Safe Patient Handling and Movement Program
May 2008
Acknowledgements

The information contained in this manual is the result of a collaborative effort between a number of occupational and environmental safety and health professionals who were tasked with developing standardized, evidence-based best practice approaches to safe patient/client/resident handling and movement within the Winnipeg Regional Health Authority (WRHA). The overall goal was to prevent work-related musculoskeletal injuries and near misses related to patient handling and movement tasks. This resource guide can be used as a training tool for new healthcare workers as well as a refresher for current healthcare workers. The core program elements described in this guidebook have been tested within many of the different facilities in the WRHA.

The WRHA acknowledges the contribution of the following members of the Safe Patient Handling and Movement Committee in the development of the WRHA Core Components of a Safe Patient Handling and Movement Program. Without your untiring attention to this ambitious project, this Manual would not have come to fruition. In alphabetical order:

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This resource guide is targeted for:

- A facility based interdisciplinary team responsible for improving the safety of both healthcare workers and patients during the performance of patient handling and movement tasks.
- Healthcare workers involved in direct patient care and patient movement, including registered nurses, licensed practical nurses, healthcare/nursing aides, patient transport technicians diagnostic and treatment technologists.
- Risk managers, safety officers, quality managers and administrators who influence workplace safety and support resources for lifting devices.
- Healthcare workers in Acute Care, Long Term Care and Home Care settings, each of which present with entirely different patients/residents/clients and environmental factors.

Thank-you again committee members for your commitment to the WRHA “culture” of safety.

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WRHA SAFE PATIENT HANDLING AND MOVEMENT PROGRAM

The WRHA would like to present the Safe Patient Handling and Movement Program. The program is based on a minimal lift and transfer environment with a major emphasis on safety for both patients/residents/clients and healthcare workers (HCWs) in each healthcare location. In this document, depending on the program area, patient refers also to residents and clients. This program meets the requirement for a Safe Patient Handling and Movement Program under the Workplace Safety and Health Regulation and will ensure all participating healthcare facilities move closer to a safer workplace that will reduce the frequency and severity of injuries to HCWs.

These guidelines are written for application to the Acute Care, Long Term Care and Home Care environments. These three environments present great differences in patient conditions, in available equipment and resources, and in space and workplace design. Nonetheless, the commitment to HCW and patient safety remains equal to all environments. Not all facilities will have equipment in place to implement these guidelines immediately. In fact, assistive patient handling equipment may seem beyond the reach of many facilities struggling with finances. However the use of such equipment provides a benefit to all: the HCWs, the patients, and the healthcare facilities. A plan for continual movement towards the acquisition of equipment and the subsequent training of HCWs to meet these standards is necessary.

The standards presented are derived from a large international body with input from all disciplines. They represent the accumulation of best practices and are evidence-based. This area of practice is continually evolving as new information and technologies emerge as a result of research and best practice trials. This document reflects safe patient handling and movement guidelines in 2008, but needs to be reviewed and updated every 3 years as per legislation or when new information is available.

Core elements are necessary in a Safe Patient Handling and Movement Program and are summarized below. All elements are addressed in depth in subsequent sections.

1. The WRHA Operational Procedure in Chapter 2 outlines the guiding principles of the Safe Patient Handling and Movement Program and assigns roles and responsibilities to all stakeholders for ensuring the safety of staff and patients.

2. In Chapter 3, Section 3.1 the Patient Transfer and Movement Assessment determines the patient’s ability to move and their need for assistance. The
assessment also determines the most appropriate means of assistance with respect to patient and HCW safety. An evaluation of a patient’s ability to move should be completed and documented prior to performing any patient handling and movement. This process should include a procedure for requesting re-assessment in the event the patient’s health and/or mobility status changes.

3. In Section 3.2 examples of Communication Tools are available and when used will provide all HCWs with critical information regarding the most appropriate way to assist the patient with safe patient handling and movement.

4. Equipment to use when assisting patients with movement tasks is listed in Section 3.3. Equipment is necessary in order to minimize the manual effort required by HCWs. The guiding principle of a Minimal Lift Environment prohibits manual lifting by HCWs in all but emergency situations, with the goal of reduced injuries in the workplace. Examples of this equipment includes: friction-reducing devices (FRDs), sit-to-stand transfer aids, mechanical floor and ceiling track lifting machines, slings, manual transfer/gait belts, height adjustable electric beds, stretchers, shower chairs and trolleys. This equipment should be in good working order and readily available for the HCW to use during patient handling and movement tasks.

5. Training and Education in Section 3.4 is necessary for HCWs, including supervisors, on basic safe patient handling and movement tasks and techniques. This section includes strategies for preventing injuries. Training needs to include documented competency testing and should occur at least every three years to ensure adequate exposure to all techniques. Department specific training should also occur for situations not included in basic orientation and refresher training. All HCWs involved in patient handling and movement must be properly trained prior to performing patient handling tasks. Safe Work Practices are the actual procedures and techniques by which the safe patient handling and movement tasks are performed. They may be customized to reflect different environments (assessment procedures, equipment/support availability, etc.), but should include detailed instructions for performing the task to ensure the safety of everyone involved.

6. Section 3.5 addresses Competency in the performance of patient handling and movement tasks ensuring HCWs are able to perform patient handling and movement tasks safely for themselves and the patient. Proper use of
equipment can be validated through a checklist used by supervisors and/or trainers. This may occur during training or over a given amount of time (e.g. 3 months) in the work environment, with HCWs demonstrating knowledge and techniques.

7. **Supervisory Enforcement** is discussed in Section 3.6 and is necessary to ensure HCWs are using appropriate techniques and equipment for assigned tasks.

8. Chapter 4 provides an overview of **Financial Planning**, and **Program Implementation and Evaluation**. This chapter outlines monitoring and possible modification of an existing program in the event of new legislation; the introduction of new technologies, equipment or techniques; and the development of services associated with new hazards. All changes should be supported by safe patient handling and movement literature.

### Special Considerations for Acute Care

Acute care settings present special challenges to HCWs providing care. Depending on the facility, HCWs can be less familiar with the patient, as patients are generally in care for short periods of time. A patient’s medical status may vary greatly over a matter of hours. Therefore, it is challenging to assess a patient’s status prior to every movement or transfer.

There may also be specialized needs in this patient population such as: acute spinal fracture and surgery requiring collars and braces to be donned prior to movement; orthopaedic fractures requiring specific patient positioning; neurological concerns associated with head injury; labour and delivery concerns where limbs need to be held; operating room challenges such as movement on and off a table; sustained holding of limbs; and the safe management of bariatric patients.

Generally, more HCWs and resources are available for problem solving and for handling unique situations than in other environments. Physiotherapy and/or Occupational Therapy are, or should be, available for timely assessment of mobility, strength, and management of specific issues such as tone and balance. A larger interdisciplinary team is often accessible for specific problem solving. In some cases, musculoskeletal specialists are available to assist with unique patient handling/movement and equipment issues. There is sometimes a shortage of equipment and HCWs are challenged to improvise or wait until equipment becomes available.
Special Considerations for Long Term Care

In a long term care facility or personal care home (PCH), the facility is the resident’s home. The expectation is that the resident and family will be consulted about decisions involving the care plan. Safe Patient Handling and Movement tasks are part of the care plan for each resident.

Most residents are considered medically stable for on admission to a personal care home and may have chronic health conditions. A resident can be medically and functionally stable for long periods during the admission to a PCH. However, due to multiple diagnoses and potential risks associated with falls, behaviours and cognitive issues, these residents can quickly deteriorate and change in acuity. HCWs require a toolkit of knowledge and equipment to respond to the change in status of the resident related to Safe Patient Handling and Movement.

Many factors will impact the assessment when determining methods or techniques used for patient handling and movement. Challenges in the population may include medical devices (e.g. feeding tubes, catheters and ostomies); presence of assistive devices (e.g. orthotic and prosthetic devices, wheelchair type, wheelchair seating, commodes, sliding boards); and specialized equipment (e.g. tub stretchers, shower chairs, type of lifts in the PCH, patient sliders). Factors such as neurological tone, weight and girth, height, behaviour and cognition will also be considered in the assessment.

Elements that may exist to facilitate consistency in application of safe patient handling and movement principles include: length of stay of the resident; consistency in HCWs; HCW familiarity with the residents; regular involvement of family; and resources available for third party funding of equipment.

Barriers to consistently apply principles of safe patient handling and movement may include lack of equipment, challenges in the physical environment, limited HCW training opportunities and high HCW turnover.

Physiotherapy and Occupational Therapy services are usually readily accessible to assist in problem solving as well as HCW training in the application of the principles of safe patient handling and movement.
Special Considerations for Community Care

Safe Patient Handling in the home environment presents many unique challenges not seen in acute care and long term care facilities. The Provincial Workplace Safety and Health Act Regulation 217/2006 clearly define the client's home as a "workplace" and a "healthcare facility" during the provision of Home Care Service. As such, specific hazards must be addressed as they would in a hospital or long-term care facility.

Client assessment services are typically contracted to an external provider or agency. While this process ensures that an appropriate Allied Health professional properly assesses the client upon entry into the home environment, non-urgent reassessment requests may take several weeks to be completed. Access to equipment is limited to what is available in the home at that time. Additional equipment is available to care providers in the home, but the requisition process may result in a delay in delivery by a day or two. This means that service may be restricted to bed care only in order to avoid exposure to an unsafe patient handling situation during the lag time.

HCWs at times deliver service in pairs but are most often performing safe patient handling and movement techniques in the home by themselves. Because service is provided in thousands of homes each day, in-person contact between HCWs and supervisors is very limited as is direct supervision of assigned tasks. It is important that adequate communication and support structures be in place as per Provincial Working Alone Regulations.

Due to a lack of supervision and support, HCWs in the home care environment should receive additional training to recognize unsafe situations. Processes must be in place to aid in appropriate decision making. It is important that care plans be flexible enough to account for fluctuations in mental or physical status (client's mood, physical capability and fatigue level). Planning must anticipate improvements or decreases in the client’s transfer ability to ensure that the proper training and equipment resources are available for the HCW when required.
Chapter 2.0 Background

1.0 PURPOSE:

The Winnipeg Regional Health Authority (WRHA) is committed to:

1.1 Promoting an organizational culture that ensures the highest possible occupational health and safety standards for all employees.

1.2 A belief that safety is the responsibility of all members of the organization including Senior Management, Managers, Supervisors and employees.

1.3 Securing its employees and other persons from risks to their safety, health and welfare arising out of or in connection with activities in their workplace.

1.4 Promoting and maintaining the highest degree of physical, mental and social well being of its employees.

1.5 Ensuring that Senior Management, Managers and Supervisors recognize and understand their role to ensure a safe and healthy workplace.

1.6 Involving employees in the management of their own occupational health and safety.

1.7 Working collaboratively with all Occupational Safety and Health Committees regarding the health and safety of the organizations comprising the WRHA.

1.8 Establishing and maintaining a Workplace Safety and Health Program that meets the requirements of this policy and The Workplace Safety and Health Act. This Program will incorporate Safe Work Practices.

1.9 Complying with all Government Health and Safety Legislation.

2.0 DEFINITIONS:

2.1 Act – The Workplace Safety and Health Act, Chapter W-210 of Manitoba

2.2 Senior Management – members of the Executive of WRHA Facilities

2.3 Worker – Any person who is contracted with the WRHA to perform a service whether under contract of employment or not and/or undergoing training or servicing. For the purposes of this policy, “Worker” shall extend to employees, students, independent contractors, physicians, volunteers and researchers

2.4 WRHA Facilities – facilities or sites within the WRHA that are directly owned or operated by the WRHA
2.5 **Safe Work Practices** — A step-by-step procedure that states how to perform a job safely and how to respond to a safety risk in an appropriate manner.

3.0 **POLICY:**

3.1 **Senior Management** shall ensure that a Workplace Safety and Health Program that meets the requirements of this policy is developed, implemented and maintained and that adequate funding is allocated to achieve this result.

3.2 **Senior Management** shall ensure that Workplace Safety and Health Committees are established and operating in accordance with the Act. **Senior Management** shall consider all recommendations made to them by the Workplace Safety and Health Committee(s) and respond to such recommendations in writing.

3.3 **Senior Management** shall ensure that appropriate processes are implemented that contractors (including prime contractors), self-employed persons, suppliers and agency staff are held accountable to meet their obligations under the Act while performing services for the WRHA.

3.4 **Managers and Supervisors** shall be responsible for applying the Workplace Safety and Health Program. Specifically, and without limitation, Managers and Supervisors shall identify hazards and enforce safe work practices and implementing effective controls, communicate safety and health hazards, investigate hazardous conditions and incidents and ensure that all equipment is properly maintained and meets currently legislated safety and health standards. Where safety and health training and/or safety equipment is required, Managers and Supervisors shall request approval for these items from Senior Management if current funding is not sufficient.

3.5 **Every Worker** shares responsibility for safety and health in the workplace and shall integrate good workplace safety and health practices into their daily work activities. All Workers shall be responsible for following the Workplace Safety and Health Program, obeying all safety and health rules, following recommended Safe Work Practices, wearing and using personal protective equipment when required, participating in safety and health training programs and informing supervisors of any unsafe work conditions.

3.6 **Senior Management, Managers, Supervisors and Workers** must abide by this policy, the Workplace Safety and Health Program and the Act.

3.7 All new Workers shall be advised of this policy and of the Workplace Safety and Health Program as part of their orientation.

3.8 **Occupational Safety and Health Committees** shall be responsible for providing recommendations on safety matters to Senior management to assist in monitoring the
effectiveness of the Workplace Safety and Health Program.

3.9 Violation of safety and health rules or responsibilities by a member of Senior Management, a Managers, a Supervisors or a Worker may result in remedial action including education and/or disciplinary action, up to and including dismissal from employment.

3.10 All Workers shall have the right to refuse to perform work where that Worker has reasonable grounds to believe and does believe that the work is dangerous to the Worker’s safety or health or the safety and health of another Worker or any other person.

3.11 A copy of this policy shall be posted on bulletin boards within worksites that have been designated to provide workers with information relating to workplace safety and health.

4.0 PROCEDURE:

A notice shall be posted on those bulletin boards as to the physical and/or electronic locations of the Safety and Health Program available in manual format that contain operational procedures.

5.0 REFERENCES:

5.1 WRHA Corporate Safety & Health Statement of Principle

5.2 Workplace Safety and Health Act Implementation Guidelines

5.3 Workplace Safety and Health “A Guide to Setting Up a Workplace Safety and Health Program”

5.4 WRHA Workplace Safety and Health Operational Procedures

5.5 The Workplace Safety and Health Act, Chapter W-210

Policy Developer: John Van Massenhoven, H.R. Legal Counsel & Director, Labour Relations
1.0 GUIDING PRINCIPLE

The WRHA is committed to:

1.1. Providing a safe and healthy working environment for all healthcare workers (HCWs) and patients/residents and clients. In this document, patient refers to resident and client as well.

1.2. Demonstrating its commitment by providing financial, physical and human resources to reduce hazards and encourage safe and healthy work practices during patient handling.

1.3. Promoting a culture of safety and shared responsibility for a minimal lift environment that includes safe patient handling and movement among all HCWs.

1.4. Ensuring HCWs use consistent safe patient handling and movement techniques.

2.0 DEFINITIONS

2.1. Accessible – Easily located, being in proper working condition and of sufficient quantity.

2.2. Controlled Clinical Environment – Certain interventions used by Allied Health Professionals may violate general Minimal Lift Principles but are required to advance patients through evidence-based progressive rehabilitation protocols. These interventions are allowed under this Operational Procedure when performed or directed by Allied Health Professionals. It is imperative, however, that the appropriate supports are in place to provide a controlled clinical rehabilitation environment that provides for safety for the patient and HCW. A controlled clinical environment can exist in facilities or resident homes. Having a controlled environment implies that the following conditions are met and accounted for: appropriate space, skills training and knowledge and adequate equipment and HCWs.

2.3. Healthcare Workers (HCWs) – Includes all contracted individuals, volunteers, students, researchers, WRHA medical staff, teachers and educators, members of the Board of Directors of the facility, information managers, and employees of the WRHA or agents of any of the above or of other health agencies.

1 The appropriate term should be used by the health care facility; “patient” is used in hospitals, “resident” in nursing homes, and the term “client” in home care.
Chapter 2.0 Background

2.4. Minimal Lift Environment – an environment which calls for HCWs to avoid manual lifting in virtually all patient care situations.

2.5. Mechanical Lift – Freestanding or ceiling mounted patient transfer device that uses a sling and mechanical lift to move patients from a bed or seated position.

2.6. Musculoskeletal Injury (MSI) – Any injury to the bones, joints, muscles, nerves and ligaments is called a musculoskeletal injury. It may include strains, sprains, fractures or dislocations.

2.7. Patient Handling and Movement – Assistance provided by HCWs to patients during repositioning, turning, transferring, transporting, ambulation or the use of a mechanical lift or device.

2.8. Patient Handling and Movement Program – An educational program that outlines injury prevention techniques for identifying and recommending the appropriate method of minimal patient lift and transfer. The components of the program are included in the training and resource manual.

2.9. Reposition – To change a patient’s position while he/she is on a surface such as a bed or chair.

2.10. Transfer – To move a patient, from one position to another. Requires the patient to weight bear at least through one leg and assist to some degree with one arm. E.g. - Move to another bed or stretcher, sit to stand, move from one area to another, stretcher to X-ray table.

3.0 PROCEDURE

3.1. All facilities and community homecare shall promote a minimal lift environment by implementing a Safe Patient Handling and Movement Program. Components of the Program shall include:
   3.1.1. Supervisory enforcement concerning worker compliance with safe patient handling and movement components.
   3.1.2. Tool/checklist to assist the professional in assessing the patient’s ability to weight bear so that safe patient handling and movement is consistent.
   3.1.3. A communication tool such as a LOGO system in the care plan and at or near the patient’s bedside for all workers to see.
   3.1.4. HCW access to patient handling equipment and devices such as mechanical lifts, sliders and transfer/gait belts and their use.
   3.1.5. Purchase of safe patient handling mechanical and assistive devices.
   3.1.6. Safe Work Procedures relevant to a program unit’s specific needs, written and available to HCWs.
   3.1.7. Completion and documentation of the initial basic, annual and ongoing training as required to correct improper use/understanding of safe patient handling and movement. Competency shall be demonstrated. Non-compliance with training methods will indicate a need for retraining.
   3.1.8. Ongoing evaluation of the Program to review current evidence and best practices.
Chapter 2.0 Background

4.0 RESPONSIBILITIES

4.1. Facility Executive Team

4.1.1. Support the implementation of the Safe Patient Handling and Movement Operational Procedure and Program.

4.1.2. Support and promote a culture of safety, shared responsibility and a minimal lift environment within the facility.

4.1.3. Assign responsibilities to HCWs within the facility to ensure the implementation of all aspects of the Safe Patient Handling and Movement Program.

4.1.4. Ensure that sufficient lifting equipment/aids and devices are available for HCWs to use when needed for safe patient handling and movement as far as is reasonably practicable.

4.1.5. Ensure that acceptable storage locations are available for the lifting equipment/aids.

4.1.6. Ensure preventive and routine maintenance of equipment is assigned.

4.1.7. Ensure education and training opportunities are available.

4.2. Managers and Directors of Patient Care or Designate Shall:

4.2.1. Support a culture of safety, shared responsibility and a minimal lift environment within their area.

4.2.2. Ensure HCWs successfully complete the basic initial Safe Patient Handling and Movement training.

4.2.3. Ensure that injured HCWs receive retraining when returning to work.

4.2.4. Ensure that an assessment is conducted prior to patient handling and movement tasks.

4.2.5. Ensure that all tasks are completed safely, using patient handling equipment/devices or other approved patient handling aids and appropriate techniques as per the completed assessment.

4.2.6. Purchase equipment within available financial resources.

4.2.7. Ensure mechanical lifting devices and other equipment/aids are available, maintained regularly, in proper working order, and stored conveniently and safely.

4.2.8. Monitor HCW compliance on safe patient handling/movement.

4.2.9. Assess need for further in-services and request refresher in-service when required.

4.2.10. Involve educators, allied health professionals, OESH or other resources as necessary to implement this procedure.

4.2.11. Provide plans to forward recommendations to Capital Planning and Construction Committees as necessary to facilitate lifting/transferring equipment use and storage.

4.2.12. Ensure that all facility policies are followed if new equipment is being trialed and/or installed.

4.3. Safe Patient Handling Educators/Designate

4.3.1. Ensure that all elements of the basic program are implemented and evaluated.
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4.3.2. Provide all new HCWs with the basic Safe Patient Handling and Movement Training at orientation. Basic proficiency must be demonstrated at time of orientation. A written record of proficiency must be retained.

4.3.3. Prioritize continuing education based on current industry standards.

4.3.4. Provide retraining when necessary or upon request.

4.4. HCWs Involved In Direct Patient Care Activities

4.4.1. Participate in and successfully complete the Safe Patient Handling and Movement Program basic orientation.

4.4.2. Demonstrate learned principles and skills related to performing safe patient handling and movement through competency checks.

4.4.3. Ensure that a patient transfer assessment has been completed, signed, dated and placed on the patient’s chart to clearly identify the recommended method(s) for patient transfer/bed movement.

4.4.4. Clearly communicate the most current techniques to be used when a patient has been assessed or re-assessed as requiring assistance to move. This should be in writing or by other visual means at or near the location of the patient.

4.4.5. Reassess the patient’s transfer abilities before each transfer, or when any change in status affects the patient’s ability to transfer.

4.4.6. Perform pre-use lift inspections and routine safety assessments of equipment and ensure documentation and records are kept of inspections.

4.4.7. Assess the environment, patient needs and available resources before starting a lift or transferring a patient.

4.4.8. Perform all safe patient handling and movement as outlined in the patient assessment using appropriate equipment and procedures.

4.4.9. Communicate specific needs and potential risks to the manager/supervisor.

4.4.10. Request assistance from the appropriate resource (physiotherapy, occupational therapy, OESH, educator) on a collaborative basis, if uncertain how to safely manage the patient handling task.

Note: Identified patient handling and movement techniques and guidelines should be followed at all times except in emergency situations. Certain interventions used by Allied Health Professionals may contravene general Minimal Lift Principles but are required to advance patient rehabilitation through evidence-based progressive protocols. These interventions are allowed under this Operational Procedure when directed by Allied Health Professionals, in a controlled clinical environment. Sufficient training must be done before having a HCW attempt the maneuver.

4.5. OESH or Designate

4.5.1. Provide Directors/Managers with a list of work related injuries and analysis of trends for review.

4.5.2. Collaborate with the patient care area manager and HCWs to identify equipment and training requirements to prevent injuries and to safely manage patient handling for all elements required.
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4.5.3. Coordinate the Safe Patient Handling and Movement Program.
4.5.4. Ensure that training records are kept.

4.6. Joint Workplace Safety and Health Committee
4.6.1. Support the Safe Patient Handling and Movement Program intent and monitor the program effectiveness.

5.0 RESOURCES
5.1. Occupational and Environmental Safety & Health Unit (OESH)
5.2. Workplace Safety and Health Regulation Part 39
Chapter 2.0 Background

PART 8
Musculoskeletal Injuries

Previous Regulation(s): NEW

Summary of requirements:

- **Musculoskeletal Injury** – defined as an injury or disorder of the muscles, tendons, ligaments, joints, nerves, blood vessels or related soft tissue including a sprain, strain or inflammation, that may occur to a worker in a workplace and that is caused or aggravated by any of the following:
  - A repetitive motion
  - A forceful exertion
  - Vibration
  - Mechanical compression
  - A sustained or awkward posture
  - A limitation on motion or action
  - Any other factor that creates a risk of musculoskeletal injury

- **Assessing risks** – where an employer is aware, or ought reasonably to have been aware, or has been advised that a work activity creates a risk of musculoskeletal injury, the employer must (a) ensure that the risk is assessed, and (b) on the basis of the assessment, implement control measures to eliminate or reduce the risk.

- **Control measures** may include one or more of the following: (a) providing, positioning and maintaining equipment that is designed and constructed to reduce or eliminate the risk, (b) developing and implementing safe work procedures, (c) implementing work schedules that incorporate rest and recovery periods, changes to workload or other arrangements for alternate work, and (d) providing personal protective equipment.

- **Monitoring control measures** – an employer must monitor the effectiveness of control measures and where the monitoring identifies that a risk is not being or has not been eliminated or reduced, implement further control measures.

- **Workers to be informed** – of the risk and of the signs and common symptoms of any musculoskeletal injury associated with the worker’s work and the worker receives instruction and training respecting any control measures implemented.

www.gov.mb.ca/labour/safety

*Note: This is high-level summary. Please refer to the Regulation for more detailed requirements.*
Chapter 2.0 Background

PART 39
Health Care Facilities

Previous Regulation(s): NEW – Previously enforced through other regulatory requirements.

Summary of requirements:
- **Application** – applies to workplaces that are healthcare facilities.
- **Safe work procedures as specified below** must be developed, implemented, and workers trained.
  - **Safe work procedures for infectious materials** must be developed and implemented if workers may be exposed to infectious materials.
  - **Safe work procedures for waste and laundry** must be developed and implemented if workers may be exposed to waste or contaminated laundry.
  - **Safe work procedures for patient handling** must be developed if a worker is required to lift, hold, turn or transfer a patient. These procedures must include procedures for assessing whether a patient requires assistance to move.
  - **Safe work procedures for lasers** required if laser equipment is used in a healthcare facility. These procedures must meet the requirements for the appropriate CSA Standard.
- **Employer to provide workers with information about any recommended vaccine**, if a worker has been, may have been, or may be exposed to an infectious material, and arrange for the vaccine if worker consents.
- **Sharps containers** that are readily accessible for waste needles and sharps such syringes, blades, scissors and other items that are capable of causing a cut or puncture.
- **Sorting areas for contaminated laundry** must be separated from the clean laundry area by a physical barrier; a negative air pressure system; or a positive air flow system from the clean laundry area through the contaminated laundry area.
- **Moving patients** – when a patient has been assessed as requiring assistance to move, the employer must ensure that the current status of the patient and the appropriate techniques to move the patient are clearly identified in writing or by other visual means at or near the location of the patient.
- **Mechanical devices to be used** when an assessment specifies the use of these devices the employer must ensure that workers do not move a patient without the use of the device.
- **Laser equipment standards** – laser equipment must be operated and maintained in accordance with the appropriate CSA Standard.

www.gov.mb.ca/labour/safety

Note: This is high-level summary. Please refer to the Regulation for more detailed requirements.
Chapter 3.0 Program Essentials

SECTION 3.1 ASSESSMENT TOOLS-TABLE of CONTENTS

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GENERAL CONSIDERATIONS

- Factors Impacting Patient Handling Tasks

SPECIAL CONSIDERATIONS

- Patient Handling Guidelines for Uncooperative Patients
  - Tips for the Healthcare Worker (HCW)
  - Tips when Patients/Family Refuse Care Plan

OTHER PATIENT ASSESSMENT TOOLS

- Red Flags Checklist for Transfers
- Quick Checklist for Bed Repositioning
- Quick Checklist for Weight Bearing Capability
- Patient Readiness for Transfers
  - Acronym for Transfer Checklist
  - Back Pocket Resource Tool
- Applying Patient's Capabilities to the Algorithms
- Algorithm #1
- Transfer Assessment Guidelines for Use with Algorithm #1
PATIENT TRANSFER AND MOVEMENT ASSESSMENT

PURPOSE

1. To comply with WSH Regulation, Part 39 requires safe work procedures for patient handling including procedures for assessing whether a patient requires assistance to move.

2. To ensure consistency in assessment across the Region, in keeping with a 'Minimal Lift' environment, and to provide standardization of practice. As part of this section, tools have been designed to assist in patient assessment to complement the healthcare workers (HCWs) skills developed through training.

3. To improve the safety of HCWs in their initial interaction with patients. Tools should not replace an Allied Health (physiotherapy and/or occupational therapy) assessment and intervention where it is available, but can serve to improve the safety of HCWs in their initial interactions with patients when an initial Allied Health assessment is not available or has been delayed for any reason. Tools can also assist HCWs when reviewing patients who have not had mobility issues.

4. To provide assessment tools, checklists and skills for HCWs to apply to the Algorithms. The Algorithms are decision trees that build upon an assessment of a patient’s capability for movement or transfer.

CORE ELEMENTS

The purpose of the patient assessment is to determine the patient’s capabilities and strength as it pertains to how they move in bed, get up to a seated position, and transfer to a different surface. The goal is to determine how much assistance the patient requires.

1. When: An assessment is necessary prior to performing any patient handling and movement maneuver.
   - It is essential at admission and should include documentation of the patient’s pre-admission abilities. For example, a patient post-surgically may not have ambulated for 5 years prior to admission. The use of any ambulation or transfer/gait aids should also be included
   - Whenever there is a change in medical status
Facility Action: A patient transfer and movement assessment form must be available in the patient's chart. Each facility has different pathways for accepting new patient care forms.

2. Who: The assessments presented in this section are designed for nurses. Physiotherapy and/or Occupational Therapy should be consulted if there are any issues related to mobility, transfers or repositioning. It should be noted that there may be sites where nursing has the main role in assessment due to limited access to Allied Health.

Facility Action: Each facility needs to determine who will complete the patient assessment on admission and how often re-assessment must be performed, based on the needs of their patient population. Patient assessment should always be done in consultation with Allied Health, when available.

3. What: This section includes several tools that can be used to determine the patient's capabilities and limitations. The goal of these assessment tools is to improve the level of knowledge of the patient's capabilities before transfers are attempted improving the chance of a safe interaction with the patient. Some tools raise awareness of issues affecting safe patient handling and movement and can be used to educate nurses and health care aides i.e. the Red flag checklist and Patient Factor Review. Other tools, including the transfer assessment, weight bearing status assessment and bed movement assessment should be used regularly on each patient that may require assistance. The purpose of these assessment tools is to provide nursing with a concrete way of assessing a patient before a Physiotherapist or Occupational Therapist has had a chance to do their assessments. The results can then be used with the Algorithms to determine the safest method of patient handling and movement. Some of the tools such as the weight bearing assessment, bed movement assessment and back pocket card/ acronym can be used by HCWs to confirm a patient's status prior to a transfer. The tools included in this section are:

- **General Considerations** - A comprehensive assessment of a patient's cognition, communication, medical status, physical status, emotional status and behaviour. This is presented in chart form as a reminder to consider all facets of the patient.

- **Special Considerations** - Bed rest, use of restraints, pregnancy, abdominal wounds, contractures, weight bearing restrictions, ulcers, pain issues and drains or tubes that will be adversely affected by the use of transfer equipment/devices and uncooperative patients.
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- **Red Flag Checklist For Transfers** - This is a mental status checklist which staff can use as an initial screen for a patient’s readiness to be moved. The checklist indicates if the patient’s level of function is so limited that mechanical assist or other equipment is required for patient handling.

- **Quick Checklist for Bed Repositioning** - This is a quick screen to determine the degree of assistance needed for bed repositioning (e.g. boosting, turning). The results can then be used with the appropriate algorithm.

- **Quick Checklist for Weight Bearing Capability** - This checklist provides staff with a step by step process for determining whether a patient has adequate strength and weight bearing capability to perform a transfer, and what degree of assistance may be required. The results can then be used with the appropriate algorithm.

- **Acronym for Patient Readiness to Transfer** - The acronym provides a quick checklist to remind HCWs of all assessed factors to date, and to assist HCWs in ensuring the patient is indeed ready to transfer as indicated in the algorithm.

- **Back Pocket Resource Tool** - This tool can be plasticized and provides prompts for HCWs.

- **Algorithms**: The above tools provide the core assessment elements to be applied to the algorithms (decision trees) presented in Section 3.4. Before referring to the algorithms, the patient assessment process should determine whether a patient is independent or requires assistance, such as supervised/standby, minimal, moderate, or completely dependent (see definitions below). Once this is determined, the algorithms provide a decision framework for determining the method of transfer, equipment required and recommended number of HCWs.

**Facility Action:**
Adapt or adopt the above tools as needed. Ensure that training for all HCWs performing patient handling tasks is updated accordingly.

4. **Communication**: This is a core element of patient assessment and is covered in more detail in Section 3.2 including:
   - A labeling or LOGO system to communicate the patient’s level of independence or level of assistance needed as well as equipment required when moving the patient.
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- A designated area in the chart/file needed for documentation of the assessment results and reassessments.
- A system whereby subsequent assessments can be documented and dated.

Facility Action:
Adapt or adopt samples included as needed. Ensure that training for all HCWs performing patient handling tasks is updated accordingly.

5. Outcomes of the Patient Assessment:
The definitions provided below are for nurses, and health care aides. Each facility has a set of descriptors that communicates the patient's ability with regards to patient handling and movement. However, with the goal of regional standardization, these definitions are used in conjunction with the algorithms, communication tools, Safe Work Practices and training objectives and guidelines in this manual.

Independent
- Requires no assistance, patient moves independently

Supervised (Standby)
- Requires assistance with equipment, environment and or footwear, set-up or verbal reminders
- Cooperates and follows directions
- Walks with or without equipment (e.g. cane or walker) unassisted
- May need verbal cuing or coaching.

Minimal Assistance
- May need minor physical assistance. This is defined as no more than 35lbs or 16kg of force exerted by the HCW (Marris, 1999).
- May need to use walking aid such as a cane, etc. or have to transport accessory equipment (O2 tank, etc.).
- May need verbal cuing or coaching.

Minimal Assistance with Transfer /Gait Belt 1-2 HCWs
- When using a transfer/ gait belt, patient must be fully weight bearing once standing and require only slight physical exertion from the HCW when rising to stand, or lowering to sit. If the patient or HCW cannot participate at this level, the task becomes a moderate assistance task.
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Moderate Assistance/ Partially Dependent

- When the patient is partially dependent some physical support for trunk or legs is required during transfer or ambulation. Moderate assistance often incorporates the use of equipment (sit to stand devices, Stedy's, FRDs) with a minimum of 1-2 HCW(s), depending upon the workplace policy/procedures and manufacturer guidelines. The determination of the amount of equipment and HCW support required is provided in the safe patient handling algorithms.

Maximum Assistance / Totally Dependent

- The patient may be dependent for turning, repositioning, standing, walking and/or transferring. The patient may have difficulty with key factors in providing assistance such as, inability to follow directions, inability to weight bear, demonstrating uncooperative behaviour, unpredictable behaviour, or inability to provide the needed level of exertion or strength required to safely perform the task. Equipment and the number of HCWs needed is identified in the safe patient handling algorithms. (See Section 3.4)

Facility Action:

Adopt these clear definitions for standardizing communication throughout the WRHA.
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GENERAL CONSIDERATIONS
Factors Impacting Patient Handling Tasks

There are many factors beyond those found in an assessment tool that impact the safety of patient handling tasks. The following tables outline patient and HCW factors, as well as environmental and work organizational factors to be considered beyond the transfer assessment. The selection of the recommended transfer method is based on both patient and other factors.

**PATIENT FACTORS**

<table>
<thead>
<tr>
<th>Communication</th>
<th>Cognition</th>
<th>Medical Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech</td>
<td>Memory</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Vision</td>
<td>Judgment</td>
<td>Pain</td>
</tr>
<tr>
<td>Hearing</td>
<td>Concentration</td>
<td>Medication</td>
</tr>
<tr>
<td>Comprehension</td>
<td>Decision making</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td>Devices</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Status</th>
<th>Emotional Status/Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>Endurance</td>
</tr>
<tr>
<td>Height</td>
<td>Muscle Tone</td>
</tr>
<tr>
<td>Range of Motion</td>
<td>Flexibility</td>
</tr>
<tr>
<td>Strength</td>
<td>Sensation</td>
</tr>
<tr>
<td>Balance</td>
<td>Skin Condition</td>
</tr>
<tr>
<td>Coordination</td>
<td>Depth Perception</td>
</tr>
<tr>
<td>Weight Bearing Status</td>
<td>Body Awareness</td>
</tr>
</tbody>
</table>

**OTHER FACTORS**

<table>
<thead>
<tr>
<th>Environment</th>
<th>Staff</th>
<th>Work Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room layout and obstacles</td>
<td>Experience &amp; Training</td>
<td>Time pressures</td>
</tr>
<tr>
<td>Flooring</td>
<td>Capabilities</td>
<td>Equipment Availability</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>Fatigue level</td>
<td>Shift work</td>
</tr>
<tr>
<td>Space</td>
<td>Size differences between co-workers</td>
<td>Workers available</td>
</tr>
</tbody>
</table>
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SPECIAL CONSIDERATIONS
There are factors that may preclude the performance of a transfer assessment or greatly influence the outcome of an assessment including circumstances or medical conditions that may interfere with the assessment of the patient or limit the patient’s ability to perform the prescribed transfer. Examples include bed rest, use of restraints, pregnancy, abdominal wounds, contractures, weight bearing restrictions, ulcers, pain issues and drains or tubes that will be adversely affected by the use of transfer equipment/devices. Assessment tools should include a section or checklist to identify any issues.

Patient Handling Guidelines for Uncooperative Patients
When using the algorithms, the first question in the decision tree asks if the patient is cooperative. If the patient is uncooperative, the HCW is then referred to the guidelines below and the patient specific Care Plan. The Care Plan should be developed with input from the team that will work through the various options and determine the safest intervention for both patient and HCW.

The definition of uncooperative is the patient’s inability or unwillingness to assist with the transfer. There may be a variety of reasons why this might occur such as:

- Learning disabilities and cognitive impairment,
- Acute mental health crisis,
- Dementias or confusion disorders,
- Violent or disoriented due to medications or under the effects of substance abuse,
- Violent due to personality disorder.
- The patient chooses not to move at that particular moment.

For patients uncooperative and non aggressive, it is recommended that a total lift be used to transfer the patient. If the maneuver puts the patient or HCWs at risk for injury, further planning is required. When the patient is aggressive or resistant and the use of a total lift would be deemed an unsafe technique, an alternative method should be considered. If there is a concern the patient will do any of the following, do not proceed with the lift.

- Strike or hit the HCW,
- Apply resistance against the maneuver where participation is required,
- Twist, flail or thrash while in the equipment causing the patient to fall or the equipment to tip.
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An alternative may be to laterally transfer the patient to a reclining chair using a friction reducing device (FRD) such as a slider. Additionally a lateral transfer with a repositioning sling into the reclined chair (chair must be able to go flat) may also be effective. This alternative is also a reasonable choice for patients that have increased pain with hip flexion or respond poorly to the stimulation of touch. The task reduces the risk associated with the lift or touching the patient.

Tips when Dealing with an Uncooperative Patient

- Stop and Wait: Do not rush into or continue with the transfer unless a life threatening medical emergency is occurring. Ensure or assist the patient to feel calm. When calm, the patient is more likely to feel safe and cooperative.
- Speak to the patient in a confident tone and determine if touch would be soothing for the patient.
- Do not touch the patient if it stimulates or accelerates the behavior.
- Be aware of the verbal and physical cues you are sending to the patient. If the HCWs are nervous, this can increase the fear and aggression in the patient.
- Be careful not to crowd an anxious patient, as this may increase the negative behavior.
- Be aware that confusion and fear often accompany sensory loss and disorientation.
- Ensure the patient is oriented and is aware of their responsibilities during the transfer.
- Use clear and concise directions.
- Be aware that floor slopes and floor patterns can create an illusion to the patient and make the pathway seem unsafe. Give as much control over movements as possible when the patient is in pain or frightened.
- Do not respond to the patient’s aggression or agitation with a confrontational tone as this approach may elicit further resistance from confused or scared patients.
- Understand that when scared or hurt the patient’s reflex response is to move in opposite direction that they are being directed.
- Remember that patients will resist if in pain.
- Avoid gripping a confused or agitated patient’s hand. Instead guide with the palm of your hand.
- Positioning yourself very close can offer security but also may trigger aggression.
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- All movement and procedures should be carefully considered and planned before hand for irrational, confused patients.

Tips when Patient/Family Refuses Care Plan
On occasion patients or family members that are coherent with sound judgment may refuse or resist the Care Plan written to provide safe patient handling and movement. This may be demonstrated by refusing to be moved with equipment. A patient at home may even refuse to have equipment brought in or furniture moved. When this happens, it is important to seek help from management and patient handling resource trainers.

The manager can offer an explanation or address the patient’s concerns. Often these concerns are related to the patient’s feelings of insecurity with HCWs or equipment capabilities. Several demonstrations using the equipment may be required to build confidence. Often the patient appreciates a demonstration with a HCW inside the lift. A patient may refuse because of pain or hurt from a previous event. If the refusal and concerns are from family members, detailed demonstrations and discussion about the benefits will need to occur. If concerns still exist, a review of alternative equipment solutions or methods should occur. Often there is more than one solution available.

If the patient/family member still refuses the Care Plan recommendations, management must be consulted to assess the risk of injury to the HCWs, against the risk to the patient, if the procedure is not carried out. The result may be to change an element of care (i.e. care for the patient in bed).
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OTHER PATIENT ASSESSMENT TOOLS

RED FLAGS CHECKLIST FOR TRANSFERS
This tool is intended for use by any HCW transferring a patient. If a HCW can answer “yes” to any of the questions, it should be a sign to re-assess before proceeding with the transfer. The checklists can be used with the patient when they are either sitting or lying supine.

The goal of these checklists is to empower HCWs in responsible decision making. These checklists provide a concrete method of determining if there is a reason not to proceed with the transfer and the need to then consult physiotherapy, occupational therapy and/or nursing for reassessment. If a transfer is necessary and issues have been identified, checklists should direct the HCW to use more assistance. It is important to empower all HCWs to make some decisions about their comfort level with each transfer performed. HCWs have the right to choose not to do a transfer or to use more assistance than indicated if they feel it is needed. They do not have the right to use less assistance without consulting with the nurse or physiotherapist/occupational therapist, as available at their site.

Facility Action - A version of a Red Flags Checklist should be available to HCWs, preferably in a form that can be displayed and used easily. It should be included in the education/training provided to all HCWs.
# RED FLAGS CHECKLIST FOR TRANSFERS—If patient is supine

If the patient demonstrates any of the following indicators that were not exhibited during the prior transfer assessment, do not proceed with the transfer until patient has been re-assessed by nursing or physiotherapy/occupational therapy. Physicians can also be involved in determining the impact of red flags on the patient’s activity level.

<table>
<thead>
<tr>
<th>Activity</th>
<th>If Yes</th>
<th>Then, Next Step…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to lift shoulders from head of bed @ 45°</td>
<td>√</td>
<td>Reassess patient and Consult physiotherapy / occupational therapy as needed to reassess transfer status.</td>
</tr>
<tr>
<td>Patient states or demonstrates ability to rise from lying to sitting as Very Difficult or Hard</td>
<td>√</td>
<td>If appropriate, proceed with care using more assist considering contraindications to mechanical lift use.</td>
</tr>
<tr>
<td>Unable to boost - independently or minimally assist</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Has not been out of bed for an extended period of time</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Significant fear, anxiety, reluctance by patient</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Unable to lift arms against gravity</td>
<td>√</td>
<td>Do not proceed with transfer. Patient should be assessed by nurse/physician to determine reason for change. When patient is medically stable, consult physiotherapy / occupational therapy or nursing as designated for your site to reassess for best transfer method.</td>
</tr>
<tr>
<td>Unable to lift legs against gravity</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Significant change in medical stability</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Patient reports significant weakness or dizziness</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Patient reports pain level 7/10 consistently and it is not diminished by pain medication</td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

When proceeding with regular manual transfer, if any of the following are true, do not proceed with a manual transfer. Consult physiotherapy / occupational therapy and/or nursing. Proceed with a safer method of transfer immediately, if appropriate.

<table>
<thead>
<tr>
<th>Activity</th>
<th>If Yes</th>
<th>Then, Next Step…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to roll in bed</td>
<td>√</td>
<td>Nursing to assess whether patient is stable and use a safer method of transfer if appropriate. Consult physiotherapy / occupational therapy or nursing as designated for your site to reassess for best transfer method.</td>
</tr>
<tr>
<td>Unable to sit up at the side of the bed unsupported</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Unable to maintain balance side-to-side in sitting</td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>
# Chapter 3.0 Program Essentials

## RED FLAGS CHECKLIST FOR TRANSFERS-if patient is seated

This tool is intended for use by any HCW transferring a patient. If the patient demonstrates any of the following indicators that were not exhibited during the prior transfer assessment, do not proceed with the transfer until patient has been re-assessed by nursing or physiotherapy/occupational therapy. Physicians can also be involved in determining the impact of red flags on the patient's activity level. If the patient must be transferred back to bed before the reassessment, use more assistance as appropriate.

<table>
<thead>
<tr>
<th>Activity</th>
<th>If Yes</th>
<th>Then, Next Step…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient states or demonstrates ability to rise from sitting to standing as Very Difficult or Hard</td>
<td>✓</td>
<td>Reassess patient and consult physiotherapy / occupational therapy or nursing as needed to reassess transfer status. If appropriate, proceed with care using more assist considering contraindications to mechanical lift use.</td>
</tr>
<tr>
<td>Significant fear, anxiety, reluctance by patient</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Unable to lift arms against gravity</td>
<td>✓</td>
<td>Do not proceed with manual transfer.</td>
</tr>
<tr>
<td>Unable to lift legs against gravity</td>
<td>✓</td>
<td>Patient should be assessed by nurse/physician to determine reason for change. Proceed with caution using more assist to get patient back into bed. Consult physiotherapy / occupational therapy or nursing as designated for your site to reassess for best transfer method.</td>
</tr>
<tr>
<td>Significant change in medical stability</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Patient reports significant weakness or dizziness</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Patient reports pain level 7/10 consistently and not diminished by pain medication</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Unable to sit up in the chair unsupported. Unable to maintain balance side-to-side in sitting</td>
<td>✓</td>
<td>Nursing to assess whether patient is stable and use a safer method of transfer if appropriate. Consult physiotherapy / occupational therapy or nursing as designated for your site to reassess for best transfer method.</td>
</tr>
</tbody>
</table>
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QUICK CHECKLIST FOR BED REPOSITIONING
This checklist is used to determine if the patient requires assistance for repositioning in bed, such as boosting or turning side to side. The appropriate algorithm can then be used to determine the type of friction reducing device (FRD) and the number of HCWs needed to do the transfer.

**Critical Components**
1. patient’s ability to assist with bridging,
2. patient’s ability to move legs,
3. patient’s ability to roll with or without use of arms,
4. patient’s weight.

**Facility Action** - Each facility is welcome to adopt/adapt this checklist and have it available to HCWs for all patients. Note: There are algorithms available for several transfers such as Lateral Transfers; Reposition in Chair Transfers; Chair to Stretcher or Exam Table Transfers. For these transfers, the checklists for weight bearing capability and/or repositioning ability should be used as appropriate.

QUICK CHECKLIST FOR BED REPOSITIONING
For Nurses and HCAs

<table>
<thead>
<tr>
<th>Can the patient.....</th>
<th>If Yes....</th>
<th>If No...</th>
</tr>
</thead>
<tbody>
<tr>
<td>− Keep shoulders and feet flat on the bed, and lift both hips off the bed?</td>
<td>Proceed to next step</td>
<td>Assist with bed movement using the Algorithm to determine the friction reducing device and number of HCWs needed.</td>
</tr>
<tr>
<td>− Move legs over one at a time in the direction of the desired movement with minimal or no assist?</td>
<td>Proceed to next step</td>
<td></td>
</tr>
<tr>
<td>− Roll from side to side with or without the use of the arms?</td>
<td>Patient should be able to do independent bed movement or with minimal assist. Friction reducing devices can still be used to facilitate movement.</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 3.0 Program Essentials

QUICK CHECKLIST FOR WEIGHT BEARING CAPABILITY

This checklist is the next step in determining a patient’s ability to transfer and is meant to identify a gross decrease in weight-bearing ability when no medical or orthopedic reason for limited weight-bearing has been identified. In most facilities it is best practice to determine a patient’s capability to weight bear prior to each move which requires weight bearing.

The following tools are designed for use by Nurses who are responsible for assessing a patient’s ability to weight-bear before the INITIAL transfer.

It can also be used by Nurses and HCAs to re-assess weight bearing when determining if the assessed transfer method is still safe to use.

Ideally a referral should be made to physiotherapy and/or occupational therapy for a proper weight bearing and transfer assessment. However, there are times and situations when access to Allied Health is limited. In those cases, the weight bearing assessment by nursing before a transfer keeps HCWs and patients safer should the patient’s status be slightly less functional compared to the original assessment.

A HCW must always follow weight bearing orders documented in the patient chart (i.e. non-weight bearing after a fractured ankle). To determine functional weight bearing status, in case it differs from the order, or if there is no weight bearing order, this checklist can be used to determine the functional Weight Bearing Capability.

There are two parts to the assessment so it can be carried out if the patient is supine lying or sitting. If the result is unclear or there are any questions, determine if the transfer is necessary and if so, a safer method of transfer should be used until a more in depth assessment can be completed. For example, if a patient transfers to a chair before lunch, and afterwards seems fatigued; it may require a sit-stand lift to return the patient to bed.

CAUTION: The successful accomplishment of these tasks does not guarantee sufficient ability to weight-bear, but will indicate if there has been a substantial decrease in ability to bear weight due to factors such as fatigue, showing that weight-bearing is not safe for that patient at that time. In these cases, a formal re-assessment of weight-bearing status should be performed by an Allied Health Professional, if available.

If there is a weight bearing order related to an orthopedic condition or surgery, it should be used as the maximum allowable weight-bearing designation. Weight bearing assessments should not be performed if a fracture is suspected or there
are post surgical conditions such as no arm strength testing after cardiac or thoracic surgery, no straight leg raises after hernia repair etc. In these cases and for orthopedic conditions, physiotherapy or another Allied Health professional should be consulted for the weight-bearing assessment.

QUICK CHECKLIST FOR WEIGHT-BEARING CAPABILITY

<table>
<thead>
<tr>
<th>Position</th>
<th>Can the patient…..?</th>
<th>If Yes….</th>
<th>If No….</th>
</tr>
</thead>
</table>
| **Supine** | - Keeping shoulders and feet flat on the bed, lift one or both hips off the bed.  
- This is the best indicator of leg strength for transfers | Assume patient has reasonable strength to bear weight. Proceed to next step in algorithm | Transfer patient using a method that does not require weight bearing. e.g. Mechanical Lift |
| **Supine or Sitting** | OR - straighten his/her leg from a bent position by pushing against your hands, placed into the soles of the patient’s feet. Test both legs. | Assume patient has reasonable strength to bear weight. Proceed to next step in algorithm | Consult with physiotherapy / occupational therapy as designated for your site to determine best transfer method. |
| **Supine** | OR - straighten and lift leg off bed about 6”. Test both legs. | Assume patient has reasonable strength to bear weight. Proceed to next step in algorithm | |
| **Sitting** | OR - with upper leg supported in the chair, straighten leg. Staff should try to bend the patient’s leg at the knee while the patient resists. Test both legs. | Assume patient has reasonable strength to bear weight. Proceed to next step in algorithm | |

To test whether patient will be able to assist with arms -

<table>
<thead>
<tr>
<th>Can the patient…..?</th>
<th>If Yes….</th>
<th>If No….</th>
</tr>
</thead>
<tbody>
<tr>
<td>- straighten a bent elbow against your resistance</td>
<td>Patient should have functional arm strength for pushing on bed or using walker</td>
<td>Use a method of transfer that does not require the patient’s use of arm strength and consult with physiotherapy for further assessment.</td>
</tr>
</tbody>
</table>
To test patient’s ability to assist moving feet -

<table>
<thead>
<tr>
<th>Can the patient.....?</th>
<th>If Yes....</th>
<th>If No....</th>
</tr>
</thead>
<tbody>
<tr>
<td>- while keeping knees straight, move his/her own foot in a circle, up and down</td>
<td>Proceed - patient has active ankle movement</td>
<td>If this condition is new, nursing/physician should assess. Use a mechanical lift with patient, if appropriate. Consult physiotherapy to recommend appropriate method for transfers if patient is medically stable.</td>
</tr>
</tbody>
</table>

Adapted from Monica Brechka, Community Therapy Services, Winnipeg, Manitoba

PATIENT READINESS FOR TRANSFERS

After all the checklists have been completed, everyone who attempts to transfer a patient should have a mini checklist to assess whether the patient is still safe for the suggested transfer. It can be used for a patient in sitting or supine lying and is quick and easy. HCWs can carry a pocket card (next page) which summarizes all the steps to date or use the following acronym to assess patient readiness.

ACES Acronym:

- A - Alert and energetic enough to perform the transfer
- C - Cooperative
- E - Extremities working sufficiently for the transfer
- S - Sits un-supported

Facility Action - Some version of a transfer readiness checklist tool should all be available to all HCWs, preferably in a form that can be carried and used easily. See Pocket Card sample.
Chapter 3.0 Program Essentials

POCKET RESOURCE CARD

Back Pocket Resource Card
Communication status
Emotional/Behavioural Status
Medical Status
Physical and Functional Status

Handshake
- Grip, push, pull

Leg Strength
- Bend knee and lift leg against force
- Ability to bridge
- Straight leg raise

Foot Movement
- Move foot up and down at ankle

Rolling
- Roll side to side

Sitting Abilities
- Get into sitting position
- Sit unassisted 10 – 15 seconds
- Right themselves against a tipping force

Standing Abilities (Transfer Belt on pt. & 2nd worker available)
- Prepare for standing (Pt. to scoot forward in chair, feet under knees & leaning forward)
- Shift weight from buttocks to thighs to feet – “nose over toes”
- Remain standing 15 – 20 seconds
- Remain balanced raising one arm at a time front and side

Walking Abilities
- Shift weight one foot to the other
- Walk or march on the spot
- Take effective steps

Independent Transfer
- displays sound judgement (is cognitive)
- can bear their body weight through part or parts of their body
- is co-operative
- is physically & mentally predictable/reliable in performance/behaviour
- can safely relocate themselves

Supervised Transfer
- requires assistance with personal articles and/or equipment
- requires verbal guidance

Minimum Assistance Transfer
- requires only slight physical assistance from HCW

1) One-person Transfer with Belt
- attachments & equipment require assistance of another worker

2) Two person Transfer with Belt
- has difficulty turning, shuffling feet and/or maintaining balance

Sit/Stand Lift (Moderate Assist/Partially Dependent)
Exhibits one or more of the following:
- has limited or partial weight bearing ability
- is unpredictable/unreliable in physical/mental performance
- is disproportionate in weight and/or height to workers

Total Lift (Maximum Assist/Totally Dependent)
Exhibits one or more of the following:
- cannot bear their own body weight
- is uncooperative (Must be assessed as appropriate method)
- must be moved from a supine position

Front of Card

Applying Patient’s Capabilities to the Algorithms

The outcome of the patient assessment is to determine the patient’s capabilities and limitations with respect to movement and transfers. Now that the patient’s capabilities have been determined (i.e. whether the patient is cooperative, weight bearing capacity, degree of assistance required) the information can be inserted into the appropriate algorithm.

The decision tree system of the algorithms will help determine what technique to use, what equipment to gather and how many HCWs are required to complete the task. Algorithm #1 has been chosen as an example in the section because it covers all the main questions.
Algorithm 1 – Sit to Sit
(Chair to Toilet, Chair to Chair, Car to Chair, Bed to Chair)

Start Here

Is patient cooperative?

NO

Stop. Refer to care plan or perform further assessment (1).

YES

Use total lift device (2)

Can patient bear weight?

FULLY

HCO assistance not needed. Standby for safety as needed.

PARTIALLY

Is only minimal assistance required? (3)

NO

Does patient have arm strength to pull themselves up?

YES

Use stand-aid or manual sit-stand device

NO

What is patient’s weight?

> 159 kg (350 lbs)

Refer to Bariatric Guidelines

< 70 kg (155 lbs)

Use transfer belt & 1 HCW to assist patient (4)

70 – 113 kg (155 – 250 lbs)

Use transfer belt & 2 HCWs to assist patient (4)

113 – 159 kg (250 – 350 lbs)

Use total lift device (2)

Does patient have strength to pull themselves up?

YES

Use powered mechanical sit-stand device

NO

Does patient have strength in at least one arm?

YES

Use powered mechanical sit-stand device

NO

1. Refer to Patient Handling Guidelines for Uncooperative Patients for assistance in determining the safest course of action
2. A total lift device refers to a floor or ceiling track sling lift. A ceiling track lift is recommended. If a floor lift is used, the care provider must ensure that the base of the lift will pass freely under the bed/chairtable prior to use.
3. Minimal assistance means that the HCW is required to lift no more than 16 kg (35 lbs) of a patient’s weight when providing physical assistance to the patient during any transferring task.
4. Any task requiring the HCW to lift more than 16 kg (35 lbs) of a patient’s weight would be classified as either a Moderate Assist or a Total Assist (Non-weight bearing) task, depending on the patient’s weight bearing status. These tasks should only be performed with the use of assistive devices (e.g., stand aid, lift, etc.).
5. This is not a Pivot Transfer. Assistance is provided during the ‘standing’ and ‘sitting’ motions only. Patient must be assessed as being able to ambulate consistently & reliably once in a standing position in order to proceed with this technique.
Chapter 3.0 Program Essentials

TRANSFER ASSESSMENT GUIDELINES
FOR USE WITH ALGORITHM #1
Sit to Sit (Chair to Toilet, Chair to Chair, Car to Chair, and Bed to Chair)

This process assumes you are aware of the patient’s medical status for all decision-making including diagnosis, cognitive status, weight-bearing orders, other precautions (e.g., abdominal surgery, hip surgery, ostomy, etc.), pain level, pain location, and medications. Walking aids are not to be used in the sit-to-stand or stand-to-sit portion of a transfer (e.g., patients should be discouraged from pulling up on a walker to stand). Walking aids should, however, be used to step from one location to the other whenever possible in order to maximize the patient’s functional capacity, if used pre-admission or determined to be appropriate for mobilizing as part of the treatment plan.

1. The **first step** when assessing patient capabilities is to assess the patient’s degree of cooperation, or compliant behaviour. If there are issues identified, do not proceed with the transfer. The recommendation is as follows:
   i. Stop and refer to the Care Plan.
      o It could be that a transfer has been already been built into the documentation based upon a more formal assessment
      o There may be further guidelines described in the Care Plan to assist the HCW with a safer transfer procedure
   ii. Review Patient Handling Guidelines for Uncooperative Patients noted earlier. This document provides descriptions of behaviour, risk factors associated with them, and some alternate methods which can contribute to the overall transfer planning.

2. The **second step** is to assess the patient’s need for assistance such as fully, partial, none. This assessment should answer the following two questions:
   i. **Is the patient independent?** (i.e. FULLY)
      a. Does not require physical assistance
      b. Does not require verbal assistance and/or help in the use of equipment (e.g., wheelchair positioning)
   ii. **Does the patient require a standby assist?** Does not require physical assistance, but requires:
      c. Verbal assistance and/or help in the use of equipment (e.g., wheelchair positioning)
      d. Close observation because of medical problems
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An answer of YES to these questions will follow the Algorithm to the decision as follows: “HCW assistance not needed. Standby for safety as needed.”

If answer is NO to both of these questions, proceed to decision process outlined in the algorithm. The decisions are based on the following questions:

TO DETERMINE LEVEL OF PARTIAL ASSIST

1. **CAN THE PATIENT SIT ON THE EDGE OF THE BED UNASSISTED?**
   (Cross references with Red Flags Checklist)
   - Use two HCWs to assess patient’s ability to sit unsupported and discontinue assessment at any time if the patient is ability is insufficient.
   - If NO, then proceed to a total mechanical sling lift.

2. **DOES THE PATIENT REQUIRE ONLY MINIMAL ASSIST?**
   (Cross references with Red Flags Checklist and Quick Checklist for Weight-Bearing Capability and Bed Movement Assessment)
   - Assess weight
   - Bed movement
   - Consider functional movement, coordination, general arm and leg strength
   - Use the arm and leg portions of the Weight Bearing Capability checklist to help assess patient’s ability to help physically
   - Must take into account deficits in sensation and body awareness
   - Use the weight bearing assessment findings to predict ability to perform the majority of the transfer.

3. **WHAT IS THE PATIENT’S WEIGHT BEARING STATUS?**
   (Cross references with Quick Checklist for Weight-Bearing Capability)
   - In some cases, determined by physician’s orders
   - In most conditions, must be evaluated using the Weight Bearing Capability Checklist
   - Possible outcomes are:
     - Full weight bearing both legs i.e. passes checklist test both legs
     - Partial weight bearing - able to complete on both legs but not as well/strongly.
     - Non weight bearing - unable to complete tests on one or both legs.
Chapter 3.0 Program Essentials

4. **DOES THE PATIENT WEIGH LESS THAN 71 kg (155 POUNDS)?***
   - For *Minimal Assist* - Can use a transfer/gait belt and 1 HCW. The limitation is that a caregiver is to provide assist only to move from sit-stand, bearing little to none of the patient’s weight (<30 lbs)
   - For *Moderate Assist* - Assess for Sit-Stand Lift (next section)

5. **DOES THE PATIENT WEIGH BETWEEN 71 kg–113 KG (155-250 POUNDS)?***
   - For *Minimal Assist* - Can use a transfer/gait belt and 2 HCWs. The limitation is that the HCWs are to provide assistance to the patient only to move from sit-stand, bearing little to none of the patient’s weight (<30 lbs)
   - For *Moderate Assist* - Assess for Sit-Stand Lift (next section)

6. **DOES THE PATIENT WEIGH BETWEEN 113-159 KG (250-350 LBS)?***
   - For *Minimal Assist* - Assess for Sit-Stand Lift (next section) as the forces required to assist sit to stand exceed safe spinal loading values for the HCWs.
   - For *Moderate Assist* - Assess for Sit-Stand Lift (next section)

7. **DOES THE PATIENT WEIGH MORE THAN 159 KG (350 LBS)**
   - Please refer to the Bariatric Guidelines

* Use caution when patient not actually weighed on scale as weight may be UNDER estimated

**ASSESS FOR SIT-STAND LIFT**

1. **CAN PATIENT FIT COMFORTABLY IN SIT-STAND DEVICE?**
   - If patient’s legs are larger, patient may not be able to adduct legs sufficiently to fit into lower leg support.

2. **DOES PATIENT HAVE ARM STRENGTH TO PULL THEMSELVES UP**
   - If the patient has adequate arm strength to pull themselves to a stand, then they may be a candidate for a sit stand device, such as a STEDY. (Cross reference with the Quick Checklist for Weight Bearing Capability).
3. **CAN PATIENT USE AT LEAST ONE ARM?**
   - Patient should be able to use at least one arm, preferably two to use a Mechanical Sit-Stand Lift. The criteria for using a Sit-Stand Lift are that the patient must have minimal weight bearing capability in at least one leg and one arm. Caution should be used when assessing Hemiplegic patients for use of Sit-to-Stand lift. (Cross reference with the Quick Checklist for Weight-Bearing Capability)

4. **DOES PATIENT FATIGUE OR IS VARIABLE IN STRENGTH?**
   - Patient may be able to perform transfer but fatigues quickly.
   - Patient may be able to do a transfer once, but not stand for any length of time.
   - Patient may be able to do transfer to chair but require more assistance to get back into bed. In this case, the patient’s return transfer is most safely executed using a Mechanical Sit-Stand Lift.

As you determine responses to these questions, you follow the path indicated by the algorithm. This is designed for assessment of transfer capabilities only, not for ambulation.
Chapter 3.0 Program Essentials

COMMUNICATION TOOLS

Purpose

The Manitoba Workplace Safety and Health Regulation (217/2006) states "when a patient has been assessed as requiring assistance to move, the employer must ensure that the current status of the patient and the appropriate techniques to move the patient are clearly identified in writing or by other visual means at or near the location of the patient." A communication tool is intended to provide timely, clear communication of transfer information to all healthcare workers (HCWs) involved in patient handling.

An effective, accurate communication tool will decrease the chance of injury caused by insufficient information. In theory, HCWs should have the assessment form, Kardex or Care Plan information, transfer logo(s) and finally the patient’s input to determine the patient’s need. Discrepancies in the information should alert staff to consult directly with the assigned nurse for clarification.

Four Core Elements of Communication Tools

1. Documentation—There must be a transfer assessment record in the chart that includes the date of the assessment as well as a signature of the assessor. The chart should be updated at the time of the initial assessment. It must include the:
   - Recommended method of transfer
     i. Number of HCWs required
     ii. Equipment needed
   - Instructions for bed mobility,
     i. Number of HCWs required
     ii. Equipment needed

2. The Comprehensive Summary of Assessment Findings (Appendix A) form can be used as part of the Kardex or Care Plan. It should include a section with the most recent information about transfers and bed mobility as well as the recommended number of HCWs needed, the type of transfer and the equipment required. Important information about other transfers (including toileting) and mobility should be noted (i.e. can ambulate with 2 assistants and transfer belt x 50 feet, must be transported on stomach on a stretcher or toileting on commode at bedside).
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3. **Transfer Logo System** - The transfer logo system can be in the form of a wristband, walking aid marker/band or logo card(s) located near the patient’s bed. See Section 3.2 Appendix B for an example of transfer logo systems. It can be adapted or used as is.

The logo system must be easy to change so that HCWs can keep the logos up to date. The logo system must be updated after the initial assessment and after each reassessment. The logo(s) should include the

- type of transfer
- bed mobility information
- equipment and number of HCWs required

4. **Re-assessments** must also be noted, dated and signed in the chart as part of the permanent legal record. (Example in Section 3.2 Appendix D) This communication tool must also include a check box where the assessor is required to sign that he/she has updated the Transfer Logo and Care Plan.

Section 3.2 Appendix A - WRHA Sample Comprehensive Summary Sheet of Patient Handling and Movement

Section 3.2 Appendix B - WRHA Sample Transfer Logos

Section 3.2 Appendix C - WRHA Sample Patient Card in Use in WRHA Facility

Section 3.2 Appendix D - WRHA Sample Change in Transfer Status Re-Assessment Form
## WRHA COMPREHENSIVE SUMMARY SHEET OF PATIENT HANDLING & MOVEMENT

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Weight:</th>
<th>Height:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit:</td>
<td>Room #:</td>
<td></td>
</tr>
<tr>
<td>Strong Side:</td>
<td>Right</td>
<td>Left</td>
</tr>
</tbody>
</table>

### Capabilities of Patient:

- **Independent**
- **Stand-by Assist**
- **Assist with Transfer Belt**
  - 1 Assist
  - 2 Assist
- **Assist – Transfer Belt Contraindicated**
  - 1 Assist
  - 2 Assist
- **Dependent**
- **Able to assist with 1 leg & assist with 1 arm**
- **Bed Rest**

- **Can move in bed without assistance**
- **Can move in bed with assistance**
- **Cannot assist movement in bed at all**

### Weight bearing

- (R) __________ (L) __________

**Comments:**

<table>
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<tr>
<th>Equipment Required:</th>
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</thead>
<tbody>
<tr>
<td>□ Ceiling Lift</td>
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<tr>
<td>□ Mechanical Lift</td>
</tr>
<tr>
<td>□ Sit-to-Stand Lift</td>
</tr>
<tr>
<td>□ Sit-Stand Aid</td>
</tr>
<tr>
<td>□ Repositioning Sling</td>
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<td>□ Sling Type and Size __________</td>
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<td>□ Special Bed - specify __________</td>
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<tr>
<td>□ Cane</td>
</tr>
<tr>
<td>□ Standard walker</td>
</tr>
<tr>
<td>□ 2-wheeled walker</td>
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<td>□ 4-wheeled walker</td>
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<td>□ Crutches</td>
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<tr>
<td>□ Step stool</td>
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<tr>
<td>□ Special Chair - specify __________</td>
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<tr>
<td>□ Other</td>
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</tbody>
</table>

**Comments:**

### Patient Handling Requirements

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<th>Task</th>
<th>Staff Members Required</th>
<th>Type of Equipment Required (Specify)</th>
<th>Comments</th>
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<td></td>
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<tr>
<td>Bed Turn</td>
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<td></td>
</tr>
<tr>
<td>Side to Side in bed</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bed to Stretcher</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bed to Chair/Commode</td>
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<td></td>
<td></td>
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<tr>
<td>Transport within</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To get to Bathroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To walk in Hall</td>
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<td></td>
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</tbody>
</table>

**Comments:**

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Section 3.2

Communication Tools – Appendix A
LOGO EXAMPLES

Independent

Independent with Cane

Cane
1 Assist
with Transfer Belt

Walker
1 Assist

Transfer Belt
1 Assist

Sit-Stand Device
1 Assist

Mechanical Lift
2 Assist

Nylon Slider
2 Assist

For full sizes of these Logos, please see Resources Chapter

APPENDIX B

Standby Assist

BED
REST

Independent
with Walker

Walker
2 Assist

Transfer Belt
2 Assist

Sit-Stand Device
2 Assist

Nylon Slider
1 Assist

1-2 Person
Assist

1-2 Person
Assist

Consult
with Nurse
Name:

DOE, John
Facility #: 00000

2 PERSONS WITH TRANSFER BELT

Nylon Slider
1 Assist

requires®
hearing aid

Blank Card for Dry Erase
Pen
WRHA Change in Transfer Status - Reassessment Form

You do not need to complete another form. Document change in transfer method below, update decals and update Kardex.

<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>INITIALS</th>
<th>TRANSFER METHOD, WEIGHT BEARING, REPOSITIONING, COMMENTS</th>
<th>UPDATED</th>
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</tr>
</tbody>
</table>
Chapter 3.0 Program Essentials

EQUIPMENT

Purpose: The guiding principle of a Minimal Lift Environment prohibits the manual lifting of patients in all but emergency situations. The WRHA Safe Patient Handling and Movement Program recommends a minimal lift environment. In order to facilitate such an environment, lifting equipment, devices and aids are necessary. With the goal of reducing injuries in the workplace specialized equipment is recommended when assisting patients with movement tasks to minimize the manual effort required by healthcare workers (HCWs). This equipment should be in good working order and readily available for HCWs to use during patient handling and movement tasks.

Proper equipment selection must be based on the specific needs of the facility, patients, staff, and management. Bariatric patients may require different equipment. (See Section 5.1 Regional Bariatric Program)

Definitions

Electric Beds have various positioning controls such as height and Trendelenburg (head lower than feet) to assist in transfer or re-positioning. Some beds have the ability to position the patient in an upright sitting position. Height controls allow for easy transfers from bed to wheelchair. These beds can be kept low to the ground for patient safety and raised for bedside care/interaction with HCWs.

Friction Reducing Devices (FRDs) are used to aid HCWs during patient repositioning in bed or lateral transfers to stretcher/exam tables. Currently, there are slippery nylon sheets and tubes, draw sheets with friction reducing qualities and air assisted devices. It is important that FRDs are incorporated in all patient bed repositioning tasks in an effort to reduce the exertion required by HCWs.

Manual Standing Aid devices allow the patient to stand using the aid to pull themselves to a full stand (i.e. floor to ceiling pole, hand rail, etc.).

Manual Sit-Stand Device (Stedy) is a light weight compact support aid used for transfers. It encourages patients to participate more fully in the transfer without lifting.
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**Mechanical Lift Machines** are devices to lift patients who cannot support their own weight. These can be further described as floor lifts or ceiling lifts (portable or fixed).

**Shower Chairs** often have a toileting feature that can eliminate multiple transfers. A patient can be moved to the shower chair, toileted, showered, and transferred back to the wheelchair. Shower stalls that allow for shower chairs to be pushed in and out on level floor surfaces are available in some facilities.

**Sit Stand Transfer Device** is a powered standing device that eliminates the need for HCWs to perform a manual sit to stand transfer. This device provides an alternative to full body sling lifts. They are very useful for a patient that is partially dependent and has some weight-bearing capability. Powered standing devices may be used to move patients in and out of chairs, for toileting tasks and to transport a patient in and out of the bathroom. These devices require that the patient have the ability to stand and have the use of at least one arm and one leg so the patient can balance themselves.

**Sliding Boards** are made of smooth rigid material used under patients to help reduce the need for lifting during transfers from one seated position to another. These boards act as a supporting bridge when seated transfers are performed so that multiple small movements can be performed when one big movement is unsafe or impossible.

**Slings** are specific to the mechanical lift to which they are attached. The sling brand and lift brand must match. They are not interchangeable between types of mechanical lifts. Slings come in different sizes of length and weight capacity. Each sling is colour coded and labelled for the weight and size. Specialty slings such as amputee slings and toileting slings are also available. Never use a sling on an amputee patient unless designed or recommended by the manufacturer.

**Toilet Seat Risers** equalize the height of the wheelchair and toilet seat, making it a lateral transfer rather than a lift up and back into wheelchair. They are also used to raise the toilet seat to allow a patient with insufficient strength or range of motion to decrease the effort needed to rise from the regular height seat.
Track Lifts or Track Systems are also known as ceiling lifts. They consist of a track, motor unit and sling and are typically ceiling mounted with a hoist and suspension component to lift, lower and move patients horizontally or vertically. The track and motor units can be portable or fixed. Slings attach to the hoist hanger bar. Ceiling tracks can be installed in varying configurations depending on the design of the facility or home. This system provides patient mobility in the bed, outside of the bed and from room to room without manual lifting. Ceiling track lift systems can lift a patient from the floor if the patient is directly under the track. A benefit of the ceiling track lift system is that it requires no floor space. If installing a tracking system to the ceiling is not possible, an alternative system is available using the same overhead track attached to upright posts.

Transfer/Gait Belts provide stabilization for ambulatory patients by allowing HCWs to hold onto the belt and support the patient during transfer or ambulation. These are not designed for lifting patients. Transfer/gait belts are recommended for patients who can stand with minimal assistance and should not to be used to lift patients. Transfer/gait belts are used for assisting patients who can perform the majority of the transfer and weight-bear sufficiently. They are wide belts with Velcro, plastic clips or D ring closures and are available in various sizes, colours and designs.

Trapeze Bars are suspended above the bed and allow patients with upper body strength to help reposition themselves. This device is particularly useful with wheelchair transfers.

**Equipment Cleaning**

The WRHA Infection Control Policy states "appropriate cleaning, disinfection and sterilization of reusable patient care equipment is important in preventing the transmission of organisms." Please refer to WRHA Facility Guidelines for cleaning.

**Equipment Maintenance**

Friction Reducing Devices (FRD) and Slings - The maintenance of friction reducing devices and slings should be a part of a facilities regular every day equipment checks. Having the items clean, not ripped or torn and labeled provides staff with the resources to provide a safe working environment. Checking the items on a routine basis maintains inventory supplies so they
Chapter 3.0 Program Essentials

are in the facility when needed such as: labeling all items with facility name and unit area; having all rips and tears repaired if possible; having the items clean and soil free and replacing any item that is not safe to use.

Mechanical Lifts - The need for equipment checks before and after use and a preventative maintenance program is required to ensure patient handling equipment is in proper working order. A maintenance program can be established with the company that sold the device to the facility or by using facility maintenance services.

Mechanical checks can include looking at overall lift condition, broken or missing parts, sticking wheels, if slings are clean and not ripped, all electronic functioning, battery charge, and no fluids leaking from equipment. If a problem is found, the equipment must be tagged with appropriate documentation and sent for immediate repair.
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TRAINING AND EDUCATION PROGRAM

FOR

ACUTE CARE, LONG TERM CARE AND COMMUNITY CARE FACILITIES

Purpose

As per the WRHA Operational Procedure, training and education is an essential component for a safe patient handling and movement program. It must be provided to healthcare workers (HCWs) prior to using or operating equipment or participating in patient handling activities. This education program is meant to provide the outline and tools each facility needs to consider for their program. These basic elements are:

1. Patient assessment and communication,
2. Algorithms to identify the safest method of transfer based on the patient assessment,
3. Safe Work Procedures with competency objectives for HCWs return demonstrations,
4. HCW assessment and training in core competencies such as body mechanics.

Facilities that have tools and educational resources in place will need to review the elements of their existing program and determine what needs to be added to meet the core requirements. For facilities that are missing tools or do not have a current program, sample tools and educational resources are provided in this document and include:

1. Reference from Benner 1984 on HCW skill levels (see Caregiver Skill Assessment Tool),
2. Theory outline and information including a recommended PowerPoint presentation, (See Resource CD)
3. Competency guidelines for "hands on" training and return demonstration using patient handling tasks and procedures from designated algorithms,
4. Discussion on sustainability and support with a sample model program,
5. Safe Work Procedures with detailed pictures and steps for performing the safe patient handling task,
6. Arjo Mobility Gallery for assistance in developing education programs, (See Resource CD)
Chapter 3.0 Program Essentials

7. NIOSH Safe Patient Handling and Movement video clip - which provides the ergonomic framework underlying the program. (See Resource CD)

The goal of this education/training program is to ensure all Nurses and Healthcare Aides are performing at a basic level (Levels 1 & 2). HCWs with advanced training as part of their education (Levels 4, 5) are equipped to perform advanced skill tasks as per the goals of patient intervention and work outside the scope of this document.

Caregiver Skill Determination

Skill ability can be determined, using the Caregiver Skill Assessment Tool, to identify who can perform which patient handling and movement tasks. It has been identified that HCWs in the system come from all different backgrounds of training in patient handling. Traditionally, there is an expectation that all HCWs perform patient handling tasks with the same skill set and, as a result of those expectations, injuries have become devastating to HCWs, their careers and to the workplace.

CAREGIVER SKILL ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Level</th>
<th>Occupational Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novice (1)</td>
<td>New Graduates:</td>
<td>− Have undergone basic training in patient handling (i.e. Corporate or Orientation Training). Need to work side by side with seasoned staff until a level of comfort is determined.</td>
</tr>
<tr>
<td></td>
<td>o Nurses</td>
<td>− Are familiar with the sliders and lifts, with limited hands-on experience.</td>
</tr>
<tr>
<td></td>
<td>o Healthcare Aides</td>
<td>− Have no experience of the situations of which they are expected to perform.</td>
</tr>
<tr>
<td></td>
<td>Home Care Workers</td>
<td>− Base decisions on universal rules, which are limited and inflexible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Novices have limited “life experience” in the application of rules, i.e. “Just tell me what to do and I will do it”.</td>
</tr>
<tr>
<td>Advanced Beginner (2)</td>
<td>Nurses Healthcare Aides</td>
<td>− Have undergone basic training in patient handling (i.e. Corporate Training or Orientation).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Have also had on-ward in-servicing and upgrading in patient handling.</td>
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<tr>
<td></td>
<td></td>
<td>− Have demonstrated competence under the guidance of a mentor in the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Confirmation of weight-bearing status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Patient assessment of safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Use of sliders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Use of mechanical lifts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Minimal-assist transfers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Application of principles is based upon experience</td>
</tr>
</tbody>
</table>
### Chapter 3.0 Program Essentials

#### Level | Occupational Group | Description
--- | --- | ---
| | | and is consistent with minimal lift guidelines.
| | | − Are comfortable with sliders and mechanical devices.
| | | − Permitted to perform minimal-assisted transfers with transfer/gait belt.

**Competent (3)**

| | | This group have undergone basic training in patient handling (i.e. Corporate Training or Orientation) |
| | | − Have also had on-ward in-servicing and upgrading in patient handling. |
| | | − Have demonstrated competence under the guidance of a mentor in the following: |
| | | o Confirmation of weight-bearing status |
| | | o Patient assessment of safety |
| | | o Use of sliders |
| | | o Use of mechanical lifts |
| | | o Minimal-assist transfers |
| | | − Decision making follows the algorithms, and demonstrates problem solving based upon life situations experience. |
| | | − Permitted to perform minimal-assisted transfers with transfer/gait belt. |

**Proficient (4)**

| | | These groups have received additional training in patient handling and problem solving, and are leaders in determining patient ability. |
| | | − This group understands centre of gravity and biomechanical issues and can direct patient movement accordingly. |
| | | − They can also integrate patient diagnoses into safe handling procedures. |
| | | − This group is permitted to perform moderate-assist transfers manually as per the Operational Procedure. |

**Expert (5)**

| | | This group have had several years experience in patient handling and are leaders in the minimal lift philosophy |
| | | − Are proficient in the application and use of patient handling equipment, are sensitive to the competency levels of the other professional groups, and can instruct and provide guidance in appropriate techniques for all other levels. |

Adapted from P. Benner 1984
Chapter 3.0 Program Essentials

EDUCATION TOOLS

Part 1: Theory Education

Required Equipment and Resources:
Based upon literature and best practice research, we recommend the following format and resources. Traditionally, patient handling education has been from an equipment perspective, i.e. “This is the equipment, this is how you use it, this is when you use it”. The literature supports providing a theoretical framework within which to problem solve through different scenarios. The algorithms provide this structure where equipment and technique come together for safe patient handling decisions, for the HCWs and the patient.

The theory portion can be presented as an interactive lecture, possibly in a classroom setting with one trainer or a computerized training module. One option is to have a self study module assigned to be reviewed prior to the session. The time allocated for the theory portion should be 60-90 minutes depending on the facility’s specific needs. The theory portion of the training should be completed before the HCW attends Part 2 - The Practical Session.

Below is a summary of what can be provided in the theory portion:

<table>
<thead>
<tr>
<th>Facilities should provide a computer and projector for the PowerPoint presentation for the lectures series.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This can be delivered as:</td>
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<tr>
<td>Handouts should include:</td>
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<td></td>
</tr>
</tbody>
</table>
Chapter 3.0 Program Essentials

Theory Presentation:
Each facility should provide the NIOSH video presentation (see Resources CD). This provides the theoretical framework of ergonomic principles upon which the entire program is built.
In addition, facilities should also include slides on the pertinent information they would like their HCWs to know (See Resources CD):

- Core Components of safe patient handling and movement to include:
  - Body Mechanics
  - Appropriate working heights
  - Principles of power position, stabilization and weight shifting
  - Patient Assessment Guidelines
  - Weight Bearing Assessment Checklist
  - Working Space and Environment
  - Caregiver Assessment Tool
- Review the WRHA Operational Procedure and identify HCWs assigned the following functions at your facility; education, patient assessments, maintenance of communication system, equipment provision, and resources for patient handling solutions.
- Facility specific - list available equipment, access to equipment care, and repair, lock and tag out procedure.
- Identify where to access patient handling reference tools: guidelines, protocols, algorithms, and safe work procedures (i.e. on line, binders on unit, etc.)
- Identify the facility method for competency training and provide the necessary competency checklists at this time, if appropriate.
- Review expectations for required knowledge regarding lift and sling equipment.

Included on the provided CD is a sample of a PowerPoint presentation called “Safe Patient Handling & Movement Program” in a format which your facility can adapt by:

- Filling in the background with your own logo and colours
- Filling in the blanks with information specific to your facility
- Clipping in photos of equipment specific to your facility
- Designing Case Studies specific to your patient population

The suggested theory topics in the PowerPoint presentation are as follows:
  - Objectives of the Training
  - Safe Patient Handling and Movement Guidelines
    ♦ Facility goals of the program
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- Explanation of best practice and evidence-based framework
  - Guiding Policies
    - Legislation
    - Facility policies
  - Identifying Most Stressful Tasks as Identified by Your Facility
    - WCB Experience Reports
    - Examples of unsafe patient handling tasks
  - Triangle Theory for Patient Handling
  - Facility Resources
    - Where to find binders, guidelines, policies
    - Safe Work Practices
    - Patient Handling Equipment
      - What
      - Where
      - How to access, regular or off hours
  - What to do when broken
    - Who to call
    - How to tag out (i.e. identify the piece of equipment as broken and needing repair)
  - HCW resources (physiotherapy, occupational therapy, trainers)
  - Guiding role of algorithms
  - Slides on Equipment Specific to Your Facility
    - Lifts
      - Total floor, sit-stand, ceiling, gantry
    - Slings and harnesses
      - How to clean/launder
      - Where are they kept
    - Friction reducing devices (FRD)/sliders
    - Hovermat™/ HoverJack™/ Airpals, if available
  - Communication Tool
    - Responsibilities
    - Logo system
    - Patient assessment
      - What is done
      - Who does it
  - Body Mechanics and Core Components of Patient Handling
  - Signs and Symptoms of Musculoskeletal Injuries
  - Case Studies (optional)
Introduction to Algorithms for Safe Patient Handling & Movement

Algorithms provide the theoretical framework for problem solving through patient handling issues. They provide the "why" and "when", to the "how" of the hands-on training using equipment. In practice algorithms are used after the weight-bearing and patient transfer assessment is completed. The algorithms are designed to assist staff in selecting the most appropriate equipment and safest techniques to transfer or reposition based on the specific patient characteristics and assessment.

As with any guidelines the content provides general direction; they walk the HCW through a decision tree which includes patient's weight, weight bearing status (from previous assessments), level of assistance required, and ability to cooperate. At the end of the tree is a transfer method which includes equipment and number of staff required. It is understood that at any time a more conservative method can be chosen over the recommended method, should the HCW not feel confident that the assessment reflects the patient's present status. The algorithm can be used to lead to a more conservative method.

Professional judgment is needed to assure the safety of patients and HCWs. Algorithms are to be used as a resource tool by nurses, licensed practical nurses, nursing assistants, healthcare aides, allied health workers, radiology technicians and patient care technicians.

NB: In training, algorithms provide the problem solving decision tree framework for linking the theory portion to the practical hands-on. (See Part 2 below)

Part 2: Practical Hands-On Training Sessions

This session is designed to educate HCWs with hands-on approach to patient handling and use of the equipment.

- The hands-on training should take place in a clinical setting with relevant equipment.
- HCWs should have a visual demonstration of the safe work procedures prior to the clinical component.
- The demonstration can be presented by video clips, or trained trainers.
- HCWs will deliver hands-on return demonstration for most patient handling tasks.

Once again, it is recommended that the format be structured around the algorithm decision tree. HCWs need to understand that prior to using the algorithms, an
assessment of the patient needs to be completed. HCWs will need training on the process and application of the patient assessment. In Sections 3.1 and 3.2, tools were provided to direct nurses in assessing the patient’s capabilities to determine their status for transfer. Nurses may require training to perform these assessments. Each facility/program will determine and advise the nurse of their role in assessment.

Once the level of assistance is determined, the HCW will check the algorithm to determine the equipment and number of HCWs required to perform the desired task. Ability to apply, provide and use the information should be demonstrated in the "hands-on" training portion of the education program.

**FACILITY ACTION:**
- Identify who completes the assessment
- How often the assessment is completed
- Decide on a communication plan
- Update and revise the plan as needed

**Education regarding Patient Assessment Tools:**
Prior to using the algorithms, an assessment of the patient needs to be completed
- Patient Factors, Other Factors, Special Considerations
- Red Flags Checklist for Transfers
  - Weight Bearing Capability
  - Quick Checklists for Bed Repositioning.
- Caregiver Skill Assessment Tool
- Readiness for Transfer
- Patient Levels of Assistance (Independent, Supervised/Standby, Minimal Assist, Moderate Assist, Dependent)

**Hands-on Training Integrating Algorithms with Equipment Instruction**

**Technique Training Guidelines**

This section brings all the tools together. Prior to performing the patient handling task, the patient assessment and level of assistance is identified and communicated through the logo system, the number of people and equipment required has been identified by using the algorithms. HCWs should now understand the theory and application that brought them to these decision points.

The following pages include the clinical training guidelines for safe patient handling and movement. They are recommended for use by the educators as benchmarks.
HCWs should meet to be considered competent in the return demonstration. The guidelines begin with identifying the algorithm for the task. Within the next portion of the section, the algorithm, the logo and assessment are reflected based on the patient assessment.

The task is then described using the benchmarks for return demonstration. The educator can use them to create a checklist, or use them as a reference, or modify them to suit their training needs.

**Note:** These guidelines are very general and do not include the specifics that pertain to different models of equipment. For example, each manufacturer has recommendations that vary, such as when to apply brakes on a lift. The techniques recommended for FRDs may be specific to only a few models or types. Therefore, where available, additional resources known as Safe Work Procedures have been provided with this manual. These procedures offer step by step instructions linking the specific tasks to equipment. They can include pictures or videos.

**FACILITY ACTION:**

- Develop Safe Work Procedures specific to your facility's equipment, patient population and desired tasks.
Table of Contents: Algorithms and Patient Handling

Algorithm 1 Sit to Sit (Chair to Toilet, Chair to Chair, Car to Chair, Bed to Chair)

**Competency Guidelines:**
- Independent
- Supervised (standby by assist)
- Minimal assist to stand with gait/transfer belt (1 person & 2 person)
- Moderate assist with sit to stand equipment
- Total assist with mechanical lift equipment

Algorithm 2 Lie to Lie (Lateral Transfer To and From: Bed to Stretcher or Trolley)

**Competency Guidelines:**
- Independent
- Total Dependency Assist
  - Transfer using FRD slider sheets and tube
  - Insertion of FRDs using tuck technique
  - Insertion of FRDs using fold technique
  - Moving patients across surfaces on FRD sheets (2)
  - Moving patients on full length FRD tube sliders
  - Moving patients with ceiling lifts

Algorithm 3 Sit to Lie (Transfer To and From: Chair to Bed/ Stretcher or Chair to Exam Table)

**Competency Guidelines:**
- Independent
- Minimal Assist
  - Over 155 lbs (Transfer Belt and 1 Caregiver)
  - 155 - 250 lbs (Transfer Belt and 2 Caregivers)
  - Over 250 lbs (Sit-Stand Lift)
- Moderate Assist - Sit-Stand Lift
- Total Assist - Total Lift

Algorithm 4 Bed Repositioning

**Competency Guidelines:**
- Independent
- Minimal Assist - Bed boost
- Moderate Assist - Bed boost
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Total Assist:
- Insertion of FRD using tuck technique
- Insertion of FRD using fold technique
- Reposition using FRDs - up in bed
- Reposition using FRDs - side to side
- Reposition using mechanical lift and repositioning sheet (sling)

Algorithm 5 Chair Repositioning

Competency Guidelines:
- Independent
- Partial Assist using verbal cues
- Moderate Assist
  - using pillow to knee technique
  - using small slider tube technique
- Dependent Assist
  - mechanical lift and sling technique
  - Sling insertion using FRD while sitting

Algorithm 6 Up from Floor

Competency Guidelines:
- Independent
- Partial assist using verbal cues and a chair
- Moderate assist, dependent assist
  - using lift device
  - using HoverJack

Assist to Sit from Lying

Competency Guidelines
- Independent
- Minimal Assist verbal cues
- Partial Assist
- Moderate Assist
  - one person assist to sit from lying technique
  - two person assist to sit from lying using FRDs
  - two person assist to sit from lying (no FRD)
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Definitions of Patient Abilities to Support the Safe Patient Handling Guidelines
These definitions are provided for nurses and healthcare aides and are to be used in conjunction with the algorithms, communication tools, and safe work procedures. Allied healthcare professionals providing rehabilitation support for mobility such as ambulation and transferring may have different definitions that guide the level of assistance they provide.

Independent
- Requires no assistance, patient moves independently

Supervised
- Requires assistance with equipment, environment and or footwear, set-up or verbal reminders
- Cooperates and follows directions
- Walks with or without equipment (e.g. cane or walker) unassisted
- No physical assistance from HCW required

Minimal Assist
- May need minor physical assistance
  - HCW is not required to lift more than 16kg (35 lbs) of a patient’s weight at anytime during the task
- May need to use equipment
- May need verbal cuing or coaching.
Sample: bed boosting/repositioning with a slider in which the HCW holds the legs.

Minimal Assist with Transfer/Gait Belt 1-2 HCWs
- When using a transfer/gait belt, the patient is fully weight bearing once standing and requires slight exertion from the HCW to rise to a stand. The HCW should not be required to lift more than 16 kg (35 lbs) of a patient’s weight at anytime during the task. If the patient cannot participate at this level then the task becomes a moderate assist. Please note that patients that require close to this threshold of assistance present the greatest risk for injury to the HCWs.

Moderate Assist/Partially Dependent
- If the HCW is required to lift more than 16kg (35lbs) of a patient’s weight at anytime during a task (i.e. physical support for trunk or leg is required during either transfer or ambulation), the patient would be classified as
Chapter 3.0 Program Essentials

partially dependent or requiring moderate assistance. Equipment such as sit to stand devices or FRDs are necessary and must be incorporated in these types of handling and movement tasks, often along with 2 or more HCWs, to reduce the physical stress on the HCW(s) assisting with the task. The determination of the amount of equipment and HCW support required is provided in the safe patient handling algorithms. Note that equipment must be the first option as opposed to adding more HCWs to the task.

Maximum Assist /Totally Dependent

- If the patient is incapable of safely participating in any or all of their movement tasks, such as turning, repositioning, standing, walking and/or transferring, they would be classified as totally dependent or requiring full/maximum assistance. There are several key elements of a patient’s status that determine this classification, including the inability to follow directions, the inability to weight bear, unpredictable behaviour, or the inability to provide the level of exertion or strength required to safely perform the task due to a medical condition. In these situations, the HCW should use the identified equipment and number of HCWs to provide the physical supports and assistive devices required as recommended for practice in the safe patient handling algorithm guidelines.
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Algorithm 1 – Sit to Sit
(Chair to Toilet, Chair to Chair, Car to Chair, Bed to Chair)

1. Refer to Patient Handling Guidelines for Uncooperative Patients for assistance in determining the safest course of action
2. A total lift device refers to a floor or ceiling track sling lift. A ceiling track lift is recommended. If a floor lift is used, the care provider must ensure that the base of the lift will pass freely under the bed/chair/table prior to use.
3. 'Minimal assistance’ means that the HCW is required to lift no more than 16 kg (35 lbs) of a patient’s weight when providing physical assistance to the patient during any transferring task
   - Any task requiring the HCW to lift more than 16 kg (35 lbs) of a patient’s weight would be classified as either a 'Moderate Assist' or a ‘Total Assist’ (Non-weight bearing) task, depending on the patient’s weight bearing status. These tasks should only be performed with the use of assistive devices (sit-stand aid, lift, etc.).
4. This is not a Pivot Transfer. Assistance is provided during the ‘standing’ and ‘sitting’ motions only. Patient must be assessed as being able to ambulate consistently & reliably once in a standing position in order to proceed with this technique.
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Algorithm 1: Sit to Sit (Chair to Toilet, Chair to Chair, Car to Chair, Bed to Chair)

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment:</strong> Independent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO ASSISTANCE REQUIRED</td>
<td></td>
</tr>
<tr>
<td><strong>Task:</strong> Assist to stand in order to transfer to chair/commode using verbal cues</td>
<td>1 worker Cane, walker</td>
<td>HCW will demonstrate the ability to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure space, assistive devices and environment appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ability to use verbal cueing as required, coaching the patient through the task.</td>
</tr>
<tr>
<td><strong>Assessment:</strong> Supervised</td>
<td></td>
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<tr>
<td></td>
<td>STANDBY ASSIST See Sample SWP 001</td>
<td></td>
</tr>
<tr>
<td><strong>Task:</strong> Assist to stand to transfer to chair using 1-2 HCWs and a transfer/gait belt.</td>
<td>Transfer/Gait belt (1 person assist)</td>
<td>HCW will demonstrate the ability to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Set up environment appropriately for the task</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Choose and apply gait/transfer Belt Correctly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Position the bed appropriately for the patient’s height</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Position self appropriately on either side of patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use proper body mechanics and technique throughout the maneuver.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use verbal cueing as required, coaching the patient through the task.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Demonstrate appropriate technique to rise:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cue and assist the patient to lower to a sitting position</td>
</tr>
</tbody>
</table>
## Chapter 3.0 Program Essentials

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="HCW(s) / Equipment Competency Objectives for HCW Demonstration" /></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Task:  
Transfer to chair assisting to stand with 2 HCWs

**Assessment:**  
Minimal Assist

**HCW will demonstrate the ability to:**
- Set up environment, chairs and bed height appropriately for the task.
- Choose and apply gait/transfer belt correctly.
- Position self appropriately on either side of patient.
- Use proper body mechanics and technique throughout the maneuver.
- Use verbal cueing as required, coaching the patient through the task.
- Demonstrate the appropriate technique to rise.
- Assist the patient to lower to a sitting position appropriately.

### Task: Transfer to chair with sit to stand lift

**Assessment:**  
Moderate Assist

**HCW will demonstrate the ability to:**
- Identify from the algorithm, assessment and logo the number of people needed to perform the task safely.
- Identify how to access sit-stand lift and slings.
- Identify the weight limit of the lift.
- Perform the pre-inspection on equipment.
- Operate the controls of the mechanical features on the equipment (including: on/off controls, remote control, manual control, and how they work).
- Use of the emergency release (down) function feature.
- Identify battery charge level and procedure to recharge.
- Set up the environment and space appropriately prior to performing the lift i.e. chair location.
- Choose the appropriate sling (by size & weight limit), inspect and apply it appropriately.
- Use verbal cueing as required, coaching the patient.
### Chapter 3.0 Program Essentials

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task: transfer to chair with mechanical lift.</td>
<td>Mechanical ceiling or floor lift with slings and 2 HCWs</td>
<td>through the task.</td>
</tr>
<tr>
<td>Assessment: Maximum Assist/Totally Dependent x</td>
<td></td>
<td>• Safely operate the lift during the transfer procedure.</td>
</tr>
<tr>
<td>See Sample SWP 008</td>
<td></td>
<td>• Verbalize how equipment and slings are laundered, cleaned and accessed (identify facilities process.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCW will demonstrate the ability to:</td>
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<tr>
<td></td>
<td></td>
<td>• Set up environment space, and equipment correctly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify the correct number of people according to the algorithm to assist with the task.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Choose correct weight rated equipment and sling.</td>
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<td></td>
<td></td>
<td>• Identify weight capacity of the lift and sling.</td>
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<td></td>
<td></td>
<td>• Perform a proper pre-inspection of the lift and sling.</td>
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<tr>
<td></td>
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<td>• Operate controls including emergency stops.</td>
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<tr>
<td></td>
<td></td>
<td>• Check the battery level and method of recharging.</td>
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<tr>
<td></td>
<td></td>
<td>• Safely apply and remove of the sling</td>
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<tr>
<td></td>
<td></td>
<td>• Safely operate the lift device.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Verbalize the facilities process for cleaning and accessing equipment and slings.</td>
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<tr>
<td></td>
<td></td>
<td>• Use verbal cueing as required, coaching the patient through the task.</td>
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</tbody>
</table>
Algorithm 2 – Lie to Lie
(Lateral Transfer To and From: Bed to Stretcher, Trolley)

This algorithm is designed for clinical situations when a patient is to be moved laterally between two of the following: bed, stretcher, trolley, or table (exam, treatment, surgical).

**Start Here**

- **Is patient cooperative?**
  - **NO**
    - **Stop.** Refer to Care Plan or perform further assessment. 1
  - **YES**
    - **Can patient perform transfer independently?**
      - **NO**
        - HCW assistance not needed. Standby for safety as needed
      - **YES**
        - **Is patient’s weight > 159kg (350 lbs)?**
          - **YES**
            - Refer to Bariatric Algorithm
          - **NO**
            - **Is patient on a backboard?**
              - **YES**
                - Use 2 FRD sheets under patient with extension straps and 2 HCWs plus an additional FRD sheet on receiving surface
              - **NO**
                - **Is a ceiling lift available?**
                  - **YES**
                    - Use hammock or repositioning sling with 2 or more HCWs
                  - **NO**
                    - **What is patient’s weight?**
                      - **< 45 kg (100 lbs)**
                        - Use 2 FRD sheets under patient with extension straps and 2 HCWs
                      - **45 – 91 kg (100 – 200 lbs)**
                        - Use 2 FRD sheets under patient with extension straps and 2 – 3 HCWs plus an additional FRD sheet on receiving surface
                      - **91 – 159 kg (200 – 350 lbs)**
                        - Use 2 FRD sheets under patient with extension straps and 3 – 4 HCWs plus an additional FRD sheet on receiving surface

**SAFETY TIPS**

- Refer to Safe Patient Handling Safe Work Procedures about this task for technical reference
- Receiving surface should be slightly lower (5cm / 2 in.) than starting surface
- Care should be taken to avoid shearing forces on the skin, especially for patients with Stage III or IV pressure ulcers
- 1. Refer to Patient Handling Guidelines for Uncooperative Patients for assistance in determining the safest course of action
### Algorithm 2–Lie to Lie (Lateral Transfer to and from: Bed to Stretcher, Trolley)

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task:</strong> Lateral Transfer Assessment: Independent or Supervised Minimal Assist</td>
<td>Stretcher 2 HCWs</td>
<td>HCW will demonstrate the ability to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Arrange environment appropriately</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure brakes are applied on stretcher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cue patient to safely perform the transfer while securing stretcher.</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Task:</strong> Lateral transfer with FRD Assessment: Moderate Assist or Maximum Assist/Dependent</td>
<td>Friction Reducing Devices (FRD sheets / sliders / tubes Air pal, HoverMatt™)</td>
<td>HCW will demonstrate the ability to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify from the algorithm, assessment and logo the number of people needed to perform the task safely.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Set up the environment, including bed and stretcher for a lateral transfer using FRDs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify the facility’s FRDs used during transfer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify how to access FRDs (Where to find, how to order) and cleaning procedures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Properly insert the slider under the patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use proper body mechanics and technique when moving the patient on and off the stretcher.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Properly remove the FRD.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use verbal cueing as required, coaching the patient through the task.</td>
</tr>
</tbody>
</table>
**Assessment & Equipment**

**HCW(s) / Equipment**  
See Sample SWPs 005 & 006

<table>
<thead>
<tr>
<th>Lateral Transfer With Ceiling Lift Device</th>
<th>Ceiling Lift</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>Requires appropriate track set-up and/or adequate space to move beds/stretchers</td>
<td></td>
</tr>
<tr>
<td>Assist/Partially Dependent or Max</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assist/Totally dependent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HCW will demonstrate the ability to:**

- Demonstrate the correct procedure for attaching and removing from ceiling track (if portable ceiling lift is used). See separate SWP
- Inspect ceiling lift and operation of controls and emergency release, stops etc.
- Choose correct sling for task, inspect the sling and apply correctly under the patient.
- Apply the sling correctly to the spreader bar.
- Perform the technique of the transfer using correct body mechanics, and safe operation of the lift.
- Determines patient’s tolerance of lift and sling fit and reacts appropriately.
- Remove the sling correctly or verbalize when the sling can be left under the patient (some repositioning slings can be left under patients).
- Identify facility practices for laundering and storage of slings.
- Ensure fixed ceiling lift returns to docking station.
- If portable ceiling lift is used, ensure it is stored and charged properly.
Algorithm 3: Sit to Lie
– Chair to Bed/Stretcher or Chair to Exam Table

1. Refer to Patient Handling Guidelines for Uncooperative Patients for assistance in determining the safest course of action.
2. A total lift device refers to a floor or ceiling track sling lift. A ceiling track lift is recommended. If a floor lift is used, the care provider must ensure that the base of the lift will pass freely under the bed/chair/table prior to use.
3. ‘Minimal assistance’ means that the HCW is required to lift no more than 16 kg (35 lbs) of a patient’s weight when providing physical assistance to the patient during any transferring task.
   - Any task requiring the HCW to lift more than 16 kg (35 lbs) of a patient’s weight would be classified as either a ‘Moderate Assist’ or a ‘Total Assist’ (Non-weight bearing) task, depending on the patient’s weight bearing status. These tasks should only be performed with the use of assistive devices (sit-stand aid, lift, etc.).
4. This is not a Pivot Transfer. Assistance is provided during the ‘standing’ and ‘sitting’ motions only. Patient must be assessed as being able to ambulate consistently & reliably once in a standing position in order to proceed with this technique.
   - Do not allow patient to lean on worker. Provide canes or walker as an alternative.
## Algorithm 3 - Sit to Lie (Chair to bed/Stretcher or Chair to Examination Table)

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for Worker Demonstration</th>
</tr>
</thead>
</table>
| **Task:** Transfer patient onto stretcher or exam table.  
Assessment: Independent or Supervised | Stretcher or Table (height-adjustable)  
Sit to Stand lift  
1 HCW | HCW will demonstrate the ability to:  
- Arrange environment appropriately, e.g. apply brakes to both surfaces, adjust heights, etc  
- Cue patient to safely perform the transfer while securing stretcher. |
| **Task:** Transfer from Wheelchair to exam table with sit to stand lift  
Assessment: Minimal Assist or Moderate Assist  
Partially dependent | | |
| See Sample SWP 007 | | |
| **Task:** Transfer from Wheelchair or chair to treatment table or exam table.  
Assessment: Moderate Assist  
Partially dependent; Maximum Assist /Dependent | Stretcher or Table (Not height-adjustable)  
Mechanical lift device (floor or ceiling) | HCW will demonstrate the ability to:  
- Set up environment space, and equipment correctly  
- Determine if the sit to stand lift can interface with the exam table prior to performing the transfer.  
- Identify the correct number of people according to the algorithm to assist with the task.  
- Choose correct weight rated equipment and sling.  
- Identify weight capacity of the lift and sling.  
- Perform a proper pre-inspection of the lift and sling.  
- Safely operate controls including emergency stops.  
- Check the battery level and method of recharging.  
- Safely apply and remove the harness.  
- Safely operate the lift device.  
- Use proper body mechanics and techniques when operating the lift.  
- Use verbal cueing as required, coaching the patient through the task.  
- Verbalize the facility process for cleaning and accessing equipment and slings. |
<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for Worker Demonstration</th>
</tr>
</thead>
</table>
| ![Assessment Logo](image.png) | Total lift Mechanical floor lift or ceiling lift. See Sample SWP 008 | • Verbalize the facilities process for cleaning and accessing equipment and slings.  
• Use verbal cueing as required, coaching the patient through the task. |
Chapter 3.0 Program Essentials

Algorithm 4 – Bed Repositioning

Start Here

Is patient cooperative? NO

NO

Refer to Bariatric Algorithm

YES

Is patient’s weight > 159 kg (350 lbs)?

YES

Refer to Bariatric Algorithm

NO

Use a Friction Reducing Device (FRD)

Can patient assist?

NO

Encourage patient to assist using a repositioning aid and/or cues

Minimal Assist: HCW to assist patient using FRD

Patient’s weight: < 91 kg (200 lbs)
Use FRD & 2 - 3 HCWs

Patient’s weight: 91 – 159 kg (200 – 350 lbs)
Use FRD and at least 3 HCWs

Verbal Assist: Cue patient to use FRD.
HCW may need to stabilize patient’s feet on bed (Bed Boost)

Patient’s weight: > 159 kg (350 lbs)
Use FRD & 2 - 3 HCWs

Or

Use repositioning sling with ceiling lift and 2 or more HCWs

FULLY INDEPENDENT

HCW assistance not needed. Patient may/may not require a repositioning aid.

STOP.

Refer to Care Plan or perform further assessment.

SAFETY TIPS

DO NOT PULL FROM THE HEAD OF BED

- When assisting a patient up in bed, the side rail should be down and the bed should be flat or in a Trendelenburg position (when tolerated) to use gravity as an aid
- Care should be taken to avoid shearing forces on the skin, especially for patients with Stage III or IV pressure ulcers
- The height of the bed should be appropriate to ensure caregiver safety (waist height of shortest caregiver involved at the time)
- Patients able to assist should be instructed & cued on how to participate & when to do so
- Assistive devices should be used for the transfer if any caregiver is required to lift more than 35 lbs (16 kg) of a patient’s weight during any patient transferring task

1. Refer to Patient Handling Guidelines for Uncooperative Patients for assistance in determining the safest course of action
### Algorithm 4 – Bed Repositioning

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s)/Equipment</th>
<th>Competency Objectives for HCW Demonstration Template</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task:</strong> Repositioning in bed</td>
<td>Trapeze bar or side rails</td>
<td>Be sure that appropriate support equipment devices are available to maintain patient's independence.</td>
</tr>
<tr>
<td><strong>Assessment:</strong> Independent or Supervised</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task:</strong> Bed repositioning up in bed with One HCW, FRD and verbal cues</td>
<td>Friction Reducing Device (FRD) 1 HCW</td>
<td>HCW will demonstrate the ability to:</td>
</tr>
<tr>
<td><strong>Assessment:</strong> Minimal Assist - hands on</td>
<td></td>
<td>- Identify from the algorithm, assessment and logo the number of people and equipment needed to perform the task safely.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Identify how to access friction reduction slider sheets (where to find, how to order)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Explain cleaning process as per facility guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assist patient to apply the FRD correctly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Coach patient into correct body position, and provide cues perform the tasks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Repeat the task until desired distance of bed boost is achieved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Coach patient to use bed features and devices to turn onto side.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ensure patient comfort</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Remove FRD appropriately.</td>
</tr>
<tr>
<td><strong>Task:</strong> Bed repositioning up in bed with one HCW, FRDs and verbal cues</td>
<td>Friction Reducing Device (FRD) 1 HCW</td>
<td>Bed Boost Patient Cues - small tube sliders and assist with leg support.</td>
</tr>
<tr>
<td><strong>Assessment:</strong> Moderate Assist</td>
<td></td>
<td>HCW will demonstrate the ability to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Identify from the algorithm, assessment and logo the number of people and equipment needed to perform the task safely.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Identify how to access friction reduction slider sheets (where to find, how to order)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Explain cleaning process as per facility guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assist patient to apply the FRD correctly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Set the correct bed height to assist with the task</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Coach patient into correct body position, and cue to perform the task.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Use correct body postures and technique when holding patients legs.</td>
</tr>
</tbody>
</table>
### Chapter 3.0 Program Essentials

#### Task: Bed repositioning up in bed with 2-4 HCWs, FRDs and verbal cues

**Assessment:**
- Maximum assist/totally Dependent

**HCW(s)/Equipment:**
- Friction Reducing Device: tubes, slider sheets, or other FRD. Minimum 2 HCWs

#### Competency Objectives for HCW Demonstration Template
- Repeat the task until desired distance of bed boost is achieved.
- Coach patient to use bed features and devices to turn onto side.
- Ensure patient comfort
- Assist patient to turn on side and removes FRD appropriately

#### Task: Repositioning In Bed Using Repositioning Sheet, Ceiling lift and 2-4 HCWs.

**Assessment:**
- Maximum Assist/Totally Dependent

**HCW(s)/Equipment:**
- Repositioning Sheet
- Mechanical Lift
  - Floor Lift
  - Ceiling lift

The ceiling lift is the preferred choice for this task 2 HCWs minimum

#### Competency Objectives for HCW Demonstration Template
- Several Options and techniques available for this task depending on the type of FRD used.
- HCW will demonstrate the ability to:
  - Identify from the algorithm, assessment and logo the number of people needed to perform the task safely.
  - Demonstrate how to set up the environment, including bed and stretcher for a lateral transfer using Friction Reducing Devices (FRD)
  - Identify the facility FRDs to be used during transfer
  - Identify how to access FRDs (Where to find, how to order) and cleaning procedures.
  - Determine if sliders will be inserted using tuck or alternative method, based on patient assessment.
  - Properly insert the FRD.
  - Use proper body mechanics and technique when moving the patient.
  - Communicate effectively with co-workers using verbal cues such as counting (“one, two, three, move”).
  - Demonstrate proper removal of the FRD.

This procedure follows the Ceiling lift basic procedure and incorporates the extra specifics of the repositioning sheet sling.

HCW will demonstrate the ability to:
- Properly load and unload the lift from the ceiling track, if a portable ceiling lift is used,
- Inspect ceiling lift and demonstrate operation of controls and emergency release, stops, etc.
- Choose correct size repositioning sling for task, inspect the sling and apply the sling correctly under patient.
- Connect sling appropriately to the spreader bar using proper loop configuration.
- Observe the patient for tolerance as lift is rising, and adjust accordingly.
- Perform the technique of the transfer using correct body mechanics, and safe operation of the lift.
- Remove the sling correctly if it needs to be changed or
### Competency Objectives for HCW Demonstration Template

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s)/Equipment</th>
<th>Competency Objectives for HCW Demonstration Template</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Sample SWP 009</td>
<td></td>
<td>determination has been made that it cannot be left under the patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Verbalize skin inspection and assessment needs to be performed if sling is left under patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Verbalize contraindications for leaving sling under patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Identify facility practices for laundering and access of slings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ensure the fixed ceiling lift returns to docking station.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ensure portable ceiling lift is properly stored and charged.</td>
</tr>
</tbody>
</table>
Chapter 3.0 Program Essentials

Algorithm 5 – Chair Repositioning

Start Here

Is the patient cooperative?

YES

Is patient’s weight > 159kg (350 lbs)?

YES

Refer to Bariatric Algorithm

NO

Can Patient Assist?

YES

What is patient’s level of assistance?

INDEPENDENT

PARTIAL ASSIST

➢ Place patient’s feet on floor
➢ Put FRD tube (small) slider underneath buttocks
➢ Have patient push with arms if able
➢ Remove FRD

NO

Does the chair recline?

YES

➢ Recline chair
➢ Insert FRD tube or FRD sheet folded in half to perform boost up in chair

NO

Use total lift device. It is suggested that this patient should be in a reclining chair

Stop.

Refer to Care Plan or perform further assessment.

1

Refer to Bariatric Algorithm

HCW assistance not needed. Stand by for safety as required.

What is patient’s level of assistance?

INDEPENDENT

PARTIAL ASSIST

➢ Place patient’s feet on floor
➢ Put FRD tube (small) slider underneath buttocks
➢ Have patient push with arms if able
➢ Remove FRD

Safety Tips

➢ DO NOT PULL FROM BEHIND CHAIR
➢ This is ideally a two-person task but can be performed as a one-person task only if assessed as safe for the patient and HCW
➢ Make sure chair wheels are locked
➢ Take full advantage of chair functions (e.g. chair that reclines) or use of chair armrest to facilitate repositioning

1. Refer to Patient Handling Guidelines for Uncooperative Patients for assistance in determining the safest course of action
### Algorithm 5 – Chair Repositioning

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment:</strong> Independent</td>
<td></td>
<td>• Patient repositions self</td>
</tr>
</tbody>
</table>
| **Assessment:** Supervised and or Minimal Assist | | HCW will demonstrate the ability to:  
  • Remind patient to lock wheelchair before doing task.  
  • Provide verbal cues to assist patient when repositioning. |
| **Task:** Reposition in Chair with one HCW assisting and pillow technique. | Pillow for knee on floor 1 HCW (Performing task with FRD is preferable) | HCW will demonstrate the following:  
  • Identify the number of people and task as per the algorithm and assessment guidelines.  
  • Ensure environment, and setting of equipment is safe and conducive to the task.  
  • Use verbal cueing as required, Coaching the patient through the task.  
  • Demonstrate the technique using the pillow according to SWP. |
| **Assessment:** Minimal Assist/Partially Dependent | | | |
| See Sample SWP 010 | | |
| **Task:** Reposition in chair using FRD and 1-2 HCWs. | Small Tube Slider or FRD Sheet 2 HCWs | HCW will demonstrate the ability to:  
  • Identify the number of people and task as per the algorithm and assessment guidelines.  
  • Ensure environment, and setting of equipment is safe and conducive to the task.  
  • Cue and communicate the procedure and the patient's role to the patient effectively.  
  • Prepare the chair and the slider device properly.  
  • Insert the FRD appropriately.  
  • Move the patient using proper techniques and body mechanics appropriately.  
  • Secure the patient before removing with FRD.  
  • Remove the FRD safely. |
| **Assessment:** Moderate Assist/partially dependent or Maximum Assist/Totally Dependent | | | |
| See Sample SWP 011 | | |
### Chapter 3.0 Program Essentials

#### Task: Reposition in Chair using mechanical lift and sling and 1-2 HCWs

#### Assessment: Maximum Assist/Dependent

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mechanical lift could be floor lift, ceiling lift or portable ceiling lift and sling, and an FRD</td>
<td>HCW will demonstrate the ability to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Properly load and unload the lift from the ceiling track, if a portable ceiling lift is used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inspect ceiling lift and demonstrates operation of controls and emergency release stops etc. if required.</td>
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<tr>
<td></td>
<td></td>
<td>• Inspect mechanical floor lift if it is the lift chosen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Choose correct size and type of sling for task.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inspect the sling and apply correctly under the patient using the FRD method for a patient in chair.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Attach sling appropriately to the spreader bar using proper loop/clip configuration.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Observe the patient for tolerance as lift is rising, and adjust accordingly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Perform the technique of the transfer using correct body mechanics, and safely operate the lift.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Remove the sling correctly using an FRD.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure safety and comfort by securing safety straps and providing pillows supports.</td>
</tr>
<tr>
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<td></td>
<td>• Verbalize the skin inspection and assessment needs to be performed if sling is left under patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Verbalize contraindications for leaving sling under patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify facility practices for laundering and access of slings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure the fixed ceiling lift returns to docking station.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure portable ceiling lift is properly stored and charged.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure the floor lift is properly cleaned, stored and charged.</td>
</tr>
</tbody>
</table>

See Sample SWP 008
Chapter 3.0 Program Essentials

Algorithm 6 – Up From Floor

Patient on floor

Refer to Bariatric Algorithm

Is patient’s weight > 159kg (350 lbs)?

Yes

Was the patient injured?

Yes

Is patient in Home Care environment?

Yes

Assess for fracture or spinal cord injury. Does patient need immobilization technique? 1

If patient is in cardiac arrest, activate EAP, initiate CPR and wait for emergency response team before moving

If spinal board is required, use 2 FRD sheets to transfer patient onto spinal board

Obtain low stretcher

Lift patient (on spinal board) onto low-lying stretcher using 6 HCWs

Alternatively, a scoop stretcher may be used if HCWs are familiar with its use

Using a Hover Jack (if available) with the spinal board is another option

NO

Can the patient assist?

Yes

HCW to stabilize a chair beside patient

Cue patient to use own strength and chair to raise self

Do not tug on patient or attempt to lift them

NO

NO

Contact patient’s family or legal caregiver

Contact supervisor (or After Hours Service) for assistance and instruction

Contact EMS when authorized to do so

Can the patient assist?

YES

SAFETY TIPS

These techniques should not be attempted without adequate equipment and staff resources present

DO NOT LIFT PATIENT OFF FLOOR

DO NOT ALLOW PATIENT TO LEAN ON HCW FOR SUPPORT

1. Immobilization Technique: Use spinal precautions if hip, pelvic or vertebral fractures are suspected – DO NOT USE LIFT

NO

YES

Can the patient assist?

NO
## Algorithm 6 – Up From Floor

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task:</strong> Transfer off floor with verbal cues&lt;br&gt;<strong>Assessment:</strong> Independent or Supervised or Minimal Assist</td>
<td>Verbal cues, one chair and 1 HCW</td>
<td>HCW will demonstrate the ability to:&lt;br&gt;• To identify who the most appropriate HCW to assess the patient for injuries as per facility/program policy&lt;br&gt;• Identify that the patient meets the criteria below to be assisted through verbal cues.&lt;br&gt;<strong>Criteria:</strong>&lt;br&gt;• The patient has stated they have no injuries.&lt;br&gt;• The patient is able to move on their own.&lt;br&gt;• An appropriate stable chair is available and can be secured for the patient.&lt;br&gt;• The patient can understand and follow appropriate verbal cues. Cue patient to sit up on floor and position into side sitting.&lt;br&gt;• Ensure patient is not pulling on HCW and HCW is not pulling on patient to assist. Hands off patient as much as possible.&lt;br&gt;• If HCW identifies if patient is having difficulty they must use the next level of mechanical assistance available.&lt;br&gt;• Cue patient to sit on chair.&lt;br&gt;• Assesses patient’s ability to walk to bed. If patient has a walker or cane then provide. If patient cannot walk steadily then provide wheelchair transport.</td>
</tr>
<tr>
<td><strong>Task:</strong> Assist off the floor with lift device&lt;br&gt;<strong>Assessment:</strong> Injured. Moderate Assist/Partially Dependent or Maximum Assist /Totally Dependent</td>
<td>Mechanical lift with sling and FRDs. Minimum 2 HCWs</td>
<td>HCW will demonstrate the ability to:&lt;br&gt;• Assess the patient for injuries by:&lt;br&gt;  ➢ having assessed by a doctor or nurse to rule out hidden injuries.&lt;br&gt;  ➢ question patient who relates they do not have symptoms of injury.&lt;br&gt;• State they will ensure patient comfort by providing a pillow and blanket while organizing next steps.&lt;br&gt;• Choose the correct equipment and number of people based on the algorithm and patient assessment.&lt;br&gt;• Explain pre-operative inspection of the lift,&lt;br&gt;• Identify the safe work load rating of the lift.&lt;br&gt;• Identify that lift is appropriately charged and method of recharging.&lt;br&gt;• Safely operate the controls of the lift, including emergency stop and lowering of boom.&lt;br&gt;• Ensure environment and space is conducive to</td>
</tr>
</tbody>
</table>
### Assessment & Logo

<table>
<thead>
<tr>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
</table>
| Inflatable Lift Device (i.e. HoverJack™) with FRD 2-4 HCWs | operating lift while patient is on the floor.  
  - Ensure the receiving surface (bed or wheelchair has breaks on correctly).  
  - Identify if space is inadequate. Identify that FRDs are required to bring patient into an open area or furniture must be removed from the area.  
  - Choose and inspect correct sling.  
  - Identify methods to insert sling under patient and identify rationale for method chosen.  
  - Communicate appropriately with patient explaining procedure.  
  - Insert sling appropriately.  
  - Place the lift in appropriate position as per manufacturers’ guidelines and injury or space limitations to lift patient from floor (may need to lift patient’s legs).  
  - Appropriately use the controls to lower spreader bar.  
  - Safely apply and remove the sling.  
  - Maintain safe work posture and ergonomics when attaching the sling to lift.  
  - Safely operate the lift and assess patient tolerance.  
  - Safely transport the patient in the lift (short distances at correct height).  
  - Position patient correctly on receiving surface.  
  - Remove sling and lift appropriately. |

### Task:
Assist patient off floor onto stretcher or bed with air device

**Assessment:** Minimal Assist; Moderate Assist/Partially Dependent; or Maximum Assist/Dependent

See Sample SWP 014

Assessment has determined that the patient needs assistance to rise off the floor. The following steps are specific to the use of HoverJack™ and can be modified for other inflatable lift devices as per manufacturers’ guidelines.

HCW will demonstrate the ability to:

- Ensure patient comfort by providing a pillow and blanket while organizing next steps.
- Choose the correct equipment and number of people based on the algorithm and patient assessment.
- Obtain all equipment and HCWs needed to perform this procedure.
- Use FRD’s to bring patient into an area where the Hoverjack can be used.
- Arrange the work space and environment appropriately, and identifies receiving equipment and pathway if applicable.
- Communicate with the patient.
- Prepare the HoverJack™ appropriately.
### Chapter 3.0 Program Essentials

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) / Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Transfer patient onto the deflated HoverJack™ using appropriate FRD procedures.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inflate the HoverJack™ correctly, ensuring the patient is centered.</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Ensure safety belts are applied once HoverJack™ is inflated. Either transports the HoverJack™ to the receiving bed or stretcher or brings the bed or stretcher to the HoverJack™.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Perform the lateral transfer using FRD’s as per the lateral transfer SWP.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Ensure patient is safely positioned and comfortable.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Deflate equipment, remove equipment properly and make appropriate arrangements for cleaning and storage.</strong></td>
</tr>
</tbody>
</table>
## Chapter 3.0 Program Essentials

### Assist to Sit From Lying - No Algorithm

<table>
<thead>
<tr>
<th>Assessment &amp; Logo</th>
<th>HCW(s) /Equipment</th>
<th>Competency Objectives for HCW Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supervised</strong></td>
<td></td>
<td>HCW will demonstrate the ability to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Raise head of bed to lessen distance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Verbal cues only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Instruct patient to lie on side facing direction they will exit bed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use other arm to push off the bed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Swing legs simultaneously to sitting position.</td>
</tr>
</tbody>
</table>

| **Minimal Assist** |                   | HCW will demonstrate the ability to:       |
|                   |                   | • Raise head of bed to lessen distance.    |
|                   |                   | • Ask patient to sit forward.              |
|                   |                   | • Slide legs over bed side, if assistance is necessary (CAUTION: do not lift). |
|                   |                   | • Use proper body mechanics and technique throughout the maneuver. |
|                   |                   | • Use verbal cueing as required, coaching the patient through the task. |
|                   |                   | • Perform the appropriate technique to assist patient to rise. |
|                   |                   | • Steady patient once in sitting position. |

<table>
<thead>
<tr>
<th><strong>Moderate Assist</strong></th>
<th>1 Person Assist with Equipment Aids (Poles, Arco Rail)</th>
<th>HCW will demonstrate the ability to:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess the status of the patient to perform this task. Allied Health may need to determine whether this is a 1 or 2 person assist. Patient must be able to push up off hand and arm.</strong></td>
<td></td>
<td><strong>One Person Assist to Sit From Lying</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Raise head of bed to lessen distance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ask patient to sit forward.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Slide legs over bed side, if assistance is necessary (CAUTION: do not lift).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use proper body mechanics and technique throughout the maneuver.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use equipment as per manufacturers' guidelines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use verbal cueing as required, coaching the patient through the task.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Perform the appropriate technique to assist patient to rise.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Steady patient once in sitting position.</td>
</tr>
</tbody>
</table>
### Chapter 3.0 Program Essentials

<table>
<thead>
<tr>
<th>2 Person Assist Sit From Lying</th>
<th>Two Person Assist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Raise head of bed to lessen distance.</td>
</tr>
<tr>
<td></td>
<td>• Ask patient to sit forward.</td>
</tr>
<tr>
<td></td>
<td>• Slide legs over bed side, if assistance is necessary (CAUTION: do not lift).</td>
</tr>
<tr>
<td></td>
<td>• Use proper body mechanics and technique throughout the maneuver.</td>
</tr>
<tr>
<td></td>
<td>• Use equipment as per manufacturers’ guidelines.</td>
</tr>
<tr>
<td></td>
<td>• Use verbal cueing as required, coaching the patient through the task.</td>
</tr>
<tr>
<td></td>
<td>• Perform the appropriate technique to assist patient to rise.</td>
</tr>
<tr>
<td></td>
<td>• Steady patient once in sitting position.</td>
</tr>
<tr>
<td></td>
<td>• Perform task in both HCW positions (one at head and another at legs).</td>
</tr>
</tbody>
</table>
Chapter 3.0 Program Essentials

Sample Safe Work Procedures
Every facility/program should have safe work procedures for all their Safe Patient Handling and Movement tasks. We have included the following Safe Work Procedures as examples that can be adapted for your own facility or program, as required.

Sample SWP 001  Supervised Transfer to Chair
Sample SWP 002  Transfer/Gait Belt - Assisting Patient to Stand.
Sample SWP 003  Transfer/Gait Belt - Assisting Patient to Stand Using 2 HCWs.
Sample SWP 004  Friction Reducing Device (FRD) - Application of Sliders under Patient Using Fold and Tuck Techniques
Sample SWP 005  FRD - Lateral Transfer from Bed/Stretcher to Bed/Stretcher
Sample SWP 006  FRD - Bed Repositioning with Verbal Cues and Slider Orange FRD
  Moving Patient
  Lateral Move/Turn with Patient Assistance
  Lateral Move/Turn without Patient Assistance
  Boost with Patient Assistance
Removing FRD
Blue FRD
  Moving Patient
  Lateral Move/Transfer With and Without Patient Assistance
Removing FRD
Purple FRD
  Moving Patient
  Boost Technique
Sample SWP 007  Sit to Stand Lift - Transfer Patient to Chair/ Commode.
Sample SWP 008  Mechanical Floor Lift - Transferring Patient from Bed to Chair.
Sample SWP 009  Ceiling Lift - Reposition in Bed using Repositioning Sheet
Sample SWP 010  Chair Repositioning with Pillow Technique and 1 HCW
Sample SWP 011  Chair Repositioning with FRD - 1-2 HCW
Sample SWP 012  Assisting Patient Up Off Floor
Sample SWP 013  Assisting Patient Up Off Floor with Mechanical Lift
Sample SWP 014  Assisting Patient Up Off Floor with an Air Assisted Device (HoverJack™).
Sample SWP 001  Supervised Transfer to Chair

Arrange Environment Correctly:

- Set commode, chair or wheelchair in proper place for transfer.
- Ensure all devices have their brakes on appropriately
- Ensure space is appropriate and uncluttered

HCW will demonstrate the ability:

- to cue the client, using verbal cueing as required, coaching in body mechanics, and explaining:
  - Where to place heels in relation to buttocks (nose over toes)
  - Where to place a walker if required
  - How to use arms to assist by pushing off surfaces, and leaning forward
- To cue patient once standing, to determine if they are balanced and not dizzy before attempting to walk, by waiting a few seconds
- To know what to look out for as the transfer progresses, such as leaning to one side, feet and legs crossing, dizziness, etc.
- To cue for sitting back down - place heels under the seat, use hands to reach for armrests, lean forward nose over toes
Chapter 3.0 Program Essentials

Sample SWP 002  Transfer/Gait Belt - Assist Patient to Stand

HCW will assist the patient to stand using the transfer/gait belt and demonstrate the following:

Transfer/Gait Belt

- Chooses correct size of belt and applies it appropriately.
- HCW able to verbalize why entire hand cannot be placed into the loop (it may become jammed and if the patient falls, you can sustain a fracture, or fall related injury)
- HCW demonstrates appropriate grasping of the outside the loops.

Position Bed

- The bed is at proper height so that the patient can reach floor with feet.
- Brakes on bed.
- Position the walker or cane.

Position Commode

- Over toilet or at bedside aligned with the bed.
- Brakes locked on.

HCW Position

- Performed from the side of the patient only, not from the front. HCW stands on patient’s weaker side.

HCW to demonstrate good body mechanics through proper positioning: Position with legs at shoulder width apart. Bend at hips and knees, back straight and tighter stomach muscles.

Cues patient as follows

- Scoot to edge of the bed/chair with feet flat on floor.
- Position nose over toes.
- Lean forward, nose over toes.
- Push down on bed/chair using hands.
- Count and rise on three.

HCW technique to rise

- Grasps loops of belt using closed fist and thumbs up grip.
- Places one hand on patient’s shoulder to stabilize patient.
- Patient then cued to grab walker or stand independently.

Assists patient to sit

- Asks patient to use arm rails, commode arms, bed rail, or toilet rails, does not allow use of walker.
- Remains at patient side holding transfer belt, assist patient to reach rails.
- Asks patient to lean forward slightly and bend knees. Stabilizes patient trunk with hand on shoulder, asks patient to sit.
Sample SWP 003

Transfer / Gait Belt - Assist Patient to Stand using 2 HCWs

Transfer / Gait Belt
HCW will demonstrate the following:

Transfer / Gait Belt
- Chooses correct size transfer /gait belt and its application.
- Verbalize why entire hand cannot be placed into the loop (it may become jammed and if the patient falls, you can sustain a fracture, or fall related injury too).
- Demonstrates appropriate grasping of the outside the loops.

Position the Bed
- At proper height so that the patient can reach floor with their feet.
- Brakes on bed.
- Position the Walker or Cane.

Position Commode
- Over toilet or at bedside aligned with the bed.
- Brakes locked on.

HCW Position
- Each HCW stands on either side of the patient facing the opposite direction of the patient.
- HCW to demonstrate good body mechanics through proper positioning: Position with legs at shoulder width apart. Bend at hips and knees, back straight and tighter stomach muscles.
- On a specified count transfer the patient from sit to stand shifting your weight through your legs.

Cues Patient as follows:
- Scoot to edge of the bed/chair with feet flat on floor.
- Position Knee’s over toes.
- Lean forward nose over toes.
- Push down on bed/chair using hands.
- Count and rise on three.

HCW technique to rise
- Grasps loops of belt using closed fist and thumbs up grip.
- Place one hand on patient shoulder to stabilize.
- Patient then cued to grab walker or stands independently.
Chapter 3.0 Program Essentials

HCW assists the patient to sit

- Asks patient to use arm rails, commode arms, bed rail, or toilet rails, does not allow use of walker.
- Remain at patient side holding transfer belt, assist patient to reach rails.
- Asks patient to lean forward slightly and bend knees. Stabilizes patient trunk with hand on shoulder, asks patient to sit.
Chapter 3.0 Program Essentials

Sample SWP 004  FRD - Application of Sliders under Patient using Fold and Tuck Techniques

When to use
- When patient is too large to roll
- Patient medical status is such that rolling is too uncomfortable
- Patient cognitive status is reduced

1. Need 2 HCW with one on each side of patient’s bed.
2. Place bed flat, with the bed surface at the top of the hipbones (iliac crest) of the shortest person performing the transfer.
3. Lower side rails and put bed brakes on.
4. Lay slider on top of patient with all handles facing ceiling. The end without handles should be just under the patient’s chin.
5. Lay second slider in same position, over top of first sheet.
6. Grasp both sliders 4” to 6” from patient’s head.
7. Fold down top of sliders into a 4” to 6” fold.
8. Repeat 5 to 6 times, folding the sliders to the bottom.
9. Grasp folded sliders, and turn over with folds facing down, away from patient.
10. Place under patient’s head or feet with open ends even with top of patient’s head, or soles of feet.
11. HCW should face end of bed where sliders are at and grasp bulk of folds with inside hand.
12. On count of three, pull straight back once, repeat until have reached the soaker.
13. Using outside hand, hold soaker, reach underneath, and grasp slider folds and continue to unfold the sliders so they go under soaker. If any resistance, depress surface of bed to assist with insertion of sliders.
14. If patient has neck precautions, a nurse must place the slider under the patient’s head. A 3rd person (nurse) must be at head of bed. That nurse must have “Transfer of Function” protocol training.
15. With any patient with cervical or spine injuries, the unfolding of the sliders must be smooth and there is to be no upward movement of sliders near the patient’s spine or neck area.
Chapter 3.0 Program Essentials

Placing Orange Slider under Soaker and Patient

Fold Technique (for patient’s who cannot be rolled i.e. fracture of arm, shoulder or legs)

1. Need 2 HCWs with one on each side of patient’s bed.
2. Place bed flat, with bed surface at top of hipbones (iliac crest) of shortest person performing transfer.
3. Lower side rails and put bed brakes on.
4. Lay slider on top of patient, closed-end at patient’s chin level.
5. Grasp orange slider 4 to 6 inches from closed end and make 3 folds into it.
6. Grasp folded slider and turn over with folds facing down, away from patient.
7. Place under patient’s head so closed end is even with top of patient’s ears.
8. Pull folded slider under patient soaker.
9. A second orange slider tube may be required for the lower body, and a pillow for under the feet.
10. With both HCWs facing the head of the bed grasp under fold with inside hand and on the count of three, pull back once.
11. Repeat until all folds have been dispensed under the patient.
Chapter 3.0 Program Essentials

Tuck Technique (to be used if patient can assist or can be rolled)
1. Need 2 HCWs with one on each side of patient’s bed.
2. Place bed flat, with bed surface at top of the hipbones (iliac crest) of shortest HCW performing transfer.
3. Lower side rails and put bed brakes on.
4. Have patient roll slightly on side or assist onto side.
5. Place orange slider on the bed lengthwise, behind patient’s back, as close to patient’s body as possible. Closed end should be even with the top of patient’s ear for boosts; open ends even with shoulders and buttocks for side to side (lateral) moves.
6. Place slider under soaker.
7. Have patient roll back onto back (supine).
8. Pull slider flat from opposite side. May need to request patient roll slightly towards opposite side be able to pull slider flat under patient’s back.
Chapter 3.0 Program Essentials

Placing Blue Slider under Soaker and Patient

Fold Technique
1. Need 2 HCWs with one on each side of patient’s bed.
2. Place bed flat, with the bed surface at the top of the hipbones (iliac crest) of the shortest person performing the transfer.
3. Lower side rails and put bed brakes on.
4. Lay slider on top of patient, open end at patient’s chin level.
5. Grasp blue slider 4 to 6 inches from open end and fold down top of slider into a 4" to 6" folds.
6. Repeat 5 to 6 times, folding the slider to the end.
7. Grasp folded slider and turn over with folds facing down, away from patient.
8. Place under patient’s head or feet.
10. Pull folded slider so open end is even with top of patient’s head or bottom of the feet.
11. With both HCWs facing the head of the bed/or end of bed grasp under fold with inside hand and on the count of three, pull back once.
12. Repeat until all folds have been dispensed under the patient.
13. If there is resistance, depress on the surface of the bed to assist with the insertion of the sliders.
Chapter 3.0 Program Essentials

**Tuck Technique**

1. Need 2 or more HCWs with one on each side of patient’s bed.
2. Place bed flat, with the bed surface at the top of the hipbones (iliac crest) of the shortest person performing the transfer.
3. Lower side rails and put bed brakes on.
4. Have patient roll slightly on side or assist onto side.
5. Place blue slider on the bed lengthwise, behind patient’s back, as close to patient’s body as possible.
6. Closed end should be even with the top of patient’s head and the other below the feet i.e. under whole body.
7. Place slider under soaker.
8. Have patient roll back onto back (supine).
9. Pull slider flat from opposite side. May need to request patient roll slightly towards opposite side be able to pull slider flat under patient’s back.
Chapter 3.0 Program Essentials

Placing Purple Slider under Soaker and Patient

Fold Technique
When to use

- When patient is too large to roll
- Patient medical status is such that rolling is too comfortable
- Patient cognitive status is reduced
- Patient is greater than 350 lbs

1. Need 2 HCWs with one on each side of patient’s bed.
2. Place bed flat, with the bed surface at the top of the hipbones (iliac crest) of the shortest person performing the transfer.
3. Lower side rails and put bed brakes on.
4. Lay slider on top of patient with all handles facing ceiling. The end without handles should be just under the patient’s chin.
5. Lay second slider in same position, over top of first sheet.
6. Grasp both sliders 4” to 6” from patient’s head.
7. Fold down top of sliders into a 4” to 6” fold.
8. Repeat 5 to 6 times, folding the sliders to the bottom.
9. Grasp folded sliders, turn sliders over with folds facing down, away from patient.
10. Place under patient’s head or feet with open ends even with top of patient’s head, or soles of feet.
11. HCW should face end of bed where sliders are at and grasp bulk of folds with inside hand.
12. On count of three, pull straight back once, repeat until have reached the soaker.
13. Using outside hand, hold soaker, reach underneath, and grasp slider folds and continue to unfold the sliders so they go under soaker. If any resistance, depress surface of bed to assist with insertion of sliders.
14. If patient has neck precautions, a nurse must place the slider under the patient’s head. A 3rd person (nurse) must be at head of bed. That nurse must have “Transfer of Function” protocol training.

With any patient with cervical or spine injuries, the unfolding of the sliders must be smooth and there is to be no upward movement of sliders near the patient’s spine or neck area.
Chapter 3.0 Program Essentials

Section 3.4

Training & Education
Sample SWP 005

FRD Lateral Transfer from Bed/Stretcher to Bed/Stretcher

1. Need HCWs distributed evenly on each side of patient.
2. Explain to patient direction they will be traveling in.
3. Place bed flat with the bed surface at the top of the hipbones (iliac crest) of the shortest HCW performing the transfer.
4. Lower side rails and put bed brakes on.
5. Place two purple sliders under patient before bed and/or stretcher are together.
6. Place a blue slider on edge of receiving surface nearest to patient.
7. If there is a gap between the surfaces use a plastic slider board to bridge the gap.
8. Have two or three straps placed in loops of top slider, even with patient's shoulders and hips. Place straps temporarily on patient.
9. Ensure all attached equipment i.e. O₂, IV, Foley, chest tubes etc. are placed out of way on receiving surface.
10. Push bed and receiving surface together at same height or receiving surface ½ inch lower, as long as there are no spinal injuries.
11. Ensure the brakes are engaged on bed and receiving surface.
12. Pass straps to receiving HCW.
13. Receiving HCW should grasp straps and on count of three, receiving HCW pulls and transfer HCW pushes patient with a gentle even motion.
14. Once patient has been transferred, remove sliders. Place in laundry or leave dedicated to patient. Send to laundry once patient does not require any more.
Chapter 3.0 Program Essentials

BED TO BED TRANSFER USING FLAT SLIDER SHEETS AND LONG SLIDER TUBE
Chapter 3.0 Program Essentials

Side (Lateral) Move with Patient Assistance
1. Explain to patient the direction they will be travelling in.
2. Place bed flat, with bed surface at top of hipbones (iliac crest) of shortest person performing transfer.
3. Lower side rails and put bed brakes on.
4. Place two purple sliders under patient. (Use Fold or Tuck technique – SWP 004)
5. Ensure slider is under soaker or sheet.
6. Any attached equipment should be moved forward so patient does not pull it out during move.
7. Instruct patient if able to move legs over to position they’re moving to.
8. Make sure the patient’s hair or IV lines etc are not caught under slider.
9. HCW furthest away from the final position, places one hand on patient’s shoulder and one hand on hip to facilitate pushing.
10. HCW on receiving side guides patient to final transfer position.
11. The receiving HCW should grasp the soaker or sheet and assist with a gentle pull on count of three.

Side (Lateral) Move or Patient Turn without Patient Assistance
1. Explain to patient the direction they will be traveling in.
2. Place bed flat, with bed surface at top of hipbones (iliac crest) of shortest person performing the transfer.
3. Lower side rails and put bed brakes on.
4. Place two purple sliders under patient. (Use Fold or Tuck technique – SWP 004)
5. Ensure the slider is below soaker or sheet.
6. Any attached equipment should be moved forward so patient does not pull it out during move.
7. Move the patient’s legs over to the position they are travelling in.
8. Make sure the patient’s hair or IV lines etc are not caught under slider.
9. HCW furthest away from the final position places one hand on patient’s shoulder and one hand on patient’s hip to facilitate pushing.
10. Receiving HCW grasps soaker and assists with a gentle pull on count of three.
Removing Sliders after Procedure
Start with bottom slider. One HCW grasps the opposite corner from underneath.

1. Pull slider hand over hand along patient, towards self, to remove slider.
2. Repeat for second slider.
Chapter 3.0 Program Essentials

SHORT TUBE SLIDERS

- Nylon patient sliders or friction reducing devices (FRDs) are to be used to reduce friction caused when moving a patient in bed when boosting, side turning, or preparing a patient for other transfers.

- Orange tubes, purple sheets, 1½ width blue sheets, double orange slider sheets, and blue tube sliders are used at HSC.

- The purchase, maintenance and cleaning of sliders is the units responsibility. Sliders should be laundered between each patient use. Mark your ward onto the slider in indelible ink.

- HCWs are required to have regular in-servicing on the use of sliders. In-servicing is available monthly through the Corporate Orientation. Site specific sessions can be arranged through OESH.

SLIDER TIPS

For patients whose height exceeds the length of the slider, add a small orange slider to the head or the feet to make up the difference.

When to use

- If patient is able to assist, or can use an overhead bar.
- If moving patient side to side, in side-lying, or boosting up in bed.
- If patient is unable to assist and under 350 lbs.

When not to use...

- If patient has a spinal, back or hip injury or fractures.
Chapter 3.0 Program Essentials

SWP 006  Repositioning In Bed with Verbal Cues and Slider

ORANGE SLIDER TECHNIQUES

Equipment & HCWs Needed
- 1 or 2 orange slider tube(s)
- Soaker pad or extra sheet if patient has an infection control issue
- 1 or 2 pillows
- 2 HCWs

Moving Patient on Orange Tube Sliders

Side (Lateral) Move or Turn with Patient Assistance
1. Explain to patient the direction they will be travelling in.
2. Place bed flat, with bed surface at top of hipbones (iliac crest) of shortest person performing transfer.
3. Lower side rails and put bed brakes on.
4. Place slider under patient, ensuring slider is under soaker, closed side to side of bed.
5. Any attached equipment should be moved forward so patient does not pull it out during move.
6. Instruct patient if able to move legs over to position they are moving to.
7. Make sure the patient’s hair or IV lines etc are not caught under slider.
8. If patient has one leg incapacitated i.e. in cast, a pillow or additional orange slider should be placed underneath the leg to facilitate a smoother transfer.
9. HCW furthest away from the final position, places one hand on patient’s shoulder and one hand on hip to facilitate pushing.
10. HCW on receiving side, guides patient to final transfer position.
11. The receiving HCW should grasp the soaker and assist with a gentle pull on count of three.

Side (Lateral) Move or Patient Turn without Patient Assistance
1. Explain to patient the direction they will be traveling in.
2. Place bed flat, with bed surface at top of hipbones (iliac crest) of shortest HCW performing the transfer.
3. Lower side rails and put bed brakes on.
4. Place slider under patient closed side to side, ensuring the slider is below soaker.
5. Any attached equipment should be moved forward so patient does not pull it out during move.
Chapter 3.0 Program Essentials

6. If patient has one leg incapacitated i.e. in cast, a pillow or second slider should be placed underneath the leg to facilitate a smoother transfer.
7. Move the patient's legs over to the position they are travelling in.
8. Make sure the patient's hair or IV lines etc are not caught under slider.
9. HCW furthest away from the final position places one hand on patient's shoulder and one hand on patient's hip to facilitate pushing.
10. Receiving HCW grasps soaker and assists with a gentle pull on count of three.

Moving Patient on Orange Tube Sliders

Boost with Patient Assistance
1. Explain to patient the direction they will be traveling in.
2. Place bed flat, with the bed surface at top of hipbones (iliac crest) of shortest HCW performing transfer.
3. Lower side rails and put bed brakes on.
4. Place slider under patient closed side at head, ensuring the slider is below soaker.
5. Any attached equipment should be moved forward so patient does not pull it out during move.
6. Place a pillow at head of bed to prevent patient's head from being bumped.
7. If patient has one leg incapacitated i.e. in cast, a pillow or second slider should be placed underneath the leg to facilitate a smoother transfer.
8. Have patient cross arms across the chest.
9. Make sure the patient's hair or IV lines etc are not caught under slider.
10. Have patient bend one leg with foot flat on bed.
11. Have patient drop chin to chest, press shoulders into bed and on count of three, press foot on bed surface and push self upwards.
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Removing a slider after procedure
1. After moving patient on side or to side of bed (laterally) the pusher will grasp slider on edges of bottom part of slider and pull towards self.
2. After boosting patient, orange tube will be in middle of patient’s back. Reach inside tube, grasp bottom of tube and pull towards self. Slider will slide right out.

BLUE TUBE SLIDERS

- Nylon patient friction reducing devices (FRDs) or sliders are to be used to reduce friction caused when moving a patient in bed when boosting, side turning, or preparing a patient for other transfers.

- Orange tubes, purple sheets, 1½ width blue sheets, double width orange sheets, and blue tube sliders are used at Health Sciences Centre.

- The purchase, maintenance and cleaning of sliders is the units responsibility. Sliders should be laundered between each patient use. Mark your ward onto the slider in indelible ink.

- HCWs are required to have regular inservicing on the use of sliders.

- Inservicing is available monthly through the Corporate Orientation. Site specific sessions can be arranged through OESH.

SLIDER TIPS
The blue tube slider can be used as an extra transfer piece.

When to use
- If patient is able to assist with transfer.
Chapter 3.0 Program Essentials

- Patient is less than 350 lbs.
- When transferring patient from: bed to bed or stretcher or exam table.

BLUE SLIDER TECHNIQUES

Equipment Needed
- 1 blue slider sheet
- 1-2 pillows for turning
- 2 HCWs for patient’s up to 350 lbs
- Soaker pad or extra sheet between patient and slider

Moving Patient on Blue Slider Tube

Side Transfer - Bed to Bed/Stretcher with/without Patient Assistance

1. HCWs should be distributed evenly on either side of patient.
2. Place bed flat, with the bed surface at the top of the hipbones (iliac crests) of the shortest HCW performing the transfer.
3. Lower side rails and put bed brakes on.
4. Place the blue slider under draw sheet before bed and/or stretcher are together. Have patient assist as much as possible if able.
5. On the receiving side of patient, grasp underside of slider and pull out 10% of slider and 90% of blue slider is under patient.
6. Have patient assist as much as possible.
7. If there is a gap between surfaces, use a plastic slider board to bridge gap.
8. Ensure all attached equipment i.e. O₂, IV, Foley, chest tubes etc. are placed out of way on receiving surface.
9. Push bed and receiving surface together at same height or receiving surface ½ inch lower, as long as patient has no spinal injuries.
10. Ensure the brakes are engaged on bed and receiving surface.
11. On count of three, transfer HCWs should push the patient with a gentle, even motion. Ideally, one should push at shoulders and hips, and the second at hips and knees.
12. Receiving HCW should guide patient when soaker is in a comfortable range to reach, grasping in a palms up grasp.
13. Once patient has been transferred, remove sliders to laundry if slider soiled with blood or body fluids.
Chapter 3.0 Program Essentials
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Removal of Sliders after Procedure
1. One HCW grasps the opposite corner of the slider from underneath.
2. Pull the slider hand over hand along the patient toward yourself to remove the slider.
3. For patient with neck or spine injuries, unfolding of sliders must be smooth with no upward movement of sliders near patient’s spine or neck.
Chapter 3.0 Program Essentials

PURPLE FLAT SLIDER SHEETS

- Nylon patient sliders or friction reducing devices (FRDs) are to be used to reduce friction caused when moving a patient in bed when boosting, side turning, or preparing a patient for other transfers.
- Orange tubes, purple sheets, 1 ½ width blue sheets, double width orange sheets, and blue tube sliders are used at Health Sciences Centre.
- The purchase, maintenance and cleaning of sliders is the ward’s responsibility. Sliders should be laundered between each patient use. Mark your ward onto the slider in indelible ink.
- HCWs are required to have regular in-servicing on the use of sliders.
- In-servicing is available monthly through the Corporate Orientation.
- Site specific sessions can be arranged through OESH.

SLIDER TIPS

- For added maneuverability when turning or moving a patient to the side of the bed (lateral), two straps can be attached by threading the straps through a loop the side of the slider; the straps should be even with the shoulders and hips.
- If straps are not available when doing a side to side or on side or to another surface (lateral) transfer, place slider under sheet and pull sheet.

When to use

- If moving patient side to side, turning onto side, boosting up in bed, or transferring sideways onto another bed or stretcher.
- If patient is unable to move independently.
- Always use two sheets together.
- Always if patient over 350 lbs.
Chapter 3.0 Program Essentials

SHEET SLIDER TECHNIQUES

**Equipment Needed:**
- 2 flat slider sheets
- 1-2 pillows for turning
- 2 HCWs for patients up to 350 lbs, add one HCW approx. for every 50 lbs
- 3 HCWs for patients on neck (cervical) precautions
- Soaker pad or extra sheet between patient and top slider sheet

**Boost Procedure**
- HCWs should be distributed evenly on either side of the patient.
- Explain to patient direction they will be traveling in.
- Place bed flat, with the bed surface at the top of the hipbones (iliac crests) of the shortest HCW performing the transfer.
- Lower side rails and put bed brakes on.
- Place sliders under patient, ensuring the sliders are under soaker.
- Place a pillow at the headboard to prevent injury to patient.
- Grab loops on upper sheet at shoulder and hip.
- HCWs to face one another, standing with legs shoulder width apart or greater. Place weight onto foot closest to the foot of the bed.
- On count of three, shift weight from the back foot onto the forefoot while simultaneously sliding soaker towards the head of the bed (called weight shifting).
- Once boost is complete, raise knee gatch and remove sliders.
Sample SWP 007  

**Sit to Stand Lift - Transfer Patient to Chair/Commode**

**Characteristics**

1. Sit-Stand lifts assist the patient into a supported stand position.
2. Sit-Stand lifts are operated with 2 HCWs.
3. Weight capacities of lifts:
   - i) Sara - 350 lbs (157 kg)
   - ii) Encore - 440 lbs (200 kg)
   - iii) Chorus - 440 lbs (200 kg)
4. The battery must be charged when not in use. Rotate batteries in charger every 24 hours or sooner if required.
5. Choose the most appropriate harness according to manufacturer’s guidelines.

**SARA LIFT**

![Sara Lift](image1)

**Encore™**

![Encore Lift](image2)

**Chorus**

![Chorus Lift](image3)
Chapter 3.0 Program Essentials

Criteria for Use
There is some flexibility in the guidelines for use listed below, depending on balance between cognitive and physical issues of patient. When there is some dispute in the assessment, Allied Health must be consulted, taking into account both HCW and patient safety.

Sit-Stand Lift is Used When Patient:
1) Can sit on the edge of the bed.
2) Is able to weight-bear on one leg and use one arm.
3) Is assessed to be a one-HCW assist or a moderate two-HCW assist for transfers.
4) Is cooperative and able to follow simple directions.

Sit-Stand Lift Cannot Be Used When Patient:
1) Has had recent knee or hip fractures or replacements.
2) Has chest tubes in place that interfere with the harness.
3) Has an epidural in place, as this will interfere with the harness.
4) Requires extra care to be taken with any ostomy product.
5) Has had open-heart surgery, 1 to 3 days post surgery.

Also cannot be used when the legs of the lift do not fit under the surface onto which the patient is being transferred (e.g. exam table without opening beneath).

Harnesses
There are 2 harnesses with the Arjo Sara lift
- Total transfer harness
- Sheepskin chest harness

There are 2 harnesses with the Encore lift
- Standing belt
- Walking harness
Chapter 3.0 Program Essentials

SIT/STAND LIFT TECHNIQUES

General Directions

- Ensure the mechanical lift is in proper working order, the battery is sufficiently charged and all attachments are available.
- Know how to operate emergency buttons or manual controls.
- Know the weight of the patient and the weight rating of the mechanical lift.
- Adjust the bed to waist level to minimize bending.
- Explain the procedure to the patient.
- Ensure there is adequate space to manoeuvre the patient in the area i.e. remove family members, separate beds, remove chairs, bed tables etc.

A) Sara Lift (Arjo)

Directions for Use:

- Move lift so that open end of base is under side of bed or around base of chair or commode.
- Place bed flat, with the bed height such that the patient can easily rest their feet on the base of the lift.
- Lower side rails and put bed brakes on.
- Remind patient to lift feet or assist patient’s feet onto footrest.
- Engage brakes.
- Place harness around patient and attach adjustable straps to lift, making sure sling is placed one hand span down from patient’s axilla (armpit).
- Buckle clip on harness and adjust for comfort. This should be snug, but not tight.
- Patient’s arms MUST BE placed on outside of sling and patient should hold onto handrails of lift.
- Patient’s shins should rest against kneepad, not their knees. Ensure that patient’s feet are placed in correct position on footplate.
- Hook harness loop that meets lift most comfortably.
- Instruct patient to lean back slightly. Ask them to look up at you.
- For patients with limited weight-bearing capability, lift them just enough so their buttocks clear surface they were sitting on by pushing the “up” button on hand held control or on main operation box on lift.
- For those who are able to and are more comfortable with fuller weight-bearing, lift into full stand position.
- If belt rides up on patient, lower them back into seated position. Instruct them to lean back once again, using your hand on their shoulder as reinforcement. Attempt to lift once again.
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- Move patient to desired location. Adjust width of base as necessary i.e. wheelchair, commode or Geri chair.
- **Keep Brakes off.** Have a second person behind receiving equipment to guide it under patient.
- Lower patient by pressing “down” button on hand held remote control or on main operation control on lift itself.
- Continue to position patient while lowering if necessary.
- Once patient is seated, detach straps, ensure feet are off footrest, move lift away and remove belt.

B) **Encore/Chorus Lift (Arjo)**

1. Encore and Chorus have unique features:

2. Curved line of actuator allows patient to be lifted in a more natural standing position, which is “nose over toes”. This allows greater rehabilitation potential for patients that allied health wish to retrain and rehabilitate.

3. Lift features a tough forearm support structure upon which patient can rely for greater upper body support. The applications for patients with cardio-vascular accidents (CVAs, or strokes and hemiplegia) are much safer and controlled than with other sit/stand lifts.

4. Harnesses-
   a. Standing- if the patient “lets go” or faints, this belt will hold them.
   b. Walking- this belt is primarily for walking.

5. The Encore lift also has a removable footplate for specialized use.
   There are 2 harnesses with the Encore lift:
   a. Standing belt
   b. Walking harness

**Directions for Use**

- Move lift so that open end of base is under side of bed or around base of chair or commode.
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- Engage locks on base for all lifts.
- Place harness around patient and attach adjustable straps to lift, making sure sling is placed around waist, (Encore) or one hand width under armpit (Chorus).
- When a patient fluctuates unpredictably in their weight-bearing, use the harness with the leg supports.
- Secure Velcro fastener/clip on harness and adjust for comfort. This should be snug, not tight.
- The patient's arms MUST BE placed on outside of sling, arms rest on armrests (Encore), patient should hold onto handrails of lift (Chorus).
- Adjust kneepad so that top rests just below bottom of patella, shins resting into kneepad, feet placed in correct position on footplate.
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- Encore - Have patient lean back and pull two cords tight; pull down to lock in holding tray.
- Chorus - Hook harness loop that meets lift most comfortably. Thread end of rope through loop on harness. Once looped, it clips into rubber cylinder.
- Pull rope through toggle on top of lift so patient is secured into lift. Pull rope downwards once placed, in order to secure rope into “cleats” of locking mechanism.

- Instruct patient to lean into back support and to stand naturally.

- Adjust width of base as necessary to accommodate receiving apparatus.
- Move patient to desired location. Lock brakes on bed or wheelchair or Geri-chair.
- Keep brakes off on lift.
- Lower patient by pressing “down” button on hand held remote control or on main operation box on lift itself.
- Continue to position patient while lowering if necessary.
- Detach straps. Lift up on ropes to release them from locking “cleats”.
- Move lift away, remove belt.
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Section 3.4 113 Training & Education

Encore Lift without the Foot Plate

1) The Encore sit-stand lift can be used without footplate where patient requires additional support to complete a transfer, but can benefit from assisted walking for short distances (i.e. 1 or 2 steps), or lower extremity exercise while standing.

2) All instructions are as above with these exceptions:
   a) Use the walking harness in case patient should lose weight-bearing status.
   b) Keep the leg straps very loose as harness may lift patient off their feet.
   c) Use under guidance of physiotherapy.
Chapter 3.0 Program Essentials

Sample SWP 008  Mechanical Floor Lift - Transferring Patient from Bed to Chair

Characteristics
1) Total lift completely lifts the patient from any surface, including the floor.
2) Require at least 2 HCW to operate.
3) Weight Capacities:
   - Maxi-Move  - 420 lbs
   - Opera  - 440 lbs
   - Brown Arjo  - 350 lbs
   - Medi-Lifter111 Plus - 600 lbs
   - Titan X - 1,000 lbs
4) Batteries for the Arjo lifts must be changed every 24 hours, as they will burn out if left on the charger, and will drain completely if left on the lift. If the latter occurs, they cannot be recharged.
5) Batteries on the Medi-Lifter need to be charged when the indicator light reaches amber or red.
Chapter 3.0 Program Essentials

Criteria for Use:
The criterion by which a HCW chooses a total lift allows some flexibility, depending on the balance between the patient's cognitive and physical issues. When there is some dispute in the assessment, Allied Health (Physiotherapy, Occupational Therapy) must be consulted, taking into account both HCW and patient safety.

Total Lift Is Used When Patient
1. Has little or no weight bearing capacity.
2. Is greater than 400 lbs, for boosts, repositioning and some transfers.
3. Has fallen to floor, and has been assessed by nursing or physician to be safe to be lifted.
4. If able to weight-bear but uncooperative, agitated or confused (refer to section “Combative and Mentally Impaired Patients”).
5. Is required to move short distances only.

Total Lift is not used when Patient Has
1. Fractured hip, knee or femur
2. Fractured vertebrae
3. Spinal cord injury

Combative and Mentally Impaired Patients
1) Patients who are combative, mentally impaired or severely head injured and therefore pose a safety risk to HCWs may still be lifted in a total lift depending on their level of agitation.
2) A confused/non-cooperative patient requires more caregiver support. For example, if there were three HCWs then patient could be lifted slightly higher, facing forward with patient’s back towards operator.
3) A second HCW can then retain full control using stabilizer handles on sling (if available). A third HCW can be in patient’s line of vision, but out of striking range.
4) If mechanical lift is not appropriate ward may consult the following resources to brainstorm about an alternate care plan as the patient is not to be lifted manually by HCWs.
   i) Physiotherapy
   ii) Occupational Therapy
   iii) OESH Disability Prevention
TOTAL LIFT TECHNIQUES

Ensure the mechanical lift is in proper working order, the battery is sufficiently charged and all attachments are available.

- Know how to operate emergency buttons or manual controls.
- Know the weight of the patient and the weight rating of the mechanical lift.
- Adjust the bed to waist level to minimize bending.
- Explain the procedure to the patient.
- Ensure there is adequate space to manoeuvre the patient in the area i.e. remove family members, separate beds, remove chairs, bed tables etc.

A) Arjo Lifts (Maxi-Lift, Opera)

Directions for Use:

- When lifting with Arjo lifts approach patients:
  - Lying on their back in bed, from side (any angle).
  - Lying on their back on the floor, from the legs.
  - Sitting in chair directly face on.

- Use remote control to spread base to increase base of support.
- Lower hanger bar to an appropriate height to attach sling. It is preferable to attach the leg fasteners first, and then attach the shoulder section.
Chapter 3.0 Program Essentials

- HCW should hear a “click”. If you do not hear a “click”, do not use this sling. Return to equipment room.
- Do NOT lock the brakes when lifting patient.
- Place all of patient’s attached equipment on hanger bar or have another HCW assist.
- Standing beside patient use remote control to raise patient slowly.
- Be aware of obstructions such as bed monkey bars, curtains, doorways.
- Once the patient is lifted, turn them towards the mast (centre pole) of lift.

- To move lift, use handle on mast to push sideways. Use this same method to turn lift.
- Move patient to designated area.
- When placing patient on bed on back, place them well up near headboard to prevent having to do an additional boost.
- When lowering patient ensure you do not crush them with the hanger bar.
- When placing patient into a chair, ensure patient is sitting as straight as possible. Adjust chair so patient’s bottom is as far back in seat of chair as possible. Guide patient by holding sling and guiding it into chair.
Chapter 3.0 Program Essentials

Removing Sling after Lift is Complete

- **From Chair:** Release clips, preferably shoulders first and legs second. Pull out leg supports carefully, grasp head end of sling and gently pull out from behind the patient.
- **From Bed:** Release clips, preferably shoulders first and legs second. Take leg supports from between legs; tuck one side of sling under patient. Have patient roll towards tucked side. Pull loose end of sling from under patient.

B) Medi-Man Lifts (Medi-Lifter 111 Plus)

**General Directions**
Ensure the mechanical lift is in proper working order, the battery is sufficiently charged and all attachments are available.

- Know how to operate emergency buttons or manual controls.
- Know the weight of the patient and the weight rating of the mechanical lift.
- Adjust the bed to waist level to minimize bending.
- Explain the procedure to the patient.
- Ensure there is adequate space to manoeuvre the patient in the area i.e. remove family members, separate beds, remove chairs, bed tables etc.

When lifting with Medi-Man Lifts, approach patients

- Lying on their back in bed, from side or angle.
- Lying on their back on the floor, from the head.
- Sitting in chair directly face on.
Chapter 3.0 Program Essentials

Directions for Use:
• Do NOT lock the brakes when lifting patient.
• Use the lever to spread the base if possible to increase the base of support.
• Lower the hanger bar to an appropriate height to attach the looped ends to the hanger bar. Ensure metal safety clips are closing the holes.
• Place all patients' attached equipment on the hanger bar or have another HCW assist.
• Standing beside the patient use the remote control to raise the patient slowly.
• Be aware of obstructions such as bed monkey bars, curtains, doorways, etc.
• Once the patient is lifted, turn them towards the mast (centre pole) of the lift.
• Once the patient is clear of the chair, bed, etc., the hanger bar should be lowered to a position in which the patient is facing the mast. A confused/non-cooperative patient should be slightly higher. The HCW can then retain better control using the stabilizer handles on the sling.
• To move the lift, use the handle on the mast to push sideways. This will break the inertia effectively. Use this same method to turn the lift.
• Move the patient to the designated area.
• When placing patient on bed in supine position place them well up near the headboard to prevent additional boost.
• When lowering patient ensure you do not crush them with the hanger bar.
• Placing patient into a chair, ensure patient is sitting as straight as possible, adjust chair so patients bottom is as far back in the seat of the chair as possible. If necessary guide patient by holding sling and guiding it into the chair.

Removing Sling after Lift is Complete
• From Chair: Release clips, pull out leg supports carefully, grasp head end of sling and gently pull out from behind the patient.
• From Bed: Release clips, take leg supports from between legs, tuck in one side of the slide under patient. Have patient roll towards tucked side. Pull loose end of slider out from under patient.
• Occupational therapy or physiotherapy must be consulted to have a sling or mesh sling left under a patient for convenience.
Sample SWP 009  Ceiling Lift - Reposition Patient in Bed using Repositioning Sheet

HCW Check List
- Identify from Activities of Daily Living (ADL) assessment the number of people required.
- Indicate what to check for (leaks, cracks, charge)
- Set height of bed appropriately
- Demonstrate operation of controls.
- Advise how to lower patient using safety feature of lift if it malfunctioned

Application of Repositioning Sheet (Sling)
- Applies sling using side to side rolling technique and right number of HCWs.

Initial Placement of Repositioning Sheet (Sling)
- Sling is positioned under patient at top of head with length hanging over foot of bed.
- If sling has already been used, HCW to assess if current sling position is appropriate for use.

Repositioning Sheet (Sling) Change or Replacement Due to Slippage
- If replacing sling, HCW will lift in current sling and put new sling on bed while patient is lifted off the bed.
- HCW identifies when sling is to be replaced.
- HCW identifies if sling can be left under patient and contraindications of skin breakdown with frequent assessment of skin tolerance.

Attaching Repositioning Sheet (Sling) to Lift
- Head of bed is flat if patient can tolerate.
- Sling bar is lengthways to patient.
- Straps attached on each side at head, shoulders, hips and lower legs.
- Assess patients tolerance.

Boost Technique
- Raise patient off the bed using controls.
- Move lift up in bed on track; gently guide patient’s body, lightly pushing on sling.
- Lower patient to bed and remove straps.

Turn Technique
- Attach straps on one side of sheet to one side of the lift.
- Sling bar is lengthways to patient.
Chapter 3.0 Program Essentials

- Raise lift to turn patient on side.
- Insert positioning pillows as required.
- Lower lift and remove sling straps.

Procedure Following Handling and Movement Task

- Once procedure is completed return cassette to storage location for recharging (do not leave hanging over patient).
- Repositioning sling may be left under the patient.
Sample SWP 010  Reposition in Chair with Pillow Technique and 1 HCW

- Give patient a prompt on what you would like them to do with a verbal cue.
- Lock wheelchair in place.
- Have patient lean upper body slightly forward.
- Position self in front of patient on one knee and place their hands on upper portion of their shins.
- On the count of three have them push with their feet while you push on the shins. Use a gentle push to move the patient to the back of the chair.
- Inform patient about the process to move them in the chair.
- Lock the brakes on the wheelchair/have someone stabilize freestanding chair.
- Position yourself in front of the patient with your knees aligned with theirs.
- Have the patient lean their upper body slightly forward.
- Place a pillow between your knees and the patient’s knees and grasp each wheelchair armrest/chair legs.
- On the count of three pull forward with your arms and push forward with your knees. The patient should slide into place on the chair. Secure seat belt on wheelchair.
Sample SWP 011  Chair Repositioning with FRD and 1-2 HCW

- Inform patient about the process to move them in the chair.
- Lock wheelchairs/stabilize freestanding chair with additional HCW.
- Remove armrests from chair if possible and place them beside each wheel. Move legs holders out of the way if possible.
- Take the tube FRD; make three 4-6 inch folds starting at the close end. If using a sheet start at the opposite ends of the fold.
- Turn folded FRD over facing down and away from the patient.
- Insert FRD behind patient’s bottom.
- Position yourself in front of the patient’s knees.
- Reach beside the patient and grasp the folds from the bottom in one hand and grasp the loose end with the other hand.
- On the count of three pull the first fold under and towards you along the chair, while stabilizing the FRD end. If possible (and safe to do so), have the patient lean slightly away from the side on which you are pulling.
- Switch to the other side and pull the first fold under and towards you along the chair.
- Switch sides again and pull the next fold under and towards you. Repeat until all folds have been pulled back and the FRD is under the patient.
- Remain in front of the patient, stabilizing the patient’s knees to prevent them from falling on the floor. If the chair seat can be tilted, move the tilt so the front of the seat is higher.
- On the count of three, push on the patient’s knees to slide them back into the chair. If possible, have the patient bring their shoulders slightly forward to aid the movement and push slightly. Patient will move to seated position when this is done.
- Secure seat belt if available.
- Remove FRD by stabilizing the patient’s knees. Pull bottom layer of the FRD towards you, until the FRD is out from under the patient.
- When patient is positioned after boost, raise knee gatch (if available) to prevent patient from sliding back down in chair.
- Replace armrests and footrests before leaving the front of the patient.
Sample SWP 012  

Assisting Patient Up From the Floor

Identify that the patient meets the criteria to be assisted through verbal cues.

Criteria:
- The patient has stated they have no injuries.
- The patient is able to move on their own.

Bring a stable chair for the patient to use to help patient up off the floor. Give patient verbal cues and stand by in case assistance is needed.

Using verbal cues and a chair:
- Assess that the patient can assist with moving up off the floor.
  - Has arm strength
  - No apparent fractures, dislocations or injuries
- Bring chair to patient.
- Cue patient to sit up on floor and position into side sitting.
- HCW holds chair in place while giving patient verbal cues to sit up onto knees using chair to assist by leaning or pulling on chair.
  - Ensure patient is not pulling on HCW and HCW is not pulling on patient to assist. Keep hands off patient as much as possible.
  - If at anytime patient cannot pull themselves up then go to assistive mechanical device (HoverJack™ or other mechanical lift).
- Cue patient to now rise to one leg while leaning on chair seat, and then to use other leg to support.
- Cue patient to sit on chair.
- Assess patient’s ability to walk to bed. If patient has a walker or cane then provide. If patient cannot walk steadily then provide wheelchair transport.
Chapter 3.0 Program Essentials

Sample SWP 013  Assisting Patient Up Off Floor with Mechanical Lift

Evaluate the situation to determine if the patient should be moved.
Place a pillow under the patient’s head for comfort.

• Place the appropriate size sling under the patient.
• Approach the patient with the base of support open. Lower the lift to floor level.
• Attach the sling.
• Raise the patient. Position patient in a chair or bed.

Start Position

End Position
Sample SWP 014  Assisting Patient Up Off Floor Using an Air Assisted Device (Hoverjack)

Nursing assessment has determined that the patient needs assistance to rise off the floor. The device available is the air assisted device i.e. HoverJack™.

- The patient needs to be assessed by a doctor/nurse before further action can be taken.
- Obtain all equipment and HCW needed to perform this procedure. Minimum of 2 HCWs.
- Place the two purple FRDs under patient using the folding technique and move the patient to an open area so they can be helped safely. Have a bed or stretcher close at hand.
- Place the HoverJack™ next to the patient and the top purple FRD to slide the patient onto the HoverJack™.
- Place HoverJack™ on floor next to the patient, making sure the chamber with Valve #4 (with the identification label) is on the top and the chamber with Valve #1 is against the floor. If the transport sheet is to be used, first attach this to the bottom of the HoverJack™ by lining up and affixing Velcro strips on the sheet to those on the bottom of the HoverJack™.
- Ensure all red-capped deflation valves (one in each chamber) are capped tightly so that inflation can be maintained.
- Using log-rolling technique, place patient on top of deflated HoverJack™ positioning patient with feet at the valve end where indicated in writing on the label. The patient can be placed on top using the HoverMatt™ Air Transfer System. (See HoverMatt™ instructions) If the HoverMatt™ is used, make certain that the HoverMatt™ and patient are properly centered on the HoverJack™. Always deflate the HoverMatt™ prior to inflating the HoverJack™. Using buckles, secure patient safety straps around the patient.
- Plug in HoverTech International air supply.
- Hold hose end against inlet Valve #1 of HoverJack™ that is in the chamber next to the floor.
- Turn on air supply.
- Inflate chamber through Valve#1 of the HoverJack™.
- When fully inflated, remove hose. Valve will automatically close, maintaining inflation in that chamber.
- Using the same process, inflate other chambers using Valve #2, Valve #3 and Valve#4 in exact succession.
- Turn off air supply and cap valves.
Chapter 3.0 Program Essentials

- Transfer from HoverJack™ onto adjacent surface using the HoverMatt™. Transfer without the HoverMatt™ Air Transfer System may cause injury.
- If it is necessary to lower patient down to the floor, release air by opening the uppermost red deflate valve. When this chamber is fully deflated, move in succession downward to fully deflate.
- **CAUTION**: Do not release all chambers at once. Let each chamber deflate completely before moving to the next.
- **NOTE**: If using the transport sheet, slide the HoverJack™ with patient atop it slowly and with care. Make certain that patient safety straps are secured before moving. Slide the HoverJack™ using the long black strap at the head-end of the device as well as the handles located at the top perimeter.
- **WARNING**: Someone should be with the patient at all times while inflating and using the HoverJack™.
- The patient is beside the bed or stretcher on the HoverJack™ and you have used the two purple FRDs to move them on to the HoverJack™. Use the top purple slider and straps with four to six HCWs to help transfer the patient across to the bed/stretcher. Place a blue FRD on the receiving bed/stretcher so the purple FRD will glide on the blue FRD. An even number of HCW on each side of the bed will make the transfer an easier process after the count of three.
- When the patient has been transferred from the HoverJack™ put up slide rails on the bed/stretcher and return all HoverJack™ equipment to the proper storage area after it has been cleaned and deflated.
Chapter 3.0 Program Essentials

COMPETENCY

Purpose - A system for ongoing assessment of competency with lifting and handling devices should be incorporated into existing protocols for behavioural observation and professional development. Proper use of equipment can be validated through a checklist used by supervisors and trainers. Some guidelines suggest annual competency training.

Having a HCW demonstrate techniques and procedures as per established criteria for competency is an objective method to determine HCW comfort and skill when using patient handling equipment. The competency objectives are built into the Tables in Section 3.4 on Training. Each facility needs to determine how to incorporate this into training/education programs for patient handling.

There are different types of competency checklists to assess HCWs. Competency checklists can be completed during training sessions and signed by trainers or they can be left to the responsibility of the ward/unit so the HCW has a window of time to become proficient. They can be checked off by a designated person such as a ward champion, manager, peer, or educator.

Facility Action steps include determining:

- Skills required to demonstrate a return demonstration
- Checklists to be used
- When and where a return demonstration will occur
- Responsibility for performing the employee assessment
- Responsibility for keeping training records
- Frequency of assessments

Sample competency checklists are included in this section and can be adapted as necessary.
### Position Specific Competencies Including Technical Skills

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>BEHAVIORS</th>
<th>SELF ASSESSMENT</th>
<th>MEETS COMPETENCY LEVEL</th>
<th>Validation Method / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates use, set-up, and care of procedures / equipment according to unit policies and procedures.</td>
<td>a) Uses assessment criteria and care plan for safe patient handling and movement appropriately.</td>
<td>I feel that I have the knowledge &amp; ability to perform these functions.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>b) Appropriately uses algorithms for safe patient handling and movement.</td>
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<tr>
<td></td>
<td>c) Selects and correctly operates lifting and moving equipment, including overhead lifts, sit-stand lifts, friction-reducing devices, and gait belts.</td>
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</tr>
</tbody>
</table>

Patient Name: ____________________________  
Date: ____________________________
Chapter 3.0 Program Essentials

SAMPLE REPOSITIONING A PATIENT IN BED
COMPETENCY CHECKLIST

Preparation and Planning
Can the HCW:

☐ Check care plan and speak to nurse about changes to medical status before transferring a patient?
☐ Choose one caregiver as a leader and the other as assistant?
☐ Ensure working area is free of obstacles?
☐ Correctly position bed (height, brakes on, bedrail position)?
☐ Use nylon slider to reposition patient?
☐ Ensure slider is positioned under patient’s hips and shoulders and patient is centered on slider?
☐ Ensure pillow is at head of bed for moving patient up in bed?

Performance of Positioning Techniques
Can the HCW:

☐ Explain clearly to the patient what is going to happen at each step?
☐ Understand the role of both leader and assistant?
☐ Give the patient clear instructions at each step?
☐ Demonstrate proper technique for repositioning patient side-to-side in bed (HCWs stand on same side of bed)?
☐ Use correct body mechanics for repositioning side-to-side in bed (does not twist spine, shifts weight properly)?
☐ Demonstrate proper technique for repositioning patient up/down in bed (HCWs stand on opposite sides of bed)?
☐ Use correct body mechanics for repositioning up/down in bed (does not twist spine, shifts weight properly)?
Chapter 3.0 Program Essentials

SAMPLE TURNING A PATIENT IN BED
COMPETENCY CHECKLIST

Preparation and Planning
Can the HCW:

☐ Check care plan and speak to nurse about changes to medical status before transferring a patient?
☐ Choose one HCW as a leader and the other as assistant?
☐ Ensure working area is free of obstacles?
☐ Correctly position bed (height, brakes on, bedrail position)?

Performance of Repositioning Technique
Can the HCW:

☐ Explain clearly to the patient what is going to happen at each step?
☐ Understand the role of both leader and assistant?
☐ Demonstrate the ability to turn patient using proper techniques with one person assist?
☐ Demonstrate the ability to turn patient using proper techniques with two person assist?
☐ Use correct body mechanics for turning patient (does not twist spine, shifts weight properly)?
☐ For one person assist, bed rail is up in the direction of the turn, and patient must be able to help to turn over?
☐ Demonstrate proper resting position of patient in side lying (pillows, limbs)?
Chapter 3.0 Program Essentials

SAMPLE REPOSITIONING A PATIENT IN A WHEELCHAIR USING A FRD COMPETENCY CHECKLIST

Preparation and Planning
Can the HCW:

☐ Choose one caregiver as a leader and the other as an assistant?
☐ Apply brakes on wheelchair, wheelchair tilted back for two person assist, remove belts, trays, groin straps?
☐ Support patient’s head if headrest is removed and patient has poor head or neck control?

Performance of Repositioning Technique
Can the HCW:

☐ Explain clearly to the patient what is going to happen at each step?
☐ Demonstrate the correct procedure for one person assist to reposition?
☐ Use correct body mechanics (does not twist spine, shifts weight properly)?
☐ Understand the role of both leader and assistant?
☐ Demonstrate correct procedure for two person assist to reposition?
☐ Re-adjust chair to normal tilt?
☐ Re-apply positioning devices, seat belt, groin straps, etc.
Chapter 3.0 Program Essentials

SAMPLE SITTING PATIENT UP OVER THE SIDE OF THE BED
COMPETENCY CHECKLIST

Preparation and Planning
Does the HCW:

☐ Check Care Plan and speak to nurse about changes to medical status before transferring a patient?
☐ Check Care Plan to make sure patient is able to tolerate sitting up?
☐ Choose one HCW as a leader and the other as assistant?
☐ Ensure working area is free of obstacles?
☐ Position bed low enough for patient’s feet to touch the floor (height, brakes on, bedrail position)?
☐ Position patient with shoes or rubber soled slippers on, in side lying near edge of bed?

Performance of Repositioning Technique
Can the HCW:

☐ Understand the role of both leader and assistant?
☐ Use any assistive devices that patient/resident may have available to make the transfer easier?
☐ Demonstrate proper technique for assisting patient to sit up over side of the bed with one person assist?
☐ Demonstrate proper technique for assisting patient to sit up over side of the bed with two person assist?
☐ Use correct body mechanics (does not twist spine, shifts weight properly)?
☐ Ensure patient is safely seated on the edge of the bed (requests patient scoots forward until feet touch the floor)?
Chapter 3.0 Program Essentials

SAMPLE APPLICATION OF A TRANSFER/GAIT BELT
COMPETENCY CHECKLIST

Preparation and Planning
Can the HCW:

☐ Confirm appropriate transfer method with transfer decal?
☐ Understand when it is unsafe to use a transfer/gait belt (feeding tube, colostomy, recent abdominal surgery, lower rib fracture, hiatus hernia)?
☐ Inspect transfer/gait belt to ensure it is in good condition?
☐ Demonstrate ability to correctly size transfer/gait belt (allows two fingers between belt and patient's waist)?
☐ Correctly put transfer/gait belt on patient's waist (ensuring Velcro meets and buckles up)?
☐ Demonstrate proper grip on transfer/gait belt loops (closed fist, thumbs up, wrists straight)?
SAMPLE RAISING A PATIENT FROM THE FLOOR
COMPETENCY CHECKLIST

Preparation and Planning
Can the HCW:
☐ Receive assessment from qualified team member (physician, nurse, OT, PT)?
☐ Have two trained HCW and extra help, with leader and assistant roles?
☐ Plan safest way to get patient up?
☐ Remove all barriers and clean up any fluids?
☐ Position patient to prepare for transfer up from the floor?

Manual Transfer
Can the HCW:
☐ Give clear instructions to the patient at each step?
☐ Monitor pain/ability/dizziness frequently?
☐ Position the bed with brakes on?
☐ Position the chair, stabilized by a third HCW?
☐ Use good body mechanics?
☐ Demonstrate correct sequence of transfer (side-lying to kneeling to pull-to-stand)?

Mechanical Lift Transfer
Can the HCW:
☐ Give clear instructions to the patient at each step?
☐ Monitor pain/ability/dizziness frequently?
☐ Position the lift and sling properly?
☐ Ensure sling clips and sling is attached properly before lifting?
☐ Use good body mechanics?
☐ Demonstrate correct sequence of transfer?
Chapter 3.0 Program Essentials

SAMPLE BED TO SHOWER STRETCHER / SHOWER TROLLEY

COMPETENCY CHECKLIST

Preparation and Planning
Can the HCW:
☐ Choose a leader and an assistant as two or more trained HCWs will perform the transfer between the bed and the shower stretcher?
☐ Check the transfer decal to ensure the correct method is being used to bathe the patient?
☐ Check with the nurse to ensure patient is medically stable and able to have a shower bath before giving a shower?
☐ Ensure that the shower stretcher and all its parts are clean and in good working order?
☐ Ensure both of the working areas are free of clutter (patient’s room and the shower room)?

Transfers and Bathing the Patient
Can the HCW:
☐ At each step, explain what will happen to the patient and how he or she can assist?
☐ Use at least two HCWs to transfer the patient between the shower stretcher and the bed?
☐ Use the appropriate nylon slider to transfer the patient?
☐ Apply the brakes on both the bed and shower stretcher appropriately?
☐ Use proper body mechanics throughout the shower bath procedure?
☐ Perform the transfer between the shower stretcher and the bed properly?
☐ Ensure that the patient is centered on the shower stretcher?
☐ Ensure that the side supports click into place and that both are up before transporting the patient to/from the shower room and for giving the patient a shower.
☐ Adjust the water temperature to a safe and comfortable temperature for the patient?
☐ Ensure that the patient is never left alone on the stretcher?
Chapter 3.0 Program Essentials

SAMPLE SIT-STAND LIFT
COMPETENCY CHECKLIST

Preparation/Planning
Can the HCW:
☐ Confirm appropriate transfer method with transfer decal?
☐ State need for 2 trained HCWs to perform lift?
☐ Decide who the leader is and who is the assistant?
☐ Determine starting and ending points of transfer?
☐ Ensure working area is free of obstacles, positions receiving chair accordingly?
☐ Ensure lift is in good working order before beginning the lift: battery level, function equipment (sling, intact sling clips, “chair” to receive the patient, etc.)?

Performance of the Lift
Can the HCW:
☐ Explain what will happen with the patient and how they can assist?
☐ Ensure sling is correctly placed (not riding up under the arms when being lifted, arms outside the sling)?
☐ Ensure leg straps are positioned appropriately and securely (2 fingers behind)?
☐ Ensure sling and clips/loops are securely attached?
☐ Ensure brakes are applied appropriately throughout the lift?
☐ Widen base of the lift when moving the lift?
☐ Position patient appropriately in “receiving chair” (recognizing when it is appropriate to stop and reposition during the performance of the lift)?
☐ Leave patient in a safe and comfortable position?
☐ Use good body mechanics throughout the lift?

Safety
Can the HCW:
☐ Demonstrate correct use of emergency release button on lift?
☐ Demonstrate correct use of lowering override feature?
☐ Demonstrate removal and replacement of battery pack if applicable?
☐ Verbalize when to change the battery if applicable?
Chapter 3.0 Program Essentials

SAMPLE MECHANICAL FLOOR LIFT
COMPETENCY CHECKLIST

Preparation and Planning
Can the HCW:
☐ Confirm appropriate transfer method with transfer decal?
☐ State need for 2 trained staff members to perform the lift?
☐ Decide who the leader is and who is the assistant?
☐ Determine starting and ending point of transfer?
☐ Ensure lift in good working order before beginning the lift (i.e. battery level, sling condition, intact sling clips, “chair” to receive patient)?
☐ Ensure correct position of the receiving chair and the bed (hip level of the shorter HCW, rails down, head of bed slightly elevated)?

Performance of the Lift
Can the HCW:
☐ Explain what will happen with the patient and how they can assist?
☐ Ensure sling is correctly positioned (base of spine, patient in the centre of the sling, head support piece in the correct position)?
☐ Ensure sling and clips/loops are correctly attached?
☐ Ensure brakes are applied appropriately throughout the lift?
☐ Widen base of the lift when moving the lift?
☐ Ensure that the assistant guides the patient in the sling?
☐ Position patient appropriately on receiving surface (recognizes when it is appropriate to stop and reposition during performance of the lift)?
☐ Leave patient in a safe and comfortable position?

Safety
Can the HCW:
☐ Show use of emergency stop button and lowering feature?
☐ Demonstrate removal and replacement of battery pack if applicable?
☐ Verbalize when to change the battery if applicable?
Chapter 3.0 Program Essentials

SAMPLE CEILING LIFTS
COMPETENCY CHECKLIST

Preparation and Planning
Can the HCW:
- Confirm appropriate transfer method with transfer decal?
- State need for 2 trained HCWs to perform the lift?
- Decide who the leader is and who is the assistant?
- Determine starting and ending point of transfer?
- Ensure lift is in good working order before beginning the lift (i.e. battery level, sling condition, intact sling loops/clips, cleanliness of equipment)?
- Demonstrate operation of controls.
- Ensure correct position of the bed directly under ceiling track (hip level of the shorter HCW, rails down)?
- Choose correct sling for task i.e. repositioning sling or hammock sling

Performance of the Lift
Can the HCW:
- Explain what will happen with the patient and how they can assist?
- Ensure sling is correctly positioned (base of spine, patient in the centre of the sling, head support piece in the correct position)?
- Ensure sling and clips/loops are correctly attached?
- Ensure brakes on bed are applied appropriately?
- Raise the patient up off the bed and ensure that the assistant gently guides the patient in the sling towards the receiving surface?
- Position patient appropriately on receiving surface (recognizes when it is appropriate to stop and reposition during the performance of lift)?
- Release sling clips or loops?
- Leave patient in a safe and comfortable position?
- Reposition straps hanging over edge of bed and side rails are raised?

Safety
Can the HCW:
- Demonstrate how to lower patient using safety feature of lift if it malfunctioned or in emergency situation.
Chapter 3.0 Program Essentials

☐ Demonstrate removal and replacement of battery pack if applicable?
☐ Verbalize when to change the battery if applicable?
☐ Identify facility practice for laundering and access of slings.
**Chapter 3.0 Program Essentials**

**SAMPLE WRHA Competency Checklist Safe Patient Handling and Movement Program**

Print Name ____________________________ Facility/Unit ____________________________

Instructions: The following is a list of skills, which are performed by healthcare workers (HCW). Please complete the self-assessment column*, and then have someone observe you perform this competency in the clinical setting. When a competency is performed correctly, the observer should fill in the date observed and the observer’s initials and then sign the signature list. Complete the “age specific care” column. The preceptor/reviewer should add any qualifying comments and initial. Once a competency has been signed off as “Can Safely Perform Without Supervision” or “Demonstrates Competency,” the HCW will be held accountable for that competency. You may be asked to repeat (update) the competency at a later date at the discretion of the director/manager.

Signatures:
I have completed the self assessment column ____________________________ Date: ____________________________

Preceptor/Reviewer Initials/Signature ____________________________ ____________________________ / ____________________________

<table>
<thead>
<tr>
<th>Safe Patient Handling &amp; Movement</th>
<th>Self Assessment</th>
<th>Demonstrates Competency/ Date/Initials of Observer</th>
<th>Competency Reviewed/Date/Initials of Observer</th>
<th>AGE SPECIFIC CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TLC 1-2-3</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. HCW safety:</td>
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<tr>
<td>• Looks at task and makes plan to keep HCW safe.</td>
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<tr>
<td>• Uses algorithm</td>
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<tr>
<td>2. Patient Safety:</td>
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<tr>
<td>• Does pro-active patient assessment to determine level of ability.</td>
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<tr>
<td>• Uses Mobility Screen</td>
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<tr>
<td>3. Team safety:</td>
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<tr>
<td>• Designates a leader</td>
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<tr>
<td>• States goal of the move</td>
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<td></td>
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<tr>
<td>• Communicates with patient and team</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Variation in height and size of team members</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Variation in ability of team members</td>
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</tbody>
</table>

Comments/Initials
## Chapter 3.0 Program Essentials

### Safe Patient Handling & Movement

<table>
<thead>
<tr>
<th>Bariatric Care</th>
<th></th>
<th></th>
<th></th>
<th>Comments/Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identifies patients classified as bariatric</td>
<td></td>
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<tr>
<td>• States patient bodyweight/height/girth/shape</td>
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<tr>
<td>• Calculates BMI</td>
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<tr>
<td>• Initiates bariatric protocols/guidelines</td>
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</tr>
<tr>
<td>Orders appropriate bariatric bed</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Demonstrates Specific Techniques</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Moves patient up in bed</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• 2 or more HCW using FRD</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repositioning sheet and ceiling lift</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Turns patient to side</strong></td>
<td></td>
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</tr>
<tr>
<td>• Using FRD</td>
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<tr>
<td>• Using Repositioning sheet and Ceiling lift</td>
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</tr>
<tr>
<td><strong>Moves patient from bed to chair /chair to bed using:</strong></td>
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<tr>
<td><strong>Transfer/ Gait Belt</strong></td>
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<tr>
<td>• States purpose for gait belt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Obtains gait belt prior to moving patient</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Demonstrates correct application</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>• Verbalizes precautions</td>
<td></td>
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</tbody>
</table>
### Safe Patient Handling & Movement

<table>
<thead>
<tr>
<th>Self Assessment</th>
<th>Demonstrates Competency</th>
<th>Date/Initials of Observer</th>
<th>Competency</th>
<th>Date/Initials of Observer</th>
<th>AGE SPECIFIC CARE</th>
<th>Comments/Initials</th>
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<tbody>
<tr>
<td>Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>144</td>
<td></td>
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<tr>
<td>Sit to Stand Device</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Lift and Sling</td>
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<td></td>
</tr>
<tr>
<td>States how to lift patient from floor</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer Chairs</td>
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</tr>
</tbody>
</table>

**Stedy**
- Completes competency sheet

**Sit to Stand Device**
- Completes competency sheet

**Lift and Sling**
- Completes competency sheet

**States how to lift patient from floor**
- Check for injury
- Applies sling
- Uses floor lift

**Transfer Chairs**
- Completes competency sheet
- Completes Occurrence Report for patient event
- Completes Work-related Injury report for HCW
Chapter 3.0 – Program Essentials

SUPERVISORY ENFORCEMENT

Early and continued success when implementing a Safe Patient Handling and Movement Program depends on the ability of supervisors to ensure healthcare workers (HCWs) are actually using appropriate techniques and equipment during assigned tasks. Resistance to change, especially in an environment with limited supervision, will delay implementation and compromise the safety of patients and HCWs.

As with any workplace initiative, management commitment at all levels is integral to its success. The importance of this commitment is reflected in both government legislation and WRHA Policies.

The Workplace Safety and Health Act assigns the responsibility to ensure that workers adhere to these policies and procedures to the Supervisor.

Section 4.1 of the Workplace Safety and Health Act states that:

4.1 Every supervisor shall:
   (a) so far as is reasonably practicable,
      (i) take all precautions necessary to protect the safety and health of a worker under his or her supervision,
      (ii) ensure that a worker under his or her supervision works in the manner and in accordance with the procedures and measures required by this Act and the regulations, and
      (iii) ensure that a worker under his or her supervision uses all devices and wears all clothing and personal protective equipment designated or provided by the employer or required to be used or worn by this Act or the regulations;

As per the WRHA Occupational Health and Safety Policy 20:10:080

Managers and Supervisors shall be responsible for applying the Workplace Safety and Health Program. Specifically, Managers and Supervisors shall identify hazards, enforce safe work practices, implement effective controls, communicate safety and health hazards, investigate hazardous conditions/incidents, and ensure that all equipment is properly maintained. Where safety and health training and/or safety equipment is required, Managers and Supervisors shall
request approval for these items from Senior Management if current funding is not sufficient.

Senior Management, Managers, Supervisors and Workers must abide by this policy, the Workplace Safety and Health Program and the Act.

Supervisory enforcement and its documentation are key to demonstrating due diligence for both HCW and patient safety. The implementation of the Safe Patient Handling and Movement Program through training, provision of resources and the creation of safe work procedures acknowledges recognition of the legislation and the risks in workplaces.

Enforcement of the Safe Patient Handling and Movement Program must be proactive, not reactive. Enforcement is not meant to punish those who have been injured or to stop injuries from being reported. The purpose of enforcement is to ensure that all HCWs follow procedures to prevent injuries to themselves and patients. This is part of the “culture of safety” where safe work procedures become part of everyday routine and are followed as closely as clinical procedures.

As per the WRHA Occupational Health and Safety Policy 20:10:080

Violation of safety and health rules or responsibilities by a member of Senior Management, a Manager, a Supervisor or a Worker may result in remedial action including education and/or disciplinary action, up to and including dismissal from employment.

All enforcement activities must be documented as per your facilities’ Human Resources procedures.

**Work-Related Injury /Near Miss Reporting**

Prevention is the purpose of an Injury/ Near Miss Investigation. It is the supervisor/manager’s job to determine corrective actions that will prevent reoccurrence of a near miss, illness or injury. The purpose is not to find fault or blame, but rather to identify the basic causes so controls can be put in place to prevent further occurrences. Information from the investigation should be documented on the Work-Related Illness/Injury/Near Miss Form. Statistics received from the Injury /Near Miss forms are also useful in identifying higher risk tasks and problem areas and can aid in the prioritization and development of annual prevention plans and further training initiatives.
Chapter 4.0 - Program Implementation and Evaluation

FUNDING

Along with the commitment to the principles of a minimal lift environment comes the need to assess and fulfill the resources required to sustain a safe patient handling & movement program. An assessment of existing infrastructure, equipment inventories, staffing levels, education capacity and availability, needs to be performed and compared to current evidenced-based patient handling guidelines. All service delivery and environmental gaps should be identified, including the availability of adequate equipment and resources to ensure the safety of both the patient and the healthcare workers (HCWs).

It is not realistic to fulfill all equipment needs at one time, but this process should not be significantly delayed. Assessments of educational requirements for HCWs should be conducted, with an educational plan developed and implemented based on the results and recommended schedules. It is recommended that resources be dedicated specifically for the rollout of the educational plan to ensure completion and sustainability, given the magnitude and scope of such a program. All of these factors need to be considered in the identification of budget requirements to support program implementation and ongoing success.

IMPLEMENTING YOUR PROGRAM

Gaining management support and assembling the team for a safe patient handling program are the foundations of the program's success.

Management Support

The initial step is to engage the support of the facility’s management team related to employee injury reduction, employee safety, ergonomics, and safe patient handling and movement. Administration's fiscal support is key to the program's success. The optimal strategy is to integrate safe patient handling and movement concepts into the existing ergonomics program and then to utilize team members in every step of the process.

Team Formation

Team formation is critical. Having the "right" members on the team will lead to the success of its efforts. Optimally the team would meet in the format of a steering committee for the safe patient handling and movement program. Define who the team will be reporting to (Executive Team, Safety Committee, Occupational Health & Safety, Nursing, or another department). A joint reporting mechanism is also an option. It is especially important to have a champion at all levels including front-
The reporting mechanism must include a process and schedule for reporting program progress toward meeting goals.

A multidisciplinary team is needed to identify key players and the roles they will play in the process. Examples of disciplines that should be included are nursing (front line and administrative), physiotherapy, occupational therapy, occupational health, education, and infection prevention and control. Other members that may be involved intermittently when their expertise is required are facility engineering, equipment technicians, purchasing, and a patient physician. Based on their involvement other ancillary or specialty departments that might be included are radiology, surgery, transport, laundry, housekeeping, and clinical engineering.

Next identify a team leader. This decision can be made by administration or by another mechanism within the facility. The leader should be provided with the resources of time and support staff to lead the program. Clerical support should be provided to assist with meeting arrangements and other support needs such as minute taking, data entry, etc. Team members should view themselves as “champions” for the program. They will help deliver and sell the message as the program is rolled out. The “champions” will serve a vital role in maintaining the program’s effectiveness and support the culture change. Consider involvement of front-line HCWs in order to achieve “buy-in” as the program moves ahead. Develop the team’s vision, mission, and objectives and then provide training to all team members so that everyone can participate on an equal basis.

**Getting Started**

The components of developing and implementing a safe patient handling and movement program include assessment, planning, implementation, and evaluation. Activities of one step can overlap or occur concurrently. There can be times when it is necessary to back up a step. Members of the team and the leader need to remain focused yet flexible as the steps are accomplished. The first step in conducting the assessment is to plan how the assessment will be conducted. Establish a time line. Enlist the help of team members and provide the support and guidance needed to complete their portions of the assessment. Determine whether training is needed for staff to conduct the assessment or if the assessment should be conducted by an outside provider. This step is a learning experience for all so allow more time than seems needed. If data is not computerized, explore ways to format data electronically for ease of retrieval and analysis.
Step 1: Assessment

The basic question that an assessment seeks to answer is this: Is there a problem in the facility? The components of the assessment include a needs assessment and data analysis.

1. Collection of Injury Data

   - Gather historical data that includes musculoskeletal injuries by department, HCW title, and body part injured, root cause of the injury and the associated costs. Review one, three, or five years of work-related injury data. A minimum of one year of data needs to be analyzed. Multiple years of data provide an historical view to evaluate trends. Strive to evaluate as many years as possible.

   - Collate injuries that require time loss. Calculate the musculoskeletal incidence and severity rates related to patient handling by department.

   - Obtain direct workers’ compensation (WCB) costs. The costs are broken down into medical costs, time loss costs, pension costs, treatment costs and other costs.

   - Determine indirect or hidden WCB costs. These costs include HCW accommodation for modified duty, manager/supervisor time, decreased staff morale that decreases productivity, and costs related to replacement HCWs. Indirect costs have been estimated to be two and a half to four times the direct cost of a claim.

2. Worksite Analysis

   - Worksite analysis refers to a comprehensive evaluation of the department needs, along with existing equipment and how/why it is or is not utilized. HCW input is essential to gain insight into the issues that are interfering with the proper use of equipment. The analysis includes:

     - Equipment inventory, including availability, storage, and use

     - Patient dependency needs

       - Independent
Supervision
- Minimal assistance
- Moderate assistance
- Dependent = Maximum assistance

- Potential high-risk patient handling tasks.
- Departments with high risk/ special needs related to patient handling.
- Break down jobs into tasks, identify hazards, and develop solutions to reduce risk.

3. Literature Review

Review the literature to see what others have done. This step gives an evidence-based approach to solving the problem. It provides an opportunity to learn what has worked and to avoid pitfalls as the program is implemented.

4. Data Analysis

Data analysis involves the following steps:
- Identify the leading types of musculoskeletal injuries related to patient handling, as well as the departments and HCWs involved in the injuries.
- Identify the root causes of injuries in the high-risk areas.
- Identify what issues prevent HCWs from using existing equipment i.e. lack of availability, lack of storage, lack of training, lack of support, the time to go get the equipment, maintenance problems, battery issues, sling availability, etc.
- Identify the costs from WCB firm experience statements associated with patient handling injuries.
- Complete a cost-benefit analysis of the return on investment and the cost to the organization if nothing is done based on history, projected forward.
Chapter 4.0 – Program Implementation and Evaluation

Step 2: Planning (Business Plan)

Brainstorm

- Consider various levels of intervention as possible solutions, including the costs for human resources, training, equipment, and potential injury reduction with projected cost savings.

- Determine the best method to roll out and maintain a safe patient handling and movement program—pilot first or whole facility.

- Determine how the methodology for safe patient handling and movement will work, i.e., unit HCWs will be responsible for their patients, a lift team, or team lifting within individual departments. What are the benefits and drawbacks of each option?

- Once the data is analyzed, an executive summary and report need to be prepared for administrative review. The report needs to include cost justification (i.e., return on investment), a plan for implementation, and staffing requirements for the program.

Policy/Operational Procedure

- Develop a policy /operational procedure on safe patient handling and movement. Ensure the guiding principle of the Safe Patient Handling and Movement Program is reflected in your workplace specific program?

Equipment

- Evaluate the type of mechanical devices that are needed to “engineer out” manual patient handling based on assessment of patient needs with a focus on safety for all HCWs, the patient, and rehabilitation goals and the guidelines. Look at a variety of devices as listed in the equipment section.

- Contact a variety of vendors who have the type of equipment the program would need. Equipment fairs are an opportunity for HCWs to see and try equipment and to talk to vendor representatives. Explore financial risk-sharing opportunities i.e. a pilot program, vendor contract conditions, HCW training, equipment maintenance and warranty agreements.
Chapter 4.0 - Program Implementation and Evaluation

- Involve front-line HCWs in the evaluation, selection, and piloting of new products to obtain buy-in for equipment use.

- Develop a process for equipment trials, product evaluation feedback, and the ordering of equipment. Always ask for pilot use of the equipment for at least two weeks to determine issues of applicability, storage, and maintenance.

Program Components

- Select the best approach for the facility’s culture and financial means. Consider:
  
  o **Task-specific:** Identify the specific patient-handling activities that will be addressed in each phase of implementation. Example: lateral transfers.

  o **Department-based:** All necessary assistive devices would be available in every department at all times. For both task-specific and department-based programs, consideration must be given to an implementation plan, development of a timeline, and training regarding what would constitute competency with equipment use.

  o **Coaches/champions:** Identify a coach or champion from every department. These individuals will be the key players in all aspects of the implementation and maintenance of the program within their departments. The coach should be viewed as an informal leader and should have the respect of other HCWs. It would be ideal to have a coach on each unit for each shift.

Education

- Develop a plan to educate both patients and their families about the program, prior to or shortly after services are provided via posters, pamphlets or in person. The program may include having the patient sign a release stating their understanding of the safe patient handling and movement practices.

- Develop a plan to investigate and assist HCWs in learning when an injury or near miss occurs. Consider implementing “after action reviews” that transfer knowledge that is learned from one task to
the same task being performed in a different setting. The review involves the interaction of a work group and facilitates learning for all involved. They can be formal, informal, or personal. Regardless of the type of review done, questions asked might include:

- what was supposed to happen?
- what happened?
- what accounts for the difference?
- how could the same outcome be avoided the next time?
- what is the follow-up plan? This should be incorporated into the Work-related Injury/Near Miss form.

- Develop a plan for regular reporting, a review of patient handling injuries, and dissemination of injury data. It is recommended that this be a minimum of quarterly in frequency. Post-injury review by the team can be an opportunity to review the injury and identify ways to prevent future injury. Annual injury reporting to the safety committee, patient care nursing directors, chief executive nursing officer, and senior executive/administration is also recommended.

- Consider using the implementation of a safe patient-handling and movement program and the data analysis associated with this program as part of the facility's process improvement efforts.

- Develop a plan for managers and HCWs who are not compliant with the Safe Patient Handling and Movement Program.

**Step 3: Implementation**

The third major step in creating a safe patient handling and movement program is the actual implementation.

- Identify a roll-out date.

- Educate by training all staff, from senior management to front-line employees, regarding the ergonomic risk factors inherent in lifting, transferring, and repositioning patients; the high risk tasks, and the new program and processes. All HCWs on all shifts need to be included. Education can be delivered in several formats such as from an education department, vendor training or through development of a
train-the-trainer program or through existing allied or occupational health departments.

- Publicize by working with current communication pathways, i.e. public relations department, newsletters, etc. to communicate, publicize, and promote the new program. Include a plan for ongoing communication throughout the program to maintain awareness of the ongoing efforts and outcomes.

- Evaluate these elements for successful implementation:
  1. Be consistent and patient as the new policy is implemented.
  2. Determine HCW competence, and identify remedial training needs.
  3. Support, encourage, and recognize the department coaches/champions.
  4. Be aware of barriers to change. It is difficult to change behavior. Manual patient handling has been the norm for the vast majority of HCWs. For generations, the “culture” of healthcare has perpetuated manual patient handling. It will not change overnight. The leader of the implementation process should prepare the team for resistance to change. Incorporate information on change into HCW education and acknowledge concerns about change. Continue with the participation of front-line HCWs in this change process to promote buy-in.
  5. Understand the complexity of the acute-care setting especially in start-up:
     - multiple layers of management
     - strong clinical and non-clinical management
     - departments that work in “silos” yet are interdependent
     - wide variety of patient care activities
     - multidisciplinary care including support departments
     - wide variety of committees
     - multiple decision makers
Step 4: Evaluating Outcomes

When implementing any program, its effectiveness must be evaluated to determine whether it has achieved its desired outcomes. Desired outcomes should be directly related to the program objectives /guiding principles:

"To prevent injuries to HCWs by providing a minimal lift environment that is achieved through providing assessment and communication tools, handling techniques and procedures, equipment and devices along with training and resources."

Outcome measures can be based on a pre and post design. This allows for evaluation of differences before and after implementation of the program, thus measuring the effects of the program.

The final step, evaluating outcomes, includes the following:

- Monitor injury data on a regular basis. Use the statistics based on Injury/Near Miss Forms (INM). Injury statistics used in the evaluation should only include the type of injury that the Safe Patient Handling and Movement Program is trying to reduce, for example, musculoskeletal injuries related to patient handling and movement. They should include the frequency, severity, mechanism, nature of injury, body part(s) injured, description of event including the activity being performed when injured, equipment involved, related costs and the department the HCW belongs to. Also include statistics and costs for the period prior to implementation of the program, at the end of the evaluation period. Identify improvements and areas that continue to have patient-handling injuries. Modify the program as indicated.

- Check employee satisfaction. Obtain employee feedback regarding implementation of the program.

- Other indicators that can be used are employee sick time or turnover rates (retention). Collaborate with Human Resources to determine an appropriate interval to reassess these indicators.

- Include the safe patient handling and movement program as an employee benefit during recruitment activities.

- Determine patient satisfaction. Develop a tool to evaluate patient and family response to patient handling with assistive devices while hospitalized and as part of a post-hospitalization patient satisfaction survey.
Chapter 4.0 – Program Implementation and Evaluation

- Finally, review the program annually for its accomplishments, set goals for the upcoming year, and modify the program, as necessary, to include new legislation, the introduction of new technologies and equipment, as well as safe patient handling and movement methods. Full or partial reviews and revision are also required when there are changes in the workplace that may affect the health or safety of HCWs and when defects or new risks are discovered. Defects/risks may be identified through HCW or patient feedback, systematic audits, and investigations related to Work-Related Injury/Near Miss reporting. The objective of this review procedure is to ensure that your program is current and addresses the issues identified.
SAFE PATIENT HANDLING AND MOVEMENT PROGRAM

Books and Articles

1. Arjo Mobility Gallery by the Ergonomics Division of Arjo, Corpus email info@corpusinfo.co.uk


7. Marras WS, Davis KG, Kirking BC, Bertsche PK. A comprehensive analysis of low back disorder risk and spinal loading during the transferring and repositioning of patients using different techniques. Ergonomics 1999; 42(7):904-926.


12. Proteau RA, Marchand D. Impact of bedding surfaces on effort required to reposition clients to the head of the bed. ASSTSAS, 5100 Sherbrook Street East, Montreal, Quebec, Canada.


15. The guide to the handling of people. 5th Edition. Published by Backcare in collaboration with the Royal College of Nursing and the National Back Exchange publishers 2005. Publication also supported by the joint Department of Health, and Health and Safety Executive ‘Back in Work’ initiative and sponsored by the Department of Health and by Arjo. British Library ISBN 0 9530582-9-8

16. Beyond getting started: A resource guide for implementing a safe patient handling program in the acute care setting. Developed by the AOHP OSHA Alliance Implementation Team, Diane Dickerson MaryAnn Gruden, Editor, June Duck Linda Haney, Jan Frustaglia Sandra Prickitt, Linda Good Denise Strode, Summer 2006


**Government Regulations**


Regional Resource References


4. Patient Lift and Transfer Policy and Procedure. Grace General Hospital

5. Safe Transfer: Area Representative Manual. Seven Oaks General Hospital

MEMO

DATE:     January 10 2007

TO:       Senior Management
          Chief Executive Officers
          Chief Medical Officers
          Chief Nursing Officers
          Program Directors
          Community Area Directors
          Diane Gantzel

FROM:     Jan Currie
          Vice President and Chief Nursing Officer

CC:       Bariatric Steering Committee
          Bariatric Care Working Group

Phone:    926-7006
Fax:       926-8008

RE:        Bariatric Care Committee Report

Over the past several months, a group of staff have come together to develop a strategy for care of bariatric patients, defined as a chronic disease of excess body fat that correlates with a Body Mass Index (BMI) of 35 or higher or with being greater than 45 kg (100lbs) overweight.

Increasing obesity rates in the population are creating demand for safe and appropriate bariatric services. Looking at the full spectrum (from normal weight, overweight and through the gradations of obesity), there are a number of factors that contribute to the end need for Bariatric care, and a range of services are needed.

The WRHA Bariatric Care Committee was formed in November 2005 with the purpose of addressing the issue of providing safe, efficient and effective care to the increasing number of Bariatric clients presenting at the various sites within the Region. Members of the Committee were tasked to look at 5 key areas: Health Promotion, Clinical Practice Guidelines, Site Consolidation, Injury Prevention and Education, and Equipment/Infrastructure. Four working Groups were formed with specific tasks assigned to each. A working group for Health promotion was not formed, but linkages were made with existing initiatives. Membership on each Working Group was expanded, at the discretion of the Group Lead, to include individuals with expertise in that given area that may not have been invited to sit on the main Committee.

Their Report is attached and has been approved by WRHA Senior Management January 3, 2007. As next steps in the process, please ensure:
1. Program Teams and sites consider this patient population in the ongoing Regional Health Plan process. This would include for example, continued attention to bariatric patient equipment during Capital Equipment process, attention to staff education, consideration in Capital construction processes, and review of ethical issues related to care of these patients.

2. Circulation of the Report within each portfolio and site. Page (i) of the Report lists those involved in the process to date. I have been impressed by the work already done by these individuals and others to meet the needs of these patients and of the population in general.

A further meeting of the various working group Chairs will be held to determine next steps to move towards the Referral Centres and other recommendations proposed in the Report.

Please join me in recognizing the work of all those involved and ensure the Report is considered in regional planning.
WRHA Regional Bariatric Care Plan 2007-2008

A Proposal submitted to the WRHA Senior Management Team
Compiled and Written by Stephen Diakow
On behalf of the WRHA Bariatric Care Committee

November 22, 2006
Acknowledgements

The WRHA acknowledges the contribution of the following members of the Bariatric Care Committee and the various working groups in the development of the WRHA Regional Bariatric Care Plan 2007-08.

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  Health Sciences Centre
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WRHA Regional Bariatric Care Plan

The WRHA Bariatric Care Committee was formed in November 2005 with the purpose of addressing the issue of providing safe, efficient and effective care to the increasing number of Bariatric clients presenting at the various sites within the Region. Members of the Committee were tasked to look at 5 key areas: Health Promotion, Clinical Practice Guidelines, Site Consolidation, Injury Prevention and Education, and Equipment/Infrastructure. Four working Groups were formed with specific tasks assigned to each. A working group for Health promotion was not formed, but linkages were made with existing initiatives. Membership on each Working Group was expanded, at the discretion of the Group Lead, to include individuals with expertise in that given area that may not have been invited to sit on the main Committee.

Background

The word ‘obesity’ was originally derived from the Latin word *obesus*, meaning to devour. The term ‘Bariatric’ was derived from a combination of the Latin word *barros*, meaning heavy or large, and the Greek word for medical treatment, *iatreia*. Health Canada (2003) defines obesity as a chronic disease of excess body fat and correlates with a Body Mass Index (BMI) of 35 or higher or with being greater than 45 kg (100lbs) overweight. BMI is measured in kilograms per metres squared, kg/m$^2$, and is calculated using the following formula:

$$BMI = \frac{\text{Weight, in kilograms}}{(\text{Height, in metres})^2}$$

BMI replaces Height/Weight Charts and is used to determine a person’s risk for developing weight-related health problems. Table 1 outlines different ranges of Health Status based on BMI (Douketis et al, 2005)

**Table 1: BMI Ranges**

<table>
<thead>
<tr>
<th>Health Status</th>
<th>BMI</th>
<th>Risk of Developing Health Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18.50</td>
<td>Increased Risk</td>
</tr>
<tr>
<td>Normal</td>
<td>18.50 – 24.99</td>
<td>Lowest Risk</td>
</tr>
<tr>
<td>Overweight</td>
<td>25 – 29.99</td>
<td>Increased Risk</td>
</tr>
<tr>
<td>Obese Class I</td>
<td>30 – 34.99</td>
<td>High Risk</td>
</tr>
<tr>
<td>Obese Class II</td>
<td>35 – 39.99</td>
<td>Very High Risk</td>
</tr>
<tr>
<td>Obese Class III</td>
<td>40 – 49.99</td>
<td>Extremely High Risk</td>
</tr>
<tr>
<td>Extreme Obesity</td>
<td>&gt; 50</td>
<td>Extremely High Risk</td>
</tr>
</tbody>
</table>
Prevalence

The prevalence of overweight and obese adult individuals in Canada has increased between 1985 and 2003. In 1998, the percentage of overweight and obese individuals within the National population was 14.8%, up from 5.6% in 1985. In Manitoba, the percentage is slightly higher than the National average, at just over 15%. (Belanger-Ducharme & Tremblay, 2005)

Obesity is significantly associated with Type II diabetes, cardiovascular disease, asthma and arthritis. Other potential health risks include sleep disorders, other respiratory diseases, and certain types of cancer. The increase in the prevalence of overweight and obesity in the population is cause for concern due to the increased risk for early disability and death, decreased quality of life and a diminished capacity to contribute to the economy. These factors translate into over $1.8 billion in direct health care costs to the Canadian health care system. (Katzmarzyk & Mason, 2006)

The percentages were calculated by Statistics Canada (2006) using self-reported information on height & weight. A smaller study (sample size: 4000) directly measured height & weight and concluded that, when self-reporting, men tend to over-estimate their height and women tend to underestimate their weight, both of which will result in a lower BMI calculation. This study showed that the National Obesity rate among Adult Canadians might actually be 24.3%, instead of 14.8%.

In the Winnipeg Health Region, there were 565 reported cases (493 inpatient admissions and 72 Day/Night Care admissions) where morbid obesity was identified in the patient abstract during the fiscal year 2004-2005. The breakdown of these cases by site and by program is listed in Table 2. These cases are distributed across all Clinical Programs as well.

In total, there were 343 female admissions and 222 male admissions. Saint-Boniface General Hospital had highest percentage of cases with 34.9% (31.8% of the In-patients and 56.3% of the Day/Night Care Patients), which is more than twice that of any other facility. Victoria General Hospital had the next highest percentage of admissions at 17.7% (16.8% of the In-patients and 23.6% of the Day/Night Care Patients), followed by Health Sciences Centre at 14.3% (15.0% of the In-patients, 9.7% of the Day/Night Care Patients). Nearly all Day/Night Care Visits where a diagnostic code of ‘morbid obesity’ was present were in the Cardiac Sciences (55.6%) and Surgery (41.7%) Programs.
Table 2: 2004-05 WRHA Morbid Obesity Admissions by Patient Type, Gender, Site & Program  
(Source: Abstracting DSS, December 2005)

<table>
<thead>
<tr>
<th>SITE</th>
<th>INPATIENTS</th>
<th>DAY/NIGHT CARE PATIENTS</th>
<th>SITE CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Site Total</td>
</tr>
<tr>
<td>St. Boniface General Hospital</td>
<td>98</td>
<td>59</td>
<td>157</td>
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<td>Victoria General Hospital</td>
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<td>Health Sciences Centre</td>
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<td>Deer Lodge Centre</td>
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<td>1</td>
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<tr>
<td>Children’s Hospital</td>
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<td><strong>TOTAL</strong></td>
<td><strong>311</strong></td>
<td><strong>182</strong></td>
<td><strong>493</strong></td>
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<th>DAY/NIGHT CARE PATIENTS</th>
<th>PROGRAM /SERVICE CONTACT</th>
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<td>Rehabilitation</td>
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<tr>
<td>Mental Health</td>
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</tr>
<tr>
<td>Obstetrics</td>
<td>19</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>311</strong></td>
<td><strong>182</strong></td>
<td><strong>493</strong></td>
</tr>
</tbody>
</table>

* Program identified by Main Patient Service (Hospital Abstract Database)

**Data Limitations:** “Obesity” is not a mandatory code for abstraction from a patient’s chart by Health Records staff, which may contribute to an underestimation of the prevalence of obese patients in WRHA facilities. Nor is a patient’s BMI abstracted, even if this information is recorded in the chart. This underestimation of cases may in part, be offset by the fact that not all patients who meet the criteria of morbid obesity would require specialized equipment.
**Bariatric Care Framework**

The fact that the health care system needs to respond to an increased service demand for safe and appropriate bariatric services represents the visible tip of the obesity epidemic iceberg. The WRHA Regional Bariatric Care Committee was brought together to address the urgent and specific need for quality services at the extreme end of the overweight/obesity spectrum, but it was quickly recognized that upstream factors needed also to be considered. Looking at the full spectrum (from normal weight, overweight and through the gradations of obesity), there are a number of factors that contribute to the end need for Bariatric care, and a range of services are needed. Figure 1 lays out the continuum from normal weight to extreme obesity, considering health and functional status in addition to body weight. It illustrates the recommended health system responses given different positions on the weight and health continuum, with one step building upon the previous.

At the basic level, our whole population benefits from health promotion interventions that address increased daily physical activity balanced with healthy nutritional intake. Further along the spectrum, the clinical management of obesity based on clinical guidelines should be used throughout the health care system to address the health risks associated with obesity. At the top of the diagram, services for clients in the community or hospital inpatients with extreme obesity or obesity with mobility or function impairments is highlighted due to the specialized care needs identified in this document.

The work of the Site Consolidation working group focused on the top box (inpatient bariatric services) while the Injury Prevention and Education, and Equipment/Infrastructure working groups addressed the top two boxes (inpatient bariatric services and supportive / safe care). The Clinical Practice Guidelines working group focused on all the levels throughout the spectrum of overweight and obesity management. A Health Promotion working group was not struck, but linkages were made with existing population-wide health promotion (obesity prevention) initiatives already underway.

The proposed framework and upstream continuum for Bariatric care (Figure 1) can be used as a backdrop to put the issue into context and to visualize the responsibilities of the whole WRHA system in caring for Bariatric clients as well as the management & prevention of obesity.
### Figure 1: Proposed Framework and Upstream Continuum for Bariatric Care

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>No Disease</td>
<td>No Disease</td>
<td>Chronic Condition</td>
<td>Good Functional Status</td>
<td></td>
<td>Supportive / Safe Care: Care and services for bariatric clients/patients with mobility issues (more direct care by providers required due to poor functional status or co-morbidity)</td>
<td>In-Patient Bariatric Care Services</td>
<td>Bariatric services in hospital settings</td>
</tr>
<tr>
<td>Weight Reduction: Care and services for overweight or obese clients/patients with various health conditions as per evidence based guidelines as per “overweight” PLUS appropriate use of pharmacotherapy, nutrition, behavior/psychological services</td>
<td>Weight Reduction: Care and services for overweight or obese clients/patients with various health conditions as per evidence based guidelines as per “overweight” PLUS additional assistance with adapted programming (related to size), possible surgery</td>
<td>Weight Reduction:</td>
<td>Management of obesity as per clinical treatment guidelines in all settings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention: Primary prevention of overweight and obesity through the promotion of healthy nutrition and physical activity through practice, programs, policies and partnerships (i.e. Winnipeg In Motion, Chronic Disease Prevention Initiative)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prevention activities**
In the initial committee planning stages, health promotion and the prevention of obesity were identified as important considerations for any Bariatric Care Plan. However, a decision was made to not form a separate working group for health promotion for this specific planning process. Instead, the committee would identify and link with the existing ongoing initiatives that are already addressing the primary prevention of obesity.

The WRHA has adopted a positive, strengths-based approach to the prevention of obesity and obesity-related chronic disease using, rather than a negative deficit-based one. As a result, there are no specific strategies framed as “obesity prevention” or “chronic disease prevention” within the WRHA. Instead, the strategy for healthy living includes the focus on positive promotion of physical activity in balance with healthy nutrition.

It is recognized that healthy living is determined by far more than individual lifestyle “choices” around behaviour. A variety of underlying factors (including socioeconomics, education, employment and working conditions, social and physical environments, cultural and societal norms etc) act in concert to create conditions that can be either conducive or obstructive to healthy living. Assisting and empowering clients and patients to consider healthier living options is informally woven into health service delivery through all parts of the WRHA. There are also many partners and organizations outside the health care delivery system, which can positively affect healthy living conditions, such as schools, workplaces, neighbourhoods and recreational environments. By influencing these interrelated factors to make healthier options easier and more acceptable, population-wide benefits of prevention can be realized.

The WRHA is currently playing a significant leadership role in two specific initiatives related to the promotion of healthy living: Winnipeg in motion and the Healthy Workplace Project.

To promote physical activity for health benefits, the WRHA has partnered with the University of Manitoba, the City of Winnipeg and Manitoba in motion to create the banner initiative Winnipeg in motion. It is a community-wide collaboration that primarily encourages Winnipeggers to be physically active, while also promoting healthy nutrition, mental health, injury prevention and Aboriginal health. Engaging citizens, groups, and organizations is an essential part to the creation of supportive communities as well as to the success of Winnipeg in motion. By working together, communities will be able to identify opportunities and barriers to being physically active and then plan, develop, coordinate and deliver services that support their residents to include physical activity in their daily lives. For more information on Winnipeg in motion, see [www.winnipeginmotion.ca](http://www.winnipeginmotion.ca).

To assist with Winnipeg in motion, the WRHA has received provincial and federal funding from the Chronic Disease Prevention Initiative (CDPI) for projects in the Seven Oaks and Point Douglas community areas. The CDPI provides funding and other support to community committees to initiate and sustain community-led activities addressing physical activity promotion, healthy nutrition and tobacco reduction at the local level. The CDPI and Winnipeg in motion are presented as integrated opportunities for members of the community.
The Healthy Workplace Project focuses on staff wellness. Through collaboration with The Wellness Institute at Seven Oaks General Hospital, the WRHA has access to a health risk appraisal and decision-making tool to identify health issues of individuals and organizations. Employees are encouraged to use the tool to create a confidential personal profile and identify their own health risks, which will help them work towards healthier lifestyles. Managers will also have access to anonymous aggregate reports, which provide information on the health risks experienced by their site/organization as a whole. This information can then be used to develop and implement strategies for addressing these risks and creating a healthy working environment.
Clinical Practice Guidelines Working Group Report
Co-Chairs: C. Rand & S. Bates-Dancho (for J. Schweitzer)

The scope of this working group was to make recommendations on treatment guidelines for both overweight and obese individuals, including both children and adults. Currently, a Canadian version of Clinical Practice Guidelines (CPGs) for obesity does not exist, however there is a draft in the final stages with expected release ‘soon’. Guidelines from other countries (Finland, the United States, and Scotland) have been researched, however the references cited and reviewed do not necessarily capture the highly complicated and multi-factorial etiology and contributing factors to obesity. Also, they do not pay due consideration to the cultural/psychosocial aspect of treatment. There is consensus among the Committee that any treatment recommendation must include and reflect essential psychosocial and cultural elements across the entire spectrum of obesity management and prevention.

The Region may not have the resources at this time to develop it’s own CPGs in a timely manner. The potential exists that such guidelines may not be consistent with the Canadian CPGs being formulated by the Canadian Obesity Network (CON-ROC). Correspondence with indicated that a draft copy of the guidelines would be forwarded when they are ready for distribution. Dr. David Lau, a member of the Board of Directors of CON-ROC, addressed the CON-ROC CPGs for the prevention and treatment of obesity at the Canadian Diabetes Association Professional Conference in October 2006. CON-ROC has not finalized a release date for the CPGs, but they expect to have them available before the end of 2006, as per correspondence on October 2, 2006.

Next Steps

1. Wait until the Canadian Clinical Practice Guidelines are available in order to make Regional recommendations for the treatment of obesity.
2. Recommend an environmental scan of the available services/tools/resources related to treatment of obesity. The information gathered will provide a starting point for recommendations related to the implementation of the Canadian CPGs, once they are available. This scan should include services available in the following sectors:
   a. Commercial/retail
   b. Not for profit
   c. Publicly funded

All services/tools/resources should also be assessed for long-term success and patient safety. This project has been proposed for a Dietetic Intern and will not require additional funds to complete.
Site Consolidation Working Group Report
Chair: J. Kaprowy

There are several benefits to consolidating the treatment & care of Bariatric patients. Equipment and resources can be used efficiently and effectively, and it offers the ability to specialize and quickly develop expertise in the management of specific client populations. Consolidation of services was examined and recommendations are provided for the following service areas: Acute Care, Long-Term Care, Chronic Care, and Home Care.

It is proposed that care for clients greater than 272kg (600 lbs) in weight should be consolidated to one site for each of the Acute Care, Long Term Care & Chronic Care Programs. All sites should have the ability to care for bariatric clients up to 272kg (600lbs) in weight. This number is based on safe working limits for equipment manufactured for safe patient handling techniques.

Acute Care

The responsibility for management and care of bariatric patients who require acute care should be consolidated at St. Boniface General Hospital (SBGH). There was consensus that consolidation should be at a tertiary site. The Health Science Centre was ruled out given the current number of tertiary programs located at this site and the need to protect the Trauma, Neurosurgery/Stroke, and Burn Programs.

The consolidation plan excludes the placement of Women’s Health bariatric patients at St. Boniface General Hospital, given the need for a regional two-site program. This is a unique population that is already centrally located. Provisions should be made to ensure that adequate resources are available for handling Bariatric patients at the current site.

Rationale

In 2004-05, SBGH managed 29% (144/427) of the adult in-patients requiring bariatric care, as well as 56% (40/71) of the adults requiring day/night care. SBGH is supported by all acute care programs, which will reduce the fragmentation of service delivery. The site is also supported by Medical and Surgical physicians associated with bariatric care, as well as all diagnostic departments. WRHA Clinical Programs support this recommendation for consolidation.

SBGH has a footprint available to receive bariatric patients. The entrance to the hospital can accommodate the admission of bariatric patients and the elevator is accessible to various patient care units/support departments. Pathways for the transport of patients are circuitous but accessible. SBGH has access to equipped and empty operating rooms with relocation of orthopedic surgery, as well as access to potential space with the transfer of the Rehabilitation Program and the closure of E6. The space in E-wing is environmentally friendly for bariatric patients, with wider doorframes, wheelchair and walker accessible bathrooms, and larger rooms.

The Physiotherapy Department at SBGH has developed expertise in this area and has an interest in management of bariatric patients. Specific processes for management and care have also been developed.
Long Term Care

The responsibility for management and care of bariatric patients requiring Long Term Care should be consolidated at Deer Lodge Centre (DLC). Consolidation at Riverview Health Centre was ruled out given current regional plans to consolidate tertiary rehabilitation at that site. Other Long Term Care facilities were eliminated, as they did not have equipment or services to support this patient population.

Rationale

DLC has physical and human resources available to accommodate bariatric patients. Specifically, the Personal Care Home has single rooms, the corridors are wide and dining rooms are spacious. The bathrooms are both wheelchair and walker accessible and the freight elevators are situated in the bank of other site elevators. Not much would be required to retrofit the facility.

DLC has developed a cadre of health care workers with expertise in care of bariatric patients in recent months. The facility has three PhD psychologists on staff and both the Occupational Therapy and Physiotherapy Departments have a growing interest in the management and care of bariatric patients. A solid educational program related to safe patient handling has been developed and is well established. It can easily be used as the framework for safe Bariatric patient handling education.

Chronic Care

The responsibility for management and care of bariatric patients requiring Chronic Care should be consolidated at Deer Lodge Centre (DLC). Consolidation of bariatric patients requiring Chronic Care and those requiring Long Term Care at DLC fosters an economy of scale leading to efficient and effective provision of care with reduced fragmentation of service delivery.

Home Care

Although site consolidation has been proposed for extremely large bariatric clients in the Acute Care, Chronic Care & Long Term Care Programs, the responsibility for management and care of bariatric patients in their homes cannot be consolidated to one site. Care would need to be available to clients throughout the region who meet the eligibility and assessment criteria for the Home Care Program. The goal is to provide safe, efficient and effective care to bariatric clients in their homes, while ensuring the safety of both the staff and the Healthcare providers.

Care planning would require a multidisciplinary team approach, including but not limited to the following: Dietician, Occupational Therapist, Physiotherapist, Physician, Home Care Coordinator, and possibly a Psychologist. Weight management/weight loss should be the priority care planning & management issue, as well as safety of the individual and the healthcare workers. In order to deliver safe and effective care to clients in their homes, several conditions would need to be met and must be ensured prior to the start of service. Individual clients would
need to have a relatively stable health status and the environment should be able to support all equipment required for the care plan.

Given the extra requirements for safe patient handling and care of Bariatric clients, Home Care would need to ensure that adequate and properly trained human resources are available in the home during service delivery. Bariatric Rehabilitation Services would also need to be provided in the home environment. Because Direct Service Staff (DSS) will likely only have limited exposure to working with Bariatric clients, it will be difficult for them to develop synergy of care and expertise in the provision of service to this patient population in the home environment. This may be addressed through specialized population and client specific training for DSS, as well as making sure that extra support (supervision, problem-solving resources) would be readily accessible. Training for DSS on safe bariatric patient handling would be facilitated by the Coordinators of Client Specific Services, Staff Development Coordinator and Instructors, although these individuals would likely require additional training on Bariatric Care themselves. Educational resources for Instructors would be available through a Regional network. Training for DSS may also be enhanced through a practicum/placement at Deer Lodge Centre (the consolidated site for Chronic Care & Long-Term Care), once it’s Bariatric program is up and running.

In addition to staff resources, adequate equipment resources must be made available to ensure the safety of both the client and the Healthcare workers. A small inventory of bariatric equipment is currently owned by the Home Care Program and is monitored by the Home Care Equipment & Supplies Program Consultant. There is a current need for additional equipment, and this need is increasing. Bariatric equipment does not require special approval through Home Care. However, any purchasing would be arranged through the Home Care Equipment and Supplies Program Consultant and WRHA Logistics following consultation the Care Team decision-makers (Therapist, Manager, etc.). It has been proposed that Home Care will also have the option to access equipment resources for extremely large clients (over 272kg/600lbs) from the Regional Bariatric Equipment Pool. Specific arrangements regarding the use of Pool equipment would have to be made, as there is potential for equipment to be used by a single client for an extended period of time.

**Next Steps**

All service delivery and environmental gaps should be identified, including additional equipment requirements. Specific attention should be given to Deer Lodge Centre and Community Health Services (Home Care). Assessments of educational requirements for staff should be conducted, with and educational plan developed and implemented based on the results. All of these factors need to be considered in the identification of budget requirements to support consolidation in the different care areas.
**Injury Prevention and Education Working Group Report**  
Chair: Betty Lou Rock

The mandate of this working group was to develop staff education & clinical guidelines for the safe patient handling of bariatric clients. The goal of the education package is the prevention of staff and patient injuries. To achieve this goal, the working group proposed and was charged with producing 4 key deliverables:

1. Standardized staff education program (video/self-learning/classroom sessions etc.) to be delivered in all practice areas (acute care, long-term care, primary care, Home Care).
   - General for all front-line staff
   - Specialized for target groups of staff

2. Identification of target staff for education
   - Numbers
   - Practice area(s)
   - Type of education required (general and/or specialized)

3. Development of guidelines & procedures for the safe handling of bariatric patients.

4. Development of an educational framework and resource tools.

This is a new area of practice for most sites and programs. The frequency of bariatric patients within most programs is low, although increasing. These clients pose a significant risk of injury to staff and themselves. Communication, mitigation of risk, patient and staff safety and problem solving will assist in the management of these individuals.

Each facility will be provided with Resource Material on the safe patient handling of Bariatric clients, to be added to their current Care Plan Manuals. Information provided within the Bariatric Resource Manual will include:

- BMI conversion chart
- A Sample Policy Template for Safe Patient Handling of Bariatric Clients
- Algorithm templates for both Emergency and Elective bariatric patient admissions processes
- Resource Safety Checklist outlining important considerations when assessing a facilities ability to care for bariatric clients to help facilitate the Client Admission and Transfer processes
- Safe Work Procedures for basic Bariatric patient handling tasks
- CD containing Educational Material for safe Bariatric patient handling

A copy of the Bariatric Resource Manual can be found in Appendix A.
Safe Bariatric Patient Handling Education

Education of employees will take place at several different levels. All employees should receive general information about the existence of specialized safe patient handling techniques and appropriate terminology related to the care of bariatric clients. All direct care providers should receive general training on safe bariatric patient handling techniques as well as specialized training specific to their unit or department. Each facility should have personnel with advanced knowledge and experience in client assessment and safe patient handling, including bariatric clients, to organize site & client specific training. Finally, the WRHA as a whole should develop expertise level knowledge in the form of a Bariatric Clinical Specialist(s) to oversee the training program and provide further client-specific consultation to the various sites & facilities within the region. It is recommended that resources be assigned for the rollout of the proposed educational plan.

General Safety & Health/Disability Management Orientation for New Employees

Information about safe work practices & procedures (S&H Legislation, Worker Rights & Responsibilities, WHMIS, Infection Control, Incident Reporting, etc.) must be given to all staff upon commencement of employment with the WRHA, as required by the Workplace Safety & Health Act. The WRHA Workplace Safety & Health Education Committee has developed templates outlining the Workplace Safety & Health material that needs to be covered at basic orientation (as well as program specific orientation, and departmental/unit specific orientation). Roll out of these templates is expected to take place in Fall 2006.

The WRHA Workplace Safety & Health Basic Orientation provides a brief overview of Safe Patient Handling Practices. This is the most appropriate platform from which to deliver basic information about the safe handling of bariatric patients, including the importance of respecting dignity. This will ensure that all employees are aware that specific strategies exist within the WRHA for providing safe care to the bariatric population. This initial orientation to bariatric clients can be brief, but should include information similar to the following:

There is an increased prevalence in Bariatric Client Admissions within the WRHA. A bariatric client is an individual with a Body Mass Index of 40 or greater and/or with a weight greater than 159kg (350lbs). In order to reduce the risk of injury to staff and clients, specialized equipment and patient handling techniques are required when dealing with Bariatric Patients. It is important to follow the procedures outlined in the patient chart and patient handling manuals. While respecting and maintaining client dignity is important in all cases, it is extremely important when dealing with Bariatric Patients. Comments about patient or equipment size (i.e. Big Boy Bed, Heavy Duty Walker, etc.) can be very detrimental to the recovery of these clients. The term “Expanded Capacity”, “EC” for short, should be used whenever possible.

Site/Departmental Specific Orientation for Direct Care Providers

All Direct Care Providers (Aides, Nursing Staff, Allied Health Personnel) should already receive regular training on Safe Patient Handling techniques & skills. Training specific to bariatric
clients should be included in these sessions, but may require separate sessions based on the prevalence of bariatric clients on the wards/units and the number of different departments with bariatric admissions. Individuals with more advanced Safe Patient Handling knowledge & skills typically lead these sessions. Our proposed education package follows the same model with respect to the different levels of training specific to safe bariatric patient handling.

General level training in safe bariatric patient handling – occurs in orientation and provides basic definitions and criteria that must be met to accept this type of client. All direct care personnel would be expected to know and demonstrate safe bariatric patient handling skills, both in the training sessions and during regular work on the wards/units. These skills & practices would include:

- **Equipment:** beds, commodes, shower chairs, sliders, patient assist devices
- **Client requirements**
  - ADL such as toileting, showering, hair care
  - Mobility – ambulatory vs. wheelchair mobility
  - Bed mobility
  - Type of transfer

As with general Safe Patient Handling Education, competency for handling Bariatric clients should be demonstrated on a regular (annual) basis through refresher training.

**Site Level Advanced Expertise in Safe Bariatric Patient Handling**

The next level of training would be a person(s) with expertise in safe Patient Handling as well as a knowledge base & experience in handling Bariatric patients. Defined by each facility, they would require the ability to assess and work with all interdisciplinary team members and across sectors within that facility, likely found in the Occupational Therapy, Physiotherapy, and/or Occupational Safety & Health Departments. These individuals would be responsible for organizing within-site education on general safe Bariatric patient handling techniques, including client-specific consultation & training, and liaising with the different site programs.

The final level of expertise would lie with a Regional Clinical Specialist for Bariatrics. This individual would have expertise with the assessment and safe patient handling of bariatric clients. Their role would involve client-specific consultations with the facilities within the WRHA and assisting different programs with the development and implementation of Safe Bariatric Patient Handling training initiatives. They would also coordinate the education & training of personnel with advanced level expertise on safe bariatric patient handling. Educational opportunities for this level of expertise may need to be sought outside the region.
The mandate of this committee was to develop short-term, mid-term, and long-term options for meeting the needs of the Bariatric population.

An assessment of current bariatric equipment inventories and occurrence of bariatric admissions was performed for each facility within the WRHA. From this information, recommendations for a minimum client capability at each facility were determined. Each facility should have baseline equipment with a capacity of up to 272 kg (600lbs) in order to safely manage a bariatric patient admission of up to this weight. This capacity exceeds the Committee’s recommended capacity of 227kg (500lbs) for all equipment in each facility mainly due to most manufacturers’ equipment capacity categories. A list of the equipment each facility is required to purchase in order to meet this minimum client capacity is given in Table 5.

A Regional Bariatric Equipment Pool should be set up to facilitate the short-term provision of equipment as an equipment support program. This would provide backup support to facilities should they have more than one Bariatric admission, meaning their equipment is already in use, or they encounter a patient heavier than 272kg (600lbs). The equipment in the Regional Pool should be able to safely handle patients up to 454kg (1000lbs). A summary of the equipment required for a Regional Pool is given in Table 6. In addition to the equipment listed, any equipment required by Home Care should be added to the pool, due to the lack of a warehousing facility in Home Care.

Recently, additional financial assistance was received from Manitoba Health for the purchase of equipment, including Bariatric equipment. On June 15, 2006, the WRHA allocated funds for the purchase of the equipment recommended for the Regional Bariatric Equipment Pool. At the same time, several facilities & programs also received funding to purchase basic bariatric equipment resources, based on their predetermined need. It is expected that each site will use the allocation to purchase the equipment recommended in Table 5 in order to meet the expected minimum client capacity. A plan has been formulated to purchase additional site-based Bariatric equipment over the next few years, however, individual sites may be required to purchase items out of their own budgets in order to meet any changing needs. WRHA Logistics is currently chairing the group that will oversee the evaluation and purchase of recommended bariatric equipment.

Infrastructure Guidelines for Bariatric Clients have been developed and will be incorporated into all future Capital Planning initiatives. Manitoba Health Construction has expressed interest in also adopting these guidelines for their other future initiatives. Infrastructure issues within existing WHRA facilities are currently being evaluated and still need to be addressed.
Table 5: Recommended Initial Bariatric Equipment Purchases for Each Site, as of June 15, 2006

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<th>ITEM</th>
<th>VGH Cost Q</th>
<th>St. BGH Cost Q</th>
<th>DLC Cost Q</th>
<th>HSC Cost Q</th>
<th>Home Care Cost Q</th>
<th>RHC Cost Q</th>
<th>CGH Cost Q</th>
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<td>1 $500.00</td>
<td>1 $500.00</td>
<td>8</td>
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<td>Stretcher Chair</td>
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<td>1 $16,430.00</td>
<td>0</td>
<td>1 $16,430.00</td>
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<td>1 $7,900.00</td>
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<td>ALLOTMENT*</td>
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<td>$57,000.00</td>
<td>$75,000.00</td>
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<td>**</td>
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<td>$64,000.00</td>
<td>$67,000.00</td>
<td>$65,000.00</td>
<td>$502,000.00</td>
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*Allocation for Home Care Equipment will be diverted to the Regional Bariatric Equipment Pool, as Home Care does not have facilities to store Equipment.
Table 6: Recommended Initial Regional Bariatric Equipment Pool, as of June 15, 2006.

<table>
<thead>
<tr>
<th>Qty</th>
<th>Description</th>
<th>Unit Price</th>
<th>Cost</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Bed with Powered Drive</td>
<td>$24,500</td>
<td>$24,500.00</td>
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<tr>
<td></td>
<td>Width: 1m/39” expandable to 1.22m/48”</td>
<td></td>
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<tr>
<td></td>
<td>Includes: Scale, trapeze, rails &amp; foam mattress with bolsters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Bed with no powered drive</td>
<td>$16,650</td>
<td>$16,650.00</td>
</tr>
<tr>
<td></td>
<td>Width: 1m/39” expandable to 1.37m/54”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Includes: Scale, trapeze, rails &amp; foam mattress with bolsters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Bariatric Air Mattress, 1m/39” width with bolsters to expand width</td>
<td>$7,350</td>
<td>$14,700.00</td>
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<tr>
<td>1</td>
<td>Portable Floor Lift with Powered Drive, 3 slings, no scale 454kg/1000lb capacity</td>
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<td>$17,500.00</td>
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<td>Semi-permanent Ceiling Lift with scale &amp; 3 slings</td>
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<td>$13,098.00</td>
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<td>2</td>
<td>Bariatric Wheelchair</td>
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<td>Wheeled Commode/shower chair, 386kb/850lb capacity</td>
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<td>Stationary Commode Chair (92cm/36” width), 454kg/1000lb capacity</td>
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<td>2</td>
<td>Electric Powered Stretcher Chair</td>
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<td></td>
<td>Seat width: 81cm/32”, Overall width 1m/39”</td>
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<td></td>
<td>Will function as both a chair and a stretcher</td>
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<td>3</td>
<td>Double-width Sliding Sheet for repositioning</td>
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<td>$1,392.00</td>
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<tr>
<td>2</td>
<td>1.5-width Sliding Sheet for repositioning</td>
<td>$464</td>
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<td>2</td>
<td>Adjustable, foldable wheeled Walker, 454kg/1000lb capacity</td>
<td>$1100</td>
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<td>Stretcher (1m/39”), 454kg/1000lb capacity</td>
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<td>Tilt Table for Standing Patient, 454kg/1000lb capacity</td>
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<td>2</td>
<td>Ramp for Patient Standing and Staff Reaching Aid</td>
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<td>TOTAL</td>
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<td>Fund Allocation as of June 15, 2006</td>
<td>$169,000.00</td>
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</table>
Recommendations for Further Development

There are several steps that should be engaged/followed in order to advance the realization of the Proposed Regional Bariatric Care Plan. They include both short-term and long-term recommendations.

In the short term, a project to implement the care plan should be created in order to enlist the assistance of the WRHA Project Management Office. This approach will greatly improve the success of implementation. A Project Lead should also be identified, with a potential lead position created as funding permits. Sites & programs should continue to assess infrastructure & process limitations and develop plans to address these issues. Sites should also continue to work with Logistic Services to meet their basic Bariatric equipment needs. The Canadian Clinical Practice Guidelines for the treatment of obesity should be adopted by the WRHA when they are made available.

The WRHA should continue to expand the ability to accommodate Bariatric clients within the regional health care system. As implementation progresses, a long-term owner of the Proposed Bariatric Care Plan should be named to ensure accountability.
References


Health Canada (2003). Canadian Guidelines for Body Weight Classification in Adults, Publication No. 4647, Her Majesty the Queen in Right of Canada


APPENDIX A

Bariatric Resource Manual

Currently under development
Completion by December 2006 is anticipated
WRHA Regional Bariatric Resource Manual
WRHA Bariatric Resource Manual Overview

The increasing obesity epidemic presents a challenge or caregivers in the handling and transfers of these patients and places them at an increased risk for injury. In an attempt to reduce this risk, this resource manual was compiled to provide healthcare workers with clinical tools, resources, educational materials, policies, safety tips and considerations for care planning. Please note that this manual is not all-inclusive and may not provide all the information & education required for staff to perform their tasks in a safe & efficient manner. Every facility/program will need to augment the information in this manual by tailoring the sample programs & education tools to meet their specific needs.

Contents

- Facility Planning Considerations
- Bariatric Admission Flow Charts
- Education Review: Helpful Tips for Safe Patient Handling of Bariatric Patients
- Medical Conditions Affecting Bariatric Patients
- BMI Nomogram
- Bariatric Risk Assessment Tools
- Mobility Screening Tool
- Bariatric Care Algorithms
- Safe Work Procedures for Basic Bariatric Patient Handling Tasks
- Sample Bariatric Policy Template (including a sample Bariatric equipment list)
- Equipment Safety Checklist

Regular standardized education is an integral part of any safe patient-handling plan. We recommend that all workers performing patient handling tasks review the items provided in the manual. The use of assessment forms and algorithms, along with return demonstrations of hands-on techniques, should be part of competency training for new & existing employees.

Acknowledgements

We wish to acknowledge the members of the Bariatric Care Committee Injury Prevention Working Group bariatric subgroup committee members for their time & effort in compiling this resource manual:

Betty Lou Rock – Working Group Chairperson
Shauna Boitson        Heather Christie        Stephen Diakow
Gail Archer-Heese     Kathy Kelly            Theresa Matviychuk
Marylou Muir          Joyce Peterson          Sandra Sanders

Additionally, we would like to thank Dr. Audrey Nelson and the VISN 8 Patient Safety Center of Inquiry, Veterans Affairs, Tampa, Florida, for granting permission to use their resource tools.
Facility Planning for the Bariatric Patient

This manual is intended to guide organizations in caring for bariatric clients entering acute care and long term care facilities as a resident, visitor or client. A Bariatric client is someone with a BMI greater than 40 or a weight greater than 159kg (350 lbs). Planning and identifying potential barriers as well as making provisions for the special needs that may be associated with the visits or admissions will assist in maintaining a safe and secure environment for the clients and the workers.

Although treatment guidelines are based on BMI, weight must also still be considered in determining appropriate care techniques in order to be able to comply with the safe load limits of patient handling equipment. Evidence-based safe patient handling techniques are available in this manual. Patient Handling Techniques also exist for the care of Bariatric clients. Many of these principles can be applied to clients with a BMI greater than 35 and/or a weight between 113 – 159kg (250 – 350 lbs), and who are partially or completely dependent for Activities of Daily Living (ADLs). Clients with no ability to assist or capacity to assist require special consideration for patient handling tasks and may exceed the weight capacity of some equipment in the facility/site or program.

Each facility/program will need to develop site-specific processes to meet requirements of both facility and best practice principles of managing bariatric clients. Templates for many of these processes are provided and should be adapted accordingly to fit the expertise, equipment and other resources available within the facility. There are several key areas that should be addressed by every site/program in preparation for providing safe & efficient care to bariatric clients.

- Review routine history and clinical assessment tools to incorporate bariatric criteria and the common conditions that may affect safe bariatric patient handling, found in Table 1.
- Conduct an inventory of equipment to determine available equipment and if additional resources are required to reduce injury and mitigate risk factors. All equipment should be labelled with its weight capacity. Any equipment that is rated higher than 113kg (250lbs) should be designated as ‘Expanded Capacity’, or ‘EC’ for short (i.e. ‘EC600’ would indicated an expanded lifting capacity of 600lbs). A sample list of recommended equipment is provided in Table 2.
- Review site/program expertise and determine educational requirement or process for receiving assistance from external sources.
- Review roles & availability of the Interdisciplinary team members. Specifically, determine whether or not an Allied Health Professional would be available to assess a client’s physical and functional status in a timely and appropriate fashion in order to contribute to the safe care plan. This may require the development of a specialty skill set with the Interdisciplinary team, depending on the program services.
- Review corporate/site/program and unit orientations to incorporate a variety of potential bariatric situations. Include a range of situations from simple to complex, depending on the likelihood of admitting the various populations.
- Complete a site inventory/review to address the following areas, where applicable:
Ancillary department access and capacity e.g. Diagnostic imaging devices, examining tables. Tables and furniture and DI equipment must be inventoried for weight capacity, width and length.

Transportation pathways for movement into the facility and between departments, including elevators, ramps, hallways, turning radii, entrances. This would be required for all clinical departments as well as other client services (i.e. hair stylist, gift shop, cafeteria).

Emergency requirements

Due to the increased risk of injury to both clients and employees, a policy specifically for the Safe Patient Handling of Bariatric clients should be developed. This policy should mimic a Minimal Lift/ Safe Patient Handling Policy with a couple of notable additions: a specific statement stressing the importance of respecting the dignity of the client, specific procedures regarding transport & transfer procedures (communication, specific equipment, etc), and procedures for weighing the client. A sample policy template is provided in this manual.

Facilities should identify their strategies for training and educational resources for assisting workers to manage the risks of the client care. Effective communication of the policies, procedures, safe patient handling techniques, how to access equipment and information is also essential components for a successful effective program. A team approach to assist with the care plan of the patient is used successfully in larger facilities.

Space Requirements


When determining space requirements for the bariatric patient, it is important to consider the type of care required and the nature of the tasks associated with that care. Bariatric admissions have been noted in the following health care settings: Acute Intensive Care (medical intensive care, surgical intensive care or post anaesthesia recovery), Regular Acute Care (regular medical or surgical unit), Long-Term Care (rehabilitation, or residential care). There is a minimum amount of space required for the healthcare providers to perform their duties in a safe and efficient manner in all of these setting, as well as to allow safe and easy passage of expanded capacity equipment.

Bariatric Rooms

The minimum required room size for the care of bariatric patients should be 4.87m x 4.04m. This will allow 2.5m on one side of the bed for transfer equipment (stretchers, lifts, etc.) as well as caregivers, and 1.0m on the other side of the bed for caregivers alone (shown in Figure 1). This will also provide for adequate free floor space for turning equipment 360° and allow the patient to exit out of the foot of the bed. The room should be extended by 1.5m if equal access to the patient on both sides of the bed is required. Also, doorways need to be 1.5m wide to allow safe patient transfers using a bariatric bed. A split door may best accommodate this structural need. In long-term care or residential care facilities, additional space for furniture and personal
belongings (personal dresser, TV unit, and cabinet) should also be considered over and above these space recommendations. (ARJO Hospital Equipment AB, 2005)

Figure 1: Space requirements around the bed (From ARJO Canada Inc., 2006)

The dark shaded area indicates minimum allotted space required. The light shaded area (plus dark area) indicates recommended extension of the working area to allow adequate space to access the client equally from both sides. These recommendations do not include the provision of space for furniture and other personal items.

Toileting and Hygiene Facilities

It is important to consider that space needs to be allotted for not only the bariatric patient, but also for the necessary equipment and the two or more caregivers in attendance. Figure 2 outlines the recommended bathroom space allotments for bariatric clients, with additional area indicated for a combination bathroom/showering area. Floor mounted toilets are recommended and should be placed 0.2m away from the back wall to give staff better access and allow lighter patients to sit on the toilet without using a commode. Current tub designs usually cannot accommodate a bariatric patient; so showering (in an appropriate shower chair/stretcher) may be a better option. Again, the bathroom door must be wide enough to allow the stretcher to pass through along with the health care providers. (ARJO Hospital Equipment AB, 2005)
**Figure 2**: Space requirements around the bathroom (From ARJO Canada, Inc., 2006)

The dark shaded area indicates minimum allotted space required. The light shaded area (plus dark area) indicates recommended extension of the working area to facilitate bathing the resident in a bariatric shower chair. If the basin is not laterally adjustable, the width of the room should be increased from 2.7m to 3.3m.

**References**

Accessed December 7, 2006

BARIATRIC PATIENT EMERGENCY ADMISSION FLOW CHART

Patient arrives at Emergency Department/Obstetrical Triage

Patient evaluated with respect to Bariatric status

NOT BARIATRIC
Standard Admission Process

BARIATRIC
Enhanced Admission Process

Immediately notified patient care unit(s) of impending admission

Patient care unit staff to refer to document regarding room design, equipment, etc.

Patient care unit staff notify ER when ready to accept transfer

Patient care unit staff schedule multidisciplinary assessment and meetings appropriate to patient needs
BARIATRIC PATIENT ELECTIVE ADMISSION FLOW CHART

Patients seen in Physician office/ambulatory care setting

NOT BARIATRIC
Standard Admission Process

BARIATRIC
Enhanced Admission Process. Processes to consider

- Destination ward to be notified of the need for expanded capacity equipment, room modifications

- All expected sites of treatment to be notified of patient requirements (such as OR, X-ray, procedure rooms, etc.)

- Process in place for notifying hospital of need for special transportation or sitting facilities upon arrival

- Process in place for in-hospital communication of special requirements prior to arrival of patient

- Process in place for notifying referring facility that destination unit is ready to accept patient
SAMPLE MANAGEMENT PROCESS FOR A HOSPITAL ADMISSION AND DISCHARGE FOR A BARIATRIC PERSON
Patient >158kg (350lbs) and/or with a BMI > 40. Flow Chart adapted from

**EMERGENCY ADMISSION**
⇒ **ELECTIVE ADMISSION**

**COMMUNITY REFERRAL**
⇒ **REFERRAL FROM A&E, Emergency / Medical / Surgical Unit, ICU, CCU, OPD, etc.**

**ADMISSION TO ASSESSMENT UNIT**
⇒ **INITIAL ASSESSMENT**

- Ascertain weight, height, Body Mass Index
- Identify appropriate equipment and training needs to be arranged

**Inform the Hospital Bed Manager**
⇒ **Agree Proposed Admission Ward & Date**

- Ward / Day Surgery Unit

**Agree Admission Ward & Date**
⇒ **Inform Ward / Departmental Manager**

**Admitting Department Risk Assessment**
- Access resource guidelines and policies for bariatric admissions
- Assess patient and identify resources needed (equipment, etc.)
- Consult appropriate Care Team members and follow processes

**Consider the Following:**
- Adequate clearance and access routes (Bed / toilet / bathroom, etc.)
- Safe working loads of the equipment (beds, mattress, cots, lifts, slings, operating table, seating systems, lateral transfer aids, canvas, waiting aids, standing aids/lifts, hygiene facilities, commodes, showers, gowns, pajamas, care of the deceased

**CONTACT EQUIPMENT POOL**
⇒ **Daily Review of Assesments**

- The documented patient handling risk assessment & safe work procedures must be reviewed on a daily basis
- Further assessment & care plan revisions may be required as the patient’s health status / care needs change

**INTER-DEPARTMENTAL TRANSFERS**
⇒ **Consider the Following:**

- A&E, Emergency / Medical / Surgical Unit, ICU, CCU, OPD, etc.
- GP Consultant appointments and preoperative clerking
- Multidisciplinary assessments from hospital, community, social services, equipment providers, patient handling staff, care home managers, etc.

**Inform the Receiving Dept. / Discharge to Place of Residence**
⇒ **DISCHARGE PROCESS**

- Consider the Following:
  - Rehabilitation / Level of Mobility
  - Equipment / Aids
  - Internal & External Home Environment – access to property, room space, adaptations required to support individual at home
  - Care Packages – in place, need restating or to begin
  - Transportation requirements
  - Financial arrangements / resources required to support this discharge

**Care of the Deceased**
- In the event of death, ward / unit staff are to inform the mortuary immediately, arrange portering services to morgue, identify required staff & equipment, etc.

**Daily Review of Assessments**
- The documented patient handling risk assessment & safe work procedures must be reviewed on a daily basis
- Further assessment & care plan revisions may be required as the patient’s health status / care needs change

**Ensure Transport Staff are fully aware of patient’s needs**
- Provide written documentation to Community staff as per discharge policy

**Ensure that all patient handling risks and safe patient handling plan have been communicated**
⇒ **Care of the Deceased**

- The documented patient handling risk assessment & safe work procedures must be reviewed on a daily basis
- Further assessment & care plan revisions may be required as the patient’s health status / care needs change

**Ensure suitable risk assessments, equipment, staff & transportation are available for discharge**
⇒ **Daily Review of Assessments**

- The documented patient handling risk assessment & safe work procedures must be reviewed on a daily basis
- Further assessment & care plan revisions may be required as the patient’s health status / care needs change

**Ensure sufficient time is allowed between booking discharge transport and actual discharge date – ideally 48 hours**
⇒ **Book Transportation**

- Inform Transport Services of patient’s needs (weight, height, etc.) and advise of required resources (staff & equipment)

**Consideration of the Following:**
- Patient Body Dynamics
- Body Mass Index
- Water Flow Assessment
- Pressure Damage Assessment
- Pain Assessment
- Medication Equipment / Aids required (Beds, lifts, slings, slide sheets, etc.)
- Current patient handling risk assessment & safe care plan

**Consider the Following:**
- Patient is safely discharged and arrives at their new Place of Residence
Helpful Tips for Safe Patient Handling of Bariatric Patients

Developed by the VA Patient Safety Center of Inquiry, Tampa, FL
Partial Funding Support provided by SIZEWISE Rentals

Problem Statement

- Safe patient handling and movement for bariatric patients can be difficult and risky for the patient and caregiver.
- Often, long intervals occur between bariatric admissions, and we forget what worked well with previous admissions.
- Each bariatric patient presents unique challenges, requiring creativity and teamwork to design solutions.
- Bariatric patients face many awkward and embarrassing situations while receiving care.

Goal

- Provide “just-in-time” training associated with safe patient handling of bariatric patients
- Provide dignified, comfortable, and safe care for bariatric patients
- Provide a safe working environment for caregivers performing patient handling tasks on bariatric patients

What is Bariatrics?

- The branch of healthcare dealing with obesity.
- Morbid obesity is defined as patients with a BMI over 40.
- This presentation addresses patients whose weight and size exceeds the capacity of your hospital’s standard equipment.
  - 300 lbs and over
  - BMI > 50

Special Reminders

- Will show points critical to consider before performing a particular task.
- Will show points where you should be particularly sensitive to the patient’s dignity.

Promoting Dignified Care

- Vulnerability
- Avoidance of Health Care
- Focus on Treatment
- Consider medical, functional, psychological and emotional needs

Identifying Equipment

- Use a generic sticker with the term “EC” for “Expanded Capacity” followed by the weight limit (i.e. EC 1000 would mean that equipment is rated for a 1,000 lb. patient).
- Avoid requesting a “Big Boy” lift, “Big” or “Oversized” equipment.
Medical Conditions to Consider
- Hip/Knee Replacements
- History of Falls
- Paralysis/Paresis
- Unstable Spine
- Severe Edema
- Postural Hypotension
- Severe Osteoporosis
- Splints/Traction
- Fractures
- Respiratory/Cardiac Compromise
- Amputation
- Urinary/Fecal Stoma
- Contractures/Spasms
- Tubes (IV, Chest, etc.)
- Severe Pain, Discomfort
- Wounds Affecting Transfer/Positioning
- Severe Diaphoresis/Sweating
- Poor Skin Integrity
- Shoulder Replacements

Medical Condition Discussion
- Stop the presentation for a few minutes to discuss why some of the medical considerations are so important to planning for safe patient transfers.

Choosing the Proper Equipment
- All equipment designed for bariatric patients is not alike—one size does not fit all.
- Use the proper equipment for your patient’s weight, height, size, shape or other special needs.
- Contact your resource expert on bariatrics.

Patient Transport
- EC Wheelchair
- EC Powered Stretcher
- EC Wheelchair Mover
- EC Powered Bed Mover
- EC Bed
- EC Standing Aids
- EC Ambulation Aids (Walkers, Canes, etc.)

Patient Lifts
- EC Ceiling Lift
- EC Gantry Lift
- EC Floor-Based Lift
- EC Sit-to-Stand Lift
- Variety of features available for each type

Patient Care Sling
- What is a sling?
- Considerations when applying a sling
- When can the sling be left under the patient?

Lateral Transfer Aids
- EC Mechanical Lateral Transfer Aid
- Air-Assisted Friction Reducing Device
- Friction Reducing Devices

Toileting/Bathing
- EC Commode Chair
- EC Toilet
- EC Shower Chair
- EC Shower Trolley or Stretcher
General Patient Room Needs
- EC Bed
- Ceiling Lift
- Low Air-Loss Mattress
- Appropriately Sized Chair

Bariatric-Specific Patient Care Items
- Appropriately sized:
  - Gowns
  - Slippers
  - Robes
  - Blood Pressure Cuffs
  - ID Wristbands
  - Bed Pans
  - Abdominal Binders

Buying vs. Renting Equipment
- Number and frequency of bariatric admissions
- Purchase cost
- Rental cost
- Space needed when using equipment
- Space needed to store equipment
- Average length of stay
- Equipment cleaning and maintenance needs
- Sufficient equipment for multiple patients of various sizes and medical conditions

TLC
Each facility should develop a system that distinguishes different sizes of gowns and other patient care items without stigmatizing bariatric patients.

Expandable Beds

Chair Positioning Feature

Lateral Rotation Therapy

Other Bed Features
- Percussion/Vibration
- Raised Knee Platform
- Powered Beds/Stretchers

Space Considerations
- Use a bariatric suite if available.
- Arrange room prior to patient’s arrival.
- Allow sufficient room for equipment, multiple caregivers, and furniture.
- Measure doorways to ensure safe entry, exit and emergency evacuation.
- Doorways should accommodate the width of a mechanical lift plus patient and caregivers.

TIP
Convert a two bed room into a one bed room if a bariatric suite is not available.
Patient Transport

- Map out the route
- Tips to consider in patient transport:
  - Can the bed fit through the doorways and elevators?
  - How easy is it to maneuver the transport device?
  - How many staff are available to assist?
  - How many transfers are required to accomplish the task?
  - How medically stable is the patient?
  - What is the least physically demanding transport device when moving a patient?

General Transfer Considerations

- Patient Assessment:
  - Level of assistance
  - Weight-bearing capability
  - Upper extremity strength
  - Level of comprehension and cooperation
  - Weight
  - Height
  - BMI
  - Medical conditions affecting transfer or repositioning
- If the patient has partial weight bearing capability, transfer to the stronger side.
- Identify a leader when performing tasks with multiple caregivers, include the patient as part of the team.

General Transfer Considerations

- Stand by for Safety:
  - Provide an obstruction free clear path
  - Identify the action plan if the patient should become unpredictable or unstable during the transfer
  - Protect the patient’s head if falling
- If any caregiver is expected to lift more than 35 lbs. of a patient’s weight, that patient is considered to be fully dependent; use an assistive device.

Lateral Transfer: Bed to Stretcher

- Assessment:
  - Can the patient assist?
    - Yes—Stand by for safety as needed and coach the patient through the transfer.
    - Be sure that you have stabilized the stretcher and bed during the maneuver.
    - Partially or No—Use a mechanical lateral transfer device, bariatric ceiling lift with supine sling, or air-assisted friction reducing device (minimum of 3 caregivers).

Lateral Transfer

- Safety Checks
  - Destination surface should be ½’ lower
  - Avoid shearing force (use friction reducing devices)
  - Check bed/stretcher width before performing transfer
  - Check brakes are locked
  - Inflate the low air-loss mattress to maximum capacity for a firm surface before transferring
- If the sides of the bed interfere with a smooth transfer, use a gantry or a ceiling lift with a supine sling.

Lateral Transfer

Toileting

- Commode shower chair over toilet with easier perineal access
- Toilet Tissue Aid
- Personal Hygiene System

Toileting

- Before starting a transfer:
  - Is the bathroom doorway wide enough to allow entry of the patient, a mechanical lift device and caregiver?
  - Assure commode and toilet can accommodate the patient’s weight.
  - Most toilets are rated up to 350 lbs.
  - If the toilet will not support the patient’s weight, or the patient cannot ambulate but can sit up on a commode chair, use an expanded capacity commode over the toilet or at the bedside.
Toileting

**Assessment:**
- If the patient is cooperative, can bear weight and ambulate and toilet can accommodate their weight, standby for safety to escort to toilet or bedside commode (1-2 caregivers).
- If the patient can partially weight bear and has upper extremity strength, use a stand assist lift and transfer patient onto a bedside commode (2 caregivers).
- If patient cannot bear weight and ambulate, does not have upper extremity strength or is uncooperative, use a full body sling lift to transfer to bedside commode (3 caregivers).

An expanded weight capacity commode chair can be used over the toilet to allow the patient private use of the bathroom toilet.

**Reposition Up in Bed**

**Assessment:**
- Can the patient assist?
  - If fully, caregiver help not needed—you may use a repositioning device to avoid shearing force.
  - Coach patient through maneuver.

**Tip**
A repositioning device can be effectively used to boost the patient up in bed using their strength, this fosters independence. If difficult, nurse can hold feet secure while patient pushes.

**Assessment:**
- If you cannot assist, is the patient cooperative?
  - If fully cooperative, use a bariatric ceiling lift with supine sling, air-assisted device or repositioning aid (minimum of two caregivers).
  - If partially or not cooperative, use a bariatric ceiling lift with a supine sling, air-assisted device or repositioning aid (minimum of three caregivers).

**Safety Checks**
- If patient can tolerate, place bed flat or in Trendelenburg position.
- Adjust bed height to comfortable working position.

**Positioning for Procedures**

**Dressing Changes**: Quite often, a limb must be held up to clean or dress a wound. This task is difficult for the caregiver and the patient but can be made easier by using a limb support sling and a patient lift.

Use a friction reducing device to slide the limb support sling under the leg. The leg should only be raised the minimal amount necessary to dress. Lower the leg periodically to offer the patient a rest between tasks to avoid neurological and vascular compromise.

Consider the use of an abdominal binder or a sheet to assist in lifting the abdominal mass.

**Positioning Patients in Bed**

**Lateral Rotation Feature**
- If available, this feature, built into some beds, works by mechanically adjusting air bladders in the mattress. This makes it easier for the caregivers as no manual work is done.

**Friction Reducing Devices**
- If the patient can assist, and the bed surface is wide enough, have them turn side to side.
- If they cannot assist, apply the friction reducing device using the head to toe method.

**How to Put on a Sling**

**Assessment:**
- Can the patient roll side to side?
- Does the bed space accommodate the patient rolling side to side?
- Can he/she tolerate the head of the bed lowered?
- If yes, use the traditional method having the patient participate.
How to Put on a Sling

- **Patient Seated/Leaning Forward**
  - Insert the sling head-to-toe under patient
- **Patient Seated/Cannot Lean**
  - Insert the sling together with a friction reducing device, slide the sling head-to-toe or toe-head under the patient
- **Patient Supine**
  - Use standard log-rolling procedure

Preventing Pressure Ulcers

- Many bariatric patients have poor heat dissipation and increased perspiration.
  - Use low air-loss mattresses
  - Use specialty mattresses

Positioning for Procedures

- **Catheterizing a Patient**:
  - There are different criteria for catheterizing a male or female patient.
- **Catheterizing a Female Patient**:
  - In side-lying position, place legs in optimal position in order to see the perineum.
- **Catheterizing a Male Patient**:
  - Lift the abdominal mass using an abdominal binder (or draw sheet) to obtain access to the penis.
  - Keeping the patient flat or supine is best. If not tolerated, elevate the head of the bed 30 degrees.

Bathing a Patient

- **Showering Assisted/Unassisted**
- **Bathe at the Bedside**
- **Tub Bathing**

Conclusion

- In this presentation you have reviewed the following major points:
  - Definition of Bariatrics
  - Promoting Patient Dignity
  - Patient Assessment
  - Equipment Assessment
  - Environmental Assessment
  - Patient Transfer Algorithms
  - Other High Risk Tasks
- Work together as a team.
- Treat bariatric patient handling tasks in a safe and dignified manner.
- Know capabilities and use of patient handling equipment.
- Achieve safe patient handling for both the patient and the caregiver.
### Common Clinical Issues Affecting Safe Bariatric Patient Handling Tasks
Adapted from “Helpful Tips for Safe Patient Handling of Bariatric Patients”, VA Patient Safety Center of Inquiry, Tampa FL.

<table>
<thead>
<tr>
<th>Clinical Issue</th>
<th>Negative Effect</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe pain and discomfort</td>
<td>Pain, inability to assist with transfer, therefore increased dependency level</td>
<td>Moving patient can increase pain and impede patient’s ability to assist safely with transfer</td>
</tr>
<tr>
<td>Hip &amp; knee replacements, joint instability, unstable spine, history of falls, fractures, contractures and spasms</td>
<td>Pain, fall risk, increased injury, extending injury to the already affected joint, ligaments or bone.</td>
<td>All movements put them at risk for pain. Weight bearing activities during transfers with these medical conditions put the patient at a risk for a fall, or extending injury to the already affected joint structure. If you try moving them in a lifting device, the sling position and posture required could put pressure on these affected body parts increasing pain and strain. Choose the least stressful in regards to pain, and stress to body parts that could cause injury when moving the patient.</td>
</tr>
<tr>
<td>Severe edema, wounds, diaphoresis, and poor skin integrity</td>
<td>Interference in healing granulation or increased skin breakdown</td>
<td>Interference in healing granulation or increased skin breakdown through shearing, rubbing, abrading and pressure from equipment i.e. slings during transfers.</td>
</tr>
<tr>
<td>Postural hypotension, paralysis/ paresis</td>
<td>Fall risk, slippage through sling, unsupported limb may be bumped, struck or caught</td>
<td>Full support (supine) slings would be required to avoid falls and slippage.</td>
</tr>
<tr>
<td>Unstable spine/severe osteoporosis</td>
<td>Pain, injury</td>
<td>Support spine properly during transfer</td>
</tr>
<tr>
<td>Splints traction, fractures</td>
<td>Misalignment and extension of injury, impedance of healing and pain.</td>
<td>If not properly supported, this could result in misalignment and extension of injury, impedance of healing and pain.</td>
</tr>
<tr>
<td>Respiratory/cardiac compromised</td>
<td>Shoulder compression and respiratory distress</td>
<td>Transferring patients in flat lying positions or in slings that are compressing shoulders and chest can cause respiratory distress for patients. Angina or chest pain from coronary insufficiency can result if patient is required to move self beyond their physical capability.</td>
</tr>
<tr>
<td>Amputation</td>
<td>Slippage and fall</td>
<td>If leg is affected and there is poor sling fit, this may cause slippage and falls, if patient is transferring in a standing position.</td>
</tr>
<tr>
<td>Stomas, wounds, tubes</td>
<td>Pain and interference with tube drainage.</td>
<td>Compression during transfer from slings or positioning can cause pain and interfere with tube drainage.</td>
</tr>
</tbody>
</table>
Body Mass Index (BMI) Nomogram

<table>
<thead>
<tr>
<th>Health Status</th>
<th>BMI</th>
<th>Risk of Developing Health Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18.5</td>
<td>Increased Risk</td>
</tr>
<tr>
<td>Normal</td>
<td>18.5 – 24.9</td>
<td>Lowest Risk</td>
</tr>
<tr>
<td>Overweight</td>
<td>25 – 29.9</td>
<td>Increased Risk</td>
</tr>
<tr>
<td>Obese Class I</td>
<td>30 – 34.9</td>
<td>High Risk</td>
</tr>
<tr>
<td>Obese Class II</td>
<td>35 – 39.9</td>
<td>Very High Risk</td>
</tr>
<tr>
<td>Obese Class III</td>
<td>40 – 49.9</td>
<td>Extremely High Risk</td>
</tr>
<tr>
<td>Extreme Obesity</td>
<td>&gt; 50</td>
<td>Extremely High Risk</td>
</tr>
</tbody>
</table>

For persons 65 years and older, the ‘normal’ range may begin slightly above BMI 18.5 and extend into the ‘overweight’ range.
# Bariatric Risk Assessment Tool

## Scoring System

<table>
<thead>
<tr>
<th>Patient Assessment Parameter</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Mass Index</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Level of Assistance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Dependence</td>
<td>Extensive Assistance</td>
<td>Supervised/Limited Assist</td>
<td>Independent</td>
<td>Immobile. Unable to shift weight or assist with movement.</td>
<td>Able to shift weight and offer minimal assistance. Will require extensive help in mobilization</td>
</tr>
<tr>
<td><strong>Patient Width</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 100cm</td>
<td>90 – 99cm</td>
<td>80 – 89cm</td>
<td>70 – 79cm</td>
<td>Exceeds standard bed width. May require expanded capacity bariatric bed. Will likely require bariatric accessories.</td>
<td>Exceeds standard bed width. Bariatric bed needed. Will likely require bariatric accessories.</td>
</tr>
</tbody>
</table>

## Total Score

<table>
<thead>
<tr>
<th>Total Score</th>
<th>3-5</th>
<th>6-7</th>
<th>8-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric Patient Handling Risk Level</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>Implement Safe Bariatric Patient Handling Protocols</td>
<td>Yes</td>
<td>Yes</td>
<td>No*</td>
</tr>
</tbody>
</table>

* Some patients with a score of 8 or more but who exceed 90cm in width may require bariatric protocol intervention
Mobility Transfer Screening Guideline

This guideline should be used immediately after admission and upon any medical condition change, in conjunction with the care plan algorithms. If the patient demonstrates any of the following indicators, a consultation with an Allied Health professional should be arranged as soon as possible. The ability to safely mobilize the patient with any of these indicators is beyond the training & ability of nurses and unit aides/assistants. If a consultation is not readily available, use a **mechanical lift** for all patient-handling manoeuvres until such time that an Allied Health professional can properly assess the patient.

- Inability to lift trunk (shoulders) from HOB (head of bed) @ 45 degree’s
- Patient states or demonstrates that the ability to rise from lying to sitting is rated as HARD or Very Difficult
- Inability to boost up in bed independently or with minimal aid or assistance
- Has not been out of bed for previous >72 hours (Allied Health consultation before first mobilization required)
- If 3 or less staff members available to assist and ability to transfer is unknown
- Significant changes in medical stability
- Orthostatic stability (weakness or dizziness)
- Pain index rating of 7 or greater on scale of 0-10
- Fear anxiety or psychological intolerance resulting in reluctance by patient
- Inability to move extremities against gravity
  - Patient cannot raise their arms
  - Patient cannot raise their legs
**Safe Patient Handling Guide for Nursing Care Plan Communication Tool**

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Weight:</th>
<th>Height:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward:</td>
<td>Room #:</td>
<td></td>
</tr>
<tr>
<td>Assessed by:</td>
<td>Date Assessed:</td>
<td></td>
</tr>
<tr>
<td>Position of Assessor:</td>
<td>Strong Side:</td>
<td>Right</td>
</tr>
</tbody>
</table>

- [ ] Staff has reviewed Large Patient Handling Guidelines

### Capabilities of Patient:
- [ ] Ambulatory
- [ ] Ambulatory with assistance (large walker)
- [ ] Non weight bearing
- [ ] Can move in bed without assistance
- [ ] Can move in bed with assistance
- [ ] Cannot assist movement in bed at all

### Requires the Following Large Patient Equipment

(Equipment Pool #5031):
- [ ] Total Body Mechanical Lift
- [ ] Wheelchair
- [ ] Armchair and Footstool
- [ ] Bed
- [ ] Commode
- [ ] Reclining Stretcher
- [ ] Slider Board
- [ ] Slider Sheets
- [ ] Step Stool
- [ ] Stretcher
- [ ] Walker

### Is the bed on the ward appropriate for this patient?
- [ ] Yes
- [ ] No, large person bed has been requested

### Patient Handling Requirements

See Algorithms as Resource:

<table>
<thead>
<tr>
<th>Task</th>
<th>Algorithm Reference</th>
<th># Staff Members Required</th>
<th>Type of Equipment Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Boost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Turn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Side to Side Movement in Bed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed to Stretcher Transfer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed to Chair/Commode Transfer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport Within the Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Comments:
Sample Policy Template: Safe Bariatric Patient Handling
Adapted from: Policy Template: Caring for Bariatric Patients (Sample Policy), Bariatric Task Force, VISN 8
Patient Safety Center for Inquiry, Tampa, FL, 2006

1. **Purpose:** To promote patient and staff safety when caring for bariatric patients. To provide the patient with the **dignity and respect** in a supportive caring culture.

2. **Definitions:**
   2.1. **Bariatric Patient:** A patient that weighs more than 159kg (350lbs) or with a BMI greater than 40.
   2.2. **Culture of Safety:** Describes the collective attitude of all employees, taking shared responsibility for safety in work environment and by doing so, providing a safe environment of care for themselves as well as patients.
   2.3. **Patient Handling:** Refers to the repositioning, lifts, turns, transfers, transports, and ambulation assistances that are provided by health care workers to the patients that need assistance.
   2.4. **Patient handling techniques:** Specific procedures that include the number of caregivers, type of equipment, and other approaches needed to perform the task safely during provision of patient care. These techniques support the use of patient handling equipment and minimal lift practices for all recommended patient handling methods.

3. **Policy:** *(Facility Name)* wants to ensure that bariatric patients and the caregivers assisting these patients are cared for safely while attending to bariatric patients. To accomplish this, a comprehensive bariatric program will be implemented to ensure provisions are made and identified to access equipment, training and resources. This is in keeping with a “Culture of Safety” in the work environment. Identified patient handling techniques and guidelines should be followed at all times except in medical emergencies. Annual competencies will assess ability to provide appropriate patient care.

   3.1. Certain interventions used by Allied health Professionals may violate general Minimal Lift principles but are required to advance clients through evidence-based progressive rehabilitation protocols. These interventions are allowed under this policy when directed, supervised and performed by Allied Health Professionals in a controlled clinical rehabilitation environment.

4. **Procedures**
   4.1. For elective admission, physicians shall indicate the need for accommodation for bariatric patient to the facility.
   4.2. For emergency admission, the nursing unit staff shall communicate the need for bariatric patient accommodation to the Admitting and to the patient care unit receiving the patient.
4.3. The Admitting Department shall:

4.3.1. Advise the patient care unit of the need to accommodate a bariatric patient, assign a private room, or semi-private room and close the other bed to accommodate equipment for the bariatric patient; as directed by the Manager of Patient Care on the admitting unit.

4.4. The patient care unit staff, which includes the Registered Nurse, Licensed Practical Nurse, Unit Assistant, Nursing Assistant, Occupational Therapist, or Physical Therapist, shall:

4.4.1. Inform the designated bariatric technical specialist or team *(name your facilities designates)*

4.4.2. Inform designate of need for ergonomic consultation and support when bariatric patients are admitted.

4.4.3. Identify equipment needs and make provisions. If equipment is not available on site then the unit will arrangements for rental.

4.4.4. Have access and authority to contracting and ordering of equipment.

4.4.5. Utilize appropriate lifting, moving and transferring techniques and equipment.

4.4.6. Inspect patient owned and facility equipment for obvious defects prior to use and during the patient's hospital stay. NOTE: Patient's own equipment and clothing are to be used where possible. Clearly label equipment and clothing with patient's name.

4.5. Facility will provide guidelines, training, and a designated contact.

4.6. Miscellaneous:

4.6.1. To weigh the patient:

4.6.1.1. The facility should identify equipment access, and capacity for weighing patients.

4.6.1.2. For patients weighing up to 320 kg (700 lbs) who can sit in a wheelchair, use wheelchair scale. Determine weight of the empty wheelchair, to be subtracted from the combined weight of the patient and the wheelchair, so patient weight can be calculated.

4.6.2. For turning or laterally transferring patients, use the repositioning sliders or friction reducing devices respectively, as well as any recommended techniques or guidelines.

4.6.3. The facility should follow the algorithms for safe lifts and transfers of the bariatric patient from the Patient safety Centre.

4.6.4. To facilitate Safe Care:

4.6.4.1. All equipment should be labelled with its weight capacity; this includes lift and transfer equipment, beds, chairs, wheelchairs etc.

4.6.4.2. The weight capacity of the toilet and fixtures needs to be identified and alternate arrangement made as appropriate, i.e., provision of commode chairs.
5. **Equipment/Supplies:**
   Bariatric equipment is available from the [insert number]

6. **Resources:**
   - Clinical Consultant (provide name and number)
   - Maintenance Department, (provide name [as appropriate] and number)

**Delegation of Authority and Responsibilities**

6.1. **Compliance:** it is the duty of employees to take reasonable care of their own health and safety as well as that of their co-workers and their patients during the care of the bariatric patient activities by following this policy. Non-compliance will indicate a need for retraining.
   - 6.1.1. Certain interventions used by Allied health Professionals may violate general Minimal Lift principles, but are required to advance clients through evidence-based progressive rehabilitation protocols. These techniques are allowed under this policy when directed, supervised and performed by Allied Health Professionals in a controlled clinical rehabilitation environment.

6.2. **Facility Director** shall:
   - 6.2.1. Support the implementation of the policy.
   - 6.2.2. Support a “culture of safety” within this medical center.
   - 6.2.3. Make provisions for sufficient equipment/aids to allow staff to use them when needed for safe patient care.
   - 6.2.4. Provide for maintenance of equipment
   - 6.2.5. Provide staffing levels sufficient to comply with this policy

6.3. **Supervisors** shall:
   - 6.3.1. Ensure high-risk patient handling guidelines are adhered to; tasks are assessed prior to completion and are completed safely, using appropriate equipment, and techniques.
   - 6.3.2. Ensure equipment is available and in good working order, maintained regularly and stored safely.
   - 6.3.3. Ensure employees are properly trained and needs for further training or refreshers are identified.
   - 6.3.4. Ensure that all untoward occurrences to either workers or patients are properly reported and documented and statistically analyzed.
   - 6.3.5. Support a “Culture of Safety” within the facility.

6.4. **Employee** shall:
   - 6.4.1. Comply with parameters of this policy
   - 6.4.2. Use proper techniques and equipment outlined in the guidelines.
   - 6.4.3. Adhere to the outlined processes
   - 6.4.4. Notify supervisors of any incidences or injury that put the worker or patient at risk for injury.
6.4.5. Notify supervisors if training or re-training is required, or if you are unsure of the safest method of patient care handling tasks.

6.4.6. Inspect all equipment devices prior to use, remove equipment that is defective, tag it out for use and notify the supervisor of its need for repair.

6.4.7. Support a ‘Culture of Safety “by identifying and reporting any safety concerns to supervisors and following policy”.

6.5. **Maintenance Services** shall:

6.5.1. Maintain and inspect all equipment as per inspection policy on a scheduled basis and assure that all equipment is in proper working order.

6.6. **Union Officials** shall:

6.6.1. Support policy intent and monitor program effectiveness in partnership with administration.

**Appendix:**

Sample Equipment List (List Facility Equipment Designated for Use and Specify Wt. limits of Equipment Available)

- Sit-Stand Lift (expanded capacity)
- Floor lifts (expanded capacity)
- Ceiling lift (expanded capacity)
- Wheelchair 66cm (26") wide and 71cm (28") wide:
- Stretchair (stretcher, 81 cm (32") wide, which converts to chair)
- Commode (expanded capacity)
- Step stool 270 kg (600 lb)
- Walker (expanded capacity)
- Armchair and footstool 364 kg
- Bariatric Bed
- Bariatric Patient bed repositioning aids (overhead bars, etc.)
- Wheelchair scales accommodating up to 400 kg. (880 lb.)
- Hospital gowns for bariatric patients
- Friction reducing devices for lateral transfers
- Repositioning devices
# Equipment Safety Checklist

To prepare for safe Bariatric patient care, the following safety checklist should be completed by your facility to ensure the availability of appropriate resources.

**HOSPITAL BED**
- Weight limit ______
- Side rail support ______
- Bed scale?
  - Yes __ weight limit ___
  - No ___
- Width of bed ______
- Bed adjustable for width?
  - Yes _ No__
- Bed adjustable for patient height?
  - Yes _ No__
- Mattress type:
  - Pressure relief __ Pressure reduction __
  - Alternating __ Rotational ___
  - Other____________________________

**WHEELCHAIR**
- Weight limit ______
- Width ______
- Seat Height_______
- Handle width ______
- Powered? Yes__ No__

**STRETCHER**
- Weight limit_______
- Width ______
- Length_______
- Side rail support ______
- Powered? Yes__ No__

**ELEVATOR DIMENSIONS**
- ______________________

**ROOM DIMENSIONS FOR PATIENT CARE ENVIRONMENT**
- ______________________

**DOOR DIMENSIONS TO PATIENT CARE ENVIRONMENT**
- ______________________

**BEDSIDE COMMODE/SHOWER CHAIR**
- Weight limit_______
- Seat width ______
- Adjustable height? Yes__ No__

**SCALE**
- Weight limit_______
- Width ______

**WALKER**
- Weight limit_______
- Width ______

**BATHROOM**
- Doorframe width_______
- Shower door width ______
- Toilet weight bearing limit ______
- Wall mounted grab bars
- Weight limit_______
- Wall mounted skin weight limit_______

**PATIENT CARE ENVIRONMENT**
- Patient chair weight limit_______ (basic seating chair not Geri/cardiac chair)
- Patient chair width ______
- Patient chair seat height_______
- Geri/Cardiac chair weight limit_______
- Geri/Cardiac chair width ______
- Geri/Cardiac seat height_______

**TRANSFER DEVICES**
- Lateral transfer devices weight limit_______
- Lateral transfer devices width ______
- Powered? Yes__ No__
- Full Body (sling) weight limit_______
- Powered? Yes__ No__
- Full Body (sling) goes to the floor? Yes__ No__
- Sit to stand devices weight limit_______
- Sit to stand devices width ______
- Powered? Yes__ No__

**ANCILLARY DEPARTMENTS**
- Door widths ______
- X-ray table weight limit ______; width ______
- CT Scan weight limit _______, width ______
- OR table limit ______ width ______
- Emergency room equipment weight limit_______ width ____
- Waiting room furniture weight limit_______ width ______
- Exam room table weight limit_______ width ______

**OTHER PATIENT CARE DEVICES**
- All patient care supplies should be carefully evaluated for bariatric capacity
Assessment Criteria and Care Plan for Safe Patient Handling and Movement

I. Patient’s Level of Assistance:
- Independent — Patient performs task safely, with or without staff assistance, with or without assistive devices.
- Partial Assist — Patient requires no more help than stand-by, cueing, or coaxing, or caregiver is required to lift no more than 35 lbs. of a patient’s weight.
- Dependent — Patient requires nurse to lift more than 35 lbs. of the patient’s weight, or is unpredictable in the amount of assistance offered. In this case assistive devices should be used.

An assessment should be made prior to each task if the patient has varying level of ability to assist due to medical reasons, fatigue, medications, etc. When in doubt, assume the patient cannot assist with the transfer/repositioning.

II. Weight Bearing Capability
- Full
- Partial
- None

III. Bi-Lateral Upper Extremity Strength
- Yes
- No

IV. Patient’s level of cooperation and comprehension:
- Cooperative — may need prompting; able to follow simple commands.
- Unpredictable or varies (patient whose behavior changes frequently should be considered as “unpredictable”), not cooperative, or unable to follow simple commands.

V. Weight: _________ Height: ___________
Body Mass Index (BMI) [needed if patient’s weight is over 300]¹:___________

If BMI exceeds 50, institute Bariatric Algorithms

The presence of the following conditions are likely to affect the transfer/repositioning process and should be considered when identifying equipment and technique needed to move the patient.

VI. Check applicable conditions likely to affect transfer/repositioning techniques.
- Hip/Knee Replacements
- History of Falls
- Paralysis/Paresis
- Unstable Spine
- Severe Edema
- Very Fragile Skin
- Postural Hypotenension
- Severe Osteoporosis
- Fractures
- Respiratory/Cardiac Compromise
- Wounds Affecting Transfer/Positioning
- Amputation
- Urinary/Fecal Stoma
- Contractures/Spasms
- Severe Pain, Discomfort

Comments: __________________________________________________________________________________________

VII. Care Plan:

<table>
<thead>
<tr>
<th>Algorithm</th>
<th>Task</th>
<th>Equipment/Assistive Device</th>
<th># Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Transfer To and From: Bed to Chair, Chair To Toilet, Chair to Chair, or Car to Chair.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Lateral Transfer To and From: Bed to Stretcher, Trolley.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Transfer To and From: Chair to Stretcher, or Chair to Exam Table.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Reposition in Bed: Side-to-Side, Up in Bed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Reposition in Chair: Wheelchair and Dependency Chair.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Transfer Patient Up from the Floor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric 1</td>
<td>Bariatric Transfer To and From: Bed to Chair, Chair to Toilet, or Chair to Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric 2</td>
<td>Bariatric Lateral Transfer To and From: Bed to Stretcher or Trolley</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric 3</td>
<td>Bariatric Reposition in Bed: Side-to-Side, Up in Bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric 4</td>
<td>Bariatric Reposition in Chair: Wheelchair, Chair or Dependency Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric 5</td>
<td>Patient Handling Tasks Requiring Access to Body Parts (Limb, Abdominal Mass, Gluteal Area)</td>
<td></td>
<td></td>
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<tr>
<td>Bariatric 6</td>
<td>Bariatric Transporting (Stretcher)</td>
<td></td>
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<tr>
<td>Bariatric 7</td>
<td>Bariatric Toileting Tasks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sling Type (circle choice): Seated_____ Seated (Amputation)_____ Standing_____ Supine_____ Ambulation_____ Limb Support_____

Sling Size: _______________

Signature: ____________________________ Date: ___________________

¹If patient’s weight is over 300 pounds, the BMI is needed. For Online BMI table and calculator see: http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm
Algorithm 1: Transfer to and From: Bed to Chair, Chair to Toilet, Chair to Chair, or Car to Chair

**Start Here**

Can patient bear weight?

- **Fully:** Caregiver assistance not needed; Stand by for safety as needed.
- **Partially:** Stand and pivot technique using a gait/transfer belt (1 caregiver) or powered standing assist lift (1 caregiver)

Is the patient cooperative?

- No: Use full body sling lift and 2 caregivers.
- Yes: Use seated transfer aid; may use gait/transfer belt until the patient is proficient in completing transfer independently.

Does the patient have upper extremity strength?

- Yes: Seated transfer aid; may use gait/transfer belt until the patient is proficient in completing transfer independently.
- No: Caregiver assistance not needed; Stand by for safety as needed.

- For seated transfer aid, must have chair with arms that recess or are removable.
- For full body sling lift, select a lift that was specifically designed to access a patient from the car (if the car is the starting or ending destination).
- If patient has partial weight bearing capability, transfer toward stronger side.
- Toileting slings are available for toileting.
- Bathing mesh slings are available for bathing.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Can patient assist?

Partially Able or Not At All Able

> 200 Pounds: Use a friction reducing device* and 3 caregivers.

< 200 Pounds: Use a friction reducing device*.

Caregiver assistance not needed; Stand by for safety as needed.

- Destination surface should be 1/2 inch lower for all lateral patient moves.
- For patients with Stage III or IV pressure ulcers, care must be taken to avoid shearing force.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Algorithm 3: Transfer To and From: Chair to Stretcher, or Chair to Exam Table

Comments:
- High/Low exam tables and stretches would be ideal.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
**Algorithm 4: Reposition in Bed: Side-to-Side, Up in Bed**

- This is not a one person task: DO NOT PULL FROM HEAD OF BED.
- When pulling a patient up in bed, the bed should be flat or in a Trendelenburg position to aid in gravity, with the side rail down.
- For patients with Stage III or IV pressure ulcers, care should be taken to avoid shearing force.
- The height of the bed should be appropriate for staff safety (at the elbows).
- If the patient can assist when repositioning "up in bed," ask the patient to flex the knees and push on the count of three.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.

---

**Start Here**

- Can patient assist?
  - Fully able: Caregiver assistance not needed; patient may/may not use positioning aid.
  - Partially able: Encourage patient to assist using a positioning aid or cues.

- **< 200 Pounds**: Use a friction reducing device and 2-3 caregivers.
- **> 200 Pounds**: Use a friction reducing device and at least 3 caregivers.

---
Algorithm 5: Reposition in Chair: Wheelchair and Dependency Chair

Start Here

Can patient assist?

- Fully: Caregiver assistance not needed; Stand by for safety as needed.
- Partially:
  - If patient has upper extremity strength in both arms, have patient lift up while caregiver pushes knees to reposition.
  - If patient lacks sensation, cues may be needed to remind patient to reposition.

Does chair recline?

- Yes: Recline chair and use a friction reducing device and 2 caregivers.
- No:
  - Is patient Cooperative?
    - Yes: Use full body sling lift or non-powered stand assist aid and 1 to 2 caregivers.
    - No: Use full body sling lift and 2 or more caregivers.

Notes:
- Take full advantage of chair functions, e.g., chair that reclines, or use or arm rest of chair to facilitate repositioning.
- Make sure the chair wheels are locked.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Algorithm 6: Transfer Patient Up from the Floor

Start Here

Was the patient injured? Yes → Was the injury minor? No → Depends on type and severity of injury (follow Standard Operating Procedures).

Was the injury minor? Yes → Can patient assist? No → Full body sling lift needed with 2 or more caregivers.

Can patient assist? Yes → Caregiver assistance not needed; Stand by for safety as needed.

Comments:
- Use full body sling that goes all the way down to the floor (most of the newer models are capable of this).
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Bariatric Algorithm 1: Bariatric Transfer to and from: Bed/Chair, Chair/Toilet, or Chair/Chair

Start Here

Can patient bear weight?

Fully

Stand-by for safety as needed*

Partially or No

Is the patient cooperative?

Partially or No

Bariatric full body sling lift (minimum of 3 caregivers)

Fully

Does the patient have upper extremity strength?

No

Bariatric stand assist lift (minimum of 2 caregivers) OR

Bariatric full body sling lift (minimum of 2 caregivers)

Fully

Use seated bariatric transfer aid; may use sliding board until the patient is proficient in completing transfer independently (minimum of 2 caregivers)

• For seated transfer aid, must have chair with arms that recess or are removable.
• Bariatric toileting slings are available for toileting.
• Bariatric bathing mesh slings are available for bathing.
• Note that a standard porcelain toilet typically has a weight limit of 350 pounds; the patient may need bariatric commode chair or steel toilet.
• In older lifts, more effort is needed to place the sling under the patient, which may require a minimum of 3 caregivers.

* "Stand-by for safety." In most cases, if a bariatric patient is about to fall, there is very little that the caregiver can do to prevent the fall. The caregiver should be prepared to move any items out of the way that could cause injury, try to protect the patient's head from striking any objects or the floor and seek assistance as needed once the person has fallen.
• If patient has partial weight-bearing capability, transfer toward stronger side.
• Consider using an abdominal binder if the patient's abdomen impairs a patient handling task.
• Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with "EC" (for expanded capability) and a space for the manufacturer's rated weight capability for that particular equipment model.
• Identify a leader when performing tasks with multiple caregivers. This will assure that the task is synchronized for increased safety of the healthcare provider and the patient.
• During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
**Bariatric Algorithm 2: Bariatric Lateral Transfer to and from: Bed/Stretcher, Trolley**

Start Here

Can patient assist?

- Partially Able or No
- Fully

Stand by-for safety as needed* (2 caregivers)

Mechanical lateral transfer device, bariatric ceiling lift with supine sling or air assisted friction-reducing device (minimum of 3 caregivers)**

---

- The destination surface should be about 1/2" lower for all lateral patient moves.
- Avoid shearing force.
- Make sure bed is the right width, so excessive reaching by caregiver is not required.
- Lateral transfers should not be used with specialty beds that interfere with the transfer. In this case, use a bariatric ceiling lift with supine sling.
- Ensure bed or stretcher doesn't move with the weight of the patient transferring.
- ** Use a bariatric stretcher or trolley if patient exceeds weight capacity of traditional equipment.

---

* "Stand-by for safety." In most cases, if a bariatric patient is about to fall, there is very little that the caregiver can do to prevent the fall. The caregiver should be prepared to move any items out of the way that could cause injury, try to protect the patient's head from striking any objects or the floor and seek assistance as needed once the person has fallen.

- Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with "EC" (for expanded capability) and a space for the manufacturer's rated weight capacity for that particular equipment model.
- If patient has partial weight-bearing capability, transfer toward stronger side.
- Consider using an abdominal binder if the patient's abdomen impairs a patient handling task.
- Identify a leader when performing tasks with multiple caregivers. This will assure that the task is synchronized for increased safety of the healthcare provider and the patient.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.

rev 5/1/05
When pulling a patient up in bed, place the bed flat or in a Trendelenburg position (if tolerated and not medically contraindicated) to aid in gravity; the side rail should be down.
- Avoid shearing force.
- Adjust the height of the bed to elbow height.
- Mobilize the patient as early as possible to avoid weakness resulting from bed rest. This will promote patient independence and reduce the number of high risk tasks caregivers will provide.
- Consider leaving a friction-reducing device covered with drawsheet, under patient at all times to minimize risk to staff during transfers as long as it doesn't negate the pressure relief qualities of the mattress/overlay.
- Use a sealed, high-density, foam wedge to firmly reposition patient on side. Skid-resistant texture materials vary and come in set shapes and cut-your-own rolls. Examples include:
  - Dycem (TM)
  - Scoot-Guard (TM): antimicrobial; clean with soap and water, air dry.
  - Posey-Grip (TM): Posey Grip does not hold when wet. Washable, reusable, air dry.

If patient has partial weight-bearing capability, transfer toward stronger side.
- Consider using an abdominal binder if the patient's abdomen impairs a patient handling task.
- Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with "EC" (for expanded capability) and a space for the manufacturer's rated weight capability for that particular equipment model.
- Identify a leader when performing tasks with multiple caregivers. This will assure that the task is synchronized for increased safety of the healthcare provider and the patient.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
"Stand-by for safety." In most cases, if a bariatric patient is about to fall, there is very little that the caregiver can do to prevent the fall. The caregiver should be prepared to move any items out of the way that could cause injury, try to protect the patient's head from striking any objects or the floor and seek assistance as needed once the person has fallen.

- If patient has partial weight-bearing capability, transfer toward stronger side.
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- Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with "EC" (for expanded capability) and a space for the manufacturer's rated weight capability for that particular equipment model.
- Identify a leader when performing tasks with multiple caregivers. This will assure that the task is synchronized for increased safety of the healthcare provider and the patient.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Can patient sustain limb position to assist in making body part accessible?

Assemble multidisciplinary team to develop creative solutions that are safe for patient and caregiver.

**Examples:**
- Modify use of a full body sling lift to elevate limbs for bathing or wound care (i.e. bariatric limb sling).
- Use draw sheet with handles for 2 caregivers (one per side) to elevate abdominal mass to access the perineal area (e.g., catheterization, wound care).
- To facilitate drying a patient between skin folds, use the air assisted lateral transfer aid to blow air or use a hair dryer on a cool setting.
- Use sealed high-density foam wedge to firmly reposition patient on side. Skid-resistant texture materials vary and come in set shapes and cut-your-own rolls. Examples include:
  - Dycem(TM)
  - Scoot-Guard(TM): antimicrobial; clean with soap and water, air dry.
  - Posey-Grip(TM): Posey Grip does not hold when wet. Washable, reusable, air dry.

- A multidisciplinary team needs to problem solve these tasks, communicate to all caregivers, refine as needed and perform consistently.
- Consider using an abdominal binder if the patient's abdomen impairs a patient handling task.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
If the patient has respiratory distress, the stretcher must have the capability of maintaining a high Fowler's position.

- Newer equipment often is easier to propel.
- If patient is uncooperative, secure patient in stretcher.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Bariatric Algorithm 7: Toileting Tasks for the Bariatric Patient

Start Here

Is patient cooperative?

Yes

Can patient bear weight and ambulate?

Yes

Can toilet accommodate patient's weight?

Yes

Stand by for safety to escort to toilet or bedside commode. (1-2 caregivers)

No

Partial

Does patient have upper extremity strength?

Yes

Use full body sling lift with a toileting sling to transfer to bedside commode. (3 caregivers)

No

Stand by for safety to escort to bedside commode. (1-2 caregivers)

Considerations:

- Is bathroom doorway wide enough to accommodate entry of mechanical lift device and patient?
- Assure equipment used meets weight requirements and is appropriately sized for patient.
- Typically, standard toilets are rated to 350 lbs. maximum capacity.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.

Use stand assist lift and transfer patient onto bedside commode. (2 caregivers)
The following is an EXAMPLE only of how the education component may be interfaced with the Caregiver Skill Levels:

**Level 1 (Novice)**

New Employee Orientation (Awards Level 1)
- 2 to 3 hour hands-on training session
  - Use of Sliders
  - Use of mechanical lifts
Requires return demonstration (sign off by ward champion or mentor?) within 3 month period from starting date.

**Level 2 (Advanced)**

On Ward Training (Awards Level 2)
- Includes:
  - Use of Sliders (Review)
  - Use of Mechanical Lifts (Review)
  - Program Specific Equipment
  - Program Specific Scenarios
This training awards an individual with Level 2 (Advanced Beginner) status, and requires return demonstration competency by Ward Champion or Trainer.

**Level 3 (Competent)**

Advanced Practice Training (Awards Level 3)
- Includes:
  - Assessment of weight-bearing capability in patients
  - Patient Readiness to Transfer Assessment
  - Application of the Algorithms
  - Resident's Gallery
  - Case Study Problem Solving
This training awards an individual with Level 3 (Competent) status, and requires return demonstration competency by Ward Champion or Trainer.
PATIENT TRANSFER ASSESSMENT

<table>
<thead>
<tr>
<th>Weight kg/lb:</th>
<th>Initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

Instructions:
1. A Registered Nurse (RN), Registered Psychiatric Nurse (RPN), Physiotherapist (PT), or Occupational Therapist (OT) to assess the patient within 24 hours of admission or upon transfer to another unit.
2. Complete the assessment based on the patient’s weight and by assessing all elements of the patient’s ability as indicated in the chart below. Determine the recommended transfer and/or bed mobility method and select the method in the appropriate column. Refer to the “General Guidelines for Completion of the Patient Transfer Assessment Form” located in the Safe Patient Handling Minimal Lift Program resource binder.
3. Keep this form on the patient’s clipboard (or chart if clipboards are not used). Place the transfer and/or bed mobility decal on the end of the patient’s bed or on their walking aid and document on the Kardex.
4. Update transfer/bed mobility method as the patient’s condition changes. The transfer/bed mobility method may be increased to provide greater assistance but not decreased until the patient has been reassessed by the RN, RPN, PT or OT (see Section E).
## CHAPTER 3 RESOURCES

<table>
<thead>
<tr>
<th>PATIENT'S ABILITY</th>
<th>&lt; 70 kg/154 lbs</th>
<th>&gt; 71 kg/155 lbs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>ALWAYS</td>
<td>SOMETIMES</td>
</tr>
<tr>
<td>Re-position in Bed</td>
<td>(always)</td>
<td>(sometimes)</td>
</tr>
<tr>
<td>Sit Unsupported</td>
<td>both legs</td>
<td>partial (indicate type)</td>
</tr>
<tr>
<td>Weight Bear</td>
<td>both legs</td>
<td>partial (indicate type)</td>
</tr>
</tbody>
</table>

### Follow Instructions

#### A) Recommended Transfer Method

- **Independent**
  - Independent Cane
  - Independent Walker
  - 1 Assist Cane
  - 1 Assist Walker
  - 2 Assist Walker
- **Transfer Belt**
  - 1 Assist
  - 2 Assist
  - No Transfer Belt (Contraindicated)
  - 1 Assist
  - 2 Assist
- **Sit-Stand Device**
  - 1 Assist
  - 2 Assist
- **Mechanical Lift**
  - 2 Assist

#### B) Bed Mobility Recommendation

- **Nylon Slider**
  - 1 Assist
  - 2 Assist
- **Nylon Slider**
  - 2 Assist
- **Nylon Slider**
  - 2 Assist

**Caution:** Shoulder pain, upper extremity weakness and/or fracture may limit use of mobility aid(s) and impact on transfer technique.
C) Special Transfer or Bed Movement Recommendations (if different from above):
   Instructions/Use of special devices (prosthesis, sling, etc.)

D) Decals in place: ☐ On the bed/ ☐ On a walking aid
   Documentation on: ☐ Kardex

E) Change in Transfer Status:
   You do not need to complete another form. Document change in transfer method below, update decals and update Kardex.

<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>INITIALS</th>
<th>TRANSFER METHOD or Bed REPOSITIONING / COMMENTS</th>
<th>UPDATED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decal</td>
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<td>Kardex</td>
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<td></td>
<td></td>
<td>Decal</td>
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<td>Decal</td>
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</tbody>
</table>
CHAPTER 3 RESOURCES

APPENDIX A-3

Safe Patient Handling and Movement Program

General Guidelines for Completion of the Patient Transfer Assessment Form

Prior to the assessment, always consider the medical stability of the patient by monitoring vital signs and blood pressure.

1. Determine the weight of the patient. This will indicate which columns are used on the Patient Transfer Assessment Form (≤70 kg/154 lbs or ≥71 kg/155 lbs).

2. Assess the patient’s abilities:

2.1 Re - position in Bed

- Can the patient move their arms and legs in bed? For example: raising arms to reach towards the ceiling, bending knees and hips to place feet flat on the bed.
- Can the patient lift their bottom (bridge) off the bed?
- Can the patient roll over using the bed rail for support if desired or required?

Based on the patient’s level of ability, choose a category (always, sometimes, never).

Guidelines for choosing a category: Re-position in Bed

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>Patient can always control the movement and strength of either one arm or both arms; one leg or both legs.</td>
</tr>
<tr>
<td>Sometimes</td>
<td>Patient does not always have control of the movement and strength in arm(s) or leg(s) (e.g. episodes of spasms, erratic movements, temporary weakness and fatigue).</td>
</tr>
<tr>
<td>Never</td>
<td>Patient cannot control the movement and strength of arm(s) or leg(s) at any time (e.g. stroke, MS, ALS, Muscular Dystrophy, fractures).</td>
</tr>
</tbody>
</table>
2.2 **Sit Unsupported**

- Can the patient roll onto their side and push themselves up into a sitting position?
- Can the patient sit on the side of the bed unsupported?
- Can the patient reach for items while seated at the edge of the bed?

Based on the patient's level of ability, choose a category (always, sometimes, never).

**Guidelines for choosing a category: Sit Unsupported**

**Always**
Patient can sit and remain upright without help. Patient has good balance while sitting up alone.

**Sometimes**
Patient can occasionally sit and remain upright without help. Patient can sometimes lose balance when sitting.

**Never**
Patient is unable to sit and remain upright at any time. Patient has no sitting balance at all.

2.3 **Weight Bear**

Always consider contraindications for weight bearing status as well as the patient's medical stability by monitoring vital signs and blood pressure.

- Are any weight bearing restrictions in place?
- Did the patient use a mobility aide prior to admission?
- With feet flat on bed, can patient lift buttocks off bed (i.e. bridging)?
- Or can the patient push out against your hand (placed in the sole of the foot), to straighten the knee?
- Or can the patient straighten the leg and lift 6 inches off the bed?

Based on the patient's level of ability, choose a category (always, sometimes, never).

**Guidelines for choosing a category: Weight Bear**

**Always**
Patient is able to sufficiently weight bear with both legs.

**Sometimes**
Patient can sufficiently weight bear with one leg.

**Never**
Patient is unable to sufficiently weight bear with either leg.
CHAPTER 3 RESOURCES

2.4 **Follow Instructions**

- Is the patient able to communicate?
- Can the patient follow instructions?
- Is the patient cooperative?
- Are there any behaviors that interfere with mobility?

Based on the patient’s level of ability, choose a category (always, sometimes, never).

<table>
<thead>
<tr>
<th>Guidelines for choosing a category: Follow Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Always</strong> Patient is able to comprehend and follow instructions at all times.</td>
</tr>
<tr>
<td><strong>Sometimes</strong> Patient can occasionally comprehend and follow instructions but is inconsistent.</td>
</tr>
<tr>
<td><strong>Never</strong> Patient does not comprehend and does not follow instructions at all.</td>
</tr>
</tbody>
</table>

3. Choose an option from Section A – Recommended Transfer Method. Document special transfer recommendations under Section C.

4. Choose an option from Section B – Bed Mobility Recommendations. Document special bed mobility recommendations under section C.

5. Place a check mark in the box indicating the decal(s) is in place and the Kardex is updated.

6. All changes in transfer/bed movement status must be documented on the reverse side of the Patient Transfer Assessment Form. Document the date/time of the re-assessment, initials and the recommended transfer/bed mobility method. Place a checkmark in the box indicating the decal(s) and Kardex is updated.

All decals are included on the reverse side of the assessment form. Ensure the recommended transfer and/or bed movement method is consistent with the decal above the patient’s bed/on the patient’s wristband.

**Note:** A language barrier may be a factor affecting comprehension of instructions. However, some patients can understand simple gestures and follow non verbal instructions.
Welcome to

Safe Patient Handling & Movement Program

Facility Name & Logo
Objectives

At the end of the presentation healthcare workers will be able to:

• Identify the best practices for patient handling
• Identify the principles guiding the program
• Be able to select appropriate methods for patient handling
• Be able to identify “your facility’s” tools, resources and proper equipment
• Demonstrate patient movement and handling techniques using proper body mechanics
Minimal Patient Movement & Handling Education

• “Facility Name” Goals
  – Goal is to prevent worker injuries caused by patient handling

• Implement best practice guidelines for patient handling throughout the facility
  (Identify the members of the patient handling team in your facility here)
Guiding Policies

• Workplace Safety & Health Legislation
  – (W210) WORKPLACE SAFTEY & HEALTH ACT
  – Effective as of February 2006

• Requires employers to
  – Provide training and equipment

• Requires employees to:
  – Comply with following safe work procedures and using equipment

• Both are subject to fines
Legislation Recognizes Principles:

- **Risk**
  - Identification of high risk tasks
  - Implementation of controls to reduce injury risks to patients and staff

- **Environment**
  - Adequate space to perform task safely
  - Free from adverse elements

- **Equipment**
  - Availability
  - Training
  - Good working condition
Legislation Recognizes Principles (Cont)

• Limitations to manual exertion
  – Restriction of manual handling to emergent or life-threatening situations only
  – Nursing can refuse to participate in an unsafe lift or transfer

• Importance of appropriate staffing levels
  – Breaks
  – Rotations
Legislation Principles (Cont)

• Evaluation
  – Annual report and prevention planning to focus on injury prevention from patient handling tasks

• Architectural planning for adequate space and equipment needs
Policies

• Identify the Policy names and numbers for Safe Patient Movement and Handling in your facility here
Research Identifies Most Stressful Tasks

• Transfers in and out of bed
• Transfers on and off commodes
• Transfers on and off stretchers
• Boosting up in bed
• Lifting up from floor
• Toileting in bed
Unsafe Patient Handling

- Example of a dangerous lift
Marras: Pivot Lifts Unsafe

- Neither one person or two person pivot transfer techniques satisfy reasonable tolerance limits
- Forces required to manage patient at 125 lbs exceed spinal loading limits
- Studies show that a pivot transfer is not therapeutic for the patient
- Physical demands are significantly decreased when using a transfer belt or a sit-stand lift device
Britain Bans “Drag” Technique

- Under axilla referred to as “the drag”
- Inefficient and dangerous to caregiver
- Law suits pending for abuse to patient’s due to injuries to
  - Brachial plexus
  - Shoulder subluxation
Triangle Theory for Patient Handling

Foster Independence

Safe for Worker

Safe for Patient
Facility Resources

• List here the following: (available in your facility)
  – Patient Handling Manuals/Binders
  – Safe Work Procedures (where to find them)
  – Any patient handling resources on line
  – Equipment inventory and location of/how to order
  – Role of algorithms
  – Role of Physiotherapy and Occupational therapy in patient handling in your facility
  – Identify the educators and/or patient handling consultants/rangers/specialists/STARS
Equipment

• Identify where your equipment inventory list is kept (so that staff know what equipment is in the facility and where to find it)
• Where is equipment stored?
• How to access equipment
• Who to call
  – Regular hours
  – Off hours
• When broken:
  – How to tag it out
  – Who to call
Mechanical Lifts

- What types do you have in your facility?
- *(E.g. MediLifter111 Plus)*
  - Weight capacity
  - Where it is stored
Slings

- List types of slings in your facility
- Provide photos if you have any
- Where are they stored
- How to size them
- Information on
  - Cleaning
  - Laundering
Sliders

List the type of sliders you have in your facility.

• Describe
• Insert photos
• Where are they kept
• Instructions on:
  – Cleaning
  – Laundering
Transfer Belts

• What types of transfer belts do you have in your facility?
• Insert photos
• Where are they stored
• Instructions:
  – Cleaning
  – Laundering
Communication Tools

• List the Patient Assessment Format used at your facility
  – Who is responsible for the initial assessment
  – Who is responsible for ongoing assessments
  – Who is responsible for communicating the results
  – What forms are used and where are they kept
Communication System

- What LOGO system or labeling system does your facility use?
  - What does it look like?
  - Where are the LOGOs or labels posted?
    - E.g. Kardex, bedside, wrist bracelet
  - Who is responsible for maintaining it?
Communication System (Cont)

• Describe how the LOGO system interfaces with the patient assessment tool
Body Mechanics in Patient Handling

• List Basic Guidelines here such as:
  – Keep work between hip and chest level
  – Maintain power position wherever possible
    • Keep knees and hips slightly flexed
    • Keep low back in \( \frac{1}{2} \) extension
  – Position bed at hip height of shortest worker
  – Initiate movement with a weight shift
Body Mechanics

Wrong

Right

The “Power” Position

Straight back.

Feet parallel.
Application to Patient Handling
Case Study # 1

• Albert is a 75 year old male, weighing 137 lbs (62 kg) is confused, becomes restless and falls onto the floor. The patient is unable to get up. What do you do?
  – Which Algorithm do you refer to?
  – What is your recommendation for
    • Equipment?
    • Method?
Case Study # 2

• A 220 lb patient, Chris, is alert and oriented. He has MS and his balance is poor. How would you transfer him from bed to chair?
  – Which Algorithm would you refer to?
  – What is your recommendation for
    • Equipment?
    • Method?
Case Study # 3

- A 77 year old female, Barbara, weighing 250 lbs, with very fragile skin and moderate pain from her cancer needs to be repositioned in bed.
  - Which Algorithm would you refer to?
  - What is your recommendation for
    - Equipment?
    - Method?
Case Study # 4

- A 25 year old male, post knee surgery needs to be boosted up in bed. How would you help?
  - What is your recommendation for
  - Which Algorithm would you refer to?
    - Equipment?
    - Method?
Case Study # 5

A 60 year old man, Carl, has had a mild stroke and needs to transfer from the bed to the chair. You are unsure of his strength and ability to weight-bear. He has some arm strength. How would you transfer him?

– Which Algorithm would you refer to?
– What is your recommendation for
  • Equipment?
  • Method?
Ward Champion Program  
(Adapted from the STAR template created at SOGH)

Goal:
- To reduce back/shoulder injuries due to improper body mechanics by both professional and unregulated healthcare providers.
- To develop capacity amongst unregulated healthcare providers to become more proficient in patient handling and movement.
- To develop a Ward Champion program for assistance with ergonomic initiatives.

Objectives:
- To increase employee awareness of proper patient handling techniques and to familiarize themselves with specific equipment/ aids so that they become confident when assessing individual patients limitations and setting up their care plans.
- To utilize our Healthcare Aids to full scope of their practice and develop potential for becoming more proficient in patient handling and movement.
- To promote safe ergonomics techniques, reduce injuries through training at the grassroots level and provide staff with the resources needed to enjoy a safe work environment.

Desired Future State
- To expand the Ward Champion program to non-patient related areas where ergonomic issues may arise, such as repetitive strain or improper lifting techniques.

What is the gap between the past state and the desired goal?
- Lack of knowledge and education, related to manufacturer’s recommendations for specific mechanical equipment.
- Old habits are hard to break.
- A lack of understanding of the limitations of scope of practice of different nursing groups.
- Employees often take short cuts when it comes to their own safety due to workload and time constraints.
- New staff is provided with patient handling training as part of their orientation program at the hospital. There is no follow up training or monitoring, or return demonstration of competency after the employee left the orientation program.
- The gap between the past state and out desired goal is training related. The desired goal is to ensure that all staff are provided the basic training in patient handling and movement, through a bi-annual certification and recertification program. The new employee program will be followed up with an on-ward mentoring program, over the first three months of employment, followed by a sign-off return demonstration competency performance managed by the ward champion.
CHAPTER 3 RESOURCES

- The Ward Champion will be identified as an expert resource and will be provided an initial training package, ongoing training and observation with a two-year recertification, and semi-annual upgrade workshops.

Action Plan and Potential Obstacles:
- To work with the Patient Care Managers in identifying potential candidates for the Ward Champion Program. It is recommended that they be a blend of nurses and healthcare aides. The obstacle will be freeing people from their already busy workloads.
- Previous work relationships have set the environment to be quite hierarchal. Effort needs to be made to recognize the importance and contributions made by each care giver discipline. This will be accomplished through education sessions, building skills and giving feedback.

Note: SOGH realized a reduction in WCB costs after the first year of their ward championship program (STAR) of approximately $17,000.00. Taking into account that their trend was previously increasing by $150,000 per year, this meant a total savings of $167,000.00.
MOBILITY GALLERY

A Classification and Assessment Tool for Care Planning
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Our policy is one of continuous development and we therefore reserve the right to change specifications without notice.
ARJO has been involved in the development of equipment and working techniques within elderly care for over 50 years. Our development activities are based on mobility issues. We have been working in close cooperation with staff and planners of elderly care facilities, always focusing on both the carer and resident – with people in mind. Some years ago, ARJO developed the Resident Gallery, a communication tool based on five different levels of functional mobility: from totally mobile and independent residents to those who are entirely bedridden. In this gallery the residents are classified according to their degree of functional mobility.

From the most mobile to the most dependent resident, you can recognise them by their alphabetical names: Albert, Barbara, Carl, Doris and Emma. Each resident has their own profile with personal characteristics and background details. Using this system brought us to the next step, the development of the Mobility Gallery, with more characters to accommodate other settings such as hospitals, special care and home care. These characters are introduced in this booklet, which we hope will help to identify and solve problems relating to different care plans and care safety issues.
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THE POSITIVE EIGHT

1. Mobility

2. Maintained capacity of the heart, lungs and blood circulation.

3. Reduced risk of pneumonia, thrombosis, incontinence, urinary tract infection, pressure sores and dizziness.

4. More active residents with maintained quality of life.

5. Reduced need for assistance. Strain is reduced.

6. Reduced strain related injuries; work becomes more productive. Psychological wellbeing of carer is improved.

7. Reduced turnover of staff, fewer sick days and greater job satisfaction.

8. Reduced costs in both long and short term. Enhanced quality of care.

Reference: Arjo Guidebook for Architects and Planners
Decades of experience working with nurses, carers and residents has shown us that the resident’s mobility/immobility plays a fundamental role in decisions made for the whole care process. This in turn means that the prerequisites for mobility – sufficient space, appropriate mechanical aids and correct working techniques – are keys to effective and safe nursing care.

Those involved in planning a nursing home or similar care facility face some very specific challenges. How can one achieve the right balance between today’s restricted budgets and requirements for high-quality care, good quality of life for residents, and safe working conditions for staff. There is also the additional challenge of meeting demands for lowest possible running costs.

ARJO can help you to find the right answers to these problems by providing solutions that improve the working environment for staff and increase quality of life for the individual in need of care. Sufficient space, appropriate mechanical aids and correct working techniques are critical factors, which play a major part in promoting the resident’s mobility, and therefore the whole care process. ARJO has over 40 years’ experience of working closely with facility managers, architects and other professionals.

The Positive Eight™
There is a clear connection between the positive effects for residents and carers. The resident’s mobility and quality of life are dependent on the quality of care performed by the carers and vice versa.

The principle is most easily demonstrated with two circles, which depict a set of eight factors where space, mechanical aids and working techniques comprise the “switching points” between the two circles. Provided you have the prerequisites in place – space, mechanical aids, and working techniques – you have created an environment where it is possible to mobilise the resident.

By promoting and maintaining the mobility of residents and making it possible for them to participate in activities of daily living, you will reduce strain on the staff and create a better working environment.
What is the Mobility Gallery?
WHAT IS THE MOBILITY GALLERY?

Introduction
Residents in nursing homes, care homes and other facilities are very different. They have different diseases and problems, different characters and backgrounds, and different wishes and expectations for the future.

We want to offer all of them high-quality care. This is the type of care that will allow them to maintain an optimum quality of life.

At the same time, this must be done without compromising the carer’s health. After all, the quality of care and quality of working conditions are closely linked. This is demonstrated by the Positive Eight concept.

The Positive Eight shows that, if the right choices are made, the quality of care and quality of working conditions will reinforce each other in a positive way.

Choices in care are made on the basis of our resident assessments. We make choices tailored to their needs and desires. It is important to recognise the fact that the ‘typical’ resident does not exist. In day-to-day care the millions of choices that are made need to be based on millions of assessments. These are often made unconsciously. In order to plan our care for residents, the choices need to be conscious and well balanced. Consequently, in combination with tailoring care to the individual resident, there needs to be some sort of standardisation and classification. This will lead to transparent care plans, monitoring of the plan’s appropriateness, and based on these results, the planning of a health care organisation’s care policy.

Mobility Gallery
This is one of the reasons ARJO developed the Resident Gallery some years ago. Using the Resident Gallery led us to the development of the Mobility Gallery, which suits all kind of health care settings. The Mobility Gallery is a classification system of five typical residents or patients. This gallery will allow development of a high standard of care stemming from insight on, and monitoring of, the requirements and preconditions for such care and for the health of carers (training, equipment and environmental conditions). There is background information on the system in the addendum, see page 74.
<table>
<thead>
<tr>
<th>MOBILITY CLASS</th>
<th>ALBERT</th>
<th>BARBARA</th>
<th>CARL</th>
<th>DORIS</th>
<th>EMMA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>![Image]</td>
<td>![Image]</td>
<td>![Image]</td>
<td>![Image]</td>
<td>![Image]</td>
</tr>
<tr>
<td>Is the resident independent?</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Is there a risk of physically overloading the carers during static load-related activities?</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Is the resident active or actively contributing to the movement?</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Is stimulating mobility desirable?</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
WHAT YOU CAN DO WITH THE MOBILITY GALLERY

More than a classification system

The Mobility Gallery is more than merely a classification system. It offers colourful images of five classes of residents or patients. The classes are based on patients you could and will actually meet in real life when you walk around in health care settings. You can almost see them alive in front of you, when looking at the drawing and reading their background information. By envisaging them, it makes it possible to discuss choices in care and rehabilitation with each other in a realistic way, while at the same time having the advantages of classification and standardisation.

The basis of the Mobility Gallery: the mobility scheme and five classes of mobility

Stimulating mobility and eventually respecting passivity is crucial from a quality of care perspective. On the other hand, we must also protect the carer and provide them with the professional working environment that they deserve. The five classes offer the right choices in order to protect the carer and provide optimum care. The classes are clearly different and each class has its own characteristics.

The overall scheme is shown on the previous page. It uses the first five letters of the alphabet. Five residents form the basis of the system with names corresponding to these first five letters. Collectively, they are called the 'Resident Gallery’. The series can be expanded with other characters, but the basic classification scheme they refer to will always remain the same.

Finally, it is important to emphasise that within each class there may be small differences in the degree of mobility and therefore the need for assistive equipment. For example: a 'mobile’ Carl may require a standing aid for transfers to the toilet, while a more passive one may need an active lifter.
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALBERT</td>
<td>BARBARA</td>
<td>CARL</td>
<td>DORIS</td>
<td>EMMA</td>
</tr>
<tr>
<td>ANNIE</td>
<td>BARRY</td>
<td>CAROLA</td>
<td>DANIEL</td>
<td>ELISE</td>
</tr>
<tr>
<td>ALBERT</td>
<td>BARBARA</td>
<td>CHRIS</td>
<td>DOMINIQUE</td>
<td>EDWARD</td>
</tr>
<tr>
<td>AB</td>
<td>BARRY</td>
<td>CHRISTA</td>
<td>DANIEL</td>
<td>EMIL</td>
</tr>
<tr>
<td>ADISA</td>
<td>BOB</td>
<td>CALVIN</td>
<td>DIANA</td>
<td>ELLA</td>
</tr>
</tbody>
</table>
Expanding to other settings
The characters of the Resident Gallery offer sufficient options for identification in a number of health care settings. However, the older figures of the basic series are not suitable for settings such as home care, acute care or care for handicapped children. Consequently, the series was expanded with more characters to cover other settings.

The same mobility scheme and classification system apply for these added patients. To underline this, they all have names with a first letter that corresponds with the mobility class they belong to.

Extra settings
It was decided to design extra characters who apply to the following settings: home or community care, hospital care, special care and bariatric care. The galleries for these specific settings are shown on the opposite page.

As mentioned above, characters with a similar first letter can be exchanged without compromising the system. As long as you end up with an A, B, C, D, E series, it is a complete system.

More options within one setting
The expanded set offers more options. By exchanging one or more characters, extra options for training and instruction are offered. For example, switching from a more acute care figure to a more chronically ill person in the same mobility class will clarify discussions. You can make discussions more practical and conclusions more generally applicable by introducing new or different characters. New characters can also make training courses more vivid without compromising the system itself.

Full case descriptions of individual gallery members are presented in this booklet to help you explore these options.

Links to the Handbook of Transfers
The five mobility classes are also presented in the Corpus Handbook of Transfers. Each transfer covered in the Handbook has an indication of the mobility class or classes it is suitable for. This gives you all sorts of options to combine the Handbook with the Mobility Gallery. Using case descriptions will make it more practical for carers in workshops. It will also make it easier to consistently note the patient’s mobility class in the patient care plan.

The overall Mobility Gallery scheme will assist in your choice of characters.

Bariatric Gallery
The Resident Gallery has been extended to accommodate bariatric patients as well.

Obesity affects all ages. Long-term care is acquiring more obese residents at a rapid rate and is not equipped to provide safe or adequate provisions to meet their needs. If we look at the demographics of a population with rapidly increasing weight, it becomes very clear that these individuals will not only require quality acute care, but also quality long-term care. Communities should begin to plan and prepare for these admissions with the appropriate environment, equipment and trained professionals to prevent injury to residents and carers.
<table>
<thead>
<tr>
<th>ELDERSLY CARE</th>
<th>HOME CARE</th>
<th>HOSPITAL CARE</th>
<th>SPECIAL CARE</th>
<th>BARIATRIC GALLERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALBERT</td>
<td>ANNY</td>
<td>ALBERT</td>
<td>AB</td>
<td>ADISA</td>
</tr>
<tr>
<td>BARBARA</td>
<td>BARRY</td>
<td>BARBARA</td>
<td>BARRY</td>
<td>BOB</td>
</tr>
<tr>
<td>CARL</td>
<td>CAROLA</td>
<td>CHRIS</td>
<td>CHRISTA</td>
<td>CALVIN</td>
</tr>
<tr>
<td>DORIS</td>
<td>DANIEL</td>
<td>DOMINIQUE</td>
<td>DANIEL</td>
<td>DIANA</td>
</tr>
<tr>
<td>EMMA</td>
<td>ELISE</td>
<td>EDWARD</td>
<td>EMIL</td>
<td>ELLA</td>
</tr>
</tbody>
</table>
Because of our ageing society, increasing demands are being placed on elderly care facilities.

Demographic trends indicate that this pressure will increase in the years to come. The residents living in this health care sector are usually very frail and often disoriented or limited in their mental capabilities. Statistics indicate that in the past few decades elderly care facility populations show a trend towards relatively more residents in categories C to E as opposed to A and B. However, in spite of this trend, residents with greater mobility in category A and B also live in these homes.

Even though elderly care facility residents are not in their own home and often will not return home again, there remains a strong desire to offer them an environment that resembles this as much as possible. This will make them feel comfortable, safe and confident in spite of their psychological and physical problems. It will also enable them to make use of the capabilities they still have and maintain this capacity along with their dignity for as long as possible.

Residents at elderly care facilities often have multiple problems that complicate their condition. This may make it difficult to choose the right type of care and support for them. As a rule, specialised equipment will provide this special and very frail group of residents with a safe environment in order to promote their mobility and meet their daily needs.

An important characteristic of elderly care facility residents is that the residents’ conditions tend to be rather stable in nature when compared to other care environments such as acute care. In many cases their condition will change gradually: it will slowly improve or deteriorate. This can make it easier to tailor the choice of equipment to the needs of any specific resident than it would in a hospital setting, where the condition may fluctuate within a few hours. In order to promote resident and carer safety, the decisions made must be written down in the patient care plan. These decisions will need to be evaluated and updated on a regular basis.

Education for the carers working in these facilities must promote their skills and confidence in using their equipment, as this will stimulate its frequent and safe use.

Traditionally, carers working in elderly care facilities have been in one of the top-10 jobs for being exposed to excessive physical load, and the incidence of back pain is among the highest of all occupations. However, studies have shown that this need not be the case. A safe working environment is possible. Back pain prevention programmes and policies will enable staff to work in a safe and professional environment without compromising their own health and experiencing back pain or other occupational health problems.
ALBERT

- Ambulatory, but may use a cane or similar for support
- Independent, can clean and dress him/herself
- Can tire quickly
- Stimulation of abilities is very important
Albert, a kind, quiet 75-year-old single man (82 kg), had a heart attack one year ago and has lived in the care home ever since. He tires quickly and often feels lonely and depressed. Outside the care home he only has a few friends, who seldom visit him. Although he is encouraged to go out, he stays in his room most of the day and rarely ventures outside.

He washes and dresses himself, and is also independent of carers in all other ADL (Activities of Daily Living). For stability he uses a walking stick, which he takes with him wherever he goes. Although he is capable of showering himself, he rarely does. When asked about it, he says washing is good enough and that he doesn’t need to shower. During intake to the care home he told the nurses he used to shower everyday and enjoyed it.

Albert is continent. Recently, the nurses noticed that he does not drink enough fluids. When offered a drink, he usually drinks only half a glass or even leaves it untouched. One of the nurses suggested that he might be reducing his fluid intake to avoid having to go to the toilet.
BARBARA

- Uses walking frame or similar
- Can support him/herself to some degree
- Dependent on carer who is present in demanding situations
- Not physically demanding for carer
- Stimulation of remaining abilities (e.g. ambulation) is very important
Barbara, an 82-year-old (62 kg) widow, has lived in the care home for three years. Her husband died seven years ago. In her working life she was a primary school teacher. Her children and grandchildren live nearby and like to visit her. She seems happy in the care home.

There is a combination of medical problems. Due to a heart condition, she occasionally gets very dizzy, and a rheumatic disease makes her joints, especially her knees, stiff and painful. She also gets tired quickly. Because of her dizziness and knee pains she is afraid of falling. The doctor encourages her to keep moving as much as possible: “If you rest, you will rust”, he says.

Some guidance and minor support are needed during daily activities such as washing and toileting. At times when her joints are especially painful, she requests support. Her pain level changes from time to time. She is not incontinent, but it is becoming a problem for her to get to the toilet in time. On these occasions she is exhausted and her knees hurt.

Sometimes it is necessary to stay with her during these activities, just to be sure.

Barbara takes a shower every day and bathes twice a week. Showering in particular makes her very tired for the rest of the day. She takes pride in her appearance, chooses her clothes with care and spends time on doing her make-up and hair. Being able to do this gives her satisfaction, but it is also tiring for her.

She uses a walking frame and gets around the home regularly, especially to visit a woman she has become good friends with. When the weather is good, she likes to take a walk in the garden. Recently this has become a problem for her, and she cannot do it anymore. Her children have suggested the use of a wheelchair, so she can go out a little more. She is against this and would rather stay inside than go out in a wheelchair. Her 12-year-old grandson was disappointed, because he does not want to stay inside all the time. “It is too hot in her room” he complains and wants to take his grandmother outside.
CARL

- Sits in wheelchair
- Is able to partially bear weight on at least one leg
- Has some trunk stability
- Dependent on carer in most situations
- Physically demanding for carer
- Stimulation of remaining abilities is very important
Carl, an 80-year-old carpenter, used to live near the care home. He was a strong man who enjoyed life to the full. Two years ago his wife died. He seemed to cope well, but a year ago he had a stroke. After being in the hospital for one week, he stayed in a rehabilitation centre for three months. He recovered somewhat, but not enough to live independently, which is why he was admitted to the care home, where he has been for six months. Now and then he has a very difficult day.

He cannot accept his present condition. At times he lashes out aggressively, both verbally and physically, at the nurses. Some of the nurses find it difficult dealing with him, because of his aggression, strength and weight.

His children phone him regularly. They only visit him once a month, as they live a long way from the home. Carl is hemiplegic, the left side of his body is paralysed. He can stand a little on his left leg and has limited control over his left arm. Now, he does practically everything with his right hand and has adapted to this well. A physiotherapist is training him to walk again using a walking aid.

He is determined to walk again, but the physiotherapist is not sure that he will. Progress is slow and his balance and coordination are still severely affected. At the moment he gets around in his wheelchair, which he drives with his right leg and right arm. He often bumps into people and furniture, and gets frustrated by this.

At over 90 kg, Carl is a heavy man. When he gets out of bed he needs considerable support to transfer to the wheelchair. For this reason, and for Carl’s safety, a standing and raising aid is used. The nurses have to move the standing and raising aid to the right side of the bed. He gets to the side of the bed with the help of a turntable and monkey pole. In the morning he goes to the toilet and is showered – on a height-adjustable shower chair – receives help with dressing and gets into his day wheelchair.

Although he is continent, sometimes he does not notice in time that he needs to go to the toilet. On these occasions he wets his trousers. He is embarrassed and worried by this development.

Carl likes to go down to the main living room to meet other people and also goes into the village. Before leaving the home he always goes to the toilet.
DORIS

- Sits in wheelchair
- No capacity to support him/herself
- Cannot stand unsupported and is unable to bear weight, even partially
- Dependent on carer in most situations
- Physically demanding for carer
- Stimulation of remaining abilities is very important
Doris, an 80-year-old woman, used to be a professional nurse. She worked until the age of 65. Doris knows and respects her limits and treasures her privacy very much. When anyone tries to get too close to her – emotionally or physically – she backs away. She likes to be on her own most of the time.

Among the residents there are a few who clearly dislike her. They say she is “bossy”, “dominant” and tries to take control of their lives. On the other hand, several other residents respect her very much and like to depend on her for all sorts of things.

She weighs 90 kg, and, as she is also very passive, transfers are very strenuous.

Doris is double incontinent. At present her incontinence level is maintained by toileting, but this is becoming a problem. She is increasingly passive and it is now more difficult to transfer her to the toilet. Some of the nurses say it is too difficult to continue using this procedure. There are also other signs that she is deteriorating; she seems to get disoriented about time and place.

As she has no capacity to bear her weight, a passive lift is used for transfers. To make this passive transfer more efficient, her personal sling is left in the chair all the time. When she gets tired, she tends to slide down in her chair. She is unable to get back up into a sitting position by herself. Doris is taken to bed in the afternoon to rest for a while. She cannot sit for too long in any case, as osteoporosis makes her back hurt. Lying down also relieves pressure on the sensitive skin on her bottom.

In bed she has difficulties turning from side to back and vice versa. She does not have the strength for this and the movement involved is also becoming painful for her. The powered upper end of the bed helps her get into a sitting position. Assistance is needed for her to move around in bed (turning, sideways and moving up the bed). Her skin is a little red and sore in some places. The nurses have expressed their concern that pressure sores could develop. She now needs extra attention on her skincare and frequent assistance to ensure mobility in bed.

Doris does not consider her appearance to be important. She needs encouragement to do her hair, refuses to cut her nails, does not use make-up and wants to wear the same clothes day after day. She can wash her own face and upper body, while sitting in her wheelchair. However she needs someone else to pass her a towel and soap and encourage her to wash.

Assistance is required for washing her lower body. Because of her weight, passivity, incontinence and sensitive skin, it is important that she is washed properly and regularly.

Her daughter lives nearby and visits every day. Doris wants a lot of attention from her daughter, who finds it a demanding relationship. During visits, there have often been arguments between mother and daughter about trivial things. This seems to have got worse over the past few weeks.

Doris has a friend on one of the other units. She goes to visit her as much as she can. They usually go down to the restaurant to have a chat and look at the people passing by.
EMMA

- Passive
- Might be almost completely bedridden
- Often stiff, contracted joints
- Totally dependent
- Physically demanding for carer
- Stimulation and activation is not a primary goal
Emma, an 86-year-old woman, used to run a small grocery shop with her husband. Her favourite hobby was gardening. She has been living in a care home for two years. At home she was not able to take care of herself anymore and began to show increasing symptoms of Alzheimer’s dementia. She forgot people’s names and where she lived. In winter, she went outside in the bitter cold without a coat on. An additional problem was that she became double incontinent. There were no children to help her and her husband has a heart problem.

After she was admitted, her health improved slightly. She seemed to be happy, less confused and even gained a little weight. However, her condition has worsened over the past year. Emma has not communicated verbally for a few weeks and has hardly reacted to anything that happens around her. She is double incontinent, barely eats or drinks and has severe contractures. Her weight is decreasing and at the moment she weighs 42 kg. She is in bed for 22 hours a day. Because of her contractures, immobility and minimal food and drink consumption there is a risk of developing pressure sores. Her skin shows the first signs of decubitus, as it is red and painful. Therefore, she is being nursed on an antidecubitus mattress.

During care routines she cries out if the nurses attempt to move her. It has become increasingly difficult to take care of her without causing pain. She is very thin and her contractures limit proper care. There are signs on her skin of pressure sores and her muscles are very tight (hypertonic).

To give her some stimulation, she is transported in a special, tilted chair to the central living room, where she spends two hours each day. There is a large cage with tropical birds there, and she seems to like their coloured plumage and birdsong, although it is not certain that she does. The people that pass by also add a little variety to her day. Her husband tries to visit as often as he can, but it is demanding for him. She does not respond to his coming or going anymore.

The transfer from bed to the special chair is performed using a sling lift. Her personal sling is left in the chair and she remains on the sling in the chair. For hygienic reasons she has a spare sling. She is not toileted anymore and no attempts are made to promote continence. Throughout the day and night she uses the highest level of incontinence pads. These are changed whenever necessary, although efforts are made in order to avoid unnecessary stress. The type of clothes she now wears permit easy dressing and undressing. In the morning she is showered on a shower trolley and her clothes and incontinence pad are changed.

Twice a week she takes a bath. Emma finds the process of undressing confusing. She does not understand where she is going and what is going to happen. Nevertheless, once she is lifted into the warm water of the bath, she relaxes quickly and seems to enjoy it. In the bathroom there is pleasant soft lighting and relaxing music. During the bathing session there are good conditions for hygienic care. It is remarkable that after the bath she remains relaxed for a while and seems to feel comfortable.
Home care is characterised by the provision of care in a patient’s own home. This situation places special demands on both the care provided and the equipment used. There is an increasing demand for professional home care. There are several reasons for this. Firstly, professional home care may be a substitute for more expensive clinical care. Another important reason is that most people prefer to stay at home in their own environment as long as they possibly can, even when they become ill or their abilities diminish. It goes without saying that this needs to be done without compromising their health. The right equipment will enable people to maintain their mobility longer than they would otherwise. This also implies that today’s home care provides care for patients with all possible levels of functional mobility: A to E.

Although care is provided in a home not designed for that purpose, working conditions for carers need to be safe. This places exacting demands on the mechanical aids used. Using the correct equipment will also prevent strain injuries in a home care environment. The carer is in some respects seen as a guest. This may cause emotional resistance to the use of equipment. This is particularly true if the equipment is mainly used to prevent back problems for the carer. The patient may not see this as an advantage and may consider the equipment to be an unwanted intrusion. Proper and timely information to the patient and his or her carers and the use of high-quality equipment will help to prevent this from occurring. In home care there may also be private homes specially designed and adapted for people with disabilities or impairments. The equipment requirements need to be integrated into the design right from the start.

Another distinctive aspect of home care is that the carer often works alone and not in a team of colleagues that can be called on for rapid assistance. Apart from the extra psychosocial burden this may place on the carer, it also places greater demands on the equipment used. It is essential that the equipment can be safely operated by one carer and is of very high quality in order to work safely and reliably under all circumstances.

In a lot of cases, home care is partly or mainly provided by family, friends, neighbours or spouses. These informal carers are often more vulnerable because they may be old or have disabilities themselves. Like the health of professional carers, their health needs to be protected too. Again, the proper choice of equipment offers the right degree of protection, enabling informal carers to provide more care for a longer period of time. In addition, it is possible that equipment will be operated by carers who lack professional training. Special consideration should therefore be give to the design and safety of equipment and how easy it is to use.

Within home care, families with disabled children is a group with special needs. The parents are often confronted with the difficult problem of seeing their children playing, growing up and developing, while at the same time facing a gradual decline in their own physical capacity. These circumstances may mean particular demands on the equipment for these children and their parents.
ANNIE

- Ambulatory, but may use a cane or similar for support
- Independent, can clean and dress him/herself
- Can tire quickly
- Stimulation of abilities is very important
ANNIE

Annie, a 28-year-old woman, lives independently on the third floor of a building in an inner city area. She has been single for a year, after living with a partner for seven years. For the past five years she has had a considerable drinking problem, although she vehemently denies this. Her drinking problem was the reason her partner finally left.

Over the last six months Annie has not taken proper care of herself or her home. At night she makes a lot of noise and this disturbs the neighbours. She lives on biscuits and crisps, and drinks more or less constantly. There is no longer any attempt to keep the apartment clean. Personal hygiene has deteriorated, she doesn’t wash herself and wears the same clothes for months on end. She has developed a habit of leaving empty bottles and rubbish in the stairwell of her apartment block.

Mentally, she finds herself in a frequent state of confusion. She has very little idea of time or place and her memory is bad. She cannot remember appointments. If someone comments on her current condition or poor memory she can be aggressive, physically as well as verbally.

Physically, she is fully mobile. However, she shakes during many of her movements and she is weaker than she was. In principle, she is able to wash, shower and dress independently. The problem is that she refuses to do so. Even when she is offered help, she refuses. If pressed on the issue by professional carers, she becomes aggressive. She recently had a fall during the night when she tripped and landed badly. Since that time she has had a leg wound that won’t heal. The wound is infected and seems to be getting bigger. She refuses to treat the wound herself or seek treatment.

People in the apartment block have been complaining about the smell, the empty bottles and dirt on the stairway, as well as the noise at night. Finally, Social Services investigated the situation, and the homecare unit (a special family care team) became involved. Now, someone from the unit calls in every day including the weekend. Where possible this is the same person, although this is not always feasible.

Consultations between the local home care unit and Social Services have led to the formulation of a number of targets for the provision of care.

The first objective is to try to establish some sort of social contact with her in order to assess her changing circumstances.

After that an attempt will be made to get the basic elements (food, personal hygiene, social relations) of her home life back to a minimum acceptable level. Meals on Wheels will provide her with a warm meal every day. Attempts will then be made to assist her in returning to an acceptable level of personal care: washing, showering if possible, and changing clothes regularly.
BARRY

- Uses walking frame or similar
- Can support him/herself to some degree
- Dependent on carer who is present in demanding situations
- Not physically demanding for carer
- Stimulation of remaining abilities (e.g. ambulation) is very important
Barry, a seven-year-old boy, lives with his parents and two sisters in a residential area that has lots of young children. The eldest of three children, he developed slower than other children his age, which was a cause of concern for his mother.

When he was one year old, doctors diagnosed a rare muscular disease. Barry’s muscles will slowly deteriorate until he will eventually die of his illness. Many people with this disease do not live past 30. Until about a year ago he was able to live quite normally. He enjoys going to primary school and has a lot of fun with two friends. They are the area’s “little rascals”.

Around a year ago Barry’s mother, Anna, noticed that Barry started having problems walking. He often tripped over. After a while he could no longer go up stairs normally and has recently started to do this on all fours. Cycling with other children has become a problem, as he is no longer able to keep his balance. He now uses a special three-wheeled bike with off-road tyres and ‘go-fast’ handlebars and has a lot of fun with this. However, at the moment cycling the distance to school has become almost too much for him. His mother pushes him part of the way. Once the school comes into view she stops pushing him and he cycles the last few hundred metres by himself.

Walking quite short distances is now too much for Barry. When the family go out together it has become necessary for him to use a wheelchair. A good wheelchair has now been bought for him that looks rugged and sporty, but for Barry this is a significant step: he doesn’t want others to see him in a wheelchair. Chris, Barry’s father, is also finding the situation difficult.

Barry knows he is ill, but he doesn’t fully comprehend, or appears not to fully comprehend, the reality of his situation. However, he remains a cheerful boy who knows how to have fun.

Daily activities are now starting to be a problem, too. Until recently he was able to dress, undress and shower himself, although he needed assistance with difficult things like zips. Lately, this has become very tiring for him. Anna now usually helps him, as this also prevents him from getting too tired to get through the rest of the day. Often she helps Barry’s younger sister at the same time and that way she can keep an eye on Barry and assist quickly if he needs help. Barry now showers twice a week, when Anna also washes his hair. Both Barry and his parents would like him to shower more often, but he simply gets too tired. Barry’s sisters have a bath or shower every day.

Barry has physiotherapy twice a week. This is aimed specifically at strengthening muscles and maintaining his condition and stamina at an optimum level.

The local home care unit have been called in to advise on how Barry can best be helped with his ADL (Activities of Daily Living), now and in the near future. At the request of his parents, the family’s way of dealing with Barry’s illness will also be discussed with a specialist home care nurse.
CAROLA

- Sits in wheelchair
- Is able to partially bear weight on at least one leg
- Has some trunk stability
- Dependent on carer in most situations
- Physically demanding for carer
- Stimulation of remaining abilities is very important
Carola is a beautiful 19-year-old woman. She takes pride in her appearance and chooses her clothes carefully. With her long, dark curly hair she has striking good looks.

Four years ago Carola was in a car accident and has been in a wheelchair ever since. She is paralysed from the waist down and her arms are also slightly spastic. The accident Carola and her friend Karin were involved in was caused by a drunk driver. Karin was not injured. After a stay in hospital and four months at a rehabilitation centre, Carola went back to live with her mother. When she turned 18, she moved out to live on her own, but her new home is close to her mother and Karin.

Carola works in a solicitor’s office three days a week, which she enjoys enormously. Normally, she does administrative work, but recently she has been given other responsibilities as well. Although she has a good education and was planning to go on to University, she was afraid this step might be too much for her. For this reason she decided to find a job instead.

For the past six months she has had a boyfriend, Roy. They are thinking about living together. However, Carola is hesitant as she greatly values her independence and worries that Ray may have problems dealing with her disability on an everyday basis.

At the moment Carola is mostly self-sufficient and lives in an assisted living environment. The house has been adapted for wheelchair use and has a small garden. If she needs any ADL support she can always ring for extra assistance, although this option is rarely used. However, an ADL assistant calls in every morning to assist Carola from her bed into the shower. The assistant helps Carola to shower, wash her hair if necessary, have a pedicure and change her catheter. The latter procedure is difficult for Carola to do herself, as it requires very precise actions. Afterwards, Carola can dressing herself almost without help and is assisted into her wheelchair.

Her ability to stand is limited. However, she can take a little weight on her spastic legs, although it can only be maintained for a few seconds. She feels this is important and it makes her feel better, although she realises that recovery is out of the question. An active lifter is used to perform the transfers.

In the evening, Carola rings for assistance to help her get into bed.
DANIEL

- Sits in wheelchair
- No capacity to support him/herself
- Cannot stand unsupported and is unable to bear weight, even partially
- Dependent on carer in most situations
- Physically demanding for carer
- Stimulation of remaining abilities is very important
Daniel, a 15-year-old boy, has been both physically and mentally disabled since birth due to a hereditary disease. He has the mental age of an 8-year-old. Communication with Daniel is very difficult. Outwardly, he shows hardly any emotion. There is little response and rarely a sign of pain, sadness or happiness. However, his parents and sister Brit are able to communicate with him quite well about everyday matters.

Virtually comprehensive ADL support is required. Daniel is slowly deteriorating, especially physically, and can do less and less. In addition, he is developing a number of deformities caused by muscle spasms. Although operations have been performed, significant problems remain. The medication he has taken for years to counteract the problem has the disadvantage of making him quite drowsy. Daniel cannot stand and must wear incontinence pads at all times. He can eat sandwiches, but with great difficulty. Eating dinner independently is not possible for Daniel, as he chokes easily and there is a considerable risk this will cause pneumonia.

Until now his parents have always provided care for him. However, they have indicated that it is becoming too much of for them. Daniel now weighs 44 kg and his mother, Marianne, severely strained her back recently and suffered a minor mental breakdown. The injury, as she puts it, was “the straw that broke the camel’s back”. As part of her recovery, Marianne and Rob, Daniel’s father, managed to get away together for a few days for the first time in years. They made a decision to put Daniel on the waiting list for a nearby facility providing care for the disabled. In the six months since then, Daniel has deteriorated further and the local home care unit is providing assistance to help his parents manage.

Once a day they receive assistance with daily care activities, either in the morning or evening. They do not receive assistance at weekends. Daniel attends a day-care centre twice a week. He does very little when he is there and has virtually no contact with the other people. It is a relief for his parents to have some time to themselves.

Daniel is picked up at 8.30 a.m. and brought back at 4 p.m. He is very tired when he comes home and just wants to sleep.

The family home has been adapted especially for Daniel. All rooms are on the same floor. There is a ceiling-mounted lift to help him get from his bedroom to the bathroom in one transfer, and the bathroom has a height-adjustable shower stretcher. Daniel loves having a shower, which seems to relax him.

Helping with daily activities such as changing, washing, drying, dressing and undressing has become very difficult for both his parents and the home care assistant, due to Daniel’s muscle spasms. Over the years, Marianne has discovered various methods and little ‘tricks’, which she is now passing on to the home care assistant. Marianne does not like the fact that home care assistance is often provided by different people. Daniel is very sensitive regarding his muscle spasms and it can cause problems if the home care assistant does not know the right way to approach and touch him.

Daniel has a specially adapted wheelchair with a seat orthosis modified for his deformities. The very heavy wheelchair is height-adjustable and electronically steered. At night Daniel uses a bed orthosis, which has been made to measure. Getting Daniel to lie in the orthosis properly is often difficult. Daniel usually dislikes it, resists vehemently and can’t really understand what is going on. In the morning, getting Daniel out of the orthosis presents similar problems.
ELISE

- Passive
- Might be almost completely bedridden
- Often stiff, contracted joints
- Totally dependent
- Physically demanding for carer
- Stimulation and activation is not a primary goal
Elise, a 35-year-old woman, has a rare muscular disease, which means she has deteriorated over the years. However, she has always enjoyed life. She worked for 20 years in a day centre where she made a lot of friends.

Her life expectancy was about 30 years. She has been virtually deaf for a year and has only partial vision. Over the past 12 months she has lost a lot of weight and is now given special nutrition.

Breathing problems in the last fortnight related to her muscular dystrophy mean that she now receives oxygen continuously via nasal intubation.

She has been in bed all day over the past few weeks and seems to have given up on life. Although she is not in a lot of pain, her breathing problems are getting worse. It is clear that she is sometimes very distressed. Communicating with her is extremely difficult, as talking and maintaining eye contact are no longer possible.

Elise is very thin, weighing only 42 kg. There is a high risk of pressure sores. For this reason, she has been given a special mattress. Even so, her hip and coccyx are becoming reddish. Her skin is in poor condition and some areas are painful. Although the carers have tried to treat these sore areas, nothing seems to help. She is turned over regularly, but this causes her a lot of pain. The use of a sliding sheet has been suggested. This would mean Elise lies on a drawsheet and a cellulose pad, with the sliding sheet underneath. This makes it easier to help her in bed and turn her over. The sliding sheet stays underneath Elise and the guard rails on the height-adjustable bed remain in place.

At present, Elise receives only liquid food via a nasal tube and she finds this acceptable. She also has a catheter. Elise’s friends visit her regularly. Somehow she seems to recognise them and shows that she likes their visits. Her friends bring flower-scented incense, which she is able to enjoy. Physical contact, such as touching and holding hands, has now become very important.
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Acute care is characterised by a rapidly changing population of patients, and by patients whose conditions can also rapidly change. Some patients’ conditions may even vary from hour to hour, and they may return home the next day. The implication is that it is more difficult to follow these developments with the correct choice of equipment than it would be, for example, in a relatively stable elderly care facility population. Nevertheless, with an adequate basic range of available equipment it will be possible to cope with these changes and individual demands in such a way that the safety of both patients and nurses will be ensured.

In recent years, hospitals have been working to shorten patients’ stays and let them go home sooner than before. The patients usually require complex medical and nursing treatment, and monitoring. However, there are also wards in which the patients are in category A or B and still require full medical or nursing care.

Another special feature of acute care is that different units have some very specific demands that need to be considered when choosing equipment. The requirements of an orthopaedic unit will differ considerably from those of a surgical or paediatric unit. This may, for instance, lead to a different set of slings for the lift in use. In addition, patients often have treatment-related attachments that need to be factored in to equipment selection. For example, special IV-lines may limit the use of some equipment or make special techniques necessary for operating equipment.

To ensure patient and carer safety, it may be necessary to provide additional training, especially as equipment will often be used in circumstances that are complicated, non-routine and subject to rapid changes.
ALBERT

- Ambulatory, but may use a cane or similar for support
- Independent, can clean and dress him/herself
- Can tire quickly
- Stimulation of abilities is very important
Albert, a kind, quiet 75-year-old single man (82 kg), had a heart attack one year ago and has lived in the care home ever since. He tires quickly and often feels lonely and depressed. Outside the care home he only has a few friends, who seldom visit him. Although he is encouraged to go out, he stays in his room most of the day and rarely ventures outside.

He washes and dresses himself, and is also independent of carers in all other ADL (Activities of Daily Living). For stability he uses a walking stick, which he takes with him wherever he goes. Albert is continent. Recently the nurses in the care home have got the impression that he is reducing his fluid intake to avoid having to go to the toilet.

Today he is being taken to the local hospital to have a general medical check up. One of the elderly volunteers from the care home, Jenny, accompanies him, as he feels it will be too much for him to go alone and is afraid of getting lost in the hospital. She has played a similar role before and helps him with things like the taxi, his insurance papers and the appointments.

After they arrive, he uses one of the hospital’s wheelchairs because several tests need to be done and long walking distances are involved. He keeps his walking stick with him in the chair. After one of the tests he suddenly needs to go to the toilet and seems to panic a little. He says he is afraid of wetting his trousers and suddenly starts to get out of the wheelchair without using his walking stick for support. Jenny does not really know what to do and asks for help. However, it is too late and despite the efforts of a nurse to keep him on his feet, Albert falls on the floor.
BARBARA

- Uses walking frame or similar
- Can support him/herself to some degree
- Dependent on carer who is present in demanding situations
- Not physically demanding for carer
- Stimulation of remaining abilities (e.g. ambulation) is very important
Barbara, an 82-year-old (61 kg) widow, has lived in the care home for three years. Her husband died seven years ago. In her working life she was a primary school teacher. Her children and grandchildren live nearby and like to visit her. She seems happy in the care home.

There is a combination of medical problems. Due to a heart condition, she occasionally gets very dizzy and a rheumatic disease makes her joints, especially her knees, stiff and painful. She also gets tired quickly. Because of her dizziness and knee pains she is afraid of falling. The doctor encourages her to keep moving as much as possible: “If you rest, you will rust”, he says.

Some guidance and minor support are needed during daily activities such as washing and toileting. At times when her joints are especially painful, she requests support. Her pain level changes from time to time. She is not incontinent, but it is becoming a problem for her to get to the toilet in time. On these occasions she is exhausted and her knees hurt. Sometimes it is necessary to stay with her during these activities, just to be sure.

Barbara takes a shower every day and bathes twice a week. Showering in particular makes her very tired for the rest of the day. She takes pride in her appearance, chooses her clothes with care and spends time on doing her make-up and hair. Being able to do this gives her satisfaction, but it is also tiring for her.

Today, Barbara is going to the hospital to have an ultrasound test relating to her heart problem. She is a little anxious about the day and has made sure she is smartly dressed. To be on the safe side, she uses a wheelchair and makes the journey on the care home’s specially adapted minibus. When she arrives, a nurse collects her from the bus and takes her into the hospital. The next step is a transfer from the wheelchair to the examination table. She is able to stand up from the wheelchair and sit on the edge of the table. But, even though the table is height-adjustable, Barbara is having problems. She finds there is not much to hold on to and the table’s surface, covered with paper for hygienic reasons, is a little slippery. She cannot get her feet up on the table and is close to the edge. After a few attempts she is getting tired and insecure. The nurse calls for assistance.
CHRIS

- Sits in wheelchair
- Is able to partially bear weight on at least one leg
- Has some trunk stability
- Dependent on carer in most situations
- Physically demanding for carer
- Stimulation of remaining abilities is very important
Chris, a 34-year-old man (86 kg), loves cross-country cycling. On a weekend ride in the woods near the village where he lives, he had an accident. He cycled fast downhill, out of the woods, but did not see a car on the otherwise very quiet road. A collision was unavoidable.

The right side of his pelvis was fractured. Chris was unconscious and fell into a coma. He suffered internal injuries, including liver damage, and his spleen had to be removed.

After surgery and nearly three weeks of bed rest, he is now finally making progress towards recovery. The internal injuries are still causing pain and make him feel weak. Although he is very unstable and has lost a lot of strength, he is now allowed to gradually start mobilising again.

Chris seems to be slightly depressed and lacks confidence in his recovery. He often says things like: “I will never be able to cycle again” and “Look what has happened to me, I am an old man now.” His doctor has said that in a few days Chris will be allowed to go home for further convalescence. Chris reacted negatively to the news, as he does not feel ready to return home. He is afraid of what awaits him when he has to do everything himself and does not want to deal with people’s questions about when he will return to work. His girlfriend is out at work during the day.

In hospital he still needs considerable support with almost every daily activity. He needs help with transfers to the toilet and to and from the wheelchair. An active lifter is used to help him, and the physiotherapist has asked the nurses to stimulate participation during these transfers. The nurses will encourage him to take weight on his own legs again and positively reinforce him while he is trying. This morning his therapist suggested he should start using a standing aid because she considers he now has enough strength for this. However, Chris refuses as he is afraid of falling when using the standing aid. He complains that: “Everyone is pushing me, but I am not ready. I don’t feel well enough yet.”

His girlfriend wants to get him home as soon as possible. However, she is worried that she will not be strong enough to help him or to stimulate his mobility sufficiently.
DOMINIQUE

- Sits in wheelchair
- No capacity to support him/herself
- Cannot stand unsupported and is unable to bear weight, even partially
- Dependent on carer in most situations
- Physically demanding for carer
- Stimulation of remaining abilities is very important
Dominique, a 14-year-old girl (55 kg), was admitted with a spinal fracture after a fall from a three-storey cabin she was building with some friends during a summer camp.

The fracture was relatively simple as there was no displacement of the fracture or neurological factors. She remained supine in bed for five weeks to stabilise the fracture. A care plan has been drawn up to address her needs without compromising the health of the nurses involved. The plan encourages her to use the muscles in her arms and legs, but keeps her back stable.

This morning she went to the diagnostic department for a MRI scan (Magnetic Resonance Imaging) to establish the degree of recovery and progress. The transfer from the bed to the examination table that enters the MRI unit involved a ceiling lift and attached horizontal stretcher.

This afternoon her doctor told her she can start mobilising very carefully over the next two weeks. Her physiotherapist will coach her during this period. Dominique is very happy that finally there is some progress, and is very eager to get out of bed. She has to be prevented from almost jumping out of bed. To stabilise her back, she wears a special orthosis.

In spite of these steps forward, she still has to remain on her back for most of the day. She can start sitting up for short periods and begin standing up with partial support. Substantial support is needed if she wants to move or make a transfer, as her muscles are weakened, she gets dizzy and the orthosis limits her movements.

Dominique’s mother and sister will be visiting this afternoon and they want to take her down to the restaurant in a wheelchair.
EDWARD

- Passive
- Might be almost completely bedridden
- Often stiff, contracted joints
- Totally dependent
- Physically demanding for carer
- Stimulation and activation is not a primary goal
Edward, a 48-year-old man weighing 100 kg, was admitted last night at the emergency room clearly suffering from heart problems. On arrival, he was transferred from the ambulance trolley to the examination table and from there to the surgical department.

He had to undergo emergency open-heart surgery in order to receive a quadruple heart bypass. The operation was carried out early this morning and he is now on his way to the Intensive Care Unit (ICU). The operating room alerted the unit and everything is now being prepared for him in the ICU. Although the surgical procedure was successful, there were some complications, mostly due to the fact that he was in poor physical shape before the operation. He is overweight, a heavy smoker, takes no exercise and lives a stressful life, as he runs his own company, which depends on him.

At the moment he has some fluid around his lungs, which was already present when he was admitted, and his heart rhythm is irregular. He also had severe blood loss and was given a blood transfusion. It was decided to keep him sedated for the next 24 hours to see how the situation develops. Edward arrives unconscious at the ICU and is transferred to a special ICU bed. He has several tubes, control devices and a catheter attached to him and has to remain supine during the transfer. Although he is breathing on his own, he is having difficulties and receives extra oxygen. Every 24 hours an X-ray will have to be taken to check his chest and the build up or reduction of fluid.

His wife is coming to visit him shortly. She was at home for a few hours to take care of their children and some other matters, but she intends to stay with him for the rest of the day.
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<td>ALBERT</td>
<td>BARBARA</td>
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<th>SPECIAL CARE</th>
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<tr>
<th>BARIATRIC GALLERY</th>
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<td>ADISA</td>
<td>BOB</td>
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People living in special care facilities often have limited physical or psychosocial capabilities. In many cases there is a combination of both types of limitation and these problems have existed from an early age, due to genetic or congenital causes. Their future prospects are based on their ability to make use of the capabilities they have.

The facilities they live in are usually small or medium-sized units where an environment is created that resembles an ordinary home and family life. Many of these units are integrated in communities, although they do offer some degree of protection or guidance. This allows the residents to participate in society and lead a life that is as normal as possible. The residents may, for example, have a job or engage in other regular paid or unpaid activities.

Their carers have professional training in this specific type of guidance. In many cases their training is more socially or psychologically-oriented, rather than focusing on strategies to cope with physical disabilities. This means that additional training may be necessary relating to equipment or techniques.

In care plans, the emphasis is on the options that are still open for the residents, rather than the things they cannot do. Step-by-step, they are guided towards a life that is as independent as possible and, if achievable, integrated in society. Nevertheless, this is not always possible and complications or special disablement may result in serious illness and even death at a young age for some residents. Today’s modern medical care allows some residents to live much longer than they would have 10 or 20 years ago. This means than even in special care, the average age of the residents is increasing. This trend leads to older, or even very old, residents facing the problems that come with age. Because of these developments, one will see residents in special care from all mobility categories.
AB

- Ambulatory, but may use a cane or similar for support
- Independent, can clean and dress him/herself
- Can tire quickly
- Stimulation of abilities is very important
For the past five years, Ab has lived with five other residents at a sheltered accommodation project in a medium-sized town. Generally speaking, Ab is a friendly, quiet man of 27, who values his freedom and modest possessions. He is mentally disabled. At times, however, he may become slightly aggressive. This mostly occurs when he thinks people are teasing him. On one such occasion he actually hit a group leader. Afterward he is always extremely sorry about such episodes.

Ab’s parents are still alive, but they are old and frail. They don’t visit often and Ab is not able to travel independently to see them.

He has a girlfriend called Elke. They enjoy listening to music, take walks together and go shopping. They live in separate houses, a few hundred metres apart, at the same project.

Ab and Elke would like to throw a party, as it is their first anniversary of ‘being together’. Elke would like to have a huge party and invite all their friends and family. Although Ab likes the idea, the more enthusiastic Elke becomes, the quieter Ab is.

It is now 10 a.m. Elke will be visiting this afternoon. She rang fifteen minutes ago to tell Ab she has more new ideas and plans. Ab is clearly unsettled by it all. He would prefer to sit quietly in his room and listen to some music. As a rule he goes to work at 11 a.m. to the garden centre up the road.

Ab is fully ADL-independent. However, he does tend to take the easiest option. He needs to be reminded to wash in the morning or put on clean clothes, or else it won’t be done. Showering is not his favourite activity and he feels once a week is more than enough. In most cases this involves getting wet for a few seconds and then quickly drying himself. He really hates it. According to Ab, he is afraid soap might get in his eyes, but everyone laughs at him when he says this. Ab should wash his hair twice a week as it looks unkempt and greasy. This subject has caused arguments in the past with Anne-Marie, his personal care assistant. They came to an agreement that he would wash his hair twice a week, but he has not done this for the past few weeks. Ab is afraid Anne-Marie will make an issue out of this. The other five residents get involved too. They know Ab has not kept to the agreement and they tease him about his “childish behaviour”. Ab becomes more and more tense.

When the unsuspecting Anne-Marie comes in to begin her shift at 10.30 a.m., Ab immediately confronts her. “Don’t think you’re the boss around here!” he shouts. “I won’t do it!” He starts to pace up and down restlessly and throws around a few plates that were left on the kitchen table after breakfast.
BARRY

- Uses walking frame or similar
- Can support him/herself to some degree
- Dependent on carer who is present in demanding situations
- Not physically demanding for carer
- Stimulation of remaining abilities (e.g. ambulation) is very important
BARRY

Barry, an eight-year-old boy, has been attending the Pinocchio day-care centre on a daily basis for a year. He lives with his parents and two sisters in a residential area that has lots of young children. The eldest of three children, he developed slower than other children his age, which was a cause of concern for his mother. When he was one year old, doctors diagnosed a rare muscular disease. Barry’s muscles will slowly deteriorate until he will eventually die of his illness.

Around two years ago Barry’s mother, Anna, noticed that walking was starting to become more of a problem for Barry. Since then, his condition has deteriorated. Barry is no longer able to attend a normal primary school, as this became too difficult for him. He really enjoys going to the day-care centre. Barry knows he is ill, but he doesn’t fully comprehend, or appears not to fully comprehend, the reality of his situation. However, he remains a cheerful boy who knows how to have fun.

Barry is now no longer able to walk distances of more than 2 metres. For this reason he always arrives in his wheelchair in the mornings. He is very proud of his brightly coloured wheelchair, which is called a ‘Squirrel’. In addition, Barry has a three-wheeled bike, which he can cycle around on. The day-care centre also has several of these trikes.

At the day-care centre, Barry spends a lot of time playing and he enjoys contact with the other children. Computers play a large part in the children’s play activities. He plays well when sitting in his electric Squirrel. He has one particular friend, Marcel, who also has a Squirrel. They play ballgames together seated in their wheelchairs.

Recently, Barry has become urine incontinent. This makes him very upset and he will not admit when he is wet. The group leaders have tried to help him cope with the new situation. He has now reached a stage where he will accept the use of incontinence pads. Changing these pads when Barry goes to the toilet is rather difficult for the care staff, as he is very small and cannot stand for long. Mary, the group leader, suggested he should get onto the changing table. There is a small ladder up to the table, but Barry, who weighs 32 kg, doesn’t like the climb.

Barry is now trying to change his own incontinence pads, but this is not always successful and when the pad doesn’t fit properly, it leaks. Consequently, Mary feels Barry should make the effort to climb onto the changing table, so that she can check the pad fits correctly.

The children go swimming three times a week in the day-care centre’s pool. Barry’s dressing and undressing routines at the sessions are becoming quite a problem. He doesn’t want any help, but it takes him so long to get ready that he holds up the rest of the group.

Barry has physiotherapy twice a week. This is aimed specifically at strengthening the muscles and maintaining his condition and stamina at an optimum level.
CHRISTA

- Sits in wheelchair
- Is able to partially bear weight on at least one leg
- Has some trunk stability on carer in most situations
- Physically demanding for carer
- Stimulation of remaining abilities is very important
Christa, a 52-year-old woman, is mentally and physically disabled, and has lived at a care home since her parents died three years ago. She enjoys living there, and has thrived since her arrival.

She has the mental age of a 10-year-old and suffers from a number of physical problems. Christa can’t walk and is unable to stand, although she does have limited standing ability using the stretching spasms in her legs. Her torso balance is good and she can sit independently, although this requires an effort. She has had a powered wheelchair for years and has become a very skilled user.

Since her youth she has been double incontinent. A year ago she needed to have a colostomy, which requires particular care.

Weighing over 100 kg, Christa is a large woman. The doctor has urged her to lose weight, not least because of her bowel problems. Dieting attempts have been made, but because Christa enjoys her food so much there has been no success. She can become very angry when others point out to her that she is overweight. Although she should not eat certain types of food, she tends to ignore this. This means she frequently has bowel problems and often needs to be changed. This also complicates care relating to her colostomy. Due to her weight and restricted movement, she also suffers from high blood pressure and occasionally has difficulty breathing.

Assisting with Christa’s daily care is, to put it bluntly, hard work. She can come to a semi-standing position with the support of an active lift, which is used as much as possible for transfers. The care routines for her colostomy and incontinence are also very taxing for the carers. This aspect has now been made slightly easier by using a height-adjustable shower chair with care function.

Christa sleeps in an electrically-operated, height-adjustable bed. In the morning at 11 a.m. it is time to go to occupational therapy, where she takes part in a number of activities. She is taken there in the care home’s mini-van, which is adapted for wheelchair users.

Today, Christa is having a day out. She has been looking forward to it, but didn’t sleep very well. After tossing and turning, she ended up at the bottom of the bed. When the group leader comes into the bedroom, Christa is angry and complains. She says she has a ‘thumping headache’ and wants to be left alone. It is not easy persuading her to get up. There is a lot to do – getting her out of bed, washing and changing – if she is to be ready to take the bus at 10 a.m.
DANIEL

- Sits in wheelchair
- No capacity to support him/herself
- Cannot stand unsupported and is unable to bear weight, even partially
- Dependent on carer in most situations
- Physically demanding for carer
- Stimulation of remaining abilities is very important
Daniel, a 15-year-old boy, has been both physically and mentally disabled since birth. He has the mental age of an 8-year-old. Daniel lives in a house with eleven other children of a similar age.

Communication with Daniel is very difficult. Outwardly, he shows hardly any emotion. There is little response and rarely a sign of pain, sadness or happiness. However, his parents and sister Brit are able to communicate with him quite well about everyday matters. His mother visits every other day.

Virtually comprehensive ADL support is required. Daniel is slowly deteriorating, especially physically, and can do less and less. In addition, he is developing a number of deformities caused by muscle spasms. Although operations have been performed, significant problems remain. The medication he has taken for years to counteract the problem has the disadvantage of making him quite drowsy. He cannot stand and must wear incontinence pads at all times.

Daniel, who weighs 44 kg, is unable to eat independently, as he chokes easily and there is a considerable risk this will cause pneumonia.

Apart from horse riding, Daniel also enjoys multi-sensory environments (Snoezelen) and responds remarkably well. Ceiling lifts are used for transfers, so he can be in the ball pond or on a special mattress. When he is around the horses or involved in multi-sensory activities, Daniel appears to relax his rigid posture and passive countenance. Attempts were made to take Daniel swimming, but he seemed to be afraid of the large expanse of water and became very tense.

The residential group’s home is very spacious. All rooms are on the same floor, there are no thresholds, and a ceiling lift can be used to help Daniel from his bedroom to the bathroom. The bathroom has a shower trolley. Daniel loves having a shower and the warmth seems to relax him. Helping with daily activities such as changing, washing, drying, dressing and undressing is very difficult because of Daniel’s muscle spasms. He is very sensitive regarding his spasms and it can cause real problems if the carer does not know the right way to approach and touch him.

Daniel has a specially adapted wheelchair with a seat orthosis modified for his deformities. The very heavy wheelchair is height-adjustable and electronically steered.

At night Daniel uses a bed orthosis, which has been made to measure. Getting Daniel to lie in the orthosis properly is often difficult. Daniel usually dislikes it, resists vehemently and can’t really understand what is going on. In the morning, getting Daniel out of the orthosis presents similar problems.
EMIL

- Passive
- Might be almost completely bedridden
- Often stiff, contracted joints
- Totally dependent
- Physically demanding for carer
- Stimulation and activation is not a primary goal
Emil, a 42-year-old man with Down’s syndrome, has lived in a group home since he was 18. At that time it became too difficult for his ageing parents to take care of him. As he was not able to live on his own, it was decided to place him in a group home. The home is located near the centre of a small town. Seven people live in the house and each of them has a private room. They share the use of the kitchen, bathroom and central living room.

Emil was born with a heart defect and has had operations relating to the problem on a few occasions. At the moment his heart is again causing him a lot of trouble. The doctor has stated that there is not much more that she can do for him. With some very strong medication, she hopes to keep him as comfortable as possible. She has warned the carers that they must prevent him from getting a serious infection, as he would have difficulties recovering or even die as a result.

Over the last few months it has become clear that his condition is deteriorating rapidly. Emil has noticed as well and has remarked that his “engine seems be out of petrol”. Besides his heart medication, he now also takes corticosteroids (prednison) to slow down his decline.

Although the team has been very attentive, last week Emil developed an airway infection. He had a very high fever and immediately received antibiotics. Nevertheless, he still has difficulty breathing. His lips and hands look slightly bluish, and his feet and legs are swollen. It seems that fluid retention has become a problem. The skin on his back and hips is becoming slightly red. Although he has been given a special mattress to prevent the development of pressure sores, it does not seem to be enough.

He has not been able to leave his bed for a week and feels rather lonely in his room. For a few days he seemed slightly confused and not very alert. He hardly moves and has to be helped to change position in bed, as it is not adjustable. As the situation seems to be worsening, his primary carer, Lilly, has ordered a wheelchair and a powered height-adjustable bed for him. She suggested taking Emil to the central living room and providing care for him there. This will give him a chance to retain contact with the other members of his group, and make it easier for the carers to tend to him. The downstairs bathroom is accessible for wheelchairs and a shower trolley, and there is more room downstairs for using a passive lift to get him out of bed.

At the moment his new bed is in the living room. He is a little disoriented and was slightly aggressive this morning when Lilly wanted to get him out of bed. She wanted to take him to the bathroom with a mobile lifter to give him a shower on the shower trolley. He did not seem to understand what was going on. However, once he was on the trolley, he seemed to enjoy the shower. Showering is also good for his skin, as he is becoming incontinent and Lilly has had problems cleaning him properly on the bed.

Due to his aggression, Lilly suggested lifting him manually tomorrow. She hopes this will be easier for him and less frightening, and says: "He will probably only live for another week or so. Why bother him with all this fuss". However, one of the other team members, Stella, disagrees and thinks he will soon get used to the mobile lifter. She also proposes to help Lilly this afternoon to ensure transfers with the mobile lifter can be performed in a relaxed way.
Introduction
The word 'baros' is derived from the Greek word for heavy or large. Bariatrics is the science of providing health care for this population. Bariatric residents are described in several literature sources by any one of the following definitions:

- Overweight by greater than 100-200 lb (45-90 kg)
- Body weight greater than 300 lb (137 kg)
- Body mass index (BMI) greater than 40 (World Health Organization)

Body Mass Index
The most common internationally accepted standard used to measure weight is the Body Mass Index. It is formulated by associating the weight and height of the person (weight in kilograms divided by the square of the height in metres (kg/m²)). People with a BMI greater than 25 are considered overweight, greater than 30 are obese, and greater than 40 are considered to be bariatric. See BMI table 1 for examples of bariatric residents based on average population heights.

<table>
<thead>
<tr>
<th>Weights (lb)</th>
<th>BMI for 1.60 m (5 ft., 4&quot;)</th>
<th>BMI for 1.75 m (5 ft., 10&quot;)</th>
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</thead>
<tbody>
<tr>
<td>68 kg (150 lbs)</td>
<td>27</td>
<td>22</td>
</tr>
<tr>
<td>91 kg (200 lbs)</td>
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<td>114 kg (250 lbs)</td>
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<tr>
<td>136 kg (300 lbs)</td>
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<td>182 kg (400 lbs)</td>
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<td>227 kg (500 lbs)</td>
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<td>273 kg (600 lbs)</td>
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<td>363 kg (800 lbs)</td>
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<td>119</td>
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<tr>
<td>454 kg (1000 lbs)</td>
<td>177</td>
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<tr>
<th>Normal weight</th>
<th>Overweight</th>
<th>Obese</th>
<th>Bariatric</th>
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</table>
Body shape
The bariatric resident is further defined by the distribution of their body weight as either:

• Pear shape (weight distributed unevenly with heavier lower body),
• Apple shape (weight distributed around the centre or torso of the body), or
• Proportional shape (weight distributed comparable to residents with an average weight)

Each shape has unique care problems associated with it. It is helpful to understand the body shapes when choosing the appropriate sling for a sling or ceiling lift, or determining the difficulties associated with ambulation.

Associated health problems and mobility
The health consequences evident for the bariatric person often lead to serious chronic illness, poor quality of life and premature death. As the bariatric person ages they are less able to ambulate due to joint stresses. Ambulation assistance is often necessary and provided through mechanical devices such as mobile walking aids, wheelchairs, canes, motorised carts etc. The death rate is 10-15 years earlier for the bariatric population. They experience health problems that may include, but are not limited to; cardiac disease, hypertension, respiratory disease, diabetes, skin breakdown, osteoarthritis, stress incontinence, hyperlipidemia, depression, lack of self-esteem, certain types of cancers, and gall bladder disease. These individuals often have difficulty with personal care and hygiene due to restrictions and limitations in body movement. The ability to provide care such as toileting and hygiene is impeded by the large skin folds and large body mass. Access to, and inspection of, the body areas requiring attention is extremely difficult. The perineum, breast folds, abdominal folds and legs are the most common sites to find skin problems in the form of excoriation, rashes or ulcers. Congestion in the skin and body can cause fluid retention, swelling in tissues and leakage of fluid through the skin. Bariatric residents often need assistance in ambulating, transferring and repositioning themselves in bed. This is not only due to their size, but the common associated heart and respiratory conditions. Often they cannot tolerate lying flat on their backs and need the head of the bed to be elevated. Almost all individuals suffer from obstructive sleep apnea and many will need assistive breathing equipment while sleeping.

Compassionate care
The bariatric resident has the right to be treated with the same comfort, dignity, respect, and privacy as other residents. They have described situations in which they felt disrespected by the insensitive manner in which carers interacted with them. Carers need to work on these sensitivity issues and acknowledge the resident as a unique individual by seeing past the weight.
ADISA

- Ambulatory, but may use a cane or similar for support
- Independent, can clean and dress him/herself
- Can tire quickly
- Stimulation of abilities is very important
Adisa, a 35-year-old woman, was admitted a year ago for gastric bypass surgery, necessitated by her extreme overweight (BMI > 40). Before hospitalisation, she had already lost 40 kg. After surgery she lost another 55 kg. Although Adisa feels a lot better and is still losing weight, she is still overweight (BMI = 39).

Due to the weight reduction, her skin folds have gradually become too large. Last week she underwent plastic surgery to reduce the excess of skin and minimise the skin folds. The operation was a success, but the skin is still very delicate, especially in sensitive places such as below her breasts and on her abdomen, where there is still irritation. The stitches have been removed and she has permission to take a careful shower from now on. Painkillers are still necessary to cope with the pain. Nevertheless, she is in a good mood and happy that the last part of her treatment is over. She wants to get home and back to normal as soon as possible.

This morning she complained of dizziness. However, her blood pressure and other physical test results appear to be normal. The problem perhaps stems from a combination of late side effects of the narcotic drugs used during surgery, her extreme weight loss over the past months and side effects of the painkillers she is currently taking. She is also a mild diabetic, but her glucose level was OK.

Adisa does not use a walking aid or wheelchair. Betty, the carer looking after Adisa, is asked to help her take a shower, check her skin condition and provide good skin care. Because she is still in pain, Adisa also needs help to get undressed. Betty has wheeled her to the bathing area for the shower in a special mobile shower chair. After Adisa stands up, Betty notices she is slightly unsteady and looks a bit pale. Betty is prepared to step in to ensure safety and has checked to see if anything needs to be moved out of the way in the event that something happens.
BOB

- Uses walking frame or similar
- Can support him/herself to some degree
- Dependent on carer who is present in demanding situations
- Physically demanding for carer
- Stimulation of remaining abilities (e.g. ambulation) is very important
Bob, a 27-year-old man, works in the ticket office of a football stadium. He has been overweight since puberty. Over the past 15 years he has steadily put on weight. Occasionally he has been on a diet, only to return to his previous weight after a short while and then increase in weight again. At the moment he weighs over 300 kg.

Being overweight has severely affected his daily life. Bob lives on his own in a house near the centre of a small town and has a very limited social network. He tends to rely on his mother to look after him and checks with her first before making any decisions. She is an attentive lady of 55, who is obviously worried about her youngest son. His mother visits him daily, cleans the house and washes his clothes. For the past six months he has been off work quite frequently and this worries him. He could not find a way to address his problems, even though his family urged him to seek help.

The situation worsened two weeks ago when he was in severe respiratory distress and his hands and feet started to swell considerably. He was also very anxious. It was unclear if there was a somatic reason for his breathing problems or if the stress of the whole situation became too much for him. With the support of his family, he consulted his doctor, who concluded there was an evident connection with his overweight. There did not appear to be a medical reason for his obesity, although his cholesterol levels were far too high. In addition, his basic physical condition is very poor and far below average for his age. He can barely stand up and walk, and needs considerable support from a walking frame to go to the toilet.

In consultation with Bob, it was decided two weeks ago that it might be a good idea to put him on a special behavioural management programme to reduce weight and develop healthy eating routines. He will also need to considerably improve his physical condition. Medication has been prescribed to relieve his breathing problems and reduce the oedema. However, firstly he needs to take a full set of physical and psychological tests to rule out any additional medical problems, check his vital functions and assess his psychological state.

He was admitted this afternoon and seems very nervous and anxious. In particular, he is afraid of anything that relates to medicine or doctors. Things like needles make him extremely nervous and he becomes slightly aggressive and combative if anyone tries to carry out tests on him, such as taking a blood sample.

Perhaps as a result of this, his respiratory distress seems to be starting up again. He is transported into the radiology department sitting in a special bariatric wheelchair. When he arrives there, he suddenly needs to urinate urgently and stands up to walk to the bathroom. The nursing aide who accompanies him notices that there is only a porcelain toilet, which is usually not suitable for patients weighing over 150 kg. There is no special bariatric toilet. Bob then begins to panic a little.
CALVIN

- Sits in wheelchair
- Is able to partially bear weight on at least one leg
- Has some trunk stability
- Dependent on carer in most situations
- Very physically demanding for carer
- Stimulation of remaining abilities is very important
Calvin, a 35-year-old man, is severely overweight and has been in the bariatric unit of a large urban hospital for one week. He was admitted because of kidney problems and needs an operation urgently. Nevertheless, due to his present condition it was decided that surgery would be more successful if it was postponed until his medical problems are more stable. More tests also need to be done.

Most parts of his body are affected by severe oedema. His heart is barely coping and shows symptoms of cardiac failure. He was put on medication to support his renal and cardiac functions and this seems to have helped. Another factor is that he has been a diabetic since early childhood. The combination of medication therefore needs to be balanced and effective before successful surgery can be performed.

This morning he complains of pain “everywhere”. At home he had created some sort of customised bed, but at the moment he is on a special bariatric bed and mattress. Apparently, he finds this less comfortable. He uses a special abdominal binder to support his body when sitting, but this is not used in bed.

His exact weight is not yet known, but it is estimated to be over 300 kg. His body is more or less pear-shaped. On admittance, his hygienic condition was poor. Apparently he could not take proper care of himself anymore. His skin shows signs of infection, especially in the perineal area. He appears to have been double incontinent, although this is probably a result of not being able to reach the toilet in time.

Before any further activities are undertaken, it is decided to give him a full body wash on the bed. Washing him is a very strenuous activity. A special washing agent is used rather than soap and water. The bed is not put in a Trendelenburg position due to his cardiac problems.

Firstly, the abdominal binder is used to get good access to the perineal area and he is given a proper wash. After this procedure, which Calvin finds very tiring, he is dressed in a special gown. A passive lift is used for transfers. The lift is specifically designed for bariatric patients and a special bariatric sling provides support. This sling is left under him, as it is too strenuous to remove it at this point and can be taken away later.

This afternoon the surgeon will visit him and the first steps of the protocol for bariatric surgery have been taken. Special precautions need to be taken to ensure that transfers and the operating table are safe for a bariatric patient like Calvin.
DIANA

- Sits in wheelchair
- No capacity to support him/herself
- Cannot stand unsupported and unable to bear weight, even partially
- Dependent on carer in most situations
- Extremely physically demanding for carer
- Stimulation of remaining abilities is very important
Diana, a very obese 37-year-old woman, weighs 254 kg. She was admitted this morning after experiencing breathing difficulties and an irregular heart rhythm. The hospital has arranged a special bariatric bed and wheelchair for her. Taking Diana to hospital posed difficult problems for the paramedics at every stage: getting her out of her home, aboard the ambulance and into the hospital. Special equipment had to be used, assistance was called in from the fire department and in total six assistants were involved. Diana was very embarrassed by all this attention and did not want to go to the hospital. However, her medical condition was too severe to let her stay at home.

She has been living on her own since her husband and children left her five years ago. Since then she has suffered from depression and started to neglect herself. She gave up cooking and ate more and more takeaway junk food, which she had delivered to her home. Although she has been overweight all her life, her weight increased considerably over the last five years. Her obesity also started to cause her problems at work. Even simple activities such as walking around and talking to customers became too difficult and she did not reach her sales targets. Two months ago she was fired.

After this shock she went home, isolated herself, and has rarely left the house since then. Her ex-husband checked on her every five days or so. He brought her fresh and healthy food and urged her to see a doctor. Although she accepted the food, she did not seek medical help.

This morning she was found on the floor of her living room. She could not stand up anymore. It was also noticed that she was very dirty, as she had not washed herself for a few days or been to the toilet for a day or so. Her medication was untouched.

Now Diana is back on her medication, has a fluid IV and taken a drink of water, so she feels a little better and is able to communicate fairly well again. She is sitting up in bed and has less trouble breathing. The doctor has given her a general examination and ordered some further tests for her heart and blood. These results will be available later in the day.

In the meantime, Diana needs to be washed. She has developed skin problems. There is red irritation in some of her deeper skin folds and the first signs of pressure sores are appearing.

At the moment, the nursing team is discussing the best way to wash her and provide skin care. They will also have to change her bed linen, as it is soiled. One suggestion is that she should be transferred from the bed to a special wheelchair, but some of the nurses argue that it is better to carry out the care routines on the bed.

This afternoon she will be taken to have an X-ray. She will then have to be transferred to an examination table. Because of her weight, special precautions will need to be taken to ensure safety. The radiology department has already been contacted to check if the table will hold Diana’s weight.
ELLA

- Passive
- Might be almost completely bedridden
- Often stiff, contracted joints
- Totally dependent
- Extremely physically demanding for carer
- Stimulation and activation is not a primary goal
Ella, a 62-year-old woman, was admitted to the nursing home from the hospital, where she had stayed for two weeks. She has often been in hospital over the past two years. Ella is a bariatric patient who has developed serious medical problems in addition, or perhaps as a result of, her extreme overweight. The reason for her excessive weight is not known. Ella herself stated that her whole family has always been “the strong kind”. She does not seem bothered by her weight and is proud to be such a ‘strong woman’ herself. Despite her present very serious condition, she wants to look good and takes proper care of herself. However, last week it became evident that her condition is rapidly declining. In spite of all efforts, her heart problems mean that she will probably not survive another month. Her heart is carefully monitored and her medication is adapted accordingly. However, nothing seems to help and her condition is deteriorating.

Special wedge-shaped foam pillows are used to give her good bodily support and change her position in bed. Using these pillows reduces pressure on sensitive skin areas. Even so, her skin shows the reddish signs of pressure sores and some areas are extremely painful. Due to this, she may switch to a special alternating pressure mattress soon.

Ella can sense that she is approaching the end of her life, but emotionally she is not prepared and she becomes easily agitated. One moment she can be aggressive or emotional and the next she is very sad and starts crying. Behaviour such as shouting, crying and even hitting the carer is not uncommon and these episodes have increased in frequency and duration.

Her nursing care plan contains a thorough strategy to provide good, comfortable, palliative care. Medical interventions are to be limited as much as possible, unless absolutely necessary. She now wears the highest level of incontinence pads.

The standard bariatric bed she was using has proved to be slightly too wide for the nurses to provide optimum care, so a narrower bed is brought in. Transferring her to this bed requires a horizontal transfer. Her bed linen is changed at the same time. A special passive bariatric lifter is used for the transfer. The chosen method is to remove the bed from under Ella and move the new bed into place, rather than move the lifter with Ella on board. Before Ella is lowered again, the opportunity is taken to provide special skin care for areas of her body that are difficult to reach. Despite the care taken to handle her gently, she is very combative.

This morning Ella hit the nurse who was taking care of her. In spite of her poor health, she can still be very strong during these brief episodes. Ten minutes later she is very sorry about what she has done and is crying in bed.
ADDENDUM

Clinical relevance
Clinicians recognise the fact that comprehensive functional assessment of elderly subjects is central to maximising their physical and cognitive functioning and their quality of life (Hawes et al., 1997). Studies empirically support this. Introducing the RAI (Resident Assessment Instrument) resulted in significantly better resident outcomes in four crucial areas (ADL function, cognitive function, urinary continence and social engagement) (Phillips et al., 1996). There was also an increase in the assessment of potential for improved functioning in residents (Hawes et al., 1997). The development of the ARJO Mobility Gallery is partly based on the RAI.

The background of the Mobility Gallery
The Mobility Gallery is based on the Resident Gallery, which is a classification of five residents. They all have their special, personal characteristics and a different personal history and background. Nevertheless, there is a clear classification in the degree of their functional mobility. The choice was made to look for functional mobility and not for the underlying specific diseases and their medical diagnoses. This means that the consequences of diseases, their impact on functioning in daily activities, are central to the classification system. After all, it is the consequences of the disease (the resulting functional mobility), not the disease itself, that determine dependency on care, and to a large extent quality of life.

For example: people with a similar medical condition (e.g. a total hip replacement or a previous heart attack) may demonstrate a very different pattern and capacity for performing daily activities. Some of them are no less active than before, while others may seem severely impaired. The way they function in daily life may be very different: some may be very active, while others may be quite passive. Besides their medical condition, all sorts of factors influence their actual level of functioning during daily activities. The result, their functional capacity, will determine what they need and what they will not need, and also how we can provide optimum care. The degree of damage to their heart or the prognosis of their hip replacement is less significant in this context. That is why it is so crucial not only be aware of the medical side, but also to make a detailed assessment of the functional capacity of residents.

Functional links to important systems
With this fundamental emphasis on functional consequences of diseases, there is a link to existing classification and assessment systems, especially the international systems, ICIDH and RAI.

The ICIDH (International Classification of Impairments, Disabilities and Handicaps), developed by the WHO (World Health Organization), is often used in rehabilitation and most physiotherapists are familiar with it.

The RAI (Resident Assessment Instrument) was developed in the USA, but in the past five years it has rapidly become established elsewhere (Australia, a large number of European countries and Japan), allowing international comparisons of care.

Originally developed in the USA for the purpose of improving the quality of care, it was also agreed that all Medicare and Medicaid facilities had to use...
it in order to apply for funding. The assumption was that a better assessment of a resident will improve the comprehensiveness and appropriateness of the care plan and thus enhance the quality of care provided. The RAI system encourages this by providing both the assessments – the Minimum Data Set (RAI-MDS) – and the guidelines for care plans in the Resident Assessment Protocols (RAPs).

In the assessment part of the RAI (the MDS) some important problem areas can be pinpointed. They will more or less automatically trigger one or more of the RAPs or Resident Assessment Protocols. The protocols outline important guidelines for specific problem areas such as incontinence or skin care.

Evaluation of facilities implementing the RAI shows that it did actually improve the quality of care (Phillips et al., 1996).

Neither the ARJO Mobility Gallery nor the Resident Gallery are similar to, or replace, the RAI or ICIDH standards, but they are linked to them in terms of functional mobility. This enables rapid understanding, combined use of data on care plans, a common language and also links the Mobility Gallery to other relevant care topics related to mobility (incontinence, skin problems, pressure sores etc.).

**Functional mobility and the Mobility Gallery**

Mobility is a basic value in human life. It is fundamental to human existence. If the ability to move is reduced, the consequences are far-reaching. There are psychological and social consequences. People will become isolated, often experience a loss of self-esteem and dignity, and may even become very depressed. On the physical side, reduced mobility leads to a rapid deterioration in muscle strength, physical condition and capacity in general. If this situation continues, problems such as immobile joints, pressure sores, osteoporosis and pneumonia often occur, see pages 4-5.

A loss of mobility can occur very quickly (for example due to a fracture after a fall), but more often it is gradual and slow (i.e. in the elderly). In the latter case it often goes unnoticed, because residents tend to adapt their lifestyles and daily habits accordingly. They go out less, they drink less so they do not need to go to the toilet so often, or it simply takes them longer to get dressed in the morning.

The outside world (including carers) may not notice this development in time. When they do notice, it can be too late, as some of the physical changes are very difficult to reverse in the elderly. Being in time, making simple but proper assessments and offering solutions may prevent the occurrence and increase of unnecessary dependency.

Research shows that elderly people will change their daily habits extensively before they actually ask for help. Proper aids and equipment for these people may postpone or eliminate this change in habits and may allow them to maintain important aspects of their life such as toileting habits and social interaction.

In this case, the aim is to prevent unnecessary dependency. The first resident in the gallery (Albert) is a typical example of this often forgotten, but highly relevant, category of residents.

Providing Albert with adequate aids, in time and tailored to his needs, may prevent him from declining unnecessarily fast. However, there are other residents, some of them already receiving assistance during daily activities. For them, stimulating, maintaining, or even increasing mobility may be just as important as it is for residents like Albert. The whole group can be divided into the five classes of the Mobility Gallery. Their mobility level is summarised in the Mobility Class table, see page 8.

By using their functional capacity, residents will gain a positive influence on health and wellbeing: ‘use it or lose it’. Even minor movements and activities can have such a positive influence, it may
even be a precondition for health. For example: coming to a standing position a few times a day can prevent loss of muscle and bone tissue, and help maintain coordination (see pages 4-5).

On the other hand, there are also residents for whom it is no longer relevant or desirable to stimulate mobility or activity. It is, for example, important to provide people in the last phase of their life with all the care we can offer them and to prevent complications from immobility such as pressure sores. Stimulating their mobility may become impossible and without any chance of success. For these residents a correct assessment may also point to the use of certain types of equipment to make their life easier and enable carers to provide optimum care without compromising their own health. Emma is an example of a resident entering that final stage. Between Albert and Emma there are three other residents, all with different desires and degrees of functional mobility. You can recognise them by their alphabetical names: Albert, Barbara, Carl, Doris and Emma, which are also used in the mobility scheme.

**Nurses, architects and planners: deciding on the future of residents**

The Mobility Gallery not only assists care planning and guides quality improvement processes, but also facilitates and provides empirical support for decision-makers at the facility level, for example when building and redesigning nursing homes and homes for the elderly. As a basis for this, ARJO developed the Guidebook for Architects and Planners. To make communication between carers and architects easier, and to create a common understanding of requirements, the Mobility Gallery takes this Guidebook one step further. The Mobility Gallery provides insight on both the practical needs and qualitative desires of present and future residents.

Combining the Guidebook for Architects and Planners and the Mobility Gallery creates a good partnership and will create a common language with the purpose of designing an environment ‘with people in mind’.
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