

## **SAFE PATIENT HANDLING STUDENT WORKBOOK GUIDE**



Session I: (5 hours)

*Introduction to Safe Patient Handling,  
Building SPH Ergonomics Teams and  
Documenting Patient Handling Injuries*

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## SESSION 1

### Participants will get:

- An introductory overview of Safe Patient Handling (SPH) including the limitation of body mechanics for preventing injuries
- NIOSH recommended lifting limits
- The nature of injuries related to individual handling
- patient handling risks and their control
- Structure & functions of SPH Ergo Committee and who needs to be included to implement and sustain a successful SPH program
- How to identify and record patient handling-related injuries on SH-900 Logs, and how to use this information to document these injuries and costs in order to compare your home's or facility's rate to the national average.

### Participants will engage in exercises in which they will:

- Brainstorm on who should be involved in facility's SPH Ergonomics Committees and how to attain 'buy-in'.
- Engage in a hands-on activity where trainees will analyze facility injury data, enter the data on SH900 Logs, calculate SPH injury rates and compare those rates to other facilities and the national average.

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## GROUP ACTIVITY 1: “Myth vs. Fact”

### ***Purpose***

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Safe Patient Handling—the use of equipment and other assistive devices to lift, transfer and reposition patients—is now considered an “*evidence-based best practice.*” However, most of our nursing and other professional schools continue to teach good “body mechanics” as a safe way to move patients, and most of our health care facilities continue to use manual lifting and transfers.

This activity is designed to get your group thinking about Safe Patient Handling vs. manual handling of patients.

## TASK ONE:

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As a group, answer the questions below. **Do not turn to the next page until you have discussed these questions.**

### Is it a Myth or a Fact?

#### Myth (M) or Fact (F)

1. M  F  Routine manual patient lifting is prohibited in some states as well as in a number of countries.
2. M  F  Proper body mechanics can prevent most healthcare worker lifting injuries.
3. M  F  The human body can safely lift 60 pounds.
4. M  F  All patient handling injuries are related to lifting, transferring and/or repositioning bariatric patients.
5. M  F  A two person lift of a 150-lb patient is safe for the caregivers.
6. M  F  It is possible for a worker to be injured without showing or experiencing any physical signs.
7. M  F  Healthcare workers that are physically fit are less likely to be injured lifting patients.
8. M  F  Safe patient lifting equipment is not affordable.
9. M  F  Repositioning patients is a high risk activity with the potential for injury.
10. M  F  The only workers who need to understand the Safe Patient Handling Program are registered nurses.

## Is It a Myth or a Fact?

1. **FACT.** At least 9 US states and a number of European countries have adopted laws requiring healthcare facilities to use equipment to lift, transfer or reposition patients.
2. **MYTH.** Healthcare workers have some of the highest back injury rates among all occupations.
3. **MYTH.** The National Institute for Occupational Safety & Health recommends a 35 lb. lifting limit for patients.
4. **MYTH.** Repetitive lifting, transferring and repositioning patients day in and day out causes back and other injuries; on average a healthcare worker lifts/moves 1.8 tons daily.
5. **MYTH.** A two-person lift of a 150 pound patient exceeds the National Institute on Occupational Safety and Health's recommended lifting limit of 35 pounds per worker.
6. **FACT.** Repetitive lifting day in and day out can damage tissue such as the discs in your back without you knowing it.
7. **MYTH.** Even physically fit healthcare workers can be injured by the excessive loads that they repetitively lift day in and day out.
8. **MYTH.** Safe patient handling equipment is reasonably priced and most facilities recover their costs within 2 to 4 years.
9. **FACT.** The amount of force that's required to reposition a group home individual often exceeds 35 pounds.
10. **MYTH.** Any frontline worker that's involved in lifting or transferring of a patient needs to understand the Safe Patient Handling program.

## GROUP ACTIVITY 2. “How Much Are You Lifting?”

### ***Purpose***

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The National Institute for Occupational Safety and Health (NIOSH) recommends that patient lifts should not exceed 35 pounds. This activity is designed to get your group to think about how much a patient (or a limb) weighs and whether you would be exceeding NIOSH’s recommendation.

## **TASK ONE:**

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Below are a number of patient lifting scenarios. As a group, determine if each lift is within the 35 pound manual lifting limit recommended by the National Institute for Occupational Safety and Health. Indicate the amount of weight you would likely be lifting for each scenario. If the lift exceeds the NIOSH recommended limit, can you think of a way it might be done safely?

### **SCENARIO 1.**

You are caring for a fully dependent 130 pound female patient and must move her from the bed to a chair. You are the only available nursing assistant.

### **SCENARIO 2.**

A 210 pound male patient needs help in standing from his chair. He is partially able to help himself and lift at least half of his weight. You and a co-worker are assisting the man to stand.

### **SCENARIO 3.**

A fully dependent patient weighing 250 pounds must be moved from his bed into a chair. Four nursing assistants are available to help with the transfer.

### **SCENARIO 4.**

One of the bariatric female patients weighing 320 pounds injured her leg and the wound dressing must be changed. In order to wrap the leg, it must be lifted off the bed. (The leg is about 16% of the total body weight.)

### **SCENARIO 5.**

The 150 pound fully dependent female patient must be repositioned so her head is closer to the top of the bed. There is only one nursing assistant and no special bedding.

GROUP ACTIVITY 3. Safe Patient Handling—WHO should be involved? HOW do we get “*Buy In*”?

***Purpose***

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This activity will help you decide who needs to be involved in shaping your Safe Patient Handling program and how you can get “*buy in*” (that is, cooperation and participation) of those that need to be involved.



## TASK ONE:

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When you set up a Safe Patient Handling program (or improve an existing one) one of the key decisions you need to make is **WHO** needs to be involved in shaping it.

In answering the **WHO** question, you need to think about the “**stakeholders**”—everyone in your facility who’s needed to make the program work.

The other **WHO** question you need to address is who you want to serve on your Safe Patient Handling Ergonomics Team.

Review: 1. – 2. **WHO ARE THE STAKEHOLDERS IN YOUR SPH PROGRAM?**  
(pages 10 – 12)

Review: 3. **WHO SHOULD BE ON YOUR SAFE PATIENT HANDLING ERGONOMICS TEAM?** (page 13)

**Question #1:** Who are the stakeholders at your facility that you think most likely would try to block your SPH project and why?

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**Question #2:** Who are the stakeholders at your facility that you think would most likely support your SPH project and why?

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**Question #3:** Who are the stakeholders—managerial and non-managerial—that you would want on your Safe Patient Handling Ergonomics Team and why?

**Managerial**

**Non-Managerial**

1. ***WHO* ARE THE STAKEHOLDERS IN YOUR SAFE PATIENT HANDLING PROGRAM?**

A ***stakeholder*** in your Safe Patient Handling program is anyone who:

- **Has a stake in the project working**
- **Can stop the SPH project**
- **Is directly impacted**
- **Will feel threatened**
- **Stands to benefit**
- **Can support the budget**

*Stakeholders*, then, are most of the staff and departments in your facility. If you have a union, it is also a stakeholder. And, of course, patients are stakeholders.

## 2. WHO ARE THE SPH STAKEHOLDERS?

**Management.** Management's stake in a SPH program is that it will lower costs associated with injuries that lead to workers' compensation and disability claims, lost work days, overtime or staff replacement costs, and staff turnover.

**Union.** The Union's main stake in a SPH program is that they represent their members' safety and health interests—injury prevention: ensuring that their members are able to remain fully employed and avoid injuries that force workers onto Workers' Compensation or permanent disability due to career-ending injuries.

**Direct Care Staff.** Anyone involved in directly lifting, transferring, repositioning and moving patients (CNAs, LPNs, RNs, OTs, PTs, etc.) has a stake in the SPH program because the use of equipment and devices is the *best practice* for avoiding painful back and other injuries, many of which are debilitating and career-ending. They also have a stake in being involved in the evaluating the SPH equipment that is purchased.

**Patients.** Patients have an interest in being moved safely and having confidence that the lifting equipment and other devices will do that.

**CFO/Finance.** Finance has a stake in knowing that the dollars invested in purchasing SPH equipment and other assists and staff training will be offset by a good *return-on-investment* due to a reduction in costs associated with Workers' Compensation insurance, and paying overtime for hiring staff to cover injured staff or training new-hires.

**Supervision.** Supervising nurses have a stake in knowing that the time and effort invested in the SPH program will improve the ability of direct care staff to handle patients safely and efficiently and reducing lost work days and short-staffing and scheduling problems.

**Human Resources/Risk Managers.** HR and Risk Managers have a stake in SPH for maintaining a stable and productive workforce and in reducing risks of injuries that lead to lost workdays, compensation claims, staff overtime and replacement workers, and staff turnover or patients' complaints.

**In-Service Training.** In-service trainers have a stake in being trained on all aspects of the SPH program, policy and guidelines, equipment, patient assessment, etc. by the SPH Ergonomics Team or the equipment vendor.

**Purchasing.** Purchasing has a stake in purchasing SPH equipment which will provide the best performance (is "user-friendly," easily maintained, a reliable vendor, etc.) for the cost.

**Occupational Health/Employee Health.** OH/EH has a stake in promoting the SPH program for preventing injuries to staff and patients and in ensuring that SPH equipment is used properly to avoid injury to both patients and direct care workers.

**Maintenance.** Maintenance has a stake in seeing that the SPH equipment that's purchased is properly maintained, has low-maintenance and is easily repaired to ensure quick turnaround time demands.

**Infection Control.** Infection Control has a stake in ensuring that the equipment that is purchased can be easily disinfected and that slings are of a quality that they will stand up to appropriate laundering, and that staff follow strict infection control guidelines when using or disinfecting equipment and laundering slings.

**Housekeeping.** Housekeeping has a stake in ensuring that the equipment, slings, gait belts, and other devices purchased can be easily wiped down to disinfect them.

**Laundry.** Laundry has a stake in ensuring that the slings and gait belts and other devices purchased are clearly marked for how they are to be washed and that, in following those guidelines, the product is durable.

### 3. WHO ARE THE STAKEHOLDERS? THE SPH ERGO TEAM.

Your facility's Safe Patient Handling Ergonomics Team is made up of a **Core Group** of your stakeholders. It provides leadership to get stakeholder "buy in" into the SPH program. It makes sure that patients are accurately assessed as to their capabilities. It provides SPH training, recommends equipment, sets up a process for investigating incidents, and annually reviews the SPH program.

#### WHO SHOULD SERVE ON THE SPH ERGO TEAM?

- **Frontline Workers** (such as nurses, OTs/PTs and CNAs) who do give direct care and have knowledge of how the work is done.
- **Non-Managerial Support Staff** who keep the facility running (laundry, transportation, engineering, maintenance, infection control).
- **Managers** who have decision-making authority and expertise (Chief Financial Officer, Human Resources, Director of Nursing, etc.)

#### WHO RUNS THE SPH ERGO TEAM?

There is a growing consensus that SPH Ergonomics Teams run best when authority is divided between workers/non-managerial support staff and management.

Nine states have passed SPH laws that require the Teams (or committees) to be one-half Frontline/Non-managerial workers and one-half Managers.

New York State legislation requires half workers and half management to serve on the Team (Committee). It also requires that the Team be co-chaired with one chair being a Frontline or Non-Managerial worker and one chair being a Manager.

## TASK TWO:

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A major challenge to making your Safe Patient Handling program work is to get “*BUY IN*” or support for the program from all the stakeholders that need to be involved. The stakeholders may have to be convinced that they should participate, especially from the Administration and from direct care workers.

Review: **4. How Do We Get Stakeholder “Buy-In”?** (page 15)

Review: **5. Listening: What Do Direct Care Workers Think?** (page 16)

Review: **6. – 8. Communicating.** . . (pages 17-19)

Review: **9. Shared Decision Making** (page 20)

**Scenario:** Your Safe Patient Handling/Ergo Team has been given the responsibility to improve your facility’s SPH program. You have collected and summarized the answers to the Safe-T Survey. Over 85% of the workers surveyed believe that the Safe Patient Handling program they now have at their facility will **not** reduce their or their patient’s chances of being injured, or improve their working conditions. **And**, the Administration is reluctant to invest in new equipment.

**Question #4:** What are some things your Team might do to get “*Buy In*” from the Direct Care Workers?

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**Question #5:** What are some things your Team might do to get “*Buy In*” from the Administration?

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#### 4. HOW DO WE GET STAKEHOLDER “BUY IN”?

##### **OPEN COMMUNICATION**

- *Listening*
- *Communicating the Facts*
- *Telling Stories*
- *Gathering & Sharing Information*

##### **SHARED DECISION-MAKING**

- *Building a SPH Team to Guide SPH Program*
- *Involving All Stakeholders*
- *Empowering Direct Care Workers*

##### **DATA GATHERING**

- *Injury/Illness Data*
- *Costs: worker’s comp, lost workdays, staff turnover*

## 5. “Listening”: What do Direct Care Workers Think?

One way to find out what Direct Care workers think is to ask them to fill out our survey. Once the surveys have been filled out and the results tabulated, you will have a “snapshot” of how the care workers feel about Safe Patient Handling. These results should be shared with the workers and administration. Below are a few questions from a survey

### SAFE-T Survey Staff Assessment of Facility Employment Topics

	Strongly agree	Agree	Disagree	Strongly disagree
1. The SPH project now being implemented at your facility will:				
(a) reduce the chances that you will be injured.....	[ ]	[ ]	[ ]	[ ]
(b) improve working conditions at your facility.....	[ ]	[ ]	[ ]	[ ]
(c) improve conditions of patients .....	[ ]	[ ]	[ ]	[ ]
2. You have opportunities to provide input into patient handling and movement procedures.....	[ ]	[ ]	[ ]	[ ]
3. The administration at your facility strongly supports safe lifting and safe patient handling efforts.....	[ ]	[ ]	[ ]	[ ]
4. Using appropriate body mechanics only, it is possible to safely lift patients.....	[ ]	[ ]	[ ]	[ ]
5. At your facility, the equipment needed for lifting or moving patients is:				
(a) usually available without a wait when .....	[ ]	[ ]	[ ]	[ ]
(b) usually in good working condition.....	[ ]	[ ]	[ ]	[ ]
6. You have received training for Safe Patient Handling projects at you facility.....	[ ]	[ ]	[ ]	[ ]



## **6. COMMUNICATING: Safe Patient Handling - Everybody Benefits!**

**FACT: *Body Mechanics is a failed injury prevention strategy.***

Health care workers have the highest number of injuries among all workers. 33% are back and shoulder injuries. 52% of health care workers complain of chronic back pain. 53,000 health care workers trained in “good body mechanics” were injured from manually lifting patients in 2005. --BLS. 2005. *American Nurses Association. 2005*

**FACT: *Safe Patient Handling Programs are good for direct care workers.***

Safe Patient Handling programs reduce health care injuries by 66%--95%.

—*National Institute on Occupational Safety & Health*

**FACT: *Safe Patient Handling Equipment is Affordable.***

A non-friction sheet costs about \$40. A Full Mechanical Lift about \$4,000. A Sit-to-Stand Lift, \$3,100. A Ceiling Lift, \$3,000 (+installation). *The average cost of a one month lost workday injury: \$20,000+.*

—*NYS Zero Lift Task Force*

**FACT: *Safe Patient Handling programs save money.***

SPH equipment reduces workers’ compensation costs by 95%; insurance premiums by 50%; medical and indemnity costs by 92%; lost workdays by as much as 100%; absenteeism by 98%. ***Return on investment on equipment averages 2—4 years due to savings on workers’ compensation alone.***

—*NIOSH, based on 9 case studies*

**FACT: *Safe Patient Handling programs improve the Quality of Life for Patients.***

Safe patient handling programs can reduce levels of depression, urinary incontinence, fall risks and increase levels of daytime alertness. Kaleida Health in Western N.Y. found that 14 months after eliminating pivot transfers and using equipment, patient fractures fell by 65%; skin tears and bruises by 37%; and an improvement in upper extremity range of motion by 28%.

—*Veterans Administration Center of Inquiry and Kaleida Health*

## **7. COMMUNICATING (continued)**

### **FACT: SPH Programs are Popular With Health Care Administrators**

*“Kaleidea Health Long Term Care began the implementation of a Safe Patient Handling Program in 2004. . .In 2003 we incurred over \$604,000 in lost wages alone due to injuries. By the end of 2006 lost wages due to compensation injuries were \$142,588—a savings of almost \$1,000,000 over three years. . .SPH programs provide a solid return on investment.”*

*—Maureen Caruana, V.P., Kaleida Health LTC*

*“Labor and Management—all of the people who worked here at the home—nobody wanted to hear of another person being injured. . .As an administrator my life here is much more pleasant. We’ve seen enormous declines in injuries related to lifting, pulling, and moving. Safe Patient Handling is part of our culture now.”*

*—Joanne Hernick, Administrator, NYS Veterans Nursing Home, Batavia, NY, 1/2011*

### **FACT: SPH Programs are Popular With Unions.**

All of New York State’s care unions including the NYS Nurses Association, NYS Public Employees Association, Communications Workers of America, Civil Service Employees Association, and 1199 Service Employees International Union support SPH programs.

*“Nurses United CWA Local 1168 members in New York’s Kaleida system pioneered a safe patient handling ‘no-lift’ program that significantly reduced injuries to not only workers, but also patients. Today, instead of lifting patients, workers won new contract protections that require the use of mechanical lifts.”*

*—Dana McCarthy, CWA 1168 Safety & Health Representative, 2012*

*“CSEA has led the nation in fighting for safe and healthy workplaces. The union is leading the way toward safe patient handling techniques to prevent injuries to health care workers who must lift or move people.”*

*—Danny Donahue, President, CSEA*

## 8. **COMMUNICATING** *(continued)*

- ***Telling personal stories***

Nothing communicates failure or success as effectively as a personal story. Testimony from injured workers who have been out on Workers' Compensation for a long period of time or who have had a career disabling injury from manually lifting patients are one of the most effective ways to "tell the story" of why a Safe Patient Handling program is needed.

Success stories are also important—testimony from direct care workers who have benefitted from using lifting equipment or other assistive devices is important.

*"Back in the early 2000's lost workdays due to patient handling injuries hovered between 1,400 and 1,800. Management had to replace those out on lost time—that was equivalent to 8 – 9 CNAs. That meant that I—we—CNAs were required to work overtime to cover the workers out on injury. It was mandated by New York State. We hated it. Now that we have a Safe Patient Handling program, there is no overtime. We went 8 months without one Workers' Comp claim."*  
—Paul Blujus, CNA and CSEA union leader at the NYS VA Hospital

- ***Gathering and sharing information***

### ***Staff Survey***

The information that was gathered from the SAFE-T survey should be shared with the administration and frontline workers. It will communicate where your facility is in terms of how staff feel about the way they move patients now. It will help make the case for improvement through SPH.

### ***Injury and Illness Data***

The Administration has PESH, Workers' Compensation and other data that will tell you what your direct care injuries related to patient handling tasks look like. The data can also tell you where your facility stands with respect to workers' compensation claims, lost workdays, overtime, and staff turnover and what it's costing you. This will help you communicate the need for a SPH program.

## **9. SHARED DECISION-MAKING**

The best way to get people to “buy into” a Safe Patient Handling is to involve them in making the decisions that will shape the program.

### ***SAFE PATIENT HANDLING ERGO TEAMS***

Your SPH Ergonomics Team is the group that bears major responsibility for shaping your Safe Patient Handling program.

To ensure shared decision making, 7 states have passed Safe Patient Handling laws that require ***equal representation*** of Non-Managerial Frontline Workers and of Administrators on the SPH Teams (or committees).

New York State’s law would also require Co-Chairs—one must be a Non-Managerial Frontline Nurse or Direct Care Worker and one must be an Administrator.

### ***EQUIPMENT SELECTION***

To ensure that equipment at your facility will be used, make sure the end-users are involved in evaluating it and selecting it. Nurses, DSAs and other direct care workers should have an opportunity to try different pieces and brands of equipment and make purchasing recommendations based on such things as safety, ease of use, how well it fits in the facility environment. Patients should also be involved in equipment decisions.

### ***CONTINUOUS IMPROVEMENT***

To ensure that the program is a success in the long run, direct care workers should be encouraged to communicate to their supervisors things that go wrong without being “blamed.” ***After-Action Reviews*** where the direct care workers and the supervising nurse on a unit sit down to discuss something that “went wrong” (such as an accident or “near-miss”) and “brainstorm” together a solution to prevent it from happening again is a way to keep everyone involved.

## GROUP ACTIVITY 4: Making the Case for SPH Programs

### ***Purpose***

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This activity will allow you to make the case for a Safe Patient Handling program at your facility by using your OSHA 300 Logs to determine your facility's incidence rate. Your facility's log of *Work-Related Injuries and Illnesses* is used to classify work-related injuries and their severity. A summary of the injuries is mandated to be posted for employees to see. Your facility's log becomes a great tool for looking at and changing your workplace to eliminate hazards and to create a safe and healthful work environment.

**TASK ONE:**

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This activity will allow you to use your OSHA logs numbers to make a case for a Safe Patient Handling program at your facility.

**Scenario**

At the last meeting of the newly-formed Safe Patient Handling Committee, the OSHA 300 Log and the 300A Summary for the past year were distributed for all to review. People thought it was interesting, but no one could figure out how this data could be useful. You and another member of the committee have volunteered to provide some more information about these numbers at the next meeting. You believe that this data can prove useful to this effort.

**Question:** How would you use the OSHA data to make your case for a Safe Patient Handling Program at your facility?

Review: **1. OSHA Form 300A Summary of Work-Related Injuries & Illnesses** (p. 23)

Review: **2. Calculating Your Facility’s Injury & Illness Rate: “Do The Math!”** (p. 24)

**How many recordable injuries & illnesses during the year?** \_\_\_\_\_

**How many injuries and illnesses involved days away from work?** \_\_\_\_\_

**Questions:**

Note: all incidence rates are per 100 full-time workers

What is your facility’s incidence rate? \_\_\_\_\_

The national incidence rate for all private industry is \_\_\_\_\_ 3.4

The national incidence rate for state government workers is \_\_\_\_\_ 4.4

The national incidence rate for all nursing homes is \_\_\_\_\_ 7.6

The national incidence rate for all hospitals is \_\_\_\_\_ 6.6

**How do the other national incidence rates compare with your facility’s rate?**

\_\_\_\_\_

# Summary of Work-Related Injuries and Illnesses

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write 0.

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

### Number of Cases

Total number of deaths	0	(G)	Total number of cases with days away from work	13	(H)	Total number of cases with job transfer or restriction	2	(I)	Total number of other recordable cases	3	(J)
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### Number of Days

Total number of days away from work \_\_\_\_\_ (K)

Total number of days of job transfer or restriction \_\_\_\_\_ (L)

### Injury and Illness Types

Total number of ... (M)	16	(4) Poisonings	0
(1) Injuries	8	(5) Hearing loss	0
(2) Skin disorders	0	(6) All other illnesses	0
(3) Respiratory conditions	0		

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average 38 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analyst, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

### Establishment information

Your establishment name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

Industry description (e.g., Manufacturer) \_\_\_\_\_

Standard Industrial Classification ( \_\_\_\_\_

OR \_\_\_\_\_

North American Industrial Classification \_\_\_\_\_

Employment information Worksheet on the back of this page to see \_\_\_\_\_

Annual average number of employees 100

Total hours worked by all employees 28,000

### Sign here

Knowingly falsifying this document is a crime.

I certify that I have examined the entries and the knowledge of the entries are true.

Company executive \_\_\_\_\_

( \_\_\_\_\_ )

Phone \_\_\_\_\_

## 2. CALCULATING YOUR FACILITY'S INJURY & ILLNESS RATE: *"Do The Math!"*

There are 100 employees at this facility.

**FORMULA:** The incidence rate =

Total number of injuries & illnesses \_\_\_\_\_

X

Total number of hours to be worked by all employees/year (for standardization, this number is 200,000 for 100 employees – 100 employees x 40 hours per week x 50 weeks/year):

200,000

÷

Number of hours worked by all employees: \_\_\_\_\_ (includes overtime hours, etc., get this # from OSHA 300A Form)

**Your facility's incidence rate = \_\_\_\_\_**



## TASK TWO:

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This activity will allow you to determine the (estimated) **cost** of patient handling injuries at your facility.

**Question:** What are the costs of patient handling injuries at your facility?

Review: **3. Calculating patient handling-related injuries at your facility** (p. 26)

The estimated cost of these injuries annually at our facility are: \_\_\_\_\_

**Question:** How would you present your facility injury rate and the annual facility costs of these injuries to top management to make the case that a comprehensive safe patient handling program would be beneficial?

### 3. CALCULATING THE COST OF PATIENT HANDLING-RELATED INJURIES AT YOUR FACILITY

To estimate (roughly) the cost of these injuries for your facility do the following steps:

1. Look at the OSHA 300A Log Summary Log, Item K.
2. Figure out the average salary for the employees. Let's say it's \$40,000/year, the day's rate would be  $40,000/2,000 \text{ hours} = \underline{\$ 20.00}$  average hourly rate.
3. Multiply the number of lost work days 500 x 8 hours to get the number of lost work hours, then multiply that number by the hourly rate.

4.  $(500) \times 8 = 4,000$

$(4,000) \times (\$20.00) = \underline{\$ 80,000}$

The estimate of the cost of these injuries is: **\$80,000**

### **TASK THREE:**

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Review: **4. Background Data: How to Find Your Facility's Recordable Injuries and Illnesses, Lost Workday Injuries and Illnesses, and No. of Hours Worked** (p. 28 )

Review: **OSHA 300 Log** (p. 29 & 30)

#### **Questions:**

- How useful is the detailed information on this log?
- Would you seek additional information on these injuries, and if so, how would you get that data?
- What tips would you give those who were filling out the logs to ensure the best amount of detail?

#### **Scenario:**

You present your findings at the next meeting and top management are very impressed with your work. They, however, want more details about the injuries and you all agree to meet again and work on this and make a report at the next meeting in two months.

#### **Questions:**

- What additional information would you gather ? (List all ideas).
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In addition to written documentation, what other information would you seek, and from whom?

Finally, a couple of the people in the group can't really understand why you are wasting our time looking at numbers and data, as everyone knows it's a problem. In two/three sentences, what would you say to them regarding the use of this data?

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**4. BACKGROUND DATA: How To Find Your Facility's Recordable Injuries and Illnesses, Lost Workday Injuries and Illnesses, and No. of Hours Worked**

- 1) To find the total number of recordable injuries and illness that occurred during the year, count the number of line entries on the OSHA Form 300, or refer to the OSHA 300A form and sum the entries for columns G, H, I and J.
- 2) To find the number of injuries and illnesses that involved days away from work, count the number of line entries on the OSHA Form 300 that received a check mark in column H, or refer to the entry for column K. on the OSHA Form 300A.
- 3) You will also need the number of hours all employees actually worked during the year. You can get this number from the OSHA Form 300A Summary form.



# Log of Work-Related Injuries and Illnesses

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

**Note: You can type input into this form and save it.** Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader. In addition, the forms are programmed to auto-calculate as appropriate.

**Attention:** This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.



Form approved OMB no. 1218-0176

Establishment name \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_

Identify the person		Describe the case		Classify the case		Enter the number of days the injured or ill worker was:		Select the "injury" column or choose one type of illness								
(A) Case no.	(B) Employee's name	(C) Job title (e.g., Welder)	(D) Date of injury or onset of illness (e.g., 2/10)	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	(G) Death	(H) Days away from work	(I) Job transfer from work	(J) Other recordable cases	(K) Days away from work	(L) On job transfer or restriction	(M) Skin disease	(N) Respiratory	(O) Poisoning	(P) Hearing loss	(Q) All other illnesses
14	Rachael Frank	LPN	7 / 28 month / day	Res Room	Back injury fall	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	18 days	0 days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16	Privacy case	LPN	8 / 23 month / day	Res Room	Needlestick	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	5 days	0 days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17	Bob Peterson	CNA	11 / 28 month / day	Hallway	L knee	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ days	_____ days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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