Musculoskeletal Injury Prevention Program

Safe Resident Handling Workshop

Participant's Manual

03/17/15
Vision
Incident free workplaces.

Mission
To create safe workplaces through the provision of education, leadership & collaboration.

Values
- Value safe work, and safe work behaviors.
- Value the right of each worker to have a safe, healthy and incident free work environment.
- Value members’ input, feedback and direction.

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Safe Resident Handling Workshop Introduction

Health care facilities have struggled with reducing worker injuries related to resident handling. While it is true, there are many devices and equipment that can help to reduce the amount of effort required for resident handling, there is still some physical effort required to move, steady or position the resident. If the resident handling tasks are not designed properly, or we use poor body mechanics, the risk of injury is increased. The incidence of Musculoskeletal Injury (MSI) in our industry has driven up costs to facilities, and adversely affected workers’ day-to-day activities.

What is a Musculoskeletal Injury (MSI)?

A MSI is an injury or disorder of the muscles, tendons, ligaments, joints, nerves, blood vessels, or related soft tissues including sprains, strains and inflammation that may be caused or aggravated by work.

With the increased costs to health care facilities, organizations must become proactive to reduce the frequency and severity rates of injuries. By having a Musculoskeletal Injury Prevention (MIP) program in your continuing care facility, you should expect to see:

Reduced:
• Injury rates
• Recruitment costs
• Overtime

Increased:
• Worker morale
• Productivity
• Positive reputation of the facility
• Reporting of hazards and incidents.
Other factors influencing health care facilities to incorporate an MIP program into their facilities are:

- Alberta Occupational Health and Safety Act, Regulation, and Code
- WCB (what is the facility paying in direct and indirect costs associated with MSI?)
- Insurance companies
- Ethical issues

The “No Unsafe Lift Workbook” produced by Work Safe AB provides a list of common “critical” features of ‘best practice’ Musculoskeletal Injury Reduction Prevention Programs. These features include:

- Management Commitment – Policies and Promotion
- Employee Participation
- Coordination
- Risk Assessment
- Biomechanical considerations
- Training
- Communication
- Area Design Considerations

This workshop discusses many of these features, while CCSA’s Injury Reduction Program (IRP) provides support for some of the other features.

The five primary outcomes expected of this program are:

1. Implement “Best Practices” into existing systems or develop a system to reduce musculoskeletal injuries
2. Provide the knowledge and skills to practice and implement the Musculoskeletal Injury Prevention (MIP) program
3. Provide tools and resources to assist the facilities in implementing, monitoring and maintaining the MIP program.
4. Provide a framework for the development of programs for facilities that face challenges in this area.
5. Identify specific needs in relation to MIP issues

Resident handling tasks are a significant cause of back, shoulder, other muscle pains/strains, incidents and slip/trip/fall injuries in all workplaces. Well-designed workplaces and resident handling tasks allow staff to not only work more safely, with less chance of experiencing a resident handling related injury; but they also allow work to be performed more effectively, efficiently, and productively.
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Safe Resident Handling Learning Objectives

By the end of this workshop, you will be able to:

1. Discuss why organizations should consider implementing a musculoskeletal injury reduction program (intro)
2. Identify the potential impact of resident handling tasks on your body (Module 1)
3. Describe what safe resident handling is and why it is important (Module 1)
4. Recognize the signs and symptoms of musculoskeletal injury in yourself and your co-workers (Module 1)
5. Identify resident handling-related hazards in your workplace (Module 2)
6. Explain why and how poor design contributes to MSI (Module 2)
7. Adapt the principles of safe lifting to resident handling situations (Module 3)
8. Correctly demonstrate each of the safe resident handling techniques presented in this workshop (Module 4)
9. Adapt the safe resident handling techniques to your daily resident handling tasks (Module 4)
10. Explain how to make simple changes to the design and organization of resident handling tasks to improve your health and well-being! (Module 4)
Exercise 1: Ice Breaker

Timeframe: 5-10 minutes

Instructions:

➢ Your instructor will introduce a warm up/introductory exercise based on the number of participants.

➢ The purpose of the warm up exercise is to:
   - Get to know each other;
   - ‘Break the ice’ – the CCSA courses are designed to include a lot of participation and interaction; breaking the ice early helps to create a safe & comfortable learning environment.
Module 1: Your Job Your Body

Like cars, our bodies have an engine (our heart and lungs) and gears (our muscles) that when healthy allow us to do many different tasks at work.

Our bodies are most happy when they are in motion using the engine and gears to their full potential. But like a car, our body’s engine and gears also have limits. Understanding our body’s limits will help you understand and recognize things that can injure you.

The following section will inform you about:

- Muscles and joints
- Body parts used in moving residents
- Safe and unsafe ways to use these body parts

Muscles, Tendons and Ligaments

Our muscles are the gears that allow our bodies to move and do work. Muscles do not work alone. Tendons and ligaments are the nuts and bolts that help our muscles do the work. Muscles are connected to bone by tendons and bones are held together by ligaments.

Most of the work done by our body is shared between our muscles, tendons and ligaments. Larger muscle groups (e.g. the muscles in our legs) are able to work longer and harder than some of our smaller muscle groups (e.g. the muscles in our shoulders). Smaller muscle groups are usually the first muscles to get injured. Two of the most frequently injured body parts are our backs and shoulders.

Next we’ll review these body parts and then take a look at some simple ways of keeping them safe using proper body mechanics.
The Back

Our back and spine have 24 bones called vertebrae spread out over four regions:

1. Cervical
2. Thoracic
3. Lumbar
4. Sacral

The bones protect the spinal cord. They also provide a place for muscles in our back to attach to. Our back has a natural curvature. We should try to keep this natural shape when we do work. Keeping the natural shape of our back helps us complete resident handling tasks safely. Tasks are safer because we reduce the amount of work our muscles, tendons and ligaments have to do.

Our head weighs about 10 pounds. When we are working with residents the best place for our head to be is in line with our shoulders. When we get in the habit of looking down when handling residents our head can add 30+ pounds of weight on our neck and back which puts these body parts in greater danger of being injured.

Source:
The opposite of your back’s natural shape (or neutral posture) is an “awkward posture.” Awkward postures move away from your neutral posture toward the extremes in range of motion. This puts more stress on your musculoskeletal system and is a contributing risk factor for Musculoskeletal Injuries (MSIs) and should be avoided.

What is the difference between a neutral back posture and awkward postures?

*Image source: http://ergo-plus.com/fundamental-ergonomic-principles/*
The Shoulder

Shoulder MSIs are associated with postures that place heavy loads on its muscles and tendons. The shoulder has the greatest range of motion of any joint in the body. In addition, your arms provide very long levers. Both of these details mean that even holding even a small load in your hand with the arm held away from the body will quickly result in shoulder fatigue and discomfort, and place substantial stress on the tendons in the shoulder.

What is the difference between neutral shoulder postures and awkward postures?

Power Position

What is the “Power Zone”?

The power zone for lifting is close to the body, between mid-thigh and mid-chest height. This zone is where the arms and back can lift the most, with the least amount of effort.

The “hand shake zone” or “comfort zone” are other common names for the power zone. The principle here is that if you can “shake hands with your work”, you are minimizing excessive reach and maintaining a neutral posture.

Working from the power zone ensures that you are working within proper heights and reaches, which reduces MSI risk factors and allows for more efficient and pain-free work.

Image source: http://ergo-plus.com/fundamental-ergonomic-principles/

How do you ensure you are working within the power zone when performing resident handling tasks?

To ensure you are working within your power zone when performing resident handling tasks, use the “Power Position.”

To get into the power position:

> Get as close to the resident as possible;
> Keep your elbows close to your sides
> Use wide ‘palms up’ grip
- Keep your lower arms at or close to 90 degrees to your upper arms throughout the task.

- Bend your knees and use the big muscles in your butt and thighs;
- Keep your head up.

How do you ensure you achieve the power position before and during resident handling tasks?

Before and during resident handling tasks ask yourself:

- What is my head doing?
- What are my arms doing?
- What are my legs doing?
Often we do not achieve this “power position”. Sometimes, it is because we use the wrong type of grip. Other times, it may be because we do not use the right equipment or we do not adjust the resident's position in his/her bed or chair to allow us to work within our power zone.

Consider the principles discussed above. Which picture looks like the staff are using the power position principles? Why?
An Introduction to Musculoskeletal Injury Prevention

Successful implementation of an MIP program begins with a common understanding of a musculoskeletal injury.

What is a musculoskeletal Injury (MSI)?

A MSI is an injury or disorder of the muscles, tendons, ligaments, joints, nerves, blood vessels or related soft tissues including sprains, strains and inflammation; work activities may cause or aggravate these injuries.

Other terms used to describe musculoskeletal injuries include:

- Sprains and strains
- Musculoskeletal Disorders (MSDs)
- Cumulative Trauma Disorders (CTDs)
- Repetitive Strain Injuries (RSIs)
- Overexertion injuries
- Soft tissue injuries
- Work related musculoskeletal injuries (WRMS)

They all mean the same thing!
Understanding Musculoskeletal Injuries

There are two ways to categorize MSI:

- **Category 1: Overexertion MSI (2 types)**
  1. **Strains:** Generally caused by a one-time exertion that tears a tendon and or a muscle.
  2. **Sprains:** Generally caused by a one-time exertion that tears a ligament.

An overexertion injury occurs when a person works beyond his or her physical capacity or, more specifically, when the physical forces required to perform a task exceed what the body is capable of doing. These types of injuries have been associated with lifting, bending at the waist with twisting, pushing/pulling, carrying, slips/trips/falls and reaching.

- **Category 2: Overuse MSI**
  - Examples include back pain, tendinitis, carpal tunnel syndrome, tennis elbow, etc.
  - These injuries are a result of exposure to a repeated type of physical activity resulting in inflamed tendons or ligaments.
  - Overuse MSIs gradually occur over time and may be ignored until they become chronic.
Recognizing the Signs and Symptoms

There are often signs and symptoms that come before an injury occurs and long before any missed work. It is very important that everyone (managers, supervisors, workers, etc.) is aware of the signs and is keeping a “look out” for:

- Reports/complaints of numbness, tingling, joint stiffness, etc.
- Stretching or rubbing muscles while working
- Quality problems, errors
- High turnover or absenteeism
- Damage to equipment/materials/property
- Etc.

Early Reporting

One of the keys to managing MSIs is to encourage a system of early reporting. It is important to report early signs and symptoms because:

- Continuing to work with an injured body part can affect other parts of the body and compound the situation.
- If left untreated, symptoms can become chronic and can lead to a disability.
- Early treatment of an injury can prevent lost time from the work place.
- It may help keep a co-worker injury free.

It is especially important to report signs and/or symptoms if the:

- Pain is persistent, severe or worsening.
- Pain radiates.
- Symptoms keep you from sleeping at night.
Legal Requirements

Employers and workers have responsibilities for workplace health and safety as specified in the Alberta Occupational Health and Safety Act, Section 2(1) and (2). These are briefly:

**EMPLOYERS:** To ensure, as far as it is reasonably practicable, the health and safety of all workers at the worksite and that all workers are aware of their responsibilities and duties under the OHS Act, Regulation and Code.

**WORKERS:** To take reasonable care to protect the health and safety of themselves and other workers, and to cooperate with the employer to protect the health and safety of themselves and other workers.

The Alberta Occupational Health and Safety Code refer to MSI prevention in several parts and/or sections of legislation. Below is a summary of the legislation, however the detailed legislation quoted from the Alberta Occupational Health and Safety Act, Code and Regulation can be found in Appendix 1.

**Alberta OH & S Code, Part 2, Hazard Assessment, Elimination and Control**

An employer must assess a worksite to identify hazards or risks associated with jobs performed. This assessment must be documented, dated and updated at regular intervals. Employers must involve workers in this assessment; implement controls for the hazards identified; and, inform workers of the methods in the workplace provided to keep them safe.

For healthcare workers especially, the risk of MSI is one of the largest hazards we face in the workplace. It is important to ensure a thorough assessment of MSI risk factors and train workers in the various methods of control available in order to keep them safe.

**Alberta OH & S Code, Part 14, Lifting and Handling Loads**

NOTE: for the purposes of the following, a heavy or awkward load includes equipment, goods, supplies, persons and animals. *(AB OHS Code, Part 14, Section 208(4))*

**Assessing Hazards** – When workers are required to perform resident handling tasks in the workplace, the employer is required to perform a hazard assessment that considers the weight, size, shape, number of times the load will be moved and the manner in which the load will be moved. Additionally, the hazard assessment should consider the worker’s physical and mental capabilities to perform the work.

**Equipment** - An employer must provide and ensure workers are using the appropriate equipment for resident handling tasks. Workers are required to use the equipment the employer provides.

**Safe Lifting Program** – There is a requirement for an employer to develop and implement a safe resident handling program when workers are required to lift, transfer or reposition residents. This safe resident
handling program must include an annual evaluation of its effectiveness. An employer also must ensure that workers comply with the program and in turn, workers are required to follow it.

Employers are required to train all workers who are at risk of MSI in order to prevent these injuries. This training must include the identification factors that could lead to an MSI injury, the early signs and symptoms of MSI injuries and preventative measures including safe work procedures, mechanical aides and personal protective equipment.

**Reporting MSI** – If a worker reports to their employer that they believe they have symptoms of an MSI, the employer is required to review the activities of that worker and also any other workers doing similar tasks to identify if there are any work related causes. If it is found that there are work-related causes the employer must take corrective measures to avoid further injuries.
Module 2: Resident Handling Hazards


This module helps you make your workplace safer by helping you identify unsafe resident handling situations that may result in a MSI injury.

Module Objectives

At the end of this module, you should be able to:

1) List the four key resident handling risk factors.
2) Identify resident handling-related hazards.
3) Perform an informal hazard assessment before performing resident handling tasks.
4) Report resident handling-related hazards.
What causes MSI?

Recognizing what causes MSI injuries is perhaps the biggest challenge for front-line workers and organizations. The reason is that some workplace hazards are easy to spot (i.e. electrical cords strung across the floor, transitions between different flooring spaces, spills on the floor, torn or frayed slings, etc.). However, most hazards are not easy to recognize and more often than not relate directly to work design or the way work is carried out!

A hazard is “a situation, condition or thing that may be dangerous to the health and safety of workers.” A hazard has the potential to cause an injury, illness or loss. Some people think of a hazard as “an incident waiting to happen”. Potential hazards are those that are foreseeable and reasonably likely to occur.

What are situations, conditions or behaviours that may expose workers to MSI risks?

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<th>Conditions</th>
<th>Behaviours</th>
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<td>State of the workplace environment.</td>
<td>The way that workers perform their tasks.</td>
</tr>
<tr>
<td>Examples include:</td>
<td>Examples include:</td>
<td>Examples include:</td>
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<tr>
<td>- Lack of appropriate resident handling equipment</td>
<td>- Clutter</td>
<td>- Not asking or offering help when needed</td>
</tr>
<tr>
<td>- Resident’s current mental and physical capabilities</td>
<td>- Wet floors</td>
<td>- Not using resident handling equipment or devices</td>
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<td>- Working short staffed</td>
<td>- Icy sidewalks</td>
<td>- Working outside of your power zone</td>
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<td>- Poor lighting</td>
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<td>- Lack of space</td>
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Understanding and Identifying Resident Handling Hazards

The following is adapted from the Work Safe Alberta “No Unsafe Lift Workbook” and the Work Safe BC “Handle with Care: Patient Handling and the Application of Ergonomics (MSI) Requirements” manual.

Alberta OH&S legislation requires the assessment and control of workplace hazards. For resident handling tasks, the assessment should not be a one-time static assessment; rather these tasks require frequent review of staff, task, equipment, environment and resident variables. An effective Safe Resident Handling Program assists in providing a systematic approach to assess risk. Consider four key risk factor groups to determine what procedures or equipment to use for resident handling tasks. These include:

1. Physical Demands

The risk factors associated with the physical demands of the task include: force, repetition, duration and work postures. Eliminating or minimizing these risk factors will reduce the risk of MSI.

   Force

   Refers to the effort required by your muscles and the amount of pressure on body parts because of different job demands. There are three basic types of force:
Repetition and Duration

Frequency of repetition (how often) and duration (how long) are important risk factors in resident handling activities. The risk of MSI increases with the frequency and length of time that workers are exposed to the MSI risk factors. Although the effort required to handle a single resident may be low, the cumulative effect of handling many residents during a shift may result in a greater risk than that associated with an occasional lift of a much heavier load.

Small muscles, such as hand muscles, often bear a considerable level of force and tire faster than larger muscles. Many care workers experience pain and discomfort in their wrist and shoulders because they lift and pull residents instead of transferring their own weight to achieve the transfer or reposition.

Some resident care activities that do not fall under the standard definition of repetition may in fact be repetitive. Examples include hand-cranking beds, assisting residents to dress and crushing resident medications. Implementing engineering or administrative controls can minimize these repetitive activities.
**Work Postures**

Work postures that require any part of the body to be positioned outside its neutral position (the position of optimal strength) are considered awkward postures. In general the more awkward the posture used, the greater the risk to the worker. When assessing resident handling tasks look for situations, conditions or behaviours that result in workers:

- **Handling loads away from the trunk of the body:**
  - Holding a load further away from the trunk of the body increases the level of stress placed on the lower back, regardless of the handling technique used.
  - Examples of resident handling tasks: moving a resident up in bed, transferring a resident from bed to chair or chair to bed, etc.

- **Handling loads in awkward, stooped postures:**
  - Stooping or bending over, particularly for prolonged periods, puts a lot of stress on the lower back.
  - Examples of resident handling tasks: raising a resident from supine to sitting position, repositioning a resident in a wheelchair, etc.

- **Twisting when lifting**
  - The effects of twisting are increased when combined with stooping or reaching and lifting.
  - This causes a high level of stress and poses a risk for MSI to the lower back.
  - Examples of resident handling tasks: repositioning the resident up in bed, transferring a resident to bed to chair or chair to bed, etc.

- **Static or fixed postures:**
  - Using awkward static postures for prolonged periods may increase the risk of cumulative injury.
  - Static postures may pose risks to the lower back, shoulders, elbows, and wrists.
  - Examples of resident handling tasks: supporting residents while providing personal care, supporting residents while toileting, etc.
2. Resident Characteristics

Working with residents presents considerably greater risk than lifting and handling boxes, equipment, etc. People feel pain, vary in size and shape and have various clinical needs. All of these factors will influence the way that you assist your residents. When assessing resident handling tasks, consider the following resident risk factors:

- **Communication**
  - Speech
  - Vision
  - Hearing
  - Understanding
  - Language barrier

- **Cognition**
  - Memory
  - Judgment
  - Concentration
  - Decision-making

- **Behavioural & Emotional Status**
  - Resistive
  - Unpredictable
  - Uncooperative
  - Depressive
  - Aggressive
  - Confused
  - Agitated

- **Medical Status**
  - Diagnosis
  - Devices
  - Pain level
  - Medication
  - Fatigue
  - Skin Integrity

- **Physical Status**
  - Weight
  - Height
  - Sensory abilities
  - Range of motion
  - Muscle strength
  - Muscle tone
  - Mobility and balance
  - Coordination
  - Weight-bearing

It is important to note that relatively light residents may pose just as much, if not more, risk to workers. When a resident is heavy, workers know they should use mechanical lifts or other transfer assist devices, along with getting assistance. Workers may not have the same appreciation of risk with lighter residents and may attempt to manually transfer them without appropriate handling equipment or without confirming the resident’s weight-bearing status. If the resident fails to weight-bear, it may result in injury to the worker.

Remember, the resident mobility assessment (completed at assessment and a regular intervals based on the organization’s internal procedures) identifies the level of assistance the resident requires. This information is typically included in the resident’s care plan and may be posted in the resident’s room for quick reference. Therefore, workers should follow the care plan unless their observations of the resident’s condition suggest it is unsafe to do so. In these situations, workers should inform their supervisors or the appropriate action should be taken to eliminate or minimize the risks. This may include reassessing the residents handling needs and updating the resident’s care plan.
3. Work Environment

Hazard (formal and informal) assessments must include characteristics of the work environment. This requires an assessment of the physical work environment, including aspects of the design of the workplace and equipment that could contribute to the risks of MSI.

- Here are examples of how the layout and condition of the work environment can affect the physical demands of resident handling:
  - Rooms, bathrooms, hallways and other spaces may be small or crowded, or may contain obstructions that prevent workers from using optimal postures.
  - Heights of resident transferring points such as beds, chairs or toilets may result in awkward postures.
- There may not be enough mechanical lifts, slide equipment or other transfer-assist devices to ensure that all workers have ready access to them.
- Manual cranks or hard-to-reach controls on beds, chairs or handling equipment may discourage workers from making the necessary adjustments, resulting in awkward postures or forceful exertions.
- Poorly maintained wheels may make moving and positioning beds and wheelchairs difficult.
- Missing or faulty brakes may cause beds or chairs to shift during transfers.
- Uneven or slippery floors may increase the risks of MSI.
- Poor lighting may disorient residents and result in residents or workers losing their footing.
- The position of beds and other furniture or equipment may not reflect the needs of the facility’s written handling procedures.
- Doorways may not be wide enough for equipment such as mechanical lifts.

4. Work Organization

The way in which work is organized can affect the risk of MSI. For example, jobs that involve frequent handling activities with little variation or many separate tasks with similar postures, such as washing and dressing a resident, may lead to chronic overuse of specific muscles increasing the risk of injury.

Current research indicates that the cumulative effects of heavy lifting in care environments poses a significant risk of chronic overuse and damage to the soft tissues of the lower back and other areas of the body.

Work organization risk assessments should consider such things as:

- Work recovery cycles
  - Work recovery cycles are opportunities to periodically rest body parts that perform physical activities.
  - Insufficient recovery time increases the risk of injury.
• Task variability
  o Tasks that are performed repeatedly over a prolonged period can result in overuse or stress of muscles or other soft tissues.
  o The longer workers perform tasks, the greater the risk of injury.

• Work rate
  o Work rate refers to the speed with which a task is carried out.
  o Excessive work rates lead to fatigue, poor technique and increased risk of injury.

Facilities can reduce risks by reorganizing work tasks. For example:

• Whenever possible, bring care to the resident rather than moving the resident.
• Improve planning and assessment to eliminate unnecessary resident handling (for example, by reducing the number of transfers required in a given activity).
• Spread handling tasks as evenly as practicable over the work shift and among staff.
• Expand jobs by increasing the variety of tasks each worker performs.
• Avoid designated bathing positions; as the staff allocated to these positions must complete the same repetitive tasks on a daily basis.
• Ensure that workers take adequate rest breaks. It is generally better to take frequent, shorter breaks than infrequent longer breaks. NOTE: a break in this context does not necessarily refer to stopping work; it may include periods of light duties or alternative task that enable stressed body parts to recover.

Additional risk factors to consider:

In addition to considering the elements in the four risk factor groups, consider the following additional risk factors:

Personal (Staff)

• Before starting a resident handling task, assess whether the task can be done safely for both the resident and staff. Consider:
  o Physical readiness to perform the task
    ▪ Am I properly warmed up, wearing proper footwear, etc.;
    ▪ How am I feeling today? Am I tired or sore?
    ▪ Do my co-workers or I have any injury or limitations that I need to be aware of?
      • Some workers may have personal limitations, such as pregnancy, that place them at greater risk of MSI.
      • Workers returning to work after an injury are at risk of re-injury. Disability prevention and return to work strategies should be employed allowing for modified work duties to help the work manage the injury while remaining productively employed.
Poor physical fitness can increase a worker’s risk of injury. Workers should be encouraged to maintain a good level of physical fitness.

However, even the fittest workers can sustain injuries when the physical demands of tasks or jobs exceed the strength and abilities of the worker.

- Do I need additional assistance from a co-worker or co-workers based on the key risk factors or my personal risk factors?
- Communication between caregivers assisting in the task is key,
  - What do I need to communicate to my co-workers and to the resident?
- What equipment do I need to use? Do I know how to properly use the equipment?

**Clothing**

It is important to wear clothing that is appropriate for performing resident handling activities.

- For example, some clothing may inhibit free worker movement or prevent the worker from getting close enough to the resident during handling activities.
- Adaptive resident clothing may make some resident care tasks easier. (for example, dressing and toileting)

So, how do these risk factors help you to identify resident handling hazards?

Unlike other risk assessments, resident handling risk assessments must take into account interdependent hazards that will affect the overall risk of the handling task. Resident handling risk assessments present the following challenges:

- Most handling procedures present multiple MSI risk factors that together increase the risk of injury.
- Without the use of specialized equipment, it is difficult to quantify the force and effort required to assist and move a person. The force or effort required by a worker changes from resident to resident, depending on the level of resident mobility.
- The functional ability of residents can change rapidly, which may significantly increase the MSI risk factors involved with the task.
- Assessing the physical demands of a task only addresses one group of risk factors involved with resident handling. Resident characteristics, work environment and work organization are also important. The emphasis on these other three groups of risk factors will depend on the specific handling situation.

**Source:** Work Safe BC “Handle with Care: Patient Handling and the Application of Ergonomics (MSI) Requirements”

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Source</th>
<th>Type of Hazard</th>
<th>Hazard</th>
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<tbody>
<tr>
<td>Physical Demands: Force</td>
<td>Equipment and</td>
<td>Physical</td>
<td>Awkward Posture</td>
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<tr>
<td>Work Environment</td>
<td>Environment</td>
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</tr>
<tr>
<td>Resident Characteristics</td>
<td>People</td>
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</tbody>
</table>
Identifying Resident Handling Hazards

What are the obvious risk factors in the above picture?
What are the obvious risk factors in the above picture?
IMPORTANT NOTE:

Remember, the resident mobility assessment (completed prior to or at admission and at regular intervals based on the organization’s internal procedures) identifies the level assistance the resident requires. This information is typically included in the resident’s care plan and posted in the resident’s room for quick reference. Therefore, workers should follow the resident’s care plan unless their observations of the resident’s condition suggest it is unsafe to do so. In these situations, workers should inform their supervisors or take the appropriate action to eliminate or minimize the risks. This may include reassessing the residents’ handling needs and updating the resident’s care plan.

Using the Safe Resident Handling Algorithms in Appendix 2 can help the caregiver decide which resident handling technique is appropriate based on the change in residents cognitive or physical status (i.e. weight-bearing ability) observed during the pre-task assessment, until the resident can be re-assessed.
Module 3: Principles of Safe Lifting

The following principles should form the basis for every safe resident handling task:

![The 8 Principles of Safe Lifting](image)

Module Objectives

At the end of this module, you should be able to:

1. List the eight principles of safe lifting.
2. Describe how the eight principles of safe lifting apply to resident handling.
3. Adapt the principles of safe lifting to resident handling situations.
4. Recognize when a resident handling task may need to be adjusted based on the principles of safe lifting.
1. Plan Your Move!

Assess the Resident.

- A resident’s body and mind can change during the day.
  - Before you assist a resident you should:
    - Review your facility’s resident information system (assessment form, care plan, etc.); and,
    - Observe & assess the resident's current status.
  - This information should give you an assessment of the ability of the resident to:
    - Provide assistance
    - Weight bear
    - Cooperate and follow instructions (are they uncooperative?)
    - Upper extremity strength of the resident (how strong are they?)
    - Resident height and weight (how tall? how heavy?)

Assess the work area.

- Look at the layout of the room and decide if you have enough room to move the resident and equipment safely.

Assess the need for help or assistance.

- Do you need help? If the task you are about to do looks like it will be difficult then it probably is; which means you should not attempt to perform the task alone. Get the help you need from a co-worker or obtain the proper equipment.

Assess the equipment needs

- Ask yourself: what equipment do I need? Is it located nearby? Then you must check the equipment prior to performing the resident handling task to determine if the equipment is working properly or not.
2. Strong Foundation

Your largest and strongest muscles are in your butt and legs. Using these muscles to build a strong base of support will reduce your effort and increase your safety.

To ensure you are in a strong foundation:

- place your feet at least shoulder-width apart; and,
- drop your butt into a squat position.

3. Your Centre of Gravity

Your body has a centre of gravity, located somewhere between your stomach and your hips. The weight of your body is evenly distributed and balanced around the centre of gravity.

You should always try to achieve postures that keep you in balance over your centre of gravity. This will help you stabilize your body and protect your smaller muscle groups. Now you can focus on using your larger muscles for resident handling tasks.

A key part of maintaining this balance is to keep your head up and the resident close to your centre of gravity. This provides a greater amount of protection from injury to your back.
4. Big Jobs Call for Big Muscles

Remember: safe resident handling tasks are big jobs that require the use of big muscles, “Big Jobs = Big Muscles”

For every resident handling activity, focus on using the big muscles in your legs and butt:

- Remember to create a **Strong Foundation** and to **Stay In Balance**;
- Avoid using smaller muscle groups in your neck, upper back and arms;
- If you are working alone adjust the equipment so that the resident is located at or close to your upper thighs;
- If you are working with a partner who is shorter than you adjust the equipment so that the resident is at or close to their upper thighs;
- People can’t grow, but tall people can “shrink”

5. Get a Grip!

Using a power grip with your palms up will reduce your effort and the risk of injury.

Pretend you are going to shake someone’s hand…now make a fist…this is what is called a power grip. When gripping equipment and materials you should always try to maintain a power grip. A power grip with your palms up improves shoulder posture, while making use of larger muscle groups.
6. Reduce Friction

Friction is the resistance to motion. When surfaces rub together, more effort is required to move or reposition the resident. Bedding rubbing against a resident's clothing; or, soaker pads rubbing against the bedding creates friction. When these surfaces rub together during a resident transfer or reposition task you have to work harder. This extra effort can increase your risk of injury.

Transfer sheets, when used properly, can significantly reduce the amount of extra effort you will need to exert. By doing so, they increase your safety.

Friction can also be reduced when the resident helps out; so, don’t forget to have the resident assist as much as they are capable of.

7. Communicate!

- With your co-worker
  - Talk to your co-worker about the move
  - Decide who will count down the move & on what count the move will happen
- With your resident
  - Let the resident know what you’re doing
  - Check in with the resident before, during and after the move
- Report errors, near misses and mistakes
  - Using your organization’s hazard reporting procedure
  - Discuss alternate approaches for residents
- Report equipment malfunctions
  - Using your organization’s maintenance log or lock out/tag out procedure
  - Let your supervisor and co-workers know if you’ve reported equipment that’s not working properly or that isn’t appropriate (i.e. not the right capacity, not the right type of slings, etc.)
- Keep the resident assessment form updated
  - Note any changes in the resident’s condition
8. Stick to the Script

You should try to apply the principles of safe resident handling to every situation.

Consistently apply them and they will become second nature to you.
Module 4: Safe Resident Handling Techniques

Overview

Now that we have an understanding of the hazards that are involved in resident handling tasks, and we’ve had a chance to practice identifying those hazards; let’s take a look at the safe resident handling techniques that can be used to safety assist residents.

Module Objectives

At the end of this module, you should be able to:

1) identify unsafe resident handling situations that may result in an injury.
2) select resident handling equipment appropriate to the resident and the environment.
3) perform the safe resident handling techniques to safely move or transfer a resident in your care.
4) apply or adapt the safe resident handling techniques to various resident handling situations in your workplace.

We will be reviewing the following techniques during this presentation:

Bed Mobility
- rolling resident in bed
- lateral slide using a slider sheet
- boosting or repositioning resident
- supine-to-sit
- sit-to-stand

Lifts
- sit-stand lift
- resident lift

Transfers (Bed to Chair; Chair to Toilet; Chair to Chair; etc.)
- 1-person transfer
- 2-person transfer

Assisted Mobility
- assisting resident to walk
- assisting resident when falling
- managing and assessing a fallen resident
- coaching an uninjured, fallen resident
- repositioning resident in a wheelchair
Bed Mobility:

Rolling Resident 1 Caregiver – Bent Legs

1. Lower the bed rail closest to you. Keep the other one up for resident safety and to allow the resident to assist if possible.

2. Ask the resident to bend either one or both of their knees so that their foot or feet are flat on the bed.
   - If the resident is not able to bend their knees themselves, or requires some assistance, assist the resident by remembering to position yourself by the resident’s knees instead of reaching away from your body.

3. Next, to reduce strain on your lower back, reposition the height of the bed so that you are able to use your legs to roll the resident (mid-thigh height). Two options are available to you based on your comfort level, they are as follows:
   i. Place one knee on the bed ensuring that your hips are level. You may need to raise or lower the bed until this position is achieved.
   ii. Firmly place both feet on the floor in a staggered stance (one foot in front of the other), toes pointed in the direction of the roll.

4. Ask the resident to cross their arms over their body (give themselves a hug). This will make the rolling motion easier to perform since the arm will not get caught during the motion.

5. With elbows close to the body and hands placed out to the side, place one hand under (cupping) the resident’s shoulder and the other hand under (cupping) the resident’s hip / upper thigh;

6. Push gently on resident’s thigh and shoulder; they should roll over with very little effort.
   - The resident should be doing most of the work you are there simply to provide support and guide the resident while they are rolling on to their side.
7. To return the resident to the start position:
   - Use the same technique but with a lowering motion instead of a pushing motion.
   *Remember*, with resident’s knees up and arms crossed, very little effort is required.

**Rolling Resident 1 Caregiver – Straight Legs**

1. Lower the bed rail closest to you. Keep the other one up, for resident safety and to allow the resident to assist if possible.

2. Ask the resident to cross their leg closest to you over their other leg.
   - If the resident is not able to cross one leg over the other on their own or requires some assistance, assist the resident by remembering to position yourself by the resident’s feet, instead of reaching away from your body, to cross the top leg in the direction of the roll.

3. Follow the same rolling procedure steps 2 through 7 as in the “rolling resident 1 caregiver – bent legs” technique.
Rolling Resident 2 Caregivers – Straight Legs

1. Since two caregivers are involved in this technique, \textit{communication is key}. Prior to performing the technique both caregivers need to discuss who will be performing each role. One caregiver will be required to roll the resident while the other caregiver will need to steady the resident.

2. Lower both bed rails.

3. Next, to reduce strain on the lower back the caregiver rolling will need to reposition the height of the bed so that they are able to use their legs to roll the resident (approx. mid-thigh height). If the worker holding the resident is taller, they would need to bend their knees to adjust to the height difference without bending at the waist. Two options are available to the caregiver rolling the resident based on comfort level; they are as follows:
   \begin{enumerate}
     \item Place one knee on the bed ensuring that your hips are level. You may need to raise or lower the bed until this position is achieved.
     \item Firmly place both feet on the floor in a staggered stance, toes pointed in the direction of the roll.
   \end{enumerate}

4. Ask the resident to cross their arms over their body (give themselves a hug). This will make the rolling motion easier to perform since the arm will not get caught during the motion. If resident is fearful the second caregiver is there to comfort and reassure the resident during the motion.

5. With elbows close to the body and hands placed out to the side, place one hand under (cupping) the resident’s shoulder and the other hand under (cupping) the resident’s hip;

6. Using your legs, push gently on resident’s hip and shoulder; they should roll over with very little upper body effort.
   \begin{itemize}
     \item Should the resident require more effort, use a small rocking motion with the legs to assist with the rolling momentum. Remember to count off (1-2-3) so that both your co-worker and the resident are aware of when the motion will be occurring.
   \end{itemize}

7. Once the rolling motion is complete, the second caregiver will steady the resident.

8. To return the resident to the start position
   \begin{itemize}
     \item Use the same technique but with a lowering motion instead of a rolling motion.
Bed Mobility:

Lateral Slide Using Slider Sheet – Two-Person Task

1. Since two caregivers are involved in this technique, *communication is key*. Prior to performing the technique both caregivers need to discuss who will be performing each role,
   i. positioning of the slider sheet
   ii. lateral slide

2. Lower the bed rails;

3. Adjust the bed height to upper thigh height of the shortest caregiver;

4. Position the slider sheet underneath the resident, using the proper rolling technique with 2 caregivers. To position the slider sheet,
   - One caregiver will need to gently roll the resident towards the other caregiver. The person rolling the resident can now tuck the slider sheet above the resident's shoulders to past their bottom, and push the slider sheet under the resident, lengthwise. Once slider is tucked as far under the resident as possible, gently roll the resident back into the start position
   - The caregiver who steadied the resident will now gently roll the resident towards the other caregiver. The person now rolling will pull the slider sheet through into position. Then roll the resident back to the start position.

5. The caregiver who is pulling the resident towards them uses a power grip (palms facing up, wrists as straight as possible) on the slider sheet handles or rolls the slider sheet up to create a handle
   - **Remember** that this is *not* a pulling motion with your shoulders but rather a sliding motion with your legs. Arms need to stay locked and knuckles remain on the bed for the duration of the movement;
6. The caregiver who is pushing the resident away from them, will place one hand on the resident’s shoulder and their other hand cupping the resident’s upper thigh/buttocks while ensuring the fabric of the slider sheet is between their hands and the resident;

7. One caregiver should count off (1-2-3) while both caregivers prepare to coordinate the push/pull movement; perform the movement on third count.

**Bed Mobility**

**Boosting or Repositioning Resident with Slider Sheet or Soaker Pad**

1. Since two caregivers are involved in this technique, *communication is key*. Prior to performing the technique both caregivers need to discuss who will be performing each role for the tasks involved,
   i. positioning of the slider sheet
   ii. boosting/repositioning

2. Lower the bed rails;

3. Adjust the bed height to upper thigh height of the shortest caregiver;

4. Position the slider sheet underneath the resident, using the proper rolling technique with 2 caregivers. Again, *communication is key*; both caregivers need to determine who will be performing each task.
   To position the slider sheet,
   - One caregiver will need to gently roll the resident towards the other caregiver. The person rolling the resident can now tuck the slider sheet above the resident’s shoulders to past their bottom, and push the slider sheet under the resident, lengthwise. Once slider is tucked as far under the resident as possible gently roll the resident back into the start position
   - The caregiver who steadied the resident will now gently roll the resident towards the other caregiver. The person now rolling will pull the slider sheets through into position. Then roll the resident back to the start position.

5. Consider using a 1/3 (one-third), 2/3 (two-thirds) rule. Both caregivers would start their body positioning on the top 1/3 of the resident body then take a step out towards the resident’s lower 2/3. This body positioning will ensure that the caregivers will not be over extending with their shoulders to complete the boost.
6. Use a power grip (palms facing up, wrists as straight as possible) on the slider sheet handles or roll the slider sheet up to create a handle;

7. One caregiver should count off (1-2-3) while both caregivers rock back and forth (shift in weight from one leg to the other) in the direction of the boost 3 times, in unison; and complete the sliding movement on the third count.
   - The goal is to “slide” and not “lift” the resident during the movement. Having your arms locked and knuckles sliding on the bed will help to slide rather than lift.

8. If appropriate, use the Trendelenburg position (the head of the bed is lowered slightly) to reduce resistance and thus strain on your back and shoulders;

9. Use the safe resident handling principles to conduct this bed reposition, safely and correctly.
Important considerations when using a soaker pad for boosting or repositioning:

**IMPORTANT NOTE:**
Healthcare workers are using soaker pads to reposition (boost or turn) patients in bed, despite the risk of sprains or strains (musculoskeletal injury) to themselves. Soaker pads, also known as incontinence pads or bed pads, are designed to absorb urine in order to keep beds and linens dry, and protect residents’ skin. Soaker pads should only be used for their intended purpose—they are not meant for repositioning residents.

There are several concerns with using soaker pads to reposition patients in bed:
- Soaker pads are not designed for repositioning patients.
- Soaker pads do not have low friction properties—sliding them requires great effort.
- Soaker pads are small and positioned under the lower part of a patient's trunk and upper legs.
- The pads do not fully support the patient's trunk and shoulders, so using them for repositioning results in an unbalanced load and greater effort.


- Since more effort is required to boost or reposition a resident using a soaker pad, the principles of safe resident handling are critical, including:
  - Focus on small movements vs. trying to complete the slide all in one motion
  - Assess the resident, particularly for changes in physical or mental capabilities
  - Ask the resident to help as much as they can
  - Ensure there are two or more staff involved in the task
  - Really concentrate on sliding not lifting
  - Communicate with the resident and co-workers before and during the task
  - Use other techniques to get the resident in as ideal a position as possible before attempting to boost/reposition
  - Use gravity and the hospital bed to your advantage – raise or lower the residents trunk or feet in the direction of the move
  - Use your big muscles in your butt and legs – focus on shifting your weight instead of using your arms and back
  - Consider using a mechanical lift – particularly if there has been a change in the resident’s condition and/or there is a significant size difference between you and the resident
Bed Mobility:

Supine to Sit: One Caregiver – Bent Knee

*Before you begin any transfer, be aware of any conditions a resident may have that would prevent a successful transfer, such as a weak side due to a stroke or recent injury. Remember always transfer a resident toward their stronger side.*

1. Adjust bed height so that when resident is in the seated position their feet will be able to touch the floor;

2. If the resident’s condition permits, raise the head of the bed until the resident is in an upright position. 
   - This will make the transfer safer for your back.

3. Lower the bed rail closest to you. Ask the resident to raise their knees. If necessary, assist the resident to raise their knees, one at a time, towards the resident’s chest.

4. For proper upper body positioning slide one hand down the resident’s back until it is between their shoulder blades (not across their shoulders); and place the other hand on the resident’s knees or upper thigh;

![Image of caregivers assisting resident]

5. For proper lower body positioning create an open stance, foot closest to the resident’s head pointing towards the bed while foot closest to the resident’s feet is open. *See picture below*
   - Remember: position your feet so that there is enough room to allow for the resident's feet come down and not collide into you. 
   - Think: hips in line with your upper body.
6. To assist the resident into the sitting position, first communicate with resident how and what they will be assisting with (such as “On “3” I want you to help by pushing up,” etc.) and begin the 1-2-3 count.

7. On “3”, gently move the resident’s knees towards you off of the bed, rotating their legs and hips. At the same time pivoting the foot closest to the head of the bed so that you are not twisting at the waist. **Think:** Toes follow your nose

8. Finish the transfer by being close to the resident providing any needed support and allowing the resident time to stabilize.

**Supine to Sit: One Caregiver – Straight Leg**

*Before you begin any transfer, be aware of any conditions a resident may have that would prevent a successful transfer such as a weak side due to a stroke or recent injury. Remember always transfer a resident toward their stronger side.*

1. Adjust bed height so that when resident is in the seated position their feet will be able to touch the floor;

2. If the resident’s condition permits, raise the head of the bed until the resident is in an upright position.
   - This will make the transfer safer for your back.

3. Lower the bed rail closest to you. Ask the resident to bring their feet towards the edge of the bed. If necessary, assist the resident to bring their feet towards the edge of the bed.

4. For proper upper body positioning, slide one hand down the resident’s back until it is between their shoulder blades (not across their shoulders); and place the other hand on the resident’s upper thigh;

5. For proper lower body positioning, create an open stance, foot closest to the resident’s head pointing towards the bed while foot closest to the resident’s feet is open.
   - **Remember:** position your feet so that there is enough room to allow for the residents feet to come down and not collide into you. **Think:** hips in line with your upper body.

6. To assist the resident into the sitting position, first communicate with resident how and what they will be assisting with (such as “On “3” I want you to help by pushing up,” etc.) and begin the 1-2-3 count.

7. On “3”, gently move the resident’s knees towards you off of the bed, rotating their legs and hips, while at the same time pivoting the foot closest to the head of the bed so that you are not twisting at the waist. **Think:** Toes follow your nose

8. Finish the transfer by being close to the resident, providing any needed support and allowing the resident time to stabilize.
Bed Mobility:

Supine to Sit: Two Caregivers

*Before you begin any transfer, be aware of any conditions a resident may have that would prevent a successful transfer such as a weak side due to a stroke or recent injury. Remember always transfer a resident toward their stronger side.*

1. Since two caregivers are involved in this technique, communication is key. Prior to performing the technique, both caregivers need to discuss who will be performing each role for the tasks involved:
   i. Head and Torso caregiver (lead caregiver)
   ii. Lower body caregiver
2. If the resident’s condition permits, raise the top of the bed until the resident is upright position.
   o This will make the transfer safer for your back.

**Caregiver # 1: Head and Torso (lead caregiver)**

1. Slide one hand down the resident’s back until it is between their shoulder blades (not across their shoulders); and place the other hand on the resident’s upper thigh;
2. Coordinate movement with co-worker using 1-2-3 count.
3. On the count of “3”, cue the resident to push up off the bed while you guide and support the resident’s trunk with your arm that is behind their back and gently pull their outside hip with your other hand;
   - **Remember:**
     - Ensure your stance is open in the direction of the movement and that you have created enough room for your co-worker to bring the legs down.
4. Finish the transfer by sitting beside the resident providing support as needed; allowing the resident to time to stabilize.

**Caregiver # 2 (Lower Body)**

1. Gently grasp the resident’s lower legs (or ankles),
2. On the count of “3”, in coordination with caregiver # 1, gently guide the residents’ feet to the floor.
   - **Remember:**
     - Ensure your stance is open in the direction of the movement and that you have created enough room for you to bring the legs down without hitting you.
3. Finish the transfer by squatting; allowing the resident to time to stabilize.
Bed Mobility:

Sit-to-Stand:

1. Adjust the height of bed so resident can reach the floor with their feet.
2. If resident is in wheelchair, ensure the brakes are on, swing footrests away, and have resident place feet flat on the floor.
3. Apply transfer belt around resident’s waist.
   - **Remember:** the transfer belt needs to be snug so that it will not move during the transfer, you should be just able to get your fingers in to grip the belt
4. Ask the resident to move to edge of bed/chair, knees over toes.
5. Ask resident to place hands on armrests, the bed or their thighs in preparation to push off.
6. Position self in front of resident, with a foot between the resident’s feet. If moving into a transfer right away remember to use the foot that will allow you to have an open stance in the direction you wish to move. Hips square to resident, knees bent, position yourself close to the resident; chin over shoulder.
7. Grasp transfer belt using the power grip (palms up) with neutral wrist position. Ensure your elbows are bent and tucked into your sides.
8. Ask resident to lean forward so nose over toes.
9. On specified count, ask resident to help by pushing with their arms and legs. Guide the resident to the standing position.
   - **Remember:** Resident needs to be able to stand independently; you are there for guidance, this is not a lift!
10. Once standing, remain close to the resident and allow resident time to steady themselves and prepare stance for walking, transferring, etc.

When Do You Need Help?

- If the resident is impulsive or uncooperative.
- If the resident cannot weight bear or is unsteady and does not have upper body strength.
- If you feel the transfer is unsafe or lifting is involved use a resident lift, or a ceiling lift.
One Person Transfer

Bed to Chair; Chair to Bed; Chair to Chair

Before you begin any transfer, be aware of any conditions a resident may have that would prevent a successful transfer such as a weak side due to a stroke or recent injury. Remember always transfer a resident toward their stronger side.

For a successful transfer, communication between caregiver and resident is critical. Since caregiver is there solely for guidance and safety purposes, it is essential that resident is aware of when and what they are to do during the transfer so caregiver's safety is optimized.

1. Determine resident's strong side;
2. Position target (chair/wheelchair/bed) at 90º to resident's strong side;
   - If using a wheelchair, remove foot rest closest to the resident, and apply brakes;
3. Apply transfer belt around resident’s waist.
   - Remember: the transfer belt needs to be snug so that it will not move during the transfer, you should be just able to get your fingers in to grip the belt
4. Raise the bed until the resident’s hips are slightly higher than their knees (with their feet flat on the floor).
5. Ask the resident to move to edge of the bed/chair, so that the resident’s knees are over their toes
6. Ask the resident to place their hands on the armrests, the bed or their thighs in preparation to push off, if possible;
7. Position self in front of resident using a staggered stance, with one foot between the resident’s feet. Hips square to resident, knees bent. Position yourself close to the resident, with your chin over the resident’s shoulder.
   - If transferring to the left, position your right foot between resident’s legs;
   - If transferring to the right, position your left foot between resident’s legs.
8. Grasp transfer belt using the power grip (palms up) with neutral wrist position. Elbows are bent and tucked into sides.
9. Ask the resident to lean forward so their nose is over their toes;
10. On specified count, ask resident to help by pushing with their arms and legs. Guide the resident to the standing position.
    - Remember: Resident needs to be able to stand independently; you are there for guidance, this is not a lift!
11. Once standing, remain close to the resident and allow resident time to steady themselves and prepare stance for walking, transferring, etc.
12. Assist the resident towards the target by shuffling / taking small steps. Remain close to the resident with elbows in a locked position. Have resident communicate when they can feel the back of their legs touch the target.

13. At this point, the resident will want to sit. Continue to remain close to the resident, elbows in and squat (butt out and knees bent) when resident is sitting down.
   - **Remember:** When the resident sits, the caregiver needs to remain in a squat (sit) position. This will help to maintain proper back position and avoid any jarring motion on the caregiver’s body.

**When Do You Need Help?**

- If the resident is impulsive or uncooperative.
- If the resident cannot weight bear or is unsteady and does not have upper body strength.
- If you feel the transfer is unsafe or lifting is involved use a resident lift, or a ceiling lift.

**Two Person Transfer**

**Chair to Bed; Bed to Chair; Chair to Chair**

*Before you begin any transfer, be aware of any conditions a resident may have that would prevent a successful transfer such as a weak side due to a stroke or recent injury. Remember always transfer a resident toward their stronger side.*

*For a successful transfer communication between caregiver and resident is critical. Since caregiver is there solely for guidance and safety purposes, it is essential that resident is aware of when and what they are to do during the transfer so caregiver’s safety is optimized.*

1. Since two caregivers are involved in this technique, *communication is key*. Prior to performing the technique both caregivers need to discuss who will be performing each role for the tasks involved,
   i. Lead caregiver: giving the directions to both resident and co-worker
2. Determine resident's strong side.
3. Position the target (chair/wheelchair/bed) at approximately a 45° angle from where you are transferring. This is to allow room for both caregivers to move unobstructed.
   - If using a wheelchair, remove foot rest closest to the resident, and apply brakes;
4. Apply transfer belt around resident’s waist.
   - **Remember:** the transfer belt needs to be snug so that it will not move during the transfer, you should be just able to get your fingers in to grip the belt
5. Raise the bed until the resident’s hips are slightly higher than their knees (with their feet flat on the floor).

6. Lead caregiver directs resident to move to edge of bed/chair, so that the resident’s knees are over their toes and to place hands on armrests, bed or thighs in preparation to push off.

7. With one caregiver on each side of resident, both caregivers block resident’s foot with his/her foot, grip transfer belt with power grip (palms up) on back and with arms crossed in front of belt. See picture.

8. Ask the resident to lean forward so their nose is over their toes.

9. On specified count, lead caregiver will ask resident to help by pushing with their arms and legs. Guide the resident to the standing position.
   - **Remember:** Resident needs to be able to stand independently; you are there for guidance, this is **not a lift**!

10. Once standing, remain close to the resident and allow resident time to steady themselves and prepare stance for walking, transferring, etc.

11. Assist the resident towards the target by shuffling / taking small steps. Remain close to the resident with elbows in a locked position. Have resident communicate when they can feel the back of their legs touch the target.

12. At this point, the resident will want to sit. Continue to remain close to the resident, elbows in and squat (butt out and knees bent) when resident is sitting down.
   - **Remember:** When the resident sits, caregiver needs to remain in a squat (sit) position. This will help to maintain proper back position and avoid any jarring motion on the caregiver’s body.

**When is a lift needed?**

- If the resident is impulsive, uncooperative or combative.
- If the resident cannot weight bear or is unsteady and does not have upper body strength.
- If you feel the transfer is unsafe or lifting is involved use a resident lift, or a ceiling lift.
One Person Transfer with a Walker

Before you begin any transfer, be aware of any conditions a resident may have that would prevent a successful transfer such as a weak side due to a stroke or recent injury. Remember always transfer a resident toward their stronger side.

For a successful transfer, communication between caregiver and resident is critical. Since caregiver is there solely for guidance and safety purposes it is essential that resident is aware of when and what they are to do during the transfer so caregiver’s safety is optimized.

1. Determine resident’s strong side.
2. Position target (chair/wheelchair/bed) at a 90° angle (or as close as possible) to resident’s strong side;
   - If using a wheelchair, remove foot rest closest to the resident, and apply brakes;
3. Apply transfer belt around resident’s waist.
   - Remember: the transfer belt needs to be snug so that it will not move during the transfer, you should be just able to get your fingers in to grip the belt
4. Raise the bed until the resident’s hips are slightly higher than their knees (with their feet flat on the floor) and place walker directly in front of the resident.
5. Ask the resident to move to edge of the bed/chair, so that the resident’s knees are over their toes.
6. Ask the resident to place their hands on the walker in preparation to push up and off, if possible.
7. Position self on the resident’s weak side using a wide stance, with one foot blocking the resident’s foot. Hips square to resident, knees bent. Position yourself close to the resident, with your chin over the resident’s shoulder.
8. Grasp transfer belt using the power grip (palms up) with neutral wrist position. Elbows are bent and tucked into sides.
9. Ask the resident to lean forward so their nose is over their toes;
10. On specified count, ask resident to help by pushing with their arms and legs. Guide the resident to the standing position.
   - Remember: Resident needs to be able to stand independently; you are there for guidance, this is not a lift!
11. Once standing, remain close to the resident and allow resident time to steady themselves and prepare stance for walking, transferring, etc.
12. Assist the resident towards the target by shuffling / taking small steps. Remain close to the resident with elbows in a locked position. Have resident communicate when they can feel the back of their legs touch the target.
13. At this point, the resident will want to sit. Continue to remain close to the resident, elbows in and squat (butt out and knees bent) when resident is sitting down.

- **Remember:** When the resident sits, the caregiver needs to remain in squat (sit) position. This will help to maintain proper back position and avoid any jarring motion on the caregiver's body.

**When Do You Need Help?**

- If the resident is impulsive or uncooperative.
- If the resident cannot weight bear or is unsteady and does not have upper body strength.
- If you feel the transfer is unsafe or lifting is involved use a resident lift, or a ceiling lift.

### Two Person Transfer with a Walker

*Before you begin any transfer, be aware of any conditions a resident may have that would prevent a successful transfer such as a weak side due to a stroke or recent injury. Remember **always** transfer a resident toward their **stronger** side.*

*For a successful transfer, communication between caregiver and resident is critical. Since caregiver is there solely for guidance and safety purposes it is essential that resident is aware of when and what they are to do during the transfer so caregiver's safety is optimized.*

1. Since two caregivers are involved in this technique, **communication is key.** Prior to performing the technique both caregivers need to discuss who will be performing each role for the tasks involved,

   i. Lead caregiver: giving the directions to both resident and co-worker

2. Determine resident’s strong side.

3. Position the target (chair/wheelchair/bed) at approximately a 45º angle (or as close as possible) from where you are transferring. This is to allow room for both caregivers to move unobstructed.

   - If using a wheelchair, remove foot rest closest to the resident, and apply brakes.

4. Apply transfer belt around resident’s waist.

   - **Remember:** the transfer belt needs to be snug so that it will not move during the transfer, you should be just able to get your fingers in to grip the belt

5. Raise the bed until the resident’s hips are slightly higher than their knees (with their feet flat on the floor) and place walker directly in front of the resident.

6. Lead caregiver directs resident to move to edge of bed/chair, so that the resident’s knees are over their toes and to place hands on walker in preparation to push up and off, if possible.
7. With one caregiver on each side of resident, both caregivers block resident’s foot with his/her foot, and, with a power grip (palms up), grip the front and back of transfer belt with arms crossed in front of the resident. *See pictures.*

8. Ask the resident to lean forward so their nose is over their toes;

9. On specified count, lead caregiver will ask resident to help by pushing with their arms and legs. Guide the resident to the standing position.

   - **Remember:** Resident needs to be able to stand independently; you are there for guidance, this is not a lift!

10. Once standing, remain close to the resident and allow resident time to steady themselves and prepare stance for walking, transferring, etc.

11. Assist the resident towards the target by shuffling / taking small steps. Remain close to the resident with elbows in a locked position. Have resident communicate when they can feels the back of their legs touch the target.

12. At this point, the resident will want to sit. Continue to remain close to the resident, elbows in and squat (butt out and knees bent) when resident is sitting down.

   - **Remember:** When the resident sits, caregiver needs to remain in squat (sit) position. This will help to maintain proper back position and avoid any jarring motion on the caregiver’s body.

**When is a lift needed?**

- If the resident is impulsive, uncooperative or combative.
- If the resident cannot weight bear or is unsteady and does not have upper body strength.
- If you feel the transfer is unsafe or lifting is involved use a resident lift, or a ceiling lift.
Lifts

Sit to Stand Lift

- Used for residents who are non-combative;
- They must also be able to partially bear their weight; and,
- They must have the upper body strength to assist you.

Technique

1. Since two caregivers are involved in this technique, *communication is key*. Prior to performing the technique, both caregivers need to discuss who will be performing each role for the tasks involved,
   i. Lead caregiver: control the lift and give the resident instructions about what is happening.
   ii. Second caregiver: stay with the resident, assist and comfort.
2. Prior to using the lift, check both sling and lift to ensure they are in good working order.
3. Attach the sling securely around the resident’s waist.
4. Lead caregiver will wheel the lift into place and widen out the wheelbase for extra support then lock the wheels.
5. Second caregiver will attach the sling straps to the lift and prior to lifting resident, lead caregiver will double check that sling straps are securely attached to the lift.
6. Lead caregiver will instruct resident to place their feet on the base of the lift; second caregiver can assist if necessary and attach foot safety strap.
7. Lead caregiver will instruct resident to grab the handles; second caregiver can assist if necessary.
8. Instruct the resident to keep their feet flat on the base of the lift throughout the movement.
9. Using the lift controls lead caregiver will raise the resident until they clear the surface.
10. Lead caregiver will steer the lift away from the bed/chair/wheelchair etc. ensuring that their elbows are locked close to 90 degrees and use their feet to prevent twisting of the back.
11. Since moving an empty object requires less effort when possible, second caregiver can then move the target (chair/wheelchair/commode) into position under the resident.
12. Lead caregiver can slowly lower the resident into the target while the second caregiver guides the resident to the target using the slings handles.
Resident Lift

- Used for residents who are not alert, are disoriented or impulsive.
- Used for residents who cannot weight bear, or are unsteady, and do not have the upper body strength to assist caregiver.
- There are many different slings available to facilities depending on a resident’s condition or situation. Contact your lift provider to discuss the many options available.

Technique

1. Since two caregivers are involved in this technique communication is key. Prior to performing the technique, both caregivers need to discuss who will be performing each role for the tasks involved,
   i. Lead caregiver: control the lift and give the resident instructions about what is happening.
   ii. Second caregiver: stay with the resident, assist and comfort.

2. Prior to using the lift, check both sling and lift to ensure they are in good working order.

3. Using the proper rolling resident - two caregiver technique, position the appropriate sling under the resident.

4. Adjust the bed so that you are working at proper care height so as to refrain from bending at the waist to attach the sling straps.

5. Lead caregiver will wheel the lift into place and widen out the wheel base for extra support.

6. Both caregivers can attach the sling straps to the lifting mechanism, according to manufacturer’s recommendations. Each caregiver should double check their co-workers sling straps checking that sling straps are securely attached to the lift and in the proper positions.

7. Using the lift controls, lead caregiver can raise resident a few inches and second caregiver can check to ensure all straps are safely attached and the sling is comfortably positioned for the resident.

8. Lead caregiver can continue raising the resident until they clear the surface.

9. Lead caregiver will steer the lift away from the bed/ chair/ wheelchair etc. ensuring that their elbows are locked close to 90 degrees and use their feet to prevent twisting of the back while second caregiver is holding on to the slings handles.

10. Since moving an empty object requires less effort when possible, second caregiver can then move the target (chair/ wheelchair/ commode) into position under the resident.

11. Lead caregiver can slowly lower the resident into the target while the second caregiver guides the resident to the target using the slings handles.
   - If the resident’s wheelchair is equipped with anti-tippers, as you begin lowering resident, tilt the wheelchair back so that front castors are approximately 6” off the floor. This will allow resident’s buttocks to be positioned as far back in the chair as is possible.
Assisted Mobility

Assisting a Resident when Walking

*Before walking with the resident…*

- Have you reviewed the resident assessment form or resident’s care plan?
- Is the resident physically able to walk at this time?
- Can they weight-bear and step effectively through?
  - You may need to check with others who have been involved with the resident’s care and rehabilitation.
- Is the resident taking medication that could affect their walking ability (coordination or mental comprehension)? If so, when did they take it?
- Is the resident able to co-operate and understand what you are expecting of them?
- Is the resident disoriented or tired?
  - Some residents may be disoriented, especially at night.
- Is the resident wearing appropriate footwear?
  - As a general rule, both resident and caregiver should be wearing flat, supportive, non-slip footwear.
- Does the resident have all necessary equipment (glasses, hearing aids, walking aids)?
  - Are they in working order?
  - Are walking aids adjusted appropriately?
- When did the resident last eat?
- Is the walking pathway clear of cords, cables and equipment?
- Will there be plenty of time to ensure that the resident is not rushed, or does not feel they are being rushed?
- Are there adequate opportunities for the resident to rest during the walk?
- If walking with a portable IV pole, is assistance required?
- If walking to a shared area, such as a toilet or shower, is it available?
  - Critical if the resident has limited walking endurance.

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**The ideal shoe**

For more information, visit: [www.findingbalancealberta.ca](http://www.findingbalancealberta.ca)
Assisting a Resident to Walk Technique

The caregiver’s technique used to assist a resident when walking is the same regardless of whether or not the resident uses a mobility aide. The main difference is the required accommodation for the mobility aide itself.

1. Place a transfer belt on the resident.
   - Remember: the transfer belt needs to be snug so that it will not move during the transfer, you should be just able to get your fingers in to grip the belt
2. Position yourself close, behind and slightly to the side of the resident, allowing you positioning to more effectively manage a fall;
3. Grip the transfer belt using the “power grip” (palms up). To avoid overreaching, grip the transfer belt at the residents mid-back and hip. See picture;
4. If a second caregiver is required, they should assume the same position on the opposite side of the resident;
5. Step with the resident but keep one foot between the resident’s feet;

When Do You Need Help?

- If the resident is unsteady.
- If the resident is uncooperative.
- If the resident may need the assistance of a mobility aid.

Assisting a Resident to Walk with a Cane

Follow all instructions for assisting a resident to walk with the following coaching and accommodations for the cane:

NOTE: Unless otherwise instructed, the cane should be held in the hand of the resident’s “strong” side or on the opposite side of their injury or weakness;

1. Once they are standing and they have their balance, coach the resident to position their cane and walk as follows:
   - The resident should place the cane firmly on the ground before they take a step, not too far ahead as the cane could slip;
   - Have the resident place all of their weight on their strong leg
   - Then move the cane and their weak leg a comfortable distance forward;
   - With the resident’s weight supported on both their cane and their weak leg, cue the resident to step through with their strong leg;
   - Repeat the cycle.
2. If going up stairs, coach the resident to:
   - Take the first step with their strong leg; their weight will be supported by the handrail, the cane and their ‘weak’ leg;
   - Then have the resident move the cane and their ‘weak’ leg to the SAME step;
   - Repeat the cycle.

3. If going down stairs, coach the resident to:
   - Take the first step down with their ‘weak’ leg and the cane;
   - Then have the resident step down with their strong leg to the SAME step; the resident’s weight is supported by the handrail, the cane and their ‘weak’ leg.

Assisting a Resident to Walk with a Walker

*Follow all instructions for assisting a resident to walk with the following coaching and accommodations for the walker.*

- Ensure that the walker is at the correct height or adjust the walker to the correct height for the resident. Resident’s upper arm should be straight up and down while their forearm should have a slight bend at the elbow.

1. Once they are standing and they have their balance, coach the resident to position their walker and walk as follows:
   - Have the resident place or roll their walker a step’s length ahead of them;
   - Make sure that the walker is firmly placed on the ground;
   - Ensure that they do not place or roll their walker too far ahead as it could slip from under them;
   - The resident should be in a forward walking posture and hold the arms of the walker for support;
   - Take a step;
   - Repeat the cycle.
Note: Making sure that residents’ have the proper mobility aid will enhance worker safety.

- Selecting the right mobility aide:
  - The aim is to select one that encourages maximum independence.
  - Select a mobility aide that is the correct height or adjust to the correct height for the resident.
    - Both canes and walkers should be approximately at the height of the resident’s wrist.
    - To measure the cane:
      - Turn the cane upside down so that the handle rests on the floor;
      - Coach the resident to stand as straight as possible with their arms at their sides;
      - The tip of the cane should be level with the resident’s wrist.
    - To measure the walker:
      - Coach the resident to stand as straight as possible in front of the walker, with their arms relaxed at their sides;
      - The height of the walker should be level with the resident’s wrist.
Assisting a Falling Resident

Fall prevention is far more effective than trying to manage a fall in progress – or the after-effects. Therefore, priority should be placed on preventing falls by identifying any risks factors and then implementing controls to eliminate, isolate or minimize them.

The risk of falling depends on many factors. Some long term care facilities and organizations have a falls prevention program that helps them identify residents at risk of falling and appropriate prevention strategies. Please check with your facility or organization to see if any such programs exist.

Note: During any handling task falls can occur; therefore, it is recommended that every facility have procedures to cope with this risk.

Technique 1 - When Walking Away from a Wall Resident Begins to Fall

This technique can only be successful if the caregiver is in the right place at the right time using the proper assisting a resident to walk technique.

1. If you get the sense that a resident is about to fall do not try to stop the fall;
2. Be prepared to keep a grip on the transfer belt.
3. Support the resident from behind with your body; you may need to push into the resident.
4. Slowly guide down, and lower the resident to the floor while protecting their head and your back by maintaining a neutral back posture and bending your knees.

Technique 2 - When Walking Close to a Wall Resident Begins to Fall

This technique can only be successful if the caregiver is in the right place at the right time using the proper assisting a resident to walk technique.

1. If you get the sense that a resident is about to fall do not try to stop the fall;
2. Be prepared to keep a grip on the transfer belt.
3. Direct the resident to the wall by leaning into the resident using your body to support
4. Slowly guide down, and lower the resident to the floor while protecting their head and your back by maintaining a neutral back posture and bending your knees.
Managing and Assessing a Fallen Resident

➢ Never try to lift a fallen resident off the floor unless there is an emergency or life-threatening situation.
  o Make sure the area around the resident is safe and that no further harm can occur.
  o Clear any spills or objects away from the immediate area.

➢ Call for help – and ask for the resident’s care plan and profile.
  o Place a pillow under the resident’s head, cover them with a blanket if appropriate, and insist they wait until they are calm and feel ready to get up.

➢ Continue the assessment using your facility approved First Aid procedures, and decide if the resident can be moved.
  o **Remember**, the resident cannot fall any further and acting without assessing the situation carefully could cause injury to you and the resident.

➢ If there is a possibility the resident is injured, do not move them, make them comfortable on the floor and seek further medical advice.

➢ If resident is not injured, give them time to calm down and then either coach them to get up (providing reassurance) or help them with a powered resident lift, or some other powered assist device like a lifting cushion.

➢ **NOTE:** It’s important that residents and their families know your resident handling policy on lifting, and understand the reason for it, so they don’t expect to be lifted by a caregiver after a fall.

➢ **NOTE:** If you find a fallen resident, you need to assess the situation carefully to ensure the resident isn’t injured further while you are trying to help them. This affects the method you use to help them – and the choice of equipment.
Assisting a Fallen Resident:

Coaching of an Uninjured Resident

- Place a chair or stable low piece of furniture near the resident – they will use this to push themselves up;

When the resident is ready, ask them to:

1. Bend their knees up and roll onto their side

2. Push themselves up into a side-sitting position

3. Move into a four-point kneeling position
4. Put their inside hand on the chair and bring their outside leg up ready to push themselves into a kneeling position.

5. Push themselves up with their outside hand on their outside knee and their inside hand on the chair.

6. Swing their hips around and,

7. Sit on the chair.

* Remember:
  o A resident’s risk of falling increases by 50% after they have fallen once, therefore, it is important to document and assess every resident’s fall.
Assisting a Fall Resident:

**Lifting an Injured Fallen Resident – 2 caregivers**

1. Since two caregivers are involved in this technique *communication is key*. Prior to performing the technique, both caregivers need to discuss who will be performing each role for the following tasks:
   - i. Positioning of the slider sheets
   - ii. Lead caregiver: control the lift and give resident instructions about what is happening
   - iii. Second caregiver: stay with the resident, assist and comfort

2. Select the correct sling for the situation and the resident – for instance, the resident’s head may need supporting and/or their condition may require a stretcher sling.

3. Make sure a bed or chair is close and unobstructed to transfer the resident to after being lifted.

4. Check both lift and sling to make sure they are in good working order.

5. Using the proper rolling technique with 2-caregivers, roll the resident to one side. The caregiver rolling can now tuck the sling, as far as possible, under the resident while other caregiver steadies the resident.

6. Gently lower the resident back. Caregiver who steadied can now roll the resident towards the other caregiver and now pull the sling through. Resident can now be lowered back to the ground;

7. Check the resident is correctly positioned on the sling.
   - o Position the sling so that equal parts are on either side of the resident. It should be far enough down their back so the leg supports can be positioned under the middle of the resident’s thigh.
   - o A stretcher sling may be needed, depending on the resident’s condition or injuries. To position a stretcher sling follow the manufacturer’s instructions.

8. The sling is now ready for lifting.

9. Lead caregiver can move the lift into position – you need to get it close enough to attach the sling.

10. Lead caregiver lowers the lift so that sling straps can be easily attached to the lift;

11. Both caregivers can attach sling straps to the lift, *according to manufacturer’s recommendations*. Each caregiver should check co-workers straps;

12. Raise the resident from the floor and position them on a bed or chair;

13. Remove the sling.
Assisting a Fallen Resident:

In an Area Difficult to Access – 2 or more caregivers

Use this technique if a resident falls in an area where you can't use a lift (e.g. between a toilet and wall) the best option is then to slide them to an area where you can use a lift;

You need at least two caregivers for this technique and two slider sheets, preferably single slider sheets with long handles;

1. Determine if the resident can move themselves at all;
2. Put the two slider sheets on top of each other;
3. Position the slider sheets under the resident by:
   - Rolling the resident onto the slider sheets or, if this cannot be done,
   - Unroll the slider sheets under the resident from head to foot;
4. Both caregivers stand with feet shoulder width apart, with one foot slightly in front of the other;
5. Both pull the top sheet forward or back, away from the obstruction, with the long handles;
   - If the slider sheet doesn’t have long handles, you need to adopt an upright kneeling position and slide the resident out by pulling the top slider sheet.
   - Take care to maintain a good posture with your back in its neutral position throughout the movement; and, ensure that your weight is shifted from your front leg to your back leg vs. using your arms and back to pull the slider sheet.
6. Move the resident just far enough to allow you to use the powered lift.
Reposition Resident in a Wheelchair- 2 caregivers

To perform this:

- Resident should be cooperative and exhibit predictable performance.
- Resident requires no more than minimal physical assistance for this task.
- Resident’s care plan does not indicate that they need lift.

Without a slider sheet or tube-slider:

1. Place wheelchair brakes on.
2. One caregiver goes around to front of chair. They position themselves with one knee on the floor, one knee bent and hands placed on resident’s shins with elbows in at sides.
3. Second caregiver asks resident to cross their arms.
4. The second caregiver positions themselves behind the wheelchair. They stagger their feet (one in front one behind) and bends at the knees (not at the waist).
5. Then the second caregiver positions their arms under the resident’s arms and lightly grasps the resident’s wrists.
6. On designated count, second caregiver at the back stands up while caregiver at the feet transfers their weight forward. This helps guide the resident into an upright-seated position while resident’s hips are being slid to the back of chair.
   - Remember all power comes from a weight transfer of the legs not the back or shoulders.
With a slider sheet or tube-slider:

*For this technique use either a tube slider or fold a slider sheet in half with handles outside*

1. Fold slider every six inches, starting from the folded end if using folded slider sheet. Leave a small piece of the slider unfolded.
2. Ensure that the wheelchair brakes on.
3. If possible and safe, remove or swing away chair sides
4. With one caregiver on each side of the resident, turn the slider over and place behind the resident’s tail bone, with the unfolded end against the backrest and the folds facing down against the bottom of the chair
5. Caregivers face back of chair on one knee with shin against resident’s shin to prevent the resident from sliding out of the chair or caregivers alternate holding both knees to restrict movement and take turns unfurling slider.
6. Caregivers secure slider with outside hand while inside hand grasps the bulk of the folds from underneath and weight shifts back to unfurl one fold of the slider under the resident. Repeat till unfurled.
7. One caregiver goes around to front of chair. He/she positions him/herself with one knee on the floor, one knee bent and hands placed on resident’s shins with elbows in at sides
8. The second caregiver positions him/herself behind the resident, encourages and may assist resident to lean forward by guiding shoulders.
9. On designated count, caregiver at legs will transfers their weight forward, sliding resident’s hips to back of chair.
10. The second caregiver encourages resident to push downward on armrests, lean forward until final positioning in chair.

**OPTION B**

1. Fold slider as described above in step 1.
2. Ensure wheelchair brakes on.
3. If possible and safe, remove or swing away chair sides
4. Caregivers, on one knee, face the same direction as resident, they insert the slider below resident’s legs, thin fold or open ends toward knees and folds facing down toward back of chair.
5. On designated count, the caregivers together unfurl the slider from knees to behind buttocks.
6. Push resident back in chair as described above in steps 7-10.

**To Remove Slider Sheet**

*Option 1: Caregiver in front of the chair grasps a handle on bottom slider and, transferring weight from forward foot back onto knee, draws slider forward; repeat procedure, alternating sides until slider is removed.*

*Option 2: Remove the slider from the back of the chair by folding the front corner of the slider under and drawing the slider under itself, from the resident’s knees toward their buttocks.*
Exercise 2: Safe Resident Handling Hands On Practice:

- The instructor will advise whether or not you will break up into smaller groups to complete the hands on practice.

- Regardless of the group format, each participant will take turns:
  1. Practicing the Safe Resident Handling Techniques by performing as many of the resident handling tasks at each practice station as possible.
  2. Assessing the technique used while performing the Resident Handling task.
  3. Playing the role of the resident.

- The participant who is practicing the Safe Resident Handling techniques performs the resident handling tasks; while the other participants assess how the tasks were performed using the Safe Resident Handling checklist.

- After each task, the participants who were the assessors should provide feedback based on what they recorded on the Safe Resident Handling checklist.

- Repeat until all each technique has been practiced by all participants.

- At the end of this exercise we’ll re-group to discuss briefly – how did it feel to perform the tasks using the safe Resident Handling techniques & how did it feel to assess a peer’s technique?
Sustaining Change

What can I do?

1. I can use the safe resident handling techniques
   - I can ask for assistance
   - I can apply the 8 principles of safe lifting

2. I can encourage my co-workers to use the safe manual materials handling techniques
   - I can use the Safe Resident Handling Checklist to provide feedback
   - I can offer to provide assistance

3. I can report resident handling hazards to my supervisor
   - I can look and listen for signs of Resident Handling hazards
   - I can report equipment that requires repair

4. I can participate in the activities I enjoy!
### General Design Guidelines for Resident Handling Tasks

The following resident handling guidelines may help **eliminate** risks of MSI to workers:

| 1. Eliminate unnecessary resident handling. | 5. Use electric beds to eliminate handling procedures such as sitting up in bed. |
| 2. Encourage residents to assist in their own transfers as much as they are safely able to. | 6. Design new facilities with resident handling needs in mind. |
| 3. Install appropriate resident assistive devices such as grab bars or rails to help the resident be more independent. | 7. Do not perform the task if a safe solution is unavailable. Use an alternative work method until a safe solution is provided. |
| 4. Use mechanical equipment such as ceiling lifts or electric beds to eliminate the need for strong manual forces. |  

The following resident handling guidelines may help **minimize** risks of MSI to workers:

| 1. Use height-adjustable beds and specialized feeding tables to avoid awkward postures. | 8. Store heavy items at more convenient heights. |
| 2. Use slide boards, transfer boards, or slide sheets to reduce forces and awkward postures. | 9. Modify tasks to reduce the amount of time workers spend stooped over. |
| 3. Develop safe work procedures that reduce the risks of MSI to workers to the lowest possible levels and ensure that workers follow these procedures. | 10. Modify or reorganize tasks to increase variety. |
| 4. Train workers to improve their techniques. | 11. Share or rotate tasks among workers. |
| 5. Ensure the resident assessments are kept up to date. | 12. Install ramps so that stretchers, carts, and wheelchairs can be moved easily. |
| 6. Observe the resident’s condition before each transfer to ensure that the designated transfer can be performed safely. | 13. Use improved handles, wheels or castors to help reduce the amount of force needed to move a load. |
| 7. Change the workplace layout for the organization of tasks to reduce distances for pushing or carrying tasks. | 14. Implement a preventative maintenance program for the moving parts of equipment. |
Workshop Summary

1. Discuss why organizations should consider implementing a musculoskeletal injury prevention program (intro)

2. Identify the potential impact of resident handling tasks on your body (Module 1)

3. Describe what safe resident handling is and why it is important (Module 1)

4. Recognize the signs and symptoms of musculoskeletal injury in yourself and your co-workers (Module 1)

5. Identify resident handling-related hazards in your workplace (Module 2)

6. Explain why and how poor design contributes to MSI (Module 2)

7. Adapt the principles of safe lifting to resident handling situations (Module 3)

8. Correctly demonstrate each of the safe resident handling techniques presented in this workshop (Module 4)

9. Adapt the safe resident handling techniques to your daily resident handling tasks (Module 4)

10. Explain how to make simple changes to the design and organization of resident handling tasks to improve your health and well-being! (Module 4)
Appendix 1: Alberta Occupational Health and Safety Act, Code and Regulation

The definitions section of the Alberta Occupational Health and Safety Act states the definitions of “employer” and “worker” are as follows;

“employer” means;

(i) A person who is self-employed in an occupation,
(ii) A person who employs one or more workers,
(iii) A person designated by an employer as the employer’s representative, or
(iv) A director or officer of a corporation who oversees the occupational health and safety of the workers employed by the corporation.

“worker” means a person engaged in an occupation.

Employers and workers have responsibilities for workplace health and safety as specified in the Alberta Occupational Health and Safety Act, Section 2(1) and (2). These are briefly:

EMPLOYERS: To ensure the health and safety of all workers at the worksite by identifying existing and potential hazards and implementing measures to eliminate or reduce the risk by involving workers in the process.

WORKERS: To take reasonable care to protect the health and safety of themselves and other workers, and to cooperate with the employer to protect the health and safety of themselves and others on the job.

Legal Requirements under the Alberta OH&S Code include:

Part 2 Hazard Assessment, Elimination and Control

Hazard assessment

7(1) An employer must assess a work site and identify existing and potential hazards before work begins at the work site or prior to the construction of a new work site.

7(2) An employer must prepare a report of the results of a hazard assessment and the methods used to control or eliminate the hazards identified.

7(3) An employer must ensure that the date on which the hazard assessment is prepared or revised is recorded on it.

7(4) An employer must ensure that the hazard assessment is repeated

(a) at reasonably practicable intervals to prevent the development of unsafe and unhealthy working conditions,

(b) when a new work process is introduced,

(c) when a work process or operation changes, or
(d) before the construction of significant additions or alterations to a work site.

7(5) A prime contractor must ensure that any employer on a work site is made aware of any existing or potential work site hazards that may affect that employer's workers.

Worker participation

8(1) An employer must involve affected workers in the hazard assessment and in the control or elimination of the hazards identified.

8(2) An employer must ensure that workers affected by the hazards identified in a hazard assessment report are informed of the hazards and the methods used to control or eliminate the hazards.

Hazard elimination and control

9(1) If an existing or potential hazard to workers is identified during a hazard assessment, an employer must take measures in accordance with this section to

(a) eliminate the hazards, or

(b) if elimination is not reasonably practicable, control the hazard.

9(2) If reasonably practicable, an employer must eliminate or control a hazard through the use of engineering controls.

9(3) If a hazard cannot be eliminated or controlled under subsection (2), the employer must use administrative controls that control the hazard to a level as low as reasonably achievable.

9(4) If the hazard cannot be eliminated or controlled under subsections (2) or (3), the employer must ensure that the appropriate personal protective equipment is used by workers affected by the hazard.

9(5) If the hazard cannot be eliminated or controlled under subsections (2), (3) or (4), the employer may use a combination of engineering controls, administrative controls or personal protective equipment if there is a greater level of worker safety because a combination is used.

The concept and practice of musculoskeletal injury prevention is based around the proactive model of hazard identification. The model contains the following steps:

Step 1: Recognize the signs and symptoms
Step 2: Identify the hazards
Step 3: Evaluate the hazards
Step 4: Control the hazards
Part 14 Lifting and Handling Loads

Equipment

208(1) An employer must provide, where reasonably practicable, appropriate equipment for lifting, lowering, pushing, pulling, carrying, handling, or transporting heavy or awkward loads.

208(2) An employer must ensure that workers use the equipment provided under subsection (1).

208(3) Workers must use the equipment provided for lifting, lowering, pushing, pulling, carrying, handling or transporting heavy or awkward loads.

208(4) For the purpose of this section, a heavy or awkward load includes equipment, goods, supplies, persons and animals.

Adapting heavy or awkward loads

209 If the equipment provided under section 208 is not reasonably practicable in a particular circumstance or for a particular heavy or awkward load, the employer must take all practicable means to

(a) Adapt the load to facilitate lifting, lowering, pushing, pulling, carrying, handling or transporting the load without injuring workers, or
(b) Otherwise minimize the manual handling required to move the load.

Work site design – health care facilities

209.1(1) An employer must ensure that appropriate patient/client/resident handling equipment is adequately incorporated into the design and construction of

(a) a new health care facility, and
(b) a health care facility undergoing significant physical alterations, renovations or repairs.

209.1(2) An employer must ensure that any new patient/client/resident handling equipment installed at an existing work site, including vehicles in which patient/client/resident handling occurs, fits adequately in the space intended for it.

209.1(3) Subsections (1) and (3) do not apply to health care facility construction, alterations, renovations or repairs started before July 1, 2009.

Patient/client/resident handling

209.2(1) An employer must develop and implement a safe patient/client/resident handling program if workers are required to lift, transfer or reposition patients/clients/residents.

209.2(2) The program required by subsection (1) must include an annual evaluation of its effectiveness at preventing worker injuries.

209.2(3) An employer must ensure that workers follow the safe handling program required by subsection (1).
209.2(4) Workers must follow the safe handling program required by subsection (1).

Assessing manual handling hazards

210(1) Before a worker manually lifts, lowers, pushes, pulls, carries, handles or transports a load that could injure the worker, an employer must perform a hazard assessment that considers

(a) the weight of the load,
(b) the size of the load
(c) the shape of the load
(d) the number of times the load will be moved, and
(e) the manner in which the load will be moved.

210(2) Before a worker performs any manual patient/client/resident handling activities, an employer must perform a hazard assessment that considers the worker’s physical and mental capabilities to perform the work.

210(3) If the hazard assessment required by section 7 and subsections (1) and (2) determines that there is potential for musculoskeletal injury, an employer must ensure all reasonably practicable measures are used to eliminate or reduce that potential in accordance with section 9.

Musculoskeletal injuries

211 If a worker reports to the employer what the worker believes to be work related symptoms of a musculoskeletal injury, the employer must promptly

(a) review the activities of that worker, and of other workers doing similar tasks, to identify work-related causes of symptoms, if any, and
(b) take corrective measures to avoid further injuries if the causes of the symptoms are work related.

Training to prevent musculoskeletal injury

211.1(1) An employer must ensure that a worker who may be exposed to the possibility of musculoskeletal injury is trained in specific measures to eliminate or reduce that possibility.

211.1(2) An employer must ensure that the training referred to in subsection (1) includes

(a) identification of factors that could lead to a musculoskeletal injury
(b) the early signs and symptoms of musculoskeletal injury and their potential health effects, and
(c) preventative measures including, where applicable, the use of altered work procedures, mechanical aids and personal protective equipments.
Appendix 2: Features of an Effective Musculoskeletal Injury Prevention Program

The “No Unsafe Lift Workbook” identifies 9 critical features based on extensive research of the best practices from programs around the world (p.17-66). These features include:

- **Management Commitment – Policies and Promotion**
  - Key aspects of management commitment:
    - Understanding the scope of the problem,
    - Defining objectives
    - Establishing the policies,
    - Roles, responsibilities and accountabilities, and
    - Follow through – attention and evaluation.

- **Employee Participation**
  - Opportunities to involve employees and ensure two-way communication include:
    - Seek employee input before drafting policy and procedures
    - Set up a formal feedback process; but also use informal means (i.e. suggestion boxes and talking to workers on the job)
    - Include worker representatives in the review, plan and action cycle.
    - Seek employee input before making big changes; such as: buying equipment or altering facilities.
    - Maintain a regular stream of communication regarding what’s happening and make sure results are communicated to all employees.
    - Encourage regular staff meetings to review progress, and use forums like training sessions to gain employee views and suggestions.
    - Seek comment on issues using means such as feedback forms in newsletters, questionnaires and surveys.

- **Coordination**
  - If possible, designating a coordinator whose full-time responsibility it is to ensure that no program element “falls through the cracks” without clear accountabilities assigned.

- **Risk Assessment**
  - An effective Safe Resident Handling Program will assist in providing a systemic approach to assess risk.
  - Four key risk assessments are required to determine what procedures or equipment should be used for resident handling. (See Appendix 3: CCSA’s Safe Resident Handling Hazard Identification Checklist Booklet)
  - These include:
    - A self-assessment for the caregiver
    - A resident assessment
A workplace assessment (including equipment and environment)

A task assessment.

- **Equipment**
  - Successful musculoskeletal injury prevention programs in continuing care facilities are those that reduce the use of manual lifting techniques and increase the sure of technological advances that limit the biomechanical stress on workers.
  - An inventory of equipment and an evaluation of equipment needs are important first steps.
  - Inclusion of a preventative as well as reparative maintenance plan is important for the program’s success.
  - Additionally, it is critical to provide thorough training on the equipment’s use and ensure that employees are competent to use each device.

- **Biomechanical Considerations**
  - Key components of New Zealand’s “LITEN UP” Program include:
    - A focus on the resident
      - Review the resident’s characteristics that may impact the handling risk, including the resident’s: age, gender, diagnosis, dependency, neurological status, size, weight, ability to cooperate, and fall risk.
    - A focus on the individual worker capabilities
      - These capabilities may include: language, education, training, physical limitations, stress, and fatigue.
    - A focus on the specific task
      - Including: the nature of the task, what has to be done, how, and when.
      - Different tasks have different requirements, each needing assessment and a unique approach.
    - A focus on the environment
      - Including: consideration of the facility design, staffing levels, culture and resources.
  - Biomechanical considerations should be a major factor in designing a musculoskeletal injury prevention program.
  - A consistent approach using standard, well-accepted good body mechanics is preferable.

- **Training**
  - As a best practice, training must be focused on proper resident assessment, proper environmental evaluation, proper use of appropriate resident handling devices, effective communication, and the management commitment to enforce the policy.
  - Successful programs encourage “big picture thinking” and problem solving skills which enable the worker to consider all aspects of the situation in a timely manner to determine the best technique to use.
Communication

- Communication of the results of the risk assessment will ensure that all workers are aware of the risk and safe handling procedures.
  - A variety of mechanisms currently exist for communicating resident risk assessments in an effective and efficient manner.
  - These can be both formal (written into care plans) and informal (mention at daily report).
- However, the resident's status may change gradually or suddenly, and reliance on a previous risk assessment may be insufficient.
- Therefore, some organizations have developed quick visual cues to indicate the resident handling requirements for each resident.
  - Consistency in the use of the cues is important.
- A process must be in place to ensure that the assessment (and any communication tool used for the assessment) is updated regularly to reflect the most up to date information about the resident.

Area Design Considerations

- A Safe Resident Handling Program must address area design issues and should include a proactive consultative approach in the design of new or renovated facilities.
- Some of the criteria that should be considered in area design/configuration to assist in reducing resident handling injuries include:
  - Ceiling lifts, where resident population warrants them, and the facility's physical structure can support them; ensure ceiling lifts track all the way into the bathroom.
  - Furniture in resident's rooms to include adjustable beds, under-bed clearance to accommodate resident lifting devises, castors on furniture legs for easier moving of beds, and chairs with armrests to assist in standing.
  - Sufficient electrical outlets arranged to reduce the need for long electrical cords or extension cords.
  - Sufficient clearance bedside, at the foot of, and on the transfer side of the bed to allow for two caregivers and equipment as necessary (equipment may include a stretcher, wheelchair, lifting devices, etc.)
  - Handrails in corridors; unobstructed corridors of sufficient width to allow resident equipment/furniture to be moved.
  - Hard, smooth flooring (no carpet) that allows for easy movement of resident wheeled equipment; permanently sealed joints in flooring to reduce tripping; non-slip flooring in bathrooms.
  - Sufficient storage space for resident handling equipment and supplies to ensure they are readily available.
Appendix 3: Sample No Unsafe Lift Policies

Sample 1 - Resident Transfers and Lifts / No Unsafe Lift

STANDARD

___________ is committed to providing a safe and healthy environment for all staff and Residents. In respect of this a no manual resident lift policy is established. Residents are not to be lifted manually unless medically contraindicated or in an emergency.

All Residents are safely transferred by staff members who have received training in the proper lifting, transferring and repositioning procedures and the principles of good body mechanics.

If a transfer is deemed unsafe or lifting is involved staff must use a mechanical lifting device. Staff are not to lift a resident without the use of the equipment. Research indicates that care givers that perform manual resident lifts are at the greatest risk of musculoskeletal injuries.

PROCEDURE

1. A Resident transfer assessment is to be completed by a Nurse and/or Therapist on admission or readmission after a stay in acute care.

   The most appropriate transfer or lift should:
   - Be safe for both the resident and caregiver;
   - Encourage the resident to assist with the move as much as possible; and
   - Provide the least possible work for the care giver by making use of good body mechanics and/or equipment.

2. Assistive devices such as transfer belts, slider sheets or mechanical lifts should be used where appropriate to aid in the transfer or repositioning.

3. The Resident is assessed whenever there is a significant change in condition. Never decrease the amount of assistance given in a transfer until a reassessment has been done. If transfer increases in difficulty, the transfer can be completed and the supervisor must be informed and will arrange for reassessment.

4. The transfer/lifting technique and sling, if required, must be documented on the Resident care plan. It is the responsibility of all staff to comply with the transfer method specified.
5. ______________ will provide and maintain equipment required for resident lifts and transfers. Staff must receive training and demonstrate competency in using the equipment prior to using for a resident transfer.

6. Staff are to receive annual training and demonstrate competency in performing resident lifts and transfers and the principles of good body mechanics.

7. Prior to doing a lift or transfer the staff does an assessment of the resident to ensure their condition has not deteriorated.

8. Prior to using a lift staff must do an inspection of both the sling and the lift.

9. Prior to doing a transfer or lift staff will ensure the transfer area is clear and free of obstruction and required equipment is in place.

10. Prior to doing a transfer or lift staff conduct a self-assessment to assess their ability to safely complete the task, assistance required, physical readiness to perform the task and establish communication with the resident and co-worker.

11. The mechanical lift will be used when possible to lift a resident who has fallen, following assessment by the RN / LPN. If a lift is not available and the Resident is unable to get up staff must call the emergency response department (911).

12. Transfer belts are readily available to all staff and must be used for all one person and two person transfers.

13. Workers found in non-compliance with this policy will receive corrective intervention from the supervisor. Non-compliance with this policy may result in disciplinary action.

**OUTCOME**

Residents will be transferred in accordance with a pre-transfer assessment and staff will not perform a manual lift.

**References**

No Unsafe Lift Workbook – Work Safe Alberta

It Doesn’t Have to Hurt - Occupational Health & Safety Agency for Healthcare in BC 2004

Musculoskeletal Injury Prevention Program - Continuing Care Safety Association
Sample 2 – Slider Sheet Policy and Procedure

STANDARD

All Residents are safely repositioned by staff members who have received training in the proper repositioning procedures and the principles of good body mechanics. Slider sheets are used to reduce the risk of injury for residents and staff.

PROCEDURE

1. A Resident transfer assessment is to be completed by a Nurse and/or Therapist on admission or readmission after a stay in acute care or whenever there is a significant change in condition. The assessment will identify residents who require assistance with repositioning.

2. Assistive devices such as slider sheets or mechanical lifts should be used where appropriate to aid repositioning.

3. Two staff are required to place and use the slider sheet.

4. Prior to doing a task, staff conduct a self-assessment to assess their ability to safely complete the task, assistance required, physical readiness to perform the task and establish communication with the resident and co-worker.

5. Prior to repositioning, assess the resident to ensure that their condition has not deteriorated.

6. Check the area around the bed to ensure the area is clear and free of obstructions.

7. Raise the height of the bed to position the resident at waist height of the shortest caregiver. The goal is to slide not lift the resident into position.

8. To place the slider sheet under the resident:
   i. One staff member on each side of the bed
   ii. Gently roll the resident to face one staff member
   iii. Place the slider sheet lengthwise at the resident’s back and gently push the slider sheet under the resident
   iv. Roll the resident back to the start position.
   v. Gently roll the resident to face the other staff member
   vi. The staff member facing the Resident’s back pulls the slider sheet into position
   vii. Roll the resident back to the start position.
9. Use a power grip (wide grip with palms up) on the transfer sheet. Create a strong foundation by placing your feet shoulder width apart in a squat position or place one knee on the bed.

10. Grasp the sheet close to the resident at the resident’s shoulder and thigh height.

11. Rock back and forth 3 times and count off 1-2-3 and perform the move on the 3rd count.

12. If removing the slider sheet from under the resident use the procedures as above.

**OUTCOME**

Residents are repositioned using a slider sheet in order to reduce risk of injury to resident and staff.
Sample 3 – Mechanical Lifts Policy and Procedure

STANDARD

All Residents will be transferred or lifted safely by staff members who have received training in the proper lifting and transferring procedures and the principles of good body mechanics.

Two staff members must assist throughout the lifting process when using all types of mechanical lifts.

If a transfer is deemed to be unsafe or lifting is involved staff must use a mechanical lift.

All mechanical lifts are to be operated in accordance with manufacturer’s instructions.

There may be a number of types of mechanical lifts at Sherwood Park Care Center: Please list the type of lifts available at the organization.

- Portable standard mechanical lift (i.e. MediMan)
- Portable sit-stand lift (i.e. MediMan SSL or ERGO SSL)

A portable sit-stand lift (SSL) transfer can be utilized only for those residents:

- Able to follow instructions;
- Are predictable in behavior;
- Can weight bear;
- Who have upper body strength;
- Are assessed by a Therapist and/or Nurse for appropriateness of use of SSL.

A standard mechanical lift transfer will be utilized for those residents:

- Who are not alert or are disoriented;
- Who are / may be unpredictable;
- Who may be inconsistent in weight bearing or
- Unable to bear weight.

Staff may operate a mechanical lift only after receiving instruction in the correct operation of the lift in accordance with the manufacturer’s instructions.

A Resident transfer assessment is to be completed by a Nurse and/or Therapist on admission or readmission after a stay in acute care.

The Resident is assessed whenever there is a significant change in condition. Never decrease the amount of assistance given in a transfer until a reassessment has been done. If transfer increases in difficulty, the transfer can be completed and the supervisor must be informed and will arrange for reassessment.
The transfer/lifting technique must be documented on the Resident care plan. It is the responsibility of all staff to comply with the transfer method specified.

**PROCEDURE**

1. Before using the mechanical lift, staff must check that the lift is in good working order:
   - All casings are free of cracks
   - Hand remote control functions
   - Lift moves freely
   - Battery is charged
   - Brakes work
   - Emergency lowering device works
   - Safety latches function on spreader bar
   - Lift is clean and free of debris

   Immediately remove from use any damaged lift and tag “Out of Order” until it has been repaired.

2. Ensure the correct sling is used for the lift and resident.

3. Inspect sling to ensure it is safe for use:
   - Check loops for wear/tear;
   - Check for fraying or loose stitching, especially at strap attachment points;
   - Check for tears or holes;
   - Ensure head support stiffeners are intact;
   - Check that label is intact and shows size, type and safe load;
   - Check for heat damage, shrinkage or rigid areas;
   - Engage clips and pull on them to ensure they stay clipped;
   - If sling has been in continuous use for over 2 years it needs to be replaced.

   If any damage is observed, remove the sling from service and report it to the Charge Nurse/designate.

4. Take lift to the Resident and explain what will be done.

5. Complete a quick assessment of the Resident to ensure that their condition has not deteriorated.

6. Prior to doing a task, staff conduct a self-assessment to assess their ability to safely complete the task, assistance required, physical readiness to perform the task and establish communication with the resident and co-worker.
7. Ensure that the entire transfer area is clear and free of obstructions.

8. Raise the bed so that you are working at elbow height with the sling straps and lower the head of the bed to a flat position.

9. When lifting the resident to or from a chair or commode the caregiver is to use proper body positioning to avoid bending or twisting their body.

10. Position sling in accordance with manufacturer’s instructions.

11. Ensure brakes on bed are engaged.

12. One staff member operates the controls and the other staff member guides the Resident in the sling.

13. Use the controls to ensure the resident’s feet clear the surface they are being lifted from and to.

14. Proceed as per manufacturer’s instructions.

15. Ensure the Resident is properly positioned and in good alignment.

16. Remove the sling from under the resident.

17. Leave the Resident safe and comfortable.

18. Return lift to appropriate area.

**Outcome**

The Resident who is to be lifted is safely lifted using a mechanical lift.
Sample 4 – One-Person Transfer Policy and Procedure

STANDARD

All Residents are safely transferred by staff members who have received training in the proper lifting and transferring procedures and the principles of good body mechanics.

A Resident transfer assessment is to be completed by a Nurse and/or Therapist on admission or readmission after a stay in acute care.

The Resident is assessed whenever there is a significant change in condition. Never decrease the amount of assistance given in a transfer until a reassessment has been done. If transfer increases in difficulty, the transfer can be completed and the supervisor must be informed and will arrange for reassessment.

The transfer/lifting technique must be documented on the Resident care plan. It is the responsibility of all staff to comply with the transfer method specified.

Transfer belts are readily available to all staff involved in direct care, and will be used for all one person and two person transfers.

PROCEDURE

1. The Resident is alert, oriented and non-impulsive and must be able to:
   - Participate to some degree in the transfer and follow instructions;
   - Partially or fully bear weight;
   - Be consistent in weight bearing capabilities;
   - Use upper body strength.

2. Ensure that the Resident is a one-person transfer and that their condition has not deteriorated.

3. Prior to doing a task, staff conduct a self-assessment to assess their ability to safely complete the task, assistance required, physical readiness to perform the task and establish communication with the resident and co-worker.

4. Explain to Resident what you are going to do and what is expected of them.

5. Ensure that the entire transfer area is clear and free of obstructions.

6. If you are unsure that you can safely transfer the resident on your own, request assistance.

7. Whenever possible, position Resident with his/her strongest side closest to transfer surface.
8. Position transfer surfaces close to each other at a 45- 90° angle and ensure that brakes are applied. If using a wheelchair/commode with footrests, remove footrests.

9. If the Resident is in bed raise the bed until the Resident’s hips are slightly higher than their knees (when Resident is sitting on the edge of the bed) and assist resident to sitting position.

10. Apply transfer belt snugly around the Resident’s waist.

11. Stand in front of the Resident. Place one foot between the Resident’s knees and the other foot on outside –do not block Resident’s knees or feet:
   - If transferring to the left use right foot
   - If transferring to the right use left foot

12. Position your palms towards the Resident and grasp the transfer belt using the power grip. Keep your elbows close to your body and shoulders down. Never let the resident put their arms around your neck or back. Use your “big muscles” to do the work and maintain a neutral body position.

13. If transferring the Resident from a chair and if the Resident is able instruct the resident to place their hands on the arm rests and lean forward and then push up.

14. Say to resident “please stand” with a rocking momentum (optional) and assist Resident to standing position.

15. Allow time for the Resident to gain balance.

16. Turn to the transfer surface, by taking small steps in the direction of the chair/bed. Instruct Resident to take small steps in the direction of the chair/bed.

17. Once you are facing the chair or bed and the Resident has the back of their knees touching the chair/bed, help the Resident to lower themselves to a sitting position by saying “Sit Down”. The Resident may reach back with their arms to touch the wheelchair, bed or chair while lowering self.

18. Ensure that the Resident is properly positioned and in good alignment.

19. Remove transfer belt and ensure the Resident is safe and comfortable.

**Outcome**

The Resident assessed as a one-person transfer is safely transferred.
Sample 5 – Two-Person Transfer Policy and Procedure

STANDARD

All Residents are safely transferred by staff members who have received training in the proper lifting and transferring procedures and the principles of good body mechanics.

A Resident transfer assessment is to be completed by a Nurse and/or Therapist on admission or readmission after a stay in acute care.

The Resident is assessed whenever there is a significant change in condition. Never decrease the amount of assistance given in a transfer until a reassessment has been done. If transfer increases in difficulty, the transfer can be completed and the supervisor must be informed and will arrange for reassessment.

The transfer/lifting technique must be documented on the Resident care plan. It is the responsibility of all staff to comply with the transfer method specified.

Transfer belts are readily available to all staff involved in direct care, and will be used for all one person and two person transfers.

PROCEDURE

1. The Resident must be able to:
   - Participate to some degree in the transfer and follow instructions;
   - Partially or fully bear weight;
   - Be consistent in weight bearing capabilities;

2. Check the Care Plan to ensure that the Resident is a two-person transfer.

3. Complete a quick assessment of the Resident to ensure that their condition has not deteriorated. If you are unsure that the Resident can be safely transferred by two staff, use a mechanical lifting device.

4. Prior to doing a task, staff conduct a self-assessment to assess their ability to safely complete the task, assistance required, physical readiness to perform the task and establish communication with the resident and co-worker.

5. Explain to the Resident what you are going to do and what is expected of them.

6. Ensure that the entire transfer area is clear and free of obstructions.
7. Whenever possible, position Resident with his/her strongest side closest to transfer surface.

8. Position transfer surfaces close to each other at a 45 angle and ensure that brakes are applied. If using a wheelchair/commode with footrests, remove footrests.

9. If the resident is in bed assist the Resident to a sitting position.

10. Raise the bed until the resident’s hips are slightly higher than their knees.

11. Apply transfer belt snugly around the Resident’s waist.

12. Each caregiver stands in front of the resident with the inner foot in front of the resident’s foot and the knee ready to block the resident’s knee, in case it should buckle.

13. Each caregiver grasps the transfer belt with a power grip on back and front of belt with arms crossing. Do not lift up under the resident's arm. Instruct the Resident to push up from the bed/wheelchair using his/hers hands. Never let the resident put their arms around your neck or back.

14. The lead caregiver establishes communication between the caregivers and the resident. When ready to assist the resident count 1-2-3 stand and smoothly guide the resident to a standing position. Bend your knees and hips and lean forward keeping your back in a neutral posture.

15. Allow time for the Resident to gain balance in the standing position.

16. Turn to the transfer surface, taking small steps and instructing the resident to take small steps to pivot around. Stop when backs of the resident's knees are against the edge of the wheelchair seat/bed.

17. Instruct the resident to reach back with one or both hands and grasp the bed/wheelchair arm(s). Tell the resident to “Sit Down” and assist him/her to sit in the wheelchair/bed. Remember to bend your knees and hips and keep your back flat.

18. Ensure that the Resident is properly positioned and in good alignment.

19. Remove transfer belt and leave Resident safe and comfortable.

Outcome

The Resident assessed as a two person transfer is safely transferred.
# Appendix 4: Sample Supervisor Follow-up Checklist

**Safe Resident Handling Assessment Form**

<table>
<thead>
<tr>
<th>Lift Preparation Assessment</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Proper footwear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Obstacles are removed as necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Determine if equipment is required</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. If equipment is required, is it in working order?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is another person required to help move the resident?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rolling Resident**

| 1. Bed height is adjusted, if possible |   |   |     |          |
| 2. Resident is cued to bend or cross legs and is prepared for roll |   |   |     |          |
| 3. One knee is on or touching the bed, while the other is behind, bent at the knee |   |   |     |          |
| 4. Hands are placed under the resident’s hip and shoulder |   |   |     |          |
| 5. Counts 1, 2, 3 before rolling |   |   |     |          |
| 6. Motion comes from the legs and resident is gently turned onto the side |   |   |     |          |

**Lateral Slide**

| 1. Bed height is adjusted, if possible |   |   |     |          |
| 2. Roll technique is used to get a slider sheet into position |   |   |     |          |
| 3. The caregiver who is pulling has a palms-up power grip on the slider sheet |   |   |     |          |
| 4. The caregiver who is pushing has hands placed palms-up under the resident’s shoulder and hip |   |   |     |          |
| 5. Counts 1, 2, 3 before sliding |   |   |     |          |
| 6. Legs are bent and power comes from the legs moving. The back is kept straight and the head is up. |   |   |     |          |

**Boosting**

| 1. Roll technique is used to get a slider sheet into position |   |   |     |          |
| 2. Both caregivers roll up the ends of the slider sheet close to the resident’s body and have a palms-up grip. |   |   |     |          |
| 3. Legs are wide and in a squat position. |   |   |     |          |
| 4. Counts 1, 2, 3, while rocking in the direction of the slide to maintain good body mechanics and build momentum |   |   |     |          |
| 5. Resident is not lifted, but slid, up the bed. |   |   |     |          |
### Supine to Sit

1. Resident’s legs are positioned close to the edge of the bed.
2. Caregiver places one hand down the resident’s spine, between the shoulder blades and the other just above the resident’s knee.
3. Legs are in a squat position and the back is straight.
4. Resident is cued to assist with sitting motion. Counts 1, 2, 3.
5. Legs are gently pulled off the bed, and caregiver pivots and provides support as the resident sits up.

### Transfer

1. Transfer belt is placed properly and is tight so only two fingers can be fit under.
2. Wheelchair is placed 90° to bed, with footrests removed and brakes locked.
3. Caregiver should have one leg inbetween resident’s legs, and the other open in the direction of the transfer.
4. Resident’s feet should be flat on the floor, knees bent to 90°, hands should be inside staff’s arms or on bed or chair for push off.
5. Staff explains process of transfer to resident, counts 1, 2, 3, stand.
6. Staff bends knees while assisting resident to standing position.
7. Staff shuffles with resident keeping their knees and feet facing the same direction.
8. When resident’s knees touch the back of the chair/bed staff counts 1-2-3-lower to assist resident to seating position.

### Mechanical Lift

1. Raise or flatten bed to appropriate position.
2. Place sling under resident’s back using rolling technique.
3. Lift is positioned over the resident and the sling attached. Sling attachments and placement is double checked.
4. Lift procedure is communicated to resident.
5. Resident is safely lifted to clear the bed with one staff member using the controls and other helping guide and support the resident.
6. Position lift over chair/bed and lowers resident safely into position.
7. Sling is removed from behind the resident.

---

Employee Name: _____________________  Employee Signature: _____________________

Observers Name: _____________________  Observers Signature: _____________________
# Musculoskeletal Injury Prevention Assessment Form

<table>
<thead>
<tr>
<th>Date: ________________</th>
<th>Location: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Name: __________</td>
<td>Position: ____________________________</td>
</tr>
<tr>
<td>Department: ________________</td>
<td></td>
</tr>
</tbody>
</table>

## Safe Lift/Transfer Checklist

<table>
<thead>
<tr>
<th>Safe Lift/Transfer Checklist</th>
<th>Y</th>
<th>N</th>
<th>NA</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check Resident and surroundings:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Resident is assessed for change in cognitive, physical or medical status?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Obstacles are removed as necessary?</td>
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<td></td>
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<tr>
<td>• Necessary equipment is handy and inspected for wear and tear?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Is another person required to assist?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• If another person is required, is there communication regarding the lift procedure prior to action?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Use a strong foundation:

• Are feet shoulder-width apart?
- Are legs bent into a squat position?

- Are arms in a palms-up grip, with elbows close to 90° if possible?

**Keep loads close to centre of gravity:**

- Is the head kept up through most of the task?

- Is the weight of the object kept as close as possible to the waist?

**Use big muscles:**

- Are the big muscles of the legs and thighs used instead of small muscles in the arms, shoulders and back?

- When turning, does the “nose follow the toes” to keep the torso straight?

- When lowering, do the legs bend into a squat position, rather than bending at the waist?

---

**Employee Name:** ___________________________  **Employee Signature:** ___________________________

**Observers Name:** ___________________________  **Observers Signature:** ___________________________
Appendix 5: CCSA’s Safe Resident Handling Hazard Identification Checklist Booklet

In order to eliminate design-related hazards associated with resident handling tasks, managers and employees must know how to recognize them. This is where the CCSA Safe Resident Handling Hazard Identification Checklist booklet is useful.

The booklet includes:

- A discussion of the ‘Key hazards associated with resident handling tasks’ including:
  1. Physical Demands of the task
     - Force
     - Repetition and Duration
     - Work Postures
  2. Resident Characteristics
     - Communication
     - Cognition
     - Behavioural & Emotional Status
     - Medical Status
     - Physical Status
  3. Work Environment
     - Design of the work space
     - Equipment
  4. Work Organization
     - Work recovery cycle
     - Task variability
     - Work rate

- Other considerations include the caregiver, their clothing and personal risk factors for workers.

- Center pull-out "Resident Handling Task Identification Checklist", which includes:
  - Physical Demands Risk Assessment
  - Pre-task Resident Risk Assessment
  - Workplace Risk Assessment

- NOTE: As with any checklist, this Resident Handling Hazard Identification Checklist does not measure the level of the risk to employees, it simply indicates that a hazard is present, even if the hazard presents a very small risk to workers. If there are hazards identified, there should be further discussion to determine whether controls are in place or may be required.
Appendix 6: Safe Resident Handling Algorithms

Making Safe Resident Handling Decisions

- In this section we will review a process;
- It is a process to help you decide on the safest way to handle a resident;
- This process is formed by The Safe Resident Handling Algorithms;
- These algorithms help to ensure that you won’t get injured during the activity;
- They were developed by the National Institute of Occupational Safety and Health, with assistance from the American Nurses Association and the Veterans Health Administration's resident Safety Center. (Source: [http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/SafePatient/Resources/ergonomics1.pdf](http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/SafePatient/Resources/ergonomics1.pdf))

When Should You Use Them?

- For every resident who needs help moving.
- For each resident handling task, use the Algorithms to determine the equipment you will need, how many co-workers you should call on to assist you, and the resident handling technique to use.
- The Algorithms provide general direction.
- Use your professional judgment in applying them to help ensure resident and caregiver safety.
- After a while, you’ll get used to using them.

What Tasks Do the Algorithms Cover?

There are algorithms for the following activities:

<table>
<thead>
<tr>
<th>Algorithm 1 Transfer To and From</th>
<th>Algorithm 2 Lateral Transfer To and From</th>
<th>Algorithm 3 Transfer To and From</th>
<th>Algorithm 4 Reposition in Bed</th>
<th>Algorithm 5 Reposition in a:</th>
<th>Algorithm 6 Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed - Chair</td>
<td>Bed - Bed</td>
<td>Chair - Stretcher</td>
<td>Side - Side</td>
<td>Chair</td>
<td>Resident up from the Floor</td>
</tr>
<tr>
<td>Chair - Toilet</td>
<td>Bed - Bed</td>
<td>Chair - Exam Table</td>
<td>Up in Bed</td>
<td>Wheelchair</td>
<td></td>
</tr>
<tr>
<td>Chair - Chair</td>
<td>Bed - Stretcher</td>
<td></td>
<td></td>
<td>Dependency Chair</td>
<td></td>
</tr>
<tr>
<td>Car - Chair</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2015 Safe Resident Handling Workshop
Algorithm 1:
Transfer to and From: Bed to Chair, Chair to Toilet, Chair to Chair, or Car to Chair

1. Start Here
2. Can patient bear weight?
   - Fully: Caregiver assistance not needed; Stand-by for safety as needed.
   - Partially:
     - Is patient cooperative?
       - Yes: Stand and pivot technique using a gait / transfer belt (1 caregiver) or powered standing assist lift (2 caregivers)
       - No: Use full body sling lift and 2 caregivers
     - No:
       - Is patient cooperative?
         - Yes: Use seated bariatric transfer aid; may use gait / transfer belt until the patient is proficient in completing transfer independently.
         - No: Use full body sling lift and 2 caregivers
Algorithm 2:  
Lateral Transfer To and From: Bed to Stretcher or Trolley

- Destination surface should be ½ inch lower for all lateral patient moves.
- For patients with Stage III or IV pressure ulcers, care must be taken to avoid shearing force.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Algorithm 3:
Transfer To and From: Chair to Stretcher or Chair to Exam Table

Start Here

Is the patient cooperative?

No → Use full body sling and 2 or more caregivers.

Yes

Can the patient bear weight?

Fully → Caregiver assistance not needed; Stand by for safety as needed.

Partially → If exam table/stretcher can be positioned to a low level, use non-powered stand assist. If not, use a full body sling lift.

No → Use full body sling lift and 2 or more caregivers.
Algorithm 4:
Reposition in Bed: Side-to-Side, Up in Bed

- This is not a one person task: DO NOT PULL FROM HEAD OF BED.
- When pulling a patient up in bed, the bed should be flat or in a Trendelenburg position to aid in gravity, with the side rail down.
- For patients with State III or IV pressure ulcers, care should be taken to avoid shearing force.
- The height of the bed should be appropriate for staff safety (at the elbows).
- If the patient can assist when repositioning “up in bed,” ask the patient to flex the knees and push on the count of three.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Algorithm 5:
Reposition in Chair: Wheelchair and Dependency Chair

Start Here

Can patient assist?
- No
  - Caregiver assistance not needed; Stand-by for safety as needed.
- Partially
  - If patient has upper extremity strength in both arms, have patient lift up while caregiver pushes knees to reposition.
  - If patient lacks sensation, cues may be needed to remind patient to reposition.
- Fully

Does chair recline?
- Yes
  - Recline chair and use a friction reducing device and 2 caregivers.
- No

Is patient cooperative?
- Yes
  - Use full body sling lift or non-powered stand assist and 2 caregivers.
- No

Use full body sling lift and 2 or more caregivers.

Comments:
- Take full advantage of chair functions, e.g. chair that reclines, or use of arm rest on chair to facilitate repositioning.
- Make sure the chair wheels are locked.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs. of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Algorithm 6:
Transfer Patient Up from the Floor

Start Here

Was the patient injured?  Yes \rightarrow Was the injury minor?  No

Yes \rightarrow Depends on type and severity of injury (follow Standard Operating Procedures).

No \rightarrow Can patient assist?  No \rightarrow Full body sling lift needed with 2 or more caregivers.

Yes \rightarrow Caregiver assistance not needed; Stand by for safety as needed.
Bariatric Algorithm 1:
Bariatric Transfer To and From: Bed to Chair, Chair to Toilet, or Chair to Chair

Start Here

- Can patient bear weight?
  - Fully: Stand-by for safety as needed*
  - Partially or No

- Is patient cooperative?
  - Partially Able or No: Bariatric full body sling lift (minimum of 3 caregivers)
  - Fully

- Does patient have upper extremity strength?
  - No: Bariatric stand assist lift (minimum of 2 caregivers) OR Bariatric full body sling lift (minimum of 2 caregivers)
  - Fully

Use seated bariatric transfer aid; may use sliding board until the patient is proficient in completing transfer independently (minimum of 2 caregivers)

- For seated transfer aid, must have arms that recess or are removable.
- Bariatric toileting slings are available for toileting.
- Bariatric bathing mesh slings are available for bathing.
- Note that a standard porcelain toilet typically has a weight limit of 350 pounds; the patient may need bariatric commode chair or steel toilet.
- In older lifts, more effort is needed to place the sling under the patient; which may require a minimum of 3 caregivers.
Bariatric Algorithm 2:
Bariatric Lateral Transfer To and From: Bed to Stretcher, Trolley

- The destination surface should be about $\frac{1}{2}$" lower for all lateral patient moves.
- Avoid shearing force.
- Make sure bed is the right width, so excessive reaching by caregiver is not required.
- Lateral transfers should not be used with specialty beds that interfere with the transfer.
- Ensure bed or stretcher doesn't move with the weight of the patient transferring.
- Use a bariatric stretcher or trolley if patient exceeds weight capacity of traditional equipment.
- “Stand-by for safety.” In most cases, if a bariatric patient is about to fall, there is very little that the caregiver can do to prevent the fall. The caregiver should be prepared to move any items out of the way that could cause injury, try to protect the patient's head from striking any objects or the floor and seek assistance as needed once the person has fallen.
- Ensure equipment used meets weight requirements. Standard equipment is generally limited to 250-350lbs. Facilities should apply a sticker to all bariatric equipment with “EC” (for extended capacity) and a space for the manufacturer's rated weight capability for particular equipment model.
- If the patient has partial weight-bearing capability, transfer toward the stronger side.
- Consider using an abdominal binder if the patient's abdomen impairs a patient handling task.
- Identify a leader when performing tasks with multiple caregivers. This will ensure that the task is synchronized for increased safety of the healthcare provider and the patient.
Bariatric Algorithm 3:
Bariatric Reposition in Bed: Side-to-Side, Up in Bed

- When pulling a patient up in bed, place the bed flat or in a Trendelenburg position (if tolerated and not medically contraindicated) to aid in gravity; the side rail should be down.
- Avoid shearing force.
- Adjust the height of the bed to elbow height.
- Mobilize the patient as early as possible to avoid weakness resulting from bed rest. This will promote patient independence and reduce the number of high risk tasks caregivers will provide.
- Consider leaving a friction-reducing device covered with drawsheet, under patient at all times to minimize risk to staff during transfers as long as it doesn’t negate the pressure relief qualities of the mattress/overlay.
- Use a sealed, high-density, foam wedge to firmly reposition patient on side. Skid-resistant texture materials vary and come in set shapes and cut-your-own rolls. Examples include:
  - Dycem™
  - Scoot-Guard™: antimicrobial; clean with soap and water, air dry.
  - Posey-Grip™: Posey-Grip™ does not hold when wet. Washable, reusable, air dry.
Bariatric Algorithm 4:
Bariatric Reposition in Chair: Wheelchair, Chair, or Dependency Chair

- Take full advantage of chair functions, e.g. chair that reclines, or use an arm rest on chair to facilitate repositioning.
- Make sure the chair wheels are locked.
- Consider leaving the sling under the patient at all times to minimize risk to staff during transfers after carefully considering skin risk to patient and the risk of removing/replacing the sling for subsequent moves.
Bariatric Algorithm 5:
Patient Handling Tasks Requiring Access to Body Parts
(Limb, Abdominal Mass, Gluteal Area)

Assemble multidisciplinary team to develop creative solutions that are safe for patient and caregiver.

Examples:
- Modify use of full body sling lift to elevate limbs for bathing or wound care (i.e. bariatric limb sling).
- Use draw sheet with handles for 2 caregivers (one per side) to elevate abdominal mass to access the perineal area (e.g. catheterization, wound care).
- To facilitate drying a patient between skin folds, use the air assisted lateral transfer aid to blow air or use a hair dryer on a cool setting.
- Use sealed high-density foam wedge to firmly reposition patient on side. Skid-resistant texture materials vary and come in set shapes and cut-your-own rolls. Examples include:
  - Dycem (TM)
  - Scoot-Guard (TM): antimicrobial; clean with soap and water, air dry.
  - Posey-Grip (TM): Posey Grip does not hold when wet. Washable, reusuable.
Bariatric Algorithm 6:
Bariatric Transporting (stretcher)

- If the patient has respiratory distress, the stretcher must have the capability of maintaining a high Fowler’s position.
- Newer equipment often is easier to propel.
- If patient is uncooperative, secure patient in stretcher.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used for the transfer.
Appendix 7: Transfer Logos

The following transfer logos were obtained from the Public Service Health & Safety Association (Ontario); Handle with Care: Logo Cards via their website:


INDEPENDENT TRANSFERS:

• This should be used when a client is able to mobilize without risk of injury and the client is comfortable with the use of mobility aids.

SUPERVISED TRANSFERS:

• This should be used when the client is able to mobility but may require verbal or minimal physical cueing. Transfer belts should be used in all cases.

ONE PERSON TRANSFER BELT / PIVOT TRANSFER:

• This should be used when a client can stand unsupported or weight bear with assistance of one person who will provide less than 40 pounds (18 kg) of assistance.
• This transfer can also be performed if a physician orders feather, toe-touch or partial weight bearing.
• For safe handling a transfer belt must be used.
TWO-PERSON STANDING PIVOT TRANSFER:

- This transfer should be used when a client can bear weight through the legs but is heavy and unreliable. This technique requires two health care workers, with the tall person behind the resident. A transfer belt must be used.

WALKER TRANSFER:

- Walker transfer should be used when a client can bear weight through at least one leg, and whose upper extremity strength and mobility are adequate. This can also be used if the physician orders feather, toe-touch, or partial weight bearing.

SIT-STAND MECHANICAL LIFT:

- This lifting technique should be used when a client can sit with minimal support at the edge of the bed and is able to bear some weight. The client may be cognitively predictable and reliable. The client is able to tolerate harness under his/her arms. This should not be used with clients who have a hemiplegic arm.

TOTAL MECHANICAL LIFT:

- A total mechanical lift should be used when a client can only minimally transfer or is not able to assist with weight bearing. This should also be used if the client is cognitively unreliable or uncooperative, has poor head control or sitting balance or is extremely large or heavy and requires assistance.
TRANSFER BELT:

- Transfer belts should be used when a client needs assistance with any transfer or for mobilization.

SLIDE BOARD / TRANSFER BOARD:

- Slide boards / Transfer boards should be used when transferring between equal height surfaces. Slide boards should also be used to facilitate transfer to wheelchair and for a client with excessive weakness in their lower limbs.

SLIDE SHEETS:

- Slide sheets should be used in repositioning a client in bed who is unable to move themselves independently. Two caregivers are required for use. Slide sheets can also be used to move a client from bed to stretcher or in an emergency situation where the client has fallen in a confined space or the mechanical lift or other transfer methods cannot be employed.
Appendix 8: Immediate Changes to Improve Resident Handling Safety

The New Zealand Resident Handling Guidelines offers the following suggestions for “Immediate changes to improve resident handling safety” as cited in the “No Unsafe Lift Workbook” (p. 66-68).

Resident Rooms:

- Keep rooms tidy and free of clutter.
- Create a permanent clear passage from the foot of the bed to the door, so there is always clear access to move equipment from the door to the bed.
- In small rooms, and where space is at a premium, attach castors to the furniture so it can be easily moved out of the way during resident handling tasks.
- Make sure beds are height adjustable.
- Make sure chairs have armrests to help resident transfers.
- Try to locate residents who need to be assisted with wheelchairs as near to day or dining rooms as possible, to minimize the distance they have to travel.
- Provide plenty of electrical sockets, to prevent trailing electrical and extension cords.
- Maintain a policy regarding acceptable furniture for residents to bring into the facility, to avoid clutter and heavy lifting for workers.

Toilets, Showers and Bathrooms

- If toilets are small, inaccessible and in difficult places in which to perform resident handling tasks safely, consider using other toileting methods such as commodes, pans or bottles.
- Consider the loading weight of toilets, especially for bariatric residents.
- If the shower or bathroom is too small and inaccessible for large resident handling equipment, consider:
  - Bed bathing the resident until an alternative is found, or
  - Using a shower chair that can be pushed into the shower or bathroom.

Corridors, Doors and Flooring

- Check corridors and access routes are free of items that restrict minimum recommended widths.
- Check that:
  - Corridor doors swing in the direction of the exit,
  - Door swings do not restrict recommended minimum corridor widths,
  - Toilet doors do not swing inwards, and
  - Items are not stored behind doors that can restrict them fully opening.
➢ Check floor coverings are tightly fixed to the floor, and permanently seal all gaps and loose edges.
➢ Check carpet edging strips are beveled and not more than 10mm above the floor.

**Resident Handling Equipment**

➢ Ensure resident handling equipment is well maintained, and repaired or replaced when damaged.
➢ Use temporary ramps for wheeled equipment to eliminate the risks associated with lifting equipment over thresholds. Install grab rails in toilets, showers and bathrooms to encourage residents to stand and sit independently.
➢ Install continuous handrails along corridors and stairs.
➢ Consider installing ceiling tracks and wall hung or gantry hoists because these require less room to move residents than mobile hoists.

**Storage**

➢ Ensure the storage area is well organized with clearly defined areas for resident handling equipment.
➢ Locate storage areas preferably within 20 meters of handling areas and within 10 meters of the nurses’ station.