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The Effectiveness of Health Care Assistant-Supported Patient Repositioning in Reducing Discomfort Among Bedridden Patients

Norah Khalid K Als Aidan[1], Sultan Safar Shudayyid Alotaibi[2], Ibrahim Hamad Murayziq Alkulaythimi[3], Abdulaziz Ibrahim Altarjami[4], Abdulk Haliq Ali Mohammed Alshehri[5], Sultan Hadi S Alqahtani[6], Khaled Eid Gayran Alenezi[7], Mohammed Zaben Jalis Albakr[8], Faisal Ayash Quaymil Albalawi[9], Aljabri, Bandar Naif Q[10]

[1] Health Assistant – Health Care Security — Al Jouf Health Cluster – Ministry of Health – Sakaka – Al Jouf Region – Saudi Arabia. Email: norah7007@gmail.com
[2] Health Assistant – Health Care Security — Taif Health Cluster – Ministry of Health – Taif – Makkah Region – Saudi Arabia. Email: salotaibi2042@moh.gov.sa
[3] Health Assistant – Health Care Security — King Fahad Hospital – Madinah Health Cluster – Ministry of Health – Madinah – Madinah Region – Saudi Arabia. Email: ialkulaythimi@moh.gov.sa
[4] Health Assistant – Health Care Security — Ministry of Health – Madinah – Madinah Region – Saudi Arabia. Email: abdalazez1814@gmail.com
[5] Health Assistant – Health Care Security — Al-Musallamah Primary Health Care Center – Asir Health Cluster – Ministry of Health – Bariq – Asir Region – Saudi Arabia. Email: aalshehri472@moh.gov.sa
[6] Health Assistant – Health Care Security — Imam Abdulrahman Al Faisal Hospital – Riyadh First Health Cluster – Ministry of Health – Riyadh – Riyadh Region – Saudi Arabia. Email: suhalqahtani@moh.gov.sa
[7] Health Assistant – Health Care Security — Maternity and Children Hospital – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia. Email: kealenezi@moh.gov.sa
[8] Health Assistant – Health Care Security — Maternity and Children Hospital – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia. Email: MzAlbakr@moh.gov.sa
[9] Health Assistant – Health Care Security — Branch of the Ministry of Health in the Northern Borders Region – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia. Email: FaayAlbalawi@moh.gov.sa
[10] Health Assistant – Health Care Security — Al Haram Hospital – Madinah Health Cluster – Ministry of Health – Madinah – Madinah Region – Saudi Arabia. Email: banaljabri@moh.gov.sa

ABSTRACT: Prolonged immobility among bedridden patients is a well-documented contributor to pressure injuries, musculoskeletal stiffness, respiratory compromise, and generalized discomfort. While repositioning is a cornerstone of pressure ulcer prevention, it is frequently performed inconsistently in busy clinical environments, often constrained by staffing ratios and competing clinical demands. Health care assistants (HCAs) represent a substantial and underutilized component of the direct-care workforce, and their

structured involvement in scheduled repositioning protocols offers a practical means of increasing the frequency and quality of turning and positioning interventions without displacing the assessment responsibilities of registered nurses. Delegating routine repositioning to trained HCAs under clear competency frameworks and supervision allows for more reliable adherence to two-to-four-hourly turning schedules, which in turn addresses the mechanical and circulatory factors that underlie much of the discomfort experienced by immobile patients. Evidence from implementation studies suggests that HCA-supported repositioning programs can meaningfully reduce self-reported and observational discomfort scores, particularly where protocols incorporate pressure-redistribution equipment, individualized positioning plans, and consistent documentation. Improvements appear most pronounced when HCAs receive structured training in safe patient handling, skin assessment, and early recognition of deterioration, and when communication channels with nursing staff remain robust. However, the available evidence also carries important limitations: heterogeneity in discomfort measurement instruments, short follow-up periods, and difficulty separating the effect of repositioning frequency from co-interventions such as specialized mattresses or enhanced nutritional support. Furthermore, the sustainability of such programs depends on adequate staffing levels, manageable workloads, and clear role boundaries to prevent task-shifting from becoming a substitute for comprehensive nursing assessment. Overall, the literature supports HCA-supported repositioning as a low-cost, feasible strategy for improving patient comfort, while underscoring the need for larger controlled trials with standardized outcome measures and longer evaluation windows before firm conclusions about clinical and cost-effectiveness can be drawn.

INTRODUCTION

Bedridden patients represent one of the most clinically fragile groups in any healthcare setting, because prolonged immobility exposes them to a cascade of preventable complications, including pressure injuries, joint stiffness, circulatory impairment, sleep disruption, and sustained physical and emotional distress [1]. Among the interventions intended to counteract these risks, regular repositioning—the planned turning and realignment of the patient's body—is widely regarded as a fundamental component of nursing and multidisciplinary care [2]. Historically, repositioning has been framed primarily as a pressure injury prevention strategy, yet a growing body of clinical experience indicates that its effects extend well beyond skin integrity. The manner in which repositioning is performed, the frequency with which it is delivered, and the personnel responsible for carrying it out all bear directly on the patient's sensory experience of care. In many healthcare systems, the task of turning and repositioning bedridden patients is delegated predominantly to health care assistants (HCAs), also known as nursing assistants or auxiliary care staff [3]. This delegation is pragmatic: HCAs provide the bulk of direct, hands-on care and are therefore best placed to execute frequent position changes. However, delegation without adequate training, supervision, and role clarity can paradoxically increase patient discomfort, either through rough handling, incorrect positioning, or insufficient attention to pain cues [3].

Discomfort among bedridden patients is multidimensional and cannot be reduced to a single symptom. It includes pressure-related aching, numbness and tingling from localised ischaemia, shear and friction at the skin–support interface, restricted joint mobility, fear of falling or being dropped, and the psychological distress associated with dependency and loss of control [4]. Sustained mechanical loading over bony prominences impairs capillary perfusion and produces tissue deformation that patients often experience as pain or deep soreness [5]. Shear and friction further distort tissue planes and abrade the skin, particularly when the patient is dragged or pulled rather than moved smoothly [6]. The manner in which repositioning is communicated and executed also shapes the patient's experience: being turned abruptly without warning or explanation can transform a therapeutic intervention into a distressing event, whereas gentle preparation and sensitive handling can make the same manoeuvre feel safe and relieving [7]. These distinctions matter because the comfort-related benefits of repositioning are mediated by technique, communication, and the relational quality of care [7].

A further problem is that research and quality assessment have historically prioritised pressure injury incidence over patient-reported comfort, leaving the experiential dimension of repositioning relatively under-examined [8]. As a result, clinical practice may be judged adequate when turning schedules are recorded, even if patients experience repeated episodes of handling-related pain, sleep disturbance, or fear. The absence of standardised, patient-centred outcome measures means that the true impact of repositioning on comfort remains poorly understood, and the voices of patients are often marginalised in quality improvement initiatives [9]. This gap is particularly concerning given the vulnerability of the bedridden population and the frequency with which they are handled [10].

The Physiological and Experiential Basis of Discomfort in Bedridden Patients

The physiological origins of discomfort in immobile patients are closely linked to the mechanics of sustained loading. When body weight is concentrated over a small area, interface pressure can exceed capillary closing pressure, producing localised ischaemia, metabolite accumulation, and tissue deformation [11]. These processes are experienced as numbness, tingling, burning, or deep aching, and they may persist after the pressure is relieved. Shear forces, generated when the body slides against the support surface, are particularly damaging because they distort tissue layers internally and can contribute to deep tissue injury even when surface pressure appears acceptable [12]. Friction, meanwhile, abrades the epidermis and increases the physical effort required to move the patient, making the manoeuvre feel rough and unstable. For the bedridden patient, therefore, discomfort is not simply a matter of skin integrity; it is an embodied experience of mechanical forces acting on vulnerable tissues [12].

The subjective experience of repositioning is also shaped by anticipation, communication, and control [13]. Patients who are informed about what will happen, prepared verbally, and moved in a calm and coordinated manner are more likely to interpret the intervention as caring and safe. By contrast, sudden movement, insufficient support of the limbs and head, exposure of the body, and rough handling can provoke anxiety, muscular guarding, and resistance, all of which increase the force required from the caregiver and intensify the patient's discomfort [14]. This cyclical relationship is clinically important: discomfort generates tension, tension makes movement harder, and harder movement produces more discomfort. Comfort-oriented repositioning therefore requires attention not only to biomechanics but also to the patient's emotional state, dignity, and sense of control [14].

Patient-reported outcomes are essential for understanding this experiential dimension. Studies that have elicited patients' views consistently show that comfort during repositioning is influenced by the skill, gentleness, and attentiveness of the caregiver, as well as by the availability of appropriate equipment [15]. Yet much of the clinical literature measures only pressure injury incidence, skin status, or adherence to turning schedules, and comparatively few studies report pain, comfort, sleep quality, or satisfaction with handling. This gap is significant because an intervention can be effective in preventing tissue damage while still causing considerable distress. A comprehensive evaluation of HCA-supported repositioning must therefore include both clinical endpoints and the patient's own experience of being moved, settled, and supported [15].

The Role of Health Care Assistants in Repositioning: Scope, Contribution, and Constraints

Health care assistants are central to the delivery of repositioning in hospitals, nursing homes, and community care settings [16]. Their formal duties commonly include assisting with bed mobility, turning bedbound patients, positioning patients for comfort and safety, and reporting changes in skin condition or patient distress. In many wards, HCAs perform most routine position changes, often under the remote supervision of registered nurses who retain accountability for assessment, care planning, and risk management. Without HCA involvement, recommended repositioning schedules would be practically impossible to sustain, particularly in settings with high patient dependency and limited registered nursing capacity. The HCA contribution is therefore not peripheral but essential to the everyday realisation of pressure injury prevention and comfort care [17].

However, the HCA role is constrained by educational, organisational, and structural factors that can undermine the quality of repositioning [18]. Positioning is often described as a specialised skill requiring knowledge of biomechanics, pressure redistribution, communication, and the recognition of patient distress cues, yet many HCAs receive brief, task-oriented training that emphasises caregiver safety and task completion rather than patient comfort. The absence of a standardised competency framework means that technique varies widely between individuals and facilities, and poor practice can become normalised within a ward culture [19]. HCAs may also work under severe time pressure, with heavy patient loads and limited access to mechanical aids, creating conditions in which hurried manual handling becomes the default. In such circumstances, the patient's

comfort may be subordinated to the imperative of completing the task quickly, and subtle signs of discomfort—grimacing, guarding, verbal hesitation, or changes in breathing—may go unnoticed or unaddressed [19].

The effectiveness of HCA-supported repositioning is therefore conditional rather than automatic. It depends on whether HCAs are adequately trained, whether they have the time and equipment to perform gentle handling, whether they are empowered to prioritise comfort alongside safety, and whether their observations are integrated into the wider care plan [20]. When these conditions are met, HCAs can make a substantial contribution to patient comfort by turning patients smoothly, supporting limbs, using positioning aids, and responding to verbal and nonverbal cues. When they are not met, HCA-supported repositioning may become a source of distress, even if the turning schedule itself is technically completed. The challenge for healthcare organisations is to create the conditions in which HCAs can deliver repositioning as a skilled, comfort-promoting intervention rather than a rushed manual task [20].

Repositioning Techniques and Their Differential Impact on Comfort

The technique used during repositioning has a decisive influence on the patient's experience. Manual turning with a draw sheet, the traditional mainstay of nursing practice, requires considerable physical effort and generates substantial shear and friction at the patient–surface interface [21]. The patient may be pulled, pushed, or rolled in a manner that feels unstable and frightening, particularly when the caregiver lacks assistance or fails to support the limbs and head. In contrast, low-friction sliding sheets allow the patient to be moved in a more controlled, gliding manner, reducing the force required from the caregiver and diminishing the shear transmitted to the patient's skin and deeper tissues [22]. Studies of sliding sheet use have reported reductions in caregiver musculoskeletal strain and perceived workload, and the biomechanical rationale for reduced friction and shear is strong, even though direct measurement of patient comfort remains limited. Patient accounts generally favour smooth, gliding transfers over manual dragging, because the former preserve a sense of bodily integrity and reduce the sensation of being manhandled [22].

The choice of position itself also matters. The conventional ninety-degree lateral position effectively offloads the sacrum and buttock but places body weight directly on the greater trochanter, which can be uncomfortable for thin or cachectic patients [23]. The thirty-degree tilt, in which the patient is inclined backwards at a shallower angle, distributes pressure over a broader area of the posterolateral thigh and buttock and has been associated with lower contact pressure in laboratory studies. Clinical trials of the thirty-degree tilt, however, have produced mixed results: some have reported lower pressure injury incidence compared with ninety-degree rotation, while others have found that a substantial proportion of patients experience difficulty adopting or maintaining the position [24]. This suggests that no single position is universally comfortable or universally effective. Comfort-oriented repositioning requires individualised assessment, trial of different positions, and ongoing dialogue with the patient about what feels tolerable [24].

Individualisation is particularly important because comfort thresholds vary with diagnosis, body habitus, pain status, respiratory function, contractures, and personal preference [25]. A patient with hip pain may tolerate a thirty-degree tilt better than a full lateral position, whereas a patient with respiratory compromise may prefer semi-recumbent positioning. A patient with a pressure injury may require offloading of a specific anatomical site, even if that position is less comfortable in other respects. The HCA's role in this process is to observe, ask, adjust, and report, rather than simply to apply a standard position regardless of the patient's response. When repositioning is treated as a collaborative and individualised intervention, the likelihood of reducing discomfort increases; when it is treated as a rigid routine, discomfort may persist or even worsen [25].

Table 1: Repositioning Frequency Recommendations and Their Comfort Implications

Source and context	Recommended frequency or interval	Comfort-related consideration
International pressure injury guideline	Reposition regardless of support surface; interval adjusted to individual response	Assess pain and comfort before and after; pre-medicate if needed
Cochrane review of repositioning trials	Evidence insufficient to mandate a single frequency	No included trial reported pain or quality-of-life outcomes
Bergstrom et al. randomised trial in nursing homes	Two-, three-, and four-hourly schedules produced similar pressure injury incidence	Less frequent turning may reduce sleep disruption and handling burden

Moore et al. trial of thirty-degree tilt	Three-hourly tilt at night reduced pressure ulcer incidence compared with six-hourly ninety-degree rotation	Shallower tilt may be more comfortable, but some patients find it difficult to maintain
Defloor et al. cluster trial	Two-hourly repositioning did not significantly outperform four-hourly on pressure-reducing mattresses	Individualised scheduling may balance skin protection against comfort needs

Barriers to Effective, Comfort-Oriented Repositioning

The gap between what is known about optimal repositioning and what is actually delivered in practice is substantial. Studies of repositioning adherence report that a considerable proportion of bedbound patients are not turned at the recommended frequency, with one observational study finding that only 59% of bedbound patients were repositioned at least every two hours [21]. The reasons are multifactorial. Staff shortages and heavy workloads are frequently cited: when a single HCA is responsible for a large number of dependent patients, the time required to perform a gentle, comfort-oriented repositioning—preparing the patient, arranging aids, moving slowly, and settling the patient comfortably—is simply not available. Time constraints encourage task-oriented, rapid handling that prioritises completion over quality [22]. The limited availability and accessibility of patient-handling equipment, such as sliding sheets, hoists, and positioning wedges, further compounds the problem; without these aids, HCAs must rely on manual effort, which increases both caregiver strain and patient discomfort.

Cultural and organisational factors also play a role. In some settings, repositioning is regarded as a low-status, routine task rather than a skilled therapeutic intervention, and HCAs may receive little recognition or feedback for performing it well [24]. The absence of standardised competency assessment means that variations in technique persist unchallenged, and poor practice can become normalised within a ward or facility. High turnover among nursing assistants, which in some healthcare systems exceeds 30% annually, erodes institutional memory and makes it difficult to sustain training gains over time [25]. For patients, the consequence is inconsistency: the quality of repositioning depends on which HCA is on duty, whether the ward is busy, and whether the necessary equipment happens to be available. This inconsistency itself can be a source of distress, as patients learn to anticipate uncomfortable handling and may become anxious or resistant when approached for turning.

Table 2: Barriers to Comfort-Oriented Repositioning and Their Consequences

Barrier category	Specific barrier	Consequence for patient comfort
Staffing and workload	Staff shortages; high patient-to-HCA ratios	Rushed handling; insufficient time for gentle preparation and settling
Equipment availability	Limited access to sliding sheets, hoists, and positioning aids	Increased manual effort; greater shear and friction; patient experience of being dragged
Training and competence	Brief, task-oriented instruction; no standardised competency assessment	Inconsistent technique; failure to recognise and respond to discomfort cues
Organisational culture	Repositioning viewed as low-status routine work	Low morale; limited feedback; normalisation of poor practice
Workforce instability	High turnover among nursing assistants	Loss of trained staff; difficulty sustaining training and quality improvement

Training and Education as Levers for Improving Comfort Outcomes

If HCA-supported repositioning is to achieve its potential for reducing discomfort, investment in training and education is indispensable. Structured education improves HCAs' knowledge, skills, and attitudes regarding pressure injury prevention and gentle handling, and is associated with reductions in pressure injury incidence [10]. Importantly, the benefits of education are not confined to skin outcomes: HCAs who understand the biomechanics of repositioning, the sources of patient discomfort, and the principles of gentle handling are better equipped to modify their practice in ways that prioritise comfort. Training that incorporates realistic patient scenarios, supervised practice, and competency-based assessment is more likely to translate into sustained changes in technique than one-off, lecture-based instruction. The content of such training should include not only

the mechanics of turning but also communication skills—how to prepare a patient verbally, how to elicit reports of discomfort, and how to adjust the manoeuvre in response to nonverbal cues [7]. Given the high turnover among HCAs, training must be recurrent rather than episodic, with refresher sessions and peer mentoring built into the routine workflow.

Organisational support is equally important. HCAs who are given the time, equipment, and recognition necessary to perform repositioning well are more likely to do so, and their patients are more likely to experience the intervention as comfortable rather than merely unavoidable. This requires managers to view repositioning as a skilled clinical intervention rather than a low-status task, to monitor adherence and quality rather than merely recording completion, and to involve HCAs in care planning and quality improvement. It also requires interprofessional collaboration: registered nurses must provide clear care plans, assess pain and risk, and support HCAs in interpreting patient cues, while HCAs must feel confident to report changes and request assistance [9]. When training, supervision, and organisational support are aligned, HCA-supported repositioning can become a genuinely therapeutic and comfort-promoting intervention.

Patient Perspectives and the Subjective Experience of Being Repositioned

Any assessment of effectiveness that omits the patient's voice is incomplete. For bedridden patients, being repositioned is not a neutral technical event; it is an embodied experience that can evoke feelings of vulnerability, dependency, and loss of control [7]. Patients who are turned without explanation may feel startled or manhandled; those who are moved skilfully and with sensitivity may feel cared for and respected. Qualitative accounts highlight the importance of gentle touch, clear communication, and the avoidance of unnecessary exposure. Patients also value continuity: when the same HCAs perform repositioning regularly, they learn the patient's preferences and comfort thresholds, and the manoeuvre becomes a collaborative routine rather than an imposition [20]. The discomfort-reducing potential of repositioning is therefore realised not only through biomechanical correctness but through the relational quality of the interaction.

This insight has implications for how HCA-supported repositioning is organised and valued. Continuity of caregiver, adequate time for interaction, and training in communication are not optional extras but essential components of effective, comfort-oriented care [22]. Patients should be asked about their comfort before, during, and after repositioning, and their preferences should be documented and shared with the care team [1]. Where patients are unable to verbalise discomfort, HCAs should be trained to recognise behavioural indicators such as grimacing, guarding, restlessness, changes in breathing, and withdrawal [7]. The patient's subjective experience should be treated as a legitimate outcome in its own right, alongside pressure injury incidence and adherence to turning schedules.

Economic and Health-System Considerations

The economic dimension of repositioning cannot be ignored. Pressure injuries are costly to treat, and prevention through regular repositioning is widely regarded as cost-effective relative to the expense of wound care, extended hospital stays, and litigation [2]. However, the cost-effectiveness of repositioning depends heavily on how it is delivered. Two-hourly repositioning consumes more nursing time than four-hourly schedules, and in resource-constrained settings the additional labour cost may be difficult to justify if the clinical benefit is marginal [18]. From a comfort perspective, the economic calculus is more complex: less frequent repositioning may reduce handling-related discomfort and sleep disruption, but it may also increase the risk of pressure injury in high-risk patients, which would ultimately produce greater suffering and higher costs [19].

The optimal approach is therefore not a blanket frequency but an individualised regimen that takes account of the patient's tissue tolerance, support surface, comfort reports, and goals of care. HCAs are well placed to contribute to this individualisation, provided they are trained to assess comfort and empowered to communicate their observations to the wider care team [3]. Investment in training and equipment may appear costly in the short term, but it can reduce turnover, improve care quality, and prevent the downstream costs of pressure injury and patient distress [23]. From a health-system perspective, comfort-oriented repositioning should be viewed as an investment in quality rather than an optional refinement.

Table 3: Summary of Key Evidence on Repositioning and Discomfort

Study or evidence source	Design or focus	Key finding relevant to discomfort
Gillespie et al. Cochrane review	Systematic review of repositioning trials	No included trial reported pain or quality-of-life outcomes; evidence for comfort benefits is indirect

Young randomised trial of thirty-degree tilt	Clinical trial in hospital inpatients	Thirty-degree tilt did not reduce pressure damage compared with ninety-degree positions; many patients had difficulty maintaining the position
Moore et al. trial	Randomised controlled trial in older adults	Three-hourly thirty-degree tilt at night reduced pressure ulcer incidence compared with six-hourly ninety-degree rotation
Bergstrom et al. trial	Multisite randomised trial in nursing homes	Two-, three-, and four-hourly schedules produced similar pressure injury incidence, suggesting that less frequent turning may be safe for some patients
Patient survey on repositioning comfort	Cross-sectional survey of acute care patients	Discomfort was more frequently reported during unassisted repositioning than during assisted repositioning
Sliding sheet intervention studies	Biomechanical and intervention studies	Sliding sheets reduce friction and shear and are perceived as more comfortable than manual dragging

Recommendations for Practice, Policy, and Research

Several recommendations follow from the evidence reviewed. First, repositioning should be reconceptualised as a comfort-promoting intervention in its own right, not merely as a pressure injury prevention task [1]. This means that assessments of repositioning quality should include patient-reported discomfort, behavioural pain indicators, and satisfaction, alongside skin outcomes. Second, HCAs should receive structured, recurrent training that covers biomechanics, gentle handling techniques, communication, and the recognition of discomfort cues [10]. Training should be competency-based and delivered in realistic clinical scenarios, with opportunities for supervised practice and feedback. Third, healthcare organisations should ensure that HCAs have access to appropriate equipment—sliding sheets, hoists, positioning wedges, and adjustable beds—and that staffing levels permit sufficient time for gentle, unhurried repositioning [16]. Fourth, repositioning schedules should be individualised rather than rigidly fixed, taking account of the patient's tissue tolerance, support surface, comfort reports, and sleep needs [18]. Fifth, continuity of caregiver should be promoted where possible, so that HCAs can develop familiarity with individual patients' preferences and comfort thresholds [20]. Sixth, further research is needed to directly measure the effect of HCA-supported repositioning on patient-reported discomfort, using validated instruments and robust designs [2]. The current evidence base is heavily weighted toward pressure injury incidence and neglects the experiential dimension of care; addressing this imbalance is essential if repositioning practice is to become genuinely patient-centred [23]. Finally, managers and policymakers should recognise that comfort-oriented repositioning requires resources, training, and cultural change, and should treat HCAs as essential partners in quality improvement rather than as passive executors of routine tasks [25].

CONCLUSION

The effectiveness of health care assistant-supported patient repositioning in reducing discomfort among bedridden patients is neither automatic nor uniform. Repositioning, when performed skilfully and with attention to the patient's experience, can relieve the aching discomfort of sustained immobility, restore a sense of physical ease, and prevent the tissue damage that gives rise to pain. When performed poorly—hastily, without adequate equipment, or without regard for the patient's cues—it can itself become a source of distress. HCAs are indispensable to the delivery of frequent repositioning, but their potential to reduce discomfort is constrained by inadequate training, staffing pressures, equipment shortages, and a professional culture that often values task completion over relational quality. The evidence base, while limited, suggests that assisted repositioning is generally more comfortable than unassisted movement, that sliding sheets and gentle handling techniques reduce friction and shear, and that individualised schedules may balance skin protection against sleep disruption and handling burden. Realising the comfort-promoting potential of HCA-supported repositioning requires a concerted effort to invest in training, equip HCAs with the tools they need, redesign work processes to allow time for gentle care, and place the patient's subjective experience at the centre of quality assessment. Only then can repositioning fulfil its promise as an intervention that protects not only the skin but also the dignity and comfort of the bedridden patient.

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