The goal of transfer training is **generalizability**. Some skills learned for one transfer can be used for other transfers. For example, W/C to bed transfer is similar to W/C to couch transfer.

Selecting a Transfer

- Based on the results of the initial eval (MMT, ROM, pain, cognition, quality of movement, etc) the PT or PTA selects an appropriate transfer method that can be performed in a method that is...
  - Consistent
  - Safe
  - Efficient
Clinician and patient safety must never be compromised. Whenever in doubt about the level of assistance required to transfer a patient safely, obtain additional assistance.

- Always stabilize W/C, carts, beds by securing wheel locks or bracing them against a wall.
- Use proper body mechanics to reduce the possibility of injury.

**Level of Transfer**

- **Independent transfers**
  - The patient consistently performs all aspects of the transfer, including setup, in a safe manner and without assistance.

- **Assisted transfers**
  - The patient actively participates, but also requires assistance by a clinician(s).

- **Dependent transfers**
  - The patient does not participate actively, or only very minimally and the clinician(s) perform all aspects of the transfer.

**Assisted Transfers**

- **Levels of an Assisted transfer**
  - Stand-by assist (aka supervision)
  - Close guarding
  - Contact guarding
  - Minimal assist
  - Moderate assist
  - Maximal assist
Stand-by Assist

- Indicated for patients who can usually perform the activity without assist, but not consistently
- Verbal cues, assistance in problem solving during a transfer, assistance if an emergency arises
- Clinician not necessarily in close proximity to the patient

Close Guarding Assist

- Indicated for patient who can usually perform the activity without assist but have a greater likelihood for needing physical assistance
- Clinician is in close proximity to the patient, immediately ready to assist

Contact Guard Assist

- Indicated for patients who can usually perform the activity but have a significant likelihood of requiring physical assistance
- Clinician maintains contact with the patient to be able to provide assistance immediately
Min, Mod, Max Assist

- **Min Assist**
  - Patient performs 75% or more of the activity
- **Mod Assist**
  - Patient performs 50%–74% of the activity
- **Max Assist**
  - Patient performs 0%–49% of the activity

Amount of Assist

- When more than one person is required for safe transfers, the number is indicated after documenting the level of assist.
- Example: If a patient required moderate assistance from 2 people... “mod A X2”

Type of Assist

- What type of assistance did you need to provide to the patient?
  - Verbal cues
  - Physical assistance (for what? Be specific)
- **Examples:**
  - Min Assist for balance
  - Mod assist X 2 for lifting
  - SBA for VC for instructions
Gait Belts

- Belts secured around a patient’s waist
- Providing a secure point of contact
- An alternative method to control patient motion during transfers
- Patients should be kept close to the PTA and not at arms length
- The gait belt must not become a handle
- In some facilities, gait belts are required equipment
- Should not be too tight or too loose
- Loose ends need to be tucked, so there is no tripping over them

Direction of Transfer

- *Typically, moving toward the “stronger” side* is easier and should be done first to bolster patient confidence
- However, eventually transferring to both sides is necessary

Instructions

- Patients **always** need to be informed about the transfer and what they are expected to do
- The PTA at the head of the patient is in charge of providing VCs to other assistants
  - 1. I will count to three and then give the command to lift
  - 2. When I say “lift,” we will lift
  - 3. Visually and verbally ensure that all assistants & the pt are ready before initiating transfer
  - 4. The PTA says, “One, two, three, lift”
Completing the Transfer

- A transfer is not complete until the patient is safely & securely in the new position
- Appropriate positioning & draping must be completed
- Necessary equipment needs to be placed within the patient’s reach

Bed Mobility

- Bed Mobility: Transfers used to adjust the patient’s body position while he/she is recumbent
  - Supine side to side
  - Supine upward
  - Supine downward
  - Supine to sidelying
  - Supine to prone
  - Prone to supine
  - Supine to sit

Supine, side to side

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Independent</th>
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<tbody>
<tr>
<td>Position one forearm under patient’s neck/upper back &amp; other forearm under middle of back &amp; gently slide upper body &amp; head toward you. Then position forearms under patient’s lower trunk distal to pelvis &amp; slide that segment toward you. Finally, position forearms under thighs &amp; legs &amp; gently slide toward you.</td>
<td>Instruct patient to flex hips/knees &amp; place feet flat on bed. One UE add, one abd. Push feet into bed to move pelvis toward abd UE, then push elbows &amp; back of head into bed to move upper trunk toward abd UE. Then, reposition LE &amp; UE to move again, or for comfort.</td>
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### Supine, Upward

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<tr>
<td>Flex patient’s hips/knees &amp; place feet flat on bed. Stand at head of bed and grasp bedsheets or chuck close to the patient and pull patient up toward HOB. With two people, one on either side, grasp bed sheet very close to patient (supination), one verbally leads and move patient simultaneously up towards the HOB.</td>
<td>Patient fully flexes hips/knees with feet flat on bed, heels close to buttocks. Elbows flexed, close to the trunk with shoulder elevation. Pt elevates pelvis using LEs &amp; elevates upper trunk by pushing into bed with elbows &amp; back of head. Then to move upward, the patient pushes on the LE and depresses the shoulders simultaneously.</td>
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### Supine, Downward

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<tr>
<td>Most easily accomplished with small sheet (a “draw”) placed under patient from upper back to buttocks or mid thighs. Patient’s LE flexed with feet on bed. By yourself, grasp draw near buttocks and slide, or with two people, one on either side, grasp sheet and simultaneously slide patient downward.</td>
<td>Patient partially flexes hips/knees with feet flat on bed. UE next to trunk with elbows flexed &amp; shoulders depressed. Pelvis is elevated using LE &amp; elevates upper trunk by pushing into bed with elbows &amp; back of head. Then to slide down, the patient pulls with the LEs while pushing up with the shoulders.</td>
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Supine to Sidelying

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<tr>
<td>May need to position pt close to the far edge of the mat (with a person, bedrail or wall protecting the pt). Stand facing the pt, place the uppermost LE over the lowermost LE; place the uppermost UE on the chest &amp; the lowermost UE in abd. Roll the pt toward you by pulling gently on the posterior scapula and posterior pelvis.</td>
<td>Instruct the patient to move to the far side of the bed. The patient needs to reach across the chest with the uppermost extremity while lifting the uppermost LE diagonally over the lowermost extremity. The patient uses head flexion &amp; abdominal muscles to roll onto her side.</td>
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Supine to Prone

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<tr>
<td>Move the pt closer to one side of the bed, prepare to roll him to the S/L position. However, the lowermost UE should be positioned either close along the side of the body (shldr ER, elbow ext, palm up, hand tucked under pelvis) or with shldr flexed with arm close to ear. Stand facing the pt, roll him to a S/L position, determine if there is enough room to complete the roll. If not, move the patient backward while S/L, then complete the roll.</td>
<td>Instruct the patient as per “dependent”</td>
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### Prone to Supine

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<tr>
<td>Move the patient close to one edge of the mat.</td>
<td>Instruct the patient as per “dependent”</td>
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<tr>
<td>Cross the uppermost leg over the lowermost leg and tuck the lowermost UE under the patient.</td>
<td></td>
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<tr>
<td>Stand on the far side of the bed, roll the patient toward you to a S/L position. Determine if there is enough space to continue. Guide the patient from S/L to supine by resisting at the posterior shoulder and pelvis.</td>
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### Supine to Sit

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<tr>
<td>Move the patient close to one edge of the bed.</td>
<td>Instruct the patient as per “dependent”</td>
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<tr>
<td>Roll the patient into the S/L position facing the edge of the bed (EOB). Lower the feet and lower extremities off of the EOB. Elevate the trunk by lifting under the shoulders (can instruct patient to push with both UE to help you). At the same time, applying downward pressure on the opposite hip.</td>
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Transfers

- Used in PT, but less often
  - Sliding Transfer
  - 2 person lift

- Frequently Used in PT
  - Transfer Board Transfer
  - Stand Pivot
  - Squat Pivot

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Sliding Transfer

- Minor, p169, Johansson, p193

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2 Person Lift

- Minor, page 181 or Jahansson p203
- W/C to floor and back
- Patient must have some UE strength & trunk control
- W/C should be close to desired transfer surface, wheel locks engaged, remove footrests & armrest on side transfer will occur
- Patient crosses arms in front & the lead PTA stands behind the patient, reaching under their UE & grasping the opposite wrists of the patient
2 Person Lift

- Other PTA places 1 arm under thighs and 1 arm under calves
- This PTA at the legs should be facing the new transfer surface
- On command, the 2 PTAs lift the patient, step toward the new surface and squat to lower the patient down using proper body mechanics

Two Person Lift..........is THIS

.....NOT THIS!!!
Sliding Board Transfer

- Used when patient has enough strength to lift most of the weight off the buttocks & enough sitting balance to move in a seated position
- Patients who are unable to perform squat pivot transfers

Sliding Board Transfer cont

- Minor, pg 190 or Johansson p270
- Use gravity to assist you
- Chair parallel to table
- Guard by standing in front of patient
- May block pt’s knees with yours so pt doesn’t slide off the board
- May assist with balance by placing hands on shoulders
- May assist by placing hands under buttocks

Sliding Board Transfer

- w/c parallel to bed
- Engage wheel locks
- Remove foot plates & place patient’s feet on floor
- Remove the armrest on the side they are moving to
- Patient weight shifts to place transfer board under buttock
- Patient performs transfer by doing a series of pushups & slides sideways
Sliding Board Transfers

- Patient may place hands flat on the board or fisted on the board, but MAY NOT grasp the edge of the board (which may cause fingers to get pinched!)
- Repeat sequence until patient is on the desired surface
- The patient weight shifts away from the transfer board to remove it

Stand Pivot Transfer

- Performed by one clinician
- Used with patients who are unable to stand independently, but can bear some weight on their LE
- Minor, page 185 or Johansson, p284–287

Squat Pivot Transfer

- A variation of the Stand Pivot Transfer
- Used with patients who are unable to stand independently, but can bear some weight on their LE
- Lower level patients than those who use stand pivot transfers
- Minor page 188, 194 & 211
- Johansson, p289–292
Assisting the Patient to move to edge of seat
- Side to side weight shifting
  - Minor, page 197
- Pelvic slide
  - Minor, page 199
- Sitting push up
  - Minor, page 200
  - Johansson, p281

Assisting the Patient to move from the EOB
- Minor, page 201

PRINCIPLES of transferring
- **Have the patient do as much as they can for themselves** (including removing footrests, applying wheel locks, removing armrests, sliding forward in the chair, propelling themselves, transfers, etc)
- Position the W/C as close to the bed as possible
- W/C generally faces the foot of the bed
- Where along the bed should it be placed?
Transfer Principles continued

- Use proper body mechanics
- Wheel locks should be engaged whenever a patient moves into or out of the W/C
- Use gait belts appropriately & safely
- Prepare the environment
  - Which direction is the patient moving?
  - Remove jewelry on hands/wrists before sliding hands under a patient
  - Remove armrests and footrests

Transfer Principles Continued

- ALWAYS inform your patient about the transfer to be performed and what your expectations of them are
- The transfer is considered complete when the patient is safely positioned and draped, with all necessary equipment within reach

Questions???