easternhealth
GREAT HEALTH AND WELLBEING

Patient Mobility Refresher scenario solutions: *things to look for mention or consider*

Scenario 1

- Perform a pat slide transfer
- You need at least 3 people when doing a pat slide transfer; probably more for this example
- Consider it may be wet and this will inhibit sliding
- Support for the patient head if they are unconscious
- People should be pushing one side and the other side pulling with legs in stride stance – force comes from transferring of weight from front foot to back foot, lock elbows. No twisting
- It is an emergency so things are moving fast - make sure everyone is on the same page – there needs to be a leader counting down to transfer

Scenario 2

- Medically: condition of the other leg, BP, patient comprehension and ability to co-operate, tubes, talk to nurses re patient condition
- Transfers: we could be looking at sitting up/lying down transfer (2), it could include rolling (3), sitting on the side of the bed (5) – so equipment might include using the electronics of the bed if available, bed sticks or ropes. Consider what side of the bed you should stand if having to assist with rolling – no leaning over the bed. And that's just to sit up on the side of the bed!
- Then if it's safe you're looking at bed to chair/commode transfer: so a slide board transfer or standing pivot if they are quite good. With regards to standing pivot you would perhaps follow the stand and step flow chart to a degree (as in they won't be hopping or stepping in the end but rather pivoting). I believe hopping is not encouraged for amputees who have vascular issues. Consider whether you remove the arm of the chair/commode you are moving to etc.
- If more than mod assist seek a second therapist or use standing machine

Scenario 3

- Here we are meant to consider that the patient is bariatric so we need to have more staff available to work with this patient when manual handling is involved
- Get the patient to assist as much as possible – facilitate this by getting him to get his bottom to the edge of the seat, feet back , using momentum of trunk leaning forward (transfer weight backwards and forwards), get patient to put hand down on chair sides so he can help push off as much as possible.
- Maybe have a frame in front of patient (make sure it is a bariatric frame with the safe weight limit – SWL -on it)
- Clear environment so therapists can stand on both sides of the patient
- Treat and handle with dignity (with regards to bariatric patients)
- If have to put in more than mod assist will need to use standing machine and check the SWL

- In the future consider whether chairs without arms should be in the CRC waiting room

Scenario 4

- This scenario shows that a patient's ability to transfer does not remain static – it is always changing and it is important to always be assessing as you go. You do not just take what is written in the patient's notes or what you are told by other staff members as gospel – you do not carry on with a transfer if you feel it is unsafe or beyond your capabilities which is what is repeated throughout the AHSM flow charts. Patient's abilities can fluctuate with what time of day it is/ fatigue levels, pain levels, anxiety and all of these things need to be considered.
- So it sounds like you would end up using the standing hoist to transfer from bed to chair. If the patient can't manage a standing hoist a sling hoist could be used as last resort. If someone brings up using a sling hoist with a patient who has had a hemi-arthroplasty it could be said that you need to weigh up the risks of dislocation with the need to sit out of bed; that you would have at least 3 people with a sling hoist: one controlling the mechanics, one behind the patient holding onto the handles of the sling and the third supporting the legs
- With regards to what you report back to nurses – this is to point out that we need to consider/ remember that nurses work under their own smart moves policies. That you will record the current transfer ability as you found it yourself and that it perhaps fluctuates according to pain levels, time of day/fatigue etc. And also a reminder that AHSM is about manual handling for therapeutic reasons and not to move a patient from A to B for other disciplines.

Scenario 5

- For the first situation this is a hint to do a floor transfer as there is no injury likely – follow the flowchart but there are also many other safe ways to get a patient up off the floor – see what people come up with and just make sure they use safe body mechanics (like keeping the load/patient close to you, bending knees) and no more than mod assist. Consider allowing time for the patient to settle down before moving off the floor, perhaps a blind/cover so everyone is not watching the patient, assure the family members who are with the patient, bring a chair both to use in the floor transfer and to sit on once standing up.
- In the second scenario even though the patient again does not appear injured she is very shaken and upset and not able to help much. This means a likely sling hoist transfer – or whatever other equipment your site has available eg hover mats etc. So this again emphasises don't be afraid to use standing machines, sling hoists when indicated – you need to save your back and should not continue with a transfer if it calls for more than mod assist or if you feel unsafe. Also the environment (mobility garden) does not make things easy for this transfer.

Scenario 6

- Consider slide transfers if no one can assist with stand and step (eg if gets vol transport)

- Consider Maxi taxi, hire of vans if he has to remain in the wheelchair
- Consider Car modifications /use of hoists/resources available/SWEP funding.
- Consider education of family, PCA. Possible use of volunteer driver.