



Work-related injury guide

for rehabilitation and return to work coordinators

Foreword	2
1. Introduction	3
Improving return to work outcomes	3
Suitable employment	5
Increasing the worker's capacity to work	6
2. Common work-related injuries	7
Acute/subacute low-back pain	7
Definition and prevalence	7
Return to work considerations	8
Expected recovery timeframes	9
Further information	9
Acute neck pain	10
Definition and prevalence	10
Return to work considerations	10
Notes for work accommodations/modifications	11
Expected recovery timeframes	11
Further information	12
Acute shoulder injuries	13
Definition and prevalence	13
Return to work considerations	13
Notes for work accommodations/modifications	13
Expected recovery timeframes	14
Further information	14
Acute elbow/wrist/hand injuries	15
Return to work considerations	15
Expected recovery timeframes – elbow	16
Expected recovery timeframes – wrist	17
Acute knee injuries	18
Definition and prevalence	18
Return to work considerations	18
Expected recovery timeframes	19
Further information	19
3. Terminology	20
Range of movement	20
4. Common terms	25
Key definitions for frequency and work characteristics	25
5. Definitions	26
6. References	27

Foreword



Welcome to the *Work-related injury guide* which will help you manage some of the most common work-related injuries. In this guide, we provide you with definitions and information about prevalence, return to work considerations and expected recovery times for each type of injury.

Your role as a rehabilitation and return to work coordinator is pivotal in assisting injured workers to return to work as soon as possible. Nobody chooses to get injured. Research shows that connection to the workplace is a significant contributor to a successful recovery and return to work. We know that it sends a powerful message when a workplace is supportive of a worker's return to work and actively seeks to accommodate their recovery. The social networks we make in the workplace and the support we have from our colleagues have also been shown to be particularly important for return to work. It is with this in mind, that we encourage you to create a workplace environment that stays in touch, remains involved, plans for return to work and above all supports your people who have been injured.

I hope you find this guide a useful tool in your 'return to work' toolbox. Remember, if at any stage you need some advice or support our Return to Work Inspectorate is just a phone call or email away.

Wayne Potter
Executive Director
Return to Work Directorate
WorkCoverSA

1 Introduction

As your workplace's rehabilitation and return to work coordinator (coordinator), it's important to keep in mind that the way you handle a worker's injury will have a huge impact on the outcome of their recovery and return to work. Your support and encouragement is crucial.

Staying home until a worker is completely recovered is often not the best thing for them to do – returning to work with the doctor's consent is an important part of recovery for many people. Being away from work for a long time can result in problems like family relationship breakdowns, poor health, social isolation and depression – so it's important to get them back to work as soon as possible.

This guide is designed to help you manage your part in this process, by detailing the major injuries sustained by workers in South Australian workplaces, and helping you to understand factors that may affect a worker's recovery. It will also help you to facilitate communication and agreement among all parties involved, identify suitable duties and develop return to work plans.

If you have any questions about the guide contact WorkCoverSA's Return to Work Inspectorate on 13 18 55 or email rtwc-support@workcover.com

Improving return to work outcomes

The prospect for a successful recovery and return to work is greatest when the process starts as soon as possible after an injury occurs. Further, having you and your employer involved in this process has been found to improve return to work rates and decrease overall costs.

The benefit of having a coordinator is that someone from the workplace is able to make immediate contact with the worker, and can identify suitable alternative or modified duties should an injury or illness occur. When the employer stays positive and is able to accommodate the injured worker in the workplace, this helps to create a positive relationship between workers and management. Research has shown that productivity and efficiency increase in an environment where everyone works together constructively.

A workplace injury potentially has physical, psychological and social consequences. However, there is strong evidence that, when a worker is injured, it's better to continue usual activities where possible, including work activities. This is associated with better recovery and return to work outcomes than traditional medical treatment alone.

Good practice points

When a worker is injured, encourage them to continue as much as possible their usual activities at work and at home.

There is also evidence that communication, cooperation and the support of all involved results in improved health outcomes. So put simply - stay in touch and try to help with everyday events and issues.

Many injured workers carry fears and beliefs about:

- the impact of returning to work
- further re-injury
- the fear of being judged by their co-workers
- loss of employment
- financial security.

There are a number of factors that may significantly influence this process including:

- the length of time away from work
- the effectiveness of the job/task modifications required to assist them in returning to work
- the work environment
- the worker's perception of how they feel when they return to work.

Your ultimate goal is to return an injured worker to pre-injury employment. If this is not possible the employer may need to provide other suitable employment.

Good practice points

- Establish and maintain good rapport with an injured worker
- Be realistic and positive
- Strive to reduce uncertainty about recovery
- Treat them as you would like to be treated
- Help them to stay at work doing doctor-approved alternative or modified duties.



Suitable employment

Suitable employment means employment in work for which the worker is currently fit, considering:

- (a) the nature of the worker's incapacity and previous employment
- (b) the worker's age, education, skills and work experience
- (c) the worker's place of residence
- (d) medical information relating to the worker that is reasonably available, including in any medical certificate or report
- (e) any rehabilitation programs that are being provided to or for the worker
- (f) the worker's rehabilitation and return to work plan, if any.

The employer is obliged to provide suitable employment as soon as an injured worker has capacity for work.

Suitable employment requires a contract of employment between the employer and the worker.

Sometimes an injured worker who has capacity for work may not be able to make an immediate return to pre-injury duties or suitable employment. A graduated return to work that necessitates modifications to the job/task may then be required. These could include a change of duties or the introduction of new tasks, further training, a change in employment hours or the provision of equipment.

The coordinator should ensure that:

- co-workers are informed of what duties the worker will be undertaking when they return to work, particularly where it impacts on other workers' job duties
- the workspace, including any recommended modification/s or adjustments, has been prepared.

It is important to remember that an injured worker does not have to be fully recovered or pain free before returning to work. Returning to work is part of the functional recovery process.

There are three types of suitable duties that may be considered when returning the worker to the workplace:

- **Pre-injury duties** – reduced hours of the pre-injury duties that the injured worker is capable of performing
- **Modified duties** – components of the pre-injury duties have been included or removed to match the injured worker's functional capacity
- **Alternative duties** – duties that are different from the pre-injury duties but allow the injured worker to remain at work or return to work

To be successful, suitable duties must be matched to the injured worker's capabilities. They should only continue for a limited time. Ideally these duties should be productive, assist the worker to increase their functional capacity, allow continued workplace social supports and be within the worker's psychological capabilities as they recover from the injury.

Good practice point

When a worker has returned to modified employment, you should monitor their progress regularly by touching base with them and their supervisor daily/weekly – go see them! You should also negotiate the worker's duties with them in line with changes in their capacity for work as certified by the doctor.

Good practice point

Ensure that goals set are SMART

- Specific
- Measurable
- Achievable
- Relevant
- Timed.

Increasing the worker's capacity to work

This may be achieved in a number of ways:

- **Increasing work hours** – The total work hours per day and/or the total number of working days per week should be increased. This should be suitably progressed to facilitate the worker's return to pre-injury hours. This approach reduces the impact of physical deconditioning and any possible psychological sequelae thus minimising the chance of the injury becoming chronic.
- **Increasing the physical demands of duties** – As the worker recovers, the physical demands of duties performed should be increased, eg, increasing lifting capacity; considering postures that may be more demanding, such as repetitive stooping, crouching or overhead reaching. How quickly this takes place is dependent on the worker's tolerance, any reconditioning required, and the availability of appropriate duties.
- **Increasing the frequency and duration of tasks** – The work pace and task duration that are performed throughout the working day should be gradually increased.
- **Avoiding too many rest breaks** – Avoid rest breaks (which may lead to deconditioning) beyond the normal allocated work rest breaks. Instead, focus on regular rotations of tasks to allow for changes in physical demands. Some examples are:
 - changes in posture from sitting to standing/walking
 - tasks involving non-repetitive upper limb movements
 - tasks requiring no or minimal lifting.

As the worker recovers and their capacity to work increases, these options should be reviewed, leading to an increase in employment hours and work duties.

Good practice point

Remember you are not expected to be a medical expert, or to understand the condition or injury your worker has. If in doubt about what restrictions or workplace modifications are appropriate, or how you can further assist the worker to return to or remain at work, contact the treating medical practitioner either by phone, fax or by asking the worker for permission to attend their next medical appointment.

Good practice point

Often it is not the task that is a problem, but the way in which it is done. Technique should be constantly monitored – coaching and supportive instruction is always good – make sure the supervisor is involved.

2 Common work-related injuries



Acute/subacute low-back pain

Definition and prevalence

Low-back pain is pain located in the lumbar and/or sacral regions of the spine, covering the region between imaginary transverse lines through the tip of the last thoracic spinous process and through the posterior sacrococcygeal joints.

Low-back pain can be classified as:

- acute – present for 4 weeks or less
- subacute – present 5 to 12 weeks after injury
- persistent (chronic) – present > 12 weeks after injury.

Episodes of acute and subacute low-back pain are common. In most cases, a specific diagnosis is unable to be made. Usually, symptoms are attributed to soft tissue structures of the low back. Many factors may contribute to the development of low-back pain.

Return to work considerations

Note: Return to work restrictions vary from patient to patient and may be influenced by other factors such as pre-existing health problems, age etc. Any restrictions prescribed for the worker should be discussed with their treating doctor.

Some examples of the types of restrictions a worker may be prescribed for this injury type include:

- lifting limit of up to 5kgs – this limit may vary depending on the worker's reported lifting tolerance and lifting technique used
- lifting between pelvis and chest height
- regular task rotation that alternates between sitting, standing and walking
- limited exposure to vibration
- pacing of activities, for example breakdown of tasks into activity and rest periods to maximise capacity.

Information about the worker's role and work demands will assist the treating doctor to provide an opinion regarding whether or not the worker is fit to return to pre-injury workplace duties, modified or other duties and to make recommendations about restrictions that need to be observed.

You may need to take into account any difficulties a worker may have travelling to and from work and how these can be accommodated. If a person cannot drive to work or use public transport, see if there are any co-workers or family that can assist with transporting them. If required, discuss with the case manager to see if temporary transportation can be arranged (ie, taxis).

Recurrence of low-back pain is common, and education regarding safe work practices for lifting, carrying, pushing, pulling, and sitting can help minimise or prevent recurrences.

Talk with the injured worker about what capacity they feel that they have to complete the current work tasks. Often workers will have a perception regarding whether or not they can manage certain aspects of their jobs. If they can't think of duties they can do within their normal range of job duties, then suitable alternative duties may need to be made available.

Helping to find suitable duties is an important aspect of the coordinator's role, as evidence shows that return to work interventions including workplace coordination have shown moderate to large effects on disability outcomes (Shaw, W. et al., 2008). If, as a coordinator, you are having difficulty identifying suitable duties, contact the case manager about the possibility of a referral for a job analysis/worksite assessment by an appropriate medical expert.

Good practice point

Return to work coordinators should plan for a return to work/stay at work with injured workers and supervisors.

Good practice point

Focus on what the worker *can* do rather than what they can't.

Ensure that wherever practical there is enough task variety to allow injured workers to rotate between different duties that allow them to regularly change postures as required.

In the longer term, you may need to look at aids or equipment that can be supplied to enable a worker to undertake their normal duties ie, lifting equipment, appropriate trolleys, change in workstation design etc. You may need assistance with this through a return to work plan from an appropriate medical expert, and your case manager can give you advice on this.

Expected recovery timeframes

Low-back pain is common and the lifetime prevalence of low-back pain is estimated to be between 70 and 80%. The majority of people with acute low-back pain recover within three months. The following is a table for expected recovery timeframes for low-back injuries.

The table should be used as a **guide only** and has been included to give estimates of recovery time. If the recovery process is significantly slower than expected then it is recommended that the treating medical practitioner or relevant health professional be contacted to discuss any concerns.

Condition	Expected healing time	Notes
Non-specific/ benign/ biomechanical low back pain	6 weeks	While pain may continue beyond six weeks from date of onset, there is strong evidence that undertaking as much activity as possible, despite the pain, is associated with a better long-term outcome.
Sciatica treated conservatively	Up to 2 years	Most sciatica will be treated conservatively. After 6 weeks from date of injury the risk of aggravation or a further disc protrusion has returned to pre-injury risk. As for benign low-back pain, resuming as much activity as possible, as soon as possible, is associated with a better long-term outcome.
Degeneration/facet joint pain	6 weeks	While pain may continue beyond 6 weeks from date of onset, there is strong evidence that undertaking as much activity as possible, despite the pain, is associated with a better long-term outcome. There is a greater likelihood of longer term pain in this circumstance.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.
Fracture	2-6 weeks	Fractures of the transverse processes are most common and activity is resumed as tolerated. Other fractures are more significant and may require a longer healing time (up to 3 and rarely even 6 months).

Further information

Information and education about low-back pain (such as advice that the condition is common, short lived, and that a good prognosis is expected) can promote effective self-management. There are a number of fact sheets available on the WorkCover website, www.workcover.com, which you can print and give to injured workers, such as *Caring for your low-back pain*.



Acute neck pain

Definition and prevalence

Neck pain is a widespread experience, and frequently persistent or recurrent. The lifetime prevalence of neck pain in adults is estimated to be between 50 to 80%. Most sufferers manage to carry on with their usual activities. Approximately 5-10% of people will find their pain disabling.

Acute neck pain refers to pain in the neck that has been present for less than three months. Acute neck pain is most commonly idiopathic (ie, arising without a known cause) or attributed to a whiplash accident; serious causes of acute neck pain are rare. Degenerative changes seen on X-rays are not predictive of neck pain.

Return to work considerations

Note: Return to work restrictions vary from patient to patient and may be influenced by other factors such as pre-existing health problems, age etc. Any restrictions prescribed for the worker should be discussed with their treating doctor.

Some examples of the types of restrictions a worker may be prescribed for this injury type include:

- lifting limit of 10kgs with bent elbows and arms remaining close by side
- lifting limit of 5kgs with outstretched arms.

Workers with neck pain should be encouraged to maintain and resume as much of their usual activities (work and non-work-related) as possible. Modification of how these activities are completed may need to occur, and often work modifications that involve an assessment of work postures are of great assistance.

An injured worker's pain may make it difficult for them to carry out their usual activities, and they might want to avoid moving their neck. However, it is important to resume normal activities as soon as possible. Maintaining the use of their neck helps to prevent long-term problems. They may need to use pain-relieving measures to help them return to their usual activity level and a plan could include a program of selected duties or reduced hours of work. This strategy also applies to home duties.

Notes for work accommodations/modifications

Avoid work that involves flexing (looking down) or extending (looking up) the neck. Repetitive activities involving use of the neck may increase symptoms.

Careful attention must be paid to the proper position of chairs, table heights, and computer keyboards; ergonomic adjustments to the work environment may be necessary. This may also mean the purchase of appropriate equipment to minimise or eliminate the time a person is sustaining inappropriate neck positions. Talk to the case manager about a referral to a medical expert for a job assessment (ergonomic assessment), which will identify any changes that may be required.

Heavy lifting and carrying should be avoided as it may aggravate symptoms. Lifting and working overhead may need to be restricted. Regular stretches that have been recommended by a medical expert should be incorporated into their work duties.

Causes of any inappropriate work stress may also need to be addressed. As coordinator, you may be able to assist with this, otherwise you can talk to your case manager about a recommendation to an external provider.

Expected recovery timeframes

The following is a table for expected recovery timeframes for acute neck injuries.

The table should be used as a guide only and has been included to give estimates of recovery time. If the recovery process is significantly slower than expected then it is recommended that the treating medical practitioner or relevant health professional be contacted to discuss any concerns.

Condition	Expected healing time	Notes
Sprain/strain including whiplash	40% have recovered by 4 weeks 60% have recovered by 6 weeks	Symptoms are frequently recurrent. The chance of recovery is maximised by undertaking as much activity as can be tolerated and by not keeping the neck in a flexed position for periods of more than 10-20 minutes.
Cervical nerve root lesions – treated conservatively	6 weeks-2 years	Generally these lesions spontaneously improve with most recovery occurring in the first 12 months.
Cervical nerve – treated surgically	6 weeks-6 months	If cervical fusion has also occurred, then heavy physical activity will need to be avoided until the fusion is solidly healed.

Further information

Information and education about neck pain can promote effective self-management. There are a number of relevant fact sheets available that you can print and give to injured workers, such as:

TRACsa: Trauma and injury recovery *A simple guide to whiplash for consumers* available from <http://www.mac.sa.gov.au/file.php?f=dj~N6U.~ntxuf.236>

National Health and Medical Research Council *Acute neck pain information sheet* available from <http://www.nhmrc.gov.au/publications/subjects/clinical.htm>

Good practice point

A worker does not have to be fully recovered or free from pain before returning to safe and suitable duties.



Acute shoulder injuries

Definition and prevalence

Acute shoulder injuries include rotator cuff disorders (the most common shoulder problem), frozen shoulder, instability disorders (acute and recurrent dislocation and other types of instability) and AC joint disorders (including dislocation and stress osteolysis) and SC joint disorders (such as sprain and dislocation).

Acute shoulder pain is pain felt in the shoulder region that lasts for up to six weeks. About 10% of people will experience an acute shoulder injury at some stage in their lives.

Return to work considerations

Note: Return to work restrictions vary from patient to patient and may be influenced by other factors such as pre-existing health problems, age etc. Any restrictions prescribed for the worker should be discussed with their treating doctor.

Some examples of the types of restrictions a worker may be prescribed for this injury type include:

- lifting limit of 5kgs
- work tasks where the arm or elbow remain close to the body
- no duties requiring over-reaching or work above shoulder height.

Notes for work accommodations/modifications

Check which arm is affected – is it the dominant or non-dominant arm?

Can you offer temporary work within the restrictions?

Can you offer tasks that do not involve repetitive upper limb movements?

Can the work be modified (rearrangement of work area to minimise the amount of repetitive and sustained arm use) or with the use of aids or equipment (raising or lowering the work to enable a person to work within their range of movement)?

Can the work station be rearranged to enable work to be undertaken close to the body?

Can some of the work be done using the other hand (take care that this is not for long periods of time as this may cause other problems)?

Can the work task be modified to break down the weights to more manageable ones that allow the worker to carry with the unaffected shoulder, with only support from the affected shoulder?

Can you provide a variety of tasks to allow rest periods for the injured shoulder?

Work site modifications can include forearm rests for individuals who use computer keyboards frequently, headsets for those who answer telephones and alterations such that repetitive activities are performed with the arms in a lower level of elevation.

If in doubt, ask the case manager for an ergonomic assessment to be undertaken by a medical expert.

If the worker requires long-term restrictions and the job cannot be modified then an alternative job will be required.

Expected recovery timeframes

The following is a table for expected recovery timeframes for acute shoulder injuries.

The table should be used as a guide only and has been included to give estimates of recovery time. If the recovery process is significantly slower than expected then it is recommended that the treating medical practitioner or relevant health professional be contacted to discuss any concerns.

Condition	Expected healing time	Notes
Sprain/strain	6 weeks	Most non-specific strain/sprain injuries should heal within 6 weeks.
Rotator cuff tendonitis	2-12 weeks	Rotator cuff tendonitis without impingement should resolve with removal of the causative activity and restricting shoulder movement to the pain-free range in the acute (first 6 weeks) phase.
Impingement syndrome	Not applicable	Removal of any causative activity will assist healing. Conservative treatment may be unsuccessful. There will generally be a pain-free range of shoulder movement and the ability to continue activity within that range of movement.
Dislocation	3-12 weeks	Healing depends on whether it is the acromioclavicular or glenohumeral joint which is dislocated, the amount of associated injury and if surgical intervention is required. In most instances healing should occur within 6 weeks.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.

Further information

Information and education about shoulder injuries can promote effective self-management. There are a number of fact sheets available on the WorkCover website, www.workcover.com, which you can print and give to injured workers, such as *Caring for your shoulder pain*.



Acute elbow/wrist/hand injuries

Return to work considerations

Note: Return to work restrictions vary from patient to patient and may be influenced by other factors such as pre-existing health problems, age etc. Any restrictions prescribed for the worker should be discussed with their treating doctor.

Some examples of the types of restrictions a worker may be prescribed for this injury type include:

- reduction in use of the affected hand
- lifting limit of 1-2kgs

The worker may be required to wear a wrist splint or elbow strap if provided by the treating medical expert. Repetitive motion, strenuous activities, or movement of the affected limb may be restricted and the worker may be temporarily unable to lift and carry heavy or bulky objects, operate equipment, or perform other tasks requiring the use of both hands.

Muscle injury in the dominant arm or hand may affect fine motor skills such as those needed to write legibly, type well, or work in a laboratory. Depending on work duties, the individual may need to be provided with temporary alternative duties.

Education regarding correct lifting techniques and movement is often helpful.

While healing occurs for the injured upper limb, activities using the other limb are usually able to be undertaken.

Modifications may be required at workstations, such as ergonomically designed computer keyboards to provide support for the individual's hand and wrist.

Arrangements may have to be made for transporting the worker to and from work if they have difficulty driving or are unable to operate a vehicle safely.

Workers who develop wrist and hand problems will be more vulnerable to a recurrence. They may need to have long-term job modifications. Rehabilitation and return to work coordinators should be considering job redesign, as whatever task precipitated the injury in one worker will potentially cause problems with other workers undertaking the same task.

These services can be undertaken by an ergonomist or by utilising the services of an appropriate medical expert to undertake a job analysis and make recommendations for job redesign.

Expected recovery timeframes – elbow

The following is a table for expected recovery timeframes for acute elbow injuries.

The table should be used as a guide only and has been included to give estimates of recovery time. If the recovery process is significantly slower than expected then it is recommended that the treating medical practitioner or relevant health professional be contacted to discuss any concerns.

Condition	Expected healing time	Notes
Medial or lateral epicondylitis	6-12 weeks if causative activity is stopped	This condition may become chronic. Removal of the causative activity in the acute phase generally results in control or resolution of symptoms.
Sprain/strain	6 weeks	Most strain/sprain injuries should heal in 2-4 weeks.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.
Fracture	4-12 weeks	The rate of healing for a fracture depends on the type and location of the fracture and whether surgical intervention is required.
Laceration involving skin and subcutaneous tissues	Up to 2 weeks	Generally activity can continue while healing occurs, particularly if the affected area can be kept dry.

Expected recovery timeframes – wrist

The following is a table for expected recovery timeframes for acute wrist injuries.

The table should be used as a guide only and has been included to give estimates of recovery time. If the recovery process is significantly slower than expected then it is recommended that the treating medical practitioner or relevant health professional be contacted to discuss any concerns.

Condition	Expected healing time	Notes
Wrist sprain/strain	Up to 6 weeks	Most wrist sprains recover in 2-4 weeks. Splinting will often assist.
Laceration involving skin and subcutaneous tissues	Up to 2 weeks	Activity can continue while healing occurs, particularly if the affected area can be kept dry.
Laceration involving tendons	Up to 6 weeks for extensor tendons Up to 12 weeks for flexor tendons	Particularly after flexor tendon repair, specific therapy to restore function will generally assist recovery.
Carpal tunnel syndrome – medically managed	Not applicable	A reduction in symptoms may occur. Exposure to vibration should be limited.
Carpal tunnel syndrome – surgically decompressed	2 weeks	Decompression reduces the pressure on the nerve and thus should enable rapid reduction in symptoms.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.
Tendonitis/Tenosynovitis	2-4 weeks or longer	If the precipitating activity is ceased, resolution generally occurs in 2-4 weeks. If not, symptoms may continue indefinitely.
Fracture	4-12 weeks	The rate of healing for a fracture depends on the type and location of the fracture and whether surgical intervention is required.
Ganglion treated conservatively	0-2 weeks	Most ganglions are symptom-free. If there are symptoms, a short period of rest may assist symptom resolution.
Ganglion treated surgically	2 weeks	Recovery should occur without further treatment.



Acute knee injuries

Definition and prevalence

Acute knee pain refers to pain experienced for up to six weeks from date of injury.

The most common diagnoses reported to WorkCover are strains and sprains, meniscal injuries, bruises/contusions, lacerations and bursitis.

Return to work considerations

Note: Return to work restrictions vary from patient to patient and may be influenced by other factors such as pre-existing health problems, age etc. Any restrictions prescribed for the worker should be discussed with their treating doctor.

Some examples of the types of restrictions a worker may be prescribed for this injury type include:

- work tasks undertaken in seated position
- minimal use of stairs
- hand-operated machinery.

Other restrictions may include no kneeling, squatting, crawling, climbing, or prolonged standing during the early phase of recovery.

Depending on which knee is injured and what type of vehicle they drive ie, manual or automatic, you may need to consider how they get to and from work. If they are on crutches, you will need to assess the risks around the work area ie, is there clear space to move around? Will the person be able to get to areas they need to?

Caution should be taken with tasks that require the person to be aware of the knee's position while twisting, turning, or lifting. You may need to reinforce this to ensure that the person moves their whole body and feet ('keep nose over toes') rather than twisting their body while keeping their knee in a fixed position.

Frequent rest periods may need to be incorporated to allow for change of posture and elevation of knee.

A foot stool to allow elevation of the injured leg when seated may need to be provided in the initial stages of rehabilitation.

Expected recovery timeframes

The following is a table for expected recovery timeframes for acute knee injuries.

The table should be used as a guide only and has been included to give estimates of recovery time. If the recovery process is significantly slower than expected then it is recommended that the treating medical practitioner or relevant health professional be contacted to discuss any concerns.

Condition	Expected healing time	Notes
Sprain/strain	2-6 weeks	Sprain/strain injuries generally heal in 2-6 weeks. Sometimes this is a provisional diagnosis and a different diagnosis is made when expected healing does not occur.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.
Meniscal (cartilage) injury treated conservatively	Not applicable	Conservative treatment of meniscal injury is generally associated with compromise to knee function and, except for minor tears is not recommended.
Meniscal (cartilage) injury treated surgically	2-4 weeks	Arthroscopic treatment of a damaged meniscus should be followed by rapid recovery unless there is other pathology within the knee joint.
Lacerations	2 weeks	Generally activity can continue while healing occurs, particularly if the affected area can be kept dry.

Further information

Information and education about knee injuries can promote effective self-management. There are a number of fact sheets available on the WorkCover website, www.workcover.com, which you can print and give to injured workers, such as *Caring for your knee sprain/strain*.

3

Terminology

Range of movement diagrams

Often medical certificates will use terms like 'avoid neck flexion' or 'avoid wrist extension'. The following diagrams may assist you in identifying suitable duties that do not involve these motions. If in doubt, contact your case manager to get an appropriate medical expert to assess the duties you have available, to ensure they are within the restrictions specified by the doctor.

Back and neck



Flexion



Extension



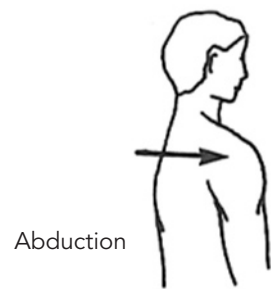
Lateral flexion



Rotation



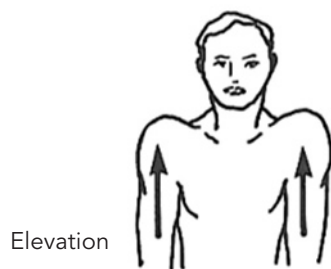
Shoulder



Abduction



Adduction

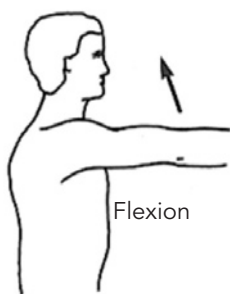


Elevation



Depression

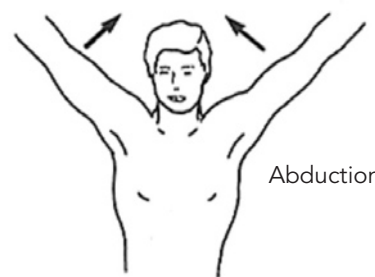
Shoulder joint



Flexion



Extension



Abduction



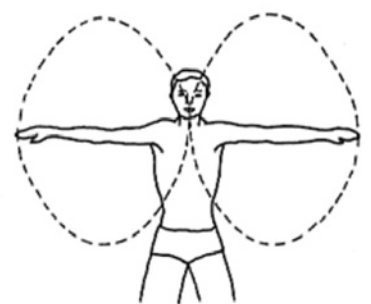
Adduction



Outward medical rotation



Inward medical rotation



Circumduction

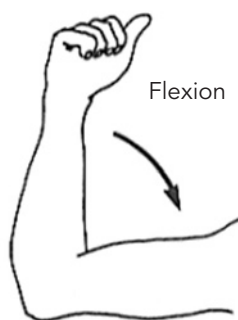
Elbow



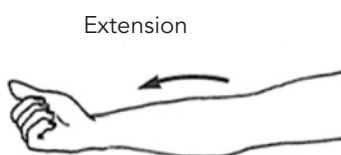
Pronation



Supination (palm up)



Flexion

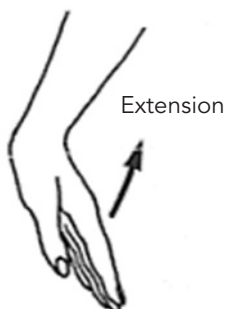


Extension

Wrist joint



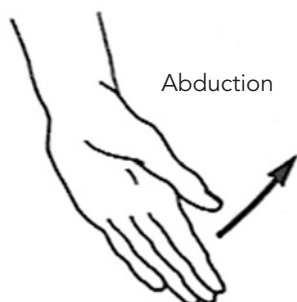
Flexion



Extension



Adduction

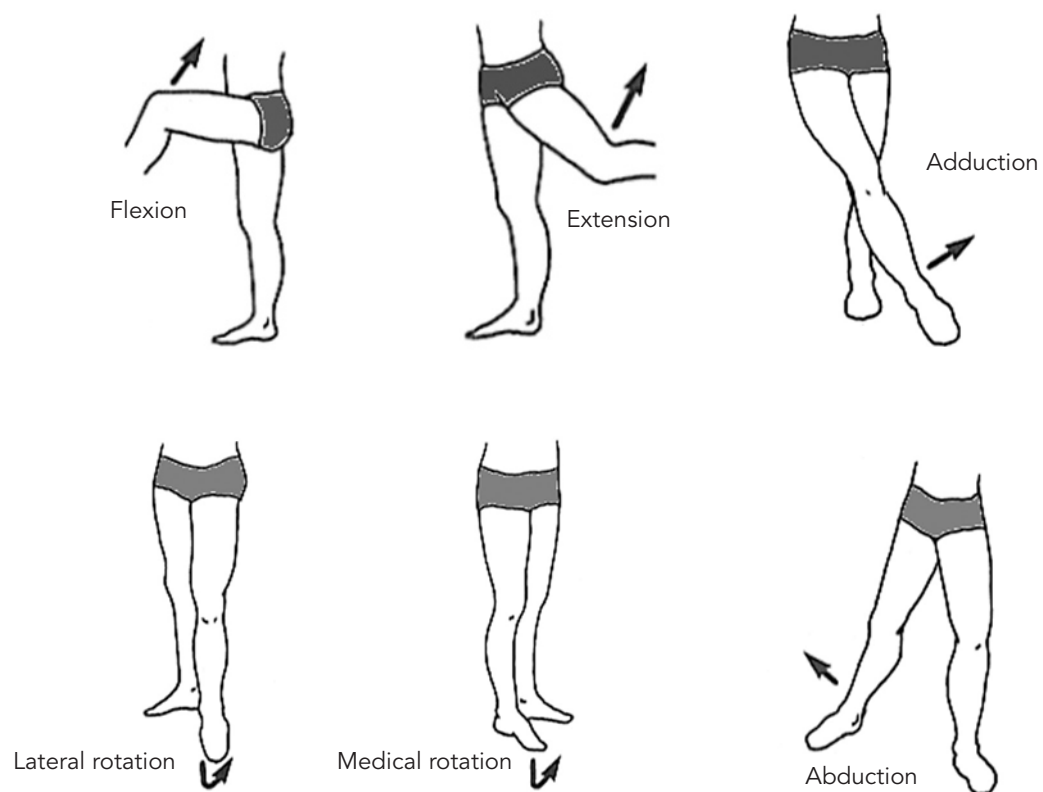


Abduction



Circumduction

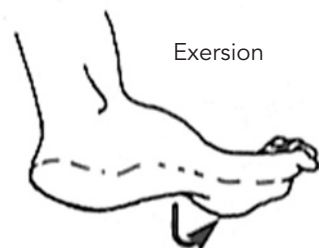
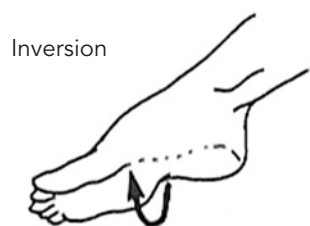
Hip joint



Knee joint



Ankle joint



Dorsi flexion



Plantar flexion



4

Common terms

Key definitions for frequency and work characteristics

	Non-material handling	Non-material handling	Material handling
Never (N)	0% of an 8 hr working day	No repetitions per day	No repetitions per day
Infrequently (I)	1-5% of an 8 hr working day	1-2 repetitions per day	1-2 repetitions per day
Occasionally (O)	6-33% of an 8 hr day	0-100 repetitions per day	3-32 repetitions per day
Frequently (F)	34-66% of an 8 hr working day	101-800 repetitions per day	33-200 repetitions per day
Constantly (C)	67-100% of an 8 hr work day	> 800 repetitions per day	> 200 repetitions per day

	Sedentary	Sedentary - Light	Light	Light - Medium	Medium	Medium - Heavy	Heavy	Very heavy
Occasional (1-33%)	4.5kgs	7kgs	9kgs	16kgs	23kgs	34kgs	45.5kgs	Over 45.5kgs
Frequent (34-66%)	Negligible	3.5kgs	4.5kgs	7kgs	11.5kgs	16kgs	23kgs	Over 23kgs
Constant (67-100%)	-	-	Neg	2kgs	4.5kgs	7kgs	9kgs	Over 9kgs
	Sit	Sit/stand	Stand/walk	Stand/walk	Stand/walk	Stand/walk	Stand/walk	Stand/walk

This information was sourced from the *Dictionary of Occupational Titles*, US Department of Labor, 1991.

5

Definitions

Alternative work	A different range of duties, temporary in nature and taking into account physical constraints or restrictions of the injured worker.
Appropriate duties	Duties that take into account an employee's skills, experience, physical constraints, ability to adapt (usually established through a process of consultation).
Chronicity	Lasting a long time or recurring often.
Deconditioning	Deconditioning may result from decreased physical activity and results in muscle loss.
Medical restrictions	A description of physical constraints a worker must comply with, as outlined by a medical practitioner.
Modifications to work duties	Original duties conducted in a different way or manner and involving a change of work routine, work practices, alteration to the work setup and may involve an introduction of special equipment, etc.
Psychological sequelae	A condition following, and usually resulting from, a previous injury.
Range of movement	The measurement of the achievable distance between the flexed position and the extended position of a particular joint or muscle group.
Relocation/alternative placement	Term to describe placement of an employee in another workplace or organisation when work cannot be provided by the original employer. If this is the case then consultation must occur with the case manager.
Suitable/meaningful employment	Negotiated tasks appropriate to the employee's skills, experience and ability.

6

References

Brian Mac Sports Coach webpage <http://www.brianmac.co.uk/musrom.htm>

Dictionary of Occupational Titles, U.S. Department of Labor, 1991

Facilitators and Barriers to Return to Work: A Literature Review, Australian Institute for Primary Care and La Trobe University

Factors affecting the organizational responses of employers to workers with injuries - Yueng-Hsiang Huang et al, *Work* 26 (2006) 75 -84

MD Guidelines website <http://www.mdguidelines.com/>

The Medical Disability Advisor, Presley Reed, MD or their website <http://www.mdguidelines.com/>

Return to Work Knowledge website <http://www.rtwknowledge.org>

WorkCover SA website http://main.workcover.com/site/treat_home.aspx

Australian Government: National Health and Medical Research Council (NHMRC)
<http://www.nhmrc.gov.au/publications/subjects/clinical.htm>

Motor Accident Commission website <http://www.mac.sa.gov.au/file.php?f=dj~N6U.~ntxuf.236>

Notes

WorkCoverSA

Enquiries: 13 18 55

100 Waymouth Street, Adelaide

South Australia 5000

Fax: (08) 8233 2990

info@workcover.com

www.workcover.com

Free information support services:

TTY (deaf or have hearing/speech impairments): (08) 8233 2574

Languages other than English: call the Interpreting and Translating Centre
- (08) 8226 1990. Ask for an Interpreter to call WorkCoverSA on 13 18 55.

Braille, audio, or e-text: call 13 18 55 and ask for required format.

WorkCoverSA is a statutory authority funded by employers to rehabilitate and
compensate South Australians injured at work.

© WorkCover Corporation of South Australia, 2010
All rights reserved

Printed July 2010