When the Injured Nurse Returns to Work: An Institutional Ethnography

by

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Abstract

Nursing is a high risk profession for injury. A Canadian survey reports many nurses are in poor physical and emotional health; they sustain more musculoskeletal and violence related injuries than other occupational groups. In Ontario, an injury management approach called Early Return to Work (RTW) requires injured workers, including nurses, to go back to work before full recovery. The Workplace Safety and Insurance Board cite this approach as beneficial to both the employer and employee. This study uses an institutional ethnographic approach to examine critically the RTW process from the standpoint of injured registered nurses. Through interviews and mapping activities with nurses, other health professionals and managers, a rendering of the social organization of hospital injury management emerges. The findings suggest that the implementation of RTW is complicated and difficult for nurses, their families and hospital employers. Injured nurses engage in significant amounts of domestic, rehabilitation and accommodation work in order to participate in the RTW process. When the returning nurse is unable to engage in full duties hospital operations become disorganized. Collective agreements and human resources procedures limit the participation of injured nurses in creative and/or new roles that could utilize their knowledge and skills. As a result, nurses are assigned to duties, which hamper them from returning to their pre-injury positions and cause their employment with the hospital to be reconsidered. The unsuccessful return of injured nurses to employment is counter to provincial retention initiatives, which seek to sustain an adequate cadre of nurses ready and able to care for the increasing health care needs of an aging population. Sites of change which could support and promote the successful return of these injured workers to nursing work are identified in this study.

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Note to the reader

Many acronyms, technical terms, and language specific to institutions and organizations are incorporated into this dissertation. To assist in navigating these terms, a glossary has been provided. Most of the definitions come from official documents and texts (Smith, 2009) associated with health care in the hospital sector, workers' compensation, provincial legislation and institutional ethnography. In sections of the dissertation, passages from official texts are used to illustrate a point or make an empirical observation. Passage from official documents are encased in a box and written in Arial font (see below).

Official text, official text, official text, official text. Official text, official text, official text, official text. Official text, official text, official text, official text (reference citation)

In contrast, informant interview is presented in an italic font.

Informant dialogue, informant dialogue (informant category)

Glossary

Term	Definition
Accommodation (WSIB discourse)	Accommodations may involve any modification, assistive device, or combination of the two, with the goal of making the essential duties of the pre-injury or alternative employment consistent with the worker's functional abilities (Workplace Safety and Insurance Board of Ontario, 2008).
Adjudication (WSIB discourse)	The process used to determine entitlement to benefits and services under the Workplace Safety and Insurance Act or the Workers' Compensation Act. (Workplace Safety and Insurance Board of Ontario, 2008).
Adjudicator (WSIB discourse)	A WSIB employee who is a decision-maker (i.e. claim approval; access to goods and services; return to work) (Workplace Safety and Insurance Board of Ontario, 2006; 2005).
Available work (WSIB discourse)	Employment that exists with the accident employer at the pre-injury worksite, or at a comparable worksite arranged by the employer (Workplace Safety and Insurance Board of Ontario, 2007).
Barrier (government-boss text)	Anything that prevents a person from fully participating in all aspects of society because of his or her disability, including: a physical barrier; an architectural barrier; an information or communications barrier; an attitudinal barrier; a technological barrier; a policy or a practice (Ministry of Community and Social Services, 2005).
Charge Nurse (union/nursing/ health care discourse)	A RN assigned to coordinate and maintain the smooth functioning of the care provided on a nursing unit during a shift. Responsibilities include: ensuring adequate staffing; assigning nurses to care for patients based on the nurse's skill and the patient acuity; coordinating the medical care for all patients; communicating with other health professionals and hospital departments. The charge nurse is usually a senior staff member. The charge nurse is paid a premium of one dollar ($1.00) per hour in addition to her or his regular salary and applicable premium allowance (Ontario Nurses Association, 2008).
Collective agreement (union discourse)	A labour contract between the employer and a union which sets out the terms and conditions of employee employment such as wages, hours of work, work conditions and grievance procedures. It also outlines the rights of the union within the facility (Ontario Nurses Association, 2008).
College of Nurses of Ontario (nursing discourse)	A provincial organization to which all nurses must belong in order to call themselves a nurse and practice in Ontario. Through provincial legislation, the College of Nurses of Ontario (CNO) is accountable for public protection by ensuring that each nurse is a safe, competent and ethical practitioner. The CNO sets the criteria for becoming a nurse and standards of practice that must be met to maintain that designation (www.cno.org).
Co-operation (WSIB discourse)	Means the employer and worker: 1) maintaining communication with each other 2) working towards identifying a suitable and available job for the worker, and 3) fulfilling reporting obligations to the WSIB (Workplace Safety and Insurance, 2007).
Coordinate (IE term)	People's activities are organized and coordinated purposefully by forces within society. In institutional ethnography the focus on coordinating is extended to language so that it is understood as coordinating individual subjectivities, providing us with a way to avoid using concepts that hide the active of thought, concepts,

	ideas, and so on in people's heads.
Discourse (IE term)	Discourse refers to translocal relations coordinating the practices of definite individuals talking, writing, reading, watching, and so forth, in particular local places at particular times. People *participate* in discourse, and their participation reproduces it. Discourses constrain what people can say or write, and what they say or write reproduces and modifies discourse.
Duty to Accommodate (government- boss text)	The "duty to accommodate" is a legal principle that requires employers to identify and change any rules, practices, expectations, or procedures that have or may have a discriminatory impact based on the Canadian Human Rights Act's prohibited grounds. A duty to accommodate is done on a case by case basis. An employee's right to equality must be balanced with an employer's right to run a productive workplace. (Canadian Human Rights Commission, 2006).
Duty to Accommodate (union collective agreement)	If a nurse becomes disabled with the result that she or he is unable to carry out the regular functions of her or his position, the Hospital may establish a special classification and salary with the hope of providing an opportunity for continued employment (College of Nurses, 2008).
Duty to accommodate obligation (government- boss text)	The employer shall accommodate the work or the workplace for the worker to the extent that the accommodation does not cause the employer undue hardship. **Duration of obligation** (7) The employer is obligated under this section until the earliest of, (a) the second anniversary of the date of injury; (b) one year after the worker is medically able to perform the essential duties of his or her pre-injury employment; and (c) the date on which the worker reaches 65 years of age (Workplace Safety and Insurance Act, 1997).
Early and safe return to work (WSIB discourse)	Employers and workers are obliged under the *Workplace Safety and Insurance Act/Workers' Compensation Act* to co-operate in the worker's early and safe return to suitable and available employment. Workers and employers (the workplace parties), and if possible, health care practitioners, are responsible for resolving return to work issues in the workplace. The workplace parties must co-operate and be self-reliant in achieving an early and safe return to work (ESRTW). The success of ESRTW efforts can be measured by the outcome of the activities of the workplace parties. The goal of ESRTW is an early return to suitable and available employment that is within the worker's functional abilities, and, if possible, restores the worker's pre-injury earnings. The WSIB is not involved in the ESRTW process, except to 1) monitor activities, progress, and co-operation of the workplace parties 2) provide dispute resolution through a mediation service 3) determine compliance with the obligations to co-operate 4) determine compliance with the obligation to re-employ 5) suggest return to work resources that the workplace parties may choose to access (Workplace Safety and Insurance Board of Ontario, 2007).
Employer (government- boss text)	A person who employs one or more workers. This includes someone who contracts for a worker's services (Ministry of Labour, 1997).
Ethnography (IE term)	A research approach used to discover and explore everyday activities and their positioning within extended sequences of action (Devault & McCoy, 2002). IE departs from other ethnographic approaches by treating those data not as the topic or object of interest but as "entry" into the social relations of the setting.

Experience (IE term)	The term *experience* is used to refer to what people come to know that originates in people's bodily being and action. Only the experience can speak of her or his experience.
Family physician's role in return to work (WSIB discourse)	Contribute medical information to decision-making e.g. restrictions, limitations, abilities • Discuss Return to Work and task limitations with your patient • Encourage return to work as part of staying active for patients with low back pain • If non-medical barriers are interfering, communicate these to WSIB (Workplace Safety and Insurance Board of Ontario, 2006).
Grievance (union discourse)	Defined as a difference arising between the parties relating to the interpretation, application, administration or alleged violation of the Agreement including any question as to whether a matter is arbitrable (Ontario Nurses Association, 2008).
Health Professional's Progress Report (WSIB discourse)	Sent via the worker when WSIB need to know worker's progress. Ensures continuity of worker's benefits (Workplace Safety and Insurance Board of Ontario, 2006).
Health Professionals report (WSIB discourse)	1st report of injury/illness – always complete for first visit - essential it reach WSIB quickly to decrease delays in claims decision-making (Workplace Safety and Insurance Board of Ontario, 2006).
IE	Institutional Ethnography
Incident report (Hospital discourse)	A text used to report adverse events or near misses (Carayon, 2007).
Injury Management (WSIB discourse)	The use of management type of approaches used to facilitate the quick return of an employee to work (Charney & Hudson, 2004).
ICU (health care discourse)	Intensive care unit.
Institution (IE term)	The term *institution* does not imply that the research is conducted on a particular type of organization. Instead attention is directed at understanding how institutional processes extend across multiple sites to coordinate the local activities and experiences (Devault & McCoy, 2001).
Institutional ethnography	A feminist research strategy developed by Dorothy Smith that uses everyday experience as a lens to examine social relations and social institutions. Power is critically important as an analytical focus which crosses boundaries and provides a view of the social organization that illuminates practices that marginalize. The aim of the approach is to analyse the organizations in action and discover how the social is organized.
IRN	Injured Registered Nurse
Labour Market Re-entry (LMR) (WSIB discourse)	Used when worker cannot return to previous employer – program assists workers to return to workforce at pre-injury wage; services vary with worker need e.g. skills assessment; job search; up-grading, training (Workplace Safety and Insurance Board of Ontario, 2006).
Meredith report (government-boss	A report created in 1913 which provided seminal recommendations to the Ontario government about workers compensation and the creation of a board. The main

text)	principles of the report are: • Collective liability, under which all employers share responsibility for benefits to injured workers; • No fault, under which workers fain the right to benefits without regards to any negligence on their own part, in return for giving up the right to sue; • Industry funding, under which the administrative board has the power to enquire into and re-hear and adjust all issues as necessary; • Security of payments, whereby the workers' claim is separated from the employers' ability to pay and guaranteed by an accident fund under the boards administration; • Calculations of benefits based on wage loss, whereby an injured worker receives benefits based on a calculation of the wages as a result of the injury (Keith & Neaves, 2007; Ministry of Labour, 2009). •
Nurse Case Manager (NCM) (WSIB discourse)	Coordinates/facilitates access to care for worker's with more complex health care needs Information bridge between patient, WSIB team, employer, health care providers Ensures continuity patient's main WSIB contact for health care issues" (Workplace Safety and Insurance Board of Ontario, 2006).
Neonatal intensive care unit (Hospital discourse)	An intensive care setting providing care to sick newborns
Nursing Act 1991 (government- boss text)	This legislation gives the CNO the responsibility for carrying out nursing regulation to protect the public interest. The text contains a scope of practice statement, as well as provisions and regulations specific to the nursing profession. Among these are definitions of the classes of nurse registration, entry-to-practice and title protection regulations, and regulations on initiating controlled acts (Ministry of Health, 1991).
Nursing schedule (health care discourse)	Determined by the hospital (Ontario Nurses Association, 2008)
Nursing supervisor (health care discourse)	A senior nurse responsible for the overall functioning of all nursing services in a hospital during evening, night and weekend shifts.
Occupational Health Nurse (health care discourse)	"The primary role of the occupational health nurse is to coordinate the delivery of comprehensive, equitable, quality occupational health services for workers and worker groups. The context for practice is dynamic and influenced by health policy, cultural, social, economic, political, technological, and environmental issues" (Canadian Occupational Health Nurses Association, 2009).
Patient assignment sheets (health care discourse)	A text created at the beginning of a shift assigning a patient: nurse pair.
Power (IE term)	Institutions are seen as generating power through the coordinating functions of language and texts.
Re-employment reporting obligation (WSIB discourse)	An employer is required to offer to re-employ a worker if: the employer regularly employs 20 or more workers; as a result of a work-related injury, the worker was unable to work; and the worker was continuously employed with the accident employer for at least one year at the time of the injury (Workplace Safety and Insurance Board of Ontario, 2004).

Refusing work (government – boss text)	Health care workers have a limited right to refuse to work in unsafe circumstance due to their responsibility to protect public safety. They cannot refuse unsafe work if the danger in question is a normal part of the job or if the refusal would endanger the life, health or safety of another person (Ministry of Health and Long Term Care, 2005; Ministry of Health 1991).
Regulated Health Professions Act (RHP) (health care discourse)	The RHPA contains procedural codes applicable to all 21 of Ontario's self-regulated health professions. This legislation provides the legal framework for nursing as a self-regulating health profession. It describes scope of practice and controlled acts that nurses are able to perform (Ministry of Health, 1991).
Regulated Nurse (health care discourse)	Regulated nurses are registered nurses (RN), registered or licensed practical nurses and registered psychiatric nurses who are in good standing with their provincial registering nursing bodies. In Ontario, nursing is one profession with two categories, Registered Nurse (RN) and Registered Practical Nurse (RPN). Differences between the two categories are evident in the length of academic preparation, knowledge expectations, patient care management skills and professional judgement (College of Nurses of Ontario, 2009). RNs have a longer academic preparation and engage in behaviours which RPNs are not legally allowed to perform. Often RNs assume leadership roles in health care settings and delegate duties to RPNs.
Ruling Relations (IE term)	The textual venues (such as legislation, governing boards, program planners, management, administration) where power is generated and perpetuated in society across multiple sites (translocal). IE asserts that these relations must be uncovered to reveal and combat "the ideological and social processes that produce experiences of subordination" (Devault & McCoy, 2002, p. 754) for individuals.
Restrictions (WSIB discourse)	Activities that workers have been advised against doing by a health professional. A work restriction may be: cannot lift more that 2kg (Workplace Safety and Insurance Board, 2000).
Return to work (RTW) (WSIB discourse)	A formal process of injury management where the injured worker is reintegrated back to their pre-injury role. Often this process is gradual (Workplace Safety and Insurance Board of Ontario, 2006).
Return to work plan (WSIB discourse)	Workers employed ≥ 1 year & firm size ≥ 20 employees = employer reemployment obligation (Workplace Safety and Insurance Board of Ontario, 2006)
Road to Zero (WSIB discourse)	Strategic plan for 2008 – 2012 *The Road to Zero* represents the WSIB's ongoing commitment to the elimination of all fatalities, injuries and illnesses in Ontario. With this focus, the WSIB will continue to demonstrate a concerted effort to ensure quality and timely health care, fair and equitable compensation and early, safe and sustainable return to work (Workplace Safety and Insurance Board, 2007).
RN (nursing health care discourse)	A registered nurse is a nurse who holds a Certificate of Registration with the College of Nurses of Ontario in accordance with the Regulated Health Professions Act, and the Nursing Act (Ontario Nurses Association, 2008)
Ruling relations (IE term)	The concept of the ruling relations directs attention to the distinctive translocal forms of social organization and social relations mediated by texts of all kinds (print, film, television, computer, and so on) that have emerged and become dominant in the last two hundred years. They are objectified forms of consciousness and organization, constituted externally to particular people and places, creating and relying on textually based realities.

Short term sick leave (Union discourse)	Short-term sick leave plan will provide payment for the number of hours of absence according to the scheduled tour to a total of 562.5 hours (Ontario Nurses Association, 2008).
Short term disability STD (WSIB discourse)	A type of insurance that pays a percentage of an employee's salary for a specified amount of time, if they are ill or injured (outside of the workplace), and cannot perform the duties of their job. Coverage usually starts anywhere from one to 14 days after your employee suffer a condition that leaves them unable to work. Many times, employees are required to use sick days before short term disability kicks in, if it's an illness that keeps them out of work for an extended period of time. This is why there is usually a different policy for short term disability for sickness versus an injury. Also known as wage loss replacement.
Seniority (Union discourse)	"...seniority shall accrue if a nurse's absence is due to disability resulting in W.S.I.B. benefits or L.T.D. benefits including the period of the disability program covered by Employment Insurance (Ontario Nurses Association, 2008). Seniority for part-time nurses shall accrue for absences due to a disability resulting in WSIB benefits, or illness or injury in excess of thirty (30) consecutive calendar days. The rate of accumulation will be based on the employee's normal weekly hours paid over the preceding qualifying twenty-six (26) weeks.
Social organization (IE term)	The purposeful concerting and coordinating of people's actual practices and activities. Distinct forms of coordinating people's doings emerge that are reproduced again and again.
Social relations (IE term)	The actual practices and activities through which people's lives are socially organized. "Concerted sequence or courses of social action implicating more than one individual whose participants are not necessarily known to one another (Smith, 1987, p. 155)".
Staff nurse (nursing /health care discourse)	A registered nurse who provides direct patient care usually in a hospital setting. Patient's admitted to hospital receive care from a staff nurse. Nurses, in staff nurse roles, are in close frequent physical contact with patients as they provide direct care (Statistics Canada, Health Canada, & Canadian Institute of Health Information, 2006).
Suitable work (WSIB discourse)	Is within the worker's functional abilities ;the worker has, or is able to acquire, the necessary skills to perform ;does not pose a health or safety risk to the worker or coworkers, and ;if possible, restores the worker's earnings (Workplace Safety and Insurance Board of Ontario, 2006).
Supervisor (government – boss text)	A person who has charge of a workplace or authority over any worker (Ministry of Labour, 1997).
Texts (IE term)	Texts are documents (any kind of document on paper, electronic file, artistic representation, law, academia, policy) or representations. They have the ability to be reproduced, copied, transferred, and disseminated by different users at different times (Grahame & Grahame, 2000). "Co-ordinates organization of what happens in settings in which the reading takes place and the multiple sites in which the same text is read as well as the local settings of work connected in the ongoing process" (Turner, 2002, p. 309).
Unable to work (WSIB discourse)	Workers are considered unable to work if, because of the injury, they: 1) are unable to perform the essential duties of their pre-injury job, or 2) require workplace modifications or assistive devices to perform the essential duties of their pre-injury job (Workplace Safety and Insurance Board of Ontario, 2006).

Undue hardship (government-boss text)	The term "undue hardship" refers to the limit of an employer's capacity to accommodate without experiencing an unreasonable amount of difficulty. Employers are obligated to provide accommodation "up to the point of undue hardship." This means an employer is not expected to provide accommodation if doing so would bring about unreasonable difficulties based on health, safety, and/or financial considerations. Undue hardship occurs when an employer cannot sustain the economic or efficiency costs of the accommodation. Employers are required to carefully review all options before they decide that accommodation would cause undue hardship. It is not enough to claim undue hardship based on an assumption or an opinion. To prove undue hardship, employers have to provide evidence. (Canadian Human Rights Commission, 2007).
Worker (government-boss text)	A person who is paid to perform work or supply services (Queen's Printer of Ontario, 2002).
Workplace (WSIB discourse)	Any place in, on or near to where a worker works. A workplace could be a building, a mine, a construction site, an open field, a road, a forest or even a beach. The test is: Is the worker being directed and paid to be there, or to be near there? If the answer is "yes", then it is a workplace (Ministry of Labour, 1997).
Workplace modifications (WSIB discourse)	Changes made to the work area, equipment, or tasks to make the job duties suitable for the worker's functional abilities. Modifications may include job re-structuring and altering the way tasks are performed; acquiring or modifying equipment or devices; creating modified work schedules; and making facilities readily accessible to, and usable by, workers (Workplace Safety and Insurance Board of Ontario, 2005).
Workplace Safety and Insurance Board (WSIB discourse)	"Ontario's Workplace Safety and Insurance Board (WSIB) play a key role in the province's occupational health and safety system. The WSIB administers no-fault workplace insurance for employers and their workers and is committed to the prevention of workplace injuries and illnesses. The WSIB provides disability benefits, monitors the quality of healthcare, and assists in early and safe return to work for workers who are injured on the job or contract an occupational disease (Workplace Safety and Insurance Board of Ontario, 2005 p. 3).
Workplace parties (WSIB discourse)	employers and workers The workplace parties must co-operate with each other in the ESRTW process. Co-operation means 1) maintaining communication with each other 2) working towards identifying a suitable and available job for the worker, and 3) fulfilling reporting obligations to the WSIB (Workplace Safety and Insurance Board of Ontario, 2004).

Chapter 1 Introduction to the problem

Nursing work is dangerous and can be hazardous to one's health. A Canadian survey, *The 2005 National Survey of the Work and Health of Nurses* (Statistics Canada, Health Canada, & Canadian Institute of Health Information, 2006), reports that many members of this profession face more physical and emotional sequela and injury incidents than the general population. The provision of care to patients by staff nurses involves close physical proximity work. Nursing work activities such as providing medication, lifting a patient, moving equipment to the patient, interacting with patients and their families in time of crisis, and even breathing the air in a patient's room, can cause nurses to become injured or ill. In Canada, some attention has been devoted to examining systemic issues in health care and their impact on a nurse's health. Work related factors, which contribute to nurses' ill health, include long and irregular work hours, understaffing, overtime, and employment organizational structures. Strategies to prevent, reduce, and/or eliminate identified risk factors and situations have received little attention from health care employers and policy makers.

While the literature affirms nurses are a high risk group for injuries and illnesses, an understanding of how injury management practices shape the lives of nurses has yet to be clearly described. The purpose of this study is to describe how return to work actually *happens* in southern Ontario acute care hospitals from the standpoint from injured registered nurses employed in staff nurse roles. In Ontario, an injury management approach called Early Return to Work (RTW) requires injured workers, including nurses, to go back to work before full recovery. The Workplace Safety and Insurance Board cite this approach as beneficial to both the employer and employee. This study uses an institutional ethnographic approach to examine critically the RTW process from the standpoint of injured registered nurses. Through interviews and mapping activities with nurses, other health professionals and managers, a rendering of the social organization of hospital injury management emerges.

This introductory chapter provides an overview of the context and background that shapes the study. The rationale for the selection of the topic and injured registered nurses (IRNs) as a study group, the research approach and the significance of the study will also be described. Finally the chapter concludes with an outline of the dissertation format.

Background and context

The health of Canadian nurses

Canada has been proactive in attempting to understand the health of the nursing workforce. Federal and provincial government projections anticipate that as the Canadian baby-boomer population ages, the health care system will become overtaxed. Nurses comprise the largest occupational group in the health care sector. Having a healthy cadre of nurses ready to care for the Canadian population as they age is essential to maintaining the functioning of the health care system. Consequently, the Canadian government's Ministry of Industry collaborated with Statistics Canada and the Canadian Institute for Health Information to design a national survey that examined the link between the work environment and the physical and mental health of regulated nurses in Canada.

Almost 19,000 regulated nurses responded to the survey which sought information about their health status such as chronic conditions, pain, self-perceived general and mental health, medication usage, and the impact of their health on the performance of nursing duties. In 2006 the final results of the study were released in a document called *Findings from the 2005 National Survey of the Work and Health of Nurses*. A multivariate analysis was used to examine the association between health care work conditions and nurses' health. Nurses reported a high percentage of back problems, migraines, cardiovascular diseases such as hypertension, diabetes, heart disease, and pain syndromes. The rates of these conditions were more prevalent in the nursing population when compared with the general population. The report attributed the poor physical and emotional health of nurses directly to their conditions of work and other tangible factors such as scheduling, shift work, overtime, not having co-worker and management support, decreased professional autonomy and a lack of respect. The following is a brief summary of key survey findings and other facts of relevance to the context of Ontario nursing.

Canadian nursing demographics

Regulated nurses represent 2% of the total Canadian workforce and female nurses represent 4% of all Canadian women in the workforce. Men make up only 5.5% of the national nursing workforce (Statistics Canada et al., 2006). In Ontario, statistics from the College of Nurses (2009) report that the average age of a RN is 46.3 years and 95.2 per cent of the RN

population are female. A predisposition to poor health is also associated with the increasing average age of this professional group. Aging working Canadians are reported to be more susceptible to the chronic health conditions such as hypertension, diabetes and cancers; a decline in physical capabilities and energy levels; increased stress due to rapid changes in the work environments; and a shift from child care to elder care responsibilities (Human Resources Development Canada, 2002).

The health risks associated with staff nursing work

Over 65 % of RNs are employed in the hospital sector and 66.1% hold a staff nurse positions.   Nurses, in staff nurse roles, are in close frequent physical contact with patients as they provide direct care from admission to discharge (Statistics Canada et al., 2006). The high physical demand of staff nurse work has a direct impact on health and contributes to injuries and poor health circumstances. Everyday patient care activities that can harm nurses include handling needles or sharp instrument, lifting or transferring heavy patients, disruptive patients and family members, physical and emotional threats and exposure to infectious diseases. Nurses missed on average a total of 23.9 days over the course of a year. Unionized work environments report slightly longer work absences.   Back injuries, arthritis and pain are the most common reasons for nurses being absent from work.

In addition to physical injuries, the nurses' reported a high incidence of depression and other mental health problems which interfered with their ability to work. A correlation between mental health problems is associated with evening and night shift work and employment in long term care facilities.   Psychosocial factors associated with this type of work create this effect. These factors include high job strain, high stress levels, low supervisory and co-worker support, low control over practice, poor nurse physician working relationships, a lack of respect from supervisors and co-workers and a high work load (Statistics Canada et al., 2006).

Canadian regulated nurses work eight and/or twelve hour shifts around the clock. Ninety three per cent of Canadian nurses worked 12 hour shifts and most engage in a rotation of days and nights. The consequence of continuous changes in work times result in irregular sleep patterns. Long and rotating shift patterns are also associated with fatigue circumstances which may cause injuries (Statistics Canada et al., 2006).

Fatigue has become a key issue for nursing organizations. In 2010 a research report, *Nurse Fatigue and Patient Safety*, released by the Canadian Nurses Association (CN) and the Registered Nurses' Association of Ontario (RNAO) contends that nurse fatigue threatens patient safety. Occupational health researchers have found that shift work, fatigue and stressful work environments are linked with health hazards such as sleep disorders; depression; breast and gastrointestinal cancer; reproductive health complications; gastrointestinal disorders; cardiovascular disease; psychological distress, mental illness and diabetes (Schernhammer, 2010; Institute for Work and Health, 2010; Sanders & Mustard, 2010). Another major challenge for nurse shift workers is the lack of availability of nourishing food from hospital workplace vendors in evening and night shift hours. This workplace condition may cause the shift worker to make unhealthy food choices and could be associated with health related illnesses and problems such as obesity, diabetes and hypertension which have an increased prevalence in nurses (Statistics Canada et al., 2006).

In sum, by virtue of their proximity work with patients, employment conditions, and an aging demographic trend, nurses are situated in circumstances rendering them susceptible to occupational hazards. These circumstances can jeopardize their health and contribute to illness and injury.

Ontario nursing recruitment strategies

Provincial strategies to recruit and retain qualified nursing staff have been launched in Ontario. A *Nursing Retention Fund*, created through the Ontario Ministry of Health and Long Term Care and the Nursing Secretariat in 2006, provides funds to public hospitals for a six month period to assist in dealing with retention issues and supporting the retraining of nurses. Also, the *Late Career Nurse Initiative* (LCNI) created in 2007, provides nurses over the age of 55 with an alternative to early retirement. The intent of the initiative is to support and retain this group of nurses working in hospitals and long term care setting by providing them with a 20% reduction in their workloads. The impacts of these efforts have yet to be reported. Despite these initiatives, demographic and work environment factors which contribute to the poor health of nurses and increase their risk injury and illness remain unchanged.

When the nurse gets hurt

When a nurse is injured, standard procedure requires the formal reporting of the injury incident to the employer through a formal system. New employee orientation sessions familiarize nurses with this expectation. The injury reporting process is further articulated in hospital policies and procedures. The extent of the engagement and the complexity of the injury management process are dependent on the severity of the injury, the recovery trajectory, and the ability for the nurse to resume full duties in her pre-injury work setting. Some nurses with minor injuries document the incident and return to work without the need for medical assistance. Others, with more significant injuries, require medical attention and time off work for treatment and recuperation.

Nurses who formally report an injury circumstance are hooked into the Occupational Health and Safety (OHS) department of the hospital via an incident report. The role of this department is to promote and maintain the health and safety of all employees, physicians, volunteers, students and contractors who are engaged in work at the institution. To do this the OHS departments provide services such as employment health assessments for new employees, communicable disease prevention clinics, ergonomics worksite evaluations, health education, employee assistance programs, musculoskeletal injury prevention training, and return to work and disability case management services. The OHS department reviews injury incident trends and reports these findings to senior hospital management.

If an injury is significant and the nurse must take time off work, other reports are generated by both the injured nurse and OHS department (as a representative of the employer) linking both to a third party agency called the Workplace Safety and Insurance Board (WSIB). The WSIB is an organization that administers a collective liability system providing compensation for employees who sustain work related injuries and occupational diseases. The financing of this system is based on an insurance scheme structure whereby employers pay premiums to the WSIB that are calculated on the basis of their organizations' injury claim records. Injured employees engaged in the WSIB process give up their rights to sue their employer for the injury. In exchange the WSIB provides disability benefits, monitors the quality of rehabilitation healthcare services, and promotes the return to work of injured workers (Workplace Safety and Insurance Board of Ontario, 2005).

Early Return to Work

Early Return to work (RTW) is a legislated injury management approach in Ontario that requires injured employees to resume paid employment prior to a full recovery from an injury. The employer is obligated to find suitable duties that fit with the functional abilities of the injured employee (Workplace Safety and Insurance Board of Ontario, 2006). These duties and the hours of employment may be different from the pre-injury position of the employee. While many injured workers successfully return to work without incident, some experience significant difficulties in the process (Krause, Dasinger, & Neuhauser, 1998; Eakin, MacEachen, & Clarke, 2003; Baril et al., 2003). For some, the process may be long and require several attempts. For others, the return may never happen due to a discrepancy between the employee's functional abilities and the type of work duties available. Studies have found that the effects of an unsuccessful return to work can have a considerable effect not only on the injured worker but also for their family (Eakin et al., 2003; MacEachen, Ferrier, Kosny, & Chambers, 2008; Tompa, Scott-Marshall, Fang, & de Oliveria, 2009; Dawson et al., 2007).

Why a study about RNs and Return to Work?

In Ontario, a Registered Nurse (RN) is a regulated health professional. This means that in order to call oneself RN the individual must have successfully completed academic and practice preparation at an accredited post secondary institution and pass a national registration examination. Then the individual submits an application requesting registration with the College of Nurses of Ontario (CNO). Acceptance and registration with the CNO allows an individual to call themselves a registered nurse and seek employment using this title. This also means that the RN must adhere to the regulations and standards of practice of the CNO.

The primary role of the CNO is to protect the Ontario public. To do this the CNO sets knowledge expectations, professional codes of conduct and practice standards, in addition to monitoring the overall quality of professional nursing practice in the province. Each Ontario nurse's competence and conduct is monitored yearly through a registration renewal process. This process requires not only an annual payment but also a written declaration of one's ongoing commitment to continually improving their nursing practice. Nurses who fail to meet CNO standards are subject to disciplinary actions. The most severe punishment would be dismissal

from the CNO and a stripping of the registered nurse title. Hence, the actions of a RN are organized by the regulations, standards and requirements of the CNO. The *registered* status and the nursing practice performance expectations set out by the CNO are what make this occupational group distinct and of interest in this research project. All of the injured nurses in this study were RNs who are required to adhere to these regulations at all times – even when they are performing modified RTW duties.

Hospitals, the primary employers of RNs in Ontario, have many expectations, processes, and indicators of performance that are set by external agencies such as the Ministry of Health; Ministry of Labour; Occupational Health & Safety Act; Industrial & Health Care regulations; Public Hospitals Act; the Mental Health Act; the Personal Information & Privacy Act: and Workplace Safety & Insurance Act legislation. The legislated directives of these bodies become the governing roots of the policies and operating procedures that shape not only Ontario hospital work environments, but also the way nurses must work when employed in these settings. These workplace features make the hospital environment of interest in this study.

Identifying the problematic of the research

Institutional ethnographers treat people's lived experiences as the problematic of a research investigation. When this study was proposed the intention was to gain an understanding of the entire injury management trajectory process – from injury incident, to reporting, to occupational health interactions, to WSIB encounters, to return to work and the resumption of full duties. As the study began and conversations with injured nurses were analysed, it became clear that the *return to work* phase of the injury experience was the most troubling for these informants. Their experiences were counter to the WSIB account of the positive benefits of early return to work. The point of disjuncture between the actualities of the injured nurse's experiences and the WSIB organizational accounts of RTW became the focus of the study.

The Researcher's standpoint

Canadian institutional ethnographers Marie Campbell and Fran Gregor (2002) propose that the researcher's "own experience matters" (p. 17) when creating and conceptualizing a study. Hence the topic I selected for this study, injured nurses and injury management, grew from my personal and career experiences as a RN.   Below, I outline how my experiential

knowledge as an injured employee, nurse manager, nursing educator and RN lead to the topic of this study.

My familiarity with nursing injuries began almost 25 years ago when, as a student nurse, I was struck by a patient. The forceful blow of an 85-year old woman with dementia resulted in a bruise on my cheek. While I reported the incident to the nurse in charge of the unit, I received no sympathy for my injury. Instead I was told that such bumps and bruises are a part of "*real*" nursing work. Throughout my nursing career, my body (and those of nursing colleagues) has been injured, hurt and damaged, not only by the daily physical demands of nursing activities, such as lifting a 300 pound pregnant woman onto the operating table for an emergency caesarean section, but also by the emotional turmoil which is the result of being with sick, abused, contagious or dying patients. These everyday occurrences in nursing work - a bruise from bumping into a bed, a sore back lifting many patients, tired feet from a 12 hour shift, or emotional turmoil of tending to patient one minute then finding them dead the next - rarely go reported, as nurses are socialized to accept these conditions as part of the job.

While I have not sustained a workplace injury that required formal WSIB reporting, I have required modifications to my regular nursing duties due to an injury which left me in a wheelchair for six months. At that time I was a nurse clinical consultant with provincial responsibilities in a large community home health care agency. This role required me to travel to various sites via car, train or plane to provide education and training to nurses in various communities. My primary workplace site, a two-storey walk up office building, was no longer accessible to me as a wheelchair user. Identifying the stairs as a barrier to my getting to work was not well received by senior management. I was told "*We are in the business of going out to sick people [in home health care]. They don't need to come to us*". Further questioning about accessibility for employees was met with the response *"We just won't hire employees like that".* When I reminded the vice-president of my mobility challenges, he told me to *"just work virtually at home".* These prejudicial words sparked my initial interest in nurses with injuries and disabilities.

My initial participation in the injury management processes came when I was a nurse manager of a newborn nursery of a large hospital. One experience that comes to the forefront of my recollections was an incident surrounding the return to work of a nurse following a back

injury. The nurse's duties were restricted to lifting only items less than ten pounds. The OHS department felt that finding appropriate nursing duties in a setting would be easy – but it was not. Instead, finding appropriate work that adhered to this functional restriction proved challenging. While the body weights of patients in a nursery are usually (but not always) less than ten pounds, the equipment necessary to provide care in this environment exceeded this weight. This encounter caused me to consider how health care organizations accommodate injured workers.

There have been many experiences in my career as a nurse educator where I have learned from my students. One key experience that influenced the selection of the topic for this study was a sculpture designed by one of my students who was assigned to an occupational health clinical placement in a local hospital (See photograph 1).

The student explains

> *My alternative reflection is a representation of what happens to a nurse's pay if she takes time off due to a work related injury. The left side of the display shows nurse #1 who has injured her back while assisting a patient at work but is still working to receive her pay. On the right side of the display shows nurse # 2 with the same injury, at home resting. Due to an extended leave she has to apply to WSIB (Workman Safety Insurance Board) in which she received 85% of her pay. Due to the fact that she can only be on WSIB for so long, she is afraid that if her pain does not subside she will have to apply to another insurance board one which only covers 55% of her pay. Therefore, this issue is a win/lose situation. If nurse #1 continues to work despite her pain, she receives her regular pay. However she may not be able to properly perform her job and may further injure herself. If nurse # 2 takes time off to heal, physically she feels better, but receiving less of her pay becomes a financial stress in her life (Julia, B. 2005).*

Of all of my student assignments, I was particularly touched by this student's work – not for the aesthetic value, but for making visible an unexplored everyday challenges that nurses face in injury management and clinical practice. This student's insight drew me to the topic of this study.

(Photograph 1a: The cost of a nurse being sick. By Julia B. Third year nursing student. This photograph reproduced with permission)

The research approach

The goal of this study is to empirically explore the process of return to work (RTW) from the standpoint of registered nurses employed in Ontario acute care hospitals using an institutional ethnographic mode of inquiry. Institutional ethnography (IE) (Smith, 1987; 1990; 1999; 2005; 2008; Campbell & Gregor, 2002; Diamond, 2006) is an analytic approach that begins to investigate the social determinants of people's everyday experience as a way of viewing institutional processes. It is important to note that when using an IE approach the object of study is not individual people but, rather, the social relations of institutions that form the ground of people's experiences. "Institutional ethnographers believe that people and events are *actually* tied together in ways that make sense of such abstractions as power, knowledge, capitalism, patriarchy, race, the economy, the state, policy, culture and so on" (Campbell & Gregor, 2002, p. 17). This emergent and transformative mode of social inquiry has proved useful when investigating organizational and institutional processes in health care (Rankin & Campbell, 2006; 2009; Campbell, 1994; Mykhalovskiy & Weir, 2004; Diamond, 1992).   The six injured nurses interviewed in this study begin to map out the social processes and governing structures of RTW. In addition, 22 individuals with key roles to play in the RTW process were interviewed, and a review of numerous publicly accessible documents relating to injury management and nursing policy were conducted. These data collection strategies enhanced the mapping of the social organization of the RTW processes in the hospital setting.

Significance

This study is both relevant and innovative because it addresses a significant nursing issue by focusing attention solely to the expertise of injured registered nurses' who have encountered injury management regimes in hospitals. The findings suggest that the implementation of RTW is complicated and difficult for nurses, their families and hospital employers. Injured nurses engage in significant amounts of domestic, rehabilitation and accommodation work in order to participate in the RTW process. When the returning nurse is unable to engage in full duties hospital operations become disorganized. Collective agreements and human resources procedures limit the participation of injured nurses in creative and/or new roles that could utilize

their knowledge and skills. As a result, nurses are assigned to duties, which hamper them from returning to their pre-injury positions and cause their employment with the hospital to be reconsidered. The account presented in this study is not consistent with the WSIB rendering of the benefits of early RTW.

Study Overview

The remainder of this dissertation is organized as follows:

Chapter Two provides an overview and synthesis of the literature in two parts. Part 1 describes the broad thematic areas that emerged: 1) Canadian nurses and their health; 2) the socially organizing structures creating disability and injury; and 3) injured worker research. Part 2 describes how institutional ethnography is used in research and identifies the merits of this type of approach.

Chapter Three introduces and explains some key theoretical terms and assumptions that underpin an institutional ethnographic approach.

Chapter Four describes the specific recruitment, data collection and analysis strategies used in the study.

Chapter Five presents the historical context of Ontario workers' compensation and the institutional policies that shape the return to work of the IRN interviewed in this study.

Chapter Six, called *The (in)visible work of return to work,* takes up Smith's notion of work and describes the actualities of the efforts of nurses as they engage in return to work. This is the first analytic goal of an institutional ethnography. Three types of work are revealed: domestic work, injury work and injured nursing work.

Chapter Seven focuses on the second analytic goal of an institutional ethnographic account - to use informant stories to bring into view the institutional fields in which they are located for the purpose of identifying institutional sites and discourses (McCoy, 2006). Building from the discussion of the (in)visible work of return to work, the chapter describes how institutional sites, processes and discourses shaped the injured nurses experiences.

Chapter Eight, the conclusion and discussion of the findings, reinforces how return to work expectations superimposed on the efficiency discourses of hospitals disorganizes return to work for both the IRN and employer. This contributes to the IRNs being unsuccessful in

returning to their pre-injury positions. The limitations and areas for future research are also described in this chapter.

Chapter 2: Literature review and synthesis

Introduction

This chapter presents a synthesis of relevant literature.   The chapter is in two parts. Part 1 presents the broad thematic areas that emerged: 1) notions of injury and disability; 2) injured worker research; 3) Canadian nurses and their health; and 4) factors contributing to unhealthy workplaces. Part 2 of the chapter describes various institutional ethnographic studies which inquire into the social organization of everyday society. The chapter begins with a description of the literature search strategy used to expose relevant literature.

Search Strategy

A systematic literature search was conducted prior to data collection (October 2007) and again during the write up phase of the study (October 2009). At these times electronic databases, working papers published by the WSIB's centres for research expertise, Ontario legislation, seminal texts and texts that informants referred to during data collection were reviewed. Nine databases were searched from 1990 (the time when research on workplace safety began to emerge in Ontario) to October 2009: Proquest Nursing, Proquest Dissertations, MEDLINE, CINAHL, EMBASE, PsycInfo, Sociological Abstracts, ASSIA (Applied Social Science Index and Abstract, and ABI (American Business Index). Searches were also conducted in Canadian and Ontario key nursing web sites including: The Canadian Nurses Association; The College of Nurses of Ontario; and the Registered Nurses Association of Ontario.

Following consultation with the library staff at the University of Toronto, a modified PICO (population; intervention/exposure; comparison/case type/condition; outcomes) approach (Schardt, Adams, Owens, Keitz, & Fontelo, 2007) was used to refine and enhance the search approach taken in October 2009. In this strategy several key terms that best describe the topic of the study were developed. As well key terms, used by the primary and secondary informant during interviews, were added to the table. The following table provides a summary of the PICO strategy and terms incorporated into the search.

PICO search strategy

P	I	C	O
• Registered Nurse • Reg. Nurse • RN • Registered Practical Nurse • Regulated nurse • RPN • Practical Nurse • Nurse • Health care worker • Health care professional • Health care provider • Care provider • Occupational health • Occupational health nurse • Occupational health coordinator • Return to work coordinator	• Injury • Disabled • Infected • Hurt • Accident • Impairment	• Accommodate • Modified • Fail • Success • Quality of Life • Full time • Part time • Casual • New graduate • Mid career • End of career • Back • Neck • Shoulder • Arm • Hand • Knee • Hip • Ankle • Needle stick • Infection • HIV • AIDS • Hepatitis • TB • Tuberculosis • Gastroenteritis • Diarrhoea • Diarrhoea • Cold • Flu • Lift • Intervention • Violence • Abuse • Patient abuse • Staff safety	• Return to work • RTW • Disability pension • Terminated • Long term disability • Short term disability • Sick time • Injury management • Disability Management • Workers compensation • WSIB • Hospital • Health care setting • Community health • Public health

Boolean operators and truncation techniques were also used. The search was limited to English language documents. Special attention was paid to finding qualitative studies as the majority of returns were studies that took a quantitative approach. All studies produced were sorted for appropriateness using titles and abstracts.   In some cases, the bibliographic data from relevant studies were reviewed to find other sources or seminal works. A total of 23 studies in the October 2007 search and 84 studies in October 2009 were yielded and deemed of relevance to this study. This increase in studies generated on the second review can be attributed to the more sophisticated and comprehensive search strategy. Information from the articles was recorded in a study summary table located at Appendix D3.

PART 1

Discourses of disability

Injured workers can experience temporary and in some cases permanent disabilities. Various models, definitions and discursive notions of disability circulate, and compete in Western culture (Barnes, 1998; Cassidy, Lord, & Mandell, 1998; Corker & French, 1999; Longmore, 2003; Priestley, 2003). While there are numerous discourses of disability, two seem prominent in the literature and of relevance to injured workers: the biomedical and social approaches to disability.

Biomedical Approach

According to Davis (1998), a biomedical model of disability dominated academic discussions prior to the 1980's. This approach hypothesizes norms in appearance, ability, mobility, and promotes the need to normalize people with disabilities through medical interventions (Butler & Parr, 1999).   Within this discourse, disability is constructed as residing within the individual and stemming directly from physiological, functional or cognitive inadequacies or failure. "Medically oriented cure and care agendas" (Fawcett, 2000, p. 17) are central to this orientation.   Health care professionals hold power in deeming people normal (able bodied) or abnormal (disabled). According to this approach, people can achieve some degree of normalcy if they adhere to medically prescribed rehabilitative therapies and medical treatments.

Critics of this medicalized construction of disability declare this approach limits the full participation of people with disabilities in all aspects of society and leads to oppressive and discriminatory practices (Barnes, Mercer, & Shakespeare, 1999; Crow, 1996; Terzi, 2004). Hughes and Paterson (1997) critique this medical view of people with disabilities as a specific consequence of physical dysfunction. For example, people with disabilities who wish to participate in work activities may be required to complete a physical assessment and demonstrate their functional abilities and/or provide medical documentation to prove eligibility and fitness for work. In higher education, certificates verifying a student's disability status are required in order to secure accommodations and access to disability support services (Jung, 2003). Injured workers experience similar requirements. Lippel (1999) verifies that injured workers must secure medical documentation to confirm their injuries and the need for accommodations. A worker claiming they are injured is insufficient.

A new outlook that is gaining prominence argues people are disabled by a social system which erects barriers to their participation (Barnes et al., 1999). This notion leads to social models of disability.

Social Approaches

Social approaches to disability, in contrast to the above individual/biomedical approach, views disability as a socially constructed form of oppression (Barnes, Mercer, & Shakespeare, 1999b).

> The social model asserts that it is not the individual's impairment which causes disability…or which is the disability….and it is not the difficulty of individual functioning with physical sensory or intellectual impairment which generates the problems of disability. Rather it is the outcome of social arrangements which work to restrict the activities of people with impairments (Thomas, 1999 p. 14).

The notion of disability in this context can be taken up in relation to gender (Morris, 1996), age (Priestly, 2003), impairment (Scott, 1969), ethnicity (Gilbert & Yerrick, 2001) and sexuality (Shakespeare, 2000) and so on. Hence, the plural *approaches* are used in most discussions of social models. Common to all approaches is a perspective where social practices, policies, cultural norms, values and attitudes towards people categorized as disabled give rise to organizing and governing structures that can shape and structure their lives (Priestley, 2003;

2001). Hence, the problem of disability shifts from the individual (as seen in the biomedical approach) to society within this approach. Disability becomes re-conceptualized as a socially constructed relation of difference (Thomas, 1999) and a social category of diversity (DePoy & Gilson, 2004). Disabling barriers (such as environments, attitudes, institutions, policies and practices) shape the experience of people with perceived impairments.

Several researchers have discussed the effect that the social organization of injury and disability management systems may have on people. Scott (1969) in his seminal work on blindness reveals that people learn to assume the social roles associated with being disabled through interactions with institutions and organizations that shape their activities and conduct. For example, social service organizations that provide services for the blind set up systems that reinforce the belief that blind people are helpless, dependant, and in need of services. Societal expectations are reinforced continuously not only in the lives of the blind but also in the lives of the sighted. He suggests that various "attitudes and patterns of behaviour that characterize people who are blind are not inherent but are acquired through social learning" (Scott, 1969 p. 23). Carried within the notion of blindness are "a series of moral imputations about character and personality" (p, 24).

This socialization process seems evident in the lives of injured workers as well and discursively conjures notions that these individuals are malingering, dishonest, and unwilling to work (Tarasuk & Eakin, 1994). Dembe's (2001) in the presentation of the social context of occupational injury and disease contends that these notions have an implicit social consequence in occupational injury, illness and disability management and extends beyond the individual to family members, co-workers, medical care providers, disability management agents and the community. It is suggested that the injured worker engages in a "web of reciprocal relationships" (p. 404) which can reinforce these notions (see next figure).

Summary of Dembe (2001)

Dembe (2001, p. 404) Injured worker's web of reciprocal relationships: The social context of occupational injuries and illnesses

Macroeconomic and Political Conditions
Recession, prevailing political climate, legal system, etc

Macrosociological Considerations
Social inequities, class and race relations, gender roles etc.

Workers' groups
- Labor Unions
- Workers with similar jobs
- Advocacy groups
- Coworkers

The Workplace
The employer ↔ Workers
→ Work conditions and methods

Workers' Compensation Insurance
- Insurance Investigator
- Lawyers
- Courts
- Regulators

Individual worker sustains occupational injury or illness

Medical Profession
- MDs & other providers
- Health care plans & systems
- Case Manager

Other benefit plans: Social security, group health, unemployment, STD, LTD

Behavioral response: depression, drugs, anger, etc

Functional response: impairment, disability pain etc.

Vocational response: absenteeism, lower wages and productivity etc

Community
School, churches, markets, political activities, housing, education, technologies, media

Worker's family & friends
- children
- Spouse
- parents
- friends
- colleagues

More recently Eakin (2005), a Canadian academic with research interests in workplace injuries in small businesses, writes that the current context of occupational health, workers compensation and return to work practices have an iatrogenic or adverse effects on injured workers. She explains that a "pervasive discourse of abuse" (p.169) surrounds injury management practices in Ontario. The discourse of abuse is described by Eakin as an "institutionally embedded expectation that injured workers in the work injury compensation and support system will violate, misuse, fail to comply with, or otherwise 'abuse' its requirements and entitlements (pp. 162-3)". The roots of the discourse extend into public consciousness, institutional structures and the responses of employers and co-workers to injured workers. The assumption is that the injured worker is taking advantage of the system by making false injury claims, exaggerating symptoms such as pain, and applying for compensation benefits to which they are not entitled. The consequence of the discourse of abuse is that injured workers need to perform or publicly demonstrate their injury, through actions such as taking prescribed medications (even when they are not warranted), as a way of maintaining their credibility and verifying their circumstances (Eakin, 2005). The social consequences of this discourse for the injured workers are an erosion of their moral identity and reputation. This results in emotional distress (Eakin, MacEachen & Clarke, 2003; MacEachen, Ferrier, Kosny, & Chambers, 2008).

All authors in the above section support the notion that institutional systems, regulatory structures, and practices in disability and injury management have social consequences that view disabled or injured people as different, deviant and delinquent in some way. These notions extend beyond the individual and into their relationships with others. The structure of the injury management system in Ontario (Eakin, 2005) and blind support services (Scott, 1969) contribute to negative societal expectations and explanations for people with injuries or disabilities which in turn has a negative psychosocial effect on the individual.

Hence two discourses of disability seem to be organizing the lives of injured workers in Ontario. First a biomedical approach, which sees disability residing in the individual and requiring medical documentation to verify the injury or disability. The path to a cure is through rehabilitation of the individual. Second, approaches which consider disabling barriers (such as the environment, attitudes, institutions, policies and practices) shape the experiences of people with perceived impairments. The province of Ontario, in its adoption of a social approach to

disability, has taken several steps to reduce and hopefully eliminate the physical and attitudinal barriers for people with disabilities. Accessibility laws and standards which mandate the removal of barriers for people with disabilities has been legislated through the Accessibility for Ontarians with Disabilities Act (2005). The provincial goal is to make Ontario accessible to all residents by the year 2025. While the province has adopted social strategies to eliminate physical and attitudinal barriers for people with disabilities, research in this area notes that negative societal expectations of injured workers are evident.

Injured worker research

Research focused in the areas of injured workers and workers' compensation has dramatically increased since the 1990's from countries such as Canada, the United States, and Scandinavia. The body of research work generated focused primarily on 1) injury management; 2) the injured worker and issues of mental health; and 3) return to work.

Injury management

Research attention has been directed towards finding strategies that can be used to manage injury claims. This type of research focuses primarily in the areas of the efficacy of clinical treatments (Busse et al., 2009; Clarke et al., 2006), measurements of health and functioning (Tarasuk & Eakin, 1994; Charney & Hudson, 2004; Carayon, 2007) compensation and benefits (Lippel, 2007; 1999; Koehoorn, Cole, Hertsman, & Lee, 2006; Beardwood, Kirsh, & Clark, 2005; Beardwood et al., 2005), and return to work (Franche et al., 2004; MacEachen, Clarke, Franche, & Irvin, 2006; Baril et al., 2003; Bernacki, Guidera, Schaefer, & Tsai, 2000; Eakin, 2005; 2003; El-Bassel, 1996; MacEachen, Ferrier, Kosny, & Chambers, 2008). Several studies (Beardwood et al., 2005; Lippel, 2007; 1999; Strunin & Boden, 2004) described injured workers negative experiences in the compensation system. Many workers feel the process is mentally disabling and negatively influenced their domestic, vocational and social roles. None of the studies above focused solely on registered nurses' experiences of the injury management system.

The injured worker and issues of mental health

Depression, anxiety, fear and stigmatization are key concepts that are experienced by workers and discussed in the literature (Lippel, 2007; 1999; Roberts-Yates, 2003; Strunin & Boden, 2004). Workers describe an overwhelming fear associated with the injury management process. Lippel (2007) identifies two sources of fear: fear about the injury and fear about the injury management process.   Immediately following the injury the workers often becomes fearful of painful diagnostic procedures and rehabilitation treatments, and the possibility of family breakdown due to the changes in their role function.   The change in role function from a productive family member to a dependant role is particularly troubling for injured workers (Lippel, 1999; Tompa et al., 2009). Adding to these pressures is the psychological turmoil which results from fear of an unknown illness trajectory process (Lubkin & Larsen, 2006). Throughout the recovery phase injury workers are afraid that they will be unable to return to pre-injury employment or that their post – injury abilities will be substandard and result in job loss. Financial hardships and possibly poverty for the individual and family can become a reality for many workers (Lippel, 2007; Williams, Westmorland, Shannon, & Amick, 2007). Injured workers become concern and distress about medical evaluations, surveillance systems, the provision of appropriate information, medical form completion and their ability to be articulate with medical evaluators, caseworkers, employers, appeal commissioners and other injury management officials.

Most injured workers report that they are stigmatized by engaging in the worker's compensation and return to work process. One half of the informants in William's et al. (2007) study noted that they felt prejudice once they were injured. Overwhelmingly workers felt that a general social suspicion about the validity of their injury especially when the injury was invisible like a back injury (Lippel, 2007). Stereotypical notions that portray injured workers as fraudulent and unworthy of compensation emerged frequently through changed relationships with co-workers, supervisors, employers and the general public (Eakin, 2005). Workers struggle to demonstrate the legitimacy of their injury (Tarasuk, 1994). In an effort to escape these uncomfortable and untrusting forces of coworkers, many workers return to work prematurely. Frequently, this results in the worker re-injuring themselves. This unfortunate circumstance requires the injured worker's rehabilitation process to begin again. Workers with subsequent

injury incidents experience an even greater amount of loss of self- esteem, self- worth, and identity. Other common circumstances experienced were social isolation, minimal social support, a loss of control, feeling of being ashamed, paperwork mix ups, and numerous interactions with the strangers of the injury management system (Roberts - Yates, 2003).

In summary, injured workers experience both physical and emotional distress when they are engaged in the injury management process. An unclear and potentially painful injury rehabilitation trajectory, fear of changes in their social and vocational roles, and the need to legitimate their injury to mistrusting others are contributory factors.

Return to work

Return to work (RTW) is a formal legislated process of injury management. A growing body of literature addresses factors that both promote RTW and contribute to delayed recovery (MacEachen, Chambers, Kosny, & Keown, 2009; Eakin, 2005; Baril et al., 2003; Beardwood et al., 2005). The results suggest that although such factors as severity of illness, type of disability, and treatment location (home convalescence vs. hospitalization) affect RTW, other factors of a structural and social nature also play a significant role in resuming work. Powerful determinants of RTW include personal resources, such as family status, family support, and educational level; economic resources, including such factors as job tenure, local job markets, and employment policy (Roberts-Yates, 2003); the work culture expressed by the beliefs of corporate executives and supervisors, (Amick et al., 2000; Friesen, Yassi, & Cooper, 2001; Shaw, Robertson, Pransky, & McLellan, 2003); and work characteristics, such as monotony, time pressures, perceived high workload, and little control over one's job (Bernacki et al., 2000).

Gamborg, Elliott, and Curtis (1992) indicate that 50% of injured workers who do return to work within six months will not work again. Findings suggest that employees who are away from work for greater than a two year period are unlikely to resume employment. Other research has retrospectively reviewed injury claims and attempted to create predictors of RTW. Krause, Dasinger, & Neuhauser (1998) report that the likelihood of return to work decreases as the duration of work absence increases. Headley (1989) and Beardwood, Kirsh, & Clark (2005) have found that workers who do not follow management prescribed patterns of RTW become entrapped within a culture that "blames" them for their lengthy recovery and perceives their

attempts at negotiation or control their work circumstances as resistance. These factors can impact on a worker's ability to resume any type of re-employment.

The perceptions of the injury management agents (such as supervisors, occupational health nurses, human resources agents) involved in RTW programs are important factors in the success of RTW. Baril et al. (2003) in a study done in three Canadian provinces found that injury management agents ascribed successful RTW with the individual characteristics of injured workers, such as personal and socio-demographic factors, beliefs and attitudes, and motivation. With respect to motivation, there were striking variations in perceptions of influences over, and origins of, motivation. Human resources managers and health care professionals related it to individual characteristics, but injured workers, worker representatives and health and safety managers attributed it to workplace culture and consideration of workers' well-being. The authors argue that "RTW program success seems to be related to labour-management relations and top management commitment to Health and Safety" (p. 2101). Although the authors do consider that the various systems affect RTW, they do not focus on workers' perceptions and experiences of these systems.

Return to work intervention studies which reduce the duration of work disability are also evident in the literature (Dawson et al., 2007; Franche et al., 2004; MacEachen et al., 2006; MacEachen, Chambers, Kosny, & Keown, 2009; Amick et al., 2006; Nelson, Baptise, Matz, & Fragala, 2009). Friesen, Yassi, & Cooper (2001) indicate that the workplace's organizational structure is as influential on RTW success as are the type of injury experienced by the worker. A good relationship between the worker, their supervisor, occupational health agents and the union are supportive of a successful reintegration. Krause, Dasinger, & Neuhauser (1998) suggest that an employer offering modified work significantly decreases the duration of the disability and improves the chances of a successful RTW. The RTW process has been laden with miscommunication and misunderstandings (MacEachen et al., 2008; Franche et al., 2004; Eakin, 2005). A primary contact person responsible for RTW coordination within an organization has also been identified as improving the success of RTW programs by significantly reducing work disability duration and associated costs.

In summary, RTW is an area of injury management in which research attention has been devoted. These studies have looked at predictive factors that promote successful RTW. Such

factors include the availability of modified work, good communication and supportive coworkers and supervisors. In all of the studies presented both nurses and other health care workers are participants. Sample of health care workers usually include all employees of health care facilities such as loading dock and kitchen staff, laboratory workers, allied health professionals, unregulated nursing staff and regulated nurses. A homogenous sample of only regulated nurses and their experiences of injury management and RTW is absent in the published the literature.

Canadian Nurses and their health

The table below presents selected findings from The National Survey of the Work and Health of Nurses.

Selected findings from The National Survey of the Work and Health of Nurses (Statistics Canada, Health Canada, & Canadian Institute of Health Information, 2006)

Significant Demographics	Majority of nurses are female Average age 44.3 years
Area of practice	90% of nurses work in direct patient care settings
Major staff challenges in patient care settings	Inadequately staffing Paid and unpaid overtime requirements Missed meal breaks
Violence in the workplace	30% report assault experiences in the workplace
Major health issues reported	Back injuries Pain significant enough to limit their work Depression
Average time away from work per year for illness	29.3 days

This report revealed that Canadian nurses, who compose the largest occupational group in the health care sector, have poor physical and emotional health. While the health challenges of nurses have clearly been identified in the literature, little has been done to create health care environments that support nurses health.

Nursing injuries and illnesses

The American Perioperative Nurses Association (2007), following an extensive review of American nurses workplace injury claims, reports that nurses are at risk for several occupational injuries because their bodies are also coming into contact with biological, ergonomic, chemical,

physical, psychological and social hazards. Nurses are exposed to a patient's bodily fluids during patient care activities such as the suctioning of oral or endotracheal secretions, the collection of blood and other bodily fluid specimens, the personal care activities involving the removal of urine and stool, and the care of a newborn immediately following a delivery. These activities expose the nurse to pathogens and infectious micro-organisms and place the nurse at high risk for infection or illness. In some instances health care workers inhaling the same air as a patient that is contaminated with chicken pox, tuberculosis or SARS have acquired the diseases of their patients (Registered Nurses Association of Ontario, 2005; Tam, Lee, & Lee, 2007; Yassi, Gilbert, & Cvitkovich, 2005). These circumstances contribute to illness and injuries for nurses.

A large number of injury claims made by nurses are for musculoskeletal injuries that are related to patient handling procedures (Charney & Hudson, 2004; Yassi et al., 1995; Dawson et al., 2007; Nelson, Fragala, & Mezel, 2003; Harber, Billet, Shimozaki, & Vojtecky, 1988). Statistics reveal that nurses experience a high incidence of manual handling and lifting associated injuries, especially of the back, that result in pain (O'Brien-Pallas et al., 2004; Nelson et al., 2003; Statistics Canada et al., 2006; Strunin & Boden, 2004). The etiology of nurses' back injuries includes individual factors such as age, previous back problems and situational factors such as low staffing levels, job strain and stress, lifting equipment not available, increasing job complexity and intensity (Dawson et al., 2007). Approximately one quarter of Canadian nurses report that they have had a back injury (Statistics Canada et al., 2006).

Back injury reduction strategies

The physicality and ergonomic characteristics of nursing work puts the bodies of the women and men employed in these roles at risk for injury. Nurses who must lift, carry and push of heavy instrument boxes, stretchers and beds in preparation for operations, stand for long periods of time in static or awkward positions during procedures, and engage in repetitive motion activities such as handing instruments to surgeons can become injured or disabled (American Perioperative Nursing Association, 2007; Marras, Davis, Kirking, & Bertsche, 1999).   Nurses, who have the closest and most frequent physical contact with patients, have been identified as the health care professional group that is most frequently involved in injury incidents due to their body work with patients (Williams et al., 2007). Many factors specifically associated with the

body work of caring for a patient put a nurse's health at risk and creates the potential for injury, disability, infections and poor health. In most health care settings a nurse may be required the use of his/her body for the lifting, moving of people, equipment or supplies. This interface of the nurses' body with the patient or object can, in some circumstances, jeopardize the nurses' health and cause injury (Kerr & Norman, 2003). The extent of the injury may vary from a mild pain that resolves immediately to a longer term injury that may require extended time away from the work setting and has the potential to have career limiting or ending consequence.

Nurses reported that there are many environmental barriers in the workplace that create situations where they are at risk for back injuries (Fragala & Bailey, 2003; Nelson et al., 2003). One preventative mechanism used to reduce back injuries from improper patient handling or lifting injuries is mandatory education in proper lifting techniques. This lifting training exposes nurses to body mechanics and positioning strategies that have been associated with reducing back injuries in manufacturing industries. Nurses reported that these sessions are of little benefit to them. The strategies needed to lift a living, ill, pain stricken and reacting patient is very different than strategies to lift a static object (Wardell, 2007; Retsas & Pinikahana, 2000).

In 2005 the Ontario Ministry of Health and Long-Term Care invested $29 million into the purchase of patient lifting devices for hospitals and long-term care facilities (Ministry of Health and Long Term Care, 2005) . These devices were mounted and fixed to ceilings in patient rooms. This equipment and the initiative were projected, by the government, to create a healthier work environment, reduce injuries for nurses and improve the quality of patient care. While initial evaluation data noted these improvements, more recent reports indicate that the initiative has had little sustained effect (Institute for Work and Health, 2007). Union representatives for nurses reported that the fixed nature of these devices over patient beds was problematic. These devices were not available in care areas, such as bathrooms and eating areas, where nurses need such devices (Ontario Nurses Association, 2009). This result is similar to other studies which report that many nurses do not use lifting or hoist equipment because it takes time to get the equipment, it is difficult to use or poorly maintained, there is not enough room to use the equipment in the patient care area, or the physical lay-out of the unit discourages equipment use (O'Brien-Pallas et al., 2004; Statistics Canada et al., 2006; Hendrickson, Doddato, & Kovner, 1990). Furthermore, nurses indicated that they have received minimal or inadequate training on how to use the

equipment.   All of these factors combined contribute to nurses' propensity to lift patients and equipment manually. When this type of lifting occurs, the nurse is at high risk for back injury (Lagerstrom & Hagberg, 1997).

Two types of back injury prevention and interventions studies have been conducted and two types are of relevance to health care workers: patient handling programs; and exercise programs. Patient handling prevention programs are often referred to in the literature as "No lift", "Zero lift", Minimal lift Lift-free or "Safe Patient Handling and Movement programs". Programs of this type have been implemented in some jurisdictions of Australia (Australian Nurses Association, 1998; Retsas & Pinikahana, 2000), Canada (Institute for Work and Health, 2007; Yassi, 1998; Ronald, Yassi, Spiegal, Tait, & Mozel, 2002), the United Kingdom (Wicker, 2000), Scandinavia (Oldervoll, Ro, Zwart, & Svebak, 2001; Lagerstrom & Hagberg, 1997) and the United States(Nelson, Baptise, Matz, & Fragala, 2009; Koehoorn et al., 2006). These approaches call for staff to avoid manual handling of patients when providing care, except in exceptional or life threatening situations (Australian Nurses Association, 1998; Retsas & Pinikahana, 2000). The state of Victoria in Australia has been a leader in no lift initiatives. An investment in the mandatory training of *all* nurses and hoist equipment has produced a dramatic reduction in back injury claims. This favourable administrative outcome is attributed to the lifting program.

Some researchers (Institute for Work and Health, 2007) are cautious about using administrative outcomes type of measures. The Australian studies have reported information for the whole workplace and not employees who were involved in patient handling specifically. Also, when an injured worker leaves their job they are replaced by a new and healthy worker. This creates a selection bias called healthy worker effect (Last, 1995; Shah, 2009).   From an epidemiologic approach this biases the data and makes the prevention program appear to be more favourable than it may be. Canadian research agencies have incorporated a different and possibly stronger study design in their approach to evaluating no lift interventions. In these studies the program tracks individual workers who are present at the initiation of the program.

No lift approaches in Ontario (Institute for Work and Health, 2007) and British Columbia (Interior Health Authority, 2004; Yassi et al., 1995) have received mixed reviews. The Ministry of Health and Long Term care invested $80 million in the purchase of 14,000 new mechanical

lifts for facilities. While this initiative was well received and increased awareness of the dangers of lifting within the health care setting, the statistical results showed minimal effect. Policy changes and education did not accompany the implementation of this intervention. Instead the researchers recommended the need for more research which incorporates a multi-faceted approach to patient handling. Included in this approach would be policy changes, the implementation of new patient handling equipment and training.

A second prominent intervention, implemented primarily in Europe, used to promote health and safe patient handling practices among nurses are exercise training programs (Oldervoll et al., 2001; Maul, Laubli, Oliveri, & Kruege, 2005). These programs combine aerobic and strength training exercises primarily targeted to improve core body strength. The programs seem promising if the programs are incorporated into the employee's work day. Research into this prevention program has yet to be conducted in North America.

Aging illness and injury

The aging of the Canadian nursing work force is a critical factor to consider when researching the physicality of nursing work. Both Canadian and international studies present demographic data identify the average age of nurses to be between 48-50 (Canadian Nurses Association, 2004; Nelson, 2005; Statistics Canada et al., 2006). The normal aging process which creates a decrease in one's ability to perform physical tasks with the same strength and vigour (Priestley, 2003; Sikorski, 2009) as younger individuals, may create challenges for nurses due to the physical demands of nursing work. Chronic health conditions, such as diabetes, arthritis, hypertension, present challenges that many aging women face (Belgrave, 1990). Given that the nursing workforce is made up of primarily aging women, more concentrated attention to research in this area is required. Research attention needs to be directed towards understanding how the effects of aging and chronic illnesses can influence a nurse's ability to perform the physical and emotional work associated with the profession (Statistics Canada et al., 2006).

Mental health

The psychological demands of nursing work often create job strain. Yassi, Wickstrom & Palacios (2004) report that specific patient case types, such as palliative, critical care, trauma and sexual assault, can have a negative effect on the nurse's mental health. Nurses can witness

tragedy, suffering and human distress in their daily working lives. The work of Linda O'Brien-Pallas (O'Brien-Pallas et al., 2004) highlights that in various work environment factors nurses experience a moderate to high degree of emotional exhaustion as a result of their work. This long term and ongoing consequence of psychological strain places nurses in a situation where they are at high risk for health problems (Lavoie-Tremblay, O'Brien-Pallas, Viens, Hamelin Branbant, & Ge Linas, 2007; Yassi, Wickstrom, & Palacios, 2004). Often this job strain manifests as increases in sick or injury time (Yassi et al., 2005). Little is known about the long term mental health consequences of being a nurse. The Statistics Canada national survey of nurses does indicates there are mental health issues in nursing, information about the prevalence, specifics challenges nurses face in practice, and strategies to improve nurses mental health is needed.

Factors contributing to unhealthy workplaces

A great deal of literature attests to the industrial and organizational challenges currently facing nurses as a result of a global nursing shortage, inappropriate nurse patient rations, physical overload, an aging workforce, casualization, bullying, abuse and violence, lack of professional autonomy, imposed organizational change, and occupational health and safety issues (Shamian, Kerr, Thomson, & Laschinger, 2002; Gordon, Buchanan, & Bretherton, 2008; Cohen et al., 2004; DeLucia, Ott, & Palmieri, 2009; Buchan, 2002). While these challenges are clearly identified, strategies to improve and/or change these circumstances are sparse in the literature.

The physical environment

The physical settings where nurses work are often suboptimal characterized by inadequate lighting on evening and night shifts, poorly designed floor plan that increase walking time, and ergonomically inflexible patient care and charting areas (Carayon, 2007; Carayon et al., 2006; Gabdois, Bourgeois, Goeh-Akue-Gad, Guillaume, & Urbain, 1992; Gallant & Lanning, 2001; Garg, Owen, & Carlson, 1992; Harber et al., 1988; Lippert, 1971; Marshall & Worthington, 1993; Morrow, North, & Wickens, 2005).

Shortages and shifts

Nursing work processes and work systems (the environment where nurses' work) have been linked to increase susceptibility to injuries (Page, 2004). DeLucia, Ott, & Palmieri (2009) contend,

> The profession of nursing as a whole is overloaded because there is a nursing shortage. Individual nurses are overloaded…by the number of patients they oversee…by the number of tasks they perform. They work under cognitive overload, engaging in multitasking and encountering frequent interruptions" (p. 28).

Long work hours add to injury susceptibility. In order to meet the needs of patients and their families, regulated nurses are in many workplaces required to work eight to twelve hour shifts around the clock. O'Brien-Pallas et al. (2004) report that adverse workplace characteristics have a disabling effect on nurses. Ninety three percent of Canadian nurses work 12 hour shifts, traditionally day shift from 7 a.m. to 7 p.m. or night shift 7 p.m. to 7 a.m. furthermore, nurses are commonly required to work overtime in situations where a patient's condition suddenly changes, or when a unit is short of staff. This situation results in nurses working long and irregular hours. The average scheduled work week for a Canadian nurses is reported at 32.2 hours but on average all nurses work an additional 5.3 extra hours per week (Statistics Canada et al., 2006). In some instances overtime work is mandatory, and in other situations nurses participate in unpaid and invisible overtime work such as coming to work early, working through breaks or staying late in an effort to get all of their work done (Rogers, Hwang, & Scott, 2004). There are health and safety consequences associated with these work practices. Working through the night which leads to poor nutrition and an increase in the fatigue levels of the nurse, furthermore continuous changes in work sleep patterns contribute to the fatigue of nurses. Forty percent of nurses reported that they were required to work mixed shifts - a combination of day, evening and night shifts (Statistics Canada et al., 2006). Thus, work hours and shift work contribute to poor workplace performance and have been linked to increased risk of injury (Lippel, 2007; 1999).

As a result of cost cutting initiatives many health care settings have shut down food vendors during the evening, night and weekend periods (Yassi, 1998). This organizational change can promote poor worker health due to a lack of nourishing food available to workers.

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This issue can cause the shift worker to make unhealthy food choices. While the consequences of the occasional poor diet choice may have no effect, long term consequences may lead to obesity, diabetes and hypertension which have an increased prevalence in nurses (Statistics Canada et al., 2006).

Exposures

A central act in the prevention of disease and infection spread in health care settings is the use of chemical agents. These agents, disinfectants, sterilizing agents, and specimen preservatives, while essential for the practice of maintaining hospital environmental standards, expose the nurse to potential adverse effects. Nurses inhale anaesthesia gases and smoke from the burning flesh during lasering and cauterizing operative procedures in the operating room, post anaesthetic care, critical care or clinic settings. Diagnostic equipment which emit radiation such as X-rays, cardiac monitors, and monitors are part of the nurses everyday work life (American Association of Critical Care Nurses, 2005). While exposure to physical hazards is part of nurses' work, the long term consequences of exposure to these physical agents is unknown and in need of investigation.

Lack of protective equipment

Protective equipment, such as latex gloves and masks, is traditionally used to prevent and limit the contact or exposure of the nurse to infectious diseases, yet repeated exposure to the chemical properties and protein used in these products creates chemical sensitivities and allergies (Sussman, 2010). In Canada it is estimated that 1.4% of the nursing population has latex allergies (Statistics Canada et al., 2006). As a result of latex allergies many nurses are required to wear very expensive and specialized protective gear (Registered Nurses Association of Ontario, 2005). In some circumstances employers have failed to provide these protective barriers for nurses that furthering the risk of allergic reactions and infection acquisition (American Perioperative Nursing Association, 2007; Tam et al., 2007).

In Ontario circumstances arose during the SARS (sudden acute respiratory syndrome) crisis where nurses become sick and some died as a result of a hospital acquired infection. The Registered Nurses Association of Ontario (2005) reported of the consequences of SARS found

that nurses expressed serious concern regarding access to, and the effectiveness of, the protective gear provided by hospitals. Hospital employers, involved in the initial phases of this outbreak, felt that the nurses' concerns about the rapid spread of the illness were unwarranted. In particular, nurses concerns about the inappropriate fit of face masks were dismissed. Hospitals controlled and refused to provide the nurses with more protective equipment. Professional standards of nursing will not allow nurses to refuse to care for patients. This situation placed nurses in a compromising and vulnerable position which resulted in them becoming sick.

Workplace Violence

The prevention of assaults, both physical and emotional, on various health care employees (particularly nurses) are becoming a major challenge in health care workplaces (Registered Nurses' Association of Ontario, 2009). The specific reasons for the assaults are speculated to be long wait times, deteriorated or impaired cognitive patients and psychiatric illnesses (Lewis Lanza & Demaio, 2005). What is known is that health care workers have suffered severe sprains, lacerations, fractures, and head trauma as a result of these incidents. Recent research has identified that health care staff suffer not only from physical but also emotional sequela (American Perioperative Nursing Association, 2007; Williams et al., 2007; King et al., 2006) . Lewis Lanza & Demaio (2005) suggest that the reporting of emotional abuse may be underestimated because statistics focus on physical assault only. They have found that all health care victims of abuse report intense and residual emotional reactions to even minor assaults and threats of assault. These reactions can significantly impact on the nurses' ability to care for patients and often results in the nurse using sick time to recuperate from the assault.

In response to this issue the Registered Nurses' Association of Ontario (2009) recently released a best practice guideline titled *Preventing and Managing Violence in the Workplace.* This document outlines health care system, organizational and individual recommendations focused on preventing and addressing violence against nurses in the workplace. Strategies include: legislation; funding for staffing, mandatory education and leadership development to prevent, identify and respond to violence in the workplace; research focused on the incidence and prevalence of workplace violence and bullying; accreditation standards that support violence free health care settings; opportunities for students to learn how to prevent and protect themselves

from violence; outreach programs to address violence; and programs that support individual nurses acquiring the knowledge and competencies to prevent, identify, and respond to potential violence. While these recommendations are available, strategies to support the update, implementation and evaluation of these programs are absent.

Summary

Part 1 of the literature review has identified that there is some research on nurses and injuries. Attention has been focused on the physical and emotion nature of nursing work that may contribute to injuries and illnesses. Some prevention work has been done to minimize back injuries through no lifting initiatives. Research had been focused on the experiences and social organization of injured workers in injury management and return to work. In this body of work information about nurses and their experiences of injury management are intertwined with the experiences of all health care employees. What is absent in the literature is attention specific to injured registered nurses experiences of injury management. This study seeks to explore this notion. The nature of their registration status may have some bearings on their injury management trajectory.

PART 2

Institutional ethnographic research

Institutional ethnography is a form of critical ethnography committed to a particular way of seeing and investigating institutional conditions of experience. A central premise is that people's experiences are organized, shaped and concerted by the power forces of institutional regimes (this will be discussed in greater detail in the next chapter). This mode of social inquiry seeks to empirically explore how the actual experiences of individuals are organized and coordinated by institutional processes. Institutional ethnographer George W. Smith (1998) studied the social organization of schooling from the standpoint of young gay male students; Ellen Pence (2003) investigated the sequence of domestic violence reporting from a 911 operator call to legal proceedings; Susan Turner (2006) used cartographic sequencing to inquire into local government decision making; Townsend (1998) described the invisible forces that controlled the delivery of community mental health services from the standpoint of occupational therapists;

Campbell, Copeland, and Tate (1999) studied the delivery of home care services from the standpoint of people living with disabilities; and Diamond (1992) investigated the mechanisms of American nursing homes from the standpoint of patients and health care workers. This research which has been used to examine the organization of professional and social services from the standpoint of patients, front-line workers and marginalized groups, has made important contributions to the disciplines of sociology, nursing, education, occupational therapy and community health.

In the development of this study two key Canadian institutional ethnographic studies were the catalyst for considering IE as an appropriate approach. First, Rankin and Campbell (2006) used an institutional ethnographic approach to problematize the routine nature of nurses' work within the reformed Canadian health care system. Their study raises important questions about the manner in which healthcare efficiency mandates are taken up in ways that subordinate and displace nurses' knowledge and work. Second, Karen Jung (2000) applied institutional ethnography to explore the workings of academic accommodation policy from the standpoint of students with chronic illness at a university. She found that the student's choices and courses of actions were concerted by organizing practices of the university's accommodation policy. In discussions with university community members, Jung found that an accommodation for a student with a disability was perceived as providing an unfair academic advantage. She uncovered a discourse of scepticism surrounding students with disabilities which required students to continually prove their disability. Jung's work highlights the accommodation work that disabled students must engage in if they are to invoke the academic accommodation policies. This discourse of scepticism echoed Eakin's (2005) notion of the discourse of abuse with injured workers. Jung's success in uncovering disability management processes in the university setting suggested that a similar approach could be taken in this study looking at injury/disability management in the health care sector.

Summary

In summary, current literature identifies that nurses are at high risk for injuries and illnesses as a result of their work in staff nurse roles but attention to their return to work experiences following an injury is absent from the literature. Furthermore, the physical,

emotional and environmental demand of the work superimposed on an aging workforce has been linked to the poor health of Canadian nurses (Canadian Institute for Health Information, 2005; Registered Nurses Association of Ontario, 2005).   Hence, nurses are injured and sick as a result of their work. In Ontario, the WSIB supports an early return to work approach and highlight the benefits of this approach for both employers and the injured worker. Some literature suggests that the successes of these programs are questionable. To date little attention has been focused on how regulated professionals, like nurses, experience injury management and return to work. In many studies nurses are only captured in data which include all types of health care workers, most of whom are unregulated. It is unclear if the regulated status of a nurse might influence their return to work. As regulated professionals, nurses are bound by codes of conduct and standards which shape how they must act, respond and behave when they are at work. An institutional ethnographic approach (Smith, 1987) was considered as the most appropriate method from which to develop a better understanding of injury management and nurses. In the next chapter Smith's approach to experience and her method of understanding the everyday is discussed.

CHAPTER 3: An alternative sociology – Institutional Ethnography

Introduction

This chapter presents the key concepts and assumptions that underpin an institutional ethnographic approach. Beginning with a brief description of the influences that shaped Smith's approach to inquiry, the chapter moves on to describe key concepts - social relations, social organization, maps, problematic, standpoint, work, texts and ruling- that shape an investigation.

Institutional ethnography (IE) is a mode of inquiry first formulated by Canadian feminist sociologist Dr. Dorothy E. Smith (2008; 2005; 1990; 1987). Smith describes the approach as an alternative sociology that explores how the experiences of people in everyday life are coordinated by external institutional forces. IE does not apply established theories and concepts to the interpretation or analysis of people's behaviour. Rather, Smith (2008) argues that a predetermined theoretical orientation to the data in research perpetuates the risk of conceptual and theoretical insulation which can limit the researcher's ability to deal with the unexpected findings. Smith (2006) proposes an alternative way of looking at the social:

> The idea is to reorganize sociology as knowledge of society so that inquiry begins where people are and proceeds from there to discoveries that are for them, for us, of the workings of a social that extends beyond any one of us, bringing our local activities into coordination with those of others. The project is to extend people's ordinary good knowledge of how things are put together in our everyday lives to dimensions of the social that transcend the local and are all the more powerful and significant in it for that reason. We participate in them without knowing what we are doing (p.3).

Thus, an institutional ethnographic approach moves beyond traditional ethnographic approaches that confine observations to the local settings, and expands exploration into the organization of power in contemporary society. The goal of this approach is not to explain the behaviours of the people. Instead this technique seeks to explicate the institutional relations of power in which people's lives are embedded. Campbell and Gregor (2002) explain that this investigative

approach seeks to reveal this organizing effect by asking "How does this happen as it does? [and] How are these relations organized?" (Campbell & Gregor, 2002, p. 7).

(Re)discovering the everyday

Influenced by Marxist materialist methods, Garfinkel's ethnomethodology and insights from the consciousness raising initiatives of the feminist movement, Smith (2005) offers a scientific social investigative approach that begins in the experiences of an individual as a way of entry into the bureaucratic, institutional and government structures of power that concert and organizes the individual. The forces of institutional power reach into the everyday actualities of people (such as injured workers) in various geographic locations by way of institutional texts. According to Smith by examining the daily work activities of both the people and the texts with which they engage, the power structures that organize and subordinate the individual can be exposed. It is important to note that it is not the goal of IE research to resolve power dynamics but rather to bring to light the forces of power that coordinate and shape the work of people (Smith, 2008). The product of an institutional ethnography (IE) is a social cartography that can be used by the people who are controlled and activists to better understand, challenge, and transform the powerful social forces that rule, conduct and coordinate their everyday (Smith G.W.1990; 1998; Campbell & Gregor, 2002; Frampton, Kinsman, Thompson, & Tilleczek, 2006).

Social relations and social organization

For Smith (2005), the world is always social and the only way a person can be in the world is as a social being. People's everyday lives are not chaotic or random but rather a series of purposefully concerted, coordinated, and organized activities. Smith (1990) maintains that this approach to the social offers a distinctive "social ontology not of meaning but of a concerting of activities that actually happens" (p. 97). When describing the social in this way Smith uses two important terms to orient the researcher: social relations and social organization.

The concept of "social relations" (p.183) is used by Smith (1987) to describe the activities that people enter into which organize and structure their experiences. These social relations coordinate a person's activities with others who may be unknown. It is important to

understand that social relations are not social relationships that can occur between people such as married partners, mother and daughter, professor and student and so on. Instead social relations refer to activities and decisions of a person in a particular local setting that are part of a coordinating sequence of action that hooks the individual into what others are doing at another location. Put another way, "people participate in social relations, often unknowingly, as they act competently and knowledgeably to concert and coordinate their own actions with professional standards or family expectations or organizational rules" (Campbell & Gregor, 2002, p. 31). The notion of social organization is another conceptually important term used in institutional ethnography. Campbell and Gregor (2002) explain that it is "the interplay of social relations, of people's ordinary activities being concerted and coordinated purposefully, that constitutes *social organization* "(p. 27).

Problematic

Institutional ethnographers treat people's lived experiences of the everyday world as the problematic of the investigation. This technical term

> …directs attention to a possible set of questions that may not have been posed or a set of puzzles that do not yet exist in the form of puzzles but are 'latent' in the actualities of the experienced world (Smith, 1987a, p. 91).

To understand the problematic the researcher must become familiar with the questions, and puzzles of the everyday that occur in the actualities of the people. The researcher sets out to learn more about, explore and explicate the problematic. As the investigation begins the researcher must "hear how people who live it talk about it"(Campbell & Gregor, 2002, p. 47). The problematic emerges as the researcher discovers how the informants participate and is hooked into institutional relations. Hence the problematic sets the direction of investigation. In the case of this study the problematic that will be explicated is how injured nurses experience the return to work phase of injury management.

Standpoint

To begin the investigation the researcher aligns with a particular subjugated position or standpoint of people outside the ruling position throughout the study. The term standpoint, as described by Dorothy Smith, is not used to depict the general attributes of the group but instead aligns with a common mode of experience that is distinctive of women's place in society. "Taking up women's standpoint as a place to begin locates the knower in her body, in a lived world in which both theory and practice go on, in which theory is itself a practice" (Smith, 1999, p. 7). Campbell and Manicom (1995) add that standpoint helps the researcher establish "whose side I am on" (p. 7). The notion of standpoint anchors the research in the experiences and concerns of a particular group of people. The people's standpoint is assumed to be distinct from the ruling or authorial accounts (Campbell & Gregor, 2002). According to Smith (2006) it is within the descriptions of the people's standpoint and daily experiences that tenets of institutional order and ruling relations exist. In the case of this study the researcher begins from the standpoint of the injured nurses who have experienced returning to work. It is assumed that these women (all who participated in the study are women) have particular insider knowledge of the social organization of injury management and return to work because they have lived it. As experts in the everyday, the subjective embodied knowledge of their insider standpoint provides a useful way to look into the social organizing forces that coordinate their experiences (Smith, 2005).

Experience

Institutional ethnographers rely on people's capacity to tell their experience. The term experience as used by Smith (2005) reflects what people come to know through their bodily being and actions. Hence, only a person who has had the experience can speak of it – making the informants in the study authorities who can inform the researcher (Smith, 2002).The researcher is not concerned if the account is an accurate telling of the events. Instead the researcher is interested in the *informant's* experience, how the story is told, and what traces of social relations and organization presents in it (Smith, 2005). These elements inform the ethnography.

Discourse

Smith (1999) describes discourse as a socially organized activity among people which are used or activated by people and have an effect on another. Discourse refers to the talk and texts evident in the social that are activated or taken up by people in their everyday lives. For institutional ethnographers

> …discourse refers to a field of relations that include not only texts and their intertextual conversations, but the activities of people in actual sites who produce them and use them and take up the conceptual frames they circulate. This notion of discourse never loses the presence of the subject who activates the texts in any local moment of its use (DeVault & McCoy, 2006, p. 44).

Like a map, a discourse directs people to knowing what they *should* be doing. For example, we come to understand ourselves as a good nurse by comparing ourselves with social notions of a good nurse (such as the ability to provide holistic and comprehensive care to a patient) that are circulated through talk and text. Hence discourses are resources that help us to understand ourselves and others.

Work

In an institutional ethnography the notion of work is analytically significant as an orientating concept operationalized in both conducting and analyzing interviews about everyday experiences (McCoy, 2006). The actual daily work activities of people in the everyday are assumed to sustain a particular institutional nexus (Smith, 2008). Work refers to "what people do that requires some effort, that they mean to do, and that involves some acquired competence (Smith, 1987a, p. 165)". Hence Smith uses the notion of work in a "generous" (p. 165) sense extending the idea beyond paid employment to include everyday work such as child care, domestic chores, managing illnesses or injury, volunteer work and so on. "The notion of work directs us to its anchorage in material conditions that are done in 'real time' – all of which are consequential for how the individual can proceed (p. 165)". In an institutional ethnography, work is any embodied experience which takes time, energy and often competence (Smith, 2005). McCoy (2006) suggests thinking of *work* as an "empirically empty term" (p. 110) then adding a detailed description of the practical activities that people do in their everyday. Evident in the

description of work will be the interface between the individual and the networks of institutional relations that permeate and shape the work experience. Diamond (1992), for example, describes the day to day work practices of a nursing home resident. As a result of institutional regimes of the nursing home management practices elderly residents engage in *waiting* work. Much time and effort in the everyday is put into waiting for meals, care, visits and so on. Hence a central characteristic of this type of work is that it is taken for granted, invisible, and unacknowledged. Yet residents are required to do this work as part of their participation in the everyday ruling mechanisms of the nursing home.

Maps

Cartographic and diagramming techniques have gained popularity in recent IE investigations (Pence, 2003; Turner, 2006) as analytic tools that can be used to display coordinating complexes of institutional sequences of action and decision making processes which engage multiple people across various geographic sites. The intricacies of the social can be mapped and social relations and social organization highlighted. These social maps can be used by the subjugated people and activists to better understand, challenge, and transform the powerful social forces that rule, conduct and coordinate the everyday (Smith G.W.1990; 1998; Campbell & Gregor, 2002).

Texts

Texts, for Smith (1990), are of central importance in IE research as they accomplish social coordination across multiple sites. The ubiquitous nature of texts, which take forms such as paper documents, electronic files, maps, policies, laws, textbooks, forms, and media images and so on, extend throughout contemporary society. A key feature of a text is that the same set of words, images and numbers can be present in multiple sites. How the texts are taken up and read at each site may differ. A text reflects the official discourses of ruling powers in contemporary society (Smith, 1990).

People respond to and/or are activated by texts. The texts tell us what to do, how to do it and when to do it. The text represents the voice of the authority ordering the people. Texts are not separable from people's doings in the local setting. For example when an injured worker

received a medical report form from the WSIB they are expected to respond and take action by completing the text and returning it to the sender.   This text, which is part of an organizing process of the WSIB, connects the injured worker in a distinct geographic location to the WSIB adjudicators at another site in predetermined ways. Both parties, while unknown to each other in a physical sense, participate in a textual interchange that acquaints them to the other.

A distinct feature of forms is that this type of text filters informants response and prescribes what can and cannot be said to the WSIB. When the injured worker completes the form they are only able to provide detail of their injuries by answering prescribed questions. These questions guide and shape the workers story of their injury. Critically, the adjudicator can only see the worker through the lens of the form.
As a result some features of the injury may be excluded because the form lacks a space in which to give this detail. As a result forms create an objectified way for the WSIB agent to know the worker.

Decision making by bureaucratic and government agencies is often based on a textual view of the client (Smith, 2008). In the case of the injured worker's claim the adjudicator's decision on whether to authorize payment is based solely on a textual view of the individual. The form, and how the injured worker completes it, mediates WSIB decision making. According to Smith (2006) this is an example of how the text filters out the individual's subjectivities and render ruling practices routine. In the case of injured workers, forms facilitate the institutional shaping of an individual. Often unknown to the injured worker when they complete the document is the fact that the form carries with it many determinations of future action based on how the adjudicator reads the text.

Texts not only function as a way of organizing and dictating social expectations to individuals and groups but also display how power is embedded within social institutions and structures (Grahame & Grahame, 2000). Reviewing a text can illuminate how people's activities are mediated by power, and organized and regulated in invisible ways (Smith, 2001). The social organization of ruling bureaucratic regimes can become visible if the researcher investigates texts and pays particular attention to how the text is read by various people. The above features make texts empirically useful to institutional ethnographers as a way of exploring the social organizational and institutional coordination of people's activities across multiple locations.

Ruling

Texts are always implicated in the ruling relations in contemporary society. Smith (2008; 1990) uses the notion of ruling as a way of understanding how power is exercised in local settings to accomplish trans-local interests. Socially organized exercises of power shape are assumed to shape people's actions and their daily lives. This takes place when the interests of those who are rule dominate the actions of those in the local setting.

Ethnography vs. Institutional Ethnography fieldwork

In traditional ethnographic approaches (Creswell, 2007) fieldwork is viewed as a process whereby the researcher translates unknown cultural practices or misunderstood groups into terms understandable to the ethnographic audience. The field researcher, as an outsider unfamiliar with the local milieu, sets out on a journey to visit, explore, and gain knowledge of a setting. The local setting is unknown or misunderstood by the wider society that is set apart by physical, economic and cultural barriers. The wider society is treated in the ethnographic account as a place outside of the local sphere permitting a range of comparisons. Hence the local world and wider society are distinct. The local world is studied and interpreted by the researcher.

Institutional ethnography, an alternative ethnographic strategy, uses fieldwork to direct attention towards mapping the relations that govern an institutional complex. The fieldwork experience in a local setting is a point of departure for a reflexive examination of the social. The inquiry begins with what people are actually doing and experiencing in the everyday world. Hence this *doing* is not abstract but rather concrete and embodied. The experience in the local setting while significant is not the final destination of the research journey. Instead the experience is the starting point for an examination of the social relations that are shaping that experience. There are multiple entry points into the complex of social relations (this study could have also begun from the standpoint of the occupational health nurse, charge nurse, manager and so on). The researcher's interest is focused on mapping an extended institutional complex. The research path moves beyond the local setting and into an examination of how the state, the profession and the corporate world of health care shape the everyday worlds in which return to work unfolds in the hospital setting.

Summary

In summary " institutional ethnography is committed to discovering beyond the individuals experience …and putting into words supplemented in some instances by diagrams or maps what she or he discovers about how people's activities are coordinated (Smith, 2006, p. 1)". The approach is useful in understanding how injured nurses experience injury management and return to work (RTW). Adopting the standpoint of the injured nurse becomes the point of entry into an exploration of the connections between her local setting and the institutional practices and trans-local ruling of the RTW authorities. The ruling relation of these agencies is assumed to coordinate the activities and actions of the nurse in her everyday recovery and reintegration to their pre-injury employment. Put another way, there is a disjuncture between two contradictory ways of knowing about RTW: the injured nurse's embodied experiential way of knowing; and the objective or ideological way of knowing embraced by WSIB, the hospital employer and injury management agents (Campbell & Gregor, 2002).   This study seeks to uncover how the everyday experiences of the injured nurse are coordinated and controlled by the WSIB and the hospital employer in the formal process of RTW. The next chapter describes the specifics methods employed to uncover this disjuncture.

CHAPTER 4: Methods of the inquiry

Introduction

This chapter presents the research procedures and methods used in this inquiry. It begins with the rationale for selecting Institutional Ethnography (IE) as the most appropriate approach to use when studying injured registered nurses experiences of injury management (IM) and return to work (RTW). The research question that initially guided the inquiry will be presented both in its initial form and as it evolved as the research progressed. The two phase design of the study is then described. Phase 1 focuses on talking with injured nurses (primary informants) and gaining an understanding of their everyday experiences. Phase 2 involves gaining a deeper understanding of injury management (IM) and return to work (RTW) through interviews with secondary informants and texts identified as significant by the informants. Methods employed in the study include interviews, mapping techniques, field notes, and text reviews plus data management and analysis strategies. Finally ethical review approval and the management of confidentiality measures are described.

Rationale for an institutional ethnographic approach

Institutional ethnography (IE), a mode of inquiry originally articulated by Canadian sociologist Dorothy Smith's (1987; 1990; 1999; 2005), was selected as the most appropriate investigative approach to use in this study for a variety of reasons. First, as a doctoral study that was focused on developing a better understanding of injury management 'for' nurses, IE privileges the standpoint of these primary informants and provides a means to understand how local experiences are coordinated by trans-local structures.

These are three salient aspects of an institutional ethnographic approach. First, the ability of IE approaches to make visible the work of people in their everyday/everynight lives was also attractive to the researcher. Griffith and Smith (1987) describe how institutions, like schools, take for granted much of mother's work rendering it (in)visible. Likewise Rankin and Campbell (2006) have described how much of nursing work becomes invisible due to the taken for granted nature of their practices within the health care system. The researcher, having had a personal

experience of being injured and *"off work"*, believed that her employer considered her to be passively recuperating at home while away from work. In actuality her days and nights were filled with attending to the demands of her injury and changed life circumstances. These demanding activities were (in)visible to the employer. An institutional ethnographic approach creates ways of making everyday work of people visible. To do this the researcher directs their attention towards what is actually happening in the organized lives of the informants. Second, peoples' everyday lives are understood as being concerted and socially organized by forces that extend beyond the individual. In the case of this study the practices of injury management, health care services and nursing work are considered socially organized forces that are coordinated textually and can therefore be empirically examined.

Finally, I was drawn to the mapping approaches used by Pence (2003) and Turner (2006; 2009). Institutional ethnographic research provides a map (both figuratively and literally) showing how people's activities in different locations are connected to one another (DeVault & McCoy, 2006; Smith, 2005). Having had the opportunity to see and hear presentations done by Pence and Turner, I wanted to incorporate these creative techniques into this work. The opportunity to present findings in this visual way to the nursing community may be useful in facilitating knowledge translation when the findings of this study are to be disseminated. Subsequently as the study progressed, the course of creating literal maps of the processes involved in injury management, nursing work and return to work helped to finely focus the study into the particular area of return to work and identify how the tethers of institutional processes link into the everyday. Maps provided a clear demonstration and showed what was actually happening.

These key features of IE have been used to craft chapter 5: Institutional discourses of Ontario workers' compensation, chapter 6: The (in)visible work of return to work, and chapter 7: Institutional discourses of Ontario health care.

The problematic

The overarching research question or puzzling piece (Campbell 2009) guiding the design of this study was: How are the everyday experiences of a regulated nurse shaped by injury management? This question was derived from the researcher's participation in the social

relations of RTW through personal and professional experiences outlined in the introduction. The language used in this question was crafted to facilitate broad recruitment and scope. For example, "regulated nurse" (any nurse registered with the College of Nurses of Ontario), was selected because of the all encompassing nature of the term. Similarly, "injury management" reflects a broad notion of the events following an injury. It was unclear, in the proposal phase of the study, if there would be an adequate number of any one nursing designation or phase of injury management available to participate in the study.

During the interviews with hospital employed registered nurses, return to work emerged as a dominant theme and place of strife in the sequences of action in injury management. Being attune to the nurses' standpoint, the study was redirected towards data building strategies surrounding the RTW phase of injury management. As a result, the research question was revised to focus on registered nurses employed in the hospital setting and return to work (RTW). Devault and McCoy (2006) liken this tactic to pulling one string from a tangled ball of yarn to illustrate this process. In consultation with the supervising committee the question guiding this study was revised to: How are the everyday experiences of hospital employed injured registered nurse shaped by return to work practices?

The informants

All individuals interviewed in this study are considered as expert *informants* in their experiences of everyday work processes and institutional practices. Institutional ethnographers use the term *informants* to signal to the reader that a sample of people is not being studied, rather, it is the social organization of institutional processes under investigation (DeVault & McCoy, 2002). Hence, each informant with their expert knowledge of injury management and return to work was considered as someone who could inform the researcher's understanding of the topic. In the study injured registered nurses (IRNs) are referred to as primary informants. The term secondary informant refers to a person with organizational knowledge of injury management and return to work. These individuals were the primary informants and interviewed in phase two of the study. The following table provides a summary on all informants interviewed by occupational category.

Summary of Study Informants

Primary Informants n=6	Secondary Informants n=22
Injured registered nurses	Occupational Health Nurse (3) Charge Nurse (3) Manager (3) Nurse Educator Peer Nurse (3) Family Member Family physician Orthopaedic surgeon Local union representative Central nursing union labour relations specialist Nursing supervisor Nursing executive Massage therapist/physiotherapist Injury advocate

Study purpose and overview

The purpose of this study was to examine the coordinating effects of return to work (RTW) on injured nurses.   A two phase study was undertaken. A summary of the process can be found in the table below.

Study phases

Phase 1	Phase 2
• Researcher's Map brainstorming • Review of texts identified in brainstorming • Recruit and interviews primary informants • Preliminarily analysis of primary informant maps and transcripts • Develop recruitment plan and revise question plans for phase 2 • Revision of researcher's map based on data collected in phase 1 • Field notes audio recordings	• Review of texts identified in primary informant dialogue • Recruit and interviews secondary informants • Field notes audio recordings • Review of local and extra local texts • Comprehensive review of data from all sources • Revision of the researcher's map • Interview 2 with primary informants

Phase 1 of the study focused on collecting data from primary informants through interviews and a mapping activity. The mapping exercises were used to elicit both the primary informant and researcher's working knowledge of IM and RTW. This approach proved valuable in identifying secondary informants to interview, relevant interview questions and texts to examine in phase 2 of the study.   Field note audio recordings were made immediately following

each interview and throughout the data collection and analysis phases of the study. The preliminary analysis of phase one data exposed the need to focus the study on RTW practices as this phase of IM appeared in the maps and discussion as a particularly problematic period for the primary informants.

Phase 2 was designed to gain an understanding of IM and more specifically the RTW processes. This was done by interviewing secondary informants and examining texts identified by all informants. Questions for each secondary informant were designed based the researcher's emerging understanding of the return to work process. For example, occupational health nurse 1, interviewed at the beginning of the study, had questions geared towards gaining a general understanding on IM and RTW. Questions for occupational health nurse 3, interviewed towards the end of the data collection, were focused on RTW. Field note audio recordings continued following each interview. Both injury management and nursing work life texts were reviewed. This phase of the study concludes with a second interview with primary informants as a way of gaining more clarity into RTW process and member checking.

It is important to note that the data collection and analysis processes used in this study were not as linear as presented in this chapter. Each piece of data added something to the researcher overall understands of the RTW process in some ways. In some instances, the significance of the data was not apparent upon the first review. It was only once subsequent interviews or texts were analysed that the significance emerged.

Ethical review

This study underwent a full ethical review at the University of Toronto and an expedited review at Ryerson University. The study was approved in both review processes.

Informed and ongoing consent

Informed consent (appendix B) was obtained prior to all oral interviews with primary and secondary informants based on the Tri Council Policy Statement: Ethical Conduct for Research Involving Humans (Canadian Institute of Health Research, National Sciences and Engineering Council of Canada, & Social Science and Humanities Research Council of Canada, 1998) and Guidelines on Use of Human Subjects (University of Toronto, 1979).

Informants were told (see interview scripts appendix D4 and D5) that they were free to not answer questions and withdraw from the study at any time. They were also assured that they were free to participate or not participate, and their decision would be kept confidential.

Confidentiality

Confidentiality was a concern that was verbalized by all primary and secondary informants. As a result the following strategies were put in place to minimize the risk of confidentiality breeches.

1) Only the researcher had access to a code computer file that linked the informants with their real name and the names used in the dissemination of this research. This document was stored in encrypted format on the hard drive of the researcher's home computer.

2) All paper documents (including consents, demographic forms and pre-interview check lists) and audio MP3 files were converted to a computer file that was stored in encrypted format on a secure network system at the researcher's place of employment. A system pass code and file password code was required to access these documents.

3) Once audiotapes were stored on a USB key in encrypted format. The key was kept in a locked filing cabinet housed in the researcher's locked office.

4) Primary informant interviews were transcribed by the researcher. All identifying information including name, specific injury type, and place of employment were removed from this document. Informants were given the opportunity to select a pseudonym. The way injury details, employer type, age characteristics and the specifics of the nurses story elements was also discussed with the informant. It was agreed that broad descriptors, such as community hospital, back injury were used to be used. All informants agreed that their age could be expressed by the terms new graduate, mid career and end of career nurse.

5) Secondary informant interviews were converted from audio to text format via a professional transcriptionist who was familiar with qualitative data management procedures. All identifying information was removed.

6) Attempts were made to minimize the production of paper copies of the transcripts. Paper copies were made only once for consultation with the project supervisor. These documents were shredded and disposed of professionally.

Conflict of interest

The researcher was employed as a faculty member at Ryerson University, Daphne Cockwell School of Nursing at the time of the study. While it was not anticipated that instructor-student relationships will be a factor, the following steps will be taken to minimize the risk:

1. All informants in this study were made aware during the informed consent process that the researcher was a faculty member at Ryerson University, Daphne Cockwell School of Nursing in the undergraduate collaborative program.

2. Recruitment for this study was limited to students enrolled in the Post Diploma completion and Masters of Nursing programs at both Ryerson University and University of Toronto. Only regulated nurses (registered nurses and registered practical nurses who have membership with the College of Nurses of Ontario) are admitted into these program streams. The researcher has no teaching responsibilities in any of these programs.

3. The researcher was given a verbal commitment from the Director of the Daphne Cockwell School of Nursing at Ryerson University that she would not be assigned any teaching responsibilities in a class where an informant was enrolled.

4. In addition any informants with whom the Investigator had any personal, direct or close indirect connections with (e.g. a parent of an undergraduate student who the Investigator is currently teaching; a teaching assistant who the Investigator is currently worked with) was to be excluded from this study.

On one occasion an informant was in attendance at a venue where this research was presented. At no time did the researcher approach the informant in the reception prior to the presentation. The informant did approach the researcher following the presentation and indicated that s/he felt that confidentiality was maintained throughout the presentation.

Data collection and analysis strategies

Institutional ethnographers tend not to use traditional formal qualitative analytic strategies such as interpretive coding (DeVault & McCoy, 2006). Instead transcribed interviews, maps, documents and field notes are reviewed using an iterative analytical process and successive reading of the data. By moving back and forth between these texts and the context

that produces it, the researcher can map out and explicate how informant experiences take shape within complex institutional chains of action (Smith, 2005).

Phase 1: Primary Informants

The focus of phase 1 in this study is to gain an understanding of the local experiences of nurses who are injured at work and have engaged in RTW.

Prior to data collection: The researcher's map

Prior to collecting data from informants, the researcher engaged in a brainstorming mapping activity around the injury management and return to work process. Turner (2009) refers to this technique as way of "identifying the researcher's working knowledge of the topic from which the research can grow". This introspective process was guided by:

- The researcher's experiential knowledge of injury management from previous professional experience as
  - o a staff nurse,
  - o nurse manager
  - o injured worker
- The literature review;
- A preliminary textual review of the WSIB web site information; and field notes collected at injured workers meetings.

This map was reviewed and refined throughout all phases of the study based on data obtained from various sources. The following map presents the research's initial understanding of injury management prior to interviews with informants in PowerPoint format.

Initial Researcher's Map: July 2008
Based on personal experience as a staff nurse and nurse manager

Ontario Human Rights Code

Nursing Act

Ontario Hospital Act

Regulated Health Professions Act

Union rep

Unit manager

Occ. Health Nurse

Adjudicator

College of Nurses

Ontario gov't

orientation

Registered Nurse

Hospital

Nursing work

Injury incident

Occ Health

File to WSIB from hospital

WSIB claim

Return to work

Modified duties

Full duties

Ontario Nursing Schools

Federal gov't

Policy and Procedures

Joint Health And Safety Committee

WHMIS

WSIB forms

Professional Practice Standards

Canadian Charter of Rights and Freedom

Canada Health Act

Occupational Health and Safety Act

Workers Compensation Act

Key: Texts, Actors, Injury management Trajectory

Primary informants: Inclusion criteria

Primary informants interviewed in the study met the following inclusion criteria:

1) Spoke English;

2) Consented to participate in the study;

3) Self identified as willing to participate in the study;

4) Resided in the Greater Toronto Area.

5) Held registration with College of Nurse of Ontario;

6) Experienced an injured as a result of health care employment;

7) Reported the injury or illness to the employer.

Recruitment strategies

Email strategy

The primary informants for this study were recruited through social networking sampling email strategies (Ross & Glass, 2008). Creswell (2007) might refer to this approach as a chain or snowball strategy, this study uses the term social network sampling (Heckathorn, 2002) because internet technology and email was used to spark the recruitment (Office of Communications UK, 2008). This approach was used as a way of gaining access to informants in a way that clearly dissociated the researcher from a hospital, WSIB or insurance company affiliation.

Once the study was approved, by the ethical review boards of the University of Toronto and Ryerson University, an email (Appendix A1) was sent to 33 of the researcher's professional contacts on September 8, 2008. All email addresses were blind copied to keep addresses confidential. All emailed contacts were registered nurses associated with the researcher through doctoral studies, and a professional nursing organization. Potential informants were asked to email the researcher for further information about the study.

This strategy proved highly successful as four informants were recruited within 24 hours of the initial email solicitation. None of the informants were directly recruited from the original 33 contacts. No informants were known by the researcher. Often a potential informant would

want to know why I was interested in this topic. The following standardized and scripted response was developed to establish rapport:

> *I am a nurse who had an injury. I am doing a study to find out more about other injured nurse's experiences. I don't work for a hospital or the WSIB.*

This response was constructed as a way of demonstrating interest in the topic, recognizing that an the experiences of other nurses are valuable and establishing trust with informants (IE working group teleconference: Dorothy Smith on IE, 2009). In total seven potential informants were recruited through this strategy and four were successfully enrolled in the study.

Introduction letter/ Flyer recruitment strategy

The researcher, a faculty member at Ryerson University, was asked by the instructor of a qualitative research course to give a presentation on recruitment strategies used in her study on September 16, 2008. The recruitment flyer (appendix A 2) for this study was provided to the class as an example. Several students asked if they could circulate the flyer to their various contacts and post them at their places of work. One informant was recruited through this strategy. This informant was not a member of the class. The flyer was also placed on a bulletin board outside the researcher's office. This resulted in two primary informant recruits.

Business card strategy

An "Injured Regulated Nurse Study" business card (appendix A3), containing the researcher's contact information, was also created and distributed to all study informants, professional and academic contacts, and group members from the Research Action Alliance on the Consequence of Work Injury (RAACWI). While this strategy was not successful in recruiting primary informants it did assist in recruiting informants for phase 2 of the study.

Summary of Phase 1 sampling and data collection

In total six registered nurses were recruited and enrolled in the study. Two informants described more than one injury experience. A total of nine injury incidents were used as phase 1 data. A data summary table (see appendix E2) presents a demographic account of these primary informants. The interview scripts found in Appendix D4a was used with all primary informants.

Interviews

Once the researcher was contacted by the informant an interview check list (Appendix D1) was initiated to collect initial demographic data. A more comprehensive demographic form was later completed at the first interview (appendix D2). Two different semi structured interview protocols were used in this study: the first was used in the primary informant initial interviews (appendix D4a); and second interview with primary informants (appendix D4b). A semi structured approach was used because this approach enables opportunities for the informants and researcher to explore unique experiences while still providing some framework for the interview (Ross & Glass, 2008).

All interviews were conducted at a site of convenience to the informant which included: the informant's home; the home of an informant's parent; and a research interview room at Ryerson University. Security procedures are discussed later in the chapter. The duration of the interviews ranged from 80 to 120 minutes. All interviews were audio recorded using digital technology. There were no incidents at any of the interview sites.

Data management and initial analysis strategies

1. Audio files on the recording device were destroyed once data was transferred to computer files for encryption.

2. To facilitate the researcher's immersion in the data an audio review of the recording occurred within 24 hours of the interview. Recordings were transcribed verbatim by the researcher into a word processing document within 2 weeks of the event. Word documents stored in encrypted format.

3. The recordings and texts were reviewed frequently over the period of September 2008 – May 2009. These were specifically examined in the following instances: when maps were reviewed; prior to phase 2 data collection; and following phase 2 data collection. This strategy was used because as Smith (2005) points out, with each successive reading, there is a rediscovery.

4. Member checking style interviews were used in Phase 2 of the study to ensure that the researcher had an accurate understanding of the informant's experience and as a way of verifying accounts.

5. Data summary tables were used to organize data obtained in interviews with injured nurse informants (Appendix E). These tables created a way of focusing the data (Bloomberg & Volpe, 2008) and were reviewed throughout the analysis phase of the study with attention to differences and similarities.

6. Phase 1 transcribed data was initially reviewed looking for:

   o <u>Talk:</u> Key phrases or language used. Secondary informants would be asked to describe these terms in phase 2.

   o <u>Texts:</u> used or referred to by the informants. These texts would be reviewed in greater detail in phase 2.

   o <u>People:</u> Individuals that an informant encountered directly and indirectly. These individuals would become secondary informants (identified by occupational type) in phase 2.

   o <u>Work</u>: Transcripts were reviewed with Smith's "generous notion of work" in mind.

7. Talk, texts, people and work elements were woven into the planning for phase 2 of the study.

8. Consultative sessions with the supervisor and committee members associated with this study also guided the analysis. The researcher met with the supervisor monthly and the committee every three months once data collection was completed. At these meetings the following was discussed: reports on the study progress, data collected, data analysis, study challenges and study refinements. These consultative sessions assisted in guiding the analysis process.

9. Consultative guidance from Dr. Dorothy E. Smith occurred prior to data collection during an intensive workshop and once at the beginning of the data analysis phase of the study.

10. The preliminary findings of this study were also presented at two nursing conferences and two workers' compensation events as a way of gaining feedback on the research, the inquiry process, analysis and findings. Feedback at these events helped to further clarify the findings.

Mapping

Mapping emerged as an unanticipated strategy for focusing injured nurse informant interviews in Phase 1 of the study. During an interview with the first informant, questions and probes failed to focus the dialogue towards the social organization of IM. Instead the informant provided great details about the injury circumstances alone. As a way of refocusing the

interview towards the research question the researcher designed a 'scaffold' map (see page 60 or appendix F2) on the back of the consent form. This map consisted of a linear series of un-linked boxes with words common to a general sequence of injury and recovery experiences that are in the literature. This strategy helped to re-orient the informant. Informants were then given a pencil and asked to provide details on the maps.

This approach proved valuable as a way of re-orienting the interview dialogue and assisted the informants in understanding what was meant by the social organization of injury management (IM) and return to work (RTW).

As a result of the success of this strategy, the scaffold maps were used in all phase 1 interviews. This activity was incorporated into the interview guide to occur after approximately 45 minutes of dialogue. Map 4c presents an example of a map created by one of the injured nurse informants. All maps created by the informants can be found in appendices F3, F4, F5, F6, F7, F8, F9, F10, F11, and F12.

Scaffold map given to the informant

Injury

Incident report

Occ Health

manager

WSIB

Return to work

Modified work

Full duties

Informant's map

Occupational Health nurse

Other staff

Volunteer job

restriction

Union

Charge Nurse

terminated

Occ. Health Dept.

days

Injury

Incident Report

WSIB

Return To work

Modified work

Full duties

surgery

meetings

Functional abilities assessment

No vacation

Husband mad

DEBT

Walk in Clinic MD

Scheduled days off

Kids need nanny

1 month no pay

All maps created by the injured nurse informants were reviewed by the researcher within 24 hours while simultaneously listening to the audio recordings of the interview. Dialogue details that were provided in the first half of the interview and prior to the mapping exercise were added to the map by the researcher. Maps were also transcribed and analysed by the researcher into a PowerPoint format so that they could be reproduced in documents.

As a way of consistently reviewing the maps, the acronym INSPECT was developed to inductively review the map content looking for patterns, people, texts and sequences of action (Smith, 2005; Clarke, 2005; Turner, 2009; Smith, 2008; Rankin & Campbell, 2009; DeVault & McCoy, 2006). The following questions were asked when interrogating each map:

I: What is **I**nteresting about this map?

N: are there **N**ew findings that require a revision in the methods, interview questions or procedures?

S: what **S**equences of action or work are evident?

P: Who are the **P**eople identified in this map?

E: are there other **E**vents that are influencing the sequence that may be (in)visible to others?

C: Are there **C**ommon **C**onnections or **C**ircumstances with this map and experiences of other informants?

T: What **T**exts are talked about?

The researcher's initial map contained little information on the specific circumstances of the return to work; this is in contrast to the injured nurses' maps which contained a significant amount of attention in this area. As a result the focus of the study was refined specifically on the RTW phase of injury management.

Informant's map following audio review of interview
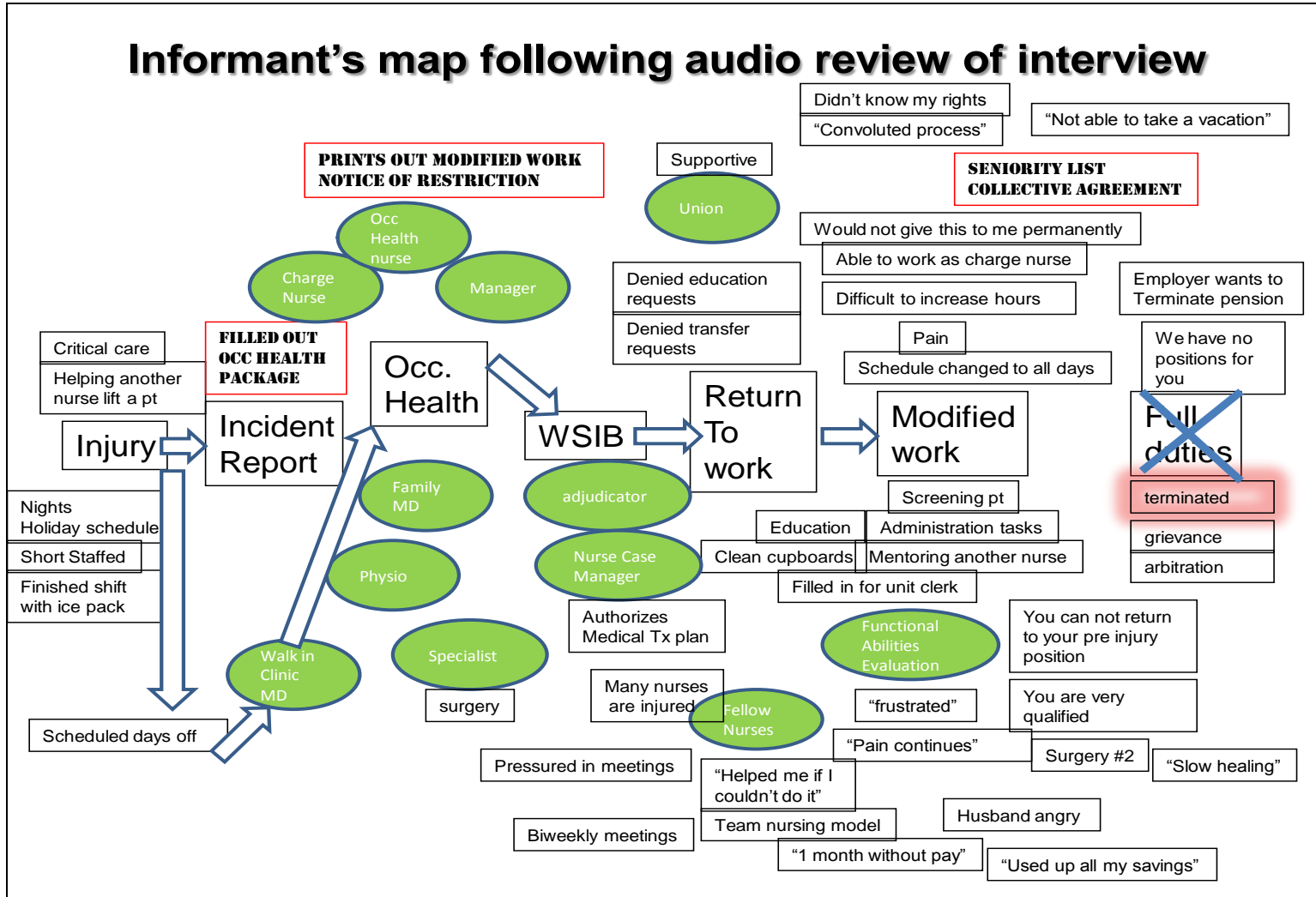
In the previous map you will note that people, who would later become secondary informants, were represented in circles. Texts discussed are represented in boxes with bold face type. Hence, the data obtained in the informant maps, interviews, text and field notes in phase 1 were used to plan phase 2.

Data from informant maps was also added to the researcher's pre study map. This map was created on a roll of artist paper, was over 12 feet long, and with a multitude of colours. The map 4e below represents this map in a format that is suitable for this dissertation document.

Researcher's Map December 2008
Focus on "Return to work"

Assignment Sheet

Schedule

Disability Benefits

Discourse Early return to work

RX benefits

Pension

Collective Agreement

Physio

Seniority List

Short term disability

Long term disability

Nursing Act

Ontario Hospital Act

Regulated Health Professionals Act

ONA central

Benefit Package

Can't report Mental ilness

Family Doctor

Early retirement

No injury management training

Union rep

Third Party Assessments

Scheduler

Re training

Co workers

College of Nurses

Ontario gov't

orientation

Union

Unit manager

Occ. Health Nurse

Adjudicator

Day shifts

Charge Nurse

Vocational assessment

Casual or PT 18% lieu pay for benefits

Restrictions

Registered Nurse → Hospital → Nursing work → Injury incident → Occupational Health → File to WSIB from hospital → WSIB claim → Return to work → Modified duties

Termination /leave

Labour Market re entry

File started

File started

WSIB forms

Doctor's note

Human Resources

Ontario Nursing Schools

Federal gov't

Policy and Procedures

Joint Health And Safety Committee

WSIB number

Educator

Getting signatures

Security

Professional Practice Standards

Change in living circumstances

Financial stress

Shifting Domestic responsibilities

Child and elder Care

Travel to appointments

Discourse Recruitment and retention

Canadian Charter of Rights and Freedom

Canada Health Act

Occupational Health and Safety Act

Workers Compensation Act

Discourse Working efficiently

Discourse Patient Safety

Key: Texts, *Actors,* Injury management Trajectory, ***Italics items identified by participants***

Field notes

Audio and typed field notes were used to capture descriptive, observational and experiential data as well as create a data audit trail (Patton, 2002; Robinson, 2003; Morse & Richards, 2002; Montgomery & Bailey, 2007).   The collection of notes began in July 2008 and throughout the pre interview, interview and data collection, data analysis and write up phases of the research. Field notation took the form of formal audio post interview notes, spontaneous notes and observational notes. Immediately following each interview with primary or secondary informants an audio field note was added to the end of the interview recording. All recordings were done in a private space, usually my car, within 5 minutes of the conclusion of the interview. All post interview audio notes were transcribed into typed notes.

All typed notes were posted directly into a web based journaling system called Penzu™. This is a virtual, encrypted, private journaling web space that provided the ability to access, create and store field notes on the internet. A decision to use the Penzu™ system was based on preliminary feedback from an ethics board reviewing this study. The research ethic boards required that all documents related to this study, including field notes and informant consent forms, be scanned and stored in an encrypted computer file format. Once stored the paper documents could be shredded and disposed of appropriately. The value of creating Penzu™ field notes in this way were: the need to scan documents was eliminated; the risk of losing paper copy field note data is eliminated; the ability to create and retrieve field notes is possible wherever internet access is available; the field note content is auto saved every three seconds minimizing the risk of files being lost; and the password protection features secure not only the overall personal journal site but also each file entry.

As well, field note entries could be cut and pasted into many files during data tracking and analysis. For example, the note "*Look that up [the seniority list] as a text maybe (IRN Laura field note Sept. 21, 2008)*" was not only stored in a Penzu file containing the whole field note, but also it was cut and pasted into another file named "texts to look at".   As well, an independent file called *"seniority list"* label was opened. Added to this file were all references "the seniority list" in any dialogue with informants or review of texts. This strategy allowed for reminder notations that kept the researcher organized, create an audit trail, and facilitated cross referencing materials.

Some file headings are included in the table below:

Analysis file headings

Injury circumstances	Witness	Walk in clinic	Family doctor	Emergency department
Incident reporting	WSIB forms	Physiotherapy	Massage	Driving
Appointments	Specialist	Chiropractor	Partner/husband	Family members
Medical notes	Surgery	Kids child care Elder care	chores	By-law
Occupational health nurse	Adjudicator	Duty to accommodate	Patient safety	Work duties
Non disciplinary	Termination	Cooperation in RTW	New job	cooperation
Ergonomist aids	Restrictions	Charge nurse	Nurse manager	WSIB
RTW	Nursing practice	LMR	accommodation	Discipline
Human Resources	Payroll	Cheque	home	parents
Money	Bank	Credit card	Debt	Mortgage and bills
Union	Educator	Probation	Transfer	College of Nurses
Grievance	Union ONA	Union CUPE	Union OPSEU	Labour relations
Husband	Kids	Neighbours	Household duties	Work duties
Peer nurses	Hospital employees	Incidentals	Driving	Rehab duties

Review of texts

Texts, including on line sources, forms, personal files and legislation, were reviewed. All documents reviewed were publically available or provided by the injured nurse informant and reviewed in their presence. While some broadly relevant textual from the WSIB and the Ontario Nurses Association web sites were reviewed prior to data collection, the majority of texts were reviewed in phase 2 of the study. The texts fell into the following categories a) texts regulating nursing work (Unit schedule, Unit daily assignment, ONA central Collective agreement); b) and texts regulating return to work (copies of physician's note, return to work plan, Workplace Safety and Insurance Act, 1997 section 5, Occupational Health and Safety Act). Some texts, such as hospital policies and procedures, could not be reviewed.

Texts were also systematically reviewed using the document summary form at appendix D3. Special attention was devoted to searching for key terms. A glossary of these terms was created. The glossary proved valuable in facilitating a comparison of key terms and definitions described in various texts such as: provincial and federal legislation, nursing collective agreements, and so on. One informant did provide and share files she had created chronicling

the document's that she had collected during IM. These personal artefacts were reviewed in the informant's presence only. The informant was asked to describe these documents during the interview so that their content could be captured in an audio format.

Phase 2: Secondary Informants

Phase 2 of the study sought to gain an understanding of the complex mechanisms of RTW through interviews with secondary informants, a review of texts and a second interviews with primary informants. This was followed by a comprehensive review of the data from all sources.

Secondary informant: inclusion criteria

All secondary informants in the study met the following inclusion criteria:

1) Spoke English;
2) Consented to participate in the study;
 3) Had knowledge of injury management;
4) Self identified as willing to participate in the study;
5) Resided in the Greater Toronto Area.

Recruitment strategies

Newsletter recruitment

To recruit occupational health nurses for the study an advertisement (Appendix A4 and A5) was placed in the fall issue of the Ontario Occupational Health Nurses Association newsletter published November 11, 2008. This strategy resulted in five email inquiries. Three occupational health nurses were interviewed in the study. The information gained from each of these informants was distinctive. For example, occupational health nurse 1 was interviewed at the beginning of the study and provided information about her role in all phases of injury management. Occupational health nurse 3, interviewed at the end of the study, provided specific detail about the return to work process.

Cold emails

All of the injured nurses interviewed were members of the Ontario Nurses Association (ON) union during at least one of their injury experiences. The union functions at a central and local/hospital.   An email outlining the study was sent on October 7, 2008 to the executive member responsible for health and safety (Appendix A6). This contact resulted in an interview with a labour relation specialist, a local union representative and various health and safety texts that the union distributes to its members. The local representative provided information about return to work meetings. The ONA central representative provided information about the WSIB appeals process and injury cases that resulted in termination.

Spouse volunteer

During one informant interview a spouse volunteered to be interviewed. The informant agreed that the partner would provide valuable information for the study. An appointment was made to interview the spouse in private at another time. The spouse provided information about the impact of injury management and return to work on the home environment.

Social networking contacts

Social networking through informant contacts proved to be the most successful mode of recruiting secondary informants. Informants and contacts would provide people with my contact information and asked them to contact me. This strategy resulted in the enrolment of three charge nurses, three staff nurses who had worked with injured nurses, a nurse manager, a former workers compensation case manager, a nursing supervisor, a non nursing manager, a nursing executive, registered massage therapist who returned to school to become a physiotherapist, and an orthopaedic surgeon. Charge nurses, staff nurses, the nurse manager and the nursing supervisor provided information about the issues of (re)assigning nursing work to a returning worker given hospital scheduling mechanisms.

Establishing rapport

Twice I was asked by potential secondary informants if I was employed by the nurses' union. Once I identified that I had no union affiliation but rather nursing managerial experience working with injured nurses their receptiveness to my recruitment request became favourable. As a way of establishing a rapport with potential secondary informants a scripted response was created.

> I am a nurse who had an injury. ***I am* also *a former nurse manager who had trouble finding appropriate modified work for a nurse.*** I am doing a study to find out more about other injured nurses experiences. I don't work for a hospital or the WSIB.

Summary of Phase 2 sampling and data collection

Interviews: secondary informants

In total 22 secondary informants were recruited and enrolled in the study. All had information about injury management in the hospital setting. A semi structured interview approach was used in secondary informant interviews (see appendix D5). All interviews were conducted at a site of convenience to the informant which included: the informant's office; a coffee shop; and a research interview room at Ryerson University. The duration of the interviews was 40 – 60 minutes. Demographic information was collected once consent was obtained (see appendix D6). A request was made at each interview for an audio recorded using digital technology to be made. Four informants refused to be recorded. They did consent to having notes taken by the researcher during the interview. Immediately following the interview the researcher made extensive audio field notes. All other interviews were transcribed.

Secondary informant interviews were converted from audio to text format via a professional transcriptionist who was familiar with qualitative data management procedures. All identifying information including name, specific job title, and place of employment were removed from this document. For example, in some hospitals the role title may be specific to the institution and using this title may reveal the informants identity. All occupational categories used in the study

were verified with the informants to ensure that they were appropriate. A data summary table outlining key findings from each informant can be found at appendix E3.

Interview: Primary informant #2

All primary informants were interviewed a second time approximately three – six months following the initial interview. The locations of the interviews were similar to the first. All interviews took a semi-structured format. Questions were individualized based on the review of informant's first interview and data obtained from other sources (see appendix D4b). Some questions focused on clarifying what was said in previous interviews. Hence this was a modified form of member checking. Procedures for handling this data were the same as in phase 1.

Comprehensive analysis and synthesis of all data

While analysis was an ongoing process throughout all data collection occasions, a more structures and comprehensive analysis of all data from all sources occurred following the completion of all secondary informant interviews. A three phased analytic approach informed by McCoy (2006) was employed when reviewing interview data. In the first phase of the review of primary informants' interviews were analyzed with the goal of describing the work involved in return to work. The following questions adapted from McCoy were used:

1. What is the work that this informant is describing?
2. What is involved in this work?
3. How is this work connected with other people?
4. What type of knowledge and skill is required to do this work?
5. What are the barriers in doing this work?
6. What are the successes in doing this work?
7. What evokes the work?
8. How is the work articulated to institutional work processes and the institutional order?

The audio interview data, informant maps and texts were reviewed and the analytic questions above answered with the intention of developing an understanding and appreciation for the individual's embodied experience.

In the second step of the analysis the informant's interviews were reviewed with attention to the interface between the informant and the institutional processes of return to work (McCoy, 2006). The goal in this portion of the analysis was to bring the institution of return to work into view. This data was also chunked together into files for review (as described above in the field note section).

Making sense of the data with maps

Mapping techniques and the use of visual representations of the data were also used by the researcher in an attempt to analyse and make sense of the data. An artist sketch book was used by the researcher to play with the data and facilitate immersion. Various attempts were made to make connections, find patterns and visually see what was happening. This process, which took over a year, was ongoing throughout the data collection and analysis phase of the study.

The researcher also returned to the writings of Smith (1987; 2006) for a re-immersion in institutional ethnography. A key passage from Smith (1987) in which she recalled her experiences as a single mother and professor sparked new insights into the data from this study. In her account she described how she was engaged in two distinct work types and settings- one in the academy and the other at home with her children. Cognizant of this approach, attention was directed towards the various types of paid and unpaid work that the IRNs engaged in during RTW. Inductively, through this drawing and mapping process, it quickly became apparent that the injured nurses engaged in three types of work in distinct geographic settings – domestic work in their homes, injury work in medical offices and accommodation work in the hospital. Next secondary informants affiliated with these types of work were added to the diagram. Finally texts described by the informants were added. The following map represents the final product of the analysis and how the findings are presented.

The work of "Return to Work"
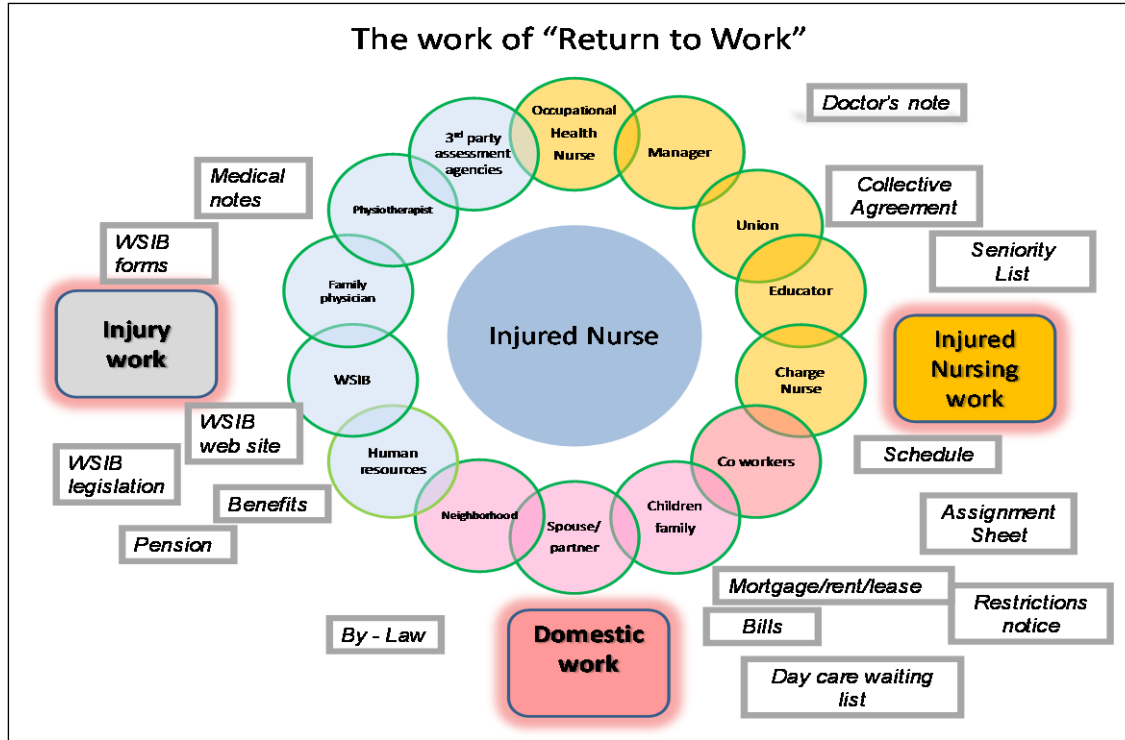
Summary

In summary in this chapter provides an account of the data collection, management and analysis strategies employed in this two phased institutional ethnography. Phase 1 of the study was designed to gain a detailed understanding of injured nurses' everyday experiences of injury management. Following preliminary analysis of the data the study focus narrowed to look at the return to work portion of injury management specifically. A pathway to secondary informants and relevant texts was created through this analysis as well. In phase 2 of the study secondary informants, people who the nurses encountered in return to work, and relevant texts were analysed. A comprehensive analysis of all the data, a review of Smith's (1987, 2005, 2006) approach and the use of mapping techniques revealed that the injured nurses engaged in three types of work during return to work- domestic, injury and injured nurses work.

Before presenting the findings chapter 5 will describe the context of Ontario workers' compensation and provide the official view of the workings of injury management and return to work. Chapter 6 called the *(in)visible work of return to work* described three types of work activities that injured nurses as they engaged as they return to work: domestic work, injury work and injured nursing work. Chapter 7 will present the institutional organizing factors of health care and how RTW "works" in Ontario hospitals.

CHAPTER 5: Institutional discourses: Ontario Workers' Compensation

This chapter presents a historical overview and brief background into Ontario workers compensation and sets the context of injury management into which the injured nurses returned. Early in the study, following interviews with a number of injured nurse informants, it became evident that policies and practices surrounding return to work were important and a central focus in the dialogue. This chapter begins with a historical overview of Canada's, and specifically Ontario's, development of ideas and approaches to workers' compensation. The chapter concludes with a discussion of current return to work practices in Ontario.

The content of the chapter emerged primarily through textual review of the Ontario Workers' Compensation and government web sites, and the review of a seminal report that created the foundational premise of Ontario workers compensation approaches by Ontario Chief Justice Meredith and supporting documents held at the archive collection of the University of Toronto. The review of these texts occurred while awaiting ethical approval prior to the commencement of recruitment. The background of policies, practices and discourses surrounding workplace compensation in Ontario provides insights into the way in which informants stories unfolded during the analysis phase of the study.

Introduction

The end of the nineteenth century was a major period of worker legislation reform in the province of Ontario. This was a period of immigration and urban development that drew many people away from the farms and the logging industry in rural sites and into the manufacturing, mining and construction sector that boomed at the beginning of the twentieth century in urban centres.   In Ontario cities such as Toronto, Hamilton, and Oshawa factories produced railway cars, harvesting machinery, automobiles, helmets and ammunition which were shipped via the Great Lakes and St. Lawrence Seaway to trading partners in the United States. The nickel mining industry became the primary employer in the Sudbury area (Winder, 1994; The Ministry of Labour, 2009). As a result of this shift in employment locations and practices several legislated acts to protect workers (see appendix E4).

With the movement to industrialized modes of production came many workplace injuries. At that time an employee's only course of action following workplace injury was to sue the employer for salary compensation and health expenses. This process resulted in much legal bantering between the parties. The injured worker required proof that the employer had failed to maintain a hazard free work environment. Alternatively, the employer had to prove that employee error cause the accident. Injury related judicial proceedings filled court dockets. The decisions of such cases in favour of the injured worker could result in large cash awards. A negative ruling would result in a dismissal resulting in no settlement. The latter verdicts often led to a path of destitution for the injured worker. On the other hand, guilty employers would be required to pay a large settlement to the worker. The amounts of these settlements could cause bankruptcy and/or business foreclosure. An employer's exoneration could lead to workplace hazards prevailing and the health and safety of other workers compromised. It is no surprise that the majority of the decisions favoured the employer and sustaining industry (Keith & Neave, 2007).

In response to these disputes Chief Justice Sir William Ralph Meredith, a former provincial leader of the conservative party, was appointed by a Royal commission of the Ontario government to study worker compensation. Meredith reviewed the systems in England, France, Belgium, Germany, the United States and other Canadian provinces. In 1913 Meredith's report was released. This document supported a compensation system based on: collective liability; no-fault insurance; independent administration; a wage-loss approach to calculating benefits for injured workers; and exclusive jurisdiction. The report reflected Meredith's concerns and alliance with injured workers. The main recommendations, which are still utilized today, were based on the principles 1) security of payment ensuring that the injured worker will have guaranteed compensation for the length of the injury on accepted claims and; 2) a no-fault system where the proof of party negligence was not required. Meredith (1913) writes in the report:

> In these days of social and industrial unrest it is, in my judgment, of the gravest importance to the community that every proved injustice to any section of class resulting from bad or unfair laws should be promptly removed by the enactment of remedial legislation and I do not doubt that the country whose Legislature is quick to discern and prompt to remove injustice will enjoy, and that deservedly, the blessing of industrial peace and freedom from social unrest. Half measures which mitigate but do not remove injustice are, in my judgment, to be avoided. That the existing law inflicts injustice on the workingman is admitted by all. From that injustice he has long suffered, and it would, in my judgment, be the gravest mistake if questions as to the scope and character of the proposed remedial legislation were to be determined, not be a consideration of what is just to the workingman, but of what is the least he can be put off with; or if the Legislature were to be deterred from passing a law designed to do full justice owing to groundless fears that disaster to the industries of the Province would follow from the enactment of it (p. 22).

Based on the Meredith recommendations, new injured worker compensation legislation, called the *Workmen's Compensation Act*, became law in 1914.

The premise of this act was that some level of workplace injury is inevitable and that compensation should be provided without regard to responsibility. This law required workers' to give up their right to sue the employer when injured in exchange for a no-fault compensation and benefits administered by a third party that would pay pre-injury income as long as the disability lasts. The intention of this system, financed solely by the employer premiums, was to relieve injured workers of the expense, risk and legal uncertainty of a lawsuit against the employer. To administer this program a third party agency called the Workmen's' Compensation Board (WCB) was established as an agency of the provincial government. From 1914 to 1998 various amendments to the legislation focused on supporting worker health, safety and financial viability. Pursuant to these amendments waiting times for compensation were eliminated; benefit levels increased; occupational diseases were deemed compensable; and an independent appeals system was created. The foundational principles outlined by Meredith's report remained intact in all of these legislative enhancements until 1998 when new workers' compensation legislation came into effect.

The Harris government: Impact on workers' compensation and health care

During the mid 1990's a shift in provincial government leadership and a mounting deficit sparked the election of Progressive Conservative premier. "The Common Sense Revolution" began with the election of the honourable Mike Harris (in office from June 26, 1995 to April 15, 2002). This neoliberal approach promised a 30% reduction in income tax over a three year period and comprehensive reform of social programs. The policy revolution resulted in dramatic changes. For example, the responsibility for social welfare programs shifted to local governments; dramatic budget cuts in public education funding emerged; several urban municipalities combined to form the Greater Toronto area (GT); hospital board restructuring, amalgamation or closure took place, and changes to labour laws emerged (Hillmer, 2009). The Harris government undertook drastic cuts to health care services. Subsequently, hundreds of full time nurses lost their positions due to budget cuts. Nurse to patient ratios increased significantly (Ontario Nurses' Association, 2009). Harris also initiated "workfare", a program which required welfare recipients to perform work or take courses in order to receive financial support. During a speech shortly after his election on June 6, 1995 Harris said:

> All able bodied recipients [of welfare] will be required to participate in a mandatory workfare or learnfare program. Those who refuse to participate will receive no money from tax payers (Canadian Broadcast Corporation, 1995).

The Harris government scrutinized the Workers' Compensation Board (WBC) as well. A growing number of high cost claims outstripped employer premium input. To rectify this imbalance a new Workplace Safety and Insurance Board (WSIB) was created in 1997 and the WCB closed.

The current context: the Road to Zero

The WSIB created a new focus on the prevention of injuries and illnesses. Workplace safety, research, education and training programs were established. The principles of the Meredith Commission (1913) continue to be foundational to the new WSIB. Disability benefits continue to be administered by this agency. However, a new focus for this organization is emerging. The slogan "The road to zero" reflects the WSIB commitment to eliminate all

workplace deaths, injuries and illnesses.   Several new features emerged in the new WSIB agenda. For example, research focused on claim duration reduction and injury prevention interventions has emerged as a priority. Strategies to monitor the effectiveness and efficiency of health care service have developed. Employer premium rates are no longer fixed but rather contingent on the injury prevention initiatives and injury claims filed for a company.   Most importantly a new approach to injury management called "early and safe return to work" (ESRTW) has been implemented as a way of reducing claim costs.

WSIB premium

A new insurance approach to employer premium calculations has developed with this model.   Ontario employers still continue to finance the compensation system however the mode of premium calculation has changed. Premium amounts are based the company payroll and can amount to between 0.18 to 15.86% depending on the industry or occupational classification scheme applied to the organization (Workplace Safety and Insurance Board of Ontario, 2008). For example, an employer in the clothing store sector pays a different rate from a health care sector employer.

The employer premium calculations are not fixed. There are penalties for employers who contribute to a worker's injury or disease.   These situations can result in a transfer of the direct costs for the claim back to their organization and/or a fine levied (Workplace Safety and Insurance Board of Ontario, 2001). Alternatively, employers receive rewards for meritorious reductions in injury claims or engaging in a workers' early return to work.   Refunds and surcharge adjustments are applied to the employer account in these circumstances (Workplace Safety and Insurance Board of Ontario, 2007). This type of system creates incentive for individual employers and the employment type sector to monitor their injury reporting patterns and participate in an early return to work program. In sum, the Meredith principle of an employer financed injury compensation system remains in this new system. However, the new system promotes an incentive-based program focusing on the prevention of injury, and reduction of costs and claims.

Injury prevention

A key public strategy used by the WSIB in the area of injury prevention was a media campaign targeted at high risk injury groups such as youth, construction and the service industry. Several televisions commercials were developed by the WSIB as part of their "prevent it" campaign. These graphic commercials, which aired on various television networks, showed the graphic details of catastrophic workplace accidents: a sales clerk falling from a ladder, a forklift driver being crushed by debris, a chef being scalded by oil; and a construction worker falling from a building (WSIB, 2008). The common message in each episode is that: an action of the individual or employer can be blamed as causing the injury scenarios; injury prevention strategies could have alleviated the injury; and employers and employees are responsible for maintaining a safe workplace. None of the media campaigns presented to the public showed health care worker injuries.

Injury Research

The initiation of the WSIB agency sparked a commitment to research based knowledge related to workplace injury and occupational health and safety (OH&S). A research advisory council was created in 1998 and three research centres were established: the Centre of Research Expertise in the Prevention of Musculoskeletal Disorders; the Centre of Research Expertise in Occupational Disease; and the Centre of Research Expertise in Improved Disability Outcomes. The purposes of the Centres were to:

- attract established and new researchers to help identify and solve work-related injury and disease problems, thereby increasing OH&S research capacity in Ontario;
- expand the interaction of researchers with employers, workers and other stakeholders in research proposal development, execution and knowledge exchange ;
- realize effective multidisciplinary research on multidisciplinary problems
- develop a coordinated, coherent, province-wide program of research ;
- improve development of transferable research-based knowledge ;
- promote a culture among potential users of finding and using current research-based knowledge to inform occupational injury and disease intervention, and ;
- produce highly qualified people at the diploma, undergraduate and graduate levels for the future
  (http://www.wsib.on.ca/wsib/wsibsite.nsf/Public/CentresResearchExpertise).

The research agenda for the WSIB was focused on interventions to prevent injuries and strategies to facilitate the return of injured workers back to employment.

Early and Safe Return to Work discourse

A formal return to work (RTW) process called *Early and Safe Return to Work* (ESRTW) is another key strategy to relieve financial pressure on the WSIB (Workplace Safety and Insurance Board of Ontario, 2007). The specifics of the process are outlined in section 5 of the Workplace Safety and Insurance Act. The premise of this approach is that the return of injured employees back to the workplace, often prior to a full recovery, is beneficial for both the employee and employer. The employee must engage in modified work created to accommodate their functional limitations and minimize the risk of re-injury. WSIB tells injured workers and employer's via web-based and pamphlet that RTW can

> minimize the human and financial impacts by focusing on getting the worker back to safe and productive work as soon as medically possible (http://www.wsib.com/wsib/wsibsite.nsf/Public/EmployersESRW).

In addition employees are told

> Returning to daily work and life activities can actually help an injured worker's recovery and reduce the chance of long- term disability (http://www.wsib.com/wsib/wsibsite.nsf/Public/ReturnToWork).

While employers are told

> The injured worker benefits by restoring their source of income and staying active and productive, both of which are important to the healing/recovery process. You benefit by retaining valuable and knowledgeable people who contribute to your company's financial and market success (http://www.wsib.com/wsib/wsibsite.nsf/Public/EmployersESRW).

Embedded in ESRTW is a shifting of administrative responsibility for the return to the injured worker away from the WSIB and to the employer.

Deeming a worker fit to return to the essential duties of their pre-injury job is a decision made by the employee's physician often in consultation with a third party functional abilities assessment agency. The WSIB has focused considerable attention on educating physicians on their role in RTW. To assist physicians a booklet, titled Injury/Illness and Return to

Work/Function: A Practical Guide for Physicians, has been published and circulated. The intention of the document is to:

> …educate physicians, residents and medical students how to manage the return to work/function of their patients following injury/illness (Workplace Safety and Insurance Board of Ontario, 2000, p. 2).

The document describes the physician's role not only in diagnosing and treating the patient but also promoting a speedy recovery through early return to work and communicating with WSIB and the employer (if consent is obtained). The document also promotes utilizing third party agencies to assist in determining a patient's functional ability.

> When filing a claim, a worker must consent to the disclosure of functional abilities information to the employer by the treating health professional. The disclosure is specifically for the purpose of aiding in the worker's return to work (http://www.wsib.on.ca/wsib/wopm.nsf/Public/190204).

To assist physicians in assessing functional abilities a formal referral process (Workplace Safety and Insurance Board of Ontario, 2006) has been established.

The ESRTW program expects that employers select "some type of meaningful work" for the worker in the reemployment process. This "modified" work, which is often quite different from pre-injury work, needs to be congruent with the returning worker's abilities. The selection of appropriate and safe modified work which minimizes the potential for re-injury is essential. The work must be within the physical capabilities of the worker and take into consideration any "restrictions" that are imposed on the worker and documented in a physician's note. Common restrictions are weight limits for lifting, reduced work hours or prescribed additional rest breaks. Mandatory and frequent meetings between the employer and injured employee, provide a way of evaluating the worker's performance and progress towards resuming their pre-injury position.

The WSIB's monitors RTW activities via progress reports and assesses the worker's functional progress by reviewing medical reports.   The WSIB plays a role in maintaining "cooperation" between the employee and employer. While the specific mechanism for monitoring cooperation is unclear, penalties can be levied by the WSIB if either the injured employee or employer are uncooperative or passively engage in the RTW process.   For the employee this charge could result in a reduction, suspension or stoppage of compensation benefits. In contrast employers could receive a fine (Ontario Workplace Safety & Insurance Act

1997).   Hence the WSIB places responsibility for the logistics of return to work on the employer and injured worker.

A critical element of the system is that compensation costs for the injured worker shift from the WSIB and to the employer as the hours of work increase. On the other hand, employers are only required to engage in this RTW re-employment process until one of the following occurs: 1) one year has elapsed from the time the worker was deemed fit to return to the essential duties of their pre-injury job; 2) two years have elapsed from the date of the injury or illness; and 3) the worker reaches the age of 65 (Ministry of Labour,1997). Once one of these criteria is met the employer is no longer obliged to support the worker in the provision of accommodated work.

Labour Market Re-entry

If the injured worker is dismissed by their employer, they may qualify for a labour market re-entry (LMR) assessment (Workplace Safety and Insurance Board of Ontario, 2007). An assessment happens when: it is unlikely the worker will be re-employed by their employer due to the nature of the injury; the worker's employer is unable to arrange suitable and available work for the worker that restores him/her to pre-injury earnings; or the employer is not cooperating in the RTW process. In these situation, compensation responsibilities for the worker shift back to the WSIB. The purpose of LMR is to ensure the injured worker has the appropriate skills, knowledge and abilities necessary to re-enter the labour market and restore their pre-injury earnings. Based on a WSIB assessment, the injured worker may be eligible for vocational retraining. As with all WSIB processes, the injured worker is required to co-operate in all aspects and activities of the LMR assessment and retraining plan if they wish to receive compensation.

Health care

Health care is classified as a high risk industry for injuries and has correspondingly high premiums (Sikorski, 2009). The patterns of injuries sustained in the health care sector are different from other sectors in Ontario. The Ontario Safety Association for Community and Healthcare (OSACH) reports that there are higher rates of musculoskeletal, violence, exposure and unclassified injuries in the health care sector. Jocelyn Sikorski (personal communication, 2009), President and CEO of OSACH, reports that statistics specific to a nurse job classification

have not been produced. Hence, the accuracy of such data may be questionable. Data entry errors in occupational title codes are problematic. This data assigns all occupational codes affiliated with nursing services such as health care aids, personal support workers and nurses, into the same category.

Summary

This chapter set the contextual background of injured worker compensation practices in Ontario. In Ontario employees who are injured or become ill at their place of employment receive compensation while recuperating from injury via an independent agency. Financial deficits due to high cost claims sparked the creation of a new compensation board known as the Workers' Compensation and Insurance Board (WSIB). This compensation system is funded solely by insurance premiums paid to the WSIB by employers. The primary focus of this organization is to reduce the number and length of injury claims and maintain the viability of the system. Injury prevention, education and research are also a priority. Financial incentives accompany low rates of injuries. Penalties and fines accompany poor performance. A key initiative, called early return to work, supports the reemployment of an injured worker prior to a full recovery. The WSIB promotes this program as beneficial for both the injured employee and the employer.

All nurses interviewed in this study were engaged in the ESRTW process. Yet none returned to work in their pre-injury roles. New graduate nurses (IRNs Laura and Linda) were unsuccessful in completing their probationary periods of employment because they had failed to demonstrate all of the required skills. Mid career nurses (Bena, Jane and Shire, IRNs) were terminated from employment by the hospital at the end of two years because the hospital indicated that they were unable to provide suitable work. Finally end of career nurse (Cindy, IRN) was encouraged to accept an early retirement package. All nurses returned to work prior to a full recovery and engaged in accommodated work as required. They all adhered to the policy of ESRTW as outlined.

In the chapters that follow a description of how the experiences of injured registered nurses were shaped by the return to work practices in the hospital setting will be presented.

CHAPTER 6: Nurses as working women

Introduction

This chapter builds from Smith's (2005) notion of work to make visible the activities that the injured nurses engaged in as they returned to employment. DeVault and McCoy (2006) suggest the concept of work should be considered as an empirically empty term that the researcher fills with the specific embodied actualities of what people do as they engage in a process. Mindful of this analytic approach I began to map the data looking for commonalities that were the result of institutional processes. In mapping the secondary participants by geographical context it became apparent that nurses were engaged in work related to their RTW in three places – in their homes, in rehabilitation and in the hospital workplace. Over a six month period of immersion in the data through a review of interviews, maps and discussions of my findings with others, a crystallization of the work in which injured nurses engaged emerged (Borken, 1999).

This chapter describes the three types of work of injured nurses during their return to work – domestic work, injury work and accommodation work. These intractable spheres of work operate in the background of the nurses paid employment duties. Yet the activities associated with this work are an essential part of RTW. Nonetheless theses duties are taken for granted in discourses of injury management and health care.

Initiating the sequence of action of return to work

Management: supporting the worker

The planning of return to work is a complex process requiring the activation and participation of multiple people within the health care setting who come together to support, educate and monitor the injured worker. Once an injured worker is medically cleared with a note from a physician or physiotherapist to return to work a meeting between the worker, occupational health, unit manager, educator and local union representative is set up. The focus of the meeting surrounds planning the returning worker's duties and work hours. The assigning of an injured nurse to an all daytime hour schedule seems to be a common practice in hospitals. An occupational health nurse explains the benefits of this standard approach.

We put them on day shift so that we can watch them push them a bit, meet with them and make sure they are safe. We push them so that they get back to work but we don't want them to get hurt again… Because we are only in day shift Monday to Friday they are put on our schedule. We are not open in the evenings, on nights or on weekends. Being on days just makes things easier. So if the worker is not feeling well, needs to rest or needs a bit of support we are there for them (Occupational Health Nurse).

An educator who has worked with nurses returning to work explains the educational benefits of this type of schedule.

My job is to make sure that nurses are practising in competent ways. So when they come back to work I need to watch them and make sure they are at the appropriate level. Sometimes I need to give them a refresher on things because they forgot or if new things have come up while they are away. You know we have to make sure they are safe. We have to. So since I only work days the nurse has to be on days too (hospital nursing educator).

Under WSIB protocols and legislation an employer has certain expectations that they must fulfill in the RTW process. Occupational health nurse 3 described how the all-day shift schedule facilitates management and union meetings with the injured worker.

Being on days makes it easier to schedule the meetings between the injured worker, the manager, union rep and me to see how things are going. It's at these meeting that we look at how the worker is doing, if we can make them do more things or if they need a little nudge to get them back. Well, actually some need a big push (Occupational Health Nurse 3).

Hence hospital management teams place returning nurses on an all day shift rotation as a way of providing access to educational and occupational health services and facilitating return to work meetings between the injured nurse, management and the union.

Shift work

Scheduling is a complex activity. As shift workers, all of the nurses interviewed in this study organized their personal, family and social activities around their employment or shift schedule. Most in-hospital staff nursing positions are affected by a requirement to work beyond

traditional Monday to Friday 9 a.m. to 5 p.m. business hours. The staff nurses interviewed in this study worked on a rotating day, evening, night and/or weekend schedule. The consistency of the nurses' schedule, often planned three to four months in advance (Nurse Manager 1), allowed for planning of family, social and personal activities around their paid employment schedule. While much of the literature notes the negative aspects of this type of work, such as fatigue, there are many benefits (Blachowicz & Letiz, 2006) that were described by the nurses interviewed in this study.   IRN Laura explained the merits of the shift rotation referred to as "*2 days, 2 nights, 5 off*" (see table 6).

> *2 days, 2 nights, 5 off is a great schedule. Especially for people like me who work in the city but live in the suburbs. You start day shift at 7 am, so you come in before the rush hour starts. Then when you go home at 7 [pm] when rush hour has finished. So you breeze home. The 5 days off are great too. And if you want to take vacation you only need to take 4 days off and have a 14 day vacation. I have gone to the Caribbean a few times now (Laura, IRN)*

Shire concurs with this view and elaborates on how the structure of this type of schedule reduced child care costs.

> *2 days, 2 nights, 5 off really minimizes my daycare costs. I only need daycare when I work a weekday day shifts. My husband looks after the kids on nights and weekend days... Now finding the daycare on the days I work was a bit difficult at first. Because I start so early and have to drop off the kids by 6am in order to get to work. But I found a neighbour and I pay her well. So now I am set. And she only has to do it 5 days a month so it is all good all round (Shire, IRN).*

To illustrate this point Shire drew the following:

Table 6: Child care schedule for 2 day 2 night schedule

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
D 12 **Child care needed**	**D 12** **Child care needed**	N12	N12	off	off	off
off	off	**D12** **Child care needed**	**D12** **Child care needed**	N12	N12	off
off	off	off	off	**D12** **Child care needed**	D12	N12
N12	off	off	off	off	off	D12

> *Here is how it goes [draws schedule]. So see, I only need a*
> *babysitter 5 days a month here, here, here, here and here (pointing*
> *to the schedule).... So it is great. I can go on school trips with the*
> *nursery school or do Mom and Tot swimming. All that Mom stuff.*
> *So even though I work shifts I know my schedule so it all works out*
> *and I can be with my kids. And if I can't be there then my husband*
> *can take them one week. So it all works out great (Shire, IRN).*

Bena, a nurse with elder care responsibilities, used her schedule to tend to her mother's needs during the week. She explained:

> *Every Wednesday is my day to take Mom shopping, get her hair*
> *done, and go to the bank. It is much better going on weekdays*
> *instead of battling the weekend crowds. Mom relies on me for our*
> *Wednesday outings (Bena, IRN).*

Cindy described how her shift schedule allowed for participation in church activities:

> *I'm really active in my church. We make up baby layettes and*
> *send them to third world countries. Most of the women in the*
> *group are retired so they meet Tuesday mornings at 10. Me being*
> *on shifts let's me be a part of this group. If I worked Monday to*
> *Friday I wouldn't be able to go (Cindy, IRN).*

The predictability of the nurse's schedule was removed once she engaged in RTW activities. As a result many of the social and personal activities of the nurse become disorganized. Activities that the nurse engaged in prior to her injury, such as engaging in church groups or family care, had to stop once they began the daytime hour RTW schedule.

Injured Nurse: working with the RTW schedule

The requirement to engage in an all-day shift schedule not only interfered with the personal, family and financial benefits of shift work once enjoyed by the nurses but also significantly interfered with domestic living and rehabilitation treatment plan. Bena in recalling her RTW, exclaimed "*Everything at home went wrong when I went back to work because of the damn schedule*" *(Bena, IRN)*. One reason for this was the unpredictability of the work days and hours. To illustrate the schedule changes IRN Laura presented the following rotation (see table 7).

Table 7: RTW graduated schedule

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total hours
1	0900 - 1200	off	off	0900-1200	off	off	off	6
2	0800 - 1200	off	0800 - 1200	off	0800-1200	off	off	12
3	0700 - 1500	0700 - 1100	off	0700 - 1500	off	off	off	20
4	0700 - 1500	0700 - 1100	0700 - 1500	off	0700 - 1500	off	off	28

As Laura created this diagram she exclaimed *"See, the schedule is all over the place. So I never knew if or when I was working" (Laura, IRN).* The schedule above created by Laura shows that the days and times of the nurse's schedule are inconsistent. Jane who initially engaged in a schedule of RTW similar to above explained that she was forced, following a relapse in her injury, to return to this type of erratic graduated shift rotation schedule shifts over and over again during a two year period following injury relapses or surgeries. This constantly changing schedule creates a significant effect in the daily lives of the nurses and caused a disorganization of their domestic and rehabilitation responsibilities.

Domestic work

Domestic work refers to at home work that the nurses were usually responsible for prior to the injury. These activities included child and elder care, house work and maintenance and relationships with other family members. When the nurses RTW much effort and work went into reorganizing their domestic responsibilities as a result of their modified work schedule. The all day shift return to work schedule created much anxiety for IRNs. Shire explains:

> *I can't just go on all day shifts (after working a normal rotation of nights and weekends). How am I going to find new day care (Shire, IRN).*

Shire's comment represents some of the work that needed to do in order to return to work. Securing child and elder care services, increased spending, more time spent travelling, waiting for money and mending family relationships were described by the nurses as some of the domestic work that they needed to engage in as they returned to work.

Child and elder care

The requirement to work an all-day shift schedule creates domestic challenges for the nurses in the areas of child/elder care, financial burden and relationships.   As previously discussed above the benefits of a shift work schedule were lost once the nurse was placed on an all day shift schedule when they returned to work. For Shire her child care needs increased dramatically from 5 days per month prior to her injury to potentially 12 (table 8) or more days a month.   In addition she had to work to find a new source of care as her regular babysitter was unable to accommodate the new schedule. Traditional licensed daycare operators were not a viable solution for this scheduling challenge as their hours of operation do not begin until 7am (the time when nursing shifts start) and there was no available of spots for three children.   The hours of operation for licensed daycare agencies are better suited for 9 to 5 Monday to Friday employment patterns.

Table 8: Child care requirements during RTW

Mon	*Tues*	*Wed*	*Thurs*	*Fri*	*Sat*	*Sun*
off	**D 4 hours 0700-1100h**	off	**D 4 hours 0700-1100h**	off	off	off
D 4 hours 0700 – 1100h	off	**D 4 hours 0700- 1100h**	off	**D 4 hours 0700-1100h**	off	off
D 6 hours 0700 – 1300h	off	**D 6 hours 0700-1300h**	**D 6 hours 07-1300h**	off	off	off
D 8 hours 0700– 1500h	**D 8 hours 0700-1500h**	off	**D 12 hours 0700-1900h**	**D 12 hours 0700-1900h**	off	off

So this is the day care I needed. But my regular babysitter couldn't take the kids on these days because she schedules her stuff around my schedule. So that was no good. And you can't just get 3 kids into a regular daycare overnight. My Mom works, my husband can't take time off work because he has already taken so much time off to drive me places when I was first off. So there was nobody. Simply nobody (Shire, IRN).

Interviewer: So what did you do?

I found an emergency daycare agency that sent someone to the house. Like a nanny. But I had to pay big bucks. And they were here everyday. I paid more in child care than I made. And it was different people all the time. So here I was trying to get back to work, with different strangers in my house each day. The kids suffered so much because of this. They were cranky, clingy, just

> *unsettled. It was a mess. They couldn't go to dance or skating*
> *lessons anymore because I was never able to get there in those*
> *days. So I just went back to work- full time, no modified. It was the*
> *only way we could get back to normal and survive (Shire, IRN).*

For Shire the disorganizing effect on her child care arrangements was so significant that she went back to work full time against medical advice.

Bena had similar challenges with her elder care responsibilities. Her irregular visiting pattern also compromised her mother's health and lead to confusion.

> *Mom really started to go downhill because the routine was gone.*
> *She didn't know when I was coming even though I put it on the*
> *calendar and would tell her. Sometimes I had to take her shopping*
> *on weekends which was so hard for her because of the crowds.*
> *This whole thing was hard on me and my family but it was*
> *especially hard on Mom (Bena, IRN).*

Bena resorted to using an internet grocery services for her mother. While this service was more costly than buying groceries in a store, Bena believed this strategy might reduce her mother's confusion.

In summary, the all day shift return to work schedule disrupted family schedules and created domestic work for the nurses as they sought strategies to secure child care and elder care services. For the children and the elderly parent this change was manifested in physical ways. Hence the new schedule and subsequent routine changes proved to be not only financially costly but also socially disorganizing for the families.

Increased spending and travelling

The injured nurses interviewed in this study explained that an all day shift rotation created an increased financial burden and required a reorganization of their everyday domestic spending. For many of the nurses in the study there were increased costs associated with working a day shift such as increased commuting costs due to premium parking rates charged at hospitals during the day, increased gas expenses and times spent wasted due to idling in rush hour traffic. Laura also experienced increased food costs at the hospital.

> *The food kiosks are open on days. So you go downstairs to (coffee*
> *chain) to get your coffee. But on nights you make a pot. I spent a lot*
> *more money on food when I went back. I didn't take in my food like I*
> *should but I was too tired to make something especially when I worked*

> *so many days in a row (Laura, IRN).*

Shire's travel cost increases were related to her inability to car pool now that she was on an all day shift schedule.

> *My girlfriend and I usually drive to work together because we are on the same schedule. But when I went back to work and only worked days we couldn't do that anymore. So I have to drive my husband to work and then go into work myself, work all day, go to physio after work, go pick up my husband and then go home. It is a really long day (Shire, IRN).*

Waiting for money

While the nurses experienced an increase in everyday expenses associated with working day shift, they also experienced a decrease in the amount of pay they received. Jane explains

> *When I went back to work I wasn't bringing home the same type of money because I wasn't getting shift premiums. So money was tight (Jane, IRN).*

The decrease in the shift premiums coupled with the nurses increased daily expenses associated with working on day shift added to the financial challenges already experienced by these nurses.

The coordination of WSIB and hospital banking practices also contributed to financial difficulties for the nurses.

> *I went so into debt when I was off and am still struggling to get my head above water [now that I am back to work]. ... WSIB doesn't do direct deposit. They send cheques and there are delays. Which meant I had to get to the mailbox, get the cheque and then go to the bank to deposit it....my problem was that I have all of my bills- the mortgage, phone, cable - coming out of my account automatically. My pay was all messed up, there were delays in payroll... so they were taking money out for bills when I didn't have the money in the bank yet (Cindy, IRN).*

For all of the injured nurses interviewed in the study the financial burdens due to their change to an all day shift schedule and delays in receiving compensation owing lead to one or more of the following choices as a way of handling the compensation delays: incurring interest and reaching maximum limits on credit cards; depleting family savings; taking a second mortgage on a home; borrowing money from family members; debt counselling; moving in with parents; stopping

children's extracurricular activities; stopping gym memberships; lapsing membership in a nursing organization; vacation cancellations; and breaking financial commitments to children.

Working on relationships

Strained relationships with partners, boyfriends, parents, children and friends were evident in the dialogue with each nurse. Financial stress and extreme fatigue which limited the injured nurses' ability to engage in activities outside of hospital work and rehabilitation contributed to troubled relationships with some family members and partners. The nurses felt that this was because their injury circumstances interfered with their normal role function in the family unit. Laura and Linda believed that they had taken a backwards step in life by having to rely on their parents again for financial and lodging help.   George, the partner of one injured nurse informant, explains the burden that can be placed on family members and a marital relationship as a result of RTW.

> *It was tough. Really tough. Everything came down to me...and when she went back to work we thought it would be easier. But it wasn't. She was so exhausted when she got home from work. So I still had to keep doing it all - look after the kids, buy groceries, cook, Forget about cleaning. We went weeks without washing the floors or anything... and we fought a lot. I thought since she went back to work she would be able to help around the house. That wasn't the case.*
>
> *And I had had enough. We had a big fight once and I left. I came back, but I had to leave. I guess I just had to get out of it. I was sick of doing it all. What about me, my job, my life. I just wanted to sit and watch the hockey game. I want to go out with the boys, go to a movie, have some fun. But you can't do that because things are so tight money wise and she is too tired all the time.*
>
> *And I couldn't leave. But I almost left for sure. I guess back then I did it more for the kids. I had to look after the kids, pick [female child] up from dance, [male child] up from karate. Plus make dinner, plus do laundry, plus cut the grass. I had to keep doing her work and my work when she went back (George, partner).*

The majority of the nurses recognized the burden that they placed on others. Laura recalled her boyfriend leaving their home.

> *[Partner name] left. He moved out. And I couldn't blame him really. He wanted to do things like we had always done- go skiing, hiking, kayaking. And there was no way I could do any of that. And I didn't want to either. I was exhausted from working, going to physio and all that stuff. When I got better we tried to get back together. But it didn't work. It wasn't the same anymore (Laura, IRN).*

Shire feels that she is in debt to her husband because he assumed responsibility for the family.

> *My husband was an angel. He took care of the house, the kids, me. He did it all. I feel so bad it all fell on him. I owe him so much (Shire, IRN).*

Bena became very upset during our conversation as we she talked about her inability to keep a promise to pay her son's post secondary tuition.

> *I feel so guilty. I had promised him that I would do that for him [pay his college tuition] when it was time. And I had to break that promise to him. I hope he will forgive me one day (Bena, IRN).*

The costs of RTW

Return to work comes with a high cost for individuals. Financial pressure and a need to reorganize the family created much stress and strain for the nurses (IRNs Linda, Laura, Shire, Cindy, Bena). Returning to work was a costly venture for all of the nurses interviewed not only in a monetary sense but also in a personal way. There were several increased expenses that nurses incurred as they returned to work including: increased travel costs due to more frequent trips to work; premium parking expenses; an increase in convenience and take-out food; increased child care costs; household maintenance costs; and bigger over the counter pharmacy expenses. There were also personal costs to the nurses. The scheduling changes and fatigue associated with returning to work spilled over into their personal life. Time needed to be spent reorganizing family activities and a reliance on family members to do domestic work, such as picking up children or making dinner, led to strained relationships with their support system members. Fatigue became a major factor which limited the nurses' abilities to resume their normal role function within the family units. This also created strain and disrupted relationships with family members.

Injury work

In the passage above George alludes to his wife working and continuing with physiotherapy as part of the RTW practice which is focused on returning the injured employee back to the workplace as early possible, often prior to a full recovery. As a result the nurse must engage in paid employment while continuing with their injury rehabilitation. The demand of this injury work is described by Bena as *"like a second job"* due to the scheduling, courier, waiting and administrative demands associated with rehabilitation. Much of injury work has to do with securing the appropriate medical documentation for the WSIB and the employer validating that the injury still exists. The rehabilitation and progress evaluation goal of the visit seemed secondary to Cindy, Bena, Shire and Jane. When engaging in injury work nurses found that they had trouble scheduling appointments, increased wait times for health care services, difficulties maintaining their rehabilitation program, and demands to deliver documentation to others.

Scheduling medical appointments

Medical appointment scheduling challenges arose for the nurses as they attempt to arrange their appointments around their hospital schedule.

> *It is so difficult to keep going to physio. I work at the hospital…then have to sit in rush hour traffic and get (to the suburbs) to physio. All the appointments at the end of the day are always taken (Laura, IRN) .*

The nurse had to try and secure appointments at the end of the day which as the during premium hours in most practices. Once the nurses arrived at the appointments they were often faced with long delays before they were seen by the practitioner.

> *I wish I knew how many hours I spent waiting in doctor's offices. I bet on average my doctor makes me wait about 1 hour every visit (Linda, IRN).*

Waiting to be seen

Rescheduling of medical appointments to fit their new all day shift rotation and an increase of time spent waiting for appointments were also work for the nurses. All of the nurses discussed having to wait and delays in getting health care services. Laura, in a conversation discussing her medical appointments, talked about the everyday delays that she experiences.

I wonder how much time I have wasted waiting in doctors and physiotherapy offices? Every time I go to see the doctor I bet I wait at least a half hour or forty five minutes. Physio is not as bad. They call you in and you start your exercises to get warmed up and then they work with you. I guess the doctors are the worst (Laura, IRN)

Most of the nurses indicated that their waiting times at appointments seemed to increase when they were back at work and accessing services at *"prime time's"* (Bena, IRN).

Prime times are the times that everyone wants. You know after work or at the end of the day. And that became a big problem when I went back to work. I would finish work, navigate rush hour traffic and then get to the doctor's office and wait, and wait, and wait (Bena, IRN).

Delays were also discussed when the nurses talked about being referred to see specialists or required surgical interventions for their injury. Jane waited 3 months before she was able to have a surgical consultation. While a surgical intervention was recommended to Jane she was told she would have to wait 13 months for the procedure. During this waiting time Jane performed accommodated duties which required her to meet regularly with occupational health, her manager and the union representative. At the RTW meetings Jane felt the *"push to get back to work"* by occupational health nurse and nursing manager. She recalls

They (manager and occupational health nurse) would keep asking me 'when is your surgery to fix this?' And I'd keep telling them "I was told he has a 13 month waiting list for his OR"...I couldn't change that. If they want me fixed sooner then they could call the surgeon and fix him. If they could have gotten me in sooner I would have gone. I didn't want to be waiting. I wanted to be back at work doing my regular job. I wanted things back to normal (Jane, IRN).

Keeping with the program

Injured nurses are expected to continue with rehabilitative exercise and treatment programs when they return to work. For Cindy this was challenging.

I was so tired when I got to physio. I stopped making progress when I went back to work. I think because I was so tired. I use to be able to do 3 sets of 10 rep[etition]s with no problem. But I remember the first day I went back after starting work. I could barely do one. I was just so tired and sore after working I couldn't do it. I was so disappointed in myself. I had worked so hard to get to that point and when I went back to work it was like starting again (Cindy, IRN).

Feelings of fatigue were a common complaint of the nurses when they returned to work.

Driving, delivering and distributing documents

Documents and update reports from physicians, surgeons and physiotherapists are a key and necessary element for accommodated work and compensation continuation.   This requirement often results in nurses doing a courier type role fetching documents from health care professionals and sending them to WSIB or their employer. Bena explains

> *I worked all day then I had to go to the doctor…and the next day*
> *go back to pick up the signed form (*Bena, IRN).

While this practice was frustrating and time consuming for the nurse, an orthopaedic surgeon interviewed in the study described the importance of precise wording in these types of reports.

> *I have learned over the years about how to choose my words. One*
> *wrong word in a WSIB report can mess up the compensation for*
> *my patient and cause them to come back to me to get the form*
> *filled out again or me having to phone WSIB on their behalf.   So I*
> *do make my patients' come back to get the report. Yes. But it is*
> *because I know how important the wording is and I can't*
> *concentrate to write them out properly when I have a waiting room*
> *full of people. So what I do is I make a tape recording at the end*
> *of the appointment. The when office hours are done I sit and do*
> *them. It takes a bit of time but in the long run it saves time in*
> *dealing with WSIB (orthopaedic surgeon).*

The nurses are also required to provide updated progress forms to the WSIB while they are engaged in accommodated work. Laura explains

> *It is the same thing, over and over. You have to send in your progress*
> *form and tick the same boxes again and again. Has my status*
> *changed – no. Have you talked to your doctor- yes. Do you have any*
> *new medical reports – no. I wish I could photocopy the darn form and*
> *send it in over and over again (Laura, IRN).*

Bena described herself as a *"secretary" (Bena, IRN)* for the WSIB and employer due to all of the administrative work associated with securing and delivering medical documentation once she RTW.

> *…coordinating appointments, doing the paper work, following-up*

on things, faxing, photocopying, calling, navigating voice mail,
picking up forms, stamps and envelopes, mailing in the forms and
keeping a copy for your records…I [have] a whole filing cabinet
full of papers and correspondence (Bena, IRN).

When the nurse returns to work she must continue with their rehabilitation regime, schedule and attend medical appointments, obtain medical reports of their functional status, and coordinate WSIB correspondence in addition to engaging in modified work at the hospital. This work in conjunction with their nursing work was physically demanding and caused a decrease in rehabilitation progress.

Accommodation work

Everything was so different when I went back…how I had to work,
what I had to do, and how people treated me. I felt like I was starting
a new job (Cindy IRN).

Cindy's statement captures the essence of what all of the nurses interviewed in this study experienced when they returned to work. For all of the nurses, returning to work was disorienting. They viewed nursing work and the hospital environment differently. Often they were assigned different duties or different work settings within the hospital. Regularly the accommodation and modified work restrictions prescribed by their physician were not adhered to by the hospital. This resulted in the need for the nurses to *"talk back" (Cindy, IRN)* to managers, occupational health nurses and peers. A key barrier in the reintegration process was finding appropriate work for the nurses to do upon their return to work.

Meeting work

During return to work the nurses were required to attend several meetings with the manager the occupational health and union representatives to discussion their work restrictions and functional abilities. A key topic of discussion was the nurse's functional abilities and restrictions. Restrictions are the work activity limitations that are identified by the worker's physician in the initial return to work documents that are given to the hospital. Based on the restrictions which reflect nurse's current functional abilities, work tasks and duties are assigned.

A common practice used in the initial RTW meeting is a "*walk around*" *(Jane)* unit tour. During this tour the manager, occupational health nurse, union representative and injured nurse survey the unit to identify tasks that the returning nurse is unable to perform. Jane explains

> *We went up to the unit. Walked around. [manager] and [occupational health nurse] carried a clip board and were making notes... They said, can't do that, can't do that…it was all things I couldn't do rather than what I could do. I could tell them lots of things I could do…then they gave me the list at the end of the tour and said "OK sign this" (Jane, IRN).*

Cindy recalls a similar experience:

> *What they [manager and occupational health] did was made a list of all the things I couldn't do. It was assumed that anything not on the list I could do. But what they forgot about was that they came to the unit when it was quiet. Not like when it was crazy busy. Things are different then. And each patient is different too. Like if the patient was petite then I could put the foetal monitor on because I could reach OK. But if the patient was obese then I couldn't. But in their minds I could always do it, the patient didn't matter (Cindy, IRN).*

These meetings occurred at least once a month for most of the nurses. During the discussions the group is updated on the recovery and functional status of the nurse.

As Laura explains

> *You go to these meetings. And the same people are there. And the occupational health nurse says "How are you doing?" And the manager says "When do you think you can get back to full duties?" It's like a trick question. They want you to commit to a date. But then the union rep jumps in and says "Don't answer that. Her physician will have to make that decision". Same questions, same responses (Laura, IRN).*

Jane presents a more cynical view of the proceedings

> *The crazy thing is when you get hurt you have to give documentation to prove "YES Jane is injured" But when you come back they assume you CAN work. It's like they forget you were injured. So now you have to documentation to prove that you are still injured and can't work (Jane, IRN).*

At these meetings in unionized settings the nurses described being told what their work restrictions and duties would be by the hospital management team. They also remembered an adversarial climate in the meetings

Laura who engaged in return to work in a unionized followed by a non-unionized hospital recalled that she was a much more active participant in the return to work at the non-unionized facility. She explains

> *…it was not the same run around that I had when I was with the unionized hospital. We had to have a meeting every single week to discuss this, that and the other. Here [non – unionized hospital] the WSIB nurse would call me up, oh but we call her an "abilities specialist" Which I like! And she would say "how is it going". In our occupational health we have [person] who is our nurse practitioner, and then the abilities specialist. She was so open, asking me how I was, and if I was a bit sore, she would tell me to fill out another incident report and that I overused it today. It was not like at the other (hospital1.) Totally different, very open, not very structured, asking me what I can't do with my arm. And I said "I can't do my IV bags and lifting overhead". And she said "OK we will work to fix that". So I was more involved in determining what my modified work would be like. And it was not as rigid. It would be like I would do my thing. And the nurse wasn't running after me to check up on me all the time (Laura, IRN).*

A nurse's active participation in return to work meetings seems beneficial based on Laura's recollection.

Responding to the label

Work restrictions imposed on the returning nurses were communicated in public ways to the nursing unit level via a note or memo generated by either occupational health or the unit manager. These documents were placed in a prominent places, such as the nursing station (Laura, Linda), a staff bulletin board (Jane), or a staff communication book (Cindy, Bena, Shire) so that all unit staff were aware that the named nurse is returning to work and will be performing modified or restricted duties.

> *Everyone knew about me when I came back to work. It was like they plastered a [criminals] wanted poster all over the unit. Everyone knew I had been hurt, everyone know that I was on modified, and everyone kept asking when are you gonna be back to full duties? So I always had to explain myself, what I could and could not do (Cindy, IRN).*

Continuing to reinforce their functional abilities status to other nurses was a common occurrence for the nurses.   One challenge that can occur when a nurse is assigned modified/restricted work is that there may not be suitable patient care jobs on the assigned unit.

> *I came to the unit expecting to work and I looked for my name on the assignment sheet. It wasn't there. So I asked the charge nurse for my assignment. She said there was no patient care work for me to do. So I had to sit around and wait for the manager to come to find out what I was going to do for the day. I waited two hours (Bena, IRN).*

In these situations nurses were given non-nursing work.

Doing non-nursing work

On several occasions the injured nurses came to their units expecting to provide patient care but were assigned to non-nursing duties. For example: Bena filed papers the nursing station; Jane cleaned out cupboards in a storage room and screened hospital visitors for communicable diseases; Shire was given a job held by volunteers; Cindy completed a Ministry of Health audit that was the responsibility of the manager; Laura performed chart audits; and Linda answered phones. While each of these tasks may have been beneficial to the institution in the short term, all nurses felt that they were insignificant and inappropriate work duties. Shire recalls:

> *They had me doing the volunteer's job in the surgical waiting room. Sure it was work that I could do. But I had to do it for months. Actually I think they forgot about me when I was down there. And after a while I thought… why am I doing this? I am a nurse, not a volunteer. I have all this knowledge and skill and they [employer] are wasting it. So I asked for a change after about 4 months of this. But the manager said "NO". They wouldn't let me look after patients, I couldn't be a nurse. I became a volunteer… [and] the worst part was when the little old ladies [volunteer] would come and tell me I was taking over their job [crying]. I didn't want their job. I wanted my job back (Shire, IRN).*

Jane's most frustrating non-nursing job was *"the hand washing police" (Jane)*. In this role, stationed at the entrance to the hospital where hand sanitizer stations were set up, Jane needed to ask everyone entering the hospital to use the hand sanitizer solution. Jane recalls

> *That was the worst job ever. People would tell me to F *** off, or walk right by me. I felt like the scum of the earth saying "welcome to (hospital X). Could you please wash your hands before you enter the building" over and over again. Like a broken record" (Jane, IRN).*

Jane did not find any of the accommodated duties that she was given meaningful particularly given her academic credentials. Jane possessed a diploma in nursing, a Bachelor of Science in Nursing, a speciality critical care certification from the Canadian Nurses Association and part of a Master in Nursing degree. She explains

> *I couldn't understand my employer. I mean here I am with all this education and they give me a volunteer and hand washing police jobs to do. Come on….there were lots of things I could do. And I suggested them to my employer. Like as a professional preceptor for new hires or people needing help. They could do the physical skills and I could tell them how. Or I could be a permanent charge nurse. But the hospital wouldn't go for that. They gave me the volunteer job to do (Jane, IRN).*

Disorganizing care

The restrictions prescribed for the nurses with little regard for the actualities of how the duties play out in the everyday. Linda recalls how she was confused when she was told of her restrictions.

> *They said I was not to lift or log-roll the patient. Which is fine except how was I going to bathe him? You need to log- roll the patient to do a bed bath. Usually I could bathe a patient like this on my own, but with my restriction I wasn't suppose to log roll. And I couldn't find anyone to help me. They were all busy with their own patients. So it is great that they set the restrictions of what you can't do but they forget to put in place a way for you to do the work. So I was put in a position where I had to decide do I just log-roll him , take a chance and do the bath or do I not do it and explain to the family and next nurse why the bath isn't done (Linda, IRN).*

Hence while restricted duties were described and well known, strategies to work within those restrictions were not provided.

Cindy, a labour and delivery nurse who was unable to lift more than 10 pounds, was told by the nurse manager and occupational health team that assisting in caesarean section deliveries would be suitable work. This duty involved not only assisting in the surgical procedure but setting up and taking down the instruments and equipment in the operating room. Cindy recalls:

> *I got into a fight with them… they told me that I could lift [a bundle with surgical instruments]. They said it was less than 10 pounds…but I knew it was heavier. But they kept saying no… So the next day the [union representative] and I had to get the baby scale and weigh the tray to prove that it was over 10 pounds. And we were right. They assume they know how much equipment and stuff weighs. But they don't (Cindy, IRN).*

Cindy required ergonomic aids, such as an adjustable office chair, back support and computer desk, which were requested by Cindy's physician in his return to work note and promised by the occupational health nurse and manager in the initial return to work meeting never materialized. Instead Cindy brought a pillow from home. She did find one chair on the unit which she could modify to accommodate her body requirements. Cindy spent several hours setting up this chair and then placed a large label on it. However this labelling process presented a problem for the nursing unit. Multiple users – nurses, physicians, and other health care professionals – use the office equipment in a nursing unit. These devices are not dedicated to a sole user. So while Cindy labelled a chair as hers, other people in the unit used the chair and fiddled with the ergonomic adjustments. Cindy explains

> *Half of the shift was spent looking for and then adjusting my chair. No one cared about my accommodations or whether I had a safe place to work. And I never got my break every two hours either. After all we are caring for patient's so you can't just say "sorry I am on break now" if someone is in the middle of delivering a baby of something (Cindy IRN).*

Dealing with unpredictable patients

The day shift in a hospital setting is described as "*the busiest shift of all (Linda RN)*" because of the often unpredictable nature of patient movement patterns that happens during this period of time. Injured nurses felt limited in their ability to respond to the changing demands of a day shift, particularly in relation to a patient's condition. Cindy RN described how objective

measures of patient acuity failed to account for how the individual patient was coping with their health situation in labour and delivery.

> *They would assign me to patients who were less than 3 cm dilated. And while that is one way to look at a patient, what they forgot to look at was how the patient was dealing with the pain…Every patient is different in how they deal with labour pain. Some women don't even flinch. But others [pause] … well they go crazy, yelling, screaming, cursing, thrashing and kicking. I was always afraid that they were going to kick me… ya sure the patient was within my restrictions but come on…it wasn't appropriate for me to look after. I would rather look after a woman who was tolerating labour well than one who wasn't coping (Cindy, IRN).*

Unpredictable work environments can also occur when there are diverse ergonomic needs for various members of the health care team who come together to provide group health care activities for patients. Jane RN, a critical care nurse, explains:

Jane	*When there's a code you have a problem. We [health care providers] come in all shapes and sizes. And we are all working on the patient in the code. So you have the RT [respiratory therapist] who is 5'10", the physician who is 6'2" and the nurse who is 5'3".*
Researcher	*So what happens?*
Jane	*These are the situations where the nurse is standing on a stool or climbs up onto the bed to get the job done. It's not safe. But you got to do it.*
Researcher	*I see.*
Jane	*And the thing is all nurses have to be ready for a code situation. So we all could be put in a situation like this where we could get hurt or re-injured. It is just a part of the nurses' work. We have a risky job where you can get hurt.*

Taking work away

Finding creative new work opportunities for nurses as they returned to work proved to be challenging, particularly in a unionized setting where collective agreements establish nursing work circumstances. Bena had the opportunity to engage in what she called "*the best job ever*"

during her RTW. A new position was created in the emergency department specifically for Bena. In this role she was responsible for assisting non-English speaking patients through the triage process and monitoring their conditions while they waited to be a physician. She also performed telephone satisfaction survey asking former emergency room patients about their experiences. She remembers:

> *...it was the perfect job for me. I love talking to people. I could sit when I needed to, or move around… but that job got taken away from me. Another nurse from emerg[ency] grieved the position. They [management] didn't post the position. And this nurse had more seniority than me. So they took it away from me. And I was left with nothing to do again (Bena IRN)*

The rules and regulations of the collective agreement and labour laws challenged the ability of the employer to find innovative and creative work opportunities for all of the nurses who were interviewed in the study.

Summary

The domestic, injury and accommodation work that the nurses engaged in during their return to work are shaped by the organizing practices injury management, hospital procedures, collective agreements and WSIB return to work procedures. These different types of work are invisible and taken for granted by institutional regimes. But as presented here, the amount of work that the nurses engage in as they return to work is significant and impacted on their engagement in the return to work process. It seems that the competing demands of unpaid domestic and injury combined with accommodation work uncoordinated and disorganized the nurses. Figure p. 106 illustrates the disorganizing nature of RTW. Domestic work became disorganized when child and elder care, financial, household maintenance, and travel/commuting to work became issues. Rehabilitation from the injury and the work associated with recovery became disorganized when the nurse was unclear about the WSIB and RTW process, medical appointments needed to be rescheduled, large amounts of time was spent waiting for medical appointments, and excessive secretarial or administrative work was required to ensure that the WSIB and Hospital employers had the right documentation. Once the nurses returned to work much energy was put into negotiating for appropriate accommodated work, attending injury review meetings and demonstrating competence. At times factors beyond the IRN's control,

such as multiple workers requiring accommodation or a missing back support for a chair, added to the disorganization and uncoordinated the RTW process.

Factors disorganizing RTW

Household chores

Child and elder care issues

Don't understand the system

Financial distress

Long commute

Waiting for treatment and assessments

Domestic Work

End of day appointments

Injury Work

Accommodation Work

Other injured workers

Unfamiliar settings

Meaningless and inappropriate work

Union turf wars

Moral Dilemma
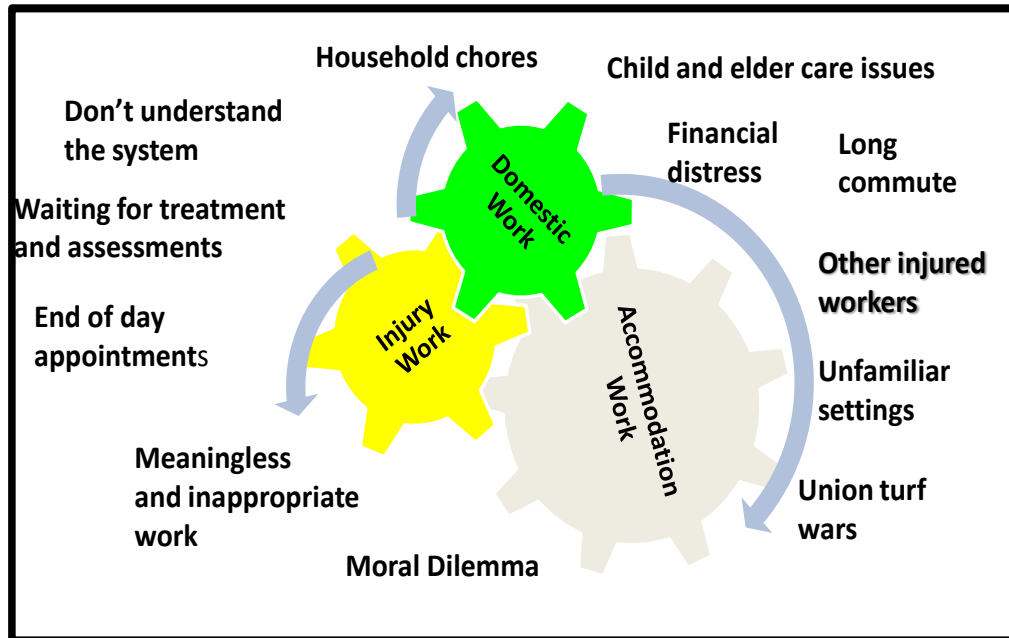
 The nurses did describe some factors that assisted in their RTW (see figure p. 107). These included: having savings that could be drawn upon in times of financial crisis; supportive family members; assistance and guidance in injury management process from an occupational health nurse; a physiotherapy office in close geographic proximity to the hospital; a team nursing work structure with members who were willing to help others; and meaningful accommodated work.

It is prudent for occupational health departments, unions, managers, the WSIB, and injured nurse to consider the factors that promote and disorganize return to work. Attention to these areas may produce more positive RTW outcomes than those found in this study.

Factors supporting successful RTW

Occupational
Health guidance
through the process

Domestic work

Savings

Partner/family support

Peers willing
to help

Physiotherapy
close
To work

Injury Work

Accommodation Work

Meaningful
Accommodated
work

Team
nursing
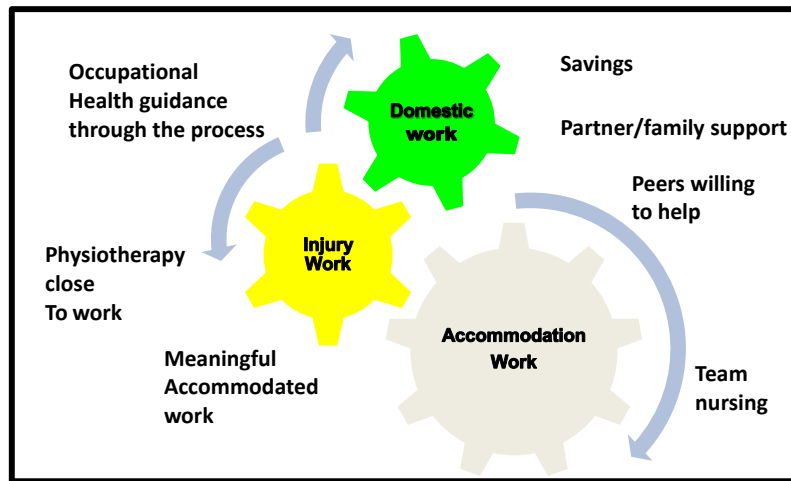
The next chapter describe in more detail the discourses of health care in Ontario that may contribute to the unsuccessful return of IRN to their pre-employment positions. This will be done by incorporating data from secondary informants and texts.

CHAPTER 7: Institutional discourses: Ontario health care

Introduction

This chapter focuses on the second analytic goal of an institutional ethnographic account - to use informant stories to bring into view the institutional fields in which they are located for the purpose of identifying institutional sites and discourses (McCoy, 2006). Building from the discussion of the institutional discourses of workers' compensation presented in chapter 5 and the (in)visible work of return to work described in chapter 6 this chapter describes how health care processes and discourses shaped the injured nurses experiences in the hospital. Traces of three authorized and dominant health care discourses are evident in the dialogue of primary and secondary informants- patient

safety, hospital efficiency and return to work. This chapter describes how these discourses organize the injured nurse's experience of hospital employment.

Patient Safety: A system priority

The Canadian health care system is faced with escalating costs, inadequate funding and a global nursing shortage. Actions to save money and cut costs have been a central focus of organizational attention in health care for the past two decades (Varcoe & Rodney, 2009; Storch, 2003). Many believe that strategies implemented to contain costs have eroded quality of health care services in Canada (Armstrong & Armstrong 2003; Carayon, 2007; Carayon, Hundt, Karsh,Gurses, Alvarado, & Smith M. 2006). Storch & Meilicke (1994) describe these times in Canadian health care as "a climate for change in the organization and management of health services that transcend[s] anything since the foundations for the current system was completed in 1968" (p. 32). This situation is the result of federal economic trends, such as budget deficits and restrictions in the role of the federal government in maintaining the principles of Medicare - universality, accessibility, comprehensiveness, portability, and non-profit administration. Financial shortfalls have resulted in pressures to reduce provincial health care spending. Strategies to contain health care costs, such as capping the number of speciality surgeries to be performed in one year, downsizing by closing hospital beds, laying off staff, reducing the length of a patient stay in hospital, and the merging of hospitals, are but a few of the approaches taken

in Ontario. Canadian data reveals that as a result of these strategies nursing workload has increased, patient care quality has been reduced and health care employees are dissatisfied (Canadian Health Services Research Foundation 2001; Dunleavy, Shamian & Thomson, 2003; Health Canada Office of Nursing Policy, 2001).

The erosion of the quality of services provided in health care has made patient safety a "health care priority" (Accreditation Canada, 2009, p. 1). Seminal reports from the American Institute of Medicine titled *To err is human: Building a safer health system* (Kohn, Corrigan, & Donaldson, 2000) and a Canadian report titled *Building a safer system: A national integrated strategy for improving patient safety in Canadian health care* written by the National Steering Committee on Patient Safety (2002) has directed attention towards medical errors and led to a patient safety movement in North American health care (Espin, 2006). Health care quality (and the negative manifestation of quality through medical errors and hospital acquired infections) has become a primary concern for funders, governments, health professionals, health organizations, the media, nurses and patients. Medical errors, which can resulted in sequela such as infections, falls, pressure ulcers, burns, wrong site surgery, medication and blood transfusion errors have been cited as not only as having a major negative consequence on the health of a patient but also as a primary source of health care expenditures.

Media attention focused on medical errors made in several prominent North American health care facilities provoked public, government and health care funder scrutiny of the health care settings. The following are two example cases that received media attention in the Toronto area and sparked public and government concern about the quality of care in hospitals. At the Toronto General hospital several employees accessed the patient chart of Toronto Maple Leaf hockey head coach Pat Quinn, in the summer of 2002. Details of Quinn's admission and medical information were leaked to the media. This breach of confidentiality resulted in several of the hospital staff being fired (Hospital News, 2002).   In 1998, Lisa Shore, a patient at the Hospital for Sick Children died 12 hours after being admitted to the hospital as a result of drug interactions (Chief Coroner Province of Ontario, 2001).   The death was deemed a homicide in a highly publicized Ontario coroner's decision. The lawyer for the Shore family, Frank Gomberg, spoke with the press following the release of the decision:

> "I do not blame the doctors in this case. But I want the nurses and other staff held accountable" (CBC news, Feb. 25, 2000).

As a result a complaint was lodged with the College of Nurses of Ontario (CNO) by the parents of Lisa shore. The CNO is the regulating body of nursing in the province who are charged under provincial legislation with the responsibility of keeping the public safe and

> ensur[ing] that RNs and RPNs are safe, competent and ethical practitioners by establishing standards of practice, setting criteria for becoming a nurse in Ontario, administrating a Quality Assurance Program and enforcing standards of practice and conduct (College of Nurses of Ontario, 2007 p. 3).

All public complaints about the care delivered by any nurse are formally investigated by the CNO (College of Nurses of Ontario., 2003). The two primary nurses who provided care to Lisa Shore were investigated as a result of a complaint. The investigation found that while there were several systemic hospital problems evident in the case the nurses did commit an error. Consequently the nurses received a reprimanded by the discipline committee of the CNO (College of Nurses of Ontario, 2006). As a result of these and other media reports of medical errors a patient safety movement emerged in Ontario hospitals as a way of renewing confidence in the system and improving the quality of care (Colquhoun, Koczmar, & Greeenall, 2006).

Strategies to monitor and evaluate patient safety permeate North American health care at the systemic (policy), organizational (health care setting) and point of care (nurse with patient(s) interface) levels. Canadian provincial governments have instituted several reporting initiatives to monitor the quality of care environments (Whicher, Chalkidou, Dhalla Irfam, Levin L., & Tunis, 2009; Hanlon, 2001) and specifically patient safety (Aiken, Clarke, & Sloan, 2000; Carayon, 2007; Carayon et al., 2006; Rankin & Campbell, 2006; Rogers, Hwang, Scott, Aiken, & Dingesm, 2004; Rogers, Hwang, & Scott, 2004)

Ensuring Ontario hospital quality

Ontario hospitals are high-risk, high-demand, high-stress settings in which the perpetually changing status of patients creates unique safety challenges (Jeffs, MacMillian, McKey, & Ferris, 2009). The result of these high pressure features of health care are medical errors. Provincial reporting structures have been set up to monitor hospital performance and

medical error rates. In Ontario, hospitals medical errors are measured by indicators such as the rates of hospital acquired infectious disease (Provincial Infectious Diseases Advisory Committee, 2007) , length of stay per medical case type (Baker et al., 2004; Morrow, North, & Wickens, 2005; Jeffs, Alfonso, & MacMillian, 2008) and patient satisfaction (Canadian Patient Safety Institute, 2006; Lipscomb et al., 2009). Hospitals are required to provide the provincial government with statistical information about these indicators that is used to monitor, compare and evaluate the performance of each hospital (Nicklin & McVeety, 2003).   Information highlighting each hospital's performance on these indicators is now publically available via the Ontario Ministry of Health and Long Term Care website. Poor performance in relation to these empirical measures is equated with longer lengths of stay for patients and financial burden on the health systems (Jeffs et al., 2009).

A concern at the point of care

Hospital nurses care for patients in fast-paced, highly technical locations. The work of a nurse demands physical dexterity and mental astuteness to oversee the needs of complex, and medically fragile patients situated in unpredictable hospital environments (Regan, Thore, & Mildon, 2009). In these stressful settings which are often hazardous, the health and safety of patients is a priority.

Accountability for patient safety at the unit level is assigned to the local unit manager (Rankin & Campbell, 2006; Sanchez McCutcheon, Doran, Evans, McGillis Hall, & Pringle, 2009) who must ensure a "patient safety culture" (Jeffs et al., 2009, p. 91) permeates the unit. In this study, patient safety is a factor considered by the unit manager and charge nurse when creating the work assignments for the returning nurses. When the IRN return to work with duty restrictions the hospital is faced the task of finding safe, suitable and meaningful work. The functional limitations of the injured nurses are an issue of concern for nurse managers as they considered how to utilize the returning worker in the hospital. A manager explains

*I have to ensure patient safety on my unit. I am responsible for that.
So I can't let her [injured nurse] look after patients. I mean what if
something happened and [patient families] found out it was an
injured worker providing care … And I could only imaging what
would happen to us if they [patient and returning nurse] both fell or
something…I needed to find other things for her [returning nurse] to
do away from the patient care area. It is safer for everyone that way
(Manager).*

Finding appropriate patient care work and maintaining a patient safety culture may be why some

nurses were assigned non-nursing duties in their return to work. For example: Jane cleaned out

cupboards in a storage room and assumed jobs assigned to volunteers; Shire was given a job held

by volunteers; Cindy completed an audit that was the responsibility of the manager; IRN Laura

performed chart audits; and IRN Linda answered phones. Tasks, such as asking visitors to wash

their hands and screening for communicable diseases, are beneficial for hospitals who are

striving to reduce infection rates and improve their rating on provincial report cards. An

occupational health nurse reports

*We have found a significant reduction in our infection rates since we
started using nurses to ask people to wash their hands when entering
the facility and screen [for communicable diseases]. Nurses' know
the importance of this and are able to talk to visitors and explain why.
So whenever we can we assign returning nurses to these types of jobs
(occupational health nurses).*

Hence while the injured nurse may find these tasks as inappropriate work, the hospital may

benefit from having returning nurses engage in patient safety tasks such as audits, and infection

reduction strategies.

Hospital Efficiencies

"Nurses participate in the corporate ideology and organize their work to maximize a

certain kind of efficiency" (Rodney & Varcoe 2009, p. 125). Workload measurement, audits,

and standardized approaches to care are but a few of the new practices that ripple into nursing

units. These systems have an effect on patient care and nursing practice (Rankin, 2003; Rankin

& Campbell 2006; Rodney & Street, 2004; Rodney & Varcoe 2009, 2001). The redesign of

health care delivery to reduce the length of patient stay, decrease wait times and improve bed

utilization capacity has resulted in nurses caring for patients sicker patients more frequently (Gordon, Buchanan, & Bretherton, 2008).

Dialogue surrounding staffing efficiencies was evident in the interviews with injured nurses, managers and charge nurses. The following is a segment from an interview with a nurse manager who explains how efficiency shapes staffing patterns.

> *We would always like to have more staff. That's for sure. But I have a set number of staff I can have on at one time. I would really have to do a lot of justifying to [name of senior administrator] if I had to bring in extra staff. But we are supposed to work at 92 – 95% efficiency. But that never happens. Often my girls [nurses] are working short.*

Researcher: *Can you explain that a bit more?*

> *Well we often work at 110% efficiency. So the girls are working really hard. That's just how it is these days. And I guess they [hospital] save money if we can work them that way... the reality is that there isn't enough money and we are not going to get extra staff.*

Researcher: *I see.*

> *So we have had to change how we look after patients. Care has changed so much from when I started as a nurse. Gone are the days when you could give a patient a back rub at night time to relax them for a good night sleep. Now you give them a pill. Or when you had time to sit with a patient and just listen to them. Support them emotionally. That doesn't happen today. There is no time for that now when you care for patients....so the reality is you have to practice differently. The hospital is a different place. So we can't spend our time whining and snivelling about it. It's not going to happen. We have to do the best we can with what we have (nurse manager).*

This passage describes how nursing work is organized through ruling relations of efficiency (Smith, 1987, 1990). The ruling relation between management and the nurses is mediated by various management technologies and sophisticated computerized information systems that organize nurses' efforts to efficiently process patients. Each time a nurse logs on to a computer, orders a laboratory test, request a medication or piece of equipment, or makes notes on a patient file the act is automatically counted, recorded and ultimately used in management decision making about workload and staffing patterns (Varcoe & Rodney, 2009). Today information systems are used to quantify patient's physical needs and prescribe the amount of nursing care

required. These technologies move decisions about patient care away from the site of patient care (the embodied locale of the nurse and patient) and into the management offices where decisions about nursing staff is calculated. As a result the provision of alternative treatments, such as a back rub, cannot be easily provided to patients because nurses do not have time allocated to such tasks.

Practice strategies to maximize nursing care efficiency

Nurses have developed practice strategies to maximize efficiency in their own work.   A staff nurses explains how she multitasks the care she provides to patients.

> *I hate when they assign someone else to do some of my work for me.*
> *What they don't get is that every time I am working with a patient I am*
> *doing so many things. So when I am giving a bed bath I am also doing*
> *my head to toe physical assessment, asking the patient about discharge*
> *and doing some teaching. I might also talk to the patient in the next bed*
> *while I am caring for another patient too. You know like while one*
> *patient is in the bathroom I start talking or teaching the next one. Or*
> *sometimes I will do health teaching with two patients at once. So if they*
> *give my bed bath to someone else to do how am I going to do all of that*
> *work (staff nurse)?*

Hence when injured nurses are assigned modified duties which disrupt and disorganize strategies that peer nurse use to work efficiently, a conflict may result. IRN Laura explains

> *They told me my job for today was to do all the vitals. But most of*
> *the nurses didn't want me to do their vitals. That wasn't a helpful*
> *thing to do. Because they need to know them. You know like when a*
> *patient is on cardiac meds like dig(oxin). The nurse giving the*
> *drugs is accountable for the knowing … (pause)… oh you know the*
> *5 rights thing that you learn in nursing school and what the college*
> *says. The nurse has to know she is giving the right drug at the right*
> *time you know. If she gives the drug she needs to have done vitals*
> *herself because she is accountable. So they would all start yelling*
> *at me as soon as report was over "DON'T DO MY VITALS (Laura,*
> *IRN).*

Non-nursing researchers (Boyle, 2009; Seaton 2004) have interpreted this type of conflict as unsupportive peer behaviours. In the scenario above this is not the case. IRN Laura recognizes why the work that she was assigned to do was not welcomed by her peer. Instead of a conflict

between the nurse colleagues being evident, this situation reflects a conflict between the nurses and the tasks that are assigned to returning workers.

The daily assignment of nursing work

The daily patient assignment roster (see figure p. 116) creates pairings of nurses assigned to work on a given shift and patients. This mode of assigning staff is a textual task that is a common practice on nursing units. The process for creating the text is complex and often takes *"over an hour"* (charge nurse) to compose. The pairing of nurse and patient is based on the acuity, the number of nursing staff, unit standards, and the geographic proximity of other patients. A charge nurse, from the night shift for example, begins the process by assessing the unit patient roster and care requirements each patient. Then the skills, abilities, and experience of staff members are taken into account. Also considered is the need to assign break times to the nurses in a way that maintains a skeletal staff on the unit to care at any given time to care patients. After much planning the assignment sheet for the day shift is created.

Daily nursing assignment sheet

Assignment Sheet				
Date:				
Charge Nurse:				
Doctor on call:				

Room	Patient	Comments	Nurse	Break
1a	Mr. A	X-ray at 10	Laura	First
1b	Mr. B		Laura	
1c	Mr. C	Discharge	Laura	
1d	Mr. D		Laura	
2a	Mrs. E	On call OR	Laura	
2b	Mrs. F		Linda	
3	Mr. G		Linda	
4a	Mrs. H	Transfer nursing home	Jane	Second
4b	Mrs. I		Jane	
4c	Ms. J	Discharge	Jane	
4d	Mrs. K		Jane	
5a	Mr. L		Linda	First
5b	Mr. M	OR at 1030	Linda	
6	Mr. N		Linda	
7a	Mrs. O		Shire	
7b	Mrs. P		Shire	
7c	Ms. Q		Shire	
7d	Mrs. R		Shire	
8a	Mr. S		Cindy	
8b	Mr. T		Cindy	
9	Mrs. U		Jane	
10a	Mr. V	Transport to MRI	Cindy	Second
10b	Mr. W		Cindy	
10c	Mr. X	OR at 8	Bena	First
10d	Mr. Y		Bena	
11a	Mrs. Z	OR at 9	Bena	
11b	Ms AA		Bena	

A major challenge arises in the creation of the nursing assignments when nursing staff members have different skill, knowledge and functional abilities.   This becomes evident in the case of assigning injured nurses with modified return to work restrictions to a unit.

> *I have had situations where there are 3 nurses who are coming off injury on one shift. I can't find something for them all to do* (Charge nurse 1)

> *I didn't know what to do with her. There were no patients that she could care for… She might as well go home* (Charge nurse 2)

It is important to note that the limited functional abilities of the returning nurse are not the only duty restriction which creates difficulties in designing the assignment sheet. On any given shift there are nurses with different skill sets, practice experience and speciality knowledge. Novice nurses, for example, may lack technical proficiency in skills such as administering specialized medications or starting intravenous infusions. On any given shift there is diversity in the knowledge and skill level of the staff. The diversity of staff creates problems in the use of information management system calculation of nursing workloads. These calculations are based on the assumption that all nurses are equal in their practice abilities. Hence it is the diversity of all nursing workers, not just the returning injured workers, that contributes to challenges in creating the nurse patient assignments.

Early and Safe Return to Work

Early and safe return to work (ESRTW) emerged as a part of neo-liberal political agenda was adopted by the Ontario government as a way to deal with a looming financial crisis (Nichols & Tucker, 2000) (see chapter 5). The adoption of this approach was supported by literature from authors like Krause, Dasinger and Neuhauser (1998) who suggest that providing modified work will reduce the number of lost work days and increase the likelihood of a successful return to work. A "boss" (Smith 2008) text, called the Workplace Safety and Insurance Act (1997), provides a means for the controlling and social organizing of the return to work process across multiple worksites in Ontario. What follows in this section is how ESRTW coordinates the nurses in the local settings.

A shifting notion of recovery

The ESRTW approach requires injured worker resuming duties prior to a full recovery. Injured workers are told by the WSIB

> Returning to daily work and life activities can actually help an injured worker's recovery and reduce the chance of long- term disability (http://www.wsib.com/wsib/wsibsite.nsf/Public/ReturnToWork).

This practice is legitimated by various shifts in the medical discourse on medical management of workplace musculoskeletal injuries. Medical approaches which previously supported recovery through with rest and strategies to pain avoidance are no longer considered effective remedies for many musculoskeletal injuries (MSK) (Wadell & Main, 1998; Waddell, Feder & Lewis, 1998).

All of the nurses in this study with MSK types of injuries returned to work in various hospitals prior to a full recovery and all reported that they experienced more episodes of pain and extreme fatigue as they engaged in return to work than when they were at home focusing on recovery (IRNs Laura, Linda, Shire, Bena, Jane and Cindy). None found this practice of benefit to their recovery.

RTW in Ontario hospitals

Early and safe return to work (ESRTW) is described by the WSIB as an approach that will

> Minimize the human and financial impacts by focusing on getting the worker back to safe and productive work as soon as medically possible (http://www.wsib.com/wsib/wsibsite.nsf/Public/EmployersESRW).

This was not the case for the injured nurses and hospital management personnel who were interviewed in this study. The injured nurses, nurse managers, occupational health nurses, charge nurses and peer nurses interviewed all reported that the return to work process resulted in a disorganization of nursing work and schedules and resulted in financial challenges for both the hospital and IRN.

Surveillance during RTW

Surveillance is a central part of the RTW process in hospitals. Nurses experienced feelings of being watched at all times when at work. Notions of surveillance of injured workers during return to work are evident in an educator's description of her role.

> *My job is to make sure that nurses are practicing in competent ways. So when they come back to work I need to watch them and make sure they are at the appropriate level. Sometimes I need to give them a refresher on things because they forgot or if new things have come up while they are away. You know we have to make sure they are safe. We have to do that sometimes (Hospital nursing educator).*

New graduate nurses confirmed experiences of hyper- vigilance when they returned to work. Linda states "*they watched you like a hawk*". At no time were these nurses told that their performance of their assigned duties was substandard. However, at the end of their probationary period the new graduates were told they *"did not provide care that could end their probation"*

(Laura, IRN). As a result, in the critical care course incentives promised during recruitment were denied. These nurses were also redeployed to less critical units. Linda recalls

> *We'd meet with the nursing educator, me and the manager periodically throughout these three months and I noticed that after I had the injury my manager would said to me "I'm not saying this as a manager, I'm saying this as a fellow nurse...you're a very small person. I don't think you can handle nursing". She started suggesting other nursing jobs like dialyses or research. I felt insulted that she was kind of brushing me off and pushing me towards other paths. I guess they were trying to make me leave now that I think about it...When they did tell me I had to go to the step down unit the educator gave me a learning plan. I was shocked by what was on it...I was told that I was going to be monitored giving medications. I had no idea why! I never made a med error; I was giving meds fine while on probation. So I asked why this was on the plan. And the educator said there were concerns. What concerns! No one told me about them! So they had been watching me. Trying to find something so that they could make me leave I think (Linda, IRN).*

Linda has described not only the surveillance of her work but also a tactic used by managers to move injured workers away from their pre-injury nursing unit and onto other units. This manoeuvre shifts the financial responsibilities for the injured nurses' compensation to another nursing unit cost centre.

Hiding places

As previously mentioned, the occupational health unit services are only available during daytime hours. As a result, IRNs are placed on an all daytime rotation. One of the reasons for this intervention is to provide the nurses with a place for rest and medical treatment such as ice packs. None of the IRNs interviewed in this study reported to the occupational health unit for these services. Instead they sought rest in private places that were more geographically convenient for rest. These places removed them from the watchful eye of the educator and occupational health department.

> *If I needed to rest, well I should say if there was time to rest, I would go in the lounge. Going to the occupational health unit, which is in the bowels of the hospital, meant that I would have to take 10 minutes to get there and another 10 to get back. Plus then they would know I wasn't doing so well. I didn't want to give them any ammunition. It is just easier to stay on my unit (Cindy, IRN).*

The costs associated with RTW

When an injured nurse returns to work she is considered a part of the unit complement of staff.   During the ESRTW period the nurse is unable to engage in her full time work activities however.   This results in a casual nurse being hired to fill the work void that the injured nurse leaves due to her injury circumstances and modified work restrictions. A casual worker receives 18% more salary in lieu of benefits (Ontario Nurses Association, 2008). Hence casual workers are costly workers. The unit manager is unable to hire a new employee to fill the work void of the returning nurse because of the rules of the collective agreements. For instance, by having Linda voluntarily or involuntarily leave the critical care unit, a new permanent staff member can be hired to replace Linda. This strategy, used to displace Linda from her position on the critical care unit is of financial benefit to the critical unit salary expenditures.   Thus the following WSIB statement was not supported by the findings in this study.

> The injured worker benefits by restoring their source of income and staying active and productive, both of which are important to the healing/recovery process. You benefit by retaining valuable and knowledgeable people who contribute to your company's financial and market success (http://www.wsib.com/wsib/wsibsite.nsf/Public/EmployersESRW).

The staff replacement costs associated with returning an injured nurse to work that contributes to a financial deficit rather than a success for nursing units. This results in strategies to displace or remove an injured nurse from employment on a given unit.

For the injured nurses returning to work, an all day schedule can cause a salary reduction as a result of lost shift premium benefits. Financial incentives, known as shift premiums or shift differentials, accompany shift work and add significantly to a nurse's base salary income (Blachowicz & Letiz, 2006). The Ontario Nurses Association (ON) collective agreement (4950, 2008) outlines standard shift differentials that are added to the base hourly rate. An ONA local union representative explains:

> *We call them shift premiums. They are in the collective agreement.*
> *Every time you work evenings, nights or weekends you get money*
> *added to your base salary. And it works out to be a lot of money in*
> *a two week pay period (ONA local representative).*

The collective agreement indicates that Ontario nurses are paid the following shift differentials:

- An evening premium of $1.40 per hour
- A night premium of $1.65 per hour
- A weekend premium of $1.80 per hour for each hour worked between 2400 hours Friday and 2400 hours Sunday (4950, 2008)

The nurses in this study who were assigned to an all day schedule as a result of RTW did not receive these premiums. This resulted in a significant financial decrease in the salaries of the nurses as they were scheduled to work when shift premiums did not apply. A reduced salary combined with an increase in travel costs to and from the hospital and medical appointments, child/elder care costs, and personal expenses such over the counter analgesics all placed a significant economic burden on the injured nurses and their families. Strategies used to reduce financial burden included using and making minimum payments on credit cards, applying for loans, taking a second mortgage, seeking more affordable housing arrangements, limiting family extra-curricular activities and resuming full duties and shift work against medical advice so that full compensation could be received.

In summary the assigning of returning nurses to an all day shift rotation is of benefit to the hospital as it facilitates ease in scheduling WSIB required return to work meetings and allows for surveillance of the returning nurses work. However there is significant replacement staff costs associated with ESRTW. The returning nurses and the nursing unit experience financial hardships associated with RTW.

Finding work

Finding appropriate duties for injured nurses to do as they returned to work proved to be challenging and costly for the hospitals. Nurse Managers' described how the nurse's duty restrictions may result in the returning nurse being assigned to non-nursing duties.

> *Some days I just didn't know what to do with them. There are really no jobs that they can do. So I still have to bring in casual staff to replace them. It kills my budget but I have no choice. They can't work with patients. So I find them other things to do. Sometimes I ask around and see if other people in the hospital can use them (manager).*

Researcher: Who do you ask?

I call other managers, nursing education, the clinics, and occ. health.
Anybody to see if there is something I can find for them to do (manager).

Finding appropriate work for a returning injured nurse becomes a burden for the hospital, particularly in cases where there are multiple injured and returning nurses on one unit. The fragile conditions of patients and the environmental barriers of bedside nursing that are beyond the restrictions placed on the nurse in return to work makes non-nursing jobs a route for assigning work. However there are consequences for assigning nurses to these non-nursing duties.

The injured nurses in this study were able to identify innovative ways that they could be utilized in the hospital to improve quality. While each of these examples has merits, hospital and union procedures prevented the positions being established. Jane suggested a role where she would be responsible for working with new nurses in a support role while they became familiar with the hospital and patient care procedures. Her employer would not entertain this idea. The addition of a new position in a hospital is not simple. Several policies and procedures for creating and initiating a role must be followed. This includes discussing the position with all unions. Most importantly funds are required to establish a role. Given the financial constraints at her hospital Jane was unsuccessful in having this role established. IRN Bena assumed a role in the emergency department assisting patients in the triage and registration process. This position was specifically created for Bena and she excelled in this role. A procedural error was made in the implementation of the role. All nurses were not given equal access to this position. A grievance was filed. The position was eliminated. In both cases the implementation of these roles was stopped by collective agreement and labour relations procedures. Hence the collective agreements can limit the opportunity to be creative in the duties assigned to returning nurses.

Obligation to accommodate

The Workplace Safety and Insurance act (1997) states that employers are only obliged to provide work accommodations for finite period of time. The Act states

> **Duration of obligation**
> (7) The employer is obligated under this section until the earliest of,
> (a) the second anniversary of the date of injury;
> (b) one year after the worker is medically able to perform the essential duties of his or her pre-injury employment; and
> (c) the date on which the worker reaches 65 years of age.
> (Workplace Safety and Insurance Act, 1997, c. 16, Sched. A, s. 41 (7); 2000, c. 26, Sched. I, s. 1 (3).

In the cases of Jane, Bena, Shire and Cindy the hospitals acted on clause 7a and terminated the nurse's employment.   A nurse manager explains the sequence of action in the termination process.

> *Occupational health knows the anniversary date is. They call you and human resources and we set up a plan to terminate the nurse. Then we inform the union. It is a non-disciplinary termination. The nurse hasn't done anything wrong but we just can't keep carrying her... Those are tough meetings because the nurse hasn't done anything wrong and she is working. She just can't do bedside nursing and that is what she was hired to do. So we can let her go (nurse manager).*

This termination practice seems to be a common practice in Ontario hospitals as several of secondary informants were familiar with this approach. While the hospital is relieved of the burden of accommodating the injured nurse they have failed to retain a nurse and have contributed to the nursing shortage.

Summary

When ESRTW responsibilities are delegated to the hospital the rules of the WSIB are activated via the Workplace Safety and Insurance Act (1997). The implementation of ESRTW process is then superimposed and incorporated into the everyday social organisation of the hospital workplace. Hence the requirements of ESRTW are thus filtered through the logic of the hospital workplace and adapted to the patient safety and efficiency discourses. Understanding the outcomes of injured nurses ESRTW, therefore, involves appreciating the social and organisational nature of patient safety and efficiency that are health care priorities in Ontario.

This study has described how implementing RTW processes in Ontario hospitals proves to be taxing for both the injured nurses and their employers. However the hospital employer is

relieved of their challenges once a two year time period has elapsed due to current legislation. For nurses this is not the case. Instead those interviewed in this study are required to leave their pre-injury employment; new graduate nurses were required to assume jobs in other units; mid career nurses were terminated for non-disciplinary reasons; and the end of career nurse was pushed towards early retirement. The rhetoric of the WSIB describes early RTW as a beneficial endeavour for both the injured worker and the employer. In the case of this study this assertion was not supported.

CHAPTER 8: Discussion and Conclusions

Introduction

This final chapter summarizes the main findings. The aims of the study were twofold: first, to draw attention to nurse injured workers; and second to provide a rendering of the social organization of return to work (RTW) in the hospital setting from the standpoint of these nurses. Key to this discussion is an analysis of the tensions and disjuncture between the Workplace Safety and Insurance Board's (WSIB) notion of the benefits of early RTW, and the injured nurses' unsuccessful experiences of the process. The study highlights how RTW disrupts hospital management and nurses' lives. Hospital employers have difficulty finding suitable *nursing* work for these employees. Injured nurses, on the other hand, are engaging in considerable amounts of domestic, injury/rehabilitation, and accommodation work in addition to their paid nursing employment. These conditions provide insights into how hospital RTW practices produce circumstances where nurses are unsuccessful in returning to their pre-injury employment. The chapter concludes with a discussion of the limitations of this work and final thoughts about the implications of the study.

Major findings of the Study

None of the IRNs returned to their pre-injury jobs and all left the hospital either by choice or force. For new graduate nurses, the adversarial and unsupportive social milieu, which blamed the injuries on the nurses' inexperience, lead to them seeking employment elsewhere. Mid career nurses, on the other hand, complied with their accommodation work plans and engaged in activities, which failed to capitalize on their clinical expertise. The result of the long term assignment of non- nursing duties which failed to support them returning to their pre-injury role was the termination of mid career nurses.

The experience of RTW for the IRN

Injured nurses engaged in additional unpaid domestic, injury/rehabilitation and accommodation work activities as a result of the RTW process. These demands were in addition to their hospital employment. These (in)visible types of work were excessive and contributed to deterioration in the nurse's rehabilitation progress.

Changing the IRNs hours of work

With Return to Work, injured nurses found themselves on a new and demanding schedule. Unlike their pre-injury work roster, IRNs work only day shifts, gradually building up their hours with increasing weekly work hours per week. An example of an informant's schedule can be found in the table below.

RTW all day schedule

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
1	0900 - 1200	off	Off	0900-1200	off	Off	off	6
2	0800 - 1200	off	0800 - 1200	off	0800-1200	Off	off	12
3	0700 - 1500	0700 - 1100	Off	0700 - 1500	off	Off	off	20
4	0700 - 1500	0700 - 1100	0700 - 1500	off	0700 - 1500	Off	off	28

It is important to note that the above RTW monthly rotation is not fixed. If an IRN has a recurrence of her injury or is unable to maintain the schedule, this timetable may be modified and/or started again at week 1. The table on p. 127 presents the regular schedule that most IRNs adhered to prior to their injuries.

Nurse regular shift schedule - two days, two nights, five off

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7am-7pm	7am-7pm	7pm-7am	7pm-7am	**off**	**off**	**off**
off	**off**	7am-7pm	7am-7pm	7pm-7am	7pm-7am	**off**
off	**off**	Off	**off**	7am-7pm	7am-7pm	7pm-7am
7pm-7am	**off**	Off	**off**	**off**	**off**	7am-7pm

Domestic work

The initial effect of the early RTW and the all day schedule ripples through the IRN's family unit. As a result, IRNs and their families experienced an increase in expenses and family care needs, a redistribution of household duties and a reduction in salary. These circumstances resulted in a physical, emotional and financial burden for the family.

Family care work

In general, all registered nurses with responsibilities for child or elder care found it difficult to secure services that meet their shift schedules. When an IRN returns to an all day schedule with gradually increasing hours per week (Table 8) their child and elder care needs dramatically increased from five to twelve days per month. IRNs in this study found that their family care providers were unable to meet the needs of their new schedules. This challenge resulted in the IRNs spending large amounts of time trying to secure additional family care services. These temporary service providers were expensive. The combination of more care needs and costly providers resulted in all the IRNs daily wages being equal to their family care expenses. The impact of a new care provider on the children and older family members was significant. These arrangements resulted in children being unsettled and elderly family members confused. These family care circumstances put even more pressure on the injured nurse.

Redistribution of Household duties work

The all day schedule also influenced the performance and assignment of regular household activities within the family. All IRNs interviewed experienced fatigue and musculoskeletal aches and pains as a direct result of engaging in hospital nursing work. Additional ill effects were the result of rehabilitation treatments or medical appointments

following a day of hospital work. Consequently, home maintenance jobs, such as cutting the grass, tending to gardens or shovelling snow, and household chores, such as vacuuming or doing laundry, were often neglected. These circumstances result in the IRN employing expensive service providers such as housecleaning and landscaping businesses. IRNs with partners or family members close by relied on their assistance with other domestic chores and responsibilities. For example, a husband took on additional tasks such as picking up children from school and cooking.

In one case there were problems for a husband who took on these added domestic responsibilities such as dropping off or picking up children from school. The husband's employers did not appreciate or value him coming to work late or leave early in order to attend to his children. This resulted in a verbal reprimand from the employer. The threat of a partner losing his job and consequentially a greater financial burden was a major source of conflict within these families.   As a result, the IRNs resorted to accumulating credit card debt and securing bank loans in order to pay for nanny and housekeeping services.

Spending work

Financial expenditures increase dramatically during RTW because of increased car expenses, more takeout food, and a need to employ domestic service providers. IRNs needed to take a car to work so that they could attend physiotherapy and/or medical appointments immediately following their day of work at the hospital.   Nurses' regular shift schedules - a combination of day, night or weekend – allowed many to use public transportation or carpool when going to work. The new RTW schedule interfered with this ability. The increased need for a car results in large amounts of time in rush hour traffic commuting, increased fuel costs and premium (daytime) parking rates costs.   Fatigue following a day of hospital and rehabilitation appointments limited the IRNs ability to purchase and prepare food for her family. As a result the IRN was more likely to purchase food at work or take-out food for family meals.

Working for less

IRNs experienced a significant financial penalty pursuant to their returning to work on an all day schedule. A nurse's salary is a combination of an hourly wage and shift premiums. Shift premiums are a monetary supplement added to a nurse's base salary when she works outside of

the 7 am to 3 pm weekday hours. These premiums, which are a significant supplement to a nurse's wage, do not apply to day-time work. The cumulative extent of these financial circumstances is so considerable that all IRNs in this study dipped into savings, took out a second mortgage, incurred mounting credit card debt or relied on parental support in order to survive financially.

Injury work

Early return to work requires IRNs to continue with their rehabilitation treatments while also engaged in hospital duties. IRNs must apply much attention to this injury work which included not only engaging in the rehabilitation treatment but also obtaining medical documents that must be circulated to the WSIB and the hospital employer. The demands of injury work are taken for granted by the WSIB, hospital employers and peers.

Rescheduling work

The effect of an all day work rotation has a significant impact on the IRN's rehabilitation treatment and progress. A large amount of the IRNs time is devoted to administrative type duties such as securing medical appointments and acquiring documentation. Working an all day schedule requires a rescheduling of physiotherapy and medical activities around their hospital day time employment hours. All IRNs found these premium time slots difficult to obtain. A physician interviewed in the study reported that most people who regularly work a Monday to Friday 9am to 5 pm hours prefer medical appointments early in the morning or end of the day. Appointments during these time slots minimize the need for an individual to take time off work. As a result, medical appointments in the early morning or at the end of the day are highly sought after in a physician's schedule. Morning appointments are unsuitable for IRNs because their workday begins at 7am. Consequently, IRNs needed to secure medical appointments at the end of the day. These time slots are even more challenging to secure and often unavailable. Subsequently, IRNs cannot maintain their prescribed rehabilitation regime due to the long delays in securing appointments.

Securing documentation work

Securing appropriate medical documentation, which provides an authorized account of the injury existence and persistence, is an important and necessary part of RTW process. IRNs waited for long periods of time in crowded offices in order to obtain these official papers. The physician rarely saw the IRNs at the time of their scheduled appointments. Hence waiting is always a part of medical appointments. During each appointment, a physical examination and a discussion of the IRN's functional abilities ensue. The meeting concludes with decisions about duty restrictions being made by the physician. Duty restrictions are functional limits placed on the worker's ability to perform tasks. The following is an example of a medical note with duty restrictions:

Medical note

Dr. X
123 Fourth Street, Toronto Ontario

MEDICAL NOTE

To whom it may concern

RE: (IRN name)

Still decreased mobility in left upper extremity.
Cannot lift more than ten pounds
Must have breaks every two hours for ten minutes.
Reassessment in 1 month.

Date: June 4, 2010   Signature: Dr. X

Obtaining this document requires more effort than just attending the medical appointment. Physicians commonly ask the IRN to return to their office and pick up this document on a different day. An orthopaedic surgeon explains that she required time to craft these official texts in language that would not be questioned by the WSIB or employer. The questioning of this letter results in the doctor needing to devote more time to a case by explaining the rationale for her decision to the WSIB or employer. As a result, many doctors have patients return for a second visit to pick up these documents. This is a preventative action to minimize the questioning of their medical decisions. While this strategy is beneficial for the physician, the nurse must make two trips to the office in order to secure this document.

Distribution work

The onus for providing these official texts to the employer and WSIB always falls to the injured worker. Once the IRN secures the appropriate documentation the text is copied, faxed, courier, mailed and filed with the WSIB and the employer. The IRNs report that third parties often misplaced, misfiled or lose these texts. As a result IRNs maintain a copy of all reports in a personal file. They also maintain a log of telephone calls, receipts of faxes and emails and any other information of relevance to their case in the file. This record keeping process is essential as the nurses frequently need to refer to their copies to verify that reports have been sent, calls have been made, and so on.

Treatment work

Accessing physiotherapy treatments following a day of nursing work proved difficult for the IRNs. Physiotherapist offices were usually located in close proximity to their homes. This allowed for easy access to treatment during the initial and acute phase of their injury. Once IRNs returned to work most physiotherapist locations were a lengthy distance from the hospital employer. Hence a long commutes to the appointment, often in rush hour traffic, was required. Consequentially, IRN came to these appointments tired not only from working all day but also sore and stiff from spending large amounts of time in the car. All IRNs reported a decrease in their functional progress at physiotherapy once they returned to work. The IRNs attribute this decline to the combined demands of hospital work and commuting.

Accommodation work

In most circumstances an early return to work means that the IRN's is unable to resume full duties. IRNs are required to attend formal meetings to discuss appropriate modified work activities and often suitable patient care activities are not assigned to the nurse. This issue requires the IRN to engage in a negotiation for appropriate duties with managers, occupational health and safety coordinators, and nursing peers on the unit.

Formal meeting work

IRNs need to be able to articulate and interpret the content of the letters, reports, and work restrictions to various parties, including management, nursing peers, physicians and the

public, within the hospital setting. In biweekly meetings, attended by a union representative, nursing manager, occupational health department representative and the IRN, the content of these documents is deciphered. Each party maintains their own notes concerning these proceedings. During the meeting formal dialogue, discussions, debates, negotiations and mediations surrounding restrictions and suitable hospital duties for the IRN occurs. The meeting concludes with the development of an accommodated work plan specific to the IRNs functional abilities. This work plan, which is copied and circulated to all meeting participants, becomes a textual form of the IRN's medical restrictions converted into hospital work language.

Translating work

This translation process is not simple and often results in nurses needing to self- advocate for adherence to the plan. For example, Cindy, a labour and delivery nurse, was required to lift instrument trays for surgical procedures, such as a caesarean section. Cindy knew from her years of experience that these trays were heavy and exceeded her ten pound lifting restriction. The hospital management disagreed. The nurse manager, a former labour and delivery nurse, indicated that she thought the trays were less than ten pounds. The occupational health department did not have data on the weights of the instrument trays. Pursuant to this conflict, Cindy and her union representative weighed the surgical instrument trays to verify their exact weights. They found that all instrument trays used in the labour and delivery unit exceeded Cindy's weight restriction. Following a review of this data, Cindy was no longer required to lift instrument trays.

Re-articulating work

The implementation of the accommodated work plan at the local nursing unit level happens by way of a unit manager creating a notice which states:

Memo to Staff

To: unit X staff
From: Nurse Manager
RE: IRN duty restrictions
Be advised IRN X cannot do A, B, C patient activities until further notice. Please do not assign her these tasks.

The manager

The manager posts this memo in a centralized area of staff communication such as a bulletin board, communication log or a prominent location at the nursing station. Hence, all unit nurses and staff are aware of the IRN's limitations. Regularly, IRNs report, staff members fail to read this memo and are unaware of their duty restrictions. As a result, inappropriate duties may be assigned to the IRN. This requires the IRN to engage in accommodation work requiring a re-articulation and negotiation of her duties with staff such as a charge nurse, physician, other nurse, the unit clerk, a porter or cleaning staff. The IRNs must repeat this re-articulation process several times per day.

In sum, the interplay of domestic, injury and accommodation work while an IRN is attempting to return to full employment is a significant, complex and multifaceted process. The effect of the RTW process ripples into all aspects of the nurse's personal and professional life and causes much disorganization. At home IRN and her family must reorganize in preparation for the RTW. Changes in child and elder care requirements, additional domestic responsibilities for partners and added financial burden are all manifestations of the disorganization. Securing medical appointments that fit with an all day shift schedule is difficult. The IRNs rehabilitation progress is affected not only by a lack of appointment times, but also by the demands of engaging in paid employment, physiotherapy and medical evaluation activities simultaneously during RTW. The physical demands of these activities are extreme and lead to fatigue. The translations of medical documents which outline the IRNs duty restrictions into suitable nursing work are difficult. Often IRNs are assigned inappropriate work duties. This result is the IRN needing to articulate, negotiate and advocate for suitable work.

The experiences of RTW for the employer

The logic of Early Return to Work is that it is meant to benefit both the injured employee and the employer. As we have seen RTW causes major challenges for the injured nurse. It appears that the process is also problematic for employers. The requirement to find work that is suitable work for a registered nurse with functional limitations is evident; scheduling too brings major challenges for unit managers. The requirement for nurses to cover their colleagues during breaks, to assist when patients require extra care or during emergencies mean that a nurse on

shift with limited functional capacity and work restrictions places a burden on their colleagues and provides organization challenges to the team.

Re-scheduling work

As previously noted, nurses engage in shift rotations that organize them to work in the day, evening and night time hours. In contrast, unit managers and the Occupational Health department personnel engage in work during the day time hours only. In order to facilitate biweekly RTW meetings, the IRN is placed on an all day shift schedule so that her schedule is congruent with the manager and OHS department. Biweekly meetings between these parties are necessary to demonstrate to the WSIB the compliance, cooperation and engagement of the employer and the IRN in the RTW process. Failure to co-operate or comply with WSIB expectations can result in the IRN having her compensation reduced, suspended or stopped.

The threat of a reduction or stoppage of compensation is something to which the IRN is constantly exposed. All injured employee correspondence received from the WSIB throughout their injury claim carries this message. This threat is taken seriously by IRNs who worry about their financial circumstances. Consequently, IRNs are eager to comply with WSIB and the employer's requests so as not to jeopardize their compensation.

The WSIB literature also warns employers about their duty to cooperate in the RTW process.   The specifics of any consequence or penalties for an employer could not be uncovered through informant interviews or text examined on the WSIB website.

The work of finding a job

The task of finding suitable duties for IRNs to engage in that fit within the functional restrictions set out by the physician is difficult for the hospital employer. Charge nurses, who are responsible for creating nursing work assignments, struggled to find appropriate IRN and patient matches. This problem is considerable when several IRNs are assigned to work the same shift on the same unit. The inability to find appropriate patient work leads to the IRN being assigned non-nursing duties and tasks. The assigning of an IRN to non-nursing duties can result in feuds between different unions (ONA, CUPE, and OPSEU) over job territories. IRN's assignments to volunteer jobs lead not only to a displacement of volunteers but also IRNs being stuck in positions that failed to allow for the utilization of their expert knowledge, skills and clinical

expertise. Hospitals assigned IRNs to non-nursing duties such as: asking hospital staff and visitors to sanitize their hands when entering and leaving the hospital; cleaning and tidying nursing unit cupboards; auditing charts; filing reports; and directing hospital visitors. All IRNs interviewed in this study were bored and angry when assigned to these tasks which supported their underemployment and the inefficient utilization of their knowledge and expertise.

Discussion of the tensions and contradictions

The experiences of injured nurses interviewed in this study constitute a narrative that is counter to established workers' compensation and health care discourses. According to the WSIB website:

Returning to daily work and life activities can actually help an injured worker's recovery and reduce the chance of long-term disability... Both you and your employer benefit in cooperating in your early and safe return to work. You benefit by restoring your source of income and staying active and productive, which are important to the healing/recovery process. Your employer benefits by minimizing the financial and human costs of your injury or illness.

This was not the case in this study. In this section a discussion to the tensions and contraddictions to this statement that were discovered in this research is presented.

An exploration of the tensions and contradictions between workers' narratives and public discourses of neoliberal reform can create an opportunity for the development of dialogue that is counter to managerial representations. Such an analysis can be used by the people to dispute established discourses and spark social change.

> The test for whether or not research has been successful is the extent
> to which it enables people to transform the world (Frampton, 2006 p.
> 3).

The above statement is reflective of the activist spirit underlying institutional ethnographic research. Dorothy E. Smith (1987; 2005; 2007), George W. Smith (1990) and others use the sociological knowledge produced from research to spark activism and social change. Hence, the findings in IE research are used as an incitement to shift the gaze so that oppressed people (and activists) can look back and see how the oppression they live is socially organized. It is hoped

that the discoveries of this study can be taken up by nurses, their unions and professional associations and employers to produce strategies for changing RTW processes.

In the section that follows three key discourses that were influential in the study are unpacked: discourses of working women; discourses of injury management; and discourses of health care. From these discoveries, site for potential change are examined.

Discourses of working women

The experiences of injured nurses interviewed in this study shed some insights into the social organization of domestic life for nurses who are shift workers. Little in the literature focused on women and shift workers beyond biomedical discussions. In this section two key issues that structure the nurse's everyday experiences, their shift schedule and premiums salary supplements, will be examined.

Shift Schedules

Most staff nurses, adhere to schedule rotation of twelve hour day and night shifts. The mechanisms to create a nursing schedule are complex. Hospital decisions about the cadre of staff to schedule are based on the analysis of an aggregation of unions collective agreements and labour regulations; patient bed utilization trends (Rankin & Campbell, 2006; 2009); medico - administrative data (Mykhalovskiy & Weir, 2004 Mykhalovskiy, 2001; Mykhalovskiy et al., 2008); and staff mix trends (Canadian Nurses Association, 2005) data. These data provide directions on how staff must be organized and scheduled to meet the projected patient volumes on a given nursing unit. A nurse's rotating shift schedule is based on these calculations.

Little has been written about the effect of scheduling on nurse's experiences in the context of their home lives. Historically, the work of women has been unacknowledged and undervalued in contemporary society. Feminist scholars have long argued for an expansion in our understandings of women's efforts in both paid and unpaid places of work (Griffith & Smith, 1987; Messing, 1998; Walter, Beardwood, Eyles, & French, 1995). Women engage in a disproportionate amount of domestic labour which includes caring for family members, cooking, cleaning and household maintenance (Luxton, 2009). Walters and colleagues (1995) have found that female RNs (with or without children) spend 24 hours a week are spent on these household

tasks, compared with 16 hours for male RNs.   Rarely discussed, beyond Walters' work, are the influence of scheduling on a nurse's domestic responsibilities. This study provides some insights into these issues illustrating the competing demands of family carer and worker become manageable through the manipulation of shift work to offset child care costs, provide the opportunity to act as a family resource person for ageing parents and active children.

It is well established that working women deal with the insistent tugs of family care giving and other domestic responsibilities, as they engage in paid jobs (DeVault, 1991; Griffith & Smith, 1987). Arlie Hochschild (1989) coined the phrase "the second shift" (p. 239) to articulate the multiple responsibilities and duties that are completed by women following a day of paid employment.   The findings from this study confirm that this observation rings true for nurses. In fact, nurses go beyond "second shift" duties. The ability to work during the night and on the weekends makes it possible for them to engage in more fully in household and community activities as compared with most working women. Hence, nurses, as working women, engage in a *third shift* in which they provide intensive service to both their families and the community.

The findings of this inquiry provide empirical evidence of how the domestic lives of nurses are tightly organized around their shift work schedule. The 12 hour shift sequences provide nurses with opportunities for extended periods of time off. Such is the case in the "*two days, two nights, 5 off*" schedule illustrated above in table 10. These long periods of time away from paid employment allow a nurse to engage in third shift duties such as providing more child and elderly family member care, engaging in volunteer activities in churches and schools, and pursuing continuing education. In some ways, their schedule allows these working women the ability to engage in a lifestyle similar to stay-at-home mothers or full time students while continuing to engage in full-time nursing work.

The non-traditional employment hours associated with nursing work make finding child and elder care services difficult.   Most licensed daycare providers supply service that meets the needs of families with Monday to Friday 7am to 6 pm needs. Nurses by virtue of their 7am or 7pm start of work and 12 hour shifts do not use these services. Instead they resort to non-licensed and informal care arrangements with family members or in-home care providers who are more accommodating of their irregular work rotation. These types of family care arrangements are a precious commodity.

Through the examination of IRNs experiences of RTW it becomes evident that a change to the regular shift schedule (table 9) of a nurse interferes with her abilities to engage in third and second shift duties.   The rationale for this scheduling change is based on the need of the employer to align the IRN's schedule with hospital injury management actors. The occupational health and safety (OHS) department and nursing unit managers oversee the daily operation of the RTW process for the returning nurse.   The supervision of administrative aspects of the IRNs return (payroll, reporting and communication with the WSIB) is coordinated by the OHS department and human resources departments. The OHS hours of operation are Monday to Friday during daytime hours, and nurse managers have similar availability. Access to OHS services are not available for nurses working in the evening, night and weekend periods. Hence, IRNs are assigned a work a schedule of convenience to the hospital.   Hospital administrators promote this schedule as a way of supporting the IRN by providing full access to OHS services for first aid and rest in case of injury exacerbation.

For injured nurses returning to work this new schedule is neither supportive nor simple to adhere to. The IRNs are no longer able to engage in family care, volunteer and academic activities. There is a dramatic increase in family care needs from five to twelve days per month. This leads to a redistribution (or neglect) of household chores as a result of the new schedule. Locating family care services to meet the new schedule is difficult. The findings of this inquiry reveal that regular family care providers and family members are rarely able to fully accommodate the new schedule of the IRN. As a result, nurses need to search for new family care and domestic service providers, in order to adhere to the RTW schedule. These services are costly and add a financial burden to the family.

Ontario demographic projections report that increasing eldercare responsibilities, especially for women, will become an employment issue that must be addressed (Duxbury, Higgins, & Schroder, 2009). Nursing, being a predominately female profession, will be hit hard by this trend. The results from this study show that this is already an issue for some nurses. While strategies are being implemented to retain qualified nurses, attention to issues that face these employees with care responsibilities for elder dependants must be considered. Little is known about the issues that face employed elder caregivers. Duxbury et al. (2009) warn that people providing home care to elderly family members are at high risk for physical and emotional strain. This notion is important to consider for nurses who already engage in work

activities that produce similar stress and strain. Hence a study looking into the challenges of elder care giving using a sample of nurses as informants should be considered. The results of this study would be beneficial not only in providing more insights into the issue of elder care giving but also employed shift workers with such responsibilities.

Recently, nursing organizations in Canada have voiced concern about the link between fatigue and patient safety. One recommendation from these initiatives is the reorganization of nursing shift work (RNAO, 2010; CNA, 2010). Based on the results of this study, nurses, their professional groups and health care employers are urged to carefully consider the ramifications of such a change. Such a systemic adjustment would have significant social consequences for nurses, their families and the community.

Shift premiums

Assigning employees to an all day schedule following RTW is of financial benefit to the hospital as the nurse does not qualify for shift premium salary supplements. The hospital is saving money because it is not paying out shift premiums to the worker. During collective agreement negotiations between the nurses union and hospital employers, shift premiums or differentials are established. Wages for work done during the evening, night and weekend hours are supplemented with premiums. Premiums added to the base salaries are a taken for granted portion of a nurse's annual income. Nurses in this study experienced financial hardship pursuant to premiums not being added to their base salary. Hence there are some monetary savings for the hospital to assign returning workers to a day shift rotation. In light of the intensive fiscal monitoring of health care expenditures, a managerial strategy like having workers adhere to an all day shift schedule may be of financial benefit to the hospital.

Discoveries and sites of change

Nurses, as shift working women, have domestic lives that are organized around their schedule. Changes to their work schedule causes disruption and disorganization within the family unit. Messing (1998) and Acker's (2006) advocate for employers to consider the work that woman do inside the home in all organizational decision making, particularly in terms of scheduling and the financial impact of this change. I concur with this recommendation and would emphasize the importance of nurses, professional associations, unions and the provincial

government to engage health care employers in discussions about the appropriateness of schedule changes in light of women's responsibilities. Access to child and elder care services that support women who are shift workers to maintain their employment is needed.   It is important for health care workers, employers and the system to recognize the social consequences that can result from changing a nurse's schedule.

While shift premiums are considered by hospital management and the WSIB as an *add-on* to a nurse's base salary, nurses become financially reliant on this supplement. Hospital management and nurses must be mindful of the reliance on shift premiums. Consideration of how an all day schedule can create financial hardships and increased expenses for nurses is required.

Discourses of injury management

The injury management approach adopted by Ontario hospitals and the WSIB adopts a purely biomedical notion of injury. This approach presumes injury to be a temporary state which resides in the worker's deficient or dysfunctional body. Medical professionals are given the authority to provide a diagnosis, treat and prognostic authorization of the presence (or absence) of the injury/disability based on tests and diagnostic criterions. Adherence to the medically prescribed rehabilitation plan leads the injured worker down the road to normalcy and recovery. This treatment path, which is laden with biomedical and functional benchmarks, is assumed to be finite, and predictable.

Disability scholars contend this approach to injury, and disability is deficient on many levels (Corker & French, 1999; Barnes, 1998; DePoy & Gilson, 2004; Priestley, 2003).   There are several limitations to a purely biomedical and functional notion of injury with set treatment plans. The influences of an individual's personal and medical circumstances are lost when this approach is used. Factors such as age, injury severity, medical complications and co-morbidities, access to a treatment, social support, work environment and individual preferences (Kerr & Norman, 2003; Regan et al., 2009; MacEachen et al., 2009) are not considered with this approach. A failure to achieve prescribed functional and rehabilitation milestones create a path for an employer to label the person as unable to return to the same job or related job. In this case the employer, under WSIB RTW legislation, is relieved of their obligation to accommodate an

injured worker on the two year anniversary of the incident.   This does not mean that the injured employee has not been working or is unwilling or unable to return to work.

Invisible injury work

The work that injured workers engage in as they return to work is unacknowledged and undervalued in the WSIB discourse of RTW. Injured workers are expected to continue in their rehabilitation programs and medical re-evaluations, in addition to paid employment as they RTW. As previously stated above standardizing approaches to rehabilitation loses sight of the person involved in the process. This study exposed *injury work* as unaccounted for in official renderings of the RTW process. The expectation that the injured employee return to paid employment, prior to a full recovery, and maintain an intensive schedule of rehabilitation and medical appointments in addition to paid employment, is physically and emotionally challenging. IRN Bena describes the strain associated with this type work as being like "*a second job*".

Discoveries and sites of change

The process of RTW from the standpoint of the injured employee exposes the interweaving of specific injury work and paid employment activities. Managing the demands of paid and injury work is demanding and challenging labour. The amount of energy, attention and effort necessary to engage in paid employment and injury work simultaneously is momentous for the injured employee.   Yet little notice is placed on these demands in discursive accounts of the RTW process, in particular when there is a regression in rehabilitation progress.

If injured employees are to be successful in RTW then consideration of the impact of injury work as a necessary component of the process is required.   A balance between the physical demands of employment and rehabilitation must be considered not only by employers but also by health professionals such as physiotherapists. Injured workers may come to physiotherapy appointments tired and taxed from a day of employment work.   Injured workers, health professionals and the WSIB must recognize that milestones in rehabilitation progress may be disrupted due the strain of employment work and competing schedules.

Employers and the WSIB must consider how demographic factors, such as age, contribute to delays in delay recovery. For example, Bena is a 55 year old nurse with a long employment history in health care. Her body had endured years of lifting, pushing, turning and carrying patients. Little is known about the long term health consequences of this type of nursing work. Unlike male dominated profession such as firefighters and coal miners where the health risks are well established, the physical and emotional consequences of multiple years of nursing work remain unidentified. Messing (1998) contends that this is due to an undervaluing of women's work.

The human body deteriorates as a natural part of aging (Priestley, 2003). The effects of aging on injury acquisition and recovery are another factor that requires research attention. Bena's initial medical reports noted that there were some symptoms of her knee joint deterioration due to aging. This information led to the WSIB dismissing her claim initially. Age related factors can nullify a claim. The deterioration of a person's body due to aging and the influences of this process on recovery are rarely considered in managed care approaches taken by the WSIB.

Access to health services also presents problems for nurses which can delay recovery. These medical delays and treatment wait times are not considered by the WSIB or hospital employers. For example Bena waited three months for an MRI test, four months for a specialist appointment and six months for surgery. Medical wait times, which Bena could not control, contributed to her delayed recovery. The WSIB and the hospital employer failed to consider these factors as contributing to a prolonged recovery trajectory. As a result Bena was terminated on the two year anniversary of her injury.

Current Ontario accessibility legislation may be a way for unions to challenge the termination of IRNs. Ontario has been a leader in protecting the rights of people from discrimination based on disability. Recently legislated initiatives have been put in place to make the province accessible. The Ontario Human Rights Code, which is the cornerstone of disability rights, provides legal protection from discrimination. In 2001, the Ontarians with Disability Act (OD) initiated approaches to accessibility within the province. The intentions of this act were strengthened in 2005 with the advent of the Accessibility for Ontarians with Disability Act (AOD). This legislation provided clear accessibility goals for organizations (including hospitals) and a deadline for implementation of January 2025.

The standards and guidelines of the AODA mandate inclusivity of goods, services, facilities, employment, accommodations and buildings. This legislation, which has been highly praised by the disability community, is congruent with a social approach to disability which regards the rates and states of disabled people as products of social processes and structures. Such is the case for injured nurses in RTW, where the workplace presents many barriers to their re-engagement in meaningful nursing work. The collective agreement, human resource and nursing work structures limit IRNs abilities to successfully RTW.

However, Ontario businesses and municipalities voice concerns that accessibility initiatives are costly and of little benefit (Kemper, Stolarick, Milway, & Treviranus, 2010). In response the Ontario government commissioned three research bodies - the Martin Prosperity Institute at the University of Toronto Rotman School of Management, the Institute for Competitiveness and Prosperity, and the Adaptive Technology Resource Centre – to examine the economic impact of providing a higher level of accessibility within the province. The report recommendations indicate that there are benefits to all employees gleaned from improving accessibility particularly in workplaces and schools. AODA legislation requires hospitals and the WSIB to demonstrate a commitment to increasing accessibility for people with disabilities. Potential opportunities may come with such a pledge. Kemper et al. (2010) has found that by improving accessibility, the participation rate of individuals with a disability could increase anywhere from between 2% to 15% and lead to not only a significant productivity increase but also social and economic gains.

The need to improve accessibility is of particular importance in Ontario as the population ages and the labour force shrinks due to baby boomer retirements. A rapid increase in the percentage of people with disabilities, from 13.5% in 2001 to 15.4% in 2006, had been attributed to this aging trend. Disability tends to increase with age, with the highest incidence occurring among individuals 45 and older. Disability scholar, Mark Priestly (2003), proposes that development can be attributed to a natural aging process where vision, mobility and reflexes slowly decline as people age. Given that the average age of nurses in the province is 45.9 (Canadian Institute for Health Information, 2005) issues of disability and accessibility need to be central in nursing workforce succession planning, work environments and patient care delivery. The nursing workforce is becoming disabled not only by injury but by aging trends. Hence improving accessibility in hospitals is of benefit to patients, staff and the community at large.

Unions need to challenge hospital and all health care employers when they do not provide accommodated or appropriate work for injured and/or aging nurses using this legislation. Such strategies may improve productivity and result in cost savings. Nursing organizations, such as the Canadian Nurses Association, the Registered Nurses Association of Ontario, the Ontario Nurses Association and the Ontario Nursing Secretariat must take a proactive stance in advocating for accessible workplaces for all nurses in all health care sectors. Nursing researchers engage in work that exposes the complexity of nursing work and create innovative proactive initiatives that protect and promote the health of nurses.

Discourses of health care

Returning to (what) work?

A foundational assumption of the WSIB's approach to RTW is that the employer will have suitable work that the injured employee will be able to engage in. Hospital employers, in this study, were unable to find appropriate roles for nurses. Hospital quality, patient safety and fiscal restraints were causal factors.

Health care quality, patient safety and fiscal responsibility are a system priority in Ontario hospitals (Ontario Hospital Association, 2010). The neoliberal health care reform in Ontario in the early 1990s, lead to the creation of the Institute for Clinical Evaluative Sciences (ICES), a provincially funded research program with a mandate to assess provincial hospital care (Rappolt, 1997). This organization uses administrative data to statistically compare hospitals. Review indicators of quality such as average lengths of patient stays, surgery rates, waiting times and patient safety indicators such as medication errors, patient falls, and infection rates (Gardam, Lemieux, Reason, van Dijik, & Goel, 2009; Mykhalovskiy et al., 2008). ICES reports revealed inconsistencies and inefficiencies in Ontario hospitals. As a result, strategies to measure the quality of hospitals and contain health care spending were instituted and the statistical reporting and comparison of hospital generated data have become the primary ways of achieving such measurements. The results of each hospitals performance would be made available to the Ontario public. At the same time hospitals were forbidden by law from running financial deficits.

The health care discourses of patient safety and fiscal constraint were evident in dialogues with IRNs and secondary informants interviewed in this study (such as occupational health nurses, managers and charge nurses). The medical label "injured" leads to presumptive

thinking of inferiority in the nurses abilities and supports the rationale for assigning IRNs to non-nursing duties rather that nursing work. Hospital management presumes that the injured nurse, being physically inferior to others, is unable to engage in nursing work with patients. The injured nurse's inability to assume full accountability for the patient, because she may be unable to perform some nursing skills, fuels this assumption. Managers voiced fears that patient safety or nursing standards will be compromised.

The *"need to keep patients safe"* (charge nurse 3) was identified by informants in this study as the primary reason for not assigning the IRN to regular nursing duties that were consistent with their functional abilities. A manager stated

> *If [the IRN] can't respond to the needs of a patient and keep them safe, then I am not going to risk it and assign her nursing duties. If she is not fully recovered then I don't want her working with patients. I'm ultimately responsible for these patients and their safety"* (Nurse Manager 2).

Two concerning notions are reflected in this statement. First, this quotation displays the idea that nurses are delegated primary responsibility for maintaining patient safety within the hospital. Instead of being a priority for the whole hospital organization, nurses are relegated responsibility for patient safety at the local unit level. The second concerning issue is the presumption that the IRN would compromise patient safety. This view reflects an ableist attitude that is consistent with the biomedical/functional approach to disability described above.

Discoveries and sites of change

All of the IRNs in this study returned to some form of work. All were eager to engage in meaningful *nursing* work. In fact, several IRNs interviewed in this study could articulate creative ways and new roles that could capitalize on their functional *abilities* and be of benefit to the hospital. For example, IRN Jane proposed to her manager, occupational health department and union, a new role designed to assist newly hired nurses or students their clinical orientation to the critical care unit. Identifying staff nurses who were willing to assist with orientation was problematic on this unit. Jane, with over 20 years of expertise in this area and numerous awards for her ability to mentor staff, felt that she was well suited for this position. The human resources department of the hospital would not entertain this proposed role.

The hospital's unwillingness to consider these alternative roles is attributed to the financial crisis that continues to loom in Ontario healthcare (Ontario Hospital Association, 2010). Managers interviewed in this study told if their angst in minimizing spending on staff. A manager stated "*I can't just create a position. Even if I wanted to. We don't have enough money to keep the staff and jobs we have right now*" (manager 1). Recent reports from the Ontario Hospital Association (OH), which represents 154 hospitals, verify this statement. Reports from the OHA caution the government and the public that health care funding for 2010 is insufficient to meet the projected demands for health care. Hence, there are no supplementary funds available to support the creation of such a new position as proposed by Jane.

There are no incentives for hospital employers to engage IRNs in patient care work. Nor are there incentives to create new roles for injured or disabled nurses. Collective agreement regulations and human resources practices are disincentives for such creativity in the creation of new work for IRNs. There are organizational incentives, however, for hospitals to engage the IRN in non-nursing duties, such as chart audits and infection control duties. These quality activities benefit the hospital's performances in provincial reporting mandates. The distinctive scientific knowledge, communication skill and professional authority that registered nurses possess, when compared with other health care workers, make them fitting candidates to perform these roles. Improved provincial ratings are linked with increases in funding from and a more prestigious public image. Yet for the IRN, these roles fail to return her to the pre-injury role.

The unsuccessful RTW of IRNs is adding to staff attrition and depletes health human resources (Shamian, Kerr, Thomson, & Laschinger, 2002; O'Brien-Pallas et al., 2004). This state of affair troubling in light of provincial efforts directed at retaining qualified nurses within the system and the establishment of the Nursing Retention Fund (NRF) (Burkoski & Tepper, 2010). This initiative is designed to retain nurses within Ontario public hospitals.   The long term consequences of this erosion of nursing human resources is a lack of qualified nurses able to tend to the needs of Ontarians as they age. The unsuccessful return of an IRN to work contributes to this shortfall. Attention to the creation of innovative ways of practicing nursing that facilitates aging, injured and disabled nurses continuing in the profession in needed.

Situating this study within the literature

The findings from this study make contributions to three major literature domains: return to work, nursing work life and qualitative methods.

Return to work

The economic and non-economic consequences of return to work are well documented in the literature (Beardwood, Kirsh, & Clark, 2005; Brown, Shannon, Mustard, & McDonough, 2007; Lippel, 2007; Tompa et al., 2009). Early return to work has been embraced by compensation agencies because improvements in rehabilitation outcomes and cost saving have been reported in large workplace organizations (Krause, Dasinger, & Neuhauser, 1998). Eakin et al. (2005; Eakin, MacEachen, & Clarke, 2003), who studies RTW in small workplaces, provides a counter rendering of the process and describes the many challenges associated with the implementation of this process in these settings. A lack of available modified work and dedicated personnel to drive and support the RTW process are but a few of the difficulties. While this study looks at RTW in hospitals, which are considered large organizations, challenges similar to those found in small businesses are evident when trying to getting injured registered nurses back to work.

A growing body of literature which addresses factors that both promote and interfere with RTW has emerged (Baril et al., 2003; Beardwood et al., 2005; Eakin, MacEachen, & Clarke, 2004; El-Bassel, 1996; King & Collins-Nakai, 1998; Institute for Work and Health, 2007; Messing, 1998; Shainblum, Sullivan, & Frank, 2000). Several factors such as the severity of illness, the type of injury, and rehabilitation treatment practices are considered influential in the recovery and return trajectories. In addition, factors including personal resources, such as family status and support, educational level, and economic resources, (Roberts-Yates, 2003); workplace culture, such as the corporate beliefs and supervisory disability management training (Amick et al., 2000; Friesen, Yassi, & Cooper, 2001; Shaw, Robertson, Pransky, & McLellan, 2003; Williams, Westmorland, Shannon, & Amick, 2007) and job characteristics, such as monotony, time pressures, perceived high workload, and perceived control are significant (Bernacki, Guidera, Schaefer, & Tsai, 2000). Little work has been done in the area of RTW from the standpoint of women or a female dominated occupational group like nursing. Nor have the day to day domestic actualities of what injured workers do as they RTW hitherto have been reported.

Nurses' health and work life

Studies reporting nursing demographics, health human resources, physical and emotional health challenges are well represented in the literature (Campbell, 1994; Hendrickson, Doddato, & Kovner, 1990; Harber, Billet, Shimozaki, & Vojtecky, 1988; Marshall & Worthington, 1993; Yassi et al., 1995; Ontario Nurses' Association, 2009; O'Brien-Pallas et al., 2004). Most studies using quantitative and epidemiologic techniques report back injuries from inappropriate lifting techniques as the most common cause of workers' compensation claims in the profession. As a result studies examining the effectiveness of back injury prevention and patient lifting interventions have emerged (Retsas & Pinikahana, 2000; Australian Nurses Association, 1998; Dawson et al., 2007; Nicklin & McVeety, 2003; Institute for Work and Health, 2007; Ronald, Yassi, Spiegal, Tait, & Mozel, 2002). None of the nurses in this study sustained back injuries as a result of lifting. The injury circumstances of the nurses in this study were the result of equipment malfunction, patient assaults or rescuing activities. Challenges to traditional understandings of how nurses are injured can be gleaned from this study.

The literature describing the complexity of nursing care (Nelson & Gordon, 2006; Gordon et al., 2008) and the gendered nature of nursing work can be enhanced with the findings of this study. This complexity is clearly illuminated when nurses become injured and the taken for granted activities of their work becomes problematic. Canadian feminists Meg Luxton (2009), Alison Griffith and Dorothy Smith (Griffith & Smith, 1987) have all contributed extensively and articulated the notion of women and domestic work. This study makes a unique contribution to this literature by describing the work that nurses, as female shift workers, must engage in to maintain their families and homes.

Qualitative methods

Cartographic techniques have been used by institutional ethnographers (Pence, 2003; Turner, 2006; 2009) as a way of visually illustrating the social organization of processes. In this study maps were used in a more comprehensive way that aids data collection and analysis. Researcher generated maps proved useful in articulating what is known about the topic prior to data collection. This technique is useful in identifying areas potential texts to be reviewed and questions to ask informants during interviews.

Maps created by IRN informants in this study provided an empirical account of the social organization of injury management from their standpoint. Each map was reviewed while simultaneously listening to the interview tape. Multiple reviews of the maps and tapes occurred throughout the data collection, analysis and write up phases of the study. This strategy facilitated the researcher's immersion in the data (Borken, 1999) . This mapping process helped to expose key secondary informants to interview, questions to ask and texts to review in the later stages of the study. Hence, the data generated in informant maps assisted in furthering study planning and refinement.

A formal process was developed to guide consistency in map reviews based on the works of other institutional ethnographers (DeVault & McCoy, 2006; Smith, 2008; Turner, 2006; Pence, 2003; Rankin & Campbell, 2006) and the situational mapping techniques of Adele Clarke (2005) . The acronym INSPECT (see below) was created to systematize the map review process.

I	What is **I**nteresting about this map?
N	Are there **N**ew findings that require a revision in the methods, interview questions or procedures?
S	What **S**equences of action are evident?
P	Who are the **P**eople identified in this map?
E	Are there other **E**vents that are influencing the sequence that may be (in)visible to others?
C	Are there **C**ommon **C**onnections or **C**ircumstances with this map and experiences of other informants?
T	What **T**exts are talked about?

The review of informant maps individually and cumulatively facilitated a heightened awareness of patterns and connections. Such patterns were further illuminated when data from the informant maps was graphed onto the researcher's initial map. This method assists in discovering what was learned from the informants during the study.

Study limitations

This study has a number of potential limitations that must be acknowledged and considered. The identification of such limitations is intended to generate new ideas and directions for other research activities. In this section, the limitations of this research will be presented followed by opportunities for future investigations.

The first limitation arises for those reviewers of this work looking for either an objective or subjective account of injured workers engaged in early RTW. The institutional ethnographic approach used in this study is a 'materialist' research methodology, in contrast to an objectivist or subjectivist one. The findings are neither an objective standard nor measure.   Institutional ethnographic research supports the discovery and analysis of "what people actually do in the physical, social, and other conditions of real life" (Townsend, 1998, p. 18). Hence, what is reported in this dissertation "does not stand independently of the actuality of which it speaks" (Smith, 2005, p. 160). Instead, "it refers back to an actuality that those who are active in it also know" (Smith, 2005, p. 160). This account is authoritative (Smith, 2005) in the sense that it is based on the actual experiences of IRN informants who are required to participate in the work process of early return to work in Ontario hospitals. The approach is also distinguishable from other qualitative approaches that seek to discover the subjective meaning informants make of their experiences (Morse, 2002). In an IE study, informants' experiences provide the starting point for the inquiry. The final destination is where those experiences are embedded in social and ruling relations that constitute the social organization of early return to work.

Experience as a basis of knowing is considered by some scholars (Butler & Scott, 1992) to be a limitation of a research approach. In an institutional ethnographic inquiry, the researcher relies of the experience of informants as important foundational data. This reliance is based on the assumption that social organization is implicit and/or evident in the language people use in dialogue about their experiences in the everyday world (Smith, 2002; 2005). Institutional ethnographers

> are not using people's experiences as a basis for making
> statements about them, about populations of individuals, or
> about events or states of affairs described from the point of view
> of individuals. For institutional ethnographers, the speaking or
> writing of experience is essential to realizing the project of
> working from the actualities of people's lives as the people
> know them. (Smith, 2005, p. 125)

The analytic goal of the IE is not to translate the experiential dialogue into factual or essential explanations of peoples experience (Campbell, 1998). Instead the people's accounts of their experiences are used as an entry point into an institutional regime or extra- locally organized

knowledge. In the case of this study, each injured nurse's experiences were used to access the social organization of RTW within the context of Ontario Hospitals.

The third limitation for an IE inquiry surrounds the risk of institutional capture (Smith, 2005) during interviewing. "When both the informant and the researcher are familiar with institutional discourse" (Smith, 2005, p. 225) institutional capture may result. The consequence is "the researcher los[ing] touch with the informant's experientially based knowledge" (p. 225). To minimize the effects of institutional capture, attention was paid to giving privilege to injured nurse informant accounts in data collection, analysis and the writing of this document. Three strategies were employed – attention to the informants' maps of injury management, the usage of informants descriptions in the write up of the project and a review of the audio recordings with attention to the researcher's performance (McCoy, 1999; Smith, 1998). As previously reported mapping was used as a technique to solicit injured nurse's visual accounts of the social organization of their injury management experiences. Upon reviewing all informants' maps and adding this data to the researcher's pre data collection map (see map 4e), it became apparent that the return to work phase of injury management was a period that the nurses described as particularly challenging. This was not anticipated by the researcher when the study was proposed. Hence, the informants' maps refocused the study on to return to work, and demonstrated what the researcher had learned from the informants. This strategy minimized institutional capture.

The writing technique used in the chapter 6 *(In)visible work of return to work* is laden with quoted excerpts from the informants (G.Smith, 1998; McCoy, 1999). This is an intention writing technique used to exhibit the informants' descriptions of their actual work. This technique also helps to prevent institutional capture.

Furthermore, a review of audio tape with attention to the researcher's performance proved also helpful in minimizing institutional capture and improving interviewing skills. Campbell and Gregor (2002), DeVault and McCoy (2002), Smith, (2005) and McCoy (2006), have all written about the risk of institutional capture and interviewing in the interest of reducing the risk of it. They advise institutional ethnographers to listen for an instance when informants may be speaking in terms of the discourse which frames the way they work. In these instances informants are often talking using discursive language rather than revealing what is actually happening when the work is being done (Campbell & Gregor, 2002). For example, in the first

interview with injured nurse informant Laura the researcher became aware during an audio review of the interview that she was cutting off the informants and adding in discursive language.

Laura   *...so they had trouble finding me an assignment.*
Researcher   *Your charge nurses makes up your assignment. Right?*
Laura   *Ummm. Yes she does…*

As a result, the researcher made a conscious effort not to jump into the dialogue and allow the informant to complete her thoughts. As well informants were asked to elaborate on points they made. Probing for further details and/or examples was also used in interview conversations. Due to the audio reviews, improvement in the researcher's performance was noted in subsequent interviews.

The final limitation surrounds the failure to recruit primary informants who had acquired an illnesses or communicable disease at their workplace. Claims for illnesses and diseases are compensable under the WSIB Act. In an effort to recruit these types of informants, an email was sent on October 7, 2008 to a professional contact of the researcher - the executive director of the Registered Nurses Association of Ontario. This individual has a known affiliation with nurses infected with the SARS virus while providing care in an Ontario hospital. A reply email indicated potential informants would be contacted by the director was received. However no informants with illnesses or diseases were recruited to the study after a 4 month period. In consultation with the supervision committee, a decision was made to no longer seek nurses with hospital acquired illnesses or diseases. This decision was based on the volume of data already collected. It is unclear how the RTW of these nurses is managed in the hospital sector. The understanding of how workplace illnesses and diseases are managed is an opportunity for future research.

Opportunities for future research

Smith (1999) uses the image of institutional ethnographers as blind scholars exploring the parts of an elephant. She believes in a study the researchers can only become familiar with the

small part of "the beast" (Smith, 1999, p. 228) they are investigating. As a result there are many opportunities for future research that are the result of this study. Injured nurses interviewed in this study gave clues as to other areas of injury management that may be worthy of investigation in the future.

Mental illness

Mental illness is described as a prominent health issue for Canadian nurses (CIHI, 2006). However under current WSIB legislation, mental health issues are not compensable under the Act.   For example, one informant provided an account of the injury/disability management of the depression. While she attributes the source of her illness to her workplace, she is ineligible for compensation under the WSIB Act. For an injury or illness claim to be compensable under the Act it must be attributable to a specific workplace incident.

> *The WSIB will deny claims which are related to mental illnesses. So I don't even let them [mentally ill nurses] put in a claim. I tell them they have to go on short term disability (*occupational health nurse 2).

There are four questions arise from this statement. 1) How are mental illnesses managed in health care? 2) What is the role of the occupational health nurses in the social organization of injury management? 3) How is short term disability organized? 4) How is long term disability organized?

Other injury management circumstances

All workers who sustain workplace injuries and file WSIB claims are socially organized with similar injury management expectations. However the health care setting in which the injury management process unfolds may be structured differently than in the context of this study. For example the management structure of public health or community nursing agencies may not have an occupational health department.   The work sites of injuries may be in someone's home or a car. The specific of how injury management operates in these settings has yet to be explored.

Other contextual factors may be important to explore in future studies. IRNs in this study hailed from large urban (southern Ontario) health care institutions. The health care injury management practices in other areas of the province, such as more rural settings have not been

explored. It would be interesting to explore how rural settings accommodate injured workers in these smaller settings.

The injury management experiences of male nurses may also be interesting to examine. While the injury management and RTW expectations are presumed to be the same as female IRNs, the social expectations for engagement in domestic responsibilities are different (Walters, 1995). Exploring issues of injury management from the standpoint of men employed in a female dominated profession such as nursing has yet to be reported.

Conclusion

In this study, the injury management process of early return to work was examined from the standpoint of injured registered nurses employed in southern Ontario acute care hospitals. Through interviews, mapping activities and a review of texts the social organization of return to work set in this context was explicated. This study has discovered that injured nurses engage in significant amounts of domestic, injury and accommodation work in addition to their in hospital jobs as a result of this institutional process. Extended wait times for diagnostic testing and medical specialist appointments may further delay the return to a nurse to her regular duties.

The findings suggest that hospital management has difficulty finding duties for the IRNs to engage in. Concerns about patient safety limit the assigning of the IRNs to patient care work. As a result, these nurses are assigned to roles which engage them in activities that may be beneficial to the hospital's government reporting mandate of infection control, morbidity and mortality, and so on but fail to return them to their pre-injury role. Furthermore, collective agreements and human resources structures within the health care setting may limit the nurse's abilities to engage in creative ways of utilizing IRNs within the employment setting. Another important factor is the number of injured nurses on a nursing unit. In some areas there are multiple injured workers requiring accommodated or modified work duties. This disorganizes hospital staffing efficiency and limits the number of work opportunities available for injured workers.

The elapsed time engaged in the injury management process is an important factor in RTW in the hospital setting for the injured worker. Under WSIB legislation an employer is relieved of their obligation to accommodate an injured worker on the two year anniversary of the injury. This study has shown that hospital employers do invoke this piece of legislation which

results in IRNs losing their positions. In light of Ontario efforts to retain experienced and qualified nurses the loss of IRNs from the health care system is counterproductive and must change. This work challenges advocates of nurses to take up the discoveries from this study about RTW in hospital settings. Armed with a more comprehensive understanding of the social organization of the RTW institutional process, changes to support and promote the successful return of all injured nurses to their pre-injury work are possible.

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Appendices

A: Recruitment Strategies

A1: social network email

The social organization of workplace injury management: An institutional ethnography of regulated nurses' experiences

Dear Fellow Nurse

My name is Laurie Clune. I am a Registered Nurse and PhD student in Nursing at the University of Toronto. I am also a nursing teacher at Ryerson University School of Nursing. I would like to tell you about a study I am conducting under the supervision of Dr. Sioban Nelson, Dean of the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto.

I am interested in finding out about nurses who have been injured, disabled or become ill as a result of nursing work and their encounters with the Workplace Safety and Insurance Board (WSIB) and occupational health and return to work. If this is your experience I would like to ask you some questions about your experiences. Or if you know someone who has had this experience please give them this information.

Your participation in this study is voluntary, anonymous and confidential. Any information that you share during any interview, email or voice mail communication will be kept in strict confidence. You may refuse to answer any of my questions or withdraw from the study at any time.

This study has been reviewed and received approval from the Research Ethics Boards of the University of Toronto and Ryerson University.

If you are a nurse who has been injured at work and would be interested in finding out more about this study please contact me at email address. You can also speak with me directly by calling xxxxxxx. If I am not able to answer you immediately your call will be forwarded to my confidential voice mail where you can leave a message. Please leave your name and a phone number or email address where I can reach you. I will get back to you as quickly as possible.

Thank you for considering this request.
Yours in Nursing

Laurie Clune, R.N.
PhD student, University of Toronto, Faculty of Nursing

A2: Primary Informant letter of introduction / Flyer recruitment

Injured **R**egulated **N**urses **S**tudy

Dear Fellow Nurse

My name is Laurie Clune. I am a Registered Nurse, a PhD student in Nursing at the University of Toronto and a nursing teacher at Ryerson University, Daphne Cockwell School of Nursing. I would like to tell you about a study that I am conducting under the supervision of Dr. Sioban Nelson, Dean of the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto.

In this study I would like to talk to Regulated Nurses (RNs or RPNs) who have been injured, disabled or become ill as a result of nursing work to find out about their experiences in injury management and return to work.

Participation in this study is voluntary and anonymous. Any information shared during any interviews, emails or voice mail communications will be kept confidential. Participants do not have to answer any questions if they are uncomfortable and can withdraw from the study at any time.

To find out more about and/or participate in this study please contact Laurie Clune at email address or call xxxxxxx. If there is no immediate answer your email or call will be forwarded to a private mailbox where you can leave a confidential message. Please leave your name, phone number or an email address where you can be reached. I will get back to you as quickly as possible.

If you know other nurses who may be interested in this study please provide them with my contact information.

Thank you for considering this request.
Yours in Nursing

Laurie Clune, R.N.
PhD student, Lawrence S. Bloomberg Faculty of Nursing
University of Toronto

A3: Business Card

Injured Regulated Nurses Study

- This study is looking at the experiences of injured regulated nurses with injury management and return to work.

- Any information shared will be kept confidential.

Laurie Clune RN

Doctoral student

XXXXXXX

(private voice mail)

Email address

(private email)

BLOOMBERG
LAWRENCE S. BLOOMBERG
FACULTY OF NURSING
UNIVERSITY OF TORONTO

A4: Cold email Occupational Health Nurses Association

Date: Wed, 08 Oct 2008 16:10:33 -0400 [04:10:33 PM EDT]

From: Laurie Clune

To: board@XXXXXXX

Cc: administration@XXXXXXX , execdirector@XXXXXXX

Subject: Injured regulated nurses study

A5: Occupational health nurse newsletter

Injured Regulated Nurse Study

Are you an Occupation health nurse who has worked with RN/RPN's who have been injured, disabled or become ill as a result of nursing work? If you are, a researcher from the University Of Toronto Faculty Of Nursing would be interested in talking to you. Participation in this study is voluntary and anonymous. Any information shared will be kept confidential. To find out more about and/or participate in this study please contact Laurie Clune at email address or call XXXXXXX.

A6: Cold email Union

Date: Tue, 07 Oct 2008 19:16:40 -0400 [10/07/2008 07:16:40 PM EDT]

From: Laurie Clune 🖋 🟥

To: XXXXXXX 🖋

Subject: Injured regulated nurses study

Dear XXX

My name is Laurie Clune. I am a Registered Nurse and PhD student at the University of Toronto in addition to being a nursing teacher at Ryerson University, Daphne Cockwell School of Nursing. I would like to tell you about a study I am conducting under the supervision of Dr. Sioban Nelson, Dean of the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto.

I am currently engaged in a study called the Injured Regulated Nurses Study (IRNS) in which nurses who have been injured, disabled or acquired a disease at work have told me about their experiences. Currently I have only been able to recruit nurses who have been injured or disabled as a result of nursing work. I have yet to be able to find a nurse who had acquired a disease.

Some injured nurses who I have interviewed have identified ONA and their local rep as key professional resources/supports who are integral in the injury management process and who can shed some light on injury management and the return to work process.

I would like to set up an appointment with you or other appropriate ONA representatives to discuss the study and see if you are willing to participate in a 60 minute interview about injury management. Can you please contact me at email address or XXXXXXX
 (private voice mail) at your earliest convenience to set up an appointment at a mutually convenient time? If I am not able to answer you immediately your call will be forwarded to my confidential voice mail where you can leave a message.   Please leave your name and a phone number or email address where I can reach you. I will get back to you as quickly as possible. Alternatively you can contact my doctoral supervisor Dr. Sioban Nelson at xxxxxxxx or email address. This study has been reviewed and received approval from the Research Ethics Boards of the University of Toronto and Ryerson University.

Your (or other ONA representatives) participation in this study is voluntary, anonymous and confidential. Any information that you share during any interview, email or voice mail communication will be kept in strict confidence. You may refuse to answer any of my questions or withdraw from the study at any time.

Thank you for considering this request.
Sincerely

Laurie Clune, R.N.
PhD student, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

Appendix B Consents

B1: Primary Informant consent

Injured Regulated Nurses Study

You are being asked to participate in a research study. This form provides information you will need to know in order to decide whether you wish to participate in this study. If you have any questions after reading this form, ask your questions to the nurse researcher.

Investigators:
Nurse Researcher: This research is being conducted by Laurie Clune RN a PhD student in Nursing Science at the University of Toronto and faculty member at Ryerson University, Daphne Cockwell School of Nursing.
Faculty Supervisor: Ms. Clune's work is supervised by Dr. Sioban Nelson, Dean of the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto.
Supervisory Committee: Members are Dr. Jan Angus and Dr. Karen Yoshida.

Study title: Injured Regulated Nurses Study.

Purpose of the Study: The purpose of this study is to understand the experiences of nurses who are injured, disabled or become ill as a result of nursing work, their encounters with injury management and return to work. This study is part of the Nurse Researcher's doctoral research.

Description of the study and your participation:
- In this study you will be asked to participate in two interviews that will be negotiated based on how you are feeling at the time. If at any time you feel tired, unwell or no longer wish to continue, the interview will be stopped and rescheduled at a better time.
- It is anticipated that the interviews will be approximately 60 – 90 minutes.
- The nurse researcher will facilitate the interview at a location, date and time that is convenient to you.
- A digital tape recorder will be used during the interview so that none of the information you give will be forgotten.
  - *Interview 1:* In this interview you will be asked to talk about: your injury, disability or illness; encounters with injury management; and return to work.
  - *Interview 2:* In this interview you can provide the researcher with any additional important information that you would like to share. You will also be asked some questions that have emerged based on what you say in interview 1.

What is Experimental in this Study: None of the procedures used in this study are experimental in nature. The only experimental aspect of this study is the gathering of information for the purpose of analysis.

Risks or Discomforts: You will not directly benefit from participation in this study, other than you may enjoy sharing and talking about your experience with the investigator. Your contributions will provide

greater understanding of injury management and return to work processes for regulated nurses. Although there are no obvious harms associated with taking part in this study, participating will involve some of your time and discussing personal issues associated with your injury, disability or illness, injury management and return to work which you may find upsetting. If you experience any emotional and psychological issues that require consultation, the investigator will discuss with you potential avenues to address your concerns.

Please let the researcher know if at any time you feel too tired, unwell or no longer can continue with the interview. The interview will be immediately stop and rescheduled at a time when you are feeling better.

If you no longer wish to continue participating in the study I will ask you if the information that you have already provided can be used in the analysis.

Benefits of the Study: Your participation in the study may not be directly beneficial to you unless you find it helpful to discuss your experiences with another person and may help others to understand nurses' experiences of workplace injury. The results of the study may benefit all injured workers who receive injury management services.

Confidentiality: Anything that you say will be kept in strictest confidence. As a doctoral student, I will be sharing the information from the taped interviews, transcripts and notes with my supervisory committee. No one else will have access to this information.

To ensure confidentiality, you will be given the option to choose a pseudo name that will be used for all documents including transcripts, computer files, publications or presentations.

The audio recording of your interviews and all documents associated with this study will be kept in a special format (called an encrypted format), and only I will have the password to open the files.

No information that could reveal your identity will be given to anyone else, unless the investigator is required to do so by law.

Results of this study may be published and presented. Aspects of your story may be retold and/or particular quotes may be used, but at no point will your name be used or any identifying information.

Incentives to Participate: You will be given 20 dollars as a token of thanks you for your time and participation in each interview.

Voluntary Nature of Participation: Your participation in this study is voluntary. There are no negative consequences to you or any care or services you are receiving if you decide not to participate in this study. No one will know if you choose to or not to participate in the study. At any point in the study, you may refuse to answer any particular question or stop participation altogether. If you decide to withdraw your consent you do not need to give any reason or explanation for doing so.

Questions about the Study: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact: Laurie Clune at 905 903-3623 or laurie.clune@utoronto.ca or her supervisor Dr. Sioban Nelson at 416 978-2862 or dean.nursing@utoronto.ca .

Consent:

I acknowledge that this study has been explained to me and that any questions I have asked have been answered to my satisfaction. I have been informed of my right not to participate and my right to withdraw at any time. I have been informed that I can decline any question during the interviews. The potential harms and benefits have been explained to me and I understand these. I have been assured that my personal identity and employer will be kept private and confidential. I acknowledge that the interviews will be audio-recorded. I have been provided with a copy of this consent form.

_____
Name of Participant (please print)   Signature of Participant   Date

_____
Signature of Investigator   Date

Interview #2 verbal consent obtained: Yes☐   No☐
_____ Signature of Investigator   Date

B 2: Secondary Informant Consent

Injured Regulated Nurses Study

You are being asked to participate in a research study. This form provides information you will need to know in order to decide whether you wish to participate in this study. If you have any questions after reading this form, ask your questions to the nurse researcher.

Investigators:

Nurse Researcher: This research is being conducted by Laurie Clune RN a PhD student in Nursing Science at the University of Toronto, and faculty member at Ryerson University, Daphne Cockwell School of Nursing.

Faculty Supervisor: Ms. Clune's work is supervised by Dr. Sioban Nelson, Dean of the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto.

Supervisory Committee: Members are Dr. Jan Angus and Dr. Karen Yoshida.

Study title: Injured Regulated Nurses Study.

Purpose of the Study: The purpose of this study is to understand the experiences of nurses who are injured, disabled or become ill as a result of nursing work, their encounters with injury management and return to work. This study is part of the Nurse Researcher's doctoral research.

Description of the study and your participation:
- In this study you will be asked to participate in one interview that will be negotiated based on your availability. It is anticipated that the interviews will be approximately 60 minutes in length.
- A digital tape recorder will be used during the interview so that none of the information you give will be forgotten.
- In this interview you will be asked to:
  - Describe your role in the injury management and return to work process.
  - Describe your experiences with nurses who have been injured at work.

What is Experimental in this Study: None of the procedures used in this study are experimental in nature. The only experimental aspect of this study is the gathering of information for the purpose of analysis.

Risks or Discomforts: You will not directly benefit from participation in this study, other than you may find sharing and talking about your experience with the investigator to be beneficial. Your contributions will provide greater understanding of injury management and return to work processes for regulated nurses. Although there are no obvious harms associated with taking part in this study, participating will involve some of your time in discussing your experiences with injured, disabled or ill regulated nurses, injury management and return to work. If at any time you no longer wish to continue participating in the study I will ask you if the information that you have already provided can be used in the analysis.

Benefits of the Study: Your participation in the study may not be directly beneficial to you unless you find it helpful to discuss your experiences with another person.

Confidentiality: Anything that you say will be kept in strictest confidence. As a doctoral student, I will be sharing the information from the tapes, transcripts and notes with my supervisory committee. No one else will have access to this information.

To ensure confidentiality, you will be given the option to choose a pseudo name that will be used for all documents including audio files, transcripts, computer files, publications or presentations.

The audio recorded interview will be transcribed into notes, and all notes will be kept as files in a personal computer that is password protected in the academic office of Laurie Clune at Ryerson University. All audiotapes, transcripts, notes and memory sticks will be password protected and kept in a locked filing cabinet for a period of seven years. Once this time has elapsed, the computer and audio files will be erased. Any written documents will be shredded and disposed appropriately.

No information that could reveal your identity will be given to anyone else, unless the investigator is required to do so by law.

Results of this study may be published and presented. Aspects of your story may be retold and/or particular quotes may be used, but at no point will your name be used or any identifying information.

Incentives to Participate: You will be given 20 dollars as a token of thanks for your time and participation in the interview.

Voluntary Nature of Participation: Your participation in this study is voluntary. At any point in the study, you may refuse to answer any particular question or stop participation altogether. If you decide to withdraw your consent you do not need to give any reason or explanation for doing so.

Questions about the Study: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact: Laurie Clune at XXXXXXX or email or her supervisor Dr. Sioban Nelson at xxxxxx or email.

Consent:

I acknowledge that this study has been explained to me and that any questions I have asked have been answered to my satisfaction. I have been informed of my right not to participate and my right to withdraw at any time. I have been informed that I can decline any question during the interviews. The potential harms and benefits have been explained to me and I understand these. I have been assured that my personal identity and employer will be kept private and confidential. I acknowledge that the interviews will be audio-recorded. I have been provided with a copy of this consent form.

_____

Name of Participant (please print)   Signature of Participant   Date

_____

Signature of Investigator   Date

Appendix C: Permission to use Penzu name

Date: Sat, 28 Mar 2009 12:40:48 -0400 [03/28/2009 12:40:48 PM EDT]
From: Alexander Mimran
To: Laurie Clune
Subject: Re: Comments

Hi Laurie,

Thank you for the email!

Please feel free to use Penzu in your presentations and papers. So glad you like the site!

Best,

*Alexander Mimran
*President & Founder, Penzu Inc.
alexander@penzu.com

Appendix D: Data Collection Strategies

D1: Interview checklist primary and secondary informants

Information	Comments
Participant pseudonym:	

Interview 1
Date:
Address:
Telephone:
Confirmation of appointment:
Dr. Nelson informed: Pre interview   Post interview
Consent:
     Date obtained: Year _____ Month _____ Day _____
     Duplicate given: Yes   No
     Audio recording   Yes   No
     Consents to contact again   Yes   No
     Can use data if unable to complete   Yes   No
Interview Start time: Stop Time:
     Interview completed   Yes   No
Honorarium:
Issues:	

Interview 2
Date:
Address:
Telephone:
Confirmation of appointment:
Dr. Nelson informed: Pre interview   Post interview
Verbal Consent:
     Date obtained: Year _____ Month _____ Day _____
     Audio recording   Yes   No
     Consents to contact again   Yes   No
     Can use data if unable to complete   Yes   No
Interview Start time: Stop Time:
     Interview completed   Yes   No
Honorarium:
Issues:
 	
Thank you post card sent	

Wishes to be informed of citation for dissemination via oral written or poster presentation? Yes No	Way to contact?
Snowball contacts:	

D2: Demographic Form Primary Informants

The content of this form is based on the works of: Eakin (2003; 2005); Lippel (1999; 2007); Meyer & Muntaner (1999); Roberts-Yates (2003); Smith (2006); Sorrels-Jones & Weaver (1999a, 1999b);Strunin & Boden (2004); Tam et al. (2007; and Tarasuk & Eakin (1994).

Participant pseudonym:	**Gender** (Lippel, 1999) ♀ ♂ **DOB:** Age:
Work setting (Eakin E.M. et al., 2003; Meyer & Muntaner, 1999; Tam et al., 2007) **Regulated Nurse**: RN RPN Years in Nursing: Years at site prior to injury: Employer: Unionized Non-unionized Practice setting type: acute care, long term care, community care, ambulatory care, occupational health, management, research, education, other: Did participant return to the pre injury employer? Yes No Current employment status: FT PT casual disability Other	Social (Eakin E.M. et al., 2003) Key support people: Changes Post injury: **Injury management contacts** WSIB: Insurance: Lawyer:
Injury (Eakin E.M., MacEachen, & Clarke, 2003; Eakin E.M., 2005; Lippel 1999; Meyer & Muntaner, 1999) Type: Setting where injury occurred: Injury circumstances: Date: Shift: Employment status at the time of the injury Treatments: medication surgery rehabilitation therapy psychotherapy counselling other:	**Return to work (RTW)** (Eakin E.M., MacEachen, & Clarke, 2003; Eakin E.M., 2005) RTW expected date: Actual date RTW: Return to modified position: Yes No Return to pre injury position: Yes No Transferred out: Yes No Support program for RTW: Yes No RTW with: (Lippel 1999) Medications Narcotics Analgesics (non-narcotic) Antidepressants Receiving treatment Physiotherapy Psychotherapy Counselling

D3: Document summary form

Developed from (Miles & Huberman, 1994pp. 54-55; Smith, 2008b)

Name of document				
Document #				
Date of document				
Date reviewed				
Participant or event with which the document is associated				
Type of document	Legislation □ Hospital □ Boss text□ Sub text □ Other :			
Key elements	Page:		Relationship to research	
Summary of text content				
Significance or purpose of the document				
Who wrote the text				
Who reads the text				
Contradictions in the document?				
Salient questions or issues to consider				
Issues				
Reflection				
Comments				

D 4a: #1 Interview script Primary Informants- Injured Nurse

Text in *italics* indicates what the researcher will say during the interview

1.	Introduction and brief description of the study.
2.	Allow for questions: *Do you have any questions for me about the study or your participation?*
3.	Inform the participant of potential risk *You may feel uncomfortable with answering questions and talking about their experiences;You are free to refuse to answer any of the questions;* *You may end any interview or withdraw from the study at any time;* *You may have your name removed from all scripts and presentations about the study.* *Do you have a pseudo name that you would like to use in this study?*
4.	Inform the participant of health risk *Your health is important to me. Please let me know if at any time you feel too tired, unwell or no longer wish to continue the interview. I will immediately stop our conversations and rescheduled at a time when you are feeling better and able to continue. If our interview is not finished can I use the information that you have provided in this study?*
5.	Allow for questions: *Do you have any questions for me before we begin?*
6.	Obtain written consent.
7.	*Before we begin I would like to ask you some demographic questions.*
7.	Begin interview: *In this study I am interested in finding out about the experiences of nurses who are injured at work. I would like to know about your work as a nurse prior to and following your injury. I want to find out how the injury has changed you and your relationships with people. Please begin with any aspects of your experience that you would like to talk about and tell me anything that you would like to say.* **Pre Injury** *I am interested in finding out about your nursing work prior to your injury. What does a nurse do in this type of setting? What are the physical, thinking and emotional activities involved in this type of work?* **Injury** *Can you tell me about your injury?* *Can you tell me some of the people who with you in the injury?* *How has this injury impacted on your ability to nurse?* **Post injury** *How are things different following your injury?* *How has your injury effected your nursing work?* *Do you provide care differently now as compared to before the injury?*
8.	Probes *Can you tell me more about that...* *Can you tell me about a typical day when you were off work following your injury?* *Can you tell me about your experiences with injury management organizations such as your employer's occupational health unit, WSIB, insurance companies and so on?* *Can you tell me about your experiences with injury management representatives such as*

	occupational health professionals such as doctors, adjudicators or case managers? *Can you tell me about the people who have been the most helpful to you in your recovery from your injury and return to work?* *Can you tell me about a typical day once you returned to work?* *Has your practice as a nurse changed since you have been injured?* *Have you relationships with others changed since you have been injured and returned to work?*
9.	To demonstrate to the participant my interest in their expert knowledge and to verify my own understanding I will use the following statement: *Let's see if I have grasped these events correctly…*
8.	Interview closing *Thank you for sharing your experiences.* *It is my intention once this study is complete to share the findings. Would you like to be informed of the citations for subsequent written, oral and poster presentations?* *How would you like to be contacted?*
9.	Snowball Recruitment: *I want to speak to several nurses who have been injured at work. Do you have any colleagues who you might be interested in this study? Could you tell them about this study and provide them with my contact information?* *Are there other key people that you think I should interview to find out more about injury management and return to work?*
9.	Give honorarium
10.	Record summary notes

D 4b: #2 Interview script Primary Informants- Injured Nurse

Text in *italics* indicates what the researcher will say during the interview

1.	Introduction and reminder about the study
2.	Allow for questions: *Do you have any questions for me about the study or your participation?*
3.	Inform the participant of potential risk *Before we begin I must ask if you consent to be interviewed for a second time?* *Are you willing to be tape recorded?*
4.	Inform the participant of health risk *Your health is important to me. Please let me know if at any time you feel too tired, unwell or no longer wish to continue the interview. I will immediately stop our conversations and rescheduled at a time when you are feeling better and able to continue. If our interview is not finished can I use the information that you have provided in this study?*
5.	Allow for questions: *Do you have any questions for me before we begin?*
6.	*How have you been since our last interview?*
7.	*I have reviewed your map that you made for me and our conversation. I wonder if you could clarify.....*
8.	*Since we last met I have talked to some other nurses about RTW. I wonder if you have had similar experiences. ....*
9.	Interview closing *Thank you for sharing your experiences.* *It is my intention once this study is complete to share the findings. Would you like to be informed of the citations for subsequent written, oral and poster presentations?* *How would you like to be contacted?*
10.	Give honorarium
11.	Record summary notes

D5: Interview script Secondary Informants

Text in *italics* indicates what the researcher will say during the interview

1.	Introduction and brief description of the study
2.	Allow for questions: *Do you have any questions for me before we begin?*
3.	Inform the participant of risk *When people participate in study interviews they may feel uncomfortable with answering questions and talking about their experiences;* *You are free to refuse to answer any of the questions;* *You may end any interview or withdraw from the study at any time;* *You may have your name and all identifying information removed from all scripts and academic presentations and papers about the study.* *Do you have a pseudo name that you would like to use in this study?*
4.	Allow for questions: *Do you have any questions for me before we begin?*
5.	Obtain written consent and demographic information
6.	Begin interview: *In this study I am interested in finding out about the experiences of nurses who are injured at work, their encounters with injury management and return to work.* 　　a) *Can you tell me about your role in nursing, injury management or return to work?* 　　b) *Can you tell me what you know about injured regulated nurses and injury management?*
7.	Specific questions for frontline professional: These will be designed based on the data that is gathered from the nurses. Questions will be specific and focused on processes. Questions will be posed in an open-ended way.
8.	Probes *Can you tell me more about that….* *Let me see if I understand what you have said….* *Can you tell me about a typical day when you work with injured workers?* *Can you tell me about any experiences with injured nurses that stand out?* *Can you tell me if injured nurses are different from other injured workers?*
9.	*Thank you for sharing your experiences.* *It is my intention to publish the results of this study once my doctoral work is completed.* *Would you like to be informed of the citations for any oral, written or poster presentations that result from this study?* *How would you like to be contacted?*
10.	*Are there other people or resources that you feel would be beneficial for me to access?*
11.	Give honorarium.
12.	Audio field note

D6: Demographic Form Secondary Informants

The content of this form is based on the works of: Eakin (2003; 2005); Lippel (1999; 2007); Meyer & Muntaner (1999); Roberts-Yates (2003); Smith (2006); Sorrels-Jones & Weaver (1999a, 1999b);Strunin & Boden (2004); Tam et al. (2007; and Tarasuk & Eakin (1994).

Participant pseudonym:	**Gender** (Lippel, 1999) ♀ ♂
Work setting (Eakin E.M. et al., 2003; Meyer & Muntaner, 1999; Tam et al., 2007) **Role**: Setting : Unionized Non-unionized Practice setting type: acute care, long term care, community care, ambulatory care, occupational health, management, research, education, other: Current employment status: FT PT casual disability Other	Direct experience with injured nurses

Appendix E: Data Summary table

E1: Demographic Summary

Injured Registered Nurses: Primary Informants	
RN's interviewed (all categories)	17
Injured RN's interviewed	6
Nurses with more than one injury incident	2
Injury incidents	9
Employer types • Hospital Unionized faculties • Hospital Non Unionized facility	 6 1
Pre injury hospital employment settings • Critical care • Surgical care • Medicine • Birthing Centre	 3 2 3 1
WSIB claims made	8
Placed immediately on short term disability	1
Employment status at the time of injury • Full time contract (Ontario New graduate initiative) • Permanent Full time • Part time • Casual	 2 3 2 2
Academic preparation of Injured Nurses • Undergraduate BScN • Diploma in nursing • Post diploma completion • (completed) • (in progress) • Canadian Nurses Association Certification • Speciality certification • Promised speciality training when hired	 2 4 1 1 1 1 2
Years since graduation at the time of the injury • On probation • Less than 1 year • 1 – 5 years • 5 – 20 years • More than 20 years	 2 1 2 2 1

Injuries	
Injury incidents	9
Injury incident types	
• Musculoskeletal	8
• Hand	2
• Knee	2
• Shoulder	3
• Back	1
• Mental illness	1
Nurse/patient interaction at the time of injury	
• Helping another nurse lift a patient	3
• Lifting equipment is inaccessible	3
• Preventing a patient fall	2
• Pushing a stretcher to a diagnostic test	1
• Patient is confused, comatose, sedated or having a negative reaction to medication or procedure	5
• Injured in non-patient care area	1
• Patient death following resuscitation efforts	1
Injured RN's return	
• Successfully returned to work at pre injury place of employment	1
• Changed unit	
• Changed hospitals	1
• Labour Market re-entry	1
• Asked to leave/terminated/unable to accommodate pre injury employer with human resources involvement	2 3
• Appealing termination	2
• Became an occupational health nurse	1

Secondary informants	22
Roles:	
• Occupational Health Nurse	3
• Charge Nurse	3
• Nurse Manager	2
• Nurse Educator	1
• Charge Nurse	3
• Family Member	1
• Family MD	1
• Orthopaedic surgeon	1
• Local union representative	1
• Central nursing union labour relations specialist	1
• Nursing supervisor	1
• Nursing executive	1
• Massage therapist/physiotherapist	1
• Injury advocate	1

Documents reviewed	

Web sites
Injury Management
    • Workplace Safety and Insurance Board (Ontario)
    • The Institute for Work and Health
    • The Research Action Alliance on the Consequences of work injury
 	
Government
    • Ontario Ministry of Labour
    • Ontario Hospital Association
 	
Legislation (on line sources)
    • The Nursing Act (Ontario)
    • The Registered Health Professions Act (Ontario)
    • The Occupational Health and Safety Act
    • The Canadian Charter of Rights
    • The Ontario Disability Act
    • The Public Hospitals Act
 	
Nursing
    • The College of Nurses of Ontario (CNO)
    • The Canadian Nurses Association (CAN)
    • The Registered Nurses Association of Ontario (RNAO)
 	
Union
    • Ontario Nurses Association of Ontario (ON)
    • Ontario Public Service Employee Union (OPSEU)
    • Canadian Labour Congress
    • Canadian Union of Public Employees (CUPE)
 	
Hard copy documents reviewed
Public
    • Patient safety: published by hospital	

E2: Primary informant data summary

To facilitate cross case analysis

Item	Laura	Linda	Bena	Jane	Shire	Cindy
# of injury experiences	3	1	1	1	2	1
Time from injury to resuming full duties	1)3 months 2) 41/2 months 3) 6 months	2 months	Terminated after 2 years	Terminated after 2 years	Terminated after 2 years	9 months
Nursing work environment	1)Precarious workers Always short 2)team nursing stable team	Precarious workers Always short	Precarious workers Always short	Team nursing Stable team	1)Team nursing 2)team nursing Stable team	Precarious workers 12 h and 8 hour shifts A lot of young nurses
Nursing culture	1)negative, senior vs. junior, hard to get help 3) positive, everyone helps	negative, senior vs. junior, hard to get help	Overworked, can't get breaks,	Positive, people help	People help	On your own
Back injury	3)yes	yes				yes
Hand, arm shoulder injury	1)yes			yes	2)yes	
Knee injury			yes		Yes	
Career phase	New grad probation	New grad probation	Mid career	Mid career	Mid career	End of career
Unit short staffed at the time of injury	1)yes 3)no	yes	yes	yes	Yes yes	yes
Pt safety was an issue in injury	1)yes 3)yes	yes	no	yes	2)yes	yes
Required surgery			yes	Yes x 2	yes	
Competence questioned	yes	yes	Self doubt			Self doubt
Return to modified schedule (all days)	1)yes 3) yes	yes	yes	yes	yes	yes
Returned to modified duties	1) yes 3) yes	yes	yes	yes	yes	yes

Item	Laura	Linda	Bena	Jane	Shire	Cindy
Assigned modified work off of unit initially	1)yes Education		Yes Emergency department screening quality assurance	Yes Education Clean cupboards Screener for infectious diseases	Yes volunteer services	Yes Hospital audit
Assigned modified work on the unit	1)yes 3)yes	yes	yes	yes	yes	yes
Able to negotiate modified work type	1)no 3)no	No	No	No	No No	No
How is modified status communicated to unit	1)note at desk from manager 3)printed note from occ H to charge nurse	Note from manager posted on unit board for all nurses	Did not attempt resuming previous duties. Reports directly to manager. No note needed	Note at the desk for charge nurse	Note at the desk for charge nurse	Note on unit bulletin board
Able to get modifications	1)no 2)yes	no	no	no	No no	no
Needed to advocate for modifications	Yes yes	yes	yes	yes	Yes yes	yes
Management response to request	Negative positive	negative	negative	negative	Negative negative	negative
Mode of resistance	1)could not talk back resigned 3)asked to re-evaluate work plan	Could not talk back Left the unit and did not go back	Grievance and appeal	Requested transfer which was denied Grievance Appeal Labour Market re-entry Fight to stay in healthcare job	Grievance Labour Market re-entry fight to be an occ. Health nurse on retraining	Brought pillow made foot stool Labelled chair
Mgt response to injury	1)Withdrew critical care course 2)changed departments	Withdrew critical care course Extended probation Forced transfer to a less critical unit Learning plan	Grievance over position leads to withdrawal from position Termination 2 years after injury anniversary	Denied requested transfer and application for a position Offered neonatal unit (nurse doesn't like) Termination 2 years after injury anniversary	Given unsatisfying modified work Termination 2 years after injury anniversary	Did not give ergonomic equipment Suggest early retirement
Unionized	1)Yes 2, 3)no	yes	yes	yes	1)yes 2) yes	yes

Item	Laura	Linda	Bena	Jane	Shire	Cindy
Union helpful	no	yes	no	yes	no	no
WSIB claim submitted	1)yes 2) no STD 3)yes	Not sure	yes	yes	1)yes 2)yes	yes
Injured helping another nurse	yes	yes	no	yes	yes	no
Experience with occ Health Nurse	Awful in unionized Positive in non-unionized	"didn't do anything"	"terrible"	"did her job"	"horrible" "Made me want to become an occ H nurse to help others"	Not helpful in telling me what to expect
Received physio	1)yes 3)yea	Yes "ordered by occ health	yes	yes	1)yes 2)yes	yes
RTW while still in Physio	Yes	Yes	Yes			Yes
RTW on medication	PRN	PRN	PRN	Yes NSAID	Yes NSAID	Yes NSAID and narcotics
Required surgery			Yes	Yes	Yes	
Social relations	• Manager • Occupational health nurse • WSIB coordinator • Charge nurse • Union • Senior nurses • Parents • Adjudicator • Physio • Family MD	• Union • Manager • Educator • Senior nurses • Occupational health nurse • Parents • Physio • Covering nurse manager • Charge nurse	• Union • Manager • Occupational health nurse • Adjudicator • Family MD • Physio • 3rd party assessment • Surgeon • Fellow nurses • patient	• Charge nurse • Occupational health nurse • Manager • Walk in clinic MD • Adjudicator • Nurse case manager WSIB • Surgeon • 3rd party assessment • Fellow nurses	• Union • Manager • Occupational health nurse • Adjudicator • Family MD • Physio • 3rd party assessment • Surgeon • Fellow nurses • Emergency department	• Fellow nurses • Occupational health nurse • Adjudicator • Walk in MD • Phsyio • Family MD • Charge Nurse • Fellow nurses • Nurse manager • ergonomist
Texts	Schedule Assignment sheet Schedule Restrictions note	Assignment sheet Physio Learning plan	Schedule Surgical report "degeneration due to aging" Termination notice	Schedule Transfer form Assignment sheet Termination notice	Schedule Termination notice	Schedule Assignment sheet
Personal circumstances	Single Boyfriend left Can't afford apartment Moved in with parents	Single Need people to drive to appointments	Married Financial burden Deplete savings Second mortgage Cannot pay son's tuition Elder care issues Domestic burden to husband and son	Married Use some savings Domestic burden to husband	Married Child care issues Deplete savings Trouble getting to appointments Husband disciplined for being away from work Domestic burden to husband Personal care worker required	Single Need to hire people to help with domestic chores (grass, snow) Trouble getting to appointments

E3: Secondary Informants data summary

Person	Role in coordination of RTW	Text used
Occupational Health Nurse 1	"I help workers get back to work, do health and wellness stuff, safety checks, first aid..." Sets up accommodated work plan	WSIB forms, RTW plan, audit forms, physiotherapy and medical reports, email communication with manager Boss texts Occupational Health and Safety Act, WSIB act
Occupational health Nurse 2	Primary responsibilities for RTW in occupational health department team. "Returns injured workers back to some type of job". "I do a lot of work with managers telling them that we are obliged to take them back"	RTW plans Medical reports Manager documentation
Occupational Health nurse 3	"I am responsible for areas (ambulatory cancer) where these are not so many physical injuries but lots of stress related injuries"	WSIB forms Notes of meeting with employees
Charge Nurse 1	Permanent position Make up the assignments for the next shift. Coordinate the shift activity.	Schedule Assignment sheet Needs accommodation notice
Charge Nurse 2	Rotating charge nurse position	Check the unit communication book for accommodation
Charge Nurse 3	Oversees the functioning of two critical care units in two separate geographic areas	Accommodation needs posted at the nursing station
Staff Nurse 1 (team nursing model)	Worked with several injured nurses. Many nurses on the unit have been hurt Has been on WSIB	Assignment sheet indicates injured nurse assignment and who is covering injured nurse
Staff Nurse 2 (non-unionized)	Works with one injured nurse	Assignment sheet Injured nurse assigned light load
Staff Nurse 3 (unionized)	Works with several injured nurses.	Assignment sheet Injured nurse assigned tasks
Nurse Manager	Involved in RTW planning Evaluated how the nurse is performing Sends reports to occupational health and Joint Health and Safety committee on progress of injured nurse	Payroll Schedule Notice of accommodations Nursing efficiencies report Joint health and safety committee report and minutes Progress report to occupational health Notification of the union Minutes of return to work meetings Collective agreement
Union local representative	Attends RTW planning meetings	Makes minutes of RTW meetings Knows the collective agreement
Union Central labour relations representative	WSIB appeals when claim is denied Termination after 2 years grievances	Grievance Appeals WSIB file Collective agreement Occupational health and safety act WSIB act
Former Nurse Case Manager WSIB		WSIB act WSIB forms
Nursing supervisor	Management overseeing all hospital units on the evening, night or weekend shift	Reports on all hospital units Hospital census

Manager (non-nurse) Certified Health Care Executive (CHE) credential	Attends RTW meetings	
Nursing Executive	Attends Joint Health and safety meetings	Joint health and safety reports
PT/RMT	Does not take WSIB patients	
Orthopaedic surgeon	Surgical assessment of msk injuries	WSIB assessment and progress forms
Spouse	Domestic support	Bills

E4: Legislated acts to protect workers in 19th century Ontario

- 1884 The Ontario Factories Act: mandates inspections to ensure safety and health standards are met;
- 1886 The Ontario Workmen's Compensation for Injuries Act (the first in Canad): establishes conditions under which a worker can take legal action against their employer;
- 1890 the Mining Operations Act: establishes rules for ventilation, blasting, manholes, lifting devices, shafts, signals, brakes, machinery and boilers;
- 1895 the Factories Act: amended as a result of an explosion at the Hamilton Powder Company killing five workers to require employers to guard workers working on dangerous machines and give notice of fatalities and injuries that result in more than six days notice from work;
- 1911 the Buildings Trades Protection Act: required safety for construction tradesmen such as scaffolding, hoists, and ladders;
- and 1912 the Mining Act: mandated prescriptive requirements in the handling of explosives (IAPA, 2008; The Ministry of Labour, 2009).

Appendix F: Maps

F 1a: Researcher's Map prior to data collection

F 1b: Researcher's Map prior to data collection

Ontario Human Rights Code

Nursing Act

Ontario Hospital Act

Regulated Health Professions Act

Union rep

College of Nurses

Ontario gov't

orientation

Union

Unit manager

Occ. Health Nurse

Adjudicator

Registered Nurse → Hospital → Nursing work → Injury incident → Occupational Health → File to WSIB from hospital → WSIB claim → Return to work → Modified duties → Full duties

Ontario Nursing Schools

Federal gov't

Policy and Procedures

File started

Joint Health And Safety Committee

WHMIS

File started

WSIB forms

Professional Practice Standards

Canadian Charter of Rights and Freedom

Canada Health Act

Occupational Health and Safety Act

Workers Compensation Act

Key: Texts, Actors, Injury management Trajectory

F 2: Scaffold map

Injury

Incident Report

Occ. Health

Manager

WSIB

Return To work

Modified work

Full duties

F3: Laura: injury incident 1, unionized, physical injury

First month as RN

"Blame Factor"

You are not competent

Don't believe me

Take vitals For the entire floor

"I can't rip Velcro on BP cuff"

"Can't abandon my pt"

The Worst

#2 Occ. Health Nurse

You caused the injury

Fellow nurses

"Try to get me to do things I couldn't do"

"Things that work For them and not for me"

"Still have pt to look after"

WSIB Hosp coordinator

VM

Weekly Meetings to Re-evaluate

Residual Pain working with a splint

Occ. Health

Letter communication

Injury → Incident Report → Manager → WSIB → Return To work → Modified work → Full duties → Quit

Asked to help another Nurse

One Day travel

Decides of modified

Modified work schedule

Union Rep

Other nurses on modified

Fill out report At the end of shift

#1 Unit manager

Sees the pt the most but doesn't direct RTW or restrictions

Not helpful

Did education stuff

Not enough Staff to do All the lifting

Family MD

Can't spike an IV bag or break an ampoule

Unable to do Leisure activities

Denied critical care course

"I became the injured Nurse"

Repetitive forms Over and over

Physio

Emotionally hard

I wasn't able to vocalize because I was a new nurse Didn't know how to advocate for myself

driving

Probation Thought I would lose my job

Difficult to get to Physio who takes WSIB rates

Culture don't like New grads

•Union Culture

What am I doing in nursing

Hospital paid me and said they Would square it up $ with WSIB

Injury stuff is On my own time Except meeting with manager, Occ Health

No support

F4: Laura: Injury incident 2, non-unionized hospital, mental illness

Ask if previous WSIB case

Knew the nurse from pre employment

Different Culture
"You take care of yourself"
"I can be open"

Better not to have a union involved.
I could talk for myself.
Managers and occ H work
for me and the unit

Nurse initiated call

#1 Occ. Health Nurse

She was phenomenal and helped to get me out

Fellow nurses

Didn't know about injury

"Complete mental breakdown"

Occ. Health

Short term disability

Return To work

Modified work

Full duties

Injury

Incident Report

No form for stress leave

WSIB

part time job in surgery

Manager

Nursing school: Don't impose your own values

I can't tell the family I have to wait until the Physician tells them

#2 Manager

ICU
"I can do the skills.
"Emotionally I can't handle it"

Moral conflict

pt

Brought back personal memories

Pushed me to work in palliative care

Saw things that were difficult to see

Having to watch

Used up benefits for counseling

Family

Nurse could filter personal information given

Code team ICU

Attending MD

Family MD

Financial difficulty

Borrowed $

"There is no peace in ICU"

Moved back to parents

F5: Laura: injury incident 3, non unionized hospital, physical injury

"A really horrible experience"

What do you think you can't do?

"Not the same run around as with the union"

Cheques
Need to go to bank
To cash

I will help you

Checked on me occasionally

I was involved in determining my modified

Occ. Health Nurse

Occ. Health

Abilities Specialist

Fellow Nurse

Injury

Incident Report

WSIB

Return To work

Modified work

Full duties

Manager

case number

Not many meetings

Working with ice pack

Adjudicator

Voice mail communication or forms

Modified work schedule

I don't think you could have done this injury

2 weeks to get forms

No live person

Paid poorly by WSIB

STRESS

"*Not about the injury. It is about all of the other stuff you have to do with the injury*"

Threats of not approving claim

Nurse Case Manager

"*I have huge files on these incidents*"

Boyfriend grew tired of no leisure time

Trouble finding people who takes WSIB rates

Physio

"*It takes over your entire life*"

Verifies the injury

Family MD

"*It takes over your life*"

"*It is more work than being at work*"

F6: Linda, unionized, physical injury

Why did I go into nursing?

Other nurses don't like me leaving

They were supportive

Manager and union rep

F7 Bena: unionized, physical injury

Occ. Health Nurse

Wants excessive medical documentation

Pt complaint
Nurse working with a cane

Can't get to physio

Manager

No trust

Schedule change weekdays

Occ. Health

Initially told not work related

Reinjured in icy parking lot

3rd party assessment

Medical/surgical unit

Union Rep

Pain Knee

Pain Back

Fell in break Room over shoes

The injury happened At work

You have to fill out Forms for long term disability

Concrete floors

Injury

Incident Report

WSIB x 2

Return To work

Modified work

HR Security

Full duties

"I didn't steal anything"

Emerg registration

They didn't recognize I was one of them

Adjudicator

6 weeks

Chairs not suitable

terminated

Treated like other pt

Surgery

Surgical report

"Aging degeneration"

RTW meeting

Modified Position

Can't accommodate

Emerg X 8 hr

Claim denied

Union Rep

Letter Can't do floor nursing

grievance

Appeals

Cut off $

Family MD

Fellow nurses

complaints

Nurses are eating their young and their peers

Need Husband $

Pay for brace On own

Pension implications

She is making it up

No child tuition $

Credit card max.

Don't call

Deplete savings

2nd mortgage

Lump sum payment

July 2002

November 2003

F8: Jane, unionized, physical injury

Prints out modified work
notice of restriction

Supportive

Seniority list

Occ
Health
nurse

Union

Would not give this to me permanently

Charge
Nurse

Manager

Able to work as charge nurse

Employer wants to
Terminate pension

Critical care

Filled out
Occ Health
Package

Denied education
requests

Difficult to increase hours

We have no
positions for
you

Helping another
nurse lift a pt

Occ.
Health

Denied transfer
requests

Pain

Schedule changed to all days

Incident
Report

WSIB

Return
To
work

Modified
work

Full
duties

Injury

Family
MD

adjudicator

Screening pt

terminated

Nights
Holiday schedule

Education

Administration tasks

grievance

Short Staffed

Physio

Nurse Case
Manager

Clean cupboards

Mentoring another nurse

arbitration

Finished shift
with ice pack

Filled in for unit clerk

Authorizes
Medical Tx plan

You can not return
to your pre injury
position

Walk in
Clinic
MD

Specialist

Functional
Abilities
Evaluation

Team nursing model

You are very
qualified

Scheduled days off

frustrated

surgery

Many nurses
are injured

Fellow
Nurses

Surgery #2

Pain continues

Didn't know my rights

Helped me if I
couldn't do it

Slow healing

1 month without pay

Used up savings

Pressured in meetings

Husband angry

Not able to take a vacation

Biweekly meetings

"Convoluted process"

F 9: Shire, injury incident 1, unionized, physical

F10: Shire, injury incident 2, unionized, physical injury, violent patient

F11 Cindy, unionized, physical

Fellow nurses

You can get compensation for travel

Surprise information

Expense report

reinjured

Phsyio

Need cooperative pt

Chronically short

Didn't get my ordered breaks

Increased work load for peers

Didn't tell me how things worked

Family aggressive

Verbally abusive

Uncooperative

Uncontrolled pain
Refusing analgesics

Kicked by a pt

Occ. Health Nurse

Ordered back to work

Gave physio exercise sheet

Walk in MD

Family MD

Difficulty finding me a patient

Problem when my pt condition changes beyond my restrictions

Charge nurse

Counted as staff

Who has the authority to take me off modified?

Schedule changes

Note on unit labeling

Injury

Incident Report

Occ. Health

WSIB

Return To work

Modified work

Full duties

Back injury

adjudicator

Recommend early retirement

Frequent worker changes x 3

Had to weigh instrument tray to prove

Won't give me proper chair
Or desk height on the nursing unit

Frustrated that I could not do a full load when short

MD will not fill out at appt.

WSIB regional assessment clinic

MD every 2 weeks

RX obtained without WSIB #

Declined claim for RX
Because employer
Benefit card used

People keep taking my chair
And changing the angles

Fellow nurses

Functional ability report

MD progress reports

Chair label removed

2 trips to doctor

Worker progress reports

Hassles

When you are working in a medical team the proper height for all can't be done

Ergonomist

Not healing as expected

I never knew. I learned through the grape vine

single

No one to help me

"I wondered if I could ever go back to work and deal with the physical demands of my job?"

Had to bring a pillow from home

"I am not a very productive worker"

Yardwork

Hire landscaper

Move equipment

Move beds

Pain at work

Can't take medication because I am caring for pt.

City bylaw warning
Re length of grass

Obese pt

Move in emergency situations

"They focus on recruitment NOT retention"

"A very interrupted life"

"I was a loyal employee"

F12 Researcher's map post data collection

Map 4 e: Researcher's Map December 2008
Focus on "Return to work"

Discourse Early return to work

RX benefits

Schedule

Assignment Sheet

Pension

Disability Benefits

~~Nursing Act~~

~~Ontario Hospital Act~~

Collective Agreement

Physio

Seniority List

Short term disability

Long term disability

~~Regulated Health Professions Act~~

No injury management training

ONA central

Benefit Package

Can't report Mental ilness

Family Doctor

Third Party Assessments

Scheduler

Early retirement

Re training

College of Nurses

~~Ontario gov't~~

Union rep

orientation

Union

Unit manager

Occ. Health Nurse

Adjudicator

Day shifts

Charge Nurse

Co workers

Casual or PT 18% lieu pay for benefits

Restrictions

Vocational assessment

Registered Nurse → Hospital → Nursing work → Injury incident → Occupational Health → Leave and (hospital) → WSIB claim → Return to work → Modified duties → ~~Fatalities~~ → *Termination /leave* → *Labour Market re entry*

Human Resources

~~Ontario Nursing Schools~~

~~Federal gov't~~

~~Policy and Procedures~~

~~File started~~

Joint Health And Safety Committee

File started

WSIB forms

Doctor's note

WSIB number

Educator

Getting signatures

Security

Professional Practice Standards

Change in living circumstances

Financial stress

Shifting Domestic responsibilities

Child and elder Care

Travel to appointments

Discourse Recruitment and retention

~~Canadian Charter of Rights and Freedom~~

~~Canada Health Act~~

~~Occupational Health and Safety Act~~

~~Workers Compensation Act~~

Discourse Working efficiently

Discourse Patient Safety

Key: Texts, Actors, Injury management Trajectory, *Italics items identified by participants*

Appendix G: Findings, Implications and Recommendation Summary

Finding	Managerial discourse challenged	Implications	Recommendations

Overall
None of the IRN interviewed in this study returned to her pre-injury role.
	WSIB early return to work	The unsuccessful RTW of IRNs is a source of nursing staff attrition (Injured regulated nurses study statistics., 2009b).
		
		The knowledge, skills and expertise of IRNs are lost from the Ontario health care system.
			WSIB
			• An evaluation of trends specific to IRNs progress during injury management and RTW.
			• An evaluation of trends specific to hospital success in RTW.
			• Implementation of mechanisms to evaluate employer's cooperation in the RTW process.
			• Publish statistics specific to RN and RPN injury/disability management.
			.
			
			Health care practice
			• The Ontario Nursing Secretariat (Jeffs et al., 2009; Burkoski & Tepper, 2010) should direct funds to
			   1) the examination of factors contributing to nursing injuries and disability; and
			   2) identifying innovative strategies that will retain injured and disabled nurses within the health care system.
			• Hospitals and nursing union specialists should collaborate in the program design and evaluations of RTW practices.
			
			Research
			Studies examining:
			• Regulated nurse injury statistics and trends.
			• The experiences and factors associated with the successful RTW of IRNs.
			• The types of duties nurses during RTW
			• New graduate nurse injuries and their return to work experiences
			• Mid career nurse injuries and their return to work experiences
			• End of career nurse injuries and their return to work experiences
			• The long-term health and mental health risks associated with nursing work

WSIB The WSIB adopt a biomedical model of disability.	WSIB approaches to workers	The WSIB adopt a biomedical approach to injury and disability. This approach is	**WSIB** • The WSIB must adopt a model of disability/injury which is congruent with Ontario disability legislation(Ministry of Community and Social Services, 2005).

		incongruent with provincial legislated mandates.	This approach should focus on the removal of barriers for injured workers.
Appropriate accommodated work is presumed to be available once an employee returns to work.	WSIB early return to work	Some nurses do not recover from their injuries and cannot resume their pre-injury roles. Strategies to retain these employees are not evident.	• Strategies to evaluate employer's commitment to the removal of physical and attitudinal barriers for injured workers (Office of the employer advisor, 2003). • Premium incentives for employers who promote the successful return to and utilization of injured workers. **Health Care Practices**
Accommodated work assigned does not always support the return of the worker to their pre-injury role.	Health care efficiency	When there is more than one injured nurse on a unit the availability of accommodated work is further decreased.	• Succession planning and attention to the needs of injured and disabled workers must be evident in all collective agreement negotiations and human resources practices. • Union representatives and hospital operations management must collaborate in the development of effective accommodation strategies for injured and disabled workers.
Employers are not monitored to assess their commitment to the successful RTW of injured workers.	WSIB neoliberal approach	There is no incentive for employers to place IRNs in work opportunities that will promote their successful return to their pre-injury duties.	• Unions ought to monitor accommodation practices in light of Ontario disability legislation. If requires mechanisms to report employers who fail to accommodate workers should be used. • Strategies to support injury and illness prevention for ALL nursing staff on ALL shifts must be adopted.
The multiple demands of injury/rehabilitation work (unpaid work) being coupled with paid employment are not recognized by the WSIB and employers	WSIB early return to work Androgynous worker	The duel physical demands of paid and unpaid work may negatively impact of the IRNs rehabilitation progress.	• Access to OHS services, wellness initiatives and nutritious food must be available to ALL health care workers at all times. • Accessibility for patients and health care employees must be adopted in hospital physical designs and human resources management practices. • An evaluation of the effective utilization of IRNs in the health care system should be conducted.
Medical appointment times are not available to meet the schedule of the prescribed rehabilitation treatment plan	WSIB early return to work Health care access to services	Issues of wait times for specialists and diagnostics (e.g.: MRI, surgery) may delay the RTW process.	• Employers should consider scheduling rehabilitation appointments before IRNs begin hospital work. • Extended wait times for medical treatments must be considered in the RTW process and progress. **Research** Studies examining: • Is early RTW beneficial for health professions with legislated and regulated standards for their work performance? • The effectiveness of early return to work when multiple injured workers require accommodations. • The health risks associated with aging

			nurses in practice.
Nurses as working women IRNs are required to RTW on an all day shift schedule. An all-day shift schedule disorganizes the family of an IRN who customarily works day/evening/night shifts. There are increased financial expenses and decreased take home pay for nurses assigned to day shifts. Women maintain primary domestic responsibility for their families even when injured.	Health care fiscal constraints Health care androgynous worker Health care androgynous worker Health care androgynous worker	Nurses (and their family) lives are organized around their shift work rotations (Walter et al., 1995). Changing a work schedule can disorganize the family unit. Child and elder care services are difficult for nurses to secure. The physical and emotional demands of rehabilitation work are not considered in the RTW process.	**WSIB:** • The Research Advisory Council must fund studies examining the influences of gender on injury management and RTW (El-Bassel, 1996). **Health Care Practice** • A pilot examining the effectiveness of reintegrating IRNs onto an evening and night shift schedule. • The financial implications of day shift work should be considered when re- assigning nursing work. • IRNs should be returned to work on their regular schedules so as to minimize family disruption and facilitate access to rehabilitation and medical appointments. • The need for child and elder care services for shift worker employees should be recognized and considered. **Research:** Studies examining: • How nurses lives are organized by shift schedules. • The rehabilitation progress of injured nurses as they RTW. • The health effects of shift work on women employed as nurses.
Health Care Hospitals terminate injured nurse as a result of WSIB legislation which releases them from the duty to accommodate after 2 years The unpredictable nature of caring for a sick person and patient safety mandates limits the IRNs abilities to be assigned direct patient care activities. It is beneficial the hospital to place IRN in positions that	WSIB RTW policy Health care ableist worker approach	There are few incentives for hospitals to return an injured nurse to her pre-injury role. Infection control and auditing roles fail to return IRNs to their pre-injury positions. These roles can lead to termination. Nurses are not recognized by hospital administration and human resources for their specialized knowledge, skills and expertise.	**WSIB:** • Mechanisms to monitor a hospital's commitment to supporting the successful return of an IRN to work should be established. • Before a hospital terminates an employee and a nurse is assigned to labour market re-entry (LMR) an assessment of the employer's efforts to provide appropriate accommodated work should be conducted. • LMR must focus on returning IRNs to positions within health care which will capitalize on their knowledge and skills. **Health Care Practice** • Staff education on RTW requirements and expectations. • Strategies to ensure that IRNs are engaged in appropriate and productive work activities must be implemented. • Strategies to evaluate the effectiveness of accommodated work must be implemented. • Hospitals as employers must take up Ontario accessibility legislation (Ministry of

support infection and quality control and satisfy ministry reporting		Human resources and collective agreement practices limited the ability for creative accommodations.	Community and Social Services, 2005) requirements and implement strategies to improve accessibility for employees and patients. • Hospitals must recognize the distinct and specialized knowledge and skills held by nurses in various practice areas. • Aspect of patient care must be considered when assigning all nursing work. (E.g. what is the cumulative total of patient and equipment weight that the nurse will lift today). • Hospitals must view nursing work as more than just patient care and recognize the non patient care aspects (e.g.: finding, lifting and carrying equipment). • Team nursing models must be implemented and evaluated. • Injury reporting and RTW education sessions must be provided to all hospital staff in creative ways (e.g.: short MP3 clip on intranet) • Peer nurse (of an IRN) workloads must be altered to allow time for assisting the IRN. **Research:** Studies examining: • The role of nursing team models and their influences on staff morale, support and productivity. • The impact of RTW on non-injured nurses and patient care. • Interventions to improve the physical and emotional health of nurses.
Nurses have specialized skills that are not transferable to different practice settings. Yet hospital employers fail to recognize this notion.	Health care androgynous worker	The supportive co-workers can facilitate RTW (Tjulin, Stiwne, & Ekberg, 2009)	
Health care unions are territorial.	Health care unionization		
IRNs can identify creative ways of using their knowledge and skills to enhance the health care system functioning.	Health care efficiency		
Established relationships with peers and a team nursing model supports the reintegration and acceptance of IRNs back into nursing work	Health care efficiency		