

Guidelines for a Safe Practice Environment

REGARDING SAFE PATIENT HANDLING

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About the author

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Issue

Patient handling has long been recognized as a job task that places nurses and other direct patient care providers at risk for injury. Nurses perform a variety of patient handling tasks such as lifting, transferring, and repositioning throughout a wide range of practice settings. A well-established body of research has documented the direct association between performing these tasks manually and work-related musculoskeletal disorders and injuries among nurses. Consequently, many nurses often work in pain or have prematurely left professional practice roles in direct patient care, thus, contributing to the nursing shortage. Additionally, there are tremendous costs to employers with respect to workers' compensation, ensuring treatment, and replacement of injured nurses. Patients are also at risk for adverse events such as falls and injury secondary to unsafe, manual patient handling.

Nurses and risk managers have contributed to the knowledge and technology advancements made that effectively reduce injury risk related to patient handling and promote quality patient care. Healthcare leaders have organized and equipped practice environments to better meet the needs of nurses to safely handle patients. Model programs and innovative methods have successfully replaced outdated, traditional nursing approaches to patient handling. In the past, nurses manually handled patients using body mechanics. Now nurses have safer methods such as incorporating the use of specialized equipment and assistive devices to protect them from suffering debilitating injury. Such changes, however, have not been widely operationalized to become standard practice in healthcare settings.

The purpose of this document is to provide guidelines to support the culture of safety for nurses and their patients. The intent is to address safe patient handling and movement concepts, injury prevention, and responsibilities of the nurse to recognize characteristics of the work environment and characteristics of job tasks that put the nurse and patient at risk.

Background

In 2006, the State of Washington legislature passed Engrossed Substitute House Bill (ESHB) 1672, known as Washington's Safe Patient Handling Law (Washington State Legislature, 2006). ESHB 1672 defines safe patient handling as "the use of engineering controls, lifting and transfer aids, or assistive devices, by lift teams or other staff, instead of manual lifting to perform the acts of lifting, transferring, and repositioning health care patients and residents" (p. 4, lines 8-11). Safe patient handling, as a philosophy and approach, has become increasingly accepted by health care organizations and employers, labor groups, and regulatory agencies. With mounting evidence demonstrating the worker health and safety benefits as well as the economic benefits for employers, the argument to

ensure that safe patient handling is incorporated into health care practice environments through regulatory measures has become more compelling. Washington's Safe Patient Handling Law, at the time of its passage, established one of the more comprehensive legal mandates of its kind in the U.S. In summary, ESHB 1672 requires hospitals to have the following:

- A safe patient handling committee, with at least half the members being front-line non-managerial employees who provide direct patient care.
- A safe patient handling program with a policy that covers all units and shifts, includes a patient handling hazard assessment, and conducts an annual evaluation.
- At least one patient handling lift per acute care unit, OR one lift for every 10 acute care inpatient beds, OR lift equipment for use by lift teams.
- Procedures that give an employee the right to refuse performing a patient handling task that may pose an unacceptable risk of injury to the patient.
- Training for staff on policies and equipment at least annually.

To date, eight other states in addition to Washington State have enacted some form of legislation addressing safe patient handling: Illinois (2009), Maryland (2005, 2007, and 2008), Minnesota (2009), New Jersey (2007), New York (2009), Ohio (2005), Rhode Island (2006), and Texas (2005) (American Nurses Association, 2010).

In November 2000, after several years of researching, drafting, and holding public hearings, federal Occupational Safety and Health Association (OSHA) issued a final ergonomics rule, the Ergonomics Program Standard (29 CFR 1910.900), that was supposed to go into effect on January 16, 2001 (OSHA, 2000). The preamble of this final rule stated that "[b]ased on its review of the evidence in the record as a whole, OSHA concludes that the final standard is needed to protect employees in general industry workplaces who are at significant risk of incurring a work-related musculoskeletal disorder but are not currently protected by an ergonomics program" (p. 68263). The passage of the federal OSHA Ergonomics Program Standard was viewed as a significant stride towards addressing a major national occupational health problem. This federal regulation would have covered health care work environments effectively requiring employers to consider and adopt safe patient handling practices. However, in March 2001 the President signed a resolution repealing the Ergonomics Program Standard. The President took this action after the U.S. Senate and House of Representatives each passed a "resolution of disapproval" of the final rule. The Ergonomics rule was the first ever finalized regulation to be repealed under the Congressional Review Act of 1996, which gives Congress the power to overturn federal regulations under certain circumstances. To date,

no national standard or law exists to address patient handling or, more broadly, workplace ergonomic concerns.

In March 2003, the federal OSHA released its first in a series of industry-specific guidelines for the prevention of musculoskeletal disorders in the workplace, which focused on the nursing home practice environment. OSHA's *Guidelines for Nursing Homes: Ergonomics for the Prevention of Musculoskeletal Disorders* provides recommendations for nursing home employers to reduce the number and severity of work-related musculoskeletal disorders in their facilities (OSHA, 2009). A key point of these guidelines is the recommendation that manual lifting be minimized in all cases and eliminated when feasible. Also, this document states that "OSHA hopes that employers with similar work environments, such as assisted living centers, homes for the disabled, homes for the aged, and hospitals will also find [the guidelines] useful" (p. 5), thus recognizing their need and relevant application for these practice environments. The Guidelines provide an effective ergonomics process that employers should follow, including the involvement of employees to identify workplace patient handling concerns and to participate in the evaluation of lifting equipment. Additional recommendations focus on applying patient handling assessment tools (algorithms) developed by the Veterans Health Administration Patient Safety Center of Inquiry and using patient handling equipment. Of important note, however, is that these guidelines are not enforceable by federal OSHA since they are not codified as a regulatory standard. However, ergonomic hazards may be cited per Section 5(a)(1) of the OSH Act of 1970 (29 USC 654), known as the general duty clause (OSH Act, 1970). The general duty clause states that "each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." The Guidelines were revised and updated in 2009.

In November 2004, the Institute of Medicine (IOM) released a report titled, *Keeping Patients Safe: Transforming the Work Environment of Nurses* (IOM, 2004). Building on two previous reports focused on error-conducive attributes of the U.S. health care delivery system, the purpose of this report was to examine issues of patient safety from the perspective of work environments in which patient care is provided. This IOM report discusses the aging nursing workforce and the subsequent implications for safety in the nursing practice environment. Specifically, the report states that "[t]he loss of strength and agility that often accompanies aging affects the ease with which nurses can perform patient care activities that require them to turn, lift, or provide weight-bearing support to patients" (p. 71). The report points out that "[e]rgonomic patient and staff furniture and work tools will be needed to decrease the risk of injuries to patients (and nurses as well)" (p. 72). Despite no explicit mention of safe patient handling programs and equipment, these statements indicate the

importance of applying sound ergonomic approaches to patient handling to achieve a safe practice environment.

Recognizing the interface between patient safety and health-care worker safety, The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]), signed an Alliance agreement with federal OSHA in July 2004 (and renewed January 2009) (OSHA, 2010). The Alliance agreement states that "[b]oth organizations are committed to protecting health care employees' health and safety." Ergonomics was identified as one of the priority occupational health issues to be addressed. The Joint Commission also released two reports that include specific recommendations directly relevant to patient handling. First, the report titled *Healthcare at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis* (The Joint Commission, 2005) noted that "[w]ith an aging nursing workforce and an increasingly corpulent population, health care organizations will find it a basic necessity to acquire ergonomic technologies that reduce the risk of physical strain and injury in the delivery of patient care" (p. 12), and, recommending that hospitals "[a]dopt information, ergonomic and other technologies designed to improve workflow and reduce risks of error and injury" (p. 21 and 27). Another report, *Health Care at the Crossroads: Guiding Principles for the Development of the Hospital of the Future* (The Joint Commission, 2008), which proposes principles for future hospital development, asserts that "hospital design is integral to protecting hospital workers and enhancing the work they do." The report recognizes that, "[a] great deal of heavy lifting, turning, and transporting patients goes on in hospitals that could be alleviated by proper hoists and other ergonomic technologies" (p. 37), and, "[i]nvolving staff in the design process is essential for creating a physical environment that improves work flow" (p. 37). While The Joint Commission does not have an official standard as part of its accreditation process, these documents alert healthcare organizations of the importance of creating a practice environment that values safe patient handling strategies and actions.

In the absence of any federal or state mandate to address safe patient handling, nationwide healthcare systems can generate organizational approaches to safe patient handling. A prime example is the U.S. Veterans Health Administration (VHA). In June 2010, the VHA issued Directive 2010-032, Safe Patient Handling Program and Facility Design (VHA, 2010). This directive provides for the implementation of safe patient handling programs throughout all VHA facilities. Specifically, the Directive states, "It is VHA policy that a [safe patient handling] SPH Program to protect caregivers and patients from injuries due to patient handling and movement must be established and maintained in all VHA facilities and that new construction and renovation projects must incorporate appropriate and necessary patient handling and moving equipment at all VHA facilities" (p. 4). Key features of this Directive include establishing a facility-based safe patient handling committee, carrying out a detailed

facility ergonomic evaluation, the use of patient handling equipment prioritizing ceiling lifts as appropriate, training of facility-wide unit peer leaders in safe patient handling, tracking and use of injury data, and supporting a 0.5 FTE safe patient handling coordinator position for each facility. Another key feature of the Directive requires that VA construction and facilities management guidelines consider the installation of ceiling-mounted or overhead lift systems and ensure adequate and accessible storage space for portable or floor-based patient handling equipment. It is important to note that this Directive was prompted by successes at VA Sunshine Healthcare Network (also known as Veterans Integrated Service Network (VISN 8) in Florida. VISN 8 houses the VA Patient Safety Center of Inquiry in Tampa, which has led the nation in developing much of the research and evidence base for safe patient handling, including documenting the reduction in injuries to healthcare workers and patients, and the economic benefit of implementing safe patient handling programs. Other large regional healthcare systems have also instituted safe patient handling initiatives throughout their facilities with much success.

As aforementioned, legislators in the U.S. have not yet enacted a nation-wide safe patient handling law or regulation. However since the late 1990s other countries have established some form of safe patient handling policy on a national level, most notably in Australia, Denmark, Finland, the Netherlands, Norway, Sweden, and the United Kingdom (Nelson, Collins, et al, 2007). In an effort towards establishing national level safe patient handling legislation, “The Nurse and Health Care Worker Protection Act of 2009” was introduced in the U.S. House of Representatives as bill H.R. 2381 on May 13, 2009 (Nurse and Health Care Work Protection Act, 2009). The bill was introduced by Representative John Conyers (D-Michigan), and, to date, has been assigned to the House Education and Labor Committee’s Subcommittee on Workforce Protections. If enacted, it would require the U.S. Secretary of Labor to propose a standard on safe patient handling and injury prevention to prevent musculoskeletal disorders for direct-care registered nurses and all other health care workers. It would require the use of engineering controls to lift patients and the elimination of manual lifting of patients through the use of mechanical devices, except where patient care may be compromised. Further, it would require the U.S. Secretary of Health and Human Services to establish a grant program for purchasing safe patient handling and injury prevention equipment for health care facilities. The stipulations of this proposed bill parallel those included in the current Washington State Safe Patient Handling Law enacted in 2006. This bill has been supported by the American Nurses Association; American Association for Long Term Nursing; American Federation of Government Employees; American Federation of Teachers; California Nurses Association; and Department for Professional Employees, AFL-CIO.

Safe Patient Handling and Movement Concepts

Despite the absence of a regulation to protect nurses and other direct patient care providers (and other workers) from work-related musculoskeletal disorders and injuries, growing efforts to address the specific hazard of patient handling had been mounting. Specifically, the concept and term “safe patient handling” was evolving through the late 1990s and early 2000s. Safe patient handling refers to a multifaceted, programmatic approach to reduce the risk of injury to nurses and direct patient care providers secondary to patient handling tasks, while also providing patients themselves a more secure, dignified means to be lifted, transferred, and repositioned. Safe patient handling is premised on ergonomic principles in which the job is fit to workers rather than forcing workers to be fit into jobs. As early as the 1990s and through the 2000s, researchers and advocates called for the need to implement ergonomic-based interventions in health care work settings. Generally, comprehensive safe patient handling programs should include the following elements (in some form or another): (1) establishment and empowerment of a safe patient handling committee; (2) assessment and evaluation of worksite environments and job tasks for patient handling-related hazards; (3) an organizational no manual lift policy; (4) use of mechanical patient handling equipment and assistive devices; (5) assessing patient handling needs and applying; (6) initial and periodic training of frontline direct patient care providers; (7) the use of lift teams, (8) overall programmatic evaluation (de Castro, 2004; Garg & Owen, 1992; Nelson et al., 2006; Owen 2000; Wardell, 2007). Utilizing a multifaceted approach that integrates each of these components has been shown to effectively reduce the occurrence of back pain and injuries and other musculoskeletal disorders and injuries, modified duty days and absences, as well as dramatically decrease costs associated with such work-related health problems (Garg & Owen, 1992; Lynch & Freund, 2000; Nelson et al., 2006).

Injury Prevention

A fundamental component of comprehensive programs is the use of patient handling equipment and devices. The principal benefits of safe patient handling equipment and devices are that they can (1) reduce the incidence and severity of musculoskeletal injuries among direct patient care staff, and, (2) improve patient safety and quality of care (in terms of security, comfort, and dignity). The development of patient handling equipment and devices has made the manual performance of patient handling unnecessary. Safe patient handling equipment and devices control the hazards associated with patient handling by technologically “engineering out” the energy/force imposed onto the nurse or other direct patient

care provider during the act of lifting, transferring or repositioning patients. Numerous studies have documented the effectiveness of using safe patient handling equipment and devices in terms of dramatically reducing risk and number of injuries, modified duty days, and lost work days/absenteeism (Allen, Jackson, Marsden, McLellan, & Gore, 2002; Baptiste, Boda, Nelson, Lloyd, Lee, 2006; Evanoff, Wolf, Aton, Canos, Collins, 2003; Fragala & Santamaria, 1997; Li, Wolf, & Evanoff, 2004; Logan, 1997; Nelson, Lloyd, Menzel, & Gross, 2003; Nelson et al, 2003; Nelson et al., 2004; Santaguida, Pierrynowski, Goldsmith, & Fernie, 2005; Trinkoff, Brady, Nielsen, 2003; Yassi, Cooper, Tate, Gerlach, Muir, Trottier, & Massey, 2001; Zhuang, Stobbe, Hsiao, Collins, & Hobbs, 1999). Some examples of safe patient handling equipment and devices include the following (taken from the “Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement” developed by the Patient Safety Center of Inquiry (Tampa, FL) of the Veterans Health Administration):

- **Air assisted lateral sliding aids.** These are devices where a flexible mattress is placed under a patient in the same manner as a transfer board. There is a portable air supply attached to the mattress that inflates the mattress. Air flows through perforations in the mattress and the patient is moved on a cushioned film of air allowing staff members to perform the task with much less effort. These technologies are particularly suitable when performing lateral transfers involving patients with special medical conditions, such as pressure sores.
- **Friction reducing lateral sliding aids.** Friction reducing lateral sliding aids can assist with bed-to-stretcher type transfers. These devices can be positioned beneath the patient or resident similar to a transfer board and provide a surface for the patient to be slid over more easily due to the friction reducing properties of the device. These are simple low cost devices, usually made of a smooth fabric that is foldable and very easy to store. Properly designed handles can reduce horizontal reach, as shown in the example.
- **Mechanical lateral transfer aids.** Stretchers are available that are height adjustable and have a mechanical means of transferring a patient on and off the stretcher. Some are motorized and some use a hand crank mechanical device. Mechanical means of mechanizing the lateral transfer are also available as independent options able to be used with most beds and stretchers, as shown. These devices eliminate the need to manually slide the patient, minimizing risk to the caregiver.
- **Transfer chairs.** Some new wheelchairs and dependency chairs can convert into stretchers where the back of the chair pulls down and the leg supports come up to form a flat stretcher. These devices facilitate lateral transfer of the patient or resi-

dent and eliminate the need to perform lift transfer in and out of wheelchairs. There are wheelchair devices that convert to stretchers which also have a mechanical transfer aid built in for a bed to stretcher or stretcher to bed type transfer.

- **Powered full body sling lifts.** Probably the most common lifting aid device in use is a full body sling lift. A number of models and configurations are available. The majority of sling lifts are mounted on a portable base; however, use of ceiling mounted sling lifts is growing. The portable base and the ceiling mounted devices have their advantages. With a ceiling mounted device, there is no need to maneuver over floors and around furniture. These units are quite easy to use; however, transfers are limited to where overhead tracks have been installed. Where overhead tracks are not available or practical, portable bases can be used to suspend full body sling lifts. Sling lifts are usually used for highly dependent patients. They can be used to move patients out of beds, into and out of chairs, for toileting tasks, bathing tasks, and for any type of lift transfer. These lifts are available with many features and there is a wide variation in the types of slings available. The newer sling designs are much easier to install beneath the patient or resident.
- **Powered standing assist and repositioning lifts.** These lifts provide an alternative to full body sling lifts. These types of lifts are very useful where patients are partially dependent and have some weight bearing capabilities. They are excellent to move patients in and out of chairs and for toileting tasks. Powered standing assist and repositioning lifts are easily maneuvered in restricted areas, such as small bathrooms. There are some variations in the sling design, but the basic concept is of simple design and very easy to place around the patient.
- **Standing assist and repositioning aids.** Some patients or residents may only need a little support to stand. In this case, they can help themselves if they have a support to grasp. Various types of devices can be provided to assist a patient from a seated to standing position by allowing them to hold on to a secure device and pull themselves up, such as demonstrated in the figure. These devices may be freestanding or attached to beds.
- **Bed improvements to facilitate transfer or repositioning.** Current bed technologies incorporate many ergonomic improvements. Some examples include beds that eliminate the need for bed to chair transfers by easily converting to a chair configuration. Another innovation in bed design, referred to as shearless pivot, reduces the need to constantly reposition a patient in the bed by minimizing the amount of slippage down to the foot of the bed experienced by the patient when raising the

head of the bed. Further innovations with bed mattress surfaces can aid rotation and move a patient as needed in many intensive care units, by utilizing air bladders incorporated into the mattress surface.

- **Sliding boards.** For seated bed-to-chair or chair-to-toilet type transfers, low cost sliding boards are available. Sliding boards are usually made of a smooth rigid material with a low coefficient to friction. The lower coefficient of friction allows for an easier sliding process. These boards act as a supporting bridge when seated slide transfers are performed. Some, but substantially reduced, manual lifting is still required to move the patient, however, sliding boards do offer considerable improvement at a minimal cost.
- **Gait/transfer belt with handles.** An object with handles improves the grasp opportunity for the worker and thereby reduces the risk. Gait/transfer belts are installed on patients or residents, usually around the area of the waist providing handles for a worker to grasp when assisting or transferring a partially dependent patient or resident, as shown. Small hand-held slings that go around the patient can also facilitate a transfer by providing handles. These options are available for patients with weight bearing capability that needs only minimal assistance.

An important aspect of investing in safe patient handling equipment and devices is that they should be evaluated carefully before any purchase is made. Products and vendors should be canvassed widely as the development and improvement of equipment of devices continues to evolve. An essential feature in evaluating equipment and devices is that a facility's safe patient handling (or safety) committee should be given the authority to recommend or decide what kinds should be purchased. Furthermore, these decisions should be made with input from frontline staff nurses and other direct patient care providers. Vendors will provide product information materials and possibly even sample equipment products for a facility to try out for a short time. When selecting patient handling equipment and devices, the following criteria should be used (taken from the "Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement" developed by the Patient Safety Center of Inquiry (Tampa, FL) of the Veterans Health Administration):

1. The devices should be appropriate for the task that is to be accomplished
2. The device must be safe for both the patient and the caregiver. It must be stable, strong enough to secure and hold the patient, and permit the caregiver to use good body mechanics

3. The device must be comfortable for the patient. It should not produce or intensify pain, contribute to bruising of the skin, or tear the skin
4. The device should be understood and managed with relative ease
5. The device must be efficient in the use of time
6. Need for maintenance should be minimal
7. Storage requirements should be reasonable
8. The device must be maneuverable in a confined workspace
9. The device should be versatile
10. The device must be able to be kept clean easily
11. The device must be adequate in number so that it is accessible
12. Cost

Responsibilities of the Nurse

It is the responsibility of the practicing nurse to recognize characteristics of the work environment and job tasks that place the nurse and/or patient at risk. Safe patient handling has the greatest impact if it is incorporated into nursing practice throughout a facility. Staff should assess patient handling needs considering patient characteristics and conditions in order to select the safest equipment and approaches. A determination should be made about who assesses patient handling practices and who updates policies and practices. Patient handling assessments should be conducted both initially and periodically as lifting, transferring, and repositioning practices may change over time.

To assist the practicing bedside nurse in handling patients safely the use of the following acronym **S-A-F-E-L-I-F-T** is recommended:

S = Space: Is the environment free from all hazards? Is there adequate space to perform a task? The area where the task is to be performed should be prepared removing obstacles that may interfere with safe movement. Potentially confusing wall/floor patterns, distance to be moved, lighting, noise, flooring, and temperature should be taken into consideration prior to the actual movement of a patient.

A = Assess: The nurse should assess the patient's physical and mental condition, care needs, ability to assist and weight-bearing capability in relation to the planned lift or transfer activity. The ability for the patient to be cooperative during the activity should be evaluated so a determination can be made regarding equipment or staff support needed. Assessing the physical ability of the patient

to provide assistance should include the ability to bear weight and/or use upper body extremity strength.

F = Function: Using the nursing assessment information, the nurse needs to determine which lifting function needs to be performed, e.g. lateral transfer, bed-to-chair, full-body lift, or repositioning. The use of safe patient handling algorithms can assist staff to undertake approaches that reduce risk for injury to both the employee and patient. Examples of safe patient handling assessment criteria and algorithms can be found at: http://www.visn8.va.gov/VISN8/PatientSafetyCenter/safePtHandling/SafePatientHandlingAssessment_Algorithms_031209.doc. For repositioning, the bed should be placed at a comfortable/safe height for the staff. Flat or trendelenburg positions should be used to aid in gravity. Side rails should be down. Nurses should be aware of the need to avoid skin shearing especially for patients with stage III and IV pressure ulcers already present. The device selected should be one designed to minimize shearing force.

E = Equipment: The nurse should select the appropriate lifting equipment based on the patient assessment and type of move to be completed. For patients exceeding 200 lbs. use of a friction reducing device with at least three staff members is recommended. Use of a bariatric algorithm should also be considered. For patients weighing less than 200 lbs. a friction reducing device should also be considered with two to three staff partially assisting the patient. One of the most frequent barriers to safe patient handling is the absence of available appropriate equipment; thus, patient care staff need to communicate to their immediate supervisor their needs such that the appropriate number, type, and location of stored equipment can be addressed. A culture of patient safety can be promoted when open communication, use of evidence-based practice, teamwork, and patient-centered care are utilized. Therefore, when necessary, consideration should be given to completing an incident report notifying administration of unmet needs such that the situation can be documented for quality improvement purposes.

L = Lift Team: It is important for the nurse to call for assistance from a designated lift team, or to obtain help from co-workers as needed. All too often short cuts can be taken on a busy unit, and a nurse may believe they can handle the patient alone. This is when serious injuries can occur. Utilizing other team members is a key approach to preventing harm to the patient and/or the nurse.

I = Injury: The nurse should be aware of the kinds of injuries that might be experienced as a consequence of patient handling tasks. Knowing how many and what types of injuries have occurred is helpful in assessing the risks and needs for a facility's safe patient handling program. Assessment data can be obtained from the OSHA injury logs as well as from worker's compensation data, incident reports, and surveillance data. The more specific the data is, the more useful it is.

A worksite analysis can also be helpful. The assessment can be focused facility-wide or on a specific unit, but should prioritize high-risk areas or tasks. Patient handling tasks should be assessed. In order to prioritize high-risk units or departments, they need to be identified and a list of existing equipment should be established and updated regularly. This information could be obtained with a walk-through and observation or with staff surveys.

F = Frequency: The nurse needs to evaluate the frequency of handling tasks for assigned patients. The workload and time of the individual nurse should be managed such that lifts and transfers can be performed safely. It should be noted that injuries occur in staff as a result of force (amount of physical effort required to perform the task or maintain control of the equipment), repetition, and/or awkward postures (assuming positions that place stress on the body such as reaching above shoulder height, kneeling, squatting, leaning over a bed, or twisting the torso while lifting).

T = Training: The nurse needs to participate in and complete training sessions to remain current and competent to perform safe handling tasks and have the correct knowledge regarding proper use of equipment and devices. The nurse needs to request additional training when needed.

Summary

In summary, nurses have the responsibility to protect themselves as well as their patients. Frontline nurses and other direct patient care workers should actively participate in shaping, evaluating, and refining overall facility-based safe patient handling program efforts (i.e., joining their facility's safe patient handling committee, engaging in safe patient handling training, assessing their work units for potential patient handling hazards, and vigilantly reporting (worker and patient) injury incidents. Workplace walk-throughs, surveying staff, and analyzing injury data can assist in recognizing hazards. The facility safe patient handling committee should be informed of noted hazards or risks. Consideration should be given to management support, budgets, staff readiness and training needs, physical space, and architectural plans.

WSNA's Continuing Role

The Washington State Nurses Association has a history of being a strong advocate for the development, implementation and ongoing monitoring of compliance with the Washington State Safe Patient Handling Law. Through the work of the Economic and General Welfare Cabinet, Professional Nursing and Health Care Council, Legislative Council, and the Occupational and Environmental Health and Safety Committee, WSNA continues to identify safe patient handling as a key issue and priority for the association requiring ongoing support. WSNA is available as a resource to nurses providing support and promptly assisting nurses when notified of potential violations of the law. Education regarding safe patient handling is made available via various resources such as providing on-line continuing education, palm cards, consultation, additional print material, and WSNA web site information including links to additional resources and a curriculum DVD developed in conjunction with Washington State University. WSNA is supportive of and interested in promoting research in this area examining the effectiveness of the Washington State Safe Patient Handling Law. Additionally, WSNA believes that the protections provided by the safe patient handling law to hospital staff should be extended to other healthcare settings such as for clinics, long-term care facilities, and home health care settings.

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