NOVA

University of Newcastle Research Online

nova.newcastle.edu.au

James, Carole, Southgate, Erica, Kable, Ashley, Rivett, Darren A., Guest, Maya, Bohatko-Naismith, Joanna, "The Return-To-Work Coordinator role: qualitative insights for nursing". Originally published in Journal of Occupational Rehabilitation Vol. 21, Issue 2, p. 220-227 (2011).

Available from: <http://dx.doi.org/10.1007/s10926-010-9270-4>

The final publication is available at www.springerlink.com

Accessed from: <http://hdl.handle.net/1959.13/920738>

Title: The Return-To-Work Coordinator role – qualitative insights for Nursing.

Authors: Carole James¹; Erica Southgate²; Ashley Kable³; Darren A. Rivett¹;
Maya Guest¹ & Joanna Bohatko-Naismith¹

Running title: The RTW Coordinator role – qualitative insights.

Correspondence:

Carole James

School of Health Sciences, University of Newcastle, University Drive, Callaghan
NSW 2308.

Tel – (02) 49216632

Fax – (02)49216998

Email – carole.james@newcastle.edu.au

¹ School of Health Sciences, Faculty of Health, University of Newcastle, NSW, Australia

² School of Education, Faculty of Education and Arts, University of Newcastle, NSW, Australia.

³ School of Nursing and Midwifery, Faculty of Health, University of Newcastle, NSW, Australia.

Abstract

Introduction:

Few studies have examined the role of RTW Coordination from the perspective of RTW Coordinator's. Furthermore there is little health specific literature on returning injured nurses to work despite the critical workforce shortages of these professionals. The study aimed to examine barriers and facilitators identified by the RTW Coordinator to returning injured nurses to work and influences on specific health sector or geographic location. The study sought to gain insights into the professional backgrounds and everyday work practices of RTW Coordinators.

Method:

Five focus groups were conducted in metropolitan and rural areas of NSW, Australia. Twenty five RTW Coordinators from 14 different organisations participated in the study. The focus groups included participants representing different health sectors (aged, disability, public and private hospital and community health).

Results:

The data analysis identified information pertaining to the qualifications and backgrounds of RTW Coordinators; the role of RTW Coordinators' within organisational structures; a range of technical knowledge and personal qualities for RTW Coordination and important elements of the case management style used to facilitate RTW.

Conclusions:

The findings identified a wide range of professional backgrounds that RTW Coordinators bring to the role and the impact of organisational structures on the ability to effectively undertake RTW responsibilities. The study found that interpersonal skills of RTW Coordinators may be more important to facilitate RTW

than a healthcare background. A collaborative case management style was also highlighted and the difficulties associated with juggling conflicts of interest, multiple organisational roles and the emotional impact of the work.

Keywords: Workplace based return to work; RTW Coordinators; Health Sector;
Qualitative

Introduction

Rates of occupational injury amongst nurses are an important professional issue for the health care workforce (1). Internationally, the prevalence of work related back injury in nursing is amongst the highest of any profession (1). Stress is also not uncommon in this profession and this may contribute to increase mental health diagnoses and to some forms of physical illness (2). A critical shortage and attrition of nurses is recognised as a key issue in health care internationally (3-5). In addition, the ageing of the nursing workforce, combined with the above factors, confirms the importance of successful return-to-work (RTW) of injured nurses to retain nurses in the workforce.

In a number of industrialised nations, the workers' compensation systems require that a designated person (internal or external to an organization) facilitate the RTW process for injured workers (6). Research has demonstrated that RTW interventions that include RTW Coordinators result in shorter durations of disability for injured employees and lower costs for employers (7). Shaw et al's recent review of the literature (6) identified the importance of understanding the complexity of the RTW Coordinator role in the effective management of disability and the types of competencies these professionals require. This review called for qualitative research to investigate the range of competencies required; to evaluate the context and setting of RTW Coordinators and how this impacts upon their effectiveness. MacEachen (8) supports the call for qualitative research in this area as it can examine day-to-day workplace realities of RTW programs and emphasize the physical, social and

organisational factors that impede or facilitate the process. Other research has highlighted the need to investigate industry specific workplace factors and how these impact upon RTW outcomes (9).

The present study responds to the recommendations by Shaw et al (6) by investigating both the role and competencies of RTW Coordinators who manage injured nurses and how these impact upon returning injured nurses to work. Few studies have documented the RTW Coordinator role, from the perspective of those who undertake this occupation (10). The importance of understanding the perspectives of key actors in the RTW process has been emphasised (11). This study uses a qualitative method of focus groups to capture the perspectives of RTW Coordinators working with injured nurses in New South Wales (NSW), Australia.

In NSW, Australia, RTW Coordinators are responsible for developing and implementing a return to work program, educating the workforce, keeping statistics and developing policies to improve systems. They also liaise with the injured worker, doctor, and insurer to coordinate and monitor progress in treatment and RTW (12).

The focus group study aimed to understand the range of professional and personal qualities that RTW Coordinators themselves suggest are essential to their role and the RTW process.

Method

Following approval from the Institutional Human Research Ethics Committee, focus groups were conducted as part of a larger study investigating occupational rehabilitation of injured nurses. Focus groups involve assembling groups of

individuals to discuss and comment on specific topics (13). Five focus groups were conducted in metropolitan and rural areas of NSW, Australia. The focus groups involved RTW Coordinators who had responsibility for the RTW of injured nurses in large health organisations. This method of data collection was chosen as it allowed for interaction between professionals who, while undertaking the same role, had wide variance in their qualifications, work experience, and the type of health organisation in which they were employed. The collective, interactive aspects of the method enabled participants to query each other and prompts explanations of practices, beliefs and attitudes (14).

Participants.

Legislation requires that employers with more than 20 employees have a designated RTW Coordinator in this jurisdiction. This individual assists injured employees return to work in a safe and durable manner and has undergone a two-day training course, for which there is no pre-requisites. The training course includes information on legislation and the regulators framework and procedures for notification and documentation of injury and RTW.

A purposive sampling framework was used to recruit participants (15). We aimed to capture a breadth of experience from several contexts: ownership (public, private and charitable); type of health organisation (government health service, private hospitals, aged care facilities and disability services); and geographic location (metropolitan and rural) (16). To be included in our study, RTW Coordinators needed to be currently employed as a Workplace RTW Coordinator in either a government health service, private hospital, aged care facility or a disability service; have worked within the last

12 months on a rehabilitation matter with a registered nurse; and be reasonably proficient in spoken English.

In all 25 RTW Coordinators from 14 different organisations participated in the study. These RTW Coordinators had a mean of 6 years experience in this role (range 6 months – 15 years). Table 1 displays the profile of RTW Coordinators who participated in the study.

All RTW Coordinators who participated in this study were employees of the organisations we contacted. No external contractors participated in this study.

Procedure

A letter with an information sheet inviting participation in the study was sent to the RTW Coordinator and Chief Executive Officer of large healthcare organisations inviting participation in the study. Focus groups of 1-1.5 hours duration were conducted between September and October 2008. A schedule of questions and prompts developed from the research literature guided the discussion. These questions and prompts covered professional background of RTW Coordinators; barriers and facilitators in the process; and factors that assist or impede RTW unique to specific workplace, health sector and geographic location. There was also time during the focus groups for RTW Coordinators to raise other issues of importance. An experienced moderator and scribe from the research team attended each focus group. The positive influence of a skilled moderator on the quality of focus group data has been advocated in previous research (17). Prior to the commencement of each focus group, participants completed consent forms and had the opportunity to discuss any issues with the researchers. Participants could withdraw from the study at any

time. Focus group discussions were audio recorded and transcribed. Transcripts were “cleaned” of any identifiers (people, place or organisation names). Pseudonyms are used in this paper.

Data Analysis

The focus group data were initially analysed according to a group meeting process, whereby the researchers read the transcripts, and coded them according to key themes, categories and issues. The group discussed and debated the categories they had created, collapsing and synthesizing these over a series of meetings. This ongoing dialogic process lead to what Kvale calls “intersubjective agreement” on final codes (18). The most experienced qualitative researcher then coded all transcripts for data entry into (19). Key themes were checked for “confirming and disconfirming evidence” within the data set to check the validity of the interpretation (20).

Results

Qualifications and background

Participants in our study came from a wide range of professional backgrounds and all worked for the organisation as employees. Commonly they had a history of working in the workers’ compensation insurance industry, human resources, or had an occupational health and safety, allied health or nursing background. To be a RTW Coordinator in NSW, Australia, they are required to undertake a two-day training course (21). All participants had completed this course, and many indicated that they would benefit from ongoing professional development but, in many instances this was

not available. This was particularly apparent for RTW Coordinators who were not situated in well-resourced teams. Some RTW Coordinators, who were nurses themselves, thought that their professional background gave them credibility with injured nurses. Others disputed this, and thought that generic professional qualities were essential to the job. This difference may reflect the sample in our study and the different backgrounds of the participants, however medical knowledge was not considered essential to the RTW Coordinator role by our participants, despite this being identified as a core competency in the literature (6).

RTW Coordinators within organisational structures

RTW Coordinators were not positioned within organisational structures in a standardised way. Some RTW Coordinators were located within human resource divisions while others worked in large multidisciplinary occupational health and safety teams or risk assessment units. This integrated approach was not, however, the norm. Indeed the variation between organisational approaches to RTW was considerable. Organisational approaches varied from well-resourced and highly supported RTW systems to poorly resourced RTW Coordinators who were unable to do the job effectively due to their part-time status or because the RTW position was just one of many “hats” or roles they assume in the workplace.

“I work as a full time registered nurse...(S)o I do administration work where I’m in charge of the hospital, on shift; so I do all that type of work. (I) manage the staff....I do rostering, and I do safety officer as well, and I do staff immunisation (and) staff health. So hats are coming on and off...in my

working day. It can be hectic, but I keep on top of it” [*Barbara, rural, private hospital, 6 years experience*].

While ‘Barbara’ kept on top of her workload, other RTW Coordinators considered that ‘juggling many jobs’ was detrimental to their ability to effectively perform the RTW Coordinators role. Adequate resourcing of the RTW Coordinators was considered key, particularly in large, complex or multi-site organisations. In addition, some RTW Coordinators were employed in a part time capacity, which did not reflect the size of the workload generated by the organisation. For example, one participant working part-time managed 480 employees across aged care, disability and community sectors in a rural setting. By her own admission she “fell into the job” coming from a finance background. This participant admitted to feeling isolated in the role and rarely visited injured workers due to a combination of the geographical distance between worksites and her part-time status.

This is in contrast to a full-time RTW Coordinator in the same rural setting who worked for a similar sized organisation locally. This RTW Coordinator was connected electronically to a centralised return-to-work system and team that provided fast, ongoing support and was supplemented by regular site visits from the manager. While some RTW Coordinators felt isolated within their organisation and from networks of peers outside of their organisation, a number were fortunate enough to operate within a supportive team environment. These RTW Coordinators remarked that there were numerous benefits of such an arrangement, including personal and professional support, particularly with emotionally difficult cases and innovative problem solving:

“That’s one of the strengths of the unit (I work in)...We have regular meetings as a group and we look at the difficult (return-to-work) cases as a group...There’s nurses around the table, but we’ve got (a) physio, we’ve got OT’s and we’ve got people from non-medical backgrounds as well. So everyone (in the team) brings different ideas to the table...So I think that’s another strength of the Unit, is that ability to share” [*Alice, urban, government aged and disability services 1 year experience*].

RTW Coordinators recognised they were often the “meat in the organisational sandwich”. They needed excellent negotiation skills and tenacity in dealing with the many and varied stakeholders in the workers’ compensation process, including the injured worker, supervisors and managers, insurer and medical practitioners. Competency in workplace negotiation has been identified as important in the literature (6).

Not only are RTW Coordinators required to have a knowledge of the workers’ compensation system, but also the business implications of increasing workers’ compensation premiums and the budgetary implications of returning nurses to work in a supernumerary capacity. Supernumery duties are those whereby the injured worker returns to work as an ‘extra’ on shift completing duties appropriate to their injury. This process relieves the co-workers of having to ‘fill the gaps’ of an injured worker returning with restrictions as part of the normal shift numbers. As Kelly, a rural RTW Coordinator with 6 years experience remarked:

“If you have large premiums and you have financial targets or accountability, (it) can be, you’re kind of in the middle of it a little”.

For many RTW Coordinators in our study it was important to return injured nurses to work as quickly as possible and this often occurred in a supernumerary capacity.

“Nursing in (our organisation)...is the only area that does this supernumerary thing for people in suitable duties. All other departments don’t get that luxury, so they just run short. [*Glenn, urban, government aged and disabilities service, 6 months experience*].

RTW Coordinators recognised the business case for returning nurses to work in a supernumerary capacity to avoid losing them from the nursing profession, due to the significant shortage of nurses. This is indicative of research that indicates that a core competency of RTW coordination is a knowledge of business and legal aspects of workers’ compensation (6, 22).

Combining technical knowledge and personal qualities

The RTW Coordinators who participated in our study emphasised that timely and successful return-to-work of injured nurses was not only a result of technical knowledge of the workers’ compensation process, but was also contingent upon the personal qualities they brought to their role.

Technical aspects of the role included knowledge of the workers’ compensation system, knowledge of the organisational structure of the workplace and business

aspects, as well as an understanding of the importance of early RTW based upon the use of suitable duties. RTW Coordinators recognised that return to suitable duties involved recognition of the importance of undertaking some clinical work for nurses, because nurses valued this highly, as well as understanding that any successful RTW on suitable duties required meaningful negotiations with all the stakeholders. RTW Coordinators who took part in our study were consistent with recommended best practice with regards to offering meaningful modified work (23). They indicated that providing suitable duties was not just a technical process but also an interpersonal one, which required insight into the injured nurse's situation:

“I mean the longer you're out the harder it is to come back. People need to see you back contributing. You need to feel good about yourself. People are worried about losing skills. They are petrified about coming back and losing skills, which is where light (suitable) duties are so important. To get people back in a capacity that's manageable. (It's) giving them self worth” [*Xavier, rural, government health services, 3 years experience*].

Personal qualities that were identified were the ability to openly and empathetically communicate with injured workers, coupled with “broad shoulders” capable of carrying the emotional outpourings of people who are distressed and in pain. Maintenance of confidentiality was considered paramount; this was consistent with findings in other studies (22, 24). Moreover, RTW Coordinators considered that they needed excellent negotiation skills and tenacity in dealing with the many and varied stakeholders in the workers' compensation process, particularly medical practitioners. RTW Coordinators also noted a need to “follow through” with actions so that trust

was maintained with the injured worker (25). A proactive, “can do” attitude was considered vital in achieving good results for all involved:

“(I) think...we’re so proactive. I mean...we get the employee back come hell or high water. It’s only in rare cases we don’t. And I think because you’re there like from the minute something happens and you’ve followed it through and you’re dogmatic about it, you usually get them back” [*Sharon, rural, private hospital, 4 years experience*].

The importance of generating ‘goodwill and trust’ has been mentioned in the literature with active planning and sensitivity to the complexity of the process essential (8, 11, 24). For a number of RTW Coordinators part of creating this goodwill and trust with injured nurses was their willingness to be available “after hours” where injured workers could phone them anytime to receive support. This was specifically important for those suffering significant psychological distress. Early and considerate contact with injured nurses was deemed important as supported in the literature (23, 24).

The role of the RTW Coordinator often involved dealing with degrees of conflict from both internal (managers, supervisors, team members) and external stakeholders (insurer, treatment providers, union representatives). As previously stated, the RTW Coordinator’s role is itself imbued with conflicts of interest, as they are both an advocate and support person for the injured worker and a representative of the employer (26, 27). They suggested that anyone taking up the role needed to be able to manage conflict:

“And when things aren’t successful, or are difficult, don’t take it personally. Because there are a lot of processes beyond your control” [*Clare, urban, private hospital, 2 years experience*].

Case management.

While not using the term case management, the RTW Coordinators in our study described the processes they used for successful RTW which reflected a particular style of case management. This style of case management not only acknowledges the need for timely information provision and support for injured workers, but is fundamentally driven by a “*collaborative* process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs” (28). Many RTW Coordinators preferred a collaborative approach to empower injured nurses. The empowerment of injured workers is recognised in the literature as important in facilitating successful RTW (29-31). This empowerment style of case management, which included a preference for empathetic communication, negotiation and allowing the injured nurse to have control over certain decisions during the process, was generally considered to be very effective in returning injured nurses to work:

“Communication at the first point and then all the way through it is important...Don’t isolate them (injured nurses)...Let them think they’ve got some control in the process...Let them have some buy-in...to make...decisions” [*Frances, urban, private hospital, 7 years experience*].

The case management process acknowledges the whole person and the need to be responsive to an individual's life circumstances, which was particularly important for female nurses with family responsibilities. This knowledge was acquired by forging an early supportive relationship with the injured nurse (6, 24). A range of individual circumstances that might impede the RTW process were identified. For example, while a shift change may initially seem appropriate after injury, this might be reconsidered if the injured nurse has set childcare arrangements or commitments to care for children, grandchildren or older relatives:

“I suppose the fact that some nurses are used to working across seven shifts... some issues with the arrangements (of) childcare and family personal circumstances arise. That is something we work together through and we'll work around and try to accommodate as much as possible. But certainly from a nurse's point of view, often the barriers come from what's going on in their personal circumstances. (You need to work) through that with the worker first before you can actually focus on moving them forwards with their injury” [*Nicole, rural, private hospital, 7 years experience*].

This integrated, collaborative case management approach used by most of our RTW Coordinators, diverges from the case management model that emphasises clinical case management and work related assessment (32, 33). The style of case management identified in our study emphasised advocacy for the injured worker while balancing the demands of the employer and the insurer.

The RTW Coordinators we spoke to also acknowledged that there was often an emotional aspect in this type of case management approach supporting injured nurses who were suffering a high degree of physical and/or emotional pain and distress. Offering support for these individuals could be construed as a form of “emotional labour”(34). Emotional labour "requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others." It requires the RTW Coordinator to maintain a constant measured supportive persona in their role. The nature of some injuries requires the RTW Coordinator to be a support person for extended periods of time and to be available as needed:

“.. actually it’s why I’ve got my phone with me because he’s (injured nurse) a little bit suicidal, I said just ring me any time, because of his injury, so it’s a major issue. It’s a crushing injury... and they’re very difficult, you know..... And it’s one or two particular people who are long-term and especially this staff member that’s a little bit suicidal at the moment because of his injury ...so he’s a little bit forgetful, and ...we’re just trying to get him back on track” [*Barbara, rural, private hospital, 6 years experience*].

Discussion

In our study, the backgrounds of RTW Coordinators varied considerably. In fact very little is known about the backgrounds of this group in the Australian context. A review of the international literature has reported that many countries have RTW Coordinators with some medical and/or ergonomic background (6). This may be the result of different workers’ compensation systems across the world. In our study, we

only captured RTW Coordinators who were employees of a health care organisation and not rehabilitation consultants who provide services to injured workers and their employer as contractors. These consultants in the Australian context do have a medical or allied health background. Our participants did not consider a medical background important to the role, indicating a nursing background was useful for creating empathy but not necessary in relation to medical expertise. This is not consistent with previous research which emphasises the medical and ergonomic competencies of the role (6).

Our study describes organisational differences in which RTW Coordinators operate. This includes wide variation in the way RTW is valued and resourced; the model for injury prevention and management; the leadership and supervisory commitment to the process; the commitment to education of the RTW process within the organisation, and professional development for the RTW Coordinators. In particular, there were large differences in the financial commitment the organisation made, and in the budgetary arrangements for funding both the RTW Coordinators role and supernumerary positions for injured nurses. Some of our RTW Coordinators wore 'many hats' not only holding the role of RTW Coordinator, but also other roles within the workplace, with others being employed in a part-time capacity. These factors affected the ability to effectively complete the job and in some cases impeded RTW process for injured nurses.

Our study provides further understanding of the way organisational structures can facilitate and/or impede the RTW Coordinator's role and as a consequence the successful RTW of injured nurses. Some studies have attempted to crack open the

“black box” of organisational culture in order to understand how it affects RTW (30, 35-38). Our study offers a unique insight into the “black box” of the health care industry, however further investigation of the organisational structure and culture and how this relates to RTW is needed including further study investigating the effect of part-time RTW Coordinator responsibilities for organisations. The issues facing RTW Coordinators in returning injured nurses to work are unique in that they are linked specifically to a workforce shortage. Despite diverse organisational resourcing and approaches to RTW, there is an imperative to rehabilitate and maintain nurses in the workforce. This may be driving the innovative approaches identified in our study. Although not investigated the pressure on RTW Coordinators to develop such approaches may not be as apparent with other workers in the health care sector, or in other industries, and further research could investigate the link between workforce shortage and approaches to RTW.

The identification and provision of suitable meaningful work as part of the RTW process is recognised as a key principle (23, 39). An important part of organisation structure is budgetary allocation for supernumerary duties. Our study identified the importance of ‘supernumerary duties’ as a method of providing suitable duties for injured nurses, to retain them in the workforce and relieve the extra work pressures put on the nursing team. This ‘luxury’ was not always available to all injured workers within health settings but was linked to the shortage of nurses. In our study, meaningful duties included clinical work as nurses valued this highly. Providing insights into the industry specific needs of injured workers has been identified as an area requiring further exploration (40). Our study adds to the body of knowledge for

returning injured nurses to the workforce, and considers the current shortage of nurses.

Some of the RTW Coordinators in our study discussed the supportive team environment in which they worked, which allowed the team to share ideas and assist in problem solving for difficult cases, whilst others worked in isolation. The need to support the RTW Coordinator within the complex process of occupational rehabilitation has not been the emphasis of previous research, this has focused on support of the injured worker, the supervisor and co-workers (11, 22, 24, 30, 41, 42). The benefits of working within a supportive, multidisciplinary team environment have been discussed in relation to medical or clinical settings (43), however further investigation into supportive team work for RTW Coordinators is required.

The RTW Coordinators in our study identified a range of personal attributes such as the ability to gain trust, create 'goodwill' and manage conflict. These were considered as important as having a technical knowledge of the workers compensation system and its business implications. Social problem solving has been identified in the literature as a core competency, however our study adds depth and a different perspective with the RTW Coordinators considering the 'goodwill' factor as a personal as well as a professional attribute (6, 8, 22, 24). Communication skills, confidentiality, empathy and trust are factors that have been identified in our study, and in previous research, as necessary in the RTW process (6, 8, 22, 24). Our study enriches the insights from a recent review of the literature outlining the core competencies required for RTW Coordination in that equal emphasis is given to the

personal attributes and interpersonal dynamics and the technical and procedural aspects of the role.

Few studies document the case management process adopted by RTW Coordinators(44). Our study provides insights into a particular style of collaborative case management used by RTW Coordinators in the process of returning injured nurses to work. We are unsure if this approach was consistent for all types of injured workers, as this study focussed specifically on nurses, who were considered by the RTW Coordinator's as precious and in some cases rare commodities. Much of the qualitative research on injured workers understandably concentrates on the experience of injury from their perspective (29, 31, 41, 45). Often this experience is negative and disempowering. Our research found that there are RTW Coordinators committed to empowering injured workers in the process in spite of the difficulties of juggling potential conflicts of interest inherent in being an employee of the organisation as well as an advocate for the injured worker. There is a growing body of research which looks at emotional labour within organisations and it's impacts upon employees. Our research has identified the emotional labour of RTW Coordinators' and the need for them to receive professional support and training.

Research has identified that there is a space to empower injured workers in the RTW process(8, 46), and in the nursing profession empowerment in workplace decision making is considered essential (5). However, it seemed to the researchers that the RTW Coordinators' in our study discussed processes of empowerment as almost incidental to their practice rather than as a formal framework for action. Professional development which includes frameworks for empowerment should be considered. The

notion of empowering of injured workers requires further exploration with RTW Coordinators. The interest in empowering injured nurses maybe limited to our sample, as the study likely attracted interested, motivated and committed RTW Coordinators.

Conclusion

The qualitative nature of focus groups limits the generalisability of the findings, however the methodology can offer insights into the work practices and attitudes of professional groups who rarely have the opportunity for discussion and debate. Our focus groups brought together RTW Coordinators from different health care sectors, with differing levels of experience working within different organisational contexts. This provided a unique window into the daily work practices of RTW Coordinators who are required to negotiate the needs of multiple stakeholders and deal with injured workers suffering pain and distress. It is a starting point in understanding the issues faced by RTW Coordinators and the importance of the organisational structures in which they work.

Funding: This research was funded under the WorkCover NSW WorkCover Assist Program. The research conclusions are those of the authors and any views expressed are not necessarily those of WorkCover NSW.

Conflicts of Interests: The authors were employees of the University of Newcastle during the conduct of this study. These authors and organisation have no financial interests that may be affected by the content of the manuscript.

References

1. Nelson A, Fragala G, Mensel N. Myths and Facts about Back injuries in Nursing. *American Journal of Nursing*. 2003;103:32-40.
2. Chang EM, Daly JW, Hancock KM, Bidewell J, Johnson A, Lambert VA, et al. The Relationships Among Workplace Stressors, Coping Methods, Demographic Characteristics, and Health in Australian Nurses. *J Prof Nurs*. 2006 2006/2//;22(1):30-8.
3. Duckett D. Health workforce design for the 21st century. *Aust Health Rev*. 2005;29(2):201-10.
4. Senate Community Affairs References Committee. The patient profession: time for action: report on the inquiry into nursing. Canberra: Commonwealth of Australia; 2002 [cited 29/04/2009]; Available from: http://www.aph.gov.au/Senate/Committee/clac_ctte/completed_inquiries/2002-04/nursing/report/index.htm.
5. Hayes LJ, O'Brien-Pallas L, Duffield C, Shamian J, Buchan J, Hughes F, et al. Nurse turnover: A literature review. *Int J Nurs Stud*. 2006;43(2):237-63.
6. Shaw W, Hong QN, Pransky G, Loisel P. A literature review describing the role of return-to-work coordinators in trial programs and interventions designed to prevent workplace disability. *J Occup Rehabil*. 2008;18(1):2-15.
7. Franche RL, Cullen K, Clarke J, Irvin E, Sinclair S, Frank J. Workplace-based return-to-work interventions: a systematic review of the quantitative literature. *J Occup Rehabil*. 2005 Dec;15(4):607-31.
8. MacEachen E, Clarke J, Franche RL, Irvin E. Systematic review of the qualitative literature on return to work after injury. *Scand J Work Environ Health*. 2006;32(4):257-69.
9. Foreman P, Murphy G, Swerissen H. Barriers and Facilitators to Return to Work: A Literature Review. Melbourne: Australian Institute for Primary Care, La Trobe University; 2006 July 2006.
10. Roberts-Yates C. Employers' perceptions of claims/injury management and rehabilitation in South Australia. *Asia Pacific Journal of Human Resources*. 2006;44(1):102-22.
11. Tjulin Å, MacEachen E, Ekberg K. Exploring Workplace Actors Experiences of the Social Organization of Return-to-Work. *Journal of occupational rehabilitation*. 10.1007/s10926-009-9209-9.
12. WorkCoverNSW. Guidelines for Return to work Programs. In: WorkCoverNSW, editor. Sydney: WorkCover NSW; 2010.
13. Powell RA, Single HM. Focus groups. *Int J Qual Health Care*. 1996 Oct;8(5):499-504.
14. Kitzinger J. The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health*. 1994;16(1):103-21.
15. Merriam SB. Qualitative research: A guide to design and implementation. San Francisco: Wiley Press; 2009.
16. Australian Bureau of Statistics. Census geography paper 03/01 ASGC remoteness classification - purpose and use. Commonwealth of Australia; 2001 [July 2008]; Available from: www.abs.gov.au/.../f9c96fb635cce780ca256d420005dc02!OpenDocument -.
17. Fern E. Advanced focus group research. London: sage; 2001.

18. Kvale S. Interviews: An introduction to qualitative research interviewing. London: Sage; 1996.
19. QSRInternational. NVivo 7.0. Doncaster, Victoria.: QSR International; 2007.
20. Erickson F, editor. Qualitative methods in research on teaching. New York: Macmillan; 1986.
21. WorkCover NSW. Guidelines for Employers, Return to Work Programs 2003: Available from: http://www.workcover.nsw.gov.au/NR/rdonlyres/8B77273D-6E45-4246-AE25-353BC2D5F1DA/0/guidelines_for_employers_return_to_work_programs_506.pdf.
22. Holmgren K, Ivanoff SD. Supervisors' views on employer responsibility in the return to work process. A focus study group. J Occup Rehabil. 2007;17:93-106.
23. Institute for Work & Health. Seven 'principals' for successful return to work. 2007 [updated March 2007; cited 31/03/2009]; Available from: <http://www.iwh.on.ca/seven-principles-for-rtw>.
24. Friesen MN, Yassi A, Cooper J. Return-to-work: The importance of human interactions and organizational structures. Work. 2001;17(1):11-22.
25. Roberts-Yates C. Examining the role of rehabilitation in the South Australian workers compensation system. Australian Journal of Rehabilitation Counselling. 2003;9(2):82-101.
26. Kenny. D. Barriers to return to work in New South Wales: Research findings and theoretical considerations. In: NSW WAO, editor. 1995. p. 1-21.
27. Langford E. Buried But Not Dead: A survey of occupational illness and injury incurred by nurses in the Victorian health service industry. The Australian Nursing Federation (Victorian Branch). 1997.
28. Case Management Society of America. What is a case manager and how do I find one? 2009 [cited 2009 18 August]; Available from: <http://www.cmsa.org/Consumer/tabid/61/Default.aspx>.
29. Beardwood B, Kirsh B, Clark N. Victims twice over: Perceptions and experiences of injured workers. Qual Health Res. 2005;15(1):30-48.
30. Baril R, Clarke J, Friesen M, Stock S, Cole D. Management of the return to work programs for workers with musculoskeletal disorders: a qualitative study in three Canadian provinces. Soc Sci Med. 2003;57(11):2101-14.
31. Parrish M, Schofield T. Injured workers experiences of the workers compensation claims process: institutional disrespect and the neoliberal state. Health Sociology Review. 2005 18 March 2005;14(1):33-46.
32. Nadler SF, Mulford GJ, Wagner KL, Stitik TP, Malanga GA, Levy AS, et al. Improving the workers compensation system: case management perspective. Am J Phys Med Rehabil. 2000 Jan-Feb;79(1):97-9.
33. Roberts-Yates C. The Dilemma of the case manager in workers' compensation : Decision-maker, system player, para legal/medical specialist, mediator or enemy? / Christine Roberts-Yates. Brisbane Australian Society of Rehabilitation Counsellors, 2002.
34. Hochschild A. The managed heart: Commercialization of human feeling. Berkeley: University of California Press; 1983.
35. Shaw WS, Robertson MM, Pransky G, McLellan RK. Employee perspectives on the role of supervisors to prevent workplace disability after injuries. J Occup Rehabil. 2003 Sep;13(3):129-42.
36. Roberts-Yates C. Employers' perceptions of claims/injury management and rehabilitation in South Australia. Asia Pacific Journal of Human Resources. 2006;44(1).

37. Andersen LP, Kines P, Hasle P. Owner attitudes and self reported behavior towards modified work after occupational injury absence in small enterprises: a qualitative study. *J Occup Rehabil*. 2007 Mar;17(1):107-21.
38. Seland K, Cherry N, Beach J. A study of factors influencing return to work after wrist or ankle fractures. *Am J Ind Med*. 2006 Mar;49(3):197-203.
39. Institute for Work & Health. Seven 'principles' for successful return to work. Work & Health [online document] [cited 2007 May 2]: [8 screens]2007 March.
40. Foreman P, Murphy G, Swerissen H. Barriers and Facilitators to Return to Work: A Literature Review. Melbourne: Australian Institute for Primary Care, La Trobe University; 2006 [cited 31/03/2009]; 68]. Available from: www.workcover.com/documents.aspx?fno=1353.
41. MacEachen E, Kosny A, Ferrier S. Unexpected barriers in return to work: Lessons learned from injured worker peer support groups. *Work*. 2007;29:155-64.
42. Jansson I, Bjorklund A. The experience of returning to work. *Work*. 2007;28(2):121-34.
43. Higgs J. Communicating in the health sciences. 2nd ed. South Melbourne: Oxford University Press; 2008.
44. Kenny D. Case management in occupational rehabilitation: Would the real case manager please stand up? *Australian Journal of Rehabilitation Counselling*. 1995;1(2):104-17.
45. Sager L, James C. Injured workers' perspectives of their rehabilitation process under the New South Wales Workers Compensation System. *Australian Occupational Therapy Journal*. 2005;52(2):127-35.
46. Gard G, Larsson A. Focus on motivation in the work rehabilitation planning process: a qualitative study from the employer's perspective. *J Occup Rehabil*. 2003 Sep;13(3):159-67.

Table 1 Study Participants

Location	Employer category	Number of participants
Metropolitan (definition)	Public Hospital	3
	Private Hospital	5
	Aged Care Facility	3
	Disability Services	4
Rural (definition)	Public Hospital	5
	Private Hospital	3
	Combined Aged Care and Disability Services	2