

Guidelines for **Nursing** Homes



Ergonomics for the **Prevention** of Musculoskeletal Disorders

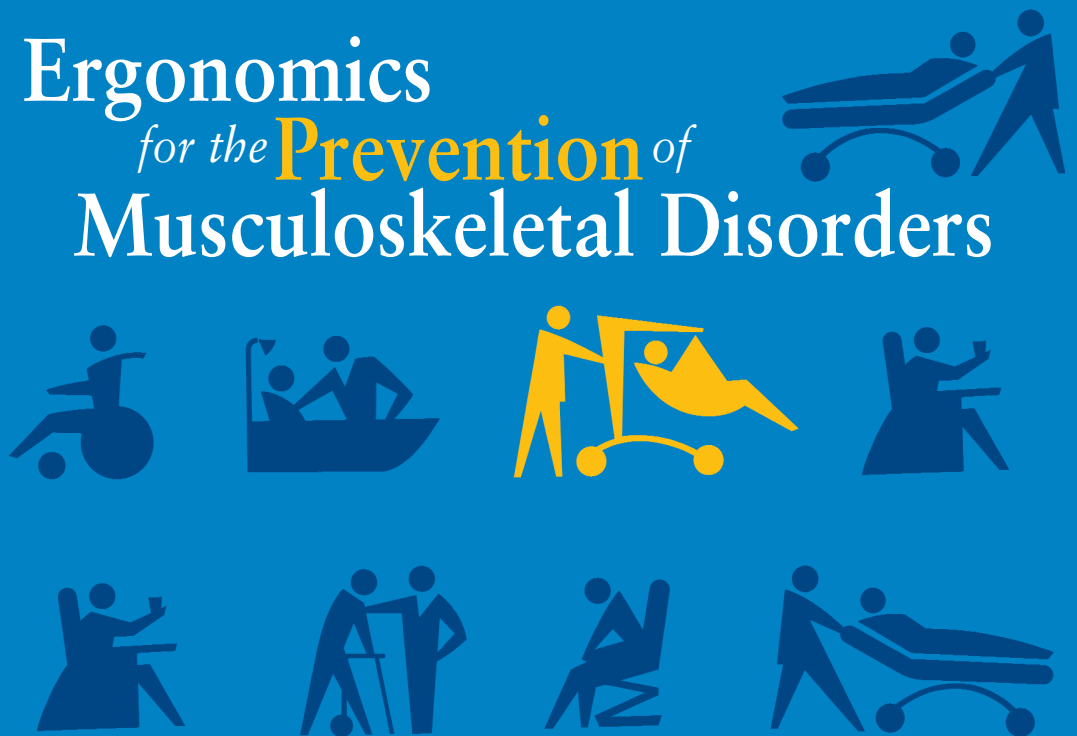


Table of Contents

Executive Summary	2
Section I. Introduction	4
Section II. A Process for Protecting Workers	6
Provide Management Support	6
Involve Employees	6
Identify Problems	6
Implement Solutions	7
Address Reports of Injuries	7
Provide Training	7
Evaluate Ergonomics Efforts	7
Section III. Identifying Problems and Implementing Solutions for Resident Lifting and Repositioning	9
Identifying Problems for Resident Lifting and Repositioning	9
<i>Figure 1.</i> Transfer to and from: Bed to Chair, Chair to Toilet, Chair to Chair, or Car to Chair	11
<i>Figure 2.</i> Lateral Transfer to and from: Bed to Stretcher, Trolley	12
<i>Figure 3.</i> Transfer to and from: Chair to Stretcher	13
<i>Figure 4.</i> Reposition in Bed: Side-to-Side, Up in Bed	14
<i>Figure 5.</i> Reposition in Chair: Wheelchair and Dependency Chair	15
<i>Figure 6.</i> Transfer a Patient Up From the Floor	16
Implementing Solutions for Lifting and Repositioning Residents	17
Section IV. Identifying Problems and Implementing Solutions for Activities Other than Resident Lifting and Repositioning	25
Section V. Training	29
Nursing Assistants and Other Workers at Risk of Injury	29
Training for Charge Nurses and Supervisors	29
Training for Designated Program Managers	29
Section VI. Additional Sources of Information	31
References	33
Appendix: A Nursing Home Case Study	34

EXECUTIVE SUMMARY

These guidelines provide recommendations for nursing home employers to help reduce the number and severity of work-related musculoskeletal disorders (MSDs) in their facilities. MSDs include conditions such as low back pain, sciatica, rotator cuff injuries, epicondylitis, and carpal tunnel syndrome. The recommendations in these guidelines are based on a review of existing practices and programs, State OSHA programs, as well as available scientific information, and reflect comments received from representatives of trade and professional associations, labor organizations, the medical community, individual firms, and other interested parties. OSHA thanks the many organizations and individuals involved for their thoughtful comments, suggestions, and assistance.

More remains to be learned about the relationship between workplace activities and the development of MSDs. However, OSHA believes that the experiences of many nursing homes provide a basis for taking action to better protect workers. As the understanding of these injuries develops and information and technology improve, the recommendations made in this document may be modified.

Although these guidelines are designed specifically for nursing homes, OSHA hopes that employers with similar work environments, such as assisted living centers, homes for the disabled, homes for the aged, and hospitals will also find this information useful.

OSHA also recognizes that small employers, in particular, may not have the need for as comprehensive a program as would result from implementation of every action and strategy described in these guidelines. Additionally, OSHA realizes that many small employers may need assistance in implementing an appropriate ergonomics program. That is why we emphasize the availability of the free OSHA consultation service for smaller employers. The consultation service is independent of OSHA's enforcement activity and will be making special efforts to provide help to the nursing home industry.

These guidelines are advisory in nature and informational in content. They are not a new standard or regulation and do not create any new OSHA duties. Under the OSH Act, the extent of an employer's obligation to address ergonomic hazards is governed by the general duty clause. 29 U.S.C. 654(a)(1). An employer's failure to implement the guidelines is not a violation, or evidence of a violation, and may not be used as evidence of a violation, of the general duty clause. Furthermore, the fact that OSHA has developed this document is not evidence and may not be used as evidence of an employer's obligations under the general duty clause; the fact that a measure is recommended in this document but not adopted by an employer is not evidence, and may not be used as evidence, of a violation of the general duty clause. In addition, the recommendations contained herein should be adapted to the needs and resources of each individual place of employment. Thus, implementation of the guidelines may differ from site to site depending on the circumstances at each particular site.

While specific measures may differ from site to site, **OSHA recommends that:**

- **Manual lifting of residents be minimized in all cases and eliminated when feasible.**

- **Employers implement an effective ergonomics process that:**
 - provides management support;
 - involves employees;
 - identifies problems;
 - implements solutions;
 - addresses reports of injuries;
 - provides training; and
 - evaluates ergonomics efforts.

These guidelines elaborate on these recommendations, and include additional information employers can use to identify problems and train employees. Of particular value are examples of solutions employers can use to help reduce MSDs in their workplace. Recommended solutions for resident lifting and repositioning are found in Section III, while recommended solutions for other ergonomic concerns are in Section IV. The appendix includes a case study describing the process one nursing home used to reduce MSDs.

Section I. Introduction

Nursing homes that have implemented injury prevention efforts focusing on resident lifting and repositioning methods have achieved considerable success in reducing work-related injuries and associated workers' compensation costs. Providing a safer and more comfortable work environment has also resulted in additional benefits for some facilities, including reduced staff turnover and associated training and administrative costs, reduced absenteeism, increased productivity, improved employee morale, and increased resident comfort. These guidelines provide recommendations for employers to help them reduce the number and severity of work-related musculoskeletal disorders in their facilities using methods that have been found to be successful in the nursing home environment.

Wyandot County Nursing Home in Upper Sandusky, Ohio, has implemented a policy of performing all assisted resident transfers with mechanical lifts, and has purchased electrically adjustable beds. According to Wyandot no back injuries from resident lifting have occurred in over five years. The nursing home also reported that workers' compensation costs have declined from an average of almost \$140,000 per year to less than \$4,000 per year, reduced absenteeism and overtime have resulted in annual savings of approximately \$55,000, and a reduction in costs associated with staff turnover has saved an additional \$125,000 (1). (see Reference List)

Providing care to nursing home residents is physically demanding work. Nursing home residents often require assistance to walk, bathe, or perform other normal daily activities. In some cases residents are totally dependent upon caregivers for mobility. Manual lifting and other tasks involving the repositioning of residents are associated with an increased risk of pain and injury to caregivers, particularly to the back (2, 3). These tasks can entail high physical demands due to the large amount of weight involved, awkward postures that may result from leaning over a bed or working in a confined area, shifting of weight that may occur if a resident loses balance or strength while moving, and many other factors. The risk factors that workers in nursing homes face include:

- Force – the amount of physical effort required to perform a task (such as heavy lifting) or to maintain control of equipment or tools;
- Repetition – performing the same motion or series of motions continually or frequently; and
- Awkward postures – assuming positions that place stress on the body, such as reaching above shoulder height, kneeling, squatting, leaning over a bed, or twisting the torso while lifting (3).

Excessive exposure to these risk factors can result in a variety of disorders in affected workers (3, 5). These conditions are collectively

After implementing a program designed to eliminate manual lifting of residents, Schoellkopf Health Center in Niagara Falls, New York, reported a downward trend in the number and severity of injuries, with lost workdays dropping from 364 to 52, light duty days dropping from 253 to 25, and workers' compensation losses falling from \$84,533 to \$6,983 annually (4).

referred to as musculoskeletal disorders, or MSDs. MSDs include conditions such as low back pain, sciatica, rotator cuff injuries, epicondylitis, and carpal tunnel syndrome (6). Early indications of MSDs can include persistent pain, restriction of joint movement, or soft tissue swelling (3, 7).

While some MSDs develop gradually over time, others may result from instantaneous events such as a single heavy lift (3). Activities outside of the workplace that involve substantial physical demands may also cause or contribute to MSDs (6). In addition, development of MSDs may be related to genetic causes, gender, age, and other factors (5, 6). Finally, there is evidence that reports of MSDs may be linked to certain psychosocial factors such as job dissatisfaction, monotonous work and limited job control (5, 6). These guidelines address only physical factors in the workplace that are related to the development of MSDs.

At Citizens Memorial Health Care Facility in Bolivar, Missouri, establishment of an ergonomics component in the existing safety and health program was reportedly followed by a reduction in the number of OSHA-recordable lifting-related injuries of at least 45% during each of the next four years, when compared to the level of injuries prior to the ergonomics efforts. The number of lost workdays associated with lifting-related injuries was reported to be at least 55% lower than levels during each of the previous four years. Citizens Memorial reported that these reductions contributed to a direct savings of approximately \$150,000 in workers' compensation costs over a five-year period (8).

Section II. A Process for Protecting Workers

The number and severity of injuries resulting from physical demands in nursing homes—and associated costs—can be substantially reduced (2, 9). Providing an alternative to manual resident lifting is the primary goal of the ergonomics process in the nursing home setting and of these guidelines. **OSHA recommends that manual lifting of residents be minimized in all cases and eliminated when feasible.** OSHA further recommends that employers develop a process for systematically addressing ergonomics issues in their facilities, and incorporate this process into an overall program to recognize and prevent occupational safety and health hazards.

An effective process should be tailored to the characteristics of the particular nursing home but OSHA generally recommends the following steps:

Provide Management Support

Strong support by management creates the best opportunity for success. OSHA recommends that employers develop clear goals, assign responsibilities to designated staff members to achieve those goals, provide necessary resources, and ensure that assigned responsibilities are fulfilled. Providing a safe and healthful workplace requires a sustained effort, allocation of resources and frequent follow-up that can only be achieved through the active support of management.

Involve Employees

Employees are a vital source of information about hazards in their workplace. Their involvement adds problem-solving capabilities and hazard identification assistance, enhances worker motivation and job satisfaction, and leads to greater acceptance when changes are made in the workplace. Employees can:

- submit suggestions or concerns;
- discuss the workplace and work methods;
- participate in the design of work, equipment, procedures, and training;
- evaluate equipment;
- respond to employee surveys;
- participate in task groups with responsibility for ergonomics; and
- participate in developing the nursing home's ergonomics process.

Identify Problems

Nursing homes can more successfully recognize problems by establishing systematic methods for identifying ergonomics concerns in their workplace. Information about where problems or potential problems may occur in nursing homes can be obtained from a variety of sources, including OSHA 300 and 301 injury and illness information, reports of workers' compensation claims, accident and near-miss investigation reports, insurance company reports, employee interviews, employee surveys, and reviews and observations of workplace conditions. Once information is obtained, it can be used to identify and evaluate elements of jobs that are associated with problems. Sections III and

IV contain further information on methods for identifying ergonomics concerns in the nursing home environment.

Implement Solutions

When problems related to ergonomics are identified, suitable options can then be selected and implemented to eliminate hazards. Effective solutions usually involve workplace modifications that eliminate hazards and improve the work environment. These changes usually include the use of equipment, work practices, or both. When choosing methods for lifting and repositioning residents, individual factors should be taken into account. Such factors include the resident's rehabilitation plan, the need to restore the resident's functional abilities, medical contraindications, emergency situations, and resident dignity and rights. Examples of solutions can be found in Sections III and IV.

Address Reports of Injuries

Even in establishments with effective safety and health programs, injuries and illnesses may occur. Work-related MSDs should be managed in the same manner and under the same process as any other occupational injury or illness (10). Like many injuries and illnesses, employers and employees can benefit from early reporting of MSDs. Early diagnosis and intervention, including alternative duty programs, are particularly important in order to limit the severity of injury, improve the effectiveness of treatment, minimize the likelihood of disability or permanent damage, and reduce the amount of associated workers' compensation claims and costs. OSHA's injury and illness recording and reporting regulation (29 CFR 1904) requires employers to keep records of work-related injuries and illnesses. These reports can help the nursing home identify problem areas and evaluate ergonomic efforts. Employees may not be discriminated against for reporting a work-related injury or illness. [29 U.S.C. 660(c)]

Provide Training

Training is necessary to ensure that employees and managers can recognize potential ergonomics issues in the workplace, and understand measures that are available to minimize the risk of injury. Ergonomics training can be integrated into general training on performance requirements and job practices. Effective training covers the problems found in each employee's job. More information on training can be found in Section V.

Evaluate Ergonomics Efforts

Nursing homes should evaluate the effectiveness of their ergonomics efforts and follow-up on unresolved problems. Evaluation helps sustain the effort to reduce injuries and illnesses, track whether or not ergonomic solutions are working, identify new problems, and show areas where further improvement is needed. Evaluation and follow-up are central to continuous improvement and long-term success. Once solutions are introduced, OSHA recommends that employers ensure they are effective. Various indicators (e.g., OSHA 300 and 301 information data and workers' compensation reports) can provide useful empirical data at this stage, as can other techniques such as employee interviews. For example, after introducing a new lift at a nursing home, the employer

should follow-up by talking with employees to ensure that the problem has been adequately addressed. In addition, interviews provide a mechanism for ensuring that the solution is not only in place, but is being used properly. The same methods that are used to identify problems in many cases can also be used for evaluation.

Section III. Identifying Problems and Implementing Solutions for Resident Lifting and Repositioning

Identifying Problems for Resident Lifting and Repositioning

Assessing the potential for work to injure employees in nursing homes is complex because typical nursing home operations involve the repeated lifting and repositioning of the residents. Resident lifting and repositioning tasks can be variable, dynamic, and unpredictable in nature. In addition, factors such as resident dignity, safety, and medical contraindications should be taken into account. As a result, specific techniques are used for assessing resident lifting and repositioning tasks that are not appropriate for assessing the potential for injury associated with other nursing home activities.

An analysis of any resident lifting and repositioning task involves an assessment of the needs and abilities of the resident involved. This assessment allows staff members to account for resident characteristics while determining the safest methods for performing the task, within the context of a care plan that provides for appropriate care and services for the resident. Such assessments typically consider the resident's safety, dignity and other rights, as well as the need to maintain or restore a resident's functional abilities. The resident assessment should include examination of factors such as:

- the level of assistance the resident requires;
- the size and weight of the resident;
- the ability and willingness of the resident to understand and cooperate; and
- any medical conditions that may influence the choice of methods for lifting or repositioning.

These factors are critically important in determining appropriate methods for lifting and repositioning a resident. The size and weight of the resident will, in some situations, determine which equipment is needed and how many caregivers are required to provide assistance. The physical and mental abilities of the resident also play an important role in selecting appropriate solutions. For example, a resident who is able and willing to partially support their own weight may be able to move from his or her bed to a chair using a standing assist device, while a mechanical sling lift may be more appropriate for those residents who are unable to support their own weight. Other factors related to a resident's condition may need to be taken into account as well. For instance, a resident who has recently undergone hip replacement surgery may require specialized equipment for assistance in order to avoid placing stress on the affected area.

A number of protocols have been developed for systematically examining resident needs and abilities and/or for recommending procedures and equipment to be used for performing lifting and repositioning tasks. The following are some examples:

- The *Resident Assessment Instrument* published by the Centers for Medicare and Medicaid Services (CMS) provides a structured, standardized approach for assessing resident capabilities and needs that results in a care plan for each resident. Caregivers can use this information to help them determine the

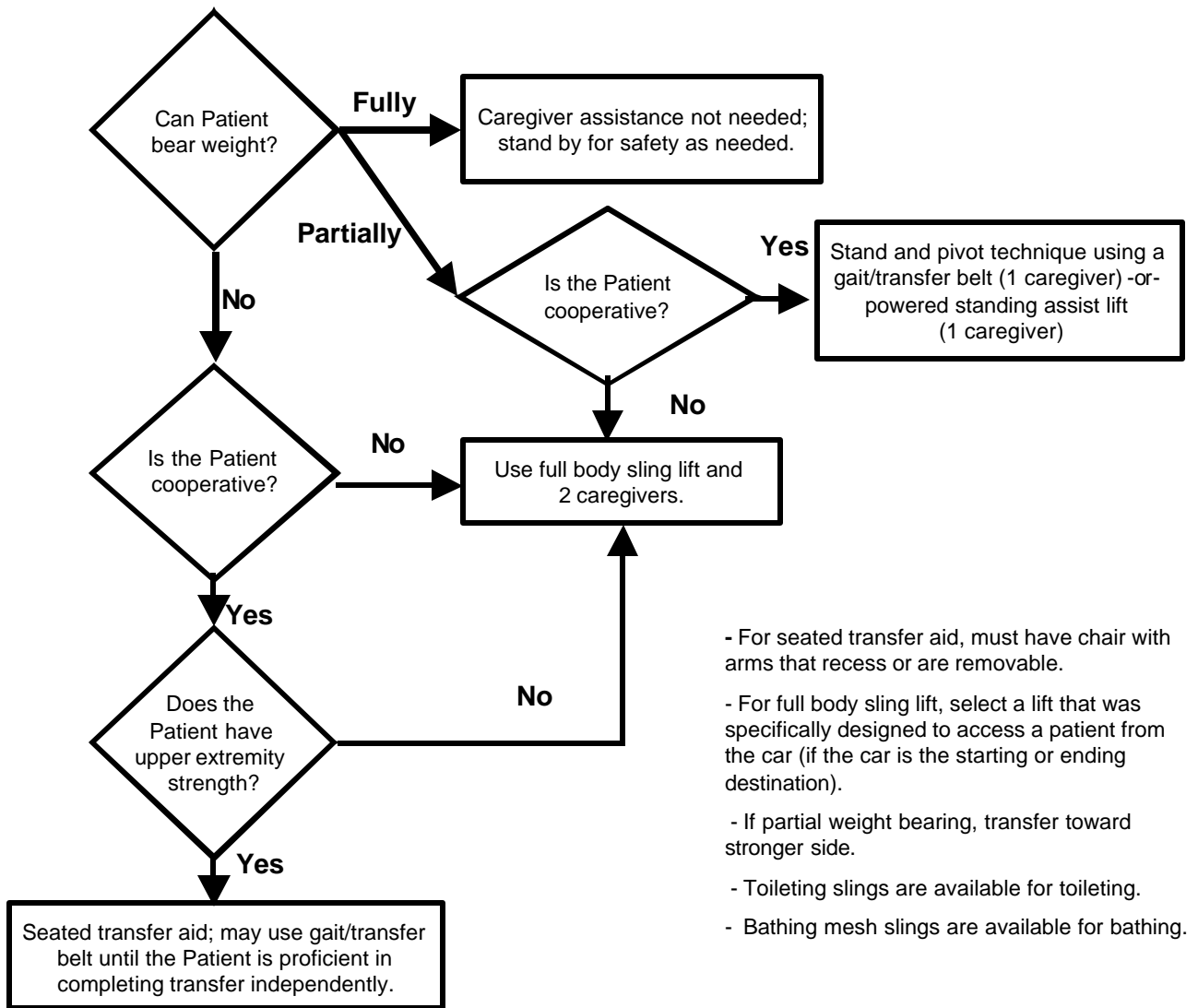
appropriate method for lifting or repositioning residents. Many nursing homes use this system to comply with CMS requirements for nursing homes. Employers can access this information from www.cms.hhs.gov/medicaid/mds20/.

- *Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement* is published by the Patient Safety Center of Inquiry, Veterans Health Administration and the Department of Defense. This document provides flow charts (shown here in Figures 1-6) that address relevant resident assessment factors and recommends solutions for resident lifting and repositioning problems. This material is one example of an assessment tool that has been used successfully. Employers can access this information from www.patientsafetycenter.com. Nursing home operators may find another tool or develop an assessment tool that works better in their facilities.
- Appendix A of the Settlement Agreement between OSHA and Beverly Enterprises entitled *Lift Program Policy and Guide* recommends solutions for resident lifting and repositioning problems, based on the CMS classification system. (A rating of “4” indicates a totally dependent resident. A “3” rating indicates residents that need extensive assistance. A “2/1” rating indicates residents that need only limited assistance/general supervision. Residents rated “0” are independent.) Employers can access this information from www.osha.gov.

The nursing home operator should use an assessment tool which is appropriate for the conditions in an individual nursing home. The special needs of bariatric (excessively heavy) residents may require additional focus. Assistive devices must be capable of handling the heavier weight involved, and modification of work practices may be necessary.

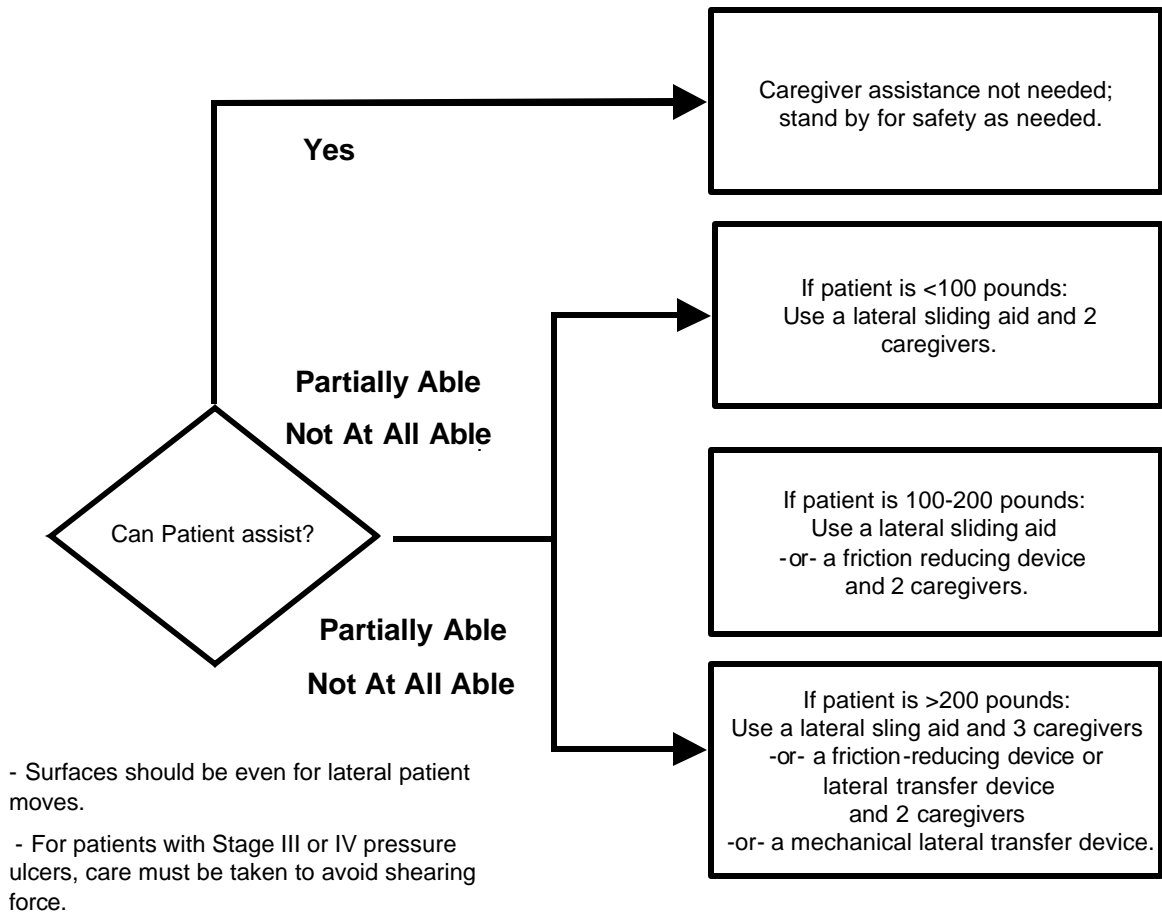
A number of individuals in nursing homes can contribute to resident assessment and the determination of appropriate methods for assisting in transfer or repositioning. Interdisciplinary teams such as staff nurses, certified nursing assistants, nursing supervisors, physical therapists, physicians, and the resident or his/her representative may all be involved. Of critical importance is the involvement of employees directly responsible for resident care and assistance, as the needs and abilities of residents may vary considerably over a short period of time, and the employees responsible for providing assistance are in the best position to be aware of and accommodate such changes.

FIGURE 1. Transfer to and from: Bed to Chair, Chair to Toilet, Chair to Chair, or Car to Chair



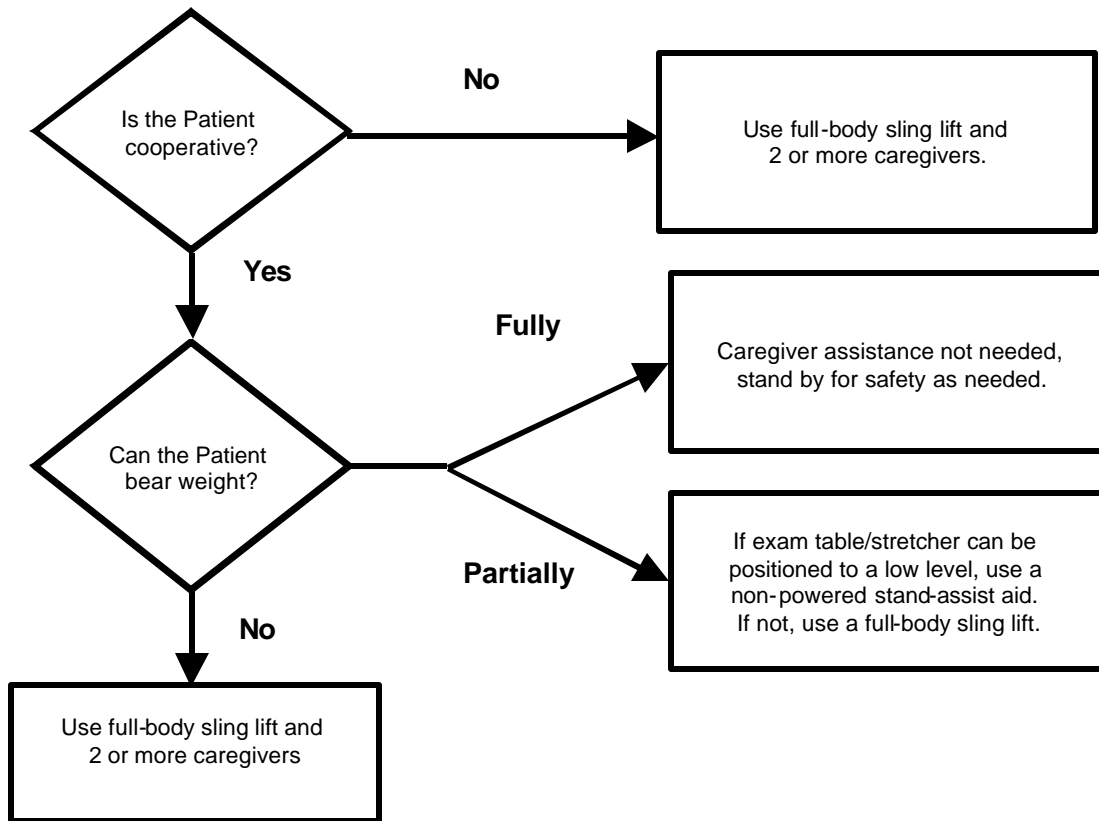
Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense, October 2001.

FIGURE 2. Lateral Transfer to and from: Bed to Stretcher, Trolley



Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

FIGURE 3. Transfer to and from: Chair to Stretcher

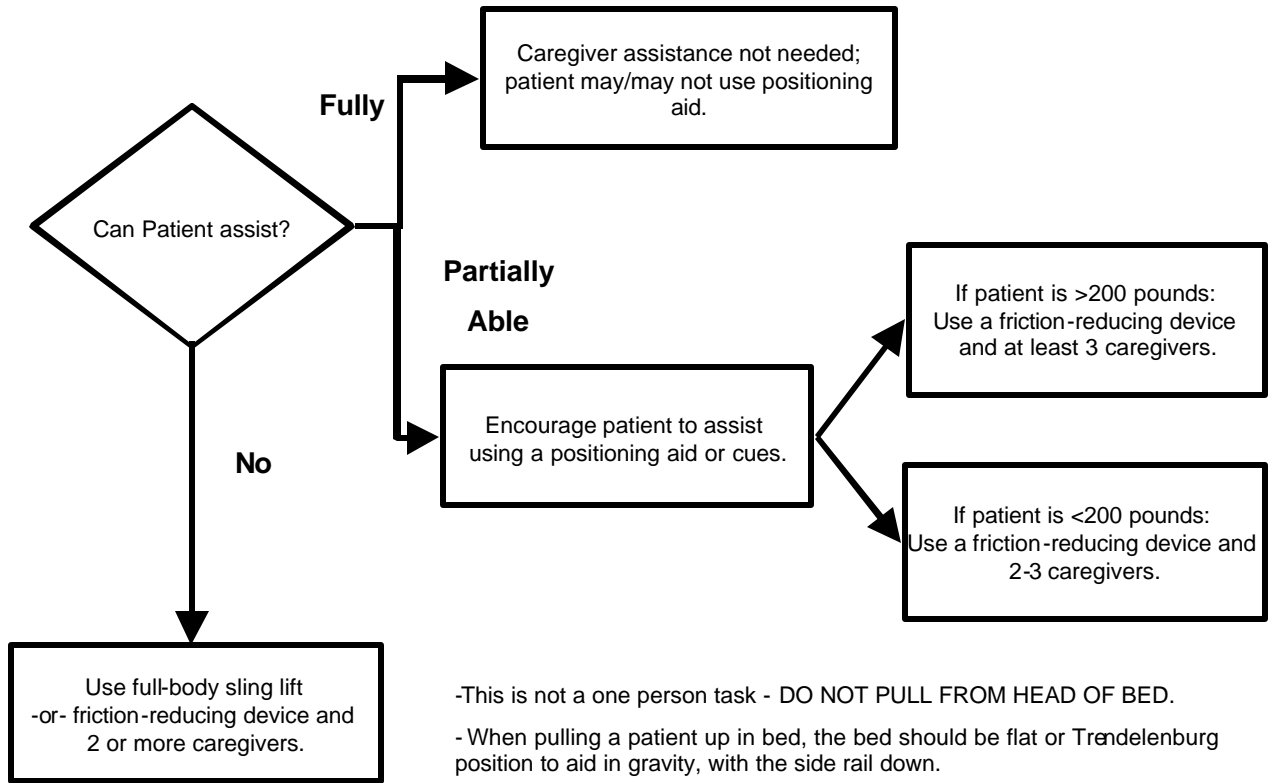


Comments:

- High/low exam tables and stretchers would be ideal.

Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

FIGURE 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 Trendelenburg position to aid in gravity, with the side rail down.

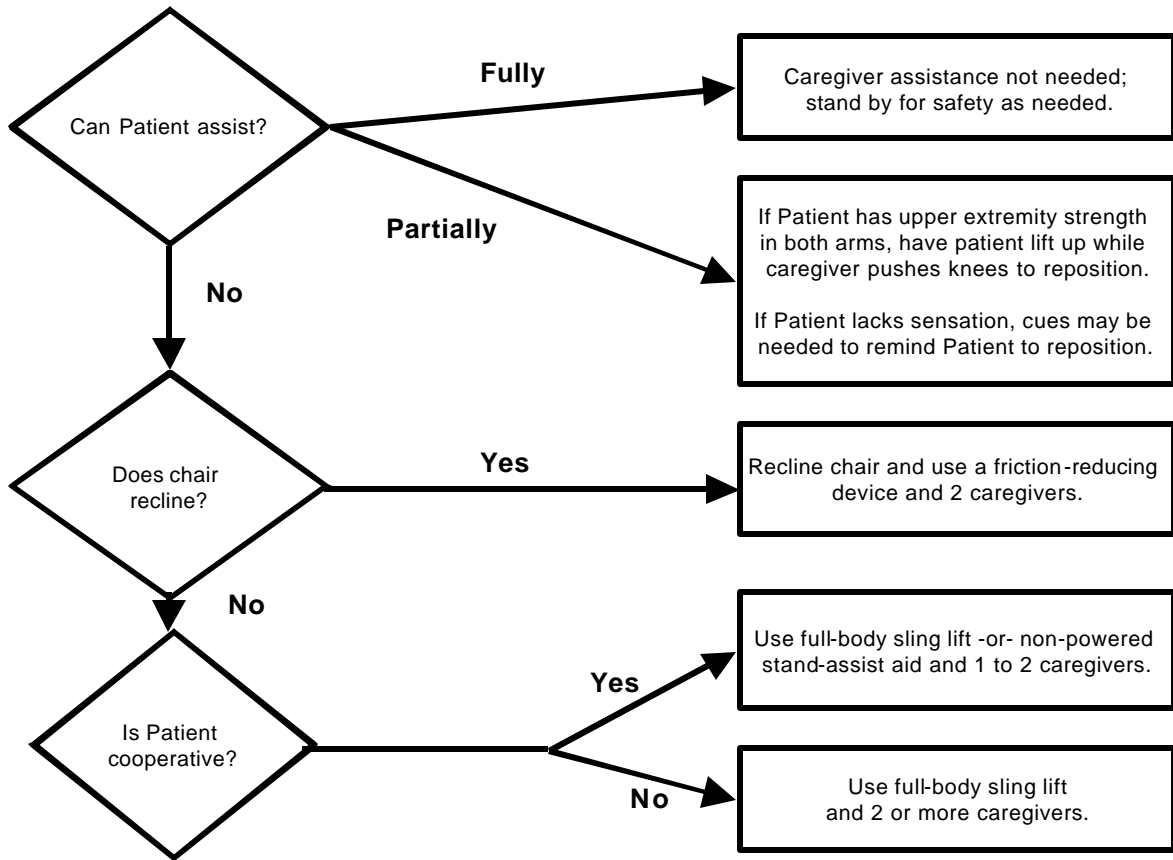
- For patient with Stage III or IV pressure ulcers, care should be taken to avoid shearing force.

- 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.

Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

FIGURE 5. Reposition in Chair: Wheelchair and Dependency Chair



Comments:

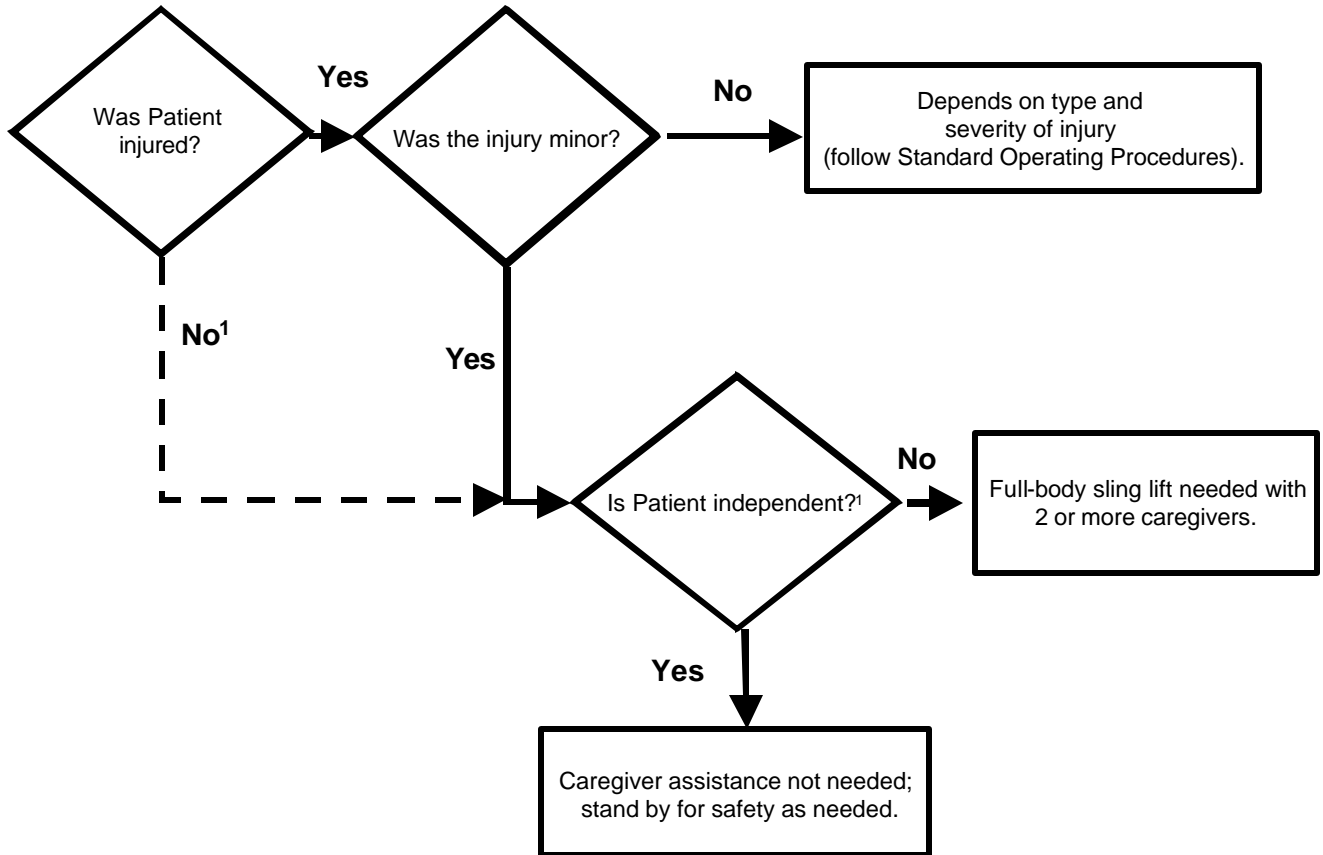
-This is not a one person task: DO NOT PULL FROM BEHIND CHAIR.

- Take full advantage of chair functions, e.g., chair that reclines, or use of arm rest of chair to facilitate repositioning.

- Make sure the chair wheels are locked.

Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

FIGURE 6. Transfer a Patient Up From The Floor



Comments:

- Use full-body sling that goes all the way down to the floor (most of the newer models are capable of this).
- ¹Modifications made with concurrence of Dr. Audrey Nelson at Veterans Administration Hospital, Tampa, Florida.

Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

Implementing Solutions for Resident Lifting and Repositioning

The recommended solutions presented in the following pages are not intended to be an exhaustive list, nor does OSHA expect that all of them will be used in any given facility. The information represents a range of available options that a facility can consider using. Many of the solutions are simple, common sense modifications to equipment or procedures that do not require substantial time or resources to implement. Others may require more significant efforts. The integration of various solutions into the nursing home is a strategic decision that, if carefully planned and executed, will lead to long-term benefits. Administrators should also be cognizant of several factors that might restrict the application of certain measures, such as residents' rehabilitation plans, the need for restoration of functional abilities, other medical contraindications, emergency conditions, and residents' dignity and rights.

The procurement of equipment and the selection of an equipment supplier are important considerations when implementing solutions. Employers should establish close working relationships with equipment suppliers. Such working relationships help with obtaining training for employees, modifying the equipment for special circumstances, and procuring parts and service when needed. Employers will want to pay particular attention to the effectiveness of the equipment, especially the injury and illness experience of other nursing homes that have used the equipment. The following questions are designed to aid in the selection of the equipment and supplier that best meets the needs of an individual nursing home.

- Availability of technical service - Is over-the-phone assistance, as well as onsite assistance, for repairs and service of the lift available?
- Availability of parts - Which parts will be in stock and available in a short time frame and how soon can they be shipped to your location?
- Storage requirements - Is the equipment too big for your facility? Can it be stored in close proximity to the area(s) where it is used?
- If needed, is a charging unit and back up battery included? What is the simplicity of the charging unit and space required for a battery charger if one is needed?
- If the lift has a self-contained charging unit, what is the amount of space necessary for charging and what electrical receptacles are required? What is the minimum charging time of a battery?
- How high is the base of the lift and will it fit under the bed and various other pieces of furniture? How wide is the base of the lift or is it adjustable to a wider and lockable position?
- How many people are required to operate the lift for lifting of a typical 200-pound person?

- Does the lift activation device (pendant) have remote capabilities?
- How many sizes and types of slings are available? What type of sling is available for optimum infection control?
- Is the device versatile? Can it be a sit-to-stand lift, as well as a lift device? Can it be a sit-to-stand lift and an ambulation-assist device?
- What is the speed and noise level of the device? Will the lift go to floor level? How high will it go?

Based on many factors including the characteristics of the resident population and the layout of the facility, employers should determine the number and types of devices needed. Devices should be located so that they are easily accessible to workers. If resident lifting equipment is not accessible when it is needed, it is likely that other aspects of the ergonomics process will be ineffective. If the facility can initially purchase only a portion of the equipment needed, it should be located in the areas where the needs are greatest. Employers should also establish routine maintenance schedules to ensure that the equipment is in good working order.

The following are examples of solutions for resident lifting and repositioning tasks.

Transfer from Sitting to Standing Position

Description: Powered sit-to-stand or standing-assist devices.

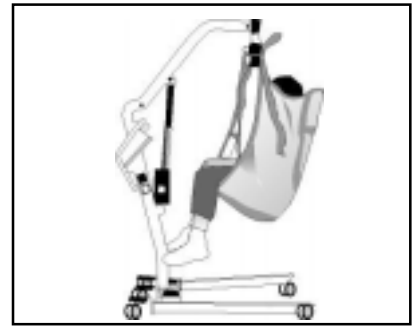


When to Use: Transferring residents who are partially dependent, have some weight-bearing capacity, are cooperative, can sit up on the edge of the bed with or without assistance, and are able to bend hips, knees, and ankles. Transfers from bed to chair (wheel chair, Geri or cardiac chair), or chair to bed, or for bathing and toileting. Can be used for repositioning where space or storage is limited.

Points to Remember: Look for a device that has a variety of sling sizes, lift-height range, battery portability, hand-held control, emergency shut-off, and manual override. Ensure device is rated for the resident weight. Electric/battery powered lifts are preferred to crank or pump type devices to allow smoother movement for the resident, and less physical exertion by the caregiver.

Resident Lifting

Description: Portable lift device (sling type); can be a universal/hammock sling or a band/leg sling

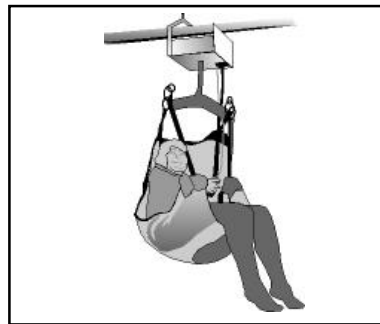


When to Use: Lifting residents who are totally dependent, are partial- or non-weight bearing, are very heavy, or have other physical limitations. Transfers from bed to chair (wheel chair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a resident fall.

Points to Remember: More than one caregiver may be needed. Look for a device with a variety of slings, lift-height range, battery portability, hand-held control, emergency shut-off, manual override, boom pressure sensitive switch, that can easily move around equipment, and has a support base that goes under beds. Having multiple slings allows one of them to remain in place while resident is in bed or chair for only a short period, reducing the number of times the caregiver lifts and positions resident. Portable compact lifts may be useful where space or storage is limited. Ensure device is rated for the resident weight. Electric/battery powered lifts are preferred to crank or pump type devices to allow a smoother movement for the resident, and less physical exertion by the caregiver. Enhances resident safety and comfort.

Resident Lifting

Description: Ceiling-mounted lift device



When to Use: Lifting residents who are totally dependent, are partial- or non-weight bearing, very heavy, or have other physical limitations. Transfers from bed to chair (wheel chair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a resident falls. A horizontal frame system or litter attached to the ceiling-mounted device can be used when transferring residents who cannot be transferred safely between 2 horizontal surfaces, such as a bed to a stretcher or gurney while lying on their back, using other devices.

Points to Remember: More than one caregiver may be needed. Some residents can use the device without assistance. May be quicker to use than portable device. Motors can be fixed or portable (lightweight). Device can be operated by hand-held control attached to unit or by infrared remote control. Ensure device is rated for the resident weight. Increases residents' safety and comfort during transfer.

Ambulation

Description: Ambulation assist device

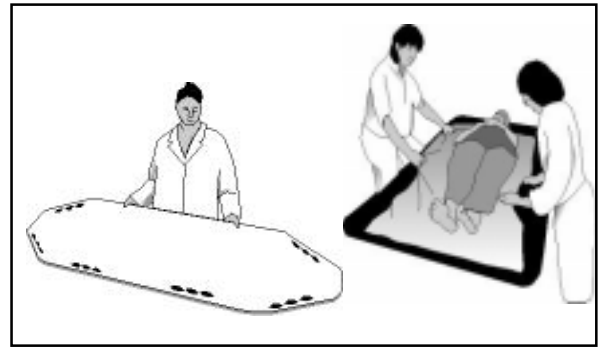


When to Use: For residents who are weight bearing and cooperative and who need extra security and assistance when ambulating.

Points to Remember: Increases resident safety during ambulation and reduces risk of falls. The device supports residents as they walk and push it along during ambulation. Ensure height adjustment is correct for resident before ambulation. Ensure device is in good working order before use and rated for the resident weight to be lifted. Apply brakes before positioning resident in or releasing resident from device.

Lateral Transfer; Repositioning

Description: Devices to reduce friction force when transferring a resident such as a draw sheet or transfer cot with handles to be used in combination slippery sheets, low friction mattress covers, or slide boards; boards or mats with vinyl coverings and rollers; gurneys with transfer devices; and air-assist lateral sliding aid or flexible mattress inflated by portable air supply.



When To Use: Transferring a partial- or non-weight bearing resident between 2 horizontal surfaces such as a bed to a stretcher or gurney while lying on their back or when repositioning resident in bed.

Points to Remember: More than one caregiver is needed to perform this type of transfer or repositioning. Additional assistance may be needed depending upon resident status, e.g., for heavier or non-cooperative residents. Some devices may not be suitable for bariatric residents. When using a draw sheet combination use a good hand-hold by rolling up draw sheets or use other friction-reducing devices with handles such as slippery sheets. Narrower slippery sheets with webbing handles positioned on the long edge of the sheet may be easier to use than wider sheets. When using boards or mats with vinyl coverings and rollers use a gentle push and pull motion to move resident to new surface.

Look for a combination of devices that will increase resident's comfort and minimize risk of skin trauma. Ensure transfer surfaces are at same level and at a height that allows caregivers to work at waist level to avoid extended reaches and bending of the back. Count down and synchronize the transfer motion between caregivers.

Lateral Transfer; Repositioning

Description: Convertible wheelchair, Geri or cardiac chair to bed; beds that convert to chairs.



When to Use: For lateral transfer of residents who are partial- or non-weight bearing. Eliminates the need to perform lift transfer in and out of wheelchairs. Can also be used to assist residents who are partially weight bearing from a sit-to-stand position. Beds that convert to chairs can aid repositioning residents who are totally dependent, non-weight bearing, very heavy, or have other physical limitations.

Points to Remember: More than one caregiver is needed to perform lateral transfer. Additional assistance for lateral transfer may be needed depending on residents status, e.g., for heavier or non-cooperative residents. Additional friction-reducing devices may be required to reposition resident. Heavy duty beds are available for bariatric residents. Device should have easy-to-use controls located within easy reach of the caregiver, sufficient foot clearance, and wide range of adjustment. Motorized height-adjustable devices are preferred to those adjusted by crank mechanism to minimize physical exertion. Always ensure device is in good working order before use. Ensure wheels on equipment are locked. Ensure transfer surfaces are at same level and at a height that allows caregivers to work at waist level to avoid extended reaches and bending of the back.

Repositioning in Chair

Description: Variable position Geri and Cardiac chairs



When to Use: Repositioning partial- or non-weight-bearing residents who are cooperative.

Points to Remember: More than one caregiver is needed and use of a friction-reducing device is needed if resident cannot assist to reposition self in chair. Ensure use of good body mechanics by caregivers. Wheels on chair add versatility. Ensure that chair is easy to adjust, move, and steer. Lock wheels on chair before repositioning. Remove trays, footrests, and seat belts where appropriate. Ensure device is rated for the resident weight.

Lateral Transfer in Sitting Position

Description: Transfer boards – wood or plastic (some with movable seat)



When to Use: Transferring (sliding) residents who have good sitting balance and are cooperative from one level surface to another, e.g., bed to wheelchair, wheelchair to car seat or toilet. Can also be used by residents who require limited assistance but need additional safety and support.

Points to Remember: Movable seats increase resident comfort and reduce incidence of tissue damage during transfer. More than one caregiver is needed to perform lateral transfer. Ensure clothing is present between the resident's skin and the transfer device. The seat may be cushioned with a small towel for comfort. May be uncomfortable for larger residents. Usually used in conjunction with gait belts for safety depending on resident status. Ensure boards have tapered ends, rounded edges, and appropriate weight capacity. Ensure wheels on bed or chair are locked and transfer surfaces are at same level. Remove lower bedrails from bed and remove arms and footrests from chairs as appropriate.

Transfer from Sitting to Standing Position

Description: Lift cushions and lift chairs



When to Use: Transferring residents who are weight-bearing and cooperative but need assistance when standing and ambulating. Can be used for independent residents who need an extra boost to stand.

Points to Remember: Lift cushions use a lever that activates a spring action to assist residents to rise up. Lift chairs are operated via a hand-held control that tilts forward slowly, raising the resident. Residents need to have physical and cognitive capacity to be able to operate lever or controls. Always ensure device is in good working order before use and is rated for the resident weight to be lifted. Can aid resident independence.

Transfer from Sitting to Standing Position

Description: Stand-assist devices can be fixed to bed or chair or be free-standing



When to Use: Transferring residents who are weight-bearing and cooperative and can pull themselves up from sitting to standing position. Can be used for independent residents who need extra support to stand.

Points to Remember: Check that device is stable before use and is rated for resident weight to be supported. Ensure frame is firmly attached to bed, or if it relies on mattress support that mattress is heavy enough to hold the frame. Can aid resident independence.

Weighing

Description: Scales with ramp to accommodate wheelchairs; portable-powered lift devices with built-in scales; beds with built-in scales.



When to Use: To reduce the need for additional transfer of partial- or non-weight-bearing or totally dependent residents to weighing device.

Points to Remember: Some wheelchair scales can accommodate larger wheelchairs. Built-in bed scales may increase weight of the bed and prevent it from lowering to appropriate work heights.

