only need to be asked of one or two people. As long as you have covered all the questions over the duration of the visit, we will have the information we need.

Guidelines for the report are as follows:

- a brief description of the process using the headings from the site visit tool
- attach policies, procedures, any promotional material, and statistics acquired
- a flow chart of how the rehabilitation process works currently
- a summary of whether or not it is working currently
- explain what is working and what is not working
- how you would rate them in terms of best practice/compliance with legislation/non compliance and provide evidence of this
- a summary of any comments or questions relevant to the implementation plan.

Script

My name is ___________ and I work for Niki Ellis and associates. We are an occupational and public health consultancy and we have been engaged by the Meat Research Council to develop a model for the best approach to rehabilitation for the meat industry. I'm here to ask you a few questions about how rehabilitation works here so that what's going well, and any areas that you think need improvement, can also be incorporated into the model.

This interview will probably take about one hour and I'll be noting down your comments so that they can be considered when we develop the plan.

Opening questions

1. What type of work is done here?
2. How many employees do you have?
3. What is the major cause of accidents and incidents?
4. Describe the rehabilitation process here?
5. How is it working?
6. Is it formalised? *(If it is, please obtain a copy.)*
7. What's good about the program; why?
8. What's not good and/or what hasn't worked in the past that you've rectified?

Management commitment

9. Who's responsible for the rehabilitation program?
10. Is their performance in carrying out their responsibilities monitored? If yes, how?

Consultation

11. How was the rehabilitation policy and program put together? Who was involved?
12. How were staff informed about it? How is staff informed of OHS and rehabilitation issues? *(Please obtain copies of any promotional materials.)*

13. How do you keep staff up to date about new work practices, and changes in the work environment?

14. How do you hear about OHS /rehabilitation issues?

15. Do you have an OHS committee? Are they active?

Reporting

16. Do you have a standard:

Incident/accident report?	Y/N
Incident/accident investigation report?	Y/N
First aid report?	Y/N
Safety audit checklist?	Y/N
Maintenance report?	Y/N

(Please ask for a copy.)

17. Who reviews these?

18. What happens then?

Rehabilitation procedures

19. When does the rehabilitation process start?
(With the incident report, the injury report, when a WC claim is lodged, in the case of a non-work-related injury?)

20. Do you have a standard format for rehabilitation plans?

21. What process is used to identify suitable duties for people on rehabilitation?

22. Do you use external rehabilitation providers?

23. Who monitors their performance and how is this done?

24. How and how often are return to work plans monitored?

25. By whom?

26. What are the barriers to rehabilitation is this industry?

27. What are some of the difficulties rehabilitation causes the meat industry?

28. What would you find helpful?

OHS/rehabilitation training

29. Who is given training in OHS and rehabilitation?

30. Is there a specific budget for OHS/rehabilitation training?

31. Who do you go to for advice, support, mentoring if you have a difficult rehabilitation issue?

Planning and review

32. What indicators does the organisation use to measure the success of the rehabilitation program? Do you know the average duration of claims? *(If they don't, ask them if they could call their WC insurer while you're still at the site to obtain the information on claims duration.)*

33. How and when is the program reviewed?

34. Do you have an overall OHS plan?

35. Does the OHS and rehabilitation plan link with the overall business plan?

36. Are employees on rehabilitation programs considered when staff numbers, rosters, task allocation and other aspects of work organisation are planned or are they considered separately?

Uptake

37. We're developing a best practice plan for rehabilitation. Would you be interested in it?

38. Once we'd developed it, what would be the best way to get it to you? *(External industry channels.)*

39. What would you do with it then? *(Internal industry channels)*
    (Prompts)
    Formal training?
    Using OHS and rehabilitation manuals and guidelines?
    (Any available?)
    Informal discussions at team meetings?
    Handbooks for learning when experiencing rehabilitation ?

40. Is there anything else that you'd like to add?

Thanks for your time and assistance.

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Compensation Manager
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Rod Beers/owner
Alan Hutchings
HR/OHS Rehabilitation
Manager
Beers Abattoirs

Andrew Westlake
Manager
Midfield Meat International

Michelle Atkins
E.G Green and Sons
Consultant Occupational Therapist/Rehabilitation Coordinator

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Hardwick Meat Processors
Kyneton VIC

Ashley Muller
South Bernett Meat Works
Murgon QLD

Des Archie
Q Meat
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Trish Richardson
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Watsons Foods