

ALL WALES  
NHS MANUAL  
HANDLING  
TRAINING  
PASSPORT &  
INFORMATION  
SCHEME



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# **1 INTRODUCTION TO THE ALL WALES NHS MANUAL HANDLING TRAINING PASSPORT AND INFORMATION SCHEME**

## **1.1 What is the Passport Scheme?**

The overall aim of the All Wales NHS Manual Handling Training and Passport Information Scheme is to ensure consistency of manual handling training within NHS Trusts in Wales, thus allowing staff to transfer their skills when moving from Trust to Trust and assisting to ensure that skills and knowledge are consistent across the NHS in Wales. This has been developed by the All Wales NHS Manual Handling Steering Group and has become known as the "Passport Scheme".

Other healthcare providers, such as Local Authorities and the private and voluntary sectors are encouraged to participate in the Passport Scheme to extend the consistency of manual handling skills and knowledge across Wales.

## **1.2 Why is it necessary?**

1.2.1 The Manual Handling Operations Regulations 1992 came into force on the 1st January 1993. However, when the group was formed the vast majority of NHS Trusts in Wales still appeared to be struggling to meet their duty for the provision of training.

1.2.2 In 1999 there was a major re-configuration of the then "Trusts" in Wales. At this time it was necessary to review existing manual handling training programmes. The main difficulties were that:-

- Existing training programmes varied in duration and content.
- Each Trust used different assessment tools, it was therefore, difficult to transfer patient information. In some cases different departments within the same Trust used various documentation.

1.2.3 If staff leave one organisation and move to another within Wales it would be beneficial to allow them to transfer their training skills, minimising duplication and time lost to the service.

## **1.3 What are the aims and objectives of the Passport Scheme?**

The aims and objectives of the Passport Scheme are:-

- To ensure consistency in manual handling training/assessment within participating organisations
- To develop a mechanism whereby skills can be transferred between participating organisations.
- To minimise duplication within participating organisations

## 1.4 Who will monitor the Passport Scheme?

- 1.4.1 The All Wales NHS Manual Handling Steering Group will continue to meet after the implementation of the Passport Scheme to ensure its integrity.
- 1.4.2 The Passport Scheme content will be constantly reviewed to ensure that it remains in line with legislation and best practice by the All Wales NHS Manual Handling Steering Group. Version 2.1 was agreed by the All Wales Steering Group on the 01/09/2009
- 1.4.3 Material/information will be added as and when required by legislation and best practice.
- 1.4.4 It is important that managers in the workplace monitor practice in accordance with the Passport Scheme by:-
  - ensuring staff are trained, assessed and / or updated regularly
  - keeping training records
  - assessing whether staff are following safer manual handling procedures
  - ensuring risk assessments are in place and are implemented

## 1.5 What is the legal position?

- 1.5.1 The ultimate responsibility for the health and safety of staff rests with the employer. This position is re-enforced in both criminal and civil law.
- 1.5.2 The participation in the Passport Scheme, does however, signify the employer's commitment to educate their staff to a consistent standard.
- 1.5.3 Participation in the Passport Scheme sets a **MINIMUM** standard against which organisations can be measured. This has been welcomed by the Health and Safety Executive and Trust legal advisors and is deemed as best practice.

Note: The material contained within this pack was up-to-date at the time of going to publication

## 1.6 Can other organisations use the pack?

Whilst the Passport Scheme was developed with the NHS in Wales in mind it represents current best practice and could equally be applicable in other organisations such as Local Authorities and the private and voluntary sectors.

## 1.7 What does this pack contain?

The pack contains 3 main standards.

### 1.7.1 **Standard 1: Manual Handling Management of Training**

It is important that employers recognise the need for training standards in manual handling. There is a requirement to ensure that those advising and training others in safer manual handling practice have the appropriate skills and knowledge.

This section outlines the skills required to perform the roles of Manual Handling Advisor (see Figure 2, page 14), Trainer and Trainer Assistants (see Figures 2a, 2b and 2c, pages 14 & 15). Participating organisations should consider the current level of expertise of those providing advice and training and their subsequent professional development needs.

This section also outlines the standards for provision of adequate training.

### **1.7.2 Standard 2: Manual Handling Foundation Training Curriculum**

This section outlines the aims and objectives of the Passport Scheme's foundation training programme.

The training programme is broken down into modules to allow for flexibility in its delivery. The modules provided should meet the training needs of the individual.

### **1.7.3 Standard 3: Manual Handling Documentation**

It is recommended that organisations use the documentation as suggested in Standard 3 of the Passport Scheme. However it is acknowledged that organisations may wish to adjust parts of the documentation to suit local needs.

## **2 Standard 1: Manual Handling Management of Training**

### **2.1 Introduction**

2.1.1 Organisations recognise the need for standards in manual handling training and the provision of advice. There is a legal requirement to ensure that employees are competent to perform their tasks, Management of Health and Safety at Work Regulations, 1999. Participation in the Passport Scheme is a path to ensuring that organisations meet training and advisory provision as set out in the standards detailed below and the manual handling training modules detailed in this package.

2.1.2 The standards offer the opportunity for current arrangements to be reviewed and practice benchmarked. Organisations must have a Manual Handling Policy, which endorses and supports the principles and minimum standards of the Passport Scheme.

2.1.3 To ensure compliance with the standards, organisations will need a robust education programme for staff. Those involved in the provision of training

and advice must have adequate time to perform their duties, protected time to provide training and adequate recognition and support.

2.1.4 The standards detailed below have been prepared to enable those responsible for the management of manual handling within an organisation, to ensure that training is provided via an acknowledged and consistent standard. The All Wales NHS Manual Handling Steering Group have considered the standards laid down by the National Back Exchange (NBE) Training Guidelines (2002), and with a few minor amendments have incorporated them into the training standards required for full participation in the Passport Scheme. They are not meant to be retrospective.

2.1.5 When the NBE prepared the guidelines the legal requirements for training were identified, and guidance was taken from other authoritative sources, such as:

The Royal College of Nursing, The Chartered Society of Physiotherapy, The College of Occupational Therapy, any client-specific guidelines, such as those from the Royal College of Midwives, Inter-professional guidance from Essential Back Up and the Inter-professional Curriculum/Curriculum Framework for Manual Handling Advisor

## **2.2 Why are standards needed?**

To assist with compliance with the law:-

- To reduce the risks to staff and people resulting from poor practice
- To reduce the likelihood of litigation/complaints
- To implement and maintain Person Specifications for Manual Handling Advisors, Trainers and Trainer Assistants
- To promote national consistency via the Passport Scheme
- To ensure the best utilisation of time/resource

## **2.3 What are the legal and professional requirements for training?**

### **2.4 Health and Safety at Work Act 1974**

Health and Safety at Work etc Act 1974, Part 1, Section 2(2)c requires employers to provide:-

- Information
- Instruction
- Training
- Supervision



## 2.5 Management of Health and Safety at Work Regulations 1999

Management of Health and Safety at Work Regulations 1999 Regulation 13(2) and (3) requires employers to provide health and safety training:

- On recruitment
- When risks change
- To be repeated periodically as appropriate
- To take place during working hours

## 2.6 Manual Handling Operations Regulations 1992

Manual Handling Operations Regulations 1992 (as amended 2002 Third Edition 2004). Regulation 4(1)(b)(i), (ii) (iii) 4 (3) and Regulation 5. Training is implicit in its requirements. In Particular regarding determining whether manual handling operations at work involve a risk of injury, Regulation 4(3) (c) states “*in determining the Appropriate steps to reduce that risk regard shall be had in particular to: (c) his Knowledge and Training*”. Under the regulations Employees should be given information on:

- Task, individual capability, load, environment and other factors
- Recognition of risk
- Safe working systems
- Use of equipment

## 2.7 The Inter-professional Curriculum Framework

The Inter-professional Curriculum Framework for Manual Handling Advisor aims to promote best practice in load handling in health and social care organisations. It identifies the need for standards of competence for Manual Handling Advisors, including previous qualifications. These have been addressed in the National Back Exchange, Trainers Guidelines (2002).

## 2.8 Maintaining Competency

### 2.8.1 What is competency

It is the ability to undertake responsibilities and to perform activities to a recognised standard on a regular basis. Competence is a combination of practical and thinking skills, experience and knowledge (HSE briefing note 2)

### 2.8.2 How can competency be effected

The competence of staff may be affected by factors such as introduction of new equipment, a change in clinical activity environment or best practice, following and incident an absence, ill health or injury.

### 2.8.3 Assessment of Competency

Systems must be in place to maintain the competency of staff gained from previous training. Maintaining competency can take a number of forms including

formal training, (HSE 1999) In order to establish the competency level of staff, an assessment process is required. See assessment tools:-

Appendix 7a - Manual Handling Self Assessment Form (Inanimate Load Handling Staff)

Appendix 7b - Manual Handling Self Assessment Form (People Handling Staff)

Appendix 8a - Manual Handling Competency Assessment Form

#### 2.8.4 Training for Competency

The content and frequency of any refresher training or maintenance of competency must be determined by a documented training needs analysis (TNA). This analysis must consider the prior learning (both formal and informal) of the individual, the manual handling tasks they are expected to undertake on a routine basis and also the risk level of the tasks undertaken. The training needs analysis is the basis for refresher training content and should be maintained as documentary evidence as to the justification for possible exclusion/inclusion of tasks taught.

#### 2.8.5 Frequency of manual handling refresher training

'Training should be provided to ensure that employees are both competent and confident to perform their duties safely. Where there are high risk activities, such as people handling, regular competency based assessment and monitoring of activities is required, this should be documented as evidence. Update or refresher training should be provided when competency assessment identifies the need for further training. The law does not specify when refresher or update training is required HSE (2009)

The evidence suggests that manual handling training would be more effective if update refresher courses were offered to employees on a regular basis, to update and reinforce their learning as part of an overall manual handling risk assessment strategy, HSE (2007) Training and assessing for competency are continuous, not 'one-off' processes HSE (briefing note 2) The Chartered Society of Physiotherapy (2008) advise the need to comply with an organisations update training program and the College of Occupational Therapists (2006) strongly advises the need to update training on a regular basis

Where there has been a significant failure to assess and maintain competency in the work place it is strongly recommended that staff members receive annual update training.

#### 2.8.6 Examples of refresher training/assessment frequencies for groups of staff following an in depth training needs analysis: - figure 1

Figure 1			
Load Type	Risk Rating	Example	Assessment,
Patient Handling	High Risk	elderly care ward staff, Physiotherapists, OT,	Annual

		Theatres staff	
Patient Handling	Medium Risk	Endoscopy	Annual
Patient Handling	Low Risk	OPD, dieticians, Speech and Language	Annual/Biannual
Inanimate Load	High Risk	Mortuary, kitchens, porters, Estates	Annual
Inanimate Load	Medium Risk	Domestic	Biannual
Inanimate Load	Low Risk	Office staff	Biannual, e-learning (for Module A only)

The Passport scheme provides a minimum core curriculum on which to build. Attending core training or refresher training is not an indicator of competency and whilst skills and knowledge may be taught and assessed in the classroom. Workplace competency can only be fully assessed within the workplace itself.

#### 2.8.7 Method of delivery

The method of delivery of formal training at refresher stage should further knowledge and skills, and provide opportunity for the development of analytical and problem solving skills and should do more than merely repeat the basics of legislation /spine awareness etc. it should also include updating staff in significant changes in manual handling practices and relevant policies and procedures.

**The evidence suggests that manual handling training is effective only if adequately reinforced with suitable materials and ongoing support within the organisation itself HSE (2007) Hignett (2006). Organisations should therefore be encouraged to provide sufficient supervision, assess competency, and monitor workplace practices to aid the implementation of the new skills and knowledge gained.**

#### 2.8.8 Maintaining competency

Relying solely on the merits of regular formal refresher training may lead to inappropriate use of resources, i.e. re-training already competent staff or on the converse, leaving incompetent staff work within the workplace for long periods of time until they attend formal training. Hence it is important that people are supervised within their workplaces and their competency assessed by suitably trained individuals "link workers"/"ward based instructors"; who themselves need to have attended more in-depth manual handling training and have the skills to assess and provide advice and coaching in practical skills at workplace level HSE (2007) This approach to maintaining competency in the workplace should be seen as a continuous process (HSE briefing note 2) where an individual's skills are updated as and when is necessary. Poor skills in a single technique may be managed by giving advice/demonstration and practice in the workplace, direct retraining etc or where there are significant issues by referral of the individual for formal training.

Precisely how staff receive an update in the necessary skills and knowledge (and how their competency is assessed) is dependent upon the nature of the persons work, i.e. peripatetic staff with no fixed workplace may find formal refresher training delivered within a discernable training venue easier to access as opposed to receiving one to one 'coaching' or 'instruction' on an on going basis. This latter method may suit individuals working within one department/ward/team.

## 2.9 What are the pre-training requisites?

The following 6 pre-training requisites are essential for the success of the Passport Scheme:

- 2.9.1 A training needs analysis to identify the level and extent of training required.
- 2.9.2 Adequate policies and procedures to promote best practice and staff health.
- 2.9.3 Management commitment and support for the training strategy and service delivery.
- 2.9.4 Allocation of sufficient resources by management to implement, develop and deliver the service in accordance with policies and procedures.
- 2.9.5 Appropriate staff to take forward the initiative e.g. Manual Handling Advisors, Trainers and Trainer Assistants (see Figures 2, 2a, 2b and 2c). Organisations will recognise the role of a *Manual Handling Advisor* as a professional one and that individuals who are employed to perform this role must be competent. The National Back Exchange recommend the "*minimum ratio 1 advisor per 1000 employees*", (Manual Handling Standard 2004).
- 2.9.6 It is essential that consideration is given to an individual's ability to perform safer manual handling techniques. This is supported by:-
  - Adequate provision of Occupational Health support/advice.
  - Adequate advice to managers on an individual's capability to perform

manual handling techniques following periods of prolonged absence/ill health.

- The acknowledgement by employees that they must report any physical restrictions which may impact on their ability to practice safer manual handling techniques e.g. pregnancy, back problems, musculo-skeletal disorders.
- Promote employees to practice “24 hour” musculo-skeletal care

## 2.10 Personal Specifications for Manual Handling Advisors / Trainers / Trainers Assistants

### Figure 2

The Person Specification for **Manual Handling Advisor** (Strategic Level) is as follows:-

- Must have a recognised, relevant professional qualification e.g. nurse, physiotherapist, occupational therapist
- Must meet their own Professional Standards for Trainers in Manual Handling
- Must have a working understanding of professional codes of ethics involved in health/social care work
- Must have attended relevant post graduate courses in Occupational Health/ Ergonomics/Back Care Management course based on the IPC Framework etc. leading to an accredited award from a professional body or academic institution
- Should have a recognised teaching qualification/experience up to City and Guilds 730/NVQ equivalent/Cert Ed.
- Must be able to demonstrate knowledge of relevant legal influences in the field, an understanding of the ergonomic principles involved and of the risk assessment processes required
- Have a working knowledge of relevant literature, research in the field, and industry specific guidance issued
- Must have sufficient status and managerial skill to be able to influence organisational change
- Should have ability to work in a team, leadership and communication skills, ability to negotiate and act as an advocate at all levels
- Should be able to co-ordinate staff from multidisciplinary backgrounds in order to promote safer handling practices aimed at facilitating rehabilitation
- Must be experienced in working in a healthcare/social care setting
- Must promote people independence, minimal lifting, use of equipment and ergonomic changes to minimise risks to staff
- Must demonstrate a practical problem solving approach to Manual Handling issues
- Must be physically capable of demonstrating good practice
- Should demonstrate efforts to keep abreast of developments in the field, by attendance at meetings, conferences and seminars, and ideally be a member of National Back Exchange.
- Maintain a Continuing Professional Development (CPD) portfolio as evidence of up to date knowledge of *manual handling practice*

(Adapted from NBE Trainers Guidelines, 2002)

### Figure 2a

The Person Specification for a **Manual Handling Trainer in People Handling** (Foundation Level) is as follows:-

- Must have a recognized, relevant healthcare professional qualification, e.g. nurse, physiotherapist, occupational therapist.
- Must have attended a post basic course in people Manual Handling, including an element of teaching
- Must have experience in working in a healthcare/social care setting
- Should be able to demonstrate knowledge of relevant legal influences in the field, an understanding of the ergonomic principles involved, and of the risk assessment processes required
- Must demonstrate a practical problem solving approach to Manual Handling issues
- Must be physically capable of demonstrating good practice
- Must promote patient independence, minimal lifting, use of equipment and ergonomic changes to minimize risks to staff
- Should demonstrate efforts to keep abreast of developments in the field, by attendance at meetings, conferences and seminars, and ideally be a member of National Back Exchange.
- Based on individual need must attend an annual training update/study day or competency assessment within the role

(Adapted from NBE Trainers Guidelines,2002)

**Figure 2b**

The Person Specification for a **Manual Handling Trainers Assistant in People Handling** (Foundation Level) is as follows:-

- Must only train modules C-F of the Manual Handling Training Curriculum under the direct supervision of the Manual handling Trainer /Advisor
- Must have attended a post basic course in people Manual Handling, including an element of teaching
- Must have experience in working in a healthcare/social care setting
- Should be able to demonstrate knowledge of relevant legal influences in the field, an understanding of the ergonomic principles involved, and of the risk assessment processes required
- Must demonstrate a practical problem solving approach to Manual Handling issues
- Must be physically capable of demonstrating good practice
- Must promote patient independence, minimal lifting, use of equipment and ergonomic changes to minimise risks to staff
- demonstrate efforts to keep abreast of developments in the field, by attendance at meetings, conferences and seminars, and ideally be a member of National Back Exchange.
- Based on individual need must attend an annual training update/study day or competency assessment within the role.

*(Adapted from NBE Trainers Guidelines,2002)*

**Figure 2c**

The Person Specification for a **Manual Handling Trainer in Inanimate Load Handling** (Foundation Level) is as follows:-

- Must have attended a post basic course in Manual Handling, including an element of teaching
- Should be able to demonstrate knowledge of relevant legal influences in the field, an understanding of the ergonomic principles involved, and of the risk assessment processes required
- Must demonstrate a practical problem solving approach to Manual Handling issues
- Must be physically capable of demonstrating good practice
- Must promote minimal lifting, use of equipment and ergonomic changes to minimize risks to staff
- Should demonstrate efforts to keep abreast of developments in the field, by attendance at meetings, conferences and seminars, and ideally be a member of National Back Exchange
- Based on individual needs must attend an annual training update/study day or competency assessment within the role

*(Adapted from NBE Trainers Guidelines,2002)*

## 2.11 Organisation and implementation of training

2.11.1 It should start with management and must include staff at all levels.

2.11.2 It must include risk management as appropriate.

2.11.3 Manual handling risk assessors must be trained to carry out and record suitable assessments for all appropriate people/inanimate load tasks.

2.11.4 All staff must be able to recognise and report hazardous situations.

2.11.5 Training must be safe and sufficiently supervised. For theoretical training there is no limit to number of trainees other than room size and seat numbers. For practical sessions a maximum of 8 trainees per trainer is recommended.

Consideration must be given to:-

- The baseline knowledge of the Trainee(s);
- The layout of the training venue;
- The equipment available to facilitate practical training, and;
- The manoeuvres to be performed.

2.11.6 All modules of the Passport Scheme must be delivered in a discreet, suitably equipped venue.

## 2.12 Training — planning and recording

2.12.1 Training must be specific to group needs, and be job specific according to level required.

2.12.2 Module A provides underpinning knowledge and must be completed via e-learning or in classroom prior to proceeding to other modules. Module A should be completed within the first week of employment and all other modules relevant to area of practice within 4 weeks of completing Module A



2.12.3 Length of training must be sufficient to encourage and develop a change in knowledge, attitude and skills. Demonstrations alone are not sufficient, and staff must have sufficient time to practice and develop practical skills under close supervision.

2.12.4 Feedback must be provided to management on attendance and ability of delegates to participate and any ongoing training needs. A health declaration form, (appendix 5) with a feedback section for managers has been developed to support this process.

2.12.5 Full records of all training must be kept, including:

- Printed names/signatures of Trainer/Trainee
- Participants job title/place of work
- Unique ID number
- Date/place of training
- Duration of session
- Content
- Handouts
- Full/partial participation
- Refusal/inability to attend
- Equipment/aids used
- Competency Assessments

### **2.13 The importance of audit and review**

2.13.1 A system must be implemented to audit and review the implementation of safer manual handling practice in the workplace. An Audit Tool has been developed to support this process, (appendix 12).

2.13.2 Managers must realise the importance of monitoring practice in the workplace and correcting staff if they do not practice safely.

2.13.3 Accidents/incidents which result as a consequence of manual handling tasks or activities must be reviewed and appropriate action taken.

2.13.4 There must be a support network in the workplace for managers and staff to support the training that has been provided and to allow them to practice safely.

## **3 STANDARD 2: MANUAL HANDLING FOUNDATION TRAINING CURRICULUM**

### **3.1 Training**

The aim of the training is to provide the individual with manual handling skills and knowledge to reduce the risk of musculo-skeletal injuries caused by poor manual handling in the workplace and hence reduce sickness absence.

### **3.2 Passport Scheme**

Organisations participating in the Passport Scheme must ensure that their training courses meet the aims and objectives specified within each training module.

### **3.3 Modules**

The training programme is broken down into modules to allow for flexibility in its delivery. The modules cover the following topics:-

- Module A – Manual Handling Theory
- Module B – Inanimate Load Handling & Practical Application of Ergonomics
- Module C – Sitting, Standing, Walking
- Module D – Bed Mobility
- Module E – Lateral Transfers
- Module F – Hoisting

### **3.4 Assessment**

At the end of each module each Trainee will be assessed with regard to knowledge and skills

### **3.5 Evaluation**

Trainees will be asked to complete an evaluation form, which will be retained by the Trainer along with the register of persons who attended the session.

### **3.6 Record of Training**

A record of attendance (appendix 9), signed and dated by the Trainee and the Trainer will be required. An individual training record – manual handling, (appendix 4) will also be completed giving details of the key topics covered in the session. One copy to be kept by individual for acknowledgement of training completed and the other retained on accordance with organisational policy.

## MODULE A – MANUAL HANDLING THEORY

The suggested time for this session is 2.5 - 3 hours.

### Aim

To provide underpinning knowledge necessary to reduce the risk of musculo-skeletal injuries caused by poor manual handling in the workplace.

**Objectives**– by the end of the session the Trainee should be able to: -

- define the term “manual handling”
- describe the causes and effects of musculo-skeletal (MSD’s).
- state basic methods of preventing and managing musculo-skeletal disorders.
- outline the legislation that applies to manual handling at work.
- describe the importance of ergonomics and risk assessment in reducing the risk of manual handling injury.
- describe the principles of safer handling.
- identify the risks involved in team handling team handling
- describe importance of good communication in relation to manual handling
- outline the management of safer handling within the organisation e.g. policy, organisation of training and occupational health.

## MODULE B - INANIMATE LOAD HANDLING & PRACTICAL APPLICATION OF ERGONOMICS

The suggested minimum time for this session is 1.5 – 2 hours.

If independently delivered Module A should be recapped.

### Aim

To provide instruction and facilitate the application of inanimate load risk assessment, including the safer handling of inanimate loads and application of ergonomic principles, to ensure the health and safety of staff.

**Objectives**– by the end of the session the Trainee should be able to: -

- state the principles of safer handling of loads including checking the weight prior to lifting
- identify the four key areas, and other related factors such as guideline weights, to be considered when undertaking a manual handling risk assessment.
- complete a formal risk assessment for an inanimate load

- identify how the principles of safer handling can be applied to the moving of large/awkward load
- outline the importance of good posture and the application of ergonomic principles, appropriate to workplace and work activity
- safely demonstrate the following techniques: -
  - Pushing and pulling
  - Lifting and lowering load from the floor or low level
  - Correct posture whilst sitting at an office desk
  - Carrying a load
- Demonstrate basic safety checks of equipment

During the training session the Trainee will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

## MODULE C – SITTING, STANDING AND WALKING

The suggested minimum time for this session is 1 ½ to 2 hours. (N.B. this is dependent on individual need).

If independently delivered Module A should be recapped.

### Aim

To provide instruction and training for the safe moving and handling of people.

**Objectives** – at the end of the session, the Trainee should be able to

- state the principles of safer handling of people
- identify the key areas of manual handling risk assessment
- complete a formal risk assessment of a person from a given scenario
- discuss unsafe practices
- competently demonstrate the following manoeuvres, with the person moving independently, moving independently with instruction, being assisted by one carer, and two carers, including where appropriate, the use of relevant handling aids: -
  - Assisting a person forward in a chair
  - Assisting a person back in a chair
  - Sitting to standing from chair
  - Standing to sitting in chair
  - Sitting to standing from edge of bed
  - Standing to sitting on edge of bed
  - Assisted walking
  - The falling person (whether Trainers demonstrate and trainees practice this is at the discretion of the Trainer and the organisation following a detailed risk assessment)
  - Raising the fallen person - instructing the person to raise him/herself (and use of emergency lifting cushion if available)
  - Assisting the fallen person out of a confined space (whether Trainers demonstrate and Trainees practice this is at the discretion of the Trainer and the organisation)
  - Bed Assisted stand

During the training session the Trainee will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

Suggested Equipment – slide sheets, tubular sheet, handling sling, handling belt, one-way slide sheet, electric profiling bed

## MODULE D – BED MOBILITY

The suggested minimum time for this session is 2 to 3 hours. (N.B. this is dependent on individual need).

If independently delivered, the principles of safer handling of people, risk assessment of a patient etc. as detailed in Module C should be included, or recapped if previously covered.

### Aim

To provide instruction and training for the safe moving and handling of people.

**Objectives** – by the end of the session the Trainee should be able to: -

- Describe the principles of working at a bed e.g. appropriate height
- outline the principles of using flat and tubular slide sheets
- discuss unsafe practices
- correct posture whilst feeding / treating / examining a person
- competently demonstrate the following manoeuvres, with the patient moving independently, moving independently with instruction, being assisted by one carer, and two carers, including where appropriate, the use of relevant handling aids:
  - Fitting and removing tubular and / or flat slide sheets
  - Turning in bed including 180° turn
  - 30° tilt
  - Sliding the supine person up/down the bed
  - Sitting a person from lying
  - Sitting a person up and onto edge of bed
  - Assisting a person to lie down from sitting on edge of bed
  - Demonstrate safe use of electric profiling beds ( if available)

During the training session the Trainee will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

Suggested Equipment – slide sheets, tubular sheet, handling sling, turntable, bed ladder, hand blocks, leg raiser, electric profiling bed.

## MODULE E – LATERAL TRANSFERS

The suggested minimum time for this session is 1 to 2 hours. (N.B. this is dependent on individual need).

If independently delivered, the principles of safer handling of people, risk assessment of a patient etc as detailed in Module C, should be included, or recapped if previously covered.

### Aim

To provide instruction and training for the safe moving and handling of people.

**Objectives** – by the end of the session the Trainee should be able to: -

- outline methods of maintaining personal hygiene and alternative techniques for toileting and clothing management
- discuss unsafe practices
- competently demonstrate the following techniques, with the person moving independently, moving independently with instruction, being assisted by one carer, and two carers, including where appropriate, the use of relevant handling aids:
  - Lateral supine transfer from bed to trolley/trolley to bed
  - Standing transfer from bed to chair/chair to bed
  - Seated transfer from bed to chair/chair to bed
  - Transfer from chair to chair/commode/toilet

During the training session the Trainee will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

Suggested equipment: - Full-length lateral transfer board, slide sheets, straight and curved transfer board, stand aid, turntable, handling belt, stand & turn disc.

## MODULE F – HOISTING

The suggested minimum time for this session is 1 ½ to 2 ½ hours. (N.B. this is dependent on individual need).

If independently delivered, the principles of safer handling of people, risk assessment of people etc as detailed in Module C, should be included, or recapped if previously covered.

### Aim

To provide instruction and training for the safe moving and handling of people.

**Objectives** – by the end of the session the trainee should be able to: -

- describe the principles of hoist use, and the types of hoist available
- outline the type, selection and use of slings
- state the main points of Lifting Operations and Lifting Equipment Regulations (LOLER) 1998
- discuss unsafe practices
- competently demonstrate the following techniques:
  - Fitting a sling with a person in bed
  - Fitting sling in bed using slide sheets
  - Fitting a sling with a person in chair
  - Fitting sling in chair with slide sheets
  - Hoisting from chair to bed / bed to chair
  - Hoisting a person from floor
  - Use of stand-aid hoist

During the training session the Trainee will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

Suggested Equipment: Sling lifting hoist (capable of lifting from the floor), stand-aid hoist, flat and tubular slide sheets and a selection of appropriate slings.



## 4 STANDARD 3: MANUAL HANDLING DOCUMENTATION

### 4.1 Ward/Department Manual Handling Induction Checklist and Induction Record (Appendix 1)

When an employee joins a new organisation it is necessary to establish their level of manual handling skill. This will be partly achieved by considering their Record of Training. A copy of employee's manual handling training record to be made available for confirmation of training completed prior to commencement of manual handling activities.

Foundation training should ideally be undertaken prior to commencement of work or as soon as reasonably practicable. It will also be necessary to undertake an induction/orientation programme. The Induction Record and Checklist will assist with this.

An Induction Record and Checklist must be completed by the Line/Departmental Manager or their representative, for all new employees to the organisation. This information should then be used to identify the future training needs of the employee. A copy of the Induction Record and Checklist should be kept in accordance with the Organisations Policy.

### 4.2 Manual Handling Risk Assessment Forms (Appendices 2 & 3)

This section provides risk assessment forms for assessment of people, tasks and objects that require manual handling (**Appendix 2**). A copy of the People Manual Handling Assessment & Safer Handling Plan (**Appendix 3**) form should accompany the person on transfer to other wards, departments etc.

### 4.3 Individual Training Record- Manual Handling (Appendix 4)

The Individual Training Record provides a record of training content and achievements as well as information on the objectives the individual did not achieve at that particular time.

A copy of this record is given to the employee. The detailed Individual Training Record must be presented to a new employer by the employee for previous training to be acknowledged.

### 4.4 Other documents include:

- Health Questionnaire (**Appendix 5**)
- Guidance for the Completion of the Manual Handling Manual Handling Competency Assessment Form (**Appendix 6**)
- Manual Handling Self Assessment form for Inanimate load handling staff and people handling staff (**Appendix 7a & b**)

- Manual Handling Workplace/Update assessment inanimate load handling staff and people handling staff (**Appendix 8a & b**)
- Record of Attendance (**Appendix 9**)
- Work book For Foundation Manual Handling Training (**Appendix 15**)

#### **4.5 Further strategic documentation has also been developed as follows:**

- Policy Framework (**Appendix 10**)
- Train the Trainer Guidance (**Appendix 11**)
- Audit Tool (**Appendix 12**)

### **5 ADDITIONAL GUIDANCE INFORMATION LINKS**

- Treatment Handling Guidelines
- Paediatric Treatment Handling Guidelines

## 6 REFERENCES

The Chartered Society of Physiotherapy. **Guidance on Manual Handling in Physiotherapy**. 3<sup>rd</sup> ed. London: The chartered Society of Physiotherapy; 2008.

The College of Occupational Therapists (2006) **Manual Handling**. College of Occupational Therapists Guidance 3. London: COT 2006

Health and Safety at Work Act 1974. HMSO: London

Health and Safety Commission 1998. “Manual Handling in the Health Services” 2<sup>nd</sup> Edition: HSE Books: Suffolk

Health and Safety Executive 2004. **Manual Handling Operations Regulations 1992 (as amended) Guidance on Regulations**. 3<sup>rd</sup> Edition HSE 2004 L23

Health and Safety ( Miscellaneous Amendments) Regulations 2002:  
<http://www.opsi.gov.uk/si/si2002/20022174.htm>

Management of Health and Safety at Work Regulations 1999.  
[www.legislation.hmsso.gov.uk/si/si1999/19993242.htm](http://www.legislation.hmsso.gov.uk/si/si1999/19993242.htm)

National Back Exchange (NBE) 2004. **Manual Handling Standard Interim Document for Healthcare Providers**: National Back Exchange: Towcester

National Back Exchange 2002. **Trainer Guidelines**:  
[www.nationalbackexchange.org.uk](http://www.nationalbackexchange.org.uk)

Manual Handling Training, Investigation of current practice and development of guidelines. RR583 research report, Work and health Research Centre Health and Safety Executive; 2007

HSE Human Factors Briefing Note No. 2 Competence

Sustaining Staff Nurse Support for a Patient Care Ergonomics Program in Critical Care Volume 19 number 2 Audrey Nelson, June 2007

Developing and Maintaining Staff Competency. HSE (2002), ISBN 0 7176 17327

Survey to investigate NHS trusts compliance with the RCN safer patient handling policy Crumpton 2002

## 7 FURTHER INFORMATION

The Royal College of Nursing – [www.rcn.org.uk](http://www.rcn.org.uk)

The Chartered Society of Physiotherapy [www.csp.org.uk](http://www.csp.org.uk)

The College of Occupational therapy [www.cot.org.uk](http://www.cot.org.uk)

The Royal College of Midwives [www.rcm.org.uk](http://www.rcm.org.uk)

The Society of Radiographers [www.sor.org.uk](http://www.sor.org.uk)

The Guide to the Handling of People 2005: 5th Edition: Backcare: Teddington

**National Back Exchange [www.nationalbackexchange.org.uk](http://www.nationalbackexchange.org.uk)**  
**Health and Safety Executive [www.hse.gov.uk](http://www.hse.gov.uk)**

**APPENDIX 1 - WARD/DEPARTMENTAL PEOPLE HANDLING STAFF INDUCTION CHECKLIST**

<b>The employee has an awareness of:</b>		<b>Y/N</b>	<b>Comments</b>
Trust Manual Handling Policy			
Their responsibilities as stated in Policy			
Local / departmental Manual Handling Policy			
Generic Load Handling Risk Assessments			
Generic People Handling Risk Assessments			
People Manual Handling Assessment and Safer Handling Plan			
Incident reporting system			
<b>Familiar with equipment in ward/department (List Equipment inc make and model)</b>			
	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Hoists			
Stand-aids			
Slings			
Slide sheets			
Trolleys			
Other			
<b>Awareness of Manual Handling safe systems of work to include:</b>			
<b>Comments</b>			
Falling person			
Fallen person			
Cardiac arrest situations			
Minimal lifting approaches			
Escorting a person			
Emergency Evacuation			
Other			
<b>Awareness of Manual Handling training requirements</b>			
Manual Handling training before commencement of duties on wards, thereafter, Updates/workplace assessment in line with Section 2.8 of the passport scheme, when situation demands, or when new equipment or methods are introduced			
<b>Contacts for Manual Handling information/advice</b>			

**Name of Manager** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Name of Employee** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

### Ward / Department Inanimate Load Handling Staff Induction Checklist

The employee has an awareness of:			
	Y/N	Comments	
Trust Manual Handling Policy			
Their responsibilities as stated in Policy			
Local / departmental Manual Handling Policy			
Generic load handling risk assessments			
Incident reporting system			
Familiar with equipment in department			
List Equipment			
	Yes	No	Comments
Awareness of Manual Handling safe systems of work to include:			
Comments			
Minimal lifting approaches			
Other			
Awareness of Manual Handling training requirements			
Manual Handling training before commencement of duties, thereafter, Updates/workplace assessment in line with Section 2.8 of the passport scheme (dependent of risk assessemst) when situation demands, or when new equipment or methods are introduced			
Contacts for Manual Handling information/advice			

Name of Manager \_\_\_\_\_ Signature \_\_\_\_\_

Name of Employee \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_

**Ward/Departmental Manual Handling Induction Record  
People and Inanimate Handlers**

**Full Name (please print)** \_\_\_\_\_

Position / Band \_\_\_\_\_ Commencement Date \_\_\_\_\_

Directorate \_\_\_\_\_ Ward/Department \_\_\_\_\_

Do you have an All Wales Manual Handling Training Passport Record of Training?

Yes  No

**If Yes, complete the following:**

Name of previous Organisation \_\_\_\_\_

Initial Training – insert date Module completed

**A**  **B**  **C**  **D**  **E**  **F**

Date of last update/assessment \_\_\_\_\_

Date update required/assessment \_\_\_\_\_

If No, additional modules required ( to be completed by manager):

Referred to \_\_\_\_\_ (name) for training Date referred \_\_\_\_\_

Modules required (tick) **A**  **B**  **C**  **D**  **E**  **F**

Key: A Manual Handling Theory D Bed Mobility  
B Inanimate load handling & Ergonomics E Lateral transfers  
C Sitting, Standing, Walking F Hoisting

Comments:

Please Return this form to: .....  
(according to Individual organisation training arrangements)

## APPENDIX 2 – RISK ASSESSMENT FORM

**ALL WALES MANUAL HANDLING  
RISK ASSESSMENT FORM**

<b>SECTION A: ADMINISTRATION DETAILS</b>	
Primary Location: ..... Secondary Location: ..... Exact Location: ..... .....	<b>Date of Review:</b> ..... Signature of Assessor: .....
Name of Assessor .....	<b>Date of Review:</b> ..... Signature of Assessor: .....
Designation .....	<b>Date of Review:</b> ..... Signature of Assessor: .....
Date of initial Assessment .....	<b>Date of Review:</b> ..... Signature of Assessor: .....
Signature.....	<b>Date of Review:</b> ..... Signature of Assessor: .....
<b>SECTION B: MANUAL HANDLING TASK</b>	
Description of task:	
Personnel Involved (e.g. clerical staff, fitter, porter, carer, nurse, health visitor, community staff, contractor, off site worker etc):	
<b>SECTION C: CURRENT RISK CONTROL MEASURES</b>	
Control measures currently in use:	Equipment currently in use:



## SECTION D: ASSESSMENT OF MANUAL HANDLING RISK

In each of the sections, *Task, Load, Individual Capability, Environment* - tick the appropriate box (Yes or No).

A "Yes" tick indicates that further action is required to reduce the risk.

TASK			LOAD		
<b>Does the task involve:</b>	<b>Yes</b>	<b>No</b>	<b>Is the load:</b>	<b>Yes</b>	<b>No</b>
Holding load away from trunk	<input type="checkbox"/>	<input type="checkbox"/>	Heavy? Indicate weight (    )	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	Bulky/unwieldy – one side heavier ➤ 75cm in diameter	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	Difficult to grasp – no conventional hand holds	<input type="checkbox"/>	<input type="checkbox"/>
Reaching upwards	<input type="checkbox"/>	<input type="checkbox"/>	Unsteady/Unpredictable	<input type="checkbox"/>	<input type="checkbox"/>
Large vertical movements from floor	<input type="checkbox"/>	<input type="checkbox"/>	Harmful, e.g. sharp, hot contaminated, patient behaviour	<input type="checkbox"/>	<input type="checkbox"/>
Long carrying distances					
Strenuous pushing/pulling					
INDIVIDUAL CAPABILITY			ENVIRONMENT		
<b>Does the task:</b>	<b>Yes</b>	<b>No</b>	<b>Does the environment have:</b>	<b>Yes</b>	<b>No</b>
Require unusual capabilities, i.e. strength, height, age	<input type="checkbox"/>	<input type="checkbox"/>	Constraints on posture, i.e. restricted space, low work surface	<input type="checkbox"/>	<input type="checkbox"/>
Constitute a hazard to those with health problems	<input type="checkbox"/>	<input type="checkbox"/>	Poor floor, e.g. uneven, slippery Unstable	<input type="checkbox"/>	<input type="checkbox"/>
Constitute a hazard to those who are pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Variations in levels, e.g. steps	<input type="checkbox"/>	<input type="checkbox"/>
Require special information and/or training	<input type="checkbox"/>	<input type="checkbox"/>	Strong air movements	<input type="checkbox"/>	<input type="checkbox"/>
Require Personal Protective Clothing	<input type="checkbox"/>	<input type="checkbox"/>	Poor lighting conditions	<input type="checkbox"/>	<input type="checkbox"/>
			Hot, Cold, Humid, conditions	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER FACTORS:</b>					

### SECTION E: FREQUENCY OF TASK

Record the number of times the task takes place during one working shift. The frequency could require additional control measures.

Frequency of task:

Number of staff exposed to the task:

Number of staff required to carry out the task:

### SECTION F: INITIAL RISK RATING FIGURE

Initial Risk Rating Figure: (to calculate see Risk Matrix)

Probable Likelihood Rating  x Potential Severity Rating  = Risk Rating

### SECTION G: ADDITIONAL CONTROL MEASURES REQUIRED

Additional control measures to be recorded within this box. The request for these measures should be subjected to a risk priority along with other risk within the location and will form part of a prioritised risk register

**No.**

**Risk Control Measures**

No.	Risk Control Measures

If the above control measures are implemented, calculate the **New Risk Rating Figure**:

Probable Likelihood Rating  x Potential Severity Rating  = Risk Rating

### SECTION H: ACTION PLAN AGREED WITH MANAGER

No.	Action Plan	Responsible person	Projected Completion Date	Date completed / Signature

Once the above action has been implemented, calculate the final Risk Rating Figure

Probable Likelihood Rating  x Potential Severity Rating  = Risk Rating

### ADDITIONAL COMMENTS

## RISK EVALUATION MATRIX

You must assess each risk against the likelihood of an incident occurring and - should it happen – the severity of the consequences.

**REVIEW OF RISK ASSESSMENTS** - You must review your risk assessments in the following three circumstances: in accordance with the specified review period, as a result of any change (internal or in external requirements) and following an incident, complaint or claim.

**LIKELIHOOD:** a likelihood score can be given based on the likelihood or probability of an event occurring, or where an incident has already occurred, the likelihood of that event recurring. The following table illustrates this:

	5	4	3	2	1
<b>Descriptor</b>	Almost Certain	Likely	Possible	Unlikely	Rare
Likelihood	More likely to occur than not	Likely to occur	Reasonable chance of occurring/may occur occasionally	Unlikely to occur	Will occur in exceptional circumstances

**CONSEQUENCE / SEVERITY:** taking into account the controls in place and their adequacy, how severe would the consequences be of such an incident? Apply a score accordingly to the following scale.

Score	Descriptor	Impact on individuals	Number of persons affected	Actual or potential impact on the organisation	Actual or potential financial loss/complaint or litigation
1	Insignificant	No injury or adverse outcome Near Miss	None	No risk to the organisation No impact on service or the environment	Complaint unlikely Litigation risk remote
2	Minor	First Aid Minor injury	1-2 people	Minimal risk to the organisation Slight impact on services/environment	Complaint possible Litigation <£50K
3	Moderate	Temporary incapacity Short term monitoring Additional medical treatment required up to 1 year	Small 3-15 people	Some service disruption Potential for adverse publicity, avoidable with careful handling Moderate impact on environment	Complaint expected Litigation possible >£50k-£500k
4	Major	Major injury (reportable) Major clinical intervention Permanent incapacity	Moderate 16 – 50 people	Service restriction Adverse publicity Impact on reputation Major impact on the environment	Litigation >£500k - £1m expected
5	Catastrophic	Death	Many 50+	National media interest Severe loss of confidence	Litigation >£1m

### RISK MATRIX

Likelihood	SEVERITY / CONSEQUENCE				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5. Almost certain	5	10	15	20	25
4. Likely	4	8	12	16	20
3. Possible	3	6	9	12	15
2. Unlikely	2	4	6	8	10
1. Rare	1	2	3	4	5

### ACTION TO BE TAKEN - DEFINITION OF ACCEPTABLE & UNACCEPTABLE RISK

Colour coding of risk	Timescale for action	Timescale for review
	Action within 12 months or accept risk	Review controls within 12 months
	Action within 3 months	Review within 6 months
	Action within 1 month	Review within 3 months
	Action immediately	Review within 1 month

# ALL WALES NHS MANUAL HANDLING RISK ASSESSMENT FORM

## Guidelines for Use

**This form can be used for assessing inanimate load handling tasks or generic people handling tasks. There is a separate People Manual Handling Assessment and Safer handling Plan Form for assessing individual people.**

The Manual Handling Operations Regulations 1992 (as amended 2002) require that tasks that involve risk should be eliminated. Only when this is not possible should an assessment be carried out to reduce the risk associated with that task to the lowest level that is reasonably practical.

**HAZARD** Source of potential harm or damage or a situation with potential for harm or damage

**RISK** Is a combination of the likelihood and severity of a specified hazard occurring

The Manual Handling Operations Regulations 1992 (as amended 2002) support the Health & Safety at Work etc Act 1974. **A breach of these statutory requirements is a criminal offence.**

**Accountability** – lies with the head of services/designated director/manager

**Responsibility** – day to day responsibility of managing risk lies with departmental/ward managers

The person carrying out the manual handling assessment (assessor) should be a competent member of staff who has undertaken the appropriate training in Manual Handling Risk Assessments. The assessment should be reviewed in accordance with the specified review period, whenever there is any change or following a manual handling incident.

The objective of risk management is to identify and reduce the LIKELIHOOD of incidents occurring that could have significant consequences for staff, people or the Trust, as far as is reasonably practicable.

There are no absolute values for incidents, but effective risk assessment, applying appropriate control measures and monitoring those measures, together with training, can help minimise the potential for injury and/or losses. The Risk Matrix will help with this process.

**The completed form must be accessible at all times**

## **Filling in the form**

### **SECTION A: ADMINISTRATION DETAILS**

- Primary Location, e.g. hospital/premises/community
- Secondary Location, e.g. ward/department, clinic, residential/care facility
- Exact Location, e.g. side room, store cupboard, corridor

### **SECTION B: DESCRIPTION OF MANUAL HANDLING TASK**

Write down the step by step details of the task for which the assessment applies, e.g. moving people, heavy equipment etc.

#### **Personnel involved:**

Identify the staff that are likely to be involved in the task, remember to consider students and other personnel e.g. porters, storemen, nurses, care workers etc.

### **SECTION C: CURRENT RISK CONTROL MEASURES**

List control measures currently in use e.g. staff training, written information/protocols. List any equipment in use in the appropriate column.

### **SECTION D: ASSESSMENT OF MANUAL HANDLING RISK**

Consider the headings **Task, Person/Load, Individual Capability Environment and Other Factors**. Tick the appropriate box that reflects most accurately what is involved in the manual handling task and document any other relevant factors not indicated in the boxes.

### **SECTION E: FREQUENCY OF THE TASK**

Record the estimated number of times the task takes place during any one working shift. The frequency of the task may identify the need for additional control measures, e.g. more than one hoist to be accessible, more appropriate equipment required etc. Make reference to the number of staff exposed to the task overall and the number of staff involved in the task at anyone time.

### **SECTION F: INITIAL RISK RATING FIGURE**

Refer to risk matrix

### **SECTION G: ADDITIONAL RISK CONTROL MEASURES REQUIRED**

This part of the form is used to determine and justify the need for additional risk control measures. There will be occasions when the additional control measures required may take some time to implement. The request for these controls should form part of the Action Plan (agreed with the manager). The new Risk Rating Number will quantify the projected reduction in risk.

### **SECTION H: ACTION PLAN AGREED WITH THE MANAGER**

The Action Plan is documented confirmation that the additional risk control measures have been identified and agreed with the manager. This should identify the expected completion date and confirm when controls have been implemented. A final Risk Rating Number should then be calculated.

## APPENDIX 3 - PEOPLE MANUAL HANDLING ASSESSMENT & SAFER HANDLING PLAN

### SECTION A: PERSONAL DETAILS

Patient's Name:..... Ward/Dept/Other: .....

Address: ..... NHS No: .....

Date of Birth: ..... Weight: (Kgs) .....

**Independent**  – no further action required

Height: .....

### SECTION B: ASSESSMENT

		COMMENTS
1	Relevant Medical History	
2	Physical Disabilities	
3	Psychological / Mental Health	
4	Pain Status	
5	Tissue Viability	
6	History of Falls	
7	Culture/religious considerations	
8	Day/Night Variation	
9	Attachments	
10	Other Considerations	

**IF THE PERSONS CONDITION CHANGES AND / OR IF ENVIRONMENT / LOCATION CHANGES THE ASSESSMENT NEEDS TO BE REVIEWED**

### SECTION C: SAFER HANDLING PLAN

**Please specify appropriate handling aid / method and the number of staff required**

	<b>Task</b>	<b>No. of people</b>	<b>Equipment (include size &amp; type of sling to be used)</b>	<b>Method</b>
1	Turning in bed			
2	Moving up/down bed			
3	Sitting in bed			
4	In and out of bed			
5	Transfer bed to trolley			
6	Transfer bed to chair			
7	Transfer chair to bed			
8	Chair to chair/commode			
9	Repositioning in chair			
10	Standing			
11	Mobilizing			



12	Toileting			
13	Bathing			
14	Other			

**SECTION D: SPECIFIC HANDLING CONSIDERATIONS/ADDITIONAL MEASURES REQUIRED**

METHOD/EQUIPMENT	RATIONALE

Can the additional measures/equipment provision be achieved? Yes / No..... Date..... (if no, please inform your manager)

Manager's Name..... Manager's Signature.....

Incident Form Completed? Yes / No..... Date.....



<b>SECTION G: USE IN COMMUNITY AND OTHER EXCEPTIONAL CIRCUMSTANCES</b>				
<b>Environmental considerations</b>	<b>Risk to person / staff / other</b>	<b>Hazards Identified</b>	<b>Action Taken</b>	<b>Date &amp; signature</b>
Space constraints on movement of handler/equipment				
Access e.g. Bed/bath/WC/passageways				
Steps/Stairs/Access				
Flooring				
Slip/Trip Hazards				
Furniture – bed Height/moveable/condition				
Bed – double / low				
Temperature/Humidity/Lighting				
Equipment Power Supply				
Pets/Children etc				
Other				
Equipment issued by:		Other Agencies Involved:		

## ALL WALES PERSON MANUAL HANDLING ASSESSMENT FORM. GUIDELINES FOR USE

**This form must be FULLY completed for patients who are considered at risk.**

The person must be fully assessed, and details of the assessment recorded by a registered member of staff. The Manual Handling Assessment should be made available to any person involved in Handling the person and **should accompany the person at all times.**

### **Section A: Personal Details - Essential Information**

- Person's name, address, date of birth, NHS Number, Ward/department/other.
- Person's weight and HEIGHT
- **If person is independent and fully mobile no further action is required please tick the box.**

### **Section B: Assessment**

Consider all factors that could affect the patient's mobility including:

1. Relevant medical history e.g. CVA, arthritis, amputation, Parkinson's Disease, Osteoporosis etc.
2. Physical disabilities e.g. eye sight, hearing and speech.
3. Psychological e.g. confused aggression etc.
  - Fully co-operative, able to conform and maintain mobility.
  - Comatosed – completely unable to comprehend any verbal commands and unable to confirm.
  - Confused and unable to understand – a person who cannot comprehend what is expected of them and unable to determine how they can help.
  - Agitated – disturbed or excitable. State of mind which may make manual handling difficult.
  - Aggressive – the patient may have unprovoked hostility and the intention to harm others.

4. Pain Status
5. Tissue Viability
6. History of fall(s) – does the person have any previous history of falling to the ground, past or present.
  - History of vertigo – does the person have a feeling of themselves or the surroundings rotating, spinning or has any balance problems.
  - Low haemoglobin – to the best of your knowledge, does the person have low haemoglobin, which may precipitate fainting or falling.
  - Spasm/Epilepsy – does the person have uncontrolled limb jerks and involuntary muscle contraction and rigidity they may or may not be aware of.
  - Other – please highlight any other medical history which may predetermine manual handling problems i.e. dizziness, fainting.
7. Culture/religious considerations
8. Day/Night Variations
9. Attachments, e.g. IV lines, catheter, oxygen therapy etc.
10. Other considerations e.g. social factors, age etc.

### **Section C: Safer Handling Plan**

Consider the person's ability with regard to each task, and identify appropriate equipment and the number of staff required to safely move the person. Then identify the method in which the person should be moved.

### **Section D: Specific Considerations / Additional Control Measures Required**

Method – Identify method / type of transfer / manoeuvre / type of equipment.

Rationale – Identify reason for the decision to person and carers.

Where the additional measures cannot be implemented / achieved, please inform your line manager and complete incident form if appropriate.

### **Section E: Signature**

The assessor must ensure they print, sign and date this section on completion of the assessment.

### **Section F: Review**

If significant/multiple changes are required to Safer Handling Plan, a new form will be required.

If a minor change has occurred, requiring minimal change to Handling Plan, draw a single line through relevant manoeuvre on section C Safer Handling Plan, initial and date. Then provide details of the change and consequent changes to Handling Plan in Section F.

Review including date and signature

The assessor must ensure that they print, sign and date this section on completion of the assessment.

### **Section G: For use in Community and Other Exceptional Circumstances**

Complete this section only if relevant. An example of exceptional circumstances is when bariatric equipment impacts of the amount of space available at the bed side. Assess the environment in which the patient is being cared for; identify any hazards involved and the actions to be taken to reduce the risks.

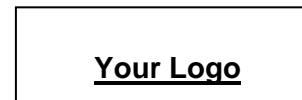
### APPENDIX 4 - INDIVIDUAL TRAINING RECORD - MANUAL HANDLING

**Other Practical Skills** - (department or speciality specific)

Practical Skills	Discussed	Demonstrated	Practised

### All Wales NHS Manual Handling Training Passport & Information Scheme

Individual Training Record – Manual Handling



#### Personal Details

Trainee Name: .....

Job Title: .....

Ward/Department: .....

Managers Name: .....

Course Dates: .....

I confirm that I have received instruction in the topics as indicated in this training record. I have also been given the opportunity to discuss relevant issues and ask questions. I confirm that I have received handouts.

**N.B. Any changes to this record with the intention to deceive will be considered as fraudulent**

Trainee Signature: .....

Trainer Signature: .....

Date: .....

#### Record of Equipment Used Including Basic Safety Checks

Passive Hoist -		Sling type -	
		Sling type -	
Active hoist -		Sling type -	
Stand-aid -			
Profiling bed –			
Flat slide sheets –			
Tubular sheets –			
Transfer boards –			

## Training Course Details

(Please ensure that you insert your initial alongside the completed topic and a cross) where topic not completed or covered)

<b>Module A – Manual Handling Theory</b>				Discussed
Definition of manual handling				
Musculo-skeletal Injuries and preventative measures				
Legislation				
Ergonomics and risk assessment				
Principles of safer handling				
Team handling				
Communication				
Safer handling within the organisation				
<b>Module B – Inanimate Load Handling</b>				Discussed
Principles of safer handling inanimate loads (including weight check prior to lifting)				
Key areas for risk assessment				
Identifying how principles of safer handling can be applied to larger/awkward loads				
The importance of good posture and application of ergonomic principles, appropriate to workplace and work activity				
Practical Skills	Discussed	Demonstrated	Practised	
Risk assessment of inanimate load				
Pushing and pulling				
Lifting and lowering from / to floor or low level				
Appropriate position whilst sitting at a desk				
Carrying a load				
Basic safety checks of equipment				
<b>Module C – Sitting, Standing and Walking</b>				Discussed
Principles of safer handling of people				
Unsafe practices				
Communication				
Practical Skills	Discussed	Demonstrated	Practised	
Risk assessment of moving & handling a person				
Assisting a person forward in a chair				
Assisting a person back in a chair				
Sitting to standing from a chair				
Standing to sitting in chair				
Sitting to standing from edge of bed				
Standing to sitting on edge of bed				
Assisted walking				
The falling person *				
Raising the fallen person				
Assisting the fallen person from a confined space *				
Bed assisted stand				

\* demonstration and practise at the discretion of the trainer and organisation

<b>Module D – Bed Mobility</b>				Discussed
Principles of working at a bed e.g. appropriate height				
Principles of using flat and tubular slide sheets				
Unsafe practices				
Correct posture whilst feeding & examining person.				
Practical Skills	Discussed	Demonstrated	Practised	
Fitting and removing tubular and flat slide sheets				
Turning in bed including 180 degree turn				
30 degree tilt				
Sliding the supine person up/down bed				
Sitting a person from lying				
Sitting a person up onto edge of bed				
Assisting a person to lie from sitting on edge the bed				
Use of profiling beds (if available)				
<b>Module E – Lateral Transfers</b>				Discussed
Methods of maintaining personal hygiene and alternative methods of toileting and clothing management				
Unsafe practices				
Practical Skills	Discussed	Demonstrated	Practised	
Lateral supine transfer from bed to trolley/trolley to bed				
Standing transfer from bed to chair/chair to bed				
Seated transfer bed to chair/chair to bed				
Transfer from chair to chair/commode/toilet				
<b>Module F – Using Hoists and Slings</b>				Discussed
Principles (of hoist use and types of hoist available)				
Selection and use of slings				
Main points of LOLER (1998) and Trust inspection protocol				
Unsafe practices				
Practical Skills	Discussed	Demonstrated	Practised	
Fitting sling with a person in bed				
Fitting sling in bed with using slide sheets				
Fitting a sling with a person in a chair				
Fitting a sling in a chair with slide sheets				
Hoisting from chair to bed / bed to chair				
Hoisting a person from the floor				
Use of a stand-aid hoist				



## APPENDIX 5 - MANUAL HANDLING TRAINING HEALTH QUESTIONNAIRE

During the training course you will be required to participate in person and/or inanimate load handling techniques. You will also carry out a number of practical exercises. In order for the trainer to train you safely and provide guidance pertinent to you personally they need to know about any pre-existing condition which you may have. The information given will be treated in confidence.

If you knowingly give incorrect information to the organisation, it can bear no responsibility for any resultant pain or injury.

You are required therefore to place a tick in the box adjacent to any factor which could affect the way in which your training is provided and sign below.

	TICK
1 . I am suffering from musculo-skeletal pain	
2. I have suffered with pain, injury and or had surgery in the last 6 months	
3. I am receiving treatment for a condition / have a medical condition which may affect my ability to engage in physical activity	
4. I am pregnant	
5. I have given birth within the last 6 months	
6. I am breast-feeding	
7. None of the above applies	

SIGNATURE: .....

DATE: .....

- If you have answered 'yes' to any of the questions numbered 1-6 the trainer may seek further information from you in confidence.
- If necessary advice will be sought from the Occupational Health Department.
- **Should you suffer any discomfort or injury during the training you must report this to the trainer immediately.**

**TRAINER / FACILITATOR USE ONLY - COMPLETE BOTH SECTIONS**

**THIS SECTION SHOULD REMAIN ATTACHED TO THE TRAINING RECORD**

Referred to Manager

**YES / NO**

Date of referral: .....

During Safer Handling practical training this person had difficulty and/or was unable to perform the following techniques because of health problems.

**TRAINER'S NAME (PRINT) .....**

**SIGNATURE ..... TRAINING DATE(S) .....**

---

**DETACH THIS SECTION AFTER COMPLETION AND  
SEND TO THE INDIVIDUAL'S LINE MANAGER**

During Safer Handling practical training this person had difficulty and/or was unable to perform the following techniques because of health problems.

**TRAINER'S NAME (PRINT) .....**

**SIGNATURE ..... TRAINING DATE(S) .....**

## **APPENDIX 6 - GUIDANCE FOR COMPLETION OF THE MANUAL HANDLING COMPETENCY ASSESSMENT**

### **Aim**

The aim of the competency assessment is to reinforce foundation level training by ensuring that knowledge and skills are being applied in the workplace.

### **Self Assessment Guidelines**

Staff members are advised to complete the manual handling **self assessment** (appendix 7a and b) to identify individual training needs, prior to this assessment being undertaken. If further training needs are indicated these should be addressed before the competency assessment is undertaken. Staff should be advised of the process involved in this assessment. The competency assessment must be completed in line with Section 2.8 of the passport scheme.

### **The Competency Assessment Form**

The form is designed to document the assessment of inanimate load handling or people handling activities and is to be completed by the Manual Handling Trainer/Link Worker. Two assessments should be completed and relevant to individual common working tasks. There are two forms, one for inanimate load handling staff and the other for people handling staff. If not practical to complete workplace assessments the forms can be used in a classroom setting to record assessment of staff knowledge and skills

### **The Process**

- ◆ Complete employee information section.
- ◆ Date of initial training and date of last update training recorded.
- ◆ Update training will be required if
  - the individual staff member has identified training needs
  - the individual staff member is not working competently
- ◆ Advise the staff member of the conclusion following the assessment.
- ◆ Employee's manager to countersign documentation and place in personal file.

Additional information on the technique observed should be available locally in a Safe System of Work for inanimate load handling or a Techniques Manual for people handling activities.

### **OBSERVATION ASSESSMENT GUIDELINES - assessor to ensure risk assessment, equipment and environment are appropriate prior to the assessment taking place**

1. Question individual on the findings of risk assessment or safe system procedure
2. If applicable, has Team leader agreed the actual procedure to be followed, with good clear instructions given to team members, and person if relevant.
3. Due regard for safety, team handling principles, equipment safety information, knowledge and skill, suitable clothing and footwear, as per uniform policy. Maximize person effort, safe environment, planned manoeuvre, use of equipment to give independence or reduce handling required.
4. Equipment/technique selected matches those indicated in Risk Assessment or Safe System of Work and is appropriate / meets individual person needs at time of assessment.
5. Checked equipment prior to use e.g. equipment functioning and adjusted height of beds/trolleys etc., and used it according to manufacturer's guidelines and Safe System of Work s

6. Employed core principles of safer handling relating to posture and stability depending on individual capability.
7. Utilised efficient movement during dynamic aspects of the transfer e.g. weight transference as opposed to muscle strength.
8. Appropriate commands used - understood by all, clear, ready, steady, move etc NOT 1, 2, 3.
9. Has the activity been effectively carried out ie: the load / person have been safely moved and are in the required place/position / the person is safe and comfortable.
10. Ensure safety by checking area at end of manoeuvre, slide sheets etc have been removed, bed rails replaced, brakes on etc.

## APPENDIX 7a - MANUAL HANDLING SELF ASSESSMENT FORM (INANIMATE LOAD HANDLING STAFF)

To be completed by staff member prior to update training / workplace assessment.

Aim - this form will identify the training you have undertaken and indicate any further training you require to work safely in your workplace

Name	Directorate/ Location	Ward/Department		
Please circle which Modules were included in your foundation level training (refer to your Individual Training record)	Module A    B	Date of foundation training ...../...../.....		
Please circle type of update undertaken	Classroom Workplace 1:1 Assessment	Date of Update / Assessment ...../...../.....		
	<b>Theoretical content:</b> Please tick appropriate box	Please indicate module necessary for your work area	Please indicate module/technique requiring update	Provided Sign & date
<b>Module A</b>	Importance of safe manual handling and legislation			
	Anatomy / causes of back pain / injury avoidance			
	Posture and exercise			
	Ergonomics			
	Risk Assessment - an introduction			
	Principles of safer handling and communication			
	Safer handling within the organisation			
<b>Module B</b>	Principles of safer handling of inanimate loads (including weight check prior to lifting)			
	Safer handling inanimate load risk assessment			
	Identifying how principles of safer handling can be applied to larger/ awkward loads			
	The importance of good posture and application of ergonomic principles appropriate to workplace and work activity			
<b>Practical Training:</b>	Please indicate practical techniques required in your area of work	Please indicate practical teaching you require Update training on		
<b>Module B</b>				
Pushing/Pulling				
Lifting & Lowering from/to Floor/Low Level				
Appropriate Position at Desk				
Carrying a load				
Basic safety checks of equipment				
<b>Comments:- Please identify any situations, theoretical or practical training you would like to discuss/have further training in that has not been identified above</b>				

**Staff Signature**.....**Date**.....

**Manual handling Trainer/Link Worker Name**.....

**Manual handling Trainer/Link Worker Signature**.....

**To be actioned by Manual Handling Trainer/Link Worker & sent to employees' manager and kept in employee personal file.**

## APPENDIX 7b - MANUAL HANDLING SELF ASSESSMENT FORM (PEOPLE HANDLING STAFF)

To be completed by staff member prior to update training / workplace assessment.

Aim - this form will identify the training you have undertaken and indicate any further training you require to work safely in your workplace.

Name		Directorate/ Location	Ward/Department	
Please circle which Modules were included in your foundation level training (refer to your Individual Training record)		Module A B C D E F	Foundation training date ...../...../.....	
Please circle type of update undertaken		Classroom Workplace 1:1 Assessment	Update/Assessment date .../...../....	
	<b>Theoretical content:</b> Please tick appropriate box	Please indicate module necessary for your work area	Please indicate module/technique requiring update	Provided 4 Sign & date
<b>Module A</b>	Importance of safe manual handling and legislation			
	Anatomy / causes of back pain / injury avoidance			
	Posture and exercise			
	Ergonomics			
	Risk Assessment - an introduction			
	Principles of safer handling and communication			
	Safer handling within the organisation			
<b>Module B</b>	Principles of safer handling of inanimate loads (including weight check prior to lifting)			
	Safer handling of inanimate load risk assessment			
	Identifying how principles of safer handling can be applied to larger/ awkward loads			
	The importance of good posture and application of ergonomic principles appropriate to workplace and work activity			
<b>Module C</b>	Principles of safer handling of people			
	Awareness of unsafe practices			
	Safer handling person risk assessment			
<b>Module D</b>	Principles of working at a bed e.g. appropriate bed height)			
	Principles of using flat slide sheets			
	Principles of using tubular slide sheets			
	Awareness of Unsafe practices			
<b>Module E</b>	Methods of maintaining personal hygiene and alternative methods of toileting and clothing management			
	Awareness of unsafe practice			
<b>Module F</b>	Principles of hoist use and types of hoists available			
	Type, selection and use of slings			
	Main points of LOLER 1998			
	Awareness of unsafe practice			

**Please continue overleaf for practical elements.**

### Practical Module Content

	Please indicate practical techniques required in your area of work	Please indicate practical teaching you require Update training on	Provided Date
<b>Module B</b>			
Pushing/Pulling			
Lifting & Lowering from/to Floor/Low Level			
Appropriate Position at Desk			
Carrying a load			
Basic safety checks of equipment			
<b>Module C</b>			
Assisted walking			
Sitting to standing from chair/bed			
Standing to sitting from chair/bed			
Raising the fallen Person			
Falling Person			
Moving a fallen person from confined space			
Re-positioning person in chair			
Bed assisted stand			
<b>Module D</b>			
Rolling			
Turning			
In/Out of Bed			
Up/Down Bed			
Use of slide sheets (fitting & removing)			
Lying to Sitting/ Sitting to lying			
Use of electric profiling beds			
Correct Posture whilst feeding/examining			
<b>Module E</b>			
Lateral transfer lying			
Lateral transfer seated			
<b>Module F</b>			
Fitting a sling			
Hoisting in/out of bed/chair			
Hoisting from floor			
Use of stand aid			

**Comments:-**

**Please identify any situations/practical training you would like to discuss/have further training in that has not been identified above**

**Staff Signature**.....

**Date**:.....

**Manual handling Trainer/Link Worker Name**:.....

**Manual handling Trainer/Link Worker Signature**:.....**Date**:.....

To be actioned by Manual Handling Trainer/Link Worker & sent to employees' manager and kept in employee personal file.

**APPENDIX 8a - MANUAL HANDLING COMPETENCY ASSESSMENT FORM****INANIMATE HANDLING TASKS**

Name: .....	Directorate/Location:- .....	Ward/Dept.:-.....
Date of foundation training:.....		
Date of last workplace assessment or update: .....		

**Observation of Inanimate Load Handling Manoeuvre - to be completed by assessor**

Manoeuvre Observed:					
Equipment used <i>No/Yes - specify type of equipment:</i>					
		Yes	No	N/A	Comments
1	Applied findings of Risk Assessment / Safe System of Work method				
2	Communicated with colleagues				
3	Appropriate equipment/technique selected				
4	Appropriate use of equipment				
5	Equipment check prior to use				
6	Check weight of item to be moved				
7	Maintained good posture and stability				
8	Use of efficient movement				
9	Appropriate commands				
10	Effective manoeuvre				
11	Check area safe at end of manoeuvre				

**Observation of Inanimate Load Handling Manoeuvre - to be completed by assessor**

Manoeuvre Observed					
Equipment used <i>No/Yes - specify type of equipment:</i>					
		Yes	No	N/A	Comments
1	Applied findings of Risk Assessment / Safe System of Work method				
2	Communicated with colleagues				
3	Appropriate equipment/technique selected				
4	Appropriate use of equipment				
5	Equipment check prior to use				
6	Check weight of item to be moved				
7	Maintained good posture and stability				
8	Use of efficient movement				
9	Appropriate commands				
10	Effective manoeuvre				
11	Check area safe at end of manoeuvre				

**Conclusion: (more than one box may be ticked)**

	Tick	Action taken
a. Safe performance of manoeuvres at time of assessment		
b. Requires update & assessment		
c. Needs to attend foundation training		
d. Should only perform manual handling tasks with supervision		

Assessor Name.....Signature.....Date.....

Staff Member Signature .....Signature.....Date.....

Managers Name ..... Signature.....Date.....

Review Date.....



**APPENDIX 8b - MANUAL HANDLING COMPETENCY ASSESSMENT FORM****People Handling Tasks**

Name: .....	Directorate/Location:- .....	Ward/Dept.:- .....
Date of foundation training:.....		
Date of last workplace assessment or update: .....		

**Observation of Person Handling Manoeuvre - to be completed by assessor**

Manoeuvre Observed:					
Equipment used <i>No/Yes - specify type of equipment:</i>					
		<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Comments</b>
1	Consulted the People Manual Handling Assessment & Safer Handling Plan for handling information				
2	Communicated with colleagues/person				
3	Appropriate equipment/technique selected				
4	Appropriate use of equipment				
5	Equipment check prior to use				
6	Maintained good posture and stability				
7	Use of efficient movement				
8	Appropriate commands				
9	Effective manoeuvre - person in required position				
10	Check person safe/comfortable at end of manoeuvre				

**Observation of Person Handling Manoeuvre - to be completed by assessor**

Manoeuvre Observed					
Equipment used <i>No/Yes - specify type of equipment:</i>					
		<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Comments</b>
1	Consulted the People Manual Handling Assessment & Safer Handling Plan for handling information				
2	Communicated with colleagues/person				
3	Appropriate equipment/technique selected				
4	Appropriate use of equipment				
5	Equipment check prior to use				
6	Maintained good posture and stability				
7	Use of efficient movement				
8	Appropriate commands				
9	Effective manoeuvre - person in required position				
10	Check person safe/comfortable at end of manoeuvre				

**Conclusion: (more than one box may be ticked)**

	<b>Tick</b>	<b>Action taken</b>
a. Safe performance of manoeuvres at time of assessment		
b. Requires update & assessment		
c. Needs to attend foundation training		
d. Should only perform manual handling tasks with supervision		

**Assessor Name**.....**Signature**.....**Date**.....

**Staff Member Signature** .....**Signature**.....**Date**.....

**Managers Name** ..... **Signature**.....**Date**.....

**Review Date**.....

**APPENDIX 9 - RECORD OF ATTENDANCE**

COURSE TITLE \_\_\_\_\_ MODULE \_\_\_\_\_ DATE \_\_\_\_\_

START \_\_\_\_\_ FINISH \_\_\_\_\_ VENUE \_\_\_\_\_

PRINT NAME	UNIQUE I.D. NUMBER	GRADE	BASE	A.M. SIGNATURE	P.M. SIGNATURE	HANDOUTS

FACILITATORS NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

TITLE: \_\_\_\_\_

FACILITATORS NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

TITLE: \_\_\_\_\_

**OTHER INFORMATION**

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**SPECIFIC EQUIPMENT USED**

## APPENDIX 10 - POLICY FRAMEWORK

### TITLE PAGE

Include:

- Trust name / Logo
- Title of Policy & Reference Number
- Version
- Review By
- Author
- Date Approved / Adopted:
- Related Documents:
- Distribution:

### CONTENTS PAGE

Include Appendices

### STATEMENT OF INTENT

Organisation's

- recognition of risks during manual handling and its commitment to reducing / removing the risks.
- intention to operate this policy to comply with MHOR and other legal requirements.
- commitment to Passport Scheme.

Also state how this policy lies within the organisation's Risk Management / Health & Safety structure and other policies that inter-relate with this policy e.g. Occupational Health, Safety & Welfare Policy, Stress Policy, Uniform Policy.

### INTRODUCTION & SCOPE

- General statistics and information e.g. number of people suffering with musculo-skeletal disorders, cost in terms of lost days and reports to HSE etc.
- Outline of organisation's arrangements e.g. avoid the need for manual handling, risk assessment if handling cannot be avoided, adoption of an ergonomic approach, training, provision of equipment, safe systems of work etc. to reduce risks and promote safer handling.
- Activities that are considered to be a risk – definition of manual handling.
- Who the policy applies to and frequency of review of the policy.

### LEGISLATION

State that the policy supports the legal duties placed on the organisation by the following: -

- Health & Safety at Work etc Act 1974
- Management of Health & Safety at Work Regulations 1999
- Manual Handling Operations Regulations 1992 (as amended 2002)
- Provision and Use of Work Regulations 1998
- Lifting Operations & Lifting Equipment Regulations 1998
- Workplace (Health, Safety & Welfare) Regulations 1992

- Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 1995
- Health & Safety Miscellaneous Amendments Regulations 2002

The Policy should also take into account Approved Codes of Practice, Guidance on Regulations, specific HSE guidance, Passport Scheme etc.

## **DEFINITIONS**

Include definition of terminology used throughout policy e.g. risk assessment, hazard, risk, load, manual handling operations, ergonomic approach, safer handling etc.

## **MANAGEMENT RESPONSIBILITIES**

State specific responsibilities for delegated people throughout the organisation – this will vary depending on the structure of the organisation. The following is an example: -

### **Chief Executive**

Responsibilities may include: -

- overall responsibility for Health Safety & Welfare of staff and others.
- along with Trust Board is accountable for managing Health & Safety.
- responsible for resources and implementation of measures to comply with legislation and guidance.

**Director of .....** (with delegated responsibility for corporate management of Health & Safety).

Responsibilities may include: -

- development and implementation of policies and Risk Management Strategy.
- ensuring competent advice.
- monitoring performance of organisation and communicating results to Chief Executive and relevant committees.
- promoting philosophy of reduction of injury and ill health by healthier lifestyle and good working practices.

### **Manual Handling Advisor**

Responsibilities may include: -

- providing competent advice in relation to manual handling activities
- .provision of appropriate aids, equipment, furniture etc.
- development, implementation, monitoring and review of Safer Handling Policy.
- implementation, monitoring and review of the Passport Scheme.
- development, implementation, monitoring and review of Training Strategy
- providing training / updating.
- promoting a healthy, safe working environment.
- advising / assisting with risk assessments and identification of appropriate control measures.
- reviewing manual handling incidents in the Trust, contributing to investigation of accidents / injuries.

- liaising with organisation's Complaints & Litigation Department and Solicitors.
- advising / reporting to relevant committees within the organisation.
- representing organisation at relevant area / national meetings.
- networking with other Trusts / organisations.
- providing input into planning / upgrading works undertaken within the organisation.
- maintaining / updating knowledge & skills.

**Director of .....** (with delegated responsibility for training within the organisation)

Responsibilities may include: -

- carrying out a Training Needs Analysis and updating it on a regular basis.
- co-ordinating training activities.
- maintaining a training database for the organisation, and identifying the need for update training.

**Director of .....** (with delegated responsibility for Occupational Health provision)

Responsibilities may include: -

- pre-employment screening
- advice to Managers and staff on musculo-skeletal disorders.
- ensuring employees with a MSD's are referred to Occupational Health Department.
- providing competent advice to management and staff through assessment and planned return to work processes.
- ensuring the requirements of Revitalising Health & Safety Agenda and Occupational Health Strategy are met.

**Director of Estates**

Responsibilities may include: -

- ensuring equipment is inspected and maintained according to LOLER (1998).
- keeping maintenance / inspection records.

**Clinical & Non Clinical Directors, Directorate / Service Managers, Department & Ward Managers etc.**

Include general statement then specific responsibilities. These can be listed under headings such as: -

- Risk Assessment
- Training
- Equipment & Aids
- Environment
- Incidents, Accidents & Ill Health
- Staffing Levels, Safe Practice & Competence
- Uniform & Clothing
- Special Circumstances (e.g. bariatric patient) & Emergency Situations

**Safer Handling Group** – if the organisation has one.

Responsibilities may include: -

- co-ordination of the organisation's actions and providing effective channels of communication.
- drafting policies, procedures documentation etc.
- monitoring & reviewing the implementation of Safer Handling Policy, Training Strategy, Passport Scheme etc. and auditing compliance with these.
- receiving training reports and measuring progress against Training Needs Analysis.
- monitoring trends in incidents and recommend appropriate action
- receiving and actioning health & safety reports.
- providing reports to other groups/ committees within the organisation.

**Safer Handling Trainers**

Responsibilities may include: -

- delivering training in accordance with the Passport Scheme.
- maintaining accurate training records.
- liaising with Manual Handling Advisor.
- demonstrating good practice.
- monitoring practice.
- advising Managers of problems.
- keeping abreast of changes / updates etc.
- promoting the principles of safer handling.
- assisting Managers to complete Passport Scheme Induction Checklists for new employees.
- assisting in identifying previous training of Passport Scheme standard.

**Employees**

Responsibilities may include: -

- taking reasonable care of their own and others health & safety.
- using any system of work provided by the organisation.
- wearing appropriate uniform / clothing and footwear.
- attending training & utilising safer handling principles and skills in the workplace.
- not using practices deemed as unsafe.
- referring to risk assessments.
- assessing their own personal safety before undertaking handling activities.
- reporting ill health, medical conditions or injury.
- reporting incidents, accidents etc.
- reporting problems to their Line Manager.

**Monitoring & Implementation of the Policy**

Action points for Managers when risk assessing and auditing compliance with this policy, may include: -

- has an assessment of all manual handling tasks undertaken by your staff been carried out?

- have arrangements been made for the participation of safety representatives and employees?
  - where manual handling is unavoidable, is there a risk of injury?
  - can the risks be eliminated or minimised?
  - is there a sufficient supply of appropriate safer handling equipment available?
  - are uniforms, footwear and protective equipment suitable for the work being carried out?
  - is there an ongoing training programme for all groups of staff?
  - have all staff been trained to the standard of the Passport Scheme?
- is there an effective incident reporting and investigation system?



## **APPENDIX 11 - TRAIN THE TRAINERS GUIDANCE OVERALL AIM**

To prepare lead individuals to manage and deliver manual handling training in line with current legislation & to the standards of the All Wales NHS Manual Handling Training Passport & Information Scheme (Passport Scheme). This will involve an ergonomic and problem solving approach being applied to the course. The length of the course should be a minimum of 5 days with no more than 8 course participants (per trainer)

### **Objective/Learning Outcomes**

At the end of the training programme the trainee must be able to demonstrate:-

- A comprehensive knowledge and understanding of current legislation, the Passport Scheme, best practice and their own organization's manual handling policy
- Underpinning knowledge and skills of the theoretical and practical aspects of the Passport Scheme to include the safe & proper use of a variety of equipment
- An ability to apply ergonomic principles to the work place
- The ability to utilize a range of training resources effectively
- Effective communication and presentation skills required to deliver training
- Effective classroom management skills to include equality and diversity issues
- Skills and knowledge required to assess the competency of course participants
- Application of knowledge and skills in the workplace and across the spectrum of occupations and specialties of staff they will be required to train and assess.

### **Assessment Criteria**

Sufficient methods of assessing theoretical and practical competencies will need to be used and should be equal or equivalent to examples shown below.

- Theoretical – Individual Questionnaire, departmental, generic, Inanimate and Person Handling Risk Assessments
- Practical – Demonstration of competency to undertake manual handling techniques
- Teaching/Presentation Skills –
  - Theoretical presentation (Approx 5 – 10 mins)
  - Practical presentation (Approx 10 – 15mins)

### **Entry Criteria**

- As per person specification in the Passport Scheme (excluding post basic course in people handling)
- Must have attended a minimum of 2 days manual handling training within the previous 2 years and work within a clinical environment utilizing manual handling skills
- Be able to commit to additional background reading and home study
- Full attendance & participation in all aspects of the course
- Be able to demonstrate physical capability required to perform manoeuvres

### **Manual Handling Training Assistants**

As above with teaching component being omitted and specific topics tailored accordingly

### **Outline Course Programme available as a guide**

**Manual Handling Train the Trainer Guide Programme for People Handlers**

<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>
<b>AM</b>	<b>AM</b>	<b>AM</b>	<b>AM</b>	<b>AM</b>
Introduction & Registration Housekeeping Overview of Programme Background to Manual Handling & Passport Scheme	Review of previous day  Ergonomics & Risk Assessment	Review of previous day  Theoretical Presentations x 6/8	Review of previous day  Practical Presentations x 6/8	Review of previous day  Practical assessments X 12/16 (as necessary)
<b>Module A</b> Legislation, Professional Standards, Policies, Accidents & Incident Statistics. Causes and effects of Musculo Skeletal Injuries. Fitness and Self Care Unsafe Practices	Role & Responsibilities of the Trainer. Management of Change Theory. Teaching/Presentation Skills, Record Keeping & Competency Assessment Documentation	Presentations continued  Analysis of presentations & discussion	Presentations continued  Analysis of presentations & discussion	Practical assessments continued
<b>PM</b>	<b>PM</b>	<b>PM</b>	<b>PM</b>	<b>PM</b>
<b>Module B - Practical</b> Safer Handling Principles. Importance of Good Posture, Team Handling. Load Handling practice using problem solving approach. Theoretical Questionnaire	<b>Module C/D - Practical</b> Patient Assessment Assisted walking/sitting. Fallen/Falling person. Bed Mobility. Use of equipment using problem solving approach. Theoretical Questionnaire	<b>Module E/F - Practical</b> Lateral Transfers & Hoisting. Use of equipment using problem solving approach. Theoretical Questionnaire	<b>Modules B- F Practical</b>	Practical assessments continued (if required)  Course review  Certificate presentation

## **APPENDIX 12 - MANUAL HANDLING COMPLIANCE AUDIT**

The purpose of the audit is to ensure that NHS Trusts, Local Authorities and independent agencies throughout Wales can demonstrate evidence of compliance with the legislative requirements for manual handling.

It will also demonstrate compliance with the principles and standards inherent in the All Wales Manual Handling Training Passport and Information Scheme (thereafter referred to as 'Passport Scheme').

Compliance with the Passport Scheme is not legally enforceable but is recognised by the Health & Safety Executive (HSE) as demonstrating best practice.

### **The audit tool comprises of 2 distinct sections –**

**SECTION A** - audit of organisational arrangements for manual handling to assess compliance with the relevant legislation

**SECTION B** – audit of manual handling training to assess compliance with the principles and standards inherent in the All Wales Manual Handling Passport Scheme

The audit tool can be used to audit the whole organisation or an individual Directorate / Division / Department. The audit can be conducted by a competent person from within the organisation with knowledge of manual handling, or by an External Auditor or an Internal Auditor appointed by the organisation. If a competent auditor with no knowledge of manual handling is conducting the audit, a suitably knowledgeable person from the organisation should be present

The requirement to complete one or both sections of the audit tool is dependent on the nature of the audit and the circumstances in which it is being undertaken. E.g. an audit of the training department by a competent person from within the organisation might only involve completion of Section B, whereas both sections might be appropriate for an audit of the organisation by an External Auditor.

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Area for Assessment 1 - Manual handling policy

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Area for Assessment 4 - Equipment

Area for Assessment 5 - Monitor and review arrangements

#### **Section B – Manual Handling Training**

Area for Assessment 6 - Systems and resources for provision of training

Area for Assessment 7 - Systems and resources for delivery of training

**ADMINISTRATION DETAILS**

**ORGANISATION** ..... **Date of Audit** .....

**1. TYPE OF AUDIT** – tick **ONE** of the following to indicate whether External, Internal or Local Audit and **PRINT** required information in the relevant section.

a.  **EXTERNAL AUDIT**

Audit organisation & name of auditor: ..... Signature: .....

Name & Designation of Knowledgeable Person:..... Signature: .....

b.  **INTERNAL AUDIT**

Audit organisation & name of auditor: ..... Signature: .....

Name & Designation of Knowledgeable Person:..... Signature: .....

c.  **LOCAL (organisation)**

Name & Designation of auditor: .....Signature: .....

If auditor is not the organisation’s competent person

Name & Designation of Knowledgeable Person:..... Signature: .....

**2. SCOPE OF AUDIT** (circle appropriate) **Organisation Division Directorate Department**

If Division, Directorate or Department – Provide details with location.....

**3. NATURE OF AUDIT**  Section A – Organisational Arrangements  Section B - Training

## SECTION 1 - AUDIT OF ORGANISATIONAL ARRANGEMENTS FOR MANUAL HANDLING

AREA FOR ASSESSMENT 1	THE ORGANISATION HAS AN UP TO DATE MANUAL HANDLING POLICY WHICH ENDORSES AND SUPPORTS THE LEGISLATIVE REQUIREMENTS				
No		Yes	No	Partial	Comments (including cross reference to evidence)
1.1	<p>The organisation has a current Manual Handling Policy, reviewed within the last 3 years, which refers to legislation and best practice.</p> <p><b>Example of evidence</b></p> <ul style="list-style-type: none"> <li>• Manual Handling Policy</li> </ul>				
1.2	<p><i>An Elected Member / Director with delegated responsibility for manual handling is identified to implement and promote the Policy.</i></p> <p><b>Example of evidence</b></p> <ul style="list-style-type: none"> <li>• Manual Handling Policy</li> <li>• Job description / Role profile</li> </ul>				
1.3	<p><i>The Manual Handling Policy is communicated at all levels.</i></p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Organisational/ local induction</li> <li>• Training</li> <li>• Intranet/locally held policies</li> <li>• Via quarterly/annual reports to Board Level</li> <li>• Health &amp; Safety Committee</li> <li>• Risk Management Committee</li> <li>• Confirmed through discussion with employees</li> </ul>				

1.4	<p><i>Procedures / protocols for specialised / complex / emergency handling situations are in place</i></p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Bariatric arrangements</li> <li>• Written Protocols</li> <li>• Safe Systems of Work</li> <li>• Inter-Agency agreements</li> <li>• Service withdrawal agreements</li> </ul>				
<b>AREA FOR ASSESSMENT 2</b>		<b>THE ORGANISATION HAS IDENTIFIED A COMPETENT LEAD PERSON TO ADVISE ON MANUAL HANDLING ISSUES INCLUDING PLANNING AND CO-ORDINATING DELIVERY OF TRAINING</b>			
No		Yes	No	Partial	Comments (including cross reference to evidence)
2.1	<p>Competent lead person identified to advise on manual handling issues including planning and co-ordinating delivery of training</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• CPD meets criteria required for Registered Member of National Back Exchange</li> <li>• Manual Handling Policy</li> <li>• <i>Job description / role profile as specified in Passport Scheme</i></li> </ul>				

2.2	<p><i>The competent lead person ensures that contracted external training providers meet the standards for trainers and training as required by the Passport Scheme</i></p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• <i>Contractual / Service Level agreement</i></li> <li>• <i>Documentary evidence from training provider</i></li> </ul>				
2.3	<p><i>Competent Manual Handling Trainers deliver people handling and / or inanimate load handling training.</i></p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• CPD meets entry criteria required for post-basic Trainers course based on the IPC framework.</li> <li>• Successful completion of an appropriate Trainers course</li> <li>• Job description / role outline complies with person specification for Manual Handling Trainer in client handling (foundation level) and inanimate load handling (foundation level) in Passport Scheme</li> <li>• Manual Handling Policy</li> </ul>				



AREA FOR ASSESSMENT 3		THE ORGANISATION HAS IDENTIFIED AND TRAINED COMPETENT PERSONS TO UNDERTAKE MANUAL HANDLING RISK ASSESSMENT			
No		Yes	No	Partial	Comments (including cross reference to evidence)
3.1	<p>Competent persons are identified to undertake manual handling risk assessments (animate and inanimate).</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>Records of attendance at manual handling, risk assessment &amp; update training</li> </ul>				
3.2	<p>Specific and generic manual handling risk assessments are correctly completed, communicated and reviewed.</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>Appropriate specific and generic risk assessments are in place</li> <li>Action plans demonstrate reduced risk</li> <li>Review &amp; communication procedures</li> <li>Evidence of availability of support mechanisms and advice</li> </ul>				
3.3	<p>Risk assessment documentation meets the requirements of the Passport Scheme or equivalent</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>Copies of appropriately documented animate and inanimate risk assessments</li> </ul>				
3.4	<p>The organisation has arrangements in place to retain / archive risk assessment documents.</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>Written statements / policy/ local guidelines</li> <li>Archive system</li> </ul>				

AREA FOR ASSESSMENT 4		THE ORGANISATION PROVIDES SUITABLE AND SUFFICIENT MANUAL HANDLING EQUIPMENT AND HAS ARRANGEMENTS IN PLACE TO ENSURE SAFE USE, MAINTENANCE AND INSPECTION OF EQUIPMENT			
No		Yes	No	Partial	Comments (including cross reference to evidence)
4.1	Suitable and sufficient manual handling equipment is provided having been identified through risk assessment. <b>Examples of evidence</b> <ul style="list-style-type: none"> <li>• Risk assessment</li> <li>• Equipment inventory</li> </ul>				
4.2	Mechanical patient lifting equipment including slings and any other individual components are inspected / maintained at least every 6 months. <b>Examples of evidence</b> <ul style="list-style-type: none"> <li>• maintenance / inspection records</li> <li>• In-date label /sticker attached to hoists etc.</li> </ul>				
4.3	Non-patient lifting equipment including individual components are inspected / maintained at least annually. <b>Examples of evidence</b> <ul style="list-style-type: none"> <li>• maintenance / inspection records</li> </ul>				
4.4	All manual handling equipment is marked with CE mark, and all Lifting Equipment marked with Safe Working Load (SWL). <b>Examples of evidence</b> <ul style="list-style-type: none"> <li>• Equipment labels</li> </ul>				
4.5	Staff are trained to use equipment, they use it appropriately and safely, and instruction booklets are available for reference if required. <b>Examples of evidence</b> <ul style="list-style-type: none"> <li>• Training records</li> <li>• Risk assessments</li> <li>• Instruction booklets</li> <li>• Safe Systems of Work</li> </ul>				

AREA FOR ASSESSMENT 5		THE ORGANISATION HAS SYSTEMS IN PLACE TO MONITOR AND REVIEW MANUAL HANDLING ARRANGEMENTS			
No		Yes	No	Partial	Comments (including cross reference to evidence)
5.1	<p><i>Employees do not undertake any hazardous handling activities until appropriate practical training has been provided</i></p> <p><b>Examples of Evidence</b></p> <ul style="list-style-type: none"> <li>• <i>Departmental risk assessment identifying training needs</i></li> <li>• <i>Records of managerial referrals for training</i></li> <li>• <i>Training Records</i></li> </ul>				
5.2	<p><i>Employees attendance at manual handling is recorded</i></p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• <i>Training records</i></li> <li>• <i>Course cancellation records</i></li> <li>• <i>Failure to attend rate records</i></li> </ul>				
5.3	<p>Training attendance records are monitored and agreed. Remedial action is reported at relevant meetings within the organisation</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Risk Management Committee minutes</li> <li>• Health &amp; Safety Committee minutes</li> <li>• Manual Handling Committee minutes</li> </ul>				
5.4	<p>Suitable arrangements are in place to monitor application of training and evaluation of skills within the workplace.</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Appropriately completed risk assessments</li> <li>• Supervision / observation notes</li> <li>• Previous audit reports</li> <li>• Specific workplace assessments / inspections</li> <li>• Evidence of advice sought and actions taken</li> </ul>				

No		Yes	No	Partial	Comments (including cross reference to evidence)
5.5	Manual handling accidents / incidents are reported, investigated, reviewed and appropriate action taken, with lessons learnt communicated as appropriate. Examples of evidence <ul style="list-style-type: none"><li>• Completed incident &amp; RIDDOR reports</li><li>• Investigation / Lessons learnt reports</li><li>• Unit / department minutes</li><li>• Health &amp; Safety Committee minutes</li><li>• Risk registers/ action plans</li></ul>				

## SECTION 2 - AUDIT OF MANUAL HANDLING TRAINING

AREA FOR ASSESSMENT 6		THE ORGANISATION HAS SYSTEMS IN PLACE AND SUFFICIENT RESOURCES FOR THE PROVISION OF TRAINING IN ACCORDANCE WITH THE PASSPORT SCHEME			
No		Yes	No	Partial	Comments (including cross reference to evidence)
6.1	<p>A manual handling training needs analysis, based on risk assessment, has been undertaken both corporately and at a local level.</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• <b>Corporate training needs analysis</b></li> <li>• Local risk assessment / accident data used to determine specific requirements / frequency of training needed</li> </ul>				
6.2	<p><i>A programme has been developed to meet the training requirement identified in the training needs analysis</i></p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• <i>Manual Handling Training Strategy</i></li> <li>• <i>Attendance sheets</i></li> <li>• <i>Room bookings / quarterly course plans</i></li> </ul>				
6.3	<p><i>Training is planned and recorded with reference to the standards outlined in the Passport Scheme.</i></p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• <i>Training records meet requirements of Passport Scheme</i></li> <li>• <i>Nomination &amp; attendance records</i></li> <li>• <i>System for recall and update training</i></li> <li>• <i>Lesson plans &amp; handouts</i></li> </ul>				

6.4	<p><i>The training contains the standard elements as outlined within the Passport Scheme and contains Modules A-F as appropriate to need.</i></p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• <i>Module/course plans</i></li> <li>• <i>Training records</i></li> </ul>				
6.5	<p>The Manual Handling Advisor / Trainer has dedicated administrative support.</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Organisation's Manual Handling structure</li> <li>• Job description / role profile</li> <li>• Service level agreements</li> </ul>				

AREA FOR ASSESSMENT 7		THE ORGANISATION HAS SYSTEMS IN PLACE AND SUFFICIENT RESOURCES FOR THE DELIVERY OF TRAINING IN ACCORDANCE WITH THE PASSPORT SCHEME			
No		Yes	No	Partial	Comments (including cross reference to evidence)
7.1	<p>Suitable and sufficient assessment of training environment and equipment has been undertaken.</p> <p><b>Example of evidence</b></p> <ul style="list-style-type: none"> <li>• Risk assessments</li> <li>• Maintenance/ inspection records</li> </ul>				
7.2	<p>Sufficient and appropriate equipment and training resources are provided to support Passport Scheme training requirements.</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Discreet training venue</li> <li>• Equipment inventory</li> <li>• Manual Handling Policy</li> <li>• Training programmes/ records</li> </ul>				
7.3	<p>There is a maximum ratio of 1 trainer to 6 trainees during practical techniques training.</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Attendance sheets</li> <li>• Training programmes / course plans</li> </ul>				
7.4	<p>Length of training is sufficient to encourage and develop a change in knowledge, attitude and skills with staff being given sufficient time to practice and develop practical skills under close supervision</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Lesson plans meet minimum suggested module delivery times as per Passport Scheme.</li> </ul>				

No		Yes	No	Partial	Comments (including cross reference to evidence)
7.5	<p>Systems are in place to reduce the risk of injury / ill health to staff during training.</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Health Questionnaires as detailed in the Passport Scheme or similar completed prior to, or on commencement of training</li> <li>• Procedure for referral to Occupational Health / Line Manager.</li> </ul>				
7.6	<p>Feedback is provided to Line Managers on attendance, ability of delegates to participate and any on-going training needs.</p> <p><b>Examples of evidence</b></p> <ul style="list-style-type: none"> <li>• Procedure for providing information</li> <li>• Training Records</li> </ul>				



## APPENDIX 12 - SCORING GUIDELINES FOR MANUAL HANDLING COMPLIANCE AUDIT

1. The scoring of responses to the areas for assessment contained within the audit is important if a robust indication of overall compliance is to be obtained for benchmarking purposes, and for demonstrating improvement over time. At the same time, it is important to recognise that it is the action planning and implementation processes resulting from self assessment against the audit that dictates its success.
2. The table below gives guidance on assigning scores against “Yes”, “No”, and “Partial” responses. Particular attention should be given to scoring against “Partial” responses as these call for a degree of judgement by the assessors.

**Response Score Rationale Table**

RESPONSE	SCORE	RATIONALE
NO	0%	<ul style="list-style-type: none"> <li>• No compliance anywhere in the organisation with any of the requirements set by the criterion.</li> </ul>
PARTIAL	1-29%	<ul style="list-style-type: none"> <li>• A low degree of organisation-wide compliance with the requirements set by the criterion.</li> <li>• Demonstrable evidence that a start has been made towards compliance in some or all parts of the organisation.</li> <li>• Percentage of compliance based on professional judgement by competent persons as part of the self-assessment process.</li> </ul>
PARTIAL	30-69%	<ul style="list-style-type: none"> <li>• A moderate degree of organisation-wide compliance with the requirements set by the criterion.</li> <li>• Demonstrable evidence that work is ongoing across most parts of the organisation to achieve compliance, though some directorates or departments may be in the very early stages of compliance.</li> <li>• Percentage of compliance based on professional judgement by competent persons as part of the self-assessment process.</li> </ul>
PARTIAL	70-99%	<ul style="list-style-type: none"> <li>• Substantive organisation-wide compliance with all requirements set by the criterion.</li> <li>• Demonstrable evidence that most parts of the organisation are meeting most of the requirements set by the criterion.</li> <li>• Only minor non-compliance's requiring, in the main, minor action(s).</li> <li>• Percentage of compliance based on professional judgement by competent persons as part of the self-assessment process.</li> </ul>
YES	100%	<ul style="list-style-type: none"> <li>• Full compliance across the whole organisation with all requirements set by the criterion.</li> </ul>

3. The assessors (whether external or internal) will indicate their assessment of compliance with each of the various 'Areas for Assessment', by using a 'Yes', 'No' or 'Partial' compliance mark. Where more than one element of evidence has been reviewed each of these elements will contribute to the assessment mark for each area of assessment. A 'Not Applicable' mark may also be given, and no score should be given against such assessments.
4. Full compliance can only be achieved if the organisation meets the compliance assessment in full for the whole year.
5. Partial compliance must be given in the following circumstances:
  - Where the organisation meets the compliance assessment in full, but not for the whole period of assessment; or
  - Where only part of the test has been met.
6. The allocation of scores for each of the 'Areas for Assessment' will then be made by the assessor, based on the assessments of compliance and the associated comments.
7. A table summarising scores for the overall exercise, with weightings, has been developed. This table will calculate your overall compliance score once you add your scores to Column D in the table.

Model Elements		Weighting	Score	W x S	Standard No 1	
Area for Assessment 1		100	0	0	<b>Manual Handling Passport Scheme</b>	
Area for Assessment 2		100	0	0		
Area for Assessment 3		50	0	0		
Area for Assessment 4		50	0	0		
Area for Assessment 5		50	0	0		
Area for Assessment 6		50	0	0		
Area for Assessment 7		50	0	0		
<b>TOTAL (A)</b>		<b>450</b>	<b>TOTAL SCORES (B)</b>	<b>0</b>	<b>Total % Score (B divided by A)</b>	<b>0%</b>

8. The scoring of responses to the areas for assessment contained within the audit is important if a robust indication of overall compliance is to be obtained for benchmarking purposes, and for demonstrating improvement over time. At the same time, it is important to recognise that it is the action planning and implementation processes resulting from self assessment against the audit that dictates its success.
9. The table below gives guidance on assigning scores against “Yes”, “No”, and “Partial” responses. Particular attention should be given to scoring against “Partial” responses as these call for a degree of judgement by the assessors.
10. The assessors (whether external or internal) will indicate their assessment of compliance with each of the various ‘Areas for Assessment’, by using a ‘Yes’, ‘No’ or ‘Partial’ compliance mark. Where more than one element of evidence has been reviewed each of these elements will contribute to the assessment mark for each area of assessment. A ‘Not Applicable’ mark may also be given, and no score should be given against such assessments.
11. Full compliance can only be achieved if the organisation meets the compliance assessment in full for the whole year.
12. Partial compliance must be given in the following circumstances:
  - Where the organisation meets the compliance assessment in full, but not for the whole period of assessment; or
  - Where only part of the test has been met.
13. The allocation of scores for each of the ‘Areas for Assessment’ will then be made by the assessor, based on the assessments of compliance and the associated comments.
14. A table summarising scores for the overall exercise, with weightings, has been developed. This table will calculate your overall compliance score once you add your scores to Column D in the table.

## **APPENDIX 13 - TREATMENT HANDLING GUIDELINES**

### **The Risk Assessment Process and Documentation**

For use with Treatment Handling Risk  
Assessment Forms and the  
LHB's/Trust's Treatment Handling  
Policy

With thanks to April Brooks MCSP Clinical Physiotherapy Specialist,  
Hampshire NHS PCT and Portsmouth City NHS Trust for sharing their  
work with us.

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3	Advice on the use of the Treatment Handling Guidelines
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## Advice on the use of the Treatment Handling Guidelines

- These guidelines are advisory, and should be used in conjunction with The Treatment Handling Risk Assessment Form and the LHB's/Trust's Treatment Handling Policy as well as the CSP's "Guidance in Manual Handling for Chartered Physiotherapists" and/or COT's "Manual Handling Guidelines" June 2006
- The Patient Ability Criteria should be used to guide the risk assessment process and choice of handling technique
- All staff must work within their level of competence (*Ref CSP Rules of Professional Conduct and Standards of Practice Rule 1*)
- Further information needs to be sought from the CSP's "Guidance in Manual Handling for Chartered Physiotherapists" and/or COT's "Manual Handling Guidelines" June 2006 if tasks are being delegated to others
- The task must be explained appropriately to the patient and consent given prior to any moving and/or treatment handling

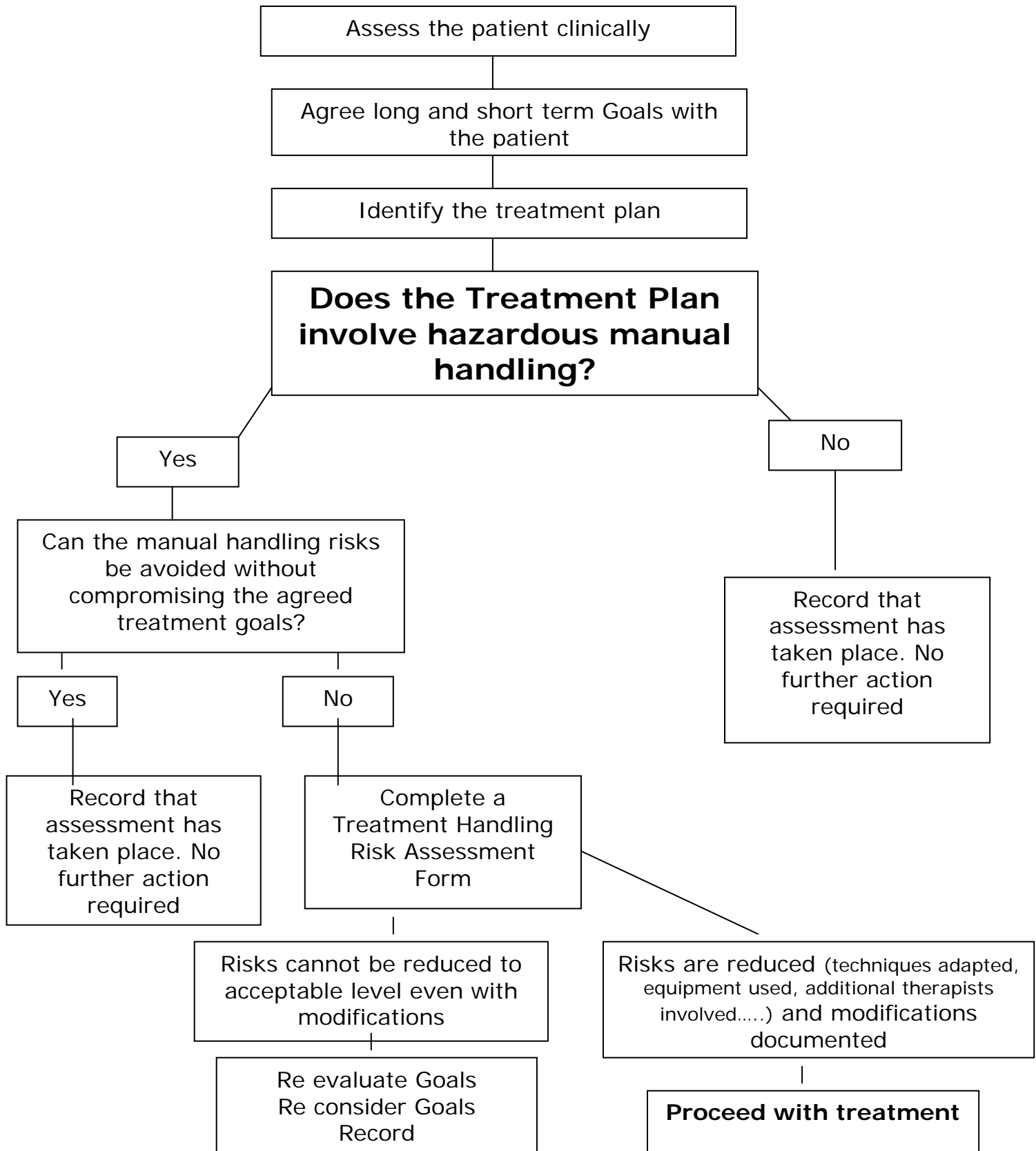
### Special Considerations

- **The REBA scores are guides only and not necessarily of "best practice", but examples of how this task is currently carried out in some areas, so care must be taken in their interpretation. These scores may need to be revised for your own areas of practice.**
- REBA reference Hignett S, McAtamney L, Rapid Entire Body Assessment (REBA), *Applied Ergonomics* 31,2002.
- These Guidelines are for the use of Therapists and are not intended for delegation or giving as handouts to parents/carers/learning support assistants
- Staff should be aware that planning their workload is an important part of reducing the risks. Variation of activities should be used to reduce repetition of high-risk tasks on any given day. Less experienced members of staff can reduce the risks by asking for additional assistance

## Clarification of Terminology

- ❖ Therapists are referred to throughout the text as “she” and the patient as “he” for clarity
- ❖ “Supervision” is to be interpreted as light tactile or verbal prompting
- ❖ “Independent” is to be interpreted as being able to complete the task without light or tactile or verbal prompting

## A. The Treatment Handling Risk Assessment Process





## **B. Patient Specific Assessment Process**

1. Assess the patient clinically.
2. Consider immediate realistic goals and functional outcomes in discussion with the patient.
3. Does the proposed treatment/therapeutic intervention involve hazardous manual handling? (If no, no risk assessment is needed).
4. Can the hazardous manual handling operation be reasonably practically avoided, when taking into consideration the utility of the intervention (the benefit to the patient) and the suitability of any aids or equipment that may be available? (If yes, record and implement changes).
5. If the hazardous handling cannot be avoided then the requirement to assess the risk arising from the task or sub-tasks (using TILE, Task, Individual, Load, and Environment) is absolute.
6. Reduce the risk arising from the hazardous manual handling, so far as is reasonably practicable by adapting the technique, the use of equipment, or the assistance of appropriately trained colleagues.
7. If satisfied:
8. Record the risk assessment and risk management protocols.
9. Proceed with the treatment/therapeutic intervention.
10. If not satisfied:
11. Re-evaluate.
12. Consider competence to proceed.
13. Re-consider goals.

## **C. Elements of a Treatment Handling Risk Assessment**

The elements of a Therapy treatment handling risk assessment follow the MHOR recommendations TILE - (task, individual therapist/carer, load (patient) and environment).

The following are examples only and in no way attempt to cover all risk encountered during therapy treatments.

### **TASK**

Does the task involve?

- ❖ A flexed position.
- ❖ Potential for twisting movements of the spine.
- ❖ Potential for an unstable base of support e.g. kneeling on the bed.
- ❖ Potential for taking the weight wholly or partially of the patient or a limb (early standing of a dependent patient).
- ❖ Abnormal movement patterns and therefore may require greater effort.
- ❖ The temptation to lift (e.g. transporting equipment).
- ❖ Pushing/pulling a load (heavy patient in a wheelchair or hoist).
- ❖ Holding a static posture (mobs, passive movements/stretches).
- ❖ Working below knee or above shoulder height (store cupboard).
- ❖ Working over a distance (pushing wheelchair, collecting equipment).
- ❖ Repeated small movements (mobs).
- ❖ Organisational issue (work rate e.g. number of new patients/patients to be seen in a given time).

### **Individual**

The therapists/technician/assistant:

- ❖ Has a musculo-skeletal injury.
- ❖ Has previous episode of back pain.
- ❖ Is tired - worked on call the night before (heavy night out!).
- ❖ Is pregnant/had recent surgery.
- ❖ Has not received adequate training/unqualified staff expected to take the lead.
- ❖ Is inappropriately dressed (jewellery, shoes, clothing).
- ❖ Is working with another member of staff (height, incompatibility, training/competence issues... the more people involved, the more risk of injury).
- ❖ Has been delegated the task.

The carer/family member:

- ❖ Any of the above apply, and additional health concerns.
- ❖ Is elderly/frail/unable to follow instructions easily.
- ❖ Is over-enthusiastic/over-protective/has unrealistic expectations.

- ❖ Has inadequate time to perform the task.

## **Load**

The patient:

- ❖ Is unable to assist.
- ❖ Confused or uncooperative.
- ❖ Has sensory loss (deafness, blindness).
- ❖ Has cognitive impairment.
- ❖ Has multiple injuries or pathology.
- ❖ Has pain.
- ❖ Is attached to medical equipment (drips, tubes, lines).
- ❖ Is more than average height or weight.
- ❖ There is a likely change in the patient's medical status (postural hypotension etc).
- ❖ Has tonal changes/altered muscle tone.
- ❖ Has altered body posture.
- ❖ Has insufficient joint/muscle activity (contractures, stiffness).
- ❖ Has impaired balance.
- ❖ Has problems with their feet.
- ❖ Has dizziness.
- ❖ Has vulnerable pressure areas/poor skin condition.
- ❖ Is tired/needs the toilet.
- ❖ Is wet (following bath or shower).
- ❖ Is fearful.

## **Environment**

The working area:

- ❖ Has lack of space due to bed/locker/equipment/clutter.
- ❖ Including a bed against the wall (e.g. in the community).
- ❖ Involves constraints of treatment cubicle (curtains, equipment).
- ❖ Includes water on the floor/potential or it (around hydro pool, bathroom, outdoors).
- ❖ Includes the use of a bed that is unsuitable for the patient (height, non-profiling, unsuitable mattress) or the handlers (it is very difficult to turn a patient on an air flow mattress).
- ❖ Has poor lighting.
- ❖ Has poor ventilation.
- ❖ Is in a humid environment.
- ❖ Contains loose pets.
- ❖ Is noisy, (TV, children, others on telephone, in Day Centre, School classroom).

It is only the risks that are documented on the Therapy Treatment Handling Risk Assessment Form. This is not exhaustive, merely some common risks encountered to prompt the completion of the form.

## Named Tasks

Task 1	Rolling
Task 2	Side Lying to sitting
Task 3	Maintaining Sitting Balance
Task 4	Sliding Board Transfer
Task5	Crouch Transfer
Task 6	Standing Transfer
Task 7	Sit to Stand
Task 8	Standing with Tilt Table
Task 9	Sit to Stand with Standing Frame
Task 10	Assisted Walking
Task 11	On to and Up from Floor
Task 12	Transfer In and Out of Car

The descriptions of tasks that follow are examples only and therapists should use their own clinical judgement depending on their clinical reasoning

## **1. ROLLING**

## **TASK 1**

### **Clinical Reasoning**

- ❖ Encourages active participation towards a functional movement goal
- ❖ Facilitates head and trunk rotation

### **Risk Assessment:**

#### **Load (patient)**

- ❖ Is it medically appropriate for the patient to roll
- ❖ Consideration is given to skin integrity
- ❖ Consideration is given to care of attached equipment such as tubes or lines
- ❖ Patient fulfils criteria

#### Patient Ability Criteria

- ❖ Patient can be positioned in side lying by therapy staff
- ❖ Patient can tolerate movement from lying to side lying

### **Environment**

- ❖ Potential hazards to be identified and removed where possible
- ❖ Sufficient bed space to be available to allow the patient to roll safely onto their sides
- ❖ Pressure relieving mattress may be deflated or stabilised to give firm base of support
- ❖ The top of the mattress must be at a comfortable working height for the therapy staff
- ❖ The height of the bed may need to be adjusted to a safe working height for the therapists

### **Particular Hazards**

- ❖ Changes in medical status of the patient
- ❖ Changes in level of cooperation/behaviour of the patient
- ❖ Tonal changes
- ❖ Patient may roll to close to the edge of the mattress

## **ROLLING**

**REBA** score for therapist 1 and 2 = 4, medium risk

The patient is lying in the centre of the bed. Therapists apply ergonomic and biomechanical principles to reduce risk of injury at all times.

- Two therapists assist with the task, both standing on the side of the bed to which the patient will turn
- Therapist (1) is at the head of the bed and takes the lead, giving instructions clearly for therapist (2) and the patient to hear
- The patient is encouraged to turn his head towards (1), and to move the near arm slightly away from his body. Assistance is given as appropriate
- The bed is raised to the appropriate working height
- Therapist (2) encourages the patient to bend the far knee with the sole of the foot flat on the bed, or to cross the far ankle over the near one
- Therapist(s) place hands on the patient as appropriate
- On the agreed command, given by Therapist(1) (normally "Ready, Steady, Roll") the therapists step back, rolling the patient as they do so

## **Modifications**

- (a) Where it is not possible to raise the height of the bed, and where the weight limit of the bed allows, the therapists may each place a knee on the bed to reduce stretching and step back off the bed as the person rolls. This method may not be appropriate with some pressure relieving mattresses
- (b) A slide sheet may be used to facilitate turning
- (c) Pillows may be used to support a patient 30 degree tilt
- (d) If the patient is able to sufficiently assist, one therapist may perform the task

## **Alternatives**

Turning Mattress

## **2. SIDE LYING TO SITTING**

## **TASK 2**

### **Clinical Reasoning**

- Encourages active participation towards a functional movement goal
- Facilitates trunk rotation
- Facilitates weight bearing around the hip
- Facilitates trunk and head righting reactions

### **Risk Assessment:**

#### **Load (patient)**

- It is medically appropriate for the patient to sit
- Consideration is given to skin integrity

- Consideration is given to care of attached equipment such as tubes or lines
- Patient fulfils criteria

#### Patient Ability Criteria

- Patient can be positioned in side lying by therapists
- Patient can tolerate movement from side lying to sitting
- Patient is able to tolerate and maintain sitting with therapists

#### **Environment**

- Potential hazards to be identified and removed where possible
- Sufficient bed space to be available to allow the patient to roll safely on his side
- Pressure relieving mattress may be deflated or stabilised to give firm base of support
- The top of the mattress must be at a comfortable working height for the therapy staff
- The height of the bed may need to be adjusted when the patient is sitting as appropriate

#### **Particular Hazards**

- Changes in medical status of the patient
- Changes in level of co-operation / behaviour of the patient
- Tonal changes

#### **SIDE LYING TO SITTING**

**REBA** score using a profiling bed = 3, low risk

**REBA** score using ordinary bed = 8, high risk

The patient is in side lying at the edge of a bed and therapists should apply ergonomic and biomechanical principles to reduce risk of injury at all times.

Two therapists assist with the task, Therapist (1) standing in front of the patient and Therapist (2) behind, using 1 knee on the bed or kneeling on the bed *if the weight allowance for the bed allows*

- Therapist(1) maintains the patient in side lying, using appropriate hand support for the patient's needs
- Therapist (2) supports the patient from behind using appropriate hand support underneath the patient's shoulder girdle and on the pelvis or trunk. Her role is to facilitate the movement of the trunk.

- Therapist (1) maintains flexion of the patient's hips and knees, and provides additional support around the patient's scapulae (as appropriate) to support the upper trunk. Her role is to control the movement of the legs and assist side flexion of the trunk.
- The patient is encouraged to assist by raising his head from the pillow and pushing down on the mattress with his hand and elbow.
- Movement takes place on the agreed command, given by Therapist (1) (normally 'Ready, Steady, Sit')

### **Modifications**

- (a) Using a profiling bed, the head of the bed may be raised to bring the patient up into long sitting or high side lying
- (b) A slide sheet may be used to assist with the movement of the legs towards the edge of the bed
- (c) If the patient is able to sufficiently assist, and is able to sit independently, one therapist may perform the task

### **Alternatives**

Use of a hoist

## **3. MAINTAINING SITTING BALANCE**

## **TASK 3**

### **Clinical Reasoning**

- Facilitates functional sitting balance
- Facilitates alignment of lower limbs, trunk alignment over the pelvis and body symmetry
- Facilitates trunk stability

### **Risk Assessment:**

#### **Load (patient)**

- It is medically appropriate for the patient to sit
- Consideration is given to skin integrity
- Consideration is given to care of attached equipment such as tubes or lines
- Patient is wearing suitable footwear (shoes or non-slip socks) or bare feet/foot as appropriate
- Patient fulfils criteria

<u>Patient Ability Criteria</u>
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- Patient can be positioned in sitting by therapy staff
- Patient is able to tolerate and maintain sitting with staff

### **Environment**

- Potential hazards to be identified and removed where possible
- Pressure relieving mattress to be put in Constant Firm Mode to give firm base of support
- The top of the mattress or plinth must be at a comfortable working height for the therapy staff
- The height of the bed may need to be adjusted as appropriate

### **Particular Hazards**

- Changes in medical status of the patient, e.g. postural hypotension
- Changes in level of co-operation / behaviour of the patient
- Tonal changes
- Poor pain control
- Poor head control

### **MAINTAINING SITTING BALANCE**

**REBA** score therapist 1 = 2, low risk

**REBA** score therapist 2 = 5, medium risk

The patient is in sitting at the edge of a bed (or on a bench or stool), and therapists should apply ergonomic and biomechanical principles to reduce risk of injury at all times.

- Two therapists assist with the task, therapist (1) standing or sitting in front of the patient and therapist (2) kneeling behind (where the weight allowance of the bed allows, or therapist (1) and therapist (2) sitting or standing on either side of the patient.
- The therapists' hands are placed appropriately to provide stability where required and to assist the patient to achieve alignment in sitting. The patient is encouraged to maintain a symmetrical sitting posture.

### **Modifications**

- a) May require more therapy staff:
- b) If the patient has poor head control one therapist may be required to support the head,
- c) If the patient is attached to a drip or drain assistance may be required

- d) Additional equipment may be used, such as a high/low table in front of the patient.

### **Alternatives**

- Using a profiling bed, the head of the bed may be raised to bring the patient up into long sitting and the patient encouraged to sit independently of support.
- If the patient is able to sufficiently assist, and is able to sit independently, one therapist may perform the task.

## **4. SLIDING BOARD TRANSFER**

### **TASK 4**

### **Clinical Reasoning**

- Encourages active participation in a functional transfer
- Facilitates lateral weight transference
- Facilitates weight bearing through hip and knee
- Facilitates balance reactions

### **Risk Assessment:**

#### **Load (patient)**

- It is medically appropriate for the patient to transfer
- Consideration is given to skin integrity
- Consideration is given to care of attached equipment such as tubes or lines
- Patient fulfils criteria
- Patient is wearing suitable footwear (well fitting shoe(s) or non-slip sock(s))

#### **Patient Ability Criteria - Sliding Board Transfer**

- Patient is able to sit on the transfer surface (e.g. bed, plinth) with minimal assistance of one
- Patient is able to flex forward in the trunk
- Patient is able to transfer their weight laterally
- Patient can place his feet / foot on the floor
- Patient's arm can be placed along the board to assist movement

### **Environment**

- The height of the two transfer surfaces (e.g. bed and wheelchair) are adjusted so that they are the same. If there is any height difference this is to be considered and recorded as part of the risk assessment process.

- Brakes are applied to equipment as appropriate.
- Arm rests and foot plates are removed as appropriate, the back of the wheelchair may be folded.
- Sufficient space is available to allow the transfer to be performed safely.
- A suitable sliding board is positioned with one third under the patient, one third to bridge the gap and one third on the new supporting surface.
- Consideration is given to the finishing position of the patient, and any adjustment that may need to be made to equipment.
- Consideration is given to the care of any tubes or lines attached to the patient.

### **Particular Hazards**

- Movement of the sliding board
- Trapping of patient's skin or fingers under the board
- Shearing forces between the patient's gluteal muscles and the board which compromise tissue viability
- Temptation by the therapist(s) to use their own effort to move the patient if the patient is wearing a handling belt
- Changes in level of co-operation / behaviour of the patient
- Changes in the medical status of the patient
- Tonal changes
- The patient may reach too far too quickly and lose his balance

### **SLIDING BOARD TRANSFER**

REBA score for therapist 1 ½ Kneeling = 6, medium risk

The patient is sitting ready to transfer Therapists apply ergonomic and biomechanical principles to reduce risk of injury at all times.

- Two therapists assist with the task, Therapist (1) standing in front/half kneeling in front of the patient, Therapist (2) behind. They work together to facilitate lateral weight transference and placement of the transfer board.
- The role of Therapist (1) is to facilitate weight transfer through the lower limb(s), and weight transfer through the pelvis. The placement of her hands will reflect the missing components of the movement that require facilitation.
- The role of Therapist (2) is to facilitate lateral weight transfer (trunk elongation and weight transfer over the pelvis). Her hand placement will reflect the missing components that require facilitation, and may be placed on the patient's pelvis, trunk or rib cage.

- On the appropriate command, given by Therapist (1) (usually 'Ready, steady, slide') the patient is encouraged to use his upper limbs to assist with the transfer.
- The therapist takes up her position in front or behind the patient. Her hand placement will reflect the missing components of the movement that require facilitation.
- The therapist may give verbal and or light tactile prompts. Her hand placement will reflect the missing components of the movement that require facilitation.

### **Modifications**

- a) Patient may wear a handling belt
- b) May require more staff to assist if the patient has tubes or lines attached
- c) Use of different types of sliding board e.g. banana board, short transfer board, S-shaped board, Easyglide board.

### **Alternatives**

- Use of hoist
- Crouch Standing or Standing Transfer with 2 (if meets Patient Ability Criteria)

## **5. CROUCH TRANSFER**

### **TASK 5**

#### **Clinical Reasoning**

- Encourages active participation in working towards a functional transfer
- Facilitates weight bearing through the legs with trunk flexion in preparation for sit to stand
- Facilitates weight transference through the legs
- Facilitates movement around the pelvis in preparation for lateral movement

#### **Risk Assessment:**

##### **Load (patient)**

- It is medically appropriate for the patient to stand and transfer
- Consideration is given to skin integrity and to care of a tracheotomy, tubes or lines
- Patient is wearing suitable footwear (shoes or non-slip socks or bare feet)
- Patient fulfils criteria

<h5><b><u>Patient Ability Criteria – Crouch Transfer</u></b></h5>
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- |  |
|--|
| <ul style="list-style-type: none"><li>▪ Patient has functional sitting balance</li></ul> |
|--|

- Patient is able to move from chair sitting to edge sitting with assistance
- Patient can place their feet on the floor
- Patient is able to initiate the sit to stand with assistance
- Patient is able to weight bear through both legs whilst maintaining crouch standing
- Patient is able to step / transfer weight laterally in crouch standing with assistance

**Environment**

- The heights of the two transfer surfaces (e.g. bed and wheelchair) are adjusted so that they are the same. If there is any height difference this is to be considered and recorded as part of the risk assessment process. Supporting surfaces are arranged at 90° to one another
- Brakes are applied to equipment as appropriate
- Arm rest(s) and foot rests are removed as appropriate
- The wheelchair back rest may be folded if appropriate
- Sufficient space is available for equipment and therapist(s) to allow the transfer to be performed safely
- Consideration is given to the finishing position of the patient, and any adjustment that may need to be made to equipment
- Consideration is given to the care of any tubes or lines attached to the patient

**Particular Hazards**

- Temptation by the therapist(s) to use their own effort to lift and move the patient
- Poor working postures
- Changes in level of co-operation / behaviour of the patient
- Changes in the medical status of the patient
- Tonal changes
- The patient may try to move sideways before having achieved forward weight transference
- The patient may not participate in the forwards weight transference, in which case the transfer must be abandoned
- The patient may reach unexpectedly for the new supporting surface and the transfer becomes unbalanced
- The patient may experience difficulty in placing his feet

**CROUCH TRANSFER**

**REBA** score therapist 1 = 4, medium risk

**REBA** score therapist 2 = 6, medium risk

Therapists should apply ergonomic and biomechanical principles to reduce risk of injury at all times. The patient is sitting ready to transfer. The patient's arms may be across their body, held at their sides, around the lower back of Therapist (1) or reaching toward the new surface in accordance with clinical goal. The patient may rest their forehead on the front of the therapist's shoulder. Therapists apply ergonomic and biomechanical principles to reduce risk of injury at all times

Two therapists assist with the task, therapist (1) standing in front of the patient, therapist (2) behind.

- The role of Therapist (1) is to control the trunk and facilitate forward weight transference. She stands with a wide base and may use her feet to stop the patient's feet from slipping, and her legs to give counter-pressure or support to the patient's knee(s) as appropriate. She places her hands to facilitate weight transference e.g. on the patient's pelvis or thorax, controlling the transfer and facilitating extensor recruitment.
- The role of Therapist (2) is to guide the patient's pelvis during the transfer. She must avoid leaning forward over the back of the chair and must ensure she maintains a good posture throughout.
- On the appropriate command, given by therapist (1) (usually 'Ready, steady, stand') the patient is encouraged to use their upper limbs to assist with the transfer.
- The Therapist takes up the position of therapist (1) above. The patient is guided forwards until he is weight bearing through his legs. He is kept in a crouch standing position and guided through a turn to the new supporting surface, when he sits.

**Crouch Transfer with Supervision**

- The Therapist may give verbal and or light tactile prompts to direct the transfer.

**Modifications**

- a) Patient may wear a handling belt
- b) May require more staff to assist if the patient has tubes or lines attached
- c) The patient may use both upper limbs to assist the transfer
- d) A stool or other solid structure may be placed in front of the patient to encourage forward flexion
- e) The patient is allowed to stand during the transfer

**Alternatives**

- Use of stand aid equipment e.g. Arjo 'Steady', Rotunda
- Transfer with sliding board
- Use of turntable
  - Standing Transfer, Use of hoist and walking jacket

**6. STANDING TRANSFER****TASK 6****Clinical Reasoning****Gives the experience of normal movement**

- Encourages active participation in working towards functional independence
- Increases sensory and proprioceptive input
- Facilitates weight bearing and weight transference through the legs
- Improves orientation

**Risk Assessment:****Load (patient)**

- If a patient is non weight bearing (eggshell weight bearing) the patient must be able to lift the leg off the floor independently throughout the task
- It is medically appropriate for the patient to stand and transfer
- Consideration is given to skin integrity and to care of a tracheotomy or attached equipment such as tubes or lines
- Patient is wearing suitable footwear (shoes or non-slip socks)
- Patient fulfils criteria

**Patient Ability Criteria – Standing Transfer**

- Patient has functional sitting balance
- Patient can place their feet/foot on the floor
- Patient is able to move from sitting to standing with assistance
- Patient is able to transfer weight through leg(s) as appropriate
- Patient is able to release leg(s) to initiate stepping with assistance

**Environment**

- The heights of the two transfer surfaces (e.g. bed and wheelchair) are adjusted so that they are the same. If there is any height difference this is to be considered and recorded as part of the risk assessment process. Supporting surfaces are arranged as close as possible
- Brakes are applied to equipment as appropriate
- Arm rest(s) and foot rests are removed as appropriate
- The wheelchair back rest may be folded if appropriate
- Sufficient space is available for equipment and therapist(s) to allow the transfer to be performed safely
- Consideration is given to the care of any tubes or lines attached to the patient

### **Particular Hazards**

- Temptation by the therapist(s) to use their own effort to lift and move the patient
- Poor working postures
- Changes in level of co-operation / behaviour of the patient
- Changes in the medical status of the patient e.g. postural hypotension
- Tonal changes
- The patient may try to turn before achieving stable standing balance
- The patient may lose their balance
- The patient may attempt to sit down before the backs of his knees are in contact with the chair

### **STANDING TRANSFER**

**REBA** score = 2, low risk

The patient is sitting ready to transfer. Therapists should apply ergonomic and biological principles to reduce risk of injury at all times.

- Two therapists assist with the task, standing on either side of the patient.
- The therapists facilitate sit to stand and extensor recruitment. The patient may be encouraged to weight bear through their upper limbs according to the clinical goal.
- The placement of the Therapists' hands will reflect any missing components in the patient's own activity e.g. shoulder girdle / hands/ pelvis / lower limb, and will be discussed and agreed prior to performance of the task.
- Therapist (1) gives verbal instructions.



- The Therapists assist with the movement from standing to sitting on the new supporting surface.

### **Standing Transfer with one**

- The Therapist stands at the appropriate side of the patient
- Giving verbal instruction the Therapist assists with sitting to standing, weight transference and stepping / placing of feet.
- The placement of the Therapist's hands will reflect any missing components in the patient's ability.

### **Standing Transfer with Supervision**

- The Therapist may give verbal and or light tactile prompts to direct the transfer.

### **Modifications**

- a) Patient may wear a handling belt
- b) May require more staff to assist if the patient has tubes or lines attached
- c) The patient may use both upper limbs to assist the transfer
- d) The 2 Therapists may stand in front and behind the patient. A therapist in front may begin in kneeling
- e) A table or other supporting surface in front of the patient may be used
- f) The patient may use an appropriate walking aid to assist the transfer

### **Alternatives**

- Use of stand aid equipment e.g. Arjo 'Steady', Rotunda
- Transfer with sliding board
- Crouch Standing Transfer
- Use of hoist and walking jacket
- Use of turntable

## **7. SIT TO STAND**

## **TASK 7**

### **Clinical Reasoning**

- Gives the experience of normal movement
- Encourages active participation in working towards functional independence
- Increases sensory and proprioceptive input
- Improves recruitment of postural tone

- Improves orientation

**Risk Assessment:****Load (patient)**

- If a patient is non weight bearing (eggshell weight bearing) the patient must be able to lift the leg off the floor independently throughout the task
- It is medically appropriate for the patient to stand
- Consideration is given to skin integrity and to care of a tracheotomy or attached equipment such as tubes or lines
- Patient is wearing suitable footwear (shoes or non-slip socks)
- Patient fulfils criteria

**Patient Ability Criteria – Sit to Stand**

- Patient is able to move from chair sitting to edge sitting
- Patient is able to maintain sitting with assistance
- Patient can place and maintain their feet/foot on the floor
- Patient is able to give assistance in the sitting to standing process
- Patient is able to maintain an upright/midline position in standing with assistance

**Environment**

- Brakes are applied to equipment as appropriate
- Arm rest(s) and foot plates are removed as appropriate
- Sufficient space is available for equipment and therapist(s) to allow the task to be performed safely
- Consideration is given to the care of any tubes or lines attached to the patient

**Particular Hazards**

- Temptation by the therapist(s) to use their own effort to lift the patient
- Poor working postures
- Changes in level of co-operation / behaviour of the patient
- Changes in the medical status of the patient e.g. postural hypotension
- Tonal changes
- The patient's knees may give way in standing
- The patient may reach forward for a supporting surface or walking aid before they are stable in standing

- The patient may attempt to sit down before the backs of his knees are in contact with the chair

### **SIT TO STAND**

**REBA** score when both therapists standing on either side of the patient = 7, medium risk.

The patient is sitting and ready to stand

Therapists should apply ergonomic and biomechanical principles to reduce risk of injury at all times.

### **Sit to Stand with 2**

- Two therapists assist with the task, standing on either side of the patient or Therapist (1) in front and Therapist (2) behind, depending on the clinical goal.
- The therapists facilitate chair sitting to edge sitting, Therapist (1) giving verbal instruction.
- Assistance is given to encourage the patient to transfer his weight forwards and extend the trunk, hips and knees as he comes up into standing. The patient may be encouraged to weight bear through his upper limbs according to the clinical goal.
- The patient is encouraged to maintain a midline position in standing with appropriate assistance. The hand positions of the therapists will reflect the patient's ability and any missing component of the movement. The therapists will **not** be taking the patient's weight.
- Checking that the patient is still in the optimum position in relation to the chair, the patient is assisted to sit. The patient may be encouraged to place his hands on the arms of the chair according to the clinical goal.

### **Sit to Stand with 1**

- The Therapist stands to one side of the patient or in front, with adequate space to assist.
- Giving verbal instruction the Therapist gives light tactile and/or verbal assistance with trunk flexion then hip, knee and trunk extension until the patient is in standing.
- The placement of the Therapist's hands will reflect any missing components in the patient's ability.

### **Sit to Stand with Supervision**

- The therapist gives verbal and/or light tactile prompts as appropriate to direct the task.

### **Modifications**

- a) May require more staff to assist if the patient has tubes or lines attached
- b) The patient may use both upper limbs to assist
- c) A variable height table (with or without knee support as appropriate) may be used in front or either side of the patient
- d) The patient may wear a handling belt
- e) The patient may use an appropriate walking aid to assist the task

### **Alternatives**

- Use of stand aid equipment e.g. Arjo 'Steady'
- Use of a riser-recliner chair
- Use of Standing Frame

## **8. STANDING WITH TILT TABLE**

## **TASK 8**

### **Clinical Reasoning**

- Gives the experience of standing
- Stimulates postural activity
- Increases sensory and proprioceptive input
- Maintains joint range of movement
- Improves orientation
- Aids circulation and bladder / bowel activity

### **Risk Assessment:**

#### **Load (patient)**

- It is medically appropriate for the patient to be in a standing posture
- Consideration is given to skin integrity and to care of a tracheotomy or attached equipment
- Patient fulfils criteria

#### **Patient Ability Criteria – Standing with Tilt Table**

- Patient is able to tolerate gradual change in posture from lying to standing
- Patient has sufficient joint range to be adequately supported by the equipment straps

### **Environment**

- Brakes are applied to equipment as appropriate
- Sufficient Pillows are placed at the head end, and the equipment straps are checked and prepared. The tray (if to be used) is checked and prepared
- Sufficient space is available for equipment and therapist(s) to allow the task to be performed safely, and the patient's wheelchair positioned at an appropriate distance from the Tilt Table to allow for transfer of the patient by hoist in supine or sitting
- Brakes are applied to the wheelchair and footplates removed
- Consideration is given to the care of any tubes or lines attached to the patient after the transfer

### **Particular Hazards**

- Changes in level of co-operation / behaviour of the patient
- Changes in the medical status of the patient e.g. postural hypotension –this may require monitoring, and the patient should be returned to a horizontal position at the first signs of distress
- Tonal changes- in particular increased extensor tone in the lower limbs (use of the Tilt Table is not considered useful for patients with severe extensor spasticity)
- The patient's head and shoulders may fall forward with the patient 'hanging' on the trunk strap. To avoid this the table is positioned a few degrees short of vertical
- The narrowness of the Tilt Table requires care to be taken when positioning the patient initially; the patient must always be closely supervised
- Instructions on the use of the particular table are to be followed and supervision is to be given on first use of a particular model

### **STANDING WITH TILT TABLE**

**REBA** score = 3, low risk.

The patient is transferred from wheelchair to Tilt Table using a hoist or from bed to Tilt Table using a PAT slide as per trust policy, and positioned appropriately. If appropriate the patient is given the control pad for the Tilt Table.

Therapists should apply ergonomic and biomechanical principles to reduce risk of injury at all times.

- The therapists apply thoracic, pelvic and knee straps and give verbal information to the patient regarding the process.
- For the manual table, the therapists take a walk standing position facing the foot of the bed on either side of the Tilt Table (for electronic table see following).

- The therapists release the handles and slowly move it until the patient is in a standing position. This may be done gradually with rest periods at different angles, according to the clinical goal.
- Pillows will be removed as appropriate.
- The handles are locked.
- Before lowering all straps are checked and pillow(s) replaced. Therapists take up a walk standing position facing the head of the bed on either side of the Tilt Table. The handles are released and the patient gradually lowered to a supine position.
  
- For the electronic table, the 'Up' button is pressed until the patient is at the angle required according to the clinical goal.
- Once the patient is in position, a therapist moves to position the tray (if required) and complete treatment objectives.
- Before lowering all straps are checked and pillow(s) replaced. The patient is gradually lowered to a supine position.

#### **Modifications**

- a) May require more staff to assist if the patient has tubes or lines attached, and to reassure the patient if necessary
- b) Loss of joint range (particularly at the ankles and hips) may be accommodated using suitable padding (e.g. a towel). Particular care must be taken to position the patient safely and securely before starting the manoeuvre.
- c) The therapist may remove or loosen a supporting strap to facilitate postural activity in standing. This will be re-applied before moving the table.

#### **Alternatives**

- Use of stand aid equipment e.g. Arjo 'Encore' or 'Stedy' if the patient fulfils the ability criteria
- Use of a hoist and walking jacket
- Use of Standing Frame
- Prone Standing Table (particularly for patients with increased extensor tone)

## **9. SIT TO STAND WITH STANDING FRAME**

## **TASK 9**

### **Clinical Reasoning**

- ***Gives the experience of normal movement***

- Stimulates recruitment of postural tone
- Increases sensory and proprioceptive input
- Maintains joint range of movement
- Improves orientation
- Stimulates kidney drainage, digestion, respiratory function,

**Risk Assessment:****Load (patient)**

- It is medically appropriate for the patient to be in a standing posture
- Consideration is given to skin integrity and to care of a tracheotomy or attached equipment
- Patient fulfils criteria

**Patient Ability Criteria – Sit to Stand with Standing Frame**

- Patient is able to move from chair sitting to edge sitting
- Patient is able to maintain sitting with assistance
- Patient is able to place his feet on the floor
- Patient is able to give assistance in the sitting to standing process
- Patient is able to weight bear in standing (*though may be unable to maintain midline position or have sufficient hip and knee control to maintain standing*)

**Environment**

- There is sufficient space for a wheelchair transfer into the frame or for transfer from plinth to frame
- Straps are checked for safety and placed within reach
- Other equipment required is within reach (e.g. pillows for tray)

**Particular Hazards**

- Therapists must resist the temptation to lift
- Changes in level of co-operation / behaviour of the patient
- Pain in joints due to positioning and alignment
- Trauma to the patient's shoulder

**SIT TO STAND WITH STANDING FRAME**

The patient is sitting either on a plinth or in a wheelchair and is ready to stand using the frame. The patient is wearing appropriate footwear or his feet may be bare in

accordance with clinical goals. He may be encouraged to push on his arms from the supporting surface or his arms may be by his sides, in accordance with clinical goals. Therapists should apply ergonomic and biomechanical principles to reduce risk of injury at all times.

The frame is positioned so that it is accessible for the patient from their wheelchair or the plinth. The straps and supports are adjusted appropriately.

With the foot plates removed the wheelchair should move forwards within the frame so that the patient's feet can be positioned correctly (this is not possible with some wider wheelchairs, and a plinth must then be used).

- It may be preferable to position the frame in front of the corner of the plinth. Some patients feel unsafe in this position and the frame is then positioned in front of the plinth. The height of the plinth is adjusted appropriately.
- The therapists position themselves on either side of the patient, facing the direction of movement.
- The patient comes forward to edge sit.
- The therapists stand close to the patient and support the pelvis and trunk, placing their hands as appropriate.
- Therapist (1) gives verbal instruction (usually 'Ready, steady, stand') and the therapists assist the patient from sitting to standing.
- Once patient is in upright position all straps and supports should be secured appropriately

#### **On completion of treatment**

- The wheelchair / plinth is positioned and the brakes applied. The patient may assist with his arms, or place his arms by his side. The therapists stand close to the patient, placing their hands as appropriate.
- On the instruction of Therapist (1) the pelvic strap is released and the patient assisted to sit, the therapists again facing the direction of movement and transferring their own weight through their legs.

#### **Modifications**

- (a) May require more staff to assist if the patient has tubes or lines attached, and to reassure the patient if necessary
- b) A thoracic / trunk strap may be used with appropriate frame support



- c) The knee strap may be adjusted to accommodate different degrees of knee flexion
- (d) Rolls and wedges may be used to achieve correct alignment (e.g. a rolled towel between the knees to enable hip abduction, or a small wedge beneath the foot to achieve foot/floor contact)

### **Alternatives**

- Use of stand aid equipment e.g. Arjo 'Steady' if the patient fulfils the ability criteria
- Use of alternative standing frame
- Use of a hoist and walking jacket
- Use of Tilt Table

## **10. ASSISTED WALKING**

### **TASK 10**

#### **Clinical Reasoning**

- Facilitates normal movement and gait pattern
- Increases sensory and proprioceptive input
- Maintains joint range of movement
- Promotes independence

#### **Risk Assessment:**

##### **Load (patient)**

- If a patient is non weight bearing (eggshell weight bearing) the patient must be able to lift the leg off the floor independently throughout the task
- It is medically appropriate for the patient to be walking
- Consideration is given to attached equipment such as tubes or lines
- The patient is wearing suitable footwear (shoes or non-slip socks)
- Patient fulfils criteria

Patient Ability Criteria – Assisted Walking

- Patient is able to move from chair sitting to edge sitting
- Patient is able to maintain sitting with assistance
- Patient is able to place his feet/foot on the floor
- Patient is able to move from sitting to standing with assistance
- Patient is able to weight bear and maintain upright/midline position in standing  
*(though requires assistance from therapists to  
a) transfer weight, b) to release leg, then c) to place foot whilst maintaining  
stand)*

### **Environment**

- There is sufficient space for the patient to stand and walk with therapist(s) where needed
- Where a walking aid is to be used it has been checked for safety and is at hand
- The floor is dry and clear of hazards

### **Particular Hazards**

- Changes in level of co-operation / behaviour of the patient
- Changes in medical status of the patient (e.g. postural hypotension)
- Tonal changes during walking
- Fatigue

### **ASSISTED WALKING**

**REBA** score = 2, low risk

The patient is standing and ready to walk and wearing appropriate footwear.

Therapists apply ergonomic and biomechanical principles to reduce risk of injury at all times.

- Therapist (1) takes the lead and gives verbal instructions. The method of facilitation and position of hands is discussed and established before the task is undertaken (e.g. proximally or distally). Hand position will vary according to the patient's level of ability and will reflect the component of movement requiring assistance. Therapist (1) will encourage weight transference and release, and work with Therapist (2) to facilitate the swing through phase of walking.
- The therapist uses light tactile and/or verbal prompt in the stand to weight transference phase, and facilitates the release – swing through phase. Hand positions chosen will reflect the missing components of movement that require assistance.

- The therapist uses light tactile and/or verbal prompts throughout each phase of walking, as appropriate.

### **Modifications**

- (a) May require more staff to assist if the patient has tubes or lines attached, and to provide a chair / wheelchair to follow behind the patient in case they need to sit down
- (b) The patient may use a suitable walking aid to assist the task

### **Alternatives**

- Use of a hoist and walking jacket
- Walking within parallel bars
- Use of Handling belt

## **11. ON TO AND UP FROM THE FLOOR**

## **TASK 11**

### **Clinical Reasoning**

- Facilitates normal movement
- Promotes independence
- Reduces anxiety in a patient who has fallen / may fall

### **Risk Assessment:**

#### **Load (patient)**

- It is medically appropriate for the patient to be getting on to and up from the floor
- Consideration is given to the patient's level of anxiety regarding the task
- Patient is wearing suitable footwear (shoes or non-slip socks)
- Patient fulfils criteria

<h4><b><u>Patient Ability Criteria – On to and up from the Floor</u></b></h4>
---

- |   |
|---|
| <ul style="list-style-type: none"><li>▪ Patient has independent sitting balance</li></ul> |
|---|

- Patient has sufficient joint range and/or muscle power in upper and/or lower limbs to achieve the task
- Patient must be able to comply with instructions

**Environment**

- There is sufficient space for the task to be completed safely
- There is a suitable sturdy object, such as a bed or chair, that the patient may use to assist in completing the task
- A 'halfway – height ' object such as a stool or block may be at hand

**Particular Hazards**

- Potential for poor posture of therapist(s)
- Temptation for therapist to lift in assisting the patient up from the floor
- Changes in level of co-operation / behaviour of the patient
- Tonal changes
- Over-exertion by the patient
- Joint pain

**ONTO AND UP FROM THE FLOOR**

**REBA** score = 6, medium risk.

The patient is sitting on a firm surface, such as a bed or chair, with their feet on the floor, ready to perform the task. Therapists should apply ergonomic and biomechanical principles to reduce risk of injury at all times. The therapist(s) position(s) will change according to the patient's needs, providing light tactile guidance as appropriate.

**Example 1**

- A stool or block is placed in front of the patient
- Using his arms on the stool the patient comes forward, turns and lowers himself to sit on it.
- The patient practises transferring back onto the bed / chair before proceeding to the next stage.
- The patient lowers himself on to the stool, as before. Placing his arms on either side of the stool, the patient lowers himself to the floor, using his arms and legs to support. The patient rests in this sitting position before placing his arms behind

and onto the stool and lifting his body back up onto it, pushing up with feet and hands.

- The patient practises transferring from floor to stool before proceeding to the next stage.
- From sitting on the floor the patient may move through high side sitting to side lying and supine lying on the floor. After a rest (for which support pillows may be required) the patient reverses the process.

## **ON TO AND UP FROM THE FLOOR**

### **Example 2**

- The patient starts in symmetrical standing facing a firm surface such as a bed or chair.
- He reaches with both hands and places them on the supporting surface of the bed / chair.
- Whilst weight bearing through his upper limbs, the patient lowers himself into a half kneeling position, facing the bed / chair.
- The patient practices rising from this position before proceeding with the task.
- The patient repeats the task to the half kneeling position and moves into upright kneeling, maintaining upper limb support from the bed / chair.
- Turning from the bed / chair to one side, the patient gets in to four point kneeling. The patient lowers their hips sideways until they are in side sitting, and may or may not move into side and supine lying.
- After a rest (for which support pillows may be required) the patient reverses the process.

### **Modifications**

(a) In example 2 the patient may rise from half kneeling along side the bed / chair using one hand for support, the stronger leg next to the surface. Raising from this position the patient transfers his bottom on the bed / chair. This method may be useful for patients with hemiplegia.

(b) Additional therapist(s) may be required

(c) A hoist must be used if at any stage the patient can not rise without assistance from therapists

### **Alternatives**

- Use of a hoist
- Use of Mangar Elk or similar riser

## **12. TRANSFER IN AND OUT OF A CAR**

## **TASK 12**

### **Clinical Reasoning**

- Promotes independence and safe practice

### **Risk Assessment:**

#### **Load (patient)**

- If a patient is non weight bearing (eggshell weight bearing) the patient must be able to lift the leg off the floor independently throughout the task
- It is medically appropriate for the patient to be getting in and out of a car (care must be taken following orthopaedic surgery)
- The patient is wearing suitable out door clothing and footwear (shoes)
- Consideration is given to the patient getting out of the car safely at the end of the journey
- Patient fulfils criteria

#### **Patient Ability Criteria – Transfer in and out of a Car**

- Patient is able to complete a crouch standing transfer with therapist(s)

Or

- Patient is able to complete a sliding transfer with therapist(s)

Or

- Patient is able to complete a standing transfer with therapist(s)

### **Environment**

- The car is parked in a way that ensures sufficient space for the task
- The car door is open as wide as possible
- The front passenger seat is set back to allow space
- The foot plates and arm rest near to the car are removed from the wheelchair

- The wheelchair is positioned at an angle close to the open door to minimise the distance from wheelchair to car, and the wheelchair brakes are applied

### **Particular Hazards**

- Potential for poor posture of therapist(s)
- Temptation for therapist to take the patient's weight in assisting them into the car
- Changes in level of co-operation / behaviour of the patient
- Changes in medical status of the patient
- Tonal changes
- Over-exertion by the patient
- The heights of the wheelchair and car seats may not be compatible. The patient may have difficulty transferring weight sideways into the car.
- The patient may knock his leg(s) or head
- The patient may feel unsafe sitting in the car without lateral support
- The patient may get into the car but not have the ability to get out again without being lifted

### **TRANSFER IN AND OUT OF A CAR**

REBA score = 6 medium risk

The patient is sitting in a wheelchair ready to perform task. Therapists apply ergonomic and biomechanical principles to reduce risk of injury at all times

#### **Transfer from wheelchair to car**

- The patient moves to edge sitting with the assistance of 1 therapist, until foot/feet are on the floor.
- The therapist positions herself to the side or in front of the patient (depending on space available) and places her hands appropriately for the particular patient, facilitating forward transfer until the patient is weight bearing through his legs. She then assists with the sideways transfer until the patient's bottom is on the car seat.
- The therapist may need to crouch to give assistance as the patient lifts his legs into the car

#### **Transfer from Car to Wheelchair**

- Taking care of her posture, the therapist assists the patient in turning and lifting his legs out of the car.

- The patient places his foot/feet on the ground and moves to edge sitting.
- The patient places his hand on the wheelchair (positioned as above).
- The therapist positions herself to the side or in front of the patient (depending on space available) and places her hands appropriately for the particular patient, facilitating forward transfer until the patient is weight bearing through his legs. She then assists with the sideways transfer until the patient's bottom is in the wheelchair.

### **Modifications**

- a) A sliding board may be used (e.g. banana board, easiglide)
- b) Additional therapist(s) may be required but postural hazards must be assessed
- c) A block may be placed under the patient's foot/feet, or the car may be parked close to a kerb to reduce height difference
- d) The patient may not have a functional upper limb next to the car and may push with the other hand in the direction of movement
- e) A turntable may be placed on the car seat to assist the patient in turning / getting his legs in to the car. **This must be removed before the car is driven.**
- f) The patient transfers using a Standing Transfer

### **Alternatives**

- Use of a wheelchair accessible taxi
  - g) Use of an Elap seat may reduce the transfer distance
  - h) Use of adapted vehicle



# Appendix 1



### All Wales Treatment Handling Risk Assessment Form

Sheet Number:

<b>Name: DoB:</b>	<b>Address:</b>	<b>Height: Weight:</b>	<b>Area seen:</b>	<b>ID No.:</b>
<b>Name of Therapist/s:</b>				

Record risks in appropriate column (\* see document –Elements of Treatment Handling Risk Assessment)

<b>Named task &amp; Clinical Reasoning</b>	<b>Date/time Signature</b>	<b>Individual(s) Assisting</b> Record job title/grade, person/s assisting where relevant	<b>Load (client)</b> Record details relevant to risk* and the Patient Ability Criteria, not just diagnosis	<b>Environment</b> Record details relevant to risk* not just location of task undertaken	<b>Risk Reducing Measures</b>	<b>Date and reason no longer applicabl e</b>

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**All Wales Treatment Handling Risk Assessment Form – Continuation sheet**

Sheet Number:

<b>Name:</b>		<b>Address:</b>				
<b>D.O.B.</b>						
<b>Named task &amp; Clinical Reasoning</b>	<b>Date/time Signature</b>	<b>Individual(s) Assisting</b> Record job title/grade, person/s assisting where relevant	<b>Load (client)</b> Record details relevant to risk* and the Patient Ability Criteria, not just diagnosis	<b>Environment</b> Record details relevant to risk* not just location of task undertaken	<b>Risk Reducing Measures</b>	<b>Date and reason no longer applicable</b>

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# Appendix 2

## **Guidelines for the Completion of the All Wales Treatment Handling Risk Assessment Form**

### Rationale

The risk of injury from treatment handling is acknowledged by the CSP and COT. Many therapists still feel that if they do not have direct 'hands-on' contact with a patient/client, then they are not delivering appropriate therapy. However, patients/clients can be rehabilitated with minimal or no risk to the therapists putting themselves at risk of injury. This can be achieved by the appropriate use of equipment or sufficient foresight before beginning a treatment session as to safer positioning of patient, therapist or equipment.

Treatment Handling risk assessment documentation is also evidence of our rationale/justification why a certain treatment intervention is undertaken should the client or therapist sustain an injury or even if the client fails to progress as expected following an injury or pathology.

THIS FORM ONLY NEEDS TO BE COMPLETED WHERE THERE IS A RISK OF INJURY FROM THE TASK TO BE CARRIED OUT.

This document need not be completed if there are no risks or a generic risk assessment / safe system of work / treatment protocol is in place and the patient/client has no additional risk factors that would interfere with the intervention.

An individual risk assessment should be carried out before carrying out an intervention that includes hazardous manual And/or treatment handling. Any change in a factor of the TILE format demands a new risk assessment to be completed. **A risk assessment remains valid unless there is any change in a factor of the risk assessment (according to Trust policy).**

**All risk assessments should be reviewed when there is any change in the client's presentation, environmental factors or individual carrying out the intervention (TILE) or according to Trust policy.**

This form should be used in conjunction with the 12 treatment handling Guidelines. These protocols identify the patient ability criteria and clinical reasoning for the particular intervention.

### **Guidelines for Completion**

- Each sheet number must be completed
- Patient/client details including name, address, date of birth, approximate height and weight (where accurate measurements are not available), location seen, hospital number etc. Where patient information sticky labels are available, these can be used.
- The name/s and signature/s of any therapists completing the form.
- Named task – what the therapist is literally doing with the patient/client i.e. the treatment intervention. E.g. assisted sit to stand, assisted walking, passive movements. If the form is used in conjunction with the 12 examples given in the guidelines, the clinical reasoning and patient ability criteria are already stated. It must be stated which example/guideline has been used.
- Clinical reasoning – why you are using that particular treatment intervention (perhaps over another) with the patient/client. What is your justification for the intervention? **This is NOT treatment goals or aims of treatment.**  
E.g. assisting client into standing frame / tilt table as unable to stand independently  
Passive movements as client unable to move limbs independently  
Assisted walking as client able to weight bear with minimal assistance, has voluntary stepping action with both feet and unable to walk independently.
- Date/time / Signature. – A risk assessment is only appropriate for that client, therapist or individual carrying out the intervention at that particular time and place. The therapist completing the risk assessment for the task must also sign in this column.
- Individual assisting – where relevant, the grade of therapist, level of experience of persons assisting should be documented. Personal details regarding the therapist's health should **not** be recorded.
- Load (this refers to the client) & Environment - examples of risks associated with these areas of TILE are detailed on the Elements of Treatment Handling Risk Assessment document. These are examples only and in no way an exhaustive list. Risks relevant to the planned intervention should be documented. It is insufficient just to state the diagnosis.
- Risk Reducing Measures – detail here any measures that have been taken to reduce the risk of injury to any party involved in the intervention, to the lowest reasonably practicable level. E.g. use of adjustable height equipment, additional persons to carry



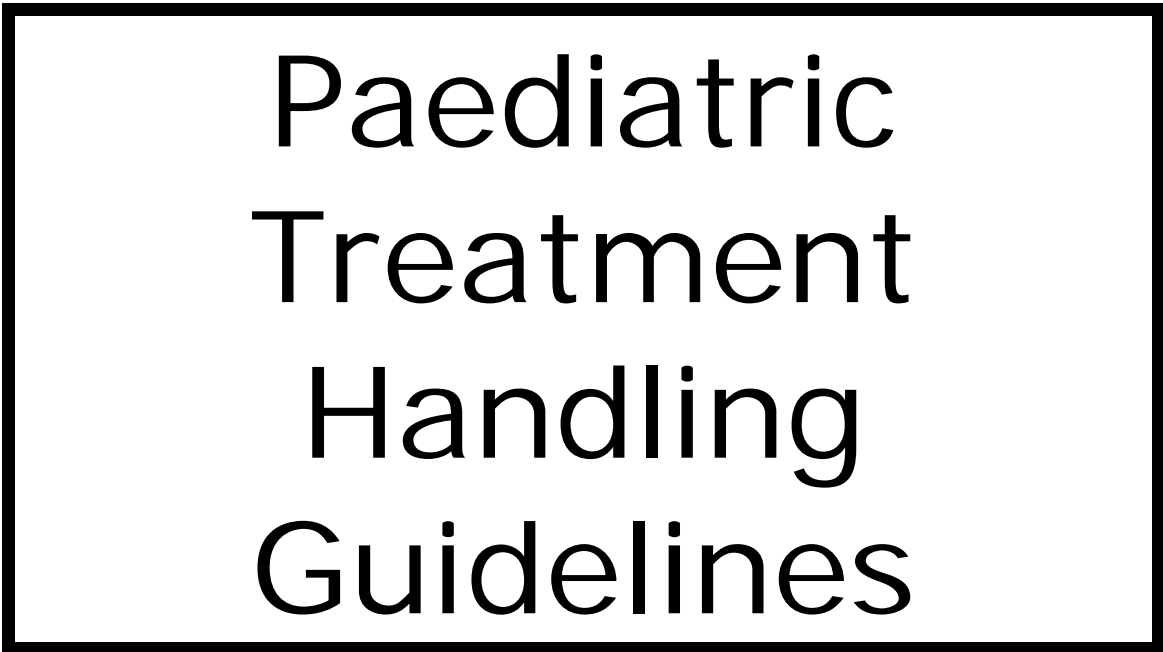
out the intervention, use of glide sheets, small handling equipment etc.

- A clear line must be put through the whole row of the risk assessment once a treatment intervention is:

No longer relevant to the client, **or** the risk assessment is invalid either because the client has improved or sustained further pathological changes or simply deteriorated

This should then be signed and dated clearly by the therapist involved and the 'Date no longer applicable' column completed.

**APPENDIX 14 – PAEDIATRIC TREATMENT HANDLING GUIDELINES**



Paediatric  
Treatment  
Handling  
Guidelines

## Guide to the use of the Paediatric Treatment Handling Guidelines

- ❖ These Guidelines are advisory and should be used in conjunction with The Therapy Risk Assessment Form and the LHB's Rehabilitation Handling Policy
- ❖ The patient ability criteria should be used to guide the risk assessment process and choice of handling technique
- ❖ All staff must work within their level of competence (*Ref CSP rules of Professional Conduct and Standards of Practise Rule 1*)
- ❖ Further information needs to be sought from the CSP's "Guidance in Manual Handling for Chartered Physiotherapists" if tasks are being delegated to others
- ❖ The task must be explained appropriately to the patient and consent given prior to any moving and handling

## Special Considerations

- ❖ These Guidelines are for the use of Therapists and are not intended for delegation or giving as handouts to parents/carers/learning support assistants
- ❖ Staff should be aware that planning their workload is an important part of reducing the risks. Variation of activities should be used to reduce repetition of high-risk tasks on any given day. Less experienced members of staff can reduce the risks by asking for additional assistance
- ❖ For some children, the adult treatment protocols may be more suitable

## Named Guideline

P1	Supine
P2	Prone
P3	Lying to Side Lying
P4	Rolling
P5	Lying to Sitting
P6	Long Sitting
P7	Sitting on a Bench
P8	Sitting to 4 Point Kneeling
P9	Four point Kneeling
P10	High Kneeling
P11	High Kneeling to Standing
P12	Sitting to Standing
P13	Standing at Table
P14	Walking – Supporting Child from Behind
P15	Walking – Supporting Child from in front
P16	Onto a Gym Ball in Prone

## **P1. THERAPY IN SUPINE**

### **Clinical Reasoning**

- Promotes symmetry
- Promotes development of eye-hand co-ordination
- Promotes bilateral hand use
- Strengthens abdominals
- Can be used to alter muscle tone
- Can be used to promote head control

### **Risk Assessment**

#### **Load (patient)**

- Is it medically appropriate?
- Consideration is given to care of attached equipment such as tubes or lines
- Child fulfils patient ability criteria

#### *Patient Ability Criteria*

- Child can tolerate being positioned in supine with assistance of one

### **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface

### **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## **METHOD**

- Therapist sits on floor
- Therapist should support their back against a suitable surface
- Position child on their back in front of therapist
- Support the child's head as appropriate

**This was assessed with therapist sitting cross legged**  
**REBA Score = 5**  
**Risk = Medium**  
**Action = Necessary**

**Therapist in long sitting**  
**REBA Score = 7**  
**Risk = Medium**  
**Action = Necessary**

### **Modifications**

- According to the child's size and ability their position may need to be altered
- Consider the use of physical supports e.g. pillows, wedge
- The therapist may work up off the floor on a suitable bench or plinth
- The position the therapist assumes will be related to the size and ability of the child and will reflect personal preference

### **Alternatives**

Use of postural support equipment

## **P2. THERAPY IN PRONE**

### **Clinical Reasoning**

- Develops head control
- Develops muscles in arms and shoulders when child pushes up on arms
- Promotes symmetry
- Develops back muscles (spinal extension)
- Increases sensory and proprioceptive input through upper limbs
- Important precursor to higher developmental skills

### **Risk Assessment**

#### **Load (Patient)**

- Is it medically appropriate
- Consider skin condition/integrity
- Consideration to care of attached equipment such as tubes or lines
- Child fulfils patient ability criteria

#### *Patient Ability Criteria*

- Child can tolerate being positioned in prone with assistance of one

### **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface

## Particular Hazards

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## METHOD

- Therapists sits on the floor
- Therapist should support their back against a suitable surface
- Position child on their tummy in front of therapist
- Support child under their chest and on their pelvis

**This was assessed with therapist sitting with one knee bent and one leg straight**

**REBA = 10**

Risk = High

Action = Necessary soon

## Modifications

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size and ability of the child and will reflect personal preference
- The therapist may work up off the floor on a suitable bench or plinth
- Consider use of physical supports e.g. pillow, wedge

## Alternatives

Use of postural support equipment

## P3. LYING TO SIDE LYING

### Clinical Reasoning

- Strengthens abdominals
- Develops righting reactions
- Develops head control
- Promotes rotation
- Promotes weight shift to the side
- Develops co-ordination for rolling
- Encourages active participation towards a functional movement goal

## **Risk Assessment**

### **Load (Patient)**

- Is it medically appropriate
- Consider skin condition/integrity
- Consideration to care of attached equipment such as tubes or lines
- Child fulfils patient ability criteria

### *Patient Ability Criteria*

- Child can tolerate being positioned in supine and side lying with assistance of one
- Child can tolerate the change in position from supine to side lying

## **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface

## **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## **METHOD**

- Therapist sits on the floor
- Position the child on their back in front of your legs
- Make sure the child's arms are down and forward
- Make sure the legs are bent and together



- Place your hands under the child's bottom
- Gently roll the child's bottom to one side
- Encourage the child to move the head, body and arms to follow

**This was assessed with****Therapist sitting cross legged****REBA = 7****Risk = Medium****Action = Necessary  
soon****Mid position****REBA = 9****Risk = High****Action = Necessary****Modifications**

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size and ability of the child and will reflect personal preference
- The therapist may work up off the floor on a suitable bench or plinth
- The child may be assisted to roll by bending up one leg only and guiding the movement from the hip
- Consider the use of physical supports

**Alternatives**

- Use of a slide sheet, blanket or towel to assist the child to move from their back to their side

**P4. ROLLING****Clinical Reasoning**

- Develops head and trunk rotation

- Encourages active participation towards functional movement goal
- Strengthens abdominals
- Develops co-ordination between pelvic and shoulder girdles
- Develops righting reactions
- Allows child to experience change of body position
- Increases sensory and proprioceptive input
- Encourages independent mobility

### **Risk Assessment**

#### Load (patient)

- Is it medically appropriate?
- Consideration is given to care of attached equipment such as tubes or lines
- Consider skin condition/integrity
- Child fulfils patient ability criteria

#### *Patient Ability Criteria*

- Child can be positioned in supine and prone with assistance of one
- Child can tolerate change in position from supine to prone

### **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate level and clean surface

### **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

### **METHOD**

- Therapist sits on the floor
- Position child on their back in front of therapist
- Encourage child to turn head in direction of roll
- Encourage child to reach across body with contra-lateral arm
- Encourage child to lead with contra-lateral leg, providing as little assistance as necessary to bring pelvis into action
- Encourage the child to move the body and arms to follow until child is on their tummy
- Assist as necessary to position arms in a comfortable position

**This was assessed with therapist sitting cross legged**

**REBA = 4**

**Risk = medium**

**Action = Necessary****mid position****REBA = 9****Risk = High****Action = Necessary soon****end position****REBA = 7****Risk = Medium****Action = Necessary****Modifications**

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size and ability of the child and will reflect personal preference
- Consider the use of physical supports e.g. pillow, wedge
- The therapist may work up off the floor on a suitable bench or plinth

**Alternatives**

- Use of a slide sheet, blanket or towel to assist the child to move from their back to their tummy

**P5. LYING TO SITTING****Clinical Reasoning**

- Encourages active participation towards a functional movement goal
- Strengthens muscles of trunk, shoulders and hips
- Develops head control

**Risk Assessment****Load (Patient)**

- Is it medically appropriate?
- Consideration is given to care of attached equipment such as tubes or lines
- Consider skin condition/integrity
- Child fulfils patient ability criteria

***Patient Ability Criteria***

- Child can tolerate being positioned in lying and sitting with assistance of one
- Child can tolerate the change of position
- Child has sufficient head control for the transition

**Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place

- Appropriate level and clean surface

### **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

### **METHOD**

- Therapist sits on the floor
- Position child lying on tummy in front of your legs
- Position child's arms forwards
- Assist child to move through side sitting to sitting with legs out in front
- Allow child to push up on their arms to assist with the transfer

This was assessed with therapist in sitting with one leg bent and the other straight

REBA = 10

Risk = High

Action = Necessary soon

### **Modifications**

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size and ability of the child and will reflect personal preference
- Consider the use of physical supports, e.g. pillows, wedge
- Modification of starting position will assist in this manoeuvre e.g. wedge or raised plinth for start position

### **Alternatives**

- Use of hoist

## **P6. LONG SITTING**

### **Clinical Reasoning**

- Develops head control
- Promotes alignment of head on trunk and trunk on pelvis

- Develops balance reactions
- Promotes trunk activity
- Improves/maintains length of hamstrings and joint range

## **Risk Assessment**

### **Load (Patient)**

- Is it medically appropriate
- Consideration is given to care of attached equipment such as tubes or lines
- Consider skin condition/integrity
- Child fulfils patient ability criteria

### *Patient Ability Criteria*

- Child can tolerate being positioned in long sitting with assistance of one

## **Environment**

- Prepare environment and appropriate equipment in advance
- Potential hazards to be identified and removed
- Sufficient space for activity to take place
- Appropriate level and clean surface

## **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Therapist at risk from repetitive movements of upper limbs
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## **METHOD**

- Therapist sits on the floor
- Therapist should support their back up against a suitable surface
- Position child on the floor between legs with their back up against therapist
- Position the child's legs slightly apart to provide an adequate base of support with knees as straight as possible
- Support child at the hips to maintain the position as necessary

**This was assessed with therapist in long sitting, leaning against a back support**

**REBA = 4**

Risk = Medium

Action = Necessary

### **Modifications**

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size and ability of the child and will reflect personal preference
- Consider the use of physical supports e.g. wedge
- A ball or small roll can be placed between the therapist and child to assist the child to sit up straight

### **Alternatives**

- Bench sitting if child unable to achieve long sitting position
- Use of postural support equipment

## **P7. SITTING ON A BENCH**

### **Clinical Reasoning**

- Promotes alignment of head on trunk and trunk on pelvis
- Modifies tone through positioning
- Promotes weight bearing through feet
- Promotes trunk activity
- Develops balance reactions
- Develops propping through upper limbs
- Promotes a functional position

### **Risk Assessment**

Load (Patient)

- Is it medically appropriate?
- Consideration is given to care of attached equipment such as tubes or lines
- Consider skin condition/integrity
- Child fulfils patient ability criteria

#### *Patient Ability Criteria*

- Child can tolerate being positioned on a bench with assistance of one

## Environment

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Bench positioned on appropriate level, firm surface
- Bench height adjusted to allow safe working height for therapist

## Particular Hazards

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Therapist at risk from repetitive movements of upper limbs
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## METHOD

- Therapist sits on the floor behind bench
- Position child sitting on bench, facing away from therapist
- Position child's arms on bench
- Therapist assists child to balance as appropriate

This was assessed with therapist  
astride bench  
kneeling on floor behind bench

Therapist sitting  
behind child

**REBA = 7**

Risk = Medium

Action = Necessary

**REBA = 7**

Risk = Medium

Action = Necessary

## Modifications

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size and ability of the child and will reflect personal preference
- Consider sitting astride the bench
- Consider use of a roll
- Appropriate support can be used under child's feet to encourage weight bearing, if bench too high for the child

- Use of a mirror to enable therapist to maintain posture, to see child's face and aid communication
- Consider use of a second person in front for assistance

### **Alternatives**

Use of alternative positioning equipment

## **P8. SITTING TO 4-POINT KNEELING**

### **Clinical Reasoning**

- Promotes positional change and weight transference from sitting to 4-point kneeling
- Preparation for crawling
- Strengthens muscles of trunk, hips, shoulders and arms
- Develops head control from one positional plane to another
- Developmentally appropriate
- Increases sensory and proprioceptive input

### **Risk Assessment:**

Load (Child)

- Is it medically appropriate
- Consideration is given to care of attached equipment such as tubes or lines
- Consider skin condition/integrity
- Child fulfils patient ability criteria
- 

#### *Patient Ability Criteria*

- Child can tolerate being positioned in sitting and a 4 point kneeling with assistance of one
- Child can tolerate the change in position from sitting to 4 point kneeling
- Child has sufficient head control



## Environment

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface
- Back support for therapist wherever possible

## Particular Hazards

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Therapist at risk from repetitive movements of upper limbs
- Temptation by therapist to use their own effort to lift and move the child during the treatment
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## METHOD

- Therapist sits on the floor
- Therapist should support their back
- Position child in sitting between therapist's legs and facing away
- Therapist places 1 hand across child's chest and the other hand on the child's bottom
- Assist the child into side sitting
- Move the child into 4-point kneeling position guiding pelvis
- Support the child's body encouraging them to push up on their arms

## Assessed with therapist sitting with one knee straight and one knee bent End position

REBA = 10

REBA = 11

Risk = High

Risk = Very High

Action = Necessary soon

Action = Necessary NOW

## Modifications

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size and ability of the child and will reflect personal preference
- When child can maintain 4-point kneeling, therapist can modify their position

- Consider use of therapists leg or a roll to support the child
- Consider use of a second person for assistance
- Arm gaiters or inflatable arm splints may be used to assist with elbow control for weight-bearing

## **P9. FOUR POINT KNEELING**

### **Clinical Reasoning**

- Developmentally appropriate
- Encourages active participation towards a functional movement goal
- Strengthens muscles of trunk, shoulders, arms, hands and legs
- Develops trunk control
- Develops balance
- Increases sensory and proprioceptive input through the upper and lower limbs

### **Risk Assessment**

#### **Load (patient)**

- Is it medically appropriate
- Child must be co-operative to assume the position
- Child should not be fearful of the position
- Child must not be too large or heavy for one therapist to support in this position
- Consideration is given to the care of attached equipment such as tubes or lines
- Consideration is given to skin condition/integrity
- Child fulfils patient ability criteria

### *Patient Ability Criteria*

- Child can tolerate being positioned in 4 point kneeling with the assistance of one
- Child has sufficient head control
- Child has independent sitting balance
- Child is able to push up in prone on extended arms
- Child has sufficient strength
- Child has sufficient exercise tolerance to maintain this position

### **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface

### **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture
- Therapist at risk from repetitive movements of upper limbs
- Temptation by therapist to use their own effort to lift and move child during the treatment
- Sudden collapse of child and danger of child banging head on support
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

### **METHOD**

- Therapist sits on the floor
- Therapist should support their back against a suitable surface
- Position the child face down across therapists thigh or the lower part of leg
- Position child's legs so that their knees are under the hips and slightly apart
- Use one hand to keep the hips and knees bent whilst using the other hand to bring the child's arms forward
- Place child's hands on the floor so they can push up on their arms

**This was assessed with therapist in long sitting**

**REBA = 9**

Risk = High

Action = Necessary soon

### **Modifications**

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size of the child and personal preferences
- Assistance may be required to position the child over the therapist's leg, give elbow support in front or to help keep the child's legs in a bent position
- Arm gaiters or inflatable arm splints may be used to assist with elbow control for weight bearing on the upper limbs

### **Alternatives**

- The child may be positioned over a therapy bench, ball, roll or other positional equipment
- Prone trolley

## **P10. HIGH KNEELING**

### **Clinical Reasoning**

- Strengthens muscles of trunk and hips
- Promotes weight bearing through hips
- Increases sensory and proprioceptive input
- Develops pelvic control as a precursor to standing
- Developmentally appropriate

### **Risk Assessment**

#### **Load (Child)**

- Is it medically appropriate
- Consideration is given to care of attached equipment such as tubes or lines.
- Consideration is given to skin condition/integrity.
- Child fulfils patient ability criteria

#### *Patient Ability Criteria*

- Child can tolerate being positioned in high kneeling with assistance of one

### **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface
- The support in front should be stable and at an appropriate height for the child

### **Particular Hazards**

#### **Changes in medical status of child**

- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Therapist at risk from repetitive movements of upper limbs
- Sudden collapse of child and danger of banging head on support
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## **METHOD**

- Therapist sits on the floor
- Position the child in high kneeling, facing the support
- Position child's arms on top of support.
- Therapist supports child's hips in alignment over knees.

**This was assessed with therapist kneeling on the floor behind the child**

REBA = 7

**Risk = Medium**

Action = Necessary

## **Modifications**

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size of the child and personal preferences
- Second person to kneel/sit opposite child in order to engage in activity and observe facial expression
- Therapist to place cushion between their bottom and heels
- Use of roll behind child to help maintain high kneeling position

## **Alternatives**

- Consider use of postural support equipment

## **P11. HIGH KNEELING TO STANDING**

### **Clinical Reasoning**

- Encourages mobility towards a functional movement goal
- Promotes weight bearing and weight transference through the legs
- Increases sensory and proprioceptive input
- Develops balance
- Strengthens muscles of the trunk and lower limbs
- Developmentally appropriate

## Risk Assessment

### Load (patient)

- Is it medically appropriate
- Child is wearing suitable footwear as appropriate
- Consideration to care of attached equipment such as tubes or lines
- Child fulfils patient ability criteria

### *Patient Ability Criteria*

- Child can tolerate being positioned in high kneeling and standing with assistance of one
- Child has sufficient balance to ½ kneel with assistance of one
- Child has sufficient head control
- Child has sufficient strength
- Child has to be co-operative during the movement sequence.
- Child has sufficient sitting balance
- Child can tolerate the change in position from high kneeling to standing

## Environment

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface
- The support in front should be stable and at an appropriate height for the child

## Particular Hazards

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture by therapist
- Maintenance of static posture by therapist
- Temptation by therapist to use their own effort to lift and move the child into the standing position
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## METHOD

- Therapist sits on the floor
- Position child in kneeling in front of support
- Therapist places both hands on child's hips
- Position child's arms on top of supporting surface

- Therapist assists child to bring 1 leg forward to assume ½ kneel position
- Whilst holding child's hips, therapist gently guides the child into standing, adjusting foot position as necessary

### **Assessed with therapist in kneeling behind child**

#### **Start position**

**REBA = 7**

Risk = Medium

Action = Necessary

#### **End position**

**REBA = 9**

Risk = High

Action = Necessary soon

### **Modifications**

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size of the child and personal preferences
- Second person to sit in front of child to encourage the child to move as independently as possible, promote communication, observe facial expression.

### **Alternatives**

- Use of postural support equipment

## **P12. SITTING TO STANDING**

### **Clinical Reasoning**

- Encourages mobility towards a functional movement goal
- Promotes weight transference
- Strengthens muscles of the trunk and legs
- Develops co-ordination of the trunk and legs
- Promotes hip extension and pelvic tilt
- Develops balance
- Developmentally appropriate

### **Risk Assessment**

## Load (patient)

- Is it medically appropriate
- Consideration is given to care of attached equipment such as tubes or lines
- Consider skin condition/integrity
- Child is wearing suitable footwear as appropriate
- Child fulfils patient ability criteria

### *Patient Ability Criteria*

- Child can tolerate being positioned in sitting and standing with the assistance of one
- Child can tolerate the change in position from sitting to standing
- Child has sufficient head control
- Child has sufficient muscle strength
- Child can place feet onto the floor
- Child can weight bear with the assistance of one
- Child has to be co-operative during the movement sequence

## **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface

## **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Therapist at risk from repetitive movements of upper limbs
- Temptation by therapist to use their own effort to lift and move child during the treatment
- Sudden collapse of child and danger of child banging head on support
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## **METHOD**

- Therapist kneels on the floor
- Position child in sitting on therapists lap with feet on the floor
- Position child's arms forward on supporting surface
- Assist child to stand

Assessed with therapist kneeling



with child sitting on lap

REBA = 7

**Risk = Medium**

Action = Necessary

End position

REBA = 8

**Risk = Medium**

Action = Necessary

### **Modifications**

- According to the child's size and ability their position may need to be altered
  - The position the therapist assumes will be related to the size of the child and personal preferences
  - The therapist places a cushion between bottom and heels
  - Use of a handling belt
  - Child sitting on low bench

### **Alternatives**

- Use of postural support equipment
- Use of a hoist and standing jacket

## **P13. STANDING AT A TABLE**

### **Clinical Reasoning**

- **Encourages mobility towards a functional movement goal**
- Strengthens muscles of the trunk, hips and legs
- Develops balance control of the trunk and legs
- Promotes hip extension and pelvic tilt
- Promotes postural alignment
- Developmentally appropriate

### **Risk Assessment**

Load (patient)

- Is it medically appropriate?
- Consideration is given to care of attached equipment such as tubes or lines
- Consider skin condition/integrity
- Child is wearing suitable footwear as appropriate
- Child fulfils patient ability criteria

### *Patient Ability Criteria*

- Child can tolerate being positioned in standing with assistance of one
- Child has sufficient head control
- Child has sufficient muscle strength
- Child has sufficient exercise tolerance to maintain the position

### **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface

### **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Therapist at risk from repetitive movements of upper limbs
- Temptation by therapist to use their own effort to lift and move child during the treatment
- Sudden collapse of child and danger of child banging head on support
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

### **METHOD**

- Therapist on the floor
- Position child in standing
- Position child's arms forward on the supporting surface
- Therapist supports child at pelvis
- Assist child to maintain standing

### **Assessed with therapist kneeling behind child**

REBA = 7

**Risk = Medium**

Action = Necessary

### **Modifications**

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size of the child and personal preferences
- The therapist places a cushion between bottom and heels
- Use of a handling belt

- Use of leg gaiters

### **Alternatives**

- Use of hoist and standing jacket
- Use of postural support equipment

## **P14. WALKING - SUPPORTING CHILD FROM BEHIND**

### **Clinical Reasoning**

- Encourages mobility towards a functional movement goal
- Strengthens muscles of legs and trunk
- Develops balance
- Develops the co-ordinated action of stepping
- Promotes weight transference
- Promotes normal movement and gait patterns
- Increases sensory and proprioceptive input through the lower limbs
- Maintains joint ranges
- Promotes independent standing and walking ability

### **Risk Assessment**

#### **Load (Patient)**

- Is it medically appropriate
- Consideration is given to tone and sensation in the lower limbs
- Child is wearing suitable footwear as appropriate
- Consideration is given to care of attached equipment such as tubes and lines
- Child fulfils patient ability criteria

#### *Patient Ability Criteria*

- Child can tolerate being positioned in standing with assistance of one
- Child can tolerate the a. Transfer of weight. b. Release of one leg, then. c. Placing of foot whilst maintaining standing with assistance of one
- Child has sufficient head control
- Child can sit with the assistance of one
- Child can move in sitting to the edge of the chair with assistance of one
- Child can move from sitting to standing with the assistance of one
- Child can weight bear in standing with the assistance of one
- Child is motivated to stand and step

## Environment

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface

## Particular Hazards

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of the therapist
- Maintenance of static posture by therapist
- Temptation by therapist to use their own effort to lift and move child during the treatment
- Sudden collapse of child and danger to child
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## METHOD

- Therapist behind child
- Position child in standing in front of therapist
- Therapist supports child at shoulders
- Assist the child to move forwards
- Assist the child to transfer their weight to one side releasing one leg for stepping forwards
- Encourage the child to maintain, an upright posture, feet facing forwards

Assessed with therapist standing behind child

REBA = 10

Risk = High

**Action = Necessary soon**

## Modifications

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size of the child and personal preferences
- The therapist may kneel or sit on a wheeled stool behind of the child
- Use of a suitable walking aid
- Second person to assist manoeuvre
- Use of extension device e.g. towel, bubble wrap

## Alternatives

- Use of a specialist supportive walker
- Use of a hoist with a walking jacket
- **Use of parallel bars**

## **P15. WALKING - SUPPORTING CHILD FROM IN FRONT**

### **Clinical Reasoning**

- Encourages mobility towards a functional movement goal
- Strengthens muscles of legs and trunk
- Develops balance
- Develops the co-ordinated action of stepping
- Promotes weight transference
- Promotes normal movement and gait patterns
- Increases sensory and proprioceptive input through the lower limbs
- Maintains joint ranges
- Promotes independent standing and walking ability

### **Risk Assessment**

#### Load (Patient)

- Is it medically appropriate?
- Consideration is given to tone and sensation in the lower limbs
- Child is wearing suitable footwear as appropriate
- Consideration is given to care of attached equipment such as tubes or lines.
- Child fulfils patient ability criteria.

#### *Patient Ability Criteria*

- Child can tolerate being positioned in standing with assistance of one
- Child can tolerate the a. Transfer of weight. b. Release of one leg, then. c. Placing of foot whilst maintaining standing with assistance of one
- Child has sufficient head control
- Child can sit with the assistance of one
- Child can move in sitting to the edge of the chair with assistance of one
- Child can move from sitting to standing with the assistance of one
- Child can weight bear in standing with the assistance of one
- Child is motivated to stand and step

## **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean and level surface

## **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Temptation by therapist to use their own effort to lift and move child during the treatment
- Sudden collapse of child and danger to child
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## **METHOD**

- Position child in standing facing therapist
- Therapist supports child around upper arms
- Assist child to transfer their weight to one side releasing one leg for stepping forward
- Encourage child to maintain, an upright posture, feet facing forwards

## **Assessed with therapist on wheeled stool in front of child**

REBA = 7

Risk = Medium

Action = Necessary

## **Modifications**

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size of the child and personal preferences
- Second person to assist manoeuvre

## **Alternatives**

- Use of a specialist supportive walker
- Use of a hoist with a walking jacket
- Use of parallel bars

## **P16. ONTO A GYM BALL IN PRONE**

### **Clinical Reasoning**

- Promotes trunk activity and shoulder girdle stability
- Develops head control
- Develops balance
- Promotes postural alignment
- Promotes weight transference
- Increases sensory and proprioceptive input

### **Risk Assessment**

#### **Load (Patient)**

- Is it medically appropriate
- Consideration is given to care of attached equipment such as tubes or lines
- Consider skin condition/integrity
- Child should not be overly fearful of the movement onto an unstable base
- Child must be co-operative to assume the position
- Child fulfils patient ability criteria

#### *Patient Ability Criteria*

- Child can tolerate being positioned in sitting and prone over a ball with the assistance of one
- Child can tolerate the change in position from sitting to prone over gym ball
- Child can weight bear in standing with assistance of one

### **Environment**

- Potential hazards to be identified and removed
- Prepare environment and appropriate equipment in advance
- Sufficient space for activity to take place
- Appropriate clean, level and non-slip surface on which to work

### **Particular Hazards**

- Changes in medical status of child
- Changes in muscle tone
- Changes in level of co-operation, motivation or behaviour of child
- Potential for poor posture of therapist
- Maintenance of static posture by therapist
- Temptation by therapist to use their own effort to lift and move the child during the treatment
- Ball may slip on the floor
- Child may fall off the ball
- Therapist must be aware of neck posture and should change neck posture frequently during treatment

## METHOD

- Position child with feet on floor
- Position ball in front of child
- Therapist leans forward and guides child to lean forward onto the ball
- Therapist straightens arms so the ball rolls slightly away and the child is fully supported on the ball

Assessed with therapist kneeling on floor, child in sitting on therapist's lap

REBA = 8

Risk = High

Action = Necessary soon

REBA = 7

Risk = Medium

Action = Necessary

## Modifications

- According to the child's size and ability their position may need to be altered
- The position the therapist assumes will be related to the size of the child and personal preferences
- Position child on stool in front of ball
- Position ball up against a wall or in a corner to prevent it from rolling away
- Second person stabilises ball and encourages communication with child in front
- Use of v-pillow to stabilise ball
- V-pillow can be used under child's chest to assist with positioning the child
- Use of a peanut shaped ball

## Alternatives

- Use of postural support equipment



## APPENDIX 15 – WORK BOOK FOR FOUNDATION MANUAL HANDLING TRAINING

### Workbook Questions

#### Module A Introduction

*P.OBJ: Define the term Manual Handling*

1. Insert the missing words

The MHOR 1992 define the term Manual Handling as

"Any transporting or supporting of a load (including \_\_\_\_\_,  
\_\_\_\_\_ ' \_\_\_\_\_' \_\_\_\_\_' \_\_\_\_\_"

or moving there of by hand or bodily force"

*P.OBJ: Identify back saving tips, relating them to prevention of injury throughout 24 hrs*

2. State at least three factors that could compromise your posture within the workplace?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

- c) State at least three activities that could compromise your posture outside the workplace?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

*P.OBJ: Outline the employers and employees responsibilities according to the MHOR 1992*

3. Insert the missing words

The MHOR 1992 states we should:

- |           |  |
|-----------|--|
| A _ _ _ _ | manual handling where possible                               |
| A _ _ _ _ | the risks where manual handling cannot be avoided            |
| R _ _ _ _ | the risks to the lowest level that is reasonably practicable |
| I _ _ _ _ | employees of measures taken to avoid risk                    |

R \_ \_ \_ \_ \_ the risk assessment

*P.OBJ: Safer Handling within each trust*

4. Insert the missing words

a) Where would you find information & guidance on Manual Handling in your organisation?

---

b) If there was a manual handling incident/accident/near miss how would you report it?

---

*P.OBJ: Define the terms Ergonomics, Hazard & Risk*

5. Complete the following

a) Ergonomics is

---

—

b) Does a Hazard have the potential to cause harm?

Yes or No

c) R \_ \_ \_ is the potential/likelihood/chance that someone can be harmed from the hazard

*P.OBJ: State the five key areas to be considered when undertaking a risk assessment*

6. There are 5 key areas of manual handling risk assessment. Provide 2 examples of factors to be considered for each key area

a) Task                      i) \_\_\_\_\_ ii) \_\_\_\_\_

b) Individual              i) \_\_\_\_\_ ii) \_\_\_\_\_

c) Load                      i) \_\_\_\_\_ ii) \_\_\_\_\_

d) Environment              i) \_\_\_\_\_ ii) \_\_\_\_\_

e) Other                      i) \_\_\_\_\_ ii) \_\_\_\_\_

*P.OBJ: Name the core principles of safer handling*

7. By incorporating the basic principles of safer handling into our daily lives we can significantly reduce the risk of injury when we move or handle loads. Insert the missing words to complete the sentences

a) Always use a \_\_\_\_\_ base

b) Try and maintain a natural P\_\_\_\_\_ (Spine in Line)

c) Keep the Load C\_\_\_\_\_ to the Body

*P.OBJ: Identify how these principles can be applied to various handling situations*

8. Can you say which of the following postures are unsafe and why?

1.



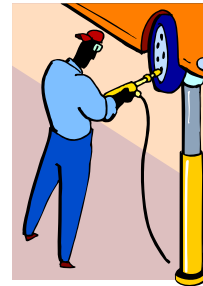
2.



3.



4.



5.



6.



1.



8.



9.



10.



*P.OBJ: Identify the risk control measures to be associated with Team Handling Situations*

9. Name at least three things that can be done to lower the risk when handling as part of a team?

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

*P.OBJ: Outline how Safer Handling is enhanced by good verbal communication skills*

10. When manual handling which of the following commands is considered to be best practice?

a) 1, 2, 3,

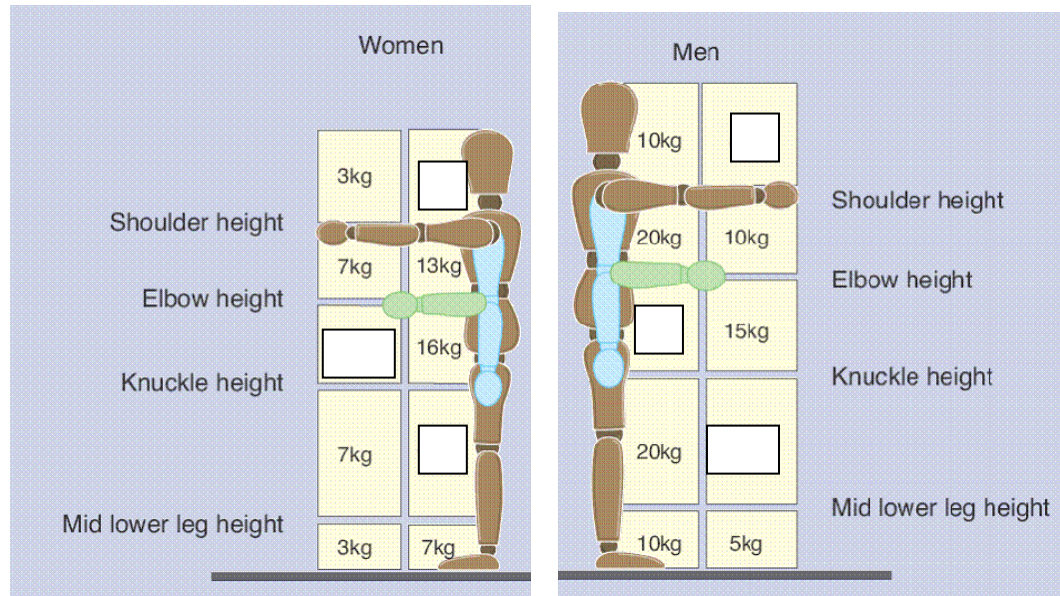
b) Ready, Steady, Go (last word being the doing word)

c) After 3, lift

## Module B Inanimate Load Handling & Practical Application of Ergonomics

*P.OBJ: Identify the five key areas, and other related factors such as guideline weights to be considered when undertaking a safer handling risk assessment*

1. On the following diagram, insert the correct guideline figures in each block



*P.OBJ: identify how the principles of safer handling can be applied to the moving of loads*

2. Complete the following sentences in relation to safe handling practice

- \_\_\_\_\_ before lifting/handling
- Keep the load \_\_\_\_\_
- Use a \_\_\_\_\_ handhold
- Avoid \_\_\_\_\_ the back or leaning sideways

*P.OBJ: Outline the importance of good posture including whilst driving and sitting at a desk*

3. State the principles of good posture being shown in the picture below



---

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4. Before starting your journey what can you do to improve your posture?

---

5. Pushing & Pulling Principles. Insert the missing words into the following statements

1. Make sure you can \_\_\_\_\_ where you are going

2. Look out for any \_\_\_\_\_

3. \_\_\_\_\_ need to be flat & non slip

## Module C Sitting, Standing & Walking

*P.OBJ: Name the principles of the handling of people*

1. Insert the missing words

Complete the following phrases outlining the basic principles of Safer Handling and Good Practice

Keep the load \_\_\_\_\_

Lead with the \_\_\_\_\_

Keep the knees \_\_\_\_\_

Keep the spine \_\_\_\_\_

Stable \_\_\_\_\_

Avoid \_\_\_\_\_

*P.OBJ: Identify the key areas of safer handling risk assessment*

2. Before handling a patient what do you need to do?

Tick all that apply

- a) Refer to the patient specific risk assessment (Handling Plan)
- b) An informal risk assessment (mental check list)
- c) Ask a friend

*P.OBJ: Discuss unsafe practice*

3. Insert the missing words

a) Complete the following statements on unsafe practices when mobilising a patient

- Supporting \_\_\_\_\_ of the person's weight is unsafe

- Anchoring a w\_ \_ \_ \_ \_ frame with your feet is unacceptable
- Avoid using \_\_\_\_\_ holds

b) Which of the following are normally considered to be unsafe lifting practices?  
Tick all that apply

- |                 |                        |
|-----------------|------------------------|
| Australian Lift | Bear Hug               |
| Drag Lift       | Top & Tail             |
| Hoisting        | Two procedures at once |
| 30 degree tilt  | Supine Slide           |

Name at least three of the dangers of unsafe practice when moving a patient

To the patient	To the carer

*P.OBJ: Demonstrate the principles of raising the fallen patient*

4. State at least two ways to raise a fallen patient from the floor

a) \_\_\_\_\_

\_\_\_\_\_

—

b) \_\_\_\_\_

\_\_\_\_\_

—

*P.OBJ: Demonstrate the principles of dealing with the falling patient*

5. According to your Trust policy/guidelines on the falling/fallen patient what should you do when a patient is falling? Tick all that apply

- a) Allow them to fall
- b) If safe to do so lower them gently to the floor
- c) Catch the patient
- d) Support them until help arrives



## Module D Bed Mobility

*P.OBJ: Outline the principles of using slide sheets*

1. a) State at least 3 advantages of moving a patient up the bed using a slide sheet

a) \_\_\_\_\_

–

b) \_\_\_\_\_

–

c) \_\_\_\_\_

–

*P.OBJ: Discuss unsafe practice and the rationale behind them*

- b) Name at least 3 advantages of an electric profiling bed

a) \_\_\_\_\_

–

b) \_\_\_\_\_

–

c) \_\_\_\_\_

## Module E Lateral Transfers

*P.OBJ: Outline methods of maintaining personal hygiene and alternative methods of toileting and clothing management*

1. List at least three aids that would help/enable a patient to tend to their own toileting needs?

a) \_\_\_\_\_  
—

b) \_\_\_\_\_  
—

c) \_\_\_\_\_  
—

*P.OBJ: Discuss unsafe practices and the rationale behind these*

2. How many people are needed to Pat Slide a patient? Tick all that apply

- It would depend on the patients handling plan
- A minimum of three staff
- Two staff

3. In relation to each other at what height should beds or trolleys be when using a Pat slide?

- a) The receiving surface should be of equal height to the starting surface
- b) The receiving surface should be higher than the starting surface
- c) The receiving surface should be slightly lower than the starting surface

4. Before using a stand and turn aid what must the patient be able to do? Tick all that apply

- a) Stand for long enough to allow the transfer?
- b) Understand what to do?
- c) Follow instructions?

## Module F Hoisting

*P.OBJ: Describe the principles of hoist use, and the types of hoists available*

2. Name at least 3 things you should check before using a hoist.

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

3. When measuring a patient for a sling what body reference points would you use?

a) \_\_\_\_\_

b) \_\_\_\_\_

*P.OBJ: Outline the type, selection and use of slings*

4. Name at least 3 things you should consider when selecting an appropriate sling

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

5. Before using a sling there are a number of safety checks that should be routinely performed. List at least three of them

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

*P.OBJ: Cite the main points of LOLER 1998*

6. Under LOLER how often should a sling be inspected?

a) every 6 months

b) every year

c) when needed

7. Under LOLER all lifting equipment must be marked with a SWL.

a) What does SWL stand for

\_\_\_\_\_

b) When is it acceptable to exceed the SWL of a piece of equipment?

\_\_\_\_\_

*P.OBJ: Discuss unsafe practice and rationale behind them*

8. What should you do if a patient refuses to be moved using a hoist?

\_\_\_\_\_

9. If the patient exceeds the SWL of the hoist or sling what should you do?

\_\_\_\_\_

10. When using a standing aid (Active hoist) what must the patient be able to do? Tick all that apply

a) Stand for long enough to allow the transfer?

b) Understand what to do?

c) Follow instructions?