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Guideline for Safe Patient Handling and Movement

PODCAST

Lisa Croke, Managing Editor

The updated AORN "Guideline for safe patient handling and movement" provides recommendations on safe patient handling and mobility (SPHM) programs to decrease patient and personnel injuries. It also provides guidance for procedure-related high-risk ergonomic activities to minimize injury to perioperative team members.[1] According to Emily Jones, MSN, RN, CNOR, NPD-BC, AORN senior perioperative practice specialist and lead author of the guideline, although the term *mobility* is seen in the literature on safe patient handling, the term *movement* was retained in the title of the updated guideline to reflect the additional high-risk ergonomic activities performed in the perioperative environment. "The OR is unique because perioperative team members not only participate in safe patient handling and mobility activities, but also perform a variety of other high-risk ergonomic tasks," she said. The updated guideline, which was first published in 2018, will be available in AORN eGuidelines+ in January 2024.

Technology and Individualized Plans

A few new recommendations were added in the section on SPHM technology. One is that patient lift equipment (eg, ceiling or boom lifts) that reduces the physical forces needed to move patients should be chosen for use in the perioperative area in collaboration with the facility's product evaluation team.[1] Because personnel are more likely to use patient lift equipment when it is readily available for use, a recommendation was added that these types of equipment should be kept in such a location.[1-4]

This update now includes a section titled "Individualized SPHM and Ergonomic Plan;" it provides both new recommendations and recommendations from the previous version of the guideline. The recommendation about the number of personnel needed to safely perform a lateral patient transfer or reposition a patient was revised from providing an exact number to indicating that the number of personnel needed to perform these tasks should be sufficient to maintain the patient's body alignment and airway and support extremities.[1,5] "Several factors are considered when transferring patients laterally and repositioning patients in the perioperative setting, such as the patient's weight, characteristics, and clinical condition; the starting position; and the ending position," Jones said. "Every situation may require a different minimum number of perioperative team members to ensure patient and staff safety." A new recommendation also was added to evaluate the need for help from additional personnel or assistive devices to lift or hold an extremity, the head, or panniculus when performing preoperative patient skin antisepsis or intraoperatively.[1,6]

Moving Equipment and Supplies

A new section on moving equipment and supplies was added that includes both new recommendations and recommendations from the previous version of the guideline. One new recommendation is that personnel should carry loads close to their bodies and



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keep twisting to a minimum.[1,7] When loads are carried away from the body, the forces exerted on the spine are increased, resulting in a greater risk of musculoskeletal injury. Twisting of the torso increases the asymmetry angle, or the positioning of the load related to the midsagittal plane, which could subsequently increase the lifting hazard.[7,8] "Realistically, performing manual lifting tasks in the OR is sometimes unavoidable, so we wanted to outline ways to help staff members who participate in lifting and carrying tasks decrease their risk of injury," Jones said. A second new recommendation indicates that the number of manual lifting tasks performed should be minimized during the workday.[1,7] More lifting tasks can increase the total daily low back loading (ie, force exerted on the spine), resulting in a greater risk of musculoskeletal injury.[7,8]

Fall Risk and Mobility Assessments

Several new recommendations were added to the newly titled section "Fall Risk and Mobility Assessments." "This was done to call attention to their importance in safe patient handling and mobility," Jones said. "This also allowed us to expand on the details of fall risk and mobility assessments, and to provide our members with the evidence that supports fall prevention strategies in the perioperative setting." Classifying a patient's fall risk is the most important step in fall prevention. Therefore, fall risk and mobility assessments that are evidence-based, comprehensive, and validated for use specific to the patient population should be incorporated in patients' preoperative evaluations.[1,9] These types of fall risk assessment tools engage patients and their families, help with determining specific fall prevention approaches for each patient, support continuity of care, and enhance communication.[1] These types of mobility assessment tools determine each patient's mobility and use of mobility technology; evaluate for gait, auditory impairment, and the need for help with mobility; and identify each patient's baseline preoperatively, which can be shared with postoperative personnel. It should be noted that fall risk should be reevaluated postoperatively before the patient attempts to walk.[1]

Conclusion

This updated guideline highlights information on SPHM programs and ergonomics in the perioperative setting. New and revised recommendations address SPHM technology, individualized SPHM and ergonomic plans, moving equipment and supplies, and fall risk and mobility assessments. "By implementing these recommendations, we hope there can be a decrease in musculoskeletal injuries during high-risk ergonomic tasks in the perioperative environment," Jones concluded. "Additionally, we hope that by implementing safe patient transfer techniques, along with robust fall prevention programs, we can reduce mobility-related patient injuries."

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