COMMUNITY THERAPY SERVICES INC.
201-1555 St. James Street, Winnipeg, MB R3H 1B5
Phone: 1-204-949-0533 FAX: 1-204-942-1428

Guidelines for the Assessment of Mobility and Transfers in the Home Care Program

Purpose of Document

a. To outline the procedures used by Community Therapy Services Inc. to determine the mobility, mechanical lift and transfer method(s) most suited to referred clients.
b. To list some of the main components of assessment by occupational and physical therapists.
c. To define terminology relevant to various types of mobility, e.g. repositioning & turning in bed, walking/ wheelchair; mechanical lifts; and transfer method(s).
d. To describe some of the special considerations inherent in the assessment and implementation of specific mobility, mechanical lifts and transfer method(s).
e. To improve the consistency and safety of the mobility, mechanical lift and transfer method(s) used in the Home Care Program.

GENERAL PROCEDURES

Assessment

In order to determine the most appropriate mobility, mechanical lift or transfer method(s), the client's physical, mental and environmental status must be assessed as appropriate.

a. Physical Status:

- Joint range of motion
- Muscle strength
- Presence of contractures
- Neurological impairment
- Muscle tone
- Sitting and standing balance
- Consistent weight-bearing potential
- Pain
- Skin integrity
- Tolerance
- Body weight

b. Mental Status of the Client:

- Cognitive function
- Behavior
- Insight and judgment
- Cooperation

c. Environmental Factors:

- Home layout
- Accessibility
- Details re: stairs, furniture, wheelchair, flooring, doorways, etc.

d. Existing Mobility and Transfer Methods:

Observation of current methods is likely to be included in the assessment. (In order to facilitate this observation process, the therapist and/or resource coordinator may request that some or all staff and other caregivers are present during the assessment.)

- **When determining the appropriate transfer method, the type of transfer must be safe for ALL STAFF assisting with the procedure and AT ALL TIMES of day.**
- An interim care plan may be needed until assessment results can be implemented e.g. new equipment, two-person assist.
- CTS will prioritize referrals that have indicated the need for safe patient handling to ensure patient and/or staff safety. CTS referrals will be also prioritized based on the urgency of client needs.

Recommendations

Once the assessment has been completed, recommendations are made regarding:

- The most appropriate mobility, mechanical lift or transfer method(s) for the referred client, including specific details that may be unique to the situation.
- Level of assistance required by the client.
- Number of caregivers required.
- Use of equipment.
- Special precautions.
- Review period, if required.

Reporting

The therapist will clearly outline the details of the recommendation(s), including all relevant data, as soon as possible following the assessment. When a situation involves significant risk to the client or the caregivers, the Home Care Case Coordinator will be

contacted by phone the day of the assessment and/or the written report will be faxed by the therapist that day. The Home Care Case Coordinator will ensure that the information from the therapy report is conveyed to appropriate staff members.

Client Review

Clients who are using a Sit–Stand Lift will be placed on CTS Sit-Stand Lift Review. To ensure continued safety, use of this lift will be reviewed every 4 months (or sooner if deemed necessary).

The review period for other mobility, mechanical lifts and transfers will be on-going until the situation is determined to be stable. The client is then discharged from CTS and can be re-referred by the Home Care Case Coordinator when issues arise.

DEFINITIONS OF RELEVANT TERMINOLOGY

The definitions and descriptions given in this section serve as guidelines for therapists when assessing mobility, mechanical lift and transfer method(s). Consistency in the use of these guidelines among all home care staff will be helpful in improving communication and client care.

Levels of assistance:

Independent: The client is able to safely perform the transfer with or without equipment, and without the need for physical or verbal assistance from the caregiver.

Supervision: The client is able to perform the transfer without any physical assistance from the caregiver. Verbal coaching or cueing and/or equipment set up may be required to maintain safety.
In the Home Care program, a mobility task that requires supervision e.g. supervised walking, mobility or tub bath with no hands on assistance from staff can be provided by a Home Support Worker.

Standby assist: The client may require verbal coaching or cueing and/or equipment set up. The client may require minor hands-on physical assistance due to anticipated changes in physical or cognitive status. If the client requires or may require hands on assistance from staff, a Home Care Attendant will be assigned.

Minimal Assist: The client consistently requires minor physical assistance and/or equipment such as a gait/transfer belt. Verbal coaching or cueing and/or equipment set up may be required to maintain safety. Staff must not lift more than 35 lbs (16 kg) of a client's weight when providing physical assistance during any transfer, repositioning task or other aspect of patient care. The client requires minor physical exertion from staff when being repositioned, rising to stand, ambulating, or lowering to sit. The client

is able to reliably and consistently fully bear weight when standing or to consistently use arms to transfer e.g. a sliding board transfer.

Moderate Assist: The client requires more than minor physical assistance and generally incorporates the use of client handling equipment with a minimum of 1-2 healthcare workers. Staff must not lift more than 35 lbs (16 kg) of a client's weight when providing physical assistance during any transfer, repositioning task or other aspect of patient care. The client is partially dependent for physical support for trunk or legs when being repositioned, or during a transfer or ambulation.

Maximum Assist: The client requires full physical assistance for repositioning, standing, turning, transferring and/or mobility. The client may have difficulty with key factors such as following directions, weight bearing, strength/exertion and/or demonstrates uncooperative or unpredictable behavior. All repositioning and transfer tasks should only be performed with the use of equipment

Mechanical Lift Transfer: Mobility, transfer and repositioning tasks that are assessed by a therapist as requiring the use of a mechanical device and one or two persons to ensure client, caregiver and staff safety.

Two (2)-person assist: Mobility, transfer and/or repositioning tasks that are assessed by a therapist as requiring two people to work together to complete the task to ensure client, caregiver and staff safety. Two (2)-person assists are considered over-protocol; require Home Care Team Manager (TM) approval and all require client specific training.

Ambulation/walking aids: Walking aids may include a cane, quad-cane, axillary crutches, elbow crutches, standard walker, walker with wheels and skis or a walker with four (4) wheels. A gutter device can be added to a wheeled walker to assist a client who is unable to bear weight on one or both wrists. Walking aids are used for balance and/or weight relief. The client should not pull up on a walking aid; he/she should take hold of the aid after standing up.

Bariatric Client: Someone with a body mass index (BMI) greater than 40 or a weight greater than 159 kg (350 lbs). Planning and identifying potential barriers as well as making provisions for the special needs that may be associated with the visits will assist in maintaining a safe and secure environment for the client and the caregiver and staff.

Best Practice Manual for Direct Service Staff (DSS): Manual that contains the safe work procedures for DSS tasks including mobility and transfers. The Nursing Procedure Manual for Home Care nurses contains these procedures also.

Client handling and movement: Includes assistance provided to clients by staff during repositioning, turning, transferring, transporting, ambulating or when using a mechanical lift.

Community Therapy Services [CTS]: A non-profit agency with which WRHA Home Care has a Service Purchase Agreement to provide occupational therapy and physiotherapy services for Home Care clients residing in the community.

Delegated Task Program: Centralized specialty program developed for the purpose of facilitating and coordinating appropriate, effective and safe delegation of tasks to care providers.

Client Specific Training: Specific training surrounding an identified task that, because of client circumstances, requires training of each care provider in the client situation, and where the training for the task is not transferable to another client.

Equipment Specific Training: Specific training surrounding an identified piece of equipment required when a care provider identifies the need for training based on unfamiliarity with a piece of equipment. This is not a delegated or client specific task and there are no Delegated Task Codes attached to this training.

Mechanical lift: Lift equipment that uses a sling to transfer and/or reposition clients. Includes electric Hoyer® lift, portable power patient lift, sit-stand lift or an overhead lift system i.e. pressure-fitted, free-standing or mounted track system (ceiling or wall mounted). See *Mechanical Lifts-Guidelines* for further details of use.

Sliders (friction reducing devices): Special fabric sheets or tubes used by staff to assist a client with repositioning in bed, chair or wheelchair. See *Sliders - Guidelines* for more details.

Transfer belt: A belt worn by the client that staff hold onto during transfer and ambulation to provide minimal assist for weight bearing clients. See *Transfer belt – Guidelines* for more details.

Weight bearing: for the purposes of mobility and transfers, "weight-bearing" is the client's ability to reliably and consistently:

- bear body weight through his/her upper and/or lower limbs in order to assist from lying to sitting and sitting to standing;
- support body weight fully or partially through his/her lower limbs when in an upright position;
- maintain bearing body weight through his/her upper and/or lower limbs through the stepping/turning portion of the transfer.

One (1) Person Minimum Assist Transfer from the Side:

- The term pivot transfer requires clarification as used in Home Care. It is acceptable for a client to pivot if the client is stable and able to weight bear without moving quickly or requiring more than minimum assist. Staff should not pivot – staff should step around to avoid twisting or moving quickly.

- If staff is providing hands on assistance, a transfer belt is required unless the client's medical condition poses a contraindication. Staff must not lift more than 35 lbs (16kg). Transfer belts are available through Home Care if staff is assisting.
- The client is able to assist from lying to sitting and sitting to standing with physical assistance provided by one caregiver.
- He/she is then able to maintain balance and full weight bearing when standing and throughout the stepping / turning portion of the transfer.
- For the purposes of this transfer the ability to turn is defined as being able to take small steps in a semi-circular pattern reliably and consistently once in a standing position.
- Staff should assist from a position beside the client, wherever possible: staff's hand close to client holds large vertical loop of transfer belt and staff's other hand away from client on client's shoulder to assist client to lean forward.
- Staff should step around with the client as the client moves from one seat to another to avoid twisting.
- The assistant will be in a wide-based stance for transfer of weight. In either case, staff is assisting the client to keep nose over toes so client can use own muscle power to stand and to move pelvis forward, putting weight on feet, to trigger a standing reaction.
- In situations where the client requires something to hold onto/pull up on in order to assist with the transfer, transfer equipment is required. Staff is NOT to allow clients to hold his/her hands or place their hands/arms around staff's neck/shoulders.
- Staff should assist the client to transfer to their stronger side. If the environment prohibits the client from transferring to stronger side or the client is unable to safely step / turn in a semi-circular pattern, transfer equipment would be recommended for use. **Examples include - transfer disc, Sam Hall Turner, E-Z Turner or a STEDY**. This equipment is not available through the Home Care Program and may require equipment or client specific training.

Two (2) Person Minimal Assist Transfer from the Side

- WRHA Home Care Direct Service Protocols indicate that a one- (1) person/staff assist to help clients with mobility, transfers and/or repositioning tasks is the standard in the Home Care Program.
- Two (2) person assists are considered over-protocol, require Team Manager approval and all require client specific training for the DSS through the Delegated Task Program.
- A two-person assist may be provided by one (1) Home Care staff with a client's family member or other caregiver/alternate serving as the second person. Client specific training for the Home Care staff is also required in these situations. When a family/caregiver is used as the second assist, their capability and availability must be assessed by the therapist to ensure safety of this transfer. Training for each family/caregiver is generally provided by CTS or the hospital based Occupational or Physical Therapist.
- Factors to consider when determining requirement for two- (2) person assist include, but are not limited to:

- Assist required exceeds 35 lbs (16 kg) of force exerted by staff, and equipment alone does not eliminate/reduce staff assist to this level;
- Assist by one- (1) staff only would compromise client, caregiver and/or staff safety;
- Staff's ability to operate or move equipment and safely provide hands on assist to the client at the same time;
- Home environment (flooring, space, room size, bed height);
- Client's weight, size, fluctuating pain, fatigue and strength, muscle tone (hypo/hypertonic);
- Client behavior and cognition (ability to participate, cooperate and/or follow directions, comfort level, fear, anxiety).
- Maintaining client, caregiver and staff safety, through evaluation of the above criteria must be considered during therapist's assessment to determine if the client situation requires two (2) Home Care staff or an alternate caregiver as the second person.

- Once client is identified as a two-person assist transfer they may not be done with one-person assist unless reassessment indicates.

Sliding Transfers – Independent, Supervised or Minimal Assistance with or without equipment

- The client must have adequate balance and be able to weight-bear through upper body and be able to direct staff in order to move across from one surface to another, with or without a sliding board.
- The client will be assessed by OT or PT to ensure safety.
- If minimal assistance is required staff may assist with set up or by using a transfer belt or slider to guide the client (unless contraindicated by a physical/medical condition). Staff must not lift more than 35 lbs. (16kg.).

Ambulation

Independent with or without equipment

- The client can walk alone with or without a walking aid, e.g. cane, quad-cane, axillary crutches, elbow crutches, standard walker, walker with wheels and skis or walker with four (4) wheels. There is a gutter device that can be added to a wheeled walker to assist a client who is unable to bear weight on one or both wrists, e.g. fractured wrist. Walking aids are used for balance and/or weight relief.
- The therapist assesses the need for a walking aid and prescribes the type, height and how to use safely. The therapist prescribes how much assistance is required, e.g. none, one or two, and where they need to stand.

Supervised With or Without a Walking Aid

- Client may require a reminder to ensure that chair is steady or that wheel locks are applied before standing and sitting. To make standing up easier and safer, client

may require a reminder to move hips forward in the chair, feet under knees, nose over toes and hands on armrests of chair or on own knees.

One Minimum Assist & Walking Aid

- One staff may be required to assist the client to move from sitting to standing, to provide tactile and/or verbal prompting to weight bear in standing and/or to assist to shift weight and step.
- The therapist who assesses the client will provide direction to indicate if it is safe to assist the client to walk and if so where staff is positioned i.e. on the client's weaker side or stronger side. This information should be included on the CTS report.
- If the task is to assist a client to walk as exercise Client requires assistance of one person to stand and to walk. Use of a walking aid is recommended. A transfer belt is required (unless contraindicated by a physical/medical condition). Staff must not lift more than 35 lbs (16kg).
- Staff walking with a client will have one hand on the closest vertical loop (coffee cup grip) on the transfer belt at client's side; other hand on client's hand on walking aid; and will walk sideways. If staff wishes to walk forward, they will stand beside and slightly behind client with one hand on the closest vertical loop (coffee cup grip) on the transfer belt at client's back and other hand is ready to assist.
- There are two schools of thought on where staff needs to stand when walking with a client – on client's stronger or weaker side. If staff walk on the weaker side, when the client needs help, staff push the client away from his/her self encouraging weight bearing on stronger side and balance; here, staff block a fall to the weaker side but if client over-balances, client may fall away from staff. If staff walks on the stronger side, when the client needs help, staff would pull the client towards his/her self encouraging weight bearing on stronger side and balance; here, staff is in position to prevent over-balancing. Therapist will recommend the safest method to use for a specific client.

Two Minimum Assist & Walking Aid

- Client requires two -person assistance to stand and to walk. Use of a walking aid is recommended. A transfer belt is required (unless contraindicated by a physical/medical condition). Staff must not lift more than 35 lbs (16kg).
- *Refer to description above* – when two people are assisting, they stand on either side of the client. Therapist will prescribe: a) Two people with transfer belt assists client to stand, gives client walking aid and walks with client [client is able to walk forward, turn and back up]; or b) Two people with transfer belt assists client to stand, gives walking aid and one person walks with client while second person follows behind with the chair [client is able to walk forward only – if client tries to turn or back up his/her knees buckle]. Under NO circumstance is the chair to be dragged along.
- Staff should not assist a client to ambulate if the required equipment is not available, if the client is unable or unwilling to ambulate, if the client has had an injury or a fall since the last visit, if the client's level of cooperation or physical/mobility status has changed and there is an increased likelihood that the person may fall.

Stairs

- **Staff will assist a client on stairs only if a therapist has assessed the client and the home and determined this is a safe activity.**
- If client requires assistance, a transfer belt is required (unless contraindicated by a physical/medical condition). Staff must not lift more than 35 lbs (16kg).
- The person assisting stands to the side away from the railing. Where there are 2 railings close together or the stairs are too narrow for a cane, a client and a person, the person assisting stands on the step below the client. If the client is going up the stairs, the person assisting will be behind the client; if the client is going down the stairs, the person will be in front of client. In the event of an incident on the stairs, staff is directed to lean into client, resting client against railing and down onto stairs, thereby preventing he/she from falling forward or backward down the stairs
- Generally speaking, when a client goes UP stairs, he/she leads with their stronger foot/leg; and when going DOWN stairs, the client leads with the weaker leg. Stairs are safer if they have railings on <u>both</u> sides. Railings can be used to lean on to take some weight off a leg and to assist with balance. Client needs to be able to stand on one foot with or without an aid (walking aid or railing). If a cane is being used, the walking aid moves with the weaker leg.
- Client going up stairs:
    - distributes weight between weaker leg, hand on railing and hand on cane,
    - steps up with stronger leg,
    - moves hand on railing and hand on cane up & forward,
    - moves weaker leg up onto step, and
    - repeat sequence.
- Client going down the stairs:
    - shifts weight to stronger leg,
    - moves hand on railing and hand with cane down,
    - moves weaker leg down to lower step,
    - shifts weight onto hands and weaker leg,
    - moves stronger leg down to same step; repeat sequence
- Extreme care should be taken when considering assisting a person to mobilize on stairs.
- Stairs that have slippery or narrow treads, are too steep or have no railings are not safe for a client with mobility problems.
- Stairs should have railings, and preferably on both sides.
- Staff will not assist a client on outside steps if the steps are snow or ice covered.
- If the therapist has deemed that going up and down the stairs is unsafe, staff is NOT to assist. The client's care will be provided on one floor.
- If a client insists on going up or down the stairs (e.g. to access a bathroom, bedroom or living room on another level) staff is to meet the client at the top or bottom of the stairs.

Stairs and wheelchair

- If the client requires assist to move an empty wheelchair between one level of the home and another or outside, an OT or PT assessment is needed to ensure that there is an appropriate grade and adequate space for staff safety. A few steps may be considered safe depending upon the assessment. A full flight of stairs would not be considered safe.
- Staff is not trained in assisting a client on stairs or moving an empty wheelchair up/down steps during orientation or refreshers. Client specific training through the Delegated Task Program may be needed.
- Staff must not assist to move a client in a wheelchair up/down steps.

Equipment

- The use of appropriate equipment is often an essential component of a specific mobility or transfer procedure.
- If the equipment is not available or if the client refuses to comply with its use, staff must not do the transfer. Further assessment of the situation may be required or the Home Care Case Coordinator and Team Manager may need to be consulted.
- Staff/caregivers must not revert to unsafe transfer methods if the equipment is not available.
- If the client requires two pieces of identical or similar equipment e.g. two stationary adjustable height commodes, an overhead lift and an electric Hoyer® lift, options for funding should be explored and if no funding is available, the Program Consultant for Home Care Equipment, Supplies, Wheelchair & Ostomy should be consulted.
- If a client requires bariatric equipment, consult with the Program Consultant for Home Care Equipment, Supplies, Wheelchair & Ostomy.

Space required in the home

- Assessment should include considerations of space requirements for use of equipment and for client and staff safety.
- The following can be used as a guide for space requirements:

Care task/equipment	Space at side of bed (inches)	Space at foot of bed (inches)
Staff working in a standing position e.g. personal care, nursing care, repositioning or transfer[1]	31”	31”
Staff kneeling by the bed to assist e.g. personal care, nursing care, repositioning or transfer[2]	45”	45”
Staff sitting on chair to assist e.g. personal care or nursing care[3]	36”	36”

Transfer with floor based lift e.g. electric Hoyer® lift[4]	67" on same side that lift is used	-
Transfer with floor based lift e.g. sit-stand lift[5]	67" on same side that lift is used	-
Transfer with overhead lift[6]	55" on same side as transfer destination	-

1, 2, 3,4,5,6 Guidebook for Architects and Planners, 2005. Arjo Canada

Mechanical Lifts

- Refer to *Mechanical Lifts – Guidelines* for more details on how to assess and how to order lifts and slings.
- Refer to the *Best Practice Manual for Direct Service Staff* for how to use the most common types of mechanical lifts used in Home Care.
- Mechanical lift transfers may require one- or two-person assist depending on the client and the home situation.
- The client should always use the sling designated for the specific lift. Slings are not interchangeable from one lift to another e.g. from the Hoyer® lift to the Voyager portable overhead lift.
- A floor mechanical lift e.g. Hoyer®, Ministand sit-stand lift, should only be used with a hard flooring surface (e.g. hardwood, vinyl, tile) or low-pile carpet (e.g. commercial style carpets such as Berber; tightly woven fibers, flat in appearance, short/tight loops*)*. If the carpet is not suitable, e.g. soft underlay or shag style, options will include a change in flooring, change to room where flooring is more suitable, or change to an overhead lift system.
- Covering carpet with a sheet of plywood, plastic office style mats, etc. must be assessed. Plastic mats are often not thick enough to significantly reduce the rolling resistance of using a floor lift. The plastic mat or plywood may not be large enough to extend far enough underneath the bed or accommodate the amount of floor space required and/or they may create a problem with overlapping edges and gaps.
- A mechanical lift transfer to a commode must be assessed to determine safety including if it is safe to leave the client unattended.
- The sling must be unhooked from the lift after a transfer to a commode with a floor based or overhead lift if the client will be left unattended e.g. for privacy. If the client will not be left alone or is seated for a very brief time, the sling may remain attached to the lift.

Sit-Stand Lift (Moderate Assistance)

The client is able to assist from lying to sitting, sitting to standing, to maintain balance in sitting and partial weight bearing on one or both legs when standing. The client is able

to hold onto handles of the lift with one or both hands. The client is able to follow a two (2) step command, “Hold on and push with your feet”. Client must be able to lean back into sling to prevent it from sliding up to axillae. The assistance of a second caregiver may be required because of such factors as heavy body weight, decreased cognition or behavior issues. This second person could be home care staff, family member or private caregiver. Physical and cognitive capability and availability of family assisting as the 2nd person must be assessed by the therapist. Upon recommendation to the Case Coordinator, a second home care staff may be approved. The therapist will provide justification for a second staff person and clearly outline the role of each in the therapy report. Therapist will specify which loop to use when attaching the sling to the machine and ensure that no force is required to do so. Staff must not lift more than 35 lbs (16kg).

Total Mechanical Lifts (Maximum Assistance)

A total lift (power floor model or overhead lift) is required when one or more of the following problems exist:

- The client is **NOT able to consistently or reliably bear weight** through his/her upper body **to assist with lying to sitting**.
- The client is **NOT able to consistently or reliably bear weight** through his/her upper and lower body in order **to assist from sitting to standing**.
- The client is **NOT able to consistently or reliably bear weight when standing in the upright position and throughout the stepping / turning portion of the transfer.**
- There is no other safe method of transfer.

Once the environment is appropriate, the mechanical lift and sling(s) have been provided, and, depending on the specific mechanical lift, the training of the Direct Service Workers (DSW) is complete, it is usual for the mechanical lift to be operated safely by one DSW. (This is different from institutional practice where mechanical lifts are generally operated by two workers). However, there may be situations in the Home Care setting where a second person is required to assist with a mechanical lift transfer (e.g. when the client is unable to assist with turning in bed to put sling on/ remove sling, when severe spasticity exists and a second person is needed to ensure safe positioning, client’s behavior poses risk for client and staff safety.) This second person could be home care staff, family member or private caregiver. Physical and cognitive capability and availability of family assisting as the 2nd person must be assessed by the therapist. Upon recommendation to the Case Coordinator, a second home care staff may be approved. The therapist will provide justification for a second staff person and clearly outline the role of each in the therapy report. Therapist will specify style/type of sling and which loop(s) to use when attaching the sling to the machine to ensure that no force is required to do so. Staff must not lift more than 35 lbs (16kg).

Repositioning in a Chair

- If a client requires assistance to move back in a chair i.e. to reposition, staff can provide cues/coaching/assistance from the front. Staff DOES NOT help the client from behind the chair.
- Client must be able to assist by bracing body, leaning/shifting weight, or pushing with arms or legs.
- If the client is unable to assist, the mechanical lift should be used to reposition the client.
- Specific procedures for one person assist to reposition in a chair are under task code P9 and if using an electric Hoyer® lift task code PA of the *Best Practice Manual for Direct Service Staff.*
- Staff should contact their supervisor if the client often needs help to reposition in the chair. The client may need to be reassessed for appropriate seating. Seat belts should only be used as prescribed as part of the seating assessment by an OT or PT. Seat belts should not automatically be used if the client is sliding in the chair. Staff should be informed if a seat belt is to be used at all times.
- There are specific techniques that staff is taught for client's who require one person assistance. Please refer to Best Practice Manual for details specific to each method.

N.B. These guidelines are general ones and exceptions may apply in certain situations. Rationale for any exceptions will be outlined clearly in the therapy report. The goal of all recommendations is to ensure as much as possible that the mobility and transfer methods performed are safe for the CLIENT and ALL caregivers involved.

Positioning and Bed Mobility

- The client should be assessed for equipment to promote independence and client and staff safety.
- Refer to *Sliders - Guidelines.*
- Slider sheets reduce shear and friction. Soaker pads should not be used to reposition clients in bed due to the high risk for skin injury to the client caused by friction and shear and also due to the high risk of injury to staff.
- Sliders can be used with one person assist if the client is able to assist.
- If the client is unable to assist he/she will need 2 slider sheets, 2 or more caregivers, access to both long sides of the bed and space to move easily around either the foot end or the head of the bed.
- Access to both sides of the bed is required when the client requires more than minimal assistance to turn or move in bed or for care tasks in bed. Space between the long side of the bed and the wall and at the end of the bed will be required depending upon the anticipated working position for staff.
- If a hospital bed is in use, the head of the bed can be lowered to help with moving a client up in bed. Staff must be informed if this is a safe option for the client.
- If an overhead lift is available, the client may be assessed for a repositioning sling to assist with turning or moving in bed.
- If staff is using a soaker pad to assist the client to turn in bed, the client should be reassessed to determine if further equipment or two-person assist is required.

Mobility Assist for Personal Care tasks or Nursing tasks when Client is in Bed

- Assessment considerations should include lighting available for the task and space at the bedside to work and set up supplies.
- Assessment should include client's ability to turn in bed, lift arms or legs and to maintain positions required while care is provided.
- If the client requires physical assistance for personal care or nursing tasks in bed (e.g., dressing, sponge bath, wound care, etc.), employees must be able to complete tasks at a safe working height (i.e., hip height) to eliminate the need to work in an awkward position (e.g., bending, over-reaching) and/or the need to lift/hold limbs for prolonged periods. Additional equipment or the assistance of a second person may be required.
- Options for additional equipment include an electric hospital bed or an electric hi/lo hospital bed and/or other assistive equipment (e.g. overhead lift and limb slings) or positioning devices (e.g. high-density foam wedges).
- Adaptive clothing (e.g., open back pants) may be required for assistance with dressing (e.g. when client cannot be rolled to pull pants up)
- Some of this equipment is available through the Home Care program by special approval; some items may have to be purchased by the client.
- Lifting and holding of limbs for prolonged periods (e.g. for wound care) should be eliminated through the use of assistive technology (e.g. overhead lift and limb slings) or positioning devices (e.g. high-density foam wedges) to elevate and support the weight of the lower extremity. The following general guidelines should be considered when determining the safety of lifting and holding client limbs:
    - The average weight of a lower extremity (including thigh, calf, and foot) is approximately 15.7% of a person's total body weight. Therefore, the weight of the leg of a client who weighs greater than 220 lbs. would exceed the 35 lb. recommended safe patient handling lifting limit under ideal conditions (ideally this is a 2-handed lift, elbows close to the body, hip height/30 inches, leg held directly in front of staff's body).
    - Under non-ideal conditions (e.g. lifting the extremity far from the body/at full arm's length), the maximum recommended weight to be lifted would be even lower (11.1 lbs for one-handed lift; 22.2 lbs for two-handed lift) (Waters et al., 2009). A client weighing > 70 lbs (one-handed lift) and > 140 lbs (two-handed lift) would exceed these limits.
    - If holding of the leg is required for more than a few seconds (up to 3 minutes), the recommended maximum weight would be even lower (6.3 lbs) (Waters et al., 2009). A client weighing > 40 lbs would exceed this limit.

Similar considerations should be taken when attempting to lift and hold the pannus of a bariatric client. A regular sling can be adapted to hold the pannus using a mechanical lift. Alternatively, a draw sheet or blanket can be placed around the pannus and either held by the client or the workers, or secured to the bed or chair if possible

Therapeutic Sleep Surfaces

- Therapeutic sleep surfaces may make positioning and transfers more difficult due to the unstable surface.
- The hospital bed should be equipped with half rails for client safety on a therapeutic sleep surface.
- Provide detail on client's mobility level and transfers and identify what transfer equipment client is using.
- If a client will be sitting up at the side of the bed and/or transfers sit<>stand an air mattress may not be the safest option due to risk of slippage if the mattress is not deflated. The manufacturer recommends deflating the mattress if a client will be sitting up at the side of the bed and if home care staff is assisting this would require client specific training.
- DSS should contact their supervisor if staff is required to assist a client to sit at the side of the bed or if staff has difficulty assisting a client to roll, reposition or transfer with a mechanical lift.
- Sliders can be used and must be removed after use. It is preferable to still use 2 purple sliders for ease of movement.
- For further details refer to the Home Care *Guidelines for Therapeutic Sleep Surfaces*

Pushing and Pulling Beds

- Pushing and pulling beds and furniture is not recommended as a routine procedure. Instead, the home environment should be set up to allow adequate space for clients and staff to move freely during their assigned tasks.
- The forces involved with pushing and pulling are highly variable and depend primarily on how quickly a person performs the task. The faster a person moves, the higher the forces that are required to perform the task. When heavier items are involved it does not take much to exceed safe working limits for pushing/pulling tasks.
- Pushing is better than pulling and the staff member must be in line with the direction of force (i.e. side to side motions relative to the person moving the bed are not permitted). Push before pull before lift.
- There may be situations in which moving the bed is occasionally necessary to access both sides of the client when the orientation of equipment and furniture cannot be altered enough to eliminate this task. Each of these situations must be assessed on a client specific basis by the appropriate professional (CTS, OESH) to determine safety for the client and staff. During the assessment the following points must be taken into account:
  - Only Home Care beds equipped with casters, or specialized hospital beds equipped with larger casters or low friction furniture sliders should be moved by Home Care staff. Beds without wheels should not be moved.
  - Beds should not be moved on carpeted surfaces; only hardwood, tile, laminate or similar surfaces are suitable for this task.
  - The client's weight must be considered if the bed is to be pushed with the client in it noting it is best that the bed is moved when the client is not in it.

- The bed should only be moved short distances, less than 3 feet.
- The minimum and typical forces involved in moving the bed should be measured to ensure that they do not exceed the safe pushing and pulling limits recommended by the Canadian Centre for Occupational Health and Safety (CCOHS).
- The movement should be performed in a controlled manner in order to minimize the forces involved.

Pushing and Pulling Wheelchairs

- Pushing is better than pulling**.**
- If the wheelchair is travelling over a bump such as a door sill, it may be safer for the client and staff to pull the chair backwards rather than push.
- Staff assisting a client to enter/exit an apartment door that self closes for fire safety may require the use of a door stop to allow the door to be propped open as staff pushes or pulls the wheelchair in/out of the apartment. The door should not be left propped open.
- If the client requires assist to move an empty, manual wheelchair between one level of the home and another or outside, an OT or PT assessment is needed to ensure that there is an appropriate grade and adequate space for staff safety. A few steps may be considered safe depending upon the assessment. A full flight of stairs would not be considered safe.
- Staff is not trained in moving an empty wheelchair up/down steps during orientation or refreshers. Client specific training through the Delegated Task Program may be needed.
- Staff must not assist to move a client in a wheelchair up/down steps.

Commode Use

- Home Care provides stationary commodes which are adjustable in height and portable commodes which have a fixed floor to seat height. Standard commodes have a weight capacity of 250 lbs.
- The Artisan Deluxe Drop Arm 500AF (adjustable frame) (weight capacity 450 lbs) is also available through the Home Care program. The seat width is preset at 20” and can be ordered at 22”.
- The back rest on the Artisan portable commode can become loose – staff are instructed to check that the knobs are tightly secure before use.
- The Artisan commode is not intended to be used as a wheelchair and using it as such may result in injury to the client. Depending on the client’s weight and the space and floor surfaces it may be assessed as suitable to move the client a short distance e.g. into the bathroom. When moving a client on a wheeled commode, the footrests should be used.
- A tilt commode may be required for some clients and the client or family would need to purchase this.

GENERAL GUIDELINES

- Home Care does not do cradle lifts where staff lift all of the client's weight by placing their arms under the legs and trunk of the client. Exceptions exist for children who weigh up to 35 lbs.
- Home Care does not do transfers or repositioning where staff's hands or arms are positioned under the client's axilla due to risk of injury to the client and to staff.
- The client should not hold onto staff or lean on staff for support; clients should hold onto a grab bar or transfer pole or other transfer equipment.
- Work situations that involve sustained awkward postures such as stooping, twisting and overreaching or exerting force in an awkward posture are considered high risk for staff injury.
- If the client is unable or unwilling to cooperate, measures to address this may require the use of additional care providers or a consult e.g. Geriatric Mental Health Team.
- DSS are instructed to use the Pre-transfer &/or Mobility Checklist card as a guide for when not to complete a transfer. Refer to WRHA Home Care *Pre-transfer and/or Mobility Checklist Cards – Guidelines for Use and Ordering.*
- DSS must report concerns about client transfers to their supervisor in a timely manner.
- Where indicated refer to equipment specific guidelines as needed.

Surface Heights

- When a transfer is performed by one or two persons, it is essential that the height of the surface from which the client is being moved is within safe limits. It is not safe for caregivers to assist clients up from very low levels, e.g. low tub seats or from the bottom of the tub.

Falls prevention and post falls response

- Fall risks are assessed and included in the home care plan through MDS.
- DSS must use safe work procedures to set up the client, equipment and work space to prevent falls prior to and when assisting a client to move or transfer. These include but are not limited to:
    - lock wheels on wheelchair/commode/bed
    - ensure client wears appropriate footwear
    - ensure client is using prescribed mobility device rather than furniture walking,
    - ensure client is wearing glasses if needed
    - ensure adequate lighting
    - communicate clearly with client
    - respond to observations of client behavior e.g. fatigue, dizziness by encouraging and/or assisting client to stop and rest
    - report changes in client ability

- perform equipment safety check prior to each use
- refrain from using and label and report equipment which requires repairs.

- Staff will inform the RC about all client falls.
- When a client, family or staff report a fall, the CC will follow-up with the client and/or family and will follow occurrence reporting guidelines.
- Staff is instructed it is unsafe to try to catch a client or hold up a client who is falling or attempt to lift a client to a higher level. A fall in progress cannot be stopped. Staff is instructed to reduce the risk of injury to the client if they can safely do so. See *Best Practice Manual for Direct Service Staff* for more details.

Transferring clients from the floor

- Home Care does NOT lift or physically assist a client off the floor who is on the floor or who has fallen to the floor.
- If the client is unable to get up independently staff is to call their supervisor for direction and wait until help arrives. If it is an emergency, staff must call 911 and then their supervisor.
- A client who has fallen will automatically try to get up. However, the fear in falling results in adrenalin being released into the blood stream which in turn increases heart and respiratory rate. This can make it difficult to impossible for a client to focus and coordinate the muscle activity required to get up safely. Client is asked to remain on floor until he/she can focus.
- Staff may provide verbal directions to the client and use one or two chairs if the client is able to get up without physical assistance. Staff will ask about pain each time the client changes position and if the client has pain, staff will stop the process and notify the RC. Ask client to do as follows:
    a) roll onto side,
    b) push or roll up, onto elbow & then hand,
    c) turn onto hands & knees,
    d) crawl on all fours to a sturdy chair/table/sofa or bring chair close to client.
    e) put hands up on the supporting surface,
    f) draw stronger leg up and put foot on floor,
    g) use hands and strong leg to stand up (client's hands need to be on a flat surface such as the seat of a chair. Client does not move hands up onto armrests for rising, as this will make the chair unstable, and may result in a second fall)
- Staff will inform the RC about all client falls.
- If the client is wheelchair dependent and transfers with a mechanical lift a fall would be considered an unexpected event. Staff should not use a mechanical lift to assist the client up off of the floor until the client has been medically assessed to ensure that it is safe to move the client.

Bath tub/shower transfers

- Home Care staff does not assist to lift a client from the bottom of the bathtub due to the high risk of staff injury.

- Clients must obtain the recommended bath seat, grab bars and/or bath lift and non-slip tub bottom or bath mat prior to receiving Home Care assistance for tub transfers.
- An OT/PT assessment may be needed to assess the client's ability to transfer and to assess the environment and equipment needs e.g. client must have adequate support to sit during bath or shower.
- Clients, who <u>are able</u> to stand on one foot and lift the other foot into & out of the tub, are able to use a bath chair. Clients who are <u>not able</u> to do this will need a **bench / board** to sit on; then they will be asked to lift their feet over side of tub and slide hips along bench/board to centre of tub.
- The assessment may also address client's ability to assist with washing. Staff may be exposed to stooping, twisting, overreaching or working in an awkward position or becoming very wet when assisting a client with bathing or showering. Alternatives should be explored including the use of a long handled sponge and/or assisting to wash hard to reach parts before or after transferring into the tub or shower.
- Consider safety when assisting to lift a client's legs into the tub. The client must be able to assist with lifting legs into/out of the tub and be able to shift position on the bath seat as the legs are moved. An average leg weighs 15.7% of the client's body weight (Nelson, Motacki & Menzel, 2009), e.g. 200 lb. client's legs would weigh 31.4 lbs. each. One reference document references the 35 lb. weight limit and another article provides a different weight limit for a 2-handed lift. **Maximum safe 2 handed lift is 22.2 lbs. (10 kg.) with staff in half kneel position beside tub.**
- If staff will be kneeling to minimize awkward postures (i.e. procedure cannot be modified to eliminate or minimize this position), extra cushioning for the knees should be used (e.g. knee-pads, a folded towel).
- Considerations should be made to reduce the risk of slips and falls for the client and for staff e.g. non-slip mats should be used or the client should have dry feet and footwear on prior to standing. Staff or the client should not stand on a towel placed on the floor.
- If the client has a roll-in shower stall, a shower chair can be used. An assessment may be required.
- If a client uses a bath lift such as Aquatec staff may receive equipment specific training from the Delegated Task Program if necessary.
- If the transfer is completed using an electric Hoyer® lift the tub must be raised and wide enough for the base of the Hoyer to be adjusted in the widest position underneath the tub. The bathroom space must allow using the mechanical lift in the same room as the client cannot be transported in the lift from another room. An overhead lift system may be a safe alternative.
- If a client transfers down into the bathtub with an overhead lift the client may require an assessment for a bath seat for support and safety.
- It is not recommended to leave the sling attached to the power unit during bathing as exposing the lift and hand control to water or moisture could cause a malfunction of the device (page 10 of the Voyager Instruction Manual).
- A sponge bath will be the method of choice if other methods are not acceptable or if equipment is not available.

Staff Training

- All Home Care Attendants [HCA], Rehabilitation Assistants [RA], Integrated Support Workers [ISW], nurses, Resource Coordinators and Case Coordinators are required to attend training in safe work procedures for transfers and mobility as part of orientation and then every 3 years.
- Orientation and refresher training includes the following safe work procedures for mobility and transfers with one person assist:
    - Use of sliders for repositioning a client in bed
    - Use of transfer belt for minimum assist transfer and when assisting a client to ambulate
    - Assisting a client to sit up at the side of the bed
    - Repositioning a client in his/her wheelchair
    - Assisting a client who has fallen
    - Sliding board transfer
    - Bathroom safety (Orientation only)
    - Use of an electric Hoyer® lift (since September 2008, manual Hoyer lift that was used prior to that date was discontinued)
    - Use of a BHM Voyager® portable overhead lift system (since September 2008; staff complete a return demonstration in orientation since September 2010 and in refreshers since January 2011)
    - Use of a BHM Ministand sit-stand lift (since September 2008; staff complete a return demonstration in refreshers since January 2011 and in orientation since January 2012)
- If a client uses a specific transfer method or a specific piece of equipment including a turner, a pivot disc, an overhead lift with a Tarzan hook, a repositioning sling, limb slings consult the Delegated Task Program if client specific or equipment specific training is needed.
- Bariatric clients may require additional specialized equipment such as larger sized slings, pannus slings, and items such as beds, mechanical lifts, commodes etc. with increased weight capacity. Staff may require additional training.
- If staff requests or requires training for mobility and transfer procedures this training should not be done by the client, client's family or by another HCA unless the client is in the Self and Family Managed Care Program.

Equipment

Often the use of appropriate equipment is an essential component of a specific mobility or transfer method. If this equipment is not available or if the client refuses to comply with its usage, further assessment of the situation by the therapist may be indicated. Staff / caregivers must NOT revert to unsafe methods if the equipment is not available for use.

Equipment / Client Specific Services

In situations when transfer method and/or equipment being recommended by the therapist is not familiar to home care staff (e.g. bath lift, Sam Hall Turner, E-Z Turner, pivot disk, sliding board) then staff must receive client specific or equipment specific training through Delegated Task Teaching Team.

All 2 person transfers being done by TWO home care staff require client specific training through Delegated Task Teaching Team. When the 2nd person assisting is a family member or private caregiver Delegated Task Teaching Team will provide the training if the training session has been scheduled with a home care staff. In situations when training is required for just a family member or a private staff without home care staff present then the CTSI therapist completes the training.

Bed Positioning and Mobility

Due to high risk for skin injury to client caused by friction and shear AND injury to staff (e.g. back and shoulder injury), soaker pads are NOT recommended for use during repositioning and turning clients in bed. **Slider sheets reduce shear and friction.** They are recommended for use with clients who are unable or minimally able to assist with bed positioning, turning and mobility. When client is completely dependent for bed positioning, turning and mobility, he/she will need: 2 slider sheets, 2 caregivers, access to both long sides of the bed and space to move easily around either foot end or head of bed. Staff will be assisting on either same or opposite sides of bed and will be required to reposition / turn client safely. There may be specific situations that require more sliders and staff. Staff must not lift more than 35 lbs (16kg).

For good body mechanics, there needs to be a minimum of 2 feet of space between long side of bed and wall. A minimum space of 12 - 18 inches is needed at end of bed to allow staff to move from one side of bed to the other safely. Larger caregivers will need more space.

Dealing with differing opinions and establishing exceptions regarding transfers and mobility

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- The Home Care program acknowledges the importance of client independence in balance with staff safety and program resources and the individual nature of clients' homes as a workplace for staff.
- It is recognized that the choice of a mechanical lift or transfer method may involve a variety of people, and the process is often a difficult one. There may be disagreement among the client, caregivers and family members regarding the preferred method for transfers and mobility (examples include client refusing to use electric Hoyer® lift, family/client refusing to have an electric hospital bed, family requesting staff move bed several times daily to assist with care). Family or client refusal is not sufficient reason to change the recommendation to a method which may be unsafe.

- If while developing a cohesive care plan, the controversy becomes unsettling, there are steps that may help the therapist resolve some of the issues:
    a. Discussion with other CTSI therapists and supervisors to assist in the problem-solving process. There may also be occasions where two therapists will arrange to visit either together or separately to help clarify particularly difficult situations. (Such arrangements will be made with the CTSI Home Care Supervisor).
    b. CTS and/or the CC, Nursing Resource Coordinator (NRC) or TM may consult OESH (MSIP) where required and a joint visit may be scheduled if:
    - The safety of the task is in question.
    - The employee exercises their right to refuse dangerous work
    - The concern is related to a staff near miss or injury report.
    - The client and/or family are not in compliance with policies/procedures or recommendations
    - New equipment or a new procedure will be used.
- The Team Manager should be informed to assist with problem solving and decision making if the CC is unable to implement the CTS or OT/PT recommendations.
- A change in the care plan (e.g. alternate equipment, bed care, and/or suspension of services) may be necessary temporarily until the appropriate equipment and safe work procedures have been implemented
- Family members and privately hired staff may use methods which are not recommended by the CTS therapist or OESH even when feedback regarding other options has been provided.
- In exceptional circumstances general guidelines can be modified. The Team Manager, Case Coordinator, Resource Coordinator/Nursing Resource Coordinator, CTS therapist, Delegated Task Program, Home Care Staff Development OT instructors and OESH (MSIP) should be consulted to assess feasibility and client and staff safety.
- These modifications must be clearly communicated as an exception to all team members including DSS.
- A reassessment plan must be established if a guideline exception is part of the care plan.
- It is also recognized that the above measures may be time-consuming but are often warranted as a means of improving the overall safety and efficiency of the care plan as well as restoring a positive team approach.

Transfer Assessments Off-Site

- CTSI therapists are usually consulted on any exercise programs, mobility or transfers assistance provided by Home Care Direct Service Workers, e.g. at alternate residence, leisure site, school or work.
- All requests for transfers at an off- site location must have an assessment of appropriateness/safety of the transfer at the off-site location if Home Care DSS will be assisting at an alternate residence, leisure site, school or work.

- There may be situations where a CTSI therapist is asked to participate in discharge planning at the hospital. The Home Care Case Coordinator would authorize this visit.
- There may be situations where a patient or a resident is being discharged back into the community and the Home Care Case Coordinator will authorized a joint visit of a CTSI therapist with the therapist(s) from a hospital to the client's home.
- Delegated Task Program or CTS may be involved to train staff on the use of transfer equipment e.g. a bath lift that is used at an off- site location if this equipment differs from the equipment commonly used in the Home Care program.
- Bath assist at a facility or assisted living site may be arranged for a specific client. Training may be done by facility staff depending upon facility policy.

Handouts on transfer assessments and procedures are available.

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