7 Mistakes allied health professionals make in prescribing standing hoists

Standing hoists are popular transfer devices for people with disabilities. Clients really like them because they allow them to keep their independence for longer. Caregivers and family also find they ease care. They enable a caregiver dress someone when they stand and tasks like helping go the toilet are simplified. It can be a win-win for everyone.

Whilst standing hoists have significant advantages, they do present risks when used inappropriately. A report by the National Health Service (NHS) in the United Kingdom reported 15 falls from hoists, some of which were attributed to standing hoists (NHS, 2015). In addition, in many instances injury to the caregiver has occurring through assisting the client with the use of a standing hoist.

In our training of health professionals, we see 7 common mistakes health professionals make in prescribing standing hoists.

1. **Transfers are seen as the sole source of rehabilitation**

Standings hoists are regularly prescribed from a rehabiliation setting with a health professional supporting the client through the rehabilitation process. The aim would be that a standing hoist can allow rehabilitation to continue in the home were the cargiver acts as the health professional in following on the process. This works very well if there is a differentiation made between transfers and rehabilitation. Transfers can be part of a rehabilitation process but they are not 'the rehabiliation process'. The amount of standing someone gets exposed to during transfers during the day may not be enough for them to maintain and improve their function in standing. This can mean the client does not achieve the skills in standing to make transfers safe for both the caregiver and the client.

2. **They don't see the lying to sitting transfer as part of the assessment process**

The standing hoist transfer is much more than just the sit to stand transfer. A standing hoist is regularly used to transfer a client into and out of bed and this involves the lying to sitting transfer. Providing assistance with the lying to sitting transfer can regularly result in a full lift of the torso, if the client does not have the skills to complete this transfer semi independently. Mechanical devices can help including the backrest of the bed and handles to pull on, yet the client needs to be able to assist with adjusting themselves during these lying to sitting transfers. The lying to sitting transfer needs to be considered as part of the standing hoist prescription process.

3. **They assess time in standing as opposed to funtional standing in assessing ability**

The ability to stand is an important part of the standing transfer. We need to ensure the ability to stand is functional, that is, the person can stand to the extent to which they need to to complete functional tasks during personal care. We need to make a list of the personal care tasks a client has to do and calculate the time in standing needed for each aspect of care. We suggest the client needs to be able to stand for double the time needed for personal care tasks in the standing hoist to allow for contingencies. These contingencies can include delays in getting a chair under the client or tangling of clothing when assisting with dressing or undressing the lower limb.

4. **They don't have criteria by which to determine when a person is a suitable candidate for a standing hoist**

Many health professionals don't have a systematic method of recommending standing hoists. They are unclear about what are the minimal skills the client has to display to use a standing hoist for the client and the caregiver to be safe. They find it difficult to explain 'safety' so the client is clear on what makes a standing hoist safe for both themselves and the caregiver assisting them.

5. **They don't have clear criteria by which to explain when a person is unsuitable for a standing hoist**

Many health professionals don't have a way to describe unsafe in a standing hoist. As a result of not being able to describe it, they are unable to simply explain this to their client. This can leave ambiguity when determining 'unsafe' in a standing hoist because 'unsafe' had been undefined. This in turn can lead to misintreptations on behalf of the client around the decision to remove a standing hoist.

6. **They don't plan the removal of a standing hoist when they prescribe it**

Many a good relationship with a client can be fractured beyond repair after a standing hoist is removed from a transfer routine. Regardless of what explanation is given, the client can sometimes misinterpret this removal as the transfer device as the therapist not being supportive of their goals to be independent. This can leave a therapist feeling they have let down their client and feeling torn about whether they should have removed the hoist at all.

Standing hoist are really easy to prescribe but very difficult to unprescribe. When a client has a degenerative condition, the chances are they will reach a

stage when they are unable to use a standing hoist. The health professional needs to plan for this to ensure a strategy is in place for when a standing hoist starts to become unsuitable.

7. **They under prescribe standing hoists**

Standing hoists are a great item of equipment with massive benefits to give a client in terms of maintaining independence and the caregiver or family in making care easier. Disability and caring can be hard and we need to take advantage of every opporutnity to make it easier. Standing hoists are an excellent device in achieving this and we need to plan their prescription and unprescription from the physical, social and emotional prespective.

Interested in finding out more about the prescription of standing hoists? Visit our website to find the next half day workshop on standing hoists or learn about standing hoists as part of the Hoisted Level 1 course.

www.riskmanaged.com.au

HOIST ED