



**Department
of Health**

Safe Patient Handling Workgroup

Report to the Commissioner of Health

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H. University of Vermont Health Network – Champlain Valley Physicians Hospital (UVM-CVPH) Lift by Exception Program Materials:

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I. Western New York Council on Occupational Safety and Health (WNYCOSH) Training Materials:

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I. Introduction

New York State's Safe Patient Handling Law (Appendix A) was enacted as part of the 2014-15 budget. The law recognizes that lifting patients often can cause injury to both patients and health care workers and that safe patient handling programs can reduce the risk of injury, protect patient dignity, improve quality of care, increase consumer satisfaction and enhance caregiver morale. The law also recognizes that there is no single approach to safe patient handling and programs will differ based on patient needs, facility characteristics, equipment and other factors.

Accordingly, the law requires the Commissioner of Health to establish a workgroup of stakeholders for the purpose of identifying Safe Patient Handling (SPH) Program best practices, sample policies, and other resources, which would inform the Commissioner's dissemination of best practices to health care facilities. Health care facilities are required to establish SPH Committees by January 1, 2016, which in turn will establish facility-specific SPH Programs by January 1, 2017. The law further provides that the Department of Financial Services shall make rules establishing requirements for health care facilities to obtain a reduced workers' compensation rate for such programs.

II. New York's Safe Patient Handling Law

A. Summary of Statutory Provisions

Public Health Law (PHL) § 2997-g sets forth the legislative finding that the implementation of SPH policies by health care facilities is in the public's best interest and can produce a number of benefits:

- Reduced risk of injury to patients, leading to improvements in quality of care and quality of life;
- Reduced risk of injury to caregivers, increasing morale, job satisfaction, and professional longevity; and
- Return on investment to health care facilities through reduced workers' compensation medical and indemnity costs, reduced lost workdays, and improved recruitment and retention of caregivers.

1. Definitions

PHL § 2997-h defines several key terms, including "safe patient handling," which is defined to mean the use of engineering controls, lifting and transfer aids, or assistive devices by staff to perform the acts of lifting, transferring, and repositioning health care patients and residents.

2. Safe Patient Handling Workgroup Members

PHL § 2997-i requires the Commissioner of Health to establish a Safe Patient Handling Workgroup consisting, at a minimum, of:

- The Commissioner of Health or his or her designee;
- The Commissioner of Labor or his or her designee;
- Representatives of health care provider organizations;
- Representatives from employee organizations representing nurses and representatives from employee organizations representing direct care workers;
- Representatives of nurse executives;
- Representatives who are certified ergonomist evaluation specialists; and
- Representatives who have expertise in fields of discipline related to health care or occupational safety.

3. Safe Patient Handling Workgroup Charge

PHL § 2997-i provides that the SPH Workgroup shall:

- Review the existing safe patient handling programs or policies, including demonstration programs previously authorized by Chapter 738 of the Laws of 2005 and national data and results;
- Consult with any organization, educational institution, other government entity, agency, or person the Workgroup determines may be able to provide information and expertise on the development and implementation of safe patient handling programs;
- Identify or develop training materials for consideration by health care facilities; and
- Submit a report to the Commissioner by July 1, 2015 identifying safe patient handling program best practices, providing examples of sample policies, and identifying resources and tools useful for providers to meet the goals of safe patient handling policies.

4. Dissemination of Best Practices and Policies

PHL § 2997-j provides that on or before January 1, 2016, the Commissioner of Health shall disseminate best practices, examples of sample SPH policies, and other resources and tools to health care facilities, taking into consideration the recommendations of the SPH Workgroup.

5. Facility Safe Patient Handling Committees

PHL § 2997-k(1) provides that on or before January 1, 2016, each health care facility shall establish a SPH Committee for the purpose of designing and recommending the process for implementing a facility SPH Program.

6. Facility Safe Patient Handling Programs

PHL § 2997-k(2) provides that on or before January 1, 2017, each health care facility, in consultation with its SPH Committee, shall establish a SPH Program through which the facility will implement a SPH policy.

7. Consistency with Other Statutes

PHL § 2997-l provides the activities enumerated in PHL § 2997-k shall be undertaken by covered health care providers consistent with PHL § 2805-j and shall be deemed activities of such program as described in such section and any and all information attributable to such activities shall be subject to provisions of PHL § 2805-m and Education Law § 6527.

8. Workers' Compensation Rates

Insurance Law § 2304(j) provides that on or before July 1, 2016, the Department of Financial Services shall make rules establishing requirements for health care facilities to obtain a reduced workers' compensation rate for SPH Programs implemented under the law. The section further requires the Department to complete an evaluation of the results of the reduced rate, including changes in claim frequency and costs, and report to the Legislature on or before December 1, 2018, and again on or before December 1, 2020.

B. Key Dates

Pursuant to the legislation:

- July 1, 2015: The Workgroup submits its report to the Department of Health
- January 1, 2016: The Department of Health makes best practices and sample policies available to health care facilities
- January 1, 2016: Health care facilities establish SPH Committees
- July 1, 2016: The Department of Financial Services makes rules establishing requirements for health care facilities to obtain reduced workers' compensation rates
- January 1, 2017: Health care facilities establish SPH Programs
- December 1, 2018: The Department of Financial Services completes its evaluation and reports the results to the Legislature
- December 1, 2020: The Department of Financial Services reports again to the Legislature

III. Activities of the Safe Patient Handling Workgroup

The Department convened the SPH Workgroup, comprised of members as described in PHL § 2997-i (see Appendix B). Specifically, members include representatives from several state agencies, including the Department of Health, the Department of Labor, and the Department of Financial Services; representatives of: health care provider organizations; employee representatives; nurse executives; certified ergonomist evaluation specialists; and experts in fields related to health care or occupational safety.

Notably, a number of members have served as leaders or members of two entities that have for some time been engaged in the development of Safe Patient Handling (SPH) programs and practices: the Western New York Council on Occupational Safety and Health (WNYCOSH), which offers training in SPH program development, and the New York State Zero Lift Task Force, comprised of health care workers, administrators, patient advocates, union representatives and safety and health professionals, and including the Department of Labor and WNYCOSH members.

A number of Workgroup members also have implemented SPH programs at their own health care facilities and/or have served as consultants in assisting other facilities in doing so. At least one member was able to rely upon funding made available under the demonstration program enacted under Chapter 738 of the Laws of 2005 to advance its SPH efforts.

The Workgroup met regularly to consider the issues and provide guidance to the Department of Health on best practices and policies for SPH. Specifically, the Workgroup was charged with reviewing SPH programs and policies, among other things, and generating a report that:

- Identifies SPH program best practices;
- Provides examples of sample policies; and
- Identifies resources and tools useful for providers to develop safe patient handling policies and programs.

The meetings generally included presentations by Workgroup members who had been involved in the development of SPH curriculum and considerations and/or who had implemented SPH programs at their facilities. The presentations were enhanced by the engagement of other Workgroup members who asked follow-up questions and offered the benefit of their own experiences. In addition, the Workgroup identified and reviewed various SPH resources, including best practices from other States such as Washington State, Minnesota, New Jersey, and other entities such as the federal Veterans Administration system.

As a general matter, the Workgroup's discussions noted that the health care facilities covered by the SPH Law are diverse in terms of type, size, and geographic location, and may face differing challenges in considering how to comply with the legislative

requirements pertaining to facility-specific SPH committees and policies. In particular, the legislation encompasses facilities and providers across the continuum of care – including but not limited to general hospitals, nursing homes, ambulatory surgery centers, other diagnostic and treatment centers (clinics), as well as other settings including psychiatric units – which involve different environmental and regulatory challenges.

Moreover, the patients and residents impacted by the legislation includes diverse populations with different challenges. The Workgroup acknowledged that its guidance should reflect such considerations. In addition, the Workgroup noted that the best practices identified herein may also be of use in other settings not covered by the legislation. The guidance and best practices are recommendations to help facilities implement SPH programs and should not be construed as mandates.

IV. Safe Patient Handling Success Stories

As noted, several Workgroup members had successfully developed and implemented SPH Programs in their own facilities, which aided the Workgroup in identifying best practices as discussed in the next section. These programs benefited from funding made available under the demonstration program enacted under Chapter 738 of the Laws of 2005 or other grant funding and/or were integrated into facility construction projects, and ultimately recognized reduced numbers of incidents, contributing to decreased rates of absenteeism and turnover.

A. Kaleida Health

Kaleida Health's SPH Program was initially developed in 2004 and 2005 and implemented beginning November 2004 through March 2006 across the system, including five hospitals and four long term care facilities. During this period, 3,651 employees were trained (at a cost of \$325,000) and 1,718 beds were converted to SPH.

Kaleida Health initially invested \$2.5 million for equipment and training, including new electric motorized adjustable beds for all facilities. In the three year post-implementation period, a complete return on investment was realized. A 73 percent reduction in lost work days was achieved prior to completion of the full three-year period.

A 3.5 hour training is offered in orientation for all clinical new hires, meaning any employee that will be using the equipment, transferring, moving or handling a resident/patient, and is offered to employees as a refresher or prior to return to work after an injury. The class is live with a hands-on SPH equipment use lab.

Kaleida Health continues to invest in SPH. In December 2011, Kaleida Health invested \$806,192 in SPH equipment and design. The new 300-bed long term care facility, HighPointe on Michigan, has ceiling tracks in every resident room,

every tub room and all therapy rooms. Kaleida purchased 87 fixed-ceiling lift motors and ten portable ceiling lift motors, as well as all of the soft goods that go with using SPH lift equipment. Non-friction sheets and mechanical floor lifts (both full lifts and sit/stand lifts) continue to be used. In 2012, the first year after the move into the new facility, there were only 36 SPH lost work days at this site. Every year since, Kaleida Health has budgeted to purchase 20 ceiling lifts at this location.

During the period 2010 through 2012, injuries related to repositioning were reduced following the use of SPH videos created by the SPH department. The SPH department also recognized the need to re-educate in a live format all licensed and unlicensed healthcare workers on SPH injury prevention for the dependent patient while in bed.

Starting in 2013, Kaleida Health has been experiencing slippage in its control of employee injuries, primarily related to injuries that occur from caring for a dependent patient in bed. Tasks like repositioning, turning, bathing/dressing and incontinent care done while in bed are very physical if not done using the SPH soft goods that mechanically move a patient. Products like friction reducing devices, tri-turners, full body repositioning slings and limb straps, to name a few, are SPH soft goods that function to facilitate patient bed mobility.

Kaleida's goal is to roll out a live SPH education program focused on SPH soft goods at each site across the entire system to increase employee skill, knowledge and compliance/accountability. Kaleida Health believes the outcome will be improved injury prevention, improved patient experience and a decreased length of stay while achieving early mobility for its patients. An assessment tool and standard of practice will be used during training to clearly state Kaleida Health's expectations of the employees.

Kaleida Health offered the following overview of its injury data and SPH Program response:

- 2003: Kaleida Health experienced 9,883 system-wide SPH lost work days
- November 2004 through the first quarter of 2006: the SPH program was rolled out
- 2006: 3,268 system-wide SPH lost work days
- 2007: 2,453 system-wide SPH lost work days
- 2008: 2,180 system-wide SPH lost work days
- 2009: 3,122 system-wide SPH lost work days, an increase which was noted
- 2010: 1,775 system-wide SPH lost work days, reflecting an action plan involving the creation of videos by the SPH team created videos, which introduced SPH repositioning soft goods to decrease injuries related to care of the dependent patient in bed
- 2011: 803 system-wide SPH lost work days
- 2012: 865 system-wide SPH lost work days

- 2013: 1,117 system-wide SPH lost work days (increase in repositioning lost work days)
- 2014: 1,399 system-wide SPH lost work days (leading to development of a new system-wide action plan developed for live on site hands-on education on the SPH soft goods used for dependent patients in bed)

Kaleida Health emphasizes that SPH programs require constant monitoring, re-evaluation and re-investment. It is imperative that the injury data be drilled down and analyzed in order to focus SPH goals and injury prevention plans of improvement. Needed SPH processes and SPH equipment should be implemented based on the injury analysis in order to mitigate the risk of injury.

Kaleida Health's Safe Patient Handling Policy is annexed as Appendix C.

B. New York State Veterans Home at Batavia

In 2002, before the New York State Veterans Home at Batavia implemented the first phase of its SPH Program, there were 41 recorded incidents at the facility related to moving or repositioning residents. In 2005-06, the facility entered a second, more intense phase of its program. In 2014, after the SPH Program was established, there were 22 incidents, representing an overall 46 percent decrease in the number of incidents. During that same time period, the number of work days lost was reduced by 94 percent from 1,413 to 242.

Rates of turnover among certified nurses' aides (CNAs) and licensed practical nurses (LPNs) also decreased. In 2000, the turnover rate for CNAs was at 48 percent, and that number decreased to 8 percent by 2010. The turnover for LPNs in 2000 was 54 percent and steadily declined thereafter. By 2010, it was at 8 percent.

The key factor that contributed to the program's success was the incorporation of SPH into the facility's culture. The Veterans Home first began a SPH program in 2003; however, in 2006 significant improvements occurred after intensive training was provided to all staff in the facility. Achieving this required the engagement of an interdisciplinary team with strong management support. Further, equipment competency was included as part of staff performance evaluations and training on SPH was included as part of staff annual in-service requirements.

In addition, it was important that facility staff record both incidents and "near misses" to help determine whether retraining was necessary for particular employees and to evaluate the overall implementation of the SPH Program.

Support for the program was provided by the Civil Service Employees Association (CSEA). CSEA and the facility produced a video that describes the SPH program implemented at the Veterans Home at Batavia as well as the

positive outcomes that resulted. See <https://youtu.be/9EzW-Uzuj8Q?list=UUVQ8bgRj5IjjiAnzf17WRFg>.

The *New York State Veterans Home at Batavia Zero Lift Policy* is annexed as Appendix D.

C. North Shore-LIJ Staten Island University Hospital

In 2007, SPH Program implementation began at North Shore-LIJ Staten Island University Hospital (North Shore-LIJ SIUH) with the formation of an interdisciplinary Ergonomics/SPH committee which reports to the Environment of Care/Hospital Safety Committee. The SPH committee members were educated on SPH goals and objectives based on available SPH research findings and met at least monthly for the assessment, planning, implementation, maintenance and evaluation of the SPH Program. One co-chair of this committee is a non-managerial nurse who has SPH knowledge. SPH training was and is conducted primarily by in-house staff. No outside funding was received for the implementation of SPH program for the 714-bed acute care facility.

Key elements of North Shore-LIJ SIUH comprehensive SPH Program's success and culture change include: (1) senior leadership support; (2) direct care worker participation, including policy and procedure development, surveys, equipment selection and feedback; (3) SPH committee involvement with environmental and equipment assessment and equipment inventory/purchase; (4) unit/department manager participation in a survey to identify perceived barriers to SPH, as well as in SPH training and monthly SPH meetings; (5) incident investigation tool development with focus on accountability; and (6) during monthly SPH meetings, staff injury investigations are reviewed to evaluate and plan program improvement.

D. Heritage Ministries

The implementation of a SPH Program in the three facilities operating as the Heritage Ministries Rehab & Skilled Nursing Facilities demonstrated the importance of: (1) educating the administrative team; (2) adopting SPH into the entire organization; (3) convening a formal steering committee; and (4) introducing SPH concepts to residents and their families, who sometimes perceived the use of SPH equipment to mean that the health of their loved ones was deteriorating. To allay these concerns, Heritage Ministries provided resident counseling and open house meetings in each of their facilities to educate their residents and family members on what SPH is and how it can be beneficial.

From 1999-2007, Heritage Ministries had 151 claims solely due to lifting and turning injuries with an indemnity of \$2.05 million. In 2010, SPH was implemented, resulting in 28 claims and \$101,666 of indemnities that year. In 2014, there were only 10 claims, with an indemnity of \$154,753.

The *Heritage Ministries Safe Resident Handling Zero Lift Policy* is annexed as Appendix E.

E. Study of Upstate County Nursing Home

A seven-year study was conducted at a 525-bed county nursing home in upstate New York, which initiated a five-step ergonomics program and purchased mechanical lifting devices. The study concluded that there was significant reduction in the number of low-back injuries per 100 full-time nursing aides from 15.7 in the pre-intervention period (1992-1993) to 11.0 in the post-intervention period. The total number of lost workdays was significantly reduced from 1,476 per year before the intervention to 625 per year after the intervention. There was also a significant reduction in the average yearly cost from \$201,100 before the intervention to \$91,800 during the intervention. If the cost of back injury had continued at the same rate as documented in the two years before the intervention, the total cost for the back injury during the five-year intervention period would have been \$546,500. The cost for lifting equipment during the five-year intervention period was \$163,910.

See Mary O'Reilly Brophy, Linda Achimore & Joyce Moore-Dawson, *Reducing Incidence of Low-Back Injuries Reduces Cost*, (2001), AIHAJ - American Industrial Hygiene Association, 62:4, 508-511, DOI: 10.1080/15298660108984653 (annexed as Appendix F).

More success stories from facilities in other states are described on the website of the Occupational Safety and Health Administration of the United States Department of Labor (OSHA) at https://www.osha.gov/dsg/hospitals/documents/3.6_SPH_profiles_508.pdf. The common characteristics that emerged from these and other SPH implementation experiences helped inform the Workgroup's identification of best practices.

V. Safe Patient Handling Best Practices

Drawing from the overarching principles that emerged during Workgroup discussions, the Workgroup identified the following best practices. These best practices are designed to help facilities achieve the aforementioned benefits of SPH, while recognizing that such facilities are diverse in terms of type, size, patient population and geographic location, and may face differing challenges in implementing SPH.

A. Acknowledging the Potential Impact of SPH Programs

Injuries arising in connection with manual lifting are among the most frequent injuries in health care – and among the most expensive, with the most “lost time” occurring as a result. The SPH programs discussed by presenters and instituted

in places such as Kaleida Health, the New York State Veterans Home at Batavia, North Shore-LIJ Staten Island University Hospital and the Heritage Ministries nursing homes demonstrate that, consistent with legislative findings reflected in PHL § 2997-g, SPH can:

- Reduce injuries to patients/residents, improving their quality of care and quality of life, and preserve their dignity;
- Reduce injuries to caregivers/staff, improving their morale and the likelihood that they will continue working in their jobs; and
- Benefit health care facilities by reducing workers compensation costs and lost workdays and improving caregiver recruitment and retention.

Statistics on occupational injuries and illnesses, including musculoskeletal disorders such as sprains or strains resulting from repetitive motion, are available from the United States Department of Labor at <http://www.bls.gov/news.release/osh2.htm>.

B. Recognizing the Importance of Flexibility

As noted, health care facilities covered by the SPH Law are diverse in terms of type, size, patient population, and geographic location, and may face differing challenges in implementing SPH. Due to this diversity, implementation of SPH programs will vary to appropriately meet the needs of patients served. It is particularly important to recognize the need for flexibility in specialty inpatient settings and outpatient settings. The use of the hazard assessment and algorithms for specific populations or settings is instrumental to the appropriate design and implementation of SPH programs in each facility. Therefore, these best practices can be scaled to fit the needs of each facility.

C. Evaluating Financial Feasibility

In determining how to initiate a SPH Program in a financially feasible manner, facilities should explore available financial resources, such as grant programs offered by various sources, or means of minimizing costs such as leasing any needed SPH equipment rather than purchasing it. The Workgroup also noted that facilities should recognize that SPH programs potentially offer a return on investment achieved through reduced workers' compensation costs, reduced lost staff days, and improved retention that avoids the cost of retraining replacements.

D. Building Facility-Wide Commitment

The Workgroup noted that the benefits of SPH programs are attainable only if there is sufficient support from management and from all others within a facility. SPH should be woven into the facility's culture. Securing the commitment of a facility's administration is paramount. Additionally, engaging others is important

as well – including physicians, direct care workers who will use the equipment, the purchasing department responsible for procuring any SPH equipment, staff who work in marketing and communications, and personnel who would be responsible for cleaning and maintaining the equipment. Involving staff in the selection of the equipment is more likely to promote effective use. Further, it should be emphasized that the purchase, evaluation and maintenance of SPH equipment is ongoing in nature.

To assist in achieving facility-wide commitment to SPH and to promote its effective implementation, it is important to communicate the importance of SPH to all facility staff. In part, this may be accomplished by including various department representatives on the SPH Committee, through appropriate training and educational materials and facility newsletters and posters, and by incorporating SPH into in-service training.

Further, it is valuable to educate patients and residents and their family members and representatives on what SPH is and how it can be beneficial to patients/residents and staff. Informational materials that can be shared and discussed with these groups are one way to approach education.

E. Establishing the SPH Committee

Under PHL § 2997-k(1), a new SPH Committee may be convened, or the committee's functions may be carried out by an existing committee.

In either case, the Workgroup noted that program development will be needed. Further, there should be recognition that the work of the SPH Committee is ongoing in nature. The Committee should have a mix of direct health care worker/staff and managerial staff and, depending on the type of facility, may include others such as nursing leadership, EMS, emergency department, radiology, patient transportation, OT, PT, biomedical engineering and risk management.

1. Formation

Pursuant to PHL § 2997-k, on or before January 1, 2016, each health care facility must establish a SPH Committee, either by creating a new committee or assigning the relevant functions to an existing committee. However formed or designated, the Committee must meet the membership and leadership requirements of the SPH Law.

2. Purpose

Pursuant to PHL § 2997-k(1), the purpose of the SPH Committee is to design and recommend the process for implementing a SPH Program for the health care facility.

In identifying best practices, the Workgroup noted that the Committee is responsible for the development and periodic evaluation and revision of the facility's SPH Program, including the evaluation and selection of patient handling equipment as appropriate based on the facility environmental hazard assessment. The Committee should identify the resources and tools needed for activity at the bedside and in other key locations as appropriate, solve problems, evaluate the root cause of injuries and near misses related to lifting, repositioning and moving of patients or residents and determine where more effort is needed to accomplish Program goals. Understanding the injury trends and data of the facility is a critical component of the Committee's effort, as this information will provide a benchmark for measuring progress.

The focus of the Committee's work should be on changing the culture of the facility through education, positive problem-solving, effective trainings and refresher trainings, and engaging all management and frontline staff in support of the Program.

3. Membership

Pursuant to PHL § 2997-k(1), the SPH Committee must include individuals with expertise or experience that is relevant to SPH, including risk management, nursing, purchasing, or occupational safety and health, and in facilities where there are employee representatives, at least one shall be appointed on behalf of nurses and at least one shall be appointed on behalf of direct care workers. Fully one-half of the members of the Committee must be frontline non-managerial employees who provide direct care to patients. At least one non-managerial nurse and one non-managerial direct care worker must be on the Committee. In health care facilities where a resident council is established, and where feasible, at least one member of the Committee shall be a representative from the resident council.

The Workgroup recommended that each facility convene a collaborative interdisciplinary team which is dedicated to the development and implementation of the Program. With regard to facilities with employee representatives, the employee representative organization should choose who will serve on the Committee. With regard to the frontline non-managerial employees who provide direct care to patients, who must comprise at least half of the committee, these members generally should be direct care staff who perform tasks that put them at risk of injury if safe lifting or mobility technology is not used.

Additionally, the Workgroup noted that leadership support should serve on the Committee to ensure management engagement in, and commitment to, the SPH Program. Further, Committee members should be provided with training and education, when appropriate, using the most current information, on SPH technology and effectiveness, and the factors that contribute to success or failure of SPH Programs. Consideration should also be given to scheduling

so that adequate coverage is available for Committee members, allowing them to participate in meetings.

4. Leadership

Pursuant to PHL § 2997-k(1), the Committee shall have two co-chairs, with one from management and one frontline non-managerial nurse or direct care worker. The Workgroup highlighted that Committee leadership should have the support of the administration.

F. Implementing the SPH Program

Pursuant to PHL § 2997-k(2), on or before January 1, 2017, each health care facility, in consultation with the facility's SPH Committee, must establish a SPH Program, with several component parts as described herein.

As noted by the Workgroup, some facilities have found it helpful to assign a management level employee with responsibility to oversee their SPH Programs. Depending on the program oversight and functions of the SPH Committee, such individual should have the ability to monitor the Program and seek adjustments as necessary based on analysis of data and feedback from staff and patients. Facility meeting agendas will vary, but potential topics may include regular updates on the effectiveness of the SPH Program, using program monitoring tools, with program status presentations by the program leader and/or SPH Committee leaders.

Further, Workgroup members recognized that the SPH Program should be a component of a facility's budget, reflective of the program's size and scope as indicated by an environmental assessment.

1. Implementing a SPH Policy

As required under PHL § 2997-k(2)(a), the facility must implement a SPH Policy, taking into account the type of facility and its services, patient populations and care plans, types of caregivers, and physical environment, for all shifts and units of the health care facility. Implementation of the SPH Policy may be phased in.

In identifying best practices, the Workgroup noted that in general, when appropriate given a facility's size and patient population, a facility's SPH Policy should establish the expectation that frontline workers will use SPH practices when transferring or repositioning patients. The Policy further requires that where appropriate, management should provide the equipment and resources to make it unnecessary to manually lift patients. The Policy further should explain the role of the SPH Committee in implementing, monitoring, evaluating and improving the SPH Program.

Finally, a SPH policy should establish the protocols for assessing patients and procedures to be followed when using mechanical lifts and other devices to transfer or reposition patients. All staff should be familiar with the SPH policy and receive training on how to carry out their tasks safely by following the organization's policy guidelines. Failure to identify root causes, examine needs for appropriate improvements, and opportunities for improvement should be written in a policy. An important part of the policy is to assign roles and responsibilities for the SPH program to key players: employees, management, and the SPH Committee.

As reflected in the SPH Law and reiterated by the Workgroup, identification of these policies is intended to give facilities assistance in developing their own policies. They are free to adapt them as necessary or develop their own policies in conformance with the law. Examples of policies are available in Appendices C, D, E, G and H.

The Workgroup recommended that a facility's SPH Policy be established as a clearly written plan, approved and signed by the facility's chief executive officer, which is disseminated to all staff engaged in or supervising patient care or activities. The facility also should make its SPH Policy available to employee representatives, patients or their health proxies or family caregivers upon request.

2. Conducting a Patient Handling Environmental Hazard Assessment

As set forth in PHL § 2997-k(2)(b), a facility's SPH Program should include a patient handling hazard assessment which should consider such variables as patient-handling tasks, types of nursing units, patient populations and the physical environment of patient care areas.

The Workgroup noted that the environmental hazard assessment, which should be conducted by the SPH Committee, should be consistent with the Policy and consider the need for appropriate SPH equipment and aids/supplies, taking into account:

- The type and size of the facility, the services offered and the patient population;
- Typical patient type and care needs for each unit;
- The categories of staff and types of patients who experience injuries and near misses related to patient handling tasks;
- When and where such injuries are occurring (department, unit, shift);
- The number and leading types of injuries and disorders among healthcare workers related to patient handling tasks;
- Types of tasks that are causing injury or are difficult or painful to perform, including, at a minimum lifting, repositioning, and transferring patients;

- Any specific equipment associated with employee or patient injuries;
- Any patient handling equipment currently in use, any problems associated with such use, and the accessibility of such equipment; and
- Potential needs for accessibility, storage, and maintenance of equipment.

See the OSHA Administration Log of Work-Related Injuries and Illnesses (OSHA Forms 300 and 301), <https://www.osha.gov/recordkeeping/RKforms.html>, and information provided in the appendices for resources available to assist in this assessment.

3. Developing a Process to Identify Appropriate Use of SPH Policy

PHL § 2997-k(2)(c) provides that a facility's SPH Program should include a process to identify the appropriate use of the SPH Policy based on the patient/resident's physical and medical condition and the availability of SPH equipment. The SPH Policy must include a means to address circumstances under which it would be contraindicated based on a patient's physical, medical, weight-bearing, cognitive and/or rehabilitative status to use lifting or transfer aids or assistive devices for particular patients.

The Workgroup recommended as a best practice that SPH Programs include a clearly communicated patient assessment process, which generally provides for completion of an assessment of each patient or resident's functional mobility before the individual is provided care, transferred or repositioned. A patient or resident assessment tool, sometimes referred to as an "algorithm" or a "decision tree," should be used to guide the health care worker in determining how to be responsive to the patient or resident's functional mobility needs. The individual may be able to move on his or her own or may need appropriate SPH equipment. SPH equipment ranges from a full mechanical lift, a sit/stand mechanical lift, and one person transfer with gait belt. See *WNYCOSH Safe Patient Handling Sample Policy* (Appendix G).

The SPH Policy should identify when the mobility needs of patients and residents should be assessed, which should include, at a minimum, an assessment at the time of initial entry to the facility and whenever a change occurs in a patient's condition. There should also be a clear recognition as to where and how the SPH plan for a particular patient or resident is documented, which should include at a minimum the care plan for that individual.

If the patient's capacity allows independent mobility, the staff may not need to use assistive equipment or aids/supplies. Where assistive equipment or aids/supplies are needed, one type of technology may be better suited to one patient than another. The policy should include these assessments. Patient

education and orientation to assistive technology is also important and should be included in the policy.

Moreover, it should be emphasized that the results of the patient assessment must be communicated to everyone who may be responsible for assisting that patient's mobility, and there should be an identified mechanism for alerting staff when there is a change in the SPH care plan for an individual patient.

In addition, SPH equipment should be appropriately accessible and consideration should be given to needs for appropriate storage. For example, the facility's hazard assessment should identify which equipment should be available in a more timely manner, depending on expected frequency of use.

Examples of algorithms are available, such as those used in the federal VA system, <http://www.tampavaref.org/safe-patient-handling.htm>, and the decision tree included in the *WNYCOSH Safe Patient Handling Sample Policy* (Appendix G). Another example is the *University of Vermont Health Network – Champlain Valley Physicians Hospital Lift by Exception Program Patient Assessment Tool* (included in Appendix H).

4. Providing Training and Education

PHL § 2997-k(2)(d) provides that a facility's SPH Program should require initial and on-going yearly training and education on SPH techniques and equipment for current employees and new hires, and establish procedures to ensure that retraining for those found to be deficient is provided as needed.

Training should be required for all staff that move or transfer resident/patients; as well as for those that supervise them. The schedule for training should include arranging for coverage for the staff member being trained and should cover all shifts. Workers should receive interactive training which gives them opportunities to ask questions and participate in problem solving specific challenging transfer and movement scenarios.

For frontline workers, SPH educational programs should include hands-on training with equipment, conducted in the environment where the equipment is going to be used. The trainer should be experienced in real actual movements and transfers, and should be able to assess patients and be able to put their hands on the patients. The hands-on portion of the training should cover all patient movement tasks with all the SPH equipment that is used in a facility.

For licensed workers, the training should cover the above-mentioned hands-on SPH lab training as well as training in patient functional mobility assessment. An assessment tool should be used to help train the licensed

worker in assessing an individual and then assigning the correct mode of patient movement based on specific patient functional mobility criteria.

Facilities may consider retaining an outside consultant to assist in developing educational programs and/or access resources referenced in the appendices. WNYCOSH has made training materials available which can be used by facilities in their current form or modified as appropriate (attached hereto as Appendix I).

Throughout the Workgroup, there was a strong emphasis on creating a positive business case that will motivate staff and care givers to utilize SPH techniques and equipment.

5. Establishing Review and Evaluation Processes

Pursuant to PHL § 2997-k(2)(e) and (f), a facility's SPH Program should include establishment and use of a process for incident investigation and post-investigation review and the performance of annual program evaluations.

Staff should be advised of the importance of tracking both incidents that result in injury and "near misses" for patients and residents as well as employees. A "near miss" means an unplanned event that did not result in injury, illness or damage, but where, given even a slight alteration in circumstances or actions, an injury, illness or damage could have occurred. The risk may have been to the patient, a health care worker or a bystander.

Review of incidents and near misses will allow review by the SPH Committee, permitting the facility to track the efficiency of its SPH program and determine where changes need to be made or staff needs to be re-educated. In reporting such incidents, the specific best practice or policy involved, and the type of injury to the patient/resident or staff/caregiver, if any, should be identified. It should be noted that offering incentives for workplace safety may be well-intentioned, but there are better ways to encourage safe work practices. These include incentives that promote worker participation in safety-related activities, such as identifying hazards or participating in investigations of injuries, incidents, are "near misses". Retaliation for notifying the facility's management of incidents or near misses is not permitted.

The annual performance evaluation should be designed to determine the effectiveness of the SPH Program, with the results of the evaluation reported to the Committee. In particular, the evaluation shall determine the extent to which implementation of the Program has resulted in a reduction in the risk of injury to patients, musculoskeletal disorder claims and days of lost work attributable to musculoskeletal disorders by employees caused by patient handling, and include recommendations to increase the Program's effectiveness.

6. Including SPH Considerations in Renovation Plans

PHL § 2997-k(2)(g) provides that when developing architectural plans for constructing or remodeling a health care facility or a unit of a health care facility in which patient handling and movement occurs, the facility should consider the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment at a later date.

The Workgroup acknowledged the importance of undertaking such considerations.

7. Including a Process for Good Faith Employee Refusals

As set forth in PHL § 2997-k(2)(h), the SPH Program developed by the facility should include a process by which an employee may refuse to perform or be involved in patient handling or movement if the employee reasonably believes in good faith it will expose a patient or health care facility employee to an unacceptable risk of injury. The law provides that such process shall require that the nurse or direct care worker/staff make a good faith effort to ensure patient safety and bring the matter to the attention of the facility in a timely manner.

The Workgroup noted that the American Nurses Association has recommended that a refusal should be made in writing and the refusal procedure should describe the process for resolving a noted hazard. SPH materials offered by Washington State include a sample model of a right to refuse policy at

http://www.washingtonsafepatienthandling.org/images/best_practices/SPH_BPGuide_Appendices.pdf.

VI. Safe Patient Handling Policy Examples

The Workgroup identified several examples of policies currently in use for general hospitals and nursing homes. None have yet been identified for clinics. The policies referenced herein are intended to serve as a resource for facilities to assist them in developing a SPH Policy and can be modified as appropriate. Facilities also are free to develop their own policies, consistent with the SPH Law.

A. Kaleida Health

The *Kaleida Health Safe Patient Handling Policy* is attached as Appendix C.

B. Zero-Lift Policy for the New York State Veterans Home at Batavia

The *New York State Veterans Home at Batavia Zero Lift Policy* is attached as Appendix D.

C. Heritage Ministries Safe Resident Handling Zero Lift Policy

The *Heritage Ministries Safe Resident Handling Zero Lift Policy*, used by the three nursing homes of the Heritage Ministries, is attached as Appendix E.

D. WNYCOSH Safe Patient Handling Sample Policy

The *WNYCOSH Safe Patient Handling Sample Policy*, made available by the Western New York Council on Occupational Safety (WNYCOSH), is attached as Appendix G.

E. University of Vermont Health Network – Champlain Valley Physicians Hospital Lift By Exception Policy

The policy for the Lift By Exception Program at the University of Vermont Health Network – Champlain Valley Physicians Hospital, together with related materials, is annexed as Appendix H.

VII. Resources and Tools

A. General SPH Information

1. Occupational Safety and Health Administration (OSHA) of the United States Department of Labor - SPH Information:
https://www.osha.gov/dsg/hospitals/patient_handling.html
2. New York State Zero Lift Task Force – SPH Information:
<http://www.zeroliftforny.org>
3. WNYCOSH - SPH Information:
<http://www.wnycosh.org/safe-patient-handling>

B. SPH Equipment and Techniques

1. New York State Department of Labor (NYS DOL) - SPH Techniques (including photos and videos portraying use of SPH equipment):
<http://labor.ny.gov/workerprotection/safetyhealth/safe-patient-handling.shtm>
2. OSHA - SPH Equipment:
https://www.osha.gov/dsg/hospitals/patient_handling_equipment.html

3. OSHA - SPH Self-Assessment Tool:
https://www.osha.gov/dsg/hospitals/documents/3.8_SPH_self-assessment_508.pdf
4. American Nurses Association (ANA) - SPH and Mobility Information:
<http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/SafePatient>
5. ANA - Current Topics in Safe Patient Handling and Mobility:
http://www.americannursetoday.com/wp-content/uploads/2014/07/ant9-Patient-Handling-Supplement-821a_LOW.pdf
6. Association of Safe Patient Handling Professionals – SPH Information:
<http://www.asphp.org>
7. National Institute for Occupational Safety and Health (NIOSH) of the United States Centers for Disease Control and Prevention (CDC) – ANA “Handle with Care” Campaign:
<http://www.cdc.gov/niosh/docs/2009-127/swf/safe11093.swf>
8. NIOSH - Web-Based Training for Nursing Students on SPH Fundamentals:
<http://www.cdc.gov/niosh/docs/2009-127/safe.html>
9. NIOSH – Safe Patient Handling Training for Nursing Schools:
<http://www.cdc.gov/niosh/docs/2009-127/pdfs/2009-127.pdf>
10. OSHA – Information on Health Care Ergonomics:
<https://www.osha.gov/SLTC/etools/hospital/hazards/ergo/ergo.html>
11. OSHA - Inspection Guidance for Inpatient Health Settings:
https://www.osha.gov/dep/enforcement/inpatient_insp_06252015.html
12. Tampa VA – *Safe Patient Handling Equipment Challenges in Inpatient Psychiatric Units: Design Recommendations and Potential Solutions*, Heather M. Monaghan, MHSc, RN (June 2011):
http://www.tampavaref.org/safe-patient-handling/Psychiatry_EquipmentRedesign.pdf
13. Tampa VA – *Safe Patient Handling Guidebook for Facility Champions/Coordinators*:
http://www.tampavaref.org/safe-patient-handling/SPHFacCoor_Guidebook.pdf
14. Nursing World – *Advancing the Science and Technology of Progressive Mobility* (explaining terminology change to Safe Patient Handling and “Mobility”):

<http://nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/SafePatient/Advancing-the-Science-and-Technology-of-Progressive-Mobility.PDF>

15. American Physical Therapy Association – SPH Information:
<http://www.apta.org/SafePatientHandling>
16. Rehabilitation Nursing – *Myths and Facts about Safe Patient Handling in Rehabilitation* (Nelson, Harwood, Tracey, Dunn)
<http://www.rehabnurse.org/uploads/files/pdf/sphchptr3.pdf>
17. AHOP - *Beyond Getting Started: A Resource Guide for Implementing a Safe Patients Handling Program in the Acute Care Setting*:
https://aohp.org/aohp/Portals/0/Documents/ToolsForYourWork/free_publications/Beyond%20Getting%20Started%20Safe%20Patient%20Handling%20-%20May%202014.pdf.pdf
18. *A Close Look at the Pivot Transfer*, Paula Pless
<http://www.zeroliftforny.org/a-close-look-at-the-pivot-transfer>

C. Existing SPH Programs

1. Western New York State Veterans Home at Batavia/CSEA – Video:
<https://www.youtube.com/watch?v=9EzW-Uzuj8Q&list=UUVQ8bgRj5ljjjAnzf17WRFg&index=5&feature=plcp>

D. Grant Funding Information

1. NYS DOL - NYS Code Rule 60 Incentive Program under the Workplace Safety and Loss Prevention and Incentive Program:
<https://labor.ny.gov/workerprotection/safetyhealth/Links/CR%2060%20Incentive%20Pg.shtm>
2. OSHA Susan Harwood Training Grant Program:
<https://www.osha.gov/dte/sharwood>
3. NYS & CSEA Partnership for Education and Training:
<http://www.nyscseapartnership.org>
4. Governor's Office of Employee Relations and Public Employees Federation – Workforce Initiatives Grant Program:
http://www.goer.ny.gov/assets/documents/Training_Development/2011-2015_WFI_Grant_Guidelines.pdf
5. Public Employees Federation Safety and Health Initiatives Program
http://www.pef.org/pef_files/docs/hs/SHIP_Grant_Application_2014-2015.pdf

E. SPH Information from Other States

1. New Jersey – SPH Law:
http://www.njleg.state.nj.us/2006/Bills/S2000/1758_11.pdf
2. New Jersey – SPH Regulations:
http://www.hpae.org/political/health_safety/njregssph
3. Minnesota Hospital Association– SPH Information:
<http://www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/patient-handling>
4. Washington Safe Patient Handling Steering Committee – *Safe Patient Handling Programs, A Best Practices Guide for Washington Hospitals*:
<http://lni.wa.gov/safety/GrantsPartnerships/SHIP/awardees/ServicesEmployeesInternationalUnion1199/SafePatientHandlingProgramGuide.pdf>
5. Washington Safe Patient Handling Steering Committee – Best Practices:
<http://www.washingtonsafepatienthandling.org/bestpractices.html>

F. Occupational Injuries and Illnesses

1. United States Department of Labor, Bureau of Labor Statistics – Statistics on occupational injuries and illnesses:
<http://www.bls.gov/news.release/osh2.htm>.
2. OSHA Administration Log of Work-Related Injuries and Illnesses (OSHA Forms 300 and 301):
<https://www.osha.gov/recordkeeping/RKforms.html>
3. PESH SH 900 Injury and Illness Log:
<https://www.labor.state.ny.us/workerprotection/safetyhealth/PDFs/PESH/sh900.pdf>
<https://labor.ny.gov/formsdocs/wp/sh900.pdf>
4. 12 NYCRR Part 801:
<https://labor.ny.gov/workerprotection/safetyhealth/Part801submittal5.shtm>

G. Educational Opportunities/Conferences

1. 7th Annual SPH Conference (October 28 and 29, 2015):
<http://www.zeroliftforny.org/conference-description>
<http://www.zeroliftforny.org/session-summaries>

H. Miscellaneous

1. Public Citizen: *Uplifting an Industry? State-Based Safe Patient Handling Laws Have Yielded Improvements But Are Not Adequately Protecting Health Care Workers*:
<http://www.citizen.org/documents/state-health-care-worker-safety-laws-uplifting-industry.pdf>

APPENDIX A

New York State's Safe Patient Handling Law

Public Health Law Provisions

Title 1-A of Article 29-D, added to the Public Health Law by Chapter 60 of the Laws of 2014, Part A, § 20:

TITLE 1-A SAFE PATIENT HANDLING

Section 2997-g. Legislative intent.

2997-h. Definitions.

2997-i. Safe patient handling workgroup.

2997-j. Dissemination of best practices, examples of sample safe patient handling policies and other resources and tools.

2997-k. Safe patient handling committees; programs.

2997-l. Activities.

§ 2997-g. Legislative intent. The legislature hereby finds and declares that it is in the public interest for health care facilities to implement safe patient handling policies. There are many benefits that can be derived from safe patient handling programs. Patients benefit through improved quality of care and quality of life by reducing the risk of injury. Caregivers also benefit from the reduced risk of career ending and debilitating injuries leading to increased morale, improved job satisfaction, and longevity in the profession. Health care facilities may realize a return on their investment through reduced workers' compensation medical and indemnity costs, reduced lost workdays, and improved recruitment and retention of caregivers. All of this could lead to fiscal improvement in health care in New York State.

§ 2997-h. Definitions. For the purposes of this title:

1. "Health care facility" shall mean general hospitals, residential health care facilities, diagnostic and treatment centers, and clinics licensed pursuant to article twenty-eight of this chapter, facilities which provide health care services and are licensed or operated pursuant to article eight of the education law, article nineteen-G of the executive law or the correction law, and hospitals and schools defined in section 1.03 of the mental hygiene law.

2. "Nurse" shall mean a registered professional nurse or a licensed practical nurse as defined by article one hundred thirty-nine of the education law.

3. "Direct care worker" shall mean any employee of a health care facility who is responsible for patient handling or patient assessment as a regular or incidental part of his or her employment, including any licensed or unlicensed health care worker.

New York State's Safe Patient Handling Law (continued)

4. "Employee representative" shall mean the recognized or certified collective bargaining agent for nurses or direct care workers of a health care facility.

5. "Safe patient handling" shall mean the use of engineering controls, lifting and transfer aids, or assistive devices by staff to perform the acts of lifting, transferring and repositioning health care patients and residents.

6. "Musculoskeletal disorders" shall mean conditions that involve the nerves, tendons, muscles and supporting structures of the body.

§ 2997-i. Safe patient handling workgroup. 1. The commissioner shall establish a safe patient handling workgroup (referred to in this section as the "workgroup") within the department. The workgroup shall consist of, at the minimum, the commissioner or his or her designee; the commissioner of labor or his or her designee; representatives of health care provider organizations; representatives from employee organizations representing nurses and representatives from employee organizations representing direct care workers; representatives of nurse executives; representatives who are certified ergonomist evaluation specialists; and representatives who have expertise in fields of discipline related to health care or occupational safety.

2. Workgroup members shall receive no compensation for their services as members of the workgroup, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties.

3. The workgroup shall be established no later than January first, two thousand fifteen.

4. The workgroup shall:

(a) Review existing safe patient handling programs or policies, including demonstration programs previously authorized by chapter seven hundred thirty-eight of the laws of two thousand five and national data and results;

(b) Consult with any organization, educational institution, other government entity or agency or person that the workgroup determines may be able to provide information and expertise on the development and implementation of safe patient handling programs;

(c) Identify or develop training materials for consideration by health care facilities; and

(d) Submit a report to the commissioner by July first, two thousand fifteen identifying safe patient handling program best practices, providing examples of sample policies, and identifying resources and tools useful for providers to meet the goals of safe patient handling policies.

5. All state departments, commissions, agencies, and public authorities shall provide the workgroup with any reasonably requested assistance or advice in a timely manner.

New York State's Safe Patient Handling Law (continued)

§ 2997-j. Dissemination of best practices, examples of sample safe patient handling policies and other resources and tools. The commissioner shall disseminate best practices, examples of sample safe patient handling policies, and other resources and tools to health care facilities, taking into consideration the recommendations of the safe patient handling workgroup. Such best practices, examples of sample safe patient handling policies, and other resources and tools shall be made available to all facilities covered by this title on or before January first, two thousand sixteen.

§ 2997-k. Safe patient handling committees; programs. 1. On or before January first, two thousand sixteen, each health care facility shall establish a safe patient handling committee (referred to in this section as a "committee" except where the context clearly requires otherwise) either by creating a new committee or assigning the functions of a safe patient handling committee to an existing committee, including but not limited to a safety committee or quality assurance committee, or subcommittee thereof. The purpose of a committee is to design and recommend the process for implementing a safe patient handling program for the health care facility. The committee shall include individuals with expertise or experience that is relevant to safe patient handling, including risk management, nursing, purchasing, or occupational safety and health, and in facilities where there are employee representatives, at least one shall be appointed on behalf of nurses and at least one shall be appointed on behalf of direct care workers. One half of the members of the committee shall be frontline non-managerial employees who provide direct care to patients. At least one non-managerial nurse and one non-managerial direct care worker shall be on the safe patient handling committee. In health care facilities where a resident council is established, and where feasible, at least one member of the safe patient handling committee shall be a representative from the resident council. The committee shall have two co-chairs with one from management and one frontline non-managerial nurse or direct care worker.

2. On or before January first, two thousand seventeen, each health care facility, in consultation with the committee, shall establish a safe patient handling program. As part of this program, a health care facility shall:

(a) implement a safe patient handling policy, considering the elements of the sample safe patient handling policies and best practices disseminated by the commissioner, as well as the type of facility and its services, patient populations and care plans, types of caregivers, and physical environment, for all shifts and units of the health care facility. Implementation of the safe patient handling policy may be phased-in;

(b) conduct a patient handling hazard assessment. This assessment should consider such variables as patient-handling tasks, types of nursing units, patient populations and the physical environment of patient care areas;

(c) develop a process to identify the appropriate use of the safe patient handling policy based on the patient's physical and medical condition and the availability of safe patient handling equipment. The policy shall include a means to address circumstances under which it would be contraindicated based on a patient's physical, medical, weight-

New York State's Safe Patient Handling Law (continued)

bearing, cognitive and/or rehabilitative status to use lifting or transfer aids or assistive devices for particular patients;

(d) provide initial and on-going yearly training and education on safe patient handling for current employees and new hires, and establish procedures to ensure that retraining for those found to be deficient is provided as needed;

(e) set up and utilize a process for incident investigation and post-investigation review which may include a plan of correction and implementation of controls;

(f) conduct an annual performance evaluation of the program to determine its effectiveness, with the results of the evaluation reported to the committee. The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in the risk of injury to patients, musculoskeletal disorder claims and days of lost work attributable to musculoskeletal disorders by employees caused by patient handling, and include recommendations to increase the program's effectiveness;

(g) when developing architectural plans for constructing or remodeling a health care facility or a unit of a health care facility in which patient handling and movement occurs, consider the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment at a later date; and

(h) develop a process by which employees may refuse to perform or be involved in patient handling or movement that the employee reasonably believes in good faith will expose a patient or health care facility employee to an unacceptable risk of injury. Such process shall require that the nurse or direct care worker make a good faith effort to ensure patient safety and bring the matter to the attention of the facility in a timely manner. A health care facility employee who reasonably and in good faith follows the process developed by the health care facility in accordance with this subdivision shall not be the subject of disciplinary action by the health care facility for the refusal to perform or be involved in the patient handling or movement.

§ 2997-l. Activities. The activities enumerated in section twenty-nine hundred ninety-seven-k of this title shall be undertaken consistent with section twenty-eight hundred five-j of this chapter by a covered health care provider and shall be deemed activities of such program as described in such section and any and all information attributable to such activities shall be subject to provisions of section twenty-eight hundred five-m of this chapter and section sixty-five hundred twenty-seven of the education law.

Insurance Law Provisions

Subsection (j) of Insurance Law § 2304, added by Chapter 60 of the Laws of 2014, Part A, § 21:

(j)(1) On or before July first, two thousand sixteen, the department shall make rules establishing requirements for health care facilities to obtain a reduced worker's

New York State's Safe Patient Handling Law (continued)

compensation rate for safe patient handling programs implemented pursuant to title one-A of article twenty-nine-A of the public health law.

(2) The department shall complete an evaluation of the results of the reduced rate, including changes in claim frequency and costs, and shall report to the appropriate committees of the legislature on or before December first, two thousand eighteen and again on or before December first, two thousand twenty.

APPENDIX B

Safe Patient Handling Workgroup Members

- Healthcare Association of New York State (HANYS)
 - Kathy Ciccone, Vice President, Quality and Research Initiatives
 - Mary Therriault, RN, MSN, Senior Director of Quality
- Greater New York Hospital Association (GNYHA)
 - Lorraine Ryan, Senior Vice President, Legal, Regulatory and Professional Affairs
- Iroquois Healthcare Alliance
 - Allan Filler, Senior Director of Policy Development
- Community Health Care Association of New York State (CHCANYS)
 - Beverly Grossman, Senior Policy Director
 - Lacey Clarke, Policy Analyst
- LeadingAge New York
 - Elliott Frost, Director of ProCare/Senior Policy Analyst
- New York State Health Facilities Association (NYSHFA)
 - Nancy Leveille, Senior Director, Member Operational Support
- New York State Association of Ambulatory Surgery Centers (NYSAASC)
 - Thomas J. Faith, President
- IPRO ESRD Network of New York
 - Susan Caponi, MBA, BSN, RN, CPHQ, Chief Executive Officer, ESRD Program
- Cerebral Palsy Association of New York State (CP of NYS)
 - Debra A. Williams, Vice President, Reimbursement & Regulatory Compliance
 - Gary Grimaldi, PhD., OT/L, ATP, Director, Rehabilitation Services
- Family Planning Advocates of New York State (FPA)
 - Ronnie Pawelko, General Counsel
- Kaleida Health System
 - Paula Pless, CEES, SPH & Movement, Injury Prevention Specialist, Workforce Safety
 - Robert Guest, MSPT, Safe Patient Handling Program Coordinator
- North Shore LIJ - Staten Island University Hospital
 - Kelly Moed, MSN, RN-BC, CSPHP, Staff Development Instructor and Co-Chair SPH/Ergonomics Committee, North Shore LIJ Staten Island University Hospital

Safe Patient Handling Workgroup Members (continued)

- University of Rochester Medical Center
 - Anne Schmidlin, MS, Industrial Hygienist, Occupational and Safety Specialist
- University of Rochester Medical Center
 - Laura Caruso, RN, Employee Health Program Manager, Occupational and Environment
- The Heritage Ministries, Heritage Park Rehab & Skilled Nursing
 - Mark Constantino, OTR/L, Director of Rehabilitation
- Lourdes Hospital
 - Toni Lehr, MSM, BA, RN COHN/CM, Director, Occupational Health Services
- State University of New York, University at Albany, Environmental Health Sciences
 - Mary O'Reilly, PhD, CIH, CPE, Adjunct Associate Professor
- Consultant
 - Linda Achimore, CSP, ARM
- New Yorkers for Patient and Family Empowerment
 - Suzanne Y. Mattei, Esq., Executive Director
- Public Employees Federation (PEF)
 - Gale Baptiste-Graham, Specialty Nurse at SUNY Downstate Brooklyn
- Communication Workers of America 1168 (CWA)
 - Denise Abbott, RN, Health & Safety Director
- NYSUT (New York State United Teacher) and UFT (United Federation of Teachers and Federation of Nurses/UFT)
 - Howard Sandau, BSN, RN, Special Representative
- District Council 37, AFSCME, AFL-CIO
 - Guille Mejia, MPH CHES, Director, Safety and Health Department
 - Jonathan Vandenburg, Principal Program Coordinator, Safety & Health Department
- 1199 SEIU United Healthcare Workers East
 - Antonella Pechtel, C.N.A., Regional Political Director
- New York State Nurses Association (NYSNA)
 - Lisa Baum, Occupational Health and Safety Representative, Nursing Education and Practice
 - Susan Mitnick, Regulatory Specialist


Safe Patient Handling Workgroup Members (continued)

- New York Organization of Nurse Executives and Leaders (NYONEL)
 - Cathy DeChance, MS, RN, Northeast President and Director, Recruitment, Columbia Memorial Hospital
 - Sabrina Nitkowski-Keever, RNC, MSN, Normet President of NYONEL and Hudson Valley Hospital Center
- Civil Service Employees Association (CSEA)
 - Janet Foley, Director of Occupational Safety and Health
- Zero Lift Task Force
 - Ann Converso, RN, Co-Chair
 - Roger Cook, MA, Co-Chair
 - Maureen Cox
- Western New York Council on Occupational Safety and Health (WNYCOSH)
 - Germain Harnden, Executive Director
- State University of New York Upstate Medical University
 - Casey Hammerle, MS, RN, CBN
- State University of New York Stony Brook Hospital
 - Carolyn Santora, MS, RN, Chief of Regulatory Affairs
 - Jill Kavoukian, CHSP, Hospital Safety Officer, EH&S Associate Director
- Helen Hayes Hospital
 - Elaine DeFrancisco Castelluccio, PT, MPT, Program Director of Spinal Cord Injury Services and Program Director of Subacute Services
- New York State Veterans Home at Batavia
 - Joanne Hernick, M.H.S.A., L.N.H.A., Ed.D, Administrator
- New York State Department of Health
 - Lisa Ullman, Office of Primary Care and Health Systems Management (OPCHSM)
 - Joan Cleary Miron, OPCHSM
 - Rae Ann Augliera, OPCHSM
 - Ruth Leslie, OPCHSM
 - Lisa McMurdo, OPCHSM
 - Shelly Glock, OPCHSM
 - Lee Weissmuller, OPCHSM
 - Nancy McBride, OPCHSM
 - Jessica Spurdin, OPCHSM
 - Shaymaa Mousa, Commissioner's Office
 - Kitty Gelberg, Ph.D, MPH, Center for Environmental Health, Bureau of Occupational Health and Injury Prevention (BOHIP)
 - Nicholas Pavelchak, BOHIP

Safe Patient Handling Workgroup Members (continued)

- Karen Langell, Occupational Health and Safety Program (OHSP)
- Diana Sollohub, OHSP
- David Hernandez, Health Facilities Management (HFM)
- Karen Cally, HFM
- Jane McLaughlin, Office of Government Affairs (OGA)
- Esti Alonso, OGA
- New York State Department of Labor (DOL)
 - Barbara Stanley
 - Leonard Schwartz
 - Mark Thorsland
 - Olushola Abolarinwa
 - Daryl Odhner
- New York State Office of Mental Health (OMH)
 - Maxine Smalling
 - Charlene Puerto
 - Crystal Scalesci
- New York State Office of Alcoholism and Substance Abuse Services (OASAS)
 - Steve Hanson
- New York State Office for People With Developmental Disabilities (OPWDD)
 - Greg Roberts
 - Francesca Grimmer
- Office of Children and Family Services (OCFS)
 - Daniel Leffingwell
- New York State Department of Financial Services (DFS)
 - Martha Lees
 - Joana Lucashuk
 - Maurice Morgenstern
 - Darlene Picard
- New York State Workers Compensation Board (WCB)
 - Patricia Furdyna
- New York State Department of Corrections and Community Supervision (DOCCS)
 - Nancy Heywood
 - Catherine Marra

APPENDIX C

 Kaleida Health POLICY	Title: Safe Patient Handling (SPH)	# CL.73
	Owner: Director Safe Patient Handling	Issued: 1/05
Keywords: no-lift, zero lift, mechanical lift		

I. Statement of Purpose

This policy will outline the Safe Patient Handling (SPH) Program for mechanical lifting, transferring, and repositioning patients/ residents. The basic objectives of the SPH program are to:

- A. Increase the quality of care, reduce injuries and reduce length of stay for the patient/resident
- B. Create a safe working environment for the staff by reducing the frequency of manual lifting, transferring and repositioning
- D. Reduce and prevent work related injuries to caregivers
- E. Reduce time hours lost due to injury and/ or fatigue in staff

II. Audience

Staff caring for any dependent patient/resident over 30 pounds must utilize Lift/transfer devices. Non- Kaleida employees, agency staff, students & site security personnel in healthcare are never the lead personnel in lifting/transferring & transporting patients/residents.

III. Instructions – (Outline necessary steps for consistent completion of process/ procedure)


- A. All lifting and transferring of patients/residents shall be performed utilizing the approved lift/transfer devices and methods to prevent patient and employee injury.
- B. All patient/residents must be assessed by a licensed professional for proper transfer and movement recommendations. The recommendation of how to safely transfer or move the patient/resident must be documented in the Electronic Medical Record (EMR) for acute care and on the plan of care for Long Term Care (LTC). (Attachment CL.73a Assessment tool).
- D. Unlicensed assistive personnel may transfer and move patients/residents after the assessment has been completed documented. The documented assessment is found in either the EMR (acute Care) or Plan of Care (LTC).
- E. All new employees responsible for lifting and transferring patients/residents shall attend the Corporate Safe Patient Handling class.
- F. Employee Competency will be validated by their assigned preceptor prior to the employee taking the lead role in lifting/transferring patients.
- G. All employees responsible for lifting/transferring & transporting patients/residents must complete the corporate annual review for SPH.
- H. Employee and patient/resident injuries or near misses during lifting/transferring/ambulating must be reported via STARS and the employees involved must be scheduled to attend the Corporate SPH Class.

- IV. **Approved by -** (Include date)
 Infection Control Committee 9/29/05, 9/4/14
 Nurse Policy Council 10/8/14
 Nurse Executive Committee 12/4/04, 5/6/05, 10/7/05, 6/9/06, 8/6/10, 12/16/14
- V. **References** (Include evidence based research, Kaleida Health policy, and regulation as applicable)
CL.73a – Safe Patient Handling Assessment Tool
American Association for Safe Patient Handling & Movement
Centers for Disease Control and Prevention – Safe Patient Handling
NYS Assembly Subcommittee on Workplace Safety. Safe Patient Handling in New York: Short Term Costs Yield Long Term Results (2011).
OSHA – Safe Patient Handling

Version History:

Effective Date:	Reviewed/ Revised
2/2/15	Revised
7/10	Revised
7/06	Revised
9/05	Revised
4/05	Revised

Kaleida Health developed these Policies, Standards of Practice, and Process Maps in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team, hospital administration and staff in making clinical and non-clinical decisions about our patients' care and the environment and services we provide for our patients. These documents should not be construed as dictating exclusive courses of treatment and/or procedures. No one should view these documents and their bibliographic references as a final authority on patient care. Variations of these documents in practice may be warranted based on individual patient characteristics and unique clinical and non-clinical circumstances. Upon printing, this document will be valid for 3/24/2015 only. Please contact Standard Register regarding any associated forms.

 Kaleida Health POLICY	Title: Proper Use of Safe Patient Handling (SPH) Equipment	# CL.72
	Owner: Director Safe Patient Handling	Issued: 3/17/15
Keywords: SPH Equipment, No-Lift, Zero Lift		

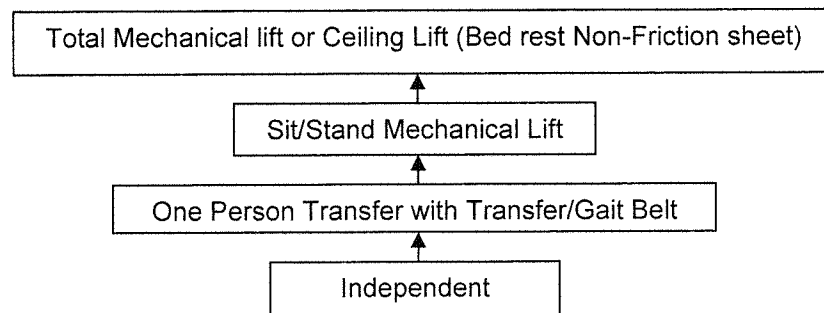
I. Statement of Purpose

Knowing how to use the safe patient handling (SPH) equipment properly is the responsibility of all employees. Proper use of SPH equipment is outlined in this document. Employees gain skill, and further knowledge on proper SPH equipment use through live hands-on demonstration by the SPH Team, on Talent Management by viewing SPH videos and through annual completion of required SPH curriculum. Competence and confidence with SPH equipment use comes with practice, viewing the SPH videos as a refresher and reference as well regular frequent use. For the purpose of this document, the term “patient” shall include acute hospital patients as well as long term care (LTC) residents.

II. Work Instructions – (Outline necessary steps for consistent completion of process/ procedure)

A. Patient Assessment

1. An initial lift/transfer needs assessment will be completed by the licensed professional on the day of admission or at the time of a change in the patient status. Additionally a quarterly assessment shall be done for long- term residents.
2. Select the appropriate lift/transfer status of the patient by referring to the *Lift/Transfer Protocol* (CL.73a) for assessment of patient criteria, contraindications, sling criteria and required staff.
****Keypoint:** A patient status may differ based on the time of day or other patient factors. This may require two different levels of transfer during a single day. A secondary lift shall be identified when appropriate.
3. The caregiver shall consider his/her own ability, the environment and the patient current status prior to any lifts or transfers. When the caregiver feels that the current patient handling technique cannot be performed safely it is acceptable to move to the next higher level of transfer (i.e. sit/stand mechanical lift to a total mechanical lift, independent to a one person transfer with transfer/gait belt).
 - a. The caregiver shall not move to the next lower level of transfer without first having a licensed professional reassess the patient’s transfer lift status.
 - b. Long term care unlicensed personnel must notify the licensed caregiver immediately prior to the lift/transfer so that a reevaluation can be done.
4. Refer to the decision tree when changing the patient lift status.



5. The patient lift/transfer shall be performed as determined by the lift/transfer assessment.
****Exception:** The licensed professional caregiver shall determine the appropriate method of lift/transfer on the patient in the event of a medical emergency or fire.

B. Lift/Transfer Equipment

1. **Mechanical Lifts** - All mechanical lifts shall be maintained in the designated area and plugged in for recharging when not in use. Do not block exits, fire alarms, and fire extinguishers with the lifts. Note: some mechanical lifts have a removable battery that requires recharging. The battery charger should be kept in a designated area and the unit should have a minimum of two batteries per lift.
2. **Slings** - Place all soiled slings in designated laundry bag/hamper.
3. **Safety**
 - a. Assess integrity and function of all lift equipment prior to use. Any broken or malfunctioning equipment shall be removed from use and tagged with a "Do Not Use" label. See SS-F.1 - Medical Equipment Management Plan. Non-functioning equipment shall be reported by calling TAC at 859-7776
 - b. Inspect all slings prior to use for signs of wear and tear or signs of compromised integrity including loose stitching, tears, or fraying straps. Remove damaged slings and tag "DO NOT USE" and return to unit manager.
****Keypoint:** Damaged slings shall be replaced never repaired. The repositioning slings must be left under the patient however never utilized as a transfer sling.
 - c. Do not leave repositioning non-friction device under the patient after move/transfer is completed.
 - d. Always close the legs of the lift when moving the lift.
 - e. The brakes are to be on when the lift is parked, being charged and during the initial set up of the sit/stand lift or total mechanical lift.
****Keypoint:** Whenever you are operating the lift or lowering the lift the brakes **must** be off. The lift has an Emergency Stop button when engaged shuts the power off to the motor. The Emergency Stop button needs to be reset to operate the lift.

C. Infection Control

1. Barriers shall be used between the patient's skin and the sling. (E.g. underwear, incontinent pad)
2. All SPH soft goods (which include slings, non-friction sheets, gait belts, air matts etc.) with minor soilage may be spot cleaned using hospital approved disinfectant wipes. See IC.21 – Non Commercial Washing Machine Use.
3. A single dedicated sling will be used for a patient on isolation/or a LTC patient known to have a multi resistant organism or communicable illness and laundered after discontinuation of isolation or discharge, whichever comes first.
4. All framework/hardware will be wiped down with hospital approved disinfectant wipes after each patient use.

D. Total Mechanical Lift

A total mechanical lift provides a safe transfer for patients from a supine to seated position or seated to seated transfer. A total mechanical lift will be used by those patients who have no weight bearing abilities or who have been assessed to need a total mechanical lift for transfer.

1. Equipment/Personnel

- a. Total mechanical lift
- b. Two (2) or more caregivers

2. Procedure

- a. There must be two caregivers interfacing with their hands on the patient & the total mechanical lift.
- b. Adjust bed to a height that promotes good body mechanics.
- c. Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
- d. Position patient on the appropriate sling.
- e. Position lift with the base open so that the spreader bar is perpendicular to the patient's shoulders and hovering above the chest.
- f. Attach the sling straps without pulling or tugging, to the desired setting.
- g. Verbally prepare patient for transfer.
- h. Gently raise patient minimally from surface.
- i. **Be sure to close the legs of the lift while moving the lift; keeping the patient's body on the inside of the lift legs. Not swinging to the outside of the lift legs.**
- j. Gently lower patient into chair. (The staff should limit the distance and time the patient is in the mechanical lift by arranging the environment. This practice is known as the zero air space procedure when transferring the individual).
- k. Remove sling from under patient (if appropriate).
- l. **Before** a patient that is on the floor is moved, touched or mechanically lifted, a licensed professional **must** assess the patient. In order to promote safe patient handling, **use** a total mechanical lift (floor or ceiling model) when getting a patient off the floor.
- m. The two methods for the hammock sling applications are the cross through method and the cradle method.
 - a. The cross-through is the recommended method for a total hip patient. The cross through method is the safer method that anchors the patient.
 - b. The cradle method is used on a patient with an amputee of their lower extremity(ies), and for a patient who experiences discomfort in the cross through method (i.e., patient with increased girth at their thigh).
- n. The universal sling may be utilized to transfer a bariatric patient. The lower limb straps are crossed between the thighs of the patient.
- o. The staff may choose to utilize a limb strap or the easy glide boards to assist in placing a sling behind a patient.

E. Ceiling Lift - when available

A ceiling lift provides a safe transfer for a patient similar to the total mechanical lift. Floor space challenges are not an issue with a ceiling lift therefore there is reduced injury risk for patient and healthcare worker. With the use of the repositioning slings the ceiling lift reduces the exertion and injury risk related to positioning tasks in bed.

1. Equipment/Personnel

- a. Ceiling lift
- b. Two (2) or more caregivers

2. Procedure

- a. There must be two caregivers present to operate the ceiling lift
- b. Adjust the height of the bed to promote good body mechanics.
- c. Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
- d. Position the patient on the appropriate sling. The two methods of sling attachment for the hammock sling are cross through and cradle method.
- e. The universal sling may be utilized to transfer a bariatric patient. The lower limb straps are crossed between the thighs of the patient.
- f. Position the motor so the carry bar is perpendicular to the patient's shoulders. If utilizing two motors position the second carry bar perpendicular to the hips.
- g. Lower the carry bar(s) attaching the sling straps to the desired setting.
- h. Verbally prepare the patient for transfer.
- i. Gently raise the patient clearing the surface they are on; guide the patient by grasping the sling and moving toward the desired transfer surface. Gently lower and position the patient to the chair or desired transfer surface. (The staff should limit the distance and time the patient is in the mechanical lift by arranging the environment. This practice is known as the zero air space procedure when transferring the individual).
- j. When performing a positioning task on a dependent patient, the staff should utilize a repositioning sling. The repositioning sling can be used with the ceiling or floor mechanical lift. The different style slings are: the tri-turner, full body and split sheet sling. The sling loops/strap buckle is attached to the carry bar by the staff without pulling or tugging.
- k. When positioning the dependent patient on their side the sling attachment loops/buckle strap is fastened to the lift carry bar(s) on one side. (Note the tri-turner and split sheet sling is only utilized to turn the patient in bed)
- l. When repositioning the patient up in bed align the carry bar parallel to the patient's trunk. The full body sling attachment loops are connected on both sides of the carry bar.
- m. When repositioning the patient with 2 ceiling lift motors both carry bars should be aligned perpendicular to the patient's trunk. The attachment loops on the full body sling will be connected on both sides of the carry bars. The full body sling is only utilized to turn, reposition and laterally transfer a patient from bed to gurney. Never utilize any of the repositioning slings to transfer a patient to a chair.
- n. The staff may choose to utilize a limb strap or the easy glide boards to assist in placing a sling behind the patient.
- o. To maintain charge the ceiling lift motor must be returned to the docking station. The amber light will indicate the motor is accepting the charge.

Please note, some fixed ceiling motors have a continuous charging track. The amber light will appear when the lift is stationary awaiting use.

- p. The ceiling lift motor has an emergency (red) pull cord to lower the carry bar. The emergency pull cord needs to be reset once disengaged to operate the motor.

F. Sit/Stand Mechanical Lift

A sit/ stand mechanical lift provides a safe seat-to-seat transfer for the patient who has partial weight bearing capabilities in one or both legs and has good cognition. The patient must be able to move from a supine position to sitting position and balance in a sitting position on the edge of the bed.

1. Equipment/Personnel

- a. Sit/stand mechanical Lift
- b. Two (2) or more caregivers

2. Procedure

- a. Apply proper harness so that the bulk of the harness rests in the patient's lower back region. Tighten the inner belts so that they fit snug to the patient. Apply leg straps if applicable. Never tighten the legs straps on the TT Harness.
- b. Position the sit/stand mechanical lift with the base of the lift open and lift is facing patient.
- c. Instruct/assist patient to place feet on the footplate of the lift. Patient's legs must be against the black calf pad at all times during the transfer.
- d. Attach the strap of the harness to the lift without pulling or tugging.
- e. Instruct/assist patient to grasp handles on lift with arms on the outside of the harness.
- f. Close the legs of on the lift during movement of the lift with patient in it.
- g. Verbally prepare patient for transfer.
- h. Instruct/ assist patient to lean back into the harness as they are gently lifted minimally from the surface.
- i. Transfer patient to new surface.

There must be two caregivers present with their hands on the mechanical lift

****Keypoint:** The patient's patella should be above the shin pad when performing a transfer with their feet stationary on the footplate. The patient's patella should be in the middle of the shin pad when ambulating with the footplate removed. The patient may be transferred with one leg resting on the shin pad. i.e. total knee patient.

G. Transfer/Gait Belt

A transfer/gait belt provides a firm, grasping surface for the caregiver, protects the patient from accidental trauma to the skin, provides a sense of security to the patient, and protects the caregiver from injury while transferring or ambulating a patient. Transfer/gait belts are used on a patient who is not independent in rising or during ambulation. The patient must be able to move their feet in the desired direction during a transfer. Also, the patient should not require lifting or need to be held up. If a patient is at risk for collapsing or falling, the transfer/gait belt is not the safest mode of transfer. A reassessment is indicated. The sit/stand lift with the TT harness and leg straps may be indicated or a full mechanical lift.

Title: Proper Use of Safe Patient Handling (SPH) Equipment	# CL.72
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1. **Equipment/Personnel**

- a. Transfer/gait belt
- b. One caregiver – second caregiver assistance used only to manage medical equipment or a wheelchair.

2. **Procedure**

- a. Explain purpose of the transfer/gait belt and the procedure of its use to the patient.
- b. Put the transfer/gait belt on over the patient's clothing and around the waist and make sure the belt is snugly in place.
- c. Assist patient to a standing position by grasping the handles on the transfer/gait belt.
****Keypoint: Caregiver should be able to insert two fingers between the belt and the patient's clothing.**
- d. Before assisting patient in transfer or ambulation, make sure that the belt is properly positioned and that the buckles are securely fastened.
- e. Do not allow patient to place hands or arms around the caregiver's neck
- f. If a patient begins to slide while getting up, lock the patient's knees against the caregiver's knees.
- g. If the patient begins to fall during transfer/ambulation, pull the patient close to the caregiver's body using the transfer/gait belt, call out for help and lower patient as far as your arms will extend to the floor.
- h. Use the total mechanical lift or ceiling lift to lift patient from floor.

H. **Non-Friction Device**

A non-friction device helps to reduce the push pull forces associated with repositioning and laterally transferring patients. The device is utilized for a patient who is dependent requiring assistance for bed mobility or lateral transfers.

1. **Equipment/Personnel:**

- a. Non-friction device
- b. Two (2) or more caregivers

2. **Procedure for use of Non-Friction Device to reposition in Bed:**

- a. Adjust bed to a height that promotes good body mechanics and place the bed in the flat position.
- b. Have the patient roll to one side. Position the non-friction device underneath the patient. Place a sheet between the patient and the non-friction device.
****Keypoint:** Do not pull the non-friction device. Utilize the sheet that is between the patient and the non-friction device. The non-friction device may be applied by tucking the device under a sheet or incontinent pad. Multiple non-friction sheets maybe utilized for a bariatric patient tucking the device half way underneath the individual. The non-friction device may be utilized when performing a portable X-ray slipping the film between sheet layers.
- c. With at least one caregiver on either side of the bed, grasp the sheet with the caregiver's palms down and maintain wrists flat on the bed while transferring.

Title: Proper Use of Safe Patient Handling (SPH) Equipment	# CL.72
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- d. Using proper body mechanics, caregivers will shift their weight sliding patient into proper position on the bed.
- e. Roll patient until the non-friction device can be removed. The non-friction device may be removed by tucking the device under the sheet or incontinent pad with the second caregiver walking and grasping the device.

3. **Procedure for use of Non-Friction Device to Laterally Transfer**

- a. Roll the patient until he/she is positioned on the non-friction device. A sheet should be positioned between the patient and the non-friction device. Note: the non-friction sheet may be tucked underneath the patient if they are dependent requiring assist to roll.
- b. Adjust bed so that it is at the same height as the stretcher and so that bed is in the flat position.
- c. **Be sure to bridge the gap between the 2 surfaces with a slide board.**
- d. The caregivers should be positioned: one on the side of the supporting surface (example: bed, stretcher, procedure table) and the other caregiver on the opposite side of the second supporting surface.
- e. The caregiver will grasp the sheet with their palms down and maintain their wrists flat on the supporting surface.
- f. Using proper body mechanics, the first caregiver shall push the patient towards the stretcher while the second caregiver receives patient and pulls the patient the rest of the distance.
- g. Roll patient until the non-friction device can be removed. The non-friction device may be removed by tucking the device under the sheet or incontinent pad with the second caregiver walking and grasping the device.

****Keypoint:** The non-friction device cannot be left under the patient after use.

I. **Air Matt**

An air matt technology increases employee and patient safety by reducing friction, push-pull forces and load during all positioning, repositioning, turning and lateral transfer acts conducted.

1. **Equipment/Personnel:**

- a. Air matt
- b. Two (2) or more caregivers

2. **Use of the Air Matt to reposition in bed:**

- a. Adjust bed to a height that promotes good body mechanics.
- b. Air matt is placed on top of the mattress under the bedding.
- c. Air matt stays under the patient for as long as needed.
- d. Air matt is always deflated under the patient.
****Keypoint:** Air matt is only inflated when caregivers are standing next to the patient and next to the bed and prepared to conduct the following tasks: turning, repositioning and performing a lateral transfer.
- e. Air matt use requires two side rails to be up before turning on the air supply and it requires the patient to be centered on the air matt.

3. Use of the Air Matt to laterally transfer:

- a. Adjust bed so that it is at the same height as the stretcher and so that bed is in the flat position.
- b. Make sure patient is centered on the air matt.
- c. The caregivers should be positioned: one on the side of the supporting surface (example: bed, stretcher, procedure table) and the other caregiver positioned close to the side of the other supporting surface (side rails positioned up if available on surface).
- d. Using proper body mechanics, the first caregiver should push the patient diagonally (feet first) towards the supporting surface while the second caregiver pulls and receives the patient (feet). Same procedure is performed when the patient torso is diagonally transferred to the supporting surface.
- e. Once patient is safely transferred to supporting surface, deflate the air matt.

4. Use of Air Matt to position patients:

- a. Adjust bed to a height that promotes good body mechanics.
- b. Make sure patient is centered on the air matt.
- c. Make sure bed rails are in the up position. A pillow should cover the bed rails in the direction the patient is rolling.
- d. The caregivers should be positioned on both sides of the bed working as a team.
- e. Using proper body mechanics, one caregiver will push the patient towards the second caregiver, while the second caregiver pushes down on the inflated air matt and pulls the straps towards them.
****Keypoint:** This will cause the patient to begin to roll easily on their side, so the caregivers should not over exert or use excessive force.
- f. Once the patient is safely positioned on their side, the air matt should be deflated.

5. Applying portable x-ray cassette for diagnostic procedure:

- a. Adjust bed to a height that promotes good body mechanics.
- b. Make sure patient is centered on the air matt.
- c. Inflate air matt and slide x-ray cassette under air matt.
- d. Deflate air matt and perform procedure/diagnostic test.
- e. Inflate air matt and remove the x-ray cassette.
- f. Deflate air matt making sure patient is properly positioned in bed.

J. Complications and Reportable Incidents

1. All damaged slings should be reported to the nurse manager or nurse supervisor.
2. Employee injury during lifts or transfers should be reported to employee health and manager. Complete incident report on STARS.
3. Patient injury during lift or transfer will be reported to the unit manager and physician. A complete incident report will be completed on STARS.
****Keypoint:** Report all of the above to the Safe Patient Handling (SPH) Director and SPH Coordinator.

III. Approved by - (include date)

Infection Control Committee	8/14
Nurse Policy Council	2/11/15
Nurse Executive Committee	2/15

IV. References

CL.73 - Safe Patient Handling (SPH)
CL.73a - Safe Patient Handling Assessment Tool
IC.21 - Noncommercial Washing Machine Use
SS-F.1 - Medical Equipment Management Plan

American Association for Safe Patient Handling & Movement

Centers for Disease Control and Prevention – Safe Patient Handling

NYS Assembly Subcommittee on Workplace Safety. Safe Patient Handling in New York: Short Term Costs Yield Long Term Results (2011).

OSHA – Safe Patient Handling

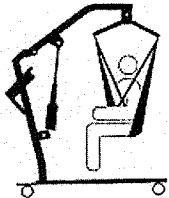
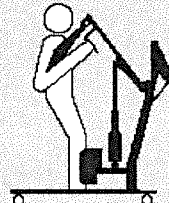

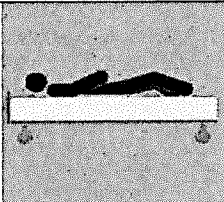
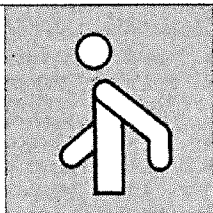
Version History:

Effective Date:	Reviewed/ Revised

Kaleida Health developed these Policies, Standards of Practice, and Process Maps in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team, hospital administration and staff in making clinical and non-clinical decisions about our patients' care and the environment and services we provide for our patients. These documents should not be construed as dictating exclusive courses of treatment and/or procedures. No one should view these documents and their bibliographic references as a final authority on patient care. Variations of these documents in practice may be warranted based on individual patient characteristics and unique clinical and non-clinical circumstances. Upon printing, this document will be valid for 3/24/2015 only. Please contact Standard Register regarding any associated forms.



SAFE PATIENT HANDLING ASSESSMENT TOOL

Lift Type	Patient /Resident Criteria	Contraindications	Sling Criteria	Staff
 <p>Total Mechanical Lift or Ceiling Lift</p>	<ul style="list-style-type: none"> Non weight bearing Not able to sit/balance on edge of bed Non weight bearing patient needing repositioning in a non-reclining chair 		Use - Hygiene sling if patient has: <ul style="list-style-type: none"> Good upper body control Cognitive Able to assist Transfer is for toileting/access to perineal area. 	2 – 2+
			Use - *Hammock sling if patient has: <ul style="list-style-type: none"> Poor upper body control Non cognitive Unable to assist. S – 45 – 100 lbs. M – 100 – 210 lbs. L – 210 – 440 lbs. XL– 440 – 800 lbs.	2 – 2+
 <p>Sit/Stand Mechanical Lift</p>	<ul style="list-style-type: none"> Partial weight bearing in one or both legs Can hold on with one or both hands Cooperative Able to move supine to sit and be able to sit/balance on edge of bed Partial weight bearing patient needing repositioning in a non-reclining chair 	<ul style="list-style-type: none"> Abdominal, chest or back surgery (if the area of surgery would be compromised resulting in harm to the patient/resident) Spinal or pelvic fracture (if the fracture site would be compromised resulting in harm to the patient/resident) Poor skin integrity in area of belt 	Use - Band Harness if patient: <ul style="list-style-type: none"> CAN bear weight continuously 	2 – 2+
			Use -TT Harness if patient: <ul style="list-style-type: none"> CANNOT bear weight continuously Band sling is not large enough If leg straps are needed Never tighten the TT Harness leg straps 	2 – 2+
 <p>Transfer/Gait Belt</p>	<ul style="list-style-type: none"> Full weight bearing and able to ambulate with guidance or hands on cueing Partial weight bearing if they can take steps and move feet Steady Sound cognition Cooperative 	<ul style="list-style-type: none"> Abdominal, chest or back surgery (if the area of the surgery would be compromised resulting in harm to the patient/resident) Spinal or pelvic fracture (if the fracture site would be comprised resulting in harm to the patient/resident) Poor skin integrity in area of belt 	None	1 + another to handle medical equipment
 <p>Non-Friction Device or Air Matt</p>	<ul style="list-style-type: none"> Bedrest Unable to assist with lateral transfer Needs repositioning in bed or reclining chair 		None	Less than 200 lbs – 2
				More than 200 lbs – 3
 <p>No Lift Device</p>	<ul style="list-style-type: none"> Full weight bearing bilaterally Steady Or patient ≤ 30 LBS 		None	0 – 1

* Patient height and weight distribution may indicate need for a larger sling.

Name _____ Unit _____ Site _____

KALEIDA HEALTH Safe Patient Handling(Zero Manual Lift) Policy Review

Please complete the following questions prior to your Safe Patient Handling (Zero Manual Lift Training) Class

1. When using mechanical lift equipment the minimal number of staff needed to safely transfer the mechanical lift equipment is _____.
2. When transferring a patient/resident with a transfer/gait belt one characteristic that the patient/resident must have is: _____.
3. Contraindications for the use of the transfer/gait belt are:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
4. To transfer a patient/resident who has partial weight bearing on one or both of their legs the equipment that must be used minimally is _____.
5. An unlicensed staff member is transferring a patient into bed who has been assessed as needing to be transferred with a Sit/Stand Mechanical Lift. The patient/resident is very tired and you suspect that they will not be able to stand or hold on to the lift. The unlicensed staff member should report this to _____ and the patient/resident should be re-assessed and transferred with _____.
6. The purpose of establishing the safe patient handling program at Kaleida Health is to:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
7. Prior to the use of each sling, the sling must be checked for:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
8. A staff member begins to place a sling on a patient for transfer and finds it shows visible signs of wear and tear; the staff member should _____.
9. Assessment of a patient/resident's transfer/lift status is to be made at the time of _____ and _____.
10. The staff member looking for a patient's transfer/lift status and the style and size of sling would find it documented in:
 - a. LTC _____
 - b. Acute Care _____
11. The patient/resident has been assessed as needing a medium size sling and one is not available. The staff member leading the transfer for this patient/resident needs to _____.

Kaleida Health Employee Acknowledgement

I, _____, do hereby acknowledge receiving a copy of
(Printed Name)
the Kaleida Health policy regarding the facility's **Safe Patient Handling Policy**. I further
acknowledge that I have been offered the opportunity to ask questions regarding this policy
and I know that failure to follow this policy will result in disciplinary action up to and
including termination.

Signature

Date

APPENDIX D

NEW YORK STATE VETERANS HOME AT BATAVIA
POLICY AND PROCEDURE MANUAL

Department: Nursing
Effective Date: 02/01/07
Revised Date: 4/14/08, 6/14/13, 6/22/15

Reviewed & Approved

Distribution: All Departments



Administrator Date 6/22/15

Subject	Page	Item No.
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POLICY:

The NYS Veterans Home at Batavia has a commitment to workplace safety and is implementing a Zero Manual Lift Program for mechanical lifting, transferring, and repositioning residents. The basic objectives of the program are as follows:

- To increase the quality of care for the resident.
 - To perform a safe and comfortable mechanical lift and/or transfer for the residents.
 - To create a safe working environment for the staff by reducing the frequency of manual lifting, transferring, and repositioning.
 - To reduce and prevent work related injuries to caregivers.
 - To reduce loss time hours related to injury and/or fatigue in staff.
- A. All lifting and transferring of residents shall be performed utilizing the approved lift/transfer devices and methods to prevent resident and employee injury.
- B. Only RN's and registered OT/PT staff should assess resident lifting and transferring needs and determine the appropriate method to lift/transfer the resident.
- C. Unlicensed assistive personnel should lift and transfer residents only after assessment has been completed by the RN or registered OT/PT staff.
- D. All employees responsible for lifting and transferring residents shall attend the Zero Manual Lift Training Program and demonstrate competency in lifting/transferring residents. (Attachment #1)
- E. The NYS Veterans Home at Batavia will provide on-going training and annually validate employee competency to improve safety and monitor compliance.
- *The Zero Lift Competencies (Attachment 1A-1) will be reviewed with each employee as part of the Annual Performance Review*
 - *Copies of the completed competencies (Attachment 1A-1) will be come part of the Employees Annual Performance Review Packet*
- F. Employee competency shall be validated and remediation provided for the following employees:
- Those transitioning back to full duty following an injury related to resident handling.
 - Those involved with any lifting/transferring resident incident.
 - Any observed poor performance related to lifting/transferring residents.

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- G. In keeping with the philosophy of Zero Manual Lift, all transfers off the floor will be accomplished with no less than 3 assist and a full mechanical lift.

IMPORTANT TO NOTE:

- Never move a resident until assessed by the RN
- Proceed with transfer as if there is a hip fracture—follow total hip replacement precautions
- Limit the distance you push the lift—lower resident to a gurney, shower chair, or reclining wheelchair that has been brought to the lift.

EXCEPTIONS: *Evacuation, emergency, fire, disaster or for a resident who is independent getting off the floor and has been assessed by the RN.*

SCOPE OF PRACTICE

All NYS Veterans Home at Batavia employees who are responsible for lifting/transferring and positioning residents.

PROTOCOL:

A. Resident Assessment and Data Collection

1. An initial lift/transfer needs assessment will be completed by the licensed professional on the day of admission, quarterly, or at the time of a change in the resident status.
2. Select the appropriate lift/transfer status of the resident by referring to the **Lift/Transfer Decision Tree**.

KEYPOINT: A resident status may differ based on the time of day or other resident factors. This may require two different levels of transfer during a single day. A secondary lift shall be identified when appropriate.

3. The caregiver shall consider his/her own ability, the environment, and the resident current status prior to any lifts or transfers. When the caregiver feels that the current resident handling technique cannot be performed safely, it is acceptable to move to the next higher level of transfer (i.e., sit/stand mechanical lift to a total mechanical lift, independent to a one person transfer with transfer/gait belt). Nurse Aide (Certified) must notify their supervisor immediately prior to the lift/transfer so that a re-evaluation can be done by RN, OT/PT.

KEYPOINT: The caregiver shall not move to the next lower level of transfer without first reassessing the resident's transfer lift status

KEYPOINT:

- First Notification
- Documentation

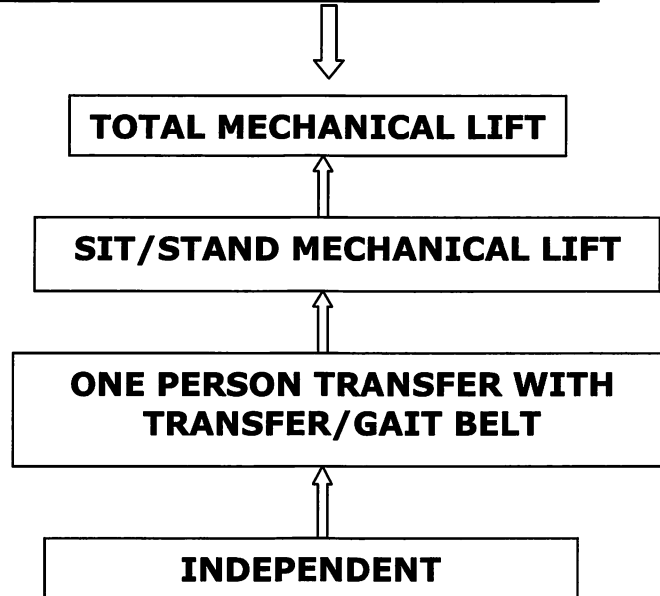
▪Change in Care Plan to reflect resident need

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4. Refer to the Lift/Transfer Decision Tree when changing the resident lift status.

LIFT/TRANSFER DECISION TREE.



B. Care and Management

Resident:

1. The resident lift/transfer shall be performed as determined by the lift/transfer assessment as documented on both comprehensive Care Plan and NAC Care Plan.

EXCEPTION: The licensed professional caregiver shall determine the appropriate method of lift/transfer on the resident in the event of a medical emergency or fire.

Lift/Transfer Equipment:

1. *Plug in rechargeable mechanical lifts when not in use*

Slings:

1. Place all soiled slings in designated mesh laundry bag and hamper located in the soiled utility rooms. To be assigned and laundered by each shift.

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C. Safety

1. Assess integrity and function of all lift equipment prior to use. Any broken or malfunctioning equipment shall be removed from use and tagged with a "Defective o Not Use" tag and returned to the unit manager. (See Environmental Services Policy 1006.5 – Identification of Equipment in Need of Repair)
2. Inspect all slings prior to use and after washing for signs of wear and tear or signs of compromised integrity including loose stitching, tears, or fraying straps. Remove damaged slings and tag "Defective Do Not Use" and return to unit manager.

KEYPOINT: Damaged slings shall be REPLACED, NEVER REPAIRED.

3. Do not leave repositioning non-friction device under the resident after move/transfer is completed.
4. For proper use of brakes and leg lift, see individual instructions posted on lift.
5. The brakes are to be on when the lift is parked and being charged and during the initial set up of the sit/stand lift.
6. Preventative Maintenance is performed according to manufacturer specification on the lifts *by an appropriate outside vendor. Documentation is maintained and available in Environmental Services Office.*
7. The wheels on the lifts are cleaned by Environmental Services as needed.

KEYPOINT: Whenever you are operating the lift, the brakes MUST be off.

EXCEPTION: WHEN LIFTING A RESIDENT OFF THE FLOOR.

D. Infection Control

1. Barriers shall be used between the resident's skin and the sling (e.g., underwear, incontinent pad).
2. Slings with minor soilage may be spot cleaned using facility approved disinfectant wipes.
3. A single dedicated sling shall be used for a resident on isolation precautions and laundered as needed during use and when isolation precautions are discontinued.
4. The framework/hardware shall be wiped down with facility approved disinfectant wipes when visibly soiled and weekly. Nursing staff will wipe down sit/stand area where resident holds on after every use. Environmental Services will clean lifts weekly.

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E. Complications and Reportable Incidents

REPORT:

- All non-functioning equipment as appropriate
- All damaged slings to unit manager for follow-up
- Report **employee injury** during lifts or transfers to nursing supervisor and complete Employee Accident Report.
- Report **resident injury** during lift or transfer to unit manager and/or nursing supervisor and then complete Resident Accident/Incident Report.

KEYPOINT: A NEAR MISS IS ANY INCIDENT OR EVENT THAT OCCURS THAT IS NOT EXPECTED OR IN THE NORM AND NO INJURY OCCURS.

PROCEDURE:

A. PROCEDURE FOR USE OF TOTAL MECHANICAL LIFT

Definition: A total mechanical lift provides a safe transfer for residents from a supine to seated position. A total mechanical lift will be used by those residents who have no weight bearing abilities and/or other indicated medical conditions as warranted by Therapies/Nursing Departments.

1. **Equipment/Personnel**
 - a. Total Mechanical Lift
 - b. Two or more caregivers
2. **Procedure**
 - a. There must be two caregivers present when using the total mechanical lift.
 - b. Adjust bed to a height that promotes good body mechanics.
 - c. Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
 - d. Verbally prepare resident for transfer.
 - e. Position resident on the appropriate sling as per resident care plan.
 - f. Position lift with spreader bar always perpendicular to the resident's shoulders and hovering over the chest.
 - g. Attach the sling straps without pulling or tugging to the desired setting. Consider elevating head of bed to facilitating ease in completion.
 - h. Gently raise resident minimally from surface. Unweight them from the bed. Perform a safety check.
 - i. Turn resident's legs towards the perpendicular support bar of the lift during the move.
 - j. Gently lower resident into chair.
 - k. Remove sling from under resident. Only leave sling under resident if care planned

KEYPOINT: FOLLOW THE INSTRUCTIONS FOR USE BULLETED ON EACH LIFT.

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B. PROCEDURE FOR USE OF SIT/STAND MECHANICAL LIFT

Definition: A sit/stand mechanical lift provides a safe seat-to-seat transfer for the resident who has partial weight bearing capabilities in one or both legs, is able to move from a supine position to sitting position, has trunk balance, can hold on with at least one hand, and able to follow step commands and/or not interfere with safety steps.

1. Equipment/Personnel

- a. Sit/Stand Mechanical Lift
- b. Two or more caregivers

2. Procedure

- a. Verbally prepare resident for transfer.
- b. Apply proper sling so that the bulk of the sling rests in the resident's lower back region. Tighten the waist belt so it fits snug to the resident and re-tighten as you are standing resident.
- c. Apply calf strap if indicated on resident care plan.
- d. Remove wheelchair pedals. Position the sit/stand mechanical lift with the base of the lift open and lift is facing resident.
- e. Instruct/assist resident to place feet in the foot plate of the lift.
- f. Attach the strap of the sling to the lift without pulling or tugging.
- g. Instruct/assist resident to grasp handles on lift with arms on the outside of the sling.
- h. Instruct/assist resident to lean back into the harness as they are gently lifted minimally from the surface.
- i. Transfer resident to new surface.
- j. Wipe down the surface area of the resident grasp handles after transfer.

KEYPOINT: MAY LOCK BRAKES DURING SET UP TO KEEP LIFT FROM MOVING WHILE SECURING RESIDENT TO THE LIFT.

C. PROCEDURE FOR USE OF TRANSFER/GAIT BELT

Definition: A transfer/gait belt provides a firm, grasping surface for the caregiver, protects the resident from accidental trauma to the skin, provides a sense of security to the resident, and protects the caregiver from injury while transferring or ambulating a resident. Transfer/gait belts are not used on residents who are dependent in rising. The resident must be able to move feet in the desired direction during a transfer. Also, the resident should not require lifting or limited assist. If a resident is at risk for collapsing or falling, the transfer/gait belt is not the safest mode of transfer. A re-assessment is indicated. The sit/stand lift may be indicated or a full mechanical lift.

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1. **Equipment/Personnel**

- a. Transfer/Gait Belt
- b. One+ (second staff, as indicated, to manage equipment) or wheelchair to follow.

2. **Procedure**

- a. Explain purpose of belt and procedure of its use to the resident.
- b. Put the belt on over the resident's clothing and around the waist. Make sure the belt is snugly in place.
- c. Assist resident to a standing position by grasping the handles on the transfer/gait belt.

KEYPOINTS:

- Caregiver should be able to insert two fingers between the belt and the resident's clothing.
- Before assisting resident in transfer or ambulation, make sure that the belt is properly positioned, re-tightened, and that the buckles are securely fastened.
- Do not allow resident to place hands or arms around the caregivers neck.
- If a resident begins to slide while getting up, lock the resident's knees against the care-giver's knees.
- If the resident begins to fall during transfer/ambulation, pull the resident close to the care-giver's body using the transfer/gait belt and lower resident as far as your arms will extend to the floor.
- Use total mechanical lift to lift resident from floor.

D. PROCEDURE FOR USE OF THE NON-FRICTION DEVICE

Definition: A non-friction device helps to reduce the push/pull forces associated with re-positioning and laterally transferring residents.

1. **Equipment/Personnel**

- a. Non-Friction Device
- b. Two or more caregivers

2. **Use of Non-Friction Device to Reposition in Bed**

- a. Adjust bed to a height that promotes good body mechanics and place the bed in the flat position.
- b. Roll the resident to one side and position the non-friction device underneath the resident. Place a pad between the resident and the non-friction device.
- c. Position the non friction sheet with closed ends at resident head and feet.
- d. With at least one caregiver on either side of the bed, grasp the **pad** with the caregiver's palms down and maintain wrists flat on the bed while transferring.
- e. Using proper body mechanics, caregivers will shift their body weight toward movement direction sliding resident into proper position on the bed.
- f. ***Remove non-friction sheet by tucking it under resident's small of back and pull out on other side.***

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**KEYPOINT: THE NON-FRICTION DEVICE CANNOT BE LEFT UNDER THE
RESIDENT AFTER USE.**

PROCEDURE FOR USE OF NON-FRICTION DEVICE TO Laterally Transfer

1. Roll the resident until he/she is positioned on the non-friction sheet. A pad should be positioned between the resident and the non-friction device. Closed ends run hip to hip.
2. Adjust bed so that it is at the same height as the stretcher and so that the bed is in the flat position.
3. The caregivers should be positioned: one on the side of the supporting surface (Example: bed, stretcher, procedure table) and the other caregiver on the close side of the other supporting surface.
4. Grasp the sheet with the caregiver's palms down and maintain wrists flat on the bed.
5. Using proper body mechanics, the first caregiver shall push the resident towards the stretcher while the second caregiver receives resident and pulls the rest of the distance.
6. *Remove non-friction sheet by tucking it under resident's small of back and pull out on other side.*

**KEYPOINT: THE NON-FRICTION DEVICE CANNOT BE LEFT UNDER THE
RESIDENT AFTER USE.**

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F. PROCEDURE FOR USE OF GULDMANN CEILING LIFT

CEILING LIFT IN TUB ROOMS

Procedure:

- a. *There must be two caregivers present when using the Guldman Ceiling Lift*
- b. *Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.*
- d. *Verbally prepare resident for transfer.*
- e. *Position resident on the appropriate sling as per resident care plan.*
- f. *Position lift with spreader bar always perpendicular to the resident's shoulders and hovering over the chest.*
- g. *Attach the sling straps without pulling or tugging to the desired setting.*
- h. *Gently raise resident minimally from surface. Unweight them from the tub. Perform a safety check.*

KEYPOINT: USE MESH SLING FOR TUB BATHS AND LEAVE SLING ON RESIDENT.

CEILING LIFTS IN RESIDENT ROOMS

Procedure:

- a. *There must be two caregivers present when using the Guldman Ceiling Lift*
- b. *Adjust be to a height that promotes good body mechanics.*
- b. *Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.*
- d. *Verbally prepare resident for transfer.*
- e. *Position resident on the appropriate sling as per resident care plan.*
- f. *Position lift with spreader bar always perpendicular to the resident's shoulders and hovering over the chest*
- g. *Attach the sling straps without pulling or tugging to the desired setting. Consider elevating head of bed to facilitate ease in completion.*
- h. *Gently raise resident minimally from surface. Unweight them from the bed. Perform a safety check.*
- i. *Move resident half way down ceiling rail*
- j. *Press Junction Connection Box on wall for 2 seconds, until it releases*
- k. *Move resident into bathroom, then lock junction connection by pressing button on wall in bathroom for 2 seconds*
- l. *Place resident on toilet following Care Plan Instructions*

KEYPOINT: DO NOT COME RIGHT UP TO THE JUNCTION WHEN MAKING RAIL CHANGES

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COMPLIANCE:

- A. Ensuring staff participation, understanding NYS Veterans Home Zero Lift program, and having a qualified resource person with whom staff members can communicate problems are all forms of compliance.

Daily compliance with the program is the responsibility of each staff member. It is mandatory that all staff members adhere to NYS Veterans Home policies and procedures regarding resident handling.

The NYS Veterans Home Zero Manual Lift Committee will meet regularly to continually adjust the program. NYS Veterans Home promotes open communication between all parties involved in the program.

Total Mechanical Lift Competency Checklist

Staff Name : _____ Date: _____ Observed By: _____

YES	NO	1. Mechanical Lift Pre-Operations Check
		a. Understands why resident needs this lift.
		b. Demonstrates how to charge lift/locate batteries.
		c. Demonstrates ability to lower resident after lift has failed.
		d. Locate emergency stop button and its purpose.
		e. Checks to ensure the sling is in good working condition, no torn or ripped areas, etc.
		f. Able to locate and read battery charge indicator.
YES	NO	2. Mechanical Lift Operation
		a. ensures two caregivers are present.
		b. Adjust bed to height that promotes good body mechanics.
		c. Visually inspects sling for signs of wear and tear. Does not use any sling that is visually damaged.
		d. Verbally prepares resident for transfer.
		e. Positions resident on the appropriate sling size and style as per resident's Care Plan.
		f. Positions lift with spreader bar always perpendicular to the resident's shoulders and hovering over the chest.
		g. Attaches the sling straps without pulling or tugging to the desired setting. Considers elevating the head of bed to facilitate ease in completion.
		h. Gently raises resident minimally from surface. Unweight resident from bed. Performs a safety check.
		i. Turn resident's legs toward the perpendicular support bar of the lift during the move.
		j. Gently lowers resident into chair in proper position.
		k. Removes sling from under resident. Only leaves sling on resident if Care Planned.

Employee Signature Date

Sit/Stand Mechanical Lift Competency Checklist

YES	NO	1. Sit/Stand Lift Pre-Operations Check
		a. Understands why resident needs this lift.
		b. Demonstrates how and when to charge lift/locate batteries.
		c. Demonstrates ability to lower resident after lift has failed.
		d. Locate emergency stop button and its purpose.
		e. Checks to ensure the sling is in good working condition, no torn or ripped areas, etc.
		f. Able to locate and read battery charge indicator.
YES	NO	2. Mechanical Lift Operation
		a. Ensures two caregivers are present. Prior to use washes the surface area where resident's hands grasp the lift.
		b. Adjust bed to a height that promotes good body mechanics.
		c. Visually inspects sling for signs of wear and tear. Does not use any sling that is visibly damaged.
		d. Verbally prepares resident for transfer.
		e. Applies proper sling so the bulk of the sling rests in the resident's lower back region.
		f. Applies the calf strap if indicated on resident Care Plan.
		g. Demonstrates proper attachment of sling and adjustment of sling.
		h. Attaches the sling straps without pulling or tugging to the desired setting. Considers elevating head of bed to facilitate ease in completion.
		i. Cues resident for highest resident participation in transfer.
		j. Gently lowers resident into chair in proper position.
		k. Removes sling and places it back with the lift.

Employee Signature

Date

Transfer/Gait Belt Competency

Non-Friction Device Competency Checklist

Guldmann Ceiling Lift Competency Checklist

Staff Name : _____ Date: _____ Observed By: _____

YES	NO	1. Tub Room Transfers
		a. Demonstrates knowledge of how lifts function.
		b. Motor Malfunction: Demonstrates competency in operating lift device manually if there was a motor malfunction.
		c. Selects proper sling size per Care Plan.
		d. Explains equipment to resident: provides an overview of the equipment operations to the resident both prior to and during use.
		e. Safe resident handling: Demonstrates proper body mechanic practices when positioning sling and operating lift. For Example: Raises bed to appropriate height, minimizes reaching by working close to resident and devices and avoids bending and twisting.

Employee Signature Date

APPENDIX E



Nursing Policy & Procedure

Subject: **Safe Resident Handling Zero Manual Lift**

Policy #: 2110

Revision/Review Date: 2014-10-14

Objective: Heritage Ministries has a commitment to workplace safety and has implemented a Zero Manual Lift program for mechanical lifting, transferring and repositioning residents.

Introduction:

The basic objectives of the program are as follows:

- To increase the quality of care for the resident.
- To perform a safe and comfortable mechanical lift and/or transfer for the residents.
- To create a safe working environment by reducing the frequency of manual lifting, transferring and repositioning.
- To reduce and prevent work related injuries to caregivers.
- To reduce loss time hours related to injury and/or fatigue in staff.

Scope of Practice:

All employees who are responsible for lifting/transferring and positioning residents.

Policy:

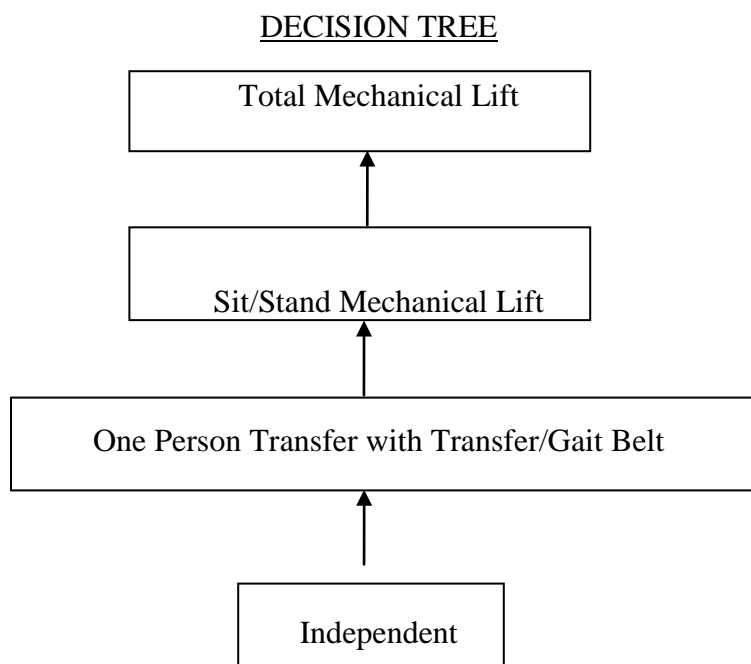
- A. All lifting and transferring of residents shall be performed utilizing the approved lift/transfer devices and methods to prevent resident and employee injury.
- B. RN's and therapists may assess resident lifting and transferring needs and determine the appropriate method to lift/transfer the resident. (see 2110.2 – Safe Patient Assessment Tool for assistance).
- C. Trained staff may lift and transfer residents after assessment has been completed by an RN or therapist.
- D. All employees responsible for lifting and transferring residents shall attend the Zero Manual Lift Training Program and demonstrate competency prior to lifting/transferring residents. (Attachment #2110.1 Employee Acknowledgement.)
- E. The organization will provide ongoing training and annually validate employee competency to improve safety and monitor compliance.

Protocol:

1. Resident Assessment and Data Collection

1. An initial lift/transfer needs assessment will be completed on the day of admission or at the time of a change in the resident status. Additionally, an annual assessment shall be done for long-term residents.
2. Select the appropriate lift/transfer status of the resident by referring to the Lift/Transfer Documentation (Attachment #2110.3) for assessment of resident criteria, contraindications, sling criteria and required staff.
Keypoint: A resident status may differ based on time of day or other factors. This may require two different levels of transfer during a single day. A secondary lift shall be identified when appropriate.
3. The caregiver shall consider his/her own ability, the environment and the resident current status prior to any lifts or transfers. When the caregiver feels that the current resident handling technique cannot be performed safely it is acceptable to move to the next higher level of transfer (i.e. Sit/Stand Mechanical Lift to a Total Mechanical Lift, Independent to a One Person Transfer with the Transfer/Gait Belt).
Keypoint: The caregiver shall not move to the next lower level of transfer without an RN/therapist first reassessing the resident's transfer lift status.

Keypoint: Long Term Care Unlicensed personnel must notify the licensed caregiver immediately prior to the lift/transfer so that a reevaluation can be done.
4. Refer to the Decision Tree when changing the resident lift status.



2. Care and Management

Resident:

1. The resident lift transfer shall be performed as determined by the lift/transfer assessment.
Exception: The RN/therapist shall determine the appropriate method of lift/transfer on the resident in the event of a medical emergency or fire.

Lift/Transfer Equipment:

1. All mechanical lifts shall be maintained in the designated area and plugged in for recharging when not in use.

Slings:

1. Place all soiled slings in designated laundry bag/hamper.

3. Safety

1. Assess integrity and function of all lift equipment prior to use. Any broken or malfunctioning equipment shall be removed from use and sent to maintenance.
2. Inspect prior to use all slings for signs of wear and tear or signs of compromised integrity including loose stitching, tears or fraying straps. Remove damaged slings and tag “DO NOT USE” and return to Nurse Manager.
Keypoint: Damaged slings shall be replaced never repaired.
3. Do not leave repositioning non-friction device under the resident after move/transfer is completed.
4. Always close the legs of the lift when moving the lift.
5. The brakes are to be on when the lift is parked and being charged and during the initial set up of the Sit/Stand lift.

Keypoint: Whenever you are operating the lift or lowering the lift the brake **must** be off.

4. Infection Control

1. Barriers shall be used between the resident’s skin and the sling. (E.g. underwear, incontinent pad).
2. Slings with minor soilage may be spot cleaned using approved disinfectant wipes.
3. A single dedicated sling shall be used for a resident on isolation and laundered after discharge.
4. Lifts will be cleaned as necessary when soiled.

5. Complications and Reportable Incidents

Report:

- All non-functioning equipment to Nurse Manager/Charge Nurse.
- All damaged slings to Nurse Manager/Charge Nurse.
- Employee injury during lifts or transfers. Complete incident report.
- Resident injury during lift or transfer. Complete incident report

6. **Documentation**

Documentation will include the following points: (for example, see attachment #2100.4)

- Identified transfer/lift status
- Identified sling/harness
- Any special transfer/lift needs
- Document in the individual resident care plan

7. **Compliance**

1. Ensuring staff participation, understanding Heritage Ministries' program and having a qualified resource person with whom staff members can communicate problems are all forms of compliance.
2. Daily compliance with the program is the responsibility of each staff member. It is mandatory that all staff members adhere to Heritage Ministries' policies and procedures regarding resident handling.
3. DONs will meet periodically to review the program as needed. Heritage Ministries promotes open communication between all parties involved in the program.
4. Each Nurse Manager/Supervisor shall provide compliance reports by completing Attachment #2110.4: Heritage Ministries Zero Manual Lift Policy Compliance Audit Tool and submitting it to the DON. These forms will be used to monitor the effectiveness of the policies on the floor and allow for continual improvement of the program.

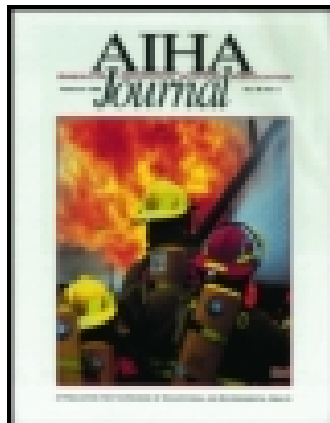
APPENDIX F

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Reducing Incidence of Low-Back Injuries Reduces Cost

Mary O'Reilly Brophy^a, Linda Achimore^b & Joyce Moore-Dawson^c

^a School of Public Health, University at Albany, 1 University Place, Rensselaer, NY 12144

^b Onondaga County, Loss Control, 421 Montgomery St., Civic Center, 15th Floor, Syracuse, NY 13202

^c Onondaga County, Health Department, 421 Montgomery St., Civic Center, 9th Floor, Syracuse, NY 13202

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AUTHORS

Mary O'Reilly Brophy^a
Linda Achimore^b
Joyce Moore-Dawson^c

^aSchool of Public Health,
University at Albany, 1
University Place, Rensselaer, NY
12144;

^bOnondaga County, Loss
Control, 421 Montgomery St.,
Civic Center, 15th Floor,
Syracuse, NY 13202;

^cOnondaga County, Health
Department, 421 Montgomery
St., Civic Center, 9th Floor,
Syracuse, NY 13202

Reducing Incidence of Low-Back Injuries Reduces Cost

To reduce musculoskeletal injuries in employees and to lower the financial costs associated with them, a 525-bed county nursing home in upstate New York initiated a five-step ergonomics program and purchased mechanical lifting devices. The five steps in the program were (1) creation of a resident transfer evaluation team, (2) establishment of an accident review committee, (3) mandatory ergonomics training for new nursing aides, (4) regular maintenance checks for lifting equipment, and (5) direct access to the management and budget process. During the 7-year period of this study, 8 smooth movers, 10 hydraulic stretchers, 7 Hoyer lifts, 1 Arjo lift, 9 Sarita lifts, and 1 Maxilift were purchased. Comparisons in health and financial outcomes were made between the preintervention period (1992–1993) and the intervention period (1994–1998). There was a significant reduction in the number of low-back injuries per 100 full-time nursing aides from 15.7 in the preintervention period to 11.0 in the postintervention period ($p < 0.05$). The total number of lost workdays was significantly ($p < 0.05$) reduced from 1476 per year before the intervention to 625 per year after the intervention. In addition, the lost workdays per full-time nursing assistant was significantly reduced from 7.8 to 3.0 ($p < 0.05$). Although the average number of lost workdays per injury decreased from 49 to 27 days, this decrease was not statistically significant. Financially, there was a significant reduction in the average yearly cost associated with low-back injuries from \$201,100 before the intervention to \$91,800 during the intervention.

Keywords: ergonomics program, low-back injury, nursing personnel, worker compensation cost

Back injury in nursing personnel has been recognized for many years as a serious problem both in terms of human suffering and financial demands.^(1–5) Several studies have identified personal and occupational risk factors that appear to be associated with an increased incidence of back injury in patient care givers.^(6,7) Each worker brings personal risk factors to the workplace, including past injuries, personality traits, and genetic factors. One of the strongest personal predictors of a future back injury is a history of previous back injury.^(8,9) Dissatisfaction with the job also has been reported as an important personal risk factor for developing a back injury.

Occupational risk factors are the conditions created in the workplace that have been associated with employee back injury. Lifting is the single most important occupational risk factor associated with low-back injury. Patient lifting has

long been identified as the primary occupational back stressor for nursing personnel.⁽¹⁰⁾ In addition to patient lifting, nursing personnel lift other heavy objects such as laundry bags and patient food trays. They also regularly push or pull objects such as wheelchairs, stretchers, food service trays, and laundry carts. Nursing personnel also engage in sustained awkward postures, most notably when caring for a patient in bed, but also when helping to feed patients and otherwise minister to their needs.⁽¹¹⁾

Because the back injury rate in nursing personnel is so high, several approaches have been described in the literature to reduce the incidence of low-back injury in the nursing profession. Some approaches have emphasized correct lifting technique,^(12,13) some have recommended ergonomic programs,⁽¹⁴⁾ and others have encouraged⁽¹⁵⁾ or discouraged⁽¹⁶⁾ the use of back belts, lifting teams, and mechanical lifting devices.⁽¹⁷⁾

Despite all the work that has been published in this area, back injuries continue to plague the nursing profession.

METHODOLOGY

One of the difficulties in understanding both the health and financial implications of occupational injuries is the multitude of ways these statistics can be calculated. To reduce some of the confusion that arises from this problem, it is important to carefully describe the basis and calculation of every statistic used. The following methodology was used to obtain information from worker compensation data maintained by the county director of loss control.

- Type of injury—only musculoskeletal injuries to the lumbar region associated with lifting, pushing, pulling, or working in awkward postures were included.
- Job title—only nursing aides were included in this study.
- Number of lost workdays associated with each injury—dividing the total number of lost workdays associated with low-back injury for the year by the number of low-back injuries in nursing aides provides the average number of lost workdays per injury.
- Medical cost associated with each case in the initial year of injury—dividing the total medical cost associated with low-back injury for the year by the total number of low-back injuries provides the average medical cost per case.
- Average weekly compensation rate—individual weekly compensation wages were averaged to determine the average weekly compensation rate each year. The average weekly compensation rate was multiplied by the total number of lost work weeks to obtain the cost of compensation wages for each year.
- Average weekly replacement rate—individual weekly replacement wages were averaged to determine the average weekly replacement rate. The average weekly replacement rate was multiplied by the total number of weeks that replacement workers were used to obtain the cost of replacement wages for each year. Replacement workers are usually nursing aides already employed at the facility who are working overtime. The time-and-a-half differential for overtime was not included in the statistics used in this study.
- The total cost of back injury for each year was obtained by adding the total medical cost to the total compensation wage and replacement wage costs.

The total investment costs were determined for each year by obtaining the purchase price from invoices for patient lifting devices and their associated replaceable parts, such as slings. The cost of training employees was not included in cost calculation because all training was performed by individuals already employed by the county and there were no additional outside costs associated with educational activity.

Intervention

The study was conducted at a 525-bed county nursing home facility in upstate New York. The county that ran the nursing home was self-insured.

The first new purchase of lifting equipment was in 1993 and included seven smooth movers and two hydraulic stretchers. The smooth mover is a board that facilitates sliding a resident from, for example, the bed surface into the wheelchair seat. In 1994 eight hydraulic stretchers, one smooth mover, four Hoyer lifts, and one Arjo lift were purchased. One smooth mover was purchased in 1995. No lifts were purchased in 1996. In 1997 nine

Sarita lifts, three Maxilifts, and one Hoyer lift were purchased. Two Hoyer lifts were purchased in 1998.

In addition to purchasing patient lifting equipment, the nursing home designed and implemented a five-step ergonomics program. The five steps were (1) creation of a resident transfer evaluation team, (2) establishment of an accident review committee, (3) mandatory ergonomics training for new nursing aides, (4) regular maintenance checks for lifting equipment, and (5) direct access to the management and budget process. Personnel involved with the ergonomics program were already employed by the nursing home and/or the county.

The evaluation team consisted of the county director of loss control, the safety director of the nursing home, a physical therapist from the nursing home physical therapy department, the employee health nurse, and a nurse trainer. The primary function of the evaluation team was to determine the transfer technique most appropriate for each resident. The team had five categories to choose from: no assistance, one-person assist, two-person assist, mechanical-lift assist, and special needs. Once the evaluation team determined the most appropriate transfer technique, nursing personnel had to follow the recommendation every time the resident was transferred. As the physical capabilities of the resident changed, the recommended lifting technique could also be changed. Any nursing aide could request that the evaluation team reassess the lifting technique recommended for a particular resident. In conjunction with determining the level of assistance required for each resident, the team also assigned the appropriate equipment to each resident and evaluated the lifting equipment to make sure that it functioned properly. All nursing personnel who took care of individual residents were required to use the specified transfer technique for the residents whenever they were moved or face disciplinary action.

The accident review committee scrutinized each accident and recommended followup action. The committee determined whether an accident was avoidable. Unavoidable accidents occur as a result of a resident's condition or action and are not specifically predictable. Avoidable accidents include personnel failure to follow procedures and/or implement proper technique, as well as mechanical malfunction of lifting equipment. Followup action to avoidable accidents could include additional observation of technique for personnel, disciplinary action, and fixing/removing broken equipment.

All new nursing aides were required to take a 7-hour ergonomics class. The ergonomics training provided an opportunity for nursing aides to learn about back injury prevention, to review the transfer and lifting equipment used at the nursing home, and to practice transfer techniques.

An integral part of the ergonomics program was maintenance. Monthly maintenance checks were performed on all equipment. The hydraulic system of the mechanical lifts was tested yearly. Nursing personnel were encouraged to recognize and immediately report equipment that needed repair. Equally important was having a maintenance department that responded quickly and was capable of performing the necessary repairs.

The fifth component in the ergonomics program was direct access to management and input into the budget process. People in the budget and purchasing departments were informed of the importance of obtaining quality equipment as well as the impact of low-back injuries on the budget. Educating management and budget personnel to view the cost of equipment in relation to the cost of low-back injuries is essential to a successful ergonomics program.

The multifaceted nature of this intervention precluded a non-arbitrary starting point, because all facets of the ergonomics program did not start at the same time. Any records available before 1992 were considered not reliable. The records for both 1992 and 1993 were used to determine the baseline for both the health and the financial outcomes. The ergonomics program was initiated in 1993 but did not come into full implementation until 1994. The first lifting equipment was purchased in 1993, but mechanical lifts were not purchased until 1994 or later. Additional lifting equipment was purchased every year beginning in 1993, except 1996.

Outcome Measures

As previously described, worker compensation data were used to calculate the number of back injuries, the number of lost workdays, and the cost of the injuries. The nursing home personnel department provided information on the number of nursing aides employed each year. The nursing home purchasing department provided information on the types and cost of equipment for each year of the study.

The outcomes used to evaluate the effectiveness of the ergonomics program were (1) the average number of low-back injuries (LBIs) each year, (2) the incidence (the number of LBIs per 100 full-time nursing assistants [FTNAs] per year), (3) the yearly average number of lost workdays (LWDs), (4) the yearly average number of lost workdays (LWDs) per FTNA, (5) the yearly average number of LWDs per injury, and (6) the yearly cost of low-back injuries. The total cost of low-back injury for each year between 1992 and 1998 is calculated by adding the total medical cost, the total compensation wages, and the total replacement wages for each year. The average cost per injury is calculated by dividing the total costs for each year by the number of cases of lower-back injury.

Data Analysis

An unpaired t-test was used to evaluate the significance at the 95% confidence level of the effect of the intervention on the number and incidence of low-back injuries, the LWDs per nursing aide and per injury, and the cost of low-back injury.

RESULTS

The average number of low-back injuries per year decreased from 30 in the preintervention period (1992–1993) to 21.5 per year during the intervention (1994–1998). This is significant at the 0.05 level. See Figure 1.

To determine whether the decrease was due to a decrease in the number of FTNAs, the number of back injuries per 100 FTNAs was evaluated. The number of FTNAs varied between a low of 173 in 1997 and a high of 217 in 1996. The incidence of back injuries per 100 FTNAs was reduced from an average of 15.7 before the intervention to an average of 11.0 during the intervention ($p < 0.05$). See Figure 1.

The yearly average number of LWDs decreased from 1476 before the intervention to 625.4 after the intervention. This difference is statistically significant at the 0.05 level. See Figure 2. The number of lost workdays per FTNA declined 62.8% from an average of 7.8 during the preintervention period (1992–1993) to an average of 3.0 during the intervention (1994–1998). This decrease is also statistically significant at the 0.05 level. See Figure 2.

There was no statistically significant difference, however, between the number of LWDs per injury in the preintervention and

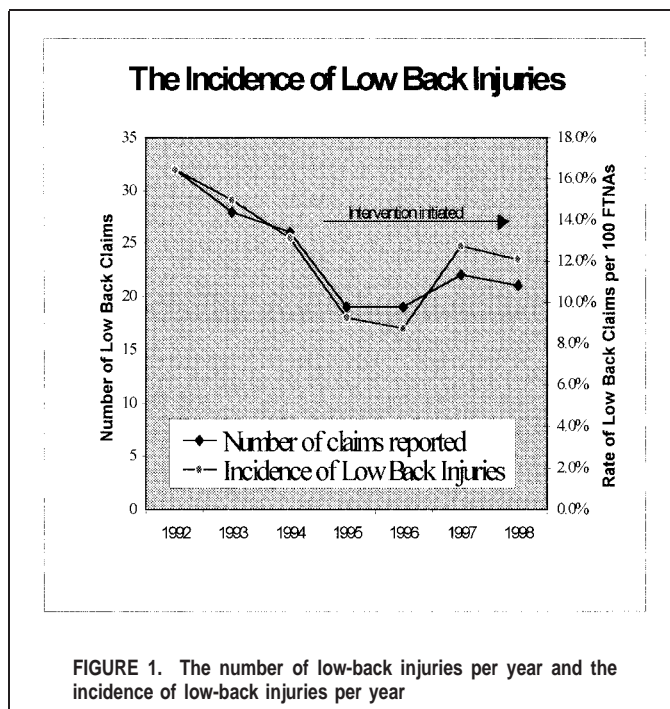


FIGURE 1. The number of low-back injuries per year and the incidence of low-back injuries per year

postintervention periods. The average number of LWDs per injury before the intervention was 50 compared with 29.4 in the post-intervention period.

The average yearly cost of back injuries before the intervention was \$201,100. The average yearly cost of back injuries during the 5 years since the initiation of the ergonomics intervention was \$91,800. This is a significant decrease in cost ($p < 0.05$). See Figure 2.

DISCUSSION

The intervention employed in this study consisted of two components: (1) lifting equipment and (2) the five-step ergonomics program. The purchase of resident lifting equipment constitutes

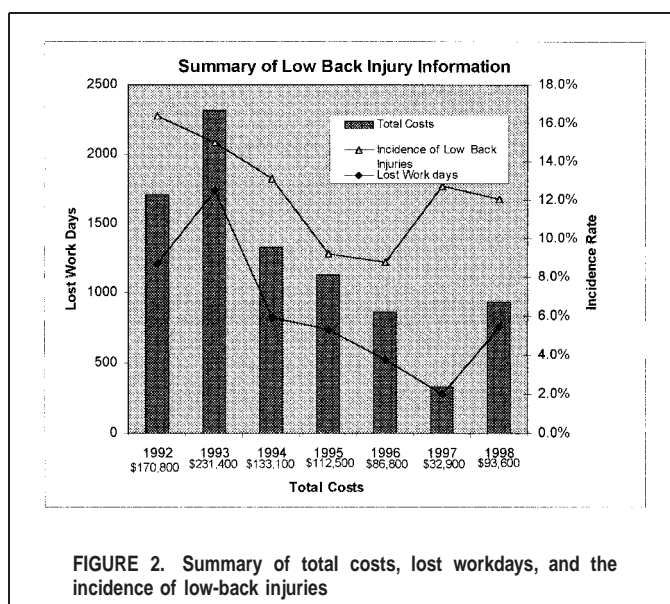


FIGURE 2. Summary of total costs, lost workdays, and the incidence of low-back injuries

modification of the workplace environment. The five-step ergonomics program constitutes behavior modification. Both these aspects were integral parts of the intervention.

The five-step ergonomics program was designed to change the behavior not only of nursing aides, but also of supervisors, administrators, and budget people. When the evaluation team determined the appropriate lifting protocol for a resident, the nursing aides were required to implement it. Disciplinary action was one of the consequences of not using resident lifting equipment when necessary. Behavior change also required prompt action to correct all mechanical problems with the lifting equipment. Additionally, a sufficient number of patient lifting devices had to be readily available. Before 1992 the few Hoyer lifts were rarely used because they did not have the appropriate number of slings and often no one knew where they were located.

The total cost of back injuries in nursing aides in this study is a very conservative estimate for three reasons. First, the replacement wages used in this study were the base rate and not the usual time-and-a-half rate. Replacement workers in the nursing home usually are other nursing aides employed by the home who are working overtime. The overtime rate is 150% of the base rate. When there is a shortage of nursing aides for a shift, some aides are recruited to work overtime. They are paid, of course, but the musculoskeletal stress from working 16 hours rather than the typical 8 hours could be increased exponentially and could and should be the subject of additional study. This cost has not been addressed either.

Second, the cost of the equipment has not been distributed across all injury types. For example, other types of injuries such as upper back, shoulder strains, and knee injuries have also been reduced by the intervention. The equipment that was purchased contributed to the decrease in these other non-low-back types of injuries. In this study, however, the full cost of the lifting equipment was balanced against only the cost of low-back injuries. This overestimates the proportion of costs that are directly related to reducing low-back injuries.

Third, none of the low-back injury cases were carried forward into subsequent years. For example, many worker compensation cases continue for more than a 12-month period. The methodology used in this article calculates only the new costs incurred each year and does not evaluate the costs associated with compensation cases that continue into the next calendar year. This underestimates the amount of money that the county is spending on compensation wages and direct medical costs.

If the compensation costs had continued at \$201,100, which was the average rate experienced in 1992 and 1993, the county would have paid an additional \$68,000 in 1994, \$88,600 in 1995, \$114,300 in 1996, and \$168,100 in 1997. Even in 1998, when the incidence and cost of low-back injuries increased again, the county still paid \$107,500 less than the average cost before the intervention. The total saved during the 5 years following the intervention was \$546,500. This is more than three times the total expenditure costs for lifting equipment and associated items, which were \$163,910.

These data support the thesis that an effective ergonomics program significantly reduces the low-back injury rate in nursing aides as well as the expenditure associated with back injury. The goal of the ergonomics intervention implemented in this study was to

change not only the workplace environment by introducing lifting equipment, but also the workplace culture. The culture change involves behavior changes that cannot be achieved or assessed quickly. When assessment of an effective ergonomics intervention occurs over a sufficiently long period of time (several years), the injury reduction, the cost savings, and the return on investment becomes apparent.

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APPENDIX G

SAFE PATIENT HANDLING POLICY

(Sample Outline)

Policy Objectives

Safe Patient Handling Program Objectives

- To increase patient quality of care.
- To perform safe and comfortable mechanical lifts and/or transfers for patients.
- To reduce the frequency of manual lifting, transferring and repositioning.
- To reduce and prevent caregiver work-related injuries.
- To reduce lost work time hours related to staff injury or fatigue.

Roles and Responsibilities

Employees

- Use lifts/transfer devices/methods for all patient lifts and transfers.
- Licensed professionals assess patient and determine appropriate lift/transfer method.
- Unlicensed assistive staff can lift/transfer patient after assessment is completed/documented
- SPH competency training required for all staff involved in patient lifts/transfers.
- Report employee and patient injuries to 'EE Health.

Management

- Support implementation of SPH policy and promote a *Culture of Safety*.
- Furnish sufficient lifting equipment/devices
- Make equipment accessible & maintain it.
- Ensure sufficient staffing to use SPH method.
- Ensure patient assessment/documentation.
- Ensure staff compliance with SPH policy.
- Ensure staff competency requirements met.
- Ensure reporting of accidents/injuries.

SPH/Ergo Committee

- Lead implementation of SPH policy/promote Culture of Safety

- Assess injury data, equipment, and facility environment to determine SPH needs.
- Oversee equipment selection
- Set criteria for evaluating patients
- Ensure staff competency training/retraining/evaluation
- Transition program onto the units.
- Oversee program audits/evaluation
- Review incidents/AAR

Protocols

Guidelines we can use to ensure good:

- Patient Assessment
- Care and Management
- Safety
- Infection Control
- Complications & Reportable Incidents
- Compliance

Patient Assessment Protocol

A Licensed Professional shall:

- Complete patient assessment
 - Upon admission
 - When there is a change in patient status
 - On a quarterly basis (reassessment)
- Use Lift/Transfer Assessment Tool
- Document Patient Lift/Transfer (patient care plan)

A Direct Caregiver shall:

- Consider his/her own ability, the environment and patient status prior to any lift/transfer
- If no change in status
 - Follow care plan lift/transfer recommendation
- If change in status, notify a licensed professional
 - Use new level of transfer if recommended

Refer to the Decision Tree when changing patient lift status

Full Mechanical Assist	Dependent
Sit/Stand Mechanical Assist	Extensive Assistance
Transfer/Gait Belt	Supervision/Limited Assistance
No lift Equipment	Independent

Care and Management Protocol

Patient

- Perform patient transfer as documented in care plan

Lift/Transfer Equipment

- Park all mechanical lifts in designated areas
- Plug in lifts for recharging when not in use

Slings

- Place all soiled slings in designated laundry bag/hamper.

Infection Control Protocol

- Use barrier between patient's skin and sling
- Spot- clean slings with minor soilage (use approved disinfectant wipes)
- Use single dedicated sling for a patient with communicable illness/M.R organism
- Launder dedicated sling after discontinuation or discharge
- Wipe down framework/hardware prior to use on another patient

Safety Protocol

- Assess all equipment prior to use.
 - Note Integrity and function
 - Remove, tag any broken equipment
 - Report any non-functioning equipment
- Inspect slings
 - Note signs of wear and tear
 - Remove damaged slings and tag

- Return to unit manager
- Non-friction device: don't leave under patient after transfer

Infection Control Protocol

- Use barrier between patient's skin and sling
- Spot- clean slings with minor soilage (use approved disinfectant wipes)
- Use single dedicated sling for a patient with communicable illness/M.R organism
- Launder dedicated sling after discontinuation or discharge
- Wipe down framework/hardware prior to use on another patient

Complications and Reportable Incidents Protocol

- Report all damaged slings to nurse manager/supervisor
- Report all employee injuries to Employees Health; do an incident report
- Report patient injury during lift/transfer to unit manager/physician
- Report all of the above to SPH Point Person(s)

Compliance

- Ensuring staff participation, understanding the SPH program, and staff communication with SPH Resource/Point Person are forms of compliance.
- Daily compliance with the program is the responsibility of each staff member.
- Adhering to the SPH policies and procedures is mandatory for all staff
- SPH Resource/Point Person will facilitate After-Action Reviews to continually adjust the SPH program.
- Each unit/floor's manager shall provide compliance reports using the Compliance Audit Tool
- The employer shall not take retaliatory action against any nurse or caregiver for raising concerns or issues regarding patient handling, filing a complaint or refusing to engage in patient handling

Documentation and Competency

Lift Transfer Competency (is your staff able to:)

- Identified transfer/lift status
- Identified sling/harness
- Identified size when indicated
- Any special transfer/lift needs

APPENDIX H-1

**CVPH MEDICAL CENTER
PATIENT SERVICES/POLICY**

Generic

SUBJECT: <i>Lift By Exception</i>		
WRITTEN BY: Christine Meister, Director of Rehabilitation Sharon Olmstead, RN, Project Co - Director		RESPONSIBLE DEPARTMENT: Safe Patient Handling Committee
CONTRIBUTING DEPARTMENT(S): Environmental Services, Facilities		
ADMINISTRATIVE APPROVAL: J. BRUNELL 12/11		POLICY CREATION DATE: 7/22/2010
STANDARDS NUMBER(S):	SUPERSEDES POLICY: NEW DATED:	<small>(Revised Date denotes the current edition of policy)</small> REVISED DATE:
REVIEW DATES & INITIALS OF REVIEWER:		
OTHER RELATED POLICIES: (LIST POLICY TITLE & DEPT. IF NOT ADMIN.)		

Purpose:

To ensure optimal level of safety for both patients and staff while transferring and moving patients.

General Content:

A. Background:

1. CVPH has a commitment to workplace safety and is implementing Lift By Exception Program for mechanical lifting, transferring, and repositioning patients/residents. The basic objectives of the program are as follows:
 - To increase the quality of care for the patient/resident.
 - To perform a safe and comfortable mechanical lift and/or transfer for the patients/residents.
 - To create a safe working environment for the staff by reducing the frequency of manual lifting, transferring and repositioning.
 - To reduce and prevent work related injuries to caregivers.
 - To reduce loss time hours due to injury and/or fatigue in staff.

B. Education and Personnel:

1. All lifting and transferring of patients shall be performed utilizing the approved lift/transfer devices and methods to prevent patient and employee injury.
2. RN's will assess patient lifting and transferring needs and determine the appropriate method to lift/transfer the patient.
3. Unlicensed assistive personnel may lift and transfer patients after RN has completed the assessment.
4. All employees responsible for lifting and transferring patients shall attend the Lift By Exception Training Program and demonstrate competency prior to lifting/transferring patients.
5. The organization will provide ongoing training to ensure safety and monitor compliance.

6. Employee Competency shall be validated and remediation provided for the following employees:
 - Those transitioning back to full duty following an injury related to patient/resident handling. Employee Health will notify director.
 - Those involved with any patient/resident incident or near miss.
 - Any observed poor performance. A record will be kept to track repeated issues for an employee, as well as a record for the nursing unit as a whole.
7. Ensuring staff participation, understanding program, and having a qualified resource person with whom staff members can communicate problems are all forms of compliance.
8. The Safe Patient Handling Committee will meet regularly to continually adjust the program. CVPH promotes open communication between all parties involved in the program.

C. Patient Assessment:

1. An initial lift/transfer needs assessment will be completed by the RN on the day of admission or at the time of a change in the patient/resident status.
2. RN will select the appropriate lift/transfer status of the patient by referring to the Lift/Transfer Protocol for assessment of patient criteria, contraindications, sling criteria and required staff.
Keypoint: A patient status may differ based on the time of day or other patient factors. This may require two different levels of transfer during a single day.
3. The caregiver shall consider his/her own ability, the environment and the patient current status prior to any lifts or transfers. When the caregiver feels that the current patient handling technique cannot be performed safely, patient should be moved to the next higher level of transfer (i.e. Sit/Stand Mechanical Lift to a Total Mechanical Lift, Independent to a One Person Transfer with Transfer/Gait Belt).
Keypoint: The caregiver shall not move to the next lower level of transfer without first reassessing the patient's transfer lift status (i.e. Total lift to Sit/Stand lift). Unlicensed personnel must notify the RN immediately prior to the lift/transfer so that a re-evaluation can be done.
4. Refer to the Patient Handling Assessment Tool located on the equipment when changing the patient/resident lift status.
Patient Handling Assessment Tool
 Independent
 One Person Transfer with Gait Belt
 Sit/Stand Equipment
 Total Mechanical Lift

D. Patient refusal

1. In the event that a patient refuses to allow staff to utilize the equipment according to policy, staff will follow this procedure:
2. First educate the patient and family in the importance of safety for patient and staff, and the fact that using the equipment is our standard. Elicit what might be an obstacle for the patient to use the life equipment.
3. Conduct a family meeting to open a dialogue about the reasons patient is refusing, such as fear, anxiety, previous bad experiences etc. Staff are to enlist the help of management to arrange family meetings etc.

4. If patient still does not agree, notify charge nurse, case coordinator and/or physician as needed, so they can attempt to counsel the patient.
5. If none of these measures help, inform patient that we will not be able to move him/her without the proper equipment and document this thoroughly in event note. Document what measures were taken to attempt to elicit compliance.
6. Whenever possible, staff should continue to attempt to persuade patient to be moved/transferred using appropriate method and equipment.
Keypoint: Staff will NOT compromise safety and quality of care by going outside the policy to move the patient at any time.

E. Reportable Incidents

1. Report following standard procedures for reporting and recording:
 - all non-functioning equipment;
 - all damaged slings;
 - employee injury during lifts or transfers;
 - patient injury during lift or transfer;
 - patient fall during lift or transfer.

F. Cleaning and infection control:

1. Barriers shall be used between the patient's skin and the sling, such as sheet, underwear, incontinence pad, gown.
2. Slings and Maxislides with minor soiling may be spot cleaned using hospital approved disinfectant wipes.
3. Maxislides will be laundered after the patient is discharged from the bed.
4. A single dedicated sling shall be used for a patient on isolation and disposed of on discharge of patient. Once patient is no longer in isolation, patient can use a regular sling.
5. The framework/hardware shall be wiped down with hospital approved disinfectant wipes prior to use on another patient.
6. Place all soiled slings and Maxislides in designated purple laundry hamper, the content of which will be retrieved by environmental services staff, not sent down the linen chute.
7. Paper slings are disposable and are not to be washed.

G. Equipment and Devices:

1. All mechanical lifts shall be kept in the designated area when not in use and batteries placed in charger when appropriate.
2. Assess integrity and function of all lift equipment prior to use, including slings. Any broken, torn or malfunctioning items shall be removed from use and reported following standard procedure.
3. For use of specific devices/equipment, refer to Procedure for use of Lift By Exception Equipment.

H. Documentation:

1. The RN shall document the appropriate level of assistance, what equipment to use and any special needs on admission and at least once per shift. The caregiver completing the transfer shall document at least once per shift the equipment used, the level of assistance and any other pertinent information regarding mobility,

transfer and lifting. Which sling to use will be noted in the comment section of the Equipment screen.

I. Departmental and Employee Responsibilities:

1. Employee is responsible for:
 - Attending education in correct use of the equipment, the policy, procedure and documentation requirements.
 - Ensuring equipment is functioning properly prior to use and to report any unsafe items.
 - Explaining to the patient the process involved and ensuring the patient's comfort during transfer.
 - Making sure reusable slings and Maxislides are put in purple hamper for washing.
 - Daily compliance with the program. It is mandatory that all staff members adhere to policies and procedures regarding patient/resident handling.
2. Department Nursing unit leadership will:
 - Be responsible for oversight of compliance using the equipment;
 - Designate a space for storing of the equipment;
 - Make sure employees properly report any issues, such as patient falls/injuries and employee injuries;
 - Provide compliance reports as requested by completing Compliance Audit Tool and submitting it to the committee.
3. Safe Patient Handling Committee will be responsible for:
 - The initiation of the program on the unit;
 - The initial staff training;
 - Providing the tools necessary to track/measure success;
 - Tracking patient injuries related to patient handling (Patient Injury Log);
 - Reporting to the Safety Council.
4. Environmental services will be responsible for:
 - Picking up the soiled slings and Maxislides from the purple hamper;
 - Completing the laundry of these and hang them to dry on the hooks in the equipment room.

APPENDIX H-2

The heart and science of medicine.

UVMHealth.org/CVPH

UVM-CVPH Lift By Exception Program

*“Safe Patient Handling”
means injury prevention that helps everyone!*

Presented by:

Gregory Freeman, RN, Supervisor of Occupational
Health & Wellness

Tracy L. Coleman, RN, BS, Clinical Education Manager

THE
University of Vermont
HEALTH NETWORK

Champlain Valley Physicians Hospital

Objectives

- To improve patient quality of care
- To reduce patient injuries during handling & transfer
- To decrease staff injuries related to patient handling & transfer
- To reduce lost work time hours related to staff injury
- To reduce costs associated with staff and patient injury related to patient handling & transfer

Safe Patient Handling Benefits Everyone Involved...

Staff:

- Decreased musculo-skeletal injuries
- Decreased staffing shortages
- Increased staff satisfaction
- Decreased staff turnover



Patients/Residents:

- Decreased falls
- Decreased skin tears
- Increased dignity
- Increased mobility and function
- Decreased length of stay

UVM-CVPH's Timeline....

- Applied for Safe Patient Handling Grant with NYS Dept. of Health 2008
- Pilot unit chosen & funded by capital budget
- 80% of staff must be trained per CVPH policy
- LBE Program roll-out July '08

Pilot Unit: R5-Med/Surg (41 Beds)

- Results after 6 Months:
 - Dramatic ↓ staff injuries
 - lost work days
 - 97% ↓ w/c costs (\$52,000 to \$1,311)
 - ↓ 23% patient falls
 - Recovered money from worker's compensation was then spent purchasing new equipment.

2009















Program was introduced to include the remaining Medical Surgical units.

- R6-39 Beds
- R7-42 Beds

2010 and 2011

New Units:

- SNF/TCU
- Progressive Care R3
- ICU

2009-2011	SNF	ICU	PROG.
Worker Comp. costs R/T Patient Handling	 97%	 96%	 95%
Staff Injuries R/T Patient Handling	 53%	 80%	 61%
Lost Days R/T Patient Handling Injuries	 70%	 85%	 70%
Transitional Days R/T Patient Handling Injuries	 66%	 100%	 90%
OSHA reportable Patient Handling Injuries	 25%	No Change	 67%

2013

Safe Patient Handling assessment through Arjo Huntleigh “Diligent” Program.

This evaluation was a complete assessment involving inpatient and outpatient services identifying:

- Unit specific needs
- Equipment available
- Equipment needed
- Processes in place
- Needed training/competencies

2013-2014

New Units:

PACU, Cath Lab, Radiology,
Emergency Care Center & Morgue
Progressive Care R4—2 ceiling lifts
installed (Feb 2014)

To Use or not to use....Use



The Patient Handling Assessment Tool

The “Lift By Exception” Algorithm

- RN always does the assessments (On admission/transfers and q shift)
- CAs/CNAs can always use a “higher level of assistance if needed”.
- Patient ability and assistive equipment needed, may change over the course of the day & need to be documented.
- Again, reassess with any change.

Patient Handling Assessment Tool

Patient Assessment:		Patient Handling Equipment:
Is Patient safe to be up alone based on “Fall Risk” assessment?	YES	Up ad lib
NO		
Can the patient step in place and bear weight? Good balance?	YES	Minimal Assist or w/ Gait Belt
NO		
Stands with minimal assist? Good upper body strength? Able to cooperate?	YES	Stedy
NO		
Can sit up with assistance? Bears some weight? Some upper body strength? Follows simple instructions? Can tolerate pressure on back?	YES	Sara (less than 440lbs)
NO		
Does the patient weigh less than 500 lbs?	YES	Maximove Lift
NO		Tenor Bariatric Lift

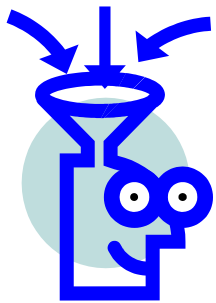
LBE Equipment

- “Stedy” - Patient Standing /Transfer Aid
- Sara3000 – Sit-to-Stand Lift
- Maximove” Total Lift
- “Tenor” Bariatric Total Lift
- “Maxislides” –Patient Transfer Sheets
- “Ultramove” - Bariatric Patient Standing/ Transfer & Ambulation Aid
- Gait belts



Staff Training

- All new staff receive education on the LBE Program during General Orientation.
- Before using any patient handling equipment staff are required to demonstrate competence skills to a LBE trainer.
- CVPH patient care staff includes: RN,LPN, CA,CNA, Transporters, & Respiratory therapists, must maintain yearly competencies on all patient handling equipment.



Unit Core-Trainers

- Act as LBE resource for peers/patients/families
- Conduct staff training on SPH issues, equipment, etc.
- Orient new employees to LBE equipment
- Assist staff with proper documentation when using equipment for patient care.

New Changes

- Standardization of equipment
- Restructuring the Model of Care to a partnership approach
- Online Injury report system includes LBE questions
- Worker's Comp monthly report
- Process evaluation/improvements

Moving Forward.....

Organizational Culture Change

Accountability

Sustainability

Patient/Family Education

For Everyone's Safety, Please Remember...

“Safe Patient Handling” means injury prevention that helps everyone.

&

Remember....."Our patients are getting thicker, sicker, and we are getting older."

Work smart!



Be safe!

Questions??

TEAMWORK



For more information, please contact:

Tracy L. Coleman, RN, BS, Clinical Education Manager
at (518) 562-7329 or tcoleman@cvph.org

Gregory Freeman, RN, Supervisor of Occupational
Health & Wellness at (518)562-7465 or gfreeman@cvph.org

APPENDIX H-3

The heart and science of medicine.

UVMHealth.org/CVPH

University of Vermont Health Network Champlain Valley Physicians Hospital Lift By Exception Program

“Safe Patient Handling”
means injury prevention that helps everyone!

Presented by:

Gregory Freeman, RN, Supervisor of Occupational
Health & Wellness

Tracy L. Coleman, RN, BS, Clinical Education Manager

THE
University of Vermont
HEALTH NETWORK

Champlain Valley Physicians Hospital

Objectives

- To identify outcomes evident by implementing a Safe Patient Handling and Mobility (SPHM) program
- To comply with NYS Legislation
- To identify barriers and challenges to sustain a SPHM program

UVM Health Network-CVPH's Journey....

- Applied for Safe Patient Handling Grant with NYS Department of Health 2008
- Pilot unit chosen & funded by capital budget
- 80% of staff trained per CVPH policy
- Lift By Exception Program (LBE) implemented in July 2008

Pilot Unit: R5-Med/Surg (41 Beds)

- Results after 6 Months:
 - Dramatic ↓ staff injuries
 - ↓ lost work days
 - 97% ↓ w/c costs (\$52,000 to \$1,311)
 - ↓ 23% patient falls
 - Recovered money from worker's compensation was then spent purchasing new equipment.

LBE Program Expansion















2009

- R6-39 Beds
- R7-42 Beds

2010 & 2011

- Skilled Nursing Facility
- Progressive Care R3
- ICU

LBE Unit Outcomes

2009-2011	SNF	ICU	PROG.
Worker Comp. costs R/T Patient Handling	 97%	 96%	 95%
Staff Injuries R/T Patient Handling	 53%	 80%	 61%
Lost Days R/T Patient Handling Injuries	 70%	 85%	 70%
Transitional Days R/T Patient Handling Injuries	 66%	 100%	 90%
OSHA reportable Patient Handling Injuries	 25%	No Change	 67%

SPHM Evaluation

Safe Patient Handling assessment by consultant.

Involved inpatient and outpatient services

Identified:

- Unit specific needs
- Equipment available
- Equipment needed
- Processes in place
- Needed training/competencies

2013 Organizational Changes

- Standardization of equipment
- Model of Care to a partnership approach
- Online Injury report system includes LBE questions
- Worker's Comp monthly report
- Process evaluation/improvements

LBE Program Expansion

2013-2014

PACU, Cath. Lab, Radiology,
Emergency Care Center, Morgue
Progressive Care R4—2 ceiling lifts
installed (Feb 2014)
Child Women Center

2014 NYS SPH Legislation

New York State Safe Patient Handling Policy:

- An Act to amend the Public Health Law and the Education Law in relation to a Safe Patient Handling Policy for Health Care Facilities. It is in the Public interest to enact a state wide Safe Patient Handling Policy

2014 Gap Analysis

Create a facility Safe Patient Handling Policy

Management commitment and employee involvement

Create SPH Committee or roll into a current Committee

Facility SPH program which will include:

- ❖ Risk assessments
- ❖ Incident investigation
- ❖ Recommendations regarding procurement of engineering controls, lifting and transfer aids, or assistive devices
- ❖ Employee training and education on SPH
- ❖ Annual program evaluation and modification

Deficits Identified by Gap Analysis

- Establish SPH committee
- SPH training and education requirements
- Post investigation review, to include a plan of correction and implementation controls

Next Steps

- **SPH Committee Formation**

Do we roll into Safety Advocate?

Quarterly report to Safety Council?

- **Training / Competencies**

How to monitor completion?

How to monitor policy compliance?

SPH Committee

- Currently Safety Advocates have been provided 4 hours per month to work on unit specific safety goals.
- Requesting an increase to 8 hours per month to help comply and excel at meeting NYS regulations.
- Safety Advocates will help to sustain a SPH program that is driven by clinical support with frontline staff to prevent injuries while performing patient handling tasks.
- Safety Advocates will be divided further into two sub-committees (depending on their work areas):
 - 1 - Safe Patient Handling
 - 2 - Personal Protective Equipment

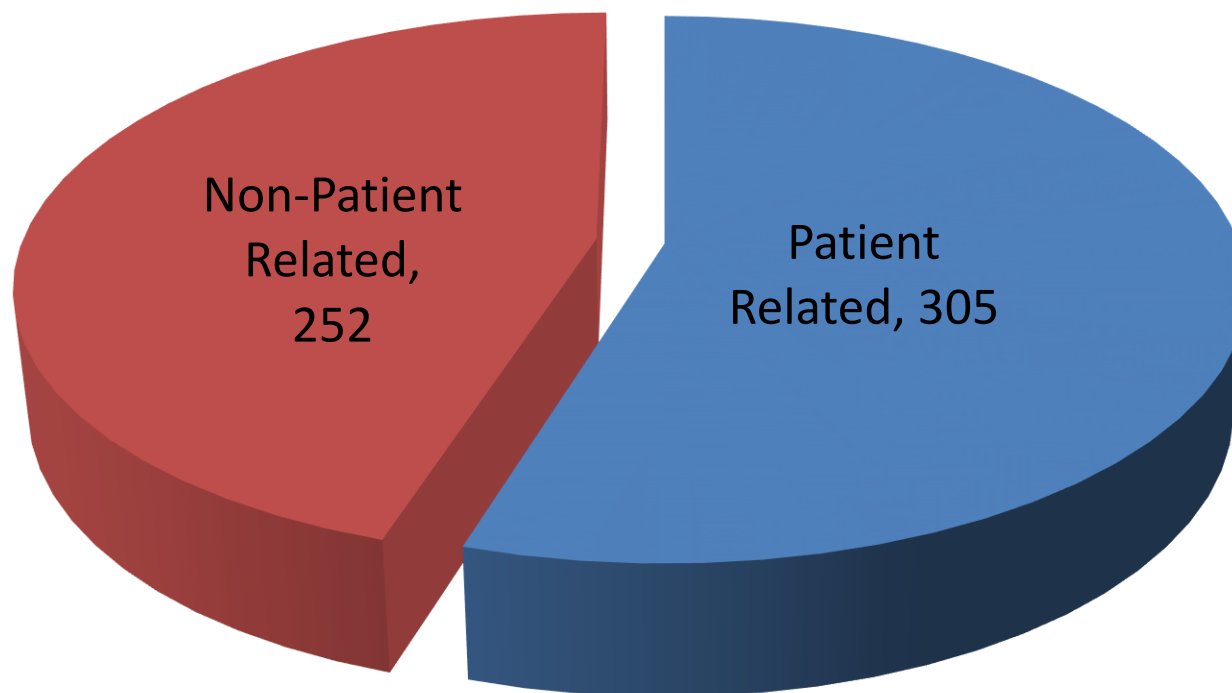
SPH Core Unit Trainers

- Support the facility's SPH program, provide leadership, and maintain communication with management regarding the status of the program.
- Seek feedback from staff and report to the Safe Patient Handling Committee.
- Conduct and document annual competencies and orient new staff in the unit.
- Act as resource person and assist with solution's for task issues.

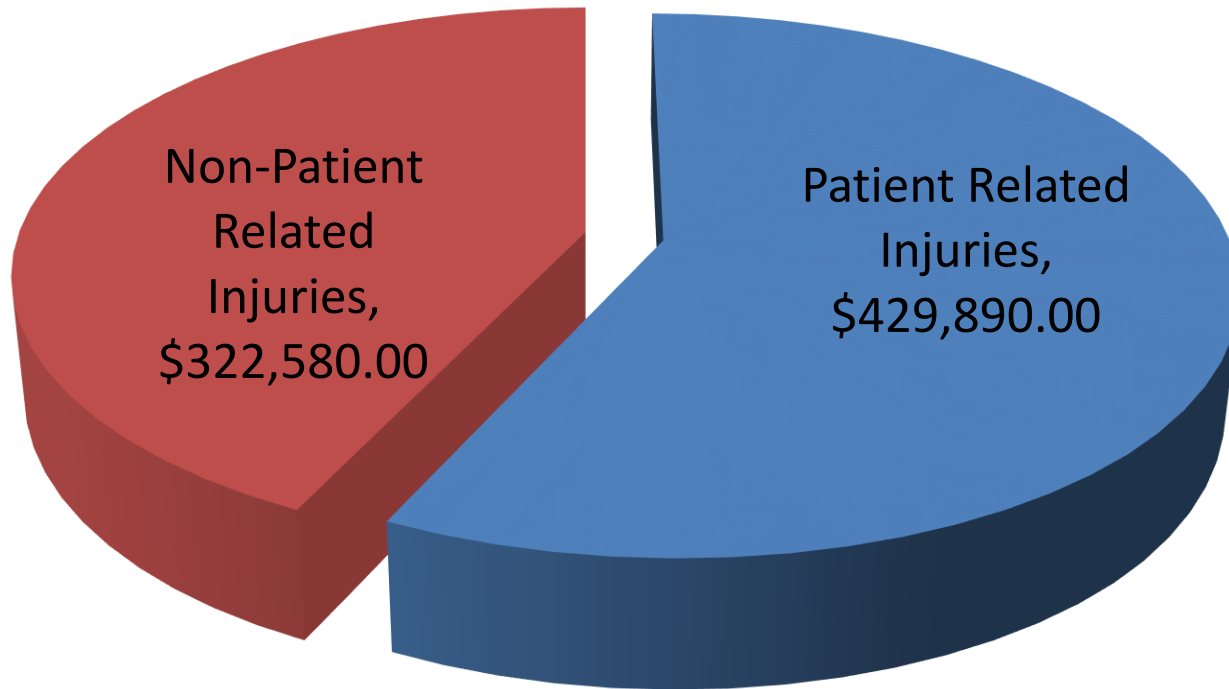
Staff Training & Education

- All new staff receive a 3 hour hands-on class on the SPH program during clinical orientation.
- All patient care staff must maintain yearly competencies on unit specific SPH equipment.
- Complete annual Health Stream modules on SPH equipment.

2013 Injury Breakdown

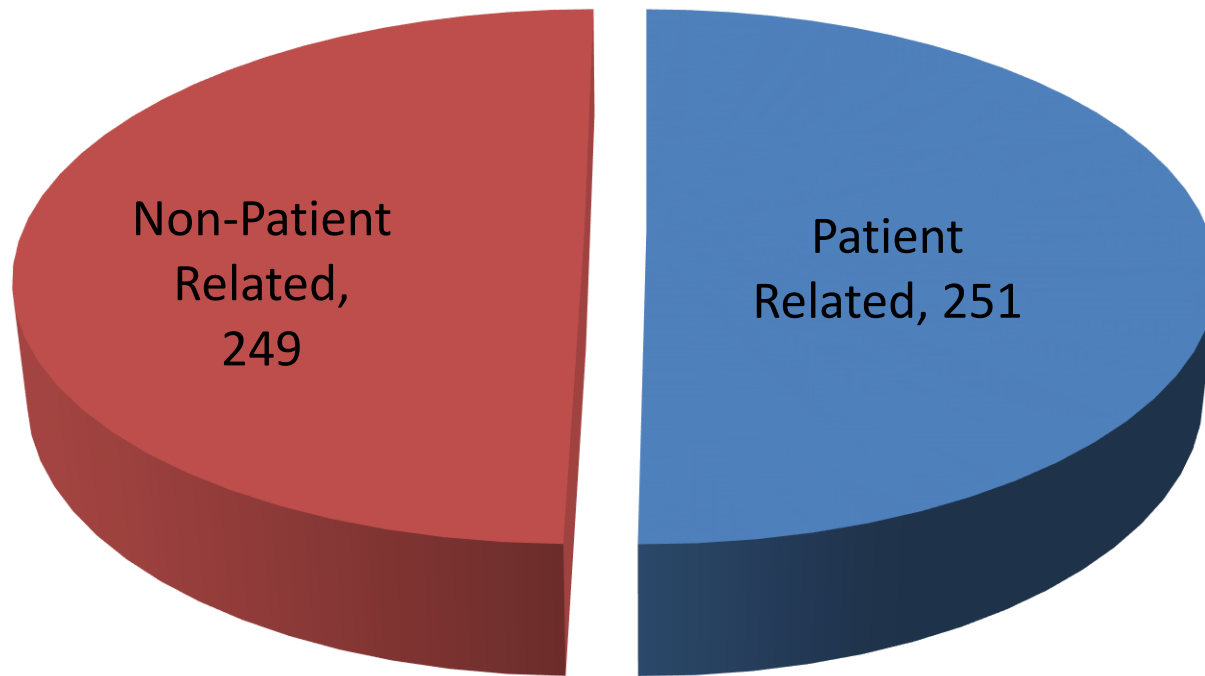


2013 Total Injury Costs

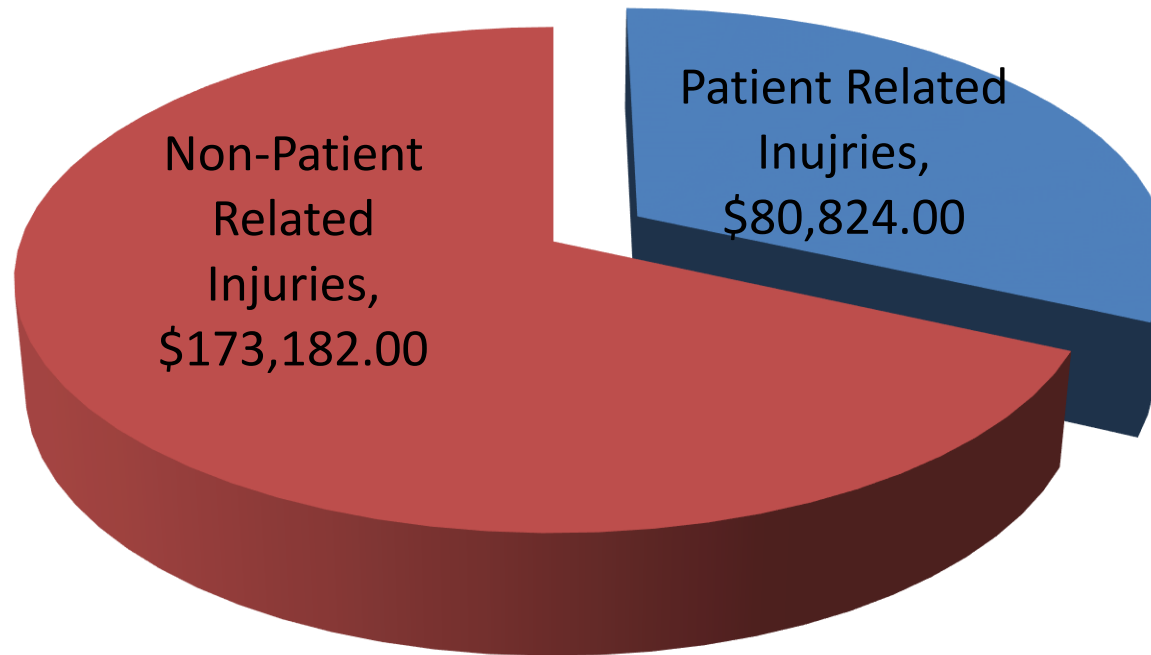


Total Costs including current reserves \$ 752,470.00

2014 Injury Breakdown

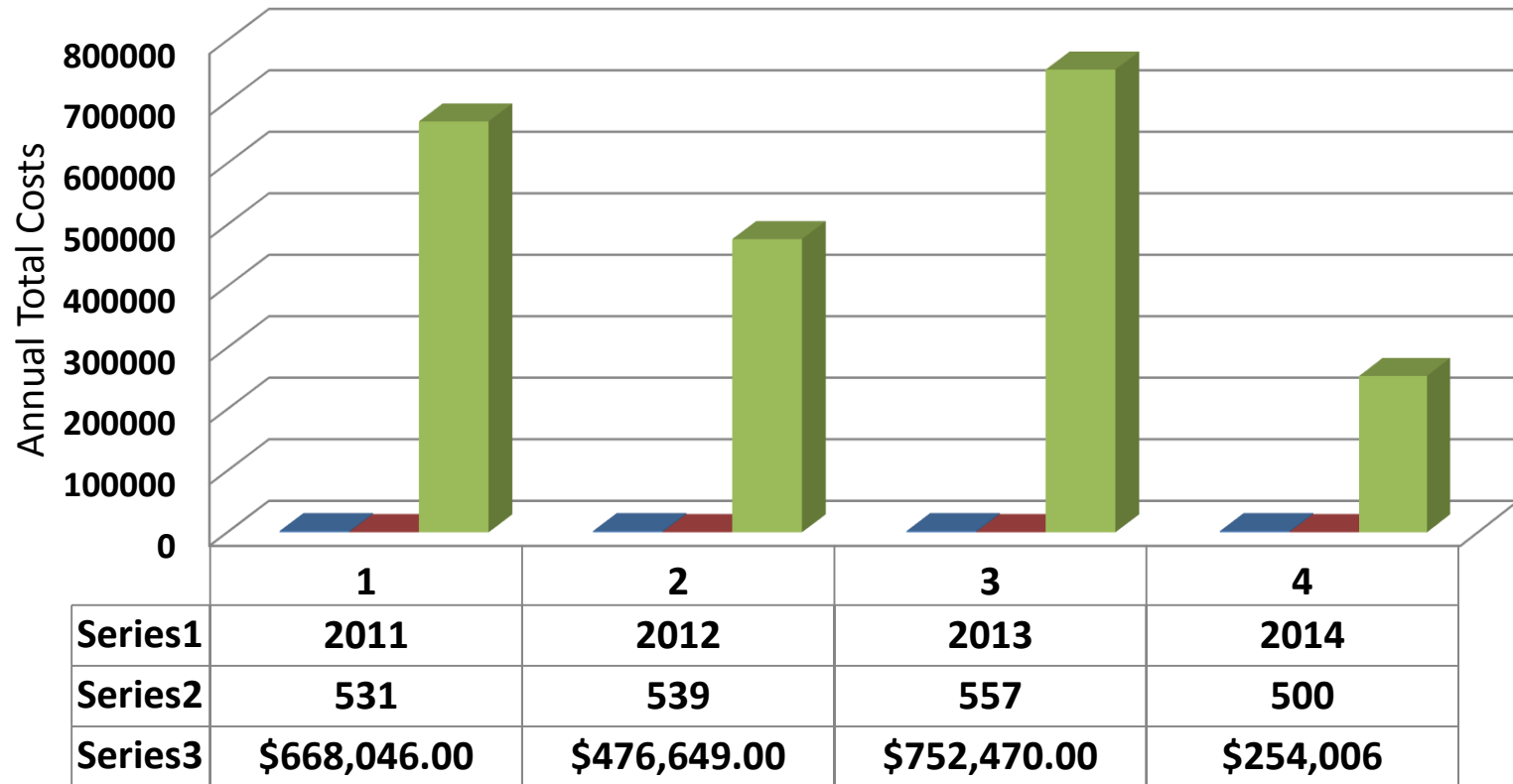


2014 Total Injury Costs



Total Costs including current Reserves = \$ 254,006.00

Annual Cost Comparison



Moving Forward.....

Organizational Culture Change

Accountability

Sustainability

Patient/Family Education

For Everyone's Safety, Please Remember...

“Safe Patient Handling” means injury prevention that helps everyone.

&

Remember....."Our patients are getting thicker, sicker, and we are getting older."

Work smart!



Be safe!

Questions??

TEAMWORK



For more information, please contact:

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APPENDIX H-4

The heart and science of medicine.

UVMHealth.org/CVPH

The University of Vermont Health Network- Champlain Valley Physicians Hospital

Safe Patient Handling Program

Presented by: Tracy Coleman, RN, BS, Clinical
Education Manager & Gregory Freeman, RN,
Supervisor Occupational Health & Wellness Center

THE
University of Vermont
HEALTH NETWORK
Champlain Valley Physicians Hospital

OBJECTIVES

- To create a sustainable, safe patient handling program that is driven by clinical support with frontline staff to prevent injuries while performing patient handling tasks.
- To become a leader among healthcare industries in the greater North Country in providing safety to our patients and our employees.
- To comply and excel at meeting NYS Safe Patient Handling regulations.



The Why?

- Evidence of back-related workers compensation claims reveal that nursing personnel have among the **highest claim rates** of **any** occupation or industry.
- Healthcare is the only profession that considers **100 lbs.** Lightweight!
- The cumulative weight lifted by a nurse providing direct patient care in a typical **8-hour** workday is estimated to be **1.8 tons**
- Nurses, CNAs and LPNs spend **20-30%** of their time bent forward or with the trunk twisted during patient care activities
- NIOSH safe weight limit for safe lifting is 35lbs
- Obesity has increase to 1:5 adults
- **Recommended “Best Practice”** based upon AOHN, AORN, APTA, Magnet and ANA Guidelines

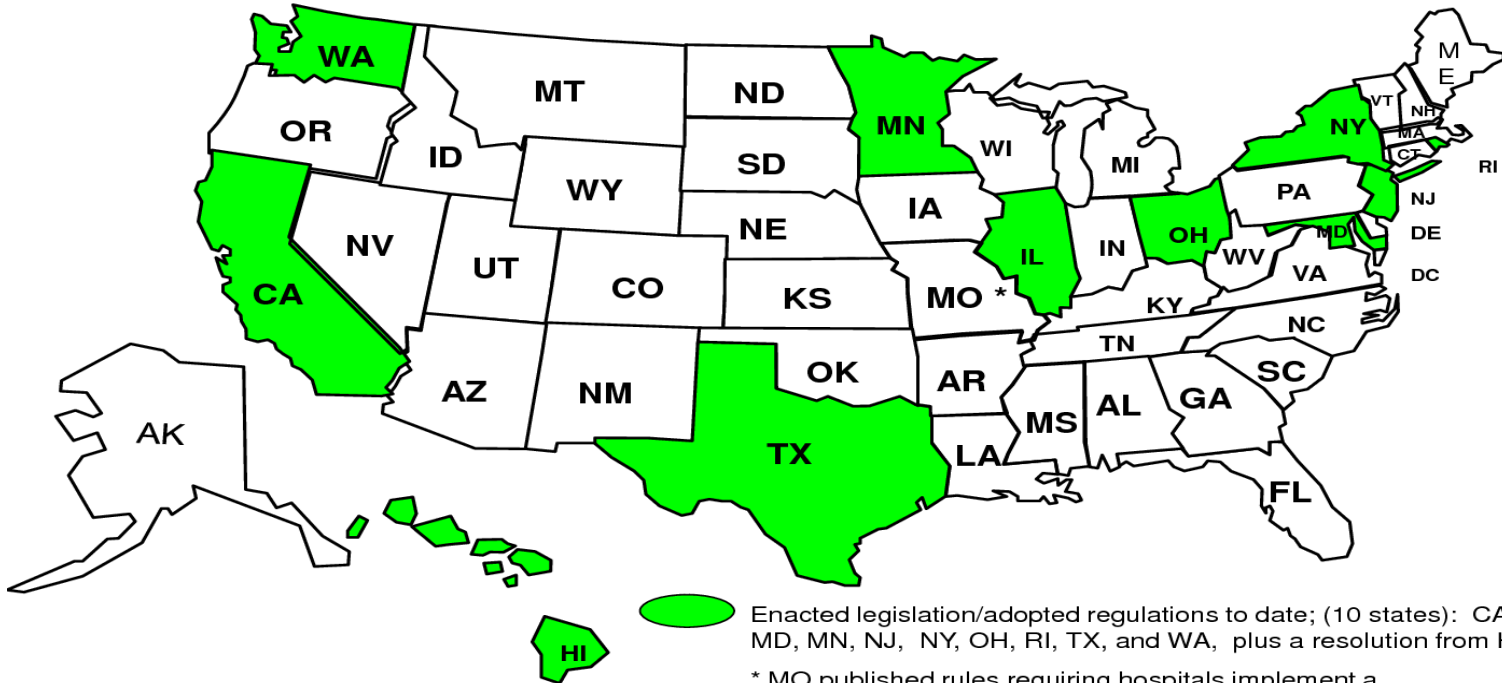
NYS Safe Patient Handling Law

- Enacts the safe patient handling act to establish a statewide safe patient handling policy for health care facilities in the state.
- Requires hospitals to set-up committees or use existing committees to implement SPH policies.
- 50% frontline staff members and co-chaired by a frontline staff employee
- Safe Patient Handling Committee created by January 1, 2016.

National Trends

The American Nurses Association's Nationwide State Legislative Agenda

SAFE PATIENT HANDLING



July 2012

How Much Do You Lift Each Day?

- Number of patients/day (P)
- Number of lifts/patient (L)
- Average weight/patient (W)
- **Average Weight/Day = P x L x W**

$$5 \times 5 \times 100 = 2500 \text{ \# / day!}$$



Quality Improvement Outcomes

- Workers Compensation savings \approx 15% of the total financial impact of SPHM



To Use or not to use....

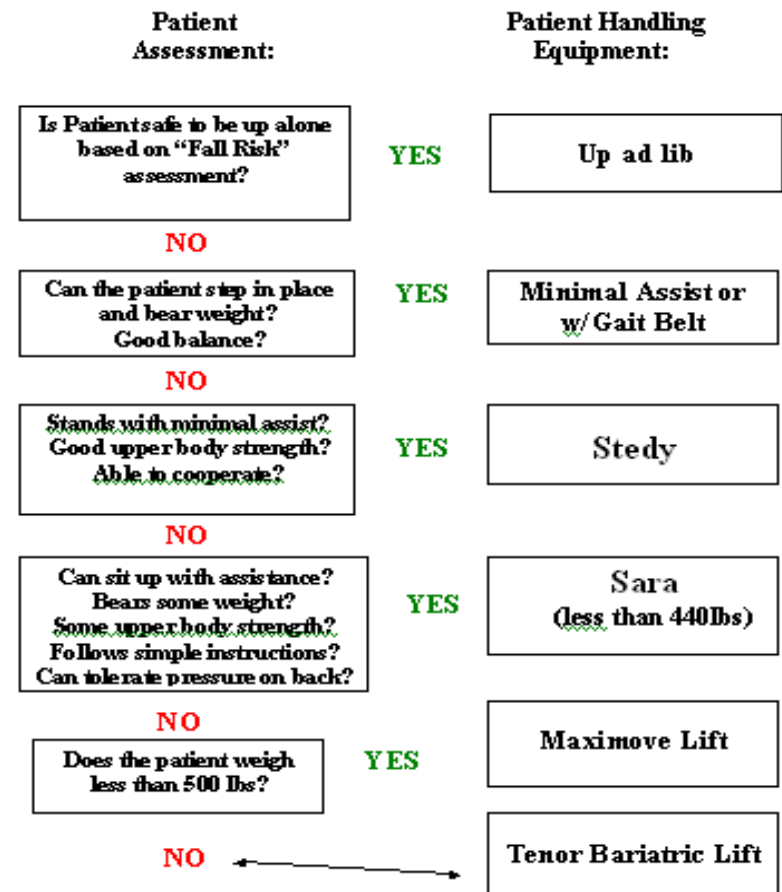


The Patient Handling Assessment Tool

The Algorithm:

- RN always does the assessments (On admission/transfers and q shift)
- CAs/CNAs can always use a “higher level of assistance if needed”.
- Patient ability and assistive equipment needed, may change over the course of the day & need to be documented.
- Again, reassess with any change.

Patient Handling Assessment Tool



The Equipment



- Stedy - Patient Standing /Transfer Aid
- Sara3000 – Sit-to-Stand Lift
- Maximove Total Lift
- Tenor Bariatric Total Lift
- Maxislides–Patient Transfer Sheets
- Ultramove - Bariatric Patient Standing/ Transfer & Ambulation Aid
- Gait belts
- Maxiaire



Education and Training

- All new staff receive education on the Safe Patient Handling Program during Clinical Orientation.
- Before using any patient handling equipment staff are required to demonstrate competence skills to a safe patient handling trainer.
- CVPH patient care staff includes: RN,LPN, CA,CNA, Transporters, Radiology Techs & Respiratory Therapists and must maintain yearly competencies on patient handling equipment.

Unit Core-Trainers

- Act as LBE resource for peers/patients/families
 - Conduct staff training on SPH issues, equipment, etc.
 - Orient new employees to LBE equipment
 - Assist staff with proper documentation when using equipment for patient care.

Patient Refusal

- Educate the patient/family in the importance of safety for patient and staff, and that using the equipment is our standard.
 - Offer to demonstrate equipment use/lift on another person
 - Explain negative effects related to remaining immobile if proper patient handling activity is refused.
 - Conduct a family meeting to open a dialogue about the reasons patient is refusing.
 - If patient still does not agree, notify charge nurse, case coordinator and/or physician as needed, so they can attempt to counsel the patient.
 - If none of these measures help, inform patient that we will not be able to move him/her without the proper equipment and document this thoroughly in event note.
- ❖ Continue to offer use proper equipment at appropriate intervals.
- Always document all measures that were taken to elicit compliance.

Proper Care of Patient Handling Equipment

Storage

- ❑ Keep equipment accessible – don't block or "bury" in storage room
- ❑ Don't block hallways with equipment.

Slings and Maxislides

- ❑ Dedicated purple hamper
- ❑ Laundered separately from regular linen –they are considered "Medical Devices"
- ❑ Save plastic head support stiffeners from disposable "Flite" slings

Batteries

- ❑ Change in yellow range
- ❑ Notify Facilities of battery problems
- ❑ Match proper batteries with proper chargers and lifts.
 - Maximove 5.5Ah batteries with 5.5 charger
 - 4.4Ah batteries with Tenor/ Sara 3000s in 4.4 charger.

For Everyone's Safety

Please Remember.....

“Safe Patient Handling” means injury prevention that helps everyone

&

Remember”Our patients are getting thicker, sicker, and we are getting older!”



Work smarter, not harder at being safe!

Questions??

TEAMWORK



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APPENDIX H-5

**CVPH MEDICAL CENTER
PATIENT SERVICES/PROCEDURE**

Generic

SUBJECT: <i>Lift by Exception Equipment Use Procedure</i>		
WRITTEN BY: Christine Meister, Director/Rehabilitation Services Sharon Olmstead, RN		RESPONSIBLE DEPARTMENT: Patient Services
CONTRIBUTING DEPARTMENT(S): Employee Health		
ADMINISTRATIVE APPROVAL: J. BRUNELL 7/11		POLICY CREATION DATE: 7/22/2010
STANDARDS NUMBER(S):	SUPERSEDES POLICY: DATED:	(Revised Date denotes the current edition of policy) REVISED DATE: 10/21/2010
REVIEW DATES & INITIALS OF REVIEWER:		
OTHER RELATED POLICIES: (LIST POLICY TITLE & DEPT. IF NOT ADMIN.)		

PURPOSE:

This procedure will guide the staff in use of mechanical equipment for the safe handling and moving of patients.

GENERAL INFORMATION:

A. Definitions of Equipment:

1. **Total Mechanical Lift** provides a safe transfer for patients to and from bed, chair, and stretcher. A Total Mechanical Lift will be used by those patients who have no weight bearing abilities or who have been assessed to need a Total Mechanical Lift for transfer.
2. **Sit/ Stand Mechanical Lift or Standing and Raising Aid** provides a safe seat-to-seat transfer for the patient who has partial weight bearing capabilities in one or both legs and has good cognition. The patient must be able to move from a supine position to sitting position and balance in a sitting position on the edge of the bed.
3. **Stedy/Quickmove is a non – pneumatic piece of equipment** used for bariatric patients who can bear weight on their legs and assist with raising up. The patient can sit unsupported and is cooperative during transfer.
4. **Transfer/gait belt** provides a firm grasping surface for the caregiver, protects the patient from accidental trauma to the skin, provides a sense of security to the patient, and protects the caregiver from injury while transferring or ambulating a patient. Gait belts are used on a patient who is not independent in rising or during ambulation. The patient must be able to move feet in the desired direction during a transfer. Also, the patient should not require lifting or need to be held up. If a patient is at risk for collapsing or falling, the gait belt is not the safest mode of transfer. A reassessment is indicated. The Standing and Raising Aid or a Total mechanical lift may be indicated.

5. **Non-Friction Device** helps to reduce the push pull forces associated with repositioning and laterally transferring patients/s.

EQUIPMENT LIST/PERSONNEL:

- A. Equipment
- B. Total mechanical Lift
- C. Standing and Raising Aid (SARA)
- D. Stedy/Quickmove
- E. Gait belt
- F. Non-friction device
- G. One (1) or more caregivers (One caregiver may be used for Stedy and gait belt use. Otherwise, 2 caregivers must be used).

Procedure for Total Mechanical Lift:

- A. Explain purpose of lift and the procedure of its use to the patient
 1. Adjust bed to a height that promotes good body mechanics.
 2. Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
 3. Position appropriate sling behind patient's back if seated or under patient if in bed.
 4. Position lift with the base open so that the spreader bar is perpendicular to the patient's shoulders and hovering above the chest. Lock brakes.
 5. Attach the sling straps without pulling or tugging, to the desired setting.
 6. Gently raise patient minimally from surface.
 7. Turn patient's legs towards the perpendicular support bar of the lift during the move.
 8. Move lift in front of chair and keep brakes unlocked
 9. Gently lower patient into chair or bed, reposition as necessary.
 10. Remove sling from behind or underneath patient.
- B. Lifting patient after fall to floor:
 1. **Before** a patient that is on the floor is moved, touched or mechanically lifted, a licensed professional **must** assess the patient. In order to promote safe patient handling, **use** a full mechanical lift when getting a patient off the floor.

Procedure for use of Standing And Raising Aide (SARA):

- A. Explain purpose of lift and the procedure of its use to the patient
 1. Apply proper harness so that the bulk of the harness rests in the lower back region and the padded part of sling under each arm. Connect and tighten belts so that they fit snugly to the patient. Apply leg straps if needed.
 2. Position the SARA with the base of the lift open and lift is facing patient.

3. Instruct/assist patient to place feet on the footplate of the lift.
4. Attach the strap of the harness to the lift without pulling or tugging.
5. Instruct/assist patient to grasp handles on lift with arms on the outside of the harness.
6. Verbally prepare patient for transfer.
7. Transfer patient to new surface.
8. Lower patient to surface with brakes unlocked

B. Patient Criteria for Sit/Stand Lift Use

1. At least 30-60% weight-bearing status. May be done with the use of one leg with the right set-up and harness.
2. Ability to hold on to the lift. If the ability to hold on is compromised then a harness needs to be selected that promotes increased safety and comfort. Harness styles vary; some incorporate lower body support to compensate for the inability to hold on.
3. Cooperation that is maintained throughout the transfer. There may be confusion, dementia, or behavior problems present as long as these conditions do not interfere with safe use of the lift. Over time, with repeated practice in a controlled setting, a patient can get accustomed to using the lift.
4. Able to move from supine to set when transferred from a bed. The risk of injury is great if the patient cannot assist with this move, as it becomes a manual lift for the caregiver.
5. Certain medical conditions are contraindicated with the use of certain harnesses. Abdominal aneurism, stomas, wounds, skin integrity issues, colostomies, and new peg tube sites or spinal fractures could prohibit the use of a harness that fits snugly around the abdomen or trunk.
6. A full mechanical lift is the only alternative if the patient does not meet the above criteria for use of the sit-stand lift. If a patient's status or condition changes, a reassessment is required. Equipment should be considered for all transfers that involve minimal, moderate, or extensive assist by the caregiver.

Procedure for use of Stedy and Quickmove:

- A. Explain purpose of equipment and the procedure of its use to the patient
 1. Position Stedy or Quickmove with legs under chair and seat cushions raised up
 2. Lock both wheels
 3. Instruct/assist patient to place feet on the foot plate with shins against shin plate
 4. Instruct/assist patient to grasp handles or horizontal bar and pull themselves up to standing
 5. Lower seat cushions behind patient and instruct patient to sit down
 6. Ensure that patient is positioned with knees against front shin plates
 7. Unlock brakes, instruct patient to hold onto frame
 8. Transfer patient to new surface
 9. Lock brakes
 10. Lift seat cushions up with patient standing
 11. Instruct patient to lower self until seated on new surface

Procedure for use of Gait Belt:

- A. Explain purpose of belt and the procedure of its use to the patient
 - 1. Put the belt on over the patient's clothing and around the waist and make sure the belt is snugly in place.
 - 2. Assist patient to a standing position by grasping the gait belt.
- Keypoint:** Caregiver should be able to insert two fingers between the belt and the patient's clothing.
- Keypoint:** Before assisting patient in transfer or ambulation make sure that the belt is properly positioned and that the buckles are securely fastened.
- Keypoint:** Do not allow patient to place hands or arms around the caregiver's neck.
- Keypoint:** If a patient begins to slide while getting up, lock the patient's knees against the caregiver's knees.
- Keypoint:** If the patient begins to fall during transfer/ambulation, pull the patient close to the caregiver's body using the gait belt, call out for help and lower patient as far as your arms will extend to the floor.
- Keypoint:** Use Total Mechanical Lift to lift patient from floor.

Procedure for use of Non-Friction Device (Maxislide) to reposition in Bed:

- A. Explain purpose of device and the procedure of its use to the patient
 - 1. Adjust bed to a height that promotes good body mechanics and place the bed in the flat position.
 - 2. Roll the patient to one side and position two of the Non-Friction Devices back to back underneath the patient. If patient cannot roll, use the Jellyroll method to unfold the device from head to toe under the patient.
 - 3. With at least one caregiver on either side of the bed, grasp the loops on the edge of the device with the caregiver's palms down and maintain wrists flat on the bed while transferring.
 - 4. Using proper body mechanics, caregivers will shift their weight sliding patient into proper position on the bed. No lifting movement should be used.
 - 5. Remove device under patient by folding the device under itself and pulling leading edge out underneath.
 - 6. If choosing to leave device under patient after transfer, leave ONLY ONE and not two to prevent patient from sliding inadvertently.

Procedure for use of Non-Friction Device (Maxislide) to Laterally Transfer:

- A. Explain purpose of device and the procedure of its use to the patient
 - 1. Adjust bed to a height that promotes good body mechanics and place the bed in the flat position.
 - 2. Roll the patient to one side and position two of the Non-Friction Devices back to back underneath the patient. If patient cannot roll, use the Jellyroll method to unfold the device from head to toe under the patient.
 - 3. With at least one caregiver on either side of the bed, grasp the loops on the edge of the device with the caregiver's palms down and maintain wrists flat on the bed while transferring.
 - 4. Using proper body mechanics, caregivers will shift their weight sliding patient into proper position on the bed. No lifting movement should be used.

5. Remove device under patient by folding the device under itself and pulling leading edge out underneath.
6. The caregivers should be positioned one on the side of the supporting surface (Example: bed, stretcher, procedure table) and the other caregiver on the side of the other supporting surface.
7. Grasp the loops on the edge of the device with the caregiver's palm down and maintain wrists flat on the bed. To avoid leaning forward across surface to grasp loops, a towel or pillowcase can be inserted through loops and used to pull with.
8. Using proper body mechanics, the first caregiver shall push the patient towards the stretcher while the second caregiver receives patient and pulls the rest of the distance.

APPENDIX H-6

Patient Handling Assessment Tool

Patient Assessment:

Patient Handling Equipment:

Is Patient safe to be up alone
based on "Fall Risk"
assessment?

YES

Up ad lib

NO

Can the patient step in place
and bear weight?
Good balance?

YES

Minimal Assist or
w/ Gait Belt

NO

Stands with minimal assist?
Good upper body strength?
Able to cooperate?

YES

Stedy

NO

Can sit up with assistance?
Bears some weight?
Some upper body strength?
Follows simple instructions?
Can tolerate pressure on back?

YES

Sara
(less than 440lbs)

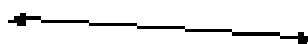
NO

Does the patient weigh
less than 500 lbs?

YES

Maximove Lift

NO



Tenor Bariatric Lift

APPENDIX H-7

Occurrence Report - Employee Injury



Occurrence Information	
Reporter Name:	<input type="text"/> *
Reporter's Department:	<input type="text"/> ▼ *
Occurrence Date:	<input type="text"/> <input type="text"/> *
Notify Date:	<input type="text"/> <input type="text"/> *
Department Event Occurred In:	<input type="text"/> ▼ *
Other Department Involved:	<input type="text"/> ▼
Shift:	<input type="text"/> ▼ *
Statement of Fact:	<div><div></div></div> *
Last Changed By:	<input type="text"/>
Last Changed:	<input type="text"/> <input type="text"/>
Evidence of harm to pt?:	<input type="text"/> ▼ *
Injured Employee Information	
Affected Party:	<u>Select</u> *
Job Title:	<input type="text"/> ▼ *
Address:	<input type="text"/> *
City, State, Zip Code:	<input type="text"/> *
Employee Number:	<input type="text"/> *
Date of Birth:	<input type="text"/> *
Date of Hire:	<input type="text"/>
Phone Number:	<input type="text"/> *

Date of Hire:	<input type="text"/>
Phone Number:	<input type="text"/> *
Assigned Shift:	<input type="text"/> *
Is This Regular Shift?:	<input type="text"/> ▼ *
On OT When Injury Occurred?:	<input type="text"/> ▼ *
# OT Hours In Last Pay Period?:	<input type="text"/> ▼ *
<div> <div></div> Injury Information </div>	
Body Location:	<input type="text"/> ▼
Type of Injury:	<input type="text"/> ▼
Activity Prior to Incident::	<input type="text"/> *
Is This Recurring Injury?:	<input type="text"/> ▼ *
If YES, Enter Type::	<input type="text"/>
If YES, Enter Cause:	<input type="text"/>
If YES, Enter Body Part:	<input type="text"/> ▼
Was Injury Preventable?:	<input type="text"/> ▼ *
If "Yes", How?:	<input type="text"/>
Injury During Pt Handling::	<input type="text"/> ▼ *
Was Other Staff Involved?:	<input type="text"/> ▼ *
Assistive Device Being Used?:	<input type="text"/> ▼ *
Lift By Exception Program?:	<input type="text"/> ▼ *
Injury Due To Assault By Pt?:	<input type="text"/> ▼ *
Behavioral Intervention Result:	<input type="text"/> ▼ *
Prior PMCS Training?:	<input type="text"/> ▼
Patient Name:	<input type="text"/>
Patient's Weight:	<input type="text"/> ▼ *
<div> <div></div> Supervisor Notification </div>	

On OT When Injury Occurred?:	<input type="text"/>	*
# OT Hours In Last Pay Period?:	<input type="text"/>	*
Injury Information		
Body Location:	<input type="text"/>	
Type of Injury:	<input type="text"/>	
Activity Prior to Incident::	<input type="text"/>	*
Is This Recurring Injury?:	<input type="text"/>	*
If YES, Enter Type::	<input type="text"/>	
If YES, Enter Cause:	<input type="text"/>	
If YES, Enter Body Part:	<input type="text"/>	
Was Injury Preventable?:	<input type="text"/>	*
If "Yes", How?:	<input type="text"/>	
Injury During Pt Handling::	<input type="text"/>	*
Was Other Staff Involved?:	<input type="text"/>	*
Assistive Device Being Used?:	<input type="text"/>	*
Lift By Exception Program?:	<div> No - Barriers - Physical barriers to use of equipment No - None No - None Indicated - None indicated for the patient No - Not Trained - Employee not trained to use equipment No - Not Working - Needed equipment not working None - None Yes - Bariatric Lift - Bariatric total lift (Tenor or Wy-East type) Yes - Cane/Walker - Cane or Walker Yes - Maxislide - Maxislide friction-reducing patient transfer sheets Yes - Sara Lift - Sit to stand hydraulic lift (Sara type) </div>	*
Injury Due To Assault By Pt?:	<input type="text"/>	*
Behavioral Intervention Result:	<input type="text"/>	*
Prior PMCS Training?:	<input type="text"/>	
Patient Name:	<input type="text"/>	
Patient's Weight:	<input type="text"/>	*
Supervisor Notification		
Supervisor Notified?:	<input type="text"/>	*
If "YES", Name of Supervisor:	<input type="text"/>	
Date/Time Supervisor Notified::	<input type="text"/>	<input type="text"/>
Response to Incident		

On OT When Injury Occurred?:	<input type="text"/>	*
# OT Hours In Last Pay Period?:	<input type="text"/>	*
Injury Information		
Body Location:	<input type="text"/>	
Type of Injury:	<input type="text"/>	
Activity Prior to Incident::	<input type="text"/>	*
Is This Recurring Injury?:	<input type="text"/>	*
If YES, Enter Type::	<input type="text"/>	
If YES, Enter Cause:	<input type="text"/>	
If YES, Enter Body Part:	<input type="text"/>	
Was Injury Preventable?:	<input type="text"/>	*
If "Yes", How?:	<input type="text"/>	
Injury During Pt Handling::	<input type="text"/>	*
Was Other Staff Involved?:	<input type="text"/>	*
Assistive Device Being Used?:	<input type="text"/>	*
Lift By Exception Program?:	<input type="text"/>	*
Injury Due To Assault By Pt?:	<input type="text"/>	*
Behavioral Intervention Result:	<input type="text"/>	*
Prior PMCS Training?:	<input type="text"/>	
Patient Name:	<input type="text"/>	
Patient's Weight:	<input type="text"/>	*
Supervisor Notification		
Supervisor Notified?:	<input type="text"/>	*
If "YES", Name of Supervisor:	<input type="text"/>	
Date/Time Supervisor Notified::	<input type="text"/>	<input type="text"/>
Response to Incident		

APPENDIX H-8

	ADL Intervention	07/09/2015	31	Collect
ergies	Supplement/Snack	<input type="text"/>	<input checked="" type="checkbox"/>	
ne Medications	Turn & Position	<input type="text"/>	<input checked="" type="checkbox"/>	
ventions	Walked	<input type="text"/>	<input type="checkbox"/>	
/ IVs	Activity	<input type="text"/>	<input type="checkbox"/>	
Admin Check	Activity Tolerance	<input type="text"/>	<input type="checkbox"/>	
es	Personal Care	<input type="text"/>	<input type="checkbox"/>	
ual Result	Mouth Care	<input type="text"/>	<input checked="" type="checkbox"/>	
essments	Skin Care	<input type="text"/>	<input checked="" type="checkbox"/>	
	Range of Motion	<input type="text"/>	<input type="checkbox"/>	
	Bed Position	<input type="text"/>	<input checked="" type="checkbox"/>	
	Pneumatic Compression Device	<input type="text"/>	<input checked="" type="checkbox"/>	
	Reason Device Not Applied: (Pneumatic Compression)	<input type="text"/>	<input type="checkbox"/>	
	Ted Stockings	<input type="text"/>	<input checked="" type="checkbox"/>	
	Reason Device Not Applied: (TEDS)	<input type="text"/>	<input type="checkbox"/>	
	Reason Device Not Applied: (Foot Pumps)	<input type="text"/>	<input type="checkbox"/>	
	Mobility/Transfer	<input type="text"/>	<input type="checkbox"/>	
	Assistive Devices for Mobility	<input type="checkbox"/> Crutches <input type="checkbox"/> Brace <input type="checkbox"/> Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> Total Lift <input type="checkbox"/> SARA Lift <input type="checkbox"/> Stedy Lift <input type="checkbox"/> Bariatric Lift <input type="checkbox"/> Max Slide <input type="checkbox"/> Wheelchair		
	ADL Pain Scale	<input type="text"/>	<input type="checkbox"/>	
	ADL Pain Scale Used	<input type="text"/>	<input type="checkbox"/>	
	Cough & Deep Breathe	<input type="text"/>	<input type="checkbox"/>	
	Cough & Deep Breathe	<input type="text"/>	<input type="checkbox"/>	
	Flutter Valve	<input type="text"/>	<input type="checkbox"/>	
	Flutter Valve	<input type="text"/>	<input type="checkbox"/>	
	Incentive Spirometry	<input type="text"/>	<input type="checkbox"/>	
	Tx Interval	<input type="text"/>	<input type="checkbox"/>	

APPENDIX H-9

Unit Assessment for Facility SPHM Program to prepare equipment solution proposal

NAME OF RESPONDENT:		DATE:
Unit Name		
# of rooms	# of beds	
Unit Manager		
Type of care on this unit		
Estimated # of patients lifted/transferred on this unit per week/month		
Describe current patient handling techniques		
Most frequent types of lift/transfer we do on this unit are:		
(Lateral Transfers, pull up in bed repositioning, OOB to chair, ambulating and gait training, lift up off floor, turn side to side, in/out of tub bed to commode)		
Avg. length of stay on this unit		
Avg. number of independent patients typically on this unit		
Avg. number of minimal assist patient typically on this unit		
Avg. number of extensive assist patients typically on this unit		
Avg. number of totally dependent patients typically on this unit		
# Patients transferred to chair, wheelchair, recliner daily		
# Patients in bed turning and repositioning		
# Patients who require sit to stand assistance		
# of Lateral Transfers done on this floor per day		
# of Patients who receive gait-ambulation training		
# patients bariatric patients admitted to the unit per month		
# amputee patients do you admit typically per month on this unit		
How are daily weights obtained?		
Describe Equipment used today for any type of safe lifting and transfer		
STAFF AND PHYSICAL UNIT		
# staff injured last 12 months, # on light duty, # out on disability?		
Are there peer leaders on this unit?		
Are there any space constraints in using the lift?		
Will other units be sharing equipment with this unit?		
EQUIPMENT PREFERENCE		
Desired type of lift on this unit? (i.e., Ceiling lifts, Floor-based lift, etc.)		
Quantity?		
SPHM COMMITTEE RECOMMENDATIONS (Committee will notify the unit)		

APPENDIX I-1

SAFE RESIDENT HANDLING:

An Instructor's Manual for Training Safe Resident Handling/Ergonomic Teams



A PROJECT OF:

wny
cosh

western new york council on
occupational safety and health
2495 Main Street, Suite 438
Buffalo, NY 14214

This material was produced under grant #SH-19481-09-60-F-36 to the Western New York Council on Occupational Safety and Health (WNYCOSH) from the Occupational Safety and Health Administration, U.S. Department of Labor. It does not necessarily reflect the views or policies of the U.S. Department of labor, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

ABOUT THIS MANUAL

This instructor's manual is intended to be a user-friendly resource for training Safe Resident Handling/Ergonomic Teams (or Committees)* on how to become effective "drivers" for the Safe Resident Handling programs in Nursing Homes.

Providing instruction for Safe Resident Handling/Ergonomic Teams is critical because there is a growing recognition that these Teams are the key component for building a successful Safe Resident Handling program over the long run. A number of states have mandated Safe Patient Handling programs within hospitals and/or nursing home with the SPH Committees playing a central role in implementing and sustaining successful programs.

This topics and materials included in this manual are intended to allow the instructor to share practical information for Safe Resident Handling/Ergonomic Teams on how to 1) work effectively as a Team, 2) understand and implement the key components of a sustainable Safe Resident Handling program at their facility, and 3) train the direct care staff at their facility on Safe Resident Handling policies and practices including the safe use of resident handling equipment.

The development of this manual would not have been possible without the invaluable assistance and generosity of Paul Pless, Ergonomic Workforce Safety Specialist, and director of Safe Patient Handling at Kaleida Health. Paula is nationally recognized as a pioneer and expert in Safe Patient Handling programs. She has selflessly given of her time and shared information about her program, much of which has been incorporated in this manual. Melissa Rowland, PTA, RN, and Workforce Safety Specialist and the Safe Resident Handling Trainer at the Western New York Council on Occupational Safety and Health, has been another invaluable contributor, sharing her hands-on knowledge of every aspect of how these programs work in the everyday life of a nursing home. Germain Harnden, director of the Western New York Council on Occupational Safety and Health has overseen the production of the manual and Candice Fletcher, graphic design consultant, was responsible for all aspects of layout and design production. Special thanks to Karl Wende, Robert Guest, Nellie Brown, Arthur Wheaton, Susan Woods, Kelly Moed and Susan McQuade for their important insights and contributions.

Special thanks to the Occupational Safety and Health Administration's Susan Harwood Grant Program, which made possible the writing and publication of this manual.

This is a first edition of this manual. Any errors are solely the responsibility of the editor.

Roger A. Cook
Editor

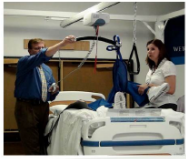
*Safe Patient Handling is the generic name for these programs. We have chosen to follow the National Institute for Occupational Safety and Health's lead using the name Safe Resident Handling when these programs are implemented in Nursing Homes. Also, the term Safe Patient Handling Committee is commonly used by OSHA and in state legislation. We have chosen to call them "Teams" because "being assigned to a committee" may be viewed as something less than positive.

HOW TO USE THIS MANUAL and POWERPOINT

This instructional manual is the hard copy version of a companion PowerPoint slide presentation. The hard copy version is intended to be a user-friendly guide which the instructor can use to prepare for the power point presentation. The power point will be used for the actual instruction of the Safe Resident Handling/Ergonomic Teams. Thoroughly reviewing the commentary for each slide in the manual before presenting the power point will allow you, the instructor, to discuss the slide without reading the commentary word for word.

Each module begins with the title of the module with a brief commentary summarizing the module (see below). Following the module title is one slide with the “*Agenda*” with an outline of the topics (“sections”) that will be covered and another with the learning “*Objectives*.” When doing the power point presentation, these slides should be read as they provide a “roadmap” for the participants about the topics that will be covered and why they are important.

Module One
Introduction to Safe Resident Handling




Summary: The purpose of this module is to give a basic introduction to Safe Resident Handling (SRH). One theme is that the job tasks of manually lifting, transferring and repositioning residents place direct care workers and residents at risk of injury. Another theme is that by adopting an ergonomic approach to resident handling job tasks and the work environment, the risk of injury can be greatly reduced. Key to understanding an ergonomic approach is the use of OSHA's “*Hierarchy of Controls*” and the use of equipment to reduce hazardous job tasks. Finally, this module looks at the central role that a Safe Resident Handling/Ergonomics Team can play in implementing and sustaining a SRH program.

The “Agenda” for each module is broken down into general topic headings. These topics will appear as sections with each new topic being introduced as Section 1, Section 2, etc. At the beginning of each section, the specific topics that will be covered in that section are outlined.

Introduction to Safe Resident Handling

AGENDA:

- An Overview of Safe Resident Handling (SRH)
- Body Mechanics and Lifting Limits
- Anatomy of an Injury
- Controlling Risk Factors
- Old vs. New SRH Practices: Changing the Culture
- SRH Stakeholders
- SRH/Ergonomic Team's Roles in SRH
- SRH Implementation Steps/Timeline



Briefly review the agenda for Module One. Explain that there will be two 10-minute breaks.


The name of the section will appear at the top of each slide with followed by a specific topic heading, in italics (see example below: *WHAT IS SAFE RESIDENT HANDLING?*).

Section 1: *An Overview of Safe Resident Handling*

WHAT IS SAFE RESIDENT HANDLING?

“A policy and practice that creates a safe work environment for patients [residents] and healthcare workers by eliminating hazardous manual lifting tasks. Transferring and repositioning patients [and residents] is accomplished by using new technologies such as mechanical lifts and repositioning devices.”

– NYS Zero Lift Task Force




A Safe Resident Handling program is a policy that guides direct care workers to stop using manual lifts, transfers and repositioning when handling and moving residents. It's a policy that requires managers to invest in new technologies such as mechanical lifts and repositioning devices to transfer and reposition residents.

The Goal of Safe Resident Handling programs is to eliminate manual resident handling tasks.


Exercise [2 minutes]: Ask the participants if they believe a Safe Resident Handling policy and practice is achievable at this facility.

Throughout each module, you will find slides that often ask questions with the word “Exercise” in the commentary box. When the word “Exercise” is used in this manual, it means that the instructor is to facilitate a discussion among the participants and jot down their responses on a Flip Chart.

Since exercises are used in each module, you should plan to have an easel, one or more Flip Chart pads, black and colored markers and masking tape for hanging individual sheets on the wall. You may want to prepare in advance, by writing on the Flip Chart some of the headings you will be using for discussion.

<p>Section 2: Body Mechanics and Lifting Limits</p> <p>NIOSH has determined that the safe lifting limit for a two-handed lift of a box held close to the body is 51 pounds.</p> <p>Is lifting a resident the same as lifting a box?</p> <p>WHY? WHY NOT?</p> <p></p>	<p>Exercise [2 minutes]: Read the slide. On the Flip Chart, write “Why” and “Why Not” and jot down their responses. Go to the next slide for NIOSH’s response.</p>
--	---

You will also find throughout each module slides with the word “Activity” in the accompanying commentary along with instructions. The word “Activity” as used in this manual means that the participants will break into groups and work together in on the question(s) being asked. For each activity, you should ask one person in the group to record the participants’ responses on a piece of Flip Chart paper (instruct them to keep the responses brief) and to be prepared to report back for the group. A recommended amount of time is suggested for each activity and the “report back” is included in that time allotment (as the instructor, you should use your own discretion, allowing less or more time as you see fit). Have the reporter tape the sheet with their responses on the wall.

<p>Section 6: Safe Resident Handling Stakeholders</p> <p>WHAT ARE THE BENEFITS?</p> <ul style="list-style-type: none">▪ For Residents?▪ For Frontline Workers?▪ For Employers <p></p>	<p>Activity [10 minutes]: Break the Team into 3 groups. Give each group a sheet of Flip Chart paper and a marker. Ask each group to take a different category of stakeholder, write their name across the top of their paper, and make a list of how each of the stakeholders might benefit. Also, ask if they believe there are any negative consequences for the each stakeholder and what they might be.</p>
---	--

Each module will include handouts for the participants. You will find reference to handouts and the name of the handout in the commentary on specific slides throughout each module. All the handouts appear in the order that they are to be distributed at the back of each module. You should make enough copies of each handout before the training for each participant.

Finally, you may want to review Part One of Module Six which has some training pointers for instructors. The key to good adult training is to actively engage and involve your “learners.” While this manual and power point has a number of exercises and activities for active participation, there are also a lot of slides and information. As the instructor, it’s important to remember that you are talking to healthcare workers who, like you, have experienced the things that you will be presenting. The more that you can “personalize” the information you are presenting by drawing on your shared experiences, the more likely that you can hold the interest of your audience. As much as possible, familiarize yourself with the commentary on each slide before your presentation so that you aren’t reading it word for word. Remember that the way you present your material is as important as what you present.

SAFE RESIDENT HANDLING INSTRUCTOR'S MANUAL FOR TRAINING SAFE RESIDENT HANDLING/ERGONOMIC TEAMS

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- Section 3: Anatomy of an Injury*
- Section 4: Controlling Risk Factors*
- Section 5: Old vs. New Resident Handling Practices*
- Section 6: Safe Resident Handling Stakeholders*
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APPENDIX — HANDOUTS BY MODULE

MODULE ONE:

Introduction to Safe Resident Handling

AGENDA

REVIEW AGENDA	(Briefly)
REVIEW OBJECTIVES	(Briefly)
Section 1: An Overview of Safe Resident Handling Handout: "Is It a Myth or Fact" Quiz	(15 Minutes)
Section 2: Body Mechanics and Lifting Limits Handout: "How Much Are You Lifting" Handout	(30 Minutes)
<i>— 10 Minute Break —</i>	
Section 3: Anatomy of an Injury Activity: Draw a "Body Map" on a Flip Chart and Provide Sticky Dots to Participants	(30 Minutes)
Section 4: Controlling Risk Factors Handout: "Hierarchy of Controls" Handout	(20 Minutes)
Section 5: Old vs. New Resident Handling Practices Handout: "Old vs. Evidence-Based Practices" Fact Sheet Activity: "A Health Care Culture: How Do We Get There?"	(20 Minutes)
<i>— 10 Minute Break —</i>	
Section 6: Safe Resident Handling Stakeholders Activity: Stakeholder Benefits	(15 Minutes)
Section 7: Safe Resident Handling/Ergonomic Teams	(15 Minutes)
Section 8: Safe Resident Handling Implementation Steps/Timeline Handout: "Timeline" Questionnaire	(10 Minutes)
EVALUATION	(5 Minutes)

Module One
Introduction to Safe Resident Handling



Summary: The purpose of this module is to give a basic introduction to Safe Resident Handling (SRH). One theme is that the job tasks of manually lifting, transferring and repositioning residents place direct care workers and residents at risk of injury. Another theme is that by adopting an ergonomic approach to resident handling job tasks and the work environment, the risk of injury can be greatly reduced. Key to understanding an ergonomic approach is the use of OSHA's "*Hierarchy of Controls*" and the use of equipment to reduce hazardous job tasks. Finally, this module looks at the central role that a Safe Resident Handling/Ergonomics Team can play in implementing and sustaining a SRH program.

Introduction to Safe Resident Handling

AGENDA:

- An Overview of Safe Resident Handling (SRH)
- Body Mechanics and Lifting Limits
- Anatomy of an Injury
- Controlling Risk Factors
- Old vs. New SRH Practices: Changing the Culture
- SRH Stakeholders
- SRH/Ergonomic Team's Roles in SRH
- SRH Implementation Steps/Timeline

why
cosh

Briefly review the agenda for Module One. Explain that there will be two 10-minute breaks.

Introduction to Safe Resident Handling

OBJECTIVES:

Participants will be able to understand...

- What SRH is and who benefits
- Why body mechanics can't prevent health care worker injuries
- Why and how manual resident handling is injuring us
- How our job tasks and work environment put us in risk of injury
- SRH is a change in our safety culture
- Need for SRH Stakeholder's involvement
- The SRH/Ergonomics Team's role in SRH
- SRH implementation/timeline planning

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Briefly review the learning objectives.

Section 1

An Overview of Safe Resident Handling

- Handling Residents: Myth vs. Fact
- Health Care Worker Rates
- What Is Safe Resident Handling
- Who Benefits?

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Review four main points you will be covering in this section.

Section 1: An Overview of Safe Resident Handling

MYTH
VS.
FACT

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Distribute the “Is it a Myth or a Fact?” handout. Read a question and ask them to respond why they think their answer is correct. Provide correct answer. Explain that you will be going over the reasons for the correct answers during training.

Answers:

- | | |
|------|-------|
| 1) F | 6) F |
| 2) M | 7) M |
| 3) M | 8) M |
| 4) M | 9) F |
| 5) M | 10) M |

Section 1: An Overview of Safe Resident Handling

WHO IS GETTING HURT?

What job titles have the highest injury rates?

Where do health care workers rank among these job titles?

Have health care worker injuries been going up, down or staying the same over time?

why
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Activity [3 minutes]: Use the Flip Chart.

Ask the participants to call out what jobs they consider to have the highest injury rates and why. Jot down their answers.

Now ask them where they believe health care workers rank among the other job titles. Jot down their answers.

Finally, ask them if they believe health care worker injuries have been going up, going down or staying the same over the past 20 years.

Section 1: An Overview of Safe Resident Handling

WHAT IS SAFE RESIDENT HANDLING?

“A policy and practice that creates a safe work environment for patients [residents] and healthcare workers by eliminating hazardous manual lifting tasks. Transferring and repositioning patients [and residents] is accomplished by using new technologies such as mechanical lifts and repositioning devices.”

– NYS Zero Lift Task Force

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A Safe Resident Handling program is a policy that guides direct care workers to stop using manual lifts, transfers and repositioning when handling and moving residents. It's a policy that requires managers to invest in new technologies such as mechanical lifts and repositioning devices to transfer and reposition residents.

The Goal of Safe Resident Handling programs is to eliminate manual resident handling tasks.

Exercise [2 minutes]: Ask the participants if they believe a Safe Resident Handling policy and practice is achievable at this facility.

Section 1: An Overview of Safe Resident Handling

HOW DO WE GET TO SRH?

- Set-up a SRH Team
- Adopt a SRH Policy
- Assess Facility Needs
- Purchase Equipment
- Training Staff on SRH
- Mentor/Monitor/Evaluate

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This is a list of some of the things your facility will have to do to have a successful Safe Resident Handling program.

Your Safe Resident Handling/Ergonomics Team will play a key role in implementing each of these components of your program.

Section 1: An Overview of Safe Resident Handling

WHO BENEFITS?



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Briefly review the bubble chart.

There are benefits for residents, direct care workers and for management.

For example, a study of 7 nursing homes and 1 hospital found that injuries dropped by 62% after a SRH program was put in place. And Lost Work Days dropped by 86% resulting in big cost savings for management.

Source: Garag. 1999.

Section 2

Body Mechanics and Lifting Limits

- Good Body Mechanics
- The Lifting Limit for Unstable Loads
- Manual Resident Lifting Using “Good Body Mechanics” Is a Failed Policy

why
cosh

Review the three main points you will be covering in this session.

Section 2: Body Mechanics and Lifting Limits

QUESTIONS:

What are good body mechanics?

How many pounds can you safely lift using good body mechanics?

why
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Activity [5 minutes]: Using the Flip Chart, ask the participants to answer the two questions on the slide. Jot down their answers.

Section 2: Body Mechanics and Lifting Limits

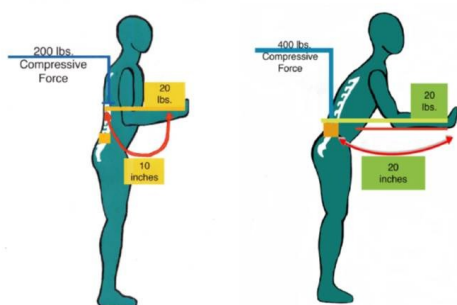
**WHEN YOU LIFT AN OBJECT
USE GOOD BODY MECHANICS**

- Bend at the knees, not the waist
- Get close to the object
- Keep your back straight and don't twist
- Plant your feet properly
- Hold objects close to your body
- Push, pull and slide when possible

why
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The class may have come up with most of these when answering the question (above). Note any they may have missed. Good body mechanics do help protect the back from injury. **Bend at the knees:** thigh muscles are stronger than your back muscles. **Get close to the object:** outstretched arms put much higher compressive forces on your lower spine. **Keep your body straight:** when you bend to lift, you are adding your trunk weight to the load you are lifting--this adds compressive force to your spine. **Plant your feet firmly:** this gives you a stable base that prevents you from twisting or falling when lifting. **Hold objects close to your body:** this minimizes forces on your spine. **Push, pull, slide an object if possible:** this allows you to use your whole body weight instead of the one or two muscle groups when lifting.

Section 2: Body Mechanics and Lifting Limits



OSHA Technical manual, Section VII, Chapter 1: Back disorders and Injuries, http://www.osha.gov/dts/osta/otm/otm_vii/otm_vii_1.html

why
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When you lift a 20 pound box close to your body, there are 220 pounds of compressive force on your lower spine. The discs between your vertebrae are being compressed slightly. (You are actually shorter at the end of the day than when you get up in the morning due to this compression.) If your arms are extended 10 inches while lifting the 20 pound box, the compressive force on your spine is 400 pounds. This is why we use good body mechanics--they protect the spine.

The US Government's National Institute for Occupational Safety and Health recommends a safe lifting weight for a healthy adult using two hands should not exceed 51 pounds. Lifting 51 pounds 10 inches from the body would put 770 pounds of compressive force on your lower spine.

Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



why
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Activity [2 minutes]: Ask the participants what risks are involved in doing the job task of cranking a bed in this position numerous times a day, week after week, year after year.

Is it easy to use good body mechanics when doing this job task?

Would you be tempted to avoid cranking the bed up, so that you are bending over the resident when doing your tasks? Do they have any crank beds at your facility or other equipment that makes it difficult to do your job safely?

Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



why
cosh

Activity [2 minutes]: Ask the participants what job task is being performed here. Are there risks involved, especially if it's done many times a day, year after year? What are they?

Would you be able to use good body mechanics to do this job?

How could this job task be done more safely?

Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



why
cosh

Activity [2 minutes]: Ask the participants what job task is being performed here. Are there risks involved? What are they?

Would you be able to use good body mechanics to do this job?

How could this job task be done more safely?

Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



why
cosh

Activity [2 minutes]: Ask the participants what job task is being performed here? Are there risks involved? What are they?

Do you do this transfer at this facility? What's it called? [Pivot Transfer]

Can you always use good body mechanics when using it? [No. Not if the resident doesn't have good weight-bearing capacity and is unstable. The resident will buckle and the caregiver's body will be twisted and the resident's weight will be put on her/his back. There's a chance that both the resident and caregiver will fall.]

How could this job task be done more safely? [Use of a mechanical lift.]

Section 2: Body Mechanics and Lifting Limits

Fact: Techniques taught through body mechanics have not reduced back injuries among healthcare workers

- Good body mechanics is not enough to prevent injuries
- Manual lifting techniques were based on stable loads held close to the body
- Manual lifting techniques were based on loads weighing less than typical residents
- Manual lifting techniques were based on studies that included only men.

Source: NYS Zero-Lift Task Force

why
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The problem with using body mechanics to try to safely lift, transfer and reposition residents is that they weigh more than 51 pounds. Even when a resident is able to help with a lift or transfer, if they are partially dependent on a CNA or other caregiver, they may be or may become an unstable load.

When the resident becomes unstable (can't bear weight, begins to fall, etc.), far more weight than 51 pounds is likely to be placed on the caregiver.

But ... is it safe to lift 51 pounds if the object is a person?

Section 2: Body Mechanics and Lifting Limits

NIOSH has determined that the safe lifting limit for a two-handed lift of a box held close to the body is 51 pounds.

Is lifting a resident the same as lifting a box?

WHY? WHY NOT?

why
cosh

Activity [2 minutes]: Read the slide. On the Flip Chart, write “Why” and “Why Not” and jot down their responses. Go to the next slide for NIOSH’s response.

Section 2: Body Mechanics and Lifting Limits

The National Institute for Occupational Safety and Health has determined that healthcare workers should lift a **maximum of 35 pounds** when transferring and repositioning patients/residents.

why
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Because residents are an unstable load when being lifted, transferred and repositioned, NIOSH recommends that a maximum human load weigh no more than 35 pounds.

Practically speaking, when a resident needs help getting up, being moved from one surface to another, or repositioned in a bed, unless you know that she or he can support most of her or his weight stably, you will likely exceed the 35 pound limit when assisting the resident. Also, remember that often you are lifting with your arms extended and are being twisted--the forces on your spine can become unacceptably high when you exceed 35 pounds.

Section 2: Body Mechanics and Lifting Limits

Our healthcare workers are getting older.

THE AVERAGE AGE OF OUR NURSES IS NOW 48+ YEARS

Our patients and residents are getting heavier.

NEARLY 40 MILLION AMERICAN ADULTS CAN NOW BE CLASSIFIED AS OBESE

why
cosh

As the size of our residents and patients and residents increases, so does the age of our healthcare workforce.

This will likely lead to an increase in injuries among CNAs and nurses. As of 2000, the American Nurses Association reported that nurses used 30% more sick leave annually due to lower back pain than the rest of the work force. The ANA also reported that 38% of nurses have been affected in some way by back injury, and that 68% of the disabling injuries that were reported were caused by overexertion from lifting residents.

Source: *ANA Website, Nursing World*. January - February 2000.

Section 2: Body Mechanics and Lifting Limits

In 2005, over 53,000 healthcare workers who were trained in good body mechanics were injured from manually lifting patients.

Source: Bureau of Labor Statistics, 2005

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Manual lifting using body mechanics is a failed safety technique for preventing healthcare worker injuries.

Section 2: Body Mechanics and Lifting Limits

HOW MUCH ARE YOU LIFTING?



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Activity [10 minutes]: Hand out the “How much are YOU lifting?” scenarios. As the Team to break up into groups of 2 or 3. Have each group take one scenario and answer the question of whether the resident can be safely lifted manually and what the total weight per healthcare worker would be. Discuss.

Answers: Scenario 1: “No.” 130 lbs. is greater than NIOSH recommended 35 lb. limit. Scenario 2: “No.” The resident is only able to lift 105 lbs. of his own weight--each coworker would be lifting 52.5 lbs. of the resident’s weight (more than the NIOSH 35 lb. limit). Scenario 3: “No.” Each coworker would be lifting 70 lbs. (more than the NIOSH 35 lb. limit). Scenario 4: “No.” 16% of 320 lbs. is 51+ lbs. (more than the NIOSH 35 lb. limit). Scenario 5: “No.” The worker would be pulling 150 lbs. (more than the NIOSH 35 lb. limit).

Section 3

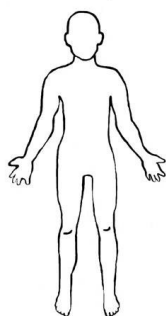
Anatomy of an Injury

- The high risks of manual handling
- Manual resident handling and “overexertion”
- “Overexertion” and excessive forces on the spinal discs

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Briefly review the main points that will be made in this section.

Section 3: Anatomy of an Injury



Where do you hurt?
Why do you hurt?

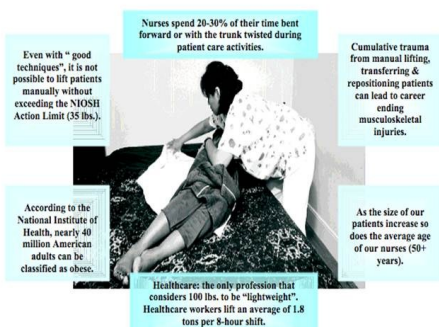
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Activity [10 minutes]: Draw a “Body Map” on the Flip Chart. Make “sticky dots” available to the participants. Ask them to take one or more dots and place them on that part of the Body Map where they hurt.

After they take their seats, ask them to talk about where they hurt and if it feels like a symptom, a pain that comes and goes or if it’s constant.

Ask if they think that the pain they have might be related to their job tasks at this facility.

Section 3: Anatomy of an Injury



why
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Briefly review the slide. Note the major points about the job tasks direct care workers perform daily might have something to do with the pain they feel. Most residents weigh more than 100 pounds and they are getting heavier.

Direct care workers are an aging workforce.

We spend much of our time doing job tasks where we are bent forward with our bodies twisted.

We do the same risky job tasks over and over daily, weekly, monthly and yearly. This overexertion can lead to cumulative trauma injuries such as musculoskeletal disorders.

Section 3: Anatomy of an Injury

HOW MUCH ARE YOU LIFTING?

The average healthcare worker manually lifts 1.8 tons per 8-hour shift. That is equal to lifting one sedan per shift.



In one year, healthcare workers lift the equivalent of an airplane that is 50% loaded.

The number of manual lifting injuries to healthcare workers in one year equals the full capacity of the new Yankee Stadium.



why
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To get an idea of how much an average healthcare worker overexerts their back and other parts of their body look at how much is being lifted daily--1.8 tons (and that’s an 8-hr. shift).

If you are manually lifting (or pushing/pulling the equivalent weight), 1.8 tons a day, month after month, year after year, you are overexerting your spine, discs, and muscles of your back.

Section 3: Anatomy of an Injury

YOUR BACK: THE SPINAL COLUMN



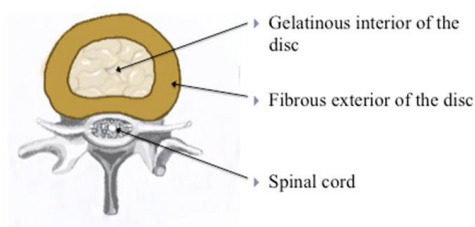
Illustrations by K. Rinker, WNYCOSH

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Your back's support system is the spinal column. The spine is made up of bones (vertebrae) stacked on top of each other. There is an opening in the back of each vertebra, and collectively they form the spinal canal. Inside your spinal canal is the spinal cord. The spinal cord travels from the brain down through the spinal canal to the last vertebra (your tailbone). The spinal cord is a bundle of nerves with branches (the nervous system) throughout the body. Messages travel back and forth along the spinal cord and its branching nerves. One of the messages that is transmitted by the nervous system is pain, including back pain.

Section 3: Anatomy of an Injury

YOUR BACK: THE DISC



Illustrations by K. Rinker, WNYCOSH

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Your back is flexible. The stacked bones, your spinal column, can bend backwards and forwards and twist from side to side. You can do this because each vertebra is fastened to the next by semi-flexible bands of tissue called ligaments. And, your spinal column is fastened to powerful back muscles and abdominal muscles, which also hold it up and allow it to move.

In between your vertebrae are your discs. They are fairly round and resemble a jelly donut with an outer ring of tough fibrous tissue surrounding a gelatin-like center. Your discs cushion the vertebrae and keep the branching nerves from being "pinched" by the bony vertebrae. Discs are also flexible and can be "squished" in various directions as you bend, twist or lift.

Section 3: Anatomy of an Injury

ACUTE BACK PAIN

- "Acute" due to temporary overexertion/trauma
- Temporary "backache"
- Muscle spasm, strain, sprain

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Your back is designed to allow you to do moderate tasks - mowing the lawn, riding a bike, shoveling light snow, raking leaves, lifting fairly light objects using body mechanics. Unless you "overdo it" you won't experience pain—maybe a little soreness that goes away quickly. But, if you "overdo it"—shovel heavy snow for an hour or so, lift an object with your arms extended, repeat a lifting task repeatedly for a couple of hours, you may experience acute back pain. The pain may take the form of a temporary backache that eventually goes away. Most of us experience this kind of pain from time to time. More serious acute pain includes muscle spasms, stretched tendons ("strain") or torn ligaments ("sprain"). If the strain or sprain is not too serious, these painful injuries can go away after a few days or weeks of rest and days away from work, with no or minimal medical intervention.

Section 3: Anatomy of an Injury

CHRONIC BACK PAIN

- Due to long-term overexertion
- Bulging, ruptured or degenerated discs
- Excruciating pain
- Potentially career-ending

why
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A more serious way you can hurt your back is by overexertion. When you do the same manual tasks day in - day out, year after year, you can develop chronic back pain. This repetitive overexertion can cause cumulative trauma to your back--your back simply can't recover. The chronic pain you feel is pain that doesn't go away. It may make it impossible for you to do your job. It can even be career-ending.

Overexertion and the resulting chronic pain results from the repetitive job tasks you do: applying force (manually lifting residents from beds to chair, repositioning them, cranking a bed), working in awkward positions (repetitively stooping to feed and bathe residents or leaning over a bed for long periods), or frequent bending and stretching (showering residents).

Section 3: Anatomy of an Injury

OVEREXERTING YOUR DISCS

► Compression Forces
► Lifting weight



► Shearing Forces
► Pulling / pushing weight



Over time lumbar discs can rupture, bulge, or degenerate

► Illustrations by K. Rinker, WNYCOSH

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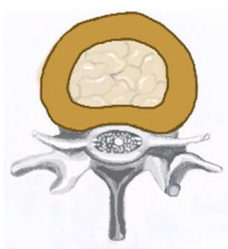
There are two types of forces on your discs which can be bad.

One is Compression Forces. Lifting and transferring dependent residents from a bed to a chair or from a chair to a toilet can put hundreds of pounds of downward pressure on the back each time it's done. The weight is likely to exceed 35lbs. This compresses the discs ("squishes" them), and when done repeatedly can result in permanent injury.

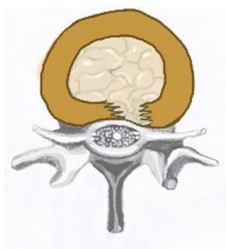
The other is Shearing Forces. Repetitively pushing and pulling residents when repositioning them, for example, creates excessive shearing forces (back and forth) on the discs which, over time, can result in permanent injury.

Section 3: Anatomy of an Injury

RUPTURED DISCS



Normal Spinal Disc



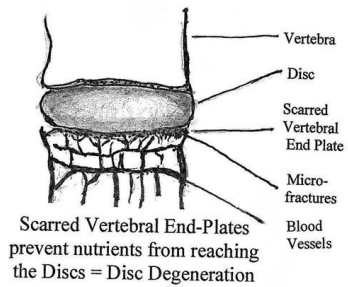
Spinal Disc w/ A Ruptured Disc

Illustrations by K. Rinker, WNYCOSH

why
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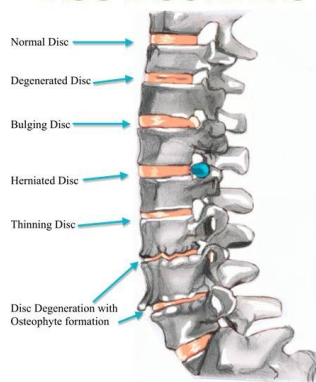
Long-term compression of the discs from manual lifting and flexion of the discs from bending, twisting, pushing and pulling can result in their deterioration. One kind of deterioration is a ruptured disc where the tough outer layer of the disc weakens and the gelatinous inner core pushes outward against the spinal nerves. This painful chronic condition is called spinal stenosis.

Section 3: Anatomy of an Injury
DISC DEGENERATION



The other kind of disc injury is degenerative disc disease. Repetitive manual handling tasks can cause small “microfractures” on the ends of the vertebrae. You don’t even feel them as they heal. But, the microfractures leave scars on the ends of the vertebra next to the disc. This prevents the blood from tiny blood vessels in your vertebrae from oozing into the discs, supplying them with nutrients and keeping them hydrated. As the discs deteriorate, the vertebrae begin to collapse, pinching nerves and causing excruciating pain.

Section 3: Anatomy of an Injury
DISC DISORDERS



Illustrations by K. Rinker, WNYCOSH

This slide shows the various painful disc disorders that can result from years of overexertion of the spine.

Section 3: Anatomy of an Injury
MSDs AMONG HEALTHCARE WORKERS

Back injuries are most common:

- 73% of MSDs reported by nurses
- 70% are of the Lumbar Spine
- 57% are due to lumbar disc problems

Other chronic MSDs:

- Rotator cuff (shoulder)
- Thoracic outlet syndrome (neck area)
- Epicondylitis (elbows)
- Cartilage deterioration (knees)
- Carpal tunnel (wrist/hand)

Note that back injuries to the lower lumbar spine and discs are the most common overexertion MSD injuries. But other parts of the body can also be affected including the shoulders, neck, elbows, knees, feet and wrist/hands.

These disorders can also be the result of cumulative trauma due to repetitive overexertion while performing manual resident handling tasks.

Section 4

Controlling Risk Factors

- “Fitting the Worker to the Job”
- “Fitting the Job to the Worker”

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Briefly review the main points in this section.

Section 4: **Controlling Risk Factors**

ERGONOMICS: THE LAWS OF WORK

Old Philosophy – “Fit the Worker to the Job”

- Body Mechanics
- Physical Fitness
- Personal Protection

New Philosophy – “Fit the Job to the Worker”

- Ergonomics
- Engineering the risk factors (hazards) out of the job

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The way we used to think about preventing injuries was to teach “proper body mechanics” to protect our back when we manually lifted. Also, exercise (getting in shape) and use of personal protections like a back belt were recommended. If you did these things, you shouldn’t get hurt. But now we know that even if you use good body mechanics and other precautions, you can still get hurt if you are making manual lifts, transfers or repositionings. Residents weigh more than 35 pounds and they’re unpredictable loads. The new way of thinking about preventing resident handling injuries is to “fit the job to the worker.” That simply means that we need to identify those hazards or job risks in resident handling that can hurt us and “fix” (reduce or eliminate) them. By “fixing” them, we can prevent injuries. The science of identifying and controlling hazards is called ergonomics (Ergo=work Nomics=Science of).

Section 4: **Controlling Risk Factors**

RESIDENT HANDLING:
RISK FACTORS (HAZARDS)

- What are some risks about your resident job tasks that can hurt you?
- What are some risks about your work environment that can hurt you?

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Activity [5 minutes]: Explain to the participants that an ergonomic approach to making the workplace safer is to look at the job tasks such as handling and moving residents. Ask them to break down their tasks during the day such as transferring a resident from a bed to a wheel chair or a wheel chair to a toilet. What are the risks or hazards of doing these tasks that can cause injuries? Jot their answers down on the Flip Sheet.

An ergonomic approach also looks at hazards in the work environment where job tasks are performed. Ask the participants to think about the resident’s rooms where they perform their tasks--are there hazards such as clutter, bathrooms that are too small, lack of lifts, etc.?

Section 4: Controlling Risk Factors

ERGONOMIC IDENTIFIES
JOB TASK RISKS

- Heavy lifting
- Applying force
- Awkward postures
- Frequent bending, twisting, stretching, reaching
- Prolonged static posture
- Overexertion/no rest = cumulative trauma

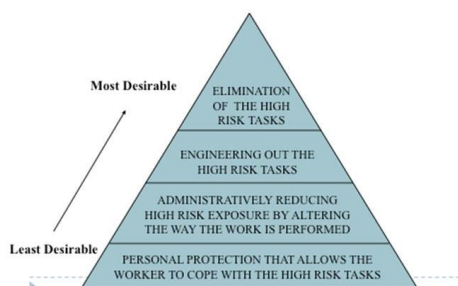
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Listed below are some examples of job task risks:

Heavy Lifting: manually lifting and transferring a resident from a bed to a chair (remember: anything over 35 lbs. is too heavy). **Applying Force:** pushing and pulling wheel chairs over carpets, high thresholds; pulling or dragging a heavy or broken cart. **Awkward Postures:** carrying or lifting a resident while your back is twisted; bending over to crank a bed. **Frequent Bending, Twisting, and Stretching/Reaching:** repositioning individuals in a bed; removing objects from a cart at heights above your shoulders. **Prolonged Static Posture:** Bathing a resident in a bent over position. **Overexertion:** Doing the above tasks repetitively day in, day out, over months and years. Remember: a nurse lifts 1.8 tons/8 hr. day on average.

Section 4: Controlling Risk Factors

THE OSHA “HIERARCHY OF CONTROLS”
TO “FIX THE JOB”



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Hand out the OSHA “Hierarchy of Controls” fact sheet.

Explain that the U.S. Occupational Safety & Health Administration has developed a “Hierarchy of Controls” for reducing job task risks. At the top of the triangle is the “Best” way of preventing injuries. At the bottom is the “Least Effective.” Explain to the participants that, practically speaking, a Safe Resident Handling program uses a combination of Engineering Controls (equipment and other handling assistive devices to “fix the job”) and Administrative Controls (training workers on the equipment, having enough staff to use the equipment, setting up a SRH/Ergo Team, using algorithms to evaluate residents, purchasing the right kind and amount of equipment, etc.).

Section 4: Controlling Risk Factors

FIXING THE JOB: EQUIPMENT



FULL MECHANICAL LIFT

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Using equipment is the alternative to manual lifting and transfers. The risk of being hurt by a manual lift/transfer has been engineered out of the job.

You or the resident can still get hurt using equipment if you don’t follow proper procedures. For example, two people should be available to operate a mechanical lift. You should always use good body mechanics when using equipment.

In this slide, a dependent resident is being safely lifted and transferred using a Full Mechanical Lift and sling. The Full Mechanical Lift should be used with Totally Dependent residents and those who need Extensive Assistance if they are unable to use the Sit to Stand Lift.

Section 4: Controlling Risk Factors**FIXING THE JOB: EQUIPMENT****Sit-to-Stand Lift (Bariatric Patient)****why
cosh**

The Sit-to-Stand Lift can be used as an alternative to the risky manual *pivot* for residents who are partial weight bearing in one or both legs and can hold on with one or both hands.

This is a fairly heavy resident. Many Sit-to-Stand Lifts are rated for lifting residents who weigh 500 pounds or more.

Section 4: Controlling Risk Factors**FIXING THE JOB: EQUIPMENT****Ceiling Lift (Bariatric Patient)****why
cosh**

A Ceiling Lift can be used with a Full Body Sling to safely lift and transfer a bariatric dependent resident from a bed to a chair. A Full Mechanical Lift could also be used if the lift has a weight-rating for bariatric residents.

Section 4: Controlling Risk Factors**FIXING THE JOB: EQUIPMENT****Ceiling Lift with Leg Strap****why
cosh**

A ceiling lift with a limb strap can be used to lift a limb for to apply a dressing. This eliminates the high risk task of manually lifting the leg and carrying out the job task.

Section 4: Controlling Risk Factors

FIXING THE JOB: TRANSFER DEVICES



Lateral Transfer Devices

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cosh

Transfer devices reduce risky manual pulling and tugging tasks to reposition or transfer residents from one surface to another. They reduce friction so the resident can be easily slid to the desired target. Slide sheets are an especially inexpensive item that can be used to easily reposition a resident who needs to be pulled towards the head of a bed.

Section 4: Controlling Risk Factors

FIXING THE JOB:
OTHER ASSISTIVE DEVICES



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These are some other assistive devices that reduce the risks of manual handling. Gel-filled pads/mats contain a thick fluid substance sandwiched between a strong material such as nylon that can be placed under the resident that can be easily slid from one surface to another.

Transfer Boards such as Slide Boards or Roller Boards are made of wood or plastic. Some have movable seats. The smooth rigid material reduces friction during a transfer. They act as a supporting bridge when seated transfers are performed. Some manual pulling or pushing may be required, but they offer considerable improvement at minimal cost.

Section 4: Controlling Risk Factors

After you have the equipment:

- Release time for your SRH team
- Right equipment and accessible
- Accurate resident assessment/care plans
- Staffing to allow for two (2) people to operate mechanical lifts/repositioning devices
- Staff training on SRH policy/procedures
- Mentoring/monitoring/evaluating staff

wny
cosh

Ordering and having the right equipment will eliminate manual handling job risks. But, equipment itself is not enough to eliminate your risks of injury.

If you don't have the right equipment, don't have an accurate assessment of the resident's abilities to assist with a lift, haven't been adequately trained to use the equipment, don't use proper body mechanics when using the equipment, and don't have 2 direct caregivers when using the mechanical lifts--you can injure yourself or the resident.

Section 4: Controlling Risk Factors

FIXING THE WORK ENVIRONMENT

Room Layout	Small Room/Clutter
Uneven Work Surfaces	Beds, Chairs and Toilets w/ Different Heights
Lifting Devices	Equipment Poorly-Maintained, Inaccessible, Wrong or Inadequate

**** Beware Slips, Trips & Fall Hazards**

why
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Exercise: [5 minutes]: Ask the participants if any of these environmental risk factors are present in their facility. How could some of these risk factors be fixed? Jot down their answers on the Flip Chart. The work environment also has to be engineered to make resident handling safe. Small rooms can be a challenge for using Mechanical Lifts, particularly when toileting. If a bathroom can't be reengineered, a portable commode might be the answer. Room clutter can also be a problem; reorganizing closets and furniture may make the use of equipment possible. One of the main problems that CNAs and other direct caregivers face is inadequate equipment or inaccessible equipment. The purchase of the right amount of equipment will make it more likely that direct care staff won't go back to manual handling. And, Lifting Equipment must be accessible--it should be parked in easy to reach areas of the hallway; it should never be stored away in a closet.

Section 5

Old vs. New Practices: Changing the Culture

- Moving From an "Old" Manual Lifting Culture to a "New" Safe Resident Handling Culture
- How Do We Get There?

why
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Review the main topics of this section.

Section 5: Old Vs. New Practices: Changing the Culture

The "Old" Resident Handling Culture:

- "Blame and Shame"
- Injuries are due to carelessness
- Reward good behavior
- Punish bad behavior
- Body mechanics = safe lifts/transfers
- Non-manual handling is impractical

why
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Hand out the "Old Practices/Evidence Based Practices" fact sheet. Briefly discuss the main points on the sheet. Note that while we are calling this the "Old Culture" the fact is that most of us in health care have been taught to think and act this way. Because we have learned and practiced this way of handling residents, it has become almost habitual. Due to our fast-paced work and other demands placed on us, it will be difficult, at first, to think and act differently. Also, learning a whole new set of practices can seem like just one more thing we have to do on top of all of our other responsibilities. This is true of everyone involved--management, direct care workers, support staff and residents. What we are trying to do with today's training session is to begin a transition to the "New No-Manual Handling Safe Resident Handling Culture."

Section 5: Old Vs. New Practices: Changing the Culture

The “New Safe Resident Handling Culture”

- The way to create a safer workplace is to “Fit the Job Task” and “Work Environment” to the worker
- Eliminate the need to manually handle residents through the purchase and use of equipment will create a safer workplace
- Train and mentor direct care workers on the proper use of equipment will move us toward a “Culture of Safety”

wny
cosh

Transitioning to a “Culture of Safety” at this facility will begin with adopting the policies and practices of Safe Resident Handling. It will require that direct care workers and the union, support staff, and the administration work together toward the common goal of making this a non-manual handling facility. There will be “bumps in the road.” When they occur, it is critical that instead of “blaming and shaming” we pull together, taking each problem on honestly and work together and try, a step at a time, to improve our program. If we can do that, we are on our way to improving the quality of life for those who care for the residents and the residents at this facility.

Section 5: Old Vs. New Practices: Changing the Culture

Moving to a New Culture of Safety:

- Commitment of leadership to safety
- Safety valued as much as efficiency/productivity through investments in equipment
- Shift away from “Shame and Blame” to looking at root causes
- Training, mentoring and monitoring
- Organizational learning from errors and near misses

wny
cosh

Building a Culture of Safety is hard work. Management and your SRH Team can lead by demonstrating a commitment to safety. Instead of “blaming and shaming” workers who get injured, your Team needs to look at root causes when injuries occur--was the equipment accessible? Did we have enough and the right equipment? Was the resident care guide accurate? Did we provide adequate training, mentoring and monitoring? And after incidents occur, is there a process for involving staff in a “after action review” process where incidents are analyzed and lessons are learned?

Section 6

Safe Resident Handling Stakeholders

- Identifying SRH Stakeholders
- Stakeholder Benefits

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In this section we will look at who needs to be involved in your SRH program. Some should be directly involved. Others need to be minimally involved, but should be informed.

Section 6: Safe Resident Handling Stakeholders

Anyone Who:

- Has a stake in the project working
- Can stop the SRH project
- Is directly impacted
- Will feel threatened
- Stands to benefit
- Can support the budget

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Stakeholders are any group of people at your facility whose “buy in” into your SRH program is critical to its success. Those who have the biggest stake in the SRH program are direct care workers, your residents (and family members) and your managers. As stakeholders, they can react positively, viewing the benefits as outweighing the costs and cooperating to make it a success. Or they can react negatively—viewing the costs (effort, time, money) as outweighing the benefits and doing what they can to undermine the project. Management’s “buy in” is especially critical since they need to support the budget for the purchase of equipment and other costs such as training and providing lost time for members of the SRH Team. Other key stakeholders are your support staff who can make or break the program: laundry, infection control, OTs and PTs, and maintenance. Your SRH Team needs to work to achieve “buy in” from all of these stakeholders.

Section 6: Safe Resident Handling Stakeholders

The Stakeholders:

- Management/Administration
- HR, Fiscal Administrator, Comptroller
- Frontline Staff (CNAs, PCAs, LPNs, RNs)
- Occupational and Physical Therapists
- Residents and Family Members
- Environmental/Laundry/Plant Operations
- Clinical Engineers
- Social Workers, Admissions and Unit Clerks
- Purchasing
- Students, New Hires, Potential New Hires

why
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Activity [5 minutes]: Run down the list of typical personnel and departments at a nursing home. Ask the participants:

What do they need to know about SRH and Why?

Section 6: Safe Resident Handling Stakeholders

WHAT ARE THE BENEFITS?

- For Residents?
- For Frontline Workers?
- For Employers

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Activity [10 minutes]: Break the Team into 3 groups. Give each group a sheet of Flip Chart paper and a marker. Ask each group to take a different category of stakeholder, write their name across the top of their paper, and make a list of how each of the stakeholders might benefit. Also, ask if they believe there are any negative consequences for the each stakeholder and what they might be.

Section 6: Safe Resident Handling Stakeholders**Benefits for Residents:**

- Improved quality of care
- Improved resident safety and comfort
- Improved resident satisfaction
- Reduced risk of falls, being dropped and friction burns
- Reduced skin tears and bruises

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These are some of the benefits of SRH for residents that have been reported in studies of SRH programs.

Section 6: Safe Resident Handling Stakeholders**Benefits for Health Care Workers:**

- Reduced risk of injury
- Improved morale
- Less pain and muscle fatigue
- Re-injury less likely for injured workers
- Pregnant workers can work longer
- Staff can work at an older age
- More energy at work shift's end

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These are some of the benefits of SRH for healthcare workers that have been reported in studies of healthcare workers.

Section 6: Safe Resident Handling Stakeholders**Benefits for Employers:**

- Reduced number and severity of staff injuries
- Improved resident safety
- Reduced restricted work days
- Reduced overtime and sick leave
- Improved recruitment/retention of direct care staff
- Fewer resources needed to replace injured staff

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These are some of the benefits of SRH for healthcare employers that have been reported in studies of employers.

Section 7

Safe Resident Handling/Ergonomic Teams

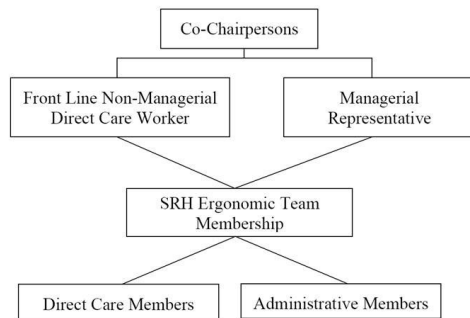
- SRH Team Structure
- SRH Team Functions

Review the topics for this section.

why
cosh

Section 7: Safe Resident Handling/Ergonomic Team Structure

SRH/ERGONOMIC TEAM STRUCTURE



why
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This is a model structure for the SRH/Ergonomics Team. A number of states have passed the Safe Patient Handling legislation using this arrangement. New York State's proposed legislation also uses this model. The Team is co-chaired by representatives from the direct care staff and from management. Direct care staff and administrative staff on the Team are equal in number. This arrangement reduces concerns that the program is dominated by either workers or administrators

Section 7: Safe Resident Handling/Ergonomic Team Structure

Direct Care Staff Members:

- Resident Care Staff (All Shifts)
- Registered Nurses
- Licensed Practical Nurses
- Certified Nursing Assistants
- Transport Staff
- Maintenance
- Environmental Services (Including Laundry)
- Physical/Occupational Therapy Staff
- Infection Control

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This is a list of Direct Care Staff positions that should be drawn from for your Team. While you may only select some members from this group, all should be considered stakeholders and have a role to play in your program.

Section 7: Safe Resident Handling/Ergonomic Team Structure

Administrative Members:

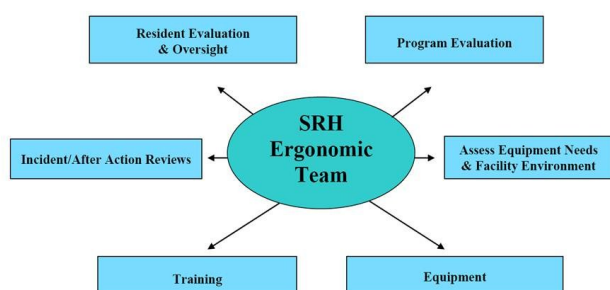
- Administration
- Business/Budget Department
- Human Resources
- Trainers/Educators
- Supervisors
- Third-Party Administrators, Benefit Coordinators, Workers Comp Case Managers
- Occupational Health/Employee Health Personnel

This is a list of Administrative Staff positions to select from for your Team. While all have a role to play, it would be especially important to have a Charge Nurse and someone who tracks workers' compensation and disability claims.

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Section 7: Safe Resident Handling/Ergonomic Team Structure

FUNCTIONS: SRH TEAM DUTIES/RESPONSIBILITIES



Your SRH/Ergonomic Team is at the hub of creating and sustaining a successful SRH program. This slide shows the functions of a Safe Handling Committee as written in New York State proposed legislation. It plays a key role in ensuring that the administrative controls are in place and functioning. **Resident evaluation oversight:** Ensure that a system for accurate evaluation of residents' abilities to assist with lifts, transfers and repositionings is in place and that Care Guides are provide information needed by CNAs to do moving tasks safely. **Training:** Conduct SPH training for all direct caregivers. Mentor, monitor, and evaluate, training of new hires, retraining. **Needs Assessment:** Assessment of risks of the environment, job tasks, and resident needs. **Equipment:** Recommend equipment purchase, set up, maintenance. **Incident Investigation:** Set up and use a process of incident investigation and after-action review and a plan for correction. **SRH Program Evaluation:** Perform an annual program assessment/evaluation.

why
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Section 8 Timeline

- Developing Your SRH Program Implementation Timeline

Review the topic that's covered in this Section.

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Section 8: Timeline**Developing a Timeline for the
Following Elements of Your SRH Programs:**

- Needs Assessment
- Equipment Purchases
- SRH/Ergonomics Team Up and Running
- SRH Policy and Procedures Development
- Stakeholders “Buy-In”
- SRH Program “Rolled Out” Onto Units
- SH Training for All Direct Care Workers
- System for Mentoring, Evaluating Direct Care Workers Established

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Facilitate a discussion of a timeline. Explain that their Team needs to begin thinking about what and when various parts of their program will be implemented. This form can be used to begin to make some projections.

Because the next few modules will provide information on how to assess equipment needs, facility environmental needs, conduct training for the direct care staff, etc., it may make sense to begin planning some of these activities in the very near future.

Notes

Notes

MODULE TWO: Team Meeting Skills for Safe Resident Handling/Ergonomic Teams

AGENDA

REVIEW AGENDA	(Briefly)
REVIEW OBJECTIVES	(Briefly)
Section 1: Team Meetings and Structure Handouts: "Task vs. Process," "Task and Process," "Team Structure and Composition"	(10 Minutes)
Section 2: Setting the Stage for Meetings Activities: "Best vs. Worst Meetings," "Establishing Ground Rules," "How to Pitch a Better Meeting"	(20 Minutes)
Section 3: Group Process Roles Handouts: "Group Process Roles" & "Key Roles in Every Meeting" Activity: "Mystery Problem" Handout	(30 Minutes)
<i>— 10 Minute Break —</i>	
Section 4: Methods of Group Decision-Making Handout: "Decision-Making" Activity: "Consensus Exercise: Items from the Latest Safety and Health Audit"	(20 Minutes)
Section 5: Conflict Resolution Skills Activities: "Interest-Based Conflict Resolution in Sequence," "Collaborative Conflict Resolution: Sample Scenario"	(20 Minutes)
<i>— 10 Minute Break —</i>	
Section 6: Natural Stages of Group Development	(5 Minutes)
Section 7: Overcoming Resistance to Change	(10 Minutes)
Section 8: Multiple Intelligences Activity: "Learner Types and Multiple Intelligences"	(30 Minutes)
EVALUATION	(5 Minutes)

Module Two
**Meeting Skills for
Safe Resident Handling/Ergonomic Teams**

Summary: The purpose of this module is to give your Safe Resident Handling Team the skills and tools to create a well-functioning and productive group. Safe Resident Handling programs can fall apart when the group that is implementing the program becomes dysfunctional--meetings turn into "gripe sessions" and "nothing gets accomplished." One theme of this module is that Teams work when members are able to attend to both "process issues" (for example, working on making all members feeling respected and included) and "task issues" (for example, members developing and carry out a program work plan). We will also examine communication in groups including group roles and stages of groups. Tools will be given for using meeting time effectively and for choosing the most effective communications methods for resolving Team conflict such as "interest-based" problem solving.

Meeting Skills for SRH/Ergonomic Teams

AGENDA:

- Introduction and Overview: Task vs. Process
- Team Structure and Composition
- Establishing Ground Rules
- Developing an Agenda
- Group Process Roles
- Methods of Group Decision Making
- Conflict Resolution Skills
- Teams and Natural Stages of Group Development
- Multiple Intelligences

Review the agenda. Explain to the participants that the topics we will be covering will help us understand what we need to do build a successful Team. In addition to talking about developing core skills, your Team will participate in exercises that allow you to practice developing them.

Introduction to Safe Resident Handling

OBJECTIVES:

SRH Team participants will be able to:

- Develop a meeting agenda
- Define the duties of each of the group process roles
- Identify the stages of group development
- Discuss how Multiple Intelligences affect communication
- Describe methods for communicating SRG messages to influence stakeholders

Explain to the Team that the reason we are doing this training is because many teams or committees fall apart because the meetings are unproductive. Nothing gets done! To have a successful Team and meetings, learning some core skills about how to get things done while making sure everyone is included and participating is critical.

Section 1:

Teams

- Team Meetings
- Team Structure

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Review the topics for this section.

Section 1: **Team Meetings**

TASK
VS.
PROCESS

TASKS are the actions, decisions and discussions of the group.

PROCESS is *how* the work of the group is performed.

why
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Review the slide and move to next slide.

Section 1: **Team Meetings**

TASKS OF THE GROUP – EXAMPLES

- Preparing an agenda, identifying issues
- Discussing an issue
- Developing selection criteria & making decisions
- Determining a plan of action

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Group “Tasks” have to do with the things you want the Team to accomplish. Discussing the issues such as “where are our direct care workers getting injured and what do we do about it?” “How much equipment do we need, and do we have money in our budget to buy more?” “Who can make the decision, and how can we get the job done?”

Section 1: Team Meetings

GROUP PROCESS ACTIVITIES – EXAMPLES

- Listening and responding
- Methods for making decisions
- Group climate
- Meeting flow

why
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Group “Process” has to do with how a Team works together. Do people listen to each other and respect each other’s opinions? Do decisions get made or are the meetings just “bull sessions?” Do the workers who participate get a say in decisions, or are they disregarded? Is there a good group climate, or are the participants hostile, bored and just going through the motions? Does the meeting have an agenda and is it followed, or are the meetings all over the place?

Section 1: Team Meetings

GROUP PROCESS

PROCESS
ISSUES BLOCK
WORK ON TASKS

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Distribute the “Task versus Process” handout.

Note that it states that “typical difficulties facing teams is that ‘tasks’ are blocked by group process problems.” The typical lists. . .do not show safety and health issues as what makes meetings good or bad, productive or not. Instead, the lists show behaviors and actions as which worked well or which frustrated meeting participants.” It was team “process issues” that blocked safety and health tasks: meetings don’t start on time, meetings drag on forever, one or two people dominate the meeting, the Team can’t make decisions, nothing gets resolved, meetings are pointless, etc.

Section 1: Team Meetings – SRH Team Structure & Composition

How a Team Would Be Structured
(Proposed in NYS Law)

- Size of team variable
- Ratio of Labor to Management (equal)
- Minimum of one (1) non-managerial nurse and 1 direct care worker on SRH Team
- Two co-chairs: one (1) management and one (1) frontline worker or managerial nurse

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The NYS proposed Safe Patient Handling legislation. The section on SRH Teams reads as follows:

“Each health care facility shall establish a Safe Patient Handling Committee either by creating a new committee or assigning the powers and duties to an existing committee. At least one-half of the members of the Safe Patient Handling Committee shall be frontline non-managerial nurses or direct care workers. At least one non-managerial nurse and one non-managerial direct care worker shall be on the Safe Patient Handling Committee. The Committee shall have two co-chairs with one from management and one frontline non-managerial nurse or direct care worker.”

Section 1: Team Meetings – SRH Team Structure & Composition**Do we have people in the Team who can accomplish the Team's tasks?**

- The stakeholders needed to make SRH work
- Representatives of relevant groups (union, management, CFO, PTs/OTs, nurses, CNAs, et cetera)
- Different shifts/units

wny
cosh

To ensure the Team is productive, you need to have members who are in a position to move the SRH program along and can make it work. You need to have the right stakeholders and decision-makers who have influence to make things happen.

Section 1: Team Meetings – SRH Team Structure & Composition**Committee Meeting Schedule/Times:**

- Regular intervals (bi-monthly/monthly)
- “As-Needed”
- “Emergency” basis
- During working time
- During non-working time
- Paid straight-hourly time

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If your Team's main task is to implement a SRH program, it should plan to meet regularly-- bi-weekly at first or, at the very least, on a monthly basis.

To ensure participation, it's important to schedule meetings when your Team members are available and to have paid leave time from their regular duties. If the meetings are well-structured and run, you can probably conduct most of your business in one hour.

Section 1: Team Meetings – SRH Team Structure & Composition**Your SRH Team's Tasks:**

- Set criteria for resident evaluations to determine what equipment is used
- Set criteria for performance of risk assessments of the environments/job tasks and resident needs
- Ensure equipment is set up, functioning
- Provide initial and on-going training
- Set up a process for incidence investigation
- Recommend equipment acquisition
- Minimally, a program assessment

wny
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Your Team has a number of tasks that need to be carried out to ensure that you have a successful SRH program. Read through the tasks.

Section 1: Team Meetings – SRH Team Structure & Composition**Minutes of Team Meetings:**

- Designate someone to take/distribute minutes
- Document issues brought up
- A record of any agreements made at the meeting and actions/recommendations made
- Use as a measurement tool to gauge extent of implementation of Team's actions

wny
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Your Team should designate someone to take and distribute minutes. They serve as the “memory” of the Team. They assure accountability and help you determine if progress is being made toward your goals.

Section 1: Team Meetings – SRH Team Structure & Composition**The Team's Authority:**

- Advisory only?
- Independent authority?
- Reactive?
- Involved in planning?

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It's important to establish what authority your Team has to make decisions to accomplish its tasks. While management retains ultimate authority for what happens at your facility, for a SRH Team to implement your facility's SRH program, it needs to be more than advisory or micro-managed by upper level management. Having management on the Team should allow the Team to actually carry out tasks.

A SRH program needs to be carefully planned following a timeline that it establishes. It should not be primarily reactive.

Section 2**Setting the State for Meetings**

- Best vs. Worst Meetings
- Ground Rules
- Agendas
- Key Roles
- Practicing Committee Role and Skills

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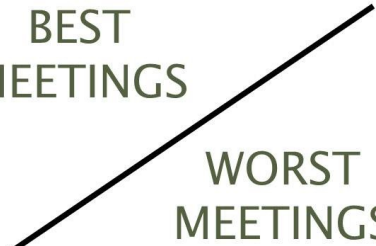
Review the list of topics covered in this session.

Section 2: Setting the Stage for Meetings

BEST vs. WORST MEETING

BEST
MEETINGS

WORST
MEETINGS



why
cosh

Activity [10 minutes]: This exercise is designed to draw on the Team members' experiences with participating in meetings--good and or bad.

Divide the Team into 2 groups. Give each group a piece of Flip Chart paper and a marker. As one group to describe what made the meetings--any kind of meeting on any topic they've been a part of--be really good. Ask the other group to describe what made meetings they've been part of really bad. Report back. Have each group post with masking tape the "Best Meeting" and the "Worst Meeting" next to each other. Ask each group to read the other group's list and add any items they feel are missing. Ask the groups to elaborate on any items they would like to describe further.

Section 2: Setting the Stage for Meetings

ESTABLISHING GROUND RULES:

- Importance
- Commitment
- Examples

why
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Activity [12 minutes]: After looking over the "Best" vs. "Worst" meetings, it will become clear that what makes meetings work well (and, when not done, makes meetings work badly) is to follow some basic rules of organization, time and courtesy. The Team members will more likely follow ground rules if they participated in developing those rules themselves and recognize their importance to the group. **Distribute the "Establishing Ground Rules" handout.** Ask the Team as a whole to discuss why ground rules would be helpful. Provide them with Flip Chart paper and ask them to refer to their "Best"/"Worst" lists. Ask them to write the ground rules they think would be useful for future Team meetings. Ask them to post their sheets on the wall. Then, ask them to review the ground rules and modify any language as appropriate. This is their work product that they can take away after the training. They can use them as is or modify them in the future, as needed.

Section 2: Setting the Stage for Meetings

GUIDELINES FOR PITCHING A BETTER MEETING:

- PLAN the meeting
- INFORM the participants
- TARGET for a productive discussion
- CONTAIN the discussion
- HASTEN the completion of action steps

why
cosh

Distribute the handout "How to Pitch a Better Meeting." Briefly mention the guidelines for ensuring a good meeting. The Team needs to know why they're meeting. They should know the purpose, desired outcomes, date/time/location and any pre-meeting assignments. When beginning the meeting, get a consensus on the agenda and outcomes--modify where necessary. The meeting should be facilitated and contained by adhering to the agenda; work to consensus on action steps, responsibilities and target dates. Hasten the completion of the agreed-upon action steps, keeping a record of who agreed to do what; set up the next meeting date and agree on what unfinished business should roll over to the next meeting's agenda.

Section 3: Group Process Roles**SRH TEAM'S PRIMARY FACILITATOR:**

- Guides group process
- Allows each member to be heard
- Suggests processes
- Keeps group focused on task

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Your Team's primary facilitator guides the group process, so the Team is staying on task and meeting the objectives of the meeting. As the primary facilitator, it's your role to keep reminding the Team that it needs to address the tasks at hand on the agenda, working toward action steps that will meet the goals of your SRH program. Working with the timekeeper and recorder, you will move the decision-making process along, looking for consensus. At the same time, the primary facilitator has to guide the group process. You will be checking for agreements and disagreements, building consensus where you can and depersonalizing differences of opinion. You will be gently guiding the conversation flow and call on silent members to get their input into decisions being made. Where there's deadlock, you may suggest alternative options. Recognize that differences of opinion and conflict are OK, but that personal attacks are out of bounds. Call for time outs or breaks to allow some time for cooling off or reflection.

Section 3: Group Process Roles**SRH TEAM'S SECONDARY FACILITATOR**

**Assists the Primary
Facilitator with keeping the
Team on task and helps
guide the group process**

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Your Team may also benefit from having another person prepared to assist the primary facilitator. Because your Team has equal representation of direct care/frontline workers and managers, you might consider having the meeting's primary facilitator come from one group and the secondary facilitator from the other.

Section 3: Group Process Roles**SRH TEAM'S RECORDER/NOTE-TAKER**

- Key ideas recorded
- Accuracy check
- Use flip charts

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Distribute the "Role of the Recorder in Effective Meetings" and the "Pointers for Flip Chart Users" handouts. It's the Team recorder's role to keep the minutes of the meeting. You will record the meeting date, who attended, who presided over the meeting, a brief description of what was discussed on each agenda item, what decisions and action steps were agreed on (or, motions made, seconded and carried), who is to carry them out, what unfinished new business is to be taken up at the next meeting, the date of the next meeting, etc. Your other role can be to keep a running visual record of the meeting, using the Flip Chart and posting the sheets on the wall as the discussion proceeds. This is particularly useful when your Team is "brainstorming" an issue. As you record on the Flip Chart, you can assist in getting an accurate record of what's being said by saying, "Am I getting this right? Or "What I think I hear you saying is...").

Section 2: Setting the Stage for Meetings**USING AGENDAS EFFECTIVELY**

- Location, date and time
- Purpose
- Attendees
- Topics in order of presentation/time
- Pre-meeting assignments
- Contact the presenters
- Distribute the agenda

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Distribute “Guidelines for Developing a Good Agenda” and the “Safe Patient Handling Team Meeting Agenda” handout. Team participants will appreciate having a well-prepared agenda. Someone on your Team needs to take responsibility for planning the agenda before the meeting. It’s always good to get it out a few days before the meeting, particularly because you will want to remind them of the location, date and time. Your Team will probably have a couple or few key issues that it will be focusing on at any particular meeting. Put them in some order. A recommendation regarding the amount of time that’s anticipated for each item can be helpful. Be sure that business tabled at the last meeting is on the agenda. Contact anyone who is supposed to be making a presentation at the meeting. Remind the Team members if there is “homework” they were supposed to do between meetings.

Section 3:**Group Process Goals**

- Group Roles
- Practicing Team Roles
- Group Development

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Review the topics that will be covered in this session.

Section 3: Group Process Roles**KEY ROLES IN EVERY MEETING**

- Primary Facilitator
- Secondary Facilitators
- Timekeeper
- Recorder/Note-taker

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Assigning key roles for every meeting will allow your Team to manage the meeting’s business and time. The core skills of facilitating, timekeeping, and recording make sure that the tasks of the Team get done while, at the same time, the members interact with courtesy and respect. Your Team may want to consider a rotational system for these meeting roles. Team co-chairs don’t need to feel they must always be the facilitator. The role of Team meeting facilitator can rotate around the group. So can the other group roles. Sometimes the rotation of roles can be very educational: disruptive or argumentative Team members can benefit from serving as facilitator—they may begin to understand how much tact it takes to manage a group when one or more members are disruptive.

Section 3: Group Process Roles

SRH TEAM'S TIMEKEEPER:

- Monitors timeframe to accomplish agenda tasks
- Keeps time check and provides update

wny
cosh

Someone needs to keep track of the time spent on the agenda items for your Team. Your Team may want to designate a timekeeper or perhaps a facilitator can do that--just make sure someone is "watching the clock." At the beginning of the meeting, the Team may agree on the amount of time that should be allotted to each item. Or, if not each item, an agreement that someone is monitoring the one-quarter mark, the half-mark, the three-quarters mark, etc. The timekeeper may simply announce, "time check--we are half-way through the meeting time" or the time allotted to an item. As your Team closes in on the last 5 minutes, a "five-minute warning" might be given. At the end of the allotted time, the Team may agree to allocate a few extra minutes. Your timekeeper can be an asset to your Team--by reminding members that you are half-way through a topic, for example, can serve as a cue to the facilitator and the participants, to keep their remarks to the point so that resolution can be found for the item at hand.

Section 3: Group Process Roles

SRH PARTICIPANT ROLE:

- Prep before the meeting
- Participate during the meeting
- Follow-up after the meeting

wny
cosh

Distribute the "Participant Role Handout." Each participant has an important contribution to make to the Team. Each of you is probably on the Team because you represent one of the stakeholder groups at your facility--CNAs, unit nurses, PTs/OTs, CFO, etc. As Team participant, therefore, you have the task of deciding and acting for the group you represent; for example, as a CNA, you need to contribute to decisions that will make the SRH program work for you and the other CNAs. The input of each of you to this Team effort is extremely important to the whole facility. Before the meeting each Team member should block out time for the meeting and attend. You should read the agenda and think of what you can contribute. During the meeting it's important to listen to others, be open to each other's ideas (disagree "respectfully"), and stay on task. After the meeting, review any action items you are responsible for; brief others as appropriate.

Section 3: Group Process Roles

PRACTICING COMMITTEE ROLES & SKILLS:

MYSTERY ACTIVITY



wny
cosh

Activity [20 minutes]: The Mystery Exercise to Practice Committee Roles/Skills provides the opportunity for the Team members to practice the skills of facilitator, recorder, and timekeeper. The trainees receive both significant and irrelevant information in the form of clues. The facilitator must draw out the information, managing the group's discussion of significant and insignificant information, while the recorder organizes the information, and the timekeeper keeps the group on task. The roles can be rotated one or more times during the exercise to give others a chance for practicing these skills. Begin by asking the Team to select a facilitator, recorder and timekeeper and indicate the task of each for this activity.

Section 3: Group Process Roles

PRACTICING COMMITTEE ROLES & SKILLS:

MYSTERY ACTIVITY

Clues:

- Information provided to your Team

Team Task:

- Sort through the information
- Figure out what the problem is
- Begin to work out your next actions to solve the problem – such as ...

why
cosh

The significant and irrelevant information is in the form of clues with each clue on a separate piece of paper. You will find the clues below. In preparation for this class, print each clue on a separate piece of paper or card and shuffle them so they're not in "significant" and "extraneous" order. Handout the clues by going around the room and giving out one clue per person; if there are more clues remaining after this, and then continue to give out clues until no more remain.

Review their task (this slide and next slide). As the instructor, you have the case story (below) and the list (below) of significant clues and irrelevant clues.

Section 3: Group Process Roles

PRACTICING COMMITTEE ROLES & SKILLS:

MYSTERY ACTIVITY

Team Task, Continued:

- What additional info do you need?
- Who needs to pursue the problem and how?
- When will they meet next on this issue and pool info?
- Potential solutions--immediate and long-term

why
cosh

Case Story: (for the instructor to know and the group to find out): Anne, a nursing assistant, fell and twisted her back while endeavoring to toilet a patient. The patient, Mrs. Andrews, is a 92-year-old woman who has difficulty supporting her own weight. She is confused and belligerent, often striking out at caregivers. On this occasion, Anne was transferring her from the wheelchair to the toilet in a lavatory with little space and handrails between toilet and wall. Anne was supporting Mrs. Andrews while pulling down her pants and absorbent pad, when Mrs. Andrews' elbow struck Anne on the side of the head. Anne fell back against the sink, sliding under the sink, which position caused her to twist her back.

Section 3: Group Process Roles

PRACTICING COMMITTEE ROLES & SKILLS:

MYSTERY ACTIVITY

?

why
cosh

Clues. Significant Information (instructor's eyes only):

- Nursing assistants doing patient care ranked transferring wheelchair patients to and from the toilet as the 2 tasks most stressful on the lower back.
- Nursing assistants working with Mrs. Andrews have reported she sometimes strikes out at caregivers without warning.
- The average time to toilet a client is 4.2 minutes.
- Anne, a nursing assistant, reported having twisted her back while toileting a patient.

Section 3: Group Process Roles

PRACTICING COMMITTEE ROLES & SKILLS:

MYSTERY ACTIVITY

?

why
cosh

- Nursing assistant Anne reported having to support the patient's weight for about 30 seconds while pushing the wheelchair to the toilet, lifting the patient in the standing position, pushing the wheelchair away; pulling pants and absorbent pad down while supporting the patient, then turning and lowering the person to the toilet seat.
- Due to limited lavatory space and handrails between the toilet and the wall, the wheelchair was often left at the door of the lavatory, the nursing assistant carried the person to the toilet.
- On average, each nursing assistant carries out 24 of the most stressful patient-transfer tasks per 8-hr. shift.

Section 3: Group Process Roles

PRACTICING COMMITTEE ROLES & SKILLS:

MYSTERY ACTIVITY

?

why
cosh

- Anne, a nursing assistant, weights 142 lbs., is 5'4" tall, and has worked in health care for about 8 years.
- Mrs. Andrews is 92 years old and weighs 136 lbs.
- The mean frequency of transfers for this toileting process: 10.8 per nursing assistant per 8 hr. shift on floor 1; 17.0 per nursing assistant per 8 hr. shift on floor 2.
- The typical toilet seat is height is 16"; wheelchair height is 18".

Clues: Extraneous Information:

- Mrs. Andrew's husband was a copy machine repairman.
- The nursing assistants on floors 1&2 are participating in a weight-loss contest

Section 3: Group Process Roles

PRACTICING COMMITTEE ROLES & SKILLS:

MYSTERY ACTIVITY

?

why
cosh

- The staff won an award for increased productivity for 2009.
- The union steward on floor 2 sprained her ankle.
- The long-term care facility recently received 5 new computers.
- Dead ants were found on the window sills of the first floor offices and mail sorting department.
- The cafeteria/kitchen's grease trap was pumped out on January 18.
- The custodians clean the patients' rooms daily & offices every other night; the restrooms and fountains every day.
- On Fridays, the cafeteria serves fish sticks; o Wednesdays, the cafeteria serves macaroni and cheese.

Section 4:

Methods of Group Decision-Making

- Decision by Authority
- Decision by Authority with Advice
- Decision by Minority
- Decision by Majority
- Decision by Consensus
- Decision by Unanimity
- Steps for Reaching Consensus
- Interest-Based Decision Making

why
cosh

Review the topics that will be covered in this section.

Section 4: **Methods of Group Decision-Making****WHAT DECISION-MAKING PROCESS
CAN OUR SRH TEAM USE?****Levels of Group Involvement:**

- Decision by Authority
- Decision by Authority w/ Advice

why
cosh

Distribute “Decision-Making” handout by Nancy Lampen, MS. There are six different ways that decisions can be made by a Team. One is the authoritarian approach. The chairperson or authority listens to the discussion and then decides. It’s efficient. For it to work, the chair has to be a really good listener. The downside is that the participants aren’t invested in the process and may feel they are being dictated to. Without real “buy in,” there is often little enthusiasm for implementing the decision. Another version of the authoritarian approach is for the chairperson to call Team members on the phone and ask each one’s opinion without group discussion. The chair announces the Team was polled and she or he has made such and such a decision. Again, Team members will likely not feel they have “buy in” and will have little enthusiasm for implementing the decision.

Section 4: **Methods of Group Decision-Making****WHAT DECISION-MAKING PROCESS
CAN OUR SRH TEAM USE?****Levels of Group Involvement:**

- Decision by Minority
- Majority Rule

why
cosh

Minority rule is a decision-making method where two or three people on a Team use tactics that can produce decisions and actions, but without the consent of the majority. Often these folks come to a powerful and quick decision among themselves and ask, “Does anyone object?” If no one answers quickly, they announce, “Let’s go ahead, then.” However, silence can be taken as consent when, in fact, the majority may feel they were “railroaded” or the decision was “shoved down their throats.” Once again, there may not be real “buy-in.”

Majority rule is a decision-making method where discussion is allowed and then all the Team members are polled (or a formal vote is taken on a motion) with the majority making the decision. Since this is a standard method of decision making in our culture, there may be “buy in.”

Section 4: Methods of Group Decision-Making**WHAT DECISION-MAKING PROCESS
CAN OUR SRH TEAM USE?****Levels of Group Involvement:**

- Decision by Consensus
- Decision by Unanimity

wny
cosh

Consensus decision making can be very effective in achieving “buy in.” Everyone will feel affirmed. The downside is that it can take a lot of time to achieve and it may interfere with the Team’s ability to spend time getting to all the tasks at hand. This method may work if, in the absence of consensus after a lively discussion, those in the minority feel they’ve had a fair hearing and are willing to “stand aside,” accepting the decision as a good-faith Team effort.

Decision by unanimous consent would achieve optimal “buy in” but likely at the price of getting to all the tasks at hand because it’s so time-consuming. Consensus may not achieve unanimity, but dissenters may feel that they had a fair hearing and will buy into the Team’s decision.

Section 4: Methods of Group Decision-Making**WHAT IS CONSENSUS DECISION-MAKING:****The consensus method encourages:**

- Difference of opinion and treats them as important considerations
- Consideration of all aspects of a problem
- Consideration of all possible courses of action to solve it
- Giving each person an equal chance to influence the outcome

wny
cosh

If you were to use a consensus method of decision-making at your Team meetings, each member of your committee needs to be treated with respect. Your Team would be open to differences of opinion and consider these differences with respect to planning and executing your SRH program. From the consensus perspective, seeing a problem from multiple perspectives is a good thing. So is a discussion of all recommendations for possible courses of action.

Section 4: Methods of Group Decision-Making**WHAT IS CONSENSUS DECISION-MAKING:****The consensus method encourages:**

- Fully utilizing the information and experiences of each person on the Team
- Integration of many points of view into a common solution

wny
cosh

Your Team is comprised of stakeholders who will see SPH policy and practices from differing perspectives. It will disrupt their routines in different ways. Take an equipment purchase, for example. What might seem like an ideal piece of equipment from Maintenance’s point of view may not be ideal from the CNA’s point of view or from the Chief Financial Officer’s point of view.

The consensus method strives to integrate the many points of view into a common solution. This is considered preferable to having a single individual coming up with the solution.

Section 4: Methods of Group Decision-Making

EIGHT STEPS TO A CONSENSUS DECISION:

Step 1: Group agrees on decision to be made

Step 2: Everyone presents his/her view clearly and logically but without excessive advocacy

Step 3: All relevant info and evidence is reviewed, including minority opinion

Step 4: Possible decision alternatives or options are identified

why
cosh

Review through the 8 Steps Toward Achieving Consensus (2 slides) and then move onto the next slide.

Section 4: Methods of Group Decision-Making

EIGHT STEPS TO A CONSENSUS DECISION:

Step 5: Pros and cons of each alternative are examined

Step 6: Differences of opinion fully explored to try to resolve disagreements

Step 7: Group discussion leading to the selection of the most positive and least negative features

Step 8: Everyone agrees to endorse the final decision

why
cosh

Review and move on to next slide.

Section 4: Methods of Group Decision-Making

CONSENSUS ACTIVITY

Prioritizing Items from the Latest Safety and Health Audit

why
cosh

Activity [20 minutes]: The purpose of this activity is to illustrate the greater wisdom of the group and the power of collaboration, when compared to an individual acting alone.

Distribute the “Consensus Exercise: Items from the Latest Safety & Health Audit” handout. Read the instructions.

First, have the Team work on column one as individuals, putting down their ranking of the hazard from highest to lowest. Then break the Team into 2 groups and ask each to discuss the ranking and to come to a group consensus. Ask each group to post its rankings on a Flip Chart so the entire Team can see the results. Then, ask each group to describe how they arrived at their decision. Finally, share the expert ranking with the class to see IF they agreed with the expert.

[Expert Ranking: 1-F; 2-A; 3-E; 4-D; 5-G; 6-C; 7-B]

Section 5:
Conflict Resolution Skills



why
cosh

Review the steps that will be discussed in working together to resolve conflicts that will arise when proposing and implementing a no-manual handling/Safe Resident Handling program.

Section 5: Conflict Resolution Skills

COLLABORATIVE CONFLICT RESOLUTION

Getting Beyond
Positions to
What People
Really Want

why
cosh

Activity [40 minutes]: Distribute the “Interest-Based Conflict Resolution

Sequence” and the “Collaborative Conflict Resolution: Sample Scenario” handouts. Explain that you will facilitate this exercise using the flipchart. First, go through a sample scenario (below). Then ask the Team to set up some other scenarios and work through the problems (scenarios might include financial issues, staffing issues, infection control, laundry, etc.--have the Team choose real problems they foresee; you may want to include internal Team conflicts as well).

Section 5: Conflict Resolution Skills

CONFLICT RESOLUTION SKILLS:
Getting Beyond Positions To What People Really Want

A vs. B

Issue
Position
Interest
Reframe
Options
Best
Solution/Agreement

why
cosh

Activity, Continued

There will always be conflicts on your Team or between your Team and the direct care staff as you begin to promote and implement your SRH program. The big Issue you are dealing with is that you are changing a whole policy and way of handling residents. For example, members of your Team or the frontline workers may have been using the pivot transfer for years on dependent residents. Now you are telling them this is not the best practice and that they will have to use a mechanical lift. Many frontline workers may be naysayers and resist. This response is normal. To resolve conflicts, you will need to take their concerns seriously.

Section 5: Conflict Resolution Skills

CONFLICT RESOLUTION SKILLS:
Getting Beyond Positions To What People Really Want

A vs. B

Issue
Position
Interest
Reframe
Options
Best
Solution/Agreement

why
cosh

Scenario: A unit head nurse observes a CNA using an inappropriate pivot transfer and states a position: “You can’t do that. Our policy that we use a lift.” The CNA states a position: “I’ve always used the pivot transfer with this resident and haven’t got hurt. Besides, I don’t have time to find the equipment.” To resolve this conflict, it’s important to move beyond the positions and look for the underlying interests of both parties. To move beyond positions, the unit nurse could respond by stating the facility’s interest: “I understand that you haven’t gotten injured. But we do have a lot of injuries and comp claims are through the roof. I think I heard you say that you don’t have time to get the equipment. Isn’t it available when you need it?” The CNA may, in turn, respond by stating an interest: “That’s right.

Section 5: Conflict Resolution Skills

CONFLICT RESOLUTION SKILLS:
Getting Beyond Positions To What People Really Want

A vs. B

Issue
Position
Interest
Reframe
Options
Best
Solution/Agreement

why
cosh

The equipment is usually at the other end of the hall when I need it. I can’t get my resident’s up and around and to breakfast if I have to keep running down the hallway or figuring out where the equipment is. I simply don’t have enough time.” Now that the issue has been put in interest terms and not unresolvable positions, it can be reframed as a problem to be solved. The unit nurse may now state the problem: “It sounds to me like the problem is that the equipment isn’t easy for you get to when you need it. I think we need to find out why. Do you have any ideas? To which the CNA might respond, “I think we don’t we have enough lifts.” This opens up an opportunity to look at options for solving the problem. The unit nurse may respond, “You might be right, but maybe we need to investigate.

Section 5: Conflict Resolution Skills

CONFLICT RESOLUTION SKILLS:
Getting Beyond Positions To What People Really Want

A vs. B

Issue
Position
Interest
Reframe
Options
Best
Solution/Agreement

why
cosh

Maybe we need to see if there’s a central location that would make it easier to get the lift --we may have to install another electrical outlet. Or, maybe we could stagger the breakfast dining schedule. I would like to have a short meeting of the other CNAs to look at the options and choose a workable solution— what do you think? The CNA might respond: “That sounds OK as long as it doesn’t it doesn’t interfere with my work. I have a lot time pressures.” At the meeting, the options to solve the problem can be investigated. Other CNAs can share what their experiences have been in accessing the lift(s) and what solutions they would propose. Let us say that upon investigation it turns out that the main problem is that the lift(s) is kept at the far end of the hallway because this is where the outlet used for charging is located. The Best Solution that everyone might agree to would be to install an outlet somewhere near the middle of the hallway to improve accessibility.

Section 6:

Natural Stages of Group Development

- Forming
- Storming
- Norming
- Performing

why
cosh

Read the topics for this section.

Section 6: **Natural Stages of Group Development**

**WHAT TO EXPECT WHEN
TEAMS ARE FIRST FORMED:**

- Unproductive at first
- Team members uncertain of roles
- Personalities may not mesh well
- Making decisions a struggle

HANG IN THERE!

This Is Normal for All Groups –
Your Team Will Move On...

why
cosh

After you name the members of your Team and come together for the first couple of times, working productively together may not come naturally. Your first meetings may seem like an uphill struggle. These are normal, natural experiences that tend to occur in all groups. It takes some time for Team members begin to work with each other and learn how to pull together.

Your Team needs to be patient. At the beginning you are going to struggle. That's normal. Relax: with time, practice, respect for differences, and using the tools shown earlier in this module, your Team will come together and tasks will be accomplished.

Section 6: **Natural Stages of Group Development**

STAGES OF TEAM DEVELOPMENT:

- Forming
- Storming
- Norming
- Performing

why
cosh

Groups are complex living entities. They are similar in many ways to individuals. They go through stages of development: infancy, adolescence, and adulthood. Each stage is unique. All groups live through these stages. Just like a person, the experiences at some stages are more pleasant than others. But each stage has to be lived through until your group becomes a coherent, functioning Team.

Think of the Forming Stage as Infancy. The Storming Stage as Adolescence. The Norming Stage as Adulthood. The Performing Stage as Maturity.

Section 6: Natural Stages of Group Development**FORMING ("Infancy"):****Tasks:**

- Learn group process
- Set ground rules
- Small decisions

why
cosh

When your Team first comes together, your first conversations may be awkward. Because some of you are management and some are CNAs or other non-managerial personnel, managerial staff may assume the role of authority on the Team and CNAs the role of subordinate. Conversations will be polite and closely guarded. To break the ice, it might be wise for the co-chairs to meet before the first meeting and talk about taking turns starting a dialogue between all the Team members about why they're on the Team, what they hope it will accomplish and what they hope to contribute. Start a conversation about the Team's ground rules, asking the other Team members how they would like to see the meetings run. Start a conversation about SRH and what small decisions might be made to get started.

Section 6: Natural Stages of Group Development**FORMING ("Infancy"):****Issues of Inclusion – Process:**

- Heavy facilitation
- Member uncertainty
- Dependent
- Polite
- Powerless
- Resist change

why
cosh

Chances are, your first couple of meetings will require heavy facilitation--the leaders (co-chairs) may do a lot of the prompting and talking. Others on the Team are still trying to figure out why they have been chosen, what they're supposed to do, what they are supposed to contribute, etc. They may be passive and overly deferential and polite (particularly those who see themselves as subordinates), and take little initiative. REMEMBER: outside of the Team setting, some of you are "bosses" and others "workers." Workers aren't used to having power and to get them to change and be full participants may take time.

Section 6: Natural Stages of Group Development**STORMING ("Adolescence"):****Tasks:**

- Leader development
- Conflict
- Minor decisions
- Make changes

why
cosh

As in childhood adolescence, members of the Team may begin to "find their voices" and state their opinions openly. Some may begin to challenge the leadership and the goals of working toward a no manual lift policy. The financial officer may declare that the task of finding money to buy equipment is impossible due falling Medicaid reimbursements. The direct care workers may push back, arguing that they already have too much to do with too few staff. The union representative may question management's commitment in the face of tense contract negotiations. Such "head-butting" is normal. There's some validity to feelings that are being expressed. This is the time for the facilitator(s) to remind the Team of the ground rules. The challenge is help the Team find common ground around some non-controversial proposal and action that will move the facility a step (perhaps a "baby step") forward to building the SRH program.

Section 6: Natural Stages of Group Development**NORMING – PERFORMING (“Adulthood”)****Tasks:**

- Use ground rules
- Share leadership
- Reach understanding
- Major decisions
- Create change

why
cosh

Just as individuals “mature,” your Team will mature in its use of group process skills. Members will have become comfortable each other, acting out of affection or caring about others in a deeper, less superficial manner than before. Instead of personal putdowns or instead of one-upmanship, Team members will recognize each other’s anxieties, weaknesses, unique talents and strengths and there will be openness to supporting and coaching one another. Mutual support becomes critical as members of the Team move from the discussing SRH to implementing of the program on the floor and the resistance and snafus that often occurs. The Team has found its “group-ness” with the ability to act as an independent entity, authorized and empowered to carry out all the functions of setting up a successful SRH program.

Section 6: Natural Stages of Group Development**NORMING – PERFORMING (“Adulthood”)****Issues of Affection – Process:**

- Use of group process skills
- Coaching
- Independent
- Test power
- Bonding

why
cosh

When the Team moves through the “Storming” phase into “Norming - Performing” phase, it has achieved “adulthood.” The use of ground rules by Team members will become natural and individuals will use “self-discipline.” Instead of one or two people leading, other members will have gained self-confidence and are prepared to lead. Understandings will be reached where members of the Team will “agree to disagree” respectfully, set aside differences and get on the task at hand of making decisions and taking actions that will move the facility in the direction of a SRH program. The Team is now in a position to establish short and long term goals for the SRH programs, develop a timeline for attaining those goals, and begin to implement the SRH program.

Section 7:**Overcoming Resistance to Change**

- Forces for Changes
- Forces against Change
- Weakening the Forces against change

why
cosh

Review the topics for this section.

Section 6: Natural Stages of Group Development

YOUR ORGANIZATION'S CLIMATE FOR SRH TEAMS:
Force Field Analysis

NEW SRH POLICY & PRACTICES
FORCES FOR CHANGE

Vs.

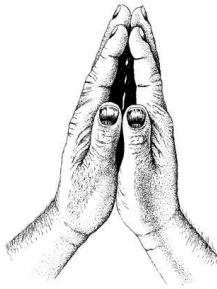
FORCES OF RESISTANCE
TO CHANGE

why
cosh

Exercise [15 minutes]: This is an instructor-facilitated exercise using the flip chart. This exercise uses the insights of the social psychologist Kurt Lewin who developed "Force Field Analysis." One of his key insights was that when changes in policies and practices are introduced into a group, there will be Forces for Change (of the new policy/practice) and Forces of Resistance. Those who are the Force for Change (the "drivers" of the new policy and practice) need to anticipate that there will be Forces of Resistance (barriers to implementing the new policy and practice). For the drivers of change, it's important to make an educated guess as to how strong the resistance is compared to the forces for change.

Section 6: Natural Stages of Group Development

YOUR ORGANIZATION'S CLIMATE FOR SRH TEAMS:
Force Field Analysis



why
cosh

Ask each participant to turn to a person next to them and place their palms against another person's palms. Now ask each of the couples to designate one person as the "Driver" or "Force for Change." Ask the driver to begin pushing against the palms of the other. Then ask, "What was the reaction of the participant who was being pushed? Did she/he begin to resist by holding firm or pushing back? That's often the normal reaction. One of the insights of "Force Field Analysis" is that it is always better to weaken the Forces of Resistance rather than pushing hard against them--that is, trying to "shove the new policy and practices down their throats." Just as with the palm driver/resistance exercise, the normal reaction to being pushed is to resist further and push back. Pushing is usually not as effective as addressing and weakening the Forces of Resistance.

Section 6: Natural Stages of Group Development

YOUR ORGANIZATION'S CLIMATE FOR SRH TEAMS:
Force Field Analysis

FORCES FOR CHANGE	FORCES OF RESISTANCE
Safe Resident Handling Policy and Practice	
Purchase of Equipment	<ul style="list-style-type: none"> Too Costly Not Enough Staff Not Assessable Not Necessary Et Cetera

-

why
cosh

This slide shows the a recommendation your SRH/Ergonomics Team-- Forces for Change-- is likely advocate for (left column: purchase of equipment). The Forces for Resistance (right column). Your facility's financial officer may raise the argument that the equipment is too costly. To weaken this argument, the Team may show a cost vs. benefit analysis--e.g., the cost of workers' comp claims vs. the cost of slide sheets or lifts; return on investment data from other facilities may help weaken this resistance. The union or staff may resist by taking the position that there's not enough time and staffing now and that adding another task (getting and using equipment) is an unacceptable burden; further, they may feel that manual lifting can get the job done more easily than using a lift. To weaken these arguments, the Team needs to assure the frontline workers and unions the incidents of injury at the facility are high and preventable and that they will participate in equipment purchases, identifying ways to make the equipment accessible, and work with the Team to ensure that the job tasks can be done without adding more pressure on the frontline staff.

Section 6: Natural Stages of Group Development

YOUR ORGANIZATION'S CLIMATE FOR SRH TEAMS:
Force Field Analysis

FORCES FOR CHANGE	FORCES OF RESISTANCE
Safe Resident Handling Policy and Practice	

Using the flip chart, ask the participants to list a few more *Forces for Change* (other things that the Team will be recommending when implementing the SRH Program) and the *Forces of Resistance* that may arise. For each *Force of Resistance* they identify, ask them brainstorm of ways that those forces might be weakened.

Section 8:

Multiple Intelligences

- Theory of Multiple Intelligence
- Which Way are YOU Smart?

Review the topics for this section.

Section 8: Multiple Intelligences

DIFFERENT WAYS YOUR
TEAM MEMBERS ARE SMART

The Theory of
**MULTIPLE
INTELLIGENCES**

As defined by
Howard Garner

"How smart are you?" There's mounting scientific evidence that there's more than the two kinds of intelligence we recognize: mathematical ability and language ability. The psychologist, Howard Gardiner, theorizes that there are at least 8 kinds of intelligence. To be counted as a form of intelligence according to Gardiner, it has to meet 3 criteria:

- be located in a specific area of the brain
- be valued by at least one culture or society in the world
- have its own language and symbols

Section 8: Multiple Intelligences

DIFFERENT WAYS YOUR
TEAM MEMBERS ARE SMART

Word Smart
Picture Smart
Body Smart
People Smart
Music Smart
Number Smart
Nature Smart
Self Smart

why
cosh

According to “multiple intelligence theory,” each Team member may learn/relate to one another through all 8 of these intelligences, but most excel in 1-2. Often, when one team member isn’t learning or relating by reading a bunch of words or statistics on a paper, it’s not because they are uninterested. It’s because it’s not tapping into their unique form of intelligence. If a Team member is visually intelligent, the statistics or words in graphic form or summarized on a flip chart may capture their imagination. Body smart members of your team will likely learn/communicate through role play, performance and hands-on demonstrations. Some members may seem quiet/shy and yet when drawn out, they will have remarkable insights — these people are reflective, meditative, deep thinkers. Others may learn and communicate through music and rhythm and others through nature, environment, and biology. Your Team will be stronger when respecting/using the diversity of talent among members.

Section 8: Multiple Intelligences

DIFFERENT WAYS YOUR
TEAM MEMBERS ARE SMART



WHAT INTELLIGENCE DO YOU PREFER?

why
cosh

Activity [30 Minutes]: Distribute the “Learner Types and Multiple Intelligences” handout. Take 8 sheets of paper, each with the names and descriptions of the different types of intelligences (if you are feeling creative, put a sketch on each as well). Tape them up around the walls of the room. Explain to the Team that each sheet describes one of the 8 intelligences--ways of being smart. Ask each person to stand beside which is her/his preferred method of processing information, communicating, or learning. Ask each participant why she/he picked this one as her/his first choice. Next, to stand by their 2nd choice. Ask why each chose the one she/he did? Finally, to stand beside the intelligence which each most dislikes--the one each Team member would most hate to communicate or learn in.

Section 8: Multiple Intelligences

DIFFERENT WAYS YOUR
TEAM MEMBERS ARE SMART

APPRECIATING OUR
DIFFERENCES

why
cosh

Ask the participants what they’ve learned about themselves, about each other, and about the Team from this exercise. One take-away is that your Team is made up of a variety of personalities and learning styles. Some will be verbal and talkative and others quiet, but reflective. The challenge for your Team is to meld your different personal styles to achieve the task of implementing a successful SRH program.

MODULE THREE:
Making the Case for Safe Resident Handling/Ergonomic Programs

AGENDA

REVIEW AGENDA (Briefly)

REVIEW OBJECTIVES (Briefly)

Section 1: Nursing Home Industry Injuries (20 Minutes)

Activities: "Ranking Injury Rates by Industry & Facility Injuries,"
"Major Healthcare Injuries and Causes" & "Are You Overexerting Yourself?"

Section 2: OSHA Logs and Forms (60 Minutes)

Handouts: OSHA Form 301, OSHA 300 Log, OSHA Form 300A &
the NYS Workers' Compensation "C-3" Form

— 10 Minute Break —

Section 3: Using Staff Surveys to Address Injuries (10 Minutes)

Handout: "Safe Resident Handling 'Safe-T' Survey"

Section 4: SRH Program: Costs vs. Benefits (40 Minutes)

Activities: "Fact: Investing in SRH & Movement Is Money in the Bank"
Fact Sheet: "The Cost of an Injury Is Far Greater than the Cost of Equipment"
Case Study: "The Wyandot Nursing Home"
"Investment in Safe Resident Handling Saves Money and Reduces Injury"

— 10 Minute Break —

Section 5: Return to Work Programs (35 Minutes)

Activity: "Return to Work in a Resident Handling Environment"

EVALUATION (5 Minutes)

Module Three

Making the Case for Safe Resident Handling Ergonomics Programs

Summary: The purpose of this module is to give your Safe Resident Handling/Ergonomic Team an overview of the costs of manually handling residents and the benefits of a Safe Resident Handling program for your facility's "bottom line" and for the safety of your direct care workers and residents. A central theme is that the costs of investing in equipment and of training your direct care staff is more than offset by the savings you will realize from preventing injuries. Return on Investment in equipment, for example, is usually 2 - 4 years. A method of calculating your facility's injury rates relative to the Nursing Home Industry as a whole is provided; knowing this rate will also allow your Team to track the impact of your Safe Resident Handling program. Finally, this module looks at the benefits of Return to Work Programs, and how Safe Resident Handling programs can contribute to their success.

Making the Case: SRH Ergonomics Programs

AGENDA:

- Injuries in the Healthcare Industry
- OSHA Logs/MSDs
- Workers' Compensation/MSDs
- SRH Survey
- SRH Programs: Cost vs. Benefits
- Return-to-Work Programs

Review the agenda.

Making the Case: SRH Ergonomics Programs

OBJECTIVES:

Participants will be able to understand...

- How the OSHA 300 Log can be used to assess the incidence of resident handling-related injuries at this facility
- How the Workers' Compensation C-2s and Loss - Run reports can be used to analyze the cost of injuries at this facility

Review the objectives for this module
(Objectives are continued on the next slide)

Introduction to Safe Resident Handling

OBJECTIVES (Continued):

Participants be able to understand...

- How your team can use the OSHA 300 Logs, Workers' Comp C2s/Loss - Run reports, direct observations and staff interviews to determine where/why resident-handling injuries are occurring at your facility
- What resident-handling equipment can be targeted to your high-injury work area and the costs of doing nothing vs. the benefits of a SRH program
- The benefits of a SRH program on having an effective claims Return to Work program

wny
cosh

Review the objectives for this session.

Section 1

Nursing Home Industry Injuries

- Where does our industry rank?
- Injury rates in nursing homes
- Lost Work Days among our CNAs
- MSDs and CNAs
- Overexertion and injuries
- Job task/work environment hazards
- Broader issues increasing job hazards

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Review the topics for this session.

Section 1: Nursing Home Industry Injuries

WHERE DOES OUR INDUSTRY RANK?

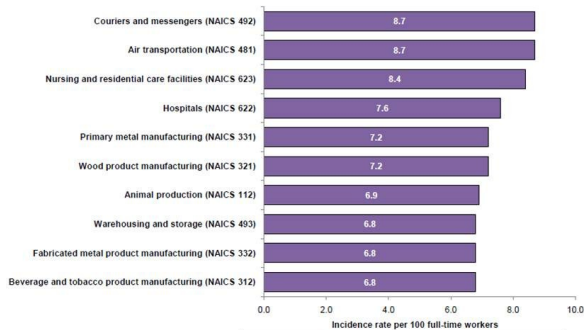
- Which industries rank at the Top 5 with respect to work-related injury rates?
- What injuries are most common?
- How do most employees get hurt?
- What's the number one injury at our facility?
- What's the cause?

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Activity [15 minutes]: Break the class into 2 or 3 groups of five. Give each a flip chart sheet and choose a reporter to make up a list when answering the questions on the slide. Ask them to report back in 10 minutes and to share their lists and discuss their responses to each of the questions.

Section 1: Nursing Home Industry Injuries

Highest non-fatal occupational injury and illness incidence rates among 3-digit NAICS industries, private industry, 2008



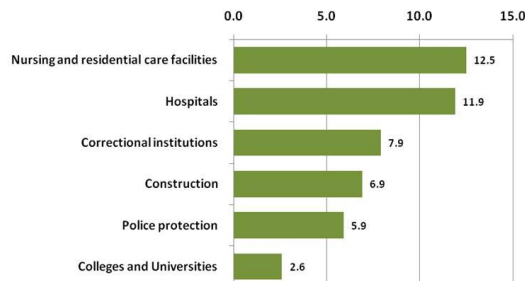
Among the ten 3-digit NAICS industries with the highest rates of nonfatal injuries and illnesses, three industries—couriers and messengers (NAICS 492), air transportation (NAICS 481), and nursing and residential care facilities (NAICS 623)—experienced rates that were more than twice the rate for all private industry (3.9 cases per 100 workers) in 2008.

Source: Bureau of Labor Statistics, US Department of Labor, October 2009

This graph shows the national U.S. Injury and Illness incidence rates among private industries as determined by the US Bureau of Labor Statistics in 2008. The Nursing Home Industry ranks third with 8.4 out of every 100 full-time workers becoming ill or getting injured. Among the top 5 industries, only two rank above us: Couriers and Messengers (8.7/100: we might speculate it's due to collisions with motorized vehicles) and Air Transportation (8.7/100: we might speculate that baggage handlers are the major victims). Two rank below us: Hospitals (7.6/100: we might speculate that this has a lot to do with the similarity between our jobs) and Primary Metal Manufacturing (7.2/100). Note that our industry along with Couriers/Messengers and Air Transportation has twice the rate of Illness & Injury of all private industry.

Section 1: Nursing Home Industry Injuries

Incidence rate of nonfatal occupational injuries and illnesses per 100 full time workers by industry, State governments, 2008

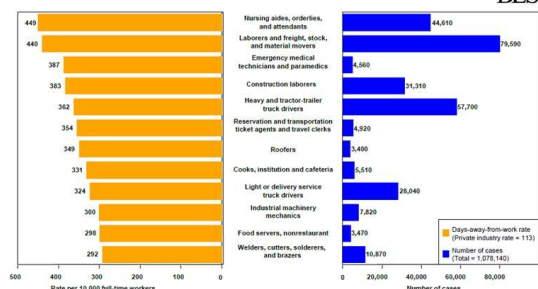


Source: Bureau of Labor Statistics, U.S. Department of Labor, October 2009

This graph shows that among nursing and residential care facilities in state governments, the rate of Illness and Injury is 12.5 out of every 100 full-time workers. That's more than one out of ten employees in these facilities. The rate is almost twice as high as the rates for correctional institutions, construction workers, and police.

Section 1: Nursing Home Industry Injuries

Incidence rate and number of injuries and illnesses for occupations with high incidence rates, 2008



These twelve occupations have at least 1/10 of one percent of employment and an incidence rate that was two and one-half times the average or greater. Nursing aides, orderlies, and attendants, and laborers and freight, stock and material movers both had the highest rates statistically. Emergency medical technicians and paramedics had a very high rate of injuries and illnesses, but a smaller number of cases.

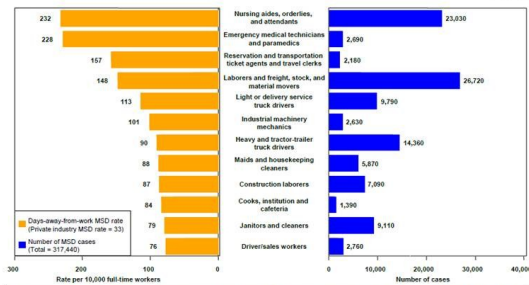
Source: Bureau of Labor Statistics, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses, cases involving days away from work.



This graph shows that among Nursing Aides, Orderlies, and Attendants, 44,610 had a recorded Injury or Illness in 2008. For every 10,000 of these workers, 449 had a Lost Work Day injury. That compares to 440 out of every 10,000 Laborers and Freight, Stock, and Material Movers. That makes our occupational group's rate the highest. Because many employees in Nursing and Residential Care are Nursing Aides (CNAs), Attendants and other aides, it should not be too surprising that when looking at occupations with the highest injury & illness rates, nursing aides, orderlies and attendants top the list. **Exercise [2 minutes]:** Ask the class what they think the major illnesses and injuries might be, and causes might be, based on their experience. Prompt them with: Are there chemicals, infectious diseases, or something else that leads to work-related injuries and illnesses. Are there procedures, protocols or equipment that prevent or reduce injuries and illnesses at their facility?

Section 1: Nursing Home Industry Injuries

Incidence rate and number of injuries and illnesses due to musculoskeletal disorders by selected occupations, 2008



These twelve occupations have at least 1/10 of one percent of employment and an incidence rate of musculoskeletal disorders (MSD) that was higher than 75 per 10,000 full-time workers. Nursing aides, orderlies, and attendants, and emergency medical technicians and paramedics had the highest rates of MSDs in 2008. Nursing aides also had the second highest number of MSD cases in this group, behind laborers and freight, stock, and material movers.

Source: Bureau of Labor Statistics, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses, cases involving days away from work.

Chart 23

Musculoskeletal disorders are the most common type of occupational injury in nearly every industry and occupation. And nursing aides, orderlies and attendants are no exception. They top the list with the highest incident rate for MSDs with 232 Lost Work Day injuries out of every 10,000 nursing aides, orderlies and attendants. Physical demands that drive these high rates are related to the amount of moving, lifting and positioning of residents and patients we do. Over one-half of the injuries in nursing aides, orderlies and attendants were MSDs (comparing this and the previous graph: 23,030 MSD injuries out of a total of 44,610 injuries/illnesses).

Section 1: Nursing Home Industry Injuries

THE HIGH COST OF NURSING HOME WORK-RELATED MSDS: UNDERREPORTING

“...the number of MSD injuries reported by healthcare workers is probably low because many injuries are underreported. In fact, it is estimated that as many as 50 percent may go unreported.”

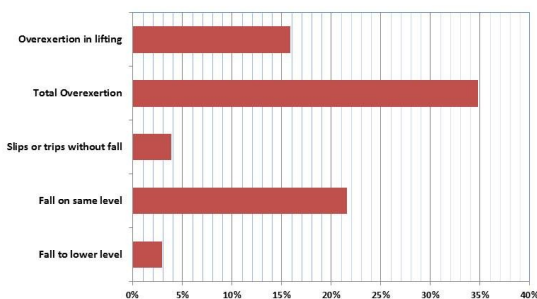
Source: Lynda Enos. *SPH. A Summary of the Issues and Solutions*. 2009. A. Nelson, et al., *Int. Journal of Nursing Studies*. 2005. B. Owen. *Int. Journal of Nursing Studies*. 2002. N. Menzel. *AAOHN Journal*. 2008.

Review the slide and move to the next slide.

Section 1: Nursing Home Industry Injuries

OVEREXERTION

Nursing and Residential Care Facilities



More than one in three worker injuries in nursing homes and residential care facilities is due to overexertion--fully 35%. Falls account for another one-quarter of the injuries.

Although the circumstances around these injuries aren't specified, overexertion and falls are not uncommon when involved with resident handling.

Musculoskeletal Disorders, particularly of the lower back, are common overexertion injuries among nursing home direct care workers. The physical effort of repetitively lifting, pulling, pushing turning, wielding carry or "tossing" residents day in, day out, year after year takes its toll, often leading to chronic debilitating career-ending injuries.

Section 1: Nursing Home Industry Injuries

WHY IS MANUAL RESIDENT HANDLING HAZARDOUS?

The work exceeds the physical capacity of the worker:

- 130+lbs vs. 35lbs
- Residents movement and transfer involves awkward positioning
- Residents represent an unstable load that may shift
- Residents are difficult to handle and don't come with handles which increase the force needed to move them
- Daily repetitive resident handling, lifting and transfers



wny
cosh

Remind the participants that the National Institute for Occupational Safety and Health has determined that the maximum weight that can be safely lifted when it comes to residents is 35 pounds. The average adult weight is 3.5 times that safe weight. Unless a resident can lift most of their weight themselves and you are basically steadying them or giving them a slight “boost” you are exceeding the safe lifting weight.

If you are doing resident handling tasks, manually, throughout the day you are overexerting your body and are a candidate for an overexertion injury — usually a MSD

Section 1: Nursing Home Industry Injuries

APPROXIMATELY HOW MUCH WEIGHT IS HANDLED DURING A DAY SHIFT?

Daily Resident Handling, Lifting, & Transfers

EXAMPLE

- 5 resident case load (dependent)
- 2 transfers – out of bed, into bed
- 2 transfers for toileting
- 3 transfer for dining

5 residents x 7 transfers = 35 transfer events in an 8 hour shift
(which suggests one each 14 minutes)

Add 3 re-positionings for each resident each day
5 residents x 3 reposition = 15

That makes approximately 50 handlings during a shift

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Review the slide and move to the next slide.

Section 1: Nursing Home Industry Injuries

APPROXIMATELY HOW MUCH WEIGHT IS HANDLED DURING A DAY SHIFT?

On average a resident ‘handling’ means providing 40 pounds of assistance.

(Not unlike moving or repositioning the equivalent of a bag of topsoil or of mulch)

THEREFORE:

50 handlings x 40 pounds =
2000 pounds or 

Source: Fragala 2003

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Activity [5 minutes]: This example was a typical direct care giver lifting, transferring and repositioning scenario developed by a health care ergonomist. His conclusion was that a typical CNA is lifting and moving a minimum of a ton per 8 hr. day shift. Ask the participants if this example pretty much describes the typical experience of a CNA at this facility. Ask them to describe some of their typical lifting, transferring and repositioning tasks. Do they feel like they’re lifting, pulling, pushing, turning, transferring more than 35 lbs. each time? If they need prompting, ask about tasks like:

Transferring from bed to chair? Transferring to commode with hug lift? Transferring with under-axilla lift? Getting a resident up to her/his feet? Getting a resident up to a walker? Getting a resident up to a scale? All involving moving or lifting 35 pounds or more?

Section 1: Nursing Home Industry Injuries

EQUIPMENT AND FACILITY DESIGN THAT PUTS
EMPLOYEES & RESIDENTS IN AWKWARD POSITIONS

- Beds not conducive to reposition patient or transfer to/from bed.
- Resident rooms that are cluttered or do not allow appropriate access to beds, chairs, etc.
- Bathing and toileting facilities that promote sustained and/or awkward employee positioning.



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In addition to manual job tasks, the work environment such as poorly designed equipment and room layout can contribute to physical stress on direct caregivers.

Section 1: Nursing Home Industry Injuries

A GROWING CRISIS?

Additional concerns for the health
of workers and of the industry...

- Aging workforce
- Nursing shortage
- Obese patients/residents

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Briefly review slide.

Section 1: Nursing Home Industry Injuries

AGING WORKFORCE

- An aging workforce in nursing is creating significant problems for the healthcare industry.
- With an average age of nurses of 46.8 years, an older workforce brings knowledge and experience to the job, but:
 - Can fatigue easily
 - Have more chronic health issues
 - May be less physically fit

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There is an increasing trend toward an aging workforce in health care. With nurses leaving the profession and the difficulty in recruiting new nurses, it's likely that there will be fewer workers doing more work and working longer hours.

Section 1: Nursing Home Industry Injuries

NURSING SHORTAGE

- 100,000 vacant nursing positions in the US & expected to reach 340,000 by 2020
- Increased overtime and mandatory overtime
- Higher workloads for individual workers
- Increased stress on workers
- Potential for more errors

From: Thomas R. Waters, Ph.D., N.I.O.S.H.

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Short staffing continues to be a problem in the health care industry. As more leave the profession and fewer join the profession, the problem will only get worse.

Short staffing leads to more mandatory overtime, increased stress, and the potential for errors.

Clearly one reason health care workers are leaving the profession and not joining is due to the physical demands being made on caregivers and the resulting chronic injuries that are being experienced.

Section 1: Nursing Home Industry Injuries

THE OBESITY EPIDEMIC

Will an obesity epidemic create yet more MSDs among our direct care workers?

- More than 30% for the population is considered to be obese
- More than 66% of the population is overweight
- In the last 5 years, 50% increase of those 100 lbs. overweight, 75% increase in those more than 100lbs overweight
- It is common for healthcare providers to see patients weighting more than 400lbs
- Bariatric care is of increasing importance

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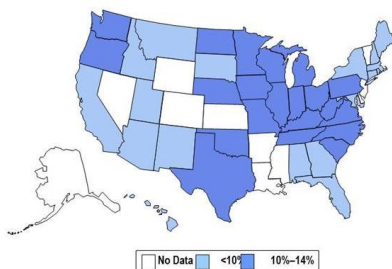
There is a clear trend in the U.S. toward heavier patients and residents. Clearly, this will increase the weight that direct care workers will have to manually lift, transfer and reposition. Because we are living longer and performing interventions such as joint replacements, it's likely that more and more of these individuals will be residents in our nursing homes. Fortunately, lifting equipment industry is designing equipment and slings that make the movement of bariatric residents manageable, reducing the likelihood of injuries to direct care workers.

Go to the next 3 slides to show the growing trend in obesity in the U.S.

Section 1: Nursing Home Industry Injuries

THE OBESITY EPIDEMIC

Obesity Trends Among U.S. Adults 1989
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



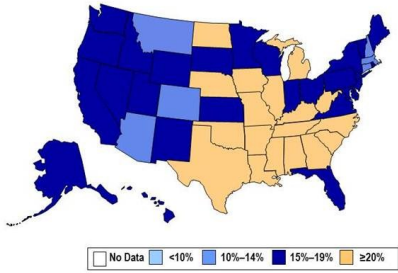
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Describe slide. Go to next slide.

Section 1: Nursing Home Industry Injuries

THE OBESITY EPIDEMIC

Obesity Trends Among U.S. Adults 1999
(*BMI ≥ 30 , or ~ 30 lbs. overweight for 5' 4" person)



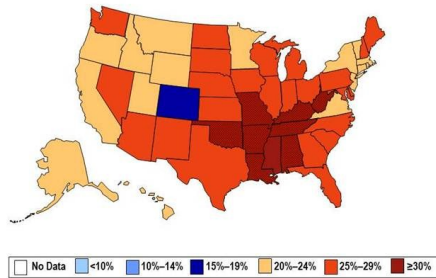
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Describe slide. Go to next slide.

Section 1: Nursing Home Industry Injuries

THE OBESITY EPIDEMIC

Obesity Trends Among U.S. Adults 2009
(*BMI ≥ 30 , or ~ 30 lbs. overweight for 5' 4" person)



why
cosh

Describe slide. Go to next slide.

Section 1: Nursing Home Industry Injuries

THE HIGH COST OF HEALTH CARE WORK-RELATED MSDS: THE HUMAN TOLL

Work-related MSDs in health care can cause situations for direct caregivers that are:

Life altering
Career ending
Disabling

Chronic (persistent/permanent pain)

Back injury MSDs due to manual handling are the #1 injury reported in health care.

why
cosh

Lynda Enos. SPH: A Summary of the Issue and Solutions. 2009

Review slide. Emphasize that back injury MSDs due to manual handling are the # 1 injury reported in health care.

Section 1: Nursing Home Industry Injuries**THE HIGH COST OF HEALTH CARE WORK-RELATED MSDS:
THE HUMAN TOLL**

- 31% of nurses reported experiencing back pain while working as a nurse
- 52% complain of chronic (persistent/permanent) back pain
- 12% of nurses "leaving for good" cite lower back pain as the main reason
- Another 12% considered leaving the profession
- 38% suffered work-related back pain severe enough to require leave from work

Source: D. Stubbs, et al. *International Journal of Nursing Studies*. 1986.
American Nurses Association "Fact Sheet." 2005

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cosh

Review slide and move forward.

Section 1: Nursing Home Industry Injuries**WORKERS' COMPENSATION COSTS**

The direct cost of an average back injury case is \$19,000.

Serious cases involving surgery average \$85,000 in direct costs.

Indirect costs to health care facilities average between four and ten times the direct costs.

Fact Sheet #5: Investing in Safe Patient Handling and Movement is Money in the Bank; NYS Zero Lift Task Force Website, Last visited March 31, 2011.

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Review slide and move forward

Section 2**Using the OSHA 300 Log and Forms**

- OSHA 300 Log – recording incidents
- OSHA Form 300A – annual total incident summary
- Work-related injuries and exceptions
- Injury reporting process
- Calculating facility injury rates
- Comparing your facility rate to other facilities/national average rates
- Calculating Lost Work Day costs from work-related illness/injuries
- Workers' Compensation "Loss Run"

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Review the topics covered in this section.

The set of OSHA 300 forms and worksheets are made available to facilitate recording of work-related injuries in an organized manner that can lead to examination of the issues relating to injuries.

OSHA 300 LOG

The log is a place to summarize the who, what and where of work-related injuries. The log is a good place to look for patterns in the injury experience of a workplace.

OSHA'S FORM 300A

The 300A summary of injuries and illnesses is the reporting tool used to report summarized injury and illness data to state and federal labor agencies. They transform the individual summaries into the broad descriptions of injury and illness experience for different industries and occupations that we reviewed earlier showing high rates in nursing facilities particularly among nurses and nursing aides.

Section 2: Using the OSHA 300 Log and Forms

THE OSHA LOG OF WORK-RELATED INJURIES & ILLNESSES

- A summary is mandated by OSHA to be posted annually for employees to see
- It is NOT meant to indicate blame
- It is NOT an indication of a violation
- It is meant as a tool to:
 - Help eliminate hazards,
 - Create a safe work environment, and
 - Keep employees healthy

why
cosh

The OSHA Form 301 is an individual incident form. The OSHA 300 Log of Work-Related Injuries and Illnesses is used to classify your work-related injuries and the extent of severity of those injuries for the year. The OSHA Form 300A is a yearly summary of the injuries and is mandated to be posted for employees to see. This is not to place blame or to mean a violation has been committed. But, it is to be used as a tool for change--for finding patterns of injuries and illnesses and for getting at "root causes."

Section 2: Using the OSHA 300 Log and Forms

WORK RELATED INJURIES THAT NEED TO BE RECORDED:

- Death
- Loss of consciousness
- Days away from work
- Restricted work activity, or job transfer
- Medical treatment beyond first aid

Additional Criteria:

- Needle sticks
- Any case that requires the employee to be medically removed
- Tuberculosis infection
- Employees hearing test that has shown a Standard Threshold Shift (STS)

why
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Work-related injuries are simply injuries that are serious enough to require treatment and were the result of, or were contributed to, by work-related activities.

Section 2: Using the OSHA 300 Log and Forms

WORK RELATED INJURIES THAT NEED TO BE RECORDED:

Work-related injuries and illnesses that are significant must be recorded.

- Any significant work-related injury or illness that is diagnosed by a physician or other licensed health care professional.
- Any work-related case involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum.

See 29 CFR 1904.7.

why
cosh

Briefly review slide.

Section 2: Using the OSHA 300 Log and Forms

WORK-RELATEDNESS

Cases are work-related if:

- An event or exposure in the work environment either caused or contributed to the resulting condition
- An event or exposure in the work environment *significantly* aggravated a pre-existing injury or illness

CFR. 1904.5

why
cosh

Briefly review slide

Section 2: Using the OSHA 300 Log and Forms

WORK-RELATEDNESS

- Work-relatedness is presumed for injuries and illness resulting from events or exposures occurring in the work environment.
- A case is presumed work-related if, and only if, an event or exposure in the work environment is a discernible cause of the injury or illness or of a significant aggravation to a pre-existing condition. The work event or exposure need only be one of the discernible causes; it need not be the sole or predominant cause.

CFR. 1904.5

why
cosh

With many chronic conditions (for example, backaches) it can be difficult to single out one event as the precipitating event or cause. Rather, a series of events or activities (usually involving overexertion) over time leads to a condition that requires attention (for example, severe back or shoulder pain).

Section 2: Using the OSHA 300 Log and Forms

WORK-RELATED EXCEPTIONS

Adds additional exceptions to the definition of work relationship to limit recording of cases involving:

- Eating, drinking, or preparing food or drink for personal consumption
- Common colds and flu
- Voluntary participation in wellness or fitness programs
- Personal grooming or self-medication

1904.5(b)(2)

why
cosh

Some things that occur to workers while at work may not be due to work-related activities of daily living. Should an injury occur, they would not be OSHA-recordable.

Section 2: Using the OSHA 300 Log and Forms

OSHA FORM 301 INCIDENT REPORT (OR COMPARABLE W.C. STATE FORM)

- One of the first pieces of paperwork completed when an employee is injured and is brought to the attention of a facility's management.
- Provides a place to record basic information about who, when, and where the injury occurred.
- Also records details of the injury and treatments provided.
- May provide place to record details of salary pertinent to compensation for the injured employee.

The process of filling out an incident report form may seem too "formal" for a particular incident, but it can help ensure that details are captured about the incident close in time to when it actually occurred.

why
cosh

Section 2: Using the OSHA 300 Log and Forms

OSHA'S FORM 301

OSHA's Form 301 Injury and Illness Incident Report

Attention: This form contains information relating to employees' health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

U.S. Department of Labor
Occupational Safety and Health Administration

This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the Log of Work-Related Injuries and Illnesses and the accompanying Summary, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form as an employer, supervisor, or other person who has knowledge of the incident. To be considered an employer's report, the information must be based on the information about the incident.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 3 years following the year in which it occurs.

If you need additional copies of this form, you may photocopy and use as many as you need.

Information about the employee

1. Full name _____

2. Street _____

City _____ State _____ ZIP _____

3. How employed _____

☐ Full-time ☐ Part-time

Information about the physician or other health care professional

4. Name of physician or other health care professional _____

5. If employee was given any time from the workplace, when was it given? _____

City _____ State _____ ZIP _____

6. Has employee received an emergency room visit? ☐ Yes ☐ No

7. Has employee been hospitalized overnight or in a hospital? ☐ Yes ☐ No

Information about the case

8. Case number from the Log _____ (Transfer to case number from the Log after you complete case)

9. Date of injury or illness _____ AM/PM

10. How employee began work _____ AM/PM ☐ Check if case cannot be determined

11. Time of return _____ AM/PM ☐ Check if case cannot be determined

12. What was the employee doing just before the incident occurred? Describe the activity, as well as the task, equipment, or material the employee was using. Be specific. Examples: "Cleaning inside while working inside material," "Spraying chemical from back sprayer," "Nails caught in machinery."

13. What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 10 feet," "Worker was struck by forklift when getting inside during replacement," "Worker developed convulsions on wet floor area."

14. What was the injury or illness? Tell us the part of the body that was affected and how it was affected. Be as specific as you can. Examples: "Strained back," "Strained knee, hand," "Finger caught in machinery."

15. What object or substance directly harmed the employee? Examples: "Concrete floor," "Machine," "Nail," "Wire," "Forklift." (This question does not apply to the incident, leave it blank.)

16. Has employee been hospitalized overnight or in a hospital? ☐ Yes ☐ No

17. If the employee died, when did death occur? Date of death _____

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An incident report may be initiated by an employee's supervisor, by a Human Resource's representative, or by the Director of Nursing. The size and structure of a facility can influence how the process is initiated, but good practice is to have a policy and procedure that everyone is familiar with.

Section 2: Using the OSHA 300 Log and Forms

INJURY REPORTING PROCESS

- Each facility may differ in who is responsible for reporting
- Procedures used for getting the reporting of work-related injuries started differ as well
- Human Resources department (or person) often given the responsibility
- It's informative for the Ergo committee to become familiar with the process
- Provides the committee with knowledge of where to access information to evaluate their injury history and costs

Review slide. Emphasize that the SRH/Ergonomic Team should become familiar with how work-related injuries, especially MSDs, are reported and recorded. The OSHA 301 Incident Form and other records are invaluable tools for the Team to evaluate their injury history and costs.

why
cosh

Section 2: Using the OSHA 300 Log and Forms

INJURY REPORTING PROCESS, Continued

- An incident report is required within 7 days after receipt of information that a work-related injury or illness has occurred.
- Forms are available from OSHA, a state's worker's compensation department or made individually by a facility.

Review slide.

WNY
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Section 2: Using the OSHA 300 Log and Forms

EXAMPLE OF PART OF A NYS WORKER'S COMPENSATION C-3 EMPLOYEE CLAIM FORM

Employee Claim **C-3**
State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ 2. Date of Birth: _____

3. Mailing address: _____

4. Social Security Number: _____ 5. Phone Number: _____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: _____

3. Your work address: _____

4. Date you were hired: _____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

WNY
cosh

Some states have forms that are similar to the incident report as part of their workers' compensation system. Some private insurers may have their version as well. The important point is to collect information about the employee and incident that includes at least as much information as is asked for on the OSHA 301 incident form.

Section 2: Using the OSHA 300 Log and Forms

EXAMPLE OF PART OF A NYS WORKER'S COMPENSATION C-3 EMPLOYEE CLAIM FORM

INSTRUCTIONS TO CARRIER

Please fill out the form completely and accurately. If the answer to any question is not applicable, indicate n/a. The Board will not accept or consider any C-7 form submitted without a complete certification, at Section D.

Section C. Factual Basis for Controverted Claim:

In order to controvert an issue, you must, at minimum, be able to factually support the following contentions. To controvert a particular issue, check the box, and specify the factual basis in the text area. The mere checking of the box, without providing the factual basis, is not sufficient to controvert an issue. The examples are provided below by way of illustration, and are not exhaustive.

- **Prima Facie Medical Evidence** – That the medical report submitted on behalf of the claimant fails to reference an injury.
- **Accident within meaning of Workers' Compensation Law** – That the alleged accident is barred, excluded, or not covered within the law. For example, that the accident is, barred by §17, an exacerbation of prior injury (no new accident); barred by §10(1), such as intoxication or off-duty athletic activity; or intentionally causing harm to self or others.
- **Accident Arising Out Of and In the Course of Employment** – That the alleged accident did not occur while in the course of employment, such that it cannot be presumed that the accident arose out of the course of employment; OR that while the accident occurred in the course of employment, there is substantial evidence to rebut the presumption that the accident arose out of the course of employment. For example, that the claimant was injured while outside scope of employment, such as in an off-premises injury which occurred when claimant was not in portal to portal status.
- **Occupational Disease within meaning of Workers' Compensation Law** – That the alleged occupational disease is barred, excluded, or not covered within the law. For example, that the disease is not a recognized condition; that there was no distinctive feature of employment.
- **Occupational Disease Arising Out of and In the Course of Employment** – That the disease arose outside of employment. For example, the condition was caused by exposure or activity outside that which was experienced in the workplace.
- **Notice (Section 18)** – That the employer received no notice; that there was improper notice (e.g. to co-workers not supervisor); or that the notice was not timely (beyond 30 days).
- **Notice (Section 45)** – That the employer received no notice, that notice was given to an improper employer entity, or that notice was untimely (more than 2 years from the date of the last date claimant knew-or-should-have-known of the occupational disease).
- **Employee-Employer Relationship** – That there was no employer-employee relationship as defined by statute or case law. For example, that claimant was an independent contractor; that there was no covered employment, such as casual employment, certain domestic employment, or certain other activities as defined in WCL Sec. 3 Group 12 through 24; General Municipal Law Sec. 207-a or c; that claimant does not fit the definition of employee under WCL Sec. 2(4); that claimant was an excluded employee such as a partner or certain corporate officers, or that the Board should be aware that there was more than one employer (dual employment which caused injury), or special-general employment. Note – a claim should not be controverted merely because claimant was concurrently employed at the time of injury as set forth in WCL Sec. 14(8), for determination of wages.
- **Causally Related Accident or Occupational Disease** – That the medical and/or other evidence does not support the assertion that there is a causal link between

WNY
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Depending on the circumstances of an incident, a worker's compensation claim may be controverted or challenged. This can be due to lack of timely notice regarding the incident/injury, or it could be due to insufficient description of the events that led to the injury. In general, a clear and detailed description will reduce chances of disagreement about the details of a claim.

Section 2: Using the OSHA 300 Log and Forms

PROBLEMS WITH CLAIMS CAN INVOLVE:

- The medical report submitted on behalf of the claimant fails to reference an injury
- That the alleged accident is barred, excluded, or not covered

For example, the accident is:

- An exacerbation of prior injury (no new accident);
- Intoxication or off-duty athletic activity, or intentionally causing harm to self or others.
- That the employer received no notice; that there was improper notice (e.g. To co-workers not supervisor); or that the notice was not timely (beyond 30 days).

Review slide.

Section 2: Using the OSHA 300 Log and Forms

- 14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
- The employee was transferring a resident that needed assistance from her bed to a chair. The employee assisted the resident by steadying her with her arm around her back and holding her arm with her other hand. During the transfer the resident's legs buckled and she began to sink to the floor. The employee maintained contact with the resident slowing her fall to the floor. As the resident was lowered to the ground, the employee's right knee and back were twisted in an awkward manner.
- 15) **What happened?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- As the employee lowered the resident to the ground, her foot was under the falling resident and the weight of the resident (225lbs.) collapsed onto the employee's right leg. The right leg twisted while supporting the resident and pain was felt in her knee. She also experienced pain in her lower (left) back as she lowered the resident to the ground.
- 16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- The employee experienced immediate pain in her right knee and lower back (left side). Later in the day, the right knee showed signs of swelling and the employee was unable to complete her shift due to painful cramping in her back.

This slide illustrates the type of detail that should be included on a claim form. The description of what the employee was doing indicates what she was doing and how she was doing it. If she had been using a gait belt, that should have been included. Describing 'what happened' should include details of how each body part was involved and injured. The injury or illness should be described in enough detail to know the body part and the nature of the injury (the description indicates a likely sprain or tear).

Section 2: Using the OSHA 300 Log and Forms

OSHA 300 LOG

OSHA's Form 300 (Rev. 10/2006)
Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees. Do not release this information to the public or to other employees.

Year 2012

Identify the person		Describe the case		Classify the case		Enter the number of days lost or restricted work		Enter the number of days lost or restricted work	
Case No.	Employee's name	Date of injury or onset of illness	When the event occurred (e.g., falling from roof)	Describe injury or illness, part of body affected, and object/condition that directly caused or contributed to the injury or illness (e.g., wet floor, no fall protection)	Severity of injury or illness	Days lost or restricted work	Days lost or restricted work	Days lost or restricted work	Days lost or restricted work
1	Alicia Jones	CNA	1/10	Res Room	4a Neck injury	2	2	2	2
2	Jonathan Fry	LPN	1/26	Res Room	Spinal Cord Injury	42	42	42	42
3	Linda Taylor	CNA	2/20	Res Room	Strain Back	2	2	2	2
4	Frank Thomas	LPN	3/16	Hallway	(B) Shoulder - 1st	2	2	2	2
5	Priscilla Cox	RN	3/26	Res Room	Neck/neck	2	2	2	2
6	Dana Sorensen	LPN	4/3	Res Room	Twisted (B) Foot	2	2	2	2
7	Betty Smith	CNA	4/23	Res Room	Back/hip	2	2	2	2
8	John Gray	CNA	5/23	Res Room	4b Back	2	2	2	2
9	Jan Trench	CNA	6/22	Res Room	Shoulder/hip	2	2	2	2
10	Mary Kline	CNA	7/14	Res Room	Lower back/leg/hip	2	2	2	2
11	Michael Bond	LPN	7/24	Res Room	Back/hip	2	2	2	2
12	Priscilla Cox	LPN	3/23	Res Room	Neck/neck	2	2	2	2
13	Bob Peterson	CNA	11/27	Hallway	(B) Knee	2	2	2	2

OSHA's Form 300 (Rev. 10/2006)

When transferring information to the log, try to provide as much information as possible. For #1 (in blue), the type of Aide could be important. #2 and #3 are examples of illegibility or poor descriptions. Numbers 4a and 4b provide little information on the nature of the injury.

Section 2: Using the OSHA 300 Log and Forms

SUMMARIZING YOUR FACILITY'S INJURIES OVER TIME

- Collect OSHA form 300A summaries from the previous three to five years
- Provides a quick indicator of the size and scope of the injury situation at your facility
- You can determine if your rates are increasing or decreasing by dividing the number of injuries by the average number of full time workers (then multiply by 100 to get the rate per 100 FT workers).

wny
cosh

Review slide.

Section 2: Using the OSHA 300 Log and Forms

CALCULATING YOUR RATE

$$\begin{array}{ccccccc} 13 & \div & 140 & \times & 100 & = & 9.3 \\ \text{\# of injuries/year} & & \text{\# of full time} & & \text{\# to make it} & & \text{\# injury rate per} \\ \text{from col. M of 300 log} & & \text{workers/year} & & \text{comparable} & & \text{100 full time} \\ & & & & \text{to 100 full time} & & \text{workers/year} \\ & & & & \text{workers/year} & & \end{array}$$

Note: Due to the issue of part time workers, the estimates of Full Time Workers at a facility will differ from the number of people working at the facility. Using hours will result in a more precise figure, but the above number will serve as a rough number for illustration purposes.

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Review the slide. Note that by using the OSHA Log, the Team can calculate the injury incident rate at their facility. Calculating the injury rate will allow your Team to compare your rate to other facilities to determine if your rates are high, low or average.

Section 2: Using the OSHA 300 Log and Forms

CALCULATING INJURY RATES

OSHA FORM 300 A: SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

- A place to find info quickly
- Summarizes from the previous 3 – 5 years, providing a quick indicator of the size and scope of your injury situation
- Indicates if rates are increasing or decreasing
- Includes number of days lost, costs of injuries, rough estimate of overall costs of injuries

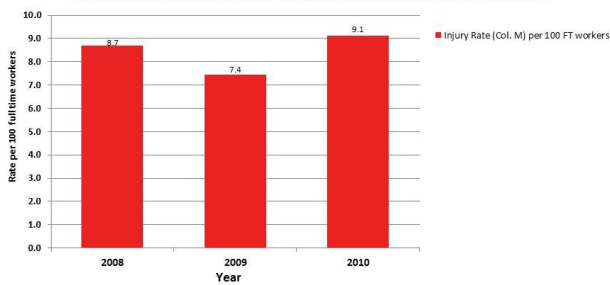
wny
cosh

Since injuries are often handled in a way that puts a facility's injury costs in departments or cost centers that aren't related to where the injury occurred, the financial impact of an injury is not realized or appreciated by supervisors or employees on the units where the injuries occurred.

Inclusion of whoever manages the Workers' Compensation process at your facility--often from Human Resources--on your SRH/Ergonomic Team can provide insight into how injuries develop. The person could also help your Team develop strategies that are helpful in reducing eliminating the injuries to begin with.

Section 2: Using the OSHA 300 Log and Forms

OSHA Log injuries and illnesses for ABC facility and comparison NAICS codes in the U.S. & New York State
Comparison groups: Nursing and Residential Care Facilities & Management of Companies & Enterprises.

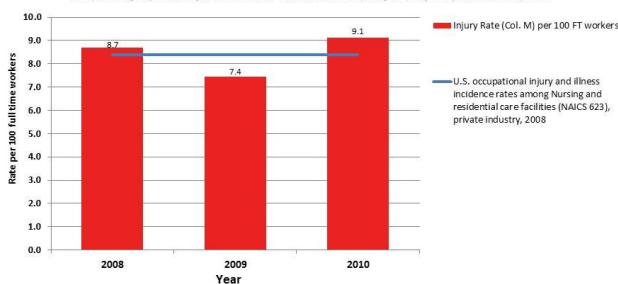


Converting to rates allows your facility to compare its injury rates to those of other facilities and to published rates. The injury rate is helpful for monitoring the success of your SRH program over time. It compares your facility's experience with state and national rates and can be used to lower Workers' Compensation insurance rates.

This slide shows the injury rates at a fictitious "ABC Facility." Move to the next slide to view comparison to the published national rate.

Section 2: Using the OSHA 300 Log and Forms

OSHA Log injuries and illnesses for ABC facility and comparison NAICS codes in the U.S. & New York State
Comparison groups: Nursing and Residential Care Facilities & Management of Companies & Enterprises.

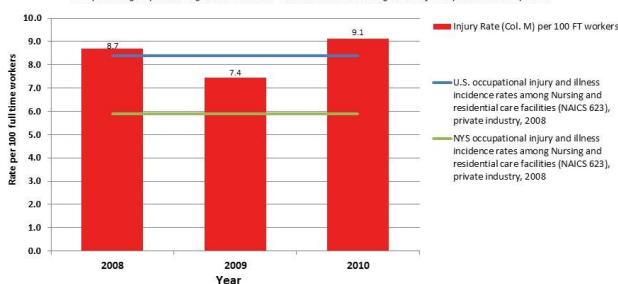


This slide shows how you can compare your facility's injury rate to the national average for Nursing and Residential Care Facilities. The blue line shows the national average (8.4 injuries/illnesses per 100 full-time workers).

In 2008, "ABC Rehab" had a slightly higher rate than the national rate for Nursing and Residential Care Facilities. The published data is only through 2008 (as of 2012), but if carried through the next two years, we find that ABC Rehab facility has a lower rate in 2009 and a higher rate than the national rate in 2010. So, compared with other nursing and residential care facilities in the U.S., its injury and illness rate is similar to or higher than the grouped rate.

Section 2: Using the OSHA 300 Log and Forms

OSHA Log injuries and illnesses for ABC facility and comparison NAICS codes in the U.S. & New York State
Comparison groups: Nursing and Residential Care Facilities & Management of Companies & Enterprises.



The larger the numbers are, the more issues that will be contributing to the overall injury problem. And while the number of injuries can be informative, it does not address the seriousness of the injuries, which usually result in longer numbers of days away from work, and therefore higher costs.

It is also not uncommon for the number of injuries to increase, particularly in the year following the beginning of an SPH program. These can happen due to more awareness of what work-related injuries are and an atmosphere that better supports recognizing and remedying injuries.

Section 2: Using the OSHA 300 Log and Forms

Nursing and Residential Care Facility Injury & Illness Rates are high compared to many other industries in the U.S.

Injury & Illness Rates may be different for your state.

IF THEY ARE LOWER FOR YOUR STATE, IS YOUR FACILITY LAGGING IN BEING ABLE TO REDUCE INJURIES?

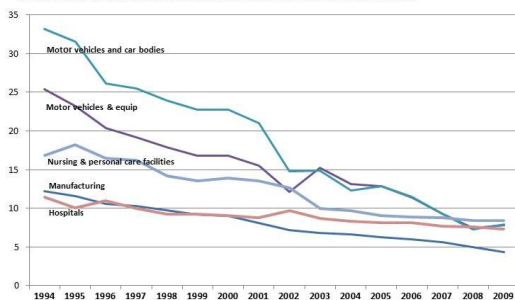
IS IT POSSIBLE THAT SRH PROGRAMS ARE RESPONSIBLE FOR LOWERING RATES IN YOUR STATE?

Review slide.

why
cosh

Section 2: Using the OSHA 300 Log and Forms

Injury & Illness incidence rates for selected industry groups, U.S. 1994-2009.
Bureau of Labor Statistics: Incidence rates represent the number of injuries and illnesses per 100 full-time workers



why
cosh

Knowing that injury incidence rates are high and that they should be lower seems like common sense. But, how low should lower be?

Looking at incidence rates over time, we can see that the industries listed have been lowering their rates. But the rates for some industries have dropped further and lower than what we find at healthcare facilities. Many industries have instituted have adopted programs that reduce lifting and product movement or repetitive motions in their facilities (such as lifting devices, powered tools, etc.). Can the healthcare industry achieve similar success through the use of equipment and devices?

Section 2: Using the OSHA 300 Log and Forms

OSHA's Form 300A and cover:
Summary of Work-Related Injuries and Illnesses

why
cosh

You can use OSHA Form 300A to determine the costs of Lost Work Day injuries at your facility.

Using Summary Form 300A, refer to the item K in the Number of Days section labeled "Total number of days away from work." Personnel costs often make up a sizable proportion of the cost to run a facility. With help from Human Resources you may be able to obtain an average salary for your facility (or they might have actual "lost salary" figures for those that were injured. If not, use an estimated amount (for example, \$80 - \$100 per day). For this example there were 377 lost work days. Multiply that by \$80 to get \$30,160 for 2010. Look at the previous 2 years as well to see how the dollars lost to injury add up over the years. Could that money be better put towards safe resident handling equipment and supplies?

Section 2: Using the OSHA 300 Log and Forms

DETERMINE A REASONABLE ESTIMATE OF AVERAGE SALARY FOR THE WORKFORCE AT THE FACILITY

Human Resources:

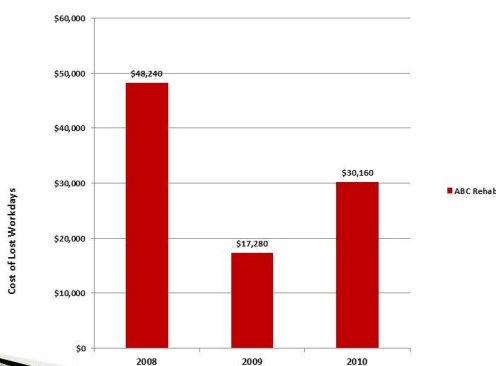
- Use an average salary
- If unsure, be conservative so that subsequent estimates aren't considered to be inflated.
- (\$10 per hour, \$80 per day, \$20,000 per year*).

* From www.payscale.com, for Certified Nurse Assistant (CNA), U.S. average salary \$10.13

This slide shows how to calculate average workplace salaries at your facility which you can then multiply by the number of Lost Work Days to get an estimate of the costs of injuries.

Section 2: Using the OSHA 300 Log and Forms

'Cost' of Lost Work Days from Work Related Illness & Injuries



Over the last 3 years, this facility would have “lost” \$95,680 in wages. This doesn’t account for all direct medical cost or insurance premiums. The result provides a quick estimate of the amount of money that’s lost due to on-the-job injury or illness. It’s unrealistic to expect that this cost can be entirely eliminated, but in the majority of cases, the losses are preventable. While not all LWDs are due to resident handling, the common experience at facilities without SRH programs is that a large proportion of LWDs can be attributed to MSDs associated with manual resident handling. Referring to another category on the 300A form, “total number of days of job transfer or restriction,” it can be helpful, as above, to plot annual totals for several years. While most facilities have few, if any, days attributed to job transfer or restriction entered into this category, the low number may be indicative of not effectively dealing with the injuries and LWDs they produce. The main reason most facilities have no restricted work for injured employees to perform during recovery is that injured workers are “off due to injury” and their time is lost—they’re often replaced with replacement workers or by co-workers performing overtime.

Section 2: Using the OSHA 300 Log and Forms

WHAT DOES WORKERS’ COMPENSATION INSURANCE COVER?

Direct Costs Only

Medical costs include:

- Medical treatment of injuries
- Drug costs

Indemnity costs include:

- Time loss costs
- Temporary & permanent disability payments
- Fatality costs/awards
- Vocational assistance costs
- Settlement costs
- Claim expense costs

Source: OR OSHA

Workers’ Compensation benefits include medical treatment for work-related conditions and cash payments that partially replace lost wages. Temporary total disability benefits are paid while a worker recuperates away from the job. If the condition has lasting consequences after the worker heals, permanent disability benefits may be paid. In the case of a fatality, the worker’s dependents receive survivor benefits.

Workers’ Compensation programs are designed and administered by the states.

A loss run is a way to look at your facility's experience over time. If you are self-insured, this would be a cost accounting of the cost of workers' compensation for injuries and illnesses for each year. Because medical expenses and time lost to injury (sick/disability time) are different kinds of expenses, they sometimes are not lumped together to get the full picture of cost at facility. If your facility uses a private insurance carrier, then that company will likely look at your injury/illness experience over time. They may look at the severity as well as the number of injuries to determine the insurance premium rate they will charge you to cover the costs associated with your claim experience. Coverage differs by insurance carrier/state but usually provision is made to be able to adequately cover injured employees over the full time of their injury or disability. Higher injury rates result in higher premiums to cover the expected number of injuries based on past experience. Lowering injury rates can save substantially on Workers' Comp insurance rates (whether you pay an insurance carrier or are self-insured).

Read the topics covered in this section.

Distribute the Safe Resident Handling “Safe-T Survey” handout.

Another tool to evaluate injuries that can help to identify “underground” or unreported injuries and to get a better understanding of attitudes with your facility is the use of staff surveys. These can be administered as paper surveys or electronically. They DO require work to distribute, collect and analyze, but are valuable because they often uncover issues that can be valuable to your Team and make for a more successful SRH program.

Section 3: SRH Staff Survey

Draft

14. Operating procedures for using patient lift equipment (handles, are reviewed and revised as necessary).....

15. Select lift or movement activity and/or device on alternate report.....

16. Using appropriate body mechanics when it is possible to safely lift patients.....

17. In general, you support mandated health and safety programs such as and safety studies during a nonworking obligation.....

18. Do you have the ability to move patients at your facility?.....

19. The standard of care of the facility that you report to the most serious injury you reported in question 15.....

20. How many injuries have you experienced in the past 12 months that were considered with lifting, moving or transferring patients?.....

21. Do you believe that you are adequately trained to use the patient lift equipment at your facility.....

22. You have a favorite type of equipment to use for lifting or moving patients.....

23. Your favorite equipment for lifting or moving patients is.....

24. Lift your favorite equipment to use for lifting patients.....

Draft

25. Lift the equipment that you do not like to use for lifting patients.....

Section 3 - Job/Workplace Satisfaction

26. The feeling of work-life accomplishment I get from my work.....

27. The extent to which I use my skills.....

28. The satisfaction I take in patient care.....

29. The extent to which my job is varied and interesting.....

30. The standard of care given to patients.....

31. The amount of personal growth and development I get from my work.....

32. The amount of supervision, thought and effort I use in my work.....

33. The time available to patient care.....

34. My workload.....

35. Overall job satisfaction.....

36. The amount of time spent on administration.....

37. The amount of respect and patient's welfare.....

38. The opportunity I have to discuss my work.....

39. The respect available to me in my work.....

40. The overall quality of the supervision I receive in my work.....

41. The degree of respect and fair treatment I receive from my supervisor.....

42. The people I talk to and work with.....

43. The respect I have with colleagues.....

44. The value placed on my work by colleagues.....

45. The degree to which I am being paid for what I contribute to this organization.....

46. The effort to improve the working conditions.....

47. The opportunity to attend seminars on continuing education benefits.....

48. Being treated for continuing education.....

49. The extent to which I have adequate training for what I do.....

Please continue on to the next page

The types of questions to include on a survey can also deal with staffing levels, adequacy of care issues, training and work satisfaction. Analyzing responses to these types of questions, anonymously, can provide your Team with grassroots-based data that workers contribute, helping to make their work experience safer, productive and satisfying.

Section 3: SRH Staff Survey

IMPACT ON STAFF SATISFACTION

Table 4. Staff-reported job satisfaction
(Mean satisfaction scale score, range 1-5)

Scale	Overall (n=169)	Does Not Lift (n=77)	Lifts Patients (n=92)
Personal satisfaction (5 items)	3.93	4.03	3.85
Workload (5 items)	3.13	3.43	2.90*
Team spirit (3 items)	4.02	4.08	3.97
Training (5 items)	3.35	3.53	3.21*
Professional support (5 items)	3.52	3.71	3.37*

Data from safety surveys can help direct your SRH/ Ergonomic Team's efforts to address the most serious staff concerns. In this case, training and workload scored significantly lower among those staff that lift residents than those that do not. Seeing that professional support is lower as well, finding ways to address these specific issues could help reduce injuries further, and may make improvements in resident care and job satisfaction.

Section 4

SRH Programs: Costs vs. Benefits

- Costs of Injuries vs. Costs of Equipment
- Direct Costs vs. Indirect Costs
- Benefits

Review the topics that will be covered in this session.

Section 4: SRH Programs – Costs vs. Benefits

WHAT ARE THE COST'S ASSOCIATED WITH
EMPLOYEE INJURIES?

- Indemnity – lost wages
- Medical treatments
- Other disbursements (salary make-up, sometimes rehab costs)

why
cosh

This slide shows the Direct Costs to a facility that's self-insured--they compensate for the worker's lost wages and medical treatment through a reserve fund they keep. Other facilities may buy a policy from a private Workers' Compensation insurance company which would pay lost wages and treatment--policy premiums will increase when lost wage claims and medical treatment demands increase. Either way, the employer pays.

Section 4: SRH Programs – Costs vs. Benefits

OTHERS COSTS TO THE FACILITY

- Overtime to replace worker
- Nurse turnover, either due to injury or due to working conditions
- Quality of service is diminished

why
cosh

Direct Costs are only part of the story. When a worker is injured and not working there are also Indirect Costs ("hidden costs") to the employer. When a worker is out with an injury, the employer has to pay extra wages to replace the injured worker (overtime and/or a replacement worker). Another cost can be "turnover"--the injured worker is no longer able to work and quits, or the worker that's forced to work overtime quits. Often, what happens is that there's a loss of productivity and quality of care due to the hiring of less-skilled temp workers and/or a permanent new-hires to replace the productive and skilled injured worker.

Section 4: SRH Programs – Costs vs. Benefits

BALANCING MECHANICAL LIFTING
EQUIPMENT COSTS vs. INJURY COSTS

Mechanical Lifting Equipment Cost:

- Variable: depends on your resident make up and census (independent minimal assist, extensive assist, totally dependent)

Employee Injury Costs:

- Variable: depends on facility size

Evidence From Facility Studies:

- Data easily favors a safe resident handling program, including the capital costs for equipment.

why
cosh

Costs of injury vs. costs of equipment tend will vary from facility to facility. However, evidence from studies on facilities that make an investment in equipment demonstrate a positive Return on Investment (that is, the costs of equipment are recovered by reduction in costs of injuries) within 2 or 3 years.

Section 4: SRH Programs – Costs vs. Benefits

THE HIGH COST OF HEALTH CARE WORK-RELATED MSDS:
THE HUMAN TOLL

Work-related MSDs in health care can cause situations for direct caregivers that are:

Life altering
Career ending
Disabling
Chronic (persistent/permanent pain)

Back injury MSDs due to manual handling are the
#1 injury reported in health care.

Lynda Enos. SPH: A Summary of the Issue and Solutions. 2009

why
cosh

While we do compensate injured workers through Workers Compensation for those temporarily injured and Disability for those permanently injured, those pay outs are never equivalent to the loss of earning power from a full-time job.

More importantly, when back injuries become chronic, the worker's healthcare career is usually at an end and quality of life is greatly diminished.

Section 4: SRH Programs – Costs vs. Benefits

DO THE BENEFITS OF A SRH PROGRAM
OUTWEIGH THE COSTS?

Costs of
Injuries

Costs of
Equipment

Costs vs.
Benefits

why
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Activity [25 minutes]: Distribute a packet of the following handouts: Fact Sheet 5, Fact: Investing in Safe Patient Handling and Movement is Money in the Bank; Fact Sheet 6, Fact: The Cost of an Injury is Far Greater than the Cost of Equipment; Case Study One: Safe Resident Handling. The NYS Veterans Home Story; Case Study Two: Wyandot County Nursing Home; and Investments in SRH Saves Money and Reduces Injuries.

Break the Team into two groups. Give each group a piece of Flip Chart paper.

Go to next slide for continuation.

Section 4: SRH Programs – Costs vs. Benefits

SRH VETERANS NURSING HOME STORY

- Major issues at the VA Home?
- Challenges setting up SRH program?
- Benefits of the VA SRH program?
- SRH and Lost Work Days: Why the “spike?” What’s the trend? Why the trend?

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Activity (continued): Ask Group # 1 to divide their paper into 3 columns. In column 1 put a heading, “Costs of Injuries.” In column 2 put a heading, “Costs of Equipment.” In column 3 put a heading, “Costs vs. Benefits.” The group should read over Fact Sheets 5 & 6 and the Wyandot County Nursing Home summary in the handout, Investments in SRH Saves Money and Reduces Injuries. Ask them to briefly summarize in each column some conclusions they might draw about (1) the costs of manual resident handling injury costs; (2) the costs of equipment to eliminate manually handling; and (3) the costs vs. benefits of investing in equipment and a SRH program. Report back.

Go to next slide for continuation.

Section 4: SRH Programs – Costs vs. Benefits

SRH VETERANS NURSING HOME STORY

- Major issues at the VA Home?
- Challenges setting up SRH program?
- Benefits of the VA SRH program?
- SRH and Lost Work Days: Why the “spike?” What’s the trend? Why the trend?

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Activity (continued): Ask Group #2 participants to take a few minutes and read through Batavia, N.Y. S. “Safe Resident Handling Veterans Nursing Home Story.” On their Flip Chart ask them to discuss the major problems they were having at the Home. What were the major challenges of setting up their SRH program? What were some of the “benefits” of their SRH program? Ask them to discuss the first graph, “Number of Lost Workdays,” noting the relationship between injuries and Lost Work Days. What might be an explanation for the “spike” in Lost Work Days after the program was introduced? Ask them to review the second graph, “Employee Turnover Rate.” What does the graph show? Why was the turnover rate so high before SRH? Why did it drop afterwards? Report back.

Section 4: SRH Programs – Costs vs. Benefits

COST/BENEFIT ANALYSIS

Cost/Benefit Ratio = $\frac{\text{Dollar value of benefit (gain/loss)}}{\text{Dollar amount of cost}}$

Example – Lateral Transfer Injuries:
Three injuries in past year

Average injury cost (direct) = \$11,000 per worker x 3 =
\$33,000 (in potential savings)

Solution investment cost (2 air mats) = \$10,000
Benefit to cost ratio = 3.3

The benefit is over 3 times the cost.

Source: OR OSHA

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A financial cost vs. benefit ratio of your SRH program can be calculated by dividing the dollar amount of cost of, for example equipment, into the dollar value of the benefit.

In this example, 3 lateral transfer injuries that occurred in the past year cost an average of \$11,000 per worker. The investment cost of equipment (2 air mats) is \$10,000 -- assuming the equipment eliminated 3 future lateral transfer injuries, the benefit of the purchase is over 3 times the cost of the equipment.

Section 4: SRH Programs – Costs vs. Benefits

SUMMARY

Studies of nursing homes that adopt SRH programs show huge reductions in:

- Injuries
- Workers' Comp costs
- Medical costs
- Indemnity costs
- Lost Work Days
- Absenteeism
- Staff turnover
- Mandatory overtime
- Increased morale/productivity

STUDIES ALSO SHOW A RETURN ON INVESTMENT
IN APPROXIMATELY THREE (3) YEARS.

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A review of numerous studies of the costs vs. benefits of SRH programs (see handout), show that the financial gains far outweigh the costs of investing in these programs.

Continue to next slide for Resident benefits.

Section 4: SRH Programs – Costs vs. Benefits

RESEARCH HAS SHOWN THAT FOR PATIENTS/RESIDENT SPH/SRH PROGRAMS:

- Decrease in combativeness (with use of lifting equipment)
- Patient/Residents report feeling more comfortable/secure
- Reduced shearing injuries in patients/residents
- Reduction in falls
- Increase in physical functioning & activity level

Source: Lynda Enos, 2009.

why
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There is also considerable evidence that SRH programs also provide significant benefits for residents.

Section 5**Return to Work (RTW) Programs
in a SRH Environment**

- Benefits of RTW programs for injured workers
- Benefits of RTW programs for employers
- Medical Managements programs
- Obstacles to RTW programs
- Overcoming obstacles

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Review the topics that are covered under this section.

Section 5: Return-to-Work Programs in a SRH Environment**COMP: THE UPSIDE/DOWNSIDE**

- Workers' Comp = wage replacement
- Wage replacement is only partial
- The compensation process is adversarial
- Needed medical treatment is delayed
- Some injured healthcare workers end up on disability

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Workers' Compensation is supposed to be a no-fault temporary wage replacement program for injured workers while until they were able to return to work. In reality, states only allow a worker to collect a portion of his/her wages (in NYS, the maximum is 2/3rd of one's wage—in reality the worker usually collects a lot less than the maximum). Often management and the insurer take an adversarial position and contest the claim, particularly in MSD cases. Sometimes workers will work injured rather than file a claim knowing that there may be a retaliatory response from the employer. If a claim is filed, the employer's insurer is likely to contest ("controvert") a MSD claim. The claimant may retain an attorney to counter. Doctors are often enlisted by both sides and there will be conflicting opinions on the degree of disability. Often no one wins. The employer loses money fighting the claim, insurance premiums go up, and the workers absence is extended as the case drags on before an administrative law judge. The worker may be put through endless medical exams, hearings and delays and not receive the needed medical treatment. Some cases end tragically—the worker drops out of the workforce and is forced to live on substandard disability benefits.

Section 5: Return-to-Work Programs in a SRH Environment

SRH:

A Philosophy and Practice for Returning Injured Workers to Their Healthcare Careers?

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Activity [15 minutes]: Distribute the “Returning to Work in a Resident Handling Environment” handout. Break the Team into 2 Groups. Ask one group to discuss Labor-Management attitudes toward Workers’ Comp claims at this facility. What are the attitudes of management toward direct caregivers who are out on Workers’ Compensation? Of co-workers? Do you have a RTW program? Does it work? Why or why not? What are the major obstacles? Ask them to jot down their answers for to Report Back. Ask the second group to read the MSD injury recovery in a manual handling vs. MSD injury recovery in a SRH environment. Does the group think a SRH program could improve your success in returning injured workers back to their jobs as direct caregivers? Would this facility be open to RTW as part of the SRH program? Why or why not? What are the major resisting vs. driving forces for a RTW program? Jot down answers and Report Back.

Section 5: Return-to-Work Programs in a SRH Environment

ARE RTW PROGRAMS EFFECTIVE?

“Return to Work programs are a **proven, cost-effective** way to control the effects of disability and absenteeism in the workplace, and work in the interests of the employer and the employee. The goal of any good Return to Work program is the **safe and timely return of employees** to transitional or regular employment.”

NYS Return to Work Task Force, 2009

why
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In 2009, the NYS Return to Work Task Force, comprised of physicians, workers’ compensation attorneys, insurers, and union representatives reviewed the outcomes of successful Return to Work programs. They concluded that both workers and administrators can benefit.

Section 5: Return-to-Work Programs in a SRH Environment

WHY INJURED WORKERS CAN BENEFIT

- After 6 month absence from work, the odds of returning to full employment drops to 50%
- After a year’s absence it drops to 25%
- After 2 year’s absence it drops to near zero
- Compensation rates in total or partial disability cases never match real earnings at the pre-injury level.

Source: Steve Levin, MD, RTW Advisory Council

why
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Studies show that injured workers, who don’t return to their jobs in a timely fashion, are less and less likely to return to their jobs and full-time employment.

For those who drop out entirely and end up on Disability, the benefits don’t match the earning power that they had when gainfully employed.

For injured workers who wish to return to their original job and career path, it is in their interest to participate in Return to Work programs that will accommodate their injuries until healing has occurred.

Section 5: Return-to-Work Programs in a SRH Environment**WHY INJURED WORKERS CAN BENEFIT****Good Return to Work Programs Can:**

- Return the worker to her/his place of employment and pay
- Provide transitional (“modified”) work at her/his place of work while recovering
- After the recovery period, return the worker to her/his original job

The logo for 'why cosh' is located in the bottom left corner of the slide. It features the word 'why' in a yellow, sans-serif font above the word 'cosh' in a black, sans-serif font. The background of the logo is a green and black geometric pattern.

Returning to work in a Safe Resident Handling environment may make the healing process easier. There are a couple of reasons. As we have seen, Lost Work Days tend to decrease in a SRH environment. This indicates that the severity of injuries is also decreasing.

The other reason is that the physical demands of handling residents are less in a SRH environment than a manual handling environment. Because many MSDs are chronic and the direct caregiver may never totally heal, the ability to perform her/his previous handling tasks using equipment and other handling devices may be possible.

Section 5: Return-to-Work Programs in a SRH Environment**WHY EMPLOYERS CAN BENEFIT****Return to Work Programs Have Been Shown to Reduce:**

- Frequency and duration of lost time
- Workers’ Compensation costs
- Medical and indemnity costs
- Litigation
- Wage replacement costs
- Use of short/long-term disability benefits
- Productivity loss

The logo for 'why cosh' is located in the bottom left corner of the slide. It features the word 'why' in a yellow, sans-serif font above the word 'cosh' in a black, sans-serif font. The background of the logo is a green and black geometric pattern.

Review the main points. Go to next slide.

Section 5: Return-to-Work Programs in a SRH Environment**WHY EMPLOYERS CAN BENEFIT**

“The New York State Insurance Fund estimates that employers who have Return to Work Programs **save 20–40% or more** in Worker Compensation costs.”

Source: Steven Levin, MD

The logo for 'why cosh' is located in the bottom left corner of the slide. It features the word 'why' in a yellow, sans-serif font above the word 'cosh' in a black, sans-serif font. The background of the logo is a green and black geometric pattern.

There is clear evidence that the employer costs of effective Return to Work programs are outweighed by the benefits of these programs.

If management’s goal is to shorten lost work days, lower the costs associated with Workers’ Compensation and worker replacement, and getting a productive worker back on the job, an investment in a good Return to Work program is worth the cost.

Medically managing an injury claim and working with the injured employee to find useful modified work while transitioning back to her/his former job is cost effective.

Section 5: Return-to-Work Programs in a SRH Environment

WHAT MAKES FOR A GOOD RETURN TO WORK PROGRAM?

- A good medial management program
- A RTW program that is funded and well-led

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There are two pieces that need to be in place to effectively transition an injured direct caregiver with a MSD involving Lost Work Days back to her/his job.

A medical management process for diagnosing, medically treating, and regularly monitoring the injury is key. Monitoring the injury will allow you to determine the limitations the injury poses during the transitional return to work period.

The second piece is to have a well-resourced Return to Work program in place. It should have a budget, a person in charge and constant communication between that person, the physician(s) and the injured worker.

Section 5: Return-to-Work Programs in a SRH Environment

MEDICAL MANAGEMENT PROGRAMS

Key Elements of a Good Program:

- Early reporting of MSD symptoms encouraged and supported in policy, procedure and training
- Referring injured workers to a qualified physician
- Filing injury reports right away/track all injuries

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Your SRH program should greatly reduce MSDs related to resident handling. But some symptoms may occur in workers who already have chronic pain from long-term manual lifting. Others may injure themselves even after your SRH program is in place. They may work in pain or they may file a compensation claim and take time from work. Early symptoms of a MSD or an actual MSD injury are likely to worsen if not addressed immediately. Having a policy and procedure in place for reporting early symptoms, seeing a physician or physical therapist, getting therapy or treatment, and returning to work is important. Injured direct caregivers should be encouraged to file injury reports when they are experiencing early symptoms as well as early injuries. This will allow you to begin tracking the injuries to get at root causes.

Section 5: Return-to-Work Programs in a SRH Environment

MEDICAL MANAGEMENT PROGRAMS

Key Elements of a Good Program:

- Ensure Workers' Comp forms filled out
- Set up a Return to Work program with modified work provisions and coordination
- Learn from injury – advise SRH/Ergo Team
- Team gets at root causes of injuries – when, where and frequency of occurrence

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A good medical management program will encourage injured direct caregivers to fill out Workers' Compensation forms. Workers should not be punished for exercising this right and should not be discouraged from speaking with their union representatives. Your Team may want to encourage your Occupational/Employee Health (or another appropriate department or individual) to set up the Medical Management program. The individual designated to coordinate the Medical Management program activities should be knowledgeable about the causes and prevention of MSDs. Your Team should work with the medical manager to determine why and how MSDs are occurring. Getting at root causes is essential for making adjustments in your SRH program.

Section 5: Return-to-Work Programs in a SRH Environment

7 PRINCIPLES FOR SUCCESSFUL RETURN TO WORK PROGRAMS

- 1) Workplace has a strong commitment to SRH
- 2) Employer makes an offer of modified work for injured/ill employee
- 3) RTW planners ensure a plan that supports returning the worker to her/his regular job
- 4) Supervisors trained in disability prevention

The NYS Return to Work Advisory Council recommends seven principles for successful Return to Work programs. If your facility has made a commitment to a Safe Resident Handling program, a modified work plan can be developed for an injured worker that can provide important services for your SRH program. For example, there are “light duty” tasks such as performing program audits or organizing residents’ closets (folding sheets, etc.) that will help direct caregivers perform their tasks. As the injury heals, it may be appropriate to assign the injured worker to another direct caregiver in using equipment to move residents. Because the goal is to return the injured worker to her/his regular job, it is important to assign the worker to her/his own unit and regular shift, with normal days off, at the regular pay rate. This ensures the injured worker is on a path back to her/his regular job.

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Section 5: Return-to-Work Programs in a SRH Environment

7 PRINCIPLES FOR SUCCESSFUL RETURN TO WORK PROGRAMS

- 5) Employer makes an early and considerate contact with injured workers
- 6) Someone is designated to coordinate the RTW program
- 7) Employers and health care providers communicate with each other

Staff assigned to run the Return to Work program should be well-versed in the medical management program. They should understand the importance of early reporting. They should be capable of working with the injured worker and the physician(s) to find modified work that is within the limitations recommended by the physician(s). They should continuously monitor the injured worker’s progress, working with both the worker and health care providers to ensure a transition back to the worker’s regular job. Finally, it’s important that someone is assigned to coordinate the Right to Work program and regularly report to your SRH/Ergo Team.

NYS Return to Work Advisory Council, 2009

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Section 5: Return-to-Work Programs in a SRH Environment

OBSTACLES

“My own real experience taking care of injured or ill workers is that *only in rare occasions have I been successful at getting them back to work in their pre-injury workplace.* The most frequent response to inquiries regarding availability of modified duty to accommodate a worker’s temporary (or permanent) functional limitations has been: ‘*They need to be able to do their old job or I can’t take them back.*’.”

Dr. Levin, a former occupational health physician at Mt. Sinai Hospital in New York City and a member of the NYS Department of Labor Return to Work Advisory Council notes that in his experience, Return to Work programs have not been eagerly embraced.

Your Team has a real opportunity to begin to change attitudes of workers, their union, co-workers, and management by openly addressing the real concerns and obstacles to implementing a good Return to Work program at your facility.

Source: Steve Levin, MD, RTW Advisory Council

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Section 5: Return-to-Work Programs in a SRH Environment**OBSTACLE: THE INJURED WORKER****The Injured Worker May Be an Obstacle Due to:**

- Resentment – modified work is often menial
- Fear of exacerbating the injury
- Fear of hostility from co-workers

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Injured workers have legitimate concerns about Return to Work programs. Employers and insurers, looking out for the “bottom line,” have been known to hire or contract with physicians who are “company doctors,” interested in getting the worker back on the job, even if it means working injured.

“Light duty” can involve meaningless “make work” programs that fail to build on the worker’s skills or fail to make a real contribution to the facility.

Section 5: Return-to-Work Programs in a SRH Environment**OVERCOMING OBSTACLES: THE INJURED WORKER**

“In unionized workplaces, collective bargaining solutions, or statutory ADR (alternative dispute resolution) remedies for issues involving and related to return to work, re-employment and job protection should be honored or approved solutions for compliance with this program.”

Source: NYS Return to Work Advisory Council, 20009

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The New York State Department of Labor Return to Work Advisory Council notes that unions can play a role in ensuring that worker interests are represented in Return to Work programs. This can be part of the solution to removing injured worker opposition.

Section 5: Return-to-Work Programs in a SRH Environment**OVERCOMING OBSTACLES: THE INJURED WORKER****RTW Program Should Emphasize the Positive (Not Stigmatize).**

- Relevant/safe modified work
- Look at what work a worker can/can’t do
- Work with physician – ascertain level of restriction
- Accommodate worker – regular schedule
- Non-punitive approach – injuries happen

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Paula Pless, director of Kaleida Health’s SPH program in Buffalo, NY, states that, “The key to having a successful Return to Work program is to accentuate the positive.” Don’t look at what the worker can’t do, but at what she/he can do. The RTW coordinator or “point person” should talk with the worker and the physician. Identify options--the variety of “light duty” tasks that might be performed within the limitations of the injury. An agreement between the injured worker, physician and RTW coordinator on working toward an estimated return date from transitional to the worker’s regular job can keep recovery focused. Normalize the return: try to assign the worker to her/his unit, shift, and pay rate. Modified job duties can contribute to the smooth operation of the unit. For example, audits may need to be performed on the SRH program. Or the SRH program may need to be explained to residents or their families. Residents may need to be socialized with or monitored. Co-workers may need assistance that the returning worker can perform. As the injury improves more duties may be added with the physician’s OK.

Section 5: Return-to-Work Programs in a SRH Environment

OBSTACLE: CO-WORKERS

- Resentment that injured worker is fully salaried
- Resentment she/she isn't pulling full weight
- Resentment that co-worker got injured

Co-workers may be resentful that one of their colleagues who got injured—a careless colleague working in a SRH environment—is being rewarded by collecting full salary while not “pulling her/his weight.”

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Section 5: Return-to-Work Programs in a SRH Environment

OVERCOMING OBSTACLES: CO-WORKERS

RTW Program Should Emphasize the Value of the Injured Worker in the Unit.

- Remind All: Many healthcare workers are “working injured”
- Accidents can happen, even with SPH
- Modified work duty can help the unit
- Transition back to old job benefits us all

Your Team can play a positive role in working with unit supervisors and co-workers to return an injured colleague to her/his former job. Although your facility has adopted a SRH policy and practice, accidents will still happen, some because of imperfections in your program and others because of human error. Using After Action Reviews and looking at root causes can be helpful. Involving the unit supervisor and the returning worker's co-workers in transitioning back to work can also defuse resentment. Ultimately, the goal is to create an atmosphere in which all on the unit pull together to return a valued colleague to her/his old job.

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Section 5: Return-to-Work Programs in a SRH Environment

OBSTACLE: MANAGEMENT

- Resentment worker got injured
- Resentment worker is costing the facility
- Resentment the worker is a malingerer
- Too difficult to find worker useful, modified work duty

Management may also resent an injured direct caregiver. In the “Old Shame & Blame Culture” injured workers were often viewed as adversaries to be punished, a cost to be avoided. As Dr. Steven Levine noted in his practice, management acceptance of a viable Return to Work programs still remains the rare exception in his experience. Your SRH Team has an opportunity to change this culture. One of the goals your SRH Team may want to adopt is promoting a Return to Work program whose purpose is to return an injured colleague to her/his direct caregiver job.

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Section 5: Return-to-Work Programs in a SRH Environment**OVERCOMING OBSTACLES: MANAGEMENT****RTW Program Should Emphasize Value of Injured Worker to Your Facility:**

- \$\$ spent transitioning vested, experienced worker to old job vs. \$\$ training new hire
- Can remain closer to being fully staffed
- Shorter amount of time paying overtime/replacement worker
- Transitioning worker can perform valuable tasks in the SRH environment
- Reduce Workers' Comp costs

The logo for WNV Cosh, featuring the letters "wnv" in a stylized orange font above the word "cosh" in a black font, all within a green and black geometric shape.

The managerial “Culture Change” that your Team may want to foster with respect to injured caregivers is that they remain a valuable resource for the facility. The money spent transitioning an injured vested direct care worker to her/his old job in a Return to Work/Safe Resident Handling environment can be less than the money required to train a new-hire. Further, a injured direct care giver in a good Return to Work program can perform valuable duties that allows the unit to be close to fully staffed. Finally transitioning an injured direct care worker in a good Return to Work program can reduce the amount paid out for overtime and/or a replacement worker and shorten the time a the worker is collecting Workers’ Compensation.

Notes

Notes

MODULE FOUR:

Equipment, Environmental and Organizational Needs Assessment

AGENDA

REVIEW AGENDA	(Briefly)
REVIEW OBJECTIVES	(Briefly)
Section 1: Equipment	
Activity: "What's Wrong With This Picture?"	(5 Minutes)
Activity: "How Much Equipment Do We Need"	(20 Minutes)
Section 2: Equipment Needs Assessment	(40 Minutes)
Handout: "How Much Equipment Do We Need?"	
Activity: "Equipment Use Inventory Checklist"	
Activity: "Purchasing Equipment"	
<i>— 10 Minute Break —</i>	
Section 3: Facility Environmental Needs Assessment	(40 Minutes)
Activity: "Unit Profile and Space/Maintenance/Storage Evaluation"	
Activity: "Facilities Design Checklist"	
<i>— 10 Minute Break —</i>	
Section 4: Organizational Needs Assessment ("Buy-In")	(50 Minutes)
Activity: "Buy-In Bubble Chart"	
Activity: "Gap Analysis: Where We Are, Where We Want to Be, How Do We Get There?"	
EVALUATION	(5 Minutes)

Module Four

**Equipment, Environmental and
Organizational Needs Assessment**

Summary: The purpose of this module is to give your SRH/ Ergo Team some tools for assessing what your facility needs to do to have a solid Safe Resident Handling Program. A successful program has to have sufficient equipment, matched to your resident needs and readily accessible to your direct care workers on each unit. Your facility environment needs to be assessed to ensure that the equipment purchased is a good “fit” for the physical environment in which it is used. And your organization needs to be assessed to determine what will be needed to achieve “buy in” from all stakeholders that a successful program depends on. Assessment tools such as checklists are provided.

**Equipment, Environmental and
Organizational Needs Assessment**

AGENDA:

- Resident Handling Equipment and Devices
- Equipment Needs Assessment
- Facility Environment Assessment
- Organizational Assessment

Review the agenda.

**Equipment, Environmental and
Organizational Needs Assessment**

OBJECTIVES:

SRH Team participants will be able to understand...

- What equipment and devices are available to eliminate high-risk resident manual handling tasks
- How to assess your equipment needs and match your purchases to your census
- How to assess your facility environment
- How to assess your organizational capacity to achieve “buy-in”

Review the objectives.

Section 1

Equipment

- Engineering Control Strategies
- Mechanical Lifts
- Ambulation Assists
- Transfer Devices
- Friction-reducing Devices
- Height-adjustable Devices

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Review the topics that will be discussed in the section.

Section 1: **Equipment**

WHAT'S WRONG WITH THIS PICTURE?



- What's this manual lift called?
- What's the risk to the worker?
Resident?
- How could we eliminate the risk?

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Activity [3 minutes]: Ask the participants to discuss these three questions. Jot down their answers on the flip chart. Note that this manual lift is usually called the “hook & toss” where the caregiver puts her/his arms under the armpits of the resident. The resident is lifted and pivoted from the wheel chair to a bed or other surface. The injury risk to the caregiver is that too much weight is exerted on the lower back. As the pivot is executed, the back is twisted also presenting a risk. If the resident is unstable, there is the added risk that the resident will begin to fall, putting yet more stress on the caregiver's back. The risk to the resident is that the shoulder joints will be stressed and injured; if the resident is unstable, there is risk of injury due to a fall. [See next slide for control strategies.]

Section 1: **Equipment**

ENGINEERING CONTROL STRATEGIES

The Preferred Control Method:

- Eliminate the need to do the hazardous activity
- Redesign the activity to reduce the hazard: equipment and other assists

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The best Safe Resident Handling ergonomic control strategy would be to engineer out the manual handling risks. Mechanical lifting assists such as a Full Mechanical Lift using a sling would be the safer method of transferring this resident from a wheel chair to a bed. The next series of slides will show examples of some of the equipment that can reduce injuries to caregivers and residents. Not of all of this equipment needs to be available in your facility to have a good Safe Resident Handling program. Equipment purchases can be phased in strategically. Relatively inexpensive items like slip sheets, for example, can have a big impact on reducing injuries to caregivers and residents. As you phase in equipment, you may want to look at those areas of your facility where your highest job risks and injuries occur and when to prioritize your purchases .

Section 1: Equipment

MECHANICAL LIFTS



Full Mechanical Lift



Sit-to-Stand Lift

Source: OSHA

These are two examples of mechanical assists. The Full Mechanical Lift using a universal/hammock sling (pictured here) or a band leg sling can be used to lift residents who are totally dependent, are partial- or non-weight bearing, or are very heavy. They can be used for transfers from bed to chair, chair or floor to bed, for bathing and toileting, or after a resident fall. A Sit-to-Stand Lift can be used to transfer residents who are partially dependent, have some weight-bearing capacity, are cooperative, can sit on the edge the bed and can bend at the hips, knees and ankles. They can be used for transfers from bed to chair, or chair to bed, or for bathing and toileting. They can be used for repositioning where space or storage is limited.

Section 1: Equipment

CEILING LIFTS

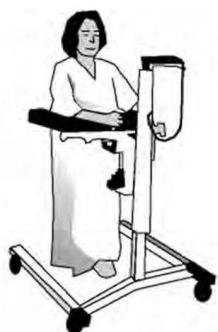


Source: OSHA

A Ceiling Mounted Lift can be used to lift residents who are totally dependent, are partial- or non-weight bearing or are very heavy. Transfers from bed to chair, chair or floor to bed, for bathing and toileting are typical uses.

Section 1: Equipment

AMBULATION ASSIST



Source: OSHA

The Ambulation Assist Device can be used for residents who are weight bearing and cooperative and who need extra security and assistance when walking.

Section 1: Equipment

FRICTION-REDUCING DEVICES



Source: OSHA

Friction-reducing devices such as Slip Sheets are a good way to reposition partial- or non-weight bearing residents (for example, sliding them up toward the head of the bed). Friction-reducing devices can be used slide a resident in a lateral transfer from one horizontal surface to another. These devices include draw sheets with handles, low-friction mattress covers, and slide boards, gurneys with transfer devices, and air-assist lateral sliding aid or flexible mattress inflated by portable air supply.

Section 1: Equipment

CONVERTIBLE WHEELCHAIR



Source: OSHA

A convertible wheelchair can be used to laterally transfer residents who are partial- or non-weight bearing. It eliminates the need to perform a lift transfer in and out of wheelchairs and to assist residents who are partially weight-bearing to a sit-to-stand position.

Section 1: Equipment

VARIABLE POSITION CHAIR

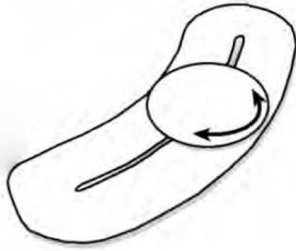


Source: OSHA

A variable position chair can be used to reposition partial- or non-weight-bearing residents who are cooperative. A friction-using device is needed if resident cannot reposition her/himself in the chair.

Section 1: Equipment

TRANSFER BOARDS



Source: OSHA

Transfer boards (wood or plastic) can be used to transfer (slide) residents who have good sitting balance and are cooperative from one level surface to another. Good for sliding residents from bed to wheelchair, wheelchair to car seat or toilet.

Section 1: Equipment

LIFT CUSHIONS AND LIFT CHAIRS

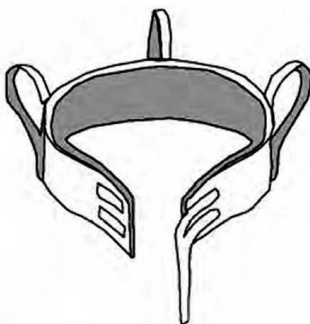


Source: OSHA

Lift cushions and lift chairs can be used to transfer residents who are weight-bearing but need assistance when standing or walking. These assists can be used for independent residents who need an extra boost to stand. Lift chairs are operated with levers or controls--residents need to have the cognitive capacity to do this.

Section 1: Equipment

GAIT BELTS



Source: OSHA

This assist can be wrapped around an independent resident who needs steadying or a partially dependent resident who has good stability and weight-bearing capacity. Minimal effort should be used by the caregiver and it should never be used for lifting – always use a mechanical assist where the safety of the transfer is in question. The gait belt is used to transfer the resident from bed to chair, chair to chair, or chair to car. It's also used for repositioning residents in chairs and for ambulation support.

Section 1: Equipment

ELECTRIC HEIGHT ADJUSTABLE BED



Source: OSHA

The electric powered bed height adjustable bed can be used for all tasks involving resident care, transfer, and repositioning in bed to reduce caregiver bending when tending to the resident. These beds are usually raised and lowered with an electric motor, replacing crank-adjustable beds, and provide a smoother movement for the resident and less physical exertion to the caregiver.

Section 1: Equipment

REPOSITIONING DEVICES



Source: OSHA

These devices work for residents who have the ability to assist the caregiver when being repositioned in bed by grabbing the trapeze bar to raise themselves up. Other assistive devices such as hand blocks and push up bars attached to the bed frame serve the same purpose.

Section 1: Equipment

HEIGHT ADJUSTABLE BATHTUBS & EASY-ENTRY BATHTUBS



Source: OSHA

These tubs can be raised to eliminate bending and reaching for the caregiver and increases resident safety and comfort. It allows for bathing of residents who sit directly in the tub or to assist ambulatory residents to climb more easily into a low tub.

Section 1: Equipment

BUILT-IN OR FIXED BATH LIFTS



Source: OSHA

This lift device can be used to raise and lower partially weight bearing residents with good sitting balance, have upper body strength, and are cooperative and can follow instructions. This device can be used in small bathrooms.

Section 1: Equipment

SHOWER AND TOILETING CHAIRS



Source: OSHA

This equipment can be used for partially dependent residents with some weight bearing ability who can sit up unaided and are able to bend hips, knees and ankles. The chair should move easily and smoothly, fit over a toilet, have a removable commode bucket for toileting, is stable and has a comfortable seat.

Section 1: Equipment

BATH BOARDS AND TRANSFER BENCHES

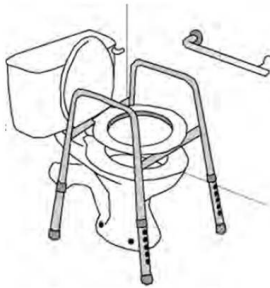


Source: OSHA

These devices can be used for independent residents and partially residents who are partially weight bearing, have good sitting balance, have upper body strength, are cooperative and can follow instructions.

Section 1: Equipment

TOILET SEAT RISERS

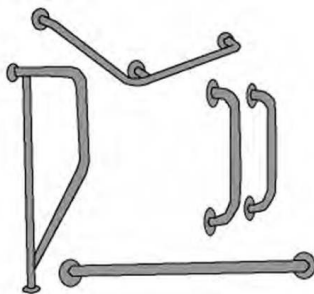


Source: OSHA

This device makes it easier for the caregiver to raise and lower partially weight bearing residents, who have upper body strength, are able to bend at the hips, knees and ankles and are cooperative. This device can also be used by independent residents.

Section 1: Equipment

GRAB BARS AND STAND ASSISTS



Source: OSHA

These devices can be used for toileting, bathing or showering residents who need extra support and security. They are appropriate for residents who are partially weight bearing, have upper body strength, and are cooperative. These devices can be permanently mounted or movable; movable grab bars on toilets minimize workplace congestion.

Section 2

Equipment Needs Assessment

- Inventory
- Maintenance
- Quantity
- Purchasing

Review the topics that will be discussed in the section. An equipment needs assessment will allow your Team to look at the equipment you have and to determine if it's in good condition. It also will allow you to determine if it's the equipment you need and what other equipment you will want to purchase. Your team will also want to look at your resident census to the degree of assistance that is required for each resident. And you will want to conduct a facility environmental assessment [next section] to make sure the equipment you purchase is a "good fit"

Section 2: Equipment Needs Assessments

EQUIPMENT USE INVENTORY

- Name of equipment/device
- Do you have it in your facility?
- If yes, how many on each unit?
- What's the weight limit (if applicable)?
- Is it in good working order?
- How often is it used on each shift?

wny
cosh

Before your Team recommends what equipment to purchase, you need to know what and how many lifts and devices you have and if they are maintained and used on each unit and shift.

As part of your equipment inventory, your Team should also inventory the slings you use with your lifts. You need to find out what types you have, if they are used, and if they are damaged. This will help your Team to come up with a sling budget for the slings you need and the ones you replace.

Section 2: Equipment Needs Assessments

EQUIPMENT USE INVENTORY CHECKLIST



wny
cosh

Activity [10 minutes]: Break the participants up into two groups and hand out the Equipment Use Inventory Checklist. Ask one of the members of each group to act as facilitator/scribe and jot down notes on a piece of flip chart paper and report back. Explain that this is an Equipment Inventory checklist. A successful inventory will require the participation of each unit and shift. A direct care worker from each unit should be included--it will help the Team to get feedback from the workers on how the equipment is or is not used for care tasks on each unit.

Section 2: Equipment Needs Assessments

EQUIPMENT MAINTENANCE



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This is a photo of the base of a Mechanical Lift taken during an equipment inventory assessment. A lock washer on the lift was loose and the wheel of the lift came off prior to getting a resident out of bed. There had been no communication between the Certified Nursing Assistants using the equipment and the supervising nurse or maintenance. The assessment found several lifts with same loose washer and a wheel about to come off.

Section 2: Equipment Needs Assessments

PREVENTIVE EQUIPMENT MAINTENANCE

Your SRH/Ergo Team should ensure procedures are developed to:

- Log and tag equipment when it enters the building
- Use the log and tags to monitor the equipment
- Develop a process to get the repaired equipment on the floor quickly
- 48 hours is a good turnaround time
- Maintain a log book of when the equipment was broken and returned

Your Team's equipment inventory assessment should include a visual inspection of the equipment to determine if any of it is broken. Preventive maintenance is critical to a successful Safe Resident Handling program. Your Team should ensure that preventive maintenance procedures are developed for your facility. New equipment should be logged in and tagged when it comes into your building. The equipment should be monitored by users and any damages reported to a persons designated by the Team (e.g., unit supervising nurses). The log and tags can be used to monitor damages that are reported to Maintenance. A process for getting the equipment repaired and back on the floor should be developed. Forty-eight hours is a good turnaround time. A log book with information on when the equipment was broken and returned needs to be maintained.

Section 2: Equipment Needs Assessments

RESIDENT CENSUS & EQUIPMENT NEEDS

- Number of Independent residents
- Number of Supervision/Limited Assist residents
- Number of Extensive Assist residents
- Number of Dependent residents

Your Team needs to establish a profile of each unit in terms of resident dependency and lifting, transfer and repositioning needs. This will allow you to determine the type and number of pieces of equipment you will need.

The Care Plans of the residents in each unit will give you your resident dependency and handling needs. The individual in your facility with access to all the resident care plans can perform the resident census for your Team. With this information, the Team is in a position to recommend what and how many of the various lifting, transferring and repositioning equipment and other devices are needed.

Section 2: Equipment Needs Assessments

HOW MUCH EQUIPMENT DO WE NEED?

EQUIPMENT TYPE	AMOUNT PER RESIDENT OF NEED ON THE UNIT
Full Mechanical Lifts	1 per 8 residents of need
Sit-to-Stand Lifts	1 per 8 residents of need
Gait Belts w/ Handles	1 per 2 residents of need
Slip Sheets/Phil-E-Slide, Maxi Slide/Surehands	1 per 8-10 residents of need
Hover Mat/Air Assists	Look at what your need is/where you'd use them
Ceiling Lifts/Tracks	# of fully-dependent and bariatric residents, tub and specialty rooms

This equipment to resident ratio is a good rule-of-thumb for determining your equipment needs. This is the ratio used by Kaleida Health in Western New York at 9 hospitals and nursing homes. Their program resulted in an 80% reduction in patient/resident-related handling injuries. Also, the way caregivers organize their work assignments should be carefully considered when determining the quantity purchased. Resident handling tasks aren't evenly distributed throughout the 24-hr. period. Usually there are peak periods where staff is competing for lifting devices. If your facility plans to eliminate manual lifting, a commitment to purchasing sufficient quantities of equipment will help ensure success. [Continued on next slide.]

Section 2: Equipment Needs Assessments

HOW MUCH EQUIPMENT DO WE NEED?

EQUIPMENT TYPE		AMOUNT PER RESIDENT OF NEED ON THE UNIT
Electric Control Beds		1 per 8 residents of need
Slings		1 per resident (Note: Sling needs should be determined by resident case load and needs)
▪ Hygiene	▪ Mesh	
▪ Universal	▪ Padded	
▪ Quick Fit	▪ Full-Body	
▪ Hammock	▪ Bathing	
▪ Sit-to-Stand	▪ Amputee	
▪ Positioning		

[Continued from previous slide]

why
cosh

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT

Questions:

- Have you made a big purchase in your life recently?
- What were you looking for?
- How did you decide to choose what you did?
- Does anyone regret his/her purchase? Why?
- How might your experience apply to the equipment you purchase?

Activity [10 minutes]: Ask the participants to break down into two or three groups and discuss the following questions. The purpose of this activity is to get everyone thinking about how they might evaluate the equipment that the Team will recommend be purchased. Just like the purchase of an item like a car or some other product, you will need to know what you want in the equipment you buy for your facility. There are many vendors out there with many products. Some have a lot of “bells and whistles.” You need to think critically about the pros and cons of what’s being offered. Remember, it needs to be something that the staff will want to use. Ask if there is equipment that’s been purchased that’s not being used and why.

why
cosh

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT: HOLD AN EQUIPMENT FAIR

- Contact vendor references
- Invite a few vendors
- Involve direct care staff/residents
- Evaluate, select and pilot use of equipment

After your Team has completed the equipment inventory and the resident census, it can move on to setting up a process for recommending what specific equipment to purchase. There are several equipment manufacturers. You may want to begin by investigating on the internet and talking to vendors on the phone. You can then choose two or three to invite to your facility for an Equipment Day or Equipment Fair. The vendors will deliver and demonstrate their equipment. In addition to your Team, administrators and your direct care staff from all three shifts should be invited to participate. Residents should also be invited. All should be encouraged to examine each product. Your Team could give them an evaluation survey in which your staff and residents give feedback on what they liked or disliked about the various products. Acceptance of the equipment by staff and residents is critical to ensuring its use. After the surveys are evaluated, the Team is in a position to make purchasing recommendations.

why
cosh

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT: SELECTION CRITERIA

- Appropriate to Task
- Fits in Facility Environment
- Safe for Resident/Caregiver
- Easily Kept Clean
- Comfortable for Resident
- Cost-Effective
- Easy to Understand
- Time-Efficient (not too many steps)

wny
cosh

These equipment selection criteria can assist the Team in making choices between products. Try to avoid standardizing the equipment that you propose to purchase. The appeal of standardization is that slings are interchangeable, maintenance is easier and buying in larger quantities may yield price discounts. The downside is that the equipment selected may not meet the needs of all staff and residents. Resident characteristics, the facility environment and staff acceptance should influence the purchase. This may result in variations across resident areas; it may make sense to standardize purchases by unit, but unique aspects of units should be noted as well. Also, the Team needs to weigh the extra cost of powered lifts. They may cost more than manually operated ones, but staff are more likely to use them as they take less time—they may be more cost-effective in the long run.

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT: KEY VENDOR QUESTIONS

- Reliability: established in our state?
- Customer Service: repair/replacement? Turnaround time?
- Training: initial and periodic? All shifts?
- Maintenance: length of battery charge? Battery life span? Vendor maintenance?
- Vendor's Responsibilities?

wny
cosh

The Team should find out the vendor's terms. Is the business well established? Will the vendor repair the equipment if it malfunctions or replace it if it fails to perform? Will the vendor provide training on the equipment? How many hours on a battery charge and what's the battery life span? What services on the battery will the vendor provide?

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT: VENDOR QUESTIONS

- Equipment Functionality?
- Infection Control?
- Bariatric Equipment?
- Slings?
- Ceiling Lifts?
- Equipment Product Support?

wny
cosh

Other questions that should be asked of the vendor:

Equipment Functionality: Life expectancy of the equipment? Storage requirements? Does it fit into the facility bathrooms? Does the base of lifts fit under beds? Does it fit in elevators? Does it have emergency shut-off switches? Are there weight capacity and operation instructions on the equipment? **Infection Control:** Are there infection control procedures? Disposable slings available? **Bariatric:** Does vendor have equipment for bariatric residents? **Slings:** How are they used? Life span? **Ceiling Lifts:** Area of track? Structural requirements for single/traverse track? **Equipment Product Support:** Warranty limitations? Vendor's equipment evaluation period?

Section 3

Facility Environmental Needs Assessment

- Building Layout
- Storage
- Park and Charge Areas
- Ceiling Lift Installation
- Floors and Doors
- Resident Rooms
- Bathrooms
- Tub and Shower Rooms

why
cosh

Review the topics that will be covered in this section.

Section 3: Facility Environmental Needs Assessment

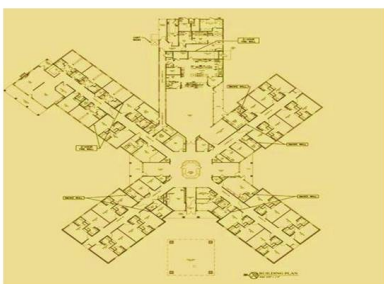


why
cosh

Your Team needs to ensure a Facility Environmental Assessment is conducted. You need to look at the physical space and characteristics of your facility. Some kinds of equipment may work better in your facility than others. When trying the equipment during the trial period, ensure it fits well in your work spaces. Generally, the physical characteristics of a facility are not a deterrent to using some kind of mechanical assists and devices. You may have to reengineer some aspects of your facility to accommodate the equipment. For example, you may need to add electrical outlets in the battery charge area--the cost of doing this usually not prohibitive. Remember: Your equipment must be easily accessed and easy to use within the physical space it's being employed or caregivers will quickly revert to manually handling residents.

Section 3: Facility Environmental Needs Assessment

BUILDING LAYOUT



why
cosh

Your Team needs to look at your building layout. Lifting equipment has to be strategically parked along hallways of your units between uses. The parking area needs to be readily accessible to direct caregivers. Caregivers should work with your Team to determine to decide the most accessible locations. Your lifts will likely be powered, so they will have to be recharged. There needs to be an agreed upon park & charge area. Common problems facilities have with conveniently locating lifts are long hallways—you need to work with direct caregivers to find a park area that provides easy access to all. Another problem is that the lifts are stored in closets—this is a bad idea because they aren't accessible.

Section 3: Facility Environmental Needs Assessment

BAD STORAGE AREAS



How likely is it that this equipment will be used?

why
cosh

Your Team must ensure that lifting equipment is never stored in closets or rooms. The common area where staff will have easy access to equipment is in a hallway or an alcove right off the hallway. While the amount of equipment purchased will tend to be on the basis of the numbers of beds and resident census, if your facility has exceptionally long hallways, the Team may need to take floor layout into account.

Section 3: Facility Environmental Needs Assessment

PARK AND CHARGE AREAS

- Designated area when not in use
- Sufficient electrical outlets to recharge
- Involve direct care staff in selecting site
- Alcoves in hallways possible sites
- May need more than one area

why
cosh

A challenge for your Safe Resident Handling program is where to park your portable lifts when they aren't being used. The lifts need to be accessible. And, they need to be plugged into an electrical outlet. The direct care staff must be involved with your Team in identifying your park and charge areas in each unit. They are in the best position to tell you where the lifts can be easily accessed. Your facility may have limited electrical outlets in the hallway or an alcove. When doing your facility environment assessment, your Team may want to meet with maintenance staff to look for locations to install more outlets. Outlets should be installed at chair rail height to create an ergonomically sound environment for plugging in your equipment.

Section 3: Facility Environmental Needs Assessment

FIXED CEILING LIFT INSTALLATION



Important Considerations:

- Structural Load Limits
- Lighting Fixtures
- Protruding Sprinkler Heads
- Air Conditioning Vents
- Asbestos
- Ceiling Height

why
cosh

Ceiling lifts are an ideal means for lifting, transferring, and repositioning fully dependent and extensively dependent residents. They allow you to perform most resident care tasks with minimal risks of injury. Unless the Ceiling Lifts were installed in your ceiling when the facility was built, you will have determine if your ceiling is suitable for putting them in after the fact. Your Team will have to determine if the ceilings have the structural strength to hold the lift and resident. The ceiling height needs to be measured to ensure there is lifting space between the bed and ceiling. You will have to see if obstacles such as lighting fixtures, sprinkler heads, and air conditioning vents are a problem or if they can be removed or reconfigured. Since installation will involve drilling or cutting into the ceiling, you need to check for asbestos. If your facility is remodeling an existing space or building new space, be sure that it's "ceiling lift friendly."

Section 3: Facility Environmental Needs Assessment

FLOORS AND DOORWAYS

Your equipment needs to be compatible w/:

- Doorway width
- Doorway handles (catch on beds/gurneys?)
- Thresholds/other obstructions in bathroom, shower and resident rooms
- Floor surfaces (carpeted? Uneven? Slippery?)
- Steep floor ramps (over 10% pitch?)

why
cosh

Narrow doorways, carpeting, slippery floors, high thresholds, ramps and floor clutter can be environmental risk factors when using equipment. They pose a risk of injury to direct care staff and residents. Your Team will need to investigate each of these factors. Doors and thresholds need to be measured where the lifts, wheelchairs, etc. are being used. You need to determine if doors can be widened and thresholds lowered (when a space is being remodeled, this is an opportunity to do this). Carpeted floors can also be an obstacle. There are a variety of wheel styles and sizes; some work better than others on carpeted surfaces and high thresholds. It's important to arrange a trial period for using the equipment before purchasing to see which equipment works best within the constraints of your facility environment. Be sure to check with the end-users--the staff and residents.

Section 3: Facility Environmental Needs Assessment

RESIDENT ROOM LAYOUT

- Private? Semi-private?
- Bathroom in room?
- Room dimensions (small or large)?
- Room clutter?
- Space under beds?
- Closet (for storage or personal items)?
- Bedside medical or electrical outlets?

why
cosh

Your Team needs to make sure the resident rooms are carefully assessed. Again, involve the direct care staff. You need to determine if mechanical lifts have the space necessary to lift residents from beds to chairs, etc. A room with one bed usually allows more space for equipment than one with two beds—you need to note how many one vs. two bed rooms you have in your facility. Room measurements should be taken to determine how much space you have to maneuver portable mechanical assists. You need to assess how much space there is between the bed and floor. The base of the mechanical lifts that are chosen must fit under the beds. Also note closet areas to determine if they can reduce room clutter.

Section 3: Facility Environmental Needs Assessment

BATHROOMS



Will your equipment fit?

why
cosh

Your Team will want to make sure the equipment fits in resident bathrooms. Some manufacturer's equipment is less bulky than others. Ask the direct care staff which equipment they find fits best in the bathroom workspace. If the mechanical assists don't fit in the bathroom, your Team should consider portable commodes that can be used in the residents' rooms. This will avoid the need to manually lift residents onto toilets.

Section 3: Facility Environmental Needs Assessment

TUB AND SHOWER ROOMS



Do any of your tub and shower rooms look like this?
How would you improve accessibility?

wny
cosh

Your Team will want to assess your facility's tub rooms. Direct care staff should be consulted about whether or not the tub and shower rooms allow them to avoid manually lifting or bending and twisting. Is there room for mechanical lifts or is there a lift mounted on the tub? Are there side entry tubs and, if not, is there space to install one? A ceiling lift might be an option--is there sufficient room between the ceiling and tub to lift a resident into the tub? This slide and the next slide show obstacles that the direct care staff might encounter when bringing a resident into a tub or shower room. Ask the staff if there obstacles that they encounter at your facility.

Section 3: Facility Environmental Needs Assessment

TUB AND SHOWER ROOMS



What's the likelihood that direct care staff will be able to easily access the tub?

wny
cosh

This is a photo taken of a tub room during an assessment. In addition to being a tub room, it's being used as a storage area. What's the likelihood that direct care staff and the resident will be able to easily access the tub?

Section 3: Facility Environmental Needs Assessment

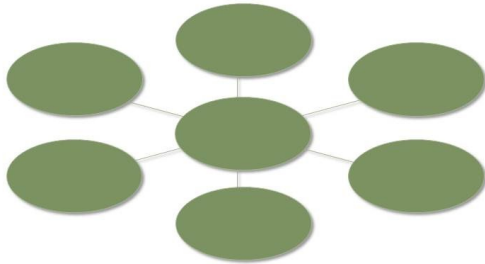
Unit Profile and
Space/Maintenance
Storage Evaluation
&
Facilities Design
Checklist

wny
cosh

Activity [15 Minutes]: Ask the participants to break down into two groups. Hand out the two checklists and ask them to review them in their groups. They should evaluate the checklists to determine if there are other items they would want to include. If the Team wants to use the forms, ask them how they might plan to conduct the assessment using the checklists, analyze the results and make recommendations. The Team should note how they would involve direct care workers in the survey.

Section 4
Organizational Needs Assessment

Buy-In



Activity [10 Minutes]: Hand out the “bubble chart” to each of the participants. Ask each of them to take 5 minutes to identify the names of departments and professions in their facility that they need “Buy In” from to have a successful Safe Resident Handling program. Ask them to write in each bubble who they think needs to be contacted by the Team and why and report back. Jot their answers down on a flip chart and discuss.

Section 4: **Organizational Needs Assessment**

Buy-In



An organizational needs assessment will allow your Team to determine where you are now in having a Safe Resident Handling (“No Manual Lift”) program and what you need to do to implement a full successful program. An organizational needs assessment allows you to look at the roles that your departments and professions will play in carrying out your program and the “buy in” you already have or need to have. This assessment will allow your Team to evaluate your organization’s strengths and weaknesses and to determine where you need to focus your energies to achieve a highly functioning Safe Resident Handling program.

Section 4: **Organizational Needs Assessment**

MANAGEMENT SRH BUY-IN

- Support SRH policy
- Provide equipment budget
- Encourage use of equipment
- Ensure support for SRH (training, et cetera)
- Ensure equipment maintenance
- Empower SRH Team/Point Person(s) to drive the program
- Promote “Culture of Safety”

Management support for the SRH program is critical for its success. Adequate budgeting for SRH equipment and personnel is the first step. Successful implementation of the program requires strong management backing of the SRH/Ergo Team, the SRH “Point Person(s),” SRH training, and to embedding SRH policy, protocols and procedures in the daily work practices of the staff.

Section 4: Organizational Needs Assessment
UNION BUY-IN

- Negotiates with management a SRH implementation plan
- Handles member's complaints/concerns
- Promotes SRH among members



Unions have been advocates for safer workplaces, good ergonomic practices, and involvement of their members on safety committees. Approaching your SRH program as a joint Labor-Management endeavor will give union members a stake in the program, increasing the likelihood of cooperation and of resolving conflicts that may arise. The union's promotion of your SRH program can contribute to a "Culture of Safety" among its members.

Section 4: Organizational Needs Assessment
DIRECT CARE STAFF BUY-IN

- Participate in SRH training/demonstrate competence
- Follow SRH policy and procedures
- Participate in identifying high-risk tasks
- Report injuries, near misses, equipment repair needs, after-action reviews
- Participate in equipment selection
- Communicate with SRH "Point Persons"



Direct care staff "buy in" is at the heart of your SRH program. Training on equipment and on-going mentoring is key. Valuing CNAs as active partners with your Team, your "Point Person(s)," and licensed professionals can increase their commitment to the program. CNAs should be respected for their "hands-on" knowledge. They should fully participate in identifying high-risk tasks, selecting equipment, reporting changes in resident status, reporting near misses and incidents, participating in after-action reviews, etc. Remember: The SRH Culture we want is not based on "shame and blame," but honest and open communication and group problem-solving. When best SRH practices are not being followed by staff, your "Point Person(s)" and Team need to investigate "why" this is the case—often it's a matter of "system failure": inaccessible or broken equipment, insufficient staffing, inadequate training and mentoring, or failure of communication.

Section 4: Organizational Needs Assessment
CFO/FINANCE BUY-IN

- Open to reviewing costs of resident-handling MSDs
- Open to reviewing projected costs of SRH
- Open to reviewing projected financial benefits of SRH



A commitment from Finance to conduct a cost-benefit analysis will help your Team make a business case at your facility. A baseline study of the costs of MSD injuries, workers' comp cases, restricted workdays, insurance premiums, and staff replacement or overtime costs, and lost productivity due to worker turnover will help make your case to the Administration. A comparison between your rates and costs and the national average will allow your Team to estimate your facility's relative costs. After your Team determines the amount of equipment and support you will need, Finance will be able to project those costs. Your Team can share cost-benefit information with Finance to project savings (see studies cited in Module 3).

Section 4: Organizational Needs Assessment

SRH/ERGO TEAM BUY-IN

Oversees Implementation of SRH and Monitors and Sustains:

- Facility ergonomic assessment
- Equipment assessment/purchases
- Resident evaluation process
- Training/staff mentoring
- Incident/After Accident Reviews
- Program evaluation

why
cosh

The SRH/Ergo Team is the central driver and champion of your SRH program. The Team meets regularly (perhaps bi-weekly at first, monthly after the program is established), allows a minimum of 1 hr. for its meeting, ensures good attendance (send out announcements), sets up and sticks to its agenda, and keeps records of its meetings. Your Team leads by example and promotes SRH policy and encourages others to do the same. It plays a central role in implementing, monitoring and sustaining the SRH program. The Team oversees key components of the program: ergonomic analysis of injuries and job tasks; resident evaluation/care planning; staff competency training on equipment and mentoring and evaluation; incident/after-action reviews; and program evaluation.

Section 4: Organizational Needs Assessment

SRH/ERGO TEAM BUY-IN (WHO)

MANAGERIAL (Administrators)	NON-MANAGERIAL (Residential Care Staff)
CFO/Finance	RN
Human Resources	CPN
Training	PT/OT
Director of Nursing	CNA
Occupational Health	Maintenance
Third-Party Benefit Coordinators	Laundry
Risk Managers	Infection Control

why
cosh

The number of individuals on SRH/Ergo Teams can differ from facility to facility. States that have developed Safe Patient Handling laws, generally require an equal number of participants from Administration and Direct Care with co-chairs from each group. While you may not have all departments or professions represented, it is especially important to involve frontline workers who handle residents, the Director of Nursing, professional staff who assess residents (OTs/PTs and administrators who are in a position to move the program forward).

Section 4: Organizational Needs Assessment

SRH LEADERSHIP BUY-IN

- SRH Leader-Motivator
- Assists direct-care staff on implementing SRH
- SRH educator for staff and resident family members
- Liaison between SRH/Ergo Team and other stakeholders

why
cosh

Successful SRH programs often have an individual or individuals who are assigned to champion the program. In some facilities they are called a "Point Person." It could be a charge nurse or a supervising nurse who may also serve on the SRH/Ergo Team. This individual(s) would be given some time by Administration to devote to the SRH program between Team meetings to keep it on track and to monitor its progress. A successful "Point Person" should be an individual who has leadership and motivational skills; is respected by the staff; is an assertive SRH champion; is a good listener; is knowledgeable about SRH policy and practices; and has good training skills.

Section 4: Organizational Needs Assessment**SUPERVISION BUY-IN**

Director of Nursing, Unit Managers,
Charge Nurses, Nighttime Supervision:

- Mentor staff on following SRH policy
- Ensure equipment/devices in working order
- Ensure direct care staff trained/retrained
- Staff injuries are referred to Occupational/Employee Health
- Accident/Injury reports are completed
- After-Action Review sessions are held

why
cosh

The supervising nurses in each unit have a key role to play in ensuring that the program is carried out. After the direct care staff receives competency training, they will need to be mentored and evaluated for a period of time—supervising nurses in each unit can play a key role in carrying out this function. They are also in a position to monitor other aspects of the program: report resident changes to PTs/OTs; report damaged equipment; ensure training/retraining of CNAs; refer injured staff to Occupational/Employee Health; complete accident/injury reports; and call After/Action Review sessions. If a “Point Person” position is created, the unit supervisors should have a working relationship with this individual.

Section 4: Organizational Needs Assessment**IN-SERVICE TRAINER BUY-IN**

- Work with SRH Point Person, Supervision, SRH Team on training
- Maintain SRH training records
- Assist with setting up/providing retraining and training of new hires

why
cosh

SRH training is key part of your program. A well-trained SRH/Ergo Team that is able to, in turn, train frontline workers on why and how to use resident handling mechanical assists and devices is a step toward the culture change you want. Good training, mentoring and evaluation of the competency of your frontline workers can guarantee its success. Your Team should reach out to your facility’s in-service trainer. An in-service trainer can be an asset to maintaining your SRH program. Including your in-service trainer in the Team train-the-trainer program could make her/him a valuable member of your group. Your in-service trainer could ensure that SRH training will routinely occur for new-hires and for retraining of staff on an ongoing basis.

Section 4: Organizational Needs Assessment**LAUNDRY BUY-IN**

- Follow laundry instructions on labels
- Set up in-house sling laundering
- Maintain inspection logs of slings after cleaning
- Removed damaged slings

why
cosh

Laundry participation is critical. If slings are sent to laundry and not quickly returned, they may not be available to your CNAs. Your Team needs to ensure a schedule is worked out between the units and laundry. Slings are distributed according to the number of residents in each unit. Each unit should have a set day when it sends its slings to laundry. Each new sling should be given a number and date it was put in service. This allows for tracking of the sling (also to take advantage of the warranty if it’s damaged. An inspection log should be kept in the laundry area; when it’s laundered, it should be logged in as “passed” or “failed.” All damaged slings should be returned to the unit supervisor for replacement. Slings should be laundered according to the instructions on the label (usually light cycle, normal detergent, no bleach, no dryer/ironing, washed separately from other laundry). Soiled slings should be sent to laundry immediately (not on scheduled day).

Section 4: Organizational Needs Assessment

HOUSEKEEPING BUY-IN

- Wipe down/disinfect equipment (monthly minimum; direct care staff on an as-used basis)
- Follow Infection Control protocol

why
cosh

Equipment infection control protocols will require Housekeeping's involvement. Housekeeping will be responsible for thoroughly wiping to clean (using disinfectant wipes) all parts of lifting devices. This should be done, minimally, on a monthly basis. **Note:** After each use, the direct caregiver should use a disinfectant wipe on handles of the lifting device and wipe any other part that was touched by the resident. If the resident is infectious or if body fluids have lightly soiled a sling or belt, the use of that sling should be confined to that resident. A wipe disinfectant can be used on the lightly soiled item. If there is heavy soiling, it should be placed in a special hamper and sent to laundry.

Section 4: Organizational Needs Assessment

HUMAN RESOURCES/INSURER/ RISK MANAGER BUY-IN

- Provide injury and illness data
- Provide workers' comp data
- Provide information on LWDs & costs
- Update and continuously monitor injury data

why
cosh

Human Resources, Insurers and Risk Managers can provide your Team with factual data and analysis that will make the case for investing in a SRH program. OSHA 300 logs are the primary source of information. The logs will describe an incident, its date and time, the unit where it occurred, the affected body parts, and the days of work lost. Other sources of information include lost work day records, workers' compensation claims, job retention/turnover records, overtime/job replacement records, accident/near-miss reports, and resident injury claims and payout records. After the SRH program is set up, HR can play an important role in tracking MSD injuries, compensation, LWDs, etc. This information will allow your Team to identify and correct weaknesses in your program. Administration should be made aware that MSD cases may initially spike due to heightened staff awareness and encouragement to early-report; these spikes are normal and tend to soon level off.

Section 4: Organizational Needs Assessment

OCCUPATIONAL HEALTH/ EMPLOYEE HEALTH BUY-IN

- Encourage early reporting of MSD symptoms
- Refer injured workers to qualified physician
- Promptly file injury reports/track MSDs
- Ensure workers' comp forms filled out accurately
- Advise SRH/Ergo Team on injury patterns and when/where they're occurring

why
cosh

Occupational/Employee Health will play an important role in your program. After your Team rolls out the SRH program, the policy of encouraging reporting MSDs and early symptoms of MSDs may cause your reported injuries to spike. Staff with pre-existing MSDs may be more willing to report. And, early reporting of symptoms will add to the numbers. This initial spiking will likely disappear as your SRH program develops. But, some staff will be injured—even the use of equipment doesn't ensure that it's used properly, that there is an occasional equipment malfunction, or that proper body mechanics aren't used with it. O/E Health should work with the Team, Point Person and/or unit supervisors to identify and analyze where the injuries are occurring and why.

Section 4: Organizational Needs Assessment**INFECTION CONTROL BUY-IN**

Develop infection control precautions that need to be taken with equipment/slugs:

- Barriers between sling and resident
- Soiled slugs
- Dedicated slugs
- Equipment
- Investigate reports of infection transmitted via slugs or equipment

The logo for WNY Cosh, featuring the text "wny" in orange and "cosh" in black, with a stylized graphic element.

Your Team will need the involvement of your Infection Control Department. Protocols to prevent the spread of pathogens by way of slugs or equipment used to handle residents must be developed and monitored. Protocols may include instructions for ensuring there is always a barrier between the sling and resident (underwear, incontinent pad); that soiled slugs are immediately placed in a hamper dedicated solely to contaminated slugs that are immediately sent to Laundry; that laundry personnel wear disposable rubber gloves when handling soiled slugs; that a single dedicated sling is used for any resident known to have a multi-resistant organism or communicable illnesses and laundered after discontinuation isolation or discharge; that caregivers wiped handles of equipment after each use with disinfectant wipes after each use; that Housekeeping staff use disinfectant wipes to a complete wipe of all part of equipment/hardware on a monthly basis. Inspection Control should investigate all incidents of suspected infection transmission from one resident to another via equipment or slugs recommend preventive measures to your Team for preventing any future occurrence.

Section 4: Organizational Needs Assessment**PURCHASING DEPARTMENT**

- Help identify equipment vendors
- Participate in vendor day event
- Monitor vendor contracts

The logo for WNY Cosh, featuring the text "wny" in orange and "cosh" in black, with a stylized graphic element.

Your facility's Purchasing Department may be assistance to your Team in identifying equipment vendors. They may also be of assistance in helping the Team "comparison shop," by comparing features and prices of the equipment you recommend for purchasing. Purchasing may also want to participate in your "vendor day event" and solicit information from various vendors on their servicing agreements, training agreements, etc. After contracts are entered into with a vendor(s), Purchasing is in position to monitor those contracts to ensure that the provisions of those agreements are carried out.

Section 4: Organizational Needs Assessment**MAINTENANCE**

- Repairs
- Damaged Equipment Reporting
- Turnaround Time

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If your facility enters into a servicing agreement with your vendor(s), they should service needed repairs and provide routine maintenance. If you don't have a service agreement or it expires, your maintenance staff may need to perform repairs and maintenance. They should receive training by the vendors, have access to repair manuals, access to the vendor's servicing department, etc. Your Team should work out procedures for reporting any equipment damage and for ensuring that repairs rise to the top of their priority list. It is critical that turnaround time is as equipment shortages on the floor may lead to manual handling.

Section 4: Organizational Needs Assessment**GAP ANALYSIS****Where We Are****Where We Want to Be****How We Get There**wny
cosh

Activity [25 minutes]: Explain to the participants do a “Gap Analysis” brainstorm about 1) where there facility currently is with its SRH program, 2) where they want to be, and 3) how they will get there. Using the Flip Chart, make the following outline:

- Where We Are (Current SRH status?)
- Where We Want to Be (Goals? Timeline?)
- How We Get There (Barriers? Assets? Strategies? Actions)

This exercise should help your Team shape your where you want to be and when and who needs to what to get to where you want to be. The group can think in terms of short-term and long-term goals. As the Team reaches consensus, this can become a roadmap for SRH implementation.

Notes**Notes**

MODULE FIVE:

Implementing and Sustaining Your Safe Resident Handling Program

AGENDA

REVIEW AGENDA	(Briefly)
REVIEW OBJECTIVES	(Briefly)
Section 1: Moving Residents: The Pivot Transfer	(15 Minutes)
Activity: Paula Pless Article	
Activity: “What’s Wrong With This Picture?”	
Activity: “Is a Two-Caregiver Assist Safer?”	
Section 2: Assessing Residents	(50 Minutes)
Handouts: “How Do We Assess Resident Dependency?” & “What Lifting/Transfer Method Do We Use?”	
Activity: “Safe Patient Handling Assessment Tool”	
Activity: Resident Care Guides/Plans Used at This Facility & Four “Model” Care Guides	
<i>— 10 Minute Break —</i>	
Section 3: Safe Resident Handling Policy	(40 Minutes)
Activity: “Roles and Responsibilities” - Questions for Employers, Management and SRH/Ergonomic Teams	
Activity: “SRH Policy Sample Outline”	
<i>— 10 Minute Break —</i>	
Section 4: SRH Training, Competency, Evaluation and Monitoring	(30 Minutes)
Handout: “Sample Audit Tool — Zero Lift Compliance”	
Handout: “Licensed Personnel” Evaluation — Zero Lift Compliance	
EVALUATION	(5 Minutes)

Module Five

Implementing and Sustaining Your Safe Resident Handling Program:

Resident Assessments, Safe Resident Handling Policy, Training, Evaluating, Mentoring and Monitoring

Summary: This module will provide information on how to implement your SRH program and on how to sustain the program over time. One key point is that direct care workers are likely to use the pivot transfer without having a proper assessment of the resident's ability to assist. Using a good resident assessment tool is crucial for the success of your program. Another key component is having a written SRH policy and procedure which sets the standards for carrying out your program. Training direct care workers on the proper use of the equipment, and mentoring, monitoring and evaluating staff, will help sustain your program over time.

Implementing and Sustaining Your Safe Resident Handling Program

AGENDA:

- Assessing the Pivot Transfer
- Resident Assessment Tools
- Safe Resident Handling Policy
- SRH Competency Training
- Competency Evaluation
- Mentoring
- Monitoring

Review the topics that will be covered in this section

Implementing and Sustaining Your Safe Resident Handling Program

OBJECTIVES:

Participants will be able to understand...

- The need for, and how to, conduct accurate resident assessments
- What resident handling information should be included in Care Guides
- Develop SRH Policy and Procedures
- Understand the role of training, competency evaluation, mentoring and monitoring of their SRH program

Review the training objectives for this module.

Section 1

Moving Residents: The Pivot Transfer

- Risks of Using the Pivot Transfer to Direct Care Workers
- Risks of the Pivot Transfer to residents
- Are two caregivers better than one?

Review the topics that will be covered in this section.

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Section 1: Moving Residents – The Pivot Transfer

TYPICAL RESIDENT LIFT /TRANSFER TASKS

- Toilet-to-Chair/Chair-to-Toilet
- Chair-to-Bed/Bed-to-Chair
- Chair-to-Bathtub/Bathtub-to-Chair
- Chair-to-Scale/Scale-to-Chair

Resident transfers from one surface to another such as a toilet to a chair can pose high risks to both the caregiver and the resident. If a resident is fully capable of assisting in the transfer, the risk of injury is likely to be low. But, if the resident can only partially assist, is somewhat unstable or has diminished mental capacity, the risks can be high. This slide shows some routine transfers that CNAs and other direct care staff do dozens of times on a daily basis. In most nursing homes, one of the most common lift/transfer methods used to accomplish these tasks is the manual Pivot Transfer. If a Pivot Transfer is used, it's absolutely necessary that the resident has been accurately assessed with respect to ability to assist with the transfer.

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Section 1: Moving Residents – The Pivot Transfer

TYPICAL RESIDENT LIFT /TRANSFER TASKS

- Describe a typical resident transfer
- What resident characteristics would make it safe to do a pivot transfer?
- Advantages of pivot transfer? Risks?
- What type of resident requires a two-person transfer?
- Have you done a pivot transfer that went wrong? Any injuries?

Activity [10 minutes]: “The Pivot Transfer.” Break the participants into two or three groups. Ask them to jot down their answers to the questions of the slide on a piece of flip chart paper and to choose a facilitator/scribe. If a group finishes one question, ask them to move on to the unassigned question – there are four total. Note to Instructor: To prepare you for this discussion, read the next few pages.

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Section 1: Moving Residents – The Pivot Transfer

WHAT IS WRONG WITH THIS PICTURE?



why
cosh

Exercise [3 minutes]: Ask the class to briefly discuss the risks of this transfer. Note that the pivot transfer is still frequently used in nursing homes to move residents with decreased weight-bearing ability despite the high risk of injury to both resident and caregiver.

Section 1: Moving Residents – The Pivot Transfer

“Frequently the [pivot] transfer becomes a **manual lift**; the caregiver just lifts the patient, so that the patient’s feet barely make contact with the floor and do not bear any weight.”

Paula Pless, “A Closer Look at the Pivot Transfer” (2005)

why
cosh

Read the full quote from Paula Pless, director of the Safe Patient Handling Program at Western New York’s largest health care company with 9 hospitals and nursing homes: “Often the resident is moved from one surface to another without his or her feet moving. . . .The caregiver twists and swings the weight of the [resident] and moves him or her to the desired surfaces with the [resident’s] feet stationary. The [resident’s] body is moved in parts; the top half is moved in the opposite direction from the planted bottom half. It is the [resident’s] trunk that is actually ‘pivoted.’ Frequently the transfer becomes a manual lift: the caregiver just lifts the patient, so that the patient’s feet barely make contact with the floor and do not bear any weight.” Paula Pless. Distribute “A Close Look at the Pivot Transfer.” *Caring for the Ages*. December, 2005.

Section 1: Moving Residents – The Pivot Transfer

CAN THEY BE DONE SAFELY?

Yes, If:

- Done on a temporary basis
- Resident can stand
- Resident can bear weight
- The caregiver does no manual lifting

why
cosh

In a true and safe pivot transfer, the resident can take at least one step, unweight at least one foot during the pivot and move toward the desired target. Only a small number of residents fit this category. Before doing a pivot transfer, an assessment should be done to determine if the resident can move her/his feet on all surfaces and to all surfaces. The ability to move her/his feet should be assessed over a 24-hour period. Caregivers from all shifts should be talked to. Observe the transfers on all shifts at different times of the day.

Section 1: Moving Residents – The Pivot Transfer

RISKS TO THE CAREGIVER

- Resident becomes unstable throwing caregiver off balance
- Caregiver ends up doing an unacceptable manual lift
- Resident can't pivot on strong side due to a confined work environment

why
cosh

This transfer tends to be used repeatedly on a resident—up to 16 times in a 24-hour period. The resident's weight-bearing ability to assist with the lift can change over this period of time. The resident may be unable to adequately assist with the pivot transfer. She/he becomes an unstable excessive load. This instability can be transferred to the caregiver who is at a risk of injury. The risk of injury to the caregiver increases with a resident who has partial weight-bearing capacity and is pivoting in a confined space environment (for example, from a wheel chair to a toilet). If the confined space only allows the resident to pivot on his/her weak side, there is increased risk of injury to the resident and the caregiver.

Section 1: Moving Residents – The Pivot Transfer

RISKS TO THE RESIDENT

- Repetitive traumas, skin tears
- Damage to soft tissue supporting the joints (hips, knees)
- Exacerbation of arthritis and degenerative joint disease (shoulder joints, loss of range of motion)
- Spiral or impact fractures at hips, knees and ankles
- Deterioration of skills

why
cosh

A pivot transfer is frequently traumatic for the resident. Arthritis and degenerative joint disease is exacerbated in shoulders that are used as leverage when performing the pivot. Trauma to other parts of the body can occur. For example, if the feet don't move during the pivot transfer, the trunk rotates putting extreme stress on hip, knee, and ankle joints. After 90 days of use, according to Safe Patient Handling expert, Paula Pless, the vast majority of residents experience injuries or joint deterioration.

Section 1: Moving Residents – The Pivot Transfer

IS A TWO-CAREGIVER ASSIST SAFER?



why
cosh

Exercise [2 minutes]: Ask the participants if they believe having a second caregiver help manually lift and transfer a resident that can't be pivot-transferred by one caregiver can be done safely. Move to the next slide for further discussion.

Section 1: Moving Residents – The Pivot Transfer

IS A TWO-CAREGIVER ASSIST SAFER?

Not Really, Because:

- Resident doesn't have the required skills or ability to assist with one caregiver
- Adding a second caregiver simply means two are performing a manual lift
- Adding a second caregiver can increase the risk of injury due to awkward postures
- A mechanical lift should be used rather than a second manual lifter

why
cosh

A 2-person lift is not a true pivot transfer. It is a manual lift that exceeds the load limit whether done with one or two caregivers. Further, adding a second caregiver increases the likelihood of injury to the caregivers. As they move the resident, there are more likely to lifting, pulling and twisting. These awkward postures create excessive forces on the body that can cause acute or, over time, chronic injuries of the back and shoulders. Note, too, the stresses on the joints of the resident. If one person can't do this lift/transfer, a mechanical lift should be used.

Section 2

Assessing Residents

- Assessment and Resident Dependency
- The Assessment Decision Tree
- The SRH Assessment Tool
- Dependency Levels and Equipment
- Useful Care Guides

why
cosh

Review the topics that will be covered in this section.

Section 2: Assessing Residents

THE PIVOT TRANSFER: ASSESSING RISKS

Before doing a pivot transfer determine if...

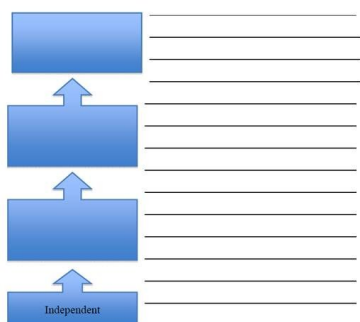
- Residents can move feet
- Resident's feet make contact with floor
- Resident has weigh-bearing ability
- Other caregivers can confirm resident is able to assist with the pivot transfer
- Any caregivers have been injured pivoting the resident off toilet or other surfaces
- The physical environment allows the resident to move with strong side first

why
cosh

From the SRH approach, a pivot transfer should not be used until we know the resident's skills and abilities to help with the transfer. Resident capabilities are determined by doing a thorough assessment using formal criteria. This is called a resident-centered approach to determining the appropriate transfer method. This slide shows some of the things that we need to know about the resident before moving him/her. In this section we will look at ways to assess residents. We will look at how an assessment tool (algorithm) can be used to evaluate a resident's capabilities. This tool will help the licensed professional who does evaluations at your facility to document the appropriate resident handling needs in the resident's Care Plan. We will also look at how CNAs and other direct caregivers can use this tool as well.

Section 2: Assessing Residents

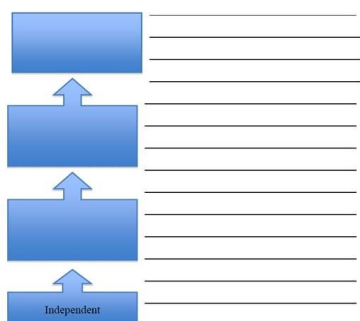
HOW DO WE ASSESS RESIDENTS?



Activity [5 minutes]: Hand out the assessment question to all the participants. Ask them to break into 2 groups and choose a facilitator/scribe and discuss the question and jot down their answers. The blanks to be filled in are the progressive levels of resident dependency. At the bottom is the independent resident who would need no or little caregiver assistance. The next level would be a first level of dependency. How is it defined at this facility? The next level? The fourth level? Go to next slide and handout.

Section 2: Assessing Residents

WHAT LIFTING/TRANSFER METHOD?



Activity [5 minutes]: Hand out the transfer question to all of the participants. Ask them to remain in their groups and to fill to discuss the question and jot down their answers. After the groups are finished, ask each facilitator to read out the answers to both questions. The blanks to be filled in are progressive levels of transfer assistance the caregiver will need to use as levels of dependency increase from 2 - 4. For each level of dependence category currently used at this facility (identified in the first handout), they should now identify the corresponding method of transfer that is used.

Section 2: Assessing Residents

WHO DOES WHAT & WHEN?

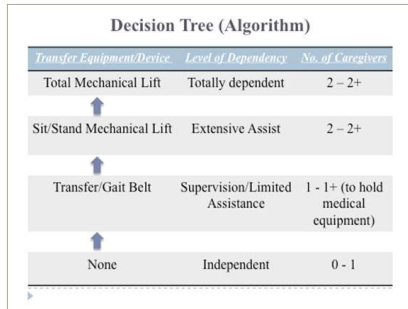
- What staff does your assessments?
- How often are they done?
- Who identifies resident changes?
- Who decides how much a resident can assist with a lift/transfer?

Activity [5 minutes]: After a brief discussion of the previous two questions, using the flip chart, ask the entire group to answer the question below and record their answers. What this exercise is likely to show is that the facility is doing limited assessments of their residents.

- What staff now does SRH assessments at your facility?
- How often are they done?
- Who identifies changes in status during the day? How is this communicated between shifts?
- Who decides how much a resident can assist in a lift/transfer when it is evaluated or re-evaluated?

Section 2: Assessing Residents

DECISION TREE (ALGORITHM)



This slide shows a “Decision Tree” or Algorithm. It’s an abbreviated version of your Safe Patient Handling Assessment Tool (hand out after this discussion). This tool can help licensed professionals assess a resident’s skill and ability to assist with a lifting/transferring/repositioning task. CNAs can also use it as a tool for noting any changes in a resident’s status and communicate that information to a licensed professional for re-evaluation. The tool is arranged like the rungs of a ladder with the lowest representing the Independent resident (usually no need for assistance). As we move up to rung 2, the resident has diminished weight-bearing capacity and will need some assistance. At rung 3, the resident has significant diminished capacity and will need a Sit-to-Stand Lift. At Rung 4, there is serious to total incapacity and a Full Mechanical Lift should be used.

Section 2: Assessing Residents

SPH/SRH ASSESSMENT TOOL;
MECHANICAL LIFTS



Hand out the SPH Handling Assessment Tool. It’s a guide for determining what mechanical lift or device is to be used (column 1) to transfer a resident from one surface to another. The tool is resident-centered. Using the Resident Assessment Criteria (column 2) allows licensed professionals and direct caregivers to determine the level of help a resident can give a caregiver when being transferred. The more dependent, the less help. As dependence increases, a mechanical lift becomes necessary. Contraindications (column 3) include special conditions such as fractures or surgeries that make use of a Full Mechanical Lift appropriate, even if the resident has partial weight-bearing ability. Slings and harnesses (column 4) are attached to the Sit/Stand and Full Mechanical Lifts; sling selection is made on the basis of ability to assist. Two caregivers (column 5) are required for all mechanical transfers (one to operate the controls and one to steady the resident).

Section 2: Assessing Residents

SPH/SRH ASSESSMENT TOOL:
REPOSITIONING



This assessment tool can also be used to determine what devices can be used to reposition residents. While Independent residents don’t require non-friction devices, a side rail or a trapeze can still be used to allow them to use upper body strength to reposition themselves. For any dependent residents, non-friction devices such as Slip Sheets or an Air Matt are appropriate. At least two caregivers are required to use these devices. A slip sheet or air matt needs to be tucked under the resident on one side and pulled from the other side before being used. Residents need to be carefully guided as they are being repositioned or transferred to prevent them from sliding off a bed or gurney.

Section 2: Assessing Residents

**LIFT/TRANSFER LEVEL #2:
SUPERVISION AND/OR GAIT BELT**

This Lift/Transfer is appropriate if the resident has the following skills and abilities:

- Full weight-bearing and able to ambulate with guidance/hands-on cueing
- Partial weight-bearing if they can take steps and move feet
- Steady
- Sound cognition
- Cooperative

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The second level of the assessment tool is Supervision/Limited Assistance. The resident is unable to make the transfer entirely by her/himself. At a minimum, the resident needs some supervision when doing a transfer or walking. The resident can't move her/his entire weight without assistance. Some residents only need supervision — minimal guidance, cueing, or light hands-on steadying.

Section 2: Assessing Residents

**LIFT/TRANSFER LEVEL #2:
SUPERVISION AND/OR GAIT BELT**



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Limited assistance from the caregiver is required if the resident is partially weight-bearing and remains steady on her/his feet. A Gait Belt can be used to do a pivot transfer if the resident is capable of moving her/his feet. To determine if a pivot transfer using a Gait Belt is appropriate, have the resident demonstrate to you over a 24-hr. period that she/he can move his/her feet on all surfaces and to all surfaces. Also, talk to other caregivers and observe the transfers on all shifts at different times of the day. Make sure the resident can understand the caregiver's instructions, cueing, or coaxing and is cooperative before doing this level of transfer. Use a mechanical lift if there is impaired cognition or non-cooperation.

Section 2: Assessing Residents

**LIFT/TRANSFER LEVEL #3:
SIT-TO-STAND LIFT**

Move up the Decision Tree ladder to this Lift Type solution if the Pivot Transfer with Gait Belt is not safe. The Sit/Stand is appropriate if the resident has the following skills and abilities:

- Partial weight-bearing in one/both legs (30–60%)
- Can hold on handles with one or both hands
- Cooperative
- Can move supine to sit
- Partial weight-bearing resident needing repositioning in non-reclining chair

wny
cosh

Extensive assistance is required from the caregiver if the resident lacks the ability to bear all her/his weight or move her/his feet. A pivot transfer is inappropriate because the resident puts too much weight on the caregiver. In a confined space like a toilet, a pivot transfer will subject the caregiver to awkward postures and the resident to stress of the hip, knee and ankle joints if the feet are planted and the trunk twisted. If extensive assistance is required, the caregiver should move up the decision tree and consider a Sit to Stand Lift. It can be used if the resident has 30% - 60% weight-bearing capacity. If the resident is unable to hold onto the lift, then a harness needs to be selected to promote safety and comfort. Cooperation needs to be maintained throughout the transfer. Residents with dementia may still be able to use this lift if they can respond to simple commands ("hold on," "stand up"); an incremental approach, adding a step each day, may work.

Section 2: Assessing Residents

LIFT/TRANSFER LEVEL #3:
SIT-TO-STAND LIFT



The resident should be able to move from supine to sit position when being transferred from a bed to the Sit to Stand Lift. If the resident can't assist with this move, the caregiver should not pull the resident up as this becomes a risky manual lift. Some residents who can't assist may be lifted using a Full Mechanical or a Ceiling Lift and transferred from the bed to a chair and then to the Sit to Stand Lift. Contraindications for use of certain Sit to Stand harnesses include abdominal aneurism, stomas, skin integrity issues, colostomies, spinal fractures, and a pet tube site. These conditions could prevent the use of a harness that fits snugly around the waist. Two caregivers should be present when using the Sit to Stand Lift. One can assist the resident and the other work the controls. The Sit to Stand lift should only be used in the resident's room. Do not use it to move a resident out of her/his room down a hallway due to the push-pull forces on the caregiver. Use a wheel chair for this purpose.

Section 2: Assessing Residents

LIFT/TRANSFER LEVEL #4:
FULL MECHANICAL LIFT

Move up the Decision Tree ladder to this Lift option if the Sit/Stand Lift option is unsafe. This Lift is appropriate if the resident has the following characteristics:

- Non-weight bearing
- Unable to balance on end of bed
- Non-weight bearing resident needing assistance
- Repositioning in a non-reclining chair

Fully Dependent residents require a Full Mechanical Lift. Non-weight bearing residents who are unable to sit on the edge of a bed, will not be able to safely use a Sit to Stand Lift. A Full Mechanical Lift can be used with a variety of slings. The slings can be attached to the Lift; some use a hook and loop arrangement and some a clip attachment. Full Body Slings provide head and neck support dependent residents often need. Universal Slings can be used for transfers from bed to chair and other surfaces. A Hygiene Sling can be used for transfers from a bed or chair to a toilet—it allows caregivers to toilet the resident without removing the resident from the sling. This lift can also be used above the bed to lift the resident. It can also be used to rotate the resident in bed to perform hygiene tasks, give injections, and other tasks.

Section 2: Assessing Residents

LIFT/TRANSFER LEVEL #4:
FULL MECHANICAL LIFT



Cooperation and comprehension is not essential for the use of the Full Mechanical Lift because when the resident is in the sling, there's minimal contact between the caregiver and the resident. It's important that the caregivers calm and reassure the resident. There are no contraindications with the Full Mechanical Lift except for residents with suspect spinal fractures after a fall or for those who have had total hip replacements. A Full Mechanical Lift can be used on residents with spinal injuries using a special sling with backboards in them. For residents with hip fractures, a Full Mechanical Lift can be used if they are not put in a full-seated position and a regular or an abductor pillow is used between their legs. Two caregivers must be involved in the use of a Full Mechanical Lift.

Section 2: Assessing Residents

RESIDENT CARE GUIDES

- Documents Licensed Professional's assessment of each resident
- Covers resident's skills and abilities to assist with lift/transfer and repositioning
- Has specific recommendations on transfers, bed mobility, and toileting
- SRH Assessment Tool a method for making good assessment
- Recommendations to be used by CAN when transferring/repositioning

Resident Care Guides are the "user-friendly" version of the Resident Care Plan that all nursing homes are mandated to keep on each resident. They are used by CNAs or other direct caregivers when caring for residents in their charge. When a resident first enters a nursing home, they are assessed/evaluated by a licensed professional such as a Physical Therapist. The resident is assessed for her/his ability to perform tasks such as bathing, grooming, and eating. These are documented in the Care Plan. A resident's level of ability to assist with handling tasks such as transfers, bed mobility, ambulation and toileting should also be assessed and documented in the Care Plan/Care Guide. The Resident Assessment Tool (or algorithms developed by the Veterans Administration) should be used to guide the assessment process. The resident's level of ability to assist with handling tasks should be documented: level of dependence, slings to be used, the number of caregivers required, and any contraindications. The Care Guides should be easily accessible to CNAs or other caregivers. They are confidential and should not be visible to visitors. Posting the Care Guide inside the resident's closet door or some other convenient location is desirable. A good Care Guide should be concise and clear, giving the CNA or other direct care staff the specific information they need to safely transfer, reposition, walk and toilet each resident in her/his care.

Section 2: Assessing Residents

RESIDENT CARE GUIDES

Independent
Supervision/Limited Assistance
Extensive Assistance
Fully Dependent Resident

Activity [20 Minutes]: Before doing this exercise, obtain representative Care Plans/Care Guides used at this facility. Get one each for an Independent, Supervision/Limited Assistance, Extensive Assistance and Fully Dependent Resident. Make copies and distribute to the participants. Also use the next 4 slides and/or make copies of the Sample Care Guides. Explain that these Care Guides give the information that a CNA or other direct caregiver needs to safely handle a resident. Ask the participants to compare their Care Guides to the ones you have provided with respect to handling tasks for each level of dependency. How do their Care Guides compare? Is there information missing from their Care Guides that might help the caregiver conduct handling tasks more safely?

Section 2: Assessing Residents

INDEPENDENT RESIDENT

TRANSFER	Independent for Transfer
BED MOBILITY	Two Siderails Up Independent for Bed Mobility
AMBULATION	Independent Ambulation On/Off Unit
WHEELING	Does Not Use Wheelchair
TOILETING	Independent for Toileting
CONTINENT OF BOWEL AND BLADDER	Monitored and Recorded BMs Every Shift

Review Care Guide category.

Section 2: Assessing Residents

SUPERVISION/LIMITED ASSIST RESIDENT

TRANSFER	Limited 1 Assist w/ Gait Belt
BED MOBILITY	Independent for Bed Mobility
AMBULATION	Ambulate on Unit w/ Rolling Walker and Gait Belt – Limited 1 Assist
WHEELING	Staff to Propel Wheelchair Off Only
TOILETING	One–Person Physical Assist
CONTINENT OF BOWEL AND BLADDER	Urinal w/in Reach Monitor Bowl Movements

Review Care Guide category.

why
cosh

Section 2: Assessing Residents

EXTENSIVE ASSISTANCE RESIDENT

TRANSFER	Sit to Stand Lift Transfer w/ 2 Assist Using Medium Blue Band Swing
BED MOBILITY	Two Rails Up; Limited 1 Assist Rolling; Extensive 1 Assist Supine to Sit with Rail; Turn and Position Q2HRs and PRN; Extensive 2 Assist Boosting Using Non–Friction Sheet
AMBULATION	Non–Ambulatory
WHEELING	Manual Wheelchair w/ Gel Cushion; Staff to Propel On/Off Unit
TOILETING	See Transfer Status; Extensive 1 Assist for Incontinent Care Every 2 Hours and PRN; Brief OOB; Vaseline to Buttocks After Care; Monitor and Record BMs Every Shift

Review Care Guide category.

why
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Section 2: Assessing Residents

TOTAL DEPENDENCE RESIDENT

TRANSFER	Full Mechanical Lift Transfer; 2 Person Assist w/ Medium 6 Strap Sling
BED MOBILITY	Total 2 Assist for Bed Mobility; Total 2 Assist for Bed Mobility, Boosting with w/ Non–Friction; Reposition Resident in Bed; Reposition Q3H and PRN in Bed; 2 Full–Padded Side Rails; Bilateral I.F.'s with Pillows on Outside of Knees; Heel Booties on Both Heels; Place Rolled Up Pad Under Lower Legs to Elevate Heels Off Bed; Elevate UE's on Pillows in Bed at all Times in Bed
AMBULATION	Non–Ambulatory
WHEELING	Staff to Propel All Destinations in W/C with Seat Belt and Chest Harness; All Straps Secured
TOILETING	Two–Person Physical Assist for Incontinent Care; Peri–Care w/ Each Incontinent Episode; Q3H + PRN; Vaseline w/ Care; Monitor Bowl Movements Daily; Bowel Management Program;

Review Care Guide category.

why
cosh

Section 2: Assessing Residents

THE NEED FOR CONTINUOUS RESIDENT ASSESSMENT

Resident dependency status may change:

- During the day
- From shift-to-shift
- Over time

As the dependency level changes, the Decision Tree should be used to reassess the resident's transfer status

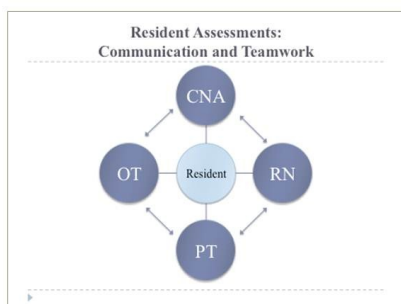
CNAs are in a key position to detect changes in resident status and make recommendations for resident re-evaluation

The Decision Tree can be used on a daily basis. A resident's degree of dependency often changes over time. For example, a resident who was assessed as "independent" upon admission may become more dependent over a few months. A resident's status can even change during the course of the day or from one shift to another. As dependency changes, so do risks to the caregiver and the resident. Therefore, the equipment or the number of staff needed to do a transfer may also need to change. CNAs who are giving direct care are often in the best position to observe these changes and use the decision tree. They should be encouraged to report their observations and recommendations for a change in transfer status to a nurse or other licensed professional.

why
cosh

Section 2: Assessing Residents

COMMUNICATION AND TEAMWORK



Resident assessments should be a team effort. Because a resident's capabilities may change, it is important that all staff involved play a role in the assessment process. Only licensed professionals such as Physical Therapists, Occupational Therapists, RNs or LPNs can make the formal assessments which are documented in the Care Plans/Care Guides. But direct caregivers such as CNAs are involved in routine daily care and are most likely to observe changes in a resident's skills and abilities. Using the SRH Assessment Tool/Decision Tree, they are in a position to seek authorization from a licensed professional for a change in transfer, repositioning assists or slings that are needed to do a handling task safely.

why
cosh

Section 2: Assessing Residents

Steps to Reduce Risks in a Safe Resident Handling Environment

Note to instructor: hand out fact sheet. Inform the class that this fact sheet summarizes the steps that should be followed for reducing risks in a Safe Resident Handling environment. It's for their use and will not be discussed in this session.

why
cosh

Section 3

Safe Resident Handling Policy

- Safe Resident Handling Policy
- SRH Policy Objectives
- SRH Roles
- SRH Policy Outline

why
cosh

Review the topics that will be covered in this section.

Section 3: **Safe Resident Handling Policy**

SAFE RESIDENT HANDLING POLICY

Policy: “A principle or rule to guide decisions and achieve rational outcomes.”

SRH Policy: “A policy and practice that creates a safe environment for patients and health care workers by eliminating hazardous manual lifting tasks. Transferring and repositioning patients is accomplished by using new technologies in mechanical lifting and repositioning devices.”

NYS Zero-Lift Task Force

why
cosh

Instructor’s Note: Read the slide. Explain to the participants that the purpose of this session is to give them some guidance for writing their SRH policy, procedures and protocols. Your SRH policy establishing the expectation that frontline workers will use safe handling practices when transferring or repositioning residents. It requires that management provide the equipment and resources to make it unnecessary to manually lift residents. It spells out the role of the SRH/Ergo Team in implementing, monitoring evaluating and improving the SRH program. Finally, a SRH policy establishes the protocols for assessing residents and procedures to be followed when using mechanical lifts and other devices to transfer or reposition residents. All staff should be familiar with your SRH policy and receive training on how to carry out their tasks safely by following your policy guidelines. The purpose of your policy is not to punish but to educate staff. Failure to follow the policy often indicates a staff member needs retraining.

Section 3: **Safe Resident Handling Policy**

SRH PROGRAM OBJECTIVES

Question:

What do you want your program to achieve?

- To increase resident quality of care
- _____
- _____
- _____
- _____
- _____

why
cosh

Exercise [5 minutes]: Ask the participants, as a group, to brainstorm about some objectives they would like to see their SRH program achieve. After brainstorming, ask the group to report back their ideas and write them on the Flip Chart.

Section 3: Safe Resident Handling Policy

SRH PROGRAM OBJECTIVES

SAMPLE:

What do you want your program to achieve?

- To increase resident quality of care
- To perform safe/comfortable mechanical Lifts/transfers for residents
- To reduce the frequency of manual lifting/transferring and repositioning
- To reduce and prevent caregiver work-related injuries
- To reduce lost work time hours related to staff injury or fatigue

wny
cosh

Review the slide noting some objectives that they may not have considered that they may (or may not) want to consider adding to their list.

Section 3: Safe Resident Handling Policy

ROLES AND RESPONSIBILITIES:
MANAGEMENT

Question:

What does your policy need to say about Management's responsibilities for you to achieve your objectives?

- Administration shall support implementation of this policy and promote a Culture of Safety
- _____
- _____
- _____
- _____

wny
cosh

Activity [15 minutes]: Hand out the "Roles and Responsibilities Questions." Explain to the group that an important part of their policy is to assign roles and responsibilities for the SRH program to key players: Employees, Management, and the SRH/Ergonomic Team. Break the participants into three discussion groups. (Suggestion: one group of just direct care workers; one group of just employers; one group of both; ask employer to suggest roles of direct care workers and employees the roles of managers and the mixed group to recommend roles of the SRH/Ergo Team. Each group should choose a facilitator/scribe and to record suggestions on a Flip Sheet. After 10 minutes, ask each group to report back. Show the next 2 slides before you break them up into groups.

Section 3: Safe Resident Handling Policy

ROLES AND RESPONSIBILITIES:
EMPLOYEES

Question:

What does your policy need to say about the Employee's responsibilities for you to achieve your objectives?

- Use approved mechanical lifting/transferring devices for resident transfers
- _____
- _____
- _____
- _____

wny
cosh

Review slide. Move to next slide.

Section 3: Safe Resident Handling Policy

**ROLES AND RESPONSIBILITIES:
SRH/ERGO TEAM**

Question:

What does your policy need to say about your Team's responsibilities for you to achieve your objectives?

- The SRH/Ergo Team shall support implementation of this policy and promote a Culture of Safety
- _____
- _____
- _____
- _____
- _____

why
cosh

Review slide.

Section 3: Safe Resident Handling Policy

**SRH HANDLING POLICY:
SAMPLE OUTLINE HANDOUT**

Policy Objectives

Roles and Responsibilities

Protocols

- Resident Assessment
- Care and Management
- Safety
- Infection Control
- Complications/Reportable Incidents

Compliance

Documentation

Procedures

why
cosh

Activity [10 minutes]: After discussing their “Roles and Responsibilities” recorded on their Flip Chart sheets, hand out the SRH Policy Sample Outline. Ask them to look at some ideas that they might want to consider when they write their policy. Take a few minutes to go through the outline. Read each heading and ask the Team to glance over the suggestions of what would be covered under each. Invite them to comment or raise questions about any of this. Explain that this is a suggested outline. Other sample policies are in the Appendix. The SRH written policy they adopt should be their own.

Section 4

**SRH Evaluation, Competency,
Evaluation and Monitoring**

- Direct Care Worker and SRH Training
- Competency Evaluation
- Mentoring
- Evaluating
- Monitoring

why
cosh

Review the topics that will be covered in this section.

Section 4: SRH Evaluation, Competency, Evaluation & Monitoring**OVERVIEW:
STAFF TRAINING/MONITORING FORMAT**

- 3-Hr Staff Competency Training
- By Unit in Groups of 15
- Initial Competency Evaluation
- Role of Preceptors/Evaluation
- Retraining

wnv
cosh

Your SRH/Ergo Team will play a key role in SRH training and mentoring your direct care staff on the “what,” “why” and “how” of your SRH program. As “trained-trainers” members of your team will be able to train direct care staff on SRH policy and on equipment. You are also in a position to act as preceptors (“mentors”/“coaches”/“super users”) for the trained staff, providing on-floor learning. You will also be in a position to identify others (unit supervising nurses, in-service trainer, PTs, etc.) who are willing to “champion” your program and might serve as preceptors. The training model is designed to provide both “baseline” knowledge and long-term learning. All staff and new-hires who have not been trained on the equipment will participate in 3-hr. competency training. It is advised that this be followed with a 12-week preceptor program, followed by an evaluation, before allowing newly-trained staff to use the equipment on their own. Retraining should be available to those w/ poor evaluations.

Section 4: SRH Evaluation, Competency, Evaluation & Monitoring**COMPETENCY TRAINING:
1 – 1 ½ HOUR CLASS**

- Myths of “Safe Manual Handling”
- Body Mechanics/NIOSH Lift Formula
- Ergo Risk Factors (Pivot Transfer)
- Anatomy of an Injury
- SRH Philosophy Overview
- Resident Assessments/Care Plans

wnv
cosh

Your Team will want to set up the SRH training program unit by unit. Your Team will want to work with your unit managers and in-service trainer to plan the sessions. Unit trainings should be broken down into a manageable number of trainees (15 appears a workable number). Equipment and other assistive devices should be available on the unit when you start your training. The 1-hr. classroom instruction of training will focus on the risks and injuries of manual resident handling and the SRH alternative. Fact sheets and other materials will be distributed to the trainees.

Section 4: SRH Evaluation, Competency, Evaluation & Monitoring**COMPETENCY TRAINING:
2-HOUR HANDS-ON**

- Sit-to-Stand Lifting/Slings
- Full Mechanical Lift/Slings
- Ceiling Lift/Slings (If Available)
- Slip Sheets
- Air Mats

wnv
cosh

Your Team/In-Service Trainer will conduct a 2-hr. hands-on demonstration of the equipment. Members of the Team who have completed the Train-the-Trainer program will be in a position to lead a hands-on demonstration of the safe uses of equipment, devices and slings. Each class participant will have the opportunity to operate the equipment with co-participants standing in as residents. Materials containing information and photos of the step-by-step use of the equipment and the OSHA Guidelines section on the safe use of equipment will be distributed to the participants. The Procedures part of your facility’s policy will also be distributed to all participants.

Section 4: SRH Evaluation, Competency, Evaluation & Monitoring**MONITORING FOR COMPETENCY**

- 3-Hour Competency Training Exam
- Preceptor Evaluation of Caregiver
- Annual Evaluation
- Don't Discipline – Coach. Retrain.

why
cosh

Your Team will want to ensure that the staff is using proper procedures when using equipment. Following the 3-hr. competency training, you will want to conduct a brief competency audit of each frontline worker. The participants should be able to demonstrate that they have a basic understanding of how to use the lifts and other assistive devices. You can use a competency audit [distribute the SRH SAMPLE AUDIT TOOL and briefly discuss] after 30 or so days into the preceptor mentoring period. At the end of the 12 week preceptor mentoring phase, you will want to conduct a more comprehensive evaluation. This will be discussed in a few minutes. Remember: failed evaluations indicate the need for coaching/retraining.

Section 4: SRH Evaluation, Competency, Evaluation & Monitoring**TRANSITION ONTO THE UNITS**

- Schedule a day the equipment will be delivered on the floor
- Go Live! Announce to the unit that they are now a SRH facility
- SRH/Ergo Team holds a brief unit meeting
- Obtain consensus on Park & Charge Areas
- Label all equipment/slides
- Explain rotation system for slings
- Explain preceptor program/introduce
- SRH/Ergo Team members, Point Person, SRH coaches, super-users

why
cosh

To create a smooth transition to each unit, your Team should work up a detailed work plan. You may want to use the outline on this slide as a work plan guide. Schedule and announce the “Go Live” day with each unit (or more than one unit if they’ve used the equipment previously). Set up brief unit meetings with each unit [allow 10 minutes/meeting]. Explain the preceptor program. Set ground rules: new trainees should not use the equipment on their own until they have mentored with designated preceptors (SRH/Ergo Team members, other “coaches”/“super users,” or an SRH Point Person). Have labels for equipment and slings made up beforehand and label all equipment and slings.

Section 4: SRH Evaluation, Competency, Evaluation & Monitoring**MONITOR/LEAD/LEARN**

- Lead/Coach by Example
- Observe/Discuss Mistakes
- Evaluate Performance
- Audits

why
cosh

Direct caregiver “buy in” into your SPH program will move your facility toward the goal of creating a SPH Safety Culture. This begins with having a good 12-week preceptor program. Your Team, “coaches,” “and/or “Point Person(s)” can lead by example. Bad habits and mistakes among the staff should be pointed out and corrected--failure to correct will be taken as a sign that it's OK to ignore SPH policy. If staff isn't using equipment and slings because of inaccessibility, poor repair, or inadequate staffing so 2 caregivers aren't available to use the lifts and other assists properly, it's important for the Team to address these barriers. To demonstrate competency of frontline workers, in addition to an evaluation 30 days into the preceptor program, a second comprehensive evaluation at the end of the 12-week program should be considered using an evaluation tool. Finally, your Team will want to ensure there is an audit of your Care Plan/Guides by a unit charge nurse or others designated by your Team [see: Sample audit form].

Section 5
After Action Reviews

- After Action Review: Getting at the Root Causes
- The After Action Review Process
- Practicing on AAR

Review the topics that will be covered in the section.

why
cosh

Section 5: After Action Reviews
AFTER ACTION REVIEWS

A means for caregivers to share information with co-workers and supervisors about:

- An injury that has occurred as a result of resident handling
- A near-miss incident
- Failure to follow policy
- Failure of equipment
- An unexpected positive outcome

An After Action Review (AAR) process is a way of dealing with the fact that sometimes things go wrong. A piece of equipment malfunctions. A resident who's assessed as "limited assistance" faints as she's being steadied by her caregiver. Or a caregiver, under time pressure, does a sit-stand pivot when equipment should have been used. In these situations a caregiver or resident may get hurt or just escapes getting hurt. AAR allows for continuous improvement of your SRH program by recognizing a problem such as an injury or near-miss and taking the question head-on as to what needs to improve so it won't happen again. AAR can also be used to discuss something unexpected that happened that actually improved your program (for example: caregivers sharing information on a better way of communicating a transfer with a difficult resident).

why
cosh

Section 5: After Action Reviews
CONDUCTING AN AFTER ACTION REVIEW

- Honest exchange
- Informal and brief
- SRH Point Person may lead
- No finger-pointing: take a team approach
- Focus on adjusting the program to prevent future incidents

AARs are similar to "chalk talks" where players and coaches gather around a chalk board post-game to evaluate the team's performance. The focus is on what went right and what went wrong and how, as a team, they can improve their game next time. After an incident occurs and is reported to a Point Person or a supervisor, a brief meeting of the caregivers on the unit should be scheduled. The Point Person may want to do this and open the discussion. The person leading the AAR should assure everyone there will be no finger-pointing or retribution for discussing the incident honestly. The key point of the AAR is to get at the root cause. For example, if a caregiver can't get to the equipment in a timely manner and does a manual transfer, the question to address is: "How do we adjust the program so the equipment is accessible and used?" Incidents that trigger AAR reviews should be shared with the SRH/Ergo Team. This will allow your Team to make adjustments in the SRH program to make compliance more likely.

why
cosh

Section 5: After Action Reviews**THE AAR PROCESS**

After Action Reviews Address:

- What happened?
- What was supposed to happen?
- What accounts for the difference?
- How to avoid a same future outcome?
- What's the follow-up plan?

why
cosh

Exercise [10 minutes]: Distribute the AAR Case Study. Explain that this scenario would be a fairly typical problem. When moving through the AAR process, following the outline on the slide will allow the group to find a resolution to the problem. You may want to have the participants read through the case study. Have each of your participants take the role of one of people involved (Sue, Nancy, Ron, etc.) and read from the script. Because AAR's should be shared with, and reviewed by, your SRH/Ergo Team it's important to have a record of the meeting. Ask someone to take notes as the case is being role-played and read them back to the rest of your Team. After the participants have gone through the case, have a brief discussion and ask the team to evaluate this process and if it would work at this facility

Notes

Notes

MODULE SIX:
Safe Resident Handling Train-the-Trainer Program

AGENDA

PART ONE: **ADULT TEACHING AND TRAINING TECHNIQUES** (50 Minutes)
Activity: "What Are My Biggest Fears as a Trainer?"
Activity: "Non-Verbal Communication is Important"

— 10 Minute Break —

PART TWO: **SRH/ERGONOMIC TEAM APPRENTICE**
Activity: "Training Practice"

Section 1: **An Overview of Safe Resident Handling** (20 Minutes)
Handout: "Myth or Fact?"

Section 2: **Body Mechanics and Lifting Limits** (20 Minutes)
Exercise: "What Are Good Body Mechanics?"
Exercises: "What's Wrong With This Picture?" (3 Parts)

Section 3: **Anatomy of an Injury** (20 Minutes)
Activity: "Draw a 'Body Map'"

Section 4: **Controlling Risk Factors** (20 Minutes)
Activity: "Resident Handling Risk Factors"
Activity: "The Pivot Transfer"

— 10 Minute Break —

Section 5: **Resident Assessments** (20 Minutes)
Handout: "Safe Patient Handling Assessment Tool"

Section 6: **Safe Resident Handling Policy** (15 Minutes)
Handout: "Safe Resident Handling Policy"

Section 7: **Safe Resident Handling: "Changing the Culture"** (15 Minutes)
Handout: "Old Practices/Evidence-Based Practices"

PART THREE: **HANDS-ON EQUIPMENT DEMONSTRATION AND PROCEDURES** (145 Minutes)
Handout: "Hands-On SRH Equipment/Devices Photos & Procedures"

EVALUATION (5 Minutes)

Module Six
**Safe Resident Handling/Ergo Team
Train-the-Trainer Program**

This Module will be broken into three parts:

- Part One: Adult Learning and Training Techniques
- Part Two: SRH/Ergo Team Training Practice
- Part Three: Hands-On Demonstration of Equipment Use

Module Six
**Safe Resident Handling/Ergo Team
Train-the-Trainer Program**

PART ONE:
Adult Learning and
Training Techniques

Adult Teaching and Training Techniques

AGENDA:

- Adult Learning Principles
- Multiple Intelligences
- Teaching Methods
- Dealing with Problem Participants
- Preparing to Teach
- Evaluating Your Training

Review agenda items for this section

Adult Teaching and Training Techniques

OBJECTIVES:

Participants will be able to understand...

- How adults learn
- The different way people learn
- How to use various teaching methods
- What techniques can be used to deal with problem participants
- The importance of preparation and of evaluation

wny
cosh

Review objectives for this section.

Adult Learning and Training: What, Me Worry?

- What are my biggest fears about being a trainer?
- What will help relieve my fears and improve my self-confidence?

wny
cosh

Exercise [5 minutes]: Using the Flip Chart, write across the top the two questions: “What makes me fearful?” and “What will relieve my fear?”

Explain to the participants that most of us aren’t natural trainers. We learn through preparation and practice how to be trainers. It is normal to be nervous at first--to feel threatened by your audience. This brief exercise will get some of the things that threaten each of us out in the open. And it’s an opportunity to begin to think about what each of us needs to know and do to relieve our fears. In this session, we will look at some of the things that will make us more self-confident.

Adult Learning and Training

ADULT LEARNING PRINCIPLES

- Focus on “real world” problems
- Emphasize how the learning can be applied
- Relate learning to the learners’ goals
- Relate materials to learners’ experiences
- Allow the debate and challenge of ideas
- Listen to/respect learners’ opinions
- Encourage learners to be resources to you and each other
- Treat learners like adults

Source: Nellie Brown, MS, CIH
Nancy Lampen, MS

wny
cosh

You will be teaching SPH principles and practices to your coworkers. As adult learners, they are interested in real world problems--the hard and risky work they do every day. You can talk to them about practical ways a SRH program will make their work safer and easier. The direct caregivers you are training will be familiar with manual handling and some equipment. What you will be providing is new information about how they can avoid most manual handling tasks and how they can effectively use equipment to accomplish those tasks. Some trainees will likely raise questions and challenge you. They may doubt that they will have time to use the equipment or that manual handling isn’t bad because they’ve been doing it for years. Be respectful of their positions--time pressures and short staffing are real issues. Ask them what solutions they would propose. You need to make the case that SRH may take more time, but make their tasks easier and safer in the long run.

Adult Learning and Training

ADULT LEARNING PRINCIPLES

Excellent Training Is:

- EFFECTIVE: Accomplishes specific objectives
- EFFICIENT: Meets objectives w/o wasting time
- ENGAGING: Is an environment for adult learning –builds on knowledge & experience of the learner

wny
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Review slide contents.

Adult Learning and Training

HOW ADULTS LEARN

Adults:

- Voluntary learners
- Learn faster what they need most
- Have a lot of life experiences
- Need to be treated with respect
- Learn more when they participate

wny
cosh

Voluntary learners: most adults learn because they want to; they learn best when they've decided they need to learn for a particular reason. **Learn fastest what they need most:** adults need to see that the subject matter and the methods are relevant to their lives and to what they want to learn. They have a right to know why what they are learning is important to them. **Come with a good deal of life experience that needs to be acknowledged:** They should be encouraged to share their experiences and knowledge. **Need to be treated with respect:** They resent an instructor who talks down to them or ignores their ideas and concerns. **Learn more when they participate in the learning process:** Adults need to be involved and active participants in the class.

Adult Learning and Training

HOW ADULTS LEARN

Adults:

- Learn best by doing
- Need to know where they're heading
- Learn best when new information is reinforced and repeated
- Learn better when information is presented in different ways

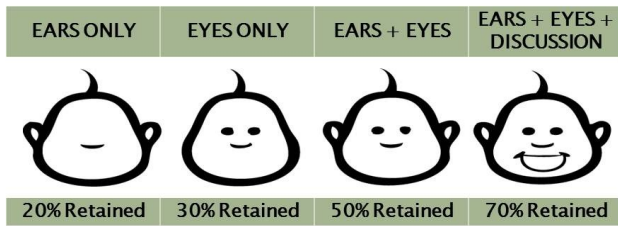
wny
cosh

Source: National Labor College, 11/2008

Learn best by doing: Adults need to “try-on” and practice what they are learning. They will remember better when they use and practice their knowledge and skills in class. **Need to know where they're heading:** Learners need “route maps” with clear objectives. Each new piece of information needs to build logically on the last. **Learn best when new information is reinforced and repeated:** Adults need to hear things more than once. The need time to master new knowledge skills and attitudes. They need to have this mastery reinforced at every opportunity. **Learn better when information is presented in different ways:** They will learn better when an instructor uses a variety of teaching techniques.

Adult Learning and Training

HOW ADULTS LEARN: OUR SENSES



EAR + EYES + DISCUSSION + PRACTICE + USE =
90% Retained

wnv
cosh

Our senses play a large part in how much information we retain in a learning environment. Each individual has a preferred learning style, of course, but when we apply the knowledge we have acquired we remember much more. The illustration on the slide depicts the impact of our senses on our ability to retain information.

Adult Learning and Training

ADULT LEARNERS ARE SMART IN DIFFERENT WAYS

Word Smart
Picture Smart
Body Smart
People Smart
Music Smart
Nature Smart
Self-Smart

wnv
cosh

The Theory of Multiple Intelligences: Most of us have some of the 8 intelligences listed on the slide. But mounting scientific evidence shows that most people excel in one or two and tend to prefer these. As instructors/facilitators, it is important to remember that some of your participants will learn best through lectures and reading, others through mathematical formula ("statistics", graphs), still others through pictures ("diagrams" and illustrations), discussion of issues or principles with others or through hands-on practice of skills. This is why it's good to combine different teaching techniques to reach your audience: power point, lecture, flip chart, group discussion, hands-on practice, etc.

Adult Learning and Training

MULTIPLE INTELLIGENCES PLANNING SHEET

Linguistic
Intrapersonal
Interpersonal
Logical/Mathematical
Visual/Spatial
Musical
Body/Kinesthetic
Naturalistic

wnv
cosh

When planning your Team's training, remember that your audience likely has a variety of "intelligences" or learning styles. Try to think about how you might "pitch" your message, using a variety of techniques. **Linguistic** ("word smart"): "How can I use the spoken word?" **Visual/Spatial** ("picture smart"): "How can I use visual aids, visualization, color, art or metaphor?" **Musical**: "How can I bring music or environmental sounds or set key points in a rhythmic or melodic framework?" **Body/Kinesthetic** ("body smart"): "How can I involve the whole body or use hands-on experiences?" **Naturalistic**: "How can I bring in nature sounds or help students to relate new learning's to natural phenomenon or occurrence?" **Logical/Mathematical**: "How can I bring in numbers, calculators, logic, classifications or critical thinking?" **Interpersonal**: "How can I engage students in peer sharing, cooperative learning, or large group learning, or large group simulation?" **Intrapersonal**: "How can I evoke personal feeling, memories, or give students choices?"

Adult Learning and Training

TEACHING METHODS TO BE USED IN THIS SRH TRAINING PROGRAM

- Lecture
- Power Point

wny
cosh

Lecture: Much of this curricular material is factual. You will present some of it in a straight-forward logical manner. Don't read what's in this manual word for word--put it in your own words. Remember, your audience is passive; as you talk, ask questions, use the flip chart. The objective of your lecture is to give them practical information they can apply to their tasks.

Power Point: This curriculum provides you with power point slides. The slides are designed to allow you to communicate visually. They will also allow you to organize the main points you want to make. Don't turn your back on your audience and simply read the slide. Do use the slides for commentary, explanation and discussion.

Adult Learning and Training

TEACHING METHODS TO BE USED IN THIS SRH TRAINING PROGRAM

- Flip Chart
- Hands-on Practice

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Flip Chart: This curriculum allows you to use Flip Charts. They are a visual aid that helps people to remember. The flip chart can be used to jot down participants' answers (just jot down key points). They also can be used for brainstorming an issue. The Flip Chart makes participants feel like they've contributed to the discussion—an important tool for adult learners.

Hand-on Demonstration: After you complete the classroom training, you will move out onto the floor, and do the hands-on equipment/assist device part of your training. The hands-on demonstration allows you to show your frontline workers the proper steps and procedures for using the equipment. They will then demonstrate their ability to use the equipment, with members of the class playing the role of the residents. Learning by doing is an effective teaching tool.

Adult Learning and Training

PERSONAL PRESENTATION TIPS

- Be yourself
- Think of the learners as a group of friends who want you to succeed
- It's how you say it
- Non-verbal communication is important

wny
cosh

Here are a few tips: Be yourself: Don't borrow someone else's style. The learners are your friends: Think of the learners as friends who want you to succeed. It's normal to feel nervous when you first start to train. Your nervousness will disappear if you concentrate on your message and remember that you are having a conversation with co-workers.

It's how you say it: 60% or more of your message is conveyed not in what you say, but how you say it according to researchers. Acceptance of your ideas depends on the learners' perception of your integrity, conviction, credibility, and confidence. A lot of this is communicated non-verbally.

Adult Learning and Training

NON-VERBAL COMMUNICATION IS IMPORTANT

Is Non-Verbal Communication Important to You?

What Do You Find Annoying?

What Do You Find Holds Your Attention?

why
cosh

Exercise [3 minutes]: Ask the Team to briefly respond to the questions on the slide and jot their answers down on the flip chart. Then look at some guidelines that generally improve effective communication of your message. Non-verbal communication is important: **Stance:** Walk to front of the room--shoulders back, hands at side, head erect. Face forward, feet shoulder width apart, shoulders back, hands at side/ready to gesture. **Eye Contact:** Establish eye contact with a learner in each part of the room in a random pattern. Sustain eye contact--3 - 5 seconds at a time. Watch for non-verbal reactions (nods, quizzical looks) and alter the pace of your presentation accordingly. Ask questions when appropriate. **Gestures:** Leave your hands unclasped. Gesture as you would in a normal one to one conversation and from the waist up. Use natural facial expressions. Remember to smile.

Adult Learning and Training

TIPS FOR LARGE GROUP ACTIVITIES

- Begin with an overview
- Use our own words
- Don't be afraid of questions
- Make information relevant
- Use the flip chart for making points
- Don't turn your back to read slides
- Make eye contact with learners
- Move around the room; vary voice
- Involve participants
- Encourage questions

why
cosh

You will be presenting Part Two of this module to a class of about 15 frontline workers. It's always good to let them know at the beginning what you are going to cover ("agenda") and what you want them to get out of it (objectives). When you go through Part Two, try not to read word for word what's written down next to your slide; review the material beforehand and use your own words and example--if you can talk about things at your own facility that they relate to, that makes it more relevant. Use the flip chart now and then. Try not to turn your back to read the slides to them. It's OK to pause and to check these notes. Make eye contact with your audience as much as possible. Move around the room and vary your voice and gestures. Get the participants involved and invite questions and pose questions. There are no stupid questions. If you can't answer a question, be honest, and tell them you will get back to them.

Adult Learning and Training

DEALING WITH THE PROBLEM PARTICIPANT

- The "Speaker of the Group"
- The "Shy Guy"

why
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During your presentation, certain participant behaviors can interrupt the smooth operation of your program. Here are some suggestions for dealing with these "problem participants." **The "Speaker of the Group":** This person answers all the questions or asks all the questions. Others can't participate. Thank this person for his/her contribution and ask for others to state their concerns or perspectives. If you're walking around the room, stand behind this person ask a question and call on others. If this doesn't work take this person aside during a break and ask him/her to assist you in having others speak, suggesting they may be reluctant and need encouragement. **The "Shy Guy":** This participant is always very quiet, never volunteering answers or questions. Try drawing this person out by asking a question and asking him/her to answer it. Keep the question to an area where she/he can relate personal experiences or learning. Don't push if there's reluctance.

Adult Learning and Training

DEALING WITH THE PROBLEM PARTICIPANT

- The “Uncaring” Participant
- The “Sleeper”

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The “Uncaring” Participant: This person displays a “who needs this?” attitude, showing no desire to get involved in your SRH program. Non-verbal cues such as folded arms, heavy sighs, disgusted or vacant facial expressions or foot tapping are early indicators of this person’s attitude. This attitude could be defensive, stemming from a fear of being made to look wrong. Sometimes such individuals have an inability to read or write and are afraid of being discovered. Avoid confrontation. Be empathetic--this may relax the participant. If illiteracy is the problem use auditory or other learning styles--read test questions or materials aloud. The “Sleeper”: Don’t take it personally if a participant falls asleep--it may have to do with how much sleep the person got. Some participants automatically get sleepy when sitting without any activity. If everyone is falling asleep, check your presentation style! You may want to announce at the beginning, if anyone is feeling sleepy to get up and move around.

Adult Learning and Training

CHECKLIST: PREPARING TO TEACH

- Review the module
- Think about your presentation
- Figure out the timing of your training
- Duplicate/organize your handouts
- Obtain easel, flipchart paper, markers
- Obtain projector, laptop and connectors, extension cord, plug adapter
- Pencils, paper for the participants
- Prepare sign-in sheet or attendance list
- Prepare evaluation forms for participants to fill out at the end of session

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Be prepared! A good rule of thumb for trainers is to plan to spend at least two hours of preparation for every hour of training. You should carefully read through the training module. When preparing, discuss your power point slides or handouts, read the background information over a number of times. Show the slides to yourself and rehearse the material. This will make it possible when you train to go over the main points without looking down and reading the material directly. It’s OK to glance down to refresh your memory. But, remember, the more eye contact you can keep with your audience the better. Also, think of ways you might personalize a point--drawing on common experiences you and the participants have shared is a good way to make a point (“Remember when we...”). Finally, be sure you have the right cords for your computer/projector, a spare bulb and all of the other materials you will need for your presentation.

Adult Learning and Training

WAS THE TRAINING SUCCESSFUL?

- Participant Evaluation
- Observer Evaluation
- Self-Evaluation

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Evaluating your training upon completion will allow you to determine if it was successful and how you might improve it next time. There are 3 kinds of evaluations that are helpful. Hand out the three evaluation tools. Participant evaluation is usually done by giving a brief questionnaire to your participants at the end of your session. The questionnaire can include questions with a sliding scale to “grade” your presentation and an open-ended question(s). Observer evaluation is usually done by your peers such as your co-trainers. This evaluation can be especially useful because you can brainstorm with each other about strengths and weaknesses in the presentation and how it might be improved in the future. Self-evaluation is your own evaluation of your performance using benchmarks that you had hoped to achieve and the ones you met and which ones you didn’t meet.

Module Six
Safe Resident Handling/Ergo Team
Train-the-Trainer Program

PART TWO:
SRH/Ergo Team
Training Practice

In Part Two, your Team will have the opportunity to conduct a “mock training.” This is training practice so you will be ready to conduct the 1-hour classroom SRH training for your frontline workers. You will work in groups of two and each group will take a different section of the “Introduction to Safe Resident Handling” manual. When 2 of you are training the rest of your Team will be your “class.” Each group should review and discuss the hard copy of the section you will be presenting. Review the agenda and objectives for your section. Study the slides and the written information that explains each slide. Also review the Handouts. Because you are team-teaching, decide who is going to cover what points.

SRH/Ergo Team Train-the-Trainer Program

GETTING STARTED

- Setting up the Power Point
- Using the Power Point format



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Explain to the Team that they will be using a power point for the section they are training on. Show them how to insert the “thumb drive” in the computer and select the section they will be presenting. Show them the first slide with section title (SECTION ONE. AN OVERVIEW OF SAFE RESIDENT HANDLING). They will see the slide on the projection screen. The slide also appears on the left side of their computer screen. Turn the Power Point, Flip Chart, and Handouts to the first two apprentice trainers.

Section 1

An Overview of Safe Resident Handling

- Handling Residents: Myth vs. Fact
- Health Care Worker Rates
- What Is Safe Resident Handling
- Who Benefits?

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Apprentice Trainers (Group 1): Explain to your participants that you are covering four topics in this section. Read the four topics from your agenda.

An Overview of Safe Resident Handling

OBJECTIVES:

Participants will learn that...

- Resident manual handling tasks puts health care workers at high risk of injury
- SRH is a safer alternative to lifting, transferring and repositioning residents
- The use of mechanical lifts and transferring and repositioning devices benefits workers, residents and employers

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Explain to your participants that there are three things that you want them to learn from this section. Read the learning objectives.

Let the participants know that they can raise questions about anything that you are presenting at any time.

Section 1: An Overview of Safe Resident Handling

MYTH VS. FACT

Handout

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Distribute the "Is it a Myth or a Fact?"

Handout to all the participants.

After you read a question, ask them to respond and to explain why they think their answer is correct. Then give them the correct answer. Explain to them that you will be going over the reasons for the correct answers as we go through this training together.

Answers:

1) F, 2) M, 3) M, 4) M, 5) M, 6) F, 7) M, 8) M, 9) F, 10) M

Section 1: An Overview of Safe Resident Handling

WHO IS GETTING HURT?

What job titles have the highest injury rates?

Where do health care workers rank among these job titles?

Have health care worker injuries been going up, down or staying the same over time?

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Use the Flip Chart.

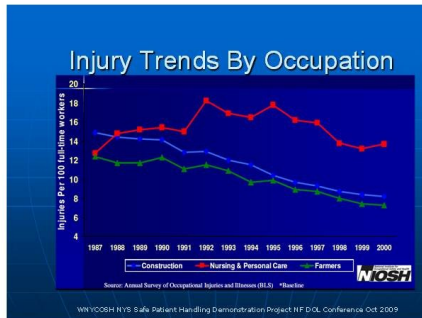
Ask the participants to call out what jobs they consider to have the highest injury rates and why. Jot down their answers.

Now ask them where they believe health care workers rank among the other job titles. Jot down their answers.

Finally, ask them if they believe health care worker injuries have been going up, going down or staying the same over the past 20 years.

Section 1: An Overview of Safe Resident Handling

WHO IS GETTING HURT?



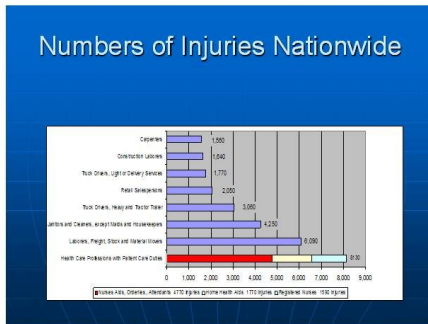
Ask the participants what this slide shows.

Ask them what might be an explanation for why health care workers injury rates have been staying pretty much the same over the past 20 years, but construction workers and farmers injury rates have been going down? One explanation is that for construction workers, powered tools/machines have replaced manual work. Powered hammers, saws, screwdrivers, and machines like lift trucks are now used, eliminating wear and tear on hands, elbows, shoulders, backs, knees and feet. In farming, machinery has also replaced many job tasks that used to be done by hand. What about health care? Do we still manually lift residents and patients?

Section 1: An Overview of Safe Resident Handling

WHO IS GETTING HURT?

Numbers of Injuries Nationwide



When you combine all of our healthcare job titles (RN, LPNs, CNAs, PCAs, etc.) and compare them to other job titles, we have the highest numbers of injuries. One explanation for this is that all of us in health care have a lot of the same job tasks: lifting, transferring and repositioning patients and residents.

Section 1: An Overview of Safe Resident Handling

WHO IS GETTING HURT?

- 29% of all workplace injuries requiring time away from work are MSDs
- The MSD rate for nursing aides, orderlies and nursing attendants is **7x higher** than the average of all occupations
- Approximately three-fourths of these MSDs are lower back disorders

Musculoskeletal Disorders (“MSDs”) include injuries to our joints, muscles, ligaments, and tendons. Mild MSDs can include soreness in our back, hands, knees, shoulders—they usually disappear in a short period of time. More painful MSDs can include tendonitis and muscle spasms. The most serious MSDs such as severe lower back pain and rotator cuff syndrome may require surgery and even force us to quit our jobs.

Health care workers who handle patients and residents are especially prone to MSDs. The majority of these are lower back disorders. MSD injuries are a major reason for lost work days for nursing home direct caregivers.

Site source.

Sources: Bureau of Labor Statistics, 2008, 2009
E. Langford, RN, 1997

Section 1: An Overview of Safe Resident Handling

WHAT IS SAFE RESIDENT HANDLING?

“A policy and practice that creates a safe work environment for patients [residents] and healthcare workers by eliminating hazardous manual lifting tasks. Transferring and repositioning patients [and residents] is accomplished by using new technologies such as mechanical lifts and repositioning devices.”

– NYS Zero Lift Task Force

A Safe Resident Handling program is a policy that guides direct care workers to stop using manual lifts, transfers and repositioning when handling and moving residents. It's a policy that requires managers to invest in new technologies such as mechanical lifts and repositioning devices to transfer and reposition residents.

The Goal of Safe Resident Handling program is to eliminate manual resident handling tasks.

Section 1: An Overview of Safe Resident Handling

WHO BENEFITS?



Quickly review the bubble chart.

There are benefits for residents, direct care workers and for management.

For example, a study of 7 nursing homes and 1 hospital found that injuries dropped by 62% after a SRH program was put in place. And Lost Work Days dropped by 86% resulting in big cost savings for management. Source: Garag. 1999.

Section 2

Body Mechanics and Lifting Limits

- Good Body Mechanics
- The Lifting Limit for Unstable Loads
- Manual Resident Lifting Using “Good Body Mechanics” Is a Failed Policy

Apprentice Trainers (Group 2): Review read the 3 main points you will be covering in this session.

Section 2: Body Mechanics and Lifting Limits

OBJECTIVES:

Participants will learn that...

- Good body mechanics can be used to safely lift stable loads
- Good body mechanics do not protect us when lifting unstable loads like residents
- Manually lifting residents using good body mechanics is a failed policy

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Review read the 3 main things you want the participants to take away from this session.

Section 2: Body Mechanics and Lifting Limits

Questions:

- What are good body mechanics?
- How many pounds can you safely lift using body mechanics?

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Activity [5 minutes]: Using the Flip Chart, as the participants to answer the two questions on the slide.

Jot down their answers.

Section 2: Body Mechanics and Lifting Limits

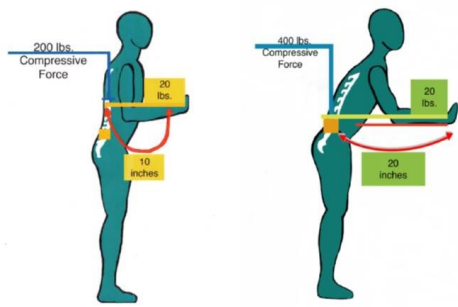
**WHEN YOU LIFT AN OBJECT,
USE GOOD BODY MECHANICS**

- Bend at the knees, not at the waist
- Get close to the object
- Keep your back straight and don't twist
- Plant your feet properly
- Hold objects close to your body
- Push, pull, slide when possible

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The class may have come up with most of these when answering the question (above). Note any they may have missed. Good body mechanics do help protect the back from injury. **Bend at the knees:** thigh muscles are stronger than your back muscles. **Get close to the object:** outstretched arms put much higher compressive forces on your lower spine. **Keep your body straight:** when you bend to lift, you are adding your trunk weight to the load you are lifting--this adds compressive force to your spine. **Plant your feet firmly:** this gives you a stable base that prevents you from twisting or falling when lifting. **Hold objects close to your body:** this minimizes forces on your spine. **Push, pull, and slide an object if possible:** this allows you to use your whole body weight instead of the one or two muscle groups used when lifting.

Section 2: Body Mechanics and Lifting Limits



OSHA Technical manual, Section VII, Chapter 1: Back disorders and Injuries, http://www.osha.gov/dts/osta/otm/otm_vii/otm_vii_1.html

When you lift a 20 pound box close to your body, there are 220 pounds of compressive force on your lower spine. The discs between your vertebrae are being compressed slightly. (You are actually shorter at the end of the day than when you get up in the morning due to constant compression.) If your arms are extended 10 inches while lifting the 20 pound box, the compressive force on your spine is 400 pounds. This is why we use good body mechanics--they protect the spine. The US Government's National Institute on Occupational Safety and health recommends a safe lifting weight for a healthy adult using two hands should not exceed 51 pounds. Lifting 51 pounds would put 750 pounds of compressive force on your lower spine--the maximum NIOSH considers safe.

Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



Exercise [2 minutes]: Ask the participants what risks are involved in doing the job task of cranking a bed in this position numerous times a day, week after week, year after year. Is it easy to use good body mechanics when doing this job task? Would you be tempted to avoid cranking the bed up, so that you are bending over the resident when doing your tasks? Do they have any crank beds at your facility or other equipment that makes it difficult to do your job safely?

Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



Exercise [2 minutes]: Ask the participants what job task is being performed here. Are there risks involved, especially if it's done many times a day, year after year? What are they?

Would you be able to use good body mechanics to do this job?

How could this job task be done more safely?

Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



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Exercise [2 minutes]: Ask the participants what job task is being performed here.

- Are there risks involved? What are they?
- Would you be able to use good body mechanics to do this job?
- How could this job task be done more safely?

Section 2: Body Mechanics and Lifting Limits

Fact: Techniques taught through body mechanics have not reduced back injuries among healthcare workers

- Good body mechanics is not enough to prevent injuries
- Manual lifting techniques were based on stable loads held close to the body
- Manual lifting techniques were based on loads weighing less than typical residents
- Manual lifting techniques were based on studies that included only men.

Source: NYS Zero-Lift Task Force

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The problem with using body mechanics to try to safely lift, transfer and reposition residents is that they weigh more than 51 pounds. Even when a resident is able to help with a lift or transfer, if they are partially dependent on a CNA or other caregiver, they may be or may become an unstable load. When the resident becomes unstable (can't bear weight, begins to fall, etc.), far more weight than 51 pounds is likely to be placed on the caregiver.

Section 2: Body Mechanics and Lifting Limits

In 2005, over **53,000** healthcare workers who were trained in good body mechanics were injured from manually lifting patients.

Source: Bureau of Labor Statistics, 2005

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Body mechanics is a failed strategy for preventing injuries in health care.

Section 2: Body Mechanics and Lifting Limits

The National Institute for Occupational Safety and Health has determined that healthcare workers should lift **a maximum of 35 pounds** when transferring and repositioning patients/residents.

The logo for WNY COSH, featuring the letters 'wnv' in a stylized font above the word 'cosh'.

Because residents are unstable loads when being lifted, transferred and repositioned, NIOSH recommends that a maximum human load weigh no more than 35 pounds. Practically speaking, when a resident needs help getting up, being moved from one surface to another, or repositioned in a bed, unless you know that they can support most of their weight stably, you will likely exceed the 35 pound limit when assisting them.

Section 3**Anatomy of an Injury****AGENDA:**

- The high risks of manual handling
- Manual resident handling and “overexertion”
- “Overexertion” and excessive forces on the spinal discs

The logo for WNY COSH, featuring the letters 'wnv' in a stylized font above the word 'cosh'.

Apprentice Trainers (Group 3): Review the agenda.

Section 3: Anatomy of an Injury**OBJECTIVES:**

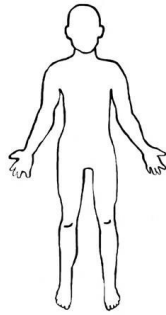
Participants will learn that...

- The repeated bending, twisting, lifting and moving involved in our job tasks results in high injury rates
- Continuous and repetitive lifting, transferring and repositioning tasks can lead to long-term (chronic) back pain
- Repetitive overexertion on the spinal discs can cause them to bulge, rupture or degenerate = chronic back pain

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Review the learning objectives for this session.

Section 3: Anatomy of an Injury



Where do you hurt?
Why do you hurt?

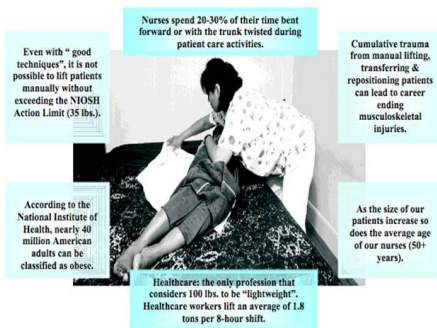
wny
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Activity [10 minutes]: Draw a “Body Map” on the Flip Chart. Make “sticky dots” available to the participants. Ask them to take one or more dots and place them on that part of the Body Map where they hurt.

After they take their seats, ask them to talk about where they hurt and if it feels like a symptom, a pain that comes and goes or if it’s constant.

Ask if they think that the pain they have might be related to their job tasks at this facility.

Section 3: Anatomy of an Injury



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Briefly review the slide. Note the major points about the job tasks direct care workers perform daily might have something to do with the pain they feel.

Most residents weigh more than 100 pounds and they are getting heavier.

Direct care workers are an aging workforce

We spend much of our time doing job tasks where we are bent forward with our bodies twisted.

We do the same risky job tasks over and over daily, weekly, monthly and yearly. This overexertion can lead to cumulative trauma injuries such as musculoskeletal disorders.

Section 3: Anatomy of an Injury

HOW MUCH ARE YOU LIFTING?

The average healthcare worker manually lifts 1.8 tons per 8-hour shift. That is equal to lifting one sedan per shift.



In one year, healthcare workers lift the equivalent of an airplane that is 50% loaded.

The number of manual lifting injuries to healthcare workers in one year equals the full capacity of the new Yankee Stadium.



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To get an idea of how much an average healthcare worker overexerts their back and other parts of their body look at how much is being lifted daily—1.8 tons (and that’s an 8-hr. shift).

If you are manually lifting (or pushing/pulling the equivalent weight), 1.8 tons a day, month after month, year after year, you are overexerting your spine, discs, and muscles of your back.

Section 3: Anatomy of an Injury

ACUTE BACK PAIN

- “Acute” due to temporary overexertion/trauma
- Temporary “backache”
- Muscle spasm, strain, sprain

CHRONIC BACK PAIN

- Due to long-term overexertion
- Bulging, ruptured or degenerated discs
- Excruciating pain
- Potentially career-ending

There are two types of back pain. One is temporary or acute back pain. It occurs when you temporarily “overdo it.” Muscle spasms, strains and sprains, while painful, are also usually temporary and eventually heal.

The other, chronic back pain, is more serious. It tends to be long-term and may never go away (surgery may or may not help). It’s caused by months and years of overexerting your spine (or other joints) while carrying out job tasks such as lifting, pulling or pushing residents day-in and day-out. Overexertion injuries involve damage to your spinal discs that can end in excruciating and career-ending pain.

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Section 3: Anatomy of an Injury

MSDs AMONG HEALTHCARE WORKERS

Back injuries are most common:

- 73% of MSDs reported by nurses
- 70% are of the Lumbar Spine
- 57% are due to lumbar disc problems

Other chronic MSDs:

- Rotator cuff (shoulder)
- Thoracic outlet syndrome (neck area)
- Epicondylitis (elbows)
- Cartilage deterioration (knees)
- Carpal tunnel (wrist/hand)

Note that back injuries to the lower lumbar spine and discs are the most common overexertion MSD injuries. But other parts of the body can also be affected including the shoulders, neck, elbows, knees, feet and wrist/hands.

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Section 3: Anatomy of an Injury

OVEREXERTING YOUR DISCS

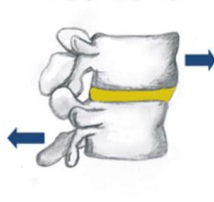
► Compression Forces

► Lifting weight



► Shearing Forces

► Pulling / pushing weight



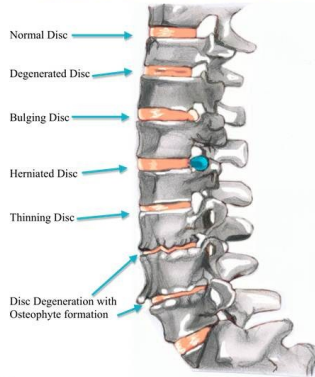
Over time lumbar discs can rupture, bulge, or degenerate

► Illustrations by K. Rinker, WNYCOSH

If you exceed 35 pounds when manually lifting residents over months and years, you are compressing your spinal discs. Exceeding 35 pounds of force when repositioning residents can cause shearing to your discs. Both of these forces can be cumulatively traumatic to your discs, resulting in chronic back pain, usually in the lower or lumbar region of your back.

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Section 3: Anatomy of an Injury
DISC DISORDERS



Illustrations by K. Rinker, WNYCOSH

Healthy discs cushion the vertebrae and are flexible and can be “squished” in various directions as you bend or lift. Repetitive overexertion of the spine from compression or shearing can cause the discs to deteriorate. One kind of deterioration is a bulging ruptured (“herniated”) disc. The other kind of deterioration is degenerative disc disease. Nerves branching from the spine can become “pinched” and inflamed as the discs bulge, rupture, or deteriorate. This can cause excruciating pain.

Section 4
Controlling Risk Factors

AGENDA

- “Fitting the Worker to the Job”
- The “Pivot Transfer”
- “Fitting the Job to the Worker”

Apprentice Trainers (Group 4): Review the agenda.

Section 4: Controlling Risk Factors

OBJECTIVES:

Participants will learn that...

- Fitness and body mechanics can’t prevent manual handling injuries
- The main manual lift/transfer technique you learned and that’s routinely used can become an unacceptable heavy lift
- Mechanical lifts and transfer repositioning devices are a safe alternative to manual handling

Review the learning objectives.

Section 4: Controlling Risk Factors

ERGONOMICS: THE LAWS OF WORK

Old Philosophy – “Fit the Worker to the Job”

- Body Mechanics
- Physical Fitness
- Personal Protection

New Philosophy – “Fit the Job to the Worker”

- Ergonomics
- Engineering the risk factors (hazards) out of the job

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The way we used to think about preventing injuries was to teach “proper body mechanics” to protect our back when we manually lifted. Also, exercising and getting in shape and using personal protections like a back belt would prevent back injuries. If you did these things, you shouldn’t get hurt. But now we know that even if you use good body mechanics and other precautions, you can still get hurt if you are making manual lifts, transfers or repositionings. Residents weigh more than 35 pounds and they’re unpredictable loads.

The new way of thinking about preventing resident handling injuries is to “fit the job to the worker.” That simply means that we need to identify those hazards or job risks in resident handling that can hurt us and “fix” (reduce or eliminate) them. By “fixing” them, we can prevent injuries. The science of identifying and controlling hazards is called ergonomics.

Section 4: Controlling Risk Factors

**RESIDENT HANDLING:
RISK FACTORS (HAZARDS)**

- What are some risks about your resident job tasks that can hurt you?
- What are some risks about your work environment that can hurt you?

why
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Exercise [5 minutes]: Explain to the participants that an ergonomic approach to making the workplace safer is to look at the job tasks such as handling and moving residents. Ask them to break down their tasks during the day such as transferring a resident from a bed to a wheel chair or a wheel chair to a toilet. What are the risks or hazards of doing these tasks that can cause injuries? Jot their answers down on the Flip Sheet.

An ergonomic approach also looks at hazards in the work environment where job tasks are performed. Ask the participants to think about the resident’s rooms where they perform their tasks--are there hazards such as clutter, bathrooms that are too small, lack of lifts, etc?

Section 4: Controlling Risk Factors

**ERGONOMIC IDENTIFIES
JOB TASK RISKS**

- Heavy lifting
- Applying force
- Awkward postures
- Frequent bending, twisting, stretching, reaching
- Prolonged static posture
- Overexertion/no rest = cumulative trauma

why
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Listed below are some examples of job task risks:

Heavy Lifting: manually lifting and transferring a resident from a bed to a chair (remember: anything over 35 lbs. is too heavy). **Applying Force:** pushing and pulling wheel chairs over carpets, high thresholds; pulling or dragging a heavy or broken cart. **Awkward Postures:** carrying or lifting a resident while your back is twisted; bending over to crank a bed. **Frequent Bending, Twisting, and Stretching/Reaching:** repositioning individuals in bed; removing objects from a cart at heights above your shoulders. **Prolonged Static Posture:** Bathing a resident in a bent over position. **Overexertion:** Doing the above tasks repetitively day in, day out, over months and years. Remember: a nurse lifts 1.8 tons/8 hr. day on average.

Section 4: Controlling Risk Factors

THE PIVOT TRANSFER



Do you use the pivot transfer at this facility?
When is it safe to use the pivot transfer?

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Exercise [5 minutes]: Ask the participants if they use this manual handling technique to move residents from chairs to beds or chairs to toilets, etc.

- Ask them to briefly explain the pivot transfer.
- Ask them when it's safe to use the pivot transfer and when it's a high risk transfer.
- Ask if anyone has had a bad experience using the pivot transfer and what happened.

Section 4: Controlling Risk Factors

THE PIVOT TRANSFER

"Healthcare workers routinely use the Pivot Transfer to move patients [or residents]. The transfer is loaded with risk due to the high level of patient function required to execute it well. Patients and health care workers are injured when patients are unable to stand and take steps, leaving the healthcare worker to bear the patient's full weight."

NYS Zero-Lift Task Force

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Read slide and move to the next.

Section 4: Controlling Risk Factors

RISKS TO THE CAREGIVER

- Resident becomes unstable throwing caregiver off balance
- Caregiver ends up doing an unacceptable manual lift
- Resident can't pivot on strong side due to a confined work environment

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Point out to the participants that a Pivot Transfer should never become a lift. If the resident has been accurately evaluated as Independent or as Supervision/Limited Assistance and can bear weight, stand, and move her/his feet on all surfaces it is probably OK to use this transfer.

The Pivot Transfer would primarily be used to reassure and steady the resident. If the resident is somewhat unsteady but has good weight-bearing ability, the transfer could be done with a Gait Belt on a temporary basis.

If a CNA believes a resident's assessment could put her/him and the resident in danger and a mechanical lift is required, she/he should speak with a unit nurse or supervisor.

Section 4: Controlling Risk Factors

RISKS TO THE RESIDENT

- Repetitive traumas, skin tears
- Damage to soft tissue supporting the joints (hips, knees)
- Exacerbation of arthritis and degenerative joint disease (shoulder joints, loss of range of motion)
- Spiral or impact fractures at hips, knees and ankles
- Deterioration of skills

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A study at a Western NY 120 long-term care facility found that in 100% of resident cases where Pivot Transfers were used for over 90 days that there were bad effects on the residents. These included: exacerbation of joint disease in the shoulders, hips or knees; deterioration or loss of weight bearing skills; below the knee spiral fractures sustained by 2 patients. Using a Sit to Stand Lift may be better for a resident who needs Supervision/Limited Assistance—it can allow the resident to use her/his own skills by using the mechanically assisted lift.

Section 4: Controlling Risk Factors

FIXING THE JOB: EQUIPMENT



FULL MECHANICAL LIFT

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Using equipment is the alternative to manual lifting and transfers. The risk of being hurt by a manual lift/transfer has been engineered out of the job. You or the resident can still get hurt using equipment if you don't follow proper procedures. For example, two people should be available to operate a mechanical lift. You should always use good body mechanics when using equipment. In this slide, the resident is being safely lifted and transferred using a Full Mechanical Lift and sling. The Full Mechanical Lift should be used with Totally Dependent residents and those who need Extensive Assistance if they are unable to use the Sit to Stand Lift.

Section 4: Controlling Risk Factors

FIXING THE JOB: EQUIPMENT



Sit-to-Stand Lift (Bariatric Patient)

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The Sit-to-Stand Lift can be used as an alternative to the risky manual pivot for residents who are partial weight bearing in one or both legs and can hold on with one or both hands.

This is a fairly heavy resident. Many Sit-to-Stand Lifts are rated for lifting residents who weigh 500 pounds or more.

Section 4: Controlling Risk Factors

FIXING THE JOB: TRANSFER DEVICES



Lateral Transfer Devices

why
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Transfer devices reduce risky manual pulling and tugging tasks to reposition or transfer residents from one surface to another. They reduce friction so the resident can be easily slid to the desired target. Slide sheets are an especially inexpensive item that can be used to easily reposition a resident who needs to be pulled towards the head of a bed

Section 4: Controlling Risk Factors

FIXING THE JOB:
OTHER ASSISTIVE DEVICES



why
cosh

These are some other assistive devices that reduce the risks of manual handling.

Section 4: Controlling Risk Factors

FIXING THE WORK ENVIRONMENT

Room Layout	Small Room/Clutter
Uneven Work Surfaces	Beds, Chairs and Toilets w/ Different Heights
Lifting Devices	Equipment Poorly-Maintained, Inaccessible, Wrong or Inadequate

**** Beware Slips, Trips & Fall Hazards**

why
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The work environment also has to be engineered to make resident handling safe. Small rooms can be a challenge for using Mechanical Lifts, particularly when toileting. If a bathroom can't be reengineered, a portable commode might be the answer. Room clutter can also be a problem; reorganizing closets and furniture may make the use of equipment possible. One of the main problems that CNAs and other direct caregivers face is inadequate equipment or inaccessible equipment. The purchase of the right amount of equipment will make it more likely that direct care staff won't go back to manual handling. And, Lifting Equipment must be accessible—it should be parked in easy to reach areas of the hallway; it should never be stored away in a closet.

Section 5
Resident Assessments

AGENDA

- Resident dependency/capabilities
- Changes in dependency/capabilities
- Resident Care Guides

Apprentice Trainers (Group 5): Read the agenda. Explain that it is important to know how capable a resident is in being able to assist a CNA or other direct care worker in lifting, transferring and repositioning task. This allows the CNA to know if and what equipment or devices need to be used to safely move a resident. The direct care staff needs to know that the resident assessment is accurate. Otherwise, a moving task may be performed without equipment or another assistive device or the wrong equipment or assistive device. This section looks at the assessment process.

Section 5
Resident Assessments

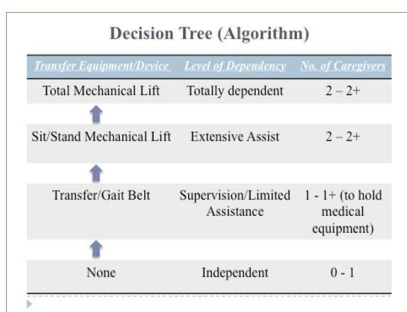
OBJECTIVES

Participants will learn that...

- A "Decision Tree" can be used to make accurate resident assessments
- The direct caregiver plays a key role in observing changes in the resident's capabilities
- Good Care Guides can give the direct caregiver the information needed for selecting the right Lift or Device

Review the training objectives of this section.

Section 5: **Resident Assessment**
DECISION TREE (ALGORITHM)



This is a "Decision Tree." It is a guide for evaluating a resident's capability to help get from a chair to a bed, a wheel chair to a toilet, a bed to a chair, etc. As the resident's ability to help with getting up or sitting down decreases, you move up the Decision Tree to decide what equipment you will need.

Go to the next slide.

Section 5: Resident Assessment

CAPABILITY LEVELS

Independent	Capable of moving up, down, repositioning without assistance
Supervision/ Limited Assist	Can assist with getting up, down, repositioning, but may need help with Gait Belt or Sit-Stand Lift
Extensive Assist	Very limited in terms of how much resident can assist in getting up, down, repositioning. If capable of hold on, Sit-Stand lift may be appropriate
Totally Dependent	Incapable of assisting. Full Mechanical Lift needed

This slide shows the definition of the different levels of a resident's ability to assist with getting up, down.

As a resident's ability to assist the direct care worker with a lift-transfer decreases, the more critical it is to move up to a higher level of mechanical assistance.

A more complete assessment tool that you should use is the "Safe Resident Handling Tool."

Hand out the tool and tell them to read it on their own.

Section 5: Resident Assessment

THE NEED FOR CONTINUOUS RESIDENT ASSESSMENT

Resident dependency status may change:

- During the day
- From shift-to-shift
- Over time

As the dependency level changes, the Decision Tree should be used to reassess the resident's transfer status

CNAs are in a key position to detect changes in resident status and make recommendations for resident re-evaluation

The Decision Tree can be used on a daily basis. A resident's degree of dependency often changes over time. A resident who was assessed as "Independent" upon admission, may become more dependent in a period of months. Some residents' capabilities may even change during the course of the day or from one shift to another. As the resident's capabilities to assist decrease, the risks of injury to the direct care worker and the resident increase. To do the lift-transfer safely, the equipment or number of people needed to assist with the lift also changes. CNAs who are giving direct care are often in the best position to see these changes. They should be encouraged to use the Decision Tree and report to a nurse or other licensed professional.

Section 5: Resident Assessment

CARE GUIDES

Resident Care Guides should tell:

- What the resident's dependency status is
- What equipment should be used
- How many caregivers are needed

The resident Care Guide documents the licensed professional's assessment of a resident with respect to a number of things such as food, grooming and bathing preferences, etc. The Care Guide also tells what the resident's capabilities are and what lifts, transferring or repositioning equipment is needed. Caregivers should follow the Care Guide. If a CNA or other direct care worker observes a change in a resident's capabilities, under a SRH program, they should be encouraged to use the Decision Tree and contact the Unit Nurse or Supervisor and recommend a reevaluation of the resident's status.

Section 5: Resident Assessment

INDEPENDENT RESIDENT

TRANSFER	Independent for Transfer
BED MOBILITY	Two Siderails Up Independent for Bed Mobility
AMBULATION	Independent Ambulation On/Off Unit
WHEELING	Does Not Use Wheelchair
TOILETING	Independent for Toileting
CONTINENT OF BOWEL AND BLADDER	Monitored and Recorded BMs Every Shift

This is an example of a good Care Guide giving the CNA the information needed for performing lifting, transferring or repositioning tasks for this Independent Resident. Note: This is only an excerpt from a resident's Care Guide. Non-handling information has been omitted.

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Section 5: Resident Assessment

SUPERVISION/LIMITED ASSIST RESIDENT

TRANSFER	Limited 1 Assist w/ Gait Belt
BED MOBILITY	Independent for Bed Mobility
AMBULATION	Ambulate on Unit w/ Rolling Walker and Gait Belt – Limited 1 Assist
WHEELING	Staff to Propel Wheelchair Off Only
TOILETING	One-Person Physical Assist
CONTINENT OF BOWEL AND BLADDER	Urinal w/in Reach Monitor Bowl Movements

This is a sample of a good Care Guide giving the CNA the information needed for performing lifting, transferring or repositioning tasks for this Supervision/Limited Assist Resident.

wny
cosh

Section 5: Resident Assessment

EXTENSIVE ASSISTANCE RESIDENT

TRANSFER	Sit to Stand Lift Transfer w/ 2 Assist Using Medium Blue Band Swing
BED MOBILITY	Two Rails Up; Limited 1 Assist Rolling; Extensive 1 Assist Supine to Sit with Rail; Turn and Position Q2HRs and PRN; Extensive 2 Assist Boosting Using Non-Friction Sheet
AMBULATION	Non-Ambulatory
WHEELING	Manual Wheelchair w/ Gel Cushion; Staff to Propel On/Off Unit
TOILETING	See Transfer Status; Extensive 1 Assist for Incontinent Care Every 2 Hours and PRN; Brief OOB; Vaseline to Buttocks After Care; Monitor and Record BMs Every Shift

This is a sample of a good Care Guide giving the CNA the information needed to perform lifting, transferring or repositioning tasks for this Extensive Assistance Resident.

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Section 5: Resident Assessment

TOTAL DEPENDENCE RESIDENT

TRANSFER	Full Mechanical Lift Transfer; 2 Person Assist w/ Medium 6 Strap Sling
BED MOBILITY	Total 2 Assist for Bed Mobility; Total 2 Assist for Bed Mobility, Boosting with w/ Non-Friction; Reposition Resident in Bed; Reposition Q3H and PRN in Bed; 2 Full-Padded Side Rails; Bilateral I.F.'s with Pillows on Outside of Knees; Heel Booties on Both Heels; Place Rolled Up Pad Under Lower Legs to Elevate Heels Off Bed; Elevate UE's on Pillows in Bed at all Times in Bed
AMBULATION	Non-Ambulatory
WHEELING	Staff to Propel All Destinations in W/C with Seat Belt and Chest Harness; All Straps Secured
TOILETING	Two-Person Physical Assist for Incontinent Care; Peri-Care w/ Each Incontinent Episode; Q3H + PRN; Vaseline w/ Care; Monitor Bowl Movements Daily; Bowel Management Program;

This is a sample of a good Care Guide giving the CNA the information needed to perform lifting, transferring or repositioning tasks for this Total Dependence Resident.

wny
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Section 6

Safe Resident Handling Policy

- Safe Resident Handling Policy
- SRH Policy Objectives
- SRH Roles
- SRH Policy Outline

Apprentice Trainers (Group 5) Exercise [5 minutes]: Ask the participants what they would like to see the facility's SRH program achieve. Explain that this facility will adopt a written SRH policy that all staff will be expected to follow in order to achieve the objectives of your program.

Jot their answers down on the Flip Chart.

wny
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Section 6

Safe Resident Handling Policy

AGENDA

- The objectives of a Safe Resident Handling Policy
- This facility's Safe Resident Handling written policy (if completed and available)

Apprentice Trainers (Group 6): Review the agenda.

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Section 6

Safe Resident Handling Policy

OBJECTIVES

Participants will learn...

- The objectives of a Safe Patient Handling Policy
- This facility's Policies and Procedures

why
cosh

Here are some possible objectives that the participants may also want to consider.

If this Team/facility has already adopted a Safe Resident Handling Policy, you may want to distribute to the participants.

Section 6: **Safe Resident Handling Policy**

SRH PROGRAM POLICY OBJECTIVES

Question:

What do you want your program to achieve?

- To increase resident quality of care
- _____
- _____
- _____
- _____
- _____

why
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Activity [5 minutes]: Ask the participants, as a group, to brainstorm about some objectives they would like to see their SRH program achieve. After brainstorming, ask the group to report back their ideas and write them on the Flip Chart.

Section 6: **Safe Resident Handling Policy**

SRH PROGRAM OBJECTIVES

SAMPLE OUTLINE:

What do you want your program to achieve?

- To increase resident quality of care
- To perform safe/comfortable mechanical Lifts/transfers for residents
- To reduce the frequency of manual lifting/transferring and repositioning
- To reduce and prevent caregiver work-related injuries
- To reduce lost work time hours related to staff injury or fatigue

why
cosh

Review the slide noting some objectives that they may not have considered that they may (or may not) want to consider adding to their list.

Section 7

Safe Resident Handling: Changing the Culture

AGENDA

- The objectives of a Safe Resident Handling Policy
- This facility's Safe Resident Handling written policy (if completed and available)

OBJECTIVES

Participants will learn that...

- Adopting Safe Resident Handling policies and practices is a major Cultural Change in the way we think and act with handling residents

why
cosh

Apprentice Trainers (Group 7): Review the agenda and the training objectives of this section

Section 7: SRH – Changing the Culture

THE “OLD” RESIDENT HANDLING CULTURE:

- “Blame and Shame”
- Injuries are due to carelessness
- Body mechanics = safe lifts/transfers
- Non-manual handling is impractical

why
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Hand out the “Old Practices/Evidence Based Practices” fact sheet. Briefly discuss the main points on the sheet. Note that while we are calling this the “Old Culture” the fact is that most of us in health care have been taught to think and act this way. Because we have learned and practiced this way of handling residents, it has become almost habitual. Due to our fast-paced work and other demands placed on us, it will be difficult, at first, to think and act differently. Also, learning a whole new set of practice can seem like just one more thing we have to do on top of all of our other responsibilities. This is true of everyone involved--management, direct care workers, support staff and residents. What we are trying to do with today's training session is to begin a transition to the “New No-Manual Handling Safe Resident Handling Culture.”

Section 7: SRH – Changing the Culture

The “New Safe Resident Handling Culture”

- The way to create a safer workplace is to “Fit the Job Task” and “Work Environment” to the worker
- Eliminate the need to manually handle residents through the purchase and use of equipment will create a safer workplace
- Train and mentor direct care workers on the proper use of equipment will move us toward a “Culture of Safety”

why
cosh

Transitioning to a “Culture of Safety” at this facility will begin with adopting the policies and practices of Safe Resident Handling. It will require that direct care workers and the union, support staff, and the administration work together toward the common goal of making this a non-manual handling facility. There will be “bumps in the road.” When they occur, it is critical that instead of “blaming and shaming” we pull together, taking each problem on honestly and work together and try, a step at a time, to improve our program. If we can do that, we are on our way to improving the quality of those who care for the residents and the residents at this facility.

Module Six
**Safe Resident Handling/Ergo Team
Train-the-Trainer Program**

PART THREE:
Hands-On Demonstration of
Equipment Use

Hands-On Demonstration of Equipment Use

AGENDA:

- Full Mechanical Lift demonstration
- Ceiling Lift demonstration
 - Turning and Positioning Sling
 - Limb Straps
- Sit-to-Stand Lift demonstration
- Gait Belt demonstration
- Non-Friction Device demonstration

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Notes

Inventory of Module Handouts

MODULE ONE: Introduction to Safe Resident Handling

Handout #1 — Is It a Myth or a Fact?
Handout #2 — How Much Are You Lifting?
Handout #3 — The OSHA Hierarchy of Controls
Handout #4 — Culture Change: Old vs. New

MODULE TWO: Team Meeting Skills for SRH/Ergonomic Teams

Handout #1 — Task vs. Process
Handout #2 — Establishing Ground Rules
Handout #3 — How to Pitch a Better Meeting
Handout #4 — Guidelines for Developing a Good Agenda
Handout #5 — Safe Resident Handling Team Meeting Agenda
Handout #6 — Group Process Roles
Handout #7 — Participant Roles
Special Instructions — Instructor's Background: Mystery Exercise
Handout #8 — Decision-Making by Nancy Lampen, MS
Handout #9 — Consensus Exercise
Handout #10 — Interest-Based Decision Model
Handout #11 — Interest-Based Conflict Resolution in Sequence
Handout #12 — Learner Types and Multiple Intelligences

MODULE THREE: Making the Case for Safe Resident Handling Ergonomic Programs

Handout #1 — OSHA Form 301
Handout #2 — OSHA Form 300
Handout #3 — OSHA Form 300A
Handout #4 — C-3 Workers Compensation Form
Handout #5 — "Safe-T" Survey
Handout #6 — SPH and Movement Fact #5
Handout #7 — SPH and Movement Fact #6
Handout #8 — Case Study One: NYS Veterans Home
Handout #9 — Case Study Two: Wyandot County Nursing Home
Handout #10 — Investments in SRH Saves Money and Reduces Injuries
Handout #11 — Returning to Work in a SRH Environment

MODULE FOUR: Equipment, Environmental and Organizational Needs Assessment

Handout #1 — How Much Equipment Do We Need?
Handout #2 — Equipment Use Inventory
Handout #3 — Unit Profile and Space Maintenance/Storage Evaluation
Handout #4 — Facilities Design Checklist
Handout #5 — Buy-In Bubble Chart

MODULE FIVE: Implementing and Sustaining Safe Resident Handling Programs

Handout #1 — A Close Look at the Pivot Transfer
Handout #2 — How Do We Assess Resident Dependency
Handout #3 — What Lifting/Transfer Method Do We Use
Handout #4 — Safe Patient Handling Assessment Tool
Handout #5 — Resident Care Guides
Handout #6 — SRH Roles and Responsibilities
Handout #7 — Safe Resident Handling Policy Sample Outline
Handout #8 — Sample Audit Tool: Zero Lift Compliance
Handout #9 — Zero Lift Compliance
Handout #10 — After Action Review Case

MODULE SIX: Safe Resident Handling Train-the-Trainer Program

Handout #1 — Is It is Myth or a Fact?
Handout #2 — Safe Patient Handling Assessment Tool
Handout #3 — Cultural Change: Old vs. New
Handout #4 — Hands-On SRH Equipment/Devices

MODULE ONE

HANDOUTS

Is it a Myth or a Fact?

Myth or Fact

M ☐ F ☐

Routine manual resident lifting is prohibited in some states as well as in a number of countries.

M ☐ F ☐

Proper body mechanics can prevent most healthcare worker lifting injuries.

M ☐ F ☐

The human body can safely lift 60 pounds.

M ☐ F ☐

All resident handling injuries are related to lifting, transferring and/or repositioning bariatric residents.

M ☐ F ☐

A two person lift of a 150 lb resident is safe for the caregivers.

M ☐ F ☐

It is possible for a worker to be injured without showing or experiencing any physical signs.

M ☐ F ☐

Healthcare workers that are physically fit are less likely to be injured lifting residents.

M ☐ F ☐

Safe resident lifting equipment is not affordable.

M ☐ F ☐

Repositioning residents is a high risk activity with the potential for injury.

M ☐ F ☐

The only workers who need to understand the Safe Resident Handling Program are Registered Nurses.

HOW MUCH ARE YOU LIFTING

Scenario 1

You are caring for a fully dependent 130lb. female resident and must move them from the bed to a chair and you are the only nursing assistant available to make the transfer.

Scenario 2

A 210 lb male resident needs help in standing from his chair. He is partially able to help himself and lift at least half of his weight. You and a coworker are assisting the man to stand.

Scenario 3

A fully dependent resident weighing 280 lbs must be moved from his bed into a chair. Four nursing assistants are available to help with the transfer.

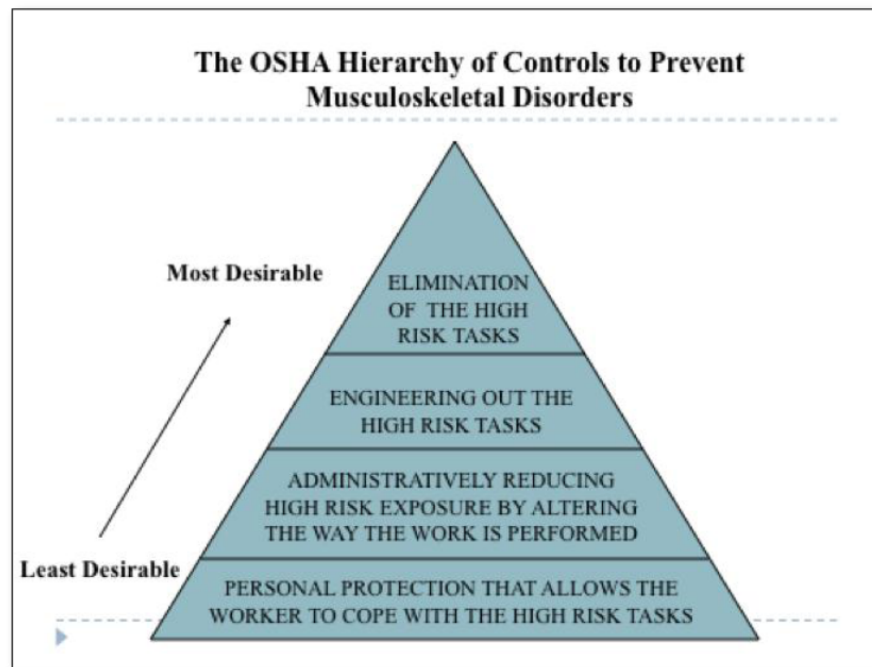
Scenario 4

One of the bariatric female residents weighing 320lbs injured her leg and the wound dressing must be changed. In order to wrap the leg, it must be lifted off of the bed. (The leg is about 16% of the total body weight¹)

Scenario 5

The 150 lb fully dependent female resident must be repositioned so her head is closer to the top of the bed. There is only one nursing assistant and no special bedding.

¹ AJN, August 2007, When is it safe to manually lift a resident, T. Waters, 107(8): 53-58



Most Desirable	
Elimination	<u>EXAMPLE:</u> Eliminate weighing residents as a separate task by using lifting equipment that also contains a scale.
Engineering Controls	<u>EXAMPLE:</u> Eliminate manual lifting tasks associated with the care of residents by using mechanical lifts that move them in and out of beds such as ceiling-mounted lift device, portable lift device with sling, transfer boards.
Administrative Controls	<u>EXAMPLES:</u> Train direct care workers on how to apply algorithms and to use lifting and repositioning devices without injuring themselves or residents; increased staffing during high-care portions of the day; scheduling resident lifting activities over a larger period of the day to ensure the best use of lifting equipment; scheduling SRH Ergonomic Team meetings at a time that allows all stakeholders to attend; providing release time for direct care workers so they can participate in the SRT meetings.
Personal Protective Equipment	<u>EXAMPLE:</u> Using “back belts” to reduce the internal forces on the spine by “stiffening” it. [Note: there is little or no evidence that back belts prevent injuries; some contend that they may increase the likelihood of injury because health care workers may believe they can lift more when wearing them.]
Least Desirable	

OLD PRACTICES...



- EXPECT WORKERS TO ADAPT TO POOR WORK DESIGNS.
- CAN INJURE THE PATIENT.
- DEMAND THAT WORKERS EXCEED THE NATURAL LIFTING LIMITS OF THEIR BODIES.
- ARE TECHNIQUES THAT ARE BASED ON LOADS THAT WEIGH FAR LESS THAN TYPICAL PATIENTS.

EVIDENCE BASED PRACTICES...



- ARE DESIGNED TO FIT WORKERS AND MAINTAIN SAFETY.
- APPLY POSITIONING AND MOBILITY TECHNIQUES THAT ARE SAFE FOR PATIENTS AND CAREGIVERS.
- SHOULD BE INCLUDED IN ALL HEALTHCARE CURRICULA TO ENSURE THAT HEALTHCARE WORKERS ARE TAUGHT PROPER TECHNIQUES TO SELECT AND UTILIZE SAFE PATIENT HANDLING EQUIPMENT.

<i>Cultural Change</i>	
OLD Resident Handling “Blame and Shame” Culture	NEW Health Care Safety Culture
Mistakes (resident or worker injuries) are due to direct caregiver’s error	Mistakes are primarily due to poorly designed job tasks and work environment
Patient and direct caregiver injury prevention can be improved through training in proper manual lifting such as two person lifts	Resident and direct caregiver injury prevention can be improved by ergonomically assessing and engineering out job task risks and work environment risks
Job task demands, short-staffing, time constraints, non-maintained/non-accessible/inappropriate mechanical assists make “no-lift” policies impractical	Administrative controls such as policies and procedures for maintaining equipment, making equipment available, ensuring equipment is appropriate to job tasks, training workers on equipment make no lift policies practical
Investment in equipment, training, release time to participate on ergonomic committees is not cost effective	Average return on investment is three years due to cost savings on worker’s compensation costs, decreased lost work days, decreased worker replacement costs, and increased job retention
Direct caregivers won’t change. It is human nature to take the easiest route; we use manual lifts to get the job done. When mistakes are made it is human nature to hide them	Direct caregivers can be trained to follow SRH policies and procedures, assess resident dependency and the right equipment to use. Administrative support for encouraging reporting of mistakes or near misses allows for continuous improvement. The point is to build effective vigilance, communication, and problem solving.

MODULE TWO

HANDOUTS

TASK vs. PROCESS

Obstacles (the “worst” meetings) (some examples)	Core skill
<ul style="list-style-type: none"> • Meetings don’t begin on time. • Meetings drag on forever. • People are rude and talk at the same time or hold sidebar conversations. 	<ul style="list-style-type: none"> • Establishing ground rules.
<ul style="list-style-type: none"> • Team members forget to prepare for the meeting. • One topic dominates the meeting and no other business gets done. 	<ul style="list-style-type: none"> • Developing an agenda. • Group process roles.
<ul style="list-style-type: none"> • One or two people dominate the meeting; others don’t get a chance to speak. • The team can’t seem to make decisions. 	<ul style="list-style-type: none"> • Establishing ground rules. • Group process roles. • Methods of group decision making.
<ul style="list-style-type: none"> • The team votes on issues, but those in the minority are unhappy, disgruntled, or sabotage the winning decision/action. • Team members can take such strong stands on issues that nothing ever gets resolved upon; no one will compromise. • Team members won’t say what they really feel. • Quiet team members feel pressured to go along. • Meetings become unproductive complaint sessions and nothing ever gets done. Members resign over the frustration. 	<ul style="list-style-type: none"> • Methods of group decision-making. • Conflict-resolution skills. • Natural stages of group development.

ACTIVITY: Establishing Ground Rules

- 1) What benefits would your Team meetings gain from setting ground rules?

- 2) What are some ground rules you would suggest for team meetings here?

HOW TO PITCH A BETTER MEETING

Guidelines

- | | | |
|--------|----------------------|---|
| Step 1 | <u>Plan</u> | Plan the meeting, being clear about <ul style="list-style-type: none">❑ why the meeting is needed❑ what outcomes the group wants,❑ who should attend,❑ what arrangements need to be made,❑ what agenda items need to be discussed,❑ how items will be addressed
(what processes will be used-brainstorming, diagnosing a problem, developing solutions, selecting a solution, reaching consensus, and so on), and❑ how much time will be needed to achieve the desired outcomes. |
| Step 2 | <u>Inform</u> | Inform meeting participants of <ul style="list-style-type: none">❑ the purpose of the meeting,❑ the desired outcomes,❑ the agenda items (the “what”),❑ the processes to be used
(the “how” of addressing agenda items),❑ the date, time, and location, and❑ any premeeting assignments. |
| Step 3 | <u>Target</u> | Develop a target for productive discussion by <ul style="list-style-type: none">❑ stating and clarifying the purpose of the meeting,❑ getting agreement on the desired outcomes,❑ allowing for modification of the agenda
(including adding or deleting items, changing the order, or adjusting the times allocated), and❑ getting agreement on the processes to be used in addressing agenda items. |

- Step 4 **Contain** **Contain** the discussion to the agreed-upon agenda by
- ❑ designating a facilitator and a recorder,
 - ❑ adhering to the agenda unless the group explicitly agrees to alter it,
 - ❑ adhering to an agreed-upon process unless there is common agreement that it is no longer useful,
 - ❑ confronting behavior that diverts the group from attaining its desired outcomes,
 - ❑ encouraging each group member to bring all his or her information to bear on the issue at hand, and
 - ❑ getting agreement on action steps, responsibilities, and target dates.

- Step 5 **Hasten** **Hasten** the completion of agreed-upon action steps by
- ❑ summarizing the meeting,
 - ❑ recording the decisions that were made,
 - ❑ recording the names of persons responsible for implementing action steps and the target dates,
 - ❑ agreeing on a date for the next meeting,
 - ❑ evaluating every meeting and agreeing on ways to “pitch” a better meeting,
 - ❑ editing and distributing minutes,
 - ❑ putting unfinished business on the agenda for the next meeting,
 - ❑ following up and encouraging task completion, and
 - ❑ monitoring and evaluating the results achieved by the group.

GUIDELINES FOR DEVELOPING A GOOD AGENDA

Specify the date, place, starting time and ending time.

Provide a statement of the overall mission or purpose of the meeting.

Identify who will attend.

List the topics to be covered, in the sequence they will be covered.

Identify the approximate time you will devote to each topic.

Identify the pre-meeting reading or assignment expected of each member.

Distribute the agenda to each group member at least one week before the meeting.

SAFE RESIDENT HANDLING TEAM MEETING AGENDA

Date:

Primary Facilitator:

Time:

Recorder:

Location:

Timekeeper:

Purpose of Session:

Desired Outcomes:

Time:

Topic:

**Person initiating or
reporting on topics:**

GROUP PROCESS ROLES

Having key roles assigned for every meeting enables the process of managing the meeting's business and time to run smoothly. The core skills of facilitating, timekeeping, and recording make sure that the tasks of the team get done while, at the same time, the members interact with courtesy and respect.

Team chairs or co-chairs need not feel that they must always be the facilitator – the role of meeting facilitator can rotate around the group (as can the other group roles). Sometimes this rotation of roles can be very educational: disruptive or argumentative team members can benefit from serving as facilitator and recognizing how much tact it takes to manage a group when one or more members are disruptive.

The timekeeper helps the group to stick to the agenda by providing guidance on how time is passing. If an issue is clearly in need of more time or energy, but not in the current meeting, it can be assigned to one or more members, or to a task force, to work on who will then report back to the group.

The recorder performs the valuable task of writing down decisions and action item assignments – this is especially helpful if done on flipchart paper in full view of the group. Any errors or clarifications can be corrected immediately. And if a team member's mind wanders (as happens to all of us), a look at the flipchart helps that member to rejoin the meeting without missing the important stuff. Also, the flipcharts automatically become the team's minutes, and the significant items can then be placed on the agenda for the next meeting. If an issue surfaces which simply cannot be addressed in the current meeting, it can be placed on a flipchart "parking lot" – this keeps an important idea from being lost.

PARTICIPANT ROLE

Before the meeting

- 1) Block time on schedule
- 2) Confirm attendance
- 3) Define your role
- 4) Determine what the facilitator needs from you
- 5) Suggest other participants who should attend
- 6) Know the objective
- 7) Know when and where to meet
- 8) Do any required homework

During the meeting

- 1) Listen and participate
- 2) Be open-minded/receptive
- 3) Stay on the agenda and subject
- 4) Limit or avoid side conversations and distractions
- 5) Ask questions to assure understanding
- 6) Take notes on your action items

After the meeting

- 1) Evaluate meeting
- 2) Review memorandum of discussion
- 3) Brief others as appropriate
- 4) Complete your action items
- 5) Follow up on action items with other people

MOD #2 – (NOT HANDOUT FOR TRAINEES) INSTRUCTOR'S BACKGROUND FOR CONDUCTING MYSTERY EXERCISE TO PRACTICE COMMITTEE ROLES/SKILLS

Below is a list of clues for use in the mystery exercise—print one clue per page and distribute to trainees (can handout one clue/trainee or one clue/ small group of trainees) and use clues from each category—significant information and extraneous information:

Significant information clues:

- Nursing assistants doing resident care ranked transferring wheelchair residents to and from the toilet as the two tasks most stressful to the lower back.
- Nursing assistants working with Mrs. Andrews have reported that she sometimes strikes out at caregivers without warning.
- Nursing assistant Anne reported having to support the resident's weight for about 30 seconds while pushing the wheelchair to the toilet, lifting the resident to "standing" position, pushing the wheelchair away; pulling pants and absorbent pad down while supporting the resident, then turning and lowering the person to the toilet seat.
- The average time to toilet a client is 4.2 minutes.
- Anne, a nursing assistant, reported having twisted her back while toileting a resident.
- Due to limited lavatory space and handrails between the toilet and the wall, the wheelchair was often left at the door of the lavatory, the nursing assistant carried the person to the toilet.
- On average, each nursing assistant carries out 24 of the most stressful resident-transfer tasks per 8-hr shift.
- Anne, a nursing assistant, weighs 142 lbs, is 5'4" tall, and has worked in health care for about 8 years.
- Mrs. Andrews is 92 years old and weighs 136 lbs.
- The mean frequency of transfers for this toileting process: 10.8 per nursing assistant per 8 hour shift on floor 1; 17.0 per nursing assistant per 8 hour shift on floor 2.
- The typical toilet seat height is 16"; wheelchair seat height is 18".

Extraneous information clues:

- Mrs. Andrews' husband was a copy machine repairman.

MOD #2 – Mystery Exercise Clues (continued)

- The nursing assistants on floors 1 and 2 are participating in a weight-loss contest.
- The staff won an award for increased productivity for 2009.
- The union steward on floor 2 sprained her ankle.
- The long term care facility recently received 5 new computers.
- Dead ants were found on the windowsills of the first floor offices and mail sorting department.
- The cafeteria/kitchen's grease trap was pumped out on January 18.
- The custodians clean the residents' rooms daily and the offices every other night.
- The custodians clean the restrooms and water fountains every day.
- On Fridays, the cafeteria serves fish sticks.
- On Wednesdays, the cafeteria serves macaroni and cheese.

DECISION-MAKING

Nancy Lampen, MS

Groups are constantly making decisions. It is hoped that the decisions made are clearly recognized and intended by the members of the group. Unfortunately, this often is not the case. For instance, a decision to do something frequently involves a complementary decision, a decision not to do something else. Economists speak of "opportunity costs" as being the sacrifices that arise from decisions. The act of deciding to commit resources to a program means that a decision was made not to commit resources to some other alternative. This alternative opportunity decision is frequently unnoticed.

Another aspect of decision-making is the decision on how to decide. Groups are established to pursue some objective, to make a decision about some task. These decisions are frequently obvious. Yet, in doing so, the group frequently decides how to go about making these decisions, which frequently is not so obvious. It is as important to recognize how and why a decision was made as to recognize the decision itself. For instance, we often assume that silence means consent. "If you don't say anything, you must be in favor of the proposals." Yet this assumption is frequently invalid. How often have you been in a meeting where someone said, "All right, it's agreed that we will. . .," and immediately afterward members began expressing reservations, doubts, objections, questions? The leader of this group assumed silence meant agreement and consent, yet many members were not in agreement.

Tragically, in these situations the task of carrying out the decision will fall on those who do not support or understand it. One of the reasons that implementation is a minor obstacle in successful decision-making is the failure of members to recognize the processes involved in the decision. Ignorance of the process by which a decision was made makes it extremely difficult to evaluate its appropriateness and to alter it if needed. Once a decision has been made, it is extremely difficult to undo. Therefore, the recognition of how groups go about making decisions is another facet of being a good observer of group processes. Edgar Schein provides the following description of the ways in which groups make decisions.

1. Decision by lack of response ("plop"). The commonest and perhaps least-visible group decision-making method is that in which someone suggests an idea, and, before anyone else has said anything about it, someone else suggests another idea, until the group finds one it will act on. All the ideas that have been bypassed have in a sense been decided upon by the group. But the decision has been a common decision not to support it, making the proposer feel that his suggestion has "plopped."
2. Decision by authority rule. Many groups set up a power structure or start with a power structure that makes it clear that the chairman or someone in authority will make decisions. The group can generate ideas and hold free discussions, but at any time the chairman can say that, having heard the discussion, he has decided to do thus and so. This method is highly efficient. Whether or not it is effective depends a great deal upon whether the chairman is a sufficiently good listener to have culled the right information on the basis of which to make his decision. Furthermore, if the group must move on to the next stage or implement the decision, the authority-rule method produces a minimum amount of involvement of the group. Hence it undermines the potential quality of the implementation of the decision.
3. Decision by averaging individuals' opinions. Each group member is separately asked his/her opinion and the results are averaged. This is often used when a group can't meet and a chairperson telephones each member and asks their opinion. The most common opinion is selected. No direct discussion is held among group members. The opinions of the least knowledgeable members may cancel out the opinions of the most knowledgeable members. Members are not likely to be very committed to implementing the decision.
4. Decision by minority. One of the most common complaints of group members is that they "feel railroaded" in reference to some decisions. Usually this feeling results from one, two, or three people employing tactics that produce action, and therefore must be considered decisions, but are taken without the consent of the majority. A common form of minority rule is for two or more members to come to a quick and powerful agreement on a course of action, to challenge the group with a quick, "Does anyone object?" and, if no one raises his voice in two seconds, to proceed with, "Let's go ahead, then." Again the trap is the assumption that silence means consent. This method may be effective when a group has a large number of decisions to be made and not enough time to deal with them all, or if the decisions do not need member involvement to be implemented.
5. Decision by majority rule: voting and/or polling. We next come to more familiar decision-making procedures, those which are often taken for granted as applying to any group situation because they reflect our political system. One simple version is to poll everyone's opinions following some period of discussion, and, if some majority feels the same way, to assume that that is the decision. The other method is the more formal one of stating a clear alternative and asking for votes in favor of it, votes against it, and abstentions.

6. Decision by consensus. One of the most effective but also most time-consuming methods of group decision making is to seek consensus. Operationally, it would be defined by the fact that those members who would not take the majority alternative nevertheless understand it clearly and are prepared to support it. It is a psychological state.
7. Decision by unanimous consent. The logically perfect but least attainable kind of decision is one in which everyone truly agrees on the course of action to be taken. For certain key kinds of decisions, it may be necessary to seek unanimity, but, for most important ones, consensus is enough, if it is real consensus.

CONSENSUS EXERCISE: ITEMS FROM THE LATEST SAFETY AND HEALTH AUDIT

Rank these items from **highest** hazard to **lowest** hazard.

- A. Karen continues to ambulate Stan, who needs two people to assist him.
- B. Betty keeps all her important files in the bottom drawer.
- C. In the clean supply room, items for bathing are kept on a shelf at the eye level of Sue who is 5' 8".
- D. Dave experienced a muscle spasm when pulling his resident up in bed. The bed was against the wall.
- E. Two-assist pivot transfers are still performed on a daily basis.
- F. A resident that was on the floor was manually lifted back into his chair.
- G. John refuses to move any furniture in his room and is dependent upon care.

Your ranking	Group ranking	Expert ranking
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Interest-Based Decision Model

- ◆ Clearly identify the issue(s)
Share relevant data/information
- ◆ Identify & explain each party's interests on the issue
Identify your own interests

Exchange and explain your interests

- ◆ Identify common/similar interests
- ◆ Identify conflicting interests
- ◆ Create options or actions
- ◆ Evaluate options with objective standards/criteria
- ◆ Develop action plan

Interests are needs, desires, concerns, fears

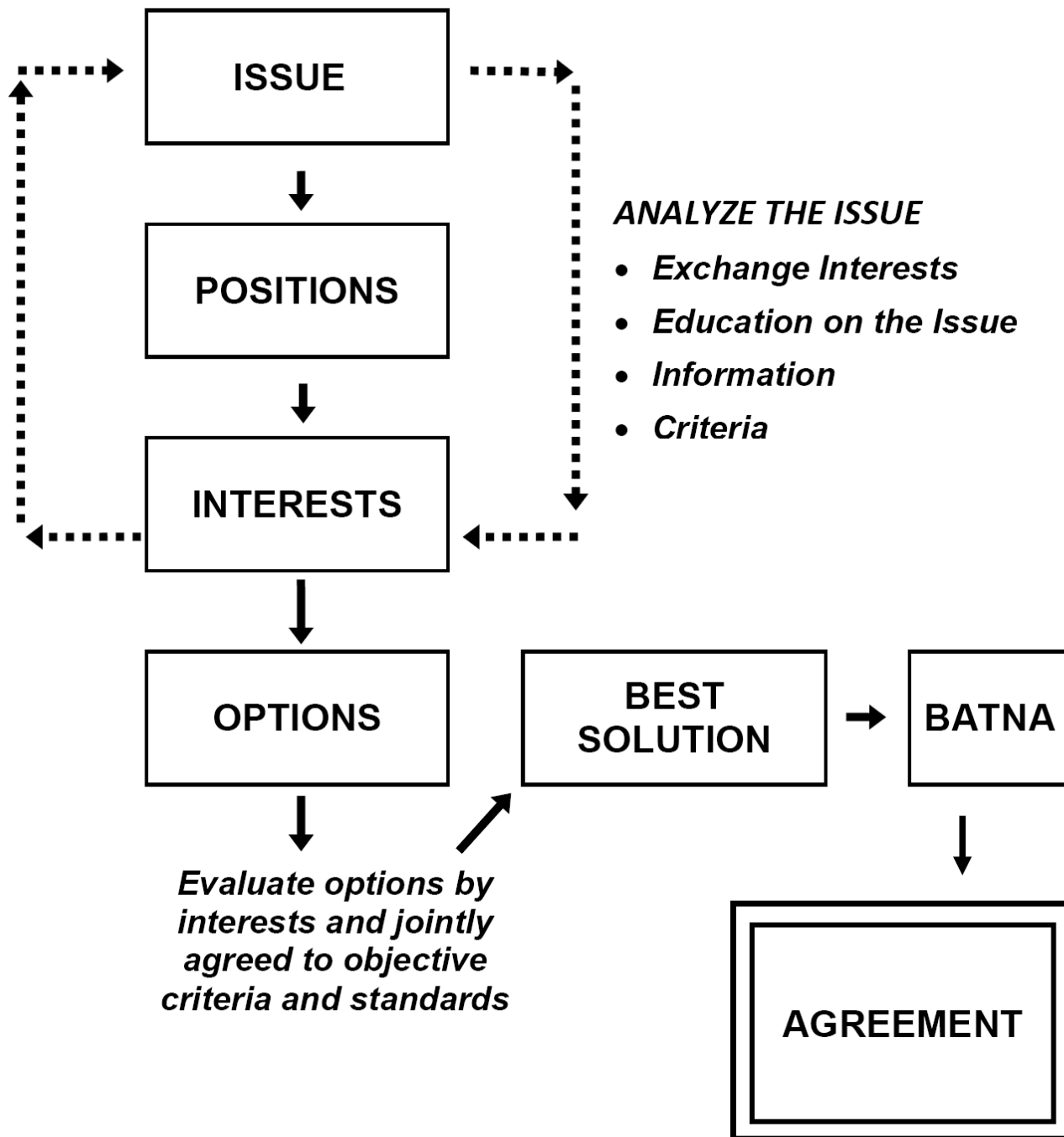
Interests reflect what one really cares about

Interests reflect the concerns that drive positions

Interests are the key!

To discover interests, yours and theirs, ask questions.

Interest Based Conflict Resolution in Sequence



LEARNER TYPES AND THE MULTIPLE INTELLIGENCES - By Howard Gardner

Learner Type	Likes To	Is Good At	Learns Best By
Musical “The Music Lover” (music smart)	<ul style="list-style-type: none"> • sing, hum • listen to music • play an instrument • respond to music 	<ul style="list-style-type: none"> • picking up sounds • remembering melodies • noticing pitch/rhythm • keeping time 	<ul style="list-style-type: none"> • rhythm • melody • music
Interpersonal “The Socializer” (people smart)	<ul style="list-style-type: none"> • have lots of friends • talk to people • join groups 	<ul style="list-style-type: none"> • understanding people • organizing • communicating • persuading • mediating 	<ul style="list-style-type: none"> • sharing • comparing • relating • cooperating • interviewing
Spatial/Visual “The Visualizer” (picture smart)	<ul style="list-style-type: none"> • draw, build, design and create things • daydream • look at slides/pictures/movies • play w/machines 	<ul style="list-style-type: none"> • imagining things • sensing things • mazes/puzzles • reading maps and charts 	<ul style="list-style-type: none"> • visualizing • dreaming • using the mind’s eye • working with colors and pictures
Kinesthetic “The Mover” (body smart)	<ul style="list-style-type: none"> • move around • touch and talk • use body language 	<ul style="list-style-type: none"> • physical activities (sports/dance/acting) • crafts 	<ul style="list-style-type: none"> • touching • moving • interacting with space • processing knowledge through bodily sensations
Intrapersonal “The Individual” (self-smart)	<ul style="list-style-type: none"> • work alone • pursue own interests • have own space 	<ul style="list-style-type: none"> • understanding self • focusing in on feelings and dreams 	<ul style="list-style-type: none"> • working alone • individualized projects • self-paced instruction
Logical/Mathematical “The Questioner” (number smart)	<ul style="list-style-type: none"> • do experiments • figure things out • work with 	<ul style="list-style-type: none"> • math • reasoning • logic • problem solving 	<ul style="list-style-type: none"> • categorizing • classifying • working with abstract patterns and relationships
Linguistic “The Word Player” (word smart)	<ul style="list-style-type: none"> • read • write • tell stories 	<ul style="list-style-type: none"> • memorizing names, places, dates and trivia 	<ul style="list-style-type: none"> • saying, hearing, and seeing words
Naturalist “The Nature Lover” (nature smart)	<ul style="list-style-type: none"> • work with animals • garden • nature walks or hiking 	<ul style="list-style-type: none"> • working with animals • “green thumb” 	<ul style="list-style-type: none"> • relating to natural phenomena or occurrences • nature sounds

MODULE THREE

HANDOUTS

Log of Work-Related Injuries and Illnesses

Occupational Safety and Health Administration

State

[illegible]

(1)	Injury
(2)	Skin Disorder
(3)	Respiratory Condition
(4)	Poisoning
(5)	Hearing Loss
(6)	All other illnesses

OSHA's Form 301

Injury and Illness Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.



U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Information about the employee

- 1) Full name _____
- 2) Street _____
City _____ State _____ ZIP _____
- 3) Date of birth ____/____/____
- 4) Date hired ____/____/____
- 5) ☐ Male
☐ Female

Information about the physician or other health care professional

- 6) Name of physician or other health care professional _____
- 7) If treatment was given away from the worksite, where was it given?
Facility _____
Street _____
City _____ State _____ ZIP _____
- 8) Was employee treated in an emergency room?
☐ Yes
☐ No
- 9) Was employee hospitalized overnight as an in-patient?
☐ Yes
☐ No

Information about the case

- 10) Case number from the *Log* _____ (Transfer the case number from the *Log* after you record the case.)
- 11) Date of injury or illness ____/____/____
- 12) Time employee began work _____ AM / PM
- 13) Time of event _____ AM / PM ☐ Check if time cannot be determined
- 14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
- 15) **What happened?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- 16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- 17) **What object or substance directly harmed the employee?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.
- 18) **If the employee died, when did death occur?** Date of death ____/____/____

Completed by _____
Title _____
Phone (____) _____ - _____ Date ____/____/____

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA, Office of Statistical Analysis, Room N-3654, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Summary of Work-Related Injuries and Illnesses



All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
(G) _____	(H) _____	(I) _____	(J) _____

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
(K) _____	(L) _____

Injury and Illness Types

Total number of ... (M) _____			
(1) Injuries _____	(4) Poisonings _____	(5) Hearing loss _____	(6) All other illnesses _____
(2) Skin disorders _____			
(3) Respiratory conditions _____			

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average 58 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3044, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment information

Your establishment name _____

Street _____

City _____ State _____ ZIP _____

Industry description (e.g., *Manufacture of motor truck trailers*) _____

Standard Industrial Classification (SIC), if known (e.g., 3715) _____

OR

North American Industrial Classification (NAICS), if known (e.g., 336212) _____

Employment information (If you don't have these figures, see the Worksheet on the back of this page to estimate.)

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

Company executive _____ Title _____
 Phone (____) _____ / _____ Date ____/____/____



Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ 2. Date of Birth: ____/____/____
First MI Last
3. Mailing address: _____
Number and Street PO Box City State Zip Code
4. Social Security Number: _____ 5. Phone Number: (____) _____ 6. Gender: ☐ Male ☐ Female
7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____) _____
3. Your work address: _____
Number and Street City State Zip Code
4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____
6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____
2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____
4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____
6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____
First Mi Last

DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____
9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____
11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
Name and address where you were first treated: _____
Phone Number: (____) _____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
Phone Number: (____) _____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**

6. Was the previous injury/illness work related? ☐ Yes ☐ No
If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

SAFE-T Survey

Staff Assessment of Facility and Employment Topics

952

Instructions: The Center for Health and Social Research at Buffalo State College is collaborating with your worksite and the Western New York Council on Occupational Safety and Health (WNYCOSH) to survey employees about worksite issues as part of the Safe Patient Handling and Movement Project.

- We are asking **all staff involved in patient care and therapy, administrators, and administrative staff** to complete this questionnaire each year as part of the project.
- The survey is short and takes only about **10 minutes** to complete.
- Your answers are anonymous -- **do not put your name on this survey**.
- By providing responses that **accurately reflect your background, experiences, and opinions**, you will be giving us valuable information to guide and improve the project.
- Thank you for participating in this survey -- your help is essential to improving the project.

Section 1 - Background and Work History

1. Which best describes your current position at this facility?
 - ☐ Certified Nursing Assistant (CNA)
 - ☐ Assistant other than CNA
 - ☐ Licensed Practical Nurse (LPN)
 - ☐ Physical Therapist
 - ☐ Occupational Therapist
 - ☐ Other clinical/professional services
 - ☐ Administration
 - ☐ Other (Specify: _____)
2. Are you best described as working:
 - ☐ Full time
 - ☐ Part time
 - ☐ Per diem or contract basis
3. How long have you worked at this facility?
 - ☐ Less than one year
 - ☐ One to two years
 - ☐ More than two years, but less than four years
 - ☐ Four years or longer
4. You are best described as working in a:
 - ☐ Supervisory role
 - ☐ Non-supervisory role
5. Your usual work shift is:
 - ☐ Days
 - ☐ Evenings
 - ☐ Nights
 - ☐ A combination of days, evenings, and nights
6. Do you usually work weekends? ☐ Yes ☐ No
7. You are: ☐ Male ☐ Female
8. Which of the following best describes your ethnicity?
 - ☐ White
 - ☐ African American
 - ☐ Asian
 - ☐ American Indian
 - ☐ Hispanic/Latino
 - ☐ Mixed race
 - ☐ Other
 - (Specify: _____)
9. In which age category are you?
 - ☐ Under 25 years
 - ☐ 25-34 years
 - ☐ 35-44 years
 - ☐ 45 - 54 years
 - ☐ 55 - 59 years
 - ☐ 60 years and above
10. Do you consider yourself to be the "caregiver" for an adult in your family (e.g., parent, aunt, sibling, etc.)?
 - ☐ Yes
 - ☐ No

Section 2 - Patient Movement Training and Opinions

11. Have you received training for the Safe Patient Handling and Movement (SPHM) project at your facility? ☐ Yes ☐ No
12. The SPMH project now being implemented at your facility will:

	Strongly agree	Agree	Disagree	Strongly disagree
(a) reduce the chances that you will be injured.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(b) improve the working conditions at your facility.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(c) improve the conditions for the patients.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. The "Ergo Team" being implemented at your facility will:

	Strongly agree	Agree	Disagree	Strongly disagree
(a) reduce the chances that you will be injured.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(b) improve the working conditions at your facility.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(c) improve the conditions for the patients.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. You have opportunities to provide input into patient handling and movement procedures.....

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------	-----------------------
15. The administration at your facility strongly supports safe lifting and safe patient handling efforts.....

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------	-----------------------

- | | Strongly agree | Agree | Disagree | Strongly disagree |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 16. Operating procedures for using patient lift equipment/machines are reviewed and revised as necessary..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17. Patient lift or movement accidents and/or misses are always reported..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18. Using appropriate body mechanics only, it is possible to safely lift patients..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19. In general, you support mandated health and safety programs such as seat belts, smoke alarms & non-smoking regulations.... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

If you **EVER** lift, handle, or move patients at your facility, please **continue on with questions 20-29**.

If you **NEVER** lift, handle, or move patients at your facility, please **skip to question 30**.

- | | |
|---|--|
| <p>20. The functional status of the majority of your patient caseload is best described as:</p> <p><input type="radio"/> Independent <input type="radio"/> Extensive assist</p> <p><input type="radio"/> Minimal assist <input type="radio"/> Dependent (total care)</p> | <p>22. Did any injury in the past 12 months cause you to... Yes No</p> <p>(a) leave work early?..... <input type="radio"/> <input type="radio"/></p> <p style="padding-left: 40px;">Were any reports made to the facility administration?..... <input type="radio"/> <input type="radio"/></p> <p>(b) take time off (miss work)?..... <input type="radio"/> <input type="radio"/></p> <p style="padding-left: 40px;">Were any reports made to the facility administration?..... <input type="radio"/> <input type="radio"/></p> <p>(c) require you to receive medical care? <input type="radio"/> <input type="radio"/></p> <p style="padding-left: 40px;">Were any reports made to the facility administration?..... <input type="radio"/> <input type="radio"/></p> <p>(d) receive worker's compensation?..... <input type="radio"/> <input type="radio"/></p> <p style="padding-left: 40px;">Were any reports made to the facility administration?..... <input type="radio"/> <input type="radio"/></p> |
| <p>21. How many injuries have you experienced in the past 12 months that were associated with lifting, moving, or transferring patients?</p> <p><input type="radio"/> None (Go to question 24)</p> <p><input type="radio"/> One</p> <p><input type="radio"/> Two</p> <p><input type="radio"/> Three</p> <p><input type="radio"/> Four</p> | |
| <p>23. Please give a brief description of the circumstances associated with the injury or injuries you experienced in the past 12 months: (Please print clearly)</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div> | |

- | | Strongly agree | Agree | Disagree | Strongly disagree |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| 24. At your facility, the equipment needed for lifting or moving patients is: | | | | |
| (a) usually available without a wait when you need it..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| (b) usually in good working condition..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25. You believe that you are adequately trained to use the patient lift equipment at your facility..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. You have a favorite type of equipment to use for lifting or moving patients..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27. Your favorite equipment for lifting or moving patients is: | | | | |
| (a) usually available without a wait when you need it..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| (b) usually in good working condition..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <p>28. List your favorite equipment to use for lifting patients: (Please print clearly)</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div> | | | | |



29. List the **equipment that you do not like to use** for lifting patients:

(Please print clearly)

Section 3 - Job/Workplace Satisfaction

	Very dissatisfied	Dissatisfied	Neither	Satisfied	Very satisfied
30. The feeling of worthwhile accomplishment I get from my work.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. The extent to which I use my skills.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. The contribution I make to patient care.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. The extent to which my job is varied and interesting.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. The standard of care given to patients.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. The amount of personal growth and development I get from my work.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. The amount of independent thought and action I can exercise in my work.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. The time available for patient care.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. My workload.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39. Overall staffing levels.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. The amount of time spent on administration.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41. The amount of support and guidance I receive....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
42. The opportunities I have to discuss my concerns..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43. The support available to me in my job.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44. The overall quality of the supervision I receive in my work.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45. The degree of respect and fair treatment I receive from my boss.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
46. The people I talk to and work with.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
47. The contact I have with colleagues.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
48. The value placed on my work by colleagues.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
49. The degree to which I am fairly paid for what I contribute to this organization.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
50. Time off to attend courses/use continuing education benefits.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
51. The opportunity to attend courses/use continuing education benefits.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
52. Being funded for continuing education.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
53. The extent to which I have adequate training for what I do.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

54. List three barriers to providing improved care to patients:

(Please print clearly)

55. List three things that would best improve your working conditions:

(Please print clearly)

56. Is there anything else that you think it would be important to share?

(Please print clearly)



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What are the Facts about Safe Patient Handling and Movement?

FACT # 5

FACT: INVESTING IN SAFE PATIENT HANDLING AND MOVEMENT IS MONEY IN THE BANK!

Two back claims in Western New York dating back to 1992 and 1999 that remain open, have total costs of over \$1.1 million. (Kaleida Health)

One back injury to an ICU nurse cost over \$1 million. (Tampa General)

The direct cost of an average back injury case is \$19,000. Serious cases requiring surgery average \$85,000 in direct costs.

Indirect costs to the facility from a back injury averages between 4 and 10 times the direct costs.

The costs of patient lifts are far lower than the cost of injuries. In nine NIOSH case studies there were:

- 60 – 95% reduction in injuries
- 95% reduction in workers' comp. costs
- 92% reduction in medical/indemnity costs
- As much as 100% reduction in lost work days (absence due to injury)
- 98% reduction in absenteeism (absence due to unreported injury)

Return on
Investment: 1 to 3
Years!



PUSH for...
Protection Using Safe Handling

**Fiscal Improvement in
Healthcare!**

For more information, please visit:

www.zeroliftforny.org

What are the Facts about Safe Patient Handling and Movement?

FACT # 6

FACT: THE COST OF AN INJURY IS FAR GREATER THAN THE COST OF EQUIPMENT

Cost of Equipment: (Average)

Full Mechanical Lifts –
\$4000 *1 per 8 patients of need*

Sit to Stand Assist Lifts –
\$3100 *1 per 8 patients of need*

Ceiling Lifts –
\$100 per foot installed, lift \$3000

**Non-Friction sheets and other
positioning devices –**
\$38 - \$3,000

Training or Re-Training-
(minimum 3 hour course)



Costs of an Injury

(Average cost of injury with one month of lost workdays.)

Direct Costs:

Medical- \$7,000

Indemnity- \$11,108

Allocated Loss of Expenses- \$1,411

Indirect Costs:

Replacement Costs- \$7,350

*(\$24.50 per hour of productivity loss)
(Overtime & Agency Fees)*

Benefit Continuation- \$635.48

*Incident Investigation- Salary of six
individuals per hour to investigate a
claim.*

*Internal Financial Management-
Salaries of six individuals per hour.*

"Kaleida Health Long Term Care began the implementation of a Safe Patient Handling Program in 2004. Over 800 employees received a three-hour training session. Long Term Care management made a commitment to the program and more importantly to our workforce. We worked with Paula Pless, our Director of Safe Patient Handling and Workforce Ergonomic Safety to ensure our success.

In 2003 we incurred over \$604,000 lost wages alone due to injuries, by the end of 2006 lost wages due to compensation injuries were \$142,588-a savings of almost \$1,000,000 over three years. Our program is successful and Paula and her team continue to work to improve our success rate and provide a safer work environment for our employees. SPH programs provide a solid return on investment."

Maureen Caruana Vice President, Kaleida Health LTC



PUSH for...
Protection Using Safe Handling

**An End to Injuries to
Healthcare Workers!**

For more information, please visit:

www.zeroliftforny.org

CASE STUDY ONE

Safe Resident Handling The NYS Veterans Home Story Batavia, NY January 2011

The NYS Veterans Home in Batavia, NY is a 126 bed Long Term Care facility. In 2001 - 2003, Lost Work Days related to resident handling injuries hovered between 1,400 and 1,800. These Lost Work Days meant that management had to replace those out on lost time--the equivalent of 8 - 9 CNAs. NY State mandated ("mandation") that the rest of the staff would have to work overtime to cover workers out on injury. The staff hated being forced to work mandatory overtime and administration was equally frustrated with the staffing headache and staff animosity. In 2003, after prodding from CSEA union leader Paul Blujus, the chief administrator, Joanne Hernick, introduced a Safe Resident Handling program at the facility. Below is part of an interview conducted by WNYCOSH staff coordinator, Donna Chapman, on July 15, 2010.

Joanne Hernick: The concept of the Zero-Lift program and the outcome of it probably became clear to us as a possibility because we were experiencing a significant number of people who were out on Workers' Comp due to injuries related to pulling, moving and lifting residents. It was impacting the Home management from the standpoint of our ability to staff the place in order to have the level of care we wanted.

Paul Blujus: We always strived to reduce the mandation which was mainly caused from workers' injuries from patient handling and this was part of our main focus. . . And so it was kind of a no-brainer to adopt this [SRH program], but I can't stress enough the good flavor of Labor-Management relations.

Joanne: I think it's a partnership. We ended up with a Zero-Lift Committee which was the group in charge. . . The first time we [implemented the SRH program we said] "We're going to train everybody and that this is our policy and then go out there and do it. . . That did not work. We learned that it has to be much more comprehensive. In our Home, we are a 24/7/365 operation. We had participation from each shift: per diem, part-time, full-time, because their work and lift experiences are different. We had representation from ancillary departments. We included our housekeeping staff, our maintenance staff. . . You know, when that lift goes down and maintenance has a million things to do they have to know that's an important thing--[the repair] has to go to the top of the pile.

Paul: Each shift has a stake in the Safe Patient Handling [program]. . . The Care Plans used to be written in stone for a certain kind of transfer. [But] the Care Plans reflected how the resident's condition was at the time of assessment. We came to the conclusion that each shift would be a little bit different. At dinner time, if they were weary, we upgraded the transfer. The same thing in the morning if they went, let's say, needed a total lift to be toileted.

Joanne: To attend committee meetings, we would pay for staff to come in from the night shift to participate. . . .Labor and Management--all of the people who worked here at the home--nobody wanted to hear of another person being injured. We've seen enormous declines in injuries related to lifting, pulling and moving. But it takes time before it becomes part of your culture. . . .It's part of our culture now. In health care, there's a certain way you wash your hands--you know, you can do it without thinking about it. And that's how we now provide assistance to our residents in lifting, pulling and moving--it's become, you know, a reflex. But it took a long time before that happened.

Paul: Years ago, before we started [the Zero-Lift program], we didn't assume we would be going home healthy. . . .Now we do expect to go home at the end of our shift, healthy. Now I think people expect to retire from nursing. It would have happened without the Safe Patient Handling program. If you asked the staff if they would ever go back to the old ways, you'd hear a resounding "NO!" Everybody has so much more energy now. With all the energy saved through Safe Patient Handling and that technology, we have more energy to do our jobs and to spend more quality time in conversation with residents, making their stay more pleasant.

Joanne: As an administrator, my life here is much more pleasant. In 2003, we had 1,396 work days lost to lifting, pulling, and moving residents with 38 accidents. We started promoting the program in 2003 and the numbers actually went up. We really encouraged people to report [resident-handling] accidents. In 2004 it was 2,344 days--the highest number of lost work days which is equivalent to more than 9 workers out. [After that] we had a steady decline.

Paul: You know [after implementing SPH] for the longest time we had no Workman's Comp injuries due to patient handling. I think the period was around 8 months--no mandatory overtime. We take pride in working in a facility that is known for things other than mandation, and I'm sure Management has that outlook too. We knew we had a problem here and we, through Safe Patient Handling, worked on it and these numbers reflect it.

CASE STUDY TWO

Wyandot County Nursing Home

Upper Sandusky, Ohio

Introduction

This case study was developed from information provided by Wyandot County Nursing Home. OSHA visited the nursing home to discuss the ergonomics program with the nursing home administrator, observe ergonomics corrective actions, and talk to employees, residents, and family members about their experiences.

Wyandot County Nursing Home used a process that reflects many of the recommendations in these guidelines to address safety and health concerns and phase-in its current program that entails no manual lifting of residents. First and foremost, Wyandot's administrator provided strong commitment and support in addressing the home's problems. He also involved Wyandot's workers in every phase of the effort. He talked to his employees, learned about stressful parts of their jobs, and then found solutions. He and his employees identified existing and potential sources of injury at the home and worked to implement solutions. He trained employees each time the nursing home introduced new equipment. He continually checked new equipment, and he continues to evaluate the overall effectiveness of his safety and health efforts. Wyandot is located in Upper Sandusky, Ohio. It is a 100-bed, county-run facility that has served Wyandot County in its present building for the past 28 years. It is divided into two sections to serve residents with different levels of need. The A-Wing, with 32 rooms, serves residents who are mostly ambulatory and require only a minimum of help with daily living. In the B-and C-Wings, with 32 double rooms and four private ones, residents receive care that ranges from extensive to total. Wyandot has 90 employees, 45 of whom are nursing assistants. This makes for a nursing staff ratio of 2.4 hours for each resident per day.

Identifying Problems Before Wyandot implemented its ergonomics program, the home was experiencing problems that were a growing concern to both the county and Wyandot's administrator. According to Wyandot, workers' compensation costs averaged almost \$140,000 from 1995-1997. The turnover rate among nursing assistants averaged over 55 percent during that same time period. This meant that of the 45 nursing assistants working at Wyandot, on average 25 new ones had to be hired each year. Wyandot's administrator began to look for more effective ways to address injuries among workers and the high turnover rate. A back injury suffered by a worker that cost Wyandot \$240,000 in workers' compensation expenses provided significant motivation to find a strategy that would work. As Wyandot's administrator investigated that injury, he also examined other sources of potential injury within the home. In doing so, he learned that resident transfer and repositioning tasks presented high risks for injuries. He called on the Ohio Bureau of Workers' Compensation (OBWC), for help because he thought Wyandot was following best practices and people were still being injured. An OBWC ergonomist visited the home and told him that he had unrealistic expectations about his nursing staff's ability to manually lift and reposition residents.

Involving Employees Wyandot's administrator thought that he could better use his existing staff. After hearing about a "no lift" policy and seeing an impressive demonstration of mechanical lifts at an industry conference, he began to consider setting up a program at

Wyandot. He became convinced that such a program would keep employees safer and help slow the turnover rate while ensuring safety and high quality care for residents. He decided that the best approach was to involve employees at every level in reducing injuries and slowing the turnover rate. More than 30 workers volunteered to examine the tasks of moving and repositioning residents. Wyandot employees concluded that better body mechanics -- the traditional method of lifting and transferring residents at most nursing homes -- was not the answer. In fact, he and his staff determined that there was no safe way to lift a resident other than with mechanical lifts. To determine what equipment would work best, Wyandot tried out various pieces of equipment, evaluated each lift, and then decided what would be most appropriate for Wyandot's needs.

Implementing Solutions With recommendations from employees, Wyandot's administrator bought several portable mechanical lifts for the B- and C-wings. These involved portable sit-to-stand lifts, walk/ambulating lifts, and total lifts. Nurses and assistants could move each of these from room to room as they worked with individual residents. However, many of the staff remained unconvinced of the value of using equipment. In fact, initially only the workers who had actually evaluated the lifts were using them. According to Wyandot's administrator, it was very difficult getting workers to overcome their insistence on doing things the old way. Because many workers said it took too long to use the mechanical lifts, one of the co-charge nurses decided to do a time study. She wanted to test how long it took to lift a resident manually compared to using a mechanical lift. The mechanical lift took about 5 minutes. Meanwhile, to perform the manual lift, a nursing assistant first had to find someone to help. This took 15 minutes. Thus, the time study showed that using the equipment actually saved time. One worker, who admitted that she did not initially use the sit-to-stand lift because it was a "hassle," reconsidered her opinion after an outbreak of the flu reduced the number of staff members available for assistance. In her words, "I was forced to use the lift. Awesome. It was just great. I was so sorry my fellow employees had to suffer with the flu bug to get me to use this contraption." Wyandot's administrator also wanted to replace the old hand-crank beds at Wyandot with electric beds. To do this, he also needed to find beds that would be used in the "low-bed" system in place for many residents. There were not many options available, so he took his ideas and engineering background to a bed company and inquired about having beds designed to fit Wyandot's needs. The bed manufacturer designed the new beds to lift from the floor to a height of about 30 inches in 20 seconds. In addition, these fast beds were designed so that residents would be less likely to slide to the foot of the bed as they were raised to a sitting position. As a result, residents would not need to be repositioned. Also, the beds could be used with a gait-belt for ambulatory residents to assist them from a sitting to a standing position. About three years after Wyandot began its ergonomics effort, the nursing home received a grant from the OBWC Division of Safety and Hygiene through an ergonomic emphasis program to deal with cumulative trauma disorders. The grant enabled Wyandot's administrator to purchase 58 fast electric beds, a

turning point for staff acceptance. When the first ceiling lifts were installed seven months later, employees were ready to use them. One nursing assistant, who has been with Wyandot for 19 years, explained why she liked the new beds so much. "We can quickly bring the bed up to our work height with a push of a button and we can reposition a resident . . . with ease without stooping or struggling." The final phase of Wyandot's program began with the introduction of the ceiling lifts. Wyandot's administrator evaluated several ceiling lift systems. Wyandot chose a system with a

motorized lift and a ceiling mounted track. Tracks were retrofitted into the rooms at a cost of about \$12,000 for two double rooms and one bathroom. The first double room had a track that extended into the bathroom. However, newer systems used a transfer between the room and bathroom, which simplified the system and reduced costs.

Providing Training As Wyandot purchased and installed new equipment, workers received training on how to use it, and guidelines for equipment use were put into place. An LPN in-service director did the training. New employees learn how to use the devices and know where to go for further instruction or help. Eventually, most of the nursing assistants adapted to the mechanical lifts and refused to use any other lifting techniques.

Providing Management Support Wyandot's administrator took a personal interest in ergonomic issues. To address high injury and turnover rates at Wyandot, he remained committed to identifying and solving problems. For example, on one occasion the staff said that the lifts were not easy to roll on the floors in the B- and C-Wings. To solve the problem, he experimented with different wheels that would roll more easily and turn in tight places with less effort. Finally, he worked with a manufacturer to find and buy better casters to suit the home's flooring.

Evaluating Efforts To start with, Wyandot's administrator spent \$150,000 to buy equipment. He later set aside another \$130,000 to continue his efforts, for a total of \$280,000. Wyandot has saved \$55,000 annually in payroll costs, according to Wyandot's administrator, because of reduced overtime and absenteeism. The home estimates savings of more than \$125,000 in turnover costs. Meanwhile, workers' compensation costs also have fallen drastically. For example, Wyandot reports that, after the program was implemented workers' compensation costs declined from an average of \$140,000 per year to began to average less than \$4,000 per year. From the time workers began to use the sit-to-stand lifts, which were among the first to be introduced at Wyandot, the incidence of back injuries stopped. Once the fast beds were introduced only six new hires were needed in the following year. Worker satisfaction has increased greatly. One nursing assistant, who has spent most of her career working in nursing homes, confessed to being sore and unhappy at Wyandot before the lifts were introduced. After the innovations at the nursing home, she reported that she is no longer hurting. She concluded that "I think my career is right here in the Wyandot County Nursing Home till my time is due to retire comfortable. And you know if my time comes to be in a nursing home I do hope I get one like ours." Mechanical lifts have also helped return a sense of dignity to Wyandot's residents. As one nursing assistant put it, through the use of the mechanical lifts, the residents are

MOD #3- Handout #9 - Wyandot County Nursing Home Case Study (continued)

able to wear normal clothing again, which "improves their self-esteem and keeps them warmer." The wife of one totally dependent resident who has been at Wyandot for eight years reports that because of her husband's size, he cannot help the nurses and nursing assistants in moving him from place to place. Before the overhead electric lifts and electric beds were installed in his room, it took three and sometimes four nursing assistants to move him from the bed to his cart or to the toilet. He had numerous bruises from falling and dreaded being moved. With the lifts in place, the resident's wife reports that the staff "can easily move him about to his chair and to the toilet. He cannot sit without help but the sling gives him comfortable support and makes it possible to have some dignity."

Source: OSHA. *Guidelines for Nursing Homes: Ergonomics and the Prevention of Musculoskeletal Disorders.*

Investments in SRH Saves Money and Reduces Injuries

Facility	Interventions	Impact on Costs and/or Injuries
Wyandot County Nursing Home (Ohio) <i>Source:</i> OR-OSHA	<u>Pre-SRH:</u> \$141,000/yr. for workers comp costs 3 yrs. prior to implementation <u>Costs of SRH Equipment</u> \$251,000 costs for equipment over 4 yrs. (1998 - 2001) <u>SRH Intervention</u> Transformed into a zero-lift facility -Equipment (ceiling lifts, FEB, sit-stand lifts) -Ergonomic & equipment training -Worker participation in all aspects -Sustainability	<u>Post-Intervention Outcomes:</u> <u>Savings</u> \$100,000 workers comp costs \$125,000 staff turnover costs (hiring time, retraining); turnover decreased from 75% to 5% \$55,000 payroll savings for sick-time/overtime \$126,000 savings in cost of additional staffing not needed <u>\$406,000 - \$251,000=\$155,000savings over 4yrs</u> <u>Benefits</u> Enhanced morale Increased productivity Better quality of care (attracted/hired best workers) <i>No MSDs in over 9 years</i>
Kaleida Health, Buffalo, NY Western NY's largest health care provider (5 hospitals, 4 LTCs); \$1.2 billion company. <i>Source:</i> Tammy Owens, VP, Kaleida Health	<u>Pre-SRH:</u> \$16 million annual Workers Comp costs (64% directly related to patient/resident handling) Injuries=27,445 LWDs (equivalent to 112 FTEs). No SPH/SRH program; outdated equipment--difficult to operate/maneuver. \$1.1 million for bed rentals for special needs patients/residents. <u>SRH Intervention:</u> instituted SPH/SRH program in 2005; new lifts/devices, beds, resident furniture, staff SPH training. <u>Costs of SRH:</u> Mechanical Lifts/Devices: \$1 million Beds & Patient/Resident furniture: \$5 million Staff Training: \$175,000	<u>Post-Intervention Outcomes:</u> 1 st yr. of implementation: sprain/strain injuries related to patient/resident lifting reduced by 68% 2 nd yr: reduction of 79% from initial baseline 2008: reduction of \$6.7 million in actuarial reserves related to implementation of new capital equipment/zero-lift program 73% reduction in bed rentals (\$800,000 annual savings)
NYS Veterans Home at Batavia, NY A 126 bed LTC facility. <i>Source:</i> Joanne Hernick, CEO, NYS Veterans Home, Batavia, NY	<u>Pre-SRH:</u> In 2002, there were 42 resident handling-related accidents resulting in 1,862 lost work days. <u>SRH Intervention:</u> A full SRH program was introduced in 2004 - 2005. Staff, volunteers, residents and families received SRH training; Ergo Team attended additional trainings and recommended purchase of additional lifts. 14 new lifts purchased for a total of 23 lifts.	<u>Post-Intervention Outcomes:</u> YR: <u>2001</u> <u>02</u> <u>03</u> <u>04</u> <u>05</u> <u>06</u> <u>07</u> <u>08</u> <u>09</u> #Acci- 41 42 38 26 32 25 20 24 11 dents: LWDs: 1413 1862 1396 2344 1766 1339 1040 177 37 Turn- over rate (CNAs): 37% 32% 27% 38% 26% 16% 28% 17% 13% -69% reduction in accidents in 3 years -95% decrease in no. of lost work days after implementation -8 months without a workers comp claim -"not one worker at the facility was out on workers' compensation and . . . the contentious issue of mandatory overtime is no longer an issue." Danny Donohue, Pres., NYS CSEA

<p>WNY Council on Occupational Safety & Health (WNYCOSH) Demonstration Project at 3 WNY Nursing Homes</p> <p><i>Source:</i> Buffalo State College Center for Health and Social Research</p>	<p><u>SRH Intervention:</u> Equipment purchases and 3 hr. competency training sessions on equipment use for staff at all 3 nursing homes (2006 - 2007).</p>	<p><u>Post-Intervention Outcomes:</u> <u>Resident Handling Incidents</u> -62% decrease in injuries at the 3 facilities after 2 yrs. <u>Lost Work Days</u> -69% reduction in lost work days at the 3 facilities after 2 yrs. <u>Direct Cost Savings</u> (on staff replacement costs for injured workers at all 3 facilities)-\$201,756 (\$172/day x 1,173 fewer LWDs after 2yrs) -other savings on medical treatment, insurance premiums, recruitment for worker replacement <u>Indirect Cost Savings</u> (associated with staff retention, absenteeism, etc.) -between \$403,512 - \$1,815,804 (indirect costs are between 2 - 9 times direct costs)</p>
<p>NIOSH-sponsored SRH/SPH Programs in 7 Nursing Homes and 1 Hospital</p> <p><i>Source:</i> Garag, 1999</p>	<p><u>SRH/SPH Intervention:</u> programs introduced at all 7 facilities</p>	<p><u>Post-Intervention Outcomes (after 51 months)</u> -62% reduction in injuries -86% reduction in lost work days -64% reduction in restricted work days -84% reduction in Workers Compensation costs -</p> <p>average payback period due to savings averaged 15 months (range of 5 - 29 months)</p>
<p>NIOSH SRH Program at a resident care facility</p> <p><i>Source:</i> Collins, et al., 2004</p>	<p><u>Pre-intervention</u> (36 months before SRH Intervention); (36 month pre-intervention/36 month post-intervention) -129 resident-handling MSD workers comp claims filed (11 workers filed more than one claim)</p> <p><u>SRH Intervention:</u> _____ - introduced SRH program</p>	<p><u>Post-Intervention Outcomes (after 36 months):</u> -56 resident handling comp claims filed (3 workers filed more than 1 claim) -61% reduction in Workers Comp injury rates -66% reduction in lost work days -38% reduction in restricted work days</p>
<p>SRH Program at 6 nursing homes</p> <p><i>Source:</i> Collins, et al., 2004</p>	<p><u>SRH Intervention:</u> Capital equipment and SRH training <u>SRH Costs:</u> \$143,556 total capital investment in equipment \$15,000 total investment in training \$26,000 average investment/home (training/equipment)</p>	<p><u>Post-Intervention Outcomes:</u> \$9,150 average annual savings/facility on workers comp</p> <p><u>Return on Investment (average time)</u> less than 3 years</p>
<p>23 High-Risk Long-Term Care Units at 7 VHA Facilities (780 nursing personnel)</p> <p><i>Source:</i> Audrey Nelson, 2006</p>	<p><u>SRH Intervention:</u> SRH equipment purchased and staff training on equipment</p>	<p><u>Post-Intervention Outcomes:</u> Equipment and training costs recovered in savings on Workers Comp in approximately 24 months</p>

MSD Prevention Program in Nursing Homes for 288 employees <i>Source:</i> Collins, et al., 2004	<i>SRH Intervention:</i> Investment in equipment and staff training for 288 employees (1 ¼ hrs. each) <i>Costs:</i> \$143,556 in equipment \$27,600 in training (\$577/employee) \$441,670 in direct injury costs	<i>Post-Intervention Outcomes:</i> -57% reduction in MSD claims (129 - 56) -\$54,870 annualized savings on direct injury costs -3+ years adjusted recovery time on investment (accounting for capital maintenance, retraining, training backfill)								
Wyoming Nursing Home Facility <i>Source:</i> Werner, 1992	<i>SRH Intervention:</i> Purchased Lifting-Aid Devices	<i>Post-Intervention Outcomes:</i> 60 % reduction in injuries								
Quebec Nursing Home Facility <i>Source:</i> Villeneuve, 1998	<i>SRH Intervention:</i> Installed Ceiling-Mounted Lifts	<i>Post-Intervention Outcomes:</i> Lost-time injuries dropped from 26 to 6.5 per year Annual average lost work days dropped from 983 to 67								
Connecticut Long-Term Care Facility <i>Source:</i> Fragala, 1996	<i>SRH Intervention:</i> Purchased Lifting Devices and training on ergonomics-based back injury prevention	<i>Post-Intervention Outcomes:</i> -74% reduction in back injuries in 3 years -\$166,412 savings in Workers Comp (from \$171,412 pre-intervention to \$4,500 post-intervention) -Lost work days reduced from 1025 (pre-intervention) to 81 (post-intervention)								
SAIF Low Lift/SRH Program (19 facilities that included acute care, skilled nursing, assisted-living, residential care, group homes) <i>Source:</i> Oregon-OSHA	<i>SRH Intervention:</i> Used zero-lift program with policies	<i>Post-Intervention Outcomes:</i>								
		<table><tr><td>Post Implementation Year</td><td>Yr 1</td><td>Yr 2</td><td>Yr 3</td></tr><tr><td></td><td>19</td><td>14</td><td>8</td></tr></table>	Post Implementation Year	Yr 1	Yr 2	Yr 3		19	14	8
		Post Implementation Year	Yr 1	Yr 2	Yr 3					
			19	14	8					
		% Reduction								
		Lift/Transfer Claims Only								
		Accepted claims	65	68	81					
		Time loss days	80	97	93					
		Incurred costs	84	97	93					
		All Claims								
		Accepted claims	31	36	61					
		Time loss days	42	80	93					
Incurred costs	38	69	88							
Summary of SRH/SPH Case Studies <i>Source:</i> Lynda Enos, 2009	<i>SRH Intervention:</i> SRH/SPH programs implemented	<i>Post-Intervention Outcomes:</i> -30 - 95% reduction in Workers Comp injury rates -66 - 100% reduction in lost work day injury rates -Up to 38% reduction in restricted work days -30 - 75% reduction in Workers Comp costs -50% reduction in insurance premiums								

RETURNING TO WORK IN A SAFE RESIDENT HANDLING ENVIRONMENT

RTW in a Manual Handling Environment

RTW in a SRH Environment

Labor-Management attitudes toward comp claims

-Management/insurer are suspicious of the validity of injury claim. Injured employees are viewed as a cost to the employer, not an asset. Claims are contested at comp hearings with the intent of claim dismissal. Doctors are enlisted to challenge the extent of the injury being claimed. Lawyers are enlisted to fight the claim at compensation hearings. Fighting claims is believed to save the facility money.

-Injured workers suspicious are of management, the insurer and "company doctor." Management is viewed as an adversary whose motive is to deny a claim and either force the injured worker to work injured or to quit. "Light duty" assignments seen as a management tool to force the injured worker back to do meaningless work.

MSD injury recovery in a manual handling environment

-Manual resident handling = chronic MSDs* = long recovery time and LWDs** and/or an end to one's career.

-Return to Work programs are often viewed as a waste of time by management. In a manual lifting environment, injured workers are frequently unable to transition to their original jobs because of physical demands. Serious MSDs in this environment can be career-ending.

*MSDs = Musculoskeletal Disorders

**LWD = Lost Work Days

Labor-Management attitudes toward comp claims

-Management/insurer work with the claimant. Encourage early reporting of a MSD injury. Refer the worker to a qualified physician (or work with claimant's physician) to ensure treatment and ongoing diagnosis to ascertain the ability of injured to return and engage in modified "light duty" work assignment. Returning an experienced employee to the original job is the goal, saving the facility money in the long run.

-An injured worker in a non-punitive workplace is likely to be motivated to cooperate with doctors and RTW manager to transition back to original job. Full participation in structuring the RTW program can facilitate a cooperative approach. In a medically-managed meaningful modified work environment, the injured worker is more likely to view getting off compensation and back to work as a positive goal.

MSD injury recovery in a SRH environment

-SRH is a less hazardous work environment = a less serious MSDs = less recovery time and LWDs.

-Return to Work programs in a SRH environment are cost-effective for management and rewarding for the injured worker. RTW programs that transition the injured worker back to their unit, at regular pay, with modified work assignments that are agreed to by the RTW coordinator and the injured worker can be a positive experience. "Full recovery" and a return to the old job is more likely where the physical demands are lessened by the use of equipment.

MODULE FOUR

HANDOUTS

How much Equipment do we need?

Equipment type	Amount of equipment recommended
Floor lifts or full mechanical lifts	1 per 8 residents of need on that unit
Sit to stand lifts	1 per 8 residents of need on that unit
Gait belts with handles	1 per resident of need, hands on assistants will require a gait belt
Non friction sheets & non friction devices, Slipp Sheet, Phil-E-slide, Maxi-Slide & Surehands products	1 per 8-10 residents of need <i>(used for lateral transfers, repositioning; reducing friction decreases the load and resistance)</i>
Hover Mat & Air Assisted devices	Look at what your need is and where you would use them
Ceiling Lifts & ceiling track systems	<i>Truly Zero-Lift; especially useful with fully dependent residents. Useful in tub rooms, therapy gyms, patient care areas, and rooms with specialty care like bariatric.</i>
Hygiene slings Universal slings Quick fit slings Hammock slings Sit-to-Stand slings Amputee slings Positioning slings Mesh slings Padded slings Full Body slings Bathing slings	2 slings per lift
Electric control beds - (avoid awkward postures)	1 per resident Beds have various sizes, styles, and functions. Bariatric beds have heavy reinforced hardware and framing.

Note: The equipment to resident ratio in this handout is used at Kaleida Health in Western New York at 9 hospitals and nursing homes that resulted in an 80% reduction in patient/resident related handling injuries. It is a good guide for determining the amount of equipment your Safe Resident Handling/Ergo Team will want to recommend at your facility. The way caregivers organize their work assignments should be carefully considered when determining the quantity purchased. Resident lifting tasks are not evenly distributed throughout a 24-hr. period. Typically, there are peak periods where staff is competing for lifting devices. If your facility plans to eliminate manual lifting, a commitment to purchasing sufficient quantities will make this feasible.

MOD #4 – Handout #2

Equipment Use Inventory							
Directions: Answer the following questions related to equipment handling/transport in your department or that you may have access to through another department.							
Department:		Employee Name:			RN/CNA	Shift: Day Night Swing	
Resident Handling Device	Do you have this equipment in your dept? Y or N If Y – what's the name or brand of equipment, e.g. 'Omega lift, Hovermat, etc)	If Yes How many on unit?	What is the weight limit of the equipment if applicable?	How often do you use it? 4=all of the time 3=most of the time 2=sometimes 1=rarely or never	Is this equipment in good working order? Y or N Comment:	If used rarely or never why?	Other Comments
1. Powered Floor Lift (Battery/electric power)							
2. Ceiling Lift							
3. Powered Sit to Stand Lift							
4. Air Mat for lateral supine transfers, e.g. Hovermat							
6. Roller mat							
7. Other types of Transfer mats or boards							

Equipment Use Inventory							
Directions: Answer the following questions related to equipment handling/transport in your department or that you may have access to through another department.							
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8. White Slide board (supine position)							
9. Slippery sheets for repositioning							
10. Gait or transfer belt <i>Please note if with handles</i>							
11. Low-friction mattress covers							
12. Shower cart or gurney							
13. Shower or toilet chair (commode)							

MOD #4 – Handout #2, Continued

Equipment Use Inventory							
Directions: Answer the following questions related to equipment handling/transport in your department or that you may have access to through another department.							
Department:		Employee Name:			RN/CNA	Shift: Day Night Swing	
Resident Handling Device	Do you have this equipment in your dept? Y or N If Y – what's the name or brand of equipment, e.g. 'Omega lift, Hovermat, etc)	If Yes How many on unit?	What is the weight limit of the equipment if applicable?	How often do you use it? 4= all of the time 3=most of the time 2=sometimes 1=rarely or never	Is this equipment in good working order? Y or N Comment:	If used rarely or never why?	Other Comments
14. Geri chair							
15. Wheel chair							
16. Other chairs that Residents use							
17. Adjustable height beds-List each make and model							
18. Other:							
18. Other:							
Other equipment:		Please also note any specific issues or problems with this type of equipment					

Equipment Use Inventory							
Directions: Answer the following questions related to equipment handling/transport in your department or that you may have access to through another department.							
Department:		Employee Name:			RN/CNA	Shift: Day Night Swing	
Resident Handling Device	Do you have this equipment in your dept? Y or N If Y – what's the name or brand of equipment, e.g. 'Omega lift, Hovermat, etc)	If Yes How many on unit?	What is the weight limit of the equipment if applicable?	How often do you use it? 4= all of the time 3=most of the time 2=sometimes 1=rarely or never	Is this equipment in good working order? Y or N Comment:	If used rarely or never why?	Other Comments
19. Carts - Medicine							
20. Carts - Laundry							
21. Carts - Food							
22. Carts – Other - Describe							
23. Gurneys/Stretchers List each make and model and if height adjustable							
24. IV /Med poles							
25. Other medical equipment							

Unit Profile and Space/Maintenance/Storage Evaluation	
1.	Directions: Describe Unit/wing, including # beds, room configurations (private, semi-private, 4-bed, etc), and bathrooms: # rooms private (1 bed) _____ # rooms with 2 beds _____ Other: _____ Bathrooms: In room? _____ Community _____ Use tub? _____ Shower chair? _____ Other: _____ Draw room configuration (on back as needed)
2.	Describe current storage conditions and problems you have with storage. If new equipment is purchased, where would it be stored?
3.	Identify anticipated changes in the physical layout of your unit, such as planned unit renovations in the next 2 years
4.	Describe space constraints for resident care tasks & use of portable equipment; focus on resident rooms, bathrooms, shower/bathing areas. <i>Are typical room doorways narrow or wide??</i> Is the threshold uneven?
5.	Describe any routine equipment maintenance program or process for fixing broken equipment. What is the reporting mechanism/ procedure for identifying, marking, and getting broken equipment to shop for repair?
6.	If potential for installation of overhead lifting equipment exists, describe any structural factors that may influence this installation, such as structural load limits, lighting fixtures, protruding sprinkler heads, other ceiling fixtures, AC vents, presence of asbestos, etc.

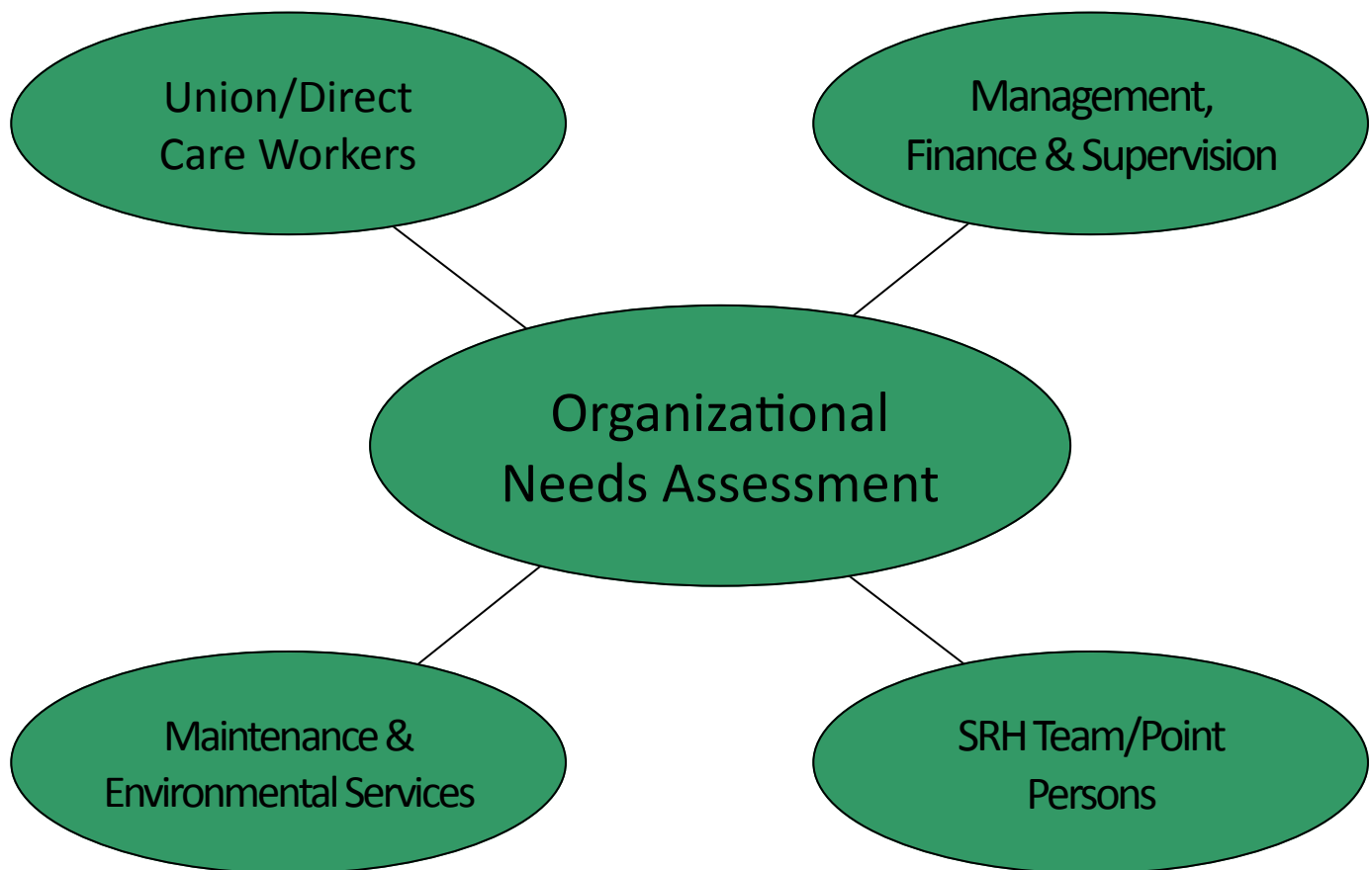
Facilities Design Checklist

Directions: Place a check mark in the space next to each item you feel may be a problem area in your dept/unit.

FACTOR	PROBLEM	LOCATION
1. High threshold or obstructions in entry ways of bathrooms, showers, hallways, etc. prevent access for assist equipment		
2. Steep ramp (greater than 10 degrees)		
3. Small or cluttered rooms/bathrooms/hallways or other spaces		
4. Door handles catch on beds/gurneys/etc.		
5. Floors slippery/uneven/cluttered		
6. Storage areas too high/low/awkward to reach		
7. Bedside medical and electrical outlets too low/only on one side		
8. Inadequate storage space		
9. No grab rails by toilets or in bathtubs or showers		
10. Toilet seats too low		
11. Other		

Buy-In Bubble Chart

Safe Resident Handling Buy-In: Who Needs to Be Involved?



MODULE FIVE

HANDOUTS

A Close Look at the Pivot Transfer

Altering Technique to reduce injury risk during patient transfer



Pless is an Injury Prevention Specialist and Director of Safe Patient Handling and Movement at Kaleida Health in Buffalo, NY. She has over 23 years of experience in health care, with nine of those years working in zero lift environments. In 1997, she spearheaded the implementation of a zero lift program in a long-term care facility in Niagara Falls, NY, expanding the program to acute care settings in 2003. She has helped many organizations and facilities implement zero lift and patient handling safety initiatives.

The pivot transfer is frequently used in long-term care to move patients with decreased weight-bearing ability, despite its high risk causing injury to both patient and caregiver. This editorial will discuss the risks involved in the pivot transfer and present a safer alternative-zero-lift sit/stand patient transfer equipment.

I have experienced reluctance on the behalf of some practitioners to acknowledge the dangers associated with the pivot transfer.

The pivot transfer is an interim transfer used while a patient is gaining skill and strength, and it warrants close monitoring when used in daily living. When used successfully, the patient moves independently during the transfer. More often than not, the pivot transfer is executed with some level of assistance from the caregiver, increasing the injury risk. In my experience conducting incident investigations, I often discover that the patient involved was performing a pivot transfer, and either the caregiver was thrown off balance because the patient could not move his or her feet or the caregiver and patient lost their balance because their feet got tangled when the patient's feet or foot did not move. However, I have experienced reluctance on the behalf of some practitioners to acknowledge the dangers associated with the pivot transfer.

Pivot Transfer – What It Is and Isn't

In a true pivot transfer, the patient has to take at least one step, un-weight at least one foot during the pivot, and move toward the desired target. The reality of what occurs during the typical "pivot transfer" is much different, and the likelihood that it will go well each time it is executed is extremely poor. The patient's function and performance can be inconsistent or can be affected by time of day and behavior.

Often, the patient is moved from one surface to another without his or her feet moving and without a gait belt. The caregiver twists and swings the weight of the patient and move him or her to the desired surface with the patient's feet stationary. The patient's body is moved in parts; the top half is moved in the opposite direction from the planted bottom half. It is the patient's trunk that is actually "pivoted". Frequently, the transfer becomes a manual lift: the caregiver just lifts the patient, so that the patient's feet barely make contact with the floor and do not bear any weight.

The pivot transfer is appropriate for a very small population. It has a sizable room for error, and it should never be used to move patients over a long period of time—patients who can perform the transfer are candidates expected to improve enough that they will not longer need the pivot transfer. In my experience, 90% of patients using the pivot transfer for 30 to 90 days experienced a deterioration of skills, exacerbated shoulder or knee injuries, or disease progression in those joints. Many had to stop using the transfer within 24 to 48 hours because of injuries suffered during the transfer. In addition, I have observed incidents or injuries in 100% of patients using the pivot transfer for more than 90 days.



After the patient is sitting upright, a band harness is placed around the lower trunk. The patient places his or her feet on the base of the lift; the lift is then pulled up close to the patient and, with the lift arms lowered, the band harness is attached to the sit/stand lift. As the caregiver activates the electronic hand control, it begins to raise the lift arms that the patient's band harness is attached to and, as the lift arms rise, the patient is brought from a sitting to a standing position with minimal to no exertion by the caregiver.

Assessing Risk – Can Patients Pivot?

The first thing to look for when deciding whether patients should use the pivot transfer is their ability to move their feet. If you believe they can and do move their feet during transfer, have them demonstrate that to you over a 24-hour period, on all surfaces and to all surfaces. Sometimes caregivers do not realize that the patient's feet barely make contact with the floor and do not bear any weight during transfer. Also, talk to the caregivers and observe the transfers on all shifts at different times of day. Some caregivers have been doing improper transfers for so long that they do not recognize the manual lifting involved in a pivot transfer that is no longer successful. Weight bearing by the caregiver during transfers and ambulation with a degree of buckling are some of the most common causes of injuries. Be sure to meet with any caregivers who have been injured pivoting someone on or off the toilet, and analyze the employee injury records to see what other transfer tasks are causing injuries.

Examine the locations where pivot transfers take place. Does the environment always allow patients to move and pivot with their strong side first? When caregivers are faced with awkward postures and confined spaces, the success of the transfer decreases the risk of injury increases. In any given 24-hour period the pivot transfer can be conducted repeatedly on a patient, as many as 16 times, with the level of weight borne by the patient and his or her ability to execute this transfer changing every time. Add to this the unpredictability of the amount of weight that the patient can bear, and the caregiver is manually lifting under the worst conditions.

Sit/Stand Lift: Caregiver Considerations

- 1) This procedure always requires two people to assist.
- 2) Patient cooperation throughout the length of the transfer is necessary.
- 3) Endurance, performance, and ability to actively participate throughout the transfer are key.
- 4) Minimize the distance that needs to be traveled during a transfer to improve the caregiver's safety and decrease the risk for injury during push or pull acts.
- 5) Floor surface: non-carpeted surface is best for the caregiver, with less friction and effort during push and pull. Lifts are stable on carpet if it has a low pile, a tight weave, and a smooth surface. All flooring types need to be seamless and without cracks or breaks. Never bring the lift onto a wet, slippery area.
- 6) Doorways should be wide enough to admit the lift and patient without either one hitting the doorframe.
- 7) Thresholds need to be smooth and seamless. The lifts should not be pushed or pulled over a threshold that offers resistance due to its height or incline.
- 8) The area where the final transfer is going to occur needs to offer enough space for two caregivers to protect the patient and maneuver the lift without having to struggle or assume awkward postures.

Injuries from Pivot Transfers

Improper pivot transfers increase the risk of injury to both the caregiver and the patient. Repetitive traumas, bruises, skin tears, damage to the soft tissue supporting the joints (especially hips and knees), and fractures of a spiral or impact nature at the hips, knees and ankles are common. A correlation is not always drawn between the accidents or incidents and the pivot transfer. However, at one facility I saw a 64% decline in fractures and a 37% decline in skin tears and bruises 14 months after implementing zero lift- as well as zero lower extremity spiral fractures, compared to two the previous year.

The pivot transfer is appropriate for a very small population.

Many times the shoulders of the patient are used as weight-bearing joints, providing leverage for the caregiver and functioning as anchors. Exacerbation of arthritis and degenerative joint disease, as well as loss of range of motion occur over time, and the subtle damage caused by each pivot begins to compound and further compromise any chance for improvement in weight bearing. The facility mentioned above experienced a 26% improvement in upper extremity range of motion overall, with fewer cases of shoulder joint decline and an increase in cases that remained stable or improved.

The use of a gait or transfer belt can reduce the risk of shoulder joint injuries, but it is not enough to correct the problems associated with the patients' inability to move their feet and take a true step toward the desired transfer target. The gait or transfer belt erroneously may also become a lifting tool when proper weight bearing and the ability to move the feet are absent.

Zero lift environments recognize these serious safety hazards. Most successful zero lift environments have stopped using the pivot transfer entirely, or have minimized and closely monitored its use, leading to reduced injuries, increased safety, and prolonged weight bearing for patients.

Patient Criteria for Sit/Stand Lift Use

- 1) At least 30-60% weight-bearing status. May be done with the use of one leg with the right set-up and harness.
- 2) Ability to hold on to the lift. If the ability to hold on is compromised then a harness needs to be selected that promotes increased safety and comfort. Harness styles vary; some incorporate lower body support to compensate for the inability to hold on.
- 3) Cooperation that is maintained throughout the transfer. There may be confusion, dementia, or behavior problems present as long as these conditions do not interfere with safe use of the lift. Over time, with repeated practice in a controlled setting, a patient can get accustomed to using the lift.
- 4) Able to move from supine to set when transferred from a bed. The risk of injury is great if the patient cannot assist with this move, as it becomes a manual lift for the caregiver, and the joints of the patient may be used as leverage. Some patients who cannot sit up may be transferred with the sit/stand lift after they have been mechanically lifted out of bed and are in a support upright position.
- 5) Certain medical conditions are contraindicated with the use of certain harnesses. Abdominal aneurism, stomas, wounds, skin integrity issues, colostomies, and new pet tube sites or spinal fractures could prohibit the use of a harness that fits snugly around the abdomen or trunk.

A full mechanical lift is the only alternative if the patient does not meet the above criteria for use of the sit-stand lift. If a patient's status or condition changes a reassessment is required. This lift should be considered for all transfers that involve minimal, moderate, or extensive assist by the caregiver.

An Alternative-Sit/Stand Lift

Sit/Stand patient transfer equipment is an alternative to the pivot transfer that allows patients to bear weight while it facilitates safe and proper joint alignment and increases protection and comfort (see photo, right). This equipment is for patients with at least 30% to 60% weight-bearing status and the ability to hold on with at least one hand, or two hands if a simple band harness is used, and who are cooperative with the use of the equipment and have the endurance to tolerate weight bearing and upper extremity use.

The distance that the lift is moved during the transfer depends on the patient's functional status with upper body use, weight bearing, endurance, fatigue, and tolerance to prolonged standing. You must always consider the type of flooring, doorways, and thresholds that patient may need to travel over. Remember this is an active participation transfer, not a passive transfer like the full mechanical lift.

The properly assessed candidate can experience an improved quality of life and increased safety. They are afforded the opportunity to be repositioned safely and more frequently, placing less burden on the caregiver's back, and can bear weight safely and for longer periods of time. Patients that were traditionally pivoted from one place to another—for example, from a wheelchair to a stable chair in a dining room or from a wheelchair to a toilet—can be transferred properly with the sit/stand lift.

Most successful zero lift environments have stopped using the pivot transfer entirely, or have minimized and closely monitored its use, leading to reduced injuries, increased safety, and prolonged weight bearing for patients.

The therapy department can also use the sit/stand lift for treatment in the clinic setting, since it is an active transfer with therapeutic value. The patient who may have difficulty accepting the transfer or who may require special considerations in use of the lift would benefit from an assessment and monitored use in this professional controlled setting. Patients with altered weight-bearing status due to orthopedic concerns can use the lift to bear weight on one leg only. Using the sit/stand lift during recovery from a total knee or hip surgery facilitates recovery with less risk of trauma or inflammation to the surgical joints. It can also decrease edema that is often caused by an improperly done pivot transfer.



The sit/stand lift is for patients with at least 30% to 60% weight-bearing status and the ability to hold on with at least one hand, or two hands if a simple band harness is used.


Assess Lifting at Your Facility


The health care industry has changed and the types of patients in our care have changed, yet some organizations have not changed their patient handling practices. The sit/stand lift is underutilized in health care, and it can be of enormous value in the care and treatment of patients. I often find either that health care workers don't know about the sit/stand lift or that there are none available in their facility. I recommend that facilities have at least one sit/stand lift for every eight to ten patients able to use one.


A system for employee training and competency with the use of sit/stand lift equipment needs to be embedded in the organization. The program needs to include new hire and present employees, and should be conducted as a yearly mandatory in-service. Repeated training and a competency check should also take place for any employee involved in an incident involving equipment use. Periodic audits conducted during routine transfers can help ensure that sit/stand lift transfers are being done properly. The very same equipment intended to prevent injuries can cause injuries if used improperly or by people who have not been properly trained.

As facilities and institutions begin to recognize the value of patient transfer equipment, they will also begin to understand the need to use this equipment in areas beyond the patient's room. When we change the culture and truly understand the impact of the misused pivot transfer, we will enhance patient and employee safety.

How Do We Assess Resident Dependency?

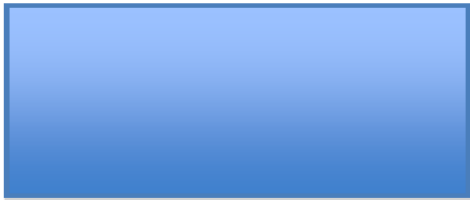


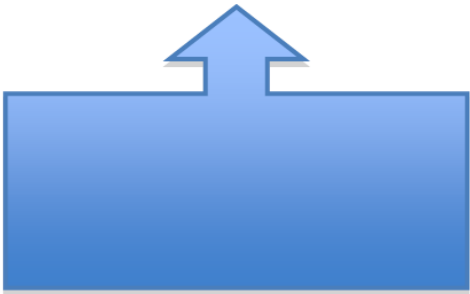


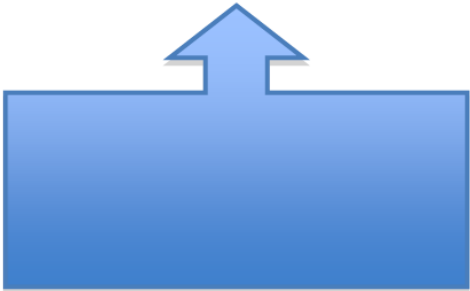


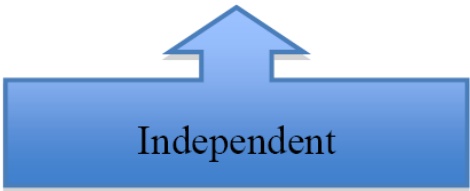
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What Lifting/Transfer Method Do We Use?




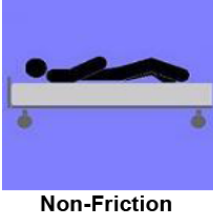









MOD #5 – Handout #4 SAFE RESIDENT HANDLING ASSESSMENT TOOL

Lift Type	Patient /Resident Criteria	Contraindications	Sling Criteria	Staff
 Total Mechanical	<ul style="list-style-type: none"> Non weight bearing Not able to sit/balance on edge of bed Non weight bearing patient needing repositioning in a non-reclining chair 		Use - Hygiene sling if patient has: <ul style="list-style-type: none"> Good upper body control Cognitive Able to assist Transfer is for toileting/access to perineal area. 	2 – 2+
			Use - *Hammock sling if patient has: <ul style="list-style-type: none"> Poor upper body control Non cognitive Unable to assist. 	2 – 2+
 Sit/Stand Mechanical Lift	<ul style="list-style-type: none"> Partial weight bearing in one or both legs Can hold on with one or both hands Cooperative Able to move supine to sit and be able to sit/balance on edge of bed Partial weight bearing patient needing repositioning in a non-reclining chair 	<ul style="list-style-type: none"> Abdominal, chest or back surgery (if the area of surgery would be compromised resulting in harm to the patient/resident) Spinal or pelvic fracture (if the fracture site would be compromised resulting in harm to the patient/resident) Poor skin integrity in area of belt 	Use - Band Harness if patient: <ul style="list-style-type: none"> CAN bear weight continuously 	2 – 2+
			Use -TT Harness if patient: <ul style="list-style-type: none"> CANNOT bear weight continuously Band sling is not large enough If leg straps are needed 	2 – 2+
 Transfer/Gait Belt	<ul style="list-style-type: none"> Full weight bearing and able to ambulate with guidance or hands on cueing Partial weight bearing if they can take steps and move feet Steady Sound cognition Cooperative 	<ul style="list-style-type: none"> Abdominal, chest or back surgery (if the area of the surgery would be compromised resulting in harm to the patient/resident) Spinal or pelvic fracture (if the fracture site would be comprised resulting in harm to the patient/resident) Poor skin integrity in area of belt 	None	1 + another to handle medical equipment
 Non-Friction Device or Air Matt	<ul style="list-style-type: none"> Bedrest Unable to assist with lateral transfer Needs repositioning in bed or reclining chair 		None	Less than 200 lbs – 2
				More than 200 lbs – 3
 No Lift Device	<ul style="list-style-type: none"> Full weight bearing bilaterally Steady 		None	0 – 1

Sample Care Guide for Independent Resident

Unit / Room:

Bathing	Supervision- Oversight help only for bathing, Nail Care on bath day - fingernails only, CHECK SKIN DAILY DURING ADL CARE, NURSE TO CHECK SKIN / FEET ON BATH DAY
Dressing	Supervision for dressing, Setup help only for dressing
Grooming	Supervision for grooming/hygiene, Set-up at bedside for daily hygiene
Oral	Setup help only for oral hygiene, Mouth care:, BID, HAS OWN TEETH
Vision	Adequate Vision
Comm/Hearing	Speech used to express needs, Use simple direct questions/answers, Able to make needs known, Speak clearly & directly to resident in a normal tone of voice
Transfer	Independent for transfers
Bed Mobility	2 SIDERAILS UP, Independent for bed mobility
Ambulation	Independent ambulation on/off unit
Wheeling	Does not use wheelchair
Safety	Call light within reach, manipulates bed controls and siderails as she wishes safely
Toileting	Independent for toileting, Continent of Bowel and Bladder Monitor and record BMs every shift
Skin	Pressure relief mattress
Eating	Supervision for eating, Diet: Carbohydrate Control Nas, Oversight, verbal encouragement to complete meals, Dining Site: Dining Room
Personal Approaches	Cooperative with care, ** FULL CODE **
Activities	Verbally inform resident re: daily recreation activities, Provide weekly Activity schedule, Invite / encourage resident to attend activities:, red hat ladies tea party, pet visits, easy crafts, game show programs, live entertainments., especially enjoys church services and bible study., She likes bingo especially \$2.00 bingo
Rehab/ROM	Notify Rehab dept with any concerns

**Sample Care Guide
for Supervision/Limited
Assistance Resident**

Unit / Room:

Bathing	Physical help in part of bathing activity, One person physical assist for bathing, Wash lower body, Apply moisturizing lotion to dry areas, Shampoo hair during shower, Nail Care on bath day - fingernails only
Dressing	Limited assistance for dressing, One person physical assist for dressing
Grooming	Limited assistance for grooming/hygiene, Set-up at bedside for daily hygiene
Oral	Setup help only for oral hygiene, Staff prepare toothbrush, Hand resident cup of water to rinse out mouth, Does not use dentures, Some missing teeth, Dental eval. per Rehab. admission schedule.
Vision	Vision is adequate
Comm/Hearing	Speech used to express needs, Allow adequate time for resident to express him/herself, Face resident when speaking, Speak clearly & directly to resident in a normal tone of voice, Eliminate background noise if possible, Impaired hearing
Transfer	limited 1 assist transfer with gait belt
Bed Mobility	independent for bed mobility
Ambulation	ambulate on unit with rolling walker and gait belt limited 1 assist
Wheeling	staff to propel wheelchair off unit only
Safety	Bed in Low to floor position., Call light within reach
Toileting	One person physical assist for toileting, Continent, Urinal within reach, Monitor bowel movements
Skin	Moisturizing Lotion with care, Observe feet for evidence of problems, Observe skin for dryness, Pressure relief mattress, Float heels on pillow while in bed.
Eating	Setup help only for eating, Diet: NAS
Personal Approaches	Help with adjustment to floor & routine changes, Provide verbal reminders R/T behavior, Monitor sadness / depression, Monitor for pain and intervene prn, Monitor for changes in cognition, Maintain consistent environment & routine, FULL CODE
Activities	Verbally inform resident re: daily recreation activities, Invite resident to all large home events and outings, Provide weekly Activity schedule, Invite / encourage resident to attend activities: , cart activities, men's club, music programs, coffee and news, He likes to play pinochle and poker. He likes to watch news and Gunsmoke, He likes Pop and Big Band music. He likes sports Buffalo Bills. He likes to read newspaper
Rehab/ROM	Ambulation Program performed by ROM CNA, notify rehab dept with any concerns

**Sample Care Guide
for Extensive Assistance
Resident**

Unit / Room:

Bathing	Physical help in part of bathing activity, One person physical assist for bathing, Check feet with shower and daily and notify Nurse of any issues.
Dressing	Extensive assistance for dressing, One person physical assist for dressing
Grooming	Extensive assistance for grooming/hygiene, Set-up at bedside for daily hygiene
Oral	Extensive assistance for oral hygiene, One person physical assist for oral hygiene, Remove dentures at hs/clean & soak overnight, Mouth care: am and pm, Has no teeth, Full upper dentures, Full lower dentures
Vision	Encourage to wear glasses, Clean vision aids
Comm/Hearing	Speech used to express needs, Provide reassurance & encourage to communicate, Speak clearly & directly to resident in a normal tone of voice
Transfer	Sit to stand lift transfer with two assist utilizing medium blue band sling
Bed Mobility	2 SIDE RAILS UP, Limited one assist rolling with rail, Extensive one assist supine to sit with rail, Turn and position Q2hrs and PRN, Extensive two assist boosting utilizing non-friction sheet
Ambulation	Non-ambulatory
Wheeling	Manual wheelchair with gel cushion, Staff to propel on/off unit
Safety	Call light within reach, Low to floor bed, OXYGEN IN USE
Toileting	SEE TRANSFER STATUS, Extensive one assist for Incontinent care every 3 hours and pm, Brief OOB, Vaseline to buttocks after care, Monitor and record BM's every shift
Skin	Bilateral heel booties on while in bed, Pressure relief mattress
Eating	Extensive assistance for eating, Diet: Carbohydrate Control Nas Mech Soft, Requires physical assist to complete meals, Dining Site: Dining Room
Personal Approaches	Address Mrs. Cummings by name. Approach in a calm and pleasant manner., Speak to resident calmly & with simple terms, Monitor anxiety, Maintain consistent environment & routine, **DNR**
Activities	Invite resident to all large home events and outings, Provide weekly Activity schedule, Invite / encourage resident to attend activities: cart activities, beauty hour, live entertainments especially guitar music by Handsome Dan, religious activities such inspirational readings, movies, being read to, likes to watch Soap operas, personal visits., I
Rehab/ROM	ROM program performed by ROM program, Notify Rehab dept with any concerns

Sample Care Guide
Total Dependence Resident

Unit / Room:

Bathing	Total dependence for bathing, Two person physical assist for bathing, Take to shower room with a nurse or RT to manage ventilation., Uses special soap, may use body wash, Apply moisturizing lotion to body, Nail Care on bath day - hands/feet, pulse ox rotation, and trach tie changes with bath
Dressing	Total dependence for dressing, Two+ persons physical assist for dressing, Resident to wear socks, sneakers/shoes when OOB
Grooming	Total dependence for grooming/hygiene, One person physical assist
Oral	Total dependence for oral hygiene, One person physical assist for oral hygiene
Vision	Resident is blind
Comm/Hearing	Observe for change in behavior, Use tactile and verbal stimulation, Speak clearly & directly to resident in a normal tone of voice
Transfer	full mechanical lift transfer 2 person assist with medium 6 strap sling
Bed Mobility	Total Dependence for bed mobility, total 2 assist for bed mobility, boosting with nonfriction sheet, Reposition resident in bed, reposition Q3H & PRN in bed, 2 FULL PADDED SIDE RAILS, bilateral LE's with pillows on outside of knees, heel booties on both heels, place a rolled up pad under lower legs to elevate heels off bed, elevate UE's on pillows while in bed, at all times in bed
Ambulation	Non-ambulatory
Wheeling	staff to propel all destinations in w/c with seat belt and chest harness, all straps secured
Safety	Ventilator dependent - alert nurse/RT for suctioning needs and/or vent alarms., Alert nurse for tremors or seizure activity.
Toileting	Two assist for incontinent care, Peri-care w/ each incontinent episode, Q3H + PRN, vaseline with care, monitor bowel movements daily, Bowel management program, Monitor bowel movements
Skin	Moisturizing Lotion with care, any signs of redness, irritation or breakdown, including ears, Pressure relief cushion on chair, Pressure reduction mattress on bed.
Eating	Tubefeed: Nutren Replete/fiber NPO, HOB elevated except during ADL care
Personal Approaches	Use tactile and verbal stimulation with care., Spend 1:1 time with the resident, Decrease stimuli (calm supportive environment), Maintain consistent environment & routine, Resident is **FULL CODE**
Activities	Provide weekly Activity schedule, massage, reading, music
Rehab/ROM	ROM performed by CNA, Notify rehab with any concerns

Roles and Responsibilities:
Management

Question: What does your policy need to say about Management's responsibilities for you to achieve your objectives?

- ▶ Administration shall support implementation of this policy and promote a Culture of Safety.
- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____

▶ _____

Roles and Responsibilities:
Employees

Question: *What does your policy need to say about Employee’s responsibilities for you to achieve your objectives?*

- ▶ Use approved mechanical lifting/transferring devices and methods for resident transfers
- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____

▶

Roles and Responsibilities:
Safe Resident Handling Ergo Team

Question: *What does your policy need to say about your SRH/Ergonomic Team's responsibilities for you to achieve your objectives?*

▶ The SRH/Ergo Team shall support implementation of this policy and promote a *Culture of Safety*.

- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____
- ▶ _____

▶ _____

SAFE RESIDENT HANDLING POLICY

Sample Outline

Policy Objectives

Safe Resident Handling Program Objectives

- To increase resident quality of care.
- To perform safe/comfortable mechanical lifts and/or transfers for residents.
- To reduce the frequency of manual lifting, transferring, and repositioning.
- To reduce and prevent caregiver work-related injuries.
- To reduce lost work time hrs. related to staff injury or fatigue.

Roles and Responsibilities

Employees

- Use lifts/transfer devices/methods for all resident lifts/transfers.
- Licensed professionals assess resident and determine appropriate lift/transfer method.
- Unlicensed assistive staff can lift/transfer resident after assessment is completed/documented
- SRH competency training required for all staff involved in resident lifts/transfers.
- Report employee/resident injuries to 'EE Health.

Management

- Support implementation of SRH policy and promote a *Culture of Safety*.
- Furnish sufficient lifting equipment/devices
- Make equipment accessible & maintain it.
- Ensure sufficient staffing to use SRH method.
- Ensure resident assessment/documentation.
- Ensure staff compliance with SRH policy.
- Ensure staff competency requirements met.
- Ensure reporting of accidents/injuries.

SPH/Ergo Team

- Lead implementation of SRH policy/promote *Culture of Safety*
- Assess injury data, equipment, and facility environment to determine SRH needs.
- Oversee equipment selection.
- Set criteria for evaluating residents.
- Ensure staff competency training/ retraining/ evaluation.
- Transition program onto the units.
- Oversee program audits/ evaluation.

Protocols

Guidelines we can use to ensure good:

- Resident Assessment
- Care and Management
- Safety
- Infection Control
- Complications & Reportable Incidents
- Compliance

Resident Assessment Protocol

A Licensed Professional shall:

- Complete resident assessment
 - Upon admission
 - When there is a change in resident status
 - On a quarterly basis (reassessment)
- Use Lift/Transfer Assessment Tool
- Document Resident Lift/Transfer (Resident Care Plan)

A Direct Caregiver shall:

- Consider his/her own ability, the environment and resident's status prior to any lift/transfer
- If no change in status
 - Follow care plan lift/transfer recommendation
- If change in status
 - Notify a licensed professional
 - Use new level of transfer if recommended

Refer to the Decision Tree when changing resident lift status

Full Mechanical Assist	Dependent
Sit/Stand Mechanical Assist	Extensive Assistance
Transfer/Gait Belt	Supervision/Limited Assistance
No lift Equipment	Independent

Care and Management Protocol

Resident

- Perform resident transfer as documented in Care Plan

Lift/Transfer Equipment

- Park all mechanical lifts in designated areas
- Plug in lifts for recharging when not in use

Slings

- Place all soiled slings in designated laundry bag/hamper.

Infection Control Protocol

- Use barrier between resident's skin and sling
- Spot- clean slings with minor soilage (use approved disinfectant wipes)
- Use single dedicated sling for a resident with communicable illness/M.R organism
- Launder dedicated sling after discontinuation or discharge
- Wipe down framework/hardware prior to use on another resident

Safety Protocol

- Assess all equipment prior to use.
 - Note Integrity and function
 - Remove, tag any broken equipment
 - Report any non-functioning equipment
- Inspect slings
 - Note signs of wear and tear
 - Remove damaged slings and tag
 - Return to unit manager
- Non-friction device: don't leave under resident after transfer

Complications and Reportable Incidents Protocol

- Report all damaged slings to nurse manager/supervisor
- Report all employee injuries to Employees Health; do an incident report
- Report resident injury during lift/transfer to unit manager/physician
- Report all of the above to SRH Point Person(s)

Compliance

- Ensuring staff participation, understanding the SRH program, and staff communication with SRH Resource/Point Person are forms of compliance.
- Daily compliance with the program is the responsibility of each staff member.
- Adhering to the SRH policies and procedures is mandatory for all staff
- SRH Resource/Point Person will facilitate After-Action Reviews to continually adjust the SRH program.
- Each unit/floor's manager shall provide compliance reports using the Compliance Audit Tool
- The employer shall not take retaliatory action against any nurse or caregiver for raising concerns or issues regarding safe resident handling, filing a complaint or refusing to engage in resident handling

Documentation and Competency

Lift Transfer Competency (is your staff able to:)

- Identified transfer/lift status
- Identified sling/harness
- Identified size when indicated
- Any special transfer/lift needs

SAMPLE - Zero Manual Lift – Policy Review Questions¹

1. When using mechanical lift equipment the minimal number of staff needed to safely transfer with the mechanical lift equipment is _____.
2. When transferring a patient/resident with a transfer/gait belt one characteristic that the patient/resident must have is: _____.
3. Contraindications for the use of the transfer/gait belt are:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
4. To transfer a patient/resident who has partial weight bearing on one or both of their legs the equipment that must be used minimally is _____.
5. An unlicensed staff member is transferring a patient into bed who has been assessed as needing to be transferred with a Sit/Stand Mechanical Lift. The patient/resident is very tired and you suspect that they will not be able to stand or hold on to the lift. The unlicensed staff member should report this to _____ and the patient/resident should be re-assessed and transferred with _____.
6. The purpose of establishing the zero manual lift program is to:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
7. Prior to the use of each sling, the sling must be checked for:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
8. A staff member begins to place a sling on a patient for transfer and finds it shows visible signs of wear and tear; the staff member should _____.
9. Assessment of a patient/resident's transfer/lift status is to be made at the time of _____ and _____.
10. The staff member looking for a patient's transfer/lift status and the style and size of sling would find it documented in:
 - a. LTC _____
11. The patient/resident has been assessed as needing a medium size sling and one is not available. The staff member leading the transfer for this patient/resident needs to _____.

¹ Created by Kalieda Health Safe Resident/Patient Handling Program

SRH SAMPLE AUDIT TOOL – ZERO LIFT COMPLIANCE

DATE: _____

Auditor(s): _____

Unit : _____

Manager : _____

PATIENT ASSESSMENT AND DOCUMENTATION	COMPLIANCE (please circle either Y for Yes, or N for No)			COMMENTS/CORRECTIVE ACTION
1. Lift/Transfer Documentation Tool filled out at the time of admission to the unit.	Y N	Y N	Y N	
2. Lift/Transfer Documentation Tool updated corresponding to the changes in the patient's medical status.	Y N	Y N	Y N	
Recommendation of Lift Type	Patient Label #1	Patient Label #2	Patient Label#3	
1. Current Lift Type is appropriate for the patient and meets the criteria for the recommendation	Y N	Y N	Y N	If the Lift Type recommendation is inappropriate or does not meet the criteria (N-answer shall be noted) underneath the patient label. Please complete question #2, 3, 4, 5, or 6. Place a check mark next to the bullet(s) that describes the deficiency for each patient label.

<p>2. Total Mechanical Lift</p> <ul style="list-style-type: none"> • Incorrect criteria for lift • No sling size given • Incorrect sling size • No sling method selected • Incorrect sling method 		Comments/Corrective Action
<p>3. Sit/Stand Lift</p> <ul style="list-style-type: none"> • Incorrect criteria for lift • No harness type selected • Incorrect harness selected • TT Harness method not selected 		Comments/Corrective Action
<p>4. Transfer/Gait Belt</p> <ul style="list-style-type: none"> • Incorrect criteria for belt 		Comments/Corrective Action
<p>5. Non-Friction Sheet or Air Matt</p> <ul style="list-style-type: none"> • Patient exceeds the width of the Air Matt (incorrect size) 		Comments/Corrective Action
<p>6. Independent</p> <ul style="list-style-type: none"> • Incorrect criteria for recommendation 		Comments/Corrective Action

Sustaining Your SRH Program

Monitor/Lead/Learn:

- ▶ Lead/coach by example
- ▶ Observe/discuss mistakes
- ▶ Evaluate performance
- ▶ Audits

The key to a successful Safe Resident Handling program is to ensure that the direct caregivers have real “buy in” into the program. Ultimately, the SRH/Ergo Team is working toward ***Cultural Change***. This begins with the 12-week “preceptor program” where new-hires and current staff who are being introduced to new equipment work with unit “coaches/super-users” (including members of the SRH/Ergo Team) on the floor of each unit during all shifts where the mentors lead by example. It is important to observe mistakes or “bad habits” and to correct pre-SRH practices. If corrective measures are not taken, staff will take that as a sign that it’s OK to ignore your SRH policy. It’s also important not to use punitive measures, but to talk with the caregiver. Also, ask them every so often if they are having any difficulty using the equipment for transfers, if there are any residents that the equipment isn’t working well for, if they are having problems accessing equipment or slings and if there are sufficient staffing to allow 2 caregivers to be present when using the equipment.

During the preceptor phase, plan to do a competency evaluation (a sample form is on the next page). You may want to do an evaluation of each caregiver 30 days into the program and again at the end of the 12-week period. If an individual caregiver fails the competency evaluation, you should speak with the individual and indicate the need for retraining.

Finally, plan to audit your program periodically. A key audit will be of your Care Plans/Guides. Each resident’s Care Plan should be evaluated by an “auditor” (a unit charge nurse or others designated by the SRH/Ergo Team). This will ensure that your licensed professionals are properly evaluating each resident’s lifting/transfer needs (a sample form is on the follows the competency evaluation

At the completion of training Licensed Personnel will be able to:

Safely utilize the mechanical lift/repositioning equipment

PERFORMANCE CRITERIA	CRITICAL INDICATORS	LEARNING OPTIONS [Mandatory	Date Met Initial Evaluator
1. Evaluate the patient to determine the correct lift/repositioning equipment to be used.	<ol style="list-style-type: none"> 1. Evaluate the appropriate method for transferring/lifting/ repositioning based on the physical condition of the patient. 2. Documents the transfer/lift status and style/size of sling on the patient/resident status transfer evaluation tool and the patient care plan/closet plan. 3. Places the evaluation tool in the designated area. 4. <u>Acute care:</u> Evaluates the need/type of lift based on any change in the patient status. <u>Long Term Care:</u> Evaluates the need/type of lift based on any change in the resident status and quarterly. 		
2. Sets up and uses specific equipment according to manufacturer's instructions.	<ol style="list-style-type: none"> 1. Non Friction device <ol style="list-style-type: none"> a. Transfers/repositions patient using non friction device <ul style="list-style-type: none"> • Transfers laterally • Repositions in chair • Repositions in bed b. Patient weight considered to determine number of caregivers necessary to complete transfer/repositioning. c. Non friction device removed from patient after transfer/reposition completed. 2. Transfer/Gait belt <ol style="list-style-type: none"> a. Identifies any contraindications to using the Transfer/Gait belt for specific patient. b. Applies transfer/Gait belt correctly. c. Transfers patient using Transfer/Gait belt as per procedure. d. Removes Transfer/Gait belt after transfer completed. e. Positions patient after transfer. 		

LICENSED PERSONNEL/CERTIFIED PERSONNEL/RN/LPN/UAP EVALUATION-ZERO LIFT COMPLIANCE

<p>3. Sets up and uses specific equipment according to manufacturer's instructions</p>	<ol style="list-style-type: none"> 1. Sit /Stand lift <ol style="list-style-type: none"> a. Identifies any contraindications to using the Sit/Stand Lift belt for specific patient. b. Uses appropriate sling as per Patient transfer evaluation tool. c. Determines patient's ability to move from a supine position to a sitting position and balance on the edge of the bed. d. Places a barrier between the patient's skin and the sling. e. Transfers the patient using Sit /stand lift as per procedure. f. Removes sling from patient after transfer. g. Positions patient after transfer. 2. Total Mechanical Lift <ol style="list-style-type: none"> a. Uses appropriate sling as per the Patient transfer evaluation tool. b. Places a barrier between the patient's skin and the sling. c. Transfers the patient using Total Mechanical Lift as per procedure. d. Removes sling from patient after transfer. e. Positions patient after transfer. 		
<p>4. Maintains and trouble shoots the lift equipment</p>	<ol style="list-style-type: none"> 1. Lifts <ol style="list-style-type: none"> a. Returns lift to designated area after use. <ul style="list-style-type: none"> • Plugs in lift to charge • Locks wheels b. Places a "do not use sign" on any lifts felt to be malfunctioning and reports to manager (?). c. Wipes down equipment and non-friction sheets with hospital approved disinfectant between uses. 2. Slings <ol style="list-style-type: none"> a. Inspects all slings for wear and tear, loose stitching and fraying straps before using. b. Tags any slings with wear and tear or compromised integrity "Do not use" and returns to manager. c. Puts dirty slings in designated laundry bags/hamper. d. Spot cleans with approved solution for minor soilage. e. Verbalizes cleaning of slings: <ul style="list-style-type: none"> • Hygiene sling • THA Hammock • TST Band harness • Total Transfer Harness 		

Mod #5 Handout #9 – LICENSED PERSONNEL/CERTIFIED PERSONNEL/RN/LPN/UAP EVALUATION-ZERO LIFT COMPLIANCE

<p><u>MASTER TRAINER ONLY</u></p> <p>5. Functions as a Master Trainer</p>	<ol style="list-style-type: none"> 1. Acts as a resource. 2. Assists with patient assessments. 3. Problem solves with staff to determine appropriate lift/transfer method. 4. Conducts audits weekly and faxes to designated number/areas. 5. Validates Lift/transfer competency of staff. 6. Investigates near misses, accidents and injuries. 7. Remediate near misses, accidents and injuries. 8. Maintains a Zero-lift notebook including <ul style="list-style-type: none"> • Zero manual lift policy • Original audits • Sling application Guide 		
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At the completion of training Certified Personnel will be able to:

Safely utilize the mechanical lift/repositioning equipment

PERFORMANCE CRITERIA	CRITICAL INDICATORS	LEARNING OPTIONS [Mandatory	Date Met Initial Evaluator
----------------------	---------------------	---------------------------------	----------------------------

<p>1. Determine the correct lift/repositioning technique/equipment to be used.</p>	<ol style="list-style-type: none"> 1. Determine the appropriate handling technique as identified on the Safe Patient Handling Tool (Acute), or the Care Plan for LTC. 2. Determine when the Patient/Resident current handling technique cannot be performed safely and utilizes the next higher level of transfer. 		
<p>2. Sets up and uses specific equipment according to manufacturer's instructions.</p> <p>The use of Non-Friction devices including the Air Matt technology increase employee and resident safety by eliminating friction, drag and load during all positioning, repositioning, turning and lateral transfer acts conducted.</p>	<ol style="list-style-type: none"> 1. Non Friction device and Air Matt <ol style="list-style-type: none"> a. Transfers/repositions patient using non friction device <ul style="list-style-type: none"> • Transfers laterally • Repositions in chair • Repositions in bed b. Patient weight considered to determine number of caregivers necessary to complete transfer/repositioning. c. Non friction device removed from patient after transfer/reposition completed. d. Air Matt is placed on top of the mattress under the bedding. e. Air Matt stays under the resident for as long as needed. f. Air Matt is always deflated when under the resident. g. Air Matt is only inflated when caregivers are standing next to the resident and next to the bed and prepared to conduct the tasks of turning, positioning and moving up or down the bed. h. Air Matt use requires the side rails to be up before turning on the air supply and it requires the resident to be centered on the Air Matt. 		

LICENSED PERSONNEL/CERTIFIED PERSONNEL/RN/LPN/UAP EVALUATION-ZERO LIFT COMPLIANCE

<p>3. Sets up and uses specific equipment according to manufacturer's instructions.</p> <p>When sling straps are left hanging down the wheelchair and into the wheels they get damaged. The straps get frayed and cut when caught in the w/c wheels.</p> <p>If a resident is left on a sling the straps must be tucked up on to the seat of the chair and not left hanging over the sides.</p> <p>When a resident is on the floor a licensed professional must evaluate them before they are touched or moved with the use of the full mechanical lift.</p> <p>Residents are transferred off the floor with a full mechanical lift, minimized movement and with the hips protected by reclining the resident in the sling so that the hips are behind the trunk.</p>	<ol style="list-style-type: none"> 1. Sit /Stand lift <ol style="list-style-type: none"> a. Identifies any contraindications to using the Sit/Stand Lift belt for specific patient. b. Uses appropriate sling as per Patient Transfer Evaluation Tool. c. Determines patient's ability to move from a supine position to a sitting position and balance on the edge of the bed. d. Places a barrier between the patient's skin and the sling. e. Transfers the patient using Sit /stand lift as per procedure. f. Removes sling from patient after transfer. g. Positions patient after transfer. 2. Total Mechanical Lift <ol style="list-style-type: none"> a. Uses appropriate sling as per the Patient Transfer Evaluation Tool. b. Places a barrier between the patient's skin and the sling. c. Transfers the patient using Total Mechanical Lift as per procedure. d. Removes sling from patient after transfer. e. If the sling is left under the resident be sure the straps are tucked up and not hanging down into the wheels. f. Positions patient after transfer. 3. Transfer/Gait Belt <ol style="list-style-type: none"> a. Identifies any contradictions to using the Transfer/Gait belt for specific patient. b. Applies Transfer/Gait belt correctly. c. Transfers patient using Transfer/Gait belt as per procedure. d. Removes Transfer/Gait Belt after transfer completed. 		
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LICENSED PERSONNEL/CERTIFIED PERSONNEL/RN/LPN/UAP EVALUATION-ZERO LIFT COMPLIANCE

<p>4. Maintains and trouble shoots the lift equipment.</p> <p>Broken lifts are tagged and removed from use. Report this to _____</p>	<ol style="list-style-type: none"> 1. Lifts <ol style="list-style-type: none"> a. Returns lift to designated area after use. <ul style="list-style-type: none"> • Plugs in lift to charge at the charge station. • Locks wheels b. Places a “do not use sign” on any lifts felt to be malfunctioning and reports to manager for follow up. c. Wipes down equipment and non-friction sheets with hospital approved disinfectant between uses. 2. Slings <ol style="list-style-type: none"> a. Inspects all slings for wear and tear, loose stitching and fraying straps before using. b. Tags any slings with wear and tear or compromised integrity “Do not use” and returns to manager. c. Puts dirty slings in designated laundry bags/hamper. d. Can verbalize how proper sling size is determined. e. Can verbalizes how to recognize Hammock slings by size. <ul style="list-style-type: none"> • Large • Medium • Small • Total Transfer Harness-for Sit/Stand Lift 		
<p><u>MASTER TRAINER ONLY</u></p> <p>5. Functions as a Master Trainer</p> <p>Know where your inventory of equipment is, communicate to others where to find it and protect it from damage.</p>	<ol style="list-style-type: none"> 1. Acts as a resource. 2. Assists the Licensed Professional with patient assessments. 3. Problem solves with staff to determine appropriate lift/transfer method. 4. Conducts audits weekly and faxes to designated number/areas. 5. Validates Lift/transfer competency of staff. 6. Investigates near misses, accidents and injuries. 7. Remediates near misses, accidents and injuries. 8. Maintains a Zero-lift notebook including <ul style="list-style-type: none"> • Zero manual lift policy • Original audits • Sling application Guide 		

<i>At the completion of training the RN/LPN/UAP will be able to:</i>			
PERFORMANCE CRITERIA	CRITICAL INDICATORS	LEARNING OPTIONS <input type="checkbox"/> Mandatory	Date Met Initial Evaluator
Set up and use specific equipment according to manufacturer's instructions.	<ol style="list-style-type: none"> 1. Air Matt <ol style="list-style-type: none"> a. Transfer/reposition patient using Air Matt <ul style="list-style-type: none"> • Transfers laterally • Repositions in bed • Turn and position • Taking Portable X-Ray b. Patient girth considered to determine size of Air Matt and number of caregivers necessary to complete transfer/repositioning. c. Air Matt stays on bed/gurney deflated on top of mattress when not in use. d. Inflate Air Matt when performing the transfer/ repositioning with the caregivers next to the patient for safety. 		

AFTER ACTION REVIEWS

Even after you have adopted a Safe Resident Handling policy, provided competency training for your entire staff, have purchased the equipment you need and have the support of all the key stakeholders, *things will still go wrong.*

After Action Reviews

A means for caregivers to share information with co-workers and supervisors about:

- ▶ An injury that has occurred as a result of resident handling
- ▶ A near-miss incident
- ▶ Failure to follow policy
- ▶ Failure of equipment
- ▶ An unexpected positive outcome

An *After Action Review* (AAR) process is a way of dealing with the fact that sometimes things go wrong. A piece of equipment malfunctions. A resident who's assessed as needing "limited assistance" suddenly faints as she's being steadied by her caregiver. Or a caregiver, under time pressure, will do a sit-stand pivot lift when equipment should have been used. In these situations, a caregiver or resident may get hurt or just escape getting hurt.

AAR allows for continuous improvement of your SRH program by recognizing a problem such as an injury or a near miss, and addressing the question of what needs to improve so it won't happen again. AAR can also be used to discuss something unexpected that happened that actually improved your program (e.g., caregivers sharing information on a better way of communicating a lift with a difficult resident).

Conducting After Action Reviews

- ▶ Honest exchange
- ▶ Informal and brief
- ▶ SRH Point Person many lead
- ▶ No finger-pointing: take a team approach
- ▶ Focus on adjusting the program to prevent future incidents

After Action Reviews are similar to the “chalk talks” where players and coaches gather around a chalk board after a game to evaluate the team’s recent performance. The focus is on the team and what went right, what went wrong and how, as a team, they can improve their game next time.

After an incident occurs and it is reported to the SRH Point Person or a supervisor, a brief informal meeting should of caregivers on the unit should be scheduled. The SRH Point Person may want to do this and open the discussion. It is important that the person leading the discussion assure everyone that there will be no finger-pointing or retribution for discussing the incident honestly. The key point of an AAR is to look at the root cause of the incident. For example, if a caregiver can’t get access to the proper equipment in a timely manner and does an improper transfer, the question is: “How do we adjust the program to ensure that the proper equipment is accessible when needed so it is used?”

The incidents that triggered AAR reviews and the outcomes should be regularly shared with the SRH/Ergo Team at its meetings by the SRH Point Person. This will allow the committee to identify changes that may be needed in the SRH program such as, for example, the need to purchase additional equipment.

After Action Reviews: The Process

After Action Reviews addresses:

- What happened?
- What was supposed to happen?
- What accounts for the difference?
- How could the same outcome be avoided next time?
- What's the follow-up plan?

AAR Case Study

During the first meeting, group members asked staff to think about what happened during the morning.

Did anything happen (near-miss or injury) that could have put them or their co-workers at risk of injury that everyone could learn from?

What Happened?

Sue, an LPN, begins.

I had to get Mr. Walker up because he was lying in a wet bed. . . I was late with my meds and I knew he needed to get to the in-service. Then, I couldn't find a sling, so I just got him up myself. While I was lifting him I kept thinking. . . 'Don't hurt yourself. . . ' I guess I was lucky I didn't!

So. . . What happened was that I lifted Mr. Walker without help, without using a lift.

What Was Supposed to Happen?

Nancy: *OK. . . So, what should have happened?*

Sue: *I should have found the sling and used the lift, but I was in such a hurry.*

Nancy: *I know . . . It's so frustrating to have all of these new lifts but not have the slings where you Where you need them. I know I've had trouble finding slings, too.*

What Accounts for the Difference?

Nancy: *Let's see . . . What accounts for the difference? Well . . . The sling wasn't available. For starters, the sling should have been in the room and on the bed side stand, where we agreed to keep them.*

Ron: *You're right, but there's not always room to put them there . . . That's where residents place their things too. . . Because of that a lot of times I put slings in places where 'I' can find them when 'I' come back in the room, but I guess that makes it hard for you guys to find them when I'm not around. . . .*

After more discussion, the group decides that the problem of 'inaccessible slings' is caused by no good location for the slings in resident rooms.

How Can the Same Outcome Be Avoided in the Next Time?

Nancy: *OK . . . We're always running around looking for slings. What do you think about placing a sling 'hook' in every resident room, right at the door, so you can easily pick up a sling upon entering and put it back when you leave?*

Fred: *That's a good idea! I also think it would help if we had more slings . . . How many more do you think we need?*

Brad: *I'll request a work order to install the hooks and after they're installed I'll make sure everyone gets the message on the new procedure.*

Ron: *I'll add the process to the new employee orientation packet.*

Fred: *I'll put a request to order 6 slings.*

What's the Follow-up Plan?

Sue: *Let's see if I have all of our recommendations. . . Put in a work order for installation of the hooks, buy more slings, spread the word, and the add process to the unit orientation packet for new employees.*

Brad: *Since this has been a continual problem, let's see how we're doing on the sling issue at an AAR in one month.*

MODULE SIX

HANDOUTS

Is it a Myth or a Fact?

Myth or Fact

M ☐ F ☐

Routine manual resident lifting is prohibited in some states as well as in a number of countries.

M ☐ F ☐

Proper body mechanics can prevent most healthcare worker lifting injuries.

M ☐ F ☐

The human body can safely lift 60 pounds.

M ☐ F ☐

All resident handling injuries are related to lifting, transferring and/or repositioning bariatric residents.

M ☐ F ☐

A two person lift of a 150 lb resident is safe for the caregivers.

M ☐ F ☐

It is possible for a worker to be injured without showing or experiencing any physical signs.

M ☐ F ☐

Healthcare workers that are physically fit are less likely to be injured lifting residents.

M ☐ F ☐

Safe resident lifting equipment is not affordable.




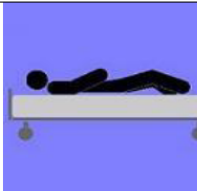

M ☐ F ☐

Repositioning residents is a high risk activity with the potential for injury.

M ☐ F ☐

The only workers who need to understand the Safe Resident Handling Program are Registered Nurses.

MOD #6 – Handout #2 SAFE RESIDENT HANDLING ASSESSMENT TOOL

Lift Type	Patient /Resident Criteria	Contraindications	Sling Criteria	Staff
 <p>Total Mechanical</p>	<ul style="list-style-type: none"> Non weight bearing Not able to sit/balance on edge of bed Non weight bearing patient needing repositioning in a non-reclining chair 		Use - Hygiene sling if patient has: <ul style="list-style-type: none"> Good upper body control Cognitive Able to assist Transfer is for toileting/access to perineal area. 	2 – 2+
			Use - *Hammock sling if patient has: <ul style="list-style-type: none"> Poor upper body control Non cognitive Unable to assist. 	2 – 2+
 <p>Sit/Stand Mechanical Lift</p>	<ul style="list-style-type: none"> Partial weight bearing in one or both legs Can hold on with one or both hands Cooperative Able to move supine to sit and be able to sit/balance on edge of bed Partial weight bearing patient needing repositioning in a non-reclining chair 	<ul style="list-style-type: none"> Abdominal, chest or back surgery (if the area of surgery would be compromised resulting in harm to the patient/resident) Spinal or pelvic fracture (if the fracture site would be compromised resulting in harm to the patient/resident) Poor skin integrity in area of belt 	Use - Band Harness if patient: <ul style="list-style-type: none"> CAN bear weight continuously 	2 – 2+
			Use -TT Harness if patient: <ul style="list-style-type: none"> CANNOT bear weight continuously Band sling is not large enough If leg straps are needed 	2 – 2+
 <p>Transfer/Gait Belt</p>	<ul style="list-style-type: none"> Full weight bearing and able to ambulate with guidance or hands on cueing Partial weight bearing if they can take steps and move feet Steady Sound cognition Cooperative 	<ul style="list-style-type: none"> Abdominal, chest or back surgery (if the area of the surgery would be compromised resulting in harm to the patient/resident) Spinal or pelvic fracture (if the fracture site would be comprised resulting in harm to the patient/resident) Poor skin integrity in area of belt 	None	1 + another to handle medical equipment
 <p>Non-Friction Device or Air Matt</p>	<ul style="list-style-type: none"> Bedrest Unable to assist with lateral transfer Needs repositioning in bed or reclining chair 		None	Less than 200 lbs – 2
				More than 200 lbs – 3
 <p>No Lift Device</p>	<ul style="list-style-type: none"> Full weight bearing bilaterally Steady 		None	0 – 1

MOD #6 – Handout #4

A. Procedure for use of Total Mechanical Lift

A Total Mechanical Lift provides a safe transfer for patients/residents from a supine to seated position or seated to seated transfer. A Total Mechanical Lift will be used by those patients/residents who have no weight bearing abilities or who have been assessed to need a Total Mechanical Lift for transfer.

1. Equipment/Personnel

- a. Total mechanical Lift
- b. Two (2) or more caregivers

2. Procedure

- a. There must be two caregivers interfacing with their hands on the patient/resident & the Total Mechanical Lift.
- b. Adjust bed to a height that promotes good body mechanics.
- c. Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
- d. Position patient/resident on the appropriate sling.
- e. Position lift with the base open so that the spreader bar is perpendicular to the patient's/resident's shoulders and hovering above the chest.
- f. Attach the sling straps without pulling or tugging, to the desired setting.
- g. Verbally prepare patient/resident for transfer.
- h. Gently raise patient/resident minimally from surface.
- i. Turn patient's/resident's legs towards the perpendicular support bar of the lift during the move.
- j. **Be sure to close the legs of the lift while moving the lift; keeping the patient/resident's body on the inside of the lift legs. Not swinging to the outside of the lift legs.**
- k. Gently lower patient/resident into chair. (adhere to zero air space procedure)
- l. Remove sling from under patient (if appropriate).
- m. **Before** a resident/patient that is on the floor is moved, touched or mechanically lifted, a licensed professional **must** assess the resident/patient. In order to promote safe resident/patient handling, **use** a full mechanical lift when getting a resident/patient off the floor.

MOD #6 – Handout #3 CULTURE CHANGE: OLD VS. NEW

OLD PRACTICES...



- EXPECT WORKERS TO ADAPT TO POOR WORK DESIGNS.
- CAN INJURE THE PATIENT.
- DEMAND THAT WORKERS EXCEED THE NATURAL LIFTING LIMITS OF THEIR BODIES.
- ARE TECHNIQUES THAT ARE BASED ON LOADS THAT WEIGH FAR LESS THAN TYPICAL PATIENTS.

EVIDENCE BASED PRACTICES...



- ARE DESIGNED TO FIT WORKERS AND MAINTAIN SAFETY.
- APPLY POSITIONING AND MOBILITY TECHNIQUES THAT ARE SAFE FOR PATIENTS AND CAREGIVERS.
- SHOULD BE INCLUDED IN ALL HEALTHCARE CURRICULA TO ENSURE THAT HEALTHCARE WORKERS ARE TAUGHT PROPER TECHNIQUES TO SELECT AND UTILIZE SAFE PATIENT HANDLING EQUIPMENT.

<i>Cultural Change</i>	
OLD Resident Handling “Blame and Shame” Culture	NEW Health Care Safety Culture
Mistakes (resident or worker injuries) are due to direct caregiver’s error	Mistakes are primarily due to poorly designed job tasks and work environment
Patient and direct caregiver injury prevention can be improved through training in proper manual lifting such as two person lifts	Resident and direct caregiver injury prevention can be improved by ergonomically assessing and engineering out job task risks and work environment risks
Job task demands, short-staffing, time constraints, non-maintained/non-accessible/inappropriate mechanical assists make “no-lift” policies impractical	Administrative controls such as policies and procedures for maintaining equipment, making equipment available, ensuring equipment is appropriate to job tasks, training workers on equipment make no lift policies practical
Investment in equipment, training, release time to participate on ergonomic committees is not cost effective	Average return on investment is three years due to cost savings on worker’s compensation costs, decreased lost work days, decreased worker replacement costs, and increased job retention
Direct caregivers won’t change. It is human nature to take the easiest route; we use manual lifts to get the job done. When mistakes are made it is human nature to hide them	Direct caregivers can be trained to follow SRH policies and procedures, assess resident dependency and the right equipment to use. Administrative support for encouraging reporting of mistakes or near misses allows for continuous improvement. The point is to build effective vigilance, communication, and problem solving.

Full Mechanical Lift

A. **Procedure for use of Total Mechanical Lift**

A Total Mechanical Lift provides a safe transfer for patients/residents from a supine to seated position or seated to seated transfer. A Total Mechanical Lift will be used by those patients/residents who have no weight bearing abilities or who have been assessed to need a Total Mechanical Lift for transfer.

1. **Equipment/Personnel**

- a. Total mechanical Lift
- b. Two (2) or more caregivers

2. **Procedure**

- a. There must be two caregivers interfacing with their hands on the patient/resident & the Total Mechanical Lift.
- b. Adjust bed to a height that promotes good body mechanics.
- c. Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
- d. Position patient/resident on the appropriate sling.
- e. Position lift with the base open so that the spreader bar is perpendicular to the patient's/resident's shoulders and hovering above the chest.
- f. Attach the sling straps without pulling or tugging, to the desired setting.
- g. Verbally prepare patient/resident for transfer.
- h. Gently raise patient/resident minimally from surface.
- i. Turn patient's/resident's legs towards the perpendicular support bar of the lift during the move.
- j. **Be sure to close the legs of the lift while moving the lift; keeping the patient/resident's body on the inside of the lift legs. Not swinging to the outside of the lift legs.**
- k. Gently lower patient/resident into chair. (adhere to zero air space procedure)
- l. Remove sling from under patient (if appropriate).
- m. **Before** a resident/patient that is on the floor is moved, touched or mechanically lifted, a licensed professional **must** assess the resident/patient. In order to promote safe resident/patient handling, **use** a full mechanical lift when getting a resident/patient off the floor.

Full Mechanical Lift



Apply the sling



Check the straps and communicate with others on which loop you are attaching.
Double check straps before lifting

Full Mechanical Lift



Begin lifting



Full Mechanical Lift



Lift over the chair or bed for safety.
Recheck for attachments before moving

Full Mechanical Lift



Look at how the back is straight for good sitting posture.
This will eliminate the need for repositioning once in the chair.



Applying light pressure to the knees will set the resident back into the chair instead of pulling from behind.

Ceiling Lift

Procedure for use of the Ceiling Lift *when available*

A Ceiling Lift provides a safe transfer for a patient/resident similar to the Total Mechanical Lift. Floor space challenges are not an issue with a Ceiling Lift therefore there is reduced injury risk for patient/resident and healthcare worker. With the use of the Turn and Position Sling the Ceiling Lift reduces the exertion and injury risk related to positioning tasks in bed.

1. **Equipment/Personnel**
 - a. Ceiling Lift
 - b. Two (2) or more caregivers
2. **Procedure**
 - a. There must be two caregivers present to operate the Ceiling Lift
 - b. Adjust the height of the bed to promote good body mechanics.
 - c. Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
 - d. Position the patient/resident on the appropriate sling.
 - e. Position the motor so the spreader bar is perpendicular to the patient/resident's shoulders. If utilizing two motors position the second spreader bar perpendicular to the hips.
 - f. Lower the spreader bar(s) attaching the sling straps to the desired setting.
 - g. Verbally prepare the patient/resident for transfer.
 - h. Gently raise the patient/resident clearing the surface they are on; guide the patient by grasping the sling and moving toward the desired transfer surface.
 - i. Gently lower and position the patient/resident to the chair or desired transfer surface.
 - j. When performing a positioning task select the appropriate sling attachment loops without pulling or tugging to the desired setting.
 - k. When positioning the patient/resident on their side attach the sling attachment loops to the spreader bar(s) on one side of the Turn and Position Sling.
 - l. When repositioning the patient/resident in bed align the spreader bar parallel to patient/resident's trunk. Attach the Turn and Position Sling attachment loops on both sides to the spreader bar.
 - m. When repositioning the patient/resident with 2 ceiling lift motors both spreader bars should be aligned perpendicular to the patient/resident's trunk. Attach the Turn and Position sling attachment loops on both sides to the spreader bars.
 - n. To maintain charge the Ceiling Lift Motor must be returned to the docking station. An amber light will indicate the motor is accepting the charge.
 - 1) The Turn and Position Sling is only utilized to turn, reposition and lateral transfer a patient/resident from bed to gurney. Never utilize the Turn and Position Sling to transfer a patient resident to a chair.
 - 2) The Ceiling Lift motor has an emergency (red) pull cord to lower the spreader bar. The emergency pull cord needs to be reset once disengaged to operate the motor.



This is a picture of a turn and positioning sling in use with a ceiling lift



Always use a barrier if not clothed



Connecting the lift to the sling.
The lift uses a hook and loop system for attachment.



Turning the bar length-wise is best when using the positioning sling.



Once up, you can move the resident laterally or up in bed.

Ceiling Lift



USING A TURNING AND POSITIONING SLING



Attaching one side of the sling allows the turning of the resident.



Using a limb strap along with the turning and positioning sling allows access for care.

USING LIMB STRAPS



Limb straps can be used for wound care.

TURNING AND POSITIONING SHEET WITH CARE OPTION



This option allows the sling to be separated in half after turning for care needs.

Procedure for use of Sit/Stand Mechanical Lift

A Sit/ Stand Mechanical Lift provides a safe seat-to-seat transfer for the patient/ resident who has partial weight bearing capabilities in one or both legs and has good cognition. The patient/resident must be able to move from a supine position to sitting position and balance in a sitting position on the edge of the bed.

1. **Equipment/Personnel**
 - a. Sit/Stand mechanical Lift
 - b. Two (2) or more caregivers

2. **Procedure**
 - a. Apply proper harness so that the bulk of the harness rests in the patient's/
resident's lower back region. Tighten the inner belts so that they fit snug to the patient. Apply leg straps if applicable. Never tighten the legs straps on the TT Harness.
 - b. Position the Sit/Stand Mechanical Lift with the base of the lift open and lift is facing patient/resident.
 - c. Instruct/assist patient to place feet in the footplate of the lift. Patient/resident's legs must be against the black calf pad at all times during the transfer.
 - d. Attach the strap of the harness to the lift without pulling or tugging.
 - e. Instruct/assist patient/resident to grasp handles on lift with arms on the outside of the harness.
 - f. Close the legs of on the lift during movement of the lift with patient in it. **Do not** move the lift with the legs open.
 - g. Verbally prepare patient/resident for transfer.
 - h. Instruct/ assist patient/resident to lean back into the harness as they are gently lifted minimally from the surface.
 - i. Transfer patient/resident to new surface.
 - j. There must be two caregivers present with their hands on the Mechanical Lift

****Keypoint:** The patient/resident's patella should be above the shin pad when performing a transfer with their feet stationary on the footplate. The patient/resident's patella should be in the middle of the shin pad when ambulating with the footplate removed. The patient/resident may be transferred with one leg resting on the shin pad. i.e. total knee patient/resident.

Sit to Stand Lift



Sit to Stand Lift



Attaching the sling properly and securely make for a safe transfer.



Sit to Stand Lift

Making sure that the knee pad is below the knee cap.



Before lifting, the resident's arms need to be placed outside the sling.



The resident needs to be able to partial weight bear and participate in this lift.

Sit to Stand Lift

The transfer can be adjusted to meet limitations within resident's abilities.



It is always recommend that two staff members help with moving the resident in the lift.



This lift allows opportunity for toileting.

Procedure for use of Transfer/Gait Belt

A transfer/gait belt provides a firm, grasping surface for the caregiver, protects the patient/resident from accidental trauma to the skin, provides a sense of security to the patient/resident, and protects the caregiver from injury while transferring or ambulating a patient/ resident. Transfer/gait belts are used on a patient/resident who is not independent in rising or during ambulation. The patient/resident must be able to move feet in the desired direction during a transfer. Also, the patient/resident should not require lifting or need to be held up. If a patient/resident is at risk for collapsing or falling, the Transfer/Gait Belt is not the safest mode of transfer. A reassessment is indicated. The Sit/Stand Lift with the TT Harness and leg straps may be indicated or a full mechanical lift.

1. **Equipment/Personnel**

- a. Transfer/Gait belt
- b. One caregiver – second caregiver assistance used only to manage medical equipment or a wheelchair.

2. **Procedure**

- a. Explain purpose of belt and the procedure of its use to the patient/resident.
- b. Put the belt on over the patient's/resident's clothing and around the waist and make sure the belt is snugly in place.
- c. Assist patient to a standing position by grasping the handles on the transfer/gait belt.

****Keypoint:** Caregiver should be able to insert two fingers between the belt and the patient's/resident's clothing.

****Keypoint:** Before assisting patient/resident in transfer or ambulation make sure that the belt is properly positioned and that the buckles are securely fastened.

****Keypoint:** Do not allow patient/resident to place hands or arms around the caregiver's neck.

****Keypoint:** If a patient/resident begins to slide while getting up, lock the patient/ resident's knees against the caregiver's knees.

****Keypoint:** If the patient begins to fall during transfer/ambulation, pull the resident close to the caregiver's body using the transfer/gait belt, call out for help and lower patient/resident as far as your arms will extend to the floor.

****Keypoint:** Use Total Mechanical Lift to lift patient from floor

Use of a Gait Belt



Using a gait belt allows a place for the caregiver to place their hands.
It is not meant to be used as a lifting device.

Use of a Gait Belt



Using the hand rails as a device to push up from allows the resident to move themselves without the caregiver pulling them to their feet.



Placing your hands for support and not assistance is the true meaning of a stand pivot transfer.



The resident should be able to stand, move their feet without any physical assistance.





Non Friction Devices

Procedure for use of the Non-Friction Device

A Non-Friction Device helps to reduce the push pull forces associated with repositioning and laterally transferring patients/residents. The device is utilized for a patient/ resident who is dependent requiring assistance for bed mobility or lateral transfers.

1. **Equipment/Personnel:**
 - a. Non-Friction Device
 - b. Two (2) or more caregivers
 2. **Procedure for use of Non-Friction Device to reposition in Bed:**
 - a. Adjust bed to a height that promotes good body mechanics and place the bed in the flat position.
 - b. Roll the patient/resident to one side and position the Non-Friction Device underneath the patient. Place a sheet between the patient/resident and the Non-Friction Device.
- **Keypoint:** Do not pull the Non-Friction Device. Pull the sheet that is between the patient and the Non-Friction Device. The Non-Friction Device maybe applied by tucking the device under a sheet or incontinent pad. Multiple Non-Friction sheets maybe utilized for a bariatric patient/ resident tucking the device half way underneath the individual. The Non-Friction

Mod #6, Handout #4 – Hands-on SRH Equipment/Devices Photos and Procedures

Device may be utilized when performing a portable X-ray slipping the film between sheet layers.

- c. With at least one caregiver on either side of the bed, grasp the sheet with the caregiver's palms down and maintain wrists flat on the bed while transferring.
- d. Using proper body mechanics, caregivers will shift their weight sliding patient/ resident into proper position on the bed.
- e. Roll patient/resident until the Non-Friction Device can be removed. The Non-friction Device may be removed by tucking the device under the sheet or incontinent pad with the second caregiver walking and grasping the device.





Non Friction sheets today can be easily placed under a resident without turning the resident. This creates an environment that eliminates the physical handling of the resident.



Tautening the care pad when placing the non-friction sheet under the resident.



Tautening the sheet on the other side allows the caregiver to get the other end of the sheet



A non-friction sheet can be used to reposition a resident. If the bed is placed in a trendelenburg position, the resident will slide up in bed with little or no effort.



Procedure for use of Non-Friction Device to Laterally Transfer

1. Roll the patient/resident until he/she is positioned on the Non-Friction Device. A sheet should be positioned between the patient/resident and the Non-Friction Device. Note: the Non-Friction Sheet may be tucked underneath the patient/resident if they are dependent requiring assist to roll.
2. Adjust bed so that it is at the same height as the stretcher and so that bed is in the flat position.
3. **Be sure to bridge the gap between the 2 surfaces with a slide board.**
4. The caregivers should be positioned: one on the side of the supporting surface.
(Example: bed, stretcher, procedure table) and the other caregiver on the close side of the other supporting surface.
5. Grasp the sheet the caregiver's palm's down and maintain wrists flat on the bed.
6. Using proper body mechanics, the first caregiver shall push the patient/resident towards the stretcher while the second caregiver receives patient/resident and pulls the rest of the distance.
7. Roll patient/resident till Non-Friction Device can be removed.

****Keypoint:** The Non-Friction Device cannot be left under the patient/resident after use.

Procedure for use of the Air Matt

An Air Matt technology increases employee and resident safety by reducing friction, push-pull forces and load during all positioning, repositioning, turning and lateral transfer acts conducted.

1. **Equipment/Personnel:**

- a. Air Matt
- b. Two (2) or more caregivers

2. **Procedure for use of the Air Matt to reposition in bed:**

- a. Adjust bed to a height that promotes good body mechanics.
- b. Air Matt is placed on top of the mattress under the bedding.
- c. Air Matt stays under the patient/resident for as long as needed.
- d. Air Matt is always deflated under the resident.

****Keypoint:** Air Matt is only inflated when caregivers are standing next to the patient/resident and next to the bed and **prepared** to conduct the following tasks: Turning, repositioning and performing a lateral transfer.

- e. Air Matt use requires two side rails to be up before turning on the air supply and it requires the resident to be centered on the Air Matt.

3. **Procedure for use of the Air Matt to laterally transfer:**

- a. Adjust bed so that it is at the same height as the stretcher and so that bed is in the flat position.
- b. Make sure patient is centered on the Air Matt.
- c. The caregivers should be positioned: one on the side of the supporting surface (example: bed, stretcher, procedure table) and the other caregiver positioned close to the side of the other supporting surface (side rails positioned up if available on surface).
- d. Using proper body mechanics, the first caregiver should push the patient/resident diagonally (feet first) towards the supporting surface while the second caregiver pulls receiving patient/resident (feet). Same procedure is performed when the patient/ resident torso is diagonally transferred to the supporting surface.
- e. Once patient/resident is safely transferred to supporting surface, deflate the Air Matt.

4. **Procedure for use of Air Matt to position patients:**

- a. Adjust bed to a height that promotes good body mechanics.
- b. Make sure patient is centered on the Air Matt.
- c. Make sure bed rails are in the up position. A pillow should cover the bed rails in the direction the patient/resident is rolling.
- d. The caregivers should be positioned on both sides of the bed working as a team.

Non Friction Devices



The air matt is a great tool to eliminate manual lifting. It is a device that is inflated with the resident on it. Once inflated, the resident is moved in a diagonal fashion to another surface. It has a wide range of weight capacity.

APPENDIX I-2

SPH Training Series - Session I

Introduction to Safe Patient Handling/ Building SPH Ergonomics Teams/Documenting Patient Handling Injuries



Western New York Council on Occupational Safety & Health (WNYCOSH)

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Introduction to Safe Patient Handling

AGENDA:

- An Overview of Safe Patient Handling (SPH)
- Body Mechanics and Lifting Limits
- Anatomy of an Injury
- Controlling Risk Factors
- Old vs. New SPH Practices: Changing the Culture
- SPH Stakeholders
- SPH Ergonomic Team's Roles in SPH
- SPH Implementation Steps/Timeline
- Assessing facility injury and compensation rates

Introduction to Safe Patient Handling

OBJECTIVES:

Participants will be able to understand...

- what SPH is and who benefits
- why body mechanics can't prevent health care worker injuries
- why and how manual handling is injuring us
- how our job tasks and work environment put us in risk of injury
- SPH is a change in our safety culture
- need for SPH Stakeholder's involvement
- the SPH/Ergonomics Team's role in SPH
- SPH implementation/timeline planning
- identifying and recording patient injuries

Section 1

An Overview of Safe Patient Handling

- Handling s: Myth vs. Fact
- Health Care Worker Rates
- What Is Safe Patient Handling
- Who Benefits?

Section 1: An Overview of Safe Patient Handling

GROUP ACTIVITY 1

Page 3 of Student Workbook Guide

MYTH

VS.

FACT

Section 1: An Overview of Safe Patient Handling

WHO IS GETTING HURT?

What job titles have the highest injury rates?

Where do health care workers rank among these job titles?

Have health care worker injuries been going up, down or staying the same over time?

Section 1: An Overview of Safe Patient Handling

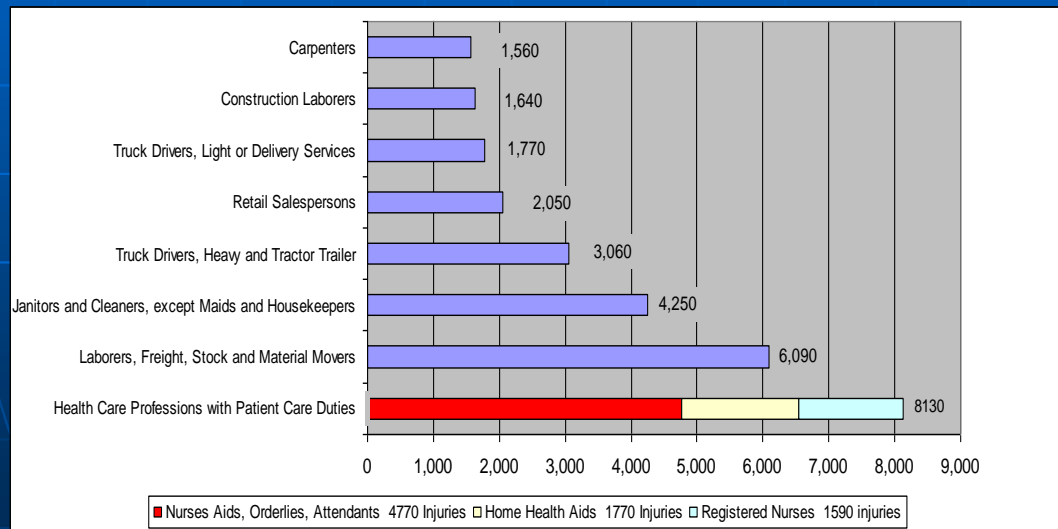
WHO IS GETTING HURT?



Section 1: An Overview of Safe Patient Handling

WHO IS GETTING HURT?

Numbers of Injuries Nationwide



Section 1: An Overview of Safe Patient Handling

WHO IS GETTING HURT?

- 29% of all workplace injuries requiring time away from work are MSDs
- The MSD rate for nursing aides, orderlies and nursing attendants is 7xs higher than the average of all occupations
- Approximately three-fourths of these MSDs are lower back disorders

Sources: Bureau of Labor Statistics, 2008, 2009
E. Langford, RN, 1997

Section 1: An Overview of Safe Patient Handling

WHAT IS Safe Patient Handling?

“A policy and practice that creates a safe work environment for patients [s] and healthcare workers by eliminating hazardous manual lifting tasks. Transferring and repositioning patients [and s] is accomplished by using new technologies such as mechanical lifts and repositioning devices.”

– NYS Zero Lift Task Force

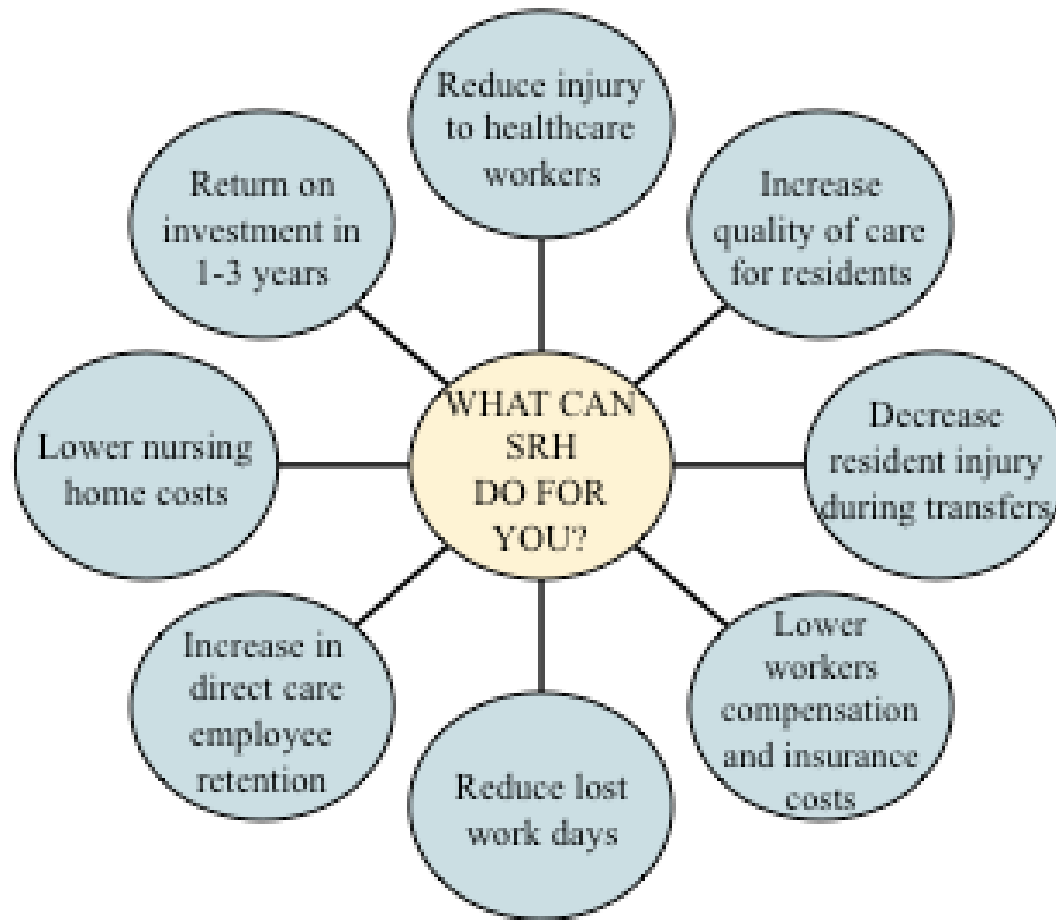
Section 1: An Overview of Safe Patient Handling

HOW DO WE GET TO SPH?

- Set-up a SPH Team
- Adopt a SPH Policy
- Assess Facility Needs
- Purchase Equipment
- Training Staff on SPH
- Mentor/Monitor/Evaluate

Section 1: An Overview of Safe Patient Handling

WHO BENEFITS?



Section 2

Body Mechanics and Lifting Limits

- Good Body Mechanics
- The Lifting Limit for Unstable Loads
- Manual Lifting Using “Good Body Mechanics” Is a Failed Policy

Section 2: Body Mechanics and Lifting Limits

QUESTIONS:

What are good body mechanics?

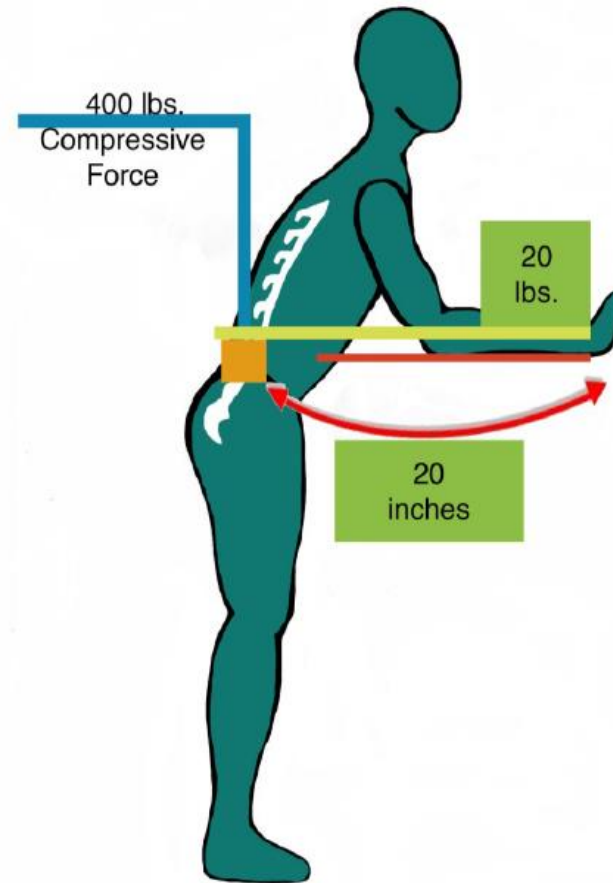
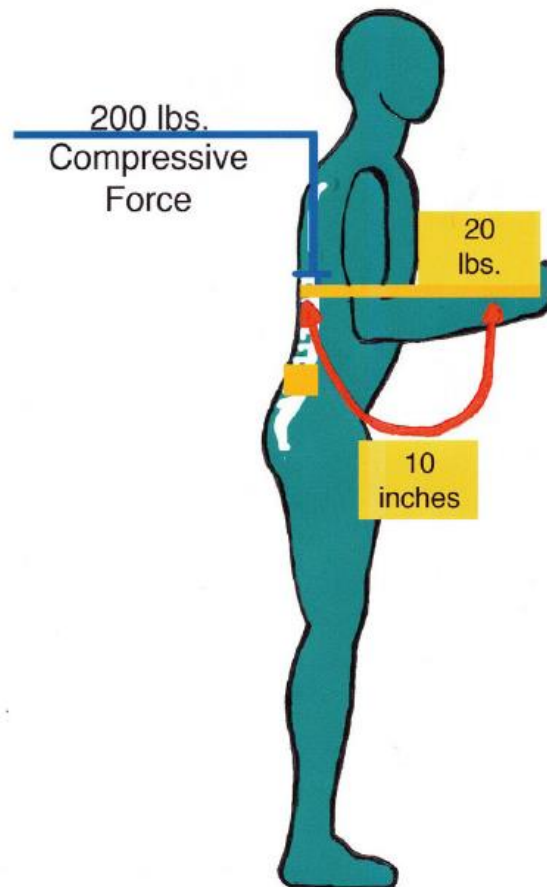
How many pounds can you safely lift using good body mechanics?

Section 2: Body Mechanics and Lifting Limits

WHEN YOU LIFT AN OBJECT USE GOOD BODY MECHANICS

- Bend at the knees, not the waist
- Get close to the object
- Keep your back straight and don't twist
- Plant your feet properly
- Hold objects close to your body
- Push, pull and slide when possible

Section 2: Body Mechanics and Lifting Limits



OSHA Technical manual, Section VII, Chapter 1: Back disorders and Injuries, http://www.osha.gov/dts/osta/otm/otm_vii/otm_vii_1.html

Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



Section 2: Body Mechanics and Lifting Limits

WHAT'S WRONG WITH THIS PICTURE?



Section 2: Body Mechanics and Lifting Limits

Fact: Techniques taught through body mechanics have not reduced back injuries among healthcare workers

- Good body mechanics is not enough to prevent injuries
- Manual lifting techniques were based on stable loads held close to the body
- Manual lifting techniques were based on loads weighing less than typical s
- Manual lifting techniques were based on studies that included only men.

Source: NYS Zero-Lift Task Force

Section 2: Body Mechanics and Lifting Limits

NIOSH has determined that the safe lifting limit for a two-handed lift of a box held close to the body is 51 pounds.

Is lifting a the same as lifting a box?

WHY? WHY NOT?

Section 2: Body Mechanics and Lifting Limits

The National Institute for Occupational Safety and Health has determined that healthcare workers should lift a maximum of 35 pounds when transferring and repositioning patients.

Section 2: Body Mechanics and Lifting Limits

Our healthcare workers are
getting older.

THE AVERAGE AGE OF OUR NURSES IS
NOW 48+ YEARS

Our patients and residents are
getting heavier.

NEARLY 40 MILLION AMERICAN ADULTS
CAN NOW BE CLASSIFIED AS OBESE

Section 2: Body Mechanics and Lifting Limits

In 2005, over 53,000 healthcare workers who were trained in good body mechanics were injured from manually lifting patients.

Source: Bureau of Labor Statistics, 2005

Section 2: Body Mechanics and Lifting Limits

HOW MUCH ARE YOU LIFTING?



GROUP ACTIVITY 2

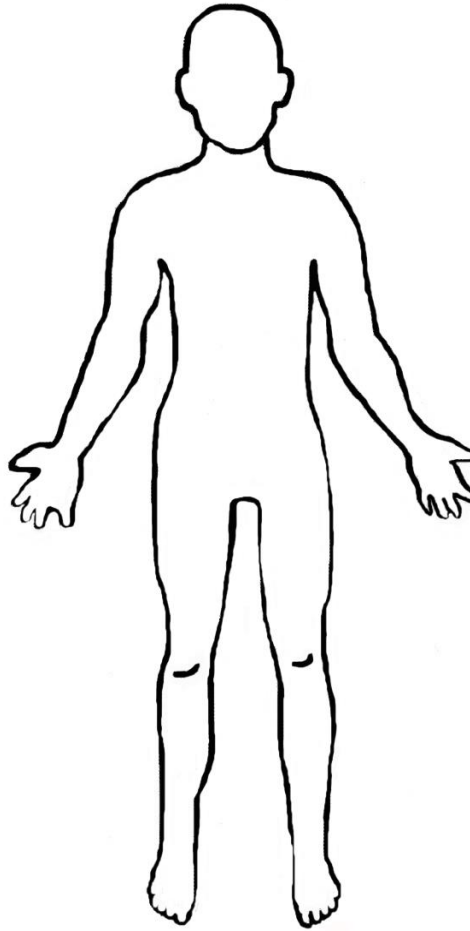
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Section 3

Anatomy of an Injury

- The high risks of manual handling
- Manual handling and “overexertion”
- “Overexertion” and excessive forces on the spinal discs

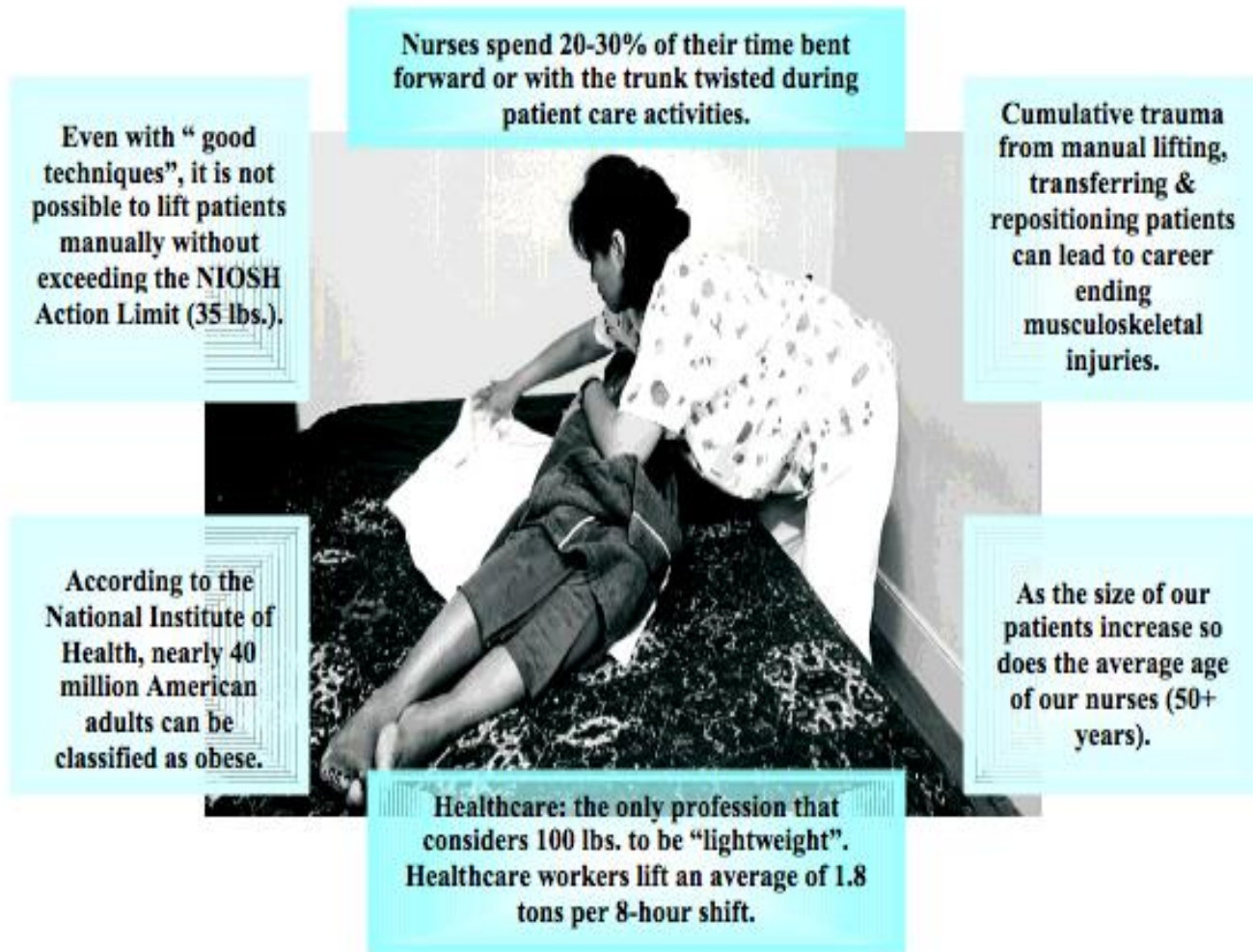
Section 3: Anatomy of an Injury



BODY CHART
ACTIVITY

Where do you hurt?
Why do you hurt?

Section 3: Anatomy of an Injury



Even with “good techniques”, it is not possible to lift patients manually without exceeding the NIOSH Action Limit (35 lbs.).

Nurses spend 20-30% of their time bent forward or with the trunk twisted during patient care activities.

Cumulative trauma from manual lifting, transferring & repositioning patients can lead to career ending musculoskeletal injuries.

According to the National Institute of Health, nearly 40 million American adults can be classified as obese.

As the size of our patients increase so does the average age of our nurses (50+ years).

Healthcare: the only profession that considers 100 lbs. to be “lightweight”. Healthcare workers lift an average of 1.8 tons per 8-hour shift.

Section 3: Anatomy of an Injury

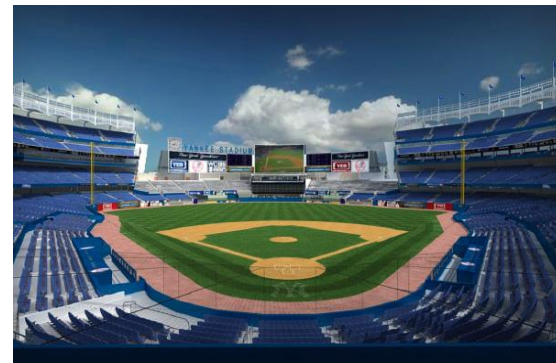
HOW MUCH ARE YOU LIFTING?

The average healthcare worker manually lifts 1.8 tons per 8-hour shift. That is equal to lifting one sedan per shift.



In one year, healthcare workers lift the equivalent of an airplane that is 50% loaded.

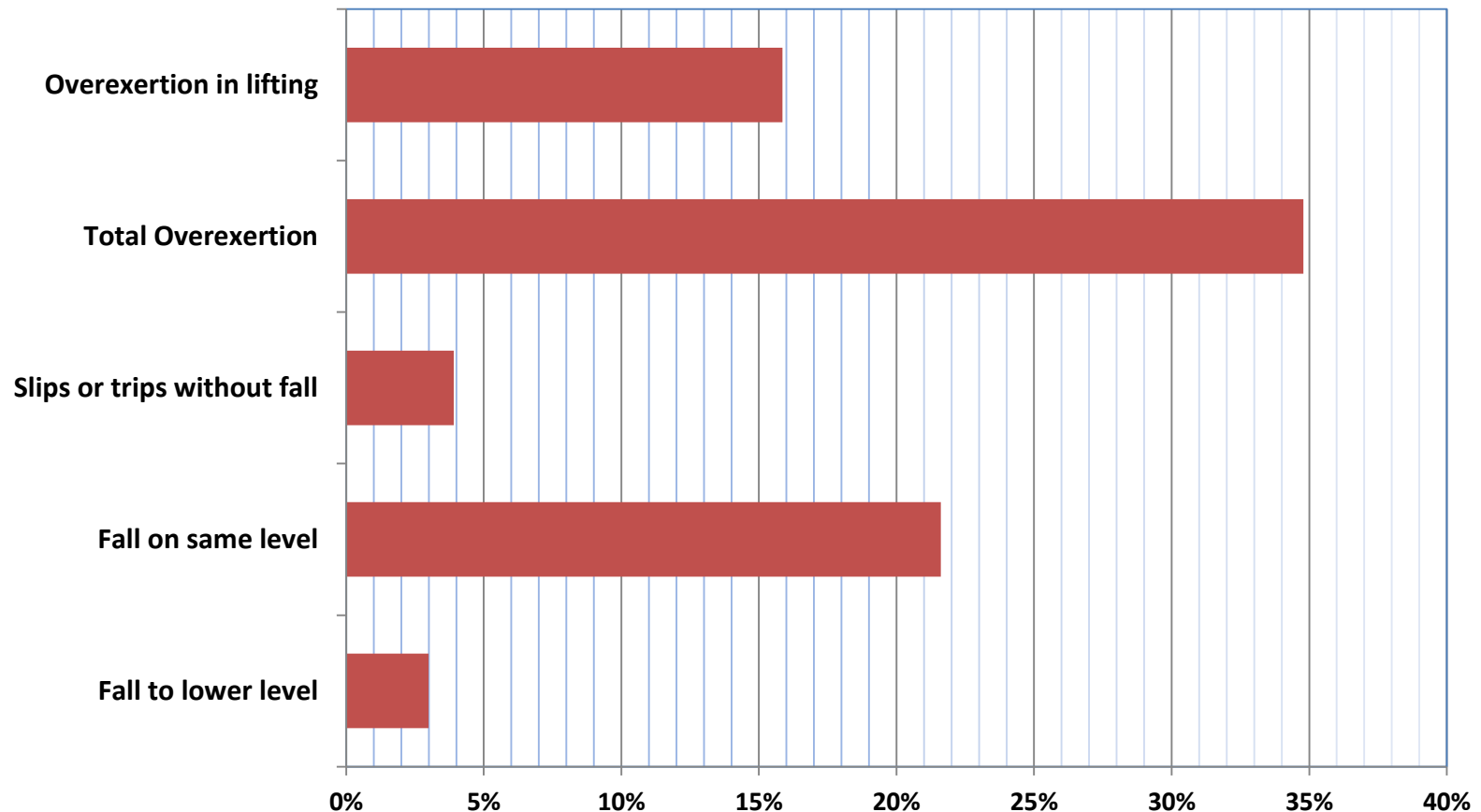
The number of manual lifting injuries to healthcare workers in one year equals the full capacity of the new Yankee Stadium.



Section 1: Industry Injuries

OVEREXERTION = CUMULATIVE TRAUMA

Nursing and Residential Care Facilities



Section 3: Anatomy of an Injury

YOUR BACK: THE SPINAL COLUMN

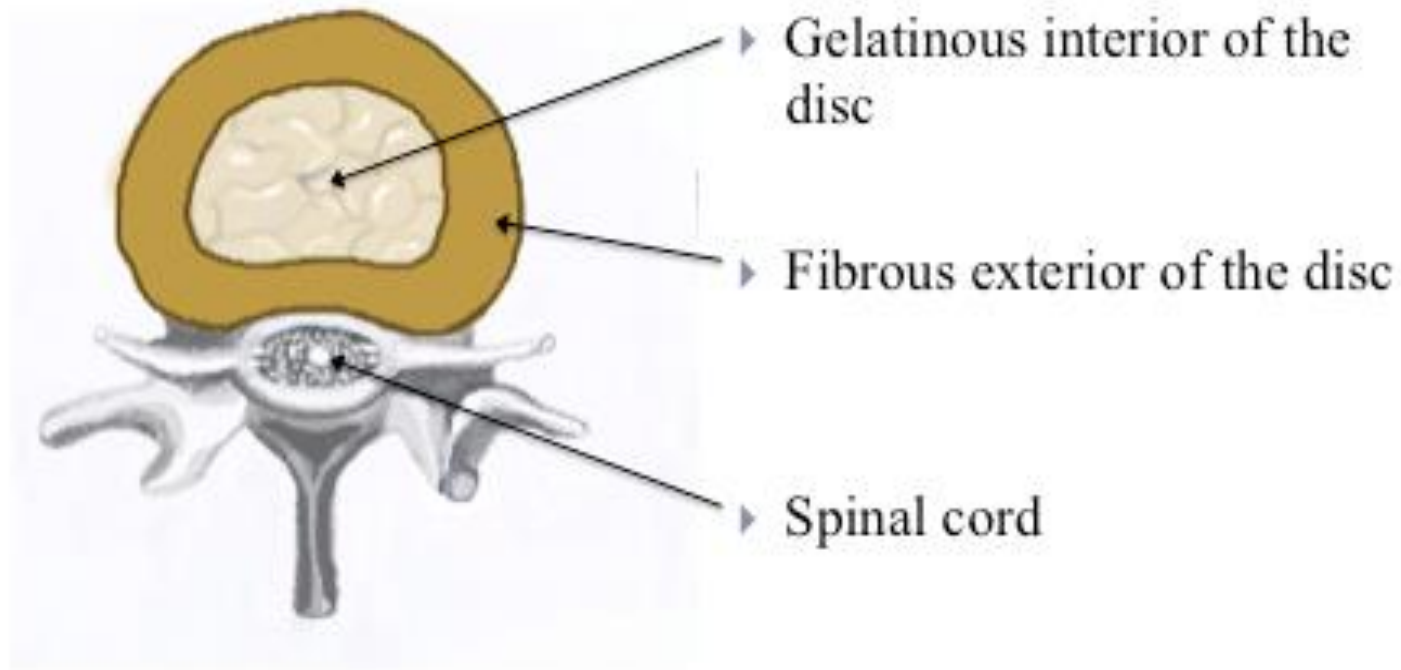


Most pain and disc problems are located in the lower back

▶ Illustrations by K. Rinker, WNYCOSH

Section 3: Anatomy of an Injury

YOUR BACK: THE DISC



▶ Illustrations by K. Rinker, WNYCOSH

Section 3: Anatomy of an Injury

ACUTE BACK PAIN

- “Acute” due to temporary overexertion/trauma
- Temporary “backache”
- Muscle spasm, strain, sprain

Section 3: Anatomy of an Injury

CHRONIC BACK PAIN

- Due to long-term overexertion
- Bulging, ruptured or degenerated discs
- Excruciating pain
- Potentially career-ending

Section 3: Anatomy of an Injury

OVEREXERTING YOUR DISCS

► Compression Forces

- Lifting weight



► Shearing Forces

- Pulling / pushing weight

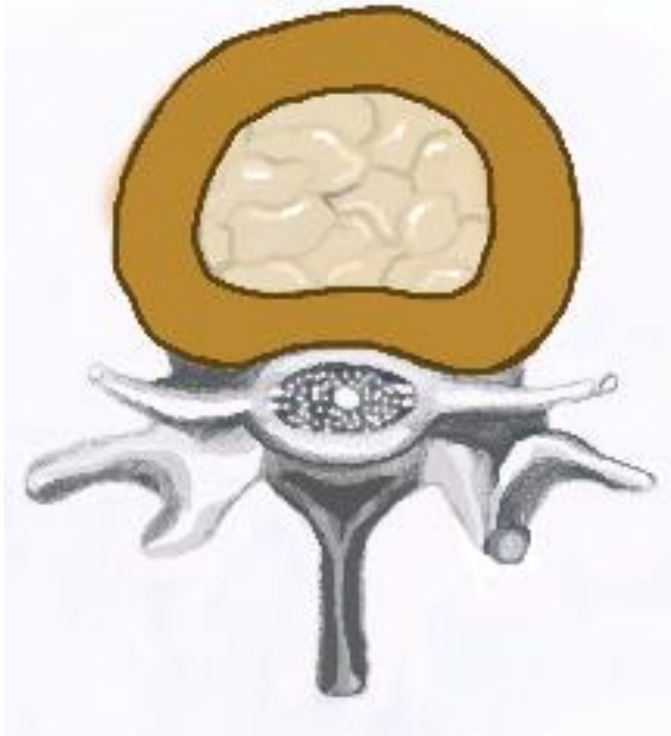


Over time lumbar discs can rupture, bulge, or degenerate

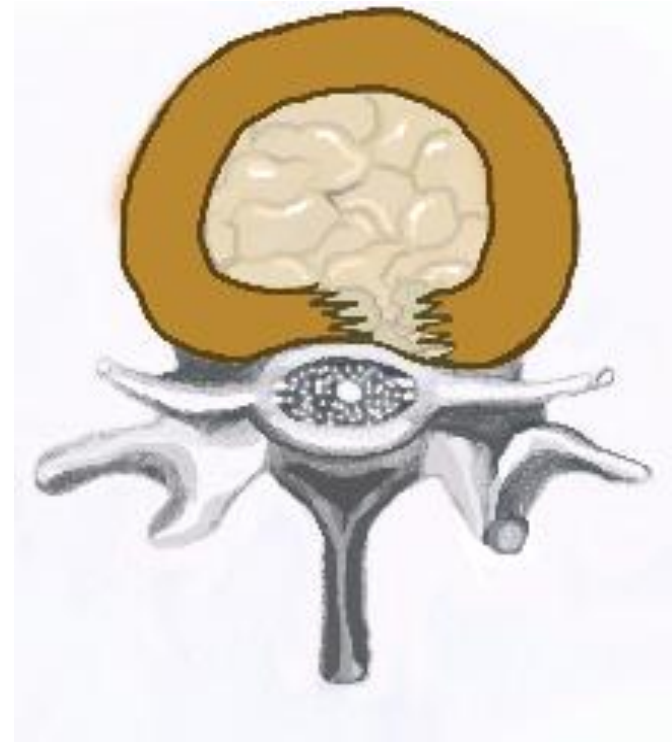
► Illustrations by K. Rinker, WNYCOSH

Section 3: Anatomy of an Injury

RUPTURED DISCS



Normal Spinal Disc

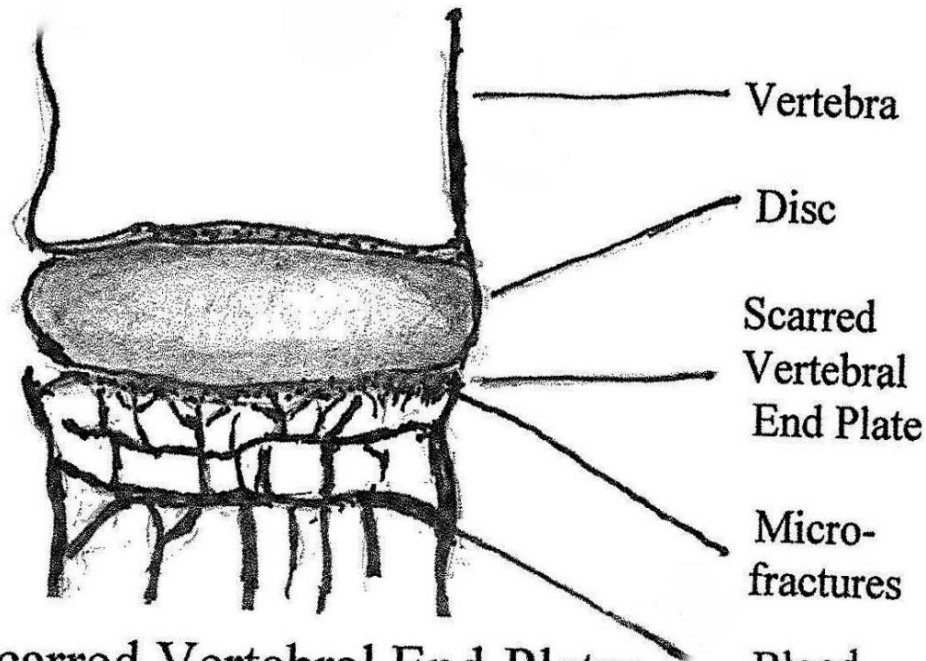


Spinal Disc w/ A Ruptured Disc

Illustrations by K. Rinker, WNYCOSH

Section 3: Anatomy of an Injury

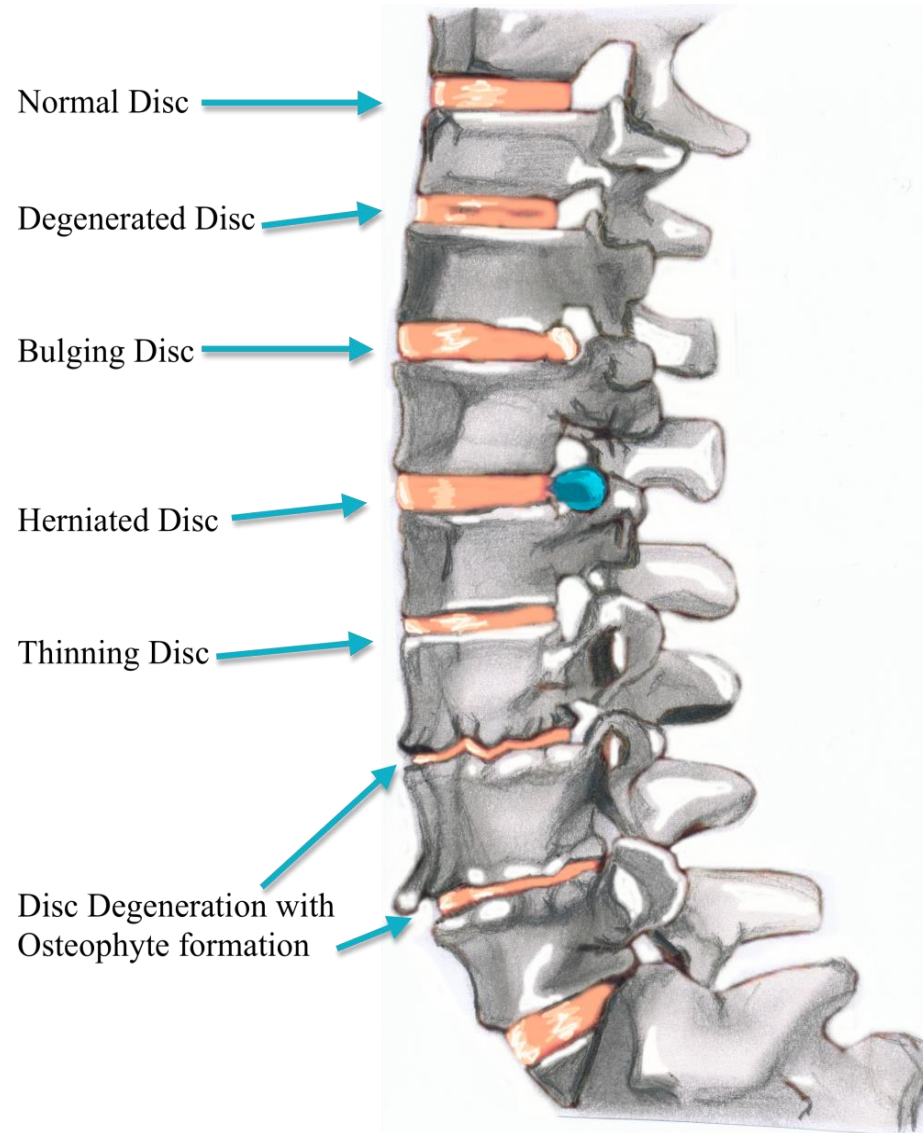
DISC DEGENERATION



Scarred Vertebral End-Plates
prevent nutrients from reaching
the Discs = Disc Degeneration

Section 3: Anatomy of an Injury

DISC DISORDERS



Illustrations by K. Rinker, WNYCOSH

Section 3: Anatomy of an Injury

MSDs AMONG HEALTHCARE WORKERS

Back injuries are most common:

- 73% of MSDs reported by nurses
- 70% are of the Lumbar Spine
- 57% are due to lumbar disc problems

Other chronic MSDs:

- Rotator cuff (shoulder)
- Thoracic outlet syndrome (neck area)
- Epicondylitis (elbows)
- Cartilage deterioration (knees)
- Carpal tunnel (wrist/hand)

Section 4

Controlling Risk Factors

- “Fitting the Worker to the Job”
- “Fitting the Job to the Worker”

Section 4: Controlling Risk Factors

ERGONOMICS: THE LAWS OF WORK

Old Philosophy – “Fit the Worker to the Job”

- Body Mechanics
- Physical Fitness
- Personal Protection

New Philosophy – “Fit the Job to the Worker”

- Ergonomics
- Engineering the risk factors (hazards) out of the job

Section 4: Controlling Risk Factors

HANDLING: RISK FACTORS (HAZARDS)

- What are some risks about your job tasks that can hurt you?
- What are some risks about your work environment that can hurt you?

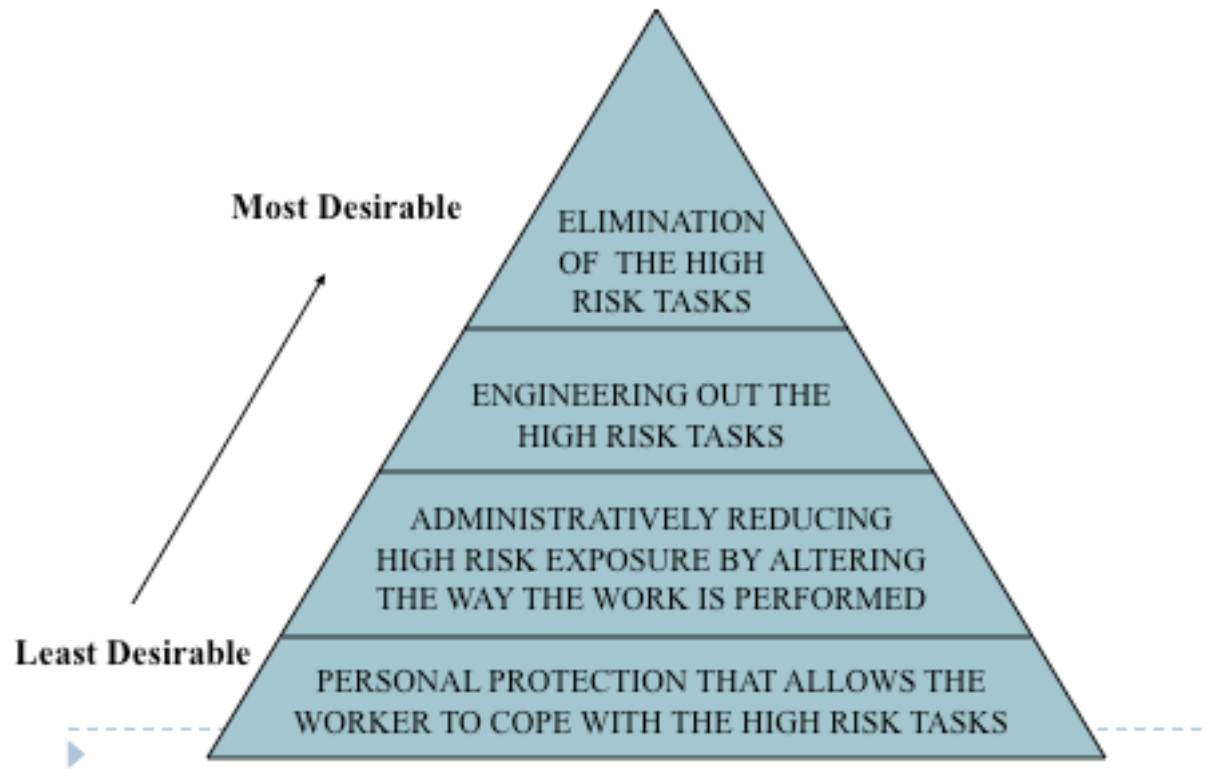
Section 4: Controlling Risk Factors

ERGONOMICS IDENTIFIES JOB TASK RISKS

- Heavy lifting
- Applying force
- Awkward postures
- Frequent bending, twisting, stretching, reaching
- Prolonged static posture
- Overexertion/no rest = cumulative trauma

Section 4: Controlling Risk Factors

THE OSHA “HIERARCHY OF CONTROLS” TO “FIX THE JOB”



Section 4: Controlling Risk Factors

FIXING THE JOB: EQUIPMENT



FULL MECHANICAL LIFT

Section 4: Controlling Risk Factors

FIXING THE JOB: EQUIPMENT



Sit-to-Stand Lift (Bariatric Patient)

Section 4: Controlling Risk Factors

FIXING THE JOB: EQUIPMENT



Ceiling Lift (Bariatric Patient)

Section 4: Controlling Risk Factors

FIXING THE JOB: EQUIPMENT



Ceiling Lift with Leg Strap

Section 4: Controlling Risk Factors

FIXING THE JOB: TRANSFER DEVICES



Lateral Transfer Devices

Section 4: Controlling Risk Factors

FIXING THE JOB: OTHER ASSISTIVE DEVICES



Section 4: Controlling Risk Factors

After you have the equipment:

- Release time for your SPH team
- Right equipment and accessible
- Accurate assessment/care plans
- Staffing to allow for two (2) people to operate mechanical lifts/repositioning devices
- Staff training on SPH policy/procedures
- Mentoring/monitoring/evaluating staff

Section 4: Controlling Risk Factors

FIXING THE WORK ENVIRONMENT

Room Layout	Small Room/Clutter
Uneven Work Surfaces	Beds, Chairs and Toilets w/ Different Heights
Lifting Devices	Equipment Poorly– Maintained, Inaccessible, Wrong or Inadequate

**** Beware Slips, Trips & Fall Hazards**

Section 5

Old vs. New Practices: Changing the Culture

- Moving From an “Old” Manual Lifting Culture to a “New” Safe Patient Handling Culture
- How Do We Get There?

Section 5: Old Vs. New Practices: Changing the Culture

The “Old” Handling Culture:

- “Blame and Shame”
- Injuries are due to carelessness
- Reward good behavior
- Punish bad behavior
- Body mechanics = safe lifts/transfers
- Non-manual handling is impractical

Section 5: Old Vs. New Practices: Changing the Culture

The “New Safe Patient Handling Culture”

- The way to create a safer workplace is to “Fit the Job Task” and “Work Environment” to the worker
- Eliminate the need to manually handle s through the purchase and use of equipment will create a safer workplace
- Train and mentor direct care workers on the proper use of equipment will move us toward a “Culture of Safety”

Section 5: Old Vs. New Practices: Changing the Culture

Moving to a New Culture of Safety:

- Commitment of leadership to safety
- Safety valued as much as efficiency/productivity through investments in equipment
- Shift away from “Shame and Blame” to looking at root causes
- Training, mentoring and monitoring
- Organizational learning from errors and near misses

Section 6:

Safe Patient Handling Stakeholders

- Identifying SPH Stakeholders
- Stakeholder Benefits

Section 6: Safe Patient Handling Stakeholders

Anyone Who:

- Has a stake in the project working
- Can stop the SPH project
- Is directly impacted
- Will feel threatened
- Stands to benefit
- Can support the budget

Section 6: Safe Patient Handling Stakeholders

The Stakeholders:

- Management/Administration
- HR, Fiscal Administrator, Comptroller
- Frontline Staff (CNAs, PCAs, LPNs, RNs
- Occupational and Physical Therapists
- s and Family Members
- Environmental/Laundry/Plant Operations
- Clinical Engineers
- Social Workers, Admissions and Unit Clerks
- Purchasing
- Students, New Hires, Potential New Hires

Section 6

Safe Patient Handling Programs

GROUP ACTIVITY 3

Page 8 of Student Workbook Guide

- Stakeholders
- SPH Ergonomic Teams
- Achieving “Buy-in”

Section 6: Safe Patient Handling Stakeholders

WHAT ARE THE BENEFITS?

- For Patients?
- For Frontline Workers?
- For Employers

Section 6: Safe Patient Handling Stakeholders

Benefits for Patients:

- Improved quality of care
- Improved safety and comfort
- Improved satisfaction
- Reduced risk of falls, being dropped and friction burns
- Reduced skin tears and bruises

Section 6: Safe Patient Handling Stakeholders

Benefits for Health Care Workers:

- Reduced risk of injury
- Improved morale
- Less pain and muscle fatigue
- Re-injury less likely for injured workers
- Pregnant workers can work longer
- Staff can work at an older age
- More energy at work shift's end

Section 6: Safe Patient Handling Stakeholders

Benefits for Employers:

- Reduced number and severity of staff injuries
- Improved safety
- Reduced restricted work days
- Reduced overtime and sick leave
- Improved recruitment/retention of direct care staff
- Fewer resources needed to replace injured staff

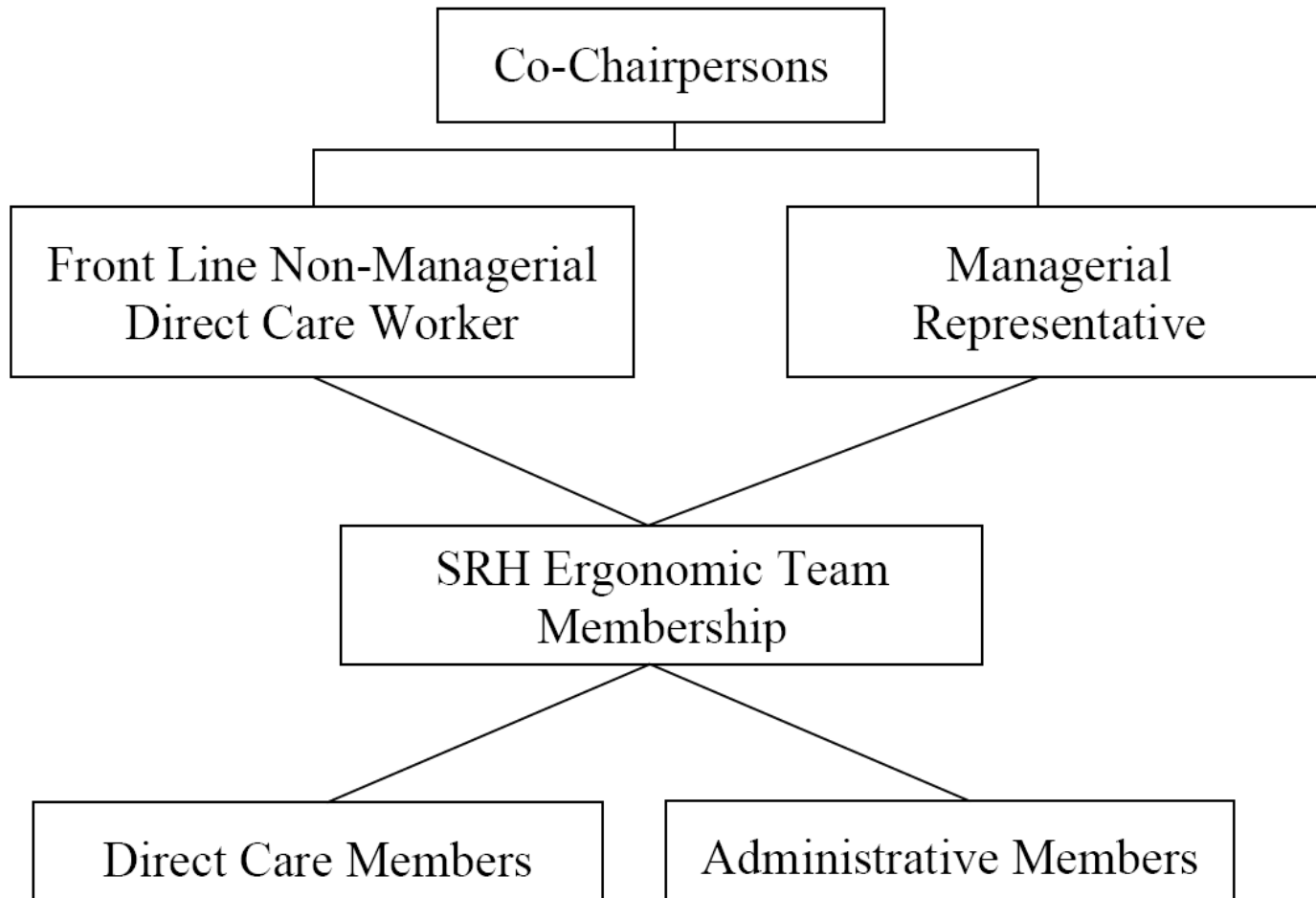
Section 7:

Safe Patient Handling Ergonomic Teams

- SPH Team Structure
- SPH Team Functions

Section 7: Safe Patient Handling/Ergonomic Team Structure

SPH/ERGONOMIC TEAM STRUCTURE



Section 7: Safe Patient Handling/Ergonomic Team Structure

Direct Care Staff Members:

- Care Staff (All Shifts)
- Registered Nurses
- Licensed Practical Nurses
- Certified Nursing Assistants
- Transport Staff
- Maintenance
- Environmental Services (Including Laundry)
- Physical/Occupational Therapy Staff
- Infection Control

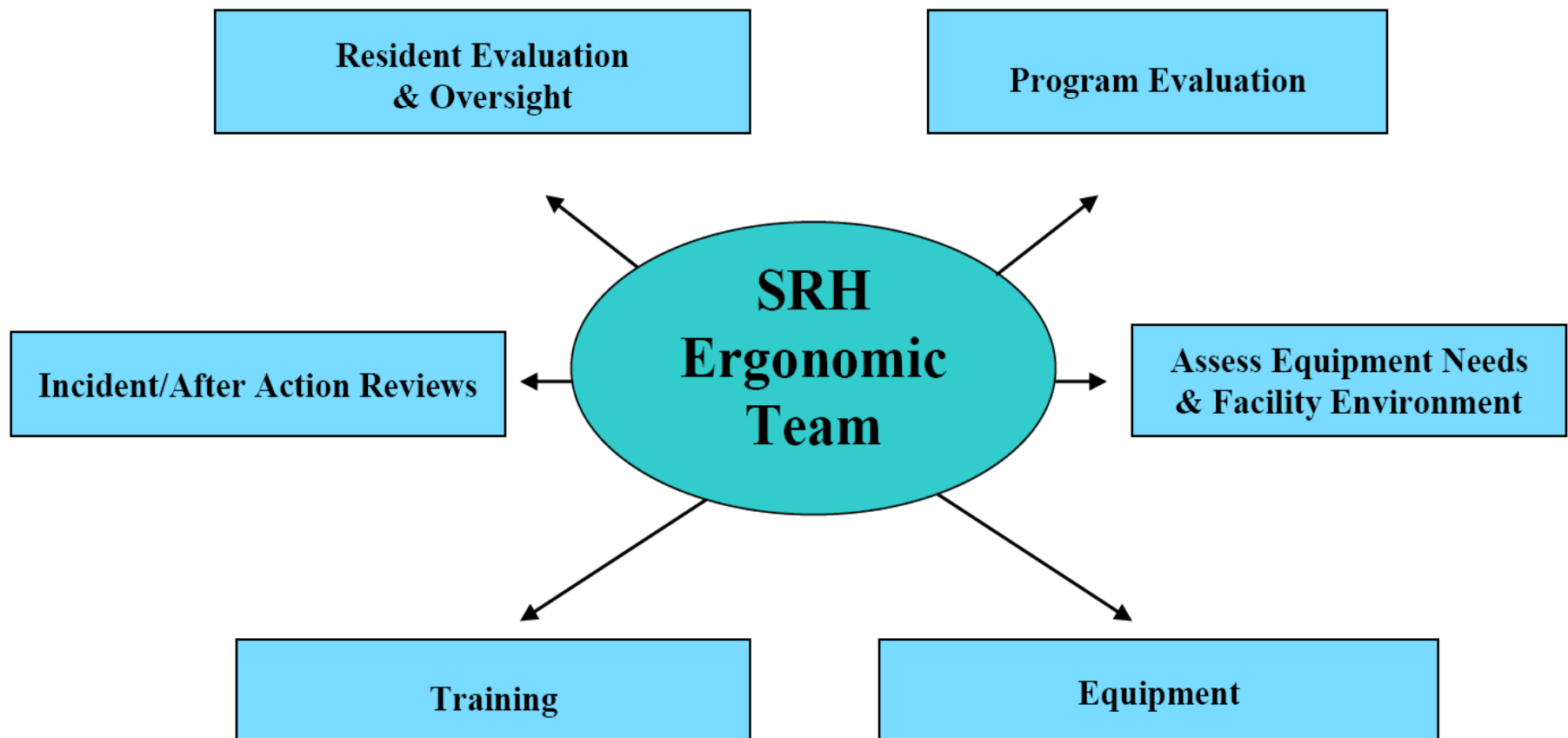
Section 7: Safe Patient Handling/Ergonomic Team Structure

Administrative Members:

- Administration
- Business/Budget Department
- Human Resources
- Trainers/Educators
- Supervisors
- Third-Party Administrators, Benefit Coordinators, Workers Comp Case Managers
- Occupational Health/Employee Health Personnel

Section 7: Safe Patient Handling/Ergonomic Team Structure

FUNCTIONS: SPH TEAM DUTIES/RESPONSIBILITIES



Section 8:

Timeline

- Developing Your SPH Program Implementation Timeline

Section 8: Timeline

Developing a Timeline for the Following Elements of Your SPH Programs:

- Needs Assessment
- Equipment Purchases
- SPH/Ergonomics Team Up and Running
- SPH Policy and Procedures Development
- Stakeholders “Buy-In”
- SPH Program “Rolled Out” Onto Units
- SPH Training for All Direct Care Workers
- System for Mentoring, Evaluating Direct Care Workers Established

Section 9:

Making the Case For Safe Patient Handling Ergonomics Programs:

Documenting Patient Handling Injuries

Section 9: Making the Case: SPH Ergonomics Programs

AGENDA:

- Injuries in the Healthcare Industry
- OSHA Logs / MSDs
- Workers' Compensation / MSDs
- SPH Survey
- SPH Programs: Cost vs. Benefits
- Return-to-Work Programs

Section 9: Making the Case: SPH Ergonomics Programs

OBJECTIVES:

Participants will be able to understand...

- How the OSHA 300 Log can be used to assess the incidence of handling-related injuries at this facility
- How the Workers' Compensation C-2s and Loss – Run reports can be used to analyze the cost of injuries at this facility

Section 9: Making the Case: SRH Ergonomics Programs

OBJECTIVES (Continued):

Participants will be able to understand...

- How your team can use the OSHA 300 Logs, Workers' Comp C2s/Loss – Run reports, direct observations and staff interviews to determine where/why –handling injuries are occurring at your facility
- What –handling equipment can be targeted to your high-injury work area and the costs of doing nothing vs. the benefits of a SPH program
- The benefits of a SPH program on having an effective claims Return to Work program

Section 9: Health Care Industry Injuries

- Where does our industry rank?
- Injury rates in nursing homes
- Lost Work Days among our CNAs
- MSDs and CNAs
- Overexertion and injuries
- Job task/work environment hazards
- Broader issues increasing job hazards

Section 9: Health Care Industry Injuries

WHERE DOES OUR INDUSTRY RANK?

- Which industries rank at the Top 5 with respect to work-related injury rates?
- What injuries are most common?
- How do most employees get hurt?
- What's the number one injury at our facility?
- What's the cause?

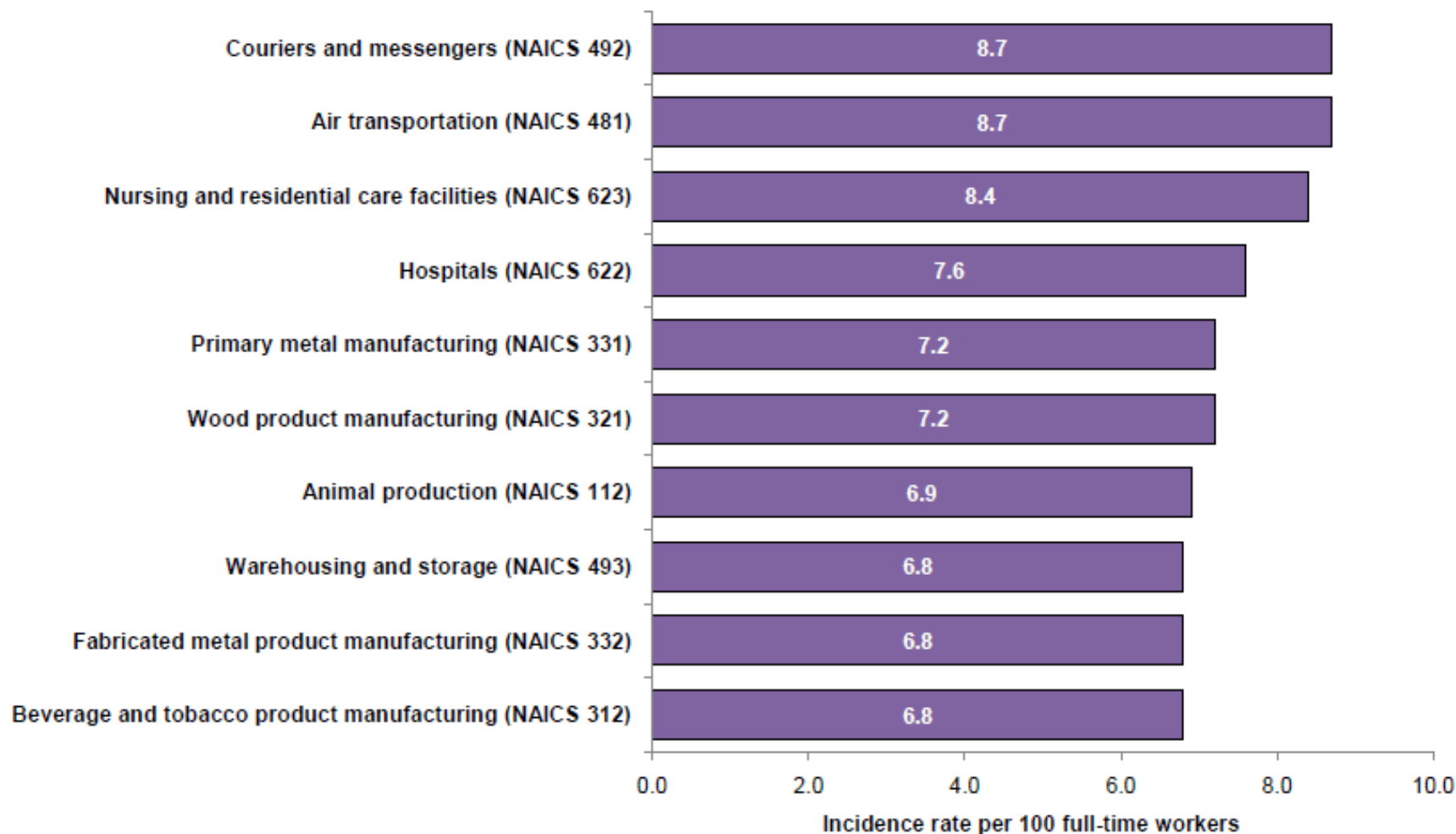
Section 9: Health Care Industry Injuries

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Section 9: Industry Injuries

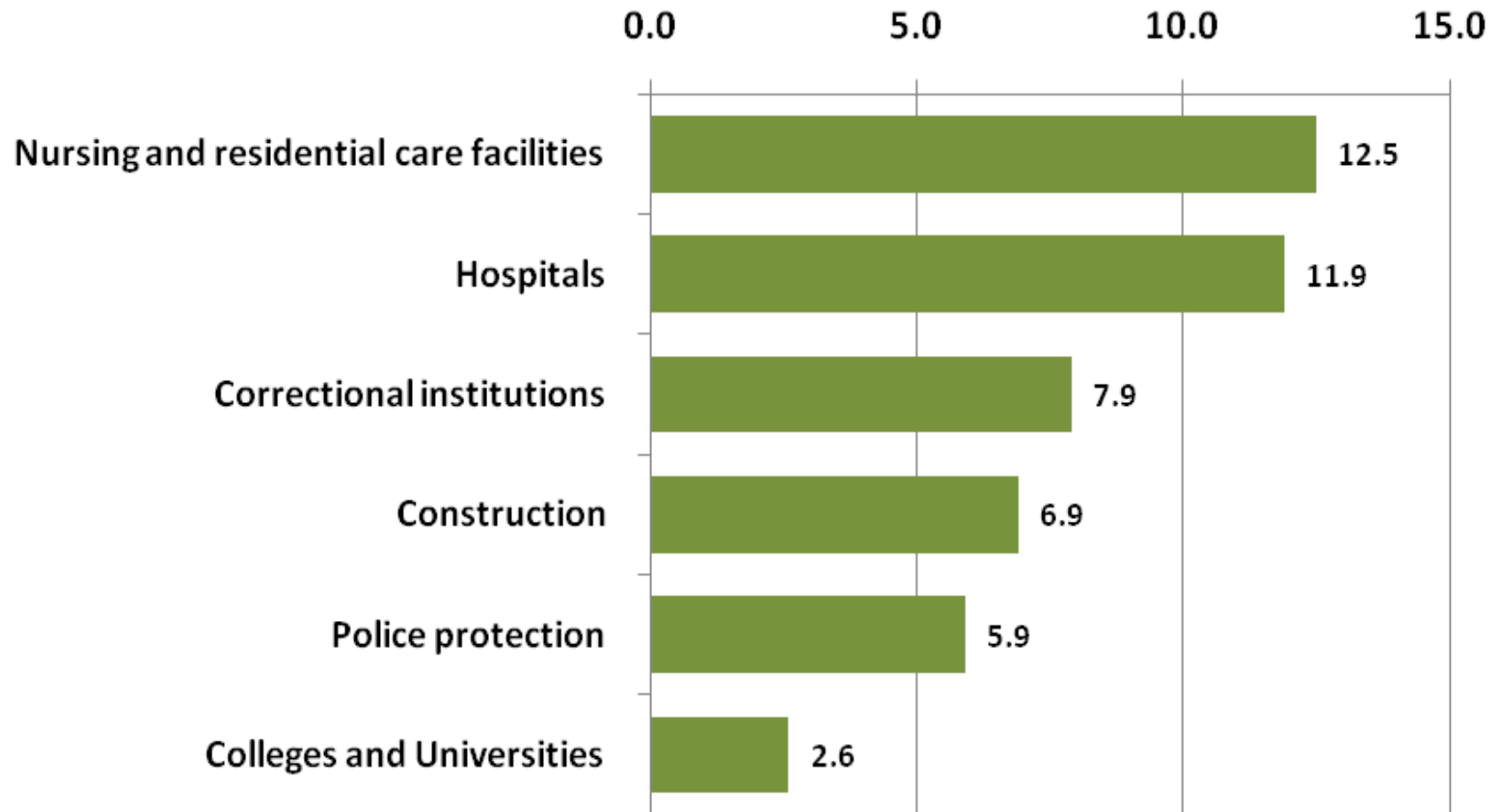
Highest non-fatal occupational injury and illness incidence rates among 3-digit NAICS industries, private industry, 2008



Among the ten 3-digit NAICS industries with the highest rates of nonfatal injuries and illnesses, three industries—couriers and messengers (NAICS 492), air transportation (NAICS 481), and nursing and residential care facilities (NAICS 623)—experienced rates that were more than twice the rate for all private industry (3.9 cases per 100 workers) in 2008.

Section 9: Health Care Industry Injuries

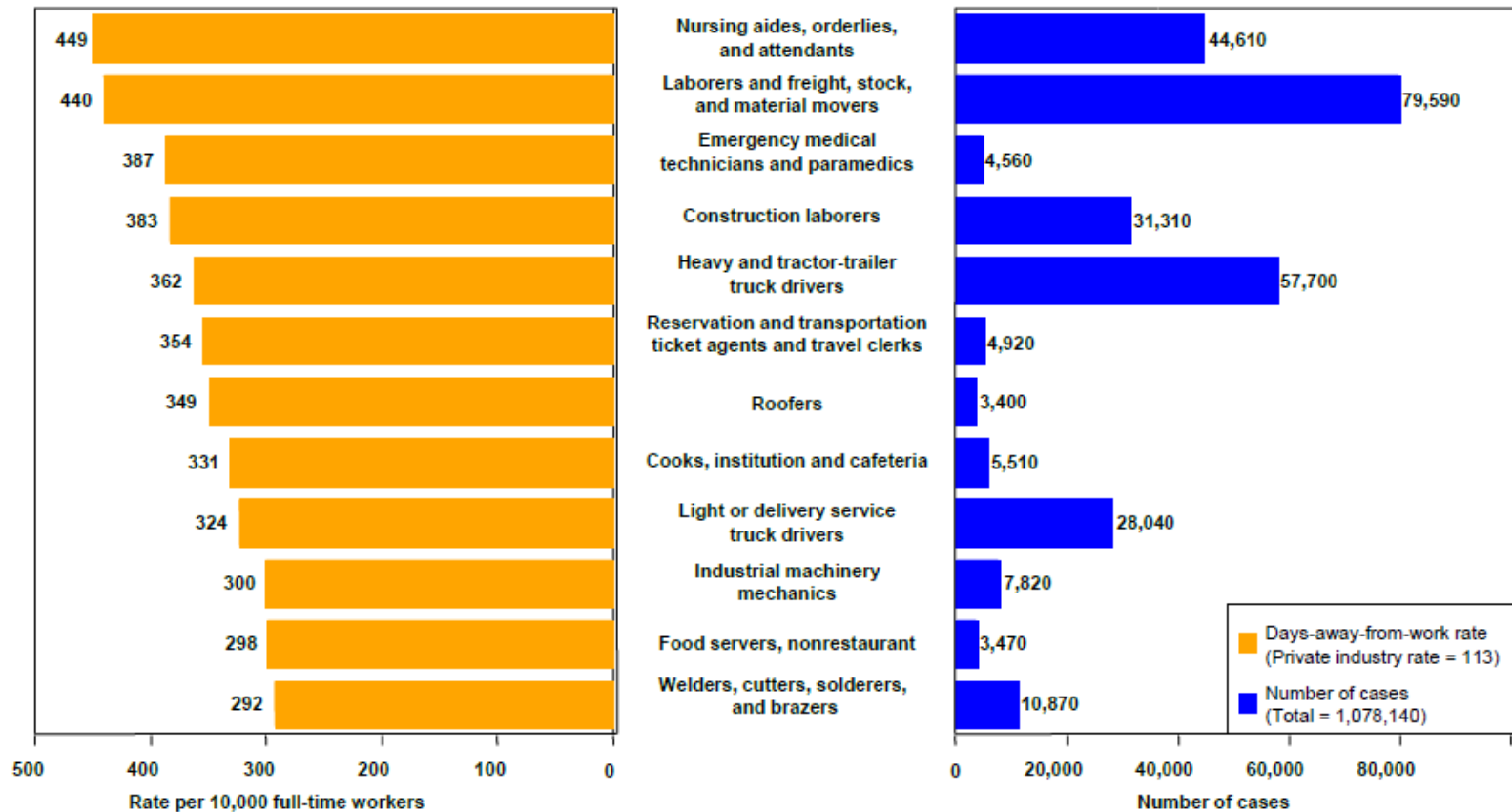
Incidence rate of nonfatal occupational injuries and illnesses
per 100 full time workers by industry, State governments, 2008



Source: Bureau of Labor Statistics, U.S . Department of Labor, October 2009

Section 9: Health Care Industry Injuries

Incidence rate and number of injuries and illnesses for occupations with high incidence rates, 2008



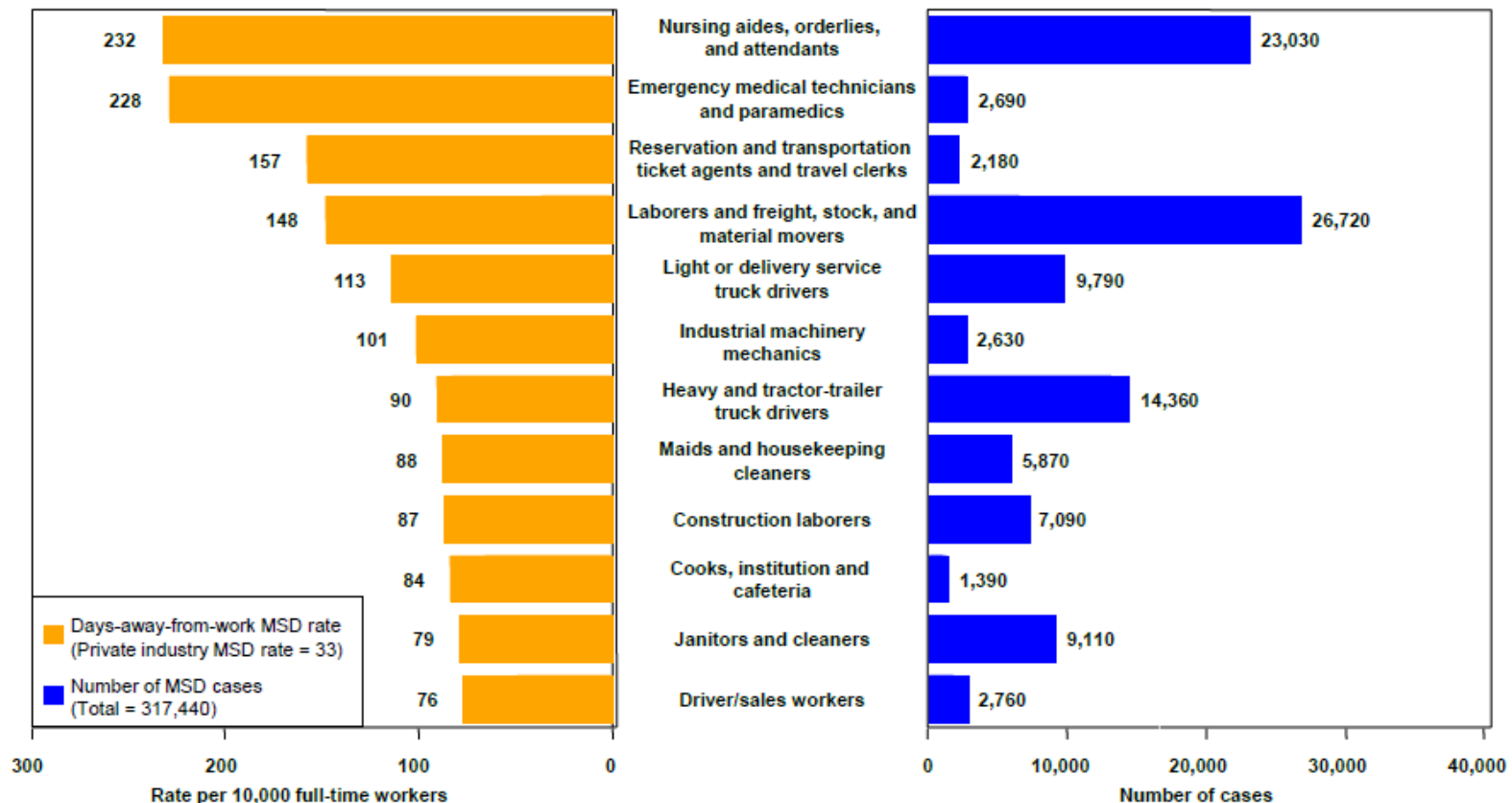
These twelve occupations have at least 1/10 of one percent of employment and an incidence rate that was two and one-half times the average or greater. Nursing aides, orderlies, and attendants, and laborers and freight, stock and material movers both had the highest rates statistically. Emergency medical technicians and paramedics had a very high rate of injuries and illnesses, but a smaller number of cases.

Source: Bureau of Labor Statistics, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses, cases involving days away from work.

Chart 5

Section 9: Health Care Industry Injuries

Incidence rate and number of injuries and illnesses due to musculoskeletal disorders by selected occupations, 2008



These twelve occupations have at least 1/10 of one percent of employment and an incidence rate of musculoskeletal disorders (MSD) that was higher than 75 per 10,000 full-time workers. Nursing aides, orderlies, and attendants, and emergency medical technicians and paramedics had the highest rates of MSDs in 2008. Nursing aides also had the second highest number of MSD cases in this group, behind laborers and freight, stock, and material movers.

Source: Bureau of Labor Statistics, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses, cases involving days away from work.

Chart 23

Section 9: Health Care Industry Injuries

THE HIGH COST OF WORK-RELATED MSDS: UNDERREPORTING

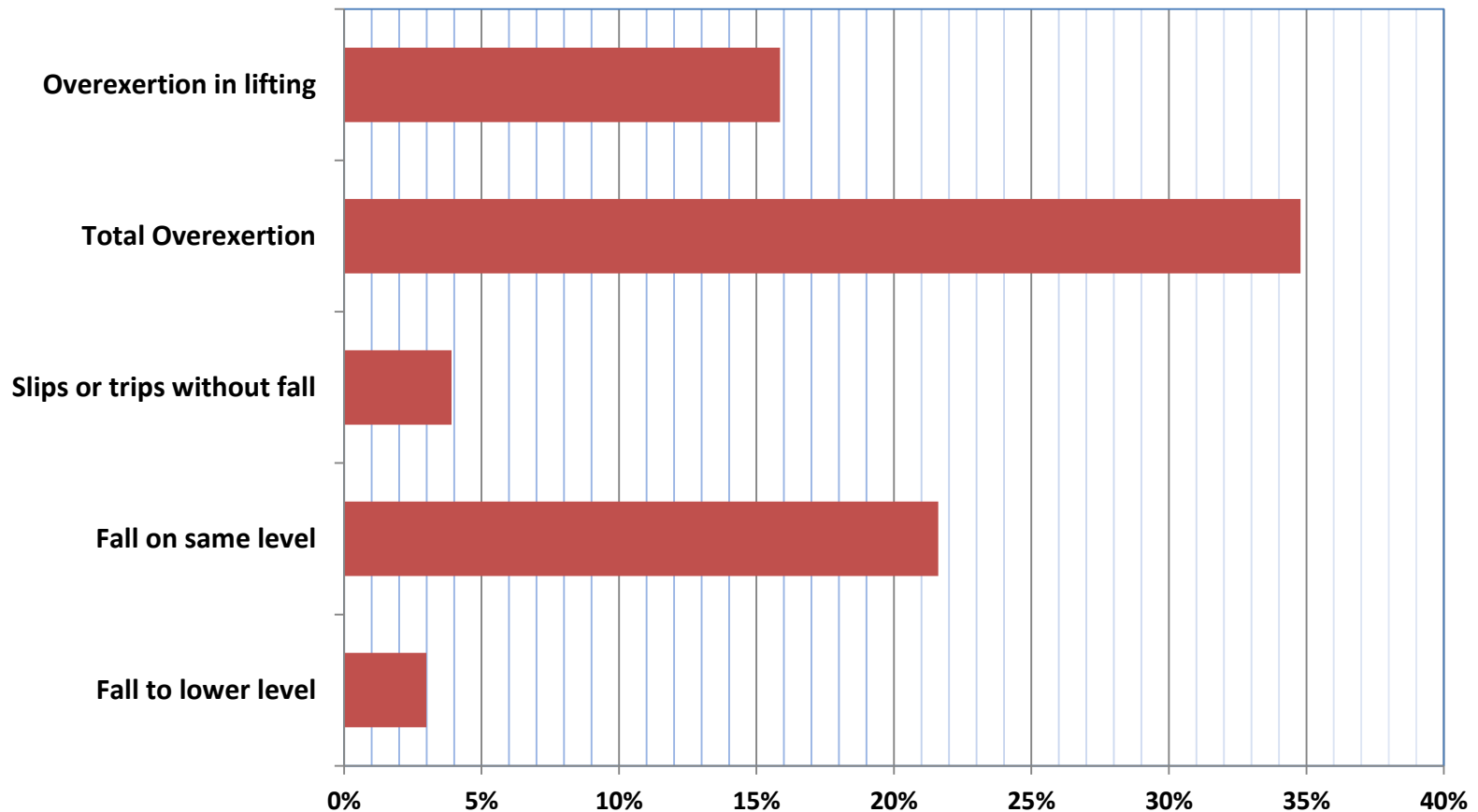
“...the number of MSD injuries reported by healthcare workers is probably low because many injuries are underreported. In fact, it is estimated that as many as 50 percent may go unreported.”

Source: Lynda Enos. *SPH. A Summary of the Issues and Solutions*. 2009| A. Nelson, et al., *Int. Journal of Nursing Studies*. 2005. B. Owen. *Int. Journal of Nursing Studies*. 2002. N. Menzel. *AAOHN Journal*. 2008.

Section 9: Health Care Industry Injuries

OVEREXERTION

Nursing and Residential Care Facilities



Section 9: Health Care Industry Injuries

WHY IS MANUAL HANDLING HAZARDOUS?

The work exceeds the physical capacity of the worker:

- 130+lbs vs. 35lbs
- Patients movement and transfer involves awkward positioning
- Patients represent an unstable load that may shift
- Patients are difficult to handle and don't come with handles which increase the force needed to move them
- Daily repetitive lifting and transfers



Section 9: Health Care Industry Injuries

APPROXIMATELY HOW MUCH WEIGHT IS HANDLED DURING A DAY SHIFT?

Daily Handling, Lifting, & Transfers

EXAMPLE

5 case load (dependent)
2 transfers – out of bed, into bed
2 transfers for toileting
3 transfers for dining

5 patients x 7 transfers = 35 transfer events in an 8 hour shift
(which suggests one each 14 minutes)

Add 3 repositionings for each patient each day
5 patients x 3 repositions = 15

That makes approximately 50 handlings during a shift

Section 9: Health Care Industry Injuries

APPROXIMATELY HOW MUCH WEIGHT IS HANDLED DURING A DAY SHIFT?

On average a 'handling' means providing 40 pounds of assistance.

(Not unlike moving or repositioning the equivalent of a bag of topsoil or of mulch)

THEREFORE:

50 handlings x 40 pounds =

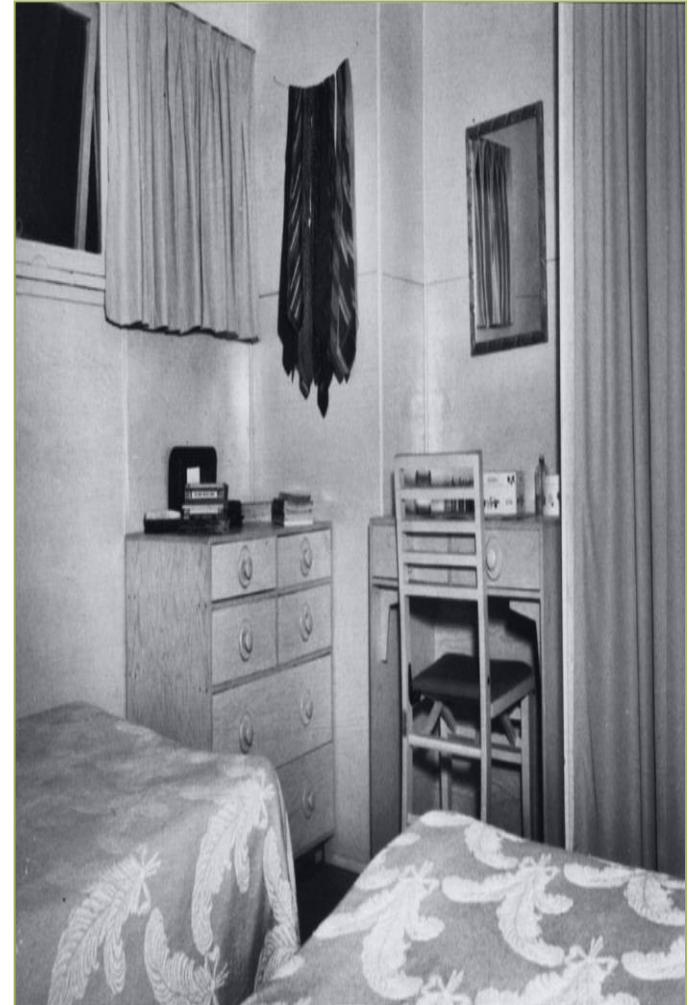
2000 pounds or



Section 9: Health Care Industry Injuries

EQUIPMENT AND FACILITY DESIGN THAT PUTS EMPLOYEES & PATIENTS IN AWKWARD POSITIONS

- Beds not conducive to reposition patient or transfer to/from bed.
- Rooms that are cluttered or do not allow appropriate access to beds, chairs, etc.
- Bathing and toileting facilities that promote sustained and/or awkward employee positioning.



Section 9: Health Care Industry Injuries

A GROWING CRISIS?

Additional concerns for the health of workers and of the industry...

- Aging workforce
- Nursing shortage
- Obese patients

Section 9: Health Care Industry Injuries

AGING WORKFORCE

- An aging workforce in nursing is creating significant problems for the healthcare industry.
- With an average age of nurses of 46.8 years, an older workforce brings knowledge and experience to the job, but:
 - Can fatigue easily
 - Have more chronic health issues
 - May be less physically fit

Section 9: Health Care Industry Injuries

NURSING SHORTAGE

- 100,000 vacant nursing positions in the US & expected to reach 340,000 by 2020
- Increased overtime and mandatory overtime
- Higher workloads for individual workers
- Increased stress on workers
- Potential for more errors

From: Thomas R. Waters, Ph.D., N.I.O.S.H.

Section 9: Health Care Industry Injuries

THE OBESITY EPIDEMIC

Will an obesity epidemic create yet more MSDs among our direct care workers?

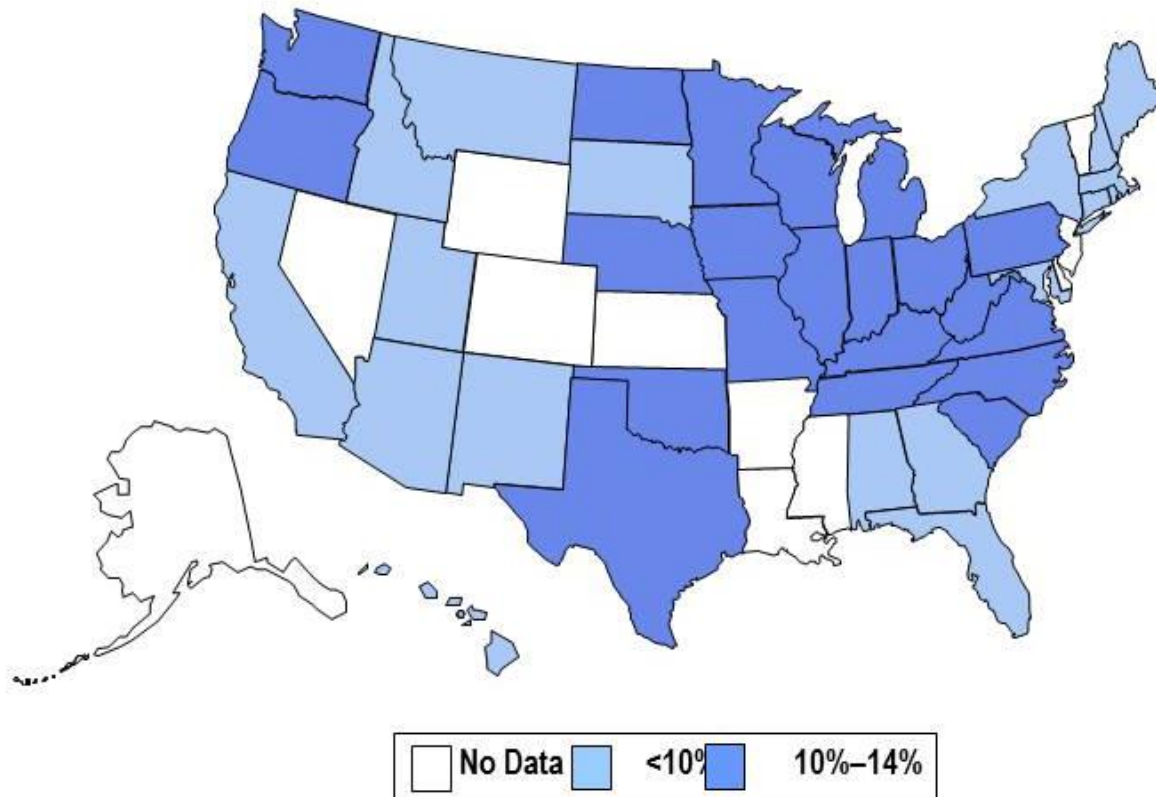
- More than 30% for the population is considered to be obese
- More than 66% of the population is overweight
- In the last 5 years, 50% increase of those 100 lbs. overweight, 75% increase in those more than 100lbs overweight
- It is common for healthcare providers to see patients weighting more than 400lbs
- Bariatric care is of increasing importance

Section 9: Health Care Industry Injuries

THE OBESITY EPIDEMIC

Obesity Trends Among U.S. Adults 1989

(*BMI ≥ 30 , or ~ 30 lbs. overweight for 5' 4" person)

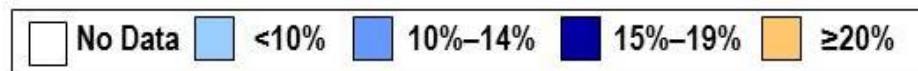
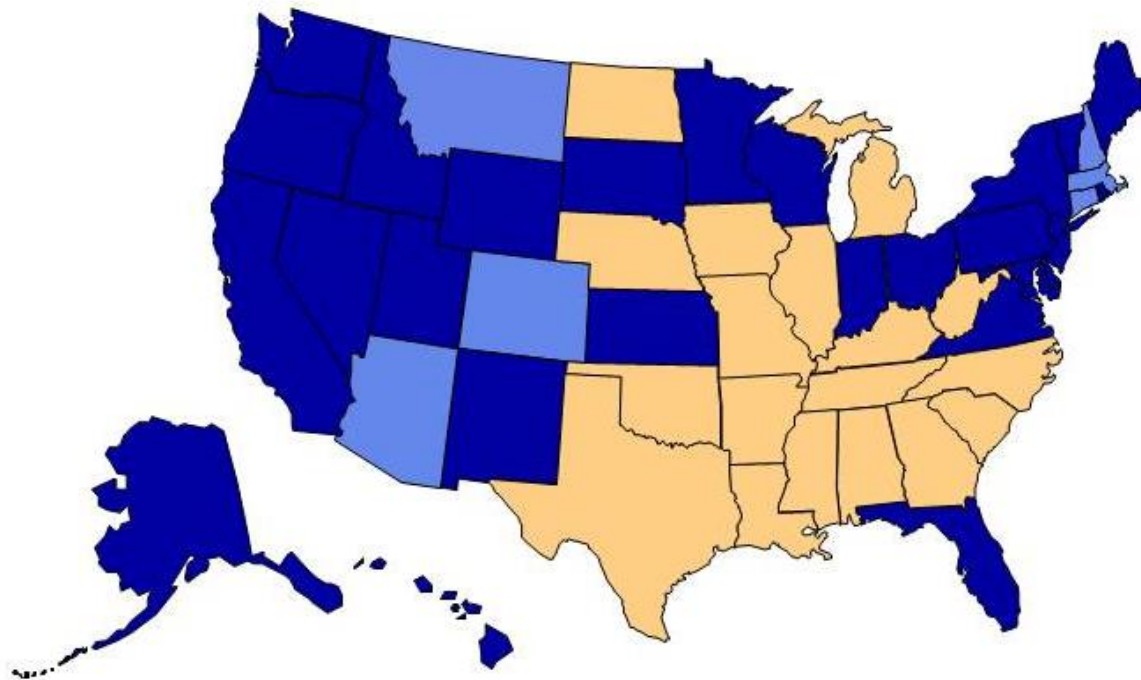


Section 9: Health Care Industry Injuries

THE OBESITY EPIDEMIC

Obesity Trends Among U.S. Adults 1999

(*BMI ≥ 30 , or ~ 30 lbs. overweight for 5' 4" person)

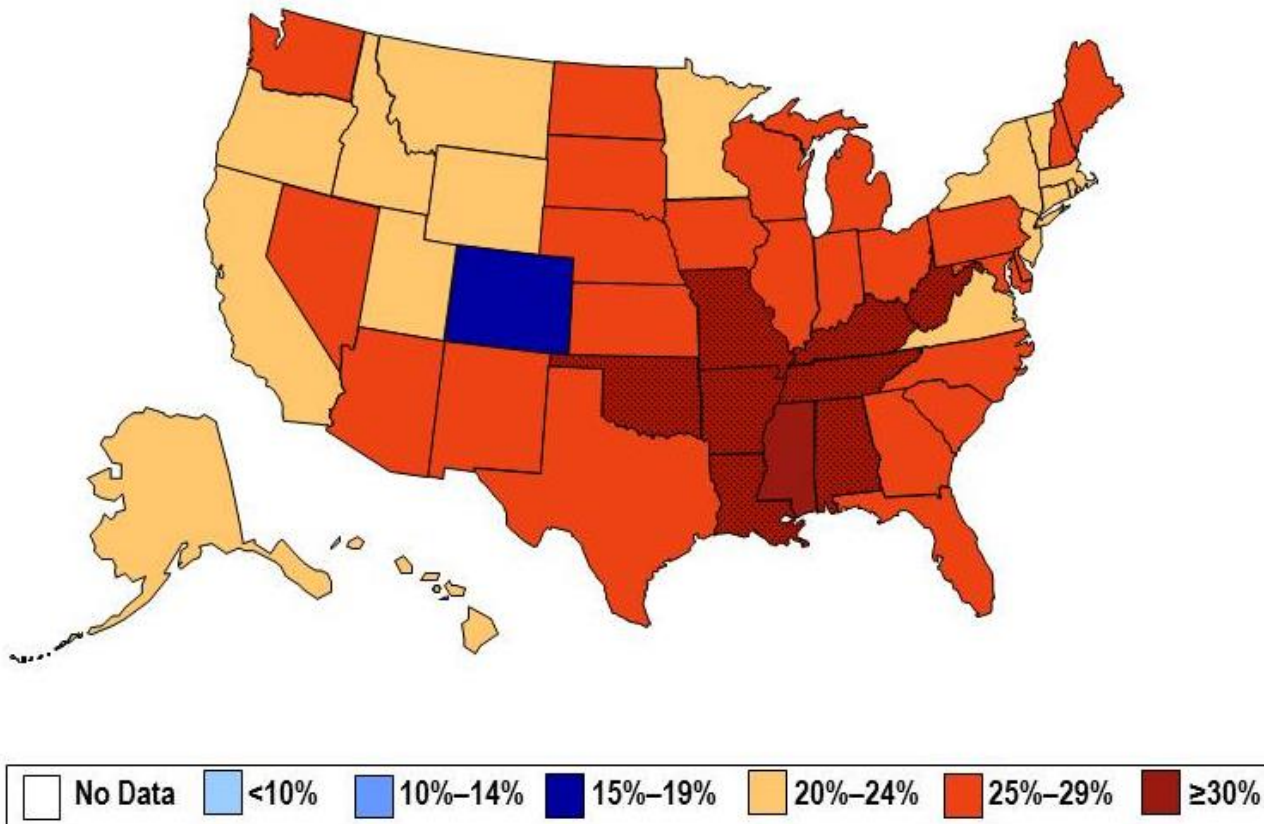


Section 9: Health Care Industry Injuries

THE OBESITY EPIDEMIC

Obesity Trends Among U.S. Adults 2009

(*BMI ≥ 30 , or ~ 30 lbs. overweight for 5' 4" person)



Section 9: Health Care Industry Injuries

THE HIGH COST OF HEALTH CARE WORK-RELATED MSDS: THE HUMAN TOLL

Work-related MSDs in health care can cause situations for direct caregivers that are:

**Life altering
Career ending
Disabling
Chronic (persistent/permanent pain)**

Back injury MSDs due to manual handling are the **#1 injury** reported in health care.

Section 9: Health Care Industry Injuries

THE HIGH COST OF HEALTH CARE WORK-RELATED MSDS: THE HUMAN TOLL

- 31% of nurses reported experiencing back pain while working as a nurse
- 52% complain of chronic (persistent/permanent) back pain
- 12% of nurses “leaving for good” cite lower back pain as the main reason
- Another 12% considered leaving the profession
- 38% suffered work-related back pain severe enough to require leave from work

Source: D. Stubbs, et al. *International Journal of Nursing Studies*. 1986.
American Nurses Association “Fact Sheet.” 2005

Section 9: Health Care Industry Injuries

WORKERS' COMPENSATION COSTS

The direct cost of an average back injury case is \$19,000.

Serious cases involving surgery average \$85,000 in direct costs.

Indirect costs to health care facilities average between four and ten times the direct costs.

Fact Sheet #5: Investing in Safe Patient Handling and Movement is Money in the Bank; NYS Zero Lift Task Force Website, Last visited March 31, 2011.

Using the OSHA 300 Log and Forms

- OSHA 300 Log – recording incidents
- OSHA Form 300A – annual total incident summary
- Work-related injuries and exceptions
- Injury reporting process
- Calculating facility injury rates
- Comparing your facility rate to other facilities/national average rates
- Calculating Lost Work Day costs from work-related illness/injuries
- Workers' Compensation "Loss Run"

Using the OSHA 300 Log and Forms

OSHA FORMS

- **OSHA 300 Log** – log to record and summarize injury and illness events
- **OSHA's Form 300A** –Summary of the column totals from the OSHA 300 log that is publicly posted each year.
- **OSHA's Form 301** – Injury and Illness Incident Report (or similar form to record individual incident information, often for Workers' Compensation purposes).

Using the OSHA 300 Log and Forms

OSHA 300 LOG

OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20__



U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

Establishment name _____

City _____ State _____

Identify the person			Describe the case			Classify the case				Enter the number of days the injured or ill worker was:		Check the "Injury" column or choose one type of illness:					
(A) Case no.	(B) Employee's name	(C) Job title (e.g., Welder)	(D) Date of injury or onset of illness	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Away from work (K)	On job transfer or restriction (L)	(M) Injury Skin disorder Respiratory condition Poisoning Hearing loss All other illnesses					
						Death (G)	Days away from work (H)	Job transfer or restriction (I)	Other recordable cases (J)			(1)	(2)	(3)	(4)	(5)	(6)
_____	_____	_____	____/____/____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ days	____ days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	____/____/____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ days	____ days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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_____	_____	_____	____/____/____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ days	____ days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Page totals ➤ _____

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

Page ____ of ____

Injury	Skin disorder	Respiratory condition	Poisoning	Hearing loss	All other illnesses
(1)	(2)	(3)	(4)	(5)	(6)

Using the OSHA 300 Log and Forms

OSHA'S FORM 300A

OSHA's Form 300A (Rev. 01/2004)

Summary of Work-Related Injuries and Illnesses

Year 20__



U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and Illness Types

Total number of . . .
(M)

(1) Injuries	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) Hearing loss	_____
(3) Respiratory conditions	_____	(6) All other illnesses	_____

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment information

Your establishment name _____

Street _____

City _____ State _____ ZIP _____

Industry description (e.g., *Manufacture of motor truck trailers*)

Standard Industrial Classification (SIC), if known (e.g., 3715)

OR

North American Industrial Classification (NAICS), if known (e.g., 336212)

Employment information (If you don't have these figures, see the Worksheet on the back of this page to estimate.)

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

Company executive _____ Title _____

() - / /
Phone _____ Date _____

Using the OSHA 300 Log and Forms

OSHA'S FORM 300A

OSHA's Form 300A (Rev. 01/2004)

Summary of Work-Related Injuries and Illnesses

Year 20__



U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

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(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and Illness Types

Total number of . . .
(M)

(1) Injuries	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) Hearing loss	_____
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Total hours worked by all employees last year _____

Sign here

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Company executive _____ Title _____

() - / /
Phone _____ Date _____

Using the OSHA 300 Log and Forms

THE OSHA LOG OF WORK-RELATED INJURIES & ILLNESSES

- A summary is mandated by OSHA to be posted annually for employees to see
- It is NOT meant to indicate blame
- It is NOT an indication of a violation
- It is meant as a tool to:
 - Help eliminate hazards,
 - Create a safe work environment, and
 - Keep employees healthy

Using the OSHA 300 Log and Forms

WORK RELATED INJURIES THAT NEED TO BE RECORDED:

- Death
- Loss of consciousness
- Days away from work
- Restricted work activity, or job transfer
- Medical treatment beyond first aid

Additional Criteria:

- Needle sticks
- Any case that requires the employee to be medically removed
- Tuberculosis infection
- Employees hearing test that has shown a Standard Threshold Shift (STS)

Using the OSHA 300 Log and Forms

WORK RELATED INJURIES THAT NEED TO BE RECORDED:

Work-related injuries and illnesses that are significant must be recorded.

- Any significant work-related injury or illness that is diagnosed by a physician or other licensed health care professional.
- Any work-related case involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum.

See 29 CFR 1904.7.

WORK-RELATEDNESS

Cases are work-related if:

- An event or exposure in the work environment either caused or contributed to the resulting condition
- An event or exposure in the work environment *significantly* aggravated a pre-existing injury or illness

CFR. 1904.5

Using the OSHA 300 Log and Forms

WORK-RELATEDNESS

- Work-relatedness is presumed for injuries and illness resulting from events or exposures occurring in the work environment.
- A case is presumed work-related if, and only if, an event or exposure in the work environment is a discernible cause of the injury or illness or of a significant aggravation to a pre-existing condition. The work event or exposure need only be one of the discernible causes; it need not be the sole or predominant cause.

CFR. 1904.5

WORK-RELATED EXCEPTIONS

Adds additional exceptions to the definition of work relationship to limit recording of cases involving:

- Eating, drinking, or preparing food or drink for personal consumption
- Common colds and flu
- Voluntary participation in wellness or fitness programs
- Personal grooming or self-medication

1904.5(b)(2)

Using the OSHA 300 Log and Forms

OSHA FORM 301 INCIDENT REPORT (OR COMPARABLE W.C. STATE FORM)

- One of the first pieces of paperwork completed when an employee is injured and is brought to the attention of a facility's management.
- Provides a place to record basic information about who, when, and where the injury occurred.
- Also records details of the injury and treatments provided.
- May provide place to record details of salary pertinent to compensation for the injured employee.

Using the OSHA 300 Log and Forms

OSHA'S FORM 301

OSHA's Form 301 Injury and Illness Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.



U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____	
Title _____	
Phone (____) _____	Date ____/____/____

Information about the employee

- 1) Full name _____
- 2) Street _____
City _____ State _____ ZIP _____
- 3) Date of birth ____/____/____
- 4) Date hired ____/____/____
- 5) ☐ Male
☐ Female

Information about the physician or other health care professional

- 6) Name of physician or other health care professional _____
- 7) If treatment was given away from the workplace, where was it given?
Facility _____
Street _____
City _____ State _____ ZIP _____
- 8) Was employee treated in an emergency room?
☐ Yes
☐ No
- 9) Was employee hospitalized overnight as an in-patient?
☐ Yes
☐ No

Information about the case

- 10) Case number from the Log _____ (Transfer the case number from the Log after you record the case.)
- 11) Date of injury or illness ____/____/____
- 12) Time employee began work _____ AM / PM
- 13) Time of event _____ AM / PM ☐ Check if time cannot be determined
- 14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
- 15) **What happened?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- 16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- 17) **What object or substance directly harmed the employee?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*
- 18) **If the employee died, when did death occur?** Date of death ____/____/____

Using the OSHA 300 Log and Forms

INJURY REPORTING PROCESS

- Each facility may differ in who is responsible for reporting
- Procedures used for getting the reporting of work-related injuries started differ as well
- Human Resources department (or person) often given the responsibility
- It's informative for the Ergo committee to become familiar with the process
- Provides the committee with knowledge of where to access information to evaluate their injury history and costs

Using the OSHA 300 Log and Forms

INJURY REPORTING PROCESS, Continued

- An incident report is required within 7 days after receipt of information that a work-related injury or illness has occurred.
- Forms are available from OSHA, a state's worker's compensation department or made individually by a facility.

Using the OSHA 300 Log and Forms

EXAMPLE OF PART OF A NYS WORKER'S COMPENSATION C-3 EMPLOYEE CLAIM FORM



Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____
First MI Last
2. Date of Birth: ____/____/____
3. Mailing address: _____
Number and Street/PO Box City State Zip Code
4. Social Security Number: ____-____-____ 5. Phone Number: (____) _____
6. Gender: ☐ Male ☐ Female
7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____) _____
3. Your work address: _____
Number and Street City State Zip Code
4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____
6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____
2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

Using the OSHA 300 Log and Forms

EXAMPLE OF PART OF A NYS WORKER'S COMPENSATION C-3 EMPLOYEE CLAIM FORM

INSTRUCTIONS TO CARRIER

Please fill out the form completely and accurately. If the answer to any question is *not applicable*, indicate *n/a*. The Board will not accept or consider any C-7 form submitted without a complete certification, at Section D.

Section C, Factual Basis for Controverted Claim:

In order to controvert an issue, you must, at minimum, be able to factually support the following contentions. To controvert a particular issue, check the box, and specify the factual basis in the text area. The mere checking of the box, without providing the factual basis, is not sufficient to controvert an issue. The examples are provided below by way of illustration, and are not exhaustive:

- Prima Facie Medical Evidence -- That the medical report submitted on behalf of the claimant fails to reference an injury.
- Accident within meaning of Workers' Compensation Law -- That the alleged accident is barred, excluded, or not covered within the law. *For example*, that the accident is: barred by 2(7); an exacerbation of prior injury (no new accident); barred by 10(1), such as intoxication or off-duty athletic activity, or intentionally causing harm to self or others.
- Accident Arising Out Of and In the Course of Employment -- That the alleged accident did not occur while in the course of employment, such that it cannot be presumed that the accident arose out of the course of employment; OR that while the accident occurred in the course of employment, there is substantial evidence to rebut the presumption that the accident arose out of the course of employment. *For example*, that the claimant was injured while outside scope of employment, such as in an off-premises injury which occurred when claimant was not in portal to portal status.
- Occupational Disease within meaning of Workers' Compensation Law -- That the alleged occupational disease is barred, excluded, or not covered within the law. *For example*, that the disease is not a recognized condition; that there was no distinctive feature of employment.
- Occupational Disease Arising Out of and In the Course of Employment -- That the disease arose outside of employment. *For example*, the condition was caused by exposure or activity outside that which was experienced in the workplace.
- Notice (Section 18) -- That the employer received no notice; that there was improper notice (e.g. to co-workers not supervisor); or that the notice was not timely (beyond 30 days).
- Notice (Section 45) -- That the employer received no notice, that notice was given to an improper employer entity, or that notice was untimely (more than 2 years from the later of the date disablement or the date claimant knew-or-should-have-known of the occupational disease).
- Employer-Employee Relationship -- That there was no employer-employee relationship as defined by statute or case law. *For example*, that claimant was an independent contractor; that there was no covered employment, such as casual employment, certain domestic employment, or certain other activities as defined in WCL Sec. 3 Groups 12 through 24; General Municipal Law Sec. 207-a or c, that claimant does not fit the definition of employee under WCL Sec. 2(4); that claimant was an excluded employee such as a partner or certain corporate officers, or that the Board should be aware that there was more than one employer (dual employment which caused injury), or special-general employment. Note - a claim should not be controverted merely because claimant was concurrently employed at the time of injury as set forth in WCL Sec. 14(6), for determination of wages.
- Causally Related Accident or Occupational Disease -- That the medical and/or other evidence does not support the assertion that there is a causal link between

Using the OSHA 300 Log and Forms

PROBLEMS WITH CLAIMS CAN INVOLVE:

- The medical report submitted on behalf of the claimant fails to reference an injury
- That the alleged accident is barred, excluded, or not covered

For example, the accident is:

- An exacerbation of prior injury (no new accident);
- Intoxication or off-duty athletic activity, or intentionally causing harm to self or others.
- That the employer received no notice; that there was improper notice (e.g. To co-workers not supervisor); or that the notice was not timely (beyond 30 days).

Using the OSHA 300 Log and Forms

- 14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* “climbing a ladder while carrying roofing materials”; “spraying chlorine from hand sprayer”; “daily computer key-entry.”

The employee was transferring a that needed assistance from her bed to a chair. The employee assisted the by steadying her with her arm around her back and holding her arm with her other hand. During the transfer the 's legs buckled and she began to sink to the floor. The employee maintained contact with the slowing her fall to the floor. As the was lowered to the ground, the employees right knee and back were twisted in an awkward manner.

- 15) **What happened?** Tell us how the injury occurred. *Examples:* “When ladder slipped on wet floor, worker fell 20 feet”; “Worker was sprayed with chlorine when gasket broke during replacement”; “Worker developed soreness in wrist over time.”

As the employee lowered the to the ground, her foot was under the falling and the weight of the (225lbs.) collapsed onto the employee's right leg. The right leg twisted while supporting the and pain was felt in her knee. She also experienced pain in her lower (left) back as she lowered the to the ground.

- 16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than “hurt,” “pain,” or sore.” *Examples:* “strained back”; “chemical burn, hand”; “carpal tunnel syndrome.”

The employee experienced immediate pain in her right knee and lower back (left side). Later in the day, the right knee showed signs of swelling and the employee was unable to complete her shift due to painful cramping in her back.

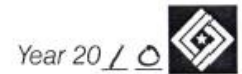
Using the OSHA 300 Log and Forms

OSHA 300 LOG

OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.



Year 20 10
U.S. Department of Labor
Occupational Safety and Health Administration
Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name ABC Rehab
City Anytown State N.Y.

Identify the person		Describe the case		Classify the case				Enter the number of days the injured or ill worker was:		Check the "injury" column or choose one type of illness:							
(A) Case no.	(B) Employee's name	(C) Job title (e.g., Welder)	(D) Date of injury or onset of illness	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Away from work (K) On job transfer or restriction (L)		(M)					
						Remained at Work											
						Death (G)	Days away from work (H)	Job transfer or restriction (I)	Other recordable cases (J)			Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
1	Roberta Jones	CNA	1/10	Res. Room	4A Back injury	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25 days	0 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Jennifer Frey	LPN	1/26	Res. Room	Sprain (R) Knee	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42 days	0 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Linda Taylor	CNA	2/20	Res. Room	Strain Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Frank Thomas	LPN	3/16	Hallway	(R) Shoulder - lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Privacy Case	RN	3/26	Res. Room	Needlestick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Dawn Seger	LPN	4/3	Parking lot	Twisted (R) Foot	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Betty Smith	CNA	4/28	Dining room	Back (L) Hip fall	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	John Grey	CNA	2/6/7	3 Courtyard	4B Neck	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Tom Terez	Aide	6/12	Laundry	(L) Shoulder + Neck	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	194 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Mary Klein	CNA	7/14	Res. Room	Lower back / Leg lifting inj	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Rachael Frank	LPN	7/28	Res. Room	Back injury Fall	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Privacy Case	LPN	8/23	Res. Room	Needlestick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Bob Peterson	CNA	11/28	Hallway	(L) Knee	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 days	1 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Page totals						0	9	0	4	377	1	13					

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-5644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

Page ____ of ____

Injury (1) Skin disorder (2) Respiratory condition (3) Poisoning (4) Hearing loss (5) All other illnesses (6)

Using the OSHA 300 Log and Forms

SUMMARIZING YOUR FACILITY'S INJURIES OVER TIME

- Collect OSHA form 300A summaries from the previous three to five years
- Provides a quick indicator of the size and scope of the injury situation at your facility
- You can determine if your rates are increasing or decreasing by dividing the number of injuries by the average number of full time workers (then multiply by 100 to get the rate per 100 FT workers).

Using the OSHA 300 Log and Forms

CALCULATING YOUR RATE

13	÷	140	×	100	=	9.3
# of injuries/year from col. M of 300 log		# of full time workers/year		# to make it comparable to 100 full time workers/year		# injury rate per 100 full time workers/year

Note: Due to the issue of part time workers, the estimates of Full Time Workers at a facility will differ from the number of people working at the facility. Using hours will result in a more precise figure, but the above number will serve as a rough number for illustration purposes.

Using the OSHA 300 Log and Forms

CALCULATING INJURY RATES

OSHA FORM 300 A:

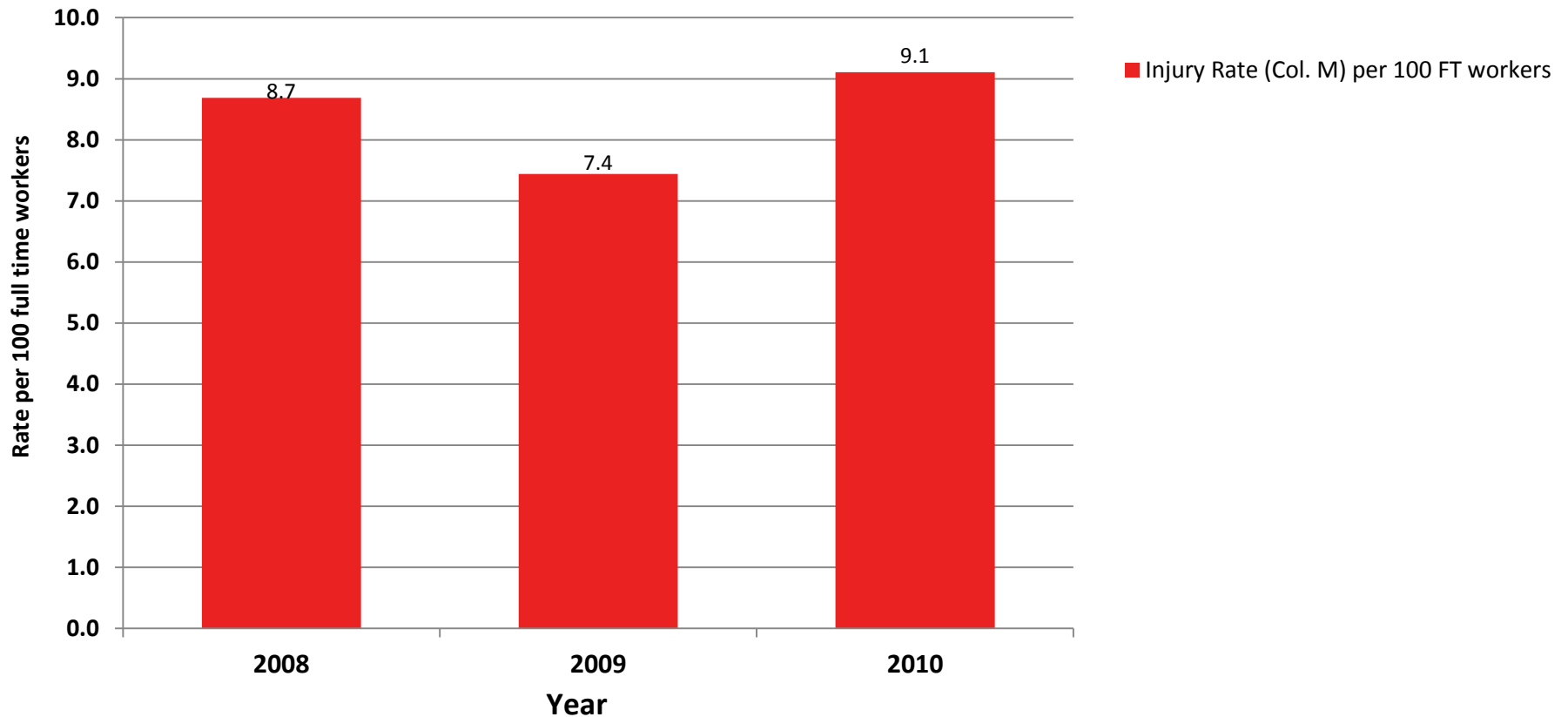
SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

- A place to find info quickly
- Summarizes from the previous 3 – 5 years, providing a quick indicator of the size and scope of your injury situation
- Indicates if rates are increasing or decreasing
- Includes number of days lost, costs of injuries, rough estimate of overall costs of injuries

Using the OSHA 300 Log and Forms

OSHA Log injuries and illnesses for ABC facility and comparison NAICS codes in the U.S. & New York State

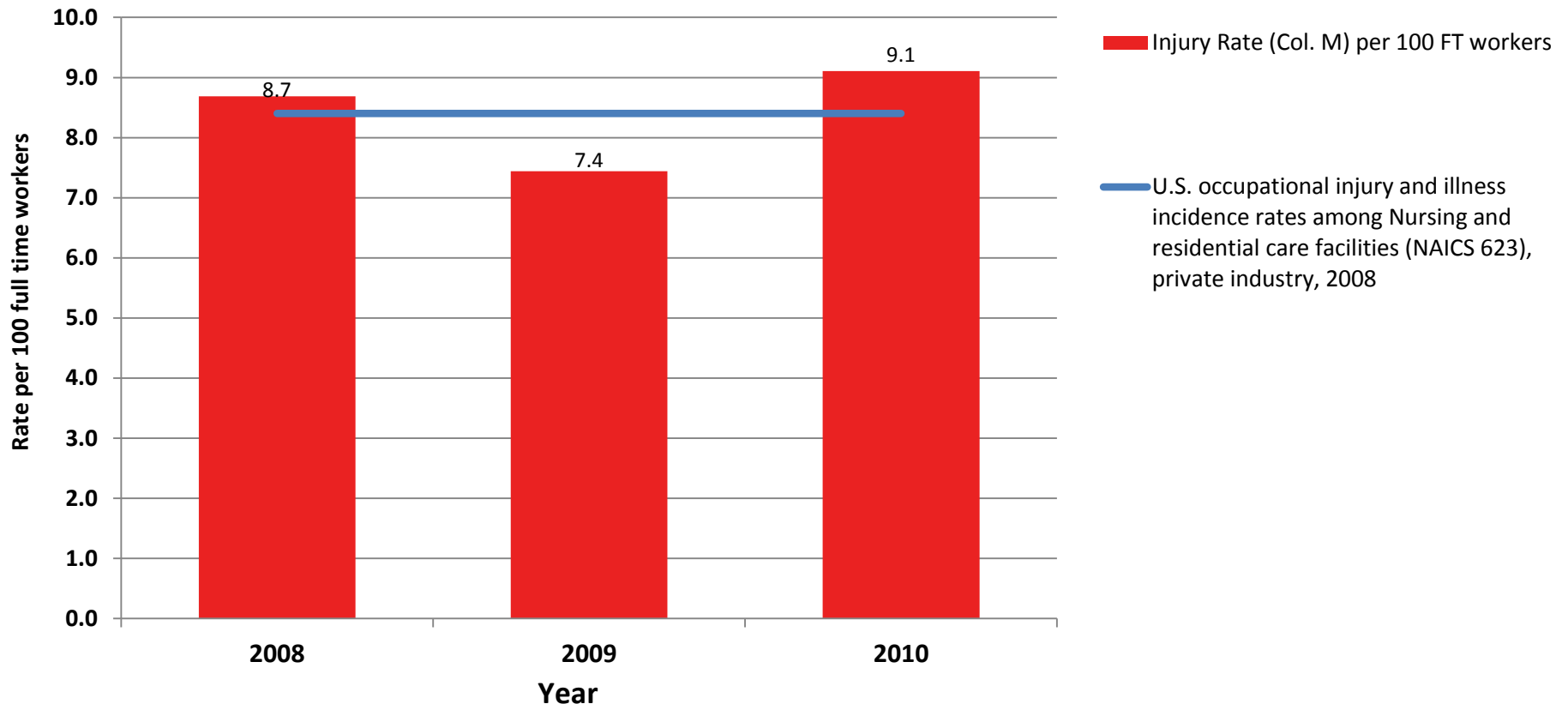
Comparison groups: Nursing and Residential Care Facilities & Management of Companies & Enterprises.



Section 2: Using the OSHA 300 Log and Forms

OSHA Log injuries and illnesses for ABC facility and comparison NAICS codes in the U.S. & New York State

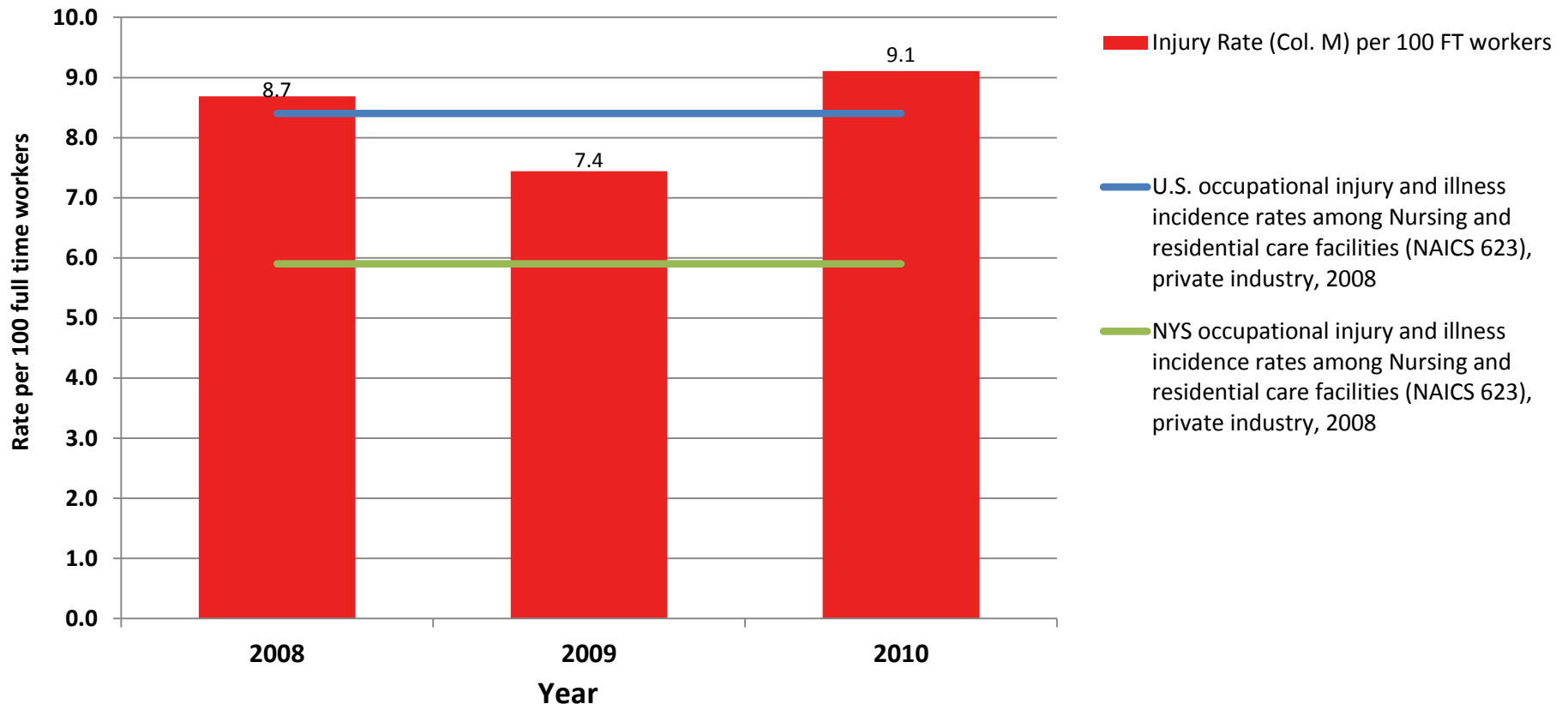
Comparison groups: Nursing and Residential Care Facilities & Management of Companies & Enterprises.



Section 2: Using the OSHA 300 Log and Forms

OSHA Log injuries and illnesses for ABC facility and comparison NAICS codes in the U.S. & New York State

Comparison groups: Nursing and Residential Care Facilities & Management of Companies & Enterprises.



Using the OSHA 300 Log and Forms

Nursing and Residential Care Facility
Injury & Illness Rates are high compared to
many other industries in the U.S.

Injury & Illness Rates may be
different for your state.

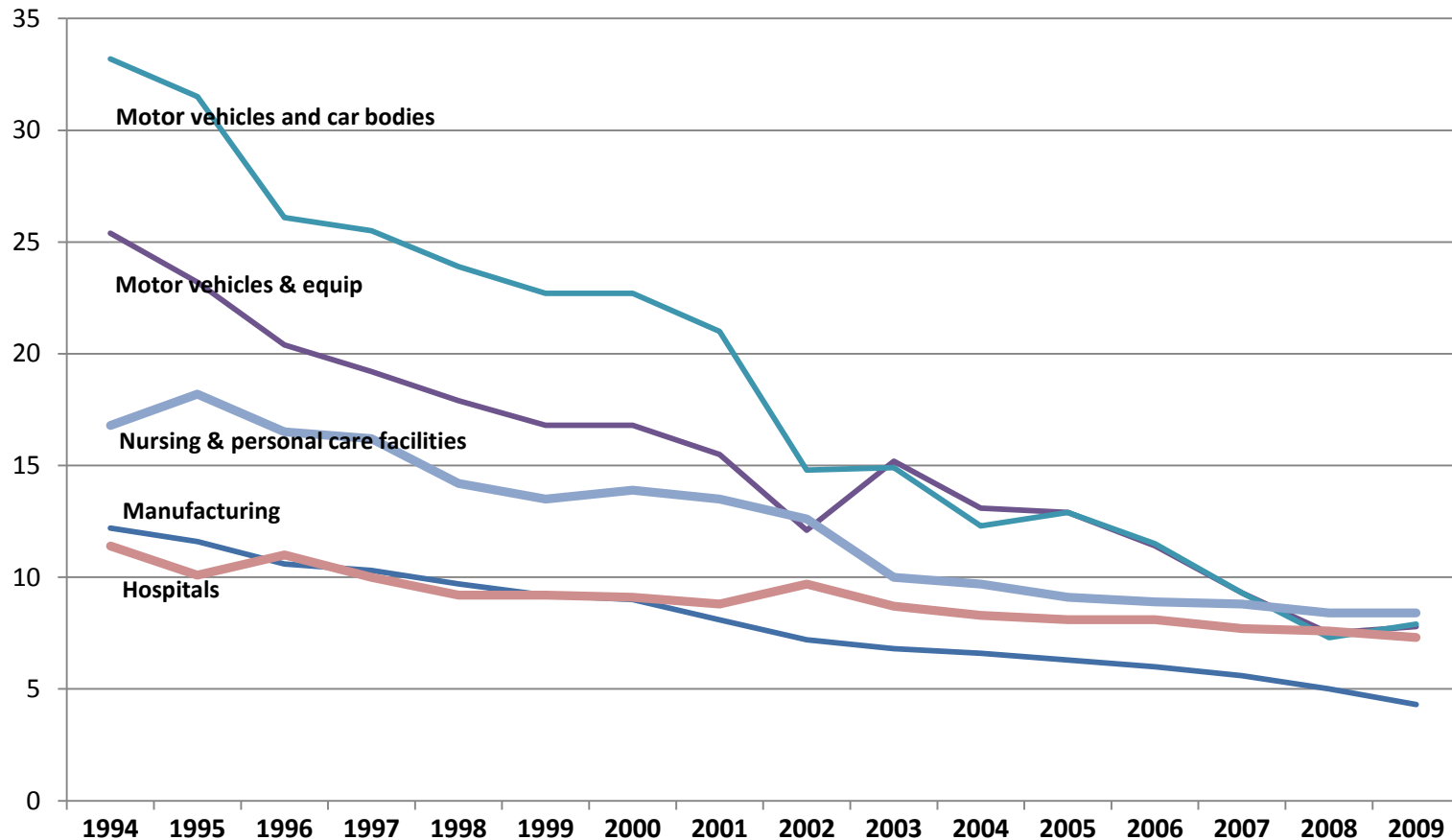
IF THEY ARE LOWER FOR YOUR STATE, IS
YOUR FACILITY LAGGING IN BEING ABLE
TO REDUCE INJURIES?

IS IT POSSIBLE THAT SPH PROGRAMS ARE
RESPONSIBLE FOR LOWERING RATES IN YOUR STATE?

Using the OSHA 300 Log and Forms

Injury & Illness incidence rates for selected industry groups , U.S. 1994-2009.

Bureau of Labor Statistics: Incidence rates represent the number of injuries and illnesses per 100 full-time workers



Using the OSHA 300 Log and Forms

OSHA's Form 300A (Rev. 01/2001)

Summary of Work-Related Injuries and Illnesses

Year 2010



U.S. Department of Labor
Occupational Safety and Health Administration
OSHA Form 300A-10-001

OSHA Form 300A is completed by Post-ITSAs at the end of the calendar year, and it is one of the types of Worksheet 300 used during the year. The number of cases for the year is the sum of the cases for each of the four OSHA 300 Log Worksheets.

Using the worksheet, the establishment can determine the number of cases for each type of injury or illness, the number of cases for each type of injury or illness, and the number of cases for each type of injury or illness.

Employers, unions, employers, and other interested parties may wish to review the OSHA 300 Log and Worksheet 300A. They should be able to find the OSHA 300 Log and Worksheet 300A in the OSHA 300 Log and Worksheet 300A.

Number of Cases

Total number of cases	Total number of cases with lost time or restriction	Total number of cases with lost time or restriction	Total number of cases with lost time or restriction
0	9	1	4
(a)	(b)	(c)	(d)

Number of Days

Total number of days lost or restriction	Total number of days of job transfer or restriction
377	1
(a)	(b)

Injury and Illness Types

Total number of cases	Total number of cases	Total number of cases	Total number of cases
(a) Injuries	13	(d) Violations	0
(b) Skin diseases	0	(e) Hearing loss	0
(c) Respiratory conditions	0	(f) All other illnesses	0

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

This reporting system is designed to help employers and employees understand the nature and extent of work-related injuries and illnesses. It is not intended to be used for legal purposes. The information provided is confidential and should not be used for legal purposes. The information provided is confidential and should not be used for legal purposes. The information provided is confidential and should not be used for legal purposes.

Establishment Information

Your establishment name: ABC REHAB
 Street: 123 Main St.
 City: Anytown State: NY ZIP: 12345

Industry, department, division, or other organizational unit:
Skilled Nursing Facility
 Street address, P.O. box, or other mailing address:
8 C.S.J.

OR
 Establishment name, street address, city, state, and ZIP:

Employment Information

Employment information for the calendar year:
 Full-time equivalent employees: 140
 Total hours worked by all employees: 285,440

Sign Here

Knowledge of filing this document may result in a fine.

I certify that I have reviewed this document and that the information is true, accurate, and complete.

Signature: _____ Date: _____
 Title: _____ Title: _____

Using the OSHA 300 Log and Forms

DETERMINE A REASONABLE ESTIMATE OF AVERAGE SALARY FOR THE WORKFORCE AT THE FACILITY

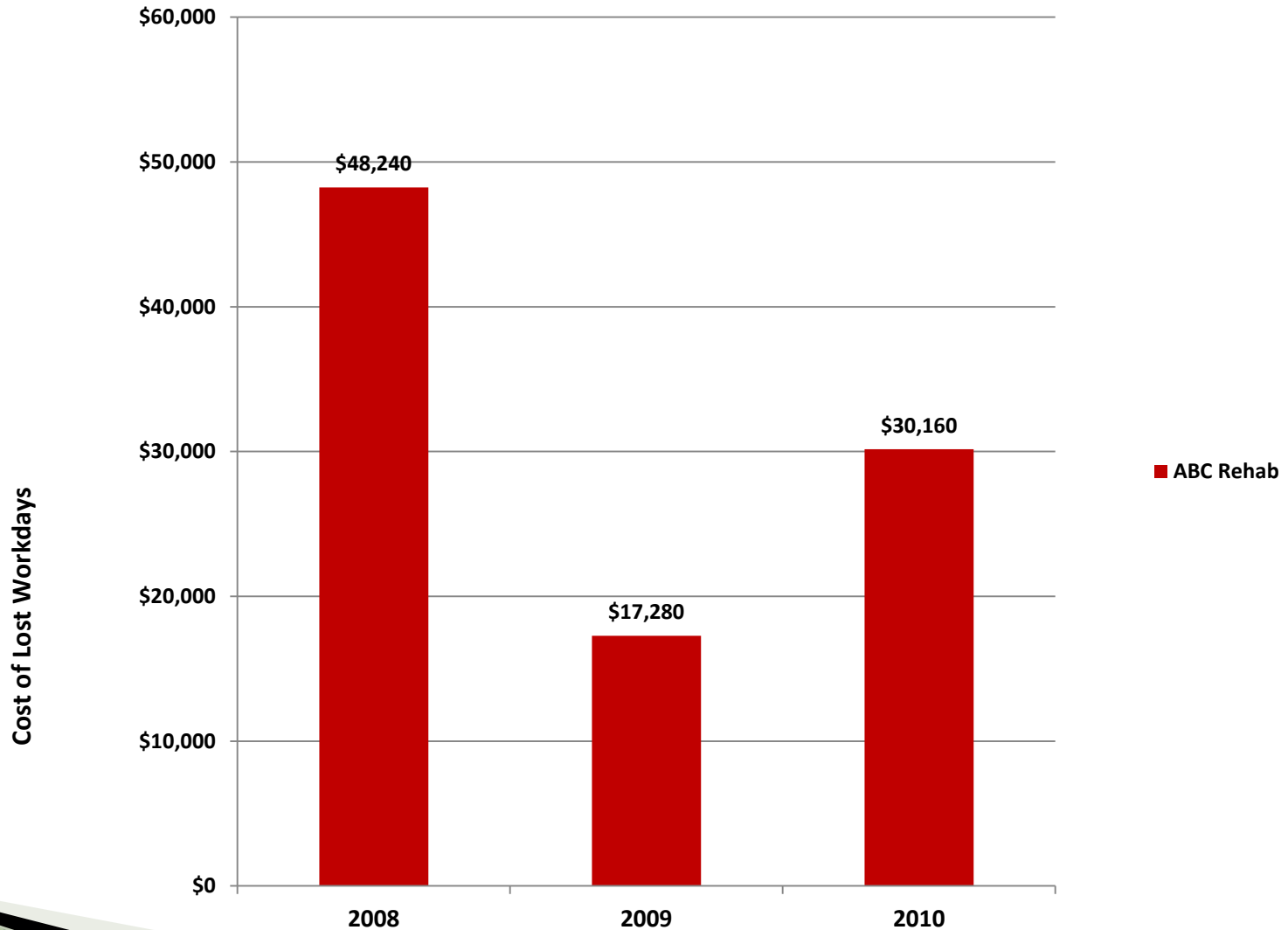
Human Resources:

- Use an average salary
- If unsure, be conservative so that subsequent estimates aren't considered to be inflated.
- (\$10 per hour, \$80 per day, \$20,000 per year*).

* From www.payscale.com, for Certified Nurse Assistant (CNA), U.S. average salary \$10.13)

Using the OSHA 300 Log and Forms

'Cost' of Lost Work Days from Work Related Illness & Injuries



Using the OSHA 300 Log and Forms

WHAT DOES WORKERS' COMPENSATION INSURANCE COVER?

Direct Costs Only

Medical costs include:

- Medical treatment of injuries
- Drug costs

Indemnity costs include:

- Time loss costs
- Temporary & permanent disability payments
- Fatality costs/awards
- Vocational assistance costs
- Settlement costs
- Claim expense costs

Source: OR OSHA

SPH Programs – Costs vs. Benefits

SUMMARY

Studies of facilities that adopt SPH programs show huge reductions in:

- Injuries
- Workers' Comp costs
- Medical costs
- Indemnity costs
- Lost Work Days
- Absenteeism
- Staff turnover
- Mandatory overtime
- Increased morale/productivity

STUDIES ALSO SHOW A RETURN ON INVESTMENT
IN APPROXIMATELY THREE (3) YEARS.

SRH Programs – Costs vs. Benefits

RESEARCH HAS SHOWN THAT FOR PATIENTS SPH PROGRAMS:

- A decrease in combativeness (with use of lifting equipment)
- Patients report feeling more comfortable/secure
- Reduced shearing injuries in patients
- Reduction in falls
- Increase in physical functioning & activity level

Source: Lynda Enos, 2009.

GROUP ACTIVITY 4

Page 21 of Student Workbook Guide

Return to Work (RTW) Programs in a SPH Environment

- Benefits of RTW programs for injured workers
- Benefits of RTW programs for employers
- Medical Managements programs
- Obstacles to RTW programs
- Overcoming obstacles

Return-to-Work Programs in a SRH Environment

COMP: THE UPSIDE/DOWNSIDE

- Workers' Comp = wage replacement
- Wage replacement is only partial
- The compensation process is adversarial
- Needed medical treatment is delayed
- Some injured healthcare workers end up on disability

SPH:

A Philosophy and Practice for
Returning Injured Workers to Their
Health Care Careers?

Return-to-Work Programs in a SPH Environment

ARE RTW PROGRAMS EFFECTIVE?

“Return to Work programs are a **proven, cost-effective** way to control the effects of disability and absenteeism in the workplace, and work in the interests of the employer and the employee. The goal of any good Return to Work program is the **safe and timely return of employees** to transitional or regular employment.”

NYS Return to Work Task Force, 2009

Return-to-Work Programs in a SPH Environment

WHY INJURED WORKERS CAN BENEFIT

- After 6 month absence from work, the odds of returning to full employment drops to 50%
- After a year's absence it drops to 25%
- After 2 year's absence it drops to near zero
- Compensation rates in total or partial disability cases never match real earnings at the pre-injury level.

Source: Steve Levin, MD, RTW Advisory Council

Return-to-Work Programs in a SPH Environment

WHY INJURED WORKERS CAN BENEFIT

Good Return to Work Programs Can:

- Return the worker to her/his place of employment and pay
- Provide transitional (“modified”) work at her/his place of work while recovering
- After the recovery period, return the worker to her/his original job

Return-to-Work Programs in a SPH Environment

WHY EMPLOYERS CAN BENEFIT

Return to Work Programs Have Been Shown to Reduce:

- Frequency and duration of lost time
- Workers' Compensation costs
- Medical and indemnity costs
- Litigation
- Wage replacement costs
- Use of short/long-term disability benefits
- Productivity loss

Return-to-Work Programs in a SPH Environment

WHY EMPLOYERS CAN BENEFIT

“The New York State Insurance Fund estimates that employers who have Return to Work Programs **save 20–40%** or more in Worker Compensation costs.”

Source: Steven Levin, MD

WHAT MAKES FOR A GOOD RETURN TO WORK PROGRAM?

- A good medical management program
- A RTW program that is funded and well-led

Return-to-Work Programs in a SPH Environment

MEDICAL MANAGEMENT PROGRAMS

Key Elements of a Good Program:

- Early reporting of MSD symptoms encouraged and supported in policy, procedure and training
- Referring injured workers to a qualified physician
- Filing injury reports right away/track all injuries

Return-to-Work Programs in a SPH Environment

MEDICAL MANAGEMENT PROGRAMS

Key Elements of a Good Program:

- Ensure Workers' Comp forms filled out
- Set up a Return to Work program with modified work provisions and coordination
- Learn from injury – advise SPH/Ergo Team
- Team gets at root causes of injuries – when, where and frequency of occurrence

Return-to-Work Programs in a SPH Environment

7 PRINCIPLES FOR SUCCESSFUL RETURN TO WORK PROGRAMS

- 1) Workplace has a strong commitment to SPH
- 2) Employer makes an offer of modified work for injured/ill employee
- 3) RTW planners ensure a plan that supports returning the worker to her/his regular job
- 4) Supervisors trained in disability prevention

Return-to-Work Programs in a SPH Environment

7 PRINCIPLES FOR SUCCESSFUL RETURN TO WORK PROGRAMS

- 5) Employer makes an early and considerate contact with injured workers
- 6) Someone is designated to coordinate the RTW program
- 7) Employers and health care providers communicate with each other

NYS Return to Work Advisory Council, 2009

Return-to-Work Programs in a SPH Environment

OBSTACLES

“My own real experience taking care of injured or ill workers is that **only in rare occasions have I been successful** at getting them back to work in their pre-injury workplace. The most frequent response to inquiries regarding availability of modified duty to accommodate a worker’s temporary (or permanent) functional limitations has been: **‘They need to be able to do their old job or I can’t take them back’.**”

Source: Steve Levin, MD, RTW Advisory Council

Return-to-Work Programs in a SPH Environment

OBSTACLE: THE INJURED WORKER

The Injured Worker May Be an Obstacle Due to:

- Resentment – modified work is often menial
- Fear of exacerbating the injury
- Fear of hostility from co-workers

Return-to-Work Programs in a SPH Environment

OVERCOMING OBSTACLES: THE INJURED WORKER

“In unionized workplaces, collective bargaining solutions, or statutory ADR (alternative dispute resolution) remedies for issues involving and related to return to work, re-employment and job protection should be honored or approved solutions for compliance with this program.”

Source: NYS Return to Work Advisory Council, 20009

Return-to-Work Programs in a SPH Environment

OVERCOMING OBSTACLES: THE INJURED WORKER

RTW Program Should Emphasize the Positive (Not Stigmatize)

- Relevant/safe modified work
- Look at what work a worker can/can't do
- Work with physician – ascertain level of restriction
- Accommodate worker – regular schedule
- Non-punitive approach – injuries happen

Return-to-Work Programs in a SPH Environment

OBSTACLE: CO-WORKERS

- Resentment that injured worker is fully salaried
- Resentment she/he isn't pulling full weight
- Resentment that co-worker got injured

Return-to-Work Programs in a SPH Environment

OVERCOMING OBSTACLES: CO-WORKERS

RTW Program Should Emphasize the Value of the Injured Worker in the Unit

- Remind All: Many healthcare workers are “working injured”
- Accidents can happen, even with A SPH program
- Modified work duty can help the unit
- Transition back to old job benefits us all

Return-to-Work Programs in a SRH Environment

OBSTACLE: MANAGEMENT

- Resentment worker got injured
- Resentment worker is costing the facility
- Resentment the worker is a malingerer
- Too difficult to find worker useful, modified work duty

Return-to-Work Programs in a SPH Environment

OVERCOMING OBSTACLES: MANAGEMENT

RTW Program Should Emphasize Value of Injured Worker to Your Facility:

- \$\$ spent transitioning vested, experienced worker to old job vs. \$\$ training new hire
- Can remain closer to being fully staffed
- Shorter amount of time paying overtime/replacement worker
- Transitioning worker can perform valuable tasks in the SPH environment
- Reduce Workers' Comp costs

APPENDIX I-3

SAFE PATIENT HANDLING STUDENT WORKBOOK GUIDE



Session I: (5 hours)

*Introduction to Safe Patient Handling,
Building SPH Ergonomics Teams and
Documenting Patient Handling Injuries*

This material was produced under grant number SH-24926-13 from the Occupational Safety and Health Administration, U.S. Department of Labor. It does not necessarily reflect the views or policies of the U.S. Department of Labor, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

SESSION 1

Participants will get:

- An introductory overview of Safe Patient Handling (SPH) including the limitation of body mechanics for preventing injuries
- NIOSH recommended lifting limits
- The nature of injuries related to individual handling
- patient handling risks and their control
- Structure & functions of SPH Ergo Committee and who needs to be included to implement and sustain a successful SPH program
- How to identify and record patient handling-related injuries on SH-900 Logs, and how to use this information to document these injuries and costs in order to compare your home's or facility's rate to the national average.

Participants will engage in exercises in which they will:

- Brainstorm on who should be involved in facility's SPH Ergonomics Committees and how to attain 'buy-in'.
- Engage in a hands-on activity where trainees will analyze facility injury data, enter the data on SH900 Logs, calculate SPH injury rates and compare those rates to other facilities and the national average.

<u>Activities</u>	<u>Page #</u>
Group Activity 1: "Myth vs. Fact"	3
Group Activity 2. "How Much Are You Lifting?"	6
Group Activity 3: Safe Patient Handling— <u>WHO</u> should be involved? <u>HOW</u> do we get " <i>Buy In</i> "?	8
Group Activity 4: Making the Case for SPH Programs	21

GROUP ACTIVITY 1: “Myth vs. Fact”

Purpose

Safe Patient Handling—the use of equipment and other assistive devices to lift, transfer and reposition patients—is now considered an “*evidence-based best practice*.” However, most of our nursing and other professional schools continue to teach good “body mechanics” as a safe way to move patients, and most of our health care facilities continue to use manual lifting and transfers.

This activity is designed to get your group thinking about Safe Patient Handling vs. manual handling of patients.

TASK ONE:

As a group, answer the questions below. **Do not turn to the next page until you have discussed these questions.**

Is it a Myth or a Fact?

Myth (M) or Fact (F)

1. M ☐ F ☐ Routine manual patient lifting is prohibited in some states as well as in a number of countries.
2. M ☐ F ☐ Proper body mechanics can prevent most healthcare worker lifting injuries.
3. M ☐ F ☐ The human body can safely lift 60 pounds.
4. M ☐ F ☐ All patient handling injuries are related to lifting, transferring and/or repositioning bariatric patients.
5. M ☐ F ☐ A two person lift of a 150-lb patient is safe for the caregivers.
6. M ☐ F ☐ It is possible for a worker to be injured without showing or experiencing any physical signs.
7. M ☐ F ☐ Healthcare workers that are physically fit are less likely to be injured lifting patients.
8. M ☐ F ☐ Safe patient lifting equipment is not affordable.
9. M ☐ F ☐ Repositioning patients is a high risk activity with the potential for injury.
10. M ☐ F ☐ The only workers who need to understand the Safe Patient Handling Program are registered nurses.

Is It a Myth or a Fact?

1. **FACT.** At least 9 US states and a number of European countries have adopted laws requiring healthcare facilities to use equipment to lift, transfer or reposition patients.
2. **MYTH.** Healthcare workers have some of the highest back injury rates among all occupations.
3. **MYTH.** The National Institute for Occupational Safety & Health recommends a 35 lb. lifting limit for patients.
4. **MYTH.** Repetitive lifting, transferring and repositioning patients day in and day out causes back and other injuries; on average a healthcare worker lifts/moves 1.8 tons daily.
5. **MYTH.** A two-person lift of a 150 pound patient exceeds the National Institute on Occupational Safety and Health's recommended lifting limit of 35 pounds per worker.
6. **FACT.** Repetitive lifting day in and day out can damage tissue such as the discs in your back without you knowing it.
7. **MYTH.** Even physically fit healthcare workers can be injured by the excessive loads that they repetitively lift day in and day out.
8. **MYTH.** Safe patient handling equipment is reasonably priced and most facilities recover their costs within 2 to 4 years.
9. **FACT.** The amount of force that's required to reposition a group home individual often exceeds 35 pounds.
10. **MYTH.** Any frontline worker that's involved in lifting or transferring of a patient needs to understand the Safe Patient Handling program.

GROUP ACTIVITY 2. “How Much Are You Lifting?”

Purpose

The National Institute for Occupational Safety and Health (NIOSH) recommends that patient lifts should not exceed 35 pounds. This activity is designed to get your group to think about how much a patient (or a limb) weighs and whether you would be exceeding NIOSH’s recommendation.

TASK ONE:

Below are a number of patient lifting scenarios. As a group, determine if each lift is within the 35 pound manual lifting limit recommended by the National Institute for Occupational Safety and Health. Indicate the amount of weight you would likely be lifting for each scenario. If the lift exceeds the NIOSH recommended limit, can you think of a way it might be done safely?

SCENARIO 1.

You are caring for a fully dependent 130 pound female patient and must move her from the bed to a chair. You are the only available nursing assistant.

SCENARIO 2.

A 210 pound male patient needs help in standing from his chair. He is partially able to help himself and lift at least half of his weight. You and a co-worker are assisting the man to stand.

SCENARIO 3.

A fully dependent patient weighing 250 pounds must be moved from his bed into a chair. Four nursing assistants are available to help with the transfer.

SCENARIO 4.

One of the bariatric female patients weighing 320 pounds injured her leg and the wound dressing must be changed. In order to wrap the leg, it must be lifted off the bed. (The leg is about 16% of the total body weight.)

SCENARIO 5.

The 150 pound fully dependent female patient must be repositioned so her head is closer to the top of the bed. There is only one nursing assistant and no special bedding.

GROUP ACTIVITY 3. Safe Patient Handling—WHO should be involved? HOW do we get “*Buy In*”?

Purpose

This activity will help you decide who needs to be involved in shaping your Safe Patient Handling program and how you can get “*buy in*” (that is, cooperation and participation) of those that need to be involved.

TASK ONE:

When you set up a Safe Patient Handling program (or improve an existing one) one of the key decisions you need to make is **WHO** needs to be involved in shaping it.

In answering the **WHO** question, you need to think about the “**stakeholders**”—everyone in your facility who’s needed to make the program work.

The other **WHO** question you need to address is who you want to serve on your Safe Patient Handling Ergonomics Team.

Review: 1. – 2. **WHO ARE THE STAKEHOLDERS IN YOUR SPH PROGRAM?**
(pages 10 – 12)

Review: 3. **WHO SHOULD BE ON YOUR SAFE PATIENT HANDLING ERGONOMICS TEAM?** (page 13)

Question #1: Who are the stakeholders at your facility that you think most likely would try to block your SPH project and why?

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Question #2: Who are the stakeholders at your facility that you think would most likely support your SPH project and why?

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-
-

Question #3: Who are the stakeholders—managerial and non-managerial—that you would want on your Safe Patient Handling Ergonomics Team and why?

Managerial

Non-Managerial

1. **WHO ARE THE STAKEHOLDERS IN YOUR SAFE PATIENT HANDLING PROGRAM?**

A **stakeholder** in your Safe Patient Handling program is anyone who:

- **Has a stake in the project working**
- **Can stop the SPH project**
- **Is directly impacted**
- **Will feel threatened**
- **Stands to benefit**
- **Can support the budget**

Stakeholders, then, are most of the staff and departments in your facility. If you have a union, it is also a stakeholder. And, of course, patients are stakeholders.

2. WHO ARE THE SPH STAKEHOLDERS?

Management. Management's stake in a SPH program is that it will lower costs associated with injuries that lead to workers' compensation and disability claims, lost work days, overtime or staff replacement costs, and staff turnover.

Union. The Union's main stake in a SPH program is that they represent their members' safety and health interests—injury prevention: ensuring that their members are able to remain fully employed and avoid injuries that force workers onto Workers' Compensation or permanent disability due to career-ending injuries.

Direct Care Staff. Anyone involved in directly lifting, transferring, repositioning and moving patients (CNAs, LPNs, RNs, OTs, PTs, etc.) has a stake in the SPH program because the use of equipment and devices is the *best practice* for avoiding painful back and other injuries, many of which are debilitating and career-ending. They also have a stake in being involved in the evaluating the SPH equipment that is purchased.

Patients. Patients have an interest in being moved safely and having confidence that the lifting equipment and other devices will do that.

CFO/Finance. Finance has a stake in knowing that the dollars invested in purchasing SPH equipment and other assists and staff training will be offset by a good *return-on-investment* due to a reduction in costs associated with Workers' Compensation insurance, and paying overtime for hiring staff to cover injured staff or training new-hires.

Supervision. Supervising nurses have a stake in knowing that the time and effort invested in the SPH program will improve the ability of direct care staff to handle patients safely and efficiently and reducing lost work days and short-staffing and scheduling problems.

Human Resources/Risk Managers. HR and Risk Managers have a stake in SPH for maintaining a stable and productive workforce and in reducing risks of injuries that lead to lost workdays, compensation claims, staff overtime and replacement workers, and staff turnover or patients' complaints.

In-Service Training. In-service trainers have a stake in being trained on all aspects of the SPH program, policy and guidelines, equipment, patient assessment, etc. by the SPH Ergonomics Team or the equipment vendor.

Purchasing. Purchasing has a stake in purchasing SPH equipment which will provide the best performance (is "user-friendly," easily maintained, a reliable vendor, etc.) for the cost.

Occupational Health/Employee Health. OH/EH has a stake in promoting the SPH program for preventing injuries to staff and patients and in ensuring that SPH equipment is used properly to avoid injury to both patients and direct care workers.

Maintenance. Maintenance has a stake in seeing that the SPH equipment that's purchased is properly maintained, has low-maintenance and is easily repaired to ensure quick turnaround time demands.

Infection Control. Infection Control has a stake in ensuring that the equipment that is purchased can be easily disinfected and that slings are of a quality that they will stand up to appropriate laundering, and that staff follow strict infection control guidelines when using or disinfecting equipment and laundering slings.

Housekeeping. Housekeeping has a stake in ensuring that the equipment, slings, gait belts, and other devices purchased can be easily wiped down to disinfect them.

Laundry. Laundry has a stake in ensuring that the slings and gait belts and other devices purchased are clearly marked for how they are to be washed and that, in following those guidelines, the product is durable.

3. WHO ARE THE STAKEHOLDERS? THE SPH ERGO TEAM.

Your facility's Safe Patient Handling Ergonomics Team is made up of a **Core Group** of your stakeholders. It provides leadership to get stakeholder "buy in" into the SPH program. It makes sure that patients are accurately assessed as to their capabilities. It provides SPH training, recommends equipment, sets up a process for investigating incidents, and annually reviews the SPH program.

WHO SHOULD SERVE ON THE SPH ERGO TEAM?

- **Frontline Workers** (such as nurses, OTs/PTs and CNAs) who do give direct care and have knowledge of how the work is done.
- **Non-Managerial Support Staff** who keep the facility running (laundry, transportation, engineering, maintenance, infection control).
- **Managers** who have decision-making authority and expertise (Chief Financial Officer, Human Resources, Director of Nursing, etc.)

WHO RUNS THE SPH ERGO TEAM?

There is a growing consensus that SPH Ergonomics Teams run best when authority is divided between workers/non-managerial support staff and management.

Nine states have passed SPH laws that require the Teams (or committees) to be one-half Frontline/Non-managerial workers and one-half Managers.

New York State legislation requires half workers and half management to serve on the Team (Committee). It also requires that the Team be co-chaired with one chair being a Frontline or Non-Managerial worker and one chair being a Manager.

TASK TWO:

A major challenge to making your Safe Patient Handling program work is to get “*BUY IN*” or support for the program from all the stakeholders that need to be involved. The stakeholders may have to be convinced that they should participate, especially from the Administration and from direct care workers.

Review: **4. How Do We Get Stakeholder “Buy-In”?** (page 15)

Review: **5. Listening: What Do Direct Care Workers Think?** (page 16)

Review: **6. – 8. Communicating.** . . (pages 17-19)

Review: **9. Shared Decision Making** (page 20)

Scenario: Your Safe Patient Handling/Ergo Team has been given the responsibility to improve your facility’s SPH program. You have collected and summarized the answers to the Safe-T Survey. Over 85% of the workers surveyed believe that the Safe Patient Handling program they now have at their facility will **not** reduce their or their patient’s chances of being injured, or improve their working conditions. **And**, the Administration is reluctant to invest in new equipment.

Question #4: What are some things your Team might do to get “*Buy In*” from the Direct Care Workers?

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Question #5: What are some things your Team might do to get “*Buy In*” from the Administration?

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-
-

4. HOW DO WE GET STAKEHOLDER “BUY IN”?

OPEN COMMUNICATION

- *Listening*
- *Communicating the Facts*
- *Telling Stories*
- *Gathering & Sharing Information*

SHARED DECISION-MAKING

- *Building a SPH Team to Guide SPH Program*
- *Involving All Stakeholders*
- *Empowering Direct Care Workers*

DATA GATHERING

- *Injury/Illness Data*
- *Costs: worker’s comp, lost workdays, staff turnover*

5. “Listening”: What do Direct Care Workers Think?

One way to find out what Direct Care workers think is to ask them to fill out our survey. Once the surveys have been filled out and the results tabulated, you will have a “snapshot” of how the care workers feel about Safe Patient Handling. These results should be shared with the workers and administration. Below are a few questions from a survey

SAFE-T Survey **Staff Assessment of Facility Employment Topics**

	Strongly agree	Agree	Disagree	Strongly disagree
1. The SPH project now being implemented at your facility will:				
(a) reduce the chances that you will be injured..... []	[]	[]	[]	[]
(b) improve working conditions at your facility..... []	[]	[]	[]	[]
(c) improve conditions of patients []	[]	[]	[]	[]
2. You have opportunities to provide input into patient handling and movement procedures..... []	[]	[]	[]	[]
3. The administration at your facility strongly supports safe lifting and safe patient handling efforts.....[]	[]	[]	[]	[]
4. Using appropriate body mechanics only, it is possible to safely lift patients.....[]	[]	[]	[]	[]
5. At your facility, the equipment needed for lifting or moving patients is:				
(a) usually available without a wait when[]	[]	[]	[]	[]
(b) usually in good working condition.....[]	[]	[]	[]	[]
6. You have received training for Safe Patient Handling projects at you facility.....[]	[]	[]	[]	[]

6. COMMUNICATING: Safe Patient Handling - Everybody Benefits!

FACT: Body Mechanics is a failed injury prevention strategy.

Health care workers have the highest number of injuries among all workers. 33% are back and shoulder injuries. 52% of health care workers complain of chronic back pain. 53,000 health care workers trained in “good body mechanics” were injured from manually lifting patients in 2005. --BLS. 2005. American Nurses Association. 2005

FACT: Safe Patient Handling Programs are good for direct care workers.

Safe Patient Handling programs reduce health care injuries by 66%--95%.

—National Institute on Occupational Safety & Health

FACT: Safe Patient Handling Equipment is Affordable.

A non-friction sheet costs about \$40. A Full Mechanical Lift about \$4,000. A Sit-to-Stand Lift, \$3,100. A Ceiling Lift, \$3,000 (+installation). *The average cost of a one month lost workday injury: \$20,000+.*

—NYS Zero Lift Task Force

FACT: Safe Patient Handling programs save money.

SPH equipment reduces workers' compensation costs by 95%; insurance premiums by 50%; medical and indemnity costs by 92%; lost workdays by as much as 100%; absenteeism by 98%. ***Return on investment on equipment averages 2—4 years due to savings on workers' compensation alone.***

—NIOSH, based on 9 case studies

FACT: Safe Patient Handling programs improve the Quality of Life for Patients.

Safe patient handling programs can reduce levels of depression, urinary incontinence, fall risks and increase levels of daytime alertness. Kaleida Health in Western N.Y. found that 14 months after eliminating pivot transfers and using equipment, patient fractures fell by 65%; skin tears and bruises by 37%; and an improvement in upper extremity range of motion by 28%.

—Veterans Administration Center of Inquiry and Kaleida Health

7. COMMUNICATING (continued)

FACT: SPH Programs are Popular With Health Care Administrators

“Kaleidea Health Long Term Care began the implementation of a Safe Patient Handling Program in 2004. . .In 2003 we incurred over \$604,000 in lost wages alone due to injuries. By the end of 2006 lost wages due to compensation injuries were \$142,588—a savings of almost \$1,000,000 over three years. . .SPH programs provide a solid return on investment.”

—Maureen Caruana, V.P., Kaleida Health LTC

“Labor and Management—all of the people who worked here at the home—nobody wanted to hear of another person being injured. . .As an administrator my life here is much more pleasant. We’ve seen enormous declines in injuries related to lifting, pulling, and moving. Safe Patient Handling is part of our culture now.”

*—Joanne Hernick, Administrator, NYS Veterans Nursing Home,
Batavia, NY, 1/2011*

FACT: SPH Programs are Popular With Unions.

All of New York State’s care unions including the NYS Nurses Association, NYS Public Employees Association, Communications Workers of America, Civil Service Employees Association, and 1199 Service Employees International Union support SPH programs.

“Nurses United CWA Local 1168 members in New York’s Kaleida system pioneered a safe patient handling ‘no-lift’ program that significantly reduced injuries to not only workers, but also patients. Today, instead of lifting patients, workers won new contract protections that require the use of mechanical lifts.”

—Dana McCarthy, CWA 1168 Safety & Health Representative, 2012

“CSEA has led the nation in fighting for safe and healthy workplaces. The union is leading the way toward safe patient handling techniques to prevent injuries to health care workers who must lift or move people.”

—Danny Donahue, President, CSEA

8. **COMMUNICATING** *(continued)*

- ***Telling personal stories***

Nothing communicates failure or success as effectively as a personal story. Testimony from injured workers who have been out on Workers' Compensation for a long period of time or who have had a career disabling injury from manually lifting patients are one of the most effective ways to "tell the story" of why a Safe Patient Handling program is needed.

Success stories are also important—testimony from direct care workers who have benefitted from using lifting equipment or other assistive devices is important.

"Back in the early 2000's lost workdays due to patient handling injuries hovered between 1,400 and 1,800. Management had to replace those out on lost time—that was equivalent to 8 – 9 CNAs. That meant that I—we—CNAs were required to work overtime to cover the workers out on injury. It was mandated by New York State. We hated it. Now that we have a Safe Patient Handling program, there is no overtime. We went 8 months without one Workers' Comp claim."

—Paul Blujus, CNA and CSEA union leader at the NYS VA Hospital

- ***Gathering and sharing information***

Staff Survey

The information that was gathered from the SAFE-T survey should be shared with the administration and frontline workers. It will communicate where your facility is in terms of how staff feel about the way they move patients now. It will help make the case for improvement through SPH.

Injury and Illness Data

The Administration has PESH, Workers' Compensation and other data that will tell you what your direct care injuries related to patient handling tasks look like. The data can also tell you where your facility stands with respect to workers' compensation claims, lost workdays, overtime, and staff turnover and what it's costing you. This will help you communicate the need for a SPH program.

9. SHARED DECISION-MAKING

The best way to get people to “buy into” a Safe Patient Handling is to involve them in making the decisions that will shape the program.

SAFE PATIENT HANDLING ERGO TEAMS

Your SPH Ergonomics Team is the group that bears major responsibility for shaping your Safe Patient Handling program.

To ensure shared decision making, 7 states have passed Safe Patient Handling laws that require ***equal representation*** of Non-Managerial Frontline Workers and of Administrators on the SPH Teams (or committees).

New York State’s law would also require Co-Chairs—one must be a Non-Managerial Frontline Nurse or Direct Care Worker and one must be an Administrator.

EQUIPMENT SELECTION

To ensure that equipment at your facility will be used, make sure the end-users are involved in evaluating it and selecting it. Nurses, DSAs and other direct care workers should have an opportunity to try different pieces and brands of equipment and make purchasing recommendations based on such things as safety, ease of use, how well it fits in the facility environment. Patients should also be involved in equipment decisions.

CONTINUOUS IMPROVEMENT

To ensure that the program is a success in the long run, direct care workers should be encouraged to communicate to their supervisors things that go wrong without being “blamed.” ***After-Action Reviews*** where the direct care workers and the supervising nurse on a unit sit down to discuss something that “went wrong” (such as an accident or “near-miss”) and “brainstorm” together a solution to prevent it from happening again is a way to keep everyone involved.

GROUP ACTIVITY 4: Making the Case for SPH Programs

Purpose

This activity will allow you to make the case for a Safe Patient Handling program at your facility by using your OSHA 300 Logs to determine your facility's incidence rate. Your facility's log of *Work-Related Injuries and Illnesses* is used to classify work-related injuries and their severity. A summary of the injuries is mandated to be posted for employees to see. Your facility's log becomes a great tool for looking at and changing your workplace to eliminate hazards and to create a safe and healthful work environment.

TASK ONE:

This activity will allow you to use your OSHA logs numbers to make a case for a Safe Patient Handling program at your facility.

Scenario

At the last meeting of the newly-formed Safe Patient Handling Committee, the OSHA 300 Log and the 300A Summary for the past year were distributed for all to review. People thought it was interesting, but no one could figure out how this data could be useful. You and another member of the committee have volunteered to provide some more information about these numbers at the next meeting. You believe that this data can prove useful to this effort.

Question: How would you use the OSHA data to make your case for a Safe Patient Handling Program at your facility?

Review: **1. OSHA Form 300A Summary of Work-Related Injuries & Illnesses** (p. 23)

Review: **2. Calculating Your Facility's Injury & Illness Rate: "Do The Math!"** (p. 24)

How many recordable injuries & illnesses during the year? _____

How many injuries and illnesses involved days away from work? _____

Questions:

Note: all incidence rates are per 100 full-time workers

What is your facility's incidence rate? _____

The national incidence rate for all private industry is _____ 3.4 _____

The national incidence rate for state government workers is _____ 4.4 _____

The national incidence rate for all nursing homes is _____ 7.6 _____

The national incidence rate for all hospitals is _____ 6.6 _____

How do the other national incidence rates compare with your facility's rate?

Summary of Work-Related Injuries and Illnesses

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this Summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write 0.

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
0	13	2	3
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work

(K) _____ (L)

Injury and Illness Types

Total number of ...	(4) Poisonings	(5) Hearing loss	(6) All other illnesses
(1) Injuries	16	0	0
(2) Skin disorders	0	0	0
(3) Respiratory conditions	0	0	0

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average .38 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspect of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 100 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment information

Your establishment name _____

Street _____

City _____

Industry description (e.g., Manufacturer) _____

Standard Industrial Classification (_____)

OR _____

North American Industrial Classification _____

Employment information Worksheet on the back of this page to es

Annual average number of employees _____

Total hours worked by all employees _____

Sign here _____

Knowingly falsifying this document _____

I certify that I have examined the entries and the knowledge the entries are true.

Company signature _____

(_____) _____

Title _____

2. CALCULATING YOUR FACILITY'S INJURY & ILLNESS RATE: *"Do The Math!"*

There are 100 employees at this facility.

FORMULA: The incidence rate =

Total number of injuries & illnesses _____

X

Total number of hours to be worked by all employees/year (for standardization, this number is 200,000 for 100 employees – 100 employees x 40 hours per week x 50 weeks/year):

200,000

÷

Number of hours worked by all employees: _____ (includes overtime hours, etc., get this # from OSHA 300A Form)

Your facility's incidence rate = _____

TASK TWO:

This activity will allow you to determine the (estimated) **cost** of patient handling injuries at your facility.

Question: What are the costs of patient handling injuries at your facility?

Review: **3. Calculating patient handling-related injuries at your facility** (p. 26)

The estimated cost of these injuries annually at our facility are: _____

Question: How would you present your facility injury rate and the annual facility costs of these injuries to top management to make the case that a comprehensive safe patient handling program would be beneficial?

3. CALCULATING THE COST OF PATIENT HANDLING-RELATED INJURIES AT YOUR FACILITY

To estimate (roughly) the cost of these injuries for your facility do the following steps:

1. Look at the OSHA 300A Log Summary Log, Item K.
2. Figure out the average salary for the employees. Let's say it's \$40,000/year, the day's rate would be $40,000/2,000 \text{ hours} = \20.00 average hourly rate.
3. Multiply the number of lost work days 500 x 8 hours to get the number of lost work hours, then multiply that number by the hourly rate.
4. $(500) \times 8 = 4,000$

$$(4,000) \times (\$20.00) = \$80,000$$

The estimate of the cost of these injuries is: **\$80,000**

TASK THREE:

Review: **4. Background Data: How to Find Your Facility's Recordable Injuries and Illnesses, Lost Workday Injuries and Illnesses, and No. of Hours Worked** (p. 28)

Review: **OSHA 300 Log** (p. 29 & 30)

Questions:

- How useful is the detailed information on this log?
- Would you seek additional information on these injuries, and if so, how would you get that data?
- What tips would you give those who were filling out the logs to ensure the best amount of detail?

Scenario:

You present your findings at the next meeting and top management are very impressed with your work. They, however, want more details about the injuries and you all agree to meet again and work on this and make a report at the next meeting in two months.

Questions:

- What additional information would you gather ? (List all ideas).
-
-
-

In addition to written documentation, what other information would you seek, and from whom?

Finally, a couple of the people in the group can't really understand why you are wasting our time looking at numbers and data, as everyone knows it's a problem. In two/three sentences, what would you say to them regarding the use of this data?

-
-
-

4. BACKGROUND DATA: How To Find Your Facility's Recordable Injuries and Illnesses, Lost Workday Injuries and Illnesses, and No. of Hours Worked

- 1) To find the total number of recordable injuries and illness that occurred during the year, count the number of line entries on the OSHA Form 300, or refer to the OSHA 300A form and sum the entries for columns G, H, I and J.
- 2) To find the number of injuries and illnesses that involved days away from work, count the number of line entries on the OSHA Form 300 that received a check mark in column H, or refer to the entry for column K. on the OSHA Form 300A.
- 3) You will also need the number of hours all employees actually worked during the year. You can get this number from the OSHA Form 300A Summary form.

Log of Work-Related Injuries and Illnesses

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8, completed from 1994-12. Feel free to use two lines for one case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Note: You can type input into this form and save it. Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader. In addition, the forms are programmed to auto-calculate as appropriate.

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

Establishment name

214

State

Identify the person			Describe the case			Classify the case			Enter the number of days the injured or disabled worker was away from work or had a restriction on job transfer or restriction			Select the "injury" column or "illness" column and choose one type of illness		
(A) Case no.	(B) Employee's name	(C) Job title (e.g., Welder)	(D) Date of injury (e.g., 7/28/01)	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from oxyacetylene torch)	(G) Death	(H) Days away from work	(I) Job transfer from work	(J) Other record-able cases	(K) Away from work	(L) On job transfer or restriction	(M) Injury	(N) Illness	
14	Rachael Frank	LPN	7 / 28 month / day	Res Room	Back injury fall	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	18 days	0 days	<input checked="" type="radio"/>	<input type="radio"/>	
16	Privacy case	LPN	8 / 23 month / day	Res Room	Needlestick	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	days	days	<input checked="" type="radio"/>	<input type="radio"/>	
17	Bob Peterson	CNA	11 / 28 month / day	Hallway	L knee	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	5 days	0 days	<input checked="" type="radio"/>	<input type="radio"/>	
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APPENDIX I-4

SPH Training Series – Session 2

Facility and Equipment Assessments and Hands-on Equipment Training



Western New York Council on Occupational Safety & Health (WNYCOSH)

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Equipment and Environmental Needs Assessment

AGENDA:

- Patient/Resident Handling Equipment and Devices
- Equipment Needs Assessment
- Facility Environment Assessment
- Hands-on Demonstrations of Equipment

Equipment, Environmental and Organizational Needs Assessment

OBJECTIVES:

SPH/SRH Team participants will be able to understand...

- What equipment and devices are available to eliminate high-risk patient/resident manual handling tasks
- How to assess your equipment needs and match your purchases to your census
- How to assess your facility environment
- How to assess your organizational capacity to achieve “buy-in”
- How to use SPH/SRH Equipment

Section 1

Equipment

- Engineering Control Strategies
- Mechanical Lifts
- Ambulation Assists
- Transfer Devices
- Friction-reducing Devices
- Height-adjustable Devices

Section 1: Equipment

WHAT'S WRONG WITH THIS PICTURE?



- What's this manual lift called?
- What's the risk to the worker? patient/resident?
- How could we eliminate the risk?

Section 1: Equipment

ENGINEERING CONTROL STRATEGIES

The Preferred Control Method:

- Eliminate the need to do the hazardous activity
- Redesign the activity to reduce the hazard: equipment and other assists

Section 1: Equipment

MECHANICAL LIFTS



Full Mechanical Lift



Sit-to-Stand Lift

Source: OSHA

Section 1: Equipment

CEILING LIFTS



Source: OSHA

Section 1: Equipment

AMBULATION ASSIST



Source: OSHA

Section 1: Equipment

FRICTION-REDUCING DEVICES



Source: OSHA

Section 1: Equipment

CONVERTIBLE WHEELCHAIR



Source: OSHA

Section 1: Equipment

VARIABLE POSITION CHAIR



Source: OSHA

Section 1: Equipment

TRANSFER BOARDS



Source: OSHA

Section 1: Equipment

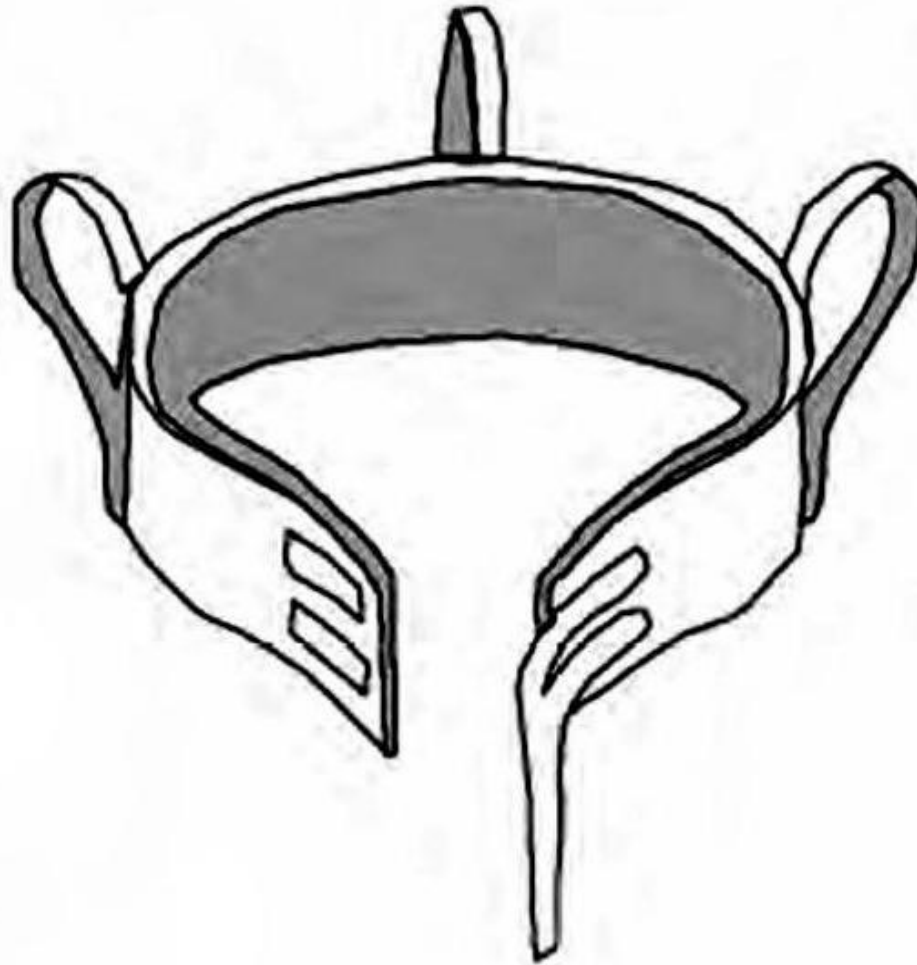
LIFT CUSHIONS AND LIFT CHAIRS



Source: OSHA

Section 1: Equipment

GAIT BELTS



Source: OSHA

Section 1: Equipment

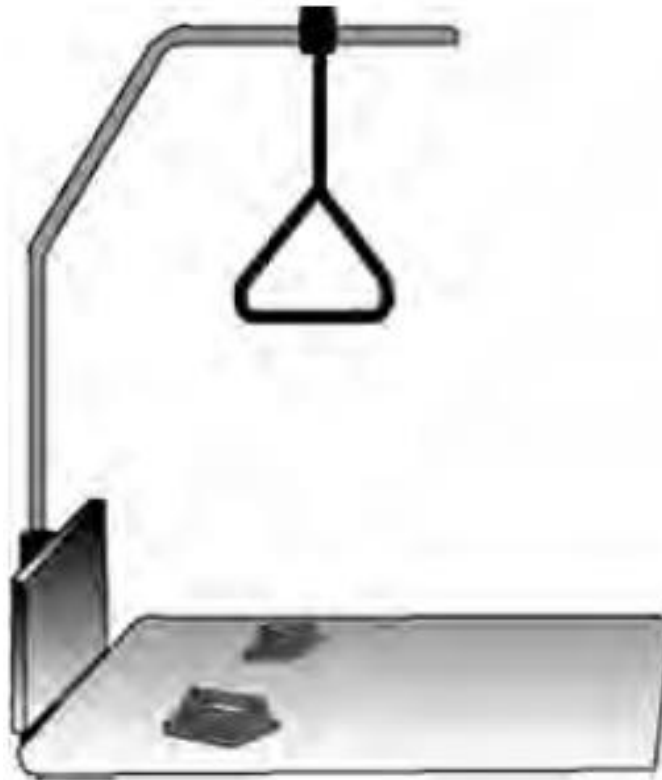
ELECTRIC HEIGHT ADJUSTABLE BED



Source: OSHA

Section 1: Equipment

REPOSITIONING DEVICES



Source: OSHA

Section 1: Equipment

HEIGHT ADJUSTABLE BATHTUBS & EASY-ENTRY BATHTUBS



Source: OSHA

Section 1: Equipment

BUILT-IN OR FIXED BATH LIFTS



Source: OSHA

Section 1: Equipment

SHOWER AND TOILETING CHAIRS



Source: OSHA

Section 1: Equipment

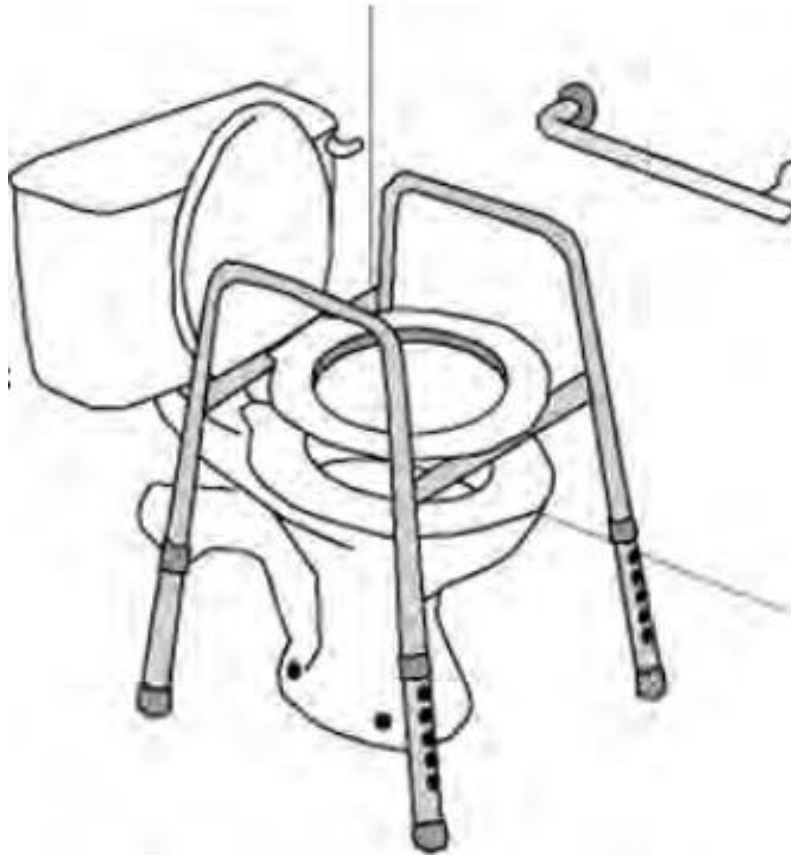
BATH BOARDS AND TRANSFER BENCHES



Source: OSHA

Section 1: Equipment

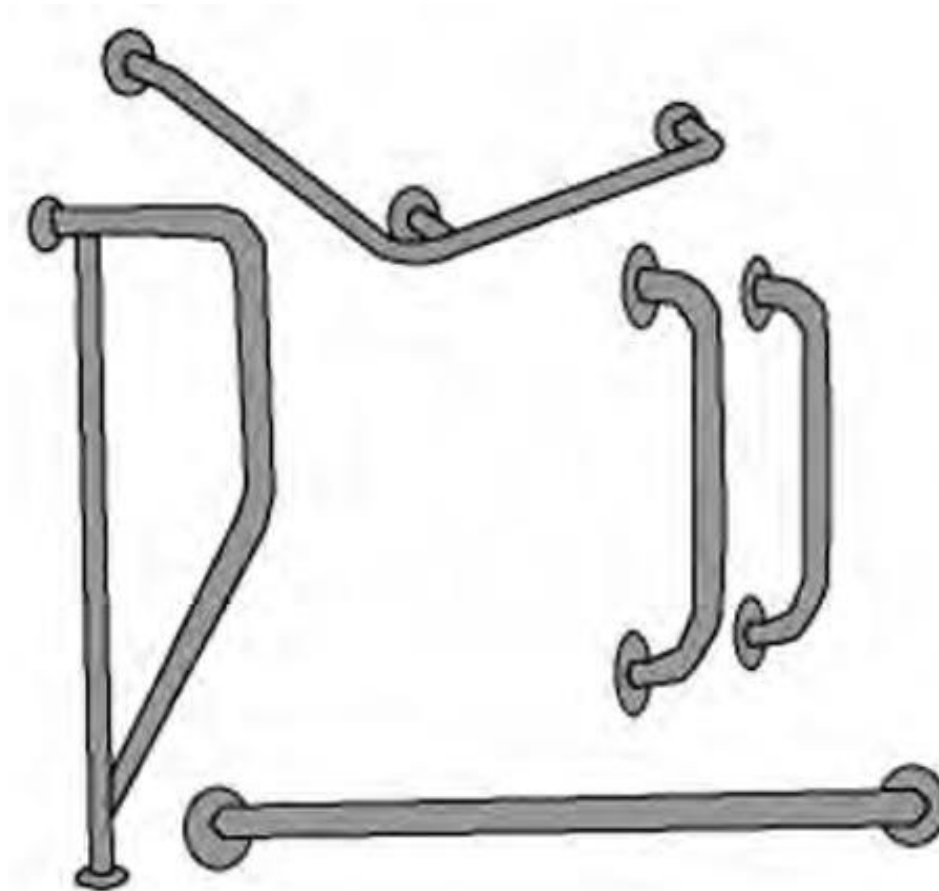
TOILET SEAT RISERS



Source: OSHA

Section 1: Equipment

GRAB BARS AND STAND ASSISTS



Source: OSHA

Section 2

Equipment Needs Assessment

- Inventory
- Maintenance
- Quantity
- Purchasing

Section 2: Equipment Needs Assessments

EQUIPMENT USE INVENTORY

- Name of equipment/device
- Do you have it in your facility?
- If yes, how many on each unit?
- What's the weight limit (if applicable)?
- Is it in good working order?
- How often is it used on each shift?

Section 2: Equipment Needs Assessments

EQUIPMENT USE INVENTORY CHECKLIST

GROUP ACTIVITY #1

Page 3 of Student Workbook Guide



Section 2: Equipment Needs Assessments

EQUIPMENT MAINTENANCE



Section 2: Equipment Needs Assessments

PATIENT/RESIDENT CENSUS & EQUIPMENT NEEDS

- Number of Independent Patients/Residents
- Number of Supervision/Limited Assist Patients/Residents
- Number of Extensive Assist Patients/Residents
- Number of Dependent Patients/Residents

Section 2: Equipment Needs Assessments

HOW MUCH EQUIPMENT DO WE NEED?

EQUIPMENT TYPE	AMOUNT PER patient/resident/Resident OF NEED ON THE UNIT
Full Mechanical Lifts	1 per 8 patients/residents of need
Sit-to-Stand Lifts	1 per 8 patients/residents of need
Gait Belts w/ Handles	1 per 2 patients/residents of need
Slip Sheets/Phil-E-Slide, Maxi Slide/Surehands	1 per 8–10 patients/residents of need
Hover Mat/Air Assists	Look at what your need is and where you'd use them
Ceiling Lifts/Tracks	# of fully-dependent and bariatric patients/residents, tub and specialty rooms

Section 2: Equipment Needs Assessments

HOW MUCH EQUIPMENT DO WE NEED?

EQUIPMENT TYPE		AMOUNT PER PATIENT/RESIDENT OF NEED ON THE UNIT
Electric Control Beds		1 per 8 patients/residents of need
Slings		1 per patient/resident (Note: Sling needs should be determined by patient/resident case load and needs)
▪ Hygiene	▪ Mesh	
▪ Universal	▪ Padded	
▪ Quick Fit	▪ Full-Body	
▪ Hammock	▪ Bathing	
▪ Sit-to-Stand	▪ Amputee	
▪ Positioning		

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT

Questions:

- Have you made a big purchase in your life recently?
- What were you looking for?
- How did you decide to choose what you did?
- Does anyone regret his/her purchase? Why?
- How might your experience apply to the equipment you purchase?

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT: HOLD AN EQUIPMENT FAIR

- Contact vendor references
- Invite a few vendors
- Involve direct care staff/patients/residents
- Evaluate, select and pilot use of equipment

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT: SELECTION CRITERIA

- Appropriate to Task
- Fits in Facility Environment
- Safe for Patient/Resident Caregiver
- Easily Kept Clean
- Comfortable for Patient/Resident
- Cost-Effective
- Easy to Understand
- Time-Efficient (not too many steps)

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT: KEY VENDOR QUESTIONS

- Reliability: established in our state?
- Customer Service: repair/replacement?
Turnaround time?
- Training: initial and periodic? All shifts?
- Maintenance: length of battery charge?
Battery life span? Vendor maintenance?
- Vendor's Responsibilities?

Section 2: Equipment Needs Assessments

PURCHASING EQUIPMENT: VENDOR QUESTIONS

- Equipment Functionality?
- Infection Control?
- Bariatric Equipment?
- Slings?
- Ceiling Lifts?
- Equipment Product Support?

Section 2: Equipment Needs Assessments

PREVENTIVE EQUIPMENT MAINTENANCE

Your SPH/SRH Ergo Team should ensure procedures are developed to:

- Log and tag equipment when it enters the building
- Use the log and tags to monitor the equipment
- Develop a process to get the repaired equipment on the floor quickly
- 48 hours is a good turnaround time
- Maintain a log book of when the equipment was broken and returned

Section 3

Facility Environmental Needs Assessment

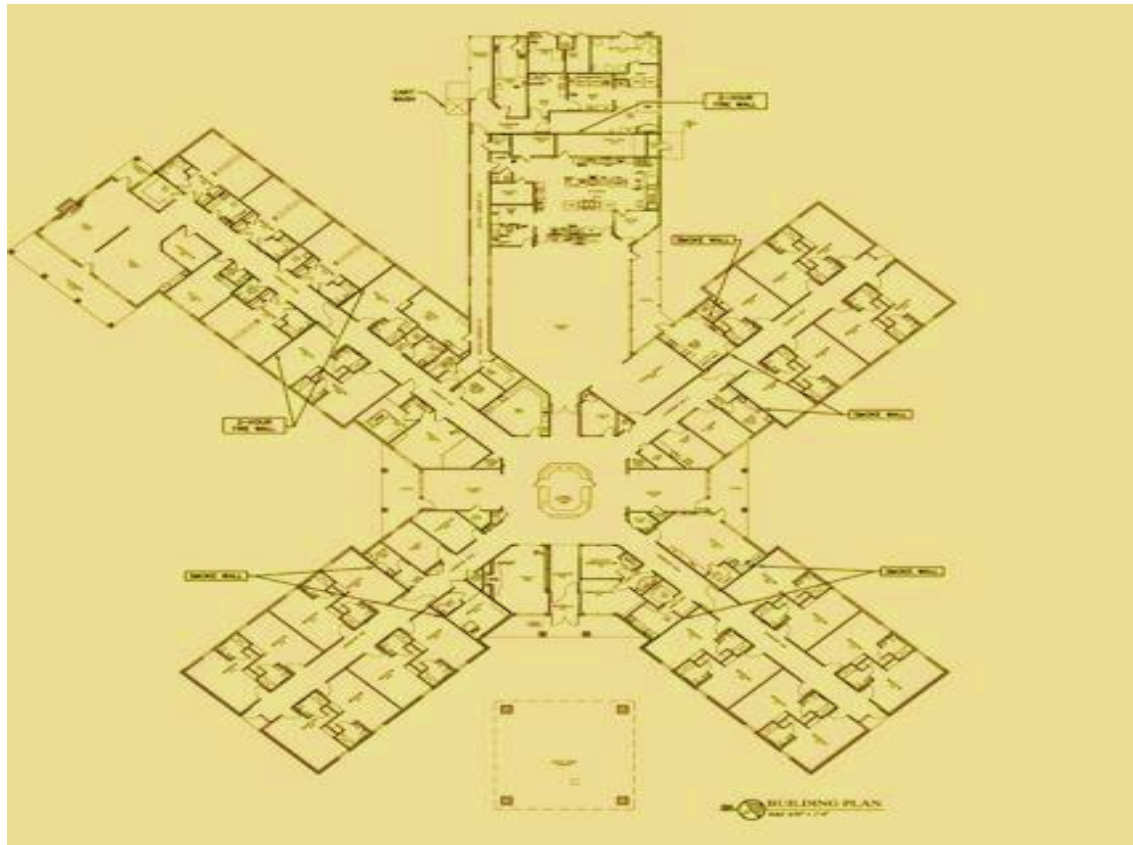
- Building Layout
- Storage
- Park and Charge Areas
- Ceiling Lift Installation
- Floors and Doors
- patient/resident/Resident Rooms
- Bathrooms
- Tub and Shower Rooms

Section 3: Facility Environmental Needs Assessment



Section 3: Facility Environmental Needs Assessment

BUILDING LAYOUT



Section 3: Facility Environmental Needs Assessment

BAD STORAGE AREAS



How likely is it that this equipment will be used?

Section 3: Facility Environmental Needs Assessment

PARK AND CHARGE AREAS

- Designated area when not in use
- Sufficient electrical outlets to recharge
- Involve direct care staff in selecting site
- Alcoves in hallways possible sites
- May need more than one area

Section 3: Facility Environmental Needs Assessment

FIXED CEILING LIFT INSTALLATION



Important Considerations:

- Structural Load Limits
- Lighting Fixtures
- Protruding Sprinkler Heads
- Air Conditioning Vents
- Asbestos
- Ceiling Height

Section 3: Facility Environmental Needs Assessment

FLOORS AND DOORWAYS

Your equipment needs to be compatible w/:

- Doorway width
- Doorway handles (catch on beds/gurneys?)
- Thresholds/other obstructions in bathroom, shower and patient/resident rooms
- Floor surfaces (carpeted? Uneven? Slippery?)
- Steep floor ramps (over 10% pitch?)

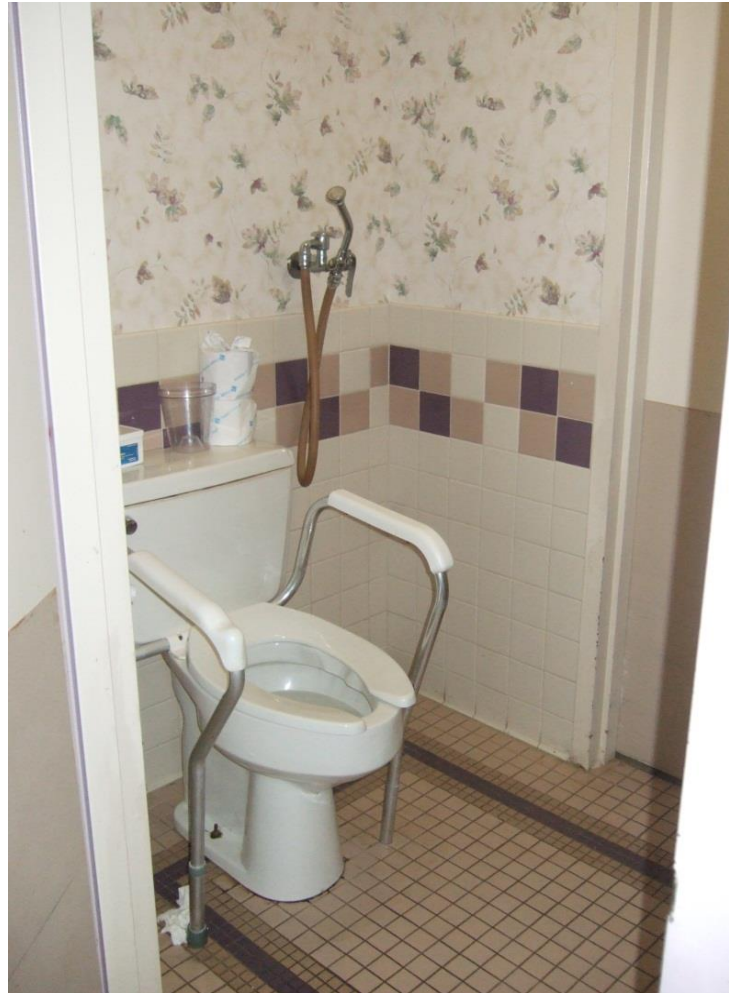
Section 3: Facility Environmental Needs Assessment

Patient/Resident ROOM LAYOUT

- Private? Semi-private?
- Bathroom in room?
- Room dimensions (small or large)?
- Room clutter?
- Space under beds?
- Closet (for storage or personal items)?
- Bedside medical or electrical outlets?

Section 3: Facility Environmental Needs Assessment

BATHROOMS



Will your equipment fit?

Section 3: Facility Environmental Needs Assessment

TUB AND SHOWER ROOMS



Do any of your tub and shower rooms look like this?
How would you improve accessibility?

Section 3: Facility Environmental Needs Assessment

TUB AND SHOWER ROOMS



What's the likelihood that direct care staff will be able to easily access the tub?

Section 3: Facility Environmental Needs Assessment

GROUP ACTIVITY #2

Page 14 of Student Workbook Guide

Facility Environmental Assessment: Equipment & Your Work Environment

Section 4: Hands-on Equipment Demonstration Activity

Repositioning in Bed: Soft Goods

- Tri-turner
- Split Sheet
- Full body
- Limb Straps

Lateral Transfers

Evacuation Equipment

Getting someone off the floor

- Easy Glide Boards
- Limb Straps
- Sling

APPENDIX I-5

SAFE PATIENT HANDLING STUDENT WORKBOOK GUIDE



Session 2: (5 hours)

Facility and Equipment Assessments and Hands-on Equipment Training

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SESSION 2

Participants will learn how to determine:

- Patient handling equipment needs at their facilities
- A process for making good equipment purchases
- Information on how to assess their facilities with respect to accommodating equipment (e.g., length of hallways, no. and location of electrical outlets, storage/recharge areas, space under beds, size of bathrooms) will be provided

Participants will learn:

- How to use an assessment tool that analyzes the patient/resident census at their facility (no. of independent, extensive assist, limited assist, and independent patients/residents)
- The outcome of this activity will allow the participants to be able to compare their facility equipment inventory with what is actually needed to implement an effective SPH program
- The procedures for using equipment, as well as hands-on demonstration on equipment use (sit-to-stand lifts/slides; full mechanical lifts/slides; ceiling lifts/slides; slip sheets/air mats)

Participants will engage in exercises using:

- Facility assessment forms
- Patient/resident census forms and care plans
- Hands-on practice with the equipment and devices for all of the trainees

<u>Activities</u>	<u>Page #</u>
Group Activity 1: How Much and What Kind of Equipment Do We Need?	3
Group Activity 2: Facility Environmental Assessment—Equipment & Your Work Environment	14

GROUP ACTIVITY 1: How Much and What Kind of Equipment Do We Need?

Purpose

To use equipment inventory forms and patient/resident census to determine how much equipment and other assistive devices that are needed at our (fictitious) “Sunrise Valley” nursing home.

“Sunrise Valley” nursing home is a 126-bed facility. There are three units with 42 single resident rooms (21 on each side of the hallway) per unit.

This activity has four tasks.

TASK ONE

Before deciding how much and what kind of equipment and other assistive devices that the Sunrise Valley needs, your Safe Resident Handling Ergo Team will need to determine what kind and how many mechanical lifts and other assistive devices already exist and if they are being used. An **Equipment Use Inventory survey** is one way to get this information

Review: **1. Equipment Use Inventory Survey** (*pages 5 & 6*)

Question: Who should receive copies of the survey and why?

Equipment Use Inventory							
Directions: Answer the following questions related to equipment handling/transport in your department or that you may have access to through another department.							
Department:		Employee Name:			RN/CNA	Shift: Day Night Swing	
Resident Handling Device	Do you have this equipment in your dept? Y or N If Y – what's the name or brand of equipment, e.g. 'Omega lift, Hovermat, etc)	If Yes How many on unit?	What is the weight limit of the equipment if applicable?	How often do you use it? 4= all of the time 3=most of the time 2=sometimes 1=rarely or never	Is this equipment in good working order? Y or N Comment:	If used rarely or never why?	Other Comments
1. Powered Floor Lift (Battery/electric power)							
2. Ceiling Lift							
3. Powered Sit to Stand Lift							
4. Air Mat for lateral supine transfers, e.g. Hovermat							
6. Roller mat							
7. Other types of Transfer mats or boards							

Equipment Use Inventory							
Directions: Answer the following questions related to equipment handling/transport in your department or that you may have access to through another department.							
Department:		Employee Name:			RN/CNA	Shift: Day Night Swing	
Resident Handling Device	Do you have this equipment in your dept? Y or N If Y – what's the name or brand of equipment, e.g. 'Omega lift, Hovermat, etc)	If Yes How many on unit?	What is the weight limit of the equipment if applicable?	How often do you use it? 4= all of the time 3=most of the time 2=sometimes 1=rarely or never	Is this equipment in good working order? Y or N Comment:	If used rarely or never why?	Other Comments
8. White Slide board (supine position)							
9. Slippery sheets for repositioning							
10. Gait or transfer belt <i>Please note if with handles</i>							
11. Low-friction mattress covers							
12. Shower cart or gurney							
13. Shower or toilet chair (commode)							

Equipment Use Inventory							
Directions: Answer the following questions related to equipment handling/transport in your department or that you may have access to through another department.							
Department:		Employee Name:			RN/CNA	Shift: Day Night Swing	
Resident Handling Device	Do you have this equipment in your dept? Y or N If Y – what's the name or brand of equipment, e.g. 'Omega lift, Hovermat, etc)	If Yes How many on unit?	What is the weight limit of the equipment if applicable?	How often do you use it? 4= all of the time 3=most of the time 2=sometimes 1=rarely or never	Is this equipment in good working order? Y or N Comment:	If used rarely or never why?	Other Comments
14. Geri chair							
15. Wheel chair							
16. Other chairs that Residents use							
17. Adjustable height beds-List each make and model							
18. Other:							
18. Other:							
Other equipment:		Please also note any specific issues or problems with this type of equipment					

Equipment Use Inventory							
Directions: Answer the following questions related to equipment handling/transport in your department or that you may have access to through another department.							
Department:		Employee Name:			RN/CNA	Shift: Day Night Swing	
Resident Handling Device	Do you have this equipment in your dept? Y or N If Y – what's the name or brand of equipment, e.g. 'Omega lift, Hovermat, etc)	If Yes How many on unit?	What is the weight limit of the equipment if applicable?	How often do you use it? 4= all of the time 3=most of the time 2=sometimes 1=rarely or never	Is this equipment in good working order? Y or N Comment:	If used rarely or never why?	Other Comments
19. Carts - Medicine							
20. Carts - Laundry							
21. Carts - Food							
22. Carts – Other - Describe							
23. Gurneys/Stretchers List each make and model and if height adjustable							
24. IV /Med poles							
25. Other medical equipment							

TASK TWO

Your Team has distributed, collected and analyzed the Equipment Use Inventory Survey. You have tabulated the results. For purposes of this task, we are only going to look at four pieces of equipment and assistive devices: Full Mechanical Floor Lift (“Powered Floor Lift”), Sit to Stand Lift, Non-friction Sheets for repositioning and Beds.

Review: **2. Summary of Findings of Equipment Use Inventory Survey at “Sunrise Valley Nursing Home” Results. * (page 8)**

Question: **If you were working at “Sunrise Valley” do you think that you you would have enough Full Mechanical Lifts in each unit to lift and transfer residents? Enough Sit/Stand Lifts?**

***Note:** for this exercise, the equipment we’ve inventoried is limited to Full Mechanical and Sit-to-Stand Lifts, Slip Sheets(non-friction sheets) and Beds. An actual inventory would include other equipment/devices referred to on the inventory checklist.

2. SUMMARY OF FINDINGS OF EQUIPMENT USE INVENTORY SURVEY AT “SUNRISE VALLEY” NURSING HOME

ASSISTIVE EQUIPMENT/DEVICES CURRENTLY IN EACH UNIT/USE	Unit One	Unit Two	Unit Three
Full Mechanical Lift (occasionally used)	1	1	1
Sit-to-Stand Lift	1 (near nurse’s station for all 3 units)		
Non-friction sheets/devices	5	5	3
	(all 3 units mostly reposition residents by pulling/pushing shoulders/trunk, bedding)		
Electric control beds	42	42	42

TASK THREE

To determine the kind and amount of equipment you need, you will need to have a *resident census* for each unit. Your census will tell you how capable the residents are in each unit in assisting the care workers with a lift, transfer or repositioning task. Capabilities can be grouped together so that residents fall into four major categories for lift/transfers.

Your census is based on the assessment by a licensed professional (OT, PT, LPN, RN) of each resident using a *Patient/Resident Assessment Tool*.

Review: **3. Safe Patient/Resident Handling Assessment Tool** (page 10)


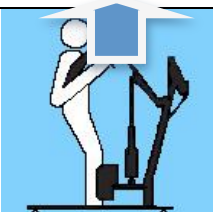



Review: **4. Resident Census at “Sunshine Valley” Nursing Home** (page 11)

Question: Using the Patient/Resident Assessment Tool, indicate what kind of equipment is needed for each level of patient capability (below):

PATIENT/RESIDENT DEPENDENCY AND LIFTS/ASSISTIVE DEVICES NEEDED

Patient/Resident Capabilities	Level of Dependency	Lift or Assistive Device Needed?
Patients/residents who are non-weight bearing; unable to balance on a bed; some are also non-cognitive.	<i>Total Dependence</i>	_____
Patients/residents who are partially capable of weight-bearing on one or both legs; can sit from supine position unassisted; all have fair to good upper body and hand strength.	<i>Extensive Assistance</i>	_____
Patients/residents who are full weight bearing and are able to ambulate with guidance or hands on cueing; others are partial weight bearing—can take a few steps and move feet. Are steady, cognitive & cooperative.	<i>Supervision/ Limited Assistance</i>	_____
Full weight bearing; steady; cognitive.	<i>Independent</i>	
Patients/residents who are unable to assist with lateral transfer or need repositioning in bed or reclining chair.	<i>Dependent for Repositioning</i>	_____

3. SAFE PATIENT/RESIDENT HANDLING ASSESSMENT TOOL

Lift Type	Patient/Resident Criteria	Contraindications	Sling Criteria	Staff
 <p>Total Mechanical Lift</p>	<ul style="list-style-type: none"> Non weight bearing Not able to sit/balance on edge of bed Non weight bearing patient/resident needing repositioning in a non-reclining chair 		Use - Hygiene sling if patient/resident has: <ul style="list-style-type: none"> Good upper body control Cognitive Able to assist Transfer is for toileting/ access to perineal area. 	2 – 2+
			Use - *Hammock sling if patient/resident has: <ul style="list-style-type: none"> Poor upper body control Non cognitive Unable to assist. 	2 – 2+
 <p>Sit/Stand Mechanical Lift</p>	<ul style="list-style-type: none"> Partial weight bearing in one or both legs Can hold on with one or both hands Cooperative Able to move supine to sit and be able to sit/balance on edge of bed Partial weight bearing patient/resident needing repositioning in a non-reclining chair 	<ul style="list-style-type: none"> Abdominal, chest or back surgery (if the area of surgery would be compromised resulting in harm to the patient/resident) Spinal or pelvic fracture (if the fracture site would be compromised resulting in harm to the patient/resident) Poor skin integrity in area of belt 	Use - Band Harness if patient/resident: <ul style="list-style-type: none"> CAN bear weight continuously 	2 – 2+
			Use - TT Harness if patient/resident: <ul style="list-style-type: none"> CANNOT bear weight continuously Band sling is not large enough If leg straps are needed 	2 – 2+
 <p>Transfer/Gait Belt</p>	<ul style="list-style-type: none"> Full weight bearing and able to ambulate with guidance or hands on cueing Partial weight bearing if they can take steps and move feet Steady Sound cognition Cooperative 	<ul style="list-style-type: none"> Abdominal, chest or back surgery (if the area of the surgery would be compromised resulting in harm to the patient/resident) Spinal or pelvic fracture (if the fracture site would be comprised resulting in harm to the patient/resident) Poor skin integrity in area of belt 	None	1 + another to handle medical equipment
 <p>Non-Friction Device or Air Matt</p>	<ul style="list-style-type: none"> Bed Rest Unable to assist with lateral transfer Needs repositioning in bed or reclining chair 		None	Less than 200 lbs. – 2
				More than 200 lbs. – 3
 <p>No Lift Device</p>	<ul style="list-style-type: none"> Full weight bearing bilaterally Steady 		None	2-2+ 0 – 1

4. RESIDENT CENSUS AT “SUNSHINE VALLEY” NURSING HOME (by unit)

To determine if we needed more equipment, we got a census of our residents, noting their capabilities in assisting our staff in making transfers or repositioning. We also inventoried the mechanical assists and devices we have in each unit. Below is a summary of the census for each unit [residents have been grouped by their capabilities] and the kinds of assistive equipment and beds that we have.

RESIDENT CENSUS	Unit One	Unit Two	Unit Three
Residents who are non-weight bearing; unable to balance on a bed; some are also non-cognitive.	16	17	13
Residents who are partially capable of weight-bearing on one or both legs; can sit from supine position unassisted; all have fair to good upper body and hand strength.	14	12	15
Residents who are full weight bearing and are able to ambulate with guidance or hands on cueing; others are partial weight bearing—can take a few steps and move feet. Are steady, cognitive & cooperative.	7	10	9
Full weight bearing; steady; cognitive.	5	3	5
Residents who are unable to assist with lateral transfer or need repositioning in bed or reclining chair.	13	15	9

TASK FOUR

Determine the kind and amount of equipment and other assistive devices that's needed in each Unit to ensure the safety of direct care workers and residents.

To do this task, your Team needs to compare "Sunshine Valley's" resident *census* (which tells you the capabilities of the residents) with the kinds and amount of equipment that's recommended for each level of capability (*Total Dependence, Extensive Assistance, Supervision/Limited Assistance, Independent*).

Review: **5. Equipment per Patient/Resident of Need Guide** (page 13)

Question: Compare the equipment you currently have at "Sunshine Valley" (below) with the equipment you need (use the 5. Equipment per Patient/Resident of Need Guide – p. 13) based on your *resident census* (use 4. Resident Census at "Sunshine Valley" Nursing Home – p. 11). Put your answers in the [].

EQUIPMENT WE HAVE & ADDITIONAL EQUIPMENT NEEDED*

	Unit One	Unit Two	Unit Three
Full Mechanical Lift (electric powered)	1 []	1 []	1 []
Sit-to-Stand Lift (electric powered)	1 []	0 []	0 []
Non-friction sheets/devices	5 []	5 []	3 []
Electric control beds	42	42	42

5. EQUIPMENT PER PATIENT/RESIDENT OF NEED GUIDE

How much Equipment do we need?

Equipment type	Amount of equipment recommended
Floor lifts or full mechanical lifts	1 per 8 patients/residents of need on that unit
Sit to stand lifts	1 per 8 patients/resident of need on that unit
Gait belts with handles	1 per patient/resident of need, hands on assistants will require a gait belt
Non friction sheets & non friction devices, Slip Sheet, Phil-E-slide, Maxi-Slide & Surehands products	1 per 8-10 patients/residents of need <i>(used for lateral transfers, repositioning; reducing friction decreases the load and resistance)</i>
Hover Mat & Air Assisted devices	Look at what your need is and where you would use them
Ceiling Lifts & ceiling track systems	<i>Truly Zero-Lift; especially useful with fully dependent patients/residents. Useful in tub rooms, therapy gyms, patient/resident care areas, and rooms with specialty care like bariatric.</i>
Hygiene slings Universal slings Quick fit slings Hammock slings Sit-to-Stand slings Amputee slings Positioning slings Mesh slings Padded slings Full Body slings Bathing slings	Slings needs should be determined by patient/resident case load and needs
Electric control beds - (avoid awkward postures)	1 per patient/resident Beds have various sizes, styles, and functions. Bariatric beds have heavy reinforced hardware and framing.

Note: The equipment to patient ratio in these slides is used at Kaleida Health in Western New York at 9 hospitals and nursing homes. Their program resulted in an 80% reduction in patient related handling injuries. This chart is a good guide for determining the amount of equipment your Safe Patient Handling Ergo Team will want to recommend for your facility. The way caregivers organize their work assignments should be carefully considered when determining the quantity purchased. Patient lifting tasks are not evenly distributed throughout a 24-hr. period. Typically, there are peak periods where staff is competing for lifting devices. If your facility plans to eliminate manual lifting, a commitment to purchasing sufficient quantities of equipment will make this feasible.

GROUP ACTIVITY 2: Facility Environmental Assessment— Equipment & Your Work Environment

Purpose

If your facility needs more and new equipment before it is purchased, two things should be considered: 1) Have the stakeholders, especially the “end-users” (nurses, CNAs, patients, residents), have a chance to evaluate it? 2) Is there a good “fit” between the equipment and the physical space in which it will be used?

This Group Activity has one task.

TASK ONE

To get “*BUY IN*” from the stakeholders on the new equipment purchases, it is important that they have a chance to have the vendor(s) demonstrate the equipment and allow the stakeholders, especially “end users” such as nurses, CNAs, patients and residents participate in “hands-on” demonstrations.

Scenario: Your Safe Patient Handling Ergonomics Team has been assigned the task of setting up an “Equipment Day” at your facility. You will be responsible for planning the event including contacting a vendor, managerial, non-managerial frontline workers/direct care workers and other personnel from other departments at your facility.

Review: Information sheets **1—8** (pages 16-23)

Question: When planning the event, whose opinions about the equipment will you want to solicit and why?

-
-
-
-

Question: What is some of the most important information you will want to collect and review before you recommend that the facility purchase a piece of equipment?

-
-
-
-

Question: What physical features at your facility may make it difficult to select certain kinds of lifts (refer to information sheets **7 & 8** – pages 22-23). How might you overcome these obstacles?

-
-
-
-

1. BEFORE PURCHASING NEW EQUIPMENT. . .THINGS TO CONSIDER

- *Set Up An Equipment Day With a Reliable Equipment Vendor*
- *Distribute a Equipment Survey to the “End Users”*
- *Do a Unit Profile and Space/Maintenance/Storage Assessment*
- *Do a Facilities Design Assessment*
- *Collect Surveys and Evaluate the Equipment*

2. SETTING UP AN “EQUIPMENT DAY” WITH A RELIABLE VENDOR

The Equipment Day

Your SPH/Ergo Team should set up an equipment day for the Administration, Non Managerial Frontline Workers/Direct Care Workers, other staff (including housekeeping/laundry, infection control, maintenance/engineering, etc.) patients and residents. You should ask the vendor to bring equipment and devices to meet your needs as determined by your patient/resident census.

- ***Involve Frontline/Direct Care Workers.*** Your Equipment Day should involve all of your Frontline/Direct Care Workers from all 3 shifts. They should have a chance to see the equipment demonstrated and should have a chance to use the equipment themselves.
- ***Involve Other Staff.*** Staff from departments such as housekeeping/laundry, infection control, maintenance/engineering should have an opportunity to see the equipment. Laundry will have an interest in slings, their durability, and washing requirements. Housekeeping in the ease with which the equipment can be disinfected and wiped down. Maintenance/engineering in repair and installation.
- ***Involve Administration.*** Managerial, supervisory staff, and physicians should be present to assess the equipment and to observe reaction of the staff. It's also an opportunity to discuss with the vendor issues such as warranties, servicing and training.
- ***Reliable Vendor.*** Select a vendor from your area that has a good reputation at other facilities for providing good customer service, training, and a reliable product.

3. EQUIPMENT FUNCTIONALITY CHECKLIST

Name of Lift _____

- What is the life expectancy?
- What is the load capacity?
- What are the storage requirements?
- How does it fit into our facility?
- Does it fit into our bathroom?
- Will it fit at bedside?
- Will it fit under beds? Under X-ray tables?
- Will it pass through all the doors in our facility?
- Does it fit on elevators?
- Does it have an emergency shut-off switch?
- Can a healthcare worker maintain proper body mechanics using it?
- Will it move a patient/resident from a car?
- Are the capacity & load instructions listed on the equipment?
- What are the infection control procedures?

Maintenance

- How long does the battery charge last?
- What maintenance required by facility? By vendor?
- Who's responsible for upgrades and recalls?
- What's the procedure for replacing defective parts? How fast shipped?
- What's lifespan of the battery?
- Warranty limitations?

Slings

- How are the slings used?
- How often do they need to be replaced?
- Is it possible for the patient/resident to slip out of the sling?
- Are the slings interchangeable within the product line? (from ceiling lift to full mechanical or sit/stand lifts?)

Bariatric

- Does the vendor offer bariatric equipment? For sale? For rent?

Adapted from Veterans Administration. Patient Care Ergonomics Resource Guide.

4. VENDOR CHECKLIST

General Vendor Information

- How long has the company been in business in your state?
- How long has the representative worked with them?
- How many clients do they service in the state?
- How many customer service representatives do they have?
- What other health facilities have this equipment and what references can they provide on those institutions' experiences?

Vendor Customer Service

- What's the average response time for service?
- Will the company replace equipment if it's not functioning correctly? If so, what is the turnaround time?
- Does the vendor have a set of service standards?
- What is the vendor's response time to resolve a customer problem?
- Does the company do problem-solving follow-up if the equipment is not functional?
- Does the vendor have state representatives that can arrive and problem solve within a short period of time?
- How fast are replacement parts shipped?

Vendor Provided Training

- Does the vendor provide training for all shifts?
- Will the vendor return and train new staff periodically?
- Does the training include the use of all types of slings available for the equipment? For example: walking slings, disposable slings, supine slings, custom-made slings for amputees?
- Will the vendor provide orientation and training for doctors?
- Does the vendor have training videos?

Equipment Product Support

- What's the vendor's equipment evaluation period (trial period)?
- What's the warranty on the equipment?
- Will the vendor assist in assessing and matching patient types with equipment?

Veterans Administration. *Patient Care Resource Guide*.

5. PRODUCT FEATURE RATING SURVEY (HEALTH CARE WORKER)

Please examine the product very carefully and answer the following questions as they relate to this product ONLY. Please answer each question using a scale from 0 to 10, by circling the number that matches your impression, where 0 indicates a very poor design and 10 indicates a very well designed feature.

We encourage you to express any ideas you may have for improving the product design. Please make your comments alongside the appropriate feature rating and other comments at the bottom.

Health Care Worker Name: _____

Mechanical Lift or Other Device: _____

1. How would you rate your OVERALL COMFORT while using this product?

Very Poor 0 1 2 3 4 5 6 7 8 9 10 Very Good

2. What is your impression of this product's OVERALL EASE-OF-USE?

Very Poor 0 1 2 3 4 5 6 7 8 9 10 Very Good

3. How EFFECTIVE do you think this product will be in reducing INJURIES?

Very Poor 0 1 2 3 4 5 6 7 8 9 10 Very Good

4. How EFFICIENT do you feel this product will be in use of your TIME?

Very Poor 0 1 2 3 4 5 6 7 8 9 10 Very Good

5. How SAFE do you feel this product would be for the PATIENT?

Very Poor 0 1 2 3 4 5 6 7 8 9 10 Very Good

6. How COMPATABLE do you feel this product is with our BEDS, DOORS, ROOMS?

Very Poor 0 1 2 3 4 5 6 7 8 9 10 Very Good

Additional Comments:

Adapted from the Department of Veterans Affairs: Technology Solutions for Safe Patient Handling and Movement.

6. Product Feature Rating Survey (Patient)

Name:	Name of Mechanical Lift or other Device	
--------------	---	--

Please examine the product very carefully and answer the following questions as they relate to this product. Please answer each question using a scale from 1 to 5 by circling the number that matches your impression, where 1 indicates a negative answer and 5 indicates a positive answer.

1. How would you rate your OVERALL COMFORT while using this product?

Uncomfortable Comfortable
1 2 3 4 5

2. How EFFECTIVE do you think this product will be in reducing STAFF INJURIES?

Difficult Easy
1 2 3 4 5

3. How EFFECTIVE do you think this product will be in reducing your (PAT/RES) INJURIES?

Ineffective Effective
1 2 3 4 5

4. How SAFE did you feel when this product was to lift, move or reposition you?

Insecure Secure
1 2 3 4 5

5. How EFFECTIVE is this product in lifting, moving, or repositioning you?

Ineffective Effective
1 2

Other Comments: _____

Adapted from the Veterans Administration

7. Unit Profile and Space/Maintenance/Storage Evaluation

1.	Directions: Describe Unit/wing, including # beds, room configurations (private, semi-private, 4-bed, etc.), and bathrooms:
# rooms private (1 bed) _____ # rooms with 2 beds _____ Other: _____ Bathrooms: In room? _____ Community _____ Use tub? _____ Shower chair? _____ Other: _____ Draw room configuration (on back as needed)	
2.	Describe current storage conditions and problems you have with storage. If new equipment is purchased, where would it be stored?
3.	Identify anticipated changes in the physical layout of your unit, such as planned unit renovations in the next 2 years
4.	Describe space constraints for patient care tasks & use of portable equipment; focus on patient rooms, bathrooms, shower/bathing areas. <i>Are typical room doorways narrow or wide??</i> Is the threshold uneven?
5.	Describe any routine equipment maintenance program or process for fixing broken equipment. What is the reporting mechanism/ procedure for identifying, marking, and getting broken equipment to shop for repair?
6.	If potential for installation of overhead lifting equipment exists, describe any structural factors that may influence this installation, such as structural load limits, lighting fixtures, protruding sprinkler heads, other ceiling fixtures, AC vents, presence of asbestos, etc.

Sources: VA, 2005, Lynda Enos, MS, RN, CPE, 2005

8. Facilities Design Checklist

Directions: Place a check mark in the space next to each item you feel may be a problem area in your dept./unit.

FACTOR	PROBLEM	LOCATION
1. High threshold or obstructions in entry ways of bathrooms, showers, hallways, etc. prevent access for assist equipment		
2. Steep ramp (greater than 10 degrees)		
3. Small or cluttered rooms/bathrooms/hallways or other spaces		
4. Door handles catch on beds/gurneys/etc.		
5. Floors slippery/uneven/cluttered		
6. Storage areas too high/low/awkward to reach		
7. Bedside medical and electrical outlets too low/only on one side		
8. Inadequate storage space		
9. No grab rails by toilets or in bathtubs or showers		
10. Toilet seats too low		
11. Other		

Adapted from Lynda Enos, MS, RN, CPE, 2005

APPENDIX I-6

SPH Training Series – Session 3

Safe Patient Handling Policy and SPH Ergonomics Teams (Committees)



Western New York Council on Occupational Safety & Health (WNYCOSH)

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Safe Patient– Handling Policy/ Team Building/ Staff Training Performance, Monitoring and Evaluation

AGENDA:

- Safe Patient– Handling Policy
- Introduction and Overview: Task vs. Process
- Team Structure and Composition
- Establishing Ground Rules
- Developing an Agenda
- Group Process Roles
- Methods of Group Decision Making
- Conflict Resolution Skills
- Multiple Intelligences
- Gap Analysis



Introduction to Safe Handling

OBJECTIVES:

SPH Team participants will be able to:

- Develop a SPH Policy
- Develop a meeting agenda
- Define the duties of each of the group process roles
- Identify the stages of group development
- Discuss how Multiple Intelligences affect communication
- How to achieve SPH Ergonomic Team consensus



Section 1:

Developing a SPH Policy



Section 3

Safe Patient Handling Policy

- Safe Patient– Handling Policy
- SPH Policy Objectives
- SPH Roles
- What Does a Bad SPH–SPH Policy look like?
- SPH Policy Outline



Section 3: Safe Handling Policy

SAFE HANDLING POLICY

Policy: “A principle or rule to guide decisions and achieve rational outcomes.”

SPH Policy: “A policy and practice that creates a safe environment for patients and health care workers by eliminating hazardous manual lifting tasks. Transferring and repositioning patients is accomplished by using new technologies in mechanical lifting and repositioning devices.”

NYS Zero-Lift Task Force



Section 3: Safe Handling Policy

SPH PROGRAM OBJECTIVES

Question:

What do you want your program to achieve?

- To increase quality of care













Section 3: Safe Handling Policy

SPH PROGRAM OBJECTIVES

SAMPLE:

What do you want your program to achieve?

- To increase quality of care
- To perform safe/comfortable mechanical Lifts/transfers for s
- To reduce the frequency of manual lifting/transferring and repositioning
- To reduce and prevent caregiver work-related injuries
- To reduce lost work time hours related to staff injury or fatigue

Section 3: Safe Patient Handling Policy

ROLES AND RESPONSIBILITIES: MANAGEMENT

Question:

What does your policy need to say about Management's responsibilities for you to achieve your objectives?

- Administration shall support implementation of this policy and promote a Culture of Safety

-

-

-

-

-



Section 3: Safe Patient Handling Policy

ROLES AND RESPONSIBILITIES: EMPLOYEES

Question:

What does your policy need to say about the Employee's responsibilities for you to achieve your objectives?

- Use approved mechanical lifting/transferring devices for transfers

-

-

-

-

-



Section 3: Safe Patient Handling Policy

ROLES AND RESPONSIBILITIES: SPH/ERGO TEAM

Question:

What does your policy need to say about your Team's responsibilities for you to achieve your objectives?

- The SPH/Ergo Team shall support implementation of this policy and promote a Culture of Safety

- ---
- ---
- ---
- ---
- ---



Section 3: Safe Patient Handling Policy

GOOD VS. BAD POLICY

GROUP ACTIVITY #1

Page 3 of Student Workbook Guide



Section 3: Safe Patient Handling Policy

SPH HANDLING POLICY: SAMPLE OUTLINE

Policy Objectives

Roles and Responsibilities

Protocols

- Assessment
- Care and Management
- Safety
- Infection Control
- Complications/Reportable Incidents

Compliance

Documentation

Procedures



Section 2:

Teams

- Team Meetings
- Team Structure



Section 2: Team Meetings

TASK VS. PROCESS

TASKS are the actions, decisions and discussions of the group.

PROCESS is *how* the work of the group is performed.



Section 2: Team Meetings

TASKS OF THE GROUP – EXAMPLES

- Preparing an agenda, identifying issues
- Discussing an issue
- Developing selection criteria & making decisions
- Determining a plan of action



Section 2: Team Meetings

GROUP PROCESS ACTIVITIES – EXAMPLES

- Listening and responding
- Methods for making decisions
- Group climate
- Meeting flow



Section 2: Team Meetings

GROUP PROCESS

PROCESS

ISSUES BLOCK

WORK ON TASKS



Section 2: Team Meetings – SPH Team Structure & Composition

How a Team (Committee) Is Structured Under NYS SPH Law

- Size of team variable
- Ratio of Labor to Management (equal)
- Minimum of one (1) non-managerial nurse and 1 direct care worker on SPH Team
- Two co-chairs: one (1) management and one (1) frontline worker or non-managerial nurse



Section 2: Team Meetings – SPH Team Structure & Composition

Do we have people in the Team who can accomplish the Team's tasks?

- The stakeholders needed to make SPH work
- Representatives of relevant groups (union, management, CFO, PTs/OTs, nurses, CNAs, et cetera)
- Different shifts/units



Section 2: Team Meetings – SPH Team Structure & Composition

Committee Meeting Schedule/Times:

- Regular intervals (bi-monthly/monthly)
- “As-Needed”
- “Emergency” basis
- During working time
- During non-working time
- Paid straight-hourly time



Section 2: Team Meetings – SPH Team Structure & Composition

Your SPH Team's Tasks:

- Set criteria for evaluations to determine what equipment is used
- Set criteria for performance of risk assessments of the environments/job tasks and needs
- Ensure equipment is set up, functioning
- Provide initial and on-going training
- Set up a process for incidence investigation
- Recommend equipment acquisition
- Minimally, a program assessment



Section 2: Team Meetings – SPH Team Structure & Composition

Minutes of Team Meetings:

- Designate someone to take/distribute minutes
- Document issues brought up
- A record of any agreements made at the meeting and actions/recommendations made
- Use as a measurement tool to gauge extent of implementation of Team's actions



Section 2: Team Meetings – SPH Team Structure & Composition

The Team's Authority:

- Advisory only?
- Independent authority?
- Reactive?
- Involved in planning?



Section 2

Setting the Stage for Productive Meetings

- Bad vs. Good Meetings
- Ground Rules
- Agendas
- Key Roles
- Practicing Committee Role and Skills



Section 2: Setting the Stage for Productive Meetings

GROUP ACTIVITY#2

Page 13 of Student Workbook Guide

BAD
MEETINGS

GOOD
MEETINGS



Section 2: Setting the Stage for Productive Meetings

ESTABLISHING GROUND RULES:

GROUP ACTIVITY #3

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- Importance
- Commitment
- Examples



Section 2: Setting the Stage for Productive Meetings

GUIDELINES FOR PITCHING A BETTER MEETING:

- **PLAN** the meeting
- **INFORM** the participants
- **TARGET** for a productive discussion
- **CONTAIN** the discussion
- **HASTEN** the completion of action steps



Section 2: Setting the Stage for Productive Meetings

USING AGENDAS EFFECTIVELY

- Location, date and time
- Purpose
- Attendees
- Topics in order of presentation/time
- Pre-meeting assignments
- Contact the presenters
- Distribute the agenda



Section 3:

Group Process Roles

- Group Roles
- Practicing Team Roles
- Group Development



Section 3: Group Process Roles

KEY ROLES IN EVERY MEETING

- Primary Facilitator
- Secondary Facilitators
- Timekeeper
- Recorder/Note-taker



Section 3: Group Process Roles

SPH TEAM'S PRIMARY FACILITATOR:

- Guides group process
- Allows each member to be heard
- Suggests processes
- Keeps group focused on task



Section 3: Group Process Roles

SPH TEAM'S SECONDARY FACILITATOR

Assists the Primary
Facilitator with keeping the
Team on task and helps
guide the group process



Section 3: Group Process Roles

SPH TEAM'S RECORDER/NOTE-TAKER

- Key ideas recorded
- Accuracy check
- Use flip charts



Section 3: Group Process Roles

SPH TEAM'S TIMEKEEPER:

- Monitors timeframe to accomplish agenda tasks
- Keeps time check and provides update



Section 3: Group Process Roles

SPH PARTICIPANT ROLE:

- Prep before the meeting
- Participate during the meeting
- Follow-up after the meeting



Section 4:

Methods of Group Decision-Making

- Decision by Authority
- Decision by Authority with Advice
- Decision by Minority
- Decision by Majority
- Decision by Consensus
- Decision by Unanimity
- Steps for Reaching Consensus
- Interest-Based Decision Making



Section 4: Methods of Group Decision-Making

WHAT DECISION-MAKING PROCESS CAN OUR SPH TEAM USE?

Levels of Group Involvement:

- Decision by Authority
- Decision by Authority w/
Advice



Section 4: Methods of Group Decision-Making

WHAT DECISION-MAKING PROCESS CAN OUR SPH TEAM USE?

Levels of Group Involvement:

- Decision by Minority
- Majority Rule



Section 4: Methods of Group Decision-Making

WHAT DECISION-MAKING PROCESS CAN OUR SPH TEAM USE?

Levels of Group Involvement:

- Decision by Consensus
- Decision by Unanimity



Section 4: Methods of Group Decision-Making

WHAT IS CONSENSUS DECISION-MAKING:

The consensus method encourages:

- Difference of opinion and treats them as important considerations
- Consideration of all aspects of a problem
- Consideration of all possible courses of action to solve it
- Giving each person an equal chance to influence the outcome



Section 4: Methods of Group Decision-Making

WHAT IS CONSENSUS DECISION-MAKING:

The consensus method encourages:

- Fully utilizing the information and experiences of each person on the Team
- Integration of many points of view into a common solution



Section 4: Methods of Group Decision-Making

EIGHT STEPS TO A CONSENSUS DECISION:

Step 1: Group agrees on decision to be made

Step 2: Everyone presents his/her view clearly and logically but without excessive advocacy

Step 3: All relevant info and evidence is reviewed, including minority opinion

Step 4: Possible decision alternatives or options are identified



Section 4: Methods of Group Decision-Making

EIGHT STEPS TO A CONSENSUS DECISION:

- Step 5:** Pros and cons of each alternative are examined
- Step 6:** Differences of opinion fully explored to try to resolve disagreements
- Step 7:** Group discussion leading to the selection of the most positive and least negative features
- Step 8:** Everyone agrees to endorse the final decision



Section 4: Methods of Group Decision-Making

GROUP ACTIVITY #4

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Prioritizing Items from the Latest Safety and Health Audit



Section 5:

Conflict Resolution Skills



Section 5: Conflict Resolution Skills

COLLABORATIVE CONFLICT RESOLUTION

Getting Beyond
Positions to
What People
Really Want



Section 5: Conflict Resolution Skills

CONFLICT RESOLUTION SKILLS: Getting Beyond Positions To What People Really Want

A vs. B

Issue
Position
Interest
Reframe
Options
Best
Solution/Agreement



Section 5: Conflict Resolution Skills

CONFLICT RESOLUTION SKILLS: Getting Beyond Positions To What People Really Want

A vs. B

Issue
Position
Interest
Reframe
Options
Best
Solution/Agreement



Section 5: Conflict Resolution Skills

CONFLICT RESOLUTION SKILLS: Getting Beyond Positions To What People Really Want

A vs. B

Issue
Position
Interest
Reframe
Options
Best
Solution/Agreement



Section 6:

Natural Stages of Group Development

- Forming
- Storming
- Norming
- Performing



Section 6: Natural Stages of Group Development

WHAT TO EXPECT WHEN TEAMS ARE FIRST FORMED:

- Unproductive at first
- Team members uncertain of roles
- Personalities may not mesh well
- Making decisions a struggle

HANG IN THERE!

**This Is Normal for All Groups –
Your Team Will Move On...**



Section 6: Natural Stages of Group Development

STAGES OF TEAM DEVELOPMENT:

- Forming
- Storming
- Norming
- Performing



Section 6: Natural Stages of Group Development

FORMING (“Infancy”):

Tasks:

- Learn group process
- Set ground rules
- Small decisions



Section 6: Natural Stages of Group Development

FORMING (“Infancy”):

Issues of Inclusion – Process:

- Heavy facilitation
- Member uncertainty
- Dependent
- Polite
- Powerless
- Resist change



Section 6: Natural Stages of Group Development

STORMING (“Adolescence”):

Tasks:

- Leader development
- Conflict
- Minor decisions
- Make changes



Section 6: Natural Stages of Group Development

NORMING – PERFORMING (“Adulthood”)

Tasks:

- Use ground rules
- Share leadership
- Reach understanding
- Major decisions
- Create change



Section 6: Natural Stages of Group Development

NORMING – PERFORMING (“Adulthood”)

Issues of Affection – Process:

- Use of group process skills
- Coaching
- Independent
- Test power
- Bonding



Section 6: Natural Stages of Group Development

YOUR ORGANIZATION'S CLIMATE FOR SPH TEAMS: Force Field Analysis

- Purpose
- Achieving Change



Section 7:

Overcoming Resistance to Change

- Forces for Changes
- Forces against Change
- Weakening the Forces against change



Section 7: Natural Stages of Group Development

YOUR ORGANIZATION'S CLIMATE FOR SPH TEAMS: Force Field Analysis

**NEW SPH POLICY & PRACTICES
FORCES FOR CHANGE**

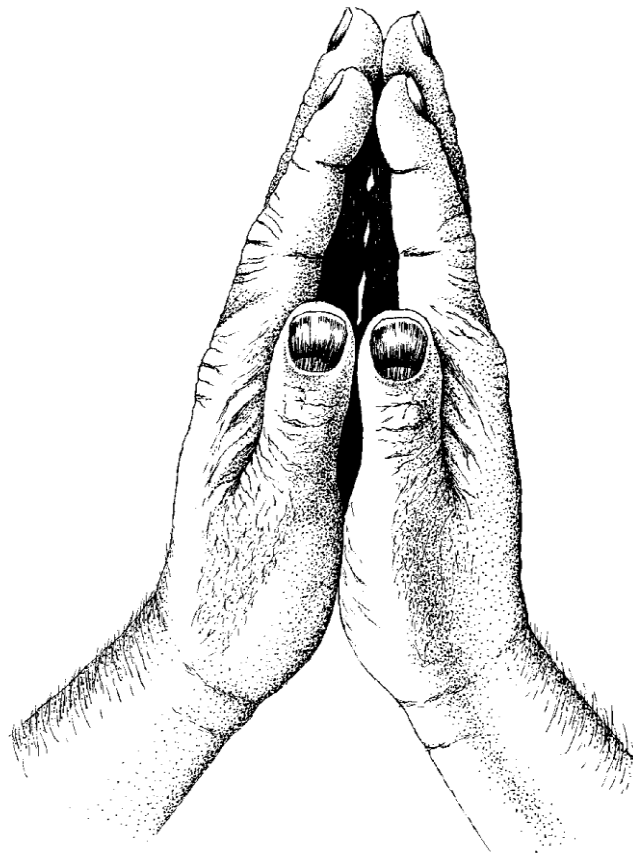
Vs.

**FORCES OF RESISTANCE
TO CHANGE**



Section 7: Natural Stages of Group Development

YOUR ORGANIZATION'S CLIMATE FOR SPH TEAMS: Force Field Analysis



Section 7: Natural Stages of Group Development

YOUR ORGANIZATION'S CLIMATE FOR SPH TEAMS: Force Field Analysis

FORCES FOR CHANGE	FORCES OF RESISTANCE
Safe Handling Policy and Practice	
Purchase of Equipment	<ul style="list-style-type: none">▪ Too Costly▪ Not Enough Staff▪ Not Assessable▪ Not Necessary▪ Et Cetera



Section 7: Natural Stages of Group Development

YOUR ORGANIZATION'S CLIMATE FOR SPH TEAMS: Force Field Analysis

FORCES FOR CHANGE	FORCES OF RESISTANCE
Safe Handling Policy and Practice	



Section 7:

Multiple Intelligences

GROUP ACTIVITY #5

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- Theory of Multiple Intelligence
- Which Way are YOU Smart?



Section 7: Multiple Intelligences

**DIFFERENT WAYS YOUR
TEAM MEMBERS ARE SMART**

The Theory of **MULTIPLE INTELLIGENCES**

As defined by
Howard Garner



Section 7: Multiple Intelligences

DIFFERENT WAYS YOUR TEAM MEMBERS ARE SMART

Word Smart

Picture Smart

Body Smart

People Smart

Music Smart

Number Smart

Nature Smart

Self Smart



Section 7: Multiple Intelligences

DIFFERENT WAYS YOUR TEAM MEMBERS ARE SMART



Nature Smart
(Naturalist)



People Smart
(Interpersonal)



Number Smart
(Logical/Mathematical)



Picture Smart
(Spatial/Visual)



Self Smart
(Intrapersonal)



Body Smart
(Bodily-Kinesthetic)



Music Smart
(Musical)



Word Smart
(Linguistic)

WHAT INTELLIGENCE DO YOU PREFER?



Section 7: Multiple Intelligences

DIFFERENT WAYS YOUR
TEAM MEMBERS ARE SMART

APPRECIATING OUR
DIFFERENCES



SPH Ergonomics Team Meeting Role Play

GROUP ACTIVITY #6

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Section 8:

SPH Evaluation, Competency, Evaluation and Monitoring

- Direct Care Worker and SPH Training
- Competency Evaluation
- Mentoring
- Evaluating
- Monitoring



Section 8: SPH Evaluation, Competency, Evaluation & Monitoring

OVERVIEW: STAFF TRAINING/MONITORING FORMAT

- 3-Hr Staff Competency Training
- By Unit in Groups of 15
- Initial Competency Evaluation
- Role of Preceptors/Evaluation
- Retraining



Section 8: SPH Evaluation, Competency, Evaluation & Monitoring

COMPETENCY TRAINING: 1 – 1 ½ HOUR CLASS

- Myths of “Safe Manual Handling”
- Body Mechanics /NIOSH Lift Formula
- Ergo Risk Factors (Pivot Transfer)
- Anatomy of an Injury
- SPH Philosophy Overview
- Assessments /Care Plans



Section 8: SPH Evaluation, Competency, Evaluation & Monitoring

COMPETENCY TRAINING: 2-HOUR HANDS-ON

- Sit-to-Stand Lifting/Slings
- Full Mechanical Lift/Slings
- Ceiling Lift/Slings (If Available)
- Slip Sheets
- Air Mats



Section 8: SPH Evaluation, Competency, Evaluation & Monitoring

MONITORING FOR COMPETENCY

- 3-Hour Competency Training Exam
- Preceptor Evaluation of Caregiver
- Annual Evaluation
- Don't Discipline – Coach. Retrain.



Section 8: SPH Evaluation, Competency, Evaluation & Monitoring

TRANSITION ONTO THE UNITS

- Schedule a day the equipment will be delivered on the floor
- Go Live! Announce to the unit that they are now a SPH facility
- SPH/Ergo Team holds a brief unit meeting
- Obtain consensus on Park & Charge Areas
- Label all equipment/slides
- Explain rotation system for slides
- Explain preceptor program/introduce
- SPH/Ergo Team members, Point Person, SPH coaches, super-users



Section 8: SPH Evaluation, Competency, Evaluation & Monitoring

MONITOR/LEAD/LEARN

- Lead/Coach by Example
- Observe/Discuss Mistakes
- Evaluate Performance
- Audits



Section 9

After Action Reviews

- After Action Review: Getting at the Root Causes
- The After Action Review Process
- Practicing on AAR



Section 9: After Action Reviews

AFTER ACTION REVIEWS

A means for caregivers to share information with co-workers and supervisors about:

- An injury that has occurred as a result of handling
- A near-miss incident
- Failure to follow policy
- Failure of equipment
- An unexpected positive outcome



Section 9: After Action Reviews

CONDUCTING AN AFTER ACTION REVIEW

- Honest exchange
- Informal and brief
- SPH Point Person may lead
- No finger-pointing: take a team approach
- Focus on adjusting the program to prevent future incidents



Section 9: After Action Reviews

THE AAR PROCESS

After Action Reviews Address:

- What happened?
- What was supposed to happen?
- What accounts for the difference?
- How to avoid a same future outcome?
- What's the follow-up plan?



Section 10: Organizational Needs Assessment

GAP ANALYSIS

GROUP ACTIVITY #7

Page 28 of Student Workbook Guide

Where We Are

Where We Want to Be

How We Get There



APPENDIX I-7

SAFE PATIENT HANDLING STUDENT WORKBOOK GUIDE



Session 3: (5 hours)

Safe Patient Handling Policy and SPH Ergonomics Teams (Committees)

This material was produced under grant number SH-24926-13 from the Occupational Safety and Health Administration, U.S. Department of Labor. It does not necessarily reflect the views or policies of the U.S. Department of Labor, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

SESSION 3

Participants will receive information on:

- The purpose of SPH policy and guidelines to write their facility policy
- SPH Ergonomics team-building (how to run a meeting, ensure inclusion of all participants, resolve conflicts and build consensus around the SPH program)

Participants will engage in exercises on:

- Reviewing a policy and critiquing it
- Running a mock meeting of the SPH Ergo Committee where they have to demonstrate to upper level management the need to implement and provide ongoing support for the SPH program
- A “a gap analysis” where participants evaluate where they are at with their SPH program vs. where they want to be/steps they need to take to make progress.

<u>Activities</u>	<u>Page #</u>
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GROUP ACTIVITY 1: Developing a Safe Patient/Resident Handling Policy

Purpose

All healthcare facilities that buy into a Safe Patient/Resident Handling program need to develop a written policy and procedures, protocols and guidelines for operating the program.

This activity will look at a “mock policy” that was developed by the (fictitious) “Sunrise Valley Nursing Home.” As a group, you are asked to review the policy and critique it.

TASK ONE

As the Safe Resident Handling/Ergonomics Team at “Sunrise Valley Nursing Home” you have taken on the responsibility to develop a Safe Resident Handling Policy.

Human Resources has given you a copy of Sunrise Valley’s current Back Injury Prevention and Safe Lifting Policy which, they contend, needs updating but is basically sound policy for preventing most caregiver and resident injuries.

Review: **1. Back Injury Prevention and Safe Lifting Policy** (pages 5 & 6)

Question: Is the current Sunrise Valley Nursing Home Back Injury Prevention and Safe Lifting Policy a “good” Safe Resident Handling policy document?

Working as a Team discuss some of the inadequacies of this policy document and list below:

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BACK INJURY PREVENTION AND SAFE LIFTING POLICY

Sunrise Valley Nursing Home

Purpose

This policy sets the expectations of sets the expectations of safe lifting practices and procedures to ensure a safe employee and resident environment. It is the expectation that employees will take reasonable care of their own health and safety as well as that of their co-workers and residents. All caregivers who are involved in lifting, transferring, repositioning or moving residents are responsible for using safe lifting techniques. Improper lifting techniques are the number one reason for nursing home injuries and missed workdays at our facility.

Policy

To equip caregivers for safety success at work, the following shall happen:

- The Back Injury Prevention and Safe Lifting Program shall serve as policy for all employees.
- Training shall occur during new hire orientation and renewed annually.
- Additional resources shall be made available throughout the year from the safety officer and management.

Procedures

The following are the basic steps of safe lifting:

- Stretch for safe lifting at the beginning of each scheduled shift.
- Assess each resident you have to lift, transfer, reposition or move to anticipate the risks involved.
- If you have assessed that the resident is too heavy or unstable, use a team lift or a mechanical lift if necessary.
- Always employ body mechanics to facilitate a safe lift.*

Compliance

It is the responsibility of all caregivers to protect their own health and safety and that of their co-workers and residents. Non-compliance will result in the following progressive discipline process:

- *First offense* of unsafe lifting practices will result in verbal warning and remedial training by a supervisor.
- *Second offense* will result in a written warning and remedial training with the safety officer and a probation period will be 90 days.

- *Third offense* will result in final warning and remedial training with a probationary period of 1 year.
- *Fourth offense* will normally result in disciplinary action up to and including termination.

Employees are required to report all injuries to the supervisor on duty. The supervisor will complete an Incident Report at work with Human Resources to complete and submit. Human Resources will maintain public reports, statistics, and follow up with employees and insurance carriers. The Safety Officer and Human Resources will hold accountable any employee who fails to report an injury in a timely manner.

*Use the following steps for safe resident lifting:

- Take a wide stance with your legs
- Maintain neutral spine alignment
- Tighten your core muscles to protect your back
- Squat bending at your knees
- Hold the resident firmly and close to the body when doing pivot and other transfers
- Lift smoothly and evenly with your legs, not your back
- Look straight up and ahead to maintain spine alignment
- Stabilize the resident prior to moving

This policy was developed by the Administration's Safety Committee, Safety Officer and Human Resources. July 17, 2004.

TASK TWO

The Policy document you reviewed in Task One is clearly inadequate as a guide for implementing and sustaining a good Safe Resident Handling Program.

Your task now, as a Team, is to recommend a Policy to “Sunshine Valley Nursing Home” management and staff some key points that should be included in a good Safe Resident Handling Policy.

Review: **2. Safe Patient/Resident Policy Check List.** (*p. 8*)

Review: **3. Safe Patient/Resident Handling Policy (Sample Outline)** (*pages 9-12*)

Question: Briefly state some of the things that you would change or add to the Sunshine Valley policy to make it good Safe Patient/Resident Handling policy.

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SAFE PATIENT/RESIDENT HANDLING POLICY CHECKLIST

To have an effective *Safe Patient/Resident Handling Program*, it is important that your policy (and guidelines, protocols and procedures) had input from stakeholders throughout your facility and key provisions for implementing and sustaining your program. The policy checklist (below) are some of the provisions that should be considered when developing a SPH policy.

- [] Policy has been developed and written with multi-disciplinary input.
- [] Policy has been updated.
- [] Policy is a Safe Patient/Resident Handling program with SPH training vs. a “Body Mechanics” training program.
- [] Policy states key job titles (frontline workers, administration, nurse managers, infection control, etc.) and departments that need to be involved in carrying out the SPH program.
- [] Policy includes tools for assessing patient/residents upon entering the facility, periodic reassessment timely reassessment when there’s a change in the patient/resident’s capabilities.
- [] Policy has a requirement for documenting the capability of each patient/resident with a clear statement in the patient/resident’s care plan indicating the mechanical equipment/device to be used by the caregiver for lifting/transferring/repositioning or moving the patient/resident.
- [] Policy states the roles and responsibilities for the Administration, Frontline Workers, Safe Patient Handling/Ergonomics Team and others in carrying out the SPH program.
- [] Policy states staff compliance requirements and a procedure for compliance evaluation.
- [] Policy is non-retaliatory with respect to a caregiver who raises concerns that complying with some aspect of the SPH program could endanger the caregiver or the patient/resident.
- [] Policy includes written procedures for the proper use of equipment and assistive devices including Full Mechanical Lift, Sit/Stand Lift, Gait Belt, Non-Friction Device, Ceiling Lift, and Air Matt.
- [] Policy has a requirement that all caregivers demonstrate hands-on competency in proper use of equipment and assistive devices.

3. SAFE PATIENT/RESIDENT HANDLING POLICY (*Sample Outline*)

Policy Objectives

Safe Patient/Resident Handling Program Objectives

- To increase patient/resident quality of care.
- To perform safe/comfortable mechanical lifts and/or transfers for patient/residents.
- To reduce the frequency of manual lifting, transferring, and repositioning.
- To reduce and prevent caregiver work-related injuries.
- To reduce lost work time hrs. related to staff injury or fatigue.

Roles and Responsibilities

Employees

- Use lifts/transfer devices/methods for all patient and resident lifts/transfers.
- Licensed professionals assess patient/resident and determine appropriate lift/transfer method.
- Unlicensed assistive staff can lift/transfer patient/resident after assessment is completed/documented
- SRH competency training required for all staff involved in patient/resident lifts/transfers.
- Report employee/patient/resident injuries to 'EE Health.

Management

- Support implementation of SRH policy and promote a *Culture of Safety*.
- Furnish sufficient lifting equipment/devices
- Make equipment accessible & maintain it.
- Ensure sufficient staffing to use SRH method.
- Ensure patient/resident assessment/documentation.
- Ensure staff compliance with SRH policy.
- Ensure staff competency requirements met.
- Ensure reporting of accidents/injuries.

SPH/Ergo Team

- Lead implementation of SRH policy/promote Culture of Safety

- Assess injury data, equipment, and facility environment to determine SRH needs.
- Oversee equipment selection
- Set criteria for evaluating patient/residents
- Ensure staff competency training/retraining/evaluation
- Transition program onto the units.
- Oversee program audits/evaluation
- Review incidents/AAR

Protocols

Guidelines we can use to ensure good:

- Patient/Resident Assessment
- Care and Management
- Safety
- Infection Control
- Complications & Reportable Incidents
- Compliance

Patient/Resident Assessment Protocol

A Licensed Professional shall:

- Complete patient/resident assessment
 - Upon admission
 - When there is a change in patient/resident status
 - On a quarterly basis (reassessment)
- Use Lift/Transfer Assessment Tool
- Document Patient/Resident Lift/Transfer (Patient/Resident Care Plan)

A Direct Caregiver shall:

- Consider his/her own ability, the environment and patient/resident's status prior to any lift/transfer
- If no change in status
 - Follow care plan lift/transfer recommendation
- If change in status
 - Notify a licensed professional
 - Use new level of transfer if recommended

Refer to the Decision Tree when changing patient/resident lift status

Full Mechanical Assist	Dependent
Sit/Stand Mechanical Assist	Extensive Assistance
Transfer/Gait Belt	Supervision/Limited Assistance
No lift Equipment	Independent

Care and Management Protocol

Patient/Resident

- Perform patient/resident transfer as documented in Care Plan

Lift/Transfer Equipment

- Park all mechanical lifts in designated areas
- Plug in lifts for recharging when not in use

Slings

- Place all soiled slings in designated laundry bag/hamper.

Infection Control Protocol

- Use barrier between patient/resident's skin and sling
- Spot- clean slings with minor soilage (use approved disinfectant wipes)
- Use single dedicated sling for a patient/resident with communicable illness/M.R organism
- Launder dedicated sling after discontinuation or discharge
- Wipe down framework/hardware prior to use on another patient/resident
-

Safety Protocol

- Assess all equipment prior to use.
 - Note Integrity and function
 - Remove, tag any broken equipment
 - Report any non-functioning equipment
- Inspect slings
 - Note signs of wear and tear

- Remove damaged slings and tag
- Return to unit manager
- Non-friction device: don't leave under patient/resident after transfer

Infection Control Protocol

- Use barrier between patient/resident's skin and sling
- Spot- clean slings with minor soilage (use approved disinfectant wipes)
- Use single dedicated sling for a patient/resident with communicable illness/M.R organism
- Launder dedicated sling after discontinuation or discharge
- Wipe down framework/hardware prior to use on another patient/resident

Complications and Reportable Incidents Protocol

- Report all damaged slings to nurse manager/supervisor
- Report all employee injuries to Employees Health; do an incident report
- Report patient/resident injury during lift/transfer to unit manager/physician
- Report all of the above to SRH Point Person(s)

Compliance

- Ensuring staff participation, understanding the SRH program, and staff communication with SRH Resource/Point Person are forms of compliance.
- Daily compliance with the program is the responsibility of each staff member.
- Adhering to the SRH policies and procedures is mandatory for all staff
- SRH Resource/Point Person will facilitate After-Action Reviews to continually adjust the SRH program.
- Each unit/floor's manager shall provide compliance reports using the Compliance Audit Tool
- The employer shall not take retaliatory action against any nurse or caregiver for raising concerns or issues regarding safe patient/resident handling, filing a complaint or refusing to engage in patient/resident handling

Documentation and Competency

Lift Transfer Competency (is your staff able to:)

- Identified transfer/lift status
- Identified sling/harness
- Identified size when indicated
- Any special transfer/lift needs

GROUP ACTIVITY 2: Bad vs. Good Meetings

Purpose

Your Safe Patient/Resident Handling Ergonomics Team has a key leadership role to play in making your SPH program a success. It has a number of **tasks** to accomplish such as recommending the purchase of patient lifting equipment, setting up a training program, etc.

Your Team will have to meet frequently to figure out how to carry out these tasks. It is important to have productive meetings where everyone feels that things are getting accomplished. Too often, however, tasks don't get accomplished because groups don't have a good **process** for getting things done. Group members complain, for example, that "Nothing is getting accomplished," "Everyone is talking at the same time," etc.

This activity is an opportunity for your Team to share your experiences about what **bad meetings** you have participated in vs. **good meetings** you have participated in and to begin to think about the lessons learned.

TASK

Your task as a group is to answer two questions:

Question 1: What is the worst meeting you have ever participated in and the reasons why and what is the best meeting you have ever participated in and why?

Question 2: What are the lessons learned and how can they be applied to the future meetings of your SPH/Ergonomics Team?

Worst Meeting	Best Meeting
<ul style="list-style-type: none">••••••	

Lessons Learned

-
-
-

GROUP ACTIVITY 3: Productive Meetings

Purpose

There are things that your Team can do to ensure that your meetings are productive—carry out **tasks**-- by having a good **process** for planning and running your meetings.

This activity will give your group an opportunity to practice some tips for having productive meetings.

TASK 1

One reason that meetings become unproductive is that there aren't clear ground rules for the group. One of the first things you will want to do when you set up your Team, is for the facilitator of the meeting to ask the members of the group what ground rules everyone should follow. An obvious ground rule is "That only one person should speak at a time." As a group, discuss the issue of ground rules for your meeting.

Question: What benefits would your Team meeting gain from setting ground rules?

Question: What are some ground rules that you would suggest for Team meetings here?

TASK TWO

Your Team meetings will be more productive if everyone knows *when*, *where*, and *why* the meeting has been called and what the *desired outcome* of the meeting will be. Your agenda should contain this information—it sets the stage for a good meeting.

Review: **Information sheets 1. through 5.** (*on the next 5 pages*)

Using the “blank” agenda below, choose a facilitator, recorder and timekeeper from your group (write in their names).

Assume that this is the first meeting of your Team and that the purpose of the session is to determine what decision-making method your Team will use (see: **5. Models for Group Decision-Making**). Use this meeting to discuss as a group the “pros” and “cons” of each method and attempt to agree, as a group, on the method you will use.

SAFE PATIENT/RESIDENT HANDLING TEAM MEETING AGENDA

Date: _____ **Primary Facilitator:** _____

Time: _____ **Recorder:** _____

Location: _____ **Timekeeper:** _____

Purpose of Session:

Desired Outcomes:

Time:	Topic:	Person initiating or reporting on topics:
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1. CHECKLIST FOR HAVING PRODUCTIVE MEETINGS

- Develop a Good Agenda
- Identify Key Group Process Roles
- Establish Ground Rules
- Identify Method of Group Decision Making
- Understand Conflict Resolution Skills

2. GUIDELINES FOR DEVELOPING A GOOD AGENDA

- Specify the date, place, starting time and ending time.
- Provide a statement of the overall mission or purpose of the meeting.
- Identify who will attend.
- List the topics to be covered, in the sequence they will be covered.
- Identify the approximate time you will devote to each topic.
- Identify the pre-meeting reading or assignment expected of each member.
- Distribute the agenda to each group member at least one week before the meeting.

3. ESTABLISH GROUND RULES FOR THE MEETING

- Meeting begins on time/ends on time
- Respect for other participants
- One person speaks at a time
- No sidebar conversations
- Allow others to speak—don't dominate meeting
- Be honest
- Keep track of time to move through agenda

4. GROUP PROCESS ROLES

When you hold your SPH Team meeting, assigning responsibilities to certain members to keep the meeting running smoothly is important. The key roles for managing the meeting include ***facilitator(s)***, ***timekeeper***, and ***recorder***.

Meeting Facilitator(s).

A meeting facilitator's role is to review the agenda and main purpose of the meeting and desired outcomes (and ask the group if there's consensus on this), ask members to state the meeting guidelines, tactfully keep the meeting on task, and help the group find agreement or consensus on how its going to accomplish the tasks before it.

Note: If your Team adopts the model of leadership that's in New York State's SPH legislation: a chair from Non-Managerial Frontline Workers and a chair from Management, may serve as your group's facilitators—perhaps they could trade off from one meeting to the next (they can also designate others to facilitate).

Timekeeper.

One of the members of your Team should serve as a timekeeper. The timekeeper helps the group stick to the agenda by providing guidance on how much time is passing.

Recorder.

The recorder performs the valuable task of writing down decisions and action item assignments. This is best done on a flip chart in full view of the group—any errors or clarifications can be handled immediately. It also helps members whose mind may wander to “rejoin” the meeting without missing the important stuff. The flip chart items become your group's minutes. Also, if a new issue surfaces that's off-topic, it can be placed on the flipchart “parking lot” for a future meeting. Finally, as the meeting winds down, items for the next meeting's agenda can be recorded.

Participants.

The other Team members who don't have *specific* responsibilities for running the meeting, can still “make or break” the meeting. All Team participants should know what's on the agenda beforehand and have done any homework assignments. During the meeting they should follow the *ground rules*, be open minded, stay on topic, listen and participate. After the meeting they should participate in evaluating the meeting, brief others as appropriate, and complete any assigned action items.

5. MODELS FOR GROUP DECISION-MAKING

Decision by Authority: The chairperson or other authority listens to the discussion and then decides on what action to take (sometimes with advice from others in the group). *Upside:* Gets things done. *Downside:* members of the group lose interest—feel their participation doesn't count.

Decision by Minority: A minority of members (usually the most influential) listen to the discussion and then decide for the whole group. *Upside:* Gets things done. *Downside:* members of the group feel the group is run by a clique and lose interest.

Decision by Majority: The members who have participated in the discussion take a vote on a course of action—the majority “wins.” *Upside:* It brings an end to discussion and gets things done. *Downside:* There are “losers”—those in the minority who may dislike or resent the majority decision.

Decision by Consensus: All of the members are encouraged to fully participate in the discussion. Discussion of all differences of opinion is encouraged. The participants agree to work toward finding common ground on a course of action, setting aside options on which there's strong differences of opinion. Everyone agrees to the final decision (for those who can't agree, they are willing to “step aside” and allow the decision). *Upside:* It fully uses the information and experiences of each person in the group. Everyone feels affirmed that their opinion matters—there aren't winners and losers. *Downside:* This model can take more time and patience than the other models.

TASK

TASK versus PROCESS

Obstacles (the “worst” meetings) (some examples)	Core skill
<ul style="list-style-type: none">• Meetings don’t begin on time.• Meetings drag on forever.• People are rude and talk at the same time or hold sidebar conversations.	<ul style="list-style-type: none">• Establishing ground rules.
<ul style="list-style-type: none">• Team members forget to prepare for the meeting.• One topic dominates the meeting and no other business gets done.	<ul style="list-style-type: none">• Developing an agenda.• Group process roles.
<ul style="list-style-type: none">• One or two people dominate the meeting; others don’t get a chance to speak.• The team can’t seem to make decisions.	<ul style="list-style-type: none">• Establishing ground rules.• Group process roles.• Methods of group decision making.
<ul style="list-style-type: none">• The team votes on issues, but those in the minority are unhappy, disgruntled, or sabotage the winning decision/action.• Team members can take such strong stands on issues that nothing ever gets resolved upon; no one will compromise.• Team members won’t say what they really feel.• Quiet team members feel pressured to go along.• Meetings become unproductive complaint sessions and nothing ever gets done. Members resign over the frustration.	<ul style="list-style-type: none">• Methods of group decision-making.• Conflict-resolution skills.• Natural stages of group development.

GROUP ACTIVITY 4. Team Collaboration—“wisdom of the group”

Purpose

The purpose of this activity is to demonstrate the “wisdom of the group” and the power of collaboration—building consensus through discussion--vs. the individual acting alone.

TASK

The exercise (**2. Consensus Exercise: Items from the Latest Safety and Health Audit**) shows how your Team working together can come up with better solutions than when each of you is acting alone.

Review: **1. Eight Steps to a Consensus Decision** (*page 26*)

Review: **2. Consensus Exercise: Items from the Latest Safety and Health Audit** (*page 27*)

Instructions:

First, each of you working on your own rank items A—G on your own.

Then, working as a group, come up with a Team ranking of the problem.

Finally, after your Team has come up with a solution, compare your answers with the “expert” ranking of the problem (see back of page).

1. EIGHT STEPS TO A CONSENSUS DECISION

There are different ways groups can make decisions. One person rule is an **authoritarian** approach. Rule of a small group within the larger group is a **minority control** approach. **Majority rule** occurs when a vote is taken and the majority “wins.” Perhaps the best approach for your Safe Patient Handling Team is to use a **consensus** approach—you discuss and debate an issue until the Team as a whole finds an acceptable solution (even if not everyone is happy with the decision, the important thing is that they are willing to live with it). Below is a step by step process for **consensus decision making**.

- Step 1:** Group agrees on decision to be made
- Step 2:** Everyone presents his/her view clearly and logically but without excessive advocacy
- Step 3:** All relevant information and evidence is reviewed, including minority opinion
- Step 4:** Possible decision alternatives or options are identified
- Step 5:** Pros and cons of each alternative or options are identified
- Step 6:** Differences of opinion are fully explored to try to resolve disagreements
- Step 7:** Group discussion leading to the selection of the most positive and least negative features
- Step 8:** Everyone agrees to endorse the final decision

2. CONSENSUS EXERCISE: ITEMS FROM THE LATEST SAFETY AND HEALTH AUDIT

Rank these items from **highest** hazard to **lowest** hazard.

- A. Karen continues to ambulate Stan, who needs two people to assist him.
- B. Betty keeps all her important files in the bottom drawer.
- C. In the clean supply room, items for bathing are kept on a shelf at the eye level of Sue who is 5' 8".
- D. Dave experienced a muscle spasm when pulling his patient/resident up in bed. The bed was against the wall.
- E. Two-assist pivot transfers are still performed on a daily basis.
- F. A patient/resident that was on the floor was manually lifted back into his chair.
- G. John refuses to move any furniture in his room and is dependent upon care.

Your ranking	Group ranking	Expert ranking
1.		
2.		
3.		
4.		
5.		
6.		
7.		

(Expert Ranking: 1-F; 2-A; 3-E, 4-D; 5-G; 6-C; 7-B)

GROUP ACTIVITY 5: Multiple Intelligences and the Group

Purpose

It is important to recognize that members of a group (or your Team) can be very different from one another. Members of your group learn, process information, and are “smart” in different ways. A member who may “nod out” during a presentation of statistical information may “come alive” when the same information is presented graphically.

This activity is an opportunity for the members of your group to better understand each other and respect each others differences. And to appreciate that these differences can contribute to the success of the group.

TASK

Your group's task is to understand "Multiple Intelligences."

Review: **1. Different Ways Members of Your Team are Smart** (page 30)

2. Learner Types and Multiple Intelligences (page 31)

Question: * First, choose the intelligence type you most strongly identify with.
Explain to the group why you choose this learning and communicating style best fits you.

Second, identify and explain your second choice.

Finally, identify the intelligence type you most dislike and explain why.

☐ **WORD SMART**

☐ **PICTURE SMART**

☐ **BODY SMART**

☐ **PEOPLE SMART**

☐ **MUSIC SMART**

☐ **NUMBER SMART**

☐ **NATURE SMART**

☐ **SELF SMART**

- **NOTE:** These "Learner Types" may also be posted on sheets of paper on the wall and members of the group can answer the 3 questions by standing by the learner types which they like and/or dislike.

1. DIFFERENT WAYS MEMBERS OF YOUR GROUP ARE SMART

- **WORD SMART** Likes to reads, writes, tells stories. Learns through saying, hearing and seeing words.
- **PICTURE SMART** Likes to draw, build, design, create things. Learns through visualizing, dreaming, working with pictures and colors.
- **BODY SMART** Likes to move around, touch and talk, use body language. Learns through touching, moving, interacting with space, processing knowledge through bodily sensations.
- **PEOPLE SMART** Likes to have friends, talk to people, join groups. Learns through sharing, comparing, relating, cooperating, interviewing.
- **MUSIC SMART** Likes to sing, listen to music, play music, respond to music. Learns through rhythm, melody, and music.
- **NUMBER SMART** Likes to do experiments, figure things out, work with Numbers. Learns through categorizing, classifying, working abstract patterns and relationships.
- **NATURE SMART** Likes to work with animals, garden, take nature walks/hikes. Learns through natural phenomena or events and nature sounds.
- **SELF SMART** Likes to work alone, pursue own interests, and have own Space. Learns through working alone, individualized projects, self-paced instruction.

2. LEARNER TYPES AND THE MULTIPLE INTELLIGENCES

Learner Type	Likes To	Is Good At	Learns Best By
Musical “The Music Lover” (music smart)	<ul style="list-style-type: none"> • sing, hum • listen to music • play an instrument • respond to music 	<ul style="list-style-type: none"> • picking up sounds • remembering melodies • noticing pitch/rhythm • keeping time 	<ul style="list-style-type: none"> • rhythm • melody • music
Interpersonal “The Socializer” (people smart)	<ul style="list-style-type: none"> • have lots of friends • talk to people • join groups 	<ul style="list-style-type: none"> • understanding people • organizing • communicating • persuading • mediating 	<ul style="list-style-type: none"> • sharing • comparing • relating • cooperating • interviewing
Spatial/Visual “The Visualizer” (picture smart)	<ul style="list-style-type: none"> • draw, build, design and create things • daydream • look at slides/pictures/ movies • play w/machines 	<ul style="list-style-type: none"> • imagining things • sensing things • mazes/puzzles • reading maps and charts 	<ul style="list-style-type: none"> • visualizing • dreaming • using the mind’s eye • working with colors and pictures
Kinesthetic “The Mover” (body smart)	<ul style="list-style-type: none"> • move around • touch and talk • use body language 	<ul style="list-style-type: none"> • physical activities (sports/dance/ acting) • crafts 	<ul style="list-style-type: none"> • touching • moving • interacting with space • processing knowledge through bodily sensations
Intrapersonal “The Individual” (self-smart)	<ul style="list-style-type: none"> • work alone • pursue own interests • have own space 	<ul style="list-style-type: none"> • understanding self • focusing in on feelings and dreams 	<ul style="list-style-type: none"> • working alone • individualized projects • self-paced instruction
Logical/ Mathematical “The Questioner” (number smart)	<ul style="list-style-type: none"> • do experiments • figure things out • work with 	<ul style="list-style-type: none"> • math • reasoning • logic • problem solving 	<ul style="list-style-type: none"> • categorizing • classifying • working with abstract patterns and relationships
Linguistic “The Word Player” (word smart)	<ul style="list-style-type: none"> • read • write • tell stories 	<ul style="list-style-type: none"> • memorizing names, places, dates and trivia 	<ul style="list-style-type: none"> • saying, hearing, and seeing words
Naturalist “The Nature Lover” (nature smart)	<ul style="list-style-type: none"> • work with animals • garden • nature walks or hiking 	<ul style="list-style-type: none"> • working with animals • “green thumb” 	<ul style="list-style-type: none"> • relating to natural phenomena or occurrences • nature sounds

GROUP ACTIVITY 6: SPH Ergonomic Team Meeting Role Play

This “mock” SPH/Ergonomics Team meeting is an opportunity to “act out” the consensus method of problem-solving to address a SPH program issue in which there is conflict.

TASK

Scenario: Your SPH/Ergonomics Team has been convened for the purpose of addressing a recommendation from the facility Head Nurse to purchase additional equipment as part of your Safe Patient Handling program. Your Chief Financial Officer and Human Relations Manager agree with only some of the recommendations. As a Team, it's your task to work through the differences and, using the *Consensus Model of Decision-Making*, to find a course of action that you can all agree on.

Members of your Team are asked to take on the following roles:

- 2 Co-Chairs (one manager and one frontline worker)—1 will act as facilitator
- 1 Timekeeper
- 1 Recorder (using flip chart)
- 1 Physical Therapist
- 1 Head Nurse
- 1 Certified Nurse Assistant
- 1 Union Representative
- 1 Human Relations Manager
- 1 Chief Financial Officer

The chair will convene the meeting and review the agenda and as a Team you will review the memos from the Physical Therapist, Head Nurse, and the HR Manager and CFO.

Review: **1. SPH/Ergonomics Committee Meeting Agenda** (page 34)

Review: **2—4. Memos** (pages 35-37)

Review: **5. The Risks of the Pivot Transfer** (page 38)

Review: **6. Sit-to-Stand Lifts: An Alternative to the Pivot Transfer** (page 39)

Review: **7. Equipment Per Patient/Resident of Need Guide: How Much Equipment Do We Need?** (page 40)

Review: **8. The Consensus Approach to Group Decision-Making** (page 41)

1. **SRH/ERGONOMICS COMMITTEE AGENDA**

AGENDA

Purpose: to discuss SPH equipment issue.

- 1) Memo from Physical Therapy
- 2) Memo from Head Nurse
- 3) Memo from HR/CFO
- 4) Action steps

2. MEMO FROM PHYSICAL THERAPY RE. PATIENT/RESIDENT CENSUS

MEMO

From: Physical Therapy
To: CFO, HR and Head Nurse
Re: Review of Care Plans for our 126 patient/residents
Date: 2/25/13

Total Dependence patient/residents—Unit One: 16; Unit Two: 18; Unit Three: 19
Extensive Assistance patient/residents—Unit One: 17; Unit Two: 16; Unit Three: 18

3. MEMO FROM HEAD NURSE RE. PROPOSED EQUIPMENT

MEMO

From: Head Nurse

To: CFO/HR

Re: Safe Patient Program

Date: 2/26/13

Currently our facility has 1 Full Mechanical Lift and 1 Sit/Stand Lift on each of our three units.

Based on PT's patient/resident assessment of each unit, I recommend that we purchase 1 additional Full Mechanical Lift for each unit (total of 3) and a Sit/Stand Lift for each unit (total 3).

This will give us 2 additional mechanical lifts per unit which conforms to the recommendation of the Veterans Administration Safety Research Center's guidelines.

Also, a CNA on Unit 3 recently sustained a serious back injury and has been out on Disability for over 1 ½ months costing our self-insured facility over \$20,000 per date.

4. MEMO FROM HR MANAGER/CFO RE. SPH EQUIPMENT

MEMO

From: CFO/HR

To: SPH Team

Re: Proposal for new Mechanical Lifts

As per recommendation that our facility purchase 6 additional mechanical lifts. We agree that the purchase of 3 additional Full Mechanical Lifts for our Total Dependence patient/residents is advisable. We do not agree to purchasing 3 additional Sit/Stand Lifts for our Extensive Assistance patient/residents. Our current 3 Sit/Stand Lifts are adequate given that many of the our Extensive Assistance patient/residents can be safely transferred using Gait Belts and pivot transfers and proper body mechanics. We cannot justify the purchase of S/S Lifts financially

5. THE RISKS OF THE PIVOT TRANSFER

The Pivot Transfer is not advisable for most patient/residents.

According to Paula Pless, Kaleida Health's Safe Patient Handling director in Buffalo, NY and an authority on Safe Patient Handling programs:

*"In a true and safe pivot transfer, the patient/resident can take at least one step, unweight at least one foot during the pivot and move toward the desired target. **Only a small number of patient/residents fit this category.** Before doing a pivot transfer, an assessment should be done to determine if the patient/resident can move her feet on all surfaces and to all surfaces. The ability to move her feet should be done over a 24-hour period."*

Risks of the Pivot Transfer to the health care worker.

"The transfer tends to be used repeatedly on a patient/resident—up to 16 times in a 24 hour period. The patient/resident's weight bearing ability to assist with the lift can change over this period of time. The patient/resident may be unable to adequately assist with the transfer. She becomes an unstable excessive load. This instability can be transferred to the caregiver who is at risk of injury. The risk of injury increases with a patient/resident who has partial weight bearing capacity and is pivoting in a confined space environment."

Risks of the Pivot Transfer to the Patient/Resident.

*"A pivot transfer is frequently traumatic for the patient/resident. Arthritis and degenerative joint disease is exacerbated in shoulders that are used as leverage when performing the pivot. **After 90 days of use the vast majority of patient/residents experience injuries or joint deterioration.**"*

Is a Two-Caregiver assist safer?

"A 2-person lift is not a true pivot transfer. It is a manual lift that exceeds the load limit whether done with one or two caregivers. . . .If one person can't do this lift and transfer, a mechanical lift should be used."

Source: Paula Pless. "A Close Look at the Pivot Transfer." Caring for the Ages. December, 2005.

6. SIT-TO-STAND LIFTS: AN ALTERNATIVE TO PIVOT TRANSFERS

The Sit to Stand Lift.

“Sit/Stand patient transfer is an alternative to the pivot transfer that allows patients to bear weight while it facilitates safe and proper joint alignment and increases protection and comfort.

“The properly assessed candidate can experience an improved quality of life and increased safety. They are afforded the opportunity to be repositioned safely and more frequently, placing less burden on the caregiver’s back, and can bear weight safely and for longer periods of time. Patients that were traditionally pivoted from one place to another—for example, from a wheelchair to a stable chair in a dining room or from a wheelchair to a toilet—can be transferred properly with the sit/stand lift.

Source: Paula Pless. 2005.

But are they affordable?

A Sit-to-Stand Lift will cost in the \$3,100--\$3,500 range. Compare that to the cost of a one-month a worker who is out on an injury and receiving workers’ compensation—the increased costs in insurance premium, the costs of replacing the injured worker and other indirect expenses—well over \$20,000.

Source: NYS Zero Lift Task Force

Sit/Stand lifts benefit workers and management.

In a National Institute of Occupational Safety & Health study, nine facilities invested in lifting equipment. **Incidence of injuries were reduced by 60%--90%. Workers’ compensation costs by 95%. Insurance premiums by as much as 50%. Lost workdays by as much as 100%. Absenteeism by 98%** (absence related to unreported injury).

Source: Audrey Nelson, Ed. Safe Patient Handling and Movement. 2006

7. EQUIPMENT PER PATIENT/RESIDENT OF NEED GUIDE: How much Equipment do we need?

Equipment type	Amount of equipment recommended
Floor lifts or full mechanical lifts	1 per 8 patient/residents of need on that unit
Sit to stand lifts	1 per 8 patient/residents of need on that unit
Gait belts with handles	1 per patient/resident of need, hands on assistants will require a gait belt
Non friction sheets & non friction devices, Slipp Sheet, Phil-E-slide, Maxi-Slide & Surehands products	1 per 8-10 patient/residents of need <i>(used for lateral transfers, repositioning; reducing friction decreases the load and resistance)</i>
Hover Mat & Air Assisted devices	Look at what your need is and where you would use them
Ceiling Lifts & ceiling track systems	<i>Truly Zero-Lift; especially useful with fully dependent patient/residents. Useful in tub rooms, therapy gyms, patient care areas, and rooms with specialty care like bariatric.</i>
Hygiene slings Universal slings Quick fit slings Hammock slings Sit-to-Stand slings Amputee slings Positioning slings Mesh slings Padded slings Full Body slings Bathing slings	Slings needs should be determined by patient/resident case load and needs
Electric control beds - (avoid awkward postures)	1 per patient/resident Beds have various sizes, styles, and functions. Bariatric beds have heavy reinforced hardware and framing.

Note: The equipment to patient/resident ratio in these slides is used at Kaleida Health in Western New York at 9 hospitals and nursing homes. Their program resulted in an 80% reduction in patient/patient/resident related handling injuries. This chart is a good guide for determining the amount of equipment your Safe Patient/resident Handling/Ergo Team will want to recommend for your facility. The way caregivers organize their work assignments should be carefully considered when determining the quantity purchased. Patient/resident lifting tasks are not evenly distributed throughout a 24-hr. period. Typically, there are peak periods where staff is competing for lifting devices. If your facility plans to eliminate manual lifting, a commitment to purchasing sufficient quantities of equipment will make this feasible.

8. EIGHT STEPS TO A CONSENSUS DECISION

- Step 1:** **Group agrees on decision to be made**
- Step 2:** **Everyone presents his/her view clearly and logically but without excessive advocacy**
- Step 3:** **All relevant information and evidence is reviewed, including minority opinion**
- Step 4:** **Possible decision alternatives or options are identified**
- Step 5:** **Pros and cons of each alternative or options are identified**
- Step 6:** **Differences of opinion are fully explored to try to resolve disagreements**
- Step 7:** **Group discussion leading to the selection of the most positive and least negative features**
- Step 8:** **Everyone agrees to endorse the final decision**

GROUP ACTIVITY 7. “Gap Analysis”

Purpose

This activity will help your Team to think about how far along you are with your Safe Patient Handling program. Where you want to be. And to think about how you will get there.

TASK

A “gap analysis” is, first, a means for looking at your **current** Safe Patient Handling program. You can look, for example, whether there is money in your facility’s budget for equipment purchases—this is one component for a successful program. List all the other components that you will need to have a good program.

Second, a “gap analysis” will allow you to figure out where you want to be and when.

Third, a “gap analysis” will allow you to brainstorm about strategies for getting to where you want to be—what, for example, are the barriers and assets you have and what actions will be need to take to move your program along.

Your **task** is to fill in the blanks below on the next page.

“GAP ANALYSIS” OF YOUR FACILITY’S SPH PROGRAM

SPH Component	Where are we?	Where do we want to be?	How do we get there?
SPH budget (<i>for example</i>)			