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February 28, 2012

To: Cal OSHA

Re: Proposed 8 CCR new Section 5120

Prior to the enactment of AB 1136 (Swanson) Ch. 554 Statutes of 2011, employers, including hospital employers, were required to have in place a written workplace Injury and Illness Prevention Program as contained in Title 8 of the California Code of Regulations, Section 3203 (8CCR§3203). These regulations consisted of the following eight elements:¹

- Responsibility
- Compliance
- Communication
- Hazard Assessment
- Accident/Exposure Investigation
- Hazard Correction
- Training and Instruction
- Recordkeeping

A model program was prepared by Cal OSHA for use by employers in industries, including hospitals, which have been determined by CalOSHA to be non-high hazard. Employers were not required to use the model program however, any employer who qualified as being non-high hazard who adopts, posts, and implements the model program in good faith would not be subject to assessment of a civil penalty for the first violation of 8CCR§3203. The requirement for employers to have a written workplace Injury and Illness Prevention Program has been in effect since 1991.

Ergonomics-History of California Standard²

In 1993 Assembly Bill 110 also added a new Section 6357 to the Labor Code, which required the California Occupational Safety and Health Standards Board--an agency separate and independent from the Division of Occupational Safety and Health--to adopt

"[O]n or before January 1, 1995...standards for ergonomics in the workplace designed to minimize instances of injury from repetitive motion."

¹ Model Injury and illness Prevention Program for Non-High Hazard Employers, Cal OSHA, Reviewed /Updated May 2011.

² Excerpted, in relevant part, directly from www.dir.ca.gov/DOSH/ergohist.htm

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At the time the legislation passed in mid-1993, the California Occupational Safety and Health Standards Board ("Standards Board") was relying on the Division of Occupational Safety and Health and its public Ergonomics Advisory Committee to develop an ergonomics standard for the Standards Board's consideration and adoption. In November of 1994, after two large public hearings, and the submission of over 6,500 written comments, the Standards Board voted down the proposed Section 5110 standard.

On 19 January 1995, the Standards Board was sued by the California Labor Federation, and three named injured workers, in Superior Court in Sacramento, California for its failure to "adopt" a standard "to minimize instances of injury from repetitive motion" by 1 January 1995. The Superior Court ordered the Standards Board to develop and adopt a standard which complied with Section 6357 by 1 December 1996.

In December of 1995, the Standards Board published a Notice of Public Hearing which contained a proposed repetitive motion standard. Hearings on the proposed standard were held on 18 (Los Angeles) and 23 (Sacramento) January 1996. On 14 November 1996, the Standards Board adopted a new 8 CCR Section 5110 entitled "Repetitive Motion Injuries." The Office of Administrative Law approved 8 CCR Section 5110 on 3 June 1997, and the new repetitive motion injury standard became legally enforceable in California on 3 July 1997. There were two court decisions following approval of Section 5110 that ultimately invalidated language having to do with small employer exemption of the standard.

Repetitive Motion Injury

According to *"A Physician's Guide to the California Ergonomics Standard"*³ Repetitive Motion Injuries (RMI) are musculoskeletal disorders (MSDs) that are caused predominantly (at least 50%) by a repetitive job, process, or operation.⁴ "Repetitive work means performing similar tasks or a series of exertions again and again. This may include such diverse activities as lifting, twisting, gripping, pushing, pulling, or keying."⁵ Jobs that have the greatest risk of potential for MSDs include activities such as handling patients.

These two standards are the backdrop against which AB 1136 (Swanson) Ch. 554 Statutes of 2011 (AB 1136) was enacted. Despite existing standards and requirements, "[i]n 2008, there were 36,130 occupational musculoskeletal disorder (MSD) cases in private industry where the source of injury or illness was a health care patient or resident of a health care facility. This accounted for 11 percent of the 317,440 total cases of MSDs that resulted in at least one lost day from work in 2008. Almost all (98 percent) of the cases involving patient handling occurred within the health care and social assistance industry, composing 55 percent of the 64,300 total MSD cases in that industry."⁷

"For MSD cases involving patient handling, almost all (99 percent) were the result of overexertion. A sprain, strain, or tear was the type of injury that was incurred in 84 percent of the MSD cases involving

³ A Physician's Guide to the California Ergonomics Standard, Hazard Evaluation System and Information Service, Occupational Health Branch, California Department of Health Services, November 2001

⁴ Ibid. p. 1

⁵ Ibid p. 2

⁶ Ibid p. 5

⁷ AB 1136 (Swanson) Ch. 554 Statutes of 2011, Section 2. (a)

patient handling. Nursing aides, orderlies, and attendants incurred occupational injuries or illnesses in 52 percent of the MSD cases involving health care patients. Registered nurses accounted for 16 percent and home health aides for another 6 percent. Other occupations with MSD cases involving health care patients included licensed practical and licensed vocational nurses, emergency medical technicians and paramedics, personal and home care aides, health care support workers, radiologic technologists and technicians, and medical and health services managers.”⁸

“Over 12 percent of the nursing workforce leaves the bedside due to back injuries each year. California's nursing workforce is aging at the same time patient acuity and obesity are rising. It is imperative that we protect our registered nurses and other health care workers from injury, and provide patients with safe and appropriate care. At a cost of between sixty thousand dollars (\$60,000) and one hundred forty thousand dollars (\$140,000) to train and orient each new nurse, preventing turnover from injuries will save hospitals money.”⁹

This newly enacted legislation is directly focused upon General Acute Care Hospitals and was intended to amend and enhance existing standards which have been found inadequate in reducing serious injuries and loss of work days in health care facilities. The California Nurses Association, the sponsors of the legislation, was successful in convincing the legislature of the need to adopt additional standards in 2004 but then Governor Schwarzenegger vetoed the bill. However, he added in the veto message, “I encourage hospitals to review their lift policies to determine the extent to which they can develop lift teams and purchase machinery to assist in lifting patients. I also encourage hospitals to consider incorporating modern lift technologies into new construction and significant renovation projects, including their seismic retrofit activities.”¹⁰

AB 1136 is now a law and is currently enforceable by CalOSHA. The promulgation of regulations to clarify and make specific Labor Code Section 6403.5 is a critical link in the completion of this 8 year chain of events that will provide a safe work environment for hospital employees and enhance the safety of patients in the General Acute Care Hospital setting.

CNA respectfully submits these recommendations to Cal OSHA for consideration when crafting language for implementing, clarifying and making specific Labor Code Section 6403.5 (LC§6403.5):

- (a) Scope and Application. CNA has used the language in the Labor Code to because it provides guidance for the section regarding the narrow focus of these enhancements to 8CCR§3203 including the licensed General Acute Care Hospitals (GACH) that are exempted from these additional requirement.
- (b) In an effort to define language used in the regulations, CNA has referenced LC§6403.5 and 22 CCR §7001 et seq. that deal with the Licensing and Certification of GACHs. CNA is familiar with the hospital regulatory requirement since most of our 86,000 members are employed in these settings. The use of terms, definitions and professional practice requirements that overlay this work setting is

⁸ Ibid. (b)(c)

⁹ Ibid (d)

¹⁰ Veto Message AB 2532 9/22/04

used by both employees and the employer. We believe that the use of terms most familiar to the employer and the employee increases the likelihood that these new requirements will be easily understood by all parties. The language we used for changes in the law in GACHs was part of the work process for CNA when developing this legislation with author, Assembly Member Swanson. CNA has also used terms and definitions that can be found in documents that have been in print by the Department of Public Health (previously called the Department of Health Services) in 22 CCR 7001 et seq. and by Cal OSHA. The legislation itself as contained in LC§6403.5 contains most of the definitions of terms.

In order to assure the safest handling of patients in a manner that protects both patient and healthcare worker, the language of the law specifies that the needs of the individual patient must be considered. This must be done as part of the registered nurses' assessment of each patient to determine whether the patient is able to walk or move on their own or if they require some assistance during the time of hospitalization. A patient's condition is quite likely to change so that even a fully ambulatory and alert adult patient who has had surgery may not be able to provide the same level of self-mobility following surgery as the patient had upon his/her admission assessment. The ongoing re-assessment of the patient's ability to move physically and the ability to assist in self-mobilization is a critical element in a safe transfer for the patient as well as for the healthcare worker.

- (c) LC§6403.5 is an extreme departure from previous standards in that it mandates the replacement of manual lifting and transferring of patients with powered patient transfer devices, other lifting devices and lift teams based on the unique needs of each patient as determined by the registered nurse and consistent with hospital safety policies. This is a vastly different from the veto message of former Governor Schwarzenegger when hospitals were "encouraged" to look at replacing manual lifting with modern lift technologies but when no requirement existed for moving forward with these changes. The clinical assessment of the registered nurse is currently a requirement for every hospitalized patient in the GACH setting. CNA has specifically referenced this existing requirement adding the additional language of "mobility" and "dependency" as it relates to this new law. Registered nurses already look at and document a safety parameter, "fall risk". There is some overlap in the mobility and dependency assessment of all patients as it relates to fall risk and to the needs for patient lifting, transferring and repositioning even though, as mentioned previously, a patients' self-mobility needs may change during the period of hospitalization. So too will a patient's "fall risk" which is reflected in policies for using bedrails, for example, following the administration of some medications.
- (d) CNA has used language that has been in effect in hospital since the promulgation of GACH regulations. Specifically, the language "at all times." It is the language of continuous compliance with the law and the expectation is that the law will be followed 24 hours a day and 7 days a week. Patient care units are defined in 22 CCR 70049 as "nursing units" which are designated as patient care areas. The risk for MSD injury by employees and for patient injury follows the patient where ever the patient receives care and in required by virtue of that care, to move or be moved. We have correspondingly clarified that all "basic service" areas where patient receive inpatient hospital services are part of defined "patient care units." Basic service areas refer to the minimum services required for GACH licensing: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. Patients are not usually moved to pharmacy or dietary service areas but in the

event patient care, diagnostic or therapeutic services were performed on patients in those areas, the requirements would apply when lifting, transferring or repositioning patients. Emergency Departments are not a part of Basic Service requirements but they are a part of many GACHs and they are nursing care units as well and would therefore also have to be considered in developing the Illness and Injury Protection Plan Safe Patient Handling policy.

- (e) The new language requiring training on the appropriate use of lifting team and equipment is central to the success of this new law and CNA has referred to the Cal OSHA training standards for other occupational risks (blood borne pathogens, RMI) as well as currently required competency validation requirements that can be found in 22 CCR §§ 70016, 70016.1 and 70213(c). The “how, where, when, why and who” of using lift devices for patient lifts, repositioning or transfer will need to be the focus of on the job training of health care worker responsible for patient moves.
- (f) The need for annual competency validation for all health care workers as well as competency validation for any new equipment prior to its use is an established standard for training in current GACH regulations as well as in several other Cal OSHA training standards that already apply to GACHs as covered industries (e.g. Blood Borne Pathogens and Aerosol Transmissible Diseases)
- (g) The registered nurse is the coordinator of patient care provided in licensed GACHs.¹¹ CNA has referenced GACH regulations to clarify the term as used in these proposed new regulations and to provide consistency with existing requirements for patient care in the GACH setting. “Observation and direction” is being defined and clarified in great part because of misunderstandings identified during the first public meeting. GACH regulations have three levels of “supervision”. The first is contained in 22 CCR §70063 (a) “Supervision means to instruct an employee or subordinate in his duties and to oversee or direct his work, but does not necessarily require the immediate presence of the supervisor.” 22 CCR §70063 (b) defines the next level of supervision, “Direct supervision means the supervisor shall be present in the same building as the person being supervised and available for consultation.” This is a higher level of supervision that requires the supervisor to have a physical presence in the same general area at the time of supervision but does not require the supervisor to directly visualize the care being performed at the time it is being performed. This is the minimum level of supervision that is expected of the registered nurse who delegates implementation of nursing care activities to other licensed caregivers or to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency and/or regulation.¹² 22 CCR §70063 (c) is the highest level of supervision, “Immediate supervision means that the supervisor shall be physically present while a task is being performed” and is the level of supervision consistent with the mandate for the registered nurse to **observe and direct** patient lifts and mobilization. CNA believed that this language was clear and unambiguous when it was included in the legislation but recent comments at the public meeting suggests the need for a clearer definition more familiar to employers and employees in GACHs. For that reason, CNA recommends using the specific regulatory language of the GACHs to more clearly define what is required for the registered nurse who is responsible for the observation and direction of patient lifts and mobilization.

¹¹ 22 CCR § 70215

¹² 22 CCR §70215 (a)(2)

“[s]hall participate as needed” is also being defined since there seemed to be some confusion during the first public forum as to the meaning of this phrase and how it relates to the following language in the statute:

“(c) 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.”¹³

There are two mandates that are described in (c). The first is, “As coordinator of care, the registered nurse **shall be responsible** for the observation and direction of patient lifts and mobilization ...” [emphasis added] and the second requirement is that “As coordinator of care, the registered nurse...” “... **shall participate as needed** in patient handling in accordance with the nurse’s job description and professional judgment.” [Emphasis added] The coordinating conjunction “and” links two equal ideas. The first has to do with the mandate to observe and direct. The second has to do with the RN directly handling the patient and operating the equipment during lifts and mobilization. The RN shall participate in accordance with the RN’s job description. If the RN is a member of a designated lift team and his/her job description includes direct patient handling and operation of the mobility devices, then the RN would likely make direct physical contact with both the patient and the equipment. However, the Lift Team RN’s professional judgment may dictate a different role to assure patient and healthcare worker safety. If the RN is not part of a designated lift team that circulates throughout the hospital but she/he is the direct care RN who has received training along with other hospital support staff, the RN may determine that the need to direct the lifts and mobilization requires him/her to not directly handle the patient or the equipment and to be available to coordinate the activities of other trained support staff.

The model depends upon the GACH’s Safe Patient Handling Policy as well as the professional judgment of the RN. The language of the statute allows employers to create designated lift teams that circulate throughout the hospitals performing the needed services as long as they are available at all times for all patient care units. The language of the statute also allows hospitals to utilize “other support staff” to perform the services.

- (h) Healthcare workers, as defined, can be configured according the needs of the individual GACH and can be made up of existing hospital employees as long as the services are available at all times and for all patient care units and the model used does not compromise direct patient care assignments. CNA has referenced the hospital staffing standards requirements since these reflect the minimum staffing consistent with safe patient care. If the GACHs Safe Patient Handling Policy requires that healthcare workers who perform lifts and mobilizations are also going to be those responsible on the patient care unit for providing direct patient care, staffing must take into consideration the additional time needed for patients with high dependency needs and with little ability to assist in

¹³ LC §6403.5 (c)

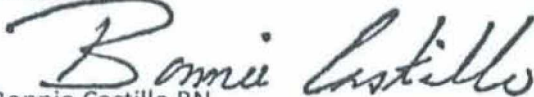
mobilization. Accessing equipment, making sure equipment is working properly, performing the lift or mobilization and then cleaning and returning the equipment to its storage site requires time taken away from other direct patient care and the GACH must plan for the additional staffing that is going to be needed when assigning lifting and mobilization to direct care staff with other patient care responsibilities. Cal OSHA does not enforce staffing in GACH but would report deficiencies to the Department of Public Health Licensing and Certification if, in the course of investigation, improper staffing appeared to be a contributing factor in the injury of a patient or a healthcare worker.

- (i) The prohibition against disciplinary action was a main focus of the hospital industry's opposition to this legislation but the conditions under which a healthcare worker can refuse are clearly stated as those related patient or worker safety or the lack of trained lift team personnel.

CHA stated in an opposition letter that a heavy patient who comes in by private auto who has had a stroke or a heart attack may need a manual lift in the interest of patient safety. This complaint by the hospital industry makes the point for the need of legislation to protect patients and healthcare workers. Hospitals know now and have always known that there are emergencies that require the immediate transfer of helpless, heavy patients in need of emergency care. They should already have had a plan to address that need. Now they will be required to have a plan in place to make sure a critical patient transfer happens without injury to the patient or to the healthcare worker. CNA recognizes that even with good plans in place, injuries are likely to occur but we are committed to working to minimize the number and severity of those injuries to healthcare workers and to enhance the safe transfer of patients in the hospital setting.

Thank you for the opportunity to submit recommendation to Cal OSHA for the proposed regulatory language to implement the patient protection and health care worker back and musculoskeletal injury prevention plan. If you have any questions, please contact CNA at (916) 491-3214 or you can reach me by my cell phone number (916) 491-3214.

Sincerely,



Bonnie Castillo RN

Director of Government Relations

California Nurses Association

Add new section 5120 to read as follows:

Section 5120. Health Care Worker Back and Musculoskeletal Injury Prevention Plan.

(a) **Scope and Application.** This Section shall apply in all general acute care hospitals. **General Acute Care Hospital** means a hospital, licensed by the Department of Public Health, having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care as defined in 22 CCR §70005.

Exception: This Section shall not apply to general acute care hospitals within the Department of Corrections and Rehabilitation or the State Department of Developmental Services.

(b) As part of the injury and illness prevention programs required by Section 3203 of Title 8 of the California Code of Regulations, or any successor law or regulation, employers shall adopt a patient protection and health care worker back and musculoskeletal injury prevention plan.

(1) **"Patient"** means a person who is receiving diagnostic, therapeutic or preventative health services or who is under observation or treatment for illness or injury or care during and after pregnancy as defined in 22 CCR §70053.

(2) For purposes of this section, **"health care worker"** means a lift team member or other staff responsible for assisting in lifting patients who is a hospital employee specifically trained to handle patient lifts, repositioning, and transfers using patient transfer, repositioning, and lifting devices as appropriate for the specific patient.

(3) **"Musculoskeletal injury"** means a class of soft-tissue disorders involving the muscles, tendons, ligaments, peripheral nerves, joints, bones, and/or blood vessels of the neck, back and upper or lower extremities.¹

(4) As used in this section, **"As appropriate for the specific patient"** means a determination that includes, but is not limited to a patient's dependency status and mobility needs based upon the clinical assessment of the registered nurse as reflected in professional occupational safety guidelines.

(5) **"Mobility"** as used in this section means the ability to move physically.

(6) **"Dependency status"** as used in this section means a determination, based on the clinical assessment of the registered nurse, of the patient's ability for self-mobilization as reflected in professional occupational safety guidelines.

(c) The plan shall include a safe patient handling policy component reflected in professional occupational safety guidelines for the protection of patients and health care workers in health care facilities.

1) For the purposes of this section, **"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.

¹ CDHS, A Physician's Guide to the California Ergonomics Standard, 2001 p. 1.

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2) For purposes of this section, **“Manual lifting”** means the lifting, repositioning or transferring of a patient done by hand without the assistance of machines.

(A) **“Lifting”** means the vertical movement of a patient.

(B) **“Transferring”** means moving a patient from one place to another (for example from a bed to a gurney)

(C) **“Repositioning”** means a change in the patient’s position on a bed, gurney, chair or other support surface.

3) **“Health Care Facilities”** as used in this section means all General Acute Care Hospitals except those within the Department of Corrections and Rehabilitation or the State Department of Developmental Services².

4) **“Clinical assessment of the Registered Nurse”** includes but is not limited to the initial and ongoing examination and assessment of a patient’s condition including mobility and dependency needs as required in 22 CCR §70215(a)(1), B&P Code §2725 (b)(4) and 16 CCR §1443.5

(d) An employer shall maintain a safe patient handling policy at all times for all patient care units, and shall provide trained lift teams or other support staff trained in safe lifting techniques in each general acute care hospital.

1) **“At all times”** means 24 hours a day and 7 days a week.

2) **“All patient care units”** means every designated nursing care unit of the hospital which is planned, organized, operated and maintained to function as a unit. It includes but is not limited to patient rooms and all other basic service areas where patients receive inpatient hospital services.³

3) **“Lift Teams or other support staff trained in safe lifting techniques”** means general acute care hospital health care workers specifically trained to handle patient lifts, repositionings, and transfers using patient transfer, repositioning, or lifting devices as appropriate for the specific patient.⁴

(e) The employer shall provide training on the appropriate use of lifting devices and equipment to health care workers.

1) **“Training”** means the acquisition of knowledge, skills, and competencies as a result of the teaching of vocational or practical skills and knowledge that relate to specific useful competencies.⁵

² Labor Code Section 6403.5 (h)

³ 22CCR §70049

⁴ Labor Code, §6403.5 (d)

⁵ Wikipedia

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- 2) This section requires the employer to provide effective training to health care workers who are being trained to handle patient lifts, repositionings, and transfers using patient transfer, repositioning, or lifting devices.
- 3) The training must be comprehensive, understandable, and recur annually, and more often if necessary. The employer shall ensure that each health care worker can demonstrate knowledge, skills and competencies in at least the following:
 - A. The appropriate use of lifting devices and equipment;
 - B. The five areas of body exposure: vertical, lateral, bariatric, repositioning, and ambulation;
 - C. The use of lifting devices to handle patients safely.

(f) The employer shall provide the training prior to requiring the healthcare worker to use patient transfer, repositioning, or lifting devices.

(g) 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.

- 1) **"Coordinator of Care"** means:
 - A. the planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission;⁶
 - B. The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient⁷;
 - C. Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.⁸
- 2) **"Observation and direction of patient lifts and mobilization"** means immediately supervising the 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.
 - A. **"Immediately supervising"** means that the registered nurse shall be physically present while a task is being performed as defined in 22 CCR §70065(c)⁹

⁶ 22 CCR §70215(b)

⁷ Ibid (c)

⁸ Ibid (d)

⁹ Three levels of Supervision are defined in §70065. The statutory requirement that the RN "observe" and direct refers to the language found in (c) Immediate Supervision which requires that the supervisor be physically present while a task is being performed.

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- 3) **"Shall participate as needed"** means the registered uses the clinical assessment of the patient, the safe patient handling policy and his/her professional judgment to determine his/her role in performing the safest patient lift, repositioning or mobilization.

(h) Lift team members may perform other duties as assigned during their shifts. 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.

- 1) **"Direct patient care assignments are not compromised"** means that nursing service staffing is fully compliant at all times with 22 CCR §70217(a)(b) and (c).

(i) 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.