Provincial Safe Resident Handling Standards for Musculoskeletal Injury Prevention in British Columbia

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Residential Care Stakeholders

Clinical nurse leaders

Clinical practice leaders

Clinical nurse educators

Family & resident council members

Frontline workers:

- Frontline staff
- Peer leaders
- Coaches

Resident care coordinators

Residential services directors

Residential site Joint Occupational Health & Safety Committee members

Residential site managers

Therapy service workers

Other Organizations and Groups

Facilities Bargaining Association – Patient Handling Group

Musculoskeletal injury prevention / ergonomic teams

Physiotherapy Association of British Columbia

Provincial Health Services Authority (Rick Hall & Cindy Kitamura, Ergonomic Specialists)

Provincial Union Leads: Health Sciences Association, Hospital Employees' Union, British Columbia Nurses' Union, B.C. Government and Service Employees' Union

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Section 1

Introduction and Background

1.1 Introduction

Residential care as a sector has one of the highest injury rates[1] in the province, with musculoskeletal injuries (MSIs) representing the largest injury category[2]. Due to the repetitive and heavy burden of care associated with resident-handling activities, the 34,000 care aides working in the sector are particularly vulnerable, with an injury rate and associated costs higher than that of any other healthcare worker classification[3]. Other at-risk employees delivering residential care in B.C. include RNs, LPNs, therapy services professionals, activity workers, and other facility workers (food service, laundry, housekeeping, activity workers, etc.).[4]

Many health care organizations have developed and implemented safe resident handling practices for reducing the risk of MSIs due to resident handling activities, to improve the safety of both care providers and residents. This document brings many of those best practices together, in the form of provincial safe resident handling standards for MSI prevention, so that residential care facilities across the province can review them and implement relevant policies and practices in their own organizations.

The standards cover 10 areas: policy, management strategies, education and training, equipment, and six sets of safe work practices for particularly high risk resident handling activities (i.e., transfers and ambulation, bed care / repositioning, positioning seated residents, resident toileting, resident bathing, and resident dressing).

The development of the standards brought together ergonomic specialists and musculoskeletal injury prevention advisors from five B.C. health authorities (Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health, and Vancouver Island Health) as well as Providence Health Care. Input was also provided by several key stakeholders including WorkSafeBC, Residential Care Joint Health & Safety Committee members, the Physiotherapy Association of BC, and a range of residential clinical workers, as well as family and resident council members. Funding support for the development of the standards was provided by the Health and Safety in Action (HSIA) project[5].

The standards are intended to inform and guide MSI prevention decision-making and management processes, such as the development of policies, procedures, protocols, educational programs, and tools.

Should the BC healthcare sector decide to develop industry recognized practices (IRPs) for MSIP / safe resident handling, this document would be a valuable starting point. In addition, it is strongly recommended that subject matter experts and key stakeholders continue to evaluate the impact of applying these standards, and revise and develop future standards as technology and processes evolve.

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[1] The injury rate for residential care was 9.45 in 2009 (Health Employers Association of BC, 2011)

[2] This is also true for healthcare as a whole in B.C.

[3] Statistics and background information in this section are from the Health and Safety in Action Initiative Charter, for Initiative 3. Provincial Musculoskeletal Injury Prevention (MSIP) (August 3, 2011)

[4] In the remainder of this report, the terms “care provider” or “staff” are used to refer to all employees who deliver direct care to residents.

[5] See HSIA Initiative Charter for Initiative 3.

How to Use this Document

This document has been designed as a tool to assist you with reviewing and/or developing your organization's safe resident handling systems and processes. It is not meant to be prescriptive, but rather to present ideas, concepts, references, and examples to help you develop, evaluate and maintain your programs.

For some residential care sites and organizations, many of the components described are already well-established, and the standards and checklists will help with recording those successes. For others, the document will assist with identifying ways to integrate safe resident handling elements into current policies and practices, in order to improve staff and resident safety.

The remainder of the document is organized as follows:

Section 1.2 provides a brief review of the evidence related to safe patient/resident handling in the healthcare industry.

Section 2 contains the provincial safe resident handling standards for high-risk resident handling activities.

Section 3 contains gap analysis tools for completing a current-state assessment of resident handling systems and processes compared with the provincial standards. After completing the analysis, managers and program planning teams are encouraged to develop systematic action plans for implementing the standards in order to address the identified gaps. For maximum benefit, it is recommended that all 10 gap analysis checklists be completed.

Section 4 outlines an implementation framework (Peer Resource Team) that has demonstrated success in enhancing safety systems in residential facilities across the province.

Section 5 provides additional resources containing information and examples to assist with understanding and implementing the standards.

The Provincial Residential Care MSI Prevention Team would like to take this opportunity to thank you for reviewing the standards and tools provided, and wishes you and your team every success in adapting, integrating, and benefiting from the province's best practices in safe resident handling.

Please Note:
The provincial standards presented in this document are intended to guide best practices in decision-making and program development in the area of resident handling. They are not intended to replace WorkSafeBC regulations or directives.

1.2 MSI Risks and Risk Reduction in Residential Care: A Brief Review of the Evidence

The 10 provincial standards focus on the highest risk resident handling activities and the most effective MSI reduction strategies, as identified through the Provincial Residential Care MSI Prevention Team's review of the research evidence and other information. This section briefly outlines that information, and is organized as follows:

Subsection:	Relates to the following standards:
Organizational Policies and Leadership	• Safe Resident Handling Policy • Management Strategies to Support Safe Resident Handling
Safety Equipment	• Safe Resident Handling Equipment
Education and Training	• Safety Education and Training
Safe Work Practices	• Transfers and Ambulation • Bed Care and Repositioning • Positioning Seated Residents • Resident Toileting • Resident Bathing • Resident Dressing

Organizational Policies and Leadership

"Safe patient handling" and "no manual handling" policies are a pledge, by all levels of an organization, to ensure that proper equipment will be in sufficient supply, adequately maintained, and available to care providers to reduce the risks of injury associated with manual resident handling (Nelson 2008; Tullar et al.). Care providers have ranked such policies as the second most effective strategy (after equipment) for reducing injuries (Nelson, 2006).

Researchers have also found that worker practices are influenced by management attitudes and perceptions regarding safety. When managers place worker safety at a lower priority than patient care, and/or do not respond in a timely manner or take appropriate action when worker incidents occur, worker compliance is lower (Gershon et al., 1995; Niven, 2002). Conversely, when managers demonstrate through their practices and formal decisions that employee safety is a corporate value, employees follow by contributing to safety improvement initiatives (Goodman, 2003).

Safety Equipment

In residential care in B.C., the majority of injury risks to care providers are due to resident handling and resident care activities. High risk resident handling care activities are tasks that impose significant forces and postural stresses on care providers (Nelson, 2008).

Research has found that the exertion required to lift residents exceeds care givers' biomechanical capacities (Collins, 2004; Nelson, 2003; Nelson, 2004; De Castro, 2006). The maximum amount of weight a caregiver should be lifting under the most ideal conditions is 16 kg (Waters, 2007), and no amount of training in proper body mechanics or lifting techniques will prevent injury when the load exceeds what the body can tolerate (Hignett, 2003; Nelson, 2004).

The use of mechanical lifts is recommended for reducing the risk of injury associated with single, heavy load events, such as manually lifting a resident (Hodder, 2010). Overhead lifts have been found to reduce care provider injuries and are superior to floor-based lifts. This is due to better accessibility at the point of care, greater ease of use in smaller spaces, increased comfort, and decreased physical demands and postural loads when assisting with moving residents during a variety of bedside care tasks (e.g., wound care, peri-care, dressing, and bathing) (Alamgir et al., 2009; Chokkar et al., 2005; Fragala, 2003; Hignett and Evans, 2006; Rice, 2009; Marras et al., 2009; Nelson et al., 2003).

Education and Training

It is rare that a one-time training event results in sustained change. To truly bring about change in practice, educating caregivers should be not a one-time exercise, but a process (Haney, 2007). In order to promote sustained change, education and training are evolving to combine formal training with informal learning events on the job. This approach recognizes that learning takes place not only before doing something new, but also when applying the new skill, while problem solving, and during incident debriefs. This process is called 'blended learning' (Gottfredson, 2011; Pulichino, 2006). Blended learning in healthcare settings may include instructor-led sessions, self-paced learning, in-the-moment bedside coaching, problem solving, safety huddles and return demonstrations. The transfer of new knowledge to a day-to-day work task can also be supported by peer leader coaching (Cohen 2010, Haney 2007; Knibbe, 2007), performance support tools such as a self-check (Gottfredson 2011), and technology, such as e-learning (Pulichino, 2006).

"Who" receives training is a key success factor for bringing about change in practice. All new managers, supervisors and clinical support staff must complete training specific to their role in implementing and supporting a sustainable safety culture for both staff and residents (Collins, 2004). To meet WorkSafeBC regulations, training for managers and leaders must also include knowledge of the OHS regulation, how to a conduct risk assessment, incident investigations, work area inspections, and safe work practice audits (Occupational Health and Safety Regulation, 2011).

Regarding the focus of care provider training, research on the effectiveness of MSI reduction has shown that care providers need to be trained in equipment use and risk assessment (Collins 2004, Hignett 2003, Hinton 2010, Nelson 2006, Nelson 2007), with less emphasis on body mechanics and manual lifting techniques (Daltroy 1997, Hignett 1996, Hignett 2003, Nelson 2003, Nelson 2007).

By supporting knowledge transfer, peer leaders and coaches can help frontline care providers build and sustain a culture of safety. To be able to fulfill this role, however, peer leaders and coaches need in-depth training in safe patient handling, as well as training in coaching techniques and change management strategies (Cohen 2010, Haney 2007, Knibbe, 2007).

Residents and families can also be encouraged to appreciate the culture of safety within their home. Upon admission and as required, they should be given information about the safe work policies, procedures and concepts associated with safe patient handling at the facility (Cohen, 2010).

Safe Work Practices

Residential care providers repeatedly exceed the National Institute for Occupational Safety and Health (NIOSH) safe lifting limit during resident handling tasks, putting them at high risk for back injury (Village, 2005). Under the *most ideal circumstances,* the maximum recommended weight limit for patient handling, derived from NIOSH guidelines, is 16 kg (35 lbs). However, in *less than ideal circumstance*s the maximum is reduced (Waters, 2007), for example, when:

- The resident does not follow instructions consistently (reduced cognition or willingness to participate in care), the transferring motion is jerky or not smooth, the resident resists or pushes away, or the weight being lifted is subject to change due to the resident's unsteadiness or loss of balance.
- The care provider's back is twisted or side bent; the care provider is standing more than a foot away from the resident when transferring; the worker has a predisposition for injury or has sustained a previous injury; or the care provider has worked more than an eight hour shift.
- The environment is cluttered or cramped.

The US Department of Labor ranked nursing aids, orderlies and attendants as the highest risk group for occupational MSIs, compared with all other workers (Nelson, 2008; Collins, 2008). Resident care tasks account for 60% of care aides' daily workload, and are associated with extreme postures and cumulative spine loads that further increase the risk of injury (Jang 2007). The greatest cumulative load is attributed to the cumulative effect of the repeated transfers, turning, limb lifting and repositioning required for resident care (Holmes, 2010). When engineering controls are not optimally implemented, and safe patient handling standards are not clearly defined, care providers are exposed to significant excessive lifting and increased risk of injury (Village, 2005).

Specific high risk resident care tasks include: surface-to-surface transfers, assisting with ambulation, providing care in bed, repositioning residents on a flat surface or in a seated position, toileting, dressing, and bathing. Two of the most strenuous and complex resident handling tasks are washing and bathing (National Back Pain Association, 1999).

WorkSafeBC has also identified several manual transfer and lift techniques that are high risk due to the awkward postures and forces required. These tasks include: one or two person low pivot transfer, chicken or drag lift, cradle or basket lift and two-person through arm lift (WorkSafeBC, 2006). In a 2002 memorandum of agreement, B.C. health authorities agreed to eliminate such manual lifting techniques during standard care practices (notwithstanding exceptional circumstances).

The risk of care provider MSIs associated with resident handling can be eliminated or reduced with effective care planning — which includes comprehensive assessment (including resident abilities), access to equipment, and safe work processes (Borden, 2010). Safe resident handling programs can also contribute to the quality of resident care, by reducing the frequency of adverse events (e.g., resident falls), and improving residents' comfort and participation in care activities (Haney et al., 2007; Nelson et al., 2004).

1.3 Terms and Abbreviations Used in this Document

Key terms used in this document are defined below.

Care provider	An employee who delivers direct care to residents (e.g., resident care aide, nurse, licensed practical nurse, therapy worker).
Community of practice	A group of people coming together who share an interest, a skill, and/or a profession. The group forms due to members' common interest in a particular domain or with the goal of gaining knowledge related to their field. The process of sharing information and experiences facilitates learning from each other, as well as personal and professional development. Groups can interact online (e.g., chat rooms, live meetings) or in person (e.g., lunchroom/boardroom gatherings).
Complex care	Provided in a community care facility for people who require 24-hour supervision, personal nursing care and/or treatment by skilled nursing staff. Also often referred to as extended care, intermediate care, long-term care or residential care (definition taken from Ministry of Health, Office of the Assisted Living Registrar).
Frontline leader	A person who manages, supervises, or directs the work of others and/or at a facility.
Independent	When a resident is physically capable of performing a task safely without help or oversight. Assistance from a care provider is not required.
High risk	Any activity or circumstance that is likely to result in a musculoskeletal injury for care providers. In relation to tasks, this may include resident handling activities such as transferring and repositioning, bathing, and dressing. In relation to resident physical function, this includes residents requiring full assistance from a care provider to move their body.
Minimal assistance	Providing directing, cueing, encouragement, guiding or steadying assistance to the resident to mobilize safely. The resident is highly involved in the activity but may require the care provider to exert minimal effort (no more than 16 kg of force) to guide, steady, support or use aides effectively.
Peer leader	A frontline representative of the care team including resident care aides, licensed practical nurses, registered nurses, clinical nurse leaders, or clinical nurse educators. The peer leader is provided with additional training regarding safe resident handling, communication and coaching.

Peer coaching	The partnering and coming alongside a care-provider in the moment of the application of skill, to help bridge the gap between knowledge and application, or assist with problem solving. A coach provides guidance, feedback and direction to help people find their own solutions.
Resident	A person who lives in a residential care facility and receives ongoing care from care providers.
Safety culture	A product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour, that determines the commitment to, and the style and proficiency of, an organization's health and safety management.
Supervision	When a resident is physically capable of performing a task but needs oversight, encouragement or cueing to complete the task safely. A care provider gives verbal or cueing support with no physical effort or exertion.
Support staff	An employee who does not provide direct resident care but supports the operations of the facility and care (e.g., housekeeper, administration clerk, facility maintenance worker).

Abbreviations

ADL	Activities of daily living
BCGEU	B.C. Government and Service Employees' Union
BCNU	British Columbia Nurses' Union
FHA	Fraser Health Authority
HEU	Hospital Employees' Union
HSA	Health Sciences Association
HSIA	Health and Safety in Action
IHA	Interior Health Authority
JOHSC	Joint occupational health and safety committees
MSI	Musculoskeletal injury
MSIP	Musculoskeletal injury prevention
NHA	Northern Health Authority
OHSAH	Occupational Health and Safety Agency for Healthcare
PHC	Providence Healthcare
VCH	Vancouver Coastal Health
VIHA	Vancouver Island Health Authority

Section 2

Provincial Safe Resident Handling Standards

2.1 Safe Resident Handling Policy

PROVINCIAL STANDARD

The organization has a policy that requires staff to use safe resident handling procedures to reduce the risk of injury and ensure quality of care. Staff must use safety equipment or assistive devices whenever more than minimal assistance would be needed to manually lift some or all of a resident's weight. The employer provides alternate risk reduction engineering controls and procedures for situations in which assistive devices cannot be used.

RATIONALE

Manually lifting, transferring and repositioning residents significantly increases the risk of musculoskeletal injury for care providers. By having a safe resident handling policy, an organization demonstrates its commitment to reducing injuries and clearly directs care providers to use the safest procedures. A safe resident handling policy is also seen by care providers as an effective injury reduction strategy (in one study, nurses ranked equipment and a "No Lift" policy as the first and second most important strategies respectively) (Nelson, 2006).

KEY PRINCIPLES

- A safe handling policy is not intended to reduce resident participation. Resident assessments are conducted to identify the equipment and care procedures that take into account both resident function and the safety of residents and staff.
- The policy permits manual lifting only in exceptional circumstances, such as during an emergency or when clinical contraindications make it necessary to use non-standard procedures in order to ensure the safety of the resident and staff. When standard procedures are clinically contraindicated, the resident's physical and cognitive status is assessed to identify the safest possible lift procedure to be used, and this information is communicated to all staff.
- New facility construction and renovations are planned in a manner that supports the safe resident handling policy.

CRITICAL ELEMENTS

1. Safety Infrastructure
   - Sufficient and accessible resident handling equipment, including maintenance systems.
   - Management commitment and support.
   - Strategies to promote and support a culture of safety.

2. Supporting Systems
   - Resident care assessment systems and processes.
   - Safety policies, procedures and/or guidelines that are integrated into resident care.
   - Communication systems for identifying unsafe resident handling situations and related changes in work practice, work environment, or equipment.
   - Processes for staff to inform their supervisor when they are unable to comply with the policy (e.g., due to the resident's condition, equipment malfunction, unfamiliarity with equipment or procedures), and to determine alternate procedures in such situations.

RESOURCES

BC health authority policy examples (FHA, VCH)

2.2 Management Strategies to Support Safe Resident Handling Initiatives

PROVINCIAL STANDARD

Managers at all levels of the organization demonstrate that employee safety is valued, and integrate safety into all activities and decisions related to operations, capital, and care delivery design.

RATIONALE

When managers' practices and formal decisions demonstrate that employee safety is a corporate value, employees respond by contributing to safety improvement initiatives (Goodman, 2003). Leadership practices that promote engagement, teamwork, and open communication have been shown to positively affect the safety climate of organizations for both staff and residents (Yassi, 2004; Squires et al., 2010). Together with comprehensive safety initiatives — including adequate equipment, appropriate training and coaching, and consistent support for "no manual lift" policies — these leadership practices can effectively reduce work-related injuries in health care (Nelson et al., 2006; Yassi et al., 2004; Tullar et al., 2010).

When directing the work of others, clinicians must ensure that all assigned and delegated work is safe for care providers to perform. The manager represents the employer in ensuring compliance with the Occupational Health and Safety Regulations.

KEY PRINCIPLES

Managers:

- Consistently demonstrate, acknowledge, and "role model" commitment to safe work practices related to resident handling.
- Ensure implementation and adherence to safety policies, procedures, and practices to create an overall safety culture that integrates resident and care provider safety with quality resident care.
- Practice participatory leadership with respect to safe resident handling by encouraging care provider input, and supporting and promoting the role of a multi-disciplinary peer resource team.
- Implement provincial safe resident handling standards. Using the gap analysis tools provided, the organization's current resident handling practice are assessed against the standards, and an action plan for improvement is developed. After implementation of the action plan, on-going gap analyses are conducted as needed.

CRITICAL ELEMENTS

1. Support Implementation of the provincial safe resident handling standards
    - Conduct/support safe resident handling gap analysis.
    - Develop and implement an action plan to address the identified gaps.

2. Regular Audits/Inspections
    - Support or participate in Joint Occupational Health and Safety (JOHS) committee inspections.

- Ensure systems (e.g., equipment inspections, work practice observations) are in place to identify staff educational needs, and audit processes and practices that support safe resident care.

3. Incident Reporting and Investigation
   - Ensure all staff are aware of, and follow, incident reporting processes including near-incident/hazard reports.
   - Review all incident reports.
   - Monitor and respond to injury trends.
   - Conduct investigations for all investigation-required incidents.
     - Support the inclusion of peer resource team members as part of the investigation team for resident handling injuries.
     - Identify and analyze root causes.
     - Develop and implement a preventative action plan.
     - Communicate the preventative action plan to staff.
     - Assess the effectiveness of preventative actions.

4. Communication
   - Ensure regular and timely communication with staff about safety.
   - Ensure communication systems that support safe resident care, and that are current and effective.
   - Include safety as a standing agenda item for staff meetings.
   - Use safety huddles (short informal meetings to promote timely and open communication and resolve specific safety issues and concerns).
   - Ensure methods are in place for promoting safety initiatives (e.g., peer resource team members and role).

5. Education and Training
   - Ensure access to a variety of formal and informal methods of learning (e.g., on-line learning, self-directed learning, safety huddles).
   - Create opportunities for staff to access training (e.g., dedicated time, bedside coaching, inservicing, computer access).
   - Maintain education records.

6. Effective Management Strategies for Enhancing Safe Work Culture and Practice
   - Maintain a regular manager/supervisor presence (e.g., daily walk-about) on each unit.
   - Address any unsafe work practices.
   - Include safety performance in care providers' employee performance reviews.
   - Ensure at least one of the manager's key performance indicators is related to health and safety.
   - Acknowledge staff contributions to safety.
   - Celebrate successes.

2.3 Safe Resident Handling Equipment

PROVINCIAL STANDARD

A safe resident handling program is in place to prevent injuries and ensure the safety and well being of care providers and residents. The program is multifaceted and includes appropriate and sufficient resident handling equipment.

RATIONALE

Resident handling equipment is a necessary and effective control for minimizing risk factors (force, posture) due to resident handling, including transferring and repositioning. Design solutions that include the use of resident handling equipment and supporting systems reduce the risk of injury to both care providers and residents, and improve the quality of resident care, including rehabilitation and mobilization (De Castro, 2004; Hignett, 2003; Nelson, 2004; Nelson, 2006).

By making resident handling equipment available, and integrating it into facility design, organizations will benefit the health and safety of residents, and ensure safe and positive work environments for care providers (Borden, 2010).

KEY PRINCIPLES

- Mechanical lifting devices are used to promote safe resident handling and injury reduction.
- Overhead lifts are the recommended option over floor-based lifts.
- Funding includes capital funding for the initial purchase and implementation of equipment, as well as annual operational funding for ongoing equipment-related needs (e.g., training, slings, maintenance).
- Equipment and slings are used in accordance with the manufacturer's specifications. Exceptions are permitted only if approved through the organization's risk management process.
- As designs and design solutions continue to evolve, relevant information is reviewed and considered on an ongoing basis.

CRITICAL ELEMENTS

1. Overhead Lifts and Slings (including ceiling-mounted, wall-mounted, or portable overhead lifts)
    - Coverage recommended for residential care:
        - 100% over residential care beds, as they are typically considered high risk; less coverage (70%) may be considered where high risk resident handling tasks are not performed due to population.
        - 100% coverage for active tub rooms.
        - Coverage for rehabilitation rooms.
        - Coverage for toilet rooms for new construction, and in renovation projects where feasible.

- Weight capacity that accommodates the greatest range of residents (approximately 440 lbs – 600 lbs). Systems (rails and boom) may be installed to a higher load bearing capacity than the motor. See section on bariatric capacity for additional considerations.
- Recommended design features:
    - X-Y gantry (traverse) system covering room, including bed and bathroom with pony-wall (pony wall is a lower wall used to separate rooms, see Figure 1 for illustration). The X-Y gantry offers care providers more options and flexibility for transfers and other resident handling activities, and improves the resident's opportunity for rehabilitation and timely assistance.
    - Manual traverse motor (the motor is moved manually by care provider, which is preferred by most care providers).
    - The system is capable of lifting residents from the floor (e.g., when a resident falls).
    - The system includes a portable or built-in scale for weighing residents, with a minimum of one scale per site. If there is only one scale the recommended location is in the bathing room.
    - The recommended maximum bed coverage for one system is two beds. Variations may be feasible but should be reviewed on an individual case basis.
    - Overhead lifts are installed to meet any and all applicable installation requirements, including the battery charging system.

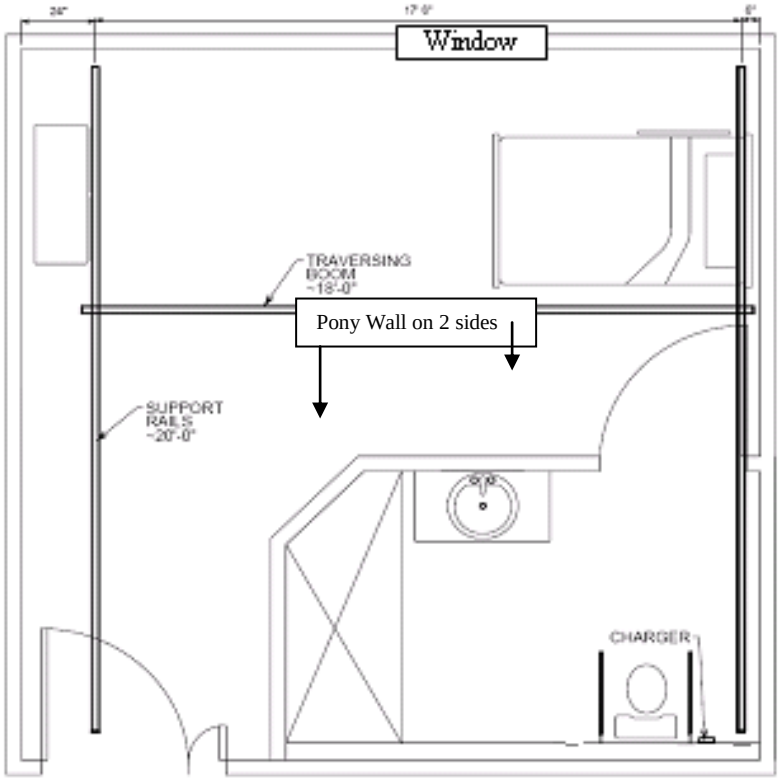


Figure 1: X-Y gantry covering a resident room and bathroom (with a "pony wall" design configuration). *Drawing courtesy of Shoppers Home Health Care.*

- As an alternative motor option, a power traverse motor may be used. This option enables care providers to move the motor and resident along the track using a handheld device.
- Alternative track design options are used only if recommended design features cannot be met, as they will limit the capabilities of the lift for resident handling activities. Alternatives include:
    - Straight or curved track configurations for small rooms in which a single track can reach all areas where resident handling and placement take place, including over the bed and locations used for transfers. A limitation of this design is that the resident needs to be directly under the track in order for the lift to be used, which may necessitate moving equipment or furniture (e.g., the bed).
    - Single tracks may be used for moving a resident from one room into another, or in combination with the X-Y gantry (e.g., for transition into bathroom)

2. Floor-Based Full-Body Lifts and Slings
    - One full body floor-based lift for each care unit or floor
    - One full body floor-based lift for every 8 to 10 non weight-bearing residents if there is no or minimal overhead lift coverage

3. Sit-to-Stand (stand assist or standing) Lifts
    - One sit-to-stand lift for each care unit or floor
    - One sit-to-stand lift for every 8 to 10 partially weight-bearing residents

4. Devices for Lateral Transfers (in order of injury risk reduction impact)
    1. Overhead lifts with positioning sling
    2. Air-assisted lateral transfer devices
    3. Friction-reducing assistive devices (e.g., slider boards, roller boards, slider sheets)

5. Devices for Lifting from the Floor (in order of injury risk reduction impact)
    1. Overhead lifts with slings
    2. Air-assisted device
    3. Full body floor-based lift

6. Beds
    - Use of electric, height-adjustable beds for reducing risk of injury to care providers.
    - Key bed features: low height (closer to floor to support falls prevention), position and ease of activation/deactivation of brakes, short side rails (no full rails), and compatibility with floor lifts.
    - Additional features that accommodate complex resident needs for transferring, repositioning, in-bed care and transporting (Nelson, 2004).

7. Bathtubs
    - In principle, side or low entry, reclinable, height-adjustable tubs are the preferred bathing equipment for residential care and should be considered when replacing tubs or building new residential facilities.

8. Bariatric Capacity Requirements (where bariatric residents are admitted)
    - Bariatric admission and care planning process in place and pathways for movement Identified.
    - A minimum of one expanded capacity / bariatric overhead lift per unit (with slings) and/or a minimum of one expanded capacity full body floor-based lift (with slings).
    - Additional equipment needs determined through assessment.
    - Room size including door widths accommodate the use of bariatric equipment, with room space for at least 3 care providers.

9. Infection Control
    - Review of, and compliance with, requirements for infection control in relation to equipment and installation.

10. Laundry Services
    - Laundering of slings and fabric assistive devices as per manufacturer's instructions.
    - Care providers are aware of required processes for accessing clean supplies and managing dirty supplies.

11. Maintenance and Preventive Maintenance:
    - Preventive maintenance program is in place.
    - Spare parts, including spare motor(s), are available.
    - Equipment is operational and in good working order.
    - Care providers are aware of processes for reporting repair issues.

12. Slings
    - Types and quantities of slings available match resident requirements.

13. Space/Layout
    - Resident rooms and/or toilet rooms have adequate space for use (including a sufficient turning radius) by one or more care providers.
    - Bathing room and hallways have adequate space.
    - If bariatric residents are admitted, bariatric equipment with appropriate weight capacities is required with adequate space and layout for care providers to use the equipment (Bordon, 2010).

14. Storage
    - Storage locations for equipment are easily accessible by care providers.
    - Adequate storage space for:
        - Unit storage for resident handling equipment: Consider a central dedicated space. Storage requirements may also include an electric supply for charging batteries and additional space for storing extra batteries.
        - Unit storage for slings and other assistive devices: Consider a central dedicated space with shelving or hooks.
        - In-room storage for resident slings (dedicated use).
        - Infrequently used equipment: An equipment bank located on or off the unit is useful for storing infrequently used equipment, such as bariatric equipment and extra floor-based lifts. An electric supply for charging batteries may be required.

15. Training
    - Care providers receive initial education and training on the proper use of resident handling equipment.
    - Ongoing education and training are provided to enable care providers to achieve proficiency and comfort with equipment use (refer to Education and Training standard).

16. Other Devices for Consideration (not specified in this standard)
    - Additional equipment needs, to be identified using a risk assessment process (see WorkSafeBC Risk Assessment Resources for more information).
    - Compatibility of equipment with other devices.

Key statements in the above section are adapted from US VHA, 2003 and Collins, 2006.

2.4 Education and Training

PROVINCIAL STANDARD

All care providers receive safe resident handling education and training on initial hire and as required (e.g., new position), to reduce injury risks associated with resident handling tasks and support quality care. The organization maintains a system to document training records.

RATIONALE

Training and education are key requirements for promoting a continued culture of safety, and go hand-in-hand with the provision of appropriate equipment for safe resident handling. The importance of reducing MSIs associated with resident handling makes training caregivers in risk assessments and the use of safe resident handling equipment a high priority (Collins, 2004, Hignett 2003, Hinton 2010, Nelson 2006, Nelson 2007). Sharing these safety practices and policies with families and residents also promotes resident-centred care.

A blended approach to training and education delivery will improve access to training opportunities, provide content consistency, and support different learning styles (Pulichino, 2006, eLearnity, 2001). See Appendix A for more information on blended learning. This approach maximizes training opportunities and key learning moments, which provide the right information at the right time (Clark & Conrad, 2008).

The British Columbia Occupational Health and Safety Regulation requires that staff who may be at risk of MSI be orientated and trained, and that a system be in place to track training attendance. As supported by research evidence and WorkSafeBC, new leaders should also be trained in how to implement and support a sustainable safety culture for both staff and residents (Collins, 2004).

KEY PRINCIPLES

- Care provider knowledge and learning promote the engagement of care providers in safety systems and processes.
- Blended training opportunities mix ‘formal’ delivery approaches such as classroom or self-paced learning (e-learning) with informal learning (safety huddles, return demonstrations, coaching).
- The transfer of knowledge to practice is supported by a variety of methods such as audits, supervision, return demonstrations, coaching, resources, and online tools.
- Residents and their families receive safety awareness education related to resident handling.
- Ongoing learning opportunities for all staff are identified by reviewing injury trends, accident investigations, audits of current work practices, and the implementation of new equipment.

CRITICAL ELEMENTS

1. Determining Site's Education and Training Needs
   The site's education and training needs are determined through:
   - Monitoring of injury trends, including:
     - Incident investigation reviews.
     - Safety huddle action reviews.
   - Gaps identified from audits (job observation and care plan / chart audits).
   - Promotion of "self-check" tools (care providers can independently monitor their own performance to identify knowledge gaps and learning needs).

2. Site Education and Training
   Includes:
   - The opportunity for new employee orientation.
   - The opportunity for training when new equipment or procedures are introduced.
   - Access to a variety of learning methods (e.g., on-line learning and resources, adequate computer access).
   - Informing staff of ongoing training and education opportunities (e.g., in-person, on-line, and coaching).
   - Opportunities for staff to access training (e.g., dedicated time, bedside coaching with peer resource).
   - Systems in place to support the transfer of knowledge to practice:
     - Staff access to peer resource team members to demonstrate learned skills (return demonstration) and to seek coaching.
     - Access to on-line resources such as safe work procedures and video demonstrations.
     - Regular peer resource team task observations and the application of coaching strategies as required.
   - Education records maintained and monitored.
   - Safety awareness education for residents and their families upon admission and when new equipment is introduced.

3. Peer Resource Team
   - There is an opportunity for the delivery and/or support of site education and training requirements.
   - There are regularly (e.g., monthly) scheduled meetings to prioritize and plan education initiatives.

4. Management Education to Enhance Safe Work Culture and Practice
   This includes:
   - Understanding safety systems, inspections, investigations and audits.
   - Leadership skill development.

RESOURCES

Health authority internal websites for safe resident handling e-learning, safe work procedures, videos, quizzes, self-check tools, and equipment operation instructions.

WorkSafeBC publication: 3 Steps to Effective Worker Education and Training
http://www.worksafebc.com/publications/health_and_safety/by_topic/assets/pdf/3-steps.pdf

2.5 Safe Work Practice Standards

This section outlines provincial safe work practice standards for six high risk resident handling activities, as follows:

Subsection Number	Safe Work Practice Standard
2.5.1	Transfers and Ambulation
2.5.2	Bed Care / Repositioning
2.5.3	Positioning Seated Residents
2.5.4	Resident Toileting
2.5.5	Resident Bathing
2.5.6	Resident Dressing

For all six of the safe work practice standards, there is one common set of critical elements that applies, as outlined below. Although each element (e.g., care planning) is described separately, the eight critical elements should be seen as a set of inter-related requirements. In each of the individual safe work practice standards, you will also find further information relating to the critical elements, as they relate to the specific resident handling activity (e.g., bathing, dressing) being addressed.

COMMON CRITICAL ELEMENTS (FOR ALL SAFE WORK PRACTICE STANDARDS)

1. Care Planning
    - A comprehensive system of care planning is in place including:
        - Initial resident assessment upon admission to determine the most appropriate resident handling methods and equipment, and incorporating resident preferences when appropriate.
        - A plan for ongoing reassessment of residents' status changes (e.g., skin checks, falls prevention) every three to six months.

2. Documentation and Communication
    - Assessment and reassessment outcomes are clearly documented and accessible to care providers at the point of care (e.g., bedside plan / ADL, care plan / Kardex).
    - Documentation of resident handling information includes the resident handling methods, level of assistance by care provider(s), and equipment required, including type of sling and size.
    - A process is in place for updating the functional care plan after reassessment, and communicating any change in status (e.g., communication book, report, safety huddle).

3. Point of Care (POC) Risk Assessment
    - Before performing a resident care task, the care provider completes a POC risk assessment to determine whether the prescribed task is safe to do at that time, in that environment, and with the identified equipment.
    - If the POC assessment indicates a change in resident status, then the care provider decides not to proceed or selects a more conservative method of transfer. An interim care plan is documented and a request for a reassessment is documented and communicated to all care providers.

- See Appendix D for more information on POC assessment.

4. Regular Audits/Inspections
   - Care Planning: Regular audits ensure that care plans are current and accurately reflect the care needs of the resident; care providers are following the plans; and communications systems are in place to reflect immediate changes.
   - Staff Competency: Regular staff audits of resident handling equipment operation are conducted to establish training and educational needs. (In order to maximize the benefits of resident handling technologies and the safety of both staff and residents, the devices need to be used properly.)

5. Education and Training
   - Educational opportunities, through various methods, cover the most effective use of resident handling equipment and safe positioning of the care provider.
   - Training is provided to all care providers on the importance of conducting POC risk assessments to alert them to changes in residents' status.
   - Safe resident handling education materials are provided to families and residents upon admission and upon changes in status, with information on the utilization of safe resident handling equipment and supporting tools in care plans to provide safe resident care.
   - Care provider educational opportunities address the process of reviewing documentation and the importance of documenting and communicating care practices.

6. Safe Work Procedures
   - Safe work procedures are in place and explain the steps to safely use resident handling equipment and safe work steps when performing care tasks.
   - Staff are aware of the safe work procedures.

7. Safe Resident Handling Equipment
   - All equipment is readily accessible and in good working order.
   - Equipment is selected to reflect the resident's function and fit (e.g., size).

8. Management Strategies to Support Safe Resident Handling
   - Managers and supervisors work with care staff to establish systems for staff and resident safety, including completion of assessments, documentation and communication of findings, and timely updates based on reassessments.
   - Managers understand the risk factors associated with these tasks and provide tools to eliminate or reduce these risks.

2.5.1 Resident Transfers and Ambulation

This standard is intended to guide decisions about transfers and ambulation related to the daily activities of providing care, and is not intended to restrict activities for the purpose of rehabilitation therapy.

PROVINCIAL STANDARD

- An initial assessment of the resident is conducted to determine the most appropriate methods for transferring and ambulating. A decision support tool is used to guide decision making as part of the assessment process (see Appendix B for a sample).
- Mechanical resident handling equipment is used for residents who need more than minimal assistance from care providers (see Appendix C for a list of examples).
- Methods for care providers to use for transferring and ambulating residents are documented in an accessible location for care providers.
- Care providers are aware of what to do if a resident's status changes (see Appendix D for sample).
- "Minimal assistance" means providing directing, cueing, encouragement, guiding or steadying assistance to the resident to mobilize safely. The resident is highly involved in the activity but may require the care provider to exert minimal effort (no more than 16 kg of force) to guide, steady, support or use aides effectively.

RATIONALE

Mechanical resident handling equipment should be used if more than minimal assistance is required by care providers in order to mobilize a resident (Village, 2005). Safe resident handling programs, including regular assessment of residents' abilities, improve care provider safety and contribute to quality resident care. Benefits include fewer adverse events (e.g., resident falls), improved comfort during transfers and care activities, and the encouragement of resident participation in care activities (Haney et al., 2007; Nelson & Baptiste, 2004).

The maximum recommended weight limit for resident handling (derived from National Institute for Occupational Safety and Health (NIOSH) guidelines) is 16 kg or 35 lbs under ideal circumstances. In less than ideal circumstances, the maximum is lower and can be reached when providing minimal assistance in a residential care setting (Waters, 2007). If it is likely that more than minimal assistance will be required during any aspect of transferring and ambulation, then the provincial safe resident handling standard requires the use of mechanical resident handling equipment.

Research evidence regarding the effectiveness of transfer/walking/gait belts is currently inconclusive. Guidelines for the use of these devices can be developed by individual Health Authorities.

KEY PRINCIPLES

- A comprehensive system of care planning is in place and includes processes for initial and ongoing assessment of residents for transfers and ambulation, for flagging changes, and for documenting and communicating outcomes.
- A support tool is used to guide decision making about resident transfers and ambulation. The tool does not override clinical judgment and specific resident needs as determined by the care team. (The use of this tool constitutes a risk assessment.)
- Complex transfer and ambulation assessments are referred to rehabilitation personnel. An interim safe plan of care is established (e.g., bed care only, use of mechanical lift for transfer).
- A variety of mechanical and non-mechanical resident handling equipment is available, allowing for a graded approach to resident mobilization (see Appendix C for a list of resident handling equipment examples).
- Resident handling equipment is used in accordance with the manufacturer's specifications. Exceptions are permitted only if approved through the organization's risk management process.

CRITICAL ELEMENTS

1. Care Planning
    - A comprehensive system of care planning is in place, including:
        - Initial assessment of the resident for transfers and ambulation, using a mobility decision support tool (see Appendix B).
        - A plan for ongoing monitoring of resident needs for transfers and ambulation and their impacts (e.g., skin checks, falls prevention).
        - Written documentation and communication of findings.

2. Documentation and Communication
    - The assessment outcomes are clearly documented, communicated and made accessible for care providers at the point of care (e.g., bedside plan / ADL, care plan / Kardex).
    - Documented information includes resident transfer and ambulation status (i.e., method/type of transferring and ambulation), level of caregiver assistance needed, equipment required, and sling type and size.

3. Point of Care (POC) Risk Assessment
    - Before and during resident transfer and ambulation, the care provider completes a point of care risk assessment (see Appendix D) to confirm that the documented transfer/ambulation is safe to do at that time.
    - If it is determined that the usual level of mobilization is not possible and/or the resident's status indicates the need for reassessment, an interim safe plan of care is determined and communicated to all care providers working with the resident.

4. Regular Audits/Inspections
    - See Common Critical Elements for Safe Work Practices, on page 24.

5. Education and Training
    - Educational opportunities are provided through various methods, covering:
        - The transfer and ambulation assessment processes, including mobility decision support tools and the completion of point of care risk assessments.
        - The use of equipment and minimal-assistance techniques based on safe work procedures, as well as instruction on safe positioning of the care provider.
    - Safe resident handling education materials are provided to families and residents on admission and upon changes, with information on how safe resident handling equipment and supporting tools may be utilized in care plans to provide safe resident care.

6. Safe Work Procedures
    - See Common Critical Elements for Safe Work Practices, on page 24.

7. Safe Resident Handling Equipment
    - See Common Critical Elements for Safe Work Practices, on page 24.

2.5.2 Bed Care / Repositioning

PROVINCIAL STANDARD

All residents are assessed for bed mobility and ability to participate in care, and to determine the level of assistance and equipment required for repositioning and/or bed care.

A ceiling lift, in combination with safe positioning of the care provider, is used to reposition residents who need more than minimal assistance to turn, maintain side-lying, boost up in bed, or lift limbs during bed care. Soaker pads, in combination with regular bottom sheets, are not to be used for repositioning residents in bed.

"Minimal assistance" is defined as directing, cueing, encouraging, or guiding the resident during repositioning. Care providers may exert minimal effort to help residents roll onto one side, maintain side lying or boost up in bed.

RATIONALE

Repeated and prolonged bending throughout a shift, and single "heavy" events such as a resident boost, turn, or transfer, are strongly correlated with low back injury in care providers (Village, 2005). Pompeii (2009) reports that 60% of care provider injuries result from bed care tasks, such as turning or pulling pants up, that often involve extreme and prolonged postures. Resident handling equipment is considered to be an effective engineering control for minimizing these risk factors, by reducing the peak and cumulative forces and postures associated with high risk resident handling tasks (Nelson, 2003; Nelson 2004).

The maximum recommended weight for resident handling, derived from National Institute for Occupational Safety and Health lifting guidelines, is 16 kg (35 lbs) under ideal circumstances. In less than ideal circumstances (e.g., while lifting with one hand or in a restricted space), the recommended maximum weight is lower (Waters, 2007), and can be reached while providing minimal assistance in a residential care setting. When repositioning tasks require more than minimal assistance, ceiling lifts are considered to be the most effective engineering controls for reducing the risk of injury (WorkSafeBC, 2006). If ceiling lifts are not available, then friction-reducing assistive devices are to be used in order to reduce the risks to care providers when repositioning residents.

KEY PRINCIPLES

- A comprehensive system of care planning is in place, including processes for initial and ongoing bed mobility assessment, flagging of changes, and communication and documentation of outcomes.
- A support tool is used to guide decision making about resident repositioning. The tool does not override clinical judgment or resident-specific needs as determined by the care team.
- When an assessment indicates that a mechanical lift is required, the repositioning sling is to remain under the resident at all times, except in individual cases for which the care team determines otherwise.
- Mesh repositioning slings are the sling of choice on specialty mattresses.
- Care plans include skin checks.
- Beds with adjustable features (e.g., trendelenburg feature) facilitate the resident's ability to participate in positioning themselves in bed.
- Assistive devices are used to hold/support the resident's limb(s) during care tasks.

- Safe work procedures — e.g., raising the bed height and/or moving along the side of the bed to avoid twisting and reaching — are in place to ensure safe body positioning when providing care either manually or with a mechanical lift.

CRITICAL ELEMENTS

1. Care Planning

   A comprehensive care planning system is in place, including assessment. Each resident is assessed for bed mobility, to determine the most appropriate positioning method and equipment, at the following times:
   - Admission: assess status using a decision support tool.
   - Point of care (POC): before performing resident care, the care provider completes a POC risk assessment to determine if the task is safe to do at that time.
   - Reassessment of resident status:
     i. When there is a change in status.
     ii. Every 3 to 6 months.

2. Documentation and Communication
   - Resident's positioning status must be documented in the following areas:
     i. At the point of care (e.g., functional care plan, ADL, etc.).
     ii. Kardex.
   - Documentation includes:
     i. Level of assistance required by care provider(s).
     ii. Equipment required (positioning sling, slider sheets, etc.).
     iii. Any instructions specific to a resident care task (e.g., band sling for heel dressing change).
   - When a resident's positioning status is formally reassessed:
     i. A system is in place to ensure that Kardex and "point of care" (e.g., ADL) documentation is updated.
     ii. A process is in place to communicate any change in status (e.g., communication book, report).

3. Point of Care (POC) Risk Assessment
   - For POC assessments that determine a change in resident status:
     i. An interim care plan is established and communicated to care providers.
     ii. A process is in place to request reassessment.

4. Regular Audits/Inspections
    - See Common Critical Elements for Safe Work Practices, on page 24.

5. Education and Training
    - Care providers are have educational opportunities, through various methods, relating to mobility assessment and repositioning / bed care equipment, including:
        - Mobility decision support tool
        - Point of care risk assessment
        - Repositioning sling
        - Slider sheet components
        - Other repositioning tools (e.g., Band slings)
    - Staff are informed of the WorkSafeBC Bulletin “Soaker pads are not for repositioning.”
6. Safe Work Procedures
    - The safe work procedures explain the steps to safely use resident handling equipment when performing care tasks. Safe work procedures are developed and staff are aware of them. The following are addressed:
        - Sling application
            - Repositioning sling
            - Band sling
            - Roller bands
            - Other, e.g., advanced uses of Universal/transfer sling
        - Mechanical equipment operation
            - Ceiling track lift
            - Total Floor Lift
        - Friction reducing devices
            - Air-assisted lateral transfer device
            - Slider sheet components
            - Other, e.g., slider tubes, gel tubes
        - Other
            - Facility specific equipment, e.g., Second Hand Band

7. Safe Resident Handling Equipment
    - See Common Critical Elements for Safe Work Practices, on page 24.

RESOURCES

WorkSafeBC Bulletin “Soaker pads are not for repositioning”
http://www2.worksafebc.com/i/posters/2009/WS%2009_01.html

2.5.3 Positioning Seated Residents

PROVINCIAL STANDARD

Optimal seating and initial positioning can reduce the need to reposition residents in chairs, and are part of a comprehensive care plan for residents with complex seating needs.

- Mechanical lifts or other assistive devices are used to reposition residents in chairs when the resident requires more than minimal assistance to lean forward.
- "Minimal Assistance" is defined as providing direction, cueing, and light assistance to aid the resident as the resident actively lift limbs and leans forward for sling placement and removal, as well as to sit back in a chair.
- Sling placement is based on assessment by the care team. If no resident contraindications or considerations exist, slings are left in place to reduce risk of care provider injury.

RATIONALE

Care providers are at increased risk of musculoskeletal injury when they are using more than minimal assistance to reposition a resident in a wheelchair. Residents with complex seating needs may also be at increased risk for skin breakdown related to sling placement. Wheelchair seating care planning should balance these risks and reduce the risk of injury for both residents and care providers, through optimal seating that minimizes the need for frequent repositioning.

If residents need moderate to maximal assistance in order to lean forward for sling removal, care providers are encouraged to leave the sling in place unless contraindicated. Doing so will reduce risk of injury to staff. The sling and lift can then also be used to safely reposition residents in wheelchairs. Repositioning with a mechanical lift or with other assistive device is the safest method to reduce the force or awkward positions that can cause injuries.

KEY PRINCIPLES

- Comprehensive assessment and care planning balance the risks to care providers and residents.
- Optimal seating set-up reduces the need to reposition, thus reducing injury risk.
- Care teams apply a consistent practice for sling placement. The care plan clearly indicates when slings are to be removed or to remain.
- Leaving slings in place can reduce staff injury when resident safety and care is not compromised. This can also facilitate using ceiling lifts to reposition a dependent resident in a wheelchair.
- Other assistive devices are also available to maintain optimal seating and/or to aid repositioning.

CRITICAL ELEMENTS

1. Care Planning
   - Each resident's seating needs and ability to reposition in a wheelchair are assessed, including.
     - Contraindications and consideration for sling placement included but are not limited to: skin integrity, ease of sling removal, resident preferences and comfort, and the sling's impact on seating and repositioning.
     - The care team is involved in the assessment.
     - Consistent decision-making processes are applied to assessment findings. See Appendix E for a sample sling removal decisions support tool.

2. Documentation and Communication
   - See Common Critical Elements for Safe Work Practices, on page 24.

3. Point of Care (POC) Risk Assessment
   - See Common Critical Elements for Safe Work Practices, on page 24.

4. Regular Audits/Inspections
   - See Common Critical Elements for Safe Work Practices, on page 24.

5. Education and Training
   - Educational opportunities are provided, through various methods, on:
     - The use of equipment when providing repositioning assistance, including instruction on assistive seated repositioning devices, wheelchair adjustment features and operation, and safe body positioning of the care provider when providing care to seated residents.
     - Decision-making process for sling placement and removal.
   - Upon admission or change in resident status, families and residents are provided with educational materials regarding seated positioning and sling placement while seated.

6. Safe Work Procedures
   - See Common Critical Elements for Safe Work Practices, on page 24.

7. Equipment
   - Mechanical lifts and slings
   - Tilt features of chair
   - Anti-slip or one way glides

RESOURCES

Tips to Reposition in Chair (FHA)

2.5.4 Resident Toileting

PROVINCIAL STANDARD

A toileting protocol is part of the resident care plan. It is based on a comprehensive assessment that considers toileting risks and the resident's abilities, and requires that care providers determine the appropriate resident transfer method and equipment. It outlines a person-centered toileting routine that is safe for both the resident and the care provider. It optimizes resident function and comfort, and considers the resident's personal toileting preferences.

RATIONALE

Care providers can be exposed to MSI risk factors such as awkward postures and excessive force while providing toileting care. Some of the reasons for this are:

- Clothing can be difficult to remove or put on during toileting. Inappropriate clothing can also result in bedpan toileting of continent dependent residents, and is one of the most common barriers to providing a more dignified, "normal" toileting routine for residents (Morgan, 2010).
- Equipment and supplies that are not readily available, or not appropriate for the resident, can delay toileting routines. This can increase a resident's protective responses and levels of agitation (OHSAH, 2003; WorkSafeBC, 2010).
- Ineffective toileting schedules and toileting urgency can cause care providers and residents to rush the transfer to the toilet, which can prevent a safe set-up, assistance, or point of care risk assessment.
- A toileting environment that is small, wet, cluttered or that lacks assistive devices such as grab bars or raised toilet seats, does not optimize the resident's ability to participate in the process, and increases the amount of physical assistance required from the care provider.
- Care providers often perform multiple functional toileting tasks at the same time. For example, a caregiver may manually assist a resident to stand while simultaneously trying to adjust clothes and pads, and cleanse (OHSAH, 2003).

With effective care planning, these risk factors can be eliminated or reduced (Borden, 2010).

KEY PRINCIPLES

- The number of maneuvers and exertions for care providers and residents is reduced by choosing clothing that is easy to put on and take off, and selecting appropriate assistive devices and equipment.
- Toileting routines are scheduled and pre-planned to reduce rushing and urgency.
- Environmental risks are considered, either by removing barriers or choosing safer toileting options, such as transferring to a commode in a more open space covered by a ceiling lift.
- Enough care providers are present to ensure care providers do not have to perform more than one functional toileting task at a time.

CRITICAL ELEMENTS

1. Care Planning
   - Assessment of resident's functional abilities:

Transfer method:	The most appropriate method to transfer onto and off toileting equipment is determined. This method is evaluated in the actual toileting environment under regular care circumstances to ensure the toileting protocol and time allocated to the resident and care provider are realistic.
Standing endurance:	The resident's ability to safely and consistently stand for the time needed to assist with hygiene and dressing is assessed. If a caregiver needs to manually assist in order to maintain resident standing while care is being provided, a second caregiver assists with hygiene and dressing.
Sitting balance and endurance:	The resident's ability to sit safely on the toileting surface, and to handle balance perturbations caused by wiping self and attending to personal hygiene, is assessed. The resident's sitting endurance (i.e., whether the resident can sit comfortably and safely for 10/15/20 minutes) is determined.

   - Clothing that is easy to remove and re-dress for toileting care is considered. This may entail larger sizing or modified clothing which is loose and easy to unfasten or remove. This can also promote safe independent toileting for the resident.
   - The resident is approached according to their schedule to prevent rushing unsafely. The resident is not left on the toilet for extended periods, in order to prevent anxiety and promote comfort and safety when on the toilet. This should reflect the resident's predetermined sitting endurance.

2. Documentation and Communication
   - The assessment and reassessment outcomes are clearly documented and accessible for care providers at the point of care. Examples of where this information should be documented include the bedside plan / ADL, and care plan / Kardex.
   - Documentation includes:
     - Resident mobility status (i.e., the method/type of transferring and ambulation to the toilet).
     - The level of assistance and method used by care provider(s) to provide toileting care.
     - Specific toileting equipment, if required, and sling type and size.
     - Additional toilet care planning needs such as toileting schedule, continence products, etc.
   - For reassessment of resident toileting care, the functional care plan (e.g., ADL, bedside care plan) is updated and a process is in place to communicate the change in status (e.g., communication book, report, safety huddle).

3. Point of Care (POC) Risk Assessment
   - If there is a change in resident toileting or mobility function identified upon POC assessment:
     - An interim care plan is established and communicated to care providers
     - A process is in place to request a reassessment

4. Regular Audits/Inspections
   - See Common Critical Elements for Safe Work Practices, on page 24.

5. Education and Training
   - Educational opportunities are provided to care providers, through various methods, on:
     - The use of equipment when providing toileting care, and minimal assistance techniques, including instruction on toileting procedures and safe body position for the care provider when providing peri-care, dressing, and transferring to and from the toilet/commode.
     - Decision support tools.
   - Upon admission or change in resident status, families and residents are provided with educational materials to regarding tools to optimize toileting care, including clothing choices and resident transfer equipment.

6. Safe Work Procedures
   - Safe work procedures are integrated into clinical practice documents for toileting care, including:
     - Use of toileting transfer equipment or minimal assistance transfer techniques.
     - Safe body position for the care provider when providing peri-care and dressing.
     - Optimal method to access peri-area in sitting, that will increase resident independence and reduce awkward postures for care providers. See Appendix F for examples of methods.
   - Repositioning slings, limb holding slings, roller bands, etc., are used to position residents when providing toileting care in bed (see Bed Care / Repositioning standard).
   - Hygiene sling are used to increase access for personal care / dressing (only after appropriate assessment and safe work procedures have been followed).
   - Transfer/Universal sling is used, in combination with adaptive clothing, for toileting.

7. Toileting Equipment

Toilet Seats:	Stable toilet seat bars facilitate sitting and standing from toilet. A toilet seat with front opening can facilitate peri-access.
Ceiling Lifts:	Toilets with ceiling tracks overhead are optimal. If the ceiling track does not reach the toilet, a ceiling lift at the bedside can be used for a commode transfer.
Floor Lifts:	Total floor lifts can be used in the absence of a ceiling lift. If bathrooms are small, a transfer onto a commode where more room is available can be considered.
Sitting Position:	Residents are not left unattended slung up in lifting device while toileting. A stable sitting surface with feet supported is a more effective voiding position.

Commodes:	Adequate supply of commodes of various sizes and styles with foot rests is available. The fit of commodes over toilets is confirmed when designing bathroom space or buying commodes.
Handheld Sprayer:	A personal use, portable warm water sprayer or “washlet” can facilitate independent cleansing after voiding.

8. Toileting Environment
   - Clutter and physical barriers are removed to create as much space around the toilet as possible.
   - Floors and surfaces are dry and non-slip, and spills are attended to in a timely manner.
   - Grab bars are used to increase standing balance while dressing/undressing and to aid transfers.
   - Call bells are within reach.

RESOURCES

Continence Promotion and Maintenance. September 2009. (VCH, Clinical Practice Document: Accessed on VCH Intranet)

2.5.5 Resident Bathing

PROVINCIAL STANDARD

A bathing protocol is part of the resident care plan. It is based on a comprehensive assessment that considers the resident's abilities and bathing risks, and requires care providers to determine the appropriate resident transfer method and equipment to complete the bathing routine safely. The bathing protocol outlines a person-centered bathing routine that is safe for both the resident and care provider. It optimizes resident function and comfort, and considers the resident's personal bathing preferences.

RATIONALE

Pushing, pulling, and lifting limbs while providing bathing care can expose care providers to MSI risk factors such as awkward postures, and excessive force and cumulative work load. Some of the reasons for this are:

Resident bathing discomfort:	Bathing can be an uncomfortable experience for the resident due to reduced dignity, discomfort, anxiety, and poor temperature control. Tone can increase and care providers will often rush to complete bathing care. This can lead to further increases in tone and protective responses by residents (OHSAH, 2003).
Complex process:	One bathing event require multiple resident transfers, turns, limb holding and repositioning (Holmes, 2010).
Equipment:	Exertion and awkward postures often result from manually pushing and pulling bath stretchers, maneuvering floor lifts to transfer residents onto bathing equipment, and a lack of assistive devices.
Environment:	Bathing rooms carry the risk of being wet and cluttered. Space also becomes confined when bathing equipment, wheelchairs and multiple care providers are present.

With effective care planning, these risk factors can be eliminated or reduced (Borden, 2010).

KEY PRINCIPLES

- Resident comfort is optimized by reducing the amount of turning, pushing, pulling, transferring or manual handling of residents during bathing. This can improve the safety of residents and care providers by decreasing resident tone and protective responses.
- The bathing process is simplified by minimizing transfers, choosing clothing that is easy to put on and take off, and using an efficient sequence in the bathing routine. This can reduce the risk exposure for care providers who complete this task multiple times during a shift.
- Suitable bathing equipment, such as ceiling lifts, height adjustable bathing equipment, and resident-appropriate tubs, is used. This can greatly reduce force exertion and awkward postures.
- Work environments are optimized to reduce risk factors associated with unfavorable conditions, such as wet, cluttered and confined spaces.

CRITICAL ELEMENTS

1. Care Planning
   Residents' functional abilities are assessed:
   - The most appropriate methods to transfer on and off bathing equipment, and to and from the bathing room, are determined. The methods are evaluated in the actual bathing space under regular care circumstances, to ensure the bathing protocol and time allocated are realistic.
   - The resident's drying and dressing functional abilities and needs are assessed, and the most efficient resident position to dry and dress is considered, taking into account the care provider body position, resident comfort, and how best to eliminate or reduce rolling and repositioning to dry and dress.
   - Clothing that is easy to remove and put on during bathing care is considered. Care friendly clothing choices can reduce or eliminate the need to reposition or roll the resident, allowing for flexibility in dressing location.
   - Enough time is allocated for both the resident and care provider to complete the bathing routine.

2. Documentation and Communication
   - The assessment and reassessment outcomes are clearly documented and accessible for care providers at the point of care. Examples of where this information should be documented include the bedside plan / ADL, and care plan / Kardex.
   - Documentation should include:
     - Method for transferring the resident to the bathing equipment.
     - Level of assistance and method used by the care provider(s) to provide bathing care.
     - Specific bathing equipment used, and details of set-up specific to resident needs.
   - Upon reassessment of resident bathing care, the functional care plan (e.g., ADL, bedside care plan, etc.) is updated. A process is in place to communicate the change in status (e.g., communication book, report, safety huddle).

3. Point of Care (POC) Risk Assessment
   - If a change in resident bathing function is identified upon POC assessment:
     - An interim care plan is established and communicated to care providers.
     - A process is in place to request reassessment.

4. Regular Audits/Inspections
   - See Common Critical Elements for Safe Work Practices, on page 24.

5. Education and Training
   - Care providers are given educational opportunities, through various methods, regarding:
     - Safe body positions during bathing, and cues for care providers to use equipment features, such as height adjustability, to reduce trunk forward bending and twisting.
     - The correct use of bathing equipment features designed to improve care and safety. For example, how to adjust the shower chair head support for resident comfort and to reduce head-holding during bathing.
   - Upon admission or change in resident status, families and residents are provided with educational materials regarding tools to optimize bathing care, including resident equipment and clothing choices.

6. Safe Work Procedures
   - Safe work procedures are integrated into clinical practice documents for bathing care, including:
     - Bathing equipment use or minimal assistance transfer techniques.
     - Safe body position for the care provider when providing washing, drying, and dressing care.
   - Bathing care steps are clearly outlined. For example, there is clarification of the order of linens/sling to lay down for drying in order to reduce repositioning, and of the need for the bed to be at a safe working height before starting.
   - Ceiling lifts and slings are used to turn residents when removing excess linens or wet slings from under dependent residents before or after a bathing transfer, in order to minimize forceful, excessive pulling.

7. Bathing Equipment

Tubs:	Side or low entry, recline-able, and height adjustable tubs (the preferred bathing equipment for residential care) are considered if replacing tubs, or in new residential builds.
Shower:	Shower equipment is height adjustable with tilt/recline options that provide optimal access for peri-care. Supportive and comfortable shower seating that accommodates a large variety of resident functional abilities is used to improve the comfort of residents. If a trolley or bathing stretcher is used, push/pull forces are reduced through the use of a power drive feature.
Slings:	Mesh or quilted slings (which absorb less water than padded slings) are used during bathing. Assessment for sling-appropriateness should consider the residents' skin integrity and functional ability, and optimal fit. Hygiene slings are used only after appropriate assessment has been completed and safe work procedures have been followed. Limb holding slings are used when a limb needs to be lifted for bathing.

Supportive Devices:	Assessment includes appropriate equipment selection and positioning of the resident in the tub or shower. This may include supportive seating, bolsters, or padding to maintain a comfortable and safe bathing position.
Washing devices:	Assessment considers additional tools and processes to aid in ease of washing, including: temperature control to reduce tone or agitation, shower nozzles to access hard-to-reach areas, and water spray controls that allow care providers to get close to the resident without getting wet. Optimal control of spay can also reduce slipping hazards in wet bathing areas.
Protective care provider clothing:	Protective clothing is used to keep the care provider dry during the bathing process, and allow care providers to get close to the resident without getting wet.

8. Bathing Environment
    - Clutter and physical barriers on the path to and from the resident's room are removed. Clutter inside the bathing room is minimized, and adequate space in the bathing room is ensured.
    - Wet floors outside the bathing area (i.e., in the resident's room or hallway) are dried in a timely manner.
    - Anti-slip devices are used in wet rooms.
    - Supporting aids are installed to support residents (e.g., grab bars and call bells are within reach).
    - A ceiling lift is a priority for residents being mechanically transferred to bathing equipment at the bedside. This will reduce awkward pushing and pulling of floor lifts and bathing equipment, especially in confined spaces.
    - Bathing room change-tables are covered by a ceiling lift, to increase dressing and drying options and reduce manual turning. Completing the bathing process in the same room can improve resident privacy and bathing efficiency, providing more time for quality care.

RESOURCES

Banfield Pavilion Criteria for Bathing Equipment, 2010 (VCH)
Patient Handling Procedure: Cushioning Options to Meet Resident Needs (IHA)
Patient Handling Procedure: Parker Tub Quick Guide Options to Prevent Residents from Slipping Forward (IHA)
Residential Shower Trolley Bathing Procedure Draft, 2011 (VCH)

2.5.6 Resident Dressing

PROVINCIAL STANDARD

The dressing needs of the resident are assessed to develop a dressing care plan and to determine when more functional clothing is required.

RATIONALE

Alternate clothing choices are indicated for residents requiring dressing assistance due to limited functional abilities, pain on limb movement, or sensitivity during dressing assistance. For residents, this minimizes awkward joint movements, pain, and discomfort. For care providers, this minimizes awkward postures and forceful exertions when handling residents.

Care planning should address the optimal body position for care providers to use while assisting with dressing. If the environment is obstruction-free and allows for proper height adjustability, the care provider will be able to position themselves in line with, and at the same height as, the care being provided. This will reduce excessive trunk bending, side bending, and twisting, which are known to be significant risk factors for musculoskeletal injuries in care providers (Village, 2005; Holmes, 2010; Nelson, 2003; Zhuang, 1999; Jang, 2007).

KEY PRINCIPLES

- Dressing care planning is completed to specify clothing adaptations and donning/doffing methods and set-up that will:
    - Improve comfort for residents during dressing.
    - Increase options for toileting and bathing by providing easier access for care.
    - Reduce the risk of musculoskeletal injury to caregivers while providing care.
- Caregivers use safe body positioning when providing care with or without a ceiling track lift (e.g., raise bed height to minimize stooping, and move along the side of the bed instead of twisting and reaching).
- If alternative clothing is indicated, further assessment is conducted to determine the type of clothing needed.

CRITICAL ELEMENTS

1. Care Planning

- A comprehensive system of care planning is in place and includes the initial assessment and periodic reassessment of the resident's dressing needs. The need for reassessment is identified using a criteria algorithm/list. See Appendix G for an example of dressing reassessment criteria.

2. Documentation and Communication

- See Common Critical Elements for Safe Work Practices, on page 24.

3. Point of Care (POC) Risk Assessment

- Observations of the resident during the point of care risk assessment may identify the need for a dressing reassessment.

4. Regular Audits/Inspections

- If audits identify that alternative clothing is required, a process must be in place to identify how the clothing will be obtained.

5. Education and Training

- Educational opportunities are provided to care providers, through various methods, on the most effective use of resident handling equipment and supportive equipment, in combination with safe positioning of the care provider, while providing dressing assistance.
- Upon admission or change in resident status, families and residents are provided with educational materials regarding care, including a variety of clothing options.

6. Safe Work Procedures

- See Common Critical Elements for Safe Work Practices, on page 24.

7. Equipment

- Safe work procedures are available for the use of ceiling lifts and other resident handling equipment (e.g., limb holding slings) used in dressing.
  - These procedures emphasize safe body positioning, and cuing care providers to use equipment features, such as height adjustability, to reduce trunk forward bending and twisting.
  - Equipment and clothing manufacturers referred to for up-to-date tools to assist with dressing (e.g., compression stockings aides).

RESOURCES

Banfield Pavilion Adaptive Clothing Process Draft, 2011 (VCH)
Banfield Pavilion Adaptive Clothing Assessment Draft, 2011 (VCH)
OHSAH Resource Guide: Adaptive Clothing In partnership with Interior Health, 2004

Section 3

Gap Analysis Tools

Gap Analysis Tools: Overview and Instructions

Residential care organizations and facilities can use the gap analysis checklists in this section to assess their current processes, systems and practices against the provincial safe resident handling (SRH) standard for MSI prevention. There are 10 checklists: one for each of the SRH standards. There is also a summary page for recording the percentage of elements in place for each of the standards, which can be used for up to three sites.

The checklists are designed to help facilities and organizations to identify opportunities for improvement, as well as to highlight their achievements to date. It is recommended that the findings be used to develop a SRH action plan. Support tools that may assist with implementing the elements are listed at the end of the checklists, as well as in the "Additional Resources" section of this document.

How to Complete the Gap Analysis Checklists

1. For each element, check off all of the sub-elements that are in place. For example, in the gap analysis checklist for the *SRH Policy* gap analysis checklist, the element *communication* has the following two sub-elements: "new employees are informed of the policy during orientation" and "staff know where to find the policy". For the *communication* element to be considered fully in place for that standard, both of those sub-elements need to be in place.
    - ► Leave the sub-element checkbox empty if the relevant process, procedure, etc., is only partially or occasionally in place.
    - ► Refer to the relevant provincial SRH standard (sections 2.1–2.5.6 of this document) for more detail about the elements and sub-elements if needed.
2. Some element sections list additional "recommended" features and/or list several options for fulfilling an element and require only a certain number (e.g., "at least one of the following"). In those cases, a line is provided for you to note which ones you have, but not all lines need to be checked off in order for the element to be considered fully "in place".
3. After checking off all the sub-elements that are met / in place for a particular element, answer whether that element is fully in place. Answer "yes" if you checked off all of the sub-elements (all checkboxes). Answer "no" if you only checked off some (or none) of the sub-elements.
4. When you reach the end of one of the checklists, indicate whether your site fully meets the standard (100% of the elements are in place). If the standard is not fully met, calculate the percentage of elements achieved. Then note the percentage of elements you achieved for that standard in the gap analysis summary form provided (on page 70).
5. Use the comments column to note:
    - ▪ Relevant processes, systems or practices currently in place, including the number and frequency (e.g., quantities of equipment, frequency of audits, etc.)
    - ▪ The type of information (e.g., inspection report) used to verify an element is in place.
    - ▪ Any other information you would like to capture.
6. After completing your gap analysis, develop an action plan to address the gaps you identified. Specify the goals, timelines, and person(s) responsible for each aspect of implementing the standard.

Who Should Complete the gap Analysis?

Most of the checklists should be completed (and supported) by frontline leaders along with other selected staff, such as peer resource team members. The gap analysis checklists for “Safe Resident Handling Policy” and “Management Strategies to Support Safe Resident Handling Initiatives” are best completed by managers, in collaboration with frontline leaders.

Note: if this is your site’s first time completing the gap analysis, it may also be helpful to obtain support and facilitation from a musculoskeletal injury prevention advisor or ergonomic specialist.

Gap Analysis — Safe Resident Handling Policy

Elements	Comments
1. Safe Resident Handling Policy A safe resident handling (SRH) policy is in place…….. ☐ The SRH policy includes the following: Employer's commitment to SRH…….. ☐ Definition of manual resident handling…… ☐ Employer's responsibility to: Support use of safety equipment and procedures as first choice for SRH…… ☐ Define what exceptions can be made and when ……..…… ☐ Workers' responsibility to follow policy…… ☐ ► Is element 1 fully in place? Yes … ☐ No… ☐	
2. Communication New employees are informed of the policy during orientation..…….. ☐ Staff know where to find the policy……..…… ☐ ► Is element 2 fully in place? Yes … ☐ No… ☐	
► **Is the Safe Resident Handling Policy standard met?** Yes, both of the elements for this standard are in place……..☐ No, _____ % of the elements are in place*……..……☐ *Number of elements in place _____ ÷ 2 X 100 = _____ %	

SUPPORT TOOLS

1. Policy:
   - ► Health authority SRH policies (FHA, VCH)
   - ► No Manual Lifting of Patients protocol (VIHA)

Gap Analysis — Management Strategies to Support Safe Resident Handling

Elements	Comments
1. Support Implementation of the Safe Resident Handling Standards Gap analysis is conducted/supported…… ☐ Action plan to address the identified gaps is developed and implemented..… ☐ ► Element 1 fully in place? Yes … ☐ No… ☐	
2. Regular Audits/Inspections Managers support or participate in Joint Occupational Health and Safety (JOHS) committee inspections/checks…….. ☐ Systems are in place to audit safe patient handling processes and practices ☐ These systems should include: ___ Equipment checks/inspections ___ Work practice observations ► Element 2 fully in place? Yes … ☐ No… ☐	
3. Incident Reporting and Investigation All staff are aware of, and follow, incident reporting process including near-incident/hazard reports…… ☐ All incident reports are reviewed upon submission…… ☐ Trends are monitored (e.g. monthly report review, JOHS reports) ……..……... ☐ An action plan is developed in response to trends…… ☐ Investigations are conducted for all investigation-required incidents as per health authority, and: Manager supports adding peer resource team member(s) to investigation team for patient handling injuries……..… ☐ Root causes are identified and analyzed ……..…. ☐ Preventative action plan is developed and implemented……..... ☐ Preventative action plan is communicated to staff…… ☐ The effectiveness of preventative actions is assessed……..... ☐ ► Element 3 fully in place? Yes … ☐ No… ☐	
4. Communication There is regular, timely, ongoing staff communication regarding safety, including: Systems that support safe resident care, which are current, effective, reflect status changes, and immediately communicate this information to all care providers (e.g., ADLs, Kardex)…….... ☐ Safety as a standing agenda item for staff meetings…….... ☐ Method to promote timely and open communication and resolution regarding a specific safety issue, e.g. safety huddle…….... ☐ Methods to promote safety initiatives (e.g., bulletin board, newsletters, posters)…….... ☐ ► Element 4 fully in place? Yes … ☐ No… ☐	

Elements	Comments
5. Education and Training A variety of learning methods (e.g., on-line learning, self-directed learning, safety huddles) are available to staff…… ☐ Opportunities to access training (e.g., dedicated time, bedside coaching with peer resource, computer access) are provided to staff……..... ☐ Managers attend education/training with on leadership/support for safety culture…..…….. ☐ Education records are maintained…….. ☐ ► Element 5 fully in place? Yes … ☐ No… ☐	
6. Effective Management Strategies Practices to enhance safe work culture and practice, including: Regular presence is maintained on each unit (e.g., daily walk-abouts)…. ☐ High risk work practices are addressed as they occur…….. ☐ Employee performance review includes safety performance (where performance reviews are completed)……..…… ☐ At least one of the manager's key performance indicators relates to health and safety……..……... ☐ Managers acknowledge staff contributions towards safety …….. ☐ System in place for communicating successes……... ☐ ► Element 6 fully in place? Yes … ☐ No… ☐	

► **Is the Management Strategies standard met?**

Yes, all (6) elements for this standard are in place……...☐

No, _____ % of the elements are in place*……☐

*Number of elements in place _____ ÷ 6 X 100 = _____ %

SUPPORT TOOLS

	Element	Tool(s)
1.	Support Implementation Standards	► Provincial Safe Resident Handling Standards Document
2.	Regular Audits/Inspections	► Facility Inspection Checklist (FHA) ► Safety Inspection Audit Tool ► MSIP Job Observation / Spot Checklist (VCH, VIHA)
3.	Incident Reporting and Investigation	► Incident Investigation Support Tool (IHA) ► Investigation Form (all health authorities)
4.	Communication	► Safety Huddle Template (FHA)

Gap Analysis — Safe Resident Handling Equipment

Elements	Comments
1. Overhead Lifts Overhead lifts present (including ceiling-mounted, wall-mounted, or portable overhead lifts): 100% over high-risk beds, or less (70%) where high risk handling tasks are not performed due to population…… ☐ 100% coverage for active tub rooms…….. ☐ Coverage for rehabilitation rooms…… ☐ Capacity to accommodate approximately 440 lbs – 600 lbs…… ☐ Recommended design features for new construction, and in existing construction where feasible ___ X-Y gantry (traverse) system ___ Coverage to toilet rooms ___ System can lift from floor ___ Weighing capability available on unit ► Is element 1 fully in place? Yes … ☐ No… ☐	
2. Floor-Based Full Body Lifts One floor-based full body lift per care unit or floor…….. ☐ If no or low overhead lift coverage, one floor-based full body lift for every 8-10 non-weight bearing residents…… ☐ ► Is element 2 fully in place? Yes … ☐ No… ☐	
3. Sit-to-Stand (stand assist or standing) Lifts One sit-to-stand lift for every 8-10 partially weight bearing residents…….. ☐ If no residents using, one sit-to-stand lift per care unit or floor …… ☐ ► Element 3 fully in place? Yes … ☐ No… ☐	
4. Devices for Lateral Transfers At least one of the devices below is available (listed in order of risk reduction)…… ☐ ___ Overhead lifts with positioning slings ___ Overhead lifts with positioning slings ___ Air-assisted devices ___ Friction-reducing assistive devices (e.g., slider board, roller boards, slider sheets) ► Element 4 fully in place? Yes … ☐ No… ☐	
5. Devices for Lifting from Floor At least one of the devices below is available (listed in order of risk reduction)…….. ☐ ___ Overhead lifts with positioning slings ___ Air-assisted devices ___ Floor-based full body lift with appropriate slings ► Element 5 fully in place? Yes … ☐ No… ☐	

Elements	Comments
6. Beds Electric, height adjustable beds…….. ☐ Compatible with floor lifts (adequate clearance underneath)…….. ☐ ► Element 6 fully in place? Yes … ☐ No… ☐	
7. Bathtubs Side or low entry, recline-able, height adjustable tubs……... ☐ ► Element 7 fully in place? Yes … ☐ No… ☐	
8. Bariatric Capacity (where bariatric residents are admitted): Process for admission, care planning, pathway; e.g., consider doorways, hallways, elevators, etc…… ☐ Minimum of one overhead lift and/or one full body floor-based lift with bariatric capacity (spreader bars required)……... ☐ Additional equipment needs identified (e.g., bariatric bed, mattress, linen, wheelchair, commode/shower chair, walker)…… ☐ Room size accommodates use of bariatric equipment……... ☐ Door widths accommodate use of bariatric equipment……... ☐ ► Element 8 fully in place? Yes … ☐ No… ☐	
9. Infection Control Requirements reviewed and in compliance as it applies to equipment use and installation……... ☐ ► Element 9 fully in place? Yes … ☐ No… ☐	
10. Laundry Services Slings and fabric assistive devices are laundered as per manufacturer's instructions…… ☐ Care providers are aware of processes for accessing clean supplies and processing dirty supplies…….. ☐ ► Element 10 fully in place? Yes … ☐ No… ☐	
11. Maintenance and Preventive Maintenance Equipment is operational and in good working order …… ☐ Care providers are aware of processes for reporting repair issues (e.g., removing equipment from service, feedback received that equipment is ready for use)…… ☐ Preventive maintenance program in place…….. ☐ Spare parts available, including spare motor…… ☐ ► Element 11 fully in place? Yes … ☐ No… ☐	

Elements	Comments
12. Slings Appropriate types of slings available (i.e., variety of slings to maximize use of ceiling lift) for all resident handling tasks……………………………….. ☐ Appropriate inventory of slings available (e.g., 2-4 slings per bed depending on laundry accessibility)……………………………………………………….. ☐ ► Element 12 fully in place? Yes … ☐ No… ☐	
13. Space/Layout Adequate space for equipment use by one or more care providers, i.e.,: Adequate space in rooms and toilet rooms…………………………… ☐ Adequate space in bathing rooms……………………………………… ☐ Adequate space in hallways…………………………………………….. ☐ ► Element 13 fully in place? Yes … ☐ No… ☐	
14. Storage Systems for Equipment and Slings Location is easy for care providers to access……………………………….. ☐ Central space for equipment storage…………………………………………… ☐ Central space for assistive devices…………………………………………..... ☐ Central space for slings……………………………………………………….. ☐ In-room storage for slings available (dedicated use)……………………………. ☐ Adequate space / designated location for infrequently used equipment……….. ☐ ► Element 14 fully in place? Yes … ☐ No… ☐	
15. Training Training for new employees on use of equipment.……………………………….. ☐ Training on new equipment for employees provided…………………………….. ☐ Ongoing training on equipment use, to maintain proficiency…………………… ☐ ► Element 15 fully in place? Yes … ☐ No… ☐	

► **Is the Safe Resident Handling Equipment standard met?**

Yes, all (15) elements for this standard are in place……..…...☐

No, _________ % of the elements are in place* ………..………☐

*Number of elements in place ______ ÷ 15 X 100 = ______ %

Gap Analysis — Education and Training

Elements	Comments
1. Determining Site Education and Training Needs On-going/refresher site education and training needs are determined based on (achieved if 1 or more is checked): …….. ☐ ___ Regular(e.g. monthly) review of site/unit injury/incident trends: ___ Workplace incidents and investigation/JOHS reports ___ Regular audits of work practices: ___ Charts / care plans are reviewed (e.g. quarterly) ___ Job observations conducted (e.g. monthly) ___ Review resolution communications regarding a specific safety issue, e.g. safety huddle ___ Employees monitor their education/training needs? e.g. use of "self-check" tools An action plan is developed, implemented and reviewed regularly (quarterly) for on-going/refresher training/education based on identified need…….. ☐ ► Is element 1 fully in place? Yes … ☐ No… ☐	
2. Site Education and Training Education and training is provided for: New employee site specific orientation to safe resident handling policies, procedures, and equipment…… ☐ New equipment or procedures…… ☐ Communication about training opportunities includes a standing agenda item at staff meetings and at least one of the following methods: ……..... ☐ ___ Newsletter ___ E-mails ___ Posters ___ Other:_____ A variety of learning methods are available (two or more) …… ☐ ___ on-line learning ___ in-person (inservicing) ___ web site resources ___ coaching Staff have opportunities to access training (one or more) ……..... ☐ ___ dedicated time ___ bedside coaching with peer resource ___ adequate number of / access to computers A system is in place to maintain education records (one of below): …… ☐ ___ Learning management system ___ Database (soft copy) ___ Binder/paper based (hard copy) Residents and families are given safety awareness education/resources: With admission package…….. ☐ When new equipment or procedures are introduced…… ☐ ► Is element 2 fully in place? Yes … ☐ No… ☐	

Elements	Comments
3. Peer Resource Team (PRT) PRT members have an opportunity to participate in delivering and/or supporting site education (note which of the following activities apply). …….. ☐ ___ PRT members conduct return demonstration ___ Observations with staff and coaching as required ___ PRT members meet regularly (e.g. monthly) to plan and prioritize team activities (i.e., training/education action plan) ___ PRT members have the opportunity to provide/support/deliver: ___ New employee resident handling orientation…… ___ Refresher education/training…… ___ Other activities (e.g., audits) to support education and training _____ ► Is element 3 fully in place? Yes … ☐ No… ☐	
4. Management Education and Strategies Managers understand safety systems (attend PRT training)…… ☐ Managers conduct inspections, incident investigations and audits…….. ☐ Managers receive leadership skill development training…… ☐ ► Is element 4 fully in place? Yes … ☐ No… ☐	

► **Is the Education and Training standard met?**

Yes, all (4) elements for this standard are in place……..☐
No, _____ % of the elements are in place* ……☐

*Number of elements in place _____ ÷ 4 X 100 = _____ %

SUPPORT TOOLS

	Element	Tool(s)
1.	Determining Site Education and Training Needs	► Self check tool (VIHA) ► Safety huddle template (FHA)

Gap Analysis — Resident Transfers and Ambulation

Elements	Comments
1. Care Planning Resident is assessed upon admission for transfers and ambulation…….. ☐ There is a process to monitor resident mobility needs and impacts (e.g., skin checks, falls prevention), including: Identification and reporting of changes in resident status…….. ☐ Communication to all staff, and up-to-date documentation of, changes in resident status…….. ☐ Consultation with family and resident…… ☐ ► Is element 1 fully in place? Yes … ☐ No… ☐	
2. Documentation Assessment outcomes are documented and accessible for care providers at point of care (e.g., ADL)…… ☐ Point of care documentation includes: Method/type of transferring and ambulation…….. ☐ Level of assistance by care providers…… ☐ Equipment required…… ☐ Sling type and size…… ☐ ► Is element 2 fully in place? Yes … ☐ No… ☐	
3. Point of Care Risk Assessment Completed prior to providing transfer or ambulation…….. ☐ If the usual level of mobilization is not deemed possible, an interim care plan is established and communicated to care providers..…… ☐ Process is in place for requesting reassessment…… ☐ ► Is element 3 fully in place? Yes … ☐ No… ☐	
4. Regular Audits/Inspections Conducted ensure that: Care plans are current and accurately reflect the resident's care needs…… ☐ Care providers are following the plans…….. ☐ Care providers are using resident handling equipment appropriately.. ☐ Communications systems are in place to reflect or trigger changes in care plans…… ☐ Leaders are assisted with identifying communication needs, and education and training opportunities (e.g., job observation audits)…… ☐ ► Is element 5 fully in place? Yes … ☐ No… ☐	

Elements	Comments
5. Education and Training Care providers have opportunities for education/training on: Mobility assessment processes (mobility decision support tool, point of care risk assessment)…….. ☐ Effective use of equipment and minimal assistance techniques as per procedures, including safe positioning of the care provider…… ☐ Residents and families receive educational materials, upon admission and change in status, regarding resident handling procedures and equipment that may be utilized for transfers/ambulation…… ☐ ► Is element 5 fully in place? Yes … ☐ No… ☐	
6. Safe Work Procedures (SWPs) Safe work procedures are developed, and staff are aware of them. Examples include the following (note which are applicable to your site): …… ☐ Sling application SWPs: ___ Transfer slings ___ Walking slings ___ Other _____ Mechanical equipment operation SWPs: ___ Ceiling lift ___ Full body floor-based lift ___ Sit-stand lift ___ Manual assisted transfers ► Is element 6 fully in place? Yes … ☐ No… ☐	

► **Is the Transfers and Ambulation standard met?**

Yes, all (6) elements for this standard are in place……..☐
No, _____ % of the elements are in place* ……☐

*Number of elements in place _____ ÷ 6 X 100 = _____ %

SUPPORT TOOLS

Element	Tool(s)
1. Care Planning ►	Mobility Decision Support Tool (Appendix B)

Gap Analysis — Bed Care / Repositioning

Elements	Comments
1. Care Planning Residents are assessed to identify the most appropriate positioning methods and equipment at the following times: Admission (refer to decision support tools for assessment criteria)….. ☐ In response to status change (as identified at POC)…… ☐ On a regular basis (e.g., every 3 to 6 months)…….. ☐ ► Is element 1 fully in place? Yes … ☐ No… ☐	
2. Documentation and Communication Resident's positioning method is documented: At point of care (e.g., ADL, functional care plan)……... ☐ In Kardex…….. ☐ Documentation includes: Level of assistance required by care provider(s)……... ☐ Equipment required (type of sling, slider sheets)…….. ☐ Instructions re specific care task(s)…… ☐ Upon re-assessment of resident status, a system is in place to ensure: Documentation is updated (e.g. Kardex. ADL sheet)…… ☐ Communication to all staff if there is a change in status (e.g., communication book, report)…….. ☐ ► Is element 2 fully in place? Yes … ☐ No… ☐	
3. Point of Care Risk Assessment Point-of-care risk assessment is completed prior to providing bed care / repositioning……... ☐ If resident status has changed, an interim care plan is established and communicated to care providers…… ☐ Process is in place to request reassessment……... ☐ ► Is element 3 fully in place? Yes … ☐ No… ☐	
4. Regular Audits/Inspections Conducted to ensure: Care plan audits are current and accurately reflect the care needs of the resident……..... ☐ Care providers are following care plan……,,… ☐ Immediate resident status changes are reflected in care plans…,…… ☐ Leaders are assisted with identifying communication needs, education and training opportunities (e.g., task observation audits)….. ☐ ► Is element 4 fully in place? Yes … ☐ No… ☐	

Elements	Comments
5. Education and Training Care providers have educational opportunities, through various methods, regarding available equipment (check those that apply): …… ☐ ___ Mobility decision support tool (note: designated staff members, such as PRT members, should be trained on this tool; and all staff may receive training to increase their general awareness of the assessment process) ___ Point of care risk assessment ___ Slider sheet components ___ Repositioning sling ___ Other repositioning tools:_____ Staff are informed of WorkSafeBC Bulletin "Soaker pads are not for repositioning"…… ☐ ► Is element 5 fully in place? Yes … ☐ No… ☐	
6. Safe Work Procedures / Clinical Practice Documents Safe work procedures are developed for equipment used at the site, and staff are aware of them (indicate which are applicable): …….…….. ☐ ___ Sling application ___ Repositioning sling ___ Band Slings ___ Roller Bands ___ Other: _____ ___ Mechanical equipment operation ___ Ceiling track lift ___ Total floor lift ___ Friction reducing devices ___ Air-assisted lateral transfer device ___ Slider sheet components ___ Other: _____ ___ Other items (e.g., second hand band) _____ ► Is element 6 fully in place? Yes … ☐ No… ☐	
7. Repositioning Equipment At least one of the following is available:……..…. ☐ ___Overhead lifts with repositioning slings ___Friction-reducing slider sheets Additional recommended equipment includes: ___Overhead lifts with band slings ___Second hand band with slider draw sheets ► Is element 7 fully in place? Yes … ☐ No… ☐	

► **Is the Bed Care / Repositioning standard met?**

Yes, all (7) elements for this standard are in place……..☐
No, _____ % of the elements are in place* ……☐

*Number of elements in place _____ ÷ 7 X 100 = _____ %

SUPPORT TOOLS

	Element	Tool(s)
1.	Care Planning	► Mobility Decision Support Tool (Appendix B) ► Repositioning Decision Support Tool (IHA) ► Point of Care Risk Assessment (Appendix D)
4.	Regular Audits/Inspections	► Safe Patient Handling Spot Check (VIHA)
5.	Education	► Training modules, e.g., e-modules, independent learning modules ► WorkSafeBC Bulletin: “Soaker pads are not for repositioning”
6.	Safe Work Procedures	► Health authority safe work procedures

Gap Analysis — Positioning Seated Residents

Elements	Comments
1. Care Planning Resident is assessed initially for contraindications and considerations for sling placement..... ☐ Process to monitor resident seating needs (e.g., skin checks) includes: Identification and reporting of changes in resident status..... ☐ Communication and up-to-date documentation of changes in resident status..... ☐ Consultation with family and resident..... ☐ ► Is element 1 fully in place? Yes … ☐ No… ☐	
2. Documentation Assessment outcomes are documented and accessible to care providers at point of care (e.g., ADL)..... ☐ Documentation at the point of care (e.g. ADL) includes: Positioning methods for complex seating (as per rehab assessment and intervention)..... ☐ Level of assistance by care providers..... ☐ Equipment required and chair set-up..... ☐ ► Is element 2 fully in place? Yes … ☐ No… ☐	
3. Point of Care Risk Assessment Completed prior to providing positioning seated residents..... ☐ If usual level of repositioning is not deemed appropriate, an interim care plan is established and communicated to care providers..... ☐ Process is in place for requesting reassessment..... ☐ ► Is element 3 fully in place? Yes … ☐ No… ☐	
4. Regular Audits/Inspections Conducted to ensure: Care plans are current and accurately reflect the care needs of the resident..... ☐ Care providers are following the plans..... ☐ Care providers are using resident handling equipment appropriately. ☐ Communications systems are in place to reflect or trigger changes in care plans..... ☐ Leaders are assisted with identifying communication needs, and education and training opportunities (e.g., job observation audits)..... ☐ ► Is element 4 fully in place? Yes … ☐ No… ☐	

Elements	Comments
5. Education and Training Care providers have educational opportunities regarding: Assistive seated repositioning devices…….. ☐ Wheelchair adjustment features and operation……... ☐ Safe body positions when caring for the seated resident…….. ☐ Families and residents, upon admission and change in status, receive education retarding seated positioning equipment and methods……. ☐ ► Is element 5 fully in place? Yes … ☐ No… ☐	
6. Safe Work Procedures / Clinical Practice Documents Consistent sling placement decision making process available to care team… ☐ Is element 6 fully in place? Yes … ☐ No… ☐	
7. Equipment Anti-slip or one way glides…….. ☐ Mechanical lifts and slings…….. ☐ Tilt features of chair…….. ☐ ► Is element 7 fully in place? Yes … ☐ No… ☐	

► **Is the Positioning Seated Residents standard met?**

Yes, all (7) elements for this standard are in place……..☐
No, _____ % of the elements are in place* ……☐

*Number of elements in place _____ ÷ 7 X 100 = _____ %

SUPPORT TOOLS

	Element		Tool(s)
1.	Care Planning	►	KCC Sling Removal Decision Support Tool (VCH)
5.	Education and Training	►	Tips to reposition in chair (FHA)
6.	Safe Work Procedures	►	KCC sling Removal Decision Support Tool (VCH)
7.	Equipment	►	Tips to reposition in chair (FHA)

Gap Analysis — Gap Analysis: Resident Toileting

Elements	Comments
1. Care Planning Resident is assessed initially for: Transfer to be used to transfer to toilet/commode…… ☐ Standing balance/endurance…… ☐ Sitting balance/endurance…… ☐ Use of care appropriate clothing…… ☐ Resident's voiding routine/schedule considered…… ☐ Process to monitor resident toileting needs and impacts (e.g., skin checks, falls prevention) includes: Identification and reporting of changes in resident status…… ☐ Communication and up-to-date documentation of changes in resident status…… ☐ Consultation with family and resident…… ☐ ► Is element 1 fully in place? Yes … ☐ No… ☐	
2. Documentation Assessment outcomes are documented and accessible for care providers at point of care (e.g., ADL). …… ☐ Documentation at the point of care (e.g. ADL) includes: Resident toilet/commode transfer…… ☐ Level of assistance by care providers for toileting care…… ☐ Equipment requirements and set-up…… ☐ Sling type and size…… ☐ ► Is element 2 fully in place? Yes … ☐ No… ☐	
3. Point of Care Risk Assessment Completed prior to providing toileting care…… ☐ If usual level of mobilization is not deemed appropriate, an interim care plan is established and communicated to care providers…… ☐ Process is in place for a request for re-assessment…… ☐ ► Is element 3 fully in place? Yes … ☐ No… ☐	
4. Regular Audits/Inspections Conducted to ensure: Care plans are current and accurately reflect the care needs of the resident…… ☐ Care providers are following the plans…… ☐ Care providers are using resident handling equipment appropriately… ☐ Communications systems are in place to reflect or trigger changes in care plans…… ☐ Leaders are assisted with identifying communication needs, education and training opportunities (e.g., job observation audits)…… ☐ ► Is element 4 fully in place? Yes … ☐ No… ☐	

	Elements	Comments
5	**Education** Care providers have educational opportunities regarding: Effective use of equipment including safe positioning of the care provider while providing toileting care…… ☐ Minimal assistance personal care techniques and transfers…… ☐ Families and residents receive education about: Toileting equipment …… ☐ Clothing choices that support toileting care…… ☐ ► Is element 5 fully in place? Yes … ☐ No… ☐	
6.	**Safe Work Procedures / Clinical Practice Documents** These procedures/documents include/address: Safety language (e.g., body position while providing toileting care)….. ☐ Toileting equipment selection and use…… ☐ Toileting care outlined…… ☐ Ceiling lift / sling use with toileting…… ☐ Peri-care methods…… ☐ ► Is element 6 fully in place? Yes … ☐ No… ☐	
7.	**Toileting Equipment** Mechanical lift is maximized for toileting transfer (e.g., remove barriers to using the lift by using adaptive clothing) …… ☐ Adequate supply of commodes / toilet seats with foot rests and hand supports available…… ☐ Personal hygiene aids (e.g., long handled wipers) …… ☐ ► Is element 7 fully in place? Yes … ☐ No… ☐	
8.	**Toileting Environment** Uncluttered toileting/commode area…… ☐ Process in place to address wet/slippery floors…… ☐ Supporting aids installed as appropriate: grab bars, toilet seat bars, raised toilet seat, call bell within reach…… ☐ Sufficient space to maneuver floor lifts for toileting transfer e.g. at the bedside if bathroom is too small…… ☐ ► Is element 8 fully in place? Yes … ☐ No… ☐	
	► **Is the Resident Toileting standard met?** Yes, all (8) elements for this standard are in place…… ☐ No, _____ % of the elements are in place*…… ☐ *Number of elements in place _____ ÷ 8 X 100 = _____ %	

SUPPORT TOOLS

	Element		Tool(s)
1.	Care Planning	►	Example toileting methods to improve access for peri-care when sitting on commode or toilet (Appendix F)
6.	Safe Work Procedures	►	Example toileting methods to improve access for peri-care when sitting on commode or toilet (Appendix F)

Gap Analysis — Resident Bathing

Elements	Comments
1. Care Planning Resident is assessed initially for Transfer method to/from bathing room and on/off bathing equipment ☐ Drying and dressing…….. ☐ Use of care appropriate clothing…… ☐ Appropriate time allocation for care…… ☐ Bathing equipment suitability (consistent with manufacturers specifications and unit selection criteria) ……... ☐ Process to monitor resident bathing needs includes: Identification and reporting of any changes in resident status…… ☐ Communication and up-to-date documentation of changes in resident status…… ☐ Consultation with family and resident…….. ☐ ► Is element 1 fully in place? Yes … ☐ No… ☐	
2. Documentation Assessment outcomes are documented and accessible for care providers at point of care (e.g., ADL)…….. ☐ Documentation at the point of care (e.g. ADL) includes: Resident bathing method and type of bathing transfer…… ☐ Level of assistance by care providers…… ☐ Equipment required and set-up……... ☐ Sling type and size…… ☐ ► Is element 2 fully in place? Yes … ☐ No… ☐	
3. Point of Care Risk Assessment Completed prior to providing bathing care…… ☐ If resident status changed and task is not deemed appropriate, an interim care plan is established and communicated to care providers…… ☐ Process is in place for requesting reassessment…… ☐ ► Is element 3 fully in place? Yes … ☐ No… ☐	
4. Regular Audits/Inspections Conducted to ensure: Care plans are current and accurately reflect the care needs of the resident…….. ☐ Care providers are following the plans…….. ☐ Care providers are using resident handling equipment appropriately… ☐ Communications systems are in place to reflect or trigger changes in care plans…….. ☐ Leaders are assisted with identifying communication needs, education and training opportunities (e.g., job observation audits)…… ☐ ► Is element 4 fully in place? Yes … ☐ No… ☐	

5. Education and Training

Care providers have educational opportunities on the topic of:

- Effective use of bathing equipment including safe positioning of the care provider during bathing…… ☐
- Bathing procedures…….. ☐

Families and residents receive education about:

- Bathing equipment…….. ☐
- Clothing choices that support bathing care…… ☐

► Is element 5 fully in place? Yes … ☐ No… ☐

6. Safe Work Procedures / Clinical Practice Documents

These procedures/documents include:

- Safety language (e.g., body position while providing bathing care)….. ☐
- Bathing equipment selection criteria and use…… ☐
- Bathing care steps…… ☐
- Ceiling lift / sling use with bathing…….. ☐

► Is element 6 fully in place? Yes … ☐ No… ☐

7. Bathing Equipment

- Ceiling lifts in bathing room…… ☐
- Tubs/showers, e.g., height adjustable, side or low entry, tilt/recline options, access to peri-area…….. ☐
- Appropriate slings available (e.g., less water absorbent) …….. ☐
- Supportive devices available (e.g., foam bolsters)…….. ☐
- Washing devices available (e.g., hand held shower nozzles) …….. ☐
- Protective clothing for care providers …… ☐

► Is element 7 fully in place? Yes … ☐ No… ☐

8. Bathing Environment

- Uncluttered bathing room; adequate space for bathing…….. ☐
- Process and anti-slip devices for wet/slippery floors…….. ☐
- Supporting aids are in place; grab bars, call bells…….. ☐
- Bathing area set-up maximizes ceiling lift use…… ☐
- Bathing room design supports ability to complete bathing process in bathing room…… ☐

► Is element 8 fully in place? Yes … ☐ No… ☐

► **Is the Resident Bathing standard met?**

Yes, all (8) elements for this standard are in place……..☐

No, _____ % of the elements are in place*……☐

*Number of elements in place _____ ÷ 8 X 100 = _____ %

SUPPORT TOOLS

	Element	Tool(s)
5.	Education and Training	► Banfield Pavilion Bathing Procedure (VCH)
6.	Safe Work Procedures	► Banfield Pavilion Criteria for Bathing Equipment (VCH) ► Banfield Pavilion Bathing Procedure (VCH)
7.	Bathing Equipment	► Patient Handling Procedure: Cushioning options to meet resident needs (IHA)

Gap Analysis — Gap Analysis: Resident Dressing

Elements	Comments
1. Care Planning Residents have an initial dressing assessment upon admission…… ☐ Frontline caregivers have a process for identifying and reporting resident status changes…… ☐ ► Is element 1 fully in place? Yes … ☐ No… ☐	
2. Documentation Assessment outcomes are documented and accessible to care providers at point of care (e.g., ADL)…… ☐ Documentation at the point of care (e.g. ADL) includes: Resident dressing method and type of clothing…… ☐ Level of assistance by care providers…… ☐ Equipment requirements and set-up…… ☐ ► Is element 2 fully in place? Yes … ☐ No… ☐	
3. Point of Care Risk Assessment Completed prior to dressing…….. ☐ If resident status changed and task is not deemed appropriate, an interim care plan is established and communicated to care providers…… ☐ Process is in place for a request for reassessment…….. ☐ ► Is element 3 fully in place? Yes … ☐ No… ☐	
4. Regular Audits/Inspections Conducted to ensure: Care plans are current and accurately reflect the care needs of the resident…… ☐ Care providers follow the plans…… ☐ Care providers use resident handling equipment appropriately ☐ Communications systems are in place to reflect or trigger changes in care plans…… ☐ Leaders are assisted with identifying communication needs, education and training opportunities (e.g., job observation audits)…… ☐ ► Is element 4 fully in place? Yes … ☐ No… ☐	
5. Education and Training Care providers have educational opportunities to learn about the effective use of equipment including safe positioning of the care provider during dressing…….. ☐ Residents and families receive education about alternative clothing options.... ☐ ► Is element 5 fully in place? Yes … ☐ No… ☐	

Elements	Comments
6. Safe Work Procedures / Clinical Practice Documents These procedures/documents include: Safety language (e.g., body position while providing dressing)…….. ☐ Dressing equipment selection criteria and use of ceiling lift with dressing…..... ☐ ► Is element 6 fully in place? Yes … ☐ No… ☐	
7. Equipment Height adjustable change surfaces…….. ☐ Contacts for suppliers of alternative clothing…….. ☐ Dressing specific equipment such as donning and doffing aides, band slings. ☐ ► Is element 7 fully in place? Yes … ☐ No… ☐	

► **Is the Resident Dressing standard met?**

Yes, all (7) elements for this standard are in place……..☐

No, _____ % of the elements are in place*……☐

*Number of elements in place _____ ÷ 7 X 100 = _____ %

SUPPORT TOOLS

	Element	Tool(s)
1.	Care Planning	► OHSAH handbook on adaptive clothing:http://www.ohsah.bc.ca/media/41-HB-AdaptiveClothingGuide.pdf ► Dressing criteria (Appendix G)
3.	Point of Care Risk Assessment	► Point of care risk assessment tool (Appendix D)

Gap Analysis Summary Page

Percentage of Elements in Place for…	Site 1 (Name):	Site 1 (Name):	Site 1 (Name):
Safe Resident Handling Policy:			
Management Strategies/Support:			
Safe Resident Handling Equipment:			
Education and Training:			
Resident Transfers and Ambulation:			
Bed Care / Repositioning:			
Positioning Seated Residents:			
Resident Toileting:			
Resident Bathing:			
Resident Dressing:			
Date of Gap Assessment::			

Additional Comments
Site 1
Site 2
Site 3
Overall

Section 4

A Peer Resource Team Model for Implementing the Standards

4.1 Evidence for Peer Resource Teams (PRT) and Coaching

Research has shown the peer leader and coaching model to be a successful intervention strategy for sustaining a safe work culture and addressing the risks associated with patient/resident handling tasks (Nelson & Baptiste, 2004; Collins et al., 2004; Knibbe & Knibbe). Peer resource team (PRT) leaders call upon their peers — the front line workers — to inform change. These frontline workers are an excellent resource for identifying areas of risk, and generating work-system improvement ideas (Field & Sinha, 2005, as cited in Tucker, 2008). Their empowerment (Frankel et al., 2005) and participation has led to the implementation of sustainable solutions (Noro & Imada, 1991, as cited in Zalk, 2001). Peer leaders use effective intentional coaching conversations to engage these front line workers, and draw out the key safety issues they are facing. These coaching conversations can then support front line workers in finding solutions that will be successful in their complex work environments (Goldberg, 1999, 1998). In addition, units with active peer leaders have demonstrated higher compliance with safe patient handling equipment policies and procedures (Stenger et al., 2007).

Why does this approach work? Peers know the work environment, and speak the same language as, and interact frequently with, their colleagues (Knibbe et al., 2007). There is tremendous value in their knowledge of the workplace (Zalk, 2001), enabling a more thorough understanding of potential problems in the work environment, and a pragmatic problem-solving approach. Drawing on their occupational knowledge, frontline workers are able to identify and create long-lasting solutions.

Working alongside their colleagues during a moment of need, peer leaders can help to bridge the gap between knowledge and the application of skill (Haney & Wright, 2007). Care providers view these peers as ”safety ambassadors” who are available for answering questions, problem solving, introductory training, and updates on equipment (Knibbe & Knibbe, n.d.). The PRT and coaching approach provides opportunities for regular interactions, collaborative problem-solving, and communication, in order to positively change safety systems and processes, all of which enhances safety culture (Turnbeaugh, 2010).

The benefits of peer leaders and coaching include the following:

- Expertise is immediately available on the unit at all times. Staff know how to perform patient handling tasks safely, where to find information, and who to go to if they have a question.
- New staff receive timely, focused coaching on safe patient handling with unit-specific equipment, procedures, and processes, as well as on related clinical issues.
- Staff have ongoing access to education/training and coaching, including new equipment and processes, and are provided with opportunities for collaboration and troubleshooting.
- Peers support and promote the development of staff knowledge and skills related to safely performing patient handling tasks. This results in reduced injuries and incidents, and has a positive impact on unit staffing, morale and retention.
- The quality of patient care, including patient safety and comfort, is likely to improve, and patient adverse events associated with patient handling are likely to decrease.
- Opportunities for growth are available to unit staff who are interested in fulfilling the peer leader role.

4.2 Implementing Peer Resource Teams

Purpose

- To engage all staff in promoting safe resident care.

Objectives of the Peer Resource Team (PRT)

- Serve as a resource for improving safety and quality of care.
- Take a systems approach to problem-solving: identify systems gaps and guide solutions; monitor and modify solutions as needed.
- Build capacity by supporting all staff in the application of safety knowledge into daily practice.
- Facilitate change: set direction, engage people, and manage communication.

Guiding Principles of a PRT

A defined and common purpose – To promote a safety culture.

Interdisciplinary — Members comprise a subset that is representative of the unit-staffing mix, including, but not limited to: site leaders, RNs, LPNs, care aides, therapy personnel, and nurse educators. Membership includes unit staff who have access to, and frequent interaction with, colleagues, and who use the expertise of staff on local units.

Collaborative and non-hierarchical — The team functions like a community of practice within a facility. Each member has an equal opportunity to participate, with recognition that workers know their jobs and can identify sustainable solutions.

Advanced knowledge base / training — Team members receive training relevant to their common purpose (e.g., safe resident handling skills, communication, understanding change, coaching, and problem solving skills).

Approach — A systems-based and practitioner-focused approach is used.

Roles and Responsibilities of PRT members

1. Participate in developing, implementing, evaluating and supporting systems, to ensure safe work practices in alignment with the provincial safe resident handling standards.
2. Be an on-unit resource, facilitate problem solving, model safe work practice, and provide and gather feedback to and from peers, unit teams, JOHS committees, and the incident investigation process.
3. Use a variety of methods, such as task-based peer coaching, to support knowledge transfer at the point of care for resident- and equipment-specific situations (e.g., ‘in the moment’ applications and/or return demonstrations).
4. Participate in training new, existing and returning employees, using formal and informal training methods.
5. Ensure communication systems are in place to support safe resident care.
6. Meet reporting requirements as per terms of reference.
7. Develop structures —including a designated meeting facilitator, and action planning and accountability processes — to maximize PRT meetings and support the above roles and responsibilities.

Year 1 PRT Activities and Tasks

- Support/conduct provincial safe resident handling gap analysis.
- Develop an action plan, timelines & team member responsibilities for addressing the identified gaps.
- Establish key success factors and celebrate team work.
- Conduct safe resident handling standards gap analysis on a recurring, annual basis.

PRT Selection Criteria

- Close connection to providing resident care at the worksite.
- Positive attitude and collaborative team approach.
- Respected by peers, maintains good relationships, and is viewed as an informal leader.
- Strong communication skills.
- Open to learning and uses problem solving skills.
- Values and advocates for safety.
- Able to attend regularly scheduled PRT meetings.

PRT Implementation Checklist

☐ Select team: Guideline for number of members: PRTs range from 6-10 members with proportional representation of staff mix (leaders, RN, LPN, care aide, rehab, etc). Consider selection from all shifts & units. Representation includes:
  - ☐ Multiple shifts
  - ☐ Multiple units
  - ☐ Care Aide
  - ☐ RN
  - ☐ LPN
  - ☐ Rehab
  - ☐ Leader

☐ Establish a regular meeting schedule, with a suggested meeting frequency of:
  - Initially: 1 to 2 meetings per month, with additional working groups
  - Ongoing: monthly

☐ Establish terms of reference (statement of purpose, meeting schedule, ground rules, documentation templates)

☐ Develop PRT activities/plan
  - Year 1: safe resident handling standards gap analysis
  - Ongoing: based on further gap analysis, unit needs, injury trends, staff feedback, equip needs, etc.

☐ Create and roll out a communication plan
  - Introduce the role and goals of the PRT to the site.
  - Communicate key PRT findings and actions to all staff, and provide regularly updates on the PRT's activities.

☐ Schedule & coordinate training for PRT (based on gap analysis and member needs). Topics may include:
  - ☐ Safe patient handling processes and equipment use
  - ☐ Coaching
  - ☐ Communication/change management processes

PRT Implementation Resources

1. Provincial Safe Resident Handling Standards & gap analysis tool (see sections 2 and 3 of this document)
2. PRT training materials – HA resources

Section 5

Additional Resources

Additional Resources

This section suggests some additional resources for implementing the standards, including supporting literature, examples of how the standards and procedure have been applied, and decision support tools.

Safe Resident Handling Policy

Health authority SRH policies (FHA, VCH)

No Manual Lifting of Patients protocol (VIHA)

Management Strategies to Support Safe Resident Handling Initiatives

Facility Inspection Checklist (FHA)

Safety Inspection Audit Tool

MSIP Job Observation/Spot Checklist (VCH, VIHA)

Incident Investigation Support Tool (IHA)

Investigation Form (all health authorities)

Safety Huddle Template (FHA)

WorkSafeBC BC website: www.worksafebc.ca (go to ergonomic regulations).

Bureau of Labor statistics

Safe Resident Handling Equipment

Efficiency of Overhead Ceiling Lifts in Reducing Musculoskeletal Injury Among Carers Working in Long-Term Care Institutions. Alamgir, H., Shicheng, Y., Fast, C., Hennessy, S., Kidd, C., and Yassi, A. (2008).Injury, 39 (5), 570-577.

Position Statement on Elimination of Manual Patient Handling to Prevent Work-Related Musculoskeletal Disorders. American Nurses Association Position Statement (2003).

Guidebook for Architects and Planners, 2nd edition. ARJO (2005) ARJO Hospital Equipment AB.

Guidelines for Nursing Homes (Revised March 2009). Ergonomics for the Prevention of Musculoskeletal Disorders U.S. Department of Labor, Occupational Safety and Health Administration, OSHA 3182, 2003.
http://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.html

Muscle Activity During Patient Transfers: A Preliminary Study on the Influence of Lift Assists and Experience. Keir, P. and MacDonell, C.W. (2004). Ergonomics, 47(3), 296–306.

The Illustrated Guide to Safe Patient Handling and Movement. Nelson, A., Motacki, K., Menzel, N. (2009). Springer Publishing Company.

The Safety and Dignity of Patients and Nurses During Patient Handling. Pellatt, G. C. (2005). British Journal of Nursing, 14(21), 1150-1156.

Effectiveness of Installing Overhead Ceiling Lifts: Reducing Musculoskeletal Injuries in an Extended Care Hospital Unit. Ronald, L.A., Yassi, A., Spiegel, J., Tate, R., Tait, D., and Mozel, M.R. (2002). AAOHN Journal, 50(3), 120-127.

Implementing a Resident Lifting System in an Extended Care Hospital: Demonstrating Cost-Benefit. Spiegel, J., Yassi, A., Ronald, L.A., Tate, R.B., Hacking, P., and Colby, T. (2002). AAOHN Journal, 50(3), 128-134.

Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement (Parts 1 and 2). US Veterans Health Administration. (2003) Tampa, FL: Patient Safety Center of Inquiry. Accessed 4/27/11 from http://www.visn8.med.va.gov/patientsafetycenter/safePtHandling/default.asp.

Designing Workplaces for Safer Handling of Patients/Residents: Guidelines for the Design of Health and Aged Care Facilities. WorkSafe Victoria. second edition. 2002. www.workcover.vic.gov.au/publications

Education and Training

Safety Huddle Template (FHA)

OHS Connect website: https://ohsconnect.ohsah.bc.ca/Pages/Default.aspx

WorkSafeBC publication: 3 Steps to Effective Worker Education and Training http://www.worksafebc.com/publications/health_and_safety/by_topic/assets/pdf/3-steps.pdf

WorkSafe BC website: www.worksafebc.com (go to ergonomic regulations).

Resident Handling Safe Work Practice Resources

Resident Transfers and Ambulation

Mobility Decision Support Tool (Appendix B)

WorkSafeBC: High Risk Manual Handling of Patients in Healthcare

Bed Care / Repositioning

WorkSafeBC: High Risk Manual Handling of Patients in Healthcare

Mobility Decision Support Tool (Appendix B)

Repositioning Decision Support Tool (IHA/NHA)

Point of Care Risk Assessment (Appendix D)

WorkSafeBC Bulletin: “Soaker pads are not for repositioning”

Safe Work Procedures (All health authorities)

Safe Patient Handling Spot Check (VIHA)

Positioning Seated Residents

KCC Sling Removal Decision Support Tool (VCH)

Tips to Reposition in Chair (FHA)

Resident Toileting

Toileting Methods to Improve Access for Peri-Care When Sitting on Commode or Toilet (Appendix F)

The Guide to the Handling of Patients, revised 4th ed. National Back Pain Association, Royal College of Nursing. (1999). Chapter 16 Toileting and Clothing. NBPA.

Scheduled Toileting Program in Long-Term Care. 2003 (OHSAH/FHA)

Adaptive Clothing Project: Final Report, 2003. (OHSAH)
https://ohsconnect.ohsah.bc.ca/OHSResources/Presentations/Report_OHSAH_adaptive%20clothing%20final%20report.pdf

Clinical Practice Document: Continence Promotion and Maintenance, 2009 (VCH, accessed on VCH Intranet)

Resident Bathing

Patient Handling Procedure: Cushioning Options to Meet Resident Needs (IHA)

Banfield Pavilion Criteria for Bathing Equipment (VCH)

Banfield Pavilion Bathing Procedure (VCH)

Banfield Pavilion Criteria for Bathing Equipment (VCH, 2010)

The Guide to the Handling of Patients, revised 4th edition (chapter 17: Washing and bathing). National Back Pain Association, Royal College of Nursing, 1999.

Patient Handling Procedure: Cushioning Options to Meet Resident Needs (IHA)

Residential Shower Trolley Bathing Procedure Draft (VCH, 2011)

Patient Handling Procedure: Parker Tub Quick Guide Options to Prevent Residents from Slipping Forward (IHA)

Resident Dressing

Banfield Pavilion Adaptive Clothing Process Draft, 2011 (VCH)

OHSAH Resource Guide: Adaptive Clothing. In partnership with Interior Health, 2004.

Contact List for Accessing Health Authority-Specific Resource Documents

Fraser Health Authority
Workplace Health
604.953.5113 (push “0” and you will be directed to a live voice during office hours).

Providence Health Care
Musculoskeletal Injury Prevention Team
604-806-8399

Interior Health and Northern Health
Workplace Health and Safety Integrated Services
250-980-5108

Vancouver Coastal Health
Musculoskeletal Injury Prevention Department
Safety and Prevention
604-875, 4111, ext 68172

Vancouver Island Health Authority
Occupational Health and Safety Department
250 519-1540 or 1 866-739-1343 toll free

Appendixes

Appendix A
Blended Learning

In blended learning, various formal and informal learning opportunities are integrated. Learning opportunities are offered to staff during key learning moments such as when hired, when putting new skills into practice, when new equipment or procedures are introduced, when safety concerns are identified, or when a workplace incident has occurred.

The type of learning opportunity offered may depend on "when" the learning is required (i.e., during which learning moment). More formal learning opportunities, such as instructor-led training, are generally recommended when an attendance record is required (e.g., during regional and site orientation, when new equipment or procedures are introduced, or when injury trends indicate the need for refresher training). Informal learning opportunities, such as bedside coaching and return demonstrations, can help staff apply formally-acquired knowledge to resident care practices.

Formal learning opportunities can include:

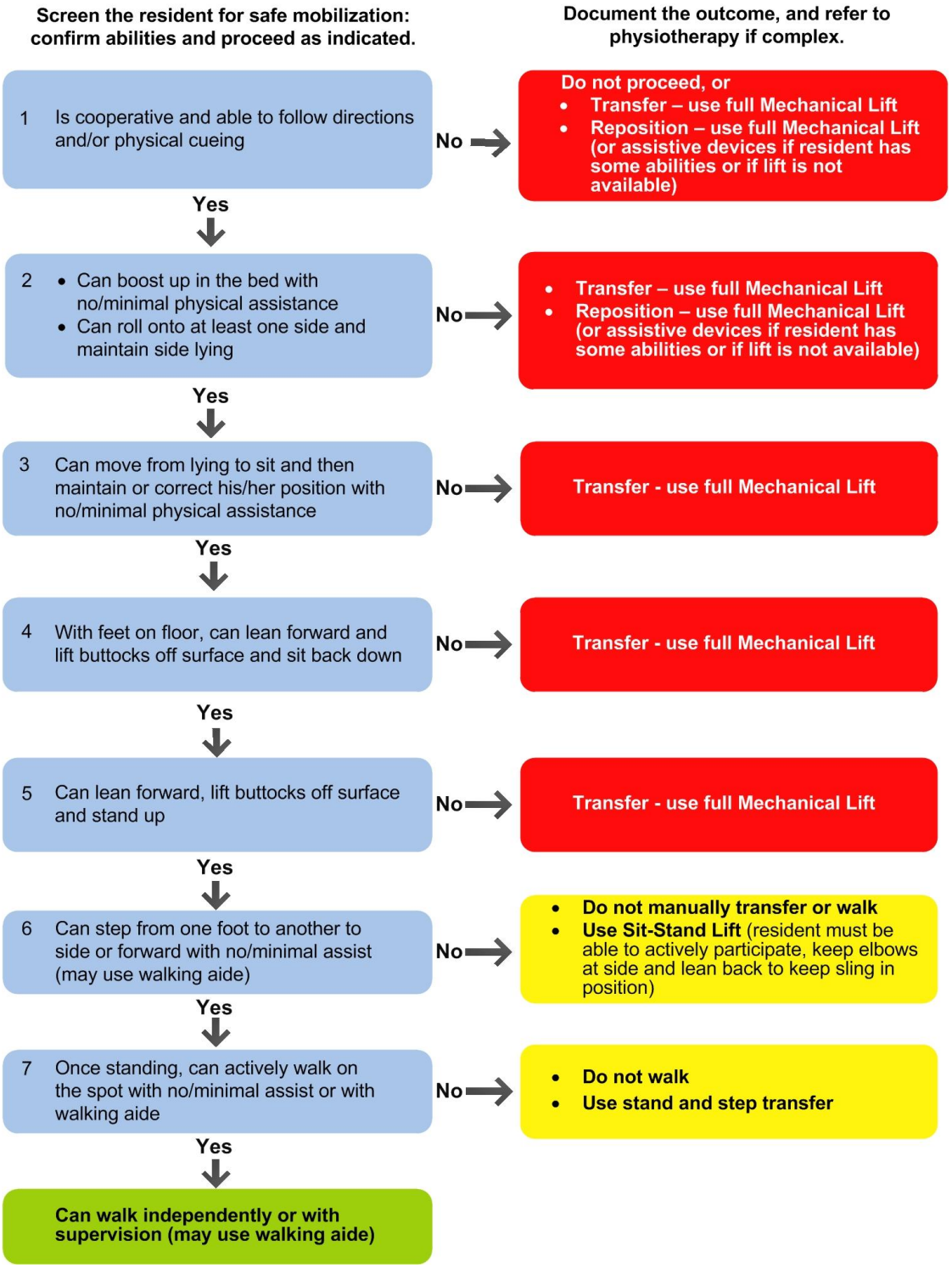
e-learning	• Self-paced modules on various safe patient handling topics. Can include video demonstrations and skills review/quizzes. • Check availability on health authority internal LMS FIRST– employee attendance is automatically tracked on local LMS; alternatively, various modules are available on OHS Connect – attendance reports must be received from OHS Connect administrator for entry into site/local attendance tracking system.
self directed learning packages	• Paper based self-paced learning packages. Health Authority may choose this option where access to e-learning modules is not feasible. • Manager may be required to print and provide copies to employees where employee access to internal websites is not possible; and , is required to maintain an employee completion tracking system.
instructor/ leader led learning	• Includes face to face classroom based sessions and web-based sessions via a conferencing and collaboration system (e.g. LiveMeeting) • Manager required to register participants – LMS system can be used if available for registration and attendance tracking.

Informal learning opportunities can include:

return demonstration	• Can be linked to completion of self-paced modules or packages. Staff may be asked/required to do a skill specific return demonstration with a member of the peer resource team. The peer resource can provide tips, guidance, and assistance with skill application at the site.
bedside coaching	• A peer resource team member can work alongside co-workers and promote application of safe work practices, model safe practices, and facilitate knowledge to practice transfer.
resource review	• Employees can be directed to or independently seek out resources such as SWP's, equipment manuals, point-of-care risk assessments, guidelines, self-check tools and policies. Review of resources can supplement knowledge gained during formal sessions, refresh knowledge as required and support peer resource team members during coaching and return demonstrations.

Appendix B
Mobility Decision Support Tool

This tool is intended to guide decisions on transfers and ambulation related to daily activities of providing care. It is not intended to restrict activities for rehabilitation therapy purposes, or to override clinical judgment and resident-specific needs, as determined by the care team.



Appendix C
Examples of Mechanical and Non-mechanical Resident Handling Equipment

The following are examples of mechanical and non-mechanical equipment (note: these are only examples and this is not intended to be an exhaustive list).

Mechanical Equipment

- Ceiling (overhead) lifts
- Full-body floor based lifts (total floor lifts)
- Sit-to-stand lifts (standers, stand assist lifts)
- Various slings available:
    - Universal transfer sling
    - Hygiene/toileting sling
    - Hammock/amputee sling
    - Band sling
    - Positioning sling
    - Turning sling
    - Limb support sling
    - Walking sling
- Air assisted transfer devices

Non-mechanical Equipment

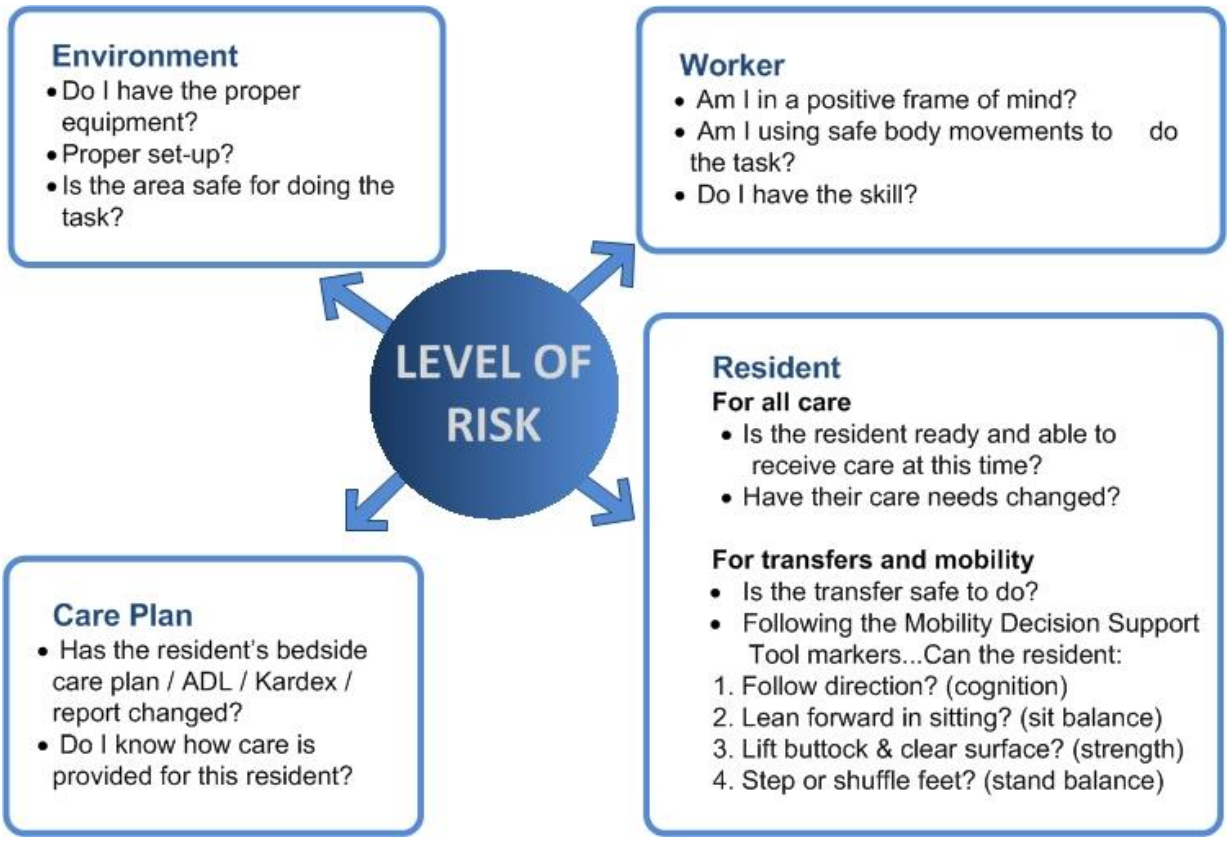
- 2nd hand band
- Bed ladder
- Pivot disk
- Platform walker
- Roller board
- SARA Stedy
- Slider bag
- Slider sheet, slider sheet system
- Transfer belts
- Transfer board
- Transfer pole
- Trapeze

Appendix D
Point of Care Risk Assessment

Why is this important?

Before and during resident care, the care provider should check the resident's current physical and mental function to ensure it matches their present care plan. Care providers are checking to confirm that care is safe to do at that point in time, for the resident and the worker. This is referred to as a "point of care risk assessment."

What should care providers check for at the point of care?



What can care providers do if they think the task is unsafe?

Report resident changes by following your facility's reporting process.

If care CANNOT be provided safely:

- Can something be done to provide safe care right now (e.g., use a ceiling lift)?
- If not, make sure the resident is safe, and talk to your supervisor about an alternative safe care plan.
- Follow the reporting process to communicate changes and update care plans.
- A re-assessment may be required.

Resources

Visit WorkSafeBC.com (Publications) to view the video "Assess Every Time."

Appendix E
Sample Kiwanis Care Center Sling Removal Decision Support Tool

Resident is **consistently** able to lean forward and requires **no** or **minimal** assistance to do so	If Yes →	Slings may be left in place to reduce staff injuries.

↓ If No

Patient is: • Inconsistent • Resistant • Unable to lean forward independently or with minimal assistance	If Yes →	**Sling is left behind the resident:** • Resident must not sit on the sling • Sling's bottom is above the coccyx • The leg straps should be either along the side of the wheelchair or tied behind the wheelchair • The leg straps **cannot** be under the buttocks

↓ If contraindications or considerations exist…

1. Skin Integrity Resident's skin has red areas and potential breakdown that could be caused by leaving the sling behind the resident	Then →	Get interdisciplinary care team together to: • Confirm the sling is actually causing the redness or skin breakdown and exclude any other causes (i.e. layering, wet clothes). • Confirm that sling was positioned correctly (as incorrect positioning may have caused the skin problem) • *If sling needs to be removed* – to brainstorm how this can be done as safely as possible for the caregivers and the resident
2. Impact on seating	Then →	Get interdisciplinary care team together to: • Evaluate the impact on seating and care planning to reduce this impact • *If sling needs to be removed* – to brainstorm how this can be done as safely as possible for the caregivers and the resident
3. Additional resident needs	Then →	Get interdisciplinary care team together to: • Evaluate the impact on resident quality of life balanced with staff safety. • *If sling needs to be removed* – to brainstorm how this can be done as safely as possible for the caregivers and the resident

↓ Last option,

Remove sling from behind the resident and *ensure that staff knows how to do this* safely

Appendix F
Safe Methods for Resident Toileting

Methods to improve toileting the continent dependent resident on a commode or toilet (reduce bedpanning)

1. A hygiene sling can increase access for personal care/dressing (after appropriate assessment and safe work procedures have been followed).

2. If it is not safe to use a hygiene sling, a universal transfer sling, in combination with care appropriate clothing, can be used to toilet a continent resident. Choose clothing that provides easy access to undergarments and continence pads while the resident is in the sling. This will allow the care provider to remove clothing and sit a resident onto a commode or toilet in a timely manner. Re-dressing will also be possible in sitting position with the sling remaining in place, removing the need for a transfer back to bed.

For example, an OHSAH study found that:

> "The rear-split pants were better received than the side snap version. The rear split pants also reduced the amount of rolling, repositioning, and manual handling. The residents that used this style of pants were all non-ambulatory, so exposed areas were not a concern. Staff indicated that they found toileting from a sling lift was easier, as was dressing the resident in either a sitting or lying position." OHSAH (2003).

Methods to improve cleansing and peri-care for residents who toilet sitting down

For residents who toilet on a commode or toilet seat, consider the following methods to access peri-area to increase independence and to reduce awkward postures for staff (NBPA, 1999):

1. Encourage resident to lean forward on the toilet/commode in a stable sitting position, to increase rear access by caregiver.

2. Encourage resident to slide pelvis forward and lean back on the toilet/commode to open hip angle and increase ease of frontal access of peri-area for independent wiping.

3. Personal use, portable warm water sprayer ("washlet") can facilitate independent cleansing after voiding.

4. When a mechanical lift is used for toileting, the resident can be lifted up to provide better access for personal care if assistance is needed.

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Appendix G
Criteria Indicating Reassess of Resident Dressing Care Plans is Needed

If ANY of the following criteria are met, reassessment of the dressing care plan is required.

1. Stiff shoulders or heavy arms; stiff or heavy legs; unable to assist with dressing.
2. Painful joints on movement when dressing.
3. Unable to roll side to side or maintain side lie position.
4. Unable to lean forward independently.
5. Uses a lift for toileting.
6. Sensitive with dressing assistance.
7. Sudden/unexpected arm or leg movement.

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