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NOTICE OF PROPOSED MODIFICATIONS TO

CALIFORNIA CODE OF REGULATIONS

TITLE 8: New Section 5120 of the General Industry Safety Orders

Safe Patient Handling

MODIFICATIONS AND RESPONSE TO COMMENTS RESULTING FROM THE 45-DAY PUBLIC COMMENT PERIOD

Pursuant to Government Code Section 11346.8(c), the Occupational Safety and Health Standards Board (Standards Board) gives notice of the opportunity to submit written comments on the above-named standards in which modifications are being considered as a result of public comments and/or Board staff consideration.

On September 19, 2013, the Standards Board held a Public Hearing to consider revisions to Title 8, New Section 5120 of the General Industry Safety Orders. The Standards Board received oral and written comments on the proposed revisions. Modifications are now proposed for subsections (b), (c), (d), (e), and Appendix A.

Subsection (b), Definitions
In subsection (b), a modification to the definition for Designated registered nurse is proposed to state that the Plan is required by subsection (c), and not simply referenced by that subsection. This is an editorial change for clarity. The definition has also been modified by changing "patients or their families" to "patients or their authorized representatives" in response to comments from the California Hospital Association that this would be consistent with health care privacy laws. The change is necessary to make the proposed text consistent in that manner.

Subsection (c)
A modification is proposed to subsection (c)(3) to remove the phrase "methods for providing" and replaced with "how employees will be provided" for clarity.

A modification is proposed to subsection (c)(4) to state that the procedures ensuring supervisory and non-supervisory employee compliance with the Plan are required to be in accordance with Section 3203(a)(2). This change is in response to several comments to the Board stating that this requirement needs to have reference to the methods that may be used to assure compliance with a policy. Since this proposed regulation is intended to be consistent with Section 3203, subsection (a)(2), describing the system for ensuring employee compliance, is the most relevant reference. This change is necessary to give the requirement the same context as Section 3203.

A modification is proposed to subsection (c)(5)(A) to state that equipment must be available and accessible at all times. This is in response to several comments stating that equipment may be "available," but not accessible, or may only be available at certain times, for example, during the

day shift. This change is needed to assure that this aspect of being able to utilize equipment is addressed. This subsection has also been modified to clarify that initial equipment evaluations done after January 1, 2012, need to meet the requirements of this specific subsection to be acceptable. This change is needed to clarify that this should apply only to the initial evaluation of equipment needs.

A modification is proposed to subsection (c)(5)(B) to state that the procedures followed by the designated registered nurse to assess patient mobility needs will be based on the nurse's professional judgment and involve the use of the listed methods. The subsection has also been modified to state that the Plan must include the means by which health care workers and supervisors licensed in other disciplines can provide input regarding the patient mobility assessment and instructions. This change was made in response to numerous comments to the Board that the previous language did not correctly reflect AB 1136, and the change is needed to clarify the role of the registered nurse as the coordinator of care, while establishing a means for interaction with other licensed health care personnel.

A modification is proposed to subsection (c)(6) to remove "For acute injuries and for cumulative trauma" in response to comments that this may limit the type of injuries that are investigated. This change is needed to remove the limitation to the type of adverse outcomes that need to be investigated.

A modification is proposed to subsection (c)(6)(B) to specify that the injury investigation assesses if the employees have been trained as required by subsection (d). This change is need for clarity.

A modification is proposed to subsection (c)(7)(B) to require procedures for locating safe patient handling equipment that is shared between units. Several commenters reported that equipment is often not used because it cannot be found when needed. This change is needed to clarify that equipment, to be available, must be locatable.

A modification is proposed to subsection (c)(7)(D) to replace the reference to a patient's family with the patient's authorized representative. This is necessary to be consistent with privacy laws as noted in the proposed modification to subsection (b).

A modification is proposed to subsection (c)(7)(E) to clarify that the Plan must include procedures by which lift teams and/or other designated health care workers will be available to perform patient handling tasks. The purpose of this modification is to clarify that lift teams and/or other designated health care workers may perform these tasks. A further modification is proposed to explain that available means that an employee does not have an assignment that would prevent the employee from performing the patient handling task within the necessary time frame, as determined by the person responsible for directing and observing the patient handling task under subsections (c)(7)(C) and (c)(7)(F). This change was made in response to numerous written and oral comments to the Board that currently, sufficient trained staff are not available to assist with patient handling tasks without taking those staff away from other assignments, and therefore employees are injured because sufficient trained staff is not available. This change is needed to reduce injuries due to a lack of available trained staff.

A modification is proposed to subsection (c)(7)(F) to require having procedures for the situations in which the patients are not cooperative with the safe patient handling instruction that is being implemented. This change is needed to clarify that the Plan must address this situation.

A modification is proposed to subsection (c)(8)(C), in response to comments, to state that it is the supervisors of designated health care workers, designated registered nurses, and lift team members, that are to be included in the review of the effectiveness of the Plan. This is necessary to clarify that the supervisors directly involved in patient handling activities are to be involved in the review.

A modification is proposed to subsection (c)(10) to replace the reference to corrective measures with the term "patient handling equipment" in response to comments that this subsection specifically addresses equipment. It has also been modified to require stating the alternative measures that will be used to protect employees until equipment is put into use. This was in response to comments that employers need to address the problem created by delays in obtaining equipment. This change is needed to clarify that this subsection refers to equipment delays and establishes the use of alternative measures, whether they are equipment or work practices.

Subsection (d)

A modification is proposed to subsection (d)(1)(B) and (d)(2) to clarify that supervisors of designated health care workers, lift team members, and designated registered nurses are the supervisors who are to receive training. This change is proposed in response to comments that the previous wording might have been interpreted to include supervisors of employees who receive awareness training since that is part of the Plan. This change is needed for clarity.

A modification is proposed to subsection (d)(2)(B) to clarify the risk factor refers to the patient's ability to cooperate. This change is needed for clarity.

A modification is proposed to subsection (d)(2)(H) to replace the phrase "perform an unsafe patient handling activity" with "lift, reposition, mobilize, or transfer a patient due to concerns about patient or worker safety or the lack of trained personnel or equipment." This is in response to comments that the training topic should be more specifically consistent with the definition of manual patient handling in subsection (b). The proposed change is needed for that reason.

A modification is proposed to subsection (d)(2)(L) to add that questions arising from training need to be addressed "with a person knowledgeable about the Plan and safe patient handling equipment and procedures." This is in response to numerous comments that have shown this to provide more effective training than with recorded material. This change is necessary to assure that effective training is provided.

A modification is proposed to subsection (d)(2)(M) to clarify that the supervisors of the employees covered by the Plan need to be trained about the employee's right to refuse to perform patient handling activities when there is concern for the employee or patient so that the supervisor knows the applicable policy and how it is to be applied to the situation. This change is necessary to assure that any supervisor of employees covered by this section, including designated health care workers, lift team members, designated registered nurses, and employees who are required to participate in awareness training, are made aware of the proper policy and procedures.

A modification is proposed to subsection (d)(2)(N) to correct a typographical error that omitted (d)(2)(J) through (d)(2)(L) from the scope of training for designated registered nurses. The term "families" has also been replaced by "authorized representatives" to be consistent with health care privacy laws. These changes are needed for clarity and consistency.

A modification is proposed to subsection (d)(3)(A) to specifically include refresher training for lift team members. This modification is necessary because a hospital that uses lift teams may assign those teams to use different lifting procedures and/or equipment than is used by other designated health care workers within the facility, and that the employer must provide refresher training that addresses the equipment and procedures they will be expected to use. This change is needed to assure that lift teams and other designated health care workers are appropriately trained in refresher training sessions.

Subsection (e)

A modification is proposed to subsection (e) to renumber the subsections to put together the inspection and training records that a GACH is responsible to have in accordance with Section 3203(b). It is also necessary to separate the requirements applying to access by the Division, access by employees and their representatives, exclusion of medical information defined by Civil Code 56.05(g), and the treatment of records falling within the Occupational Injury or Illness Reports and Records regulations.

Appendix (A)

Modifications have been proposed to Appendix (A) to remove "Facility Safe Patient Handling Policy (Template)," U.S. Department of Veterans Affairs, March 22, 2010, and two other references are proposed to be listed instead. These are:

> Safe Patient Handling and Mobility Interprofessional National Standards, American Nurses Association 2013, and Safe Patient Handling Guidebook for Facility Champions/Coordinators, Matz, 10/29/2013.

The proposed change is necessary to provide recommended resources in response to comments.

A copy of the full text of the standard, with these modifications clearly indicated, is attached for your information. In addition, a summary of all oral and written comments regarding the original proposal and staff responses is included.

Pursuant to Government Code Section 113456.8(d), notice is also given of the opportunity to submit comments concerning the addition to the rulemaking file of the following documents relied upon:

> Association for Occupational Health Professionals AOHP Beyond Getting Started: A Resource Guide for Implementing a Safe Patient Handling Program in the Acute Care Setting, Summer 2011 (http://aohp.org/aohp/Portals/0/Documents/AboutAOHP/BGS_Summer2011.pdf)
>
> Safe Patient Handling and Mobility Interprofessional National Standards, American Nurses Association 2013 (http://www.nursingworld.org/sphm)
>
> Safe Patient Handling Guidebook For Facility Champions/Coordinators, Matz, 10/29/2013

Copies of these documents are available for review during normal business hours at the Standards Board Office located at the address listed below.

Any written comments on these modifications and the additional documents relied upon must be received by 5:00 p.m. on May 5, 2014, at the Occupational Safety and Health Standards Board, 2520 Venture Oaks Way, Suite 350, Sacramento, California 95833 or submitted by fax to (916) 274-5743 or e-mailed to oshsb@dir.ca.gov. This proposal will be scheduled for adoption at a future business meeting of the Standards Board.

The Standards Board's rulemaking files on the proposed action are open to public inspection Monday through Friday, from 8:00 a.m. to 4:30 p.m., at the Standards Board's office.

Inquiries concerning the proposed changes may be directed to the Executive Officer, Marley Hart, at (916) 274-5721.

OCCUPATIONAL SAFETY AND HEALTH
STANDARDS BOARD

Original signed by

Date: April 16, 2014

Marley Hart, Executive Officer

PROPOSED MODIFICATIONS
(Modifications to the text are indicated in underline wording for new language and strikeout wording for deleted language.)

(Modifications to Appendix A (Non-Mandatory) are indicated in bold underline wording for new language and bold strikeout wording for deleted language.)

PROPOSED STATE STANDARD,
TITLE 8, DIVISION 1, CHAPTER 4

Add new Section 5120 to read:

§ 5120. Health Care Worker Back and Musculoskeletal Injury Prevention.

(a) Scope and Application.
This Section shall apply to all general acute care hospitals.
EXCEPTION (1): This Section shall not apply to general acute care hospitals within the Department of Corrections and Rehabilitation or the State Department of Developmental Services.
EXCEPTION (2): This section shall not apply to units within a general acute care hospital that are separately licensed as a distinct part under Title 22 Section 70625 and 70627.
NOTE to subsection (a): This section does not preclude the application of Section 3203 or other Title 8 safety orders to patient handling in health care facilities, services and operations not covered by this section, nor does it preclude the application of other sections of Title 8, including but not limited to Sections 3203 and 5110, to patient handling in general acute care hospitals.
(b) Definitions.
"Designated health care worker" means an employee responsible for performing or assisting in patient handling activities who is specifically trained to handle patient lifts, repositioning, and transfers using patient transfer, repositioning, and lifting devices as appropriate for the specific patient.
"Designated registered nurse" means a registered nurse who has responsibilities under the Plan ~~referenced to in~~ required by subsection (c), including, but not limited to, the responsibilities of a designated health care worker, preparation of a safe patient handling instruction, the observation and direction of patient lifts or mobilizations, or the communication of patient handling information to patients or their authorized representatives ~~families~~.
"Emergency" means unanticipated circumstances that can be life-threatening or pose a risk of significant injuries to the patient, staff or public, requiring immediate action.
"Equipment" means a powered or non-powered device that effectively reduces the forces exerted by or on employees while they perform patient handling activities, including all accessories necessary for the operation of the device. Devices and accessories include replaceable and disposable items.
"General acute care hospital" (GACH) means a hospital, licensed by the California Department of Public Health as such in accordance with Title 22, California Code of Regulations.
"Lift team" means designated health care workers specifically trained to work together to perform patient handling activities using equipment as appropriate for the specific patient.
"Lifting" means the vertical movement of a patient or the support of part or all of a patient's body.
"Manual patient handling" means the lifting, transferring, repositioning, or mobilizing of part or all of a patient's body done without the assistance of equipment.

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"Mobilizing" means the putting into movement, or assisting in the putting into movement, of part or all of a patient's body.
"Musculoskeletal injury" means acute injury or cumulative trauma of the muscles, tendons, ligaments, bursa, peripheral nerves, joints, bone or blood vessels.
"Patient" means a person who is receiving diagnostic, therapeutic or preventive health services or who is under observation or treatment for illness or injury or for care during and after pregnancy.
"Patient care unit" means a unit or department that is included within a general acute care hospital's license that provides direct patient care including but not limited to nursing units, diagnostic imaging, emergency department, or rehabilitation and behavioral health.
"Patient handling" means lifting, transferring, repositioning or mobilizing of part or all of a patient's body.
"Repositioning" means changing a patient's position on a bed, gurney, chair or other support surface.
"Safe patient handling policy" means a policy that requires 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 employer's safety policies and the professional judgment and clinical assessment of the registered nurse.
"Transferring" means moving a patient from one surface to another (for example from a bed to a gurney).
(c) Patient protection and health care worker back and musculoskeletal injury prevention plan. As part of the Injury and Illness Prevention Program (IIPP) required by Section 3203, each hospital covered by this section shall establish, implement and maintain an effective written patient protection and health care worker back and musculoskeletal injury prevention plan (Plan). The Plan shall be maintained and implemented at all times for all patient care units. The Plan may be incorporated into the IIPP, or may be maintained as a separate document. The Plan applicable to the unit shall be available to employees in each patient care unit at all times. The Plan shall include:
(1) An effective safe patient handling policy component reflected in professional occupational safety guidelines for the protection of patients and health care workers in health care facilities.
NOTE to subsection (c)(1). Examples of professional occupational safety guidelines for the protection and care of patients and health care workers are listed in Appendix A.
(2) The names and/or job titles of the persons responsible for implementing the Plan.
(3) The methods the hospital will use to coordinate the implementation of the Plan with other employers whose employees have work assignments that include being present on patient care units. These methods shall include ~~methods for providing~~ how employees will be provided with the awareness training required by subsection (d)(4), and procedures for investigation and recording of injuries associated with patient handling. In addition, the hospital's Plan shall include procedures to ensure that the Plan is implemented for employees of other employers who are responsible for performing or assisting in patient handling activities, including the provision of training required for designated health care workers.

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(4) Procedures to ensure that supervisory and non-supervisory employees comply with the Plan and use specified procedures and equipment when performing a patient handling activity, in accordance with Section 3203(a)(2).
(5) Procedures for identifying and evaluating patient handling hazards, in accordance with Section 3203(a)(4) including all of the following:
(A) A procedure to determine the types, quantities and locations for powered patient handling equipment and other patient handling equipment required for each unit covered by the Plan. This procedure shall include determining where permanent and portable equipment should be placed in order to ensure its availability and accessibility at all times. The equipment needs for each unit shall be initially evaluated by {OAL to insert date 60 days after effective date} unless an initial evaluation meeting the requirements of this subsection ~~(c)~~ was conducted after January 1, 2012. GACH facilities or units that become operational after {OAL to insert date 60 days after the effective date} shall have this procedure conducted prior to the start of patient handling operations in that facility. The procedures shall include how designated health care workers can participate in the evaluations.
(B) Procedures by which the designated registered nurse, as the coordinator of care, will assess the mobility needs of each patient to determine the appropriate patient handling procedures based on the nurse's professional judgment using assessment tools, decision trees, algorithms or other effective means, and prepare safe patient handling instructions for the patient. The Plan shall ~~also include the means by which the professional judgment of designated health care workers in other disciplines outside of nursing will be incorporated into the patient mobility assessment~~ include the means by which health care workers and supervisors licensed in other disciplines can provide input to the designated registered nurse regarding the patient mobility assessment.
(C) Evaluation of the need for, use, availability, accessibility, and effectiveness of patient handling equipment and procedures. These evaluations shall be conducted:
1. When the Plan is first established;
2. Whenever the equipment or conditions change in a manner that may affect safe patient handling;
3. Whenever the employer is made aware of a new or previously unrecognized patient handling hazard; and
4. At least annually for each unit covered by the Plan.
(6) Procedures for the investigation of musculoskeletal injuries related to patient handling. ~~For acute injuries and for cumulative trauma t~~To the extent that relevant information is available, this shall include:
(A) Review of any patient specific risk factors and the designated registered nurse's safe patient handling instruction;
(B) Review of whether the Plan was effectively implemented, including the availability and correct use of equipment, the availability and use of sufficient staff, and whether the employees involved had been trained as required by subsection (d); and
(C) Solicitation from the injured employee and other staff involved in the incident of their opinions regarding the cause of the incident, and whether any measure would have prevented the injury.

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(7) Procedures for correcting hazards related to patient handling, including:
(A) The evaluation and selection of patient handling equipment, including the involvement of designated registered nurses and other designated health care workers, and, where utilized, lift team members;
(B) How sufficient and appropriate patient handling equipment, selected in accordance with subsections (c)(5) and (c)(7)(A), will be made available on each unit covered by this section. This shall include procedures for procurement, inspection, maintenance, repair, and replacement of appropriate patient handling equipment~~;~~. Where equipment is shared between units, these procedures shall also include the means by which the current location of the equipment can be determined;
(C) The procedures by which the designated registered nurse will observe and direct patient lifts and mobilizations on each patient care unit, in accordance with Labor Code Section 6403.5 and Title 22, California Code of Regulations, Section 70215;
(D) The procedures by which the designated registered nurse will communicate the nurse's assessment regarding patient handling practices to the patient and patient's ~~family or~~ authorized representatives, in accordance with Title 22, California Code of Regulations, Section 70215;
(E) The procedures by which lift teams and/or other designated health care workers will be available to perform lifts and other patient handling tasks in each patient care unit at all times in accordance with the Safe Patient Handling Policy. An employee is not considered to be available if the employee's other assignments prevent the person from participating in the patient handling tasks within the timeframe determined to be necessary by the person designated to observe and direct the patient lifts and mobilizations in accordance with subsection (c)(7)(C) and (c)(7)(F). Designated health care workers and lift team members shall follow the safe patient handling policy, including replacement of manual patient handling with powered patient transfer devices and lifting devices as appropriate for the specific situation and patient.
(F) The procedures to be followed by designated health care workers and lift team members in performing patient handling tasks under normal circumstances, in emergencies, in situations in which there is no designated registered nurse present, in situations in which patients are not cooperative with the safe patient handling instruction, and in those situations in which there is no applicable individual safe patient handling instruction.
(G) Procedures for correcting problems found during the review of the Plan.
(8) Procedures for communicating with employees regarding safe patient handling matters, including:
(A) The method by which the designated registered nurse's safe patient handling instruction for each patient will be documented and communicated to designated health care workers and lift team members providing care to that patient;
(B) The means by which employees may communicate without fear of reprisal their concerns regarding performing a patient handling activity as instructed, and the means by which concerns and reported hazards will be investigated and corrected as necessary; and
(C) The means by which designated health care workers, lift team members, designated registered nurses, and their supervisors can participate in reviewing the effectiveness of the Plan in their work areas or departments.

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(9) Procedures for providing training to employees who may be present in patient care units in accordance with subsection (d).
(10) For facilities or units in existence as of {OAL to insert effective date}, a list of the patient handling equipment ~~corrective measures~~ identified in (c)(7)(B) that cannot be implemented by the effective date of the standard shall be made. For each listed item ~~measure~~, this shall include ~~the control measure and method of implementation,~~ the reason for the delay, and the schedule by which the ~~measures~~ equipment will be ~~implemented~~ put into use, and alternative measures to protect employees until the equipment is put into use. In any event, any equipment identified shall be put into use ~~These elements shall be implemented~~ no later than one year after {OAL to insert the effective date of the standard}.
(11) Procedures for reviewing, at least annually, the effectiveness of the Plan in each patient care unit, which shall include a review of injury data and trends. The Plan shall include an effective procedure for obtaining the active involvement of employees in reviewing and updating the Plan with respect to the procedures performed by employees in their respective work areas or departments. Deficiencies found during this review shall be corrected, in accordance with subsection (c)(7) and Section 3203.
(d) Training. The employer shall provide training to all employees whose work assignments include being present on patient care units, that effectively addresses the activities they are reasonably anticipated to perform under the Plan. Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.
(1) Frequency of training. Employees shall be trained as follows:
(A) Initial training shall be provided when the Plan is first established, to all new employees, and to all employees given new job assignments for which training has not previously been received;
(B) At least every twelve months, designated health care workers, lift team members, designated registered nurses and their supervisors ~~of employees covered by the Plan~~ shall also receive refresher training.
(C) Employers shall provide additional training when new equipment or work practices are introduced. The additional training may be limited to addressing the new equipment or work practices.
(2) Initial training for designated health care workers, lift team members, designated registered nurses and their supervisors ~~of employees covered by the Plan~~ shall include at least the following elements as applicable to the employee's assignment:
(A) The areas of body exposure and types of injuries associated with manual patient handling activities including risk associated with vertical and lateral movement, bariatric patients, repositioning and ambulation, and the importance of early recognition and management.
(B) How risk factors, such as the patient's ability and willingness to cooperate, bariatric condition, clinical condition, etc., are assessed and controlled during patient handling tasks including the following: vertical lifts, lateral transfer, repositioning, and ambulation.
(C) How to communicate with patients regarding the use of patient handling procedures and equipment.

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(D) The appropriate use of powered and non-powered equipment to reduce injuries to patients and employees. This shall include practice using the types and models of equipment that lift team members and other designated health care workers will be expected to use.
(E) Procedures to be followed in order to safely perform manual patient handling when necessary.
(F) The importance and process for reporting concerns regarding equipment availability, condition, storage and maintenance**,** and concerns regarding availability of sufficient staff to perform patient handling activities.
(G) The elements of the employer's Plan and safe patient handling policy and how the Plan will be made available to employees.
(H) The right to refuse to ~~perform an unsafe patient handling activity~~ lift, reposition, mobilize, or transfer a patient due to concerns about patient or worker safety or the lack of trained personnel or equipment, and how a health care worker can communicate concerns regarding the designated activity to an appropriate supervisor.
(I) The role of the designated registered nurse as the coordinator of care, and how the registered nurse will be responsible for the observation and direction of patient lifts and mobilization.
(J) The role of the supervisor to be familiar with the Plan, the safe patient handling policy, and the patient handling hazards in their unit.
(K) How the employee can request additional training.
(L) An opportunity for interactive questions and answers with a person knowledgeable about the Plan and safe patient handling equipment and procedures.
(M) In addition to the training specified in subsections (d)(2)(A) through (d)(2)(L), supervisors of employees covered by the Plan shall also be trained on the hospital's policy that a health care worker may not be disciplined for refusal to lift, reposition or transfer a patient due to concerns about patient or worker safety or the lack of trained designated health care workers or equipment.
(N) In addition to the training specified in subsections (d)(2)(A) through (d)(2)~~(I)~~ (L) designated registered nurses who will assess patients in accordance with subsection (c)(5)(B), shall be trained in how to assess patients' mobility needs, how to communicate with patients and their ~~families and~~ authorized representatives, and how to communicate with supervisors, designated health care workers, and other health care workers regarding safe patient handling practices for specific patients.
EXCEPTION to subsection (d)(2): For employees who have received initial training in the year preceding the effective date of the standard, only training on the elements which were not included in the training need be provided.
(3) Refresher training for designated health care workers, lift team members, designated registered nurses and supervisors shall include at least the following elements as applicable to the employee's assignment:
(A) The use of powered and non-powered equipment to handle patients safely. This shall include practice using the types and models of equipment that the lift team members and/or designated health care workers will be expected to use.
(B) Procedures to be followed in order to safely perform manual patient handling when necessary. This training shall include practice in performing tasks involving multiple employees.

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(C) A review of the items included in the initial training.
(D) An opportunity for interactive questions and answers with a person knowledgeable about the Plan and safe patient handling equipment and procedures.
(4) Awareness Training. Training for employees, other than those identified in subsections (d)(2) and (d)(3), whose job assignment includes being present on patient care units, shall address the recognition of the patient interactions that require the involvement of designated health care workers, or lift teams, how to obtain that involvement when necessary, and procedures to follow for emergencies relating to safe patient handling.
(e) Records.
(1) The hospital shall develop and maintain the following records in accordance with Section 3203(b) as records of the implementation of the Plan:
~~(1)~~(A) Records of inspections, including hazard identification and evaluation, shall include:
~~(A)~~ 1. records regarding the evaluation, selection, and placement or installation of patient handling equipment or devices and the availability of this equipment at all times on each unit covered by the Plan;
~~(B)~~ 2. records of initial and periodic inspection of patient handling procedures; and
~~(C)~~ 3. records of investigation of occupational injuries and illnesses related to safe patient handling.
~~(2)~~ (B) Training records shall be created and maintained for a minimum of one year and include the following information: training dates; contents or a summary of the training sessions; types and models of equipment practiced during training; names and qualifications of persons conducting the training; and names and job titles of all persons attending the training sessions.
~~(3)~~ (C) All records required by this subsection shall be made available on request to the Chief of the Division of Occupational Safety and Health and his or her representatives for examination and copying.
~~(4)~~ (D) All records required by this subsection shall be made available on request to employees and their representatives for examination and copying in accordance with Section 3204(e)(1) of these orders.
~~(5)~~ (E) Records of injury investigations shall not include “medical Information” as defined by Civil Code Section 56.05(g).
~~(6)~~ (F) Records required by Division 1, Chapter 7, Subchapter 1, Occupational Injury or Illness Reports and Records, of these orders shall be created and maintained in accordance with those orders.
NOTE: Authority cited: Section 142.3, Labor Code. Reference: Sections 142.3 and 6403.5, Labor Code.

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Appendix A (Non-Mandatory):

The following are examples of professional occupational safety guidelines for the protection of patients and health care workers in health care facilities:

Facility Guidelines Institute Patient Handling and Movement Assessments: A White Paper by the 2010 Health Guidelines Revision Committee, April 2010 **(http://www.fgiguidelines.org/pdfs/FGI_PHAMA_whitepaper_042810.pdf)**

Association for Occupational Health Professionals AOHP Beyond Getting Started: A Resource Guide for Implementing a Safe Patient Handling Program in the Acute Care Setting, Summer ~~**2006**~~ **2011 (http://aohp.org/aohp/Portals/0/Documents/AboutAOHP/BGS_Summer2011.pdf)**

Centers for Disease Control National Institute of Occupational Safety and Health, NIOSH Safe Patient Handling Training for Schools of Nursing DHHS Publication No. 2009-127 November 2009 **(http://www.cdc.gov/niosh/docs/2009-127/)**

~~***Facility Safe Patient Handling Policy (Template)*, U.S. Department of Veterans Affairs, March 22, 2010, http://www.visn8.va.gov/VISN8/PatientSafetyCenter/safePtHandling/PolicyTemplate_SPH_032210.doc***~~

Safe Patient Handling and Mobility Interprofessional National Standards, American Nurses Association 2013 (http://www.nursingworld.org/sphm)

Safe Patient Handling Guidebook For Facility Champions/Coordinators, Matz, 10/29/2013

NOTE: Authority cited: Section 142.3, Labor Code. Reference: Sections 142.3 and 6403.5, Labor Code.

SUMMARY OF AND RESPONSE TO COMMENTS

SUMMARY OF, AND RESPONSE TO, WRITTEN AND ORAL COMMENTS

I. Written Comments

Bonnie Castillo, Director of Government Relations, California Nurses Association (CNA) by written comments dated September 19, 2013.

Comment BC#1:
The CNA, representing 86,000 registered nurses (RN), sponsored Assembly Bill 1136 which established Labor Code (LC) 6403.5 and has a vested interest in this proposed rulemaking. They recognize the importance of having a regulation that will fully implement, clarify, and specify its important protections. CNA by and large supports the proposed regulations and the Standards Board and Division staff for their efforts to draft a comprehensive standard that implements LC 6403.5 with specificity and clarity. The language is consistent with regard to requiring a patient protection and health care worker back and musculoskeletal injury prevention plan (Plan) that contains many elements that should improve worker and patient safety in hospitals. It also establishes the role of the RN as the coordinator of care, addresses equipment needs, sets training requirements for employees and supervisors, and sets recordkeeping requirements for accountability. CNA specifically acknowledges the provisions throughout the regulation that require employee involvement in the Plan review and evaluation, and equipment needs. Employee input is critical for developing and implementing an effective Plan. CNA also acknowledges the training requirements and believes that inadequate employee training has been a consistent widespread problem.

Response:
The Board thanks the commenter for their support of these aspects of the proposal.

Comment BC#2:
The CNA is very concerned regarding the omission of language referencing LC 6403.5 subsection (d) that prohibits hospitals from pulling RNs from ongoing activities to perform patient handling activities in ways that compromise direct patient care assignments. CNA specifically added language to AB 1136 to ensure that patient assignments are not compromised in the event that employees are pulled from their assignments. Omitting this provision will likely allow hospitals to force RNs to leave patients unattended while conducting patient handling with others. Consequently, subsection (c)(7)(E) presents significant concerns. The experience of its members shows that it is common for RNs and other health care workers to be pulled from their direct assignments in order to perform safe patient handling duties, especially in hospitals that do not utilize lift teams. Since many hospitals are chronically understaffed, RNs pulled from their assignments are forced to leave patients less attended, which is unsafe. CNA added language to AB 1136 to prevent this, and is seen in LC 6403.5 (d) describing lift teams. “A general acute care hospital shall not be required by this section to hire new staff to comprise the lift team so long as direct patient care assignments are not compromised.” Subsection (c)(7)(E) does not include that statement even though it requires procedures to have lift teams and designated health care workers to be available at all times. CNA believes that the Board is not restricted from preserving patient care assignments. Labor Code Sections 6307 and 6308 provide Cal/OSHA with broad authority to require safeguards and safe practices. In order to ensure that Cal/OSHA will be able to properly enforce LC 6403.5 as intended by AB1136 CNA recommends this amended language to subsection (c)(7)(E):

(E) The procedures by which lift teams and other designated health care workers will be available to perform lifts and other patient handling tasks in each patient care unit at all times in accordance with the Safe Patient Handling Policy. The procedures must include provisions ensuring that direct patient care assignments are not compromised in order to make lift teams and other designated health care workers available at all times. Designated health care workers and lift team members shall follow the safe patient handling policy, including replacement of manual patient handling with powered patient transfer devices and lifting devices as appropriate for the specific situation and patient.

Response:
The comments provided by Ms. Castillo and others in writing and at the public hearing regarding a lack of available staff due to conflicting assignments are consistent with the Division's experience during investigations of employee patient handling injuries. In those situations where employees are performing other tasks and are not able to assist in a necessary patient handling task, nurses often attempt the task without sufficient assistance, and have suffered serious injuries. Therefore, a sentence is proposed to be added to subsection (c)(7)(E) to clarify that employees will not be considered to be available if the employee's other assignments prevent the employee from assisting in patient handling tasks in the necessary time frame. To clarify what is meant by necessary timeframe, the proposed modification states that it is the time frame that is determined by the designated registered nurse, referenced in subsection (c)(7)(C), or, for units in which there are no RNs present or in an emergency, as determined by the Plan in conformance with subsection (c)(7)(F).

Comment BC#3:
The CNA also is very concerned regarding language contained in subsection (c)(5)(B) which requires a means by which the professional judgment of designated health care workers in disciplines outside of nursing would be incorporated into the patient mobility assessment because it does not identify which type of designated health care workers would be authorized. The language is "include the means by which the professional judgment of designated health care workers in other disciplines outside of nursing will be incorporated into the patient mobility assessment." Since this language does not identify the circumstances or parameters for incorporating that judgment, this appears to undermine the position and authority of the RN to fulfill the duty of primary coordinator of care. Language should also be added that will ensure that the procedures for the RN to assess mobility needs of patients and prepare instructions are based on the RN's professional judgment. References to the professional judgment of the RN is made in Labor Code 6403.5 and the ISOR for this proposed regulation, and should be added in subsection (c)(5)(B). CNA recognizes the potential for situations in which an RN assessment of patient handling needs has not been performed. This would be a common situation in General Acute Care Hospital (GACH) outpatient settings, for example, physical therapy, where there is rarely an RN present to do a mobility assessment and it may be that there has not been a recent mobility assessment completed by an RN. In this case, the physical therapist should make the mobility assessment. This would be in the case of a patient with a musculoskeletal disorder that requires outpatient physical therapy. As the coordinator of care for each patient, it is the responsibility of the RN to perform the nursing assessment of the individual patient mobility needs. However, if a patient needs to be seen in a physical therapy unit, which does not regularly have RNs, patient care within the licensed physical therapist scope of practice, which would include patient handling, would appropriately be supervised by the physical therapist rather than

the RN. In cases where there has not been a nursing mobility assessment, the GACH must have procedures in place on the appropriate handling of that patient by the physical therapist. The current language may inadvertently undermine the role of the RN as the primary coordinator of care by allowing another designated health care worker to incorporate their judgment into the mobility assessment even when an RN is present. For example, a patient could have a restriction that limits mobility based on conditions other than musculoskeletal concerns, outside the purview of the physical therapist's evaluations and the RN's assessment must prevail for patient safety. CNA thus proposes these amendments to subsection (c)(5)(B):

> *Procedures by which the designated registered nurse, as the coordinator of care, will assess the mobility needs of each patient to determine the appropriate patient handling procedures based on his or her professional judgment, using assessment tools, decision trees, algorithms or other effective means, and prepare safe patient handling instructions for the patient. The Plan shall also include the means by which the professional judgment of designated health care workers licensed in other disciplines outside of nursing will be incorporated into the patient mobility assessment for units or situations in which a registered nurse is not present, or has not made an individual patient mobility assessment.*

This assures that only licensed health care workers can incorporate judgment into a patient mobility assessment and specifies the circumstances under which they may incorporate their judgment into a mobility assessment.

Response:
The Board thanks CNA for clarifying its view of how the professional practice of RNs and other licensed health care professionals can be preserved under the proposed regulation. The intent of this subsection as originally proposed was to ensure that health professionals in other disciplines, such as physical or occupational therapists, could provide input to the registered nurse, who develops the mobility assessment and instructions regarding patient handling. In order to clarify this intent, the Board has included in this notice proposed changes to subsection (c)(5)(B). The commenter's concern regarding situations in which a registered nurse is not present or has not made a patient mobility assessment is addressed in subsection (c)(7)(F), and the Board does not believe it is necessary to include that provision in this subsection.

Comment BC#4:
Proposed subsection (a) establishes Exception (2) which states that Section 5120 "shall not apply to units within a general acute care hospital that are separately licensed as a distinct part under Title 22 Sections 70625 and 70627." Sections 70625 and 70627 of Title 22 pertain to distinct part skilled nursing facilities (DP-SNF) in which patients, whose primary need is for the availability of long-term skilled nursing care, receive skilled nursing and supportive care. These patients often have significant needs when it comes to mobility as maintaining their mobility is generally a part of their daily care routine and aims to help maintain and improve their function and well-being. For some, inadequate mobilization could be life threatening. RNs and health care workers providing care in DP-SNFs perform many of the same patient handling tasks as those providing care in other units within the GACH. It does not then follow that these RNs, health care workers, and patients should not be provided with the same protections proposed in Section 5120. Although there is no clear exemption of DP-SNFs in Labor Code Section 6403.5, the OSHSB

appears to have interpreted the statute to be exclusive of DP-SNFs. This is a concern because it is unlikely that GACHs will voluntarily enact safe patient handling policies in these units.

Response:
The Board acknowledges that there are many patient handling related injuries in skilled nursing facility operations. However, LC 6403.5(b) specifically applies to GACHs. AB 1136 did not define the term General Acute Care Hospital; however, that term is used in the Health and Safety Code, Section 1250(a), and is further described in the California Code of Regulations Title 22, which is enforced by the California Department of Public Health Licensing and Certification Unit (CDPH L&C). In order to avoid conflict between the codes, the Board has determined that the term "general acute care hospital" should be interpreted consistent with these other laws and codes.

In developing this regulation, the Division sought the advice of CDPH L&C, regarding whether distinct part skilled nursing units are considered patient care units within the hospital's license as a GACH. In the process Division staff learned that a distinct part skilled nursing unit or facility might be located within a hospital building, on the hospital campus in a separate building, or may be remotely located. Some facilities are licensed as GACHs even though a minority of their beds are licensed as acute care beds. In January 2013, Cassie Dunham representing the CDPH L&C answered questions posed by Division staff regarding the status of distinct part skilled nursing units, and that email was provided as part of the rulemaking file. That document stated in part "When skilled nursing services are provided in a distinct part of a GACH, skilled nursing facility regulations apply to the care provided (Title 22 California Code of Regulations (CCR) Section 70627)." Under the Health and Safety Code and Title 22, SNFs differ from GACHs in terms of patient needs, services provided, and staffing profile. In order to avoid a conflict between the laws and regulations, the proposal excepted distinct part skilled nursing facilities from this section. The determination that a distinct part skilled nursing unit is not considered a "patient care" unit of the GACH is further demonstrated by Health and Safety Code Section 1262.5 which requires that a "transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital."

The Board agrees with the commenter that employees in skilled nursing facilities, whether they are a distinct part of a GACH or licensed under other sections, are at increased risk of injuries due to patient handling. The Board included a note to the scope subsection to clarify that Section 3203 and other sections of these orders may apply to patient handling activities in these and other facilities. The Board notes that the hazards in distinct part skilled nursing units, and the available means to reduce risks, are similar to the hazards in other SNFs not directly associated with GACHs. Under Section 3203 all employers have a responsibility to develop and implement Injury and Illness Prevention Programs to address recognized hazards. The Board also notes that the current rulemaking project does not preclude development of further regulations to specifically address those environments.

Comment BC#5:
The term "designated health care worker" is consistent with AB 1136 as it refers to lift team members and other employees who conduct patient handling.

Response:
The Board appreciates this analysis.

Comment BC#6:
The definition of lift team appropriately distinguishes lift team members from other designated health care workers by being trained to work together in concert to conduct lifts. CNA wanted to assure that this concept was included in AB 1136 because it is proven that the use of lift teams reduces employee injuries and workers compensation costs, as illustrated by the experience of Kaiser Permanente in 2003. CNA hopes that the proper use of lift teams will be more widely adopted by GACHs as a way to reduce staff injuries, enhance patient safety, and reduce long-term costs for the facility.

Response:
The Board thanks the commenter.

Comment BC#7:
CNA supports the definition of the term “designated registered nurse.” AB 1136 provides that, "as 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." This is a keystone provision of the bill, and should be appropriately reflected in the implementing regulations in order to cement the intended role of the RN. The inclusion of a definition of "designated registered nurse" aids in that effort.

Response:
The Board thanks the commenter.

Comment BC#8:
The definitions of equipment appropriately clarifies the reference in LC 6403.5 stressing that the device must reduce the amount of muscular effort required to perform the task.

Response:
The Board thanks CNA for this comment.

Comment BC#9:
The definition of lifting appropriately captures the act of lifting, particularly with the inclusion of language specifying that lifting includes "support of part or all of a patient's body."

Response:
The Board thanks CNA for this comment.

Comment BC#10:
The definition of “patient care unit” clarifies that any unit or department under the GACH license that provides direct patient care is considered a "patient care unit" subject to Section 5120. This definition makes it clear that the patient protection and health care worker back and musculoskeletal injury prevention plan (Plan) must include *all* patient care units under the GACH license where direct patient care is provided, including inpatient and outpatient settings

and clinics. This definition is consistent with Labor Code Section 6403.5 and achieves the intent of AB 1136.

Response:
The Board thanks CNA for this comment.

Comment BC#11:
CNA supports the language in subsection (c) requiring the hospital to incorporate the Plan in its IIPP in all patient care units at all times. The language of 3203(a) requires the Plan to be established, implemented and maintained. This is supported by 22 CCR Section 70213. They strongly support the language requiring the Plan to be in effect and available in all patient units at all times. The concept of at all times is consistent with 22 CCR Section 70217 language and will be clearly understood in these settings.

Response:
The Board appreciates this clarification.

Comment BC#12:
Although subsection (c)(2) requires that the Plan include the names or job titles of the individuals who are responsible for implementing the Plan, it does not address situations where persons who are not in the unit and not able to provide direct supervision are identified as being the responsible parties. To identify clear accountability, the Plan should identify the individuals who directly supervise health care employees in patient care units. The September 2012 draft of Section 5120 included this language. CNA recommends this language:

> (c)(2) The names and/or job titles of the persons responsible for implementing the Plan. *Employers who do not exercise direct supervision in the hospital shall also include in the Plan the names and/or job titles of the employer's representatives responsible for coordinating application of the Plan in units to which employees are assigned.*

Response:
The language included in the September 2012 draft had been intended to address situations in which employers other than the hospital exercised direct supervision over one or more employees who were not directly employed by the hospital. Since that time, the Division learned that GACHs are required to act in direct supervision of staff, even if they are provided by other employers. Therefore this sentence is not appropriate. Subsection (c)(3) of the current proposal contains requirements for how requirements of this section will be addressed between GACHs and other employers in the hospital. The Board does not believe there needs to be any further change.

Comment BC#13:
CNA supports the language of proposed subsection (c)(3) and believes it requires coordination of the Plan’s implementation in an appropriate manner by requiring communication of the Plan as well as training that contract employees would need to implement the Plan for that facility.

Response:
The Board thanks the commenter.

Comment BC#14:
Subsection (c)(4) requires the Plan to include procedures to ensure that supervisory and non-supervisory employees comply with the Plan, and use specified procedures and equipment when performing a patient handling activity. The ISOR expresses the intent for employers to implement this provision "in keeping" with Section 3203(a)(2). However, the proposed subsection (c)(4) makes no reference to Section 3203(a)(2). Subsection (c)(4) should be amended to cross-reference Section 3203(a)(2), or otherwise explicitly list the elements of Section 3203(a)(2) employers would need to include.

Response:
The Board concurs that adding a reference to Section 3203(a)(2) would add clarity and proposes that modification.

Comment BC#15:
Subsection (c)(5)(A) is an integral provision to the successful implementation of a hospital's Plan. A common complaint of RNs is that their hospitals do not provide them with the equipment necessary to safely handle a patient. Having procedures to determine the types, quantities, and locations for powered and other patient handling equipment is a basic, fundamental part of enacting an adequate Plan, and will result in improved worker and patient safety. CNA strongly supports subsection (c)(5)(A)'s requirement that the procedure provides for the manner in which designated health care workers can participate in the evaluations. Input from users who engage in patient handling activity is necessary and invaluable to the effort to ensure that the appropriate lift equipment is provided and available when needed. CNA suggests two amendments to subsection (c)(5)(A). The first is to ensure that determination of accessibility of equipment is included in the procedure. Many times equipment may be "available," but because it may not fit in the room it is not "accessible." There is also an incorrect reference. Subsection (c)(5)(A) states that the equipment needs of each unit must be initially evaluated by 60 days after the effective date of Section 5120, "unless an initial evaluation meeting the requirements of subsection (c) was conducted after January 1, 2012." The proposed language is:

> (A) A procedure to determine the types, quantities, and locations for powered patient handling equipment and other patient handling equipment required for each unit covered by the Plan. This procedure shall include determining where permanent and portable equipment should be placed in order to ensure its availability *and accessibility*. The equipment needs for each unit shall be initially evaluated by {OAL to insert date 60 days after effective date} unless an initial evaluation meeting the requirements of ~~subsection (c)~~ *subparagraph (C) of this paragraph*. The procedures shall provide for the manner in which designated health care workers can participate in the evaluations.

Response:
The Board agrees that the term "accessibility" should be included and proposes that modification. In terms of the reference to initial evaluations that have been completed prior to the effective date of this Standard, the Board believes that the specific reference is to the requirements of subsection (c)(5)(A). Therefore this language is proposed to be changed to "meeting the requirements of this subsection."

Comment BC#16:
CNA supports (c)(5)(C), and believes it is necessary to assure GACH's routinely evaluate their equipment and procedures to improve and enhance their Plan as needed. They also strongly support the inclusion of designated health care workers in the evaluation as provided for in subsection (c)(5)(A).

Response:
The Board thanks CNA for supporting this rulemaking. The Board notes that subsection (c)(11) contains further provisions for employee involvement in the review of the Plan, and therefore declines to add further requirements to subsection (c)(5)(C).

Comment BC#17:
CNA supports the provisions of (c)(6) since it is vital that employers investigate musculoskeletal injuries related to patient handling in order to identify causes to improve and enhance their Plan and prevent future injuries. These procedures, such as soliciting employee opinions regarding what could have prevented the injury, parallel procedures incorporated into the Bloodborne Pathogens and Aerosol Transmissible Disease Standards makes compliance easier for both employees and employers.

Response:
The Board thanks CNA for this comment.

Comment BC#18:
CNA supports the language of (c)(7)(A)-(D) with regard to requiring procedures for correcting the hazards related to patient handling procedures including the involvement of designated health care workers and lift teams, procedures to assure sufficient and appropriate patient handling equipment in each unit; procedures for the RN to observe and direct patient lifts and mobilization on each unit; and communication of the nurse's assessment regarding patient handling practices to the patient, patient's family or representatives. It also supports (c)(7)(F) requiring procedures for normal circumstances, emergencies, situations in which there is no designated RN present, and situations where there is no applicable safe patient handling instruction in conjunction with their recommended language for subsection (c)(5)(B).

Response:
The Board thanks CNA for its support of these provisions.

Comment BC#19:
CNA supports subsection (c)(8), especially the requirement ensuring that employees may communicate without fear of reprisal concerns regarding patient handling activities, investigation, and correction of reported hazards. This is especially important for RNs who frequently speak out against unsafe practices and policies. They strongly support the participation of designated RNs, health care workers, and lift team members in reviewing the Plan's effectiveness.

Response:
The Board thanks CNA for this comment.

Comment BC#20:
CNA has concerns regarding subsection (c)(10) because it does not provide a means for hospitals to ask permission to take up to one year to obtain and implement safe patient handling measures, such as equipment, from Cal/OSHA. Cal/OSHA should devise an implementation timeline for each hospital not to exceed one year from the implementation of this Section for these measures. They recommend this language to be added:

> (c)(10) For facilities or units in existence as of {OAL to insert effective date}, a list of the corrective measures identified in (c)(7)(B) that cannot be implemented by the effective date of the standard shall be made. For each measure, this shall include the control measure and method of implementation, the reason for the delay, and the schedule by which the measures will be implemented. These elements shall be implemented pursuant to a timeframe deemed appropriate by the Department of Occupational Safety and Health, not to exceed later than one year after {OAL to insert the effective date of the standard}. Where measures are delayed, the employer shall identify and document interim measures that will reduce risk in accordance with their IIPP.

Response:
The Board would like to clarify that the proposed subsection does not allow an employer to wait for this Section to go into effect to begin identifying and implementing the safe patient handling measures that they need. AB 1136 took effect in January of 2012, and employers were required by that legislation to begin the process then. The Board is cognizant of the fact that the Plans and methods of implementation vary among the GACHs in the state, with some adopting more extensive control measures than others, including installation of equipment such as wall or ceiling mounted lifting equipment. Some stakeholders have suggested delaying various provisions for up to a year beyond the effective date of the standard. However, the Board notes that over two years have passed since the legislation became effective and therefore believes that the sixty day period for implementation of certain measures is appropriate. The up to one year delay was meant to provide time for approval by other authorities including the Office of Statewide Health Planning and Development for installed equipment. Based on this comment, and comments from the California Hospital Association, the delay proposed in this subsection has been clarified in this notice to apply only to equipment that cannot be implemented within 60 days. Without this provision, each hospital that could not implement required equipment would have to apply to the Division for a temporary variance in accordance with Labor Code Section 6450. The temporary variance application would have to address the same issues as are required to be addressed in this provision. Therefore the Board believes that it is reasonable to include this limited delay, and avoid unnecessary paperwork. Clarifications are proposed to subsection (c)(10) by replacing the reference to control measures with the term “equipment” and to require stating the alternative measures that have been put into use during the delay.

Comment BC#21:
CNA supports subsection (c)(11) especially the inclusion of injury data and trends in the Plan review. This will enhance the ability to pinpoint specific areas within the Plan that need modification or improvement. They also strongly support the involvement of employees in the Plan review.

Response:
The Board thanks CNA for this comment.

Comment BC#22:
CNA generally supports the training provisions in subsection (d). The provisions that all employees who may be in a patient care unit receive appropriate training will provide added safety to employees and patients. It is also important to have training about how to report concerns regarding the equipment and availability of staff, and the right to refuse to perform an unsafe patient handling activity for both employees and their supervisors. Hospitals are cutting staffing levels so the process of notifying the employer of the need for additional staff initiates a process for obtaining additional staff. They also especially support the requirements for refresher training which has often not been provided by some employers. The opportunity for employees to engage in interactive questions and answers with a person knowledgeable about the Plan, equipment, and procedures is important as an improvement over computer training which provides no hands-on training. The inclusion of awareness training is also supported. However, there are some recommendations to several subsections. The first is to amend subsection (d)(2)(B) to clarify and confirm that "ability and willingness to cooperate" referred to the patient:

> (B) How risk factors, such as the patient's ability and willingness to cooperate, bariatric condition, clinical condition, etc…

Response:
The Board notes that this was the intent of the language but agrees that it would be useful to make this very clear and proposes a modification to make this change.

Comment BC#23:
Subsection (d)(2)(L) requiring an opportunity for interactive questions and answers during the initial and refresher training omits the qualification of the responder providing the opportunity for interactive questions and answers and proposes this amended language:

> (L) An opportunity for interactive questions and answers with a person knowledgeable about the Plan and safe patient handling equipment and procedures.

Response:
The Board agrees that adding this phrase would provide consistency and improve the quality of refresher training in general. This change has been proposed in this notice.

Comment BC#24:
Subsection (d)(2)(N) which outlines the training items that designated RNs would receive omits (d)(2)(J)-(L) which cover the role of the supervisor in the Plan. This suggests that RNs would not know about the role of their supervisor in the Plan, how employees can request additional training, and the opportunity for interactive questions and answers. The language should be modified to include this content:

> (N) In addition to the training specified in subsections (d)(2)(A) through ~~(d)(2)(I)~~ (d)(2)(L).

Response:
The Board concurs that the recommended change would improve the overall clarity of the training content.

Comment BC#25:
Overall, CNA supports subsection (e) and appreciates the inclusion of the language that makes clear the access employees and employee representatives have for records pertaining to safe patient handling.

Response:
The Board thanks CNA for supporting this rulemaking and providing a detailed review of the proposed text.

Gail M. Blanchard-Saiger, Vice-President, Labor & Employment, California Hospital Association (CHA), by letter dated September 16, 2013.

Comment GB#1:
CHA, representing 400 hospitals and health systems, appreciates Cal/OSHA's work leading to this rulemaking and responsiveness to many issues raised during that time. There are concerns that are presented in this letter.

Response:
The Board thanks CHA for participating in this rulemaking.

Comment GB#2:
Throughout the pre-regulatory stakeholder process, Cal/OSHA has been clear that the regulations do not require hospitals to utilize lift teams. As "designated health care worker" includes "lift team members," it is redundant and confusing to refer to both in the substantive sections, particularly in Sections (c)(8)(C), (d)(1)(B), (d)(2), (d)(2)(D), (d)(3) and (d)(4). Thus, we would recommend the approach taken in Section (c)(3), which only references "designated health care worker" or, at a minimum, the approach taken in Section (c)(7)(A), which references "designated health care workers and, where utilized, lift team members."

Response:
The intent of this rulemaking is to implement AB 1136 which does not require that a hospital utilize lift teams, but does require that sufficient trained personnel be available to perform patient handling tasks safely. The Board believes that the concept and terminology of "lift team" held enough significance to be specified in AB 1136 and should be included in the proposed language. Further, if a hospital utilizes a lift team, the training, equipment and procedures used by members of the lift team may be different than the training, equipment and procedures used by other designated health care workers in the facility. For example, a lift team may have certain designated equipment that only they are trained to use. For that reason, lift teams are separately named in some sections.

To clarify that lift teams are not required, or if present may not be performing the same duties as other designated health care workers, the phrase and/or has been inserted in subsections (c)(7)(E) and (d)(3)(A) to make it clear that the hospital must have effective procedures to ensure that lift team members and/or other designated health care workers are available to perform patient handling tasks at all time. The Board does not believe that further clarification is necessary.

Comment GB#3:
The proposed regulation should not use, or should plan to change the definition of "patient" based on Title 22 because that definition is outmoded and is being revised by the California Department of Public Health.

Response:
The Board has used the definition in Title 22, in order to provide consistency with existing regulations. If the definition in Title 22 changes, the Board will consider changes to this regulation to maintain consistency.

Comment GB#4:
CHA understands that hospitals must develop a patient protection and health care worker back and musculoskeletal injury prevention plan that covers all patient care units. However, there is not an obligation to develop such a Plan for *each* patient care unit. We are concerned that the last sentence of Section (c) could be interpreted to impose that obligation. Thus, CHA requests that issue be clarified and proposes the following: "The Plan shall be available to employees in each patient care unit at all times." Similarly Section (c)(5)(C)4. would be revised as follows: "At least annually for the Plan."

Response:
The language of this subsection provides that a hospital's Plan apply at all times to all patient care units. It further requires that the Plan applicable to a specific unit be available on that unit. The intent of this language is not to require different Plans for each unit, but to allow a hospital to provide specific Plans for units or groups of units that may differ from each other. If an employer chooses to have a separate Plan for a specific unit, that is the Plan that must be available on that unit. If the hospital has only an overall Plan, that Plan must be available on each unit. The current language is also consistent with (c)(11) which requires an annual review of the effectiveness of the Plan as it applies in each unit. For clarity and consistency, the Board declines to make the recommended changes.

Comment GB#5:
Concerning the role of the registered nurse to assess the mobility needs of each patient, there are a variety of qualified health care providers qualified to conduct an assessment such as physical therapists and other rehabilitation providers. CHA interprets Section (c)(5)(B) to allow such qualified health care providers to continue that work. However, CHA requests that the reference in Section (c)(5)(B) to "designated health care workers in other disciplines" be revised to delete the term "designated" since it has a specific and limited definition in the context of the proposed regulations. CHA wants to ensure that a qualified health care worker is able to conduct an assessment regardless of whether they have been specially trained as a "designated" health care worker. For example, a physical therapy supervisor may not be a "designated health care worker" because he/she is not responsible for performing or assisting in patient handling activities. Nonetheless, he/she is qualified to conduct a mobility assessment.

Response:
The Board agrees with the commenter that professionals licensed in other disciplines, whether or not they are to perform patient handling activities as "designated health care workers" should be able to give input to the registered nurse regarding the patient mobility assessment and instruction. The Board concurs that removing "designated" would allow supervisors with the

appropriate licensure to be involved with the patient mobility assessment as needed. A change has been proposed in this notice.

Comment GB#6:
Regarding an employer's obligation to conduct an investigation after a musculoskeletal injury is reported, CHA maintains it is unnecessary to create specific investigation protocols for musculoskeletal injuries. However, if subsection (c)(6) is retained CHA believes that the wording should be changed to reflect that there are different types of injuries than "acute" and "cumulative trauma," such as chronic injuries or exacerbations, and that some information may not be available for those types of injuries as well. CHA thus recommends the first paragraph be revised as follows: "Procedures for the investigation of musculoskeletal injuries related to patient handling. To the extent that relevant information is reasonably available, this shall include..."

Response:
The Board concurs that the current language unnecessarily limits the types of injuries and the criteria that should be investigated. Consequently, the Board proposes to make the recommended change.

Comment GB#7:
Subsection (c)(6)(C) requires the investigation to include "solicitation from the injured employee and other staff involved in the incident of their opinions regarding the cause of the incident, and whether any measure would have prevented the injury." CHA requests that the proposed section delete the reference to "employee's opinion" and that investigation follow typical investigation protocol and align with Cal/OSHA investigation protocol, which includes the following questions: "What immediate or temporary action(s) could have prevented the accident or minimized its effect? What long-term or permanent action(s) could have prevented the accident or minimized its effect?" This information would be asked of the parties participating in the investigation.

Response:
The injury investigation protocol is similar to the protocol used in other health care settings, including Section 5193 Bloodborne Pathogens, and Section 5199 Aerosol Transmissible Diseases. The Board believes that the health care workers would be much more familiar with this more pertinent approach, than investigation protocols used by the Division when investigating accidents that occur in any type of workplace in California and therefore declines to make the recommended changes.

Comment GB#8:
Section (c)(7)(C) requires the hospital to specify the "procedures by which the designated registered nurse will observe and direct patient lifts and mobilizations on each patient care unit in accordance with Labor Code section 6403.5 and Title 22, California Code of Regulations Section 70215." Based on our involvement in the stakeholder process, CHA understands this section to mean that a designated registered nurse is not required to personally observe and direct each patient lift and mobilization. Rather, in accordance with Title 22, California Code of Regulations Section 70215, this aspect 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." In the interest of clarity, we would suggest the following amendment to this section:

> The procedures by which the designated registered nurse will observe and direct patient lifts and mobilizations on each patient care unit, "or will delegate that responsibility" in accordance with Labor Code Section 6403.5 and Title 22, California Code of Regulations, Section 70215.

Response:
LC 6403.5 states that the registered nurse "shall be responsible for the observation and direction of patient lifts and mobilization." The facilities to which this Section applies are also regulated under Title 22, Section 70215, and other agencies determine the lawful scope of nurse practice. In planning for patient handling activities, hospitals must determine how these requirements interact in their specific settings. In addition, the proposal acknowledges that there may be situations where a registered nurse is not available to observe and direct patient lifts. The Board declines to add the term "delegate" since it is not included in LC 6403.5, and is not defined in that context.

Comment GB#9:
Section (c)(10) focuses on situations where a hospital cannot implement, by the effective date of the regulation, the procurement of sufficient and appropriate patient handling equipment as identified during the assessment process. CHA's concerns with this section relate to clarity. In particular, it is not clear what is meant by reference to "control measures." Instead, the following language is recommended:

> For facilities or units in existence as of {OAL to insert effective date}, a list of the patient handling equipment identified in (c)(7)(B) that cannot be put into use by the effective date of the standard shall be made. For each item, this shall include the reason for the delay and the schedule by which the equipment will be put to use. In any event, any equipment identified shall be put into use no later than one year after {OAL to insert effective date}.

Response:
The Board agrees that the recommended change to refer specifically to equipment would be clearer and more consistent than the language originally proposed, and in this notice proposes this modification.

Comment GB#10:
With regard to section (c)(11), CHA requests that the reference to subsection (c)(7) and Section 3203 be deleted as it creates some confusion. CHA requests that the last sentence of this section be revised as follows: "Deficiencies found during this review shall be addressed."

Response:
The Board notes that subsection (c)(11) requires an evaluation of the effectiveness of the Plan that must be based on the implementation of the Plan whose elements are listed in subsection (c)(7). Section 3203 has a similar process, and the reference is provided for clarity. The Board believes that the current language is clearer than the recommended change and declines to make the revision.

Comment GB#11:
CHA believes that hospitals should be permitted to follow the training obligations as outlined in their Injury and Illness Prevention Program. CHA notes that hospitals currently have detailed orientation and training programs for the various job classifications utilized in the hospital. With regard to new employees, some employees may participate in the hospital's general orientation within the first few weeks of employment, while other employees, particularly clinical staff, participate in a substantial orientation process that may span several weeks. Additionally, all employees must currently participate in annual training on such topics as privacy, safety and other compliance issues. In order to avoid any confusion over when initial training must be provided and in recognition of workplace realities, CHA requests that the following time frames be included in Section (d)(1)(A):

> Initial training shall be provided *within 180 days of* when the Plan is first established, to all new employees *covered by the Plan within 45 days of hire*, and to all employees *covered by the Plan* given new job responsibilities for which training has not previously been received, *within 30 days of the new job responsibilities*.

Response:
The Board notes that new employees, in general, are likely to be the ones who have the least experience with safe patient handling techniques and equipment that are used where they start to work. The comment provides no assurance that a new designated health care worker will not be exposed to patient lifting hazards and will not have to use the equipment for the first 45 days of employment, so it must be assumed that these new employees will have occupational exposure to those hazards. Similarly, if an employee is transferred to another unit that has different equipment or procedures, there is no reason to assume that the occupational exposure will not be immediate. The Board believes that training before employees participate in patient handling procedures is crucial as a preventive measure, and declines to make the suggested change.

Comment GB#12:
CHA also included proposed language to clarify that the training obligation extends only to those employees covered by the Plan. Hospitals employ individuals who would not be covered by the Plan, such as business office staff, facilities staff and others who are not present on a patient care unit. Subsection (d)(1)(B) as currently drafted, appears to require anyone who supervises an employee "who may be present in a patient care unit" to participate in refresher training. To clarify that refresher training is only required for supervisors of employees who must participate in refresher training CHA recommends the following language:

> At least every 12 months, designated health care workers, designated registered nurses <u>and their supervisors</u> shall also receive refresher training.

Response:
The Board concurs that this change will improve the clarity of the requirement and proposes that modification in this notice.

Comment GB#13:
CHA believes that subsection (d)(2) has the same issue as subsection (d)(1)(B). To clarify the scope, CHA recommends the following language:

> Initial training for designated health care workers, designated registered nurses and their supervisors shall include at least the following elements as applicable to the employee's assignment . . .

Response:
The Board concurs that this change will improve the clarity of the requirement and proposes that modification in this notice.

Comment GB#14:
With regard to subsection (d)(2)(A), CHA requests replacing this provision with standard hazard communication language. For example, "Risks associated with the various types of patient handling tasks such as repositioning, vertical transfers, lateral transfers and ambulation."

Response:
The Board notes that subsection (d)(2)(A) contains elements that appear in Labor Code section 6403.5 and are included for that reason. Therefore the Board declines to make the recommended change.

Comment GB#15:
CHA understands the intent of subsection (d)(2)(B) but requests the following minor change to clarify the intent:

> "How risk factors, such as ability and willingness *of the patient* to cooperate, bariatric condition, clinical condition, etc…."

Response:
The Board concurs that it is the ability and willingness of the patient that needs to be considered. The proposed change would remove any ambiguity and a similar modification has been proposed in this notice.

Comment GB#16:
CHA has a concern about subsection (d)(2)(F). Hospitals recognize that it is important for employees to report any concerns they have regarding the workplace. Thus, we do not believe it is appropriate to amplify this element of the safe patient handling plan. Accordingly, CHA requests this provision be revised as follows:

> The ~~importance and~~ process for reporting concerns regarding equipment availability, condition, storage . . .

Response:
The Board believes that AB 1136 mandates a heightened awareness of patient handling issues in GACHs, and identifies equipment as a key part of reducing injuries. The Division was made aware that the availability, condition, and accessibility of the equipment are common patient handling issues during the advisory meetings and through its inspection experience. The Board believes that the issue cannot be readily addressed unless a problem is properly reported within a GACH. The Board therefore declines to make the recommended change.

Comment GB#17:
In subsection (d)(2)(H) the reference to "unsafe patient handling activity" is subjective. Thus, in an effort to achieve clarity, CHA requests the following objective language be used:

> "The right to refuse to lift, reposition or transfer a patient due to concerns about patient or worker safety or the lack of trained personnel or equipment. "

Response:
The Board concurs that "unsafe patient handling activity" might be subjective, and has proposed a similar language change in this notice. The proposed change also includes reference to a "lack of trained personnel or equipment" which has been emphasized in the advisory meetings as a critical issue, and proposes a modification that utilizes the definition used in subsection (b) for patient handling activity.

Comment GB#18:
Also with regard to subsection (d)(2)(H), CHA believes it is important to set forth the provision relevant to discipline identified in existing Section 3203(a)(2). This section provides the employer with the right to discipline employees who fail to follow the employer's policies. We are concerned that employees and supervisors are not fully apprised of the issue. CHA continues to request that the following language be included in the regulations:

> Where the employer has implemented a Safe Patient Handling Policy and the employee's conduct is in contravention of that policy, the employer may discipline the employee in accordance with 8 C.C.R. § 3203(a)(2).

Response:
With the comments pertaining to this subsection and subsection (c)(4), the Board acknowledges that clearer reference to Section 3203(a)(2) would better state the requirement that an employer have procedures to enforce the safe patient handling policies. Section (c)(4) is proposed to be modified to include a clear reference to Section 3203(a)(2). The Board believes that subsection (c)(4) is the correct place to reference requirements to adhere to safe patient handling practices. This subsection was created to help hospitals implement the requirements of Section 6403.5(g) that, "A health care worker who refuses to lift, reposition, or transfer a patient due to concerns about patient or worker safety or the lack of trained lift team personnel or equipment shall not, based upon the refusal, be the subject of disciplinary action by the hospital or any of its managers or employees."

Comment GB#19:
With reference to comment GB#8 involving the "Procedures for Correcting Hazards," CHA proposes to have an express reference to the nurses' ability to delegate the responsibility for the observation and direction of patient lifts and mobilizations in subsection (d)(2)(I) such as:

> The role of the designated registered nurse as the coordinator of care, and how the registered nurse will be responsible for the observation and direction of patient lifts and mobilization, *including delegation in accordance with Title 22, California Code of Regulations 70215*.

Response:
Please see the response to comment GB#8. Since the Board declined to make that recommended change, this proposed revision is also declined.

Comment GB#20:
Subsection (d)(2)(K) as written could be construed to require an employer to provide additional training at the request of an employee, regardless of how much training was already provided. There is a balance to be struck with regard to requests for additional training, and an expectation that an employee will achieve competency after reasonable training opportunities are provided. Thus, CHA requests this provision be deleted.

Response:
The Board notes that the subsection does not set a lower or upper limit for additional training sessions. The Board recognizes that there may be individuals who find that safe patient handling techniques, especially with regard to the use of specialized equipment, may be complex enough to be difficult to achieve competency in one session. As written, the requirement is to instruct employees how they can request more training. Patient handling duties should not be performed by employees who are not sufficiently trained, since that would pose a risk to the employee, other employees, and the patient. This provision is a proactive way for an employee to request additional training, rather than noticing during a patient handling procedure that the employee is unsure of how to do the task.

Comment GB#21:
Regarding subsections (d)(2)(L) and (d)(3)(D), the reference to "interactive questions and answers" is somewhat vague. CHA recommends replacing this language with that adopted by the Fair Employment and Housing Commission with regard to effective supervisor sexual harassment training: "An opportunity to ask questions, to have them answered and otherwise to seek guidance and assistance" from 2 CCR 7288.0(a)(2)(C).

Response:
The Board notes that the proposed language is similar to the training requirements in Section 5193 Bloodborne Pathogens, and 5199 Aerosol Transmissible Diseases to provide a familiar framework. The Board believes that the suggested language does not address the question of who would answer the question. In response to the issue of who would answer the question, the Board proposes a modification. Please see the response to comment BC#4.

Comment GB#22:
In subsection (d)(2)(M), to be consistent with earlier comments regarding the reference to "supervisor," the reference in this section is too broad. We would suggest modifying the phrase as follows: "supervisors of employees covered by the plan." In addition such supervisors should also be trained that "where the employer has implemented a Safe Patient Handling Policy and the employee's conduct is in contravention of that policy, the employer may discipline the employee in accordance with 8 C.C.R. § 3203(a)(2)."

Response:
The Board concurs that the term "supervisor" should be qualified as recommended for clarity. The Board also believes that this subsection should be modified to be consistent with (d)(2)(H).

The Board does not wish to focus supervisor training on the use of discipline as the only means to achieve compliance with this regulation. Please see the response to comment GB#18.

Comment GB#23:
With regard to subsection (d)(2)(N) CHA recognizes the challenge Cal/OSHA faced to draft language that focuses on employee safety and does not dictate patient care protocols. This section may exceed the scope of the regulations to the extent that it requires training on patient communication, and CHA requests that the phrase "how to communicate with patients and their families and representatives" be deleted. At a minimum, however, we believe that sentence should be revised to take into account the fact that many patients do not have family members involved and, further, due to privacy laws, health care providers can only communicate with authorized representatives. Thus, we would suggest the following modification:
"how to communicate with patients and their authorized representatives."

Response:
The success of many patient handling procedures requires the cooperation and/or compliance of the patient. An adverse patient reaction may jeopardize the procedure. Therefore it is necessary that there be effective communication with the patient and/or the patient's representative. The hospital therefore should train personnel in how to communicate about the procedures, rather than simply relying on individual communication skills. However, the Board appreciates the importance of privacy laws, thanks CHA for raising this issue, and proposes in this notice to delete the reference to families and include the term "authorized representative."

Comment GB#24:
Regarding the subsection (d) Exception, CHA appreciates the attempt to credit training that was previously conducted and that satisfies the proposed regulatory standards. CHA requests that the look-back period be expanded to include any training conducted on or after January 1, 2012, the effective date of the statute. Otherwise, employers who took steps to comply with the statute immediately after its effective date would be penalized despite their prompt action.

Response:
This standard is likely to take effect in the second half of 2014, over 2 and one half years after January 1, 2012. If the sole full training took place in January 2012, it is unlikely that it either included all required elements (since the standard had not yet been drafted), or all training content may not have been retained, even if annual refresher training were conducted. To make the modification requested by the commenter, the exception would also have to require documentation of not only the initial training, but subsequent refresher training, and the content. Therefore the Board is limiting the exception to training provided one year prior to the effective date.

Comment GB#25:
CHA believes that the refresher training obligation in subsection (d)(3) recognizes that hospitals utilize various training models and methods, and the intent is to allow them to apply those models and methods in this context. For example, some hospitals conduct annual competency assessments utilizing either simulations labs or rounding. Through this method, a trainer evaluates how an employee performs his/her job duties. Where the employee demonstrates competency, no additional training is needed or provided. However, where competency has not

been demonstrated, additional training is provided. As we understand the proposed regulations, they permit this model to be applied in the context of safe patient handling activity.

Response:
The Board believes that refresher training can include competency assessment, and in the form of hands on performance assessment and correction as needed, this can be very effective. The hospital must ensure that refresher training include the opportunity to practice with all required equipment, and to practice lifting procedures, including group lifting procedures, the employee will use. Refresher training must also review the basic points of the initial training. This subsection encourages hospitals to use any effective means to provide the required refresher training to employees.

Comment GB#26:
In subsection (d)(3)(C) the requirement for refresher training to include "a review of the items included in the initial training" is unclear. If the intent is to require specific elements of the initial training, those should be specified. It would not be appropriate to include all of the elements of the initial training, as that would eliminate any distinction between the two types of training.

Response:
The Board believes that the concept of a review as opposed to a repeat is clear to employers. Employers need to review the basic concepts of their Plan with employees as a means of reminding them of the procedures that they are to follow and how to implement them. The Board notes that hospitals routinely distinguish in various subjects between a review of elements in refresher training as compared to initial training.

Comment GB#27:
CHA has serious concerns about the administrative burden imposed by subsection (e)(4). There is no justification for applying the employee exposure record rules to the broad array of records required under the Safe Patient Handling Policy. CHA requests that this section be deleted.

Response:
Subsection (e)(4) references Section 3204(e)(1), which provides a framework for providing records to employees and/or their representatives upon request. For example, it provides that an employer must provide a requested record to an employee within 15 days, and provides a mechanism for the employer to get an extension from the Division of Occupational Safety and Health if necessary. It also defines the number of free copies an employer is required to provide to an individual. This framework for providing records has been successfully applied in a number of standards, and is one familiar to employees, employers, and employee representatives. Some records created or referenced in this Plan may be either employee exposure records or employee medical records and subject therefore to the full provisions of Section 3204. Therefore the Board declines to delete the subsection. The Board has proposed renumbering of subsection (e) for clarity.

Comment GB#28:
Subsection (e)(6) indicates that "records required by Division 1, Chapter 7, Subchapter 1 shall be created and maintained in accordance with those orders." Please confirm that section is the five-year retention period for Cal/OSHA Form 300, the privacy case list (if one exists), the Cal/OSHA Form 300A, and the Cal/OSHA Form 301 Incident Reports.

Response:
The reference is to the Division of Labor Statistics and Research, Subchapter 1. Occupational Injury or Illness Reports and Records and it does refer to the 300 Log (Form 300), and related requirements. The Board thanks CHA for seeking this clarification.

Comment GB#29:
Under current IIPP regulations, 8 CCR 3203(b), exception number 4, district hospitals are not required to keep records concerning the steps taken to implement and maintain the IIPP. Please confirm that as the Patient Protection and Health Care Worker Back and Musculoskeletal Injury Prevention Plan and its Safe Patient Handling Policy is a component of the IIPP, it follows that district hospitals likewise are not required to maintain records concerning the steps to implement and maintain this Plan.

Response:
The Board notes that originally, district hospitals were established under "special districts" created in 1946, and 85 districts were formed since that time. The hospitals were originally operated by the districts which would be exempt from the recordkeeping under Section 3203(b) exception 4. However, the California Healthcare Foundation reported in 2006 that 33 districts no longer directly operate hospitals, some were closed and others were sold to for-profit or non-profit organizations. Since the actual employer within such a GACH may not be a "district," the Board cannot provide a categorical answer, and leaves the determination to be made on a case by case basis, to determine who employs and has responsibility for the designated health care workers and designated registered nurses. The Board thanks CHA for pointing out this issue.

Katherine Hughes, RN, CCRN, Labor Specialist/Nurse Alliance of California Liaison, Service Employees International Union, by electronic mail sent September 18, 2013 (these comments were also submitted at the September 19, 2013, Public Hearing).

Comment KH#1:
SEIU on behalf of 35,000 Registered Nurse members thanks the Department for its dedication to health care workers in California and the opportunity to comment on the proposed regulation.

Response:
The Board appreciates and thanks the SEIU Nurse Alliance for their participation in this rulemaking.

Comment KH#2:
Regarding Exception (2) in subsection (a), the intent of the law, speaking as an organization that helped write and pass the legislation and the discussion that resulted at the public hearings, made it very clear that all units/departments licensed under a GACH were to be covered. The fact that these units are included in the license issued to the GACH under Title 22, regardless of the type of patient care provided, should include them in the Standard, and not exempt them.

Response:
Please see the response to comment BC#4.

Comment KH#3:
Referring to the definition of "Safe patient handling policy," the professional judgment and clinical assessment of the registered nurse is relied on. We believe the guidelines for the IIPP outline in the Plan what is reasonable so a nurse can't simply declare that lift equipment is not needed.

Response:
The Board concurs that the nurse's judgment must be consistent with the policies of the Plan regarding the need to use equipment, and that would preclude a nurse from simply declaring that lift equipment is not needed.

Comment KH#4:
Subsection(c)(2) requires the Plan to have the names and/or job title of the persons responsible for implementing the Plan. SEIU Alliance agrees that these individuals should be identified and would extend this to include individuals responsible for all aspects of the Plan.

Response:
The Board believes that the current wording is consistent with Section 3203 and allows employers the flexibility to designate individuals at each level of their operations who have the responsibility and accountability for implementing the part of the Plan that is appropriate. The Board does not believe the current wording omits any aspect of the Plan and declines to change that subsection.

Comment KH#5:
Subsection (c)(5)(A) lists procedures for determining equipment. In that paragraph the phrase "to ensure its availability" appears to be vague. Subsection (e)(1)(A) has "availability of this equipment at all times on each unit covered by the Plan." If that phrase was included in (c)(5)(A) that would clarify the term "availability."

Response:
The Board notes that subsection (c)(5)(A) refers to implementation of the Plan and making an initial determination of where specific equipment should be deployed. It has added the term "accessibility at all times" to further clarify what is meant by availability. For further discussion see the response to comment BC#15.

Comment KH#6:
In subsection (c)(7)(F) a sentence should be added that would require the employer to develop procedures to document when equipment should have been used but was not, such as during an emergency or other circumstance, along with a written reason given in each case. These records could then be accessed and reviewed to see if anything could have been done differently to avoid unsafe manual handling under these same circumstances in the future.

Response:
The Board notes that the Division considered a provision of this type but decided it would be difficult to implement by the employer, and difficult to enforce by the Division. The Board believes that this type of information should be forthcoming in the course of an investigation of an injury involving patient handling, and also should be discovered during the annual review of the Plan. Therefore, the Board declines to make the recommended change.

Comment KH#7:
There should be a mechanism for tracking equipment so it can be easily located, maintained and readily available for use.

Response:
The Board agrees and notes that this issue has arisen in inspections conducted by the Division. A sentence reflecting this requirement has been added to subsection (c)(7)(B).

Comment KH#8:
Regarding subsection (c)(8)(C), there are many areas where workers are given a chance to be involved and participate in the Plan; determining the types of and storage of equipment, evaluating the Plan and reviewing its effectiveness, etc.

Response:
The Board concurs with this assessment.

Comment KH#9:
In subsection (d) Training, all aspects of training are covered, including the comprehensiveness of training session, the right to refuse an unsafe patient handling activity, opportunity for interactive questions and answers and awareness training.

Response:
The Board thanks the SEIU Nurse Alliance for providing this assessment.

Comment KH#10:
This is overall a very good regulation that SEIU will be able to use to educate and mobilize our hospital members around so they know their safe patient handling rights, can bring enforcement to issues of non-compliance, prevent worker injury, and ensure patient safety.

Response:
The Board thanks the SEIU Nurse Alliance for their evaluation of the proposed regulation and their involvement in this rulemaking.

Mark Catlin, Industrial Hygienist, Service Employees International Union (SEIU), by letter dated September 19, 2013.

Comment MC#1:
SEIU represents 700,000 employees in California including nurses, LVNs, professional hospital employees, doctors, lab technicians, and other support staff in health care, many of whom will be impacted by this regulation. Overall, SEIU is pleased with the proposed regulation and supports the inclusion of an opportunity for interactive questions and answers during training, and the "awareness" training. SEIU believes that this regulation, once enacted, will reduce the very high injury rate for workers in the health care industry.

Response:
The Board thanks SEIU for its support and participation in this rulemaking process.

Comment MC#2:
With reference to subsection (a) Exception 2, SEIU believes that the discussion at the legislative hearing and the legislation itself require all units/departments licensed under a GACH to be covered by the regulation.

Response:
Please see the response to comment BC#4.

Comment MC#3:
Referring to the definition of "Safe patient handling policy," the professional judgment and clinical assessment of the registered nurse is relied on. SEIU believes the guidelines for the IIPP outline in the Plan what is reasonable so a nurse can't simply declare that lift equipment is not needed.

Response:
Please see the response to comment KH#3.

Comment MC#4:
Subsection(c)(2) requires the Plan to have the names and/or job title of the persons responsible for implementing the Plan. SEIU agrees that these individuals should be identified and would extend this to include individuals responsible for all aspects of the Plan.

Response:
Please see the response to comment KH#4.

Comment MC#5:
Subsection (c)(5)(A) lists procedures for determining equipment. In that paragraph the phrase "to ensure its availability" appears to be vague. Subsection (e)(1)(A) has "availability of this equipment at all times on each unit covered by the Plan." If that phrase was included in (c)(5)(A) that would clarify the term "availability."

Response:
Please see the responses to comments KH#5 and BC#15.

Comment MC#6:
In subsection (c)(7)(F) a sentence should be added that would require the employer to develop procedures to document when equipment should have been used but wasn't, such as during an emergency or other circumstance, along with a written reason given in each case. These records could then be accessed and reviewed to determine ways to avoid unsafe manual handling under these same circumstances in the future.

Response:
Please see the response to comment KH#6.

Colin J. Brigham, CIH, CSP, CPE, CPEA, CSPHP, Past President, Association of Safe Patient Handling Professionals (ASPHP), by letter dated September 18, 2013.

Comment CJB#1:
ASPHP has participated in the advisory meetings and submitted three written evaluations and comments on the draft regulation versions in 2012 to the Division and proposes comments on this version.

Response:
The Board appreciates the participation of ASPHP in this rulemaking process and notes that the Division has received and considered all the comments received in the advisory process.

Comment CJB#2:
There should be a subsection added to (d)(1)(D) "Employers shall provide training prior to Plan implementation for all others who play a role in support of designated health care workers, explaining their role and how it hopes to meet the overall requirements of the Plan."

Response:
The Board notes that the proposed regulation essentially identifies two sets of employees within a GACH, employees who conduct or have direct supervision for the safe patient handling procedures, and other health care workers. Subsection (d)(4) Awareness Training, requires that the other health care workers are trained about the existence and intent of the Plan, how to get assistance for patient handling while conducting their own work, and in patient handling emergencies. The Board believes that this should provide the other health care workers with the information in the recommended language. Hospitals also may choose to supplement the minimum requirements for awareness training for specific job classifications or work assignments. Consequently the Board declines to use the recommended language.

Comment CJB#3:
The ASPHP recommends adding two documents to Appendix A. The first is the ANA Safe Patient Handling and Mobility Interprofessional Standards, and the other is the ISO/TR 1226:2012 "Ergonomics-Manual Handling of People in the Healthcare Center."

Response:
There are many other references on this topic, and the references in Appendix A are only a sample. However, the Board has added the ANA publication, since it has become a widely used reference.

Mary Hale, RN, NP, COHN-S, President, California State Association of Occupational Health Nurses, (CSAOHN), by letter dated September 12, 2013.

Comment MH#1:
CSAOHN is an approximately 300-member organization of occupational and environmental health nurses who are committed to the health and safety of employees and their families, and work with employers to achieve and maintain healthy and safe work environments and conditions. CSAOHN has a significant interest in the regulation to ensure safe patient handling and to protect healthcare workers from musculoskeletal injuries and wishes to make several comments on the text.

Response:
The Board thanks CSAOHN for participating in this rulemaking process, reviewing the proposed regulation, and providing suggestions.

Comment MH#2:
Subsection (b) Definitions, does not include contractors. Properly trained contractors need to be able to perform these duties. The subsection should include contractors by adding: "Designated health care worker, means an employee or contractor responsible for performing or assisting…"

Response:
Contractors are addressed by subsection (c)(3). See response to comment BC#12.

Comment MH#3:
The language in subsection (c)(7)(C) is not clear whether it requires the designated registered nurse to be present at every patient handling. This is not feasible, but also the nurse's direct observation and presence may not be needed for all patient handling and mobilization. Under the professional judgment of the registered nurse, such a role may be delegated to other designated health care workers. The language should be clarified for situations where the designated registered nurse is not directly present.

Response:
Please see the response to comment GB#8.

Comment MH#4:
There are situations where the patient refuses to follow the safe patient handling instruction or the family member insists on performing or assisting with patient mobilization. We suggest that the Plan has a procedure for these situations. We suggest the following underlying point be added to section (c)(7)(F): and in situations in which patients or families are not cooperative with the safe patient handling instruction.

Response:
The Board concurs that this particular type of problem would need a specific procedure that can be followed at a GACH, and proposes the following addition to subsection (c)(7)(F): "and in situations in which patients or their representatives are not cooperative with the safe patient handling instruction." Note that the reference to families has been revised to representatives.

Dorothy Wigmore, MS, Occupational Health Specialist, Worksafe, by electronic mail sent on September 19, 2013.

Comment DW#1:
In general, the proposal provides a solid framework to implement and enforce the *Labor Code* section in general acute care hospitals, and to protect the health and safety of hospital workers and patients. In particular, Worksafe supports: including in IIPPs this thorough approach to an effective "safe patient handling" policy and "back and musculoskeletal injury prevention plan" that links patient protection and worker health and safety; recognizing it is the hazards of patient handling that must be eliminated or greatly reduced; addressing the equipment needs for patient care unit workers; the appreciation of real-life issues (e.g., a variety of health care workers can be involved in patient handling, the need for equipment and staff to be available, including staff

in equipment selection so it fits their needs and those of patients); the participatory approach that involves a broad range of affected workers (e.g., interactive training, policy development and evaluation, decisions about lift equipment needs); the extensive training requirements for when people start a job and when something changes, with regular refreshers and coverage for supervisors, registered nurses, and other health care workers, as well as the general awareness training; record-keeping rules that will ensure hospitals are held accountable for their "safe patient handling" programs; pointing out [in NOTE to subsection (a)] that these requirements can be used in excluded health care facilities, services and operations and the need for general application of the IIPP and ergonomics (RMI) standards; and guidance provided in Appendix A.

Response:
The Board thanks Worksafe for participating in this rulemaking process and reviewing the proposed regulation.

Comment DW#2:
The Board should delete Exception (2) to subsection (a). These units are included in the license issued to general acute care hospitals under Title 22 and the workers in these units should not be legally exempted from this important policy and plan.

Response:
Please see the response to comment BC#4.

Comment DW#3:
The regulation should include the language of LC section 6403.5(d) that protects direct patient care assignments. Staffing issues are recognized to some extent in this proposal. It is critical to protect direct patient care assignments. The regulation should state the corollary of the *Code* section that hospitals shall hire new staff when lift team activities compromise direct patient care assignments.

Response:
Please see the response to comment BC#2.

Comment DW#4:
Subsection (c)(5)(B) should be clarified to ensure there is a procedure for when and how a "designated health care worker" who is not a registered nurse contributes their professional judgment to assessments of a patient's mobility.

Response:
The Board concurs that clarification of this subsection is needed. Please see the response to comment BC#3.

Comment DW#5:
A requirement that patient handling equipment fits the space intended for it should be added. Too often, equipment is added to already-crowded hospital spaces so that it is difficult to use protective devices.

Response:
Subsections (c)(5)(A) and (C) require procedures that include evaluating the size of the

equipment to fit the room in order for the equipment to be effectively used. Subsection (c)(11) also requires an annual review of the Plan, which provides a framework to address problems such as these. On this basis, the Board declines to add another requirement.

Comment DW#6:
Subsection (c)(6)(B) should be revised to change the phrase about training to read: " … whether the employees involved had been trained appropriately" or "trained as required" to be sure that the training was conducted properly.

Response:
The Board agrees that assuring that the training for the employee(s) involved in the occurrence of an injury should be emphasized and proposes to modify the passage with "trained as required by subsection (d)."

Comment DW#7:
In subsection (c)(6)(C) the last part should be revised to "... and what measures would have prevented the injury." There rarely is one way to prevent an injury; multiple hazards and other factors often are present.

Response:
The Board believes that the current wording is similar to the language used in Section 5193 for investigating exposure incidents, and does not limit the responder to identifying one measure. Therefore the Board declines to make the modification.

Comment DW#8:
This standard should apply to all health care facilities. Studies and statistics from enforcement agencies show that acute care hospitals are only one type of health care facility where patient handling is a serious hazard. While it may not be possible under this specific Labor Code section, it could be done using other routes. As entities responsible for protecting the health and safety of California workers, Cal/OSHA and the Board should advocate for this coverage.

Response:
The Board is aware that similar patient handling issues exist in other types of health care industries. However, this rulemaking has, from its inception, been based on implementing LC 6403.5 through a regulation. The Board also notes that the advisory meeting process primarily involved stakeholders from general acute care hospitals. Consequently, proposing such a significant change to this proposed standard would require, essentially, starting the process over again with the participation of all potential representative stakeholders. Therefore the Board respectfully declines to make the recommended change in this rulemaking.

Brittany Howze, RN, electronic mail dated September 19, 2013.

Comment BH:
At her hospital unit they have access to lift equipment, but the process of getting the sling underneath the patient in order to use the lift equipment still requires the assistance of at least 2 employees, if not more, in almost all cases. Additionally, with the patient population there are many lift devices that are contraindicated for use on many patients. For example, the patient that has had spine surgery and has activity restrictions that prevent the use of a machine that would

pull on the spine in a way that is not allowed by their surgeon, the only choice for getting them out of bed and on the road to recovery is to get multiple staff members to work in coordination to assist the patient in and out of bed. This is problematic because there is no longer a lift team even though lift teams were safer. The problem with the current language of California Labor Code 6403.5, is that the term "lift team" does not specifically state that it is to be comprised of individuals without direct patient care assignments. Unless the language of the regulation is specifically changed to state that there must be non primary care staff to assist with patient mobility, hospitals will interpret the language to fit the cheapest price per day. Hospitals are not the best entity to solve the problems nurses face, and they will only work to solve the problems if they are forced to.

Response:
The Board believes that the scope of this regulation is limited by LC 6403.5 which does not require a GACH to have lift teams. Consequently, the Board cannot require specific staffing for GACHs. A related problem has been partially addressed. Please see the response to comment BC#2.

Steve Russell, by electronic mail dated September 19, 2013.

Comment SR#1:
The commenter is a RN who has worked for 33 years in Northern California. Labor Code 6403.5 should focus less on the requirement to use equipment, and should not give hospitals the discretion of having a dedicated Lift Team or not. This regulation should mandate having dedicated lift teams so that nurses will not have to leave their patients unmonitored to do multiple lifts.

Response:
Please see the response to comment BC#2.

Jeanne P. Lee, by electronic mail dated September 19, 2013.

Comment JPL#1:
The commenter has been a bedside nurse for the last 38 years and appreciates the work that has gone into the Safe Patient Handling Act. The training for the regulation should be required yearly or every other year for two hours. Current competency testing is done over 30 minutes at most. There needs to be a review of how to use the equipment.

Response:
The Board notes that there were several comments regarding training. The proposed standard requires at least annual refresher training that includes a hands on component and an opportunity for interactive questions and answers. Employers must ensure that the training program is effective. Comments regarding the content include BC#22, BC#23, BC#24, GB#2, KH#9 and DW#6 resulting in some proposed modifications as shown in the responses to those comments. Comments regarding the frequency and adequacy of competency training were also raised, please see comments GB#11, GB#25, and GB#26.

Comment JPL#2:
Lift teams should be required.

Response:
Please the responses to comments BC#2 and GB#2.

Comment JPL#3:
The regulation should require that there is enough equipment that is accessible to the staff.

Response:
The Board has proposed modifications regarding these issues. Please see the discussion and responses to comments BC#15, KH#5, KH#7, and MC#5.

David Y. Shiraishi, MPH, Area Director, U.S. Department of Labor, Occupational Safety and Health Administration by letter dated September 11, 2013.

Comment DS:
Mr. Shiraishi stated the proposed occupational safety and health standard appears to be commensurate with the federal standard.

Response:
The Board thanks Mr. Shiraishi for his comment and participation in the rulemaking process.

II. Oral Comments

Oral Comments received at the September 19, 2013, Public Hearing in Oakland, California.

Margie Keenan, California Nurses Association.

Comment MK#1:
Ms. Keenan stated that the proposal will give the Division the enforcement authority it needs to keep hospitals accountable to their patients and workers. Despite AB 1136, hospitals continue to have inadequate staffing and safe patient handling procedures, and the Division continues to cite them for patient handling violations. Strong and comprehensive regulations are needed to spell out the terms of AB 1136 and ensure that hospitals follow the law. The proposal includes almost everything needed to implement AB 1136. She is very pleased about the provision that requires employee involvement in plan review, evaluation, and decisions regarding equipment needed, as well as the training requirements in the proposed standard.

Response:
The Board thanks Ms. Keenan for evaluating the proposed regulation and coming to the Hearing to support this part of the rulemaking.

Comment MK#2:
The standard does not reference language in AB 1136 that explicitly protects direct patient care assignments. Employers now give their employees very basic training in using lifts, and when lifts are used, RN's are required to leave their assigned patient to assist, which increases risks to patients and staff. The language in AB 1136 clearly protects direct care patient assignments and needs to be included in the standard to ensure its enforcement and to provide a safe environment for workers and patients.

Response:
The Board has proposed a modification regarding patient care assignments. Please see comment BC#2.

Comment MK#3:
The language that refers to the means by which the professional judgments of designated healthcare workers in disciplines outside of nursing would be incorporated into a patient's mobility assessment is a concern. The proposed standard does not provide parameters as to situations or circumstances in which a designated healthcare worker could incorporate their judgment into a patient's mobility assessment, and this appears to undermine the position and authority of the RN as the coordinator of care. This language needs to be changed.

Response:
The Board has proposed a modification to this subsection. Please refer to response to comment BC#3.

Jacquelyn Evans.

Comment JE:
The Board should remove exception #2 in the proposed standard regarding facilities within a hospital that are separately licensed. Patients in skilled nursing facilities in a hospital or that are in recovery rooms that are separately licensed are usually incapacitated and have a lot of trouble moving, and nurses in those facilities also need to be protected.

Response:
Please see the response to comment BC#4.

Deborah Amore.

Comment DA#1:
Having to assist with lifts leaves patients unattended, putting them and staff at risk. A provision that requires lift equipment to be available at all times in all units would really help because some units are adequately equipped with this type of equipment, but others are not.

Response:
The proposal includes, in subsection (c)(7)(B) a requirement that the hospital ensure that there is sufficient equipment available in all units. This notice proposes to add the term "accessible at all times" to that subsection. The Board thanks the commenter for her comment on this issue.

Comment DA#2:
There should be provisions requiring annual hands-on training for lifts, question and answer periods after the training.

Response:
The proposal includes requirements in subsection (d) for initial and refresher training including hands-on training on equipment use and patient handling procedures, and requires an opportunity for interactive questions and answers. The Board thanks the commenter for her support of these issues in the proposal.

Comment DA#3:
There should be opportunities to submit input to management regarding concerns with patient handling procedures.

Response:
The Board agrees that employee input is important in implementing safe patient handling. Opportunities for employee input are referenced in subsections (c)(5)(A), (c)(8)(B), and (c)(11).

Charlene Peek.

Comment CP#1:
Training needs to be ongoing; some people aren't trained on the equipment that has been provided.

Response:
The proposal would require initial and refresher training, including hands-on training on equipment, and would further allow employees to ask for additional training. Therefore the Board believes that the proposed regulation establishes a sufficient amount of training for employees and declines to increase the amount required.

Comment CP#2:
Lift equipment requires more than one person to safely move a patient. When the hospital got lifts, they reduced the number of patient care assistants who are responsible for assisting with moving patients. This resulted in nurses having to leave their patients in order to help with the lift.

Response:
Subsection (c)(7)(E) requires employers to have procedures to assure sufficient staff. This notice proposes to modify that subsection to require that this staff must be available without compromising direct patient care assignments. For more information see the response to comment BC#2

Tina Guliamati.

Comment TG:
The commenter stated that she supported the comments of Charlene Peak based on her experience as a nurse.

Response:
The Board thanks Ms. Guliamati for her participation.

Rhonda Watts.

Comment RW:
Ms. Watts stated that her hospital is following AB 1136 because she and other RN's demanded that the hospital follow the law. They also went before the County Board of Supervisors to ask for the money to buy lift equipment. As a result, the hospital now has lift equipment available throughout the facility, and the number of injuries has been greatly reduced, but there is not

enough staff available to assist with the lift and not impact patient care in the process. Ms. Watts also stated having lift equipment available at all units at all times will greatly reduce injuries. The RN's at her hospital are the coordinators of care for the patients, and that really helps.

Response:
The Board thanks the commenter for reporting how AB 1136 has helped in her case. Please also refer to the response to comment BC#2.

Lataushia Hall.

Comment LH#1:
Requiring hospitals to have both properly trained lift teams and lift equipment available would greatly help with handling patients safely. It is not always possible to get the lift equipment right away, especially in an emergency situation; so lift teams are essential.

Response:
The Board believes that the basis for the proposed regulation, LC 6403.5, does not mandate hiring specific staff, and the regulation is limited by that fact. However, the Board notes that there are several requirements for having lift equipment and trained staff available.

Comment LH#2:
Requiring hospitals to have adequate staffing to handle patients without making nurses leave their assigned patients is also necessary.

Response:
Please see the response to comment BC#2.

Margaret McManis.

Comment MM:
Ms. McManis supported Ms. Hall's comments.

Response:
The Board thanks Ms. McManis for her participation.

Anthony Barceros.

Comment AB#1:
Often, when there is not enough lift equipment and staff available nurses do not use it. Also, when staff is not adequately trained in how to use the equipment, it may be used incorrectly. Because of this, he would like to see requirements for hands-on initial and refresher training.

Response:
See response to comment CP#1.

Comment AB#2:
When injuries happen to staff, hospital management places the blame on the staff member and does not take further steps to help prevent the situation from happening in the future. He would

like to see RN's continue to be the coordinator of care and to allow them to voice their opinions regarding patient care procedures.

Response:
Subsection (c)(6) of the proposal requires hospitals to investigate patient handling injuries, including obtaining the injured employee's and supervisor's opinion regarding how the injury could have been prevented. Injury data is also required to be part of the annual review of the Plan, which includes a means to involve employees in that review, which is required by subsection (c)(11). For a further discussion of employee involvement provisions, see response to comment DA#3.

Leesa Evans.

Comment LE:
The regulation should require adequate staffing at all times for patient handling and increased staffing when the patient population is high.

Response:
Please see the response to comments LH#1 and BC#2.

Betty Android.

Comment BA:
The commenter stated that she supported the comments of Ms. Evans, regarding the need for adequate staffing, based on her experience.

Response:
The Board thanks Ms. Android for her participation in this Hearing.

Katherine Hughes, RN, SEIU 121.

Comment KH:
Ms. Hughes reiterated her written comments dated September 18, 2013.

Response:
Please see the summary and response to comments KH#1 through KH#10.

Ingela Dahlgren, SEIU Nurse Alliance of California.

Comment ID:
Ms. Dahlgren thanked the Board staff for their work on this proposal and reiterated several of the previous comments.

Response:
The Board thanks Ms. Dahlgren for her participation in this rulemaking process and attending this Hearing.

Richard Negri, SEIU 121 RN.

Comment RN:
Mr. Negri supported the comments of Ms. Hughes regarding the need for a way to track the location of equipment and several other comments regarding the need for proper training.

Response:
The Board thanks Mr. Negri for attending this Hearing and providing this testimony.

David Brown, California Hospital Association.

Comment DB:
Mr. Brown stated that he supports the proposed regulation, but feels that it will only be successful if it is truly a collaborative effort that is coordinated between all designated healthcare delivery workers, including nurses.

Response:
The Board concurs that cooperation among the affected health care workers and management will better insure the successful implementation of this regulation.

Steve Derman, Medishare Environmental Health and Safety Services and the California Industrial Hygiene Council.

Comment SD:
Mr. Derman supports having a good safety and health program that uses engineering controls and administrative support to help eliminate injuries. He stated that clarification is needed regarding the exceptions listed in the proposed regulation, including the exceptions for acute care facilities and the exceptions that exclude long-term care facilities from following it.

Response:
Please see the response to comment BC#4.

Board Members Stock and Smisko:

Board Members Stock and Smisko asked the Board staff to clarify the role of the RN as the coordinator of care, as well as the situations where other health care workers can help with that.

Response:
Modifications have been proposed to clarify the role of the RN, and also to explain further the requirement that the Plan to include the means by which lift teams and/or designated health care workers will be available at all times to perform patient handling tasks. Please see the responses to comments BC#2 and GB#2 regarding staffing, and BC#2 regarding the role of the RN.