

# **Safe Patient Handling Program**

**January 2016**

## **ACKNOWLEDGEMENTS**

The information contained in this manual is the result of a collaborative effort between a number of Occupational and Environmental Safety and Health professionals who were tasked with developing standardized, evidence-based best practice approaches to safe patient/client/resident handling and movement within the province of Manitoba. The overall goal was to prevent work-related musculoskeletal injuries and near misses related to patient handling and movement tasks. The core program elements described in this guidebook have been tested within many of the different facilities throughout Manitoba.

The membership of the Provincial Workplace Safety and Health Working Group (PWSHWG) consists of representation from:

Interlake-Eastern Regional Health Authority  
Northern Regional Health Authority  
Prairie Mountain Health  
Southern Health – Sante Sud  
Winnipeg Regional Health Authority  
Diagnostic Services Manitoba  
CancerCare Manitoba  
Manitoba Health  
Labour Relations Secretariat

The Provincial Workplace Safety and Health Working Group acknowledge the contribution of the following people in the development of the Safe Patient Handling Program. Without your untiring attention to this ambitious project, this manual would not have come to fruition.

Sylvia Horvath  
Susan Thorvaldson  
Gail Archer-Heese  
Suzanne Dyck  
Trish Lavergne  
George Matos  
Monique Wichenko  
Cara Windle

Thank you, committee members for your commitment to the “culture” of safety.

Shaun Haas  
Chair  
On behalf of the Provincial Workplace Safety and Health Working Group

## **THIS RESOURCE GUIDE IS TARGETED FOR:**

- An interdisciplinary team responsible for improving the safety of both healthcare workers and patients during the performance of patient handling and movement tasks.
- Healthcare workers involved in direct patient care and patient movement, including but not limited to registered nurses, licensed practical nurses, healthcare aides, physiotherapists, occupational therapists, rehabilitation assistants, respiratory therapists, patient transport technicians, diagnostic and treatment technologists.
- Risk managers, safety coordinators, quality managers and administrators who influence workplace safety and support resources for lifting devices.
- Workplace Safety & Health Committees.
- Healthcare workers in Acute Care, Long Term Care and Home Care settings, each of which present with entirely different patients/residents/clients and environmental factors.

Note: Throughout this document, depending on the region/facility/site/program OESH refers to the Occupational and Environmental Safety and Health / Occupational Safety and Health department/unit. WRHA policies and operational procedures are provided as samples.

# TABLE OF CONTENTS

## Province of Manitoba Safe Patient Handling Program

---

### **1.0 INTRODUCTION AND BACKGROUND**

- 1.1 [Purpose of the Guidelines and Resource Manual](#)
- 1.2 [What is Safe Patient Handling](#)
- 1.3 [Hazards Related to Patient Handling](#)
- 1.4 [Guiding Documents, Principles and Legislation](#)
- 1.5 [Special Considerations](#)
  - 1.5.1 [Acute Care](#)
  - 1.5.2 [Emergency Rooms](#)
  - 1.5.3 [Emergencies & Codes](#)
  - 1.5.4 [Operating Rooms](#)
  - 1.5.5 [Labour & Delivery](#)
  - 1.5.6 [Ambulatory Care Clinics](#)
  - 1.5.7 [Allied Health](#)
  - 1.5.8 [EMS](#)
  - 1.5.9 [Long Term Care](#)
  - 1.5.10 [Community Health Services Care](#)
  - 1.5.11 [Bariatric Patients](#)
  - 1.5.12 [Pediatrics](#)
  - 1.5.13 [Uncooperative Patients](#)
  - 1.5.14 [Post Mortem Care](#)
  - 1.5.15 [Falls prevention and response](#)
  - 1.5.16 [Wound Care](#)

### **2.0 PROGRAM COMPONENTS**

- 2.1 [Hazard Classification](#)
- 2.2 [Identification of Hazards](#)
- 2.3 [Hazard/Risk Control](#)
- 2.4 [Patient Transfer and Movement Assessment](#)
- 2.5 [Documentation and Communication](#)
- 2.6 [Safe Patient Handling Equipment](#)
- 2.7 [Safe Work Procedures](#)
- 2.8 [Training Plan and Competency](#)
- 2.9 [Monitoring and Enforcement](#)
- 2.10 [Injury Reporting/Corrective Action](#)
- 2.11 [Medical Management – Graduated Return to Work](#)

### **3.0 IMPLEMENTING YOUR PROGRAM**

- 3.1 [Management Commitment](#)
- 3.2 [Safe Patient Handling Implementation Team](#)
- 3.3 [Roles and Responsibilities](#)
- 3.4 [Program Implementation Checklist](#)
- 3.5 [Program Evaluation](#)

## 4.0 RESOURCES

- 4.1 Resources: Legislation and Guiding Documents
  - 4.1.1 [Workplace Safety and Health Act Section 4: Duties of Employers](#)
  - 4.1.2 [Workplace Safety and Health Regulation Part 2.2.1: New Worker Orientation](#)
  - 4.1.3 [Workplace Safety and Health Regulation Part 8: Musculoskeletal Injuries](#)
  - 4.1.4 [Workplace Safety and Health Regulation Part 39: Healthcare Facilities](#)
  - 4.1.5 [WRHA Policy 20.20.030 Workplace Safety and Health](#)
  - 4.1.6 [WRHA OESH Operational Procedure – Safe Patient Handling and Movement](#)
  
- 4.2 Resources: [Musculoskeletal Hazards in Patient Handling](#)
  
- 4.3 Resources: Assessment & Communication
  - 4.3.1 [Risk Assessment: General Considerations and Red Flags Checklist](#)
  - 4.3.2 [Risk Assessment: Patient Assessment Procedures and Screening Tool](#)
  - 4.3.3 [Safe Patient Handling Assessment Form](#)
  - 4.3.4 [Transfer Logo Samples](#)
  
- 4.4 Resources: Hazard Control Options
  - 4.4.1 [Patient Handling Control Measures](#)
  - 4.4.2 [Safe Work Procedure Samples](#)
  
- 4.5 Resources: Training and Education
  - 4.5.1 [Risk Assessment: General Considerations and Red Flags Checklist](#)
  - 4.5.2 [Risk Assessment: Patient Assessment Procedures and Screening Tool](#)
  - 4.5.3 [Patient Capability Assessment Outcomes](#)
  - 4.5.4 [Safe Patient Handling Algorithms](#)
  - 4.5.5 [Sample Competency Checklists](#)
  
  - 4.5.6 [PowerPoint Presentation Training Sample](#)
  
- 4.6 Resources: Monitoring & Enforcement
  - 4.6.1 [Monitoring Sample Checklist](#)

## **1.0 INTRODUCTION AND BACKGROUND**

### **1.1 Purpose of the Guidelines and Resource Manual**

The Provincial Workplace Safety and Health Working Group would like to present the revised Safe Patient Handling Program. The program is based on a minimal lift and transfer environment with a major emphasis on safety for both healthcare workers (HCWs) and patients/residents/clients in each healthcare location. In this document, depending on the program area, patient refers also to residents and clients. This program meets the requirement for a Safe Patient Handling Program under the Workplace Safety and Health Regulation and will ensure all participating healthcare facilities move closer to a safer workplace that will reduce the frequency and severity of injuries to HCWs.

The standards presented are derived from a large international body with input from all disciplines. They represent the accumulation of best practices and are evidence-based as of 2015. This area of practice is continually evolving as new information and technologies emerge as a result of research and best practice trials. These guidelines will be updated on ongoing basis as new information is available and/or additional resources are developed.

### **1.2 What is Safe Patient Handling?**

Safe patient handling involves using the appropriate equipment, techniques, body mechanics and care to optimize staff safety, patient safety and patient independence. The ultimate goal is to eliminate or minimize the risk of injury to health care workers while enhancing patient safety.

Safe patient handling includes lifting, lowering, holding, pushing, or pulling of the patient using bodily force of the care provider.

### **1.3 Hazards Related to Safe Patient Handling**

Hazards associated with safe patient handling can be present at any point in time during a given task. Physical injuries can result from awkward postures, overexertion, unexpected patient behaviour and poor body mechanics when attempting to handle and move patients. The unpredictability of patient behaviour can include a sudden loss of balance or strength, reactive behaviour and violence and aggression towards staff. Inappropriate use of equipment, poor technique, limited staffing, uncooperative patients, time/deadline pressures and exposure to emotional situations are also hazards related to patient handling and movement. Performing tasks recognized as hazardous which are deemed no longer acceptable pose threats to staff safety as well. Examples of these “out of practice” handling techniques include, but are not limited to, the pivot transfer, axilla drag and firefighter carry/cradle/basket lift, holding or lifting a patient upwards during a fall, transfer belt or blanket lift from floor. The focus is to recognize and reduce these and other hazards in order to promote a positive and injury-free work environment for both staff and patients.

### Links

[Musculoskeletal Hazards in Patient Handling](#)

#### **1.4 Guiding Documents, Principles and Legislation**

The Manitoba Workplace Safety and Health Act, W210 and Part 39 of Manitoba Workplace Safety and Health Regulation, MR217/2006, require specific actions to prevent musculoskeletal injuries in the workplace.

Part 39 of the Regulation, the summary, and bulletins related to safe patient handling are found in the Resources Section 4.1. These include safe work procedures, assessment, communications tools, monitoring and enforcement.

Workplace Safety and Health regional policies should define rights and responsibilities for workplace safety and health throughout facilities/sites/ programs. For example, the WRHA Policy 20.20.030 specifically states that “WRHA Facilities are committed to: Establishing and maintaining Workplace Safety and Health Programs that meet the requirements of this policy and the Workplace Safety and Health Act.”

Operational Procedures should also outline specific workplace safety and health programs and include definitions, procedures, responsibilities and training required to ensure compliance with policy and Provincial Legislation. A sample WRHA Occupational and Environmental Safety & Health (OESH) Operational Procedure – Safe Patient Handling can also be found in the Resources Section 4.1. This Operational Procedure outlines the guiding principles of the Safe Patient Handling Program and assigns roles and responsibilities to all stakeholders for ensuring the safety of staff and patients.

### Links

[Workplace Safety and Health Act: Section 4 – Duties of Employers](#)

[Workplace Safety and Health Act: Section 4.1 – Duties of Supervisors](#)

[Workplace Safety and Health Act: Section 5 – Duties of Workers](#)

[Workplace Safety and Health Regulation: Part 2.2.1 - New worker orientation](#)

[Workplace Safety and Health Regulation: Part 8 – Musculoskeletal Injuries](#)

[Workplace Safety and Health Regulation: Part 39 – Healthcare Facilities](#)

[WRHA Policy 20.20.030: Workplace Safety and Health](#)

[WRHA Safe Patient Handling Operational Procedure 2014](#)

## 1.5 Special Considerations

### 1.5.1 Special Considerations for Acute Care

Acute care settings present special challenges to HCWs providing care. Depending on the facility, HCWs can be less familiar with the patient, as some patients are in care for short periods of time. Because a patient's medical status and functional abilities can vary greatly in a short period of time, it is imperative to perform a screen of a patient's capabilities prior to assisting the patient with all repositioning or transfer tasks.

Generally, more HCWs and resources are available for problem solving and for handling unique situations than in other environments. Physiotherapy and/or Occupational Therapy are, or should be, available for timely assessment of mobility, strength, and management of specific issues such as tone and balance. A larger interdisciplinary team is often accessible for specific problem solving. HCWs are encouraged to share equipment and/or resources to ensure that all patient handling tasks are performed safely or if necessary, delay the transfer until the appropriate equipment and resources are available.

#### Links

[Acute Care Resources](#)

### 1.5.2 Special Considerations for Emergency Rooms

In emergency rooms, patients can present with a myriad of illness or injury including cardiac emergencies, various traumas, fractures or other ailments. Patients may also arrive by a number of different methods (e.g. EMS, stretcher service, personal vehicle), resulting in unique and varying transfer needs. In this fast paced environment, workers are faced with competing priority lists with triage of patients with whom they have no prior knowledge. Patient volume and turnover can be very high, resulting in little time to assess the appropriate transfer techniques. Adding to the potential of high stress levels are factors such as lack of patient cooperation. This could result from a number of causes, such as altered state due to drug use, improper medication, dementia and other



mental health concerns. Recognizing and addressing these concerns during safe patient handling in emergency room environments is the key to reducing or eliminating injuries.

**Links**

**Safe Work Procedures:**

[Car Transfers: Transfer Responsive Patient Out of Front Seat to Chair](#)

[Car Transfers: Transfer Unresponsive Patient Lying in Back Seat to Stretcher](#)

[Car Transfers: Transfer Unresponsive Patient Out of Front Seat to Stretcher](#)

### **1.5.3 Special Considerations for Emergency/Code Situations**

Emergencies or code situations (code blue, code 25) are serious and potentially life threatening situations. The main consideration is the survival of the patient. Whenever possible, reducing injury risk to staff without jeopardizing the immediate delivery of care must be attempted.

One main goal to achieve safety for staff is to treat the patient on the surface where they are found. i.e. on the floor or on the bed. If the patient is seated during the code, they should be lowered to the floor in order to provide appropriate treatment. The patient should not be lifted unless absolutely necessary.

To maximize compression force and reduce injury during CPR, the HCW must be in a stable position. It is preferable to be on the floor or on a stable stool to achieve sufficient elevation. Performing CPR while on the bed with the patient should be a last resort due to insufficient space and an unstable surface.

**Links**

[Emergency Code Resources](#)

### **1.5.4 Special Considerations for Operating Rooms**

The operating room provides a unique environment for safe patient handling. Patients may be affected by varying types of anaesthetic, which will impact the amount of assistance the patient requires. Patients may also experience a state of confusion as a side effect of the anaesthetic used. As well, the state in which the patient enters an anesthetic state will often determine their state when they emerge. This is observed with aggressive behaviour.

Surgical patient positioning will depend on the type of surgery being performed, and can include positions not often seen in other healthcare environments. These include, but are not limited to fully prone and lithotomy positions. Positioning devices can include items such as skull supports, leg stirrups, gel pads/rolls and a variety of limb supports.

The goals of surgical positioning are to allow optimum access to the operative area, to support normal body processes and to prevent injury. The lifting and holding of limbs during skin preparation should also be monitored and minimized wherever possible. Alternatives to manual holding of limbs should be considered when equipment is available.

### Links

[AORN Guidance Statement: Safe Patient Handling in the Perioperative Setting](#)

[WRHA Best Practice Guidelines: Patient Positioning for Surgical Procedures](#)

[Safe Work Procedure: Air-Assisted Device \(HoverMatt & HoverJack\)](#)

[Presentation: Safe Patient Handling in Operating Rooms and Orthopaedic Settings](#)

#### **1.5.5 Special Considerations for Labour & Delivery**

During labour and delivery patient handling may be required for both the mother and infant, including guiding or catching the infant out of the birth canal or dealing with shoulder dystocia. HCW's may be required to assist mothers in and out of unique birthing positions which may include unstable surfaces such as birthing balls and other equipment. They may also be required to assist patients in unfavorable conditions such as slippery surfaces and low work surfaces (e.g., during water births, wet/slippery floors from birthing). HCW's may be accustomed to using their bodies to support and/or hold the limbs of the expectant mother during delivery which can put additional strain on the worker.

Although the weight of an infant would fall within safe lifting guidelines, HCW's may be required to lift, carry or hold infants in awkward positions and/or for sustained periods of time (e.g., while demonstrating and/or instructing on breastfeeding or bathing techniques). Attending to infants in fixed height bassinets may also result in awkward postures.

During delivery the mother's strength and functional capabilities may be temporarily reduced if an epidural is used for pain control. A quick pre-transfer assessment is imperative. Mothers may also become unpredictable, agitated or aggressive during the birthing process secondary to pain or a rapid change in their medical status (e.g., suddenly unable to bear weight or fainting).

Midwives are faced with additional challenges in the home environment to obtain ideal work heights for tasks such as suturing, catheter insertion, and

birthing in pools. The manual handling of equipment and supplies to and from the client's home also adds to the risks.

**Links**

[Biomechanics for Shoulder Dystocia During Child birth](#)

[Chapter Reference for Labour & Delivery](#)

### **1.5.6 Special Considerations for Ambulatory Care Clinics**

Outpatient clinic staff members are exposed to the same potential risks of safe patient handling as those staff within acute care facilities. Considerations for safe patient handling include limited resources, patient handling equipment, and appropriate staff education. Space allocation in treatment rooms is always of a concern, particularly with heavier patients. Limitations in room size affect the options for bariatric patient handling equipment. When combined with a greater frequency of larger sized individuals, this presents workers with an increase in complexity for bariatric care.

**Links**

[Ambulatory Care Resources](#)

### **1.5.7 Special Considerations for Allied Health**

Allied health professionals, including but not limited to occupational therapists and physiotherapists, play an integral role in the treatment and progressive rehabilitation of a patient throughout the healthcare system. As such, they may be exposed to a greater degree of risk when attempting to progress the physical capabilities of a patient. While some of these risks can be inherent to the job, allied health professionals can and should mitigate these risks whenever possible through the use of equipment or other methods. New equipment and technologies that better meet rehabilitation goals should continue to be explored and incorporated into practice.

**Links**

[Allied Health Resources](#)

### **1.5.8 Special Considerations for Emergency Medical Services (EMS)**

Safe patient handling is not limited to facility-based patients. In fact, patients often begin their path through the continuum of care with Emergency Medical Services (EMS) personnel. This includes both fire and paramedic personnel.

EMS staff must adapt to several different factors when performing safe patient handling tasks. Environments are extremely variable, including but not limited to patient's homes, public places, and outdoor locations. Weather conditions may be a factor, as well as the potential for dangerous situations such as performing patient care roadside with traffic traveling past. There are a number of variables which cannot be accounted for beforehand, such as a lack of an elevator and the amount of space or obstacles within the area. The emergent nature of some situations may not allow for proper safe patient handling procedures to be followed. However, whenever possible, EMS staff should strive for proper body mechanics and equipment use in order to prevent staff and/or patient injury. When transferring patient care to a facility, it is important that both EMS and hospital staff work together to ensure safe patient handling procedures are being followed for the safety of all parties. This can pose additional challenges when different equipment or procedures are utilized at various facilities.

### Links

[EMS Resources](#)

#### **1.5.9 Special Considerations for Long Term Care**

In a long term care facility or personal care home (PCH), the facility is the resident's home. The expectation is that the resident or substitute decision maker will be consulted about decisions involving the care plan. Safe patient handling tasks are part of the care plan for each resident.

A resident can be medically and functionally stable for long periods during the admission to a PCH. However, due to multiple diagnoses and potential risks associated with falls, behaviour and cognitive issues, these residents can quickly deteriorate and change in acuity. HCWs require a toolkit of knowledge and equipment to respond to the change in status of the resident related to safe patient handling.

Factors such as neurological tone, weight/girth, height, behaviour and cognition will impact the assessment when determining methods or techniques used for safe patient handling such as medical devices (e.g. feeding tubes, catheters and ostomies); presence of assistive devices (e.g. orthotic and prosthetic devices, wheelchair type, wheelchair seating, commodes, sliding boards); and specialized equipment (e.g. tub stretchers, shower chairs, type of lifts in the PCH, patient sliders).

Length of stay of the resident, consistency in HCWs, HCW familiarity with the residents, regular involvement of the resident or substitute decision maker; and resources available for third party funding of equipment help to facilitate consistency in safe patient handling.

Depending on the personal care home, physiotherapy and occupational therapy services may be accessible to assist in problem solving as well as HCW training in the application of the principles of safe patient handling and movement.

#### Links

##### **Dementia Resources**

[P.I.E.C.E.S. Assessment for Dealing with Reactive Behaviours](#)

[Alzheimer's Society](#)

[Chapter Reference for Long Term Care](#)

[Safe Work Procedure – Bath Stretcher](#)

#### **1.5.10 Special Considerations for Community Health Services**

The Provincial Workplace Safety and Health Act Regulation 217/2010 clearly defines the client's home as a "workplace" and a "healthcare facility" during the provision of Home Care Service. As such, specific hazards must be addressed as they would in a hospital or long-term care facility.

Safe patient handling in the home environment presents many unique challenges that are not present in acute care and long term care facilities. Space limitations, different flooring surfaces (e.g., carpet), and low work surfaces (e.g., beds, bathtubs) are frequently encountered. The client and/or client's family may refuse, resist or be financially or physically unable to make the necessary changes to the home or care plan to ensure safe patient handling and movement (e.g., equipment, moving furniture, etc.). The Homecare team must resolve these issues and find the right balance between the safety of the HCW and the needs of the client.

An appropriate allied health professional should assess the client in the home environment whenever possible (regional staff or contracted agency). However, initial client assessments may need to be delegated to nursing staff and referred for more detailed assessments as required. Non-urgent (re)assessment requests may take time to be completed.

Access to equipment in the home may be limited. Some clients may not have the resources to obtain special equipment that the Home Care Program does not provide or fund. There may be delays in obtaining equipment that is provided by the program due to the requisition process or waiting lists (e.g., overhead lift). This means that service may be restricted to bed care in order

to avoid exposure to an unsafe patient handling situation while waiting for an assessment and/or equipment.

The majority of HCW's in the community are performing patient handling and movement techniques on their own, unless assessed as requiring two or more persons. There is a greater reliance on HCWs in the home care environment to recognize and report unsafe patient handling situations to aid in appropriate decision making on whether to proceed with a particular transfer/mobility task. HCW's may be reluctant to report in fear of compromising the working relationship with the client. It is also important that each client's care plan accounts for fluctuations in mental or physical status (e.g., mood, physical capability, fatigue level, etc.) to ensure that the proper training and equipment resources are available for the HCW when required.

### Links

#### **WRHA Community Care Resources**

[Home Care Direct Service Staff Best Practice Manual](#) (Intranet access required)

[Home Care Mobility & Transfers and Equipment Guidelines](#) (Intranet access required)

#### **1.5.11 Special Considerations for Bariatric Patients**

A bariatric patient is defined as someone with a body mass index (BMI) greater than 40, or someone who weighs more than 350 pounds. It is important to note, however, that due to body shape and size, individuals who do not meet these exact criteria may still benefit from the techniques and equipment used for bariatric patients. For example, these techniques could be recommended for patients weighing as little as 250 pounds. Individual differences will include height, the presence of a pannus, as well as the size and shape of the pannus.

Bariatric patients often require specialized equipment that is larger in size and/or has an increased weight capacity. Whenever possible, using mechanized equipment is preferred to reduce the forces incurred by staff. These items can include, but are not limited to, gowns and clothing, expandable beds, stretchers, chairs, wheelchairs, commodes, mechanical lifts, friction reducing devices (sliders) and gait/transfer belts. Extra bed features are also available to minimize handling and the physical demands required by HCWs. For example, beds can be converted into chairs (e.g., cardiac or neuro chair) or the bed's pressure redistribution surface can be used to turn a patient (turn assist features). Beds are also available with power drive options to assist with transporting. Tuggers can also be attached to beds or wheelchairs to provide power assist.

It is important to note that even lifting limbs in the bariatric population can exceed recommended lifting limits. The size and weight of the patient must

also be taken into account when ordering diagnostic tests. The suitability of the test (e.g. ultrasound) and the weight/size limits of the machines must be considered.

Larger equipment will necessitate more space to maneuver within the room. Staff need to consider the amount of equipment needed in the room, dimensions of the room and the size of doorways, elevators etc. when caring for a bariatric patient.

Several clinical factors will affect patient handling for the bariatric patient. Staff must be cognizant of the increased potential for skin breakdown and shearing. Other potential factors include elevating the head of the bed to prevent respiratory distress, skin breakdown and/or shearing, and the size and shape of the pannus.

In most cases, additional staff will be required to ensure the safety of all staff members when performing patient handling tasks. While additional equipment and resources are necessary when dealing with this patient population, staff must also attempt to preserve the dignity of the patient during care. As with all patients cared for by healthcare workers, respectful care is paramount in the treatment of the bariatric population.

<u>Links</u>
<b>Bariatric Algorithms</b>
<ul style="list-style-type: none"><li>○ <a href="#">Bariatric Bed Repositioning</a></li><li>○ <a href="#">Bariatric Chair Repositioning</a></li><li>○ <a href="#">Bariatric Lie to Lie</a></li><li>○ <a href="#">Bariatric Sit to Sit</a></li><li>○ <a href="#">Bariatric Toileting Tasks</a></li><li>○ <a href="#">Bariatric Wound Care Access</a></li></ul>
<b>WRHA Bariatric Care Resources</b>
<ul style="list-style-type: none"><li>○ <a href="#">WRHA Regional Bariatric Website</a> (Intranet access required)</li></ul>
<b>WRHA Regional Bariatric Resource Manual</b>
<ul style="list-style-type: none"><li>○ <a href="#">WRHA Bariatric Patient Emergency Admission Flow Chart</a></li><li>○ <a href="#">WRHA Bariatric Risk Assessment Tool</a></li><li>○ <a href="#">WRHA Body Mass Index Nomogram</a></li><li>○ <a href="#">WRHA Bariatric Equipment Pool Link</a></li><li>○ <a href="#">WRHA Bariatric Bed Evaluation – Things To Consider</a></li><li>○ <a href="#">WRHA Bariatric Equipment and Supply Decision Making Criteria</a></li><li>○ <a href="#">VGH Special Considerations for Care of Obese Patients</a></li><li>○ <a href="#">Bariatric Space Requirements</a></li><li>○ <a href="#">Bariatric Chapter Reference</a></li></ul>

### 1.5.12 Special considerations for Pediatric Patients

When dealing with pediatric patients, the HCW is presented with a dynamic population that can vary greatly in both age and size. Patients can range from newborns to potentially fully grown teenagers, and this can create unique patient handling issues. Patient handling equipment including slings, transfer belts and sliders must be appropriately sized for the population. When caring for newborns or young children, isolettes or cribs are used, which can potentially limit staff positioning for patient handling. When manually lifting young children, staff need to be aware of proper body mechanics and must be careful not to underestimate a child's weight.

Other factors to consider include the physical, mental and emotional development of the patients. Bones, muscles and joints may not be fully developed in the child, and can affect patient handling techniques. In particular, specific techniques are used to account for those children with varying levels of muscle tone and those highly susceptible to fractures. This is done to reduce chance of injury and optimize the transfer for the patient and staff.

Cooperation of the child may be a challenge due to several factors. The child may not be able to understand any directions given during the transfer due to cognitive delays or age. This lack of understanding can also lead to patient fear of the HCW and of the equipment being used. The HCW may have to spend more time introducing new equipment as a result.

Communication is important not only with the child, but potentially with family members as well in order to educate them on the benefits and reasoning for using safe patient handling techniques.

#### Links

[Pediatric Chapter Reference](#)

[Pediatric Slings Guide Reference](#)

#### **Safe Work Procedures**

- [Lifting and Lowering Infants Into Car Seat On The Floor](#)
- [Lifting Infant From Floor \(Tripod Lift\)](#)
- [Turning While Holding An Infant](#)

### **1.5.13 Special Considerations for Uncooperative Patients**

An uncooperative patient is one who is unable or unwilling to assist with a given transfer. Poole (2009) has identified four basic causes for a patient to be considered uncooperative: aggression, delirium, depression and dementia. The reasons for these causes can be quite varied, including brain injuries, medication/substance use as well as mental illness. Understanding the reasons for the uncooperative behaviour can help determine the best methods for transferring the patient, or whether to transfer them at all. In simple terms,



uncooperative patients can be classified as aggressive or non-aggressive. Non-aggressive patients can likely be transferred with a maximum assist such as a mechanical lift or friction reducing device. Other methods such as a minimal or moderate assist will require too much effort on the part of the HCW. If a patient is combative or aggressive, even passive transfers are unsafe and are therefore contraindicated. For these patients, the team must come up with an appropriate care plan for the patient. This may involve specialty beds or linking with family to find a safe way to manage skin integrity and hygiene issues until the patient becomes more cooperative.

#### Links

[Tips When Dealing with Uncooperative Patient](#)

#### **Dementia Resources**

- [P.I.E.C.E.S. Assessment for Dealing with Reactive Behaviours](#)
- [Alzheimer's Society](#)

[Provincial Violence Prevention Program](#)

#### **1.5.14 Special Considerations for Post Mortem Care**

Post mortem care can require delicate yet challenging handling of the patient. Equipment can vary widely depending on the facility, with large ranges in heights to be accessed. Mechanical devices should be used whenever possible. Friction reducing devices such as sliders can be used in conjunction to ensure smooth and dignified transfer methods that are compatible with the mechanical devices used in the facility's morgue area.

#### Links

[Post Mortem Care Resources](#)

#### **1.5.15 Special Considerations for Falls Prevention and Response**

A fall is defined as "Unintentionally coming to rest on the ground, floor or other lower level with or without an injury." (Developed by the Canadian Falls Prevention Curriculum and adopted by the Manitoba Falls Prevention Network, October 31, 2008).

Fall Prevention involves considering both the safety of the patient and the safety of staff simultaneously. The goal in fall prevention is to reduce the frequency and severity of falls without jeopardizing the safety of our healthcare workers and support staff. Proper fall prevention includes proper assessment of the patient with respect to transfers and fall risk and the identification and implementation of appropriate interventions and equipment. Another

important aspect of fall prevention is being very attentive to the patient during transfers or ambulation to identify changes in patient status.

During the fall, there is often a tendency for staff to catch or hold up the patient. However, a fall in progress must not be stopped. This has potential to hurt the staff member as well as the patient. In very rare cases, with very specific criteria to be met, staff may be permitted to attempt to safely assist the person to the ground. These criteria include the location of the patient and the HCW, the height of both the patient and the HCW, and the direction that the patient falls. However, this must not involve catching, holding or lifting the patient up to a higher level. An attempt should be made, when safely possible, to redirect the patient if they are likely to hit their head or land on something dangerous.

#### Links

[WRHA Falls Prevention Toolkit \(includes Post Falls Algorithm\)](#) (Intranet access required)

[Staying on your feet](#)

[Safe Work Procedure - HoverMatt/HoverJack](#)

#### **1.5.16 Special Considerations for Wound Care**

During wound care, HCWs are often lifting and/or holding heavy limbs and/or adopting sustained awkward postures. Equipment such as mechanical lifts, limb slings, height adjustable beds, stools, bolsters and/or pillows are often required to eliminate lifting, obtain a good working height and client-nurse set-up.

Some types of compression therapy can also require excessive force to apply (e.g., compression stockings) or may be repetitive in nature (e.g., wrapping Coban). Equipment such as sliders and special gloves can significantly minimize these forces. Application technique and other work practices can also significantly reduce risks (i.e., hand positions, grip type, rest breaks, stretches).

#### Links

[Recommended Weight Limits for Lifting & Holding Limbs](#)

[WRHA Pressure Ulcer and Management Clinical Practice Guidelines](#)

## 2.0 PROGRAM COMPONENTS

### 2.1 Hazard Classification

Hazards are usually **classified into five categories** as listed below. The following are common hazards which may be present during safe patient handling in the workplace in each hazard category:

#### Physical Hazards

- Slips, trips and falls on patient handling equipment, slippery/inappropriate surfacing on floors, etc.
- Hands caught between moving parts of mechanical lifts, beds, walls, doors
- Feet caught under wheels of mechanical lifts
- Property damage when mechanical lifts etc. come into contact with walls, doors and other objects.

#### Biological Hazards

- Blood or body fluid exposures through bites, splashes, etc. from patients being transferred
- Transmission of infection

#### Chemical Hazards

- Chemical exposure when cleaning equipment

#### Ergonomic Hazards

- Forceful exertions when lifting, lowering, pushing, and pulling (equipment or patients)
- Repetition
- Postures – awkward and/or sustained
- Gripping
- Contact stress

#### Links

[Musculoskeletal Hazards in Patient Handling](#)

#### Psychosocial Hazards

May apply dependent upon workplace

- Exposure to emotional situations

- Exposure to violent/aggressive/reactive patients
- Control issues
- Time/deadline pressures
- Multitasking
- Degree of cooperation required
- Exposure to confrontational situations
- Level of responsibility / accountability required

**2.2 Hazard Identification** related to safe patient handling must be done during all stages related to planning and procurement to ensure proper performance of safe patient handling and movement tasks. Steps to ensure issues are not overlooked are outlined as below.

**2.2.1 Planning** including design is necessary as it relates to new construction and renovations as it entails dealing with the hazard before any exposure occurs. This step is crucial in the elimination of hazards and is cost efficient as opposed to making changes after construction. During new construction and/or renovations, consider the following:

- Consultation from members of the OESH department/Facility based Multi-Disciplinary Team during both the planning of construction projects and design phases.
- The environment in which the job or task is being performed can significantly affect the performance of the employee. Ensure that sufficient room, space, width and height is allocated for efficient and safe patient handling and maneuvering of specialized lift equipment such as floor or ceiling lifts, bariatric equipment etc. Proper lighting is also important for these tasks.
- Consider the space requirements necessary for the workers performing their job tasks.
- Consider storage requirements and type of materials to be stored. Ensure that storage is easily accessible and at suitable height to prevent awkward postures such as overreaching.
- Determine the physical job requirements to assist in the planning/design process, such as weights of materials and equipment.
- Obtain user feedback through employee surveys, questionnaires, and interview consultations.

**Links**

[Bariatric Space Requirements](#)

[Space Requirements For Total Lifts](#)

**2.2.2 Procurement** relates to the purchase or replacement of equipment and tools related to safe patient handling and movement. During procurement, consider the following:

- Consultation with OESH/Musculoskeletal Injury Prevention Specialist (MSIP) prior to purchase/ replacement of equipment.
- Consultation with OESH/MSIP during the contracting and group purchasing processes.
- Standardization of equipment and tools wherever possible through consultation with Logistics/ Purchasing. This is crucial for the equipment training component.
- Review of tasks to evaluate the need for ergonomic equipment.
- Preventative maintenance requirements.
- An inventory review of equipment to ensure it is accessible and available in sufficient numbers to all required users.

**2.2.3 Performance** of safe patient handling tasks and hazard identification during exposure can be accomplished through:

- Completion of a Job Hazard Analysis that will assist with the determination of hazards/risks relevant to safe patient handling and movement.
- Workplace Inspections.
- Observation of staff while performing their work/tasks.
- Work Flow Analysis.
- Signs and Symptoms Surveys.
- Injury and Incident Reporting and Investigation.

#### Links

[WorkSafe BC Bulletin: Patient Handling - Weighing the Risks](#)

[Job Hazard Analysis](#)

## 2.3 Hazard/Risk Control

According to Part 2 of the WSH Regulation, employers must, if reasonably practicable, eliminate risk to the safety or health of workers through design of the workplace or work process or use of engineering controls. Any remaining risks must be controlled by implementing safe work procedures and use of personal protective equipment to address any uncontrolled risks that the worker may be exposed to. *Please note that for all tasks involving safe patient handling, safe work procedures are required as outlined in Part 39 of the WSH Regulation. This also applies where elimination or engineering controls have been implemented.*

Hazard control options for patient handling must therefore be considered in order of the **Hierarchy of Controls:**

- **Elimination**
- **Engineering Controls**
- **Administrative Controls**
- **Personal Protective Equipment (PPE)**

When evaluating potential controls of risk, it is generally accepted that the closer the control is placed to the source of the hazard the greater the degree of risk reduction for the worker. Where risks cannot be eliminated, a combination of control methods can also be employed to optimize injury reduction.

**Elimination** is the most effective way to control a risk and must always be considered first and used whenever possible. Elimination is the process of removing the hazard from the workplace. Eliminating the source of the hazard in patient handling (i.e., the patient) is often not reasonably possible; however, some examples of elimination in patient handling include but are not limited to:

- Not performing a hazardous task when it is not required (e.g., utilizing a patient's capabilities in situations where patient is able to perform the task independently)
- Patient equipment that promotes independence with transfers and eliminates reliance on HCWs to manually assist them (e.g., floor to ceiling poles, stand assist chairs, triangle trapeze bars, etc.)
- Repositioning slings that eliminate the manual repositioning and rolling of patients

**Engineering controls** are generally considered to be the next closest control to the risk and must be considered when elimination is not possible. Engineering controls involve a change in the physical nature of the work or workplace that minimizes the hazard. Engineering controls are a very reliable way to control worker exposures as long as the controls are designed, used and maintained properly. Examples include but are not limited to:

- Changes in the design of the workplace
- Equipment/mechanical devices that reduce the force required to move a patient (e.g., mechanical lifts, friction-reducing devices)
- Adjustable work surface heights to reduce bending/stooping (e.g., height-adjustable electric hospital beds)
- Rearranging, modifying, and/or redesigning processes or work flow that reduces the source of exposure to the hazard

***Most hazards can be eliminated or reduced through engineering controls although there are instances where cost or required change to the process make the control unattainable.***

**Administrative Controls** are considered less effective than engineering controls in that they do not eliminate or change the source of the physical hazard itself. They lessen the duration and frequency of exposure to the hazard or alter the manner in which a task is performed (i.e., work practices controls) to minimize risk of exposure (e.g., by reducing body sprain and strain potential). Administrative controls are applied when the cost or practicalities of engineering controls are prohibitive. Examples include but are not limited to:

- Workplace policies
- Developing, implementing and training on safe work procedures (e.g., safe patient handling training, proper body mechanics training, housekeeping and/or service schedules for equipment and work areas, etc.)
- Rest breaks
- Additional employees performing a lifting task
- Job rotation or job enlargement such as added task variety or sharing tasks among groups to eliminate or reduce repetition and overuse of the same muscle group.

**Personal protective equipment (PPE)** is the least effective method of controlling injury risk and is commonly used as a last resort and in conjunction with administrative and some engineering controls. PPE is equipment worn by individuals to reduce exposure such as contact with chemicals or exposure to noise. Examples include but are not limited to:

- Knee pads to reduce contact stress during kneeling
- Respirators
- Protective clothing such as gloves, face shields, eye protection, and footwear that serve to provide a barrier between the wearer and the chemical or material.

**Determining Controls** for the hazards identified begins with a clear understanding of the work process and work flow through:

- Documentation in the form of a detailed list of the steps required to complete the task (completed by the worker who performs it).
- Observation of the task being performed from start to finish. A flow chart or photos of the process is suggested.
- Assessment of the flow of the task
  - Steps that can be eliminated—are there unnecessary movements? Can steps be combined to reduce movement of patients?
  - Preventive measures where hazards are identified
- Assessment of the physical demands of the work tasks.
- Assessment of the method by which the task is performed.
  - If physical demands cannot be reduced through reduction/substitution, can mechanized lifting/movement of equipment be introduced to reduce physical demands?

Once the controls are proposed, test the modifications, if possible. Ensure that worker input and support is obtained before proceeding. Ensure that the modifications will 'fit the process' and do not introduce other hazards.

Once changes have been implemented, follow-up to ensure the modifications meet the intended goal. It is common for workers to find further improvements once a change has been made. Always consider any engineering change to be evolutionary, that is, subject to change and improvement as better methods are developed and equipment continues to evolve through design improvements.

### Links

[SafeWork Manitoba Bulletin 268: Ergonomics - Safe Patient Handling and Moving \(Hierarchy of Controls\)](#)

[WorkSafe BC Bulletin: Patient Handling - Reducing The Risks \(Hierarchy of Controls\)](#)

## **2.4 Patient Transfer and Movement Assessment**

### **2.4.1 Purpose**

- To comply with WSH Regulation, Part 39 which requires safe work procedures for patient handling, including procedures for assessing whether a patient requires assistance to move.
- To assess potential hazards based on the patient's capabilities and establish how much assistance the patient requires. This will determine how to safely move and/or transfer the patient.
- To ensure consistency in assessment across the Region, in keeping with a 'Minimal Lift' environment, and to provide standardization of practice. Tools have been designed to assist in patient assessment to complement the healthcare workers (HCWs) skills.
- To provide nursing with a concrete way of assessing a patient, but also to recognize when there are mobility issues beyond the scope of this general assessment and/or when a more in-depth assessment is required (referral to OT/PT).
- To improve the safety of HCWs during all their interactions with patients. Although the assessment tools presented should not replace an Allied Health (physiotherapy and/or occupational therapy) assessment and intervention where it is available, it can serve to improve the safety of HCWs when an Allied Health assessment is not available in a timely manner or has been delayed for any reason. Tools can also assist HCWs when reviewing patients who have not had mobility issues.

### **2.4.2 When to Assess**

The assessments presented in this section are designed for nurses; however screening for changes should be everyone's responsibility to ensure the safety of all HCWs. Patient assessment may be done in consultation with Allied Health (Physiotherapy and/or Occupational Therapy), when available, particularly when there are any questions, unresolved issues related to mobility, transfers or repositioning.

An assessment/screen should be performed:

- At admission and should include documentation of the patient's pre-admission abilities. For example, a post-surgical patient may not have ambulated prior to admission.
- Prior to any patient handling task for changes in the patient's functional status. This should be done by anyone completing the patient handling task
- Whenever there is a change in medical or functional status



- On a regular basis for long term care facilities or units/wards (e.g., rehab) as outlined in your facility policies
- When the patient is being discharged from the hospital and transitioning back to the community. A Home Visit may be required to evaluate the client's home environment and any impact it may have on safe patient handling procedures and equipment.

#### 2.4.2.1 Assessment Components

There are some general considerations that will impact the patient's capabilities and independence with transfers, which will alert the HCW that a patient may not be ready for movement. Considering these factors before transfers are attempted will improve the chance of a safe interaction with the patient. Some of this information is inherent to nursing practice, but should be emphasized as a determining factor for patient handling and movement.

#### Links

[Risk Assessment: General Considerations and Red Flags Checklist](#)

#### 2.4.2.2 Patient Function/Capability

The patient's capabilities will determine the level of assistance required. Depending on the transfer task being performed, the following patient capabilities may need to be assessed:

- Ability to cooperate and follow instructions
- Ability to assist with moving in bed (up/down, side/side, roll, sit)
- Ability to weight bear and lower limb strength
- Upper limb strength
- Ability to sit unsupported
- Ability to stand unsupported
- Ability to walk

#### Links

[Risk Assessment: Patient Assessment Procedures and Screening Tool](#)

#### 2.4.2.3 Assistance Level Required

##### **Independent**

The patient is able to safely perform the transfer with or without equipment, and without the need for physical or verbal assistance from the caregiver.

##### **Supervised**

The patient is able to perform the transfer without any physical assistance from the caregiver. Verbal coaching or cueing and/or

equipment set up may be required to maintain safety (e.g., placement of walker)

### **Standby Assist**

The patient may require verbal coaching or cueing and/or equipment set up. The patient may require minor hands-on physical assistance due to anticipated change in physical or cognitive status.

### **Minimal Assistance**

The patient consistently requires minor physical assistance and/or equipment such as a gait/transfer belt. Verbal coaching or cueing and/or equipment set up may be required to maintain safety. As a general guideline, if staff is required to lift or exert greater than 35 lbs. of force, staff should use patient handling equipment and/or ask for additional assistance to reduce/eliminate risks, where reasonably practicable. The patient requires minor physical exertion from staff when being repositioned, rising to stand, ambulating, or lowering to sit. The patient is able to reliably and consistently fully bear weight when standing.

### **Moderate Assistance/ Partially Dependent**

The patient requires more than minor physical assistance and the procedure generally incorporates the use of patient handling equipment with a minimum of 1-2 healthcare workers. As a general guideline, if staff is required to lift or exert greater than 35 lbs. of force, staff should use patient handling equipment and/or ask for additional assistance to reduce/eliminate risks, where reasonably practicable. The patient is partially dependent for physical support for trunk or legs when being repositioned, or during a transfer or ambulation.

### **Maximum Assistance /Totally Dependent**

The patient requires full physical assistance for repositioning, standing, turning, transferring and/or mobility. The patient may have difficulty with key factors such as following directions, weight bearing, strength/exertion and/or demonstrates uncooperative or unpredictable behaviour. All repositioning and transfer tasks should only be performed with the use of equipment.

#### **2.4.2.4 Transfer Method (Safe Patient Handling & Movement Control Measures)**

The framework for determining a safe transfer method is provided by several Safe Patient Handling Algorithms. These are decision-making trees that apply the patient's assessed capabilities and level of assistance required to determine:

- Transfer type - this may include rolling/turning, boosting, lateral transfers, lie ↔ sit, bed ↔ chair, toilet ↔ chair, chair ↔ chair,

walking in hallway, and bathing. Where appropriate it should include distance information for mobility.

- Equipment required
- Recommended number of HCWs to safely perform the task.

They are also helpful to assist the HCW to recognize when there are mobility issues beyond the scope of this general assessment and/or when a more in-depth assessment is required (referral to OT/PT).

### Links

[Algorithm: Bed Repositioning](#)

[Algorithm: Chair Repositioning](#)

[Algorithm: Lie to Lie \(Lateral Transfer\)](#)

[Algorithm: Sit to Sit](#)

[Bariatric Algorithm: Bed Repositioning](#)

[Bariatric Algorithm: Chair Repositioning](#)

[Bariatric Algorithm: Lie to Lie \(Lateral Transfer\)](#)

[Bariatric Algorithm: Patient Handling Tasks Requiring Access to Body Parts](#)

[Bariatric Algorithm: Sit to Sit](#)

[Bariatric Algorithm: Toileting Tasks](#)

[Post Fall Assessment and Management Algorithm](#)

## **2.5 Documentation & Communication**

The Manitoba Workplace Safety and Health Regulation (217/2010) states “when a patient has been assessed as requiring assistance to move, the employer must ensure that the current status of the patient and the appropriate techniques to move the patient are clearly identified in writing or by other visual means at or near the location of the patient.” A communication tool is intended to provide timely, clear communication of transfer information to all healthcare workers (HCWs) involved in patient handling.

Communication is a core element of patient assessment. An effective, accurate communication tool will decrease the chance of injury caused by insufficient information. All HCWs should have access to the assessment results, shift report, Kardex or Care Plan information, transfer logo(s), and finally the patient’s input to determine the patient’s need. Discrepancies in the information should alert staff to consult directly with the assigned nurse for clarification. Various methods of communication include:

**2.5.1 Chart Documentation** - There must be a transfer assessment record in a designated area in the chart/file as a part of the permanent legal record. It should include the transfer method (transfer type, number of HCW’s, equipment), date of the assessment and a signature of the assessor.

Reassessments should occur whenever there is a change in the patient's status and at pre-determined regular intervals (suited to the nature and needs of the ward/unit). This communication tool must also include a check box where the assessor is required to sign that he/she has updated the Transfer Logo and Care Plan.

**Links**

[Sample Safe Patient Handling Assessment Form](#)

The patient Kardex should also be updated where applicable.

**2.5.2 Transfer Logo System** – A labeling or logo system to quickly communicate to HCW's how to safely move/transfer the patient. The transfer logo system can be in the form of a wristband, walking aid marker/band logo card(s), communication board or a combination of these, but must include information above and be located "at or near the location of the patient". The logo system must be easy to change so that HCWs can keep the logos up to date. The logo system must be updated after the initial assessment and after each reassessment. Patients requiring transport should have the logo system travel with them to their intended destination (e.g. diagnostics).

**Links**

Transfer logo samples:

- [Grace General Hospital](#)
- [Health Sciences Centre](#)
- Victoria General Hospital
  - [1 Person Assist](#)
  - [Bed Mobility](#)
  - [Standby Assist](#)
  - [STOP](#)
- [Deer Lodge Centre](#)
- [Prairie Mountain Health](#)
- [Southern Health](#)
- [Additional samples](#)

## 2.6 Safe Patient Handling Equipment

Equipment is necessary to minimize the manual effort required by HCWs in a minimal lift environment. Every effort should be made to ensure equipment is in good working order and readily available for HCWs to use during patient handling and movement tasks.

Proper equipment selection must be based on the specific needs of the facility, patients, staff, and management. Bariatric patients may require specialized equipment.

**2.6.1 Mechanical Lifts** are devices to lift patients that require either moderate or maximal assistance. There are several types of mechanical lifts, which are used with various slings in order to best transfer and/or reposition the patient.

**2.6.1.1 Overhead Lift Systems** can be ceiling or wall mounted track systems, or can involve free standing tracks. Overhead systems offer the best alternative to reduce forces when transferring a patient.

**2.6.1.2 Total Floor Lifts** provide the ability to be used with multiple patients; however do involve higher forces when pushing the lift between transfer surfaces. There are also portable floor lifts designed to handle bariatric patients.

**2.6.1.3 Sit-Stand Lifts** are designed to help clients rise to a standing position with mechanical assistance. This can also help to facilitate maintaining/improving strength for some patients.

### Links

[Choosing The Right Equipment](#)

**2.6.2 Slings** are available in a variety of styles for the various mechanical lifts. Depending on the brand of mechanical lift, slings may come in either a loop style or clip style attachment. The style of attachment must be compatible with the mechanical lift being used. Different manufacturers may have restrictions or regulations regarding the compatible brands of slings. Review the user manual for further details. Aside from the standard sling, there are a number of specialty slings available, including repositioning, hygiene and amputee slings.

### Links

[Choosing The Right Equipment](#)

**2.6.3 Sit-Stand Aids (Non-Mechanical)** include a number of items to help or facilitate a patient to stand.

**2.6.3.1 Manual Sit-Stand (e.g. Sara Stedy)** is a light-weight compact support aid used for sit-stand transfers. A manual sit-stand minimizes the need for assistance from HCWs during sit-stand transfers by giving the patient leverage to help pull him/herself up to a standing position.

**2.6.3.2 Manual Standing Aid** devices aid the patient to pull him/herself to a full stand. Examples include a floor to ceiling pole, hand rail etc.

**2.6.3.3 Patient Turners** are patient-specific devices primarily used in the home environment. Patient turners allow the patient to pull themselves into a standing position and rotate to access a chair/wheelchair etc. with minimal assistance from the HCW.

**2.6.3.4 Transfer/Gait Belts** are used with minimal assist patients to provide support during the sit to stand transfer. They are not designed for the HCW to lift the patient. The belt is placed around the patient's waist for support and cueing during the transfer.

**Links**

[Choosing The Right Equipment](#)

**2.6.4 Friction Reducing Devices (FRDs)** allow for reduced force when assisting with repositioning in bed, chair or wheelchair, or between surfaces. There are several varieties of FRDs.

**2.6.4.1 Air-Assisted Transfer Devices** are designed primarily for lateral transfers. The mattress attaches to an air supply, which allows for a significant force reduction when transferring a patient. The HoverMatt can also be used in conjunction with a HoverJack to raise a fallen patient from the floor.

**2.6.4.2 Slider Sheets** are nylon sheets that are easily inserted and removed from under the patient. Two sheets are used together for repositioning or lateral transfers between surfaces for patients that are unable to help with the transfer. Extension straps can be added to eliminate overreaching. Slider sheets come in a variety of sizes to accommodate different sized patients.

**2.6.4.3 Slider Tubes** are made of the same fabric as the slider sheets, but are one continuous piece of fabric. Slider tubes move in one direction at a time (e.g. boost in bed, lateral transfer). There are no handles on a

slider tube, which can increase the reach of the HCWs using the equipment.

**2.6.4.4 Special Fabric Bed Sheets** do not have to be inserted and/or removed before and after each transfer. There is a narrow strip of friction-reducing fabric that allows for repositioning in one direction only.

#### Links

[Choosing The Right Friction Reducing Device](#)

**2.6.4.5 Roller Boards** are used for lateral transfers. Similar to a slider tube, these sturdy boards are placed under the patient and have a revolving fabric layer that ‘rolls’ the patient to another surface during a lateral transfer. There are no handles on a roller board, which can increase the reach of the HCWs using the equipment.

**2.6.5 Bathing Assist** devices range based on the needs of the patient and the facility/home environment. A bath seat allows the patient to sit in the existing tub. A transfer bench provides additional help in accessing/transferring to and from the tub. A bathtub lift is a mechanical device which transfers patients to the bottom of a tub. A shower chair can be pushed into a shower stall where the patient can be washed. A shower trolley provides an alternative to a bath for those patients who are unable to assist.

**2.6.6 Other:** There are various other pieces of equipment which help in improving a patient’s independence with transfers. These pieces of equipment include:

**2.6.6.1 Sliding Boards** act as a supporting bridge when seated transfers are performed and eliminate the need for lifting the patient from one surface to another.

**2.6.6.2 Toilet Seat Risers** decrease the amount of effort needed for patients with insufficient strength or range of motion to sit on or rise from the toilet.

**2.6.6.3 Trapeze Bars** (also referred to as monkey bars) are suspended above the bed and help patients to reposition themselves. Patients grab onto the bars to aid in moving around the bed.

#### **2.6.7 Equipment Cleaning and Maintenance**

The WRHA Infection Control Policy states “appropriate cleaning, disinfection and sterilization of reusable patient care equipment is important in preventing the transmission of organisms.” Other regions may have similar policy statements. Please refer to your facility guidelines and/or manufacturer’s

instructions for cleaning. Follow manufacturer's guidelines for maintenance and operation as needed.

**Friction Reducing Devices (FRD) and Slings** -The maintenance of friction reducing devices and slings should be a part of a facilities regular equipment checks. Having the items clean, intact and labeled provides staff with the resources to provide a safe working environment. Checking the items on a routine basis maintains inventory supplies so they are in the facility when needed.

**Mechanical Lifts** -The need for equipment checks before and after use and a preventative maintenance program is required to ensure patient handling equipment is in proper working order. A maintenance program can be established with the company that sold the device to the facility or by using facility maintenance services.

Mechanical checks can include looking at overall lift condition, broken or missing parts, sticking wheels, properly functioning electronics, battery charge, and no fluids leaking from equipment. If a problem is found, the equipment must be tagged with appropriate documentation and sent for immediate repair.

## 2.6.8 Equipment Procurement

- Evaluate the type of mechanical devices that are needed to eliminate or minimize manual patient handling based on assessment of patient needs with a focus on safety for all HCWs, the patient, and rehabilitation goals and the guidelines. Look at a variety of devices as listed in the equipment section.
- Contact a variety of vendors who have the type of equipment the program would need. Equipment fairs are an opportunity for HCWs to see and try equipment and to talk to vendor representatives. Explore financial risk-sharing opportunities i.e. a pilot program, vendor contract conditions, HCW training, equipment maintenance and warranty agreements.
- Involve front-line HCWs in the evaluation, selection, and piloting of new products to obtain buy-in for equipment use.

## 2.7 Safe Work Procedures

Safe Work Procedures may be required based on the hazard/risk identified for the specific task. Consult the [WRHA OESH Operational Procedure - Safe Work Procedures](#) for responsibilities and a template with required information to use.

### Links

Safe Work Procedures (SWP) requirements and samples: [Safe Work Procedures](#)

## 2.8 Training Plan



As per the Workplace Safety and Health Act and Regulations and the [Operational Procedure](#), training and education is an essential component for a Safe Patient Handling program. It must be provided to healthcare workers (HCWs) prior to using or operating equipment or participating in patient handling activities. This education program is meant to provide the outline and tools each facility needs to consider for their program.

#### Links

[Workplace Safety and Health Act: Section 4 – Duties of Employers](#)

[Workplace Safety and Health Regulation: Part 2.2.1 - Orientation for new workers](#)

### **Part 1: Theory Education**

The theory portion can be presented as an interactive lecture, possibly in a classroom setting with one instructor or a computerized training module. One option is to have a self-study module assigned to be reviewed prior to the session. The theory portion of the training should be completed before the HCW attends Part 2 – Practical Hands-on Training.

#### **Presentation**

Facilities should include slides on the pertinent information for HCWs. Core components of safe patient handling and movement should include:

- Review of the Operational Procedures and responsibilities
- Body mechanics, power position and weight shifting
- Appropriate working heights
- Patient transfer and movement assessment
- Algorithms
- Documentation
- Facility specific information
- Equipment provision, usage and maintenance
- Where to access safe patient handling reference tools/guidelines/protocols/ algorithms/safe work procedures (e.g. online, posters, binders etc.)

#### Links

[Sample SPH Training PowerPoint Presentation](#)

### **Part 2: Practical Hands-on Training Sessions**

This session is designed to educate the HCWs with a hands-on approach to safe patient handling and movement, use of the equipment, methods of transfer and safe work procedures.

- Sufficient time should be allowed when introducing new equipment or techniques to allow for practice and return demonstration

- Hands-on training should take place in an appropriate setting with relevant equipment available.
- HCWs should have a visual demonstration of the techniques (video or participatory).
- HCWs should deliver a hands-on return demonstration using proper body mechanics for safe patient handling and movement tasks.
- Focus should be on assessing the needs of the patient and how to choose appropriate transfer methods, equipment and number of people necessary to perform transfer.

### 2.8.1 Competency

As per regulation requirements, a system for ongoing assessment of competency with safe patient handling and movement devices should be incorporated into existing protocols for behavioural observation and professional development. Proper use of equipment can be validated through a checklist used by supervisors and/or instructors.

There are different types of competency checklists to assess HCWs. Competency checklists can be completed during training sessions and signed by instructors or they can be left to the responsibility of the supervisor.

#### Links

##### Sample competency checklists

- Community: [Part 1](#) and [Part 2](#) and [Ratings Guidelines](#)
- [Health Sciences Centre](#)
- [Other Checklists](#)

## 2.9 Monitoring and Enforcement

Early and continued success when implementing a Safe patient Handling Program depends on the ability of supervisors to ensure workers are using appropriate equipment and techniques during assigned tasks. Resistance to change, especially in an environment with limited supervision, will delay implementation and compromise the safety of workers and patients.

As with any workplace initiative, management commitment at all levels is integral to its success. The importance of this commitment is reflected in both government legislation and regional policies.

The Manitoba Workplace Safety and Health Act assigns the responsibility to ensure that workers adhere to these policies and procedures to the Supervisor. **Section 4.1 of the Workplace Safety and Health Act** states that:

*Every supervisor shall:*

*(a) so far as is reasonably practicable,*

- (i) take all precautions necessary to protect the safety and health of a worker under his or her supervision,*
- (ii) ensure that a worker under his or her supervision works in the manner and in accordance with the procedures and measures required by this Act and the regulations, and*
- (iii) ensure that a worker under his or her supervision uses all devices and wears all clothing and personal protective equipment designated or provided by the employer or required to be used or worn by this Act or the regulations.*

**The WRHA Occupational Health and Safety Policy 20:20:030** states:

*Managers and Supervisors shall be responsible for applying the Occupational Safety and Health Program. Specifically, and without limitation, managers and supervisors shall identify hazards and enforce safe work practices and implement effective controls, communicate safety and health hazards, investigate hazardous conditions and incidents and ensure that all equipment is properly maintained. Where safety and health training and/or safety equipment is required, managers and supervisors shall request approval for these items from Senior Management if current funding is not sufficient.*

*Senior Management, managers, supervisors and staff must abide by this Policy, the Occupational Safety and Health Program and the Act.*

Supervisory enforcement and its documentation are key to demonstrating due diligence for safety. The implementation of the **Safe Patient Handling Program** through training, provision of resources and the creation of Safe Work Procedures/Practices (SWP) acknowledges recognition of the legislation and the risks in workplaces.

Enforcement of the Safe Patient Handling Program and associated procedures must be proactive, not reactive. Enforcement is not meant to punish those who have been injured or to stop injuries from being reported. The purpose of enforcement is to ensure that all HCWs follow procedures to prevent injuries. This is part of the “culture of safety” where safe work procedures/practices become part of everyday routine and are followed as closely as clinical procedures. The **WRHA Occupational Health and Safety Policy 20:20:080**:

*Violation of safety and health rules or responsibilities by a member of Senior Management, a manager, a supervisor or a Staff person may result in remedial action including education and/or disciplinary action, up to and including dismissal from employment.*

All monitoring and enforcement activities must be documented as per your facility’s Human Resources procedures.

**Links**

[Sample monitoring tool](#)

## 2.10 Injury Reporting/Corrective Action

Prevention is the purpose of a work related injury/ near miss investigation. It is the supervisor/manager's job to determine corrective actions that will prevent reoccurrence of the injury /near miss. The purpose is not to find fault or blame, but rather to identify the basic causes so controls can be put in place to prevent further occurrences. Information from the investigation should be documented on the **Work-Related Injury/Near Miss Form**. Statistics received from the Injury /Near Miss forms are also useful in identifying higher risk tasks and problem areas and can aid in the prioritization and development of annual prevention plans and further training initiatives.

Responsibilities of managers/supervisors include:

- reporting and investigating all incidents relevant to patient handling and determining corrective action to be implemented
- ensuring that the employee is consulted relevant to the discussions pertaining to the corrective action
- providing the OESH Team with details of the corrective action

Responsibilities of workers include:

- reporting all patient handling related injuries and/or near misses immediately to supervisor and OESH
- participating in the development of corrective actions
- reporting any time loss or if medical care required to supervisor and OESH
- contacting the Worker's Compensation Board (WCB) if injury results in any time loss and/or medical care

Responsibilities of the OESH Team include:

- monitoring the number of incidents relevant to patient handling and reporting to Senior Management Team
- assisting Managers in determining the corrective action (some equipment/processes may require major costs and/or modifications)
- providing regular summary reports of incidents and corrective action to Workplace Safety and Health Committees

Areas demonstrating high numbers of work-related injuries shall be deemed "high risk" and must be evaluated proactively in an effort to reduce the number of work-related injuries in these areas. The OESH team can be contacted to assist with this evaluation.

## 2.11 Medical Management – Reasonable Accommodation and Return to Work

Employees with musculoskeletal disorders must be promptly evaluated by a health care provider and appropriate treatment and follow-up provided.

Worker accommodation will be available to assist the employee in returning to work safely and as soon as possible based on the medical information provided. OESH

leads the process in cooperation with the injured worker, Human Resources, Manager and union where applicable. OESH may utilize tools such as push/pull force gauges; weigh scales and Physical Demands Analyses to assess restrictions and tasks.

### **3.0 IMPLEMENTING YOUR PROGRAM**

#### **3.1 Management Commitment and Support**

As in any type of program, management support relevant to required resources are the foundations of the program's success. Responsibilities of the various levels of management are included in the sample [WRHA OESH Operational Procedure – Safe Patient Handling](#).

#### **3.2 Safe Patient Handling Implementation Team**

As outlined in the sample WRHA OESH Operational Procedure entitled Occupational and Environmental Safety & Health Program Appendix 1 – Site Strategic Plan, the following gives direction as to how safety and health is made operational. *“In order to ensure that each site's Occupational and Environmental Safety & Health Program is implemented, communicated and monitored, each site's Human Resources, OESH teams and Senior Leaders must develop site specific strategic management health and safety plans with delegation of responsibility/accountability.....”*

Team members should view themselves as champions for the program. They will help deliver and sell the message as the program is rolled out. They will serve a vital role in maintaining the program's effectiveness and support the culture change. Involvement of front-line workers in each support services area is necessary in order to achieve buy-in as the program moves ahead. The reporting structure of this committee or working group should include the Joint Workplace Safety and Health Committee. The initial mandate of the committee/team is to ensure the implementation of all aspects of the OESH Operational Procedure Safe Patient Handling and Movement Program. The ongoing mandate of the committee or work group is to:

- Review injuries/incidents relevant to ergonomic issues
- Report statistics to Joint WS&H Committee
- Make recommendations to Senior Management relevant to corrective action
- Review employee training requirements
- Review ergonomic solutions and promote awareness of ergonomic issues
- Participate in the procurement processes

#### **3.3 Roles and Responsibilities**

Responsibilities for the implementation of the Safe Patient Handling Program are included in the sample [WRHA OESH Operational Procedure – Safe Patient Handling](#).

#### **3.4 Program Implementation Checklist**

STEP	DESCRIPTION	ACTION	
1. Develop Operational Procedures	Review Operational Procedures and revise to make specific to your facility.	Consult with Workplace Safety and Health Committee on revised Operational Procedure prior to forwarding to Executive Group for approval and implementation.	<input type="checkbox"/>
2. Implement Planning and Design Component	Review forms and protocols and revise accordingly for your facility/site/program.	Forward forms and protocols to Facilities Management, Capital Planning, Logistics for their consideration during planning, design and purchasing / contracting.	<input type="checkbox"/>
3. Develop Risk Assessment Process	Review Job hazard analysis and determine tasks/jobs that are high risk.	Develop controls for the hazards using the hierarchy of controls, including the development of Safe Work Procedures.	<input type="checkbox"/>
4. Develop Incident Reporting Process	Review process and forms for MSI related incidents and hazards.	Implement process and forms. Review injury data with safety committee, supervisors, and senior administration as necessary.	<input type="checkbox"/>
5. Develop Training Plan	Review existing training and expand where necessary.	Implement training plan <ul style="list-style-type: none"> <li>- Ergonomics overview</li> <li>- Specific training dependent on the department and equipment.</li> </ul>	<input type="checkbox"/>
6. Develop Medical Management Process	Review existing processes and expand where necessary.	Implement processes for Return to Work and accommodation through training and meetings.	<input type="checkbox"/>
7. Develop an evaluation process to determine if your program is effective	Review existing process and expand where necessary.	Implement processes through training and meetings with management.	<input type="checkbox"/>

### 3.5 Program Evaluation

As with any safety program, a Safe Patient Handling Program must be reviewed at least once every three years or if there is a change in legislation or change in the workplace. However, it is suggested the program is reviewed annually for its accomplishments, goals set for the upcoming year, and the program modified, as necessary, to include new legislation, the introduction of new technologies and equipment, as well as safe patient handling methods. These may be identified through HCW feedback, systematic audits, and investigations related to Work-Related Injury/Near Miss reporting.

## 4.0 RESOURCES

- 4.1 Resources: Legislation and Guiding Documents
  - 4.1.1 [Workplace Safety and Health Act Section 4: Duties of Employers](#)
  - 4.1.2 [Workplace Safety and Health Regulation Part 2.2.1: New Worker Orientation](#)
  - 4.1.3 [Workplace Safety and Health Regulation Part 8: Musculoskeletal Injuries](#)
  - 4.1.4 [Workplace Safety and Health Regulation Part 39: Healthcare Facilities](#)
  - 4.1.5 [WRHA Policy 20.20.030 Workplace Safety and Health](#)
  - 4.1.6 [WRHA OESH Operational Procedure – Safe Patient Handling and Movement](#)
  
- 4.2 Resources: [Musculoskeletal Hazards in Patient Handling](#)
  
- 4.3 Resources: Assessment & Communication
  - 4.3.1 [Risk Assessment: General Considerations and Red Flags Checklist](#)
  - 4.3.2 [Risk Assessment: Patient Assessment Procedures and Screening Tool](#)
  - 4.3.3 [Safe Patient Handling Assessment Form](#)
  - 4.3.4 [Transfer Logo Samples](#)
  
- 4.4 Resources: Hazard Control Options
  - 4.4.1 [Patient Handling Control Measures](#)
  - 4.4.2 [Safe Work Procedure Samples](#)
  
- 4.5 Resources: Training & Education
  - 4.5.1 [Risk Assessment: General Considerations and Red Flags Checklist](#)
  - 4.5.2 [Risk Assessment: Patient Assessment Procedures and Screening Tool](#)
  - 4.5.3 [Patient Capability Assessment Outcomes](#)
  - 4.5.4 [Safe Patient Handling Algorithms](#)
  - 4.5.5 [Sample Competency Checklists](#)
  
  - 4.5.6 [PowerPoint Presentation Training Sample](#)
  
- 4.6 Resources: Monitoring & Enforcement
  - 4.6.1 [Monitoring Sample Checklist](#)