Aintree University Hospitals NHS
NHS Foundation Trust

THE MANUAL HANDLING OF LOADS POLICY

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DOCUMENT SUMMARY

DEFINITION

"Manual handling means any transporting or supporting of a load by hand or bodily force. This includes tasks that involve pushing, pulling, carrying, holding or lifting loads." (HSE 1992)

POLICY AIMS AND OBJECTIVES

The Manual Handling Operations Regulations 1992 "As amended" (MHORs) identifies specific responsibilities to both employer and employee. When implementing the contents of the Regulation the employer must also be mindful of other Acts and Regulations that are relevant:-

- The Health and Safety at Work etc Act 1974
- The Management of Health and Safety at Work Regulations 1992
- The Workplace (Health, Safety and Welfare) Regulations 1992
- Lifting Operations and Lifting Equipment Regulations 1998
- Human Rights Act 1998
- Disability Discrimination Act 1995

The aim of this document is to clarify the responsibilities for Executives, Managers and Staff in order that the risk of injury from manual handling tasks can be reduced to the lowest level reasonably practicable. The Chief Executive retains overall responsibility in law but managers have specific responsibilities to ensure that the Regulations and Acts are implemented at the work site. The policy outlines the following objectives:

- The responsibilities for Executives, Managers, Staff and Volunteers.
- Training requirements including frequency and content.
- Access to competent advice for manual handling issues.
- The risk assessment process relating to human and inanimate loads.
- Monitoring and audit of manual handling incidents.
- The reporting process for risk assessments and provision of control measures.

SCOPE

This document is intended to be used by all members of staff and to promote the philosophy of a minimal and safer handling culture. Loads can be inanimate objects or human loads. Within a hospital environment the majority of manual handling tasks are associated with the care of human loads. The use of a standard risk assessment tool that is applicable to both human and inanimate loads is problematic and it is therefore necessary to identify the different assessment tools to be used. Manual handling risk assessments can be divided into generic assessments and individual load assessment.

Relevant control measures highlighted in the risk assessment must be addressed until the risk has been reduced to the lowest level "reasonably practicable" i.e. any cost, time and effort must not be totally disproportionate to the benefits achieved.

The relevant assessment tools are described in sections 3.2 and 3.4

REFERENCES

Health & Safety Executive (1992)	*Manual Handling Operations Regulations 1992 (as amended), Guidance on Regulations L23.*HMSO London.
Health & Safety Executive (1998)	*Manual Handling in the Health Services.* HMSO London.
National Health Service (2005)	The Management of Health, Safety and Welfare issues for NHS staff 2005

AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
THE MANUAL HANDLING OF LOADS POLICY

1. INTRODUCTION

1.1 Back Facts

Back pain in the general population is common and 80% of individuals may experience an episode of back pain during their life. Nearly a third of all accidents reported each year to the enforcing authorities are associated with manual handling in the health services, that proportion rises to over a half. Patient handling is attributed to more than 60% of the cases reported.

There is clear evidence that musculo-skeletal disorders (MSDs) are a serious problem in the NHS. Manual handling incidents account for 40% of all sickness absence in the NHS, there is an associated cost in the region of £400 million annually. (NHS 2005) The cost of agency, bank staff and overtime is estimated to cost a further £50 million.

1.2 Load Management Legislation

The legislation highlights the need to avoid manual handling tasks where there is a significant risk of injury. If the task cannot be avoided, then the risk must be assessed and reduced to the lowest level reasonably practicable. All employees must be given information relating to the loads they are dealing with e.g. the weight, and instructions on how to carry out the manoeuvre including the use of equipment if appropriate. Guideline weights for manual handling are issued by the Health and Safety Executive (HSE 1992): these are not set limits but simply a guide indicating when a more detailed risk assessment may be required. etc. ***It must be noted, however, that almost all adult patients will exceed the HSE guideline figures and therefore it is essential that an individual patient assessment is carried out if there are mobility problems.*** Guideline forces are also published by the HSE and following research these forces were reduced in 2004. Employers and Managers must ensure that employees are not exposed to excessive forces when pushing / pulling loads e.g. beds, trolleys, cages, bins etc

1.3 Evidence based research.

Research has shown that training alone will not resolve the problems associated with manual handling. Training should be a supplement to, and not a substitute for the redesign of the handling task and other improvements. The legislation encourages an **ergonomic** approach to be taken in which the task, load, environment and individual capability are considered. All patient handling procedures should follow evidence based theories and postural analysis tools should be considered before making equipment choices and purchases.

1.4 Duties for Trust employees

This Policy sets out roles and responsibilities with regard to the manual handling of loads for:

- The Chief Executive and Board of Directors
- Divisional / Directorate Managers.
- Ward Managers
- Volunteer Manager

- Manual Handling Advisor
- Manual Handling Cascade Trainers
- Admitting and Named Nurse
- All employees

2. RESPONSIBILITIES

2.1 Chief Executive and Board of Directors

The Chief Executive of Aintree University Hospitals NHS Foundation Trust has the overall responsibility to ensure that the duties under The Manual Handling Operations Regulations 1992 (As amended) are implemented and:-

- To approve a manual handling of loads policy
- To ensure that risk assessments are conducted and control measures implemented.
- To ensure that adequate equipment and staffing resources are available.
- To consider the manual handling implications at the design and planning stage of new build projects – to seek input from the Manual Handling Advisor.
- To ensure that Trust employees and Volunteers receive manual handling mandatory training and any additional information, instruction and training relevant to the level of risk.

2.2 Divisional, General and Directorate Managers

Senior Managers at this level must ensure that the policy is implemented and adhered to within the areas under their sphere of control and they:-

- Remain accountable to the Chief Executive for ensuring that the employer's responsibilities under the MHOR 1992 are implemented.
- Must ensure that their managers have the resources to control hazardous manual handling activities for tasks that cannot be avoided..
- Must ensure that their managers provide opportunities for their staff to attend manual handling mandatory training.
- Must ensure that a formal reporting system is in place for managers to report any resource deficiencies needed to reduce manual handling risks.

2.3 Ward Managers / Departmental Heads / Office Managers / Senior Divisional Nurses

Managers at this level have a responsibility to implement the following:-

- To implement the contents of the Trust policy and manual handling regulations within their workplace.
- To ensure that sufficient Manual Handling Cascade Trainers are appointed with the appropriate level of presentation skills.
- To ensure that the relevant ergonomic manual handling risk assessments are carried out, documented and the action points addressed through the appropriate channels.

- To take account of any environmental and equipment factors that may cause enforced poor posture, i.e. fixed height equipment, shelving, storage areas.
- To ensure that all staff have information relevant to the loads they are dealing with e.g. weight, size, shape and any other pertinent facts including the actions needed to reduce or control the risk.
- Must ensure that all their staff are given opportunities to attend manual handling mandatory training at the required frequency.
- Ward managers to ensure that all patients with mobility problems are assessed on an individual basis and accurate records kept in the care plan.
- In areas of high patient throughput it may be acceptable to group together common manual handling tasks and form generic statements. Local policies must be in place to implement this and all staff are trained and aware of the generic process and also how to deal with any variance from the generic statement. Typical areas may include AED, Theatres, and OPD.
- Ward Managers to ensure that adequate control measures are in place, this may include training or the provision of patient handling aids. There must be sufficient quantities depending on the level of risk and in the case of slings must include sufficient sizes and types suitable for the level of patient dependency and clinical condition.
- All patient handling procedures must whenever possible be evidence based and follow best practice in line with The Guide to the Handling of Patients (current edition)
- Particular attention and training must be given to any vulnerable staff that may have increased risk of muscular skeletal injuries. This may include but not limited to the following groups – students, staff with pre-existing medical conditions or disabilities, young persons aged 16 – 18, new or inexperienced staff, new and expectant mothers, agency workers and bank staff.

2.4 Volunteers Manager

Volunteer staff must be afforded the same level of protection as regular employees of the Trust.

- Manual handling training appropriate to the level of risk exposure must be provided for all Volunteer staff.
- The training must be provided by staff within the volunteer department as part of the induction procedure.
- The staff providing the training must be able to demonstrate that they themselves have received the relevant training as a Cascade Trainer and attended annual updates.

2.5 Manual Handling Advisor

The Manual Handling Advisor will act in an advisory capacity for Executives, Managers and other employees within the Trust. The main duties of MH Advisor are to:

- Facilitate the implementation of the Manual Handling Operations Regulations 1992 (As amended) and any associated Regulations and Acts.

- Design and facilitate the education programmes for Cascade Trainers dealing with inanimate and human loads
- Provide advice regarding the purchase of manual handling equipment for handling inanimate objects and human loads.
- Provide advice as required for complex manual handling issues, incorporating an ergonomic approach.
- Maintain own competence by attending relevant training courses, conference, workshops and meeting relevant to the speciality.
- Work with managers to recognise and recommend the need for change in work practice and to follow evidence based guidelines.
- Review and monitor M.H. incidents/injuries, audit compliance at ward / dept level.
- Inform Trust Managers regarding any non compliance with industry or professional standards relating to manual handling.
- Provide advice to managers regarding risk management techniques for the reduction of manual handling incidents.
- Network with other professionals / Advisors within the region in order to collate and disseminate examples of good practice in the Trust.
- Establish a working relationship with designers, manufacturers and suppliers of manual handling equipment.
- Provide information to Executives, Divisional and General Managers at the design and planning stage of any building projects that may have manual handling implications for patients and staff.

2.6 Manual Handling Cascade Trainers

The provision of manual handling mandatory training in this large Trust is dependent on a cascade system of training. The role of the cascade trainer is therefore pivotal and essential for the implementation and continuation of mandatory training. They are trained to support their direct line managers in carrying out specific responsibilities relating to the Manual Handling Operations Regulations 1992. All these factors must be considered during the nomination process and it is essential that the person selected is well motivated and possesses the relevant knowledge, attitude and skills to carry out the duties effectively.

Their duties will include the following:

- To participate and provide specific instruction and training to employees within the ward, department or directorate as required paying particular attention to new, temporary and inexperienced staff.
- To promote a culture and philosophy of minimal and safer handling using evidence based guidelines and in the case of human loads making reference to the “Guide to the Handling of Patients” current edition.
- Must retain a brief lesson plan for all training activities that take place this can be either paper based or entered electronically in the relevant training management database.
- To assist their managers in carrying out and documenting the relevant manual handling risk assessments. This may be a generic assessment of a ward or department or specific to an individual patient or object.

- To advise the immediate manager or supervisor of any areas where compliance with the legislation may be compromised due to unsafe systems of work, insufficient or inappropriate equipment, environmental and ergonomic factors etc.
- To be aware of the contents in the Trust policy on manual handling and to inform employees how to access the information.
- To be actively involved in unique problem solving activities.
- To alert managers and other employees of the need to change current practice when necessary, paying particular attention to the elimination of unsafe and condemned lifts e.g. orthodox lift.
- To endeavour at all times to promote safe handling practices and utilise specific equipment when provided.
- To liaise with the Manual Handling Advisor to ensure that current practice meets with industry and professional standards.
- To ensure that signed registers are maintained for all training sessions and also to record the names of the participants into the relevant training management database in use at the time. The Cascade Trainer is directly responsible to ensure that this recording takes place as soon as possible after the training event.
- All Cascade Trainers must ensure that they attend annual training updates.

2.7 Admitting and Named Nurse

- The Admitting Nurse will ensure that a manual handling mobility assessment is carried out and documented for those patients presenting with mobility problems and all patients that have a history of falls. This process must be verified within a 12 hour period by a Registered Practitioner i.e. Named Nurse.

2.8 Employees Responsibilities

Health & Safety Legislation places specific responsibilities on employees and it is essential that each individual is aware of his or her own responsibilities under the different sections of legislation.

- **The Manual Handling Operations Regulations 1992 (As amended)**
- The employee has a duty: "… to make full and proper use of any system of work provided by the employer …"
- Risk assessment is the key to identifying the necessary components needed for a safe system of work.
- **The Health & Safety at Work etc Act 1974**
  The employee should endeavour, " while at work to take reasonable care of the health and safety of himself and of other persons who may be affected by his acts or omissions …" and "… to co-operate with the employer to enable him to comply with his health & safety duties …".
- Employees must use handling aids where appropriate when they are provided by the employer. Senior or experienced staff **must** lead by example and not omit to inform new, temporary or inexperienced staff of the safe systems of work in use within their environment. If specific manual handling equipment is identified following a risk assessment and is not available, then the matter should be reported to the ward/department manager.
- **The Management of Health & Safety at Work Regulations 1999**
  The employee is required "… to make use of appropriate equipment provided

for them, in accordance with their training and the instructions the employer has given them …"

Patient handling equipment such as hoists and sliding aids are provided for the reduction of risks. Where appropriate, employees **must** use such equipment but only after having received the appropriate training. Employees must **not** operate patient hoisting equipment until they have received suitable training. Competency forms must be completed for any equipment defined as a medical device e.g. patient hoists and electric profiling beds.

3 MANUAL HANDLING RISK ASSESSMENT

3.1 Risk Assessment Process

A key factor of the Manual Handling Operations Regulations 1992 (As amended) is the avoidance of hazardous manual handling tasks. If it is not possible to avoid the task then a risk assessment must be carried out. The risk assessment process should be proactive and well planned with the aim to provide a safe system of work. In the event of an incident occurring then a reactive and reflective approach will be taken to critically analyse the methods of working. The overall aim of the reactive assessment will be to identify possible areas where patient and staff safety can be improved.

All Managers have a responsibility to ensure that the relevant manual handling risk assessments are completed at the work site. This is a statutory obligation under the Manual Handling Operations Regulations 1992 and also the Management of Health and Safety at Work Regulations 1999. Specific guidance regarding risk assessments in general is available in the Trust's **Risk Assessment Policy and Guidance** which can be accessed on the Intranet. Ward or department managers are responsible for tasks performed by the staff working for them. No employee should be expected to manually handle patients or objects in circumstances likely to cause them harm. Managers must therefore ensure that adequate control measures are in place to reduce the risk of injury. The assessments will vary depending on the location but must in most cases be proactive and encompass the following:

- Assessment of risks
- Reduction and control of risks
- Provision of information on the load
- Review of risk assessments

Managers or persons delegated by them carrying out a risk assessment in their work area must adopt an ergonomic approach. There are five key steps to be considered as part of the assessment process and the manager **must:**

- Decide if there is a problem.
- Decide who might be harmed.
- Evaluate the risks and decide whether existing precautions are adequate or more should be done.
- Record the findings.
- Develop and pursue an action plan to obtain the necessary resources.

The ergonomic approach must consider risks under four headings:

- Task
- Load
- Individual capability
- Environment

3.2 Moving and Handling Process – Human and Inanimate Loads

The moving and handling process must stem from a risk assessment and whenever possible be evidence and research based. Postural analysis tools should be used as a reference to indicate lower risk methods of moving and handling. The provision of training is not a replacement but a supplement to other risk control measures. The following process must be adhered to:-

- Avoid manual handling if possible.
- Risk assess any tasks that cannot be avoided.
- Utilise control measures that are provided including equipment and any related information instruction and training.
- Test that they are working – reassess and evaluate.
- Use hoists and sliding aids for human loads if appropriate.
- Use powered driving devices for beds and trolleys on steep gradients.
- Adjust variable height equipment as required to improve individual posture e.g. beds, trolleys, examination couches.
- If the appropriate equipment is not available report the fact to your immediate Manager or Manual Handling Advisor.

3.3 Provision of Equipment

Equipment needs and other resources that may be identified but not available following a risk assessment must be incorporated into an action plan. The action plan and business case must clearly identify the requirements and associated costs. The person responsible for presenting the case should be named and also the forum to which the case will be presented. The provision of small manual handling aids such as slides sheets and handling belts will normally be funded at ward level. Similarly small handling aids used for inanimate loads will be addressed at a local level. Refer to appendix 1 of the Trust **Risk Assessment Policy and Guidance** for additional guidance relating to the acquisition of resources. The Manual Handling Advisor will develop business plans and present any case for resources that have a Trust wide and strategic impact.

3.4 Patient Specific Areas (Human Loads)

- Cascade Trainers (Patient handling) have been trained to assist their Managers with the assessment process.
- A generic manual handling assessment of the ward or other patient centred departments including the mortuary must be done; any pushing or pulling activities must be included. **(Appendix 8)**

- Risk assessments should consider any foreseeable but not necessarily routine manual handling that may occur in the following scenarios; bariatric patients, cardiac arrest situations, young persons age 16 -18 years, new and expectant mothers and the management of falling or fallen patients.
- Individual patient assessments – to be documented in the care plan. **(Appendix 1)**
- In areas of high patient throughput it may not be feasible to conduct an individual patient assessment – an alternative option in these areas is to group together the common patient handling tasks in the form of a generic statement. This local policy must be agreed and available for all employees that are involved. Instruction and training must be provided for any control measures that may be listed. The accident and emergency dept, outpatient dept, and theatres are the areas where generic statements are likely to be used.
- All departmental risk assessments should be reviewed at least annually or sooner if an incident occurs. **(Appendix 2)**
- Any outstanding control measures requiring funding and resources must be documented and pursued through the relevant health & safety reporting channels within the directorate or division.

3.5 Rehabilitation or Therapeutic Handling

It is accepted that all professions must abide by the Manual Handling Operations Regulations. However, healthcare professionals, assessing the patient's situation from different perspectives, sometimes arrive at different solutions to manual handling questions. There may be times when the avoidance of manual handling may appear to conflict with the treatment and rehabilitation of patients. For example a patient may be admitted after experiencing a stroke. If manual handling was to be avoided and the patient was hoisted then it is suggested that this would conflict with the rehabilitation process. Other professionals including Physiotherapists and Occupational Therapists may wish to include rehabilitation handling and transfers such as the "Bobath Methods": these problems are recognised by the professional bodies. The Chartered Society of Physiotherapists, The College of Occupational Therapists and The Royal College of Nursing have issued a joint statement:

> *"When professionals, following assessment, wish to delegate an ongoing task, including manual handling, to another professional, care worker or relative / carer, they should take a number of considerations into account … these include: the knowledge, training, skill, competence, health and physical capabilities of the person accepting the delegation."*

For individuals accepting the delegation, part of their own assessment would be to consider their own capabilities, not only physical, but also the knowledge and skills necessary for carrying out the task in question.

3.6 Non Patient Areas (inanimate loads)

This will include all areas that involve only inanimate load handling, the majority of areas will be office environments and may include but not restricted to laboratories,

estates and maintenance departments, laundry, textile services etc. Managers must decide whether there are significant risks and can refer to the HSE screening tool as an aid. **(Appendix 3**). This will help to determine whether a more detailed risk assessment is required.

- Cascade Trainers (inanimate objects) have been trained to assist their Managers with the assessment process.
- A lifting and lowering screening tool can be used to determine if a more detailed risk assessment is needed**.**
- A risk assessment form (inanimate loads) must be completed if there are significant risks that cannot be avoided. **(Appendix 4)**

4 MANUAL HANDLING AUDIT AND MONITORING

All Ward Managers must ensure that a manual handling Audit is carried out annually. This is a self audit procedure to monitor the effectiveness of the various systems that are in place. Random sampling will be carried out to ensure compliance. A copy of the audit form to be returned to the Manual Handling Advisor. (**Appendix 5)**

Reporting of Manual Handling Accidents, Incidents including Near Misses

- All manual handling incidents involving staff or patients must be reported in line with the Trust Incident Reporting and Management Policy.
- Manual handling incidents will be investigated by the Manual Handling Advisor.
- Manual handling incident reports will be forwarded from the Legal Dept to the Manual Handling Advisor at the earliest opportunity.
- If an employee is involved in a manual handling incident during a patient handling task then **both** the **patient** and **employee** details must be recorded.
- Manual handling incident frequency and demographics will be recorded by the Legal Department.

4.1 Monitoring Incidents

The frequency of manual handling incidents will be one method used to monitor compliance with the policy. The incident analysis will be included in the Trust quarterly Risk, Complaints and Claims Report and be reviewed by the Risk Management Strategy Group. Manual handling incident charts for the previous 10 years are available to illustrate long term progress.

4.2 Monitoring Training

The Trust utilises a Learning Management System (LMS) in the form of a database. Training activity carried out by Cascade Trainers can be monitored using the LMS. Training activity registers must also be retained for all manual handling mandatory training that is carried out. Approximately 20% of patient areas i.e. wards and departments and 10% of non patient areas will be selected annually to ensure compliance with training records and Cascade Trainer activity.

4.3 Monitoring Manual Handling Risk Assessments

Random selection checks will be conducted by the Manual Handling Advisor. Approximately 20% of patient areas i.e. wards and departments and 10% of non patient areas will be selected annually to ensure compliance with risk assessment documentation.

5 MANUAL HANDLING MANDATORY TRAINING

There is a statutory obligation for the employer to provide the appropriate health and safety training and for staff to cooperate with the employer to allow those duties to be carried out. Manual handling training is mandatory for all staff and session planning is based on the findings of the Mandatory, Training - Training Needs Analysis Document. A theory session forms part of the Corporate Induction Training and additional practical training including equipment competency with patient hoists etc must be covered during the local induction procedure. The frequency of manual handling refresher and update training will be dependent on the level of risk for the different occupational groups and is outlined in **(Appendix 6)** The handling of human loads will encompass additional clinical skills and impact on the quality of care. Inappropriate manual handling techniques that result in injury to the patient are classed as physical abuse by the Nursing and Midwifery Council. This presents and additional responsibility for Nurse Managers ensure adequate clinical supervision for their staff.

- All Trust employees with direct patient contact must receive manual handling training when first employed and annually thereafter.
- All other employees dealing with inanimate loads only will receive manual handling training when first employed and either annually, bi or tri annually thereafter depending on the level of risk.
- The manual handling advisor will personally train all Manual Handling Cascade Trainers, and provide sufficient sessions based on a training needs analysis
- All manual handling Cascade Trainers must attend an annual update.
- All Managers with direct responsibility for the supervision of staff must ensure that training records are maintained in the approved Learning Database being used by the Trust.

5.1 Training Content

The content of all manual handling training within the Trust will be set out by the Manual Handling Advisor and will follow current best practice and recommendations from government and professional bodies as outlined below.

- Royal College of Nursing
- Chartered Society of Physiotherapists
- College of Occupational Therapists
- Ergonomics Society.
- Health and Safety Executive.
- National Back Exchange.
- ROSPA.
- NHS Back in Work Campaign.
- The Inter-professional Curriculum for Back Care Advisors.
- The guide to the handling of patients (Current edition)

A minimum handling philosophy and an ergonomic approach will be promoted at all times. The following key topics will form the basis for any lesson planning.

- Risk assessment

- Legislation – employer and employee responsibilities.
- Anatomy of the spine and basic biomechanics.
- Posture and 24 hour back care.
- Ergonomic approach.

5.2 How Moving and Handling Training should be Delivered

Moving and handling training for the following staff groups will be delivered by the Manual Handling Cascade Trainers:

- Nursing
- Allied Health Professionals
- Maintenance Technicians
- Administrative and Clerical
- Pharmacists
- Pharmacy Technicians
- Technical

Moving and handling training for the following staff groups will be delivered by the Manual Handling Advisor:

- Porters
- Ancillary
- Medical Staff

5.3 Training Resources

All Manual Handling Cascade Trainers can have access to a number of training resources in the Trust.

- Dedicated manual handling lecture suite complete with all patient handling devices including electric profiling beds, powered hoists, small handling aids and supporting audio and visual aids.
- Video training packages and supporting documentation.
- Centaur – Manual Handling for Porters. Complete Training Package
- Centaur – Manual Handling for Estates. Complete Training Package
- Centaur- Peri-operative Manual Handling. Complete Training Package
- Centaur- Load Management Theory and Client Handling Techniques. Complete Training Package
- Training and Learning for Care Ltd-Moving and Handling People. Complete Training Package
- Vocam-Manual Handling in the Office Environment. Video
- Human Focus – Office Ergonomics. Video
- Shell- Catering for Lifters. Video

5.4 Access to Specialist Advice

Additional specialist advice can be sought from the Trust's Manual Handling Advisor and the ward or dept based Cascade Trainers.

6 THE MANAGEMENT OF THE EXTREMELY HEAVY (BARIATRIC) PATIENTS

All adult patients will exceed HSE guideline weights and may constitute a significant risk of injury if they present with mobility problems.

The risk assessment principles for bariatric patients are no different than those encountered with other patients. Bariatric patients may present with additional problems and necessitate the use of specialised equipment and procedures. Careful planning is required in order to minimise discrimination and allow dignified care to be administered. There is little doubt that a significant risk of injury to the carer may occur, what is less obvious in the possibility of equipment failure if the safe working load is exceeded.

It is essential that all Managers in patient areas consider the hazards and risks that may occur in the event that an extremely heavy patient was admitted into their facility. The approach must be proactive and failure to consider the implications could have a significant impact on health and safety for staff and the patient.

6.1 Bariatric - origin

The word “bariatric” is derived from the Greek word “Barys” meaning heavy and “Iatros” meaning Physician. Bariatric medicine is the study of morbid obesity and is not limited to weight loss surgery. Bariatric patients may be admitted to all specialities within the Trust.

6.2 Bariatric Definition (NICE)

The National Institute for Clinical Excellence (NICE) defines morbid obesity as a body mass index of 40 or above or a BMI between 35 and 40 and co-morbid conditions. The use of the patient’s weight and or body mass index to trigger action points in a manual handling policy can be unreliable.

6.3 Bariatric definition – Aintree Hospitals Manual Handling Policy

A patient will be defined as bariatric if, there are limitations in health and mobility as a result of excess weight or high body mass index .The consequences are severe enough to impact on the choice of equipment, staffing levels and the environment. In all case a sound clinical judgement should prevail.

6.4 Admission protocol

Bariatric patients may be admitted as planned or emergency cases and a collaborative approach is required for the successful management during their stay in hospital. A detailed risk assessment is essential and must consider equipment, environmental, ergonomic and staffing levels.

The Manual Handling Advisor, Tissue Viability Nurse Specialist and Bed Managers must be notified as soon as practicable for all emergency and planned admissions

6.5 Accurate weight

Obtaining an accurate weight must be the starting point in order to safely plan additional resource needs. Specialised bariatric scales are available in the following areas:-

- Outpatient department - Aintree
- Outpatient department – Walton
- Physiotherapy department – Walton
- Integral scales – Contoura 1080 bariatric bed (Trust owned)

6.6 Patient hoists – High weight capacity

All wards within the Trust are equipped with powered lifting hoists. The safe working load will vary depending on the individual model and manufacturer, the safe working load will always be displayed on each hoist. If the patient exceeds the safe working load or there are difficulties due to the body mass then the following heavy duty options are available.

- Liko Viking hoist 300 kg (47 st) capability – stored in critical care and can be accessed at all times.
- Liko Masterlift Ultratwin gantry hoist – 318 kg (50 st) capability. Must be assembled by maintenance dept. Installation and removal during office hours only Monday – Friday

6.7 Bariatric Beds

There is 1 purpose designed bariatric bed within the Trust, this bed is the Contoura 1080 and has a capacity of 451 kg (71 st). There are a number of factors additional to the patient's weight that must be considered when choosing the appropriate bed. The patient's weight may be below the maximum for the bed but limitations may occur due to the body mass exceeding the bed dimensions. Pressure ulcer risk must also be considered and if any dynamic mattress options are used then the maximum therapeutic range should be observed.

The following electric profiling beds also have a high load capacity and can be considered as an interim measure for patients that may be admitted during the night or at weekend.

- Sidhil Independence beds 222 kg (35 st) capacity 178 beds in total
- Hill-Rom Avant Guard beds 210 kg (33 st) daily use or 250 kg (40 st) occasional use. 359 beds in total.

6.8 General bariatric equipment

Other items of bariatric equipment are located throughout the Trust and include the following:-

- Static chairs
- Wheelchairs
- Commodes
- Shower stools
- Powered riser recliner chairs
- Transportation chairs
- Slide sheets
- RepoSheets™
- Transfer board

More details are listed in (**Appendix 7)**

There may be occasions when several extremely heavy patients are admitted at the same time, if all the Trust resources are in use there will then be a requirement to rent items of heavy duty equipment. This will be a ward / directorate responsibility and an order number must be obtained from the supplies department before placing an order with any of the suppliers. Managers must ensure that systems are in place to authorise the rental of necessary items of equipment that may be required during the night or at the weekend.

Appendix 1 The Manual Handling of Loads Policy

Individual Patient Assessment Tool

Standard statement: All adult patients with mobility problems can pose a risk of injury to the Carer, a risk assessment and subsequent control measures must be documented in the Care Plan. The clinical condition must always be considered.

Generic statement may be considered in areas that have high volume of patients i.e. AED, OPD and Theatres.

The initial assessment should be carried out by the Admitting Nurse and verified by a Registered Nurse within 12 hours.

- If the patient is fully independent in all mobility tasks then there is no need to proceed with the assessment.
- Consider all the risk factors before making a decision.
- An assessment must be carried out in all cases when there is a history of falls.
- The assessment is an ongoing process and must take into account any improvements and deterioration of the patient's condition e.g. on admission the patient may be fully mobile but this may change the following day if surgery has been carried out.
- Whenever possible a multidisciplinary approach must be used and also include the patient.
- The person carrying out the initial assessment must sign and date the form.
- All subsequent assessments / reviews must be signed and dated.

The following details should be included in the care plan.

- What is the mobility problem e.g. walking, sitting or standing?
- List any equipment that is needed or rehabilitation technique required to assist mobility?
- How many Carers are required to carry out the transfer / manoeuvre?
- What method is to be used?
- Document separate instructions for each task.

PATIENT ASSESSMENT – MOVING & HANDLING

Patient ID Sticker	Weight (if known) Always check the maximum safe working load of the bed, trolley, commode, hoist etc	Is the Patient fully independent in all mobility tasks? NO – Proceed with assessment YES – No need to proceed Consider all risk factors before making a decision
Can patient respond to direct instruction? Yes ☐ No ☐ Sometimes ☐ Seems confused ☐		Level of Understanding Full ☐ Some ☐ None ☐ Cannot Assess ☐
Does the Patient have a history of falls? Yes ☐ Complete assessment in all cases No ☐ Do not know ☐		List any mobility aids normally used by patient: Are they available? Yes ☐ No ☐

Review Date:												
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
IV lines/Monitors/Pumps												
Catheter in situ												
Feeding Tubes – Peg/NG												
Pain – List site												
Skin Damage												
Hearing Impairment												
Sight Impairment												
Immobile												
Other Factors												
Admitting Nurse Signature:												
Print Name:												
Registered Nurse Signature:												
Print Name:												

First Assessment:

Date: …… Time: …… Assessors Name: ……..

MOVING & HANDLING CARE PLAN & EVALUATION

AIM:- To maintain maximum comfort and safety of the patient and minimum risk of injury to Handlers.

CARE PLAN:

1. **Consider A Multidisciplinary Approach when appropriate (AHPS)**
2. **Give explanations and instructions on techniques and equipment as required**
3. **Seek co-operation and understanding of the patient prior to moving & handling**
4. **List instructions for each task**

TASK	DATE	ASSESSORS SIGNATURE	INSTRUCTIONS	EQUIPMENT	REVIEW DATE
REPOSITIONING IN BED					
LIE TO SIT					
GETTING ON BED					
BED TO CHAIR					
GETTING OFF BED					
TRANSFERING: BED-> TROLLEY TROLLEY-> BED					
SIT TO STAND					
BATHING					
TOILETING					
REPOSITION IN CHAIR					
WHEELCHAIR -> PLINTH					
OTHER					

NB: REHABILITATION HANDLING MAY DIFFER FROM TECHNIQUES LISTED ABOVE, AND TAKE ACCOUNT OF EXPERIENCE ANS DESCRETION OF THE THERAPIST CONCERNED

MANUAL HANDLING RISK ASSESSMENT UPDATE (Generic Assessment)

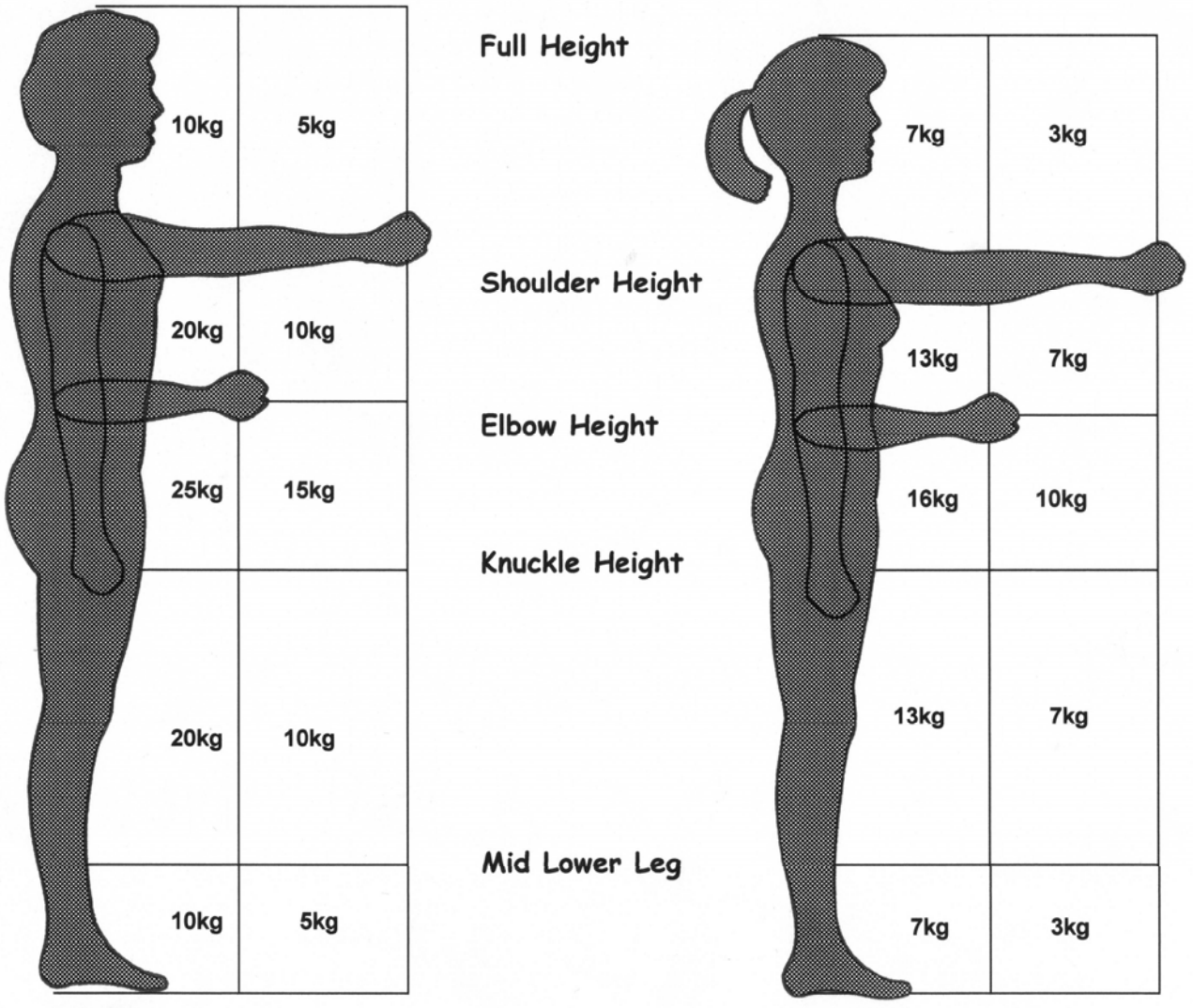
WARD/DEPT---------- DATE REVIEWED / /

RELEVANT CHANGES TO THE LEVEL OF RISK SINCE THE LAST ASSESSMENT List positive & negative changes. Consider the environment e.g. re-location of ward or speciality, manual handling incidents.
CONTROL MEASURES / IMPROVEMENTS INTRODUCED SINCE THE LAST ASSESSMENT:- List new equipment, variable height trolleys, beds, couches, hoists changes to work practices or training implemented to reduce risk.
OUTSTANDING ISSUES:- List further control measures / equipment still required to reduce the risk. Include hydraulic beds,. Document a summary of needs and an action plan required to achieve the objectives. Give target dates and persons responsible for resources and implementation. Continue on a separate sheet if necessary.

Person Responsible ---------- Job Title ----------

On completion, attach to the original assessment held on the ward. **Return a copy of this update to**:-
Ken Cookson --- Training & Development

Weight Guidelines - Lifting and Lowering



Aintree University Hospitals NHS Foundation Trust

RISK ASSESSMENT INANIMATE LOADS

DEPARTMENT: ..... **LOCATION: .....**

ASSESSMENT TEAM: .....

ASSESSMENT DATE : ..... **REVIEW DATE: .....**

Section 1	HAZARD	YES	LIST MEDIUM to HIGH RISK HAZARDS
Tasks: - do they involve... • Twisting? • Stooping? • Reaching upwards? • Large vertical movement? • Long carrying distances? • Strenuous pushing or pulling? • Unpredictable movement of loads? • Repetitive handling? • Insufficient rest or recovery? • A work rate imposed by a process? **The loads:- are they...** • Heavy? • Bulky/unwieldy? • Difficult to grasp? • Unstable/unpredictable? • Intrinsically harmful (e.g. sharp/hot?) **The working environment:- are there** • Constraints on posture? • Poor floors? • Variations in levels? • Hot/cold/humid conditions? • Strong air movements? • Poor lighting conditions? **Individual capability**: - **does the job...** • Require unusual capability? • Hazard those with a health problem? • Hazard those who are pregnant? • Call for special information/training? **Other factors:** - • Is movement or posture hindered by clothing or personal protective clothing?			

Section 2	WHO MIGHT BE HARMED

There is no need to list individuals by name:- consider all staff carrying out manual handling tasks e.g.:-

Office staff Operators Maintenance staff Contractors Technicians

Pay particular attention to:-

- Staff with disabilities
- New/Inexperienced staff
- Lone workers
- Those who may be pregnant
- Technicians
- Young People age 16 - 18

– they may be more vulnerable.

Provide numbers / details of staff groups who may be at risk.

Section 3	IS THE RISK ADEQUATELY CONTROLLED?

Have you already taken precautions against the risks from the hazards you listed? For example, have you provided:-

- Adequate information for the staff.
- Adequate systems or procedures?

Do the precautions:-

- Meet the standards set by a legal requirement?
- Comply with a recognised industry standard?
- Represent good practice?
- Reduce the risk as far as reasonably practicable?

If so, then the risks are adequately controlled, but you need to indicate the precautions you have in place. You may refer to procedures manuals, company rules etc, giving this information.

DETAILS

Section 4	WHAT FURTHER ACTION IS REQUIRED TO CONTROL THE RISK?

What more could you reasonably do for those risks which you found were not adequately controlled?

You will need to give priority to those risks, which affect large numbers of people and/or could result in serious harm. Apply the principles below when taking further action, if possible in the following order:-

- Remove the risk completely
- Automation / mechanisation.
- Modify the load.
- Ensure an adequate level of knowledge and training.
- Provide mechanical assistance
- Involve the workforce in the assessment and task design.
- Use industry specific guidance
- Produce written policy which states aims and objectives of manual handling

SUMMARY OF NEEDS AND ACTION PLAN

List person responsible for action
Set a date for review.
Provide details of cost.
Consider trial before purchasing any equipment

Use separate sheet if required

To be completed by the office / dept manager and MH Cascade Trainer

Assessment adapted from HSE document Five Steps To Risk Assessment 1998

SAFETY AUDIT

MANUAL HANDLING – SYSTEMS OF WORK
QUALITY ASSURANCE

Ward/Department: _____

Ward Manager _____

Date of Audit: _____

Audit Team: _____

_____

INTRODUCTION

Auditing and performance review are important steps in any health and safety management control system and will enable an organisation to maintain, reinforce and develop further its ability to reduce risks.

Organisations use “audit” in different situations and in the business environment audit may relate to financial controls; within the health and safety environment the following definition is applied;

The structured process of collecting independent information relating to manual handling systems of work and associated risk control measures. It is a method whereby the efficiency, effectiveness and reliability of a safety management system can be assessed and identify areas requiring remedial action.

Legislation imposes a number of statutory obligations on both the employer and employee. Certain responsibilities are delegated from the employer to individual managers. Aintree Hospitals NHS Trust Manual Handling Of Loads Policy takes account of these obligations.

Health and Safety at Work etc Act 1974
The Management of Health and Safety at Work Regulations 1999
The Manual Handling Operations Regulations 1992
The Workplace (Health, Safety and Welfare) Regulations 1992
Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 1995
Lifting Operations and Lifting Equipment Regulations 1998

4 main areas are considered in the audit document;

The audit document should be kept with the Trust Manual Handling of Loads Policy Folder and retained for inspection as necessary.

SELF AUDIT PROCESS

A selection of wards will be chosen for self audit and it is suggested that the following team carry out the audit

- Ward Manager
- MH Cascade Trainer

The audit team should **focus on the evidence** and the criteria laid down in each section. The audit team will indicate in the scoring box whether sufficient evidence is available and make comments in the relevant section.

A score of 0 in any section will indicate that none of criteria have been met, a score of 3 will indicate that all the criteria have been met.

On completion the audit team will write up their findings on the summary sheet, if required an action plan should be included with a review date not exceeding 8 weeks later.

A copy should be sent to the Manual Handling Advisor – Ken Cookson - Aintree Training % Development Centre.

COLLECTION OF EVIDENCE

The audit team will be looking for evidence that indicates compliance with the criteria laid down in the assessment tool. This can be either:-

ORAL (O)

Evidence obtained following discussion with patients and staff. i.e.

I. Record if staff can demonstrate knowledge of manual handling safe systems of work..

II. Record what patients/relatives say about points raised from the audit tool

WRITTEN (W)

Evidence obtained from documentation within the audit area i.e.

I. Record that essential information was found to be in the correct place and updated as necessary.

VISUAL (V)

Evidence that good manual handling procedures are being adhered to i.e.

I. Patient transfer techniques are being encouraged in line with good practice.

II. Relevant Health and Safety documents and posters are displayed.

ESSENTIAL DOCUMENTATION / ITEMS REQUIRED BY THE AUDIT TEAM

	Documentation Available	Yes	No
1	Manual Handling of Loads Policy folder.		
2	Manual handling original risk assessment (Generic)		
3	Annual updates since original assessment		
4	Individual patient risk assessment details.		
5	Manual handling training records / lesson plans. (Cascade Trainer)		
6	Manual handling Incident report forms if applicable.		
7	Laundry collection procedure hoisting slings		
8	Small handling aids, inventory.		
9	Disposable Sling Protocol		
10			

Comments regarding the above documents

SECTION 1 RISK ASSESSSMENT - GENERIC

Standard – All managers must ensure that a manual handling risk assessment is carried out within the ward/dept area.

	Criteria	Evidence of	0	1	2	3	Comments
1.1	Manual Handling Operations Regs 1992. **Manual handling must be avoided if there is a significant risk of injury and a risk assessment carried out if it cannot be avoided.**	Ward/dept based manual handling assessment + annual reviews.					
1.2	Health and Safety at Work etc Act 1974. **Safe systems of work**	Control measures are in place for any hazardous manual handling tasks that cannot be avoided. Eg equipment is being used					
1.3	Management of Health And Safety At Work Regulations 1999 **Formal risk assessments**	Controls have been put in place following risk assessment. These measures are evident e.g. Hoists, small handling aids, slide sheets. **Refer page 12 for list of small handling aids**					

Page 6 - Maximum attainable score = 9 Actual score achieved =

SECTION 2 -RISK ASSESSMENT – INDIVIDUAL PATIENT

Standard – All patients with mobility problems must be assessed in order to ensure maximum safety of the carer and quality of care.

	Criteria	Evidence of	0	1	2	3	Comments
2.1	Royal College of Nursing **Patient handling standards.** Aintree Nursing assessment and care planning document.	Patient assessment/ care plans.					
2.2	Health and Safety Commission Manual Handling in The Health Service **Managers are responsible for the tasks carried out by their staff.**	Staff are consulted and made aware of procedures e.g. management of extremely heavy patients.					
2.3	The Management of Health and Safety at Work Regulations 1999 **Competent person Appointments**	Cascade trainers appointed for the ward. Trainers have attended an annual refresher. **Check date of last refresher**					
2.4	Lifting Equipment Lifting Operations Regulations 1998. **Weight of person or object must be known before using hoisting equipment**	Extremely heavy patients are weighed in order that the safety of equipment is not compromised. Staff are aware of the hoisting equipment limitations and safe working loads.					

Page 7 – Maximum attainable score = 18 Actual score achieved =

SECTION 3 - HEALTH AND SAFETY - EQUIPMENT

Standard – All health and safety equipment must be readily available, appropriate and maintained in good working order.

	Criteria	Evidence of	0	1	2	3	Comments
3.1	Provision and Use of Work Equipment Regulations 1998	Employees are instructed how to use hoisting equipment.					
3.2	Lifting Operations and Lifting Equipment Regulations 1998 **All lifting appliances and attachments must be inspected.**	Hoists and slings are inspected 6 monthly. (Maintenance dept)					
3.3	Health and Safety at Work etc Act 1974. **Employers / managers must safeguard the health, safety and welfare of employees.**	Manual handling safe systems of work i.e. suitable and sufficient items of manual handling equipment are provided, the use of equipment is encouraged when appropriate.					
3.4	Trust procedure for the identification of slings is adhered to. All existing and new slings must be stencilled by the maintenance dept. Prefixed with letters **AS**	**Fabric slings are appropriately marked by maintenance dept prefixed with the letters** AS Disposable slings are discarded when soiled or when the patient is discharged.					
3.5	Trust procedure for laundering / collection of slings is adhered to	All slings are clearly marked with the ward name and staff are familiar with the Trust procedure for sending slings to the laundry.					

Page 8- Maximum attainable score = 18 Actual score achieved =

SECTION 4 -INFORMATION, INSTRUCTION AND TRAINING

Standard – Employers/Managers must provide information instruction and training i.e. Induction, Job specific, Refresher.

	Criteria	Evidence of	0	1	2	3	Comments
4.1	***The Management of Health and Safety at Work Regulations 1999*)** Employees must receive information instruction and training.	New staff receive induction training to include the safe use of lifting equipment. All staff receive a manual handling update on an annual basis.					
4.2	(Manual Handling Operations Regulations 1992) **Employers / Managers must provide information on the load. e.g. Essential manual handling information is documented in the patient assessment tool / care plans**	Mobility problems and specific instructions are documented in the patient care plan. **Evidence that the patient has been weighed is documented.**					
4.3	**Manual Handling in the Health Services. (Health & safety Commission 1998)**	Employees are familiar with the extremely heavy patient protocol eg arrangements for obtaining heavy duty equipment beds, chairs, commodes walking frames and hoists etc.					
	Aintree Hospitals Manual Handling of Loads Policy. **The management of the extremely heavy patient.**	Ward Managers have systems in place to authorise equipment rentals during the night and at the weekend.					

Page 9 – Maximum attainable score = 18 Actual score achieved =

Appendix 6
The Manual Handling of Loads Policy

Manual Handling Training Frequency

Occupational Group	Frequency	Main Provider	Comments
Nursing	Annually	Cascade Trainers	All ward, clinic and theatre staff
Allied Health Professionals	Annually	Cascade Trainers	Therapists, Radiographers, Sonographers
Porters	Annually	MH Advisor	Patient and Inanimate loads
Maintenance technicians	Annually	Cascade Trainers	All maintenance techs, craftsmen etc
Ancillary	Annually	MH Advisor	Textile care, Laundry
Admin and clerical	Bi Annual	Cascade Trainers	
Pharmacists	Tri Annual	Cascade Trainer	
Pharmacy Technicians	Tri Annual	Cascade Trainer	
Technical	Bi Annual	Cascade Trainer	Biomedical eng, MFU lab.
Medical Staff	At induction	MH Advisor	

Appendix 7

The Manual Handling of Loads Policy

Bariatric Equipment Location List

TEAL BARIATRIC CHAIR 250 kg and 318 kg Capacity

Static chair	Teal	250 kg	24 / 25	**Deliver to 24**
Static Chair	Teal	250 kg	22/23	**Deliver to 22**
Static Chair	Teal	250 kg	20/21	**Deliver to 20**
Static Chair	Teal	250 kg	18/19	**Deliver to 18**
Static Chair	Teal	250 kg	16/17	**Deliver to 17**
Static Chair	Teal	250 kg	14/15	**Deliver to 14**
Static Chair	Teal	250 kg	12/11	**Deliver to 12**
Static Chair	Teal	250 kg	10/9	**Deliver to 9**
Static Chair	Teal	250 kg	30/31	**Deliver to 30**
Static Chair	Teal	250 kg	32/33	**Deliver to 33**
Static Chair	Teal	250 kg	34	**Deliver to 34**
Static Chair	Teal	250 kg	**MAU**	**Deliver to MAU**
Static Chair	Teal	250 kg	1	**Deliver to 1**
Static Chair	Teal	250 kg	2	**Deliver to 2**
Static Chair	Teal	250 kg	3	**Deliver to 3**
Static Chair	Teal	250 kg	28	**Deliver to 28**
Static Chair	Teal	250 kg	ARDU	**Deliver to ARDU**
Static Chair	Teal	318 kg	AED	**Deliver to AED**
Static Chair	Teal	318 kg		**Deliver to OPD**

Teal bariatric chair 250 kg (40 st) drop down arms, height adjustable

Cefndy Shower Stool 250 kg Capacity (40st)

4 Shower stools have been purchased and will be delivered as follows

Item	Supplier	SWL	Wards	Comments
Shower stool	Cfendy	250 kg	2/3	Deliver to 2
Shower stool	Cfendy	250 kg	14/15	Deliver to 14
Shower stool	Cfendy	250 kg	30/31	Deliver to 30
Shower stool	Cfendy	250 kg	22/23	Deliver to 22

Cefndy Bariatric Commode 250 kg Capacity 250 kg (40st)

Features
Height adjustable, drop down arms, castors, 250 kg capacity.

Item	Supplier	SWL	Wards	Comments
Commode	Cfendy	250 kg	24/25	**Deliver to 24**
Commode	Cfendy	250 kg	22/23	Deliver to 22
Commode	Cfendy	250 kg	20/21	Deliver to 20
Commode	Cfendy	250 kg	18/19	Deliver to 18
Commode	Cfendy	250 kg	16/17	Deliver to 17
Commode	Cfendy	250 kg	14/15	Deliver to 14
Commode	Cfendy	250 kg	12/11	Deliver to 12
Commode	Cfendy	250 kg	10/9	Deliver to 10
Commode	Cfendy	250 kg	2/3	Deliver to 2
Commode	Cfendy	250 kg	33/34	Deliver to 33

Bariatric Hoists

Liko Ultra Twin Gantry Hoist 318 kg

This hoist is located in the bed store and is available for use with any patient within the Trust.

The hoist must be assembled by the maintenance technicians and requests to the Manual Handling Advisor tel 2235 bleep 2066.. The hoist will normally be assemble between 0800 – 1600 hrs Monday to Friday.

Liko Viking – Mobile Bariatric Hoist 300 kg

Stored in Critical Care and can be used for any patient throughout the Trust. May be useful if extremely heavy patients are admitted during the night or at the weekend. Contact CC direct evenings or weekends and the MH Advisor at all other times.

Bariatric Bed

The Huntleigh Contoura 1080 bariatric bed (445 kg) is located in the Respiratory Lab (WD 14) This bed can be loaned if a patient is admitted and their weight exceeds the maximum load of the available ward beds.

Contact the Respiratory Dept staff Tel 3808 to arrange a loan, another lower capacity electric profiling bed must be provided for the exchange. The bed must be cleaned before it is returned to the Resp Lab.

Weighing Scales

High capacity weighing scales can be loaned from the OPD tel 3379, there are two types of scale including a wheelchair weighing scale.

Walking Frame (Zimmer) 300 kg

These can be loaned from the Physiotherapy Department tel 3340

Riser recliner chairs (powered)

2 x 40st capacity 24” and 27” seat width
1 x 50 st capacity

Barton Bariatric Transportation Chair

2 Chairs available 150 kg and 300 kg – Contact MH Advisor for details
Tel 2230 Bleep 2066

Liko Horizontal Flexo lift

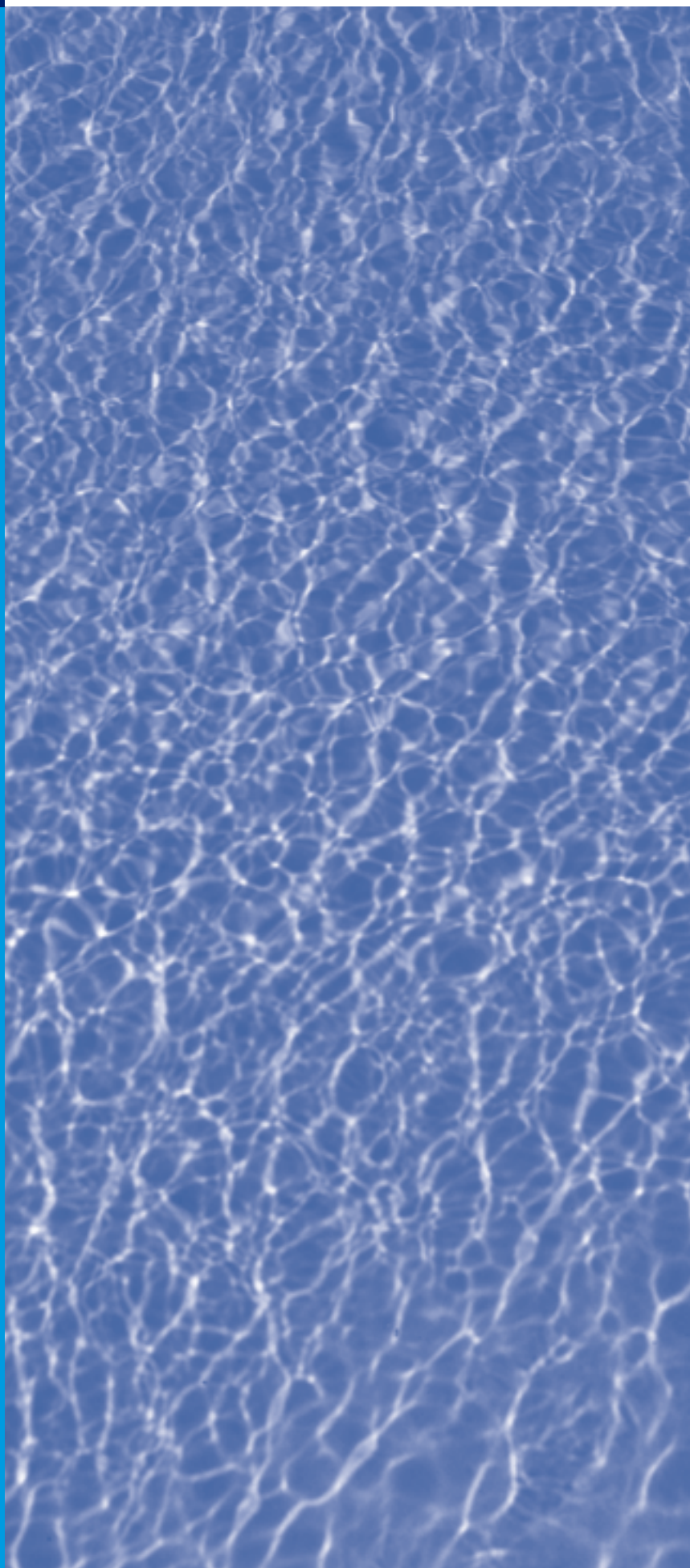
300 kg capacity – Contact Manual Handling Advisor for details
Tel 2235
Bleep 2066

Wheelchairs x 3
Porters 47 st capacity
OPD 35 st capacity
Physio 35 st capacity

working well initiative

Manual Handling Assessments in Hospitals and the Community

An RCN Guide



Royal College of Nursing


Royal College
of Nursing

Manual handling assessments in hospitals and the community

An RCN guide

Regulations require both hospital and community trusts to carry out manual handling assessments. But when you work in a large organisation, dealing with a variety of situations, where do you start? How do you avoid assessments becoming a useless paper exercise? How much should be done in writing and what forms should be used?

This Royal College of Nursing guide aims to give practical advice on these topics. It is aimed at all those with responsibility for staff's back care. This includes everyone from senior managers to moving and handling co-ordinators, back care advisers, occupational health departments and health and safety advisers. The guide does not attempt to cover assessment of any specific manual handling situation, nor does it describe the regulations. You should consult other sources for more guidance on these aspects (see references).

Why do risk assessments?

The regulations require it

The Manual Handling Operations Regulations 1992 require risk assessments to be carried out if the employer cannot avoid the need for a manual handling action which involves a risk of injury. Once assessments are made, the employer must take appropriate steps to reduce the risk of injury to the lowest level reasonably practicable. 'Reasonably practicable' means reducing the risk until the cost of any further precautions – in time, trouble or money – would far outweigh the benefits.

It's a logical method for reducing accidents and ill-health

If you are planning to start a major training programme or are about to buy some handling equipment you will probably already have an idea of what is required. But is your picture accurate? Are your efforts really going where they are needed? Risk assessments will enable you to make your decisions on the basis of informed judgement. They will help you identify what the main risks are, and where the main needs exist in your particular organisation.

Assessments increase awareness

Both managers and staff need to be involved in obtaining risk assessments for their areas. This will make everyone more aware of situations where extra vigilance is required. The exercise will also highlight the individual's responsibility to do everything within their power to make their workplace safer. In many hospitals the introduction of risk assessments has improved knowledge and awareness of safety issues and prompted a tightening-up of handling policies among staff.

For use when something goes wrong

In cases of accident or criticism from inspectors, written assessments will demonstrate that a safe system of work is in operation. If the system is not yet perfect, well-kept records will show that you do have plans and have budgeted for improvements. If an accident has happened, it may mean that your assessment was faulty and should be revised, but at least it will help to show that you acted according to your best judgement at the time.

What is a risk assessment?

Firstly, assessing risk means being aware of the problem areas. It then helps determine how concerned you need to be about the problem. For instance, does it place many staff at risk? Is the problem met frequently or rarely? Is it likely to cause a major injury, or could it be one of the many tasks where each time it is carried out it contributes to cumulative strain? But a risk assessment is useless unless it leads to action on reducing risks. This could be an immediate decision to change a simple work practice, or it could be the basis for budgeting over several years to purchase a large number of handling aids.

Policies and procedures

If you have written policies and procedures which explain how a task is to be done safely, this may remove the need for a written assessment of each individual task. A separate assessment would only be needed if the procedure did not control the risk sufficiently. If that is the case you need to justify the present system and make a note of plans for the future.

Should risk assessments be done by numbers?

Some risk assessments are carried out using numerical techniques, where various risk factors are given scores which are then multiplied to produce an overall risk score. Risks can then be ranked to determine priorities. The system seems objective and some argue it is justifiable to ignore any risks under a certain score. But the technique has major limitations.

Part of the problem with a formula is that it is inflexible and only takes accounts of specific risk factors. But an experienced assessor can use judgement to look at the picture as a whole, taking a wide range of factors into account. For this reason numerical assessments are not recommended.

How much should be written down?

The guidance to the regulations states that

> *'in general, the significant findings of the assessment should be recorded and the record kept, readily accessible, as long as it remains relevant.'*

However, the assessment need not be recorded if:

> *'it could very easily be repeated and explained at any time because it is simple and obvious.'*

or

> *'the manual handling operations are quite straightforward, of low risk, are going to last only a very short time, and the time taken to record them would be disproportionate.'*

Staff should record relevant information in care plans but it is also important for senior management to record their plans, if only through the minutes of meetings or copies of correspondence. This should meet the requirements of the regulations as well as provide useful evidence in the event of a civil court case. Patient care plans should be used to provide information and instructions on patient handling but they should also be supported by written policies or procedures where appropriate. For instance a handling policy or procedure might determine in which cases hoists or lateral transfer aids must be used.

Do bear in mind that written records are useless if they do not reflect reality. And a written procedure or instructions in a patient care-plan are valueless unless they are enforced.

There are three levels of assessments. These are:

❖ Patient-based level

There is nothing new in doing an assessment, at least mentally, at patient level. This should be further developed so that the patient care-plan contains clear information on the patient's movement abilities and needs. The design of the care plan may need to be changed or, if more space is needed, an extra page may be added. The plan should include instructions on handling aids, techniques and the number of nurses to be used for various moves. In the community, this is the main assessment and should include an evaluation of the environment and of the handling aids required.

In hospital these assessments can be trimmed down to be more relevant to particular types of wards. This enables nurses to tick or circle some items, for instance the type of handling aids used for various tasks. If a ward nearly always uses the same method for particular tasks, for instance, if nearly all patients are placed in the bath with a bathing hoist, then wards could record this in a general procedure. This removes the need to write it in each care plan.

❖ Department or ward level

This is an assessment of the general situation usually found in the ward or department. It cannot easily be done in the community, because every patient's home is different. An assessment at ward level only needs to be done occasionally. It can be reviewed annually, and amended whenever there are changes in the ward. This assessment should include a whole range of information from space in bathrooms and availability of handling aids to training of staff. An example of a form for such an assessment is included in this guide. Other areas, such as theatres or clinics, should also carry out departmental assessments.

❖ Top level

Whenever senior management considers the requirements of the organisation as a whole, this is implicitly based on some kind of risk assessment. Decisions on training, uniforms, budgets for works or new handling aids, should all be based on a proper evaluation of risks. Much of the necessary information will be provided by departmental assessments (or for the community, a survey will need to be done to evaluate general needs). Management may not need to record risk assessment, but it is advisable to have a written plan for reducing risk, with justifications.

Introducing a risk assessment policy

There are many ways of carrying out risk assessment and every organisation needs to devise its own system according to its personnel resources and management structure. The main stages in the process are:

❖ Appoint an assessment co-ordinator

Senior management should be familiar with the main issues surrounding assessments but a specific person should be appointed to co-ordinate the introduction of assessments. A back care adviser or similar is an ideal person for the job.

Otherwise consider someone with an occupational health or health and safety remit. It may be necessary to second someone with an interest in the subject – a nurse, physiotherapist or occupational therapist. The task of co-ordinating assessments may require several months of full-time work. The co-ordinator should have received training in handling assessments.

Choose the assessors

In the case of the community this will be the community sisters/charge nurses. In hospitals two different approaches have both worked well, though each has advantages and disadvantages. The first method is to have ward managers do the assessment for their own areas (after some training). The second method is to put together a small team of assessors who will then go round the wards carrying out assessments with the ward managers. This team could be made up of nurses, physiotherapists, occupational therapists and works officers, all allocated time for their own training needs and for carrying out assessments.

If ward managers do their own assessments:

This encourages them to take more responsibility for the practices in their area and to take time to involve their staff in the assessment process. Letting people 'own' the process means more follow-up and better implementation. Training is crucial as unless awareness among ward managers is high, they may not appreciate all the risks and may miss possible improvements. They may also see the task as a burden that they do not feel competent enough to do.

If there is a small assessment team:

The advantage is that ward managers receive a lot of support from a well-informed team, who may prompt them to think about risks in a new way. The drawback is the possibility that ward staff do not feel sufficiently involved and do not take ownership of the process. This method also requires considerable time to be allocated to members of the assessment team.

Planning and preparation

The nursing director or the assessment co-ordinator should already have a rough idea of where the main problems are. It is useful, before embarking on the risk assessment exercise, to put together an outline plan of action and likely costs for issues such as staff training, handling methods, handling aids and uniforms. Otherwise an opportunity is wasted to put important policy messages across during training, for example when handling aids should be used or which manual handling techniques are condemned.

Another reason for having a rough plan is that it helps convince assessors and ward managers that senior management are committed to putting resources into improvements.

It is also important to consult any accident or sickness statistics available for your organisation. This is usually not the time to start trying to compile new statistics as it could seriously delay the risk assessments process. Leave that for later to help you monitor the effectiveness of new measures. At this stage, the finance and works managers should be warned of likely outcomes of the risk assessments.

Assessment co-ordinators should produce an assessment method and form and these should be tested out in a few areas before being printed, as a badly designed form may waste a lot of time.

Remember:

- Avoid confusing wording or layout
- Don't forget the overall view. An individual lift may seem quite safe, but it may be one of many frequently repeated tasks which cause cumulative strain
- The form must encourage people to think for themselves. Numerical risk assessments tend to hinder this as does asking people to decide at every single step whether a risk is high, medium or low
- Don't overload people with questions that are irrelevant for their particular area
- The form must include a section for the measures required to reduce the risk.
- Assess "TILE" (task, individual, load and environment)

Training assessors

If ward managers are doing their own assessments, or if you work in the community, the assessment co-ordinator will need to set up a training programme. If assessors already have good awareness of handling issues, for example if they already have had practical moving and handling training, then a two-hour training session may be sufficient. This could be a large general lecture, but small groups are preferable so that assessors can ask questions. Assessors should be offered support from the co-ordinator if they need it.

Where there is a small team of assessors that will visit wards, the assessment co-ordinator should offer thorough training plus practical experience followed by feedback. This could take several days. The team will be seen as a group of experts, so their training should be thorough enough to enable them to deal with the full range of situations they may encounter. It is important that when the team arrives on award, the ward manager understands what the visit is about and is motivated to seek improvements. For this reason, some training or information for ward managers will also be necessary before assessments begin.

Issues training should cover:

- Risk factors and assessing risk
- Manual handling regulations

- Current local policies
- Practical ways to reduce risk
- How to fill in the assessment form
- Need to involve local staff
- Where to get further help
- A demonstration of handling aids.

Carrying out ward assessments

In a hospital setting

Assessors should carry out assessments in the wards. Local staff, including physiotherapists and occupational therapists and any union safety representatives, should be involved in the assessment. Consultation will help ensure that all the risks are covered, that the best solutions are devised, and that staff have the motivation to follow better practices. There may be a need to consult a works officer, for instance if changes are needed in bathrooms. If the assessor identifies a need for a hoist, a trial should be organised. Ward managers should implement any measures which are within their authority and inform their senior manager of any other needs. Although this should be done in writing, it is also important at this stage to have a feedback session attended by ward managers, their senior manager and the assessment co-ordinator. This is the time for senior managers to discuss any needs identified by the ward managers, to solve some of the more straightforward problems, and for the co-ordinator to advise and to check that assessments were properly carried out.

Once ward managers have implemented what they can, it is up to those at the next level above them, for instance, clinical nurse managers, to take any further action and to advise the nursing director of anything which they cannot implement. At this stage the issue of how changes will be financed may rear its head so the manager must have a clear understanding of risks and priorities. The assessment co-ordinator should assist in gauging these.

Once the nursing director is advised of needs and costs, a plan of action must be drawn up, or the initial plan revised. The general manager and the finance manager should be brought in now. Ward managers should receive feedback on the plans and the progress of the requests they put in.

In a community setting

The sister carrying out the assessment should have received training. Management can minimise the amount of local assessment required by producing generic assessments wherever possible. A generic assessment also serves as a guide for a sister assessing a particular manoeuvre in a patient's home.

Possible areas for generic assessments include:

- bed to chair/commode/toilet transfers
- patients who have a history of falls
- bathing
- floor coverings (hoists on carpets/slippery bathroom floors)
- difficulties in using hoists. carpets, lack of space
- in/out of car
- babies in high-sided cots
- Handling supplies (packages/boxes) at a health centre.

Monitoring and reviewing progress

Ward based assessments should be reviewed about once a year or when there are changes to the working environments such as new equipment or building works, in consultation with staff. It may be possible to update forms without having to re-write them. Once again there should be a meeting with the senior manager and with the assessment co-ordinator to discuss progress, results and any new needs. The nursing director should assess the effectiveness of the previous year's action and amend plans, policies and budgets accordingly.

Monitoring can be done by analysing statistics, by watching people work in a sample of wards or patients' homes, or by examining a sample of patient care-plans. The co-ordinator can judge any improvement in awareness through discussions with staff and managers, and they may also learn a lot about what actually happens in practice from physiotherapists or occupational therapists. Some hospitals have 'link nurses' or 'resource persons' in each directorate who promote good handling practices locally. Regular feedback from them is also a good way of monitoring.

An example of a generic assessment in the community

Task

Caring for patients in low (divan) beds and on double beds

Including:

- clinical procedures carried out on a patient in bed
- turning in bed
- moving up or down the bed
- sitting patient to lying and vice-versa
- bed-bathing
- getting patient in/out of bed.

Main risks

- prolonged stooped postures when attending to patient
- awkward posture when moving patient in bed
- awkward posture when attending to a patient in a double bed.

At risk: nurses, carers, family, physiotherapists, chiropodist etc.

Control measures

The level of risk depends on the patient and the environment and should be assessed locally. For medium to high risks, all or some of the following measures should be used:

- place knee(s) on bed or floor to reduce stooping when attending to a patient
- provide adjustable single hospital bed
- provide a hoist or sliding board for transfers to/from bed
- provide a fabric sliding aid or a hoist for moves up/down in bed
- provide a fabric sliding aid for turning in bed
- provide a one-way sliding aid to stop patients sliding down in bed
- temporarily keep the patient in bed until equipment is available
- provide extra staff
- provide low stool for carers and staff.

Assessments are likely to result in recommendations to move or furniture or introduce handling equipment. This will need to be discussed with patients and their family. If any resistance is encountered, nurse managers should assist in negotiations for a safe system at work. Otherwise management may have to consider withdrawal of service.

Checklist for assessing risks

The load

- ☑ Heavy, bulky or unwieldy?
- ☑ Asymmetrical?
- ☑ Unstable or could move suddenly?
- ☑ Texture/temperature/sharp corners?
- ☑ Difficult to grasp?

Posture and movement

- ☑ Holding loads away from the body?
- ☑ Twisting and/or stooping?
- ☑ Reaching upwards?
- ☑ Large vertical movement (e.g. floor to overhead)?
- ☑ Long carrying, pushing, pulling distances?
- ☑ Awkward posture, hand/limb position, grip?
- ☑ Fatiguing, strenuous?
- ☑ Restrictions on posture from clothing/uniform?

Duration, frequency and job design

- ☑ How long, how often?
- ☑ Fixed, static work?
- ☑ Repetitive? Forced pace?
- ☑ Sufficient rest or recovery time?
- ☑ Are there other tasks the worker does which may load him/her further?
- ☑ Is the task always done by the same worker/is there job rotation?

The working environment

- ☑ Enough room to move freely in a good posture?
- ☑ Provision for alternative working positions/seats?
- ☑ Machinery/workbench at a convenient height?
- ☑ Is the floor slippery/uneven/littered?
- ☑ Lighting adequate?
- ☑ Too hot, too cold, draughty?

The worker

- ☑ Is unusual strength or height required?
- ☑ Any danger to those with a health problem? To those who regularly get back pain?
- ☑ Any danger to pregnant women?
- ☑ Any reports of pain/problems with this task? Is sickness absence high?
- ☑ Is training required?
- ☑ Worker's attitude to safe handling/working with others?
- ☑ Does worker suffer from stress/poor job satisfaction?

The organisation

- ☑ Are procedures enforced/followed?
- ☑ Suitable handling equipment provided/maintained?
- ☑ Involvement of management?
- ☑ Is there appropriate communication with other departments whose action may affect the load on the worker?

You need not try to reply to every question in the checklist just note areas of concern. Consider not only heavy manual handling tasks but also tasks which may strain the body in other ways (e.g. causing small but cumulative damage). Identify any high risks as they will require your attention first.

Checklist for controlling the risk

The load

- ☑ Can mechanical equipment take some of the strain (eg. hoists, trolleys)?
- ☑ Can the weight be reduced (e.g. by negotiating for smaller containers)?
- ☑ Could handles, wheels or castors help to reduce the load?
- ☑ Can the task be automated or mechanised?
- ☑ Can the load be team-handled instead of by one person?

Posture and movement

- ☑ Could equipment be better designed for easier use?
- ☑ Could adjustable equipment and furniture reduce awkward movements or posture?
- ☑ Can loads be carried for shorter distances? (This may mean changing the workplace layout)
- ☑ Can heavy items be stored at convenient heights – not too high or too low?

Duration, frequency and job design

- ☑ Can rest breaks or less tiring spells of work be introduced around the task?
- ☑ Can the job be re-designed to minimise fixed postures? To provide more variety?
- ☑ Can the task be shared/rotated between staff

The working environment

- ☑ Could ramps be installed so that trolleys, hoists, wheelchairs etc. can be easily moved?
- ☑ Can heights or work surfaces be harmonised to reduce lifting from one to the other?

The worker

- ☑ Can worker's technique/movement be improved?
- ☑ Can training be given to change workers' attitude/perception of risk?
- ☑ Should the workers who are prone to back ache etc. be prevented from doing this task?

The organisation

- ☑ Should there be written procedures?
- ☑ Is there a need for more management reinforcement/supervision?
- ☑ Is there a need for consultation with other departments (e.g. supplies dept)?
- ☑ Can consultation with management/maintenance/designers facilitate changes?
- ☑ Can there be more consultation with workers on measures to reduce risk?

To assess whether your control measures are sufficient, use the legal concept of reducing risk 'to the lowest level reasonably practicable'. This means reducing the risk until the cost of any further precautions (in time money or trouble) would be out of all proportion to the risk.

Ensure that whenever possible, risks are combated at source. Try to adapt work to the individual, especially the workplace design, the choice of equipment and when selecting working methods.

For each of the main risks you have identified, make a note of control measures presently in place and any you will consider introducing in the future. Decide which possible new measures would be effective and 'reasonably practicable'.

Decide on priorities, then write an action plan with target and review dates. Once new measures are in place, revise your risk assessment to see if risks are now sufficiently controlled.

The risk assessment form

If some questions cannot easily be answered by a yes or no, note your comments, if necessary attaching an extra page to the form. You should record suggested measures to further reduce risk. This should include any measures which go beyond your budget or authority so that a decision can be taken at a higher level. You may decide, while filling in the form, that you need to change some of your work practices. To be successful this may need a step-by-step approach, including trials and consultation. To allow time for this, make a note of your plan of action and update the form when practices have changed.

Some example risk assessment forms are included here for guidance:

Example risk assessment forms

Task or group of tasks/activity/hazard

Main risks/areas of concern + level of risk + persons at risk (see checklist)

Existing control measures (see checklist)

Further control measures to be considered

Department/location .....

Approved by .....

(name of senior manager)

Date						
Signature						

(user a new box each time form is reviewed)

Administration details

Ward: or clinic, area, surgery, etc

Hospital: or health centre

Assessment Team

Ward manager (name) (signature)

Others

For example:
- ✓ Moving and handling coordinator
- ✓ Health and safety adviser
- ✓ Other nursing staff
- ✓ Safety representatives

Ward details

Speciality:

Typical age range of patient:

Typical number of patients:
on a typical shift

Male ☐

Female ☐

Mixed ☐

Handling aids

List handling aids used or available in your ward, whether your own or regularly borrowed

Name of handling aid	How many	Is it based in your ward?	If not, where is it borrowed from?	In good working condition, any attachments in place?	Suitable? (if not, why?)

Examples of handling aids:
- ✓ Monkey pole
- ✓ Patient hand blocks
- ✓ Rigid sliding aids/boards
- ✓ Sheet/cushion sliding aids
- ✓ Rope ladder
- ✓ Turning disk
- ✓ Transfer belt
- ✓ Blue sling
- ✓ Hoist (sling lifter)
- ✓ Hoist (stand aid)
- ✓ Hoist (bath seat)

If you use a hoist: has it had a safety check and maintenance in the last 12 months?

Yes ☐ No ☐

If other handling aids could further reduce risk, or if there is a need for maintenance, give details:

Bathing

What type of bath or shower are in the ward	How many	Suitable? (if not, why)

For example:
- ✓ Ordinary bath
- ✓ Parker bath
- ✓ Variable height bath
- ✓ Ordinary shower
- ✓ Shower cabinet
- ✓ Shower trolley

System of work: List methods used for patients of various degrees of dependency. Which methods are most most frequently used; which used only occasionally?

- ✓ If patients are LIFTED into the bath, seek a safer alternative

Are there any manual handling problems with assisting patients in or out of the bath or shower?

For example:
- ✓ Enough room to move freely in a good posture?
- ✓ Enough room to use a hoist?
- ✓ Stooping, twisting?
- ✓ Lifting?
- ✓ Convenient grab rails etc?
- ✓ Floor slippery?
- ✓ Type of patient?

Additional measures to consider to reduce risk

For example:
- ✓ Use a hoist, shower trolley, bathing stretcher
- ✓ Wheel patients into the shower
- ✓ Cut out casing around bath to improve hoist access
- ✓ Install or move grab rails
- ✓ Take most dependent patients to other ward with better bathroom
- ✓ Re-schedule bathing to spread out the workload
- ✓ Install a different type of bath
- ✓ Move bath away from wall
- ✓ Remove partition walls
- ✓ Change floor covering

From the above possible measures, list all requirements in the summary form at end

Toiletting

System of work: List methods used for patients of various degrees of dependency. Which methods are most most frequently used; which are used only occasionally?

✓ If a patient's whole weight is being lifted, seek a safer alternative

Are there any manual handing problems with assisting patients?

For example:

- ✓ Enough room to move freely in good posture?
- ✓ Enough room to use a hoist?
- ✓ Stooping, twisting?
- ✓ Lifting?
- ✓ Convenient grab rails etc?
- ✓ Commodes adequate?
- ✓ Floor slippery?
- ✓ Type of patient

Additional measures to consider to reduce risk

For example:

- ✓ Use a hoist (standing hoist, sling lifter)
- ✓ Wheel commode over WC
- ✓ Move WC or partition wall for more space
- ✓ Widen doorway
- ✓ Install or move grab rails
- ✓ Get door to open outwards
- ✓ Change floor covering

From the above possible measures, list all requirements in the summary form at end

Seats, wheelchairs and commodes

System of work: List methods used for patients of various degrees of dependency. Which methods are most most frequently used; which are used only occasionally?

✓ If a patient's whole weight is being lifted, seek a safer alternative

Sit to stand/stand to sit – repositioning in seat – etc

Are there any manual handing problems with assisting patients?

For example:

- ✓ Seats too low/too deep
- ✓ Arms get in the way
- ✓ Hoist cannot get close
- ✓ Brakes or wheels defective
- ✓ Not enough wheelchairs
- ✓ Floor slippery?
- ✓ Type of patient

Additional measures to consider to reduce risk

For example:

- ✓ Use a hoist (standing hoist, sling lifter)
- ✓ Use a sliding board
- ✓ Use a turning disk
- ✓ Sit patient on one-way sliding aid
- ✓ Sit or kneel by patient rather than stoop
- ✓ Change type of seats used
- ✓ Get door to open outwards
- ✓ Label defective items for maintenance

From the above possible measures, list all requirements in the summary form at end

Bed and trolley moves

System of work: List methods used for patients of various degrees of dependency. Which methods are most most frequently used; which are used only occasionally?

✓ If a patient's whole weight is being lifted, seek a safer alternative

Moving up/down the bed – Move on/off bed pan – Transfer bed to seat – Transfer bed to trolley

Are there any manual handing problems with assisting patients?

Moving up/down the bed – Move on/off bed pan – Transfer bed to seat – Transfer bed to trolley – Attending to patients on beds, trolleys or examination couches – Bed bathing

For example:

- ✓ Enough room to move freely in good posture?
- ✓ Enough room to use a hoist?
- ✓ Furniture around bed easy to move?
- ✓ Stooping, twisting?
- ✓ Lifting?
- ✓ Mechanism for height adjustment of cotside /headrest adequate
- ✓ Brakes and wheels in good working order?

Additional measures to consider to reduce risk

For example:

- ✓ Get height adjustable beds/couches
- ✓ Put only the most independent patients in fixed height beds
- ✓ Use a Spenco mattress
- ✓ Label defective items for maintenance
- ✓ Use handling aids
- ✓ Hoist
- ✓ Sliding/transfer aid
- ✓ Monkey pole
- ✓ Rope ladder
- ✓ Patient hand blocks

From the above possible measures, list all requirements in the summary form at end

Transfer from floor level

Are falls to the floor frequent? Are patients frequently at floor level? List methods used and precautions taken to reduce risk associated with the falling patient and the fallen patient

For example:

- ✓ Limit chances of patient falling
- ✓ Check that nurses know technique for dealing with falling patient
- ✓ Use a hoist for fallen patient

Other areas of concern

Describe other problem areas, handling patients or objects (you need not include handling tasks which are unlikely to create a significant risk of injury).	
Describe any problem areas	Describe present system of work, or additional measures to consider for the future

For example:

- ✓ Uniform/footwear adequate?
- ✓ Remaining in awkward postures
- ✓ Supporting patients' limbs
- ✓ Handling laundry
- ✓ Handling food containers
- ✓ Heavy/awkward objects placed too high, too low, too far
- ✓ Carrying equipment
- ✓ Difficulties with other departments/services
- ✓ Fitness/skill/number of staff

Management checklist

The following are reminders to managers of systems that should be in place.

Training

The RCN has produced *Safer staff, better care: RCN manual handling training guidance and competencies*, publication code 001 975. You can obtain a copy by calling RCN Direct on 0845 772 6100 and quoting the publication code, or by downloading a copy from the RCN website at www.rcn.org.uk

☐ Yes ☐ No Comments:

Reporting accidents or pain

- An incident/accident report form is completed when a member of staff reports an onset of pain in the back or limbs or has an accident
- After an incident form is completed, Occupational Health is notified by phone at the earliest opportunity (daytime hours)
- Staff are advised to consult the Occupational Health Unit if they have a problem with their back or limbs

☐ Yes ☐ No Comments:

☐ Yes ☐ No Comments:

☐ Yes ☐ No Comments:

☐ Yes ☐ No Comments:

☐ Yes ☐ No Comments:

Safe system of work

- An initial assessment of each patient's mobility/handling requirements is made during their admission procedure, and updated whenever changes are needed
- Handling methods, staff numbers and equipment to be used are specified in the patient care plan
- Nurses in charge have been made aware of their duty to ensure, so far as is reasonably practicable, that methods specified in the patient care plan are used, recommended moving and handling practices are used, defective equipment is put out of action

☐ Yes ☐ No Comments:

☐ Yes ☐ No Comments:

☐ Yes ☐ No Comments:

Action for the Ward Manager

- By the time you have completed this form, you should have initiated some risk-reducing measures which are within your authority.
- Some measures will go beyond your budget or authority. List and justify these using the summary sheet following this form. Copy this to your senior manager. It is important to justify any requests as decisions must be made on the basis of risk or benefit versus cost.
- You should review and update this form at least once a year, or whenever there is a change to record.
- Keep this form in the ward as a written record of your manual handling risk assessment.

Summary of needs and action plan

The following changes will be introduced in the ward's work practices (with target dates).
The following equipment, work etc is needed.

Remember to justify any needs on the basis of risk levels, cost, and benefits that would be gained. For example:

- ✓ Why is the change needed?
- ✓ How would it improve the present situation?
- ✓ How many staff/patients would it help?
- ✓ How frequently would it be used?
- ✓ Would it bring other benefits (eg independence to patients, quality of care)?
- ✓ Have you consulted anyone on the technical feasibility? Had a trial?
- ✓ Have you already intended or written to request this?

Continue on additional pages if necessary

Patient care plan in the community: moving and handling section

Patient's name

District nurse

Body build Obese ☐ Above average ☐ Average ☐ Below average ☐ Tall ☐ Medium ☐ Short ☐

Weight (if known)

Risk of falls High ☐ Low ☐

Problems with comprehension, behaviour, cooperation (identify)

Handling constraints, eg disability, weakness, pain, skin lesions, infusions (identify)

Tasks (see examples)	**Methods to be used** (see examples)	**Describe any remaining problems, list any other measures needed** (see examples)

Date(s) assessed:				
Assessor's signature				
Proposed review dates:				
				Finishing date:

Examples of tasks:
- ✓ sitting/standing
- ✓ toiletting
- ✓ bathing
- ✓ transfer to/from bed
- ✓ movement in bed
- ✓ sustained postures
- ✓ walking
- ✓ in/out of car

Examples of methods/ control measures

Organisation
- ✓ Number of staff needed?
- ✓ Patient stays in bed

Equipment
- ✓ Variable height bed
- ✓ Hoists
- ✓ Slings/belt
- ✓ Bath aids
- ✓ Wheeled sani-chair
- ✓ Monkey poles
- ✓ Patient hand blocks
- ✓ Rope ladders
- ✓ Turntable
- ✓ Sliding aids
- ✓ Stair lift

Furniture
- ✓ Reposition/remove

Examples of problems/ risk factors

Task
- ✓ Is it necessary? Can it be avoided?
- ✓ Involves stretching, stooping, twisting, sustained load?
- ✓ Rest/recovery time?

Patient
- ✓ Weight, disability, ailments, etc.

Environment
- ✓ Space to manoeuvre, to use hoist
- ✓ Access to bed, bath, WC, passageways?
- ✓ Steps, stairs?
- ✓ Flooring uneven? OK for hoist?
- ✓ Furniture: moveable? height? condition?
- ✓ Bed: double? low?

Carers
- ✓ Fitness for the task, freshness or fatigue?
- ✓ Experience with patient and with handling team?
- ✓ Skill: handling, using equipment?

Furniture
- ✓ Reposition/remove

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References

R Birkbaum, A Cockcroft B Richardson N Corlett (1991) *Safer Handling of Loads at Work – A Practical Ergonomic Guide* Institute for Occupational Ergonomics, University of Nottingham

Health and Safety Executive *Getting to Grips with Manual Handling – A short guide for Employers.* IND(G) 143L, HMSO

Health and Safety Executive (1992) *Manual Handling, Guidance on Regulations* HMSO

Health Service Advisory Committee (1992) *Guidance on Manual Handling of Loads in the Health Service* Health and Safety Commission, HMSO

Health Services Advisory Committee (1993) *Getting to grips with Manual Handling Problems* Health and Safety Commission, HMSO

National Back Pain in collaboration with the Royal College of Nursing (1998) *The Guide to the Handling Patients.* Fourth Edition available from Backcare (formerly the National Back Pain Association), 16 Elmtree Road, Teddington, Middlesex TW11 8ST, tel: 020 8977 5474

Royal College of Nursing (2002) *Introducing a Safer Patient Handling Policy* RCN London. Publication code 000 603

Royal College of Nursing (2002) *RCN Code of Practice for Patient Handling* RCN London. Publication code 000 604

Royal College of Nursing (2001) *Changing practice, improving health: an integrated back injury prevention programme for nursing and care homes.* RCN London. Publication code 001 255

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