

Focus on...

Safety options



Gait belts

- A tool for patient and nurse safety
- Hardwiring safety at the point of care

Gait belts 101: A tool for patient and nurse safety

Tips for assessing patient mobility and using gait belts

By Wendy Wintersgill, MSN, RN, CRRN, ONC, ACNS-BC



All nurses want to keep their patients safe, but falls and injuries when moving patients are a common problem. According to the Agency for Healthcare Research and Quality, patient falls occur at a rate of three to five per 1,000 bed-days, 700,000 to 1 million hospitalized patients fall each year, approximately 50% of the 1.6 million U.S. nursing home residents fall every year, and nearly 10% of Medicare skilled nursing facility residents experience a fall resulting in significant injury. Among RNs, overexertion and bodily reaction (the way that the body responds or reacts to an external influence) were the most prevalent events (45.6% of all cases within the profession) that led to occupational injuries and illnesses, according to a 2016 U.S. Bureau of Labor Statistics report.

Gait belts, which typically are used by physical therapists, also can be used by nurses and other properly trained patient caregivers to protect themselves and their patients. (See *Gait belt options*.)

Although no randomized clinical trials have been conducted that prove gait belts reduce falls and injury, it's easy to see how they can help with walking and transferring, providing a valuable prevention strategy. Incorporating gait belts into your practice involves patient assessment, proper application and use of the selected belt, and understanding how the belt can help prevent injury in situations where patients do fall.

Mobility assessment

Before using a gait belt, assess the

patient's mobility. You'll want to have a gait belt, a standard walker that's properly adjusted for the patient's height, and a second person to help you.

The assessment includes four elements: cognition, strength, balance, and endurance. (See *4 elements of mobility assessment*.) While the patient is in the bed, ask him or her to roll or turn side to side. The patient may or may not use the side rails—either is fine. If the patient's cognition is intact, he or she will perform the task as requested. This exercise assesses bed mobility.

If the patient can turn side to side, ask if he or she can sit up. To assist the patient, elevate the head of the bed. When the patient is seated, observe for trunk stability. If the patient can sit up or is able to sit up while holding the bed rail or self-supporting with arms placed to either side of the body on the mattress, test his or her quadricep strength with straight-leg raises. Ask the patient to hold one leg out straight and count to five. Do the same with the opposite leg.

Perform a mobility assessment the first time a patient is mobilized and then once every 24 hours. Assessments also should be performed after procedures, if the patient's condition changes, and in accordance with state practice requirements. Always mobilize the patient according to the most current assessment, and never use three people to assist; more than two helpers will interfere with a clear path for transferring and walking may place caregivers and patients at risk for injury.

Although conducting a mobility assessment may seem time-consuming, it usually takes no more than 10 minutes. Document the assessment results in the electronic health record, and verbally communicate the assistance level (one- or two-person), equipment requirements, and gait belt placement to other members of the patient's healthcare



team and at hand-offs. Also communicate the information when the patient leaves the unit (via a "trip ticket" or phone call) and on a whiteboard or similar tool at each point of care. The plan of care for *impaired mobility* or *at risk for falls* should include an assessment schedule for mobility or safe mobi-

Perform a mobility assessment

the first time a patient is mobilized and then once every 24 hours.

lization, identify use of the proper number of helpers, level of assistance, and equipment to be used, including the gait belt.

Even if the patient passes the mobility test elements, address any concern that a knee might buckle, the patient could become dizzy, or something could go wrong. If that is the case, a gait belt should be used. In the facility where I work,

nurses use a gait belt for any patient who is not independent to promote safety.

Gait belt contraindications

Flail chest or chest trauma that includes multiple rib fractures that separate ribs from the skeletal wall are contraindications to gait belt use. These painful conditions would make proper tightening of the gait belt intolerable. Other contraindications include behavioral aggression (for example, during alcohol withdrawal), where the patient might use the gait belt as a weapon, and patients at risk for suicide who might use the gait belt to harm themselves.

Applying and using the belt

If no contraindications exist, place the gait belt snugly around the patient's waist while he or she is sitting on the edge of the bed. You barely should be able to get your fingers under the belt to provide support. If the patient has a colostomy or percutaneous drain, place the belt higher up, as high as below the axillae. Use your critical-thinking skills to determine the best placement and communicate that information to the care team.

After the belt is properly secured, ensure that the patient's feet are placed flat on the floor (no tiptoes or dangling feet). If your patient is short and unable to reach the floor while sitting on the bed, consider a specialized low bed or a stepstool that offers a wide base of support. Next, place a walker in front of the patient and ask him or her to push up from the bed to stand. Instruct the patient not to reach for the walker or to pull up on it and not to grab or pull on you for support. You also must be passive and not grab the gait belt to pull the patient up to stand. A gait belt is used to steady a patient—it is *not a lifting device*. You can help the patient by raising or lowering the bed.

When the patient is able to stand for a full minute, ask if he or she

4 elements of mobility assessment

Your mobility assessment should include these four elements.

1 Cognition Can the patient follow directions? You can provide redirection, assist with hand placement, and cuing. If the patient is cooperative and can demonstrate bed mobility, you have a green light to continue.

2 Strength How much help do you have to provide? How well does the patient perform the straight-leg raise? Does this activity elicit pain? Use your critical-thinking skills to ascertain whether the patient can complete the strength testing activities with a minimum, moderate, or maximum level of assistance. Perhaps cuing or hand-placement assistance is all that's required.

| Assist level | Amount of work patient can do | Amount of work helper does |
|---------------|-------------------------------|----------------------------|
| Independent | 100% | 0% |
| Supervision | 100% | Eyes on the patient |
| Contact guard | 100% | Hands touching the patient |
| Minimum | 75% | 25% |
| Moderate | 50% | 50% |
| Maximum | 25% | 75% |

3 Balance The assessment examines balance at two important junctures: when trying to sit at the bedside and in the single-point stance. When the patient is sitting at the bedside, look for trunk control. Is the patient steady or wobbly? Is he or she using the bed rail or bed surface for support? In the single-point stance, you want to determine if the patient can follow directions, if he or she is strong enough to stand without lifting assistance, and if he or she is light-headed or dizzy.

4 Endurance This is an estimation of the patient's ability to perform a task to exertion. Ideally, a physical therapist (PT) should assess this element. Limit the patient's walk to short distances at first and request a PT consult.

feels light-headed or dizzy. If the answer is yes, help the patient to sit back onto the bed. For patients who may be dehydrated or who have blood loss or a suspected bleeding condition, assess orthostatic vital signs when they initially stand. If all is well, test the patient's balance by having him or her step forward and back at least three times. If the patient does well, take a walk with the patient starting with two or three steps; do this at least three times to ensure balance before testing the patient for any endurance.

If hands-on assistance is needed, walk alongside the patient with one hand on the gait belt in front and the other on the belt in the back. If only one hand is needed, hold the belt from the back. Always use an

underhand grip on the gait belt; it offers a stronger grip and reduces your risk of injury.

If the patient demonstrates good cognition, strength, and balance, you can relax your position and meet the patient at his or her proper level of assistance—from barely touching (contact guard) up to two-person assistance.

What if the patient falls?

If you're walking with a patient who becomes dizzy or experiences a syncopal event, you may not be able to prevent a fall. But you can help to prevent injury by holding on to the gait belt and guiding the patient to the floor, supporting him or her on your thigh and with your large quadriceps muscle as you slow descent to the floor. Go to the floor

with the patient in a controlled manner. Be aware that with or without a gait belt, the patient might reflexively grab on to you, even though you have instructed him or her not to.

Tool for safety

Gait belts are inexpensive and effective tools for patient and nurse safety, so be sure to integrate them into your clinical practice. The article on page 32 addresses organizational strategies for gait belt use. ★

Resource

Gait belts are one option for steady-ing patients and should never be substituted for lifting devices. For more information about safe patient handling, visit the Handle with care section of the American Nurses Association's website (nursingworld.org/practice-policy/work-environment/health-safety/handle-with-care).

Wendy Wintersgill is a clinical nurse specialist in the orthopedic service line at Penn Medicine Lancaster General Health in Lancaster, Pennsylvania, and director of the Association of Rehabilitation Nurses.

Selected references

- Falls and falls with injury. American Nurses Association. nursingworld.org/practice-policy/advocacy/federal/agencies-regulations/falls
- Hoyer EH, Brotman DJ, Chan KS, Needham DM. Barriers to early mobility of hospitalized general medicine patients: Survey development and results. *Am J Phys Med Rehabil.* 2015;94(4):304-12.
- Miller H, Rockefeller K, Townsend P. International round table discussion: Do gait belts have a role in safe patient handling programs? *Int J Safe Patient Handl Mobil.* 2017;7(3):116-21.
- Occupational injuries and illnesses among registered nurses. Bureau of Labor Statistics. November 2018. www.bls.gov/opub/mlr/2018/article/occupational-injuries-and-illnesses-among-registered-nurses.htm
- Patient safety primer: Falls. Patient Safety Network. January 2019. psnet.ahrq.gov/primers/primer/40/Falls
- Safe patient handling and mobility. Association of Rehabilitation Nurses. February 2018. rehabnurse.org/resources/position-statements/safe-patient-handling

Hardwiring safety at the point of care

An organizational road map to gait belt use.

By Wendy Wintersgill, MSN, RN, CRRN, ONC, ACNS-BC, and Gary A. Greenslade, MPT

Safe patient handling training for nurses, physical therapists, occupational therapists, and nurse aides should include the use of transfer aids, lifts, and gait belts. (See *Mobility and lift safety tips*.) Gait belts, the focus of this article, can help enable functional mobility and reduce patient falls and patient and staff injuries. Without gait belt use, an organization has a gap in its safe patient handling and mobility programs. (See *Fall prevention and organizational health*.)

To change practice in your organization and improve safety with gait belts, make a plan, choose the gait belts that are right for your organization and patient population, build an education team, develop a sustainability strategy, and reward compliance.

Change organizational practice

Start by educating nurses on mobility assessment (see the article on page 32) and set the expectation for gait belt use with policy revisions, standard work (step-by-step guide that reduces the chance of variation), and a competency skills behavior checklist. These tools make expectations clear and establish that a gait belt must be used to mobilize any patient or resident who isn't independently mobile.

Standardizing work to reduce variation has been a golden rule in healthcare improvement for years. It sounds simple, but the Advisory Board research company recently reported that two out of every three



Mobility safety tips

Because gait belts allow patients to participate in transfers, which is beneficial to early mobility and rehabilitation, more healthcare workers—nurses, physical and occupational therapists, and nurse aides—are learning how to use them. Keep these gait belt and general safety tips in mind.

- Use gait belts to safely steady patients; never use them to lift patients.
- Boost patients from their bottom to help them complete a transfer and ambulate safely with proper assistance (1- or 2-person), contact guard to moderate assistance and using a walker or appropriate assistive device.
- Never use more than two people to assist a patient. More than two helpers can increase risk of patient and staff injury.
- If the patient requires two helpers, each providing more than minimal assistance, consider a partial standing lift or a total sling suspension lift.

Fall prevention and organizational health

Fall prevention efforts should always focus on patient and staff safety. But an organization's financial health and reputation also should be kept in mind as they can be damaged when falls occur

- After a fall, the organization is responsible for the patient's care and follow-up (X-rays, computed tomography scans, increased nurse surveillance, and longer hospital stays), which, according to The Joint Commission, can cost up to \$14,000.
- If goals for falls prevention aren't met, an organization might see reductions in overall payments from the Centers for Medicare and Medicaid Services (CMS).
- Poor outcomes lower organizations' scores on the CMS hospital compare website and among consumer advocacy groups where consumers may shop for the best performing hospitals.
- High fall rates, falls that result in injury, and high nurse injury rates can jeopardize Magnet® designation.

healthcare change initiatives fail. To increase the chance for success, engage staff in the planning and implementation process.

Plan for change

Plan your change with your organization's calendar in mind, and involve nurse managers in this decision; they'll know where to balance initiatives around other resource-intensive calendar activities, such as new employee onboarding, competency skill days, and meetings.

More important than the launch date are the people who will be involved. All stakeholders (the people who will help to establish the plan and make it work) must be engaged from the outset. Stakeholders will vary depending on the organization and its culture, but a good start should include the full spectrum of nurses (managers, direct care, clinical nurse specialists, clinical educators,

professional development specialists, nurse aides, and patient care assistants); physical and occupational therapists; transport teams; infection preventionists; purchasing staff; environmental services, housekeeping, and maintenance staff; and patients.

Choose your product

A wide range of gait belts is available. Some belts are single-use and others can be cleaned and used with multiple patients. Many acute care and post-acute care settings provide a single cotton web belt for each patient, labeling it with the patient's name to prevent mix-ups. If a sturdy, cost-effective wipeable belt is part of the patient environment of care, partner with environmental services or housekeeping team members to wipe belts clean when a patient is discharged so that it's ready for the next patient. Use a permanent marker to label the belt

with the assigned room number and location (for example, bed A, bed B, D [door], or W [window]).

Some acute care hospitals prefer wipeable belts in all areas except in orthopedic and joint replacement units, where a single-use belt makes sense. In these units, therapists can instruct family and other caregivers how to safely continue to use the gait belt at home.

Many companies manufacture gait belts in a variety of colors, patterns, sizes, buckle types, grab loop options, and prices. Begin your selection with a product review event to include all disciplines that will use the belts (nurses, physical and occupational therapists, aides, and techs) as well as all purchasing stakeholders (infection preventionists and members of your value analysis or new products committee). If your organization has a patient advisory or community consumer group, invite them to provide a patient perspective, which can be used to craft the right messaging for patient education, brochures, and videos. Make the product review a fun event by welcoming participants and offering beverages with a light snack. Provide a simple paper or electronic survey so that everyone can vote for the belt he or she likes best. Be transparent and share the survey results with all stakeholders before making a final decision.

As part of your planning, discuss where gait belts will be located. To ensure consistent use, they should be placed at the point of care, next to every patient bed. Belts for larger patients can be kept in the clean utility room and exchanged for standard-length belts when needed. (See *Gait belt placement*.)

Identify your education team

Work with clinical nurse specialists, the staff professional development team, or clinical educators to revise your organization's falls prevention policy, develop standard work, and create a competency behavioral

skills checklist for staff education. Depending on organizational culture and previous gait belt experience, you may want to include a physical therapy team member. The education team can provide training and complete competencies for unit-based rising star champions and staff from ancillary departments, such as transport, imaging, and the catheterization lab, who will need to know how to use gait belts. These education team members can lead peer-to-peer gait belt competency checks for implementation.

Sustain use

Begin to reinforce gait belt use with staff observation. For example, if you see a staff member walking a patient without a gait belt, ask, "Is your patient independent?" Those using light-touch or hands-on will get the message because their patient can't ambulate independently. If a gait belt is needed, help walk the patient safely back to his or her room or get a chair for the patient until a gait belt can be retrieved and securely placed. Being present and using this just-in-time education for the first 2 to 3 weeks of implementation establishes the expectation that gait belts will be used. As compliance rounding becomes regular, so does gait belt use. Measures of success are reduced falls, reduced severity of patient injuries when falls do occur, and fewer staff injuries. Unfortunately, the value of gait belt use is felt most when someone doesn't use a gait belt and a patient falls.

Reward compliance

Recognize staff who use gait belts as expected. Thank them for being a gait belt champion and cheer them for their contribution to patient safety. Some organizations use electronic kudos (an electronic gift card or a simple email) and others may use handwritten notes. Pizza celebrations also work well. Use whatever reinforcement you can to reward gait belt users for following through.



Gait belt placement

Gait belts should be placed next to every patient bed to reinforce their use. However, many rooms have limited space and walls already are covered with medical and patient care equipment. In addition, the layout of the rooms may vary. Enlist nurses to tour all of the patient rooms to identify the best location in each. They can place a sticky note at each location, which can then be critiqued by other nurses and staff. When the final locations are chosen, place a maintenance request to have hooks installed where the gait belts will hang.

Gait belts
should be placed
next to every
patient bed.

Share your success

Although we can't scientifically prove the efficacy of gait belts with randomized clinical trials, we can show how they improve safety and outcomes and are an important part of evidence-based practice (EBP).

Disseminating your story and its outcomes is the final step in EBP. Partner with someone to publish or present your experience (via a poster or podium presentation) or write an abstract for conferences. Show how your staff expertly implemented a culture of gait belt use and demonstrate that you've reduced patient and staff injury. Post-acute care organizations can present their stories at the annual Association of Rehabilitation Nurses REACH conference. If a national conference isn't feasible, consid-

er a local or regional meeting.

Whatever the venue, share your success and publish your story. Each retrievable citation grows the body of evidence that gait belt programs are valuable to patients and an organization's safety culture. ★

The authors work at Penn Medicine Lancaster General Health in Lancaster, Pennsylvania. Wendy Wintersgill is a clinical nurse specialist in the orthopedic service line at Penn Medicine Lancaster General Health and director of the Association of Rehabilitation Nurses in Lancaster. Gary A. Greenslade is a physical therapist.

The content in this Focus On does not necessarily represent the views of the American Nurses Association.

Selected references

- Joint Commission, The. Sentinel event alert 55: Preventing falls and fall-related injuries in health care facilities. September 28, 2015. jointcommission.org/assets/1/6/SEA_55_Falls_4_26_16.pdf
- Miller H, Rockefeller K, Townsend P. International round table discussion: Do gait belts have a role in safe patient handling programs? *Int J Safe Patient Handl Mobil*. 2017;7(3):116-21.
- Vonderhaar K. Research report: Drive organizational change—without overloading managers: Best practices for maximizing managers' finite capacity. September 17, 2017. advisory.com/research/hr-advancement-center/studies/2017/drive-organizational-change-without-overloading-managers