

XTRAwise™

a publication for the medical community

DAY AFTER DAY, NURSES DAMAGE THEIR BODIES

getting patients out of bed, transferring them to stretchers, chairs and toilets, and pulling them up in bed. In 2009, a curriculum was developed in partnership with the National Institute for Occupational Safety and Health (NIOSH), the Veterans Health Administration (VHA) and the American Nurses Association (ANA) entitled *Safe Patient Handling Training for Schools of Nursing Curricular Materials*. According to this curriculum and associated research, the answer to decreasing injury occurrence is not in improving manual lifting techniques or hiring stronger nursing staff, but in assessing tasks in terms of what is needed for safe task completion.

IN THIS ISSUE,

meet two nurses who gave their careers to nursing, were injured and have turned their experience into something positive as advocates for the safe patient handling needs of nurses everywhere. Also included in this issue is a new Pulse on Research—suggested reading and guidelines on the topic of safe patient handling.

SAFE TASK ASSESSMENT INCLUDES:

- IDENTIFYING AND ADDRESSING RISK FACTORS IN THE WORK ENVIRONMENT
- DEVELOPING PROPER PROTOCOLS
- DETERMINING CORRECT AIDS FOR CARRYING OUT TASKS

1ST PERSON ACCOUNT: BEING AN ADVOCATE FOR BACK INJURED NURSES

BY ANNE HUDSON, RN, BSN

Anne Hudson is a public Health Nurse with the Coos County Public Health Department in Coos Bay, Oregon.

I was unaware of the magnitude or severity of back injuries among nurses until I myself became injured in 2000. (For more on Anne's personal injury story, please see Xtrawise issue 9.2.) Following surgery for my injury, permanent lifting restrictions, daily pain, and loss of ability to enjoy many former activities, in addition to workers' compensation legal struggles, I began to research nursing work injury and found abundant evidence of the dangers of manual patient lifting. My days as an advocate began in that research.

REALITY: THE FACTS

Cumulative trauma microfractures to the spine from lifting hazardous weights and spinal injury to nurses from lifting patients has been well documented. Because there are no pain receptors in the disc center, where micro-fractures from lifting excessive weights typically

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BECAUSE THERE ARE NO PAIN RECEPTORS IN THE DISC CENTER, WHERE MICROFRACTURES FROM LIFTING EXCESSIVE WEIGHTS TYPICALLY BEGIN, MUCH DAMAGE CAN OCCUR OVER TIME WITHOUT PAIN.

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THERE ARE CURRENTLY “NO ACTIVE SAFE PATIENT HANDLING BILLS IN EITHER THE HOUSE OR SENATE. BOTH EXPIRED AT THE END OF THE LAST SESSION AND HAVE YET TO BE INTRODUCED IN 2011.”

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THE BUREAU OF LABOR STATISTICS (BLS) CONTINUALLY RANKS NURSES IN THE TOP TEN FOR WORK-RELATED MUSCULOSKELETAL DISORDERS (MSDS).

begin, much damage can occur over time without pain. By the time the trauma has worked its way to the nerves in the outer ring of the disc and excruciating pain is felt for the first time, extensive damage has already taken place. By then, a career-ending injury may have already developed.

Back injury is a serious problem among nurses. Now it became an enormous personal problem, and I wanted to learn more. In 2000, online searches returned no results for “back injured nurse.” I started a website, “BIN There – Back Injured Nurses,” in 2001 with friends to put “back injured nurses” into the search engines.

The term “patient handling” lead to much more information on the subject. I found that 38 percent of nurses require time away from work due to back injuries, 12 percent of nurses leave permanently due to back injuries, and the Bureau of Labor Statistics (BLS) continually ranks nurses in the top 10 for work-related musculoskeletal disorders (MSDs). In 2007, registered nurses suffered 8,580 reported and accepted MSDs requiring days away from work, the seventh highest number of MSDs in the country. While research had proven since 1991 that patient lift equipment used by specially trained “lift teams” or by nurses could prevent injuries, nurses were still lifting manually and still suffering severe injuries. I found no efforts toward legislation for the safe handling of patients.

“ MORE THAN 12 OF EVERY 100 HOSPITAL NURSES, AND MORE THAN 17 OF EVERY 100 NURSING HOME NURSES, ARE AFFECTED BY ERGONOMIC INJURIES, AND 38 PERCENT OF ALL NURSES SUFFER BACK INJURIES ON THE JOB.”

From: Meier E. Ergonomic Standards and Implications for Nursing. Nursing Economics January, 2001. Available at http://findarticles.com/p/articles/mi_m0ESW/is_1_19/ai_n18611327/

WORK INJURED NURSES' GROUP USA (WING USA)

In 2002, the website name “BIN There” was changed to “Work Injured Nurses’ Group USA” (WING USA) at www.wingusa.org. WING USA provides information about back injury from manual patient lifting and serves as a meeting place for injured nurses, nurse assistants and other healthcare workers. A new effort offers the assistance of WING USA “State Leaders” as contacts for injured nurses in their area, for mutual support and encouragement and for sharing experiences and information.

Nineteen WING USA State Leaders cover 30 states and Washington, DC, and are involved in a variety of activities such as group meetings, writing for publication, media outreach, speaking events and political involvement for Safe Patient Handling–No Manual Lift legislation. The hope is that national nurse organizations will initiate broad programs to help injured nurses, in particular advocacy programs to help work-injured nurses remain with their employers as nurses.

LEGISLATIVE EFFORTS FOR SAFE PATIENT HANDLING & CHAPS

Since 2001, I have worked to advance “Safe Patient Handling–No Manual Lift” legislation. Progress has been made in some states.

AN INJURED NURSE PERSPECTIVE ON THE STATE OF SAFE PATIENT HANDLING (SPH)

BY IRIS WILDE, RN, PNP

Iris Wilde is a Wing USA Regional Leader and is a community network coordinator (CNC) and Acting State Leader for Soldiers' Angels. She can be reached at rn_imw@yahoo.com

INTRODUCTION

One of my favorite sayings is, "I am Amer-I-CAN, not Amer-I-CANT." Throughout my nursing career, I tried to focus on the solution rather than the problem. In order to find an answer, one must have an understanding of the question or problem at hand. After my caregiver injury, I asked, "Why do nurses get hurt, and what can be done in terms of prevention?"

IDENTIFYING, ASSESSING AND ADDRESSING THE PROBLEM(S)

In my own case of work injury, the cause had been a combination of factors. My work shift was one. I knew the shift was unsafe and short-staffed—but I didn't feel comfortable questioning it. The unit consisted of bariatric patients, confused patients and patients who required help for ambulation and were also at risk for frequent falls. I've often wondered why lifting has ever been a nursing duty. However, that was the least of my concerns that shift. Just trying to keep my patients safe from harm was proving to be overwhelming. Sadly, my case wasn't a lone statistic.

The work environment for nurses is often dangerous. Nursing schools are now beginning to teach students how to assess if their workplace provides a safe working environment. Without this, nursing retention will not happen. Students are also learning it is acceptable to not do something that threatens their safety. Before, concern for the needs of our patients often would cause us to overlook our own safety needs. Such was the case when I accepted a shift that I knew was not safe. Now, academically and in the workplace, we are moving toward a better balance in terms of safety needs of both the nurse and patient—so that both are addressed with equal importance.

THE NURSE'S KNOWLEDGE BASE & PREVENTION

At present, we have made progress but still have a long way to go. Based on information from the American Nurses Association (ANA), Bureau of Labor Statistics (BLS), and other sources in the literature, the statistics regarding occupational injury are staggering.

They did not always teach these things in nursing school. Many tasks performed by a bedside nurse involve wear-and-tear on the discs of the back. Tasks often require awkward positioning, lifting heavy loads, excessive pushing and pulling, frequent repeated lifting and moving of items, reaching and working on uneven work surfaces (i.e., transfers from bed to chair, bed to toilets of varying

heights, bed to stretcher). There are frequently space limitations, with much equipment in small rooms, and falling and tripping hazards for the nurse. Nurses need to be made aware of these

" I HAD BEEN TESTED ON MY LIFTING TECHNIQUES AND WAS TOLD I WAS DOING EVERYTHING 'RIGHT'. SO WHY DID I GET HURT?"

risk factors so that they can plan for them and ensure their own personal safety, as well as that of their patients.

THE NURSE AND LIFTING

I thought I knew what I needed to know in order to be safe. I prided myself in proper lifting techniques, many of which I had been taught in nursing school. I taught untrained caregivers in hospice home settings how to move their loved ones and optimize preventing injury to themselves and their patients. I had been tested on my lifting techniques and told I was doing everything "right." So why did I get hurt?

The expectations placed on nurses regarding lifting are often unrealistic. Warehouse workers are not permitted to lift more than 50 pounds under ideal conditions, and they have weightlifting equipment (i.e. forklifts) that has long been associated with their

" WOULD NURSES KNOWINGLY, WILLINGLY GIVE UP THEIR HEALTHY BACKS TO CARE FOR THEIR PATIENTS?"

line of work. NIOSH states that no care provider should lift more than 35 pounds of a patient's weight; some bariatric patients' extremities alone weigh that much. There are no "forklifts" for nurses.

Lack of equipment is one concern, but it also takes staff working together to optimize safe lifting techniques, which is a continued problem due to the issue of short-staffing. Being short-staffed means one nurse is often forced to do the work of what should be done by more than one person, including lifting. Can we think outside the box on staffing-related solutions? Can a physical therapist (PT) or other staff members be trained and available to help with lifting tasks during odd hours if the nursing unit is short on personnel? Is there a reason that lifting has to be a nurse's duty alone?

CHALLENGE: TAKING CARE OF AND PROTECTING ONESELF

Physical Conditioning. In nursing school, an instructor said, "There are generally two speeds in life once one becomes a nurse—full speed ahead or dead stop and rest." This resonated with me, as I know now that often nurses are exhausted after their shifts and do not have the energy to exercise and take proper care of themselves. We eat on the run when we are at work and, like other care providers, take care of ourselves last. Moreover, nurses who are considered physically strong are often asked to assist with patient lifting tasks thus opening themselves up to more potential injury.

Cumulated traumatic injury. As our generation of nurses age, many will be faced with "cumulated traumatic injury." By 2012, nurses in their 50s are expected to account for almost one quarter of the nursing workforce. The longer one works doing the same repetitive type of duties, the greater the chances are for injury. Would nurses knowingly, willingly give up their healthy backs to care for their patients?

SOLUTIONS: RETENTION, LIFT TEAMS, AND PROPER EQUIPMENT

What are the answers to the questions of nurse injury prevention? First, keeping our nurses in the work field is crucial. The nursing shortage could seriously curtail simply by reducing back injuries and keeping our force of experienced nurses healthy and working. Retention of nurses is an area of concern for the healthcare industry. One factor that plays into high retention is whether a facility utilizes a lift team. Appropriate use of equipment that is widely available and the implementation of lift teams has proven successful at reducing back injuries. I would still be working today if there had been a lift team available in my facility! I would be healthy and have the career that I worked hard for and loved.

Ergonomics. In a recent University of Michigan survey, 75 percent of nurse respondents said that poor working conditions interfere with their ability to offer the best possible patient care. They also believe that the image of their profession is damaged in part because their working conditions are substandard. It's time to be ergonomically smart! Using ergonomics means fitting the task to the worker

"IS THERE A REASON THAT LIFTING HAS TO BE A NURSE'S DUTY ALONE?"

rather than the worker to the task. Ergonomics provides us with understanding of limits of performance capabilities of our bodies. Ergonomics deems that when a job's physical demands seem greater than our physical abilities, we must be careful and exercise caution, because it is then that we are at higher risk for injury.

Ergonomics gives specific steps to take to reduce risk of injury and helps identify risk factors at work that may injure nurses. The Aging RN Workforce Research Summary states, "Considerations for ergonomic design, better lighting, spaces that encourage peer collaboration or concentrated, private work, and efficient patient floor and core unit layouts will improve the work environment for all nurses, whether they are 25 or 55."

Occupational Safety & Health Administration (OSHA). There are OSHA-recommended algorithms that have been designed by nursing experts to keep both the patient and nurse safe. These algorithms give step by step processes that allow you to find the safest way to accomplish tasks you are trying to perform, such as transferring a patient from bed to chair. They cover a wide range of patient activity, and they enable the caregiver to double-check the safest approach for both the worker and the patient. These algorithms can be used to make care plans that cover safe patient handling and movement.

A CARE PLAN SHOULD INCLUDE THE FOLLOWING FACTORS:

- **PATIENT'S LEVEL OF ASSISTANCE**
- **WEIGHT-BEARING CAPABILITIES**
- **BILATERAL UPPER-EXTREMITY STRENGTH**
- **LEVEL OF COOPERATION AND COMPREHENSION**
- **WEIGHT, HEIGHT AND SPECIAL CONDITIONS THAT ARE APT TO AFFECT TRANSFER/REPOSITIONING TECHNIQUES**

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In a care plan, an area should also be made available for comments relative to the patient's unique needs.

Finally, the appropriate lift/transfer devices needed for safe lifting should always be noted in the care plan. Perhaps physical therapy and/or a multidisciplinary approach to these care plans could be used instead of being considered documentation for the nurse alone.

Cost Savings. Using appropriate patient lift equipment and lift teams has proven to pay for itself over and above the initial investment. Considering the average cost of MSDs is \$160,000 per 100k hours worked, implementing SPHM strategies can produce substantial cost savings. In a 2005 study "the annualized savings in medical care and associated employee costs was estimated at slightly over 200,000 dollars per year" in addition the authors concluded that absenteeism decreased by 18% for work related injuries and reduced the number of workdays lost for rehabilitation from injury.

CHARACTERISTICS OF HEALTHCARE UNITS AT HIGH RISK FOR BACK AND OTHER INJURIES TO CAREGIVERS:

- **HISTORY OF FREQUENT INJURIES**
- **HIGH PROPORTION OF DEPENDENT PATIENTS**
- **LACK OF USE OF LIFTING EQUIPMENT IN GOOD REPAIR**
- **LOW STAFFING LEVELS**

*From Training for Schools of Nursing Curricular Materials; available at www.cdc.gov/niosh/docs/2009-127/pdfs/2009-127.pdf.

CONCLUSION

Being able to keep our nurses and patients safe will change today and tomorrow's health field in positive ways. We will be keeping nurses like me at the bedside, enabling us to care for the patients to whom we have devoted ourselves and our careers. 🌟

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Texas is the first state to require hospitals and nursing homes to implement a safe patient handling program. A few states have passed laws that lend support to safe patient handling and movement (SPHM), while laws in seven states require development of SPHM policies, implementation of SPHM programs, and/or use of mechanical patient lifting equipment. A number of other states have also introduced legislation.

In May 2009, I became a founding member of the Coalition for Healthcare Worker and Patient Safety (CHAPS). According to Marsha Medlin, CHAPS founder, currently there are "no active safe patient handling bills in either the House or Senate. Both expired at the end of the last session and have yet to be introduced in 2011."

LOOKING AHEAD

Lifting patients by hand caused permanent harm to my body and career, but I feel privileged to be part of the historic fight for the safe handling of the patients and residents in our care.

I look forward to the day when SPHM is addressed as a public health crisis in the hope that nurses who have sacrificed their health and well-being in the care of others are no longer treated as disposable. 🌟

Pulse on Research

THERE IS MUCH TO BE LEARNED ON THE TOPIC OF SAFE PATIENT HANDLING. HERE IS THIS ISSUE'S PULSE ON RESEARCH, WHICH INCLUDES CURRENT ARTICLES RELATED TO SPHM THAT HAVE BEEN PUBLISHED OVER THE PAST FEW YEARS.

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