Cal/OSHA Safe Patient Handling; AB1136 Advisory Meeting
Tuesday January 24, 2012 9:30-4:00
Elihu Harris State Building 1515 Clay Street
Oakland, California

Participants:

Dee Kumpar, RN
Dan Perrot, Director EH&S Sutter Health
John Vaughan, Stanford Hospital
Marsha Baselice, Manager EH&S Cottage Health System
Ken Clark, Willis Insurance, ASSE
Frank Noguchi, St. Joseph Health System
Annette Britton Cordero, Providence Health System
Steven Bartlett, CNA
Linda Pryor, Northbay Health Care
Matt Carlson, Safety Officer, UCSF Medical Center
Helen Archer-Duste, Kaiser Permanente
Erika Young, EHS Director, University of California
Kathryn Andrews, Loss Control UHS Inc.
Katherine Hughes, RN SEIU 121 RN
Jy Nowlin, Manager, John Muir Health
Kelly Gabrielson, Director Critical Care, O'Connor Hospital
Kristen Cederlind, Director of Rehab Services, Emmanuel Medical Center
Lin Zenki RN, SEIU retired
Pam Dannenberg, CSAOHN Board of Directors
Lorraine Thiebaud, SEIU Local 1021 RN, San Francisco General Hospital
Barbara Brown, Program Manager Occ. Health, Solano County
Susie Genna, Workers Comp Specialist, Enloe Medical Center
David Brown, System Director of Rehab, Sharp Health Care, CHA Bd
Jill Peralta-Cuellar, Manager Employee Health, Salinas Valley Memorial Hospital
Nancy Mayer, Rehab Manager, Enloe Medical Center
Susan Genna, Employee Health, Enloe Medical Center
Samuel Romano, Director Employee Relations, Good SamaritanHospital
Eric Davidson, Corporate Sales, ARJO Huntleigh
Erika Moody-Gilliard, HCW Coordinator SEIU
Gail Blanchard-Saiger, VP Labor & Employment, California Health Care Association
Kathy Harlan, Dir. Risk Management Services, O'Connor Hospital
Patricia Rappaport, Research Assistant, UCSF
Paula Lewis, EORM
Judy Araque, RN, Kaueah Delta Medical Center
Stephanie Roberson, Lobbyist, California Nurses' Association
Linda Roquemore, Mgr, Employee Health and Safety, Good Samaritan Hospital
Cindy Swickard, St. Rose Hospital
Nimfa Santos, Childrens' Hospital of Orange County
Brenda Weyrauch, Director Risk Management, Sierra View DH
Cynthia Clipper-Gray, Ins. Prev. Manager, Eisenhower Medical Center
Rachel Toro, Dir. WC & Risk Operations, Dignity (Catholic HC West)
Linda W. Campbell MSN, RN, COHN, St. Louise Reg. Hosp. Gilroy
David Schmidt, Business Development, Atlas Lift Tech
Mary Spangler, Director OHS, Stanford Hospital and Clinics

Maggie Robbins, National Dir. Safety and Health Coalition of Kaiser Permanente Unions
Dave Rogers, ICULCCU, Salinas Valley Memorial Healthcare System
Maricris Baronia, RN, Greater El Monte Hospital
Gary Griffin, Director of PT, Southwest Healthcare System
Rosalie Sheveland, Director of EHS, O'Connor Hospital
Paula Smith, P, Director of Rehab, O'Connor Hospital
Richa Amar Esq, Staff Attorney, UNAC/UHCP
Charles Parsons, Dir. Workers' Comp, Adventist Health
Anthony Donaldson, National EH&S Consultant, Kaiser Permanente
Darlene Wetton, COO, Corona Regional Medical Center
Bill Borwegan, Director of Occ. Health and Safety, SEIU
Hillery Trippe, Diginity Health
Steven Snitzer, Manager Rehab, Children's Hospital LA
Jim Hively, Safety Coordinator, Community Hospital of Monterey
Kim Hadden, Chief Nurse Executive, Kaiser Permanente
Edgar Soto, Risk Manager, LA County Dept. Health
Derek Nolde, Account Manager, Sandel Medical
Trina Caton, AVP, Keenan & Associates
Betsy Laff, Sr. Loss Control, Keenan & Associates
Trenton Koch, Employee Health Manager, Dignity Health
Patrick Bell, Principal Safety Engineer, DIR/DOSH
Tim Havel, Kaiser Permanente
Vickie Wells, DPH, City/County of San Francisco
Karen Cauther, CNO, Palm Drive Hospital
Anthony Robinson, Nova Medical
Ernest Harris, SEIU 521
Linda Ankeny, RN, Good Samaritan Hospital
Robert Hunn, President, Hospital Safety by Design
David Rempel, MD, UCSF
Grace Delizo, Cal/OSHA Consultation
Michael Coleman, Workers Comp Mgr, UCSF Medical Center
Michael Manieri, Principal Safety Engineer, OSH Standards Board
Ryan Rodriguez, Safety Coordinator, Marin General Hospital
Brenda McGuire, Director of Training, Alpha Fund
Thomas Sanchez, Account Expert, ARJO Huntleigh
Trinh Pham, Santa Clara Valley Medical Center
Veronica Villalon, Sr. Industrial Hygienist, UCSF Medical Center EHS
Scott Borrell, Ergonomics, North Bay Hospital
Robert Wozniak, Corporate Senior Director, Scripps
Randy Schlemmer, Risk Consulting, Stanford Medical Center
Rachelle Wenger, Dir. Public Policy & Com. Advocacy, Dignity Health
Marc Schmilter, Employee Health Specialist, Saint Francis Memorial Hospital
Barbara Materna, Chief Occupational Health Branch, CA Dept. of Public Health
Victoria Vandenberg, RN ARJO Huntleigh Diligent Services
Julie Lavezzo, Director Safety & Security, Marin General Hospital
Wendy Arellano, Education Coordinator, Greater El Monte Comm Hospital
Carmen Morales, RN, Fnp
Cindy Young, California Nurses Association
Edward Hall, Risk Management, Stanford Hospital
Mary Ader, Senior Advisor, Kaiser Permanente
Shari Lyons, EHS Manager, El Camino Hospital

Shannon Gallagher, Atlas Lift Tech
Steven Elliott, VA Healthcare System Palo Alto
Elizabeth Smith, Regional Director, Sutter Health East Bay
Eric Race, President, Atlas Lift Tech
Natividad (Gigi) Beckner, SPHM Facility Coordinator, VA Healthcare Palo Alto
Cindy Pederson, HR, Biggs-Gridley Memorial Hospital
Teri Hollingsworth, VP HR Services, Hospital Association of So California
Beverly Fick, Nurse Manager, Seton Medical Center
Christine Ferguson, Claims Assistant, Dignity Health
Moriah Wells, PA, Seton Medical Center
Dorothy Wigmore, Worksafe

Division : Ellen Widess, Deborah Gold, Janice Prudhomme, Grace Delizo, Robert Barish, Robert Nakamura

Deborah Gold convened the meeting at 930, thanked all the attendees for coming to the meeting regarding Safe Patient Handling under AB 1136, and the implementation by Cal/OSHA. She briefly reviewed the agenda noting the presentations that would provide background: the implementation of SPH programs by the VA Hospital in Palo Alto, and an economic analysis conducted at Stanford Medical Center. Next the meeting would really be about having attendees share their experiences in implementing programs, and their concerns about the new law and regulation. She introduced Ellen Widess, Chief of DOSH, for introductory comments.
Ellen Widess thanked everyone for coming and helping Cal/OSHA develop a safe patient handling regulation: We're pleased with the passage of this legislation. It took several years of commitment from Cal/OSHA and myself to work with stakeholders, experts, and labor groups. The administration of this governor has assured me it is committed to worker protection. AB1136 provides the opportunity to address the specific and recognized problem of ergonomic hazards. It is not taking on the whole range of ergonomic problems in all California workplaces, but there are already programs and models designed to correct the serious problems that occur in general acute care facilities. We know that health care is a vital sector of the economy. We are committed to health care with good jobs, and we are trying to make other jobs safer by looking at other regulations such as the lead standards and the Permissible Exposure Limits. This way, we can begin to address, with limited resources, some real hazards to workers and provide help for employers in retaining skilled workers. I am glad to have Deborah Gold as the Deputy Chief for Occupational Health which has been vacant for a number of years. We hope to beef up the occupational health program. Deborah Gold is well respected for her knowledge, fairness, and ability to manage complicated processes like this one may be. We are also working to restore the DOSH Occupational Health focus in several ways including training, eg. air sampling classes, and other training, increasing laboratory involvement and other ways of investing in our people to make the programs more effective. With regard to AB1136, this provides an opportunity to address significant elements of ergonomic hazards in a discrete area with serious ergonomic problems. We are happy to have David Rempel advising us, and we have several other experts helping today to see possibilities for meeting these goals focusing first on what the VA has done already. And there are several unions and hospitals here today so we appreciate all your help today and ongoing involvement.
Significant legislative findings that were the basis for1136 are that there were 36,130 MSD cases in 2008 from work with patients or residents in health care facilities. This was 11% of all MSD cases, and in MSD cases, 99% were due to overexertion. Over 12% of nursing workforce leaves each year due to back injuries. These findings show the importance of what we are doing today and with this ongoing process to develop the regulation for this.
She turned the meeting over to Deborah Gold.

Deborah Gold said that the process today continues the practice of the Division and health care stakeholders working together that started in the1980s for Hepatitis B in the Bloodborne Pathogens standard, and other regulations for healthcare. This is another healthcare project and the purpose today is to get rolling on it. We know many of you here have been involved with issues like this in your hospitals, and learn from each other, and working on this even before 1136 was passed. This was the third attempt to pass a lifting bill. The legislation requires the Division to develop a regulatory proposal for the Standards Board (referring to the OAL rulemaking flowchart). This is really pre-rulemaking, and we plan to have another Advisory meeting this March or April. After this, a formal proposal goes to the Board and there is a 45 day public comment period and the Board votes on the proposal. But with 1136 passed and in the Labor Code, OSH Standards Board sent to OAL a Section 100 change to just adopt the law into regulation without having the public input process. We will hear by February 3 if the law becomes a regulation in that process. But either way, we've heard enough from stakeholders that there are lots of concerns such as not enough definitions from the bill, so we may need to make a revision that is more reasonably enforceable and understandable. The purpose today is to trade information and get a regulation that's clear in meaning and will move hospitals forward in the most efficient and best way possible. She introduced DOSH staff for the project, and noted that David Rempel has been signed up to help; he is a tremendous asset as an expert (one of the best known ergonomists in the state, and probably nationally)and he has worked actively to move ergonomic principles into the workplace, and make effective regulations.

Instead of self-introductions, she asked for raised hands for people from hospitals (the largest group); hospital management, hospital labor representatives; ergonomics safety professionals, academics and doctors, equipment manufacturers and service providers, lawyers.

Bill Borwegan informed the group that there is a tremendous annual SPH program in Orlando in the winter, and in San Diego in September, and almost every vendor of equipment attends.

DGold turned the meeting over to David Rempel.

David Rempel introduced speakers from the VA which is well recognized as having an excellent program in place. Then there will be a speaker from Stanford, Ed Hall, to present a Cost Benefit analysis, and his work in several states.

Steven Elliott, Chief Engineer for the VA Palo Alto Health Care System

S Elliott said he wanted to start by talking about the things that no one usually wants to talk about; the engineering aspects of lifting equipment, eg. ceiling based lift systems, and he had an experience where the staff was so anxious to use it, they had the rail slip off because they used it before it was ready.

The presentation covers three types of reviews for a room installation, and the electrical review is really important especially for patient safety.

Start with the structural engineer; the attachments are key and you need a structural review of the manufacturer's drawing – even if OSHPD reviewed them since the facility owner has final responsibility. It is best to get an independent engineer to do the assessments. Since the load is moving it must be handled as a dynamic, not static load, especially in areas where there can be earthquakes.

Next, do a fire and life safety review considering that it has to work with all the things in the patient space like the poles, curtains, carts, etc. You also need a review by a fire protection engineer.

Finally, have an electrical review as referenced in NFPA 99. It is especially important to have proper bonding and grounding. You also need to make sure it does not interfere with HVAC systems. Maintenance issues are to make it easy and safe without getting in the way of other fixtures eg. light bulb changing or HVAC air flow.

For device maintenance it is best to do at least what the manufacturer recommends. Train nursing staff to check cords to make sure they are still good and working before each use.

D Rempel took questions for Elliott:

How does he handle structural inspections annually? Answer: They a have structural engineer on staff at VA/PA and they can use an outside company.
Matt Carlson asked what the average time to install equipment? Answer: about 4 months depending on additional work they have to do for facilities modifications of each room as needed.
Dan Perrot asked what the average cost per room was? Answer: for 400 lifts cost about $1.5 million though that doesn't include overhead costs such as for Elliott and his staff.
D Rempel introduced the next speaker: Natividad Beckner "Gigi" is the Coordinator for Safe Patient Handling for the VA Palo Alto.
Gigi Beckner said she is here speaking for Mary Matz of the Tampa Florida VAH who is the national coordinator for lifting. She has spent the last 3 years doing a program at the VA in Pennsylvania. The implementation process is a complex thing that involves many people and disciplines such as nursing, engineering, biomed, environmental control, and housekeepers, so it basically involves everyone in facility. You need a motivated group to buy in. In the implementation of a program, training is critical and it needs to be sustained over time, not treated like a fad. It is also key have a safe lifting coach which we call a "unit peer leader" who has safety huddles and debriefing about problems.
After the installation, there needs to be the use of assessments, algorithms, and care plans.
At the VA facilities, each policy is facility generated, there is no nationally used "program". The coordinator might be in nursing, PT, safety, or even other departments. The coordinator provides leadership to unit peer leaders.
In terms of equipment, sling care is another key component.
Tracking patient handling injuries is also critical to see which injuries are occurring and how they are related to patient handling. There is a VA convention in Orlando in the 3rd week of March. Also, on the west coast there is a conference that usually happens annually.
A safe patient handling committee is key to implement the program, track injuries and facilitate equipment purchases.
Unit peer leaders are key because they do a lot to assure compliance with the program at the unit level. They also champion the program in the unit and facilitate the information flow in the unit. It is best to have a UPL for each shift, but that is hard to do so the VA in PA has one UPL and one backup.
Safety Huddle and Risk Reduction This includes a review of near misses, not to blame someone but to identify problems and possible solutions. Root cause analysis for all incidents should be done.
Patient assessments and algorithms are used to help assure consistent safe patient handling. You have to tailor handling to each patient and patient types, eg. determining what equipment is needed and how many staff are needed.
Slide: Ergonomic Algorithm 1: there are algorithms for bariatric and non-bariatric patients and for orthopedic patients perioperative area.
VA safe patient handling and moving: SPH originated in the UK and we consult with them too about SPH issues. There are facility guidelines.
Whitepaper: American Society of Healthcare Engineers has specifics on nursing and non-nursing areas as well as transporters and volunteers, and includes notes.
Patient care ergonomics evaluation slide.
Lift slides: floor based vs. ceiling and wall based lifts: proper sling selection is key for each patient
Lateral transfer devices slide.
Repositioning slings slide: can even be just for the leg etc.
Slide: VA program overview $200 million over 3 years. 75% coverage by end of this year, 2006-2011, 34% injury rate decrease.
Once the ceiling lifts were installed they had less use of portable lifts and ceiling lifts are great for patient weighing.

Lessons Learned (slides 21-24): Facility coordinators are key to making the safety culture change with the implementation. Implementation was found to take one or two years.
Social networking/media can be a useful tool. D Rempel took one question: Gail Blanchard-Saiger, asked if they have dedicated lift teams or not?
GiGi said no, there are no dedicated lift teams, and all patient handlers have to go through SPH training.
D Rempel introduced the next speaker, Ed Hall, Senior Director for Risk Management at Stanford University Medical Center.
Edward "Ed" Hall: people should try to present the business case for this. (slides 3-4) You need to consider risk financing capital, and the California legal requirement. You can leverage the investment by going to the insurance company and taking a higher deductible. The risk retention helps free up capital to invest, and now you also have legal justification to do that. Another way to free up capital is by contracting out services for maintenance etc. Also, there can be closer injury management/case management and assessment of loss prevention.
It is helpful to make simple for senior leadership to understand the issue in the organization (slide 5) He did an assessment for each lift each unit.
You need to assess the patient population to determine the need, eg. at Stanford 36% of patients typically need total lift. (slides 6-9)
You also need to assess where the costs are with transfers and other procedures eg. handling other manipulations, transport, repositioning. Assess costs to replace the staff lost to injuries, and the lost workdays to maintain required nursing ratios etc. Include also the costs of patient falls, other injuries, eg. the cost of head injuries as part of malpractice claims.
Assess rate of return on investment on SPH; (slide 16) these are values that SHP brings to the organization. The greatest cost saving was turnover prevention since there are savings on training, experience etc. That was greater than workers compensation, we found over 5 years normal turnover cost $4 million, this was reduced with SPH to ~1.5 million. Cost Benefit approach helps with estimating uncertainties etc.
SPH for the new Stanford Hospital cost 2.8 million dollars for the ceiling lifts (slides 20-26). Time/motion studies showed that ceiling units were much better since they were always available in the unit and nurses like it, so they went full coverage with ceiling mounts. We found that SPH helps employees feel they have the tools to do the job. There were also some additional patient referrals and returns for care because the patients felt they received more dignified handling.
D Rempel took questions.
Linda Campbell, asked why patients prefer safer handling and they get more patient returns.
E Hall said the patients feel better because they don't feel they are putting staff at risk to ambulate them.
Dana Rogers agreed; they did a focus study on the bariatric unit and patients feel better about treatment, more dignified procedures so they prefer that hospital for treatment.
Break:
Nursing practice and workload.
Bill Borwegan Ingela Dahlgren Stephanie Roberson Carmen Morales supported the use of support staff, not just nurses, to do the patient handling. Numbers of support staff is starting to be an issue. Bill Borwegan noted that lift team members are cheaper to employ than nurses, eg. Kaiser program. Annette Britton-Cordero said the non-nurse handlers' injuries occur more often. Repositioning is causing more injuries and lift teams are not used for repositioning.
Gail Blanchard-Saiger said the role of the nurse in the scope should be clarified and specified in the regulation, as noted in earlier comments to DOSH.
Pam Dannenberg, as a nurse and ergonomist, noted that 1136 implies a RN is to be present during all lifts but nurses have lots of responsibilities, so it may be unrealistic to have a RN at each reposition and lift. Also, physical therapists are especially trained and skilled in lifting so maybe they can or should be able to be lift team leaders. Also, if the bill had said "patient care"

facilities, it would have included rehab etc where there are many injuries occurring.
K Clark suggested clarifying the "nurse's job description and professional judgment" and asked if patient protection is within the purview of Cal/OSHA? D Gold said yes. If a situation involves only a patient safety issue then DOSH will refer it to licensing. Also, the issue of retaliation for filing Cal/OSHA complaints or being discriminated against for a health and safety issue, eg. refusing unsafe activity as covered in 1136, is being discussed with the Division of Labor Standards Enforcements to set a procedure.
K Clark asked about item (3) in (c) in the draft regulation, D Gold said the program needs to say when equipment should be used and how to use it safely. Employees need training on the lifting algorithm and training on how to conduct them safely.
Richa Amar asked how accessible does lift equipment must be; if it's not easily accessible in a room it won't be used. 1136 appears to leave it to a facility to develop policy, and the staff including the nurses should be involved in that policy development. Is it usually now the charge nurse, or a patient's nurse or a designated nurse in charge? A Britton-Cordero said with Providence it's the primary nurse.
Eric Race asked if training of lift staff more than for just the care staff ? How extensive is the effect of AB394 on staffing ratios and scope creep? Lift teams are not a substitute for proper equipment and proper training to use it.
Dave Brown questioned having a RN observing physical therapy practice; the regulation should let RNs do what they are trained to do. CHA says anyone who touches patients in any way should receive lift training, in part to relieve patients of so much responsibility.
D Gold reminded everyone that 1136 is a law, and has primacy over regulation, so we can provide clarifications and maybe increase the scope some other time. Now we need to focus on this legislation.
D Gold said by February 3rd we will know if the Section 100 change was accepted by the Office of Administrative Law. Yhe plan is to develop an amended regulation with clarifications where possible. For example the terms like transfer, lift, reposition, mobilization are used seemingly interchangeably in 1136. We think lift teams are not required but all HCWs who are doing it need to be trained on the equipment and policies, including when powered equipment needs to be used. We interpret that a lift team is not an alternative to lifting equipment. Current FAQs from us on the table shows our understanding of the law and what the regulation is from the law that we have today. The next step will be to have another meeting in March or April to amend the 5120 that goes through OAL on a Section 100 process, or if it doesn't, to amend the 5120 proposal passed out at the meeting.
Lunch
SPH Policy
D Gold reopened the discussion starting with the SPH policy, and asked the group how many have one? Most raised hands in the affirmative, a few showed they did not.
B Borwegan asked if the lift hazard identification under the IIPP would still apply to non-acute and other facilities. D Gold said yes IIPP would apply where 1136 doesn't for this.
T Havel asked if the focus in 5120 is on the IIPP; is there a difference for actual acute settings and non-acute settings that are in acute licensed facilities? The bill says all patient care areas in acute care hospitals. D Gold said it certainly applies to all acute licensed areas and to be safe employers should also apply it in nonacute licensed facilities that are associated with acute licensed hospitals. If employees are exposed to the same safety hazards in licensed or non-licensed acute, it should be addressed in the policy.
Kim Hadden said she would like a clarification of "unit" because a department like imaging doesn't always have nurses when they need to do lifting etc.D Gold agreed and noted that physical therapy units typically have no nurses and they lift all the time.
Horace Austin asked if 1136 applies to out patient areas?
D Gold said she is talking with the Dept of Public Health, Cal Licensing about that and will talk

with them on a case by case basis as to what areas are within acute care license when questions come up. She asked the group to comment about what's within the license for acute care.
Nancy Meyer said they have an acute rehab facility, would that be covered?
D Gold said that if it is in the acute licensed facility then it's in.
Paula Lewis asked if the terminology of hospital employees includes all hospital employees, such as the temps or volunteers?
D Gold said to refer to the FAQ on Bloodborne Pathogens regarding direct employees vs true volunteers and contract employees (eg. most MDs). Many doctors are employees of physician groups so a hospital is at least at risk under the dual employer or multiemployer responsibility. A hospital has some liability for anyone who's an employee in the hospital; they may not need to supervise or train directly but employers must at least make sure they are properly supervised. As this type of issue has come up before with HepB vaccine and the ATD vaccinations, hospital lawyers should be familiar with the policy DOSH has.
G Blanchard-Saiger siad most California hospitals can't hire doctors. D Gold this is not about employees of a facility. The trend of appeals decisions suggest support of this thinking.
Role of the RN
D Gold asked what people think is meant by "observation and direction" and "coordinator of care"?
Katherine Hughes said that when she works in a hospital she assesses the patient mobilization needs and the writes it in the care plan eg. in the ER, she is responsible for patient care or the evaluation for getting a PT. It's like the lab drawing blood; she's there but she is "responsible" for it. If she sees something bad she will report it. She views "observation" as a general term with focus on the plan of care.
C Morales noted that the term "observation" in the Nurse Practice Act says the nurse shall observe signs and symptoms of a patient, eg. a dangerous lab result. Observation doesn't mean standing by the bedside and watching but making a care plan, and when something changes, taking the appropriate action. The Nurse Practice Act may provide some answers.
Nimfa Santos said some outpatient clinics have no RN there. D Gold acknowledged that and added it is the same for x-ray and other departments.
She asked the group how this would apply and be done in other units that have no RNs, eg. diagnostic units, outpatient, imaging, PT, OT? Even home care might be on a hospital license.
K Hughes said the care plan goes with the patient to x-ray so filling out the care plan would constitute the required RN observation.
Gail Blanchard Saiger said some home health is a department for an acute licensed hospital.
D Gold said so you need to address "hospital based" but not in-hospital activities.
Kim Hadden said you can have separate licensing for a hospital and SNF at the same location and agrees with what other RNs have said about assessing mobility status. But patient conditions can change so they should have assessment before each move.
Sean Bartlett added about "observing", patient assessments are ongoing so the RN can't observe every lift. RNs are there to direct other staff and he is concerned employers will not provide adequate resources. The RN needs to be involved and do some observation but there is no way they can be expected to watch every lift: some delegation needs to happen.
P. Lewis asked, is the intent to focus on patient safety or team safety? You could make the regulation general enough to provide for general RN supervision.
B Borwegan said it is really that the SPH terminology is just historic terminology.
D Gold said you can't separate out patient safety from worker safety with this, and it is good it doesn't separate them out. It is a challenge for Cal/OSHA but we already did that with TB etc.
Gary Griffin said PTs are the primary for mobility assessment and for transfers, though RNs do most of repositioning. As a PT he is licensed by the state to treat without a referral so it is not clear how he can assess patient mobility if nurse assessment addresses that?
K Hughes said they do it now since they already do mobility assessments. S Roberson added that

transfers are not addressed in 1136. K Hadden said that RNs do screens for PT, OT, and speech per developed standards. D Gold said that DOSH generally refers to the Licensed Healthcare Professional but 1136 refers specifically to RNs. We'll look at the Nurse Practice Act.
D Brown said there should be a distinction between lift and transfer. The RN may say lift where the PT would say transfer. He cautioned against trying to replace all manual elements with equipment since part of movement therapy is ambulation etc. so don't lose "manual" procedures that are relevant to patient care.
Lift Teams
D Gold said that part (b) of the law covers powered lift equipment and lift teams. There are lots of overlapping concepts in law, but basically 1136 implies that whoever is going to lift patients has to have specialized training and access to powered lift equipment. They may be called a lift team or not but whoever does the lifting has be treated as part of a lift team.
S Bartlett said with all the new demands of the last 5 years on RNs it is impossible to expect RNs in acute care to be right there to assure proper safe lifting especially since 1136 provides that hospitals do not have to hire more staff. Inevitably patient care will be compromised if RNs have to do more. The regulation needs to require a team or let others do the actual lifting. It is not realistic that everyone is on the lifting team.
D Gold wanted to clarify, if they had 7 employees on a floor designated as lift team versus 7 employees on the floor having been trained and available for lift help, she doesn't see a big difference if you call it a lift team or not. S Bartlett said if everyone is trained that's great but then it is unrealistic to expect the RN to really be a nurse at the same time. If an RN is to be part of the lift team they should be free of patient assignment.
KHughes said it's possible that assigning a RN to a lift team will compromise patient care. Staffing ratios eliminated lots of help staff, including the transfers. They helped write the bill including allowing for not hiring new staff. They and the hospitals recognized nurses need to be able to do their job and hospitals need to be able to do theirs.
D Gold asked if part of the concern that being available to help with lifts does not compromise RN work at providing care? S. Roberson said the purpose of 1136 was for the RN not to operate any differently than they do now. CHA didn't want to have to train all staff. 1136 requires 24/7 coverage for lifting, it can't be done without some level of a dedicated lift team.
G Blanchard-Saiger said 1136 says lift teams and other support staff can do other duties. So who determines if care is or is not compromised by safe lifting? Many hospitals have 100% lifts and training so how would that not satisfy 1136? D Gold noted 1136 says employers will have a SPH policy in the context of the IIPP, so what about putting into the plan how staff will be mobilized for lifting? G Blanchard Saiger said yes that's fine.
D Gold said that could be done even on a unit by-unit basis as a performance requirement.
A Britton-Cordera said everyone seems to assume it is all for manual repositioning. Her experience shows a sling lift takes 2 people but without slings more people are needed so maybe you can handle it safely with less staff and the proper assessment .
C Young said if the goal is just to train current staff, a hospital could just hire a consultant to do some training and that would be it, but the intent of 1136 is to have a dedicated lift staff.
D Gold said generic training is not okay, you need to have specialized training. C Young said there should be a special designation to assure they handle specific patients to prevent the injuries.
Victoria Vandenburg cautioned to look closely at lift teams versus individual responsibility. Every RN who might do lifting is responsible for the patient, so individual competency should be a prime concern.
E Race said there seems to be confusion and uncertainty over a lift team model. But there is no-one-size-fits-all approach ie. for one lift team to use one equipment more and another to use other equipment more. It is up to a facility to decide what lift team is in compliance with 1136.
S Roberson said patient safety is critical too; the driver should be patient acuity and condition.

Some patients may need a team for repositioning others may need a lift team.
D Rempel asked Roberson if she meant that a RN shouldn't be on a lift team.
S Roberson said no. 1136 says a RN can be on a lift team as needed as long as that doesn't compromise patient care.
I Dahlgren concurred that all these efforts need to be working together and they need to educate all HCW in lifting, repositioning etc., and all need to have access to equipment.
D Gold said that studies show that lift teams not using equipment suffer higher injury rates so it is not enough to just have lift teams or equipment; you can increase safety and reduce the staff burden with the proper use of lifting equipment. The key thing is to have a readily available lift team, or equipment or both so that the nurse and staff will not have to ponder how to do something and are forced to do an unsafe lift. It appears that we need to flesh out in the regulation how to use a lift team versus the trained RNs in the context of all the comments we have just had.
G Blanchard-Saiger said the VA was held up as a good example, but they don't have lift team, and 1136 doesn't require lift teams. Marsha Bacelles said they spent millions on overhead lift equipment to be used by everyone, so requiring them to have a dedicated lift team would be a big step back. We have the policy of everyone being able to do the lifts. N Santos suggested, in (g) "replacement of manual lifting" could mean zero manual lifting.
Definitions
Darlene Wetton asked if the non-correctional hospital provides treatment to correctional patients is that covered by the law? D Gold said it is, the only exception is for the actual Department of Corrections and Developmental Service operated facilities.
G Blanchard -Saiger asked how does the MSD prevention plan differ from the SPH plan? The regulation needs to clarify the 5 areas of body exposure. D Gold said we also want to clarify what's in the Safe Patient Handling Policy.
Eric Davidson said there should be a Health Care Worker definition to separate them from the other staff with responsibilities. So the HCW would be everyone, even if not trained, because the provision prohibiting retaliation would apply to someone who is not trained and still expected to perform lifting.
K Hadden said there needs to be a definition of what is meant by "assessment"; if that is prior to admission or when.
Training
D Gold said training is supposed to be done in the context of IIPP training that includes separate supervisory training in addition to worker training. Does the bill establish these 2 levels of training one for the performance level vs. an awareness level and are hospitals able to choose which HCWs gets whichever training level? And do RNs have to have supervisory type training as required by 3203?
C Morales said there needs to be a specified training interval whether it is yearly, or 6 months or some other time period. G Blanchard-Saiger said CHA believes that the training contents, the specifics, and who gets each type of training should be determined by the employer. D Gold asked if that meant specifying those things in the employer plan, and G Blanchard Sager said yes.
S Roberson said they crafted the 1136 language to have training limited to patient handlers (eg. not pharmacists), so it is left up to hospitals to decide that and detail the scope of who is covered by training. Pre-designated teams are a key concept. D Gold asked if the non-designated staff (all beside) would get any training? S Roberson said they would.
B Borwegan cautioned against losing the definition and understanding of SPH that is derived from the profession and other states' laws; he read a definition. Ideally, the employer should document why manual lifting was performed ie. not just contraindicated.
G Blanchard-Saiger said the documentation requirement was left off from an earlier version of the bill. The hospital policy should designate who gets training (not necessarily all as the CNA advocates). D Gold asked if an untrained employee needs to know what to do if a patient falls in

front of them? G Blanchard-Saiger agreed they should get some sort of awareness training.
I Dahlgren said if hospitals decide who gets trained, and I get a job at a place where all the training has been scrapped and most of the staff in not trained, what am I to do?
Shannon Gallagher said turnover is corrosive on the institution and turnover increases with the injury rate. As shown by Ed Hall, SPH helps decrease the turnover rate, so continual training is important. A Cordera-Britton, said you have to be sure staff competence is acceptable so you need assessments and training. Competency maintenance is addressed by the Joint Commission and DPH rules so there isn't a need to prescribe how many specifically to train, should let hospitals determine what is needed.
D Gold noted that the group needs to understand that is not how Cal/OSHA does things. DOSH found the BBP requirement for training all employees with exposure to be more effective than the general licensing requirement which was to have the hospital determine the need. And we found with respirator use that the Cal/OSHA requirement to document training seems to bring order to health care institutions that general requirements for competencies don't. There is also the need to establish that training is effective, as in IIPP, and this means to train initially on the program as it's established and then we want to be sure people are trained on equipment to use, as well as to train whenever you change the equipment or policies and make sure they happen together. For example, if you need two people with the air mattress transfer, you want to be sure both people know how to work together with it. This is the kind of thing that argues for unit training and periodic training. It has borne out fairly well for us, with the newer standards we have passed.
Dorothy Wigmore noted that a key need is to have evaluation of the effectiveness of training. You don't need injuries to show that it's not working. Most employers are not very good about making training evaluations; it should be in regulation.
D Gold said the agenda had included algorithms ie. decision trees in the program, when to use them, training about them, but the question really is what's going to be in the SPH policy.
Refusal and Discipline
D Gold asked if a person is not trained, can they be disciplined? That should be addressed in the SPH policy. How do you document a refusal? Will the discipline force employees to not perform things safely because they fear reprisals? The IIPP should allow for communication, and employers need to deal with employees' concerns about SPH. Preventing discrimination is important, and Cal/OSHA will work with the Division of Labor Standards Enforcement about handling those issues.
K Hadden said an algorithm might be developed to address refusal and retaliation protection, especially where employees haven't been trained, or even where they have. Their own research involving shadowing employees for 200 hours, found that most employees preferred doing manual moves with help from other employees rather than use the equipment.
Maggie Robbins said that managers are often too quick to see refusal as just refusal but it usually means something deeper, and they need to look for the root cause. Employers need more of a sophisticated policy than to just treat an incident as simple refusal. Some earlier spoke about the importance of building in SPH into the general safe practices culture. A key is to do Root Cause Analysis on refusals.
D Wigmore said that in Canada refusal to work is more respected, for example a reason for refusal has to be told to the next person doing the job. She has found in teaching that this one of the rules that employees just have to believe.
G Blanchard-Saiger said you need to keep patient care in mind, and this may take too long
D Wigmore said it is a law in Manitoba.
S Bartlett said that in insubordination cases, there is always some subjectivity even if refusal is reasonable on safety grounds. There is a problem when the nurse thinks it is unsafe but the hospital plan says it is okay. This erodes the nurse's professional assessment role. If patient care must not be compromised, that's key to preventing abuse. Some algorithms allow different opinions, so you need to rely on the RN's assessment in each particular situation.

Chuck Parsons, noted there could be ADA issues involved. They don't see many refusals to lift, and when they occasionally do it is generally for a good reason. If a refusal is personal, ie. the employee needs a special accommodation, then there must be some expectation that the employer has flexibility to move people around to accommodate these needs.
Nancy Myer said her experience with refusal is different: the staff is trained and has the equipment but they choose not to use it because they say it is faster without, how should we handle that? She has had many staff tell her that. D Gold said that the IIPP has to have an enforcement mechanism of the safety policy. But we are looking now at issues like not getting trained, or not having the equipment, as causes for refusal.
S Bartlett said sometimes a RN will work in a telemetry unit and then float to other assignments, but if they are not oriented they may not really be capable of SPH in the new assignment. Lifting should be looked at the same way, there needs to be some frequency of lifting to be truly competent, and refusal in that situation should be allowed.
C Morales said that you need to remember that when a nurse accepts a task they are saying "I can do that", then, if I'm floated to another unit and misread the information or something like that, then I'm in trouble because I accepted the task. This is really a nurse practice issue.
Other Issues
D Perrot said there needs to be a discussion about the use of appropriate equipment, such as defining powered equipment, eg. would slippery sheets constitute lifting equipment?
D Gold responded that the law says the SPHA policy means not defaulting to manual lifting. So there could be cases where lifting equipment may mean non-powered transfer devices, or sit-stand devices. The main thing is to have and use powered equipment and other devices and LTs/other trained people. It's our understanding that preference is not to default to manual equipment, there is a push for powered equipment and what others call assistive devices, and it's about using the IIPP, eg. if you are having injuries with gait belts as patients collapse, this isn't a static experience. You're in health care and have many plans. Make the first cut, dealing with the most risky operations -then review data a year later and see what's happening, and get feedback from frontline HC workers. This is an iterative process. Move to powered equipment as appropriate, deal with where you don't have it and keep moving forward. That is what the VA and Stanford did, and what you've done on issues like safety needles or other things. Make the change and move forward; what's different is the enormous capital outlay. In picking the right equipment it is really important to frontload this with the input of workers using this equipment. It is not in the bill but Cal/OSHA has found that this is more likely to achieve a successful outcome.
Julie Lavezzo said she wanted to thank those who put 1136 together even though there may be lots of struggle ahead with the details and people get their hackles up a bit etc.
D Gold said yes we're thankful for the opportunity to have another tool to address HCW safety.
D Gold concluded that the next meeting would be in March or April but we would appreciate that if anyone has comments on definitions, or terms with their meaning, or other clarifications of terms, or other comments that's great. Whatever you see needs clarification, let us know and send us the comments and ideas for clarifying the terminology. We would also like to see ideas for SPH policy, and ideas for items in the regulation. Try to send them to Bob Nakamura by the end of February.
We'll post minutes and the comments received on the 1136 AC website. We will also email you about the decision from OAL on the outcome of the proposed section 5120, and the date for the next meeting.