

WorkCover SA

# A guide to assessing and managing red and yellow flags for workers compensation patients

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## **Disclaimer**

The information produced by WorkCover Corporation of South Australia in this publication is correct at the time of printing and is provided as general information only. In utilising general information about workplace health and safety and injury management, the specific issues relevant to your workplace should always be considered. This publication is not intended as a substitute for the requirements of the *Workers Rehabilitation and Compensation Act 1986* or the *Occupational Health Safety and Welfare Act 1986*.

## Red flags

### Red flags include:

- features of Cauda Equina Syndrome\*
- severe worsening pain, especially at night or when lying down
- significant trauma
- weight loss, history of cancer, fever
- use of intravenous drugs or steroids
- your patient is over 50 years old.

At your initial assessment of your patient's condition it is critical to screen for 'red flags', which may indicate other physical or serious condition/s that may need to be considered or excluded. They are not always confined to the site of the pain eg, shoulder pain presentation of a heart attack. If red flags are present, appropriate investigation, diagnosis and management is required. Referral for specialist management should be considered.

### Red flags in general

(may indicate other physical conditions):

- Significant trauma
- Unintended weight loss
- History or possibility of cancer/malignancy
- Fever/chills/malaise
- Drug use eg, alcohol, narcotics (especially intravenous)
- Steroid use
- Patient is aged over 50 years
- Severe unremitting night-time pain
- Pain that gets worse lying down
- Bowel or bladder symptoms
- Increasing neurological deficit
- Pulmonary or neurovascular compromise
- Unexplained deformity/ swelling
- Dizziness and/or nausea
- Tinnitus, dysphagia, dysarthria, diplopia, drop-attacks ie, vertebro-basilar insufficiency

### **Other red flags in low back pain**

- Bowel or bladder symptoms, saddle area anaesthesia or paraesthesia

**Note: Cauda Equina is a medical emergency and requires urgent spinal surgeon attention. You must contact a neurosurgeon/spinal surgeon directly to ensure that immediate action is taken.**

Features of Cauda Equina Syndrome include some or all of the following:

- Back of thigh/buttock numbness, paraesthesia
- Saddle area numbness
- Urinary infection, incontinence or retention
- Faecal incontinence or retention
- Widespread neurological symptoms and signs in the lower limb including gait abnormality
- Lax anal sphincter

### **Other red flags in knee injuries**

- Neurovascular damage (high velocity injury, absent pulses, foot drop, multiple plane laxity)
- Extensor mechanism rupture (can't actively straight leg raise, palpable gap, change in height of patella)
- Bleeding disorders (eg, haemophilia)
- Knee giving way or locking

### **Other red flags in shoulder injuries**

- Significant or unexplained sensory/motor deficit not due to pain

If red flags are present, your patient should be referred for medical review or intervention, with the appropriate degree of urgency and investigations to the clinical situation.

### **Referrals and investigations**

If red flags are present, we recommend:

- all patients with symptoms of Cauda Equina Syndrome be referred immediately (hours count) for medical review. You must contact a neurosurgeon/spinal surgeon directly to ensure that immediate action is taken.
- patients with red flags be referred for medical review or intervention

- blood tests looking for infection or inflammation, radiology or bone scan are the most common tests and are indicated depending on the clinical situation.

Investigations in the first 4-6 weeks of an acute back pain episode are extremely unlikely to change clinical management, unless there are red flags.

Radiological investigations (X-rays and CT scans) carry the risk of potential harm from radiation-related effects and should be avoided if possible. MRI scans are not indicated for non-specific acute low back pain.

Many people without symptoms show abnormalities on X-rays, MRI<sup>1</sup> and CT scans. The chances of finding coincidental findings eg, disc bulges increase with age. It is important to correlate clinical findings with investigations before advising invasive treatment eg, surgery. Always consider if conservative management is possible even if this is for a limited period.

## Communication

### The claims management perspective

Contact the claims manager and explain the urgency, possible diagnosis and recommended treatment. This will enable the claims manager to make rapid and appropriate decisions in relation to the acceptance of liability and costs, where appropriate.

### You and the injured worker

It is important to appropriately explain urgency and possible diagnosis, investigations, treatment and compensation issues eg, where the red flag impacts the compensability of their claim in any way. Communication may involve the injured workers family, as appropriate.

### You and the employer

Where appropriate, communicate with the employer. Employers are keen to ensure they are providing appropriate duties that are not causing harm. They are often keen to support best and timeliest health outcomes for their employees regardless of the compensable nature of the condition.

### You and other health professionals

Communicate concerns to other health care providers involved, the urgency of the situation, the possible diagnosis and the feedback required. If you are a medical practitioner and you have referred your patient to the emergency department of a hospital, it is recommended contact is made directly with the emergency department medical officer.

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<sup>1</sup> In individuals who have never experienced back pain or sciatica, 65 per cent of people over 50 years of age will show abnormalities on plain X-rays, 33 per cent will show evidence of disc abnormality on MRI, with 20 per cent of people under 60 showing evidence of a herniated disc . Source: ACC New Zealand Acute Back Pain Guide, October 2004

## Yellow flags

Yellow flags are indicators of psychosocial, workplace and other factors that increase the risk of developing or perpetuating long-term disability and work loss associated with musculoskeletal conditions.

Identification of risk factors should lead to appropriate management of the individual, interpersonal, work and other relevant issues. Individual treatment usually includes cognitive and behavioural management and may also involve workplace liaison and intervention. Assessing the presence of yellow flag risk factors should lead to a clinical decision as to whether more detailed assessment is required, specific treatment/intervention is required and/or it may identify salient factors that can be subject of specific intervention. Strategies can be devised to address any systemic or workplace employer issues.

Yellow flags should be identified in the first six weeks of treatment wherever possible. Yellow flag risk factors can cover three areas:

### Personal, family and social issues

#### Issues around your patient's:

- high levels of pain
- attitudes and beliefs about their pain and dysfunction (avoidance, fear of re-injury, catastrophising)
- diagnosis and treatment
- emotional state eg, anxiety depression, grief
- family/ relationship difficulties

### Workplace and injured worker interaction

#### Issues around your patient's:

- work environment (physical, safety issues, past safety record)
- interpersonal life and relationships at work (support, reaction to injury, return to work)
- specific return to work issues (availability of duties, industrial pressures).

### Workers compensation, financial and legal

#### Workers compensation issues such as:

- a dispute about the injury or cause of injury
- a dispute about income maintenance payments
- financial hardship if no income maintenance
- claim lodgement delays
- lack of understanding of workers compensation eg, your patient or their employer misunderstands the compensation or rehabilitation process or the information provided.

## **Categories of risk**

### **Attitudes and beliefs about their pain and dysfunction**

- Belief that pain is harmful or disabling resulting in fear-avoidance behaviour eg, the development of guarding and fear of movement
- Belief that all pain must be abolished before attempting to return to work or normal activity
- Expectation of increased pain with activity or work, lack of ability to predict capability
- Catastrophising, thinking the worst, misinterpreting bodily symptoms
- Belief that pain is uncontrollable
- Passive attitude to rehabilitation

### **Behaviours**

- Use of extended rest, disproportionate 'downtime'
- Reduced activity level with significant withdrawal from activities of daily living
- Irregular participation or poor compliance with physical exercise, tendency for activities to be in a 'boom-bust' cycle
- Avoidance of normal activity and progressive substitution of lifestyle away from productive activity
- Report of extremely high intensity of pain eg, above 10, on a 0 to 10 Visual Analogue Scale (VAS)
- Excessive reliance on use of aids or appliances
- Sleep quality reduced since onset of pain
- High intake of alcohol or other substances (possibly as self-medication), with an increase since onset of pain
- Smoking
- Distrust/stubbornness
- Premorbid pessimism
- Somatisation

### **Compensation issues**

- Lack of financial incentive to return to work
- Delay in accessing income support and treatment cost, disputes over eligibility
- History of claim(s) due to other injuries or pain problems
- History of extended time off work due to injury or other pain problem (eg, more than 12 weeks)
- History of previous pain, with a previous claim(s) and time off work

- Previous experience of ineffective case management (eg absence of interest, perception of being treated punitively)

### **Diagnosis and treatment**

- Health professional sanctioning disability, not providing interventions that will improve function
- Experience of conflicting diagnoses or explanations for back pain, resulting in confusion
- Diagnostic language leading to catastrophising and fear (eg, fear of ending up in a wheelchair)
- Dramatisation of back pain by health professional producing dependency on treatments, and continuation of passive treatment
- Number of visits to a health professional in the last year (excluding the present episode of pain)
- Expectation of a 'techno-fix' eg, requests to treat the body as if it were a machine
- Lack of satisfaction with previous treatment for pain
- Higher cooperativeness during treatment
- Advice to withdraw from job

### **Emotions**

- Fear of increased pain with activity or work
- Depression (especially long-term low mood), loss of sense of enjoyment
- More irritable than usual
- Anxiety about and heightened awareness of body sensations (includes sympathetic nervous system arousal)
- Feeling under stress and unable to maintain a sense of control
- Presence of social anxiety, disinterested or withdrawal in social activity
- Feeling useless and not needed

### **Family**

- Over-protective partner/spouse, emphasising fear of harm or encouraging catastrophising (usually well-intentioned)
- Solicitous behaviour from spouse (eg, taking over tasks)
- Socially punitive responses from spouse (eg, ignoring, expressing frustration)
- Extent to which family members support any attempt to return to work
- Lack of support person to talk to about problems

## **Work**

- History of manual work, notably from the following occupational groups:
  - fishing, forestry and farming workers
  - construction, including carpenters and builders
  - nurses
  - truck drivers
  - labourers
- Work history, including patterns of frequent job changes, experiencing stress at work, job dissatisfaction, poor relationships with peers or supervisors, lack of vocational direction
- Belief that work is harmful, that it will do damage or be dangerous
- Unsupportive or unhappy current work environment
- Low educational background, low socio-economic status
- Job involves significant bio-mechanical demands, such as lifting, manual handling heavy items, extended sitting, extended standing, driving, vibration, maintenance of constrained or sustained postures, inflexible work schedule preventing appropriate breaks
- Job involves shift work or working 'unsociable hours'
- Minimal availability of selected duties and graduated return to work pathways, with unsatisfactory implementation of these
- Negative experience of workplace management of pain (eg, absence of a reporting system, discouragement to report, punitive response from supervisors and managers)
- Absence of interest from employer

## **How to identify a person at risk**

A patient may be considered to be 'at risk' if:

- there is a cluster of a few very salient factors
- there is a group of several less important factors that combine cumulatively.

The presence of risk factors should alert the clinician to the possibility of long-term problems and the need to prevent their development. Specialised psychological referrals should only be required for those with psychopathology, or for those who fail to respond to the simple management advocated in this guideline.

## **Highest risks**

- High unremitting pain, pain related distress, emotional aspects of pain
- Significantly reduced activity levels
- The expectation that passive, not active, treatments will help

- The belief that person has a serious injury
- Past long term pain difficulties
- The belief that pain is harmful or potentially disabling
- Evidence of fear avoidance behaviour, catastrophising
- Tendency to low mood and significant anxiety, avoidance of feared activities, distress

Questions during your subjective examination investigating your patient's beliefs and feelings towards the problem, home situation and influences from or on the workplace are an effective way of deepening rapport and giving you a first hand impression of how your patient is coping.

**Some questions for a patient (to be phrased in your own style) include:**

- History: Have you had time off work in the past for your injuries?
- What do you understand is the cause of your pain?
- What are you expecting will help you?
- When do you think you will return to work?
- How are your employer/ co-workers/ family responding to your condition?
- What are you doing to cope with your pain?
- Have you had similar injuries in the past, how long did these take to improve?
- Are you worried about not getting better?

A questionnaire may help you to identify risk issues relevant to the person.

Any full assessment **MUST** also consider situational and interpersonal issues - work support, relationships, barriers as well as other non-work issues (family, social).

There are two kinds of individual assessments:

1. Global screeners that give you an indication of risk eg, ALBPQ or Örebro. Further investigation of relevant issues needs to take place.
2. Specific instruments or procedures that target one or more of the key dimensions of risk eg, FABQ, DRAM. Interpretation of the specific instruments should be limited to an appropriately trained clinician. Generally a more comprehensive assessment would be undertaken by a psychologist or psychiatrist.

For more information, see [www.workcover.com/TREAT](http://www.workcover.com/TREAT)

**Suggested steps to help those patients 'at risk'**

The key first step is to listen to the concerns and, wherever possible, tailor the suggested steps below to address these concerns. Establishing good rapport makes your input more effective.

1. Provide a positive expectation that your patient will return to work and normal activity. This is true of the majority of injuries other than catastrophic injuries. Organise for regular expression of interest from the employer. If the problem persists beyond 2-4 weeks, provide a reality-based warning of what is going to be the likely outcome (eg, decreased fitness, impact on quality of life).
2. Be directive in scheduling regular reviews of progress. When conducting these reviews, shift the focus from symptoms (pain) to function (level of activity). Instead of asking "How much pain are you in?" ask "What have you been doing?". Maintain an interest in improvements, no matter how small. If another health professional is involved in treatment or management, specify a date for a progress report at the time of referral. Delays in resolving issues with an 'at risk' patient increases their disability or reduces the best possible outcome.
3. Keep your patient active and at work if at all possible, even for a small part of the day. This will help to maintain work habits and work relationships. Consider reasonable requests for selected duties and modifications to the workplace. After 4-6 weeks, if there is little improvement, review vocational options, job satisfaction, any barriers to return to work, including psychological distress. Once barriers to return to work have been identified, these need to be targeted and managed appropriately. Job dissatisfaction and distress cannot be treated with a physical modality.
4. Acknowledge difficulties with activities of daily living, but avoid the assumption that these indicate all activity or any work should be avoided. Arrange an activities of daily living (ADL) assessment if necessary.
5. Help to maintain positive cooperation between the individual, the employer, the claims and rehabilitation staff and other health professionals. Encourage collaboration wherever possible. Inadvertent support for a 'collusion' between 'them' and 'us' can be damaging to progress.
6. Make a concerted effort to communicate that having more time off work will reduce the likelihood of a successful return to work. In fact, longer periods off work result in reduced probability of ever returning to work and normal life activities. At the six-week point, consider suggesting modifications, seeking suitable duties with your patient's current employer.
7. Be alert for the presence of beliefs that your patient should stay off work until treatment has provided a 'total cure'. Watch out for expectations of simple 'techno' fixes'.
8. Promote self-management and self-responsibility. Encourage the development of self-efficacy to return to work. Be aware that developing self-efficacy will depend on incentives and feedback from treatment providers and others. If recovery only requires development of a skill such as adopting a new posture, then it is not likely to be affected by incentives and feedback. If recovery is hindered by fear of movement, fear of pain or fear of re-injury, these issues need to be specifically addressed.
9. Be prepared to ask for a second opinion (including 'independent clinical assessment') provided it does not result in a long and disabling delay. Use this option especially if it may help clarify that further diagnostic work up is unnecessary. Be prepared to say "I don't know" rather than provide elaborate explanations based on speculation.
10. Avoid suggesting (even inadvertently) that the person from a regular job may be able to work at home, or in their own business. This message, in effect, allows pain to become a behaviour that may produce a deactivation syndrome with all the negative consequences. Self-employment nearly always involves more hard work.
11. Encourage patients to recognise, from the earliest point, that pain can be controlled and managed so that a normal, active working life can be maintained. Provide encouragement for

'well' behaviours – including alternative ways of performing tasks, and focusing on transferable skills.

12. If the barriers to return to work are identified and are too complex to manage, you should consider referral for full psychosocial assessment and intervention by a psychologist or psychiatrist with appropriate interest, experience and skills, in cooperation with the physical treatment providers.

*Based on the NHMRC Guidelines and ACC New Zealand Acute Low Back Pain Guide, October 2004.*

## Communication

### The claims management perspective

Where identification of yellow flags results in other services, such as referral to psychologist or workplace intervention, the claims manager should be advised. The PMC should be updated with the appropriate information if there is referral to a psychologist for assessment or intervention.

Contact with the workplace may be crucial to positive treatment outcomes and needs to be undertaken in cooperation with the claims manager.

### You and the injured worker

Therapeutic rapport and fostering self-efficacy is essential to ensure successful treatment outcomes.

### You and the employer

Contact with the workplace may be crucial to positive treatment outcomes and needs to be undertaken in cooperation with the claims manager. It may also involve the other key parties eg, treatment providers.

### You and other health professionals

If you believe that referring your patient to other health providers will help your patient manage identified yellow flags, then this should be done early in the process.

It is important to keep in contact with other health providers who are treating your patient, so that everyone is kept up-to-date with progress and flags identified that may impact their management of the injury.

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