CARE HANDLING FOR PEOPLE IN HOSPITAL, COMMUNITY AND EDUCATIONAL SETTINGS

A CODE OF PRACTICE

DERBYSHIRE
INTER-AGENCY
GROUP

This document has been written by the

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Important – Please Read This Before Using The Code Of Practice

This Code of Practice has been produced by the Derbyshire Inter Agency Group (DIAG) as a procedures document for use within the participating agencies.

It has been developed with reference to the current standards and guidance produced by the Health and Safety Executive and professional bodies. It is intended to be used as a model of good practice.

It was never the purpose of the DIAG Group to allow the Codes of Practice (COP) to be used as a stand-alone document but was designed to be accompanied by training as specified in the COP.

All organisations which use this COP as part of their risk management, assessment and training systems for moving and handling must ensure that they comply at all times with their statutory duties and responsibilities.

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Background to Derbyshire Inter Agency Group

This document aims to provide the information to allow managers, carers, whether employed or informal, and those requiring assistance to move, to reduce the risks of injury to both carer and those requiring assistance, when carrying out a manual handling activity.

It is hoped that the Derbyshire Inter Agency Group system (DIAG) will provide for the safety and well being of the people cared for in Derbyshire and those who assist them.

Back Injury and Ill-Health

Musculoskeletal disorders are by far the most common form of work related ill health in Great Britain, creating a great deal of suffering and hardship to individual workers and is costly to their employers and health and social care provision.

A self-reported survey in 2001/2 estimated that 1.1 million people in Britain suffer from musculoskeletal injuries. Manual handling accidents account for over a third of accidents reported each year and health and social care workers are among the highest risk occupations with injuries caused by their work. This is an increasing trend, 54% of all accidents in the care sector are manual handling (MHOR 1992, 1998.)

Musculoskeletal injuries through manual handling can occur almost anywhere in the body. However, the most common area affected is the spine accounting for 47% of all reported injuries, 69% of which are sprains and strains.

Occupational Ill Health Nationally

The Institute of Directors and The Health and Safety Commission (2006) in the report Leading Health and Safety at Work, state that 30 million days lost in the UK due to occupational illness and injury cost the economy £30 billion, approximately 3% of the GDP. The Pricewaterhouse Coopers report on Building the Case for Wellness (2008) quotes the Confederation of British Industry stating that sickness absence can cost roughly £495 per employee per year.

Specifically with regards to musculoskeletal disorders, the HSE estimates that there were 9.6 million lost working days 2005/6 costing £4.8 million. A self reported survey in 2001/2 estimated that 1.1 million people in Britain suffer from musculoskeletal injuries.

Occupational Ill Health in the NHS

The House of Commons Public Accounts Committee report, A Safer Place to Work: Improving the Management of Health and Safety Risk to Staff in the NHS Trust (2003), estimated that the cost of sickness absence in the NHS equated to £400 million per

year. NHS staff has a relatively high level of sickness absence with on average, staff absent for some 10.7 days a year. The public sector as a whole take on average 9.7 days and the private sector of 6.4 days.

Current levels of sickness absence mean that 10.3 million working days are lost in the NHS in England each year. This equates to an annual direct cost of absence of £1.7 billion a year. With regards to musculoskeletal disorders, the sickness absence accounts for around 40%.

Presenteeism

The extent to which staff work when they are not really fit to do so is known as presenteeism. The Boorman review of NHS staff reported that over a 4 week period over 65% of NHS staff reported that they had not taken time off work despite feeling ill enough to do so. It quotes that 71% of qualified nurses and midwives reported presenteeism compared to 45% in corporate services

The costs of presenteeism, defined as reduced performance and productivity due to health while at work, are more difficult to measure. It is estimated that in the UK presenteeism costs the employer 2 to 7 times more than absenteeism. (PWC 20)

Manual Handling Injuries

Manual handling accidents account for over a third of accidents reported each year and health and social care workers are among the highest risk occupations with injuries caused by their work. This is an increasing trend, 54% of all accidents in the care sector are manual handling (MHOR 1992, 1998).

Improving the Current Situation

Reducing current levels of sickness absence across the NHS by 1/3 would result in a gain of 3.4 million days a year, equivalent to 14,900 extra whole time equivalent staff and an annual direct saving of £555 million.

To help achieve this the following reports provide guidance for implementing health and well-being changes within working environments.

The NHS Constitution – The NHS Belongs to Us All (Jan 2009) applies to all staff, doing clinical or non-clinical NHS work.

The Constitution summarises the existing rights of staff with the development of pledges to ensure that staff:

- Have a good working environment with flexible working opportunities,
- Have a healthy and safe working conditions
- Take reasonable care of health and safety at work for themselves, their team and others, and to co-operate with employers to ensure compliance with health and safety requirements

- Take up training and development opportunities provided over and above those legally required of your post;

It also outlines as an employer, the NHS commits to provide:

- all staff with personal development, access to appropriate training for their jobs and line management support to succeed (pledge);
- support and opportunities for staff to maintain their health, well-being and safety

The recent report by Dame Carol Black, **Working for a Healthier Tomorrow**, called for the promotion of a working environment that offers employees a degree of responsibility and self worth. This 'good work' is fundamental to the evidence on the positive effects of work on health for the individual. There are many factors that contribute to 'good work', however, control of hazards, development and training, physical and emotional demands, and workplace environment are included (TUC 2010).

The Boorman Report – **NHS Health and Well-being Review 2009**, analysed the reasons behind staff absence. The distribution of self reported illnesses caused or made worse by work compared non NHS staff and NHS staff found that bone, joint or muscle problems equated to 42% in NHS compared to 58% in non NHS. Nearly half of all NHS staff absence is accounted for by musculoskeletal disorders.

Legislative Framework

There are several pieces of legislation that can influence the way we assist a person to move or manage inanimate loads. The six key regulations are as follows:

1. The Health and Safety at Work Act 1974

The duty of care of the employer and the employee is set out clearly in this legislation. The employer needs to provide the employee with a safe and healthy working environment and safe systems of work. The employee must comply with these safe systems of work and take responsibility for their own actions and those that may affect others health, safety and welfare.

2. The Manual Handling Operations Regulations 1992 (MHOR)

This refers to the application of human effort at work to a moveable object which includes people and animals, by pushing, pulling, lifting, carrying, moving, lowering, throwing or supporting.

The MHOR 1992 advises that avoidance of manual handling activities be undertaken, where there is a significant risk to employees. The regulations establish a clear hierarchy of measures.

- Avoid hazardous lifting so far as reasonably practicable
- Make suitable and sufficient assessment of any hazardous manual handling that cannot be avoided
- Reduce the risk of injury so far as is reasonably practicable

3. The Management of Health and Safety at Work Regulations 1999

This requires employers to assess the risk to their employees prior to them undertaking such work and anyone else who may be affected by their undertaking.

Where risk is significant it must be assessed, recorded and measures put in place to reduce the risk to the lowest level reasonably practicable.

4. Mental Capacity Act (2005)

This Act deals with a persons capacity to make decisions for themselves. The Act states that the person should be assessed for their capacity in each individual situation where a decision is required. Although during this process, some decisions may appear unwise to others, this is not necessarily an indication that the person lacks capacity. Staff should seek guidance from their local policy in order to ensure compliance with this Act.

5. Disability Discrimination Act (DDA) 2005

Within the DDA an organisation has to demonstrate the following:

- Eliminate discrimination against disabled people on the grounds of their disability
- Eliminate harassment of disabled people related to their disability
- Promote equality of opportunity between disabled people and other persons
- To take into account disabled peoples disability and needs even where it involves treating disabled people more favourably than other persons
- Promote positive attitudes towards disabled people
- Not to treat disabled people less favourably than anyone else due to their disability

Carers should seek further advice from their agency with regards to local policies and procedures of how these are developed within specific agencies.

6. Human Rights Act 1998

The Human Rights Act came into force on 1st October 2000, and addresses these areas:

- It makes it unlawful for a public body, to breach the European Convention on Human rights, unless an Act of Parliament meant it couldn't have acted differently
- It means that cases can be dealt with in a UK court or tribunal. Until now, anyone who felt that their rights under the Convention had been breached had to go to the European Court of Human Rights in Strasbourg
- The Act states that all UK legislation must be given a meaning that fits with the Convention rights, if that's possible. If a court says that's not possible it will be up to Parliament to decide what to do.

It is important to remember that the Act aims to ensure that everyone's rights are properly respected. When addressing manual handling issues, the rights of the person being assisted and the carer must both be addressed. This means that in normal everyday situations, the rights of the carer cannot be compromised by the wishes and rights of the person requiring assistance.

Working Towards Providing Safer Personal Assistance - Balancing the Requirements of Health & Safety Legislation and Human Rights and Disability Legislation

Under health and safety legislation managers are required to 'reduce risk to the lowest level reasonably practicable.' Traditionally reasonably practicable relates to weighing up the level of risk to employees against the cost of doing something to reduce/eliminate that risk. However the term reasonably practicable does not necessarily mean that all risk be removed.

In order to reconcile health and safety at work legislation with community care legislation and human rights legislation, managers must make every effort to balance the needs and human rights of carers (including paid and informal carers) alongside the assessed needs and rights of the person. The emphasis of this process must be that neither one overrides the other. Indeed doing so is no more than basic good professional practice.

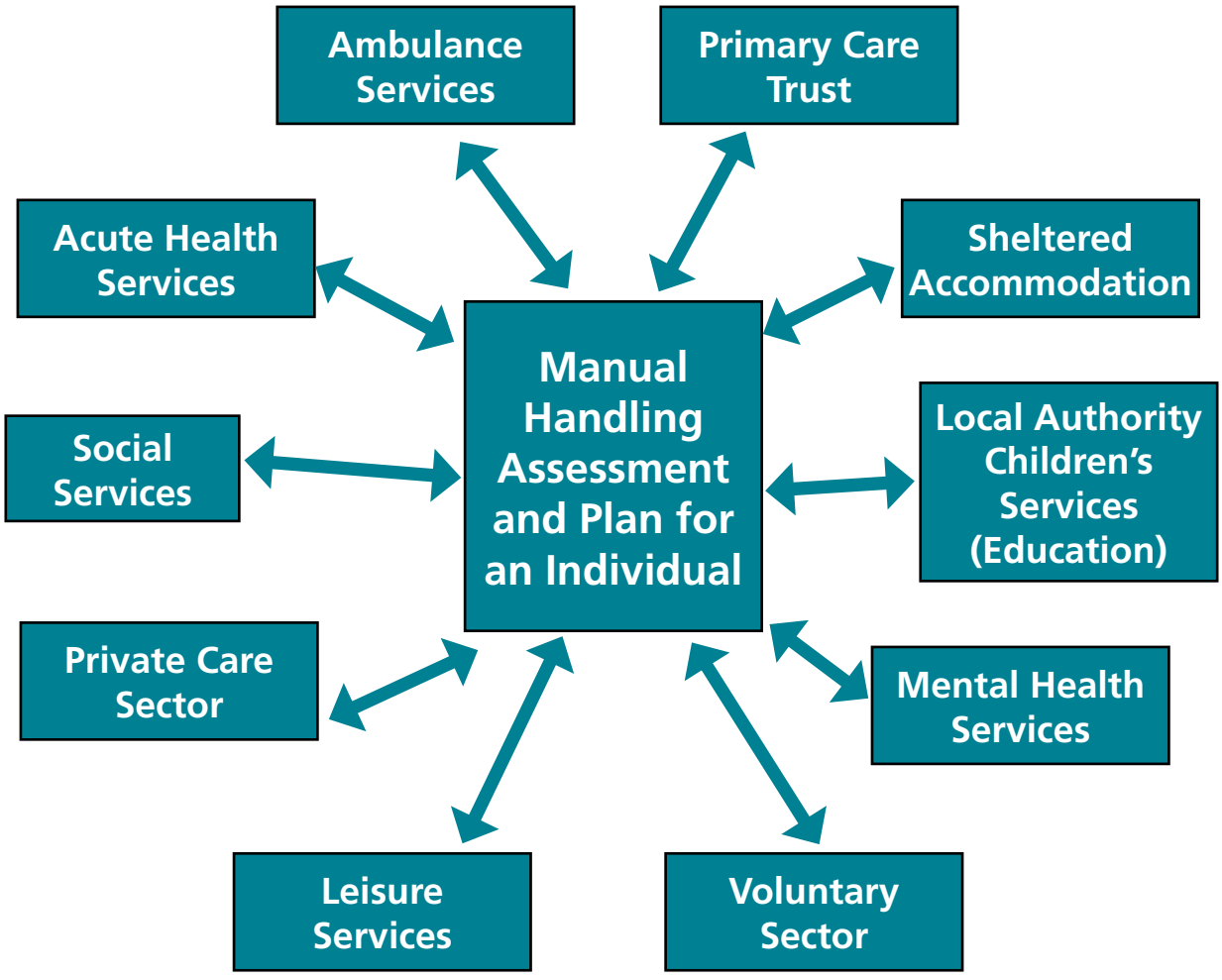
Whilst recognising that this will not always be easy, an effective and equitable risk assessment, that involves the person at the earliest opportunity and throughout the process, can help to ensure that apparently intractable situations can be resolved. In an effort to achieve this balance, carers may be required to work at higher (but not unacceptably high) levels of risk in order to assist the person not only within the home/establishment but also to access and participate in the wider community. At the same time managers must be capable of managing these situations so that balance is maintained and carers supported.

Within the DIAG system, activities that involve a higher level of risk are managed, implemented and monitored by the use of the Variance Risk Assessment process.

Introduction to the Derbyshire Inter-Agency Group

It is in everyone's interest within the health, educational and social care sector that institutions work together. One area in which closer working could prove to have tangible benefits is in the activities associated with the manual handling of people. It is the aim of this Code of Practice to present a series of documents, methods and techniques to simplify the whole process of managing the problems associated with the handling of people across all care providers in Derbyshire.

At the centre of the risk assessment process are the handling needs of a person requiring assistance. This will allow the development of a handling plan, which provides for the needs of the person and ensures the safety of all. This handling assessment and plan will be transferable between all agencies that are signed up to the package.



This process includes the manual handling risk assessment and the accompanying handling plans, the structure, format and content of training, and contains detailed procedures for all situations where carers may be required to assist a person to move.

Statement of Intent

The Derbyshire Inter-Agency Group's (DIAG) statement of intent is that all participating agencies are committed to working in partnership to meet the social, developmental, therapeutic, educational, ergonomic, housing, environmental and care needs of those using its service.

The DIAG System aims to provide a consistent approach in assisting adults and children. These documents should reduce the need for repeated assessments and plans by different agencies. Every person is unique and their different ability, preferences, attitudes, and beliefs require an inclusive personalised assessment and care planning system. Inappropriate assistance causes injury to people, loss of their dignity and reduction in their functional ability.

The responsibility to develop a safe, accessible and enabling environment in which to meet the care needs of the person lies jointly with:

- The person or their advocates
- Managers of care services
- Carers

N.B. Please note that due to the multiagencies involved, DIAG refers to the patient, client, service user as PERSON, and staff, therapist and family member as CARER.

The DIAG system recognises the need for carers to have both the physical skill to carry out manual handling activities and to be able to recognise any change in circumstances. It also hopes to provide an awareness of the need to respond appropriately and be supported in looking for solutions that would reduce the risk to the lowest level reasonably practicable.

Statement of Commitment

We the undersigned are committed to continue the work in partnership to meet the social, developmental, therapeutic, educational, ergonomic, housing, environmental and care needs of those who use our services. The agencies appreciate that the moving and handling involved in the delivery of care has the potential to cause injury to those being assisted and their carers, both formal and informal. We will therefore work together to promote safer handling procedures and environments, accommodating the need for the encouragement of maximum independence whilst protecting the health and safety of all.

We will co-operate in working within the relevant legislative framework, guidance and professional standards of good practice as outlined by the Derbyshire Inter-Agency Group.

We will develop a strategy for implementation for the Derbyshire Inter-Agency Codes of Practice.

We will provide the resources and facilities to allow compliance, including the provision of equipment, a safe handling environment, training, information and documentation, with the Derbyshire Inter-Agency Group Risk Assessment Guidance and Codes of Practice.

We will continue to participate in the Derbyshire Inter-Agency forum and to review the moving and handling policies in light of changes in legislation and professional guidance to ensure, and maintain good standards of moving and handling practice.

Chief Executive Derbyshire Community Health services

Chief Executive Derby City PCT

Strategic Director of Derbyshire County Council Adult Care

Strategic Director of Derbyshire County Council Children and Younger Adults

Chief Executive Chesterfield Royal Hospital NHS Foundation Trust

Chief Executive Derby Hospitals NHS Foundation Trust

Chief Executive of East Midlands Ambulance Service NHS Trust

Chief Executive of Derbyshire Mental Health Services NHS Trust

Introduction to the Code of Practice

The Derbyshire Inter Agency Group has produced a variety of documents which can be divided into two main sections:

1. The Risk Assessment Process

The Risk Assessment Process is primarily a manager's guide for the management of care handling to allow the completion of risk assessments and to implement safe systems of work for all people and carers. It explains how and where risk assessments should be completed and gives detailed guidance on how decisions should be made to remove risks.

The manager's guide explains the whole process of managing manual handling risk and can be divided into the following sections:

- ### Establishment Risk Assessment

  This covers any buildings or work places in which carers may need to conduct manual handling tasks.

- ### Load Handling Risk Assessment

  This covers the assessment of inanimate loads for single activities or for the management of load handling activities.

- ### Personal Handling Risk Assessment and Personal Handling Plan

  This is a person specific risk assessment and handling action plan that will give the agreed details as to how a person is to be moved.

- ### Specific Environmental Risk Assessment

  This is used when a person who needs assistance to move is in an area that is not covered by an Establishment Risk Assessment, e.g. a person's home.

- ### Variance Procedure

  This is when the routine care handling situations covered in the practical guides are not sufficient and further assessment is required to reduce the risk to the lowest possible level.

- ### Training

  This section provides guidance on the provision of suitable training including standards of training, personal specifications of people delivering training and the content, learning objectives and outcomes of training.

- ### Audit

  This section outlines the audits used to assess the performance of an organisation or an area with respect to the Derbyshire Inter Agency Group Code of Practice.

2. The Practical Guidance

The Practical Guide for Care Handling gives detailed advice and guidance to allow the safe handling of people. This section is aimed at managers and carers who are responsible for completing the personal handling plans and risk assessments. It is also aimed at those who are involved in the training and supervision of carers. The content of this section will be used when completing the handling plans for all people requiring assistance to move. It can also be used to clarify the content of training sessions for carers to achieve competency in safe handling.

The practical guides are procedural documents that give specific guidance on acceptable methods for assisting a person to move. There is a structure to the guidance including:

1. General Advice
2. Safe Movement Principles for Handling Activities
3. Avoidance of Unsafe Practices
4. Glossary of Terms
5. Guidelines for using Care Handling Procedures
    - Assessment criteria
    - Independent movement
    - Manual assistance
    - Use of hoist
6. Guidance for Care Handling Situations

How to use the Code of Practice

For all the organisations involved in the Derbyshire Inter-Agency Group (DIAG) to be able to work together carrying out manual handling activities, there needs to be agreement about which handling methods are safe to use. This document outlines which methods are accepted as current best practice. It is based upon all the recent guidance, which has been published, and the experiences of the Manual Handling Advisers of all the participating agencies. A list of reference documents is found in the bibliography.

The selection of chosen methods is based upon sound scientific principles such as biomechanics, physiology and ergonomics. It also uses advice found in models of efficient human movement, which have been adopted in practice within various areas. The methodology of the guidebook has allowed all of these principles to be utilised to present a robust guidance document that should be transferable to all sectors of health, education and social care.

This Code of Practice is written as a document that will assist manual handling advisers, manual handling trainers and supervisory carers who have proven skills in manual handling, to clarify and improve the knowledge and practice of all carers who are involved in the handling of people. It may also be used as a supporting document to any personnel who are involved in the risk assessment process e.g. managers, therapists, specific risk assessors.

It is not designed to be a stand-alone document but a part of the whole package of managing manual handling risks. Every effort has been made to clarify and simplify the content within the document but if read by individuals there is always the possibility of personal interpretation. The Code of Practice must be supplemented by training courses, evaluation and audit to ensure the whole package is being adhered to. All diagrams within the document are representations of the DIAG Manual Handling Advisers Group and also form part of the training support.

The DIAG manual can also be used as a complete guide to introduce anyone to the process of managing manual handling risks. If problems are found when using the content of this book please refer back to your organisations manual handling advisers for assistance.

CARE HANDLING FOR PEOPLE IN HOSPITAL, COMMUNITY AND EDUCATIONAL SETTINGS

RISK ASSESSMENT PROCESS

GENERAL RISK ASSESSMENT PROCESS
THE DIAG RISK MANAGEMENT PROCESS

DERBYSHIRE
INTER-AGENCY
GROUP

Introduction to the Risk Assessment Process

This section looks at two specific areas:

1. The General Risk Assessment Process

This section provides the general background to carrying out risk assessments by asking fundamental questions.

2. The DIAG Manual Handling Risk Management Process

This section looks at how the DIAG system can be used to address the risk assessment requirements.

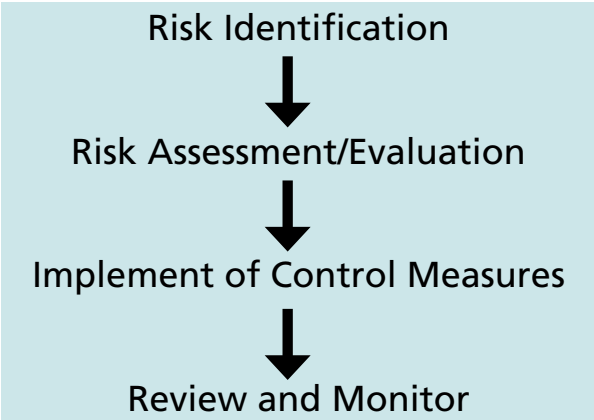
1. The General Risk Assessment Process

i. What is a Risk Assessment and why is it required?

The risk assessment process must comply with the following Risk Assessment Standards:

- The risk assessment process must be based on the appropriate legislation i.e. Health and Safety at Work Act 1974 (HSWA,) Management of Health and Safety at Work Regulations 1999 (MHSW,) Manual Handling Operations Regulations 1992 (MHOR) as amended 2002
- Appropriate trained and competent personnel must be available to carry out all risk assessments
- All documentation of the risk assessments must be completed appropriately and be available to all carers
- All risk assessments must be regularly reviewed and updated
- Risk assessors must strive to achieve a balance between the safety of carers and the activities that are required to be carried out. The views and opinions of **ALL** people involved must be taken into consideration.

A risk assessment is a process by which a risk can be systematically reduced to the lowest possible level. As a system it has a series of stages which are:



Risk Identification

To be able to control the possible dangers to carers all potential hazards must be identified. These could include environmental issues i.e. working at low surfaces, or physical activities i.e. moving inanimate loads or assisting people to move.

Risk Assessment/Evaluation

Evaluation or assessing the level of risk requires a decision making process which balances the level of risk and its potential harm.

Implementation of the Control Measures to Reduce Risk

When a risk assessment has been completed a control method should be chosen to eliminate the risk or reduce the risk to the lowest possible level. This must be documented so all carers can follow the safe system of work.

The information may include the number of carers, equipment required, method of manual handling, variances etc., which should be documented on the appropriate assessment forms.

Monitoring/Review

All risk assessments should be continually reviewed to assess for change. Triggers which would instigate a review would be following an accident or incident, a change in the persons or carer's condition, new information comes to light, or request from the therapist, person or carer. When assisting people to move it is vitally important that carers continually review their activities and levels of risk.

ii. When is a risk assessment required?

A risk assessment is required if a hazard is identified whether inanimate or when assisting a person to move.

iii. Who carries out the risk assessment?

Risk assessments should be carried out by a competent person who is able to determine whether an identified hazard is an issue which requires further intervention.

This person may have the overall responsibility of the organisation or may be responsible for their local work area. Whether a general or a local assessor they should provide the area with the following:

- Points of contact for managing the risks including manual handling issues
- Information regarding appropriate training and equipment
- Specific information when required e.g. manual handling tasks

All carers have a responsibility not to put themselves or others at risk (HSWA 1974 and MHSW 1999.) They therefore have a responsibility to find, read and follow a documented manual handling plan.

2. The DIAG Manual Handling Risk Management Process

Each agency which is involved with a care service whether that is in acute care, long-term care, social care or educational settings has an equal responsibility to provide a safe work environment. The risks associated with assisting people to move are well documented and are very important to all who signed up to the Derbyshire Inter-Agency Group Statement of Commitment. This manager's guide gives a complete system for the management of manual handling risk and aims to both simplify the process for each participating agency and standardise the methods used.

The guidance for the management team to provide a local management system within their work areas is divided into the following sections:

i. A Manual Handling Policy
ii. The DIAG Risk Assessment Process
iii. Provision of Training
iv. Use and Provision of Equipment
v. Monitor and Review

i. A Manual Handling Policy

The manual handling policy must:

- Mirror the DIAG Moving and Handling system
- Outline the local line management responsibilities
- Outline the arrangements for the risk assessment and the monitoring process
- Outline the accident and incident reporting process
- Outline the process for selection, recruitment, training and competency/ assessment of the workforce

ii. The DIAG Risk Assessment Process

The most important part of any health and safety package is the completion of appropriate risk assessments. For the management of manual handing to be effective across a number of agencies and care scenarios, it is necessary to have a comprehensive range of assessment tools.

The following are included in this section:

- Establishment Risk Assessment
- Inanimate Load Handling Risk Assessment
- Personal Handling Risk Assessment and Personal Handling Plan
- Specific Environmental Risk Assessment
- Variance Risk Assessment
- Staff Workplace Risk Assessment

These assessments can be divided into three sections:

- Assessing the environment
- Assessing the person requiring assistance to move or an inanimate load
- Assessing the carer

The assessment of the environment allows for the management to assess, monitor and audit the environment in which manual handling activities take place. It can also be used to assess the compliance to the DIAG guidance. The Establishment Risk Assessment can be for day centre to hospital ward whereas the Specific Environmental Risk Assessment considers the risk in a person's home or mainstream educational facility.

The assessment of the person utilises the Personal Handling Risk Assessment, the Personal Handling Plan, and Variance Risk Assessment forms. The purpose of these assessments is, in collaboration with the person, to identify the person's care needs and select the appropriate methods to assist that person to move which are outlined in the practical guidance. The assessment of a specific object or the management of load handling activities utilises the Load Handling Risk Assessment forms.

Assessment of the Carer

The assessment of the carer commences on appointment to ensure that the person is physically able to undertake the tasks required of them. This may be a questionnaire that the staff member completes declaring any musculoskeletal problems they have and is usually carried out via Occupational Health departments.

If a member of staff sustains a musculoskeletal injury or problems carrying out their work activities, then the Staff Workplace Assessment should be triggered.

The assessment should be done with the carer, and if appropriate the manager, and identify how and when the injury occurred, symptoms, any current limitations, and tasks that ease or aggravate the problem. A description and demands of the job should then be identified. Once these issues have been identified, an action plan with recommendations should be drawn up, and a review date set.

iii. The Provision of Training

All carers who are involved in the practical aspects of moving people need specific skills to carry out their jobs. Further details are included in the training section and outlines the following aspects of training:

- Standards and requirements for advisors, trainers and trainees
- Content of training
- Frequency of training
- Trainer and trainee ratios
- Assessing competence of trainees

Each agency will ensure that appropriate resources and facilities are available to allow carers gain a level of competency. Carers need to have competence to perform their work tasks. A competent person should be available to complete the risk assessment process.

iv. Use and Provision of Equipment

The risk management and risk assessment process outlined here will direct all carers and care managers into considering the appropriate use and purchase of equipment. Over recent years, the range of equipment for care handling activities has widened dramatically and those providing care should be aware of the range of equipment that are available on the market. It is important that the local management package examines all of the available options and provides a suitable level of equipment where appropriate.

v. Monitor and Review

All managerial systems need to have a robust method for review and monitoring for quality and development purposes.

DIAG audit tool can be used for this purpose.

CARE HANDLING FOR PEOPLE IN HOSPITAL, COMMUNITY AND EDUCATIONAL SETTINGS

RISK ASSESSMENT DOCUMENTATION

Establishment Risk Assessment
Load Handling Risk Assessment
Personal Handling Risk Assessment
Personal Handling Plan
Specific Environmental Risk Assessment
Variance Risk Assessment
Staff Workplace Risk Assessment

DERBYSHIRE
INTER –AGENCY
GROUP

ESTABLISHMENT RISK ASSESSMENT

DERBYSHIRE INTER –AGENCY GROUP

The Establishment Risk Assessment

Introduction to the Establishment Risk Assessment

Aim of the Establishment Risk Assessment

This is an assessment of the manual handling situations found in a ward, department, unit or establishment. It should be reviewed annually and amended whenever there are changes within the unit. It should include information on the various activities, the systems of work employed, the associated problems and possible measures considered that may reduce residual risk.

The Assessment Team

The designated risk assessor should complete the assessment, in conjunction with carers/staff, the manual handling specialist and any other competent persons. This encourages the carers to take more responsibility for the practices in their area and allow ownership of the process. This allows more follow up, implementation and compliance with recommended systems.

The risk assessor and team need to be competent assessors, with training and awareness of the MHOR 1992 (as amended 2002.) They need to be aware of the risk assessment process, the DIAG Codes of Practice and those activities or methods that fall outside of the DIAG Codes of Practice. They need to be aware of manual handling options and equipment that may reduce the risks.

Implementation of Control Measures

The risk assessor is responsible for implementing control measures. If any of these measures cannot be implemented by the unit manager, they should report it to their line manager who will take action or inform more senior management.

Monitoring and Review Process

The assessment should be reviewed annually in consultation with carers. This review needs to be inclusive of new developments in the DIAG System. Audit should be documented by the unit manager.

Guidance for Completing the Establishment Risk Assessment

This form is designed to allow managers to:

- Examine current handling methods, ensuring that techniques chosen comply with the guidance given in the DIAG Codes of Practice
- Audit handling equipment, its suitability, sufficiency and state of repair
- Assess the handling environment to allow necessary improvements to be made
- Audit management systems
- Ensure systems are in place to provide for a trained and fit team of carers.

The Establishment Risk Assessment form can be divided into a number of simple sections. The guidance for completing each section is given as follows:

Part 1
Completing the Introduction to the Establishment Risk Assessment

Part 2
Completing the Establishment Risk Assessment - Preliminary Risk Assessment

Part 3
Completing the Establishment Risk Assessment Manual Handling Equipment

Part 4
Completing the Establishment Risk Assessment - Area Risk Assessment

Part 5
Completing the Management Checklist

Part 6
Completing theSummary of Needs Action Plan

Part 7
Completing the DIAG Manual Handling Audit

Part 1 Completing the Introduction to the Establishment Risk Assessment

Establishment	The agency in which the risk assessment is being carried out should be recorded here.
Department	The area in which the Establishment Risk Assessment is being carried out should be recorded here e.g. Ward.
Assessment Team	The name, designation and signature of the persons involved in the risk assessment should be recorded here. The assessment team may include the manager of the area. Other members of the assessment team may include the designated risk assessor, Back Care Advisor and Health and Safety representative.
Date of Assessment	The date that the assessment is completed.
Speciality of Care	The general speciality of care given to persons in that establishment should be recorded here i.e. care of the elderly, rehabilitation, respite care etc.
Typical age range of people receiving care	An estimation of the ages of the people receiving care should be recorded here.
Typical population of people receiving care	Indicate by ticking the appropriate box which category of the population the establishment comes under.
Areas where manual handling occurs	This should include the geographical areas within the establishment. For example bathing area, living area etc

INTRODUCTION TO THE ESTABLISHMENT RISK ASSESSMENT

Establishment:		**Department:**	
Assessment Team			
Name	**Designation**	**Signature**	
Date of Assessment			
Establishment Details			
Speciality of care			
Typical age range of people receiving care			
Typical population of people receiving care	**Male**	**Female**	**Mixed**
The following areas are where manual handling activities occur:			

Part 2 Completing the Preliminary Establishment Risk Assessment - Preliminary Risk Assessment

The Establishment Preliminary Assessment is a primary tool for the initial identification of manual handling tasks that could be hazardous. It may be useful for carers working within the area to complete this form in preparation for the assessment taking place.

Agency/Location	The agency/location in which the assessment is being carried out must be recorded here.
Establishment/ Department	The establishment/department within the agency should be recorded here.
Date of Completion	The date on which the assessment was completed must be recorded here.
Assessor's Details	The name, designation and signature of the person carrying out the assessment must be recorded here.
List of Manual Handling tasks requiring assessment	All activities that occur within the establishment which require assessment should be recorded here. This should be a collaborative discussion with carers within the establishment.
Name or carer group (optional)	Carer(s) identifying the task as a problem should be recorded here. This is only to obtain clarification of the activity identified by the assessment team if required.

PRELIMINARY RISK ASSESSMENT	
Agency / Location	
Establishment / Department	
Date of Completion	
Assessors Details	
Name	
Designation	
Signature	
List of Manual Handling Tasks Requiring Assessment	**Name or carer group (optional)**

Part 3 Completing the Establishment Risk Assessment - Manual Handling Equipment

A list of all manual handling equipment that is currently being used within the establishment must be completed. This includes hoists, sliding sheets, transfer aids, slide boards, specific bathing equipment, etc. The following factors must be recorded.

Type	What function, e.g. hoist, sliding aid.
Manufacturer	This is the company who makes the equipment.
Serial No.	The serial number of the equipment
Asset No.	The asset number for the agency if appropriate
Model Name	This is the name that the manufacturer calls the equipment.
Date of manufacture	The date of manufacture of the equipment if known
Number	This is the amount of this particular piece of equipment that you have in your establishment.
Based in area	Please indicate by ticking if the equipment belongs to your establishment.
Loaned from	If you loan the equipment from another establishment, please indicate where this is loaned from.
Date of last service	This particularly applies to the hoists and must follow the guidance of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). This regulation requires that all lifting devices must be inspected six monthly. Therefore the date of the last service test must be recorded in this section.
Safe working load	The safe working load of the equipment should be recorded here, this is especially significant when the persons weight is being taken by the equipment, i.e. hoist, transfer board.
Assessor's details	Name and designation of the person who is completing the assessment must be recorded here.
Date of completion	The date of the assessment must be recorded here.

ESTABLISHMENT RISK ASSESSMENT - MANUAL HANDLING EQUIPMENT ASSESSMENT

List below any manual handling equipment that is available or loaned on a regular basis, within your establishment.

Examples of manual handling equipment			
Trapeze	Hoists (all types)	Transfer sheets	Sliding sheets
Rope ladders	Pat slide	Framed turning discs	Turning discs
Handling blocks	Slide board	Hoist slings	Bath types

Type	Manufacturer	Serial No.	Asset No.	Model name	Date of Man.	Number in area	Based in area	Loaned from	Last service date	Weight limit

Assessor's Details	Name	Designation	Signature	Date

Part 4 Completing the Establishment Risk Assessment - Area Risk Assessment

Within an establishment i.e. department or ward more than one manual handling activity can occur. The Establishment Risk Assessment should enable the manager to identify the current practice in each area and identify the problems that may occur.

The following areas are covered. However, if there is a location which is not within the printed format then the blank area sheet can be used.

- Bedroom or Sleeping Area
- Assisting a Person with Toiletting
- Assisting a Person with Bathing
- Day Room or Activity Area
- Load Handling
- Hydrotherapy Pool / Swimming Pool Area
- Assisting a Person into / Out of Car / Buses / Minibus
- Therapeutic Areas, e.g. Standing frames, wedges, tricycles, soft play
- Blank Area Sheets
- Other Issues of Concern

All appropriate areas must be completed.

There are three main questions to be answered in each area assessment:

1. What are the manual handling activities that occur in the area?

2. Do they comply with the guidance within the DIAG Code of Practice or give cause for concern amongst carers?

3. What measures do we need to take to reduce the risk of injury?

All area assessments will cover the following questions:

1. Are any of the following tasks carried out in your area?

List the manual handling activities that occur in this area. Activities not included on the printed list can be identified in the blank boxes.

Activity	Yes	No
Sit ⟷ ⟶ Stand		
Transferring from surface to surface in sitting		
Walking		
Assisting a person up from the floor		
Repositioning in a chair		

Example

2. Which activities, if any, fall outside the DIAG Code of Practice or give cause for concern among carers? Please give reasons why

The activities must be assessed to whether they comply with the guidance and procedures in the DIAG Code of Practice or give cause for concern amongst carers.

This section should list all the tasks which carers may have problems with. These are the issues which should be addressed in the following sections.

Which activities, if any, fall outside the DIAG Code of Practice or give cause for concern among carers? Please give reasons why.	
Example	For example Fixed height surfaces Lack of space Poor height – adjustment/ cot side mechanism Insufficient room for hoist Poor posture No profiling beds

Note any environmental issues that may interfere with the ability to move and handle correctly, for example:

- Is there enough room to achieve good posture
- Are there enough carers to carry out the activity safely
- Is there enough room to move hoist
- Is furniture easy to move
- Does the equipment have adjustable height
- Are the brakes and wheels in good working order
- Is there sufficient equipment

Other factors which may need to be taken into account are:

- Carers capability
- Training issues
- Non-compliance with safe systems

3. Action plan to improve compliance with the DIAG Codes of Practice

This should be used to suggest a plan for safer handling. This must be completed for all the specific tasks identified as problems in the sections above.

Examples of the action plan are:

- Training of carers
- Increase number of carers available
- Increase or improve equipment available
- Purchase special handling equipment, i.e. sliding sheets, transferring aids, trapeze
- Adjustable height equipment
- Redesign layout of the area

Action Plan to improve compliance with the DIAG Codes of Practice?	
	For example
Example	Height adjustable surfaces Profiling beds Overhead hoisting system Carer training Purchase sliding aids

Additional Sheets

The additional sheets are available to ensure that all aspects are covered in the Establishment Risk Assessment. The following two forms can be used as required to do this.

‘Blank’ Area Sheets

The area in which the assessment is taking place must be written at the top of the Blank Area Sheet, e.g. Clinic areas, x-ray departments, mortuary, CT scanning.

Other Issues for Concern

Any other factors, which prevent compliance with the guidance for safe handling, should be included here. Some examples are given, but this is not a complete list as the relevant factors are wide-ranging. Consider any issues connected with the physical environment, the carers (including clothing, fatigue, communication and work partnerships) allocation of work and work rate, postures etc.

BEDROOM OR SLEEPING AREAS

Are any of the following tasks carried out in your area?

Activity	Yes	No	Activity	Yes	No
Sit ⟷ Stand			Rolling/positioning on a bed		
Transferring from seat to seat			Lying to sitting		
Walking			Moving up a bed		
Assisting a person from floor			Assisting a person on/off bed		
Repositioning in a chair			Transfers in lying		

Which activities, if any, fall outside of the DIAG Codes of Practice or give cause for concern amongst carers? Please give reasons why.	
	For example Fixed height surfaces Lack of space Low level working Poor height adjustment/ bed rails mechanism Insufficient room for hoist Poor posture No profiling beds
Action Plan to improve compliance with DIAG Code of Practice	
	For example Height adjustable surfaces Profiling beds Overhead hoisting system Carer training Purchase sliding aids

TOILET AREAS		
Is assistance given with toileting?	**Yes**	**No**

Does this activity fall outside of the DIAG Codes of Practice or give cause for concern amongst carers? Please give reasons why.	
	For example
	Poor posture
	Lack of space
	Lack of hoists
	Lack of or poor quality of commodes
	Poor floor surface
	Lack of grab rails

Action Plan to improve compliance with DIAG Code of Practice	
	For example
	Purchase of suitable commodes
	Purchase suitable hoisting system
	Purchase framed turning disc
	Carer training
	Purchase slide boards
	Install grab rails
	Improve floor covering
	Alter doorways
	Adapt space
	Raised toilet seats
	Automatic toilet

BATHING AREAS

Is assistance given with bathing?	Yes	No

Which activities, if any, fall outside of the DIAG Codes of Practice or give cause for concern amongst carers? Please give reasons why.

	For example
	Poor posture Fixed baths Lack of hoists Lack of bath seats Lack of grab rails Low level working

Action Plan to improve compliance with DIAG Code of Practice

	For example
	Purchase of suitable bath Overhead hoisting system Carer training Purchase bath-boards/ seats etc Install shower and use trolley

LIVING ROOM/DAY ROOM ACTIVITY AREA		
Are any of the following tasks carried out in your area?		
Activity	**Yes**	**No**
Sit ⟷ Stand		
Transferring from surface to surface in sitting		
Walking		
Assisting a person up from the floor		
Repositioning in a chair		

Which activities, if any, fall outside of the DIAG Codes of Practice or give cause for concern amongst carers? Please give reasons why.	
	For example
	Lack of equipment
	Lack of carers
	Poor floor surfaces
	Low level working
	Lack of space
	Lack of rails/grab rails
	Seating design – height/ width/depth
	Defective seating
	Fixed foot-plates
Action Plan to improve compliance with DIAG Code of Practice	
	For example
	Purchase of appropriate equipment
	Training and availability
	Redesign layout
	Repair defective equipment

LOAD HANDLING

Activity	Yes	No	Activity	Yes	No
Storage			Moving a bed/chair with a person on it		
Moving equipment			Cleaning tasks		
			Moving furniture		

Which activities, if any, fall outside of the DIAG Codes of Practice or give cause for concern amongst carers? Please give reasons why.	
	For example Lack of equipment Lack of space Low level working Poor postures Lack of staff/carers Poor training
Action Plan to improve compliance with DIAG Code of Practice	
	For example Purchase of equipment Rearranging storage Carer/staff training Carer/staff rotas Smaller loads

HYDROTHERAPY/SWIMMING POOL AREAS

Is assistance given with this activity?	Yes	No

Which activities, if any, fall outside of the DIAG Codes of Practice or give cause for concern amongst carers? Please give reasons why.

	For example
	Lack of equipment Lack of space Low level working Lack of carers

Action Plan to improve compliance with DIAG Code of Practice

	For example
	Purchase of appropriate equipment Training and availability Redesign layout

TRANSPORTATION e.g. CARS, MINIBUSES

Is assistance given with this activity?	Yes	No

Which activities, if any, fall outside of the DIAG Codes of Practice or give cause for concern amongst carers? Please give reasons why.

	For example
	Lack of suitable/accessible transport Lack of carers Steps Carer training Low level working

Action Plan to improve compliance with DIAG Code of Practice

	For example
	Use of accessible bus/taxi Car hoist Carer training & availability Use of small handling equipment, i.e. Turn disc Car adaptations

THERAPEUTIC AREAS

Is assistance given with these activities?	Yes	No
Assisting into standing frames		
Assisting on and off wedges		
Soft Play		

Which activities, if any, fall outside of the DIAG Codes of Practice or give cause for concern amongst carers? Please give reasons why.	
	For example
	Lack of hoists Standing people who have a history of falls Lack of carers Working at floor levels for long periods of time

Action Plan to improve compliance with DIAG Code of Practice	
	For example
	Purchase of hoist Purchase of lifting cushion Training & availability Rescheduling of work load, i.e. Increase rest period Give assistance on raised surface if possible

AREA	

Activity	Yes	No	Activity	Yes	No
Sit Stand					
Transferring from seat to seat			Lying to sitting		
Walking			Moving up a bed		
Assisting a person from the floor			Assisting a person on/off bed		
Repositioning in a chair			Transfers in lying		

Which activities, if any, fall outside of the DIAG Codes of Practice or give cause for concern amongst carers? Please give reasons why.	
	For example Fixed height surfaces Lack of equipment Lack of space Poor posture No profiling beds Low level working
Action Plan to improve compliance with DIAG Code of Practice	
	For example Height adjustable surfaces Profiling beds Training Purchase appropriate equipment Redesign layout

OTHER ISSUES OF CONCERN	
Are there any other manual handling/postural issues that cause concern?	
	For example
	Work organisation Poor working postures Insufficient rest periods Poor environments i.e. space, floor condition, lighting Lack of suitable and maintained equipment Unsuitable uniforms or clothing/footwear Poor communication with other departments/ services Fitness/skill/numbers of carers Systems of work
Action plan to reduce risk	
	For example
	Improvements in the environment Purchase and maintenance of appropriate equipment Training Suitable clothing Supervision Review work schedules

Part 5 Completing the Management Checklist

Using the Management Checklist

This part of the form should be completed for all services that involve manual handling.

This includes services where:

- Handling takes place only in one main establishment
- Handling takes place in an environment where a Specific Establishment Risk
- Handling is provided to areas outside the control of direct line management

The checklist can be used:

- As part of a full Establishment Risk Assessment
- To initiate a full Establishment Risk Assessment, to show where action may be needed
- It may be used as an audit tool to evaluate compliance with the DIAG Codes of Practice in any area where carers are being involved in manual handling

Completing the form

There are three sections to the form, evaluating the performance in:

- Reporting accidents/incidents, pain or discomfort
- Training, supervision and specialist support
- Risk Assessment Procedures

All sections must be completed. Where procedures are not applicable (e.g. assessments for outside visits) write n/a in the comments box.

Where systems and procedures are not in place, put N on the Y/N box, any action to be taken should be included in the 'Summary of Needs and Action Plan' at the end of Establishment Risk Assessment Form.

MANAGEMENT CHECKLIST		
Reporting accidents/incidents/pain/ discomfort	**Y/N**	**Comments**
Incident/accident forms are completed according to the local procedure.		
Occupational Health Services are consulted where a carer has musculo-skeletal difficulties.		
Training, supervision and specialist support	**Y/N**	**Comments**
Records are kept of carers / staff attendances on training programmes.		
All carers have attended moving and handling induction training.		
All carers have received regular manual handling update training.		
Appropriate action is taken where trainers report that carers are not yet competent following training.		
Specialist advice is sought (e.g. from Back Care Adviser) where the need arises.		
Risk Assessment Procedures	**Y/N**	**Comments**
A Personal Handling Risk Assessment and Personal Handling Plan are completed on admission to the service and made available to all carers.		
A variance form is completed and made available to all carers when care given falls outside the DIAG Code of Practice.		
Procedures are written for foreseeable emergency handling.		
Specific Environment Assessment are completed for activities carried out off site/ away from home.		
Action plans passed up through the appropriate line management routes.		

Assessor's Details	Name	Designation	Signature	Date

Part 6 Completing the Establishment Risk Assessment - Summary of Needs and Action Plan

This section should represent the annual action plan for the area in question.

- All the measures, which need to be actioned should be summarised here
- All actions should have named individuals responsible for implementation
- All actions should include target dates for completion

Where the action required goes beyond the responsibility of the assessor, the summary action plan should indicate to whom the issue has been referred. It is important for issues to be referred through the management chain to achieve compliance. If actions are not completed it may be necessary to document where, when and by whom the decision was made not to carry out the action. If actions are cancelled or refused an alternative control measure should be added at the time of review.

Review

The form should be updated annually or whenever there is a change that needs to be recorded.

SUMMARY OF NEEDS AND ACTION PLAN

Action	Action by Date	Action by Person

- This form should be reviewed and updated annually, or whenever a change needs to be recorded
- It should be kept in the establishment as a record of action taken
- Where action is not within the manager's budget or authority, senior managers must be notified

Assessor's Details	Name	Designation	Signature	Date

Part 7 Completing the DIAG Manual Handling Audit - Establishment Risk Assessment Audit

An annual audit of each agency should take place to audit their implementation and compliance with the Code of Practice. This could be for the agency as a whole or for each establishment within the agency.

There are four sections in the audit, each with a different weighting:

Section 1
Policy 10%

Section 2
Organisation 10%

Section 3
Arrangements/Implementation 75%

Section 4
Review 5%

Scoring System

- For each question indicate your response score in either the Yes, No or Partial boxes.
- The score for each answer is indicated at the top of the column.
- If the score is 'No' or 'Partial' please complete the 'Comments/Action' box.
- Add the vertical columns and record in the shaded box.
- Add scores in the shaded boxes for the total in each sub section.
- All elements should be answered even if there is no compliance.

Have Key personnel have been identified to:	**Yes 4**	**No 0**	**Partial 2**	**Comments/Actions**
2.1 Co-ordinate the implementation of the DIAG Code of Practice	4			Example
2.2 Provide specialist support	4			
2.3 Provide training			2	Key trainers cascade training but not in all areas
2.4 Carry out risk assessments	4			
	12		**2**	**Total 14/16**

Completing the Introduction to the Establishment Risk Assessment Audit

Agency – the name of the Agency being audited

Establishment – the name of the Establishment within the agency being audited

Date – the date of the audit

Audited by – the name of the auditor

Completing the Establishment Risk Assessment Audit

Section 1 Policy

1.1 Is there a policy in place providing for safer handling?

Is there a policy in the organisation that details arrangements for safer handling?

1.2 Do all carers have access to the policy?

Is the policy kept in an accessible place and do carers know where to find it?

1.3 Does it mirror the DIAG policy?

Does the policy refer to the DIAG policy? Are there any contradictions to the DIAG policy?

1.4 Does the policy outline the local line management responsibilities?

Are there details of the responsibilities of all lines of management?

1.5 Does the policy outline arrangements for implementing the Code of Practice?

Section 2 Organisation

Have key personnel been identified to co-ordinate the implementation of the Code of Practice?

Is there a named person to:

2.1 Co-ordinate the implementation of the Code of Practice?

2.2 Have key personnel been identified to provide specialist support?

Is there access to a specialist in the field of manual handling?

2.3 Have key personnel been identified to provide training?

Is there a training system in place with identified people or organisations to deliver training?

2.4 Have key personnel been identified to carry out risk assessments?

Is there training in risk assessment with people identified to carry out risk assessments?

Section 3 Arrangements/Implementations

There are six parts to the Arrangements/Implementation section.

3.1 Implementation Plan

3.1.1 Has a plan been developed for the implementation of the DIAG Code of Practice?

Is there evidence of a plan that details the implementation of the DIAG Code of Practice in the organisation?

3.2 Training

3.2.1 **Is there an induction training programme in place for care handlers?**

Is there evidence of an induction programme in place for care handling? Does this take place before care handlers start work? If not, how long after starting work is induction held?

3.2.2 Is there a refresher programme in place for care handlers?

Is there evidence of a regular refresher training programme for care handlers?

3.2.3 Is there a training programme in place for load handlers?

Is there evidence that load handlers have access to a training programme?

3.2.4 Have all carers received training over the last 12 months?

Is there evidence that all carers have attended either induction or refresher training in the last year?

3.2.5 Are appropriate training records kept?

Are training records available detailing, for example, attendance/ non-attendance, the content of training, handouts, competencies and training diaries?

3.2.6 Is the effectiveness of training evaluated, including via direct observation in the workplace?

Are there any systems in place to evaluate the effectiveness of training? Are carers observed in the workplace or given a competency assessment? What evidence is there to show this is happening?

3.2.7 Are records kept of the trainers evaluation of the training?

Are there any records kept by the trainers on their reflection of the training?

3.3 Risk Assessment

3.3.1 Has compliance been achieved with the Establishment Risk Assessment?

Is there evidence that all areas have completed an Establishment Risk Assessment?

3.3.2 Have action plans from the last audit been completed?

Has appropriate action been taken following the Establishment Risk Assessment and in accordance with the action plan? Is evidence available to back this up?

3.3.3 Has compliance been achieved with the Personal Handling Risk Assessment and Personal Handling Plan?

Have Personal Handling Risk Assessment and Personal Handling Plans been completed for all persons who require assistance to move?

3.3.4 Has compliance been achieved with the load handling assessment?

Have risk assessments been recorded for all load-handling activities?

3.4 Compliance

3.4.1 Are arrangements in place to monitor and supervise handling activities?

Is there evidence of a system in place to monitor handling activities? Are carers supervised whilst care handling?

3.4.2 Are handling plans appropriate to the needs of the person?

Do the completed handling plans reflect the care handling needs of the person?

3.4.3 Are carers observed to be following handling plans?

Do the carers carry out handling as documented in the handling plan?

3.4.4 Is appropriate action taken when carers are observed as not yet competent?

When carers are observed as not yet competent during a training session, is appropriate action taken to ensure the safety of the carers and those who require assistance to move?

3.5 Access to DIAG material

3.5.1 Do carers know where to find the DIAG Code of Practice folder and other written documentation?

Do all carers know where to find the Code of Practice and any other relevant written documentation?

3.5.2 Do all carers have access to DIAG risk assessment documentation including handling plans?

Do all carers know where to find risk assessments, care plans etc and can they access them?

3.6 Consultation

3.6.1 Are people and their carers consulted about manual handling matters, including during risk assessments and contribute to the development of safe systems of work?

Scoring for the Arrangements/Implementation section

The totals for the six parts are added together to find the score for the Arrangements/Implementation section.

Section 4 Review

4.1 Is compliance with the Code of Practice audited annually?

Section 5 Organisations Audit Score

The total score for the audit is found by adding the scores for the four sections in the box at the end. The auditor should complete their details, sign and date the form to complete the audit.

Section 6 Action Plan

All the actions from the audit should be documented on the Action Plan at the end of the audit. The person responsible and date for completion should also be recorded. The auditor should complete their details, sign and date the form to complete the audit.

ESTABLISHMENT RISK ASSESSMENT AUDIT

Introduction

Agency:	Date:
Establishment:	Audited by:

Scoring System

Compliance with each element should be scored with either yes, no or partial:

	Yes Score	No Score	Partial Score	Comments/Action
Q1	Score			
Q2	Score			
Q3			Score	
	Total	**+**	**Total**	**= Total**

Indicate by a score against each question in the appropriate column. Add any comments or action necessary.

Calculate score by adding the vertical columns and recording in the shaded box. Add across the shaded boxes to find the total

Section 1 POLICY

No.	Question	Yes 2	No 0	Partial 1	Comments/Actions
1.1	Is there a policy in place providing for safer handling?				
1.2	Do all carers have access to the policy?				
1.3	Does it mirror the DIAG policy?				
1.4	Does the policy outline local line management responsibilities?				
1.5	Does the policy outline arrangements for implementing the Code of Practice?				
					Total /10

Section 2 ORGANISATION

No.	Have Key personnel have been identified to:	Yes 2.5	No 0	Partial 1.25	Comments/Actions
2.1	Co-ordinate the implementation of the DIAG Code of Practice?				
2.2	Provide specialist support				
2.3	Provide training				
2.4	Carry out risk assessments				
					Total /10

Section 3 ARRANGEMENTS/IMPLEMENTATION

No.	3.1 Implementation Plan	Yes 4	No 0	Partial 2	Comments/Actions
3.1.1	Has a plan been developed for the implementation of the DIAG Code of Practice?				
					Total /4

No.	3.2 Training	Yes 4	No 0	Partial 2	Comments/Actions
3.2.1	Is there an induction training programme in place for care handlers?				
3.2.2	Is there a refresher training programme in place for care handlers?				
3.2.3	Is there a training programme in place for load handlers?				
3.2.4	Have all carers received training over the last 12 months?				
3.2.5	Are appropriate training records kept e.g. - Attendance / non-attendance registers - Contents of training - Training diaries - Handouts - Competencies				
3.2.6	Is the effectiveness of training evaluated including via direct observation in the workplace?				
3.2.7	Are records kept of the trainer's evaluation of training?				
					Total /28

No.	3.3 Risk Assessments	Yes 4	No 0	Partial 2	Comments/Actions
3.3.1	Has compliance been achieved with the establishment risk assessment form?				
3.3.2	Have action plans from the last audit been implemented?				
3.3.3	Has compliance been achieved with the Personal Handling Risk Assessment and Personal Handling Plan?				
3.3.4	Has compliance been achieved with the load handling assessment?				
					Total /16

No.	3.4 Compliance with safe systems of work	Yes 4	No 0	Partial 2	Comments/Actions
3.4.1	Are arrangements in place to monitor and supervise handling activities?				
3.4.2	Are handling plans appropriate to the needs of the person?				
3.4.3	Are carers observed to be following handling plans?				
3.4.4	Is appropriate action taken where carers are observed as not yet competent?				
					Total /16

No.	3.5 Access to DIAG material	Yes 4	No 0	Partial 2	Comments/Actions
3.5.1	Do staff / carers know where to access the DIAG Code of Practice folder or other written documentation?				
3.5.2	Do all staff / carers have access to DIAG risk assessment documentation including handling plans?				
					Total /8

No.	3.6 Consultation	Yes 3	No 0	Partial 1.5	Comments/Actions
3.6.1	Are people, carers and members of staff consulted about manual handling matters?				
					Total /3

Section 4 REVIEW

No.		Yes 5	No 0	Partial 2.5	Comments/Actions
4.1	Is compliance with the DIAG Code of Practice audited annually?				
					Total /5

Section 5 ESTABLISHMENT RISK ASSESSMENT AUDIT SCORE

Bring the scores from the previous section and enter them in the boxes below.

<table>
<tr><td>1. Policy</td><td>/10</td></tr>
<tr><td>2. Organisation</td><td>/10</td></tr>
<tr><td>3. Arrangements/Implementation
<table>
<tr><td>3.1 Implementation Plan</td><td>/4</td></tr>
<tr><td>3.2 Training</td><td>/28</td></tr>
<tr><td>3.3 Risk Assessment</td><td>/16</td></tr>
<tr><td>3.4 Compliance</td><td>/16</td></tr>
<tr><td>3.5 Access</td><td>/8</td></tr>
<tr><td>3.6 Consultation</td><td>/3</td></tr>
<tr><td>Total for Arrangements/Implementation</td><td>Total /75</td></tr>
</table></td><td>/75</td></tr>
<tr><td>4. Review</td><td>/5</td></tr>
<tr><td>Total Percentage Score</td><td>/100</td></tr>
</table>

Assessor's Details	Name	Designation	Signature	Date

Section 6 ACTION PLAN

ACTION PLAN			
Section	**Action**	**Action by Date**	**Action by person**
1			
2			
3.1			
3.2			
3.3			
3.4			
3.5			
3.6			
4			

- This form should be reviewed and updated annually, or whenever a change needs to be recorded
- It should be kept in the establishment as a record of action taken
- Where action is not within the manager's budget or authority, senior managers must be notified

Assessor's Details	Name	Designation	Signature	Date

INANIMATE LOAD HANDLING AND GENERIC MANUAL HANDLING TASKS

RISK ASSESSMENT FORM

DERBYSHIRE

INTER-AGENCY

GROUP

Guidance on Assessing Manual Handling of Inanimate Loads and Generic Manual Handling Activities

The purpose of the risk assessment process is to reduce the potential for injury to the lowest level reasonably practicable during manual handling activities. There are a number of issues or options to help reduce the potential for injury when handling inanimate loads. They are divided into the following sections (TILEO.)

T ask

I ndividuals

L oad

E nvironment

O ther factors

The following should be considered to prevent injury.

Task

- Check if the move can be avoided or if equipment can be used to do the work
- Can they slide the load closer to them?
- Can the load be 'walked', pivoted, slid or rolled instead of lifting?
- Can a trolley or wheeled transport be used?
- Can the load be stored differently to avoid a difficult lift?
- Can the load be held as near to the base as practicable, using a palmar hold where appropriate (some objects will require a fixed grasp)
- Can the task be completed by lifting in stages?
- Can the activity be planned so as to reduce the amount of lifts involved in the task?
- Can repetitive tasks be avoided?
- Can routines be broken up or activities shared between different carers?

Individuals

- Can the task be done more safely with more people, remembering the additional risks imposed by sharing a load?
- Are the people involved fit, capable and competent to perform the task?
- Can carers use a more suitable method, hold or body position to complete the task?
- Designate a co-ordinator or leader if more than one person is involved and establish a plan for the activity using the DIAG principles
- Specific consideration should be made for new or expectant mothers and people with little experience of manual handling

Loads

- Can the load be divided, made lighter or smaller?
- Can the load be made more stable?
- Test the weight to ensure it is within the person's capabilities
- Is personal protective equipment required to protect against contamination, sharp edges, hot or cold surfaces?
- Would handles make the load easier to handle?
- Can the load be changed to make it easier to handle, e.g. wheels, slide plates, runners etc?

Environment

- Remove any obstacles that need to be removed before the task is performed safely
- Can the person get nearer to the load?
- Can they slide the load closer to them?
- Is the lighting suitable?
- Are floors level, anti-slip, free from debris?

Other factors

- Personal Protective Equipment and clothing
- Staff consultation
- Work organisation
- Perception and views of staff/carers
- Equipment
- Communication
- Clothing and footwear

Completing the Inanimate Load Handling or Generic Risk Assessment

Initial Assessment

Task

This form is designed for a single task or work activity, or to assess and document a generic risk. A brief description of the task must be recorded here.

Is a Detailed Risk Assessment necessary?
Does the task involve any activities that fall outside the guidance or the DIAG Safe Principles of Moving and Handling or give cause for concern?

The assessor should tick 'yes' in any of the following circumstances:

- The worker does not control the pace of work
- The handler is in an unstable body position
- The load is difficult to grasp with both hands
- Working conditions are unreasonable
- Handling is frequent or repetitive
- The handler is not able to apply safe movement principles, i.e.
    - Offset base
    - Close proximity to load
    - Mobile base
    - Avoidance of top-heavy posture
    - Avoidance of twisting
    - Avoidance of sustained loading
    - Avoidance of fixed holds
    - Lead with the head
- There are pushing and pulling activities involving risk of injury. Staff / carers reporting pain or discomfort or inability to carry out a push / pull activity should trigger an assessment.
- The activity involves lifting beyond the thresholds indicated in the HSE risk assessment filter

The above load handling hazards should have been identified as part of the Environment Risk Assessment.

If the load handling activity falls within safe principles for moving and handling, tick 'no', complete the Assessor's Details i.e. name, designation, signature and date and the assessment is complete.

Complete the Initial Assessment Table by recording the following details:

Description of Task	Describe the activity requiring assessment.
Location	The agency and establishment in which the assessment is being carried out must be recorded here.
Staff/Carers Involved	All staff / carers that would be involved with the activity that is being assessed must be taken into account when carrying out the assessment and recorded here.
Date of Assessment	The date on which the assessment is being carried out must be recorded here.
Diagrams or other Information	Any further information can be recorded here i.e. diagrams, photographs.

Please note: For more complex tasks more than one risk assessment may be required.

Detailed Assessment

Problems that occur with this activity	List all the identified problems with this activity using the list of examples "Factors to be taken into account in the assessment of this activity"
Remedial action	Identify remedial steps in order of priority. (Refer to 'Guidance on Assessing Manual Handling of Inanimate Loads.')
Date by which action should be taken	A realistic time scale must be recorded here by which the remedial action must be taken. A manager should sign to agree the action plan and timescale.
Date for assessment	The time scale, which has been recorded above must correlate with the date of reassessment, which must be recorded here.
Assessor's details	Complete the assessor's details i.e. name, designation, signature and date

INANIMATE LOAD OR GENERIC RISK ASSESSMENT

Initial Assessment

Task: . . . . . .

Does the task involve any activities that fall outside the guidance or the DIAG Safe Principles of Moving and Handling or give cause for concern?

Yes	
No	

If ***'No'*** complete the assessor's details below and the assessment need go no further.

Assessor's Details	Name	Designation	Signature	Date

If **'Yes'** continue assessment.

Description of Task *(Details)*	Diagrams or other information
Location	
Staff / Carers Involved	
Date of Assessment	

Detailed Assessment

Problems that occur with this activity (description)

Task	Individual	Load	Environment	Other Factors
Close proximity to load	Health problem	Heavy	Constraints on posture	Communication
Twisting	Pregnant	Bulky	Poor floors	PPE/Uniform
Top heavy posture	Specialist training	Unwieldy	Uneven levels	Perception of staff
Reaching upwards	Specific information	Difficult to grasp	Hot/Cold/Humid	
Carrying distances		Unstable	Poor light	
Repetitive		Hot/Cold		
Excessive pushing/ pulling				

Remedial Action

Remedial steps in order or priority:
1.
2.
3.
4.
5.
6.
7.
8.

Date by which action should be taken	
Date of reassessment	

Assessor's Details	Name	Designation	Sign	Date

PERSONAL HANDLING RISK ASSESSMENT AND PERSONAL HANDLING PLAN

DERBYSHIRE

INTER-AGENCY

GROUP

Introduction to the Personal Handling Risk Assessment (PHRA)

A Personal Handling Risk Assessment and Plan must be completed for every person receiving a service within the organisation. This may require no more than completing the persons details and indicating that they are fully independent. This must then be signed and dated.

When carers assist a person to move, an assessment must be carried out. This involves the same processes as the other risk assessments mentioned previously i.e. identifying risks, methods to reduce risks and reviewing the situation.

Key points for the risk assessment process in person handling:

- People without sitting balance should not be left in unsupported sitting positions.
- People without the strength, balance, co-ordination and co-operation to stand should not be left in unsupported standing positions.
- People without the strength, balance, co-ordination and co-operation to walk should not be left in unsupported walking situations.

In real terms:

ONLY SIT PEOPLE WHO CAN SIT

ONLY STAND PEOPLE WHO CAN STAND

ONLY WALK PEOPLE WHO CAN WALK

This advice may lead to conflict for those carers involved with rehabilitation and in managing a person who can be aggressive or non-co-operative. Carers dealing with these situations should be placed at no higher risk than any one else. The principles relating to the control of risk from these specific handling situations is exactly the same. These carers should have the higher level of risk assessment skills required to progress a persons ability or use mechanical means to support people instead of their own strength. These specific risks will be discussed in later sections e.g., Variance Risk Assessment procedure.

The Personal Handling Risk Assessment and Personal Handling Plan are the documents that identify the risks and outline the methods of reducing the risks to the lowest possible levels for both the carer and the person requiring assistance to move. These assessments are essentially one document that records the persons abilities, difficulties and a plan of how the carers are going to assist the person to move.

Within DIAG there are different versions of this PHRA/PHP document, i.e. clinics, standard and long term, however, they contain the same information and are transferable both intra and inter agency. In light of electronic patient records, the information recorded on these forms may be held on a computer and a printed version may only contain the sections that are relevant to the person requiring assistance to move.

The timescale for completion and review of the Personal Handling Risk Assessment and Personal Handling Plan should comply with local policies and procedures.

Completing the Personal Handling Risk Assessment (PHRA)

The PHRA should be completed with the person or with their advocate.

Fill in the persons details in full. State the place of assessment if not the home address e.g. ward or department. State if the height and weight are estimated or actual.

The following questions should be asked when carrying out the assessment on a person. This process will enable you to complete both the Personal Handling Risk Assessment and Personal Handling Plan.

Does the person require assistance to move?

If the person does not require assistance to move no further action is required

- This assessment should then be recorded on the Personal Handling Risk Assessment by ticking the person is 'Fully Independent' box. The assessor's details should then be completed to indicate the assessment has taken place i.e. name, designation, signature and date.

  This assessment must be regularly reviewed and if circumstances alter then the assessment and plan must be completed as necessary.

If the person does require assistance to move

- The risk assessment process begins with assessing the person's abilities i.e. what the person can do for themselves. This process looks at the person's sensory/ behavioural and physical qualities and determines if they affect the person's ability to move. If any of these factors affect the person's ability to move then they should be ticked.

The following factors should be considered:

Sensory and Behavioural Qualities

1. Communication

Is the person able to communicate with the carer directly/indirectly?

Is it verbal or non-verbal communication?

What language do they speak/ understand?

Are the carers aware of communication skills, e.g. cues, symbols, touch?

2. Comprehension

Is the person able to understand instructions or requests from carers?

If not what is required to achieve co-operation?

Do relatives, personal carers need to be involved to achieve this?

3. Sight /hearing

Does the person have any problems with sight or hearing?

If so are glasses or hearing aids available and functioning.

Do they need guidance either verbally, by touch or by signing?

4. Behaviour

Does the person have appropriate reactions when approached or are they likely to be aggressive or non-co-operative?

If so, what considerations need to be taken e.g. a special approach or to stick to a daily routine?

5. History of falls or seizures

Does the person have a history of falling or seizures?

How will this affect the way they move or are assisted?

6. Medication

Is the person on any medication which affects their ability to move e.g. pain relief, sedatives, anti-spasmodics etc?

Do you need to time the movement of the person to coincide with or avoid the affects of their medication?

Physical Qualities

7. Sitting balance

Can the person sit independently on the side of a bed or in a chair without using the backrest for support?

8. Sitting to stand

Can the person lift their hips/bottom off the seat to stand up independently?
If not can they achieve this with prompts or instruction, provision of equipment or manual facilitation?

9. Weight bearing on single leg

Can the person weight bear on at least one leg?

If not then what equipment or assistance is needed?

10. Walking

Can the person walk independently?

If not can they achieve this with equipment e.g. Zimmer frame walking sticks, crutches, rollator etc?

Do they need manual assistance and from how many people?

11. Upper limb strength

Can the person take weight through their upper limbs e.g. push up from a chair alter their position whilst sitting, support their weight with a walking stick, Zimmer frame etc?

12. Head control

Can the person control and voluntarily move their head?

If not does the person require support during movement?

What support is required e.g. head/body brace, head support in hoist sling?

13. Range of joint movement

Does the person have restricted range of movement in any joint?

Does it affect the person's ability to move independently?

If so what problems does this cause and what considerations are necessary e.g. handling, support, positions, equipment application?

14. Muscle power/tone

Does the person have any difficulties with muscle weakness or high/low tone?

If so, how will this affect their handling e.g. appropriate selection and use of equipment, position of limbs and facilitation by carers?

15. Involuntary movement

Does the person have involuntary movement and if so how does this affect their ability to move?

Do they require equipment or manual assistance?

16. Supports/attachments

Does the person use any supports or have any attachments, e.g. braces, calipers, drips, catheters, stomas, prostheses, external fixators etc?

If so what considerations need to be taken e.g. appropriate equipment, selection of hand-holds for manual assistance?

17. Pain

Does the person experience any pain?

Can it be reduced by medication or positioning?

Does the pain affect the person's functional ability, co-operation or willingness to move?

What needs to be taken into account prior to movement e.g. medication time, time of day, hand-holds or support, equipment selection and positioning?

18. Skin condition

Does the person have any skin problems that will affect their manual handling e.g. pressure sores, weeping wounds, infections?

If so what special precautions need to be taken e.g. single person use sling, hand positions for manual assistance, use of gloves, gown etc?

19. Other

Are there any other factors that need to be taken into account to ensure an appropriate handling method is selected e.g. cultural or religious background and beliefs?

Does the person have different handling needs at different times of the day?

Comments Box

If any of these factors are indicated, further details can be recorded in the comments box. Each factor can be referred to by the number on the list of factors.

Assessor's Details

The Assessor's details should then be completed. All assessor's details must be completed i.e. assessors name and designation printed, assessor's signature and the date the assessment is completed.

Review Details

The same quality of information must be recorded in the review dates according to the person's ability.

PERSONAL HANDLING RISK ASSESSMENT

Person's Name: Place of assessment:

Date of Birth: Height: Weight:

Home Address: (State if estimated or actual)

With the person, please consider by ticking and commenting, which of the following factors need to be considered, when assistance to move is required.

Initial Assessment			Fully Independent Yes❑ No❑
1 ❑ Communication	7 ❑ Sitting balance	13 ❑ Range of joint movement	
2 ❑ Comprehension	8 ❑ Sitting to stand	14 ❑ Muscle power/tone	
3 ❑ Sight/hearing	9 ❑ Weight bearing	15 ❑ Involuntary movement	
4 ❑ Appropriate behaviour	10 ❑ Walking	16 ❑ Supports attachments	
5 ❑ History of falls/seizures	11 ❑ Upper limb strength	17 ❑ Pain	
6 ❑ Medication	12 ❑ Head control	18 ❑ Skin condition	
		19 ❑ Other	

Comments

Assessor's Name	Designation	Signature	Assessment Date	Review Date

PERSONAL HANDLING RISK ASSESSMENT

Person's Name: Place of assessment:

Date of Birth: Height: Weight:

Home Address: (State if estimated or actual)

With the person, please consider by ticking and commenting, which of the following factors need to be considered, when assistance to move is required.

Initial Assessment			**Fully Independent Yes❑ No❑**
1 ❑ Communication	7 ❑ Sitting balance	13 ❑ Range of joint movement	
2 ❑ Comprehension	8 ❑ Sitting to stand	14 ❑ Muscle power/tone	
3 ❑ Sight/hearing	9 ❑ Weight bearing	15 ❑ Involuntary movement	
4 ❑ Appropriate behaviour	10 ❑ Walking	16 ❑ Supports attachments	
5 ❑ History of falls/seizures	11 ❑ Upper limb strength	17 ❑ Pain	
6 ❑ Medication	12 ❑ Head control	18 ❑ Skin condition	
		19 ❑ Other	
Comments			

Print Name: **Designation:** **Signature:** **Date:**

Review Assessment			**Fully Independent Yes❑ No❑**
1 ❑ Communication	7 ❑ Sitting balance	13 ❑ Range of joint movement	
2 ❑ Comprehension	8 ❑ Sitting to stand	14 ❑ Muscle power/tone	
3 ❑ Sight/hearing	9 ❑ Weight bearing	15 ❑ Involuntary movement	
4 ❑ Appropriate behaviour	10 ❑ Walking	16 ❑ Supports attachments	
5 ❑ History of falls/seizures	11 ❑ Upper limb strength	17 ❑ Pain	
6 ❑ Medication	12 ❑ Head control	18 ❑ Skin condition	
		19 ❑ Other	
Comments			

Print Name: **Designation:** **Signature:** **Date:**

Review Assessment			**Fully Independent Yes❑ No❑**
1 ❑ Communication	7 ❑ Sitting balance	13 ❑ Range of joint movement	
2 ❑ Comprehension	8 ❑ Sitting to stand	14 ❑ Muscle power/tone	
3 ❑ Sight/hearing	9 ❑ Weight bearing	15 ❑ Involuntary movement	
4 ❑ Appropriate behaviour	10 ❑ Walking	16 ❑ Supports attachments	
5 ❑ History of falls/seizures	11 ❑ Upper limb strength	17 ❑ Pain	
6 ❑ Medication	12 ❑ Head control	18 ❑ Skin condition	
		19 ❑ Other	
Comments			

Print Name: **Designation:** **Signature:** **Date:**

Introduction to the Personal Handling Plan (PHP)

A Personal Handling Risk Assessment and Plan must be completed for every person receiving a service within the organisation. This may require no more than completing the persons details and indicating that they are fully independent. This must be then signed and dated.

If a person requires any assistance to move then the plan should be completed. As this is part of the DIAG process a previous Personal Handling Risk Assessment and Plan may have been completed by another agency and should be reviewed. If the Plan is appropriate then continue with the methods as outlined.

The form is designed to give any carer sufficient information to carry out manual handling activities safely. It should always contain information related to the procedures contained within the Codes of Practice. This should include the method for providing assistance to the person, the equipment needed and the number of carers needed. If a hoist is to be used there needs to be sufficient information on which hoist, which sling, how the sling is applied and any special precautions.

Actions to Avoid

Certain methods have been shown to be higher risk and should be avoided in PHP's. These include:

1. Full weight lifts

2. Activities which take most of the person's weight

3. Front assisted transfers and drag lift

Comprehensive guidance on these manoeuvres and the risks involved can be found in the Practical Guide.

Completing The Personal Handling Plan (PHP)

When completing the Personal Handling Plan all relevant sections should be completed.

Person's Name

Enter the full name of the person who requires assistance by printing and underline the surname. If possible add the hospital identification number and date of birth. A hospital sticker may be used to provide this information.

Assessment

Each assessment column must have the date and time that the assessment was carried out clearly stated.

Tasks

The left hand column of the Plan indicates the tasks that can be carried out by the person. Each task must be considered when completing the Personal Handling Plan. Guidance for DIAG accepted activities are found in the Procedures and Guidance Notes in the Practical Guides for Care Handling.

The tasks are as follows:

- Sit–Stand
- Sit-Sit
- Toiletting
- Walking
- Moving up/down bed
- Turning in bed
- In/out bed
- Bathing or showering

For each task the following information must be completed:

Not Applicable?

If the task is inappropriate then tick the box. E.g., person is on bed-rest then sit to stand assessment is 'Not Applicable'. If this is the case then go onto the next task box.

Independent

Indicate if the person is independent or not, by circling the appropriate 'YES' or 'NO'.

If the person is not independent, circle 'NO' and complete the rest of the task box.

If the person is independent, circle 'YES' and go to the next task box. It may be necessary to have a 'YES' independent but have equipment detailed e.g. a slide-board for sit to sit transfers.

Number of Carers

Indicate the number of carers required to carry out the task safely, by circling the appropriate number.

Equipment

Name the type of equipment that is required to carry out the activity safely i.e. zimmer frame, walking sticks, slide sheet etc. Further details of the hoist and sling are described at the end of the form.

Method

Provide a brief description of the handling method. The method selected should be taken from the practical guides and should be in accordance with the descriptors used in the Procedures outlined in the DIAG Codes of Practice i.e. for standing 'oblique behind', for moving up a bed 'feet flat on floor'.

For certain handling situations it may be appropriate to add more specific information e.g. specific hand-holds or verbal encouragement needed. There may also be the need for information relating to changes in the environment e.g. moving furniture.

If a local procedure has been developed this should be referred to.

For complex hoisting situations it may be necessary to include sling fitting or loop fitting information in the method box.

Note that activities identified as high risk which fall outside the Code of Practice should NOT be included.

Variance

If any handling technique is required which falls outside the Care Handling Code of Practice, then indicate this by ticking the 'YES' and complete the variance procedure form. Support and advice from a Back Care Adviser needs to be sought before completing the Variance Risk Assessment procedure.

The risk assessor can complete the Variance Risk Assessment procedure form. Information and advice can be given by the therapists when completing the Variance Risk Assessment procedure. Specific assessment and training of competence for the carers who will carry out the activity must be recorded.

Hoist and Sling Details

If a person needs hoisting then this section must be completed. The number of carers needed should be identified within each task box.

Hoist Details

Hoist Make e.g. Oxford, Arjo, Promed, Liko, Molift.

Hoist Model e.g. Mini, Maxi, Pixel, Maximove, Delta, Viking. Include battery or hydraulic.

Hoist Function - Indicate whether the hoist is Active or Passive. Please refer to Selecting a Hoist in the Guidance Notes for further information.

Sling Details

Sling type - e.g. Quickfit, Deluxe, Toileting / Access, Walking Harness, Special, Universal.

Sling size - e.g. XS, S, M, L, XL, if colour coding system is used on the sling note the colour and the size not just the colour.

Sling fitting - tick the applicable fitting method.

- **Standard**
  The only way this sling can be fitted according to the make and model e.g. slings with a locking key system of fixation.

- **Under leg**
  The leg straps are crossed under the person's thighs and attached to the spreader bar. This will keep the person's legs together when hoisting.

- **Through leg**
  This involves the leg straps placed between the person's legs and directly up attaching to the hoist spreader bar.

- **Through legs crossed**
  The leg straps are passed between the person's legs. Dependent upon the sling type the sling can then be:

  - Crossed, loops linked through each other and attached to the opposite side of the spreader bar

  - Brought together and joined by connecting interlocking leg loops and attaching to the same side of the spreader bar. The connecting interlocking leg loops system can be a small loop or a band of tape.

Loop Fitting

If using a sling with loop fittings, record which loops are attached to the spreader bar. Loop No.1 is closest to the body of the sling the numbers increase as they get further away from the body of the sling. If different coloured loops are present the colour of the loop should be indicated.

Assessor's Details

The person who is completing the Personal Handling Plan must record the following information:

- Printed name
- Designation
- Signature
- Date of initial assessment
- Date of review assessment

Review Assessment

Proposed review dates must be recorded in the assessor's details. All assessments must be reviewed on a regular basis and can be triggered by a change in the person's condition, new processes instigated or the treatment changes. The appropriate information must then be recorded under the review assessment.

If no change has occurred since the last assessment of that task, then this can be recorded by 'arrowing' to the next review assessment box.

Blank Boxes

If other tasks need assistance which are not included in the form indicate by ticking the 'Is there any information or activities recorded overleaf' box on the end of page 3 of the personal handling plan and continue to record the required information on page 4.

The task must be written in the shaded area and appropriate assessment details recorded.

Examples of additional assessments are:-

- On/off the floor
- On/off bed pan
- Standing frame
- Transport
- Hydrotherapy or swimming pools
- Therapeutic wedges
- Lateral transfers

Range of Personal Handling Risk Assessments and personal Handling Plans

Three types of Personal Handling Plan form are included here:

Single assessment – this is aimed at areas that deliver long-term care. It is presumed that the handling plan will not change frequently in the areas that use this form.

Two reviews – for acute health or where the person's condition is likely to change it will be simpler to review and update the handling plan on the same form. Each column of tasks must have instructions in each box. It is sufficient to 'arrow' the instructions from the previous assessment and plan.

Clinic/A&E assessment – in areas where only limited activities are carried out e.g. X-ray, A&E, Clinic etc, it is acceptable and quicker to have a shortened form where the assessment need only include the activities that need to be completed.

The risk assessment box is identical to the other forms and the Personal Handling Plan should state only the relevant tasks and the appropriate actions.

PERSONAL HANDLING PLAN

Personal Details:		
Assessment Criteria	Assessment	
	Date:	
Sit ⟷ Stand	Not applicable ❑	Variance ❑
Independent	Yes	No
Number of carers	1 2 3 4	
Equipment		
Method		
Sit ⟷ Sit	Not applicable ❑	Variance ❑
Independent	Yes	No
Number of carers	1 2 3 4	
Equipment		
Method		
Toiletting	Not applicable ❑	Variance ❑
Independent	Yes	No
Number of carers	1 2 3 4	
Equipment		
Method		
Walking	Not applicable ❑	Variance ❑
Independent	Yes	No
Number of carers	1 2 3 4	
Equipment		
Method		
Moving Up/Down Bed	Not applicable ❑	Variance ❑
Independent	Yes	No
Number of carers	1 2 3 4	
Equipment		
Method		

Personal Details				
Assessment Criteria	Assessment			
	Date:			
Turning in Bed	Not applicable ❑		Variance ❑	
Independent	Yes		No	
Number of carers	1 2 3 4			
Equipment				
Method				
In/Out of Bed	Not applicable ❑		Variance ❑	
Independent	Yes		No	
Number of carers	1 2 3 4			
Equipment				
Method				
Bathing/Showering	Not applicable ❑		Variance ❑	
Independent	Yes		No	
Number of carers	1 2 3 4			
Equipment				
Method				
Hoisting System Section	**Not applicable ❑**			
Hoist Details				
Sling Details				
Loop Fitting	Shoulder:		Leg	
Fitting Method	Standard	Under leg	Thro' leg	Thro' cross
Comments:				

Assessor's Name	Designation	Signature	Assessment Date	Review Date
Is there any information or activities recorded overleaf? Yes ❑				

	Date:
Task	Variance ❑
Independent	Yes / No
Number of carers	1 2 3 4
Equipment	
Method	
Task	Variance ❑
Independent	Yes / No
Number of carers	1 2 3 4
Equipment	
Method	
Task	Variance ❑
Independent	Yes / No
Number of carers	1 2 3 4
Equipment	
Method	
Task	Variance ❑
Independent	Yes / No
Number of carers	1 2 3 4
Equipment	
Method	
Task	Variance ❑
Independent	Yes / No
Number of carers	1 2 3 4
Equipment	
Method	

Assessor's Name	Designation	Signature	Assessment Date	Review Date

PERSONAL HANDLING PLAN

PERSONAL DETAILS :			
Assessment Criteria	**Initial Assessment**	**Review Assessment**	**Review Assessment**
	Date	Date	Date
Sit to Stand	Not Applicable ❑	Not Applicable ❑	Not Applicable ❑
Independent?	Yes / No	Yes / No	Yes / No
No. Carers	1 2 3 4	1 2 3 4	1 2 3 4
Equipment			
Method			
Variance	Yes ❑	Yes ❑	Yes ❑
Sit to Sit	Not Applicable ❑	Not Applicable ❑	Not Applicable ❑
Independent?	Yes / No	Yes / No	Yes / No
No. Carers	1 2 3 4	1 2 3 4	1 2 3 4
Equipment			
Method			
Variance	Yes ❑	Yes ❑	Yes ❑
Toiletting	Not Applicable ❑	Not Applicable ❑	Not Applicable ❑
Independent?	Yes / No	Yes / No	Yes / No
No. Carers	1 2 3 4	1 2 3 4	1 2 3 4
Equipment			
Method			
Variance	Yes ❑	Yes ❑	Yes ❑
Walking	Not Applicable ❑	Not Applicable ❑	Not Applicable ❑
Independent?	Yes / No	Yes / No	Yes / No
No. Carers	1 2 3 4	1 2 3 4	1 2 3 4
Equipment			
Method			
Variance	Yes ❑	Yes ❑	Yes ❑
Moving Up/ Down Bed	Not Applicable ❑	Not Applicable ❑	Not Applicable ❑
Independent?	Yes / No	Yes / No	Yes / No
No. Carers	1 2 3 4	1 2 3 4	1 2 3 4
Equipment			
Method			
Variance	Yes ❑	Yes ❑	Yes ❑

Assessment Criteria		Initial Assessment		Review Assessment		Review Assessment	
		Date		Date		Date	
Turning in Bed		Not Applicable ❑		Not Applicable ❑		Not Applicable ❑	
Independent?		Yes	No	Yes	No	Yes	No
No. Carers		1 2 3 4		1 2 3 4		1 2 3 4	
Equipment							
Method							
Variance		Yes ❑		Yes ❑		Yes ❑	
In/Out Bed		Not Applicable ❑		Not Applicable ❑		Not Applicable ❑	
Independent?		Yes	No	Yes	No	Yes	No
No. Carers		1 2 3 4		1 2 3 4		1 2 3 4	
Equipment							
Method							
Variance		Yes ❑		Yes ❑		Yes ❑	
Bathing or Showering		Not Applicable ❑		Not Applicable ❑		Not Applicable ❑	
Independent?		Yes	No	Yes	No	Yes	No
No. Carers		1 2 3 4		1 2 3 4		1 2 3 4	
Equipment							
Method							
Variance		Yes ❑		Yes ❑		Yes ❑	
Hoist Details							
Sling Details							
Fitting	**STANDARD** **UNDER LEG** **THRO' LEG** **THRO'CROSS**						
Loop Fitting	**SHOULDER**						
	LEG						

Assessor's Name	Designation	Signature	Assessment Date	Review Date

Assessment Criteria	Initial Assessment	Review Assessment	Review Assessment
	Date	Date	Date
Task:			
No. Carers	1 2 3 4	1 2 3 4	1 2 3 4
Equipment			
Method			
Variance	Yes ❑	Yes ❑	Yes ❑
Task:			
No. Carers	1 2 3 4	1 2 3 4	1 2 3 4
Equipment			
Method			
Variance	Yes ❑	Yes ❑	Yes ❑
Task:			
No. Carers	1 2 3 4	1 2 3 4	1 2 3 4
Equipment			
Method			
Variance	Yes ❑	Yes ❑	Yes ❑
Task:			
No. Carers	1 2 3 4	1 2 3 4	1 2 3 4
Equipment			
Method			
Variance	Yes ❑	Yes ❑	Yes ❑

Assessor's Name	Designation	Signature	Assessment Date	Review Date

PERSONAL HANDLING RISK ASSESSMENT AND PLAN

Person's Name: Place of assessment:

Date of Birth: Height: Weight:
Home Address: (State if estimated or actual)

With the person, please consider by ticking and commenting, which of the following factors need to be considered, when assistance to move is required.

Initial Assessment		**Fully Independent Yes ❑ No ❑**
1 ❑ Communication	7 ❑ Sitting balance	13 ❑ Range of joint movement
2 ❑ Comprehension	8 ❑ Sitting to stand	14 ❑ Muscle power/tone
3 ❑ Sight/hearing	9 ❑ Weight bearing	15 ❑ Involuntary movement
4 ❑ Appropriate behaviour	10 ❑ Walking	16 ❑ Supports attachments
5 ❑ History of falls/seizures	11 ❑ Upper limb strength	17 ❑ Pain
6 ❑ Medication	12 ❑ Head control	18 ❑ Skin condition
		19 ❑ Other

Comments

Assessment Criteria	**Initial Assessment**		**Review Assessment**		**Review Assessment**	
	Date		**Date**		**Date**	
Task:						
Independent?	Yes	No	Yes	No	Yes	No
No. Carers	1 2 3 4		1 2 3 4		1 2 3 4	
Equipment						
Method						
Variance	Yes ❑		Yes ❑		Yes ❑	
Task:						
Independent?	Yes	No	Yes	No	Yes	No
No. Carers	1 2 3 4		1 2 3 4		1 2 3 4	
Equipment						
Method						
Variance	Yes ❑		Yes ❑		Yes ❑	

Assessor's Name	**Designation**	**Signature**	**Assessment Date**	**Review Date**

SPECIFIC ENVIRONMENTAL RISK ASSESSMENT

DERBYSHIRE

INTER-AGENCY

GROUP

Completing the Specific Environmental Risk Assessment

The Specific Environment Risk Assessment Form should be used when care is delivered in a specific environment where the completion of an Establishment Risk Assessment is not appropriate. This may be, for example, in a person's own home, or in an establishment where only one or two individuals are assisted (such as in a mainstream school) and the full Establishment Assessment is not warranted.

It should be completed in conjunction with the Personal Handling Risk Assessment Plan.

A range of individuals will need to be consulted and included in the assessment process – the person, their carers, and other professionals (such as members of the discharge team if the assessment is done as part of a hospital discharge.)

Person's details

Where the assessment is of a person's own home, the person's name should be recorded here.

Date of Assessment

The date on which the assessment is carried out should be inserted here

Place of Assessment

The address of the house, establishment or facility assessed should be noted here.

Assessment Team Details

All carers who are involved with the assessment should have their names, designations and signatures recorded.

Review Date

The review date identified by the assessment team should be recorded here.

Identify the areas where there is an increased manual handling risk

The only areas that need to be listed here, are those where there is an increased risk from manual handling and not all the areas where manual handling activities occur.

An explanation needs to be given as to why these areas pose an increase to the manual handling risk e.g. loose fitting rugs, uneven surface areas in playgrounds etc.

Are there any other areas of concern?

The specific environmental assessment may be used to assess areas where services are already being provided, and may therefore identify areas of concern not connected with the physical aspects of the building, but which nevertheless prevent safe handling guidance being adhered to. Examples might include poor inter-agency communication, or inappropriate clothing being worn by carers.

Action Plan

Details should be included here of appropriate control measures to reduce the risks to the lowest possible level. This should include both short term and long term measures, and the names and designations of carers responsible for completing the actions.

SPECIFIC ENVIRONMENTAL RISK ASESSMENT

Person's Name	Date of Assessment
Place of Assessment	Review Assessment Date

Assessment Team Details		
Names	**Designation**	**Signature**

This assessment should be done in conjunction with the Personal Handling Risk Assessment and Personal Handling Plan.

Identify the areas where manual handling activities need to be assessed. Please give reasons why.	
	For example Lounge/Bedroom/ Kitchen/Bathroom/Toilet Internal / External access Doorways Thresholds Floors Furniture height/ clearance Power points Lighting Classrooms Outdoor space including playgrounds

Are there any other areas of concern?			For example
			Equipment not maintained Lack of training Poor communication Inappropriate clothing Handling plans unavailable
Action Plan			**For example**
Action	Action by Date	Action by Person	Equipment checks Training Complete handling plans

VARIANCE RISK ASSESSMENT

DERBYSHIRE

INTER-AGENCY

GROUP

Introduction to the Variance Risk Assessment Process

A Variance Risk Assessment is required when the handling situation falls outside of the guidance in the Practical Guide of the Code of Practice. This may be in either a care situation or part of a therapeutic procedure. The Back Care Adviser should be consulted whenever a Variance Risk Assessment is considered.

Variance Procedure

The DIAG Code of Practice gives specific procedures in the practical guide for a large array of handling situations, which may be used in the delivery of care and therapy. It is envisaged that for most situations this comprehensive list of procedures and guidance should be sufficient for all care provision. There will however, be situations where it may not be possible for the Code of Practice to be followed. If this does occur then a Variance Risk Assessment must be triggered.

A Variance Risk Assessment is **NOT** a method that allows dangerous practice to be sanctioned. All the options for safe handling within the Code of Practice must be considered before the variance procedure is actioned.

However on very rare occasions a person's needs are so pressing and significant and all avenues of safer assistance have been exhausted and help can only be given using a higher risk method, for example a full weight lift. Because the risk of injury is higher, the situation should be managed with extreme care and diligence using the variance process. Assessors should **always** refer to the agency's Back Care Adviser before including higher risk strategies.

Therapeutic Handling

The process of rehabilitation is complex and at certain times it may be necessary to use handling methods which are against the key principles of safe handling, e.g. standing a person who is unsteady on their feet to develop walking ability. If these activities are essential, need to be repeated by a number of carers and cannot be avoided, then a Variance Risk Assessment needs to be completed. The purpose of the Variance Risk Assessment is to ensure that staff/carers carrying out these activities, are not being put at an unacceptable risk. This is of benefit to both the carer and person in the rehabilitation process.

The situations that would trigger a Variance Risk Assessment may be for example:

- A Personal Handling Plan suggests a piece of equipment that is not available within a certain area and the handling activity cannot be carried out by any other method within the Code of Practice. In this instance the variance should only be for a short time until the equipment is made available.
- A person's needs are sufficiently complex that standard guidance is not applicable.
- A person's condition is sufficiently complex that the information on the standard Personal Handling Plan is not sufficient for carers to deliver care appropriately. This may include specific hoisting advice or guidance to use combinations of equipment.

The therapy situations that would trigger a Variance Risk Assessment include

- A task that involves carers assisting a person to move in a way which falls outside the recommended methods of care handling
- A task that forms part of the rehabilitation process.
- A task of short term duration
- A task with a distinct aim and measurable outcome

A Variance Risk Assessment Form must be completed by an appropriately skilled risk assessor with experience in the area of work.

Delegation of duties to colleagues/other carers

The consequences of the risk assessment process are multiplied if the therapist then delegates the high-risk activity to assistants, colleagues or other carers. All professional bodies involved in healthcare situations have produced codes of practice outlining the roles and responsibilities of delegation, (RCN, CSP, COT)

Tasks can only be delegated when:

- The risk assessment process has been completed appropriately
- The therapist is aware of the competencies and physical capabilities of the carers to carry out the task
- The diagnosis, stability and severity of the person's condition is known
- The person's response to the activity is known
- The act of delegation is not likely to place the carers at any significant risk of injury

Competencies can only be given to a carer when:

- They have been instructed in the task
- They have understood the requirements of the task
- Have been seen to safely complete the task without discomfort or undue strain
- Have signed to agree competency

Both the person and the carer could be put at risk if the process for agreed competencies is not followed.

If an activity is causing any particular concern it should be stopped immediately. For further guidance contact your local manager or the Back Care Adviser

Local Procedures for Handling Variances

In some situations where a handling variance is repeated regularly, there may be the need to write a local procedure or a local guidance note. If this situation arises help should be sought from the Back Care Advisor within the agency.

VARIANCE RISK ASSESSMENT FORM

DERBYSHIRE

INTER-AGENCY

GROUP

Completing the Variance Risk Assessment Form

The Variance Risk Assessment Form must be completed if the manual handling task that is being assessed falls outside the DIAG Care Handling Codes of Practice.

The Variance Forms must be completed by a risk assessor or therapist who has explored all the alternative manual handling techniques within the Codes of Practice.

The process is one based on the principles of risk management. The risk assessor and all carers need to balance the risk of injury, to themselves and colleagues, against the benefits to the person of the handling activity.

The risk assessor must accept the responsibility to document, instruct, supervise and therefore deem the person competent in the variance procedure. This must also be repeated with all persons who will encounter the manual handling variance.

The following information must be recorded on the Variance Forms:

Personal/Establishment Details

Agency/Establishment - This refers to the area in which the manual handling activity is taking place. This may be the person's home, a department, hospital ward or at a specific location.

Person's Details

Complete the person's details in full according to local standards within each agency.

Description of the Activity/Task

This includes information on the manual handling activity you wish to carry out with the person i.e. sit to stand, walking, moving up the bed.

Information should be included here about why it is necessary to carry out the task and the benefit to the person of the activity.

Why is the Code of Practice not applicable?

The Code of Practice may not be applicable for a variety of reasons. These might include:

- Suitable equipment may not be available in the short or long term
- The person's needs and abilities may be complex; and standard guidance may not match their needs
- There may be environmental constraints such as insufficient space to use a hoist
- The variance may be required due to the need for an emergency intervention
- The person may be in a transitional phase of consolidating movement skills from a therapeutic situation to one where the handling falls within standard care handling guidance
- The handling is part of a rehabilitation / therapeutic programme

What are the risks associated with this activity?

All hazards need to be documented here. These could include:

- Holding the weight away from the trunk
- Poor posture e.g. kneeling, low level working, twisting, stooping
- Sudden or unpredictable movement
- Excessive carrying distances
- Prolonged or frequent holding
- Application of excessive force
- Hazards associated with the person assisted (e.g. weight, level of ability, behaviour)
- Hazards in the environment, such as lack of space

What consideration has been given to a longer-term solution?

Sometimes the variance procedure might need to be followed because of lack of suitable facilities – for example inaccessible transport or the lack of a suitable hoist.

The assessor must give details of any action taken to resolve this issue in the longer term. This might include investigating the purchase of equipment, referring the matter to a senior manager if necessary. This should link in with the Establishment Risk Assessment so that longer term solutions are considered.

Method for carrying out this task.

Information should be included to indicate:

- Appropriate holds
- Working positions and postures
- How the carer should perform the movement
- What should be done in the event of an emergency (e.g. fall)
- What signs should alert the carer of the need to refer back to the risk assessor or therapist

Competency Statement

The names of carers who have been given instruction in how to carry out the task should be included here. The carers must inform their manager or therapist if they have any concerns about their safety while carrying out the activity, or if there are any changes which should trigger a review.

A carer can only be deemed competent when:

- They have been instructed in the task
- The have understood the requirements of the task
- Have been seen to safely complete the task without discomfort or undue strain
- Have signed to agree competency

Assessment Details

The following details must be recorded at the end of the variance form:-

Carers Details	-	Name
		Designation
		Date Observed
		Signature
Assessor's Details	-	Name
		Designation
		Signature
		Date of Assessment
Manager's Details	-	Name
		Designation
		Signature
		Date of Signature

Review Date

Variance Risk Assessments are not designed to be long-term. They should be interim measures until practice can be changed to something within the Codes of Practice. The review date should therefore not be an extensive period of time.

VARIANCE RISK ASESSMENT

Person's Details:	Establishment where activity is being carried out:

Description of task or activity and benefit to the person

Why is the Code of Practice Guidance not applicable?	Example
	Equipment unavailable Environmental constraints Person's needs are complex Person needs more than minimal assistance

What are the risks associated with this activity?	Example
	Non compliance with movement principles Lifting beyond guideline threshold Environmental hazards Risks associated with comprehension, compliance, level of active participation

What consideration has been given to a longer term solution?	Example
	Purchase of equipment

Method for carrying out the activity (give detailed instructions including any additional precautions to reduce the risks to carer and person being assisted.)

Competency Statement

The following people have been instructed and are aware of their rights and responsibilities in carrying out this task.

Carer's Name	Designation	Date Observed	Signature

This identified activity is an accepted risk for the carers named above. Only carers who are deemed to be competent and capable in this process will be expected to carry out this activity

Assessor's Details	**Name**	**Designation**	**Signature**	**Date**
Manager's Details	**Name**	**Designation**	**Signature**	**Date**

Planned Review Date: . . . . . .

STAFF WORKPLACE
RISK ASSESSMENT FORMS

DERBYSHIRE
INTER-AGENCY
GROUP

Introduction to the Staff Workplace Assessment Process

Musculoskeletal Disorders (MSDs) can be sustained whilst performing manual handling activities at home or at work. They can be caused by activities where staff assist patients with movement, moving, carrying or supporting inanimate loads, or adopting awkward, sustained and repeated postures. They can affect any part of the musculoskeletal system i.e. joints, muscles, ligaments, tendons etc.

Recent independent and government health and well-being reports outline the importance of organisational management of employees with MSDs and promoting the positive link between health and work. They are aimed at supporting people with ill health conditions so they can remain in employment. These reports include:

- The Black Report : Working for a Healthier Tomorrow – March 2008
- The Government Response ; Improving Health and Work – Changing Lives – November 2008
- NHS Constitution : The NHS Belongs to Us All – January 2009
- The Boorman Review : NHS Health and Well-being. Final Report – November 2009

The evidence in these reports demonstrates that :

- People in work are generally healthier
- Being at work can help health conditions get better
- Returning to work can improve health

Each organisation should have a specific policy within their Occupational Health strategy, outlining procedures that should be in place to allow the efficient management of those employees within the organisation who are potentially susceptible to or have Musculoskeletal Disorders (MSDs).

The following sections outline the areas that should be considered in developing health and wellbeing strategies with regards to musculoskeletal health:

- Employers Duties
- Employees Duties
- Workplace Assessment

Employer's Duties

Employers have a legal obligation to protect the health and safety of their workforce. Regulation 3, of the Management of Health and Safety at Work Regulations 1999, requires, that all employers assess the risks to the health and safety of their employees while they are at work. This includes managers having:

- An awareness of work related health problems
- To monitor and manage work related musculoskeletal disorders
- The ability to manage and undertake changes recommended through workplace assessments

Each agency should have access to an Occupational Health Service. It is important for a member of staff with a musculoskeletal disorder to be managed properly throughout their absence and return to work process. A case manager, i.e. occupational health team or the member of staffs line manager, should ensure that the process runs smoothly and lines of communication between the member of staff and the employer are effective. Work place assessments can be carried out by a variety of personnel within their organisations and may include:

- Back Care Advisers or a member of their team
- Occupational Heath Service Team
- Health and Safety Advisers
- Specialists i.e. ergonomists

Managers should have the appropriate levels of training in awareness, counselling, disability matters and management practices in order to provide the workplace with the required skills to manage work absence. Good working practices should provide open and approachable environment for employees to discuss any health / workplace issues. As outlined in the 'Fit for Work' report by The Work Foundation, 'the role of the line manager is crucial, both in work retention and rehabilitation'.

If a manager suspects that an employee is experiencing difficulties with their working practice a discussion should take place and appropriate referral if required, should be made to a practitioner or for a Workplace Assessment. This may include a member of the Occupational Health Team or Fast Tracking Physiotherapy service.

An example of the referral form for the line managers is given in the Staff Workplace Assessment Referral from. This form can be completed as soon as a musculoskeletal issue arises. However, it can also be utilised for staff that are finding aspects of their work duties difficult due to limitations that they have. This will instigate an assessment taking place from the appropriate specialist with the aim to prevent ill health absence.

Employees Duties

Employees have clear responsibilities under the legislation to manage their health and safety at work which includes:

- The Manual Handling Operations Regulations states that each employee while at work shall make full and proper use of any system of work provided for his use by his employer in compliance with regulation 4(1)(b)(ii).
- The Health and Safety at Work Act (1974) section 7, outlines that the employee should also 'take reasonable care for their own safety and that of others who may be affected by their activities' and 'co-operate with their employers to enable them to comply with their health and safety duties'.
- The Management of Health and Safety at Work Regulations 1999, highlights the responsibility of the employee to inform their employer of any work situation that represents a serious and immediate danger to health and safety.

All organisations should have a policy which should outline the systems for staff to report an episode of absence or sickness. Each organisation should also have a system in place to record, monitor and effectively manage sickness absence in their organisation.

An employee should report any musculoskeletal issues to their manager at the earliest opportunity. This should identify any absence due to musculoskeletal disorders and should indicate if a return to work assessment may be required. The employee should notify the employer about the following:

- An episode of absence
- Reason for absence
- Expected duration of absence
- Necessary certification
- Expected return to work
- Their medical status

Workplace Assessment

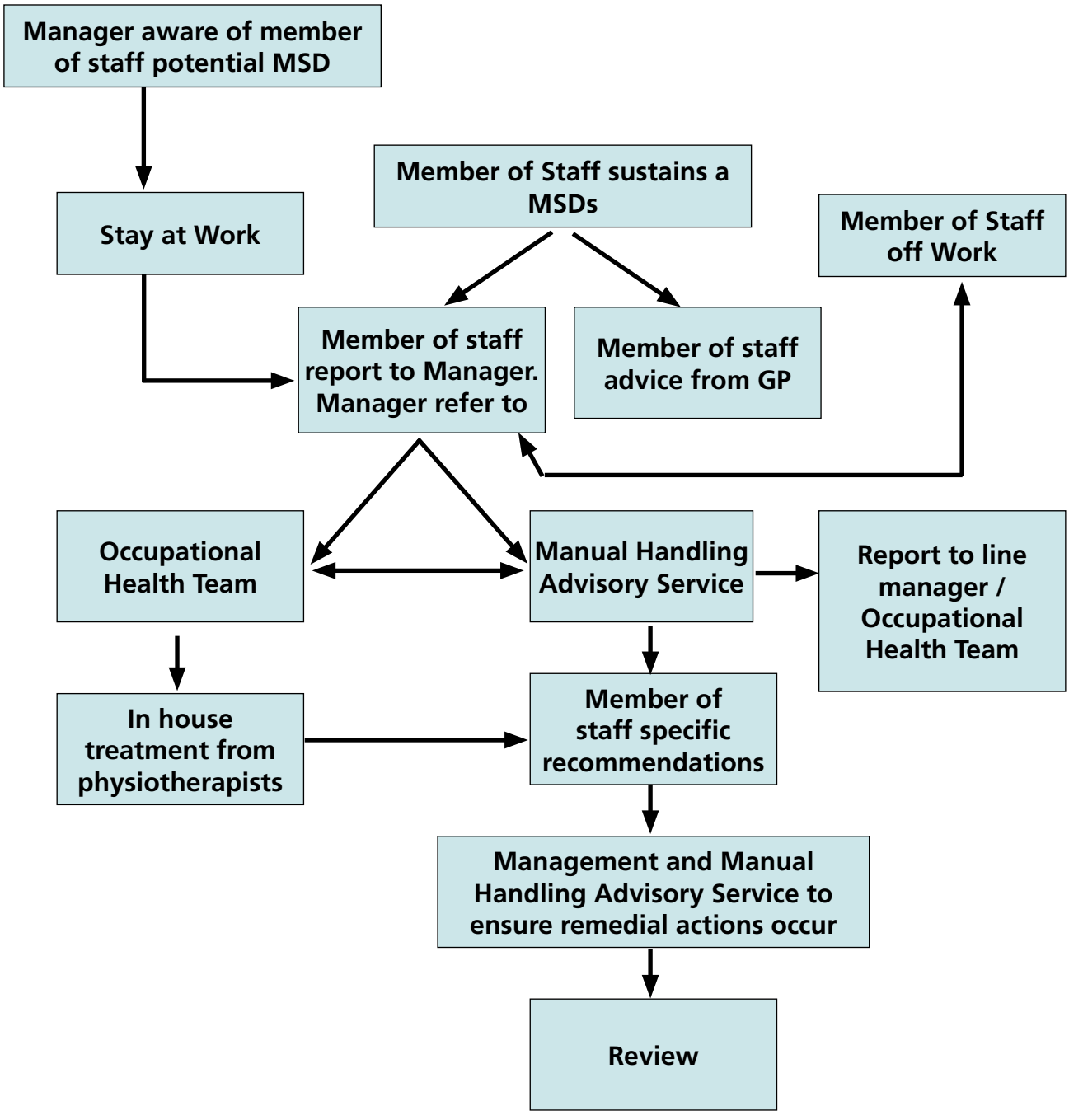
Referral Process

Referrals for workplace assessments can be received from a variety of sources:

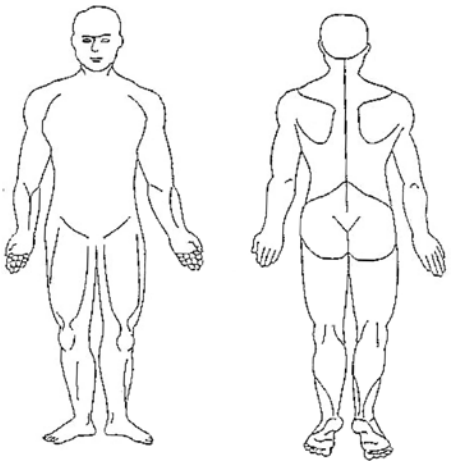
- The persons manager
- The Occupational Health Service Team including in-house therapists
- The person

The DIAG Workplace Assessment Referral form is illustrated following the Workplace Assessment process flowchart.

The Workplace Assessment process flowchart illustrates the stages that should be followed when managing an employee with MSDs:



STAFF WORKPLACE ASSESSMENT REFERRAL FORM

Staff Details			
Name			
Designation			
Area of Work			
Currently at Work	**Yes**	**No**	
If 'No' when is the planned return			
Normal work duties	**Yes**	**No**	**Limited**
Referring Agent Details			
Name			
Designation			
Area of Work			
Contact Number			
Referral Details			
Date of Referral			
Reason for Referral (Please circle or identify on the body chart)	**Neck Problem**	**Wrist Problem**	**Hip Problem**
	Shoulder Problem	**Thoracic Problem**	**Knee Problem**
	Elbow Problem	**Lumbar Problem**	**Ankle Problem**
			
Any Specific Issues experiencing in workplace	**Yes**	**No**	
	If 'Yes', please give details i.e. patient handling activity, postural position, using equipment etc.		
Referral made			
(Circle all specialist referred to & send a separate copy to each)	**Back Care Advisory Service**	**In House Physiotherapy**	**Orthopaedic Team**
	Rheumatology Team	**Occupational Health Team**	**Counselling Team**

Assessment Process

It would be difficult to develop a specific formula which would provide a complete workplace assessment risk assessment Proforma which covers all occupations in each agency. It is important to understand that every assessment should be tailored to the needs of the person who is being assessed. However there are certain aspects of an assessment that should be covered in a workplace assessment and an example of the DIAG Workplace Assessment Proforma is included in this section.

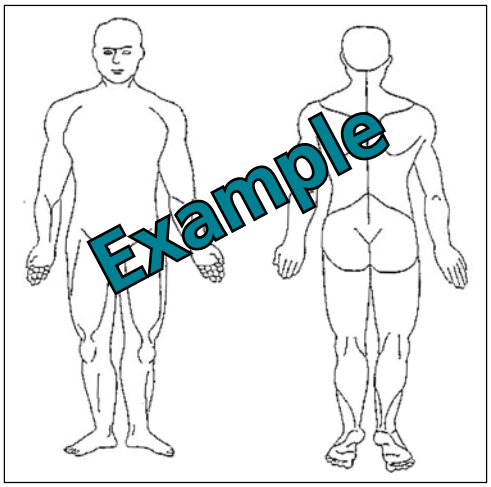
It is essential that the information gained through this assessment process remains confidential, and consent must be sought from the individual to disclose any information to management or any other health care professionals involved in the management of the individuals MSD. It is the intention of DIAG that this process is utilised positively to support an individual in work and the recommendations are acted upon by management to prevent MSDs exacerbating resulting in sickness absence.

The work place assessment must be carried out with the employee and should contain the following information:

- Persons Details
  - Name
  - Area of work i.e. department, directorate, hospital site
  - Date of Assessment
- Assessors Details i.e. the person carrying out the assessment. This could include the Back Care Advisor, Manual Handling Trainers. It can be carried out in conjunction with other health care professionals.
- Reason of referral
  - History of symptoms, for example
- Previous relevant musculoskeletal issues
- When the injury / symptoms started
- How the injury / symptoms occurred
- Medical interventions to date

It is important to note that consent must be sought form the individual regarding the recording of this level of detail and the information recorded will depend on who will view the report.

- Body pain chart



Symptoms may be indicated on the body chart e.g.

Pins & Needles

Numbness

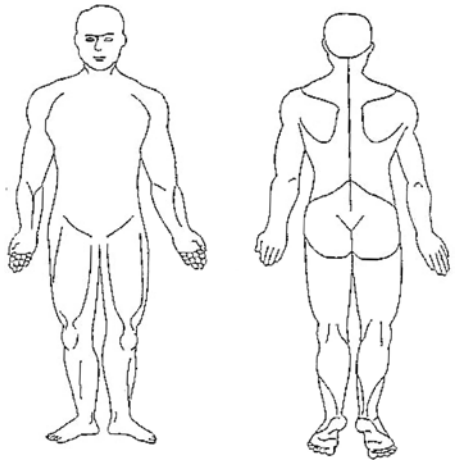
Pain

- Limitations of daily living
    - Issues at work and at home due to symptoms
- Activities that aggravate and ease symptoms
    - This list can be expanded to include activities that are not included in the list

Activity	Difficulties		Comments
	Yes	No	
Bending			
Kneeling			
Reaching			
Tilting / Turning			
Pushing / Pulling			
Lifting / Carrying			
Sitting			
Standing			
Walking			
Hand / Wrist function			

- Description of Job including
    - Description of job i.e. job title
    - Demands of job
- Frequency of activities
- Posture
- Weights moved
- Heights of objects moved
- Distances moved
- Environmental factors
- Recommendations – 6 options are indicated on the form however, the list can be expanded as appropriate. Examples of areas to consider are:
    - Work changes
    - Phased return to work programme
    - Limitations of activities
    - Adaptations of activities
    - Alterations to working hours
    - Training and advice given
    - Equipment provision
- Review dates

WORKPLACE OR RETURN TO WORK ASSESSMENTS

Name	Date of Assessment
Area of Work	
Assessors Details	
Reason for Referral	
History of Symptoms	Body Pain Chart 
Limitations of Daily Living	
Symptoms	
Aggravate	Ease

Activity	Difficulties		Comments
	Yes	No	
Bending			
Kneeling			
Reaching			
Tilting / Turning			
Pushing / Pulling			
Lifting / Carrying			
Sitting			
Standing			
Walking			
Hand / Wrist function			
Other			
Description of Job			
Demands of Job			
Environmental Factors			
Recommendations	1. 2. 3. 4. 5. 6.		
Review Date			

SUMMARY OF RISK ASSESSMENT FLOW CHART

DERBYSHIRE

INTER-AGENCY

GROUP

The Risk Assessment Flow Chart

The risk assessment process has been diagrammatically represented in the form of a flow chart. This chart includes the following assessments:

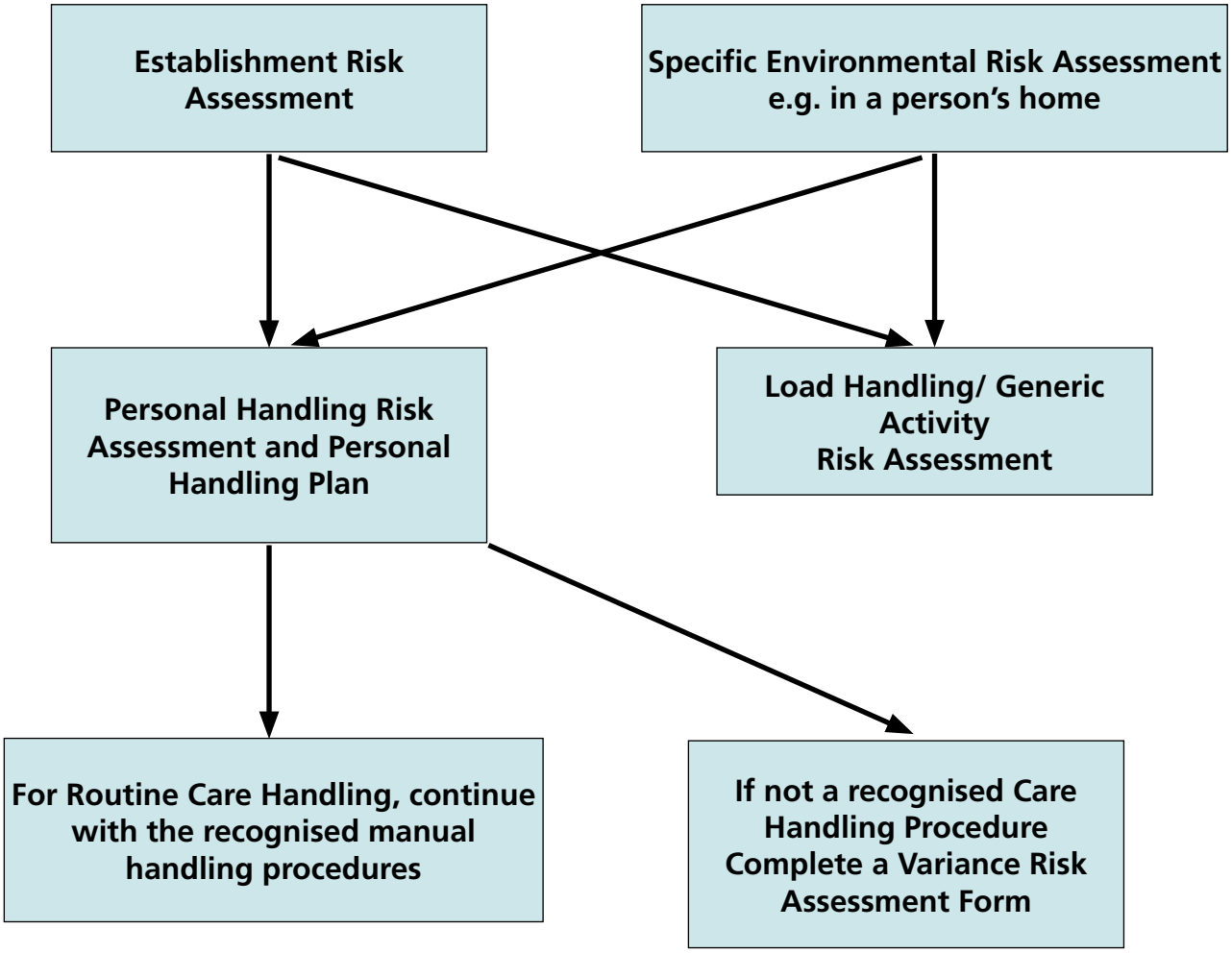
- Establishment Risk Assessment
- Specific Environment Risk Assessment
- Load Handling Risk Assessment
- Personal Handling Risk Assessment and Personal Handling Plan
- Variance Risk Assessment

The flow chart allows each assessment situation to be explained and followed logically to an appropriate conclusion.

Managerial and Personal Responsibility

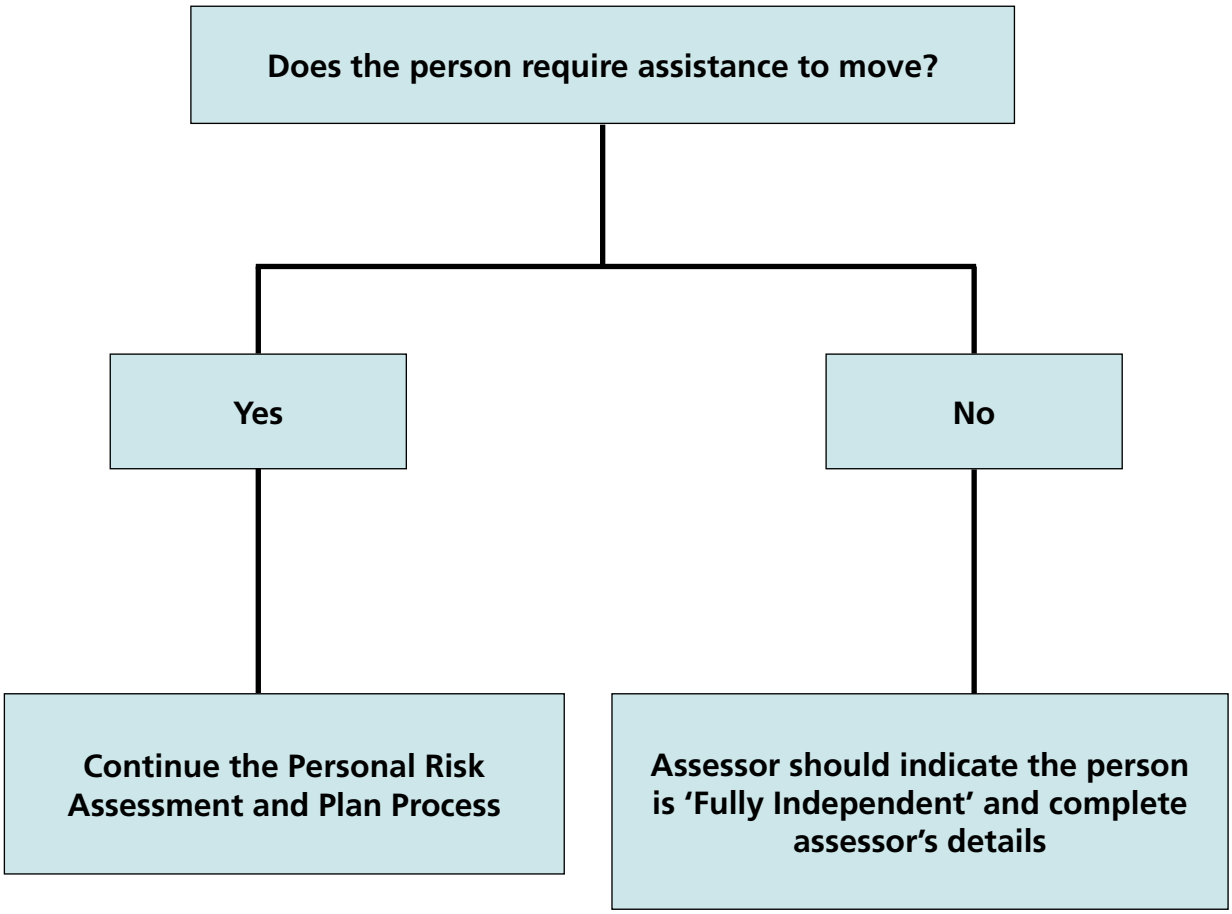
It is the responsibility of all concerned with the delivery of care to ensure that it is delivered in a safe way. This will result in the provision of care to the best quality, as poor handling practice for the carers is also detrimental to the person receiving care. The management in each area should have systems in place to create an appropriate Personal Handling Plan, which avoids these unsafe practices. Each and every carer has a responsibility to not place themselves at risk, (HSAW Act 1974, MHSW 1999.) This requires them to find, read and follow the documented Personal Handling Plan.

Flowchart 1 - Overview of the Risk Assessment Process



The risk assessment process, illustrated by the flow chart, should be completed as follows:

Flowchart 2 - Personal Handling Risk Assessment



- **Does the person require assistance to move?**

The risk assessment process begins with the persons abilities i.e. tick and comment on the factors to be considered when assistance to move is required

This process of assessment is carried out via the Personal Handling Risk Assessment form and takes into account the persons sensory/behavioural and physical qualities.

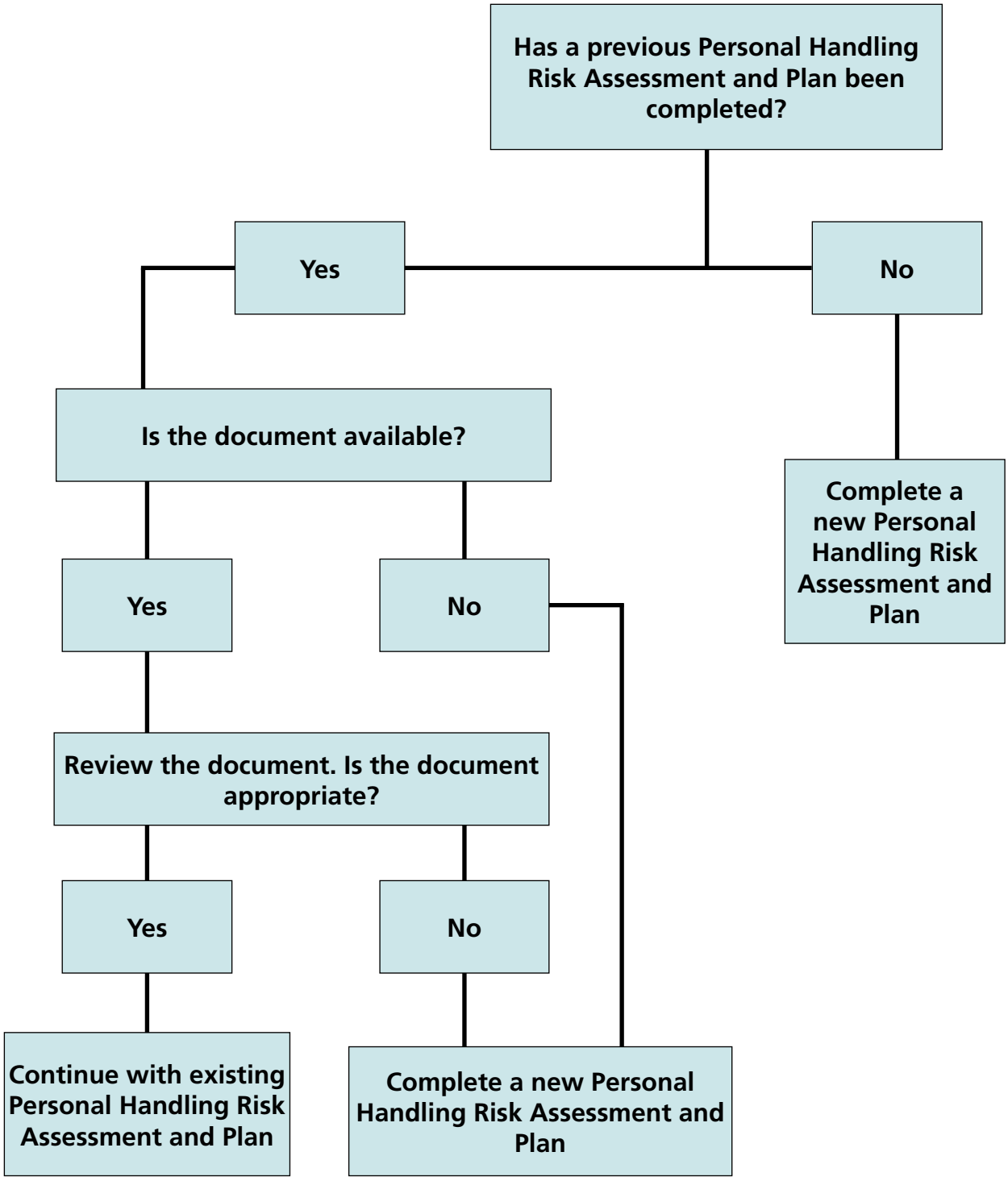
If YES, then go to the Personal Handling Risk Assessment.

If NO, then no further action is required.

This information must be recorded on the Personal Handling Risk Assessment by ticking the 'Fully Independent' box. The assessors details i.e. name, designation, signature and date must be recorded to indicate that the assessment has taken place.

However, if circumstances alter then the assessment and plan must be reassessed and completed as necessary.

Flowchart 3 - Completing the Personal Handling Plan



A Personal Handling Risk Assessment and Plan must be completed for every person receiving a service within the organisation. This may require no more than completing the person's details and indicating that they are fully independent. This must be then signed and dated.

If a person requires some assistance to move then the Personal Handling Plan must be completed. As Handling Plans are inter-agency one may have been completed previously.

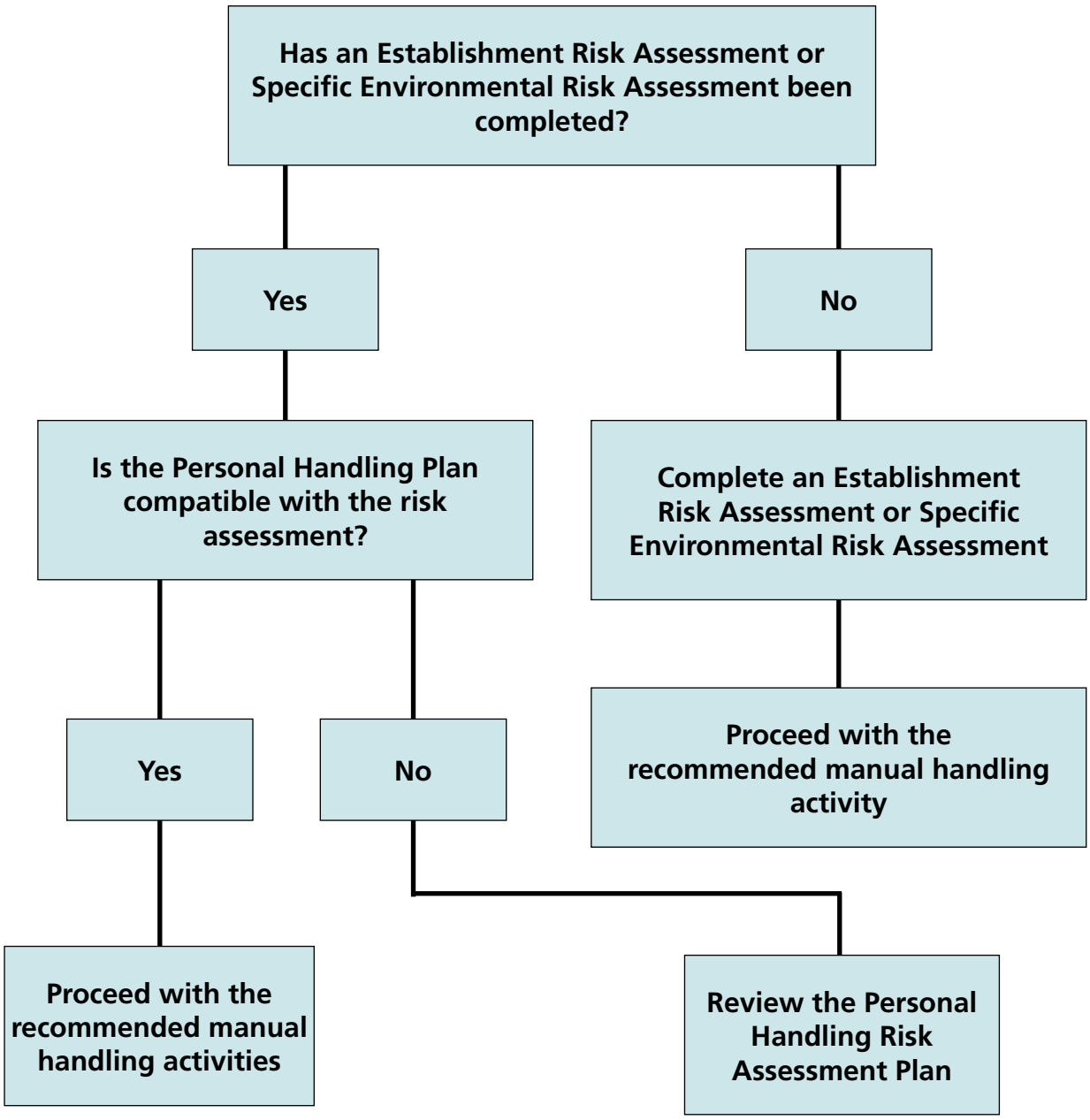
- **Has a previous Personal Handling Plan been completed?**
- **If YES is the document still appropriate?**

The assessments and plans are required to be updated on a regular basis which should be recorded at the bottom of the third page of the personal handling form. Therefore the current assessment and plan should still be relevant.

- **If NO then complete a Personal Handling Risk Assessment and Plan**

This assessment and plan should then be the current record of the person's ability and should have a date for review recorded.

Flowchart 4 - Implementing the Personal Handling Plan



This refers to the establishment in which the manual handling activity is taking place.

- **Has an Establishment Risk Assessment Form been completed?**
- **If YES, review the Personal Handling Plan.**

Is the information relevant to the establishment in which the manual handling is now taking place?

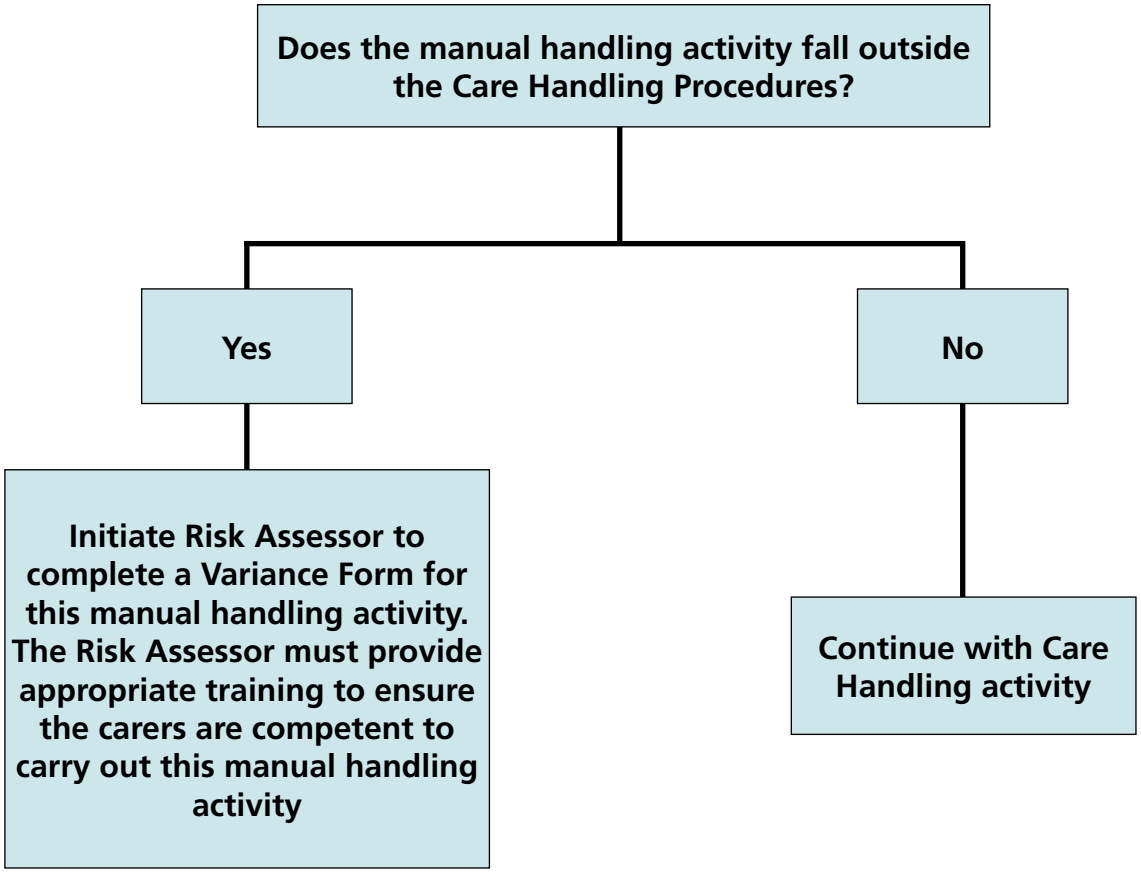
- **If NO, complete a Specific Environment Risk Assessment Form.**
- **Proceed with Personal Handling Plan**

Flowchart 5 - Variance Risk Assessment

The agreed procedures are documented in the Practical Guide.

If a complex or therapeutic situation arises which means that the agreed procedures cannot be followed, a Variance Risk Assessment Form should be completed. The Risk Assessor will determine the alternative method of manual handling and put into place the appropriate controls for this task which falls outside the DIAG Codes of Practice.

The risk assessor should always seek advice from and inform the Back Care Adviser when carrying out a Variance Procedure.



The Variance Risk Assessment Form requires specific training and supervision of the carers to achieve the required level of competency.

CARE HANDLING FOR PEOPLE IN HOSPITAL, COMMUNITY AND EDUCATIONAL SETTINGS

TRAINING PROVISION

DERBYSHIRE INTER-AGENCY GROUP

Provision of Appropriate Training

In order for each agency to achieve the aims of the DIAG system, it is the duty of each manager to provide appropriate training for all staff/carers. Each agency or establishment that adopts the DIAG System may adopt different structures for the provision of the training.

An organisation may adopt any of the following to provide an appropriate level of training and advice:

- Manual Handling Adviser/Back Care Adviser
- Manual Handling Trainers
- Manual Handling Key Mover/Key Trainer

Some agencies may choose to have several different people fulfilling these roles e.g. external consultants, training or health and safety co-ordinators. It is advisable that this person is deemed competent to fulfil this role and should hold the appropriate qualifications e.g. health and safety qualifications, degree in ergonomics, post graduate certificate/diploma or masters degree in Back Care Management.

Training Needs Analysis

A Training Needs Analysis (TNA) enables an organisation to prepare a comprehensive breakdown of their training requirements. It should be carried out for the organisations permanent staff but the tool could be utilised for any other group within the organisation. It provides a systematic approach to risk management training and can be used specifically for manual handling training.

An organisations TNA ensures training provision is co-ordinated, uses the approved documentation, enable checking that all appropriate staff have been trained, followed up if they have not attended, and monitoring systems are in place.

An example of a TNA template can be seen opposite.

Training Needs Analysis

Manual Handling Training		Staff Groups									
Training Requirement											

The Person Specification for the Manual Handling/Back Care Adviser (Strategic Level) is as follows:

- Must have a recognised, relevant professional health or social care qualification e.g. nurse, physiotherapist, occupational therapist, ergonomist
- Must meet their own professional standards for trainers in moving and 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
- Desirable a recognised teaching qualification/experience e.g. City & 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 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 and compliance with DIAG
- 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 healthcare/social care setting
- Must promote client independence, minimal lifting, use of equipment and ergonomic changes to minimise risks to staff
- Must demonstrate a practical problem solving approach to moving and handling issues
- Must be physically capable of demonstrating good practice
- Should be a member of National Back Exchange and be able to demonstrate efforts to keep abreast of developments in the field, by attendance at meetings, conferences and seminars, to meet continuous professional development standards

The Person Specification for the Manual Handling Trainer in Care Handling (Foundation Level) is as follows:

- Must have a recognised, relevant health or social care professional qualification, e.g. nurse, physiotherapist, occupational therapist, ergonomist, etc, or be a registered NBE member
- It is desirable to have a teaching qualification/experience up to City & Guilds 730/ NVQ equivalent/Cert Ed
- It is essential that the trainer appreciates the needs and objectives of the organisation and the trainees and that they receive support in their role to achieve this from the management
- Must have attended a post basic course in moving and handling, including an element of teaching
- Must have experience in a health care/social care setting

- Should be able to demonstrate knowledge of relevant legal influences in the field, an understanding of the ergonomic principles involved, and the risk assessment processes required including DIAG
- Must demonstrate a practical problem solving approach to moving and handling issues
- Must be physically capable of demonstrating good practice
- Must promote client independence, minimal lifting, use of equipment and ergonomic changes to minimise risks to staff
- Should demonstrate an ability to assess competency
- 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

The following level is optional and depends upon the training needs analysis of the organisation.

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 moving and 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 the risk assessment processes required
- Must demonstrate a practical problem solving approach to moving and handling issues
- Must be physically capable of demonstrating good practice
- Must promote minimal lifting, use of equipment and ergonomic changes to minimise 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

The Personal Specification for a Key Mover/Key Trainer in Inanimate Load or Care Handling is as follows:

- Be committed to improving the status and quality of manual handling
- Act as role models
- Be approachable
- Provide motivation for staff to comply with DIAG and provide a practical feedback source for staff
- Provide an information source for staff
- Provide cascade training for staff
- Ensure manual handling skills are up to date and attend regular updates from the Manual Handling Team (MHT) or Back Care Team (BCT)
- Achieve the appropriate levels of observational skills
- Achieve the appropriate levels of problem solving skills

- Achieve the appropriate levels of teaching skills
- Monitor the manual handling equipment in area and liaise with BCT for purchasing new equipment
- Provide the BCT with accurate cascade training records
- Liaise with the BCT
- To achieve this specification the Key Trainer must receive the following:
  - Support from management for the attendance at training sessions
  - Support from management for protected time to prepare for training
  - Support from management to provide training

Learning Aims

The objectives of the training sessions are that trainees will achieve the following pertinent to their area of work. At the end of the training sessions the trainee should have met the following objectives:

- An awareness of the causes and effects of back injury
- Have an awareness and understanding of legislation and local policy and guidance
- Have knowledge and understanding of safe movement principles and general advice
- Have an awareness of the risk assessment process
- Are able to demonstrate safely a range of handling activities
- Are able to use a range of manual handling equipment

Trainers will check that participants can carry out activities safely during the course, which will be recorded on the appropriate training record. All carers that attend training must disclose any physical problem which may affect their ability to carry out the activities in the work place. This can be done by the use of the manual handling training health questionnaire. If the trainee is unable to carry out the activity safely during the course the line manager should be informed.

It should be noted that competency can only be achieved by ongoing practice and supervision at the workplace.

In order to achieve these learning objectives the following must be adhered to:

- Sufficient time
- Provision of training facilities according to type of training being carried out
- Practical sessions will consist of a maximum ratio of 1 trainer to 6/8 trainees.

Training Contents

The following structure can be used to ensure that all elements of manual handling are included within the training programme. Module 1 may be delivered separately or linked together, with Module 2 or Module 3. All employees should receive training in current best practice prior to undertaking manual handling operations. New starters should complete the appropriate modules prior to them starting work.

Module 1 Introductory Module

This module should introduce carers to the background information needed before being involved in handling activities.

The suggested time for this session is 2–3 hours.

Module 1 will contain the following:

- Incidence, causes and effects of musculo-skeletal injuries
- Structure and function of the spine and musculo-skeletal injuries
- Ergonomics and risk assessment
- Legislation
- Local policy
- General advice including avoidance strategies
- Safe movement principles

Module 1 Trainee Objectives

By the end of the training session the trainee should be able to:

- Cite activities and causative factors associated with musculoskeletal injuries
- Identify how a musculoskeletal injury can affect the individual in personal and financial terms
- Identify how such injuries affect the employer and society
- Describe the basic structure of the spine
- Identify back saving tips, relating them to prevention of injury throughout 24 hours
- Describe the management of injuries
- Cite the relevant pieces of legislation relating to manual handling
- Outline the employers and employees responsibilities according to the Manual Handling Operation Regulations 1992 (as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002)
- Outline the implications of the following pieces of legislation:
  - Health & Safety at Work Act 1974
  - Management of Health and Safety at Work Regulations 1999
  - Workplace (Health, Safety and Welfare) Regulations 1992
  - Lifting Operations and Lifting Equipment Regulations (LOLER) 1998
- Cite the risks and identify the control measures to be associated with team handling
- Outline the importance of both verbal and written communication with regards to safer handling
- Cite the Safe Movement Principles and General Advice outlined in DIAG
- Identify how these principles and General Advice can be applied in various handling situations

Module 2 Inanimate Load Handling Skills

For staff to be safe at work they should have had instruction, information, supervision and practice in all the handling activities that they may need when they enter their own workplace.

The suggested time for this session is 1-2 hours.

If delivered separately, Module 1 should be recapped.

Identification of hazardous postures and the application of safe movement principles in relation to working postures.

Application of the risk assessment process, avoidance strategies, general advice, principles to appropriate handling situations i.e. load handling.

This includes: Pulling/Pushing
Lifting/Carrying
Turning/Reaching

Module 2 Trainee Objectives

By the end of the training session the trainee should be able to :

- Cite the DIAG Safe Movement Principles and General Advice
- Be able to identify hazards associated with the handling of inanimate loads
- Discuss the application of safe movement principles to moving / large / awkward loads
- Outline good posture and ergonomic principles whilst sitting, standing and driving
- Safely demonstrate the following:
  - Pushing and pulling
  - Lifting and lowering loads from the floor or low levels
  - Carrying a load
  - Appropriate work postures e.g. whilst working at a desk/bench

Module 3 Care Handling Skills

To achieve competency approximately 20 minutes should be allowed to practice each activity i.e. assisting a person from Sitting to Standing, Assisting a Person to Roll etc. Trainees need only practice techniques applicable to their work area.

If delivered separately the Safe Movement Principles and General Advice should be recapped

Participants should be made aware of high-risk practices.

Training will be given in the skills that are appropriate to the needs of the staff group in each working environment.

Training sessions should provide carers with the appropriate level of knowledge and skill to carry out their regular work without fear of injury. Each activity should be demonstrated, observed and practiced by all carers to attain the suitable level of competency.

- Examples of handling activities may include:
- Chair activities
- Hoists
- Bed activities
- Wheelchair, trolley, bed
- Transport
- Emergency

Module 3 Trainee Objectives

By the end of the training session the trainee should be able to :

- Cite the DIAG Safe Movement Principles and General Advice
- Carry out a formal risk assessment of a person
- Recognise unsafe/high risk manual handling activities
- Identify hazards when assisting people to move including, where appropriate, risk assessment of the person
- Safely demonstrate relevant techniques and guidance outlined in the Training Needs Analysis
  - Assisting a Person from Sitting to Standing
    - Oblique In front
    - Oblique Behind
  - Assisting a Person from Standing to Sitting
    - Oblique In front
    - Oblique Behind
  - Assisting a Person to Reposition in a Chair
    - Reposition with 1 Carer
    - Reposition with 2 Carers
  - Stand Up and Reposition

- Transferring a person from Sitting to Sitting
    - Slide Board
    - Framed Turning Disc
    - Stand Walk Sit
    - Change Seat
- Supporting a Person in Walking
    - Supported Walking
- Assisting a Person to Get up From the Floor
- Assisting a Person to Roll
    - Roll
    - Combined Slide and Roll
- Assisting a Person to Sit Up From Lying
    - Half Kneeling
    - Standing
    - Roll and Sit Up
- Transferring a Person From Surface to Surface in Lying
    - Lateral Transfer
- Assisting a Person to Move Up the Bed
    - Feet Flat
    - Half Kneeling
- Assisting a Person to Get Out of Bed
    - Roll and Sit Up

- To apply the Principles of Movement to various pieces of manual handling equipment that the carer will come across in their workplace such as:
    - Slide sheets
    - Transfer sheets
    - Pat slides
    - Slide boards
    - Framed turning disc
    - Hand blocks
    - Rope Ladders
    - Hospital beds
    - Mattress elevators
- Undertake basic safety checks on manual handling equipment
- Describe the principles of hoist use and the types of hoists that are available
- Outline the type, selection and use of slings
- Cite the main points of Lifting Operations and Lifting Equipment Regulations (LOLER) 1998

- Demonstrate the following techniques using a hoist:
  - Fitting a sling on a bed / floor / chair
  - Hoisting a person from
    - Bed to chair
    - Chair to bed
    - To or from the floor
  - Use of a transferring hoist to transfer a person from a seat to a seat position
- Be aware of guidance notes related to participant specific area of work e.g. transport, working at floor level etc.

Module 4 Update/Refresher Module

Members of staff need to maintain a level of skill and application in manual handling activities to maintain safe practice.

Updates should be provided for all members of staff who are involved in handling activities. The content of these sessions should mirror the activities that are necessary in the specific handling skills module, as these activities are needed to achieve competency. The time between refreshers is subject to the level of risk and the exposure of different groups to handling activities. It is recommended that for carers who are regularly involved in the handling of people in care situations this update should be at least annual.

Ensuring Adequate Levels of Competency

A definition of competency is that the person is able to demonstrate the appropriate level of knowledge, skill, and attitude during an activity according to the DIAG Codes of Practice.

To achieve this level of competence the following must be adhered to during the training process:

- Sufficient time and adequate training facilities, in order to achieve competence
- The practical sessions will consist of a maximum ratio of 1 trainer to 8 trainees
- During training the carers will demonstrate their competencies in activities which are pertinent to their area of work
- Documentation of the carer's knowledge and skill will be made during the training
- The line manager will be notified if competency is not achieved

Competency achieved during training can only be maintained by ongoing monitoring of practice in the workplace.

Where non-competence or non-compliance occurs in the classroom or in the workplace, the management or responsible person must take appropriate action.

Purchasing Training Provision

Many of the participating agencies will have the resources to provide training for carers, link workers and training in-house. However, some agencies may elect to buy in the training services. Clearly in this case, the onus is on participating agencies to ensure that the training services purchased conform to the standards within the DIAG Codes of Practice, and in particular, those related to training content, trainer/trainee ratio, and assessment of competency. Training agencies will need to be aware of DIAG. Clearly, the training agreement will need to be carefully agreed and drawn up. The training requirements will need to be explicitly agreed in writing. Training services must be monitored and audited to ensure that the appropriate standards are met.

MANUAL HANDLING HEALTH QUESTIONNAIRE

During the training course you will be required to participate in care or inanimate load handling techniques.

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 that you give will be treated in confidence.

To the best of my knowledge the following information is correct and I understand my personal responsibilities in informing the course leaders of any medical issues that could affect my ability to participate in manual handling activities.

1. I suffer from musculoskeletal pain or injury

    i. Back ❑

    ii. Neck ❑

    iii. Shoulder ❑

    iv. Hip ❑

    v. Knee ❑

    vi. Other, please specify: .....

2. I am receiving treatment for a condition which may affect my ability to engage in physical activity without pain or injury ❑
3. I am pregnant ❑
4. I have given birth in the last 6 months ❑
5. I am breastfeeding ❑
6. None of the above applies ❑

I declare all the information provided on this form is truthful and to the best of my knowledge and no information has been withheld which may influence the trainer in my assessment.

Signature: ..... Date: .....

- If you have answered 'yes' to any of the questions 1-5 the trainer may seek further information from you in confidence
- If necessary your manager or the Occupational Health Department maybe consulted with your consent
- Should you suffer any discomfort or injury during the training you must inform the trainer immediately

Derbyshire Inter- Agency Group - Training Record

Trainers Name	Trainers Designation	Trainers Signature	Date

Trainees Name	Trainees Designation	Trainees Area of Work	Signature	Date

Indicate by ticking (✓) the DISCUSS / DEMONSTRATED / PRACTICED if successfully completed on the course
Place a cross (✗) or N/A in the box where an activity has not been covered

Theory	Covered (✓)	ACTIVITY	Discuss	Demo	Practice	COMMENTS
Incidence of musculoskeletal injuries		**Sit to Stand**				
Causes of musculoskeletal injuries		Oblique behind with 1				
Effects of musculoskeletal injuries		Oblique behind with 2				
Structure & function of the spine		Oblique in front with 1				
Ergonomics & risk assessment		Oblique in front with 2				
Legislation		Combination-1 ob infr /1 ob beh				
DIAG		Repositioning in Chair				
Local Policy		**Seat to Seat**				
General Advice		Slide Board				
Safe Movement Principles		Framed Turning Disc				
Load Handling		Stand Walk Sit				

Hoisting	Discuss	Demo	Practice	Change Chair				
Passive				**Mobility**				
Active				Walking				
Slings and Fittings				The Falling Person				
Equipment				The Fallen Person				
Slide Sheets				**Bed Movements**				
Slide Board				Rolling				
Framed Turning Disc				Combined Slide and Roll				
Long Handled Transfer Sheet				Moving up the bed Feet Flat				
Easy Glide				Sitting up in Bed-Emergency				
Patslide				Sitting Up from Lying in Bed				
Other				Lateral Transfers				

Trainee must sign here to indicate that they have completed the indicated (✓) Theory and Activities	signature

CARE HANDLING FOR PEOPLE IN HOSPITAL, COMMUNITY AND EDUCATIONAL SETTINGS

PRACTICAL GUIDE

Overview to the Practical Guide

For all the institutions involved in the Derbyshire Inter-Agency Group to be able to work together in manual handling activities, there needs to be agreement about which handling methods are safe to use. This Practical Guide outline which methods are accepted as current best practise and are based upon all the recent guidance which has been published and the experiences of the Back Care Advisors of all participating agencies. A complete list of reference documents is found in the bibliography.

Selection of the chosen methods is based upon sound scientific principles such as biomechanics, physiology and ergonomics. It also uses advice found in models of efficient human movement, which have been adopted in practice in various areas. The Practical Guide allows all of these principles to be utilised, and present a robust guidance document that can be transferred to all sectors of health and social care.

Use of the Practical Guide

The Practical Guide is written as a document that will assist managers, key trainers and risk assessors who have proven skills in manual handling, to clarify and improve the knowledge and practice of all carers who are involved in the handling of people. It is not designed to be a stand-alone document but a part of the whole package of managing manual handling risks as outlined in the Risk Assessment section. It is designed to be supplemented by training courses, evaluation and audit to ensure the whole package is being adhered to. It may be used as a supporting document to assist any personnel who are involved in the risk assessment process e.g. managers, risk assessors, therapists etc.

The Practical Guide contains the following:-

Introduction to the Practical Guides

- General Advice for Handling Activities
- Safe Movement Principles for Handling Activities
- The Avoidance of Unsafe Practice

Practical Guide

- Care Handling Procedures – a number of specific methods and activities to assist a person to move from one position to another
- Care Handling Guidance Notes – for use when specific problems may arise and help may be needed to assess the situation and arrive at a suitable solution

Practical Guide for Smaller Children

Guidance related to smaller children is included where relevant in the shaded sections at the end of each activity/procedure.

Introduction to the Methodology

The publication of evidence based reviews (Hignett et al 2003, Smith (ed) 2007) has prompted patient handling advisors to consider the collection and dissemination of scientific evidence to back up their chosen methods and processes. There is still a dearth of information that formally evaluates patient handling methods though individual studies have evaluated specific actions.

The format of this 2nd edition of the DIAG Code of Practice contains general guidance and range of methods for specific handling solutions. As a code of practice for application in a complete management system it does not include individual patient transfers devised specifically for single workplace solutions. The guidance for risk assessment and the practical guide are to be used as part of a system based safety management approach that uses local expertise; a competency based training system, risk assessment and risk management. However to allow a convincing argument to be developed it is important to support the findings and recommended practice with suitable evidence to clarify:

- The relative risks associated with the different methods
- Inclusion/exclusion criteria for future reference
- Areas that may need extra supervision or support in the workplace following appropriate risk assessment and selection of the most suitable solution

Evidence Collection

The DIAG Code of Practice has always been a consensus process created by its participating organisations. The agreement process directed the author group to exclude any method or technique that was deemed to have a higher element of risk. This approach was supported by the external guidance provided in documents as Lloyd (ed) 1998 and others. In addition this 2nd edition has allowed a more formal evaluation to be completed and evidence collected to support the methods, guidance and techniques included in its pages.

Over a number of years various methods have been developed to enable people to be moved or assisted to move. Most of the methods that are now accepted as being unsafe involved the person being lifted, or involved the carer taking all or most of the person's body weight. The first publication of the DIAG Code of Practice used these principles to develop its guidance document and all of these hazardous tasks were excluded from the document.

Methodology

Each method of assisting a person to move in the Practical Guide has been analysed using a number of tools to provide the evidence behind the decision as to whether a method is recommended or should be avoided as a high-risk activity.

Participants

Ethically it was not possible to carry out this assessment tool with people receiving care within the participating organisations, so a series of laboratory based observation trials were completed. Work colleagues and family members agreed to take the role of people requiring assistance. These 'volunteers' were fit, healthy and pain free, and must be taken into consideration when using these scores. This volunteer group of people are therefore unlike many of the people that require assistance to move. In all cases the people demonstrating the tasks were experienced handlers that had a good working knowledge of the DIAG Codes of Practice.

Observers

The members of the author group were selected as the observers of each task (n=7). All observers were employed as the lead person for manual handling in their organisation and had suitable qualifications and experience to use the tools appropriately. Data collection sheets were devised to allow for the recording of scores for each task.

Method

The data collection took place over a period of six months. A series of observation sessions were required due to the large number of methods to be analysed. The tasks were performed by the participant group and observed by the attending members of the Author group. The number of observers per task varied from 4-7 because of availability. Explicit instructions were given to the participants for demonstration of the tasks and a specific moment in time was identified for the observation. This point in time was:

- During the loading phase for the carer
- Using bilateral weight bearing during transfer tasks
- Using appropriate equipment
- Using hand positions and postures selected by the carer

Photographs were taken of all tasks and analysed in order to determine the observed scores. The scores from each observer were recorded and an average score recorded for the tasks. Due to time constraints only single measures were possible from each observer. The process of consensus was required and any erroneous measures were repeated if necessary. Any variations or anomalies of the data collection were discussed by the group prior to publication.

Data Collection Tools

The four tools used in the analysis of each care handling activity;

1. DIAG Safe Movement Principles (SMP).

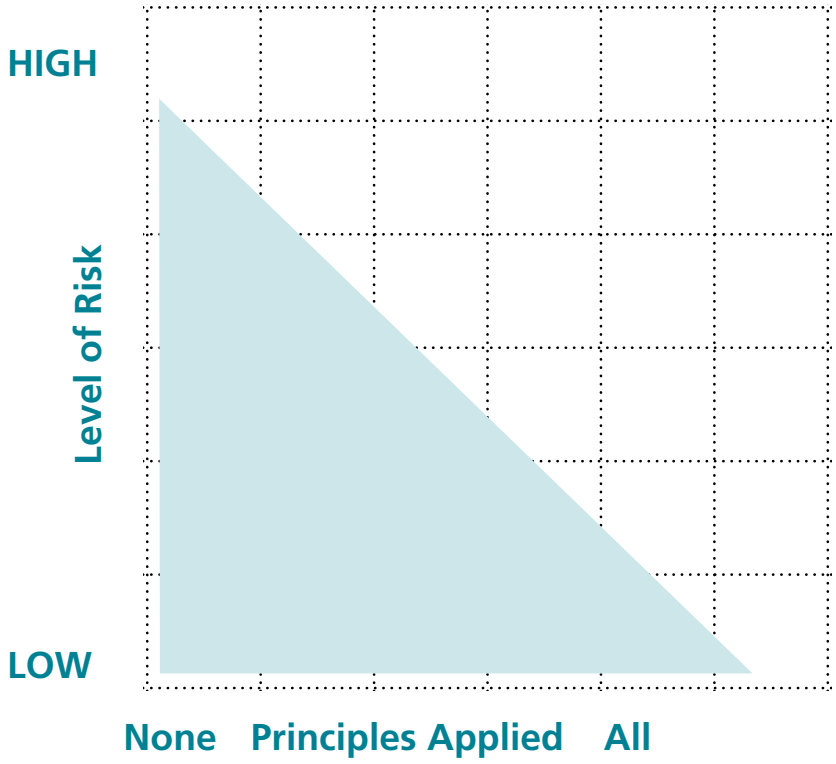
There are a number of approaches, which have been suggested as a basis for good human movement. All of these approaches have been investigated and the most appropriate of these adopted as the DIAG Safe Movement Principles for all care activities. The series of 8 DIAG principles were included in the HSE Delphi exercise

(HSE 2004) to assist the updating of the MHOR in 2004.

The interaction of the first 4 safe movement principles is vital:

- Offset base
- Close Proximity to the load
- Mobile Base
- Avoid top heavy postures
- Avoid twisting
- Avoid fixed holds
- Avoid sustained loading
- Lead with the head

It is important to consider that the more principles that are followed the better the activity.



The level of agreement with the DIAG principles was scored by the number of good movement principles adopted. A score of 8 gives perfect agreement and 0 gives no agreement.

2. Rapid Entire Body Assessment (REBA)

REBA (McAtamney and Hignett, 2000) is an assessment tool that allows the observer to analyse the posture adopted by a carer whilst assisting a person to move. REBA is an event driven tool, used to identify the severity of a risk likely to result in a musculoskeletal injury. It analyses the full body posture, considering the trunk, neck and limb positions, the load and coupling quality involved in the activity. REBA analysis produces a risk level, and an action level for controlling risk.

REBA score	Risk Level	Action to be taken
1	Negligible	None necessary
2-3	Low	May be necessary
4-7	Medium	Necessary
8-10	High	Necessary Soon
11-15	Very High	Necessary NOW

Photographs were taken of each task including those deemed unsafe and the photographs were analysed in order to determine the number of safe movement principles used and to obtain the REBA score.

3. Borg scale of perceived effort

Carers assisting people to move will often choose methods thinking it is the easiest method requiring little preparation or equipment. The Borg Scales (Borg 1998) are designed to assess the amount of effort or exertion required during physical activity. The CR-20 scale (6-20) is illustrated below as an example: point 6 would be the equivalent of sitting down doing nothing, 9 would be walking gently, 13 a steady exercising pace and 19/20 the hardest exercise you have ever done.

Score	Activity Level
6	
7	Very, Very Light
8	
9	Very Light
10	
11	Fairly Light
12	
13	Somewhat Hard
14	
15	Hard
16	
17	Very Hard
18	
19	Very, Very Hard
20	

Studies have shown that the language and scaling of the Borg system can be used to represent the measure of physical effort. Carers were asked to score their perceived amount of effort on the CR-20 scale when assisting people to move with the various methods.

4. Likert Comfort Scale

The first three assessment tools used consider the posture and effort required by the carer when assisting a person to move. It is however important to consider the comfort, safety and response of the person being moved. A Likert scale, defined below, was used to record the person's response to the transfer method.

The question asked was:

"On a scale of 1 to 10, how comfortable did you feel when being assisted to move? Consider any pain experienced, and how safe you felt whilst being moved. In the scale 1 to 10, 1 equates to experiencing pain and or discomfort, or being afraid that you might be dropped, rising to 10, when 10 equates to feeling comfortable, safe and secure"

Results

Excluded Methods

To confirm the inclusion and exclusion criteria for the safe methods in this code of practice evidence was collected for methods that had been excluded in the original document.

Table 1. Observations for Full Weight Lifts

Activity	DIAG SMP	REBA		Perceived Effort	Comfort Scale
		Score	Risk Level		
Top and Tail Lift	1	10	High	16.3	3.1
Arm and Leg Lift	1	11	V High	18	4.1
Shoulder/ Australian Lift	1	12	V High	16	5.1
Orthodox on a Bed	1	11	V High	18.1	3.8
Orthodox on a Chair	2	13	V High	17	4

Table 2. Observations for Lifts With Most of Body Weight

Activity	DIAG SMP	REBA		Perceived Effort	Comfort Scale
		Score	Risk Level		
Drag Lift from Chair in front	2	10	High	13.5	2.2
Drag Lift from Chair Behind	4	5	Medium	14.3	2.3
Drag Lift from Bed in front	1	12	V High	17.5	2
Through Arm Lift in a Chair	1	13	V High	15	3
Walking a Person Linking Arms	2	11	V High	15	3

Table 3. Observations for Front Assisted Transfers

Activity	DIAG SMP	REBA		Perceived Effort	Comfort Scale
		Score	Risk Level		
Bear Hug	1	13	V High	15	3.7
Clinging Ivy	2	11	V High	16.3	4.3
Hand Drag	1	8	High	11	8
Pivot	2	12	V High	17	2.3
Handling Belts / Slings	1	11	V High	14	2.5
Elbow Lift	1	11	High	17	1.8

Exclusion Criteria for Poor Methods

The methods that had previously been excluded identified that the exclusion boundary could be set at the following where the method is excluded if it scores against 3 out of 4 of the criteria scores. In real terms these levels are less than half of the safe movement principles from DIAG being applied, a high postural risk, perceived effort rated as hard work, and patient comfort less than 4/10.

Table 4. Exclusion Boundaries

Activity	DIAG SMP	REBA		Perceived Effort	Comfort Scale
		Score	Risk Level		
Exclusion Boundary	<4	>10	High	>13	<4

Two methods challenged the measure for exclusion. The drag lift from a position behind a chair allows a very good posture to be adopted so scored preferably on REBA and postural risk level. The hand drag method can only be used with someone that has very good assisting ability and scores more favourably on carer effort and person comfort.

Included Methods

These activities were selected as acceptable for use in care handling tasks following a suitable risk assessment. There are no data presented for the complex tasks of seat to seat transfers as the individual tasks of sit to stand, assisted walking and stand to sit are covered in the included analysis

Table 5. General Mobility Transfers

Activity	DIAG SMP	REBA		Perceived Effort	Comfort Scale
		Score	Risk Level		
Sit to Stand Oblique Behind	8	4	Medium	10.5	9
Sit to Stand Oblique In Front	7	5	Medium	10	8.3
Stand to Sit Oblique Behind	8	4	Medium	9	9
Stand to Sit Oblique in Front	8	2	Low	8	9
Repositioning in Chair (1carer)	7	4	Medium	10.6	7.8
Repositioning in Chair (2carers)	8	5	Medium	8.5	8
Supported Walking	8	2	Low	8.8	9.2

The selection process based on the applications of the DIAG movement principles is identified in the almost perfect application of principles in the observed transfers. In addition posture scores and patient comfort scored very favourably. These tasks do require the effort to assist a person with limited ability so the perceived effort scores are higher but only equate to lower than fairly light on the Borg scale.

Table 6. Bed Transfers

Activity	DIAG SMP	REBA		Perceived Effort	Comfort Scale
		Score	Risk Level		
Assisting a Person to Roll	7	3	Low	10.6	8.8
Combined Slide and Roll	6	3	Low	11.5	9.1
Roll and Sit Up	7	4	Medium	9.3	8.5
Slide a Person up the Bed	6	5	Medium	10.6	9.3

Table 6 shows the evidence for tasks related to bed mobility. The observations closely follow the evidence and inclusion criteria for the general transfers.

The DIAG Codes of Practice are designed to be used not only in hospitals and controlled working environments but in the full range of community settings. This variety of location directs the guidance to include some tasks that are selected as appropriate for single interventions or emergency solutions when the environment cannot be managed in the time frame available. Table 7 shows the data for the emergency activities.

Table 7. Emergency Tasks

Activity	DIAG SMP	REBA		Perceived Effort	Comfort Scale
		Score	Risk Level		
The Falling Person – supported	7	5	Medium	13	6
The Falling Person	6	9	High	13	3
Emergency Sit Up - Carers Kneeling	6	10	High	14.5	3
Emergency Sit Up – Carers Standing	7	5	Medium	13.5	3

Inclusion Criteria for Safe Methods

The inclusion criteria fell into two scenarios in the guide (Table 8). Firstly there are the most widely used transfer methods for mobility assistance, hygiene and daily living. The second set of criteria are for those activities that may be required in exceptional circumstances e.g. person falling, emergency sit up in bed when choking etc..

Table 8. Inclusion criteria

Activity	DIAG SMP	REBA		Perceived Effort	Comfort Scale
		Score	Risk Level		
Inclusion for routine tasks	>6	<6	Medium	<11	>8
Inclusion for emergency tasks	>6	<9	High	<14	N/A

The inclusion criteria for the routine care tasks shows clear difference from the exclusion criteria. 7 or 8 safe movement principles should be applied, medium risk for posture and a perceived effort of fairly light are the carer assessments required. When considering the process of risk assessment for potentially more hazardous tasks there is a criteria set for short term or one off solutions. 7 or 8 movement principles should be applied, the posture scores less than 10 on a REBA score and an effort rating of somewhat hard rather than hard. The task in this section that challenged was the emergency sit up with the carers kneeling on the bed. Posturally this scores higher than other tasks because of the leg position and the perceived effort is raised due to the biomechanical weakness of kneeling.

Conclusion

The DIAG Codes of Practice (2001) were devised entirely on a consensus process. The field of assisting people to move now requires evidence to support the 2nd edition. The evidence collected and presented here shows that there is a clear demarcation between the included tasks and the excluded tasks. There is also sufficient evidence with the emergency task criteria to support the risk assessment process for tasks not included in this guide that might be required as a short term solution under the variance process.

General Advice for Handling Activities

Promote Independence

One of the main objectives of caring for people is to promote the functional independence of that person. If a person is able to undertake an activity then we should provide them with the necessary time and support. During rehabilitation, difficulties may be experienced, e.g. a person who can slowly stand and walk with assistance urgently needing the toilet. In this situation it may be safer and more dignified to use a wheelchair to transport the person to the toilet and then let them walk back.

Check Understanding of the Person

The action of assisting a person to move is much easier with the co-operation and understanding of that individual. Ensure that the consent of the person has been obtained in line with organisational guidelines on the Mental Capacity Act. If the person does not co-operate, or comprehend instructions, the carer should always refer on to the manager, link person, or moving and handling co-ordinator, and local procedures.

Communication

Communication is important with all activities that involve assisting a person to move. Good and appropriate communication is the best way to ensure that we are not working against the will of the person receiving care. It is also important that there is good communication between all carers that are involved in the task. All carers should understand the procedure and they should have agreed a prompt for the movement e.g. ready, steady, stand.

Prepare for the Activity

A risk assessment is completed so that the carer has a safe system of work to follow. The Personal Handling Plan will direct them to use certain pieces of equipment and techniques. All carers should prepare the environment, the equipment, the person and most importantly themselves prior to commencing the activity.

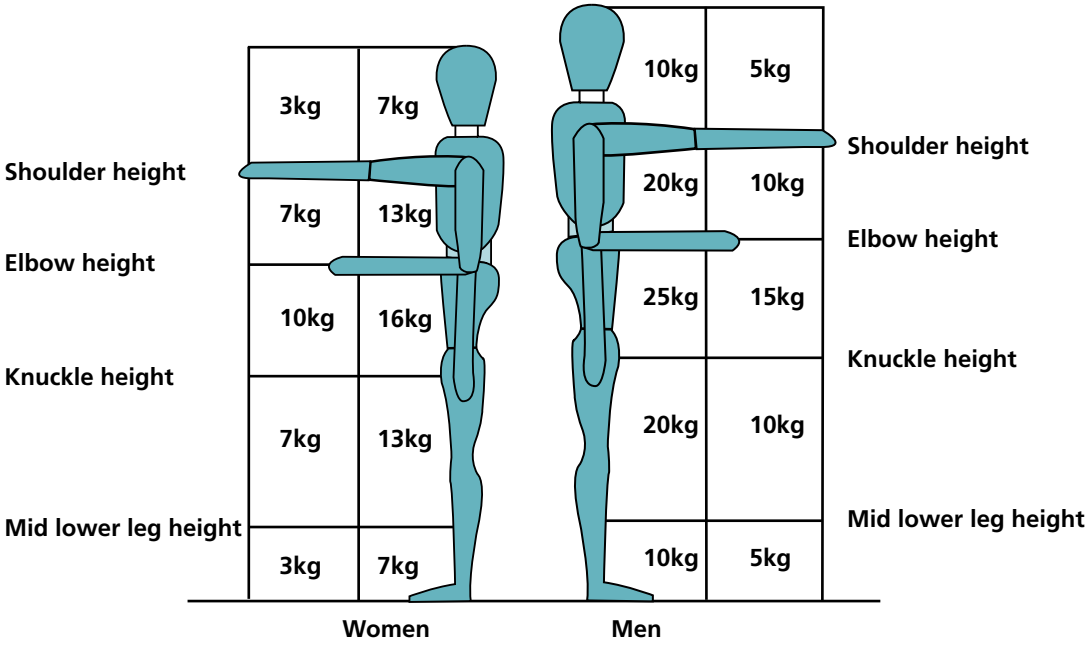
Re-assess Prior to the Activity

Once prepared there should be a visual check of the person and situation to avoid any potential problems that might have occurred during the initial preparation.

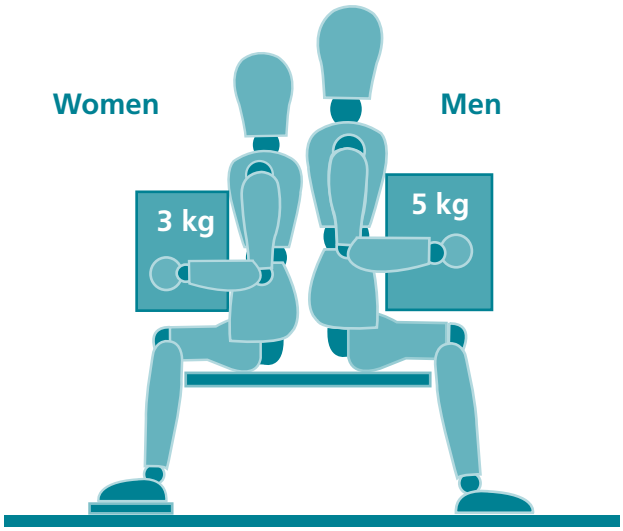
Avoid Hazardous Handling and Lifting

The HSE provides guidance about lifting weights in a range of positions. Beyond this weight guidance lifting should be considered hazardous and a risk assessment carried out in accordance with the manual handling operations regulations.

Guideline Figures for Lifting and Lowering

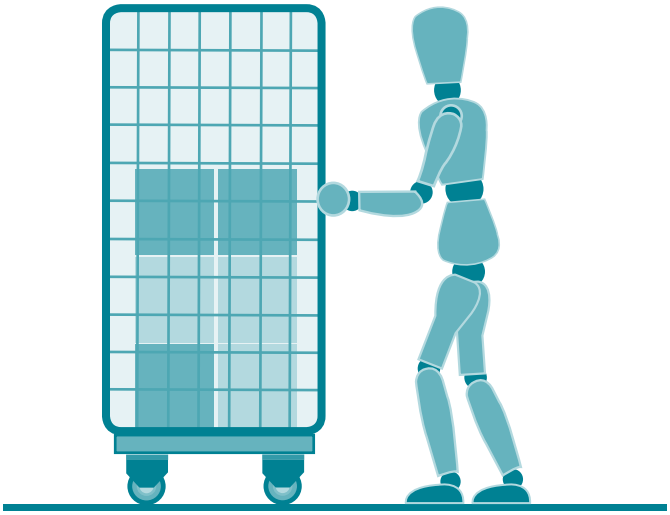


Guideline Figures for Handling Whilst Seated



Women	Men
3kg	5kg

Guideline Figures for Pushing and Pulling



Action	Women	Men
Stopping / starting a load	15kg 150 Newtons	20kg 200 Newtons
Keeping a load in motion	7kg 70 Newtons	10kg 100 Newtons

Minimise Low Level Working and Associated Risks

Working at low, particularly floor level involves particular hazards including:

- Use of prolonged fixed postures
- Excessive pressure on knee, ankle joints and toe joints
- Prolonged and excessive neck flexion/extension
- Frequent involvement of top heavy posture
- Frequent used of fixed base leading to twisting movements

Consideration must be given to whether activities can be carried out at a higher level e.g. use of a plinth, changing table. where working at floor level is unavoidable.

- Allow for frequent breaks
- Allow for changes in activity and posture
- Consider the use of knee protection
- Avoid high kneeling on two knees as this significantly reduces stability

Personal Responsibility

It is important that all carers are aware ***that they must not put themselves or others at risk***. If at any time the carers or anyone involved in the activity feels unsafe or at risk they should feel comfortable with the idea of stopping the activity and getting some help.

Record Different Activities

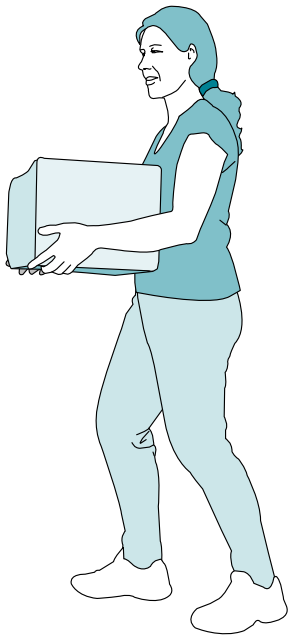
If manual handling activities are carried out which are different to those noted in the Personal Handling Plan or the situation or person have changed, then the changes should be documented. It may be necessary to report the changes to senior care staff at this time. This may lead to a revision of the plan for future activities.

Safe Movement Principles for Handling Activities

There are a number of approaches, which have been suggested as the basis for good human movement. All of these have been investigated and the most appropriate of these have been adopted as the movement principles for all care activities. These principles are the rationale for all the handling procedures included in the DIAG Practical Guide.

Offset Base

Carers should adopt an offset base during all handling activities. The use of an offset base gives a wider and deeper base of support and stability in all directions. Balance can be improved by relaxing knees and hips when using an offset base.



Close Proximity to Load

It is essential to reduce the effect of leverage. This is best achieved by staying as close to the load, or person, as possible.

Mobile Base

Carers should be encouraged to follow the movement of the load to maintain short levers and maintain good control of the activity.

Avoid Top Heavy Postures

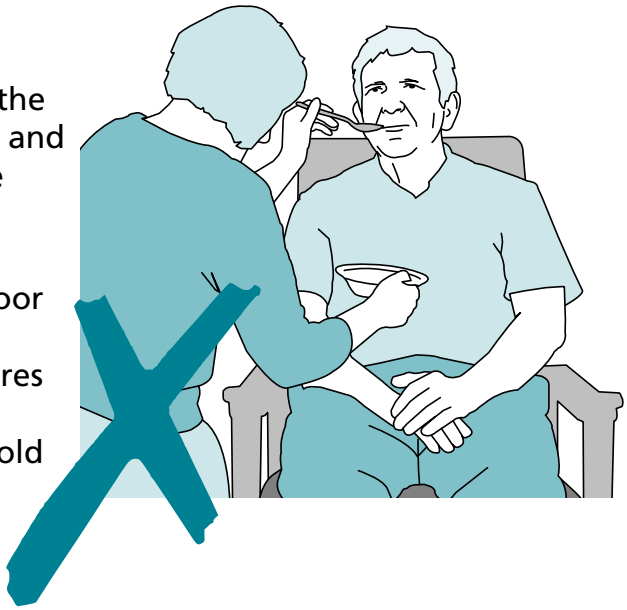
The body should be in balance throughout all physical movement. Any activity that takes the centre of gravity outside the base of support causes increased muscle work. The body has to use its postural muscles to prevent the body falling over, which then makes physical lifting or moving harder. Top-heavy positions can be exacerbated by poor positioning of the limbs or by having a small fixed base.

Avoid Twisting

Twisting in the spine simply acts to reduce the effectiveness of the joints and muscles. This decreases the body's capacity to do work and increases the chance of injury.

Avoid Sustained Loading

Muscles are not designed to work for long periods of time. Sustained holding restricts the blood flow in the muscles, increases fatigue and the chance of injury. Muscles should only be active for short periods and then rested.



Long-term loading should be avoided for poor posture activities and where force is being applied as part of the task. Top heavy postures are indicated as a major cause of sustained holding as the muscles have to constantly hold parts of the upper body in place.

Avoid Fixed Holds

For applying large forces to certain items a fixed grip is essential. For most care handling activities the aim is to move the person with minimal effort. It is therefore not necessary to adopt a strong, fixed grip for most of the activities outlined in the Care Handling Guide. An open hand placed on the person needing assistance spreads the load across the palm and is more comfortable for carer and person and is usually the most appropriate method of applying force.

Lead with the Head

All moves need to be planned and prepared. The movement of the body should be led from the head. This acts to increase the body's extensor pattern and recruit the large extensor muscles. A posture, which maintains flexion in neck and trunk, will tend to make the person lift with their arms.

Summary Note

All of the standard procedures have been developed with these principles in mind. The application of the principles is considered to be best practice. However there will be situations where there may need to be some flexibility in their use. It is important to consider that the more of the principles that are followed then the better the activity.

The interaction of the first four principles is vital:

- Offset base
- Close to the load
- Mobile Base
- Avoid top heavy postures

Any activity, which does not fulfil these four principles will take a carer into a poor position and should be avoided.

An example of this balance may be seen when using a slide sheet. A carer may have to grip the sheet but if at least the first four principles are adopted there should be no major problems.

The Avoidance of High Risk Manual Handling Activities

All activities which involve assisting a person to move, must be documented on a Personal Handling Risk Assessment and Personal Handling Plan Form.

There are a number of manual handling techniques which are known to be associated with far higher risk of injury. Some of these techniques also cause pain and discomfort to the carers, the people being assisted, and limit active participation by the person. Guidance issued by the Royal College of Nursing, Backcare, Chartered Society of Physiotherapy and the College of Occupational Therapists indicates that the following techniques should be avoided as far as possible.

Full Weight Lifts

Advice based on MHOR 1992 indicates thresholds beyond which lifting is hazardous and requires assessment.

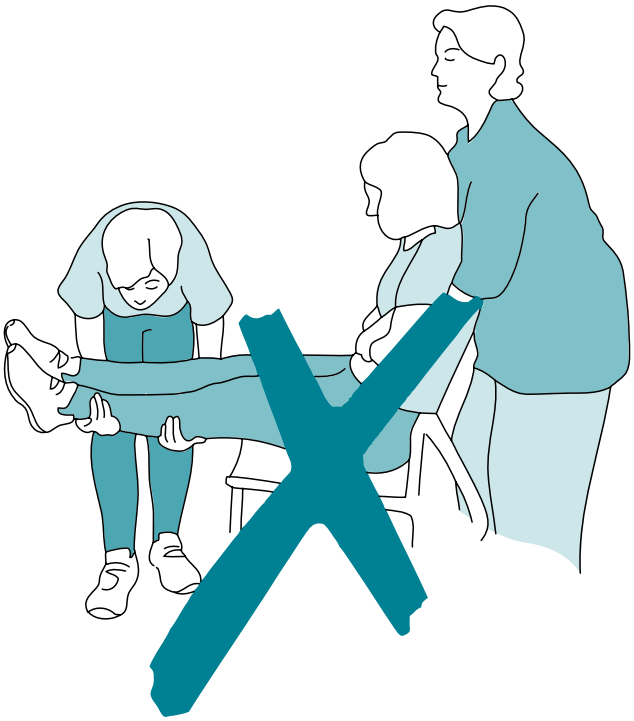
This guidance indicates that it would be dangerous for carers to physically lift all or most of the body-weight of an adult person with one or two carers.

Consequently a number of techniques would be considered very high risk in care situations and must be avoided and not undertaken unless a comprehensive risk assessment has been carried out.

The following lifts are considered as unsafe:

i. Top and Tail Lift

The full weight is shared unevenly between two carers one at the shoulders and one at the legs.

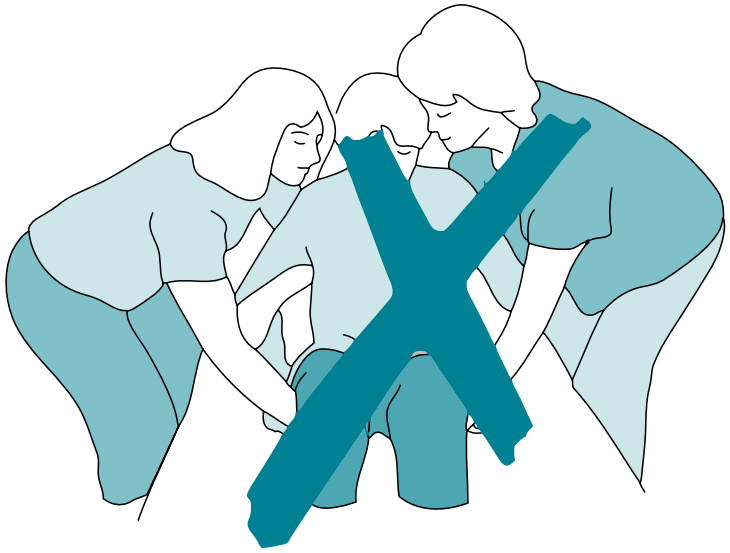


Top and Tail from Bed to Chair

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Top and Tail Lift	1	10	High	16	3

ii. Arm and Leg Lift or Hammock Lift

The full weight is shared between two carers each taking arm and legs.



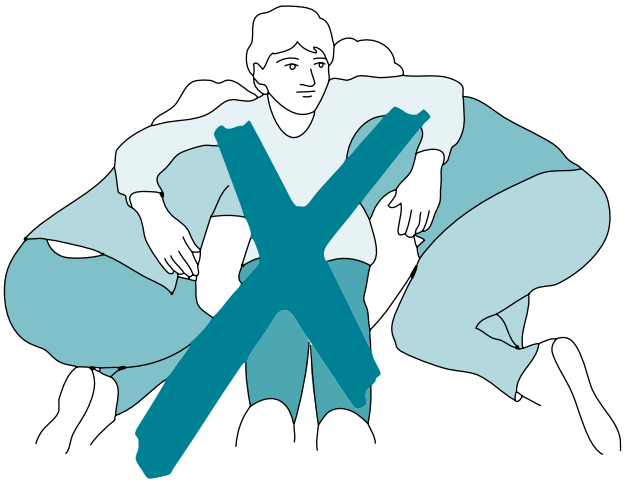
Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Arm and Leg Lift	1	11	Very High	18	4

iii. Two Poles and Canvas Lift

Though the use of poles may seem to add control to the situation two carers are still taking the full weight of the person being moved.

iv. Shoulder (or Australian) Lift

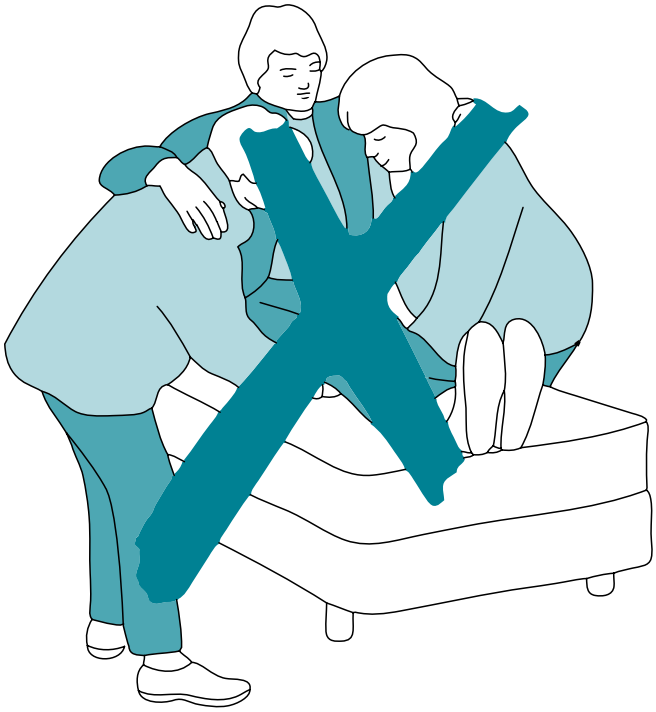
When the shoulder lift is used to reposition a person in a chair or when used to move a person up the bed, this results in carers taking the full weight of the person. The person's weight is lifted by applying pressure under the arm.



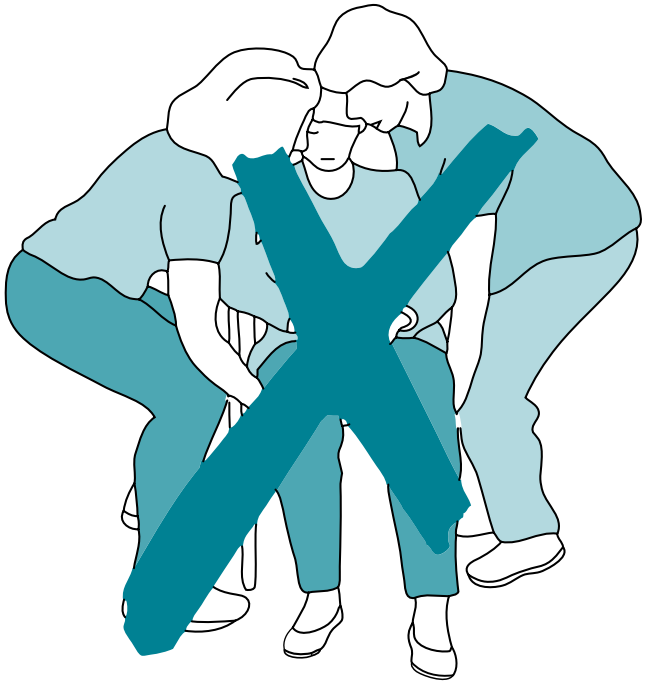
Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Shoulder/ Australian Lift	1	12	Very High	16	5

v. Orthodox Lifts on a bed or chair

This lift involves the carers arms linked under the body and thighs of a person. It can include situations when just a part of the body is lifted e.g. the Flip Turn.



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Orthodox on a Bed	1	11	Very High	18	4



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Orthodox on a Chair	2	13	Very High	17	4

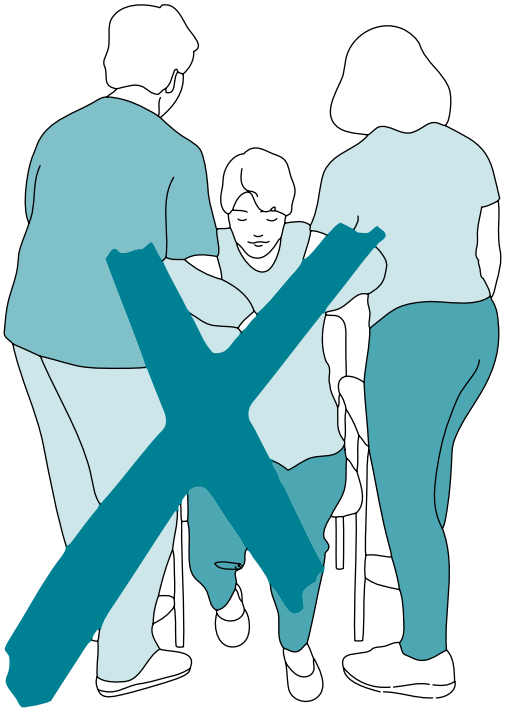
Activities which take most of the Person's Body Weight

Even when the person being moved appears to take some of their own weight through their feet, activities can be dangerous. Some handling tasks do not encourage the person to be weight bearing and others encourage the person to use the carer for support. If either of these occur then the carer is not in control and therefore at high risk of injury.

i. Drag Lifts for Lifting or Supporting People from Beds or Chairs

Lifting a person under the arms may encourage them to slump and pull on the carers. It discourages independent movement and reduces the ability to assist in the activity. It is possible for the person to lift both feet clear of the floor when using this activity. It is unsafe to support a person's weight using an axilla hold.

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Drag Lift from Chair Behind	4	5	Medium	14	2

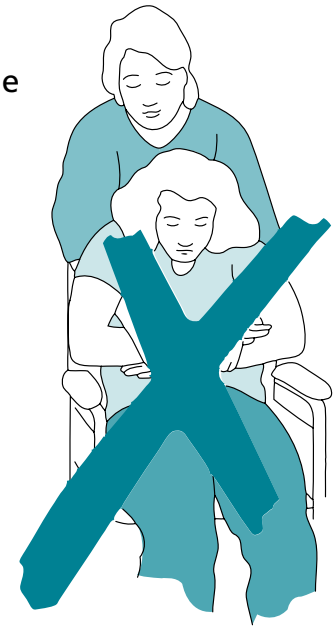


Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Drag Lift from Chair in Front	2	10	High	14	2

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Drag Lift from Bed in Front	1	12	Very High	18	2

ii. Through Arm Lifting In a Chair

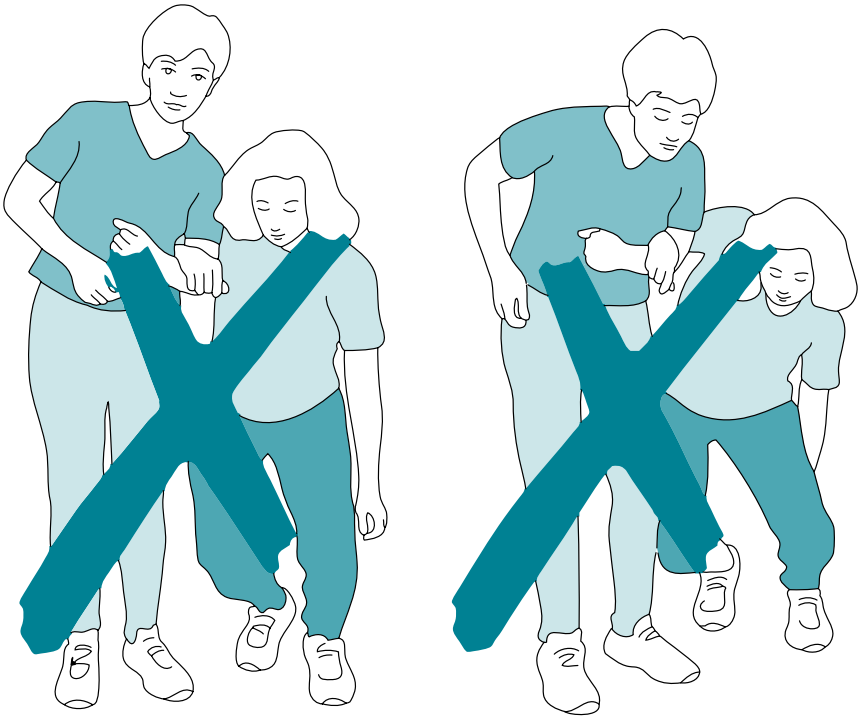
Even with the person assisting this activity it is possible for the carers to bear a large proportion of the weight.



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Through Arm Lift in a Chair	1	13	Very High	15	3

iii. Walking a Person Linking Arms

If a person falls or loses balance during walking they will hang on to the carer and the carer will be powerless to free him or herself from the situation. This situation is made many times worse when carers are positioning the feet of the person walking as both carer and person are unstable.



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Walking a person Linking Arms	2	11	Very High	15	3

iv. Steps and Stairs

If the person falls or loses their balance on steps or stairs the carer has no control over the person's stability and is therefore placed in a vulnerable position.

It is therefore inappropriate to assist people in these high risk situations as part of a regular handling plan.

v. Palm to Palm Holds

If a person and carer adopt a palm-to-palm hold in walking or movement, a potentially hazardous situation may occur. If the person falls, the person or carer will grip the other and a large proportion of the person's weight will be supported on the hand and arm.

vi. Handling Belts and Slings

None of the activities outlined in this guide will show the use of handling slings or handling belts. The use of belts and slings acts against the principle of avoiding fixed holds. Handling belts are usually used when the person is walking. If the person falls when the carer has a fixed grip on a handling belt the carer may take the full weight of the person. This is a potentially dangerous situation.

Front Assisted Transfers

When standing directly in front of the person (face to face) the carer is mechanically disadvantaged due to the distance from the person. It discourages independent movement and reduces the ability to assist in the activity. These factors will present an unacceptable risk to the carer and person.

The following are some examples. It is important to know that if the person being moved at any time grabs the carer then the risk of injury is increased.

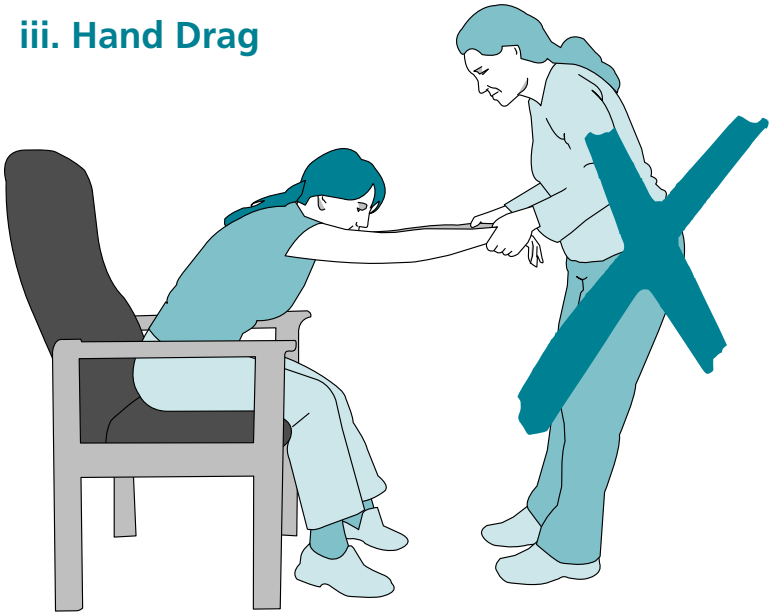
i. Bear Hug

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Bear Hug	1	13	Very High	15	4

ii. Clinging Ivy

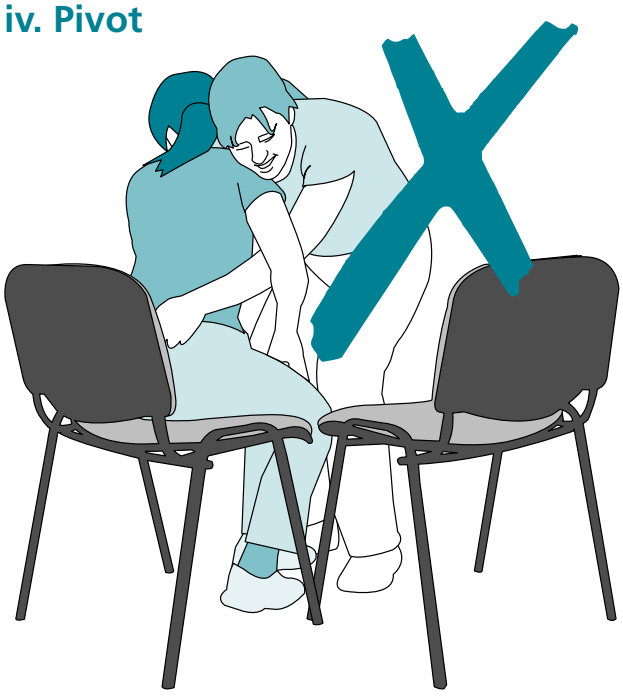
Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Clinging Ivy	2	11	Very High	16	4

iii. Hand Drag



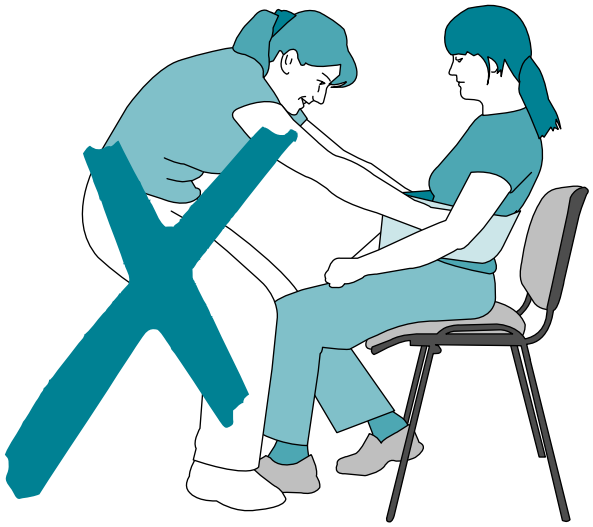
Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Hand Drag	1	8	High	11	8

iv. Pivot



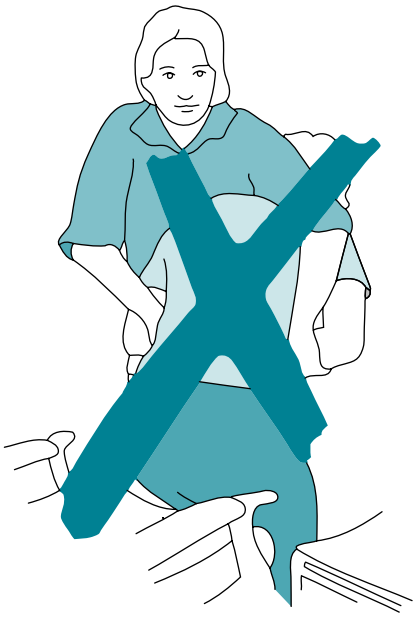
Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Pivot	2	12	Very High	17	2

v. Belt/Sling Holds



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Handling/ Slings	1	11	Very High	14	3

vi. Elbow Lift



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Elbow Lift	1	11	High	17	2

There may be circumstances, however, where it is judged acceptable to use higher risk methods, following a careful risk assessment, and by balancing the risks to carers with the needs of the person.

In this case, the activities should be documented clearly according to the variance risk assessment procedure. All carers should be assessed that they are competent, capable and willing to carry out these high risk manual handling activities. The Manual Handling / Back Care Adviser should always be consulted, and the activity should be monitored and reviewed on a regular basis.

Glossary of Terms

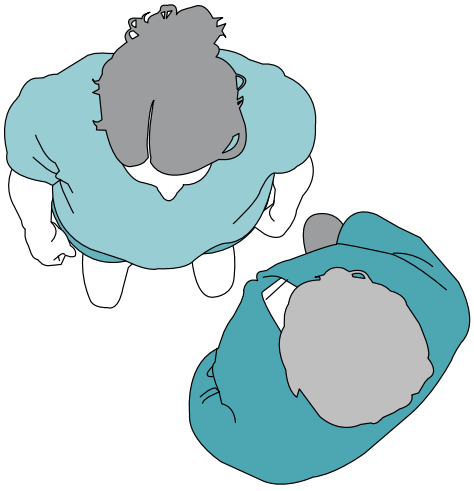
Person is the patient, service user, client, resident, child, pupil, student or tenant who requires the assistance.

Carer is the carer, assistant, staff, nurse, therapist who is providing the assistance.

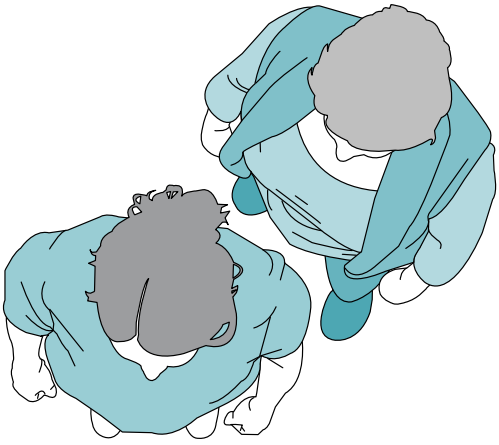
Weight Bearing for people to be categorised as weight bearing they should be able to support themselves in standing.

Positions

Positions Carers Starting the positions outlined below are designed to give best access and support for the person and carer when assisting movement. They are consistent through all procedures outlined in this document. When working with people of shorter stature or on low surfaces, it may be necessary to adopt these positions in half-kneeling to prevent the carer using top-heavy postures.



Oblique in front

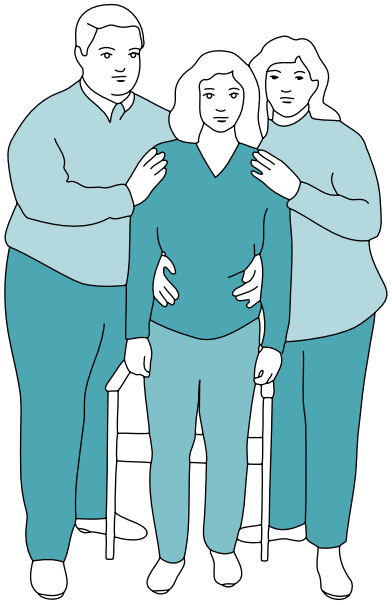


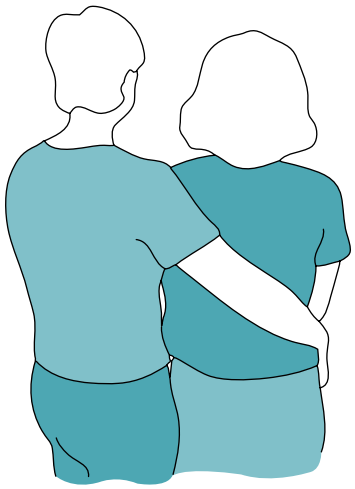
Oblique behind position

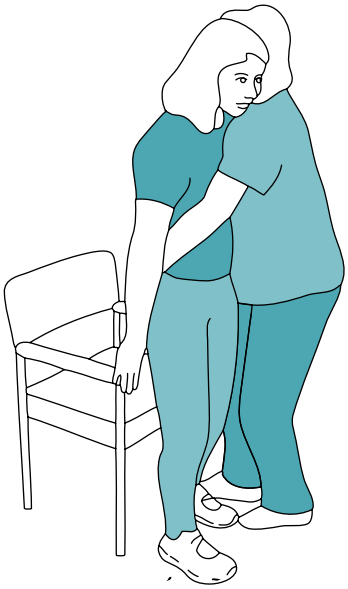
Holds

Acceptable Hand Hold the hand holds for most care activities are based on having an open palm and avoiding a fixed grip. This open palm hold can be used on the person's forearm, shoulder, scapula, rib cage, spine or pelvis. These are shown in the following illustrations.

The Long Low Hold the aim of the long low hold is to apply gentle assistance to the person whilst still maintaining a good position. It also allows the person's pelvis to be secured and perception of movement to be felt. The open palm of the carer can be placed on the hip, or the lower back area depending on the sizes of the person and carer involved and the amount of support needed.



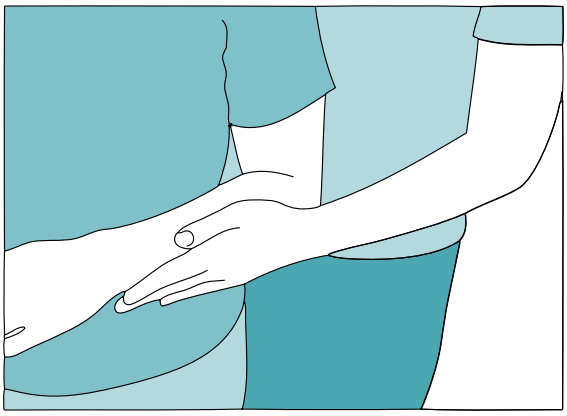




Shoulder Hold the palm can be placed on the shoulder. Care needs to be taken not to place too much pressure through the person's shoulder.

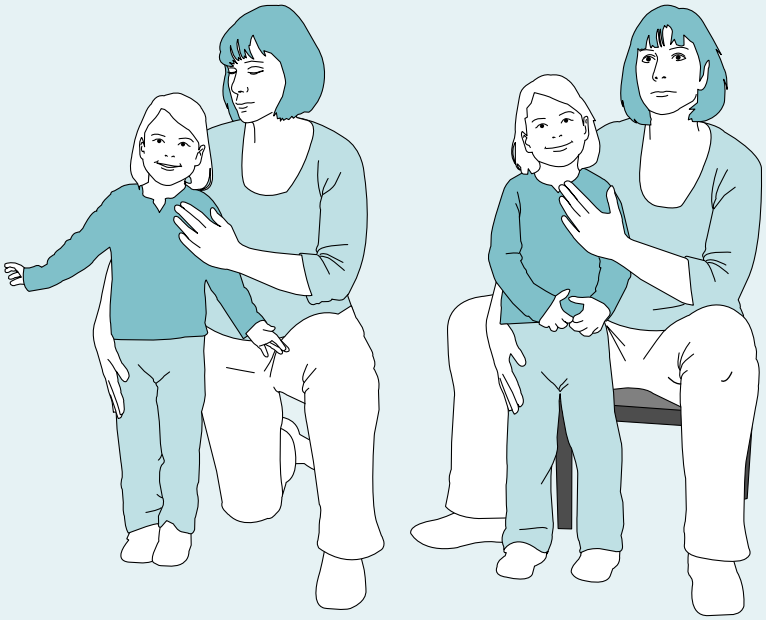
Lateral Rib Hold support may be given to a person by supporting the trunk. The hand should be placed around the rib cage.

Elbow or Forearm Support the flat palm can be placed against the arm to aid balance or offer support. Care must be taken not to elevate the person's shoulder.

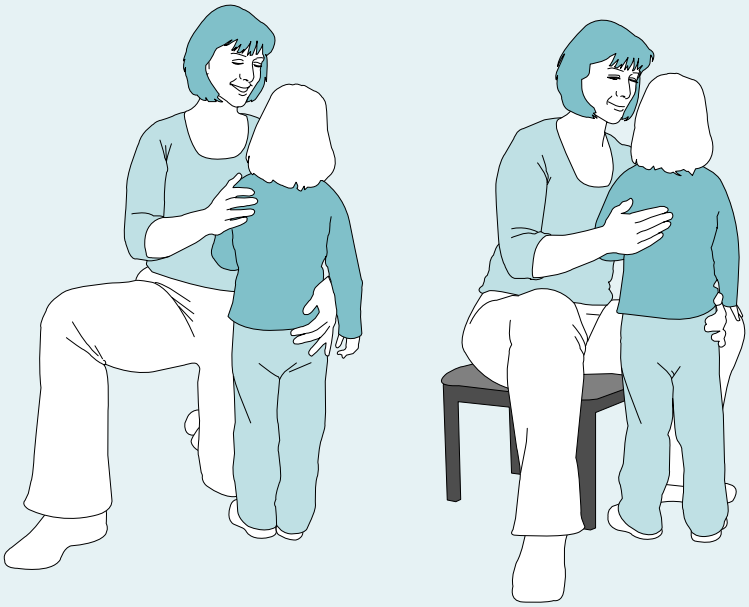


Kneeling and Low Sitting Positions

When working with smaller children, the above positions can be adapted for half-kneeling and sitting positions (for example on a wheeled stool). For very small children, assisting in kneeling positions may be face-to-face.



Long low holds with smaller children- oblique infront and behind position in kneeling and sitting on wheeled stool



Equipment Terminology

AFOs	ankle foot orthoses (foot supports)
Bed Levers	grab rails/hand rails that are fixed to a bed frame to assist with independent movement.
Braces	braces are available in a range of designs including body braces and hip braces.
Chair and Bed Raisers	purpose made fixtures that when fixed to furniture raise the level of the entire bed or chair to aid independence.
Changing Table/Couch	a table, usually wheeled, and with a height adjustment mechanism, for changing pads or clothing etc.
Electric Beds	electric beds have multiple functions, adjusting bed height, back rest angle, knee break angle and bed frame tilt. Any or all of these functions can be used to assist a person to move on the bed. They can also be used to assist a person to move in and out of a bed.
Framed Turning Disc	a solid framed turning platform with a braking mechanism e.g. Rotunda, Rotalite. Used to turn a person in standing to aid transfers.
Gaiters	supports for lower leg or whole leg.
Grab Rails/ Hand Rails	fixed rails fastened to wall or floor to aid independent movement.
Hand Blocks	blocks or plates with comfortable hand holds which can be used to assist movement in a bed.
Hoists	lifts and / or transfers the person in sitting, standing or lying positions. A wide range of systems are available, including overhead systems (ceiling track or gantry) mobile or fixed.
Mattress/Pillow Elevators/ Variators	powered devices to assist a person into sitting from lying in bed.
Moulded Seats/ Insert	custom made firm inserts designed to give support to people with asymmetrical body shape.
Plinth	a wide couch similar in design to changing tables/couches.

Pommels	Devices for use with seating systems to promote a good sitting posture, and helps to maintain a good hip position.
Rolls	PVC covered rolls which children can lie over.
Rope Ladders	rope ladders fastened to the bed may be used to aid a person to sit up in bed.
Seating System	wheelchair insert providing enhanced support.
Seat Variators/ Ejector Seats	a powered seat raiser to aid standing from chair
Slide Sheets	low friction sheets, which can assist a person by sliding instead of lifting. These can be single flat sheets, double flat sheets or tubular rolling sheets. Some are manufactured to only slide in one direction.
Standing Frames	frames of a wide range of designs which support a person in a standing position.
Therapy Stool	a low wheeled stool which can be used to improve the carer's posture when assisting smaller children.
Transfer/Slide Boards	a device, which acts as a low friction bridge between two surfaces. These can be many shapes, sizes and materials and can be used between chairs, beds or trolleys.
Trapeze	a handle that is attached on a pole to a bed over the person's head to aid independent movement in bed.
Turntable	a flat disc, may be hard or cushioned, which allows rotational movement around a central pivot, allowing a person to turn whilst seated or to position feet during a transfer.
Walking Aids	a range of products that help people to be mobile for example sticks, walking frames, K Walkers, rollators etc.
Wedges	large PVC covered foam wedges which children lie on.

Guidelines for Using the Standard Procedures

Each procedure has been written in a standard format. Each activity, when adopted in practice, should be documented as part of the Personal Handling Plan in a clear and concise way.

The format of each procedure is as follows:

Assessment Criteria

The first section indicates the factors which carers or the assessor should consider. These factors indicate the abilities and any limitations the person may have when carrying out the activity and the environment in which the activity will take place. This might include for example, the height of the chair, person's footwear etc. The assessment criteria may indicate potential problems that may identify the activity as being more hazardous.

The carer should always carry out a risk assessment prior to undertaking any manual handling task.

If a change occurs the Personal Handling Risk Assessment and Plan should be reviewed and amended.

Independent Movement

This section provides guidance on how to promote independent movement. This includes positioning prior to movement, how to move in ways which maximise independence, and equipment to aid independence.

Allowing sufficient time and communicating effectively, are essential to facilitate independent mobility.

Promoting independence not only allows people to maintain and develop skills and abilities; it also allows carers to avoid the use of manual interventions, which is always recognised as the best method to reduce the risk of a musculo-skeletal injury.

Manual Assistance

This section gives advice and guidance for the trainer or carer to carry out manual assistance of a person if it cannot be avoided. There are usually a number of options available in this section and a preference may be stated.

Hoisting

Where appropriate, hoisting options are included.

GUIDANCE FOR CARE HANDLING OF PEOPLE IN HOSPITAL, COMMUNITY AND EDUCATIONAL SETTINGS

PRACTICAL GUIDE

DERBYSHIRE

INTER-AGENCY

GROUP

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Practical Guide for People

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Assisting a Person to Move from Sitting to Standing

Assessment Criteria

When assessing the sit to stand activity the following criteria should be considered :

- Weight bearing capacity
- Trunk and upper limb control
- Suitable co-operation and comprehension
- Knee flexion – one knee should bend to >90°, unless on a raised seat
- Hip flexion – poor hip flexion will affect sitting positions and trunk movement
- Appropriate balance and control
- Appropriate footwear/orthotics
- Characteristics of seating and the environment
- Does the person need to be stood?
- Can they assist in the action of standing from the chair?

Independent Standing

This should be encouraged by verbal or visual prompting only. Environment needs to be suitable for activity to take place.

Floors
Should be level and not slippery or wet

Chairs
- Should be the right height for the person to stand from. Seat height can be raised using thicker seat cushions or chair raisers
- If wheeled chairs are used ensure brakes are applied
- Should have suitable arms to assist the person to stand

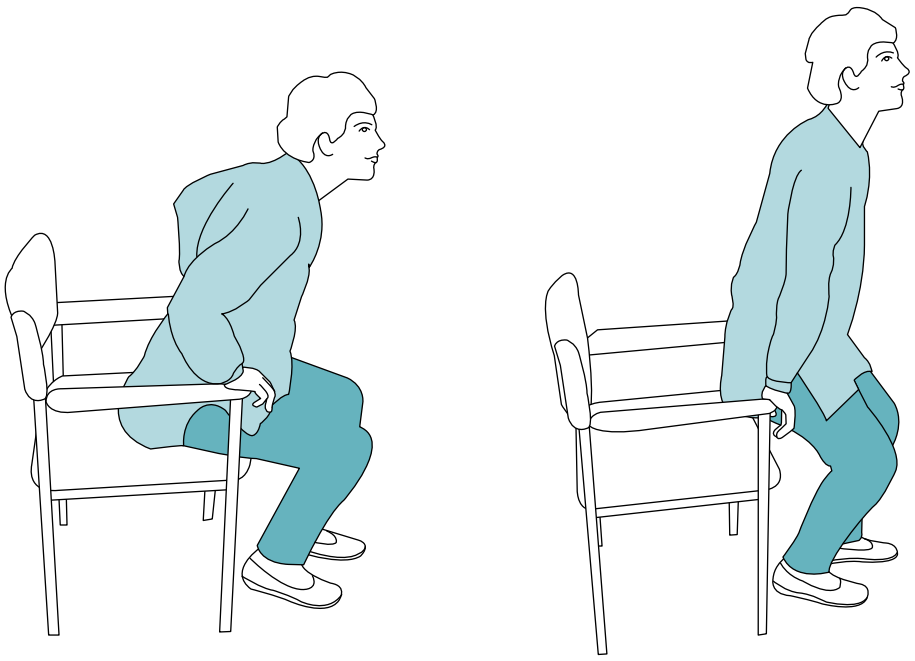
Beds
- Height adjustable beds – Ensure the person's feet are securely on the floor. Raise the bed, bringing the person into a standing position
- Hand blocks to push on
- Bed lever

Equipment
- Powered riser chairs
- Power assisted cushions or inserts to raise the person from the chair
- Standing frame
- Chair levers
- Grab rails

Person's Position Prior to standing

The person needs to be in the appropriate position in sitting prior to standing:

- Shuffle hips or bottom to front of chair or bed (can be assisted or taught using technique for Repositioning in Chair)
- Person should adopt an offset base and lead the movement with their head
- Encourage the person to lean forward (nose over toes) and push into standing leading with the head
- Push on arms of chair or thighs to assist the stand



Manual Assistance

All methods can be considered with one or two carers. Care needs to be taken when there is a height difference between carers and/or the person.

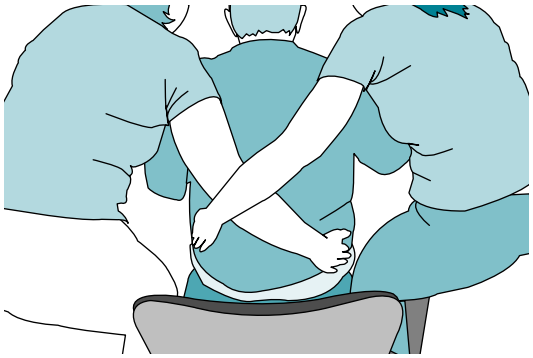
The methods below are intended to assist people who can stand and not to stand people with very poor ability. Standing people who have poor ability requires specific skill and is considered to be in the domain of therapeutic handling and should have a Variance Risk Assessment, i.e. do not stand those who cannot stand.

The following are accepted methods for assisting a stand. The **oblique behind** is always the preferred option as it gives greatest support to the person.

Oblique Behind

Space is needed at the side of the chair for the carers to achieve a long low hold.

- Carer takes the oblique position behind the person
- Carer uses long low hold with the arm closest to the person
- Carer can use palm to arm, ribs or shoulder for the arm furthest from person
- Carer moves from a low start position and steps forward into standing, leading with the head
- Remain in a close oblique behind position, using a mobile offset base to support the person as they come into standing
- Person should be encouraged to assist by pushing up on chair arms or their thighs



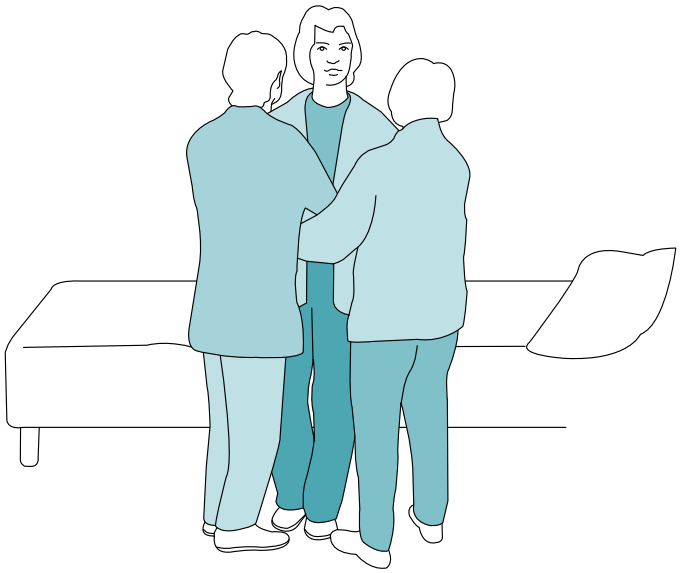
Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Sit to Stand Oblique Behind	8	4	Medium	11	9

Oblique in Front

Can be used for example where there is limited space at the sides of chairs or from a bed. **This is the only method that can be used when assisting a person to stand from a bed.**

- Carer takes the oblique position in front of the person
- Use a long low hold with the arm closest to the person
- Take scapula/thoracic spine hold, or lateral rib hold, to encourage forward movement with the hand furthest from the person
- Carer moves from a low start position and raises to standing, leading with head
- Remain in a close oblique in front position, using a mobile offset base to support the person as they come into standing
- Person should be encouraged to assist pushing up on arms of chair, thighs or hand blocks if on a bed

NB: The handholds are interchangeable for left and right hands depending upon the persons and the carers ability and the environment.



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Sit to Stand Oblique in Front	7	5	Medium	10	8

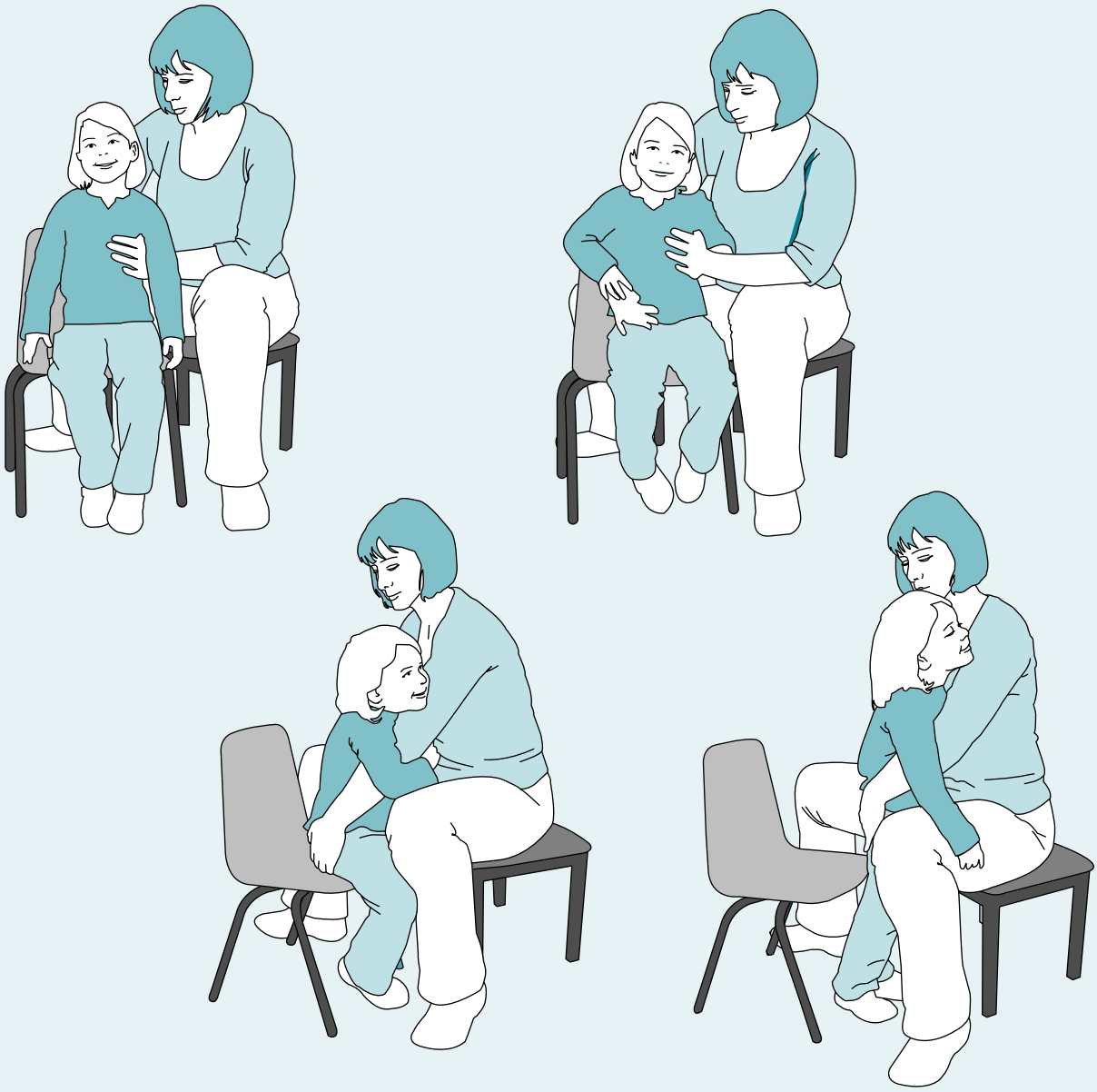
Combination

Following the risk assessment, when two carers are required, it may be more appropriate to use a combination of oblique in front and behind.

Assisting Smaller Children to Stand

The methods for assisting smaller children to stand should be in the same basic positions as for larger children – oblique behind position or oblique in front.

For smaller children it may be necessary to adopt a half kneeling position as a starting posture and move from low kneeling to high kneeling or to extend into an upright position from a relaxed one. With both patterns of movement there should be a wide, offset, mobile base, and movement should be led with the head. The carer should not forcibly push the child into standing. Assistance may be given with the carer sitting on a wheeled stool. With very small children, a thoracic or hip hold may be taken, depending on the stability of the child; the position may need to be taken face-to-face.



Hoisting

If the person does not have good standing ability then they should not be stood, unless they are supported mechanically.

For using or selecting a hoist for standing activities see the appropriate guidance notes

Assisting a Person to Move from Standing to Sitting

Assessment Criteria

When assessing for sitting the following criteria should be considered:

- Weight bearing capacity
- Trunk and upper limb control
- Co-operation and comprehension
- Knee flexion
- Hip flexion – poor active hip flexion will affect sitting action and trunk movement
- Appropriate balance and control
- Appropriate footwear/orthotics
- Characteristics of seating and the environment
- Severe rigidity or extensor pattern movement
- Can the person sit without physical assistance

Independent Sitting

This should be encouraged by verbal or visual prompting only. The environment needs to be suitable for the activity to take place.

Floors

- Should be level and not slippery or wet

Chairs

- Should be the right height for the person to sit on. Seat height can be raised using thicker seat cushions or by fitting chair raisers
- If wheeled chairs are used ensure brakes are applied
- Should have suitable arms to assist the person to sit

Beds

- Height adjustable beds – to appropriate height
- Hand blocks to assist sitting
- Bed lever

Other Equipment

- Powered riser chairs for lowering
- Self-lowering cushions or inserts. (Powered or spring loaded)
- Chair levers
- Grab rails

Person's Position Prior to Sitting

- The person needs to be in the appropriate position prior to sitting.
- Encourage the person to move back so that legs are touching edge of chair or bed
- Feet flat on floor a little distance apart
- Person must have ability to bring head forward and flex at the hips. (Trunk moving forward – nose over toes)
- Person places hands on their thighs, seat arms, bed or blocks to support sitting

Manual Assistance

When sitting someone down in a chair the support the carer gives is only a guiding movement. It is therefore important to recognise that as soon as the person is sitting safely the carer should return to normal upright posture and should avoid staying too long in a low position.

The following are all accepted methods for assisted sitting and are suitable for one or two carers.

Oblique Behind

Space is needed on either side of the chair for the carers.

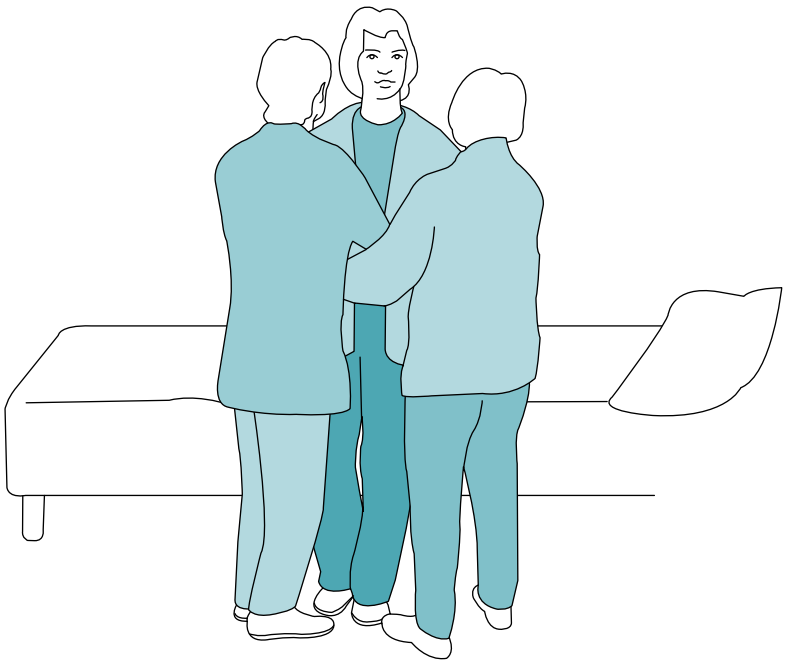
- Carer takes an oblique position behind the person
- Carer uses a long low hold for the arm near the person
- A forearm, lateral rib, pelvis, or shoulder hold can be used as a supplementary hold
- Person places hands on thighs or arms of chair
- Lower into a seated position, with the carers using mobile offset base

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Stand to Sit Oblique Behind	8	4	Medium	9	9

Oblique in Front

Can be used with minimal space at the sides of chairs or from a bed. **This is the only method that can be used when assisting a person from standing to sitting on a bed.**

- Use a long low hold, maintain arm in a comfortable position
- Take scapula/thoracic spine hold, or lateral rib hold, to encourage forward movement with other hand
- Carer moves smoothly from an upright position into a low position. It maybe necessary to take a small step to maintain balance and support
- Person can assist by supporting themselves on the arms of a chair, or thighs, or hand blocks if on a bed



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Stand to Sit Oblique in Front	8	2	Low	8	9

Combination

Following the risk assessment when two carers are required, it may be more appropriate to use a combination of oblique in front and behind.

Assisting smaller children to sit

The methods for assisting smaller children to sit should be in the same basic position as for larger people, ie oblique behind or oblique in front.

For smaller children it is acceptable for the carer to adopt a half kneeling position and lower in a controlled way to support the child sitting down. Alternatively, the carer may be sitting on a low wheeled stool. With very small children, the position may need to be taken face-to-face. Small children may also need a foot block to raise them to the height of the chair (for example in the case of small wheelchairs).

Assisting a Person to Reposition in a Chair

Assessment Criteria

Repositioning in a chair can be forwards or backwards. However if the person has slipped too far forwards and is unable to move back independently the person should be encouraged to lower to the floor. Prior to repositioning someone in a chair or seat the following issues should be considered:

- Type of chair
- Transfer of weight from side to side
- Sitting posture and shape
- Trunk and upper limb strength and control
- Co-operation and comprehension
- Appropriate balance and control
- Asymmetrical posture or shape, or uneven effort
- Knee flexion
- Hip flexion – poor active hip flexion will affect trunk movement
- Appropriate footwear/orthotics
- Severe rigidity or extensor pattern movement
- Attachments, i.e. catheters, IV drips etc
- Medical complications, e.g. medication effects, particularly timing of treatment

Independent Repositioning

The need for a person to be repositioned in a chair may be avoided by providing appropriate seating which supports people in the correct position and prevents slipping. It may be useful to consider the following:

- Reconfigure seating to prevent slipping
- Tilt the seat base to maintain position
- Use of pommels
- The use of one-way glides, ensuring tissue viability assessment is carried out

Independent Repositioning – verbal encouragement only

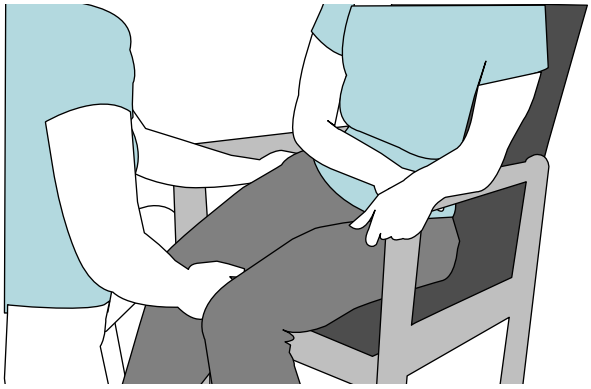
- Encourage person to lean forwards
- Rock/shuffle themselves backwards in the chair. Encourage the person to hitch the hips up and back independently
- Use the chair arm for assistance

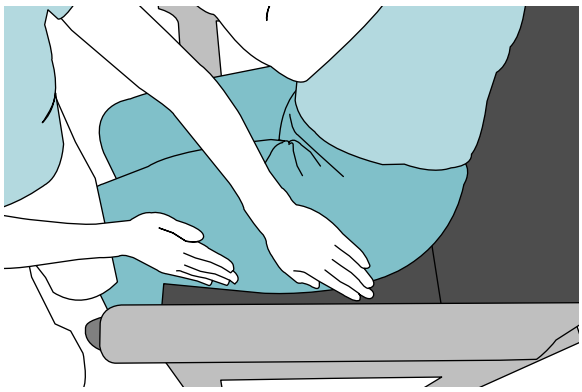
Manual Assistance

This can be completed with one or two carers. The action is to assist the person to take the bodyweight off each buttock and reposition the limbs.

Repositioning with One Carer

- The carer adopts an oblique in front position either with a low balanced position or in half kneeling
- The person moves their body weight to one side. The person can support themselves on the arms of the chair or the carer can support by using lateral rib hold
- The carer facilitates the movement of the person by holds on the hip
- The person should be encouraged to move the buttock upwards and forwards/ backwards
- If the person is able to support themselves on one side and raise the buttock, the carer can assist to move the pelvis and thigh forwards or backwards using a flat palm hold

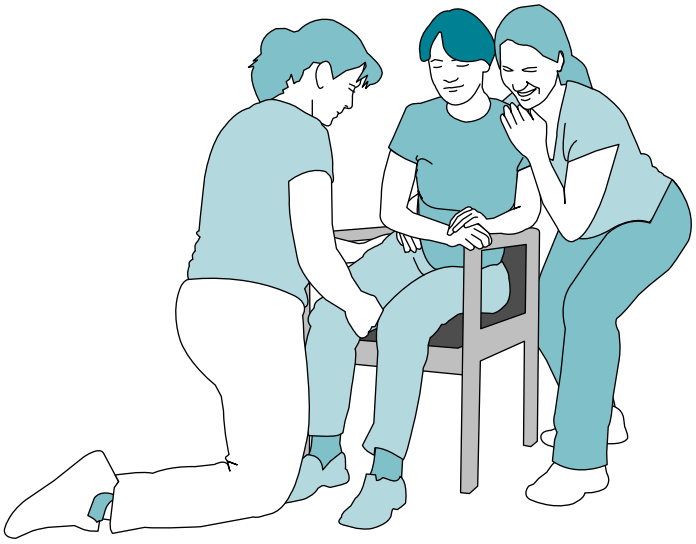




Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Repositioning in Chair (1 carer)	7	4	Medium	11	8

Repositioning with Two Carers

- One carer adopts an oblique behind position, supports the person's trunk with a long low hold and brings the trunk towards them. This should take the weight from the opposite hip
- The other carer adopts an oblique in front position in half kneeling
- The carer in front facilitates the movement of the person by a hold on the hip and thigh
- The person should be encouraged to move the hips upwards and forwards or backwards
- The movement may need to be repeated on alternate hips until the person is repositioned



Activity	Carer	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
			Score	Risk Level		
Repositioning in Chair (2 carer)	Carer kneeling	8	5	Medium	8.5	8
	Carer oblique behind position	8	4	Medium	11	9

Stand Up to Reposition

- Stand the person using the appropriate methods shown earlier, oblique behind, oblique in front with one or two carers
- Once standing and stable, encourage the person to step back closer to the chair
- Assist the person to sit back down with buttocks as far back in the chair as possible
- Alternatively the chair can be brought forwards closer to the person if they are unable to step back

Equipment to Reposition in Seat

- Hoist - consider leaving the sling in situ if repeated repositioning is needed
- Framed turning disc with knee block
- Sit to stand aids with knee block

Transferring a Person from Sitting to Sitting

Assessment Criteria

For a person to be suitable to transfer from sitting to sitting the following issues need to be considered

- Weight bearing capacity and independent foot placement
- Trunk and upper limb strength and control
- Asymmetrical posture or shape, or uneven effort
- Knee flexion – one knee should bend to >90° unless on a raised seat
- Hip flexion – poor active hip flexion will affect sitting action and trunk movement
- Appropriate footwear/orthotics
- Severe rigidity or extensor pattern movement
- Walking aids
- Stamina and distance capabilities and the route considered
- Attachments, i.e. catheters, IV drips, etc.
- Medical complications e.g. medications effects, particularly timing of treatment

Other factors that need to be considered include:

- Space
- Height of surfaces
- Floor surface
- Urgency

Independent Transfer – verbal or visual prompting only

- Ensure the correct height of surfaces
- Use powered or sprung seat raisers if indicated
- Place the surfaces close together at suitable angle
- Provide a sliding board if the person is able to use one independently
- Remove arms from the chair or wheelchair
- Encourage the person to adopt an appropriate position to transfer i.e. Knees bent, feet flat on floor, trunk in flexion, body weight forward with the leading arm, shoulder and foot towards finish position
- Encourage person to take small movements or shuffle if appropriate
- Turntable or turn discs for feet
- Grab rails or levers

Manual Assistance

Sliding Board

There may be occasions where someone can be independent with a sliding board but needs some guidance.

The assistance given by the carer should be minimal providing facilitation/guidance in the direction of movement.

- Ensure seats are of similar height
- The person is prepared to undertake the transfer
- Position the person's limbs in appropriate position i.e. knees bent, feet flat on floor, trunk in flexion, body weight forward, with the leading arm, shoulder and foot towards the finish position
- The person needs to be instructed to take some weight on the leading arm to assist the transfer of weight
- Carers adopts an oblique front and/or oblique behind position
- Guidance can be given to aid the person with hands on shoulder, scapula, lateral rib or hip

If significant physical effort is required to assist a person to transfer between seats when using a slide board this should trigger the selection of an alternative method to achieve a seat to seat transfer or the variance risk assessment process should be instigated.

Transfers through Standing

Transfers through standing should be carried out in accordance with the guidance relative to standing from sitting, walking and sitting from standing.

The different methods depend upon the person's level of ability and the environment in which the transfer is to be undertaken. There are three options:

Stand Walk Sit
Change Seat
Using Equipment
- Framed Turning Disc
- Transferring devices
- Active Hoist
- Passive Hoist

Stand Walk Sit

If the assessment indicates a good level of ability it is possible to assist a person to stand, support them through a few short steps and then assist them to sit in the new position. The person ***MUST*** have good balance and independent foot placement to complete this task. This can be completed with one or two carers. Care needs to be taken if there is a significant height difference between the person and/or carers.

The preferred method is to have two carers in the oblique behind position to assist the stand. If space is limited carers could take the oblique in front position to assist the stand phase only.

- Space needed on both sides of the chair
- Place chairs with enough space for carers and person to move between the chairs
- Person must be able to take the few steps between the chairs, either independently, with walking aid or with the support of one carer in an oblique behind position
- Support from the oblique in front position should not be used whilst the person is walking
- There may be equipment that can assist these activities. The person can use walking aids or grab rails

The risk assessment must be clear for this activity to be safe. The person must be able to make the few steps from one chair to another. The role of the carer is one of guiding movement and not one of supporting the person's weight whilst walking.

This should not be attempted if the person has:

- Poor balance
- Poor standing ability
- Poor gait or is unable to step independently with both feet
- A history of falls which indicates the person is at significant risk

Changing the Seat

For a person with good standing but poor stepping ability it may be safer to stand the person and change the seat

- Ensure adequate space around the chair
- One or two carers can assist the person to stand
- If necessary the person could be supported in standing by one or two carers or by using equipment e.g. frames, handrails, levers etc.
- The carer who is not supporting the person in standing can change the seat
- The person can then be assisted to sit

Pivot transfers with small children

For very small children, assistance can be given with guiding a pivot transfer with the carer face to face. If the child is sufficiently small, this can be done in kneeling; as children become bigger there is a likelihood of the carer twisting, and a wheeled stool should be used. The following method should be used:

- Position the second surface close by and at an angle.
- Encourage the child to move forward in the chair.
- Encourage the child to place the feet apart if possible.
- Encourage the child to stand, stabilizing the hips and trunk with an open palm hold.
- Encourage the child to reach for the chair if they are able.
- Guide the child round to the new chair giving verbal cues as appropriate.
- Framed discs are available with an integral block for the use with small children

Equipment

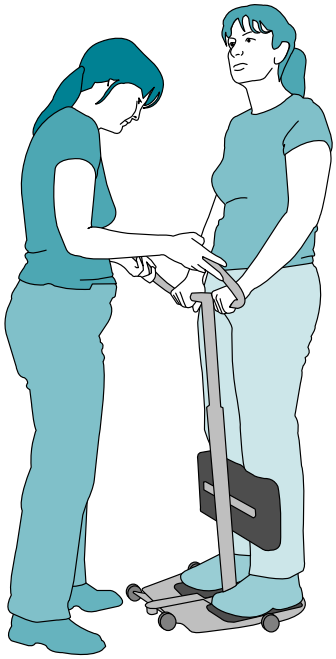
Framed Turning Disc

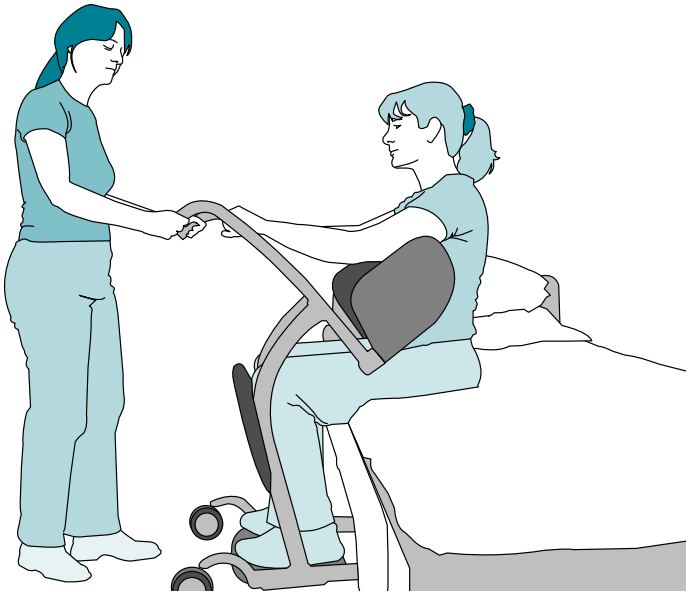
This activity can be carried out with one or two carers. **The framed turning disc cannot be replaced with a flat turning disc for this task.**

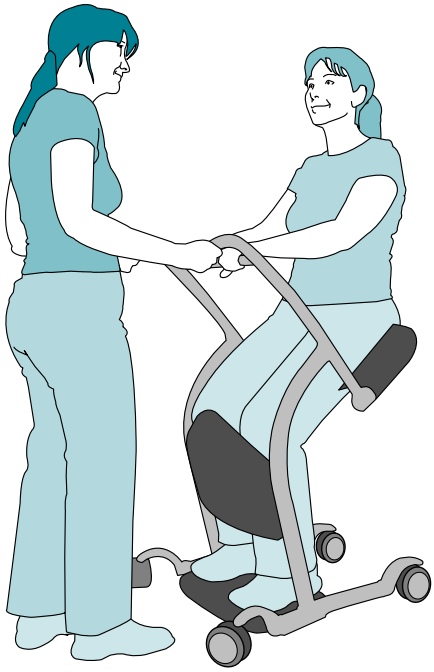
- Chairs placed at 90°
- Carers may use an oblique behind position to assist the stand if required
- Framed turning disc is used to transfer through 90°
- Carers can adopt an oblique behind to assist the sit if required

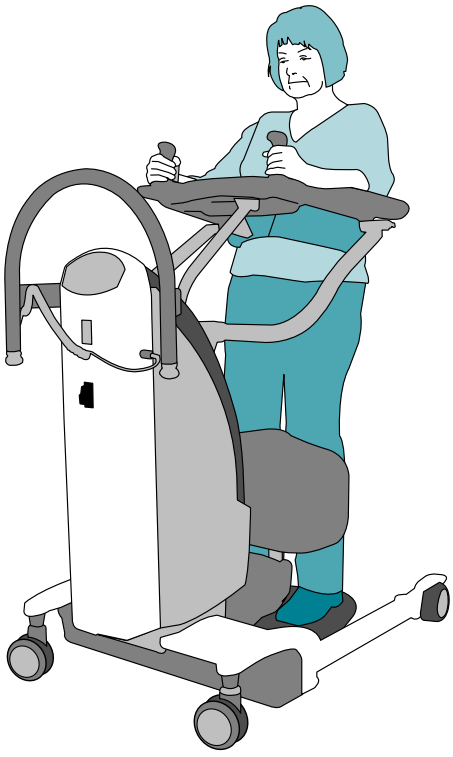
Mobile Transfer Aid, for example Arjo Stedy or Liko Rollon

This equipment can aid seat to seat transfers where people have sufficient weight bearing ability and sitting balance.









Using an Active Hoist

- The person needs some weight bearing ability
- The person needs good trunk control
- The person needs good comprehension and co-operation

Using a Passive Hoist

For a dependent person mobile or overhead type hoists may be used.

See Guidance Notes for advice on hoist and sling selection.

Supporting a Person in Walking

Assessment Criteria

A person who is at significant risk of falls should not be supported manually in walking.

A person should be able to take weight on either leg and be able to independently place both feet. At no time should carers place a person's feet whilst walking. When assisting for walking activities the following criteria should be considered:

- Trunk and upper limb control
- Co-operation and comprehension
- Appropriate balance and control
- Asymmetrical posture or shape, or uneven effort
- Appropriate footwear/orthotics
- Walking aids
- Stamina and distance capabilities and the route considered
- Attachments, e,g. catheters, tubes, feeds, lines etc.
- Medical complications e.g. medication effects, particularly timing of treatment
- Floor surface and slipping, tripping hazards
- Independent foot placement
- History of falls

The activity of standing and walking a person for the first time as part of the assessment process should be carried out by appropriately skilled carers. This guidance is for walking which is a routine part of the Personal Handling Plan.

Stairs, steps and ladders ***MUST NOT*** be attempted as part of a routine care handling plan. There is no method to prevent a serious fall if someone collapses in these situations. (Please refer to Guidance Notes for further advice.)

Independent Walking

Person walks independently

- Needs only verbal or visual prompting and no aids or adaptations

Person walking independently with equipment

- Walking sticks / tripods / crutches / frames / rollators
- Fixed rails may be in situ
- Hydraulic walking frames

Manual Assistance

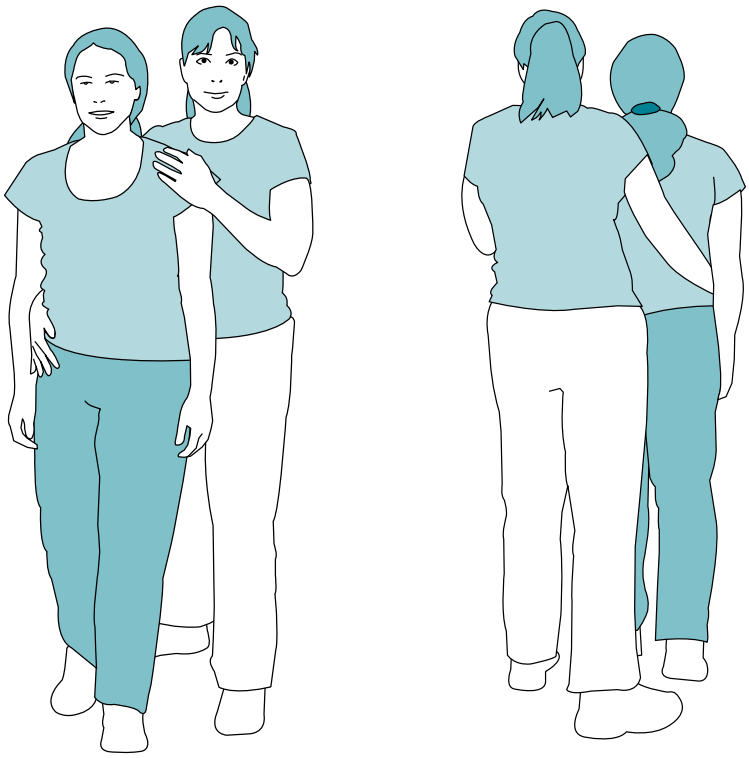
Is there anything to be gained from walking the person for this particular activity? Is the task part of a rehabilitation programme or therapy? Would it be safer, quicker and no detriment to the person if they were transported to a better environment?

Care must be taken when there is a difference in height between the carers and / or person.

Supported Walking

Using one or two carers:

- Carers to take up oblique behind position
- Use a long low hold round person's waist. If possible place a flat palm on the distant hip
- Carer's hip should be close to/touching person's pelvis
- Carer can support with other hand via; palm to arm, shoulder, lateral rib or nearside hip
- Carer should follow person's movement as closely as possible and verbally encourage safe stepping pattern



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Supported Walking	8	2	Low	9	9

The Falling Person

An appropriate risk assessment should identify a person's needs prior to assisting a person to walk. It should also identify the steps to minimise the risk of a person falling.

There is no guaranteed safe method for catching a falling person. Several scenarios may happen in the normal course of duty. The role of carer in supporting walking may involve supporting the person in a standing position by using the appropriate assistance. If a carer feels unable to assist the person in a standing position safely, they should allow them to slide to the ground.

Falling Person – Out of Carer's Reach

- The carer ***MUST*** let the person fall

Falling Person – Within the Physical Reach of Carer

This situation is where the person falls within reach of the carer but is not being supported in walking.

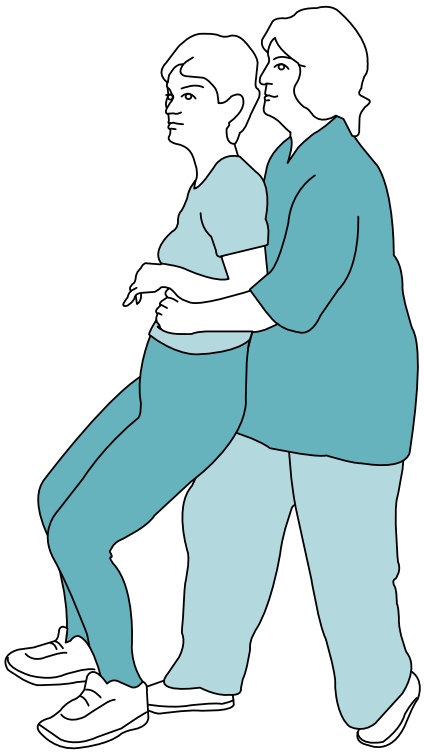
The carer ***MUST*** not catch a falling person. It may be possible to either:

- Move furniture or dangerous objects out of the way of the person's fall line
- If considered safe, protect the person's head from anything that may cause them serious harm, e.g. tables, beds and furniture

Falling Person from Supported Walking

There may be situations where carer(s) are supporting walking and are in close proximity to the person in the oblique behind position. If a person requires two carers to assist walking, difficulties may be seen if the person collapses. One carer must take the lead in these circumstances.

- If the fall is away from the carer they MUST let the person fall to the floor.
- If the fall is towards the carer and they are comfortable with the action it may be possible for the carer to prevent the fall.
- Better control of a falling person is found from the supported walking position, oblique behind
  - Stay close to the person
  - Initially step backwards to adopt a wider and deeper base of support against the direction of the fall
  - Do not take a fixed grip on the person as they fall, use only open palm contact
  - It is possible at this stage to prevent a fall by supporting the person in a relaxed standing position.
  - From this position it may be possible to return the person to walking



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
The Falling Person - Steadying	7	5	Medium	13	6

If the person cannot resume walking or the fall is sudden or uncontrolled:

- Guide the person's torso to the floor by sliding them down the carer's leg. Do not grab limbs or take an axilla hold
- If possible take small steps to maintain a mobile base as the person falls
- Carers should bend their knees and relax the spine through the descent phase
- Do not take all the person's weight through the muscles of the trunk or upper limbs

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Lowering the Falling Person	6	9	High	13	3

Using a walking hoist

For a walking hoist the person must have:

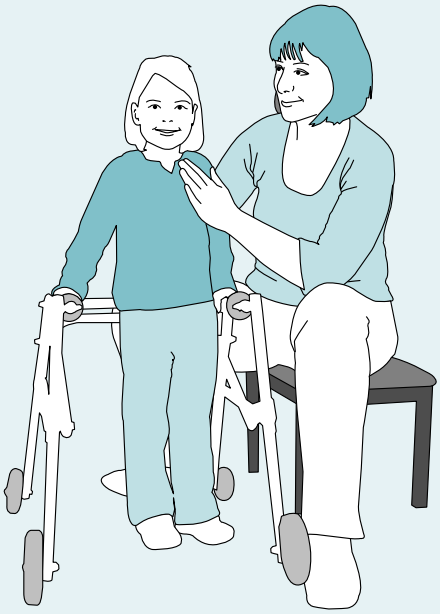
- Some weight bearing ability
- Trunk and upper body control
- Ability to follow instructions
- Upper limb function

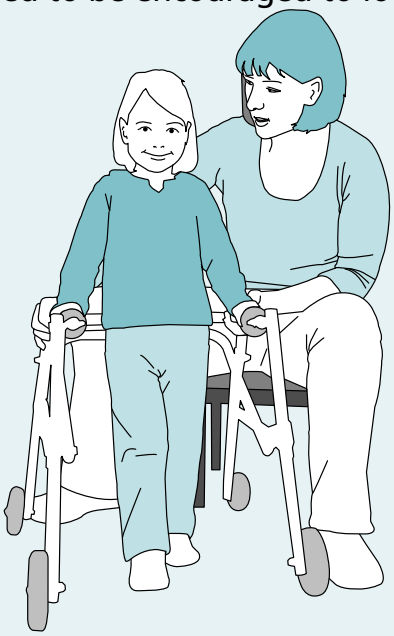
Assisting Smaller Children to Walk

Carers may occasionally need to assist small children who are learning to use walking aids eg K Walkers. A wheeled stool should be used so that the carer avoids stooping; open palm holds may be taken on the trunk/hips. Consideration needs to be given to the length of time appropriate for giving this level of assistance as it involves a degree of postural stress.

Some small children can be assisted to walk with the carer on a wheeled stool using a trunk/hip hold.

Whenever children are assisted to move they need to be encouraged to look ahead.





‘Shoulder walking’

It may occasionally be appropriate to assist children to walk by offering support on the shoulders. This will usually be in environments where use of a walker is not possible, eg non-adapted toilet areas, or off-site visits/field trips. The following points should be considered:

- Individual assessment is essential
- This activity should be seen as part of a therapy programme, requiring the therapist to carry out a risk assessment and to give instruction and regular supervision to carers.
- It is important that the carer maintains an upright rather than stooped posture. This means that the activity cannot be carried out with all children, and that distances covered will be limited.

Assisting a Person to Get Up from the Floor

Assessment Criteria

When person has fallen the following should be assessed:

- Check ABC – Airway, Breathing, Circulation
- Fractures, bruising, pain, behaviour etc.
- The reason for the fall, e.g. medical condition, faint, slip etc.
- Check the Personal Handling Plan, if one exists, to assess if the person had reasonable mobility prior to the fall.

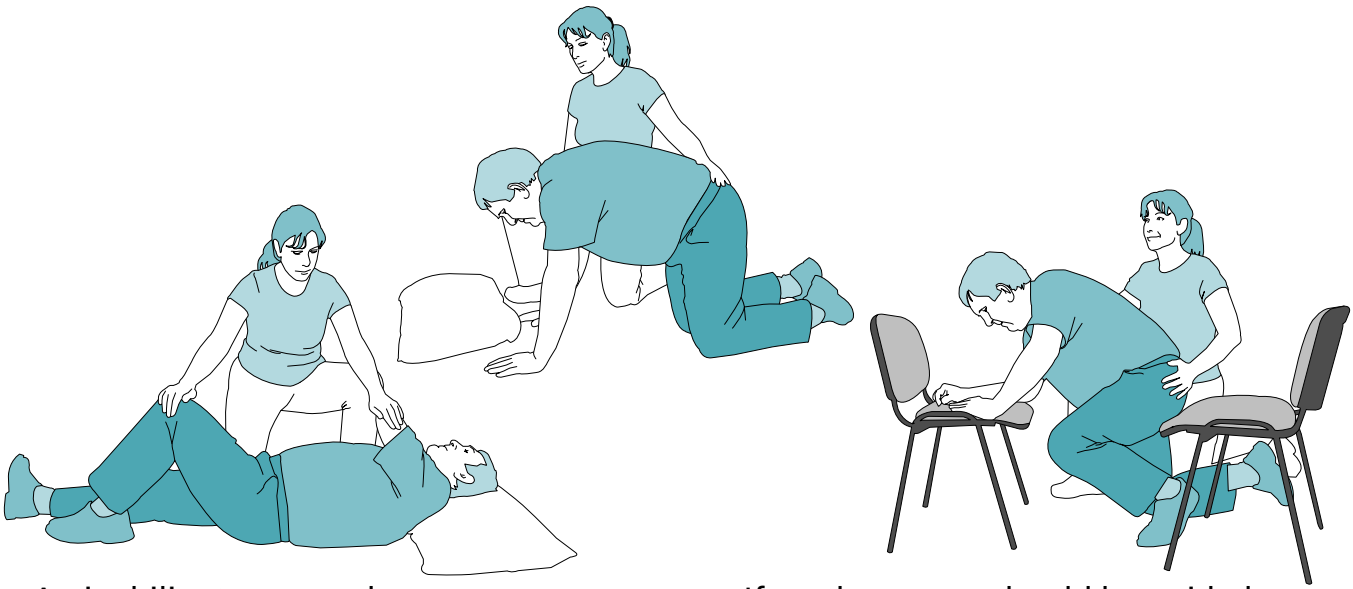
If there is any doubt about the person's condition then they should be left where they are. Timing or delay may be an issue. A person who has just fallen will be disorientated but after a rest may well be capable of getting up independently. Do not rush a situation and put the carer at risk. Make the person comfortable and allow them to stand in their own time.

The movement of people on or up from the floor is a dangerous activity. The human body does not work effectively in kneeling or reaching to the floor from a low squat. The amount of physical force, which carers can apply in these situations, is very low.

Independent Movement

Ideally this should be with verbal encouragement. Physical assistance should be limited to tactile prompts. The sequence of events should be as follows:

- Bend knees up
- Encourage the person to roll onto their side
- Push up on hands into side sitting (or half sitting)
- Roll onto all fours
- Rest hands on a chair or stool and move in to upright position. This can be aided by allowing the person to sit on a small stool
- Push with hands on the chair and raise bottom onto chair



An inability to proceed may occur at any stage. If so, the person should be guided back to a safe position until appropriate equipment can be obtained.

Manual Assistance

Manual assistance is only suitable where there is insufficient space to use a mechanical lifting device. The only available option for emergency movement is therefore to slide a person to a location where a hoist can be used. It is not safe to lift a person from the floor with bodily effort.

Moving a Person in a Confined Space

Does the person need moving? Can they adjust their position to make the task easier?

- Minimum of two carers preferably more
- Use two flat sliding sheets with long handles or pull straps where possible
- Slide sheets may be inserted by either rolling the person or unfolding the slide sheets under the person
- Carers should adopt a comfortable balanced and upright position to slide the person holding the sheet or pull straps
- Be careful to avoid single thickness sheets as the slide develops. Use more sheets if necessary
- Maintain a suitable posture and a mobile base through the task
- Only slide the person the minimum distance to allow the hoist access

Hoisting

For when a person is unable to assist themselves into standing:

- Seated sling hoist
- Stretcher hoist

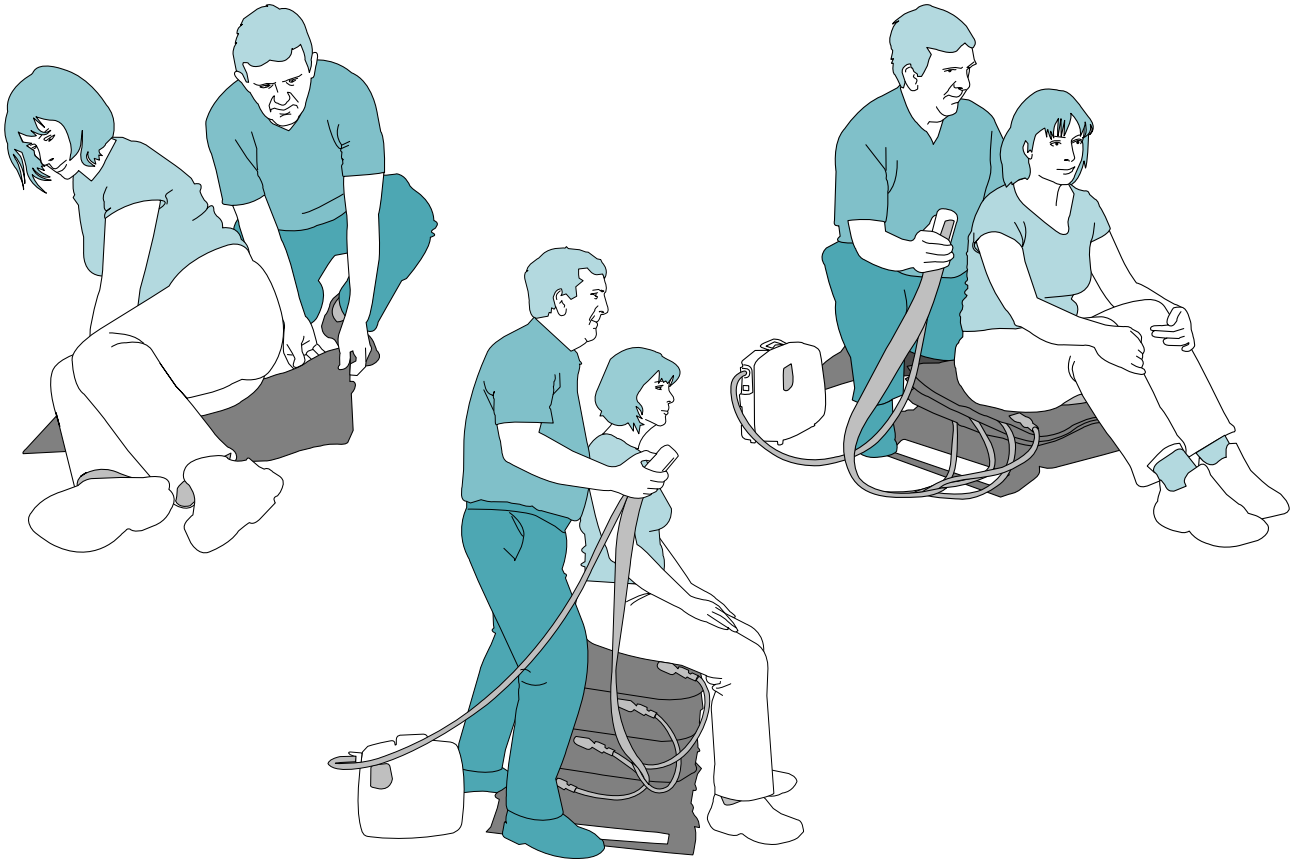
If emergency resuscitation situations are common within an area it may be appropriate to write a local procedure that explains the routine of treatment first, hoist and movement later. This may include instructions on the location of the hoist, how it should be applied etc. (Further information can be found in the Guidance Notes.)

Other Lifting Devices

Equipment other than hoists is available to raise a person from the floor, e.g. air filled or mechanical lifting devices. (Mangar Elk or Camel)

- Manoeuvre person onto lifting device
- Ensure sitting balance and co-operation, provide support if necessary
- Raise to appropriate height for sit to stand or seat to seat transfer

A local procedure may be needed for the use of this specific equipment.



Assisting Children Who Have Fallen

When a child has fallen the following should be checked:

- The reason for the fall – for example medical condition, faint, slip, seizure
- First aid checks – airways, fractures, bruising, pain, etc. If there is any doubt as to the person's condition they should be left where they are and medical assistance sought.

For children who are known to be likely to fall (eg due to fits, or conditions such as muscular dystrophy) a plan should be developed detailing how to prevent falls as far as possible, and, where assistance from the floor is needed, how this may be given safely. These plans should take into account areas where the falls might happen.

Prevention measures might include educating other children not to push into the child, or changing areas ahead of other children to avoid overcrowded corridors.

Time should be allowed for safe recovery. Where children are likely to fall in environments where assistance needs to be given without delay (such as adverse weather conditions, busy roads etc) the variance procedure should be followed.

Variances for emergency assistance from the floor.

Variance strategies might include:

- Use of slide sheets indoors to transfer to a quiet area while the child recovers
- Be alert to early warning signs to minimise the risk of a fall.

Develop strategies with other professionals to limit the risk of injury in these circumstances eg use of wheelchair in certain areas

Assisting Older Children to Get Up From the Floor

The movement of people onto, or up from, the floor can be a dangerous activity. The human body does not work effectively in kneeling or reaching to the floor from a low squat. The amount of physical force which carers can apply in these situations is very low. Therefore, strategies selected should focus on encouraging independent movement or, failing that, using equipment.

Assessment criteria

- Head control
- Sitting balance
- Upper body strength
- Comprehension
- Behaviour
- Weight-bearing ability
- Attachments
- Weight
- Size

Independent transfer

Where children have the potential to stand independently, the key issue is often to provide the right kind of prop so that they can use arm strength to push themselves into standing. Useful props might be chairs, tables, blocks etc. Props need to be easily accessible in all situations and should be sufficiently stable to ensure a safe manoeuvre.

The following guidance is suitable where the child requires no more assistance than verbal prompts or minimal physical guidance.

Assisting children with disabilities from the floor into standing

Independent movement (with prompts/minimal guidance)

- From lying, move into side lying and then push up into side sitting.
- Bend knees and bring pelvis round to roll onto all fours
- Use the prop to push up into standing.
- A transitional half kneeling position is helpful to some children; assistance may be required to achieve this position.
- For some young children standing can be achieved by adopting a very deep squat and then pulling up on a solid fixture.

Hoisting

When a child cannot safely be assisted from the floor using the above guidance, equipment should be used, for example hoists. See guidance on hoisting for further information.

Lifting Babies and Small Children

Assessment criteria

Although small children are fairly light, the physical impact of frequent lifting combined with working for long periods in stooped or floor level positions can be very significant for carers. There is evidence that most staff working with small children experience aches and pains associated with their work.

As children become bigger, the hazards associated with lifting increase. Where children have disabilities and complex needs, lifting can be especially problematic. The child may, for example, have variable tone, poor head control, attachments such as body braces, or be very frail.

Lifting from the floor can be particularly hazardous. Guidance produced by the HSE states that lifting beyond the following weights can cause injury and therefore necessitates a risk assessment

- Lifting at chest height – 13kG for women and 20kg for men
- Lifting at elbow to knuckle height 16 kg women; 25kg men
- Lifting at knuckle to knee 13kg women and 20kg men
- Lifting below knee height 7kg for women 10kg for men
- Lifting from the floor when kneeling 13kg women and 20kg for men

Where the child is held away from the body the threshold greatly reduces (see the 'General Advice for Care Handling Activities' section for more information about the HSE risk assessment filter).

The amount which can be lifted safely changes with the height relative to the carer, and although it is not possible to avoid all lifting from the floor of small children, some consideration should be given to ergonomic solutions which reduce the problem (see below).

Other factors which need to be considered when lifting small children are:

- Height of the child
- Sight or hearing loss
- Spasm, particularly extensor patterning
- Bodyshape – joint and limb deformity, windswept deformity or any condition which results in the weight distribution being asymmetrical or uneven.
- Lack of head control
- Flaccidity or rigidity
- Behaviour and developmental stage
- Pain
- Skin condition
- Braces, spicas, callipers or afo's
- Frequency of lifts
- Activity preceding the lift eg prolonged static postures

The following guidance is for lifting within these weight guidelines only. Lifting beyond these thresholds should trigger the variance procedure.

Independent movement

Where small children have the capacity to move independently carers should encourage them to do this.

Manual assistance

Lifting babies onto the floor

a) Babies without sitting balance
Adjust the baby's position so that they are held lying on their back.

- Lower into half kneeling, then high kneeling and finally low kneeling.
- Slide the baby down onto the floor taking care to support the head.

b) Babies with sitting balance
Adjust the baby's position so that they are in a sitting position with back against carer, with the carer's hand supporting the bottom, and the other hand supporting the chest.

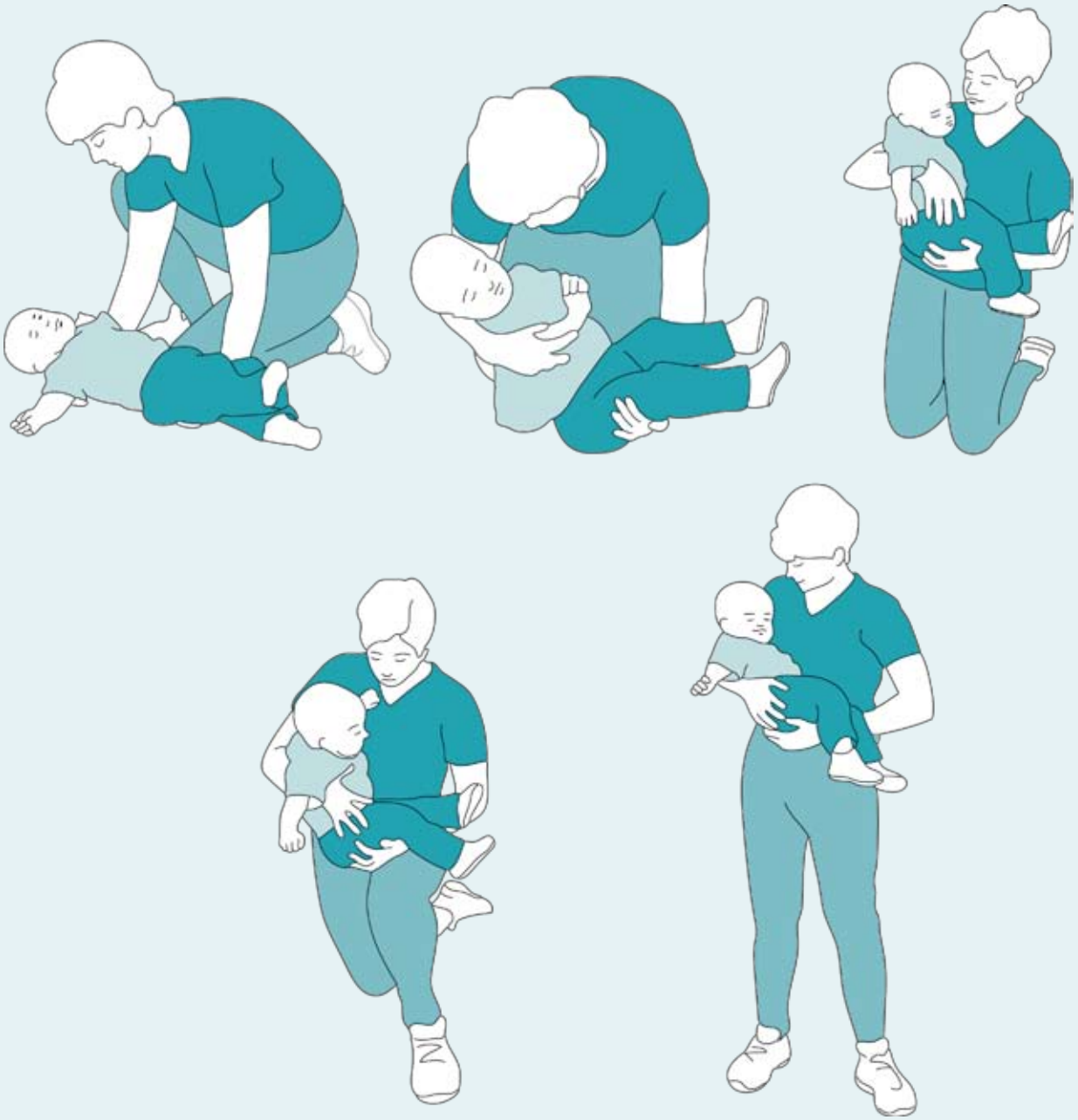
- Lower into half kneeling, then high kneeling and finally low kneeling.
- Slide the baby down onto the floor supporting the bottom and thighs.

Lifting a baby/small child from the floor

There are two possible options for lifting from the floor.

a) With the child on their back

- The carer adopts a low kneeling position at the child's side.
- Place one arm behind the child's shoulder protecting the head if necessary
- If lifting a baby place the hand through the legs and up onto the bottom
- For heavier babies place a hand under both legs.
- Lift onto carer's thighs and gather the baby in.
- Raise into high kneeling and then half kneeling.
- The child can then be passed to another carer. Only where babies are very light should carers raise into standing holding the child.



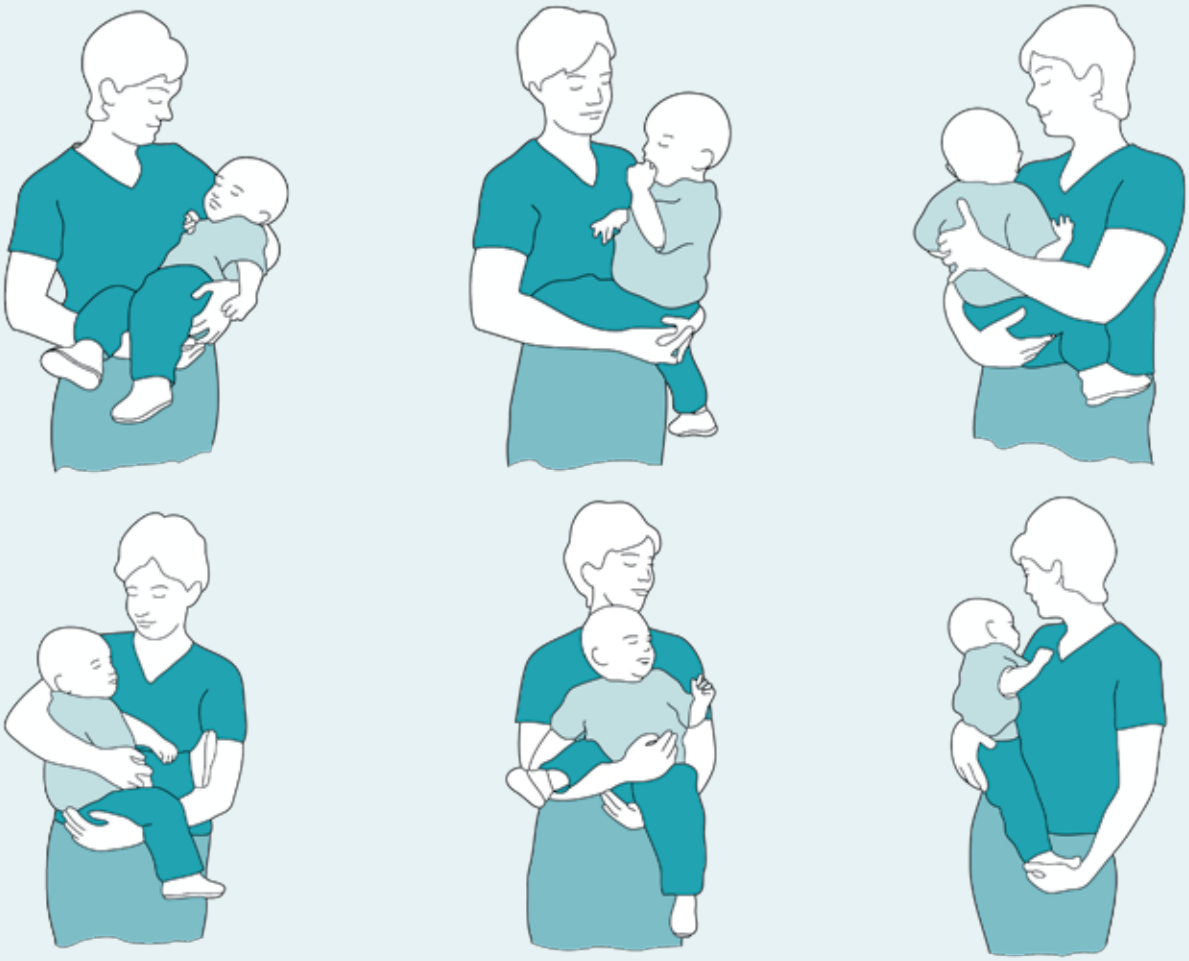
b) With the child on their stomach
This method is only suitable for small babies

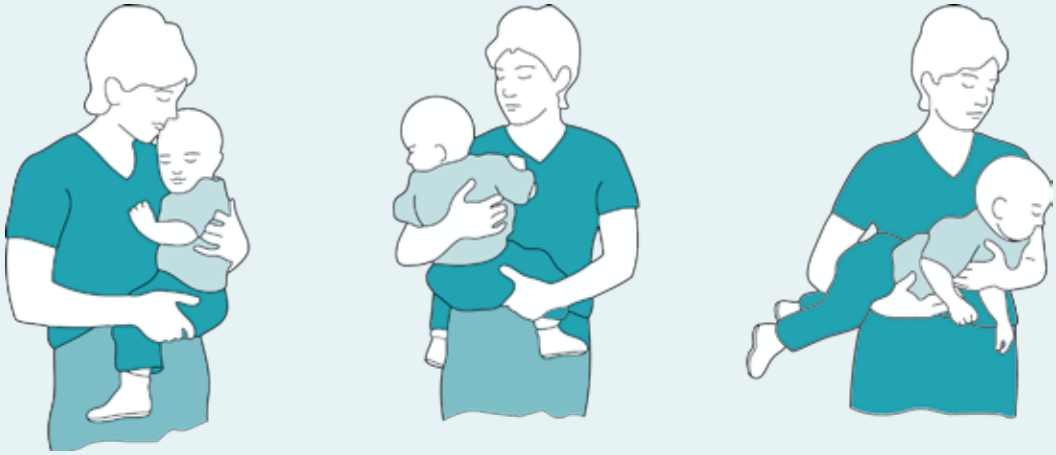
- The carer adopts a low kneeling position.
- Place one arm between the child's legs and the hand on the child's stomach. Place the other hand on the child's chest.
- Roll the child slightly towards you and raise into high kneeling then half kneeling.
- The child can then be passed to another carer. Only where babies are very light should carers raise into standing holding the child.

c) With the child in a sitting position

- The carer adopts a low kneeling position either behind or to the side of the child.
- If behind, hold the child with one arm round the trunk and the other under the thighs and bottom.
- If at the side, place one arm behind the shoulders/back and the other under the thighs/bottom.
- Slide the child onto the carer's thighs and gather the child in.
- Raise into high kneeling and then half kneeling.
- The child can then be passed to another carer. Only where babies are very light should carers raise into standing holding the child.

Positions for holding and carrying babies and small children





Lifting a small child with a disability to and from the floor

Lifting children with disabilities from the floor can be a very hazardous activity, especially children with poor head control or low, high, or mixed muscle tone, and alternatives should be sought wherever possible. A child can participate in a group activity such as story time equally well in a low chair as on the floor. Many activities often carried out at floor level, such as playing with car mats, can be carried out at table height. Physiotherapy exercises can be carried out on a plinth; nappies/ incontinence pads should be changed with the child lying on a higher surface.

However there will be occasions where children do need to be at floor level, such as in soft play areas or sensory rooms, for PE activities, or to allow opportunities for developing gross motor skills.

If lifting to and from the floor is unavoidable the following methods should be used. The area should first be prepared to ensure there is sufficient space to move safely. Equipment should be positioned nearby to eliminate the need to carry the child.

Lifting onto the floor

One carer is in a standing position holding the child in a cradle position (the child lies on their back. The carer supports the upper back and head with one arm and places the other arm under both legs). The second carer is in a half kneeling position.

- The first carer passes the child to the second carer.
- Second carer moves to high kneeling then low kneeling.
- Slide the child onto the floor.
- Release the leg/bottom hold and then the upper back hold, taking care to support the head as appropriate.

Lifting from the floor

With the child on their back

- The carer adopts a low kneeling position at the child's side.
- The carer places one arm under the shoulder, cradling the head if necessary.
- The other arm is placed under the child's thighs and bottom.
- The carer slides the child back onto their thighs, and readjusts holds to raise and gather the child in close. This can be especially helpful where children are prone to extensor spasm.
- The carer rises into a high kneeling position, and then half kneeing to improve stability.
- The second carer adopts a standing position close to and facing the kneeling carer.
- The second carer lowers to scoop the child, also using a cradle hold, and raises back into standing in preparation for a transfer.
- Alternatively the second carer could position the relevant piece of equipment, enabling the kneeling carer to lower the child into position.

The above technique can also be adapted for children with sitting balance.

The hold is taken round the back and then under the thighs, and then the child is slid onto the carer's lap as above.

Lifting a small child out of a buggy or pushchair

- Apply the brakes.
- Release and move back the straps.
- Stand as close as possible to the buggy/pushchair, on an angle.
- The child can be lifted either by holding the child's trunk or using a cradle hold, supporting the head. If the child does not have good head control, a cradle lift must be used.
- If the buggy is three-wheeled, the lift should be approached from the side.
- If the child is a toddler they can be lowered into a standing position.

Lifting a baby/small child from a cot

Cots are available with sides which can lower so the child can be reached easily. Height adjustable cots are also available which reduce the postural problems often associated with looking after children in cots.

Where older children with disabilities need to use cots, designs are available with profiling mechanisms.

To lift a child from a cot,

- Lower the cot side and stand at a slightly oblique angle
- Get as close as possible to the child. If lifting a small baby, the sheet can be untucked and the child slid towards the carer before lifting.

- Support the child using a cradle hold (one arm/hand under the upper back/neck and the other under the thighs/bottom). The child may be in a lying or sitting position.
- If lifting a toddler, encourage them to stand up, and take a trunk hold.

When lowering a child into a cot,

- If the child is asleep, ensure that the sides are lowered first.
- Reverse the process for lifting to lower the child into the cot.

Assisting a Person to Roll

Assessment Criteria

If the person requiring help is conscious then the following factors may need to be considered:

- Head and neck control
- Size, weight and resistance to movement
- Trunk, upper and lower limb activity
- Co-operation and comprehension
- The positioning of a person following a stroke is a particular issue for these activities
- Bed height is key and should be positioned to prevent too much forward flexion
- Type of bed, condition of bed, firmness, material etc.
- Type of trolley, surface, changing table, plinth etc.
- Attachments, catheter, drains etc.

Some movements in a bed can safely be carried out with an unconscious person but care must be taken to position the person appropriately to maintain airways, reduce spasticity etc.

Independent Rolling

With verbal prompting/encouragement the person should where possible turn/roll towards the carer

- Person turns their head in the direction they are turning/rolling
- The arm/hand nearest the carer should be moved to a position to prevent it being rolled on
- The arm/hand furthest away should be placed across the chest in the direction of travel
- Encourage person to bend one or both knees upwards then towards direction of travel encourage person to turn. If one knee is being bent, then this should be the one furthest away from the direction that the person is being moved towards.
- A sliding sheet can be used under the pelvis to make independent rolling easier
- Some people may find it beneficial to hold onto the mattress, edge of bed, integral bedrails if appropriate, or bed levers during this manoeuvre

It is important to note that for rehabilitation purposes it may be contraindicated for people to pull on equipment such as grab rails, confirmation may need to be sought from the therapists.

Mechanical/Powered Turning Device

- Specialised bed/mattress
- Turning devices

Manual Assistance

Points to consider when manually assisting people to turn/roll or slide in bed.

- Sliding and rolling can be taken as separate tasks
- If possible the task should be completed on an adjustable height bed or trolley
- For areas where sliding/rolling needs to be completed on low or floor surfaces the carer needs to assume a safe position which may involve placing a knee on the bed or a half-kneeling position on the floor

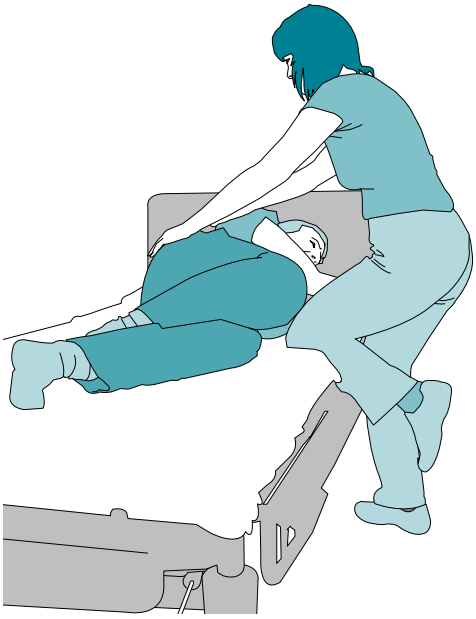
Rolling

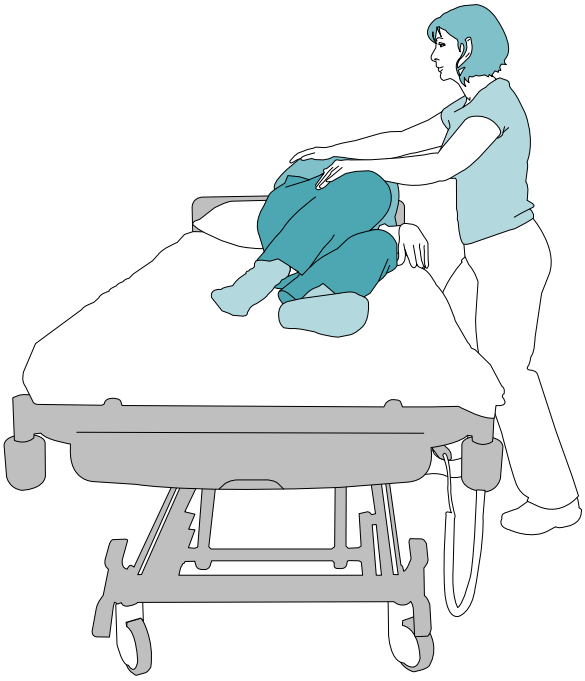
This activity can be carried out by one or two carers.

- Position bed to the appropriate height if it is adjustable. When using low beds the carer may need to place one knee on the bed
- If possible, position one carer on either side of the bed. It is acceptable for a carer to roll a person away from them if there is a wall, frame or bed rail on the opposite side of the bed
- Position the person with head in the direction of movement, the distant arm across the body and the distant hip and knee flexed
- Carers place their hands on scapula/shoulder and hip or knee and roll the person towards them. Start in a low flexed position and extend leading with the head. Following a careful risk assessment it may be more appropriate in some circumstances for the carers to hold the bed sheet to aid rolling
- The second carer can support the person's new position with pillows (e.g.30° tilt)

For people with painful hips or low tone following a stroke, care should be taken with the hip position and using the leg as a lever. The person should be moved on a full-length slide sheet.

SPACE REQUESTED?



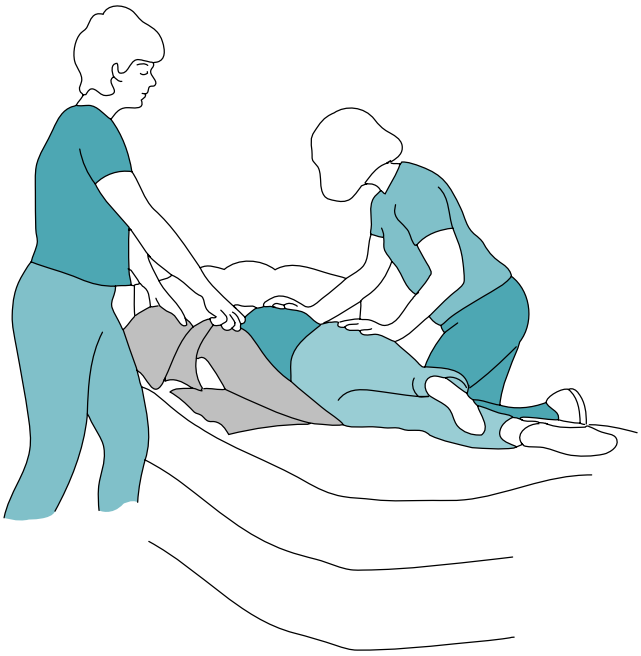


Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Assisting a Person to Roll	7	3	Low	11	9

Turning a Person using a Slide Sheet

There are occasions where a person needs to turn so that they finish lying on their side away from the edge of the bed. Where a person is unable to achieve this independently a slide sheet will be used. Two carers are needed for this.

- Position one carer on either side of the bed.
- Introduce the slide sheet following the guidelines found in the Guidance Notes for Introducing and Removing Slide Sheets
- The carers should adopt a comfortable, balanced position with an offset base and with a comfortable hold on the sheet move away from the person. Or with a comfortable hold on the sheet in a relaxed position the carer can extend to an upright position to turn the person away from them
- One carer may support the person on the side away from the movement if appropriate

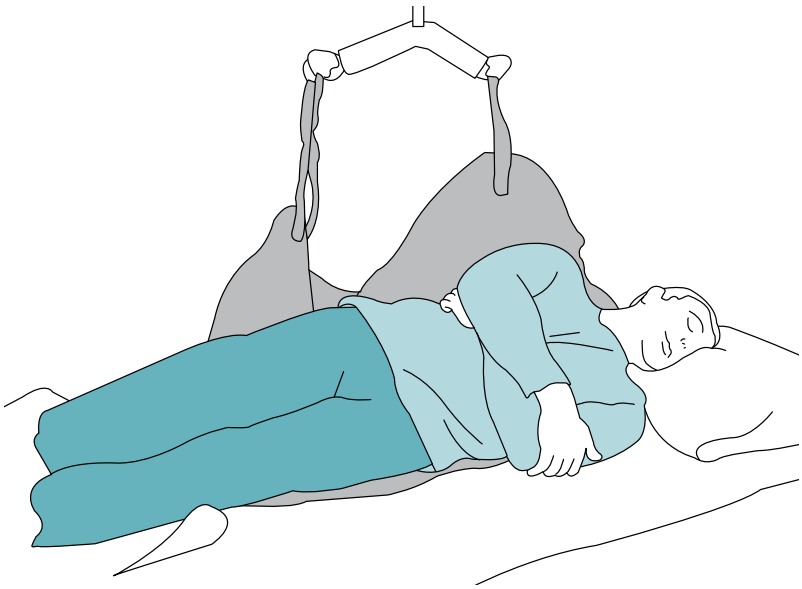


In some circumstances it may be appropriate to slide the person towards the edge of the bed before turning them away from that edge.

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Turning a Person Using a Slide Sheet	6	3	Low	12	9

Hoisting

It is possible to turn or roll a person by using the standard hoist mechanism. The sling should be attached with the loops or fasteners from one side of the person and the spreader bar lies along the mid-line of the person i.e. head-to-toe. As the hoist is then raised the person is tilted. This can be useful for large people or for people who act against the activities of the carers.



Assisting a Person to Move from Lying to Sitting

Assessment Criteria

The following issues should be considered prior to commencing activity:

- Sitting balance
- Co-operation and comprehension
- Abdominal muscle control
- Medical status of a person
- People with extensor spasm patterns
- Trunk and upper limb control
- Bed Height – can the persons feet touch the floor
- Bed / Mattress type – air filled mattresses or soft foam mattresses tend to round at edges and people can slide off
- Abdominal surgery
- Size and weight
- Supports attachments

Physically assisting a person to sit up in a bed should be for the short term only, prior to providing suitable equipment and should not be part of a regular handling plan.

There are two possible outcomes for this activity whether the person requires assistance to move or they are able to achieve the activity independently. They are:

- Method 1 - Sitting in the bed in a long legged sitting position
- Method 2 - Sitting on the edge of the bed with the persons feet on the floor

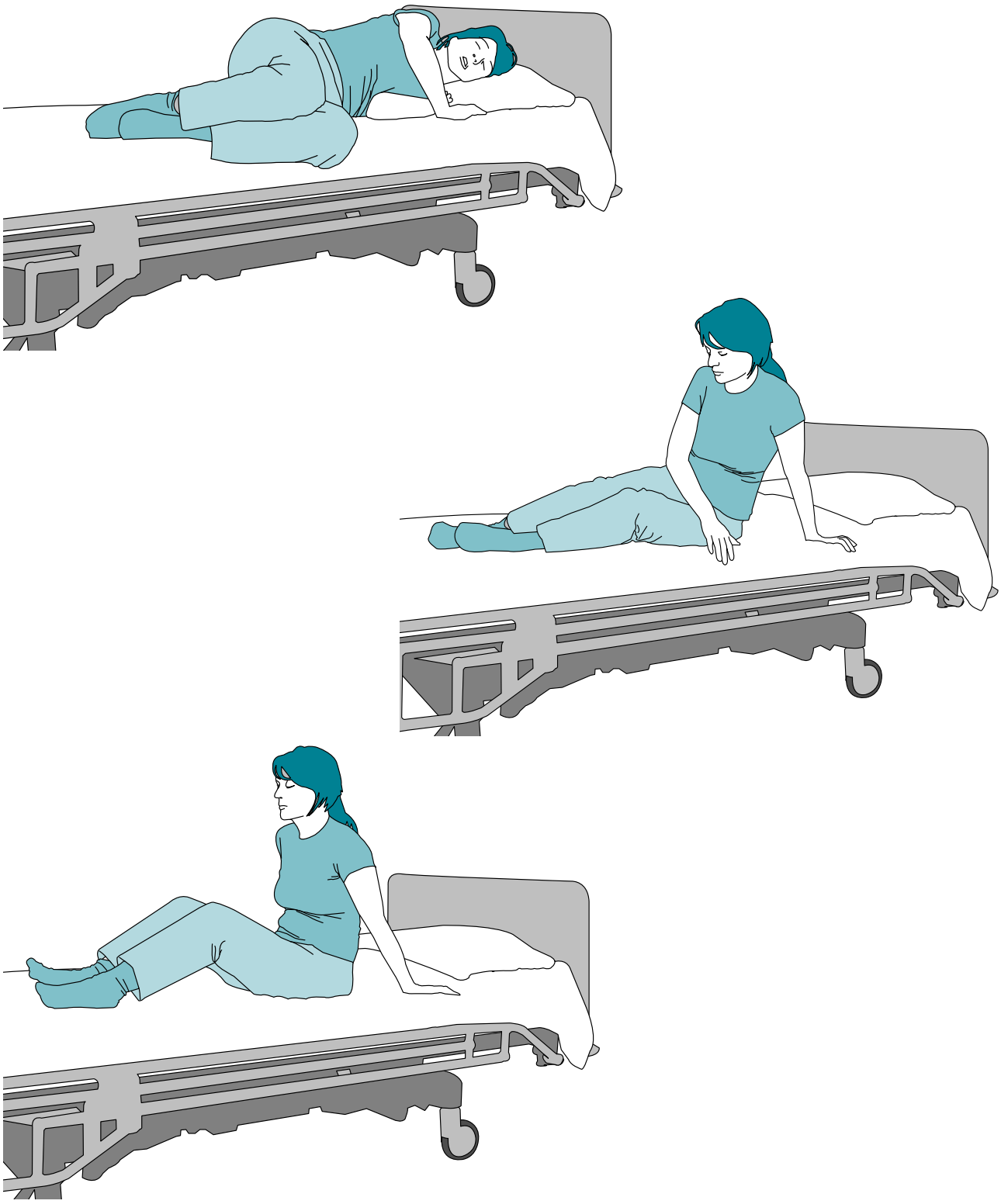
Independent Movement

Person sits from lying by rolling

Teach or encourage the following routines:

Move from lying to sitting in the middle of the bed

- Roll onto side with both knees bent
- Push up with elbow and hand into side sitting position
- Person sits into a long legged sitting position



Lying to sitting on the side of the bed

- Roll onto side with both knees bent so that knees protrude over the edge of the bed
- Lower the legs over the side of the bed
- Push up with elbow and hand into sitting position
- Person sits over the edge of the bed

Equipment

Method 1

- 4-section profiling beds can be used to facilitate sitting up and can reduce slipping down the bed (with a non profiling bed slipping down the bed can be reduced by tilting the bed to a head down position and with the use of pillows, wedges etc.)
- Powered profiling beds increase a person's independence and reduce handling
- Gas assisted raising backrests can cause poor posture and require two carers to operate. Carers must only use handles on the same side on which they are standing.
- Mattress variators / pillow raisers
- Rope ladders
- Bed levers
- Trapeze

Method 2

For people with good sitting balance it may be possible to use a slide sheet to assist getting out of bed. The person sits up on a slide sheet and moves the feet round gradually. Care must be taken to ensure the person does not slide off the bed. Do not allow the slide sheet to be positioned at the edge of the bed. Always ensure person's feet are on the floor when sitting on the side of the bed.

Bed levers can be used to allow the person to pull themselves into a sitting position.

Manual Assistance

The carer may be involved by facilitating this activity initially, to encourage the rolling and sitting up part of the movement, when teaching this activity for independence. The guidance should be minimal and the person must be capable of following instructions.

Lying to sitting on the side of the bed

The only method by which carers can give assistance to get someone out of bed is by facilitating the independent action outlined above.

For this to be safe the person MUST be able to provide significant assistance. The carer is only guiding the movement.

- Communicate with the person to agree initiation of movement e.g. roll, push up, sit up
- Bend knees up
- Roll onto side
- Slide knees over the side of the bed – consider slide sheet under legs to assist
- Provide assistance with long low hold under lower shoulder and on opposite hip
- Ensure person pushes with hand and elbow on bed
- Guide hip down whilst person pushes upwards

The person can then be stood in accordance with the sit to stand plan and procedure.

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Roll and Sit Up	7	4	Medium	9	9

Emergency Situations

Sitting a person from lying who is unable to participate following the guidance above, is heavy work and must not be carried out as part of a regular handling package, i.e. **do not sit those who cannot sit**. If a person needs to be sat up in bed in a long legged sitting position as an emergency the following techniques may be used.

The carer's position may be improved by using a transfer sheet or bed sheet. Place the sheet so that it supports the person's shoulders as well as the neck and head. Care should be taken not to force the head into flexion.

Caution is needed when sheets are used, as they are not designed for this task and some sheets may not be strong enough.

Carer Half Kneeling

This must be completed with two carers.

- The person must be able to bend at the hip and have some sitting balance
- Bend person's knees slightly (supported with pillow if necessary)
- If possible adjust bed height to enable carers to place foot of supporting leg on the floor (adjusted for shorter carer)
- Carers take an oblique position facing the person with one knee on the bed
- Carers take a comfortable hold on the sheet

Either:

- Start from a low relaxed position placing knee at around hip level and extend into an upright position bringing the person up into sitting

Or:

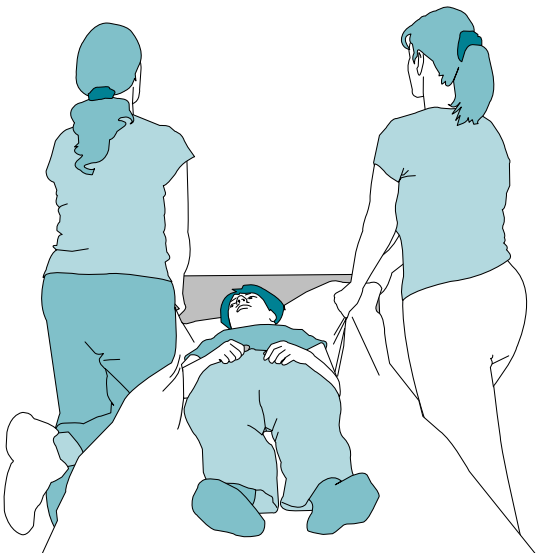
- Start in a high upright kneeling position place knee just below the hip area and sit down onto your heel into low kneeling

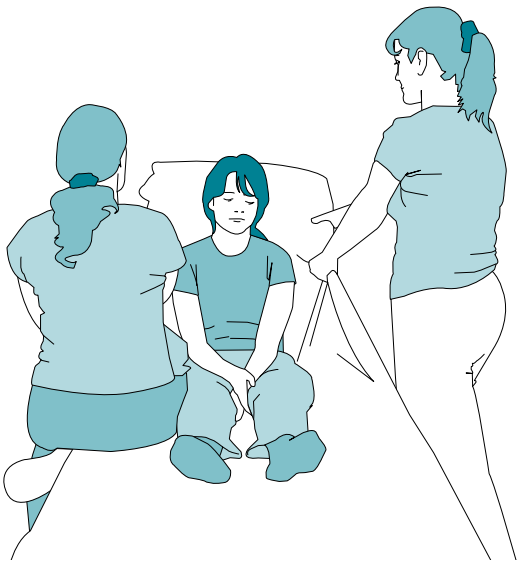
If the person has no sitting balance it is difficult for the carers to support the person with this technique. At the very least a third carer should support behind the person's trunk.

Carer Standing

This must be completed with two carers.

- The person must be able to bend at the hip and have some sitting balance
- Bend person's knees slightly (supported with pillow if necessary)
- If possible adjust bed height to a comfortable level
- Carers take an oblique position facing the person with feet flat on floor
- Carers take a comfortable hold on the sheet
- Carers move away from the person, backwards and/or upwards to raise them into sitting





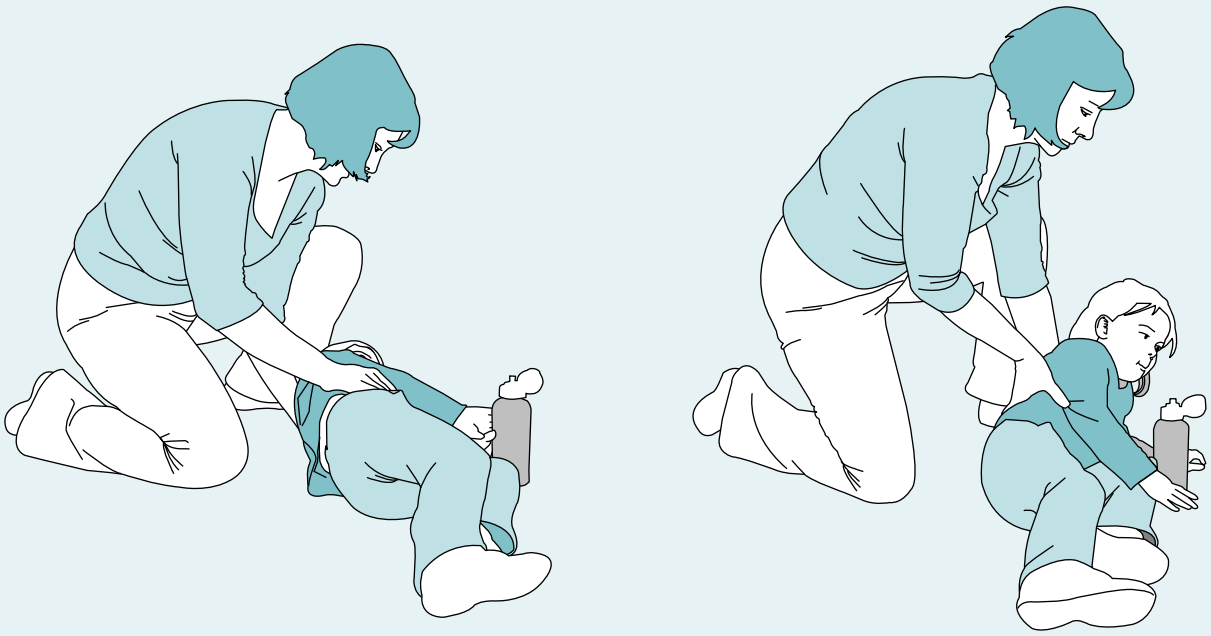
Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Emergency Sit Up - Carers Kneeling	6	10	High	15	3

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Emergency Sit Up - Carers Standing	7	5	Medium	14	3

Assisting smaller children into sitting from lying

For smaller children who have a high level of ability and participation in the task of sitting from lying it is possible to use the following method

- Encourage the child to begin to roll into the sit up action with chin on chest
- The carer takes an oblique behind position in half kneeling
- The carer can support the child with long low holds round the trunk up into sitting adjusting position to keep near the child
- Alternatively, the carer can sit behind the child, place their palms behind the child's shoulders, raise the shoulders moving in close as the child comes into a sitting position



Hoisting

The solution for some people may be to hoist from lying to sitting, this may be due to weight/size of the person or lack of flexibility, high or low muscle tone, the surface on which they are lying.

Transferring a Person from Surface to Surface in Lying

Assessment Criteria

The following assessment criteria need to be considered when transferring a person from surface to surface in lying.

- Rolling ability
- Head and neck control
- Spasm and unusual body shape
- Very large or heavy people
- Bridging or bottom shuffling
- Types of equipment and environment being used.
- High risk groups, e.g. spinal fractures, poor skin quality and open pressure sores, brittle or weak bones, bony metastases.
- Co-operation and comprehension
- Attachments, catheters, drains etc.

Independent Movement

With a full-length slide board in position the person can be encouraged to shuffle across in sitting or lying. Some may find it easier to roll through 360° across the board.

Equipment Options

The following points should be considered as to whether the activity is independent or requires manual handling assistance

- Ensure the surfaces are at equal heights or that the movement is slightly downhill
- Provide a full-length slide board to bridge between the two surfaces
- Ensure the brakes are effective and are fully on before the activity takes place

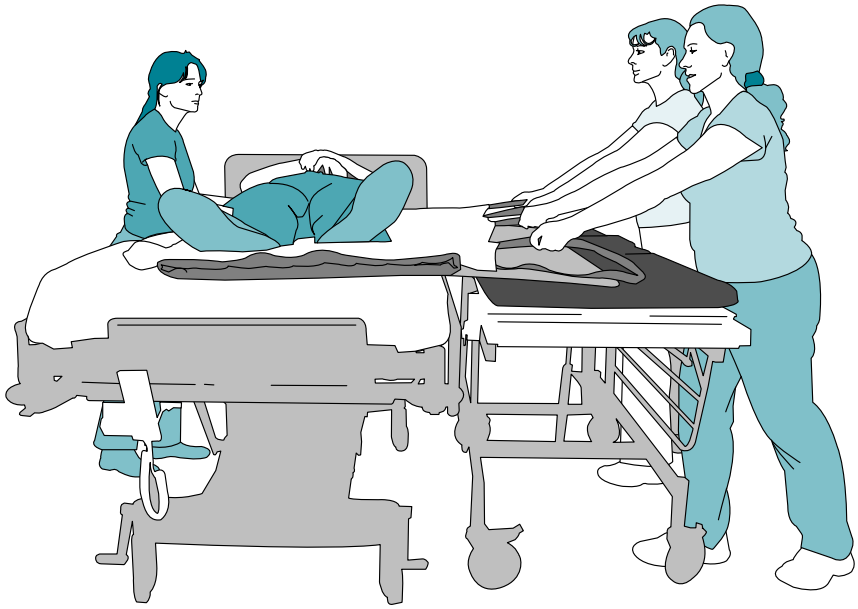
Manual Assistance

Ideally equipment required includes:

- A transfer board to provide a support between the two surfaces
- A full-length low friction roller to reduce the friction between the person and the bed
- A long handled transfer sheet to prevent the carer moving into a top-heavy posture

Method

- Roll the person onto their side using an appropriate method
- Place the low friction roller and the long handled transfer sheet under the person. The persons whole body needs to be on the transfer sheet to prevent dragging.
- If necessary roll the person in the opposite direction to fully position the roller and transfer sheet
- Place the slide board under the person, the transfer sheet and the roller as far as possible but ensuring that the gap between the surfaces will be completely covered
- Move the second surface into place. Ensure the heights are the same or there is a slightly downhill transfer and that the brakes are applied
- Carers should be on both sides of the surfaces for safety, but only the carers who are on the receiving side will activate the movement. Carers on the leaving side may assist to initiate the movement
- The carers should hold firmly onto the extended handles and move backwards i.e. walk or start in a low relaxed position and extend upright
- It is important to move a person in a controlled and smooth manner, but it is not necessary to complete the whole move in the same action i.e. several short moves may be taken if space is limited



Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Transfer from Surface to Surface in Lying	7	6	Medium	11	9

There are a number of lateral transfer aids, which remove the need for manual assistance in this situation.

Examples include air filled devices, which inflate under the person and which will allow the lateral movement of the person.

Hoisting

Stretcher Hoist

Hoists are available that will lift a person in a lying position either as a specific function of the hoist or by using specific attachments.

Assisting a Person to Move up the Bed

Assessment Criteria

For the promotion of independence or assistance in the movement of people up a bed the following criteria should be considered:

- Sitting balance
- Upper limb strength and shoulder movement to be able to support trunk
- Co-operation and comprehension
- Understanding the persons preferred or prescribed sitting position
- Tissue viability or pressure care status
- Care should be taken when sitting acute stroke patient, spinal injuries, abdominal surgery etc

Consider the following options in order to reduce the number of times a person may need to be moved up a bed:

- Use a 4-part electric bed to prevent slipping down the bed. If the person continues to move down the bed, use the knee break button prior to raising the backrest.
- Raise the foot of the bed to reduce slipping down
- Support sitting with pillows or a foam wedge beneath knees and thighs
- One-way glides
- Tuck in sheets below feet or provide pillows or foot board as foot rest

Independent Movement

It is possible to initiate independent actions to prevent the need for carers' intervention. Allow the person to move themselves by:

Either by:-

- Encouraging the person to roll onto their side and push up into a half side sitting position.
- Roll back to achieve a long legged sitting position
- Hip hitching on alternate sides
- Pushing up bed with feet and legs

OR

- Get out of bed and reposition higher up the bed

Equipment Options

Equipment may be supplied that may make the task manageable with only limited supervision or instruction. Assistance could be given by using:

- One-way glides
- Slide sheets
- Hand blocks
- Trapeze

The carer then may need to give support to stabilise the person's feet to aid purchase on the bed.

Manual Assistance

Points to consider:

- Weight limit of the bed
- Combined weight of person and carers during manoeuvre as the weight at one end of bed may cause some styles of bed to tip
- Height of bed
- Methods of inserting/removing sliding sheets

These must always be completed with the aid of a slide sheet and with two carers.

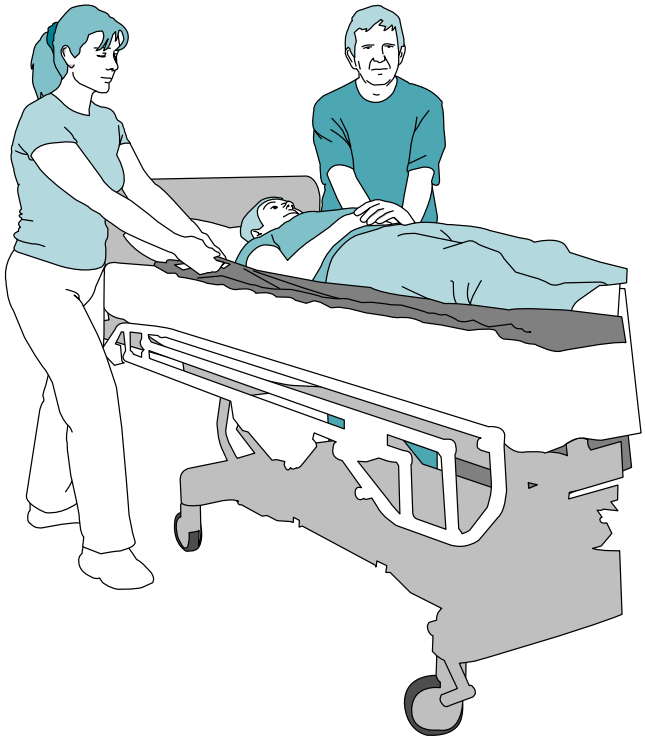
The environment should be prepared prior to the task and sufficient space and equipment provided. The bed should be at the appropriate height for the carers.

This activity is for moving a person in a flat lying position. It is not appropriate to slide onto pillows or into a sitting position because of the lifting and twisting actions.

Slide up the Bed with the Carers in Standing

- Place slide sheet in position underneath person. Ensure all key friction points are on the slide sheets (i.e. head, shoulders, elbows, sacrum, hips, calves and heels). Use additional slide sheets if key friction points are not on the slide sheet.
- Move the bed away from the wall if on wheels.
- The head of the bed may be removed if necessary.
- A pillow can be placed next to the head of the bed to protect the person's head
- Ensure enough space on either side of the bed for carers
- If possible adjust the bed to an appropriate working height. When using a low bed the sheet needs to be long enough to ensure carers do not lift the person
- Take a comfortable hold on the slide sheet at the shoulder level
- The carer should move backwards towards the head of the bed
- A balanced position of the carer should be maintained by adopting a mobile base. This can be achieved in smaller staged movements. Care should be taken not to twist when sliding a person
- Adjust the person's position and remove the slide sheet

Activity	DIAG SMP	REBA		Borg Effort	Likert Comfort Scale
		Score	Risk Level		
Slide a person up the Bed	6	5	Medium	11	9



Slide up the bed with the carer in half kneeling

- Place the slide sheet in the position as above
- Move the bed from the wall if on wheels, remove the bed head if necessary. Ensure that there is sufficient space on either side for the carers.
- Adjust the height of the bed to knee height for the smallest carer.
- Carers should position themselves with knee on the bed, in a half kneeling position facing the foot of the bed. The position of the knees should be above the level of the persons shoulder.

This movement can be actioned in two ways but always with two carers.

Half Kneeling - Low to High

- From a low relaxed kneeling position, the carer holds the slide sheet close to the persons shoulders and/or hips, facing the head of the bed
- The carer extends to an upright kneeling position
- This movement should bring the person up the bed
- Reposition and repeat as necessary

Half Kneeling - High to Low

- From a high kneeling position (behind the persons shoulder), the carer holds the slide sheet with an extended arm close to the persons shoulder and hip, facing the foot of the bed
- With an extended arm and in a controlled action, the carer sits down backwards onto their heels
- This movement should bring the person up the bed
- Reposition and repeat as necessary

Hoisting

Hoisting should be considered if the above methods are not effective.

Assisting a Child into a Standing Frame

Assessment Criteria

- Weight bearing capability
- Trunk and upper limb control
- Level of co-operation and comprehension
- Ability to bend at the knee
- Ability to bend at the hips
- Balance and control
- Footwear/orthotics/gaiters
- Design of frame
- Position and design of chair/wheelchair prior to standing

Independent Movement

Normally, physical assistance is required to assist children into standing frames. However, occasionally children with good stepping ability may be able to move forward into the frame with verbal guidance.

Alternative Equipment

Wherever possible standers should be provided which remove the need for the hazardous handling frequently involved in assisting children in and out of standing frames. Alternatives might include

- Electric standers (a range of designs is available)
- Tilt tables

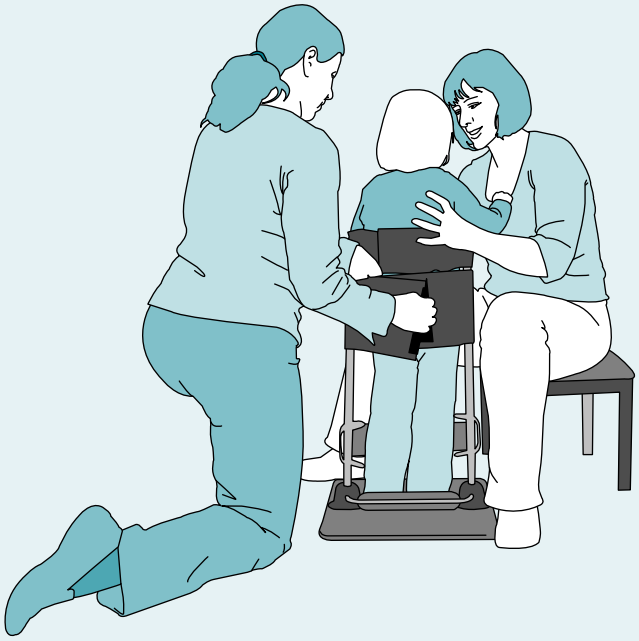
Manual assistance

Manual assistance is only appropriate where the capabilities of the child are such that they can be assisted to stand up into the frame following the guidance for assisting a person to stand from sitting. In other words they must have sufficient ability to bear weight (the guidance for assisting a person to stand from sitting should be referred to for more detailed information concerning assessment criteria). Assistance can be given by one or two carers in an oblique behind position. In offering manual assistance the following should be considered:

- Manual assistance to stand up into a frame is only appropriate where the design of both the frame and the chair/wheelchair are such that the child's feet can be placed on the frame prior to standing. The child needs to be able to bend sufficiently at the hips and knees to be able to participate.
- Using a rise/fall couch can be of great assistance assisting some children into standing frames. The child sits on the edge of the couch at its lowest setting. The feet are placed on the footplates of the stander, and the couch is raised to bring the child to a stand. The child is encouraged to pull/push themselves into standing. This method is suitable for children with good sitting balance and arm strength.

- Supporting a child to stand while at the same time bending or twisting to adjust straps can be hazardous. If support is needed a second carer is required to adjust the straps.

For all other assistance, the variance risk assessment procedure should be followed.



Hoisting

A child may be assisted into a frame using a hoist with walking harness. Some hoists and vest type harnesses may be adequate in themselves in offering standing opportunities in some circumstances.

Where the child uses a frame which moves them from lying to standing, a full support sling should be used to hoist them onto the standing frame set onto a horizontal position.

CARE HANDLING FOR PEOPLE IN HOSPITAL, COMMUNITY AND EDUCATIONAL SETTINGS

GUIDANCE NOTES

DERBYSHIRE
INTER-AGENCY
GROUP

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Assisting a Person to use the Toilet/Hygiene Routines

A person who requires assistance to move may access toileting facilities in a number of ways. All the techniques outlined in the Practical Guide provide the methods in how assistance maybe given to the person i.e. sitting to standing, transferring from seat to seat. Included in the guidance are the standard examples of equipment that also may be used i.e. framed turning disc, transfer board etc.

Although in many cases the activity of assisting a person to the toilet may involve transfers in sitting, there are specific issues that need to be taken into account regarding toileting. These may include:

- Environmental constraints
- Facilities available
- Equipment options
- Persons specific needs i.e. general mobility, urgency, frequency etc
- Children/young people should be encouraged to indicate their needs, and to use the toilet on a 'needs led' basis; it is not necessary or appropriate to insist that a large group of children all use the toilet at the same time. When assisting children with toiletting/hygiene routines, children should be encouraged to use well established movement and transfer skills following the guidance in the Code of Practice. Other environments will be more suitable for practicing less well developed skills.

Environmental Constraints

Many bathroom facilities are limited in the available space for carers, the person and often equipment that is required.

It is essential that where a person requires more assistance the largest available toilet space should be chosen. This may result in not accessing the toilet area the nearest to where the person is situated.

When designing new facilities, it is essential that sufficient space is provided in toileting areas taking into account all the activities that may take place. Equipment required and storage must also be considered in the planning stage.

Facilities Available

Toileting facilities within the establishments will differ depending on their client group. Some will be larger areas accommodating a number of toilets whilst others can have ensuite facilities for single rooms.

Other facilities that maybe available include:

- Wash and blow automatic toilets
- Elevating toilet seats
- Variety of toilet heights available in an organisation
- Hygiene suites incorporating toilets, changing tables, shower trolleys, etc

Equipment Options

The following could be considered as equipment options to facilitate the person to move independently.

- Grab rails and levers
- Toilet frames
- Seat raisers. Normal height for high-level seat would be at knee level to place the knee at 90°. It may be possible to have a higher seat if the person has problems with standing from knee level
- Mobile commode
- Elevating toilet seats
- Height adjustable toilets
- Walking aids – zimmer frame, rollator
- Transfer board for unaided transfers onto flat surface commodes or toilets. Specific toileting transfer boards are also available which have apertures over the toilet bowl. If using transfer boards, carers should bear in mind that bare damp skin does not slide well over the surface of transfer boards. Appropriate measures should be made to reduce the friction i.e. the person can sit on a towel, draw sheet etc.
- Framed Turning Discs for people who require assistance to move or turntable for the persons feet if they are able to transfer independently
- Space adaptations
- Turntable for the feet

Considerations for Children

- Toilets of the right height. Ideally, environments used by children should be planned so that there is a range of options for children of different heights and ability levels
- A block may be needed of the toilet is too high, shaped to fit around the toilet
- Reducer seats aid stability in sitting

For problems related to clothing, dressing and personal hygiene the following may be considered:

- Wash and blow automatic toilets
- Adapt the person's clothing. Flap trousers, no underwear, Velcro fastening, french knickers, baggy boxer shorts
- Continence aids
- Specialist equipment e.g. Carendo shower/toiletting chair

Persons Specific Needs

When assessing a persons needs the following should be taken into account prior to deciding which toileting activity is selected:

- Effects of time, frequency and urgency
- Frequency of assistance given
- Range of tasks i.e. sit to stand, walking, stand to sit, seat to seat transfers
- Number of carers required
- The person's level of ability i.e. sitting balance, trunk stability / strength, upper limb and lower limb strength, endurance, co-operation and comprehension, co-ordination

It may be appropriate to transfer the person in an area where more space is available from the bed side to a mobile device e.g. a wheeled commode. The person can then be moved into the toilet area.

If rehabilitation is of prime concern, the person can then be transferred back to the bed side using the methods outlined in the PHRA and PHP.

Toiletting in Bed

There are occasions when a person requires to use the toilet and is unable to get out bed. In these situations the persons abilities need to be carefully assessed. These include the following:

- Sitting Balance
- Trunk control and upper limb activity, sufficient to raise their bottom off the bed
- Type of bed, condition of bed, firmness/stability of mattress
- Co-operation and comprehension
- Equipment required for female or male patients e.g. females consider the use of a slipper pan and male patients use bottles

When possible, the person should be encouraged to move independently to toilet in bed whilst carers can position the appropriate equipment. This can involve the following activities:

- Encourage the person to press down with shoulders and feet, elevating the bottom (bridging) so that carers can slide bedpan underneath with the person in lying
- The person with good upper limb strength could use the trapeze to raise themselves above the surface of the bed so that the carer can insert the bedpan
- The person could raise their bottom from the bed using hand blocks to push down on whilst pushing with their feet into the bed with the person sitting

However, there are occasions when manual handling assistance is required for the person to be positioned correctly on appropriate equipment. This can include the following stages:

The person starts in a semi-reclined position, supported by a backrest or pillows. The person should be encouraged to roll on to their side towards the carer. The person should be encouraged to look in the direction in which they are moving.

- The arm/hand nearest the carer should be moved to a position out of the way to prevents it being rolled on
- The arm furthest away from the carer should be placed across the persons chest in the direction of travel
- Encourage the person to bend their knees and roll towards the direction of travel, encourage to turn. Some people may find it beneficial to hold on to the mattress or edge of bed during this manoeuvre
- A second carer places the bedpan level with the buttocks and allows the person to roll back onto the surface of the bedpan. The carer may need to maintain the position of the bedpan throughout the rolling
- When taking the bedpan out, the pan should be stabilised by the carer as the person is once more encouraged to roll or is rolled by the second carer

If the person is unable to actively participate as above due to their posture being poor or the condition of bed/mattress being unhelpful, the person can be hoisted onto the bedpan. The person will be supported by the hoist sling during the activity.

Assisting babies and small children with hygiene routines

As with older children, assisting small children with hygiene routines should be done in a way which promotes the dignity of the child , and promotes independence as far as possible. Although babies will be dependent, toddlers can be encouraged to participate – for example providing children with stools can aid children in getting into the bath. Parents should be consulted so that assistance is as consistent as possible and is appropriate to the needs of the child. It should be carried out in an unhurried manner, involving active communication, and with opportunities taken for encouraging development and learning as appropriate.

A key issue is the ergonomics of the work area. As far as possible, areas in which assistance is given with hygiene routines should be designed to minimise the need for working at floor level, prolonged stooping and frequent lifting.

Potties and toilet seats should be chosen which maximize a child's abilities to get on and off - especially where children have mobility difficulties.

The use of equipment such as size reducing inserts can reduce the need to hold a child in position while using the toilet.

Assisting small children with changing nappies/incontinence pads

Changing children on the floor where this is a regular part of the carer's routine involves considerable postural stress.

Ideally a raised surface such as a changing table should be used. Toddlers can be encouraged to climb on, especially if provided with a stool, or where the changing table is height-adjustable. However, care should be taken not to leave children on a changing table unattended.

Where children have standing ability, and nappies are not heavily soiled, pads can be changed with the child standing up. The carer may use a stool or wheeled stool to improve posture.

While it may be acceptable to lift both legs in one hand to place the nappy when changing babies, this is not appropriate with older children for example children with disabilities who continue to need incontinence pads. The child should be rolled to position the pad.

Assisting children / babies to bathe

Babies bath inserts or bath stands can help reduce the postural problems associated with bathing babies.

The carer should stand close to the child and support the head if required.

With small children - To reduce the degree of stoop when lifting toddlers out of the bath, the child should be encouraged to stand prior to lifting them.

While assisting the child to bathe, discomfort to the knees can be reduced by the use of a knee pad.

Assisting children with disabilities to bathe

There may be a need for specialist equipment/seating to support the child during bathing activities.

Lifting children in and out of the bath who are not able to participate actively can be very hazardous, as it involves poor posture and arm's length holding.

Where facilities allow, level showering arrangements can offer a safer solution and overhead hoisting facilities can also be investigated.

Assisting a Person in a Manual Wheelchair

People who need wheelchairs should have access to a suitable, appropriate and well-maintained wheelchair. For some people wheelchairs may be used as a temporary means of mobility. This has an inherent risk, as the wheelchair may not be designed to take the person's weight, size, shape or specific needs. When assisting a person in a wheelchair you must check if the chair is the correct size and takes into consideration the person's particular needs. Regular checks and maintenance are required for all wheelchairs.

Check tyres are inflated to the correct air pressure (this is found on the rim of the tyre) for the following reasons:

- allows the brakes to work fully
- If the person is transported in their chair, safer clamping can be achieved
- It is easier to move the wheelchair and person and it affords more comfort to a wheelchair user

The following checks also need to be made:

- the brakes work
- the footplates are attached and adjusted to the correct height for the person's feet. Their thighs should be parallel to the wheelchair seat
- A person should not stand on the footplates during transfers in and out as they are not designed to weight bear and can cause the chair to tip.
- the seating canvas is intact
- the straps are in place and effective
- the handle grips are secure
- For children's wheelchairs ensure that the handles are not too low which may cause the carer to stoop. Extension handles can be fitted to prevent this.

If the wheelchair fails any of the above safety checks report any faults to your manager and do not use the wheelchair.

Always apply brakes:

- before opening and closing a wheelchair
- before lifting a wheelchair
- before assisting a person into and out of the wheelchair.

General guidance for lifting a wheelchair into and out of a car

The weight, size and shape of the wheelchair, the type of car you are using, and the person's capabilities all play a part in deciding whether the task is safe. This may require a specific assessment.

A method which can be used to avoid manually lifting a wheelchair into a car is to utilise a wheelchair hoisting system. However, advice for lifting a wheelchair into a car is as follows:

- Use a car that affords easy access
- Bring the wheelchair close to the car
- Secure the brakes and remove all detachable parts, e.g. footplate, arm, headrests and battery
- Close the wheelchair and fold the backrest if possible
- If placing the wheelchair into the boot of the car a board and an old blanket may be placed over the boot and rim of the car, this will aid placement
- Adopt an offset base and avoid top heavy twisting postures
- Take a hold low down on the frame of the wheelchair. Lift the chair up into the car, onto the rim of the car
- The carer should reposition themselves and slide the wheelchair down into the car
- When removing the wheelchair it should be moved close to the edge before lifting out by pulling on the blanket. Once the wheelchair is on the rim of the car it can be eased down on to its wheels.

Assisting a person in a wheelchair

When assisting a person in and out of the wheelchair ensure that the brakes are on, the footplates do not restrict access and the armrest removed if required to assist with the transfer.

- Ensure the person is fit to travel in a chair, that the wheelchair is designed to take the person's weight, size, shape and offer appropriate support
- Before moving a person in a wheelchair ensure their feet are on the footplates and that they are adjusted to a comfortable and safe height for the person
- Secure straps, supports and attachments. Carers must ensure that any straps are secured. Ensure that supports and attachments (e.g. panels, knee blocks) are also secured
- If you are required to assist a person up and down slopes and kerbs and you are much smaller, taller or lighter than them, you should seek help or guidance and inform your manager as your physical capacity may not match the needs of the person's requirement

Assisting a person in their wheelchair requires physical effort to push and pull them. Never lift a wheelchair with the person in it; let the wheels take the weight. In some circumstances it may be necessary to plan a route to locate dropped kerbs and to avoid kerbs, steps and steep inclines. If these situations cannot be avoided carers should use the following guidance.

Remember to use the safe handling principles:

- Keep close to the wheelchair when moving it
- Keep a mobile base
- Avoid top heavy postures when moving the wheelchair, applying brakes, or replacing attachable parts

- Avoid twisting
- Use a full fist grip to hold the wheelchair handles
- Avoid moving the wheelchair too quickly
- Check for a person's understanding and wishes.
- Communicate with them at all times, especially when starting to tilt the wheelchair back

Assisting a person down the kerb in a wheelchair

Find a drop kerb or lower kerb if possible. If not possible utilise the following method:

- The wheelchair should only be reversed off the kerb
- Caution needs to be taken and consideration given to oncoming traffic
- The carer steps down the kerb into the road
- Allow the back wheels to gently roll down the kerb by pushing down the handles
- Move the wheelchair backwards until the front wheels are at the edge of the kerb
- Using the tipping lever raise the front wheels from the kerb
- Move the wheelchair backwards to clear the foot-plates from the kerb
- Using the tipping lever, gently lower the front wheels back down to the floor

Assisting a person up a kerb in a wheelchair

The wheelchair should be moved forwards up a kerb.

- Facing the kerb ensure the foot-plate and front wheels are clear of the kerb
- Tilt the wheelchair using the tipping level and pushing on the handles
- Push the wheelchair forwards so that both back wheels are touching the kerb edge
- Roll the wheels up onto the pavement

Turning a wheelchair

- Use a push and pull movement
- Using an oblique stance push on one handle and the wheelchair will rotate on the opposite wheel

When planning to use a wheelchair in conjunction with other forms of transport try to plan the event. It may be possible to access some of the following:

- A tail gate lift system
- Low loading vehicles and ramps
- A person and wheelchair hoisting system

Guidelines for Selecting a Hoist

There are a wide range of hoists and slings available. To enable Personal Handling Plans to be completed correctly, the appropriate hoist(s) and sling(s) need to be selected. This guidance identifies the issues and decisions that need to be considered through this equipment assessment/ selection process.

It is important that when selecting a hoist it meets all of the necessary criteria to make it suitable. When selecting a hoist the following issues need to be considered:

- Persons needs
- Environmental issues
- Powered vs manual
- Purpose of the hoist

Person's Needs

- Size, weight and shape
- Level of ability and disability
- Ability to control their own actions and be independent
- Comfort and dignity

The hoist should meet all the handling and personal needs of the individual and their carers.

Environmental Issues

- The space available - for areas where space or storage is limited it is usually beneficial to use either a ceiling mounted or gantry hoist.
- Clearance, e.g. under a bed
- Floors - even and level, carpeted, load bearing capacity
- Frequency of use of the hoist
- Access/egress to rooms
- Overhead space

Specific safety issues may also have an effect:

- The weight limits of the hoist and the user population
- The electric supply and battery charging facilities
- Whether water is involved, hydrotherapy pools or bathing
- Ease of use
- Does it comply with other hoisting equipment in the area
- Are there training or documentation issues to consider prior to use
- Number of carers required for the task and their skill level will have an effect on selection of hoist type

Powered Vs Manual Hoists

Electric/battery hoists are preferable as they are physically easier for the person to control, manoeuvre and for the carers to use.

Manually raised hydraulic hoists can be used if:

- The manual hoist is being used as an interim measure
- Handling is infrequent or occasional
- Where there is no appropriate electricity supply
- Where water in the environment may be a cause for concern
- Where recharging of batteries may be difficult

The Purpose of the Hoist

A task-based assessment should indicate all of the activities for which the hoist will be used. For some areas or individuals the hoist may have to fulfil the requirements of several of the following tasks:

- Bathing
- Toileting
- Seat-to-seat activities
- Bed manoeuvres
- Indoors or outdoors
- Transport
- Lifting to/from the floor

Hoist Types

Mobile

They have a wheeled carriage as part of their structure and can be used to move people from one surface to another but they are not designed to be used as transportation devices.

Fixed

These can be attached to the ceiling (via tracking) walls, or floor.

Gantry hoists are also available and can be used in confined areas.

Hoist Functions

Hoists can be used for the following activities:

Passive Transfers

This transfer system is suitable for people who are unable to bear weight.

- Sitting to Sitting, e.g. chair to bed, chair to chair etc.
- Lying to Lying, e.g. bed to trolley
- Lying to sitting, e.g. bed to chair, floor to chair etc.

Active Transfers

This transfer system is suitable for people who have sufficient weight bearing, comprehension, trunk and upper limb control.

- Sitting to Standing
- Sitting to Sitting (transferring through standing)
- Walking
- Standing Practice

Selecting hoists and slings for use in children's settings

In selecting hoists for use with children the following points should be borne in mind:

- Often in paediatric settings such as schools and nurseries, space in toilets is very limited. In these circumstances overhead hoists are generally preferable, especially room covering designs.
- Mobile hoists can be a cost effective option in areas where the hoist needs to be used in more than one location, and there are limited numbers of children who need access to it. Mobile hoists can be hazardous in some areas, however, for example in nurseries where there are small children on the floor or moving around.
- Wall mounted hoists can offer a space-saving solution but can only be used in a limited area.
- Many manufacturers are developing hoist designs which are appealing to children – eg lifting cassettes shaped like space ships.
- There may well be a need for a number of hoists, for example one in the classroom and another in the hall, if the hoist cannot easily be moved from one area to another.
- Portable hoists including gantry/ 'A frame' hoists may be appropriate for off-site visits or holidays.
- A wheeled gantry hoist may be a good option in a classroom as it can easily be moved should the child change class.
- Careful consideration needs to be given to the activities for which the hoist will be needed e.g. lifting from the floor or up onto a trampoline. A hoist needs to be selected which is capable of lifting to the required level.

- Overhead hoists are the best option for ball pools, soft play areas and sensory rooms. It is possible to adapt soft play and sensory rooms so that the mats are on a raised platform with sufficient access for a mobile hoist underneath. However access to the area will be more limited. Movement of pupils e.g. using slide sheets can be hazardous and should be very carefully assessed. Where access is especially difficult it may be necessary to give consideration to whether other activities could meet the children's needs equally well.
- Consideration needs to be given to other equipment the hoist will be used in conjunction with e.g. plinths and an assessment made as to whether access is possible.

Selecting a Sling

The selection of the appropriate sling is important as it will ensure a person's safety and comfort. Sling selection is primarily concerned with the assessment of the person's condition, size, shape and ability.

The following criteria will influence the choice of sling.

Persons size

The size of the sling is crucial for the person's comfort and safety. Too big and the sling is not secure around the person due to excess sling fabric and the person may slip through it. Too small and the person is held very tightly and is uncomfortable. When using a sling which is too small it increases the pressure at the key pressure points (the thighs and round the shoulders)

The trunk control of the person

Access slings or toileting slings are not suitable for people with poor trunk control or when hoisting a person from/to lying

Head and neck control

Standard sitting slings do not always extend to support the head and a sling that offers support to the head may be required

Tissue Viability

Tissue damage can be caused by a poor fitting sling. Use of a sling with narrow leg supports for larger people are a particular concern as the sling can become narrower when the persons weight is taken and can cause pressure under the thighs. Wider legs supports may also cause pressure behind the knee.

Further advice can be sought from Tissue Viability Nursing Team regarding leaving slings in situ. Care must be taken with people with a tissue viability risk when leaving slings in place for extended periods of time.

The presence of involuntary movements or spasm

Involuntary movements or spasm may make hoisting a difficult or dangerous task. Great care needs to be taken with such people when hoisting.

Sling Function

The function of the sling is also important, as this will affect both the hoist and sling choice. The following are different types of slings, which may be available.

Standard sitting slings

This sling supports the length of the back and moves the person in a sitting position.

Toiletting slings

Give open access to allow toileting and the removal or movement of clothing

Stretcher slings

Allows a person to be moved in a flat position. This is useful for unconscious people or people who have difficulty in sitting

Standing slings or harnesses

These are specific to each of the hoist companies and machines. The most common version is a vest, which picks up from the shoulders. Lift pants and full trunk body suits are also available.

Disposable or person specific slings

This type of sling is used to prevent cross infection issues and should be prescribed specifically to a person until soiled or they are no longer required.

Bathing slings

These are made of lighter material, usually mesh, and stay in situ throughout the bathing task, drying rapidly after use.

Specialist slings

These are available for some tasks, e.g. slings for people with bilateral amputation. If the process of evaluation for fitting a sling does not provide a solution it is also possible to have one made to measure for a particular person.

Compatibility issues

Due to the large range of hoists and slings the issue of compatibility between different manufacturers is a major issue. As far as is practical the same company should provide both the hoist and the sling. If a different sling is recommended it

will be the responsibility of the assessor to ensure that the equipment is compatible. A note to this effect should be included in the hoisting plan. Details of hoist and sling compatibility can be obtained from sling and hoist companies. Any details of compatibility issues should be included in your local management procedures and/or policy.

Environment where assistance is required

A final consideration for this selection process is that the decisions can either be based on one particular person who needs assistance or across a whole establishment, ward or area. The aims of the decision will be the same, i.e. equipment should be provided that allows all the people involved to be hoisted safely and comfortably. Due note should be taken of the range of people, the frequency of use and the laundry facilities for the slings, when providing slings for an area.

Maintenance and Inspection

Provision and Use of Work Equipment Regulations 1998 (PUWER) and Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) state that there is a requirement to have appropriate inspection and maintenance systems for all equipment used in care handling. LOLER specifically states that a competent person should carry out full inspections of mechanical hoisting systems and slings, every six months.

When using a hoist regularly in a given area provision must be made for maintaining the charge in the batteries and a procedure should be clearly written for actions in the event of the hoist failing. This should include emergency procedures, i.e. how to get the person out of the sling in a breakdown situation and hoist replacement.

Selecting a sling for children

A sling assessment should include the therapists, moving and handling specialists, staff involved in handling, and parents should be consulted. Sling manufacturers may well also be able to offer considerable expertise in sling selection and design. The standard ranges of slings will meet the needs of many children. However where the child has complex needs, many suppliers manufacture slings in special designs/fabrics which can meet particular requirements.

Selecting a sling for a child with low tone

Where children have low tone, slings should be selected which give sufficient support. Slings are available with head support, stays, hip/lap/thoracic supports. Toiletting/access slings should never be used as there is a risk of the child falling out. There may be a need to have a special sling manufactured. The child needs to be hoisted in a slightly reclined position.

Selecting a sling for a child with extensor spasm

Slings should not be applied with both leg pieces under both legs – the sling should be applied in the through-leg position. A Velcro lap strap will improve security and

safety. Using shorter leg loops so the knees are slightly drawn up with reduce the likelihood of spasm. Slings with head support should be selected.

Selecting slings for very small children

Some standard slings have especially small apertures. Some slings are shaped/ gathered at the aperture. A Velcro lap strap as well as head support will also often be required.

Leaving slings in situ between transfers

It is normal practice to remove slings following transfers, because of the risk of pressure sores associated with leaving slings in place. There may also be problems of temperature regulation if children are sitting on nylon fabrics for long periods. Therefore efforts should be made to resolve difficulties associated with sling application so that slings can be removed, wherever possible. However, sometimes inserting or removing the sling causes significant risk to carers, for example where the child is using a moulded seating system. It may be acceptable on such occasions to leave slings in-situ, after a careful risk assessment. In these circumstances, only slings designed for this purpose should be used, manufactured from specialist fabric. The child's therapists (OT and Physio) should be consulted as part of the sling assessment. The assessment should include consideration of the increased risk of pressure sores, and may also need to include input from tissue viability nurses.

Decisions to leave slings in-situ should not be determined by staffing pressures, to save time, but only on grounds of increased safety for carers/increased quality of care for children. If any slings other than specialist leave-in slings are used, the variance procedure should be followed.

In any circumstances where leave-in slings are used, staff should be made aware of early signs of tissue breakdown, and who to alert should these be noticed.

Use of vest/harness slings

- These slings can be useful for vertical lifts eg onto equipment.
- There is a need to select a hoist capable of lifting high enough.
- Vest slings can be helpful with standing, walking and sitting activities where the child's weight bearing ability is poor/unreliable and manual assistance is hazardous.

Guidelines for Using a Hoist

Contraindications

There are certain people for whom it may be unsafe to use a standard hoist and sling.

- People with major extensor spasm problems
- People with uncontrolled movements
- People with aggressive/challenging behaviour

In these cases specialist hoist and sling assessments may be required.

Checking the Sling

Prior to using the sling it should always be inspected to ensure suitability for the activity. The following points should be considered by all carers prior to use.

- Cleanliness of the sling
- Does the sling meet the specification of the handling plan, i.e. is it the right one?
- Does it have all the correct plastic inserts (if applicable)?
- Does the sling show any signs of damage? i.e. Frayed edges, damaged stitching, unpicked seams or cracked clips etc.?

If any of the above are noted then it will be unsafe to use a sling.

Infection Control Issues

For infection control purposes and issues of hygiene, best practice is that slings must not be shared.

There are dangers of passing infection from one person to another. Hoisting equipment could, if not used appropriately, cause/contribute towards the spread of infection.

The level of risk of cross infection should be accounted for and documented in the management plan for certain people.

Hoist slings must be deemed single person use when one of the following is suspected or following confirmation:

- MRSA
- Hepatitis
- Clostridium Difficile infections

The slings should not be transferred between areas or to different people without being cleaned using a suitable method to remove the infection, i.e. 70° wash, (manufacturer's washing/care instructions must be followed). A possible solution to these issues is that consideration is given to the use of disposable slings.

Systems should be put in place to ensure that the hoist is cleaned when it is being moved between areas of high risk.

Fitting a Sling

Fitting slings to people can involve a significant amount of manual handling and as such can cause potential problems. If hoists and slings are used regularly there may be problems caused by postural positioning and repeated actions. It is therefore important to consider the following items:

- Does the person need to be moved at all?
- The ability of the person being hoisted.
- The position of the person, i.e. lying or sitting
- How many carers are required?
- Can the sling be left in situ?
- Is more handling involved when putting the sling in place than by the use of an alternative handling activity?

Fitting a Sling in Lying

- Ensure the correct sling is being used for the person and for the task
- Roll the person using standard method
- Concertina half the sling up lengthways and place the sling in the appropriate position under the person. Alternatively, place the sling over the person and tuck the remainder underneath the shoulders and hips
- Roll the person to the opposite side and unravel the remainder of the sling
- Before attaching the sling to the hoist, ensure that the sling is in the correct position. Pay particular attention to the position of shoulders and the location of the long straps round the thighs

Fitting a Sling in Sitting

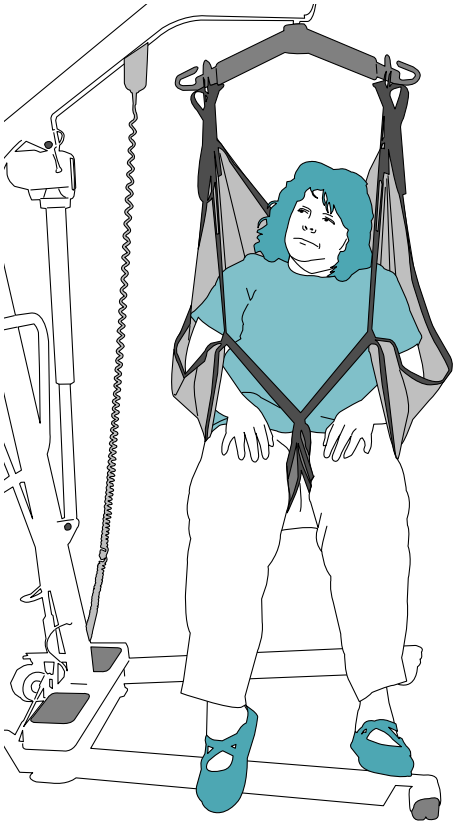
- Ensure the correct sling is being used for the person and for the task
- Carers must avoid the use of prolonged top heavy postures while applying slings
- Encourage the person to lean forward to allow the sling to be placed between the person and the back of the chair. If this cannot be achieved, assistance can be provided using the appropriate open palm holds on the trunk
- Ensure the sling is positioned down to the base of the spine and that the shoulder loops/fittings are at shoulder level. The sling must be centrally positioned
- The carer can move in front of the person, from where the leg pieces can be positioned. If necessary the carer can pull the leg pieces to ensure a good fit. If the person has sufficient sitting balance they can be encouraged to lean to one side to ease placement of the leg pieces. Additionally removing wheelchair sides or lowering chair arms can also improve access
- It is not appropriate to lift the person's leg while at the same time bringing the leg pieces under the thigh. Encourage the person to lift their leg to create enough room. Alternatively, a person's foot can be placed on the carer's thigh if the carer is in the kneeling position
- Before attaching the sling to the hoist, ensure that the sling is in the correct position. Pay particular attention to the position of the persons shoulders and the location of the long straps around the thighs

Methods for Fitting a Sling

The most frequently used methods for applying slings are outlined below. Specific fitting information for each sling type will be found with the manufacturer's instructions.

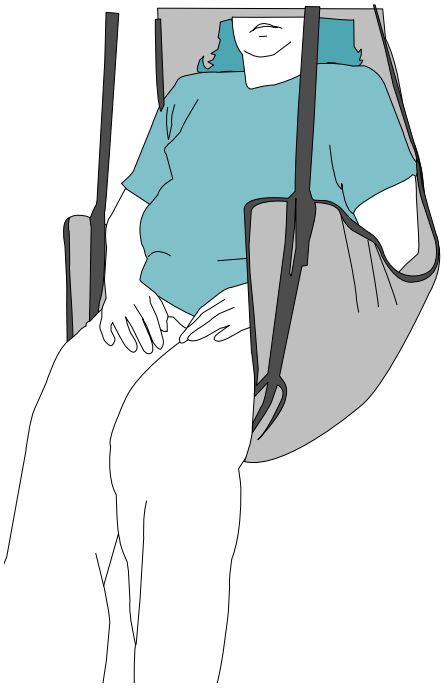
Standard

The only method that can be used for this type of specific sling. This is most commonly found on slings with a locking clip fixation on a wishbone type spreader bar.



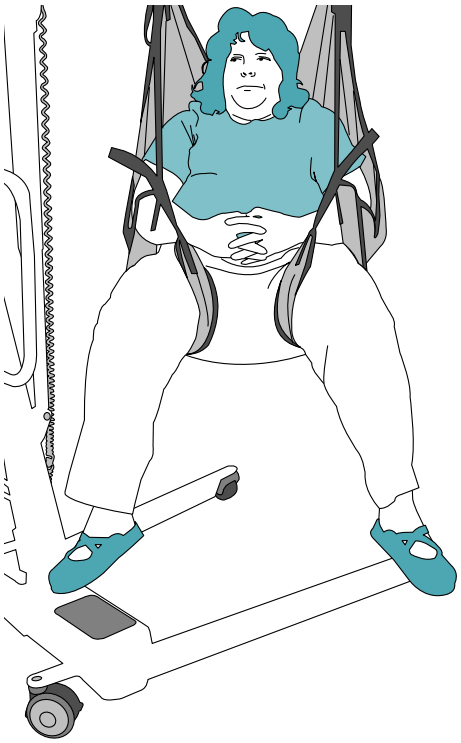
Through Legs Crossed

- The leg pieces are passed under each leg
- The loops are then crossed or interlocked with a 'modesty strap'
- These loops are then linked with the outer longer loops
- The outer long loops are then attached to the opposite side of the spreader bar



Under Legs

This fitting takes two leg pieces and places them under the legs of the person and attaches the loops to the spreader bar. This fitting keeps the person's knees close together and will be suitable if hip movement is painful.



Through Legs

The leg pieces are passed under each leg and the loops are attached to the spreader bar on the same side.

Using the Hoist Safely

Checking the Hoist

Before hoisting activities, carers must check the hoist and the sling and the hoisting environment, paying particular attention to the following:

- Ensure that the motors or hydraulics work appropriately and that batteries are sufficiently charged
- Observe the fabric of the hoist. Are there any obvious problems with it e.g. cracks in welding, bits missing, wheels running freely etc
- Check the environment for hazards e.g. obstacles, lack of space, electric cables etc.
- Check that the sling is clean, and shows no signs of wear (e.g. frayed loops, loose stitching, cracked clips) and is correct for the individual
- The carer must check that they know how to operate the emergency lowering mechanism if they are using an electric hoist
- If the hoist fails to lift or lower check that the emergency stop button has not been activated and that the batteries are fully connected
- The sling should have a legible manufacturers label which details the washing/care instructions, year of manufacture, safe working load, size etc

Introducing the Hoist

It needs to be recognised that accepting the need for a hoist can be a challenge for both professional and family carers, requiring changes in routines, the development of new skills and so forth. The successful introduction of a hoist will require the following:

- Good communication
- careful planning
- good co-ordination
- thorough assessment
- appropriate selection of equipment
- adequate training and support.

When positioning the hoist the following points are taken into account:-

- Position the hoist after the sling has been positioned
- Depending upon the environment, mobile hoists can be positioned from the front, or at an angle
- Ensure that the boom is not at the person's eye level as you introduce the hoist

Where the child is capable, having the opportunity to lift a mannequin, or operate the handset with another person in the hoist can help make the activity more fun and less anxiety-provoking. Some children may cope better if their parent is the first person to hoist them.

Operating and Manoeuvring the Hoist

- Brakes should be left off during hoisting except where manufacturer's instructions specifically state otherwise
- Carers should check that loops are correctly attached prior to lifting the person and that the person is protected from contact with the hoist
- Consider the dignity of the person being hoisted. They should be involved as much as possible in the process
- Position equipment appropriately prior to lifting the person, to minimise the distance between transfer surfaces and the time spent suspended in the sling
- Carers should only lift the person high enough to clear the surface of the chair/bed
- When moving a person on or off a bed, care should be taken to protect the person's heels from dragging on the bed
- When lifting a person from lying, their head should always be supported even if a sling with a built in head support is being used
- It is important that carers adopt good pushing and pulling positions when moving a hoist. The hoist should be moved in a straight line where possible. The carer should use a mobile offset base and avoid top heavy postures, twisting and side-to-side movements as outlined in the Safe Movement Principles earlier in the Practical Guide

Using hoists outdoors

- The manufacturer's advice about using the hoist outdoors should be checked and adhered to.
- Where it is acceptable to use a hoist outdoors, a careful risk assessment should be carried out. Particular consideration should be given to the ground surface; where this is unstable or uneven, so that the stability of the hoist is compromised, it should not be used.

Managing hoists in classrooms

- There is a need to look at hoisting activities in the context of the whole day, sequencing activities to minimise unnecessary transfers
- It may be helpful to identify a clear area in a classroom which can be designated a 'transfer area' where transfers take place. In many classrooms the carpeted area can be suitable for this. An overhead gantry hoist may be used in such an area.
- It is helpful to show other children the hoist and how it works/what it is for, so that it becomes an ordinary part of the school environment. Other children should be given clear information about not playing with or interfering with the hoist.
- Remember that there may not always be a need to transfer – for example, the child can access carpet time equally well by remaining in their chair, or by lowering the class chair to the lowest setting.
- Transfers need to be planned to ensure that the environment is clear. If all of the group are moving to a particular area the transfer may need to take place ahead of time.
- Where space for transfers is very limited, an area outside the classroom may be designated for transfers, for example a therapy room or other space.

Lowering the Person into a Chair

When lowering a person into a chair it is important that they are seated far enough back in the chair. A good sitting position can be achieved in the following ways.

Looped Slings

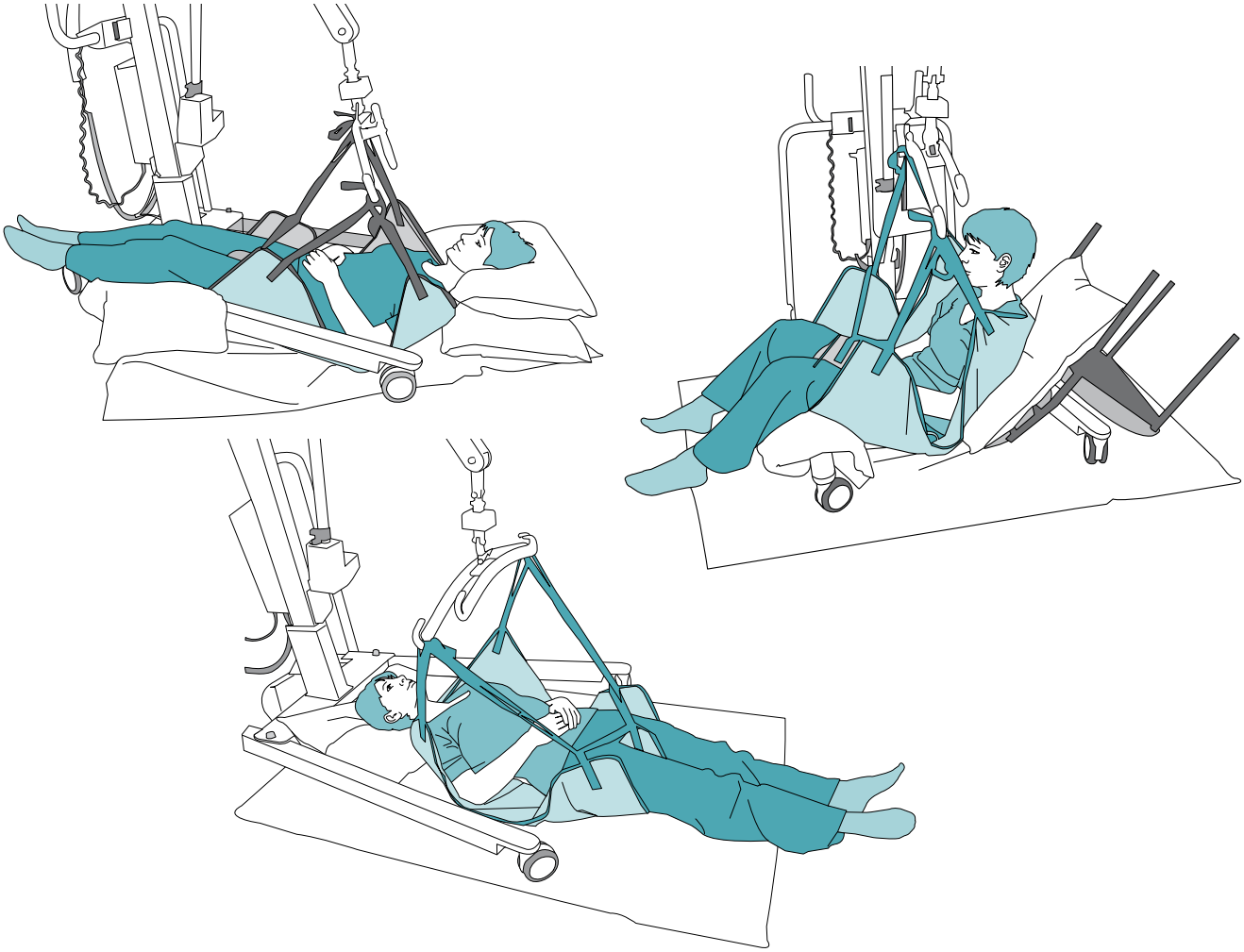
- To achieve a good sitting position the person should be lifted using shorter loops at the shoulders and longer loops from the legs
- The person can be brought to a more upright position as they are lowered, by the carer pushing the person's knees, if possible through a cushion or pillow, pushing on the hoist straps or pulling the sling handles from behind the person
- If the person is being lowered into a manual wheelchair, the carer can tilt the wheelchair using the tipper bar with the brakes off and lower the wheelchair once the person is well back in the chair

Clip Slings

Some hoists have a wishbone style spreader bar, which allows the carer to tilt the person into a more upright position prior to lowering

Hoisting a Person From the Floor

Care needs to be taken when hoisting a person from the floor. Ensure that the hoist is designed to lift a person from the floor. If possible follow manufacturer's instructions for this activity. There are a number of methods used to approach the person to ensure a safe lift.



Guidelines for Using Slide Sheets

A range of different sizes and designs of low friction rollers is available, and care should be taken when purchasing this equipment that it is suitable for the activity. There are two main types; single sheets which can be used in pairs or folded to produce a double layer, or rolls/ tubes. Some designs are available with handles. The sheet selected needs to be sufficiently wide that carers can hold it easily when it is positioned underneath a person.

Slide sheets are used for a number of activities. These include:

- Moving up a bed
- Sliding across a bed
- Turning a person in lying
- Lateral transfers
- Introducing a sling in lying
- Introducing a sling in sitting

The guidance in the Handling Procedures section gives details of how low friction aids should be used in these circumstances.

- When using slide sheets the following safety guidance should be adhered to:
- When pulling slide sheets, the safe movement principles should be followed. Using slide sheets with poor pulling actions (e.g. involving twisting, stooping, lifting the sheet upwards, and sudden, jerky actions) can be hazardous
- Twisting can be avoided by adopting a starting position on an oblique angle so that the carer's hands are always in front (never to the side) and the pull is towards the carer's mid line
- The carer should use a series of short pulls rather than one big pull
- Care should be taken that these pieces of equipment are not left on floors or on the edge of a bed where people may slip on them
- Local procedures related to prevention of cross infection must be followed

To introduce the aids the following methods can be used.

Introducing a roller/slidesheet lengthways in lying prior to moving up the bed

Method 1

Two carers are needed for this task.

- Adjust the bed to an appropriate height
- Fold the slide sheets/roller into 15cm folds along its length
- One carer feeds the roller through under the pillow to the other side, with the second carer pulling it through. The folds should be down towards the surface of the bed to ease the unrolling
- Working together, the carers unfold the slide sheet one fold at a time underneath the person

- Alternatively, the sheet may be placed underneath the feet and unfolded towards the head

A variation of this method would be to concertina/gather the slide sheets and introduce them at waist level. The slide sheet should be unravelled towards the direction of the head with the remainder unravelled towards the feet.

Method 2

Two carers are needed for this task.

- Adjust the bed to an appropriate height
- Roll the slide sheet lengthways
- Roll the person onto their side
- One carer supports the person while the other tucks the roller underneath them, roll facing downwards, taking care that finger pressure goes down towards the mattress rather than uncomfortably towards the person. It can be helpful to ease the roll through with fingers between the layers of fabric. The sheet should be underneath all the main friction points (shoulders and hips)
- The person is rolled onto their back, and the second carer pulls the sheet through. It can be helpful to start this at the level of the shoulder
- It is not normally necessary to roll the person the other way, but this may be needed if it is not easy to pull the sheet through
- Where the slide sheet is not long enough to go underneath both shoulders and feet, a second smaller sheet may be needed underneath the feet to prevent friction problems

These methods can also be followed with two single layer slide sheets to aid positioning a sling in lying. Once the slide sheets are in place the sling can be introduced between the layers and slid up from the feet, down from the head or from the side.

Positioning a slide sheet width-ways prior to turning a person/ sliding across the bed.

Two carers are needed for both of these methods.

Method 1

- Adjust the height of the bed as appropriate.
- Roll or gather up the sheet two thirds of its length.
- Roll the person onto their side
- One carer supports the person while the other tucks the roller underneath them, roll facing downwards, taking care that finger pressure goes down towards the mattress rather than uncomfortably under the person. It can be helpful to ease the roll through with fingers between the layers of fabric
- The sheet should be underneath both shoulders and hips, otherwise the person will not roll into a comfortable position

- The person is rolled onto their back, and the second carer pulls the sheet through. It can be helpful to start this at the level of the shoulder
- It is not normally necessary to roll the person the other way, but this may be needed if it is not easy to pull the sheet through

Method 2

- The person lies on their back
- Gather up the slide sheet width ways
- Hold onto the slide sheet with the carers hand on top of the slide sheet
- Insert the slide sheet in the lumbar region with downward pressure onto the mattress
- The carer on the opposite side receives the gathered slide sheet
- Both carers gather the foot end of the slide sheet and co-ordinate the unravelling by pulling downwards
- This is repeated for the head end of the slide sheet

Removing slide sheets

- Reach underneath the person in an area where the contact with the bed is reduced for example underneath the knees
- Grasp the underneath layer and pull through
- It can be helpful to pull at an angle, and to change the angle of the pull if the sheet becomes stuck. If two sheets are used the bottom layer should be removed first and then the top. The fabric should be folded under before pulling so that the fabric slides back against itself coming out more easily

Guidelines for Manual Handling Issues in Fire Evacuation

The risks of fire in care premises can be catastrophic. Though the likelihood is rare we must have plans in place to ensure that carers can safely and rapidly evacuate our work areas. Fire, although considered an emergency is a foreseeable event and as such our evacuation plans should allow for the safe movement of all.

An evacuation strategy will be dependent upon the type of building, its use, and the occupancy profile, including staff levels. It should ensure progressive horizontal evacuation, which enables occupants to move away from a fire to a place of safety on the same level. Occupants can then await further evacuation to another similar adjoining area or vertically down the building using the stairway.

Other buildings i.e. clinics, day centres, educational settings may operate on the principle of full evacuation on the activation of the fire alarm.

Evacuation Procedures

It is essential that all carers read and understand the local fire evacuation procedure. The important information to ascertain is the safest and most suitable routes from the premises for the type of evacuation you may have to adopt (e.g. bed evacuation etc). This will be to move people progressively away from the fire, aiming to have a door between you and the fire (or the person and the fire.)

Method of Evacuation

The method of evacuation needs to be planned. This includes knowing how many beds, wheel chairs etc. can go in to the decant areas. Are there any activities, which occur during this evacuation, which you would not usually do? E.g. lateral transfers, evac chairs, ski pads and ski sheets.

If there are specific activities, which are not part of the normal care handling then the carers in that area need to be taught those specific skills.

The safety of carers and recipients of care is paramount throughout any evacuation process. This includes the dangers of fire but also the potential for injury during the process. These are some issues, which you may want to consider when planning your evacuation.

- Speed is of the utmost importance
- People in imminent danger should be removed first

There should then be a series of priorities to evacuate the rest of the area.

- Ambulant independent people should be removed first to a place of safety
- People who can transfer easily onto wheelchairs, commode chairs, trolleys or beds can also be rapidly removed from the danger areas
- People who have complex handling needs or are in a difficult situation will then need to be dealt with, e.g. in the bath, in a toilet or have fallen. This will also include people who are attached to equipment with a power supply. What happens if the power supply is removed? e.g. ventilators, syringe drivers, monitors etc.

Manual Handling Risks

The situation demands urgent action, which immediately raises the potential for injury. When faced with an emergency evacuation carers should, as far as possible, follow the handling plans, which were in place before the incident. These handling plans should be the safest methods for assisting the movement of people. Carers are reminded that their own safety is important and assistance should be sought if an activity is perceived as being too strenuous.

Assisting A Person on Steps/Stairs

It is not safe to give a person physical support in climbing steps or stairs.

If the person falls or loses their balance the carer has no control over the person's stability and is therefore placed in a vulnerable position.

Physically supporting a person who is unable to step up unaided will frequently involve supporting most of their weight, which is hazardous.

Many methods of promoting independent movement can be investigated. These would include:

- Hand rails
- Ramps
- Lifts/stair lifts

Where routes involve steps, investigate planning alternative routes which avoid the need to use a step.

Where possible managers should arrange facilities in their establishments so that those with mobility difficulties are not required to use steps and stairs.

In some circumstances it may be appropriate to use a mechanical stair climber to transport the person in their wheelchair. However this should be assessed to ensure compatibility between the stair climber and the wheelchair.

Risks associated with the stair climber need to be evaluated including the presence of other people, over-frequent or prolonged use and any associated handling problems.

Assisting a Person who is Unable/Unwilling to Co-operate

Assessment criteria

It is recognised that assisting a person to move who is non-compliant can be a high risk activity. Each agency will have local policies and procedures which ensure compliance with legal requirements for managing challenging behaviour and staff should receive specialised training to equip them to deal with these issues. In particular, carers should ensure that the requirements of the Mental Capacity Act are adhered to.

The guiding principle for managing situations where the person is unable or unwilling to co-operate with the task is that risk to carers should be minimised and that the activity should be avoided if at all possible.

However there are circumstances where intervention is essential to prevent further risk to the person and others.

A detailed risk assessment and handling plan should be carried out using the variance procedure and form. Where the local behaviour management policy/procedure involves a behaviour management plan, the handling plan should incorporate the strategies identified in the behaviour management plan. These strategies should take into account

- Patterns of non-compliance
- Trigger factors for example environmental changes, changes in routine, inter-personal conflict
- Behaviour management
- Emotional state
- The person's preference of carer
- The person's comprehension of the situation/activity

The handling plan should indicate strategies for avoiding assisting a non-compliant person to move where appropriate. Such strategies might include

- Attempting the activity at a later time or deferring the activity altogether if not essential
- Methods of calming or distracting the person, such as appropriate music or access to a quiet space.
- Planning non- essential activities to take account of expected fluctuations in mood. For example if a person is known to experience anxiety/distress in response to certain situations (such as anxiety about imminent respite care) it may be necessary to limit handling to a minimum where the anxiety will inhibit co-operation.

Carers must not be put at risk through handling non-compliant people if it can be avoided. Carers should be made aware that they have a responsibility to themselves and that they should not participate in dangerous situations.

Manual assistance

Manual assistance may only be provided where the risk assessment has been carried out and a detailed handling plan indicates that handling is appropriate. The handling plan should give detailed information about the following and should have been developed within the principles of the DIAG Code of Practice:

- Stances and holds
- Possible opt-out routes
- Number of staff required
- Stances and positions which minimise the risk of being hit, bitten grabbed, pinched etc.
- Strategies for avoiding the possibility of being grabbed and pulled to the floor – ensure that the carer holds the person and not the other way round.
- Stages of intervention – exactly when certain interventions are appropriate.
- When intervention is not appropriate. It is only acceptable to intervene where the person is resisting, where there is imminent danger to the person or others, and intervention must be in line with the organisation's written policies and guidance. In any other circumstances, carers must not get involved with a person who is physically resisting the task involved

Assisting a Person into and out of Transport

Manually assisting people in and out of vehicles involves an element of risk. There is rarely enough space for carers to manoeuvre and position themselves correctly so that the person is assisted safely. The risk assessment must always be carried out before any assistance is offered.

This Code of Practice suggests that if the handling activities fall outside the DIAG care handling procedures then the Variance Risk Assessment Procedure for assessing risk should be used.

This guidance recognises the following:

- The D.E.T.R's Guidance on the Safety of Passengers in Wheelchairs on Buses
- Medical Devices Agency's bulletin on the Safe Working Practices for Wheelchair and Vehicle Passenger Lifts

Assessment Criteria

- Ability to weight bear
- Ability to climb steps
- Trunk, upper body control and strength
- Design and accessibility of the transport

Independent Movement / Equipment solutions

Consider the following to make transportation easier for a person with handling needs.

Bus Travel

- For a person with appropriate ability a form of transport with independent access is preferred
- For a person using a wheelchair, vehicles that allow the person to travel in their wheelchair are preferable
- Some buggies are designed to be suitable for use in buses. This shoud be checked.
- A person who is able to walk but can't climb steps should be aided by verbal or visual prompts only (using rails as appropriate.) They will require the use of a tail lift, a mobile portable short rise lift or a ramp to enable access onto vehicles
- They will need to be escorted via the lift onto the bus before the people in their wheelchairs, thus avoiding access difficulties
- Prior planning is required where groups of people require assistance onto buses

Car Travel

Many car adaptations are possible to promote independence or reduce the handling need. The following should be considered for car travel situations.

- Swivel seats, low sills, wide doors enable easy access in and out of the car
- Two-door cars provide much more space to access the front seats than a four-door car

- A person with mobility difficulties must not be placed in to the rear seats of a two door car
- Equipment to assist a person in and out of the car e.g. turnplates/thigh raisers, rise and fall seats, transport boards, turning cushions
- Storage for a person's wheelchair in the vehicle
- In-car adaptations e.g. self load extended seat runners, car hoists, roof mounted hoists, boot mounted hoists, ramps for estate cars, trailers, lifts, winches, Wymo roof garage, chair rack
- Boot mounted manual and electric wheelchair hoist systems
- Independent movement can be promoted by the use of handles, door (with window wound down) and by sitting down and then bringing legs into the car (reverse procedure for getting out of the car)
- Adjustable seats with variable height or movement to enable the person to get in and out of the car independently or enable safe manual assistance
- Swivel and sliding cushions and seat mechanisms enable people to turn a minimum of 90° for seated assisted transfers
- Turning disk for independent use
- Transfer sliding boards for independent use
- Hand rails, handles and hand blocks also aid independence
- Organisations and licensed taxis will have policy statements concerning children travelling in front seats, and these should be followed. The key issue is that children need to be properly restrained using seat belts and child seats.

Hoist

Specialised car hoists are available which allow transfers from car to wheelchairs. A small mobile hoist could also be used.

Wheelchair Accessible Vehicles

- Small vans
- MPV's
- Ramped taxis

Safety Considerations for People Travelling in Wheelchairs

The following considerations need to be taken into account:

- The wheelchair must be secured facing forwards as wheelchairs have very little lateral strength
- Separate securing devices for the person and their wheelchair must be used. An independent seat belt for the person plus webbing and clamping for their wheelchair
- Secure attachments are only to be used with fixtures that are part of the vehicle and capable of withstanding the forces that would be involved should the vehicle be involved in a crash or emergency stop. Correct installation is required that complies with the transportation of wheelchair regulations
- Floor attachments need to be recessed to prevent tripping accidents
- Head support must be in place for any person travelling in a vehicle whilst seated in a wheelchair

Manual Assistance

The only activities that are appropriate for physical assistance are those where the DIAG procedures can be followed. These are:

Assisting a person from wheelchair to car/bus seat

See procedure for Transferring a Person from Sitting to Sitting

Using a slide board

- Can only be used when the person is independent or needs minimal guidance from the carers

Transfer through standing

- The design of the transport may make this activity difficult
- Place the wheelchair close to the car/bus seat
- The person must be able to step independently to move from one seat to another

Repositioning in the seat

This is a common problem due to the turning action to face the front of the vehicle due to resistance of the person's clothing and the sliding action required.

- A swivel cushion and/or slide sheet placed on the seat may help. The slide-sheet should not be left in situ for the journey and the swivel cushion should be secured to the car seat
- Adopt an offset, mobile base close to the task. This may mean one foot in the car and one out
- Facilitate short hip hitching movements to assist with repositioning (see procedure for Assisting a Person to Reposition in a Chair)

Adapted car seats that turn outwards enables extra space and avoids the need for repositioning, however these are not suitable for people with long legs who have stiff knee joints as their legs still need to clear the car door opening.

All other manual assistance should be individually assessed using the variance procedure. It should be noted that it is not appropriate to lift large children in and out of cars or on/off buses. Accessible transport should be arranged.

Lifting babies and small children into car seats

- A key issue is the selection of a car seat which is easy to install and use. It has become more common in recent years to select seats with carry handles which can be converted into a pushchair. Lifting a child in one of these seats can involve considerable strain as the baby is held at a distance form the body, often in a twisted position. Ideally the child and seat should be carried to and from the car separately. Where this is not possible, the seat should be held with both hands close to the trunk.
- Wherever possible small children should be encouraged to climb into seats.
- Where a lift is assessed as safe, the child may be held in a cradle lift or with palm holds on the ribs. It is important to place one foot in the car to avoid stooping during the lift and while fixing straps.

Assisting a person from a wheelchair to a car/bus seat.

Some of the methods in the guidance on transferring from surface to surface in sitting are applicable.

- The semi-stand pivot method can be used to transfer into car seats, with the optional use of a slide board.
- The person can use the stand step sit method only if assistance is minimal. The person needs to be able to maintain a standing position independently while the carer adjusts the hold from oblique behind to oblique in front to facilitate sitting down.
- A walking aid may be used to allow the person to step to the car and turn.
- A turning cushion can assist the person to bring the legs into the car.

Guidelines for Assisting a Person with Dressing

Assessment Criteria

When assisting a person with dressing a thorough risk assessment is essential, the following points are important:

- The personal handling risk assessment will indicate the capabilities and needs of the person and this must, as always, form the basis of dressing routines, so that the person is able to do what they can independently
- Where assistance is needed, methods of providing support and facilitating movement should be used which have been described elsewhere in the practical guide

Clothing adaptations may also be considered, e.g. Velcro fastenings. Specialist clothing is also available.

Manual Assistance

- Care should be taken to avoid fixed postures, especially prolonged stooping. Carers should keep an appropriate mobile base as they carry out the tasks and if attending to one area for a period of time, will need to consider sitting (e.g. on a wheeled stool or equivalent) if stooping is involved
- When a limb needs to be supported for more than a few seconds (e.g. when putting on support tights) support the limb e.g. use a cushion, stool, foam block, to reduce the risk of sustained holding
- Clothing may be chosen which is easier to remove. Baggy boxer shorts, french knickers, trousers/skirts with elasticated waists, loose fitting tops, trousers with 'popper' side openings are all examples of clothing which may make dressing easier

The following activities are acceptable methods for dressing and undressing a person where physical assistance is indicated. DIAG procedures should be followed for all sit to stand, sitting to sitting, repositioning in a chair and bed manoeuvres that may be included in the dressing scenario. A person can be dressed whilst in lying using rolling methods to move the person.

Trousers and underclothes may be taken off using the sit to stand procedures if the person has sufficient standing ability. Trousers and underclothes may be put on or taken off in sitting, if the person is leaned to alternate side using a long low hold (see procedure for Assisting a Person to Reposition in a Chair). When dressing the upper body, long low holds and other open palm holds may be used to support the trunk and limbs

Care should be taken to avoid one carer supporting a person while at the same time dressing them. Where support is needed, one carer should support while another dresses the person.

Guidance for Assisting a Person to Move in a Double Bed

Where possible, working with a person in the middle of a double bed must be avoided. The start and finish point may be in the middle of the bed for medical or safety reasons. Any treatments or personal care activities must be carried out with the person on one side of the bed to avoid the carers adopting a top-heavy posture.

Where possible, consideration must be given to the person sleeping in a single bed

Assessment Criteria

- Head and neck control
- Size and resistance to movement
- Trunk, upper limb and lower limb activity
- Co-operation and comprehension
- Specific positioning requirements
- Bed height
- Type of bed, condition of bed and mattress, firmness etc
- Environment, access to both sides of the bed
- Rolling ability
- Very large or heavy people
- Bridging or bottom shuffling
- Types of equipment used (particular high risk groups, spinal fractures, poor skin quality, open pressure sores, weak or brittle bones)

Some movements can be safely carried out when the person is unconscious but care must be taken to position appropriately to maintain airways, reduce spasticity etc.

Independent Movement

The person may be able to roll, shuffle or bridge their way from the centre of the bed. A trapeze may assist the person to be able to achieve this.

Equipment Options

Extra wide slide sheets or handle extensions on standard slide sheets should be used. Person positioning systems are available e.g. 4 way glide

Manual Assistance

Points to consider:

- Weight limit of the bed
- Combined weight of person and carers during manoeuvre.
- Height of bed
- Methods of inserting/removing sliding sheets

The environment should be prepared prior to the task and sufficient space and equipment provided.

In some situations where the person is unable to move, the slide sheets may be left in position under the bed sheet. Extra wide (double the standard width) slide sheets must be used to allow the carers to adopt a safe posture.

Slide sheets may be placed in position either by unfolding the folded up sheets under the person from the head to the toes, or by two people carrying out the standard roll.

Both of these manoeuvres may require the carer to place one knee on the bed in order to adopt a safe posture.

Once at the side of the bed, all the standard procedures can be used to carry out the following:

- Slide across the bed
- A combined slide and roll, rolling the person to face the middle of the bed
- Assisting a person out of bed
- A standard roll to get the person facing the edge of the bed

Assisting a Person into/out of a Hydrotherapy/ Swimming Pool

Assessment Criteria

- Weight bearing ability
- Ability to climb steps
- Ability to transfer from surface to surface in sitting (see guidance)
- Level of co-operation/comprehension
- Fatigue (e.g. after swimming)
- Effect of temperature
- Trunk and upper body control
- Presence of high muscle tone/likelihood of spasm
- Level of balance and control

A key issue in avoiding hazardous handling in swimming areas is the choice of suitable facilities. Pools should be selected which are suited to the needs of those who use them. Consideration should be given to the suitability of the pool access arrangements, but also to changing areas, to ensure that these also are suitably equipped (eg with changing tables, hoists and accessible showers and toilets as appropriate).

Variances

In some circumstances, adaptations can be made to the pool which make steps easier to negotiate. Portable steps are available which can be placed inside the pool. Ladders or steps can be adapted to include wider treads and grab rails.

In any circumstances where it is considered acceptable for manual assistance to be given, however, the variance procedure should be followed.

Independent Movement

For those who do not have the ability to enter a pool independently via steps, with only verbal or visual prompts, independent access into swimming pools may be possible where there is a sloped entry to the pool.

Manual Assistance

It should be noted that assisting a person into a pool either using a full body lift or by giving physical support on steps or ladders is not appropriate (see guidance on unsafe practices).

Hoisting

Pool Hoist

A range of pool hoists is available, suited to different levels of need and ability of the person using the pool. The main types of hoist are as follows:

Hoist with fixed seat (e.g. Arjo Otter)

These hoists are suited to those who have sufficient ability to transfer safely into the hoist chair at the poolside following the guidance for transferring from surface to surface in sitting. It is not possible to transfer into the hoist chair using a mobile hoist because of the proximity of the poolside.

The chair needs to be assessed to ensure that it is suited to the needs of the person (e.g. height, level of support required)

Hoist with detachable wheeled seat (e.g. Arjo Mark 1, Oxford Dipper)

These hoists are suitable for those who may need to be assisted into the seat using a hoist, as the transfer can take place away from the poolside, e.g. in the changing area. The chair needs to be assessed to ensure that it is suited to the needs of the person (e.g. level of support, height etc.)

Hoist with detachable stretcher trolley

This hoist is suited to those who need to be lowered into the pool in a supine position.

Overhead tracking hoist

An overhead tracking system (e.g. gantry or other suitable overhead system) may be suitable in some environments.

Specialist slings are now available with buoyant inserts to ease sling positioning.

Guidance for Working with Children on the Floor

There are many postural difficulties associated with working at floor level. There may be occasions when the child's needs may be met equally well when they are at a higher level. For example in a nursery/infant school setting, where a child has a rise and fall class chair, this can be set at its lowest height, avoiding the need to support the child at floor level.

If floor based activities are chosen as the best or safest for the development of the child then the following points may be useful:

- Carers should try to protect the knees with padding, pillows or cushions, particularly on hard floors. A pillow may be placed behind the knees and another underneath the shins to support the body weight in kneeling to avoid going into a full knee bend. This may not be helpful where the activity requires the carer to be more mobile.
- It will be necessary to make frequent changes in position to avoid twisting, and top-heavy/ fixed postures.
- Consider using a wheeled stool if appropriate.
- Kneeling stools can offer a more comfortable position but will limit mobility and may not be suitable for all activities.

Carers should avoid kneeling for extended periods of time. Change the working position regularly. The day should be managed so that kneeling/low level working is interspersed with activities in other postures. Wherever possible work rotas should be organized so that low level working is shared among the staff group.

Assisting a Child / Young Person On / Off a Wedge

Assessment Criteria

Before assessing how to assist a child on and off a wedge the following should be considered:

- Ability to bear weight through legs and arms
- Ability to roll
- Design of wedge
- Level of co-operation and comprehension

Independent Movement

Some children may have the capability to crawl onto the wedge. Smaller children may be able to sit down on the edge of the wedge, lie down and turn into a prone position, crawling up the wedge if necessary, with verbal or visual prompts.

Manual Assistance

Manual assistance is only appropriate where minimal assistance is required.

A variance form should be completed. Where safe manual assistance is not possible, hoisting options should be investigated.

Alternative Equipment

Inflatable wedges are available, which can reduce positioning difficulties.

Hoisting

- Children can be hoisted in a prone position using a standing vest. Care should be taken to protect the child's knees, endeavouring to keep the child's weight forward. A second carer can assist by encouraging the child forward and with adjusting the wedge as the transfer takes place.
- Where the use of a standing vest is not appropriate, the child can be hoisted onto their back in a suitable sling and than rolled into a prone position. Where the wedge is narrow, a sliding sheet may be used to facilitate the turn. A second carer will need to ensure the child does not slip back down again. It may be possible to use the sling also to facilitate the turn, although guidance from the sling manufacturers should be sought.

This method can also be used to assist a child onto a roll.

Assisting a Child In / Out of a Ball Pool

Assessment Criteria

Where children are assisted in and out of ball pools, the following should be considered:

- Design of ball pool
- Ability to crawl
- Level of co-operation and comprehension

Independent Movement

Wherever possible, children should be encouraged to use independent movement skills to get in and out of ball pools, with visual or verbal cues only.

Manual Assistance

Manual assistance into a pool is considered hazardous where it involves lifting the full weight of a child, or supporting a child in negotiating steps.

Where the design of the pool allows safe manual assistance, this should be individually assessed using the variance procedure.

Hoisting

Although hoisting children into a ball pool using an overhead hoist is relatively straightforward, lifting children out again is extremely difficult, as it is problematic attempting to position the sling. A harness style sling may offer one solution. However, where children have significant mobility difficulties, consideration should be given as to whether the benefit to the child of this particular activity warrants the effort required to assist the child into the pool. It may be that alternative activities can meet the child's needs equally well. One option would be to take a smaller quantity of balls to another area (such as a portion of the soft play area separated by soft play equipment) or to consider an entirely different activity.

Assisting Children On / Off Play Equipment

Lifting children on/off play equipment such as swings/slides can be extremely hazardous as it often involves lifting at arm's length, at high levels, or from surfaces which are unstable.

Wherever possible, children should be encouraged to use equipment which they can access independently. Play areas should be designed with consideration to access for children with a range of abilities; this is especially so in play areas specifically designed for children with special needs. Wherever children with physical disabilities are assisted in play areas, more accessible equipment should be selected. It should be remembered that not all children need to access all pieces of play equipment in order to benefit from the play experience.

Assisting onto Slides

Slides should only be used by children who can climb independently.

Assisting into Swings

To lift a small child into a bucket-style (divided leg) seat, approach the swing from behind holding the child in a seated position, and slide the child into the seat.

To lift a child onto a standard swing:

- Carers should try to select play areas where the height of the swings are suitable for the age of the children so that lifting is not required.
- Where the child is sufficiently light weight, ideally one person should hold the swing steady while the other person lifts the child onto the swing.
- Where only one carer is available, they should stand behind the swing and lift the child back onto the seat.
- Care should be taken to follow safe movement principles during the lift.

Assisting Children on Outside Visits

Taking children with disabilities on outings and holidays may involve additional risks, especially where environments offer poor access and facilities. Each organization should have a local procedure and guidance for assessing such visits, which should always be followed.

The following points should be considered:

- There should be a written risk assessment for all children; this should include arrangements for children with disabilities.
- Carers, parents and wherever possible the child should be consulted as part of the assessment.
- Specialist advice should be sought (eg from therapist/ back care adviser/safety professional) as appropriate.
- It is advisable to visit the venue well ahead of time to check facilities. Even if accommodation is stated as being adapted it may not meet the needs of all children. Particular care should be taken to check toilet facilities, showering/ bathing facilities, access routes including fire evacuation, availability of equipment such as hoists, sleeping arrangements, wheelchair accessibilities of outside environments, and so forth.
- Transport should be accessible, and not involve staff in lifting and carrying children on/off buses.
- Sufficient staff should be allocated to ensure hazardous handling is avoided.
- All staff should have received training in safe manual handling prior to the visit.

Organisations are required not to treat disabled children less favourably, and to make 'reasonable adjustments' to ensure that children with disabilities have access to outings and visits. Sometimes a fairly straightforward adjustment can be made, such as providing accessible transport. However, there may be occasions when a visit cannot be made accessible, such as an outing to a cave. In these circumstances a reasonable adjustment might be to offer an alternative outing to all the children involved.

As far as possible, efforts should be made to ensure that handling activities follow the methods ordinarily indicated in the child's handling plan. Where the child is usually transferred using a hoist, and a hoist is not available, a hoist should be taken on the outing. Hoists which can fold down can be used; there are also light weight, easy to erect gantry hoists, which might be suitable for such situations.

It is especially important to consult children and parents about mobility/care needs which fall outside the times of day when care is ordinarily provided. It is also important to recognize that a child's abilities (eg mobility) may be influenced by the unfamiliarity of the environment, and assistance given should reflect this,

Assisting Children With Orthotics

There is a range of body braces available, including the following:

- Spicas/body braces
- Hip braces
- Lycra body suits
- Body jackets
- 'Twister' braces
- 'Swash' braces

It needs to be accepted that assisting children in and out of braces can be very difficult and there are no known easy answers. On occasion it can involve supporting/ lifting most of the child's weight, in which case the variance procedure should be followed. Each individual would need to be assessed with their own equipment.

The following points should be considered:

- With very small children, the equipment can be slid into place relatively easily by lifting the legs and bottom and sliding the brace underneath. The legs should be lifted just enough but not too much, taking care not to put the child's neck under too much pressure.
- Older/heavier children should be rolled to position the equipment. At least two carers will be required. To maximise the comfort of the child, the child should be rolled and then the equipment positioned with the strap side down and closest to the child. Ensure the straps are accessible once the child is rolled back and not trapped inside the brace. If they do become trapped the child should be rolled back again rather than attempting to pull the straps through damaging the child. Some positional adjustments may be required once the child is in the equipment to achieve the optimum position and comfort.
- The same technique is advisable for body braces with spinal jackets.
- Care plans should identify (and these must be read by carers) the preference for placing the equipment eg under jumper, between particular layers of clothing.
- Advice needs to be sought from the therapist/ orthopaedic surgeon and orthotist as to whether the brace needs to be locked; this needs to be indicated on the care plan.
- If the brace does need to be locked, this does not need to be done when the child is in a lying position. This is easier for the carer and more comfortable for the child if the brace is locked whilst in a sitting position either in the sling or in the chair.
- Some children have the capacity to participate in fitting the equipment, and strategies should maximise these opportunities.
- Consideration should be given as to whether hoisting the child into the brace is possible. Some slings may make this activity easier, eg slings made from silky materials.

Each assessment should also address the following issues:

- The posture of carers. Generally, assistance will need to be given on an adjustable height plinth/changing table with access both sides.
- Where giving assistance is strenuous, some staff (eg those with musculo-skeletal problems or who are pregnant) may need to be excluded.

Other Orthotics

Ankle splints eg AfO's

Carers should ensure that they adopt appropriate postures while assisting children with afo's. Kneeling pads can be used to protect the knees. Low stools can also be used. It may be helpful, while in a kneeling/low sitting position, to rest the child's foot on the carer's thigh while putting on the splint.

Initial guidance should be sought from the therapist about correct fitting of the splint.

Children in Plaster Following Surgery

Careful multi-disciplinary planning is essential prior to surgery, with immediate and ongoing reviews post-surgery. The key issues to consider are access, transport, personal care needs, positioning, staffing, and handling management. Each child will need an assessment to meet their individual needs.

Assisting Children with PE and Sports Activities

Children with disabilities in schools are equally entitled to access to the PE curriculum. The aim should be to include the child if at all possible in the established activities, differentiating where necessary. For example, rules may be adapted; a child may be able to bat in rounders with another child running; or they may need to use a lighter hockey stick for a game of indoor hockey. What is not acceptable is that the child has physiotherapy treatment while the rest of the class engages in a sport activity. It is also not acceptable for staff to facilitate inclusion by taking unnecessary high risks, such as lifting children onto high equipment; staff should only be expected to support children who are working at their own skill level.

Advice should be sought from PE specialists about adapting the curriculum or the activity. A range of specialist equipment and alternative activities is available.

Trampolining

Hoists can be used to assist children onto trampolines. However an assessment needs to be carried out to ensure the hoist has a high enough lifting range. A slide sheet may be needed to assist the child to the centre of the trampoline.

Where children need assistance on the trampoline, staff should receive appropriate training in how to give safe assistance.

For children with sufficient ability a set of steps may ease access.

Horse Riding

Lifting children onto horses and supporting children with poor sitting balance on horses involves considerable risk. Where children who cannot mount horses independently are taken riding, accessible facilities should be selected. Hoists and specialised lowered mounting facilities are available which can reduce many of the problems. If horse riding is part of a child's therapy programme, then assisting a child to maintain position on a horse should be carried out following the therapeutic variance procedure.

Riding facilities need to be assessed ahead of time to ensure that they are sufficiently accessible for people with disabilities.

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