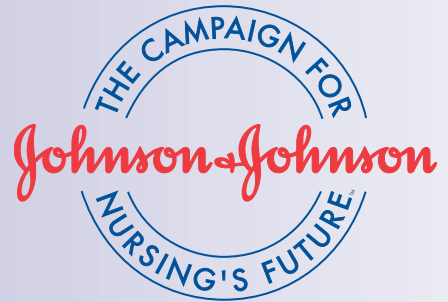


*Handle with Care*



Supported by



# Letter from ANA President



Dear Colleague:

ANA is excited to announce “Handle with Care,” an ambitious initiative aimed at preventing potentially career-ending back and other musculoskeletal injuries among nurses. This campaign is designed to support this nation’s nurses by enhancing workplace health and safety. The mission of Handle with Care is to mount an industry-wide effort in health care to prevent back and other musculoskeletal injuries through greater awareness and training, and increased use of assistive equipment and patient-handling devices. The campaign also seeks to reshape nursing education and federal and state ergonomics policy by highlighting the ways technology-oriented safe patient handling benefits both patients and the nursing workforce.



ANA believes that organizational decision-makers are instrumental in realizing the goals of Handle with Care. That is why we are counting on individual health care and nursing administrators to act as “agents of change” to help in this cause. Included in this brochure is information that describes how musculoskeletal injuries hurt nurses, and how nurses and their employers can benefit from adopting a patient-care ergonomics program in their facilities. Also enclosed is a CD-ROM that details a comprehensive cost-savings approach to patient-care ergonomics. After reviewing the materials — which outline just how much money facilities can save simply by installing safe patient-handling equipment and practicing safe handling techniques — you will realize how simple and inexpensive it is to address common but easy-to-avoid ergonomics hazards in health care. With your commitment, we can put an end to preventable work-related injuries while eliminating unnecessary health care operating expenses.

Overall, ANA sees the Handle with Care campaign as a way to dramatically improve the health and safety of nurses, increase the safety of patient care and substantially reduce health care costs. Of course, we also must keep in mind that an effort like this requires both shared vision and shared responsibility. That is why we at ANA look forward to working with you and your organization on this important issue and to achieving change together.

Sincerely,

A handwritten signature in blue ink that reads "Barbara A. Blakeney". The signature is fluid and cursive, with a large loop at the end.

Barbara A. Blakeney, MS, RN  
President

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# Background

Over the past decade, ergonomic hazards have emerged as a primary health and safety concern among health care workers — with professional nursing groups, labor organizations, industry, regulatory agencies and the scientific community all converging in an attempt to solve the problem. Yet, despite this recognition, the incidence of musculoskeletal disorders (MSDs) persists at high rates for nursing personnel, thus signaling the need for continued action.

Following are some facts that describe the nature and extent of this problem:

## Nursing and Musculoskeletal Disorders

- Patient-handling tasks are the primary cause of MSDs among nurses. Of greatest concern are back injuries and shoulder strains, both of which can be severely debilitating.
- Patient-handling tasks are typically performed manually and often repetitively, and include such movements as lifting, transferring and repositioning patients.
- Patient-handling tasks most frequently associated with low back pain include lifting and forced, sudden or strained movements (such as those involved in patient fall interventions).
- Continuous or repeated performance of these activities throughout one's working lifetime greatly increases the chances of developing MSDs.
- The physical environment of the health care setting also contributes to work-related MSDs. Configurations of areas within patient rooms and the placement of furniture and treatment equipment (e.g., critical care unit monitors, ventilator machines) can pose ergonomic hazards for nurses.
- There is no safe way to manually lift a physically dependent adult patient. Traditionally taught to nurses to counteract the physical stress of patient handling — such as lifting heavy patients — so-called “proper” body mechanics do not result in fewer injuries for nurses, in part because early studies were based on static loads (i.e., boxes with handles) and primarily focused on men. Further, body mechanic methods primarily concentrate on the lower back for lifting and do not account for other vulnerable body parts involved in patient-handling tasks, such as lateral transfers from a gurney to a bed along a horizontal plane.

## A Profession at Risk

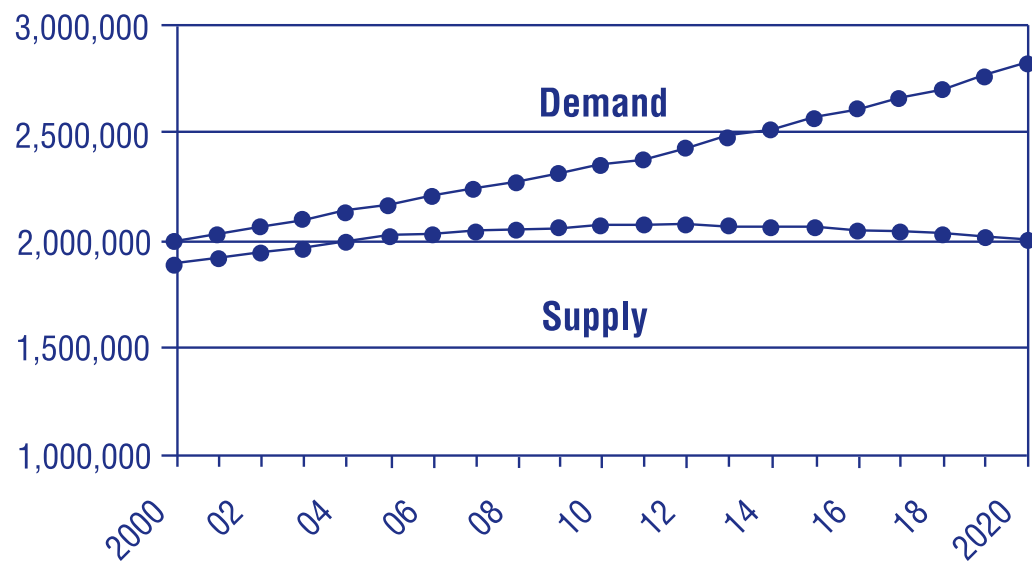
- Compared to other occupations, nursing personnel are among the highest at risk for MSDs. The Bureau of Labor Statistics lists nurses aides, orderlies and attendants as first in a list of at-risk occupations for strains and sprains, with truck drivers second, laborers third, RNs sixth, stock handlers and baggers seventh and construction workers eighth.

- Additional estimates for the year 2000 show that the incidence rate for back injuries involving lost work days was 181.6 per 10,000 full-time workers in nursing homes and 90.1 per 10,000 full-time workers in hospitals, whereas incidence rates were 98.4 for truck drivers, 70.0 for construction workers, 56.3 for miners and 47.1 for agriculture workers.
- Lower-back injuries are also the most costly injuries affecting workers, despite the fact that many of these injuries go unreported. Studies of back-related workers' compensation claims reveal that nursing personnel have the highest claim rates of any occupation or industry.

## Exacerbating the Growing Nursing Shortage

The Department of Health and Human Services projects our nation will experience an acutely severe nursing shortage as we progress through the 21st century. In 2000, there was a demand for 2 million RNs, but there were only 1.89 million RNs in the labor pool (a shortage of 6 percent). This shortage is expected to increase to 20 percent in 2015 and nearly 30 percent in 2020.

**Chart 1: National Supply-and-Demand Projections for Full-Time Equivalent Registered Nurses: 2000–2020**



Source: Bureau of Health Professions, RN Supply-and-Demand Projections

*(Assumes 40 percent increase in demand between 2000 and 2020, with a 6 percent growth in supply.)*

The extent of MSDs among the U.S. nursing workforce is particularly distressing when considered in the context of the current nursing shortage. Research regarding the impact of musculoskeletal injuries on nurses has shown the following:

- 52 percent complain of chronic back pain.<sup>1</sup>
- 12 percent of nurses report that they have left nursing “for good” because of back pain.<sup>2</sup>

- 20 percent of RNs transferred to a different unit, position or employment because of lower back pain, with 12 percent considering leaving the profession.<sup>3</sup>
- 38 percent of RNs have suffered occupational-related back pain severe enough to require taking leave from work.<sup>4</sup>
- 6 percent, 8 percent and 11 percent of RNs reported changing jobs for neck, shoulder and back problems, respectively.<sup>5</sup>

Injuries secondary to patient-handling tasks compound factors driving the nursing shortage. The aging nursing workforce (the average nurse's age was 43.3 years old in 2000) is increasingly unable to tolerate the physical rigors of patient care in the current health care climate. As a result, experienced professional nurses must consider alternative careers that are less physically demanding. Also, the recruitment of new nurses is hampered by the threat of work-related injury.

“The loss of strength and agility that often accompanies aging affects the ease with which nurses can perform patient care activities that require them to turn, lift or provide weight-bearing support to patients,” according to the Institute of Medicine’s “Keeping Patients Safe: Transforming the Work Environment of Nurses” report (November 2003). The report concludes that, “Ergonomic patient and staff furniture and work tools will be needed to decrease the risk of injuries to patients (and nurses as well).”

### Effectiveness of Safe Patient-Handling Equipment & Devices

- The development of assistive patient-handling equipment and devices has essentially rendered unnecessary the act of strict “manual” patient handling as a function of nursing care.
- Assistive patient-handling equipment and devices control the ergonomic hazards associated with patient handling by technologically “engineering out” the energy/force imposed onto the nurse during the act of lifting, transferring or repositioning patients.
- Assistive patient-handling technology is applied by designing and fitting the job or work task to match the capabilities and limitations of the human body.
- A growing number of health care facilities have reported dramatically positive results after incorporating patient-handling technology. Injuries among nurses have significantly declined since implementing patient-handling equipment and devices along with an institutional commitment to the safest available methods. As a result, the number of lost work days secondary to injury and staff turnover has declined.



*A nurse uses a lateral transfer aid to move a patient from gurney to bed.*

Cost-benefit analyses have shown that assistive patient-handling technology successfully reduces workers' compensation costs for MSDs.

## Patient Concerns and Benefits

- Weights and sizes of patients can vary significantly, particularly considering geriatric and bariatric (obese) patient populations.
- The potential for patient injury (such as falls and skin tears) as a consequence of a manual handling mishap is reduced by using assistive equipment and devices. These devices provide a more secure process for lifting, transferring or repositioning tasks. Patients are afforded a safer means to progress through their care. Moreover, assistive equipment helps relieve any anxiety related to having a person susceptible to injury perform the task of manually lifting a patient.
- Using assistive patient-handling equipment contributes to patient comfort. Awkward or forceful handling — which patients may experience during manual lifting, transferring or repositioning — can be avoided. Rather than manipulating a patient's body parts, equipment and devices are utilized.
- Patient dignity is protected by using assistive equipment and devices. A patient's self-esteem and privacy can be compromised during difficult manual patient-handling situations. The use of technology for such circumstances can offer a considerate way of completing patient-handling tasks that respects a patient's sense of dignity.
- Assistive patient-handling equipment can be selected to match a patient's ability to assist in his or her own movement, thereby promoting patient autonomy and rehabilitation.



*Stand-assist lifts provide patients with greater autonomy.*

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4. Owen, B.D. (2000). Preventing injuries using an ergonomic approach. *AORN Journal*, 72, 6: 1031–1036.
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# *Economic Argument*

Manual lifting and moving of patients and residents in the health care industry can be a risky business. Nurses who assist these dependent patients and residents have a high risk of suffering a musculoskeletal disorder, and patients and residents risk accidental drops or falls. Moreover, if a nurse who is assisting dependent patients and residents suffers a musculoskeletal injury, the health care facility faces a severe financial burden, thus contributing to excessive losses for the entire industry.

## **Direct and Hidden Costs**



This cost burden is even more severe than most people realize. When considering the cost of occupational injuries, normally only the direct costs are considered. These direct costs include compensation paid to injured workers and medical payments to treat the injuries.

In addition to these direct costs, the health care industry incurs many additional indirect costs as a result of ergonomics injuries. These indirect costs include employee replacement costs, investigation time, supervisors' and managers' time, additional training, loss of productivity, liability costs from possible patient injury, overtime and many other operational costs.

Insurance protects employers from many direct costs. However, indirect costs take away operational dollars.

## **Investing in a Safe Patient Handling Program**

One common obstacle to ergonomic management programs is the cost of new equipment. Such equipment typically includes mechanical lifts, transfer aids, and new beds and chairs with ergonomic features. The good news, however, is that the return on investment for this new equipment is achieved in a very short time.

In addition to saving money, new and improved equipment reduces the number of injuries to nurses, lost work days and, most important, the cost of injuries. For example, in a case study conducted by Nelson, Fragala and Associates in 2002, injuries reported by nurses were reduced by 31 percent after their facility implemented an ergonomic management program. Moreover, the injury incidence rate was reduced by 30 percent, modified duty days were cut by 88 percent, lost work days went down 18 percent and injury costs were reduced by 58 percent. The result: improved quality of work life for nurses — thus leading to more nurses staying in nursing — as well as improved quality of care for patients.

In another study [Fragala and Associates] in 1995, direct costs of back injuries resulting from patient handling were reduced from \$77,708 to \$743 — or 99 percent annually!

Still other studies reveal similar cost savings. For example, in a three-year study, conducted at Salina Regional Health Center in Salina, KS, which measured the number of nurse employee injury claims before and after ceiling-mounted lift system devices were installed, a net savings of \$208,479 in injury-related medical and indemnity costs was revealed. The study was conducted between 2001 and 2003, with 30 injuries in 2001 before ceiling-mounted lift systems were installed and 21 injuries in 2003 after lift systems were phased in. In addition, lost-duty days dropped from 17 in 2001 to zero in 2003, and light-duty restriction days dropped from 22.3 in 2001 to 7.8 in 2003. Overall, the cost per event dropped from \$7,124 in 2001 to \$252 in 2003, and total injury-related medical and indemnity costs dropped from \$213,734 to \$5,265.

Another success story comes from Trident Health System in Charleston, SC, where the company experienced a 30 percent reduction in injuries in one year after spending approximately \$265,000 on lift equipment.

And finally, in a case study reported by the Department of Health and Human Services in conjunction with the Centers for Disease Control and Prevention (CDC) and the National Institute for Occupational Safety and Health (NIOSH), a company that owns and manages five nursing homes reported a two-thirds drop in workers' compensation costs — from \$165,000 to about \$60,000 per year — after the company installed lifting equipment. The initial cost to install the equipment and train employees was \$143,000; however, managers estimated that it took less than two years to recover these costs. In addition, employees rated patient transfers as less stressful than before the new equipment was installed, and fewer injuries occurred. Overall, the study provided strong evidence that installing lifting equipment prevented back injuries at the company's nursing homes.

These various case studies demonstrate that there are real savings involved in making an investment in the proper equipment and training.



*A ceiling-mounted lift protects both the nurse and patient from injury.*

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# Nurses Speak Out

*The following testimonials reveal the excruciating costs — in human terms — of failing to use patient-handling equipment and devices, and neglecting to implement greater awareness and training in health care facilities.*

## **Anne Hudson, RN, BSN**

### ***Cumulative-trauma back injury***

My name is Anne Hudson, and I am a registered nurse. In June 2000, I suffered a cumulative trauma injury to lumbar discs in my back from years of lifting patients. Now, because I have lifting restrictions, I am unable to return to work as a floor nurse.

I hope telling my story will let other nurses know how spinal discs can be injured over time, often with no perception of pain until it is too late; how such injuries can lead to disability and the end of a nursing career; and how hospitals can avoid most of the injuries by mandating use of safe-patient lift equipment.



***Anne Hudson, RN, BSN***

After receiving a nursing degree at the age of 40, I worked for over 10 years in medical-surgical, telemetry and intermediate care units in a hospital. My nursing class was told that nurses are at high risk of back injury, especially cumulative trauma injury from lifting patients, but why or how this occurs was not explained to us. We were taught body mechanics and were told, “Take care of your back — your job depends on it.”

Lifting heavy patients many times every shift was a regular part of my job. I felt strong and was unaware of damage occurring to my spine from compressive forces associated with lifting excessive amounts of weight. One day, walking through my kitchen, sudden incapacitating low-back pain announced my spinal injury, the end of my hospital nursing career and the beginning of years of dealing with the workers’ compensation system.

During two years of conservative measures leading up to surgery, the hospital permitted only two 90-day periods of light duty. Lifting restrictions were my only limitation, and I did well working light duty. If I had been allowed to continue working as a nurse, I may have accepted the injury as just part of the job and may never have looked into back injury among nurses, but, like many hospitals, my employer did not provide permanent light duty for a nurse with lifting restrictions.

With a bit of research, what I discovered was horrifying: Back injury to nurses has been documented for decades with interventional studies proving since at least 1991 that use of safe lift equipment could prevent most of the injuries. Still, 38 percent or more of nurses suffer a back injury, 83 percent work in spite of back pain, and many back-injured nurses lose their positions when unable to continue lifting.

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What I have experienced and learned led me to become an activist for back-injured nurses. But when I presented information on safe, gentle patient lift equipment to the hospital's Back Injury Prevention Task Force, they said, "We know all that. We've been looking into this issue for three years." I was so naïve; I thought I was bringing new information to help them learn how injuries could be prevented. They had the information and could have implemented protection for nursing staff years ago! I suppose hospital administration thought it was cheaper to allow injuries and to replace "broken" nurses rather than protect them.

In May 2002, I had spinal-fusion surgery but have since experienced complications, so further treatment is being planned. Meanwhile, I am left with daily pain, limitations in many activities I once enjoyed, a huge financial impact and an ongoing workers' compensation battle with the hospital.

One positive outcome is my wonderful new job as a public health nurse. My job is stimulating and challenging, I have terrific co-workers and I'm very grateful to be working as a nurse again. But anyone who attempts to minimize the impact of back injury to floor nurses by saying, "There are so many other things nurses can do," needs to realize that back-disabled nurses can experience great losses with starting over, and many never work as nurses again — either because they are too severely injured to work or because they are unable to find an employer willing to accept them.

With abundant evidence for both nurse and patient safety, it is clearly time to bring safe-patient lift equipment to the forefront of discussions on improving nurses' work environments and increasing patient safety.

Thank you for allowing me to tell my story.

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## **Maggie Flanagan, RN, Washington State** *Acute lifting injury*

My name is Maggie Flanagan, and I'm a registered nurse, wife and mother of two small boys. I live and work in Washington State and am a member of ANA and the Washington State Nurses Association. I have 21 years of experience working as a nurse in hospitals caring for high-risk infants.

Until I am able to explain my story, people often look puzzled when I say that I sustained a disabling injury from caring for newborns. But, take it from me, even though our patients are small, the ergonomic hazards are very real and very serious. Providing nursing care in a newborn intensive care unit (NICU) is complex, fast-paced and stressful, in part because newborns in distress require split-second interventions.

Caring for sick newborns also requires long periods of standing and bending, frequently in awkward postures. Increasingly, NICUs are cramped and loaded with high-tech equipment. In most hospitals, the expanded amount of equipment was not planned for in original designs. With equipment arranged like this, our everyday work involves long horizontal and vertical reaches. Alarm soundings from machines can number in the hundreds during a 12-hour shift and must be silenced by reaching high and far. Before my injury, I would reach past the point of discomfort to silence these alarms — alarms that could potentially damage the underdeveloped hearing of my fragile patients.

As a result, for years leading up to my eight-month disability, I found that it took longer and longer to recover from a 12-hour shift. Back, neck and shoulder pains plagued me even on my days off. But I didn't realize that these cumulative aches and pains could develop into a chronic injury.

In addition to these cumulative problems, I was acutely injured while lifting patient monitoring equipment. The lifting activity involved moving a 75-pound monitor. Looking back, I now know that performing this heavy move was the exact motion I had used in silencing all the hundreds of alarms that occurred in my daily work. The repetitive strain of answering those alarms had taken its toll. My musculoskeletal injury from the heavy lift had occurred in the same areas that had already been damaged in my day-to-day work.

The injury I sustained was excruciatingly painful. I attended physical therapy several times a week. I had a hard time sleeping. I experienced spasms and a lot of pain, and I had to take long-term painkillers. For months afterwards, I could not bathe or dress my children. And my family life suffered because we had to put our children in daycare while I attended rehabilitation services. I am lucky that I was able to return to work. But I am also frustrated — because all that pain, anguish and suffering could have been avoided if the facility where I worked in Alaska had simply implemented the ergonomics measures that were recommended. I know I am not the first person hurt at my job. But what I can't live with is that I won't be the last unless we start protecting nurses and other health care workers immediately from ergonomic hazards in the workplace.



*Maggie Flanagan after testifying at a July 2001 ergonomics hearing before the U.S. Department of Labor in Chicago.*

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## **Gina Severino, RN**

### *Nurse activist*

My name is Gina Severino, and I have been a registered nurse for the past 18 years. Although I have never had a serious musculoskeletal injury, I have had years of wear and tear on both my back and shoulders resulting from direct patient care. Lifting, turning, pulling and repositioning patients has taken a toll on my back. I worry every day about suffering or being disabled by a cumulative-trauma injury. And although I love nursing, I do not want to be unnecessarily disabled by it.

I am not alone, either. It distresses me to see my colleagues disabled and financially burdened as a result of musculoskeletal injuries acquired while attempting to provide quality patient care. Of course, our patients are our number one priority, but nurses should not have to sacrifice their backs in the patient-care process.

Just like their patients, nurses deserve adequate preventive care that consists of implementing a zero-lift policy, the proper assistive lifting and handling equipment, and adequate training in lifting and handling techniques — so they can avoid experiencing painful and often career-ending back injuries and musculoskeletal disorders.

As a nurse who has returned to the classroom to pursue a master's degree in chronic illness, with a focus on nursing education, I see a great value in taking a proactive approach to ergonomics and other nursing-related issues. In addition, both safe patient-handling training and nursing education in general deserve better funding — so that our future nurses are able to protect themselves through proper ergonomics measures and techniques, and so that we have more future nurses to protect!

The education, training and ergonomics changes that are necessary are uncomplicated and inexpensive for health care administrators to make, and they end up saving the average facility hundreds of thousands of dollars in reduced workers' compensation and medical care claims, not to mention needless pain and suffering on the part of individual nurses.

It's time to make nursing care safer — not just for patients but for the nurses who care for them as well. Thank you.

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# *Health Care Administrator Success Stories*

*Several studies and pilot programs have shown the cost-effectiveness of having strong ergonomics measures in place.*

## **‘Healthy Moves’ Equals Healthy Savings**

In one study involving the Glens Falls Hospital in upstate New York, patient-handling injuries were cut in half, while related workers’ compensation costs decreased by 45 percent — a direct cost savings of nearly \$125,000 — after the hospital implemented a new “minimal lift” ergonomics program in January 2002.

As Ron Zimmerman, safety director at Glens Falls Hospital, notes, the savings really do add up. Since introducing the program, dubbed “Healthy Moves,” with an initial outlay on equipment of \$350,000, the hospital has reduced workers’ compensation claims by 28 percent and the average cost per claim by 24 percent. As a result, he says, not only are patient-handling-related injuries disappearing, but the severity of the injuries that do still occur is greatly diminished. As evidence, Great Falls Hospital cut its OSHA-recordable patient-handling injuries nearly in half as compared to its track record before program implementation — from 43 injuries in 2001 to 23 injuries in 2003.

But more important than the mere cost savings involved, finding a way to reduce back injuries is “the right thing to do for both staff and patients,” says Zimmerman. “Improved job satisfaction and how that translates into better patient care and staff not worrying about hurting themselves on the job — you just can’t put a price tag on that.”

## **The Wyandot Way**

Joe Joliff, a former administrator at Wyandot County Nursing Home in Upper Sandusky, OH, has a similar success story after his facility implemented “sound ergonomics practices,” including implementing a no-manual lifting policy and several pieces of assistive-lifting equipment.

As Joliff relates, it cost Wyandot an initial \$116,000 to buy the proper equipment, “but the savings have been much greater — in reduced staff turnover and workers’ compensation alone.” For example, he says, after implementing the new ergonomics program, the facility only had to replace five nursing assistants — rather than the usual 30 who left the facility per year — which translated into approximately \$125,000 in savings.

In addition, overall workers’ compensation went down, he says. Originally averaging almost \$140,000 per year between 1995 and 1997, Wyandot’s compensation claims dropped to below an average of \$4,000 in 2000 and 2001.

But that's not all. "In addition, we experienced other substantial savings — amounting to approximately \$55,000 to \$60,000 per year — in the form of reduced overtime, sick time and overall reduced hours, while staffing levels remained the same," he says.

"The benefit to our staff was apparent almost immediately," Joliff adds. "Some nursing assistants began telling us that the work was now 75 percent easier. Others were saying that if we had doubled the staff, it would not have helped as much as having the equipment. Still, others were telling us that they would not work at another facility without the equipment even if they were paid \$10 more per hour. And finally, a nursing assistant's husband came by and said 'thanks' for giving him 'a new wife' resulting from the energy she now has when she comes home from work."

Overall, the new ergonomics program has resulted in "increased quality of care for our residents, increased morale of employees and enhanced administration of our facility," says Joliff.



*Assistive devices allow nurses to transfer patients safely and easily.*

### **Pilot Program Yields 'Proof Positive' Results**

In yet another pilot project involving St. Thomas Hospital in Nashville, TN, behavioral changes became the key goal — and the route to reducing patient-handling injuries. As the facility's employee health nurse practitioner, Sharon Craig, APRN-BC, relates, involving bedside nurses at the beginning of the pilot produced the most positive results. In addition, nurses with a prior patient handling injury were found to be the most receptive to the program concept and to changing their behavior. And finally, patient-care managers who supported and encouraged safer patient handling were found to have 36 percent fewer patient-handling injuries than managers who did not participate. The study's conclusion: "When nurses anticipate potential patient-handling device needs for each patient, and when they choose and use appropriate patient-handling assist devices and educate patients and their families regarding safe patient handling, the result is fewer patient-handling incidents."

# Implementing a Safe Patient-Handling Program

Every day, nurses across the country suffer from debilitating back injuries, strains and sprains — work-related musculoskeletal disorders that come as a consequence of dealing with ergonomic hazards in health care settings. The majority of these injuries result from patient-handling tasks — such as lifting, transferring and repositioning. Others occur from working in a poorly designed physical work environment. But the good news is that back injuries and other musculoskeletal disorders are preventable with a safe patient-handling and movement program.

Why is such a program important? Because *breaking your back* should not be a part of the job.

How can a safe patient-handling and movement program be instituted in your facility?

## 1) Create an ergonomics committee.

The primary responsibility of an ergonomics committee should be establishing, implementing and monitoring a comprehensive ergonomics program — through management support and frontline employee participation. The ergonomics committee may be formed independently or as part of your organization's workplace health and safety committee. Members should include managers, purchasers, risk managers and employee/occupational health representatives, as well as direct caregivers.



*Patient comfort can be enhanced through the use of transfer aids.*

## 2) Analyze the data, conduct a walk-through and survey employees.

Review Occupational Safety and Health Administration 300 Injury/Illness Logs, incident reports and other reporting systems. Then perform a “walk-through” involving all units on all shifts to look for risk factors. Survey employees regarding their concerns, experiences and suggestions, and examine and explore any apparent injury patterns or trends.

## 3) Assess patient-dependency levels.

Consider patients' needs and abilities when making decisions regarding which equipment and devices to use. For example, different patients have varying and distinct levels of assistance-providing requirements, different bearing weights, differing upper- and lower-extremity strength, and different heights and weights, as well as special circumstances and specific care instructions.

#### **4) Assess risky patient-handling tasks.**

Perform an ergonomics hazard assessment based on information and data. This assessment should consider such variables as patient-handling tasks, types of nursing units, patient populations and the physical environment. Determine which tasks pose a risk for injury on each unit. Is it frequent lifts of dependent patients in rehabilitation? Multiple transfers for geriatric residents? Repositioning bariatric (obese) patients in the ICU? Each of these potential risks should be calculated and assessed.

#### **5) Develop and adopt a safe patient-handling policy.**

Institute a “no-lift” policy that discourages manual patient handling and requires the use of appropriate equipment and devices as necessary. This policy may be applied facility-wide or tailored to be unit-specific to meet staff needs. Avoid language in the policy that disciplines employees.

#### **6) Research, evaluate and select a pilot project.**

Include frontline health care workers in every step of any pilot projects that involve selecting, testing and implementing new equipment. When testing devices, such as mechanical lifts, lateral transfer aids, gait belts and transfer chairs, seek input from staff and patients. Use criteria to evaluate and select patient-handling equipment, including patient comfort and safety, caregiver stability and safety, task appropriateness, efficiency, maintenance, storage, availability and cost-effectiveness. Contact a variety of equipment and device manufacturers to keep updated on the latest technology, and establish a timeline for investing in capital equipment purchases.



*Patient-lift devices protect nurses and patients.*

#### **7) Provide comprehensive and interactive training for staff.**

Train staff on policies regarding equipment and devices before implementing them. Consider the need to train new employees or to rotate health care workers. Identify and train “peer” back-injury prevention leaders.

#### **8) Encourage reporting of back injuries, strains and other musculoskeletal injuries.**

Create a blame-free environment for reporting work-related injuries or illnesses. Staff must feel comfortable to report any injury or illness without negative consequences. Not only can employees be promptly treated, but corrective action can be taken to eliminate or minimize the hazard.

#### **9) Track patient and worker injuries and evaluate the program.**

Continue to routinely collect and analyze data and update the program with the latest policies, best practices and most advanced technology.

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# *Patient Care Ergonomics Resource Guide:*

## *Safe Patient Handling and Movement*

Included in this brochure is the “Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement” (on CD-ROM) developed by the Patient Safety Center of Inquiry, Veterans Health Administration in Tampa, FL. This guide offers direction to design and implement a comprehensive program to prevent on-the-job injuries related to patient handling and movement tasks. The program elements described are based on scientific research, professional consensus and best practices.

**Comprehensive program elements include:**

**Ergonomic Workplace Assessments of Patient Care Areas**

**Patient Assessment Criteria**

**Algorithms for Safe Patient Handling and Movement**

**Equipment Selection, Storage and Maintenance**

**Peer Safety Leaders (Back-Injury Resource Nurses)**

**Lifting Teams**

**After-Action Reviews**

**No-Lift Policy**

*More information related to this guide can be accessed at [www.patientsafetycenter.com](http://www.patientsafetycenter.com).*

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# *Resources*

## **American Nurses Association**

8515 Georgia Avenue  
Suite 400  
Silver Spring, MD 20910-3492  
(800) 274-4ANA  
[www.NursingWorld.org](http://www.NursingWorld.org)



## **Handle With Care**

[www.NursingWorld.org/handlewithcare](http://www.NursingWorld.org/handlewithcare)

## **Patient Safety Center of Inquiry Veterans Health Administration**

11605 N. Nebraska Avenue (118M)  
Tampa, FL 33612  
(813) 558-3902  
<http://www.patientsafetycenter.com>

Supported by a grant from

*Johnson & Johnson*



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