Lifts and Transfers

Employee Orientation

Presented by Therapy Services
2017
Session Objectives

To provide an brief overview of:

1. Terminology.
2. Key steps before beginning a lift or transfer.
3. Patient mobility categories.
4. Common techniques and supporting equipment.
5. Practical scenarios
   • Will be reviewed onsite during orientation
Terminology

**Repositioning** = procedure where a patient is moved to a new position on the same surface
  – e.g., repositioning in bed or while seated

**Lift** = procedure used to carry the entire weight of a patient
  – e.g., mechanical lift

**Transfer** = procedure used to assist a patient, who can bear weight at least through one leg or both arms to move from one surface to another.
  – e.g., sit-to-stand
Are **YOU** Assessing?

Risk Reduction Strategies

1. Environment
2. Equipment
3. Patient
4. **Provider** (also consider Caregiver)
1. Environment

• Set up is important!

• Scan the room and set it up for success.
  - layout, space, lighting, temperature, obstacles, flooring (clean and dry), etc.
  - Move furniture to make more room.

• Check white board in patient’s room for transfer information.

• Have gait aid/chairs ready and accessible.
2. Equipment

• Adjustments should be made to bed and/or chair
  o height, lock brakes, remove arm rests, lower bed rails
  o position chair at appropriate angle to bed.

• Supportive aids need to be accessible
  o sliding board, sara stedy, mechanical lift, etc.

• Ensure all devices are in good working order.
  o belts, lifts, slings, etc.

• Protect lines and tubes.
  o unplug IV pole/move lines and catheters
Supportive Equipment/Devices

Transfer/Sliding Boards
- Vary in material, size, weight and design.
- They are used primarily for patients unable to weight-bear, due to neurological and orthopaedic conditions.
- Use requires the patient to have good upper extremity strength.
- The amount of assistance required varies from patient to patient and is usually to help with control of the patient’s trunk while he/she pushes his/her body along the board.

Transfer/Gait Belts
- Wide cloth belts that can be adjusted by either buckles or velcro.
- Helpful for patients that need assistance and a more secure handhold is required.
- Should be snug at the patient’s waist.
- Provider grasps the belt at the back with both hands, prior to proceeding with the planned transfer.

Mechanical Lifts
- Use for maximally dependent patients and those who are unable to follow instructions, or are unpredictable.
- Decrease the risk of injury by eliminating/reducing forceful movements, awkward postures and repetitive motions associated with manual lifting.
3. Patient set-up

- **Assess patient’s status**
  - Change in medical status (decline will make transfers more difficult)
  - Patients ability to communicate
  - Change in cognitive and emotional status (i.e., confused, drowsy)
  - Level of cooperativeness
  - Physical abilities (ROM, strength, balance)

- **Confirm weight bearing status**

- **Explain what you are doing, along with the risks and benefits.**

- **Drape appropriately for patient comfort and dignity.**

- **Use eye glasses, hearing aids, and footwear (anti-slip socks).**

- **Encourage patient to participate as much as possible.**
4. Provider (also applies to Caregiver)

- Think body mechanics and maintain at all times.
  - Good posture, neutral spine (back and neck)
  - Move your entire body in the direction of the transfer by weight-shifting, stepping or pivoting.

- Must be comfortable and confident

- Use the adjustable bed to assist
  - Raise the height of bed
  - Raise head of bed for supine to sit transfers,
  - Make sure knees are down
  - Apply trendelenburg function
  - Use bed rail
  - Foot board can be removed
Provider Preparation

• Complete assessment/re-assessment to ensure appropriate lift
• Discuss the plan to the patient and transfer partners *(if applicable)*
• Perform the transfer in the shortest distance possible.
• Use simple instructions/one step commands with patient and partners
• Be prepared for the unexpected
• Postpone the lift/transfer if the patient is resisting, unable to follow instructions at the time, or aggressive.
• Position to ensure the patient feels safe, can hear and see the HCP, and you are able to assume the appropriate body mechanics.
Are **YOU** re-Assessing?

- A brief re-assessment must be done prior to a lift/transfer being attempted each time.
  - patient’s abilities can change from day to day, or even at different times during a day, due to medications, fatigue, stress or pain.

- Must evaluate when a patient’s condition improves or deteriorates to ensure the most appropriate technique is implemented.
  - Communicate any change in mobility status to the PT/OT for s/he to re-evaluate.
Patient Mobility Categories
Appropriate Lift or Transfer

- Is safe and comfortable for the patient, HCP and caregiver.
- Enables the patient to be as independent as possible without harm.
- Provides the least amount of strain on the HCP to reduce any harm.
- HCPs should consult on complex cases, in order to prescribe interventions and/or equipment to improve transfers when indicated.
Lifting and Transferring Options

- Independent
- Supervised
- Assistance
  - Minimum: patient performs at least 75% of the activity
  - Moderate: patient performs at least 50% of the activity
  - Maximum: patient performs less than 25% of the activity
- One-Person Assist
- Two-Person Assist
- Sit-Stand device (requires 2 staff)
- Total mechanical lift (requires 2 staff)
- Repositioning sheets (not soaker pads)
Independent

- This patient does not require physical assistance rising from sitting or during walking.
- Verbal cueing and supervision is not necessary.
- Is cooperative.
- Full weight bearing.
- Pivots or steps independently between surfaces.
- Consistently displays reliable standing balance.
- Manages mobility aids and footwear independently.
- Independently transitions from lying and sitting.
Supervised

- The patient does not need physical assistance rising from sitting or during walking.
- Verbal cueing or supervision is necessary.
- Is cooperative.
- Full weight bearing.
- Pivots or steps independently between surfaces.
- Consistently displays reliable standing balance.
- Independently transitions from lying and sitting.
- Pushes up on foot pedals and armrests to move to the back of seat with no physical assistance.
Minimum Assistance

- Patient needs physical and/or verbal cueing rising from sitting or during walking.
- Set up assistance or reminders are necessary to manage mobility aids and required footwear.
- At risk of becoming unsteady and requiring physical assistance.
- Is cooperative and able to follow direction.
- Full weight bearing.
- Steps between surfaces with minimal assist of one HCP.
- Displays no more than a mild deficit in standing balance.
- Moves between lying and sitting positions with no more than one person minimal assistance.

- N.B. a transfer belt should be used when walking this patient due to balance concerns.
One-Person Assist

- Patient is full weight bearing and needs assistance rising from a seated position.
- Is cooperative and able to follow direction
- Bears substantial portion of weight consistently.
- Steps between surfaces with one person minimal assistance.
- Displays no more than a mild deficit in standing balance.
- Transitions from lying and sitting positions with no more than one person minimal assistance.

N.B. a transfer belt should be used when walking this patient due to balance concerns.
Two-Person Assist

- Patient is full weight bearing, but needs assistance rising from a seated position.
- Is cooperative.
- Bears the majority of weight consistently.
- Steps between surfaces with the assistance of two people.
- Displays mild to moderate standing balance deficits.
- Transitions from lying and sitting with no more than two person minimal assistance.

- If the patient weighs more than 250 lbs, or if you are unsure of their balance, consider a sit to stand or mechanical lift.

  N.B. a transfer belt should be used when walking this patient due to balance concerns.
Sit-Stand Lift

- Required for a patient that weight bears partially through at least one leg and both arms.
- Can hold onto the handle with at least one hand.
- Patient has unknown or unpredictable balance/strength.
- Is cooperative.
- Follows simple directions consistently.
- Stands securely on the standing platform.
- Transitions from lying and sitting positions with no more than two person minimal assist.
- Can tolerate the sling under his/her arms.
Mechanical Lift

- Patient is non-weight bearing or otherwise unsuitable for the sit-stand lift.
- Is not able to cooperate consistently.
- Weight bears inconsistently or unable to do so.
- Displays limited ability to participate in lift/transfer.
Important Consideration

• The lift and transfer definitions are purposely designed to be more conservative than the full assessment completed by a PT or OT.
  ◦ We want to ensure you and the patients are safe until further assessment is completed by a PT/OT.

• When appropriate a PT/OT may challenge a patient to perform at a higher mobility level than the general care plan may indicate.
When is a Transfer Complete?

- A transfer is not complete until the patient is safely and securely in their new position.

- Appropriate positioning and draping of the patient must be completed.

- Necessary equipment (e.g., call bell) needs to be placed within the patient’s reach.
COMMON TECHNIQUES

IMPORTANT: If a patient is not able to complete the actions identified in a technique, then his/her transfer level will need to be downgraded until further re-assessment by the Physical Therapist (PT) or Occupational Therapist (OT).
Supine to Sitting (One-Person)

**HCP Position**

- Stand facing the patient.
- Once the patient is on his/her side, reach across the patient’s top leg and grasp the bottom leg.
- Place the other arm under the patient’s shoulders; be mindful to support his/her head and shoulders.

**Patient Position**

- Have the patient roll onto his/her side if able. Provide assistance as needed to facilitate.
- Ask the patient to flex his/her hips and knees. If he/she is able, ask to place heels over the edge of the bed.
- Instruct the patient to push up on his/her bottom elbow, pushing up with the other hand.

**Action**

- Encourage the patient to be independent throughout the transfer.
- When assistance is required, the HCP shifts weight from front to back leg, lowering the patient’s legs over the edge of the bed and at the same time bring his/her head and shoulders to an upright position.
Rolling (One-Person)

**HCP Position**
- Stand on the same side of the bed.
- Stand facing the bed as close as possible to the bed with weight on the front foot.
- Grasp both ends of the draw sheet (placed under the patient from hips to shoulder) on the far side of the patient.

**Patient Position**
- Ensure patient is not touching the foot of the bed.
- Position the patient close to the edge of the bed.
- HCP can assist the patient, if he/she is unable to move the arm nearest to you up and away from their body. Other arm is to be placed across his/her chest.
- Instruct the patient to bend his knees up or to cross the farthest leg over the near one if able.

**Action**
- Grasp the draw sheet at both ends of the patient’s shoulders and hips.
- On the command “1, 2, 3, turn,” roll the patient on to his/her side when the HCP transfers weight onto their back foot.
Repositioning in Bed  
- Bed Square

• Moving patients up the bed and turning them from one side to the other are the type of tasks that can be carried out easily and with a minimum amount of stress.

• Requires the use of purple Arjo sheets (N.B. bariatric sheets are blue)

• Technique:
  • Have patient roll onto side; reach for bedrail to assist.

• Requires 2 HCPs
  o HCPs need to weight shift with their legs when boosting a patient.
  o Adjust the height of bed for the shortest person.
  o Can use trendelenburg to assist

• Do not leave sheet under patient; laundered between patients
• Can be used to place slings.
http://www.youtube.com/watch?v=cEZBn7Qw74Us

VIDEO
Bed to stretcher using Roller Board

- Must be wiped down between patients.
- Not to be used with patients over 400 lbs
  - Hospital policy
- Used for horizontal transfers only.

Technique:
- Roll the patient towards you
- Use the bedsheets to assist
- Partner pushes roller board next to patient’s back
- Roll patient onto back
- Grab edge of sheet in grip with palms up
- Pull patient towards you and slide board out the other side
Slide Board Transfer

Bed to Wheelchair

• **Technique:**
  - Patient sitting at edge of bed and angled towards chair.
  - Armrest of wheelchair is removed.
  - Have patient lean to the side and slide one end of board under the their hips/buttocks and the other end half-way covering the transfer surface (chair/bed).
  - Encourage the patient to use their arms to scoot along the board.
  - HCP can assist at the hips/buttocks as needed to complete transfer.
  - Once the patient is settled in the chair, have them lean to the side again to remove the board.

• **Tips:**
  - Adjust the two surfaces between the sliding board to be a similar height (if possible, position height of bed so patient is going downhill).
  - Ensure the patient does not place his/her fingers under the ends of the board, because as they shift their bodyweight their fingers will get pinched underneath.
  - If using a wheelchair, ensure the brakes are on, and the arm rest and foot rest on the appropriate side are removed.
https://www.youtube.com/watch?v=msPBI-LVJ1o

VIDEO
Sit to Stand Transfer (One-Person)

HCP Position

- Face the patient.
- You can block and support the patient's weaker leg by placing your feet on either side of their feet and using your knee (if necessary).
- Place your hands around the patient's waist or under the buttocks.
- A transfer/gait belt can be helpful to provide handholds.

Patient Position

- Ensure the patient's feet are flat on the floor.
- Have the patient scoot their bottom to the edge of the bed/chair; if unable to do this independently the HCP can assist him/her by "bum walking".
- The patient brings their feet back (knee flexion and ankle dorsiflexion) to the chair so they are underneath of him/her when standing. Knees are positioned around 80-90 degrees.
- Patient leans forward (trunk/hip flexion) in preparation for standing. It is imperative that they lean their 'nose over their toes.' To bring their center of mass forward. He/she can hold onto a piece of equipment, the therapist's forearms or hips.

Action

- Encourage your patient to become independent. The patient is encouraged to "push-up" through his/her feet and knees.
- Assist the patient to straighten his/her knees and hips by providing a forward and upward pressure on their pelvis.
- The patient's knees can be blocked/supported if required.
- Once up, ensure the patient is steady and able maintain their safety independently before letting go.
MINIMUM ASSISTANCE

Sit to Stand

https://www.youtube.com/watch?v=GqP5_I_Lmtw

VIDEO
MAXIMUM ASSISTANCE

Sit to Stand

https://www.youtube.com/watch?v=R4JgmfZFkVw

VIDEO
One-Person with Sara Stedy

• Used to quickly and easily transport or transfer residents from one sitting position to another.
• Patient is full weight bearing and needs assistance rising from a seated position.
• Is cooperative.
• Fear and anxiety are a barrier.
• Patient displays mild cognitive impairment.
• Bears substantial portion of weight consistently.
• Can hold onto the handle with at least one hand.
• Displays no more than a mild deficit in standing balance.
• Displays limited ability to pivot transfer in standing position.
ONE-PERSON with SARA STEDY

https://www.youtube.com/watch?v=Cnn_4Rpuq5E

VIDEO
Standing Pivot (One-Person Assist)

**HCP Position**

- Standing in a walk stance with knees slightly flexed and toes pointing toward the chair.
- Maintain lumbar lordosis, lean forward and place hands behind the patient’s lower back/pelvis.
- When necessary, therapist blocks the patient’s weaker leg by placing his/her feet on either side of the patient’s feet and using their knees to support the patient’s weaker leg.

**Patient Position**

- Patient sits on edge of the bed with his/her feet on the floor, toes pointing away from the chair.
- When necessary, protect the affected side in a hemiplegic patient (e.g., shoulder).
- The patient is to lean forward - “nose over toes”
- The patient can place his/her hands on the transfer surface, or the HCP’s waist or forearms.
- Transfer toward the patient’s stronger side.
- Patient assists by full or partial weight bearing.
- Position (wheel) chair at a 30-degree angle to the side of the bed. The chair should be positioned so that transfer occurs towards the patient’s stronger side.
- If applicable, remove the foot rest and arm rest nearest to the patient.

**Action**

- Patient stands at the side of bed (with assistance from the HCP as necessary).
- HCP assists patient to swing hips around to the chair as necessary.
- Patient places hands on arm of chair and lowers down.
Standing Pivot (Two-Person Assist)

Refer to Standing Pivot (One-Person Assist) for technique.

HCP #1 Position
- Standing in a walk stance with knees slightly flexed and toes pointing toward the chair.
- Maintain lumbar lordosis, lean forward and place hands behind the patient’s lower back/pelvis.
- When necessary, therapist blocks the patient’s weaker leg by placing his/her feet on either side of the patient’s feet and using their knees to support the patient’s weaker leg.

HCP #2 Position
- Stands behind the patient.
- His/her hands are behind the patient’s lower back/pelvis.
- Facilitates the patient to stand, swinging their hips around to the chair, and then lowering them onto the chair.
Standing Low Pivot (Two-Person Assist)

Similar to “Standing Pivot” but the patient does not stand upright
• Patient is encouraged to assist by reaching for bedrail/armrest
• Remove armrest of wheelchair to assist.

HCP #1 Position
• Standing in a walk stance with knees slightly flexed and toes pointing toward the chair.
• Maintain lumbar lordosis, lean forward and place hands behind the patient’s lower back/pelvis
• When necessary, therapist blocks the patient’s weaker leg by placing his/her feet on either side of the patient’s feet and using their knees to support the patient’s weaker leg.

HCP #2 Position
• Stands behind the patient.
• His/her hands are behind the patient’s lower back/pelvis.
• Facilitates the patient to stand, swinging their hips around to the chair, and then lowering them onto the chair.
Re-Positioning in a Chair (One-Person)

HCP position
• Stand in front of the patient
• Block/support the patient’s knees if required
• Place hands under the patient’s pelvis/buttock

Patient position
• Patient sitting with feet flat on the floor and slightly apart
• Patient will lean forward to offload his/her buttocks

Action
• Encourage/facilitate the patient to “bum walk” back in the chair
• Assist as necessary by raising one side of the sacrum and then the other. • Apply gentle pressure to the patients legs to assist in shifting them backward
Group Facilitation Exercises

In a small group, you will demonstrate various lifts, transfers or repositioning techniques.

See you on day #3
Alarms and Call Bell System

Employee Orientation

Presented by Therapy Services
2017
Wheelchair Alarm

- Lightweight compact fall alarm
- Alerts HCPs to attempted bed, chair or toilet seat exits by high fall risk patients.
- Alarming Mechanisms:
  - clip
  - belt
  - pad
Room Display Lights

- **Red is Fire**
- **Solid Green is Patient Call**
- **Flashing Green is Washroom Call**
- **Yellow is Bed Exit and Staff Assist**
- **Blue is Code Blue**

  - Each colour has a distinctive tone.
  - Flashing has an intermittent tone.
  - Annunciator wording is what shows on the console.
  - Yellow will read whichever is activated; bed exit or staff assist.
# 1. Resetting / Zeroing Bed

## Standard Instruction

**Date Issued:** April 1st, 2013  
**Number of Steps:** 3

**Issued by:** Falls Quality Working Group

<table>
<thead>
<tr>
<th>NO.</th>
<th>Process Step</th>
<th>Key Points</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ensure bed is empty and in lowest position</td>
<td>Fig. 1</td>
<td>Bed must be empty for the alarm to be reset and activated</td>
</tr>
<tr>
<td>2</td>
<td>Press enable button on bed alarm keypad – green button with key</td>
<td>Green light on - Fig. 2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Press and hold zero/ reset exit button</td>
<td>Press and Hold until lights flash 3 times - Fig. 3</td>
<td></td>
</tr>
</tbody>
</table>

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**Head of Bed Fig. 1**

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**Fig. 2**

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**Fig. 3**

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**Bed Alarm keypad**

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**Zero/ reset**
## 2. Setting Bed Alarm Standard Instruction

**Date Issued:** April 1st, 2013  
**Issued by:** Falls Quality Working Group  
**Number of Steps:** 4

<table>
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<th>REASONS</th>
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<tbody>
<tr>
<td>1</td>
<td>Have patient in bed</td>
<td>Both sides of the bed have the same keypad functions</td>
<td>You can work from either side of the bed</td>
</tr>
<tr>
<td>2</td>
<td>Locate the keypad to set the bed alarm</td>
<td></td>
<td><img src="image" alt="Bed Alarm Keypad" /></td>
</tr>
</tbody>
</table>
| 3   | Press the Enable button followed by the Sensitivity button (choose sensitivity) and hold for 2 seconds | Green light will go on and when you let go 1 audible beep confirms alarm IS set  
**Multiple** rapid beats then alarm is NOT set  
If all lights in the sensitivity area are flashing, follow standard instruction for “Resetting Bed Sensitivity” | ![Enable Button](image)  
![Sensitivity Buttons](image) |
| 4   | Adjust the volume setting                         | Lights indicate volume level                                                |                                                                                             |
# 3. Disarming Bed Alarm Standard Instruction

**Date Issued:** 9 February, 2017  
**Issued by:** Falls Quality Working Group  
**Number of Steps:** 4

<table>
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<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Press the Enable button followed by the Sensitivity button (choose sensitivity) and hold for 2 seconds</td>
<td>Green light will go off and 1 audible beep confirms alarm IS Deactivated</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Press Reset button “Red C” on Code Blue Button</td>
<td>Red light will go off</td>
<td></td>
</tr>
</tbody>
</table>
## 4. Check Cord Connections
### Standard Instruction

**Date Issued:** 9 February 2017  
**Issued by:** Falls Quality Working Group  
**Number of Steps:** 3

<table>
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<tr>
<th>NO.</th>
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<th>PHOTOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ensure the bed <strong>power</strong> is plugged into the wall at the power outlet.</td>
<td>It is best to check from the wall to the bed, then patient to head wall.</td>
<td>Ensure the 3 cables are plugged into place and are snug. 1 cable for power, 1 for communication and 1 for the patient call bell.</td>
<td><img src="image1.jpg" alt="Image" /></td>
</tr>
<tr>
<td>2</td>
<td>Ensure the communication cable for bed exit is plugged into the bed at one end and into the Y connector in the bottom of the Code Blue button. The green dome light will appear over the door and the scrolling marquis will announce “Patient call - Room #” Clear the call by pressing the “Red C” not the Code Blue button.</td>
<td></td>
<td><img src="image2.jpg" alt="Image" /></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Ensure the Call Bell for the patient is plugged into the Head Wall receptacle.</td>
<td>Make sure the call bell is left within the patient’s reach so they may use it.</td>
<td></td>
<td><img src="image3.jpg" alt="Image" /></td>
</tr>
</tbody>
</table>

If after these connections have been checked, the call bell does not work, please contact Maintenance through Megamation request.
# Call Bell Replacement and Connection

**Standard Instruction**

**Date Issued:** 10 February 2017  
**Issued by:** Falls Quality Working Group  
**Number of Steps:** 5

<table>
<thead>
<tr>
<th>NO.</th>
<th>PROCESS STEP</th>
<th>KEY POINTS</th>
<th>REASONS</th>
<th>PHOTOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Call ESA ext 4900 for replacement call bell.</td>
<td>Call bells are kept in Environmental Services</td>
<td>Call bells are logged to track inventory in Central Supply.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Unplug old call bell from the Headwall input</td>
<td>Grasp firmly and pull straight back</td>
<td></td>
<td><img src="null" alt="Image" /></td>
</tr>
<tr>
<td>3</td>
<td>Plug new call bell into the headwall.</td>
<td>Press firmly into place.</td>
<td>To maintain functionality of call bell lights and bed alarm system.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Check to ensure the communication cable from bed to wall is plugged into Y Connector on the Code Blue Button on the Headwall.</td>
<td>This cable is different from the Call Bell cable</td>
<td>To ensure correct connections and functionality</td>
<td><img src="null" alt="Image" /></td>
</tr>
<tr>
<td>5</td>
<td>Test call bell</td>
<td>If the call bell does not work, try another call bell cable. If it continues to fail, contact Maintenance.</td>
<td>To ensure the bed is fixed immediately to prevent falls.</td>
<td></td>
</tr>
</tbody>
</table>

*If after these connections have been checked, the call bell does not work, please contact Maintenance through Megamation request.*
Problem Resolution

The Communication Stations all have the number for KR Communications to deal with any problems. They offer 24-hour response and can dial-in for most issues. If onsite presence is required they are 35-45 minutes away based in New Hamburg.

Contact Number: (519) 684-7570

• Please ensure that if beds have been red-tagged for repair that they do not remain on the units and that a work order is generated through Megamation.

• Call bells and Y-connectors are to remain in the patient rooms when beds are moved.
Group Demonstration

In a small group, the demo will take place.

See you on day #3