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In This Issue

PRESIDENT'S MESSAGE

Dear Members:

The American Society for Healthcare Risk Management's (ASHRM's) Annual Conference in Austin Texas offered a great variety of risk management and patient safety presentations that proved to be interesting, informative and timely. New York was well represented with noted subject matter experts serving as presenters in all domains of the ASHRM program. The AHRMNY cocktail reception for our New York attendees was very well attended at Max's Wine Dive, with an atmosphere which truly reflected a New York City loft vibe. Thank you to the membership, supporters and sponsors of AHRMNY.

Our academic year started off with a highly successful webinar on the New HIPAA Rule by Margaret (Margie) Davino, Esq. of Kaufman Borgeest & Ryan, LLP. The webinar was well attended, with almost two hundred participants, as the topic was timely and the material was informative.

The Education Committee continues to work to plan conferences and webinars for this year. We ask that you save the date for Friday, December 13, 2013 for a half day conference at Beth Israel Medical Center-Podell Auditorium in the Bernstein Pavilion. The topics include social media and jury trials presented by Robert Gibson, Esq. and Jessie Capell, Esq. of Heidell, Pittoni, Murphy & Bach, LLP. As well, Laurie Cohen, Esq. of Nixon Peabody LLP will present on the topic of an enterprise risk management (ERM) approach to pay for performance and patient satisfaction. Registration for this event is in progress. In addition, join us for an upcoming webinar, scheduled for Wednesday, February 12, 2014, with guest speaker Ronette Wiley, Vice President of Performance Improvement and Care Coordination from Bassett Medical Center, in Cooperstown, NY who will speak on the topic of Patient Safety Coaches. Save the date; details to follow.

In-line with the committees, there is still time to join a committee that you are interested in. Our Membership Committee reports a robust launch of our membership renewal and new members joining the Association. If you have not yet renewed your membership, or you are interested in joining the Association, please do so as soon as possible.

The Publications Committee continues to diligently work on articles, and preparing the Risk Management Quarterly (RMQ.) We are sure that you will find this edition as informative and engaging as ever. The Public Relations, Bylaws and Fundraising committees continue proactive efforts to support our goals, mission and vision.

As always, we are appreciative for our generous sponsors without whom; these events would not be possible. Their support is essential to our organization.

On behalf of the Board of Directors, I would like to take this opportunity to wish everyone a happy and healthy holiday season. Looking forward to seeing you in December.

Best regards,

Francine

Francine A. Thomas
President
July 1, 2013-June 30, 2014

SAFE LIFTING AND MOVING IN HEALTHCARE: AN EMERGING TREND OF CARING TECHNOLOGY

By Suzanne Y. Mettei, Esq.

Modernization in medicine has affected many aspects of healthcare. New technologies allow for better precision in surgery, coordination of pharmaceutical prescriptions, and other improvements. Yet some aspects of direct bedside care have not kept up with the times. This is particularly true with regard to lifting and moving of patients. Too often, direct care workers still lift and move patients by hand, an approach that entails risk for the patient and the healthcare worker. The United States Veterans Health Administration and several states are leading the way toward safer lifting and moving in healthcare through an initiative that combines the use of modern equipment with training and engagement of direct care staff. The objective is to eliminate completely the manual lifting of patients. The result is improved safety for both patients and healthcare staff, as well as substantial cost savings for hospitals and nursing homes.

Lifting or repositioning of patients can occur many times in a workday. Typical scenarios for lifting include transferring a patient between a bed and a chair, or between a wheelchair and a shower, and laterally transferring a patient between a bed and a stretcher.[1] Repositioning occurs even more frequently. A patient's position on a bed often must be changed to prevent bedsores, minimize pooling of upper-respiratory fluids, optimize infusion of oxygen into the lungs, prepare a patient for eating or swallowing liquids, or position a patient for an examination or personal hygiene task.[2] Indeed, repositioning activities may take up as much as 50 percent of a healthcare worker's time with patients.[3]

Manual lifting and moving is risky for patients. It can result in back pain, shoulder damage, joint or muscle pain, bruises, skin tears, aggravation of pressure sores, or falls.[4] Sometimes a fall can be fatal. The death of nursing home resident Sinia Malone, in February 2012, was reportedly due to a fall she suffered during a bed to wheelchair transfer at the Tarrytown Hall Care Center in Westchester County, New York. Her care plan, reportedly, required the use of a mechanical lift and two persons to move her from her bed to a wheelchair, but an aide attempted the transfer alone.[5]

Many healthcare workers, in turn, suffer from chronic back pain due to manual moving of patients. A report for the Veterans Health Administration noted that, “Pushing and pulling actions, regularly performed during the repositioning of patients, was the most commonly cited single cause of injuries” for its nursing home direct care workers.[6] The rate of musculoskeletal injuries for nursing aides, orderlies and nursing attendants is higher than that of construction workers, and seven times higher than the average of all occupations. The federal Occupational Safety and Health Administration (“OSHA”) notes that “More workers are injured in the healthcare and social assistance industry sector than any other.”[7] Unfortunately, many more injuries go unreported. One survey found that nearly 84 percent of nurses from two acute care hospitals had experienced work-related low back pain, and over 36 percent had experienced it in the prior year to an extent that it limited movement or interfered with routine activities.[8] This poses a risk to quality of care as well, since patients need experienced healthcare givers who can devote their full energy to the job.

The National Institute for Occupational Safety & Health (“NIOSH”), recommends that a worker should manually lift no more than 35 pounds of a person's body weight.[9] To put this in context, the leg of a 200-250 pound person generally weighs between 21 and 39 pounds.[10] Also, as safety engineer Thomas Waters reported in his ground-breaking research on this topic, lifting 35 pounds should be allowed only if the patient is cooperative and able to follow directions; the lifting is smooth and slow; and the body and hand positions of the worker in relation to the person being lifted and the amount of weight lifted are not subject to change.[11] Dr. Waters noted that the threshold should be lower if the task is performed under unfavorable circumstances, such as:

- Lifting with extended arms;
- Lifting when near the floor;
- Lifting when sitting or kneeling;
- Lifting with one's trunk twisted or the person off to the side of one's body;
- Lifting with one hand;
- Lifting in a restricted space; or
- Lifting during a shift lasting longer than eight hours.[12]

Many lifts in a healthcare setting fall among these categories.

Unfortunately, even though the hazards of lifting and moving are worsening, as patient weight has increased and facilities suffer from limited staff,[13] outdated methods are still widely used. The old “Hook and Toss” approach (in which a worker hooks his or her arms under the armpits of the patient) and the old “Bear Hug” method (in which a worker places both arms around the patient's waist) are commonly used to hoist a patient. Another risky measure is the

"Pivot Transfer," which requires the patient to stand and take a step. If a patient is unable to do so, the healthcare worker may suddenly bear the patient's full weight.[14] These practices fly in the face of common sense and run counter to the goal of "evidence-based medicine."

Under a proper safety program, trained healthcare workers use modern mechanical lifts and repositioning devices to move patients, rather than trying to bear the patient's weight themselves. The equipment ranges from items as simple as "frictionless sheets" (which allow a patient to slide into or out of a bed or to be turned or repositioned more easily) to mobile mechanical patient lifts and ceiling-mounted lifts. Such equipment is not used to prolong dependence, but rather to promote patient autonomy. By regularly re-evaluating the patient and adjusting equipment selection and use, the program fosters patient rehabilitation.[15]

A well-planned program better maintains the patient's health and dignity. It reduces the risk of injury and promotes patient mobilization (important to help prevent pneumonia, deep vein thrombosis, constipation and other ailments), and also helps care givers devote more energy to patients' health needs.[16] The Administrative Nursing Director for the largest nonprofit healthcare provider in the Northwest reported to Congress that many bariatric patients are able to walk more rapidly after surgery because they no longer fear falling and – interestingly – that patients report feeling "less guilty about staff potentially hurting themselves while assisting them" and "less embarrassed when the right equipment is there and appropriately sized."[17] Intermountain Healthcare, a nonprofit system of 22 hospitals and over 100 clinics in Utah and Idaho, launched its program in 2008, and after two years documented a 49 percent reduction in patient falls related to lift and transfer activities. A study of 111 nursing home residents in six Veterans Administration facilities found that after three years of implementation, residents exhibited improved urinary continence, higher engagement in activities, and greater alertness.[18] The long-term benefits, clearly, can be substantial.

The Kaleida Health System in New York, which implemented safe lifting and moving systems at several hospitals and long-term care facilities, has achieved positive results. Its HighPoint on Michigan complex, a long-term and sub-acute care facility with a complex rehabilitation center that opened in late 2011, provides a model for new facility construction, with track and ceiling lifts throughout the facility.[19] Kaleida Health launched its original program in late 2004 and recovered its investment in less than three years, primarily through reduced staff Lost Work Days.[20] Lost Work Days in its long-term care facilities dropped by 77 percent within the first four years,[21] and has continued to decline.[22] This indicates a substantial increase in safety that clearly benefited the staff.

The trend toward system-wide change in safe lifting and moving in healthcare is growing. The James A. Haley Veterans Administration Hospital in Tampa, Florida, was a pioneer in the early development of a safe lifting and moving program in the United States. After federal studies documented that "safe patient handling" programs improved health and safety,[23] the United States Veterans Health Administration, Department of Veteran's Affairs, issued a 2010 Administration Directive requiring all of its facilities to establish and maintain a "program to protect care givers and patients from injuries due to patient handling and movement."[24]

Eight states – California, Illinois, Maryland, Minnesota, New Jersey, Rhode Island, Texas and Washington – now have statutes that similarly require hospitals to establish a "safe patient handling" system. All but California and Washington also require such programs for nursing home residents with mobility needs.[25] Minnesota's 2007 law was amended in 2009 to expand coverage to clinical settings such as outpatient surgery facilities.[26]

Substantial real world experience with "safe patient handling" programs indicates that an investment in such equipment can be recovered in roughly three years or less.[27] This is a faster return than many investments that large institutions make, and certainly such a short lag in the return on investment is a better alternative than continued tolerance of musculoskeletal injuries among direct care staff.

While investments can be made gradually and are reasonably expected to be recouped quickly, financial incentives could help. The State of Washington's law provides that hospitals with proper programs can qualify for a tax credit for purchase of equipment and for a special reduced premium workers compensation risk class.[28] Ohio has a no-interest loan funding program for hospitals and nursing homes to purchase equipment and fund training.[29] Such approaches could speed the implementation of programs for safe lifting and moving in healthcare.

Maintaining a program is a challenge. A 2008 analysis conducted for the Veterans Health Administration found that its "safe patient handling" program elements "were generally not well maintained" over time despite staff appreciation of their value. It noted greater success at facilities that maintained a site coordinator with strong upper management support.[30] Active administrative support, establishment of "coaches" for each unit to engage staff, and regular re-evaluation of patients' needs and the effectiveness of equipment and protocols are key ingredients for long-term success.[31]

Germain Harnden, Executive Director of the Western New York Committee for Occupational Safety & Health, similarly reports, "It's not that no safety programs exist. Several health institutions have programs. The problem is consistency – keeping them vigorous." She notes that in training workshops on safe lifting and moving, participants often report that a program has become less effective over time because of communication issues, lack of retraining and re-assessment of plans, and lack of management commitment. She observes, "All it takes is a little staff turnover and there are missing pieces."[32] Thus, even if a facility establishes a program, steps must be taken to ensure its vitality over time. A lack of accountability means that a program can atrophy and no one outside the facility will know, leaving the public unprotected.

Facilities need some flexibility to adapt programs to the unique configurations of their buildings and the populations they serve. Still, uniform requirements can help create a "level playing field" of competition, to avoid the unfair situation in which one hospital or nursing home invests in a proper safety program while another facility chooses to give the matter short shrift. Also, continuing oversight can help ensure that long-term effectiveness of a program. Requiring healthcare facilities to provide reports on the results of their programs, for example, would help spur them to keep the programs current.

Engagement of healthcare workers is critical. Direct care staff can help identify what kinds of equipment will be useful and how much they need. Such staff also are likely to have a good sense of how near a piece of equipment must be for them to retrieve and use it efficiently. A Veterans Health Administration study found that accessibility was the number one issue in using lifting equipment.[33] Safety equipment is less likely to be used if the equipment is in a closet at the far end of the hall.

Finally, healthcare facilities should engage patients and nursing home residents in planning and evaluating safety programs. OSHA recommends that facilities evaluate patient and family response to lifting and moving protocols while hospitalized and in post-hospitalization patient satisfaction surveys.[34] The following are examples of questions that a healthcare facility could ask regarding its lifting and moving practices:

1. Are you aware that, except in an emergency situation, a healthcare staff member is not allowed to manually lift or transfer you?

2. Have you ever been lifted or transferred in a way that made you feel unsafe? Would you describe what occurred?

3. Have you ever been injured during a lift or transfer? Would you describe what occurred?

4. Have you ever felt that there was too much body-to-body contact during a lift or transfer? Would you describe what occurred?

5. Do you feel that you received enough information about a lifting device, before its use, for you to feel comfortable and safe?

6. Does any of the equipment we use for lifting worry you or make you feel unsafe?

7. Do you have suggestions for improving our approaches to lifting or moving patients?

Responses to these questions could provide useful feedback for assessing the facility's program.

The field of bedside care cannot afford to lag behind in the move toward modernization. The federal Veterans Health Administration and several states have paved the way with comprehensive programs for safe lifting and moving in healthcare. Patients, nursing home residents, healthcare workers and concerned loved ones need to know that proper programs are in place to prevent injuries from unsafe methods of lifting and moving. Engagement of direct care workers in planning, open discussion with patients or nursing home residents and their loved ones, commitment of healthcare administrators to maintain and improve the program, and vigilant standards and oversight are essential factors that must be in place to ensure safety.

References Listed on page 26

About the author

Suzanne Mattei, Esq., a graduate of Yale Law School, has pursued public interest policy and law for thirty years, and has extensive management experience in both the government and nonprofit sector. She served as a senior policy analyst in the New York City Comptroller's Office and Office of the Public Advocate, and directed a regional office of the State Department of Environmental Conservation. In her work in the nonprofit sector, she played a leading role in obtaining passage of the Childhood Lead Poisoning Prevention Act in New York City and testified by invitation to Congress on the health needs of 9/11 Ground Zero responders. As Executive Director of New Yorkers for Patient & Family Empowerment, Ms. Mattei authored the first report in the nation comparing state laws on safe lifting and moving in healthcare, and also has authored two groundbreaking reports, in coordination with the New York Public Interest Research Group (NYPIRG) and in consultation with Lambda Legal, challenging restrictions in hospital visiting policies.

SAVE THE DATE FOR THESE UPCOMING LOCAL AND OUT-OF-STATE EVENTS

February 12, 2014 10:00am – 11:30 am
Webinar: Patient Safety Coaches
Speaker: Ronette Wiley, VP – Basset Medical Center

March 12, 2014 5:30pm – 9:00 pm
Evening Educational & Networking Event
Location: Lighthouse International, NYC
Potential topics and speakers TBD

June 6, 2014 8:30 am – 3:30 pm
Annual Educational Conference
Location: Lighthouse International, NYC
Potential topics and speakers TBD

Visit www.npsfcongress.org for additional conference and registration details

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