My Mother's Story

This is a story about how poor patient handling practices can negatively impact patient recovery, particularly with the elderly. My mother, age 84, was admitted to a hospital with a urinary tract infection (UTI), high fever, and some cognitive impairment on Saturday, July 30, 2011. The impairment was apparently due to her UTI. During her initial assessment at that hospital (Hospital 1), it was determined that she may have suffered mini-strokes, affecting her right side. It was decided that a higher level of care would best be provided at an affiliated hospital (Hospital 2).

My sister accompanied my mother to Hospital 2. Upon admission to the cardiac care unit (CCU), she was taken to a room. My sister was in that room but had the curtain drawn between her and my mother. The nurse (Nurse 1) attempted to move my mother (weight of 151 pounds) to a chair by herself. During this transfer my sister heard my mother fall and groan. Nurse 1 then summoned the aid of two additional staff members who assisted with the movement of my mother. My sister questioned and was told, almost indignantly, that my mother failed to provide any assistance during the transfer. My sister told Nurse 1 that my mother had no strength in her right side because of her illness and asked Nurse 1 if she had read my mother's chart. Nurse 1 admitted that she had not, that she normally doesn't work in the CCU.

My mother was later transferred to a dual occupancy room. My wife and I arrived and visited my mother on Saturday, August 7. We live over 300 miles from my mother and sister. During that day and the next 2 days I observed 3 transfers, 2 of which were poorly performed. The first involved the movement of my mother from a bed to stretcher in her room by a 2-person team on August 7. A Smooth Mover transfer board was used. I believe that 1 of the 2 people had a Lift Team sticker. They didn't appear to work well as a team, with the board left partially under my mother. She was in discomfort. I discussed with them the use and benefits of air-assisted lateral transfer devices as one transfer option that is easier to use and less likely to cause harm.

The next day my mother again was transferred from bed to stretcher. In the interim my mother had been placed on a brown, inflated mattress that had an air cylinder attached to it. The transfer was from a Hill-Rom bed to a Stryker stretcher. The stretcher did not have a sheet on it. There was a gap of a few inches between the bed and stretcher. I believe that again a 2-person team was involved in the transfer. During the transfer the mattress on the stretcher buckled and the mattress deflated. My mother's back side was hanging partially between the bed and stretcher. My mother was again in discomfort. I spoke to 2 other nurses, telling them that I would assist, reached across, and helped complete the transfer. We asked them if they had been trained in SPH and one nurse said she had not. I was extremely disturbed by the staff lack of knowledge and the impact it had on my mother.

The third transfer took place later in the day. It was from stretcher back to bed and by a 4-person team. I was the only other one in the room with the door closed. I asked them specifically how they were going to perform the transfer, instructed them to move the bed and stretcher closer together, and asked them if they used a count to identify when to coordinate the start of the move. I believe that it was a lift team member who said "yes", counted down, and they completed the move without incident. I told them "good job" and left the room.

After first hearing of my mother being dropped, I started asking questions regarding what safe patient handling (SPH) equipment was available and approaches used. One nurse replied that there was some equipment around but it was not readily available. At a minimum, the facility needed better horizontal transfer equipment and approaches. There was no evidence of mobility assessments being performed. The list of other shortcomings was long.

When I first arrived at the hospital I was telling my family about the good reputation that this medical center had for safe patient transfer, in part due to the involvement of a professional that I had known since at least 1995 when we both had SPH articles published in the same magazine, *Health Facilities Management*. Obviously, my opinion changed dramatically since my mother was admitted. Without a process for sustainability, even the best programs fail.

There was bruising, discoloration and discomfort caused by the initial dropping incident with my mother. She was in pain on one side during much of her stay. I believe that the patient handling incidents negatively impacted her eventual outcome. She was much less willing to try to move because she knew it would hurt, and the less she moved the stiffer she became and the more she hurt. This made her depressed, which also inhibited her ability to recover.

During the subsequent months my mother had some good periods and bad periods, moving several times back and forth to rehab facilities. She had periods when she was lucid and hopeful to return home. Unfortunately, that never happened. My mother died on October 19, 2011.

I am a certified safe patient handling professional (CSPHP) who has been helping healthcare clients to prevent harm to care givers and care recipients associated with patient handling since around 1983. While I have seen improvement in SPH equipment, practices, and programs over the years, the improvement has been painfully slow and erratic. National standards are necessary to assure that care givers and care recipients are both provided the level of protection from harm that they deserve. There is extensive and growing evidence that comprehensive SPH programs prevent harm to care givers, their employers, care recipients and their families in a cost-effective manner, yielding a high return-on investment in both financial and quality of care terms.

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