BRANT COMMUNITY HEALTHCARE SYSTEM
MANUAL

Policy/Procedure

CATEGORY:	**Organizational Health**	NUMBER:	**X-90**
ISSUED BY:	**Senior Leadership Team**	PAGE:	**1 of 21**
		Date:	**March 1988**
SIGNATURE:	**PRESIDENT**	Review:	
DISTRIBUTION:	**All Management Manuals**	Revision Date:	**January 2007**
SUBJECT TITLE:	**Modified Work Program/ Early and Safe Return to Work**		**(Policy** **(Procedure**

POLICY

The Brant Community Healthcare System is committed to developing and maintaining a safe work environment. The modified work program is very flexible, comprehensive and proactive with the intention to provide positive outcomes for our employees.

In addition, the intention is:

1. To make every effort to provide modified work within the employee's normal job and working conditions as medically appropriate.
2. To make reasonable efforts to provide modified work of a temporary nature to an employee recovering from an illness or injury.
3. To consult with the appropriate health professional who may best treat and manage the workplace illness or injury.

DEFINITION

The temporary modified/transitional work re-entry program allows the employee to return to gainful employment in a modified work capacity within their medical restrictions.

Modified work may take the form of any or all of the following:

- **Modified Time** – the employee performs all regular duties or modified work but has an altered or reduced schedule
- **Modified Work** – the employee performs the pre-injury job in the regular hours, but changes are made according to restrictions prescribed by the physician

- **Alternate Work** – the employee is assigned to duties that are different from the employee's regular duties

- **Physical Demands Analysis/Job Description-** Is a systemic procedure to quantify and evaluate all the physical and environmental demand components of tasks of a job

The duration of modified/alternate duties will be a maximum of 12 weeks; the extension of program will be under the discretion of Occupational Health & Safety (OH&S)/Manager/Employee/Rehabilitation Services. If a temporary or permanent accommodation has been identified, Organizational Health reserves the right to request updated medical information from time to time to support the continued accommodation to a maximum of three times per year.

Eligibility

The Modified Work Program is mandatory for all employees who have temporary physical limitations due to a workplace injury or illness.

The Modified Work Program is available for employees recovering from non work related illness or injury.

The Modified Work program will be communicated through orientation and as required.

Modified Work Program

The Modified Work Program consists of a team working together to meet identified objectives within a specified time frame, and eventually allowing the injured/ill employee to assume their regular duties.

The Modified Work Program team consists of:

1. Employee
2. Supervisor/Manager
3. Occupational Health Nurse (OHN), Disability Management Coordinator
4. Co-ordinator, Occupational Health & Safety
5. Rehab Services internal/external

And as required:

6. Union Representative
7. Occupational Health Physician

FUNCTIONS OF THE MODIFIED WORK PROGRAM TEAM MEMBERS

Employee's Role:

1. Report workplace injury/illness immediately to manager and/or Organizational Health and complete Employee Incident Report with Manager/Supervisor.
2. Obtain and take Treatment (RX) Memo and Injured Worker's Package to treating Health Professional.
3. Return RX memo to Organizational Health the following day.
4. Participate in Modified Work Program.
5. Arrange appointment with Organizational Health to document modified work.
6. Complete Daily Journal while on Modified Work
7. Participate in Educational Programs.
8. Have Union Representation for support and direction if desired, when applicable.
9. Complete evaluation form and return to Organizational Health

Co-ordinator, Occupational Health and Safety:

Co-ordinate Modified Work Program (MWP) which includes:

1. Complete appropriate forms/letters. (WSIB Form 7 if medical attention received)
2. Arrange MWP meetings for workplace injuries
3. Follow-up with employee/Perform ergonomic assessment. Arrange for PDA
4. Assist with Educational Programs.
5. Contact appropriate medical personnel as required to confirm and discuss treatment session and health progress.
6. Assist managers and employees to identify and resolve potential concerns about their modified duties
7. Assist and provide information regarding remuneration for injured employee.

Occupational Health Nurse's Role:

Assist with Modified Work Program, which includes:

1. Provide immediate first aid measures and/or medical treatment to injured employee.
2. Assessment of employee.
3. Refer to Occupational Health Physician as required.
4. Referral to Rehab Services as required.
5. Contact employee weekly for evaluation and support.
6. Contact medical personnel as required to confirm and discuss treatment sessions and health progress.
7. Assist with Educational Programs.

8. Assist managers and employees to identify and resolve potential concerns with modified work.

Occupational Health Physician's Role:

1. Assess medical condition of employee upon request by Occupational Health Nurse or Safety Co-ordinator.
2. Consult with medical personnel and MWP team members.
3. Make referrals when necessary.
4. Assist with Educational Programs.

Supervisor/Manager's Role:

1. Ensure injury/illness is reported to Occupational Health and Safety within 24 hours.
2. Complete Employee Incident Report with employee and submit to Organizational Health
3. Review remuneration for employee with Safety Co-ordinator.
4. Assist in developing, monitoring and implementing Modified Work Program.
5. Discuss concerns with Safety Co-ordinator or Occupational Health Nurse.
6. Provide support and encouragement to the injured employee.

Union Representative's Role:

1. To assist employee in the Modified Work Program as needed.

Rehabilitation Services' Role:

1. Assess and treat employee as per referral by Organizational Health, which includes:
   (a) Fast-tracking (work-related) 24-48 hours post injury
   (b) Regular tracking (non-work-related) – 3 days to 3 weeks.
2. Assist with ergonomic assessment as required and or PDA
3. Assist in developing Educational Programs.
4. Provide Organizational Health with any related medical information which will assist employee to return to regular duties (with employee's consent).
5. Assist with MWP as required.

Physical Demands Analysis/Job Description:
Are intended to provide a description of the job duties performed and movements required during a specific job.

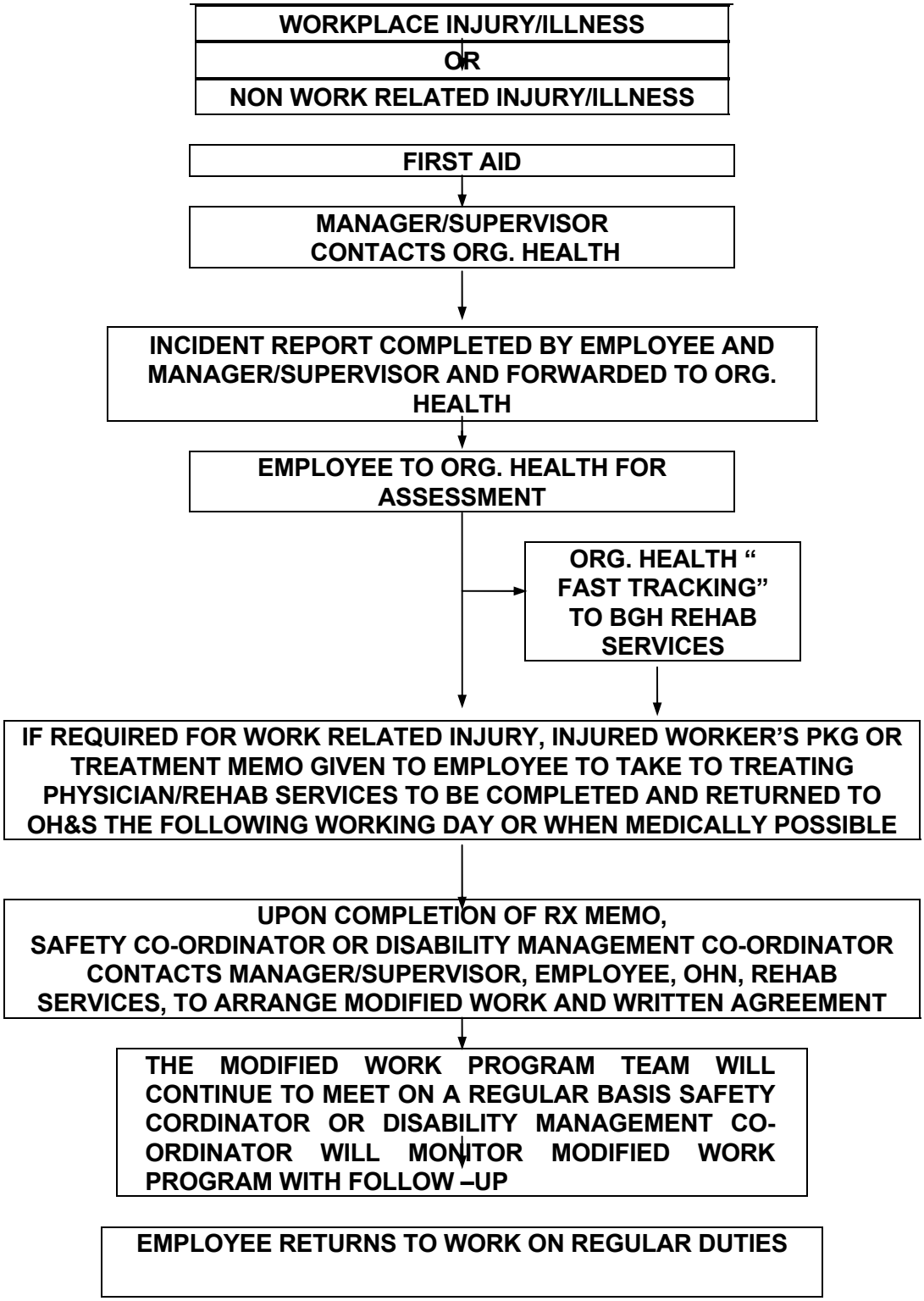
Obligation to Re-employ (workplace injury or illness):

Under the Workplace Safety and Insurance Act 1997 when the worker is medically able to perform the essential duties of his or her pre-injury employment, the employer shall,

(a) offer to re-employ the worker in the position that the worker held on the date of injury; or

(b) offer to provide the worker with alternative employment of a nature and at earnings comparable to the worker's employment on the date of injury

MODIFIED WORK PROGRAM FLOW CHART



Required Forms & Documentation

1. Treatment Memorandum
2. Attending Physician's Statement
3. Modified/Transitional Work Re-Entry Plan
4. Employee's Daily Journal
5. Physician Letter
6. WSIB Workers Claim/Consent Form
7. Assignment of Compensation
8. Thank You Letter
9. Employee Modified Work Program Evaluation
10. Work Restrictions Posting
11. Physical Demands Analysis (Blank form)

Ref: Workplace Safety and Insurance Act 1997. Chapter 16- Schedule A

APPROVAL BY:	**Operations Team**	**APPROVAL BY:**	**Senior Leadership Team**
Date:	January 17, 2007	Date:	February 6, 2007
APPROVAL BY:		**APPROVAL BY:**	
Date:		Date:	
If applicable:		If applicable:	
TWH – Date Originated:		**BGH** – Date Originated:	
Original Policy No:		Review Contact Position: VP Resources/Development	

Brant Community Healthcare System

Treatment Memorandum

1. To be completed whenever a hospital employee requires health care as a result of illness or injury other than first aid. This form is given to the employee to take to the attending/treating physician/ rehabilitation services.

Employee: _____ **Tel #:** _____
Department: _____ **Position:** _____
Nature of Illness/injury: _____

MODIFIED WORK IS AVAILABLE

Dear Physician/Rehabilitation Services: ***Please complete the sections below and return the form with the employee. This form will assist us in planning for the return to work of this employee, and if necessary, will provide the documentation required to substantiate their claim.***

2. Date of examination on which the report is based _____
Rehabilitation/Treatment required? ❑ Yes ❑ No
Is the worker capable of returning immediately without restrictions? ❑ Yes ❑ No If no please complete next section.

3. Please complete where capabilities are known or limitations recommended. Note: 'as tolerated' implies that restrictions are recommended but must be quantified in the workplace.

Capabilities: **Comments**

Walking: ❑ short distance only ❑ as tolerated ❑ other (eg. uneven ground) _____
Standing: ❑ less than 15 min ❑ less than 30 min ❑ as tolerated ❑ other _____
Sitting: ❑ less than 30 min ❑ less than 1 hour ❑ as tolerated ❑ other _____
Lifting floor to waist: ❑ less than 10 Kg ❑ less than 25 Kg ❑ as tolerated ❑ other _____
Lifting waist to shoulder: ❑ less than 10 Kg ❑ less than 25 Kg ❑ as tolerated ❑ other _____
Stair climbing: ❑ none ❑ 2-3 steps only ❑ short flight ❑ own pace ❑ as tolerated _____
Ladder climbing: ❑ none ❑ 2-3 steps only ❑ 4-6 steps only ❑ own pace ❑ as tolerated _____
Limited ability to use hand to: ❑ hold objects ❑ grip ❑ type ❑ write _____

Limitations:

❑ Bending or twisting of _____
❑ Repetitive movement of _____
❑ Chemical exposure to _____
❑ Environmental exposure to _____
❑ Operating motorized equipment _____
❑ Restrictions related to medications (specify) _____
❑ Above-shoulder activity _____
❑ Below-shoulder activity _____

Exposure to vibration: ❑ high frequency ❑ low frequency
Limit physical exertion to: ❑ mild ❑ moderate ❑ as tolerated
Recommendation for Work Hours : ❑ Full-time hours ❑ Modified hours ❑ Graduated hours
Complete Recovery Expected? ❑ No ❑ Yes Estimated Duration of Limitations _____

Health Professional's Name (Please print)	Health Profession	Date of next appointment for Review of Capabilities day/month/year
_____	_____	_____

Full Address	City/Town	Province	Postal Code
_____	_____	_____	_____

Date	Area Code Telephone Number	Signature
_____	(_____) _____	_____

Employee's consent: I understand the reason for this form and authorise my physician/rehabilitation specialist to discuss the details of my return to work with the Brantford General Hospital's Occupational Health and Safety Dept. Employee signature: _____ Date: _____ ORGANIZATIONAL HEALTH FAX #: (519) 751-589

ATTENDING PHYSICIAN'S STATEMENT X-90 Appendix C

To _____ **From** _____

Employee's Name _____ **Position** _____

Employee's Signature _____ **Date** _____

I understand the reason for this form and authorize my physician/rehabilitation specialist to discuss the details of my current illness/disability & return to work with the Brant Community Healthcare System's Organizational Health Services.

The Hospital, in accordance with the Ontario Human Rights Code – duty to accommodate, would like to assist your patient in the prompt and safe return to work. We will arrange modified work according to your recommendations. Our comprehensive program may include Fast-Track referrals to Mental Health Services, Physiotherapy, Occupational Therapy and/or ergonomic assessment, designed to accommodate all levels of restrictions.

A Job description and a Physical Demands Analysis are attached for your consideration in determining the level of ability of your patient (if applicable).

Please contact Organizational Health at (519)751-5544 extension 5528.

1. **Diagnosis: Primary** _____
   Secondary _____
2. **Objective Findings (test results):** _____
3. **Subjective symptoms:** _____
4. **Current treatment:** _____
5. **Has patient ever had similar condition?** □ **Yes** □ **No explain** _____
6. **Is condition due to injury or illness arising out of employment** □ **Yes** □ **No** □ **Unknown**
7. **Return to Modified Work** □ **Yes** □ **No expected return** _____
8. **How long will modified work be required?** _____ **Within the following limitations and capabilities:** _____
   _____
9. **Return to Regular Work** □ **Yes** □ **No Date** _____

Rehabilitation
Please check:

10. **Referral to Internal Hospital Program** □ **Yes** □ **No, please specify:** _____
11. **Requires Physiotherapy?** □ **Yes** □ **No**
12. **Requires Occupational Therapy?** □ **Yes** □ **No**
13. **Referral to Mental Health Services?** □ **Yes** □ **No**

Please return this Confidential Form to Organizational Health office c/o Brant Community Healthcare System.
Confidential Fax #: (519)751-5892

Physician's Signature _____ **Date** _____

MODIFIED/TRANSITIONAL WORK RE-ENTRY PLAN

Modified/Transitional Plan For : _____ Date: _____

Injury: _____

Week #	Date (D/MY)	Monday (# hrs)	Tuesday (# hrs)	Wednesday (# hrs)	Thursday (# hrs)	Friday (# hrs)	Saturday (# hrs)	Sunday (# hrs)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

** Maximum 12 Weeks of temporary accommodation*

I understand that the following limits have been set for me and I agree not to exceed these limits.

Signed: _____ Date: _____

Manager Signature: _____ OHN Signature: _____

OH&S Co-ordinator: _____ Union Signature: _____

Week 1

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ___

_____

Changes to plan: _____ Initial _____

Week 2

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ___

_____

Changes to plan: _____ Initial _____

Week 3

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____

_____

Changes to plan: _____ Initial _____

Week 4

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ____

_____

Changes to plan: _____ Initial _____

Week 5

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ____

_____

Changes to plan: _____ Initial _____

Week 6

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ____

_____

Changes to plan: _____ Initial _____

Week 7

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ____

_____

Changes to plan: _____ Initial _____

Week 8

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____

_____

Changes to plan: _____ Initial _____

Week 9

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ____

_____

Changes to plan: _____ Initial _____

Week 10

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ____

_____

Changes to plan: _____ Initial _____

Week 11

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ____

_____

Changes to plan: _____ Initial _____

Week 12

Restrictions/Limitations: _____ ____

Tasks which may be performed: _____ ____

Comments: _____ ____

_____

Changes to plan: _____ Initial _____

EMPLOYEE'S DAILY JOURNAL

NAME:_____
List progress, setbacks, problems and how problems were resolved:

	ISSUES	RESOLUTIONS
Sunday **Date:** **Shift:** **Hours worked:**		
Monday **Date:** **Shift:** **Hours worked:**		
Tuesday **Date:** **Shift:** **Hours worked:**		
Wednesday **Date:** **Shift:** **Hours worked:**		
Thursday **Date:** **Shift:** **Hours worked:**		
Friday **Date:** **Shift:** **Hours worked:**		
Saturday **Date:** **Shift:** **Hours worked:**		

The above journal is to be submitted at every Modified Work Program meeting.

Brant Community Healthcare System

Dear Healthcare Provider

Please be advised that our approach is supportive, holistic, and confidential. We offer fast-tracking to services such as: Physiotherapy, Occupational Therapy, Occupational Health Physician and EAP for our employees, which may assist them to full recovery. As you are aware, we also have a very flexible, comprehensive and proactive **Return to Work** program with positive outcomes for our employees. We can accommodate any limitations or restrictions that you place on the employee as a result of their workplace injury through this transitional period.

It is our intent to accommodate our employees for a timely and safe return to work. Please complete the attached treatment memorandum noting any capabilities, limitations or restrictions that are required due to the injury.

Our Modified Work Team consists of the employee, union representative, supervisor/manager, and an Organizational Health representative. The team reviews the treatment memorandum and collaborates in determining suitable work duties within the restrictions.

Please return the signed treatment memo by fax (519) 751-5892 or with the employee.

If you have any questions, please feel free to contact us at:
(519) 751-5544, extension 2248.

Regards,

Organizational Health Staff
Margaret McMahon RN, OHN, Manager Organizational Health
Cindy Hayward-Dale RN COHN[C], Disability Management Co-ordinator

WSIB Workplace Safety & Insurance Board
CSPAAT Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Worker's Claim/Consent Form
Demande de prestations et consentement du travailleur

DO NOT RETURN THIS TO THE WSIB.
NE PAS RETOURNER LE PRÉSENT FORMULAIRE À LA CSPAAT.

Worker's Signature By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the Board's "Functional Abilities for Timely Return to Work" form.	**Signature du travailleur** En signant ci-dessous, je réclame des prestations en vertu de la *Loi de 1997 sur la sécurité professionnelle et l'assurance contre les accidents du travail*, pour une lésion ou une maladie reliée au travail. De plus, j'autorise tout professionnel de la santé qui me traite à remettre à mon employeur, à la Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail et à moi une copie du formulaire intitulé *Détermination des capacités fonctionnelles pour un retour au travail rapide*, sur lequel il aura fourni les renseignements sur mes capacités fonctionnelles.
Print Name (in full)	Prénom et nom de famille (en caractères d'imprimerie)
Signature / Date signed	Signature / Date de la signature
Accident Date / Description of Injury/Disease	Date de l'accident / Description de la lésion
Employee ID / SIN / Employer FAX Number	Identification de l'employé / NAS / Numéro de télécopieur de l'employeur

Employer Instructions: Use this form when you cannot get your employee's signature on the Form 7. Keep your copy on file. Send the white copy to the worker's health professional as permission from the worker to release functional abilities information, if required, to help with a safe return to work plan.
Message à l'employeur : Veuillez utiliser ce formulaire lorsque vous êtes incapable d'obtenir la signature de votre employé sur le Formulaire 7. Conservez votre copie dans vos dossiers et envoyez la copie blanche au professionnel de la santé. Par l'entremise du présent formulaire, le travailleur autorise le professionnel de la santé à divulguer les renseignements portant sur ses capacités fonctionnelles, si besoin est, afin d'aider les parties à élaborer un programme de retour au travail sécuritaire.

Brant Community Healthcare System

ASSIGNMENT OF COMPENSATION

The Brant Community Healthcare System agrees to advance_____ 85% of net earnings which may be payable by the ***Workplace Safety & Insurance Board*** upon approval of the claim.

_____ agrees to make arrangements with the benefits administrator should their WSIB claim be denied.

Employee Signature: _____ *Date:* _____

Manager Signature: _____ *Date:* _____

OH&S Signature: _____ *Date:* _____

Finance: _____ *Date:* _____

The Brant Community Healthcare System is obligated to continue to contribute to the benefit plan provided the employee continues to contribute while absent from work for WSIB related reasons.

Do you wish to continue to contribute to you benefit plan and have the BCHS continue as well?
☐ YES ☐ NO

PLEASE ARRANGE FOR BENEFITS THROUGH THE BENEFITS/COMPENSATION SPECIALIST

Agreement begins: _____

Agreement expires: _____

PAYROLL USE ONLY

Compensation Issued: _____

Pay Period: **From:** _____ **To:** _____

NOTE: THIS INFORMATION WILL BE FORWARDED TO THE WORKPLACE SAFETY & INSURANCE BOARD FOR REIMBURSEMENT TO THE HOSPITAL.

Brant Community Healthcare System
The Willett, Paris
The Brantford General

March 15, 2006

Dear:

Thank you for participating in our Modified Work Program. As of _____, you have recovered enough to perform your essential duties.

Your determination and co-operation have been vital components in your recovery and this program.

Please take a few moments to fill out the attached evaluation form. This information will help us to evaluate and eliminate barriers which will enable us to enhance Occupational Health and Safety Services.

Thank you

Organizational Health

c. Human Resources
Department Manager

EMPLOYEE
MODIFIED WORK PROGRAM EVALUATION

Please take a moment to complete the following evaluation from. It will greatly assist us in further improving the Modified Work Program.

DEPARTMENT: **DATE OF INJURY:**

INJURY: **BEGINNING DATE:**

LENGTH OF PROGRAM:

	YES	NO
1. Were Modified Duties offered as soon as appropriate?	❑	❑
2. Was the Modified Work Program fully explained to you?	❑	❑
3. Were any questions that you may have had explained to your satisfaction?	❑	❑
4. Did the Modified Work Program respect your "restrictions"?	❑	❑
5. Did the team members explore all possibilities in order to come with the most appropriate Modified Work Program for you?	❑	❑
6. Did the follow - up(s) during the program respond appropriately to any changes or concerns that arose?	❑	❑
7. Were your co-workers supportive of the program?	❑	❑
8. Was the length of the program appropriate?	❑	❑

If "NO" please explain if it was it too long or short?

9. Do you have any suggestions that may assist us in improving the program?

10. Please give an overall rating of the program (circle a number)

Poor Excellent
1 2 3 4 5 6 7 8 9 10

Signature Date (dd/mm/yy)

Work Capabilities

Employee:

Restrictions: in place from

- Lifting: Floor to waist:
- Lifting: Waist to shoulder:
- Bending:
- Twisting:
- Sitting:
- Standing:
- Pulling/Pushing:
- Reaching
- Repetitive actions:
- Other:

✓**Yes**: Modified in compliance with capabilities in collaboration with Supervisor/Manager

Direction to co-workers:
Bring any concerns to the supervisor.

Modified schedule:

Additional Notes:

To be reassessed on . Documentation from assessment to be forwarded to Organizational Health office. Next modified work meeting arranged for .

Agreement to above restrictions:

Signed by: _____ _____
Employee Supervisor/Manager

This information may be posted in the dept. with the written permission from the injured worker only.
Agreement to post in dept.
Employee_____ Date:_____

The BCHS works in partnership with the employee and unions to ensure a safe return to work.

Brant Community Healthcare System

PHYSICAL DEMANDS ANALYSIS

Worker's Name: (Surname) (Given Name)

Job Title:	**Date:**
Employer's Name:	Brant Community Healthcare System 200 Terrace Hill Street Brantford, ON 519-751-5544

Activities	**How Often? Please Comment**			
	Seldom (daily)	**Frequent (1/3-2/3 of workday)**	**Continuous (> 2/3 of workday)**	**Never**
Must lift or carry on occasion				
• Up to 10lbs/4.5kg				
• 20lbs/9.1kg				
• 50lbs/23+kg				
• 100+lbs/45+kg				
Must push/pull objects				
• 50lbs/23kg				
• 100lbs/45kg				
• 100+lbs/45+kg				
Must be able to climb ladders/poles				
Must use stairways				
Must operate self powered equipment				
Must drive a car				
Must drive a truck				
Must work standing				
Must work seated				
Must be able to walk				
• 50ft/15m				
• 300ft/90m				
• longer distances on even surfaces				
• longer distances on uneven surfaces				
Must be able to run				
Must be able to jump down				
Must be able to crawl				
Must be able to squat				
Must be able to kneel				
Must be able to look over both shoulders				
Must be able to work with arms above shoulders				
Must use both arms to full length				
Must do repetitive hand work				
Must use a keyboard				
Must use vibrating tools				
Must have full use of both hands				

Must be able to work in a very hot environment				
Must be able to work in cold/freezing environment				
Must work in confined spaces				
Must work at heights				
Must work in isolation (no co-workers present)				
Must wear respirator regularly				
Must wear respirator only in emergencies				
Other				

General
Comments:

_____
_____
_____
_____
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_____
_____

*Complete by:*_____ *Date:*_____