Safe Patient Handling & Mobility Program for Hospice and Home Health

The Rationale
For decades long-term care facilities and related medical services have been providing training on body mechanics, proper lifting technique and “how to safely perform two-person transfers of residents.” To date the results have been marginal at best.

OSHA and the Bureau of Labor and Statistics (BLS) have indicated that “Nursing home facilities ranked third highest in nonfatal occupational injuries and illnesses among U.S. industries with over 200,000 injuries and illnesses, behind couriers and air transportation. This is more than double the incident rate of 4.2 for industry as a whole.”

Nursing aides, orderlies and attendants had an MSD (musculoskeletal disorders) rate of 252 cases per 10,000 workers, a rate more than seven times the national MSD average for all occupations, based on injuries in 2007.

Our own data shows that 45% of those who have had a back injury will have a repeat occurrence, with 58% having that second occurrence within the next year. Almost one in five will have the second episode within the next three months. The number of convalescent or long-term care facility repeaters is double that of any of our other business sectors.

Numerous studies have been conducted over the past 20 years showing that manually transferring residents cannot be performed safely for either the resident or the caregiver. It has been stated by Friele and Knibbe that emphasis only on training in body mechanics implies that a person can do anything with his or her body, as long as correct body mechanics are used.

For all of the above reasons United Heartland has developed the following Safe Patient Handling and Mobility program. It is our hope this program will provide a foundation for our clients to develop their own program to reduce work-related injuries associated with assisting, repositioning and transferring patients.

Program Goals and Objectives
The goals and objectives of United Heartland’s Safe Patient Handling and Mobility program are:
1. To reduce the injury potential for both the patient and caregiver during transferring.
2. To facilitate the safe use of transfer aids and equipment.
3. To provide an objective, easy to understand, consistent means of evaluating patient transfer needs.
4. To provide a consistent technique for the assisting, repositioning or transfer of patients.
5. To encourage maximum participation within a Safe Patient Handling and Mobility program.

The Program
1. Written requirements.
   Development and implementation of a written Safe Patient Handling and Mobility program. Policies and procedures should include, but not be limited to, addressing all patient transfers and transfer devices: Lateral transfers, assisting of patients and the use of gait belts/walking belts, sit-to-stand devices, etc. The written policy should address management’s commitment, task assessment process, responsibility and accountability, and the handling of special considerations, i.e. bariatric transfers, combative patients, etc.

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1 Friele RD, Knibbe JJ. Monitoring the barriers with the use of resident lifts in home care as perceived by the nursing personnel. In: C. Occupational Health For The Health Care Workers (Hagberg et al eds.) Landsberg Germany 1995, 360-363.

Our safety evaluations, reports and recommendations are made solely to assist your organization in reducing hazards and the potential of hazards and accidents. These recommendations were developed from conditions observed and information provided at the time of our visit. They do not attempt to identify every possible loss potential, hazard or risk, nor do they guarantee that workplace accidents will be prevented. These safety evaluations, reports and recommendations are not a substitute for ongoing, well-researched internal safety and risk management programs. This report does not warrant that the property inspected and its operations are compliant with any law, rule or regulation.

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2. Objective criteria to be determined for transferring of patients. **Minimum suggested guidelines**^2^ are:
   
   a. Patient can be standing for 4 seconds bearing weight without assistance. Gait belt or walking belt transfer.
   b. Patient can stand for less than 4 seconds bearing weight with some assistance. Sit-to-stand mechanical lift transfer.
   c. Patient is non-weight bearing. Total body transfer.
   d. Fallen patient. A total body transfer should be utilized if available, unless the patient can get up on his or her own.
   e. Lateral transfer devices (LTD) or friction-reducing devices (FRD) to be used for lateral transfers or repositioning. Draw sheets, trash bags, incontinence pads, etc. cannot be used in place of FRD or LTD.
   f. Two persons are recommended for all mechanical lift-aided transfers and repositioning. **If lift-aided transfer is completed with one caregiver (home environment), strict safety parameters should be documented for this.**
   g. The policy should state cases when a one-person transfer is not allowed and what the caregiver should do if these situations arise (i.e.: combative, mentally disabled or bariatric patients; flooring or space challenges; etc.)
   h. The caregiver can, at any time, increase the level of transfer from what is stated in the care plan based on the patient’s inability to assist or comprehend the transfer (i.e. sit-to-stand transfer could be increased to a total lift transfer; however, the caregiver can never reduce the level of device use.). **If increase of transfer level results in the need for transfer equipment that is not readily available or needs to be purchased/rented, the policy should state what the caregiver will do in the interim to ensure safe transfer for both the caregiver and patient.**
   
   For example:
   i. Caregiver will inform supervisor of need for equipment and obtain direction immediately. If not able to contact supervisor immediately, this communication must occur before end of shift.
   ii. Caregiver will transfer patient as little as possible with safest means to provide adequate care until supervisor can assess and appropriate transfer equipment is obtained (i.e.: utilize bedpan for toileting; turn/reposition every 2 hours if not getting up – use 2 caregivers if patient cannot assist; use 2 or more caregivers and gait belt if transfer to bedside commode must be done and patient can bear some weight; perform bed bath; change linens by rolling patient, have staff equipped with portable lifts to use until patient equipment is obtained, etc.)

3. Quality Assurance
   
   a. For home care patients, the home safety assessment should include questions regarding ability to safely use a mechanical lift in the patient’s home (i.e.: floor covering, door frame width, etc.). This will allow the agency and patient/family to be prepared for necessary changes should the need for a mechanical lift arise. (See Home Safety Assessment Form as an example.) Regular observation of the transferring of patients should take place through unannounced evaluations.
   b. Transfer incidents/injuries will go through a loss review process.
   c. Patient transfer needs should be evaluated and documented on a regular basis. For facilities (versus individual patient homes), quarterly comparison of equipment vs. transfer needs should be written and documented.

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^2^ Additional consideration or time may be necessary for the assisting, repositioning or transferring of obese or bariatric patients. If the person has varying levels of ability to assist due to fatigue, medications, medical condition, etc., then an assessment should be performed before each task is performed. In these cases more time may be required to be added to the assessment criteria.

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4. Obtaining Equipment
   a. A standing list of durable medical equipment companies should be devised, as well as methods for payment. This list should include both rental and purchase scenarios.
   b. If the hospice patient resides in an “outside” facility, and equipment must be obtained, the nurse case manager or designated individual should communicate a recommended change of transfer status with the facility. The designated hospice individual should then coordinate obtaining transfer equipment and how transfers will be handled while obtaining the necessary equipment (lift, FRD, etc.).

5. Education and Training. Staff training to include initial, annual and as required to correct improper use/understanding of safe patient handling and mobility. Training should also be completed post-injury. All employee training should be “hands on” with return demonstration to include individual employee participation as a patient for each device. The written component should include:
   a. All new hires before being assigned to a floor and/or transferring, regardless of experience.
   b. After all transfer-related incidents.
   c. After an employee has been off of work on a leave lasting longer than 90 days.
   d. Annually.
   e. Topics should include but not be limited to:
      i. Use of gait belts
      ii. Use of mechanical lifts
      iii. Use of lateral transfer and friction-reducing devices
      iv. Falling/fallen patients
      v. Repositioning of patients in wheelchair or bed
      vi. Transfer reduction and/or planning of transfers
      vii. Pain control prior to transfer/move
      viii. Combative patients
      ix. Scenarios where only one staff member is present
      x. Planning the transfer to account for environmental hazards (i.e. rugs, cords, pets, moving of furniture)

6. Progressive step disciplinary program.

7. Equipment inspection and maintenance.
   a. Prior to all transfers.
   b. Daily visual by staff.
   c. Preventive Maintenance. Monthly formal inspection with documentation by lift.
   d. Hospice case manager should ensure the facility has adequate lift inspection and maintenance procedures in place for any equipment being used to transfer/ move their hospice patient(s).

There are a number of resources available to assist you in the development and implementation of a Safe Patient Handling and Mobility program and policy. In addition to the program spelled out here, please consider the following resources to assist you in program development. United Heartland’s Loss Control Department is always available to assist you in any aspect of program implementation.

Additional Source Materials:
- Centers for Medicare & Medicaid Services – Patient Assessment Instrument
- U.S. Department of Labor, OSHA, [www.OSHA.gov](http://www.OSHA.gov) – Guidelines for Nursing Homes: Ergonomics for the Prevention of Musculoskeletal Disorders
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