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Transfers for the School Therapist

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Main Principles:

- Keep back straight at all times & stick your buttocks out. Lean forward by hinging at the hips.
- Keep child close to you (greater the distance b/w you & the child, the greater the relative weight of the child). Force= Mass x Distance.

This also applies when you transfer a dependent child holding onto his/ her trunk and legs are dangling. The relative weight of that child increases, increasing your risk for injury. (This is acceptable only if the child can weightbear, thereby minimizing the actual amount of weight you have to lift/ support.)

- In general, position the wheelchair (W/C) close to the surface to which you are transferring. If the child is on the floor, have the child crawl towards or bring the child close to the W/C prior to lifting him/ her back in the chair. (Exception: For small children who can not crawl to the W/C, it may be better to lift the child from the start & bring them directly to the W/C. Otherwise, you may end up doing a lot of hunching over.)
- Do not transfer children by holding onto their arms - can sublux/ dislocate & cause shoulder impingement over time. The shoulder is an inherently unstable joint because the labrum (shoulder socket) is very shallow compared to the humeral head. Better to firmly grasp around the child's trunk prior to lifting.
- Many children with spasticity will thrust legs out unexpectedly (due to extensor tone). Important to flex child's hips or have the child sit up before lifting the child in order to break up the extensor tone. This will help minimize the unpredictable movements and protect the safety of the therapist and the child. This should be done when transferring the child out of the W/C as well as when transferring back into the chair.
- When you need to pivot around as with various transfer techniques, take a *series of small steps*. You will need to instruct para's & teachers to do so as well.
- Always complete the lift before you begin to turn or pivot.
- Telling children what you are going to do or how they can assist can help minimize unpredictable movements by the child, lessen your work during the transfer, and increase yours and your student's safety.
- Make sure W/Cs are locked when taking a child out of the chair or when putting the child back in the chair. Instruct staff members of this as well.
- For your safety, make sure you have proper footwear so that you don't fall or slip during transfers. If you slip, you endanger yourself and the child.
- The seat belt should be the last part unfastened when taking the child out of the W/C and the first part fastened when putting the child back in the chair. The chest harness is

the next of importance. Once these are secure, the child's safety is assured and you can now focus on putting back the armrests, footrests, & foot straps.

- Make sure the surface you are moving the child to is stable. Often helps if you put that surface (i.e., classroom chair, stander, etc.) against the wall so the wall can help stabilize it.
- Transfers in tight spaces require some problem solving on the part of therapists, teachers, and paraprofessionals (i.e., bathrooms). Make it a collaborative effort so that they feel their input is valuable and that you value them as part of the team.

Remember that proper body mechanics & transfer techniques are valuable, but they only go so far. If a child is extremely heavy, respect your limitations; use a hoist lift or ask others for assistance. Be willing to help others so that in turn, they will be willing to help you.

As part of your role as a therapist, you will need to instruct these principles to the school staff. It is best to share the information such that they know you have their best interest and well-being in mind. You may need to reinforce these principles on a continual basis.

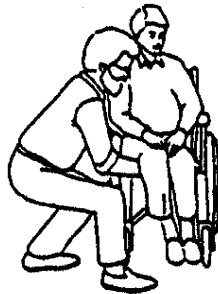
Most Common Transfers used by School-Based Therapists

1- Person Dependent Transfer TO a surface:

•Have W/C directly facing the floor mat or mat table. If transferring to a mat table, it is helpful to leave a little bit of space (but not too much) between the W/C and the table so that you will have room to pivot using small step.

The therapist should scoop up the child by standing to the child's side and having one arm around the child's trunk & one arm under the child's knees. Complete the lift before you turn.

Observe proper body mechanics and the principles noted above. Your initial focus is to get the child's buttocks in contact with the surface so that the surface is now taking all of the child's weight. You can then reposition the child on the mat table as desired.



1- Person Dependent Transfer FROM a surface:

Sit the child up first (flex the hips). Position yourself to the side of the child and lift the child up onto your knee which is flexed to 90 degrees. Check that you have a stable grasp, and then proceed to stand as you lift the child.



2-Persons Dependent Transfers:

•Side-Side method:

Have the W/C directly facing the mat table or floor mat. With the mat table, you may need to have a little space between the W/C and the table in order to have room to pivot.

One therapist should be on one side of the child and the other therapist on the other side. Both therapists should try to wrap one of their arms around the child's trunk and the other arm under *both* of the child's knees. Holding both knees gives you more control than if each therapist took one leg each (i.e., if a child suddenly goes into extensor tone, you can flex the child's hips more easily). It is helpful for the two therapists to do the above while interlocking your arms together.

Coordinate the lifting while counting to 3. Your initial concern is just to have the child contact the surface so that it is taking all of the child's weight; you can then proceed to reposition the child once on that surface.

This method is good if the two therapists are of generally equal strength or if the child is extremely heavy so that the weight must be distributed equally between the 2 therapists.

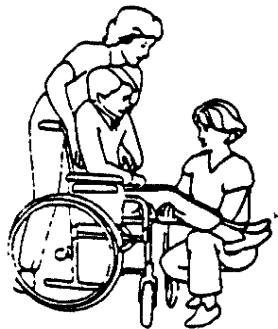


•Top-Bottom method:

Should have the W/C directly facing the floor mat. If going to a mat table, can have the W/C at 45 degrees to the table; the top therapist should move the child to the table using weightshifting from one leg to the other leg (must be diligent to keep your back straight with this). The other therapist supports the child's legs. You can also position the W/C so that it is directly facing the mat table and sufficient space is available between the W/C and the table for pivoting.

One therapist, preferably the taller one, wraps both his/her arms around the child's upper trunk/ across the chest while the other therapist is to the side of the child supporting both of the child's legs.

This method is good if the top therapist is stronger as he/she will need to take most of the weight. Top person should coordinate the transfer by counting to 3 so that both therapists lift at the same time.

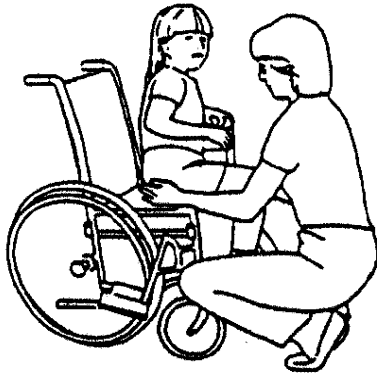


Stand-Pivot Transfer (Therapist in front of the child):

Have the child scoot forward first if they are able, and then use "Nose over your toes" to get child to shift weight forward prior to standing. If the child is not able to do this due to spasticity in lower extremities, poor muscle control, or impaired cognition but can weightbear, you can flex the child's trunk and use your hands to scoot the child forward alternating the left and right hips.

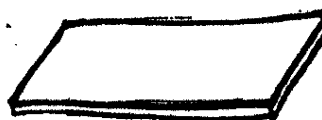
In both cases, you can stand in front of the child and support him/ her around the trunk. The therapist should put one foot in between the child's and one foot near the transferring surface, and then bring the child to standing. If possible, have the child place his/ her hands on the armrests and push up to stand. Caution: the child should not begin to stand until they are at the edge of the W/C and their feet are properly placed.

If the W/C seat is too high, it will be difficult to get the child back in using the stand-pivot method. You may need the child to step up onto a stable foot stool prior to getting back into the chair. When the child turns around on the foot stool to get into position to sit, make sure his/ her knees/ legs are not being excessively torqued. Have the child's buttocks contact the seat, and then refine the position by either going behind the child, wrapping your arms around their trunk (usually good for heavy/ older children) and then lifting the child all the way back, or by going in front of the child, blocking their knees with your knees and then lifting by their trunk under the axilla.



Standing Transfer (Therapist behind the child):

If a child can weightbear, but requires more assistance from you to maintain upright (i.e., 2^o to poor trunk control or poor foot/ lower extremities alignment), you can do a standing transfer by going behind and slightly to the side of the child. You can then wrap your arms around the child's trunk and then coordinate the standing with the child so he/ she can assist. This method is helpful if you are going directly to the floor mat and if the child can walk/ reciprocate to assist you.

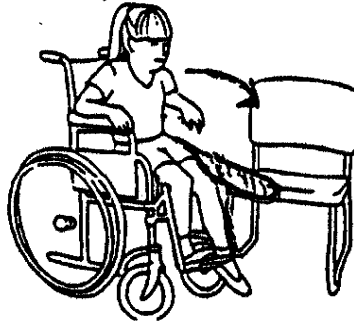


Sliding Board Transfers:

Make sure the child has removeable armrests for this or if the child is due for a new W/C, request removeable armrests.

Position the W/C at 45 degrees to the mat table or transfer surface. Assist the child to scoot forward in the W/C first and make sure the sliding board is securely positioned under the child's buttocks. Assist the child as needed and initially guard closely until the child becomes skilled at this.

As a treatment idea, you can have the child scoot sideways all along the edge of the mat table in both direction.



Transfers in extremely tight spaces (i.e. bathrooms)

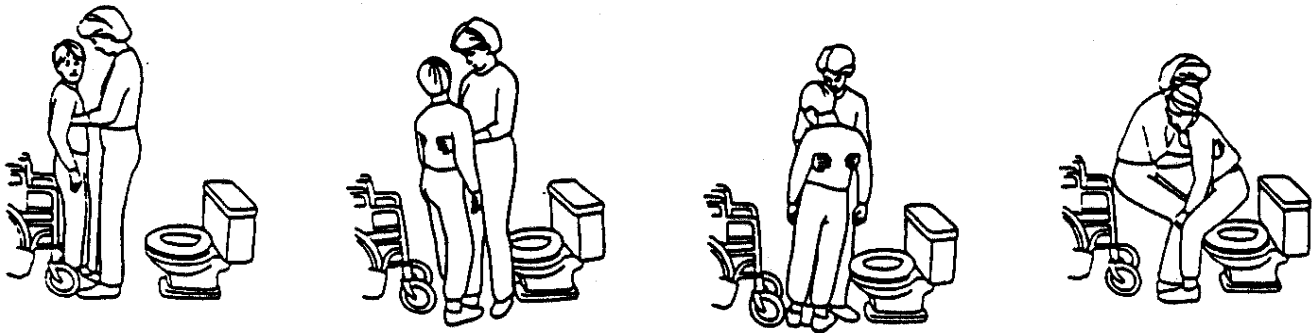
Can use the 2 persons side-side or top-bottom methods discussed earlier. Have the W/C at 45 degrees or directly facing the changing table, but leave sufficient space between the W/C and the table for you to pivot using small steps.

If transferring a child from the W/C to a Rifton toilet seat, make sure the toilet seat brakes are on and ideally stabilized against a wall or sturdy surface. Position the W/C at 45 degrees to the toilet seat. Stand in front of the child for the stand-pivot method. If the child is dependent for transfers, position the chair at 45 degrees to the toilet seat, leaving some space for the therapist to pivot. It is preferable to use the top-bottom method since this will take up less space to complete, but the side-side method can also be used.

If there are grab bars on the wall, it will be helpful to bring the W/C close to the grab bars so that the child can hold onto them while standing. Make sure the child's feet are properly positioned so that standing is not compromised. Support the child as needed around the trunk as you pull the child's pants down for the toilet. Push the W/C away if necessary. Have the child take small steps with you to turn to sit on the toilet while still having at least one hand on the grab bar.

When toilet use is completed, have the child reach for the grab bars so that he/ she can stand while pants are pulled up and the W/C is brought behind him/ her. Another approach is to bring the W/C directly in front of the child while he/ she is still on the toilet. Using the stand-pivot method, stand in front of the child (having someone help you pull up the pants) and then pivot around together using a series of small steps.

If transferring to the regular toilet seat, you will usually need to have the W/C close to the toilet and directly facing it since there is not enough room in school bathrooms to have the W/C next to the toilet at a 45 degree angle. Stand in front of the child and use a stand-pivot method if they can assist. If the child can not assist with the transfer, position the W/C directly facing the toilet, leaving sufficient space for the therapists to turn. Either the side-side or the top-bottom methods can be used here.



Hoyer Lifts:

Make sure you acquaint yourself with the hoyer lift prior to training para's or others to use it. Identify how to widen the base so it can slide around the wheelchair base. Identify how to crank the handle to lower and raise the hoyer. Identify the hoyer lift brakes. For every heavy child using the hoyer lift, try to have the child get his/ her own sling and come to school with it underneath his/ her buttocks everyday. This way, staff members do not have to strain themselves to lift the child just to get a sling underneath him/ her before even using the hoyer lift. The child's social worker or hospital equipment clinic can help with ordering the child's own sling.

When using the sling & the hoyer, it is extremely important that the sling is positioned so that the thighs are fully supported or such that the child's hip are in greater flexion than 90 degrees. Otherwise, the child runs the risk of falling out of the sling while he/ she is suspended in the air. (This could turn into a possible law suit).

Keep in mind that some bathrooms are very small so you will have to problem solve using a hoyer lift in it. If space is tight, one idea is to widen the base of the hoyer so that it can surround the W/C bottom/ base; then put the hoyer hooks onto the child's sling. Crank the child up and pull the W/C away or forward while keeping an eye at all times on the child. Move the hoyer closer to the changing table and lower it until the child is supported by the table. Remove the hooks from the sling so that the child can be changed.