District Council 37
Safety and Health Department

Safe Patient Handling and Mobility:

A Guide for Health Care Workers

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Table of Contents

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Introduction

SAFE PATIENT HANDLING (SPH) programs have proven to be effective in reducing injuries and risks among direct-care workers and patients in hospitals, clinics and long-term care facilities.

If implemented properly, a SPH Program can result in numerous benefits:

- Injury rates among health care workers can be reduced;
- The severity of the injuries can be mitigated;
- Costs to injured workers can be greatly reduced as they do not have to rely on the Work ers' Compensation system for lost wages and benefits;
- Employers save monies because experienced and healthy workers stay on the job which makes good business sense; and
- Patient experience improves.

Healthy workers are vital to a healthy work environment. A SPH Program helps achieve this goal. A comprehensive program advocates for improvements in processes, procedures, and practices related to safe patient handling and the elimination of manual lifting tasks through the use of appropriate equipment.

This booklet brings awareness to the hazards posed by manual patient handling and discusses solutions. It defines and outlines the problem, introduces the NYC H+H SPH Policy and offers tips for implementing a comprehensive program. Chapter nine is a resource guide and offers opportunities to learn more about the topics.

Within each NYC H+H facility, personnel have been given the responsibility of implementing a SPH Program. If you have questions about the policy and its application, reach out to your facility SPH Champion. If you need assistance with equipment or instructions on how to use it, talk with the Unit Peer Leader in your area.

The facility-based SPH Committee that exists within your facility plays an important role in the implementation of the NYC H+H Policy. If you have questions or concerns about the program, talk to the committee members as they may be able to address these and other issues that may arise.

Despite efforts to create a safe work environment, accidents do occur often, resulting in physical injuries or diseases. Reporting workplace incidents, accidents, or near-misses is important. If we are going to try to figure out what led to the injury and identify ways to prevent future incidents, we need to review a facility's injuries and illnesses. This is the best place to start.

If you or a co-worker are injured, inform your supervisor and union representatives immediately so that an investigation can be initiated quickly to avoid further harm to workers. We can also engage management and move them towards complying with a basic safety and health principle: prevent hazards from arising.

Chapter 1:
Safe Patient Handling (SPH)

WHEN individuals are admitted to health-care facilities with severe illnesses or injuries, it is primarily because they require medical care that can only be attained within these facilities. When admitted, those with the most severe illnesses may have lost some of their ability to move on their own, reposition themselves in a bed or a chair, or move about. Understandably, assistance must be provided to these patients.

These responsibilities are placed on the health-care workers who provide the necessary care. Direct care of patients often requires manual lifting and repositioning. Some of these tasks may include, among others, repositioning a patient to prevent bed sores or to promote comfort. A patient may also need to be transferred from a bed or stretcher to a chair or an examination table. Direct care providers are also responsible for assisting patients when they must travel to centralized services, such as radiology, oncology, and kidney dialysis.

As a result of this responsibility, the single greatest risk factor for injuries among health-care workers is manual lifting, moving and repositioning of patients, residents or clients, i.e., manual patient handling. Health-care workers have among the highest rates of musculoskeletal injuries when compared to other industries, such as manufacturing, in the United States. Data from the Bureau of Labor Statistics (BLS) show that in 2014, the rate of injuries averaged across all industries was 33 per 10,000 full-time workers. By comparison, the overexertion injury rate for hospital workers was about twice the average (68 per 10,000), the rate for nursing home workers was over three times the average (107 per 10,000), and the rate for ambulance workers was over five times the average (174 per 10,000).[1]

Research shows that by replacing manual patient handling with safer methods that are based on ergonomic principals, injury rates can be reduced. In the case of patient handling and mobility, the use of mechanical devices/equipment, procedures and safe work practices have been shown to dramatically eliminate the need for manual exertion and dramatically reduces risks of injuries.

Despite the evidence that caregivers are at a higher risk for injury because of their manual lifting tasks, employers have been slow in taking proactive actions to decrease the incidences of musculoskeletal disorders. A lack of mandates and incentives to keep the rates of injuries down among health-care workers has been a roadblock to creating safer work environments. Fortunately, states have begun to take action. Mobilizing around the need for better protection for healthcare workers took root with the banding together of many, as well as actions by labor leaders and activists.

[1]BLS Table R8. Incidence rates for nonfatal occupational injuries and illnesses involving days away from work per 10,000 full-time workers by industry and selected events or exposures leading to injury or illness, private industry, 2014.)

Activists, organizations and practitioners in the field of occupational safety and health as well as labor leaders have mobilized around the need for better protection for health-care workers. The strength and determination of individual groups, as well as numerous coalitions that have formed, have finally brought this hazard to the forefront and paved the way for the passage of protective legislation at the local, state and federal levels. But legislation is only part of the larger campaign to create and sustain safer workplace for health-care workers

State Initiatives

Eleven States in the U.S. have enacted safe patient handling legislation[2]

State	Legislation	Effective Date
California	Labor Code Section 6403.5	October 7, 2011
Illinois	Public Act 97-0122	July 30, 2011
New Jersey	S-1758/A-3028	January 2008
Minnesota	HB 712.2	May 2007
Maryland	SB 879	April 2007
Rhode Island	House 7386 and Senate 2760	July 7, 2006
Hawaii	House Concurrent Resolution No. 16	April 24, 2006
Washington	House Bill 1672	March 22, 2006
Ohio	House Bill 67, Section 4121.48	March 21, 2006
Texas	Senate Bill 1525	June 17, 2005
New York	Companion bills A11484, A07836, S05116, and S08358	October 18, 2005

[2]http://www.cdc.gov/niosh/topics/safepatient/default.html

New York State Safe Patient Handling Efforts

Health-care workers, administrators, patient advocates, union representatives and safety and health advocates in New York State have recognized that strenuous manual lifting tasks involved in transferring and repositioning patients must be eliminated. As such, the New York State Zero Lift Task Force (www.zeroliftforny.org) was formed to advance legislative agendas and advocate the enactment of a law that required health-care employers to develop within their facilities a comprehensive program to reduce injuries experienced by health-care workers. From its inception, District Council 37 has been a member as we too recognize that one of the ways to reduce injuries among the titles we represent within NYC H+H is to take a leadership role.

Working with the Zero Lift Task Force, District Council 37 played a critical role in advocating for legislation. Finally, in 2005, the concerted efforts to advance legislation protecting health-care workers from injuries related to patient handling were successful when the NYS Safe Patient Handling law was passed. All hospitals, nursing homes, diagnostic treatment centers and clinics licensed under Article 28 of the New York State Public Health Law, which also covers state operated group homes as well as health care units in prisons are subject to the tenets of the law. A main directive of the law is that employers must establish facility-based committees that will assist in the development and implementation of a safe patient handling program. The law also requires each facility to have a written SPH program with a policy, a comprehensive assessment of the current equipment, the number of each type of equipment, patient assessment procedures, maintenance schedule of the equipment and procedures for decontamination and/or taking the equipment out of service.

The law, and in particular, section 2997-I, required the creation of a workgroup that would be convened to deliver a report that would provide and offer employers and others guidance on how to facilitate compliance. Once again, DC 37 was selected to be a member of this statewide group.

The workgroup's responsibility was to write and submit a report to the Commissioner of the New York State Department of Health. After several meetings, discussions, and reviews of draft reports, the final report identified and presented safe patient handling best practices, including information on established programs within the state and sample policies that demonstrated successes. Most importantly, the group was successful in gathering, suggesting, and providing resources and tools for health care providers to meet the goals of safe patient handling law. For the employer's benefit, the report also includes sample SPH policies, procedures, assessment tools, recordkeeping systems and evidence from contributors of the financial gain for all employees and patients whose risks for injuries are reduced through effective implementation of a program. The report can be found at: http://www.health.ny.gov/statistics/safe_patient_handling/docs/sph_report.pdf.

What follows is the NY State's Safe Patient Handling Law, 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 faculties, 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 of 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.
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, 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 authored by chapter seven hundred thirty-eight of the laws of two thousand five and national data and results;
   (b) Consult with any organization, education institution, other government entity or agency or person that the workgroup determines may be able 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, proving 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.

§ 2997-j. Disseminations of best practices, examples of sample safe patient handling polities and other resources and tools. The commissioner shall disseminate best practice, 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 Harding policies, and other resources and tools shall be made available to 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, subcommittee thereof. The purpose of a committee is to design and recommend

the process for implementing a safe patient handing 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-managerial direct care worker shall be on the safe patient handling committee. In health care facilities where a resident council is establish, 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 nosing 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-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 Provision

Subsection (j) of Insurance Law § 2304-j, 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 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.

Establishing a law is one thing. Enforcement is another. In fact, the current law is silent on enforcement and does not allow the NYS Department of Health to assess penalties against an employer who fails to comply with the law.

So where does this leave workers, their union representatives and advocates?

Here are a few ways to strengthen worker protections:

The DC 37 Safety and Health Department can request the involvement by the NYS Department of Labor Public Employee Safety and Health Bureau if NYC H+H or another public-sector employer is not addressing workers' injuries, reducing risks or eliminating hazards using engineering and administrative controls.

DC 37 has language in the Citywide Contract as well as in some unit contracts that has proven to be effective in protecting members against workplace injuries. Article 14 Section 2 (b) of the Citywide Contract states that the employer must provide a workplace that is clean, safe, structurally sound and sanitary. Article 14 of the Citywide Contract mandates the establishment of joint labor/management safety and health committees. These committees have been established in many NYC agencies and within NYC H+H. If you want to be involved in these committees, let your local leaders and council representatives know. Participation in these committees' enables conversations that are crucial to understanding the current state of workplace safety in your facility.

Amend the current law to provide authority to the NYS DOH to develop regulations that require employers to develop, implement, and evaluate a safe patient handling program. NYS DOH can then work with all stakeholders: employers, employees' representatives, legislatures, and other organizations, towards 100 percent compliance.

Work collectively with like-minded groups and individuals to secure a federal standard that protects ALL healthcare workers. Support DC 37 in its efforts to push for improvements in your places of work.

Chapter 2:
NYC Health+Hospitals' Safe Patient Handling Program

All NYC H+H facilities must create and implement a SPH Program. Given the number of facilities within the system, NYC H+H has implemented a system wide policy that can be adapted to meet the needs of any facility. This policy is the result of a collaborative effort by union representatives, safety and health specialists, labor relations, human resources, information technology, nursing, various specialists and administrators. The policy is a "live" document, meaning the stakeholders who created it can propose improvements. A functional policy will improve both employee and patient experiences.

More than 15,000 District Council 37 (DC 37) members work for NYC H+H and of these over 5,000 provide direct patient care. Some of the titles covered include, but are not limited to:

Nurse's Aides
Operating Room Technicians
Patient Care Associates
Psych/Social Health Technicians
Physical Therapists
Social Workers
Service areas include Medical Transport, Bio-Med, and Environmental services.
Patient Care Technicians
Medicine Surgery Technicians
Respiratory Therapy Technicians
Respiratory Therapists
Physician Assistants
Mental Health Assistants

The risks of musculoskeletal injuries to workers in these job titles exist and it is DC 37's resolve to work closely with NYC H+H to obtain better workplace protections for the membership. We have partnered with the system, have been active in the pre-implementation activities and will ensure that an all-inclusive program is maintained.

NYC H+H and DC 37 share a vision of safe and productive healthcare facilities and recognize that a SPH program reduces employee and patient injuries. As partners in this endeavor to protect workers, there is a mutual commitment to build trust and a culture of safety.

Fewer injuries improve the quality of work for the direct health-care providers as well as the quality of care for patients.

Employees injured on the job can lead to staff shortages and increased risks of injuries and illnesses to other staff. Moreover, temporary and permanent health conditions can be career ending for the injured worker and move employers to spend additional money on hiring and training new employees. Preventing such scenarios is beneficial to both employees and their employer and is likely to occur through the implementation of a Safe Patient Handling Policy and Program. Below is the NYC H+H system-wide policy covering all employees who may be required to move, transfer or reposition patients/residents as a part of their job.

This policy was created through a collaborative effort between NYC H+H and numerous stakeholders, including DC 37. The intent of the policy is to set the framework for facility-specific programs that must be in place at each of the NYC H+H sites. The key provision in the policy is the limit it sets on how much an employee can manually lift when performing patient handling and mobility tasks. The limit is set at 35 pounds, except in the instance of a medical emergency.

NYC H+H has appointed a dedicated Safe Patient Handling Director to ensure that NYC H+H is in compliance with the law. The Safe Patient Handling Director provides assistance and guidance to all facilities as they transition to a more positive approach to safety.

The Safe Patient Handling Director works closely with a SPH Facility Champion at each facility. The SPH Facility Champion is the lead program administrator at a facility and is the liaison among Central Office, management staff, and employees. The Champion's main responsibility is to ensure the SPH program is operational in all areas of the facility. They should be contacted directly about any issues or concerns.

NYC H+H has formed a SPH Steering Committee to assist in the full transition to a culture of safety in safe patient handling and mobility and to discuss and review implementation of the SPH program system-wide. The committee is made up of the unions, staff educators, the SPH Director, Labor Relations officials and other high-level department representatives. Facility-based committees have also been formed and are comprised of union members, staff development and other department personnel involved with patient handling or in the implementation of the program in their facility.

Chapter 3:
Just Culture Concept

THE NYC H+H Safe Patient Handling Policy outlines how the organization has created the infrastructure necessary to be compliant with the NYS Safe Patient Handling Law. The goal of the law and the mission of NYC H+H is to create a safe environment for employees and patients by reducing the number of injuries related to patient handling. In order to thoroughly investigate and review injuries that are related to patient handling, NYC H+H has adapted a *Just Culture* approach.

What is Just Culture?

Just Culture has proved effective in reducing errors and improving safety in many industries such as the airline industry where errors have dire consequences and sometimes catastrophic repercussions. In healthcare, errors can have serious consequences for the patient as well as the healthcare worker. The framework of a *Just Culture* ensures balanced accountability for both individuals and the employer, NYC H+H, who is responsible for creating and following a Safe Patient Handling Program.

When injuries and accidents occur, more often than not, the blame is put on the injured worker: they failed to follow orders; they failed to pay attention; they failed to use the equipment provided; they were careless, etc. A *Just Culture* approach emphasizes learning from the errors and the circumstances that existed at the moment an injury occurred. *Just Culture* lets management and employees plus their representatives take part in an investigative effort that is focused on making the workplace a safer better environment and not disciplinary action.

The process and set of rules used to identify how an injury occurred is crucial to creating a base for *Just Culture*. Employees should not be discouraged from reporting injuries related to patient handling for this is crucial to supporting a *Just Culture*. A *Just Culture* approach to understanding an error and injury evaluates the role of the individuals involved but also the "system" they work in. Both management and the injured individual are assessed to better understand how a particular incident occurred.

Punitive action is not the first response in a Just Culture environment. Emphasis is placed on prevention and learning. But this does not eliminate the possibility that an action that results in an injury will be followed by disciplinary action. By adopting a *Just Culture* approach NYC H+H is trying to find a balance between individual versus institutional accountability.

If you have any questions about your involvement in reporting an incident or an investigation, please contact your union representative. We are working closely with NYC H+H, the DC 37 divisions and staff to ensure that the Safe Patient Handling Program is supported by this Just Culture approach.

Chapter 4:
Elements of a SPH Program

AS STATED in the New York State Safe Patient Handling (SPH) Law, each health-care facility is responsible for implementing a Safe Patient Handling Program. The program should be tailored to each facility and be based on the types of medical care and services provided, the number of beds, staffing levels and the support services on hand that allow for its full implementation. A comprehensive program includes information on the physical layout of each patient care unit or floor, storage needs, accessibility of the equipment by staff, and equipment repair and replacement.

An effective program includes at a minimum the following elements:

- A SPH Policy;
- Provisions for conducting a Patient Handling Environment Hazard Assessments;
- A clear description of areas and/ or tasks where the policy apply and that require the use equipment;
- A training and education component for all workers covered by the SPH Law;
- Procedures for proper review and evaluation of the program and allied processes;
- A process to incorporate a renovation plan that a SPH program needs; and
- Guidance on "Good Faith" Employee Refusals

The SPH Policy

NYC H+H's Safe Patient Handling Policy describes their commitment to comply with the law while considering the needs of the patient populations served and the employees who provide the care. The NYC H+H system-wide policy describes the expectations of the staff charged with patient handling, concerning lifting, transferring and repositioning patients. In the policy, NYC H+H highlights its commitment to employee safety by making available equipment, resources, and training opportunities so staff will no longer need to manually lift patients. NYC H+H policy speaks to the role of the SPH Committee and identifies individuals responsible for the implementation, monitoring, evaluation and improvements to the Safe Patient Handling Program. Lastly, the policy establishes protocols for patient assessments; sets the maximum weight where lifting equipment is not necessary and states the minimum number of staff required for each type of equipment or task. The policy also makes it clear that employees who are asked to perform what they perceive to be unsafe can refuse to do so. A brief procedure for the exercising of this right can be found in the policy.

Patient Handling Environment Assessments

Each NYC H+H facility program must have a process to review the equipment currently in use/available for patient transfers and repositioning. The assessment should consider the type of care provided in each unit, the patient population, the physical setting of each patient care area, and the number of direct-care employees per shift. The information gained through these assessments must be communicated directly to all staff. If inventory changes or the equipment is not available, workers should be informed and provided with interim measures that are just as protective as having the proper equipment.

If workers become aware of problems or concerns with the equipment, they should communicate that to a supervisor or a facility SPH Champion.

Below is a list of facilities and the vendors that currently provide mobile lifts. The list was compiled by Crothall in 2015. A more current list should be gathered by the committee members to review and update as newer equipment is purchased.

Facility	Manufacturer
Bellevue	Arjo
Metropolitan	Ferno
Coney Island	Liko
Elmhurst	Sunrise, Hoyer, Joerns
Harlem	Liko
Jacobi	Arjo, Liko
Kings	Invacare
North Central Bronx	Liko
Queens	Liko
Woodhull	Arjo
Lincoln	Arjo
Sea View	Arjo
Carter	Arjo
McKinney	Liko
Coler	Arjo
Gouverneur	Arjo
Morrisania	Arjo
Belvis	None
Cumberland	None
Renaissance	None
East New York	None
Riker's Correctional Health Services	Hoyer

An equipment assessment conducted by Hill-Rom, NYC H+H, and DC 37 in 2016 included visiting and studying areas where patient care or services are provided, identifying the maximum occupancy/census of the area, revealing the wide-ranging levels of medical needs and care routinely required by the patients in these areas and verifying the staffing shortages in these areas and the methods in which patient mobility limitations are communicated during a shift and to the incoming shift.

The table to the left provides a partial summary of the findings. The complete reports were provided to each facility. SPH Committee members are encouraged to review the findings and recommend improvements in their facility.

Facility	Avg. Census	# Total Care and Moderate Asst. Patients	Equipment needed			Estimated Number of staff needing training
			Total lifts	Sit to Stand	Transfer Boards	
Bellevue Hospital	460	337	24	22	95	647
Kings County Hosp.	289	242	27	13	86	698
Jacobi Hospital	290	215	13	15	87	584
Elmhurst Hospital	280	238	24	15	77	747
Woodhull Hospital	200	118	10	6	60	326
Lincoln Hospital	234	171	16	7	68	516
Coney Island Hospital	230	230	9	9	69	536
Harlem Hospital	141	76	10	6	40	260
Queens Hospital	146	119	11	7	34	310
Metropolitan Hospital	120	76	11	6	16	166
North Central Bronx Hospital	62	44	4	4	10	231
Carter Specialty	336	330	28	2	27	413
Coler LTC	744	631	57	24	52	690
McKinney LTC	298	281	11	5	9	236
Seaview LTC	309	276	6	6	8	189
Gouverneur LTC	223	205	15	17	15	109

Source: NYC H+H

Having equipment is not enough. Other physical needs and additional staffing must be considered.

- Having sufficient staff to move or reposition a patient is critical. Not being able to ask for help increases risks for an employee.
- Another hazard is the equipment may not be available and operational. There may not be a place to properly store it and to keep it in good repair. Taking the time to clear adequate space and designating it as storage for the lifting equipment will result in keeping the equipment functional and ready for immediate use.
- Along with proper storage space, a power source is needed to guarantee the equipment can be operated. There is nothing more frustrating than finding the equipment was not plugged into an outlet and is not ready for use.
- Signage reminding employees about the SPH Policy and Program encourages observance and buy-in by everyone.
- Uneven floors and stretchers, beds, chairs, toilets at different heights make it even more difficult for workers as they now need to exert additional effort.
- Procedures for reporting damaged equipment and submitting work orders must be formulated and communicated to staff.

Tasks, services, and care covered by the policy and program

Many tasks performed in a hospital or other similar environments can be deemed hazardous and can create a workspace that has a higher risk for injury. Safe Patient Handling practices and procedures help prevent staff from engaging in the following behaviors that can lead to injury:

- Awkward postures
- Lifting heavy loads
- Excessive pushing or pulling
- Frequent/repeated lifting and moving
- Tasks that lasts a long time
- Reaching

The first step in preventing staff from engaging with a patient in an unsafe manner is understanding what the patient requires in terms of care and the specific equipment and staffing levels necessary to carry out their care plan. NYC H+H accomplishes this through the use of a patient mobility assessment tool called the Banner Mobility Assessment Tool (BMAT). The BMAT is a systemic approach to identify patients' abilities to move on their own. Conducting the patient assessment directs health-care workers to the types of equipment required to carry out necessary tasks and the number of staff required to complete the tasks.

A sample is provided for your information. Patient assessments are conducted only by licensed clinicians and their findings must be communicated to all members of the care team.

BMAT PATIENT ASSESSMENT TOOL

Test	Task	Response	Fall = Choose Most Appropriate Equipment/Device(s)	Pass	Caregiver(s)
Assessment Level 1 Assessment of: •Cognition •Trunk strength •Seated balance	SIT and STAND: From a semi-reclined position, ask patient to sit upright and rotate to a seated position at the side of the bed, may use the bedrail Note patient's ability to maintain bedside position. Ask patient to reach out and grab your hand and shake making sure patient reaches across his/her midline Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable	Sit: Patient is able to follow commands, has some trunk strength, caregivers may be able to try weight-bearing if patient is able to maintain seated balance greater than two minutes (without caregiver assistance). Shake: Patient has significant upper body strength, awareness of body in space, and grasp strength.	MOBILITY LEVEL 1 - Use total lift with sling and/or repositioning sheet and/or straps -Use lateral transfer devices such as roll board, friction reducing (slide sheets/tube) or air assisted device NOTE: *If patient has "strict bed rest" or bilateral "non-weight bearing" restriction, do not proceed with the assessment, patient is MOBILITY LEVEL 1*	Passed Assessment Level 1 ► Proceed with Assessment Level 2	Min. 3 caregivers
Assessment Level 2 Assessment of •Lower extremity strength •Stability	STRETCH and POINT: With patient in seated position at the side of the bed, have patient place both feet on the floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and straighten the knee, then bend the ankle/flex and point the toes. If appropriate, repeat with the other leg.	Patient exhibits lower extremely stability, strength and control. May test only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast.	MOBILITY LEVEL 2 -Use total lift for patient unable to weight-bear on at least one leg -Use sit-to-stand lift for patient who can weight-bear on at least one leg	Passed Assessment Level 2 ► Proceed with Assessment Level 3	2 -2+
Assessment Level 3 Assessment of: •Lower extremity strength for standing	STAND: Ask patient to elevate off the bed or chair (seated to standing) using an assistive device (cane, bedrail). Patient should be able to raise buttocks off bed and hold for a count of five. May repeat once. Note: Consider your patient's cognitive ability, including orientation and CAM assessment if applicable.	Patient exhibits upper and lower extremity stability and strength. May test with weight-bearing on only one leg and proceed accordingly (e.g. stroke patient, patient with ankle in cast). If any assistive device (cane, walker, crutches) is needed, patient is Mobility Level 3.	MOBILITY LEVEL 3 -Use non-powered raising/stand aid; *default to powered sit-to-stand aid available* -Use total lift with ambulation accessories -Use assistive device (can, walker, crutches) NOTE: Patient passes Assessment Level 3 but requires assistive device to ambulate or cognitive assessment indicates poor safety awareness: patient is MOBILITY LEVEL 3	Passed Assessment Level 3 AND no assistive device needed ► Proceed with Assessment Level 4 Consult with Physical Therapist when needed and appropriate	1-2
Assessment Level 4 Assessment of: •Transfers •Balance •Gait	WALK: Ask patient to march in place at bedside. Then ask patient to advance step and return each foot Patient should display stability while performing tasks. Assess for stability and safety awareness.	Patient exhibits steady gait and good balance while marching, and when stepping forwards and backwards Patient can maneuver necessary turns for in-room mobility Patient exhibits safety awareness	MOBILITY LEVEL 3 If patient shows signs of unsteady gait or fails Assessment Level 4, refer back to MOBILITY LEVEL 3; patient is MOBILITY LEVEL 3	MODIFIED INDEPENDENCE Passed = No assistance needed to ambulate; use your best clinical judgment to determine need for supervision during ambulation	0-1

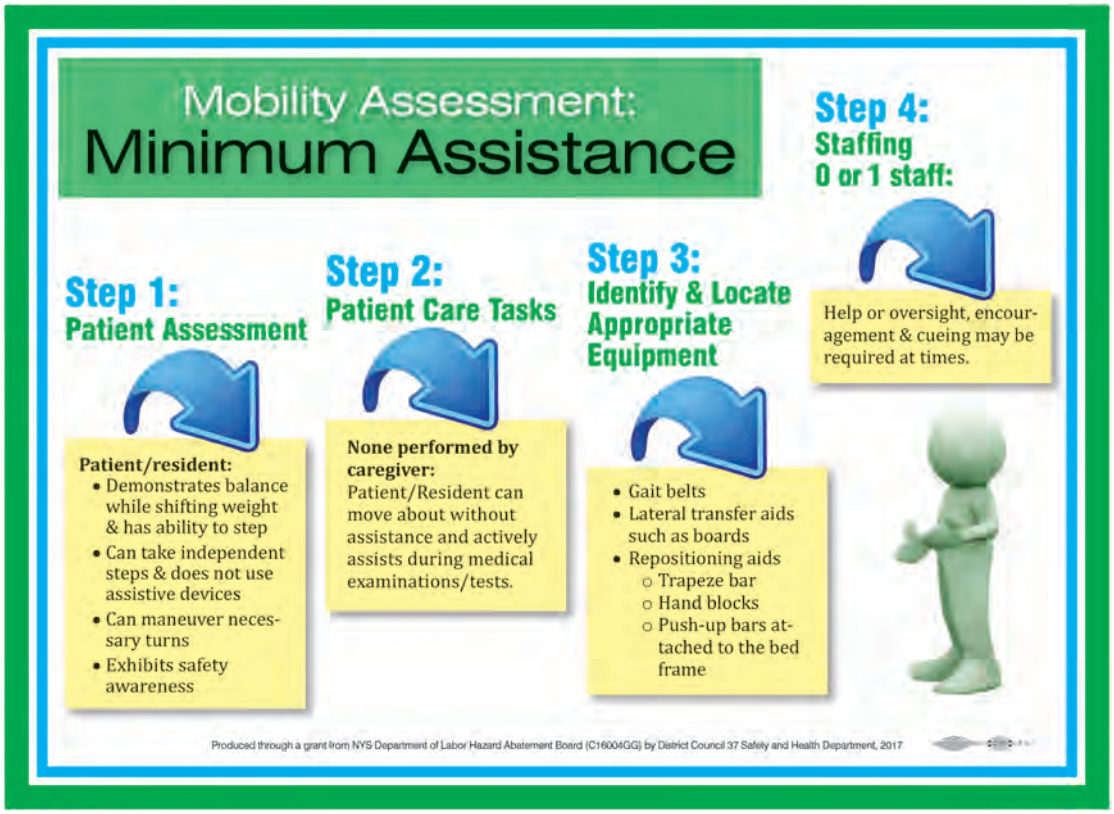
Always default to the safest lifting/transfer method (e.g. total lift) if there is any doubt in the patient's ability to perform the task.

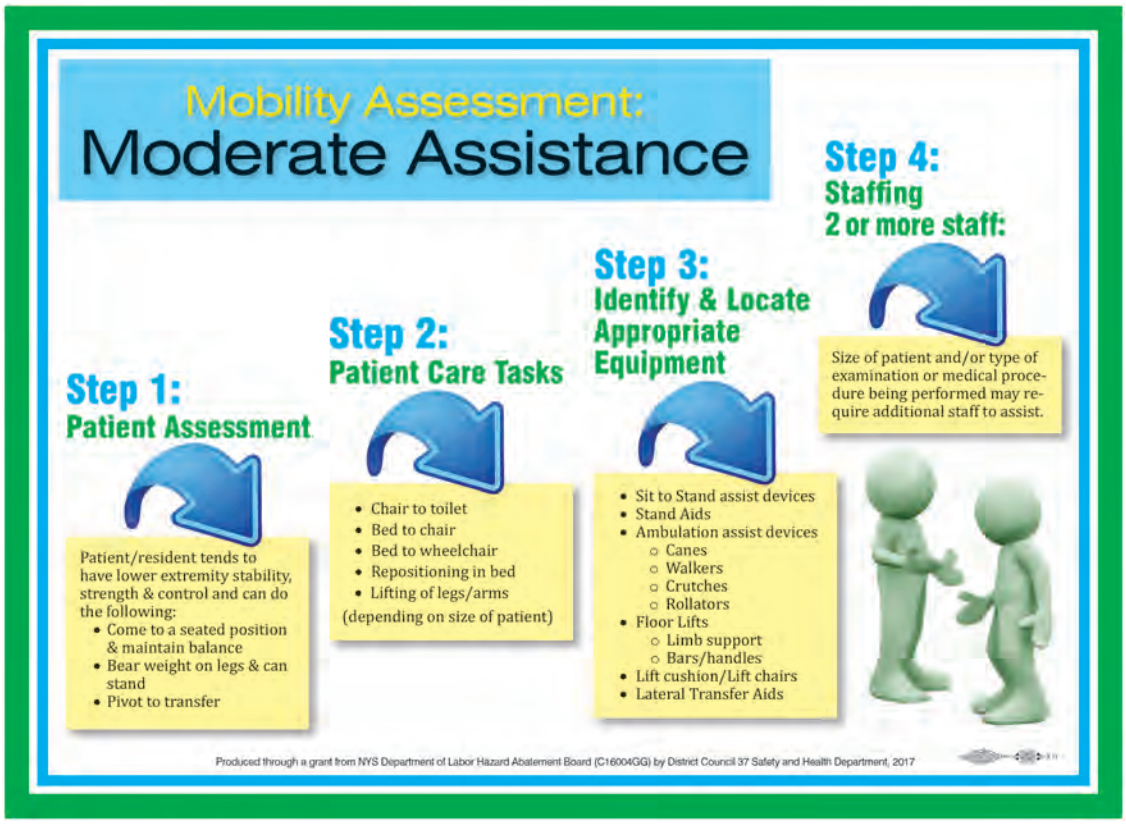
There are three terms used within NYC H+H to inform caregivers of a patient's assessment findings:

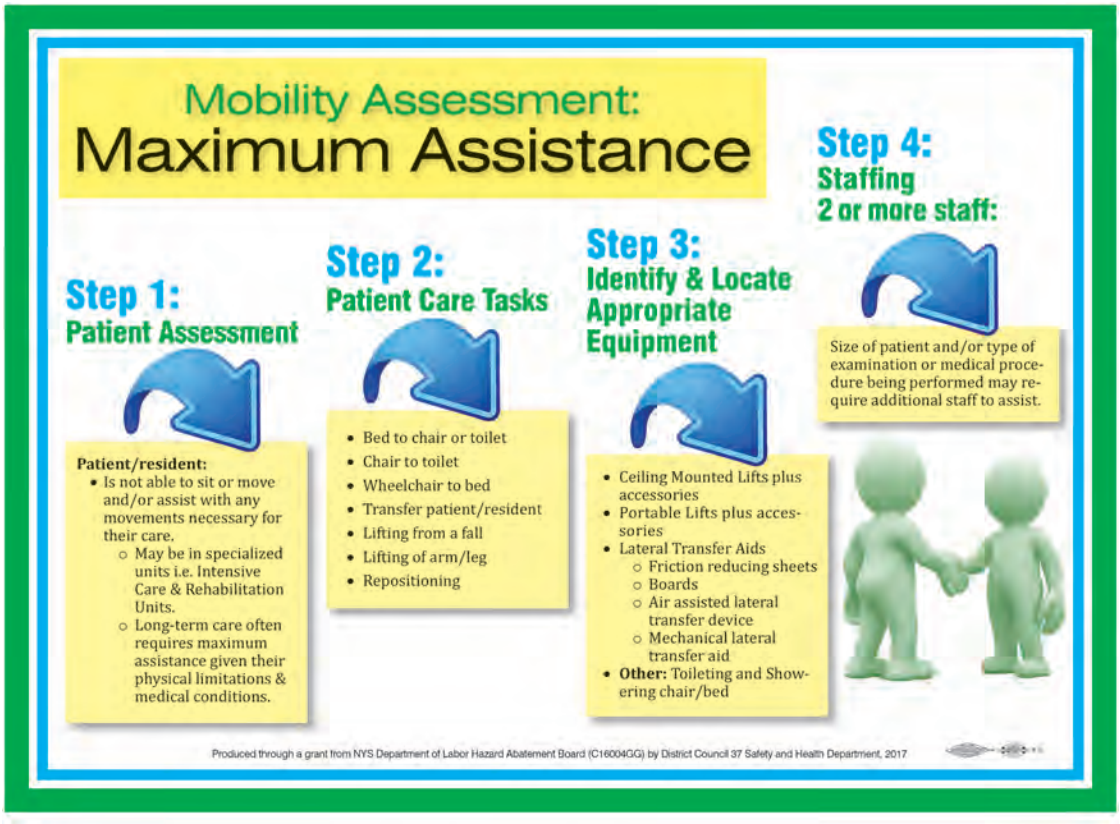
Minimum Assistance, Moderate Assistance and Maximum Assistance

Based on a patient's mobility, patient care tasks are identified as well as the equipment and staff necessary to carry out the tasks.

Please refer to the visual aids below that describe this process as it relates to the identification of the three terms cited earlier.




Mobility Assessment:
Moderate Assistance
Step 1:
Patient Assessment
Patient/resident tends to have lower extremity stability, strength & control and can do the following:
• Come to a seated position & maintain balance
• Bear weight on legs & can stand
• Pivot to transfer
Step 2:
Patient Care Tasks
• Chair to toilet
• Bed to chair
• Bed to wheelchair
• Repositioning in bed
• Lifting of legs/arms
(depending on size of patient)
Step 3:
Identify & Locate Appropriate Equipment
• Sit to Stand assist devices
• Stand Aids
• Ambulation assist devices
o Canes
o Walkers
o Crutches
o Rollators
• Floor Lifts
o Limb support
o Bars/handles
• Lift cushion/Lift chairs
• Lateral Transfer Aids
Step 4:
Staffing
2 or more staff:
Size of patient and/or type of examination or medical procedure being performed may require additional staff to assist.
Produced through a grant from NYS Department of Labor Hazard Abatement Board (C16004GG) by District Council 37 Safety and Health Department, 2017


Mobility Assessment:
Maximum Assistance
Step 1:
Patient Assessment
Patient/resident:
• Is not able to sit or move and/or assist with any movements necessary for their care.
o May be in specialized units i.e. Intensive Care & Rehabilitation Units.
o Long-term care often requires maximum assistance given their physical limitations & medical conditions.
Step 2:
Patient Care Tasks
• Bed to chair or toilet
• Chair to toilet
• Wheelchair to bed
• Transfer patient/resident
• Lifting from a fall
• Lifting of arm/leg
• Repositioning
Step 3:
Identify & Locate Appropriate Equipment
• Ceiling Mounted Lifts plus accessories
• Portable Lifts plus accessories
• Lateral Transfer Aids
o Friction reducing sheets
o Boards
o Air assisted lateral transfer device
o Mechanical lateral transfer aid
• Other: Toileting and Showering chair/bed
Step 4:
Staffing
2 or more staff:
Size of patient and/or type of examination or medical procedure being performed may require additional staff to assist.
Produced through a grant from NYS Department of Labor Hazard Abatement Board (C16004GG) by District Council 37 Safety and Health Department, 2017

The following sample form can be used to record daily patient assessments that may be required as the patient's condition, physical ability and mobility change:

Daily Assessment Sheet

Patient Name:			Completed by: Date:		
Type of equipment →	Total mechanical lift	Sit/Stand lift	Gait/Transfer Belt	Repositioning device	Independent
Type of Transfer ↓					
Bed to wheelchair					
Wheel chair to toilet					
Wheelchair to other surface (chair, bench)					
Bathing					
Showering					
Repositioning in bed					
Transportation					
Other					

Training and education

Successful implementation of a safety program cannot occur unless workers are equipped with the knowledge, tools, and support essential to understanding the hazards in their worksites and what is being done to eliminate them.

Training and ongoing education inform workers of the SPH Policy and Program at a facility. This education makes clear what equipment is available, where it is stored, when it should be used, how many staff members are required for the use of each piece of equipment, and where to get or read a patient's handling and mobility needs. Workers are encouraged, by both management and labor, to report and or discuss any concerns or misunderstandings with management without fear of retaliation or punitive actions.

Program Evaluations

To find out if the safe patient handling program is effective, an evaluation process must be established. The SPH Committee at each facility should set aside time, quarterly or annually, to review the different elements of the program and verify that each is current and effective.

The overall success of the program can be measured by an observable reduction in staff injuries and by a noticeable decrease in time away from work or return-to-work with restrictions. The amounts of work orders for SPH equipment repairs may indicate to the SPH Committee that additional equipment or a new different vendor is required. A review of the training program and referrals for refreshers may point to the need for better training materials or different training methods.

What makes a program successful? To find out if your facility program is successful, consider the following:

- Manual handling injury rates decrease more rapidly than:

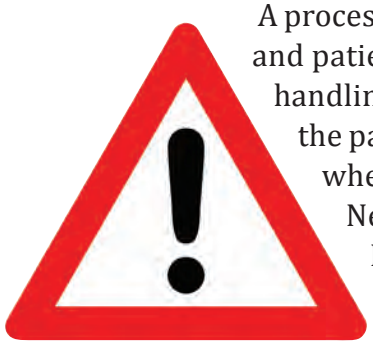
  Before the program was implemented;
  When compared to other institutions.
- Staff is actually using the equipment and is involved in the whole process.
- Absences due to injuries are reduced, eliminating the added stress on workers who have to double up on duties when co-workers are out because of a preventable injury.

An Awareness of Renovations and Remodeling Projects

Any renovation that a health-care facility is planning should consider the prospect of installation of new safe patient handling equipment, such as a ceiling mounted lift, in patient care rooms, units and floors. Changes to a floor footprint should not eliminate storage areas for mobile lifting equipment.

Information on projects whether planned, funded, or executed, should be shared with the SPH committees so they can ensure that the renovations or repairs do not negatively affect the facility's Safe Patient Handling Program. The committees can also propose additional equipment or storage needs during the planning stages of any renovation. If any new equipment is recommended, workers should be given the opportunity to try out a variety of models on the market and participate in the selection of ones that are best suited for their unit.

Good Faith Employee Refusals



A process for Good Faith Employee Refusals is necessary to protect both employee and patient. The SPH law says that an employee can refuse to complete a patient handling task if she or he believes, in good faith, that an injury to themselves or the patient can occur. The employee must inform their supervisor immediately when they are confronted with a task they are uncomfortable completing. Next, ask that the hazard be corrected, and request for alternative work. Notify your union representative immediately. Document the incident as soon as possible in writing and provide copies to your supervisor and union representative. The employee will be protected from any disciplinary action as long as the worker follows the process established and communicated via the

Your District Council 37 Representatives can be reached as follows:

Blue Collar	(212) 815-1010
Clerical	(212) 815-1020
Hospital and Health Care Professional	(212) 815-1030
Professional and Cultural	(212) 815-1040
Schools	(212) 815-1050
White Collar	(212) 815-1060

Safe Patient Handling Program Checklist

INSTRUCTIONS: This sample checklist highlights many of the important components of a safe patient handling program or policy, including development, management and staff involvement, needs assessments, equipment, education and training, and evaluation. You can use the checklist to help identify those components of your safe patient handling program or policy that are well developed, as well as those that need further development. The checklist can be customized by adding or deleting components specific to your hospital. It is recommended that the checklist be completed at frequent intervals to ensure ongoing program evaluation.

This checklist is advisory in nature and informational in content. It is not a standard or regulation, and it neither creates new legal obligations nor alters existing obligations created by OSHA standards or the Occupational Safety and Health Act.

FACILITY NAME: _____

UNIT ASSESSED (if applicable): _____

ASSESSMENTS TO BE CONDUCTED: (check one)

☐ Monthly ☐ Bi-monthly ☐ Quarterly

☐ Semi-annually ☐ Annually

DATE OF ASSESSMENT: _____

CONDUCTED BY: _____

Safe Patient Handling Program Checklist

I. Policy Development	In Place	Not Done	Will Adopt
A. A safe patient handling policy that eliminates manual lifting to the extent feasible is in place and communicated to all staff. *It is important for a hospital to have a policy in place that is understood by all staff and reviewed on a regular basis. Systematic clarification of the roles and responsibilities of staff in the form of a written safe lifting policy helps maintain program sustainability.*	☐	☐	☐
	Notes (timelines, responsibilities, etc.)		
B. Patients are made aware of the safe patient handling policy. *Making patients aware of the safe patient handling policy will help patients understand how using patient handling equipment will benefit both them and their caregivers.*	☐	☐	☐
	Notes		
C. Management reinforces the safe patient handling policy. *Having management at all levels consistently reinforce the policy is critical.*	☐	☐	☐
	Notes		

II. Management and Staff Involvement	In Place	Not Done	Will Adopt
A. Management fosters safe patient handling and a culture of safety. *Successful programs embrace a culture of safety that includes safe patient handling, as employees appreciate knowing that senior managers care about their well-being.*	☐	☐	☐
	Notes (timelines, responsibilities, etc.)		
B. A safe patient handling committee represents all levels. *Hospitals should form committees that include a range of staff from all affected departments, including members representing administrators and frontline staff.*	☐	☐	☐
	Notes		
C. Staff is involved during every step. *Involve staff during every step of safe patient handling program implementation (e.g., hazard assessment, technology procurement, education and training, program evaluation).*	☐	☐	☐
	Notes		
D. Super users, safety coaches, or champions exist in each unit. *Safety coaches, "champions," or "super users" continually remind and educate their peers about the program, answer questions, troubleshoot issues, and promote the culture of safety. There should be a dedicated staff member who fills this role in each unit.*	☐	☐	☐
	Notes		
E. The safe patient handling program has nurse manager support. *Nurse managers also need to support and reinforce safe patient handling with staff in every unit.*	☐	☐	☐
	Notes		

Safe Patient Handling Program Checklist

F. Laundry, maintenance, and engineering staff support the safe patient handling program. *It is essential that departments such as laundry, maintenance, and engineering understand how vital they are to support a hospital's safe patient handling program.*	☐	☐	☐
	Notes		
III. Needs Assessment	**In Place**	**Not Done**	**Will Adopt**
A. Mobility assessment criteria are established and applied to each patient. *Every patient has unique characteristics and mobility capabilities that need to be assessed on a regular basis.*	☐	☐	☐
	Notes (timelines, responsibilities, etc.)		
B. A patient handling plan is communicated for each patient. *Once each patient's level of mobility and need for assistance is assessed, that information needs to be communicated to all relevant caregivers.*	☐	☐	☐
	Notes		
IV. Equipment	**In Place**	**Not Done**	**Will Adopt**
A. Frontline staff is involved in selecting equipment. *The workers who actually move and transfer patients are a valuable resource when determining the most effective equipment.*	☐	☐	☐
	Notes (timelines, responsibilities, etc.)		
B. Equipment is chosen based on units' needs. *Individual units may have different movement and transfer needs, so make sure to involve staff from all units.*	☐	☐	☐
	Notes		
C. Equipment is convenient, available, and accessible. *Having appropriate and easy-to-use safe patient handling equipment conveniently located encourages routine use.*	☐	☐	☐
	Notes		
D. Equipment cleaning and maintenance systems are in place. *Equipment needs to be maintained properly and charged at all times. Responsibility for cleaning equipment should be clearly designated.*	☐	☐	☐
	Notes		
E. Partnership with vendor(s) is considered. *Vendors can help to develop safe patient handling specifications, troubleshoot issues, answer questions, and maintain equipment.*	☐	☐	☐
	Notes		

Safe Patient Handling Program Checklist

F. Construction and remodeling projects take safe patient handling considerations into account. *When undertaking construction and remodeling at a hospital, it is more effective to design with safe patient handling in mind than to retrofit afterward.*	☐	☐	☐
	Notes		
V. Education and Training	**In Place**	**Not Done**	**Will Adopt**
A. All relevant staff is trained on using equipment. *If the caregiver uses the equipment correctly and efficiently, patients will feel more comfortable.*	☐	☐	☐
	Notes (timelines, responsibilities, etc.)		
B. All staff is educated on the importance of safe patient handling. *By educating all staff, including physicians, about the safe patient handling program, hospitals can reduce instances of a clinician asking—or expecting—colleagues to move patients manually.*	☐	☐	☐
	Notes		
C. Staff is trained on equipment annually. *Including safe patient handling in annual competency reviews helps promote the program and equipment proficiency.*	☐	☐	☐
	Notes		
D. Patients/families are educated on policy/equipment. *Educating patients and their family members about your hospital's policy and use of equipment will engage them in the safe patient handling process.*	☐	☐	☐
	Notes		
VI. Program Evaluation	**In Place**	**Not Done**	**Will Adopt**
A. Metrics are tracked to evaluate program success. *You can track the success of your program by examining the number and type of staff injuries, specific activities that led to these injuries, number of lost work or modified duty days, and the effectiveness of the safe patient handling policy. Consulting your OSHA 300 logs and your supplemental 301 or workers' compensation forms can be an excellent way to gather this information.*	☐	☐	☐
	Notes (timelines, responsibilities, etc.)		
B. Improvements to the safe patient handling program are considered. *Every program needs adjustment after being put into practice. Even small changes can improve safe patient handling tremendously in your hospital.*	☐	☐	☐
	Notes		

For more information on safe patient handling, visit www.osha.gov/dsg/hospitals.

OSHA Occupational Safety and Health Administration

Chapter 5:
The Facility-Based Committee

EVERY HEALTH-CARE facility must have a safe patient handling (SPH) committee. As per the New York State's Safe Patient Handling Law, the purpose of the committee is to design and recommend the processes, procedures and protocols for implementing a SPH program. The makeup of the committee should have staff with different responsibilities related to safe patient handling, such as risk management, purchasing and direct care workers (nursing, patient care technicians or nurse's aide). The committee must have co-chairs, one management and one front-line worker appointed by the union. Half of the committee members need to be front-line, non-managerial workers who provide direct care to patients. This is important to address issues directly related to safe patient handling, such as maintenance and cleaning of equipment or lack of working equipment on a particular unit or floor.

The purpose of the committee is to work on changing the culture of their respective facility through education, problem-solving, valuable trainings and encouragement to all front-line staff and management. Under the law, the committee is responsible for making sure the SPH program has at minimum the following elements:

- SPH Written Policy
- Environmental Hazard Assessment
- Patient Assessment Process
- Training and Education
- Incident Investigation and Review
- Annual Performance Evaluation
- Plans for Construction/Remodeling
- Workers' Right to Refuse

Some of the areas that can require follow up from the committee on an on-going basis including the environmental hazard assessment, patient assessment process, training & education, incident investigation and workers' right to refuse.

Let's talk about some of the responsibilities of the facility based committees.

The committee receives and reviews the environmental hazard assessment. This document shows what equipment is available and recommends what equipment could be used on a particular unit or floor based on the type of patient population and handling tasks. The patient assessment process can be reviewed if there are issues reported such as the assessment tool not capturing the patient's needs or access to the assessment tool is limited or unavailable.

It is also vital that the committee track and review any training on equipment or safe patient handling. A training schedule and completion rate should be provided to the committee. This will help measure the effectiveness of training and if any further changes need to be made. Initial training on new equipment is often provided by the vendor. Refresher trainings or annual competency can be presented by the staff education or human resources departments.

When investigating safe patient handling incidents, the committee should review the incident report, determine the injuries, if any, that occurred, (whether staff or patient) and what corrective measures can be taken to reduce or eliminate this type of incident/injury in the future.

The committee should meet on a regular basis with an agenda indicating what will be discussed. Agendas are a productive way to keep focus and track of issues to be addressed during meetings. All facilities are required to keep minutes of every meeting to record what was discussed and to document if there are any items that require follow up. Minutes from the meeting are a summary of the business conducted and explain why the meeting was held. For example, if there are agenda items that require follow up, the minutes should reflect this information. Furthermore, the minutes are a great way to review if someone is not present for the meeting and allows senior management to know what the facility's staffs concerns are based on what was reported and discussed.

For a list of the members of your committee speak with the SPH champion identified below:

Facility	Name	Email	Address
Bellevue	Kevin Shao, MS, CHSP, CHEP	Kevin.shao@nychhc.org	462 1st Ave. A732, Administration Bldg. New York, NY 10016
Coney Island	Joan Bell, RN	Joan.bell@nychh.org	2601 Ocean Parkway Brooklyn, NY 11235
	Oliver Knight, RN	Olivia.knight@nychhc.org	
Elmhurst	Karl Gray	Grayk@nychhc.org	79-01 Ocean Parkway Elmhurst, NY 11373
	Joann Gull	Gullj@nychhc.org	
	Saima Baig	Baigs@nychhc.org	
Harlem	Carol Brutus	Carol.brutus@nychhc.org	506 Lenox Ave New York, NY 10037
	Pamela Bradley	Pamela.bradley@nychhc.org	
Jacobi	Rami Weiss	Rami.weiss@nbhn.net	1400 Pelham Parkway South, Bronx, NY 10461
	Imelda Kong	Imelda.Kong@nbhn.net	
Kings County	Walid Sleiman	Walid.Sleiman@nychhc.org	451 Clarkson Ave Brooklyn, NY 11203
	Marshle Fontilus	Marshle.Fontilus@nychhc.org	
	Dr. Robert Deporto	Robert.Deporto@nychhc.org	
Lincoln	Dionne Johnson, MSN, RN	Dionne.Johnson@nychhc.org	234 East 149th Street Bronx, NY 10451
Metropolitan	Noreen Brennan	Brennann1@nychhc.org	1901 First Ave New York, NY 10029
	John Costello	John.Costello@nychhc.org	
North Central Bronx	Mathew Marzullo	Mathew.Marzullo@nbhn.net	3424 Kossuth Ave Bronx, NY 10467
	Mary Anne Marra	marram@nychhc.org	
Queens	Wanda Mejias-Gonzalez RN DDS CCS	Mejiasgw@nychhc.org	82-68 164th Street Jamaica, NY 11432
	Sheila Robinson, RN MSN MHA	Robinssh@nychhc.org	
	Delia Beaudouin	Beaudoud@nychhc.org	
Woodhull	Angela Edwards	Angela.Edwards@woodhullhc.nychhc.org	760 Broadway Brooklyn, NY 11206
	Ramon Villa-Real	Ramon.Villa-Real@woodhullhc.nychhc.org	
Long Term Care			
Coler	Stephen Catullo	stephen.catullo@nychhc.org	900 Main Street Roosevelt Is., NY 10044
	Simone Warren	simone.warren@nychhc.org	
Gouverneur	Isabel Marin	isabel.marin@nychhc.org	227 Madison Street New York, NY 10002
	Sue Ling Lee BSN MPH	sueling.lee@nychhc.org	
	Danny Wong	Danny.Wong@nychhc.org	
Carter	Stephen Catullo	stephen.catullo@nychhc.org	1752 Park Ave New York, NY 10035
	Simone Warren	simone.warren@nychhc.org	
McKinney	Beverly Gardner-Samuel	Beverly.Gardner-Samuel@nychhc.org	594 Albany Avenue Brooklyn, NY 11203
Sea View	Liza Panicker RN MSN	liza.panicker@nychhc.org	460 Brielle Ave Staten Island, NY 10314
Diagnostic Treatment Centers			
Cumberland	Monica Peart	monica.peart@nychhc.org	100 North Portland Ave Brooklyn, NY 11205
	Linda Phinazee	phinazel1@nychhc.org	
East NY	Astrid Benjamin	astrid.benjamin@nychhc.org	2094 Pitkin Ave Brooklyn, NY 11207
Morrisania	Rosa Beniquez	Rosa.beniquez@nychhc.org	1225 Gerard Ave Bronx, NY 10452
	Steven Suarez	steven.suarez@nychhc.org	
Renaissance	Oluwadamilare Adeosum	Oluwadamilare.Adeosun@nychhc.org	264 West 118th St New York, NY 10026
Belvis	Amber Featherstone-Uwague	feathera1@nychhc.org	545 East 142nd St Bronx, NY 10454
	Gifty Amankwah	gifty.amankwah@nychhc.org	
Other Facilities			
Riker's Island	Nancy Arias	narias@nychhc.org	

Chapter 6:
Equipment for Safe Patient Handling

HEALTH-CARE FACILITIES, such as acute care or a long term care facilities, provide a range of services. Such services include emergency room care, rehabilitation, medical-surgical, radiological and intensive care. Direct health-care workers engage in different tasks based on the medical treatment outlined for the patient/resident, such as physical therapy, sitting up in bed or transfers from a bed to a chair. During these types of tasks health-care workers, such as nurse's aides and patient care associates/technicians, are on the front line to assist a patient's mobility while under the purvey of their care in a facility.

Safe patient handling is an ergonomic approach to safety that puts emphasis on engineering and administrative controls to reduce injuries related to patient/resident handling activities. Below is a chart that identifies equipment options bases on a patient's assessment.

Equipment Options

MOBILITY LEVEL 1 Dependent	MOBILITY LEVEL 2 Moderate Assist	MOBILITY LEVEL 3 Minimal Assist	MOBILITY LEVEL 4 Modified Independence
			

The following table presents a variety of assist equipment and devices that are routinely used as part of an effective SPH Programs. In some cases, more than one type may be required for both the patient and the healthcare worker to complete a task.

Assist Equipment and Devices	
Lifts	
Total-body	These devices that move or lift totally dependent patients/residents are designed to support the entire body weight.
Stand/Assist	These lifts move patient to and from a variety of surfaces: chairs, toilets, beds, shower stalls. Patients who used this type of equipment can handle their own weight, and have upper-body strength and control.
Ambulation	These lifts support a patient/resident during ambulation (walking). The lift is pushed by the patient as she or he walks. A strap, paddles, seat or other object prevents the patient from falling down.
Bathtub and shower	Similar to the lifts installed for pools, these lifts are used for transfers from bed or chair to bathtub or shower. A patient/resident can stay on the lift during the cleansing process.
Lateral Transfers	
Transfer Boards	The board is placed between two surfaces and the patient slides across. If surfaces are of unequal height this may present a stability risk. This may be uncomfortable for some patients.
Draw sheets/ Incontinence pads	These sheets are used to slide patient/residents between two horizontal surfaces or for repositioning in beds and chairs. These should be used in combination with friction reducing devices such as slide boards, slippery sheets, plastic bags, or low-friction mattresses covers.
Slide Boards	This is a board that reduces friction. Some come equipped with hand-holds. The patient is slid or rolled onto the board and then the board is pushed or pulled to accomplish the task. A draw sheet or pad should be used.
Roller Boards/Mats	Covered boards or mats with rollers are placed, between two transfer points. The patient is placed on the device and rolled to a new position.
Gurneys with transfer devices	These are height adjustable gurneys that have built-in slide boards or are mechanized to laterally move patients.
Friction/slippery sheets	These can be used under draw sheets to reduce resistance on lateral transfers. Slippery sheets or plastic bags can also be used.
Transfer mats	These are smaller mats that provide low resistance. One is placed and secured under the head and one is strapped under the hips. The mats are pulled to accomplish the task.
Ambulation, Repositioning, Manipulations	
Fixtures and Stands	Devices that hold arms, legs, and extremities when a patient is receiving medical care or during surgical procedures or similar care.
Gait Belts	These are fastened around a patient's/resident's waist and the caregiver grips the belt during ambulation. The belt may be used to help a patient/resident sit-up or be repositioned. Precautions to consider when using the gait belt are: it can slid up and cause injury; it is not to be used with heavy or non-weight bearing patients and residents; if tightened too much, it causes the caregiver difficulty in grasping the belt; there are limitations for their use, i.e. recent abdominal/back surgery or other condition that can be made worst by the use of the belt.
Transfer Belts with Handles	These are wider than the gait belt and have padded handles on each side that are easier to grip and allow better control.
Hand blocks	These enable a patient/resident to raise themselves up and reposition in bed.
Lift chair	A chair that is equipped with a lift that slowly raises upward and tilts forward. These chairs help the patient/resident stand up.
Lift Cushions	These are spring action cushions that raise patients/residents up.

Pivot Disc	A disc that might remind you of a Lazy Susan. They are placed on the floor and the patient/resident steps on it so they can be rotated to sit onto a bed or chair.
Push-up Bars	Usually found on the side of the bed to allow the patient/resident to reposition themselves.
Range of Motions Machines	Machines that automatically move or manipulate arms, legs, or extremities.
Trapeze Bar	A bar suspended from an overhead structure that allows the patient/resident to reposition themselves.
Activities of Daily Living	
Hand tools for showering, bathing and cleansing	These include shower heads, wash or scrub brushes, and other items that reduce the amount of bending, stretching, reaching, and twisting washing the patient's/resident's legs, feet, trunk.
Shower-toileting Chairs	These shower chairs have wheels and are high enough to fit over the toilet. Eliminates need to transfer.
Shower carts or gurneys	These are lined with waterproof materials so that the patient can be undressed, showered, dried, and redressed.
Ramp or bed scales	Eliminates transfers by weighing patients/residents in beds and wheelchairs
Bath boards	Boards are leveled between the shower seat or bathtub. The patient/resident slides or is assisted from a chair or wheel chair into the bathtub or shower. These can be used for non- or partial weight-bearing individuals with upper-body strength and control.
Pelvic Lift Devices (hip lifter)	Inflatable lifts that are positioned under the hips. They are inflated like a pillow and lifts the hips so that a special bed pan can be easily inserted and removed
Height-adjustable bathtubs	Bathtub with lifting and lowering mechanisms. Patients who can walk have an easier time climbing into a low bathtub. Those that cannot walk can be lowered in by a lift. The bathtub can be raised to eliminate bending and reaching during patient care and when cleaning the bathtub.
Toilet seat riser	Plastic seats that sit on top of toilet and reduce the distance and amount of effort needed to lower and raise the patient/resident.
Source: A Back Injury Prevention Guide for Health Care Providers, written and edited by Mario Feletto, Cal/OSHA Consultation Service, Education and Training Unit, Sacramento California and Walter Graze, CAL/OSHA Consultation Service, Headquarters, San Francisco, CA	

Proper training is necessary to use the right equipment to assist the patient/resident for care. Initial training in your facility should typically be provided by your employer and/or vendor.

Quick reference guides attached to the equipment or even displayed in storage areas serve as a good reminder of the various types of tasks the equipment can be used for. Also Unit Peer Leaders can be utilized as a point of reference for daily usage. Refresher trainings can be presented by clinical educators in your facility. Knowing how and where to access the right equipment for safe patient handling will protect the patient/resident and your body to minimize injury.

Chapter 7: Ergonomics

ERGONOMICS is the study of how a workplace can be best designed to ensure the comfort, productivity and safety of the worker. In a health-care facility, good ergonomic practices are vital in preventing musculoskeletal disorders (MSDs). Caregivers, who frequently lift and reposition patients, are very susceptible to musculoskeletal disorders. The National Institute of Occupational Safety and Health (NIOSH) states that the safe lift limit is 35 pounds.[3] However, caregivers are presented with challenges beyond weight limits. The patients themselves often do not present caregivers with ideal lifting scenarios.

A patient's mental state, i.e. being combative or argumentative and their susceptibility to fall or lose balance, both make working with patients less than ideal. Finally, transferring patients in the confines of small bathrooms and rooms often cluttered with medical equipment and furniture works against the workers being able to use proper body mechanics. All of these factors lead to injuries, especially musculoskeletal disorders, and we believe that this can be prevented with a comprehensive Safe Patient Handling program.

MSDs are health conditions that involve the nerves, tendons, muscles and supporting structures of the body. The areas of the body that are typically impacted are the neck, shoulders, back (upper & lower), legs, knees and even your feet. Daily functions, such as walking, sitting or lifting, can become uncomfortable or even painful if you are affected by one of these disorders.

The most common type of musculoskeletal disorder is low back pain. According to the National Institute of Arthritis and Musculoskeletal and Skin Disease (NIAMS), low back pain tends to impact adults in their 30s and 40s. Other types of MSDs are pinched nerve, herniated disc and meniscus tear.

The exact cause of MSDs can be dependent on age, occupation, activity level or lifestyle. Work-related MSDs tend to have higher risk in such occupations as nurses, direct-care workers, laborers and firefighters.

Symptoms can include overall body ache, fatigue and loss of sleep. Being aware of the symptoms can prevent further damage to your body and with the correct treatment reduce pain and further MSDs.

Research conducted by the Bureau of Labor Statistics, shows that direct-care health workers are ranked number two for state and local government and ranked number one in the private sector as a high risk occupations for MSDs. Fifty-four percent of total cases occurred among nursing assistants. It is likely that this number is also low because of a culture of underreporting work-related injuries as a result of a lack of understanding or fear of reprisal.

[3]http://www.cdc.gov/niosh/topics/safepatient/

Causes of Musculoskeletal Disorders

Two causes of musculoskeletal disorders are improper mechanics and tasks that are performed by health-care workers.

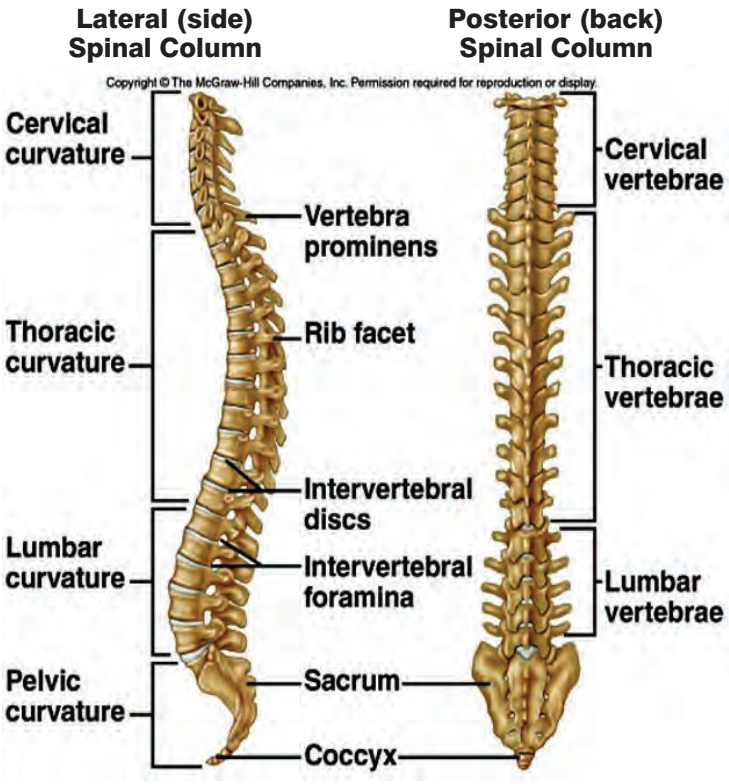
• Improper body mechanics

Have you ever re-positioned a patient in bed without any form of assistance? Have you felt your lower back or knees hurt from excessive lifting or bending? Do you find yourself having to take pain relievers to minimize pain in your lower back after coming home from work? If any or all of these have happened to you, one of the reasons is that you may be relying more on your body instead of patient transfer/lift equipment.

How you move your body during day-to-day activities is referred to as body mechanics. As a health-care worker you may find yourself, throughout the day, bending, reaching up or assisting a patient out of the bed to the bathroom or to receive care in another part of the hospital or skilled nursing facility.

Research has concluded that proper body mechanics should no longer be the only method promoted for moving patients in order to reduce the risk of injury.

Body parts involved in manual lifting



The main parts of your body that are utilized for lifting or bending are your back, legs and knees. Your back consists of your spine, which include bones or vertebrae and cartilage or disks that are set in three natural curves. Your neck- the cervical curve – supports your head while the middle back, the thoracic curve, is supported by your rib cage. Lastly, your lower back, the lumbar curve, does the most work in your back by supporting your entire upper body. Since your lower back supports the most weight and is constantly in motion, this area has the highest risk of injury[4].

The body depends on the muscles in your legs and joints in your knees. When the body is used correctly for walking, standing or lifting, your leg muscles do more of the work by eliminating weight on your back. Your knees, with constant bending and walking, can be subject to wear and tear when too much weight is placed on these joints. Arthritis and backache are a few of the medical conditions that over time are caused from overuse of your back and knees. Stretching from time to time during the day can keep muscles from getting tight[5].

[4] http://www.mountnittany.org/articles/healthsheets/3780

One way to reduce your risk of injury is maintain good posture. This can be challenging due to bad habits, such as slouching, but can be corrected with being aware of your body and practice. Some best practices for maintaining good posture when lifting is to stand with your feet apart with one slightly in front of the other, keep your back straight and bend with your knees and hips. Whenever possible utilize patient lift/transfer equipment and seek assistance from other direct-care workers, as necessary, to safely move/transfer patients.

Dos and Don'ts

DO utilize patient transfer/lift equipment to protect your body from injury.

DO move your torso (shoulders to hips) as one unit to avoid twisting injuries.

DO keep your abdominal muscles tight to sustain your body movements.

DON'T stand on your tiptoes for long periods of time to reach a high level such as a supply room since this will place unnecessary strain on your neck and back.

DON'T stand in one position for extended periods of time. Try to alternate pressure from one side of the body to the other to minimize stress on your spine, increase circulation and reduce muscle fatigue.

DON'T bend forward at your waist with your knees straight since this is placing all of the weight on your back.

•Tasks performed by health-care workers

Every day health-care workers perform physically demanding tasks at work. These tasks can be hazardous and lead to injury. If exposed, tasks can be classified as ergonomic hazards. Examples include:

- Turning a patient in bed (repositioning)
- Assisting a patient out of bed to a chair or wheelchair (transfers)
- Supporting a patient while walking for therapy (ambulation)

Ergonomic hazards can be prevented if the employer uses best practices, such as providing assistive equipment, to reduce injuries. Exposures to these hazards can lead to temporary to permanent pain, loss of work days, and possibly an early end to a career.

Areas of the body that are usually impacted when the tasks are performed:

- Neck
- Shoulders
- Back (upper and lower)
- Legs
- Feet

Symptoms can include:

- Overall body ache
- Fatigue
- Loss of sleep

[5]http://www.coloradospineinstitute.com/subject.php?pn=wellness-body-mechanics

Being aware of the symptoms can prevent further damage to your body and, with the correct treatment reduce pain and further MSDs. Protect yourself and the patient/resident from lifting/repositioning injuries by using assistive equipment such as a Hoyer lift, repositioning sheets/boards or a sit-stand lift.

Report activity you experience after assisting a patient/resident.

Report problems with getting the equipment and/or its condition that prevented its use.

If you have concerns about the patient/resident's condition and it may not match the assessment communicated to you, say something.

Chapter 8:
Accident and incident investigations

WHENEVER an accident or incident occurs, it is vital that an investigation takes place as quickly as possible. Every effort must be made to conduct a thorough review of the factors involved and the chronology of the event.

The SPH Committee should gather the facts, analyze the facts, and correct the process, procedures, and other failed controls that may have been identified as contributors to the accident or injury.

Details to consider:

Who?

When?

Where?

What happened?

How did it happen?

Why did this happen?

How will it be prevented from happening again?

Other questions to ask:

What is supposed to happen?

What usually happens?

What happened that day?

What was different about that day?

For the *Just Culture* approach to work, it is important to evaluate NYC H+H systems vulnerabilities first then individual performance.

Examples of potential NYC H+H system's weaknesses:

Ineffective communication

Inadequate training

Inadequate policies and procedures

Lack of accountability

Lack of proper supervision and management

Environmental barriers

Equipment barriers and failures

Poor scheduling and low staffing

Cultural norms

Investigation finding

The conclusions of any investigation should be communicated to the staff so that they are made aware of changes to procedures or process.

Corrective actions to prevent further risks to workers should be reinforced during daily debriefings.

Preventive actions

Identify triggers that led to the accident or incident that resulted in injury:

- Remove the reasons why it occurred.
- Set up procedures in the event that it happens again.
- Follow up to ensure things are properly put in place to prevent more accidents and injuries

The SPH committee can make recommendations to improve many areas of its program that were identified as deficient during an investigation.

Chapter 9: Resources

The following are a variety of resources that offer more breadth and depth to the topic of safe patient handling and provided useful information.

Safe Patient Handling Workgroup from the NYS DOH

https://www.health.ny.gov/statistics/safe_patient_handling/

12 Facts about the Safe Patient Handling Movement

http://www.zeroliftforny.org/wp-content/uploads/2015/04/SPH-FactSheets.pdf

Safe Patient Handling Techniques Videos

https://www.labor.ny.gov/workerprotection/safetyhealth/safe-patient-handling.shtm

Busting the Myths on Safe Patient Handling

https://www.osha.gov/dsg/hospitals/documents/3.1_Mythbusters_508.pdf

Sample Checklist for Safe Patient Handling

https://www.osha.gov/dsg/hospitals/documents/3.2_SPH_checklist_508.pdf

Education and Training on Safe Patient Handling

https://www.osha.gov/dsg/hospitals/education_training.html
https://www.osha.gov/SLTC/healthcarefacilities/safepatienthandling.html
https://www.cdc.gov/niosh/docs/2009-127/pdfs/2009-127.pdf
http://www.publichealth.va.gov/employeehealth/patient-handling/index.asp

Safe Patient Handling Movement

http://www.cdc.gov/niosh/topics/safepatient/
https://www.osha.gov/dsg/hospitals/patient_handling.html
http://www.asphp.org/

Legislation on Safe Patient Handling

http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-SafePatientHandling
https://www.congress.gov/bill/114th-congress/senate-bill/2408/text?q=%7B%22search%22%3A%5B%22%5C%22s2408%5C%22%22%5D%7D&resultIndex=1
https://www.congress.gov/bill/114th-congress/house-bill/4266/text?q=%7B%22search%22%3A%5B%22%5C%22hr4266%5C%22%22%5D%7D&resultIndex=1

Statics on Nonfatal Occupational Injuries

http://www.bls.gov/news.release/pdf/osh2.pdf

Musculoskeletal Disorders

http://www.healthline.com/health/musculoskeletal-disorders
http://www.webmd.com/pain-management/guide/musculoskeletal-pain
http://www.cdc.gov/niosh/docs/2012-120/pdfs/2012-120.pdf
https://www.osha.gov/SLTC/ergonomics/

Ergonomics on Safe Patient Handling

https://www.osha.gov/SLTC/etools/hospital/hazards/ergo/ergo.html
http://www.oregonrn.org/?101

Facility-Based Committees

http://www.zeroliftforny.org/wp-content/uploads/2015/11/final-SPH-Committee-Formation-NYS-SPH-Conf-Saratoga-NG-and-KM-October-29-2015.pdf
http://www.ala.org/yalsa/sites/ala.org.yalsa/files/content/aboutyalsa/yalsahandbook/effectivecommittees.pdf
http://www.diycommitteeguide.org/resource/running-effective-meetings
http://www.mycommittee.com/BestPractice/Committees/tabid/135/Default.aspx

Body Mechanics

http://www.coloradospineinstitute.com/subject.php?pn=wellness-body-mechanics
http://www.mountnittany.org/articles/healthsheets/3780
https://www.drugs.com/cg/proper-body-mechanics.html
http://my.clevelandclinic.org/health/diseases_conditions/hic_Posture_for_a_Healthy_Back

Just Culture

https://www.health.ny.gov/professionals/patients/patient_safety/conference/2007/docs/patient_safety_and_the_just_culture.pdf
http://nursingworld.org/psjustculture
https://psnet.ahrq.gov/resources/resource/1582

Equipment

http://www.aohp.org/aohp/Portals/0/Documents/ToolsForYourWork/free_publications/Beyond%20Getting%20Started%20Safe%20Patient%20Handling%20-%20May%202014.pdf.pdf
http://www.arjohuntleigh.us/products/patient-transfer-solutions/
http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/ucm308622.htm

History of Safe Patient Handling

http://www.asphp.org/learning-center/
http://assembly.state.ny.us/comm/WorkPlaceSafe/20110527a/index.pdf
http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-SafePatientHandling

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