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National Environmental, Health & Safety

Mr. Robert Nakamura
Senior Safety Engineer
Division of Occupational Safety and Health
Research and Standards Health Unit
P.O. Box 420603
San Francisco, CA 94142

Re: Comments on the Division of Occupational Safety and Health's draft regulations regarding the implementation of AB 1136, the Hospital Patient and Health Care Worker Injury Protection Act from Assembly Bill 1136

Dear Mr. Nakamura:

The enclosed comments are submitted on behalf of Kaiser Permanente in response to a request by the Department of Industrial Relations' Division of Occupational Safety and Health ("DOSH") for public participation on the proposed regulation to enforce the requirements of AB 1136, the Hospital Patient and Health Care Injury Protection Act ("AB 1136"). We appreciate the opportunity to provide you with information that we believe is necessary to develop clear and effective regulations.

Kaiser Permanente is one of the nation's largest not-for-profit health plans, serving over 6.5 million members in California alone. Approximately 175,000 physicians, staff, and administrators serve patients in our hospitals. Our patients and our employees are the subjects of AB 1136; the law seeks to protect our staff from back injuries that may result in the course of necessary patient handling and mobilization. We take this opportunity to comment on the implementation of AB 1136 as a health care provider with a significant interest in the impact the law will have on how we provide care.

As a threshold matter, our comments represent our initial thoughts on DOSH's implementation of AB 1136. We expect to participate in the upcoming advisory meeting with DOSH on March 29, 2012 and, to the extent necessary, provide additional written comments at a later date. The initial comments below address the interpretation of some specific language and terminology used in AB 1136 that was discussed during the January 24, 2012 advisory meeting.

Role of registered nurses. Section 3(c) of AB 1136 states that "[a]s the coordinator of care, the registered nurse shall be responsible for the observation and direction of patient lifts and mobilization, and shall participate as needed in patient handling in accordance with the nurse's job description and professional judgment." The California legislature intended to give registered nurses a high-level coordinating role in patient handling and mobilization. Where necessary, registered nurses will directly participate in patient handling and mobilization. In situations where such a direct role is not needed in the professional judgment of the registered nurse, other hospital staff members must be able oversee and direct patient handling and mobilization according to the scope of their practice and consistent with their training and licensure.

Any regulation implementing AB 1136 should not limit the ability of qualified and licensed hospital staff members to oversee and direct patient handling and mobilization where such care is appropriate. In the first clause of Section 3(c), the legislature recognizes registered

nurses as "coordinator[s] of care." Registered nurses, depending on the scope of their duties, often coordinate, oversee, and direct hospital staff in patient handling and mobilization. Indeed, state regulations governing nursing practice explicitly authorize registered nurses to exercise their professional judgment to delegate certain patient care functions to other licensed as well as unlicensed staff.[1] Registered nurses are not physically present at all patient handling events and must communicate with and direct other qualified hospital staff to carry out patient handling as necessary.

As explained above, when registered nurses are not present, and when the circumstances require it, other qualified hospital staff must be able to oversee and direct patient handling and mobilization. DOSH must make clear that the legislature did not intend to limit the ability of trained and competent hospital staff, other than registered nurses, to perform their established patient handling functions. Examples of qualified hospital staff include, among others, certified nursing assistants, mobility technicians, and rehabilitation aides.

The practice of inpatient physical therapy offers a particularly strong example of why regulations implementing AB 1136 must clarify who may oversee and direct patient mobilization. Patient handling and mobilization is a core element of physical therapists' professional practice; physical therapists must have significant control over these aspects of patient care in order to treat patients with the various tools that define physical therapy.[2] Other qualified hospital staff, including those mentioned above, have similar practice requirements and training experiences. All of these qualified and licensed hospital staff members must not be prevented from fulfilling their responsibilities to their patients.

Application of the law to acute care hospital units. As was noted in the January 24, 2012 advisory meeting, the use of the term "licensed acute care area" in AB 1136 needs further clarification. Consistent with the AB 1136's focus on safety *within* hospital patient care units, we suggest that DOSH define "licensed acute care areas" as inpatient nursing units where patients are routinely bedded in licensed acute care hospital space.

In drafting AB 1136, the legislature sought to prevent injuries to patients and hospital staff members resulting from patient handling and mobilization. The legislature was specifically concerned with "patient care units" where patient handling and mobilization is most common and frequent. The above definition focuses on the precise areas that the legislature seeks to regulate: the inpatient nursing areas of a licensed acute care hospital where patients are routinely bedded and where patient handling and mobilization is most common and frequent. This definition would be clearly understood by regulated entities because licensed acute care hospitals and inpatient nursing units within those hospitals are easily identifiable. In this manner, DOSH can efficiently exclude from regulation areas that were clearly not intended to be regulated, such as hospital departments where there are no patients.

Methods of safe patient handling. AB 1136 requires regulated entities to develop "safe patient handling polici[es]" defined in Section 3(f) as "polic[ies] that require[] replacement of manual lifting and transferring of patients with powered patient transfer devices, lifting devices, and lift teams, as appropriate for the specific patient and consistent with the

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[1] Cal. Admin. Code tit. 22, § 70215(a)(2) ("The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation."). See also Cal. Admin. Code. tit. 16, § 1443.5(5) (registered nurses must "[e]valuate[] the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and *health team members*, [] modif[y] the plan as needed.") (emphasis added).

[2] Cal. Bus. & Prof. Code § 2620(a).

employer's safety policies and the professional judgment and clinical assessment of the registered nurse."

We agree that safe patient handling should include assessments of patients' individual needs by trained hospital employees as well as the opportunity to choose from a wide variety of safe lifting methods and technologies to suit those needs. As DOSH knows, patient needs differ substantially from one person to another, especially when patient handling and mobilization is required. Hospital personnel must have the flexibility to assess the situation of a particular patient and tailor the method of patient handling and mobilization appropriately.

To ensure safe patient care in every different patient handling and mobilization situation, there must be a wide variety of patient movement and lifting options and technologies available to hospital personnel including, but not limited to: manual lifting with a minimum of two trained hospital personnel, lift teams as defined in AB 1136, friction reducing aids, non-powered lift devices and transfer devices, mechanically powered lift devices and transfer devices, and electrically powered lift devices and transfer devices. All of these devices have roles in guaranteeing safe patient handling and the professional in charge should decide which safe lifting method to adopt in a particular situation. By giving hospital personnel a variety of safe patient handling options to meet patient needs, we can ensure the safety of both our patients and our hospital personnel.

Thank you in advance for your consideration of our comments. We look forward to the opportunity to discuss the above issues at the next advisory meeting on March 29, 2012. Please feel free to contact us regarding the content of our comments at any time. The best person to contact is Anthony Donaldson, Principal Consultant with KP National Environmental, Health & Safety. He can be reached by telephone at 510-625-7145 or by email at anthony.w.donaldson@kp.org.

Sincerely,

Barbara Smisko

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