<table>
<thead>
<tr>
<th>Title</th>
<th>Manual Handling Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of document</td>
<td>To ensure all the necessary processes and resources exist to prevent and avoid harm, or reduce the risk of harm associated with hazardous work related manual handling and associated posture. To ensure Norfolk Community Health and Care NHS Trust is compliant with its duties under the Health &amp; Safety at Work etc Act 1974, and associated regulations.</td>
</tr>
<tr>
<td>Scope</td>
<td>All staff employed by or working on behalf of Norfolk Community Health and Care NHS Trust and contractors on trust property will be covered under this policy. The content reflects the varying roles all persons covered under this policy, and addresses both people and object handling and associated posture risk management.</td>
</tr>
<tr>
<td>Author and Designation</td>
<td>Richard Eldred Manual Handling Advisor, Norfolk Community Health and Care NHS Trust</td>
</tr>
<tr>
<td>Equality Impact Assessment</td>
<td>An EIA was carried out on 19.01.12 and was found to have no impact.</td>
</tr>
</tbody>
</table>
| Associated Documents  | NCH&C Health and Safety Policy  
NCH&C Risk Management Strategy  
NCH&C Reporting Investigation and Management of Incidents Policy  
NCH&C Uniform Policy  
NCH&C Cleaning and Disinfection of Equipment Policy  
NCH&C Falls Policy  
NCH&C New and Expectant Mothers Trust Guidance  
NCH&C New and Expectant Mothers Trust Risk Assessment  
NCH&C Mandatory Training Policy |
| Supporting References | Health and Safety at Work Act, 1974.  
Management of Health and Safety at Work Regulations 1999.  
See Section 13 for full Bibliography |
| NHSLA Risk Manag. Standards / CQC Regulation | NHSLA 2.9 and 3.4  
CQC Outcomes 4, 11 and 14. |
| Consultation or Development Process | Clinical Governance Leads and Managers throughout Norfolk Community Health and Care NHS Trust (2008)  
NHSLA review committee (2011) |
| Training Implications | Trust mandatory induction and refresher update programmes. Please refer to section 10 of policy for further information. |
| Process for Monitoring Compliance | Yearly line manager self assessment using internal audit tool (Appendix 16) |
PATIENT MANUAL HANDLING RISK ASSESSMENT
PERSON RECEIVING CARE / TREATMENT / SERVICE USER

LOCATION:                                  DATE:

PATIENT NAME:                              DOB:
(ID Sticker if available)
NHS. NO.                                    WEIGHT:

SECTION A: If in doubt answer No
Can the Person currently transfer themselves independently?  YES / NO
If YES sign below and set review date on page 3
If NO then continue with assessment and sign at end of page 3

NAME:                                      SIGNATURE:          DATE

Describe the handling activity / transfer

SECTION B - More detailed assessment:

<table>
<thead>
<tr>
<th>INDIVIDUAL HANDLER CAPABILITY.</th>
<th>YES/NO</th>
<th>Details, comments</th>
<th>Level of Risk (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider: does the activity / task:</td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Pose a risk for a new/expectant mother?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pose a risk for staff with fitness or health problems?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is special training required?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is unusual capability/strength required?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there concerns about training or information?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THE WORKING ENVIRONMENT
Consider are there:
Constraints on posture?
Poor floor surfaces?
Poor lighting?
Inadequate working spaces?
Temperature or humidity problems?
Variations in working height levels?
### Section B continued:

<table>
<thead>
<tr>
<th>The Patient- Consider:</th>
<th>Yes</th>
<th>No</th>
<th>Details, comments</th>
<th>Level of Risk (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a known history of falls?</td>
<td></td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Is the person's behaviour / mobility unpredictable?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Is the person very large (18+ stone)?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Does the patient have medical issues- affecting the task/activity?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Does patient use own mobility / transfer aids?</td>
<td></td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Are there drips / drains / catheters?</td>
<td></td>
<td></td>
<td></td>
<td>Low</td>
</tr>
</tbody>
</table>

### Does the Task involve:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Handling away from your trunk?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stooping?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twisting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repetitive handling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficient time for rest or recovery?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sustained handling positions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual lifting of most / all patient’s weight?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Stressful pushing / pulling?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Protective Clothing and Equipment Consider:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Is movement or posture hindered by clothing or personal protective eqpt?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a lack of suitable eqpt?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is Personal Protective Eqpt. absent or not being worn?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient’s weight exceed the Safe Working Load of any eqpt. used?</td>
<td>SWL=</td>
<td>Kg/St</td>
</tr>
</tbody>
</table>

### SECTION C- WHAT IS YOUR OVERALL ASSESSMENT OF THE CURRENT RISK OF INJURY?

**RISK= LIKELIHOOD AND SEVERITY OF INJURY**

- LOW= minor injury possible
- MED= significant injury likely
- HIGH= serious injury likely

**LOW / MEDIUM / HIGH**

### SECTION D – Action Plan:
<table>
<thead>
<tr>
<th>Further Action Required</th>
<th>By whom?</th>
<th>By when?</th>
<th>Done? Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REVIEW DATE</td>
<td>OUTCOME/ACTION</td>
<td>NEXT REVIEW</td>
<td>SIGNATURE</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
</tbody>
</table>

TAKE ACTION AND ENSURE ALL STAFF ARE INFORMED
SEEK ADDITIONAL ADVICE FROM LINE MANAGER/HEALTH AND
SAFETY/MANUAL HANDLING ADVISORS IF REQUIRED

PATIENT MANUAL HANDLING RE-ASSESSMENT FORM

PATIENT NAME:                                           NHS NO:

<table>
<thead>
<tr>
<th>REVIEW DATE</th>
<th>OUTCOME/ACTION</th>
<th>NEXT REVIEW</th>
<th>SIGNATURE</th>
</tr>
</thead>
</table>

SIGNATURE       DATE       REVIEW DATE
<table>
<thead>
<tr>
<th>Duties, Accountability and Responsibility</th>
<th>Please refer to section 5</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dissemination</th>
<th>Is there any reason why any part of this document should not be available on the public web site? ☐ Yes ☑ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This procedural document will be published on NCH&amp;C’s Intranet and also communicated to all staff via the Monthly Briefing Exchange.</td>
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<table>
<thead>
<tr>
<th>Approval Process</th>
<th>Shelia Adams O’Shea, Interim Chief Operating Officer, February 2008</th>
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<tr>
<td></td>
<td>Tracey Parkes Interim Director HR March 2012</td>
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</table>

<table>
<thead>
<tr>
<th>Ratification Process</th>
<th>Tracey Parkes – Director of HR – 23/03/12</th>
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<table>
<thead>
<tr>
<th>Review Arrangements</th>
<th>February 2013 by the Manual Handling Advisor, Norfolk Community Health and Care NHS Trust or sooner should changes to legislation or guidance require it.</th>
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</table>

<table>
<thead>
<tr>
<th>Date of issue</th>
<th>23rd March 2012</th>
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| Archiving Arrangements | This document will be archived in line with the Policy for Procedural Documents. |
## Manual Handling Policy

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<td>4  Procedure for Implementation</td>
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<td>6  Management of Manual Handling Risk within Clinical Governance</td>
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<td>7  Manual Handling Risk Assessment</td>
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<td>8  Patient Assessment</td>
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<td>9  Reporting Accidents, Near Misses or Incidents</td>
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<td>10 Training</td>
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<td>11 Moving and Handling Equipment</td>
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<td>12 Monitoring</td>
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</tr>
<tr>
<td>Addendum 3  Guidelines for Safer Handling during Resuscitation in a</td>
<td>35</td>
</tr>
<tr>
<td>Healthcare Setting</td>
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</table>

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**Addendum 1**  Bariatric Protocol

**Addendum 2**  Guidelines for the Falling and Fallen Patient

**Addendum 3**  Guidelines for Safer Handling during Resuscitation in a Healthcare Setting
## Document Control

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<th>Author</th>
<th>Status</th>
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<tr>
<td>1.0</td>
<td>20.02.08</td>
<td>Richard Eldred</td>
<td>Approved</td>
<td>Confirmation of approval at NORSAP.</td>
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<tr>
<td>1.1</td>
<td>02.02.10</td>
<td>Richard Eldred</td>
<td>Update</td>
<td>Updated to include NHSLA minimum requirements</td>
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<tr>
<td>1.2</td>
<td>11.04.11</td>
<td>Hannah Rose</td>
<td>Update</td>
<td>Updated to reformat into Trust template and update of all hyperlinks.</td>
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<tr>
<td>1.3</td>
<td>24.01.12</td>
<td>Richard Eldred</td>
<td>Update</td>
<td>Policy transferred into new policy for procedural documents format and min requirement for TNA inserted</td>
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<tr>
<td>1.4</td>
<td>14.03.12</td>
<td>Richard Eldred</td>
<td>Update</td>
<td>Policy updated following NHSLA mock review, including Logo update and minor rewording of several bullet points to clarify trust processes. Removal of all costs from Bariatric rental info</td>
</tr>
</tbody>
</table>
1. **Introduction**

1.1 The Health and Safety at Work Act 1974 places a general duty on employers to “ensure so far as is reasonably practicable, the health, safety and welfare at work of all staff”. (Section 2(1)).

1.2 The Management of Health and Safety at Work Regulations 1999 and the Manual Handling Operations Regulations 1992 (amended 2002), which came into effect on 1st January 1993, supplement the employers’ existing responsibilities with specific duties. These regulations require that the employer should avoid hazardous manual handling or where not possible to avoid, carry out suitable and sufficient (ergonomic) assessments of the risks, to reduce those risks as far as is “reasonably practicable”.

2. **Policy Statement**

2.1 The Trust Board and Chief Executive of Norfolk Community Health and Care NHS Trust, (and Other Trusts or Organisations under the jurisdiction of this policy); fully accept their legal responsibilities under the 1974 Health and Safety at Work etc Act, and associated regulations. In observing these responsibilities, the Trust aims to create a safe environment for all staff, visitors and patients, where hazardous manual handling activities are avoided, or the risk of harm from them reduced as far as is reasonably practicable.

3. **Definitions**

3.1 Manual Handling

The manual handling of loads by direct or indirect human effort, (by hand or other bodily force). This definition applies to: transporting a load, or the supporting of a load in a static posture, and includes: lifting, lowering, pushing, pulling, intentional dropping and throwing. (the application of human effort for a purpose other than transporting or supporting a load is not a manual handling operation)

3.2 Definition of load

A “load” is defined as a discrete movable object. This can be a person or inanimate object, including material supported on a shovel or fork; but not an implement, tool or machine whilst being used for its intended purpose

3.3 Definition of patient
A patient within the context of the Trust can be an: in or out patient, deceased patient, service user, client, resident or prisoner (HMP Norwich – healthcare unit)

4. **Procedure for Implementation**

4.1 This policy will be implemented via board level planning and organisation, where its effectiveness will also be measured, reviewed and audited. Implementation at local level will involve training, hazard avoidance, risk assessment and incident and accident reporting

5. **Duties, Accountability and Responsibility**

5.1 The Trust Board or delegated Executive Director will as far as is reasonably practicable; take steps to meet their responsibility by ensuring:

5.1.1 The implementation of this policy

5.1.2 Adequate provision of suitable staffing levels, working conditions and environments

5.1.3 Adequate provision and maintenance of suitable equipment

5.1.4 Trust employees are properly informed and trained

5.1.5 A comprehensive audit process is maintained to measure and review policy compliance and effectiveness

5.1.6 Adequate resources are made available

5.2 Directors / Heads of Service are accountable to the Chief Executive for ensuring this policy is implemented and adhered to within the areas under their control. They will monitor, review and report on the effectiveness of this policy via an annual Health and Safety audit. Directors who commission services from outside agencies will ensure that the employees, contractors or staff supplied by that agency, follow safe manual handling working or best practice, when on Trust sites or business. They will request evidence of training and risk assessment when necessary

5.3 Managers have responsibility for the following:

5.3.1 To implement manual handling regulations and best practice within their workplace. **The techniques to be used in the moving and handling of patients and objects (including the use of appropriate equipment) are reflected in:**

- The Manual Handling Operation Regulations 1992
- The Handling of People 6th Edition
- Trust mandatory manual handling training
- Practical techniques guides in this policy appendix
• Local dept induction training and or demonstration delivered against legal and best practice frameworks by the Trust manual handling advisor or experienced and competent staff

5.3.2 to seek additional advice or training on manual handling risk management where indicated

5.3.3 to ensure their staff are aware of, and are trained sufficiently, relating to manual handling, posture and ergonomics, and records are kept of this training. This applies to new and current staff

5.3.4 staff needing to reschedule their attendance at manual handling training will give seven working days notice

5.3.5 to ensure full and sufficient assessments of hazardous manual handling activities within their departments are carried out. These must be documented and reviewed when something relevant changes or yearly.

5.3.6 The appendices carry examples of current manual handling risk assessments within Norfolk Community Health and Care NHS Trust.

5.3.7 to ensure that only risk assessed patient manual handling practices are used, and those unsafe and high risk techniques e.g. the drag lift, are avoided.

5.3.8 to ensure patients manual handling needs are identified, particularly at the time of reception and when referred on to other care providers.

5.3.9 to ensure that working practices and procedures are designed to reduce the risk of injuries to the lowest level, this will include adequate staffing levels and working environments.

5.3.10 to ensure all bank or agency staff are adequately trained before commencing work.

5.3.11 to ensure that their departments are sufficiently provisioned with suitable equipment to facilitate safe handling and working postures.

5.3.12 to ensure staff use manual handling aids wherever they can reduce the risk of injury, whilst maintaining a balance with the needs of the patient

5.3.13 to ensure all further action plans on manual handling risk assessments are acted upon and signed for within the agreed timescale.
5.3.14 to avoid the need for staff to work in hazardous postures, and where this cannot be avoided, to carry out risk assessments which result in action being taken to reduce that risk, i.e. via the provision of suitable equipment.

5.3.15 to proactively avoid or reduce working conditions that cause undue physical or mental stress to staff.

5.3.16 to seek advice from the manual handling advisors when required.

5.3.17 to document and report to their directors any circumstance which prevents them from reducing identified risks.

5.3.18 to report any environmental or design issues that have a negative impact on safe working practice

5.3.19 to ensure that all accidents, incidents and near misses are reported.

5.3.20 to ensure that any uniforms and protective clothing provided is worn when needed but that it does not hinder safe working practice

5.3.21 to ensure they use the Trust form to risk assess members of their staff who are new and expectant mothers.

5.3.22 to ensure staff affected by work related ill health are assessed by occupational health where necessary.

5.3.23 pay particular attention to vulnerable staff groups – such as students and new or inexperienced staff, ensuring they receive appropriate induction, support and supervision; and are made fully aware of manual handling hazards, risk assessments and safe systems of work.

5.4 All Employees

5.4.1 All employees have a general duty under the Health and Safety at Work Act 1974 to take reasonable care of their own and others safety whilst undertaking manual handling operations and to co-operate with the Trust in meeting its health and safety responsibilities.

5.4.2 In particular, all employees are responsible for:-

5.4.2.1 attending any training provided and acting upon the information provided.

5.4.2.2 ensuring they follow safer systems of work as indicated in documented manual handling risk assessments.
5.4.2.3 staff wishing to reschedule their attendance at manual handling training for whatever reason will give seven working days notice to the training dept. If training is cancelled within less than seven working days for legitimate reasons, this is acceptable if explained to the training dept.

5.4.2.4 reporting immediately to their manager any shortcoming in their training, knowledge, skill, competency, ability or experience, which compromises their safe working practice relative to manual handling, working postures and documented risk assessments.

5.4.2.5 ensure they can demonstrate their manual handling activities are directly linked to the relative manual handling risk assessments.

5.4.2.6 using manual handling aids whenever identified as appropriate via manual handling risk assessment.

5.4.2.7 avoiding controversial manoeuvres, e.g. Drag lifts, Australian slide, Cradle lifts etc, which are described as high risk and unsafe in best practice guidelines (RCN / NBE / BackCare Handling of People 5th edition)

5.4.2.8 promptly reporting any accidents, incidents or near misses at work relating to manual handling to their manager or safety representative.

5.4.2.9 reporting to their manager any issues relating to their health or fitness that may have an adverse effect on their manual handling safety or ability (including pregnancy)

5.4.2.10 wearing suitable clothing and shoes at work, and will avoid personal issues, items or accessories that may cause injury during patient handling.

5.4.2.11 adhering to and working from risk assessments and safe systems of work.

5.4.2.12 reporting any working or workplace conditions that have and adverse effect on their musculoskeletal health.

5.4.2.13 ensuring equipment is clean and in visually good condition prior to use

5.5 Moving and Handling Advisor

Arrangements: for access for appropriate specialist advice contact Manual Handling Advisor on 01603 697336 / 07887983619 or Health and Safety Dept 01603 697423 or 07979987969
5.5.1 Contact details: Office: 01603 697336, Fax: 01603 697490, mobile: 07887983619. Email: Richard.eldred@nchc.nhs.uk.

5.5.2 The Moving and Handling Advisors responsibilities will include giving proactive, reactive or requested advice at strategic, departmental and individual levels.

Advice may include areas such as:

5.5.2.1 Risk avoidance or management, and subsequent safer systems of working – relative to manual handling, posture and ergonomic issues throughout the organisation.

5.5.2.2 Hazardous manual handling activities and associated load, individual, task, environmental and other risk factors

5.5.2.3 Developing and providing training in manual handling, risk assessment and safer systems of work, to include safer handling techniques, posture and ergonomics

5.5.2.4 Reviewing accident/incident or near miss forms involving manual handling, posture and ergonomics

5.5.2.5 Audits of compliance with manual handling risk assessments

5.5.2.6 Advising on the purchase of all types of manual handling equipment

5.5.2.7 Advising on equipment and other control measures relative to ergonomics and posture

5.5.2.8 Advising on risk assessments and complex manual handling problem solving

5.5.2.9 Attending meetings, seminars, workshops and training courses to ensure maintenance of knowledge and skills competency.

5.5.2.10 Carrying out a 3 yearly review of the manual handling policy and associated protocols and appendices or sooner if required

5.6 Staff / Occupational Health

5.6.1 The Occupational Health Department should be contacted by managers if:
5.6.1.1 advice is required regarding staff ill health or injury related to work.

5.6.1.2 advice is required with regard to staff returning to work following time off work due to ill health or injury.

5.6.1.3 the Trust will work with Occupational Health to actively support injured staff to return to work as quickly and as safely as possible, and if necessary modify or alter tasks or employment, to facilitate recovery.

5.6.1.4 staff will be deemed fit by occupational health, for employment prior to starting work.

5.6.1.5 a strategy for the rehabilitation of chronic musculoskeletal injury and absenteeism will be available to staff.

5.6.1.6 referral of staff to the NCH Physiotherapy out Patient Dept: Tel 01603 776776 should be considered for access to a “fast track staff appt” for those with musculoskeletal ill health problems.

5.6.1.7 new and expectant mothers will be offered altered or alternative working conditions or arrangements if identified as necessary via risk assessment.

5.6.2 Statistical Information provided by Occupational health will contribute to strategic audit.

6. Management of Manual Handling Risk

6.1 There is an absolute requirement to undertake where appropriate risk assessments for the moving and handling of patients and objects. Therefore moving and handling risks will be managed proactively and occasionally reactively; this will take the form of:

6.1.1 Trust health and safety generic risk assessment or a more detailed ergonomic manual handling risk assessment (specific or generic)
See Trust Health and Safety policy and Appendix for trust manual handling risk assessment forms

6.1.2 Accident, incident and near misses will be reported via Datix

6.2 Manual Handling Risk Assessments

6.2.1 Process: A manager or appointed person will carry out risk assessments using either the trusts health and safety risk

New and Expectant Mothers Trust Guidance
New and Expectant Mothers Trust Risk Assessment
assessment form or trusts manual handling risk assessment forms. The more detailed manual handling form is advised if risks are not managed by the more generic H&S form, or they are complex or moderate to significant in risk of harm occurring / outcome, and therefore will require a more detailed approach. These must be completed to reduce the risk of harm from hazardous manual handling activities that cannot be avoided. From this assessment process a safer system of work will be indicated. Where identified all further actions will have a specific completion date and person responsible. All forms will be dated and signed with specified review dates. (See Appendix for paperwork)

6.3 **Arrangements for ensuring that action is taken** as a result of risk assessments and reporting concerns

6.3.1 Managers have a duty to implement risk assessment action plans by an agreed date

6.3.2 The processes as described in the Trust Risk Management Strategy 2012 will compliment and support all risk management arrangements and processes relative to moving and handling risk

6.3.3 Staff are instructed to discuss any manual handling concerns or issues during training. Staff are also required to report to their line manager any concerns relating to safe handling practice or working postures. They are encouraged to promote good practice with colleagues at all times.

6.3.4 **Processes for monitoring compliance** with moving and handling risk management will include monitoring and audit of:

6.3.5 Adverse incidents which are monitored through Datix and where required followed up by the Manual Handling advisor, discussed at locality meetings, health and safety meetings and where required included in the Chairs report to the Quality and Risk committee.

6.3.6 A formal bi-annual manual handling risk assessment compliance audit on inpatient units. Plans to access System One based manual handling risk assessments for audit are being investigated

6.3.7 RIDDOR, accident and incident forms, sickness absence, ill health retirement and compensation claims relative to manual handling will also be monitored and actioned as required

6.3.8 Measurable data relative to policy compliance and effectiveness will be made available when requested by the Health and Safety committee and the board and directors as part of the Trust wide Health and Safety audits. All relevant accident and incident forms will be forwarded to the Manual Handling Advisor, with reports on
trends and area breakdown presented on request to the Clinical Governance Committee.

6.3.9 Checks can be carried out by the moving and handling advisor at anytime

7. Manual Handling Risk Assessment

7.1 As part of their health and safety responsibilities each manager must ensure that any hazardous manual handling activity in their area that can’t be avoided is subjected to a suitable and sufficient manual handling risk assessment to reduce risk (likelihood and severity of harm occurring) using the appropriate trust form. Where manual handling is unavoidable, it is the manager’s responsibility to ensure that all staff involved in the handling are appropriately trained and have been referred to relevant technique guides- see Appendix.

7.2 Manual Handling risk assessments can include people (patient) moving and handling, inanimate load lifting and handling, to include pushing and pulling.

7.3 It is sometimes acceptable to do a Generic manual handling assessment, Generic Manual Handling Risk Assessment one that is common to several employees or to more than one site or type of work. However if specific factors exist that prevent the generic approach from adequately controlling the risk factors then a specific risk assessment should be done.

7.4 All handling hazards considered to be reasonably foreseeable and yet unavoidable, must be subjected to an assessment (generic if necessary) to reduce risk via safer systems of work, particularly for critical handling scenarios such as: falls, fire evacuation / containment, Bariatric patients (see specific protocol), cardiac arrest / epileptic seizures / collapse scenarios – i.e. bath, chair, bed. This should include all departments, units, wards and community and domiciliary settings.

7.5 Each Manager will be responsible for escalating the risk assessment to the relevant risk register in line with the NCH&C Risk Management Strategy; especially note: Section 4.0: Risk Management Process, Accountability and Reporting Structures.
Compliance will ensure action is taken as a result of risk assessment.
Elements of this process will be monitored through bi-annual manual handling risk assessment audits carried out against this policy; by the Manual Handling Advisor.

7.6 Risk assessment advice on hazardous manual handling operations can be requested from the manual handling advisors or the health and safety advisor.

7.7 It is recognised and accepted that specialist areas within Norfolk Community Health and Care NHS Trust e.g. Therapies and Children’s Services have developed additional directorate approved manual handling best practice and risk assessment.
See in Appendix: Therapeutic Handling Guidance and Paediatric Risk Assessment. These are based on legally required frameworks and best practice guidelines, and are designed to permit the recording of additional specialist information.

7.8 Multi-agency working practice. Where staff from different employers work together on a common task, the risk assessment and safer system of work will be shared. Where different agencies are working with the same patient/client interface, then manual handling risk assessment information will be shared to promote maximum quality of patient care and worker safety.

7.9 Non-Compliance Situations. The Trust will support staff in their decisions to refuse elements of manual handling where the health and safety of staff or client/patient outweighs the client/patient’s right to choice. However this decision would then need to be ratified via a very robust risk assessment which may also need to embrace wider issues, i.e. human rights, disability discrimination act, psychosocial factors. All risk assessments will demonstrate balanced decision making, clinical reasoning and where possible shall be evidence based. It is recommended that the advice of the Manual Handling Advisor is sought in these situations. Employees have an important role in the assessment and management of risk from manual handling and will notify their supervisor or manager of any manual handling situations that cause concern.

8. **Patient Assessment**

8.1 Following clinical assessment that a patient is not independently mobile, a patient manual handling risk assessment should be completed or already be in existence (i.e. generic), and a safe system of work decided upon. This should be clearly documented and accessible, and all staff made aware. The assessment must be amended when a change has occurred or signed off in long term care conditions- no longer than every 6 months (i.e. see Paediatric risk assessment).

8.2 If a significant change has occurred then a re-assessment must be carried out, and documented in the re-assessment section of the risk assessment. In certain circumstances it may be necessary for the nursing staff to refer a patient who requires specialist handling, to a therapist; similarly the decision may be made independently by the therapist. It is essential that there are good channels of communication within the multi disciplinary team regarding the assessment, sharing, recording and application of manual handling information. In very complex cases advice from the trust Manual handling Advisor should be sought if necessary.

8.3 **Therapeutic Handling**

8.3.1 Therapists or Clinical specialists often have to apply both complex and sometimes higher risk handling techniques as an essential component of their assessment and treatment regimes. In order to minimise risks they should ensure that they work within the
8.3.2 They should (in addition to the MHOR 92 regulations), reflect in these assessments the guidance promoted by their professional bodies i.e. Chartered Society of Physiotherapy, ACPIN: the Association of Physiotherapists in Neurology and the College of Occupational Therapists. Also Therapists should avoid delegation of specialist techniques to other healthcare professionals, unless adequate training and competence can be demonstrated.

8.4 It will not be necessary to complete a specific manual handling risk assessment for individual patients attending clinics or outpatient settings who clearly do not require manual handling, however these units should have generic (or in some cases specific) safe systems of work for dealing with reasonably foreseeable manual handling needs that may arise i.e. collapse or hoisting.

9. Reporting of Accidents, Near Misses or Incidents

9.1 All adverse events relating to manual handling will be reported using the Trust Incident reporting system: Datix

9.2 Any occurrences of back disorders or other ailments possibly associated with manual handling or poor working postures should be reported and investigated by the manager of the department, possibly in liaison with Occupational Health and the Manual Handling Advisor and the appointed Human resources Support Advisor. It is also important to record on the incident form the number of days/hours/shifts absent from work if the person affected was a member of staff.

9.3 All incidents and follow up reports will be recorded on the database at Trust Headquarters. This will enable information to be collated regarding:-

9.3.1 The number of incidents which have occurred

9.3.2 Where the incidents have occurred

9.3.3 The types of incidents

9.3.4 The types of injuries

9.4 This information can then be analysed in order to establish underlying trends and monitoring for strategic risk management.

10. Training
10.1 Managers must ensure all permanent staff complete relevant moving and handling training as identified in the Trust's strategic training needs analysis, Norfolk Community Health and Care NHS Trust Strategic Training Needs Analysis. The process for following up those who fail to attend relevant moving and handling training, will be by HR support staff checking training registers and sending an email to the non-attending staff's manager requiring them to ensure the staff members attendance at an alternative training session. The process for monitoring compliance with above will be via the monthly training attendance audit.

10.2 This will cover health and safety, risk assessment, handling principles, ergonomics and postural issues. Where applicable practical handling techniques and principles appropriate to the tasks and risks that staff encounter in their jobs will also be covered.

10.3 Managers can identify local staff training need by contacting HR Support 01603 697444

10.4 The purpose of their training is to:

10.4.1 Inform staff of the Trust policies and procedures

10.4.2 Inform staff of their responsibility to look after their own health and safety and of those who may be affected by their acts and omissions.

10.4.3 Provide practical advice and training on best practice in manual handling and working postures for their work area. The unit manager is responsible, as well as staff, in ensuring their attendance at manual handling training.

10.4.4 To advise staff of their responsibility to seek additional training and advice as and when necessary. Induction and refresher practical training cannot cover every scenario staff may encounter during their working lives but is does educate staff to be responsible and proactive in seeking additional training or advice as required.

10.4.5 Emphasise the need for safer systems of work based on ergonomic manual handling risk assessments, which in people care will be influenced by clinical reasoning, balanced decision making, evidence based practice

10.6 Induction Training for all Staff

10.6.1 All new staff will receive manual handling training at induction. This comprises a 15 minute sign posting advisory session. The outcome will be that all staff:

10.6.1.1 Receive manual handling training pathway information
10.6.1.2 Understand how to log on to complete the mandatory NHS Core Learning Unit in annual handling theory

10.6.1.3 Understand what practical training they require and how to access it

10.6.1.4 Receive the theory Induction handout to compliment the NHS Core learning Unit online training

10.6.1.5 Understand how to source additional advice and support

10.6.1.6 Understand how to access the fast track staff Physiotherapy service

10.6.1.7 Understand Display Screen Equipment (DSE) self assessment requirement

10.7 Practical training Information for new staff

10.7.1 All staff to read to Back Care Advice Handout provided at 15 min signposting session

10.7.2 All staff using a computer / laptop for work for more than a total of 60mins per day to complete the Norfolk Community Health and Care NHS Trust DSE Risk Self Assessment and submit to line manager

10.7.3 All staff to complete NHS Core learning theory unit on Manual Handling.

10.7.4 GROUP A: New Inexperienced Clinical staff- new to patient care or lacking current competencies: Attend a Full day Clinical practical skills course

10.7.5 GROUP B: Experienced Clinical staff handling dependent patients but experienced and competent- attend 3 hour pt handling refresher with devices course to demonstrate competency

10.7.6 GROUP C: Experienced Clinical staff with minimal handling of patients i.e. Out Pt staff- attend 2 hour pt handling refresher without devices course

10.7.7 GROUP D: Non-clinical staff with handling responsibilities i.e. porters- attend 2 hour object handling course

10.7.8 GROUP E: Clerical Staff with no heavy handling in role: Complete Trust DSE r/a and read Induction Back Care Handout and check with line manager regarding any local risk assessments and specialised training requirements

10.8 Update Training for Clinical Staff
10.8.1 All clinical staff will be required to attend yearly update training. The update training will include generic reminders regarding issues such as health and safety, risk assessment, safe systems of work, 24 hour back care and ergonomics at work and home, good body mechanics and posture. Additionally practical demonstrations or practice as required by the particular group or individuals will be available as requested or indicated. There is a strong emphasis that requires staff to demonstrate competencies at these sessions, and to proactively seek advice if these competencies are lacking.

(See appendix for current MH refresher Training handout)

10.8 Yearly update programmes

10.8.1 Annually for all clinical staff, depending on level of patient handling; GROUPS A or B

10.8.2 Estates, catering, porters and other staff whose job includes regular manual handling of inanimate loads: GROUP C

10.8.3 All staff that use a computer will complete a new Trust DSE risk assessment form if their workstation significantly changes

10.8.4 GROUP A. Experienced Clinical staff handling dependent patients but experienced and competent- attend 3 hour pt handling refresher with devices course to demonstrate competency

10.8.5 GROUP B. Experienced Clinical staff with minimal handling of patients i.e. Out Pt staff- attend 2 hour pt handling refresher without devices course

10.8.6 GROUP C. Non-clinical staff with handling responsibilities i.e. porters- attend 2 hour object handling course

10.9 Display Screen Equipment (DSE) Risk Assessment

10.9.1 To be completed by all staff who use DSE for a total of 60mins or more per day. (or less if concerns are identified).This risk assessment enables staff to risk assess postural and ergonomic risks from Display Screen Equipment and associated equipment. Assessments must be handed to line managers for reference and where required further actioning. If a more complex situation is identified then advice can be sort from the Health and Safety Dept Tel: 01603 697423 or the Manual Handling Dept 01603 697336

10.9.2 Non clinical staff requiring practical handling advice or training can access this via their manager or direct communication with the Manual Handling Department.
10.9.3 Associated generic or ergonomic inanimate load risk assessments will normally be required

10.10 It will be the responsibility of Norfolk Community Health and Care NHS Trust managers to ensure that all their staff have completed their Mandatory Training by keeping up to date records and monitoring attendance as per the Mandatory Training Policy.

10.11 The HR Support Services (HRSS) will be responsible for identifying and following up any non-attendance at Manual Handling Training in line with Mandatory Training Policy. The HRSS will send a notification to the relevant manager. It will then be the manager’s responsibility to ensure that any non-attendees are booked onto the next available Manual Handling Training course.

10.12 Additional training requests

10.12.1 In addition to the above mandatory training, advice regarding specific training needs regarding any aspect of safe handling practice, risk assessment, postural and ergonomic issues, can be discussed with the Manual Handling Department Tel 01603 697336 or email richard.eldred@nchc.nhs.uk (where specific issues are to be addressed, the Manual handling Department will usually require the appropriate risk assessment to be sent through at the time of request).

10.13 Students

10.13.1 Educational bodies requesting that the Trust accept students on clinical work placements must be able to demonstrate to the Trust that their students have received suitable and sufficient manual handling training. This training will reflect current and best practice guidelines, and should ideally be yearly for those students involved in people handling.

10.14 Agency staff

10.14.1 The Trust will ensure that it only commissions agencies who can demonstrate that they supply suitably trained staff, which comply with, and are aware of, up to date manual handling best practice, and where involved in people handling have attended regular refresher training.

10.15 Volunteers

10.15.1 The Trust will provide volunteers with suitable and sufficient levels of manual handling training and instruction relative to their roles, and associated risk assessments. It is the responsibility of managers to organise this training with the training dept or Manual Handling Advisor.
10.16 Training Records

10.16.1 All class registers from training sessions will be forwarded to the Human Resource Support Services on a periodic basis in order for the electronic staff record training database to be updated. This database will be used to record all manual handling training so that this information is accessible across the Trust and monitor mandatory training requirements.

11. Moving and Handling Equipment

11.1 As part of the assessment process Managers and Manual Handling Advisors may identify the need for mechanical aids or other manual handling or postural devices in order to eliminate or reduce the risk of injury from manual handling, or stressful working postures. Responsibility for the purchase of such aids will rest with the individual Directorates. The Manual Handling Advisors should be consulted for advice before purchasing new equipment or replacing old systems. The Trust Equipment group may be contacted for advice also.

11.2 Staff will have access to, and have read all relevant operating instructions; and be fully conversant in the safe use of any manual handling equipment in their area.

11.3 Managers will ensure they have an up to date register of manual handling equipment and knowledge of its safe working load where applicable. All moving and handling equipment will be kept in good working order and will be subjected to statutory safety and maintenance checks i.e. (Lifting Operation Lifting Equipment Regulations 1998) - contact estates or manual handling dept if in doubt. Equipment will be clean and subjected to appropriate decontamination protocols to avoid cross-infection. Staff will visually inspect all equipment prior to use to check for cleanliness and any obvious damage.

11.4 If Trust staff are using equipment belonging to the patient then it is advisable to check that the required maintenance has been carried out (Lifting Operations Lifting Equipment Regulations 1998) and the equipment is in safe working order. Staff are required to refuse to operate equipment that is, or appears to be unsafe.

12 Monitoring

12.1 This policy will be monitored as part of Norfolk Community Health and Care NHS Trust Policy Monitoring programme bi-annually or sooner if required.

12.2 All managers will be responsible for an initial audit against this policy using the Audit Tool at Appendix 16 and thereafter if any changes warrant a re-audit.
The results of such audits will identify areas of local concern that must be reported to Locality Managers. The Manual Handling Advisor can then be contacted for further advice as required.

13. **Bibliography**


13.2 RCN 2002 *Introducing a Safer Handling Policy*. Ref 000603


13.4 *Management of Health & Safety at Work Regulations* 1999. HMSO Bookshops


13.7 *The Health & Safety at Work Act* 1974. HMSO Bookshops


13.12 Nurse and Midwives Council 2002 *The Code Of Professional Conduct*

13.13 BackCare 1999 *Safer Handling Of People in the Community* ISBN 0-9530582-6-3


13.15 Benbow, M. 2002 Tissue Viability Nurse *The challenge of nursing obese patients*. Mid Cheshire Hospital Trust, Vol 02 issue 11


13.19 *Core Standards of Physiotherapy Practice 2005*

13.20 *Guidance in Manual Handling for Chartered Physiotherapists January 2002*

13.21 *Guidance on Manual Handling in Treatment ACPIN 2001 (CSP)*

13.22 RCN 2002 *Your Rights and Safety* ref 0001771


13.28 HMSO Book shops *Getting to Grips with Manual Handling – A Short Guide for Employers Health & Safety Executive.*

13.29 Faculty of Occupational Medicine Guidelines on Management of Back Pain at Work 2000. [www.facoccmed.ac.uk](http://www.facoccmed.ac.uk)

13.30 HSE 2001 *Handling Home Care*, ISBN 0 7176 2228 2


13.35 Guidance for safer handling during resuscitation in healthcare settings: November 2009 see Appendix 19.
Appendices

1. Patient Manual Handling Risk Assessment
2. Object Lifting and Carrying Manual Handling Risk Assessment
3. Object Pushing and Pulling Manual Handling Risk Assessment
4. Generic Manual Handling Risk Assessment
5. Paediatric Manual Handling Risk Assessment
6. Therapeutic Handling Guidance
7. New and Expectant Mothers Trust Guidance
8. New and Expectant Mothers Trust Risk Assessment
9. Induction Theory
10. Falling Patient Handling – Practical Techniques Guide
12. Safer Object Handling – Practical Techniques Guide
13. Training Refresher Handout (Jan 2010)
14. Display Screen Equipment Risk Assessment
16. Audit Tool – Internal
17. NCH&C Strategic Training Needs Analysis
18. Wheelchair Training Handout
Bariatric Protocol

1. **Rationale**

Bariatric people handling is in principle no different from all people moving and handling as stated in the Trust Manual Handling Policy, however due to the size, weight or body dynamics of this person group, special consideration may need to be given to certain aspects of the overall care package. Contact Norfolk Community Health and Care NHS Trust Manual Handling Advisor for advice support or guidance on any aspect of Bariatric care or risk management if indicated.

2. **Definitions**

2.1 **Bariatric: Clinical Definition: (Baros = heavy and iatros = physician)**

The branch of medicine that deals with the causes, prevention and treatment of obesity, and disease associated with obesity. A patient is clinically described as “Bariatric” when their BMI score is greater than 40, a level that is also referred to as “morbidly obese”.

2.2 **Bariatric: Norfolk Community Health and Care NHS Trust Policy Definition**
Any patient whose exceeds a BMI of 40 and whose size, weight or body dynamics exceed the safe working loads or capacity of the existing equipment or care capabilities, and whose size, weight or body dynamics may also require exceptional staffing, equipment and environmental considerations.

3. **Aim**

To give the Trust guidelines for the care and management of Bariatric patients, especially in the provision of suitable equipment, care, environments and staffing numbers.

4. **Objectives**

To provide clear pathways of action for all staff, should a Bariatric patient be admitted and require Bariatric equipment, extra staffing or environmental considerations. This protocol should also ensure that Bariatric patients are not discriminated against and that they receive the same care standards expected by and provided to all patients.

5. **Scope**

All Norfolk Community Health and Care NHS Trust employees, and non-employees on Norfolk Community Health and Care NHS Trust property e.g. Paramedics and undertakers, who may be required to handle or care for patients with a BMI over 40, or more importantly whose weight or body dynamics exceed current care provision capacity. In the event of employees of different employers working together, risk assessment information will be shared to create a common safe system of work.

6. **Notification**

Wherever possible Bariatric patients should be identified PRIOR to admission (either by Social Services, Community or GP staff, and Ambulance or Acute Trust systems). To ensure adequate equipment and resource is in place prior to admission.

7. **Identification**

It is essential that the weights of patients are known from the admitting unit (i.e. NNUH) or they should be weighed as soon as possible after they are accepted or admitted. All wards or units likely to receive patients above the weight of existing weighing devices, will ensure they purchase or rent in suitable scales along with other equipment that will be needed. Many websites on the internet have a BMI calculator; one is available on NHS direct: [BMI Calculator](#).

8. **Risk Assessment**

The process, method, standard and documentation for ergonomic manual handling risk assessment, including all associated risk management strategies, will be the same as in the main Manual Handling Policy.

9. **Manager and Employee Responsibilities**

The standard and expectation of responsibilities will remain the same as described in the main Manual Handling Policy.
10. Important issues for consideration

10.1 Space

In the ward situation two standard bed spaces may be needed to provide sufficient space to manoeuvre equipment. Standard door widths range from 830mm to 910 mm. Heavy duty wheelchairs (23st / 150kg) can be up to 1000mm wide. Double doors may be necessary for access for specialist equipment i.e. Bariatric beds.

10.2 Floor surface

Avoid carpeted areas i.e. when moving a wheelchair, bed or hoist as this significantly increases the handling forces required.

10.3 Structural loading issues

Trust owned Ground floor wards/units may be more appropriate as the safe loading of upper floors can be exceeded by the weight of specialist equipment, the patient, and carers. If first floors or above are to be used, estates must be informed at the earliest opportunity and requested to check/authorise the point loading on the floor for safety.

10.4 If the equipment is being placed into Non – Trust owned property and there are concerns as to the structural integrity of the floor/building then the manager can contact the Principal Structural Engineer at Norfolk Property Services (NPS) who will carry out a structural survey and advice on the structural capacity and integrity of the property. (NPS carries out the same service for Norfolk Social Services): It should be noted that NPS charge an hourly fee for their services. (contact NPS for current pricelist)

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<td>Principal Structural Engineer</td>
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- tel: 01603 706681
- fax: 01603 706700

http://www.nps.co.uk

10.5 Safe working load

The safe working load of any lifts should be checked, and an emergency evacuation or containment procedure for the patient must be established.

10.6 Communication
All staff especially any agency or bank staff, will be fully informed of all relevant information

11. Equipment

11.1 Unit managers will check and record their unit equipments safe working load; this will include all handling equipment, beds, trolleys, wheelchairs etc.

11.2 Patients under 125 kg (20 stone) can usually be accommodated on most existing equipment except for some wheelchairs, walking aids, armchairs and x-ray tables where the maximum safe working load is often as low as 114 kg (18 stone).

11.3 Each unit likely to receive larger patients should have access to a pair of wide slide sheets with extension handles, as these cannot be rented. If the patient has their own wheelchair, the carers or relatives could be requested to make it available for use if necessary and safe to do so.

11.4 The Trust is currently increasing its portfolio of Bariatric equipment. The Central Equipment Store (CES) may be able to provide some equipment i.e. profiling beds and chairs up to 40 - 50 stone. Contact the CES Manager on: 01603 780911. Benjamin Court in Cromer, Pine Heath in Kelling, and Ogden Court in Wymondham, Alder and Beech Wards in the Mulberry Unit NCH Norwich have Bariatric Facilities. Caroline House (Colman Hospital site Norwich from mid 2011)

12. Ordering in Rental Bariatric equipment

12.1 If all the existing resources have been explored and cannot address the need, then the Unit Manager or Authorised Senior Staff will have no choice but to authorise the rental of equipment from a specialist company – see Hyperlinks in section 13.6.

12.2 Managers should ensure that key staff are trained in the use of the Trusts equipment ordering system (EROS) and that there will be someone on duty who is able to place requisitions and someone to authorise them. The provision of this equipment through EROS is dependant on this. If there is any doubt over this please contact the Procurement Department or the EROS Administrator 01603 268020 who will be able to advise further. Information on EROS and its use can be found on the Norfolk Community Health and Care NHS Trust Intranet site.

12.3 Emergency

Pre-agreed “CALL OFF ORDERS” (numbered ordering codes) should be arranged with Procurement beforehand. These can then be activated quickly and easily for use at any time of day or night, to avoid unnecessary delay and compromise of staff and patient care and safety.

13. Procedures and associated Bariatric Patient care planning

13.1 Initial phone contact is made: by referring authority i.e. N&NUH – you must establish:

   a) weight, size and mobility status of patient
   b) what equipment is currently in use
   c) what is needed
   d) What is available on site or via CES ( All wards must have created their own equipment lists – contact manager or senior person on site if not sure)
13.2 **Arrange inpatient site visit** – pre admission (to NNUH etc). Decide if a structural survey is required before you accept the patient – especially if discharging to the community or a first floor of a Norfolk Community Health and Care NHS Trust property.

13.3 **Advise Manual Handling Dept** (during daytime weekday hours) that a Bariatric admission is anticipated [richard.eldred@nchc.nhs.uk](mailto:richard.eldred@nchc.nhs.uk) 01603 697336 / 07887 983619

13.4 **Multi-disciplinary team meeting** *(if necessary- more for very large patients)*, get the process started by discussing equipment availability. Anticipate what equipment is going to be required i.e. Bed, Hoist, Commode, Chair; establish what is currently available in the Trust. Ensure clinical staff are prepared for clinical aspects of bariatric care i.e. caution with supine and left side lying positions with some patients due to possible respiratory difficulties and cardiac compromise.

13.5 **Gain agreement and an ORDER NUMBER from manager for rental**

13.6 **Bariatric Hire Companies**: The preferred provider is 1<sup>st</sup> Call Mobility based in Harlow Essex - see contact info below. If they are unable to assist with your requirements then call either of the other 2 companies suggested: Benmor or Nightingale.

   **1st Call Mobility Bariatric Hire Information**: (Tel: 01279-425648 office hours or for the Out-of-Hours Service Call: 07711231555)

   Alternatively try:
   **Nightingale Beds Bariatric Hire Information**: Call 01978 661699 – anytime

   Or:
   **Benmor Medical**: Call: 02392 473107- anytime

   *Costs vary but are usually based on a minimal rental period of 7 days. Depending on what is ordered prices can vary- check with Trust Procurement Dept for current pricelist 01603 268005*

13.7 **Enter the equipment request on EROS and generate order number, advise Purchasing Dept. Delivery costs are expensive so anticipate the need to aim for one delivery only.**

13.8 **Contact Companies** see Hyperlinks and contact details above- provide your: name, title, Dept, full address (including delivery access to your dept), telephone no, Order Code and Eros no.

13.9 **Rental for “Emergency” out of hours ordering.** Ensure you have manager’s approval, if orders have to be placed directly with the company then give full details. Use your pre-agreed “CALL OFF NUMBER” if available, if unavailable see if the company will respond without one if it is an “Emergency” Also provide the company with all your contact details and your line manager details and tell them that you will complete an EROS order on the next work / week day and ring them immediately you have done so with the details.

13.10 **If 1<sup>st</sup> Call Mobility in Harlow Essex** are unable to provide the desired equipment then try Nightingale, if they cannot provide the equipment then try Benmor Medical
(all contact details in 13.6), all these companies should be found on EROS). Contact Purchasing for advice if in doubt.

13.11 **Prepare the environment.** Create a space for the Bariatric patient and the equipment (ground floor location may be preferable – and typically two normal bed spaces are required). A pair of extra wide slide sheets should be held by each dept / hospital site for use when needed. Ward managers to ensure these are readily available, and staff know where to locate them.

13.12 **Training.** On receipt of equipment ensure as many staff as possible receive training from the Equipment provider representatives. Cascade training to other staff; ensure no staff use equipment without appropriate training. Document in risk assessment. Seek advice from Norfolk Community Health and Care NHS Trust Manual Handling Advisor at earliest opportunity: Tel 01603 697336 or 07887983619.

13.13 **Inform Maintenance Manager** (Estates Dept) of receipt of equipment

13.14 **Receive patient** and work with ambulance staff to transfer patient from trolley to bed using appropriate technique or equipment. Norfolk Community Health and Care NHS Trust staff should ultimately lead the transfer when working with paramedic staff (If immobile – transfers will probably be by Patslide or Hoist system)

13.15 **Carry out individual Risk Assessment,** establish safe systems plan for patient transfers, and involve multi-disciplinary team. Request extra staffing levels if required and advise manager. **This must include a safer system of work for procedures in the event of Fire, either patient specific or if suitable your Generic Protocol**

13.16 **Reflection and review of the admission process.** Can it be improved? Are there any lessons to be learned for the future? – Liaise with your manager and Manual Handling Advisor.

13.17 **Equipment no longer required.** As soon as you anticipate that the rental equipment is no longer likely to be needed, organise for it to be collected by Equipment provider.

13.18 **Review discharge plan** and liaise with Ambulance headquarters if transport issues exist. Other agencies, organisations, departments or individuals who may be involved in the ongoing care of the individual must be contacted, to ensure equipment and on going care packages are in place. If patient is deceased then all departments should follow the action plan from their dept / site Bariatric deceased risk assessment (managers must ensure this process is in place for their areas)

13.19 **Delivery and Receipting of Equipment.** On delivery of the equipment staff should Goods Receipt it against the order number this will normally be done by the person who did the original requisition. This ensures that the right equipment is received and is confirmed on EROS which in turn enables Accounts Payable to clear the suppliers invoice for payment. Once received the equipment should be demonstrated by the supplier to be in good working order, and they should also carry out training and instruction in the safe use of the equipment to staff who will be responsible for its use. It is down to the department manager to ensure the relevant staff are available for training and to confirm the details of this with the supplier.

13.20 **Investigations and Treatments in Other Units / Clinical Areas.** If the patient needs to go to another department or clinical area for treatment or investigations, staff from that department should be notified by the senior nurse on the shift of the patient’s size
and weight. Prior to the visit the department should draw up a safe system of work for the investigation or treatment. If this is not possible the treatment or investigation should either be delayed or carried out in an alternative way or unit where it is safe. An immobile patient should be transported in their own wheelchair or bed. They should be not transferred onto another trolley / chair / bed / couch unless the safe working load of that equipment has been checked and is known to be adequate. Pushing and pulling should also be risk assessed and to ensure adequate staff are available. Operator controlled electrically assisted wheelchairs should be used wherever possible.

13.21 **Discharge / Transfer** When the patient is discharged or transferred the senior clinician in charge of the patient should notify those responsible for the patient’s ongoing care of the moving and handling needs of the patient. Where appropriate a risk assessment to ensure patient and staff safely during the transfer should be undertaken and a safe system of work planned. Where appropriate the senior nurse or therapist should organise the transfer of specialist equipment to the patient’s home or the new unit. This should either travel with the patient or be available when they arrive. If the Patient Transport Service (Ambulance Trust) is to be used the Ambulance Trust Control should be informed well in advance of the proposed transfer date so they can make suitable arrangements for the safe transfer of the patient. The Fire Service database should be notified if the patient is to return home. Contact the Norfolk Community Health and Care NHS Trust Manual Handling Advisor for further advice if in any doubt.

13.22 **Death of the Patient** If the patient should die whilst in hospital, the senior nurse should arrange for the body to be moved on the mortuary trolley if safe to do so. If it is not possible to store the body in the mortuary, the body should remain on the bed in the mortuary until removal by the undertakers. The funeral directors should be notified as to the patient’s size and weight. Enquiries should be made as to how the funeral directors intend moving and transporting the patient. Trust equipment and staff should be offered to the funeral directors to assist them in safe moving and handling of the patient to a pre-agreed dispatch point on the premises. The site manager can advise on the agreed dispatch point.

13.23 **Audit**

Managers will, as part of their risk assessment reviews, check that this protocol and associated guidelines are suitable in managing the risk, and will inform the Manual Handling Advisor if not.

13.24 **Support and Additional Advice**

Additional support or advice on risk assessment, space and equipment requirements, staffing levels and manual handling safe systems of work can be sought from the Manual Handling Advisor Tel: 01603 697336, once a full patient manual handling risk assessment has been carried out first.

13.25 **Planning**

It is essential that units plan for these events before hand so these patients can be cared for in an appropriate manner immediately on arrival or very soon after. The manual handling advisor is not always immediately available, however with adequate forward planning this should not impact on the immediate care of the patient as generic safe systems of work will have been established before the event.
Addendum 2

Guidelines for the management of the falling and fallen patient

1. Guideline Statement

Norfolk Community Health and Care NHS Trust recognises the risk to staff and patients from falls situations. In order to avoid or reduce manual handling injury risk to staff; and trauma risk to patients; these guidelines should be considered as part of the existing controls and standards as laid out in the Trust Manual Handling Policy.

2. Background

Falls in the community environment tend to occur more frequently amongst the elderly population i.e. 35% of people over 65 years old and 50% of those over 85 years old will fall. Fifteen percent of falls require hospital admission; of these a third will sustain a fractured hip and of these 20% will die. Within the service user population of Norfolk Community Health and Care NHS Trust, it is not just the elderly who must be considered at risk of falls.

Annually, approximately 250 serious incidents are reported nationally from the health care sector to the HSE. These typically involve staff who have sustained a major injury. Of these injuries – 90% resulted from involvement in a falling patient incident (Health and Safety Executive 2006).

Every falls situation has the potential of high risk of injury to both patient and staff.

3. Purpose and Scope

Norfolk Community Health and Care NHS Trust is committed to following legal requirements and national best practice guidelines; and will achieve this via policy, planning, risk assessment, balanced decision making, clinical reasoning and where available evidence based practice.

A review of incident forms will allow the guideline to be audited and measured.

4. Definitions

a) **Staff and Carer**: Persons under “Employee” Health and Safety jurisdiction of Norfolk Community Health and Care NHS Trust

b) **Faller and Patient**: Any person who falls; usually a person already under the formal care of Norfolk Community Health and Care NHS Trust staff or carers, but could also be a Visitor or relative etc.

5. Objectives

The primary objective is to **prevent** a fall from occurring in the first place (as far as reasonably practicable within the framework of patient care and rehabilitation). When falls do occur the objective where practicable is to minimise injury to both staff and patient. Incident reporting will ensure staff learn from the event to avoid or reduce reoccurrence.

6. Prevention of Falls

The key to a successful falls prevention strategy is an awareness of the causation of falls. It is the responsibility of staff and managers to assess these risk factors, within
the framework of clinical and falls risk assessments and manual handling risk assessments (where applicable).

Despite all preventative measures some patients will still fall with the risk of harm to themselves and their carers.

Betts and Mowbray (Hop 5, 2005) identified a moral dilemma, in that some staff perceive allowing a person to fall to the ground is unacceptable, and is a contradiction of their duty of care towards the patient.

They are reminded that an equal duty of care is expected under the Health and Safety at Work etc Act 1974, towards themselves.

7. Management of the Falling Patient

Refer to pages 12 – 16 of the Norfolk Community Health and Care NHS Trust Practical Manual Handling, Clinical Training Handout. Or Appendix 10

National best practice guidelines advocate a limited range of intervention options dependent on presenting criteria.

7.1 All current guidelines recommended that staff do not attempt to catch or support the full body weight of a falling person. (See picture in training handouts if required)

7.2 If staff are right beside the person and are able to get behind, adopting a braced and stable upright posture, they may be able to guide the person to the ground by acting as a slide (see picture sequence in training handout if required).

It is advisable that the staff member is not smaller in stature and weight than the faller. They should also have received training in how to adopt the braced and stable posture.

7.3 Staff on restricted duties through ill health, pregnancy, new mother or injury, are advised to avoid intervening in this manner. Also any staff untrained in this procedure should not intervene.

7.4 A final act of intervention may be in the form of a staff member redirecting (via pushing or pulling) the faller away from an obvious source of harm i.e. window, traffic, stairs etc. This should not involve supporting full body weight and should aim to avoid hazardous postures.

Staff may also try and move a hazardous object or place a pillow etc to soften the fall.

7.5 When falls occur during transfers involving lying (i.e. off a bed, assessment couch), sitting and crouching; or access to the person is restricted by equipment or environment, then the staff may chose to follow point 4 or they may decide to let the patient fall.

7.6 At no time in any falls event will a member of staff be expected to intervene, the decision rests entirely with their dynamic on the spot assessment of the situation. If there is any doubt do not intervene, as a post fall intervention maybe required. (I.e. the need for resuscitation- which is potentially more beneficial to the faller but not if compromised through staff injury)

7.7 The post fall incident form and review will examine why they fell, not why they weren’t caught.
7.8 All interventions carry risk and it is the responsibility of staff to choose the appropriate response, (balancing the risk to themselves and the faller). **If in doubt – Do Not Intervene.**

7.9 In reality the vast majority of fallers will be in a situation where they are beyond the point for help or intervention from staff.

8. **Management of the Fallen Patient**

A fallen person must be assessed, to establish if they require resuscitation, emergency admission to A/E, or a non emergency (medical) assessment. Help from colleagues or “good Samaritans” will probably be required, and should be summoned immediately. The faller should not be moved until assessed as safe to do so.

8.1 **If deemed safe to move**

Options will vary depending on mobility status of faller, equipment available and environment – but they could include:

- Faller is able to independently transfer themselves unaided (off the floor) into a suitable position
- Faller uses one or two chairs, (slid into place and steadied by carers) to lean and push on, to assist themselves into a sitting position – (see picture sequence in training handout if required)
- Faller is hoisted from floor – to (wheel) chair or bed
- Staff use a Mangar booster cushion (if available) to raise faller off floor
- Where fallers are in a confined space, slide sheets with extension handles can be used to slide faller to an area with better (hoist) access.

8.2 **The Emergency services are not there to be used as a “lifting service”**. 
All reasonably foreseeable falls risks should be managed via risk assessment and the subsequent provision of suitable training and equipment.

8.3 Seek advice on manual handling risk management from your line manager or the Manual Handling advisor if unsure.
Guidance for safer handling during resuscitation in healthcare settings

1. Guideline Statement

Norfolk Community Health and Care NHS Trust recognises the risk to staff and patients from unplanned critical clinical situations. In order to avoid or reduce manual handling injury risk to staff; and trauma risk to patients; these guidelines should be considered as part of the existing controls and standards as laid out in the Trust Manual Handling Policy and staff clinical training.

2. Background

Cardio-respiratory arrest is seen as the most acute medical emergency faced by Healthcare providers and the speed of response is essential because delays in providing cardiopulmonary resuscitation (CPR) reduce the chance of survival. In approximately 80% of adult cases there are clinical signs of deterioration; therefore cardio respiratory arrest is a foreseeable event. As such, this situation should be assessed for risk with plans and provisions being implemented locally, to handle the emergency situation safely as far as is reasonably practicable.

In response to the requirements laid down by the Manual Handling Operations Regulations 1992, risk assessments are performed for most situations.

Moving and handling training is a statutory requirement under the Health and Safety at Work etc Act 1974 and expanded on in the Management of Health and Safety at Work Regulations 1992. Managers and staff have to consider the working environment and plans should be in place for dealing with identified medical emergencies.

3. Purpose and Scope

Norfolk Community Health and Care NHS Trust is committed to following legal requirements and national best practice guidelines; and will achieve this via policy, planning, risk assessment, balanced decision making, clinical reasoning and where available evidence based practice. Monitoring of incident forms will allow the guideline to be audited and measured.

4. Definitions

a) Staff and Carer: Persons under “Employee” Health and Safety jurisdiction of Norfolk Community Health and Care NHS Trust

b) Patient: Any person already under the formal care of Norfolk Community Health and Care NHS Trust Staff or Carers, but could also be a Visitor or relative etc.

5. Objectives

The primary objective is to ensure staff know how to respond to a critical event- i.e. arrest or seizure, with regard to their safer handling practice and procedure
6. **Prevention of Injury risk**

   The key to a successful injury risk reduction strategy is via risk assessment, planning and an awareness of best practice guidelines through mandatory training. It is the responsibility of staff and managers to assess these risk factors, within the framework of clinical risk assessments and specific manual handling risk assessments (where applicable).

   It is also worth reminding staff that they are not expected to expose themselves to unacceptable risk in these events and that an equal duty of care is expected under the Health and Safety at Work etc Act 1974, towards themselves.

7. **Manual Handling Guidance for safer handling during resuscitation in Healthcare settings:** See Appendix 19 for Resuscitation Council Guidelines

   National best practice guidelines advocate a range of intervention options dependent on presenting criteria.

   7.1 The Resuscitation Council guidelines represent generic recommendations and can be used to inform safer practice, however a dynamic risk assessment carried out at the time may require methods to be adapted to accommodate the presenting situation and the staff abilities and resources available.

   7.2 Staff on restricted duties through ill health, pregnancy, new mother or injury, are advised to consider their limited abilities before intervening. Also any staff who feel unable to apply safer handling principles should seek immediate assistance and further training advice.

   7.3 Some patient groups may present greater handling challenges in these critical situations, i.e. Bariatric patients - where the size and weight of the patient, equipment and environmental considerations may severely restrict positioning opportunities. Also the bariatric patient's weight, body shape and increased tissue mass can make the patients breathing, airway management and CPR technically more difficult - particularly if they are in a true supine position as opposed to around 30 degree sitting up. Also staff need to consider clinical factors with other patient groups, such as late term pregnancy where recovery positioning on the left side is recommended to reduce pressure on the inferior vena cava which is increased in right side lying.

   7.4 **Environmental factors** such as an arrest in a bath can be particularly difficult to deal with. Generic risk assessment and safer system planning are required before the event. The safest way to move somebody from a bath for CPR is to use a mechanical device i.e. hoist or mechanical bath chair. If this is not reasonably practicable due to time or equipment availability then other alternatives are to manually lift the patient out with 2 staff. However staff must be aware that all manual types of lift are extremely high risk. If all else fails empty the bath and attempt elements of CPR in situ until paramedics arrive - who have been specifically trained to deal with these events. At no time in any CPR event will a member of staff be expected to put themselves at risk. The decision to lift for example rests entirely with their dynamic on the spot assessment of the situation. If there is any doubt do not manually lift in these situations. See Resus Council guidance in Appendix 19
7.5 Seek advice on manual handling risk management from your line manager or the Manual Handling advisor if unsure.
**OBJECT MANUAL HANDLING RISK ASSESSMENT**

**LIFTING AND CARRYING**

<table>
<thead>
<tr>
<th>DEPARTMENT:</th>
<th>DATE:</th>
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Assessment team NAME:  
SIGNATURE:

Describe the task to be assessed:

<table>
<thead>
<tr>
<th>Approx. weight of load</th>
<th>Carrying distance of load</th>
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<tbody>
<tr>
<td>...........kg/pounds</td>
<td>............mtrs/yards</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Lifting/lowering height of load</th>
<th>Pushing /Pulling distance of load</th>
</tr>
</thead>
<tbody>
<tr>
<td>.............cm/inches</td>
<td>...........mtrs/yards</td>
</tr>
</tbody>
</table>

**DO YOU ALSO NEED TO DO A PUSHING/PULLING RISK ASSESSMENT?**  
YES / NO

**SECTION A - Preliminary** If in doubt answer YES

<table>
<thead>
<tr>
<th>Q1 Do the operations involve a significant risk of injury?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If ‘Yes’ continue with assessment. If ‘No’ go to page 3 and set review date.</td>
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</table>

<table>
<thead>
<tr>
<th>RISK</th>
<th>Likelihood and severity of injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>minor injury possible</td>
</tr>
<tr>
<td>MED</td>
<td>significant injury likely</td>
</tr>
<tr>
<td>HIGH</td>
<td>serious injury likely</td>
</tr>
</tbody>
</table>

**SECTION B - More detailed assessment:** (Lifting & Carrying)

<table>
<thead>
<tr>
<th>INDIVIDUAL HANDLER CAPABILITY. Consider: does the task:</th>
<th>YES /NO</th>
<th>Details, comments</th>
<th>Level of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pose a risk for a new/expectant mother?</td>
<td></td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Pose a risk for staff with fitness/health problems?</td>
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<tr>
<td>Require special training?</td>
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<tr>
<td>Is unusual capability/strength required?</td>
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<tr>
<td>Are their concerns with training or information?</td>
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<table>
<thead>
<tr>
<th>THE WORKING ENVIRONMENT Consider are there:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constraints on posture?</td>
</tr>
<tr>
<td>Poor floor surfaces?</td>
</tr>
<tr>
<td>Poor lighting ?</td>
</tr>
<tr>
<td>Inadequate working spaces?</td>
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<tr>
<td>Temperature or humidity problems?</td>
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<tr>
<td>Variations in working height levels?</td>
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</tbody>
</table>

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Page 1 of 4  
NPCT/MHteam/301204/RE/RG
### Section B continued:

<table>
<thead>
<tr>
<th>The Load. Consider:</th>
<th>Yes/No</th>
<th>Details, comments</th>
<th>Level of Risk</th>
<th>√</th>
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</thead>
<tbody>
<tr>
<td>Is the load unstable/unpredictable?</td>
<td></td>
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<td>Low</td>
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<tr>
<td>Is the load bulky/unwieldy?</td>
<td></td>
<td></td>
<td>Med</td>
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<tr>
<td>Is the load difficult to grasp?</td>
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<td>High</td>
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<tr>
<td>Is the load harmful, e.g. hot/cold/sharp?</td>
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</table>

### Does the Task involve

<table>
<thead>
<tr>
<th>Holding loads away from trunk?</th>
<th></th>
<th></th>
<th>Low</th>
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</thead>
<tbody>
<tr>
<td>Stooping?</td>
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<td>Med</td>
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<tr>
<td>Twisting?</td>
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<td>High</td>
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<tr>
<td>Low or high lifting positions?</td>
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<td>Carrying distances over 10 metres?</td>
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<td>Repetitive handling?</td>
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<td>Insufficient rest or recovery?</td>
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<tr>
<td>Sustained handling positions?</td>
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<td>A workrate imposed by a process?</td>
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### Protective Clothing and Equipment Consider:

<table>
<thead>
<tr>
<th>Is movement/posture hindered by clothing or Personal Protective Eqpt?</th>
<th></th>
<th></th>
<th>Low</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Is there a lack of suitable eqpt?</td>
<td></td>
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<td>Med</td>
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<tr>
<td>Is Personal Protective Eqpt. absent or not being worn?</td>
<td></td>
<td></td>
<td>High</td>
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</table>

### SECTION C – What is your overall assessment of current risk of injury?

**LOW / MEDIUM / HIGH**

### SECTION D – Action Plan:
### Further Action Required

<table>
<thead>
<tr>
<th></th>
<th>By whom?</th>
<th>By when?</th>
<th>Done? Y/N</th>
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<tbody>
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</table>

**SIGNATURE:**

**DATE:**

**RE-ASSESSMENT DATE:**

---

**TAKE ACTION AND ENSURE ALL STAFF ARE INFORMED**

SEEK ADDITIONAL ADVICE FROM LINE MANAGER/HEALTH AND SAFETY/MANUAL HANDLING ADVISORS IF REQUIRED
## OBJECT MANUAL HANDLING RE-ASSESSMENT FORM

<table>
<thead>
<tr>
<th>REVIEW DATE</th>
<th>OUTCOME/ACTION</th>
<th>NEXT REVIEW</th>
<th>SIGNATURE</th>
</tr>
</thead>
</table>

**LOCATION:**

**TASK:**

COPY AS PER DISTRIBUTION ON PAGE 3
MANUAL HANDLING RISK ASSESSMENT
PUSHING AND PULLING

<table>
<thead>
<tr>
<th>DEPARTMENT:</th>
<th>DATE:</th>
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</table>

<table>
<thead>
<tr>
<th>ASSESSMENT TEAM NAME:</th>
<th>SIGNATURE:</th>
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</table>

Describe the task to be assessed:

Approximate weight of load ...............kg/pounds  Pushing / Pulling distance of load .............mtrs/yards

DO YOU ALSO NEED TO DO A LIFTING RISK ASSESSMENT?  YES / NO

SECTION A - Preliminary-If in doubt answer YES

Q1 Do the operations involve a significant risk of injury?
   If ‘Yes’ continue with assessment. If ‘No’ go to page 3 and set review date..
   Yes / No

RISK= Likelihood and severity of injury ie how likely, how bad
LOW = minor injury possible        MED= significant injury likely         HIGH = serious injury likely

SECTION B - More detailed assessment: (Pushing & Pulling)

<table>
<thead>
<tr>
<th>INDIVIDUAL HANDLER CAPABILITY. Consider: Does the task:</th>
<th>YES /NO</th>
<th>Details, comments</th>
<th>Level of Risk</th>
<th>(✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pose a risk for a new/expectant mother?</td>
<td></td>
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<td>Low</td>
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<td>Med</td>
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<tr>
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<td>High</td>
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<tr>
<td>Are there concerns with information or training?</td>
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<tr>
<td>Require unusual strength/capability?</td>
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</table>

The working environment. Consider: are there

Constraints on posture?
Confined spaces/narrow doorways?
Poor floor surfaces?
Sharp edges?
Trapping or tripping hazards?
Poor lighting conditions?
Hot/cold/humid conditions?

Section B continued:

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>✓</th>
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</table>
### The Load. Consider:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Details, comments</th>
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<tr>
<td>If on wheels/castors, are they:</td>
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<tr>
<td>• Unsuitable for the type of load or flooring?</td>
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<tr>
<td>• Difficult to steer?</td>
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<tr>
<td>• Damaged or defective?</td>
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<tr>
<td>• Without brakes or difficult to stop?</td>
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<tr>
<td>• With ineffective brakes?</td>
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<tr>
<td>• Without adequate maintenance?</td>
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</table>

### The Task. Consider: do they involve

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Details, comments</th>
<th>Low</th>
<th>Med</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>High forces to move/stop load?</td>
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<tr>
<td>High forces to keep the load in motion?</td>
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</tr>
<tr>
<td>High forces to manoeuvre/position load?</td>
<td></td>
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<tr>
<td>Awkward postures to manoeuvre load?</td>
<td></td>
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<tr>
<td>One-handed operations?</td>
<td></td>
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<tr>
<td>Hands below waist or above shoulder?</td>
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<tr>
<td>Movement at high speed?</td>
<td></td>
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<tr>
<td>Movement over long distances?</td>
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<tr>
<td>Repetitive pushing/pulling?</td>
<td></td>
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</tr>
</tbody>
</table>

### Equipment. Consider:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Details, comments</th>
<th>Low</th>
<th>Med</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is movement or posture hindered by clothing or Personal Protective Eqpt?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is Personal Protective Eqpt. absent or not being worn?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Are trolleys/carts/barrows in poor condition?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Is there a lack of maintenance?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION C– What is your overall assessment of current risk of injury?:

**LOW / MED / HIGH**

### SECTION D: Action plan:
<table>
<thead>
<tr>
<th>Further Action required</th>
<th>By whom?</th>
<th>By when?</th>
<th>Done Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
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<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SIGNATURE:  
DATE:  
RE-ASSESSMENT DATE:

TAKE ACTION AND ENSURE ALL STAFF ARE INFORMED  
SEEK ADDITIONAL ADVICE FROM LINE MANAGER/HEALTH AND  
SAFETY/MANUAL HANDLING ADVISORS IF REQUIRED
PUSHING AND PULLING RE-ASSESSMENT FORM

<table>
<thead>
<tr>
<th>LOCATION:</th>
<th>TASK:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>REVIEW DATE</th>
<th>OUTCOME/ACTION</th>
<th>NEXT REVIEW</th>
<th>SIGNATURE</th>
</tr>
</thead>
</table>

Copy as per distribution List page 3
### Manual Handling Hazard:

### TASK:

### Safer Systems of Work options:

<table>
<thead>
<tr>
<th>Potential TASK Risks</th>
<th>Potential associated STAFF Risks</th>
<th>Potential risks from PATIENT</th>
<th>Potential ENVIRONMENT Risks</th>
<th>OTHER Potential Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### REQUIRED ACTION:

Generic Manual Handling Risk assessment NHS Norfolk, NCHC April 2008, Ref RE MH DEPT
SPECIALIST CHILDREN’S SERVICE: MOVING AND HANDLING RISK ASSESSMENT and CARE PLAN

Completed by:  Designation:  Date:

Location:

- **Child’s Details:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Known as:</th>
<th>Male / Female</th>
<th>NHS No:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Current Health Issues:**

- Are the current health conditions: Please circle Long Term / Short Term / Mixed

  Explain as necessary

- **Current Mobility Status:**

<table>
<thead>
<tr>
<th>Is the child independently mobile:</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>if yes, there is no need to complete the form further.</td>
<td></td>
</tr>
</tbody>
</table>

Signed ………………………Date……………

- **Tasks: Existing tasks and methods:** Refer to child’s notes if necessary

<table>
<thead>
<tr>
<th>Tasks (transfers)</th>
<th>Equipment</th>
<th>No of staff</th>
<th>Task</th>
<th>Equipment</th>
<th>No of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed to Seating</td>
<td></td>
<td></td>
<td>Seating to Bath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seat to Standing Frame</td>
<td></td>
<td></td>
<td>Therapy Activity please specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair to Toilet / Commode</td>
<td></td>
<td></td>
<td>Other please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Examples:** Please specify exact equipment, where important e.g. hoist type, hook/clip, sling type / make, K-Walker etc.

- **Specific Moving and Handling Risk Assessment Questions:**

  - **Child: Issues (numbered) which may increase handling risk:**

<table>
<thead>
<tr>
<th>Are there issues with:</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gastrostomy / Tracheotomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Contractures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Splints / Casts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Weight above 16kg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ability to follow instructions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Issues**

<table>
<thead>
<tr>
<th>Issues</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

Child’s Name: Manual Handling Risk Assessment for Children (Oct 2007)
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Incontinent</td>
<td>15. History of falls</td>
</tr>
<tr>
<td>11. Emotional State</td>
<td>16. Epilepsy</td>
</tr>
<tr>
<td>12. Tissue Viability</td>
<td>17. Infection</td>
</tr>
<tr>
<td>13. Other – please specify</td>
<td></td>
</tr>
</tbody>
</table>

If yes to any of above – additional comments if necessary:

- **Staff: Risk factors (numbered) for those working with the child**

<table>
<thead>
<tr>
<th>Are there issues with:</th>
<th>No</th>
<th>Yes</th>
<th>If Yes: Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Anyone in the team being a new/expectant mother?</td>
<td></td>
<td></td>
<td>Must have a pregnant worker risk assessment and work within the resulting specific recommended guidelines</td>
</tr>
<tr>
<td>19. Inadequate training</td>
<td></td>
<td></td>
<td>Must be up-to-date with organisational &amp; local moving &amp; handling training</td>
</tr>
<tr>
<td>20. Inadequate Staff numbers</td>
<td></td>
<td></td>
<td>Must have adequate numbers to perform transfers safely</td>
</tr>
<tr>
<td>21. Staff health issues</td>
<td></td>
<td></td>
<td>Must work within their personal risk assessment</td>
</tr>
<tr>
<td>22. Communication barriers</td>
<td></td>
<td></td>
<td>Must be able to adequately communicate with the child</td>
</tr>
<tr>
<td>23. Other specify</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- **Risk factors caused by the Environments (in venue) and Tasks within them**

<table>
<thead>
<tr>
<th>Location</th>
<th>No</th>
<th>Yes</th>
<th>Risk Factor(s) Numbered below</th>
<th>Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toilet</td>
<td></td>
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</tr>
<tr>
<td>Bathroom</td>
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<tr>
<td>Bedroom</td>
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<tr>
<td>Dining Area</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Living Room</td>
<td></td>
<td></td>
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<tr>
<td>Classroom</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Therapy Area</td>
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<td></td>
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<tr>
<td>Other</td>
<td></td>
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</table>

- **Risk factors (numbered)**

  **Environments**: 24. Restrictive space 25. Floor surface *e.g. carpet, slippery, slopes* 26. Lighting 27. Tripping or trapping hazards 28. Lack of adaptations

  **Does Task involve**: 29. Stressful Lifting / Pushing / Pulling 30. Lack of suitable equipment 31. Stressful postures *e.g. bending / twisting / overreaching /sustained / repetitive* 32. Other specify
### Moving and Handling Care Plan

(Please ensure to check for additional updated instructions on final page)

<table>
<thead>
<tr>
<th>Transfer (Task)</th>
<th>Risk Factors (numbered 1-32)</th>
<th>Method of Transfer Including number of staff</th>
<th>Further actions required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

- If child’s condition has changed in a way that alters safe systems of work, detailed above in the Moving & Handling Instructions, please complete update on page 4.
- Put line through any obsolete transfers

**Child’s Name:** Manual Handling Risk Assessment for Children (Oct 2007)
**UPDATED RISK ASSESSMENT & CARE PLAN**

For minor changes to situation, complete below. For long-term or significant changes a: **new** manual handling risk assessment and care plan form requires completion.

<table>
<thead>
<tr>
<th>Task (Transfer)</th>
<th>Changes</th>
<th>New/Remaining risk factors (Numbers 1-32)</th>
<th>New method of transfer</th>
<th>Further actions still required</th>
<th>Signed, name &amp; date</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

- **Formal Reassessment Plan**

  Please tick to indicate minimum frequency of review (sooner if required)

<table>
<thead>
<tr>
<th>Daily</th>
<th>Next admission</th>
<th>1 week</th>
<th>1 month</th>
<th>6 month</th>
</tr>
</thead>
</table>

**Dates of reassessments:**

I have reviewed the Moving and Handling Risk Assessment and Care Plan and am satisfied that it is still suitable & sufficient

<table>
<thead>
<tr>
<th>Date</th>
<th></th>
<th></th>
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<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Designation</th>
<th></th>
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<th></th>
</tr>
</thead>
</table>

Child’s Name: Manual Handling Risk Assessment for Children (Oct 2007)
Colman Centre for Specialist Rehabilitation Services

Standards and Protocols for Therapeutic Handling

March 2012

Prepared by the Physiotherapy Team, Colman Centre for Specialist Rehabilitation Services
Introduction

The following document represents ongoing work carried out over the last three and a half years by the Physiotherapy Team, Colman Centre for Specialist Rehabilitation (CCSRS). The purpose of the documentation is to help guide therapists involved in therapeutic handling. It does not replace the need for the Trust manual handling assessment, but is intended to be used alongside. This is to help therapists consider not only the clinical need of the patient when selecting therapy for a patient, but to reflect on the best possible approach to how treatment is achieved. The guidelines are not intended to be prescriptive, but to help support effective safe practice.

Acknowledgement should be given to the original work carried out by ACPIN which was used as a starting point for this document. Ongoing advice and support has gratefully been received from Richard Eldred as the Trust manual handling advisor.

The team involved with this work so far has been:

Clare Bennett-Lloyd
Joni Cox
Olivia Giller
Nicky Hammond
Hilary Illingworth
Rachel Hardy
Kate Lee
Ailsa Magee
Nina Melville

Future Plans
As a team we will continue to expand on the individual guidelines. The team will discuss with NORSAP the value of using this work to establish standards in therapeutic handling across Norfolk.

In the meantime the physiotherapy team at CCSRS would welcome any constructive comments to further develop this piece of work. These can be sent to:

Nina.melville@nchc.nhs.uk
1. Every patient to have a Trust Manual Handling Risk Assessment form completed, according to Trust Policy.

2. The Manual handling Assessment should be updated as the patient’s ability improves or deteriorates.

3. Where there is a risk relating to therapeutic handling e.g. assisting sit to stand, a therapeutic handling risk assessment form should be completed.

4. Therapeutic handling should follow the relevant protocols, unless an alternative or modified approach is specified or a specific procedure identified.

PT Team
Nov 2006
1. A manual handling assessment should be completed prior to any therapeutic handling. For in-patients it may often be the nurses who complete this. It is important that therapists review this, and on occasions may wish to suggest modification.

2. Prior to any therapy task where there is a specific manual handling risk, a therapeutic risk assessment form should be completed. This will involve the following considerations:
   • The task the patient is to achieve
   • The patient’s ability
   • The clinical reasoning (why is it relevant, what are you trying to achieve)
   • Alternatives
   • Patient’s position
   • The therapist’s role
   • The therapist’s position
   • Modifications
   • Hazards / risks

3. These headings are all covered in the specific protocols. The protocols may not cover all tasks. Where this is the case a procedure for carrying out the task while minimising risk should be identified and documented.

4. When completing the therapeutic risk assessment form the following should be identified:
   • The date of review
   • The task
   • The minimum skill mix
   • The therapeutic protocol to be used
   • Modifications

5. The therapeutic risk assessment should be updated as the patient’s ability changes, and the task is altered, or additional tasks added.

6. If a handler does not feel happy to do a task, they should not carry out the task (does not feel competent, recent injury, pregnancy)

PT Team, Nov 2006
Colman Centre for Specialist Rehabilitation
Flow Chart re Therapeutic Handling

Patient admitted to the ward

Assessed by Nursing staff, with or without OT and PT

Manual Handling assessment reviewed by Treating Physiotherapist

Therapeutic Risk Assessment completed by Treating Therapist

Therapeutic Risk Assessment Regularly updated as patient progresses

Manual Handling Assessment updated as patient progresses

Assessment of handling / therapy risk within the home environment prior to discharge

Discharge

Completion / Photocopy of Manual Handling risk assessment within Day Patient Notes

Review of risk within home environment as patient’s ability changes (improves or deteriorates)
THERAPEUTIC HANDLING – RISK ASSESSMENT FORM

- Date of initial assessment:
- Patient’s Name:
- Height: Estimate / subjective  Weight: Estimate/ subjective / from nursing notes
- Cognition / comprehension: NAD / Details
- Diagnosis:
- Handling constraints: None / Details
- Manual Handling Risk Assessment: None / details:

<table>
<thead>
<tr>
<th>Date of Review</th>
<th>Task</th>
<th>Minimum skill mix required</th>
<th>Name of protocol</th>
<th>Modifications (TILE) TASK, INDIVIDUAL CAPABILITY, LOAD, ENVIRONMENT</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

If not confident to carry out therapy task, DON’T do it (for example injury, pregnant, not competent)
<table>
<thead>
<tr>
<th>Date of Review</th>
<th>Task</th>
<th>Minimum skill mix required</th>
<th>Name of protocol</th>
<th>Modifications (TILE) TASK, INDIVIDUAL CAPABILITY, LOAD, ENVIRONMENT</th>
<th>Signature</th>
</tr>
</thead>
</table>

If not confident to carry out therapy task, DON’T do it (for example injury, pregnant, not competent
Index of Protocols

- Supine to sidelying with assistance provided
- Supine to sitting on edge of bed with assistance of one
- Supine to sitting on edge of bed with assistance of two
- Crouch standing transfer with supervision of one
- Crouch standing transfer with one person
- Crouch standing transfer with two people
- Sliding board transfer with supervision
- Sliding board transfer with one person
- Sliding board transfer with two people
- Sitting to standing with one person
- Sitting to standing with two people
- Ross return transfers with 1
- Ross return transfers with 2
- Standing transfer using the Encore stand aid with one people (minimum)
- Standing transfer using the Encore stand aid with two people (minimum)
- Standing transfer using the Pallas stand aid with one people (minimum)
- Standing transfer using the Pallas stand aid with two people (minimum)
- Standing transfers with supervision of one
- Standing transfers with one person
- Standing transfers with two people
- Training Family / Carers to assist with and/or supervise a transfer
- Assisted standing using the Liko Hoist with two people
- Tilt table
- Assisted standing using the Insignis Standing Frame with two people
- Stand in the Oswestry Frame with assistance of one
- Stand in the Oswestry Frame with assistance of two
- Hoisting patient from the floor
- On/off floor based on reverse chain method
- Motomed
- Transferring from MSI to bench
- Practice steps
- Stairs – full flight of stairs
## Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Supine To Side-lying with assistance provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that the patient is aware of what you are doing at all times.</td>
<td></td>
</tr>
</tbody>
</table>

| Patient’s ability | • The aim is for the patient to be as actively involved as possible in the transition from supine to side-lying  
• Able to cooperate |

| Clinical Reasoning | • To encourage weight bearing and muscle recruitment in trunk and lower limb  
• To enable side-lying in a safe environment and decrease manual handling risks  
• To maintain and prevent reduction in muscle length and strength  
• To promote confidence and reduce anxiety by providing experience of movement  
• To increase patient’s motivation and self esteem  
• To stimulate systems, e.g. bladder, bowel, cardiovascular and vestibular  
• To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments |

| Alternatives | • Glide sheet – multi (2 sheets) or Tubular  
• Cot sides on profiling bed  
• Bed lever on standard bed  
• Split bed longitudinal |

| Patient position | • The patient will lie supine on a flat bed or wide plinth with his/her body as close to the opposite edge as possible. Patient will have no more than one pillow under his/her head preferably  
• Adjust the bed to the correct working height for the following |

| Therapist’s role | • The lead therapist will be on the side that the patient is rolling to (i.e. left side)  
• The assisting person, if needed, will stand on the opposite side (i.e. right side)  
• The lead therapist will provide verbal instruction to encourage the patient to position themselves as independently as possible  
• The therapist will place the patient’s affected upper limb carefully across their chest and encourage them to hold on to it with their other hand at the elbow  
• The therapist will encourage, facilitate or flex the right knee with the foot on the bed  
• The therapist will encourage, facilitate or turn the |
The therapist will place their hands on the patient’s shoulder and hip and roll the patient towards them. If the patient is lying on their affected side, the therapist will slide their hand under the patient’s affected shoulder on to the scapula and ease the patient’s arm forward to position the affected upper limb correctly and prevent the risk of injury. The therapists can use pillows to maintain the position, one behind the patient’s back the other under the patient’s top lower limb. If the patient is lying on their unaffected side then a pillow can be placed under the affected upper limb to keep it elevated.

**Therapist’s position**
- The lead therapist will stand on the side of the bed or plinth that the patient is rolling towards.
- The bed or plinth will be raised to waist height to allow easier handling.
- The therapist’s hands should be positioned in order to facilitate the upper limb, lower limb and head.
- The assisting person on the opposite side will hold and pull the glide sheet with the cot rail down in order to roll the patient onto his/her side under the direction of the lead therapist.

**Modifications**
- As stated, the glide sheet may also be used to roll the patient on to his/her side.
- The patient may be encouraged to reach for the cot rail.

**Hazards/risks**
- Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted.
- Patient’s level of fatigue, anxiety and understanding.
- Unexpected changes in tone during the movement.
- Changes in the patient’s medical status, e.g. drop in blood pressure.
- Affected upper limb being trapped under the patient’s body or upper limb falling behind the patient’s back if on top.
- Precautions taken with the lower limb if the patient has had a total hip replacement.
- Correcting the height of the bed or plinth to protect the therapist’s back. If unable to raise then the therapist need to position him/herself, i.e. kneel/half kneel.
# Therapeutic Handling Protocols

| Task | Supine To Sitting on edge of bed with assistance of 1  
| Ensuring that the patient is aware of what you are doing at all times.  
| Ensure you gain and document consent from the patient |
|------|-------------------------------------------------|
| - The patient will be assisted from supine to side lying, and then from side lying to sitting over the edge of the bed |

| Patient’s ability | When carrying out the transfer on the patient’s own bed, ensure the patient has carried it out safely on the plinth  
| The aim is for the patient to be as actively involved as possible in the transition from supine to sitting over the edge of the bed  
| Must be able to sit with the minimal assistance of 1  
| Must be able to move from supine to side lying with assistance of 1  
| Must be able to assist pushing up from side lying to sitting  
| Able to cooperate and be aware of the goal  
| Must be medically appropriate for the patient to sit  
| Must have appropriate muscle length to enable sitting (less than 100˚ hip flexion and enough knee ROM to allow feet to be in contact with the floor)  
| Consider head control |

| Clinical Reasoning | To encourage weight bearing and muscle recruitment in trunk and lower limb  
| To encourage active participation  
| To enable moving to sitting in a safe environment and decrease manual handling risks  
| To maintain and prevent reduction in muscle length and strength  
| To promote confidence and reduce anxiety by providing experience of movement  
| To increase patient’s motivation and self esteem  
| To stimulate systems, e.g. bladder, bowel, cardiovascular and vestibular  
| To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments |

| Alternatives | Glide sheet – multi (2 sheets) or Tubular  
| Bed rails on profiling bed (for use when moving from supine to side lying)  
| Bed loop on standard bed  
| Split bed longitudinal  
<p>| Supine to sitting on edge of bed with assistance of 1 |</p>
<table>
<thead>
<tr>
<th><strong>Patient position</strong></th>
<th><strong>Therapist’s role</strong></th>
</tr>
</thead>
</table>
| • The patient will lie supine on a flat bed or wide plinth with his/her body as close to the opposite edge as possible. Patient will have no more than one pillow under his/her head preferably. | • The therapist will be in front of the patient (on the side of the bed that the patient will sit over)  
• Bed must be positioned at a suitable height for the therapist  
• Potential hazards to be identified and removed where possible  
• The therapist will provide verbal instruction to encourage the patient to position themselves as independently as possible  
• The therapist will place the patient’s affected upper limb carefully across their chest and encourage them to hold on to it with their other hand at the elbow  
• The therapist will encourage, facilitate or flex the knee so the patient’s foot is on the bed  
• The therapist will encourage, facilitate or turn the patient’s head towards them  
• The uppermost arm can be used to assist rolling  
• The therapist will place their hands on the patient’s shoulder and hip to assist the patient rolling towards them.  
• If the patient is lying on their affected side, the therapist will slide their hand under the patient’s affected shoulder on to the scapula and ease the patient’s arm forward to position the affected upper limb correctly and prevent the risk of injury  
• The therapist positions one hand to support underneath the shoulder girdle, and the other hand on the patient’s pelvis  
• The patient should be encouraged to assist in sitting up by pushing down with their hand and shoulder  
• Bed height should then be lowered so that the patient’s feet can reach the ground |

<table>
<thead>
<tr>
<th><strong>Therapist’s position</strong></th>
<th><strong>Modifications</strong></th>
</tr>
</thead>
</table>
| • The therapist will stand on the side of the bed or plinth that the patient is rolling towards  
• The bed or plinth will be raised to waist height to allow easier handling  
• The therapist’s hands should be positioned in order to facilitate the upper limb, lower limb and head | • The glide sheet may also be used to roll the patient on to his/her side  
• The patient may be encouraged to reach for the bed rail  
• A leg lifter can be used |

<table>
<thead>
<tr>
<th><strong>Hazards/risks</strong></th>
<th></th>
</tr>
</thead>
</table>
| • Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted  
• Patient’s level of fatigue, anxiety and understanding  
• Unexpected changes in tone during the movement  
• Changes in the patient’s medical status, e.g. drop in |
<table>
<thead>
<tr>
<th>blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Affected upper limb being trapped under the patient’s body or upper limb falling behind the patient’s back if on top</td>
</tr>
<tr>
<td>• Precautions taken with the lower limb if the patient has had a total hip replacement</td>
</tr>
<tr>
<td>• Correcting the height of the bed or plinth to protect the therapist’s back. If unable to raise then the therapist need to position him/herself, i.e. kneel/half kneel</td>
</tr>
</tbody>
</table>
Therapeutic Handling Protocols

| Task | Supine To Sitting on edge of bed with assistance of 2
Ensure that the patient is aware of what you are doing at all times.
Ensure you gain and document consent from the patient
• The patient will be assisted from supine to side lying, and then from side lying to sitting over the edge of the bed |

| Patient’s ability | When carrying out the transfer on the patients own bed, ensure the patient has carried it out safely on the plinth
• The aim is for the patient to be as actively involved as possible in the transition from supine to sitting over the edge of the bed
• Able to cooperate and be aware of the goal
• Must be medically appropriate for the patient to sit
• Must have appropriate muscle length to enable sitting (less than 100˚ hip flexion and enough knee ROM to allow feet to be in contact with the floor)
• Consider head control |

| Clinical Reasoning | To encourage weight bearing and muscle recruitment in trunk and lower limb
• To encourage active participation
• To enable moving to sitting in a safe environment and decrease manual handling risks
• To maintain and prevent reduction in muscle length and strength
• To promote confidence and reduce anxiety by providing experience of movement
• To increase patient’s motivation and self esteem
• To stimulate systems, e.g. bladder, bowel, cardiovascular and vestibular
• To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments |

| Alternatives | Glide sheet – multi (2 sheets) or Tubular
• Bed rails on profiling bed (for use when moving from supine to side lying)
• Bed loop on standard bed
• Split bed longitudinal |

| Patient position | The patient will lie supine on a flat bed or wide plinth with his/her body as close to the opposite edge as possible. Patient will have no more than one pillow under his/her head preferably |

| Therapist’s role | The lead therapist will be in front of the patient (on the side of the bed that the patient will sit over) |
- The second person will be on the opposite side of the bed
- Bed must be positioned at a suitable height for the therapists
- Potential hazards to be identified and removed where possible
- The lead therapist will provide verbal instruction to encourage the patient to position themselves as independently as possible
- The therapist will place the patient’s affected upper limb carefully across their chest and encourage them to hold on to it with their other hand at the elbow
- The therapist will encourage, facilitate or flex the knee so the patient’s foot is on the bed
- The therapist will encourage, facilitate or turn the patient’s head towards them
- The uppermost arm can be used to assist rolling
- The therapist will place their hands on the patient’s shoulder and hip and roll the patient towards them.
- If the patient is lying on their affected side, the therapist will slide their hand under the patient’s affected shoulder on to the scapula and ease the patient’s arm forward to position the affected upper limb correctly and prevent the risk of injury
- The person from behind positions one hand to support underneath the shoulder girdle, and the other hand on the patient’s pelvis
- The patient should be encouraged to assist in sitting up by pushing down with their hand and shoulder
- Both staff should simultaneously assist to bring the patient up into sitting
- Bed height should then be lowered so that the patient’s feet can reach the ground

<table>
<thead>
<tr>
<th>Therapist’s position</th>
<th>The lead therapist will stand on the side of the bed or plinth that the patient is rolling towards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The bed or plinth will be raised to waist height to allow easier handling</td>
</tr>
<tr>
<td></td>
<td>The therapist’s hands should be positioned in order to facilitate the upper limb, lower limb and head</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modifications</th>
<th>The glide sheet may also be used to roll the patient on to his/her side</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The patient may be encouraged to reach for the bed rail</td>
</tr>
<tr>
<td></td>
<td>A leg lifter can be used</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hazards/risks</th>
<th>Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient’s level of fatigue, anxiety and understanding</td>
</tr>
<tr>
<td></td>
<td>Unexpected changes in tone during the movement</td>
</tr>
<tr>
<td></td>
<td>Changes in the patient’s medical status, e.g. drop in blood pressure</td>
</tr>
<tr>
<td></td>
<td>Affected upper limb being trapped under the patient’s body or upper limb falling behind the patient’s back if on</td>
</tr>
<tr>
<td>top</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>• Precautions taken with the lower limb if the patient has had any orthopaedic surgery</td>
<td></td>
</tr>
<tr>
<td>• Correcting the height of the bed or plinth to protect the therapist’s back. If unable to raise then the therapist need to position him/herself, i.e. kneel/half kneel</td>
<td></td>
</tr>
</tbody>
</table>
The Colman Centre for Specialist Rehabilitation Services

Therapeutic Handling Protocol

<table>
<thead>
<tr>
<th>Task</th>
<th>Crouch Standing Transfer with Supervision of One</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Ensure that the patient is aware of what you are doing at all times.</em></td>
</tr>
</tbody>
</table>
| Patient’s Ability | • Able to sit unsupported with a functional reach  
|                  | • Able to sit at edge of chair  
|                  | • Feet can be placed on the floor  
|                  | • Able to initiate sit to stand  
|                  | • Able to weight transfer in crouch standing |
| Clinical Reasoning | • To encourage/increase patient involvement to achieve rehabilitation aims  
|                  | • To increase ability to weightbear through limbs  
|                  | • To give experience of movement  
|                  | • To experience awareness of the affected side |
| Alternatives | • Hoist  
|              | • Sliding board with, or without, a sliding sheet  
|              | • Use of a turntable, although often the support is too small to utilise this  
|              | • Therapist may have to manually facilitate transfer |
| Patient Position | • The patient may be perched, sitting on the edge of the bed, a wheelchair or ward chair with one therapist in front and one behind  
|             | • Patient’s feet should be flat on the floor  
|             | • Arms may be reaching forwards bilaterally or reaching to the new surface |
| Therapist’s Role | • The therapist should be positioned at the front or the side as for transfers with one  
|                 | • The therapist can use verbal facilitation to ensure a safe manoeuvre and appropriate weight transfer |
| Modifications | • The degree of patient trunk flexion, extension facilitated by the therapist may be varied  
|                | • Patient’s feet can be placed in a step position  
|                | • Direction of the transfer to the left or right |
| Hazards/risks | • Different surface heights  
|               | • Tonal changes during the transfer  
|               | • The new surface, e.g. the mattress, may move during the transfer  
|               | • The level of co-operation may change during the transfer |
## Therapeutic Handling Protocol

### Task  
**Crouch Standing Transfer with One Person**
*Ensure that the patient is aware of what you are doing at all times*

### Patient’s Ability
- Able to sit unsupported and forward reach
- Can lift bottom off the supporting surface and hold for 5 seconds
- Able to edge sit with the assistance of one
- Feet can be placed on the floor
- Can weight bear and control knees in crouch standing
- Able to initiate sit to stand with the assistance of one
- Able to assist with weight transfer in crouch standing with assistance from in front and behind
- The aim is for the patient to be actively involved with the transfer and for the staff to be guiding through the movement, not for the patient to be physically lifted between the two transferring surfaces by the staff. If this is the case, an alternative method should be used.

### Clinical Reasoning
- To encourage/increase patient involvement to achieve rehabilitation aims
- To increase ability to weight bear through limbs
- To give experience of movement
- To experience awareness of the affected side

### Alternatives
- Hoist
- Sliding board, with or without a sliding sheet
- Use of a turntable, although often the support is too small to utilise this

### Patient Position
- The patient may be perched, sitting on the edge of the bed, a wheelchair or ward chair with one therapist in front and one behind.
- Patient’s feet should be placed flat on the floor
- Patient’s arms may be across their body, reaching to the new surface or by the patient’s side

### Therapist’s Role
- The therapist is front or side
- The lead therapist initiates movement of facilitation of the patient coming forwards and guiding them round to the bed/chair, controlling the transfer process and facilitation extensor recruitment

### Therapist’s Position
- Therapists hands are positioned so they are able to control the trunk and facilitate forward weight transference, e.g. using the lower ribs
- The patient could be wearing a handling belt to assist the therapist with the facilitation
<table>
<thead>
<tr>
<th>Modifications</th>
<th>Hazards/Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If possible, remove the back of the chair or wheelchair to ensure easy access to the patient</td>
<td>• Flexed and rotated position of the therapist</td>
</tr>
<tr>
<td>• The degree of patient trunk flexion, extension facilitated by the therapist may be varied</td>
<td>• The therapist may have an unstable base of support</td>
</tr>
<tr>
<td>• Patient's feet can be placed in a step position</td>
<td>• Different surface heights</td>
</tr>
<tr>
<td>• Direction of the transfer to the left or right</td>
<td>• Tonal changes during the transfer</td>
</tr>
<tr>
<td>• The therapist may vary their hand position</td>
<td>• Care of tracheostomies during the transfer</td>
</tr>
<tr>
<td></td>
<td>• The new surface, e.g. the mattress, may move during the transfer</td>
</tr>
<tr>
<td></td>
<td>• The level of co-operation may change during the transfer</td>
</tr>
</tbody>
</table>
## Therapeutic Handling Protocol

<table>
<thead>
<tr>
<th>Task</th>
<th>Crouch Standing Transfer with Two People</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient’s Ability</strong></td>
<td>Ensure that patient is aware of what you are doing at all times</td>
</tr>
<tr>
<td></td>
<td>• Able to sit unsupported and forward reach</td>
</tr>
<tr>
<td></td>
<td>• Can lift bottom off the supporting surface and hold for 5 seconds</td>
</tr>
<tr>
<td></td>
<td>• Able to edge sit with the assistance of one</td>
</tr>
<tr>
<td></td>
<td>• Feet can be placed on the floor</td>
</tr>
<tr>
<td></td>
<td>• Can weightbear and control knees in crouch standing</td>
</tr>
<tr>
<td></td>
<td>• Able to initiate sit to stand with the assistance of one</td>
</tr>
<tr>
<td></td>
<td>• Able to assist with weight transfer in crouch standing with assistance from in front and behind</td>
</tr>
<tr>
<td></td>
<td>• The aim is for the patient to be actively involved with the transfer and for the staff to guiding through the movement, not for the patient to be physically lifted between the two transferring surfaces by the staff. If this is the case, an alternative method should be used</td>
</tr>
<tr>
<td><strong>Clinical Reasoning</strong></td>
<td>• To encourage/increase patient involvement to achieve rehabilitation aims</td>
</tr>
<tr>
<td></td>
<td>• To increase ability to weightbear through limbs</td>
</tr>
<tr>
<td></td>
<td>• To give experience of movement</td>
</tr>
<tr>
<td></td>
<td>• To experience awareness of the affected side</td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
<td>• Hoist</td>
</tr>
<tr>
<td></td>
<td>• Sliding board, with or without a sliding sheet</td>
</tr>
<tr>
<td></td>
<td>• Use of a turntable, although often the support is too small to utilise this</td>
</tr>
<tr>
<td><strong>Patient Position</strong></td>
<td>• The patient may be perched, sitting on the edge of the bed, a wheelchair or ward chair with one therapist in front and one behind.</td>
</tr>
<tr>
<td></td>
<td>• The patient’s feet should be placed flat on the floor</td>
</tr>
<tr>
<td></td>
<td>• Patient’s arms may be across their body or reaching to the new surface</td>
</tr>
<tr>
<td><strong>Therapist’s Role</strong></td>
<td>• The therapist in front is the leader of the transfer, initiating movement of facilitation of the patient coming forwards and guiding them round to the bed/chair, controlling the transfer process and facilitating extensor recruitment</td>
</tr>
<tr>
<td></td>
<td>• The therapist behind guides or minimally assists the patient between the two transferring surfaces, ensuring there is enough room for their own position to be</td>
</tr>
</tbody>
</table>
maintained throughout the transfer.

- Therapists may choose to place one knee on the bed

<table>
<thead>
<tr>
<th>Therapist's Positions</th>
<th>Therapist in front should position their hands so they are able to control the trunk and facilitate forward weight transference, e.g. using the lower ribs. The patient could also be wearing a handling belt.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The therapist behind should position hands so they are able to control the trunk and facilitate forward weight transference, e.g., using the lower ribs. The patient could also be wearing a handling belt</td>
</tr>
</tbody>
</table>
## Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Sliding Board Transfer with Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient’s Ability</strong></td>
<td>Ensure that the patient knows what you are doing at all times</td>
</tr>
<tr>
<td></td>
<td>• Able to be flexed forward in trunk</td>
</tr>
<tr>
<td></td>
<td>• Able to place feet on floor</td>
</tr>
<tr>
<td></td>
<td>• Able to set up wheelchair for transfer, i.e. position chair, apply brakes, remove armrests and footplates</td>
</tr>
<tr>
<td></td>
<td>• Able to place sliding board</td>
</tr>
<tr>
<td></td>
<td>• Able to place own arm</td>
</tr>
<tr>
<td></td>
<td>• Able to move towards placed arm transferring bottom across board</td>
</tr>
<tr>
<td></td>
<td>• Able to remove board and maintain unsupported sitting balance</td>
</tr>
<tr>
<td><strong>Clinical Reasoning</strong></td>
<td>To promote independence and self confidence</td>
</tr>
<tr>
<td></td>
<td>• To encourage weight bearing and muscle recruitment</td>
</tr>
<tr>
<td></td>
<td>• To improve sense of movement and dynamic sitting balance</td>
</tr>
<tr>
<td></td>
<td>• To increase awareness of affected side</td>
</tr>
<tr>
<td></td>
<td>• To encourage safety awareness</td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
<td>Hoist</td>
</tr>
<tr>
<td></td>
<td>Lyco</td>
</tr>
<tr>
<td></td>
<td>Stand-Aid</td>
</tr>
<tr>
<td></td>
<td>Turntable</td>
</tr>
<tr>
<td></td>
<td>Transfer with one</td>
</tr>
<tr>
<td><strong>Patient Position</strong></td>
<td>Sitting on edge of supporting surface, feet firmly on floor, patient places sliding board under bottom and to surface to which being transferred. Patient reaches toward direction of transfer, using arm as support and lever to slide across the board to the new surface.</td>
</tr>
<tr>
<td><strong>Therapist position</strong></td>
<td>Standing or sitting close enough to patient to assist if necessary, but generally only observing and/or making suggestions</td>
</tr>
<tr>
<td><strong>Modifications</strong></td>
<td>Use of glide sheet</td>
</tr>
<tr>
<td></td>
<td>Use of rail or wheelchair armrest to pull on to complete transfer</td>
</tr>
<tr>
<td><strong>Modifications</strong></td>
<td>The degree of patient trunk flexion, extension facilitated by the therapist may be varied</td>
</tr>
<tr>
<td></td>
<td>Patient’s feet can be placed in a step position</td>
</tr>
<tr>
<td></td>
<td>Direction of the transfer to the left or right</td>
</tr>
<tr>
<td>Hazards/risks</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• The front therapist may vary their hand position</td>
<td></td>
</tr>
<tr>
<td>• Any drains or lines in situ</td>
<td></td>
</tr>
<tr>
<td>• Flexed and rotated position of the therapist behind</td>
<td></td>
</tr>
<tr>
<td>• The therapist behind may have an unstable base of support</td>
<td></td>
</tr>
<tr>
<td>• Different surface heights</td>
<td></td>
</tr>
<tr>
<td>• Tonal changes during the transfer</td>
<td></td>
</tr>
<tr>
<td>• Care of tracheostomies during transfer</td>
<td></td>
</tr>
<tr>
<td>• The new surface, e.g. the mattress, may move during the transfer</td>
<td></td>
</tr>
<tr>
<td>• The level of co-operation may change during the transfer</td>
<td></td>
</tr>
</tbody>
</table>
## Therapeutic Handling Protocols

| Task | Sliding Board Transfers with one person

*Ensure that the patient knows what you are doing at all times*

| Patient’s Ability | • Able to sit on bed or plinth
• Able to be flexed forward in trunk
• Can place feet on the floor
• One arm can be placed in the direction of movement and maintained
• Able to consistently co-operate with the transfer |

| Clinical Reasoning | • To increase patient’s motivation and self-esteem
• To encourage weight bearing and muscle recruitment
• To improve dynamic sitting balance
• To gain experience of movement |

| Alternatives | • Hoist
• Lyco
• Stand-Aid
• Turntable
• Sliding board transfer with two |

| Patient Position | Sitting over edge of supporting surface, feet firmly on the floor, sliding board placed securely under the patient’s bottom and across to the surface to which the transfer is being made, preferably downhill. Patient’s leading arm should be reaching in direction of the transfer. The other arm is supported as necessary. |

| Therapist Position | Therapist in front with feet and knees blocking patient’s feet and knees as appropriate, either from standing or from stool. Hands placed on patient’s lower trunk/pelvis as necessary to assist with the movement, but not lifting. |

| Modifications | • Use of handling belt
• Use of glide sheet |
## Therapeutic Handling Protocols

<table>
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<tr>
<th>Task</th>
<th>Sliding Board Transfers with two people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ensure that the patient knows what you are doing at all times!</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s Ability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Able to sit on bed or plinth with minimal assistance of one</td>
<td></td>
</tr>
<tr>
<td>• Able to be flexed forward in trunk</td>
<td></td>
</tr>
<tr>
<td>• Feet can be placed on the floor</td>
<td></td>
</tr>
<tr>
<td>• One arm can be placed in the direction of movement</td>
<td></td>
</tr>
<tr>
<td>• Able to co-operate with the transfer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Reasoning</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• To gain experience of movement and awareness of affected side, if appropriate</td>
<td></td>
</tr>
<tr>
<td>• To encourage weight bearing and muscle recruitment</td>
<td></td>
</tr>
<tr>
<td>• To increase patient’s motivation and self-esteem</td>
<td></td>
</tr>
<tr>
<td>• To improve dynamic sitting balance</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternatives</th>
<th></th>
</tr>
</thead>
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<td>• Hoist</td>
<td></td>
</tr>
<tr>
<td>• Lyco</td>
<td></td>
</tr>
<tr>
<td>• Stand aid</td>
<td></td>
</tr>
<tr>
<td>• Turntable</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Position</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Perch sitting over edge of supporting surface, feet flat on the floor, if possible, sliding board placed securely under patient’s bottom and across to the surface to which the transfer is being made, preferably downhill.</td>
<td></td>
</tr>
<tr>
<td>Patient’s arms: Arm reaching in the direction of the transfer, other arm supported as necessary.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapist Position</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist in front is leading the transfer and gives direction to the therapist behind. The therapist in front blocks the knees or feet of the patient with their knees and/or feet as necessary. Hands may be placed on patient’s pelvis, lower trunk or under gluteal fold of ischial tuberosities to guide. Therapist behind may be supporting the trunk or also having their hands around the pelvis to guide the movement, not lifting. The therapist behind may have one knee on the surface to which the transfer is being made.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modification(s)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use of handling belt</td>
<td></td>
</tr>
<tr>
<td>• Use of glide sheet</td>
<td></td>
</tr>
<tr>
<td>• Additional people if more support is needed for tubes, head control or tracheostomy supervision</td>
<td></td>
</tr>
</tbody>
</table>
# Therapeutic Handling Protocols

| Task | Sitting to standing with assistance of 1  
Ensure that the patient is aware of what you are doing at all times.  
Ensure you gain and document consent from the patient |
|---|---|
| **Patient’s ability** | • Able to cooperate  
• Must have independent dynamic sitting balance and righting reactions  
• Must have active head control  
• Aim is for the patient to be actively involved in the sit to stand and for the therapist to be guiding throughout the movement, not for the patient to be physically lifted |
| **Clinical Reasoning** | • To encourage weight bearing and muscle recruitment in trunk and lower limb  
• To promote functional independence by encouraging active participation to allow: lower half dressing, toileting, pressure relief, preparation for transfers  
• To maintain and prevent reduction in muscle length and strength  
• To promote confidence and reduce anxiety by providing experience of movement  
• To increase patient’s motivation and self esteem  
• To stimulate systems, e.g. bladder, bowel, cardiovascular and vestibular  
• To increase level of awareness of consciousness, sensory, visual  
• To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments |
| **Alternatives** | • Insignis standing frame  
• Assisted standing using the Liko hoist  
• Oswestry standing frame  
• Sitting to standing with assistance of 2 |
| **Patient position** | • The patient will be sitting, positioned towards the edge of the bed or wheelchair  
• Patients feet must be on the floor  
• Patients arms may be at the patients side, held by the therapist in order to facilitate activity, on the plinth or the arms of the chair, or reaching to a surface in front |
| **Therapist’s role** | • The therapist initiates the movement of the patient coming forwards, guiding them upwards controlling the |
transfer process, maintaining alignment and facilitating recruitment of extension
- The therapists hands can be positioned to:
  - control the trunk and facilitate forward weight transference by using either the lower ribs laterally, the pelvis from behind, or the sternum
  - facilitate knee extension for example hands on lower quadriceps or gluteal region

<table>
<thead>
<tr>
<th>Therapist’s position</th>
<th>The therapist can stand at the patient’s affected side or behind or in front of the patient</th>
</tr>
</thead>
</table>
| Modifications        | Use of a handling belt
                     | Patients feet can be placed in a step position
                     | Foot position to have Therapeutic effect e.g. one forward |
| Hazards/risks        | Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted
                     | Patient’s level of fatigue, anxiety and understanding
                     | Unexpected changes in tone during the movement
                     | Changes in the patient’s medical status, e.g. drop in blood pressure
                     | Attachments e.g. Catheters
                     | Flexed position of either therapist
                     | Tonal changes during stand
                     | Potential for unstable base of support of the therapist dependent on their position |
# Therapeutic Handling Protocols

| Task | Sitting to standing with assistance of 2  
*Ensure that the patient is aware of what you are doing at all times.*  
*Ensure you gain and document consent from the patient* |
|---|---|
| **Patient’s ability** | • Able to co-operate cueing into the automatic  
• Must have some sitting balance and beginning of some righting reactions  
• Must have active head control  
• Aim is for the patient to be actively involved in the sit to stand and for the therapists to be guiding throughout the movement, not for the patient to be physically lifted |
| **Clinical Reasoning** | • To encourage weight bearing and muscle recruitment in trunk and lower limb  
• To promote functional independence by encouraging active participation to allow: lower half dressing, toileting, pressure relief, preparation for transfers  
• To maintain and prevent reduction in muscle length and strength  
• To promote confidence and reduce anxiety by providing experience of movement  
• To increase patient’s motivation and self esteem  
• To stimulate systems, e.g. bladder, bowel, cardiovascular and vestibular  
• To increase level of awareness of consciousness, sensory, visual  
• To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments |
| **Alternatives** | • Tilt table  
• Insignis standing frame  
• Assisted standing using the Liko hoist  
• Oswestry standing frame  
• Sitting to standing with assistance of 1 |
| **Patient position** | • The patient will be sitting, positioned towards the edge of the bed or wheelchair  
• Patients feet must be on the floor  
• Patients arms may be at the patients side, held by the therapist in order to facilitate activity, on the plinth or the arms of the chair, or reaching to a surface in front |
| **Therapist’s role** | • One therapist is the lead of the manoeuvre  
• The therapists initiate the movement of the patient coming forwards, guiding them upwards controlling the
**Transfer process, maintaining alignment and facilitating recruitment of extension**

- The therapists hands can be positioned to:
  - control the trunk and facilitate forward weight transference by using either the lower ribs laterally, the pelvis from behind, or the sternum. Consider key points of movement
  - facilitate knee extension for example hands on lower quadriceps or gluteal region

<table>
<thead>
<tr>
<th>Therapist's position</th>
<th>One therapist can stand each side of the patient. Alternatively one therapist can stand at the patients affected side with one behind or in front</th>
</tr>
</thead>
</table>
| Modifications        | Use of a handling belt                          
|                      | Alter bed height – accordingly for therapeutic reasons                                         
|                      | Patients feet can be placed in a step position                                                  |
| Hazards/risks        | Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted  
|                      | Patient's level of fatigue, anxiety and understanding                                           
|                      | Unexpected changes in tone during the movement                                                   
|                      | Changes in the patient's medical status, e.g. drop in blood pressure                            
|                      | Attachments e.g. Catheters                                                                       
|                      | Flexed position of either therapist                                                              
|                      | Tonal changes during stand                                                                       
|                      | Potential for unstable base of support of the therapist dependent on their position              |
## Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Ross Return Transfers with 1</th>
</tr>
</thead>
</table>
|      | **Ensure the patient knows what you are doing at all times**  
      | **Ensure you gain and document consent from the patient**    |
| Patient’s Ability | • Patient to be cognitively able to participate in the transfer  
                  | • Patient to be able to pull themselves into standing with their arms |
| Clinical Reasoning | • To enable the patient to increase their functional independence to allow toileting, bed to chair/wheelchair transfers  
                      • To maintain and prevent reduction in muscle length and strength  
                      • To encourage weight bearing and muscle recruitment  
                      • To promote confidence and reduce anxiety by providing experience of movement  
                      • To increase patient’s motivation and self esteem  
                      • To stimulate systems, e.g. bladder, bowel, cardiovascular and vestibular  
                      • To decrease undesirable compensations, to improve movement deficits and to prevent further secondary impairments |
| Patient’s Role and Position | • The patient will be sitting, positioned towards the edge of the supporting surface, e.g. plinth, wheelchair, etc.  
                                      • The patient will place their feet on the footplate of the Ross Return with the knees positioned at the knee rests.  
                                      • The patients will position their hand(s) on the bar of the Ross return  
                                      • The patient will pull up with their hand(s) into standing  
                                      • The patients will lower themselves onto the surface they have been transferred to |
| Application of Equipment | • The knee rests should be adjusted to the patient.  
                           • The height of the handle should be adjusted to the patient  
                           • The two transfer surfaces should be placed at 90˚ to each other |
| Therapist’s Role and Position | • The therapist will position the Ross Return in front of the patients’ feet.  
                                      • If necessary they will assist the patient placing their feet on the footplate and their hand(s) onto the handle  
                                      • The therapist will apply the breaks and use their foot to anchor the Ross Return  
                                      • The therapist will remove the breaks and turn the Ross Return 90˚ so the patient is in front of the surface they }
are transferring to, then will apply the breaks and anchor the Ross Return
  • Once the patient is seated the therapist may help to release the hand(s) from the handle and the feet from the footplate if necessary.
  • The breaks can then be released and the Ross Return wheeled away

<table>
<thead>
<tr>
<th>Modifications</th>
<th>Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The patient may be able to use one hand only, for example, in the case of a patient with a non-functional hemiplegic arm</td>
</tr>
<tr>
<td></td>
<td>Use of the hip strap</td>
</tr>
<tr>
<td></td>
<td>Use of a handling belt</td>
</tr>
<tr>
<td></td>
<td>Standaid (Encore/Pallas) with 1/2</td>
</tr>
<tr>
<td></td>
<td>Ross Return Transfers with 2</td>
</tr>
<tr>
<td></td>
<td>Crouch Transfer with 1/2</td>
</tr>
<tr>
<td></td>
<td>Standing Transfer with 1/2</td>
</tr>
</tbody>
</table>

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<tr>
<th>Hazards/Risks</th>
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</tr>
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<tbody>
<tr>
<td></td>
<td>Appropriate footwear for the patient, or if none available, bare feet (danger of exposed skin)</td>
</tr>
<tr>
<td></td>
<td>Patient fatigue</td>
</tr>
<tr>
<td></td>
<td>Unexpected changes in tone during the transfer</td>
</tr>
<tr>
<td></td>
<td>Changes in patient co-operation and behaviour during the transfer</td>
</tr>
<tr>
<td></td>
<td>Additional assistance required if there are drains/lines in situ which need to move with the patient</td>
</tr>
<tr>
<td></td>
<td>Changes in the patient’s medical status during the transfer, e.g. a drop in blood pressure which leads to fainting</td>
</tr>
</tbody>
</table>
### Therapeutic Handling Protocols

| Task | Ross Return Transfers with 2  
|---|---  
| Ensure the patient knows what you are doing at all times  
| Ensure you gain and document consent from the patient |  
| Patient’s Ability |  
| | • Able to sit to stand with assistance of 1  
| | • Able to maintain standing balance with assistance of 1  
| | • Patient to be cognitively able to participate in the transfer  
| | • Patient to be actively involved in the pulling up and sitting down |  
| Clinical Reasoning |  
| | • To progress from stand aid  
| | • To enable the patient to increase their functional independence to allow toileting, bed to chair/wheelchair transfers – to enable transfers in smaller spaces where stand aid is not possible  
| | • To maintain and prevent reduction in muscle length and strength  
| | • To encourage weight bearing and muscle recruitment  
| | • To promote confidence and reduce anxiety by providing experience of movement  
| | • To increase patient’s motivation and self esteem  
| | • To stimulate systems, e.g. bladder, bowel, cardiovascular and vestibular  
| | • To decrease undesirable compensations, to improve movement deficits and to prevent further secondary impairments |  
| Patient’s Role and Position |  
| | • The patient will be sitting, positioned towards the edge of the supporting surface, e.g. plinth, wheelchair, etc.  
| | • The patient will assist to place their feet on the footplate of the Ross Return with the knees positioned at the knee rests  
| | • The patients will position their hand(s) on the bar of the Ross return with assistance from the second therapist  
| | • The patient will pull up with their hand(s) into standing  
| | • The patients will lower themselves onto the surface they have been transferred to |  
| Application of Equipment |  
| | • The knee rests should be adjusted to the patient.  
| | • The height of the handle should be adjusted to the patient  
| | • The two transfer surfaces should be placed at 90° to each other |  
| Therapist’s Role and Position |  
| | • One lead therapist should be positioned opposite the patient and will manoeuvre the Ross Return. The other therapist should be at the patients weaker side  
| | • The lead therapist manoeuvring the Ross Return will |
position it in front of the patients’ feet. The second therapist will assist the patient placing their feet on the footplate.

- The lead therapist will apply the breaks and use their foot to anchor the Ross Return
- The second therapist will assist the patient placing their hand(s) on the handle
- The lead therapist will remove the breaks and turn the Ross Return 90° so the patient is in front of the surface they are transferring to, then will apply the breaks and anchor the Ross Return
- Once the patient is seated the second therapist will help to release the hand(s) from the handle and the feet from the footplate if necessary.
- The breaks can then be released and the Ross Return wheeled away

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</tr>
<tr>
<td>Standaid (Encore/Pallis) with 2</td>
</tr>
<tr>
<td>Ross Return Transfers with 1</td>
</tr>
<tr>
<td>Crouch Transfer with 1/2</td>
</tr>
<tr>
<td>Standing Transfer with 1/2</td>
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<td>Changes in patient co-operation and behaviour during the transfer</td>
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<tr>
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<td>Changes in the patient’s medical status during the transfer, e.g. a drop in blood pressure which leads to fainting</td>
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</table>
### Therapeutic Handling Protocols

**Task**

**Standing transfer using the Encore Stand Aid with 1 person**

*Ensure that the patient is aware of what you are doing at all times*

*Ensure you gain and document consent from the patient*

<table>
<thead>
<tr>
<th>Patient’s ability</th>
<th>Clinical Reasoning</th>
<th>Patient position</th>
<th>Transfer process and therapist position</th>
</tr>
</thead>
</table>
| • Able to be flexed forward in the trunk  
• Feet can be placed on the floor  
• Able to co-operate with the process  
• Able to tolerate modified standing  
• Able to edge sit with the assistance of 1  
• Reasonable upper body strength to help support their weight on the arm rests  
• Sufficient lower limb strength to support the body in a modified standing position  
• Sufficient ROM at the lower limbs must have no more than 15° flexion contracture shortening at hips/knee  
• Must be able to lie/ sit with assistance of 1 (see separate protocol) | • Supports arms better than Pallas  
• To encourage weight bearing and muscle recruitment in trunk and lower limbs  
• To enable the patient to increase their functional independence to allow toileting, bed to chair/wheelchair transfers  
• To enable standing in a safe environment and decrease manual handling risks  
• To maintain and prevent reduction in muscle length and strength  
• To promote confidence and reduce anxiety by providing experience of movement  
• To increase patient’s motivation and self esteem  
• To stimulate systems e.g. bladder, bowel, cardiovascular and vestibular  
• To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments | The patient may be stood either from the wheelchair, bed or treatment plinth. A sling of correct size for the patient should be fitted | For the first time of use positioning of the knee rest will have to be identified, and these positions noted.  
• The Encore should be wheeled up to the patient where they should lift their feet to place them on the footplate with assistance if necessary. The breaks should be on going up, off coming down with encore only  
• Therapist should control the Encore  
• The patient should place their arms on the rests with assistance if...
necessary

- The sling can then be linked up to the Encore by passing the cords of the Encore through the sling and pulled simultaneously to bring the patient forwards.
- When the patient is ready the therapist should give the patient warning and then use the controller so the patient is moved into a modified standing position.
- Once the patient is safely standing the therapist can move the Encore to bring the patient in front of the surface they are to be transferred to.
- The patient should then be warned and lowered to the new surface.
- Once the patient is safely seated the sling should be released from the Encore, the patient given assistance (if necessary) to lift their feet up from the footplate and the Encore taken away.
- The sling can then be removed.

**Modifications**

- The sling with the leg straps can be used.

**Hazards / risks**

- Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted.
- Wear and tear of the sling/cords of the Encore.
- Appropriate footwear for the patient.
- Patient fatigue.
- Unexpected changes in tone during the movement.
- Changes in the patient’s medical status during the standing e.g. drop in BP.
- A patient not standing/sitting in time with the Encore.

**Alternatives**

- Hoist.
- Pallas standaid.
# Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Standing transfer using the Encore Stand Aid with 2 persons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Ensure that the patient is aware of what you are doing at all times</em></td>
</tr>
<tr>
<td></td>
<td><em>Ensure you gain and document consent from the patient</em></td>
</tr>
</tbody>
</table>

| Patient’s ability                           | • Able to be flexed forward in the trunk  |
|                                           | • Feet can be placed on the floor  |
|                                           | • Able to co-operate with the process  |
|                                           | • Able to tolerate modified standing  |
|                                           | • Able to edge sit with the assistance of 2  |
|                                           | • Reasonable upper body strength to help support their weight on the arm rests  |
|                                           | • Sufficient lower limb strength to support the body in a modified standing position  |
|                                           | • Sufficient ROM at the lower limbs must have no more than 15° flexion contracture shortening at hips/knee  |
|                                           | • Must be able to lie/sit with assistance of 2  |

| Clinical Reasoning                         | • Supports arms better than Pallas  |
|                                           | • To encourage weight bearing and muscle recruitment in trunk and lower limbs  |
|                                           | • To enable the patient to increase their functional independence to allow toileting, bed to chair/wheelchair transfers  |
|                                           | • To enable standing in a safe environment and decrease manual handling risks  |
|                                           | • To maintain and prevent reduction in muscle length and strength  |
|                                           | • To promote confidence and reduce anxiety by providing experience of movement  |
|                                           | • To increase patient’s motivation and self esteem  |
|                                           | • To stimulate systems e.g. bladder, bowel, cardiovascular and vestibular  |
|                                           | • To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments  |

| Patient position                          | The patient may be stood either from the wheelchair, bed or treatment plinth. A sling of correct size for the patient should be fitted  |

<table>
<thead>
<tr>
<th>Transfer process and therapist position</th>
<th>For the first time of use positioning of the knee rest will have to be identified, and these positions noted.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The Encore should be wheeled up to the patient where they should lift their feet to place them on the footplate with assistance if necessary. The breaks should be on going up, off coming down with encore only</td>
</tr>
<tr>
<td></td>
<td>• One therapist should be at the patients weaker side and one should be controlling/manoeuvring the Encore</td>
</tr>
</tbody>
</table>
• The patient should place their arms on the rests with assistance if necessary
• The sling can then be linked up to the Encore by passing the cords of the Encore through the sling and pulled simultaneously to bring the patient forwards.
• When the patient is ready the therapist should give the patient warning and then use the controller so the patient is moved into a modified standing position
• Once the patient is safely standing the therapist can move the Encore to bring the patient in front of the surface they are to be transferred to
• The patient should then be warned and lowered to the new surface
• Once the patient is safely seated the sling should be released from the Encore, the patient given assistance (if necessary) to lift their feet up from the footplate and the Encore taken away.
• The sling can then be removed

Modifications
• The sling with the leg straps can be used

Hazards / risks
• Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted.
• Wear and tear of the sling/cords of the Encore
• Appropriate footwear for the patient
• Patient fatigue
• Unexpected changes in tone during the movement
• Changes in the patient’s medical status during the standing e.g. drop in BP
• A patient not standing/ sitting in time with the Encore.

Alternatives
• Hoist
• Pallas standaid
## Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Standing transfer using the Pallas Stand Aid with 1 person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ensure that the patient is aware of what you are doing at all times</td>
</tr>
</tbody>
</table>

### Patient’s ability

- Able to be flexed forward in the trunk
- Feet can be placed on the floor
- Able to co-operate with the process
- Able to tolerate modified standing
- Able to edge sit with the assistance of 1
- Reasonable upper limb ROM/strength to be able to hold onto the arms of the standaid
- Sufficient lower limb strength to support the body in a modified standing position
- Sufficient ROM at the lower limbs must have no more than 15° flexion contracture/ shortening at hip/knee
- Must be able to lie/sit with 1 – see separate protocol

### Clinical Reasoning

- To encourage weight bearing and muscle recruitment in trunk and lower limbs
- To enable the patient to increase their functional independence to allow toileting, bed to chair/wheelchair transfers
- To enable standing in a safe environment and decrease manual handling risks
- To maintain and prevent reduction in muscle length and strength
- To promote confidence and reduce anxiety by providing experience of movement
- To increase patient’s motivation and self esteem
- To stimulate systems e.g. bladder, bowel, cardiovascular and vestibular
- To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments

### Patient position

The patient may be stood either from the wheelchair, bed or treatment plinth. A sling of correct size for the patient should be fitted

### Transfer process and therapist position

For the first time of use positioning of the knee rest will have to be identified, and these positions noted.

- The Pallas should be wheeled up to the patient where they should lift their feet to place them on the footplate with assistance if necessary. If transferring from a wheelchair, the breaks should be on. The knee strap should be fastened and tightened
- 1 therapist to control Pallas
- The patient should reach their hands to the arms of the standaid with assistance if necessary
• The sling can then be linked up to the Encore by hooking the correct coloured loops onto the handles of the standaid. The choice of coloured loop depends on how far the patient will go into a stand
• When the patient is comfortable the therapist should give the patient warning and then use the controller so the patient is moved into a modified standing position
• Once the patient is safely standing the therapist can move the Pallas to bring the patient in front of the surface they are to be transferred to
• The patient should then be warned and lowered to the new surface
• Once the patient is safely seated the sling should be unhooked from the Pallas, the knee strap released, the patient given assistance (if necessary) to lift their feet up from the footplate and the Pallas taken away.
• The sling can then be removed

| Modifications          | Posterior sling
|                       | The sling with the leg straps can be used

| Hazards / risks        | Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted.
|                       | Wear and tear of the sling
|                       | Appropriate footwear for the patient
|                       | Patient fatigue
|                       | Unexpected changes in tone during the movement
|                       | Changes in the patient’s medical status during the standing e.g. drop in BP
|                       | A Patient not standing/sitting in time with the Encore

| Alternatives           | Hoist
|                       | Encore standaid
# Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Standing transfer using the Pallas Stand Aid with 2 people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ensure that the patient is aware of what you are doing at all times</td>
</tr>
<tr>
<td></td>
<td>Ensure you gain and document consent from the patient</td>
</tr>
</tbody>
</table>

### Patient’s ability
- Able to be flexed forward in the trunk
- Feet can be placed on the floor
- Able to co-operate with the process
- Able to tolerate modified standing
- Able to edge sit with the assistance of 2
- Reasonable upper limb ROM/strength to be able to hold onto the arms of the standaid
- Sufficient lower limb strength to support the body in a modified standing position
- Sufficient ROM at the lower limbs must have no more than 15° flexion contracture/shortening at hip/knee
- Must be able to lie/sit with 2 see separate protocol

### Clinical Reasoning
- To encourage weight bearing and muscle recruitment in trunk and lower limbs
- To enable the patient to increase their functional independence to allow toileting, bed to chair/wheelchair transfers
- To enable standing in a safe environment and decrease manual handling risks
- To maintain and prevent reduction in muscle length and strength
- To promote confidence and reduce anxiety by providing experience of movement
- To increase patient’s motivation and self esteem
- To stimulate systems e.g. bladder, bowel, cardiovascular and vestibular
- To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments

### Patient position
The patient may be stood either from the wheelchair, bed or treatment plinth. A sling of correct size for the patient should be fitted.

### Transfer process and therapist position
For the first time of use positioning of the knee rest will have to be identified, and these positions noted.

- The Pallas should be wheeled up to the patient where they should lift their feet to place them on the footplate with assistance if necessary. If transferring from a wheelchair, the breaks should be on. The knee strap should be fastened and tightened
- One therapist should be at the patients weaker side and one should be controlling/manoeuvring the Pallas
- The patient should reach their hands to the arms of the standaid with assistance if necessary
- The sling can then be linked up to the Encore by hooking the correct coloured loops onto the handles of the standaid. The choice of coloured loop depends on how far the patient will go into a stand.
- When the patient is comfortable the therapist should give the patient warning and then use the controller so the patient is moved into a modified standing position.
- Once the patient is safely standing the therapist can move the Pallas to bring the patient in front of the surface they are to be transferred to.
- The patient should then be warned and lowered to the new surface.
- Once the patient is safely seated the sling should be unhooked from the Pallas, the knee strap released, the patient given assistance (if necessary) to lift their feet up from the footplate and the Pallas taken away.
- The sling can then be removed.

<table>
<thead>
<tr>
<th>Modifications</th>
<th>Posterior sling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The sling with the leg straps can be used</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hazards / risks</th>
<th>Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wear and tear of the sling</td>
</tr>
<tr>
<td></td>
<td>Appropriate footwear for the patient</td>
</tr>
<tr>
<td></td>
<td>Patient fatigue</td>
</tr>
<tr>
<td></td>
<td>Unexpected changes in tone during the movement</td>
</tr>
<tr>
<td></td>
<td>Changes in the patient’s medical status during the standing e.g. drop in BP</td>
</tr>
<tr>
<td></td>
<td>A Patient not standing/sitting in time with the Encore</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Hoist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Encore standaid</td>
</tr>
</tbody>
</table>
## Therapeutic Handling Protocol

| Task | Standing transfers with two people
| Ensure the patient knows what you are doing at all times |
| Patient’s Ability | Able to sit to stand with assistance of two
| | Able to maintain standing balance with assistance of two
| | Able to transfer weight in standing with assistance of two
| | May require assistance of one to release either leg to initiate stepping |
| Clinical Reasoning | To enable the patient to increase their functional independence to allow toileting, bed to chair/wheelchair transfers
| | To maintain and prevent reduction in muscle length and strength
| | To encourage weight bearing and muscle recruitment
| | To promote confidence and reduce anxiety by providing experience of movement
| | To increase patient’s motivation and self esteem
| | To stimulate systems, e.g. bladder, bowel, cardiovascular and vestibular
| | To decrease undesirable compensations, to improve movement deficits and to prevent further secondary impairments |
| Patient Position | • The patient will be sitting, positioned towards the edge of the supporting surface, e.g. bed, wheelchair, etc.
| | • The patient’s arm position will alter depending on their physical ability and the position of the therapists. The patient’s arms could be actively involved in initiating sit to stand on the arms of the chair or from the supporting surface, or they may be holding the therapist’s hands.
| | • The patient’s feet should be placed hip width apart, below or slightly behind the knee, and facing forwards and flat on the floor |
| Therapist’s Role | • One therapist should be the leader of the manoeuvre, instructing/guiding both the patient and additional therapists |
| Therapist’s Position | • A therapist will be positioned on either side of the patient with adequate room to assist with sit to stand and to be able to move during the transfer. On some occasions, the therapists may choose to position themselves one in front and one behind for the same manoeuvre.
| | • The hand positions chosen will reflect the patient’s level of ability and component of the movement which requires facilitation. These may change as the patient moves round to the new surface. The hand positions used |
should be discussed and established between the two therapists prior to facilitating the patient into standing, e.g. facilitate forward weight transfer by using either the lower ribs laterally, the pelvis from behind or the sternum and/or facilitate knee extension by placing hands on lower quadriceps, greater trochanter/gluteal region

- The therapist’s feet should always be positioned to allow weight transfer in the direction of movement

| Modifications | • The patient may be able to use one hand only, for example, in the case of a patient with a non-functional hemiplegic arm
  • Use of the handling belt if felt appropriate |
| --------------|--------------------------------------------------|
| Hazards/Risks  | • Appropriate footwear for the patient, or if none available, bare feet (danger of exposed skin)
  • Patient fatigue
  • Unexpected changes in tone during the transfer
  • Changes in patient co-operation and behaviour during the transfer
  • Additional assistance required if there are drains/lines in situ which need to move with the patient
  • Changes in the patient’s medical status during the transfer, e.g. a drop in blood pressure which leads to fainting |
# Therapeutic Handling Protocol

<table>
<thead>
<tr>
<th>Task</th>
<th>Standing transfers with supervision of one</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient’s Ability</strong></td>
<td>Ensure that the patient knows what you are doing at all times</td>
</tr>
<tr>
<td>• Able to sit to stand</td>
<td>• Able to maintain standing balance</td>
</tr>
<tr>
<td>• Able to transfer weight in standing</td>
<td>• Able to release either leg to initiate stepping</td>
</tr>
</tbody>
</table>

| Clinical Reasoning    | To enable the patient to increase their functional independence to allow toileting, bed to chair/wheelchair transfers |
|-----------------------|• To maintain and prevent reduction in muscle length and strength |
|• To encourage weight bearing and muscle recruitment |• To promote confidence and reduce anxiety by providing experience of movement |
|• To increase patient’s motivation and esteem |• To stimulate systems, e.g. bladder, bowel, cardiovascular and vestibular |
|• To decrease undesirable compensations, to improve movement deficits and to prevent further secondary impairments |

| Patient Position     | The patient will be sitting, positioned towards the edge of the supporting surface, e.g. bed, wheelchair, etc |
|----------------------|• The patient’s arm position will alter depending on their physical ability. The patient’s arms could be actively involved in initiating sit to stand on the arms of the chair or from the supporting surface |
|                      |• The patient’s feet should be placed hip width apart, below, or slightly behind the knee, and facing forwards and flat on the floor |

| Therapist Position   | The therapist may be positioned at the front or to the side of the patient |

| Modifications        | Direction of transfer to the left or right |

| Hazards/Risks        | Appropriate footwear for the patient or bare feet |
|----------------------|• Patient fatigue |
|                      |• Unexpected changes in tone during the transfer |
|                      |• Changes in patient co-operation and behaviour during the transfer |
|                      |• Additional assistance required if there are drains/lines in situ which need to move with the patient |
|                      |• Changes in the patient’s medical status during the transfer, e.g. a drop in blood pressure |

| Alternatives         | |
|----------------------| |
|
# Therapeutic Handling Protocols

| Task | Training family/carers to assist with and/or supervise a transfer  
*Ensure you gain and document consent from the patient* |
|------|-----------------------------------------------------------------|
| **Clinical Reasoning** | - The carer needs to have the tasks demonstrated to them if they will be carrying it out with the patient  
- To establish the fitness of the carer to carry out the technique and to see if any further assistance will be required  
- To establish if the technique needs to be modified  
- To establish that the carer would be able to recognise when it would not be safe to assist with a technique and to ensure that they would inform the relevant people |
| **Training protocol** | - A risk assessment would be completed prior to taking the decision to train a carer in a transfer technique  
- The reasons for needing to assist with a transfer will be discussed with the carer and patient  
- The risks associated with carrying out a technique will be discussed with the carer and patient  
- A standard information sheet will be provided to the carer  
- It would be explained to the carer reasons when the technique should be modified or not carried out  
- The carer will attend sessions to observe and practice the technique. Training sessions may include practise on a member of staff and/or practise with their relative/friend under supervision  
- The carer will demonstrate the technique to the physiotherapist without physical assistance or verbal prompts  
- The carer will practice in the environment where the technique will be used  
- The carer will be provided with a written copy of the technique, a copy of this will also be held in the patients notes  
- All of the above will be accurately recorded in the patients notes (possibly using a Training Carers Checklist formed from the steps above) |
| **Advice and Guidance for Carers** | - Explain to the carer that these factors should be considered each time a transfer is undertaken as it may impact on the patients ability to participate in the transfer |
|   | A) How is the carer feeling? If the carer is feeling unwell this could affect their ability to carry out the transfer making it unsafe  
|   | B) How is the patient feeling? Health problems including pain, pressure sores, UTI, change in medication could all affect the patients ability to be involved in the transfer  
|   | C) Is the environment safe? Ensuring there is enough space to manoeuvre, positioning equipment, hazards are removed e.g. loose rugs, the height of the bed/chair  
|   | D) Posture? The carer should always be reminded to consider their posture during the transfer and to remember they are to be guiding and not lifting during the manoeuvre  
|   | E) Manual Handling Training if privately employed carers/direct payment |
### Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Assisted Standing using the Liko Hoist with two People (minimum)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Ensure the patient knows what you are doing at all times.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s Ability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Able to sit with minimal assistance of one</td>
<td></td>
</tr>
<tr>
<td>• Able to be flexed forward in trunk</td>
<td></td>
</tr>
<tr>
<td>• Feet can be placed on the floor</td>
<td></td>
</tr>
<tr>
<td>• Able to cooperate with the process</td>
<td></td>
</tr>
<tr>
<td>• Able to initiate active extension in lower limbs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Reasoning</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• To encourage weight bearing and muscle recruitment in trunk and lower limbs</td>
<td></td>
</tr>
<tr>
<td>• To enable standing in a safe environment and decrease manual handling risks</td>
<td></td>
</tr>
<tr>
<td>• To maintain and prevent reduction in muscle length and strength</td>
<td></td>
</tr>
<tr>
<td>• To promote confidence and reduce anxiety by providing experience of movement</td>
<td></td>
</tr>
<tr>
<td>• To increase patient’s motivation and self esteem</td>
<td></td>
</tr>
<tr>
<td>• To stimulate systems, e.g., bladder, bowel, cardiovascular and vestibular</td>
<td></td>
</tr>
<tr>
<td>• To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Position</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• The patient will be sitting, positioned towards the front of the supporting surface</td>
<td></td>
</tr>
<tr>
<td>• The patient’s feet should be placed hip width apart, below or slightly behind the knee, facing forwards and flat on the floor</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Application of Equipment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Select and fit an appropriate sized vest to the patient. Put the vest on from the front, with user’s arms placed through the shoulder straps. Behind the back draw each loop strap across the back and pull it through the metal D-ring on the opposite side</td>
<td></td>
</tr>
<tr>
<td>• Crotch straps should always be applied unless the patient is able to reliably maintain active extension</td>
<td></td>
</tr>
<tr>
<td>• The hoist should be positioned in front of the patient with the spreader bar held by one of the therapists behind the patient’s head/shoulders and the vest attached to it. With the sling bar behind the user’s back, attach the loop straps, using a suitable loop, and then attach the shoulder straps on the sling bar.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapists Role and Position</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• One therapist should guide the spreader bar and control the movement using the electronic handset, whilst the other therapist checks and maintains the patient’s foot</td>
<td></td>
</tr>
</tbody>
</table>
position during the movement. Raise the spreader bar slightly using the controls to tighten the straps without lifting the patient off the seat, and check that the pressure distribution around the body feels comfortable for the patient. If need be, lower the spreader bar again and reposition the vest. Ensure the boom is lifted away from the patient's head as far as comfortable so head does not catch boom upon standing. Once comfortable, the patient can be assisted into a standing position.

- The therapists should be positioned on either side of the patient.

<table>
<thead>
<tr>
<th>Modifications</th>
<th>• After the sit to stand movement, the chair/wheelchair/plinth may be removed to allow the therapists to alter their position in order to facilitate the patient in standing/walking.</th>
</tr>
</thead>
</table>
| Alternatives        | • Hoist  
• Stand-aid  
• Standing in standing frame |
| Hazards/Risks       | • Ensure the patient remains comfortable in the vest throughout the movement and that respiratory effort is not restricted  
• Wear and tear of the vests  
• Ensure the mains power is switched off before connecting/disconnecting the hoist for battery re-charging  
• Appropriate footwear for the patient, or bare feet  
• Patient fatigue  
• Unexpected changes in tone during the movement  
• Unexpected changes in behaviour or co-operation during movement  
• Additional assistance may be required if there are drains/lines in situ which need to move with the patient  
• Changes in the patient's medical status during the transfer, e.g. a drop in blood pressure  
• Patient may hit head on the boom upon standing if very tall and the boom has not been lifted high enough. Ensure patient facilitated correctly and consider different equipment if the Liko hoist is not appropriate. |

## Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Equipment to be used</th>
<th>Tilt Table</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ensure the patient knows what you are doing at all times</strong></td>
<td></td>
</tr>
</tbody>
</table>

| Patient’s Ability | The tilt table may be used for most patients regardless of ability, with consideration for weight bearing status, contractures, any blood pressure or cardiac precautions and medical condition |

| Clinical Reasoning | • To promote upright position and/or allow for gradual progression to upright especially after having been bed bound for prolonged periods  
• To allow the use of gravity to assist with body functions  
• To permit weight bearing through lower limbs  
• To gradually develop head, trunk or limb control/strength in a supported upright position |

| Alternatives | • Bed angle adjustment  
• Recliner or recliner wheelchair  
• Tilt in space wheelchair  
• Stand-Aid (for more advanced activities)  
• Lyko (for more advanced activities)  
• Electric standing frame |

| Patient Position | Patient is hoisted or transfers to the tilt table surface and positioned supine so that the feet are on the footboard. The three straps are placed securely across the patient at the chest, pelvis and knees. A pillow is placed under the head for comfort. |

| Therapist Position | The therapist remains close to the patient to monitor for any adverse reaction such as diaphoresis, nausea, vomiting, blood pressure changes or fainting. The therapist uses the control to gradually raise the height of the tilt table from flat to as high as 85°, lowering the patient gradually to 5-10° at the end of the treatment session or when adverse reaction is identified. |

| Modifications | • The number of straps used may be changed, depending on the goal of the treatment session  
• The footplate angle may be changed  
• A block may be placed under one foot to prevent weight bearing on the other  
• Straps may be loosened to promote trunk or lower limb movement after patient has reached position desired  
• A glide sheet may be used to facilitate movement on the table  
• The number of pillows used at the head or to support other parts of the body may be varied, including pillows or blankets under the straps for patient comfort |
- A supportive surface, such as an adjustable height table, may be placed in front of the patient once upright, for upper limbs.
<table>
<thead>
<tr>
<th>Alternatives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lyko</td>
<td></td>
</tr>
<tr>
<td>• Oswestry standing frame</td>
<td></td>
</tr>
</tbody>
</table>
## THERAPEUTIC HANDLING PROTOCOL

| Task | Assisted Standing using the Insignis Standing Frame with 2 people (minimum)  
Ensure that the patient is aware of what you are doing at all times |
|------|----------------------------------------------------------------------------------------------------------------------------------|
| Patient’s ability | • Able to be flexed forward in the trunk  
• Feet can be placed on the floor  
• Able to co-operate with the process  
• Able to tolerate full standing |
| Clinical Reasoning | • To encourage weight bearing and muscle recruitment in trunk and lower limbs  
• To enable standing in a safe environment and decrease manual handling risks  
• To maintain and prevent reduction in muscle length and strength  
• To promote confidence and reduce anxiety by providing experience of movement  
• To increase patient’s motivation and self esteem  
• To stimulate systems e.g. bladder, bowel, cardiovascular and vestibular  
• To decrease undesirable compensations, to improve movement deficits and to prevent secondary impairments |
| Patient position | The patient may be stood either from a wheelchair or they may be stood from a treatment plinth. Preparation to stand and application of equipment will be described for standing from a wheelchair. |
| Preparation to stand – from wheelchair | For the first time of use positioning of the heel bar, toe bar and chest support will have to be identified, and these positions noted.  
• The frame should be positioned with adequate space to allow access of the therapists on all sides of the frame, and close to a power socket. The frame should be moved by tipping it onto the front wheels (see manual). **PLEASE TAKE GREAT CARE NOT TO TRAP THE CABLE UNDER THE FRAME. THIS COULD CAUSE DAMAGE TO THE CABLE AND CAUSE AN ELECTRIC SHOCK.**  
• When plugging into the power supply first test the circuit breaker.  
• Heel bar, toe bar and chest support should be set up as noted for that patient.  
• For powered wheelchair users, switch off the power, disengage the wheels, and apply the manual brake. |
- Flex the patient forward with one therapist assisting from in front and the other from behind. The therapist behind slides the pelvic strap under the patient’s bottom (to just below the ischial tuberosities).
- Take foot plates off and wheelchair as far forwards as possible (until arm supports touch frame). Place feet between the heel and toe bars.
- With a therapist at either side remove arm supports one at a time. While one therapist removes the arm support, the other supports the patient, and visa versa.
- Bring chair right forwards so the knees are firmly against the knee supports.
- Re-check foot position.
- Attach bottom sling taking care that the straps lie flat within the cam buckles.
- With one therapist behind and one on the patient’s right side assist the patient forward to fasten the chest support. The back support-webbing strap should be passed through the loops on the back support cushion. The webbing strap should be passed through the cam-buckle at the user’s right hand side, drawn sufficiently for the comfort and support of the user, and then locked into that position. Check arms are comfortably forwards on tray.
- **Slowly** raise the patient into standing. Check for comfort and ensure the chest support does not slide upwards. If this happens the patient must be lowered and the chest support readjusted. Check that feet remain plantigrade and within the heel and toe supports.

| Lowering the patient and removing straps/supports | Lower the patient slowly. **Check the arms are comfortably on table and that the fingers are not over the edge where they could be trapped during lowering.**
| | Undo the chest support with one therapist behind to gentle let the patient back. The other therapist is to the right to undo the buckle.
| | Undo the buckles on the bottom strap.
| | Remove support from behind the heels.
| | Place patient’s arms across their lap.
| | Manually reverse the chair back from the frame. With a therapist either side replace the sides of the wheelchair.
| | Replace the footplates.
| | Remove pelvic strap by one therapist bringing the patient forward from in front and one assisting form behind. The therapist behind can then easily slide the strap out.
| | Re set the wheelchair for powered control.

| Modifications | As stated the patient may also be stood from a plinth. In this case the patient may be hoisted onto the plinth with the pelvic strap already positioned appropriately. In this situation if the patient does not have sitting balance one therapist must be behind the patient until the chest strap has been
| Hazards / risks | • Ensure the patient remains comfortable throughout the movement and that respiratory effort is not restricted.  
|                | • Wear and tear of the straps  
|                | • Appropriate footwear for the patient  
|                | • Patient fatigue  
|                | • Unexpected changes in tone during the movement  
|                | • Changes in the patient’s medical status during the standing e.g. drop in BP  
|                | • Fingers being trapped under the table during lowering.  
|                | • Patient falling sideways in the chair before chest support fastened. |
| Alternatives   | • Lyko  
|               | • Tilt-table  
|               | • Oswestry standing frame |
## Therapeutic Handling Protocol

<table>
<thead>
<tr>
<th>Task</th>
<th>Stand in Oswestry Frame with Assistance from Two People</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ensure the patient knows what you are doing at all times</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Patient’s Ability
- Able to sit unsupported
- Able to edge sit with the assistance of two
- Feet can be placed on floor
- Able to initiate and carry out sit to stand with assistance from two
- Able to assist with sit to stand with use of one or both arms to pull to standing

### Clinical Reasoning
- Allow upright posture and weight bearing through lower limbs
- Improve systems functioning, i.e. cardiovascular, respiration, digestion
- Prevention of muscle shortening and maintaining or increasing muscle strength
- Increase endurance and tolerance for standing
- Improve patient’s self esteem and motivation

### Positioning of Patient
- The wheelchair is placed within the frame
- The patient moves forward in the wheelchair so that their feet are on the floor, facing forward in front of the heel strap
- Hands may be positioned to push up from the wheelchair or pull up on the sides of the Oswestry frame

### Therapists Position and Role
- A therapist will be positioned on either side of the patient with adequate room to assist with sit to stand and to be able to move during the transfer
- Both therapists facilitate the patient moving into standing by assisting with weight transference and extensor recruitment as appropriate
- The therapists’ hand position may vary depending on the patient’s level of physical ability and may also vary between the two therapists
- The therapists may choose to facilitate sit to stand from the pelvis/trunk or with the arms
- The hand positions used should be discussed and established prior to assisting the patient into standing
- The hand positions chosen will reflect the patient’s level of ability and the components of movement which require assistance
- Once the patient is standing, one of the therapists will secure the hip strap tightly across the hips

**Modifications**
- The patient’s use of upper limbs may vary
- A handling belt can be used to assist with sit to stand
- A mechanical device, e.g. Liko stand hoist could be used to lift the patient forwards onto the table of the standing frame
- Use of a table or box on the frame to promote upright position

**Hazards/Risks**
- Postural hypotension
- Poor standing posture and balance
- Change in tone
- Malalignment of joints through poor positioning
- Ineffective weight bearing
- Excessive use of arms in standing
- Change in patient’s behaviour or co-operation

**Alternatives**
- Liko standing hoist
- Electric standing frame
- Stand-aid
## Therapeutic Handling Protocol

<table>
<thead>
<tr>
<th>Task</th>
<th>Stand In Oswestry Frame with assistance from one person Ensure the patient knows what you are doing at all times</th>
</tr>
</thead>
</table>
| **Patient’s Ability**     | • Able to sit unsupported  
• Able to edge sit independently  
• Feet can be placed on the floor  
• Able to initiate and carry out sit to stand with assistance from one  
• Able to assist with sit to stand with use of one or both arms to pull into standing |
| **Clinical Reasoning**    | • Allow upright posture and weight bearing through lower limbs  
• Improve systems functioning, i.e. cardiovascular, digestion, respiration  
• Prevention of muscle shortening and maintaining or increasing muscle strength  
• Increase endurance and tolerance for standing  
• Improve patient’s self esteem and motivation |
| **Positioning of Patient**| • The wheelchair is placed within the frame  
• The patient moves forward in the wheelchair so that their feet are on the floor, facing forward in front of the heel strap  
• Hands may be positioned to push up from the wheelchair or pull up on the sides of the Oswestry frame |
| **Therapist’s Position**  | • A therapist will be positioned to one side of the patient with adequate room to assist with sit to stand and to be able to move during the transfer, preferably on the side of the frame at which the pelvic strap is fastened to allow ease of securing the strap once the patient is stood  
• Hand position depends on the patient’s level of physical ability and may be on the pelvis or trunk or on the arms, depending on which components of the movement require assistance |
| **Role of the therapist** | • The therapist facilitates the patient moving into a standing position by assisting with weight transference and extensor recruitment as appropriate  
• The hip strap is securely fastened, if indicated |
| **Modifications**         | • The patient’s use of upper limbs may vary  
• A handling belt can be used to assist with sit to stand  
• Use of table or box on the frame to achieve a more upright position or increased thoracic support |
<p>| <strong>Alternatives</strong>          | • Liko standing hoist |</p>
<table>
<thead>
<tr>
<th>Electric standing frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stand-aid</td>
</tr>
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</table>

<table>
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<tr>
<td>Change in tone</td>
</tr>
<tr>
<td>Malalignment of joints through poor positioning</td>
</tr>
<tr>
<td>Vulnerable pressure areas e.g. knee strap area</td>
</tr>
<tr>
<td>Ineffective weight bearing</td>
</tr>
<tr>
<td>Change in patient’s behaviour or level of co-operation</td>
</tr>
<tr>
<td>Overuse of upper limbs in standing</td>
</tr>
</tbody>
</table>
## Therapeutic Handling Protocol

### Task

**Walking forward with one person**  
*Ensure that the patient is aware of what you are doing at all times.*

### Patient’s ability

- Have to be able to fully weight bear
- Can transfer with weight fully to either side with one person
- Have sufficient hip and knee control and, with minimal assistance from one person, be able to make a step with left and right foot
- If aids are required, i.e. AFO, Swedish knee cage, etc., these must be in place correctly

### Aim

- The aim for the patient is to receive minimum amount of facilitation in order to achieve a safe and normal gait to maximise his or her own functional potential

### Clinical Reasoning

- To encourage the patient to achieve rehabilitation aims
- To give the experience of normal movement
- To challenge balance mechanisms
- To decrease the dependence on others
- To improve confidence

### Alternatives

- Two people to facilitate
- Walking aids
- Parallel bars
- Treadmill

### Patient Position

- Standing (consider the environment suitability for the task)

### Therapist’s Role

- Facilitator
- Monitor of patient performance
- Feedback to the patient

### Therapist’s Position

- Body either to the front, behind or side of the patient
- Hands – anywhere where facilitation is required, e.g. scapula, ribs, pelvis, axilla, elbow, hand and ankle
- Hip/knee – to assist in facilitating knee extension, hip extension
- To monitor or control trunk and to facilitate movement (weight transfer) as required. Patient could also wear a handling belt if required.

### Modifications

- Follow with wheelchair
- Vary position for facilitation
- Vary speed of gait

### Hazards/risks

- Environmental – reaching out, flooring
- Falling
| • Anxiety, fear  
| • Fatigue  
| • Footwear  
| • Eyesight  
| • Change in level of co-operation  
| • Therapist may get into flexed and rotated position  
| • Turning  
| • Tonal change |
## Therapeutic Handling Protocol

### Task

**Hoisting Patient from the floor (minimum of two people)**

*Ensure the patient knows what you are doing at all times*

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Patient’s Ability** | - Patient should be conscious and uninjured after incident that has caused them to be on the floor.  
- If the patient is unconscious, refer to CPR protocol  
- Patient should be able to cooperate and participate in procedure to some degree |
| **Clinical Reasoning** | - Patient has fallen or has been lowered to the floor and needs to be returned to a sitting or lying position on plinth, bed or wheelchair |
| **Patient Position** | - The patient could be positioned on the floor in any part of the treatment area  
- It MUST be established that no injury has occurred. Medical consultation may be required.  
- The patient may need to be moved to a location where the hoist can reach or a sling can be safely placed under them (refer to manual handling training for best way to accomplish this) |
| **Therapist Position** | - This will depend on the position of the patient  
- Consider the number of people that will be required to safely carry out this procedure, which will be at least two, but possibly more  
- The lead therapist should give instructions to others assisting to ensure the safety of the patient and that all are aware of their responsibilities |
| **Hazards/Risks** | - Patient has been injured in the fall  
- Patient loses consciousness  
- Patient has fallen in an awkward position without easy access  
- Patient’s co-operation and behaviour changes during the transfer  
- Patient’s medical status changes during the transfer |
| **Alternatives** | - Call ambulance service  
- Assist patient off the floor with assistance of one to two people |
# Therapeutic Handling Protocol

<table>
<thead>
<tr>
<th>Task</th>
<th>Use of the Motomed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient’s Ability</strong></td>
<td>Ensure the patient knows what you are doing at all times</td>
</tr>
<tr>
<td></td>
<td>• Must have no less than 90° passive flexion at hips</td>
</tr>
<tr>
<td></td>
<td>• Must have no less than 90° passive flexion at knees</td>
</tr>
<tr>
<td></td>
<td>• Must have no less than 90° passive flexion at shoulders</td>
</tr>
<tr>
<td></td>
<td>• No fixed flexion contractures at elbows</td>
</tr>
<tr>
<td></td>
<td>• No shoulder pain on movement</td>
</tr>
<tr>
<td><strong>Clinical Reasoning</strong></td>
<td>To enable assisted or active-assisted movement of arms or legs</td>
</tr>
<tr>
<td></td>
<td>• To maintain joint mobility</td>
</tr>
<tr>
<td></td>
<td>• To assist circulation</td>
</tr>
<tr>
<td></td>
<td>• To increase muscle strength</td>
</tr>
<tr>
<td></td>
<td>• To maintain muscle length</td>
</tr>
<tr>
<td></td>
<td>• To allow the sense of movement in the limbs</td>
</tr>
<tr>
<td><strong>Patient Position</strong></td>
<td>For legs, patient is positioned in wheelchair or chair in</td>
</tr>
<tr>
<td></td>
<td>front of the motomed, close enough to allow comfortable</td>
</tr>
<tr>
<td></td>
<td>full rotation of the legs when feet are strapped onto the footplates</td>
</tr>
<tr>
<td></td>
<td>• For arms, the wheelchair or chair is positioned in front of the motomed so that</td>
</tr>
<tr>
<td></td>
<td>upright supported posture is maintained and comfortable rotation of the arms is</td>
</tr>
<tr>
<td></td>
<td>achieved when arms are strapped onto the arm plates</td>
</tr>
<tr>
<td><strong>Therapist’s Position</strong></td>
<td>Therapist should be able to move about to ensure safe</td>
</tr>
<tr>
<td></td>
<td>positioning of patient and secure straps</td>
</tr>
<tr>
<td><strong>Modifications</strong></td>
<td>• Use of spasm control button</td>
</tr>
<tr>
<td></td>
<td>• At times, two people may be required to position patient</td>
</tr>
<tr>
<td><strong>Hazards/Risks</strong></td>
<td>• Straps may become undone</td>
</tr>
<tr>
<td></td>
<td>• Limbs may fall off or become inadequately positioned in arm or foot plates</td>
</tr>
<tr>
<td></td>
<td>• Patient’s behaviour or co-operation may change</td>
</tr>
<tr>
<td></td>
<td>• Tone may increase</td>
</tr>
<tr>
<td></td>
<td>• Patient may have change in medical status</td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
<td>• Passive movement of the limbs by therapist</td>
</tr>
<tr>
<td></td>
<td>• Treadmill</td>
</tr>
<tr>
<td></td>
<td>• Stationary bicycle</td>
</tr>
</tbody>
</table>
# Therapeutic Handling Protocol

<table>
<thead>
<tr>
<th>Task</th>
<th>Transferring from MSI to bench</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Ability</td>
<td>Able to sit but not aid in transfer or unable to sit unsupported</td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>To transfer the patient safely</td>
</tr>
<tr>
<td>Patient’s Position</td>
<td>To maintain the safety of patient carers</td>
</tr>
<tr>
<td>Patient’s Position</td>
<td>The patient will be sitting within the MSI with a sling left in place when possible</td>
</tr>
<tr>
<td>Patient’s Position</td>
<td>If a tilt in space chair is available, the chair should be tilted prior to the hoisting to allow for easy repositioning</td>
</tr>
<tr>
<td>Therapist’s Role and Position</td>
<td>The therapist should be familiar with the hoist in use and identify the appropriate sling for the patient</td>
</tr>
<tr>
<td>Therapist’s Role and Position</td>
<td>The therapist is positioned so that movement around the patient is possible</td>
</tr>
<tr>
<td>Therapist’s Role and Position</td>
<td>The need for additional staff assistance should be identified by the therapist</td>
</tr>
<tr>
<td>Therapist’s Role and Position</td>
<td>The therapist should risk assess the patient</td>
</tr>
<tr>
<td>Modifications</td>
<td>Use of max glides to insert sling</td>
</tr>
<tr>
<td>Hazards/Risks</td>
<td>Unexpected changes in tone</td>
</tr>
<tr>
<td>Hazards/Risks</td>
<td>Changes in patient cooperation and behaviour during transfer</td>
</tr>
<tr>
<td>Hazards/Risks</td>
<td>Additional care and assistance required if there are drains/lines in situ which need to move with the patient</td>
</tr>
<tr>
<td>Alternatives</td>
<td>There are no safe alternatives to this manoeuvre</td>
</tr>
</tbody>
</table>
## Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Car Transfers</th>
</tr>
</thead>
</table>
| **Patient’s Ability**     | • Able to sit unsupported  
|                           | • Able to weightbear on lower limb or use sliding board  
|                           | • Able to follow directions  
|                           | • Able to consistently co-operate with the transfer  |
| **Clinical Reasoning**    | • To increase patient’s motivation and self esteem  
|                           | • To allow patient to travel in a car or other vehicle  
|                           | • To improve independence  
|                           | • To gain experience of movement  |
| **Alternatives**          | Wheelchair taxi or van  
|                           | Ambulance  |
| **Therapist Position**    | • Therapist is in front of the patient between the patient and the vehicle  
|                           | • Door to the vehicle is open as wide as possible  |
| **Patient Position**      | • See Therapeutic Handling protocols for Sliding Board transfers or Standing Transfers  
|                           | • Ensure the wheelchair is as close to the vehicle as possible with footrests removed  |
| **Modifications**         | • Use of handling belt  
|                           | • Use of glide sheet  
|                           | • Use of turntable either on floor or on vehicle seat  |
**Therapeutic Handling Protocol**

<table>
<thead>
<tr>
<th>Task</th>
<th>Use of the Stationary Bicycle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient’s Ability</strong></td>
<td><em>Ensure the patient knows what you are doing at all times</em></td>
</tr>
<tr>
<td></td>
<td>• Must be able to achieve sit to stand with or without assist</td>
</tr>
<tr>
<td></td>
<td>• Must have good sitting balance</td>
</tr>
<tr>
<td></td>
<td>• Must be able to stand on one leg for at least 10 seconds with or without assist</td>
</tr>
<tr>
<td></td>
<td>• Must have no less than 60° passive flexion at the hips</td>
</tr>
<tr>
<td></td>
<td>• Must have no less than 90° passive flexion at the knees</td>
</tr>
<tr>
<td><strong>Clinical Reasoning</strong></td>
<td>• To enable active or active-assisted movements of the legs</td>
</tr>
<tr>
<td></td>
<td>• To challenge co-ordination mechanisms</td>
</tr>
<tr>
<td></td>
<td>• To maintain joint mobility</td>
</tr>
<tr>
<td></td>
<td>• To assist circulation</td>
</tr>
<tr>
<td></td>
<td>• To increase muscle strength</td>
</tr>
<tr>
<td></td>
<td>• To maintain muscle length</td>
</tr>
<tr>
<td></td>
<td>• To allow sense of movement in the limbs</td>
</tr>
<tr>
<td></td>
<td>• To increase endurance and for other cardiovascular benefits</td>
</tr>
<tr>
<td></td>
<td>• To improve confidence and encourage the patient to achieve rehabilitation aims</td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
<td>• Motomed</td>
</tr>
<tr>
<td></td>
<td>• Treadmill</td>
</tr>
<tr>
<td></td>
<td>• Assisted active movements of the lower limbs</td>
</tr>
<tr>
<td></td>
<td>• Walking</td>
</tr>
<tr>
<td><strong>Patient Position</strong></td>
<td>• The patient is assisted onto the bicycle, usually leading with the weaker limb first, and the feet are placed onto the footplates/stirrups</td>
</tr>
<tr>
<td></td>
<td>• The seat height is adjusted for patient comfort</td>
</tr>
<tr>
<td></td>
<td>• The hands are placed on the handle bars</td>
</tr>
<tr>
<td><strong>Therapist’s Position</strong></td>
<td>• Therapist should be able to move about to ensure safe positioning of patient</td>
</tr>
<tr>
<td><strong>Modifications</strong></td>
<td>• A second person may be needed to assist the placement of the foot and hand</td>
</tr>
<tr>
<td></td>
<td>• Resistance, speed of pedalling and length</td>
</tr>
</tbody>
</table>
| of time may be adjusted  
• Seat height may be adapted according to results desired  
• Use of handling belt  
• Additional support from staff members may be required  

| Hazards  
• Loss of balance  
• Feet may come out of the stirrups  
• Limbs could become entangled in the equipment  
• Patient’s behaviour and co-operation may change  
• Tone may increase  
• Patient may have change in medical status  |
## Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Practice Steps</th>
</tr>
</thead>
</table>
|      | *Ensure that the patient is aware of what you are doing at all times.*  
|      | *Ensure you gain and document consent from the patient* |

### Patient’s ability
- Initial ability – must be able to ascend and descend individual 6″ step 3 times
- Able to cooperate
- Medically stable. If patient has asthma/angina ensure appropriate medication is taken with the patient (e.g. GTN, inhaler)

### Clinical Reasoning
- To assess safety on the practice steps prior to assessment for the full flight of stairs, home visit and discharge home.
- To assist with exercise tolerance and stamina and to build up fitness levels
- To assist with strengthening of legs
- To build confidence of patient using stairs
- To assess for causative factors of knee pain

### Alternatives
- Full flight of stairs (see protocol)

### Patient position
- Initial assessment: Patient to stand in between two therapists on the steps
- Patient to stand in the middle of the steps and hold on to both rails either side – see modifications

### Therapist’s role
- To prompt the correct way to carry out the practice steps as regards strength of legs/arms
- To give feedback and assess safety and ability

### Therapist’s position
- Two therapists for initial assessment on steps, then one if patient is assessed to be safe. When one therapist present, the therapist is to stand behind the patient as they ascend the steps, and in front of the patient as they descend. If one therapist present the pendant alarm must be worn

### Modifications
- Consider the patient only holding on to one rail if able or not using a rail at all – this will depend upon upper limb movement/strength and stair set up at home
- Chair at the other side of the practice steps positioned to allow the patient to rest – to be returned after use.
- Use of walking aids over steps, if necessary for patient to use walking aids on steps/stairs after discharge

### Hazards/risks
- Patient collapsing/arresting on the steps and potentially falling and causing injury to themselves and the
<table>
<thead>
<tr>
<th>therapists – if only one therapist is present, ensure pendant alarm is worn</th>
</tr>
</thead>
<tbody>
<tr>
<td>• See Stair Protocol re: Brace in event of fall</td>
</tr>
</tbody>
</table>
# Therapeutic Handling Protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Stairs – Full flight of stairs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient’s ability</strong></td>
<td>Ensure that the patient is aware of what you are doing at all times.</td>
</tr>
<tr>
<td></td>
<td>• Individual risk assessment to be carried out prior to stairs being completed by the patient – to include taking medical history into account such as medical condition, medical stability e.g. labile blood pressure, asthma, angina, ensuring appropriate medication is taken with patient if necessary (e.g. inhaler)</td>
</tr>
<tr>
<td></td>
<td>• Patient must be able to negotiate the step and threshold into Harmer Lodge without a rail – consider testing on a step in the gym. Rails soon to be fitted over these steps and step to be widened to allow for frame</td>
</tr>
<tr>
<td></td>
<td>• Initial ability – to be able to negotiate the small flight of stairs in the gym successfully four times with a rest in between to determine ability to manage full flight of stairs.</td>
</tr>
<tr>
<td></td>
<td>• Able to cooperate</td>
</tr>
<tr>
<td><strong>Clinical Reasoning</strong></td>
<td>• To assess safety on the stairs prior to a home visit and discharge home. This could include testing for potential community stairs even if patient lives in a bungalow</td>
</tr>
<tr>
<td></td>
<td>• To assist with exercise tolerance and stamina and to build up fitness levels</td>
</tr>
<tr>
<td></td>
<td>• To assist with strengthening of legs</td>
</tr>
<tr>
<td></td>
<td>• To build confidence of patient using stairs</td>
</tr>
<tr>
<td></td>
<td>• To assess for causative factors of knee pain</td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
<td>• To only carry out small flight of stairs if risk assessment gives cause for concern – these may be assessed with just one therapist and can be carried out by assistant after assessment depending on the individual risk assessment and if pendant alarm in the gym used as per protocol</td>
</tr>
<tr>
<td></td>
<td>• If patient is unable to access Harmer Lodge and/or if the stairs in Harmer Lodge are deemed inappropriate (for example too steep or narrow), then consider assessing only on the home visit</td>
</tr>
<tr>
<td></td>
<td>• Consider use of Jubilee House Stairs which are wider and can be accessed with no step into building. However these only have one rail. When rail in situ at Harmer Lodge this is less of an issue</td>
</tr>
</tbody>
</table>
| Patient position | - Patient to stand in-between two therapists on the stairs – one therapist behind and one in front - though consider one therapist and one TA or potentially two TAs following risk assessment. Always to have two people present  
| Therapist’s role | - Patient to stand in the middle of the stairs and hold on to both rails either side – see modifications |  
| Therapist’s position | - To prompt the correct way to carry out the stair assessment as regards strength of legs/arms  
| | - To give feedback and assess safety and ability |  
| Therapist’s position | - Therapist to walk behind the patient on the way up and in front of the patient on the way down to steady if needed. Second person to be the other side of the patient so always one person in front and one behind. If 2 Therapy Assistants: one to be in front and one behind – following risk assessment. Consider carers/families assisting with this as preparation for discharge home  
| | - Students can be included as a member of staff  
| | - In the event of the patient falling or collapsing the members of staff may choose to intervene to assist as appropriate. This is based on individual risk assessment and is not deemed as mandatory  
| | - One member of staff can get help if needed |  
| Modifications | - Consider the patient only holding on to one rail if able or not using a rail at all – this will depend upon upper limb movement/strength and stair set up at home  
| | - Consider three people to accompany the patient if medical reasons to support this  
| | - Consider walkie talkies to aid safety in the event of an emergency to facilitate calling for help. Check member of staff present in the building  
| | - Chair at the top of the stairs positioned to allow the patient to rest – to be returned after use. |  
| Hazards/risks | - Patient collapsing on the stairs/arresting on the stairs and potentially falling and causing injury to themselves and the assistants – check member of staff in building who could go for help if needed. Always to have two or three people with patient so one can get help if needed |
GUIDELINES FOR THE HEALTH & SAFETY OF NEW & EXPECTANT MOTHERS AT WORK

INTRODUCTION

Pregnancy should not be equated with ill health. It should be regarded as a part of everyday life and its health and safety implications can be adequately addressed by normal health and safety management.

Many women work while they are pregnant, and many return to work while they are still breastfeeding. Some hazards in the workplace may affect the health and safety of new and expectant mothers.

GENERAL DUTIES OF EMPLOYERS

The law requires the employer to assess the risks to all employees, including new and expectant mothers and to do what is reasonably practicable to control those risks. It specifically requires the employer to take particular account of the risks to new and expectant mothers when assessing risks in the work place. If we cannot avoid the risk by other means we will need to make changes to working conditions, hours, offer suitable alternative work, or if that is not possible give the workers paid leave for as long as necessary to protect her health or safety or that of her child.

‘New or expectant mothers’, means a worker who is pregnant, who has given birth within the previous six months or who is breastfeeding. Additional advice, if required can be obtained from the Personnel Department, Health & Safety Department or Occupational Health Department.

ASSESSMENT AND CONTROL OF RISKS

In assessing the risks we need to pay attention to workers who are new or expectant mothers, and to take action to ensure that they are not exposed to any significant risk. Risks include those to the unborn child or child of a woman who is still breastfeeding, not just risks to the mother herself.

STEP 1 – LOOK FOR THE HAZARDS (POTENTIAL TO CAUSE HARM)

Physical, biological, chemical, radiation and working conditions which may affect the health and safety of new or expectant mothers. (See Appendix 1.)

STEP 2 – DECIDE WHO MIGHT BE HARMED AND HOW

The assessment may show that there is a substance or work process in the workplace that could damage the health or safety of new or expectant mothers. We need to bear in mind that there could be different risks depending whether workers are pregnant, have recently given birth or are breastfeeding.
STEP 3 – CONTROL THE RISK

If you have identified a significant risk to the health and safety of a new or expectant mother, we need to decide what actions to take. There may be a significant risk, say from a chemical which is covered by the COSHH regulations, but by following the information on the COSHH assessment we will normally be doing enough to control the risk. As a general rule we should in all cases consider removing the hazard or seek to prevent exposure to the risk.

If there is still a significant risk at work to the safety or health of a new or expectant mother, which goes beyond the level of risk to the expected, outside the workplace, then we must take the following steps to remove her from the risk.

• Temporarily adjust her working conditions and/or hours of work or if it is not reasonable to do so, or would not avoid the risk.

• Offer suitable alternative work if any is available or if this is not feasible, we must:

• Suspend her from work (paid leave) for as long as necessary to protect her safety or health of that of her child.

These actions are only necessary where as the result of the risk assessment there is a genuine concern with regards to the safety and health of the new or expectant mother. Personnel must be consulted before suspending her from work. Advice on suitable alternative work is available from Personnel.

STEP 4 – KEEP THE RISKS UNDER REVIEW

We will need to keep the risk assessment under review, although any hazards are likely to remain constant. The possibility of damage to the foetus as a result of a hazard will vary at different stages of the pregnancy.

There are different risks to consider for workers who are breastfeeding. We will need to ensure that workers who are breastfeeding are not exposed to risks that could damage their health and safety for as long as they continue to breastfeed.

STEP 5 – TELL THE EMPLOYEES ABOUT THE RISK

If the risk assessment does reveal a risk we should explain what we would do to make sure that new or expectant mothers are not exposed to risks that could cause them harm.
## Appendix 1

<table>
<thead>
<tr>
<th>HAZARDS FOR CONSIDERATION</th>
<th>WHAT IS THE RISK</th>
<th>HOW TO CONTROL THE RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHYSICAL AGENTS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MANUAL HANDLING</td>
<td>Pregnant workers are especially at risk from manual handling injuries. E.g. hormonal changes can affect the ligaments, increasing susceptibility to injury and postural problems may increase as the pregnancy progresses. With heavy physical work there may be an increased risk of prematurely or low birth weight. There can also be risks for those who have recently given birth, for example after a caesarean section there is likely to be a temporary limitation on lifting and handling capability. There is no evidence that breastfeeding mothers are at greater risk from manual handling injury than any other employee. Manual handling assessments will have already been carried out for employee, and various control measures will already be in place for all workers. It may be necessary to address the specific needs of the new or expectant mother and reduce the account of physical work, or provide aids to reduce the risks she faces. Contact the Manual Handling Department for advice if needed.</td>
<td></td>
</tr>
<tr>
<td>- NOISE</td>
<td>There appears to be no specific risk to new or expectant mothers or to the foetus, but prolonged exposure to loud noise may lead to increased blood pressure and tiredness. No particular problems for women who have recently given birth or who are breastfeeding. The requirements of the Noise at Work Regulations should be sufficient to meet the needs of new or expectant mothers. Contact the Health &amp; Safety Advisor for advice if needed.</td>
<td></td>
</tr>
<tr>
<td>- IONISING RADIATION</td>
<td>Significant exposure to ionising radiation can</td>
<td>Work procedures should be designed to keep</td>
</tr>
</tbody>
</table>
• **EXTREMES OF COLD OR HEAT**

be harmful to the foetus and this is recognised by placing limits on external radiation dose to the abdomen of the expectant mother for the declared term of pregnancy.

When pregnant, women tolerate heat less well and may more readily faint or be more liable to heat stress. The risk is likely to be reduced after birth but it is not certain how quickly an improvement comes about:

Breastfeeding may be impaired by heat dehydration.

No specific problems arise from working in extreme cold, although clearly for other Health & Safety reasons, warm clothing should be provided.

exposure of pregnant women as low as reasonably practicable and below the statutory dose limit for pregnant women.

Pregnant workers should take great care when exposed to prolonged heat at work.

Rest facilities and access to refreshments should be made available.

• **NIGHT WORK**

The H.S.E. are not aware of any risks to pregnant or breastfeeding women from specifically working at night.

If there are concerns with regards to working at night, referral should be made to the Occupational Health Department.

Offer suitable alternative day work if available.

• **MOVEMENT & POSTURE**

Fatigue from standing or other physical work has long been associated with miscarriage, premature birth and low birth weight.

Excessive physical or mental pressure may cause stress and can give rise to

Ensure that hours of work and the volume and pacing of work are not excessive, and where possible the employees have some control over how their work is organised.

Ensure seating is available where
<table>
<thead>
<tr>
<th><strong>VIOLENCE / AGRESSION FROM CLIENTS / PATIENTS</strong></th>
<th>Violent attacks to expectant mothers: being kicked / hit in the abdominal area risk injury whilst carrying out physical intervention on clients.</th>
<th>Staff who work in high risk areas should be if possible, moved to a lower risk area / duties, or if this is not possible, suitable alternative work must be made available or as a last resort paid leave will need to be considered.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BIOLOGICAL AGENTS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ANY BIOLOGICAL AGENT OF HAZARD GROUPS 2, 3 AND 4</strong></td>
<td>Many biological agents within the 3 risk groups can affect the unborn child if the mother is infected during pregnancy. These may be transmitted through the placenta whilst the child is in the womb or during or after birth, for example through close physical contact between mother and child. Examples of agents where the child might be Infected in one of these ways are (HEPITITAS (GROUP 3), HIV (GROUP 3), HERPES (GROUP 3), T.P. (GROUP 3) CHICKENPOTS (GROUP 2) and TYPHOID (GROUP 3) For most workers, the risk of infection is not higher at work than living in the</td>
<td>Depends on the risk assessment.</td>
</tr>
</tbody>
</table>
Certain occupations exposure to infections are more likely i.e. Health Care Workers!

<table>
<thead>
<tr>
<th>LIST OF AGENTS/WORKING CONDITIONS</th>
<th>WHAT IS THE RISK?</th>
<th>HOW TO AVOID THE RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3 CHEMICAL AGENTS – The following chemical agents in so far as it is known that they endanger the health of pregnant women and the unborn child.</td>
<td>There are about 200 substances labelled with these risk phrases: R40, R45, R46 and R47 under Directive 67/548/EEC (since amended or adapted on a number of occasions)</td>
<td>With the exception of lead and asbestos these substances all fall within the scope of COSHH. For work with hazardous substances, which include chemicals which may cause heritable genetic damage, employers are required to assess the health risks to workers arising from such work, and where appropriate prevent or control the risks. In carrying out assessments employers should have regard for women who are pregnant, or who have recently given birth.</td>
</tr>
<tr>
<td>5.3.1 Substances labelled R40, R45, R46 and R47 under Directive 67/548/EEC (since amended or adapted on a number of occasions)</td>
<td>R40 possible risk of irreversible effects R45 may cause cancer R46 may cause heritable genetic damage R47 may cause birth defects – this is due to be replaced in 1994/95 by the risk phrases:- R61 may cause harm to the unborn child R63 possible risk of harm to the unborn child R64 may cause harm to breastfed babies</td>
<td>The actual risk to health of these substances can be only be determined following a risk assessment of a particular substance at the place of work- i.e. although the substances listed may have the potential to endanger health or safety, there may be no risk in practice, for example if exposure is below a level which might cause harm.</td>
</tr>
</tbody>
</table>
| Mercury and mercury derivatives | No clear evidence of adverse effects on developing foetus from studies of humans exposed to mercury and inorganic mercury compounds.  
No indication that mothers are more likely to suffer greater adverse effects from mercury and its compounds after the birth of the baby.  
Potential for health effects in children from exposure of mother to mercury and mercury compounds is uncertain.  
In the long term these drugs cause damage to genetic information in sperm and eggs. Some can cause cancer. Absorption is by inhalation or through the skin. | Guidance Notes  
EH17: Mercury – health and safety precautions  
MS12: Mercury – medical surveillance give practical guidance on the risks of working with mercury and how to control them.  
There is no known threshold limit and exposure must be reduced to as low a level as is reasonably practicable. Assessment of the risk should look particularly at preparation of the drug for use (pharmacists, nurses), administration of the drug, and disposal of waste (chemical and human).  
Those who are trying to conceive a child or are pregnant or breastfeeding should be fully informed of the reproductive hazard.  
HSE’s Guidance Note MS21 Precautions for the safe handling of cytotoxic drugs gives information about the health hazards and |
### 5.3.5 Carbon monoxide

<table>
<thead>
<tr>
<th>WORKING CONDITIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work with Display Screen Equipment</strong></td>
<td></td>
</tr>
</tbody>
</table>

Carbon monoxide readily crosses the placenta and can result in the foetus being starved of oxygen. Data on the effects of exposure to carbon monoxide on pregnant women are limited but there is evidence of adverse effects on the foetus. Both the level and duration of maternal exposure are important factors in the effect on the foetus.

There is no indication that breastfed babies suffer adverse effects from their mother’s exposure to carbon monoxide, nor that the mother is significantly more sensitive to carbon monoxide after giving birth.

---

advice on avoidance / reduction of risk.

Take special precautions to prevent skin contact. Where possible, use engineering methods to control exposure in preference to personal protective equipment, such as gloves, overalls or face shields. For example, perhaps you could enclose the process or redesign it so that less spray is produced. Where you must use personal protective equipment (either alone or in combination with engineering methods), ensure that it is suitable.

**Other Legislation**

COSHH

HSE’s guidance note EH43: Carbon monoxide – gives practical advice on the risks of working with carbon monoxide and how to control them.

It warns that pregnant women may have heightened susceptibility to the effects of exposure to carbon monoxide.

**Other Legislation**

None specific – except for the general requirements of COSHH in relation to hazardous substances.
(VDUs)

<table>
<thead>
<tr>
<th>Although not specifically listed in the Pregnant Workers Directive, HSE is aware that anxiety about radiation emissions from display screen equipment and possible effects on pregnant women has been widespread. However, there is substantial evidence that these concerns are unfounded. The HSE has consulted the National Radiological Protection Board, which has the statutory function of providing information and advice on all radiation matters to Government Departments, and the advice below summarises scientific understanding –</th>
</tr>
</thead>
<tbody>
<tr>
<td>The levels of ionising and non-ionising electromagnetic radiation which are likely to be generated by display screen equipment are well below those set out in international recommendations for limiting risk to human health created by such emissions and the National Radiological Protection Board does not consider such levels to pose a significant risk to health. No special protective measures are therefore needed to protect the health of people from this radiation.</td>
</tr>
<tr>
<td>In the light of the scientific evidence pregnant women do not need to stop work with VDUs. However, to avoid problems caused by stress and anxiety, women who are pregnant or planning children and worried about working with VDUs should be given the opportunity to discuss their concerns with someone adequately informed of current authoritative scientific information and advice.</td>
</tr>
</tbody>
</table>
# MATERNITY RISK ASSESSMENT FORM

<table>
<thead>
<tr>
<th>Hazards</th>
<th>Who Might Be Harmed</th>
<th>Summary of Existing Controls</th>
<th>Controls OK?</th>
<th>What Further Action is Necessary to Control the Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Site/Locality** ………………………………………………………

**Section** ……………………………………………………………

**Activity** ……………………………………………………………

Assessment No: ….................................................................

Date Assessment Undertaken: …...........................................

Signed …........................................... Date …......................

Assessment Review Date: ….................................................
WELCOME  PLEASE SIGN IN
MANUAL HANDLING TRAINING

HANDOUT: THEORY

- MANUAL HANDLING
- ERGONOMICS
- POSTURE
- 24 HOUR BODY CARE

NCH&C MANUAL HANDLING ADVISOR:
RICHARD ELDRED  MCSP

TEL: 01603 697336 or FAX: 01603 697494
EMAIL: richard.eldred@nchc.nhs.uk
WEB LINK: Policy and MH Risk assessments can be accessed via the: Trust Intranet - Policy documents - Manual Handling resource link - Risk assessment forms

MANUAL HANDLING DEPARTMENT  NPCT  UPDATED  06/04/05
AIMS AND OBJECTIVES

- RAISE AWARENESS OF TRUST POLICY
- THE LAW AND RISK ASSESSMENT
- PRINCIPLES OF SAFER MANUAL HANDLING
- WORKING FROM RISK ASSESSMENTS
- SAFER SYSTEMS OF WORK
- ERGONOMICS AND POSTURAL ISSUES
- SEEKING ADVICE WHEN YOU NEED IT
- UNDERSTANDING 24 HOUR BACKCARE AND POSTURE
TEST YOUR KNOWLEDGE

- IN TWO`S OR THREE`S COMPLETE THE QUIZ PAPER
- USE EXISTING KNOWLEDGE OR WHAT YOU THINK ARE THE LIKELY ANSWERS
- 5 – 10 MINUTES
- ANSWERS AT END
EPIDEMIOLOGY

- 80% of people suffer from back pain at some point in their lives.
- Healthcare is top risk profession for manual handling injuries.
- 75% of back pain reoccurs.
- Main cause of sick leave.
CAUSES OF MUSCULOSKELETAL PAIN

- Evolution
- Poor Posture
- Environment
- Poor Lifting Technique
- Cumulative Stresses
- Poor Fitness
- Unhealthy Lifestyles
- Stress/Time
ANATOMY AND PHYSIOLOGY

THE SPINE

- CERVICAL - 7
- THORACIC - 12
- LUMBAR - 5
- SACRUM - 5
- COCCYX - 4
**INTERVERTEBRAL DISCS**

- **VERY STRONG**
- **SHOCK ABSORBERS**
- **AID FLEXABILITY**
- **ACT AS SPACERS**
- **PROTECT SPINAL CORD**
INTERVERTEBRAL DISCS

- DAMAGED BY STRAIN -
- CUMULATIVE
- REPETITIVE
- SEVERE ACUTE TRAUMA
- THEY CAN PROLAPSE
  USUALLY POSTERIOR-
  LATERAL
- SLOW TO HEAL
- LIMITED NERVE AND
  BLOOD SUPPLY
Examples of Harmful Working Postures
What makes a Posture Harmful?

- When it is:
  - Unbalanced
  - Unsupported
  - Twisted
  - Bent
  - Static
  - Repetitive
  - Stressed
  - Awkward
  - Painful
  - Prolonged
Ergonomics: The Law Of Work

- Designing the task to suit the Person

Benefits:
- Reduces risk
- Increases efficiency
- Reduces Injury
THE LAW
HEALTH AND SAFETY AT WORK ACT

- **EMPLOYER:**
  - PROVIDE SAFE PLACE OF WORK
  - PROVIDE TRAINING

- **EMPLOYEE:**
  - SAFE SYSTEMS OF WORK
  - FOLLOW PROCEDURES
  - REPORT PROBLEMS
  - ACT RESPONSIBLY
RISK MANAGEMENT

2 KEY DEFINITIONS TO UNDERSTAND

1. THE HAZARD
   = SOURCE OF INJURY

2. THE RISK
   = COMBINATION OF LIKELIHOOD AND SEVERITY
Manual Handling Definition

- Transporting
- Supporting
- Lifting
- Carrying
- Pushing
- Pulling
- Intentional dropping
- Throwing

Of a Load
THE LAW
MANUAL HANDLING REGULATIONS

- Load = Object/Animal/Person
- Avoid Hazardous Handling
- Risk Assessment
- Risk Reduction
- Inform
- Act
- Review
- Document
RISK ASSESSMENT WEIGHT
GUIDELINES: MANUAL HANDLING

Weight Guidelines for Risk Assessment

- NO LEGAL MAXIMUM LIMIT
- 90% OF WORKERS SAFE WITHIN THESE GUIDELINE LIMITS
- MUST RISK ASSESS ALL HANDLING ABOVE GUIDELINES
- GUIDELINES ALSO EXIST FOR PUSHING / PULLING

Number of Handlers and their combined capacities

<table>
<thead>
<tr>
<th>One person</th>
<th>Two people</th>
<th>Three people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25Kg</td>
<td>33.3Kg</td>
<td>37.5Kg</td>
</tr>
<tr>
<td>3st 13lb</td>
<td>5st 3lb</td>
<td>5st 12lb</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.6kg</td>
<td>22.2Kg</td>
<td>25Kg</td>
</tr>
<tr>
<td>2st 8lb</td>
<td>3st 7lb</td>
<td>3st 13lb</td>
</tr>
</tbody>
</table>
MANUAL HANDLING RISK ASSESSMENT - CONSIDER:

- L - LOAD
- I - INDIVIDUAL
- T - TASK
- E - ENVIRONMENT
LOAD - OBJECT

- WEIGHT
- SHAPE
- GRIP
- HOT/COLD
- SHARP
- BULKY
- CENTRE OF GRAVITY
- STABLE
LOAD - PEOPLE

- WEIGHT
- ABILITY
- COMPLIANCE
- MEDICAL HISTORY
- PREDICTABLE?
- FALLS RISK
- DRIPS/DRAINS
- OTHER
INDIVIDUAL -- DOING TASK

- FIT AND WELL
- PREGNANCY
- TRAINING
- ABILITY
- EXPERIENCE
TASK

- BENDING
- TWISTING
- OVERREACHING
- REPETITION
- SUSTAINED
- INSUFFICIENT REST
- HEIGHT
- CAN IT BE AVOIDED
ENVIRONMENT

- SPACE
- FLOORS
- OBSTRUCTIONS
- TEMPERATURE
- POSTURAL CONTRAINTS
- LIGHTING
- TRIP HAZARDS
- NOISE
**OTHER FACTORS**

- **EQUIPMENT**
  - AVAILABLE
  - SUITABLE

- **SAFE WORKING LOADS**

- **MOVEMENT HINDERED BY PPE**

- **REPORT UNSAFE EVENTS ON INCIDENT/NEAR MISS FORM**
PRINCIPLES OF OBJECT HANDLING

- On the spot reassess tile
- Check load
- Secure grip
- Keep load close
- Avoid/reduce spinal:
  - Bending
  - Twisting
  - Over-reaching
- Move smoothly
- If in doubt seek advice
POOR LIFTING TECHNIQUE

- BENDING
- TWISTING
- OVERREACHING
- NARROW BASE OF SUPPORT
- LOAD OUTSIDE BASE OF SUPPORT
CORRECT LIFTING TECHNIQUE

- Load close
- No twisting
- Neutral spine
- Stable base of support
- Load within base of support
- Head up during lift
- Good grip
Pushing and Pulling

- Neutral Spine
- Use Body Weight
- Use Strong Leg Muscles
- Head Forward
- Smooth Movement
PRINCIPLES OF PEOPLE HANDLING

- Assess: Lite
- Encourage Independence
- Promote Normal Movement
- Use Equipment
- Good Body Mechanics
- Seek Advice
- Document
Unsafe and high risk techniques:

- Drag - Bed and Chair
- Orthodox or Cradle
- Pivot, Bear Hug or Bobath
- Top and Tail
- Through Arm
- Australian Slide
- Flip Turn
VDU RISK ASSESSMENT

- USE TRUST FORM
- CONSIDER:
  - POSTURE
  - CHAIR
  - DESK
  - VDU
  - ENVIRONMENT
  - SEEK ADVICE
VDU RISK ASSESSMENT PRACTICAL EXERCISE
BENEFITS OF EXERCISE

- Fitness
- Reduce health risks
- Increase strength
- Increase flexibility
- Sense of well being
- Gives energy
- AIDS circulation
- Promotes healing
ANSWERS TO QUIZ
SO WHERE FROM HERE?

- Ask if not sure
- Risk assess
- Postural awareness
- Good body mechanics when manual handling
- Keep fit
- 24 hour back care
CURRENT AND FUTURE THINKING?

- WHAT'S IN IT FOR ME?
- WHAT HAVE I LEARNED?
- WHAT WILL I DO DIFFERENTLY?
- TAKE CARE OF YOURSELF
- YOU ARE VERY IMPORTANT!
APPENDIX TO HANDOUT

- QUIZ
- RISK ASSESSMENT WEIGHT GUIDELINES
- VDU PRACTICAL PICTURE
- VDU R/A FORM
- EXAMPLES OF UNSAFE PEOPLE HANDLING
- EMERGENCY HANDLING EXAMPLES
- ACCIDENT / INCIDENT / NEAR MISS FORM
- MANUAL HANDLING R/A FORMS-PATIENT / OBJECT / PUSHING AND PULLING
Norfolk Community Health & Care

Manual Handling Policy: Addendum 2

Guidelines for the management of the falling and fallen patient:

Guideline Statement

Norfolk Community Health and Care Trust recognises the risk to staff and patients from falls situations. In order to avoid or reduce manual handling injury risk to staff; and trauma risk to patients; these guidelines should be considered as part of the existing controls and standards as laid out in the Trust Manual Handling Policy.

Background

Falls in the community environment tend to occur more frequently amongst the elderly population i.e. 35% of people over 65 years old and 50% of those over 85 years old will fall. Fifteen percent of falls require hospital admission; of these a third will sustain a fractured hip and of these 20% will die. Within the service user population of Norfolk
Community Health and Care Trust, it is not just the elderly who must be considered at risk of falls. Annually, approximately 250 serious incidents are reported nationally from the health care sector to the HSE. These typically involve staff who have sustained a major injury. Of these injuries - 90% resulted from involvement in a falling patient incident (Health and Safety Executive 2006). Every falls situation has the potential of high risk of injury to both patient and staff.

**Aims**

Norwich PCT is committed to following legal requirements and national best practice guidelines; and will achieve this via policy, planning, risk assessment, balanced decision making, clinical reasoning and where available evidence based practice. A review of incident forms will allow the guideline to be audited and measured.

**Definitions:**

Staff and Carer: Persons under “Employee” Health and Safety jurisdiction of NPCT

Faller and Patient: Any person who falls; usually a person already under the formal care of NPCT
Staff or Carers, but could also be a Visitor or relative etc.

Objectives

The primary objective is to prevent a fall from occurring in the first place (as far is as reasonably practicable within the framework of patient care and rehabilitation). Where falls do occur the objective where practicable is to minimise injury to both staff and patient. Incident reporting will ensure staff learn from the event to avoid or reduce reoccurrence.

Prevention of Falls

The key to a successful falls prevention strategy is an awareness of the causation of falls. It is the responsibility of staff and managers to assess these risk factors, within the framework of clinical and falls risk assessments and manual handling risk assessments (where applicable).

Despite all preventative measures some patients will still fall with the risk of harm to themselves and their carers.
Betts and Mowbray (Hop 5, 2005) identified a moral dilemma, in that some staff perceive allowing a person to fall to the ground is unacceptable, and is a contradiction of their duty of care towards the patient.

They are reminded that an equal duty of care is expected under the Health and Safety at Work etc Act 1974, towards themselves.

Management of the Falling Patient

National best practice guidelines (The guide to the handling of people, 5th edition 2005, and Handling in the Community, 1999) advocate a limited range of intervention options dependent on presenting criteria.

1. All current guidelines recommended that staff do not attempt to catch or support the full body weight of a falling person. (See picture)
DANGERS OF TRYING TO CATCH A FALLING PERSON: IT CAN INCREASE
THE RISK OF INJURY TO PERSON OR CARER
A THOROUGH RISK ASSESSMENT IS BEST RISK REDUCTION STRATEGY

2. If staff are right beside the person and are able to get behind, adopting a braced and stable upright posture, they may be able to guide the person to the ground by acting as a slide (see picture sequence).
It is advisable that the staff member is not smaller in stature and weight than the faller. They should also have received training in how to adopt the braced and stable posture.
CONTROLLING AN UNBALANCED OR POTENTIALLY COLLAPSING PERSON

- Dynamic on the spot risk assessment to decide if intervention is reasonable
- You must be already right by patient
- Assume braced and stable position behind patient
- Avoid grip that can’t be released easily
- Do not intervene if you think unsafe for you to do so, or feel unsure of the process
- Do not attempt to catch or hold up a falling or non weight bearing patient
- Encourage weight-bearing—shout: “Standup”
- Allow patient to slide to floor if necessary
- Falls or collapse risk is best managed by pre-activity risk assessment

CONTROLLING A COLLAPSING PERSON—SLIDE TO THE FLOOR

This sequence aims to represent the principles of a sliding intervention approach. Each case may be slightly different, but intervention if decided upon, should aim to follow these principles of sliding and stable body posture—see next page: picture 5 also.

Carer is already close by and slightly behind person

Person starts to collapse so carer releases hand grip and adopts a stable position behind person. Hands are now guiding patient—not trying to catch them or hold them up.

Person fails to regain independence—no attempt is made to manually hold persons weight—person is allowed to slide to floor by carer

Carers primary objectives are to reduce persons head injury risk whilst protecting self

23 May 2006 Manual Handling Dept NPCT 13
CONTROLLING A COLLAPSING PERSON- SLIDE TO FLOOR
(CONTINUED)

REALISTICALLY MOST COLLAPSES AND FALLS WILL PROBABLY NOT BE SUITABLE FOR SLIDING INTERVENTION, HOWEVER THERE MAY BE SOME SITUATIONS WHERE THE CARER DECIDES THAT ON BALANCE OF RISK A SLIDING INTERVENTION IS ACCEPTABLE

A SLIDING INTERVENTION WILL REQUIRE THE FOLLOWING:
• Carer must already be standing close to side / behind person collapsing, and understand the process
• 2 or more carers probably cannot intervene at the same time and in same way, with this method-agree intervention plan beforehand
• Carer must be in a stable upright posture
• Carer must not be limited by personal health issues
• The collapsing person should not be significantly larger than carer
• The collapsing person must not be falling away from carer
• Carer must have adequate space
• Carer must release their grip and purely act as a guide and slide,
• Protecting the persons head is a key objective
• Do not catch or hold any weight or physically lower patient

YOU ARE NOT OBLIGED TO INTERVENE
• THE RISKS TO YOU AND THE PERSON ARE POTENTIALLY VERY HIGH IF YOU GET IT WRONG!
• IS YOUR EXISTING RISK ASSESSMENT UP TO DATE AND THE RESULTING SAFE METHOD OF WORK ADEQUATE?

Have you already taken reasonable and suitable precautions to avoid the need to intervene in this manner

• Be Pro-active: seek advice on risk reducing measures AND SAFER ways of mobilising people

3. Staff on restricted duties through ill health, pregnancy, new mother or injury, are advised to avoid intervening in this manner. Also any staff untrained in this procedure should not intervene.
4. A final act of intervention may be in the form of a staff member redirecting (via pushing or pulling) the faller away from an obvious source of harm i.e. window, traffic, stairs etc. This should not involve supporting full body weight and should aim to avoid hazardous postures. Staff may also try and move a hazardous object or place a pillow etc to soften the fall.

5. When falls occur during transfers involving lying (i.e. off a bed, assessment couch), sitting and crouching; or access to the person is restricted by equipment or environment, then the staff can follow point 4 or decide to let the patient fall.

At no time in any falls event will a member of staff be expected to intervene, the decision rests entirely with their dynamic on the spot assessment of the situation. If there is any doubt do not intervene, as a post fall intervention maybe required. (i.e. the need for resuscitation is potentially more beneficial to the faller but not if compromised through staff injury)

The post fall incident form and review will examine why they fell, not why they weren’t caught.

All interventions carry risk and it is the responsibility of staff to choose the appropriate
response, (balancing the risk to themselves and the faller). **If in doubt- Do Not Intervene.**

In reality the vast majority of fallers will be in a situation where they are beyond the point for help or intervention from staff.

**Management of the Fallen Patient**

A fallen person must be assessed, to establish if they require resuscitation, emergency admission to A/E, or a non emergency (medical) assessment. Help from colleagues or “good Samaritans” will probably be required, and should be summoned immediately. The faller should not be moved until assessed as safe to do so.

**If deemed safe to move:**

Options will vary depending on mobility status of faller, equipment available and environment- but they could include:

1. Faller is able to independently transfer themselves unaided (off the floor) into a suitable position
2. Faller uses one or two chairs, (slid into place and steadied by carers) to lean and push on, to assist themselves into a sitting position- see picture sequence
INDEPENDENT PATIENT TRANSFER FROM FLOOR USING 2 CHAIRS AND VERBAL PROMPTS
STAFF WILL PROBABLY NEED TO STABILISE CHAIRS

3. Faller is hoisted from floor- to (wheel)chair or bed
4. Staff use a Mangar booster cushion (if available) to raise faller off floor
5. Where fallers are in a confined space, slide sheets with extension handles can be used to slide faller to an area with better (hoist) access.

The Emergency services should not be used as a “lifting service”.
All reasonably foreseeable falls risks should be managed via risk assessment and the subsequent provision of suitable training and equipment.

Seek advice on manual handling risk management from your line manager or the manual handling department if unsure.
References and Bibliography


Legal and Best Practice

1. Health and safety at work etc Act 1974
3. Manual Handling Operation regulations 1992 (as amended)
5. Safer Handling of People in the Community Backcare 1999
2 HOUR MANUAL HANDLING, POSTURE AND ERGONOMICS
CLINICAL TRAINING HANDOUT

- A PICTORIAL GUIDE OF HANDLING TECHNIQUES AND PRINCIPLES: FOR STAFF TRAINED BY NORFOLK PCT / MANUAL HANDLING DEPT ©

- FOR MORE INFORMATION OR ENQUIRIES CONTACT YOUR MANUAL HANDLING ADVISOR:
  - RICHARD ELDRED MCSP
  - MANUAL HANDLING DEPT NPCT
  - TEL: 01603 307141 OR FAX: 01603 307391

EMAIL: richard.eldred@nchc.nhs.uk

WEB LINK: Nexus Extranet ► NPCT ► Quality and Development Team ► Healthcare

Norfolk Community Health and Care

NHS
IMPORTANT: READ THIS FIRST

- This Pictorial Guide is a general reminder only, and is intended to support, not replace adequate training and risk assessment.

- The following are examples of handling techniques: discussed, demonstrated or practiced in NPCT Manual Handling training.

- This information shows a sample of techniques only, instructions listed are key points, not the total information given in training.

- All techniques rely on suitable and sufficient manual handling risk assessment and training.

- The number of staff required for any transfer is based on risk assessment.

- Suitable training or guidance is essential in understanding current best practice.

- None of these techniques should be attempted, unless you have been adequately trained by NPCT.

- All staff are accountable for their actions.

- Always use good body mechanics and clear instructions to colleagues and the individual.

- Report fitness to work or training competency concerns immediately.

- All techniques can be, or may need to be adjusted or modified, depending on risk and clinical assessment, and individual experience, training and competency.

- Techniques can change in terms of current best practice: always seek current advice if in any doubt.

- Never just copy a technique, always work to a documented risk assessment, and understand why and how you are doing it- techniques are based on principles not prescription.

- Always seek advice at your refresher training or sooner if unsure.

(if this handout is more than a year old from date below, check that the information is still valid)

I have read and understood the above information.

NAME:                                  SIGNATURE:                                  DATE:

22 March 2012                                  Manual Handling Dept NPCT

2
KEY PRINCIPLES

• RISK ASSESSMENT, CLINICAL REASONING, BALANCED DECISION MAKING AND EVIDENCE BASED PRACTICE
• AVOID HANDLING IF POSSIBLE
• ENCOURAGE INDEPENDENCE
• ENCOURAGE NORMAL INDEPENDENT MOVEMENT WHERE POSSIBLE
• CONSIDER ENVIRONMENT AND MAKING CHANGES TO CREATE SPACE, CHECKING HEIGHT OF BEDS, CHECKING BRAKES
• USE GOOD (SAFER) BODYPATHWAYS
• USE SAFER HAND POSITIONING
• COMMUNICATE EFFECTIVELY
• USE APPROPRIATE EQUIPMENT WHERE INDICATED - TAKE CARE OF PATIENTS SKIN
• REASSESS AND RECORD REGULARLY
• WORK WITHIN YOUR ABILITIES, TRAINING AND COMPETENCY
• IMMEDIATELY REPORT ANY CONCERNS
• REPORT PREGNANCY AND HEALTH OR FITNESS CONCERNS

• SEEK ADVICE IF UNSURE
GOOD BODY MECHANICS AND
“POWER POSTURES”
THE THEORY

- WHEN PERFORMING ANY MANUAL HANDLING TASK (THAT YOU CANNOT
  AVOID) TRY AND ENSURE YOU USE GOOD (SAFER) BODY MECHANICS AND
  ADOPT A “POWER POSTURE”- THE CRITERIA IS THAT THE:

- SPINE IS KEPT IN NEUTRAL:- AVOID OVER BENDING/EXTENDING TWISTING,
  OVERREACHING
- HEAD IS KEPT LOOKING FORWARD DURING THE LIFT/MOVE
- STRONGER LEG/BUTTOCK MUSCLES CREATE THE POWER BEHIND THE
  LIFT/MOVE
- BEND HIPS AND KNEES
- SPINAL MUSCLES BRACE AND STABILISE YOUR SPINE, BUT AREN’T THE
  PRIMARY MOVERS FOR PUSHING/PULLING, LIFTING /LOWERING
- CREATE A STABLE AND BALANCED BASE OF SUPPORT
- YOUR WEIGHT TRANSFER DURING A MOVE IS THROUGH THE LEGS NOT THE
  SPINE- AVOID TWISTING
- YOUR CENTRE OF GRAVITY (USUALLY AROUND THE LOWER SPINE/PELVIC
  AREA) REMAINS WITHIN YOUR BASE OF SUPPORT DURING ALL MOVES
- ALL MOVES ARE PERFORMED SMOOTHLY
- SECURE A GOOD GRIP
- ALWAYS WORK WITHIN PERSONAL CAPABILITIES
EXAMPLES OF “GOOD” (SAFER) BODY MECHANICS AND POWER POSTURES IN VARIOUS TASKS
POOR BODymeCHANICS
AND LIFTING- THE THEORY
(ILLUSTRATED WITH OBJECT HANDLING SCENARIOS)

• SEVERE SPINAL BENDING WILL DRAMATICALLY INCREASE RISK OF INJURY TO YOUR BACK
• HANDLING LOADS AWAY FROM BODY- SIGNIFICANTLY INCREASES SPINAL STRESSES AND STRAIN
• TWISTING WILL ALWAYS INCREASE STRAIN ON YOUR SPINE
• AVOID USING (POSTURAL) BACK MUSCLES AS MAIN SOURCE OF POWER- WHEN LIFTING, PUSHING OR PULLING- USE STRONGER LEG MUSCLES
• AVOID SLOUCHED WORKING POSTURES
IMPROVED (GOOD) BODY MECHANICS AND LIFTING-THEORY
ILLUSTRATED WITH OBJECT HANDLING SCENARIO

- **USE A POWER POSTURE:**
  - UPRIGHT SPINE
  - LOAD KEPT CLOSE
  - USE OF LEG POWER MUSCLES- QUADRACEPS, HAMSTRINGS, GLUTEAL (BUTTOCK)
  - NO TWISTING
  - GOOD GRIP
  - IMPROVED ACCESS TO LOAD
  - LOAD WITHIN CAPABILITIES OF HANDLER
  - LOAD WITHIN BASE OF SUPPORT
  - LIFT SMOOTHLY
THE FOLLOWING ARE EXAMPLES OF PRACTICAL PERSON HANDLING TECHNIQUES CURRENTLY TAUGHT BY NPCT

REMEMBER:

- REVIEW AND SEEK ADVICE WHEN NECESSARY
- SAFER HANDLING METHODS
- RISK ASSESSMENT
- TRAINING
HAND HOLD WITH ONE OR TWO

- Palm to palm grip
- Avoid thumb grip
- Stand to weaker or preferred side or as indicated on Risk Assessment
- Stand slightly behind
- Place other hand on lumbar area or opposite hip
- Handling belt use and number of staff dependent on Risk Assessment
ASSISTED WALKING

- Can be with one or two staff - dependent on risk assessment
- Minimal assistance required
- Palm to palm grip
- One hand on lumbar or hip of patient
- With or without handling belt - dependent on risk assessment
- To side and slightly behind
CONTROLLING AN UNBALANCED OR POTENTIALLY COLLAPSING PERSON

- **DYNAMIC ON THE SPOT RISK ASSESSMENT TO DECIDE IF INTERVENTION IS REASONABLE**
- **YOU MUST BE ALREADY RIGHT BY PATIENT**
- **ASSUME BRACED AND STABLE POSITION BEHIND PATIENT**
- **AVOID GRIP THAT CAN'T BE RELEASED EASILY**
- **DO NOT INTERVENE IF YOU THINK UNSAFE FOR YOU TO DO SO, OR FEEL UNSURE OF THE PROCESS**
- **DO NOT ATTEMPT TO CATCH OR HOLD UP A FALLING OR NON WEIGHT BEARING PATIENT**
- **ECOURAGE WEIGHTBEARING- SHOUT: “STANDUP”**
- **ALLOW PATIENT TO SLIDE TO FLOOR IF NECESSARY**
- **FALLS OR COLLAPSE RISK IS BEST MANAGED BY PRE-ACTIVITY RISK ASSESSMENT**
CONTROLLING A COLLAPSING PERSON - SLIDE TO THE FLOOR

This sequence aims to represent the principles of a sliding intervention approach. Each case may be slightly different, but intervention if decided upon, should aim to follow these principles of sliding and stable body posture - see next page: picture 5 also

- Carer is already close by and slightly behind person
- Person starts to collapse so carer releases hand grip and adopts a stable position behind person. Hands are now guiding patient - not trying to catch them or hold them up
- Person fails to regain independence - no attempt is made to manually hold persons weight - person is allowed to slide to floor by carer
- Carers primary objectives are to reduce persons head injury risk whilst protecting self

22 March 2012 Manual Handling Dept NPCT
CONTROLLING A COLLAPSING PERSON- SLIDE TO FLOOR
(CONTINUED)

• REALISTICALLY MOST COLLAPSES AND FALLS WILL PROBABLY NOT BE SUITABLE FOR SLIDING INTERVENTION, HOWEVER THERE MAY BE SOME SITUATIONS WHERE THE CARER DECIDES THAT ON BALANCE OF RISK A SLIDING INTERVENTION IS ACCEPTABLE
• A SLIDING INTERVENTION WILL REQUIRE THE FOLLOWING:
• Carer must already be standing close to side / behind person collapsing, and understand the process
• 2 or more carers probably cannot intervene at the same time and in same way, with this method-agree intervention plan beforehand
• Carer must be in a stable upright posture
• Carer must not be limited by personal health issues
• The collapsing person should not be significantly larger than carer
• The collapsing person must not be falling away from carer
• Carer must have adequate space
• Carer must release their grip and purely act as a guide and slide,
• Protecting the persons head is a key objective

• Do not catch or hold any weight or physically lower patient
• YOU ARE NOT OBLIGED TO INTERVENE
• THE RISKS TO YOU AND THE PERSON ARE POTENTIALLY VERY HIGH IF YOU GET IT WRONG!
• IS YOUR EXISTING RISK ASSESSMENT UP TO DATE AND THE RESULTING SAFE METHOD OF WORK ADEQUATE?
• Have you already taken reasonable and suitable precautions to avoid the need to intervene in this manner
• Be Pro-active: seek advice on risk reducing measures AND SAFER ways of mobilising people

“IMMEDIATELY OUT of CONTROL”:
Falls, slips, trips, collapses cannot be managed with this method, DO NOT ATTEMPT. If you can reasonably re-direct (push/pull) the person away from an area of extreme harm then do so i.e.: if about to: fall down stairs, or into busy road or badly strike head
DANGERS OF TRYING TO CATCH A FALLING PERSON: IT CAN INCREASE
THE RISK OF INJURY TO PERSON OR CARER
A THOROUGH RISK ASSESSMENT IS BEST RISK REDUCTION STRATEGY
INDEPENDENT PATIENT TRANSFER FROM FLOOR USING 2 CHAIRS AND VERBAL PROMPTS

STAFF WILL PROBABLY NEED TO STABILISE CHAIRS
ENCOURAGING INDEPENDENT MOVEMENT IN A CHAIR

- Offer verbal- and tactile guidance (if necessary) via hip and knee area.
- Encourage maximal independence.
- Ensure you maintain a good posture.
- Remember to create space around the individual to improve safety and working posture.
SIT TO STAND WITH ONE OR TWO: HANDS ON- CARER FORWARD FACING

- CLOSE TO PATIENT
- STABLE BASE FOR PATIENT AND CARER
- CARER NEUTRAL SPINE
- CARER GRIP: HAND TO HAND AND HAND TO LUMBAR OR HIP
- GIVE CLEAR COMMANDS: READY-STAND
- ENCOURAGE INDEPENDANCE
- MINIMAL CARER EFFORT
- REAR FOOT POSITIONED NEAR BACK OF CHAIR IN CASE PATIENT SUDDENLY SITS- THIS ALLOWS YOU TO FLEX DOWN VIA YOUR LEGS NOT YOUR BACK
- WHETHER OR NOT YOU USE A PRE-STAND ROCKING MOVEMENT WILL DEPEND ON INDIVIDUAL RISK ASSESSMENT
- USE OF HANDLING BELT IS DEPENDENT ON RISK ASSESSMENT
- USE OF ONE OR TWO STAFF DEPENDENT ON RISK ASSESSMENT
ASSISTED SIT TO STAND- WITH ONE OR TWO: CARER FACING SIDE ON

- USEFUL IF WORKING FROM WIDE CHAIRS OR THOSE WITH WINGS
- CARER HANDS: STERNUM OR SHOULDER AND LUMBAR OR HIP
- ENCOURAGES PATIENT TO PUSH WITH BOTH HANDS WHERE APPROPRIATE
- STABLE STANCE AS PREVIOUS METHOD
- USE OF HANDLING BELT AND ONRE OR TWO STAFF DEPENDENT ON RISK ASSESSMENT
SIT TO STAND WITH ONE OR TWO-
WITH A HANDLING BELT

• ALL SIT TO STAND METHODS CAN INCLUDE THE USE OF A HANDLING BELT (WITH ONE OR TWO)- DEPENDENT ON RISK ASSESSMENT
• HOLD OUTSIDE OF LOOPS TO AVOID ENTRAPMENT
• AIDS PATIENTS ABILITY AND BALANCE
• AVOID SIGNIFICANT LIFTING EFFORT
ENCOURAGE INDEPENDENT BED MOVES I.E LYING TO SITTING
HIGH RISK DISCONTINUED TECHNIQUES

DRAG SLIDE OR LIFT

AUSTRALIAN SLIDE OR LIFT

BEAR HUG, PIVOT OR BOBATH LIFT

ORTHODOX, CRADLE OR TRADITIONAL LIFT
HIGH RISK DISCONTINUED TECHNIQUES

- Top and Tail Lift
- Through Arm Lift or Slide
- Drag Lift into Standing
- Drag Lift into Standing
FINAL THOUGHTS

• BE AWARE THAT THERE ARE MANY OTHER HANDLING TECHNIQUES NOT CURRENTLY ILLUSTRATED IN THIS HandOUT
• IF NEEDED SEEK (SPECIALIST) ADVICE OR ADDITIONAL SPECIFIC TRAINING
• WORK WITHIN YOUR OWN COMPETENCY LEVELS
• BE RESPONSIBLE AND ACCOUNTABLE
• KEEP FIT FOR YOUR JOB
• CHALLENGE UNSAFE PRACTICE
• TAKE GOOD CARE OF YOURSELF, COLLEAGUES AND THE PERSONS UNDER YOUR CARE
NPCT: PRACTICAL MANUAL HANDLING: 2 hr OBJECT HANDLING TRAINING HANDOUT

Norfolk Community NHS Health and Care

- A PICTORIAL GUIDE OF OBJECT HANDLING TECHNIQUES FOR STAFF TRAINED BY NORFOLK PCT / MANUAL HANDLING DEPT ©

- FOR MORE INFORMATION OR ENQUIRIES CONTACT THE MH ADVISORS:
  - RICHARD ELDRED MCSP

- MANUAL HANDLING DEPT NPCT
  - TEL: 01603 307141 OR FAX: 01603 307391

EMAIL: richard.eldred@nchc.nhs.uk

WEB LINK: Nexus Extranet ► NPCT ► Quality and Development Team ► Healthcare
IMPORTANT: READ THIS FIRST

- **THIS PICTORIAL GUIDE IS A GENERAL REMINDER ONLY, AND IS INTENDED TO SUPPORT, NOT REPLACE ADEQUATE TRAINING AND RISK ASSESSMENT**

- **THE FOLLOWING ARE EXAMPLES OF HANDLING TECHNIQUES: DISCUSSED, DEMONSTRATED OR PRACTICED IN NPCT MANUAL HANDLING TRAINING**

- **THIS INFORMATION SHOWS A SAMPLE OF TECHNIQUES ONLY, INSTRUCTIONS LISTED ARE KEY POINTS, NOT THE TOTAL INFORMATION GIVEN IN TRAINING**

- **ALL TECHNIQUES RELY ON SUITABLE AND SUFFICIENT MANUAL HANDLING RISK ASSESSMENT AND TRAINING**

- **THE NUMBER OF STAFF REQUIRED FOR ANY TRANSFER IS BASED ON RISK ASSESSMENT**

- **SUITABLE TRAINING OR GUIDANCE IS ESSENTIAL IN UNDERSTANDING CURRENT BEST PRACTICE**

- **NONE OF THESE TECHNIQUES SHOULD BE ATTEMPTED, UNLESS YOU HAVE BEEN ADEQUATELY TRAINED BY NPCT**

- **ALL STAFF ARE ACCOUNTABLE FOR THEIR ACTIONS**

- **ALWAYS USE GOOD BODY MECHANICS AND CLEAR INSTRUCTIONS TO COLLEAGUES AND THE INDIVIDUAL**

- **REPORT FITNESS TO WORK OR TRAINING COMPETENCY CONCERNS IMMEDIATELY**

- **ALL TECHNIQUES CAN BE, OR MAY NEED TO BE ADJUSTED OR MODIFIED, DEPENDING ON RISK ASSESSMENT, AND INDIVIDUAL EXPERIENCE, TRAINING AND COMPETENCY**

- **TECHNIQUES CAN CHANGE IN TERMS OF CURRENT BEST PRACTICE: ALWAYS SEEK CURRENT ADVICE IF IN ANY DOUBT**

- **NEVER JUST COPY A TECHNIQUE, ALWAYS WORK TO A DOCUMENTED RISK ASSESSMENT, AND UNDERSTAND WHY AND HOW YOU ARE DOING IT- TECHNIQUES ARE BASED ON PRINCIPLES NOT PRESCRIPTION**

- **ALWAYS SEEK ADVICE AT YOUR REFRESHER TRAINING OR SOONER IF UNSURE**

(Iif this handout is more than a year old from date below, check that the information is still valid)

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION

NAME:                          SIGNATURE:                          DATE:

22 March 2012 Manual Handling Dept NPCT
KEY PRINCIPLES

- RISK ASSESSMENT, TRAINING, BALANCED DECISION MAKING AND COMMON SENSE
- AVOID HANDLING IF POSSIBLE
- CONSIDER ENVIRONMENT AND MAKING CHANGES TO CREATE SPACE, CHECKING HEIGHT OF WORK SURFACES, ACCESS TO AND CONDITION OF EQUIPMENT
- USE GOOD (SAFER) BODYMECHANICS
- USE SAFER HAND POSITIONING
- COMMUNICATE EFFECTIVELY
- USE APPROPRIATE EQUIPMENT WHERE INDICATED.
- REASSESS AND RECORD REGULARLY
- WORK WITHIN YOUR ABILITIES, TRAINING AND COMPETENCY
- IMMEDIATELY REPORT ANY CONCERNS
- REPORT PREGNANCY AND HEALTH OR FITNESS CONCERNS
- SEEK ADVICE IF UNSURE
GOOD BODY MECHANICS AND “POWER POSTURES”
THE THEORY

• WHEN PERFORMING ANY MANUAL HANDLING TASK (THAT YOU CANNOT AVOID) TRY AND ENSURE YOU USE GOOD (SAFER) BODY MECHANICS AND ADOPT A “POWER POSTURE”- THE CRITERIA IS THAT THE:
  • SPINE IS KEPT IN NEUTRAL: AVOID OVER BENDING/EXTENDING TWISTING, OVERREACHING
  • HEAD IS KEPT LOOKING FORWARD DURING THE LIFT/MOVE
  • STRONGER LEG/BUTTOCK MUSCLES CREATE THE POWER BEHIND THE LIFT/MOVE
  • SPINAL MUSCLES BRACE AND STABILISE YOUR SPINE, BUT AREN’T THE PRIMARY MOVERS FOR PUSHING/PULLING, LIFTING /LOWERING
  • CREATE A STABLE AND BALANCED BASE OF SUPPORT
  • BEND HIPS AS WELL AS KNEES
  • YOUR WEIGHT TRANSFER DURING A MOVE IS THROUGH THE LEGS NOT THE SPINE- AVOID TWISTING
  • YOUR CENTRE OF GRAVITY (USUALLY AROUND THE LOWER SPINE/PELVIC AREA) REMAINS WITHIN YOUR BASE OF SUPPORT DURING ALL MOVES
  • ALL MOVES ARE PERFORMED SMOOTHLY
  • SECURE A GOOD GRIP
  • ALWAYS WORK WITHIN PERSONAL CAPABILITIES
EXAMPLES OF “GOOD” (SAFER) BODY MECHANICS AND POWER POSTURES IN VARIOUS TASKS
POOR BODYMECHANICS AND LIFTING- THE THEORY

(ILLUSTRATED WITH OBJECT HANDLING SCENARIOS)

- SEVERE SPINAL BENDING WILL DRAMATICALLY INCREASE RISK OF INJURY TO YOUR BACK
- HANDLING LOADS AWAY FROM BODY- SIGNIFICANTLY INCREASES SPINAL STRESSES AND STRAIN
- TWISTING WILL ALWAYS INCREASE STRAIN ON YOUR SPINE
- AVOID USING (POSTURAL) BACK MUSCLES AS MAIN SOURCE OF POWER- WHEN LIFTING, PUSHING OR PULLING- USE STRONGER LEG MUSCLES
- AVOID SLOUCHED WORKING POSTURES
IMPROVED (GOOD) BODY MECHANICS AND LIFTING-THEORY
I ILLUSTRATED WITH OBJECT HANDLING SCENARIO

- **USE A POWER POSTURE:**
  - UPRIGHT SPINE
  - LOAD KEPT CLOSE
  - BEND HIPS AND KNEES
  - USE OF LEG POWER MUSCLES- QUADRACEPS, HAMSTRINGS, GLUTEAL (BUTTOCK)
  - NO TWISTING
  - GOOD GRIP
  - IMPROVED ACCESS TO LOAD
  - LOAD WITHIN CAPABILITIES OF HANDLER
  - LOAD WITHIN BASE OF SUPPORT
  - LIFT SMOOTHLY
Pushing and Pulling

• NEUTRAL SPINE
• USE BODY WEIGHT
• USE STRONG LEG MUSCLES
• HEAD FORWARD
• SMOOTH MOVEMENT
CAR BOOT HANDLING

• **To remove load from boot:**
  • Flex hips and knees and stand as close to car or brace against it
  • Slide object towards you and if possible over lip of boot to thigh
  • Maintain neutral spine
  • Lift with leg muscles
  • Avoid twisting
  • Create clear access to boot and load
  • **Reverse above for placing load in boot**
TEAM LIFTING

- CONSIDER HEIGHT, STRENGTH, TRAINING AND OVERALL ABILITIES OF ALL THE HANDLERS INVOLVED

- FOLLOWING SAFE LIFTING OR PUSH/PULL PRINCIPLES

- CLEAR COMMUNICATION

- CAN EQUIPMENT BE USED
WHERE INDICATED BY RISK ASSESSMENT- USE EQUIPMENT
REMEMBER:

RISK ASSESSMENT

TRAINING

REVIEW AND SEEK ADVICE WHEN NECESSARY

SAFER HANDLING METHODS

RISK ASSESSMENT
HANDLING OF WEIGHTS ABOVE THESE MUST BE RISK ASSESSED
SELECTION OF LIFTING TECHNIQUES
(SUBJECT TO RISK ASSESSMENT)

- Diagonal lift
- Power lift
- Tripod lift
- Partial squat lift
- Golfers lift
- Overhead lift
- Pivot transfer

Please request specific training if you are required to use any of these lifts but are unsure how to perform them safely
FINAL THOUGHTS

• BE AWARE THAT THERE ARE MANY OTHER HANDLING TECHNIQUES NOT CURRENTLY ILLUSTRATED IN THIS HANDBOOK
• IF NEEDED SEEK (SPECIALIST) ADVICE OR ADDITIONAL SPECIFIC TRAINING
• WORK WITHIN YOUR OWN COMPETENCY LEVELS
• BE RESPONSIBLE AND ACCOUNTABLE
• KEEP FIT FOR YOUR JOB
• CHALLENGE UNSAFE PRACTICE
• TAKE GOOD CARE OF YOURSELF AND COLLEAGUES
• USE SAFER PRINCIPLES AT HOME AND WORK
Manual Handling & Musculoskeletal Risk Awareness Workshop

2 hour Moving & Handling without Devices (refresher)

2 hour Moving & Handling for non-clinical staff (refresher)

or 3 Hour Moving & Handling with devices (refresher)

Delegate name:

Date:

Area of Work:

NB: You must advise the trainer if you are pregnant or have recently become a new mother, or have health issues which prevent you from full participation.
Think About Your Workplace.

Using the list below, indicate the manual handling transfers / techniques that you use or could use as part of your work, then indicate what you think is your current competency level.

<table>
<thead>
<tr>
<th>People Handling</th>
<th>I use</th>
<th>I feel competent</th>
<th>I do not feel competent</th>
<th>I feel competent after training?</th>
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<tr>
<td>Hand-holds</td>
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<td>Assisted walking</td>
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<td>Failing patient braced posture</td>
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<td>Moving forwards / backwards in chair</td>
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<td>Sit to/from standing – assisted (hands on)</td>
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<td>Sit to/from standing – assisted (transfer belt)</td>
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<td>Turntable transfer</td>
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<td>Glide board transfers</td>
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<td>Bed controls</td>
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<tr>
<td>Bed moves: patient active rolling / bridging</td>
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<td>Active lying to sitting in bed / edge of bed</td>
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<td>Assisted sit to stand from edge of bed</td>
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<td>Passive log rolling</td>
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<tr>
<td>Inserting slide sheets</td>
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<tr>
<td>Up bed with slide sheets</td>
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<td>Log roll with slide sheets</td>
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<td>Hoisting operations and transfers</td>
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<td>Standaid operation and transfers</td>
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<td>Inserting sling with slide sheets</td>
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<td>Emergency slide from chair to floor</td>
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**Any others? Please list below**

| Object Handling                          |       |                  |                         |                                 |
| Lifting objects / equipment              |       |                  |                         |                                 |
| Pushing / pulling objects / equipment    |       |                  |                         |                                 |

**Any others? Please list below**

Agreed and signed on course date by
Delegate: 
Trainer: 

Staff must report to their line manager any shortcomings in their training, knowledge, skill and competency, as it their manager’s role to ensure that their staff are trained sufficiently, relating to manual handling, posture & ergonomics.

More than a third of all over-three-day injuries reported each year to HSE and local authorities are caused by manual handling (the transporting or supporting of loads by hand or by bodily force).

DON’T BECOME A STATISTIC – learn how to handle correctly and always maintain good practice and follow the handling risk assessment.

Ensure you are familiar with the manual handling policy for your area of work and conform to it.
Ensure you are familiar with the ‘Handling Risk Assessment’s for your area of work. These are available from your line manager or you may be required to complete them yourself.
Where at all possible, avoid manual handling.
Where possible, use mechanical and handling aids e.g. hoists, trolleys.

Always THINK before lifting / handling. Assess the load and plan the lift / movement.

Adopt a suitable position. Keep the feet apart, maintain balance and move the feet to maintain stability.

Start in a good posture. At the start of the lift, slight bending of the back, hips and knees is preferable to fully flexing the back (stooping) or fully flexing the hips and knees (squatting).

Get a good hold on the load. Use handles if appropriate. Keep the load close to the waist and keep the heaviest side of the load next to the body.

Keep the head up when handling. Look ahead, not down at the load once it has been held securely.

Avoid twisting the back or leaning sideways, especially while the back is bent.

Put down and then adjust. If precise positioning of the load is necessary, put it down first, and then slide it into position.
3. **Manual Handling – Risk Assessment Refresher**

Under the 4 key headings, list as many risk factors that you can think of (an example is given for each).

<table>
<thead>
<tr>
<th>LOAD</th>
<th>INDIVIDUAL</th>
<th>TASK</th>
<th>ENVIRONMENT</th>
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<td>e.g. weight</td>
<td>e.g. pregnancy</td>
<td>e.g. bending</td>
<td>e.g. temperature</td>
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4. **Posture and its Important Influence on Musculoskeletal Health**

**What is poor and good posture?**

**Poor posture** can be defined as a faulty relationship of the various parts of the body, which produces increased strain on the supporting structures, and in which there is a less efficient balance of the body over its base of support.

**Good posture** can be defined as that state of muscular and skeletal balance which protects the supporting structures of the body against injury or progressive deformity. Under such conditions the muscles will function most efficiently and the optimum positions are afforded for the thoracic and abdominal organs.”

**Effects:** the symptoms and effects of poor posture can range from minor and seemingly transient discomfort to more serious and longer term disability. For example, the chronic effects of poor posture are far more likely to be the underlying cause of spinal injuries rather than blaming the one-off “straw that broke the camels back” lift for our symptoms.

**Research** has demonstrated that poor posture can lead to unhealthy alterations in our bone and soft tissues: bone spurs, intervertebral disc damage and fibrotic scar tissue can all be an outcome. Evidence also exists that some postural positions can compromise neural tissue by changing blood flow, and connective tissues can develop unhealthy changes that can become permanent. This is probably why many individuals who exhibit the postural abnormalities cannot be placed or maintained into proper postural alignment with immediate or short-term methods.

**If you have concerns about your posture then be proactive and seek appropriate professional advice**

5. **Ergonomics: from the ancient Greek words: Ergo and Nomos, which literally means “The Law of Work”**

Ergonomics in relation to this training is that ergonomics defines a positive relationship between people and their work design, practice and environment. Therefore safe manual handling practice and good posture are important components of successful Ergonomics.
6. Workstation Posture and Ergonomics

Make your computer body-friendly by carrying out a Trust work station (DSE) risk assessment. Sitting badly in front of a computer for hours on end is storing up trouble. Structures within the body can tolerate being in one position for only a short period of time before they like to be adjusted. Positioning your monitor, keyboard and mouse correctly can help to promote a good posture at the computer; also a proper chair is essential. Repetition – performing the same movement over and over again – can also lead to muscle fatigue or injury, especially if your body is badly positioned. Here are some ways to keep your computer and body in harmony.

Look straight ahead: make sure your monitor is directly in front of you at arm’s length. You shouldn’t need to turn your head at all to see the screen properly. When you’re working on a document, the top line of text should be just below eye level and you’ll look down slightly to read the text in the middle of the screen. Don’t forget that if you change the position of your chair, you need to adjust the monitor as well.

Keyboard in front: your keyboard should be directly in front of you. It sounds obvious, but it’s not unusual to see people twisting around to use a keyboard that’s off-centre. Your shoulders should be relaxed with your upper arms free at your sides. Turn your chair sideways to check that your elbow is level with the spacebar for the correct height.

Avoid ‘mouse shoulder’: putting the mouse too high or too far away means that the upper arm is forced away from the body when you use it. This puts the shoulder in an awkward position and places strain on the muscles. If the position is held for a long period of time, the entire "mouse" side of the body is affected, from the neck to the upper back. Make sure you can use your mouse without stretching and with your elbow comfortably bent. Adjustable height keyboard / mouse trays allow the mouse to be placed conveniently beside the keyboard.

Take care with your chair: by law office chairs (those used at workstations) must meet a certain minimum standard. They must be stable – the classic office chair with five legs in star shape. They must allow the user easy freedom of movement and a comfortable position – this means that the height must be adjustable and the seat back is adjustable in both height and tilt; ideally the seat back should move independently of the seat to allow for a more comfortable position.

When you’re seated your thighs should be at right angles to your body or sloping slightly down. If your chair is properly adjusted your feet should be firmly on the floor, but if it’s more comfortable, use a footrest. The basic rule is to plant your feet on the floor and support your back.

Keep moving: never forget that the human body is not designed to sit for long periods, even in the best posture. Don’t lock yourself into a position for long stretches of time. Get up and move around. Shift your position often – at least every 10 minutes - and stretch.

Using laptops for long periods should be avoided without a separate keyboard, mouse & raised screen. Alternatively, use a laptop docking station. Wherever a laptop is used a risk assessment should be done.
7. Driving Posture and Ergonomics

The perfect car seat for back pain sufferers has not yet been invented and scientific research has not found the ideal seat, which will care for people of different heights, weights and size.

Many people spend a lot of time in the car seat, often driving under stressful conditions. It is therefore important to find one which is comfortable and can be adjusted for height, angle of back support, and distance from the steering wheel. Good lumbar support is also an advantage.

Always read manufacturer’s information and instruction manuals

- Raise your seat as high as is comfortable to achieve good vision of the road, good pedal control but allow adequate clearance from the roof.
- Adjust the seat forward until you can easily depress the clutch and accelerator pedal.
- Adjust seat cushion tilt angle (where available) so thighs are supported along the length of the cushion, avoiding pressure behind the knees.
- Adjust / recline driving seat to a comfortable and fully supported position between the base of the spine and the shoulders. Most people find somewhere between 10 - 30 degrees off the upright is the ideal.
- However avoid reclining the driving seat too far back from the upright (30 degrees max), as this can reduce seat belt contact, create awkward neck postures and create a sliding forward feeling / effect in the seat.
- Where applicable adjust the seat’s lumbar support to give even pressure, avoid pressure points or gaps.
- Adjust steering wheel for comfortable reach, ensure good clearance for knees and that you can see the control panel clearly.
- Adjust all head restraints so they offer full support behind you and your passengers head in the event of an accident, some are often set too low - these will offer little protection, especially in rear end shunts where whiplash can result in a serious injury.

Balanced head position. Correctly adjusted headrest close enough but not pushing head forward.

Back rest in contact with whole spine to base of neck.

Adequate lumbar support

Thighs comfortably flexed with no seat pressure behind knees.

Adjust steering wheel if possible, to allow relaxed arm position
8. Health and well being

Reducing musculoskeletal risk is so much more than just Manual Handling Training; it is about a holistic approach to personal well being and injury prevention. It needs to embrace several lifestyle choices such as healthy eating, exercise, being a non-smoker and a good awareness of safe limits if you drink alcohol. Also if you find you are suffering from negative or chronic stress then seek professional advice on what help and support is available and how to help yourself. Also be aware that the Trust has a stress policy to keep you safe at work - don’t be afraid to discuss this with your line manger or occupational health.

Some interesting general facts

**Exercise:** It is recommended that people exercise or do some form of physical activity for 30 minutes at least five days a week, leading to fewer aches and pains and increased energy levels overall. It can help reduce stress levels, keeps organs like your heart healthy. It burns off unnecessary fat in your body and keeps your body in balance. Some interesting general facts

**Smoking** seriously damages your musculoskeletal as well as cardio-vascular health. It will lead to atherosclerosis (hardening and furring up of arterial blood vessels); this can also contribute to lower back pain and degenerative disorders of the intervertebral discs - primarily due to the associated vascular damage. Each puff contains 4000 harmful toxins, which have an adverse effect on the body’s natural chemical processes and mechanisms. And if that’s not bad enough, the longer you smoke and the more cigarettes you consume, the greater your risk of: fracture in old age, longer injury healing time - up to 45% longer in certain fractures; significant bone density loss with an increased risk of Osteoporosis in older women and men.

Women who smoke often produce less oestrogen and tend to experience menopause earlier. Smokers are exposed to an increased risk of rheumatoid arthritis and severity of symptoms

**Alcohol consumption:** maximum recommended levels are 14 units per week for women and 21 for men.

**Sleep requirements**: maximum recommended levels are 7-9 hours per night.

<table>
<thead>
<tr>
<th>Quick Quiz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete the following statements:</td>
</tr>
<tr>
<td>A food with _______ sugar per 100g is considered high in sugar content</td>
</tr>
<tr>
<td>A food with _______ sugar per 100g is considered low in sugar content</td>
</tr>
<tr>
<td>What is the recommended limit of salt intake for adults? Men _______ Women _______</td>
</tr>
<tr>
<td>What are the Government’s recommended daily unit guidelines of alcohol for men and women?</td>
</tr>
<tr>
<td>Complete the following sentence. It is recommended that the adult population engages in _______ minutes of daily physical activity at a _______ intensity on _______ days of the weeks in order to achieve health promoting benefits.</td>
</tr>
<tr>
<td>What units can be used to objectively measure, health promoting physical activity?</td>
</tr>
<tr>
<td>How can you subjectively measure physical activity levels?</td>
</tr>
<tr>
<td>What BMI range is classified as being obese?</td>
</tr>
<tr>
<td>What equation is used to calculate BMI?</td>
</tr>
<tr>
<td>True of False? The incidence of smoking is directly linked to socio-economic status?</td>
</tr>
<tr>
<td>True or False? Inactivity is directly linked to socio-economic status?</td>
</tr>
</tbody>
</table>
Finally

Having been given the opportunity to identify and address your training needs please now indicate your new perceived level of competence with a tick (‘feel competent’) or a cross (‘still do not feel competent’) as appropriate on the list on page 1.

If you still feel you have unresolved training needs, or unresolved risks at work, seek additional advice from the workshop trainer, your line manager or Richard Eldred, the Trust Manual Handling Advisor, 01603 697336.

You must do this before you attempt to use any techniques you have identified as ‘do not feel competent’.

Thank you for attending this refresher workshop
DISPLAY SCREEN EQUIPMENT (DSE) ASSESSMENT

Surname:  Forename:  
Department:  Date:  

Under the Health & Safety (Display Screen Equipment) Regulations 1992, the Trust is required to perform a suitable and sufficient assessment of all workstations used by regular computer users. For the purpose of the regulations, “Users” are those who use computers continuously for an hour or more each day. Please read each question fully and answer by ticking either the Yes or No box.

### A Workstation/Work surface

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you arranged your workstation to meet your specific needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is there space in front of the keyboard to support your hands and forearms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Do you have sufficient legroom to allow a comfortable working position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Is your workstation and surrounding area free from obstructions and hazards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is the workstation of a suitable size to allow for positioning of equipment and documents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you require wrist, forearm or back supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Do you require a document holder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### B Display Screen

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is the information displayed on your screen clear, stable and easy to read</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Can the brightness and contrast be adjusted easily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Does the monitor swivel and tilt adequately in each direction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Is the height of the screen adjustable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is the display screen at the comfortable distance from the user (350mm-700mm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>When looking at the screen are the eyes cast down at an angle (15-20degrees)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Is the screen clean</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### C Keyboard

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is the keyboard separate from the screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Can the tilt of the keyboard be altered/adjusted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Are the key symbols easy to read, legible and clean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Does the keyboard have a matt surface to avoid reflected glare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is the keyboard easy and comfortable to use</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### D Work Chair

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is the chair comfortable, stable and can the height and backrest be adjusted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is the chair on castors and of a 5-star base configuration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Do you know how to adjust the position of the chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Can all adjustments be made easily and safely and do they work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### E Lighting, Reflections and Glare

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Has your equipment been situated to avoid direct glare and reflections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is the workstation surface and equipment of low reflectance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Is the screen free from reflections and glare</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>Does the lighting allow you to work comfortably</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Are windows fitted with blinds to prevent glare where necessary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### F Environment, Temperature and Noise

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>1</td>
<td>Is the temperature/humidity maintained at a level that ensures operator comfort</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Have all sources of noise been reduced to acceptable levels</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>G Posture</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Can you sit comfortably and easily change your posture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Can you adjust your equipment to a comfortable viewing position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Can you place your feet firmly on the floor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Do you need an adjustable footrest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Do you have any problems concerning visual fatigue, headaches, pins and needles, cramps, pains in neck, arms, wrists, legs or back etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>H Training and Information</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Do you know how to adjust your workstation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you received adequate training in how to use the software and DSE equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Are you encouraged to take regular breaks from DSE activities</td>
<td></td>
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<tr>
<td>4</td>
<td>Are aware that the Trust will, in certain circumstances, provide free eye tests for DSE users (using continuously for one hour each day)</td>
<td></td>
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<tr>
<td>5</td>
<td>Have you had an eye test within the last two years</td>
<td></td>
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<tr>
<td>6</td>
<td>Do you know how to report defects with DSE equipment or your workstation</td>
<td></td>
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<tr>
<td>7</td>
<td>Have you read the DSE Policy (Section 5 of the Health &amp; Safety Policy)</td>
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<td></td>
<td>I Other Areas</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Has the workstation’s electrical equipment been tested for electrical safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Are the workstation electrical leads secured safely to prevent trip hazards</td>
<td></td>
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<tr>
<td>3</td>
<td>Are there any other issues you wish to raise about your workstation (If Yes, please give further details below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional comments:

**ACTION REQUIRED:** (to be completed by Line Manager)

<table>
<thead>
<tr>
<th>Required Action</th>
<th>Responsible Department</th>
<th>Proposed close out date</th>
<th>Actual Close Out date</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Signed by DSE user:</td>
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<td></td>
<td></td>
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<tr>
<td>Print Name:</td>
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<td></td>
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<tr>
<td>Date:</td>
<td></td>
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<td></td>
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<tr>
<td>Signed by Line Manager:</td>
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<td></td>
<td></td>
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<tr>
<td>Print Name:</td>
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<td></td>
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<tr>
<td>Date:</td>
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</table>

<table>
<thead>
<tr>
<th>Follow up required</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up comments:</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed by DSE user:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Signed by Line Manager:</td>
</tr>
<tr>
<td>Print Name:</td>
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<tr>
<td>Date:</td>
</tr>
<tr>
<td>Signed by H&amp;S Dept.</td>
</tr>
<tr>
<td>Print Name:</td>
</tr>
<tr>
<td>Date:</td>
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</tbody>
</table>

**Additional Information**

**Job Design**
Everyone must take regular breaks from DSE work. This should be achieved by planning work away from screen. If this is not possible, regular frequent breaks should be taken. Short microbreaks have been found to be more effective than longer breaks which may be further apart. A 30-120 second break every 20 minutes is recommended, even if only to get out of chair or change your position.

**Eyestrain**
Eyestrain can be caused by looking at the same distance for too long. The blinking rate is reduced when concentrating on the screen. Eyestrain can be minimised by frequent breaks. Looking away from the screen, re-focusing the eyes at a different distance, shutting eyes tightly and opening wide and blinking a few times, every 20 minutes is very effective.

**Eye Tests**
The Trust will provide a free eye test with a recognised optician for DSE users. Where required DSE users will be offered an agreed sum towards the cost of a basic pair of spectacles where there is correction needed specifically at DSE length vision. The Trust does not pay for spectacles where they are required for any other reason. (Safety spectacles are considered separately.) Contact your line manager to arrange for this testing and provision of corrective eyewear.

**Glare**
Where glare on the screen is a problem, try moving the screen or changing the angle of tilt. Try adjusting blinds and lighting and altering the contrast and brightness on the computer. If all else fails, it may be necessary to purchase an anti-glare filter.

**Document Holders and Footrests**
Should be provided for those who need them

**Environmental Investigation**
Where problems such as lighting, heating, humidity, draughts or noise are highlighted, these should be investigated with your line manager and where necessary the H&S Department.

**Chairs**
The chair should have 5 wheels and swivel. If it does not, it should be replaced. All chairs supplied shall be adjustable. The seat height, height of backrest and tilt of backrest shall be adjusted. The chair should be adjusted to suit the person. The chair may need readjusting through the day according to the work activity. If the individual is uncomfortable the chair should be adjusted and attention paid to how they sit and work. NO chair will compensate for poor posture and work practices. Arms on the chair can prevent the user getting close enough to the keyboard comfortably or encourage the user to sit on the edge of the seat and work unsupported by the chair. Where chair arms are causing such a problem, arrangements may be required to have them removed.

**Comfort and Posture**
There is no one ideal posture. All users should vary their position regularly to avoid fatigue.

**The following are general guidelines:**

The wrists should be relaxed, straight and level with the forearms. There should not be an angle between the back of the hand and the forearm.

Shoulders should be relaxed and not hunched. The upper arms should be comfortably by the user’s side.

The user should sit back in the chair with the back supported, especially the lumbar region (small of the back).

The user’s thighs should be parallel to the floor.

The user’s feet should be flat on the floor. If once the chair is adjusted, the feet will not reach, then they must use a footrest. They should not cross their legs.

The user should not rest their arms on armrests while they are using the keyboard/mouse.
Our Ref: 
To: 

Employee's Name: 
Location: 

This letter introduces the above employee as a user, as defined by the Health & Safety (Display Screen Equipment) Regulations 1992, who requires an Ophthalmologic eyesight examination in connection with their use of display screen equipment.

Norfolk Primary Care Trust will meet the cost of the Ophthalmologic examination and an amount towards the cost of any corrective appliances, (eg single vision spectacles) prescribed solely for operating display screen equipment. (up to a total maximum of £85 including VAT) If the employee wishes to spend more than the agreed amount, they may do so at their own expense.

It would be appreciated if you could complete the section below and return it to our employee in order that they may claim back the costs incurred.

Alternatively, you may be prepared to bill the Trust for the sum involved, up to a maximum of £85 specified.

Yours faithfully

…………………………………………………………………………………………………

Line Manager

I confirm that I have examined the above employee’s eyes and recommend the following:

Spectacles are required specifically for display screen equipment use. Yes/No*
Spectacles are required for general use. Yes/No*

*Please delete as appropriate.

A re-examination is recommended in ………… months.

Signed …………………………………….. Print Name ……………………………………

Name of Practice ………………………………………. Date ……………………………
Our Ref:

To:
Paymasters Section
Norfolk Primary Care Trust
St Andrew’s House, Northside
Thorpe St Andrew
Norwich
NR7 0HT

From:

Date:

REQUEST TO RAISE PAYMENT IN ACCORDANCE WITH THE HEALTH & SAFETY
(DISPLAY SCREEN EQUIPMENT) REGULATIONS 1992

Please raise a payment for £ ……. (up to a maximum of £85) and send it to the employee’s home address as shown, charging it to the cost centre and account number shown below:

Employee’s Name: …………………………………………………

Home Address: …………………………………………………

………………………………………………

………………………………………………

Cost Centre: ………………………………………………………

Account Number: …………………………………………………

Signed: ……………………………………………………………….

Title ………………………………………………………………….

Location: ……………………………………………………………..
Guidance for safer handling during resuscitation in healthcare settings

Working Group of the Resuscitation Council (UK)

November 2009
Guidance for safer handling during resuscitation in healthcare settings

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November 2009

Review date: 2014 (or earlier if necessary)

Published by the Resuscitation Council (UK)
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Tavistock Square
London WC1H 9HR

Tel: 020 7388 4678  Fax: 020 7383 0773  E-mail: enquiries@resus.org.uk
Website:  www.resus.org.uk

Registered charity no. 286360

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* Members of the National Back Exchange

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Particular thanks go to:

Steve Brindley and Rich Taylor for the illustrations
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Gavin Chambers
Kay James
Mary Muir
Anita Rush
Sara Thomas
Clive Tracey
Executive Committee, Resuscitation Council (UK)
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Introduction

This advisory document is a revision of previous guidance from the Resuscitation Council (UK) published in Guidance for safer handling during resuscitation in hospitals (2001). It is aimed at healthcare providers, resuscitation officers and manual handling advisors involved in resuscitation. It is primarily for adult patients but may be appropriate for children over 8 years. It cannot provide all the answers and is unable to cover all possible situations, nor is it intended to replace existing manual handling procedures written by hospitals, or other establishments, following full risk assessments; rather it is hoped these principles can be adapted as a resource to assist in the making of local decisions and guidelines.

The aims of the working group were to:

- Identify areas of concern
- Provide realistic principles for dealing with manual handling situations which have been scored using Rapid Entire Body Assessment (REBA)\(^1\) and taking into account the urgency of the cardiac arrest situation (see glossary of terms)
- Consider that each healthcare setting will have different facilities and will face different situations
- Minimise the risk to the resucer “as far as is reasonably practicable”
- Base the recommendations on current safer practice.
Background

Manual handling operations have been defined by the Health and Safety Executive as “any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or by bodily force”. 2

In 2003/04 an estimated 4.9 million working days (full day equivalent) were lost in the UK because of back pain caused or made worse by work. It has been identified that one in four nurses has taken time off as a result of back injury sustained at work. 3

It is estimated that four out of five adults will experience back pain at some stage in their life. 4 Poor manual handling accounts for more than 52% of reported incidents in the health service. 2 Although many injuries to the back are the result of cumulative stress rather than from an isolated incident, careful and safe manual handling during resuscitation must be considered at all times.

Cardiorespiratory arrest is seen as the most acute medical emergency faced by healthcare providers and the speed of response is essential because delays in providing cardiopulmonary resuscitation (CPR) reduce the chance of survival. In approximately 80% of adult cases there are clinical signs of deterioration, therefore cardiorespiratory arrest is a foreseeable event. 5 As such, this situation should be assessed for risk and the outcome of this should lead to plans and provisions being implemented locally to handle the emergency situation safely as far as is reasonably practicable. For example, patients who are at risk of cardiac arrest should be on an appropriate bed type.

In response to the requirements laid down by the Manual Handling Operations Regulations 1992, manual handling advisors are now employed by most hospitals and healthcare settings and risk assessments are performed for most situations. 2 Moving and handling training is a statutory requirement under the Health and Safety at Work etc Act 1974 and expanded on in the Management of Health and Safety at Work Regulations 1992. 6, 7 Managers and staff have to consider the working environment and plans should be in place for dealing with identified medical emergencies. The principles for moving bariatric patients are the same, however healthcare settings should have a policy which takes into account the increased risk and provision of suitable equipment. The term ‘bariatric patient’ has been used in this document to describe a patient who is overweight or obese. Resuscitation guidelines for basic and advanced life support still apply with bariatric patients. Their weight, body shape and increased tissue mass can make airway management, CPR and defibrillation technically more difficult.
A common dilemma is how to manage the patient as they collapse to the floor. When a patient collapses, the urgency of the situation may distract rescuers from using safe handling techniques. If the patient is out of reach it is unrealistic to be able to lower them in a safe manner. Most healthcare settings have developed local guidance on the management of the falling person.

Whilst this document does not address specific issues (e.g., protection of the cervical spine), before starting the resuscitation attempt the rescuer must rapidly and correctly assess the risks to both the patient and the rescuer. This is the first action in the sequence of events for basic life support (BLS). The rescuer must take into account their own individual capability and experience, and the weight and build of the patient before handling them. Environmental factors such as space must also be rapidly assessed. Care must be taken to avoid any injury to the rescuer during the resuscitation procedure as this may prevent them performing effective CPR. Within the clinical setting it is likely that additional rescuers will arrive at the scene rapidly and it may be more appropriate to wait for such help rather than risk personal injury. In the community, lone workers should refer to their local policies/guidelines.

Low-friction material devices, e.g., sliding sheets are now widely available and used commonly. They are especially useful for turning or moving a patient. These should be readily available and it is recommended that they be kept in strategic areas within the hospital and other healthcare settings. If space permits they should be kept on, or next to, the emergency resuscitation trolley, or at the nearest location to this which is easily identifiable.

Performing chest compressions is physically demanding and may exhaust or strain the rescuer. Another rescuer should take over CPR about every two minutes to prevent fatigue.

This document does not address mechanical hoists because there is a plethora of appliances being used in practice. There is a statutory duty under the Provision and Use of Work Equipment Regulations 1998 (PUWER), to train employees in the use of work equipment and more specifically the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) place a duty on employers to ensure that every lifting operation is planned and prepared properly and carried out by competent persons. The moving and handling of resuscitation training equipment has also not been addressed. This is beyond the scope of the working group and is an issue that should be dealt with locally following full risk assessment. Similarly, local policies should be established for the unique situation of the MRI scanner. Generic handling procedures, such as how to log-roll a patient and insertion of sliding sheets should be addressed in staff training sessions. If you are unfamiliar with these procedures, seek appropriate training and advice. This document only pertains to safer handling techniques and methods that are specific to CPR.
Glossary of terms

Kneeling positions:
- High Kneeling  
  [REBA score 2]

- Half Kneeling  
  [REBA score 2]

- Low Kneeling  
  [REBA score 2]

Neutral position of the wrist:
- No flexion, extension or twisting

Innermost: Nearest to the patient

Outermost: Furthest from the patient

Walk stance:
- An example of a dynamic stable base
Rapid entire body assessment (REBA):
A tool designed to assess postures for risk of work related musculoskeletal disorders.

<table>
<thead>
<tr>
<th>REBA score</th>
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<tr>
<td>1</td>
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<tr>
<td>2 - 3</td>
<td>Low risk</td>
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<tr>
<td>4 - 7</td>
<td>Medium risk</td>
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<tr>
<td>8 - 10</td>
<td>High risk</td>
</tr>
<tr>
<td>11 - 15</td>
<td>Very high risk</td>
</tr>
</tbody>
</table>

Reasonably practicable duties:
It is a statutory duty that the employer must take safety precautions 'so far as is reasonably practicable'. In this instance, the employer has to weigh up the risks involved in a particular situation against the costs of removing or reducing the risk.
Aide memoire to safer handling

**ASSESS THE SITUATION**

**Communication**
One person co-ordinates the commands. The commands must be clear, ensuring that people know who is doing what, when and where.

A commonly accepted command is
“Ready?  Steady?  Move”

**Stay close to the patient**
Ensure you have a stable dynamic base of support.

**Avoid twisting**
Keep your spine in the neutral position. Alter your base of support rather than twist your body to ensure that you face the patient/object straight on.

**Maintain your balance**

- good posture
- straight spine
- stable dynamic base
- close to load
  [REBA score 4]
- bad posture
- C-shaped spine
- unstable base
- reaching and twisting
  [REBA score 9]
If a patient is found collapsed on the floor, CPR should be carried out on the floor. Start CPR as quickly as possible and try to provide the best quality CPR, particularly chest compressions, that is possible in the circumstances. Do not move the patient unless there is inherent danger to the patient or rescuers in that location.

If the patient has collapsed in a public area (such as a waiting room) consider the use of screens to provide some privacy. Alternatively, ask the other patients and members of the public to leave the area.

If access to the patient is restricted, where possible, move the furniture. If it cannot be moved quickly and safely it may be necessary to slide the patient horizontally across the floor to an area that is less restricted. Use sliding sheets to achieve this to reduce the risk to the rescuers. Poor access to the patient may result in the rescuers having to twist and bend awkwardly and this may impair the quality of CPR or risk potential injury to the rescuer.
Chest compressions

It is important that the rescuer minimises twisting their spine and applies force vertically down from their shoulders. This reduces the risk of injury and makes compressions more effective.

- Kneel in the high kneeling position with your knees shoulder-width apart at the side of the patient's chest
- Position your shoulders directly above the patient's chest and keep your arms straight
- The force of compressions should come from flexing your hips not from bending the arms
- With hands kept in position, allow the chest to recoil to its fullest extent before starting the next compression.

Airway management and ventilation

It is important there is sufficient space around the patient to enable rescuers to manage the airway effectively. Access from behind the head of the patient, as well as from the side, is required.

Bag-mask ventilation

The two-person technique for bag-mask ventilation is preferable.\(^5\)

- Kneel behind the patient’s head with your knees shoulder-width apart
- Rest back to sit on your heels in the low kneeling position
- Keep your back as upright as possible and keep your arms straight while holding the mask on the patient's face.
Bag-mask ventilation (continued)

Mouth-to-mask

- Kneel behind the patient’s head with your knees shoulder-width apart
- Rest back to sit on your heels in the low kneeling position
- Bend forwards from your hips and lean down to blow into the mask
- Resting your elbows on your legs may offer some support
- Using a pocket mask may be less comfortable for the rescuer compared with bag-mask ventilation.
Airway devices

Supraglottic airway devices (e.g., laryngeal mask airway)

- Kneel behind the patient’s head with your knees shoulder-width apart
- Rest back to sit on your heels in the low kneeling position
- Place one hand behind the patient’s head to keep it tilted back
- During airway insertion lean forward slightly from your hips.

Tracheal intubation

- Kneel behind the patient’s head with your knees shoulder-width apart
- It will be necessary to bend forward considerably, from the hips, in order to see the vocal cords
- Resting your elbows on the floor or widening your knees may provide more stability
- Intubation will require considerably more bending forward than using any of the supraglottic airway devices
- No intubation attempt should take longer than 30 seconds.
Following resuscitation

The safest method of transfer is to use a hoist with a stretcher attachment that enables direct lifting from the floor because it keeps the patient horizontal. If this is not available, a hoist and sling may be used as long as this enables direct lifting from the floor and the following criteria are met:

- The hoist sling must provide adequate support to the patient’s head and trunk
- The hoist sling is inserted underneath the patient using either a log-roll technique or by using sliding sheets if the patient is too unstable to be rolled
- During hoisting care is taken to ensure the patient’s trunk and head remain as horizontal as possible. A good team approach is vital when managing this transfer to ensure the safety and comfort of the patient
- If the patient re-arrests whilst in the hoist, either continue the transfer onto the bed or trolley or lower them back to the floor depending on which is the quickest or easiest
- Always use mechanical lifting devices when lifting bariatric patients.

Try to keep the patient horizontal. A head down position increases the risk of regurgitation and makes ventilation more difficult.

Extra Caution!
The use of the stretcher attachment on a hoist may lower the hoist’s overall safe working load. Always check the safe working load of any attachments and never exceed it.

Alternative mechanical floor lifting devices

If a hoist is not available then the patient can be log rolled onto a solid flat surface (e.g., a scoop stretcher) and raised with a mechanical lifting cushion. The patient must be kept in a horizontal position; therefore sufficient staff must be available to ensure the surface is well balanced on the cushion. Once raised transfer the patient laterally across onto the receiving bed or trolley using a minimum of four handlers.

Manual lift from floor

Manual lifts from the floor (especially those within confined areas) are high risk. A mechanical lift using a hoist is undoubtedly the safest method of lifting a patient from the floor. However, if a hoist transfer cannot be achieved, for example if the patient has collapsed in an area that is inaccessible to a hoist, a manual lifting transfer may be the only alternative.

Determine the safest method: this should take into consideration the varying heights of the rescuers, the environment and the optimal positioning of the trolley. The risks are significantly increased if transferring directly to a bed because a bed is wider than a trolley. This causes the rescuers to hold the patient further away from their trunk, which increases the load on their spine.
This type of transfer is high risk – consider it only as a last resort. Make all individuals involved aware of the risks associated with this transfer and the physical abilities that will be required of them.

The following is advised:

- The transfer must be well planned and all rescuers briefed – in total 8 people will be required to assist
- One person co-ordinates the commands and lifting activity; this person is required to support the head
- Ensure that a designated lifting sheet (i.e., a sheet that has been designed for lifting) is available. A scoop stretcher may be used
- Log roll the patient onto the lifting sheet
- A minimum of three people are positioned on each side of the patient

An additional person will need to position the trolley under the patient
Each rescuer faces the patient and drops down into the half-kneeling position (or into a position they feel comfortable in and are able to rise from)
Each rescuer grasps the lifting sheet (or handles if present) with their wrists in a neutral position
On the command the rescuers stand lifting the patient to approximately waist-height
The patient is transferred onto an appropriately positioned height-adjustable trolley.

If the resuscitation is unsuccessful, and hoist access is available, hoist the patient and transfer onto a trolley, bed or directly onto the mortuary trolley.
Cardiopulmonary resuscitation on a bed or trolley

This is the most likely scenario faced by healthcare providers within the hospital setting. There are numerous types of beds and trolleys available; therefore, it is more useful for rapid assessment and intervention, that two categories are considered. This document addresses the general issues faced in relation to electrically powered and manually operated beds or trolleys. The use of height-adjustable beds and trolleys with electric profiling frames will eliminate many of the handling risks faced in the following situations by avoiding poor posture and actual moving and handling. It is the responsibility of the healthcare provider to ensure that they are fully familiar with any moving and handling equipment, including beds and trolleys. Significant injury can occur if individuals who have not received the relevant training attempt to use these devices.

To enable effective CPR, ensure the patient is supine. Keep a pillow because it may be needed to optimise the patient’s position during laryngoscopy and tracheal intubation.

The following describes the general principles of how to get a patient on an electrically powered height-adjustable / profiling bed from a semi-reclined position into a supine position for performing CPR:

- Clear the environment of any hazards
- Ensure that the brakes are on and, if applicable, bedrails are lowered
- Depending on Make / Model / Specifications*, one or two rescuers should use a dynamic stable based position
- With one hand to steady the raised part of the bed and the other to release the marked ‘CPR’ handle, the rescuers lower the bed slowly to a horizontal position. If available, the powered CPR button should be used.

* Some electrically powered beds have ‘controlled’ release mechanisms; others may require the rescuer to release the bed while manually supporting the load. In these cases, be very careful to avoid bad postures, traumatic loadings and trapping hazards.
The following describes the general principles of how to get a patient on a manually operated height-adjustable bed from semi-reclined to supine to enable CPR to be performed:

- Clear the environment of any hazards
- Ensure that the brakes are on and, if applicable, bedrails are lowered

- **If a sliding sheet(s) is in position** (i.e. ICU / HDU patient)
  - With the bed at approximately hip-height, grasp the top layer of the sliding sheet and slide the patient down the bed away from the backrest until supine

- **If a sliding sheet(s) is readily available**
  - It may be possible to insert this quickly underneath the patient’s hips/buttocks by rolling the patient to one side. Use the technique outlined above to move the patient down the bed away from the backrest

- **If no sliding sheet is available do NOT use the bed sheet as a sliding aid:**
  - Lower the bed to the lowest height
  - Each rescuer faces the patient and positions themselves on either side of the bed
  - The innermost knee of each rescuer rests on the bed whilst their outermost leg remains on the floor

  - The patient’s legs are flexed at both knees and hips
  - Each rescuer grasps behind the back of the knee closest to them. One hand is placed in the crease of the knee and the other behind the calf
- On command, the rescuers transfer their body weight backwards towards their heels pulling the patient with them

- Re-position and repeat as necessary
- Readjust the height of the bed. The optimal height positions the patient between the knee and mid-thigh of the person performing chest compressions
- Consider the combined weight of the rescuers and the patient when using this approach; the total weight must not exceed the manufacturers guidance or specified safe working load of the bed.

If the patient has had a lower limb amputation, the rescuers’ handgrips are modified according to the level of the amputation.

In the event that the resuscitation takes place on a trolley where there is a manual “pull up” backrest, two rescuers are required to lower the backrest using safer handling principles.

When resuscitating a patient on a pressure relieving bed or mattress, refer to the manufacturer’s instructions. For resuscitation to be effective, a firm surface is required underneath the patient.
Chest compressions

The optimal height of the bed places the patient’s chest level between the knee and mid-thigh of the person performing chest compressions. Teamwork is essential and the bed may need to be adjusted according to the different heights of the rescuers.

- Stand at the side of the bed
- Place your feet shoulder-width apart
- Flex forward from your hips
- Ensure that the compression force comes from flexion of your hips and that your shoulders are positioned directly over the patient’s sternum

If necessary, kneel with both knees on the bed. The bed must be clear of any hazards e.g., needles, blood. Ensure that your weight combined with the patient’s does not exceed the safe working load of the bed.

- Do not remain on the bed if the patient is being defibrillated.

If a patient has arrested on a fixed-height bed or trolley, a firm stool or steps must be provided. These must be of a suitable height to ensure that the rescuer performing chest compressions is able to stand with the patient level between their knee and mid-thigh region. The stool or steps must have a non-slip surface area, which is large enough to accommodate the rescuer standing with their feet shoulder-width apart. Kick stools are not suitable for this procedure. No attempt should be made to kneel on a trolley.
Airway management and ventilation

For mouth-to-mouth, or mouth-to-mask ventilation (one rescuer):

- Stand at the side of the bed facing the patient, level with their nose and mouth
- Bend forwards from your hips to minimise flexion of the spine

- Support your weight by leaning your legs against the side of the bed frame.

To intubate the patient’s trachea or to provide mouth-to-mask or bag-mask ventilation (with two rescuers present), enable access by moving the bed away from the wall and removing the backrest.

- Position yourself at the top of the bed facing the patient
- Place your feet in the walk-stance position
- Once the tracheal tube has been inserted adopt a comfortable position and avoid prolonged static postures.
Dealing with a cardiac arrest in a sitting position

To provide effective chest compressions the patient must be lowered to the floor. This manoeuvre should be carried out in a safe and controlled manner. Transferring a patient from a seated position onto the floor is high risk. Do not move the patient directly from the chair to the bed/trolley. An exception to this may be if the patient is already sitting on a sling and a hoist is readily available.

The optimal number of people required to perform this transfer is three. If fewer than three people are available, a less than optimal transfer may have to be attempted. Wherever possible wait for additional people to provide assistance.

**Three-person transfer**

- The chair must be secure, with any brakes in the ON position
- If a sliding sheet is readily available, place it under the patient’s feet and extend their legs to enable the feet and legs to slide away from the chair as the patient is lowered onto the floor
- One rescuer supports the head by standing at the side of the chair, level with the patient’s head
- The other two rescuers face the patient in the chair, and position themselves slightly in front and to the side of the chair
- These rescuers get into a half-kneeling position with their innermost knee on the floor and grasp hold of the patient at the back of the pelvis/hip region with their outermost hand and behind the patient’s knee with their innermost hand. An alternative is to use the high-kneeling position which some rescuers may find more comfortable.

[REBA score 9 of kneeling rescuers]
If the patient is dressed it may be helpful to grab hold of their clothing or belt.

On the command from one rescuer, each kneeling rescuer transfers their body weight back towards their heels. This pulls the patient forwards out of the chair into a sitting position on the floor with their back resting against the chair.

NOTE: A pillow placed on the floor to cushion the fall acts as a hindrance rather than a help.

Once in this position, either move the chair and lower the patient’s head and chest carefully to the floor, OR pull the patient’s legs forwards away from the chair until the patient is supine.

**Two-person transfer**

Both rescuers face the patient in the chair, and position themselves slightly in front and to the side of the chair.

If readily available place a sliding sheet under the patient’s feet.

Both rescuers get into a half-kneeling position with their innermost knee on the floor and grasp hold of the patient at the back of the pelvis/hip region with their outermost hand and behind the patient’s knee with their innermost hand. An alternative is to use the high-kneeling position which some rescuers may find more comfortable.
If the patient is dressed it may be helpful to grab hold of their clothing or belt.

On the command from one rescuer, each kneeling rescuer transfers their body weight back towards their heels. This pulls the patient forwards out of the chair into a sitting position on the floor with their back resting against the chair.

[REBA score 11]

NOTE: A pillow placed on the floor to cushion the fall acts as a hindrance rather than a help.

Once the patient is in the sitting position on the floor, one rescuer takes responsibility for supporting their head, whilst the other pulls the patient’s legs forwards and away from the chair, or if there is enough room, moves the chair. Alternatively, one rescuer gently pushes the patient sideways towards the other rescuer who lowers them to the floor.

**One-person transfer**

Wherever possible one rescuer should not undertake this task and they should wait for assistance to arrive. However, it is recognised that in some situations a rescuer may decide to begin resuscitation and will need to transfer the patient to the floor. This is a high risk activity it should only be undertaken in life-threatening or exceptional circumstances.

- Kneel on the floor to one side of the patient
- Position the patient’s arm that is closest to you across their chest
- Push against the patient’s thigh which is nearest to you with both your hands to position the patient’s hips at the front of the chair
- Place your hand around the patient’s furthest hip. Place your other hand on the patient’s thigh which is closest to you

[REBA score 12]
• Push / pull the patient down to the floor.

Cardiac arrest on the toilet

If a patient has a cardiac arrest on the toilet it is likely the patient will fall either sideways or forwards. Before transferring the patient onto the floor it is important that the door is kept open. This will ensure that the entrance is not blocked and will enable other rescuers access to the room. If they still remain on the toilet they will need to be transferred to the floor using a similar technique as previously described for a sitting position.

• If the patient is dressed it may be helpful to grab hold of their upper clothing
• Avoid entrapment of the genitalia!
Dealing with a cardiac arrest in a bath

This is an extremely difficult topic to address because shapes and sizes of bathrooms differ and access to the patient varies. Any physical technique of removing a collapsed patient from a bath is hazardous and includes high risk of injury. Risk assessments of this potential situation must be carried out locally, especially for those patients who are at risk of cardiac arrest, and evacuation procedures established.

To enable resuscitation to be attempted the patient needs to be out of the bath. Remove the plug so that the water can begin to drain from the bath before starting the transfer. The rationale for this is that the water will render the area hazardous and slippery for the rescuers, whilst also making it dangerous for attempting defibrillation. Towels, or other absorbent materials, should be placed on the floor before removing the patient from the bath. The patient must not be lying in a puddle of water and their chest must be dried before attempting defibrillation.

**NOTE:** Local evacuation procedures must also be established for birthing pools. After 20 weeks gestation (or obvious signs of a pregnancy) a woman's uterus can press against the inferior vena cava resulting in reduced cardiac output and hypotension. Whenever a pregnant woman collapses the rescuers need to place the patient either in a full left lateral position or, if this is not possible, a 15 degrees tilt to the left to relieve caval compression. This can be achieved by using sand bags, firm pillows, a wedge or the thighs of the kneeling rescuers to tilt the torso, or by manually and gently displacing the uterus to the left.
Dealing with a cardiac arrest in a hydrotherapy pool

Each organisation must have a local policy in place for evacuating a collapsed patient from the hydrotherapy pool and the procedure must be practised regularly. Many hydrotherapy pools now have a ceiling track hoist installed and this is often the preferred method of evacuation from the pool in an emergency.

The following describes an alternative method for a rapid evacuation from the pool:

- The rescuer in the water pulls the emergency cord to summon help
- An inflatable neck support is placed around the patient’s neck
- The rescuer floats the patient to a side of the pool which enables open access

- The next rescuer to arrive puts an “evacuation board” into the pool and joins the other rescuer in the water to assist supporting the patient
- Further rescuers take over supporting the patient from either inside or outside the pool whilst the rescuers in the pool place the evacuation board under the patient
• Secure the patient onto the board with the straps provided
• Position the board so that the head-end is at the side of the pool
• The two rescuers in the water press down on the foot of the board to raise the head end high enough to rest it on the side of the pool

![Diagram showing resuscitation process]

• The board can be pushed out of the pool directly onto the floor or onto a trolley if the pool is above ground level.

NOTE: Do not exceed the weight limit indicated on the evacuation board.
The principles for moving bariatric patients are the same as those already described in this document. Healthcare settings must ensure suitable equipment is available for their staff when dealing with these patients and that they are trained in its use. The following is additional guidance that should be taken into account to provide safer handling and effective CPR when a bariatric patient has a cardiac arrest.

**Airway management and ventilation**

Airway manoeuvres and maintaining an adequate airway can be difficult due to the increased size of the head and neck and glottic oedema. Bariatric patients have a higher risk of regurgitation and aspiration.

Inflating the lungs during ventilation can be harder due to the patient’s body shape, tissue mass, and because they are lying flat. Sitting the patient up slightly can make airway manoeuvres and ventilation easier but this will make chest compressions more difficult. Identifying chest movement can also be difficult. Adequate ventilation often requires early tracheal intubation by an individual who is already competent in this skill.

**Chest compressions**

Identifying landmarks for chest compressions can be difficult. It is important that the rescuer maintains a stable base and minimises the risk of extending their reach when giving compressions. Chest compression quality may be compromised because of the increased physical effort required to achieve the full compression depth of 4 - 5 cm (for an adult) at a rate of 100 per minute. Adequate staff must be available to rotate rescuers every two minutes, or sooner, to reduce fatigue and ensure effective chest compressions.

**Transferring and handling the bariatric patient**

- If the patient is on the floor with restricted access and has to be moved, use a bariatric sliding sheet with extension straps
- When transferring the patient following resuscitation, the hoist and associated sling must be suitable for the bariatric patient’s body shape and weight
- Consider the hoist and sling safe working load, wider leg opening, and sling shape in relationship to the patient’s body shape and tissue mass
• The use of hoists with stretcher attachments tends not to be appropriate for bariatric patients as the stretcher attachments may not be wide enough or have a suitable safe working load to accommodate the patient

• Bariatric patients should be cared for on an appropriate electrically operated bed

• Manual lifts are not recommended with bariatric patients.
References


## Conflict of interest declaration

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Conflict of interest</th>
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<tbody>
<tr>
<td>Sara Wright (Chair)</td>
<td>Freelance</td>
<td>None</td>
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<tr>
<td>Manual Handling Trainer/Advisor</td>
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### Useful websites

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<thead>
<tr>
<th>Organisation</th>
<th>Website address</th>
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<td>Resuscitation Council (UK)</td>
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<td>National Back Exchange</td>
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<td>The Royal College of Nursing (RCN)</td>
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<td><a href="http://www.rospa.com">http://www.rospa.com</a></td>
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AUDIT STANDARDS FOR:
NCH&C
Manual Handling Policy

1. Is there access to a copy of the (Jan 08) up to date Manual Handling Policy in your dept, and have you read and understood it.  
   Yes □  No □

2. Have you discussed with your staff the manual handling activities within your area of work, and risk assessed those considered hazardous.  
   Yes □  No □

3. Has the Bariatric policy been understood where applicable.  
   Yes □  No □  N/A □

4. Are specific patient / object risk assessments being carried out where required and being kept up to date and actioned.  
   Yes □  No □  N/A □

5. Do you have adequate equipment to manage or reduce manual handling risk within your area of work.  
   Yes □  No □  N/A □

6. Do you have documented (generic) safer systems of work for handling in critical events i.e. Cardiac arrest, Fire etc.  
   Yes □  No □  N/A □

   Do you know how to contact the manual handling advisor?  
   Yes □  No □  N/A □

Additional Comments
## TRAINING NEEDS ANALYSIS

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<thead>
<tr>
<th>Statutory, mandatory and risk courses</th>
<th>Comments</th>
<th>Frequency</th>
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<tr>
<td><strong>Fire</strong></td>
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<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td><strong>Risk assessment (including slips, trips and falls)</strong></td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
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<tr>
<td><strong>Equality and Diversity</strong></td>
<td>3 yearly</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
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<tr>
<td><strong>Corporate induction</strong></td>
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<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
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<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
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<tr>
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<td>3 yearly</td>
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<td>2 yearly</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td><strong>Display Screen Equipment</strong></td>
<td>on appointment or change of work station</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
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<tr>
<td><strong>Local assessment</strong></td>
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<td><strong>Safeguarding adults awareness</strong></td>
<td>staff not working directly with adult patients</td>
<td>3 yearly</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Frequency</td>
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<tr>
<td>Safeguarding adults</td>
<td>staff working directly with adult patients</td>
<td>3 yearly</td>
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<tr>
<td>Safeguarding children foundation/level A</td>
<td>staff not working directly with children</td>
<td>3 yearly</td>
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<td>Safeguarding children Level B</td>
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<tr>
<td>Safeguarding children level C</td>
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<tr>
<td>Patient handling</td>
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<tr>
<td>Posture and ergonomics</td>
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<tr>
<td>Safer object handling</td>
<td>all staff who handle heavy loads</td>
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<tr>
<td>Inanimate object handling</td>
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<td>Blood transfusion</td>
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<tr>
<td>Medicines management</td>
<td>staff involved in managing medicines</td>
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<td>Training Area</td>
<td>Training Target</td>
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<td>---------------------------------------------------</td>
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<td>Infection control, inc hand hygiene</td>
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<tr>
<td>Resuscitation and anaphylaxis</td>
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<tr>
<td>Defibrillation</td>
<td>Identified staff where a defibrillation machine is insitu</td>
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<tr>
<td>Breakaway</td>
<td>all prison staff</td>
<td>annual</td>
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<tr>
<td>Team Teach</td>
<td>all children's services staff</td>
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<tr>
<td>Prevention and management of aggression</td>
<td>All learning disabilities staff</td>
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</tr>
<tr>
<td>Food hygiene</td>
<td>all staff handling patients food</td>
<td>tbc</td>
</tr>
<tr>
<td>First Aider</td>
<td>for nominated staff only</td>
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Wheelchair Training
For staff at Norfolk Community Health and Care

This information should be read and further training requested from the Manual Handling Dept if felt to be necessary

Awareness of the different types of wheelchair available

There are a wide range of wheelchairs available depending on patients needs, including:

- Self-propelled manual wheelchair – patient can propel themselves using the hand rim which is situated on the outside of the wheel (see diagram below, part labelled 9). A self-propelled wheelchair will also have push handles (1). It is important to remember that if a patient asks you to push them that you check that their hands and arms are resting on the armrests (3) or in their lap to avoid the wheel or hand rim injuring their hands/arms.
- Transport wheelchair – this has small wheels at the back and is generally used for transporting patients' short distances – i.e. to/from a vehicle, treatment room etc.
- Electric wheelchairs – these are operated by the patient and must not be pushed/pulled manually.

Technical Aspects of the Wheelchair

1. Push handles
2. Backrest sling
3. Armrest
4. Seat sling
5. Footrest
6. Casters
7. Quick-release axles
8. Wheel locks/brake
9. Hand rim
10. Rear wheel
11. Tipping bar

Swing away footrests-enable easier forward transfers from the chair to be performed.
Operating the Wheelchair

Safety Tips

When pushing a wheelchair please ensure that you follow these rules:

- Wear comfortable clothing and flat shoes
- Always put the chair’s brakes on when stationary.
- Before the patient gets in or out of the wheelchair, fold the footplates up and swing them to the side of the chair. The patient must never stand on the footplates.
- Be aware that when the footplates have been moved to the side of the chair they are not secured and therefore can swing back.
- Ensure that any fault in the wheelchair is immediately reported i.e. brakes not working efficiently, wheels not running true and tyres inflated to the correct pressure and all parts of the wheelchair are included and fitted correctly.
- It is important to know how to collapse and open the wheelchair correctly and be correctly trained in its use, for example using tipping levers on the back of the wheelchair to assist with counter levering it up a step or kerb. The weight of the carer relative to the weight of the person is important so that the carer can comfortably push and manoeuvre the wheelchair without creating unacceptable loading on their back.

Opening the chair

- With the chair in front of you, push the armrests outwards about a foot apart.
- Keep fingers turned towards the middle of the seat.
- Push down with the flat of the hand on the two sides of the seat until the chair is completely open.

Closing the chair

- Turn the footplates to the upright position and remove any cushions from the seat or backrest
- If using heel straps, pull them forwards.
- Grasp the middle of the seat canvas at the front and back and give a sharp pull upwards.
- Press the arms inwards (together) until the chair is fully closed.

Releasing footrests

To release the footrest push the release latch (1) toward the frame (2), and rotate the footrest outward. To remove the footrest from the chair lift vertically from this position.

Replacing Footrests

To replace footrest place the swingaway pivot saddle (3) into the receiver (4) on the frame (2) with the footrest facing outward from the frame. Rotate the footrest inward until it locks into place on the locking stud (5).
Folding the backrests
• Useful for stowing a chair in a vehicle:-
• To fold the backrest, stand behind the chair, grip the two small levers on each side of the backrest and slide them upwards. Fold the backrests down.
• To put the backrests upright, push the handles upwards and forwards and then slide the levers downwards.

Making the Patient Comfortable
• Only use a wheelchair which has been assessed by Occupational Therapy as being appropriate for the patient – always check with staff if unsure.
• Use an appropriate wheelchair cushion – again this will have been assessed by staff.
• Seatbelts - some patients may require seatbelts at all times (this will have been assessed by Occupational Therapy). All patients should wear a seatbelt in a wheelchair when outdoors.
• See that arms, legs and feet are tucked in as the patient may have no sensation. Make sure blankets, clothing and bags are not catching in the wheels.

Patient Awareness
• When pushing a person in a wheelchair, do not regard yourself as simply a pusher. You are also a companion and an interpreter, introduce yourself - you have to interpret the wheelchair occupant’s wishes into action. Be especially aware of their needs and wishes and be ready to carry them out. When you talk, be sure the patient can hear.
• Don’t forget to face the chair towards whatever is happening (except when going down kerbs).
• Always tell the patient what you are about to do i.e. when tipping the chair. Reassure the patient and ensure the patient feels safe at all times. Tell the patient if you need to leave them alone for a short while.
• Respect a patient’s independence and do not help too much if they like to propel themselves. Let the patient know you are there to help if needed.
• Changing Places - think about how you would like to be treated if you were a wheelchair user yourself.

Wheelchair Stability
• Generally for a wheel chair to remain stable it must be upright on its wheels with the combined centre of mass of the wheelchair and user being within the wheel base of the chair.
• Ramps and slopes can present a high risk to users if they try to climb, descend or travel across slopes that are steeper than the safe working limit of the wheelchair. Appropriate gradients and surfaces should not cause problems if they are within the capability of the wheelchair, the user or the attendant. Wheelchairs should only be used on ramps or slopes that are less than the maximum safe slope specified by the wheelchair manufacturer.
• When travelling up, down or across a slope or contact with relatively small obstacles can cause instability leading to tipping or sliding. Hitting obstacles can also cause the seated occupant to slide forwards or fall forwards out of the wheelchair. Use on soft ground can lead to similar problems as small or narrow wheels tend to sink into the ground.
Some wheelchairs will have anti tip devices that can be added to the front or rear of the wheelchair to give physical restriction to the amount of tipping that can occur.

Weather Conditions
Care should be taken in wet or icy weather, particularly on sloping pavements or vehicle run-ups, as wheelchairs tend to slide to the lowest point.

Managing the Wheelchair

- Look for ramps to use if possible.
- When going up kerbs, even small ones, the pusher should tip the chair back using the tipping levers at the back of the chair. Remember to tell the occupant you are tipping.
- When going down kerbs, turn the wheelchair around and take the back wheels down first.
- Don’t hurry or run or turn the chair around too quickly. Tell the patient what you are about to do. They should feel safe at all times. Try to choose a smooth route avoiding ruts and holes, as a bump or jolt can be really painful, or even tip the occupant out of the chair.
- Never leave the chair alone without putting on the brakes and informing the occupant.
- Do not help too much. If the person likes to propel themselves, do allow them to be independent, just helping at slopes and kerbs.

Tips for descending a kerb or a single step

- Always stay behind the wheelchair.
- Before you reach the edge of the kerb or step, turn the chair around and pull it backwards.
- While looking over your shoulder, carefully step back until you are off the kerb or step and standing on the lower level.
- Pull the chair towards you until the rear wheels reach the edge of the kerb or step. Then allow the rear wheels to slowly roll down onto the lower level.
- When the rear wheels are safely on the lower level, tilt the chair back to its balance point. This will lift the front casters off the kerb or step.
- Keeping the balance position and take small steps backwards. Carefully lower the front castors to the ground.
Tips for climbing a kerb or single step
Always stay behind the wheelchair.
• Face the kerb and tilt the chair upon the rear wheels so that the front castors clear the kerb or step.
• Move forward placing the front castors on the upper level as soon as you are sure that they are past the edge.
• Use the momentum and continue forward until the rear wheels contact the face of the kerb or step. Roll the rear wheels to the upper level.

Transfers (Verbal prompt only)
If the patient is able to transfer himself/herself from wheelchair to chair/car seat you may assist by providing a verbal prompt only.

If the patient requires assistance to transfer to or from a wheelchair, please ask a member of staff. Volunteers must not lift or assist patients into or out of a wheelchair.

Going into town, out and about
• Plan ahead; see that the route is clear and that all doors, gates, etc are open so that the person can go in and out easily.
• Make sure the car is parked as close as possible to the exit you will use. Remember that you will need clear access to open the car doors and position the wheelchair alongside the car. If you need to load equipment such as a wheelchair into a boot, park the vehicle to allow plenty of working space at the back so that you can get to the boot easily and load up safely without having to adopt poor posture.
• Try to be familiar with the layout of the town or city being visited. You should pay particular attention to the location of disabled parking facilities and wheelchair access toilets and the location of lifts in department stores. In some larger stores maps are provided which show the gradients and any areas with steps. Ask for information e.g. leaflets which show disability information.
• Carry a mobile phone if possible and ensure you have all relevant contact numbers in case of a problem or emergency.
Staff Accountability

- Never be worried about asking for help and guidance if you require it. Senior/experienced or manual handling dept. staff are here to help you.
- You can contact the Manual Handling department directly if this is preferable.
- If you are asked to do something you have not done before or are not confident in doing, ask for support and/or training.
- Always ask for more information or training if you require it.
- Never be afraid to say ‘NO’ to something you do not feel competent to do.
- Remember it is your responsibility to protect your own health and well being.