

Soteria Strains

Safe Patient Handling and Mobility Program Guide

Section 4 – Special Considerations

Section 4.2 – Bariatric Patients

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soteria

STRAINS

A provincial strategy for healthcare workplace musculoskeletal injury prevention.

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Section 4 – Special Considerations sub-sections will be expanded and/or modified as required based on input from experience and observations during program implementation.

4.2 Bariatric Patients

Introduction

This section contains suggestions to address the special needs of bariatric patients. Bariatric patients have a body mass index (BMI) greater than 30. The BMI is calculated by dividing patient weight (kg) by height squared (m²). This classification system is internationally accepted. Refer to Table 4.2.1 – Definition of Bariatrics by BMI.

| International Standards | BMI |
|-------------------------|-----------|
| Underweight | <18.5 |
| Normal | 18.5-24.9 |
| Overweight | 25-29.9 |
| Obese 1 | 30-34.9 |
| Obese 2 | 35-39.9 |
| Obese 3 | >40 |

Table 4.2.11 – Definition of Bariatrics by BMI

Risk of injury to the health care worker and bariatric patient during patient handling and mobility tasks is increased due to the patient's weight combined with atypical body mass distribution. Providing care to bariatric patients provides special challenges to all health care professionals when performing tasks such as turning, repositioning in bed, transferring in/out of bed, holding a limb while performing patient care tasks, and other activities of daily living. Additionally, environmental concerns, such as doorway clearances, weight capacity of scales, and tolerance of equipment must be addressed. Risk associated with patient handling and mobility is magnified as the patient's body mass index increases.

Also, a bariatric patient's condition rapidly deteriorates in a hospital setting when activity levels are decreased. Therefore, a holistic approach to care that considers multiple aspects and focuses on early mobilization and discharge is important to reduce risk to healthcare workers and bariatric patients. A thorough assessment and understanding of a bariatric patient's condition is required as risk is not only related to their size. In fact, many bariatric patients will pose less risk to healthcare workers than smaller patients, depending on their level of independence.

Consider the Patient

Safe patient handling and mobility requires health care providers to consider many factors. For bariatric patients it is particularly important to ensure that the patient feels psychologically safe and secure, and not belittled or discriminated against. If the patient does not feel psychologically safe they may be less cooperative during patient handling tasks. In order to help ensure the best outcomes:

- Deal with the bariatric patient as a person, not just with their obesity
- Learn from the patient and family members about the patient's capabilities and how he / she typically does certain things
- Encourage staff to seek methods of care to protect patient dignity and prevent patients from needlessly feeling like a burden or unwanted (e.g. ensure appropriately sized gowns are available and provided)

- Adequately explain processes of care and reasons for potential delays to the patient and family members (e.g. while waiting for appropriate bariatric patient handling equipment to arrive)
- Do not discuss concerns related to the safe handling of bariatric patients in front of them.

Upon Admittance

Health care providers are exposed to increased risk immediately upon admission of a bariatric patient. If the special needs of this patient population are not addressed early in the admission process, the likelihood of a negative patient outcome and employee injury increase.

Each facility should develop a plan for addressing the immediate patient handling and mobilization needs for bariatric patients when they are first admitted. Each admitting area should have a plan that considers the manner in which the patient arrives at the facility and why they are there. For instance, the plan should consider bariatric patients:

- arriving by ambulance and the need to transfer the patients from the stretcher to a bed
- arriving at the emergency clinic for treatment
- arriving at the facility for tertiary care (investigative/diagnostic test, etc.)

The plan should highlight issues like what patient handling equipment is available, number of staff to be utilized for a transfer, other immediate actions that need to be taken, etc. This plan should be implemented upon initial admission, based on the best judgment of the attending physician or RN.

The First 48 Hours

There are several processes/activities that need to occur to help ensure safe patient handling and mobility tasks. These activities should be completed in the first 48 hours of any patient being admitted. They will also need to be repeated on a regular basis and when changes occur (e.g., transfer of patient between units, prior to discharge, change in mobility and/or medical status).

These activities are:

- Patient risk profile
- Mobilization plan development and communication
- Multidisciplinary case meeting
- Staffing plan
- Access to algorithms
- Identification of required / appropriate equipment/supplies

Ideally an RN (or other appropriate member of the health care team) should be assigned and provided adequate time to develop a care plan and procure necessary supplies and equipment. This may require redistributing a portion or the care provider's entire, current, case load.

The information provided below outlines the recommended changes and additions required for each of the above activities to account for the needs of bariatric patients.

Patient Risk Profile

Refer to “Section 2.3 – Patient Risk Profile” for details on assessing patients to establish a safe patient handling and mobility plan. Below are some key items to consider when assessing a bariatric patient.

Weight Distribution

- Weight distribution affects the risk level, type of risk factors present, and type of equipment required. The two most common bariatric body types are:
 - Pear-shaped
 - Predominately found in females
 - fat is stored primarily around the hips and thighs.
 - Increased tissue around the thighs and hips of the patient reduces their ability to mobilize unassisted, leading to a potential for increased risk of falling.
 - Apple-shaped or central obesity
 - Predominately found in males.
 - fat is stored primarily around the abdomen.
 - Increased tissue in the abdomen with less distribution in the legs, allowing for easier mobilization, but an offset center of gravity increases the risk for falls.

Endurance

- Endurance is often decreased in bariatric patients.
- Low levels of endurance can lead to unexpected interruptions (e.g., needing to sit, falls) during interventions.
- Bariatric patients often think they can do more than they can. This is due to the rapid decline in endurance that occurs with this population with decreased activity while in hospital (bed rest)
- Reports based on patient information are not sufficient. An objective measure must be used. For example, when assessing walking, a patient may be asked to stand up and sit down three to five times at the edge of the bed before attempting to walk to ensure endurance is adequate. This extra level of assessment is warranted due to the potential impact on the patient and health care workers if the bariatric patient is unable to sustain weight bearing and, as a result, falls.

Physical Assessment - Add this activity to the PACE mobility check

To ensure adequate endurance include the following check prior to ambulation:

Ask the patient to stand up and sit down three to five times at the edge of the bed. This extra check is warranted due to the potential impact on the patient and health care workers if the bariatric patient is unable to sustain weight bearing and, as a result, falls.

Respiratory Status

- Most bariatric patients have some level of respiratory impairment.
- There is often shortness of breath when mobilizing.
- Respiratory problems can be anxiety provoking and may lead to unexpected movement or repositioning.
- The use of certain equipment (e.g., slings) can provoke anxiety and respiratory challenges.
- This assessment needs to be performed very carefully and respectfully, incorporating the patient's perceptions and the assessor's observations. Sufficient health care workers should be available to assist.

Skin Integrity

- Many bariatric patients have compromised skin integrity that should be considered when establishing a safe patient handling and mobility plan. For instance, it may not be appropriate to use certain types of equipment and/or slings if they will exacerbate the already compromised skin integrity.

Mental Health

- With bariatric patients, issues such as depression and anxiety will more likely be a factor that will influence their perception of and tolerance to pain and activity, as well as impact their motivation. Understanding the presence and impact of mental health issues is important in mitigating the risk of injury to patients and healthcare workers.

Pain Levels

- Bariatric patients often have other forms of pain not related to the admission. In many cases this is musculoskeletal in nature - back and/or joint pain. This can effect the patient's ability to assist during care. Having a clear and thorough understanding of the patient's pain is important for mitigating the increased risk associated with assisting this patient population to move.

Care/Mobility Plan

Importance

- Bariatric patients lose their ability to mobilize or perform self-care activities within a few days if it is not practiced. It may take weeks to recover what is lost in only a few days. A mobility plan should be developed upon admission by the admitting nurse in collaboration with the physician and physiotherapist and/or occupational therapist.
- If the patient has restrictions, the plan should be focused on maintaining the baseline mobility within the restrictions.

ER Coverage

Currently most bariatric patients are admitted through the ER. In Nova Scotia, the ER is often not covered by rehabilitation/PT services. This is a significant gap for this patient population and should be addressed by organizations implementing a safe patient handling and mobility program.

Multidisciplinary Case Meeting

Importance

- Each bariatric patient benefits from a multidisciplinary case meeting to discuss treatment, care, and discharge planning. As noted above, a holistic approach to care will help to ensure the risk to both the patient and healthcare providers is minimized.
- It is vital that an appropriate safe patient handling and mobility plan be developed and finalized at the initial meeting. The safe patient handling and mobility plan should also be reviewed at future meetings and updated as required.

This multidisciplinary meeting should be scheduled by the admitting nurse and all stakeholders should be informed and attend.

Timing

- First meeting within the first 48 hours
- Patient Risk Profile completed prior to the first meeting
- Other meetings as required (significant change in status, transfer of accountability, etc.)

Stakeholders as they relate to Safe Patient Handling and mobility

This is a list of stakeholders that should be involved in the creation of the safe patient handling and mobility plan. More may be added depending on the situation.

Nursing

- Primary health care workers most often affected by risks involved with treating bariatric patients

Peer Champions

- As individuals who have enhanced knowledge of safe patient handling and mobility issues, they can provide information about risk assessment and control, available equipment, etc.

Physicians

- If available, the physician can provide information about comorbidity or issues that may limit the use of certain safe patient handling and mobility equipment or techniques.

Unit Support (Aides/Clerks)

- Often well informed about equipment availability and supply options

Physical Therapist/Occupational Therapist

- Role is to help establish a sustainable mobility and self-care plan
- Provide creative problem solving
- Not the sole provider of mobilization interventions, but a valuable resource for assessment and problem solving

Safety/Injury Prevention

- Not traditionally included in patient care, but often have knowledge in prevention processes
- Can provide unique insights and often have knowledge of ergonomic principles that can be helpful

Patient and Family

- Helpful in identifying barriers experienced at home
- May provide helpful tips that can be implemented early on
- May also provide further information regarding co-morbidities such as depression

Manager(s)

- Equipment purchase and lease may be required and firsthand knowledge of the issues will help inform the manager
- If additional staffing is required, a manager who can approve the increase will benefit from understanding the patient's needs

Dietician

- Caloric needs of the bariatric patient different than other patients
- Important to ensure patient has adequate caloric intake to avoid lethargy and decreased abilities

Home Care

- May provide information regarding levels of mobility prior to admission and needs upon discharge
- Often can clarify perceptions reported by the patient regarding mobility status

Social Work

- Discharge planning must be initiated upon admission particularly in cases where the patient may end up going to a long term care facility

Others

- Other disciplines considered on a case-by-case basis
- Possible other disciplines include chaplaincy and mental health practitioners

Elements to include in the Safe Patient Handling and mobility Plan

Staffing Plan

When admitting high-risk bariatric patients, assessing the work schedule and planning who will be assigned to the patient ahead of time can decrease exposure to injury risk. This also helps to ensure the right people are aware of the care plan and gaps in staffing are identified (i.e., staffing levels may require reorganization or bolstering to ensure appropriate staffing ratios).

Access to Algorithms

Algorithms are available for high-risk tasks and have been shown to help reduce risk. See Appendix 4.2.1 – Bariatric Algorithms for Safe Patient Handling and mobility. Establishing a common practice/process for reviewing and using these algorithms improves consistency of care. Having a consistent approach, that is used by all the healthcare providers, helps to improve the patient's experience while also reducing risk to employees and the patient.

Obtaining Specialty Equipment/Supplies

- It is crucial to ensure that the correct supplies and equipment are available and used. As this can be a time consuming process, it is important that this be recognized and the appropriate resources and systems be in place to ensure that any delays are minimized.
- Having equipment ordered and set up in a timely manner should occur in the first eight hours of admission.
- Ideally, on admission, an RN (or other appropriate member of the health care team) should be assigned and provided adequate time to develop an immediate care plan and procure necessary supplies and equipment. This may require redistributing a portion or all of the care provider's current case load.

Equipment and facility design considerations

There is a common misconception that bariatric patients can be accommodated by using equipment designed for a "large size." Most of the attention is focused on the bed and the lift to accommodate the patient, but there are many aspects that need to be considered. Knowing the weight capacity of existing equipment, for example, is critical for safety. Bariatric equipment may be indicated by using a label indicating "EC" (expanded capacity) and weight limits. In addition to patient handling and mobility equipment the dimensions and weight capacity of the bedside recliner chairs and toilets must be considered.

Below is a list of issues to consider when procuring / considering equipment and facility design issues for use with a bariatric patient.

Equipment Weight Capacity Label System

Awareness of the weight limits for equipment is an ongoing challenge because equipment labeling is not standardized. A standardized approach is extremely important because using equipment that is not designed for the loads it is being subjected to is unsafe for the patient and health care workers.

A labeling system should be consistent and clearly indicate the weight capacity of all equipment (e.g., location on the equipment, font, units (lbs/kg.)). Labels should be located so that they are clearly visible to the users. A simple example is to create a label with a C (for Capacity) followed by the capacity in pounds (e.g., a lift or bed with a capacity of 300 lbs. would be labeled C300).

Patient Care Environment

- Doorframe width - some bariatric beds are adjustable allowing health care workers to narrow the width for moving in and out of doorways.
- Elevator door width and capacity

Bathroom

- Doorframe width
- Shower door width
- Weight capacity of wall-mounted grab bars
- Toilets and Commodes
 - Weight capacity
 - Porcelain toilets typically have a weight capacity of 350 lbs. Bracing wall-hung toilets is not helpful as it does not increase the weight capacity of the toilet (the porcelain may still fracture if exposed to greater weight than it is built for).
 - Portable commodes are available with extended weight capacity and appropriate widths.
 - Same criteria for selection as the chair (should be as high as possible but still allow the patient to touch the ground with their feet)
 - Skin care protection
 - Adjustable height
 - Foot rests
 - Arm rests

Hospital Beds

Body shape and weight distribution are often more important than weight when considering the appropriate bed for a patient. Procurement specialists should be actively involved in needs assessments to ensure understanding of requirements and provide information regarding products and suppliers and purchase/rental options. Other considerations include:

- Weight capacity of bed, frame, and mattress
- Weight capacity of the side rail support
- Weight capacity of the bed scale
- Width of the bed (some have a width adjustment)
- Length of the bed (Beds are available for very tall patients.)
- Motorized power drive vs. non-powered
- Mattress type: pressure relief, pressure reduction, alternating, rotational
- Caster design and maintenance
- Brake design and maintenance

Stretcher

- Weight capacity
- Width
- Length
- Weight capacity of side rail support
- Powered vs. non-powered
- Caster design and maintenance
- Brake design and maintenance

Friction-Reducing Devices

- The various friction-reducing devices have distinct advantages and disadvantages. There are a few products that can be kept under the patient; however, many cannot due to deleterious effects on skin integrity.
- These devices need to be used consistently and correctly to reduce injury risk.

Transfer Devices

- weight capacity, dimensions and fit with existing/other equipment of:
 - Lateral transfer devices
 - Full-body sling lift
 - Over-bed/ceiling lift
 - Stand-assist lift

Lifts

- There are two main categories of lifts – ceiling and floor. In general, ceiling lifts are preferable as they are safer (no tipping risk), require no floor space for storage, and are easily accessible.
- Adapting how the equipment is used is often required from patient to patient (e.g., correct sling placement).
- Lifts can also be used to lift limbs if the patient cannot do that independently.
- Health care workers should always be aware of the weight capacity of a lift being used and the weight of the patient being lifted. Exceeding the rated capacity of a lift is extremely unsafe.

Chairs

- Extended-capacity chairs are an integral component of the mobility plan.
- The chair should be as high as possible but still allow the patient to touch the ground with their feet. Footstools are to be avoided.
- Family members may also require extended capacity chairs to accommodate them. This should be taken into account when setting up the room.

Wheelchair

- Weight capacity
- Width of the chair
- Seat height
- Handle width
- Armrest
- Powered vs. non-powered
- Wheel design & maintenance
- Brake design and maintenance
- Anti tipping guards design and maintenance

Wheelchair Scales

- Weight capacity
- Width

Walker

- Weight capacity
- Width

Shower Bars

- Most shower and safety bars have weight restrictions that are not able to support bariatric patients. These can be reinforced, but often this requires the wall to be replaced. Alternatives such as an appropriate walker or shower chair can be used in cases where the existing safety bars are not able to accommodate a patient's weight.

Gowns and Linen

- Right-size linens and gowns are essential to offering safe and dignified care.
- Linen that is too small may not stay in place increasing the need to turn and tug the patient while exposing the patient to an increased risk of skin breakdown.
- Gowns that are too small can reduce mobility, comfort, and dignity as well as increase issues of skin integrity.
- Oversized gowns can entangle patients resulting in increased tugging and pulling for comfort and safety.

Ancillary Departments

- Door widths
- X-ray table (weight capacity, width, length)
- CT Scan/MRI (weight capacity, width, length)
- OR table (weight capacity, width, length)
- Emergency room equipment (weight capacity, width, length?)
- Waiting room furniture (weight capacity, width, length)
- Exam room table (weight capacity, width, length)

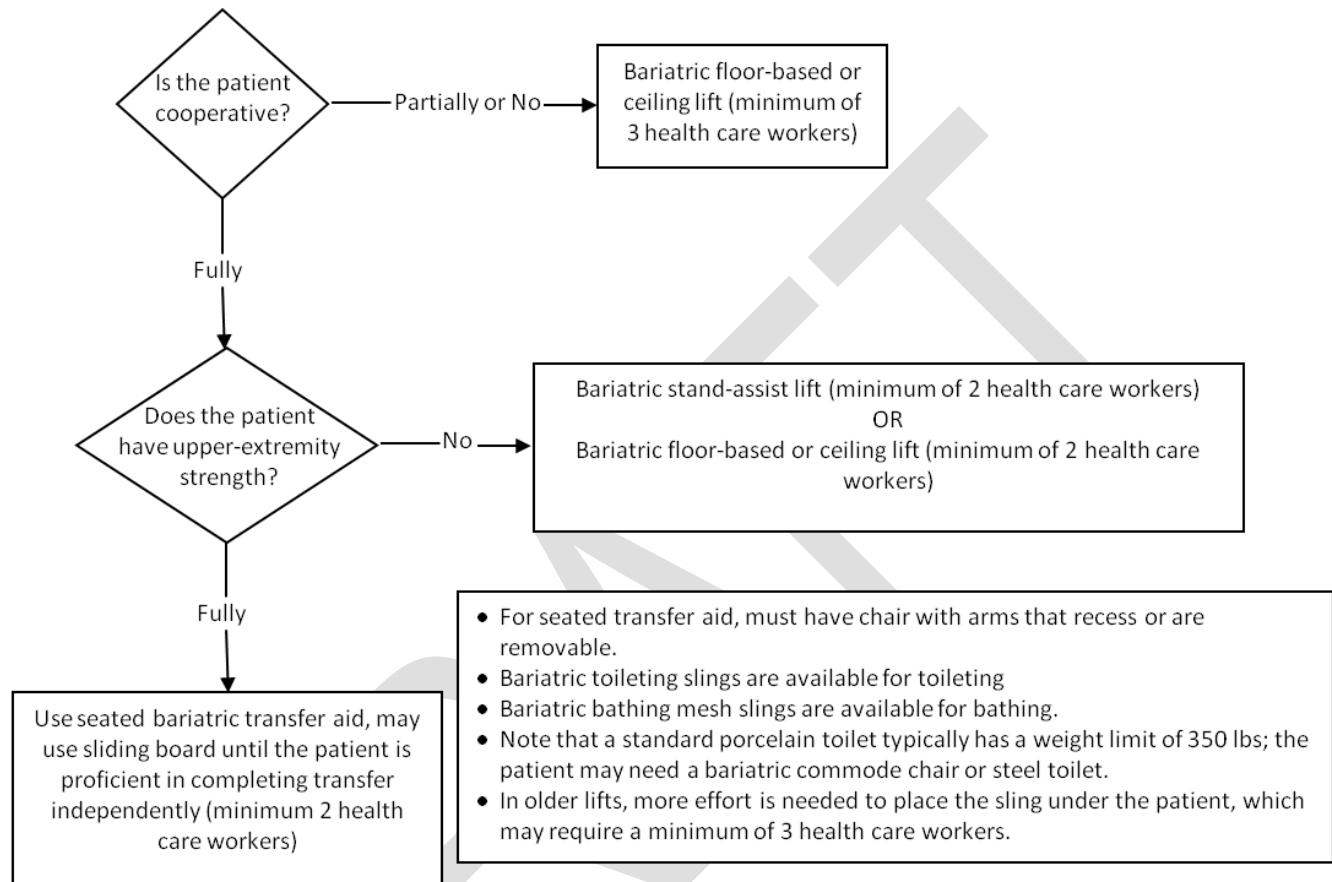
Other Patient Care Devices

- All patient care supplies need to be evaluated for appropriateness in bariatric care (e.g. blood pressure cuffs)
- Abdominal binders may be useful in lifting the abdominal girth out of the way when providing care, e.g., cauterization, skin care and dressing changes.

Appendix 4.2.1 – Bariatric Algorithms for Safe Patient Handling and Mobility

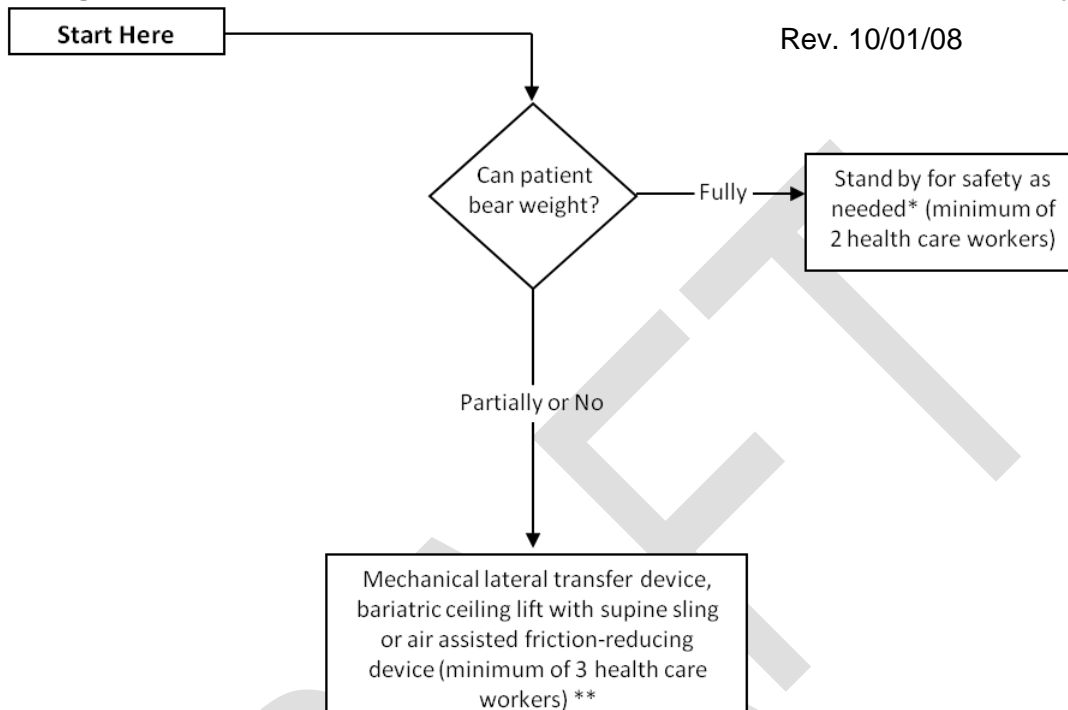
Bariatric Algorithm 1: Bariatric Transfer to and From: Bed/Chair, Chair/Toilet, or Chair/Chair

Rev. 10/01/08



- “Stand by for safety.” In most cases, if a bariatric patient is about to fall, there is very little that the health care worker can do to prevent the fall. The health care worker should be prepared to move any items out of the way that could cause injury try to protect the patient’s head from striking any objects or the floor and seek assistance as needed once the person has fallen.
- If patient has partial weight-bearing capability, transfer toward stronger side.
- Consider using an abdominal binder if the patient’s abdomen impairs a patient-handling task.
- Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with “EC” 9for expanded capacity) and a space for the manufacture’s rated weight capacity for that particular equipment model.
- Identify a leader when performing tasks with multiple health care workers. This will assure that the task is synchronized for increased safety of the health care worker and the patient.
- During any patient transferring task, if any health care worker is required to lift more than 35 lbs of a patient’s weight, then the patient should be considered to be fully dependent and assistive devices should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? American Journal of Nursing, 107[8], 53-59)

Bariatric Algorithm 2: Bariatric Lateral Transfer To and From: Bed/Stretcher/Trolley

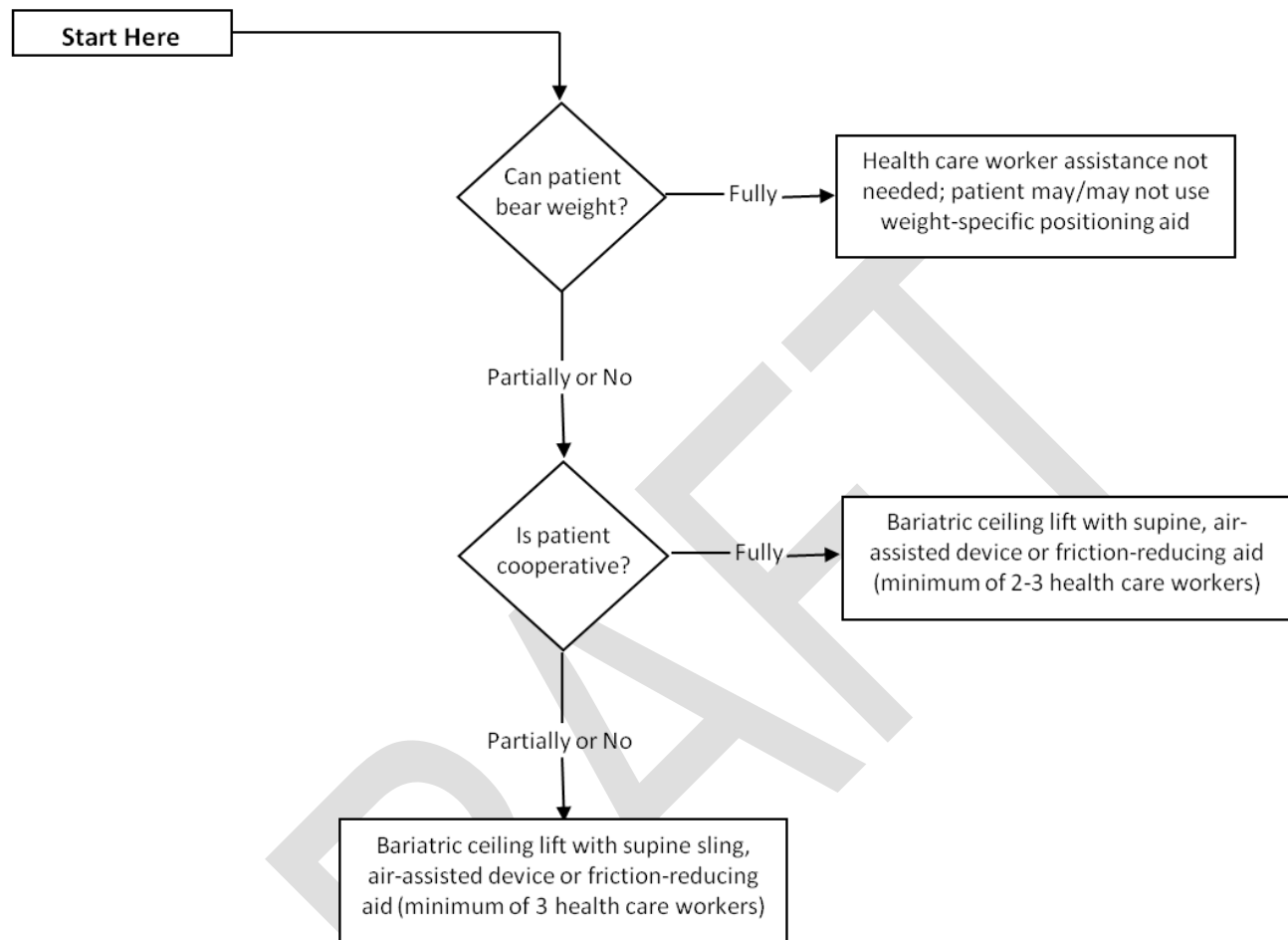


- The destination surface should be about ½” lower for all lateral patient moves.
- Avoid shearing force.
- Make sure bed is the right width, so excessive reaching by health care worker is not required.
- Lateral transfers should not be used with specialty beds that interfere with the transfer. In this case, use a bariatric ceiling lift with supine sling.
- Ensure bed or stretcher doesn’t move with the weight of the patient transferring.
- **Use a bariatric stretcher or trolley if patient exceeds weight capacity of traditional equipment.

- “Stand by for safety.” In most cases, if a bariatric patient is about to fall, there is very little that the health care worker can do to prevent the fall. The health care worker should be prepared to move any items out of the way that could cause injury try to protect the patient’s head from striking any objects or the floor and seek assistance as needed once the person has fallen.
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Bariatric Algorithm 3: Bariatric Reposition in Bed: Side-to-Side, Up in Bed

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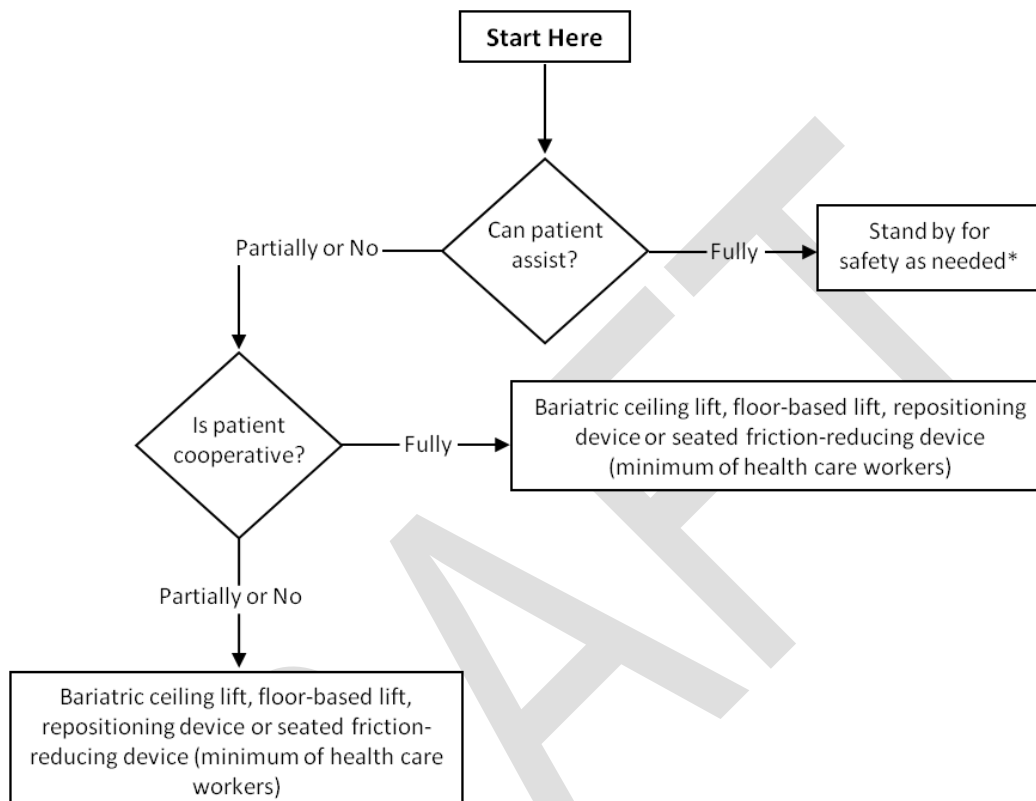


- When pulling a patient up in bed, place the bed flat or in a Trendelenburg position (if tolerated and not medically contraindicated) to aid in gravity; the side rail should be down.
- Avoid shearing force.
- Adjust the height of the bed to elbow height.
- Mobilize the patient as early as possible to avoid weakness resulting from bed rest. This will promote patient independence and reduce the number of high-risk tasks health care workers will provide.
- Consider leaving a friction-reducing device covered with draw sheet, under patient at all times to minimize risk to staff during transfers as long as it doesn't negate the pressure relief qualities of the mattress/overlay.
- Use a sealed, high-density, foam wedge to firmly reposition patient on side. Skid-resistant texture materials vary and come in set shapes and cut-your-own rolls.

- If patient has partial weight-bearing capability, transfer toward stronger side.
- Consider using an abdominal binder if the patient's abdomen impairs a patient-handling task.
- Assure equipment used meets weight requirements. Standard equipment is generally limited to 250-350 lbs. Facilities should apply a sticker to all bariatric equipment with "EC" (for expanded capacity) and a space for the manufacturer's rated weight capacity for that particular equipment model.
- Identify a leader when performing tasks with multiple health care workers. This will assure that the task is synchronized for increased safety of the healthcare provider and the patient.
- During any patient transferring task, if any health care worker is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used. (waters, T. [2007]. When is it safe to manually lift a patient? *American Journal of Nursing*, 107[8], 53-59.)

Bariatric Algorithm 4: Bariatric Reposition in Chair: Wheelchair, Chair, or Dependency Chair

Rev. 10/01/08



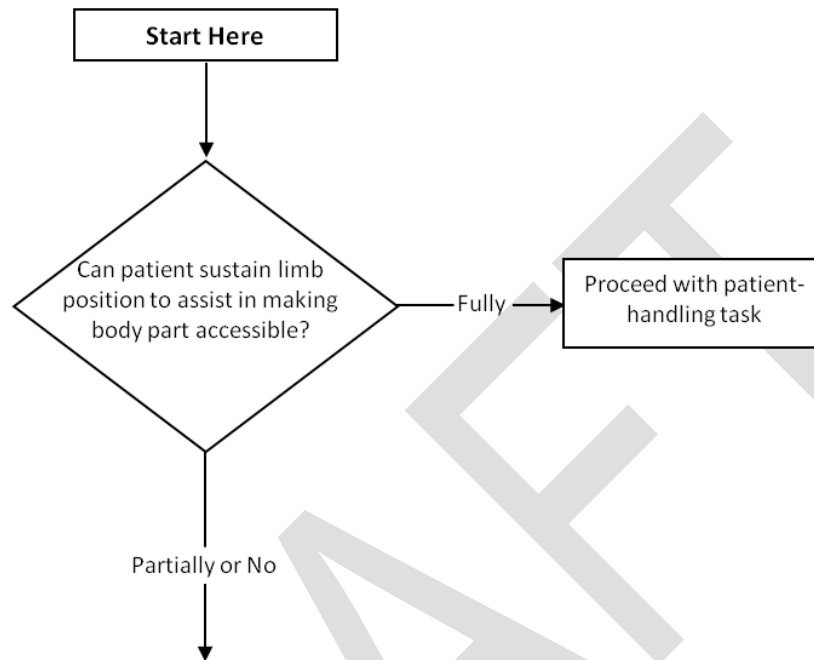
- Take full advantage of chair functions, e.g., chair that reclines, or use an arm rest of chair to facilitate repositioning.
- Make sure the chair wheels are locked.
- Consider leaving the sling under the patient at all times to minimize risk to staff during transfers after carefully considering the skin risk to patient and the risk of removing/replacing the sling for subsequent moves.

- "Stand by for safety." In most cases, if a bariatric patient is about to fall, there is very little that the health care worker can do to prevent the fall. The health care worker should be prepared to move any items out of the way that could cause injury try to protect the patient's head from striking any objects or the floor and seek assistance as needed once the person has fallen.
- If patient has partial weight-bearing capability, transfer toward stronger side.
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Bariatric Algorithm 5: Patient-Handling Tasks Requiring Access to Body parts

(Limb, Abdominal Mass, Gluteal Area)

Rev. 10/01/08



Assemble multidisciplinary team to develop creative solutions that are safe for patient and health care worker.

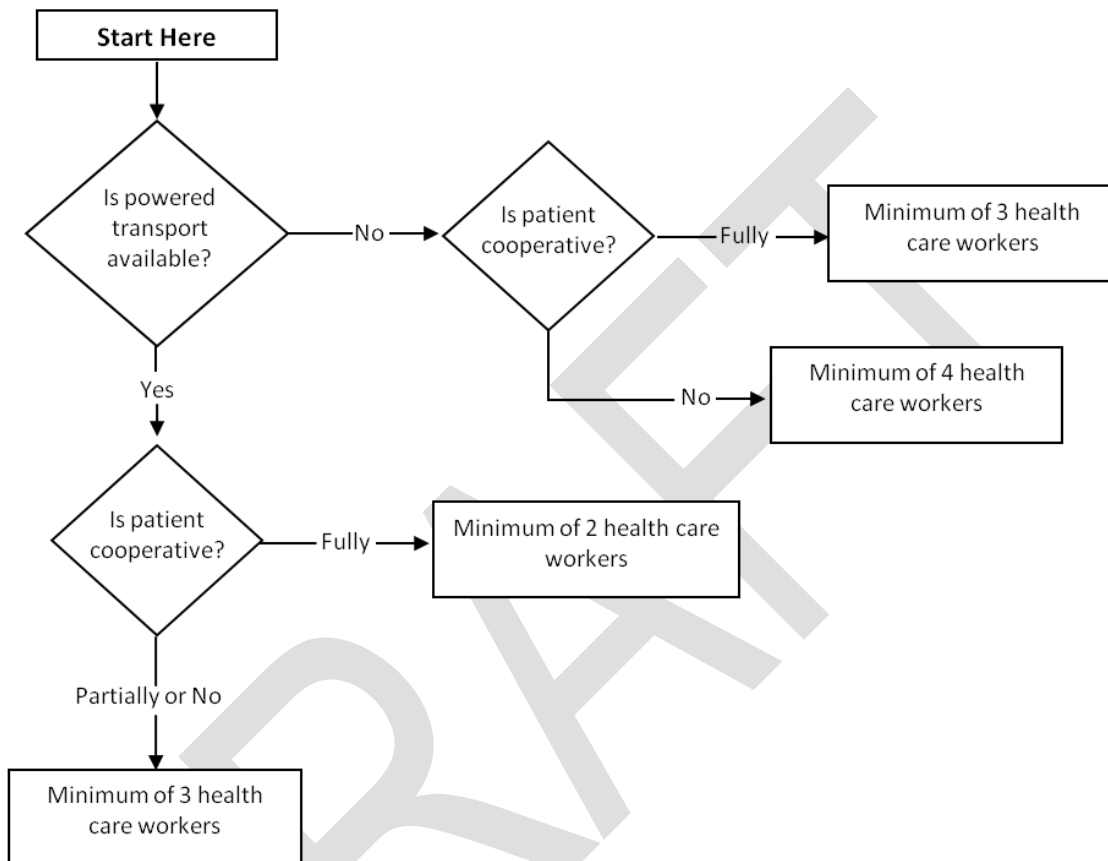
Examples:

- Modify use of a full body sling lift to elevate limbs for bathing or wound care (i.e. bariatric limb sling).
- Use draw sheet with handles for 2 health care workers (one per side to elevate abdominal mass to access the perineal area (e.g. catheterization, wound care).
- To facilitate drying a patient between skin folds, use the air-assisted lateral transfer aid to blow air or use a hair dryer on a cool setting.
- Use sealed high-density foam wedge to firm reposition patient on side. Skid-resistant texture materials vary and come in set shapes and cut your own rolls.

- A multidisciplinary team needs to problem solve these tasks, communicate to all health care workers, refine as needed and perform consistently.
- Consider using an abdominal binder if the patient's abdomen impairs a patient handling task.
- During any patient transferring task, if any health care worker is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? American Journal of Nursing, 107[8], 53-59)

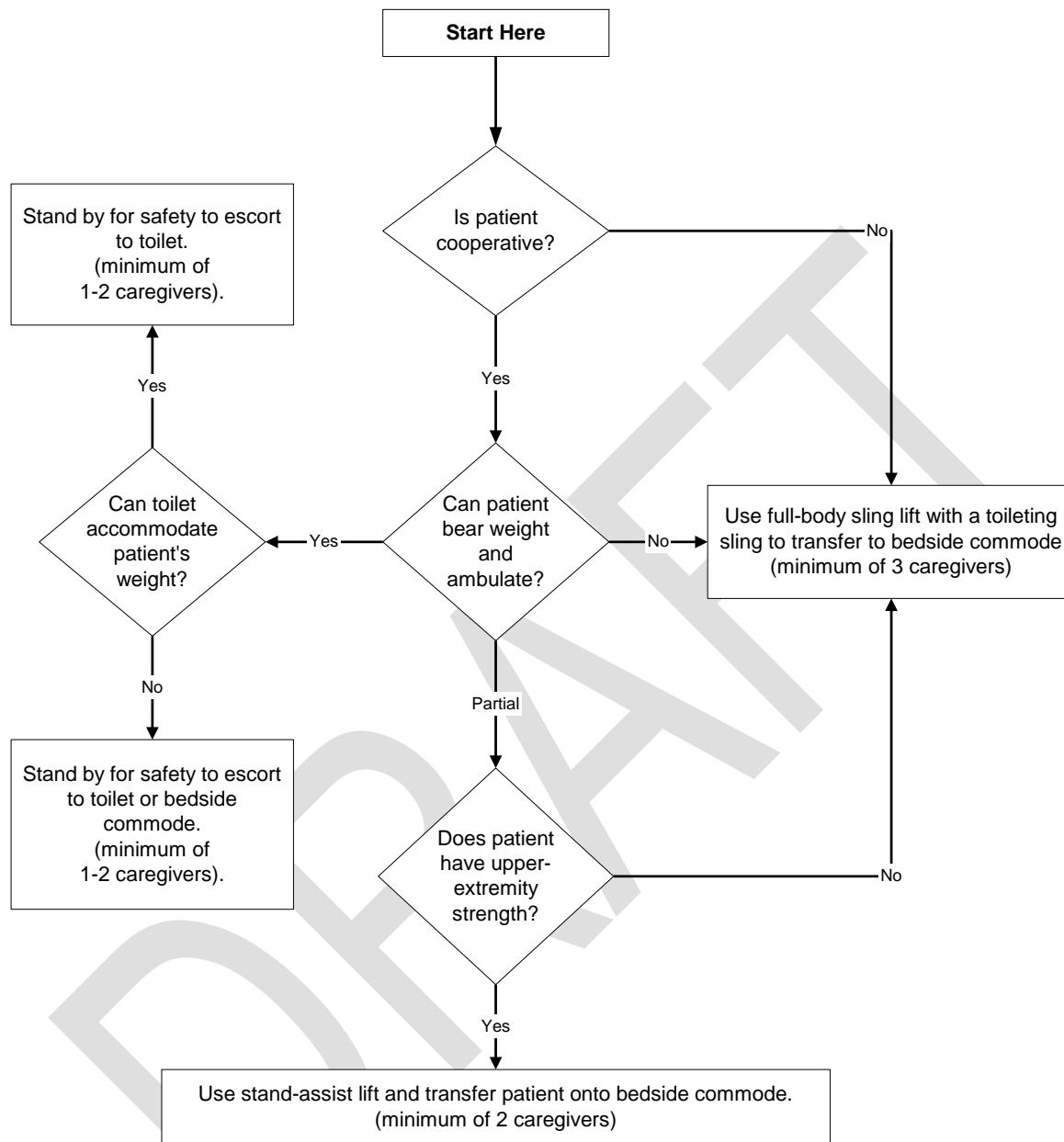
Bariatric Algorithm 6: Bariatric Transporting (Stretcher)

Rev. 10/01/08



- If the patient has respiratory distress, the stretcher must have the capability of maintaining a high Fowler's position.
- Newer equipment is often easier to propel.
- If patient is uncooperative, secure patient in stretcher.
- During any patient transferring task, if any health care worker is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? *American Journal of Nursing*, 107[8], 53-59)

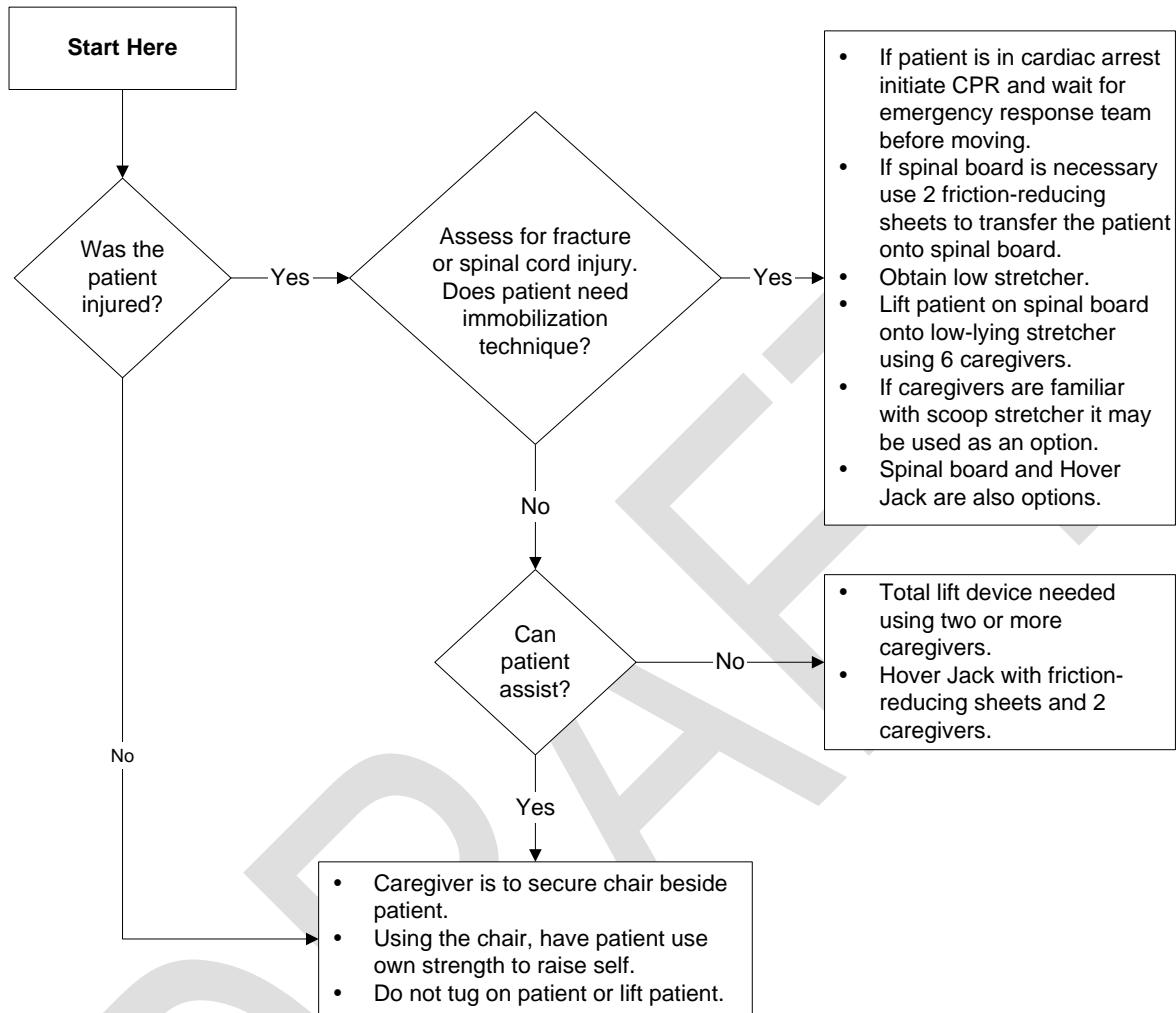
Bariatric Algorithm 7: Toileting Tasks for the Bariatric Patient Rev. 10/01/08



Considerations:

- Is bathroom doorway wide enough to accommodate entry of mechanical lift device and patient?
- Assure equipment used meets weight requirements and is appropriately sized for patient.
- Typically, standard toilets are rated to 350 lbs maximum capacity.
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? *American Journal of Nursing*, 107[8], 53-59.)

Bariatric Algorithm 8: Transfer a Bariatric Patient Up From the Floor (Rev. 10/01/08)



- Do not lift patient off floor.
- Do not allow patient to lean on caregiver for base of support.
- "Immobilization Technique" definition: use spinal precautions if can't use lift due to suspect hip, pelvic, or vertebral fractures.
- Use floor-based lift that goes all the way down to the floor (most of the newer models are capable of this).
- During any patient transferring task, if any caregiver is required to lift more than 35 lbs of a patient's weight then the patient should be considered to be fully dependent and assistive devices should be used. (Waters, T. [2007]. When is it safe to manually lift a patient? *American Journal of Nursing*, 107[8], 53-59.)