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Healthy Back Promotion Program: Barriers to Implementation

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Healthy Back Promotion Program: Barriers to Implementation

Abstract

The Occupational Health Nurse Practitioners (OHNPs) and the education specialist at a community hospital in northern California designed and implemented the Patient Lifting Equipment Program and protocol. After 1 year, the investigator used a questionnaire to identify and describe 17 female subjects' barriers to implementing the new equipment and protocol and their risk factors for back injuries. The barriers that the subjects cited most often were increased time to prepare and use the devices and the lack of staff who could assist with the lifts. Risk factors, e.g., age, body mass index, hours worked, stress on the job, and social support influenced some subjects' risk taking behaviors for back injuries. By considering the multiple factors involved in providing healthy back promotion/injury prevention principles for their clients, primary care providers and OHNPs can determine when a client with a work-related back injury may return safely to work.

Healthy Back Promotion Program: Barriers to Implementation

In a 200-bed community hospital in northern California, the Occupational Health Nurse Practitioners (OHNPs) in Employee Health Services (EHS) and the education specialist designed and implemented a Patient Lifting Equipment Program in the Radiology Department and six nursing units to comply with the updated state and federal safety standards. The program focused on new lifting/transferring equipment and safe body mechanics and formed the foundation for the hospital's new protocol for lifting/transferring patients.

This study identifies and describes several barriers and risk factors for implementing the new equipment and protocol that may have influenced the outcomes of that program after one year. These barriers and risk factors were (a) the employee's understanding and skill of safe lifting/transferring techniques, (b) the employee's internal and external barriers to use the lifting/transferring equipment and to implement the hospital protocol, and (c) the employee's risk factors for work-related back injuries. Not only are these factors important for a hospital program, but also for primary care providers and OHNPs to provide effective healthy back promotion and protection principles to their clients.

LITERATURE REVIEW

Changes in staffing pattern

Recent restructuring of the staffing patterns in many hospitals resulted in an increase in the numbers of unlicensed workers and an increase in the ratio of unlicensed workers to registered nurses. According to Coleman and Hansen (1994), an increase of unlicensed workers results in an

an increase of back injury occurrences due to a comparative lack of knowledge of safety issues and proper body mechanics.

Lifting/transferring Issues

Owen and Garg (1991) stated that the most stressful lifting/transferring nursing tasks involved transferring patients on/off the toilet and in/out of bed, bathing patients, and weighing patients. These tasks occurred multiple times during a 24-hour day. Similarly, epidemiological studies by Moore (1993) and Scheer, Robinson, Rondinelli, and Weinstein (1997) demonstrated that physically heavy work, repetitive action, frequent bending and twisting, lifting or forceful movement, prolonged static work postures, and stress are work-related risk factors for low back injuries. According to Owen and Garg (1991), stress on low back muscles while performing some of these repetitive lifting tasks can be decreased by using assistive devices. However, the devices must meet acceptable maximum weight and static strength standards during asymmetric lifting. The current standards are based upon the use of a nonmoving, counterbalanced, rectangular box. These conditions differ greatly from actual patient lifting situations. Lifting activities in health care facilities are not ergonomically ideal because patients can be combative, rigid, spastic, and often unpredictable.

An important factor to consider when evaluating the appropriateness and utility of lifting and transferring devices is the amount of time needed to use an assistive device. If employees perceive that it takes an increased amount of time to perform a task with an assistive device, the likelihood of their using it decreases. Increased time to use a device may be due to (a) preparation

time and after-use care, (b) method and location of equipment storage, (c) availability of the equipment, and (d) doubts about the stability of the equipment (Owen and Garg, 1993).

Another factor that can decrease the use of lifting devices and encourage risk taking behavior for back injuries, is a cultural acceptance of back pain as part of bedside patient care. Owen and Garg (1993) found nurses often do not file incident reports about their injuries; yet, they have been ranked fifth nationally for workers' compensation claims for back injury. Another study conducted by Owen and West in 1989 (as cited in Feletto and Graze, 1997), reported that only one-third of nurses who had work-related back injuries actually reported those injuries.

Not only must the OHNPs or nurse practitioner consider methods to assist employees to use the new lifting devices and protocol, but also how to incorporate their use into the employee's lifestyle. Pender (1996) stated that social support is a primary force in sustaining lifestyle change and can be provided in the workplace through contact with coworkers. Workplace social support includes hospital administrators, unit managers, and staff members. Ness (1997) cited the importance of management commitment to and concern for the health and safety of their employees. Organizational stressors such as work organization, load, flow, and environment are not controlled by the employees, but can influence their state of health and cause stress related disorders. Social support is another area that can influence behavior changes. Daltroy, Iverson, Larson, Ryan, et al. (1993) stated that social support has long been considered beneficial for workplace health promotion, even though there is little research to support its effects on behavioral changes or maintenance.

Personal Characteristics and Risk Factors

There are some personal characteristics that may contribute to work-related back injuries: age, lack of experience on the job, smoking, obesity, heavy alcohol consumption, job dissatisfaction, negative attitude, lack of job identity, prior history of back trouble, and physical condition (Daltroy, Iversen, Larson, Ryan, et al., 1993; Lahad, Malta, Berg, & Deyo, 1994; Smedly, Egger, Cooper, & Coggon, 1997; Shi, 1993). Daltroy, Iversen, Larson, Lew, et al. (1997) reported younger workers are at a higher risk for back injuries and Shi (1993) stated that the persons most likely to have back injuries are 41-50 years old.

Several studies have listed obesity as a risk factor for back pain and/or injury. Smedley, et al. (1997) were unable to find an increase in risk of back pain or injury due to weight or body mass index (BMI), but obesity may cause back injuries because it may cause poor posture.

Personal habits such as smoking may increase the risk of developing low back pain. Lahad and associates (1994) speculated that smokers have a risk of developing low back pain that is 1.5 to 2.4 times higher than nonsmokers because vertebral disc oxygen supply is decreased due to arteriolar constriction caused by nicotine. A study of identical twins, where one was a smoker and the other a nonsmoker showed an increase in degenerative spinal changes in the smoker (Lahad, et al., 1994).

Current studies cannot provide evidence that smoking cessation, weight loss, or reduction in psychological risk factors will decrease or prevent the incidence of back injury or pain (Lahad, et al., 1994). However, modifying these risk factors may decrease the predisposition for

developing low back pain and may decrease the perception of pain or disability following an injury (Lahad, et al., 1994). An evaluation study of an instructional program to prevent back injury among nursing personnel concluded that back injuries are too complex a problem to be solved by a single intervention with a limited focus (Venning, 1990). The long-term benefits of a back injury prevention program would be determined by a favorable, supportive work environment, and continued vigilance of positive behavioral changes (Owen and Garg, 1993; Shi, 1993).

Conceptual Framework

Primary care providers and OHNPs can consider two theoretical concepts when considering behavioral changes for healthy back promotion and injury prevention. The Health Belief Model (HBM) assumes that individuals will take action if they perceive an immediate threat to personal health and that the action chosen will outweigh the barriers they encounter, such as inconvenience, cost, or pain (Salazar, 1991; Pender, 1996). Pender (1996) identifies several important modifying factors (age, stress level, and personality) and action cues (knowledge base, prior contact, and advice from a healthcare professional) as indirect influences on action tendencies in the HBM. The actions, beliefs, and attitudes of significant others, peers, and others held in high esteem by the employee can assist or be barriers for achieving positive behavior goals (Pender, 1996). Perceived barriers and perceived susceptibility are powerful components of the HBM (Salazar, 1991; Pender, 1996). Perceived barriers can predict and explain various health behaviors and perceived susceptibility is a key factor in understanding

preventive behavior (Pender, 1996).

As in the HBM, perceived barriers and susceptibility are factors in the Transtheoretical Model for behavior change (Prochaska, Norcross, and DiClemente, 1994). One needs to assess the employee's openness to change before that individual will accept cues to action. This model focuses on 5 stages of change: precontemplation, contemplation, preparation, action, and maintenance. Identifying which of the 5 stages of change the employee occupies may help guide health care providers to choose the appropriate teaching and motivational methods.

RESEARCH DESIGN

This nonexperimental, ex post facto, descriptive study was used to determine the internal and external barriers and the risk factors that influenced the implementation of the Patient Lifting/Transferring Equipment Program and protocol. Data were analyzed with descriptive statistics.

METHODS

Subjects

Of the twenty-two subjects (ages 21 - 58) identified as eligible for interviews by EHS, seventeen subjects were included in this study because they met the criteria of having injured their backs on the job while lifting and/or transferring patients after the intervention. Five subjects were excluded from this study because 2 subjects left the organization, one injured her wrist, and 2 had no intervention. No male employees reported back injuries during this period. All subjects' injuries occurred while working on one of the nursing units involved in the program: skilled nursing, medical, postsurgical, telemetry, transitional care, or critical care. The Radiology Department withdrew participation after the first 3 months of program implementation.

Instruments

The instruments used were developed for this study. The OHNPs developed The Patient Lift or Transfer-Related Injuries Supplemental Information Sheet (El Camino Hospital Employee Health Services, 1997) and gave the investigator permission to use the tool. This questionnaire was pilot tested on EHS staff members and on a convenience sample of medical nursing staff members after a three-month implementation period. The questionnaire elicited information on each injury incident in detail: the physical and mechanical aspects of the incident, the subject's knowledge base of lifting mechanics, and use of one's lifting/transferring skills. The Questionnaire Addendum developed by the investigator examined the subject's risk factors for back injury: physical activities, exercise, muscle stretching/toning, smoking, stress level on/off the job, and willingness to change behavior and the subject's barriers to implementing the Patient Lifting Equipment Program and protocol. This tool was not pilot tested.

Data Collection

The investigator contacted each subject in person or by phone and obtained a written informed consent. The investigator read the tools' questions in a consistent manner for the subject, to help control for bias, and transcribed the employee's responses. Two subjects' weight and height were measured, fourteen subjects stated their measurements, and one refused to reveal her measurements. The data were categorized by subject: demographics, internal and external barriers, and risk factors.

RESULTS

Risk Factors

Of the seventeen subjects, eleven were nurses (10 registered nurses and 1 licensed

vocational nurse) and six were certified nursing assistants (CNAs). Their risk factors for back injury were the following:

1. A mean age of 40.59 years with the subjects' age distribution of (a) 21-30 years, $n = 3$; (b) 31-40 years, $n = 4$; (c) 41 - 50 years, $n = 7$; and (d) 51 - 60 years, $n = 3$.
2. A mean BMI for sixteen subjects of 26.20 with the subjects' BMI distribution of (a) acceptable ≤ 25 , $n = 10$; (b) overweight $> 25 - < 30$, $n = 3$; and (c) obese ≥ 30 , $n = 3$ (adapted from Bennion, Bierman, Ferguson, and Editors of Consumer Reports Books, 1991).
3. A 23% positive cigarette smoking response.
4. Scheduled work of 32 - 40 hours per week for fourteen of the subjects (82%), 59% of the subjects worked 7 a.m. - 3:30 p.m (day shift), and 71% of the injuries occurred within the first four hours of the three shifts.
5. A perceived job stress level of ≥ 7 on a Likert-like scale of 0-10 (0 = no stress and 10= very stressed) for 76% of the subjects and a perceived overall stress level of ≥ 7 for 35%.
6. A perceived ability to control work conditions $\geq 50\%$ of the time by 88% of the subjects based on a Likert-like scale of 0-100% (0% = no ability to chose and 100%= ability to chose).

At the time of interview, 4 subjects had changed their work practices for a healthy back (maintenance stage), 8 were in the action stage, 3 were in the planning stage, 1 was in the contemplating stage, and 1 was not thinking of changing (precontemplating stage).

Eleven subjects stated that general physical conditioning does influence maintaining a healthy back and fourteen subjects perceived themselves as physically active. Ten subjects exercised ≥ 3 times per week for 30 - 60 minutes. Fourteen walked and seven did aerobic

exercises. Of the seven, three did a combination of walking and aerobics. Fourteen subjects stretched before and after exercise. Ten subjects did muscle strengthening and toning exercises 1 - 10 times per week. At the time of interview, 4 subjects were routinely doing conditioning exercises (maintenance stage), 5 were in the action stage, 7 were in the contemplation stage, and 1 in the precontemplation stage.

Internal barriers

All seventeen subjects verbalized an understanding of the protocol, including body mechanics theory and the importance of using patient lifting/transferring equipment. During the incidents that caused their injuries, seven of these subjects practiced the body mechanics techniques taught in the program; and 10 did not. Sixteen subjects (94%) did not use the equipment during the incident; they chose to lift, move, or transfer a patient with an assistant and a drawsheet, gait belt, smooth mover (a 5 x 2.5-foot stiff, smooth, plastic board), or nothing. One subject hurt her back attempting to catch a patient sliding out of a new lifting device. Five subjects reported that height and strength differences negatively impacted their lifts/transfers.

External barriers

All seventeen subjects verbalized difficulty obtaining assistance to lift/transfer patients. Six subjects (35%) stated that staff was not readily available for team lifts because of high patient to staff ratios or increased activity on the nursing unit. Three subjects perceived increased time to use the lifting/transferring equipment and another three subjects perceived too much preparation time to use the lifting/transferring equipment. One subject did not know where the lifting/transferring equipment was kept and felt other staff members were also unaware.

DISCUSSION

Patient lifts and transfers are high risk activities among the nursing staff (nurses and CNAs) at this hospital, similar to findings of Owen and Garg (1991). However, unlike results from the Coleman and Hansen (1994) study, more nurses than CNAs had back injuries. Both groups attended and were taught identical information about the lifting devices, safety issues, and proper body mechanics. All seventeen subjects successfully completed a competency check-off list after demonstrating proper body mechanics and use of the new lifting/transferring equipment; but they continued high risk patient lifting/transferring behavior by continuing to use old methods to lift/transfer patients. These subjects, according to the HBM, did not perceive an immediate threat to their personal health while using the old methods of lifting/transferring patients. The subjects' perceived increased time to use the equipment and perceived inconvenience in the amount of preparation time to use the equipment are similar to the external barriers discussed by Owen and Garg (1993). The location of equipment storage may have contributed to both perceptions as it was not readily accessible or difficult to find. Other perceived barriers that need to be addressed: (a) injury sustained while being assisted by a new, untrained staff member during hospital reorganization, (b) height and strength differences among staff members that compromised lifting and moving effort, (c) unfamiliarity of the lifting equipment after 1 year, and (d) perceived lack of availability of staff members for team lifts and/or equipment use.

The ages of the subjects in this study were of early and middle adulthood, similar to the literature. It may be that during this period, adults perceive added stressors in their lives, e.g., questions of career advancement, reassessment of life goals and accomplishments, complex personal and work schedules, and family and financial pressures. Increased stress could influence

risk-taking behaviors.

According to the literature, increased exposure to repetitive movement is a risk factor for back injury. Fourteen subjects (82%) were exposed to frequent repetitive bending, twisting, and/or forceful movement. The majority of the injuries occurred during the day shift and within the first four hours of a shift. There may be more patient lifting/transferring activities during these hours. Because of increased activity, the subjects may have perceived an increased stress level. This may have influenced the subjects' risk-taking behavior; although fifteen subjects felt they could make their own choices about their work schedule $\geq 50\%$ of the time. Perceived stress can also be influenced by social support. The OHNPs at the hospital in this study attempted to increase social support by changing the entire staff's patient lifting and transferring methods. By training all employees involved in patient lifting/transferring to use the new devices, a new group norm of avoiding manual lifts could be established and reinforced. Figures 1 and 2 give percentages of perceived stress at work and perceived overall stress.

Other risk factors to consider for back injury prevention are exercise and physical conditioning and maintaining optimum weight (BMI). The majority of the subjects perceived a positive relationship between maintaining physical conditioning and optimum weight and a healthy back; and they began practicing injury prevention and healthy back promotion behavior in the workplace after their incident due to heightened perceived susceptibility to back injury. The majority had made changes to establish a regular conditioning routine after injury. Four subjects learned stretching and strengthening exercises while being treated in physical therapy. Although obesity may be a risk factor, the majority of the subjects had an acceptable BMI (<25).

Limitations and Threats to Validity and Reliability

Although the Patient Lift or Transfer-Related Injuries Supplemental Information Sheet was pilot tested, the subjects (both nurses and CNAs) demonstrated some difficulty interpreting the questions either due to misinterpretation, language barrier, or educational level. Other threats to validity were (a) a small, narrowly defined sample size limited generalizability, (b) some of the subjects had difficulty or could not recall details of the incident due to maturation, and (c) the lack of a control group with similar characteristics did not allow for comparison. Because the Questionnaire Addendum was not pilot tested, reliability of this instrument was undetermined.

Implications for future research

Future research studies concerning work-related back injuries will benefit by larger samples. Larger sample sizes will allow for the measurement of the frequency and severity of back injury occurrences possibly revealing a relationship between type of injury and risk factor. Future research studies can also study the correlation of lifting equipment and back injuries. For example, changes in the design of lifting equipment may change the frequency of back injuries. Data from these future studies will be a valuable asset to the family nurse practitioner to develop an improved, multifactorial, multidisciplinary intervention program that has frequent reinforcement of concepts and practice.

IMPLICATIONS FOR FUTURE PRACTICE

Action at the organizational and individual level is needed for a healthy back promotion and protection program in the workplace. Dedicating lifting equipment to each nursing unit rather than to each floor would help decrease the preparation time to use them and possibly increase their use. (There are two units on each floor with eighteen to thirty-two beds each.) To help

motivate the staff to use the equipment, the OHNPs can provide regular patient lifting/transferring refresher courses for all staff members and conduct periodic ergonomic observations of the staff members while lifting/transferring patients. Figure 3 gives an example of a program. In this manner, confidence will be increased and will reduce hesitancy to use the equipment, provide opportunities for each employee to reevaluate their own lifting practices, and increase awareness of equipment location and availability. Equipment availability and optimal performance can be assured with frequent inventory and maintenance of the equipment. An incentive or bonus system may encourage regular self-evaluation of the employee's lifting practices and increased use of lifting equipment.

Current staffing practices must provide adequate staff for safe lifting and transferring of patients. The addition of lifting assistants during the first four hours of a shift will increase the availability of help during peak activity. Assignments of mobility-impaired or obtundent patients must be rotated to reduce exposure of repetitive motion and stress that can be potentially injurious. Staff members who work together as a team can provide support for each other and can decrease the load of each patient lift/transfer and/or decrease the preparation time to use a device.

Administrators, managers, and employees must take responsibility to promote the maintenance and protection of healthy back behaviors. The use of posters, flyers, contests, rallies, or recognition for outstanding work for a healthy back are methods to increase healthy back promotion and injury prevention in the workplace. Employees can participate in stress reduction/meditation classes, group support, counseling, or therapeutic back strengthening classes that are offered at reduced costs through the hospital. The hospital could develop an employee wellness center at a minimal cost to employees for fitness and nutrition counseling. The

development of an employee wellness center shows support and concern for the employees.

Information from on-going surveys of employees who sustained back injuries while lifting and transferring patients in the hospital can be used in the development of future healthy back promotion and protection classes. Ideally, classes can be developed by grouping employees according to their stage of change to overcome barriers and risk factors or modifying the teaching technique used to encourage and reinforce the importance of behavioral change.

Another useful tool to use in conjunction with training programs would be a self-evaluation scale for personal risk factors for back injury. If a positive correlation between type of injury and personal risk factors exists, the development and use of this tool would demonstrate the importance of changing lifestyle to promote healthy back behavior and prevent work-related back injuries.

Primary care providers and OHNPs must keep in mind that promoting healthy back behaviors and preventing back injuries is complex and multifactorial. A recommendation that an individual return to work, after a work-related back injury, is not only based on one's physical condition and prognosis, but includes an accurate understanding of the individual's (a) work setting, (b) work support system, (c) perceived barriers to promote a healthy back, (d) perceived susceptibility for back injury, and (e) personal risk factors. Figure 4 lists these factors. The challenge for the OHNPs will be to keep the momentum of healthy back promotion and protection active within the hospital culture and keep these activities within budgetary boundaries.

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Figure Captions

Figure, 1. Perceived stress at work

Figure, 2. Perceived overall stress

Figure, 3. An example of a healthy back teaching tool

Figure, 4. Client return to work consideration guide for OHNP practice

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Figure 1. Perceived stress at work

TOP

Figure 2. Perceived overall stress

Design:

The OHNPs, NPs, and Education Specialist will

- 1. Observe and identify high risk activities for each unit**
- 2. Create teaching objectives and goals based on individual unit needs**
- 3. Collaborate with the unit manager**
  - A. Generate curiosity, interest in healthy back promotion and injury prevention**
  - B. Identify interested and motivated staff members (resource for unit staff members)**
  - C. Assist staff members to create a teaching module for their unit**
  - D. Provide compensation for resource staff members' time**
- 4. Provide assistance for staff resource members and staff members**

Measure:

- 1. Number of staff participants on each unit**
- 2. Effectiveness of program**
  - A. Pretest/posttest 6 months after implementation**
  - B. Preprogram/postprogram observations**

Assess:

- 1. Cost of program vs lost days of work**
- 2. Change in work pattern/culture**
  - A. Development of staff members working in teams for patient lifts/transfers**
  - B. Increase in use of lifting/transferring devices with decrease in manual lifts**
- 3. Managerial support**

Improve:

- 1. Areas identified as needing improvement after 6 months of program implementation**

TOP

Figure 3. An example of a healthy back teaching model (format adapted from Joint Commission on Accreditation of Healthcare Organizations, 1998).

- ▶ **Client's work setting**
- ▶ **Client's work support system**
- ▶ **Client's perceived barriers to promote a healthy back**
- ▶ **Client's perceived susceptibility for back injury**
- ▶ **Client's personal risk factors**

TOP

Figure 4. Client return to work consideration guide for OHNP practice