Safe Resident Handling & Mobility Program for Long-Term Care Facilities

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 Statistic’s (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 a 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 3 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.1

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

Program Goals and Objectives

The goals and objectives of United Heartland’s Safe Resident Handling and Mobility program are:

1. To reduce the injury potential for both the patient as well as 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 Resident Handling and Mobility program.

The Program

1. Written requirements
   Development and implementation of a written Safe Resident 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: Landsberg Germany 1995, 360-363.
2. Objective criteria to be determined for transferring of patients.
   Minimum suggested guidelines 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, 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 must be present for all mechanical-aided transfers and repositioning.
   g. The caregiver can at any time increase the level of transfer from what is stated in the care plan based on the resident’s ability 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.)

3. Quality Assurance
   a. 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. Quarterly comparison of equipment vs. transfer needs should be written and documented.

4. Education and Training. Staff training to include initial, annual and as required to correct improper use/understanding of safe resident handling and mobility. Training should include post-loss training with documentation following any injury or incident involving transferring, repositioning or assisting of a patient or training event. All employee training should be “hands on” with return demonstration to include personal 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. Dealing with combative patients
      ii. Use of mechanical lifts
      iii. Use of lateral transfer devices
      iv. Repositioning of patients in wheelchair, Geri chair or bed
      v. Transfer reduction and/or planning of transfers
      vi. Transfer reduction i.e. use of wheelchair scales. Transfer from bed to shower chair vs. bed to wheelchair to shower chair. Use of shower chair for toileting etc.

5. Progressive step disciplinary program.

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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.
6. Equipment inspection and maintenance.
   a. Prior to all transfers.
   b. Daily visual by staff.
   c. Preventive Maintenance. Monthly formal inspection with documentation by lift.

There are a number of resources available to assist you in the development and implementation of a Safe Resident 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. Our 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
- Health Care Health & Safety Association of Ontario, Handle With Care: A Comprehensive Approach To Developing And Implementing A Client Handling Program
- National Back Pain Association In Collaboration With The Royal College Of Nursing – The Guide To The Handling Of Patients Introducing A Safer Handling Policy
- American Nurses Association – [www.nursingworld.org](http://www.nursingworld.org)