wny cosh
western new york council on occupational safety and health

SAFE PATIENT HANDLING STUDENT WORKBOOK GUIDE

Session 3: *(5 hours)*

Safe Patient Handling Policy and SPH Ergonomics Teams (Committees)

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SESSION 3

Participants will receive information on:

- The purpose of SPH policy and guidelines to write their facility policy
- SPH Ergonomics team-building (how to run a meeting, ensure inclusion of all participants, resolve conflicts and build consensus around the SPH program)

Participants will engage in exercises on:

- Reviewing a policy and critiquing it
- Running a mock meeting of the SPH Ergo Committee where they have to demonstrate to upper level management the need to implement and provide ongoing support for the SPH program
- A "a gap analysis" where participants evaluate where the are at with their SPH program vs. where they want to be/steps they need to take to make progress.

Activities **Page #**

GROUP ACTIVITY 1: Developing a Safe Patient/Resident Handling Policy

Purpose

All healthcare facilities that buy into a Safe Patient/Resident Handling program need to develop a written policy and procedures, protocols and guidelines for operating the program.

This activity will look at a “mock policy” that was developed by the (fictitious) “Sunrise Valley Nursing Home.” As a group, you are asked to review the policy and critique it.

TASK ONE

As the Safe Resident Handling/Ergonomics Team at "Sunrise Valley Nursing Home" you have taken on the responsibility to develop a Safe Resident Handling Policy.

Human Resources has given you a copy of Sunrise Valley's current Back Injury Prevention and Safe Lifting Policy which, they contend, needs updating but is basically sound policy for preventing most caregiver and resident injuries.

Review: **1. Back Injury Prevention and Safe Lifting Policy** *(pages 5 & 6)*

Question: **Is the current Sunrise Valley Nursing Home Back Injury Prevention and Safe Lifting Policy a "good" Safe Resident Handling policy document?**

Working as a Team discuss some of the inadequacies of this policy document and list below:

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BACK INJURY PREVENTION AND SAFE LIFTING POLICY

Sunrise Valley Nursing Home

Purpose

This policy sets the expectations of sets the expectations of safe lifting practices and procedures to ensure a safe employee and resident environment. It is the expectation that employees will take reasonable care of their own health and safety as well as that of their co-workers and residents. All caregivers who are involved in lifting, transferring, repositioning or moving residents are responsible for using safe lifting techniques. Improper lifting techniques are the number one reason for nursing home injuries and missed workdays at our facility.

Policy

To equip caregivers for safety success at work, the following shall happen:

- The Back Injury Prevention and Safe Lifting Program shall serve as policy for all employees.
- Training shall occur during new hire orientation and renewed annually.
- Additional resources shall be made available throughout the year from the safety officer and management.

Procedures

The following are the basic steps of safe lifting:

- Stretch for safe lifting at the beginning of each scheduled shift.
- Assess each resident you have to lift, transfer, reposition or move to anticipate the risks involved.
- If you have assessed that the resident is too heavy or unstable, use a team lift or a mechanical lift if necessary.
- Always employ body mechanics to facilitate a safe lift.*

Compliance

It is the responsibility of all caregivers to protect their own health and safety and that of their co-workers and residents. Non-compliance will result in the following progressive discipline process:

- *First offense* of unsafe lifting practices will result in verbal warning and remedial training by a supervisor.
- *Second offense* will result in a written warning and remedial training with the safety officer and a probation period will be 90 days.

- *Third offense* will result in final warning and remedial training with a probationary period of 1 year.
- *Fourth offense* will normally result in disciplinary action up to and including termination.

Employees are required to report all injuries to the supervisor on duty. The supervisor will complete an Incident Report at work with Human Resources to complete and submit. Human Resources will maintain public reports, statistics, and follow up with employees and insurance carriers. The Safety Officer and Human Resources will hold accountable any employee who fails to report an injury in a timely manner.

*Use the following steps for safe resident lifting:

- Take a wide stance with your legs
- Maintain neutral spine alignment
- Tighten your core muscles to protect your back
- Squat bending at your knees
- Hold the resident firmly and close to the body when doing pivot and other transfers
- Lift smoothly and evenly with your legs, not your back
- Look straight up and ahead to maintain spine alignment
- Stabilize the resident prior to moving

This policy was developed by the Administration's Safety Committee, Safety Officer and Human Resources. July 17, 2004.

TASK TWO

The Policy document you reviewed in Task One is clearly inadequate as a guide for implementing and sustaining a good Safe Resident Handling Program.

Your task now, as a Team, is to recommend a Policy to "Sunshine Valley Nursing Home" management and staff some key points that should be included in a good Safe Resident Handling Policy.

Review: **2. Safe Patient/Resident Policy Check List.** *(p. 8)*

Review: **3. Safe Patient/Resident Handling Policy** (**Sample Outline)** *(pages 9-12)*

Question: **Briefly state some of the things that you would change or add to the Sunshine Valley policy to make it good Safe Patient/Resident Handling policy.**

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SAFE PATIENT/RESIDENT HANDLING POLICY CHECKLIST

To have an effective *Safe Patient/Resident Handling Program,* it is important that your policy (and guidelines, protocols and procedures) had input from stakeholders throughout your facility and key provisions for implementing and sustaining your program. The policy checklist (below) are some of the provisions that should be considered when developing a SPH policy.

[ ] Policy has been developed and written with multi-disciplinary input.

[ ] Policy has been updated.

[ ] Policy is a Safe Patient/Resident Handling program with SPH training vs. a "Body Mechanics" training program.

[ ] Policy states key job titles (frontline workers, administration, nurse managers, infection control, etc.) and departments that need to be involved in carrying out the SPH program.

[ ] Policy includes tools for assessing patient/residents upon entering the facility, periodic reassessment timely reassessment when there's a change in the patient/resident's capabilities.

[ ] Policy has a requirement for documenting the capability of each patient/resident with a clear statement in the patient/resident's care plan indicating the mechanical equipment/device to be used by the caregiver for lifting/transferring/repositioning or moving the patient/resident.

[ ] Policy states the roles and responsibilities for the Administration, Frontline Workers, Safe Patient Handling/Ergonomics Team and others in carrying out the SPH program.

[ ] Policy states staff compliance requirements and a procedure for compliance evaluation.

[ ] Policy is non-retaliatory with respect to a caregiver who raises concerns that complying with some aspect of the SPH program could endanger the caregiver or the patient/resident.

[ ] Policy includes written procedures for the proper use of equipment and assistive devices including Full Mechanical Lift, Sit/Stand Lift, Gait Belt, Non-Friction Device, Ceiling Lift, and Air Matt.

[ ] Policy has a requirement that all caregivers demonstrate hands-on competency in proper use of equipment and assistive devices.

3. SAFE PATIENT/RESIDENT HANDLING POLICY (*Sample Outline)*

Policy Objectives

Safe Patient/Resident Handling Program Objectives

- To increase patient/resident quality of care.
- To perform safe/comfortable mechanical lifts and/or transfers for patient/residents.
- To reduce the frequency of manual lifting, transferring, and repositioning.
- To reduce and prevent caregiver work-related injuries.
- To reduce lost work time hrs. related to staff injury or fatigue.

Roles and Responsibilities

Employees

- Use lifts/transfer devices/methods for all patient and resident lifts/transfers.
- Licensed professionals assess patient/resident and determine appropriate lift/transfer method.
- Unlicensed assistive staff can lift/transfer patient/resident after assessment is completed/documented
- SRH competency training required for all staff involved in patient/resident lifts/transfers.
- Report employee/patient/resident injuries to 'EE Health.

Management

- Support implementation of SRH policy and promote a *Culture of Safety.*
- Furnish sufficient lifting equipment/devices
- Make equipment accessible &maintain it.
- Ensure sufficient staffing to use SRH method.
- Ensure patient/resident assessment/documentation.
- Ensure staff compliance with SRH policy.
- Ensure staff competency requirements met.
- Ensure reporting of accidents/injuries.

SPH/Ergo Team

- Lead implementation of SRH policy/promote Culture of Safety

- Assess injury data, equipment, and facility environment to determine SRH needs.
- Oversee equipment selection
- Set criteria for evaluating patient/residents
- Ensure staff competency training/retraining/evaluation
- Transition program onto the units.
- Oversee program audits/evaluation
- Review incidents/AAR

Protocols

Guidelines we can use to ensure good:

- Patient/Resident Assessment
- Care and Management
- Safety
- Infection Control
- Complications & Reportable Incidents
- Compliance

Patient/Resident Assessment Protocol

A Licensed Professional shall:

- Complete patient/resident assessment
  - Upon admission
  - When there is a change in patient/resident status
  - On a quarterly basis (reassessment)
- Use Lift/Transfer Assessment Tool
- Document Patient/Resident Lift/Transfer (Patient/Resident Care Plan)

A Direct Caregiver shall:

- Consider his/her own ability, the environment and patient/resident's status prior to any lift/transfer
- If no change in status
  - Follow care plan lift/transfer recommendation
- If change in status
  Notify a licensed professional
  - Use new level of transfer if recommended

Refer to the Decision Tree when changing patient/resident lift status

Full Mechanical Assist	Dependent
Sit/Stand Mechanical Assist	Extensive Assistance
Transfer/Gait Belt	Supervision/Limited Assistance
No lift Equipment	Independent

Care and Management Protocol

Patient/Resident

- Perform patient/resident transfer as documented in Care Plan

Lift/Transfer Equipment

- Park all mechanical lifts in designated areas
- Plug in lifts for recharging when not in use

Slings

- Place all soiled slings in designated laundry bag/hamper.

Infection Control Protocol

- Use barrier between patient/resident's skin and sling
- Spot- clean slings with minor soilage (use approved disinfectant wipes)
- Use single dedicated sling for a patient/resident with communicable illness/M.R organism
- Launder dedicated sling after discontinuation or discharge
- Wipe down framework/hardware prior to use on another patient/resident
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Safety Protocol

- Assess all equipment prior to use.
    - Note Integrity and function
    - Remove, tag any broken equipment
    - Report any non-functioning equipment
- Inspect slings
    - Note signs of wear and tear

- Remove damaged slings and tag
- Return to unit manager

• Non-friction device: don't leave under patient/resident after transfer

Infection Control Protocol

- Use barrier between patient/resident's skin and sling
- Spot- clean slings with minor soilage (use approved disinfectant wipes)
- Use single dedicated sling for a patient/resident with communicable illness/M.R organism
- Launder dedicated sling after discontinuation or discharge
- Wipe down framework/hardware prior to use on another patient/resident

Complications and Reportable Incidents Protocol

- Report all damaged slings to nurse manager/supervisor
- Report all employee injuries to Employees Health; do an incident report
- Report patient/resident injury during lift/transfer to unit manager/physician
- Report all of the above to SRH Point Person(s)

Compliance

- Ensuring staff participation, understanding the SRH program, and staff communication with SRH Resource/Point Person are forms of compliance.
- Daily compliance with the program is the responsibility of each staff member.
- Adhering to the SRH policies and procedures is mandatory for all staff
- SRH Resource/Point Person will facilitate After-Action Reviews to continually adjust the SRH program.
- Each unit/floor's manager shall provide compliance reports using the Compliance Audit Tool
- The employer shall not take retaliatory action against any nurse or caregiver for raising concerns or issues regarding safe patient/resident handling, filing a complaint or refusing to engage in patient/resident handling

Documentation and Competency

Lift Transfer Competency (is your staff able to:)

- Identified transfer/lift status
- Identified sling/harness
- Identified size when indicated
- Any special transfer/lift needs

GROUP ACTIVITY 2: Bad vs. Good Meetings

Purpose

Your Safe Patient/Resident Handling Ergonomics Team has a key leadership role to play in making your SPH program a success. It has a number of ***tasks*** to accomplish such as recommending the purchase of patient lifting equipment, setting up a training program, etc.

Your Team will have to meet frequently to figure out how to carry out these tasks. It is important to have productive meetings where everyone feels that things are getting accomplished. Too often, however, tasks don't get accomplished because groups don't have a good ***process*** for getting things done. Group members complain, for example, that "Nothing is getting accomplished," "Everyone is talking at the same time," etc.

This activity is an opportunity for your Team to share your experiences about what ***bad meetings*** you have participated in vs. ***good meetings*** you have participated in and to begin to think about the lessons learned.

TASK

Your task as a group is to answer two questions:

Question 1: What is the worst meeting you have ever participated in and the reasons why and what is the best meeting you have ever participated in and why?

Question 2: What are the lessons learned and how can they be applied to the future meetings of your SPH/Ergonomics Team?

Worst Meeting	Best Meeting

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Lessons Learned

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-
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GROUP ACTIVITY 3: Productive Meetings

Purpose

There are things that your Team can do to ensure that your meetings are productive—carry out ***tasks***-- by having a good ***process*** for planning and running your meetings.

This activity will give your group an opportunity to practice some tips for having productive meetings.

TASK 1

One reason that meetings become unproductive is that there aren't clear ground rules for the group. One of the first things you will want to do when you set up your Team, is for the facilitator of the meeting to ask the members of the group what ground rules everyone should follow. An obvious ground rule is "That only one person should speak at a time." As a group, discuss the issue of ground rules for your meeting.

Question: What benefits would your Team meeting gain from setting ground rules?

Question: What are some ground rules that you would suggest for Team meetings here?

TASK TWO

Your Team meetings will be more productive if everyone knows *when, where,* and *why* the meeting has been called and what the *desired outcome* of the meeting will be. Your agenda should contain this information—it sets the stage for a good meeting.

Review: **Information sheets 1. through 5.** *(on the next 5 pages)*

Using the "blank" agenda below, choose a facilitator, recorder and timekeeper from your group (write in their names).

Assume that this is the first meeting of your Team and that the purpose of the session is to determine what decision-making method your Team will use (see: **5. Models for Group Decision-Making**). Use this meeting to discuss as a group the "pros" and "cons" of each method and attempt to agree, as a group, on the method you will use.

SAFE PATIENT/RESIDENT HANDLING TEAM MEETING AGENDA

Date: **Primary Facilitator:**

Time: **Recorder:**

Location: **Timekeeper:**

Purpose of Session:

Desired Outcomes:

Time:	**Topic:**	**Person initiating or reporting on topics:**

1. CHECKLIST FOR HAVING PRODUCTIVE MEETINGS

- Develop a Good Agenda
- Identify Key Group Process Roles
- Establish Ground Rules
- Identify Method of Group Decision Making
- Understand Conflict Resolution Skills

2. GUIDELINES FOR DEVELOPING A GOOD AGENDA

- Specify the date, place, starting time and ending time.
- Provide a statement of the overall mission or purpose of the meeting.
- Identify who will attend.
- List the topics to be covered, in the sequence they will be covered.
- Identify the approximate time you will devote to each topic.
- Identify the pre-meeting reading or assignment expected of each member.
- Distribute the agenda to each group member at least one week before the meeting.

3. ESTABLISH GROUND RULES FOR THE MEETING

- Meeting begins on time/ends on time
- Respect for other participants
- One person speaks at a time
- No sidebar conversations
- Allow others to speak—don't dominate meeting
- Be honest
- Keep track of time to move through agenda

4. GROUP PROCESS ROLES

When you hold your SPH Team meeting, assigning responsibilities to certain members to keep the meeting running smoothly is important. The key roles for managing the meeting include ***facilitator(s), timekeeper, and recorder.***

Meeting Facilitator(s).

A meeting facilitator's role is to review the agenda and main purpose of the meeting and desired outcomes (and ask the group if there's consensus on this), ask members to state the meeting guidelines, tactfully keep the meeting on task, and help the group find agreement or consensus on how its going to accomplish the tasks before it.

Note: If your Team adopts the model of leadership that's in New York State's SPH legislation: a chair from Non-Managerial Frontline Workers and a chair from Management, may serve as your group's facilitators—perhaps they could trade off from one meeting to the next (they can also designate others to facilitate).

Timekeeper.

One of the members of your Team should serve as a timekeeper. The timekeeper helps the group stick to the agenda by providing guidance on how much time is passing.

Recorder.

The recorder performs the valuable task of writing down decisions and action item assignments. This is best done on a flip chart in full view of the group—any errors or clarifications can be handled immediately. It also helps members whose mind may wander to "rejoin" the meeting without missing the important stuff. The flip chart items become your group's minutes. Also, if a new issue surfaces that's off-topic, it can be placed on the flipchart "parking lot" for a future meeting. Finally, as the meeting winds down, items for the next meeting's agenda can be recorded.

Participants.

The other Team members who don't have *specific* responsibilities for running the meeting, can still "make or break" the meeting. All Team participants should know what's on the agenda beforehand and have done any homework assignments. During the meeting they should follow the *ground rules,* be open minded, stay on topic, listen and participate. After the meeting they should participate in evaluating the meeting, brief others as appropriate, and complete any assigned action items.

5. MODELS FOR GROUP DECISION-MAKING

Decision by Authority: The chairperson or other authority listens to the discussion and then decides on what action to take (sometime with advice from others in the group). *Upside:* Gets things done. *Downside:* members of the group lose interest—feel their participation doesn't count.

Decision by Minority: A minority of members (usually the most influential) listen to the discussion and then decide for the whole group. *Upside:* Gets things done. *Downside:* members of the group feel the group is run by a clique and lose interest.

Decision by Majority: The members who have participated in the discussion take a vote on a course of action—the majority "wins." *Upside:* It brings an end to discussion and gets things done. *Downside:* There are "losers"—those in the minority who may dislike or resent the majority decision.

Decision by Consensus: All of the members are encouraged to fully participate in the discussion. Discussion of all differences of opinion is encouraged. The participants agree to work toward finding common ground on a course of action, setting aside options on which there's strong differences of opinion. Everyone agrees to the final decision (for those who can't agree, they are willing to "step aside" and allow the decision). *Upside:* It fully uses the information and experiences of each person in the group. Everyone feels affirmed that their opinion matters—there aren't winners and losers. *Downside:* This model can take more time and patience than the other models.

TASK

TASK versus PROCESS

Obstacles (the "worst" meetings) *(some examples)*	**Core skill**
• Meetings don't begin on time. • Meetings drag on forever. • People are rude and talk at the same time or hold sidebar conversations.	• Establishing ground rules.
• Team members forget to prepare for the meeting. • One topic dominates the meeting and no other business gets done.	• Developing an agenda. • Group process roles.
• One or two people dominate the meeting; others don't get a chance to speak. • The team can't seem to make decisions.	• Establishing ground rules. • Group process roles. • Methods of group decision making.
• The team votes on issues, but those in the minority are unhappy, disgruntled, or sabotage the winning decision/action. • Team members can take such strong stands on issues that nothing ever gets resolved upon; no one will compromise. • Team members won't say what they really feel. • Quiet team members feel pressured to go along. • Meetings become unproductive complaint sessions and nothing ever gets done. Members resign over the frustration.	• Methods of group decision-making. • Conflict-resolution skills. • Natural stages of group development.

GROUP ACTIVITY 4. Team Collaboration—"wisdom of the group"

Purpose

The purpose of this activity is to demonstrate the "wisdom of the group" and the power of collaboration—building consensus through discussion--vs. the individual acting alone.

TASK

The exercise (**2. Consensus Exercise: Items from the Latest Safety and Health Audit)** shows how your Team working together can come up with better solutions than when each of you is acting alone.

Review: **1. Eight Steps to a Consensus Decision** *(page 26)*

Review: **2. Consensus Exercise: Items from the Latest Safety and Health Audit** *(page 27)*

Instructions:

First, each of you working on your own rank items A—G on your own.

Then, working as a group, come up with a Team ranking of the problem.

Finally, after your Team has come up with a solution, compare your answers with the "expert" ranking of the problem (see back of page).

1. EIGHT STEPS TO A CONSENSUS DECISION

There are different ways groups can make decisions. One person rule is an ***authoritarian*** approach. Rule of a small group within the larger group is a ***minority control*** approach. ***Majority rule*** occurs when a vote is taken and the majority "wins." Perhaps the best approach for your Safe Patient Handling Team is to use a ***consensus*** approach—you discuss and debate an issue until the Team as a whole finds an acceptable solution (even if not everyone is happy with the decision, the important thing is that they are willing to live with it). Below is a step by step process for ***consensus decision making.***

Step 1: Group agrees on decision to be made

Step 2: Everyone presents his/her view clearly and logically but without excessive advocacy

Step 3: All relevant information and evidence is reviewed, including minority opinion

Step 4: Possible decision alternatives or options are identified

Step 5: Pros and cons of each alternative or options are identified

Step 6: Differences of opinion are fully explored to try to resolve disagreements

Step 7: Group discussion leading to the selection of the most positive and least negative features

Step 8: Everyone agrees to endorse the final decision

2. CONSENSUS EXERCISE: ITEMS FROM THE LATEST SAFETY AND HEALTH AUDIT

Rank these items from **highest** hazard **to lowest** hazard.

A. Karen continues to ambulate Stan, who needs two people to assist him.

B. Betty keeps all her important files in the bottom drawer.

C. In the clean supply room, items for bathing are kept on a shelf at the eye level of Sue who is 5' 8".

D. Dave experienced a muscle spasm when pulling his patient/resident up in bed. The bed was against the wall.

E. Two-assist pivot transfers are still performed on a daily basis.

F. A patient/resident that was on the floor was manually lifted back into his chair.

G. John refuses to move any furniture in his room and is dependent upon care.

Your ranking	Group ranking	Expert ranking
1.		
2.		
3.		
4.		
5.		
6.		
7.		

(Expert Ranking: 1-F; 2-A; 3-E, 4-D; 5-G; 6-C; 7-B)

GROUP ACTIVITY 5: Multiple Intelligences and the Group

Purpose

It is important to recognize that members of a group (or your Team) can be very different from one another. Members of your group learn, process information, and are "smart" in different ways. A member who may "nod out" during a presentation of statistical information may "come alive" when the same information is presented graphically.

This activity is an opportunity for the members of your group to better understand each other and respect each others differences. And to appreciate that these differences can contribute to the success of the group.

TASK

Your group's task is to understand "Multiple Intelligences."

Review: **1. Different Ways Members of Your Team are Smart** *(page 30)*

2. Learner Types and Multiple Intelligences *(page 31)*

Question: ***** First, choose the intelligence type you most strongly identify with. Explain to the group why you choose this learning and communicating style best fits you.

Second, identify and explain your second choice.

Finally, identify the intelligence type you most dislike and explain why.

[ ] WORD SMART

[ ] PICTURE SMART

[ ] BODY SMART

[ ] PEOPLE SMART

[ ] MUSIC SMART

[ ] NUMBER SMART

[ ] NATURE SMART

[ ] SELF SMART

- **NOTE:** These "Learner Types" may also be posted on sheets of paper on the wall and members of the group can answer the 3 questions by standing by the learner types which they like and/or dislike.

1. DIFFERENT WAYS MEMBERS OF YOUR GROUP ARE SMART

- **WORD SMART** — Likes to reads, writes, tells stories. Learns through saying, hearing and seeing words.
- **PICTURE SMART** — Likes to draw, build, design, create things. Learns through visualizing, dreaming, working with pictures and colors.
- **BODY SMART** — Likes to move around, touch and talk, use body language. Learns through touching, moving, interacting with space, processing knowledge through bodily sensations.
- **PEOPLE SMART** — Likes to have friends, talk to people, join groups. Learns through sharing, comparing, relating, cooperating, interviewing.
- **MUSIC SMART** — Likes to sing, listen to music, play music, respond to music. Learns through rhythm, melody, and music.
- **NUMBER SMART** — Likes to do experiments, figure things out, work with Numbers. Learns through categorizing, classifying, working abstract patterns and relationships.
- **NATURE SMART** — Likes to work with animals, garden, take nature walks/hikes. Learns through natural phenomena or events and nature sounds.
- **SELF SMART** — Likes to work alone, pursue own interests, and have own Space. Learns through working alone, individualized projects, self-paced instruction.

2. LEARNER TYPES AND THE MULTIPLE INTELLIGENCES

Learner Type	Likes To	Is Good At	Learns Best By
Musical **"The Music Lover"** **(music smart)**	• sing, hum • listen to music • play an instrument • respond to music	• picking up sounds • remembering melodies • noticing pitch/rhythm • keeping time	• rhythm • melody • music
Interpersonal **"The Socializer"** **(people smart)**	• have lots of friends • talk to people • join groups	• understanding people • organizing • communicating • persuading • mediating	• sharing • comparing • relating • cooperating • interviewing
Spatial/Visual **"The Visualizer"** **(picture smart)**	• draw, build, design and create things • daydream • look at slides/pictures/ movies • play w/machines	• imagining things • sensing things • mazes/puzzles • reading maps and charts	• visualizing • dreaming • using the mind's eye • working with colors and pictures
Kinesthetic **"The Mover"** **(body smart)**	• move around • touch and talk • use body language	• physical activities (sports/dance/ acting) • crafts	• touching • moving • interacting with space • processing knowledge through bodily sensations
Intrapersonal **"The Individual"** **(self-smart)**	• work alone • pursue own interests • have own space	• understanding self • focusing in on feelings and dreams	• working alone • individualized projects • self-paced instruction
Logical/ Mathematical **"The Questioner"** **(number smart)**	• do experiments • figure things out • work with	• math • reasoning • logic • problem solving	• categorizing • classifying • working with abstract patterns and relationships
Linguistic **"The Word Player"** **(word smart)**	• read • write • tell stories	• memorizing names, places, dates and trivia	• saying, hearing, and seeing words
Naturalist **"The Nature Lover"** **(nature smart)**	• work with animals • garden • nature walks or hiking	• working with animals • "green thumb"	• relating to natural phenomena or occurrences • nature sounds

GROUP ACTIVITY 6: SPH Ergonomic Team Meeting Role Play

This “mock” SPH/Ergonomics Team meeting is an opportunity to “act out” the consensus method of problem-solving to address a SPH program issue in which there is conflict.

TASK

Scenario: Your SPH/Ergonomics Team has been convened for the purpose of addressing a recommendation from the facility Head Nurse to purchase additional equipment as part of your Safe Patient Handling program. Your Chief Financial Officer and Human Relations Manager agree with only some of the recommendations. As a Team, it's your task to work through the differences and, using the *Consensus Model of Decision-Making,* to find a course of action that you can all agree on.

Members of your Team are asked to take on the following roles:

2 Co-Chairs (one manager and one frontline worker)—1 will act as facilitator
1 Timekeeper
1 Recorder (using flip chart)
1 Physical Therapist
1 Head Nurse
1 Certified Nurse Assistant
1 Union Representative
1 Human Relations Manager
1 Chief Financial Officer

The chair will convene the meeting and review the agenda and as a Team you will review the memos from the Physical Therapist, Head Nurse, and the HR Manager and CFO.

Review: **1. SPH/Ergonomics Committee Meeting Agenda** *(page 34)*

Review: **2—4. Memos** *(pages 35-37)*

Review: **5. The Risks of the Pivot Transfer** *(page 38)*

Review: **6. Sit-to-Stand Lifts: An Alternative to the Pivot Transfer** *(page 39)*

Review: **7. Equipment Per Patient/Resident of Need Guide: How Much Equipment Do We Need?** *(page 40)*

Review: **8. The Consensus Approach to Group Decision-Making** *(page 41)*

1. SRH/ERGONOMICS COMMITTEE AGENDA

AGENDA

Purpose: to discuss SPH equipment issue.

1) Memo from Physical Therapy
2) Memo from Head Nurse
3) Memo from HR/CFO
4) Action steps

2. MEMO FROM PHYSICAL THERAPY RE. PATIENT/RESIDENT CENSUS

MEMO
From: Physical Therapy
To: CFO, HR and Head Nurse
Re: Review of Care Plans for our 126 patient/residents
Date: 2/25/13

Total Dependence patient/residents—Unit One: 16; Unit Two: 18; Unit Three: 19
Extensive Assistance patient/residents—Unit One: 17; Unit Two: 16; Unit Three: 18

3. MEMO FROM HEAD NURSE RE. PROPOSED EQUIPMENT

MEMO
From: Head Nurse
To: CFO/HR
Re: Safe Patient Program
Date: 2/26/13

Currently our facility has 1 Full Mechanical Lift and 1 Sit/Stand Lift on each of our three units.

Based on PT's patient/resident assessment of each unit, I recommend that we purchase 1 additional Full Mechanical Lift for each unit (total of 3) and a Sit/Stand Lift for each unit (total 3).

This will give us 2 additional mechanical lifts per unit which conforms to the recommendation of the Veterans Administration Safety Research Center's guidelines.

Also, a CNA on Unit 3 recently sustained a serious back injury and has been out on Disability for over 1 ½ months costing our self-insured facility over $20,000 per date.

4. MEMO FROM HR MANAGER/CFO RE. SPH EQUIPMENT

MEMO
From: CFO/HR
To: SPH Team
Re: Proposal for new Mechanical Lifts

As per recommendation that our facility purchase 6 additional mechanical lifts. We agree that the purchase of 3 additional Full Mechanical Lifts for our Total Dependence patient/residents is advisable. We do not agree to purchasing 3 additional Sit/Stand Lifts for our Extensive Assistance patient/residents. Our current 3 Sit/Stand Lifts are adequate given that many of the our Extensive Assistance patient/residents can be safely transferred using Gait Belts and pivot transfers and proper body mechanics. We cannot justify the purchase of S/S Lifts financially

5. THE RISKS OF THE PIVOT TRANSFER

The Pivot Transfer is not advisable for most patient/residents.

According to Paula Pless, Kaleida Health's Safe Patient Handling director in Buffalo, NY and an authority on Safe Patient Handling programs:

"In a true and safe pivot transfer, the patient/resident can take at least one step, unweight at least one foot during the pivot and move toward the desired target. ***Only a small number of patient/residents fit this category.*** *Before doing a pivot transfer, an assessment should be done to determine if the patient/resident can move her feet on all surfaces and to all surfaces. The ability to move her feet should be done over a 24-hour period."*

Risks of the Pivot Transfer to the health care worker.

"The transfer tends to be used repeatedly on a patient/resident—up to 16 times in a 24 hour period. The patient/resident's weight bearing ability to assist with the lift can change over this period of time. The patient/resident may be unable to adequately assist with the transfer. She becomes an unstable excessive load. This instability can be transferred to the caregiver who is at risk of injury. The risk of injury increases with a patient/resident who has partial weight bearing capacity and is pivoting in a confined space environment."

Risks of the Pivot Transfer to the Patient/Resident.

"A pivot transfer is frequently traumatic for the patient/resident. Arthritis and degenerative joint disease is exacerbated in shoulders that are used as leverage when performing the pivot. ***After 90 days of use the vast majority of patient/residents experience injuries or joint deterioration****."*

Is a Two-Caregiver assist safer?

"A 2-person lift is not a true pivot transfer. It is a manual lift that exceeds the load limit whether done with one or two caregivers. . . .If one person can't do this lift and transfer, a mechanical lift should be used."

Source: Paula Pless. "A Close Look at the Pivot Transfer." Caring for the Ages. December, 2005.

6. SIT-TO-STAND LIFTS: AN ALTERNATIVE TO PIVOT TRANSFERS

The Sit to Stand Lift.

"Sit/Stand patient transfer is an alternative to the pivot transfer that allows patients to bear weight while it facilitates safe and proper joint alignment and increases protection and comfort.

"The properly assessed candidate can experience an improved quality of life and increased safety. They are afforded the opportunity to be repositioned safely and more frequently, placing less burden on the caregiver's back, and can bear weight safely and for longer periods of time. Patients that were traditionally pivoted from one place to another—for example, from a wheelchair to a stable chair in a dining room or from a wheelchair to a toilet—can be transferred properly with the sit/stand lift.

Source: *Paula Pless. 2005.*

But are they affordable?

A Sit-to-Stand Lift will cost in the $3,100--$3,500 range. Compare that to the cost of a one-month a worker who is out on an injury and receiving workers' compensation—the increased costs in insurance premium, the costs of replacing the injured worker and other indirect expenses—well over $20,000.

Source: NYS Zero Lift Task Force

Sit/Stand lifts benefit workers and management.

In a National Institute of Occupational Safety & Health study, nine facilities invested in lifting equipment. **Incidence of injuries were reduced by 60%--90%. Workers' compensation costs by 95%. Insurance premiums by as much as 50%. Lost workdays by as much as 100%. Absenteeism by 98%** (absence related to unreported injury).

Source: Audrey Nelson, Ed. Safe Patient Handling and Movement. 2006

7. EQUIPMENT PER PATIENT/RESIDENT OF NEED GUIDE: How much Equipment do we need?

Equipment type	Amount of equipment recommended
Floor lifts or full mechanical lifts	1 per 8 patient/residents of need on that unit
Sit to stand lifts	1 per 8 patient/residents of need on that unit
Gait belts with handles	1 per patient/resident of need, hands on assistants will require a gait belt
Non friction sheets & non friction devices, Slipp Sheet, Phil-E-slide, Maxi-Slide &Surehands products	1 per 8-10 patient/residents of need *(used for lateral transfers, repositioning; reducing friction decreases the load and resistance)*
Hover Mat & Air Assisted devices	Look at what your need is and where you would use them
Ceiling Lifts & ceiling track systems	*Truly Zero-Lift; especially useful with fully dependent patient/residents. Useful in tub rooms, therapy gyms, patient care areas, and rooms with specialty care like bariatric*.
Hygiene slings Universal slings Quick fit slings Hammock slings Sit-to-Stand slings Amputee slings Positioning slings Mesh slings Padded slings Full Body slings Bathing slings	Slings needs should be determined by patient/resident case load and needs
Electric control beds - (avoid awkward postures)	1 per patient/resident Beds have various sizes, styles, and functions. Bariatric beds have heavy reinforced hardware and framing.

Note: *The equipment to patient/resident ratio in these slides is used at Kaleida Health in Western New York at 9 hospitals and nursing homes. Their program resulted in an 80% reduction in patient/patient/resident related handling injuries. This chart is a good guide for determining the amount of equipment your Safe Patient/resident Handling/Ergo Team will want to recommend for your facility. The way caregivers organize their work assignments should be carefully considered when determining the quantity purchased. Patient/resident lifting tasks are not evenly distributed throughout a 24-hr. period. Typically, there are peak periods where staff is competing for lifting devices. If your facility plans to eliminate manual lifting, a commitment to purchasing sufficient quantities of equipment will make this feasible.*

8. EIGHT STEPS TO A CONSENSUS DECISION

Step 1:	**Group agrees on decision to be made**
Step 2:	**Everyone presents his/her view clearly and logically but without excessive advocacy**
Step 3:	**All relevant information and evidence is reviewed, including minority opinion**
Step 4:	**Possible decision alternatives or options are identified**
Step 5:	**Pros and cons of each alternative or options are identified**
Step 6:	**Differences of opinion are fully explored to try to resolve disagreements**
Step 7:	**Group discussion leading to the selection of the most positive and least negative features**
Step 8:	**Everyone agrees to endorse the final decision**

GROUP ACTIVITY 7. "Gap Analysis"

Purpose

This activity will help your Team to think about how far along your are with your Safe Patient Handling program. Where you want to be. And to think about how you will get there.

TASK

A “gap analysis” is, first, a means for looking at your ***current*** Safe Patient Handling program. You can look, for example, whether there is money in your facility’s budget for equipment purchases—this is one component for a successful program. List all the other components that you will need to have a good program.

Second, a “gap analysis” will allow you to figure out where you want to be and when.

Third, a “gap analysis” will allow you to brainstorm about strategies for getting to where you want to be—what, for example, are the barriers and assets you have and what actions will be need to take to move your program along.

Your ***task*** is to fill in the blanks below on the next page.

"GAP ANALYSIS" OF YOUR FACILITY'S SPH PROGRAM

SPH Component	Where are we?	Where do we want to be?	How do we get there?
SPH budget (*for example)*			