UNIT PEER LEADER

SAFE PATIENT HANDLING
UNIT BINDER
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I. FACILITY UNIT PEER LEADERS & FACILITY COORDINATOR CONTACT INFORMATION
| **Unit Peer Leader/Facility Coordinator** |
| **CONTACT INFORMATION** |
| **Name** | **Unit** | **Extension/Pager** | **Nurse Manager Extension/Pager** | **Extension/Pager** |
| Facility Coordinator | Bariatrics | Resource | Staff |
| | | | |
UNIT PEER LEADER
ROLES & RESPONSIBILITIES

Act as Unit SPHM Champion
- Act as unit expert and resource on patient care ergonomics, equipment use, and safe patient handling techniques for managers/supervisors, peers, patients, families
- Problem solve patient handing issues
- Motivate/coach peers – encourages co-workers in use of patient handling equipment and compliance with SPHM Program
- Bariatric SPHM resource/expert
- Assist in SPHM Program implementation

Train peers/mangers/patients/families
- Conduct staff in-services/training on SPHM issues, equipment, etc.
- On unit, orient new employees to SPHM & UPL role
- Facility-wide, participate in new employee orientation training
- Train, re-train co-workers on new & existing equipment
- Complete or assist in completion of equipment competency assessments
- Assist co-workers in patient/family training when needed

Facilitate SPHM Knowledge Transfer
- Maintain communication with other UPLs through
  - Face-to-face facility UPL meetings
  - UPL Email Group
  - Conference calls
- Share best practices learned during UPL meetings with co-workers/ management
- Communicate with Facility Champion
  - One-on-one as needed
  - UPL meetings
  - Ensure facility champion is aware of UPL personnel changes – resignation, transferring etc.
- Implement Safety Huddle (AAR) Program, Initially take lead in Safety Huddles
- Train staff on and ensure compliance with use of Algorithms

Monitor unit SPHM Program status/compliance
- Complete UPL Log to capture
  - UPL activity
  - SPHM Program status
  - SPHM Program acceptance
- Track equipment use
- Others
Equipment Super User

Equipment Use/Management
- Assist in conducting unit equipment needs evaluation
- Assist staff in selection of equipment through trials/equipment fairs
- Implement equipment introductions on unit
- Train staff on use of equipment (after initial manufacturer training)
- Track equipment locations, storage & ensure accessibility
- Track operational status and need for maintenance of equipment/batteries/slings
- Ensure annual/preventative maintenance is accomplished
- Track sling types, quantities, and condition
- Facilitate battery/sling/equipment orders when needed
- Notify appropriate staff when patient handling equipment problems/incidents arise
- Ensure facility & manufacturer infection control requirements are followed

Act as Unit liaison with
- Facility Champion/Coordinator
- equipment manufacturer/vendor
- purchasing
- Engineering/Facilities Management
- Infection control
- others

Conduct Ergonomic ongoing environmental/ergonomic evaluations, perform walkthroughs to assess equipment use and function

Maintain current knowledge of SPHM issues, technology, and best practices
- Attend facility UPL meetings, regional/national conference calls
- Participate in equipment manufacturer training
- Attend annual SPHM conferences

Follow unit injuries & close calls
- Assist in documentation and tracking of injuries and close calls
- Foster reporting of injuries, near misses, and safety concerns

Demonstrate Systems Thinking
- Participate in facility-wide SPHM initiatives and projects
- Foster supportive relationship with manager-supervisor
- Be knowledgeable of and provide input on facility policies/procedures
DEVELOPING A SAFE PATIENT HANDLING & MOVEMENT ACTION PLAN

A. What goals do you want to achieve for yourself, your co-workers, and your unit?

B. What specific Program Objectives do you want to attain?

C. Identify Social Marketing Target Group/s. Who do you want to target? Why?
D. Identify potential barriers to implementation. Remember, these can be at staff, resident, and organization level.

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Strategies to Overcome Barriers</th>
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<tbody>
<tr>
<td>Staff</td>
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<td>Resident</td>
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</tbody>
</table>
E. **Identify facilitators to implementation.** Remember, these can be at staff, resident, and organization level.

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Strategies to Aid Facilitators</th>
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<tbody>
<tr>
<td><strong>Staff</strong></td>
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<td><strong>Resident</strong></td>
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</tbody>
</table>
**F. Social Marketing Plan** – Identify what angle will be most convincing to each target group, related to changing practice to prevent musculoskeletal injuries in nursing staff. The chart below is only an example. Develop your own.

<table>
<thead>
<tr>
<th>Cost Savings</th>
<th>Decrease Injuries</th>
<th>Decrease Injury Severity</th>
<th>Decrease Nursing Turnover</th>
<th>Employer of Choice</th>
<th>Decrease Light Duty</th>
<th>Increase Resident Safety</th>
<th>Other?</th>
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<tbody>
<tr>
<td>Nursing Staff who provide resident care</td>
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<td>Nurse Managers</td>
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<td>Administration</td>
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<td>Staff Development/ Educators</td>
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<tr>
<td>Risk Management</td>
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<td>Other?</td>
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<td>Other?</td>
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</tbody>
</table>
G. Prioritize strategies you think will decrease the incidence/severity of nursing work-related injuries at your facility:

- Back Injury Resource Nurses
- Education/training
- Safety Huddles
- Resident Handling & Movement Policy
- Assessment, Care Plan & Algorithms Care Areas
- Equipment (specify)
- Providing feedback to staff
- Ergonomic Assessments of Resident Others

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
<th>Target Audience</th>
<th>Plans and Target Dates</th>
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</thead>
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</table>


H. What strategies will you use to evaluate your success?

I. What strategies will you use to maintain the interventions over time?

J. Identify the first five tasks that you will undertake.

a. ________________________________
b. ________________________________
c. ________________________________
d. ________________________________
e. ________________________________
UNIT PEER LEADER MEETING
NOTES/MINUTES
II. EQUIPMENT INFORMATION
<table>
<thead>
<tr>
<th>PATIENT CARE EQUIPMENT</th>
<th>Manufacturer/Style/Name (Ex: Arjo Maxi Move)</th>
<th>Inventory (Total # you have now)</th>
<th>In working order?</th>
<th>Use (% being used now) Comment:</th>
<th># &amp; Date of introduction of new equip</th>
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<tbody>
<tr>
<td><strong>FULL BODY SLING LIFTS</strong></td>
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<tr>
<td>Floor-based, Powered Lifts</td>
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<tr>
<td>Ex: Arjo Maxi Move</td>
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<tr>
<td>Floor-based, Non-Powered Lifts</td>
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<tr>
<td>Ex: Hoyer</td>
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<td>Ceiling Mounted Lifts</td>
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<td>Ex: BHM Voyager</td>
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<tr>
<td>Bathing Lifts</td>
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<td><strong>LATERAL TRANSFER AIDS</strong></td>
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<tr>
<td>Mechanical Lateral Transfer Aids</td>
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<tr>
<td>Ex: Mobilizer, TotaLift II, On-3</td>
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<tr>
<td>Friction Reducing Lateral Sliding Aids</td>
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<tr>
<td>Ex: Sliding/Surf Boards, RTA, Phili slide</td>
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<td>Air Assisted Lateral Transfer Aids</td>
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<td>Ex: AirPal; Hovermat</td>
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<tr>
<td>PATIENT CARE EQUIPMENT</td>
<td>Manufacturer/Style/Name (Ex: Arjo Maxi Move)</td>
<td>Inventory (Total # you have now)</td>
<td>In working order?</td>
<td>Use (% being used now)</td>
<td>Comment:</td>
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<tr>
<td>TRANSFER CHAIRS</td>
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<tr>
<td>Ex: Transitchair</td>
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<tr>
<td>POWERED STANDING ASSIST &amp; REPOSITIONING LIFTS</td>
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<tr>
<td>Ex: Translift, Raisa Lift</td>
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<tr>
<td>STANDING ASSIST &amp; REPOSITIONING AIDS (Non-Powered)</td>
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<tr>
<td>Ex: Super/Pivot Pole, Bed-Bar</td>
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<tr>
<td>ERGONOMIC SHOWER CHAIR</td>
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<tr>
<td>Ex: ARJO Carrendo</td>
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<tr>
<td>MOTORIZED BED/ WHEELCHAIR</td>
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<tr>
<td>BED OR WHEELCHAIR MOVERS</td>
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<tr>
<td>OTHERS</td>
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</tbody>
</table>
UNIT PATIENT HANDLING EQUIPMENT VENDORS/MANUFACTURERS
CONTACT INFORMATION

Patient Handling Equipment: ________________________________

Company/Manufacturer: ________________________________

Website: ___________________________________________

Facility representative: __________________________________

Contact Information:
Cell Phone #: _______________________________________

Office Phone #: ______________________________________

Fax #: _____________________________________________

Other Information:

Patient Handling Equipment: ________________________________

Company/Manufacturer: ________________________________

Website: ___________________________________________

Facility representative: __________________________________

Contact Information:
Cell Phone #: _______________________________________

Office Phone #: ______________________________________

Fax #: _____________________________________________

Other Information
EQUIPMENT/SLINGS PHOTOS
### SLING SELECTION CHART

<table>
<thead>
<tr>
<th>Activity</th>
<th>Sling Choices</th>
<th>Criteria</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vertical Transfers (to/from bed/ wheelchair/ commode/ dependency chair/etc.)</td>
<td>SEATED</td>
<td>Patient can tolerate sitting position and has adequate hip &amp; knee flexion</td>
<td>Consider presence of wounds for sling application and patient positioning. Consider precautions of total hip replacement patients. Consider presence of wounds for sling application and patient positioning.</td>
</tr>
<tr>
<td></td>
<td>STANDING</td>
<td>Patient can grasp &amp; hold handle with at least one hand, has at least partial weight bearing capability, has upper body strength, and is cooperative &amp; can follow simple commands</td>
<td></td>
</tr>
<tr>
<td>Lateral Transfers (to/from bed/ stretcher/ Shower trolley/ gurney) Bathing</td>
<td>SUPINE</td>
<td>Patient cannot tolerate sitting position and has restricted hip &amp; knee flexion. Patient can tolerate supine position. Do NOT use if patient has respiratory compromise or if wounds present may affect transfers/positioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SUPINE</td>
<td>Patient cannot tolerate sitting position and has restricted hip &amp; knee flexion. Patient can tolerate supine position. Do NOT use if patient has respiratory compromise or if wounds present may affect transfers/positioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SEATED</td>
<td>Patient can tolerate sitting position and has adequate hip &amp; knee flexion</td>
<td>Consider presence of wounds for sling application and patient positioning. Consider precautions of total hip replacement patients. Consider wounds, comfort, circulation, neurovascular and joint conditions, if task is of long duration Consider presence of wounds for sling application and patient positioning. Consider precautions of total hip replacement patients. Consider presence of wounds for sling application and patient positioning.</td>
</tr>
<tr>
<td></td>
<td>LIMB SUPPORT</td>
<td>Sustained holding of any extremity while bathing in bed</td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>SEATED</td>
<td>Patient can tolerate sitting position and has adequate hip &amp; knee flexion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>STANDING</td>
<td>Patient can grasp &amp; hold handle with at least one hand, has at least partial weight bearing capability, has upper body strength, and is cooperative &amp; can follow simple commands</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Sling Choices</td>
<td>Criteria</td>
<td>Special Considerations</td>
</tr>
<tr>
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<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Repositioning in Chair         | SEATED        | Patient can tolerate sitting position and has adequate hip & knee flexion| Consider presence of wounds for sling application and patient positioning.  
Consider precautions of total hip replacement patients. |
| Repositioning UP in Bed         | SUPINE        | Patient cannot tolerate sitting position and has restricted hip & knee flexion. Patient can tolerate supine position. | Do NOT use if patient has respiratory compromise or if wounds present may affect transfers/positioning. |
|                                | SEATED        | Patient can tolerate sitting position and has adequate hip & knee flexion| Consider presence of wounds for sling application and patient positioning.  
Consider precautions of total hip replacement patients. |
|                                | REPOSITIONING| Patient can tolerate supine position.                                    | Do NOT use if patient has respiratory compromise or if wounds present may affect transfers/positioning. |
| Turning a patient in bed        | SUPINE        | Patient cannot tolerate sitting position and has restricted hip & knee flexion. Patient can tolerate supine position. | Do NOT use if patient has respiratory compromise or if wounds present may affect transfers/positioning. |
|                                | REPOSITIONING| Patient can tolerate supine position.                                    | Do NOT use if patient has respiratory compromise or if wounds present may affect transfers/positioning. |
| Making an Occupied Bed          | SUPINE        | Patient cannot tolerate sitting position and has restricted hip & knee flexion. Patient can tolerate supine position. | Do NOT use if patient has respiratory compromise or if wounds present may affect transfers/positioning. |
|                                | SEATED        | Patient can tolerate sitting position and has adequate hip & knee flexion| Consider presence of wounds for sling application and patient positioning.  
Consider precautions of total hip replacement patients. |
<p>| Functional Sit- Stand           | STANDING      | Patient can grasp &amp; hold handle with at least one hand, has at least partial weight bearing capability, has upper body strength, and is cooperative &amp; can follow simple commands | Consider presence of wounds for sling application and patient positioning. |</p>
<table>
<thead>
<tr>
<th>Activity</th>
<th>Sling Choices</th>
<th>Criteria</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>STANDING</td>
<td>Patient can grasp &amp; hold handle with at least one hand, has at least partial weight bearing capability, has upper body strength, is cooperative &amp; can follow simple commands</td>
<td>Consider presence of wounds for sling application and patient positioning.</td>
</tr>
<tr>
<td></td>
<td>LIMB SUPPORT</td>
<td>Sustained holding of any extremity while dressing in bed</td>
<td>Consider wounds, comfort, circulation, neurovascular and joints, if task is of long duration</td>
</tr>
<tr>
<td>Pericare</td>
<td>STANDING</td>
<td>Patient can grasp &amp; hold handle with at least one hand, has at least partial weight bearing capability, has upper body strength, and is cooperative &amp; can follow simple commands</td>
<td>Consider presence of wounds for sling application and patient positioning.</td>
</tr>
<tr>
<td>Ambulation training and support</td>
<td>WALKING</td>
<td>Partial weight bearing, level of cooperation, consult Dr. &amp; therapist for readiness</td>
<td>Do NOT use if wounds present that affect transfers and positioning</td>
</tr>
<tr>
<td></td>
<td>STANDING</td>
<td>Patient can grasp &amp; hold handle with at least one hand, has at least partial weight bearing capability, has upper body strength, and is cooperative &amp; can follow simple commands</td>
<td>Consider presence of wounds for sling application and patient positioning.</td>
</tr>
<tr>
<td>Wound Care/Dressing</td>
<td>LIMB SUPPORT</td>
<td>Sustained holding of any extremity while dressing/caring for wounds while patient in bed</td>
<td>Consider wounds, comfort, circulation, neurovascular and joints, if task is of long duration</td>
</tr>
<tr>
<td>Surgical Procedures</td>
<td>LIMB SUPPORT</td>
<td>Sustained holding of any extremity while performing surgical procedure in bed</td>
<td>Consider wounds, comfort, circulation, neurovascular and joints, if task is of long duration</td>
</tr>
<tr>
<td>Fall Rescue</td>
<td>SUPINE</td>
<td>Patient cannot tolerate sitting position and has restricted hip &amp; knee flexion. Need for patient to remain flat. Patient can tolerate supine position.</td>
<td>Do NOT use if patient has respiratory compromise or if wounds present may affect transfers/positioning</td>
</tr>
<tr>
<td></td>
<td>SEATED</td>
<td>Patient can tolerate sitting position and has adequate hip &amp; knee flexion</td>
<td>Consider presence of wounds for sling application and patient positioning.</td>
</tr>
</tbody>
</table>

Consider precautions of total hip replacement patients.
EQUIPMENT INSTRUCTIONS BROCHURES
OR LOCATION OF THESE

INSERT CLEAR PLASTIC SHEETS FOR INSERTING BROCHURES
FACILITY &/OR MANUFACTURER CLEANING, INFECTION CONTROL PROTOCOLS/PROCEDURES

Develop SOP with facility infection control practitioner for cleaning all patient handling equipment and slings.
LINK TO PATIENT SAFETY CENTER WEBSITE FOR INFORMATION ON PATIENT HANDLING EQUIPMENT

Technology Resource Guide:

http://www.visn8.va.gov/patientsafetycenter/safePtHandling/default.asp
III. SPHM PROGRAM ELEMENTS
SPHM POLICY/PROCEDURES
1. PURPOSE: This SPH Policy provides procedures and responsibility for implementation and maintenance of a multi-faceted Safe Patient Handling (SPH) Program that integrates evidence-based practice and technology to minimize both the human and capital expenses associated with employee injuries caused by patient handling and movement within ___________________(facility name).

2. POLICY: _____________ (facility name) wants to ensure that its patients/residents are cared for safely, while maintaining a safe work environment for employees. To accomplish this, a Safe Patient Handling and Movement Program will be implemented in order to ensure required infrastructure is in place to comply with components of this safe patient handling and movement policy. This infrastructure includes patient handling and movement equipment, program elements to support use of equipment, employee training, and a “Culture of Safety” approach to safety in the work environment. Mechanical lifting equipment and/or other approved patient handling aids must be used to prevent the manual lifting and handling of patients/residents except when absolutely necessary, such as in a medical emergency. This policy is applicable in any location where patient handling occurs and where there is sufficient patient handling equipment in place for attainment of a ‘safe patient handling’ or ‘minimal manual lift’ work environment.

3. PROCEDURES:

A. Compliance: It is the duty of employees to take reasonable care of their own health and safety, as well as that of their co-workers and their patients/residents during patient handling activities. Non-compliance will indicate a need for retraining.

B. Safe Patient Handling and Movement Requirements:
1. Avoid hazardous manual patient handling and movement tasks whenever possible. If unavoidable, assess them carefully prior to completion.
2. Use patient handling equipment and other approved patient handling aids for high-risk patient handling and movement tasks except when absolutely necessary, such as in a medical emergency.
3. Use patient handling equipment and other approved patient handling aids in accordance with instructions and training.

C. Training:
1. Training will be provided by staff with training and expertise in Safe Patient Handling and Movement.
2. Training will be incorporated into the
   a. current curriculum for new employees
   b. unit based competencies
3. Mandatory annual training updates will be completed by all staff who move and handle patients

D. Patient Handling Equipment:
1. Patient handling equipment will be accessible to staff.
2. Patient handling equipment will be maintained regularly and kept in proper working order.
3. Patient handling equipment shall be stored conveniently and safely.

E. Safe Patient Handling (SPH) Program Elements

1. Patient Care Ergonomic Evaluations
2. Patient Handling Equipment and Aids
3. Safe Patient Handling Assessment, Algorithms, and Care Plan
4. Unit Peer Leaders (UPL)
5. Safety Huddle/After Action Review (AAR) Process

F. Reporting of Injuries/Incidents:
1. Nursing staff shall report all incidents/injuries resulting from patient handling and movement.
2. Supervisors shall report patient handling injury information as required by the facility. They may also collect supplemental patient handling injury statistics as required by the facility and the Safe Patient Handling Program.
4. DEFINITIONS:

A. **High Risk Patient Handling Tasks**: Patient handling tasks that have a high risk of musculoskeletal injury for staff performing the tasks. These include but are not limited to transferring tasks, lifting tasks, repositioning tasks, bathing patients in bed, making occupied beds, ambulating patients, dressing patients, turning patients in bed, tasks with long durations, standing for long periods of time, bariatric, and other patient handling tasks.

B. **High Risk Patient/Resident Care Areas**: Inpatient hospital wards with a high proportion of dependent patients, requiring full assistance with patient handling tasks and activities of daily living and who are frequently moved in and out of bed. Analysis of facility injury data and use of a tool for prioritization of high risk tasks may assist in designation of high risk areas. These units have the highest incidence and severity of injuries due to patient handling tasks and are priorities for patient handling equipment interventions.

C. **Manual Lifting**: Lifting, transferring, repositioning, and moving patients using a caregiver’s body strength without the use of lifting equipment/aids that reduce forces on the worker’s musculoskeletal structure.

D. **Patient Handling Equipment and Aids** – decrease the risk of injury from patient handling activities and includes, but is not limited to the following.

1. **Lifting Equipment** includes both ceiling-mounted and portable/floor-based designs and their accompanying slings that function to assist in lifting and transferring patients, ambulating patients, repositioning patients, and other patient handling tasks.

2. **Lateral Transfer Devices** provide assistance in moving patients horizontally from one surface to another (e.g., transfers from bed to stretcher).

3. **Beds** that provide assistance with patient handling tasks such as lateral rotation therapy, transportation, percussion, bringing patients to sitting positions, etc.

4. **Stretchers/Gurneys** that are motorized provide assistance with transporting patients.

5. **Repositioning Aids** provide assistance in turning patients and pulling patients up to the head of the bed and up in chairs.

6. **Equipment/bed/wheelchair transport assistive devices** assist caregivers in pushing heavy equipment.

7. **Patient Handling Aids**; Non-mechanical equipment used to assist in the lift or transfer process. Examples include stand assist aids, sliding boards, and surface friction-reducing devices.

E. **Culture of Safety** describes the collective attitude of employees taking shared responsibility for safety in a work environment and by doing so, providing a safe environment of care for themselves, co-workers, and patients/residents.

F. **Safe Patient Handling Assessment, Algorithms, and Care Plan** - Assists nurses in selecting the safest equipment, techniques, and number of staff required for completing high risk patient handling tasks based on specific patient. ([www.visn8.va.gov/patientsafetycenter/](http://www.visn8.va.gov/patientsafetycenter/))

G. **Patient Care Ergonomic Evaluations** – As needed, these are conducted by trained staff in all clinical areas/units where patient/resident handling occurs. Includes risk identification, risk analysis, and generation of equipment, procedure, and policy recommendations.
H. Safety Huddle/After Action Review (AAR) Process – this is an optional but powerful program element. Use of Safety Huddles is an effective method of sharing knowledge between staff that incorporates staff into the problem-solving process. Safety Huddles are held as a result of an injury incident, near-miss/close-call incident, or a safety concern to decrease the chance of the recurrence. (See Attachment A)

I. Unit Peer Leaders (UPLs) – are staff members from clinical units/areas where patient handling occurs, including nursing, therapy, radiology, the morgue, and other diagnostic, treatment, and procedure areas. They act as the patient handling and movement unit/area champion and resource person. (Attachment B)

J. Facility Champions/Coordinators are nursing or therapy staff with expertise in patient handling and movement techniques and knowledge of patient handling equipment/aids and Safe Patient Handling Program elements. (Attachment C)

K. Facility Safe Patient Handling Team/Task Force consists of a multidisciplinary group of clinical staff, facilities management staff, infection control staff, union representative, safety, and others responsible for assisting in implementation of the SPH Program. (Attachment D)

5. DELEGATION OF AUTHORITY AND RESPONSIBILITY:

A. FACILITY DIRECTOR shall:
1. Support the implementation of this policy and the associated Safe Patient Handling Program.
2. Support a “Culture of Safety” within this medical center.
3. Furnish sufficient patient handling equipment/aids to ensure safe patient handling and movement.
4. Furnish acceptable storage locations for patient handling equipment/aids.
5. Ensure patient handling equipment/aids are well maintained and repaired in a timely fashion when necessary.
6. Provide staffing levels sufficient to support safe patient handling and movement.

B. NURSE MANAGERS shall:
1. Support the implementation of this policy and the associated Safe Patient Handling Program.
2. Ensure high-risk patient handling tasks are assessed prior to completion and are completed safely, using patient handling equipment and other approved patient handling aids and appropriate techniques.
3. Ensure patient handling equipment and other equipment/aids are available, maintained regularly, in proper working order, and stored conveniently and safely.
4. Ensure employees complete safe patient handling awareness training on program elements and rationale for program. Ensure employees complete initial, annual, and additional equipment use training as required if employees show non-compliance with safe patient handling and movement or equipment use. Maintain training records for a period of three (3) years.
5. Refer all staff reporting injuries due to patient handling tasks to
Occupational Health.
6. Maintain Accident Reports and supplemental injury statistics as required by the facility.
7. Support a “Culture of Safety”.

C. EMPLOYEES shall:
1. Comply with all parameters of this policy.
2. Use proper techniques, mechanical lifting devices, and other approved equipment/aids during performance of high-risk patient handling tasks.
3. Notify supervisor of any injury sustained while performing patient handling tasks.
4. Use appropriate procedures for reporting patient handling equipment in need of repair.
5. Notify supervisor of need for re-training in use of patient handling equipment and aids and program elements.
6. Complete and document Safe Patient Handling and Movement training initially, annually, and as required to correct improper use/understanding of safe patient handling and movement.
7. Complete and document safe patient handling and movement equipment training initially and as required to correct improper use/understanding of safe patient handling and movement.
8. Support a “Culture of Safety”.

D. UNIT PEER LEADERS (UPLs) are responsible for the implementation and maintenance of the Safe Patient Handling Program in their unit/area, providing expertise in the safe patient handling and moving of patients and residents, assisting in Program monitoring & evaluation, training co-workers in Program elements, acting as staff resources, coaches, and team leaders, and sharing other applicable knowledge. (Attachment B.)

E. FACILITY CHAMPIONS/COORDINATORS are responsible for implementing and maintaining the facility Safe Patient Handling Program, providing leadership for the Unit Peer Leaders, and maintaining communication with administration and management regarding the status of the Program. (Attachment C.)

F. FACILITY SAFE PATIENT HANDLING TEAM/TASK FORCE consists of a multidisciplinary group of clinical staff, facilities management staff, infection control staff, union representative, safety, and others responsible for assisting in implementation of the SPH Program. (Attachment D)

G. FACILITIES MANAGEMENT shall
1. Maintain patient care equipment in proper working order
2. Consult with equipment manufacturers in order to provide safe equipment installations.
3. Provide guidance, assistance, and support to the safe patient handling and movement team.
H. **INFECTION CONTROL** shall provide expertise in determining appropriate cleaning/disinfecting procedures for patient handling equipment aids.

I. **SUPPLY/PROCESSING/DISTRIBUTION (SPD)** shall assist in the purchase, maintenance, tracking, and provision of patient handling equipment and slings to units/areas where appropriate.

5. **REFERENCES:**


Attachment A

Safety Huddle/AAR Brochure
**Points to Remember**

- Hold Safety Huddles regularly—either at a regularly scheduled time or at the end of a defined part of work, e.g. after morning care is completed. Schedule them at a time that is best for your particular unit and staff.

- Keep meetings brief. Safety Huddles may be accomplished in as little as 15 minutes.

- During the meeting the group asks:
  1. What happened to threaten patient or staff safety?
  2. What should have happened?
  3. What accounted for the difference?
  4. How could the same outcome be avoided the next time?
  5. What is the follow up plan?

Assign one person to take responsibility for making sure that follow up is done.
What is a Safety Huddle?

Safety Huddles are based on After Action Review (AAR), a highly successful method of knowledge transfer that is used in high performing organizations, such as the United States Army. AAR is a method for transferring knowledge a team has learned from doing a task in one setting to the next time that team does the task in a different setting (Dixon, 2000). This process moves unique knowledge that an individual holds into a group setting so that the knowledge can be integrated, understood by the whole team and used when individuals face similar circumstances.

Often, knowledge generated in work settings is not shared and therefore not usable. Safety Huddles provide a structured method for making tacit knowledge explicit among team members, thus usable next time a similar situation is faced.

Safety Huddles offer an effective means for learning from both safety mishaps and near misses. It is an informal process in which there are no recriminations, reports are not forwarded to supervisors, and meetings are facilitated locally. In Safety Huddles staff should feel free to share knowledge without fear of embarrassment or recrimination.


Safety Huddles are compatible with established mechanisms for dealing with errors and near misses such as incident-reporting and root cause analysis. The advantage to a Safety Huddle is that it becomes part of the routine way that a work team goes about its business to maximize patient safety.

When should Safety Huddles be conducted?

Safety Huddles are most successful when held on a regular basis. Either schedule them at the same time every day or after some defined unit of work, e.g. after morning care is completed. The more frequently you conduct them the more comfortable you will become with learning from experience without placing blame. Routine meetings held frequently may be easier to keep brief and highly focused.

Who should attend Safety Huddles?

Everyone involved in direct care should be involved in Safety Huddle meetings. Each person’s information and ideas are necessary to get a full picture of what happened and to generate ideas about how to incorporate the learning into future actions. Not attending will suggest that the Safety Huddle results are not a product of everyone involved, and that some members can not contribute to learning from experience.

How long should Safety Huddles last?

Keep the meetings brief. They may be accomplished in as little as 15 minutes. The group asks:

1) What happened to threaten patient or staff safety,
2) What should have happened,
3) What accounted for the difference,
4) How could the same outcome be avoided the next time, and
5) What is the follow-up plan?

Engage in open discussion based on objective facts without blaming individuals.

Should minutes be recorded?

Keep only informal notes, and make them available to other staff if it will help them to avoid patient errors and staff injuries. Do not formalize notes, nor send them to supervisors. Keep in mind that the focus of Safety Huddles is to help the team itself learn from its own experiences. One person should be responsible for making sure that corrective actions were taken.
Attachment B

Unit/Area Peer Leaders
SELECTION
ROLES/RESPONSIBILITIES
SPH Unit/Area Peer Leaders
SUGGESTED Selection Criteria

Eligibility
- Any direct patient care staff (i.e., RN, LPN, CNA, PT, OT, diagnostic tech, etc.) with at least 6 months experience with handling patients
- Employed on unit for at least six months or a UPL in another area previously
- Anticipates working on unit at least one year or more

Qualities
- Satisfactory performance evaluation
- Respected by colleagues & management
- Responsible and reliable
- Flexible
- Takes initiative/proactive
- Good time management qualities
- Outgoing
- Resourceful
- Assertive (appropriately)
- Maintains good relationships w/ management

Skills
- Patient handling experience
- Effective oral/written communication skills
- Physically able to perform job duties
- Critical thinking skills (appropriate for duties)
- Ability to teach peers using established training programs
- Informal Leader – credible with & respected by peers
- Computer skills
- Ability to learn, apply, and transfer new knowledge
SPH Unit/Area Peer Leaders
SUGGESTED Roles/Responsibilities

Act as Unit SPH Champion
- Act as unit expert and resource on patient care ergonomics, equipment use, and safe patient handling techniques for managers/supervisors, peers, patients, families
- Problem solve patient handing issues
- Motivate/coach peers – encourages co-workers in use of patient handling equipment and compliance with SPH Program
- Bariatric SPH resource/expert
- Assist in SPH Program implementation

Train peers/mangers/patients/families
- Conduct staff in-services/training on SPH issues, equipment, etc.
- On unit, orient new employees to SPH & UPL role
- Facility-wide, participate in new employee orientation training
- Train, re-train co-workers on new & existing equipment
- Complete or assist in completion of equipment competency assessments
- Assist co-workers in patient/family training when needed

Facilitate SPH Knowledge Transfer
- Maintain communication with other UPLs through
  - Face-to-face facility UPL meetings
  - UPL Email Group
  - Conference calls
- Share best practices learned during UPL meetings with co-workers/ management
- Communicate with Facility Champion
  - One-on-one as needed
  - UPL meetings
  - Ensure facility champion is aware of UPL personnel changes – resignation, transferring etc.
- Implement After Action Review (AAR) Program, Initially take lead in AARs
- Train staff on and ensure compliance with use of Algorithms

Monitor unit SPH Program status/compliance
- Complete UPL Log to capture
  - UPL activity
  - SPH Program status
  - SPH Program acceptance
- Track equipment use
- Others

Equipment Super User
Equipment Use/Management

- Assist in conducting unit equipment needs evaluation
- Assist staff in selection of equipment through trials/equipment fairs
- Implement equipment introductions on unit
- Train staff on use of equipment (after initial manufacturer training)
- Track equipment locations, storage & ensure accessibility
- Track operational status and need for maintenance of equipment/batteries/slings
- Ensure annual/preventative maintenance is accomplished
- Track sling types, quantities, and condition
- Facilitate battery/sling/equipment orders when needed
- Notify appropriate staff when patient handling equipment problems/incidents arise
- Ensure facility & manufacturer infection control requirements are followed

Act as Unit liaison with

- Facility Champion/Coordinator
- equipment manufacturer/vendor
- purchasing
- Engineering/Facilities Management
- Infection control
- others

Conduct Ergonomic ongoing environmental/ergonomic evaluations, perform walk-throughs to assess equipment use and function

Maintain current knowledge of SPH issues, technology, and best practices

- Attend facility UPL meetings, regional/national conference calls
- Participate in equipment manufacturer training
- Attend annual SPH conferences

Follow unit injuries & close calls

- Assist in documentation and tracking of injuries and close calls
- Foster reporting of injuries, near misses, and safety concerns

Demonstrate Systems Thinking

- Participate in facility-wide SPH initiatives and projects
- Foster supportive relationship with manager/supervisor
- Be knowledgeable of and provide input on facility policies/procedures
Attachment C

Facility Safe Patient Handling
Champion/Coordinator

SAMPLE FUNCTIONAL STATEMENT
Facility Safe Patient Handling Coordinator
Sample Functional Statement
DRAFT

Position Summary
The Safe Patient Handling Coordinator (SPH Coordinator) provides leadership and assumes continuing responsibility for the development, implementation, coordination, maintenance, and evaluation of the Safe Patient Handling program at the facility level. This includes integrated programs that cross service and/or discipline lines and influence organizational mission, vision, values, and strategic priorities.

Principle Duties and Responsibilities
The Safe Patient Handling Coordinator is responsible for:

- Implementation and maintenance of the facility’s Safe Patient Handling (SPH) Program
- Continuous evaluation of the facility’s Safe Patient Handling (SPH) Program; collection and submission of facility and national SPH performance measures and data call requests
- Development, leadership, coordination, expansion, and maintenance of the patient handling Unit Peer Leader (UPL) program
- UPL SPH education, training, and competency assessment in use of equipment and program elements
- Staff SPH education, training, and competency assessment in use of equipment and program elements
- Evaluation of compliance with JCAHO standards and planning and implementation of programs
- Identification, proposal, and oversight of equipment to meet current and future facility needs for safe patient handling
- Development and implementation of facility equipment and sling tracking programs
- Collaboration with facility infection control practitioners to develop and implement facility infection control program for patient handling equipment
- Communication of SPH goals and objectives and SPH Program status to facility administrators/Environment of Care Committee
- Leadership and coordination of facility multidisciplinary SPH committee
- Provision of expertise and oversight of SPH in all relevant clinical areas
- Provision of expertise and oversight of facility SPH bariatric issues
- Communication and coordination of equipment selection, installation, and maintenance with facility contracting, facilities management, and other applicable services
- Communication and coordination of remediation of equipment issues with manufacturers and facility contracting, facilities management, and other applicable service
FACTORS

Knowledge Required by the SPH Coordinator Position

Incumbent is a graduate of an accredited PT, OT, or RN program and holds a current and unrestricted license to practice their respective profession.

A Master’s Degree or Ph.D. (may be in a variety of related fields including Nursing, Ergonomics, Physical Therapy, Occupational Therapy, or other relevant areas) is desirable.

Proficiency in English is required.

At least three (3) years of exemplary clinical experience with demonstrated leadership skills is required.

The SPH Coordinator must possess solid interpersonal and collaboration skills. The SPH Coordinator must also demonstrate well honed communication abilities. As such the SPH Coordinator must be a team player that clearly illustrates how the Safe Patient Handling program segues with and complements existing programs.

Scope and Complexity

The Safe Patient Handling Coordinator must collaborate, elicit support, and network with interdisciplinary personnel, SPH experts/resources outside the facility and the VA Safety Center and equipment vendors.

Practice: Uses an analytical framework to create, develop and maintain the SPH program; as such the following practice components will be effectuated:

- Ongoing data collection and use of research to demonstrate progress/success of the SPH program
- Development of the unit peer leader program to facilitate facility-wide implementation of the SPH program. Education, supervision and support of the unit peer leaders
- Collaborate with managers to develop a strategy for dissemination of information, education, and justification of SPH program to nursing unit staff and other disciplines
- Develop and implement a plan to “sell” or market SPH program and educate interdisciplinary staff
- Collaborate with nursing and other related clinical professional management/staff in equipment selection and implementation.

Quality of Care: Provides leadership in improving and sustaining the quality and effectiveness of care in SPH program.
Performance: Implements standards of professional practice consistent with applicable accrediting bodies’ regulations.

Education/Career Development: Develops unit peer leaders for progression of responsibility. Anticipates new knowledge needs for changing practice environment/population groups. Plans, implements and evaluates strategies to meet those needs.

Collegiality: Contributes to the professional growth and development of colleagues and other health care providers at the local, regional, state, and national level including VA counterparts.

Ethics: Provides leadership in addressing ethical issues that impact the clients or staff involved with the SPH program.

Collaboration: Demonstrates leadership in developing productive working relationships with groups in other programs, services, academic settings and community settings.

Research: Collaborates with staff, other disciplines, faculty and peers in developing, conducting and evaluating SPH research activities and programs.

Resource Utilization: Designs, modifies, and implements systems compatible with professional standards and with the mission and the goals of the organization to improve cost-effective use of resources.

Guidelines

Guidelines consist of relevant clinical practice and administrative policies as they relate to Safe Patient Handling. This will require the SPH Coordinator to exercise considerable adaptation and interpretation for relevant SPH issues and applications. Existing precedents provide a basic outline of results desired, but do not go into sufficient detail as to the specific implementation of the SPH program. Within the context of broad regulatory guidelines the SPH Coordinator may refine or develop more specific guidelines such as implementing standards of practice and other related methods. Incumbent must have the ability to follow guidelines within the parameters of the overall SPH program.

Supervisory Controls

The Safe Patient Handling Coordinator is directly accountable to the Nurse Executive/Associate Director for Patient Care Services for their professional practice and administrative performance.

The supervisor and SPH Coordinator will develop a mutually acceptable project plan which typically includes identification of the task to be accomplished, the scope of the project, and deadlines for its completion. Within the parameters of the SPH program, the
incumbent is responsible for planning and organizing the work, estimating costs and requirements, coordinating with staff and line supervisors potentially controversial findings, issues, or problems with widespread impact. Completed projects, evaluations, reports, or recommendations are reviewed by the supervisor for compatibility with overall organizational goals, guidelines, and effectiveness in achieving intended objectives. Incumbent will work independently without daily close supervision; and as such will maintain SPH programs on an ongoing basis.

**Personal Contacts**

Personal contacts are extensive and include patients, clinical staff, facility leadership and others directly affected by the Safe Patient Handling program. Ongoing interaction will be maintained with respective program officials in VACO.

**Purpose of Contacts**

The purpose of the contacts outlined above, is to educate patients and related staff on the components of Safe Patient Handling and to fully implement/integrate the SPH program.

The SPH Coordinator also collects information from these contacts and provides ongoing qualitative analysis of the program’s effectiveness. This comprises a continuous quality improvement process for the SPH program.

**Work Environment**

Work is performed in a clinical setting within the medical center.

**IT Security Statement**

In the performance of their official duties, the SPH Coordinator has regular access to print and electronic files containing sensitive information which must be protected under the provision of the Privacy Act of 1974, HIPAA, and other applicable laws and regulations. The incumbent is responsible for (1) protecting all relevant information against unauthorized release or deletion and, (2) following applicable regulations and instructions regarding access to computerized files, release of access codes, etc., as set out in their computer access agreement which the employee signs for IT access.
Attachment D

Facility Safe Patient Handling Committee
Facility Safe Patient Handling Committee

Membership

- SPH Facility Champion
- Unit Peer Leader Representative
- Nursing Administrator
- Nursing Staff (CNA, LPN, RN)
- Nursing Service Safety Rep
- Risk Manager
- Union
- Nurse Educator
- Therapy Staff (OT, PT, ST)
- Purchasing
- Engineering
- Employee Health/Safety
- Patient
- Others

Roles/Responsibilities

- Implements and maintains SPH Program
- Identifies SPH Program Goals and Objectives, utilizes them to drive Program
- Develops Policy and Procedures
- Reviews/trends Data
- Ensures incidents/injuries are investigated and remediated, if feasible
- Facilitates Equipment Purchases
- Others
SAFETY HUDDLE
After Action Review (AAR)
Points to Remember

- Hold Safety Huddles regularly—either at a regular meeting or at the end of a defined time. Schedule them at a time that is best for your particular unit and staff.
- Keep meetings brief. Safety Huddles may be accomplished in as little as 15 minutes.
- During the meeting, the group asks:
  1. What happened to threaten patient safety?
  2. What should have happened?
  3. What accounted for the difference?
  4. How could the same outcome be avoided the next time?
  5. What is the follow-up plan?
- Assign one person to take responsibility for making sure that follow up is done.

Department of Veterans Affairs

Safe Patient Handling Unit Binder 10/29/2013/Matz
What is a Safety Huddle?

Safety Huddles are based on After Action Review (AAR), a highly successful method of knowledge transfer that is used in high performing organizations, such as the United States Army. AAR is a method for transferring knowledge a team has learned from doing a task in one setting to the next time that team does the task in different setting (Dixon, 2000). This process moves unique knowledge that an individual holds into a group setting so that the knowledge can be integrated, understood by the whole team and used when individuals face similar circumstances.

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Safety Huddles are compatible with established mechanisms for dealing with errors and near misses such as incident-reporting and root cause analysis. The advantage to a Safety Huddle is that it becomes part of the routine way that a work team goes about its business to maximize patient safety.

When Should Safety Huddles be Conducted?

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Who Should Attend Safety Huddles?

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How Long Should Safety Huddles last?

Keep the meetings brief. They may be accomplished in as little as 15 minutes. The group asks:
1) What happened to threaten patient or staff safety,
2) What should have happened,
3) What accounted for the difference,
4) How could the same outcome be avoided the next time, and
5) What is the follow-up plan? Engage in open discussion based on objective facts without blaming individuals.

Should Minutes be Recorded?

Keep only informal notes, and make them available to other staff if it will help them to avoid patient errors and staff injuries. Do not formalize notes, nor send them to supervisors. Keep in mind that the focus of Safety Huddles is to help the team itself learn from its own experiences. One person should be responsible for making sure that corrective actions were taken.

Department of Veterans Affair

VA Patient Safety Center (118W)
11605 N. Nebraska Avenue
Tampa, FL 33612-8738

Phone: 813-556-3911
Fax: 813-556-3990
www.vistb.va.gov/patient/safetycenter/
SAFETY HUDDLE QUESTIONS

(1) What happened?

(2) What was supposed to happen?

(3) What accounts for the difference?

(4) How could the same outcome be avoided the next time?

(5) What is the follow-up plan?

For More Information: Safe Patient Handling & Movement: A Practical Guide for Health Care Professionals, Ch. 7 (M. Matz, author; A. Nelson, editor)
SAFETY HUDDLE 
RECOMMENDATIONS TEMPLATE

Date of Safety Huddle:____________________________

RECOMMENDATION #1:

STAFF RESPONSIBLE FOR FOLLOW-UP:

Contact Information:

FOLLOW-UP DATE/S:

RECOMMENDATION #2:

STAFF RESPONSIBLE FOR FOLLOW-UP:

Contact Information:

FOLLOW-UP DATE/S:

RECOMMENDATION #3:

STAFF RESPONSIBLE FOR FOLLOW-UP:

Contact Information:

FOLLOW-UP DATE/S:

10/29/2013/Matz
<table>
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<th>Date of initial Safety Huddle/AAR</th>
<th>Recommendation</th>
<th>Progress Notes</th>
<th>Follow-up Date/s</th>
<th>Recommendation Completion Date</th>
<th>Date Staff Informed of Status</th>
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10/29/2013/ Matz
SAFE PATIENT HANDLING ASSESSMENT, ALGORITHMS, & CARE PLAN
Assessment Criteria and Care Plan for Safe Patient Handling and Movement

I. Patient’s Level of Assistance:
   _____ Independent—Patient performs task safely, with or without staff assistance, with or without assistive devices.
   _____ Partial Assist—Patient requires no more help than stand-by, cueing, or coaxing, or caregiver is required to lift no more than 35 lbs. of
   a patient’s weight.
   _____ Dependent—Patient requires nurse to lift more than 35 lbs. of the patient’s weight, or is unpredictable in the amount of assistance
   offered. In this case assistive devices should be used.

   An assessment should be made prior to each task if the patient has varying level of ability to assist due to medical reasons, fatigue, medications, etc. When
   in doubt, assume the patient cannot assist with the transfer/repositioning.

II. Weight Bearing Capability
   III. Bi-Lateral Upper Extremity Strength
   _____ Full      _____ Yes
   _____ Partial     _____ No
   _____ None

IV. Patient’s level of cooperation and comprehension:
   _____ Cooperative — may need prompting; able to follow simple commands.
   _____ Unpredictable or varies (patient whose behavior changes frequently should be considered as “unpredictable”), not cooperative, or
   unable to follow simple commands.

V. Weight: _________ Height: ___________
   Body Mass Index (BMI) [needed if patient’s weight is over 300]\(^1\): ___________

   If BMI exceeds 50, institute Bariatric Algorithms

   The presence of the following conditions are likely to affect the transfer/repositioning process and should be considered when identifying equipment and
   technique needed to move the patient.

VI. Check applicable conditions likely to affect transfer/repositioning techniques.
   _____ Hip/Knee/Shoulder Replacements
   _____ History of Falls
   _____ Paralysis/Paresis
   _____ Unstable Spine
   _____ Severe Edema
   _____ Very Fragile Skin
   _____ Respiratory/Cardiac Compromise
   _____ Wounds Affecting Transfer/Positioning
   _____ Amputation
   _____ Urinary/Fecal Stoma
   _____ Contractures/Spasms
   _____ Tubes (IV, Chest, etc.)
   _____ Fractures
   _____ Splints/Traction
   _____ Severe Osteoporosis
   _____ Severe Pain/Discomfort
   _____ Postural Hypotension

Comments: ________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________
_________________________________________________________________________________

VII. Appropriate Lift/Transfer Devices Needed:

Vertical Lift: ______________________________________________________________________________________
____________________________________________________________________________________

Horizontal Lift: _____________________________________________________________________________________
____________________________________________________________________________________

Other Patient Handling Devices Needed: ______________________________________________________________________________________
____________________________________________________________________________________

Sling Type: Seated____ Seated (Head Support) _____ Seated (Amputee)_____ Hygiene_____ Supine_____ Ambulation_____ Limb Support_____
Sling Size: ______________

Signature: _______________________________________________ Date: _________________

¹ For Online BMI table and calculator see: http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm

10/29/2013/Matz
Algorithm 1: Transfer to and From: Bed to Chair, Chair to Toilet, Chair to Chair, or Car to Chair

Start Here

Can patient bear weight?

No

Partially

Is the patient cooperative?

No

Yes

Use full body sling lift and 2 caregivers.

Is the patient cooperative?

No

Yes

Stand and pivot technique using a gait/transfer belt (1 caregiver) or powered standing assist lift (1 caregiver).

Does the patient have upper extremity strength?

No

Yes

Seated transfer aid; may use gait/transfer belt until the patient is proficient in completing transfer independently.

Caregiver assistance not needed; Stand by for safety as needed.

- For seated transfer aid, must have chair with arms that recess or are removable.
- For full body sling lift, select a lift that was specifically designed to access a patient from the car (if the car is the starting or ending destination).
- If patient has partial weight bearing capacity, transfer toward stronger side.
- Toileting slings are available for toileting.
- Mesh slings are available for bathing.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
Algorithm 2: Lateral Transfer To and From: Bed to Stretcher, Trolley

Start Here

Can patient assist?

> 200 Pounds: Use a ceiling lift with supine sling, a mechanical lateral transfer device or air-assisted device and 3 caregivers.

< 200 Pounds: Use a friction reducing device.

Caregiver assistance not needed; Stand by for safety as needed.

- Destination surface should be 1/2" lower for all lateral patient moves.
- For patients with Stage III or IV pressure ulcers, care must be taken to avoid shearing force.
- During any patient transferring task, if any caregiver is required to lift more than 35 bs. of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
Algorithm 3: Transfer To and From: Chair to Stretcher or Chair to Exam Table

Start Here

Is the patient cooperative?

Yes

Can the patient bear weight?

Fully

Caregiver assistance not needed; Stand by for safety as needed.

Partially

If exam table/stretcher can be positioned to a low level, use non-powered stand assist. If not, use a full body sling lift.

No

Use floor-based lift and 2 or more caregivers.

No

Use floor-based lift and 2 or more caregivers.

- High/Low exam tables and stretchers would be ideal.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
Algorithm 4: Reposition in Bed: Side-to-Side, Up in Bed

- This is not a one person task: DO NOT PULL FROM HEAD OF BED.
- When pulling a patient up in bed, the bed should be flat or in a Trendelenburg position (when tolerated) to aid in gravity, with the side rail down.
- For patients with Stage III or IV pressure ulcers, care should be taken to avoid shearing force.
- The height of the bed should be appropriate for staff safety (at the elbows).
- If the patient can assist when repositioning “up in bed,” ask the patient to flex the knees and push on the count of three.
- During any patient handling task, if the caregiver is required to lift more than 35 lbs. of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used.
Algorithm 5: Reposition in Chair: Wheelchair and Dependency Chair

Start Here

Can patient assist?

Fully able

Caregiver assistance not needed; Stand by for safety as needed.

- If patient has upper extremity strength in both arms, have patient lift up while caregiver pushes knees to reposition.
- If patient lacks sensation, cues may be needed to remind patient to reposition.

Partially able

Can the patient bear weight?

Yes

Recline chair and use a seated repositioning device and 2 caregivers.

No

Use floor-based lift or stand assist aid and 1 to 2 caregivers.

No

Is patient cooperative?

Yes

Use floor-based lift and 2 or more caregivers.

No

- Take full advantage of chair functions, e.g., chair that reclines, or use arm rest of chair to facilitate repositioning.
- Make sure the chair wheels are locked.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
Algorithm 6: Transfer a Patient Up From the Floor

- Use floor-based lift that goes all the way down to the floor (most of the newer models are capable of this).
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient's weight then the patient should be considered to be fully dependent and assistive devices should be used. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
**Bariatric Algorithm 1: Bariatric Transfer To and From: Bed/Chair, Chair/Toilet, or Chair/Chair**

**Start Here**

- **Can patient bear weight?**
  - Fully
  - **Stand-by for safety as needed***

- **Is the patient cooperative?**
  - Partially or No
  - **Bariatric floor-based or ceiling lift (minimum of 3 caregivers)**
  - Fully

- **Does the patient have upper extremity strength?**
  - No
  - **Bariatric floor-based or ceiling lift (minimum of 3 caregivers)**
  - Fully

- **Use seated bariatric transfer aid:** may use sliding board until the patient is proficient in completing transfer independently (minimum of 2 caregivers)

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- For seated transfer aid, must have chair with arms that recess or are removable.
- Bariatric toileting slings are available for toileting.
- Bariatric bathing mesh slings are available for bathing.
- Note that a standard porcelain toilet typically has a weight limit of 350 pounds; the patient may need a bariatric commode chair or steel toilet.
- In older lifts, more effort is needed to place the sling under the patient, which may require a minimum of 3 caregivers.

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**Stand-by for safety:** In most cases, if a bariatric patient is about to fall, there is very little that the caregiver can do to prevent the fall. The caregiver should be prepared to move any items out of the way that could cause injury, try to protect the patient’s head from striking any objects or the floor and seek assistance as needed once the person has fallen.

- If patient has partial weight-bearing capability, transfer toward stronger side.
- Consider using an abdominal binder if the patient’s abdomen impairs a patient handling task.
- Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with “EC” (for expanded capacity) and a space for the manufacturer’s rated weight capacity for that particular equipment model.
- Identify a leader when performing tasks with multiple caregivers. This will assure that the task is synchronized for increased safety of the healthcare provider and the patient.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
**Bariatric Algorithm 2: Bariatric Lateral Transfer To and From: Bed/Stretcher/Trolley**

The destination surface should be about 1/2" lower for all lateral patient moves.
- Avoid shearing force.
- Make sure bed is the right width, so excessive reaching by caregiver is not required.
- Lateral transfers should not be used with specialty beds that interfere with the transfer. In this case, use a bariatric ceiling lift with supine sling.
- Ensure bed or stretcher doesn't move with the weight of the patient transferring.
- "Stand-by for safety." In most cases, if a bariatric patient is about to fall, there is very little that the caregiver can do to prevent the fall. The caregiver should be prepared to move any items out of the way that could cause injury, try to protect the patient's head from striking any objects or the floor and seek assistance as needed once the person has fallen.
- Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with "EC" (for expanded capacity) and a space for the manufacturer's rated weight capacity for that particular equipment model.
- If patient has partial weight-bearing capability, transfer toward stronger side.
- Consider using an abdominal binder if the patient's abdomen impairs a patient handling task.
- Identify a leader when performing tasks with multiple caregivers. This will assure that the task is synchronized for increased safety of the healthcare provider and the patient.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
**Bariatric Algorithm 3: Bariatric Reposition in Bed: Side-to-Side, Up in Bed**

**Start Here**

- **Can patient assist?**
  - **Fully**
    - Caregiver assistance not needed; patient may/may not use weight-specific positioning aid
  - **Partially or No**

- **Is patient cooperative?**
  - **Fully**
    - Bariatric ceiling lift with supine sling, air-assisted device or friction-reducing aid (minimum of 2-3 caregivers)
  - **Partially or No**

**Bariatric ceiling lift with supine sling, air-assisted device or friction reducing aid (minimum of 3 caregivers)**

- When pulling a patient up in bed, place the bed flat or in a Trendelenburg position (if tolerated and not medically contraindicated) to aid in gravity; the side rail should be down.
- Avoid shearing force.
- Adjust the height of the bed to elbow height.
- Mobilize the patient as early as possible to avoid weakness resulting from bed rest. This will promote patient independence and reduce the number of high risk tasks caregivers will provide.
- Consider leaving a friction-reducing device covered with drawsheet, under patient at all times to minimize risk to staff during transfers as long as it doesn’t negate the pressure relief qualities of the mattress/overlay.
- Use a sealed, high-density, foam wedge to firmly reposition patient on side. Skid-resistant texture materials vary and come in set shapes and cut-your-own rolls. Examples include:
  - Dycem (TM)
  - Scoot-Guard (TM): antimicrobial; clean with soap and water, air dry.
  - Posey-Grip (TM): Posey-Grip does not hold when wet. Washable, reusable, air dry.

- If patient has partial weight-bearing capability, transfer toward stronger side.
- Consider using an abdominal binder if the patient’s abdomen impairs a patient handling task.
- Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with “EC” (for expanded capacity) and a space for the manufacturer’s rated weight capacity for that particular equipment model.
- Identify a leader when performing tasks with multiple caregivers. This will assure that the task is synchronized for increased safety of the healthcare provider and the patient.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
**Bariatric Algorithm 4: Bariatric Reposition in Chair: Wheelchair, Chair, or Dependency Chair**

- Can patient assist?  
  - Fully: Stand-by for safety as needed*
  - Partially or No

- Is patient cooperative?  
  - Fully: Bariatric ceiling lift, floor based lift, repositioning device or seated friction reducing device (minimum of 2 caregivers)
  - Partially or No

- Bariatric ceiling lift, floor based lift, repositioning device or seated friction reducing device (minimum of 3 caregivers)

- Take full advantage of chair functions, e.g., chair that reclines, or use an arm rest of chair to facilitate repositioning.
- Make sure the chair wheels are locked.
- Consider leaving the sling under the patient at all times to minimize risk to staff during transfers after carefully considering skin risk to patient and the risk of removing/replacing the sling for subsequent moves.

* "Stand-by for safety." In most cases, if a bariatric patient is about to fall, there is very little that the caregiver can do to prevent the fall. The caregiver should be prepared to move any items out of the way that could cause injury, try to protect the patient's head from striking any objects or the floor and seek assistance as needed once the person has fallen.
- If patient has partial weight-bearing capability, transfer toward stronger side.
- Consider using an abdominal binder if the patient's abdomen impairs a patient handling task.
- Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with "EC" (for expanded capacity) and a space for the manufacturer's rated weight capacity for that particular equipment model.
- Identify a leader when performing tasks with multiple caregivers. This will assure that the task is synchronized for increased safety of the healthcare provider and the patient.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]

**Bariatric Algorithm 5: Patient Handling Tasks Requiring Access to Body Parts (Limb, Abdominal Mass, Gluteal Area)**

10/29/2013/Matz
Can patient sustain limb position to assist in making body part accessible?

- Fully
- Partially or No

Proceed with patient handling task

Assemble multidisciplinary team to develop creative solutions that are safe for patient and caregiver.

**Examples:**
- Modify use of a full body sling lift to elevate limbs for bathing or wound care (i.e. bariatric limb sling).
- Use draw sheet with handles for 2 caregivers (one per side) to elevate abdominal mass to access the perineal area (e.g., catheterization, wound care).
- To facilitate drying a patient between skin folds, use the air assisted lateral transfer aid to blow air or use a hair dryer on a cool setting.
- Use sealed high-density foam wedge to firmly reposition patient on side. Skid-resistant texture materials vary and come in set shapes and cut-your-own rolls. Examples include:
  - Dycem(TM)
  - Scoot-Guard(TM): antimicrobial; clean with soap and water, air dry.
  - Posey-Grip(TM): Posey-Grip does not hold when wet. Washable, reusable, air dry.

- A multidisciplinary team needs to problem solve these tasks, communicate to all caregivers, refine as needed and perform consistently.
- Consider using an abdominal binder if the patient's abdomen impairs a patient handling task.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
**Bariatric Algorithm 6: Bariatric Transporting (Stretcher)**

- If the patient has respiratory distress, the stretcher must have the capability of maintaining a high Fowler's position.
- Newer equipment often is easier to propel.
- If patient is uncooperative, secure patient in stretcher.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
Bariatric Algorithm 7: Toileting Tasks for the Bariatric Patient

Start Here

Is patient cooperative?

Yes

Can patient bear weight and ambulate?

Yes

Can toilet accommodate patient's weight?

Yes

Stand by for safety to escort to toilet or bedside commode. (minimum of 1-2 caregivers).

No

Stand by for safety to escort to toilet. (minimum of 1-2 caregivers).

No

Use full body sling lift with a toileting sling to transfer to bedside commode (minimum of 3 caregivers).

No

Partial

Does patient have upper extremity strength?

Yes

Use stand assist lift and transfer patient onto bedside commode. (minimum of 2 caregivers)

No

Considerations:
- Is bathroom doorway wide enough to accommodate entry of mechanical lift device and patient?
- Assure equipment used meets weight requirements and is appropriately sized for patient.
- Typically, standard toilets are rated to 350 lbs. maximum capacity.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used.

Bariatric Algorithm 8: Transfer a Bariatric Patient Up From the Floor

- Do not lift patient off floor.
- Do not allow patient to lean on caregiver for base of support.
- "Immobilization Technique" definition: use spinal precautions if can’t use lift due to suspect hip, pelvic, or vertebral fractures.
- Use floor-based lift that goes all the way down to the floor (most of the newer models are capable of this).
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient's weight then the patient should be considered to be fully dependent and assistive devices should be used. [Waters, T. (2007). When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59.]
**Orthopaedic Algorithm #1: Turning Patient in Bed (Side-to-Side) Patient with Orthopaedic Impairments**

**START**

- Is the patient cooperative?  
  - No: Use a mechanical device\(^1,2,3\) or bed-assisted technology (min. 2 caregivers)
  - Yes: Can patient assist?
    - Fully: Encourage patient to assist using a position aid (repositioning pole or side rail) (see recommendations by weight (next 3 boxes))
    - Partially: Caregiver assistance not needed; patient may/may not use a bed-mounted repositioning aid

**FOOTNOTES:**
1. Maintain orthopaedic precautions as prescribed while performing this activity such as total hip, knee, shoulder, or spine precautions.
2. Select sling to meet and maintain the patient's pre-op or post-op positioning guideline/precautions for the affected limb/body part(s).
3. Examples of repositioning mechanical devices are: **Turning clips**: these simple slips attach to a bed sheet and can be used with a floor-based lift or ceiling-based lift to facilitate turning a patient. **Turning straps/slings**: one end of these straps or slings is connected to the bed and the other end is attached to either a ceiling or floor based lift to facilitate turning the patient. **Powered mechanical devices**: a ceiling lift is a powered overhead lift that can be used with a repositioning sling to turn a patient in bed. **Friction reducing devices**: either tubular in design, or two separate pieces of material are placed under the patient to assist in turning the patient in bed or moving the patient to the head of the bed. **Pulley systems**: these devices work by use of a pulley system and an overhead frame. The user turns a crank, which engages the pulley system to retract straps that are connected to a rod and bed sheet, thus turning the patient on the side.
4. If the patient weighs more than 234 lbs. mechanical assistive devices should be used to assist. Use your best clinical judgment for the number of caregivers required to assist.

**GENERAL NOTES:**
- For any patient who has, or is at risk for a pressure ulcer, care should be taken to avoid shearing force (such as using a friction reducing device for repositioning in bed). Shearing force is when there are two forces moving in opposite directions adjacent to each other (like scissors).
- The height of the bed should be appropriate for staff safety (at elbow height).
- During any patient handling task, if the caregiver is required to lift more than 35 lbs./(16 kg.) of a patient's weight, then the patient should be considered fully dependent and an assistive device should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? *American Journal of Nursing*, 107(8), 53-59).

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\(^1,2,3\) Use a mechanical device or bed-assisted technology (air bladder or bed-repositioning system) (min. 2 caregivers)

\(^4\) Use a mechanical device or bed-assisted technology (air bladder or bed-repositioning system) (min. 3 caregivers)
Orthopaedic Algorithm #1: Turning Patient in Bed (Side-to-Side)
Patient with Orthopaedic Impairments
September 25, 2008

START

Is the patient cooperative?

No

Use a mechanical device or bed-assisted technology (min. 2 caregivers)

Yes

Can patient assist?

Fully

Caregiver assistance not needed; patient may/may not use a bed-mounted repositioning aid

Partially

Encourage patient to assist using a position aid (repositioning pole or side rail) (see recommendations by weight (next 3 boxes)

< 78 lbs/(35 kg.)
Use manual repositioning (min. 1 caregiver)

78-156 lbs/(35-69 kg.)
Use a mechanical device or bed-assisted technology (air bladder or bed-repositioning system) (min. 2 caregivers)

156-234 lbs/(69-106 kg.)
Use a mechanical device or bed-assisted technology (air bladder or bed repositioning system) (min. 3 caregivers)

FOOTNOTES:
1. Maintain orthopaedic precautions as prescribed while performing this activity such as total hip, knee, shoulder, or spine precautions.
2. Select sling to meet and maintain the patient's pre-op or post-op positioning guideline/precautions for the affected limb/body part(s).
3. Examples of repositioning mechanical devices are: Turning clips: these simple slips attach to a bed sheet and can be used with a floor-based lift or ceiling-based lift to facilitate turning a patient. Turning straps/slings: one end of these straps or slings is connected to the bed and the other end is attached to either a ceiling or floor based lift to facilitate turning the patient. Powered mechanical devices: a ceiling lift is a powered overhead lift that can be used with a repositioning sling to turn a patient in bed. Friction reducing devices: either tubular in design, or two separate pieces of material are placed under the patient to assist in turning the patient in bed or moving the patient to the head of the bed. Pulley systems: these devices work by use of a pulley system and an overhead frame. The user turns a crank, which engages the pulley system to retract straps that are connected to a rod and bed sheet, thus turning the patient on the side.
4. If the patient weighs more than 234 lbs. mechanical assistive devices should be used to assist. Use your best clinical judgment for the number of caregivers required to assist.

GENERAL NOTES:
- For any patient who has, or is at risk for a pressure ulcer, care should be taken to avoid shearing force (such as using a friction reducing device for repositioning in bed). Shearing force is when there are two forces moving in opposite directions adjacent to each other (like scissors).
- The height of the bed should be appropriate for staff safety (at elbow height).
- During any patient handling task, if the caregiver is required to lift more than 35 lbs./16 kg. of a patient's weight, then the patient should be considered fully dependent and an assistive device should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59).
Orthopaedic Algorithm #2: Vertical Transfer of a Post-Operative Total Hip Replacement Patient (Bed to Chair, Chair to Toilet, Chair to Chair, or Car to Chair)

START

Is the patient cooperative?  

No  

Use a mechanical lift (min. 2 caregivers)

Yes

Can the patient bear weight with lower extremities?  

No

Is the patient cooperative?  

No

Use a mechanical lift (min. 2 caregivers)

Yes

Can the patient bear weight with lower extremities?  

No

Use mobility aid as prescribed (e.g., walker, cane, crutches); caregiver assistance not needed; stand by for safety as needed.

Yes

Can the patient bear weight with lower extremities?  

No

Use mobility aid as prescribed (e.g., walker, cane, crutches); caregiver assistance not needed; stand by for safety as needed.

Fully

Stand and pivot technique using a gait/transfer belt (1 caregiver) or powered standing assist lift (1 caregiver)

Partially

Stand and pivot technique using a gait/transfer belt (1 caregiver) or powered standing assist lift (1 caregiver)

FOOTNOTES:
1. See 1A, 1B, 1C, 1D below for techniques to position patient at side of bed.
2. Moving from supine head of bed elevated to sitting at edge of bed requires: Patient's ability to shift their seated weight in a sitting position. Typically accomplished by unweighting one buttock and moving it toward the edge of the bed; repeating this in alternating fashion until patient is sitting at edge of bed.
3. With an impaired upper or lower extremity, caregiver might need to support the limb while patient attempts #1A.
4. If patient is unable to accomplish #1A with #1B and the amount of assistance from caregiver will exceed 35 lbs., then a mechanical lift device should be used to achieve sitting position at the edge of the bed.
5. Anti-friction sheets and seated discs might be useful when the amount of caregiver assistance is close to recommended limits; be aware of skin shearing risks. Shearing forces are caused when there are two forces moving in opposite directions adjacent to each other (like scissors).

GENERAL NOTES:
- If patient has partial weight bearing capacity, transfer toward stronger side.
- For car transfers: a) If patient cannot tolerate a seated position when doing a car transfer use a stretcher transfer or alternative transportation may be required; b) All car transports should comply with state laws for both children and adults; c) Don't forget to use all of the features of the car (i.e., adjustability of the seat) during the transfer.
- The height of the bed should be appropriate for staff safety (at elbow height).
- During any patient handling task, if the caregiver is required to lift more than 35 lbs./16 kg. of a patient's weight, then the patient should be considered fully dependent and an assistive device should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59).
Orthopaedic Algorithm #3: Vertical Transfer of a Patient with an Extremity Cast/Splint

START

Is the patient cooperative?

Yes

Can the patient bear weight with lower extremities?

Fully

Use a mechanical lift (min. 2 caregivers)

Partially

No

Caregiver assistance not needed; Stand by for safety as needed. Utilize mobility aids as prescribed or as determined by team (crutches, walker, cane).

FOOTNOTES:
1. Moving from supine head of bed elevated to sitting at edge of bed requires a patient's ability to shift their seated weight in a sitting position:
   a. When assistance is not required, this is typically accomplished by unweighting one buttock and moving it toward the edge of the bed; repeating this in alternating fashion, until patient is sitting at the edge of the bed.
   b. With an impaired upper or lower extremity:
      • if the amount of assistance from caregiver does not exceed 35 lbs., caregiver may provide limb support while patient moves unassisted to side of bed (see a. above)
      • if the amount of assistance from caregiver may exceed 35 lbs., then a limb support strap/sling with a mechanical lift will provide limb support while patient moves unassisted to side of bed (see 1a. above)
   c. If patient is unable to accomplish a. and/or b. then utilize one of the following options:
      • mechanical lift device with a seated sling to lift patient to side of bed
      • friction-reducing device to assist staff in pulling patient to side of bed.
   d. Friction-reducing devices and seated discs may be useful when the amount of caregiver assistance is close to recommended limits, but be aware of skin shearing risks. Shearing is caused when there are two forces moving in opposite directions adjacent to each other (like scissors).
2. Select sling to meet and maintain the patient's pre-op or post-op positioning guideline/precautions for the affected limb/body part(s). For more information on sling selection, see Appendix A.
3. Patient can bear weight on one leg only (e.g., weight bearing on unaffected limb or limited weight bearing on affected limb).

GENERAL NOTES:
• Need to test the fit of the sling with an immobilized extremity.
• Maintain affected extremity immobilization/alignment.
• Use lift device with limb sling if applicable.
• During any patient handling task, if the caregiver is required to lift more than 35 lbs./(16 kg.) of a patient's weight, then the patient should be considered fully dependent and an assistive device should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59).
**Orthopaedic Algorithm #4: Ambulation**

**START**

Can patient bear weight on lower extremities? 

- **No**: Do not ambulate.  
  
- **Partially or Fully**
  
  Is patient a safety risk?
  
  - **Low Risk**: Stand by for safety as needed. Use assistive devices as prescribed or as determined by team (crutches, walker, cane) (1-2 caregivers).
  
  - **High Risk**: Use ceiling lift or floor-based lift with ambulation sling (1-2 caregivers).

Does patient have upper extremity strength and ability to grasp with at least one hand?

- **Yes**: Use ceiling lift or floor-based lift with ambulation sling (1-2 caregivers) or sit to stand lift with ambulation capability.
- **No**: Use ceiling lift or floor-based lift with ambulation sling (1-2 caregivers) or sit to stand lift with ambulation capability.

---

**FOOTNOTES:**
1. Non-weight bearing: Patient is unable to bear weight through both lower extremities or weight-bearing through both lower extremities is contraindicated.
2. Partial weight bearing: This will include situations where the patient may be allowed: a) Limited weight bearing on one lower extremity and full weight bearing on the other extremity; b) Partial weight bearing through both lower extremities.
3. Safety risks may include: decreased cognition; decreased ability to cooperate/ combativeness; medical stability.
4. Factors that contribute to low safety risk: a) Lack of combativeness; b) Ability to follow commands; c) Medical stability; d) Experience with the assistive device.
5. Factors that contribute to high safety risk: a) Combativeness; b) Lack of ability to follow commands; c) Medical instability; d) Lack of experience with the assistive device, e) neurological deficits.

---

**GENERAL COMMENTS/DISCUSSION:**
- In healthcare, weight-bearing is often used to describe the amount of weight bearing that the patient can or has done. In orthopedics, weight-bearing status is prescribed by the physician based on the patient’s ability to safely bear weight through the musculoskeletal system. Exceeding the prescribed weight-bearing status may be detrimental to the patient.
- Patients should be assessed for safety risks as described above. If patients are determined to be at significant risk for falls, then care givers assisting with ambulation are also at risk for assisting patients to prevent fall. In high risk situations precautions should be taken, and devices such as walking slings should be used. At some point in care, the team will need to weigh the risks of falls with the benefits of ambulation and take a “therapeutic” risk in order to functionally advance the patient.
- Need to test the fit of the sling with an immobilized leg. For more information on on sling selection, see Appendix A.
- Maintain affected extremity immobilization/alignment.
- During any patient handling task, if the caregiver is required to lift more than 35 lbs./16 kg.) of a patient’s weight, then the patient should be considered fully dependent and an assistive device should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? American Journal of Nursing, 107(8), 53-59).
Orthopaedic Clinical Tool #1: Lifting and Holding Legs or Arms in an Orthopaedic Setting

Introduction
Often when orthopaedic care is being provided, the care giver must lift and/or hold a limb in place while some type of treatment is being provided, such as cast application. It is assumed that you are maintaining a neutral (upright) body posture (not fully flexed); adjust the height of the table. When a caregiver must lift a leg or arm, it is important to make sure that the weight of the limb being lifted does not exceed the strength capability of the caregiver. An ergonomic tool has been developed to assist caregivers in determining whether a specific lift and/or hold of a limb is acceptable and whether some type of lift or hold assist device is needed. For lifts of limbs with casts, an alternate method is presented for assessing whether the lift is acceptable or not as presented in Table #1.

This tool shows the calculation of the average weight for an adult patient’s leg and arm as a function of whole body mass, ranging from slim to morbidly obese body type. Weights are presented both in pounds (lbs.) and metric (kg.) units. Maximum lift and hold loads were calculated based on 75th percentile shoulder flexion strength and endurance capability for US adult females, where the maximum weight for a one-handed lift is 11.1 lbs. and a two-handed lift, 22.2lbs.

Table 1. Ergonomic Tool: Lifting and Holding Legs or Arms in an Orthopaedic Setting*

<table>
<thead>
<tr>
<th>Patient Weight lbs. (kg.)</th>
<th>Body Part</th>
<th>Body Part Weight Lbs. (kg.)</th>
<th>Lift 1-hand</th>
<th>Lift 2-hand</th>
<th>Hold 2-hand 1 min.</th>
<th>Hold 2-hand 2 min.</th>
<th>Hold 2-hand 3 min.</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40 lbs.</td>
<td>Leg</td>
<td>&lt;6.3 lbs. (3 kg.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(&lt; 18 kg.)</td>
<td>Arm</td>
<td>&lt;2.0 lbs. (1 kg.)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>40-90 lbs.</td>
<td>Leg</td>
<td>&lt;14.1 lbs. (6 kg.)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(18-41 kg.)</td>
<td>Arm</td>
<td>&lt;4.6 lbs. (2 kg.)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>90-140 lbs.</td>
<td>Leg</td>
<td>&lt;22.0 lbs. (10 kg.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(41-64 kg.)</td>
<td>Arm</td>
<td>&lt;7.1 lbs. (3 kg.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>140-190 lbs.</td>
<td>Leg</td>
<td>&lt;29.8 lbs. (14 kg.)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(64-86 kg.)</td>
<td>Arm</td>
<td>&lt;9.7 lbs. (4 kg.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>190-240 lbs.</td>
<td>Leg</td>
<td>&lt;37.7 lbs. (17 kg.)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(86-109 kg.)</td>
<td>Arm</td>
<td>&lt;12.2 lbs. (6 kg.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>240-290 lbs.</td>
<td>Leg</td>
<td>&lt;45.5 lbs. (21 kg.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(109-132 kg.)</td>
<td>Arm</td>
<td>&lt;14.8 lbs. (7 kg.)</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>290-340 lbs.</td>
<td>Leg</td>
<td>&lt;53.4 lbs. (24 kg.)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(132-155 kg.)</td>
<td>Arm</td>
<td>&lt;17.3 lbs. (8 kg.)</td>
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</tr>
<tr>
<td>340-390 lbs.</td>
<td>Leg</td>
<td>&lt;61.2 lbs. (28 kg.)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(155-177 kg.)</td>
<td>Arm</td>
<td>&lt;19.9 lbs. (9 kg.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>390-440 lbs.</td>
<td>Leg</td>
<td>&lt;69.1 lbs. (31 kg.)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(177-200 kg.)</td>
<td>Arm</td>
<td>&lt;22.2 lbs. (10 kg.)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 440 lbs.</td>
<td>Leg</td>
<td>&gt;69.1 lbs. (31 kg.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(&gt;200 kg.)</td>
<td>Arm</td>
<td>&gt;22.2 lbs. (10 kg.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* No shading: Lift and hold is appropriate but use clinical judgment and do not hold longer than noted.

Heavy shading: Do not lift alone; use assistive device or more than one caregiver.

The shaded areas of the table indicate whether it would be acceptable for one caregiver to lift the listed body parts with one or two hands or hold the respective body parts for 1, 2, or 3 minutes with two hands. Respecting these limits will minimize risk of muscle fatigue and the potential for musculoskeletal disorders. If the limb weight exceeds the values listed in the table it is recommended to use assistive technology, such as a ceiling lift.
or floor based lift with a limb support sling. Orthopaedic caregivers must use clinical judgment to assess the need for additional staff member assistance or assistive devices to lift and/or hold one of these body parts for a particular period of time.

**Note:** It is important to remember that the chart shows the acceptable weights for limbs without a cast in place. If the caregiver is lifting a limb with a cast, the additional weight of the cast should be added to the weight of the limb to determine whether the lift is acceptable. An alternate method is provided below for limbs with casts. These are guidelines for the average weight of the leg and arm, and are based upon the patient’s weight. The maximum weight for a 1-handed lift is 11.1 lbs. and a 2-handed, 22.2 lbs.

Patient weight is divided into weight categories (see Table 1), ranging from very light to morbidly obese. Normalized weight for each leg and each arm are calculated as a percentage of body weight where each complete arm weighs 5.1% of total body mass and each leg weighs 15.7% of total body mass (Chaffin, Anderson, & Martin, 1999). All weights are presented in both pounds and kilograms, rounded to the nearest whole unit.

To accommodate 75% of the US adult female working population, maximum load for a 1-handed lift is calculated to be 11.1 lbs. (5.0 kg.). This is determined by calculating the strength capabilities for 25th percentile US adult female maximum shoulder flexion movement (the mean equals 40 Newton meters, standard deviation equals 13 Nm) (Chaffin, Anderson, & Martin, 1999) and 75th percentile US adult female shoulder to grip length (the mean equals 610 mm, the standard deviation equals 30 mm) (Pheasant, 1992). Maximum loads for one person for a 2-handed lift (i.e., 22.2 lbs. /10.1 kg.) are calculated as twice that of a 1-handed lift. Muscle strength capabilities diminish as a function of time, therefore, maximum loads for 2-handed holding of body parts are presented for 1, 2, and 3 minute durations. After 1 minute, muscle endurance has decreased by 48%, decreased by 65% after 2 minutes, and, after 3 minutes of continuous holding, strength capability is only 29% of initial lifting strength (Rohmert, 1973a, b). If the limits in ergonomic Table 1 are exceeded, additional staff members or assistive limb holders should be used.

References


Orthopaedic Clinical Tool #2: Alternate Method for Determining Safe Lifting and Holding of Limbs with Casts

Table 2.1. Predicted Weight for Different Types of Casts

<table>
<thead>
<tr>
<th>Limb</th>
<th>Limb Weight Factor</th>
<th>1-hand</th>
<th>2-hands</th>
<th>2-hands 1 min.</th>
<th>2-hands 2 min.</th>
<th>2-hands 3 min.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leg</td>
<td>0.157</td>
<td>11.1 lbs. (5.1 kg.)</td>
<td>22.2 lbs. (10.2 kg.)</td>
<td>11.6 lbs. (5.3 kg.)</td>
<td>7.8 lbs. (3.5 kg.)</td>
<td>6.4 lbs. (2.9 kg.)</td>
</tr>
<tr>
<td>Arm</td>
<td>0.051</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multiply the patients’ weight times the limb factor (0.157 for leg and 0.051 for arm) and add the weight of the cast. Compare the calculated weight to the value in the appropriate task box. If the total limb weight exceeds the weight in the appropriate box, then the caregiver should not manually lift the limb alone, but should use an assistive device or more than one caregiver to perform the lift. On the other hand, if the calculated weight is less than the value in the appropriate box, then it is acceptable to manually lift and hold the limb and the caregiver should use clinical judgment and not hold longer than noted.

For example if the patient weighs 200 lbs. and has an arm cast weighing 5 lbs., then the total arm weight would be 200 lbs. x 0.051 plus 5 lbs., or 15.2 lbs. In this case, the arm should not be lifted with one hand (i.e., 15.2 lbs. > 11.1 lbs.) but could be lifted with two hands (i.e., 15.2 lbs. < 22.2 lbs.), but not held in that position less than a few seconds (15.2 lbs. > 11.6 lbs.). Similarly, if the patient weighs 75 lbs. and has a 5 lb. leg cast, then the total limb weight would be 75 lbs. x 0.157 plus 5 lbs., or 16.8 lbs. In this case, it would not be acceptable to lift the limb with one hand (i.e., 16.8 lbs. > 11.1 lbs.), but it would be acceptable to lift it with two hands (i.e., 16.8 lbs. < 22.1 lbs.), but should not be held more than a few seconds (16.8 lbs. > 11.6 lbs.).

Table 2.2. Predicted Weights for a Fiberglass Cast

The following Table 2.2 provides some predicted weights for a fiberglass cast.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5 lbs.</td>
<td>1 lbs.</td>
<td>2 lbs.</td>
<td>3.0 lbs.</td>
<td>2 lbs.</td>
<td>4lbs.</td>
</tr>
<tr>
<td>2 rolls 3”</td>
<td>1 roll 2”</td>
<td>4 rolls 4”</td>
<td>3 rolls 3”</td>
<td>2 rolls 2”</td>
<td>5 rolls 3”</td>
</tr>
<tr>
<td>+ webril*</td>
<td>+ webril*</td>
<td>+ webril*</td>
<td>+ webril*</td>
<td>+ webril*</td>
<td>+ webril*</td>
</tr>
<tr>
<td>3 rolls 3”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Weight of webril is 0.25 lb. per packet
Orthopaedic Appendix A: Helpful Hints on Slings

Selection of the appropriate sling accessory for movement / lift / transfer, must include the following considerations:

- Decision to transfer patient in sitting vs. supine position – choose correct functionality of the sling
- Select appropriate size
- Maintain alignment of the affected body part(s) according to pre-operative/post-operative guidelines
  - Consider the patient’s body size, shape and features (e.g. very large abdominal girth can limit degree of hip flexion)
  - Features of sling:
    - consider where material covers the patient
    - strap options for seated slings: the length of material for strap supports of the lower extremities can often be modified by selecting differing loop attachment points of the sling onto the hanger bar (e.g. providing more material length will allow lower extremity to be in less flexed position)
    - seated slings back height can vary from supporting whole trunk and head to covering pelvis/waist only. When upper extremities are involved, consider height of the sling – high back slings will wrap around and enclose an upper extremity, while a low back sling will allow upper extremity to be free
- If alignment/positioning guidelines cannot be met with available sling accessory, transfer patient supine with sheet style sling or anti-friction methods, then sit upright.
- The “Patient Care Sling Selection and Usage Toolkit” is available for download at: [http://www.visn8.va.gov/patientsafetycenter/safePtHandling/toolkitSlings.asp](http://www.visn8.va.gov/patientsafetycenter/safePtHandling/toolkitSlings.asp)
OR Algorithm 1: Lateral Transfer from Stretcher to and from the OR Bed

- Can patient transfer without assistance?  
  - Yes → Caregiver assistance not required. Stand by for safety as needed.
  - No → What is the starting position?

- What is the starting position?  
  - Prone → Use 2-3 caregivers*
  - Supine → Is weight > 73 lbs?
    - Yes → Use assistive technology (min. 3-4 caregivers)*  
      A mechanical device is preferable for this task. Additional technologies are needed for turning a patient from supine to prone and from prone to supine.
    - No → Use lateral transfer device (min. 4 caregivers)*

- Is weight > 73 lbs?  
  - Yes → Will patient stay supine?
    - Yes → Use one of the following: mechanical lift with supine sling, mechanical lateral transfer device or air-assisted lateral transfer device (min. 3-4 caregivers)*
    - No → Use lateral transfer device (min. 4 caregivers)*
  - No → Is weight > 157 lbs?
    - Yes → Use one of the following: mechanical lift with supine sling, mechanical lateral transfer device or air-assisted lateral transfer device (min. 3-4 caregivers)*
    - No → See Rationale

- Note: < means less than; > means greater than

- * One of the caregivers may be the anesthesia provider
- The number of personnel to safely transfer the patient should be adequate to maintain the patient's body alignment, support extremities, and maintain patient's airway.
- For lateral transfers it is important to use a lateral transfer device that extends the length of the patient.
- Current technologies for supine to prone include: Jackson Frame, Spine Table, etc.
- Destination surface should be slightly lower for all lateral patient moves.
- A separate algorithm for prone to jackknife is not included as this is assumed to be a function of the table.
- If patient's condition will not tolerate a lateral transfer, consider the use of a mechanical lift with a supine sling.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, assistive devices should be used for the transfer.
- While some facilities may attempt to perform a lateral transfer simultaneously with positioning the patient in a lateral position (ie, side-lying), this is not recommended until new technology is available.
- The assumption is that the patient will leave the operating room in the supine position.
OR Algorithm 2: Positioning and Repositioning the Patient on the OR Bed to and from the Supine Position

1. Safety Patient Handling Unit Binder
2. 02/29/2013/Matz
3. 80
4. OR
5. Algorithm 2: Positioning and Repositioning the Patient on the OR Bed to and from the Supine Position
6. Manual positioning approved (min. 4 caregivers)
7. See (3) below
8. Manual lifting or lowering of torso (min. 3 caregivers)
9. See (3) below
10. To/From semi-Fowler using beach chair device
11. See (1) below
12. Is the patient < 68 lbs?
13. Yes
14. Manual lifting or lowering of torso (min. 3 caregivers)
15. See (3) below
16. No
17. Use assistive technology (min. 3 caregivers)
18. See (1 and 2) below
19. Proceed with procedure
20. To/From Lateral
21. Is the patient < 115 lbs? *
22. Yes
23. Use assistive technology (min. 3 caregivers)
24. See (1) below
25. Proceed with procedure
26. No
27. Use assistive technology (min. 3 caregivers)
28. See (1) below
29. Proceed with procedure
30. To/From Lithotomy
31. Is the patient < 141 lbs?
32. Yes
33. Manual 2-handed lift of legs (min. 2 caregivers [1 each leg]) or use assistive technology
34. See (1) below
35. Proceed with procedure
36. No
37. Use assistive technology or (min. 4 caregivers)
38. See (1) below
39. Proceed with procedure
40. Note: < means less than; > means greater than
41. (1) Mechanical devices are preferable for this task, but their practicality has not yet been tested. There are special slings and straps that can be used with mechanical devices. For example, turning straps can be used to turn a patient to and from lateral or supine, or limb support slings can be used to lift the legs to and from lithotomy. More research is needed.
42. (2) Use the automatic semi-fowler positioning feature of your electric table if available.
43. (3) One of these caregivers could be the anesthesia provider to hold the head and maintain the airway.
44. * Note: This differs from Algorithm 1 (157) lbs because a 4th caregiver is involved.
45. During any patient handling task, if any caregiver is required to lift more than 35 lbs. of a patient's weight, an assistive device should be used. The number of personnel to safely position the patient should always be adequate to maintain the patient's body alignment.
46. A separate algorithm for prone to jackknife if not included as this is assumed to be a function of the table.
OR Algorithm 3: Prolonged Standing

Start -> Does caregiver stand in the same position more than 2 hours continuously or more than 30% of the work day?

Yes -> Use fatigue-reducing technique (eg alternate propping one foot on foot stool, anti-fatigue mats, sit/stand stool and supportive footwear)

No -> Does procedure require the use of lead aprons?

Yes -> Limit to 1 hour, use a portable sit to stand stool or a portable lead shield

No -> No intervention required

GENERAL RECOMMENDATIONS

- Caregivers should wear supportive footwear that has the following properties: does not change the shape of the foot; has enough space to move toes; shock-absorbing cushioned insoles; closed toe; height of heel in proportion to the shoe.
- Caregivers may benefit from wearing support stockings/socks.
- Anti-fatigue mats should be on the floors.
- Anti-fatigue mats should be placed on standing stools.
- The sit-stand chair should be set to the correct height before setting the sterile field so they will not be changing levels during the procedure.*
- Be aware of infection control issues for non-disposable and anti-fatigue matting.
- The 2-hour limit on prolonged standing incorporates accommodations for pregnancy.
- Scrubbed staff should not work with the neck flexed more than 30 degrees or rotated for more than one minute uninterrupted.
- 2-piece lightweight lead aprons are recommended.
- During the sit-to-stand break, staff should look straight ahead for a short while.

**OR Algorithm 4: Retraction**

- Assistant should be at an optimal working height/posture for manual retraction.*
- Hold retractor as close to body as possible and maintain a good posture.

* Optimal working height is defined as area between the chest and the waist height to operative field. Optimal posture is defined as perpendicular/straight-on to the operative field; asymmetrical posture may be acceptable depending on load and duration; torso twisting should be avoided at all times.
- Arm rests should be used as possible, and be large enough to allow repositioning of the arms.
- Under optimal working height and posture, an assistive device should be used to lift or hold more than 35 lbs.
- Further research is needed to determine time limits for exposure. This is a high risk task, therefore, team members should take rest breaks or reposition when possible.
- Avoid using the hands as an approach to retraction, it is very high risk for musculoskeletal or sharps injuries.
**OR Clinical Tool 1: Lifting and Holding Legs, Arms, and Heads for Prepping in a Perioperative Setting**

**Key**
- **No shading**: OK to lift and hold, use clinical judgment, do not hold longer than noted
- **Heavy shading**: Do not lift alone, use assistive device or more than one caregiver

<table>
<thead>
<tr>
<th>Patient Weight lbs (kg)</th>
<th>Body Part</th>
<th>Body Part Weight lbs (kg)</th>
<th>Lift 1-hand</th>
<th>Lift 2-hand</th>
<th>Hold 2-hand &lt;1 min</th>
<th>Hold 2-hand &lt;2 min</th>
<th>Hold 2-hand &lt;3 min</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;120 lbs (&lt; 54 kg)</td>
<td>Leg</td>
<td>&lt;19 lbs (9 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arm</td>
<td>&lt;6 lbs (3 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Head</td>
<td>&lt;10 lbs (5 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>120-160 lbs (54-73 kg)</td>
<td>Leg</td>
<td>&lt;25 lbs (11 kg)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arm</td>
<td>&lt;8 lbs (4 kg)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Head</td>
<td>&lt;13 lbs (6 kg)</td>
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</tr>
<tr>
<td>160-200 lbs (73-91 kg)</td>
<td>Leg</td>
<td>&lt;31 lbs (14 kg)</td>
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</tr>
<tr>
<td></td>
<td>Arm</td>
<td>&lt;10 lbs (5 kg)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Head</td>
<td>&lt;17 lbs (8 kg)</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>200-240 lbs (91-109 kg)</td>
<td>Leg</td>
<td>&lt;38 lbs (17 kg)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arm</td>
<td>&lt;12 lbs (6 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Head</td>
<td>&lt;20 lbs (9 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>240-280 lbs (109-127 kg)</td>
<td>Leg</td>
<td>&lt;44 lbs (20 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arm</td>
<td>&lt;14 lbs (6 kg)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Head</td>
<td>&lt;24 lbs (11 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>280-320 lbs (127-145 kg)</td>
<td>Leg</td>
<td>&lt;50 lbs (23 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arm</td>
<td>&lt;16 lbs (7 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Head</td>
<td>&lt;27 lbs (12 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;360 lbs (&gt;163 kg)</td>
<td>Leg</td>
<td>&gt;57 lbs (26 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arm</td>
<td>&gt;18 lbs (8 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Head</td>
<td>&gt;30 lbs (14 kg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**OR Clinical Tool 2: Lifting and Carrying Supplies and Equipment**

<table>
<thead>
<tr>
<th>Lifting Task</th>
<th>Lifting Index</th>
<th>Level of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,000 ml irrigation fluid</td>
<td>&lt;0.2</td>
<td>Minimal risk</td>
</tr>
<tr>
<td>Sand bags</td>
<td>0.3</td>
<td>Safe to lift</td>
</tr>
<tr>
<td>Linen bags</td>
<td>0.4</td>
<td>Minimal risk</td>
</tr>
<tr>
<td>Lead aprons</td>
<td>0.4</td>
<td>Minimal risk</td>
</tr>
<tr>
<td>Custom sterile packs (eg, heart or spine)</td>
<td>0.5</td>
<td>Minimal risk</td>
</tr>
<tr>
<td>Garbage bags (full)</td>
<td>0.7</td>
<td>Minimal risk</td>
</tr>
<tr>
<td>Positioning devices off shelf or rack (eg, stirrups)</td>
<td>0.7</td>
<td>Minimal risk</td>
</tr>
<tr>
<td>Positioning devices off shelf or rack (eg, gel pads)</td>
<td>0.9</td>
<td>Considerable risk</td>
</tr>
<tr>
<td>Hand table (49” x 28”)-largest hand table-used infrequently</td>
<td>1.2</td>
<td>Considerable risk</td>
</tr>
<tr>
<td>Fluoroscopy Board (49” x 21”)</td>
<td>1.2</td>
<td>Considerable risk</td>
</tr>
<tr>
<td>Stirrups (2- one in each hand)</td>
<td>1.4</td>
<td>Considerable risk</td>
</tr>
<tr>
<td>Wilson frame</td>
<td>1.4</td>
<td>Considerable risk</td>
</tr>
<tr>
<td>Irrigation containers for lithotripsy (12,000 ml)</td>
<td>1.5</td>
<td>Considerable risk</td>
</tr>
<tr>
<td>Instrument pans</td>
<td>2.0</td>
<td>Considerable risk</td>
</tr>
</tbody>
</table>

**Key**

<table>
<thead>
<tr>
<th>No shading</th>
<th>Light shading</th>
<th>Heavy shading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal risk – Safe to lift</td>
<td>Potential risk – Use assistive technology, as available</td>
<td>Considerable risk – one person should not perform alone or weight should be reduced.</td>
</tr>
</tbody>
</table>

10/29/2013/Matz
### OR Clinical Tool 3: Pushing, Pulling and Moving Equipment on Wheels

<table>
<thead>
<tr>
<th>OR Equipment</th>
<th>Pushing Force lbF (kgF)</th>
<th>Max Push Distance ft / (m)</th>
<th>Ergonomic Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrosurgery unit</td>
<td>8.4 lbF (3.8 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td>12.4 lbF (5.6 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>X ray equipment portable</td>
<td>12.9 lbF (5.9 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>Video towers</td>
<td>14.1 lbF (6.4 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>Linen cart</td>
<td>16.3 lbF (7.4 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>X ray equip – C-arm</td>
<td>19.6 lbF (8.9 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>Case carts – empty</td>
<td>24.2 lbF (11.0 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>OR stretcher unoccupied</td>
<td>25.1 lbF (11.4 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>Case carts – full</td>
<td>26.6 lbF (12.1 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>Microscopes</td>
<td>27.5 lbF (12.5 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>Hospital bed – unoccupied</td>
<td>29.8 lbF (13.5 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>Specialty equip carts</td>
<td>39.3 lbF (17.9 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>OR stretcher - occupied 300 lbs</td>
<td>43.8 lbF (19.9 kgF)</td>
<td>&gt;200ft (60m)</td>
<td></td>
</tr>
<tr>
<td>Bed - occupied 300 lbs</td>
<td>50.0 lbF (22.7 kgF)</td>
<td>&lt;200ft (30m)</td>
<td>Min 2 caregivers required</td>
</tr>
<tr>
<td>Specialty OR beds unoccupied</td>
<td>69.7 lbF (31.7 kgF)</td>
<td>&lt;100ft (30m)</td>
<td></td>
</tr>
<tr>
<td>OR bed unoccupied</td>
<td>61.3 lbF (27.9 kgF)</td>
<td>&lt;25ft (7.5m)</td>
<td>Recommend powered transport device</td>
</tr>
<tr>
<td>OR bed occupied 300 lbs</td>
<td>112.4 lbF (51.1 kgF)</td>
<td>&lt;25ft (7.5m)</td>
<td></td>
</tr>
<tr>
<td>Specialty OR beds - occupied 300 lbs</td>
<td>124.2 lbF (56.5 kg)</td>
<td>&lt;25ft (7.5m)</td>
<td></td>
</tr>
</tbody>
</table>

#### Key
- **No shading** | Minimal risk - Task is acceptable for 1 caregiver
- **Light shading** | Moderate risk – Minimum of 2 caregivers or powered device recommended
- **Heavy shading** | Considerable risk - Recommend powered transport device
IV. Program/Staff/UPL Monitoring
**SAFE PATIENT HANDLING**

UNIT PEER LEADER ACTIVITY & PROGRAM STATUS LOG

### PART I: BEING A PEER LEADER FOR YOUR CLINICAL UNIT

1. Indicate the number of times during the past week…

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. One of your coworkers asked you for your advice about patient handling &amp; movement</td>
<td>#</td>
</tr>
<tr>
<td>b. You met in person with a nurse on a one-to-one basis about patient handling tasks</td>
<td></td>
</tr>
<tr>
<td>c. You met in person with staff in a group setting or meeting about patient handling tasks</td>
<td></td>
</tr>
<tr>
<td>d. You demonstrated the use of patient lifting equipment (Portable or Ceiling Mounted Sling lifts, Stand Assist lift, etc.)</td>
<td></td>
</tr>
<tr>
<td>e. You demonstrated the use of other patient handling or movement equipment (lateral transfer aids, stand assist aids, transfer/dependency chairs, transfer/gait belts, etc.)</td>
<td></td>
</tr>
<tr>
<td>f. You were asked to deal with a problem in the operation of a lifting device.</td>
<td></td>
</tr>
</tbody>
</table>

### PART II: OTHER ACTIVITIES RELATED TO BEING A PEER LEADER

2. Indicate the number of times during the past week…

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. You demonstrated the use of the Algorithms for Safe Patient Handling &amp; Movement or one of your co-workers asked you for your advice about their use.</td>
<td></td>
</tr>
<tr>
<td>b. You were asked to evaluate a potential ergonomic/safety hazard on your unit.</td>
<td></td>
</tr>
<tr>
<td>c. You performed an Ergonomic Hazard Evaluation on your unit.</td>
<td></td>
</tr>
<tr>
<td>d. You led an AAR.</td>
<td></td>
</tr>
<tr>
<td>e. You participated in an AAR led by another.</td>
<td></td>
</tr>
<tr>
<td>f. You attended activities related to being a peer leader, other than those above. (Meetings w/ NM, other peer leaders, Site Coordinator, or training, etc.)</td>
<td></td>
</tr>
<tr>
<td>g. You completed paperwork related to being a peer leader.</td>
<td></td>
</tr>
<tr>
<td>h. You asked your Nurse Manager for support/info/help related to being a peer leader.</td>
<td></td>
</tr>
</tbody>
</table>
### PART III: SUPPORT & INTEREST

3. During the past week…  

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. My nurse manager was enthusiastic about the Back Injury Prevention Program and supported my efforts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Nursing co-workers were enthusiastic about the Back Injury Prevention Program and supported my efforts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Patients, Residents &amp;/or families were enthusiastic about the changes taking place or supported what they knew of my/our efforts.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PART IV: PROGRAM EFFECTIVENESS

4. How effective do you think these have been in preventing musculoskeletal incidents & injuries?

<table>
<thead>
<tr>
<th>Activity</th>
<th>NOT AT ALL EFFECTIVE</th>
<th>SOMEWHAT INEFFECTIVE</th>
<th>NO EFFECT</th>
<th>SOMEWHAT EFFECTIVE</th>
<th>EXTREMELY EFFECTIVE</th>
<th>UNSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit Peer Leader</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Safety Huddles</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Use of Lifting Equipment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ergonomic Hazard Analyses</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Safe Patient Handling &amp; Movement Policy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Algorithms for Safe Patient Handling &amp; Movement</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
PATIENT HANDLING EQUIPMENT USE STATUS WALK-THRU CHECKLIST

Please complete the following survey during unit safe patient handling walk-thru. These walk-thru checks should be randomly timed. When the walk-thru check is completed, fax this checklist to ___________.

Date ______________            Time ______________      Unit _____________

For the transfers you observed (use a second page if necessary):

<table>
<thead>
<tr>
<th>Transfer #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the transfer require equipment (per patient handling algorithm)? 1 = Yes 2 = No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was equipment used? 1 = Yes 2 = No 3 = Equipment not needed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What equipment was used? 1 = Philly slide 2 = Hill Rom 3 = Other 4 = Equipment not needed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the equipment used properly? 1 = Yes 2 = No 3 = Equipment not needed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please give us your feedback:

1. Do you feel that the SPHM Program is currently being accepted and used on this unit? Yes No

2. Since the last walk-through, have staff identified any problems or made any recommendations regarding the program? Yes No

   If Yes, what have they identified? ____________________________________________________________

3. Please offer any additional comments or concerns regarding the SPHM Program or the interventions in the space below.
### TOOL FOR PRIORITIZING HIGH-RISK PATIENT HANDLING TASKS

**Directions:** Assign a rating (from 1 to 10) to the tasks that you consider to be high risk for contributing to musculoskeletal injuries. A “10” should represent highest risk and “1” for lowest risk. For each task, consider the frequency and duration of the task (high, moderate, low), and musculoskeletal stress (high, moderate, low). Delete tasks not typically performed on your unit. Add tasks you perceive as high risk but not included.

Have each nursing staff member on a unit complete the form. Summarize the data by unit and shift. An alternative is to have staff work together by shift to develop the ratings by consensus.

<table>
<thead>
<tr>
<th>TASK FREQUENCY/ DURATION</th>
<th>STRESS OF TASK</th>
<th>RANK</th>
<th>RESIDENT HANDLING TASKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>H= high</td>
<td>H= high</td>
<td>10= high-risk</td>
<td>Transferring patient from bathtub to chair</td>
</tr>
<tr>
<td>M= moderate</td>
<td>M= moderate</td>
<td>1= low</td>
<td>Transferring patient from wheelchair or shower/ commode chair to bed</td>
</tr>
<tr>
<td>L= low</td>
<td>L= low</td>
<td></td>
<td>Transferring patient from wheelchair to toilet</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Transferring a patient from bed to stretcher</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lifting a patient up from the floor</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Weighing a patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bathing a patient in bed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bathing a patient in a shower chair</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bathing a patient on a shower trolley or stretcher</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Undressing/dressing a patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Applying antiembolism stockings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lifting patient to the head of the bed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Repositioning patient in bed from side to side</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Repositioning patient in geriatric chair or wheelchair</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Making an occupied bed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Feeding bed-ridden patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Changing absorbent pad</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Transporting patient off unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other Task:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other Task:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other Task:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SKILL</th>
<th>BEHAVIORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates safe &amp; efficient use of sit to stand lift</td>
<td>Selects appropriate sling taking into consideration patient size, shape, weight, task to be performed, medical conditions, skin integrity, pressure points, sling design, etc. Inspects sling prior to insertion/use Applies sling safely &amp; properly Uses lift effectively &amp; safely, observing equal tension of sling straps, position of patient in sling, and signs of discomfort/distress Removes sling safely &amp; properly Knows location for sling storage</td>
</tr>
<tr>
<td>Demonstrates safe &amp; efficient use of floor-based lift</td>
<td>Selects appropriate sling taking into consideration patient size, shape, weight, task to be performed, medical conditions, skin integrity, pressure points, sling design, etc. Inspects sling prior to insertion/use Applies sling safely &amp; properly Uses lift effectively &amp; safely, observing equal tension of sling straps, position of patient in sling, and signs of discomfort/distress</td>
</tr>
</tbody>
</table>

**SPHM Skills/Competency Check-off**

<table>
<thead>
<tr>
<th>SELF ASSESSMENT</th>
<th>SKILL/COMP LEVEL</th>
<th>VALIDATION METHOD/COMMENTS</th>
<th>TRAINER INITIALS/DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel I have the knowledge &amp; ability to perform these functions.</td>
<td>C N N F A P</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Demonstrates safe & efficient use of ceiling lift

Selects appropriate sling taking into consideration patient size, shape, weight, task to be performed, medical conditions, skin integrity, pressure points, sling design, etc.
Inspects sling prior to insertion/use
Applies sling safely & properly
Uses lift effectively & safely, observing equal tension of sling straps, position of patient in sling, and signs of discomfort/distress.
Removes sling safely & properly
Knows location for sling and lift storage

Demonstrates safe & efficient use of FRD (air assisted lateral transfer device)

Selects appropriate friction reducing device taking into consideration patient size, shape, weight, task to be performed, medical conditions, skin integrity, pressure points, FRD design, etc.
Inspects FRD prior to insertion/use
Inserts safely & properly
Uses FRD effectively & safely, observing position of patient and signs of discomfort/distress.
Removes FRD safely & properly
Knows location for FRD storage

Completes /uses Safe Patient Handling

Licensed Nurse: Completes Care Plan using information from the patient assessment & facilities algorithms to determine patient’s

and signs of discomfort/distress.
Removes sling safely & properly
Knows location/s for sling and lift storage

and signs of discomfort/distress.
Removes sling safely & properly
Knows location/s for sling and lift storage
<table>
<thead>
<tr>
<th>Documentation Appropriately</th>
<th>SPHM needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>ALL</strong> Uses information from Care Plans along with algorithms to identify appropriate equipment &amp; # of staff needed to safely perform patient handling tasks <strong>ALL</strong> Demonstrates how to use the facilities algorithms in a changing situation ie patient fall, post surgery etc.</td>
</tr>
</tbody>
</table>

| Is able to demonstrate knowledge of the correct procedure for cleaning the SPH equipment | States when and with what the equipment should be cleaned |
| Is able to state the process for laundering the slings | Demonstrates awareness of when it is appropriate to use disposable slings/Hovermats/Hovermat covers etc. |

| Demonstrates knowledge of who to contact if unsure of any infection control issues related to SPH equipment | **C** = Competent  
**NFP** = Needs Further Practice  
**NA** = Not in use in area of practice |

August 23rd 2008
<table>
<thead>
<tr>
<th>SKILL/RUN</th>
<th>BEHAVIORS</th>
<th>SELF ASSESSMENT</th>
<th>SKILL/COMP LEVEL</th>
<th>VALIDATION METHOD/COMMENTS</th>
<th>TRAINER INITIALS/DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates safe &amp; efficient use of sit to stand lift</td>
<td>Selects appropriate sling taking into consideration patient size, shape, weight, task to be performed, medical conditions, skin integrity, pressure points, sling design, etc. Inspects sling prior to insertion/use Applies sling safely &amp; properly Uses lift effectively &amp; safely, observing equal tension of sling straps, position of patient in sling, and signs of discomfort/distress. Removes sling safely &amp; properly Knows location/s for sling storage and lift storage</td>
<td>I feel I have the knowledge &amp; ability to perform these functions.</td>
<td>C N N F A P</td>
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<tr>
<td>Demonstrates safe &amp; efficient use of floor-based lift</td>
<td>Selects appropriate sling taking into consideration patient size, shape, weight, task to be performed, medical conditions, skin integrity, pressure points, sling design, etc. Inspects sling prior to insertion/use Applies sling safely &amp; properly Uses lift effectively &amp; safely, observing equal tension of sling</td>
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<tr>
<td>Task</td>
<td>Description</td>
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<tr>
<td><strong>Selects appropriate sling</strong></td>
<td>Selects appropriate sling taking into consideration patient size, shape, weight, task to be performed, medical conditions, skin integrity, pressure points, sling design, etc.</td>
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<tr>
<td><strong>Inspects sling</strong></td>
<td>Inspects sling prior to insertion/use</td>
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<tr>
<td><strong>Applies sling</strong></td>
<td>Applies sling safely &amp; properly</td>
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<tr>
<td><strong>Uses lift effectively &amp; safely</strong></td>
<td>Uses lift effectively &amp; safely, observing equal tension of sling straps, position of patient in sling, and signs of discomfort/distress.</td>
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<tr>
<td><strong>Removes sling safely &amp; properly</strong></td>
<td>Removes sling safely &amp; properly</td>
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<tr>
<td><strong>Knows location for sling storage</strong></td>
<td>Knows location for sling storage</td>
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<tr>
<td><strong>Demonstrates safe &amp; efficient use of ceiling lift</strong></td>
<td>Demonstrates safe &amp; efficient use of ceiling lift</td>
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<tr>
<td><strong>Selects appropriate friction reducing device</strong></td>
<td>Selects appropriate friction reducing device taking into consideration patient size, shape, weight, task to be performed, medical conditions, skin integrity, pressure points, FRD design, etc.</td>
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<tr>
<td><strong>Inspects FRD</strong></td>
<td>Inspects FRD prior to insertion/use</td>
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<tr>
<td><strong>Inserts safely &amp; properly</strong></td>
<td>Inserts safely &amp; properly</td>
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<tr>
<td><strong>Uses FRD effectively &amp; safely</strong></td>
<td>Uses FRD effectively &amp; safely, observing position of patient and signs of discomfort/distress.</td>
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<tr>
<td><strong>Removes FRD safely &amp; properly</strong></td>
<td>Removes FRD safely &amp; properly</td>
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<tr>
<td><strong>Knows location for FRD storage</strong></td>
<td>Knows location for FRD storage</td>
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<tr>
<td><strong>Completes Safe Patient Handling Documentation</strong></td>
<td>Completes Safe Patient Handling Documentation</td>
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<tr>
<td><strong>Accurately assesses patients</strong></td>
<td>Accurately assesses patients for their patient handling needs.</td>
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<tr>
<td><strong>Uses information from assessment</strong></td>
<td>Uses information from assessment along with algorithms to identify patient handling needs.</td>
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</tr>
</tbody>
</table>
on appropriately appropriate equipment & # of staff
needed to safely perform patient handling tasks
If appropriate, completes Care Plan using information from assessment & algorithms

Uses
Problem Solving
Skills in
Safe Patient Handling Challenges (Safety Huddles)

Understands rationale for use of Safety Huddles
Lists situations/conditions that would warrant Safety Huddles
Gives examples of use of Safety Huddle questions
Relates understanding of need for sensitivity and respect of others views

Uses
Appropriate Resources for the Specific Needs of the Bariatric Patient

Identifies the criteria for determining a patient has specific Bariatric needs (policy, weight etc)
Demonstrates knowledge of the specific equipment available at the James A. Hayley VAMC for bariatric patients and how it may be obtained.
Has knowledge of location and route of access to bariatric patient supplies such as gowns etc.
Knows where to find Unit Bariatric Binder

Uses
Problem Solving

Attends a program on the principles of teaching and coaching in the clinical areas.
Skills in Safe Patient Handling Challenges (Phase 2)

Demonstrates the principles of adult learning through the delivery of a SPHM training program in their local area.

Demonstrates knowledge of effective communication through reflecting on a ‘Crucial Conversation’ they have had with a colleague.

Gives 2 examples of how effective coaching skills have improved SPHM practice with a colleague.

Is able to demonstrate knowledge of the correct procedure for cleaning the SPH equipment.

States when and with what the equipment should be cleaned

Is able to state the process for laundering the slings

Demonstrates awareness of when it is appropriate to use disposable slings/ Hovermats/ Hovermat covers etc.

Demonstrates knowledge of who to contact if unsure of any infection control issues related to SPHM equipment

C = Competent
August 23rd 2008

NFP = Needs Further Practice
NA = Not in use in area of practice
V. BARIATRIC PATIENT HANDLING
FACILITY BARIATRIC CONTACT/RESOURCE STAFF

Name: ___________________________________________________________________

Service/Unit: _____________________________________________________________

Cell Phone #: ___________________________________________________________

Office Phone #: _________________________________________________________

Fax #: ___________________________________________________________________
BARIATRIC EQUIPMENT ACQUISITION

PROCEDURE FOR ACQUIRING BARIATRIC EQUIPMENT

FACILITY CONTACTS FOR ACQUISITION OF BARIATRIC EQUIPMENT

Purchasing/Leasing Contact during Normal Duty Hours

Name: ________________________________________________________________
Cell Phone #: __________________________________________________________
Office Phone #: _________________________________________________________
Fax #: _________________________________________________________________

Purchasing/Leasing Contact during Off Duty Hours

Name: ________________________________________________________________
Cell Phone #: __________________________________________________________
Office Phone #: _________________________________________________________
Fax #: _________________________________________________________________
BARIATRIC EQUIPMENT VENDORS/MANUFACTURERS

Patient Handling Equipment: ____________________________

Company/Manufacturer: ______________________________

Website: __________________________________________

Facility representative: ______________________________

Contact Information:
Cell Phone #: ______________________________________

Office Phone #: ____________________________________

Fax #: _____________________________________________

Other Information:___________________________________

____________________________________________________

Patient Handling Equipment: ____________________________

Company/Manufacturer: ______________________________

Website: __________________________________________

Facility representative: ______________________________

Contact Information:
Cell Phone #: ______________________________________

Office Phone #: ____________________________________

Fax #: _____________________________________________

Other Information:___________________________________
BARIATRIC EQUIPMENT VENDORS/MANUFACTURERS

Patient Handling Equipment: ___________________________________________________

Company/Manufacturer: ______________________________________________________

Website: ___________________________________________________________________

Facility representative: ________________________________________________________

Contact Information:
Cell Phone #: _______________________________________________________________

Office Phone #: _____________________________________________________________

Fax #: _______________________________________________________________

Other Information:

Patient Handling Equipment: ___________________________________________________

Company/Manufacturer: ______________________________________________________

Website: ___________________________________________________________________

Facility representative: ________________________________________________________

Contact Information:
Cell Phone #: _______________________________________________________________

Office Phone #: _____________________________________________________________

Fax #: _______________________________________________________________

Other Information
UNIT ADMISSIONS PROCESS/FLOWCHART/CHECKLIST

Insert plan for admission or treatment of bariatric patients to your unit /area.
### Location of Bariatric Supplies/Equipment

<table>
<thead>
<tr>
<th>Bariatric Items</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gowns</td>
<td></td>
</tr>
<tr>
<td>Slippers</td>
<td></td>
</tr>
<tr>
<td>Robes</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure Cuffs</td>
<td></td>
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<tr>
<td>ID Wristbands</td>
<td></td>
</tr>
<tr>
<td>Bed Pans</td>
<td></td>
</tr>
<tr>
<td>Abdominal Binders</td>
<td></td>
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<tr>
<td>CPAP</td>
<td></td>
</tr>
<tr>
<td>Scale</td>
<td></td>
</tr>
<tr>
<td>OR Equipment/Case</td>
<td></td>
</tr>
<tr>
<td>Cart</td>
<td></td>
</tr>
<tr>
<td>Gurney</td>
<td></td>
</tr>
<tr>
<td>Treatment Tables</td>
<td></td>
</tr>
<tr>
<td>Exam Tables</td>
<td></td>
</tr>
<tr>
<td>Patient/Visitor Chairs</td>
<td></td>
</tr>
<tr>
<td>Lifts</td>
<td></td>
</tr>
<tr>
<td>Air Assisted Lateral</td>
<td></td>
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<tr>
<td>Transfer Device</td>
<td></td>
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<tr>
<td>Bed Mover</td>
<td></td>
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<tr>
<td>Wheelchair Mover</td>
<td></td>
</tr>
<tr>
<td>Other patient handling equipment</td>
<td></td>
</tr>
</tbody>
</table>
Bariatric Equipment Safety Checklist

HOSPITAL BED
- Weight limit ______ lbs
- Side rail support ______ lbs
- Bed scale?
  - Yes__ if yes weight limit ______ lbs.
  - No__
- Width of bed ______ inches.
- Bed adjustable for width?
  - Yes__ No__
- Bed adjustable for patient height?
  - Yes__ No__
- Mattress type:
  - Pressure relief__
  - Pressure reduction__ Alternating__
  - Rotational__
- Other____________________________

WHEELCHAIR
- Weight limit ______ lbs.
- Width ______ inches
- Seat height ______ inches
- Handle width ______ inches
- Powered? Yes__ No__

STRETCHER
- Weight limit ______ lbs
- Width ______ inches
- Length ______ inches
- Side rail support ______ lbs
- Powered? Yes__ No__

BEDSIDE COMMODE/SHOWER CHAIR
- Weight limit ______ lbs
- Seat width ______ inches
- Adjustable height? Yes__ No__

SCALES
- Weight limit ______ lbs
- Width ______ inches

WALKER
- Weight limit ______ lbs
- Width ______ inches

BATHROOM
- Doorframe width ______ inches
- Shower door width ______ inches
- Toilet weight bearing limit ______ lbs
- Wall mounted grab bars
- Weight limit ______ lbs
- Wall mounted skin weight limit ______ lbs

PATIENT CARE ENVIRONMENT
- Patient chair weight limit ______ lbs (basic seating chair not Geri/cardiac chair)
- Patient chair width ______ inches
- Patient chair seat height ______ inches
- Geri/Cardiac chair weight limit ______ lbs
- Geri/Cardiac chair width ______ inches
- Geri/Cardiac seat height ______ inches

TRANSFER DEVICES
- Lateral transfer devices weight limit ______ lbs
- Lateral transfer devices width ______ inches
- Powered? Yes__ No__
- Full Body (sling) weight limit ______ lbs
- Powered? Yes__ No__
- Full Body (sling) goes to the floor? Yes__ No__
- Sit to stand devices weight limit ______ lbs
- Sit to stand devices width ______ inches
- Powered? Yes__ No__

ANCILLARY DEPARTMENTS
- Door widths ______ inches
- X-ray table weight limit ______ lbs, width ______ inches
- CT Scan weight limit ______ lbs, width ______ inches
- OR table limit ______ lbs, width ______ inches
- Emergency room equipment weight limit ______ lbs, width ______ inches
- Waiting room furniture weight limit ______ lbs, width ______ inches
- Exam room table weight limit ______ lbs, width ______ inches

OTHER PATIENT CARE DEVICES
- All patient care supplies should be carefully evaluated as to bariatric capacity.
UNIT TRANSPORTATION PLAN FOR BARIATRIC PATIENTS

Map out the safest and most feasible route for transporting your bariatric patients off your unit to treatment, diagnostic, and other areas. Use measurements of wheelchairs, beds, gurneys, etc. as well as door widths, elevator widths, etc. to develop these pathways.
VI. UNIT PEER LEADER TRAINING PROGRAM
• Insert Hard copy here
• include plastic holder for CD
• insert information on how to access online
VII. STAFF SPHM TRAINING PROGRAM
- Insert Hard copy here
- include plastic holder for CD
- insert information on how to access online

You may develop your own and insert here or use the powerpoint received at the Safety Champion conference.
VIII. RESOURCES & WEBSITES
PATIENT SAFETY CENTER & OTHER RESOURCES

Website: [http://www.visn8.va.gov/patientsafetycenter/safePtHandling/default.asp](http://www.visn8.va.gov/patientsafetycenter/safePtHandling/default.asp)

- Patient Care Ergonomic Resource Guide
- Sling Toolkit
- Bariatric Toolkit
- Technology Resource Guide
- Bariatric Technology Resource Guide

Website: [http://vaww1.va.gov/nursing/page.cfm?pg=125#dir](http://vaww1.va.gov/nursing/page.cfm?pg=125#dir)  (Find 2/3 down on right side)

- Bariatric Surgery Nursing Guidelines

Website: [http://www.washingtonsafepatienthandling.org/additionalresources.html](http://www.washingtonsafepatienthandling.org/additionalresources.html)

- Safe Patient Handling in Washington State

Website: [www.osha.gov/ergonomics/guidelines/nursinghome/index.html](http://www.osha.gov/ergonomics/guidelines/nursinghome/index.html)

- OSHA 2003 Ergonomic Guidelines for Nursing Homes