Evaluation of Mobility and Handling Training for Personal Support Workers

CRE-MSD | Centre of Research Expertise for the Prevention of Musculoskeletal Disorders

PURPOSE & SCOPE

Evaluation of Mobility and Handling Training for Personal Support Workers

This framework is designed to assist you in evaluating your mobility and handling training for personal support workers (PSWs)[1], with specific reference to sit-to-stand training (although the principles apply to other core skills). It is assumed that this training is part of a broader safe mobility program.

Resource Development

This resource was developed with the engagement of the CRE-MSD/PSHSA Client/Patient Handling Community of Practice (CoP), composed of over 800 healthcare providers from across the healthcare continuum. It is informed by a literature review, evaluation of training materials from CoP members, workshops with a multi-professional panel and CoP feedback.

CARE PHILOSOPHY

Restorative Approach

This evaluative framework and accompanying materials support a restorative approach as the best practice in providing care[2]. Engaging a client[3] to the greatest possible extent in their own mobility and daily activities promotes the maintenance and restoration of function, improves self-rated health, improves confidence and well-being, and decreases needs for ongoing care. Conversely, care not focused on assisting individuals to improve their functioning inadvertently contributes to the disablement process.

Restorative care may initially take a little longer than care in which the care recipient adopts a more passive, dependent role, but the extra time is well spent as this client-centred approach improves client and care worker well-being and satisfaction and reduces clients' and caregivers' risk of injury. In the longer-term, this approach has been shown to be more time-efficient than non-restorative care provision.

INSTRUCTIONS

This framework is designed to assist you in evaluating your sit-to-stand training. It is divided into two sections: **CONTENT** and **PRESENTATION AND APPROACH**.

1. Consider how well each item in the framework is addressed in your existing training. Record your assessment using the tick boxes.
2. After considering how well each item is addressed, use the space below to record any additional observations, and your plans for strengthening your training.

[1] Personal Support Workers are direct care workers who support the client to do what they would do for themselves, if they were physically and cognitively able. Such activities may include personal care, homemaking tasks, personal interaction and some clinically-based activities. Workers with similar roles may be called direct care aides, home health aides, personal care aides, carers, or care aides, among other titles.

[2] Please see the reference list for studies and resources supporting this international best-practice approach.

[3] 'Client' is used throughout this document to refer to the person receiving care.

CONTENT	Covered Well	Partially Covered	To Add	Notes
Caregiver Knowledge				
Core principles & knowledge – human movement[4]				
• Posture				
⇒ What is good posture (neutral positions of back, neck, legs, arms & wrists); importance of symmetry	☐	☐	☐	
⇒ Gravity: centre of mass/gravity, line of gravity	☐	☐	☐	
⇒ Postural balance: line of gravity vs. base of support	☐	☐	☐	
• Weight bearing status[5] (full, weight bearing as tolerated, partial, toe-touch, non-weight bearing)	☐	☐	☐	
• Anatomy				
⇒ Basic anatomy of the back & joints (visual) – bones, joints, ligaments, muscles	☐	☐	☐	
⇒ Function of spine; parts of back	☐	☐	☐	
⇒ Natural cervical, thoracic, lumbar curves (vs. diminished/ exaggerated)	☐	☐	☐	
• Injury prevention: A positive and proactive approach				
⇒ The role of good posture in injury prevention	☐	☐	☐	
⇒ Good body mechanics	☐	☐	☐	
⇒ Use of leverage (hands-on demonstration recommended)	☐	☐	☐	
⇒ Acute vs. cumulative injury; consider frequency	☐	☐	☐	
⇒ Risks: strained ligaments, muscle fatigue, joint & disk degeneration	☐	☐	☐	
Core principles - sit-to-stand transfers				
• Normal movement patterns (demonstration recommended)	☐	☐	☐	
• Optimal start position for success: edge sitting (visual advised)	☐	☐	☐	
• Benefits of sit-to-stand transfers for client (rationale for activity)				
⇒ Physical and physiological benefits	☐	☐	☐	
⇒ End goals	☐	☐	☐	
⇒ Current & potential abilities of client	☐	☐	☐	

[4] If training exists as part of a larger safe mobility program, training participants should already have been exposed to this content. Ideally, these principles will be referenced, and a brief refresher provided as part of each training module. These principles should be presented within the context of and with application to sit-to-stand transfers. [5]This categorization drawn from Reference #6.

CONTENT	Covered Well	Partially Covered	To Add	Notes
Caregiver Knowledge				
Core Principles - Choosing a Movement Strategy				
• Discussion of Balanced Decision Making – the need to balance:				
⇒ Client goals, preferences and dignity of risk	☐	☐	☐	
⇒ Workers' right to be safe, including relevant legislation	☐	☐	☐	
• Clinical order of preference in choosing movement strategy[6]	☐	☐	☐	
• What to do if the strategy prescribed in the care plan contradicts these principles (e.g. due to client improvement, deterioration or non-restorative approach)	☐	☐	☐	
Before the Move				
Consider Current Abilities and Characteristics of Each Person				
(note: this may differ from time of assessment and development of care plan)				
• Client to be assisted				
⇒ Predictability of behaviours	☐	☐	☐	
⇒ Cognitive capacity	☐	☐	☐	
⇒ Communication	☐	☐	☐	
⇒ Physical capabilities, including endurance	☐	☐	☐	
⇒ Physical characteristics				
• Risk considerations: Cause and consequences of physical discomfort	☐	☐	☐	
• Risks for psychological discomfort (e.g. personal space)	☐	☐	☐	
• Caregiver				
⇒ Capabilities & training	☐	☐	☐	
⇒ Affect (calm, confidence, not rushed)	☐	☐	☐	
⇒ Risk considerations:				
• Cause and consequences of physical discomfort	☐	☐	☐	
• Risks for psychological discomfort (e.g. personal space)	☐	☐	☐	

[6] Some organizations may have existing decision trees to support the selection of movement strategies. One excellent resource for this is Reference #7.

CONTENT	Covered Well	Partially Covered	To Add	Notes
Before the Move				
Selection of approach for transfer with reference to the care plan				
• Need for client agreement and permission at each visit	☐	☐	☐	
• Understanding that the status of the client or environment may have changed since the care plan was developed, and the prescribed approach may no longer be appropriate (or may not be appropriate today)	☐	☐	☐	
Physical preparation of Environment, Equipment and People				
• Environment:				
⇒ Clear path, privacy if necessary	☐	☐	☐	
• Equipment:				
⇒ Mobility equipment within reach	☐	☐	☐	
⇒ Safe, clean, suitable, ready for transfer	☐	☐	☐	
⇒ Caregiver trained in use	☐	☐	☐	
⇒ Client comfortable in use	☐	☐	☐	
• Client to be assisted:				
⇒ Has any required sensory aides (glasses, hearing aides, etc.)	☐	☐	☐	
⇒ Wearing appropriate footwear	☐	☐	☐	
⇒ Clothes positioned to avoid catching during transfer	☐	☐	☐	
⇒ Plan to manage IV attachments, tubing, drains, catheter bag	☐	☐	☐	
• Caregiver:				
⇒ Posture & positioning to enable good body mechanics	☐	☐	☐	

CONTENT	Covered Well	Partially Covered	To Add	Notes
The Move				
Communication with client to complete the task				
• Caregiver within client's visual field when communicating	☐	☐	☐	
• Encourage client to do as much as possible	☐	☐	☐	
• Clear and appropriate communication (provide examples)				
⇒ Simple, positive action words	☐	☐	☐	
• Ready, steady, stand; not 1, 2, 3	☐	☐	☐	
Client-caregiver contact				
• Purpose of physical contacts	☐	☐	☐	
• Support without physical or psychological discomfort	☐	☐	☐	
Movement techniques for each level of assistance[7]				
• Techniques recommended	☐	☐	☐	
• Techniques cautioned against, and why	☐	☐	☐	
Completion				
Client safe and ready for next activity				
• Confirm that client feels stable 'finds their balance' before disengaging (positive wording – avoid suggesting symptoms)	☐	☐	☐	
• Ensure that client has or can reach any necessary aids for next activity (e.g. walking)	☐	☐	☐	
Reflection on activity				
• Caregiver's reflection:				
⇒ Could the client have done more themselves?	☐	☐	☐	
⇒ Risks/different ways to do it?	☐	☐	☐	
• With client – was it okay? Anything to do differently next time?	☐	☐	☐	
• In retrospect, were other resources needed?	☐	☐	☐	

[7] Many organizations will have existing resources describing preferred techniques and techniques that should be avoided. One excellent resource for this is Reference #7.

CONTENT	Covered Well	Partially Covered	To Add	Notes
Resources				
Organization-specific contacts and procedures				
• Who can help with what challenges, and how to contact	☐	☐	☐	
• Gaps in coverage (e.g. weekend, night)	☐	☐	☐	
• Procedures to request additional resources (equipment, referrals)	☐	☐	☐	

PRESENTATION AND APPROACH	Extensive	Moderate	To Improve	Notes
Format				
Communication approaches for a range of learning styles				
• Plain-language text	☐	☐	☐	
• Images/videos/demonstration	☐	☐	☐	
• Physical practice	☐	☐	☐	
• Case studies	☐	☐	☐	
Educational Approach				
Are there opportunities for caregivers to:				
• Be exposed to new knowledge	☐	☐	☐	
• Reflect on new knowledge	☐	☐	☐	
• Consider opportunities to change – practices to start, stop and continue	☐	☐	☐	
• Actively try new strategies & techniques	☐	☐	☐	
Evaluation				
• Evaluation of caregivers' knowledge	☐	☐	☐	
• Practical evaluation of caregivers' ability	☐	☐	☐	
• Evaluation of training by caregiver	☐	☐	☐	

PRESENTATION AND APPROACH

	Extensive	Moderate	To Improve	Notes
Tone				
• Focus is on how to do job safely and effectively, not on injury risk	☐	☐	☐	
• Considers client and caregiver needs equitably	☐	☐	☐	
• Language is concrete, avoids euphemism	☐	☐	☐	

ASSESSOR'S SUMMARY AND NEXT STEPS

Strengths of our current training

Areas for improvement

Plan for revising training

Lessons Learned from implementation of revisions (fill this out after testing your revised training)

References for Restorative Care

1. Baker DI, Gottschalk M, Eng C, Weber S, Tinetti ME (2001). The Design and Implementation of a Restorative Care Model for Home Care. Gerontologist, 41(2) 257-63.

2. Lumsden K, Ball D (2015) Central West Community Care Access Centre (CCAC) Home Independence Program (HIP), GTA Rehab Network. Obtained from: http://www.gtarehabnetwork.ca/uploads/File/bpd/2015/Presentations/RPP6_Home_Independence_Program_Karyn_Lumsden_Daniel_Ball.pdf

3. Glendinning C, and Newbonner E. (2008) The Effectiveness of Home Care Reablement – Developing the Evidence Base. Journal of Integrated Care, 16(4):32-39.

4. Care Services Efficiency Delivery (2010) Homecare Re-ablement Prospective Longitudinal Study Final Report Summary. Department of Health and the Care Services Efficiency Delivery, UK Available from: https://webarchive.nationalarchives.gov.uk/+/www.csed.dh.gov.uk/asset.cfm?aid=6672

5. UK Care Services Efficiency Delivery (2011) Homecare Re-ablement Toolkit. Available from: https://webarchive.nationalarchives.gov.uk/20120907090351/http://www.csed.dh.gov.uk/homeCareReablement/Toolkit/

6. Weight-Bearing Restrictions. Orthopaedic Specialists of North Carolina. Louisburg, NC. https://orthonc.com/uploads/pdf/Weight-Bearing_Restrictions.pdf

7. Smith J, editor. The Guide to the Handling of People: A Systems Approach 6th Edition. Teddington: BackCare; 2011. 260 pp.

Weight Bearing Definitions (adapted from those given by the Orthopedic Surgeons of North Carolina)

Full Weight Bearing (FWB)	⇒	Client may place their full body weight on their legs or arms
Weight Bearing as tolerated (WBAT)	⇒	Client should place only as much weight as feels comfortable on their affected leg or arm.
Partial Weight Bearing (PWB)	⇒	Client may place some body weight on the affected leg(s). A doctor will decide on the appropriate amount of weight.
Toe-touch weight bearing (TTWB) or Touch-Down Weight Bearing (TDWB)	⇒	Client may only touch the floor for balance (sensory input only). Client should not place any body weight on the leg. It may help to imagine that they have an egg under their foot that they must not crush.
Non-Weight Bearing (NWB)	⇒	Client must place no weight on their injured leg/arm. Their affected leg must not touch the floor.

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