



# Limit Liability With Lift Programs

*The use of mechanical lifts to aid caregivers in patient transfers means fewer staff and patient injuries and a strong return on investment for providers.*

**S**KILLED NURSING FACILITIES (SNFs) are among the primary targets for inspections under the Occupational Safety and Health Administration's (OSHA) new National Emphasis program, and the reasons why are not difficult to understand. SNFs are a consistent leader in lost workdays due to injury and illness (LWDII) when compared with other U.S. industries. In calendar year 2000, for example, SNFs' LWDII were 2.5 times the average for all private industries, according to the Bureau of Labor Statistics (BLS).

This high rate of on-the-job injuries can be traced largely to three basic tasks: manual lifting, transferring, and repositioning of patients, BLS says. As a result, one of the focal points for OSHA inspectors will be ergonomics related to patient handling.

From a risk management standpoint, the most effective way to manage a hazard is to eliminate it. And while the routine handling of patients cannot be eliminated in SNFs, the ergonomic stressors related to patient handling can be greatly mitigated.

The National Institute of Occupational Safety and Health (NIOSH) is specific on this matter. "No one should routinely lift any stable object that weighs more than 51 pounds," a NIOSH directive states. A SNF patient generally weighs more than 100 pounds and could not be considered a "stable object." In a draft of guidelines released in September 2002, OSHA recommends that "manual lifting of residents should be minimized

in all cases and eliminated when possible."

Some nursing facilities have successfully minimized the ergonomic stressors related to patient handling by implementing what is called a limited-lift policy (LLP). In addition to preventing on-the-job injuries, the proper use of mechanical lifts can have money-saving benefits for providers, studies show.

## How The Policy Works

An LLP is a patient-handling directive designed to eliminate the need for caregivers to lift any weight greater than approximately 25 pounds when transferring patients. One suggested way to assess this weight limit is to say that the smallest caregiver on staff should be able to complete a transfer with minimal assistance at the weakest time of day or night for the patient. If more than minimal assistance is needed, the patient may be a candidate for a lifting device. Therefore, the number of lifting devices a limited-lift facility requires is directly proportional to the acuity of the patients in that facility.

The electronic "total lift" is for more dependent patients. The electronic "stand lift" is for patients that can bear weight on at least one leg or have independent sitting balance. Friction-reducing devices are utilized for bed mobility of obese or completely dependent patients.

## Implementing An LLP

An LLP is not successfully implemented with equipment investment alone. It typically requires about six to eight

weeks of acuity evaluation, patient-transfer assessment, equipment evaluation, equipment selection, program introductions, staff training, worksite analysis, quality assurance, and program evaluation. In the process, a facility will have to alter its caregiver and patient culture, which has often been acclimated to manual lifting of patients for years or even decades.

Owners, administrators, directors of nursing (DONs), and department heads must all be committed to the program—from its outset through full implementation.

A typical LLP implementation consists of four distinct phases, including:

- *Evaluation and introduction (Phase I).* During this first phase, the facility's current mechanical lifting equipment and patient acuity are evaluated; nursing staff get to examine various brands of equipment available on the market; and lifting equipment is then ordered based on acuity, facility layout, and staff input. This is also the phase in which questions and concerns are addressed via programs and equipment introductions aimed at staff members, individual patients, patients' council, admissions coordinators, patients' families, and physicians.

- *Education and assessment (Phase II)* At this point, caregiving staff are educated on the policy directives and safe use of the lifting equipment. Qualified

---

JESSE MORENO, a licensed physical therapist and certified strength and conditioning specialist, is a risk management consultant for Diamond Insurance Group, Northbrook, Ill.

personnel assess each patient for the safest method of transfer, and this is posted via a coding system (to maintain patient privacy) in the patient's room. As appropriate, caregivers should communicate perceived changes in a patient's condition to the charge nurse for possible transfer-status change. Equipment checklists are implemented into the maintenance department with

thank-you party for their assistance in implementing the LLP. Providers should continue the audits on a quarterly basis to ensure ongoing success.

### Benefits Of The Program

Once a facility fully implements an LLP, no caregiver should be called upon to manually lift more than about 25 pounds. This minimizes the

caregivers in other ways as well. Improvements were found in bowel and bladder programs, skin care, transfer capability, gait-training programs, patient/family security, patient dignity, caregiver morale, and decreased nursing staff turnover rates.

### Investment And Return

Still, instituting an LLP requires an initial investment for equipment and training. The total- and stand-lift equipment cost approximately the same amount, depending on the weight capacity. For a stand lift that has a 350- to 400-pound capacity, or a total lift with a 500- to 650-pound capacity, the cost is approximately \$3,000 to \$5,000.

The number of lifts purchased to implement an LLP is directly related to the number of patients who will be using the equipment. The ideal ratio is one piece of equipment for every eight to 10 patients who use it. Thus, if there are 20 patients designated as stand transfers, two stand lifts would be recommended.

Recommendations may be affected by the layout of the facility (multilevel facilities can create problems in moving equipment, for example) or staff input (the caregiver in charge of showers requires one stand lift exclusively in the morning).

The return on investment is seen directly by the decreased dollars spent on workers' compensation claims. According to OSHA and BLS, the workers' compensation cost for the average back injury is \$11,297, and this does not include the indirect costs of training new employees, employee turnover, claim investigation, overtime pay, decreased productivity, patient injuries, work stoppage following an accident, rescheduling shifts, and decreased morale. ■

### For More Information

■ The author can be contacted via e-mail at [jmoreno@diamonddwc.com](mailto:jmoreno@diamonddwc.com).

## COMPARATIVE RETURNS ON INVESTMENT OF LIFTS FOR THREE SNF CHAINS 2001-2002

	Percent decrease in OSHA recordable resident handling injuries	Percent decrease in lost workday injuries related to resident handling	Percent decrease in total workers' compensation claims	Percent decrease in total workers' compensation claims dollars incurred
Heritage Enterprises	96%	94%	30%	57%
Dynamic Health Care	89%	75%	47%	27%
Christian Homes	97%	86%	44%	57%

Source: Diamond Insurance Group—pre- and post-policy year comparison information from limited lift audits

vendor contact information to ensure the lifts are operational and safe for use at all times. Sling-laundering instructions and checklists are given to the laundry department to ensure slings are in safe condition after every laundering.

■ *Front-line employee involvement (Phase III)* Specific front-line nursing staff are selected by the DON to serve as the "product champions." These individuals are schooled to assist with training of new employees and to provide feedback on the equipment itself. They also handle all staff and patient issues related to the equipment. The product champions are perhaps the most integral part of the policy besides the equipment itself with regard to employee "buy-in" and compliance.

■ *Program evaluation and appreciation (Phase IV)* In this final phase, the administrator, DON, and product champions complete audits of the equipment, patient acuity and concerns, and staff issues. Once recommendations based on the audits are implemented, staff are treated to a

ergonomic stressors associated with patient handling and greatly reduces the potential for employee injury.

A concurrent benefit—and one that should not be overlooked—is the reduction in potential injury to patients. Transfers have been cited as a risk factor for falls in the *Journal of the American Medical Association* and by other sources as well.

If, for example, a patient should "give out" during a stand-pivot transfer, a stand lift is far more likely to prevent a fall than one or two caregivers trying to hold the patient up. The patient is also at decreased risk for skin tears from an improperly used gait belt that might be employed for support during a standard manual lift. The patient's upper extremities are at decreased risk for injury because the individual's arms are no longer used inappropriately as a hoist during transfers.

Post-implementation audits of limited-lift facilities, completed by the insurance industry, reveal an improved quality of life for patients and care-