

Soteria Strains

Safe Patient Handling and Mobility Program Guide

Section 2 – Identifying Hazards and Assessing Risk

Section 2.1- Identifying Priority Areas

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STRAINS

A provincial strategy for healthcare workplace musculoskeletal injury prevention.

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Section 2.1 – Identifying Priority Areas

Introduction

This section includes various tools and methods for site coordinators, patient safety divisions, senior management, and OH&S departments that will assist in identifying priority areas/units and their activities.

Implementing organizations may already have a prioritization process in place. Here you'll find suggestions to consider when reviewing those processes. However, the processes for selecting priority areas should change as the safe patient handling and mobility program matures from initial implementation to program maintenance. This should reflect a move to formalize processes and progress from a reliance on lagging indicators to leading indicators.

Suggested steps to identifying priority areas:

Step/Activity	Tools
1. Clarify prioritization process	Tools that may be created during early adoption and referenced in the final program draft: <ul style="list-style-type: none"> • Sample Report Card • Sample Scoring Matrix for Analyzing Data
2. Identify/select key indicators	
3. Review lagging indicators	
4. Review leading indicators	
5. Analyze data and create a list of priority areas	

Step 1 – Clarify the Prioritization Process

It is important to make the prioritization process explicit so it can be communicated to the organization. This will assist in ongoing communications and managing expectations as the program is implemented across the organization. The process should contain the following information:

- Who will participate (e.g., OH&S, executive sponsor, Multi-Stakeholder Safe Patient Handling and Mobility Program Coordinating Committee/Coordinator)
- What role the participants will have (e.g., collecting/presenting data, reviewing and decision-making, providing expert opinion)
- How decisions will be made (via executive decision, committee, consensus, etc.)
- How the data will be analyzed/reviewed (e.g., scoring matrix)

Step 2 - Identify/Select Key Indicators

An essential step when prioritizing areas in any facility is to understand the risk to workers and any hazards that might lead to an injury for each location in the facility. Knowledge of current conditions will help ensure resources are allocated strategically and offer the most significant return on investment. This step involves identifying what indicators to review when creating the priority list.

Initially lagging indicators, shown in Table 2.1.1, will be an organization’s primary focal point when it comes to identifying existing hazards related to patient handling and prioritizing areas for change. As the organization matures, leading indicators will become the primary data source for identifying priority areas.

Table 2.1.1 – Examples of Leading and Lagging Indicators

Leading Indicators	Lagging Indicators
<ul style="list-style-type: none"> • Near-Miss Reports 	<ul style="list-style-type: none"> • Previous Injury Statistics
<ul style="list-style-type: none"> • Staff-Perception Reports 	<ul style="list-style-type: none"> • Insurance Premiums
<ul style="list-style-type: none"> • Hazard Identification Reports 	<ul style="list-style-type: none"> • Past-Incident Reports
<ul style="list-style-type: none"> • Risk Assessment 	<ul style="list-style-type: none"> • Sickness/Absence

Refer to “Section 1.4 —Program Evaluation and Measurement Framework” for examples of more tools and indicators.

Step 3 - Review Lagging Indicators

Baseline injury data that is collected and reviewed should focus on injuries related to patient handling and mobility. Data should at minimum capture:

- A description of the incident including the patient-care activity performed at the time of the injury (bathing, repositioning, transfer from bed to chair, etc.)
- The cause of the injury (pull, push, reach, struck, etc.), the type of injury (sprain/strain, contusion, etc.)
- The time of the incident
- The unit/location where the incident occurred
- The body part(s) affected
- Days of work lost
- Modified duty days required

Other injury-data sources include:

- Direct workers' compensation costs:
 - medical costs
 - earning-replacement benefits
 - treatment costs
- Indirect costs associated with:
 - transitional duties
 - accommodations
 - replacement workers
 - decreases in productivity and morale

Typically, data from the last twelve months is collected then analyzed so that trends can be identified; however, multiple years of data will provide a historical view to better evaluate trends over time, so it is important to evaluate as many years as possible.

Analyses should first be performed by units and then aggregated across units to provide an overall assessment of the facility(s). Unit analysis will minimally address the incidence, severity (defined as lost and modified-duty days), primary task(s) involved in the injuries, and the primary cause(s) of injuries on the unit.

Those units with a high incidence and severity of injuries are classified as high-risk units. While every unit in an ergonomic assessment/improvement initiative will eventually be included, prioritizing time and resources is frequently necessary. High-risk units will have the greatest incidence of patient-handling injuries, the most workdays lost, and the highest concentration of staff on modified duties. Keep in mind that there are likely to be variations by unit as well as by shift.

Step 4 – Review Leading Indicators

Many organizations may not have access to all leading indicators until later in their implementation process. The indicators used in the prioritization process should be reviewed regularly to reflect this evolution. Leading indicators described in this step are health care worker reports, incidents and near-miss reports, existing-hazard identification reports and risk assessments.

Health Care Worker Reports

It is important to identify and assess staff perceptions of high-risk tasks. The highest-risk tasks are likely to vary between patient care units, depending on patient characteristics, availability of equipment, physical layout, and work organization. For example, some studies have indicated that bathing, toileting tasks, and transfers from beds to chairs are high-risk tasks for health care workers. Other units may prioritize lateral transfers from bed to stretcher or turning patients from side to side in bed.

Health care worker opinion regarding factors contributing to injuries can be collected through the use of staff surveys. A simple open-ended survey asking something like: “What is contributing to the injuries occurring on your unit?” may bring up significant issues such as lack of equipment, equipment maintenance and repair, storage, staffing, or problems with modified-duty assignments. Interviews may also bring up pertinent issues that cannot be gleaned from injury data. Ideally, management interviews will take place during a walk-through of the unit. Job observations and brainstorming sessions with health care workers can also be used to identify and prioritize high-risk tasks and units.

Incidents and Near-Miss Reports

Learning opportunities for preventing problems is the purpose of any incident and near-miss investigation. It is the supervisor/manager’s job to determine the corrective actions that will prevent reoccurrence of a near-miss, illness, or injury. The purpose is not to find fault or blame, but rather to identify the basic, root causes so that controls can be put in place to prevent further occurrences.

Information from the investigation should be documented in an incident/near-miss reports. Statistics received from these reports are also useful in identifying higher-risk tasks and problem areas, and can aid in setting priorities, developing annual prevention plans, and identifying training initiatives.

Existing Hazard Identification Reports/Risk Assessments

Existing hazard identification reports/risk assessments can be used to prioritize which areas of the facility should be targeted for enhanced controls. Typical hazards that will be identified in these reports would include activities found in Table 2.1.2.

Table 2.1.2 – Hazards Specific to the Health Care Industry

Hazards might include:
1) Reaching and lifting with loads far from the body
2) Lifting heavy loads
3) Twisting while lifting
4) Experiencing unexpected changes in load demand during the lift
5) Reaching too low or too high to begin a lift
6) Moving/carrying a load a significant distance
7) Identifying environmental hazards such as cluttered patient-care areas, confined space in bathrooms, or broken equipment

Step 5 – Analyze Data and Create a Prioritized List of High-risk Units

How an organization prioritizes its various areas will depend on its program maturity. As the safe patient handling and mobility program matures, the importance of lagging indicators should shift to leading indicators. Developing a process that accounts for all indicators enables organizations to customize priorities based on updated information sources (See Figure 2.1.1).



Figure 2.1.1

Once the data is reviewed and analyzed, a list of units should be prepared based on priority. The next step is then performing unit-based assessments to identify the hazards present and assess the risk these hazards pose.

Step 6 –Consider Organizational and Environmental Factors to Confirm Priority List

Initially, organizations should select a number of units that can realistically be assessed and solutions implemented based on the available human and capital resources. Other organizational and environmental factors such as (commitment, readiness, competing priorities, existing equipment and human resource distribution, etc) should be considered when confirming the list of priority units/areas.

For planning purposes, it may be helpful to use a gross budget-estimation process based on experience in jurisdictions within Nova Scotia and PEI.

$$\text{Estimated Cost/Unit} = (\# \text{ beds}) \times (\$3000 \pm 15\%)$$

This estimate includes cost of equipment and training, but not maintenance of equipment. Also, there is an assumption that no major structural issues are present within the facility that would require significant renovations and/or upgrades.

Tools that may be created during early adoption and referenced in the final program draft

- Sample Report Card
- Sample Scoring Matrix for Analyzing Data