EP30EO: Describe and demonstrate two (2) workplace safety improvements for nurses that resulted from the structures and processes in EP30.

Two workplace safety improvements for nurses that resulted from the structures and processes previously discussed in EP30 are minimizing disruptive behavior and reducing the incidence of back injuries. These examples represent Riverside's commitment to improving workplace safety for nurses.

Example 1: Reducing Disruptive Behavior Through Implementation of the Code of Behavior Program and Examination of VHAUM, AHRQ, and NDNQI Data

Purpose, Participants, and Background

Improving workplace safety for Riverside nurses has evolved from our patient safety program. We began our current journey by joining the VHA Upper Midwest (VHAUM) Patient Safety Collaborative in 2003. VHA, Inc. (2010, ¶1) is "a nationwide network of leading community-owned healthcare organizations and physicians" formerly known as the Voluntary Hospitals of America. Our CEO attended a VHAUM Executive Leadership Conference where patient safety was discussed and a challenge was issued for hospitals, specifically nurses, to be involved and take active leadership roles in patient safety. Riverside’s involvement included attendance at VHAUM meetings three times a year, and regular teleconferences regarding ongoing projects.

Nurses from all levels – executive leaders, directors, managers, and staff nurses - were included in the collaborative: Cheryl Tyson, RN, BBA, Manager of the 3rd Ortho/Neuro Unit; Amy Memenga, RN, BHA, Manager of the 5th Telemetry Unit; Candace Carpenter, RN, BSN, staff nurse on the 2nd Med/Surg Unit; Dave Duda, RN, MSN, then Vice President of Patient Care Services (Riverside’s CNO equivalent at that time); Mary Schore, RN, MSN, Director of Quality Improvement; and the Director of Risk Services. He was appointed as the Patient Safety Officer for Riverside and he attended Institute for Healthcare Improvement (IHI) Patient Safety Executive Training program.

The VHAUM collaborative used the work and standards of the IHI and The Joint Commission, and identified a connection between behavior, stress, human failure, errors, and safety. The VHAUM learned the first step in ending disruptive behavior is to identify it. According to Dr. Don Berwick of the IHI, healthcare workers must be safe and feel safe in order to provide patients with safety. Internally our patient safety improvement initiatives were spurred by a meta-analysis of our Root Cause Analyses performed by Mary Schore, RN, MSN, Director of Quality Improvement; the Director of Patient Safety/Employee Health, and Dave Duda, RN, MSN, Senior Vice President of Operations, Chief Operations Officer (COO), and Chief Nursing Officer (CNO). From this meta-analysis, we found that staff intimidation was a key factor in miscommunication, which was a root cause in many of safety events. A review of the incident reports submitted by our nurses and other staff reinforced the significance of our patient and employee safety problems.

VHAUM Measures, 2003
One of the initial projects in the VHAUM Collaborative was to conduct a survey to assess the impact of disruptive behavior in the workforce, and specifically the impact of physician/nurse disruptive behavior. We conducted our initial survey in 2003.

**Analysis and Implications:** The survey revealed that physicians and nurses believed disruptive behavior was a significant challenge at Riverside Medical Center (see graph below). These results were shared with staff throughout all levels of the hospital.

![2003 VHAUM Survey Results](graph)

**Methods and Approach**

One of the actions implemented from the results of our initial survey was to develop a Code of Behavior Policy, which is included below. Employees and our medical staff have adopted this policy.

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**Riverside HealthCare**

**Kankakee, Illinois**

**Policy & Procedure**

**Subject:**
Riverside HealthCare Code of Behavior
Policy:
This Code of Behavior has been developed to provide every person who works for, or provides services to, Riverside HealthCare, including medical staff members, administrators, employees, students, and volunteers, with professional standards of behavior. As an organization, we are committed to the best professional service and patient satisfaction possible. We recognize that employee satisfaction equals patient satisfaction and high quality care. We agree to practice this code of behavior.

Procedure:
Our Mission and Values Guide Us In:
- **We will at all times treat one another with friendliness, courtesy and respect.** We will reject rudeness as a way of expressing ourselves.
- **Treating others with professionalism.** We recognize that we each have areas of expertise.
- **Showing consideration.** We will be sensitive to others’ inconvenience and consider another’s priorities in addition to our own when making last minute requests.
- **Demonstrating tolerance.** We recognize that conflicts may exist among co-workers, but professional courtesy is expected. We will set aside differences when working together for the good of our patients and customers and realize that we all have shortcomings.
- **Providing support for co-workers.** We will offer help when possible and cooperate in the workplace.
- **Maintaining reliability** - to co-workers, patients and the Riverside Healthcare organization.
- **Welcoming new co-workers.** We will be supportive by offering help and setting an example of cooperation in the workplace, and serve as mentor or coach for others when needed.
- **Maintaining honesty in all interactions with others.**
- **Respecting the privacy of co-workers and others.**
- **Guarding others self-esteem.** Never chastising, humiliating or embarrassing co-workers, colleagues or other employees, especially in the presence of others.
- **Directing constructive criticism to the appropriate person.** We will remember that non-supervisory co-workers may not have the authority to make procedural changes.
- **Maintaining accountability.** We will take full ownership of our actions and will avoid assigning blame or making excuses, either verbally or in the medical record.
- **For Riverside employees, all other policies apply with regards to behavioral expectations and guidelines.**

In addition to executing the Code of Behavior policy, our medical staff and hospital administration formed the Physician Workplace Interaction Committee (PWIC). The committee exists at the request and approval of the Medical Executive Committee (MEC). The President of the Medical Staff appoints physician members of the PWIC. Their term of services is no less than three years. Members include Juan Jimenez, MD;
The goals of this committee are

1. To promote patient safety through effective communication between physicians and other health care workers providing care for patients.
2. To review reported episodes of physician interactions that would potentially be a breach of the Riverside Code of Behavior policy.
3. To investigate these reports and identify potential behavioral concerns and patterns.
4. When necessary to make recommendations to the MEC regarding disciplinary actions to be taken based on the results of the investigative work of this committee.
5. To make recommendations to the MEC regarding educational needs of the Medical Staff with regards to communication and patient safety.
6. Interactions decision-making algorithm (see below)

Reporting of disruptive or inappropriate behavior became an expectation. Nurses (and employees) were asked to use our electronic incident reporting system to share incidents of inappropriate behavior with the Director of Patient Safety/Employee Health. Whenever the PSEH Director received these incident reports, he addressed them, using the following algorithm:

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Mobolaji R. Suleiman, MD; Roger Taylor, MD; and Renuka Ramakrishna, MD. Riverside representatives are Becky Hinrichs, Vice President of Human Resources; Deena Layton, RN, MSN, Vice President of Nursing Services; John Jurica, MD, Vice President of Medical Affairs; Lisa Zipsie, Director of Physician Services; the Director of Patient Safety/Employee Health; Mary Schore, RN, MSN, Director of Quality Improvement; and Sandra Viall, RN, MSN, Director of Patient Care Services.
ALGORITHM FOR ADDRESSING REPORTS OF WORKPLACE INTERACTION/BEHAVIOR INCIDENTS

1. Staff reports disruptive behavior episode to Patient Safety Hotline or U/O

2. Director of Pt Safety forwards report to Director of area from which report came and assists director to investigate

3. Director of PS/EH forwards To Chair of Physician Workplace Interaction Committee (PWIC) or Director of PS/EH will notify VPMA if incident requires immediate action, i.e. impaired person, imminent risk to others

4. **Egregious behavior?**
   - **YES**
     - VPMA notified
   - **NO**
     - PWIC Chair reviews and forwards to PWIC member (MD) for further investigation and reporting to committee

5. Professional Conduct Committee (PWIC) reviews

6. **Action**
   - **EDUCATIONAL LETTER**
     - Letter to physician w/ summary of investigation & recommendations & CC Dept. Chair
   - **ADDITIONAL ACTION RECOMMENDED**
     - MEC follows bylaws in conducting hearing and assigning disciplinary measures
   - **NONE**
     - Kept as part of Committee Minutes
An educational program, Behavior of the Month, was also implemented as a tool to provide ongoing education for all staff. Individuals who do not meet the standards within the Code of Behavior are re-educated and may have disciplinary action taken. Since the implementation of this process, there has been a decrease in the reports of disruptive behavior, and in the same period, there has been an increased awareness nationally of physician behavior having a direct effect on patient safety. At the hospital, nurses have reported an increase in incidences of physicians apologizing to the nurses after episodes of disruptive behavior.

For example, recently in one of our intensive care units, our Critical Care Advance Practice Nurse (APN) overheard a nurse telling two nurse co-workers that a physician stated he did not trust the nurses to care for his patients. This nurse was understandably upset by the physician’s statement. The APN questioned the nurse about the interaction with the physician. The APN paged the physician to address his inappropriate behavior. When the physician returned the page, the APN asked the physician to clarify his comment. After a brief period of quietness on the phone, the APN again asked the physician to clarify his statement. The APN asked the physician to provide a specific situation that led the physician to make this statement, and shared with the physician that she wanted to identify the need for an educational opportunity for the ICU staff. The physician stated the comment was made in a “jovial manner,” and that there weren’t any care specific situations that evoked the physician’s comment. This message was shared with the nursing staff on the unit by the APN. The next day, the physician apologized in person to the nurse involved. The APN helped the nurses realize that disruptive behavior will not be tolerated and that nurses need to address these concerns directly rather than assuming that disruptive behavior by physicians, or any staff member, is tolerated.

VHAUM Measures, 2006

In 2006, we repeated the same VHAUM workplace interaction survey.

Analysis and Implications: The results demonstrated a significant increase in satisfaction with nurse-to-nurse and nurse-to-physician interaction as well as a decrease in disruptive behavior. Respondents also reported an overall increase in satisfaction with the performance improvement processes related to nurse-physician interactions from 2003 to 2006. (See graph below.)
VHAUM Survey Results, 2003 and 2006

How serious is the problem with disruptive behavior in your organization?

<table>
<thead>
<tr>
<th>Scale of 1 - 10, the higher the score, the more serious the problem</th>
<th>2003</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMC Physicians</td>
<td>7.02</td>
<td>6.17</td>
</tr>
<tr>
<td>RMC Nurses</td>
<td>6.15</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Decrease shows improvement

AHRQ Measures, 2009

In 2009, as part of our ongoing culture of safety improvement process, Riverside leaders made the decision to conduct the Survey on Patient Safety Culture from the Agency for Healthcare Research and Quality (AHRQ). The Culture and Communication Committee, a subcommittee of the Patient Safety Committee and the PWIC, made this decision. The survey was completed in May 2009.

Analysis and Implications. While the focus of this survey was not solely on disruptive behavior, results did provide us with useful data on communication as it occurs around patient care. This survey demonstrated that 64% of the respondents, 40% of which were nurses, saw patient safety as a priority for the organization. Leaders saw patient safety as a priority for the organization including all levels of staff. Seventy-seven percent of the respondents indicated that teamwork within the work unit was very good, while 65% indicated that interdepartmental communication was good as well.

<table>
<thead>
<tr>
<th>AHRQ Safety Culture Survey Items</th>
<th>Riverside Composite Score Average % of positive responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Perceptions of Safety</td>
<td>64%</td>
</tr>
<tr>
<td>(4 items--% Agree/Strongly Agree)</td>
<td></td>
</tr>
</tbody>
</table>
In 2003, 697 employees responded to the VHAUM survey. In 2006 the number of respondents dropped to 259. In 2009, the number of respondents to the AHRQ survey increased to 694.

**NDNQI Measures, 2007 - 2009**

Another measure of nurse satisfaction with nurse-physician interactions is the National Database of Nursing Quality Indicators (NDNQI) RN Survey’s Practice Environment Scale (PES) component, Collegial Nurse-Physician Relations. Collegial Nurse-Physician Relations is an indicator denoting positive work relationships between nurses and physicians (NDNQI, 2009). This indicator is scored on a scale of 1 – 4, with 1 indicating strong disagreement, 2 indicating disagreement, 3 indicating agreement, and 4 indicating strong agreement. According to NDNQI (2009, p. 12) “the higher the score, the more positive the rating reported. When aggregated, unit level data represent the mean of all responding unit RN scores. Hospital level data represent the mean unit score of all units in the hospital.”

**Analysis and Implications**: Over the 3-year period in which Riverside has participated in this national survey (2007 – 2009), our aggregate score for this indicator outperformed the national mean of all NDNQI hospitals for two of the three years, in 2007 and 2009. Our score was only 0.02 lower than the national mean in 2008 (See graph below.)
The NDNQI measure, Collegial Nurse-Physician Relations, is another indication of the outcomes of our work to improve workplace safety for nurses. A patient care setting where nurses feel safe in sharing their concerns about physician behavior creates a working environment that is conducive to optimal care delivery.

**Summary – Reducing Disruptive Behavior**

Qualitative outcomes from Priscilla Lynch’s work with our nurses and quantitative data from VHAUM, AHRQ, and NDNQI surveys demonstrate our progress in reducing disruptive behavior and improving collegial relations between Riverside nurses and physicians.

**Example 2: Improving Workplace Safety through Implementation of a Minimal Lift Program and Examination of Employee Injury Data**

**Purpose and Background**

In 2004, through the process of assessing employee injuries, our Patient Safety/Employee Health Director noted patient handling activities were the leading cause of injury for nurses. As part of the assessment, injuries were reviewed over a five-year period or time. A goal was established to reduce the injury rate and injury severity by reducing the physical stress created by patient assist activities. The awareness of our aging workforce was taken into consideration, and we also identified the specific patient care activities, which most frequently contributed to injuries. Patient transfers were a leading cause of nurse injuries.

**Participants, Methods, and Approach**
The Patient Safety/Employee Health Department conducted a literature review for safe patient handling practices. A committee composed of nurse leaders, staff nurses, Patient Safety/Employee Health staff, Educational Services staff, and Rehabilitation Services staff was then formed to evaluate several different minimal lift programs and products. The decision was made to create a Minimal Lift Program modeled after the Veterans Health Administration Safe Handling Program. Key elements of the VHA’s program are use of an ergonomic assessment protocol, clinical decision algorithms, and safe handling equipment (Siddharthan, Nelson, Tiesman, & Chen, 2005). The American Nurses Association (ANA) also has based their back injury prevention program on the success of the VHA initiative (ANA, 2006), noting the VHA program has “led to a 60-95% reduction of injuries at various VHA hospitals” (p. 2). The ANA (2006) has outlined four steps in developing a safe patient handling program to reduce back injuries:

1. Create an ergonomics committee
2. Analyze the injury data and conduct walkthrough of departments
3. Survey employees
4. Assess patient dependency levels (p. 2)

The Minimal Lift team completed all four steps when developing and implementing our Minimal Lift Program. The Director of Patient Safety/Employee Health secured leadership support and funding to implement the program, even though the costs associated with purchasing the equipment and conducting training was unbudgeted. This unexpected resource allocation demonstrated administrative and leadership support of workplace safety initiatives for direct-care nurses.

As part of our Minimal Lift program, we developed policies to guide nurses and direct care staff in assessing, documenting, and evaluating equipment use for our patients. These policy names, policy statements, and policy overviews are described in the table below.

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Policy Statement</th>
<th>Policy Overview</th>
</tr>
</thead>
</table>
| Minimal Lift Patient Transfer Program | To establish protocols for the lifting, transferring and repositioning of patients, ensuring consistency and safety for the patients and reducing or preventing work related injuries for caregivers. | Establishes the overall purpose and goals of the program.  
- Use of mechanical lifts  
- All inpatients are assessed  
- Use of a train-the-trainer concept |
| Minimal Transfer Procedure Definitions | The color code system will be used in assessing and identifying patients' transfer needs. The assigned color and corresponding transfer equipment and technique will be followed when transferring patients. | Total Lift = PINK  
Sit/Stand Lift = BLUE  
One Person Transfer =LIGHT GREEN  
Independent = GREEN  
CARD/STICKER  
Bedrest = YELLOW |
<table>
<thead>
<tr>
<th>Minimal Lift Assessment Process</th>
<th>Assessment is the process by which a worker identifies and eliminates or manages risks when moving a patient/object. A risk is any factor that has the potential to jeopardize the safety of the worker(s) and/or patient.</th>
<th>Defines the three critical assessment areas as: - Self - Environment including equipment - Patient/objective</th>
<th>Describes the process for conducting assessments in all 3 areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient assessment for minimal lift program</td>
<td>To ensure that the appropriate minimal lift device(s) and protocols are followed, every patient will be assessed for transfer needs upon admission.</td>
<td>Outlines the entire procedures for assessing the patient, including the algorithms for: - Determining proper technique and equipment - Weight limits - Number of staff needed to complete the lift/transfer</td>
<td></td>
</tr>
<tr>
<td>Minimal Lift Patient LOGO System</td>
<td>Logos for every patient will be placed on the light fixture over the head of the bed.</td>
<td>Shows the logos for: - Stop/reassess - Bedrest - Independent - Sit/stand - Total lift - One-person belt transfer</td>
<td></td>
</tr>
<tr>
<td>Minimal Lift Lying to Sitting Repositioning</td>
<td>Appropriate technique and body mechanics will be used to reduce risk of injury for patients and employees during a lying to sitting repositioning</td>
<td>Describes staff and patient positioning for this type of transfer</td>
<td></td>
</tr>
<tr>
<td>Positive Reinforcement of the Minimal Lift Program</td>
<td>There will be appropriate reinforcement and consequences for employees in adhering to the Minimal Lift Program</td>
<td>Outlines remediation for staff who do not follow minimal lift policies, including progressive discipline.</td>
<td></td>
</tr>
</tbody>
</table>
Our Minimal Lift initiative also included the purchase of adequate numbers of mechanical transfer devices and deployment in all nursing work areas. We provided initial and ongoing education and training on the proper use of this equipment. Initial training included self-study modules and hands on training.

In 2006 the hands on education component of the program was discontinued. We noted an increase in the incidence and severity of patient-assist related injuries for nurses (graph included later in this SOE). Staff nurses were asked to share what they believed to be the problem. They indicated a lack of equipment availability when needed, which resulted in decreased safety practices. In response to this increase in injuries and staff-identified barriers to equipment use, more equipment was purchased. Storage areas were identified in close proximity to each patient care area where lift equipment could be stored and readily accessible. Another change implemented was the assignment of equipment cleaning and restocking to a specific employee. This helped to assure that equipment was readily available when and where nursing staff needed it.

Another change since 2003 included updating the policy regarding weight limits for minimal lift equipment. The minimum weight needed to utilize the minimal lift equipment was decreased to 200 pounds. This change increased compliance with minimal lift equipment. Despite implementing these ongoing changes, we continued to see a rise in our patient assist related injuries.

In 2008, the Patient Safety Officer and Director of Patient Safety/Employee Health, presented an analysis of the injury data to our Senior Management Team. Our executive staff decided to completely reevaluate the employee safety program in order to reduce our patient-assist related injuries. A new committee was formed, named the Employee Safety Injury Prevention Committee (ESIPC). The committee met monthly through 2009 and will meet quarterly in 2010. The purpose of the ESIPC is to promote a safe work environment for all Riverside employees and to reduce the risk and incidence of injuries. Objectives include:

1. Promote workplace safety through education and workplace practices
2. Promote a culture of employee safety
3. Reduce the experience of employee injuries
4. Reduce work-related safety hazards

This committee began planning improvements to our Minimal Lift Program. Members are listed in the table below.

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Department/Unit</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joy Allen, RN</td>
<td>5 ICU</td>
<td>Manager</td>
</tr>
<tr>
<td>Christine Anthony, RN, BS</td>
<td>Behavioral Services</td>
<td>Director</td>
</tr>
<tr>
<td>Director of Patient Safety/Employee Health</td>
<td>Patient Safety/Employee Health</td>
<td>Director</td>
</tr>
<tr>
<td>Rich Grillion</td>
<td>Biomedical Engineering</td>
<td>Director</td>
</tr>
<tr>
<td>Barbara Hamilton, RN</td>
<td>4 Rehab</td>
<td>Manager</td>
</tr>
<tr>
<td>Name</td>
<td>Department/Service</td>
<td>Role</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Renee Hess, RN, BSN</td>
<td>3 Med/Tele</td>
<td>Manager</td>
</tr>
<tr>
<td>Tanya Huston, RN, BSN</td>
<td>Emergency Department</td>
<td>Manager</td>
</tr>
<tr>
<td>Rob Jones</td>
<td>Crothall (contracted service)</td>
<td>Director of Plant/Facilities</td>
</tr>
<tr>
<td>Jennifer Jordan</td>
<td>Morrison (contracted service)</td>
<td>Food &amp; Nutrition</td>
</tr>
<tr>
<td>Kathy Grevenstuk, RN</td>
<td>Patient Safety/Employee Health</td>
<td>Employee Health/Safety Nurse Coordinator</td>
</tr>
<tr>
<td>Allen Kelly, RN, BSN, MHSA</td>
<td>Administration</td>
<td>Vice President, Perioperative and Procedural Services</td>
</tr>
<tr>
<td>Jean Koehler</td>
<td>Human Resources</td>
<td>Employment &amp; Employee Relations Manager</td>
</tr>
<tr>
<td>Mary Kohl, RN</td>
<td>Perioperative Services</td>
<td>Director</td>
</tr>
<tr>
<td>Eileen Krach, RN, BSN</td>
<td>2 Med/Surg</td>
<td>Manager</td>
</tr>
<tr>
<td>Debra Liebendorfer, RN</td>
<td>Senior Living Services</td>
<td>Director</td>
</tr>
<tr>
<td>LeAnn McCormick, RN, BSN</td>
<td>Educational Services</td>
<td>Onboarding Coordinator</td>
</tr>
<tr>
<td>Diane McGrath, RN</td>
<td>4 Med/Peds</td>
<td>Manager</td>
</tr>
<tr>
<td>Amy Memenga, RN, BHA</td>
<td>5 Telemetry</td>
<td>Manager</td>
</tr>
<tr>
<td>Julianne Post, RN</td>
<td>O.R.</td>
<td>Manager</td>
</tr>
<tr>
<td>Amber Residori</td>
<td>Indian Oaks Academy (contracted service)</td>
<td>Unit Manager</td>
</tr>
<tr>
<td>Cheryl Rogers, RN, MSN, CCRN</td>
<td>2ICU</td>
<td>Manager</td>
</tr>
<tr>
<td>Rebecca Schiltz</td>
<td>Rehabilitation Services</td>
<td>Director</td>
</tr>
<tr>
<td>Hazel Tucker</td>
<td>Crothall (contracted service)</td>
<td>Director of Environmental and Laundry Services</td>
</tr>
<tr>
<td>Cheryl Tyson, RN, BBA</td>
<td>3 Ortho/Neuro</td>
<td>Manager</td>
</tr>
<tr>
<td>Vladinka Vranjes</td>
<td>Radiology</td>
<td>Operations Manager</td>
</tr>
</tbody>
</table>

One of the improvement processes included a patient safety vendor fair, where our nursing staff could see and trial various minimal lift equipment ranging from patient slide equipment to motorized carts and wheelchairs. Resources were allocated to purchase wheelchair movers and motorized carts to improve patient and nursing workplace safety and thus decrease patient-assist related injuries.

In July 2009, Diane McGrath, RN, Manager of the 4<sup>th</sup> Med/Peds Unit chaired a subcommittee of the ESIPC, the Minimal Lift Committee, which included Renee Hess, RN, BSN, Manager of 3<sup>rd</sup> Med/Tele; Amy Memenga, RN, BHA, Manager of 5<sup>th</sup> Tele; and Barbara Hamilton, RN, Manager of 4<sup>th</sup> Rehab. The purpose of this subcommittee was to address why the minimal lift equipment was not being utilized. They identified two issues: staff had difficulty accessing the equipment and staff were not comfortable using the equipment. To address the first issue, more equipment was purchased and
relocated on the units to address the accessibility issue. To address the second issue, the committee determined a need to re-train all nursing staff to ensure everyone was using the equipment correctly and consistently.

The committee decided to appoint master trainers who would conduct hands-on training and return demonstrations on all equipment during a 2-hour class. Class size was limited to 12 employees so master trainers could spend adequate time with each class member. Managers and team leaders of all hospital units submitted names of their staff to become master trainers on the minimal lift equipment. The members were staff RN and medical/surgical techs (MST) or certified nursing assistants (CNAs) who were familiar with the equipment. The Radiology department also sent master trainers since they used the same equipment in their areas. The committee believed it would be advantageous from a work and budget perspective to include CNAs and MSTs as master trainers because the CNAs and MSTs used the minimal lift equipment as much (if not more) than RNs did. In addition, this would help control the labor costs for the conducting the classes. Minimal lift equipment master trainers were:

- Erin Tolley, Med-Surg Tech (MST), 4th Med/Peds
- Amanda Nicholson, Certified Nursing Assistant (CNA), E.D.
- Wanda Selin, MST, 5th Tele
- 2 Med/Surg CNA
- Patty Dunn, RN, 2nd Med/Surg
- Abby Pfeiffer, RN, BSN, 5th Tele and Educational Services
- 4th Med/Peds RN
- Heather Davis, RN, 4th Med/Peds
- Katherine Hamblin, RN, 5ICU
- Tanya Parks, Imaging Access Team Leader, Radiology
- Sharon Calabria, Supervisor CT Tech, Radiology

Representatives from the minimal lift equipment company trained the master trainers. The subcommittee and master trainers then scheduled the 2-hour, mandatory, training sessions in the education department. Sixty classes were scheduled to accommodate the number of staff who used the equipment. This training was completed in the fall of 2009. Training sessions included use of the following equipment and techniques:

- The Hover mat is used to slide patients who weigh 200 pounds or more from bed to bed, or cart to bed. The Hover Mat is also used to slide patients up in bed.
- The patran is used to slide patients under 200 pounds with minimal strain on the nursing staff.
- The total lift is used to lift patients who are unable to get out of the bed by themselves. The machine can lift them from bed to chair with minimal assistance from the nursing staff.
- The sit-to-stand lift is used for patients with minimal weight bearing status or strength, and who can assist with the lift/transfer. This equipment aids the nurse or tech in moving the patient from bed to chair and back.
- The Bari lift is used for total lifts for patients weighing over 300 pounds.
• Gait belts were demonstrated for proper use in transfers and walking.
• Also included in the return demo was the correct way to reposition a bed-bound patient from a lying to sitting position.

**Measurements – Quantitative and Qualitative Data**

In 2003, we saw patient assist related injuries account for 48% of the injuries at a cost of $889,279.00. In 2004, 53 injuries were related to patient assist injuries, accounting for costs of around $453,000. We implemented our initial minimal lift program in 2004. After initial implementation, we saw the injury claims reduced by half and costs decreased by half as well (see graph below).

In 2006, hands-on method of training was discontinued, and training was changed to an on-line self-study via OLIE during orientation and initial training of equipment took place during unit orientation. We saw both dollars spent and number of claims increase. As previously mentioned, in 2008, after examining our data, the decision was made to resurrect hands-on training for new and incumbent nursing staff. In 2009, our claim count and dollars spent on injuries decreased dramatically, proving that hands-on minimal lift training was an essential element in reducing patient assist injuries.

The hands-on training component of the minimal lift program was revived to increase enculturation of minimal lift equipment use for our nursing staff. Education for directors
and managers on how to better prevent injuries and manage employee compliance with the existing safety programs was also provided. As a result of these changes, there has been a significant decrease in patient assist-related injuries in 2009, shown in the graph above.

After attending the hands-on class, nursing staff reported they felt more comfortable with using the equipment. Some also realized there were more reasons to use the equipment than they had previously thought. The return demonstrations and opportunities to actually using the equipment outside of the patient care setting helped staff understand how the equipment was to be used, and also how it felt to be a patient when the equipment was being used. Staff also came to the realization that using minimal lift equipment was important to their personal health and wellbeing as well as for their patients. One staff nurse described her experience and change of opinion using minimal lift equipment from her first training to the re-training in 2009:

“Riverside Medical Center has given the staff nurse many things to provide safe care to the patients. A few examples are minimal lift equipment, medication scanning, and the electronic medical record. As a staff nurse I know that when I use the equipment as trained I can be confident that I provide a safe environment for my patients. When the minimal lift equipment first came to Riverside, we were taught how to use the equipment. I was never really concerned about using the equipment because my unit is an orthopedic unit and we want our patients to use their own muscles to get out of bed and walk. Whatever procedure was done, the patients really needed to get up and moving [sic] by their own power. Some patients were too de-conditioned and needed more time to recover so they went to rehab or skilled nursing. Even in these places lift equipment was not used.

When our unit became an ortho/neuro unit, we saw a different patient mix. Recently we became certified as a stroke center and my thoughts began to change. Many of our patients now had different diagnosis such as cranial surgery and stroke. The patients may have lost use of their arm or leg. Or perhaps were paralyzed from the neck down. How best could we move these patients without hurting them or ourselves? The minimal lift equipment - that’s how! The CNAs had more use of the minimal lift equipment than I did, so when a refocus of the minimal lift returned to Riverside I wanted to be there. The class was small which I liked and I received individual attention. I got to be the “patient” and I got to be the “nurse”. It really opens your eyes to how vulnerable a patient feels being lifted by a lift even though they are safe. It was a good refresher course and I listened and practiced… When the time comes to use the equipment on a patient I will do so with confidence.”
Summary

Two workplace safety initiatives described herein have resulted in a safer work environment for our nursing staff. Our structures and processes, described in EP30, have provided foundations for our improved outcomes. Our examination of quantitative data – VHAUM, AHRQ, and NDNQI RN Surveys for reducing disruptive behavior and Dollars and Claims data for reducing patient assist injuries – as well as qualitative data – resulted in the implementation of initiatives that have improved workplace safety at Riverside Medical Center. Both examples demonstrate our staff and nursing leaders' dedication to providing a safer workplace environment for nurses and nursing staff.

References


