

Safe Patient Handling

The South Shore Health Journey

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A Process Without End...

- 2004 – University of Lowell Ergonomic Assessment
- 2004 - First ceiling lift installed in ICU
- 2005 - Safe patient handling Task Force created
- 2006 - Roller boards adopted house wide
- 2014 - 50th ceiling lift installed/1st Bariatric room
- 2016 - Zoom stretchers for Birthing Unit
- 2017 - 75th ceiling lift /10th EMS Power stretcher
- 2018 - Hovermats introduced/6th Bariatric room
- 2019 - Standard work created for extraction of Emergency patients from cars

Objectives

- **Lessons Learned:** it's a process, need front line SME, and it is a culture change (no quick fix) to USE TOOLS WHENEVER POSSIBLE
- **Benefits:** Increase colleague trust, increase patient safety, lower costs, retain talent
- **Challenges:** culture change takes time, turning side/side and boost up use of mechanicals, multiple variables such as increasing number of bariatric patients
- **Measures Used:** OSHA reportable rate, lost work days, number of injuries
- **Measures of Success:** above plus safety survey and colleague survey
- **Gaps remain:** as noted in challenges, in ambulatory settings with fragile patients and in Birthing Unit w/use of leg lifts/holders

Tools That Humans (Should) Use



Employee Incident/Injury Summary

All Incidents/Injury	2019 (Jan – May 30)	2018
Total Incidents	286 vs (102 Hospital + 16 HCD = 118)	583 (196 Hospital & 17 HCD = 213)
Lost Time Cases	43 (37 Hospital + 6 HCD)	91 (77 Hospital & 14 HCD)
Lost Work Days	1,812 (1,413 Hospital + 399 HCD)	6,302 (Hospital 5, 212 & HCD 1,090)
Workers Compensation Costs \$	\$578,300.00	\$1,879,580.00

The Fuel to Always Improve Outcomes from Data and Culture



SAFETY												
AUGUST 2019												
				1	2							
				3	4							
				5	6							
7	9	11		13	15	17	19	21				
8	10	12		14	16	18	20	22				
				23	24							
				25	26							
				27	28							
				29	30/31							

- Daily review begins at the local level that moves to the senior leader
 - Why did this happen?
 - How to contain?
 - How to prevent future occurrences?
- Leadership rounding/role modeling (pressure audit prevalence, patient transport, etc.)
- The goal is always keeping the patient and colleague safe