In 2014, more than 11,000 registered nurses (RNs) suffered injuries while assisting patients and performing their jobs. Every day, nurses and other caregivers suffer debilitating pain and often career-ending musculoskeletal disorders due to manually lifting and repositioning patients. This includes an estimated 3,600 pounds per shift.¹

The American Nurses Association (ANA) surveyed 14,000+ registered nurses and nursing students in their Health Risk Appraisal survey from 2013-16. Fifty-one percent of respondents reported musculoskeletal pain at work. Additionally, the survey showed that 73 percent had access to safe patient handling and mobility (SPHM) equipment, while only 51 percent used that technology every time they transferred or moved a patient.²

Caregivers’ daily activities tend to carry high risk because of the potential for neck, shoulder, and back injuries (see Sidebar Examples of High-Risk Activities in Healthcare).

**Trends in SPHM**

A growing number of hospitals and nursing homes require SPHM programs that reduce and/or eliminate lifting activities by caregivers—often because of relatively new state laws. In 2003, the ANA launched its Handle With Care® campaign to “build a healthcare industrywide effort to prevent back and other musculoskeletal injuries.”³ Ten years later, the ANA published Safe Patient Handling and Mobility: Interprofessional National Standards.

**States with SPHM Mandates**

To date, 11 states have enacted safe patient handling laws or promulgated rules and regulations to address and prevent workplace injuries to nursing staff: Ohio, Texas, Washington, Rhode Island, Maryland, New Jersey, Minnesota, Illinois, New York, Missouri, and California. The laws and programs vary from state to state. Some programs include financial compensation for training and procurement of equipment, while legislation provides for the implementation of policies, processes, and analysis of risk. Some of the states mention staff education and design of the work environment, or include a lift policy or committee at the hospital or unit level.

Enforcement of the legislation already in place varies greatly. Monitoring bodies may include state inspections, surveys by The Joint Commission, or self-monitoring—but enforcement is not a given. In fact, in New York, critics charge the current law is “silent on enforcement and does not allow the NYS Department of Health to assess penalties against an employer who fails to comply with the law.”⁴ Hospitals may face sanctions from accreditation bodies if they do not meet the standards developed by legislation and hospital policies. It is more common for nurses to sue their employer for significant on-the-job injuries. These claims include compensation for missed worked time, as well as pain and suffering.
Best Practices

Traditionally, caregivers have utilized manual lifting or whatever lifting equipment is available, rather than assessing the patient and utilizing the equipment best suited to the task. Assessments and subsequent care plans can improve patient safety and comfort and reduce the possibility of caregiver injury. It can decrease the intensity, duration, and frequency of musculoskeletal pain that occurs during unsafe patient handling activities.\(^3\)\(^6\)

Assessment Tools

Assessment tools should assess the patient’s ability to assist with activity; patient’s weight-bearing status; general strength and specifically upper-body strength; ability to follow directions; patient’s height and weight; and specific physician orders, recommendations, restrictions, or equipment that could interfere with transfer or repositioning activities.\(^5\)

One example of an assessment tool is the Bedside Mobility Assessment Tool (BMAT). The BMAT is a tool designed for clinicians to assess patient mobility in acute care, and allows clinicians to determine the appropriate SPHM equipment or device.\(^5\) Once an assessment is determined, the clinician can use predetermined algorithms for safe patient handling tasks, including the appropriate equipment.

Impact of SPHM on Patients

While clinicians understand the need to turn, reposition, and promote early mobility, critically ill patients 18 years and older noted that pain during manual turning/repositioning activities was greater than during tracheal suctioning, tube placement, or wound dressing changes.\(^6\)

The Centers for Medicare and Medicaid Services (CMS) track a short list of hospital-acquired injuries, but none are broken down into SPHM-related complications.\(^7\)

- Falls and Trauma
- Fractures
- Dislocations
- Intracranial Injuries
- Crushing Injuries
- Burn
- Other Injuries

Uncommon Language, Competing Priorities

An ongoing challenge for clinicians is a lack of a common language amongst the different disciplines that participate in patient care, which makes communication difficult. For example, “get the patient up” may mean to get the patient out of bed and into a chair, or it can mean to get the patient walking. Even phrases like “moderate assist” or “maximum assist” may mean different things to a physical therapist than to a nurse.

Different disciplines treat SPHM with different points of view. While nurses understand the value of mobilizing patients early in their hospital stay, it may be a lower priority on a busy day—especially in a critical care setting. A physical therapist, on the other hand, is more likely to focus on early mobility of the patient. This can lead to competing priorities.

For example, Fall Teams traditionally focus on preventing falls, since they inflict a high burden and cost to the facility. Despite this, early mobility initiatives are shown to foster independence more quickly. What is not always understood is the reason for falls, which may be the different education and training that each discipline receives. One solution may be to implement competency-based assessments and universal training on the use of SPHM equipment. Vendors can supplement SPHM education with training on equipment, as they have expert knowledge on the use of their equipment.

Conclusion

SPHM continues to be a hot topic as hospitals feel the pressure to discharge patients as early as possible. While there always be some disagreement among the different disciplines, caregivers are willing to share their ideas and are open to further discussion. Opportunities exist to get involved regionally and nationally. Areas to consider for engagement include research, developing best practices, staff education, and patient and staff advocacy.
Examples of High-Risk Activities in Healthcare

— Patient transfer: bed to chair, chair to toilet, chair to chair, car to chair
— Lateral patient transfer: bed to stretcher, stretcher to exam table
— Patient repositioning in bed: both side-to-side and up
— Patient repositioning in wheelchair or dependency chair
— Lifting patients up from floor
— Tasks requiring sustained holding of limbs or access to body parts on bariatric patients
— Transporting bariatric patients on a stretcher, wheelchair or walker
— Bariatric toileting tasks

Online SPHM Resources

International Journal of SPHM
sphmjournal.com

Dept. of Labor/OSHA
osha.gov/dsg/hospitals/patient_handling.html

Association of Safe Patient Handling Professionals
asphp.org

Safe Patient Handling and Mobility: A Guide for Health Care Workers
dc37.net/wp-content/uploads/about/graphics/safepatienthandling/SafePatientHandling Guide.pdf
B MAT Assessment Tool

— Developed during a multi-hospital SPHM implementation
— Answers the questions: “What type of equipment do I use?” and “What is my patient’s mobility level?”
— Validated assessment for SPHM and a functional mobility assessment
— May reduce witnessed falls and promote early mobility practices
— Recommends equipment for safe patient transfers and mobility
— Reduces variation in care related to the risk of patient handling and falls

References

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PUB-0046-0918