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What Elements of the 2013 American Nurses Association Safe Patient Handling and Mobility Standards are Reflected in State Legislation?

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Abstract

Many professional organizations have endorsed and provided guidance on the implementation of safe patient handling and mobility (SPHM) programs. In 2013, the American Nurses Association published the interprofessional standards of SPHM. Eleven states have passed laws to implement statewide SPHM programs. This article describes the evaluation of the quality of SPHM legislation against the ANA standards. Information gleaned from this analysis could be used to strengthen existing legislation, craft new bills in the 39 states without SPHM legislation, and provide direction for national legislation.

Keywords

safe patient handling and mobility; legislation; American Nurses Association; standards

Introduction

Universal implementation of safe patient handling and mobility (SPHM) in all healthcare settings, for all healthcare workers who assist in patient mobility, and for all patients who require assistance with mobility is a goal of practitioners and leaders in the field. Universal implementation could be achieved by incremental change one facility and one healthcare system at a time, increasing the number of individual states that pass legislation, or passing federal legislation. In the United States, given that there are over 5,700 registered hospitals with over 920,000 staffed beds,[1] over 15,600 nursing homes with over 1.7 million operating beds,[2] and nearly 1.5 million patients receiving home health care every day,[3] incremental change facility by facility is likely never to achieve universal implementation. Likewise, given that only 11 states have passed legislation from 2005 to 2014, state-based legislation is not likely to achieve universal implementation, or it will take a very long time. Federal legislation has potential to achieve national implementation, yet has not been passed to date. The most recent attempt for federal legislation was during the 113th Congress, when Congressman John Conyers, with 16 cosponsors, introduced HR 2480, the Nurse and Health Care Worker Protection Act of 2013.[4] The bill was referred to 3 committees for consideration but did not go any further. This bill would apply to all healthcare employers and would “direct the Secretary of Labor to issue an occupational safety and health standard

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to reduce injuries to patients, nurses, and all other health care workers by establishing a safe patient handling, mobility, and injury prevention standard…." Items addressed in the bill were program development, technology and equipment purchase and management, healthcare worker participation, data tracking and review, incorporation of technology into the design of new facilities or facility remodeling, and education and training.

Professional organizations such as the American Nurses Association (ANA) and affiliations (eg, the Association of Perioperative Registered Nurses), the American Physical Therapy Association, and oversight and regulatory bodies such as The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, and the National Institute for Occupational Safety and Health (NIOSH) have all supported SPHM and promulgated guidance, but the influence on regulation and legislation is not clear. In 2013, the American Nurses Association released *Safe Patient Handling and Mobility: Interprofessional National Standards* "to infuse a stronger culture of safety in health care work environments and provide a universal foundation for policies, practices, regulations and legislation to protect patients and health care workers from injury."[5,6] The 8 interprofessional standards are listed as follows: (1) Establish a culture of safety, (2) Implement and sustain a safe patient handling and mobility (SPHM) program; (3) Incorporate ergonomic design principles to provide a safe environment of care; (4) Select, install, and maintain SPHM technology; (5) Establish a system for education, training, and maintaining competence; (6) Integrate patient-centered SPHM assessment, plan of care, and use of SPHM technology; (7) Include SPHM in reasonable accommodation and post-injury return to work; and (8) Establish a comprehensive evaluation system.[6]

The goal of this analysis was to evaluate the quality of SPHM legislation against the ANA standards. The aims were to (1) compare and contrast definitions of safe patient handling and mobility across laws; and (2) identify the presence of the standards in the language of each law. Information gleaned from this analysis could be used to strengthen existing legislation, craft new bills in the remaining 39 states without SPHM legislation, and provide direction for national legislation.

Methods

Legislation was limited to bills signed into law; no pending bills or bills that were not passed were reviewed. Information about existing state legislation was obtained from the ANA and NIOSH Web sites. Texts of each bill were located, downloaded, and prepared for analysis (Table 1). Content analysis was used to identify the presence of the ANA standards in the texts. Two analysts preformed the content analysis separately and then met to review each other's coding and reconcile differences.

Results

Aim 1

Eight of 11 states' laws included a definition of SPHM. Texas,[7] Hawaii,[8] and Maryland[9,10] did not include a definition. Washington's law had the most succinct definition as stated, "*Safe patient handling* means the use of engineering controls, lifting and transfer aids, or

assistive devices, by lift teams or other staff, instead of manual lifting to perform the acts of lifting, transferring, and repositioning health care patients and residents."[11(p3)] Five of the 8 definitions specifically mentioned devices such as sit-to-stand floor lifts, ceiling lifts, or electric beds.[11-14,18] Six laws referred to specific tasks such as lifting, transferring, and repositioning.[11,13,15,16] Other common terms used within the definitions of SPHM *were policy,*[11,17,18] *minimizing injury to staff and patients,*[17,18] *education,*[12,15,18] and *financial incentives.*[12]

Aim 2

Table 2 shows the presence of the ANA standards in legislation by state, including the number of laws with each standard (column totals) and the number of standards addressed in each law (row totals). The laws that included the most standards were Washington[11] and New York.[15] Washington legislation was passed in 2005, well before the standards were written.[11] One state, New York passed legislation after the standards were published and included 8 standards.[15] The majority of standards addressed standards for employers, as the states regulate healthcare facilities; however, the ANA standards also addressed the responsibilities of healthcare workers. Standards for healthcare workers were not included in this analysis. Each standard will be briefly reviewed.

1. "Establish a culture of safety" consisted of 5 standards to be addressed by employers. Five laws included a system for right of refusal. Most had a strong statement about retaliating against any employee who refused to perform a lifting procedure. For example in New Jersey, "A covered health care facility shall not retaliate against any health care worker because that worker refuses to perform a patient handling task due to a reasonable concern about worker or patient safety, or the lack of appropriate and available patient handling equipment or aids"[14(lines199-203)] Illinois[17] and New York[15] laws addressed safe levels of staffing to support SPHM by collaborating with and providing an annual report to the nurse staffing committee. Other than the formation of a committee, no state addressed establishing a system for communication and collaboration. No legislation addressed the first employer standard of a written statement of a culture of safety.

2. "Implement and sustain a safe patient handling and mobility (SPHM) program" consisted of 7 employer standards. The most frequently addressed standard in the laws was designating a committee (Texas, Washington, Rhode Island, Maryland, New Jersey, Minnesota, and New York).[7,9-11,13-16] Most of these states specified the composition of the committee and required involvement of healthcare workers. Identifying tasks that placed a healthcare worker at risk for injury was also commonly represented in the laws. Reducing the physical requirements of high-risk tasks was mentioned in the Texas and New Jersey laws.[7,14] However, performing a needs assessment for equipment was written only into Texas law.[7] Only the Rhode Island law emphasized integrating the program across all units and all shifts.[13] Only 2 states, Hawaii[8] and Ohio,[12] did not address the program components of SPHM. The Hawaii action was a resolution endorsing the ANA Handle With Care® program and only addressed the education standard.[8]

3. "Incorporate ergonomic design principles to provide a safe environment of care" included 2 employer standards. The first standard, planning for ergonomic safely in new construction and renovation, was covered by 6 states' laws (Texas, Washington, Maryland, Illinois, Minnesota, and New York).[7,9-11,15-17] One strong example was in the Minnesota law to "recommend procedures to ensure that, when remodeling of patient care areas occurs, the plans incorporate safe patient handling equipment or the physical space and construction design needed to accommodate safe patient handling equipment at a later date."[16(p5)] The second employer standard, including input from healthcare workers at all stages of new construction, rebuilding, and remodeling, was not covered by any state.

4. "Select, install, and maintain SPHM technology" included 7 employer standards. In general, the laws specified the purchase or acquisition of equipment. Other sub areas of standard 4 were not included in the laws, such as performing a needs assessment for equipment or providing opportunities for staff to try out and provide feedback on equipment and other details for installing and maintaining the technology. Several states provided specific details related to the amount and types of equipment that should be installed and dates on when installation must be completed. For example, the New York law stated, "Each health care facility shall complete, at a minimum, acquisition of its choice of a) one readily available lift per acute care unit on the same floor, unless the Safe Patient Handling committee determines a lift is unnecessary in the unit; b) one lift for every ten acute care available inpatient beds; or c) equipment for use by lift teams."[15(p2)] Six state laws required the installation of equipment, see Table 2. The Ohio[12] and Rhode Island[13] laws included mechanical devices in their definitions of SPHM, yet neither state required the purchase of devices. Only New Jersey[14] and Minnesota laws[16] required facilities to establish a maintenance program. New Jersey was the only state law that addressed storage and compliance with manufacturer's recommendations.[14]

5. "Establish a system for education, training, and maintaining competence" had the most employer standards, eight, and was addressed by all laws. This detailed standard addressed all workers from across the continuum of care, time for training, providing technology, documenting competence, engaging and educating recipients, and ongoing competence evaluations. Most states, however, only referred to education in a general way, such as "must train staff on policies, equipment, and services at least annually."[11(p3)] The strongest education sections were in the New Jersey[14] law, which specified paid time, annual competencies, and resources for patients and their families. Illinois[17] was the only law to address the need to educate patients and families and to bring them into the decision about what type of lift should be used. The Illinois law required "A policy of advising patients of a range of transfer and lift options, including adjustable diagnostic and treatment equipment, mechanical lifts, and provisions of a trained safe lifting team the right of a competent patient, or guardian of a patient adjudicated incompetent, to choose among the range of transfer and lift options."[17(lines85-94)] Regarding the cost of education, Minnesota[16] required that "the commissioner shall make training

materials on implementation of this section available to all health care facilities at no cost as part of the training and education duties of the commissioner."[16(p3)]

6. "Integrate patient-centered SPHM assessment, plan of care, and use of SPHM technology" addresses the need to assess the physical condition of the patient and provide the correct lift and sling type that meets the patient's mobility needs. It requires ongoing reassessments to determine the changing needs of the patient and including these needs in the plan of care. There are 4 other employer standards in this section, for a total of 7. Six laws required a procedure to evaluate a patient's SPHM status (Washington, Rhode Island, New Jersey, California, Illinois, and New York).[11,13-15,17,18] Three laws (Washington, New Jersey, and Illinois) also specified that education was an ongoing procedure.[11,14,17] Only one state, Rhode Island,[13] came close to addressing the issue of a patient refusing the use of SPHM technology, stating, "Develop a process to identify the appropriate use of the safe patient handling policy based on the patient's physical and mental condition, the patient's choice…"[13(p3)]

7. "Include SPHM in reasonable accommodation and post-injury return to work" addresses 3 employer standards: facilitate the employment of disabled workers (not addressed in any law), monitoring healthcare worker injuries, and facilitate early return to work following injury (not addressed in any law). Monitoring healthcare worker injuries was addressed by 5 states.[7,11,13,15,16] The Rhode Island law included language requiring the monitoring of worker's compensation musculoskeletal disorder claims and lost days of work attributed to patient handling.[13(p4)]

8. "Establish a comprehensive evaluation system" included 6 employer standards, including a written comprehensive evaluation plan, data sources and measures, standardized definitions and methods, disseminating findings, quality improvement plan, and compliance with privacy laws and other regulatory language. Six states referred to an annual evaluation plan in general terms.[7,9-11,13-17] Three states referred to measuring implementation, program effectiveness, or measuring the deployment of technology and outcomes.[11,13,15] The Rhode Island law provided strong evaluation language, stating, "The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in musculoskeletal disorder claims and days of lost work attributable to musculoskeletal disorder caused by patient handling, and include recommendations to increase the program's effectiveness."[13(p4)]

Not directly related to the ANA standards, other findings were as follows:

- The intended target of the legislation varied. Six of the laws applied to most or all healthcare facilities ("healthcare facilities," "licensed providers"), three applied to only hospitals (Washington, Illinois, California),[11,17,18] and one applied to only long-term care (Ohio),[12] see Table 1. California[18] specifically excluded acute care hospitals in the department of corrections or rehabilitation, or in the State Department of Developmental Services.

- Six states included the language of *lift teams*, a term not addressed in the ANA standards. Often the term was included in a list of definitions.[7,9-11,15,17,18] For example, according to the Rhode Island law, "*Lift team* means health care facility employees specially trained to perform patient lifts, transfers, and repositioning in accordance with safe patient handling policy"[13(p2)]
- Only two laws (New Jersey, Minnesota) explicitly offered provisions for regulatory oversight.[14,16] Others (eg, Washington, California, Illinois, New York) implied regulatory oversight because they were amendments to existing laws with regulatory oversight.[11,15,17,18] For example, California situated SPHM legislation within existing California Occupational Health and Safety Administration legislation.[18]
- Five laws (Texas, Rhode Island, Maryland, Minnesota, and New York) provided economic incentives to facilities via tax or other credits.[7,9,10,13,15,16] One state, Ohio,[12] established a program for the Bureau of Workers' Compensation to operate a long-term care loan fund for nursing homes to borrow money with no interest to purchase, improve, install, or erect specific types of equipment, and to pay for education and training of personnel.[12]

Discussion

In our analysis of current state SPHM legislation, we found moderate variability in the definition of SPHM, the presence of language that reflected the ANA standards, and the types of facilities to which the law applied, eg, only hospitals or to all healthcare facilities. Notably absent was the explicit inclusion of outpatient settings and home care. While the standards were represented to some degree in all of the legislation, none addressed the majority of employee sub-standards outlined by the ANA document. For example, eight of the laws included policy requirements; yet policy statements were limited to policy that provided for right of refusal to transfer, move, or reposition a patient if the worker is at risk for injury. No law included verbiage to address establishment of a culture of safely. On the other hand, a number of laws included lift teams in some way; yet lift teams were not included in the ANA standards. Standard 7 was included least often in state legislation, probably because reasonable accommodations to healthcare workers who were injured is likely covered by other state and federal laws.

The most comprehensive laws were from Washington,[11] Illinois,[17] Rhode Island,[13] Minnesota,[16] and New York,[15] with New York being the most recently enacted, see Table 2. However, the Washington[11] law applied only to acute care hospitals while the others pertained to "healthcare facilities" or to "licensed providers." To our knowledge, Washington is the only state to have conducted an evaluation of its legislation. In a 5-year evaluation of the influence of Washington's legislation compared to Idaho, a state with no legislation, Silverstein and Schurke[19] found positive results with decreased injuries in Washington hospitals and nursing homes. They also noted continued high workers' compensation claims for ambulance workers and paramedics not covered by the legislation. Also, Washington State hospitals reported greater SPHM program implementation compared to Idaho.[20]

Strikingly absent from most of the laws was the lack of explicit enforcement provisions. Given ongoing competing priorities for healthcare institutions for quality, safely, and reduced costs, sustaining successes without enforcement and institutionalization into the state's health oversight organizations is likely to be an ongoing challenge.

In conclusion, while only 11 states have promulgated SPHM legislation or resolutions, they can be used to guide how other states move forward in introducing and passing legislation with the eventual goal of federal legislation to achieve universal implementation of evidence-based SPHM throughout all health care. The ANA standards provided a useful framework for analyzing existing law and ensuring that essential elements of SPHM are included in future legislation. Provisions for statewide evaluation of legislation into the language of new laws could help shape future policy.

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Table 1

Eleven States With Laws, Rules, Regulation, or Resolutions Addressing Sphm

State	Bill, Law, or Statute	Year Signed into Law*	Applies to
Texas[7]	Amendment to Subtitle B, Title 4, Health and Safety Code, Chapter 256	2005	hospitals and nursing homes
Washington[11]	HB 1672	2006	hospitals
Hawaii**[8]	HCR NO.16	2006	broad healthcare facilities
Ohio[12]	HB 67, Section 4121.48	2005	long-term care
Rhode Island[13]	S 2760 Substitute A	2006	healthcare facility means hospitals and nursing facilities
Minnesota[16]	Statute 182.6551 to 182.6554	2007	healthcare facility means hospital, outpatient surgical center, and nursing home
Maryland (a)***[9]	HB 1137-hospitals	2007	hospitals
Maryland (b)***[10]	HB 585-nursing homes	2008	nursing homes
New Jersey[14]	S-758/A-3028	2008	healthcare facilities, including psychiatric hospitals, state developmental centers
Illinois[17]	Public Act 097-0122/HB 1684	2009	hospitals
California[18]	AB 1136	2011	acute care hospitals
New York[15]	Bill S6914-2013	2014	licensed hospital providers

*Year signed into law was not always the same as the effective date.

**Hawaii was the only state that passed a resolution rather than a law, rules, or regulations.

***Because Maryland laws are essentially the same, except one applies to nursing homes and one applies to hospitals, the two laws are treated as one for the purposes of this article.

Table 2

Presence of ANA Standard in Legislation by State

Standard	1 Culture	2 Program	3 Ergonomic Design	4 Technology	5 Education	6 Patient Care	7 Post-injury	8 Evaluation	Total
1. Texas	1	1	1	0	1	0	1	1	**6**
2. Washington	1	1	1	1	1	1	1	1	**8**
3. Hawaii	0	0	0	0	1	0	0	0	**1**
4. Ohio	0	1	0	0	1	0	0	0	**2**
5. Rhode Island	1	1	0	0	1	1	1	1	**6**
6. Maryland a. Hospital b. Nursing Home	1	1	1	1	1	0	0	1	**6**
7. New Jersey	1	1	0	1	1	1	0	1	**6**
8. California	1	1	0	1	1	1	0	0	**5**
9. Illinois	1	1	1	0	1	1	0	1	**6**
10. Minnesota	0	1	1	1	1	0	1	1	**6**
11. New York	1	1	1	1	1	1	1	1	**8**
Total	**8**	**10**	**6**	**6**	**11**	**6**	**5**	**8**	**60**

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