



The patient pictured had been in the middle of dental treatment at another clinic where several teeth had been prepared for crowns and with temporary crowns in place. Then he had a major stroke, leaving him very disabled. At this point, he needed a mechanical lift for transfers. His wife called many dental offices looking for a practice that would treat him and also could do a mechanical lift transfer, but she was unsuccessful. She then called the ADA in Chicago, where the staff knew of our U of M geriatrics program and referred her to us. Assuming his care at Walker Dental Clinic, we were able to complete the

crowns. His wife was very grateful, and when I told her we wanted to use his picture to illustrate our safe patient handling article for *Northwest Dentistry*, she was very pleased, since she remembers the difficulties they encountered finding him care.

Myths and Facts About Minnesota's New Safe Patient Handling Statute and Your Dental Practice

Stephen Shuman, D.D.S.,* Peggy Simonson, RDH, B.S.,** Breca Tschida, CPE,† Mary Owen, D.D.S., M.S.,‡ John Ofstehage, D.D.S.,§ and Patricia Glasrud, RDH, M.P.H.¶§§ on behalf of the Minnesota Dental Association Elderly and Special Needs Adults Committee

Introduction

In 2007, the Minnesota legislature first passed a Safe Patient Handling (SPH) statute (182.6553) to protect the health and comfort of patients and staff members when patients required assistance for movement in clinical care settings such as hospitals, nursing homes, and outpatient surgical centers. In 2009, this statute was amended to also include medical and dental clinics (182.6554). This regulation (Figure 1) specified that each clinical setting covered by the regulation needed to develop a safe patient handling program by July 1, 2010, with actual implementation of that program by January 1, 2012, including acquisition of appropriate equipment and staff training as necessary to assist in patient movement. While a few dental practices care for large numbers of special needs patients who might require assistance in moving, many practices may only encounter these situations on an occasional basis, although this seems very likely to increase in the coming years due to the aging of the population, improvement in medical care for those with disabling conditions, and the current societal emphasis on promoting maximum accessibility in public accommodations, beginning with the passage of the Americans With Disabilities Act in 1990.

Minnesota's dental professionals were concerned when the new safe patient handling statute was enacted due to its potential impact in terms of legal obligations and costs if specialized equipment and training were needed. To address those concerns during the legislative process and subsequent implementation, the Minnesota Dental Association's newly chartered Elderly and Special Needs Adults (ESNA) Committee has been working closely with the Minnesota Department of Labor and Industry (DLI) to assemble information and materials to help Minnesota dental practices comply with this new statute in a practical manner that is sensitive to how dental offices typically function and the patients they serve. MDA's ESNA Committee, in collaboration with staff from DLI, has prepared this summary of myths and facts about Minnesota's new safe patient handling statute to help dental professionals better understand the new regulation and achieve compliance by the January 1, 2012 deadline.



Simpler dental procedures can sometimes be provided directly in a patient's wheelchair using devices such as wheelchair headrests.

MYTH 1: Injuries or other problems occurring in dental practices contributed to their inclusion in the new Minnesota safe patient handling regulations.

FACT: The most common settings in which transfer injuries occur are hospitals and long-term-care facilities, where some staff members may lift the accumulated equivalent of thousands of pounds a day during patient

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***Dr. Shuman** is Associate Professor and Director, Oral Health Services for Older Adults Program, Department of Primary Dental Care, University of Minnesota School of Dentistry, and Chair, MDA Elderly and Special Needs Adults Committee. Email is shuma001@umn.edu.

****Ms. Simonson** is a dental hygienist and adjunct instructor, Oral Health Services for Older Adults Program and Division of Dental Hygiene, Department of Primary Dental Care, University of Minnesota School of Dentistry. Email is simon018@umn.edu.

†**Ms. Tschida** is Ergonomics Program Coordinator, Workplace Safety Consultation, Minnesota Department of Labor and Industry.

‡**Ms. Owen** is Clinical Specialist, Oral Health Services for Older Adults Program and Division of Comprehensive Care, Department of Primary Care, University of Minnesota School of Dentistry, and member, MDA Elderly and Special Needs Adults Committee.

§**Dr. Ofstehage** is Director, Geriatric Dental Programs and General Practice Residency Program, Minneapolis Veterans Administration Medical Center, and Adjunct Professor, Oral Health Services for Older Adults Program, Department of Primary Dental Care, University of Minnesota School of Dentistry, and Consultant, MDA Elderly and Special Needs Adults Committee.

¶¶**Ms. Glasrud** is Director of Policy Development, Minnesota Dental Association.

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care.¹ The nursing home employee injury incidence rate is about twice the U.S. industry average.² It is the increasing frequency of work-related injuries in health care settings, about 9,000 a day in the US,³ that is primarily driving the implementation of SPH regulations across the country; currently nine states now have such statutes, and more may be on the way.⁴ The movement of disabled patients in *ALL* clinical care settings potentially carries some risk of injury to both the staff and the patients themselves, which is why medical and dental offices are also included. However, these settings are recognized to be lower risk environments than hospitals and long-term-care facilities, where movement of highly dependent patients occurs on a continual basis.

MYTH 2: Dental providers must be prepared to treat any patient with a disability at any time or they risk violation of SPH regulations.

FACT: While dental providers must develop an appropriate safe patient handling program for their offices and then determine what appropriate measures must be taken to safely move patients who typically are seen in their practices (i.e., staff training and acquisition of appropriate equipment), this does *NOT* mean that all dental offices must prepare themselves to move and treat *ANY* patient who requires *ANY* type of assistance for movement. For example, if, based on their SPH program and hazard assessment, a dental practice determines mechanical lift equipment is not necessary based on the profile of their patients, then that practice would not be required to immediately provide care for a 240-pound disabled patient needing total assistance during transfers. However, if this dental practice intends to eventually provide care for this or similar patients, then a revision of their SPH program and hazard assessment would be necessary to determine what accommodations are needed, including acquisition of appropriate equipment and staff training.

MYTH 3: To avoid dealing with Safe Patient Handling requirements, dental providers can decide not to see patients who need mechanical assistance for movement.

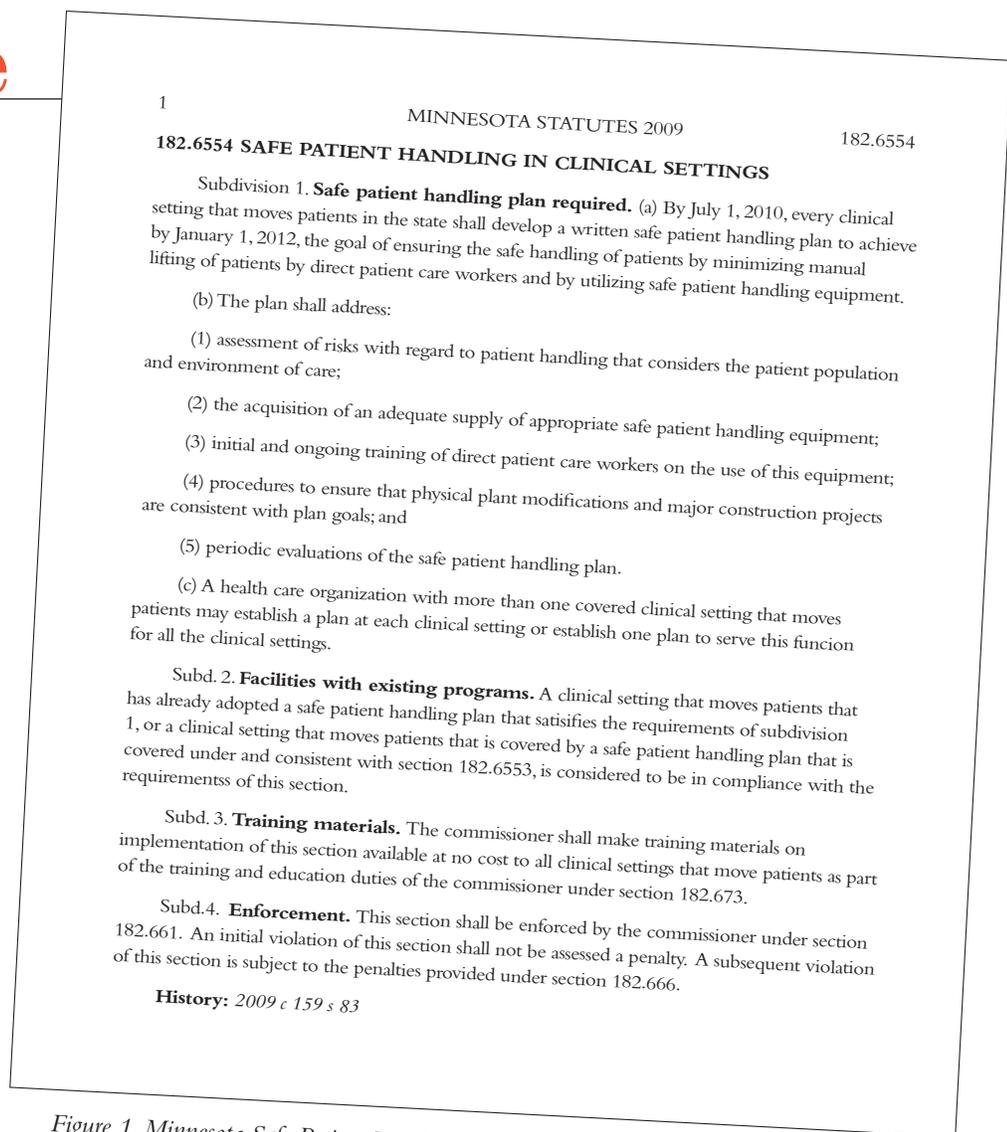


Figure 1. Minnesota Safe Patient Handling Statute

FACT: While some practices might contemplate coping with the new SPH regulations by simply deciding not to treat patients requiring mechanical assistance for movement, there is a distinct possibility that this could be construed as a potential violation of the 1990 Americans with Disabilities Act (AwDA). AwDA was enacted to ensure open access to public accommodations for disabled individuals, and dental offices are included in this mandate. A deliberate decision or policy to exclude disabled individuals from a dental practice could raise the possibility of an accusation of discrimination in violation of AwDA.⁵

MYTH 4: To avoid direct responsibility for patient handling, I can ask to have someone accompany patients to transfer them.

FACT: Again, while it might seem tempting for dental practitioners to seek to transfer responsibilities for patient handling to others who might accompany the patient, there are potential risks associated with this strategy. First and foremost, the dentist is still ultimately responsible for

the welfare of a patient in his or her office and under their care. If another individual moving a patient encounters difficulties and that person or the patient is injured during the transfer, it seems doubtful the dentist would be absolved of all responsibility and potential liability. Despite this, it clearly could be helpful to have the advice and possible assistance of caregivers who may be more familiar with the patient's transfer abilities. A sensible approach would dictate that dental staff members obtain as much information and assistance as possible from companions or caregivers who have accompanied the patient, while being careful to avoid situations in which companions or caregivers suggest or attempt approaches that could pose risk to anyone involved, whether the patient, the dental staff, or themselves.

MYTH 5: I have to pay an outside consultant to conduct a hazard assessment at my dental office.

FACT: While the use of outside consultants is certainly an option and might be helpful for some practices, this is not required or expected under the Minnesota SPH regulations. A protocol for conducting a hazard assessment for Minnesota dental offices is in development for use by dental staff in conjunction with the SPH program guidelines developed by the Minnesota DLI in collaboration with MDA's ESNA Committee. In fact, the staff caring for patients at a dental practice may be in the best position to assess the potential risks associated with patient handling based on their knowledge of the practice's physical facilities, patient profile, and the capacity of the staff.

MYTH 6: Staff training about safe patient handling must be obtained from paid outside consultants or equipment vendors.

FACT: Staff training about safe patient handling can be obtained from any knowledgeable source. Training materials are now in development by the University of Minnesota School of Dentistry's Continuing Dental Education Program in association with the school's Oral Health Services for Older Adults Program, and training about safe patient handling can also be obtained from physical therapists who also regularly work with patients and caregivers to manage these issues. Dental practices should be cautious about obtaining training from vendors of mechanical lift equipment who may have a vested interest in promoting their own products, which may or may not be needed by dental offices depending upon their patient profile.

MYTH 7: I need to buy equipment now to achieve compliance with the Minnesota safe patient handling regulations.

FACT: Dental offices do not need to implement their Safe Patient Handling plan until January 1, 2012, and decisions about possible equipment purchases should be deferred until dental practices complete their own hazard assessments to determine if any special equipment is needed and what type would be the most appropriate. It is important for dental practices to be careful about selection of potential equipment and training to effectively meet the needs of the practice and avoid unnecessary expense and wasted time. The Minnesota Department of Labor and Industry is more interested in dental practices making the *RIGHT* decisions concerning safe patient handling rather than making decisions quickly but incorrectly.

MYTH 8: The "equipment" mentioned in the Minnesota safe patient handling regulations specifically refers to mechanical lifts.

FACT: Safe patient handling "equipment" could include anything from a simple transfer or gait belt with handles for use during a stand pivot transfer (about \$15) to a transfer board (about \$25) to a free-standing mechanical lift (about \$3,000 to \$5,000) to a ceiling lift (about \$8,000 to \$12,000). The specific type of equipment needed for any given dental practice will depend upon the profile of patients typically seen and the hazard assessment for that practice. It should be noted, however, that devices like gait belts with handles are only recommended for use with cooperative, able patients during specific types of tasks such as ambulation, a stand pivot transfer, guiding a patient along a transfer board, or during seated transfers. They are not designed for the manual lifting of patients.

MYTH 9: According to the Minnesota safe patient handling regulations, patients who use wheelchairs will always require a mechanical lift to provide dental care.

FACT: Aside from the other simpler equipment options already mentioned to help transfer patients from wheelchairs into the dental chair, practitioners should remember there are other options to provide dental care for patients who use wheelchairs. Some patients may only

Dental offices
do not need
to implement their
Safe Patient
Handling plan until
January 1, 2012.

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use wheelchairs as a means of transportation over a distance and may be fully capable of transferring themselves with minimal assistance from the dental staff. At the other end of the spectrum, there are patients who may be completely unable to support their own weight and require a mechanical lift to safely move. However, even for these highly dependent patients, options may exist to provide dental care without moving them to a dental chair. Simpler dental procedures can sometimes be provided directly in a patient's wheelchair using devices such as wheelchair headrests to provide head and neck support (e.g., Trico Wheelchair Headrest™), or wheelchair tilting devices that are also now on the market for use in dental offices (e.g., Versatilt™). Another option may be to treat wheelchair-bound patients in a reclining wheelchair that can be tipped back to facilitate dental care without requiring a transfer to the dental chair.

MYTH 10: Yes, but isn't the ceiling lift considered the "gold standard" for safe patient handling equipment in the dental office?

FACT: Not necessarily. Ceiling lifts may make sense for some practices depending upon their patient profile and hazard assessment, but may not be the best choice for all practices. For example, a dental practice with multiple operatories and a need for flexibility in moving highly dependent patients might be better served by a more portable type of mechanical lift. Other offices might opt to avoid the need for mechanical lifts by simply providing care in a reclining wheelchair or with a wheelchair tilting device. The Minnesota Department of Labor website includes further information on safe patient handling equipment and manufacturers (www.dli.mn.gov/WSC/SPHlegislation.asp), and additional information on dental equipment to facilitate care for patients with limited transfer ability can be obtained from the Special Care Dentistry Association's Product Guide (www.scdonline.org/associations/2865/files/SDCNov-Dec07-ProdGuide.pdf), or by contacting MDA's ESNA Committee via the MDA Central Office.

Summary

With the passage of a safe patient handling statute in 2009, Minnesota became one of a growing number of states requiring health care providers to become more aware and accountable about providing appropriate assistance

during the movement of patients in clinical care settings. The Minnesota Department of Labor and Industry and the Minnesota Dental Association have been working together to ensure that Minnesota's SPH regulations are as practical as possible for dental providers while still achieving the objectives of the statute. A template Safe Patient Handling Program for Clinics has been developed with substantial input from MDA's ESNA Committee and is now available on the DLI website: www.dli.mn.gov/WSC/SPHlegislation.asp

All Minnesota dental practices should use this template to develop their own safe patient handling program as soon as possible. Additional background information and resources related to Minnesota's SPH regulations are also available on the DLI website. MDA and DLI are currently also developing a hazard assessment tool for

dental practices to assess their specific risks associated with patient movement. This hazard assessment will, in turn, guide decisions about what type of safe patient handling equipment and staff training will be necessary for total compliance with the new statute. MDA, in cooperation with DLI, will continue to keep dental professionals informed about when these materials will be available.

Additionally, MDA is working to ensure appropriate training options will be available for compliance with SPH regulations. The University of Minnesota's School of Dentistry's Oral Health Services for Older Adults Program and Department of Continuing Dental Education have been regularly providing such training in conjunction with the school's "Miniresidency in Nursing Home and Long-term Care for the Dental Team," and efforts are now underway at the dental school to create stand-alone training options for Minnesota's dental professionals. Further information about SPH training may also be found on the DLI website (www.dli.mn.gov/WSC/SPHlegislation.asp). MDA members can also contact MDA's Elderly and Special Needs Adults Committee via the MDA central office. ■

All Minnesota dental practices should use this template to develop their own safe patient handling program as soon as possible.

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