Repositioning

Purpose

The purpose of this procedure is to provide guidelines for the assessment of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chairbound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.
2. Assemble the equipment and supplies as needed.

General Guidelines

1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief.
2. Assessment of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Such plans should be addressed in the comprehensive plan of care consistent with the resident's needs and goals.
3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning.
4. The care plan for a resident at risk of friction or shearing during repositioning may require the use of lifting devices for repositioning.
5. Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing.

Assessment

Assessment for Appropriate Repositioning

1. Assess residents who can reposition independently to determine the following:
   a. Is a positioning device needed to maintain independent positioning?
   b. Does the resident need instruction about why turning is important?
   c. Does the resident need encouragement to reposition?
   d. Does the resident require monitoring to assure that turning occurs?
2. Assess the resident for an existing pressure ulcer. If present, positioning the resident on the existing ulcer should be avoided.
3. Assess residents who sit or recline in a chair with the back of the chair (or the back of the bed) elevated to or above a 30 degree angle:
   a. Does the resident need hourly position changes?
   b. Does the resident need position changes more frequently than hourly?
4. Components to assess when a resident is in a chair:
   a. Does the resident need intervention to maintain postural alignment?
   b. Is the resident's weight distribution even?
   c. Does the resident need devices to maintain sitting balance?
   d. Is the resident able to learn? If so, teach resident to shift his/her weight every 15 minutes while in the chair.
5. Does the resident have a Stage I pressure ulcer?

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Interventions/ Care Strategies

A turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. A program is defined as a specific approach that is organized, planned, documented, monitored and evaluated.

1. Residents who are in bed should be on a q 2 hour turning program.
2. If ineffective, the turning and repositioning frequency will be increased.
3. Avoid placing resident on the greater trochanter for more than momentary placement.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.
2. Assemble the equipment and supplies as needed.

Equipment and Supplies

The following equipment and supplies will be necessary when repositioning.

1. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

Repositioning the Resident in Bed

1. Check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure.
2. Wash and dry hands thoroughly.
3. Apply gloves.
4. Raise the bed to waist level.
5. Lower the side rail, if applicable, on the side where you are standing.
6. Encourage the resident to participate if able.
7. Lower the sheets.
8. Check for incontinence. Follow steps to care for the incontinent resident, if necessary.
9. Use two people and a draw sheet to avoid shearing while turning or moving the resident up in bed. Encourage resident to place feet flat on bed and assist with pushing up. Encourage the use of an overhead trapeze if resident is able to use one.
10. Raise the head of the bed as little and for as short of a time as possible, and only as necessary for meals, treatments and as medically necessary.
11. Move the resident to his or her back.
12. Move the resident's top leg and shoulder in the direction of the turn.
13. Encourage resident to hold the side rail with the top arm in the direction of the turn, if possible.
14. Place the resident in a comfortable position in accordance with the resident's individualized care plan.
15. Prevent skin-to-skin contact with use of sheets, pillows or positioning devices.
16. Lower the bed into lowest position and place the side rails in the appropriate position as indicated in the resident's plan of care.
17. Reposition the bed covers. Make the resident comfortable.
18. Place the call light within easy reach of the resident.
19. Wash and dry hands thoroughly.
20. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.

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Steps in the Procedure (continued)

Repositioning the Resident in the Chair

1. Encourage the chairfast resident, who is able to move, to change positions or shift weight at least every fifteen (15) minutes, or as often as possible.
2. Check the care plan, assignment sheet or the communication system to determine resident-specific positioning needs including special equipment; resident level of participation and the number of staff required to complete the procedure.
3. Ask the resident's permission to reposition or assist in repositioning. Take the resident to a private location, if indicated.
4. Assist the resident to change his or her position in the chair. Monitor the need for toileting or incontinence care when changing position.
5. Place resident in a comfortable position in accordance with the resident's individualized care plan.
6. Prevent skin to skin contact with use of sheets, pillows or positioning devices.
7. Wash and dry your hands thoroughly.

Documentation

The following information should be recorded in the resident's medical record as necessary:

1. The position in which the resident was placed. This may be on a flow sheet.
2. The name and title of the individual who gave the care.
3. Any change in the resident's condition.
4. Any problems or complaints made by the resident related to the procedure.
5. If the resident refused the care and the reason(s) why.
6. Observations of anything unusual exhibited by the resident.
7. The signature and title of the person recording the data.

Reporting

1. Notify the supervisor if the resident refuses the procedure.
2. If the resident refuses care, an evaluation of the basis for refusal, and the identification and evaluation of potential alternatives is indicated.
3. Report other information in accordance with facility policy and professional standards of practice.

References	
MDS (RAPs)	M5c; (RAP #16)
Survey Tag Numbers	F309; F314
Related Documents	
Risk of Exposure	Blood–Body Fluids–Infectious Diseases–Air Contaminants–Hazardous Chemicals
Procedure Revised	Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____