

4 Transfers and positioning support

4.1 Transfers and positioning including the use of therapeutic equipment

Children and students may require assistance to be transferred (for example, from chair to toilet, chair to vehicle) or to be repositioned for comfort, safety and curriculum access. Such needs may be short-term (for example, a student who is in plaster) or long-term (for example, a student who has a physical disability). The level of assistance required will also vary. Some children and students may require supervision for safety and some guidance with their movement; others may be able to participate in transfers and positioning with staff assistance; while others may be fully dependent for all transfers and require the support of up to two assistants or the use of lifting equipment.

Care plan for transfers and positioning

Workers may be requested to assist with transfers and positioning. They will need a written care plan to be completed by a physiotherapist (or other relevant health professional) and signed and released by the parent, guardian or adult student.

The transfer and positioning care plan is written by a physiotherapist (or other relevant health professional) to advise on safe, consistent work practices in the transfers and repositioning of children and students. The plan is developed specific to the needs of the child/student, relevant to the setting that has requested the care plan.

In developing the plan, the following factors should be considered:

- The needs of the child or student, the family, education and childcare workers and the therapists, as they relate to accessing the setting or curriculum/activities.
- The personal care needs of the child/student (for example toilet support).

- The goals of the child or student (for example to maximise the child's or student's abilities and independence, to minimise the risk of future orthopaedic problems).
- Child/student's comfort, dignity, independence and learning.

This care plan will form the basis of an individual child or student health support plan. The physiotherapist should be available to provide additional information, training, clarification or demonstration as requested in relation to the clients for whom they have developed care plans.

A suitable plan for transfers and positioning in care and education settings will include, as relevant to the child or student, recommendations regarding:

- situations in which assistance is required (for example, toilet transfer)
- level of assistance required (such as standby assistance, cooperative assistance, total dependence)
- type of transfer or positioning required
- equipment required to perform transfer
- situational advice (for example, mobility skills indoors and outdoors, use of special equipment such as sticks and walking frames, or postural equipment for repositioning)
- communication between the worker and the child or student
- learning targets
- any documentation requested from workers (for example, an observation log)
- any other relevant information (for example, minimise muscle spasms by holding the child's or student's hips during transfer).

Various types of additional information can be attached to the plan. There may be some more detailed information about a particular transfer; a transfer and positioning log, in which observations are recorded; or further information about the child's or student's care and positioning needs.

Chest harnesses are used with some students to assist them to maintain upright posturing. Chest harnesses can potentially be a choking hazard: expert information on the safe use of harnesses must always be attached to the plan where there is a harness being used by the student.

The care plan should be readily accessible to all staff at all times. A new staff member should be familiar with and trained to implement a child's or student's care plan before they undertake any manual handling tasks with the child or student.

The staff members supporting the child or student should follow the care plan at all times, unless they consider that the safety of the child or student or their own safety is being compromised. If this is the case, the worksite manager should ensure the family and the physiotherapist who wrote the plan are informed as soon as possible. Changes to the care plan can then be negotiated with the physiotherapist and the family.



A proforma for the [transfer and positioning care plan](#) is available from [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

Support plan for transfers and positioning

Duties which education and childcare workers agree to undertake to support an individual care plan should be based on the care plan; negotiated with the family; and documented and agreed via a health support plan. The support plan should address routine and special events including excursions.

In negotiating a support plan, the worker will describe and allocate duties in a way which supports the safety and well-being of the child or student and upholds occupational health and safety principles. Where there is more than one worker, the support plan will encompass an equitable allocation of duties, including arrangements to cover staff illness, injury or absence.

Workers should be able to access training, as required, encompassing the use of equipment as specified in the care plan. They must act to take responsibility for their own health, safety and well-being. This includes an obligation to use mechanical lifting assistance as specified in the support plan. While at times a manual lift may appear quicker and easier, mechanical assistance is provided to prevent injury that can occur as a result of chronic exposure to unsafe lifting. While a worker may not appear to be injured at the time, harm may be incurred over time.

Sometimes facilities cannot accommodate equipment available to assist the worker. For example, some worksites do not have room to accommodate a nappy change table. This situation can be discussed

with a continence specialist to minimise the need for changing to occur at the site. Where changing is required, a physiotherapist can be asked for advice about how to do this work safely. It can be safer, for example, to change a child on the floor, especially where this avoids the need to lift a child onto a change table. Workers can access training to assist them to safely do this and other floor-level work.

Generally, education workers cannot take responsibility for provision of therapy. They may, however, negotiate with families and therapists to identify ways in which routine care and curriculum activities can also support therapy outcomes.

The health support plan can be reviewed at any time if there are many issues or concerns regarding the safety of child/student or staff when conducting transfers documented in the current plan. The plan could be reviewed if:

- the student's skills deteriorate
- the student's skills improve
- there is a change of equipment for the student
- orthopaedic surgery is to occur
- there is transition to a new site and/or environmental changes e.g. upstairs classroom
- the staff/carer is having difficulty performing the transfer.

Staff members can be requested to document their observations to assist in the review of the plan. For example, a student may use standing transfers that are becoming increasingly difficult. The physiotherapist could request staff members to document their experiences in assisting the transfers over a few weeks, to gain a clearer picture of the student's abilities and difficulties. A decision would then be made by all people involved regarding whether it was safe to continue with standing transfers.

Reviewing the plans

Care plans should be reviewed at least annually.

The support plan should be reviewed whenever an updated care plan is requested or received.



For further information about planning transfers and positioning support see [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

4.2

General principles when transferring and positioning

For children and students who have limited ability to change positions, optimal posturing and regular positional changes are essential.

Regular positional changes are required to:

- enhance comfort of child/student
- assist in prevention, minimisation or delay of joint or muscular tightness or development of deformities caused by spending prolonged periods in static and asymmetrical positions
- assist in prevention of pressure sores caused by too much pressure concentrated on one area of body
- provide a variety of experiences.

It is recommended that at least three positional changes are provided throughout the school day, but this can vary from one student to another, depending on the physical status of the child and other risk factors (for example, susceptibility to development of skin breakdown). Positional changes can include:

- lying on their front (supine), back (prone) or side
- sitting on the floor
- sitting in a seat
- standing.

If a child or student has a ‘tilt in space’ function built into their wheelchair, this can be regarded as another change of position. It is likely that considerable tilt is necessary before there is a measurable reduction in the pressure on the skin.

Optimal posturing in any of these positions is required to:

- ensure child functions at his or her best (for example, a child is going to be able to use their hands more effectively if their trunk and pelvis are well supported and aligned)
- promote interaction and communication
- reduce fatigue and enhance concentration
- facilitate oromotor control, respiration and digestion.

The use of a floor (corner) seat can allow the child to achieve a better sitting position on the floor and to be able to see and use his or her arms for play. The person providing support can then position themselves to interact with the child and assist him or her with the activity.

Positional equipment is often required to achieve positional changes and optimal posturing. Assessment by the child's physiotherapist is required to determine the most suitable equipment required and the program of use. Staff should always contact the physiotherapist if they have any concerns about the use of the prescribed equipment.

4.3 Communication during transfers and positioning

Just as communication is vital in all aspects of life, it is vital during transfers and positioning. If a child or student is moved without understanding what is happening, the experience is likely to be frightening and upsetting. Even though children and students will vary in the level of their responses to communication, that should not change whether or not you communicate with them. Some children and students are used to responding to specific words or phrases during transfers. If you are unsure about this, check with other staff members who are familiar with the child's or student's care.

The benefits of good communication during transfers are that the child or student:

- is more likely to assist and/or cooperate with the transfer
- becomes a participant in the transfer, rather than a passive recipient
- has the opportunity to practise communication in a meaningful way during everyday activities.

As communication is a two-way process, there are two sections on the care plan relating to its use: communication by the support worker and communication by the child or student.

Your communication with the child or student should take into account his or her level of understanding, if this is known. Some children and students will understand your message much better if, in addition to speaking to them, you use symbols, signs or gestures. For others, simplifying what you say will be sufficient.

The type of communication used by the child or student can also vary. Some children and students use speech as the primary method of communication. Others use what is termed Augmentative and Alternative Communication (AAC). This refers to any system a person uses to communicate, in addition to or instead of speech. Some examples of AAC are using pictures or symbols, gestures, eye-pointing, communication boards and electronic devices.

If unsure about how to communicate with a child or student, the best thing to do is to speak to the child's or student's family and speech pathologist. Other staff workers who have known the child or student for a long time should also be able to assist.

Therapists can provide workers with specific manual handling training related to implementation of an individual care plan.

This can include:

- top and tail transfer
- cradle transfer
- side to side transfer
- moving mechanical lifters
- applying hoist sling
- lifting a wheelchair into a car

- wheelchair to car-seat transfer
- working at low levels
- sitting on the floor
- lying positions
- sitting in a seat
- types of seats
- standing
- mobility and mobility equipment
- special considerations for early childcare workers.



For further information about transfers and positioning safe practice principles see [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

Further information

www.chess.sa.edu.au



A – Z Health Support Index

4.4 Glossary

Abduction	Any limb movement away from the body sideways (for example, raising an arm or leg out to one side).
Adduction	Movement of limbs towards the body sideways (for example, ringing legs together).
Ambulator	A person who uses walking as his or her main method of mobility. There are two categories: <ul style="list-style-type: none">▪ community ambulator-walks indoors and outdoors for some activities, but sometimes uses a wheelchair for long trips▪ household ambulator-walks indoors with/without use of special equipment, frequently independent for transfers. Wheelchair is needed for community access.
Cerebral palsy	A disorder of posture and movement resulting from damage to the developing brain. It is non-progressive but not unchanging over time.
Contracture	Shortness of tendon, ligament and/or muscle, which limits joint movement.
Cooperative assistance	The person helps with the transfer according to the person's own abilities, but the transfer must be assisted by one or more adults to be successful.
Cradle lift	A transfer assisted by one person, where the child is cradled in his or her arms. Only recommended for use with small, light children (for example, 16kg or under).
Cross-legged sitting	Sitting on the floor with legs crossed in front.
Deformity	An abnormal position of any body part that cannot be corrected actively (by the person) or passively (by another person's hands or a splint).
Dependent assistance	The child or student is fully dependent upon the assistance of one or more adults for transfers.
Diplegia	Weakness or paralysis of the lower limbs but there may be some involvement, to a lesser extent, of the upper limbs.

Glossary cont...

Diplegia	Weakness or paralysis of the lower limbs but there may be some involvement, to a lesser extent, of the upper limbs.
Extension	Straightening of the limbs or body.
Extensor spasm	Increased tightness of the muscles which normally straighten the body and limbs (for example, extensor spasm in the arm muscles will straighten it out).
Flexion	Bending of the limbs, head or body
Flexor spasm	Increased tightness of the muscles that bend the body.
Half-ring sitting	Sitting on the floor with one leg straight and the other leg rotated outwards and bent at the knee.
Hemiplegia	Weakness or paralysis of the limbs on one side of the body.
Hypotonic	Lower than normal muscle tone, leading to an excessive amount of movement around joints.
Independent assistance	The child or student transfers by him or herself, while one or more adults stand by in case of unforeseen safety issues.
Kneeling	<ul style="list-style-type: none">▪ Four point—on hands and knees.▪ Upright—on knees only.▪ Half-kneeling—on one knee with the other bent and foot flat on the floor in front.
Long-sitting	Sitting on the floor with legs out straight in front.
Lunge position	A position adopted by assistants for transfers. It involves standing with your feet at least shoulder width apart. One foot points forwards, and the other foot points in the direction you are transferring towards.
Mechanical lift	A transfer assisted by two people using a hoist. One person operates the hoist while the other person guides the child's or student's position.
Paraplegia	Weakness or paralysis affecting the legs only. This term usually refers to paralysis after a spinal cord injury.

Glossary cont...

Passive movement	Movement performed by you using the child's or student's limbs or body (that is, bending and stretching the foot).
Pelvis	Muscles, bones and joints around the hips and lower back region.
Prone	Lying on the stomach.
Quadriplegia	Weakness or paralysis affecting all four limbs.
Rotation	Turning of the legs at hips, arms at shoulders, twisting of the trunk between shoulders and hips.
Side-to-side transfer	A transfer assisted by two people. One person supports and moves the left side of the child's or student's body and the other person supports and moves the right side of the child's or student's body in the direction of the transfer.
Spasticity	Increased stiffness or muscle tone felt in a person's limbs or trunk. The muscle spasm can often be felt as resistance when the body parts are moved. The limbs are hard to bend or straighten because of the spasticity of the muscles.
Standing transfer	A transfer assisted by one or two people, who support the child or student in standing. In order to use this transfer, the child or student must be reliable at taking his or her weight through the feet.
Supine	Lying on the back.
Top and tail lift	A transfer assisted by two people. One person supports and moves the upper part of the child's or student's body and the other person supports and moves the lower part of the child's or student's body in the direction of the transfer.
Triplesia	Weakness or paralysis affecting three limbs with one limb relatively spared.
Trunk	The part of the body between, and including, the shoulders and hips.

Health



chess Training

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chess Research

Details of the research partnerships



chess A – Z Health Support Index

Information and forms for health support planning. Care plans, resources and support related to conditions and care needs



chess Education Services

Hospital (and other health) education services



chess Resource Materials

child health and education support services resources and forms