A Resource Guide: Implementing a Safe Patient Handling and Mobility Program in the Acute Care Setting
Beyond Getting Started

A Resource Guide:

Implementing a

Safe Patient Handling and Mobility Program

in the Acute Care Setting

Fourth Edition

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Introduction

A primary goal of the Association of Occupational Health Professionals in Healthcare’s (AOHP) Alliance with the Occupational Safety and Health Administration (OSHA) is to develop educational materials related to the targeted areas identified in the Alliance. Patient handling, bloodborne pathogens, and emergency preparedness are the three focus areas for the Alliance. The Alliance recognizes that patient handling practices impact both healthcare personnel (HCP) and the patient. Safe patient handling practices reduce the risk of the patient falling or experiencing skin breakdown from repositioning or lateral transfers in bed. The goal is to utilize safe patient handling equipment to mobilize patients sooner, more often, and to their highest mobility level. In addition, implementing safe patient handling practices will reduce the facility’s financial burden with regard to patient and workers’ compensation claims.

This resource guide addresses patient handling with the goal of providing the necessary tools for the occupational health professional (OHP) to implement a safe patient handling and mobility (SPHM) program. Since this guide was first published, the body of evidence that demonstrates the benefits of SPHM programs has continued to grow, and this resource guide attempts to consolidate that evidence into a useful format for the OHP or other healthcare professionals charged with implementing a SPHM program.

SPHM programs frequently are initiated by or become the responsibility of the OHP. In some cases, this new responsibility may not include the additional resources to implement a program effectively and efficiently. This resource guide identifies the basic steps and processes necessary to implement a SPHM program in a comprehensive manner, including the need for adequate funding.

Background information and the differences among acute, long-term, and ambulatory care settings are reviewed in Sections 1 and 2. Building a foundation for the program’s success is outlined in Section 3. Sections 4 and 5 describe the process (assessment, planning, implementation, and evaluation) of establishing a SPHM program. Appendix A includes the AOHP position statement on safe patient handling. Lastly, Appendix B shows samples of items that might need to be developed for the program, along with a reference section of links to the web for easy access to information.

AOHP hopes that the fourth edition of this resource guide will serve as a valuable tool in establishing and maintaining a safe working environment for HCP. Feedback is much appreciated and can be forwarded to the AOHP national office via e-mail at info@aohp.org.
Section 1
Background

Musculoskeletal injuries, especially back injuries, have been among the most frequently cited injuries by healthcare personnel (HCP) who provide bedside nursing care. These injuries can be debilitating, potentially career-ending, and impact the injured person’s life forever. For over 25 years, these types of injuries have gained and continue to sustain national attention. This section will review common patient handling myths, legislative activity to mitigate the risk, national standards, and advances related to patient mobility assessment, equipment, education, and certification.

Safe Patient Handling Myths

A number of myths perpetuate manual patient handling and transfers. These myths have been reinforced by a culture that accepted musculoskeletal injuries related to patient handling as the norm. Dr. Audrey Nelson, Director of the Patient Safety Center of Inquiry at the James A. Haley Veterans Administration Medical Center in Tampa, Florida, was an early nurse researcher and leader who utilized evidence-based findings to dispel the myths and support the use of safe patient handling equipment. Dr. Nelson’s colleagues continue her work to provide best evidence-based practices to support ongoing use of equipment for patient handling.

Common myths associated with safe patient handling include:

➢ Body mechanics training is effective in preventing patient handling-related injuries.
➢ Back belts are effective in reducing risks to caregivers.
➢ Nurses who are physically fit are less likely to be injured than nurses who are not physically fit.
➢ It is safe to lift a 200-pound patient.
➢ Safe patient handling equipment is not affordable.
➢ If a facility purchases safe patient handling equipment, staff will use it.
➢ Lifting patients is the only high-risk patient handling task.
➢ Injuries to nurses can be prevented by careful screening of nurses before hiring.
➢ All safe patient handling equipment is equally effective.
➢ Use of safe patient handling equipment eliminates the risks involved in manual lifting.
➢ If a facility has a no-lift policy, HCP will stop lifting.

Legislative Activities

In 2000, the Occupational Safety and Health Administration (OSHA) issued an ergonomic standard. AOHP participated in the development of this standard by providing testimony in Washington, D.C. and in Chicago during the public hearings. Although the final ergonomic standard was repealed by Congress in 2001, OSHA addressed the issue of patient handling in nursing homes with the historic Beverly Settlement. In this settlement, OSHA required the development of a mandatory safe patient handling program within the facility.

As a result of the Beverly Settlement, OSHA also developed a set of guidelines for the nursing home industry as a whole. These Guidelines for Nursing Homes: Ergonomics for the Prevention of Musculoskeletal Disorders recommend that “manual lifting of residents be minimized in all cases and eliminated when
feasible.” Although the guidelines are written for nursing homes, OSHA has recommended that they be adopted in acute care facilities as well. While there is no national, formal standard for safe patient handling, OSHA addresses ergonomic concerns, including safe patient handling, through the general duty clause, which requires every employer to provide a safe and hazard-free work environment.

In July 2004, AOHP issued a position statement on safe patient handling. It includes additional background information, strategies to reduce injuries related to safe patient handling and mobility, and references (Appendix A).

In 2005, the American Physical Therapy Association (APTA), the Association of Rehabilitation Nurses (ARN), and the Veterans Administration (VA) published a white paper regarding safe patient handling. As a result of this collaboration, representatives from these groups had met periodically to discuss safe patient handling and mobility and the therapeutic use of safe patient handling technology.

On June 17, 2005, Texas became the first state to initiate a law requiring hospitals and nursing homes to implement a safe patient handling program. This law required the adoption of a policy “to identify, assess, and develop strategies to control the risk of injury to patients and nurses associated with the lifting, transferring, repositioning, or movement of a patient.” The policy must include “an evaluation of alternative ways to reduce risks associated with patient handling, including the evaluation of equipment and the environment” and “restriction, to the extent feasible with existing equipment and aids, of manual patient handling equipment or movement of all or most of a patient’s weight to emergency, life-threatening, or otherwise exceptional circumstance.”

In March 2006, legislation was signed in the State of Washington that mandated safe patient handling programs. This legislation required Washington hospitals to establish a safe patient handling committee by February 1, 2007, and to purchase equipment by January 30, 2010. A stated ratio of lifting equipment of one lift per 10 acute care beds is also included in the bill. Perhaps most importantly, the state established a $10 million fund to assist facilities with the purchase of such equipment.

By 2011, 10 additional states enacted safe patient handling laws, directives, resolutions, or promulgated rules/regulations. Today, with 12 states (CA, HI, IL, MD, MN, MO, NJ, NY, OH, RI, TX, WA) that have safe patient handling legislation, nine require a comprehensive program in healthcare facilities including an established policy, guidelines for securing appropriate equipment and training, data collection, and program evaluation.

Note: As early as 1993, England established a national policy that prohibited nurses from lifting patients. Other countries, including the Netherlands, Switzerland, Australia, Finland, Ireland, and Canada, also have laws and directives that prohibit the manual handling of patients. These countries struggle with enforcement, similar to the United States.

In January 2014, OSHA announced its new website for hospitals, Worker Safety in Hospitals: Caring for Our Caregivers, which includes resources for safe patient handling (https://www.osha.gov/dsg/hospitals/). These resources are available to the public and provide guidelines for voluntary use.
On June 25, 2015, OSHA sent an enforcement memorandum to its inspectors issuing guidance for all inpatient healthcare settings in the North American Industry Classification System (NAICS) Major Groups 622 (hospitals) and 623 (nursing and residential care facilities). The memo focused on the hazards identified in the recent National Emphasis Program of Nursing and Residential Care Facilities. Musculoskeletal disorders (MSDs) relating to patient or resident handling was the number one hazard. The memorandum outlines the inspection procedures for these healthcare facilities in relation to the musculoskeletal hazards and covers three basic areas: program management, program implementation, and employee training.

**Interprofessional National Standards**

In 2012, the American Nurses Association (ANA) brought together a National Work Group comprised of subject-matter experts identified across multiple healthcare disciplines to develop the Safe Patient Handling and Mobility Interprofessional National Standards. The standards, which were published in June 2013, can be found at: [https://www.nursingworld.org/~4ade7a/globalassets/catalog/book-toc/sphm-standards_toc.pdf](https://www.nursingworld.org/~4ade7a/globalassets/catalog/book-toc/sphm-standards_toc.pdf).

Three noteworthy points related to ANA’s leadership in this issue are:

➢ Prior to the development of the national standards in 2003, the ANA launched the *Handle with Care* initiative to reduce MSDs related to patient handling. This program served as the impetus for the above-mentioned state-based patient handling legislation and the foundation for the national standards.

➢ During the development of the standards, a decision was made to add the word “mobility” to the phrase “safe patient handling” to more fully reflect the scope of the initiative; that is, to improve HCP and patient safety through optimized handling and mobility practices. In this document, the more comprehensive term “safe patient handling and mobility” (SPHM) will be used.


*Note:* The ANA will be consolidating the standards and implementation guide into one document in the near future. At the time of this release, the consolidated document is not yet available.

**Advances in Mobility Assessment and Equipment**

Consistent assessment of a patient’s mobility status and the use of the appropriate equipment to assist in patient handling tasks is essential to maintain patient and HCP safety. There has been an evolution in assessment tools to effectively assess the patient’s mobility status. In the past, mobility assessments were most often performed by physical therapy (PT) and may not have been clearly understood, communicated, or conducted when the patient’s condition changed because PT was not always with the patient. In 2014, recognizing that nurses needed to have an effective assessment tool - and that not all patients have an acute PT need - Banner Health developed and validated the Bedside Mobility Assessment Tool (BMAT). The BMAT assigns mobility levels from Level 1 (Dependent) to Level 4 (Independent) that correspond to appropriate SPHM equipment. BMAT is conducted on the patient’s admission, every shift, and at any time there is a change in the patient’s
condition. Currently, it is the only valid assessment tool that is easily implemented by nursing staff, PT, and other disciplines at the bedside. It also contributes to early and safe mobilization of patients.

As assessment has evolved, the nature of equipment has also changed. In the early days of safe patient handling initiatives, equipment was known as “mechanical lifting equipment”. Today, equipment is no longer only mechanical or only used for lifting patients. A wide variety of devices with various capabilities are available to assist patients with their mobility needs. With this broadening capability, equipment once known only as “mechanical lifting equipment” is now known as SPHM technology.

**Nursing School Curriculum**

The creation of a nursing school curriculum for SPHM was developed by the ANA, Dr. Nelson, and the National Institute for Occupational Safety and Health (NIOSH). It was piloted by 29 nursing schools that worked with vendors to secure equipment for training nursing students. In the spring of 2006, NIOSH posted the curriculum for public comment. The goal of creating and incorporating this curriculum into nursing programs across the country was to contribute to a necessary paradigm change and create a true culture of safety within healthcare settings. As this effort continues to move forward, consideration also needs to be given to developing similar curricula for other allied health professionals who handle patients (e.g., physical and occupational therapists).

**Professional Association and Certification**

In 2001, the Association of Safe Patient Handling Professionals, Inc. (ASPHP) was established with the mission to improve the safety of caregivers and their patients by advancing the science and practice of SPHM. The ASPHP provides education on SPHM via webinars, regional networking events, and an annual conference, and it is the only organization to provide national/international SPHM certification. Three levels of certification are offered: 1) Certified Safe Patient Handling Associate (CSPHA); 2) Certified Safe Patient Handling Clinician (CSPHC); and 3) Certified Safe Patient Handling Professional (CSPHP). Professional SPHM certification is for those who seek greater understanding of the field and who have a desire to become proficient enough to lead or participate in the development, implementation, and maintenance of successful and sustainable SPHM programs. Individuals must meet a set of specific, rigorous requirements, including passing an examination for the latter two levels. SPHM certification is recognized as valid credentialing through OSHA, the Veterans Administration, and the American Nurses Credentialing Center Magnet Recognition Program®. A study by Missar found that SPHM programs that employed a Certified Safe Patient Handling Professional demonstrated 74% lower workers’ compensation claims costs.
## Section 2
### Differences Among Acute, Long-Term, and Ambulatory Healthcare Settings

The differences among acute, long-term, and ambulatory healthcare settings regarding patient handling and mobility needs are shown in the following table:

<table>
<thead>
<tr>
<th>Acute Care</th>
<th>Long-Term Care</th>
<th>Ambulatory Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes hospitals, outpatient surgical centers, and clinics.</td>
<td>Includes facilities that provide skilled or non-skilled nursing care. Might have a specialization in head trauma or Alzheimer’s.</td>
<td>Includes physician offices, surgical centers, and other medical facilities where diagnostic and medical treatment is provided on an outpatient basis.</td>
</tr>
<tr>
<td>Frequently a specialty facility - for example, children, orthopedic, trauma, university medical center, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usually a temporary facility. An individual is admitted as a “patient” to receive treatment.</td>
<td>Individuals are considered “residents.” HCP provide a service in the place of residence.</td>
<td>Patients are not admitted to any facility.</td>
</tr>
<tr>
<td>Mobility tasks quite varied:</td>
<td>Mobility tasks more standardized:</td>
<td>Mobility tasks focused on several areas:</td>
</tr>
<tr>
<td>➢ Frequent procedures, diagnostic testing, surgery, etc.</td>
<td>➢ Minimal routine testing and diagnostic procedures.</td>
<td>➢ Patients may have mobility impairments and arrive with assistive devices and/or assistants. Modes of arrival may include ambulation, wheelchair, or stretcher.</td>
</tr>
<tr>
<td>➢ Major focus - many lateral transfers, boosting up in bed, ambulation, higher emphasis on rehabilitation, rapid progression from a passive lift to an active one toward independent mobility; increased emphasis on early mobility, especially with critically ill/ICU patients</td>
<td>➢ Major focus - getting out of bed, positioning, ambulation, transfers to/from chair, toileting, boosting up in bed, and increasing functional capabilities</td>
<td>➢ Major focus - seated and lateral transfers to examination or treatment table. May require assistance with toileting.</td>
</tr>
<tr>
<td>Short length of stay - ≤ 4 days</td>
<td>Extended length of stay - ≥7 days</td>
<td>Short length of stay - ≤ 1 day</td>
</tr>
</tbody>
</table>
times during a stay (even hourly). As a result, mobility needs can change frequently, even within an eight-hour shift. Thus, there is a need for a quick, reliable means of assessing patient mobility.

throughout the day as a result of medication change, fatigue, or “sundowner’s” effect. HCP should reassess for appropriate mobility level at the time the task is being performed.

visit. Not every outpatient is independent. Mobility screening (which can be accomplished by unlicensed personnel) recommended either when appointment is made and/or upon arrival to ensure safety during visit.

Numerous departments with “high-risk” tasks. Many specialty areas such as operating room (OR), emergency department, radiology, bariatrics, rehabilitation, orthopedics, etc.

“High-risk” tasks tend to remain constant throughout the facility. Few specialty areas such as nursing, dietary, environmental services, physical and occupational therapy.

Numerous environments with “high-risk” tasks, including radiology, OR, and specialty treatment clinics. Treatments may result in short-term mobility impairment/changes.

Higher ratio of registered nurses as compared to ancillary staff, such as patient care associates / aides, transport staff, and radiology staff.

Higher ratio of ancillary staff, such as certified nursing assistants, as compared to registered nurses.

Higher ratio of ancillary staff, such as medical assistants, as compared to registered nurses.

<table>
<thead>
<tr>
<th>Licensure by State Department of Health – required</th>
<th>Licensure by State Department of Health – required</th>
<th>Licensure by State Department of Health – required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare and Medicaid (CMS) – voluntary</td>
<td>Centers for Medicare and Medicaid (CMS) – voluntary</td>
<td>Centers for Medicare and Medicaid (CMS) – voluntary</td>
</tr>
<tr>
<td>Commission on the Accreditation of Rehabilitation Facilities (CARF) – voluntary</td>
<td>Commission on the Accreditation of Rehabilitation Facilities (CARF) – voluntary</td>
<td>The Joint Commission (TJC) Accreditation regulations – voluntary</td>
</tr>
<tr>
<td>The Joint Commission (TJC) accreditation regulations – voluntary</td>
<td>The Joint Commission (TJC) Accreditation regulations – voluntary</td>
<td></td>
</tr>
<tr>
<td>American Nurses Credentialing Center Magnet designation – voluntary</td>
<td>American Nurses Credentialing Center Magnet designation – voluntary</td>
<td></td>
</tr>
</tbody>
</table>

OSHA Mandates
Traditionally, much of the focus on SPHM programs has been directed toward long-term healthcare settings because the injury statistics have been so high. In 2003, OSHA published *Guidelines for Nursing Homes: Ergonomics for the Prevention of Musculoskeletal Disorders*. OSHA’s expectation was that acute care facilities would follow these guidelines and increase the use of assistive devices to reduce manual patient handling. However, because of the differences shown in the previous table, SPHM programs in acute care are far more complex to implement than in long-term care.

The Joint Commission (TJC) has had an Alliance with OSHA since July 27, 2004. One of the goals of the original Alliance was to develop training and education materials related to ergonomics. In addition to its Alliance with OSHA, TJC has also included reducing the risk of patient harm resulting from falls as one of its national patient safety goals. The elimination of manual handling practices and the proper use of assistive devices aids in fall reduction.

In November 2012, TJC published *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation*. This document was developed through the NIOSH National Occupational Research Agenda’s Healthcare and Social Assistance Council. The monograph is intended to stimulate greater awareness of the potential synergies between patient and worker health and safety activities. Using actual case studies, it describes a range of topic areas and settings in which opportunities exist to improve patient safety and worker health and safety activities. It is designed to bridge safety-related concepts and topics that are often siloed within the specific disciplines of patient safety/quality improvement and occupational health and safety. It is important to note that the first sentence in section 3.1.1- Safe Patient Handling states, “Few activities in healthcare link patient and worker safety more directly than lifting, transferring, repositioning, and ambulating patients.”

OSHA created a new web resource that was released in January 2014, *Worker Safety in Hospitals: Caring for Our Caregivers*. Three areas of focus on the website include understanding the problem, safety and health management systems, and safe patient handling. The site has a wealth of information that will be useful in program development, including standardized templates.

Many facilities are pursuing Magnet designation through the American Nurses Credentialing Center. The current Magnet model focuses on outcomes, specifically addressing the organization’s culture of safety in the exemplary practice component of the model. The facility’s documentation must include examples of workplace improvements for nurses. A SPHM program is one example of addressing safety for nurses and patients.

In conclusion, a variety of differences exists among acute, long-term, and ambulatory care when analyzing patient handling. However, the basic steps for implementing a SPHM program are the same regardless of the setting. The specific steps for such an implementation are outlined in the following sections.
Section 3
Building a Foundation

OSHA’s web resource Worker Safety in Hospitals: Caring for Our Caregivers identifies six core elements for safety and health management systems (SHMS). These core elements can be utilized as a framework to design a facility’s program. Components include: 1) management leadership; 2) employee participation; 3) hazard identification and assessment; 4) hazard prevention and control; 5) education and training; and 6) system evaluation and improvement. In addition, the ANA’s Safe Patient Handling and Mobility Interprofessional National Standards provide key elements for inclusion when establishing a SPHM program. Gaining executive management support, building a culture of safety, and assembling the team for a SPHM program are the foundations of the program’s success. The remainder of this document will address these core elements as they relate to SPHM programs.

Management Leadership

Before embarking on the establishment of a SPHM program, the initial step is to engage the support of the facility’s executive team in terms of employee injury reduction, employee safety, ergonomics, and SPHM. Executive support is required for several reasons:

➢ To be consistent with the objectives of the organization when establishing a program. In addition, other factors such as TJC accreditation requirements (Environment of Care; Worker Safety Initiative) and the desire to achieve Magnet designation, the Malcolm Baldrige National Quality Award, or the OSHA Voluntary Protection Program Star Award can have a positive influence in gaining approval for the program. Also, it is important to include OSHA’s position on patient handling.

➢ To allocate the human and monetary resources necessary to implement such a program. Facility leadership often question whether or not they can afford a SPHM program, as costs for equipment and training may seem exorbitant. The SPHM program leaders will need to emphasize that the real question is whether or not the organization can afford to not implement the program. A thorough cost-benefit analysis, including return on investment (ROI), will make the financial case.

➢ To determine how to integrate SPHM into facility-wide ergonomics/injury prevention, for which the OHP should have an integral role.

Administration’s fiscal support is key to the program’s success. The optimal strategy is to integrate SPHM concepts into the existing ergonomics program or quality improvement program and then to utilize team members in every step of the process. The controller may be able to assist with the organization’s ROI requirements, and vendors can help with a cost-benefit analysis for implementing a program.
Employee Participation - Team Formation

Team formation is critical. Having the “right” members on the team will lead to the success of its efforts. Also, be aware that there are some states with SPHM legislation that outline specific team requirements.

Consideration of the following factors is key to success:

➢ Define to whom the team will be reporting – Safety Committee, Occupational Health, Nursing Service, or another department. A joint reporting mechanism is also an option. The higher up the executive chain the reporting structure, the more effective it will be. It is especially important to include the senior nursing executive as a champion, as well as front-line employees. The reporting mechanism needs to include a schedule for reporting program progress toward meeting goals. Optimally, results of SPHM programs should be reported to all levels of the organization, from the front-line employees to the board of directors. Reporting may be daily, weekly, monthly, and no less frequently than quarterly.

➢ Determine members of the team. A multidisciplinary team is needed to identify key players and the roles they will play in the process. Examples of disciplines that should be included are nursing (front-line and administrative), patient care associates, physical therapy, occupational therapy, occupational health, education, infection control, facility engineering, purchasing, and physicians. Ancillary or specialty departments also need to be included, such as radiology, surgery, transport/escort, laundry, marketing, housekeeping, and clinical engineering. Expand the membership as needed, and when in doubt, include a representative of the department.

➢ Identify a team leader. This decision can be made by administration or by another mechanism within the facility. The leader should be provided with the resources of time and support staff to lead the program. Clerical support should be provided to assist with meeting arrangements and other support needs such as minute taking, data entry, etc.

➢ Be sure that team members view themselves as “champions” for the program. They will help deliver and sell the message as the program is rolled out. The champions will serve a vital role in maintaining the program’s effectiveness, supporting the culture change, and ultimately assisting with sustainability.

➢ Involve front-line employees to achieve “buy-in” as the program moves ahead.

➢ Develop the team’s vision, mission, and objectives.

➢ Provide training to all team members so that everyone can participate on an equal basis.
Section 4
Pre-Implementation

The components of developing and implementing a SPHM program include assessment, planning, implementation, and evaluation. Not unlike the nursing process, activities of one step can overlap or occur concurrently, and there can be times that it is necessary to back up a step. These components also correlate with the remaining four core elements of OSHA’s Safety and Health Management System (SHMS) programs – hazard identification and assessment, hazard prevention and control, education and training, and system evaluation and improvement. The team leader and members need to remain focused yet flexible as the steps are accomplished.

Step 1: Assessment

The assessment seeks to answer: Is there an existing problem within the facility? The components of the assessment include the completion of the risk assessment and data analysis.

Risk Assessment

Elements of the risk assessment include three major components: collection of injury data, a worksite analysis, and a literature review.

1. Collection of Injury Data

- **Historical data:** Gather historical data that include musculoskeletal injuries by department, type of healthcare worker, body part injured, and root cause of the injury. Review one, three, or five years of work-related injury data. Note that a minimum of one year of data needs to be analyzed. Multiple years of data provide a historical view to evaluate trends that are often more important than raw numbers. Strive to evaluate as many years as possible to increase the clarity of data. If the team leader does not have specific injury data, ask the facility workers’ compensation carrier to provide a loss run report (details discussed below) for the time period to be analyzed.

- **OSHA recordable injuries:** Identify all OSHA recordable injuries related to SPHM. Calculate the musculoskeletal incidence and severity rates (treatment beyond first aid, transfer, or days away from work) related to patient handling by department using the OSHA 300 logs.

- **Direct workers’ compensation (WC) costs:** Loss run reports can be obtained from the facility’s WC carrier. These reports detail all dollar costs associated with all injury claims. The costs are broken down into medical costs, indemnity costs (lost wages), and other costs. Also, obtain the dollar amount allotted for reserves (the money anticipated for claims). The loss run report will provide injury detail if there is no on-site electronic capability to track injuries. These injuries are cumulative in nature and can sometimes result in debilitating and career-ending injuries. Direct costs associated with injuries due to manually handling patients can vary greatly depending on the severity of injury. Missar’s
study estimates that an average patient handling claim costs $14,100. Remember, WC costs come off the bottom line of the facility’s balance sheet.

- **Indirect WC costs:** In addition to the direct WC costs, there are also indirect or hidden costs related to an injury. A multitude of factors affect indirect costs. Some of the major factors include staff accommodation for modified duty, supervisor time, decreased staff morale that decreases productivity, costs related to replacement workers including their hiring and training, and use of per diem staff.
  - Indirect costs have been estimated to be two-and-one-half to four times the direct cost of a claim, depending on the severity. Some calculation tools also include profit margin of the organization to arrive at the projected revenue required to offset losses due to manual handling injuries. Although chief financial officers and financial analysts tend to discount indirect costs, they are real nonetheless.
  - A recent review of national trends by Missar indicated SPHM programs that use the ANA Interprofessional Standards have 56% lower claim costs.

- **Other data:** Gather other data, including the employee turnover rate and employee population demographics such as age. Human Resources can provide this data. The employee turnover rate is an important piece of data for comparison once the program is implemented. If the turnover rate data includes why the employee left the department or the organization, reviewing the data might provide additional support for a SPHM program.

2. **Worksite Analysis**

Worksite analysis refers to a comprehensive evaluation of the department needs, along with existing equipment and how/why it is or is not utilized. Staff input is essential to gain insight into the issues that are interfering with the proper use of equipment. The analysis includes:

- Conducting an equipment inventory, including its availability, storage, and use by staff. Consideration needs to be given to planned renovation or new construction and the impact on potential installation and/or storage needs. Since 2014, the Facilities Guidelines Institute (FGI) has required a Safety Risk Assessment (SRA) prior to renovations or new construction of healthcare facilities. Safe patient handling capabilities is one element of the SRA. An online tool was developed by The Center for Health Design (CHD), in conjunction with the FGI, to provide assistance in completing the assessment (https://www.healthdesign.org/sra).

- Evaluating patient dependency needs, including the use of mobility assessments and identification of special populations:
  - Identify the type of mobility assessments being utilized, communicated, and documented between disciplines such as nursing, PT, and occupational therapy. Mobility levels and definitions may vary based on which assessment tool is used and what disciplines are involved. For example, a PT assessment may have components
and documentation requirements that differ from a nursing mobility assessment. Regardless of the assessment tool utilized, effective communication among disciplines is required to ensure continuity, patient safety, and HCP well-being. PT mobility levels include:

- Independent
- Stand-By Assist
- Contact Guard Assist
- Minimal Assist
- Moderate Assist
- Maximum Assistance
- Dependent

Departments with potential high-risk or special needs related to patient handling. Staff can easily identify high-risk tasks within their department. Break down jobs into tasks, identify hazards, and develop solutions to reduce risk. Examples of departments with high-risk tasks in acute care include:

- Bariatric
- Critical/Intensive care
- Emergency
- Neurological
- Operating room
- Orthopedics
- Radiology
- Rehabilitation

3. Literature Review

➢ Review the literature to see what others have done. This step gives an evidence-based approach to solving the problem. It provides an opportunity to learn what has worked and to avoid pitfalls as the program is implemented. Note: The reference section of this resource guide provides sources to conduct the literature review.

➢ Review articles about success stories (e.g., Tampa General Hospital).

The first step is to plan how the assessment will be conducted and establish a timeline. Enlist the help of team members and provide the support and guidance needed to complete their portions of the assessment. Determine what training is needed for staff to conduct the assessment or if the assessment should be conducted by an outside provider. It is usually better to do as much of the analysis as possible using inside resources, but at times, an outside provider may be necessary to evaluate complicated situations. Ensure that outside providers work with staff, as this step is a learning experience for all team members. Allow more time than seems needed. If data are not computerized, explore ways to format data electronically for ease of retrieval and analysis. Consider that vendors and clinical professionals who work with vendors might be able to perform equipment assessments, usually at no charge.
Data Analysis

Data analysis involves the following steps:

➢ Identify the leading types of musculoskeletal injuries related to patient handling, as well as the departments and staff involved in the injuries.

➢ Identify the root causes of injuries in the high-risk areas.

➢ Identify what issues prevent staff from using existing equipment: lack of availability, storage, training, support, and time; maintenance problems; battery issues; sling availability; etc.

➢ Identify the costs from the loss run reports associated with patient handling injuries.

➢ Complete a cost-benefit analysis and ROI to determine the cost to the organization if no action is taken based on the history projected forward.

Step 2: Developing a Plan

Developing a business plan includes brainstorming options for a program model, determining the selection of equipment, gaining administrative approval (if not obtained during the assessment step), and creating an implementation plan.

➢ Brainstorm options for program models based on the data analysis. Consider various levels of intervention as possible solutions, including the costs for human resources, training, equipment, and potential injury reduction with projected cost savings. Determine the best method to roll out and maintain a SPHM program in the facility - implementing a pilot program first or launching facility-wide. Determine the methodology for SPHM (e.g., each caregiver responsible for their patients, a lift team, or team lifting within individual departments). Consider the benefits and drawbacks of each option. Be sure to incorporate the following into the SPHM program model:
  ○ OSHA Safety and Health Management Systems: A Road Map for Hospitals (six program elements)
  ○ ANA Interprofessional National Standards (eight program elements)
  ○ CHD SRA, if appropriate

➢ Develop a SPHM policy and unit-specific implementation plans based on the model adopted (Appendix B - SPHM Policy Components).

➢ Make the case for administration. Once the data is analyzed, an executive summary and report need to be prepared for administrative review. The report needs to include cost justification, a plan for implementation, and staffing requirements for the program.

➢ Equipment - Safe Patient Handling Technologies
Based on the assessment of patient needs, with a focus on safety for the caregiver, the patient, and rehabilitation goals, evaluate the type of SPHM technology that is needed to eliminate manual patient handling. A variety of devices are available, including:

- Friction-reducing repositioning/transfer sheets
- Air-assist devices that reposition and turn, including vertical air-assist
- Lateral transfer devices that can convert into a sitting position
- Beds that automatically turn patients or change into a sitting position
- Ceiling lifts
- Sit-to-stand devices with ambulation option
- Non-mechanical stand-aids
- Floor-based full-body lifts that are able to turn, reposition, and lift patients up from the floor
- Vehicle extractors
- Other SPHM technology that aligns with early mobility initiatives

Contact a variety of vendors who have the type of equipment that would be needed. An equipment fair is an opportunity for staff to see equipment, try it, and talk to vendor representatives about their products. Explore financial risk-sharing opportunities. These may include a pilot program, vendor contract conditions, training, maintenance, and warranty agreements. In addition, some vendors offer options for clinical support.

- Contact vendor references.
- Involve front-line staff in the evaluation, selection, and piloting of new products to obtain buy-in for equipment use as the program rolls out.
- Develop a process for equipment trials, product evaluation feedback, and the ordering of equipment. Always ask to trial the equipment for at least two weeks to determine issues of applicability, storage, and maintenance.

**Special note:** With obesity trends on the rise in the United States, healthcare organizations are frequently treating more and more patients of size; that is, individuals with a body mass index of 30 or greater. This can pose significant clinical challenges for providers, clinicians, and HCP. Many vendors and equipment manufacturers offer SPHM technology that is designed with the bariatric patient in mind. It is important that facilities explore these options and integrate them into their program to keep both patients and staff safe. It can also be helpful for facilities to create a list of their SPHM technology (including bariatric bed frames) and their storage locations so that there is an accurate inventory of this equipment.

**Special note:** In 2019, the FGI released the Second Edition of the Patient Handling and Mobility Assessments (PHAMA), which delves further into the coverage recommendations for each type of equipment per patient care area. For more information, please visit: [https://www.fgiguidelines.org/wp-content/uploads/2019/10/FGI-Patient-Handling-and-Mobility-Assessments_191008.pdf](https://www.fgiguidelines.org/wp-content/uploads/2019/10/FGI-Patient-Handling-and-Mobility-Assessments_191008.pdf)

Determine if any of the current equipment can be reallocated within the facility. Have front-line employees participate in this process.

Develop components, including policy formation, to support the program. Select the best approach for the facility’s culture and financial means (Appendix B - Comparison of Implementation Plans for SPHM). There are three basic approaches to select from:
■ Task-specific: Identify the specific patient handling activities that will be addressed in each phase of implementation (e.g., lateral transfers).

■ Department-based: All necessary assistive devices would be available in every department at all times. *Note:* For both the task-specific and department-based programs, consideration must be given to an implementation plan (staged or facility-wide), development of a timeline, and training with regard to what would constitute competency with equipment use.

■ Lift team: Composition of team, job description, lift team policy, dress code, log sheets, paging criteria/system, competency-based.

○ Identify a coach or champion from every department. These individuals will be the key players in all aspects of the implementation and maintenance of the program within their departments. The coach should be viewed as an informal leader in the department and should have the respect of staff. It would be ideal to have a coach on each unit for each shift.

○ Utilize resources such as the ANA’s *Implementation Guide to the Safe Patient Handling and Mobility Interprofessional National Standards.* Review patient mobility assessment tools such as BMAT, and algorithms for patient transfers. These can be adopted and implemented. In addition, vendors may have resources related to program planning and implementation.

○ Develop a plan to educate patients and their families about the program prior to both a scheduled admission and an emergency admission. The program may include having the patient sign a release stating his/her understanding of the SPHM practices and marketing materials such as brochures, posters, or videos.

○ Develop a plan to investigate and assist staff in learning when an injury or near miss occurs. Consider implementing “after action reviews” (AAR). An AAR is a process of transferring knowledge learned from one task to the same task being performed in a different setting. The Army and a number of successful companies including Shell, Motorola, and General Electric have implemented AARs. They have also been adopted by the Veterans Health Administration (VHA) as back injury prevention programs have been deployed throughout their system. The AAR involves the interaction of a work group and facilitates learning for all involved. AARs can be formal, informal, or personal. Regardless of the type of AAR, the questions that are asked include:

■ What was supposed to happen?
■ What happened?
■ What accounts for the difference?
■ How could the same outcome be avoided the next time?
■ What is the follow-up plan?

*Note:* For more information on AARs, see the References section of this guide.
○ Develop a plan for monthly reporting, a review of patient handling injuries, and a procedure to disseminate injury data. Post-injury review by the team can provide an opportunity to review the injury and identify ways to prevent recurrent injuries. It also facilitates a method of working with the unit manager to develop an action plan for prevention of future injuries. Injury data should be reported to the front-line employees, department managers, safety committee, chief executive nursing officer, senior administration, and board of directors.

○ Consider using the implementation of a SPHM program and the data analysis associated with this program as part of the facility’s process improvement efforts that are required for TJC.

○ Develop a plan for managers and employees who are non-compliant with the program.
Section 5
Getting Started and Keeping It Going

Step 3: Implementation

The third major step in creating a SPHM program is implementation.
➢ Identify a roll-out date.

➢ Educate by training all staff, from senior management to front-line employees, on: the ergonomic risk factors inherent to lifting, transferring, and repositioning patients; the high-risk tasks; and the new program and processes. All staff on all shifts need to be included. Work with staff education to implement the training and ensure competency. This may also include vendor training or the development of a train-the-trainer program for the facility.

➢ Work with the media/public relations department to communicate, publicize, and promote the new program and its results once implemented. Include a plan for ongoing communication throughout the program to maintain staff awareness of the effort.

➢ Evaluate these elements for successful implementation:
  ○ Remember that the program is designed to change the organization’s culture and individual human behavior. This is not an easy task!
  ○ Be consistent, patient, and persistent as the new policy is implemented.
  ○ Determine clinical staff competence, and identify remedial training needs.
  ○ Support, encourage, and recognize the department coaches/champions.
  ○ Assess the ability of designated individuals to oversee the implementation process.

➢ Be aware of barriers to change:
It is difficult to change behavior. Manual patient handling has been the norm for the vast majority of healthcare workers. For generations, the “culture” of healthcare has perpetuated manual patient handling. It will not change overnight. For example, at one long-term nursing facility, staff would take the equipment into the room, close the door, and act as though they had used the equipment to transfer the patient when, in fact, they had reverted back to the familiar manual patient handling process. Therefore, it is imperative that the leader of the implementation process prepares the team for resistance to change. Incorporate information on change into staff education, and acknowledge staff concerns about change. Continue with participation of front-line staff in this change process to further promote buy-in.

➢ Recognize the complexity of the acute-care setting, especially at inception:
  ○ Multiple layers of management
  ○ Strong clinical and non-clinical management
  ○ Departments that work in “silos” yet are interdependent
  ○ Wide variety of patient care activities
  ○ Multidisciplinary care, including support departments that provide care
  ○ Wide variety of committees
  ○ Multiple decision makers
Step 4: Evaluating Outcomes

To ensure effectiveness and sustainability of the program, routinely monitor and evaluate the following outcomes:

➢ Elements of the risk assessment. Monitor injury data on a monthly basis using components of the assessment phase. Identify improvements and areas that continue to experience patient handling injuries. Modify the program as indicated.

➢ Employee satisfaction. Obtain employee feedback regarding implementation of the program. Encourage employees to report any injury in a non-punitive environment.

➢ Note the employee turnover rate. Collaborate with Human Resources to determine an appropriate interval to reassess the employee turnover rate and ensure the program is included as an employee benefit during recruitment activities.

➢ Determine patient satisfaction. As part of the post-hospitalization patient satisfaction survey, develop a tool to evaluate patient and family feedback to patient handling with SPHM technology.

➢ Review the program annually for its accomplishments, and set goals for the upcoming year. Modify the program as indicated. Very few, if any, SPHM programs are ever “completed” or “finished”. Most continue on their journey and evolve as needed.

➢ Report successes or challenges to management and staff.

➢ Stay the course!
References


Appendix A

AOHP Position Statement

Safe Patient Handling

The Association of Occupational Health Professionals in Healthcare (AOHP) strongly supports the provision of a safe and healthy environment for the nurse/caregiver and patient. Back injuries and other musculoskeletal disorders related to patient handling are the leading cause of workplace disability for nurses and other direct patient care providers. The importance of developing reliable approaches for prevention of back injuries and other musculoskeletal disorders related to patient handling is critical. AOHP supports actions, policies, and laws that will help to establish a safer environment of care for nurses, other direct patient care providers, and patients as they relate to safer patient handling and prevention of injuries.

➢ Employer and management commitment are needed to adopt an institutional policy that encompasses the safest approach for the caregiver, as well as the patient, when handling, moving, and transporting patients. The safest approach is the use of assistive equipment that discourages the use of manual handling. There needs to be initial and ongoing investment in adequate supply of appropriate devices, ensuring: availability of and adequate storage space for equipment; proper disinfection based on infection control principles; education of staff on usage; and designating resource personnel for ongoing assessment and evaluation.

➢ Employee participation is vital in the assessment and implementation process to encourage acceptance and success of the program. Staff have a wealth of essential information about specific hazards in their work environment associated with patient handling and can assist in guiding actions that will ensure program effectiveness and positive outcomes. Staff must also be involved and given authority in the evaluation and selection of patient handling devices and equipment. They should participate in initial and ongoing education/training activities related to patient handling and the use of assistive devices and equipment.

➢ Regulation and enforcement of a standard to control ergonomic hazards in the healthcare industry is necessary to prevent back injuries and musculoskeletal disorders. The regulation should include the use of engineering controls for patient handling activities. AOHP supports a continued call to OSHA and state legislators to develop such standards that are appropriate and reasonable to healthcare employers.

➢ Support of research and evidence-based practice is crucial to continue the ongoing development of interventions to prevent back injuries and musculoskeletal disorders related to patient handling. Further study is also recommended to redesign other high-risk tasks to promote safer work environments for nursing staff. Prompt communication of current study findings to the association and partnering organizations is critical in reducing these injuries and disorders.

In summary, AOHP believes that manual patient handling is unsafe for the caregiver and patient. Such handling is also directly responsible for disabling back injuries and musculoskeletal disorders in nurses and other direct patient care providers. Utilizing safe patient handling reduces stress for
nurses to help them stay in the profession. Safe patient handling can occur with assistive devices, ensuring improved quality patient care and outcomes. The ultimate benefits are afforded to the nurse/caregiver, patient, and employer. AOHP welcomes the opportunity to work collaboratively with regulatory agencies and professional associations to promote safe patient handling and reduce healthcare worker injuries.

References


Appendix B

SPHM Policy Components

Developing a SPHM policy reinforces accountability and will help to identify the roles and responsibilities of staff within the facility as they pertain to the program. The following components are recommended for inclusion in any SPHM policy:

➢ Statement of Purpose
  ○ Goals

➢ Policy
  ○ Include aspects of state SPHM legislation, if appropriate

➢ Procedures
  ○ Equipment/SPHM technology
  ○ Staff roles and responsibilities, including SPHM Committee and who is responsible for providing education
  ○ Injury reporting process
  ○ Unit-specific customized procedures, including bariatrics
  ○ Right of Refusal

➢ Definitions

➢ Resources
# Product Evaluation Tool

**Date:**

**Name of Product and Manufacturer:**

<table>
<thead>
<tr>
<th>Job Category:</th>
<th>RN</th>
<th>PCA</th>
<th>Rad Tech</th>
<th>Transport</th>
<th>PT</th>
<th>OT</th>
<th>Other</th>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

- Comfortable
- Easy to use
- Stable when in use
- Versatile
- Easily cleaned/disinfected
- Effective in reducing injuries
- Efficient use of time
- Willing to use this product

**Comments:**
Worker Attestation

Hospital Policy Concerning Worker Safety/Injury Prevention

I, ____________, (print name) understand that following the Worker Safety/Injury Prevention Policy is important for my own safety, as well as that of the patients and my co-workers. Accordingly, I acknowledge that if I violate this Policy, I will be subject to the disciplinary process in accordance with Hospital Policy. This Policy (include policy number), is in the Hospital Policy Manual located in each department.

I also understand and acknowledge that, if I sustain an injury while violating this Worker Safety/Injury Prevention Policy, disposition of Workers’ Compensation benefits is subject to review, whereupon the third party administrator has the final discretion.

If I have any questions regarding the Policy, I know that I am to contact the Safety Officer, ____________, at ____________.

________________________________         __________________
Employee Signature                                         Date

________________________________         __________________
Witness Signature                                           Date

Refusal to Sign Acknowledgement of Hospital Policy Concerning Worker Safety/Injury Prevention

___________ was educated on the safe patient handling and mobility (SPHM) policy and procedures, including the use of SPHM technology (equipment), and given the opportunity to review the Worker Safety/Injury Prevention Policy and to ask related questions.

___________ refused to sign the Acknowledgement of Hospital Policy concerning Worker Safety/Injury Prevention. He/She has been notified of the consequences of violation of this policy and understands, despite not providing a signature, the disciplinary process will remain unchanged.

________________________________         __________________
Employee Signature                                         Date

________________________________         __________________
Witness Signature                                           Date

________________________________          _________________
Manager Signature                                          Date
### Potential Types of Equipment by Hospital Department

Every patient care area performs a variety of patient handling tasks on a day-to-day basis (e.g., lateral transfers, repositioning and boosting, bed-to-chair/chair-to-bed transfers, toileting, ambulation, etc.) Thus, it is imperative that they are equipped with the SPHM technology to safely and effectively complete these tasks. It is recommended that at a minimum, each patient care area have the following:

- Lateral transfer devices, including friction-reducing/ repositioning and air-assist devices
- Floor-based lifts:
  - Non-mechanical stand-aids
  - Sit-to-stand devices
  - Full-body lifts
- Ceiling lifts

In addition, certain patient care areas will find that there are special types of SPHM technology that will be more useful and applicable to their areas. They are listed in the chart below.

<table>
<thead>
<tr>
<th>Department</th>
<th>SPHM Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>✔ Vehicle extraction lift</td>
</tr>
<tr>
<td>Operating Room</td>
<td>✔ Roller boards&lt;br&gt;✔ Limb slings/bands&lt;br&gt;✔ Ceiling lifts</td>
</tr>
<tr>
<td>Intensive/Critical Care</td>
<td>✔ Motorized bed-moving equipment&lt;br&gt;✔ Beds that convert to a chair/ have egress capability</td>
</tr>
<tr>
<td>Orthopaedics/Rehabilitation</td>
<td>✔ Hi-low shower chair with wheels&lt;br&gt;✔ Pivoting devices&lt;br&gt;✔ Sliding boards&lt;br&gt;✔ Gait training option on sit-to-stand devices&lt;br&gt;✔ Ambulation slings for ceiling lifts</td>
</tr>
<tr>
<td>Outpatient</td>
<td>✔ Vehicle extraction lift</td>
</tr>
</tbody>
</table>

**Note: If beds do not weigh patients, consider integrating scales into SPHM technology.**
# Comparison of Facility-wide, Phased-in, and Lift Team Implementation Plans for Safe Patient Handling

## Facility-wide

<table>
<thead>
<tr>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiered education process works better</td>
<td>May not be organizationally “ready”</td>
</tr>
<tr>
<td>Provides an opportunity to do a good job with internal “social marketing”</td>
<td>Middle management support may be absent</td>
</tr>
<tr>
<td>Allows the organization to quickly incorporate into their recruitment and advertising efforts</td>
<td>Up-front costs</td>
</tr>
<tr>
<td>Allows the organization to quickly take advantage of the reduced injury/reduced injury payback</td>
<td>Intense time to train and mobilize everyone</td>
</tr>
<tr>
<td>Everyone feels included in the initiative</td>
<td></td>
</tr>
</tbody>
</table>

## Phased-in

<table>
<thead>
<tr>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity to work out the “kinks”</td>
<td>Implementation is “choppy”</td>
</tr>
<tr>
<td>Spreads out up-front costs</td>
<td>Harder to keep focus</td>
</tr>
<tr>
<td>Gives more time to build a coalition/support</td>
<td>Less consistent patient handling approaches from unit to unit</td>
</tr>
<tr>
<td>Grabs “low-hanging fruit” for injury cost savings if done on worst units first</td>
<td>Creates “haves” and “have-nots” among staff regarding facility’s protection of staff</td>
</tr>
<tr>
<td>Takes advantage of enthusiastic units so that success is quick and the “buzz” is good</td>
<td>If union facility, can create additional issues between management and labor</td>
</tr>
<tr>
<td>May be a way for organization to internally sell the program without much financial risk</td>
<td>More difficult to see return on investment and positive impacts on patients, staff, etc.</td>
</tr>
<tr>
<td></td>
<td>Support departments have a difficult time with “exceptions”</td>
</tr>
<tr>
<td></td>
<td>Problems for staff who float from unit to unit, including training and use</td>
</tr>
<tr>
<td></td>
<td>Orientation of new hires more difficult if only a few units are involved</td>
</tr>
<tr>
<td></td>
<td>Facilities unwilling to change documentation until program is facility-wide</td>
</tr>
<tr>
<td></td>
<td>Areas that are not specifically nursing units might be left until last, which can be detrimental. Examples include radiology, transport, therapy services, security (often called to assist when patients fall to the floor), etc.</td>
</tr>
</tbody>
</table>

## Lift Team

<table>
<thead>
<tr>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff likes the “lift team” concept</td>
<td>Lift Team requires extensive training</td>
</tr>
<tr>
<td>Literature supports injury reduction success</td>
<td>May be laid off as “non-essential” staff if budgeting becomes tight</td>
</tr>
<tr>
<td>Can respond to planned or emergent requests</td>
<td>Difficulty responding promptly to individuals who may have to go to the bathroom quickly or for a STAT request for testing</td>
</tr>
<tr>
<td>Transfers much of the injury risk to a few rather than many</td>
<td>May travel with appropriate equipment or may use appropriate lifting equipment stored on each unit</td>
</tr>
<tr>
<td>Can focus on high-risk tasks</td>
<td>Often little education in healthcare and may not recognize situations where lift/transfer should not be carried out as previously determined</td>
</tr>
<tr>
<td>Patient length of stay may improve because of lift team’s focus on SPHM</td>
<td>Does not eliminate all patient handling from nursing</td>
</tr>
<tr>
<td>Work-related injuries and cost of injuries decrease</td>
<td>Response time varies</td>
</tr>
<tr>
<td>Patient satisfaction increases</td>
<td>Tends to further myth that “big strong guys” are not at risk of injury</td>
</tr>
<tr>
<td>Nursing staff on modified duty may still be able to do their normal work</td>
<td>Furthers the myth that physical selection will prevent injuries</td>
</tr>
<tr>
<td></td>
<td>Requires very careful selection of lift team members for education and aptitude</td>
</tr>
<tr>
<td></td>
<td>May not be available for all shifts</td>
</tr>
</tbody>
</table>

*Note: Chart courtesy of Linda Haney, RN, COHN-S, MPH, Diligent Services.*