DRAFT Safe Patient Handling and Mobility Standards Revision
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For Public Comment
Safe Patient Handling and
Mobility Standards Revision

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Contributors

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About the American Nurses Association
The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 4.2 million registered nurses. ANA advances the profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA is at the forefront of improving the quality of health care for all. For more information, visit www.nursingworld.org
The Continuing Need for Safe Patient Handling and Mobility (SPHM) Standards

Are healthcare workers still being needlessly injured at work? According to the 2018-2019 (Check with Holly for most recent data) Healthy Nurse Healthy Nation® Survey 40% of respondents consider lifting and repositioning one of the hazards that they face at work. 58% of respondents indicated that they had experienced musculoskeletal pain at work during the past year. Do they experience pain because they do not have access to technology? No, 72% of respondents either agreed or strongly agreed that they have access to safe patient handling and mobility (SPHM) technology. This information just from nurses is indication that we still have work to do. We are far from universal SPHM.

Universal SPHM has been a goal of ANA for quite some time. To move this forward ANA and the Veterans Health Administration, Tampa VA Research and Education Foundation, Inc. (formerly the James A. Haley Veterans Research and Education Foundation, Inc.) brought together a holistic group of stakeholders in 2016 to discuss how to achieve universal SPHM. For 18 months this group formed sub-groups to discuss the different facets of how to reach and educate professionals towards a mindset of universal SPHM. Strides were made. Unfortunately, the group disbanded without a concrete resolution or plan. All agreed, however that universal SPHM is the only way that all professionals who interact with patients can remain safe in the workplace.

Development of the SPHM Standards

In the summer of 2013, the first version of the Safe Patient Handling and Mobility Interprofessional National Standards were released, followed shortly by the Implementation Guide to the Safe Patient Handling and Mobility Interprofessional National Standards. The SPHM standards were developed to be:

- Useful in healthcare settings across the continuum of care
- Useful for healthcare workers, ancillary/support staff, and organizational leadership
- Realistic and attainable, while raising the bar
- Evidence-based and outcome-focused

This revised version of the standards is a combination of the Standards and the Implementation Guide, capturing the essence of the original standards while incorporating assessments, tools, exemplars, and updated resources. Note that the Standards content has not changed.

Timeline of History of SPHM

1900-1950s  Various devices developed to move, reposition, and lift patients*
1958  Ted Hoyer developed a powered patient lift*
1976-1990  Air-assisted patient transfer and movement devices patented*
1972
Journal article indicating nursing staff have higher incidents of back
injuries*

1984
National Institute for Occupational Safety and Health (NIOSH) recognizes
lifting injuries in nurses is similar to construction and warehouse workers*

Late 1980s
Introduction of ceiling lifts and adjustable beds*

1992
"Ergonomic Guidelines for Manual Material Handling" published by State
of California, Department of Industrial Relations, Division of Occupational
Safety and Health (DOSHA) known as CAL/OSHA and United States,
Department of Health and Human Services (DHHS), DHHS (NIOSH)
Publication No. 2007-131

Late 1990s
Introduction of Lift Teams*
Occupational Safety and Health Administration (OSHA) General Duty
Clause Citation criteria

2001
First Annual SPH Conference presented by the Patient Safety Center and
the Department of Veterans Affairs (VA)

2002
OSHA vs. Beverly Enterprises (U.S. largest nursing home chain)
settlement requires lifting equipment to avoid ergonomic injuries.

2003
"Guidelines for Nursing Homes – Ergonomics for the Prevention of
Musculoskeletal Disorders" published by OSHA

2004
ANA’s ‘Handle With Care’ Campaign

2004
Audrey Nelson SPHM evidence-based practice research

2005
Texas is the first state to pass a state safe patient handling law

2008
National VA Roll Out approved for $205 Million for SPH Implementation

2009
Federal Nursing and Healthcare Worker Protection Act. Reintroduced in
2013 and 2015

2011
Association of Safe Patient Handling Professionals (ASPHP) established

2011
ASPHP Professional Certification program initiated

2011
Journal first published: International Journal of SPHM begins publication
(formerly American Journal of SPHM)
Demographics and characteristics of the US population

The population of the U.S. continues its upward trajectory and is aging. In 2016, the median age reached a new maximum of 37.9 years, due in large part to the aging baby boomer cohort.\(^1\) Life expectancy also continued to increase after several years of decline, reaching 78.6 years in 2017.\(^2\) Organizations and manufacturers are responding, by expanding SPHM programs and technologies into additional healthcare environments, including long-term, home care, emergency response and ambulatory settings.

Obesity rates are steadily rising in all fifty states.\(^3\) Each state has now recorded a rate of at least 20%. From 2000 through 2018, the prevalence of obesity rose from 30.5% to 42.4%; with the category of severe obesity (BMI >40) growing from 4.7% to 9.2%. Factors including race, socioeconomic status and age influence obesity rates. This situation presents one of the highest risks and stressors for healthcare workers.

Mortality rates affect in-patient hospitalization, patient characteristics and SPHM. The CDC reported in 2019 that the three leading causes of death in 2016 and 2017 remain consistent.\(^4\) They are heart disease, cancer, and accidents. In addition, deaths from the leading eight causes significantly increased from 2016-2017, (Influenza and pneumonia by 8.0%; unintentional injuries by 5.3%; suicide by 4.9%; Alzheimer disease by 4.6%; diabetes by 4.4%; Chronic lower respiratory disease by 3.6%; stroke by 3.0%; and heart disease by 1.9%). Some of these conditions do require extended in-patient care, presenting increased risks from immobility, and increased need for patient handling and rehabilitation. Others require increased care outside the hospital environment further highlighting the need to expand SPHM progress to these settings.
Continuing Trends and Issues Regarding SPHM

1. Culture of Safety

A culture of safety involves a continuum of care approach starting with commitment, collaboration, and communication at all levels of the organization. Recognized high-reliability industries include the airline industry, nuclear industry and oil industry which are complex and sometimes hazardous environments with the priority that safety comes first. HROs can manage potential safety incidents by promoting safe behaviors. (Houmanfar, Anbro, Burleigh, Hebein, 2017). [Reference Leadership and Crew Resource Management in High-Reliability Organization: A Competency Framework for Measuring Behaviors, Journal of Organizational Behavior Management, Volume 37, 2017, Issue 2, Pages 142-170]

Health care organization striving to become High Reliability Organization (HROs) have the key aspects including preoccupation with failure, reluctance to simplify, and sensitivity to operations, among others. (Weick, Sutcliffe, and Obstfeld, 2008). [Referenced in Creating high reliability organizations using mindfulness, Journal of Business Research, Volume 69, Issue 8, August 2016, Pages 2873-2881]

According to the Joint Commission, the definition of Safety Culture, “Safety culture is the sum of what an organization is and does in the pursuit of safety. The Patient Safety Systems (PS) chapter of The Joint Commission accreditation manuals defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and patient safety.” (Joint Commission, Sentinel Event Alert, Issue 57, March1, 2017). From research from James Reason, a “Just Culture” is defined as “people are encouraged, even rewarded, for providing essential safety-related information, but clear lines are drawn between human error and at risk or reckless behaviors; “Reporting culture - people report their errors and near-misses”. A “Learning culture - the willingness and the competence to draw the right conclusions from safety information systems, and the will to implement major reforms when their need is indicated”. (Joint Commission, Sentinel Event Alert, Issue 57, March1, 2017, Adapted from Reason J. Managing the Risks of Organizational Accidents. Ashgate.1997). [https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_57_safety_culture_leadership_0317pdf.pdf]

Key features of a culture of safety in health care includes a commitment from all levels of the organization: organizational leadership, managers, healthcare workers, and ancillary/support staff. Commitment, collaboration, and communication by all levels of the organization, works across the continuum of care to promote safety for both the health care recipient and health care worker in SPHM programs.

In nursing, it is the ethical responsibility of every registered nurse to protect the health and safety of patient and self. The ANA position statement, Patient Safety: Rights of Registered Nurses When Considering a Patient Assignment, addresses the concept of right of refusal (ANA, 2009). The position statement lists recommendations for
registered nurses, the employer/healthcare agency, and the patient and consumer. The statement distinguishes between refusing an assignment before accepting responsibility and abandoning the care of a patient.

The 2019 ANA’s Principles for Nurse Staffing identifies five principles to guide decision-makers: healthcare consumer, interprofessional teams, workplace culture, practice environment, and evaluation. Staffing levels, quality, along with the identification and development of process and policies can promote the delivery of safe care while improving nursing staffing at the different practice levels and settings (ANA, 2019).


Successful SPHM programs include a culture of safety and clear communication and collaboration between all settings, departments, and levels throughout the organization. Collaboration includes leaders, managers, healthcare workers, ancillary/support staff, and healthcare recipients is included in Standard 1.1.5. Using a collaborating approach has advantages as all members of the team can provide valuable input to implement and promote successful SPHM programs.

2. Patient outcomes focus

3. Technology

Innovations in SPHM technology continue in response to an increased demand for ways to safely mobilize healthcare recipients. As manufacturers research the needs across the continuum of care, they are designing new devices which can assist with a single task, such as turning; and those designed to assist with multiple tasks, such as ambulation and lifting. A wider range of devices with increased weight capacities are also available to accommodate bariatric healthcare recipients.

Most notably, manufacturers are providing evidence on patient quality and risk reduction. Quantifiable data on the ergonomic reduction of risk assists buyers in justifying purchases and comparing similar products in a device category. Evidence that supports patient safety ensures that SPHM technology will not adversely affect patient quality of care. Moreover, it promotes increased acceptance of SPHM technology utilization by all clinical disciplines. For example, evidence is available for single-use products, such as air-assist mats and slings, to ensure that pressure injuries (PIs) and other complications are not exacerbated by leaving these items under patients for extended periods of time.

“Smart” lifts and power-assisted devices are available with electronic controls and memories that enable the user to operate the controls more easily, access instructions and capture usage data. Power-assist lifts have motorized drives to propel the devices in multiple directions, turn the wheels, and move the healthcare recipient, without exertion from the healthcare worker.
Lastly, technology to promote early mobilization is expanding. There are now more accessories available to use with existing overhead lifts to enable progressive mobility during rehabilitation. Electronic beds have additional features to not only assist with turning, but with sitting, standing and egress. Portable total and sit-to-stand lifts are being designed to allow for more functional activity and can be adjusted to provide different levels of support as the healthcare recipient progresses through rehabilitation.

4. SPHM and Future Technology

There has been a significant advance in the use of robotics and artificial intelligence (AI) in health care during the past decade. In several countries around the world, governments are heavily investing in the development of AI-enabled robotic assistive ‘caregivers’ and other devices for home use that not only lift and move patients but can complete simple care tasks and health monitoring. The goal of this growing movement is to address the mobility and care needs of an expanding aging population, insufficient number of caregivers, and a focus on providing community-based care that reduces the need for hospitalization whenever possible (Van Aerschot & Parviainen, 2020; Kajitani & Wakita, 2017). AI technology is also being increasingly incorporated into the design of powered SPHM devices such as floor and ceiling lifts. These features improve device safety for caregivers and patients. Examples include, powered steering or movement and object proximity controls, intuitive control interfaces, and a more comprehensive ability to collect data about device use, maintenance needs, and technology that allows customized functions to suit a patient’s clinical and mobility needs (Sivakanthan et. al, 2019; Matz, 2019). Automated patient lift systems that allow a patient to transfer to and from wheelchair to bed using a computer-based application that is operated by the caregiver, and robotic assist transfer systems that can be operated by the patient without caregiver assistance, are already available. Although these systems may currently be cost prohibitive for many patients, the increase use and advances in robotic technology should make these technologies more affordable and practical for community use in the not too distance future (Humphreys, et.al, 2017; Sivakanthan, et. al, 2019).

Research into the use of Exoskeletal technology in healthcare is also increasing, both in the application of patient handling, in the operating room environment or use by surgeons to reduce upper extremity fatigue during surgery, and as a rehabilitation tool to promote mobility for patients with gait related disorders (Cha, et al., 2020; Young, & Ferris, 2016). To date, this technology has mostly been used in the military and manufacturing environments to enhance the physical capabilities of soldiers and blue-collar workers to perform physically demanding tasks such as manual materials handling. However, limitations of exoskeleton use such as the need to custom fit the device for each individual worker need to be addressed if they are to be considered as another tool to reduce caregiver injuries related to patient handling. Patient safety and experience must also be evaluated when considering the use of exoskeleton technology by caregivers.

As the use of robotic and AI technology grows in the SPHM and rehabilitation industry, there is also a global effort to harmonize medical devices regulations/standards with that has several goals including reducing the time to bring newer technologies in the market and enhancing patient safety. One of these global standards that US based manufacturers and distributors of
powered lifts and slings are expected to meet, is the International Organization for Standardization (ISO) 10535:2021 Hoists for the Transfer of Disabled Persons – Requirements and Test Methods. This standard has recently been revised to specifically address the increase use of AI in lift technology and compatibility related issues due to the wide-ranging variability in design of patient lifts and slings, with the goal of increasing patient safety and comfort by decreasing the risk of caregiver error when choosing and using SPHM technology.

It will be critical that the SPHM technology of the future is not only easy to use for caregivers, but that it is integrated within a system of care for the patient that considers all physiological needs including pressure injury and falls prevention, mobility, and rehabilitation goals, and that interfaces seamlessly with the care environment in which it is to be used.

References


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https://fgiguidelines.org/resource/patient-handling-and-motion-assessments/


Manual handling, moving, and mobilizing patients and residents is hazardous work. In recognition of this fact, in 2010, the Facility Guideline Institute developed and approved design requirements for their *Guidelines for Design and Construction of Health Care Facilities*. The goal of these design requirements was to support safe patient handling and movement practices. The need to educate design professionals on safe patient handling, movement and mobility (SPHM) was apparent, so the FGI committee wrote the original PHAMA White Paper to provide information about the rationale for and relationship of the physical environment and safe patient handling techniques. Continuing and expanding on the original goal, the FGI published the
second edition of this paper in 2019. The second edition updates information on Guidelines
design requirements and incorporates those for care of individuals of size and to facilitate
patient and resident mobilization. The second edition also provides detailed information to
facilitate and implement SPHM programs as well as develop a business plan to assist
organizations in ensuring appropriate technology and program elements are included for
success. States that adopt these Guidelines are required to follow design criteria within,
including the PHAMA. The Joint Commission has no specific criteria statements related to
SPHM, but it does require facilities who are building new buildings or undergoing major
renovations to use the FGI Guidelines, or the state construction guidelines, which are often FGI
Guidelines. Since the FGI Guidelines include the PHAMA, such construction must then abide by
the PHAMA.

6. Value of using data

Implementation of a multifaceted SPHM program as described in these standards, has been
shown to decrease caregiver injuries and associated workers compensation costs, and produce
a return on investment ranging from two to four years. (Matz, 2019; Teeple et al, 2017)
However, the value and return on investment (ROI) of SPHM programs for healthcare
organizations is far greater than solely reducing the direct costs of caregiver musculoskeletal
disorders (MSDs). Evidence supports the positive relationship of SPHM as a facilitator of early
and safe patient mobility that reduces the negative outcomes of immobility. Benefits include falls
reduction and improved patient experience. Other benefits that can be used to build a
successful business case for implementing and sustaining SPHM programs include caregiver
efficiency and perceived improvements in safety culture by caregivers has improved. (Matz,
2019; Gibson et. al 2017)

There is a growing body of evidence to support that the same characteristics of the health care
work environment that contribute to physical injuries and psychological harm to healthcare
workers such as, MSDs, workplace violence, fatigue, stress, and burnout, also contribute to
adverse events for patients. These factors negatively impact an organization by increasing the
cost of workers injuries and staff turnover, and decrease reimbursement for ‘never’ events, and
contribute to sub-optimal patient experience metrics. (Berkowitz, 2016; Loeppke et al, 2016;
Gibson et. al 2017)

As many healthcare organizations in the US face considerable financial challenges as a result
of the covid-19 pandemic, it is more important than ever to demonstrate the ROI of SPHM using
a holistic or systems approach that illustrates the relationship between the benefits to workers,
patients, and the organization. Organizations must understand the that such programs improve
organizational effectiveness while enhancing patient safety and outcomes and supporting
healthier workforces. (Loeppke et al, 2016)
When assessing standards, it is imperative to benchmark implementation of the standards with their intended purpose of reducing risk to employees that fall under the protection of the standard. In this case the ANA standards have been put forward to protect healthcare workers in reducing their risk of injury from patient or resident movement tasks. The question many readers may have is does the ANA standard have any impact on the severity of an injury associated with patient or resident movement tasks? If organizations are going to invest in implementing or partially implementing the ANA standards proposed in this document, what can be the expected cost savings should an injury occur? Can we compare organizations who have implemented or partially implemented the ANA standard on a national level to understand the financial impact?

In the 2016 Healthcare Barometer Report, Aon, using actuarial and risk professionals, analyzed their health care workers’ compensation database consisting of 330,746 non-zero claims, representing $2.4 billion in incurred loss dollars from 50 states. The database contained historical claim information for ten accident years (2006 through 2015). The estimated payroll for all states totaled $40.6 billion. In the 2016 report, for those systems implementing the ANA standards, the average total cost of a workers’ compensation claim was $6,000 versus $7,800 for those healthcare systems not using the standards. Thus, using the ANA standards resulted in 23% lower average total per cost claim. Repeating the analysis in 2018, Aon found even more validation for implementing the ANA standards. In an even larger dataset consisting of $3.0 billion in incurred loss dollars from 50 states and estimated payroll totals of $70.3 billion, those systems following or partially following the ANA standards achieved even better results from the 2016 study. In the 2018 Aon report, for those systems implementing or partially implementing the ANA standards, the average total cost of a workers’ compensation claim was $5,900 versus $9,200 for those healthcare systems not using the standards. Thus, using the ANA standards resulted in 36% lower average total per cost claim, showing tangible cost savings to the workers compensation program for each claim incurred. The evidence from the 2016 and 2018 reports show that the standards may be a positive influencer on the overall culture of safety and an effective cost mitigation strategy. See Table 1 for more details.

Another area of interest is whether having certified safe patient handling professionals impacts workers’ compensation claim costs companies. In the 2016 Healthcare Barometer Report, Aon studies found that healthcare systems that have less than 25% of their staff certified in safe

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### References

https://fgiguidelines.org/resource/patient-handling-and-movement-assessments/


patient handling have significantly higher costs average total cost per claim ($7,300) than those systems that have more certified staff ($4,200) or 42% lower cost. Thus, is appears that having certified safe patient handling staff is another cost reducing measure organizations can take to improve their safe patient handling program in addition to implementing the ANA standards.

- **Table 1: Comparison of Average total cost of a workers' compensation claims for healthcare systems following or not following the ANA Standards for Safe Patient Handling**

<table>
<thead>
<tr>
<th>Data Analyzed</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following ANA Standard</td>
<td>$6,000</td>
<td>$5,900</td>
</tr>
<tr>
<td>Not Following ANA Standard</td>
<td>$7,800</td>
<td>$9,200</td>
</tr>
</tbody>
</table>

References

8. Policy/legislation

The ANA Standards have continued to fill a void from the lack of federal SPHM regulations. In 2015, a congressional SPHM bill was introduced by Representative John Conyers, Jr., known as the Nurse and Health Care Worker Protection Act of 2015. The bill died in committee. During the same year and following a three-year National Emphasis Program of planned inspections (2012-2015) which continued to highlight the high number of musculoskeletal injuries previously identified amongst healthcare staff, OSHA issued a directive for hospitals, nursing and residential care facilities, outlining specific SPHM program elements and policies to be reviewed when a facility receives a compliance visit. The directive emphasizes that patient handling injuries are a recognized hazard as defined by OSHA and subject to regulatory oversight. General Duty clause violations and Hazard Alert letters continue to be written under this directive.

At the state level, no additional states have added SPHM legislation or resolutions since 2011. At present, twelve states have some form of legislation or resolution; nine require a comprehensive program. The states are: California, Hawaii, Illinois, Maryland, Minnesota, Missouri, New Jersey, New York, Ohio, Rhode Island, Texas, and Washington.

Other standard promulgating bodies have also issued guidelines for effective safety and management programs: ISO 45001 Occupational Health and Safety Management Systems 2018 and ANSI/ASSP Z10 Occupational Health and Safety Management Systems 2017. Elements in these standards may be applied when establishing any safety and health program, including SPHM.
Standard 1 – Establish a Culture of Safety

EMPLOYER STANDARDS

Standard Number 1.1.1 Establish a statement of commitment to a culture of safety.

Organizational policy will include a written commitment to a culture of safety that will be used to guide the organization’s priorities, resource allocation, policies, and procedures. The written statement regarding safe patient handling and mobility (SPHM) will describe layers of accountability across sectors and settings.

Introduction: The concept of a culture of safety evolved from studies of high-reliability industries outside of health care. Individuals working in these areas, e.g., air traffic controllers and nuclear power plant employees, do complex and hazardous work while maintaining a commitment to safety at all times. Key features of a culture of safety include acknowledgment of risk, a commitment to provide resources to consistently achieve safe operations, a blame-free environment where individuals can report errors or incidents without fear, an emphasis on collaboration across sectors and settings, and a work environment in which managers and healthcare workers emphasize safety over other competing goals. Numerous healthcare organizations define and incorporate the term “culture of safety” [American Nurses Association (ANA), 2016; Institute for Health Improvement (IHI), 2020].

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Articulation of the value of a culture of safety as it relates to safe patient handling and mobility (SPHM) and contextualization within the current organizational culture.
- Identification of primary stakeholders in the development of a culture of safety as it relates to SPHM.
- Creation of a document stating commitment to a culture of safety, as described below.
- Generation of administrative support/approval of the statement of commitment, specifically as it serves as a charter for a task force.
- Formation of a task force aligned with the mission, vision, and values of the healthcare organization responsible for making the standards actionable.

Implementing Standard 1.1.1
1. Recognize the value of aligning this effort with the quality improvement service of the institution because this service line is responsible for safety and quality initiatives throughout the organization.

2. Provide formal training on the meaning and impact of a “culture of safety” to healthcare workers and other employees.
   - Relay the definition and description of a culture of safety.
   - Identify the current culture.
   - Communicate why a culture of safety is important.
   - Share early success stories through newsletters, bulletins, intranet pages, and verbal communications e.g., safety huddles and shift reports.

3. Identify economic support for a culture of safety task force.

4. Charge the task force with:
   - A written commitment to the culture of safety - the cornerstone for organizational success.
   - Define resource allocation, policies, and procedures.
   - Describe layers of accountability across sectors and settings.
   - Ensure administrative written approval of the document, once completed.

5. Utilize organizational leaders, stakeholders, and frontline employees to identify eight to ten individuals within the organization and from a variety of disciplines, experiences, or practice settings, such as nurses, therapists, assistants, and ancillary staff members, to participate in a culture of safety interdisciplinary task force. Be sure to include individuals from subacute areas who have direct or indirect contact with healthcare recipients. Recruit individuals who have an interest in one or more of the following.
   - SPHM
   - Healthcare worker safety and prevention of injury
   - Culture of safety
   - Behavioral or organizational culture change
   - Other relevant interests (see Standard 2.1.1 for a more detailed account of this subheading).

6. Create a task force charter consistent with those of other organizational teams.

7. Develop a 10-item culture of safety commitment document, including a checklist identifying behaviors and attitudes that may compromise the safety of healthcare workers and/or healthcare recipients. The following are examples.
   - Staff using manual handling methods
   - Lack of accessible lifts or slings on a clinical area/unit
   - Poorly maintained technology
   - Organizational culture of defiance; staff may feel empowered by resisting new procedures in favor of doing things “their way”
   - Administrative behavioral barriers, e.g., inadequate or nonexistent policies and procedures

8. Obtain administrative support for the culture of safety commitment document.

1.1.1 TIPS
This standard is included in the SPHM Standards as the first and primary standard because it provides the foundation for all standards that follow. Because the drafting of the commitment to a culture of safety is a team effort undertaken by a task force of stakeholders, it is essential to identify these stakeholders and establish buy-in. This project asks that we:
   - Identify stakeholders.
   - Make a brief list of the ways a culture of safety stands to serve these stakeholders.
• Ask each stakeholder to make a brief list of the ways they feel a culture of safety stands to serve them.
• Meet individually with each stakeholder to compare lists.
• Use these meetings to prioritize benefits and goals.
• Meet collectively to present benefits and goals before drafting the commitment to a culture of safety in order to unify the vision of the task force and expedite the drafting of the document.

The existing culture of safety must be evaluated within clinical areas/units, other work areas, and the organization as a whole. These evaluations should identify psychosocial factors, such as relationship dynamics within a department, staffing shortages, and staff and management attitudes toward healthcare worker and healthcare recipient safety. The goal is to identify the readiness for culture change (i.e., a change in practice related to lifting and moving of healthcare recipients) and potential barriers that must be addressed to successfully implement an effective SPHM program.

A validated survey tool should be used to assess the culture of safety. The Johns Hopkins Center for Innovation in Quality Patient Care maintains a website on safety culture in health care with strategies for measurement.


1.1.1 References


Standard Number 1.1.2 Establish a non-punitive environment. Organizational policy will support a system to encourage healthcare workers to report hazards, errors, incidents, and accidents, so that the precursors to SPHM errors can be better understood, and organizational issues can be changed to prevent future incidents and injuries. Healthcare workers know that they are accountable for their actions but will not be held accountable for problems within the system or environment that are beyond their control.
Introduction: The concept of a fair and “Just Culture” evolved from the work of behavioral, management, and clinical researchers who found that the way an organization responds to errors influences the prevention of future errors. An organization that practices “Just Culture” recognizes that many errors are caused by predictable interactions between employees and the systems within which they work. All employees may make errors and must be encouraged to report these in real time. This information is used by the organization to investigate causes and to correct system issues. Employees (e.g., healthcare workers) are not held responsible for system issues over which they have no control, but are held accountable for reckless behavior.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Establishment of a consistent process, within an organizational policy, for reporting and evaluating real and potential hazards and incidents within the healthcare organization as they pertain to safe patient handling and mobility (SPHM).
- Establishment of policy that ensures healthcare workers are not held accountable for incidents that result from problems within the organization or environment that are beyond their control, but clearly states healthcare professionals are accountable for their own actions.
- Defining channels by which incident, injury, and near-miss reporting is guaranteed to be non-punitive.

Implementing Standard 1.1.2

1. Integrate the organization’s risk management service into the SPHM task force by involving a representative from the risk management team.
2. Establish a healthcare organization-wide process for identifying and addressing SPHM hazards.
3. Identify a current administrative hierarchy/organizational chart as a precursor for generating administrative buy-in down the line.
4. Establish a system to facilitate a non-punitive work environment.
   - Foster improvements in interpersonal relationships.
   - Train all staff on what a non-punitive work environment means and its benefits, e.g., provide training for management on how to handle reported errors using a non-punitive approach.
   - Educate leadership and staff so they will understand how SPHM fits into operations.
   - Cultivate willingness to identify and examine organizational and individual weaknesses.
   - Encourage organizational learning and improving safety by examining system weaknesses.
   - Facilitate staff acceptance of and confidence in methods to relay concern and/or seek assistance when concerned about a threat to quality or safety.
5. Provide healthcare worker support when workers share concerns.

1.1.2 TIPS

Consider conducting a workshop where the mission of the workshop is to bridge gaps between administrative goals and the logistical challenges of care delivery as they pertain to reporting workplace hazards. In such an interactive workshop activity, staff members from human resources and risk management unite to host training for leadership outlining the policy and procedure surrounding non-punitive reporting as it relates to the SPHM program. Healthcare staff would be included in the review of policies and procedures, and their input would serve to shape the guidelines moving forward.
It is recommended that the “crucial conversations” model be introduced as a communication strategy during the workshop. This model facilitates understanding and communication of complex challenges, e.g., when administrators must address issues at a facility-wide level (Gallagher, Steadman, Gallagher, 2010). As well, the American Nurses Association (ANA) position statement “Just Culture” provides guidance for the application of “Just Culture” for nursing and health care in a variety of settings (ANA, 2010) and may be appropriate to include in the workshop.

It is also suggested that the workshop discussed above be paired with the workshop recommended in Standard 1.2.2. This workshop is concerned with healthcare worker responsibilities surrounding reporting injuries and other incidents. Although the 1.1.2 workshop is distinct from the 1.2.2 workshop, combining these brings together two essential aspects related to injury and incident reporting.

Other relevant areas of focus for this workshop include:

- Inclusion of healthcare worker input in discussions surrounding the selection, use, and issues with technology as well as other safety issues of concern.
- Use of safety huddles or similar mechanisms to provide open, safe environments for obtaining healthcare worker input.
- Integration of SPHM reporting policies and procedures into an organization’s larger reporting system.
- Open communication and close relationships between Human Resources, Risk Management, and healthcare professional staff.
- Healthcare recipient safety, privacy, and dignity in relaying challenging mobility situations that resulted or may result in injury to the healthcare recipient or healthcare provider.

1.1.2 References


Standard Number 1.1.3 Provide a system for right of refusal. Organizational policy will provide the healthcare worker the right to accept, reject, or object to any healthcare recipient transfer, repositioning, or mobility assignment that puts the healthcare recipient or the healthcare worker at risk for injury. The refusal shall be made in writing, without fear of retribution. The policy will describe steps for resolving the hazard.

Introduction: It is the ethical responsibility of every healthcare worker to protect the health and safety of healthcare recipients and themselves. The American Nurses Association (ANA) position statement, “Patient Safety: Rights of Registered Nurses When Considering a Patient Assignment”, addresses the concept of right of refusal (ANA, 2009). This position statement lists
recommendations for registered nurses, the employer/healthcare agency, and the healthcare recipient and consumer. The statement distinguishes between refusing an assignment before accepting responsibility and abandoning the care of a healthcare recipient. Regardless, all healthcare workers have an obligation not to knowingly perform unsafe or harmful care – thus a right to refuse is a healthcare recipient and healthcare worker safety strategy.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Establishment of a consistent process to accept, reject, or object to any caregiving task deemed by healthcare providers to be prohibitively hazardous for the healthcare recipient and/or the healthcare worker, included within an organizational policy.
- Provision of a system, within an organizational policy, for reporting and recording situations that result in refusal to carry out a task and/or objections to performing the task. Such records facilitate the identification of safer options that may be utilized in the future. No retribution will be allowed.
- Establishment of a performance improvement process, within an organizational policy, to address unsafe situations related to the care of healthcare recipients.

Implementing Standard 1.1.3

1. Integrate/adapt the ANA Policy on the “Right to Refuse” in addressing healthcare workers’ refusals to carry out hazardous tasks (see Standard 1.1.4).
2. Recognize the value of and utilize the expertise of risk management and quality improvement staff, members of the organization’s legal team, and patient care services staff.
3. Establish an interdisciplinary team as described in Standard 1.1.1.
4. Establish a written policy that describes the organization’s precise description of, meaning of, and procedures for “Right to Refuse” policy. This policy:
   - Permits workers to refuse an assignment when they do not possess the required knowledge and competencies or feel the activity is unsafe.
   - Includes training of healthcare workers on the policy regarding the right to refuse an assignment.
   - Incorporates a routine policy review at annual competency or performance reviews.
   - Uses clear and concise language.
   - Includes all healthcare workers or employees who may be at risk or placed in an unsafe situation, including, but not limited to healthcare workers, such as care associates, licensed practical nurses, certified nursing assistants, radiology technicians, home health aides, volunteers, transport staff, and members of the valet parking service team.
   - Incorporates a written procedure describing safe and meaningful ways to invoke the “Right to Refuse”.
   - Identifies situations that are potentially unsafe to the healthcare worker, healthcare recipient, or both.
   - Ensures proper written reporting methods, both immediate and long term, and ensure that reports are directed to appropriate individuals.
   - Outlines appropriate follow-up of “Right to Refuse” actions utilizing mechanisms of communication, e.g., an after-action review or safety huddle. An alternate healthcare organization-specific investigation process may also be employed.
5. Post the “Right to Refuse” policy statements in highly visible locations - in break rooms and common areas, on the inside of bathroom stall doors, and in policy and procedure manuals. The “Right to Refuse” policy should be provided to all healthcare workers caring for a
A healthcare recipient who poses an increased risk, e.g., a highly rigid, very combative, or obese healthcare recipient.

1.1.3 TIPS
A pamphlet should be developed concurrently with the “Right-to-Refuse” policies and procedures outlining appropriate situations to refuse and question tasks, proper channels of communication to report a refused or questioned task and/or healthcare recipient, rights of the healthcare worker, and after-action review requirements. The pamphlet should emphasize that refusal is an effective strategy for identifying and spontaneously addressing hazardous situations, and that it serves the healthcare recipient and the organization in the long term. The pamphlet model is effective in this situation because there may be external pressure to perform unsafe tasks and the presence of an objective resource isolates healthcare workers from this pressure and allows them to make an informed, independent decision in a potentially heated situation. This pamphlet should be available digitally and in print. It must be distributed widely so that it is available at a moment’s notice.

1.1.3 References

Standard Number 1.1.4 Provide safe levels of staffing. An evidence-based system will be used to determine safe and appropriate caseloads. Adequate staffing levels will support safe patient handling and mobility, including allocated time for training and education.

Introduction: The American Nurses Association’s (ANA’s) “Principles for Nurse Staffing” identifies the major elements needed to achieve optimal staffing, which enhances the delivery of safe, quality care. The principles and supporting material in that publication guide nurses and other decision-makers in identifying and developing the processes and policies needed to improve nurse staffing at every practice level and in any practice setting (ANA, 2020).

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:
- Utilization of an evidence-based system to determine safe and appropriate caseloads.
- Utilization of required staffing levels in each clinical area/unit to ensure the successful implementation of a Safe Patient Handling and Mobility (SPHM) program and technology within these areas.

Implementing Standard 1.1.4
1. Integrate/adapt the ANA’s “Principles for Nurse Staffing” into staffing for healthcare workers, irrespective of practice setting or discipline.
- Safe levels of staffing should be established with input from frontline healthcare workers.
- The following factors should be considered in determining staffing levels.
Number of healthcare recipients
Level and intensity of care required
Admissions, discharges, and transfers (ADT) activity
Architectural and physical plant barriers
Storage location of SPHM technology
Time required to access SPHM technology
Distances driven to access healthcare recipients (e.g., home care workers)
The experience and skills of the healthcare workers who will be providing care
The staffing recommendations of discipline-specific professional organizations
- Staffing should consider architectural or geographic barriers regardless of practice setting, e.g., when a home care worker must drive long distances between healthcare recipients, this poses barriers to the actual numbers of individuals who may be treated in a day.
- Consider the location of available SPHM technology and the time required to access that technology in practice settings.

2. Establish a written policy permitting healthcare workers to refuse an assignment when they do not possess the required knowledge and competencies (see Standard 1.1.3).
- Create a practice model that matches healthcare recipient needs with healthcare workers’ competencies.
- Train healthcare workers on the policy regarding the right to refuse an assignment.

3. Establish a process for healthcare workers to question the appropriateness/safety of staffing assignments.

4. Establish an action plan for unexpected periods of increased activity and/or acuity.

5. Develop a written management protocol for handling healthcare worker's invocation of the right to refuse an overtime mandate.

6. Review and evaluate incidents, errors, and near misses in relation to staffing variables present at the time of the event.

7. Seek out new technologies to improve healthcare worker and healthcare recipient safety as well as improve staff efficiency.

1.1.4 TIPS
Consult with the Information Technology (IT) Department to develop or acquire software that compares clinical area/unit-specific healthcare recipient census with staffing levels to assign a numerical ratio to each clinical area/unit. This can be used to lend credence to “green lighting” requests for additional staffing, or used in retrospect to identify staffing levels that correlate to the likelihood of breaches of healthcare recipient or worker safety. The availability of this data and its review offer the healthcare organization the opportunity to optimize staffing levels as they relate to the proven potential for injury, leveraging a fluctuating but predictable cost against shock loss claims involving healthcare recipient or worker injury. These data-driven projects offer an additional benefit in that they are documented and can be presented to the organization’s insurance providers in premium negotiations if they show consistent results over the 3+1year period that is often the standard for consideration.

1.1.4 References
**Standard Number 1.1.5 Establish a system for communication and collaboration.**

Collaboration among all sectors and settings is critical. The organization will utilize a variety of communication systems to inform and engage the healthcare workers and healthcare recipients about SPHM.

**Introduction:** Communication and collaboration are critical to establishing a culture of safety and to the success of a Safe Patient Handling and Mobility (SPHM) program. The organization is charged with developing and/or utilizing a variety of communication systems to inform and engage the healthcare worker and health care recipient. Collaboration among leaders, managers, healthcare workers, ancillary/support staff, and healthcare recipients is imperative.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Identification of channels of communication through the use of the organizational chart.
- Identification and utilization of a process to employ innovative forms of communication that foster collaborative efforts and target healthcare recipients as well as the needs of a diverse workforce.

**Implementing Standard 1.1.5**

1. Identify key stakeholders, by title, in the SPHM effort. Keep in mind that each individual title has set goals and accountability relationships. As an organization’s SPHM program develops, it becomes important to effectively collaborate - linking the goals of the individuals and departments with the goals of the SPHM program.
   - Organizational stakeholders include members of the management and leadership teams, which may use the following titles: Chief Nursing Officer (CNO), Chief Financial Officer (CFO), Chief Operating Officer (COO), Chief of Human Resources (CHR), risk management, quality improvement, and others.
   - Clinical area/unit-specific stakeholders include members of the management and clinical area/unit-based teams, which may use the following titles: department manager, charge nurse, homecare lead team, and others.
   - Discipline-specific stakeholders include members of specific professions or groups, which may be called home health aides, certified nursing assistants, registered nurses, therapists, radiology technicians, dieticians, emergency management service (EMS) workers, infection control practitioners, and others.

2. Utilize a variety of communication systems to inform and engage the healthcare workers and healthcare recipients about SPHM.

3. Establish a culture of communication that encourages questions.
   - Include critical thinking skills when discussing the healthcare recipient.
   - Encourage healthcare workers to scrutinize and question SPHM information.

4. Recognize the value of marketing efforts in communicating SPHM program elements and technology to various individuals and departments, including communication to these and others:
   - Healthcare recipients, visitors, and family members (see Standard 5.1.6).
   - Facility consultants.
   - Members of the inter-professional teams.
   - Occupational safety/risk management.
   - Occupational health.
   - Healthcare recipient safety.
   - Engineering and facilities management.
   - Housekeeping.
1.1.5 TIPS

As the standards are delegated, one document should be created that includes all the efforts that are underway throughout the organization. This document may then be shared with all teams and individuals. Many of the standards are closely related and interconnected. The document will help prevent redundant work and encourage effective communication and collaboration between teams. The document should be updated regularly so that all parties are aware of the healthcare organization’s efforts at each stage of roll-out.

Organizational communications must address each of the eight standards. Principles of adult learning should be considered when developing communication strategies. Healthcare workers must be able to describe how to submit ideas; report hazards, incidents, accidents, and near misses; and know whom to ask if there are questions about the SPHM program.

Collaborative and collegial efforts between sectors and settings, i.e., committees or task forces, must include the perspectives of organizational leadership, healthcare workers, ancillary/support staff, and healthcare recipients, as appropriate.

Organizational clinical area/units or specific settings may need their own internal communication systems about SPHM, e.g., management reports or safety huddles. Positive communication, e.g., celebrating quick wins or small successes, is an important strategy to build the support of healthcare workers. The Joint Commission (TJC) report on improving patient and worker safety contains tools for improving safety communication (TJC, 2020).

1.1.5 Resources


HEALTHCARE WORKER STANDARDS

Standard Number 1.2.1 Participate in creating and maintaining a culture of safety. The healthcare worker will actively participate in creating and maintaining a culture of safety.

Introduction: A culture of safety in health care encompasses the core values and behaviors resulting from a collective, consistent, and sustained commitment by organizational leadership, managers, healthcare workers, and ancillary/support staff to emphasize safety over competing goals. Leaders drive the culture of safety by demonstrating their commitment; providing the resources to achieve the desired results; and ensuring that policies and behaviors related to safety become widely accepted practice. A culture of safety in health care includes a fair and non-punitive culture, as described in “Just Culture” principles; a process for the right of refusal; a system for safe staffing; and open, collaborative, and congenial communication.

It is the responsibility and right of the healthcare worker to actively engage in efforts to promote and sustain a safety culture (Morath, 2011).
Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Active participation of healthcare workers in creating and maintaining a culture of safety.
- Healthcare worker involvement in the identification and resolution of environmental barriers to their participation in the Safe Patient Handling and Mobility (SPHM) program.
- Healthcare worker involvement in the identification and resolution of personal limitation barriers to their participation in the SPHM program.
- Healthcare worker involvement in the implementation of strategies to overcome barriers to their participation in the SPHM program as they arise.

Implementing Standard 1.2.1

1. Healthcare workers actively participate in creating and maintaining a culture of safety.
   - Participate in communication training, use after-action-reviews, and other methods to clearly and safely express their thoughts.

2. Healthcare workers have a professional obligation to raise concerns regarding any assignment that puts the healthcare recipient or worker at risk for harm. Healthcare workers should:
   - Recognize experiential limitations when deciding whether the healthcare worker has the experience to carry out an assigned mobility task, e.g., a newly hired home health aide raises concerns about how to safely assist a morbidly obese individual in the shower at home.
   - Recognize knowledge limitations that may preclude a healthcare worker from fully understanding the dangers inherent in an unsafe practice.
   - Recognize skill limitations, especially if the healthcare worker has not had the opportunity to return-demonstrate the use of technology.
   - Recognize physical limitations that may reduce the amount of weight the healthcare worker may lift, push, or pull.
   - Recognize language barriers that interfere with understanding the skills necessary for an assignment.
   - Recognize cultural differences that may result in feelings of inadequacy if the healthcare worker is required to ask for assistance.
   - Avoid inappropriate staffing mix of various disciplines, e.g., registered nurses, certified nursing assistants, licensed practical nurses, and clinical nurse specialists.
   - Recognize the lack of proper technology, e.g., lack of a proper lateral transfer device that led to a fall-related injury.
   - Recognize dangers inherent in “floating”; when floating is necessary, the healthcare worker should be assigned to areas with comparable healthcare recipients or skill needs.
   - Recognize their level of physical, mental, and emotional fatigue. When healthcare workers recognize their own emerging fatigue, they are responsible for communicating, taking a brief break, asking for help with unfamiliar or strenuous tasks, and using SPHM technology, if appropriate.
   - Exercise good judgment when deciding to accept overtime (mandatory or voluntary), taking into account how well he or she has functioned in the past in the presence of overtime conditions. Historically, a healthcare worker is more likely to ignore stresses or fatigue and go into work to help out a colleague even if doing so is against his or her best judgment. A safe healthcare environment discourages this type of sacrifice because research suggests that this leads to errors in SPHM and creates other threats to safety.
   - Advocate for themselves, their co-workers, and healthcare recipients by creating an expectation of safety and discussing SPHM and what the organization or care environment does to ensure that technology is used appropriately and when required.
Accountable to provide care that is consistent with safe practice for themselves, co-workers, and the healthcare recipient.

1.2.1 TIPS
A staff survey can help identify barriers to SPHM implementation in the initial stages of implementation. Addressing staff concerns from the outset increases the willingness to participate. Using the barriers listed in the bullet points as a guide for the survey, staff members can list their impact on a scale from one to ten. This should create a snapshot of initial barriers to program success in a healthcare organization.

1.2.1 References

  
  [Link](http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No3-Sept-2011/Nurses-Creat%e2%80%93eCulture-of-Patient-Safety.aspx#:~:text=Nurses%20play%20an%20essential%20role%20in%20developing%20the%20leadership%20to%20strengthen%20the%20culture%20of%20safety)

Standard Number 1.2.2 Notify the employer of hazards, incidents, near misses, and accidents. The healthcare worker will notify the employer of hazards, near misses, incidents, and accidents related to SPHM as soon as possible, using the reporting procedures defined by the employer.

Introduction: Continuous safe patient handling and mobility (SPHM) quality improvement requires that healthcare staff consistently report hazards, incidents, near misses, and accidents. Successful implementation of standard 1.1.2 (i.e., establishing a non-punitive environment) helps to ensure that this occurs. This standard establishes and maintains a culture of reporting among employees to improve SPHM program participation, refine best practices, and tailor the SPHM program to the specific needs of the healthcare organization.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Adherence to a clear and consistent process for reporting and evaluating hazards, near-miss events, incidents, accidents, injuries, and work-related illnesses, per organizational policy.

Implementing Standard 1.2.2

1. Follow organizational processes for reporting hazards, incidents, near misses, work-related illnesses, and accidents (e.g., a fall or near-fall, combative healthcare recipient, technology in poor repair, work-related stress, and others).
2. Identify and report situations as defined by the employer.
3. Ensure a non-punitive response to the receipt of reports. The process should be based on education and re-education, and designed to ensure that the healthcare worker will feel comfortable filing future reports as needed.

- Acknowledge the value of a near miss.
- Establish a process to report and analyze a near miss, e.g., consider the healthcare recipient who presented well on initial mobility assessment and then deteriorated so that the healthcare worker had to manually handle the healthcare recipient. The healthcare
worker may or may not have sustained an injury as a result. In either case, however, questions should be asked to fully investigate what happened. Based on the findings, follow-up education should occur with the healthcare worker, the healthcare recipient, the recipient's family members, and others as needed.

1.2.2 TIPS
Plan and conduct a workshop to inform employees of the non-punitive reporting process regarding SPHM hazards, incidents, and near misses. Include an activity where employees work in small groups to outline the appropriate course of action for reporting specific hazardous situations. The hazardous situations may be prepared in advance by the workshop leader or elicited directly from the participants on the day of the workshop. The workshop leader should facilitate a discussion regarding the gaps between current reporting practice and the newly created non-punitive reporting process.

Standard Number: 1.2.3 Use the system to communicate and collaborate. The healthcare worker will engage, verbally, and in writing, with others about SPHM.

Introduction: As the Safe Patient Handling and Mobility (SPHM) program takes shape, the healthcare worker plays a key role in communicating effective strategies, data set improvement, and healthcare recipient responses. This communication between healthcare workers and stakeholders serves to improve the SPHM program in the short term and create a record of the program in the long term. Documentation does present the employee with additional responsibilities and this must be recognized in terms of the scope of their position so that primary responsibilities such as direct healthcare recipient care are not compromised.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

1. Open communication between healthcare staff about the SPHM program.
2. Provision of channels of communication, both verbal and written, to address concerns and ideas generated by conversations between healthcare providers and others.

Implementing Standard 1.2.3
1. Identify best-practice forms of written communication and collaboration.
   - Organization-wide.
   - Practice area-specific.
   - Discipline-specific.
2. Recognize the value of interprofessional communication training.
   - Knowledge transfer (classroom training, safety huddle/after-action-review).
   - Skills acquisition (practical, scenario, case-based, hands-on training).
3. Identify the need for “Crucial Conversations” (Maxfield, et al, 2005; Patterson et al, 2012; Sherman, 2012) as a tool for having discussions with colleagues who may not be on board with SPHM.
   - Stakes are high.
   - Opinions vary.
   - Emotions run deep.
4. Identify steps to “Crucial Conversations”.
   - Observe the situation.
   - Accentuate the positive.
• Question of concern (open-ended).
• State the consequences.
• Solution question (open-ended).
• Get the agreement (clarify).

1.2.3 TIPS
Conversations under stress can be challenging. The “Crucial Conversations” model (see “Implementing Standard 1.2.3”, number 4.) and others are designed to create a structure for these types of situations and can be helpful for healthcare workers who are faced with colleagues who are resistant to SPHM. Consider conducting a workshop to explore specific steps to plan for resistance. Leaders of the activity can demonstrate the model and attendees can replicate the use of this method around hypothetical situations. Because these can be emotionally charged conversations, and this model is being introduced and practiced, there must be a previously agreed upon “out”, along with a timer. This avoids escalation of tensions if the model is not followed or if it fails to yield the intended result. Difficult situations may be drawn from the ideas generated under “1.2.2 TIPS”.

Explore the Technology Innovation Center at Johns Hopkins for several different tools that can be used to measure the culture of safety within health care. 
https://www.hopkinsmedicine.org/technology_innovation/

1.2.3 References
https://www.emergingmleader.com/crucial-conversations/

PLEASE INSERT WHERE APPROPRIATE: “The words of the writer, Rhonda Turner, reflect her personal view and do not necessarily represent the views of her employer, Banner Health”.

Standard 2. Implement and Sustain a Safe Patient Handling and Mobility Program

EMPLOYER STANDARDS

Standard Number 2.1.1 Designate a group or groups of stakeholders to develop, implement, evaluate, remediate, and maintain an SPHM program. An organizational committee will identify or develop systems that support SPHM programs. The committee will receive and review data about SPHM and make recommendations for improvement. The work
of the committee will reflect collaboration among organizational leadership, the healthcare worker, and ancillary/support workers.

Introduction: A comprehensive program requires input from every perspective on every level. The outcome of an engaged Safe Patient Handling and Mobility (SPHM) interdisciplinary team will be a sustained culture of safety. To facilitate an effective culture of safety, situations, and conditions that put healthcare providers and recipients at risk for injury must be determined. SPHM programs are focused on avoiding ergonomic risks and providing interventions that reduce such risk from what are called “high-risk tasks”. A high-risk task is a care activity, e.g., repositioning in bed, lateral transfer, and others, that can result in musculoskeletal injuries in healthcare workers. These tasks are considered high risk based on the frequency of repetitive motions, duration of stress, and the degree of musculoskeletal stress imposed by the task (Matz et al., 2019). High-risk tasks may also negatively impact healthcare recipients.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Identification of potential internal and external stakeholders for participation in the SPHM Committee/Task Force and identification of contributions each potential stakeholder can make to the SPHM program as well as ways in which they would benefit from an effective program.
- Committee/Taskforce identification and development of systems that support the SPHM program and reflection of collaboration among organizational leadership, healthcare workers, and ancillary/support workers.

Implementing Standard 2.1.1

1. Incorporate experts from the organization’s insurance brokers/stakeholders because insurance carriers often have dedicated money which can help with the initial funding of an SPHM program. Such stakeholders can be identified by working with occupational health, risk management, and quality improvement services within the organization.
2. Reach out to organizational leaders, stakeholders, and frontline employees to identify eight to ten individuals who are interested in the development of an SPHM program. This is the discovery part of the SPHM program. It involves asking, listening, and connecting with individuals in a way that clarifies roles and responsibilities. Also, consider using the "Who can get me what I want?" tool when identifying opportunities for these stakeholders to be included. Consider the following individuals/groups:
   - Any individual who expresses interest in SPHM.
   - An employee who is involved in healthcare worker safety and prevention of injury, i.e., the occupational health coordinator. He/she understand the human and economic costs of injuries.
   - An individual already recognized within the organization’s safety culture; this individual will already understand the barriers and opportunities inherent in framing SPHM as a safety initiative.
   - Behavioral or organizational culture change agents who may assist in understanding the necessary process to accomplish culture change within the organization.
   - A representative whose primary responsibility is for the fiscal health of the organization, clinical area/unit, or discipline and who will serve as a champion once the business case has been established.
   - The risk management team as it is instrumental in providing data and serves as a champion once successes become measurable.
• The quality improvement team since it is instrumental in providing data and serves as a champion once successes become measurable.
• A representative from engineering because engineering is essential to facilitate the installation of technology.
• A representative from materials management (Central Supply Service) is important, as this department is called on to assist with locating appropriate, available, and compatible equipment and technology.
• A representative from environmental services is essential, as laundry service is necessary for sling management and more.
• Other relevant and interested parties.

3. Organize an interdisciplinary Committee/Task Force comprised of these identified, interested individuals from a variety of backgrounds.

4. Create a Committee/Task Force charter consistent with that of other organizational teams.

5. Capture baseline data related to healthcare worker injuries from handling, moving, and caring for healthcare recipients for a specific period of time. Include the following, if available. At a later time, use these data for comparison and trending purposes.
   • Incidence of musculoskeletal disorders (MSDs)
   • Cost of MSDs
   • Severity of MSDs. Severity is defined by lost time and modified duty injuries.
     o Number of light/modified/restricted duty injuries.
     o Total number of days from all light/modified/restricted duty injuries.
     o Number of lost workday injuries.
     o Total number of days from all lost workday injuries.
   • Prevalence of musculoskeletal discomfort

6. Capture baseline data related to healthcare recipient injuries when initiating a program or project. At a later time, use these data for comparison and trending purposes.
   • Adverse healthcare recipient events: fall-related injuries.
   • Adverse healthcare recipient events: deep vein thrombosis (DVT)/pulmonary embolism (PE).
   • Adverse healthcare recipient events: pneumonia.
   • Adverse healthcare recipient events: hospital-acquired pressure ulcer (HAPU).
   • Frequency with which healthcare workers can mobilize healthcare recipients
   • Healthcare worker retention.
   • Readmission of healthcare recipient within 30 days.

7. Determine what goals associated with SPHM are important to stakeholders, e.g., those aligned with current safety initiatives or high-cost, high-risk, or high-frequency outcome goals.

2.1.1 TIPS
Building a strong interdisciplinary SPHM team takes patience and perseverance. Once you have recognized the gaps within your organization, start with three to four peers that have that same calling or passion that will dedicate themselves to the focused mission. First, you must gain leadership approval to move forward. This involves setting up time with the key stakeholders of your C-suite or executive branch and stating your request.

Once you have that necessary support to move forward, set the meeting times, meet with your peers, complete your research, and create your vision. This vision must remain the primary goal. Where do you want to see your team go and how are you going to get there? It can be a simple one to two-line statement. Next, begin selling your team. Market your vision through
multiple pathways such as flyers, roaming education, setting up displays at key locations throughout the organization, partnering with skills labs, and seeking out department leader support to ask for liaisons from their clinical area/unit, while relaying the fact that this is a valuable contribution not only to the department but to the overall culture of safety. Set the expectation for success and be visible.

Being consistent and persistent will grow your team. If there is one single point that I would like to instill in the readers' hearts is “don’t give up!” It will happen. I do believe the turning point for our team was when we recognized that many people who were passionate about safe patient handling and mobility were also passionate about falls prevention. We joined forces, and that was where the magic happened. Before we knew it, we had enough interdisciplinary team members who were excited, willing, and ready to pull together to build a stable foundation.

We started a pilot program with an interdisciplinary instructor team to bring that peer-to-peer teaching style to the table. The classes were open to all who wished to have a refresher or who needed practice. Before we knew it, the critical care service line and transport team began sending all newly hired staff to our classes. The classes grew from one facility to a three-hospital regional training program, and soon we were building a business case to bring our hands-on education across the system, with the expectation that each facility would replicate our peer-to-peer teaching platform and provide the class to each new hire.

There is nothing more rewarding than witnessing staff members growing in confidence and owning their piece of the culture of safety on every level. We pulled from each other’s experiences and designed an engaged team with the energy we needed to sustain the journey.

Our vision from 2015 has reached a point of sustainability thanks to early persistence and bringing the right stakeholders to the table. This must always be a team effort, even if your team is only three to four people. Expect a culture shift, always do your research, and move forward with positive energy.

2.1.1 References


Standard Number 2.1.2 Perform a comprehensive assessment of SPHM. The organization will initially and periodically perform a comprehensive assessment of patient handling, mobility, and technology, including an SPHM technology needs assessment (see Standard 4.1.1).

Introduction: Completing a safe patient handling and mobility (SPHM) focused gap assessment is imperative to shift the culture of safety (see Figure 2.1. SPHM Gap Assessment Tool). An SPHM gap assessment must be inclusive of all components of the eight American Nurses Association (ANA) SPHM Interprofessional National Standards (SPHM Standards) to

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Knowledge of how to define and prioritize all areas of opportunity after completion of a comprehensive SPHM program assessment that includes evaluation of patient handling efforts, mobility endeavors, SPHM technology, and an SPHM technology needs assessment.
- Utilization of an interdisciplinary team with varied perspectives when conducting the assessments, understanding outcomes from the assessments, and implementing measures to resolve gaps found during assessments.
- Consistent and comprehensive review of the SPHM program.

Implementing Standard 2.1.2

1. Assess attitudes and support.
   - Administrative staff.
     - Identify economic and resource support; establish who/what departments is/are responsible for financing the SPHM program.
     - Recognize personal support; determine those who are the points of contact and who is willing to be a part of the SPHM committee or task force.
   - Healthcare workers.
     - Assess healthcare workers' understanding of SPHM goals.
     - Identify any role misunderstandings.
     - Determine compliance with the SPHM technology, policies/procedures, training, and culture.

2. Staffing levels.
   - Assess whether staffing levels support SPHM goals.
   - Ensure that staffing levels are appropriate (i.e., the ratio of healthcare workers to healthcare recipients).
   - Ensure that staffing mix, i.e., the ratio of appropriate disciplines, is appropriate. Staff to consider include registered nurses (RNs), licensed practical nurses (LPNs), clinical nurse specialists (CNSs), certified nursing assistants (CNAs), and others.
   - Determine if healthcare workers have opportunities to attend SPHM education and training sessions.

3. Application of appropriate ergonomic principles.
   - Assess the application of appropriate ergonomic principles.
   - Recognize handling and mobility tasks that stress the body beyond healthy limits, such as (but not limited to) lifting 35 pounds or more of a static load, or lifting a load weighing less than 35 pounds which is awkward, unstable, or in motion; portable floor lifts with poorly functioning castors or carpeted floors that create drag or resistance when moving wheeled objects.
• Identify clinical area/unit- and discipline-specific handling and mobility hazards, e.g., limb lifting by the wound care expert to treat the underside of the lower leg in the home care setting, moving the healthcare recipient from a wheelchair to a radiology table in the clinic setting, or early progressive mobility in the critical care setting. Each such scenario poses hazards.

• Determine whether ergonomic principles are applied to match the healthcare recipient to the handling and mobility task.

4. Training.

• Assess training methods.

• Determine whether relevant clinical area/unit- and discipline-specific training is available to healthcare recipients, e.g., educating healthcare recipients on ways they may become involved with their own mobility in the healthcare organization and maintaining mobility once they are discharged. This education should also be received by family members and/or healthcare workers at the next level of care.

• Identify healthcare workers who have attended training by title, number, or percent of total; this can be monitored electronically or via written reports.

5. Physical environment.

• Assess the physical environment.

• Identify whether floor coverings are low-resistance.

• Determine safe door widths. These are usually designated by building codes; however, from a practical perspective, sometimes the door widths must be enlarged to accommodate the needs of special healthcare recipient populations, e.g., in the case of a room designated for individuals of size, the door to the patient care room must be wide enough to allow larger technology to pass easily. A width of 60 inches is considered sufficient to accomplish this goal. Options for a 60-inch opening include a sliding door or a pair of unequal-leaf swinging doors, with one door 42 inches wide and the other 18 inches wide.

• Identify rooms with thresholds as a danger, because the uneven surfaces at door and shower thresholds can create many problems, e.g., fall/trip hazards for the healthcare recipient or worker, or difficulty moving rolling technology safely over this obstacle.

• Identify room layout, size, and clearance requirements for various SPHM tasks, e.g., determine whether two beds fit in a room, along with a gurney, lateral transfer device, and at least two healthcare workers assisting in a transfer. Use a measuring tape to establish if the room layout allows healthcare workers sufficient room to safely assist in the transfer.

• Ensure that technology is conveniently located. This includes technology e.g., crash carts, electrocardiogram (ECG) carts, SPHM technology, and/or any other technology that requires physical effort to be lifted or pushed (wheeled) into place. The use of alcoves interspersed throughout a large clinical unit facilitates technology access.

• Determine whether technology enhances healthcare recipient dignity by interviewing healthcare workers and recipients, and by monitoring satisfaction surveys and liability claims when appropriate. Further, keep in mind that SPHM education enhances dignity by promoting safe, sensitive care.

• Determine whether technology promotes safety for healthcare recipients and workers by reviewing healthcare workers’ injury data and healthcare recipient safety indicators, e.g., National Database of Nursing Quality Indicators® (NDNQI®) and others.

• Assess the compatibility of new technology with existing technology, e.g., determine whether floor lifts easily interface with bedframes, endoscopy tables, and/or radiology tables.
• If incompatible technology is in use, ensure that technology is sufficiently labeled as such and easily viewed.
• Ensure that power sources (i.e., outlets and batteries) are available to meet technology needs.
• Ensure that technology storage locations are clearly identified and marked.
• Identify appropriate uses of technology, e.g., properly placed and positioned slings on a lifting device, and proper inflation of air support surfaces for lateral transfers; match technology or combinations of technology to meet the mobility task.
• Identify the type of frame and support surface (i.e., bed and mattress), and the mechanical advantages provided.
• Ensure that clear directions, either written or a photo narrative, are provided for cleaning/processing before and after use. Include information such as the description of the technology; what classifies it as clean or dirty; and the process to clean the technology, equipment, or device. Post these documents in common areas where cleaning/processing occurs and where the SPHM technology is located.

2.1.2 TIPS

One lesson I learned is that a comprehensive program must be evaluated consistently. It is a fluid program that must always meet the needs of the end-user and all stakeholders to keep injury prevention as a top priority. On every level of program implementation within Banner Health, a gap assessment was performed before determining our team focus. We always wanted to ensure that our energy and actions were purposeful and meaningful. When it was time to assess system-level needs, we did the same process, a gap assessment, and began where it was needed.

We utilized an amazing tool that assessed multiple categories that were supported by the eight ANA SPHM Standards. The eight major categories had subtasks or statements such as “We have a strong mix of interdisciplinary team members”. That subtask was given a score of one to five. The numbers were tallied, and this highlighted the greatest areas of opportunity with the lowest scoring categories for subtasks. It was the expectation that every facility would complete its own gap assessment each year.

We completed the review of the 28 facility results and clearly saw that we had consistent gaps or needs across the system. The four categories of opportunity were: leadership oversight, program monitoring, education, and caring for individuals of size. We then divided to conquer! We created focused workgroups, partnered with key stakeholders, and devised a business plan to present to the Banner Health Nursing Executive Council (NEC).

It is important to keep requests clear and to the point. We found that we needed to show what the presentation is about, state our request, offer our research (gap assessment results, healthcare workers’ compensation claims related to SPHM, and other focused data), map out our action plan, and then share our two to three-year vision.

We presented our business case in a consolidated nine slide PowerPoint to our NEC. Our executive sponsor presented and with only two questions, we gained quick approval to forge ahead with all requests. The process took ten minutes, yet there were six months of work and research to prepare. Every moment was worth it to hear that “YES”.
Our key to success was that we learned ‘you can’t fix what you don’t know needs fixing’! How often do we spin around a broken area without gaining a sustainable fix? I have been in healthcare for 33 years and have seen multiple “band-aids” placed around SPHM programs. You must find the root cause of what needs to heal before you can move forward with sustainable practices. Shifting a wounded culture takes patience, continued assessments, and the flexibility to adjust as needed.

Each healthcare organization will have a representative of its workers’ compensation provider assigned to manage its cases (facility/organization). This single point of contact will be able to provide an organized four-year (three plus one) loss history detailing reportable injuries sustained in the facility, with some including healthcare recipient handling injuries. This insurance “case manager” is often responsible for many facilities, so his or her time will be limited. This is all the more motivation for the insurance representative to provide you with a wealth of data as you implement your SPHM program, as this initiative stabilizes the risk due to workplace injuries in their account. Compared to most other classifications of workplace injuries, healthcare recipient handling injuries present the likelihood of “shock losses”. These are large, unpredictable payouts that are often paid out over years, especially if the healthcare worker’s claim, for example, includes extensive rehabilitation following a costly surgery. Stabilizing or eliminating this risk is extremely beneficial to the insurance company and offers the healthcare organization the opportunity to renegotiate a lower premium without cutting into the insurance provider’s net profits. Therefore, consider this opportunity when identifying meaningful relationships for successful SPHM program efforts.

2.1.2 References


*Standard Number 2.1.3 Develop a written SPHM program, with goals, objectives, and a plan for ongoing evaluation, compliance, and quality improvement.* The written SPHM program will address each of the eight standards of Safe Patient Handling and Mobility: Interprofessional National Standards, and will reflect compliance with federal, state, and local laws and regulations. The written program will include short- and long-term goals and objectives, and a realistic plan and timeline to meet the goals and evaluation requirements. The written SPHM program will identify, by title, those individuals who have responsibility, authority, and accountability for developing and implementing the plan. The written SPHM program also will establish a clear reporting hierarchy to monitor compliance.

*Introduction:* When developing a Safe Patient Handling and Mobility (SPHM) program, sustainability must be the priority. The key to ensuring the success of the program design is to ensure the program results in effective practices in all climates, from the frontline to the executive branch. Having all disciplines involved in the foundation of the program will help to establish a clear vision with the end goal being an engaged culture of safety.
Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Production of a healthcare organization-specific document organized in parallel to the eight SPHM Interprofessional National Standards.
- Stakeholder commitment and reciprocal accountability.
- Availability of draft and final SPHM program documents to stakeholders and interested parties.
- Building a fluid SPHM program with consistent re-evaluation.

Implementing Standard 2.1.3

1. Identify, by title, those individuals who have responsibility, authority, and accountability for developing and implementing the SPHM plan.
2. Establish a clear reporting hierarchy to monitor compliance.
3. Identify specific federal, state, and local laws and regulations, including pending legislation; this information can be found on the American Nurses Association (ANA) website electronically, in the risk and quality departments within the organization, or through the Department of Health, Occupational Safety and Health Administration (OSHA), or the Joint Commission (TJC).
4. Find and use applicable standards, guidelines, and competencies identified by healthcare organizations, e.g., the American Nurses Association, the American Nurses Credentialing Center’s Magnet Recognition Program, the Joint Commission, and the American Hospital Association.
5. Incorporate steps to yield a written SPHM program:
   - Determine the need for an SPHM program based on a business case model or through evidence-based studies that attest to the need.
   - Create an interprofessional team (see Standard 2.1.1).
   - Establish buy-in at all levels, creating collective support.
   - Select preliminary program goals.
   - Introduce the structural components of an SPHM program (e.g., policies, procedures, training).
   - Create succession plans.
   - Integrate the eight SPHM Standards.
   - Incorporate a process for ongoing evaluation, compliance, and quality improvement including monitoring the satisfaction of healthcare workers and recipients, technology use, technology maintenance, technology availability, loss history/injury data pertaining to healthcare workers, and safety outcome measures for healthcare recipients related to SPHM technology use (e.g., falls, urinary tract infections, pneumonia, bed days of care, others).
6. Develop a written plan which includes short- and long-term goals and objectives for the SPHM program. Determine what goals associated with SPHM are most important to stakeholders. Prioritize the goals and incorporate them into a realistic plan and timeline.

2.1.3 TIPS

Throughout my career, I have witnessed and been a part of the ongoing cycles of implementing a sustainable SPHM program. My facility would implement an SPHM program and it would dwindle within two to three months. Once our SPHM team discovered the eight ANA SPHM Standards and utilized those concepts as a foundation for our program, we began to have great success with sustainability.
The first step is to have a clear vision, keeping that as your focus as your team moves forward. We found it imperative to outline goals and identify who is responsible for each step. The common theme throughout each of the standards is to ensure that there is a continual interdisciplinary approach. We are all accountable to ensure success.

It is recommended to adjust your written program along the way as your team grows. The key is to be transparent and evaluate post-implementation. There are times when you will not feel you are making progress. Review and reflection of the documentation of your beginning steps are helpful during those times. Any step forward is a win and it is especially important to celebrate along the way!

Please see Figure 2.2, “SPHM Policy Template” and Figure 2.3, “SPHM Policy-build Worksheet”. Use the worksheet to develop organizational outcome statements/expectations for each SPHM Standard. This information populates the Policy template.

**INSERT SPHM POLICY TEMPLATE** [fig. 2.2]

**INSERT SPHM Policy-BUILD WORKSHEET** [fig 2.3]

**Standard Number 2.1.4 Customize and integrate the SPHM program across the continuum of care.** The SPHM program will be customized for, and integrated into, care settings throughout the organization and continuum of care, ensuring that SPHM is addressed through transitions of care.

**Introduction:** As you begin to dive into how and why safe patient handling and mobility (SPHM) technology is used, areas will open that were not on your radar in the foundational steps. SPHM is intertwined in every area of health care from admission to discharge and in-home care and outpatient settings.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Integration of a customized SPHM program into care settings throughout the healthcare organization and continuum of care.
- Inclusion of SPHM through transitions of care.
- Identification of healthcare organization-specific challenges facing the implementation of an SPHM program or difficulties with any facet of these standards.
- Provision of evidence-based solutions for such healthcare organization-specific challenges.
- Examination of evidence-based solutions to similar circumstances in other healthcare organizations and settings

**Implementing Standard 2.1.4**

1. Identify care settings, within the facility/organization, that pose actual or historical SPHM risks based on an analysis of at least one year of facility injury data, Occupational Safety and Health Administration (OSHA) 300 logs, and worker’s compensation data.
2. Prioritize high-risk areas through analysis of noted data sources and use of evidence-based research that points to common areas in need of SPHM programs and technology to phase in technology if necessary.
3. Recognize universal, healthcare organization-wide SPHM and mobility needs that transcend practice.

4. Identify unique patient care needs based on specific settings, e.g., radiology, emergency department, spinal cord injury units, physical therapy, podiatry, dental service, and others.

5. Evaluate high-risk tasks performed by certified nursing assistants, healthcare techs, and staff in other high-risk positions in long-term care settings. Consider risk during routine emergency management service (EMS) calls and home care which likely do not have the processes and technology necessary for safe transfers, mobilization, and transport.

6. Include SPHM/mobility information within all transitions of care reports/hand-offs.

2.1.4 TIPS
When we first started teaching our SPHM hands-on classes as a pilot, the class was open to all. I would share why I was vested in SPHM and what drives me to keep sharing the message of SPHM and an effective culture of safety. I would then ask each participant why they were vested and what inspired them to come to the class.

It was our 6th class when I started the same questioning. We had around 15 participants in the class that day. When I got to the seventh staff member, she stated very clearly, “I do not want to be here. I have been in health care for 25 years. I know what I am doing, and my manager made me come”. Now, as a very young instructor, I was not sure how to handle that. I graciously thanked her for her transparency and proceeded with the class.

Ronnie, a certified nursing assistant and certified safe patient handling associate, is one of our instructors. He was involved in the training I noted above. During training, he always shares his story of how he was injured when he was six months into his 26-year career. A resident, who they later determined was a total lift, needed to be transported from a skilled nursing facility to the connected hospital for a doctor’s visit. Ronnie assisted two healthcare workers with a stand pivot transfer. As he placed his hands on the gait belt and turned with the resident, the other two healthcare workers let go of the resident. Ronnie heard a snap and pop, and then felt the worst pain he had ever felt. It radiated from his toes to his lower back. He arrived at the connected hospital before the healthcare recipient did. He now speaks of the “drive-thru” mentality that we have adopted within healthcare.

Ronnie always shares how he should have advocated for use of the lift, stopped the manual lift, and gone to get the lift. It was right across the hall. He was off work for six months. During that time, he adopted an Amazon parrot to keep him company. After a few weeks, he noticed that this parrot would say “whew” every time he began to sit down. The parrot learned it from Ronnie. Twenty-five years later, that parrot will still say “whew” when someone goes to sit down. He ends his personal story with, “Take your time, no need to rush, talk about the transfer, include the patient, and get the right technology because I want you to go home to your family at the end of the day without pain. We need to defeat this drive-thru mentality together, or you may end up with a parrot that says ‘whew’ every time you sit down.”

The beauty of this moment came when the staff member who was adamant about not needing to be in the class, slowly relaxed as Ronnie was talking. When he was done, she gently eased her hand up in the air. Her words are engraved in my heart. It was so eye-opening. She said, “I was wrong, I do need to be here. I work in radiology and I injured my neck years ago. It still hurts when I move a healthcare recipient. You have me, and thank you for sharing”. She is now our best advocate for that department and that was five years ago. Up to that point, I had not
considered how SPHM is intertwined in our ancillary departments. As we continued to share our message through the steady work of our team, home healthcare and outpatient clinics began reaching out for SPHM education. My perspective has grown immensely from our beginning work.

For a comprehensive look at high-risk tasks and solutions by departments, please review Figure 2.4, the VHA “SPHM Solutions Everywhere for Everyone: In the best interest of the patient and their caregivers”.

For a comprehensive look at high-risk tasks and solutions by departments, please review Figure 2.4, the VHA “SPHM Solutions Everywhere for Everyone: In the best interest of the patient and their caregivers”.

**INSERT SPHM SOLUTIONS EVERYWHERE fig 2.4**

**Standard Number 2.1.5 Provide funding to implement and sustain the program.** The employer will identify and allocate funding to implement and sustain the program based on business-case and return-on-investment analytics or cost/benefit analysis.

**Introduction**: Establishing a business case for funding of safe patient handling and mobility (SPHM) technology is one of our greatest areas of opportunity in the healthcare world of today. Leaders must see and understand the final impact of financial support for SPHM programs and adequate levels and types of SPHM technology.

**Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:**

- Evaluation of the need for funding through review of the current state of the SPHM program relative to technology, staff education, SPHM staff funding, maintenance, and other program costs.
- Staff understanding of the rationale for and importance of SPHM technology and why it should be consistently utilized.
- Generation of cost/benefit and/or return-on-investment data that facilitates leadership acceptance of the business case for investing in the implementation and sustenance of the SPHM program and required technology.

**Implementing Standard 2.1.5**

1. Identify individuals within the organization who understand ways in which an SPHM program can reduce not only healthcare worker injury costs but also organizational costs. Their expertise and data analytics are essential in developing a true cost/benefit analysis that incorporates costs/benefits for both healthcare workers and healthcare recipients. By the better understanding of safety concerns (e.g., falls) and medical outcomes (e.g., hospital-acquired pneumonia, urinary tract infections) pertaining to healthcare recipients, as well as costs related to staff training, staff retention and recruitment, satisfaction scores for healthcare workers and recipients, and other organization-specific direct and indirect costs, more accurate and supportive data will be generated.

2. Identify competing claims for available funding sources.

3. Evaluate the capital and operating budgets for the inclusion of each element of the organizational SPHM plan. This will include but is not limited to, the cost to establish the program, the procurement of appropriate amounts/types of SPHM technology, maintenance, training, education, and updating as needed.

4. Identify organizational fiscal decision-makers and what business case methodology they prefer.

5. Consider various business case methodologies (Celona, 2019).
• Simple cost/benefit analyses give you a start in identifying the key benefits and costs by quantifying each category. It is the simplest analysis, however, it usually does not take into consideration important healthcare recipient benefits. It is very beneficial at the beginning of the business case process though.
• The decision analysis approach is the most comprehensive, detailed, and complicated, however, it is used by large corporations to ensure, for example, their new product decisions are the best possible. SPHM decision analysis includes data related to healthcare recipients, healthcare workers, and the SPHM program, technology, staffing, and other SPHM costs/benefits.
• Return-on-investment (ROI) is a well-known method to assist in generating a business case, however, it does not reveal which entity being studied creates the most value or the greatest cost savings and it does not always result in the most accurate decisions. Use of the Net Present Value (NPV) provides greater detail for making a business case.

6. Recognize the effects of variation on the cost/benefit model.

2.1.5 TIPS
I have been in healthcare for 33 years now. I have seen and been included in the short-term solutions to try to engage staff members in the culture of safety by consistently utilizing SPHM technology.

I find this pattern:
Staff are being injured → we have SPHM technology that leaders have supported by purchasing → the message goes out "we need to use the SPHM technology to prevent injuries" → staff are motivated for about 30 days to use the technology → the focus slips away → we resort back to old habits and staff injury rates go up → we start over. It seems to be an endless cycle.

I was tasked to inventory all the SPHM technology and accessories throughout our facility. There had been several clinical units that had relocated, and in those transitions, all of the technology had been moved and not assigned to the new units. I found bins of new accessories and SPHM technology just collecting dust in our empty units and on-shelf spaces.

When I was asked to lead the facility SPHM team, one of my primary goals was to ensure that we were using the current technology that was already purchased before we would ask our leaders to purchase more or even trial anything new. It was at this point that I realized the impact of not having hands-on training classes any longer. The classes had evolved into videos for new staff to watch. My primary goal then changed to building a business case to pilot the reintroduction of hands-on classes within one facility. I pulled the research together, presented it to the leadership team, and gained approval. I told our leadership that we needed to teach staff members to use what technology we have in a sustainable manner. My goal was accomplished by reviewing best practices, implementing the eight American Nurses Association (ANA) Interprofessional National Standards (SPHM Standards) within our SPHM program, and partnering with peer-to-peer instructors.

Outcomes included:
• Steady increase in our use of our current accessories and SPHM technology.
• Increased conversations and engagement within our bedside teams.
• Requests for focused SPHM education from bedside to leadership at staff meetings.
• Peer-to-peer instructors being asked for “in the moment’ education.
Within the first year, the class moved from one facility to a three-hospital region. Two years later when building a business case for hands-on education at the system level, we recognized the financial impact of this pilot program. There was a 49% decrease in workers’ compensation claims, which equated to a significant reduction in costs. Injuries were also less severe. We found a great return on investment with class attendance. These were the rationale presented to executive leadership to demonstrate the importance of hands-on SPHM education.

Five years later, across the system, we have seen greater pockets of sustainability with improved outcomes. We can now look at building a case with an action plan for future purchases. It is a slow and steady process. The greatest and most simple lesson I have learned is to show that you use what you have before you ask for more.

The leadership team clearly recognizes the impact not only on injury prevention but how SPHM technology greatly improves healthcare recipient outcomes. There is a system-wide multidisciplinary team working to roll out an early mobility strategic initiative. This is such exciting work and is driven from the top down, but inclusive of bedside staff, clinical informatics, clinical education, and is physician-led. It is pure testimony as to the importance of groundwork. The more thorough and transparent you are with your baseline gap assessment, partnered with a clear vision of where you want to go, the more likely you can build a sustainable, fluid culture of safety. The key to shifting the culture is to present your message to reach the hearts of the end-user and all stakeholders.

Evaluate the capital and operating budgets for the inclusion of each element of the organizational SPHM plan. This will include but is not limited to, the cost to establish the program, the procurement of appropriate amounts/types of SPHM technology, maintenance, training, education, and updating as needed. The organization may perform a cost/benefit analysis. The Facilities Guidelines Institute (FGI) provides an overview of tools to determine ROI (Celona, 2019).

2.1.5 References


Standard Number 2.1.6 Identify the essential physical functions and high-risk tasks of jobs. The organization will identify the essential physical functions of a job in a written job description. An evidence-based process or review of scientific literature will be used to identify activities that place the healthcare worker at high risk for injury.

Introduction: Review of healthcare worker injuries is imperative to ensure the Safe Patient Handling and Mobility (SPHM) program is supporting those at the greatest risk of injury from performing healthcare recipient care tasks. Regularly reviewing and analyzing injury data from comprehensive injury-reporting systems utilized by your organization will assist your team to identify areas of opportunities.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Drawing connections between individual employee’s descriptions of exposure to high-risk tasks and published evidence-based data on the subject.

- Incorporating this understanding of exposure into program strategies.
• Development of written job descriptions that identify essential physical functions of each job.

Implementing Standard 2.1.6

1. Review clinical area/unit-specific and facility-specific outcome data. These data are reflected in workers’ injury data and also available from risk management service.

2. Identify high-risk jobs, e.g., the certified nursing assistant (CNA) in a long-term care facility who is asked to provide a bed-to-chair transfer without the proper technology, or the endoscopy technician who does not have the skill or technology to move the healthcare recipient safely from the supine to the prone position on a narrow endoscopy exam table set on a post that does not allow the use of a portable floor lift. To make high-risk job determinations use outcomes from job analyses, research findings, and/or facility injury data sources.

3. Conducting job analyses of healthcare worker tasks that are considered high-risk will identify essential physical functions of each job analyzed. Use the information from the job analyses to develop written job descriptions.

4. Identify where high-risk tasks occur, both facility-wide and clinical area/unit/discipline-specific, e.g., a surgical suite where staff performed urinary catheterization on an anesthetized 600-pound woman, or in a home, where a frail, elderly, contracted man may require colostomy care.

5. Perform a general literature review seeking activities and clinical areas that are considered high-risk for healthcare workers.

6. Perform a focused literature review seeking discipline-specific activities that put healthcare workers at risk for injury.

2.1.6 TIPS

A review of the injury reporting system at Banner Health showed that we could make adjustments to our injury reporting system. This would help capture the contributing factors to the injuries that were occurring at the bedside, e.g., we added an option to choose if injuries occurred while caring for an individual of size. We also expanded and brought clarity to the data collection system wording, e.g., a selection might be “during patient care”, with options such as “repositioning during a lateral transfer”. Making those simple adjustments has produced a fabulous report that relays our greatest needs. Aligning with the national data, injuries were the highest among healthcare recipient repositioning tasks. We can now adjust our education, technology support, and processes to ensure they support the staff as they give care.

Strategies for identifying the tasks that put healthcare workers at high risk include the use of ergonomic assessment and evaluation tools, literature reviews, analysis of incident and accident reports, job analyses, and interviews with healthcare workers and organizational leadership. Ergonomic or other needs assessments used to determine high-risk tasks are performed initially; when occupational injuries or incidents related to patient handling and mobility tasks are reported; when a job, task, or process substantially changes; when healthcare recipient population characteristics change; when new jobs are introduced; at concept stage related to the introduction of new SPHM technology or clinical or work processes; and when a redesign of existing or building of new workspaces and facilities takes place [International Organization for Standardization (ISO), 2012].

2.1.6 Resources

2.1.6 References


**Standard Number 2.1.7 Reduce the physical requirements of high-risk tasks.**

The organization will focus on reducing the physical requirements of high-risk healthcare recipient transfer, repositioning, and mobilization, and other applicable tasks through engineering, safe work practice, and/or administrative controls.

**Introduction:** With leadership support, an organization must begin with a clear policy that lays out the expectations for the provision of adequate numbers and styles of Safe Patient Handling and Mobility (SPHM) technology and the requirements for use of such technology, with injury prevention a priority. Leaders must also support training and instruction for safe patient handling and mobility SPHM technology.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Reduction in the physical requirements of high-risk tasks through the design and implementation of interventions aimed at limiting staff exposure to high-risk tasks.
- Team efforts to control risk while utilizing the expertise of stakeholders with knowledge in administration procedures/policies, engineering/ergonomics, and training/education.

**Implementing Standard 2.1.7**

1. Design the facility and/or clinical area/unit to reduce healthcare worker and recipient risk (e.g., smooth floor transitions, adequate door widths for individuals of size, adequate clearance within a healthcare recipient room for healthcare workers to perform SPHM tasks).
2. Focus on tasks that have been identified as historically high-risk tasks as determined by using evidence-based research findings and data from facility injury logs, OSHA 300 logs, and workers’ compensation data.
3. Eliminate unsafe tasks or substitute safer tasks (e.g., provide in-room physical therapy as compared to performing therapy in a therapy department, which may require multiple transfers and transportation to the department).
4. Use SPHM technology, an engineering control, to remove or reduce the risk of injury (e.g., installation of overhead lifts, use of air-assisted lateral transfer devices).
5. Integrate safe work practices.

- Develop written task-specific procedures that offer safer alternative procedures for high-risk tasks, e.g., a description of the use of an air-assisted lateral transfer device to perform lateral transfers in radiology, from a gurney to a radiology table.
- Identify administrative controls aimed at reducing exposure to hazards, e.g., monitoring unsafe flooring conditions that may lead to slips, trips, and falls during mobility activities.
or consider staffing requirements to accommodate healthcare recipient acuity, census, and special healthcare recipient populations (e.g., obese, confused, or complex).

- Incorporate the principles of the 2019 American Nurses Association (ANA) “Principles for Nurse Staffing” in nurse and other healthcare worker staffing (ANA, 2019).
- Seek staffing alternatives to mandatory overtime.
- Ensure that healthcare workers get and take rest breaks.

2.1.7 TIPS

When designing and building a comprehensive SPHM policy, keep in mind the importance of floor rescue. This practice is a perfect blend of SPHM competence and healthcare worker safety needed to support Standard 2. In the event of a fall, the healthcare recipient is in their most vulnerable position and it is imperative that staff are confident in their floor rescue skills utilizing lifting technology.

At our facility, it was recognized that there was not a clear process for floor rescue in spite of our policy stating," All floor rescues must be completed utilizing a mechanical lift". Staff were placing themselves at high risk for injury by trying to manually lift a healthcare recipient off the floor, utilizing a flimsy slide board, or even a repositioning sheet with a team of healthcare workers. A decision was made to develop a “Floor Rescue Algorithm” to align policy with best practice. With leadership support via policy, educational support, and technology purchases, Banner Health was able to roll out this defined best practice.

Floor rescues must be treated as a code, in other words, everyone has a defined role and it is taught as a part of the onboarding and roaming education. It is designed in such a manner that while the primary nurse is assessing the healthcare recipient, the secondary healthcare worker is acquiring the proper lift and sling accessories. If there is a major injury suspected, such as a hip injury, head trauma, or neck or back pain, then the specific hard backboard is utilized. The healthcare recipient is secured on the backboard, a low gurney is acquired, and then a team of six staff members who must clearly communicate and move as one, manually lift the healthcare recipient to the gurney. This is the only exception to the stated policy.

If "no injuries" are suspected per the primary register nurse’s (RNs) assessment, then the team continues to utilize the SPHM technology to bring the healthcare recipient from the floor to the gurney or bed. It is important to note that staff members must take their time during this process. Staff must remember that the healthcare recipient is not going to fall any further. Staff members tend to want to hurry to get the healthcare recipient off the floor, and this is when the safety of the healthcare provider and the recipient is highly compromised.

Outcomes have shown that staff members are more confident with their SPHM skills when they have a clearly outlined process to follow. This allows for healthcare worker safety as well as healthcare recipient safety. The post-fall process is clearly outlined within the “Floor Rescue Algorithm”. A post-fall huddle must be completed that includes the necessary components and documentation required after a fall. Our facility also utilizes an event review tool, and all falls must be documented in that program. Our facility has seen a dramatic increase of healthcare workers noting “mechanical lift utilized in floor rescue.” This alone is strongly indicative of an engaged culture of safety, resulting in improved outcomes, notably, decreased healthcare provider and recipient injuries.
HEALTHCARE WORKER STANDARDS

Standard Number 2.2.1 Participate in the SPHM program. The healthcare worker will actively engage in the SPHM program, following the policies and procedures of the organization’s SPHM program.

Introduction: A Safe Patient Handling and Mobility (SPHM) program requires consistent engagement from all healthcare workers across the continuum of care for program success and to promote a culture of safety. It takes more than just creating a policy and providing technology. Healthcare workers need to understand the importance of incorporating safe patient handling technologies in their day-to-day work for their safety as well as the safety of their healthcare recipients. Leadership must be supportive of initial and ongoing healthcare practitioner education to support an SPHM program.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

• Healthcare worker acceptance of the importance of a comprehensive SPHM program and policy.
• Healthcare worker engagement in the SPHM program demonstrated by active involvement in and abiding by SPHM policies and procedures.
• Utilization of interdisciplinary staff to support the training and expectations of the SPHM policy.
• Blending of healthcare worker and recipient safety, ultimately creating an engaged culture of safety.

Implementing Standard 2.2.1

1. Locate organizational and/or clinical area/unit-specific SPHM program policies and procedures.
2. Complete surveys of or hold regular safety huddles with healthcare providers to identify opportunities for improving the SPHM program, including technology, training, support, and others.
3. Take action on healthcare worker suggestions. Apprise them of the status of their suggestions/ideas, even if a response to an idea is “it can’t be done”.
4. Ensure healthcare providers are given the time, and participate in educational opportunities, e.g., bedside training, annual competency training and education, regional or national SPHM conferences, and/or SPHM webinars.
5. Ensure healthcare providers are given the time, and participate in skills acquisition training for high-risk tasks, e.g., proper healthcare worker hand placement during lateral transfers, or proper head placement of the healthcare recipient who has a suspected unstable cervical injury and requires a lateral transfer.
2.2.1 TIPS
One of the most common barriers to comprehensive SPHM program success is the lack of engagement on multiple levels. Successful programs have been initiated from the bottom-up and also from the top-down. The keys to success though, are leadership buy-in with financial support and healthcare worker support and compliance.

Standard 3 – Incorporate Ergonomic Design Principles to Provide a Safe Environment of Care

EMPLOYER STANDARDS

Standard Number 3.1.1 Plan for a safe environment of care during new construction and/or renovation. New construction and remodeling plans will incorporate a review of ergonomic and other safety and health risk factors into the design of all projects. These plans include facility design, process flow, evaluations of different SPHM technology, and accessibility issues.

Introduction: Design can prevent or reduce occupational and healthcare recipient injuries and exposures when risks and hazards in the environment of care are adequately addressed. Interventions that eliminate hazards and minimize risks must be implemented early in the design or redesign process. Safe design must be utilized throughout all phases of hazard and risk mitigation, as well.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Institution of a Safe Patient Handling and Mobility (SPHM) Construction and Remodeling Design Task Force.
- Assessment of the relationships between workflow, ergonomic design principles, and current facility design.
- Inclusion of review of ergonomic and other safety and health risk factors into the design of all construction and remodeling projects.
- Inclusion of SPHM staff, and healthcare professionals from areas under design, in project designs from the very beginning, with continual review and update of design plans to accommodate SPHM program needs.
- Incorporation of a review of ergonomic and other safety and health risk factors into the design of all projects, new construction, and remodeling plans. These plans include healthcare organization design, process flow, evaluations of different SPHM technology, and accessibility issues.

Implementing Standard 3.1.1

1. Develop an interprofessional SPHM Construction and Remodeling Design Task Force that includes individuals who understand the workflow in patient care areas (see Standard 2.1.1). Consider representatives from the following:

- Patient care areas.
- Ancillary services (e.g., nutrition, physical, occupational, and speech therapies).
- Patient safety.
- Organization safety.
2. For every design/construction project, complete a Patient Handling and Mobility Assessment (PHAMA) and a Safety Risk Assessment (SRA) (Matz, et al., 2019).

3. Submit SPHM needs assessments to the design team, to incorporate appropriate SPHM technology and design features, i.e., raised ceilings to accommodate lift installation and use, or enlarged doorways for transporting oversized beds and stretchers.

4. Utilize process mapping (e.g., Lean) or other approaches to fully understand the workflow.
   - The goal of “Lean” is to preserve value with less work, which is best accomplished with a clear understanding of processes.
     - Maps are created that describe each step of a task.
     - For example, the “Lean” process may explain the infrequent use of clinical unit-based lifts when determining the compatible lift slings are located off the unit in the basement. The identified solution, relocation and storage of the slings near the lifts, preserve value when both are used more efficiently with less work.
   - The “Lean” manufacturing process has been successful in healthcare organizations where an understanding of motion/activity has led to improved outcomes.

5. Incorporate ergonomic design principles.
   - Identify high-risk tasks (see Standard 2.1.1 Introduction) using actual loss data from Occupational Safety and Health Administration (OSHA) 300 logs, along with workers’ compensation reports, healthcare organization injury data logs, healthcare worker interviews and surveys, capture of near-miss data, and other risk-related data (e.g., after-action reviews that do not result in workers’ compensation reports).
   - Identify high-risk areas, i.e., emergency department, surgical services, radiology, long-term care, and others (Gallagher, 2013; Matz, et al., 2019).
   - Identify high-risk healthcare recipients, i.e., those who are more dependent, with medical issues such as contractures, who are combative, with many tubes and lines, and who are larger (Gallagher, 2013) in weight, width, and height.
   - Identify SPHM technology with design features that minimize the risk of injury.

6. Design new construction and remodeling projects to specifically address high-risk tasks, patient care areas, and healthcare recipients.

7. Encourage transparency to solicit necessary feedback while exploring methods that identify strengths and opportunities.

8. Identify opportunities to reduce physical healthcare recipient transfers and handoffs with variable-acuity or variable-use designs.

3.1.1 References

Standard Number 3.1.2 Include diverse perspectives related to ergonomic design principles. Input will be gathered from healthcare workers and ancillary/support staff at all stages throughout all new construction, rebuilding, and remodeling activities.

Introduction: Communication and collaboration must occur across and between multiple areas and levels of the healthcare organization to successfully integrate ergonomic design principles throughout the environment of care. Key stakeholders are readily identified and recruited during the planning phases of new construction and remodeling projects to address potential design omissions, flaws, and ergonomic barriers that preclude safety. This collective effort reduces risks and hazards, and will eventually save money, time, and manpower.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Utilization of a survey instrument or interviews to gather healthcare worker input on safe patient handling and mobility (SPHM)/ergonomic design in their existing clinical area/unit.
- Data trending and recognition of unsafe patterns from healthcare worker surveys/interviews to prioritize actions.
- Consistent institution of interventions that address SPHM needs in care areas, using the most recent developments in technology and design.

Implementing Standard 3.1.2

1. Develop a survey instrument that captures SPHM and general healthcare recipient care needs (e.g., an electronic or one-page survey form with closed- and open-ended questions).
2. Collect, analyze, and report data to team members and other key stakeholders, i.e., architects, designers, and members of the clinical advisory team.
3. Integrate survey feedback into all new construction and remodeling projects. Examples include door width requirements for healthcare recipient-specific needs; toilet mounting according to population demographics (i.e., wall-mounted toilets have a limited weight capacity that increases the risk for fall-related injuries); or the specific surfaces recommended for safe use of assistive technology with wheels.

3.1.2 TIPS
An orthopedics inpatient unit was relocated to a larger area within the healthcare organization. Plans included ceiling lifts in every healthcare recipient room, enlarged doorways, and an open layout throughout the healthcare recipient care area. Installation of ceiling lifts followed recommendations for minimum clearance during healthcare recipient transfers from bed to chair (3 feet x 10 feet 6 inches) and bed to stretcher/bed (5 feet 6 inches x 10 feet 6 inches) within a standard-sized room (Matz, et al., 2019). However, none of the planning discussions addressed the fit between the new ceiling lifts and various traction set-ups on orthopedic patient beds. The beds currently in use had over bed traction frames that were not compatible with the new ceiling lifts. The frames had to be removed before beds from the original orthopedics unit could be utilized elsewhere. Suboptimal design of the new healthcare recipient rooms resulted from healthcare recipient-specific details that were missed.

Healthcare workers will be asked about challenges in their current work environment and for their ideas on improving safety and efficiency. A walk-through with the architect will also inform
the project. An example of using critical thinking is to problem-solve before the design is relayed.

A hospital-wide meeting was scheduled to discuss plans for selection, procurement, and purchasing new beds for all healthcare recipient care areas. Representatives from all divisions, departments, specialties, and services were invited to attend. A suggestion to select beds based on healthcare recipient acuity was made and cohorts were formed to discuss options in greater detail. The critical care cohort examined current evidence and the needs of healthcare recipients in medical, surgical, trauma, burn, cardiothoracic, neurological, and oncology intensive care units. Group consensus was reached regarding bed preferences for medical, surgical, trauma, cardiothoracic, and oncology intensive care units. However, the options for burn and neurological intensive care unit beds warranted further discussion. Healthcare recipient-specific needs for burn care were unique and therefore bed preferences were highly prescriptive. Similar circumstances in the neurointensive care unit required specific beds for healthcare recipients on spine precautions that would also fit into the unit’s computerized tomography (CT) scanner. An initial decision was made to order the same beds for medical, surgical, cardiothoracic, trauma, and oncology intensive care units, based on the cohort’s review and discussion. Plans for the remaining intensive care unit beds would be discussed at a later date.

3.1.2 References


**HEALTHCARE WORKER STANDARDS**

**Standard Number: 3.2.1 Provide input into the design.** The healthcare worker and ancillary/support staff will provide input into the design of construction and remodeling projects.

**Introduction:** Safety is compromised by healthcare workers' static postures and awkward body positions during any work performed with repetition, external loads, and/or against resistance. Such behaviors often occur when working in small or cramped spaces, using technology that is incompatible or does not fit within a healthcare recipient care area, or working around other design flaws within the environment of care. Healthcare worker input provides the context of healthcare recipient care, where work is performed. Construction and remodeling plans must include healthcare workers’ valuable insights to achieve optimal design. Effective engineering solutions will design out or eliminate ergonomic risks and hazards that occur during healthcare recipient care.

**Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:**

- Provision of a means for healthcare workers to provide input relevant to healthcare recipient and healthcare worker safety.
- Effective and continual communication and collaboration with key stakeholders involved in the design project throughout the planning processes for new construction and remodeling projects.
Implementing Standard 3.2.1

1. Require healthcare worker participation during the early planning processes to provide input on the integration of ergonomic design principles throughout the environment of care in their specific clinical area/unit.

2. Engage healthcare professionals and other key stakeholders by emphasizing the importance and value of their input related to safety.
   - Recognize the safety needs of the healthcare worker.
   - Recognize the safety needs of the healthcare recipient.
   - Optimize the fit between healthcare workers and the work they perform.

3.2.1 TIPS

Mark is a patient safety quality improvement specialist who visited a life-sized model of a new clinical unit before construction. He noticed a wheelchair that did not fit through the doorway of a patient bathroom, necessary monitors and technology located away from healthcare recipient care areas, and multiple rooms without ceiling lifts. Mark discussed his findings with a facility representative on site. He solicited additional input from healthcare workers, who engaged their colleagues to provide input, as well. Other healthcare workers were reminded via e-mail about the importance of their participation and input by the hospital’s leadership team. The information was gathered and distributed to hospital leadership, healthcare workers, architects, engineers, and contractors for further discussion on the new clinical unit’s design before finalizing construction plans.

3.2.1 Resources


Standard 4 – Select, Install, and Maintain Safe Patient Handling and Mobility Technology
EMPLOYER STANDARDS

Standard Number 4.1.1 Perform an organizational SPHM technology needs assessment.

An interprofessional group of stakeholders and/or subject-matter experts will perform the organization’s SPHM technology needs assessment within all environments of care.

Introduction: This standard assures that a safe patient handling and mobility (SPHM) technology needs assessment is performed for the acquisition of the correct type and quantity of SPHM technology on each clinical area/unit. The assessment should be conducted systematically to assure critical elements are considered.

When a needs assessment is not completed, this may result in the purchase of technology that does not meet the actual needs of healthcare workers and recipients, storage issues, and incompatibility with the clinical area/unit design. Without input into the selection process, poor employee buy-in and support may result. Injuries may continue to occur.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Inclusion of specific evidence-based criteria in your SPHM technology needs assessment.
- Utilization of an SPHM needs assessment to identify the types and quantities of SPHM technology needed within all environments of care, on a clinical area/unit basis.
- Inclusion of staff as well as vendors to determine appropriate clinical area/unit-specific technology needs.
- Knowledge of evidence-based support for SPHM technological interventions aimed at reducing risk exposure while performing high-risk care tasks.

Implementing Standard 4.1.1

1. Establish an interdisciplinary task force (see Standard 2.1.1).
   - Include key players as participants in the needs assessment (see Standard 2.1.1).
     - SPHM facility leader/coordinator/manager educated/trained in the use of an SPHM risk assessment such as that found in the **Patient Handling and Mobility Assessments** (PHAMA), 2nd edition (Matz, et al., 2019).
     - Occupational health/Organizational safety to obtain injury data for high-risk task identification in the units/areas under consideration.
     - Risk management to obtain healthcare recipient outcomes/events (e.g., falls, pressure ulcers, and others).
     - Therapy to assist with healthcare recipient population analysis and involvement in assessment.
     - Nurse manager and front-line staff to provide feedback and input on high-risk tasks, frequency of tasks, healthcare recipient population analysis, current SPHM barriers, and suggestions on possible solutions.
     - Engineering/Facilities Management/maintenance to evaluate building and ceiling structures for possible ceiling lift installation and other challenges.
     - Information technology to obtain objective data from the electronic medical record on the healthcare recipient population and level of function for each clinical area/unit.

2. Develop SPHM technology needs assessment forms for your healthcare organization and conduct an assessment of each clinical area/unit. Develop recommendations for each
specific clinical area/unit and discuss these with area/unit staff and with organizational
leadership. The PHAMA, 2nd edition, goes into detail on what to include in and how to
conduct a needs assessment (Matz, et al., 2019). The Occupational Safety and Health
Administration (OSHA) also has information on needs assessments (DOL, n.d.).

Suggestions follow regarding what to include in an SPHM needs assessment which will be
specific for each clinical area/unit.

- Injury analysis of clinical area/unit.
  - Obtain data from organizational safety/occupational health regarding work-related
    injuries in the clinical area/unit.
  - Analyze injury data to determine which high-risk task(s) are related to injuries in the
    clinical area/unit. This will assist in identifying high-risk tasks requiring technology
    controls on each area/unit.

- Documentation of general healthcare recipient characteristics in the clinical area/unit.
  - Number or percentage of healthcare recipients at each of these four levels of
    dependency (total assist, extensive assist, partial assist, and independent) plus
    those with ambulation assistance requirements.
  - Population analysis (primary diagnosis, special considerations).
  - Average weight and size of healthcare recipients.
  - Frequency of admission of individuals of size, average number within the clinical
    area/unit at the same time, and the greatest weight admitted per clinical area/unit.

- High-risk task identification.
  - High-risk tasks can be identified by the amount of weight lifted; the distance lifted as
    well as the frequency of the task. Other considerations to consider are space
    constraints, awkward postures, number of staff utilized, and mental status of the
    healthcare recipients.
  - Interviews with staff shed light on how often and where high-risk tasks occur,
    informing recommendations for quantities of technology and ancillary supplies e.g.,
    slings for lifts.
  - High-risk tasks are identified in many publications, including the PHAMA, 2nd edition,
    Appendix A (Matz, et al., 2019; Veterans Health Administration (VHA), 2016).
  - SPHM technology inventory (see Figure 4-1, Clinical Unit/Area Characteristics and
    Ergonomic Issues Survey).

[INSERT Clinical Unit/Area Characteristics.... Fig 4-1]

- What types and numbers of each technology are currently available in the clinical
  area/unit (e.g., lifts, sit-to-stand devices, slide sheets, others)?
- If technology is available, is it being used? If not, why not? Also, determine what
  processes currently exist for cleaning technology, refreshing clinical area/unit supply,
  obtaining extra supplies, as well as procedures for maintenance pick-up and return.
  Suggestions to improve processes?

- Interview of front-line staff.
  - Interview staff for input on tasks that they feel place them at risk of injuries and how
    often the task is performed (e.g., bathing, toileting, transfers in/out of bed,
    repositioning in bed, and others).
  - Ask staff what they feel would be helpful as it pertains to technology for SPHM tasks
    to reduce injuries and maximize healthcare recipient safety.
  - If technology is available, obtain vendor information, and discuss staff likes and
    dislikes about current technology.
Discuss any barriers with current technology, and concerns or ideas about future technology.

- Observation of healthcare recipient handling activities.
  - Observe healthcare recipient handing tasks occurring on clinical area/unit and how each task is currently performed (note frequency of tasks, manual lifting, if technology is used, and others).

- Space and structural considerations.
  - Storage space for SPHM technology - proximity, electrical availability, and accessibility. Having technology readily available and accessible is critical to SPHM program compliance.
  - In-room - space around bed or chair for various SPHM tasks, bathroom layout and space, width of doorways, and electrical availability and proximity.
  - Overhead lifts - ceiling structural assessment and location of items attached to ceiling or walls within the room, e.g., televisions, light fixtures, air conditioning (AC) vents, and items above the ceiling, e.g., pipes, AC ductwork.

- Include facility engineering/maintenance expertise. Resources are available related to the above and inclusion of SPHM in design (Matz, et al., 2019; VHA, 2016; Center for Health Design, n.d.).

3. Perform a general literature review to identify universal technology needs for various high-risk tasks. Based on the high-risk tasks identified, research technologies that would eliminate manual lifting and reduce the risk of injuries for the identified tasks.

4. Perform a clinical area/unit- or discipline-specific literature review to identify focused technology needs for each unique healthcare recipient population.

- If a clinical area/unit has specific needs to consider, e.g., orthopedic precautions, care of individuals of size, operating room procedures, and others, a literature search for those special circumstances should be conducted. The National Association of Orthopedic Nurses (NAON) and the Association of periOperative Registered Nurses (AORN) provide specific SPHM guidance for their healthcare recipient needs (NAON, 2009; AORN, 2007). Articles and book chapters provide information on safe patient handling needs of individuals of size (Gallagher, et al., 2020; VHA Bariatric Guide, 2015).

- Networking with other facilities is also very helpful, as is social networking on the various safe healthcare recipient handling platforms.

5. Establish whether technology is available to the region, healthcare organization, or practice setting.

- Contact the existing vendor and others who may meet your technology needs and become familiar with their technology.
- Discussion with procurement staff may be helpful at this stage to understand any limitations in contacting vendors or special group pricing agreements.
- Discussion with linen service and distribution may be helpful to identify any barriers before technology introduction.

6. Meet with the management team to review findings from the needs assessment and provide recommendations.

- Provide an approximate quantity and type of technology needed for each clinical area/unit to plan for capital technology needs and obtain buy-in and support from leadership. A cost/benefit analysis is important when sharing this information with leadership (see Standard 2).

- Estimating the required quantity of lifting technology: [cited from the PHAMA, 2nd edition, pp. 65 and 66 and Appendices I and J (Matz, et al., 2019)]

  - Overhead lifts, i.e., ceiling- or wall-mounted lifts, are recommended in all rooms throughout care areas in which healthcare recipients are being moved, handled,
lifted, and/or ambulated. Refer to PHAMA, 2nd edition, Appendix I, for overhead lift recommendations for clinical areas (Matz, et al., 2019).

- If unable to install overhead lifts facility-wide, then prioritize areas, e.g., critical care units, and phase-in the lifts throughout the clinical areas/units of the healthcare organization.
- When phasing-in overhead lifts, determine the number of overhead lifts needed for each clinical area/unit by calculating the average number of dependent and extensive assistance healthcare recipients, plus those who will be undergoing ambulatory rehabilitation. This calculation will provide the number of overhead lifts required.
- The number of rooms with overhead lifts will be determined by the configuration of the rooms - private, semi-private, multi-patient, and other factors.
  - For every eight to ten dependent and extensive assist healthcare recipients on the clinical unit, there should be one floor-based full body sling lift available.
  - For every eight to ten semi-active healthcare recipients on the clinical unit, one motorized sit-to-stand device should be available.
  - Consider the purchase of non-motorized standing aids for healthcare recipients who require stand-by assist, can stand but are unable to pivot, and are at risk of falls. These are helpful for healthcare recipients who are post-operative, recovering from a spinal block, are at risk of falls, and anxious.
  - Example for those healthcare organizations phasing in lifting technology:
    - How many lifts are required under these circumstances? If a clinical unit has 50 beds, and on average have 20 healthcare recipients are dependent or extensive assist, 10 healthcare recipients are semi-active, 10 require stand by assist, and 10 are independent.
    - Purchase recommendations: If feasible, install lifts over every bed, if not, install overhead lifts over at least 20 beds. If no overhead lifts can be purchased, provide two floor-based full body sling lifts, one motorized sit-to-stand lift, and one non-powered standing aid for the unit.

- Other technology to consider:
  - Lateral transfer devices (air-assisted, friction-reducing, others)
  - Other transfer assistive devices (transfer boards, transfer chairs)
  - Toileting and showering devices
  - Wound care and limb holding devices
  - Specialty bed or transporting devices
  - Ambulatory devices
  - Activities of daily living devices
  - Various types of slings

### References


Standard Number 4.1.2 Develop a plan for the selection of SPHM technology.
A plan will be identified to ensure that SPHM technology meets quality and safety standards and that devices and accessories are compatible and interoperable within the organization or facility.

Introduction: In conjunction with the needs assessments, become familiar with your healthcare organization's policies, procedures, and guidelines surrounding technology trials and purchasing. This will assure that the correct technology is evaluated and purchased following the healthcare organization’s purchasing, quality, and safety requirements. The technology should meet regulatory standards if applicable, and accessories should be evaluated to ensure they are interoperable with available technology.

If this step is skipped, purchasing requirements may be over-looked that create challenges in purchasing appropriate, preferred technology. Also, time and energy may be spent trialing the wrong technology as it does not correlate with your healthcare organization’s quality or safety standards thus making it harder to obtain buy-in and support from management and front-line staff.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:
• Identification of vendors and technology which meet your healthcare organization needs based on contract and group purchasing agreements.
• Use of your healthcare organization’s biomedical engineering and/or purchasing department guidelines for trialing and purchasing technology.
• Identification of your healthcare organization’s quality and safety requirements as it pertains to technology trials and purchases.
• Awareness of regulatory standards that may affect technology trials or purchase.
• Proposed accessories and devices are compatible with current technology.
• Budget constraint and policies are followed as it pertains to the purchase of safe patient handling and mobility (SPHM) technology.

Implementing Standard 4.1.2
1. Meet with procurement leadership to review existing vendor agreements and group purchasing agreements.
• Knowledge of purchasing agreements and contracts will assist you to select the right vendors for your technology trials and maximize buy-in and support.
• Understand the process to add a vendor to your healthcare organization’s procurement system if needed.
• Review organizational vendor policy and procedures to assure you know the process for technology trials, and that vendor meets requirements, e.g., immunization, credentialing, etc.

2. Meet with the biomedical engineer to understand their involvement in purchasing, maintenance, and repair. Become acquainted with their policy and procedures.
   • If a device has electrical components, your biomedical engineer department will most likely need to inspect and tag technology before trial and purchase.
   • Understanding biomedical department policies is important to assure there are no delays in trials or purchase of technology.
   • Technology to be trialed or purchased must meet biomedical safety requirements [Food and Drug Administration (FDA), 2020; International Organization for Standardization (ISO), 2006; ISO, 2012].
   • Understanding the organization’s maintenance requirement and repair guidelines is important to assure staff know who to contact and what procedure to follow if technology is broken.

3. Meet with the quality council, if needed, to review safety and quality requirements as they pertain to technology trials and purchases involving healthcare recipients.
   • Some facilities require that all technology trials be pre-approved by certain committees, e.g., quality council, research department, or the value analysis committee. Also, healthcare worker expertise is often called upon to assure quality and healthcare recipient safety.
   • Certain trials may be designated as research studies and require Institutional Review Board (IRB) approval.

4. Perform a literature search to identify any state or other regulatory standards. Understand your state legislation and regulatory standards before a trial or purchase of technology to assure correct training recommendations take place.

5. Meet with vendors to review their technology and assure that their accessories and devices are compatible with current technology.
   • Technology characteristics for consideration include ease of use, portability, versatility, size of device, ability to fit under existing beds or around radiology table pedestals, weight capacity, price, accessories, cleaning (involve infection control), service, and warranties.
   • Sling characteristics for consideration include reusables and/or healthcare recipient-specific, available sizes and weight capacities, ease of use, breathability (in order for the sling to be left underneath the healthcare recipient - consult skincare team). If there are too many different types of slings, users may get confused or this may cause compliance and training issues.
   • If certain technology is in place already, evaluate whether proposed slings and accessories can be used with current technology.
   • Utilization of one lift vendor across the healthcare organization and over time provides consistency in purchasing, training, and the use of lift technology, creating a safer environment of care for healthcare workers and recipients. If the use of one vendor is not possible within a healthcare organization, ensure technology is similar to current technology.

6. Discuss budget constraints and policies with the interdisciplinary team to help guide technology trials and/or purchasing decisions.
Identify budget constraints.
  - Differentiate between cost, value, and pricing by creating an economic and clinical model to evaluate barriers or opportunities using a particular technology.
  - Include risk management and quality improvement representatives when possible.

4.1.2 TIPS
The following are examples of poor planning for technology needs.

**Situation 1**: Team did not meet with procurement leadership.

**Outcomes**: An equipment fair was held, and the vendor of choice was not in the facility or system group purchasing agreement, therefore the technology was not purchased. The second choice was purchased and the facility struggled with buy-in and support as staff members preferred the other technology and were upset that the first choice was not selected.

**Situation 2**: Team did not meet with the biomedical engineer team before the equipment trial.

**Outcomes**:
1) An equipment trial was planned and technology was delivered, however, Biomed was unable to tag it as there was no purchase order associated with the trial of the technology, which was required. This delayed the trial, and storage had to be found for equipment pending a “no charge” purchase order.
2) An equipment trial was about to begin. Upon receipt of the technology, while Biomed inspected the device, they realized that it did not have FDA approval as a medical class type 2. The trial was canceled, as the technology was not inspected prior to the trial proposal.

**Situation 3**: Team failed to meet with the value analysis committee or quality council.

**Outcomes**:
1) A walking device for individuals of size was brought to the therapy department to trial. Patients and staff loved it and could not wait to use it further. Once the purchase order was written, purchasing contacted the therapy department as this was a new product and the vendor was not in the system. Purchasing requested to see the value analysis approval which in this case was skipped. The technology purchase was delayed by three months.
2) A new bed for individuals of size was trialed successfully on one clinical unit. When a different unit identified a healthcare recipient who might benefit from this bed, the physician placed the order, and the team was notified. However, this unit had not received training on the bed as required in the current vendor policy. The policy stated that 90% of the staff members needed to be trained before a product can be used in a clinical unit. The patient was not placed on the bed until 90% were trained, which took two weeks.

4.1.2 References


**Standard Number 4.1.3 Provide opportunities for trial and provide feedback about SPHM technology.** The organization considering the purchase or rental of SPHM technology will provide healthcare workers with opportunities to try out the technology and provide feedback.

**Introduction:** Safe patient handling and mobility (SPHM) technology trials should be conducted in an organized, systematic fashion following your healthcare organization's policies and procedure and allowing for front-line staff to provide feedback before the purchase of technology. Failing to include front line staff or failing to trial technology in the actual environment can affect staff compliance and the technology might not work in the given environment. This can be very costly to an organization and can affect future administrative support. The Patient Handling and Movement Assessment (PHAMA), 2nd edition, has information and surveys related to equipment fairs and trials (Matz, et al., 2019).

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Conducting technology trial(s) to obtain staff feedback on technology preferences.
- Selection of technology for your healthcare organization based on trial results and the weighing of cost, value, and vendor service capabilities of the various technology package options.

**Implementing Standard 4.1.3**

1. Conduct Equipment/Technology Fair(s) if appropriate and feasible.
   - Equipment fairs can be helpful when many vendors have the same technology that might meet your needs and they can foster a sense of teamwork as staff work together in evaluating the technology.
   - Equipment fairs allow you to obtain brief feedback on technology from your key players and identify any possible concerns or barriers.
   - Equipment fairs can be limiting and should not be the only means to evaluate technology before purchase. Fairs have limitations such as not testing the technology in the actual care environment - to evaluate space constraints and other barriers. Also, staff do not always have adequate time to thoroughly inspect all of the available technology and may miss critical issues. Fairs usually provide no healthcare recipient feedback.
   - Coordinating the trial takes time and effort. Ensure adequate space is available and that the event is marketed well to capture all shifts to obtain valid feedback.
   - Key players should include front-line staff, therapy, biomedical engineer, maintenance staff, wound care, infection prevention, facility management, linen services if needed, education, procurement, and anyone else who will be involved in the use, purchase, or care of the technology.
   - Have a brief feedback survey at the fair and make sure all attendees fill it out. Let staff know that their responses will be taken into consideration when purchase decisions are made. To foster involvement, have a drawing from the completed and returned forms for a prize of some sort. Suitable survey forms are found in the PHAMA, 2nd edition, (Matz, et al., 2019).
• Following the fair, analyze results based on survey feedback to help your team narrow technology down to one to three vendors/products.

2. Conduct Equipment /Technology Trial(s) if appropriate and feasible.
• Trial technology in the actual environment in which the technology will be used. This is important prior to purchase to ensure it is compatible with existing technology in the rooms, that there are no space constraints during use, and there are no other concerns, for example, a facility conducted a vendor demonstration for a floor-based lift, however, they failed to conduct an equipment trial on a clinical area/unit that will use it. Upon purchase, they found that the lift would not fit under their stretchers and the base did not open wide enough to fit around their recliners.
• Identify clinical areas/units that may benefit from an equipment/technology trial by considering the following.
  o Management support.
  o Clinical area/unit technology needs assessment identified this technology as being beneficial and will maximize outcomes (e.g., when trialing a repositioning device, select a clinical unit that has many repositioning injuries. Track those outcomes during/after the trial).
  o Clinical area/unit does not have too many other projects which may affect compliance and training.

• Obtain support to trial technology and select the desired outcomes.
  o Present the technology trial proposal and desired outcomes to your key players and other pertinent committees, e.g., quality, value analysis, others.
  o Involve your biomedical engineers in the trial to assure the technology meets safety regulations and any other standards [Food and Drug Administration (FDA), 2020; International Organization for Standardization (ISO), 2006; ISO, 2012].

• Plan and coordinate trial details.
  o Contact vendor(s) and include procurement to negotiate trial details (length of trial, cost, education requirement, quantity of products, and others).
  o Plan for delivery and storage of technology (e.g., order technology, coordinate delivery and inspection of the product, plan for the storage location before and during trial).
  o Establish processes to assure they are communicated during training. (e.g., establish cleaning procedures, plan process for obtaining accessories during the trial - may need to involve linen service or distribution).
  o Create educational materials if needed.
  o Market the trial.
  o Develop an evaluation form/survey (see Figure 4-2, Lift Evaluation Form).

**INSERT LIFT EVAL FORM – Fig 4-2**

- Evaluation form should be readily accessible to staff, be short and concise, and preferably one page.
- Consider including the following items on your evaluation form.
  - Times technology was used during the trial.
  - Ease of use.
  - Time it took to use technology.
  - Healthcare recipient comfort.
  - Healthcare worker and recipient safety.
  - Technology accessibility and availability.
  - Maneuverability in clinical environment.
- Force required to utilize.
- Likes/dislikes/suggestions.
- Would technology be beneficial for this clinical area/unit or other units/areas?
- Complete staff training.
  - Refer to your healthcare organization's policy regarding training requirements before initiation of the trial. Some facilities require 90% trained before starting the trial.
  - If the vendor is conducting the training, review with the vendor any healthcare organization processes they may need to know, e.g., maintenance, laundering, others.
- Conduct the trial.
  - Stay in communication with each clinical area/unit during the trial to obtain feedback on any barriers or issues.
  - Conduct focus groups if needed during or after the trial.
  - Market trial and send reminders to assure trial will be valid and users participate.
- Collect and analyze data.
  - Once the trial period is completed, analyze written and verbal results.
  - Analyze selected outcome measures (e.g., injury reduction, fall rates, and others).
  - When selecting technology of choice, also consider cost, service (local or not), warranties, turnaround time when parts are needed, maintenance, quality, durability, etc.
- Present feedback to the decision-making team/task force/leadership.
  - Use existing communication processes to share compatibility, preferences, and economic impact of prospective technology.
  - Consider including a presentation by an end-user to discuss the qualities of the technology being considered.
- Obtain support to purchase technology (see Standard 2.1.5).

4.1.3 TIPS

Considerations when evaluating new technology:

- Weight capacities needed.
- Infection control: If it takes too long to clean, this may affect compliance or infection rates. Does item have straps, cloth, Velcro, or anything that will require sending item to linen after each use? Can hospital disinfectants be used on product?
- Reusable or patient-specific slings: If patient-specific, is there an opportunity to recycle product? Can item be reprocessed to help save on cost? If cloth, what is the linen process, and who will re-stock?
- Technology components: Does technology have too many separate components or parts that might easily get lost? Evaluate impact on whether technology can still be used if a component is missing.
- Ease of use: If technology is too complicated and not intuitive, compliance will be affected.
- Portability: Is technology light enough to have one staff member carry or move without risking injury?
- Storage: Is there adequate storage on the clinical area/unit and how close is it to the point of care? The farther away technology is stored, the less the compliance.
- Variety of beds used in the healthcare organization: Is technology compatible with all bed types?
- Seating: Does technology fit around or under current seating or toileting aides?
- Charging technology: How durable is adaptor/battery which inserts into device? Is it evident when technology is charging? Can more than one piece of technology be
charged in the charging unit? How often do batteries need to be replaced? Can the biomedical department purchase batteries from any distributors or can they only purchase them from the vendor? Does an extra battery need to be purchased? Is there wall space to mount battery charger in preferred storage location(s)?

4.1.3 References


Standard Number 4.1.4 Develop an SPHM technology procurement plan and introduction schedule. The SPHM technology procurement plan and introduction schedule will be developed and communicated to the healthcare worker.

Introduction: Once the technology has been trialed, evaluated and you have obtained support to purchase the technology, a plan to introduce and implement the use of technology must be in place to assure compliance and successful outcomes.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Technology procurement plan detailing plans for acquiring the capital purchase, delivery to the organization (location/date/time/staff necessary to assist), and storage until introduced, if necessary.
- Technology introduction/installation timeline detailed for each clinical area/unit receiving the technology. Include date(s) of arrival, introduction/installation, and healthcare worker training.
- Communication of elements of the technology introduction/installation timeline to healthcare workers for them to anticipate and be prepared for the arrival of and training for the technology. For overhead lift installations, managers will need to make arrangements for room outages and other issues that may affect healthcare recipient care and other aspects of normal care in their clinical area/unit.

Implementing Standard 4.1.4

1. Assemble a task force for developing:
   - Technology procurement plan.
   - Introduction schedule, which is based on the familiarity workers have with the technology and the complexity of the technology, as well as the common activities and nuances
within their clinical area/unit that may be impacted, especially with overhead lift installations.

2. Consider the following representative departments to serve as members of the task force.

- Education, for coordination of training on new technology.
- Engineering, to coordinate any evaluation of and work involved in installation activities.
- Risk management, to oversee procurement and introduction processes from a liability and safety perspective.
- Quality improvement, to oversee procurement and introduction processes from a quality and safety perspective.
- Patient care services, and others, to offer feedback as end-users.
  - Nursing
  - Therapy
  - Diagnostics
  - Surgery
- Environmental, to coordinate processing of slings and other reusable devices.
- Distribution, to coordinate distribution and par levels pertaining to technology.
- Purchasing, to assure vendor is in the organization’s system, technology, and accessory items are added to the system for future ordering purposes, and to assist with purchase order(s) if needed and contract negotiations.
- If installing ceiling lifts and rooms need to be closed, consider adding the following to your team.
  - Bed control and staffing office representatives.
  - Nursing Leadership (director and/or vice president/chief nursing officer) to obtain support to close rooms down.
  - Vendor/Installer to discuss timeline.
  - Infection prevention to ensure the Infection Control Risk Assessment (ICRA) and other related guidelines and standards are followed. The ICRA can be found in the Patient Handling and Movement Assessment (PHAMA), 2nd edition, Appendix N (Matz, et al., 2019).
  - Facilities management to coordinate the installation of fixed technology.
  - Environmental services to assure rooms are cleaned after installation.

3. Determine whether a process is in place to introduce new technology.

- If no process is currently in place, establish a process for SPHM technology procurement and an introduction plan by benchmarking with similar organizations or departments within the organizations that have provided similar procurement and introduction strategies for like initiatives.
- Ensure that accountability is in place for the introduction process by first communicating expectations with stakeholders, seeking commitment, and accountability.
- Ensure that data are captured.

4. Identify steps toward, and a reasonable and attainable timeline for, the SPHM technology procurement based on the complexity of the technology and organization.

5. Identify steps toward, and a reasonable and attainable timeline for, the introduction schedule based on input from marketing, education, healthcare management and workers, and other stakeholders.

6. Ensure that facility healthcare worker injury data, including all clinical practice areas, analyzed by clinical area/unit, are used to prioritize training.

- High-risk areas (e.g., custodial care in-home care or long-term care settings).
- High-risk tasks (e.g., early, progressive mobility in critical care).
- High-risk discipline (e.g., certified nursing assistant in a rehabilitation unit or surgical technician in a metabolic surgery center).
4.1.4 TIPS

The following is an example of poor planning during technology introduction.

**Situation:** A 500-bed hospital implemented the use of sit-to-stand devices. They were anxious to order the technology prior to year-end and failed to plan implementation. They trained the users, distributed slings, and assigned storage location.

**Outcomes:** Minimal time was spent establishing processes and communicating with the users. One year later, upon follow-up by the administration, they realized that some clinical units had stopped using the technology altogether. It was not being used because the technology was not working. No plan existed for who was to ensure batteries were charged, for re-stocking slings, and for entering maintenance requests (a few of the footplates were missing). New employees were not being trained upon hire, so utilization was very low. Reducing healthcare recipient falls and team member injuries were not impacted by the implementation of this device as planned.

Figure 4-3 (below) is an example of an implementation plan for air-assisted technology at a 1000 bed, level one trauma center.

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<tr>
<td>Contract, specification, and equipment ordering.</td>
<td>Training of nursing leadership to discuss patients, sit-to-stand units, communication ofoken employees who will test units.</td>
<td>Train SPHR and IT team on how to use the new technology.</td>
<td>Assess ongoing training needs.</td>
<td>Continuation of training and education.</td>
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<td>Establish process for ordering supplies and</td>
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<td>Nurse manager, nursing PCT, unit</td>
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<td>management, operating room nurse.</td>
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<td>Establish policy and procedure</td>
<td>Establish communication/coordinated care plan for</td>
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4.1.4 References
Standard Number 4.1.5 Provide and strategically place SPHM technology for accessibility. The organization will develop a process for providing SPHM technology that ensures ease in accessibility. The quantity and type of SPHM technology will be sufficient to minimize risk for the healthcare recipient population served and the environment of care.

Introduction: Having technology readily accessible, available, and in good working condition will maximize compliance and outcomes. It is common knowledge that "time" is the number one barrier as to why healthcare workers fail to use technology. However, it is not the time to use the technology, it is the time to obtain the technology. Having a plan in place for storage is critical to program success. As well, sufficient quantities of styles, sizes, and weight capacities of technology and accessories must be available or technology will go unused.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Utilization of long-term and standardized organizational and maintenance strategies for technology that must be stored.
- Storage strategies to address safe patient handling and mobility (SPHM) technology accessibility within each clinical area/unit throughout the healthcare organization.
- For every clinical area/unit, sufficient quantities of types, sizes, and weight capacities of each type of necessary SPHM technology to minimize risk for the healthcare recipient population served and the environment of care.

Implementing Standard 4.1.5

1. Order the right quantity of type, sizes, and weight capacities of technology based on high-risk tasks identified, frequency of use, healthcare recipient population analysis, and needs assessment (Matz, et al., 2019) (see Standards 4.1.1, 3.1.1 and 2.1.1).
2. Perform a literature search regarding the impact of having SPHM technology readily available and accessible and how this impacts compliance. Communicate results to key players.
3. Identify storage needs and opportunities with key players (Matz, et al., 2019).
   - Calculate storage need for technology being purchased.
   - Visit clinical area/unit to evaluate current storage space and unused space that may be remodeled for storage of slings, mobile technology, and others. Involve key players in the clinical area/unit as well as others who may share storage rooms such as, therapy and others.
   - Ensure access to power source/battery, if needed.
   - Assure technology is as near as possible to the task.
   - Involve facilities management if needed to build wall holders, shelves, install hooks, cabinets, etc. for better management of accessories and technology.
   - Provide an organized environment that reflects the importance of storing technology in the line of sight, clearly labeled, within reach, and at adequate par levels.
   - Ensure a clear path to easily access technology.

• Standardize whenever possible to allow staff who float or support staff to always know the location of SPHM technology regardless of the clinical area/unit they work on.

• Work with the design team to plan future healthcare recipient care areas and renovations to ensure storage space is adequate. Calculate storage space needed based on the type and number of each technology and provide recommendations.

4. Apply a systematic approach to the storage of SPHM technology similar to the manufacturing industry can be helpful, especially when storage space is very limited.

• Consider involving process engineers if available at your facility or forming a task force to evaluate storage and applying the “5S” strategies for organizing storage areas (Visco, 2018).

• The “5S” Strategies:
  o Sort: sort through materials in the storage area and keep only essential items.
  o Set in order: assure every item has a designated place where it is accessible. Consider labeling storage space and bins to assure no other technology will end up in its place. Strategically ergonomically place technology: place heavy items in middle and light items at top and bottom.
  o Shine: keep technology clean and space clean.
  o Standardize: have technology in the same location on all clinical units - helps to maximize compliance.
  o Sustain: assign a clinical area/unit expert to ensure the technology storage area is clean and organized, and all technology is clean, up-to-date on servicing, accessible, available, and in good working condition. Maintaining logs can be helpful. Relaying storage issues during environment of care rounds can be helpful to engage leadership.

4.1.5 Resources


4.1.5 References


**Standard 4.1.6 Install fixed SPHM technology according to manufacturer’s specifications.**

*Fixed SPHM technology, such as ceiling- or wall-mounted lifts, or bariatric toilets will be installed according to the manufacturer’s specifications.*

**Introduction:** Research has shown many benefits of fixed safe patient handling and mobility (SPHM) technology. Ceiling- and wall-mounted lift systems that are readily available at the point of care positively affect both healthcare workers’ and healthcare recipients’ risks of injury and...
healthcare recipients' clinical outcomes. It is highly recommended that these overhead systems include coverage of all or most of the space within a healthcare recipient room or treatment area. Continuation into the healthcare recipient bathroom is also suggested, if feasible.

While many of the systems appear similar, each manufacturer has specific recommendations, instructions, and techniques for the installation of their technology. It is necessary to either have the manufacturer install their technology or closely follow manufacturer instructions for installation. Some manufacturers will not allow facilities to install their overhead lifts. Providers and healthcare organization staff responsible for the design and engineering of technology within the building should be included in the planning, implementation, and installation portions of integrating fixed systems into new and existing buildings. Ensuring adherence to manufacturer specifications for installation and consideration of room coverage, power source, charging style, design, layout, capacity limits, and fastening are imperative to the ease of use and overall safety of the system. Engineering personnel should determine the structural capacity of the supporting structures and account for additional environmental or geographical features, e.g., seismic hazards. Manufacturers will have detailed installation requirements and frequently employ technicians specifically trained in the installation of their systems. However, all plans should be reviewed by engineers, and post-installation inspection should occur to avoid system failures.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Installation of fixed SPHM technology according to the manufacturer's specifications.
- Facility engineering review of installation plans and structural features, documentation of post-installation inspection, and documentation of other reviews/inspections as required.

Implementing Standard 4.1.6

1. Recognize the value of engineering as the primary resource to review/inspect the mechanical safety of technology, monitor safe installation according to manufacturer's specifications, and recognize any structural or design concerns. Engineering reviews installation plans and structural features, documents post-installation inspection, and other reviews/inspections as required.
2. Keep manufacturers' specifications for all SPHM technology in a location (paper and/or electronic file) that can be easily accessed and where appropriate staff know it is located.
3. Keep installation inspection reports in a location (paper and/or electronic file) that can be easily accessed and where appropriate staff know it is located.
4. Ensure that installation of fixed SPHM technology adheres to manufacturers' specifications.
   • Evaluate plans for initial installation.
   • Develop a process to monitor safety at regularly scheduled intervals by first engaging engineering services, or another designee, as a significant stakeholder in the SPHM process. The goal is to integrate safety monitoring of SPHM technology using existing processes for such monitoring.
5. Develop provisions for unexpected inoperability of technology, i.e., repair, or removal and replacement, of such technology.

4.1.6 TIPS
The function of fixed SPHM technology is primarily clinical; however, steps required to reach the point of healthcare recipient use are primarily logistical and engineering. This presents a unique struggle because it can sometimes be challenging for those who are primarily clinical staff to know the language of the engineering and technology staff and vice versa. Therefore, the ability to work together can make or break the ease of technology installation and use. Many areas of overlap must be seen from the perspective of the other party, e.g., privacy curtains in multi-healthcare recipient rooms are frequently a challenge with fixed technology. The clinical staff and healthcare recipients need the curtains in place for privacy, however, location and movement of the fixed system may require modifications to the curtains to achieve functional use. The limitations and strengths associated with each perspective should be considered and negotiated to reach the best outcome for the healthcare organization and users overall. See examples in the following table.

<table>
<thead>
<tr>
<th>Consideration</th>
<th>User Perspective</th>
<th>Engineering Perspective</th>
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<tbody>
<tr>
<td>Wall-mounted vs Ceiling-mounted</td>
<td>Ceiling-mounted lift systems may be considered more aesthetically pleasing. They usually do not require modification of existing wall-mounted cabinetry. Compliance in use improves when readily accessible.</td>
<td>Ceiling-mounted lift systems may not be reasonable or possible due to structural limitations that prevent the support of the lift system and may be cost-prohibitive to modify. The cost of fixing structures related to seismic issues may prevent installation in certain geographic areas. Also, the space above the ceiling may be full of air conditioning ductwork, pipes, and other items.</td>
</tr>
<tr>
<td>Straight vs Traverse tracking</td>
<td>Traverse tracking provides far greater usability and flexibility. The systems can be used throughout the space with healthcare recipients with a variety of mobility and transfer needs.</td>
<td>Straight tracks have a smaller overall footprint and interfere less with existing structures, e.g., headwalls, privacy curtains, and fire suppressant systems.</td>
</tr>
<tr>
<td>Power supply</td>
<td>Users are not concerned with this engineering issue.</td>
<td>Electrical requirements may not allow for power cords extending down the wall, additional in- or above-ceiling outlets are required.</td>
</tr>
<tr>
<td>Location of fixed system</td>
<td>Prioritizing which rooms, hallways, or spaces</td>
<td>Prioritizing which rooms, hallways, or spaces</td>
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</table>
receive fixed SPHM technology is primarily based on clinical decisions, projected acuity and demographics, current and projected use of space, proximity to the nurse’s station, and other clinical factors.

received fixed SPHM technology is primarily based on installation technique, structural considerations, interference with other systems, building code, impact on the overall structure of the facility.

Consider compliance with manufacturer’s specifications that includes ensuring the architectural integrity of existing facilities to support the load of fixed SPHM technology. Any remodeling or construction will be done in accordance with Standard 3. For additional information regarding the implementation of SPHM technology in new and existing facilities please reference the Patient Handling and Mobility Assessments (PHAMA), 2nd edition, (Matz, et al., 2019).

4.1.6 References


Standard Number 4.1.7 Establish a system to clean, disinfect, maintain, repair, and upgrade SPHM Technology. The employer will develop procedures for regular cleaning, disinfection, and maintenance. SPHM technology will be maintained and repaired per the manufacturer’s specifications. The responsibility for monitoring, and acting on, upgrade or recall notices for equipment or software will be assigned to a specific position.

Introduction: Before safe patient handling and mobility (SPHM) technology installation, processes must be put in place for cleaning, disinfecting, and maintaining the technology and for monitoring recall notices and manufacturer alerts. The safety of the healthcare worker and recipient, the usability of the system, and the longevity of the investment depend on standards of practice to ensure that it remains clean, defect-free, and in good working order. When healthcare providers enter a room, they should be confident that the technology they are going to use is safe for them and their healthcare recipient. Similarly, healthcare recipients and their family members should be confident that they or their loved ones are receiving the highest quality of care with no additional risk of infection or injury.

Ensuring that all relevant parties are brought into the decision-making and standards of practice development surrounding the use and maintenance of these technologies is essential. Regarding cleaning and disinfection, designated staff should be trained and directed on the appropriate cleaners to use, and the frequency and technique requirements for minimizing the risk of contamination of the fixed systems. Each manufacturer should provide cleaning instructions, and specific cleaning requirements to maintain product integrity. The infection control staff should be brought in to understand the potential risks and how to minimize or eliminate those risks. Manufacturers will provide basic technology-specific instructions,
however, the expertise of the infection control team will ensure that additional healthcare organization and regulatory requirements are met. Their support of the use of technology can influence the overall success of the SPHM program.

Accountability for the regular maintenance and repairs of the technology must be determined. This may be through maintenance contracts with the manufacturer or manufacturer-approved entity. Alternately, local biomedical engineering or medical maintenance staff can be trained by the manufacturer and demonstrate competence in the regular maintenance and repair requirements. Regardless of who completes the work, SPHM technology must be placed on a regular maintenance schedule. Frontline staff and management must know who and how to contact persons to assist in emergencies and to simply know the procedure to submit repair requests.

A staff member must be appointed that is responsible for monitoring potential recall notices, manufacturer alerts, and upgrades of the systems to ensure the continuous safety of both healthcare providers and healthcare recipients. The designated office should know where to find manuals, training guidance, and specifications regarding the SPHM technology. As is true of any medical technology, the designated office should monitor the safety alerts and recall notices for any related to their specific manufacturer and technology. These should be part of a continuous learning and updating process related to the selected technology.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Utilization of procedures for regular cleaning, disinfection, and maintenance.
- Understanding and knowledge of the physical location of the manufacturer’s recommendations, and healthcare organization policy and procedure for cleaning and care of SPHM technology and related accessories.
- Institution of an annual maintenance schedule for all technology requiring such.
- Designation of staff to monitor and act on manufacturer alerts and upgrades, and recall notices.
- Supportive services’ capability to fulfill ancillary cleaning and maintenance duties.
- Healthcare professional procedure for requesting repair and maintenance of technology.

Implementing Standard 4.1.7

1. Recognize the value of engineering and environmental services to support processes to clean, disinfect, repair, and/or upgrade technology.
2. Identify or develop a process to clean and disinfect technology based on manufacturer and healthcare organization infection control recommendations.
3. Identify or develop a process to maintain and repair technology that includes instructions for healthcare workers to request repair and maintenance of technology.
4. Identify or develop a process to upgrade technology based on evolving clinical needs and manufacturers’ recommendations for longevity. This can be done by first engaging members of the clinical team, engineering service, or other designees, who then collectively establish an open-ended communication process for determining necessary upgrades based on evolving clinical or technology requirements.
5. Identify, by title, who is responsible for monitoring, and acting on, manufacturer alerts and upgrades, or recall notices for technology (technology or software). This can be done by
first engaging engineering services, or another designee, as a significant stakeholder in the
SPHM process, with the goal of managing upgrade or recall notices for technology.

4.1.7 TIPS

When initiating the inclusion of technology into an SPHM program, much of the focus typically
centers on the clinical aspects of the technology (e.g., what type of technology, weight
capacities, and style of slings are needed based on the healthcare recipient population
demographics and dependencies). However, equally important to the overall success of the
change in clinical practice of moving from a manual handling standard of care to an SPHM
technology-supported standard of care is the buy-in and integration of support from non-clinical
services. For example, consideration must be given to the potential increase in linens
associated with providing significant quantities of fabric slings to be laundered. The secondary
outcomes to this increase may include training on appropriate sling cleaning and laundering for
laundry services staff, additional laundry cart and storage needs, changes to linen distribution,
developing a system for return of specific slings to specific clinical areas/units, and possible
modifications to laundry contracts to account for the additional linens. Another example is the
addition of new training and new responsibilities for regular technology checks and maintenance
of the systems by the biomedical or engineering team. In a healthcare organization where large
quantities of SPHM technology are being added, there will be a cost in both time and materials
to add this technology to the engineering team's responsibilities. These examples present
operational challenges that must be identified and resolved to have success with the overall
program. The alternative is having expended significant time and cost to implement SPHM
technology that does not have slings available, is not cleaned, or is not functioning.

A systems approach or task analysis should be done to track each step in the process from
initial interaction with a healthcare recipient through to the end of the interaction, and through to
the start of the interaction with the next healthcare recipient. This will identify each step required
for successful technology cleaning, use, storage, and maintenance and sling laundering,
storage, distribution, and maintenance.

The SPHM technology vendor can help establish procedures for cleaning and disinfection of
technology and supplies. Refer to the Centers for Disease Control and Prevention (CDC) for
more information about laundry and prevention of infection (CDC, 2019). The SPHM technology
vendor will also assist with the recall of technology, supplies, and/or software. Refer to the U.S.
Food and Drug Administration (FDA) web site for more information about recalls (FDA, 2020).

For additional guidance please refer to the Patient Handling and Mobility Assessments
(PHAMA), 2nd edition, Appendix N: Infection Control Risk Assessment (ICRA) Matrix of
Precautions for Construction and Renovation. Also see the sidebar within the PHAMA, 2nd

4.1.7 References

- Centers for Disease Control and Prevention (CDC), “Guidelines for Environmental
  Infection Control in Health-Care Facilities”, CDC, 2019, retrieved September 12, 2020,
  from https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf
- Matz, Mary, and others. Patient Handling and Mobility Assessments, Facility Guidelines
  Patient-Handling-and-Mobility-Assessments_191008.pdf
HEALTHCARE WORKER STANDARDS

**Standard Number 4.2.1 Participate in the SPHM technology needs assessment.** The healthcare worker will participate in the SPHM technology needs assessment and other processes, as appropriate.

**Introduction:** When selecting and prioritizing the type, style, and features of safe patient handling and mobility (SPHM) technology it is important the primary stakeholder, the healthcare worker, participates. The healthcare workers provide insight into the needs of their healthcare recipient population, the limitations of use as related to care plans, perceived physical and administrative barriers to use, and knowledge of idiosyncrasies within the specific care system and clinical area/unit.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Healthcare worker involvement in clinical area/unit needs assessment that addresses shortcomings in the availability of various types of SPHM technology and ancillary equipment, hazards, storage issues, and other issues, including policy ones, impacting the safety of healthcare recipients and workers.
- Healthcare worker input related to the identification of causes of technology scarcity or unavailability.

**Implementing Standard 4.2.1**

1. Healthcare workers participate in the SPHM technology assessment in their clinical area/unit.
   - Before and during the SPHM needs assessment, healthcare workers must provide input to the SPHM assessment team and/or management through one-on-one discussions, interviews, and/or surveys.
   - Healthcare workers provide information to the SPHM assessment team related to specific concerns on their clinical area/unit. Examples follow.
     - Identify existing areas where manual handling currently occurs and provide input on potential technology to minimize or eliminate existing or foreseeable manual handling.
     - Report the impact on healthcare workers in specific cases where, had technology been available, the outcomes for healthcare recipient and provider would have improved (e.g., lack of a slide sheet for a 100-pound woman whose mobility assessment indicated maximum assistance and who required frequent in-bed repositioning results in back pain in her healthcare provider).
     - Report the impact on the healthcare recipient when a near miss occurs (e.g., the inability to use available SPHM technology because of inadequate quantities or inappropriate style/size sling options, results in a healthcare recipient nearly falling).
Report the impact on family members when appropriate technology is not available
or adequate for a healthcare recipient to safely perform and increase their mobility
independence (e.g., a healthcare recipient mobility assessment indicated a need for
moderate assistance, but due to the lack of appropriate technology, a fall-related
injury occurs. A fall-related injury may require extended acute care, rehabilitation,
and long-term care experience).

Report incompatible technology or technology with features that are not
interoperable as expected (e.g., floor-based lifts with casters that are too high to fit
under power drive beds or air-assisted lateral transfer devices that are unable to be
used in certain diagnostic settings results in healthcare workers using manual patient
handling methods).

2. Report to management at any time, in writing or verbally, per policy, incompatible
technology, or technology with features that are not interoperable as expected, need for new
or more technology, and other issues. Concern regarding policy issues impacting the safety
of healthcare recipients and workers should also be raised.

4.2.1 TIPS
Healthcare workers should provide an assessment of not just the technology and accessories
but also the systems within the healthcare organization that directly impact the use of the
technology. This may include troubleshooting the laundering and storage of slings, locations for
storage of technology, and charging stations for battery-powered technology. Staff may provide
a review of the healthcare recipient census and demographic information needed to ensure the
correct style and quantities of technology, slings, sling bars, scales, and other ancillary
technology that are assessed. The clinical staff participate in the task analysis or system
engineering process of technology use and help to identify stop points and barriers, e.g., narrow
doorways or low ceiling heights that prevent accommodation of technology. They also provide
input on ways to ensure slings are returned to the correct clinical area/unit, and where the multi-
use slings should be stored for each healthcare recipient in the healthcare recipient room.
Employees identify opportunities for improvement and establish informal and formal processes
for sharing the successes, limitations, and challenges encountered constructively.

A variety of tools are available to support staff involved in technology needs assessments,
provide a format to gather staff review of technology, and provide a formal documenting of the
involvement. The Patient Handling and Movement Assessment (PHAMA), 2nd edition, relays
such tools in Appendix E. Patient Care Ergonomic Evaluation Process, Appendix F. Patient
Care Ergonomic Evaluation Staff Interview Template, and Appendix G. SPHM Equipment

4.2.1 References
- Matz, Mary, and others. Patient Handling and Mobility Assessments, Facility Guidelines
  Patient-Handling-and-Mobility-Assessments_191008.pdf

**Standard Number 4.2.2 Participate in SPHM technology selection.** The healthcare worker
will participate in the selection of technology as appropriate.
Introduction: Many high-risk tasks have been identified throughout a variety of healthcare recipient care environments. Some of these tasks include vertical and lateral lifts and transfers, repositioning, wound care, ambulation, personal hygiene and toileting, and holding limbs. Engineering controls in the form of patient handling technology can assist with many of these tasks however the selection of which technologies are most appropriate depends on the needs of the staff and healthcare recipients for that particular clinical area, the most common high-risk tasks in the specific clinical area, the dependency levels and ambulation status of healthcare recipients, existing patient handling technology, and other strengths and limitations found in facilities and standards of practice. The staff members are invaluable resources to answer many of these questions. It is imperative that the healthcare worker be both empowered and personally responsible to participate and provide feedback in the selection of technology.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

• Healthcare worker participation in the selection of technology for their clinical area.
• Healthcare worker participation in the cost analysis of proposed safe patient handling and mobility (SPHM) technology purchases as appropriate.

Implementing Standard 4.2.2

1. Encourage healthcare professional participation in cost analysis discussions to include features and quantities of SPHM technology, impact on healthcare worker and recipient safety and satisfaction, healthcare recipient outcomes, and other topics.
2. Provide an avenue for healthcare workers to provide input to identify and troubleshoot risk, quality, and usability features of technology, e.g., ask healthcare workers to evaluate a walker with attachments for accessories/devices to encourage and improve early progressive mobility in intensive care.
• Consider secondary benefits of technology, e.g., use full-body lateral rotation as an adjunct to repositioning for purposes of promoting skin health and preventing healthcare worker injury.
• Recognize the cost/value of technology, e.g., consider the cost benefits of rental technology compared with purchasing the technology.
3. Hold equipment fairs and/or equipment trials that include the participation of healthcare workers in evaluating the technology. Importantly, healthcare workers should record their thoughts on the technology being trialed using surveys/forms.
4. Healthcare organization staff, including clinical, environmental, engineering, logistics, etc., should attend technology fairs and equipment trial activities. These activities provide the opportunity for all stakeholders to evaluate the technology from their perspective.
5. Provide candid feedback on existing and proposed SPHM technology.

4.2.2 TIPS

Management and staff from a variety of disciplines with involvement in SPHM technology must recognize the value of healthcare worker input during technology trials, selection, and use. Staff should provide information on the types and quantities of technology and accessories needed to create a new SPHM program or supplement an existing program. This input will improve the overall programmatic and technology use outcomes. Continuous improvement efforts to expand comfort and expertise with SPHM technology can increase healthcare provider and recipient...
satisfaction and safety. Staff members who actively participate in healthcare recipient care have

great insight into what will work best in their care environment. Evaluation of technology during

the selection process can identify barriers to use and ensure that the technology purchased is

appropriate for the high-risk tasks, easy to use, and compatible with the overall work

environment. As well, healthcare workers must ensure that the manufacturer of the technology

being trialed provides sufficient ancillary materials, e.g., a variety of types, sizes, and weight

capacities of slings. As an example of the importance of healthcare worker input, if, during an

equipment trial, staff find that a floor-based sling lift wheelbase is too high to fit underneath the

facility's power drive beds, that knowledge will eliminate the risk of purchasing incompatible

technology.

Work environments in which healthcare workers have the opportunity to review and provide

feedback on technology, assist in facilitating a quality working environment where ideas are

heard and acted upon. This will result in much-needed buy-in early in the SPHM technology

implementation process. Significant changes of practice, as is frequently seen when changing

the way employees move, handle, and mobilize healthcare recipients from a manual handling to

a technology-based process, can be difficult. Gaining the benefit of staff opinions and buy-in

early in the transition can greatly improve acceptance, successful implementation, and

sustainability.

A variety of tools are available to both encourage employee involvement in technology needs

assessments and provide formal documentation of their involvement and reviews. Tools are

found in the Patient Handling and Mobility Assessment (PHAMA), 2nd edition: Appendix E.

Patient Care Ergonomic Evaluation Process; Appendix F. Patient Care Ergonomic Evaluation

Staff Interview Template; and Appendix G. SPHM Equipment Evaluation and Selection (Matz, et

al., 2019).

4.2.2 References

• Matz, Mary, and others. *Patient Handling and Mobility Assessments*, Facility Guidelines

Institute, 2nd ed. 2019. [https://www.fgiguidelines.org/wp-content/uploads/2019/10/FGI-


Standard 5 – Establish a System for Education, Training, and

Maintaining Competence

EMPLOYER STANDARDS

*Standard Number 5.1.1 Establish an education and training system.* SPHM education and

training will be provided to the healthcare worker and ancillary/support staff as appropriate, at

orientation, annually, and with the introduction of new competencies or technology solutions.

Select a methodology that meets the needs of the adult learner.

Introduction: Healthcare workers continue to manually lift and mobilize healthcare recipients

simply because it’s “the way we’ve always done it.” While the intentions of manual lifting and
mobilization are honorable, this practice continues to be unsafe (Fitzpatrick, 2014, p. 1). The Safe Patient Handling and Mobility (SPHM) program should include evidence-based theory and practice that includes the following three elements: “education, training, and competency” (Perez, 2016, p. 113). Applied methodologies shown to yield higher levels of knowledge and confidence include traditional classroom lecture (theory), hands-on training of SPHM technology, real-time feedback, and competency assessment (see Standard 5.1.5).

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Provision of a training and education program designed to serve the needs of the healthcare organization and that facilitates healthcare worker and ancillary support staff participation in the organization’s SPHM program.
- Provision of initial SPHM training during orientation.
- Identification of intervals for retraining/skills review.
- Development of a process to ensure additional training for new technology or new evidence-based practices.
- Identification of situations when retraining is necessary.

Implementing Standard 5.1.1

1. Recognize the value of and utilize the education department, as this department has processes and mechanisms in place to coordinate and integrate SPHM information into new and existing training/education efforts.
2. Recognize the difference between education (knowledge transfer) and training (skill acquisition), as the formats for these activities are different.
   - Education generally occurs as a workshop, lecture, or self-directed study module; in contrast, training is best accomplished in a simulation laboratory/center, on the clinical area/unit using hands-on demonstrations, and/or return demonstration or workshop.
3. Use adult learning strategies and those that focus on individual learning styles.
4. Develop training appropriate for new healthcare providers, for regular/annual updates, for re-training of healthcare workers who display a lack of competence in understanding of SPHM and/or use of technology, and for new technology or best practices.
5. Ensure a strong focus on facility orientations.
   - Emphasize the organization’s commitment to a culture of safety.
   - Integrate SPHM solutions into facility orientation, e.g., through interactive scenario-based training.
   - Provide evidence pertaining to SPHM, e.g., the science supporting lift limits or the pathophysiology of back injuries.
   - Allow hands-on skill acquisition specific to each practice area.
   - Provide training that specifically explains the therapeutic features and thus benefits for healthcare recipients when utilizing good SPHM practices.
   - Provide training that explains the mechanical features of the technology, e.g., bed operations as a means to optimize the mechanical advantage of SPHM practices. Also, include limitations of the technology.

5.1.1 TIPS

Root Cause Analysis (RCA) of healthcare worker injuries can be a helpful tool to identify and track educational gaps or issues in SPHM programs. Often, a lack of knowledge or a clear understanding of how to properly use SPHM technology is revealed during this process and can be addressed immediately during the RCA. Also, because key stakeholders, e.g., healthcare...
workers, clinical area/unit director, worker’s compensation (WC) coordinator, SPHM program coordinator, are present at the RCA, solutions reached through this collaborative effort can be communicated by those stakeholders during daily huddles, on education boards, and added to orientation/refresher courses.

**Examples of SPHM education/training programs:**

1. Initial training for new clinically-designated healthcare workers includes the following:
   - Video learning module demonstrating the steps of a mobility assessment used at the healthcare organization before the live initial training course.
   - Two-hour live course:
     - Introduction and history of SPHM - lecture format with questions and answers (Q & A).
     - Relevant statistical evidence (national trends in injury rates as well as hospital-specific rates).
     - Overview of ergonomics, demonstrating the pathology of injuries, thus the need for SPHM initiatives/programs.
     - Hands-on technology stations - live simulation.
       - Class is broken up into two or three groups that are paired with mobility levels (i.e., Bedside Mobility Assessment Tool (BMAT) level one = station one).
       - Healthcare workers rotate through each station and participate in the process of healthcare recipient assessment, identification of appropriate technology based on assessment findings, and proper use of that technology.
       - Competency assessment/checkoff with scenario-based problem solving and demonstration.
2. Annual Skills review/training for clinical healthcare workers:
   - Each clinical area/unit works with the education department to include an SPHM skills station during the annual skills fair. This station uses a demonstration/simulation model, is taught by a clinical area/unit “super-user” or “peer leader”, and includes a competency checkoff of clinical area/unit-specific technology.
3. Introduction of new technology or practice:
   - Introduction of new technology is coordinated through the education department who schedules in-service/training with the vendor, clinical area/unit managers, and clinical area/unit SPHM super users/peer leaders. The area/unit super-users and education department track and maintain records of sign-in sheets and skills checklists.
   - New evidence-based SPHM practice should be introduced by the SPHM facility lead and/or super-users in coordination with the education department to all applicable clinical areas/units and staff.
4. Training of non-clinical staff:
   - Non-clinical staff members who may or may not be present in clinical care areas but who are present in the facility (e.g., registration, administration, volunteers) should receive training focused on the following:
     - Recognition of the need for SPHM practices (e.g., falls prevention, healthcare worker injury prevention)
     - A notification process (e.g., rapid response) to ascertain appropriate technology and healthcare workers trained and competent in SPHM.

5.1.1 Resources
5.1.2 Include healthcare workers from across the continuum of care.

The content of the education and training will be specific to the role and setting of the healthcare worker or ancillary/support staff.

Introduction: Healthcare workers in the organization need safe patient handling and mobility (SPHM) education and training that is specific to their role and setting. The continuum of care includes roles of and settings where healthcare workers (e.g., nursing, therapy, radiology) and ancillary/support staff (e.g., security, volunteers, transporters) perform their duties. SPHM training must provide information to facilitate a safe environment of care for all involved in using SPHM technology with healthcare recipients. Without education and training tailored to each healthcare worker’s role and responsibilities, the organization could experience unforeseen safety conditions with the potential for injury to the healthcare worker and/or the healthcare recipient.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Provision of evidence-based training and education on specific high-risk tasks, targeted at staff most likely to perform these tasks.
- Provision of evidence-based training and education on specific high-risk tasks, targeted at staff who infrequently perform these tasks.

Implementing Standard 5.1.2

1. Determine area-specific high-risk tasks for both healthcare providers and ancillary/support staff.
   - Identify by healthcare worker/ancillary/support staff feedback/input.
   - Identify in scientific literature.
   - Base on clinical area/unit injury data, i.e., number and severity (see Standard 8 for details).

2. Train healthcare providers and ancillary/support staff on high-risk tasks they may perform.

3. Create “just-in-time” clinical area/unit-based skills training (i.e., on-unit, point-of-care, and as-needed).

4. Develop activities to address clinical area/unit-specific hazards.

5.1.2 TIPS
Assessing the clinical area/unit-specific hazards is important in ensuring that the appropriate education and training are provided and that current and appropriate technology is being used during training activities (see Standard 5.1.4). The organization can assess different ways to evaluate high-risk tasks in ancillary departments to determine the most effective education and training for those areas. Such education and training activities promote a safe environment of care for the organization’s healthcare worker and healthcare recipient.

For example, a person who weighs 400 pounds falls on the floor in the hospital cafeteria and good Samaritans run over to help manually lift the person from the floor. A transportation staff member asks the good Samaritans to please wait. He knew the safest and best practice was the use of a portable lifting device because they had learned about it during hospital awareness training. In this example the hospital worker’s awareness training allowed ancillary staff to know to retrieve appropriate lifting technology and prevent potential injuries.

Remember, identifying high-risk groups should include all healthcare workers along the continuum of care, including some who may not be quickly recognized as such, e.g., transport or escort staff. As a part of their job, they may be asked to transport healthcare recipients to clinic areas and come across a piece of SPHM technology that they have not been trained to use. If the transporter decides to use the unknown piece of technology, it could be used incorrectly with negative consequences.

5.1.2 Resources


Standard Number 5.1.3 Provide time for employees to participate in learning sessions.
Employee participation will be facilitated by providing time and scheduling support services. Education and training will be provided during scheduled work hours, including alternate shift work.

Introduction: All too often healthcare workers will report: “we don’t have time to attend safe patient handling and mobility (SPHM) training”. Also, during new employee orientation, hours allocated for SPHM education are sometimes limited by organizational time constraints. This training, from a safety standpoint, is unquestionably a high priority, despite competing healthcare worker demands and budgetary challenges.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:
• Integration of healthcare worker training and education opportunities into scheduling.
• Involvement of appropriate stakeholders to ensure adequate time and staffing levels.

Implementing Standard 5.1.3
1. Provide time and support for healthcare workers to actively participate in SPHM education and training in order to initiate and maintain competence in SPHM elements and technology.
   • Provide education and training during scheduled work hours, including alternate shift work.
   • Provide opportunities for healthcare workers to attend external training and conferences.
2. Establish a train-the-trainer (e.g., mobility/SPHM coach/champion) to provide or assist in furnishing learning opportunities in the clinical area/unit.
   • Integrate point-of-care training by an SPHM coach/champion, mobility/lift coach, or lift team member.
   • Monitor skills acquisition.
   • Ensure that healthcare workers have hands-on training opportunities.
   • Provide clinical area/unit-, discipline-, and/or facility-specific training.

5.1.3 TIPS
According to the Occupational Safety and Health Administration (OSHA), there are several challenges for individuals managing SPHM programs [Department of Labor (DOL), 2013]. Finding the needed time for healthcare worker training seems to be a universal issue. Dedicated time for employee education and training is an extra expense to the organization; however, when leadership realizes the overall benefits of SPHM programs, the reasoning for budgeting for additional healthcare worker hours is seen as an overall cost-savings.

Another challenge is the time allotted for periodic refresher training. Research on several methods for delivering refresher training includes training in the clinical area/unit during various shifts and/or during annual skills education days. It should be taken into account that there should be sufficient time to allow hands-on refresher training of existing SPHM technology as well as time to learn new SPHM techniques and work practices. Offering continuing education hours for refresher training and annual champion/coach training is popular with healthcare workers. Also, some employers offer paid-time-off for outside SPHM training or conferences. Such venues take healthcare workers out of their work environment where they are more focused on what they are learning. As well, such training often offers new ideas and information that can be shared with co-workers to enhance the quality and safety of the workplace environment (see Standard 1.1.4).

5.1.3 Resources

- Enos, L; Eldredge, D; Rockefeller, K. *Educational Case Report: A Safe Patient handling and Mobilization Training Program in an Academic Medical Center*. Am J SPHM September 2016 Vol 6, No3, pgs.120-129.

**Standard Number 5.1.4 Provide appropriate SPHM technology for education and training.**

Interactive education and training will be conducted using the same types of SPHM technology used for healthcare recipient care within the organization. Simulation or point-of-care training is preferred.

**Introduction:** Education and training activities are most effective when training uses the same types of safe patient handling and mobility (SPHM) technology within a healthcare worker’s clinical area/unit. Utilizing their own technology fosters healthcare worker and healthcare recipient safety. Utilizing technology that is not the same type of SPHM technology that is used in the healthcare provider’s clinical areas/units can result in confusion, impede skill development, and hinder understanding of the SPHM technology in their unique clinical care setting. Simulation and point-of-care training provide a safe environment for healthcare workers to learn how to use SPHM technology. These training modalities enhance technology understanding and skills prior to the direct use with healthcare recipients.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:
• Provision of relevant hands-on training on technology healthcare workers are likely to encounter.
• Provision of point-of-care training or training within a simulation center to familiarize healthcare workers with technology before direct use on healthcare recipients in clinical care situations.

Implementing Standard 5.1.4

1. Determine whether there is consistency between the technology used for training and the technology available in the actual clinical care areas of the healthcare workers being trained.
2. Conduct training in a simulation center, if available. If one is available, use point-of-care training as a follow-up to learning in the simulation center. If one is not available, use point-of-care training.
3. Integrate only the use of technology actually available in healthcare recipient care areas.
4. Discard all inoperable, incompatible, inconsistent, or outdated technology.

5.1.4 TIPS

Knowing the types of SPHM technology used in clinical areas is necessary to provide the correct education and training for the areas where the healthcare worker will be moving and handling healthcare recipients. Effective and meaningful training environments include that in the area the technology is being used and/or preferably, in a simulation center. Simulation centers integrate appropriate technology and simulation scenarios. This provides a safe environment for the healthcare worker to learn healthcare recipient handling skills through a hands-on approach. Follow-up learning sessions and point-of-care training can be useful to move the healthcare worker from the novice to the expert level of competence. Removing outdated, incompatible, and inoperable SPHM technology from the training environment increases the overall safety during training.

The danger of using obsolete, although similar to current technology in a simulation or education room is that it may cause safety concerns when using the actual current technology on the floors. For example, training healthcare workers on a lifting device that requires slings with “clip” attachments and ‘is not’ found in their care area versus training them on a lifting device requiring a “loop” attachment, which ‘is’ found in their clinical area, can create a safety hazard. When the healthcare worker is working in their clinical area/unit and cannot find a “clip” sling, it could cause the healthcare worker to not use the technology and move the healthcare recipient manually, as they are not familiar with the “loop” slings. Or, they may try to connect the “clip” sling onto the “loop” sling hanger bar with the potential for a healthcare recipient injury during the transfer. Making sure that the education and training on the exact technology used in the clinical area/unit is key to the safety of the healthcare worker and healthcare recipient.

5.1.4 Resources

Standard Number 5.1.5 Require and document healthcare worker competence. The healthcare worker will demonstrate competence with SPHM prior to providing actual care. The effectiveness of education and training will be monitored.

Introduction: Initial and ongoing competency-based education and training must be a carefully considered component of a Safe Patient Handling and Mobility (SPHM) program. Lack of effective education and training, e.g., relying solely on video demonstration or lecture-based information, will quickly derail any culture change and sustainability efforts of an SPHM program. Utilizing a variety of educational platforms and providing opportunities for employee engagement, especially hands-on sessions and scenario-based return demonstration, is an advisable well-rounded approach to ensuring quality healthcare worker performance.
Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Establishment of a standard by which SPHM competencies are defined.
- Provision of the means to establish and document competence within the scope of the standard.
- Effectiveness of the education and training within the scope of the standard.

Implementing Standard 5.1.5

1. Establish a standard by which SPHM competencies are defined.
2. Create a system to document competence for all varieties of training and education modalities, e.g., simulation, hands-on, required return demonstrations, and others.
3. Develop a system to document attendance for all learning sessions/courses, e.g., provide on-unit or point-of-care coach/train-the-trainer signoff.
4. Provide scenario- or case-based training.
   - Encourage healthcare workers to share examples of challenging tasks and best practices.
   - Provide training in ways to mitigate the expressed challenges and incorporate the best practices.
5. Ensure annual competence training; consider including the topic in an annual skills fair.
6. Build in adult learning concepts and different learning styles into your education and training programs. Take into account the reading and comprehension levels of various groups as well as language barriers.
7. Develop a system for clinical area/unit- or discipline-specific ongoing monitoring of the effectiveness of training and education.
   - Manage accountability.
   - Manage expectations.

5.1.5 TIPS

Designing a well-rounded approach to education, especially ensuring hands-on training of SPHM technology is of utmost importance for the safety of the healthcare worker and healthcare recipient.

Case Scenario: Mary is a new graduate registered nurse on the medical-surgical floor. During employee orientation, she completes a 30-minute online module and post-test regarding SPHM (the cognitive domain of learning). Part two of her institution’s SPHM education plan includes training in the classroom/simulation lab. The instructors provided a nice lecture-style format and demonstrate the use of the ceiling lift, other technology, and ancillary materials, e.g., slings, straps, vests, and others. Mary, not having the chance to fully engage in hands-on learning, (the psychomotor domain of learning), reports to her supervisor she feels unprepared, uncomfortable, and frankly unable to use the SPHM technology with healthcare recipients. Would you say Mary was adequately trained? Would you say this novice nurse has met the basic requirements for SPHM competency? The answer is no. Mary has not met the expectations for competence.

How often have you seen a simple checklist used to evaluate competency? A checklist is just one of many ways to verify competency. Providing several verification methods to measure SPHM competence is ideal. This approach creates employee commitment and buy-in.

Various methods to evaluate competency:

- Return Demonstration
5.1.6 Provide time and resources for the education of healthcare recipients. The organization will allocate time and learning resources for healthcare workers to educate healthcare recipients and their families about SPHM, as appropriate.

Introduction: Entering a healthcare environment is usually worrisome for healthcare recipients and their families. Clear and frequent communication with the healthcare recipient and family fosters quality care and healthcare recipient satisfaction and cooperation. Communication regarding the safe patient handling and mobility (SPHM) process and technology must be provided before admission if possible, on admission, throughout the stay, and upon and beyond discharge to home/family or discharge healthcare organization. Standard 6 details communication goals and methods for relaying SPHM information to healthcare recipients and their families/caregivers when they are receiving care within the healthcare facility.

Most healthcare facilities are greatly concerned their employees are competent in all areas of SPHM, however, this important issue has not gained the same attention in the home environment. Family and caregivers commonly assist family members with impaired mobility; however, these caregivers are unlikely to have been educated and appropriately prepared to perform these important SPHM tasks in the home. For this reason, healthcare recipient and family education and training are critical.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

Please use the following link to find a sample SPHM Staff Training Competency Checklist from the Washington State Hospital Association (WSHA).
https://www.wsha.org/wp-content/uploads/Worker-Safety_SAMPLE-...

5.1.5 Resources

5.1.5 References
• Generation of a written policy for healthcare recipient education on the SPHM program that includes the allocation of time and learning resources for healthcare workers.
• Inclusion of SPHM program, rationale, and technology communication/training in the healthcare recipient’s care plan from admission through discharge planning.
• Inclusion of family members/caregivers in SPHM rationale and technology training.
• Recording/relaying of healthcare recipient satisfaction reactions to use of SPHM technology to foster use at home and/or discharge healthcare organization.

Implementing Standard 5.1.6
1. Recognize the value of customer relations, public relations, patient care services, healthcare workers, and others to support education and awareness for the healthcare recipient, family members, caregivers, and visitors.
2. Establish a task force to determine the best processes for educating healthcare recipients, and their families/caregivers in SPHM rationale and use of technology.
3. Develop a written policy describing processes for educating the healthcare recipient, family/caregivers, and visitors about the SPHM program.
   • Specifically, relay methods for healthcare workers to describe expectations, including mobility activities and technology based on the assessment of the healthcare recipient’s mobility/SPHM status.
   • Allocate time and learning resources for healthcare workers to conduct education/training.
4. Use written/electronic tools to reinforce healthcare recipient education (see Standard 6).
   • Online education
   • Written brochures/pamphlets

5.1.6 TIPS
Preparing the healthcare recipient and family/caregivers for successful discharge to home from the hospital is an interdisciplinary effort. It is imperative for all health care providers interacting with the patient and family in both the inpatient and outpatient setting, to relay common tips for safe mobility. Healthcare providers should provide referrals to specialists when healthcare recipients have complex mobility and other needs, e.g., a physical therapist will need to evaluate a rehabilitating healthcare recipient to determine the most appropriate assistive device(s) based on the person’s level of function and ambulation goals. They would also need to discuss the technology and reasons why the technology is necessary to use as well as provide the healthcare recipient and family/caregiver with written educational materials as well.

For more information and a sample card for healthcare recipients regarding the organization SPHM program. Please view Figure 5-1, SPHM Mobility card, and Figure 5-2, "Teaching Family Caregivers to Assist Safely with Mobility".

5.1.6 Resources
• National Alliance for Caregiving, Caregiving in the U.S., AARP Public Policy Institute, June 2015. Retrieved October 14, 2020, from

Fig 5-1
Fig 5-2

INSERT SPHM MOBILITY CARD HERE

INSERT TEACHING FAMILY SPHM HERE
HEALTHCARE WORKER STANDARDS

Standard Number 5.2.1 Establish and maintain competence. The healthcare worker will actively participate in education and training to maintain competence related to SPHM, and serve as a role model for safe behavior.

Introduction: Work-related musculoskeletal disorders (WMSD) continue to be a major safety concern in the health care industry. Also, WMSDs result in high incurred costs to healthcare organizations as well as lost income and career-ending injuries for healthcare workers. Barriers that contribute to WMSD include interpersonal, situational, organizational, and environmental influences that both indirectly and directly influence healthcare workers’ decisions to use or not use safe patient handling and mobility (SPHM) technology (Noble & Sweeney, 2018).

Healthcare workers must commit to their own safety as well as that of their healthcare recipients, which requires ongoing SPHM education, participation, and commitment to safe, professional, work practices.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Healthcare workers’ competence in all aspects of the SPHM program.
- Healthcare workers’ active participation in SPHM education and training.
- Establishment of a pathway for healthcare worker feedback on participation in the SPHM program and training.

Implementing Standard 5.2.1

1. Healthcare workers actively participate in SPHM education and training in order to initiate and maintain competence in SPHM elements and technology.
2. Develop a system that makes safe behavior a key component in healthcare worker evaluations.
   - Annual competency.
   - Required participation in unit-/discipline-specific and/or other education and training opportunities.
3. Healthcare workers serve as role models for safe behavior.

5.2.1 TIPS

Root Cause Analysis (RCA) is a method of analysis that assists with process improvement and is excellent for shared learning and problem-solving. When an injury occurs related to SPHM, holding an RCA with the injured employee and key stakeholders facilitates identifying and addressing gaps in the SPHM program, e.g., technology needs and accessibility, SPHM educational needs, unsafe practices, and lack of a culture of safety. The identified gaps are specific to the clinical area/unit where the injury occurred. Healthcare workers who participate in RCAs often agree to become “super-users” or “peer leaders” by taking additional training. They can then serve as role models for safe behavior and clinical area/unit trainers for ongoing education.
Peer-to-peer education and an ongoing commitment of SPHM experts to seek out solutions to barriers are not only imperative for successful SPHM programs, but it's also invaluable to healthcare workers and healthcare recipients. Each healthcare worker is responsible for establishing their competence, working as a team, and all the while promoting patient safety. The following is a relevant story.

As an SPHM program coordinator, I have witnessed several successful patient mobilization scenarios using SPHM technology that were thought not to be possible. One of my biggest challenges as an SPHM program coordinator occurred in an Acute Rehabilitation unit where we had been experiencing staff resistance to using SPHM technology. I often heard from these therapy staff “it is our job to mobilize patients and make them independent not dependent on these lifts!” I also heard, “you’re a nurse, you don’t know what we physical therapists do.” Realizing and understanding the barrier that was present in this clinical area, I asked a physical therapist (PT) colleague to come to my facility and teach a specialized class for our rehabilitation staff. He was an expert in SPHM, well versed in the challenges and objectives in an acute rehabilitation facility, and most importantly, spoke “PT language”. The class was “highly recommended” by the unit director and had great attendance.

Soon after the class was held, a 21-year-old healthcare recipient who had suffered a traumatic brain injury was admitted to the acute rehabilitation unit. He had contractures of his upper and lower extremities and was unable to communicate verbally. One day, during my rehabilitation unit rounds, I had the pleasure of watching the staff use a lift with an ambulation vest to begin ambulation training with this patient. With the safety and trust of the technology and staff, the patient began moving his contracted legs, stretching them forward, and touching his toes down to take his first steps since his injury. The smiles on everyone’s faces lit up the room! As the patient squealed with delight, tears welled up in my eyes and rolled down my cheek. I had just witnessed a transformative moment, for both the patient and staff.

As I pulled myself together and began quietly walking out of the activity room where this patient had achieved the beginning steps of his long journey to walk again, one of the PTs turned to me and said, “Thank you!” She too had tears of joy. I smiled, nodded, and more tears began to flow. We all had made a difference in this young man’s life.

5.2.1 References

5.2.1 Resources

**Standard Number 5.2.2 Engage and educate the healthcare recipient regarding SPHM.**
The healthcare worker will engage and educate healthcare recipients, family, community, and co-workers in a manner that is easily understood by the learner.
**Introduction:** A key component to a successful Safe Patient Handling and Mobility (SPHM) program is the ability to educate and train all involved regarding the benefits of SPHM and the use of technology to improve and/or sustain mobility. Healthcare recipients are often unaware of these benefits and how SPHM can positively impact their recovery, overall mobility, and quality of life. It is imperative that experts in SPHM share knowledge and skills with colleagues and healthcare workers so they in turn can formulate appropriate mobility/SPHM care plan(s) to share, engage, and teach healthcare recipients, families, and others about the benefits of SPHM. Standard 6 details communication goals and methods for relaying SPHM information to healthcare recipients and their families/caregivers when they are receiving care within the healthcare facility.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Healthcare worker engagement with and education of healthcare recipients and their family/caregiver, co-workers, and the community, if feasible.
- Inclusion of the positive impacts of the SPHM program in the healthcare recipients’ care plan.

**Implementing Standard 5.2.2**

1. In a manner that is easily understood by the learner, educate healthcare recipients and their family/caregiver, co-workers, and the community, if feasible.
2. Provide feedback on written/electronic SPHM education tools pertaining to a healthcare recipient’s understanding of SPHM information.
3. Engage reluctant healthcare recipients by demonstrating technology and/or bringing in external expertise.
4. Develop confidence in using appropriate technology.
5. Educate the family/caregiver on the SPHM Standards, especially across the care continuum into the home. Knowledge of the SPHM Standards empowers the healthcare recipient and family/caregivers to take action as they are more aware of SPHM benefits, issues, and solutions.

**5.2.2 TIPS**

Preparing the healthcare recipient and family/caregiver for successful discharge to home from the hospital is an interdisciplinary effort. It is imperative for all healthcare providers who have interacted with the healthcare recipient and family/caregiver, in the inpatient and outpatient setting, to have input on how to best ensure safe mobility and/or care of dependent healthcare recipients. These healthcare professionals should also be prepared to provide referrals to specialists when healthcare recipients have complex mobility needs and/or evaluate healthcare recipients to determine the most appropriate assistive devices based on the person’s level of function and/or ambulation goals.

Healthcare recipients and family/caregivers are often unsure or non-trusting of the reasoning behind using SPHM technology or the technology itself. It sometimes takes several attempts to convince them it’s the safest and most comfortable way for everyone involved. The following tips can be used to help reassure them of the safety and reliability of SPHM technology.

- Explain exactly how the technology will help them in their current situation e.g., the use of ambulation slings with a lift will keep them from falling.
- Describe a previous successful scenario of how technology helped you to mobilize a previous healthcare recipient.
• Anticipate questions and be well prepared to answer them honestly.
• Ask a colleague to get in the sling and demonstrate to the healthcare recipient and family/caregiver how it works.
• Familiarize yourself with the maintenance record/sticker of the lift and be prepared to answer questions about its safety.
• Be prepared to look for and offer different solutions if available, e.g., use of an air-assisted lateral transfer device in place of a repositioning sheet with lift.

As the SPHM program coordinator, I often assist staff with problem-solving challenging healthcare recipients and/or situations. I was called to the intensive care unit to assist with an individual of size who had excoriated skin and several pressure injuries. He was fearful of sitting and being lifted with a sling due to pain. The nurse and I spoke with him about how turning, repositioning, and getting out of bed would be the only way his wounds would heal. The nurse reminded him of his pain medication given 30 minutes prior, and I assured him we had the correct sized sling and would do everything possible to ensure his safety and comfort. He agreed, and we successfully transferred him to an appropriately sized chair. After a few minutes in the chair, he said "wow, I'm not in as much pain as I thought I'd be in". With a little time, appropriate preparation, reassurance, and education, we were successful on our first attempt to get him to a chair. This success set up the next step, weight-shifting using a lift and ambulation sling for safety.

The following are links to the American Journal of Nursing (AJN) video library with tips on educating healthcare recipients on safe mobilization.

https://journals.lww.com/ajnonline/Pages/videogallery.aspx?videoid=108&autoPlay=true
https://journals.lww.com/ajnonline/Pages/videogallery.aspx?videoid=109&autoPlay=true
https://journals.lww.com/ajnonline/Pages/videogallery.aspx?videoid=110&autoPlay=true

5.2.2 Resources

Standard 6 – Integrate Patient-Centered SPHM Assessment, Plan of Care, and Use of SPHM Technology

EMPLOYER STANDARDS
Standard Number 6.1.1 Provide a written procedure on the SPHM assessment and plan of care. The written procedure outlines how to evaluate a healthcare recipient’s SPHM status, establish goals, select technology for specific care tasks, and address roles and responsibilities of the healthcare worker related to assessment and scoring, evaluation, plan of care, and documentation.

Introduction: The Safe Patient Handling and Mobility (SPHM) assessment/screening process informs mobility and safety needs triggered by comprehensive and continuous screening conducted by all healthcare workers who participate in the care and physical movement of the healthcare recipient. This interprofessional systems approach provides a holistic plan of care by combining the clinical and medical assessment of the healthcare recipient’s physiological, psychological, sociological, and spiritual status in conjunction with the SPHM screen which includes mobility status (scoring), SPHM technology selection, documentation, continuous assessment and updating of the interdisciplinary care plan.

Determination of mobility status is a key aspect of clinical care and determining resource needs that have an impact on healthcare recipient outcomes. Immobility or delayed mobility has been linked to several complications of hospital-acquired conditions that result in healthcare recipient harm and increased length of stay [Matz et al., 2019; Veterans Health Administration (VHA), 2016; Wang, 2018].

Healthcare recipients tend to overstate their own ability to move in bed or out of bed without support or assistance. The mobility assessment provides clear objective measurements to help support the safest way to accomplish the moving task instead of relying only on the healthcare recipient’s estimate of their ability.

All clinical and medical assessments should be communicated and accessible to the entire healthcare team within the electronic medical record or other acceptable locations based on the type of facility. Siloed documentation and the use of discipline-specific language will prevent other members of the team from accessing key information that may subsequently negatively impact the plan of care.

Upon completion of the implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Construction of an organization-wide system assessment of healthcare recipients in the context of SPHM best practices and which includes a mobility assessment that includes a screening tool appropriate for use and access by all healthcare workers.
- Generation of a standard tool or tools that apply to the healthcare recipient population and individualized to the healthcare recipient.
- Utilization of understandable language within the standard tool(s) used by licensed healthcare practitioners to communicate with everyone concerning mobility and functional limitations.
- Generation and use of a written procedure that outlines how to evaluate a healthcare recipient’s SPHM status, establish goals, select technology for specific care tasks, and address roles and responsibilities of the healthcare worker related to assessment and scoring, evaluation, plan of care, and documentation.

Implementing Standard 6.1.1

1. Develop a written procedure and/or policy including:
• Stepped approach to guide the assessment for SPHM and mobility status, select the appropriate SPHM technology when needed to conduct high-risk care tasks, and communicate mobility status and technology needs throughout the care team.

• Written plan to achieve healthcare recipient mobility goals, e.g., ambulate 50 feet today using technology if needed, as determined by the mobility assessment.

• Roles and responsibilities of the healthcare worker related to assessment and scoring, evaluation, plan of care, and documentation.

• System’s approach to understand the status and needs of the healthcare recipient by designated members of the healthcare team.

2. Utilize a standardized process to match the healthcare recipient’s needs and SPHM and mobility goals with appropriate resources and technology, such as the VA Safe Patient Handling and Mobility Algorithms (VHA, 2016) or the Bedside Mobility Assessment Tool (BMAT) (Boynton, et al., 2014).

3. Include the following in a mobility tool: 1) ability to sit upright without compromise to hemodynamic status; 2) ability to maintain seated balance; 3) ability to transition from sitting to standing; 4) ability to balance while standing; and 5) ability to balance while standing and moving (i.e., stepping back and forth) with or without an assistive device.

6.1.1 TIPS

Using the mobility score (status) as a part of the mobility subscale for skin assessment (i.e., Braden skin assessment) and the fall risk screen (i.e., Morse fall risk tool or another) helps align clinical concepts and adopt SPHM practices as necessary interventions. The systems approach should include the mobility screening tool to ensure positive healthcare recipients’ outcomes.

6.1.1 References


Standard Number 6.1.2 Require initial and ongoing assessment or process to determine SPHM needs. The healthcare recipient will be evaluated for physical, cognitive, clinical, and rehabilitative needs that impact mobility needs, both initially and on an ongoing basis. The outcome of the assessment, evaluation, or scoring system will be incorporated within the individual plan of care.

Introduction: The initial healthcare recipient assessment will determine functional capacity, safety, and needs regarding mobilization. A tool for safe patient handling and mobility (SPHM)
and mobility assessment/screening should be used to establish a previous level of function and
a baseline when the healthcare recipient first presents for care. This information will help guide
appropriate mobility goals and outcome measures for the healthcare recipient. Mobility and
SPHM assessments, evaluations, and scoring systems should be specific to the organizational
setting and context.

Upon completion of the review/implementation of this standard, you/your healthcare
organization should understand and/or demonstrate the following:

• Establishment of plans and tools for use to determine the initial SPHM needs based on a
  full assessment of medical status for SPHM and mobility status or limitations.
• Establishment of methods to evaluate physical, cognitive, clinical, and rehabilitative
  needs that impact mobility, both initially and ongoing.
• Documentation of the healthcare recipient progress with regards to mobility and
  identification of SPHM practices that accommodate the current medical status as well as
  SPHM/mobility goals.
• Incorporation of outcomes of the assessment, evaluation, or scoring system within the
  individual plan of care.
• Adjustment of the goals for mobility as the status of the healthcare recipient changes.
  The mobilization plan should align with the current mobility status and should monitor
  progress.

Implementing Standard 6.1.2

1. Develop a procedure to assess a healthcare recipient’s SPHM needs that affect immobility:
   • Determine a frequency for ongoing assessment of various mobility levels of healthcare
     recipients based on organizational policy supported by evidence-based research and
     best practices.
   • Include provisions for evaluation of physical, cognitive, clinical, and rehabilitative needs
     that impact mobility, both initially and on an ongoing basis, such as those included in the
     Veterans Health Administration (VHA) “Safe Patient Handling Guidebook” (VHA, 2016).
   • Establish a method and designate a location to document findings from the assessment,
     evaluation, or scoring system that is related to the individual plan of care and which may
     be adapted to interdisciplinary documentation, such as documentation consistent with
     American Nurses Association (ANA) “Principles for Nursing Documentation” (Matthews
     & Brufat, 2010).
   • Establish a method for communicating assessment findings as required.
   • Integrate the documentation into the Electronic Medical Records system to provide
     interdisciplinary communication.

6.1.2 TIPS

Please review the sample healthcare recipient screening tool, Figure 6-1, BMAT - Bedside
Mobility Assessment Tool for Nurses. This tool was reproduced with permission from Liko, a
Hillrom Company, and Banner Health ©2013.

6.1.2 References

• Boynton, Teresa, Lesly Kelly, and A. Perez. "Implementing a mobility assessment tool
Standard Number 6.1.3 Include SPHM in the plan of care. The individual plan of care will specify required SPHM technology and methods and expected outcomes. The plan of care should promote the healthcare recipient’s independence or return to baseline as appropriate.

Introduction: The plan of care provides direction to the care team on actions that should be carried out with the healthcare recipient as a part of daily care, when transferred from clinical area to clinical area, and prior to and after discharge. Standards of care need to be adhered to with policies and procedures which will allow for outcomes to be measured and monitored.

Using appropriate, evidence-based decision-making methods to perform specific high-risk care tasks, e.g., turning or boosting a healthcare recipient up in the bed using a lift and repositioning sling, fosters best practices. When such decision-making directly links the healthcare recipient’s safe patient handling and mobility (SPHM) and/or mobility assessment to the task at hand and aligns the guidance to the most appropriate technology to safely complete the care task, healthcare recipient success is facilitated.

For example, a care plan may state to ambulate a healthcare recipient twice daily and increase the distance walked to 200 feet before discharge as the goal or objective. The plan of care should align to the SPHM policy and procedure(s) that direct the care team to use a lift and walking sling to support the healthcare recipient during the activity, allay the fear of falling, and keep the care team safe in the event the healthcare recipient becomes weak or stumbles. In this example, the goal is for the healthcare recipient is to gain confidence and strength as the care team works to assist the recipient with the return to their baseline and/or mutually acceptable levels of mobility and function before discharge.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Integration of SPHM into existing care plans using individualized interventions based on the SPHM and/or mobility assessment and other assessment/screening tools discussed in Standard 6.1.1.
- Support of the standardization of practice by utilization of SPHM technology to promote independence or return to baseline as appropriate in the care plan.
- Inclusion of care teams’ involvement in safely strengthening and mobilizing the healthcare recipient and preventing complications of immobility (e.g., hospital-acquired weakness), as outlined in the care plan.

Implementing Standard 6.1.3
1. Establish a process to link the individual plan of care to SPHM technology and methods such as a clinical pathway or concept map, which incorporates mobility assessment findings,
task to accomplish, and technology and healthcare worker(s) to support the task, as well as a timeline to achieve certain mobility goals.

2. Identify strategies to link the individual plan of care to expected outcomes.
   a. Incorporate data collection into the documentation process, such as with a mobility assessment indicator (e.g., minimal, moderate, maximum), the Braden score for assessment of pressure injury risk, or the Fall Mobility sub-scale used in the facility.
   • Establish a method to analyze collected data with a cross-functional team, recognizing that risk management, quality improvement, occupational health, and other departments are continuously collecting this data; it is then a function of identifying the point of contact for the data and coordinating the distribution of the data.
   • Communicate outcomes data to leadership and clinical teams that have been collected and analyzed to determine whether individual care plans (along with required technology) are meeting expected outcomes. Communication of outcome data may be accomplished through clinical area/unit-based reports, area/unit-based meetings, or individual verbal communication.
   • Manage and monitor outcomes data as necessary for continuous improvement such as activities described in Standard 8.1, to meaningfully link practice to outcomes.

3. Include the mobility/SPHM assessment in each plan of care.

4. Include the healthcare recipient, family members, and visitors in discussions of care plan outcomes to better manage expectations associated with the use of technology and healthcare worker support.

6.1.3 TIPS
The selection of SPHM technology will be based on the individualized needs of the health recipient; the goals; the results of the assessment, evaluation, or scoring system; and the use of algorithms or other decision-making tools. The SPHM technology must be safe, comfortable, efficient, readily available, and appropriate for the task or activity to be accomplished.

The individual plan of care will specify the SPHM procedures, the required SPHM technology, and the parameters for its use. Changes will occur over time with healthcare recipient progression or deterioration.

Recognize mobility as a strategy to return to baseline, an approach consistent with early, progressive mobility practices, pressure injury prevention, and fall prevention.

Standard Number 6.1.4 Address SPHM at transitions of care. The shift report, transfer, or discharge plan will include information and resources for SPHM, as appropriate.

Introduction: Proper communication and conveyance of essential information between clinicians or other members of the health care team must occur during a shift change, and with transitions to a new environment of care, either within the same healthcare organization, to an outside agency or home environment. Proper exchange of information in the form of handoffs will allow for continuity of care, continued improvements in mobility, and greater healthcare recipient safety. Care information on the current state should be documented and available for all healthcare workers who may mobilize the healthcare recipient in any capacity.

The processes for the exchange of safe patient handling and mobility (SPHM) information and resources should be listed in the policies and procedures associated with the SPHM program.
and written into the individual job title processes established through the healthcare organization. Standards should be set for access to SPHM healthcare recipient information and should be made available to all members of the care team.

Optimal communication of mobility status and assessments occur when using shared electronic health records for all members of the health care team to access. Healthcare recipient communication boards must be kept up to date, noting the date and time of entries, with up-to-date information regarding mobility status. Inter-facility and personnel handoff communication should provide a history of the SPHM mobility status, technology used, and goals in the plan of care. This information should be integrated into the form or format used in the handoff.

Handoff communication to an outside healthcare organization/agency should include the mobility status described in terms of the receiving healthcare organization/agency can understand, including all technology types required for use with the healthcare recipient. The availability of SPHM technology should be a factor in determining suitable and appropriate facilities for transfer. For individuals of size, the inclusion of appropriate SPHM technology is critical for successful, safe handoff, and progression of care.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Consistent communication of healthcare recipient’s SPHM needs between all parties responsible for mobility and transition.
- Development of a plan for clear communication of mobility status with change-of-shift and change-of-department handoff communication.
- Redundancy of communication of SPHM/mobility needs by utilization of verbal and written information and posting in areas where all staff responsible for mobility can access.
- Provision of a communication plan for discharge to outside agencies which can be easily understood related to providing the appropriate level of SPHM/mobility care and support technology.

Implementing Standard 6.1.4

1. Develop a written communication tool to address SPHM at transitions of care (i.e., discharge plan).
   - Consider integrating communication processes into existing communication tools.
   - Identify the use of specific SPHM technology.
   - Indicate the response of the healthcare recipient to SPHM technology.

2. Integrate SPHM information/resources into hand-off communications (see Figure 6-2, Downtime Transport Hand-off Checklist. (*Good Samaritan* needs to be deleted)

   • Develop a policy/procedure to incorporate SPHM information and resources, including the specific technology the healthcare recipient has used. As well, include assessment scores such as from the Bedside Mobility Assessment Tool (BMAT) for mobility assessment, the Braden score for assessment of pressure injury risk, and the fall mobility sub-scale used in the facility.
   • Provide processes, such as steps to handoff communication, either verbally, electronically, or in hard-copy form.
6.1.4 References


**Standard Number 6.1.5 Provide a system to resolve healthcare recipient’s refusal.** A system must be developed to address the safety of the healthcare worker and the healthcare recipient if the healthcare recipient refuses the use of SPHM technology.

**Introduction:** Healthcare recipients maintain the right to refuse medical care as a fundamental principle of liberty and healthcare recipient's rights. The right to refuse the use of safe patient handling and mobility (SPHM) technology during care should be thoroughly understood based on risk to the healthcare recipient if proper care cannot be achieved without the use of SPHM technology, and the risk to the healthcare worker and team if technology use is refused. Once education is provided and the healthcare recipient continues to refuse any assistive technology, this should be communicated and documented according to organizational policy.

Healthcare recipient and family education on the use and benefits of SPHM technology and the risk of injury to the healthcare recipient and healthcare workers when technology is not used is critical. This pre-education is necessary to prevent healthcare recipient refusals and is often included in the admission process using various educational resources. It must be noted that the healthcare worker maintains the right of refusal to accept an unsafe assignment as outlined in Standard 1.1.3.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Utilization of a written procedure that addresses healthcare recipients’ refusal of SPHM practices with dignity and concern for care staff.
- Development of educational materials, including scripts that facilitate the education of healthcare recipient and family/visitors on SPHM technology that may be used within the organization, and specifically with them, while emphasizing the impact of technology on their mobility and safety, and the safety of healthcare workers.
- Escalation of refusal through proper healthcare organization channels.

**Implementing Standard 6.1.5**

1. Recognize the value of the risk manager, hospital attorney, and patient service/advocate as individuals who fully understand the liability and risk associated with failure to provide safe care to the healthcare recipient because the recipient refuses to accept SPHM technology. Enlist their assistance when appropriate.

2. Develop a policy to address healthcare recipient refusal.

- Communicate with healthcare recipients using a standard and clear explanation of expectations related to SPHM within the healthcare organization.
- Establish a chain-of-command to address the issue with staff identified (by title) who should have input into the refusal and will make themselves available to address the worker’s and healthcare recipient’s concerns.
• Implement procedures for healthcare recipient refusal which are similar to, and congruent with, healthcare organization-wide policies.

3. Utilize materials and tools that educate healthcare recipients and family members about the use and benefits of SPHM technology as well as risks for both healthcare recipients and staff when SPHM technology is not used when necessary.

4. Reinforce strategies to address healthcare recipient refusal as part of staff education/training. Include communication skills and methods to approach the introduction of technology.

5. Review the use of electronic/written tools to present the SPHM program, in a manner that supports the learning needs of the healthcare recipient, family members, or visitors.

6. Provide clinical area/unit- or discipline-specific appropriate training to establish healthcare worker confidence in technology use, to include hands-on training or information on how to access resources.

6.1.5 TIPS
Keep in mind that a clear explanation delivered in a standard and acceptable format is a strategy for communicating safe handling and mobility expectations with the healthcare recipient. It is helpful to include communication skills and methods to approach the introduction of technology such as determining why the refusal has occurred. For example, does the healthcare worker seem to lack confidence in the use of technology? Should the lift coach or champion introduce technology if the healthcare worker initially lacks confidence? Is there another solution that would better serve the safety of the healthcare worker and recipient?

For more information and tools, see Figure 6-3. BMAT Patient and Family Education; Figure 6-4. Patient Lifts – Communications for Patients; and Figure 6-5. Need a Lift? Patient Lifts – Caring for you or your loved one.

Standard Number 6.1.6 Provide a written procedure on the SPHM tool and plan of care.
The written procedure outlines how to determine a healthcare recipient’s SPHM status, establish goals, select technology for specific care tasks, and address roles and responsibilities of the healthcare worker related to assessment and scoring, evaluation, plan of care, and documentation.

Introduction: Determination of mobility status is a strong driver of clinical care and necessary resources that impact the healthcare recipients’ outcome. Delayed mobility has been linked to several complications of immobility and hospital-acquired conditions that result in healthcare recipient harm and increased length of stay.

Healthcare recipients tend to overstate their ability to mobilize themselves without support or assistance. A simple mobility tool can help the care team consistently recognize mobility challenges. Mobility tools and other safe patient handling and mobility (SPHM) assessments and screening tools facilitate selecting the most appropriate SPHM technology to support a
healthcare recipient’s care task such as boosting, turning, transferring, standing, and ambulating.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Implementation of a written procedure for an SPHM-focused plan of care.
- Practicable utilization of the written procedure by all healthcare workers who move, transfer, handle, and mobilize the healthcare recipient.
- Clear application of the written procedure to the healthcare recipient population served.

**Implementing Standard 6.1.6**

1. Develop a written procedure for a care plan that includes:
   - Plan and tools to assess a healthcare recipient’s mobility level and SPHM status to select appropriate SPHM technology for specific care tasks and establish healthcare recipient goals.
   - Roles and responsibilities of healthcare workers related to assessment and scoring, evaluation, plan of care, and documentation.
   - Guidance for the safety of both the healthcare recipient and the healthcare worker.

2. Implement the use of an assessment or screening tool that will match healthcare recipient needs and goals with SPHM technology, such as the VA Safe Patient Handling and Movement Algorithms (VHA, 2016) or Bedside Mobility Assessment Tool (BMAT) (Boynton, et al., 2014).

**6.1.6 TIPS**

Use of the mobility score as a part of the mobility subscale for skin assessment (i.e., Braden skin assessment) and the fall risk screen (i.e., Morris fall risk tool or other) helps align clinical concepts and adopt SPHM practices as necessary interventions.

**6.1.6 References**


**Standard Number 6.1.7 Support safe delegation of SPHM tasks and activities.** The organization will support the delegation or assignment in a manner consistent with its state’s practice act or other legislation governing licensure.

**Introduction:** In accordance with the “Scope and Standards of Nursing Practice” [American Nurses Association (ANA), 2015], a healthcare recipient assessment cannot be delegated to a non-licensed care team member. Delegation of care activities such as screening, toileting, hygiene, and ambulation can be delegated to a non-licensed care team member. In the absence of a registered nurse to complete a mobility assessment, the facility must determine the best practice and how to assess/screen for the mobility deficits of the healthcare recipient. All healthcare workers should receive education on how to screen for and recognize mobility...
challenges. Any change noted in healthcare recipient status or concerns should be reported to
the nurse, physical therapist, and/or occupational therapist for further evaluation. The mobility
challenges (deficits) of the healthcare recipient will guide the healthcare team in the selection
and use of the most appropriate lifting technology. The healthcare team should always default to
the safest way to complete the care activity.

Upon completion of the review/implementation of this standard, you/your healthcare
organization should understand and/or demonstrate the following:

- Utilization of a plan to delegate SPHM tasks to appropriate staff.
- Provision of guidelines outlining the SPHM programs adherence to relevant legislation,
i.e., the “Scope and Standards of Nursing Practice” (ANA, 2015).
- Determination of practice for conducting mobility assessments in the absence of a
registered nurse.

Implementing Standard 6.1.7

1. Evaluate the delegation of SPHM tasks and activities as to whether they are in keeping with
the healthcare worker's training, experience, education, and license.
2. Recognize and abide by state practice acts.
3. Recognize and abide by legislation governing licensure.
4. Recognize and abide by specific regulations pertaining to unlicensed personnel.
5. Recognize and abide by SPHM legislation (state/national) pertaining to tasks and activities.

6.1.7 TIPS
Screening tools are sometimes differentiated from assessment tools and might be considered in
areas where a registered nurse is not available to assess the mobility level of the care recipient.

6.1.7 References
  Retrieved October 30, 2020, from https://www.lindsey.edu/academics/majors-and-
  programs/Nursing/img/ANA-2015-Scope-Standards.pdf

HEALTHCARE WORKER STANDARDS

Standard Number 6.2.1 Perform initial and ongoing assessment of mobility and SPHM
needs. The healthcare worker will perform initial and ongoing assessments of mobility and
SPHM needs, as per organizational policy.

Introduction: Mobility status can change frequently, and it is every healthcare provider’s duty to
assess/screen for mobility and safe patient handling and mobility (SPHM) status changes before
performing the care task at hand, such as mobilizing a healthcare recipient. This provides safety
for both the healthcare recipient and the healthcare provider.

The organization is responsible for training the healthcare worker regarding SPHM assessment,
policy, and procedures, including the use of mobility and/or SPHM technology. It is also the
responsibility of the healthcare worker to ensure that they receive this training. The healthcare
worker must be able to demonstrate comprehension and be competent in accordance with their
job responsibilities. The healthcare worker is responsible for using the appropriate technology and following the organizational SPHM policy and procedures.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Integration of the healthcare organization SPHM/mobility assessment/screening tool with a systems assessment of a healthcare recipient’s clinical status for safe mobilization specific to the type of organization, the department, specialty, and healthcare recipient population.
- Implementation of a training program for all healthcare workers who perform high-risk care tasks including mobilization of healthcare recipients.

Implementing Standard 6.2.1

1. Research and approve the SPHM/mobility assessment/screening tool(s) you plan to use.
2. Include guidance when developing tool(s) based on the Patient Handling and Mobility Assessments (PHAMA) (Matz, et al., 2019) and/or other resources.
   - Perform an initial overarching medical assessment concerning mobility and communicate findings (i.e., medical record as indicated).
   - Perform ongoing assessment per policy or as indicated based on professional judgment and change of healthcare recipient's medical status.
3. Ensure communication of mobility status is available for all healthcare workers to access/view and notify healthcare recipients of any change in procedures.
4. Train healthcare workers on the use of the technology(s), as necessary for safety and progressive healthcare recipient mobility. Training will include hands-on use of the assessing/screening tool and technology for SPHM.

6.2.1 TIPS
The healthcare worker should always inform the healthcare recipient and family of the reason the tool is used and request the healthcare recipient perform instructions related to the tool to the best of their independent ability.

6.2.1 References

Standard 6.2.2 Communicate with the healthcare recipient and family. The healthcare worker will educate the healthcare recipient and family, as appropriate, about the purposes and safe use of SPHM technology.

Introduction: Being in the healthcare system can be a stressful event for a healthcare recipient and family members. The healthcare process itself is usually unfamiliar and can result in fear and stress for the healthcare recipient. Clear and frequent communication with the healthcare recipient and family throughout the process is a key element for quality care and healthcare recipient satisfaction and cooperation.

Safe patient handling and mobility (SPHM) communication must also be a part of the overall care plan. The organization should have a plan of communication that starts on entry into the
system regarding the SPHM process and the use of technology. The SPHM communication plan should continue throughout the healthcare recipient’s stay, and all care team members should be aware of the communication and any changes that occur. When still required, SPHM technology recommendations and instructions should be given to the healthcare recipient and family, and to any discharge healthcare organization.

When the healthcare recipient and their family are included in communication there is a better opportunity for cooperation and collaboration, including mobility goals. A healthcare recipient will be less likely to refuse the use of SPHM technology if they can participate in goal setting and understanding how technology can assist them to meet their goals.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

• Communication with the healthcare recipient and family members regarding the need for SPHM as a component of the care plan.
• Communication with the healthcare recipient and family members regarding the SPHM process and technologies that may be included in the care of the healthcare recipient.
• Attainment of established care plan goals related to the integration of SPHM technology through cooperation with the healthcare recipient and family members.

Implementing Standard 6.2.2

1. Utilize organizational marketing, patient care services, clinical departments, customer relations, end-users, and others to create meaningful communication materials that include an organization-wide story to share with the healthcare recipient and family members.

2. Upon or prior to admission, provide a means of communication to ensure the healthcare recipient and family members understand the process for SPHM and technologies that may be utilized during treatment/stay. This can be accomplished in several ways.
   • Written information about the SPHM program in welcome brochures or as informational brochures in waiting rooms.
   • Informational videos available in areas that may be accessed by both the healthcare recipient and the family.
   • Direct verbal communication as part of healthcare recipient education on admission or at the start of care which explains the SPHM rationale and technology.
   • Real time communication when the healthcare recipient’s mobility status changes indicating a need for a change in the use of technology or resources.

6.2.2 TIPS

Communication should be in a format and manner appropriate to the language, education, and cognitive level of the individual healthcare recipient and family. Consider a read-back approach to healthcare recipient education to ensure understanding and use of varied communication methods.

Communication should include a rationale for why the technology is being used, stressing the healthcare recipient safety as well as the safety of the healthcare worker. Every time the technology is introduced, the healthcare worker should communicate what is happening, why, and guide the healthcare recipient verbally throughout the process of mobilization. The healthcare recipient should be an active participant throughout the process being able to ask questions and give their input.
Below is a link to a sample patient education video that was developed by Hillrom™ to help educate healthcare recipients and their families when admitted to a facility.
[https://youtu.be/sc2jcM4Bf9A](https://youtu.be/sc2jcM4Bf9A)

For an example of an SPHM educational tool for healthcare recipients, please view Figure 6-6.

Gundersen Health System is a Safe Lifting Zone!

**Gundersen... Safe Lifting Zone!** Fig 6-6

**Standard Number 6.2.3 Address SPHM at transitions of care.** The healthcare worker will include SPHM in shift reports, transfer reports, and discharge planning.

**Introduction:** Communication of the healthcare recipient’s mobility status during transitions of care, handoffs, and in preparation for discharge, is an essential part of safety for both the healthcare recipient and the healthcare worker. The Joint Commission (TJC) cites inadequate communication as one of the most frequent causes of medical errors. Special attention must be paid to the quality of content, standardization, and exchange of pertinent information.

During discharge planning, the healthcare recipient’s mobility status and technology needs must be taken into consideration. This should include appropriate vehicles, technology, and trained personnel for transportation. At the discharge site, appropriate technology and trained personnel that can handle the level of mobility assistance required must be available. Poor planning results in inappropriate delays in transfers, care, follow up, and could result in injuries to healthcare workers and harm to healthcare recipients.

During outpatient visits, plan for transport into/out of the healthcare facility and into/out of exam and other rooms for medical appointments/treatments. Unplanned and lack of support for healthcare recipient mobility can present problems in an ambulatory setting with limited resources. An ambulatory care organization should have policies and procedures that address all situations and circumstances, such as requiring transport or appropriate means of egress for internal and external movement if the family or healthcare recipient is unable to assist.

Ensuring a solid plan at all steps of discharge and treatment can alleviate barriers and allow for the proper and timely planning of resources.

**Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:**

- Inclusion of safe patient handling and mobility (SPHM) status in shift reports, transfer reports, and discharge planning generated by healthcare workers.
- Documentation of the transfer of information regarding healthcare recipients’ mobility status and SPHM technology needs across shifts, departments, and post-discharge.

**Implementing Standard 6.2.3**

1. Provide information about SPHM technology, necessary tasks/skills, and assessment/screening scores during transitions of care.
- Provide policies and procedures that ensure healthcare worker and healthcare recipient safety and that address all levels of care, SPHM and mobility needs, and transportation.
This will ensure the care destination staff or co-workers during the next shift are knowledgeable of the healthcare recipient’s level of need.

- Provide written information per organization policy, such as a “Ticket-to-Ride” for transfers to imaging, surgery, or other specialty departments.
- Provide verbal communication per organization policy during the bed-side report, during a change of shifts, or verbal communication to another clinical area/unit.

2. Include the SPHM plan of care in discharge planning; this can be accomplished using the hard-copy or electronic discharge planning form or other communication documents.

3. Include the SPHM plan of care at each transition of care, such as from long-term care or transitional care to home care, from special education to the public-school setting, or from home care to an assisted living facility. This can be accomplished verbally, electronically, via the medical record and/or other Health Insurance Portability and Accountability Act (HIPAA) protective documentation approved by your healthcare organization.

6.2.3 TIPS
Consider the healthcare recipient who is independent upon admission to pre-op, undergoes surgery, and is admitted to surgical intensive care where they are no longer independent. The healthcare team, including physical therapy, will incorporate activities and may utilize SPHM technologies designed to return the healthcare recipient to their previous level of function while they progress from the intensive care unit to the medical-surgical unit to home or other long term or non-acute facility.

Some areas in the acute care hospital have their own guidelines for SPHM such as the standards developed by the National Association of Orthopedic Nurses (Sedlak, et al., 2009) and the Association of periOperative Registered Nurses (AORN, 2007).

As a physical therapist, I can recall from years ago how discharge planning often lacked a clear communication on what needs were necessary for mobility at the point of discharge. One time that comes to mind was when I was a new physical therapist and there was a discharge from our transitional care unit, with the patient going home. The patient was only a marginal household ambulator, meaning that they could walk a few feet with a walker with independence. In spite of the family being involved during treatment, the day of discharge they showed up with a motorhome! I remember having five to six people who had to help lift the patient upstairs and through a narrow passageway into the back of this vehicle. We had no SPHM technology available to assist with this type of transfer and we were expected to provide the care. It was a miracle the patient and staff were not injured!

Later in my career, working on injury prevention, I stressed with departments the importance of this planning, especially on the orthopedic units. Too often, “grandma” was picked up after her total hip replacement by a kindhearted family member in a huge 4 x 4 truck or other SUV that made transfer close to impossible. I witnessed too many staff injuries happening, usually with nursing assistants or transporters, who were tasked with this job. Good mobility planning can prevent this from happening!

6.2.3 References
- Sedlak, Carol A., Margaret O. Doheny, Audrey Nelson, and Thomas R. Waters. "Development of the National Association of Orthopaedic Nurses guidance statement on

**Standard Number 6.2.4 Delegate care tasks in a safe manner.** The healthcare worker will ensure that delegation or assignment of SPHM tasks is completed in a manner consistent with state professional practice acts or other applicable laws or regulations.

Introduction: As noted in the National Council Licensure Examination® (NCLEX®) registered nurse (RN) examination review document, healthcare recipient needs, staff skills, staff position or job description, healthcare organization policies and procedures, and legal aspects of care must be incorporated in decision-making to ensure successful and safe delegation of care tasks (RegisteredNursing.org, 2020).

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Delegation or assignment of safe patient handling and mobility (SPHM) tasks are to appropriate staff, in accordance with state professional practice acts or other applicable laws or regulations.
- Education of the team on proper and improper assignment or delegation is in accordance with applicable laws and regulations.

**Implementing Standard 6.2.4**

1. Identify state professional practice acts or other applicable laws or regulations about delegation or assignment of tasks. Professional practice acts can be found electronically, or the risk manager or compliance officer may provide guidance as to applicable laws or regulations. Unions representing healthcare workers are often very well informed on these statutes and are forthcoming with this information. The organization or health system’s attorneys can be valuable partners if resources allow.
2. Identify job descriptions, policies, or procedures of the organization that pertain to delegation or assignment of tasks.
3. Inform healthcare workers, through organizational policy and procedures, to refer to the SPHM/mobility assessments/screening documentation and care plan to provide the safest, individualized, and most appropriate approach of providing care to prevent injury to the healthcare recipient and the care team.

**6.2.4 References**


**Standard 7 – Include SPHM in Reasonable Accommodation and Post-Injury Return to Work**

**EMPLOYER STANDARDS**
Standard Number 7.1.1 Facilitate the employment of disabled workers. The organization will have a system to match the physical capability of an injured healthcare worker to the physical demands of a job. The use of safe patient handling and mobility (SPHM) technology is one strategy to facilitate the employment of disabled or injured workers.

Introduction: Facilities should have a system in place where the physical capability of an injured healthcare worker can be compared to the physical demands of a job. If this process is not in place, the injured healthcare worker may return to work when he/she does not have the physical strength or endurance to perform specific tasks of the job, potentially resulting in re-injury. The use of safe patient handling best practices can facilitate this process and provide a safer return to work as it reduces the manual handling involved in most healthcare tasks/transfers when technology is used.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Utilization of an organizational system that matches the limitations of injured staff returning to work with appropriate tasks.
- Training of injured staff on SPHM best practices and/or use of technology, when appropriate.

Implementing Standard 7.1.1

1. Establish a method to evaluate physical limitations of the healthcare worker and ensure that the method is compliant with the Americans with Disabilities Act (ADA, 1990).
2. Identify the physical demands of the job, e.g., pushing, pulling, and lifting. Healthcare workers, under ideal circumstances, should lift no more than 35 pounds (Waters, 2007).
3. Establish a process to match an injured healthcare worker to the physical demands of the job:
   - Utilize ergonomic analyses, when appropriate.
   - Review SPHM technology, e.g., lifts, slings, and transfer slides.
   - Train employees in SPHM skills e.g., sling selection, selection of appropriate transfer devices, use of full-body lateral rotation air support as an adjunct for turning, and others.

For templates to aid in return-to-work (RTW) physician referrals, see Figure 7-1, Functional Capacity Evaluation (FCE) Physician Referral Form; Figure 7-2, Initial Doctor Referral Letter; and Figure 7-3, FCE Referral Process.

7.1.1 TIPS

Conducting a return to work (RTW) plan can be challenging when trying to carefully match a healthcare worker’s capabilities to the physical demands of a job. If the functional ability evaluation does not accurately simulate the worker’s daily tasks, then the data collected will not accurately depict the true efforts needed to complete the tasks. We know that sling application, log rolling a healthcare recipient in bed, lateral transfers using a draw sheet, and performing sit-to-stand tasks are all high risks. There is data that quantifies how much force is required for these tasks (Baptiste, A, 2011). The National Association of Orthopaedic Nurses (NAON) has
published guidelines for safe transfers for orthopedic staff and the Perioperative Nurses Association (AORN) has done the same for operating rooms (Sedlak, et al., 2009; Link, 2018). These should be used as guidelines in the RTW process.

Waters (2007) determined that 35 lbs. was the maximum safe lifting limit for patient handling, but only under ideal situations (Waters, 2007). However, the majority of healthcare recipient handling situations are far less than ideal. This understanding led to National Institute for Occupational Safety and Health (NIOSH) scientists agreeing with patient handling professionals that the purpose of safe patient handling programs should be to eliminate all manual lifting [Centers for Disease and Control Prevention (CDC), n.d.].

An ergonomic analysis can assist in establishing the physical demands of a job or task. If there is no way to objectively quantify the necessary tasks, then it is a guessing game as to whether the healthcare worker has the strength and physical capabilities to return to that job. However, in the nursing profession, many if not all of the patient handling tasks have been researched and deemed high risk to perform manually. The use of patient handling lifts and devices such as lateral transfer aids is the only solution to reduce the risk of re-injury as they significantly lower the amount of injurious forces on the healthcare professional.

The following is an example that demonstrates the use of safe patient handling technology as a solution to safely returning an injured healthcare worker to work.

Deanne, a 45-year-old registered nurse (RN) injured her lower back when she performed a sit-to-stand transfer of a healthcare recipient who was six feet tall and weighed 275 pounds. During the transfer, his legs buckled as he stood up. In an attempt to prevent a fall, the healthcare worker tried to catch him. In doing so, she pulled her lower back muscles. Deanne had to seek medical treatment, and upon returning to work, she participated in an RTW plan which included a functional capacity evaluation where her strength and endurance were tested in various simulations of job tasks. This simulation of job tasks was done to determine if her physical capabilities matched the physical demands of the job.

To find out the job demands, an ergonomic analysis was conducted of all the sub-tasks of her job duties. Measurements were taken of push/pull forces and lifting capabilities/limits. A physical demands analysis was also conducted. Results indicated that her lifting limit was 20 pounds from the floor to 41” height, and 18 pounds from waist to shoulder level. The job requirements are 60 pounds from the floor to a 41” shelf, and 40 pounds from waist to shoulder height. Based on her physical limitations, Deanne was able to perform some of her duties but not all. She was required to incorporate the use of technology-based on her physical limitations. Her abilities were less than the requirements for the lifting and carrying aspects of her job as indicated below in an excerpt from her functional demand analysis report, adapted from the WorkWell Functional Capacity Evaluation (WorkWell, 2011).

<table>
<thead>
<tr>
<th>LIFTING AND CARRYING</th>
<th>Client’s abilities</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor to 41 inches shelf lift of 60 lbs. frequently</td>
<td>20 lbs. rarely 20 lbs. occasionally</td>
<td>Low back weakness and pain</td>
</tr>
<tr>
<td>Waist to shoulder lifting of 40 lbs.</td>
<td>18 lbs. rarely 15 lbs. occasionally</td>
<td>Low back weakness and pain</td>
</tr>
</tbody>
</table>
In her RTW training, Deanne learned about the appropriate and proper use of safe patient handling technology as well as her physical limitations. She learned that after assessing the healthcare recipient who fell, Deanne could have used either a minimal or moderate assist sit-to-stand lift to help transfer him from bed to chair. Both technological options would have been safer than the independent manual transfer she used.

7.1.1 References


*Standard Number 7.1.2 Monitor healthcare worker injuries associated with patient handling and mobility.* Monitoring will include determining the frequency, severity, and cost of healthcare worker injuries associated with lifting, transfers, repositioning, and mobility. Data will be used to prevent future injuries.

**Introduction:** Careful monitoring of healthcare worker injuries associated with patient handling and mobility is vital because the organization can be proactive in identifying locations and job tasks that pose risks. Solutions to eliminate or reduce the number of injuries must be in place to decrease workers’ compensation costs.

Frequency, severity, and cost data associated with patient handling injuries should be monitored. This should be expanded to include the intersection of healthcare recipient falls and/or pressure injuries with patient handling injuries. All relevant stakeholders, e.g., patient safety, occupational health, employee safety, nursing, and others, should convene for related discussions. The electronic medical record should integrate these three so that opportunities for a fall assessment trigger use of safe patient handling technology and the same for pressure injury management. Data can be monitored to identify risks for both healthcare recipients and caregivers.
Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Organizational ability to produce a current snapshot as well as trends of healthcare worker injuries associated with patient handling and mobility to reduce the number and severity of future injuries.
- Assessment of patient handling events in the context of larger trends that consider tasks, locations, and patient populations that correlate with risk.

**Implementing Standard 7.1.2**

1. Recognize that a standard, accepted format for recording occupational injuries is in place, in the form of Occupational Safety and Health Administration (OSHA) 300 logs. However, recognize that the data is limited and does not include minor injuries/discomfort. Facility injury data is also useful for the identification of occupational injuries associated with patient handling and includes all injuries, minor and serious. These two, in conjunction with worker’s compensation data, provides a comprehensive picture of healthcare worker risk. Injury data include frequency and severity, in addition to costs over time per injury.

2. Identify, by title, the individual(s) within the organization who manage healthcare worker injury data associated with healthcare recipient lifting, transfers, repositioning, mobilization, and other high-risk tasks. Slips, trips, and falls may also count as healthcare recipient-related if linked to patient handling.

3. Collect baseline healthcare worker injury data and trend injuries over time. Gather data on injury:
   - Frequency.
   - Severity (i.e., number of lost time injuries, total number of days of lost time for all injuries, number of modified duty injuries, and total number of days on modified duty for all injuries).
   - Cost.

4. Analyze data for purposes of meaningful injury management once the Safe Patient Handling and Mobility (SPHM) program is in place and aim to:
   - Reduce frequency.
   - Reduce severity.
   - Reduce costs.

5. Recognize that even though the frequency of injuries is likely to increase at the beginning of an SPHM program due to increased reporting of injuries, severity and therefore costs can be expected to decrease. Review Chapters 1 and 4, *Patient Handling and Mobility Assessments* (PHAMA), 2nd edition, for more detailed information related to patient handling injuries (Matz, et al., 2019).

**7.1.2 TIPS**

Standard 8 discusses how to establish a comprehensive evaluation system. Such a system includes identifying data sources and outcome measures that are quality indicators. These quality indicators are inter-related with, and often reflect, healthcare worker injuries.

The organization should utilize evidence-based methods for data collection and analysis but should also consider conducting a root cause analysis (RCA) after a healthcare worker’s injury. When feasible, the utilization of an RCA is an integral post-injury analysis that establishes facts and factors at play to make changes, if necessary. Understanding the root cause will expose latent errors and contribute to creating a more highly reliable organization.
OSHA provides an online packet of forms for employers in regulated entities to record occupational illness and injury. The OSHA 300 Log is a primary resource for the evaluation of an SPHM program. Entities not regulated by OSHA may be subject to a state plan or other industry-specific regulation and will use a standard, accepted format for recording occupational injury and illness [Department of Labor (DOL), n.d.]. Consistency in definitions, measures, and collection techniques is critical for obtaining meaningful, actionable data. The Bureau of Labor Statistics (BLS) provides industry-wide comparative data on occupational injuries. The data can be used for benchmarking, although the government definitions should be compared closely with the organizational definitions.

Some healthcare facilities have developed a specific incident report for their safe patient handling program that includes sub-categories, e.g., repositioning, transporting, laterally transferring, and others. This granularity provides the organization more information to determine what activity was involved in a majority of injuries, facilitating the institution of control measures for that primary cause.

Sometimes, organizational issues impact the occurrence of a healthcare worker injury. For instance, a healthcare worker’s injury may be due to lack of technology on a clinical area/unit; therefore the caregiver proceeds with the manual healthcare recipient transfer and sustains an injury. In this case, the facility is at fault for not providing an adequate supply of technology to maintain a safe environment of care for their healthcare workers. This highlights the importance of examining the entire situation and conditions surrounding an injury. This facilitates finding the root causative and contributory factors so modification(s) can be instituted in an effort to decrease further risk of injury.

The following is an example that relays the importance of avoiding injury monitoring in silos.

Betty is taking care of her healthcare recipient who is at risk for pressure injuries and falls. She needs to be transferred from bed to commode. Betty correctly uses the floor-based lift but fails to protect the healthcare recipient’s skin during the transfer. The healthcare recipient has a stage two (2) pressure injury under her leg, and during sling application, shouts out in pain when the edge of the sling touches the affected area. If the electronic medical record had integrated pressure injury, falls and safe transfers, Betty would have been reminded that this healthcare recipient requires friction-reducing devices for all bed mobility, including sling application.

This example highlights the importance that monitoring should not take place in a silo, but stakeholders who work to reduce falls and pressure injuries should be working together with those working to reduce injuries associated with patient handling.

7.1.2 References

**Standard Number 7.1.3 Facilitate early return to work following injury.** The employer will establish, implement, and sustain a process to help injured healthcare workers return to work as quickly as possible to jobs that are medically suited to their needs. The process will be managed to ensure that restrictions are honored, preventing harm, and expediting recovery during the restricted work activity period.

**Introduction:** If a facility does not have a transitional return to work (RTW) process, it leads to a delay in return to work following an injury. This is a result of a lack of effective communication strategies between employee health, human resources, employee-manager/s, and the safe patient handling program manager/members. As part of the transitional RTW process, educational information and job retraining must be based on findings from the post-injury investigation report. This report should be used for injury prevention as well as progressive recovery from the injury.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Utilization of a consistent transitional return to work process involving essential stakeholders that facilitates the return to work as quickly as possible to jobs that accommodate the individual limitations of injured healthcare staff.
- Management of the return to work process so that physical limitations are integral to a return to work plan that facilitates recovery and prevents additional harm.

**Implementing Standard 7.1.3**

1. Involve human resources, employee health, occupational medicine, patient care, and other integral services in safe and early return to work strategies.
2. Establish, implement, and sustain a process to help injured healthcare workers return to work as quickly as possible to jobs and activities that are medically suited for their needs.
   - Identify ergonomic opportunities (see Standard 7.1.1).
   - Recognize medical restrictions.
3. If available and feasible, utilize a standardized functional capacity screening process to determine the highest level of functional job description the employee can return to safely.
   For an example of a Functional Capacity Evaluation (FCE), please see the WorkWell sample (WorkWell, 2011).

**7.1.3 TIPS**

Return to work processes includes practices that are necessary to help determine the highest level of functional tasks the employee can perform. These should not only evaluate the ability of the employee to perform the task(s) but should also test the ability of the employee to perform the task in a relatable number of repetitions and over the length of time of the work shift.

The organization may find consultation with a subject-matter expert helpful. Insurance brokers and companies that provide worker’s compensation and/or disability insurance may be helpful as they employ staff with expertise in return to work programs.

**7.1.3 References**

HEALTHCARE WORKER STANDARDS

**Standard Number 7.2.1 Notify the employer of physical limitations or restrictions.** The healthcare worker will notify the employer of any physical limitations and provide up-to-date medical documentation of physical limitations or restrictions.

**Introduction:** When a healthcare worker is transparent about their health status, medical, cognitive, emotional, or physical, the healthcare organization can utilize their strengths, protect their vulnerabilities, and partner with them in improvements, if possible. However, when a healthcare worker chooses to misrepresent their physical abilities, emotional state, and/or medical conditions, they may be asked to perform tasks that exceed their capabilities, potentially resulting in an unnecessary injury.

Lack of specificity and objectivity in the return to work (RTW) plan, quite often results in the inability of the employee health professional to initiate the preliminary steps with appropriate stakeholders in facilitating a safe transitional return to work. If the employee does not accurately express elements such as pain or discomfort, that employee may be returned to work while they are predisposed to an injury. In cases where an employee is making maximum efforts to return to work due to financial or personal reasons, the possibility of under-reporting of discomfort may occur.

Functional screening may be used to determine the physical status of a healthcare worker before and after an injury. During the screening, the healthcare worker should be monitored for any expressive signs of pain and/or discomfort while the employee performs a task, along with any and all compensatory movement patterns exhibited which may be a result of pain or weakness.

Prior to the screening process, a thorough and specific discussion should be held with the employee regarding the significant risk they will expose themselves to, along with the potential for long-term impact, if they do not communicate pain, discomfort, or inability when performing the screening tasks.

**Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:**

- Open communication from healthcare workers of any physical limitations or other medical concerns when first employed and/or when they surface after employment.
- Open communication from injured healthcare workers who are involved in return to work programs.
- Open and continual communication from injured healthcare workers regarding the monitoring and progress of rehabilitation goals.

**Implementing Standard 7.2.1**

1. Make healthcare workers aware of facility-specific policies for notifying their employer of any physical limitations.
2. Provide up-to-date medical documentation.
   - Identify occupational restrictions. e.g., cognitive, physical, or other limitations.
   - Identify any limitations, e.g., lifting limits, activity intolerance over the expected time of the work shift, or specific movements or tasks that may result in pain and discomfort to the level of causing a vulnerability for a re-injury.
3. Monitor the progress of rehabilitation goals which are developed based on the functional job description of the employee.

For a sample Functional Capacity Evaluation (FCE) questionnaire for supervisors, see Figure 7-4, Functional Capacity Evaluation Job Questionnaire: Supervisor.

(INCLUDE FCE QUESTIONNAIRE HERE). Fig 7-4

7.2.1 TIPS
Upon the employee’s return to work, the employee should meet regularly with the Safe Patient Handling and Mobility (SPHM) program manager/team members regarding their health status. The employee must be educated in advance that they are expected to proactively report any change in activity tolerance from the time that the functional screen took place.

Standard Number 7.2.2 Participate in the return to work plan. The injured healthcare worker will be accountable for complying with the medical treatment plan and for returning to work in a role that accommodates medical restrictions.

Introduction: Success of a return to work (RTW) plan is dependent upon the cooperation and partnership among workers, employers, and healthcare providers with a common goal of returning the injured healthcare worker to employment. The healthcare worker must participate in this process to successfully achieve their return to work. They must comply with their medical treatment plan and the level of activities recommended.

Workplace culture may foster hiding true abilities due to pressure from colleagues or superiors to return to the job faster, before they are ready. If the injured healthcare worker fails to communicate discomfort during or true tolerance to certain activities/tasks, then the RTW team may not find them a suitable modified job that accurately matches their physical capabilities.

Healthcare worker compliance in the organizational formal return to work plan will benefit not only the injured healthcare worker, but their co-workers, the organization, and healthcare recipients.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Healthcare worker compliance in the organizational RTW program.
- Education of the injured healthcare worker regarding the need for them to fully participate in the RTW process.
- Rewarding injured healthcare workers’ participation in RTW programs.

Implementing Standard 7.2.2

1. Relay barriers in the RTW process.
2. Request reasonable accommodation from the employer, if necessary.
3. Report any further injuries promptly.
4. Stay in contact with healthcare providers.
5. Attend all medical treatment appointments.
6. Follow medical restrictions both on and off the job.
7. Accept transitional work (modified or alternate work duties) as provided by the employer if you are unable to return to your pre-injury job.

8. Communicate any physical problems you may have with transitional work.

### 7.2.2 TIPS

In a systematic review of the literature, published in 2016, the authors looked at various factors that affect return to work after an injury or illness. Findings were based on the synthesis of 56 systematic reviews that met their criteria. This article lists principles for successful return to work that were previously established for musculoskeletal disorders by the Institute of Work and Health in 2007. These include: (1) strong workplace commitment to health and safety; (2) work accommodation; (3) support of the returning worker without disadvantaging co-workers/supervisors; (4) supervisors training in work disability prevention and included in RTW planning; (5) early and considerate contact with injured/ill workers by the employer; (6) RTW coordination; and (7) communication between employers and healthcare providers about the workplace demands”. These guidelines were intended for all workplaces and RTW professionals (Cancelliere, et al., 2016, p. 2).

Many documented barriers prevent an injured healthcare worker from a successful return to work (Grant, Joanne, Froud, Underwood, & Seers, 2019). In 2001, 826 nurses across the U.S. participated in the American Nurses Association (ANA) (2001) survey of the health and safety of nurses. Approximately 30% of injured nurses failed to report their injuries because they: (i) “Didn’t think the injury was significant; (ii) Were too busy; (iii) Feared retribution; (iv) Were not encouraged to report the injury and seek treatment; (v) Had no one to cover for them; and (vi) Had no mechanism for reporting injuries” (Suban & Moylan, 2007, p. 19).

A solution is to implement an RTW policy, which stipulates open communication among all involved, including the injured healthcare worker. Such a policy should include safety inspections and accident investigation procedures that provide healthcare workers and healthcare organizations with solutions/tools for reducing and eliminating workplace injuries and illnesses. The following may be helpful resources:


### 7.2.2 References

Standard 8 – Establish a Comprehensive Evaluation System

EMPLOYER STANDARDS

Standard Number 8.1.1 Establish a comprehensive evaluation system.
The organization will establish a comprehensive evaluation and performance/quality improvement system during the planning phase, based on the goals and objectives of the SPHM program. Formative and summative evaluations will be performed, including process and outcome measures. Evaluations will be conducted regularly. The program evaluation methods will change depending on the maturity of the SPHM program. A mechanism will be used to provide organizational leadership and key stakeholders with the results of these analyses. Positive outcomes will be emphasized, and remediation plans will be developed for substandard outcomes.

Introduction: "What gets measured gets done," said Jack Welch, former Chairman, and CEO of General Electric. The healthcare industry has many stakeholders who have expectations regarding care provider performance. Identifying those stakeholders, their expectations, and developing systems to evaluate the meeting of expectations is a critical step in assuring continuous performance/quality improvement.

The American Industrial Hygiene Association (AIHA) has a process they call the “Value Strategy” (AIHA, n.d.). It is well-grounded in generally accepted business practices, familiar to, and routinely used by corporations. The strategy is a decision logic and framework to help health, safety, and environmental professionals develop a business argument to support their control measures or program recommendations. It is one tool available to establish and maintain a comprehensive evaluation system. It has been used to build the business case for effective Safe Patient Handling and Mobility (SPHM) programs.

The Occupational Safety and Health Administration (OSHA) has a “Safe Patient Handling Self-Assessment Checklist” (find as Figure 8-1) and on their website [Department of Labor (DOL), n.d.]. This sample advisory checklist highlights many of the important components of an SPHM program or policy, including development, management, and staff involvement, needs assessments, technology, education and training, and evaluation. You can use the checklist to help identify those components of your SPHM program or policy that are well developed, as well as those that need further development.

The International Organization for Standardization (ISO) 45001, Occupational Health and Safety Management Systems – Requirements with Guidance for Use (ISO, 2018) provides a process for protection that discusses seven factors (context of the organization, leadership and worker participation, planning, support, operation, performance evaluation, and improvement) considered necessary for the presence of effective programs.
The potential ergonomic risk to healthcare workers arising from the handling and movement of healthcare recipients, and the resultant reduction in the ability to provide quality care to healthcare recipients, is well documented. The AIHA publication, *The Facts About Ergonomics: Dispelling Myths* (AIHA, 2019), provides evidence regarding ergonomic risk as well as successful risk reduction approaches (find as Figure 8-2). *Insert Facts About Ergonomics....*) *Ode to a Healthcare Worker* (see Figure 8-3) provides a discussion of this risk. *(Insert Ode to HCW Here)*

Each of these documents, along with these current SPHM Standards and associated guidance, serve as resources in helping you to develop your system.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Establishment of a system detailing program metrics and evaluation criteria.
- Establishment of a system for recording and comparing program data over time.
- Institution of a process to report these findings at regular intervals to stakeholders and leadership.

Implementing Standard 8.1.1

1. Guarantee quality/performance improvement during planning phases (see Standard 1.1.1) by ensuring SPHM goals and objectives align with other safety initiatives of the organization. Consider early progressive mobility initiatives that serve long- and short-term healthcare recipient quality indicators. Without an SPHM culture of safety, this practice can be a threat to healthcare worker safety. Or, consider a new customer service initiative at the outpatient center which includes free valet parking. However, employees may be asked to assist visitors and healthcare recipients from their vehicles without mechanical technology or training, which poses a threat to healthcare worker safety.

2. Recognize the value of ongoing measurement activities. Institution of these measurement activities will be as unique as the organization, clinical area/unit, discipline, and individual healthcare worker. Metrics should align with data, as described in Standards 2.1.1 and 8.1.3:
   - Systems/organizational performance should be measured, e.g., determine if slide sheets are available in adequate quantities for safe in-bed positioning based on collected data that describe the numbers of in-bed positioning tasks over a designated period of time.
   - Clinical area/unit- and discipline-based performance should be measured (e.g., by investigating the length of time it takes certain healthcare recipients in a critical care unit to achieve pre-determined mobility levels).

3. As an example, the state of California healthcare worker performance may be measured by determining the numbers of healthcare workers who have learned the “Five Areas of Exposure” as defined by California (CA) Assembly Bill (AB) 1136, Employment safety: health facilities (California Assembly, 2011), along with technology to address the healthcare task in the area of exposure.

4. Recognize the interdisciplinary evolution/maturity of the SPHM program and modify metrics as needed.

5. Develop remediation plans for substandard outcomes and highlight positive outcomes.

6. Develop a strategy to provide organizational leadership and key stakeholders with the results of analyses.
Develop the evaluation during the planning phase (see Standard 2.1.3). Evaluation metrics will be adapted over time, based on progress toward an environment of care that significantly reduces injuries to healthcare recipients and healthcare workers.

8.1.1 TIPS
One common element in all the benchmarking tools that are mentioned above is a commitment to a culture of safety (see Standard 1.1.1). This needs to start from the top-down and spread throughout all levels and parts of the organization that are affected or affecting. The presence of culture can be evaluated through measures, primarily leading indicators, that are discussed in the documents mentioned above.

8.1.1 References

Standard Number 8.1.2 Identify a variety of data sources and measures. The organization will identify appropriate performance/quality improvement indicators that reflect the content of Safe Patient Handling and Mobility: Interprofessional National Standards, assess the effectiveness of the SPHM program and the processes implemented during program development, and identify selected program outcomes.

Introduction: The stakeholders, relative to the way healthcare recipient handling is performed, include healthcare recipients and their family and friends, healthcare workers and their family and friends, the organizations providing healthcare workers, the regulators of healthcare workers, insurers, and others. Each of these individuals has desired expectations regarding the provision of care. These expectations can be translated into measures of two types, trailing and leading indicators. The trailing (or lagging) indicators are typically indicators of harm. The leading indicators are those measures that may be taken to prevent this harm.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:
- Production of a document outlining relevant Safe Patient Handling and Mobility (SPHM) program data sources.
Implementing standard 8.1.2.

1. Assemble an interdisciplinary team (see Standard 2.1.1).

2. Identify appropriate quality indicators for measurement (see Standards 2.1.2 and 8.1.3).
   a. Perform a literature search to identify appropriate metrics for healthcare workers, e.g., injuries, lost-time injuries, job satisfaction, musculoskeletal discomfort, and others.
   b. Metrics gathered may include:
      o Clinical area/unit-specific, e.g., falls during toileting because of failure to accommodate elderly, weak healthcare recipients who believe they are capable of ambulating independently to the bathroom. The majority of all metrics will be area/unit-specific.
      o Discipline-specific, e.g., a healthcare recipient who becomes combative during manual handling when a therapist attempts strengthening activities.
      o Facility-specific, e.g., poor communication about the process for laundering and storing slings.
      o Process-specific, e.g., the development, implementation, and use of a program for individuals of size.

3. Identify, by title, the individual most closely aligned with/accountable for the management of quality indicators (see Standard 8.1.1 Introduction).
   - Identify the most standardized, widely accepted tool for measuring the quality indicator.
   - Identify standard definitions and terms pertaining to the quality indicator.
   - Establish a data collection, analysis, and reporting mechanism, such as the National Database of Nursing Quality Indicators® (NDNQI®) and others, if such a mechanism is not already in place.

8.1.2 TIPS

Data sources should provide evaluative information on all eight standards. The *Patient Handling and Mobility Assessments* (PHAMA) (Matz, et al., 2019) and the Veterans Health Administration (VHA) “Safe Patient Handling and Mobility Guidebook” provide examples. The U.S. Department of Labor (DOL)/Occupational Safety and Health Administration (OSHA) “Safe Patient Handling Self-Assessment Checklist” is another data source (DOL, n.d.).

8.1.2 References


Standard Number 8.1.3 Utilize evidence-based methods for data collection and analysis.

The organization will use standardized definitions and evidence-based methods for data collection and analysis. Evaluation methods may change depending on the maturity of the SPHM program.
Introduction: Overall program evaluation should be performed at least annually. This allows top management and other stakeholder involvement to affect process change. There should be consistency in the way data is collected to allow accurate performance/quality improvement tracking.

While the Center for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), and the Occupational Safety and Health Administration (OSHA) have communicated their recognition of the interrelation of healthcare worker and healthcare recipient safety, some healthcare systems/providers have failed to have individuals and/or departments responsible for preventing harm to either population work together. This is necessary for performance/quality improvement. Fall/wound care/individual of size/safe patient handling and mobility (SPHM) committee interaction can lead to this improvement.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Generation of document(s) detailing baseline data.
- Production of a document defining terms and practices for uniformity of reporting.

Implementing standard 8.1.3

1. Identify, by title, the individual(s) most closely aligned with/accountable for the management of the various quality indicators (see Standard 8.1.2).
2. Create a method to sustain interest and enthusiasm in the program by creating and publicizing some early and meaningful quality indicator wins.
3. Obtain baseline data on as many quality indicators as possible, except for healthcare recipients, as noted below.
4. Quality indicators for healthcare recipients.
   - In the early stages of the SPHM program development, consider identifying a limited number of healthcare recipient safety and/or quality of care indicators to study. The limited number of quality indicators should be decided by seeking high-cost, high-frequency, high-risk indicators. Once these are identified, this limited number of indicators should be measured very frequently (e.g., quarterly) and reported frequently.
   - Healthcare recipient safety is monitored by the risk management and or quality improvement departments using universally appropriate measurement tools as mandated by the Nursing Database of Nursing Quality Indicators® (NDNQI®), The Joint Commission, the state departments of health, and others. The data must be collected, monitored, reported, and available for purposes such as associating the SPHM program with the following quality indicators.
     - Adverse healthcare recipient event: fall-related injuries.
     - Adverse healthcare recipient event: deep vein thrombosis/pulmonary embolism.
     - Adverse healthcare recipient event: pneumonia.
     - Adverse healthcare recipient event: hospital-acquired pressure ulcers.
     - Frequency with which healthcare workers can mobilize healthcare recipients.
     - Readmission within 30 days.
     - Others:
       - Satisfaction on the part of the healthcare recipient.
       - Community awareness and support.
5. Quality indicators for healthcare providers
   - Healthcare worker injury data primarily become available by analyzing, facility injury data, OSHA 300 logs, and worker's compensation claims to establish the injury/illness
costs specific to healthcare recipient handling. These data are available from the risk management department or its designee.

- Frequency of musculoskeletal disorders (MSD) and/or musculoskeletal injuries (MSI).
- Costs of MSD/MSI.
- Severity of MSD/MSI.
  - Number of light/modified/restricted duty injuries.
  - Total number of light/modified/restricted duty days from all injuries.
  - Number of lost workday injuries.
  - Total number of days of lost time from all injuries.

- Standardized definitions are critical to ensure consistency of measures related to healthcare worker injury (see Standard 7) and must be consistent over time. The organization should consult with its insurance company to help standardize descriptions of incidents, accidents, and lost-time accidents, and to clarify which incidents and accidents will be measured as associated with the SPHM program. A written evaluation will include any evidence of deviation from the use of standardized definitions, e.g., if the incident, accident, and worker's compensation reports were not analyzed to identify events related to SPHM, this would be noted.

- The prevalence of musculoskeletal discomfort in healthcare workers may be evaluated using an anonymous survey tool or by interviewing healthcare workers.

- Leading indicators are SPHM training quality and completion, rounding, mobility assessment quality, physician, and family education.

- Others:
  - Healthcare worker recruitment and retention.
  - Satisfaction on the part of the healthcare worker.
  - Healthcare provider perception of stress from performing healthcare recipient handling tasks. A tool developed by Bernice Owen and Arun Garg, “Perception of High-Risk Tasks”, can be used for this purpose and is found as Appendix H, Tool 1, in the Patient Handling and Mobility Assessments (PHAMA), 2nd edition (Matz, et al., 2019).

8.1.3 TIPS

While CMS, TJC, and OSHA have communicated their recognition of the interrelation of healthcare worker and healthcare recipient safety, some healthcare organizations/providers have failed to have individuals and/or departments responsible for preventing harm to either population work together. This is necessary for performance/quality improvement. Fall/wound/patient of size/SPHM committee interaction can lead to this improvement.

Each of the standard-setting bodies mentioned in the 8.1.3 Introduction uses the measures listed above, and others, to evaluate performance. Failure to meet the standard and/or performance requirements can result in denial of reimbursement to the medical provider for medical services provided, failure to provide accreditation, and/or fines. Insurance companies are another stakeholder. They may use some of the measures above to either decline or increase the cost of insurance coverage.

Standardized definitions are critical to ensure consistency of measures related to healthcare worker injury (see Standard 7) and must be consistent over time. The organization will consult with its insurance company to help standardize descriptions of incidents, accidents, and lost-time accidents, and to clarify which incidents and accidents will be associated with the SPHM program. The written evaluation will include any evidence of deviation from the use of
standardized definitions. For example, if the incident, accident, and worker’s compensation
reports were not analyzed to identify events related to SPHM, this will be noted.

8.1.3 References

- Matz, Mary, and others. *Patient Handling and Mobility Assessments*, Facility Guidelines
  Patient-Handling-and-Mobility-Assessments_191008.pdf

**Standard Number 8.1.4 Disseminate findings.** *The organization establishes a formal process
of informing all stakeholders of the SPHM outcomes using a variety of techniques, including, but
not limited to, online summary of data; printed materials distributed to the healthcare worker;
and regularly scheduled meetings, management meetings, and organizational meetings (see
Standard 1.1.5).*

**Introduction:** Information provides no value if it is not shared, reviewed, and acted upon. To
assure all three steps occur, accountability mechanisms must be set in place to assure all three
steps occur.

Upon completion of the review/implementation of this standard, you/your healthcare
organization should understand and/or demonstrate the following:

- Composing reports of past and present program data for comparison.
- Contextualizing this data comparison in terms of program goals.
- Establishing a facility-friendly manner to share data.

**Implementing Standard 8.1.4.**

1. Identify existing methods within the organization for disseminating findings pertaining to
other initiatives, such as monthly unit meetings, annual state-of-the-organization
presentations, and intranet communication boards.

2. Identify creative, interesting methods to communicate findings to all stakeholders.

- Provide electronic summaries of data.
- Develop attractive printed and electronic materials:
  - Flyers
  - Posters
  - Others
- Utilize group meetings to discuss/present safe patient handling and mobility (SPHM)
  findings.
  - Include healthcare workers.
  - Include the management team.
  - Include the leadership team.
  - Include community members, when appropriate.
  - Include healthcare recipients, when appropriate, e.g., long-term care resident/family
    meetings.

3. Focus on success.

- Feature an individual (e.g., healthcare worker), when appropriate.
- Feature successful processes.
- Feature clinical area/unit- or discipline-specific successes.

8.1.4 TIPS
A formal process must be in place for informing stakeholders of the SPHM program outcomes. The International Organization for Standardization (ISO) 45001:2018, *Occupational Health and Safety Management System Requirements with Guidance for Use*, Section 7.4, details what it requires for communication (ISO, 2018). The process must include what, when, and with whom to communicate. It must include how to communicate, taking into consideration language, literacy, and other differences.

Some individual state standards (e.g., California, New Jersey, New York, Washington) provide detail of how SPHM program information must be communicated [Association of Safe Patient Handling Professionals (ASPHP), 2017]. The U.S. Department of Labor (DOL)/Occupational Safety and Health Administration (OSHA) “Safe Patient Handling Self-Assessment Checklist” also provides guidance (DOL, n.d.).

The American Industrial Hygiene Association (AIHA), in its Alliance with OSHA, has developed a “Tip Sheet – Safe Patient Handling and Mobility” (AIHA/OSHA, 2014) that also details communication methods for SPHM outcomes (see Figure 8-4).

(Insert OSHA QUICK Tips Sheet) Fig 8-4

### 8.1.4 References


**Standard Number 8.1.5 Develop a plan for performance/quality improvement and remediation of deficiencies.** A diverse group of stakeholders (Standard 2.1.1) will review the data and develop recommendations. The organization will develop and implement a plan or activities to remediate deficiencies within a reasonable time.

**Introduction:** The ability to track and achieve performance improvement is a normal component of any business management system, including health and safety management systems. “Corrective and preventive actions” (CAPA) tracking is a part of this process [U.S. Food and Drug Administration (FDA), 2014].

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Generation of evidence-based program recommendations based on program data and stakeholder input.

Implementing standard 8.1.5
1. A diverse group of stakeholders (see Standard 2.1.1) will review the data and develop recommendations. The organization will develop and implement a plan or activities to remediate deficiencies within a reasonable time.

2. Assemble a peer-review, interdisciplinary team.
   - Quality/performance improvement.
   - Risk management.
   - Patient care services:
     - Therapy
     - Nursing
     - Medicine
     - Others

3. Review opportunities for improvement, e.g., near misses, adverse outcomes, decreases in satisfaction, increases in severity of injuries, and/or increases in costs of injuries.

4. Identify appropriate opportunities for improvement.

5. Examine why deficiencies exist.
   - Is administrative support in place and visible?
   - Is a systems deficiency involved?
   - Do quality indicators accurately assess process and structure outcomes?
   - Are healthcare workers held accountable, as is reasonable, in the SPHM initiative?
   - Is a process for change management in place?
   - Is there another explanation for deficiencies?

6. Develop recommendations.
   - Implement an action plan to remediate deficiencies.
   - Create provisions to continually measure outcomes.

8.1.5 TIPS
Accident/incident investigation is a critical requirement for preventing future harm arising from similar causative conditions. When performing investigations that occurred during healthcare recipient handling, it is beneficial to provide the investigator with questions to determine if the proper work practices were used and conditions present. These may include:
   - Was a healthcare recipient mobility assessment performed?
   - Were the assessment findings readily available?
   - Did the assessment findings reflect the healthcare recipient's condition at the time of the incident?
   - Was appropriate technology readily available?
   - Was the technology in good condition?
   - Was it used?
   - Was the care provider trained and competent in the use of the technology involved in the incident?
   - Others.

A thorough accident/incident investigation allows you to establish and track CAPAs (FDA, 2014).

The Safe Patient Handling and Mobility (SPHM) committee or SPHM program manager must recommend a plan to organizational leadership for quality improvement and remediation of deficiencies. The International Organization for Standardization (ISO) 45001:2018, Occupational Health and Safety Management System – Requirements with Guidance for Use, Section 9, details what it requires for performance evaluation (ISO, 2018). The process must include what
needs to be monitored and measured, the methods used, the criteria that serve as benchmarks, the evaluation of compliance, and the specific requirements for management review.

Some individual state standards (e.g., California, New Jersey, New York, Washington) provide details of how SPHM program performance improvement should be tracked. The U.S. Department of Labor (DOL)/Occupational Safety and Health Administration (OSHA) “Safe Patient Handling Self-Assessment Checklist” also provides guidance (DOL, n.d.).

8.1.5 References


**Standard Number 8.1.6 Comply with the organization’s policies, professional codes of ethics, privacy laws and regulations, and other regulatory language.** The SPHM program will comply with organizational policies, appropriate professional codes of ethics, the Health Insurance Portability Privacy and Accountability Act, the Americans with Disabilities Act, state workers’ compensation laws, and other applicable codes and regulations.

**Introduction:** Healthcare organizations are regulated by numerous governmental and regulatory bodies. They are also served by many professions. These bodies and professions represent some of the stakeholders that must be served, along with those others previously mentioned. Along with the nature of services provided and the environments of care where these services are provided, these define the context of each organization. Safe Patient Handling and Mobility (SPHM) programs that are developed need to match well within the context of the organization they seek to serve.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Evaluation of SPHM program compliance with organizational policies, and applicable codes and regulations
- Construction and implementation of adjustments to guarantee compliance

**Implementing standard 8.1.6**

1. Recognize the value of the corporate compliance department, risk management, quality/performance improvement, legal team members, facility leadership, and others in complying with policies, regulations, and more. Utilize their expertise when necessary.
2. Review the SPHM program for compliance with existing organizational policies, appropriate professional codes of ethics, the Health Insurance Portability and Accountability Act (HIPAA), the Americans with Disabilities Act (ADA), state worker’s compensation laws, and other applicable codes and regulations.
8.1.6 TIPS
Organizational policies and practices must be consistent with a code of ethics, the law, privacy requirements, and other policies. The American Industrial Hygiene Association (AIHA) “Value Strategy” is one tool that may be used to evaluate that consistency (AIHA, n.d.). Figure 8-5, "The Value Strategy Building Blocks for SPHM" (below) shows the building blocks for one such healthcare system in assessing consistency and value to the organization.

8.1.6 References
HEALTHCARE WORKER STANDARDS

Standard Number 8.2.1 Assist with data collection. The healthcare worker will provide accurate information during data collection and communication of results.

Introduction: The frontline healthcare worker is the one who knows the most about their clinical area, e.g., the healthcare recipient population, jobs, tasks performed with healthcare recipients, the environment of care conditions, technology conditions and availability, and work practices used. While others may know individual components of their environment of care better, the frontline healthcare worker must bring them all together daily to provide care. Their involvement in providing information is critical.

Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Rewarding individuals whose contribution to the Safe Patient Handling and Mobility (SPHM) program data collection is notable.
- Defining, implementing, and maintaining methods by which frontline healthcare workers assist with data provision and collection.

Implementing standard 8.2.1

1. Frontline healthcare workers participate in data collection when possible and provide accurate information during the data collection process.
2. Frontline healthcare workers participate in communication activities:
   - Clinical area/unit-specific opportunities
   - Discipline-specific opportunities

8.2.1 TIPS

The American Industrial Hygiene Association (AIHA)/Occupational Safety and Health (OSHA) Alliance “Tip Sheet – Safe Patient Handling and Mobility” provides information regarding the ways frontline healthcare workers may assist with data provision and collection (AIHA/OSHA, 2020).

8.2.1 References


Standard Number 8.2.2 Comply with the organization’s policies, professional codes of ethics, privacy laws and regulations, and other regulatory language. The healthcare worker will be accountable for knowing and following the policies of the organization, following a professional code of ethics, and respecting the privacy of healthcare recipients and co-workers.

Introduction: Healthcare providers and the organizations for which they work have many performance benchmarks they must recognize and seek to achieve to provide care in an ethical, effective, efficient, and exemplary manner. There must be a process in place to help them meet or exceed these benchmarks.
Upon completion of the review/implementation of this standard, you/your healthcare organization should understand and/or demonstrate the following:

- Establishment of a consistent compliance standard for adherence to policies, procedures, and other regulatory languages.

Implementing standard 8.2.2.

1. Identify organizational policies.
   - Review and integrate general policies into practice.
   - Review and integrate Safe Patient Handling and Mobility (SPHM) policies, procedures, guidelines, and healthcare recipient SPHM assessments into practice.

2. Identify professional codes of ethics.
   - Comply with state and federal regulations.
   - Provide personal privacy for:
     - Healthcare workers.
     - Healthcare recipients.

3. Comply with discipline-specific codes of ethics and practice acts.