

# Dining Chair Classification System

A care-progression system - from passive furniture to active mobility solutions

Class A

Class B

Class C

Class D

## • Purpose...

The **Dining Chair Classification System (DCCS)** exists to ensure that seating within care communities is intentionally designed and selected to match the mobility, safety, and dignity needs of residents, while reducing physical strain and injury risk for caregivers.

## • Did you Know...



1. Dining chairs were never designed to move with a seated person in the chair.
2. Chairs rely on friction to remain stable.
3. Cushioned flooring (reduces injuries) increases the physical demands of caregivers providing mealtime assistance.



## • As a Result...

### Position the Chair



...caregivers instinctively place the chair at a 45° to the table

### 1. Getting Seated



...seating the person requires shuffling, stepping back, and leaning on the table

### 2. Move the Seated Person



...caregivers are expected to push the seated person from behind to position them at the table

## • Why Understanding the TRIP ZONE Matters...



Class A

- Standard dining chair
- The **TRIP ZONE** is created when a standard dining chair is used in a dependent care community

The '**TRIP ZONE**' is the area around the front of table into which a person needing assistance must navigate.

Trips and falls occur often in this area as both the senior and caregivers are expected to:

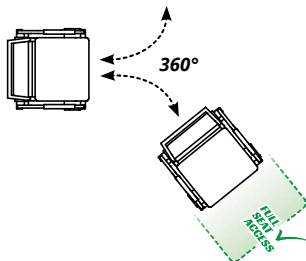
- (1) shuffle sideways
- (2) step backwards
- (3) lean on the table

for balance as the caregiver assists an individual get seated.

A design fails when human effort is required.

## • Chair Designs Which Eliminate the TRIP ZONE...

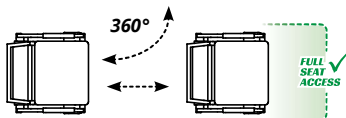
Class B



FULL SEAT ACCESS

FALL RISK: LOW ⬇

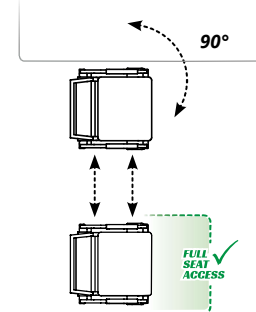
Class C



FULL SEAT ACCESS

FALL RISK: LOW ⬇

Class D



FULL SEAT ACCESS

FALL RISK: LOW ⬇

## Standard Chair

## Class A



### Not Designed to Move

- **Features:** Arms or armless, fixed glides
- **Use Case:** Traditional dining environments

Residents who can safely self-transfer and reposition.

## Class B

## Controlled Movement

### Move the Chair Not the Person - By Default, Always Locked

- **Features:** Prevent falls
  - Chair Caddie 360°
  - Rear brakes
- **Use Case:** Caregiver-directed movement with manual braking

Residents requiring significant assistance or guided positioning.



## Class C

## Independent Extension

### Move the Chair Not the Person - Do It Yourself

- **Features:** Arms
  - Chair Caddie 360°
  - Resident controlled brake system
- **Use Case:** Supports controlled mobility and independence

Residents at high risk of falls or unsafe movement; emphasis on controlled stability.



## Class D

## Guided Mobility

### Eliminates Interference with the Table

- **Features:** Arms
  - Swivel-locking system
  - 18" or 20" seat height
  - Inline Chair Caddie
- **Use Case:** Adds controlled movement while maintaining stability

Residents who require occasional assistance or stability support.



- When a chair's design requires human effort to perform a task (move a seated person up to the table) the system has FAILED!

## DESIGNING BETTER CARE

Not designed to be moved with a person seated in the chair



Move the chair Not the person.

The chair is always locked by default.



Requires a caregiver to push - pull - shove - twist on the back of the chair

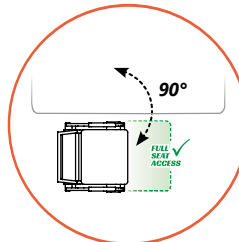
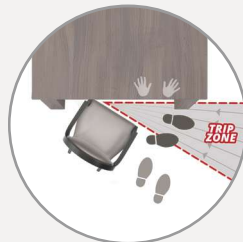


Reduces physical demands of caregiver.

Enables a relationship bond to develop between the resident and caregiver



Creates the TRIP ZONE. Increased risk of falling

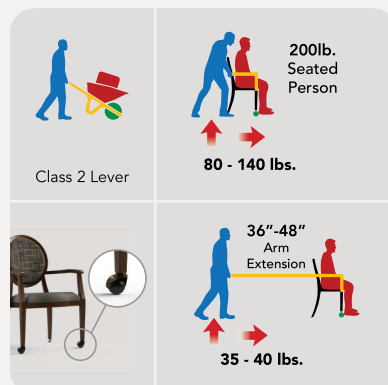


Eliminates the TRIP ZONE. Provides full access to the seat of the chair. No shuffling sideways /no stepping backwards



How much effort does it take to move a 200 pound person to the table safely?

Do the math!



| LIFT    | PUSH    | PULL    |
|---------|---------|---------|
| ↑       | →       | ←       |
| 35 lbs. | 28 lbs. | 42 lbs. |
| 35 lbs. | 40 lbs. | 60 lbs. |

OHS/NIOSH compliant  
Creates a safer, healthier and more enjoyable work environment



# Bulletin

## Preliminary Findings

Last Update: January 2025

The need to review issues associated with dining services in senior living communities is becoming increasingly important as the operational costs of caring for residents with reduced mobility continue to rise.

Premature replacement of dining chairs and flooring (5–7 years instead of the projected 10–12 years) creates significant unplanned expenses.

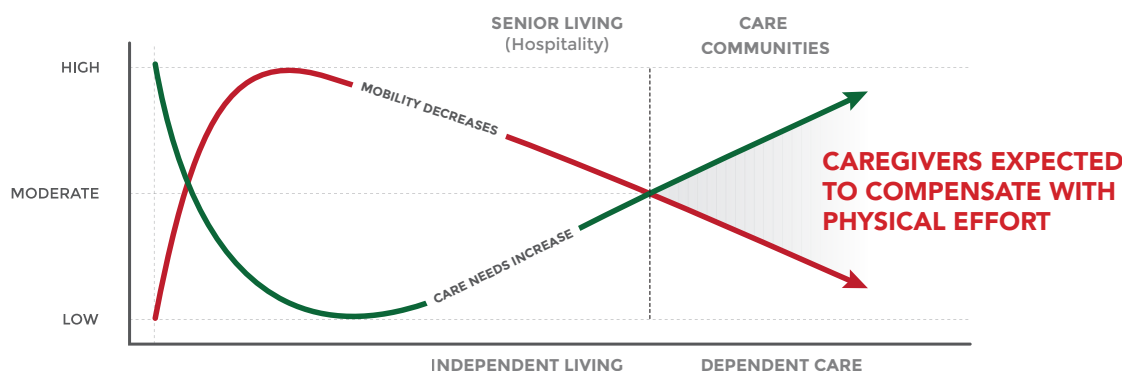
Labour shortages, reduced access to immigrant workers, and an aging workforce including early retirees returning to work, also contribute significantly to the overall cost of care.

Developing a dining chair classification system that prioritizes durability, floor protection, caregiver ergonomics, and resident independence helps reduce lifecycle costs while supporting safer, more dignified care.

### Preliminary findings associated with providing improved chair design solutions for dependent care communities are as follows:

#### As Care Needs Change...

Care needs change when a senior's mobility decreases to the point that a caregiver is required to provide assistance getting him/her seated and moved into position at the table.



## Observations:

1. The need for physical assistance when seating persons with reduced mobility at mealtimes may indicate that traditional dining chair designs are incomplete or inadequately suited to the task.
2. Dining chair designs have changed very little over the past two decades. Chairs equipped with casters on only the front or rear legs were not originally designed to reduce the physical demands placed on care staff during mealtime assistance.
3. The “TRIP ZONE” remains a significant obstacle when caregivers assist residents into traditional dining chairs. This creates ongoing fall risks for seniors and increases the likelihood of work-related injuries for staff, even when accepted transfer techniques are properly followed.
4. Many care communities have successfully returned existing chairs to active service through the addition of the retrofittable Chair CADDIE. This suggests that conventional chair designs may not be well suited to supporting persons with reduced mobility.
5. Extending the usable life of existing chairs through retrofitting can help reduce annual operating costs by decreasing the frequency of chair and flooring replacement.
6. There is growing evidence that the swivel-locking action incorporated into certain chair designs increases residents’ awareness and appreciation of the physical effort caregivers expend during mealtime assistance.
7. Anecdotal observations indicate that residents experiencing cognitive impairment may be less agitated and more cooperative with staff during mealtimes when assisted using mobility-enhanced chair designs.
8. Because dining rooms are highly visible care environments, chair designs that reduce the awkwardness of seating and table access may improve a resident’s sense of dignity, comfort, and self-worth.
9. The broader financial benefits of reducing physical demands on caregivers—including potential reductions in overtime, absenteeism, and insurance-related expenses—have not yet been fully documented and warrant further study.
10. Reduced physical workload demands may positively influence both recruitment and retention efforts within care communities. Early retirees could represent a valuable labor source where physical job requirements remain manageable, while lower physical strain may also contribute to improved long-term staff retention.