Classifications of workplace injuries:

Recording and classification of workplace injuries in Australia has historically been unregulated and lacking in guidance for employers, writes ***Goran Prvulovic***

Apart from severe injuries specifically mandated by the regulatory authorities and associated standards, little information exists to assist employers with appropriate recording of injuries, especially in the selection of lag performance indicators associated with injury frequency rates other than lost time. This creates an existence of practices and behaviours aimed at undermining severity of injuries, resulting in a loss of opportunities for improvements in overall organisational safety performance. In some cases, these practices can also create further damage to injured persons and, as a result, increase adverse legal exposure for the senior decision makers.

Even when recorded accurately, injury frequency rates have very limited value as a lag performance indicator. Although widely acknowledged as a better lag indicator, accumulated financial losses arising from workplace injuries are still sparsely used by many organisations.

Recordable injuries and injury classification

Despite all efforts and progress made in occupational health and safety, disabling workplace injuries continue to occur. On top of the 186 workplace fatalities in 2013 alone, many Australians sustained injuries that resulted in a complete absence from the workplace or restrictions in hours or duties. Just in 2011–2012, a total of 128,050 cases of injuries occurred in Australia that led to temporary or permanent incapacity to perform work for one week or more (Safe Work Australia, 2013). Those are only injuries which are deemed to be reportable or notifiable by each regulatory jurisdiction. Their timely reporting is mandatory and required by legislation. In addition, there are other groups of injuries which are often left unreported, undermined and relatively unrecognised by organisations and regulators. These are:

- Medically Treated Injuries (MTIs), which require medical treatment beyond the first aid capability or authority of an industrial paramedic
- Restricted Work Injuries (RWIs), which are injuries resulting in some restrictions of duty or work hours lasting less than one week.

Neither of these non-reportable categories is properly and uniformly recorded or used at the national level for setting any meaningful reporting standards, targets and requirements for employers. They are seldom used for driving any national injury prevention initiatives or strategies unless the injury actually results in a workers compensation claim. Large numbers of those injuries are associated with the potential for a more significant outcome, and an increased focus in this area would represent a more proactive, upstream approach in measuring safety performance. Instead, most Australian regulatory jurisdictions focus primarily on lost time injuries (LTIs), fatalities and data from known and reported injury compensation claims. On the other hand, most organisations do use MTIs and RWIs as part of their overall safety performance lag indicators. When reported and correctly classified, they form part of the Total Recordable Injury Frequency Rate (TRIFR), which is often used as a primary and, sadly in some cases, the only organisational lag indicator of safety performance.

To a large extent, employers in Australia are left to define their own methods of measuring their safety performance and associated lead and lag performance indicators. Lag indicators have traditionally been heavily based on personal injuries and their frequency rates. In terms of those, most organisations use a combination of LTIFR and TRIFR or, in some cases, All Injury Frequency Rates (AIFR). In most cases the primary measure is LTIFR, which draws most attention by senior decision makers and is usually a mandatory reporting element going to boards of company directors. TRIFR and AIFR are also sometimes used at the board level as a secondary performance lag indicator, although to a far lesser extent. In any case, the concept is to implement organisational systems able to record personal injuries, track their trends and use this data as part of the overall organisational proactive strategies in injury prevention. That is the theory; however, the practice is often different.

Manipulative practices

The methods used to distort the warning system are many. It is not uncommon in

why are we deluding ourselves?

some organisations to have a practice where someone delivers a couple of procedures to an injured person's home and considers this as an active duty, therefore eliminating a need to classify such injury as lost time. In many cases an employee is brought back to work with little if any capacity to perform any duties, and this is done for no meaningful reason other than to prevent a recordable injury, especially where there is a long-standing LTI record at stake or a department bonus involved.

Obtaining an alternative medical opinion – known as "doctor shopping" – is another popular strategy. In some cases, return-to-work programs are developed and utilised contrary to medical certificates. This can prolong recovery of the injured person and delay rehabilitation to pre-existing duties. Some organisations have taken a completely different angle to recordable injuries and have simply opted to discard whole categories of recordable injuries such as RWIs. This practice ensures that only those restricted work cases that have resulted in administration of specific medical interventions get accepted as recordable, thus driving a range of personal injuries resulting in restricted duties out of the TRIFR calculation. Medically treated injuries are treated in a similar fashion.

Of particular concern are some practices involving actual delays of proper medical assessments and treatments. This is done in an apparent attempt to "manage" injuries in-house and reduce or avoid the risk of receiving first medical certificates with partial or full disability. Admittedly, in some cases there is simply no need for a person to be assessed by a general practitioner, as the injury is well within the scope of local paramedics. The real issue is with cases which do require proper medical examination and where this is denied or delayed due to internal written or unwritten expectations and protocols. In other words, pressures are applied to site-based treating health professionals, and in some cases, this is a clear management expectation and unwritten, but accepted, way of managing recordable injuries. The ethical norm of "erring on the side of caution", which is so deeply entrenched in all health professionals through their training, is compromised, which causes extreme discomfort, dissatisfaction and stress through cognitive dissonance in the workplace.

There are cases where a general practitioner is consulted over the phone but the action taken is not always in line with the advice received. This is a quite unique situation in the medical arena where a nurse or a paramedic is actively encouraged by non-medical personnel to act contrary to the advice received by a medical person of higher training and qualifications. Much can be said about the ethical dilemmas, legal ramifications and potential of further harm to the injured person. It may be difficult to believe, however, sadly, this does occur.

Over-focus on TRIFR

It is interesting to note the practices in some organisations around the promotion of senior personnel based on a TRIFR as a key performance indicator. The impact these promotion practices have on an open and honest information flow to the top decision makers cannot be underestimated. People can be the greatest barrier to effective communications, especially when their key interests are at stake. Another important factor involved in the incorrect classification of recordable injuries is a state of silent acknowledgement, which is present in some organisations. This is a conscious acceptance of the failure to manage risks to the advertised acceptable levels combined with a strong need to stay competitive and

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compare favourably to other organisations. This acceptance is often unspoken and even denied, yet easily observable through actions of individuals and organisational practices.

The limited importance, intention and purpose of TRIFR as one of the key lag performance indicators used in measuring overall organisational safety performance is generally well known. It is simply a measure of harm (above a defined point) to employees as a result of various organisational system failures.
It is a reactive measure, not predictive of the future performance, and has limited ability to provide specifics in terms of system failures and issues. It is really one of the last alarms for the organisation indicating occasions where all control has been lost, and there is a need for evaluation and change of the applied risk controls.

One of the most damaging effects of this behaviour is a simple chain reaction. As the severity of injuries is undermined, the need for a comprehensive root causes analysis investigation is often driven down; the underlying causes are not uncovered and addressed appropriately. The issues now lay dormant, waiting to combine with other workplace factors and surface again, often with unpredictable consequences far more severe than the original injury itself.

Where TRIFR becomes important is in consideration of the overall strategic business planning and resourcing for safety. In absence of better measures, it becomes a focal point of attention for senior decision makers and one of the key factors potentially influencing the allocation of funds towards health and safety strategies.

TRIFR and LTIFR have been with us for a long time. The practices discussed in this article do not suggest lack of understanding on what those statistical measures are meant to achieve, rather they represent a set of intentional, although impulsive actions aimed at avoidance of negative perceptions and creating an illusion of better performance.

Is there a better way?

A lot can be at stake for managers – not only a potential promotion but also an annual bonus, pay rise and company shares. In some cases, survival in the organisation is a primary goal. However, if we look at the problem from the standpoint of some senior managers, it is far easier and faster for someone to "tweak" a figure than to seriously engage and apply efforts in management of health and safety. If this kind of practice was to be done with some other organisational process, other indicators would be able to show the anomaly and it would not be tolerated. With recordable injuries, there is usually not much in place to provide secondary checks of data accuracy and there are rarely any redundancies in the system, although it's worth noting that some organisations have specific auditing processes in this area.

Most organisations have dedicated budgets for some injury-related costs, however, they do not usually have detailed systems for tracking business losses specifically associated with the occurrence of recordable injuries. It is unfortunate that the monetary costs of injuries is treated this way, as it is a much better reactive safety performance indicator than any recordable injury frequency or duration rates currently used in the industries. Injury management and rehabilitation costs, including various secondary losses such as time lost managing the injury, time off work for injured employee, retraining, replacement of injured personnel and other similar factors, are far more capable of defining true impacts of workplace injuries on the organisational performance and profitability. Any costs associated with injuries are losses straight off the bottom line, yet there is still a lot of reluctance to use it as a lag indicator. Maybe this is the case of decision makers simply being afraid of what they may find out, or perhaps it is just a case of ignorance on behalf of some advisers.

Workers compensation insurance is

mandatory in all Australian jurisdictions, and it is seen by most businesses as an unavoidable operating cost. Although conceptually everyone will agree that this cost can and should be driven down, in practice this cost tends to be accepted and many opportunities to reduce it are left unexplored. Unless there is a drastic increase in these costs and premiums, these costs are simply normalised. There are many reasons for this, including previously mentioned human tendency to focus on tangible and certain and ignore intangible and uncertain. This is why many decision makers find it difficult to commit resources in the upstream injury prevention

strategies, even when all evidence points towards much more costly consequences if resources are not directed at the problem proactively. As per the old saying – there is never enough money or time available to do it right but enough time and money to do it again.

There are simple and more effective strategies which can be implemented to better measure business losses arising from injuries. They are systems aimed at measuring hidden costs associated with workplace injuries. Most financial mechanisms needed for effective implementation are often present and operating as part of the organisational systems. The new, additional measure could simply be called the Injury Cost Index (ICI) and could include inputs such as:

- individual breakdown of the injury costs (injury management and rehabilitation, insurance premiums)
- labour replacement costs
- injury management and investigation costs
- administration costs
- training and overtime
- loss of productivity (interrupted schedules), and many others.

Quantifying, collating and reporting these inputs may not be an easy task and it may require careful selection of automated systems, training and procedures; however, any expenses incurred will most likely be far superseded by potential benefits.

Conclusion

The reality is that good safety performance and reliability is very difficult to achieve and sustain. It requires constant attention to something which is largely intangible. Proper resourcing, mature systems, well-developed operational discipline and, above all else, an organisational commitment and appetite to succeed are paramount. Successful management of health and safety requires substantial organisational effort as a whole. Understanding how safety works is paramount, as is respect for monitoring and preventative systems and correct risk management advice, which is not always available. Above all, just like in any other operational setting and environment, if the operational discipline and organisational culture is not in place to prevent silencing of critical warning systems, no strategy will ever truly work. This will continue to create a culture of mistrust, injury-related business losses which are relatively easily preventable, and will enable existence and tolerance of systemic conditions capable of creating significant personal and organisational damage.

We have the ability to change inappropriate injury classifications by examining our own behaviours and changing the key underpinning factors involved in creation of such practices. The change is within our power and sphere of influence, we just need to change our thinking and reach within ourselves. The answers are there. ■

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Wellness
putting the H in OHS

There are a number of important reasons for improving the health and wellbeing of employees. ***Craig Donaldson*** *looks at how two organisations have approached this successfully and speaks with industry experts about different facets of health and wellbeing*

Links between health and wellness and better business outcomes are well established, and a number of research reports have evidenced these links over the years. A 2010 paper by Harvard researchers, for example, reported that for every dollar large employers spent on wellness programs, they saw company medical costs fall about US$3.27. The paper, which was based on a meta-analysis of 36 studies into the business benefits of corporate wellness programs, also found that for every dollar spent on wellness programs, the companies' absenteeism-related costs fell about US$2.73.

There are many other research reports into the benefits of health and wellbeing programs (see box), and a number of companies have personally seen the bottom line benefits of health and wellbeing programs for themselves.

Seqwater's holistic health approach

Seqwater is one of Australia's largest water businesses and is responsible for the bulk drinking water supply for 3.6 million people across South East Queensland. With operations extending from the New South Wales border to the base of the Toowoomba ranges and north to Gympie, it also supplies water for irrigation to about 1200 rural customers, provides essential flood mitigation services and manages catchment health as well as popular lake recreational areas visited by more than 2 million people each year.

"Be Healthy, Be Wealthy" is Seqwater's workplace health and wellbeing program that delivers targeted health initiatives based on identified health risks and wellbeing issues present in the staff population and the SNAPOM (smoking, nutrition, alcohol, physical activity, obesity/overweight and mental health) risk factors for chronic disease. The program, which was awarded the best workplace health and wellbeing initiative at the Queensland Safe Work Awards 2014, operates with full board, CEO and management endorsement to continue to support employees in improving their physical, mental and emotional wellbeing, while reducing their health risk profile, in particular for cardiovascular and other chronic disease.

"Be Healthy, Be Wealthy" origins

Seqwater's injury management and health program coordinator, Tracy Co, recalls that the journey of "Be Healthy, Be Wealthy" began with a conversation between management and a registered nurse who was employed at Seqwater. The nurse was relaying stories from her decades of clinical experience where she encountered