Manual Handling

College of Occupational Therapists

Guidance 3

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This publication is available in large print if required

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Published April 2006

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Manual Handling
College of Occupational Therapists Guidance
Contents

Introduction

This guidance document aims to enable all occupational therapy personnel to work safely, using the principles of risk management, underpinned by a broad understanding of the law and legal requirements related to manual handling. It also considers the provision of manual handling equipment and the demonstration, instruction and training of safe manual handling to others. The document is shaped by the College's approach to manual handling, which is one of balancing the welfare and safety of workers and carers, with meeting the needs and wishes of service users; providing a professional service that seeks to enable service users to exercise control and autonomy in their lives.

Manual handling is often intrinsic to occupational therapy assessment and treatment, as part of direct service user care or in providing guidance or instruction to others. The extent of injuries sustained by occupational therapists during, or following manual handling activities is not entirely clear, as there is little researched evidence in this area. However, considering the nature of occupational therapy and the research findings of professions such as nursing and physiotherapy, it is likely that the occurrence of work-related musculo-skeletal injuries to occupational therapists is considerable (Cromie *et al* 2000; Royal College of Nursing 1996).

Following the implementation of the *Health and Safety at Work Act 1974,* subsequent European legislation enacted during 1992, and updated Health and Safety Executive (HSE) guidelines during 1999 and 2004, occupational therapists have been obliged by law to ensure that they use manual handling practices which maintain their own safety, the safety of their co-workers and also the safety of the people being handled.

A joint statement issued by the Chartered Society of Physiotherapy (CSP), the College of Occupational Therapists (COT), and the Royal College of Nursing (RCN) in 1997, illustrated the professional bodies' commitment to the prevention of back injuries to staff and the implementation of manual handling legislation. A number of documents from allied health and nursing professions and other national advisory groups are referred to throughout this document in terms of implementation, best practice and further guidance.

Occupational therapy personnel need to consider the guidance provided in this document alongside the requirements defined by the *College of Occupational Therapists code of ethics and professional conduct* (2005) and *the Professional standards for occupational therapy practice* (2003).

1 The law and legal requirements related to manual handling

1.1 Current legislation and guidance

The current legislation that relates to manual handling builds a framework of requirements and practices. They identify the responsibilities of employers and their staff in maintaining the health and safety of themselves and others. The overall aim is to eliminate or reduce the risk of any harm occurring.

The key pieces of legislation to consider are the:

- *Health and Safety at Work Act (HSWA) 1974*;
- *Management of Health and Safety at Work Regulations (MHSWR) 1999*; and
- the *Manual Handling Operations Regulations (MHOR) 1992*.

Reference will also be made to other legislation such as the *Human Rights Act 1998.*

It is important to recognise that law as it relates to health and safety is part of criminal law, as opposed to civil law, which governs disputes between private individuals. Criminal law relates to actions which can result in criminal proceedings and hence prosecution. The Health and Safety Executive (HSE) is responsible for the enforcement of health and safety legislation and associated regulations. This means that the HSE has the power to prosecute for breeches of duty related to this law and is also able to issue formal enforcement in the form of improvement or prohibition notices.

The Health and Safety Executive has produced some guidance on the legislation. In 2004 it published the 3rd edition of the *Manual handling: manual handling operations regulations 1992 (as amended). Guidance on regulations (L23)*. The Health and Safety Executive and the Health and Safety Commission have also produced Approved Codes of Practice (ACOPs), which have special legal status. If it is proved that employers have not followed provisions within relevant ACOPs, a court can find them at fault, unless they can show that they have complied with the law in another way. There are Approved Codes of Practice concerning the relevant regulations, manual handling, lifting and the use of equipment (HSC 1998b, HSC 1998c, HSE 2000).

1.2 The *Health and Safety at Work Act 1974*

The *Health and Safety at Work Act 1974* imposes duties on both the employer and the employee. The employer may be the employing organisation, or an individual who has direct managerial and employer responsibilities at local level. An occupational therapy manager will have employer responsibilities delegated by the organisation, but where the manager is acting in the course of his/her employment, he/she is still protected by 'vicarious liability', and the organisation retains accountability for the manager's actions. The employee is an individual who has a 'contract of service' from an organisation. Self-employed individuals will often have a 'contract for services', although in some instances they may still have the same rights as an employed person. In the example of a private agency, whilst a carer may be considered self-

employed for tax purposes; in the event of a personal injury claim concerning a manual handling incident, the carer would almost certainly be treated by the court as an employee of the agency (Lane v Shire Roofing Co (OXFORD) Ltd), cited in Mandelstam (2002).

The *Health and Safety at Work Act 1974* imposes a basic duty upon the employer to 'ensure so far as is reasonably practicable, the health, safety and welfare at work of all his employees' (Great Britain, Parliament 1974 Section 2(1)). The words 'reasonably practicable' indicate that the duty is not an absolute one. The employer need only comply with the duty if the cost (financial, time and resources) of providing the control measure is not grossly disproportionate to the benefit derived.

Section 2 describes additional duties related to the provision of safe systems of work, information, instruction, training and supervision, and also the need to ensure safety when using, handling and storing articles and substances.

Section 3 of the Act extends to persons not directly employed by the primary employer but who may be affected by their activities, such as contractors, volunteers, or employees visiting from another organisation. In such a case, there is a joint responsibility on both employers to ensure a worker's safety and welfare. For example, a local authority occupational therapist may visit a service user within an acute hospital site to undertake agreed duties. The primary employer and the NHS Trust would have a shared responsibility. Likewise, if a local authority is contracting out services (e.g. personal care/manual handling) to a private agency, then it must pay reasonable care to the tendering process and the monitoring of the contract. If failure to do this jeopardises the safety of service users or employees of the agency, then the local authority may be in breech of Section 3 of the *Health and Safety at Work Act 1974* (Mandelstam 2002).

Section 7 of the *Health and Safety at Work Act 1974* imposes specific duties upon the employee while at work 'to take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work'. Also 'to co-operate with him (the employer) so far as is necessary to enable (any) duty or requirement to be performed or complied with' (Great Britain, Parliament 1974, Section 7).

In addition, the employee may also have civil duties to another individual (i.e. colleague or person whom they are treating) under common law, an issue that will be discussed later in this document in Section 1.5.

1.3 The *Management of Health and Safety at Work Regulations (MHSWR) 1999*

The principle objective of the *Management of Health and Safety at Work Regulations 1999* is to ensure 'suitable and sufficient' risk assessments are done (Great Britain, Parliament 1999, Section 3). There is an overlap of these regulations with others such as the *Manual Handling Operations Regulations 1992.* In such a case, where a manual handling risk assessment has been

undertaken, a separate risk assessment under the *Management of Health and Safety at Work Regulations 1999* will not need to be done.

Central to the *Management of Health and Safety at Work Regulations 1999* is the requirement that 'every employer shall make a suitable and sufficient assessment of -
(a) the risks to the health and safety of his employees to which they are exposed whilst they are at work; and

(b) the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking.'
(Great Britain. Parliament 1999, Section 3 (1))

For manual handling purposes, generic risk assessments may be undertaken by the manager (and relevant employees) on tasks such as loading/unloading and carrying equipment and people into vehicles, fitting equipment in people's homes or treatment handling within a specific environment.

The purpose of this type of risk assessment is to identify hazards (the aspects that have the potential to cause harm) associated with undertaking a task, and to evaluate the extent of the risks (the likelihood and severity of injury). This can be followed by the implementation of 'generic' systems of work which support employees in the management of risks, such as the use of a vehicle with a tailgate or the use of variable height equipment within a department.

The findings of these risk assessments should be made available to all staff, may be incorporated into departmental procedures, and will support risk assessments undertaken by employees relating to the needs of specific service users. Managers are required to periodically monitor and review the risk assessments and subsequent procedures.

Hignett (2001) undertook a 2-year qualitative ergonomic study in one occupational therapy department, rationalising manual handling risks into generic themes (see section 2.4) and then undertaking subsequent assessment of the found risks. The study can be used to identify possible areas for general risk assessment.

The Health and Safety Executive has produced a useful and simple explanation of how the *Management of Health and Safety at Work Regulations 1999* may be implemented in their document *Five steps to risk assessment* (HSE 1999). The leaflet provides helpful notes on good practice and suggests the following steps to assist with assessment of risks in the workplace:
Step 1: Look for the hazards.
Step 2: Decide who may be harmed and how.
Step 3: Evaluate the risks and decide whether the existing precautions are adequate or whether more should be done.
Step 4: Record your findings.

Step 5: Review your assessment and revise if necessary.

Self-employed workers must also comply with the requirements of the *Management of Health and Safety at Work Regulations 1999*. Occupational therapists in private practice should undertake suitable risk assessments and implement appropriate control measures to maintain their own safety, in addition to the safety of other people with whom they will work.

The *Management of Health and Safety at Work Regulations 1999* also consider the risk assessment requirements for people who may be at specific risk of injury due to work-associated hazards, such as 'new and expectant mothers' and 'young people'. In such instances, it is the responsibility of the employer to do a specific risk assessment, (a task usually delegated to the line manager), and where the risks cannot be avoided, to take preventative measures such as:

a) alter the working conditions or hours of work;
b) offer suitable alternative work; or if this is not feasible
c) suspend from work on full pay.

1.4 The *Manual Handling Operation Regulations (MHOR) 1992*

The *Manual Handling Operations Regulations 1992* should be considered alongside *Management of Health and Safety at Work Regulations 1999*. Where a generic risk assessment indicates risks associated with the handling of people or loads, then the requirements of the *Manual Handling Operations Regulations 1992* will apply.

The term 'manual handling operations' is defined in the regulations as 'any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or by bodily force' (Great Britain, Parliament 1992, Section 2). Manual handling also involves the need to 'support' or 'steady' a load in one position by the hands, or other part of the body. For example, the use of a hoist to lift a person can still be considered a 'manual handling operation'. Whilst the hoist may lift and lower the person, the handler is still required to push, pull and manoeuvre the hoist. An occupational therapist who is required to hold and support a person's limb whilst making and fitting an orthosis is also performing a manual handling operation.

There are many examples of operations (tasks) where occupational therapy personnel are required to support objects or people for a period of time, and the effects of such sustained postures should not be overlooked when considering the risks from manual handling.

It is important to note that the *Manual Handling Operations Regulations 1992* neither require nor advocate a definitive 'no lifting' standpoint. The regulations (specifically Regulation 4) establish a clear hierarchy of measures to follow:

a) AVOID hazardous manual handling operations so far as is reasonably practicable.
b) Make a suitable and sufficient ASSESSMENT of any hazardous manual handling operations that cannot be avoided.
c) REDUCE the risk of injury so far as is reasonably practicable.

To this could be added a fourth step:
d) RE-ASSESS as required.

The Health and Safety Executive guidance, *Manual handling: manual handling operations regulations 1992 (as amended). Guidance on regulations (L23)* as mentioned in Section 1.1, does not have the force of the law, but provides persuasive argument in civil claims and also offers interpretation of the legislation. If an organisation fails to demonstrate that it is complying with the guidance, it is likely to leave itself open to claims of negligence.

1.5 Duty of care and negligence

The law recognises that a duty of care exists where one person can reasonably foresee that his or her actions or omissions could cause harm to another person (Dimond 1997). Hence a duty of care will always exist between an occupational therapist and the service user, and also others who may be affected by his/her acts or omissions, including carers, colleagues, assistants and volunteers.

Unlike the health and safety legislation previously discussed, which comes under criminal law, situations and claims of negligence concerning duty of care come under civil or common law. If a claim were to arise, then the plaintiff would have to show that:

1. the defendant (the occupational therapist) owed a duty of care;
2. the defendant was in breech of that duty; and that
3. the breech of duty caused harm to the plaintiff which was reasonably foreseeable.

In order to determine whether there was a breech of the duty owed to the service user by the occupational therapist, the required 'standard' would have to be established. A well-known test used by courts is the 'Bolam Test' (Bolam v Friern Hospital Management Committee 1957 cited in Mandelstam 2002). This test is applied to ascertain whether the defendant was acting in the manner of an 'ordinary skilled man exercising and professing to have that special skill'. An occupational therapist in a negligence case would be judged according to what would be seen as reasonable and ordinary competence in terms of occupational therapy knowledge, skills and experience.

If an employee was acting in the course of employment and was found to be negligent, it is unlikely that he/she would be sued personally since the employer would be vicariously liable for his/her actions. A recent negligence case involved an occupational therapy assistant who suffered a back injury when helping a physiotherapist to walk an overweight service user in a day hospital. The policy of the physiotherapy department was to keep the service user mobile for as long as possible. The court found the Trust vicariously liable. The case is a notable one in the judicial attempt to try to identify the balance between staff safety and service user need, in terms of what constituted an acceptable risk to staff (Mandelstam 2005).

Independent practitioners would have to accept personal liability for their own actions, hence the importance of private practitioners ensuring that they have arranged proper professional liability insurance.

2 Risk management in manual handling

2.1 Avoiding risk completely

A general assessment carried out under the *Management of Health and Safety at Work Regulations 1999* may indicate some risk of injury from manual handling. As in any risk management situation, the occupational therapist needs to consider whether the hazardous situation, the manual handling task/s, can be avoided, without compromising the desired outcome of intervention.

The Chartered Society of Physiotherapy (CSP 2002) suggests that, in relation to the manual handling of people, the 'utility of the act' (the potential benefit of the manual handling of the person) is vital in considering whether the complete avoidance of manual handling is reasonable or practicable. Like physiotherapy, occupational therapy is a profession concerned with the rehabilitation of the person during intervention, where manual handling may be a core element of that intervention. Discarding a 'hands on' approach may reduce the effectiveness, value or benefit of the intervention, and have a detrimental effect on the rights and personal choices of the service users.

Avoidance of lifting in its totality is not advocated by the previously mentioned regulations or the Health and Safety Executive's guidance on the manual handling regulations (HSE 2004). Instead, avoidance is advised only if 'reasonably practicable'.

The HSE guidance on the *Management of Health and Safety at Work Regulations 1999* (HSE 2000) suggests that, due to the conflict between the need to provide the public with an adequate service and the need to maintain the health and safety of the handler, what is reasonably practicable may not be easy to ascertain. Mandelstam (2005) suggests that understanding the term 'reasonably practicable' is crucial in understanding all health and safety at work legislation. He defines the term as an approach that weighs up the level of risk to employees against the cost of doing something about it, in terms of resources, staff, time and effort. Later guidance from the Health and Safety Executive states that 'an employer does not have to take measures to avoid or reduce the risk if they are technically impossible, or if the time, trouble or cost of the measures would be grossly disproportionate to the risk.' What the law requires is for employers to 'look at what the risks are and take sensible measures to tackle them' (HSE 2003, p 2).

Dimond (1997) suggests that in the case of occupational therapy it would be very difficult to remove the risk of injury entirely without reducing service user choice to unacceptable levels.

The College of Occupational Therapists provided a witness statement for the Disability Rights Commission in 2002. At the time the College was aware of some local authority blanket bans on lifting, mainly issued to avoid employee injury and the risks of subsequent litigation. The College clearly stated that it

believes such total bans 'act against the objectives of good rehabilitation and practices that promote the individual's independence.' The College went on to state that blanket policies 'limit the responsibility and ability of professionals to exercise sound professional judgement in arriving at handling regimes that are sensitive to the needs and wishes of individual service users and their family carers' (College of Occupational Therapists 2002, Section 10). Thus, occupational therapists need to seek a balance between maintaining their own safety and the safety of others involved with the rehabilitation needs and personal wishes of the service user and their carers. Of primary importance is the best interest of the individual service user concerned.

2.2 Risk assessment for manual handling

A risk assessment must be done if the occupational therapist, with the service user, agrees that manual handling is required. The legal requirement of undertaking a suitable and sufficient risk assessment is an absolute. Under the current *Manual Handling Operation Regulations 1992* there would be no defence for the lack of an assessment for a manual handling task which needs to be undertaken by employees.

The purpose of a risk assessment is to identify to the employer and the employee/s, or self-employed person, the measures that ought to be taken to reduce the identified risks to the lowest reasonably practicable level.

2.3 The appropriateness of manual handling

Occupational therapists must be aware at all times of the appropriateness, or the perceived appropriateness, of any manual handling of a service user. Consideration must be given to how a service user or their carer will understand and respond to the use of touch, hold and positioning. Discussion and explanation is vital, as are clear instructions and records.

2.4 Generic risk assessment

As already discussed in section 1.3, the *Management of Health and Safety at Work Regulations 1999* require the employer (the manager), to undertake generic risk assessments of any situations at work which may present a risk of injury. Such generic risk assessments may either relate to groups of service users for whom intervention/treatment is provided, or relate to commonly undertaken tasks, such as routine transfers, home visits, carrying equipment in vehicles, etc.

Where a generic risk assessment does not meet the needs of a specific situation or service user, the occupational therapist involved will need to undertake a specific service user assessment. Broadly speaking, a generic risk assessment should record:

- the significant hazards;
- the existing control measures in place; and
- the people who may be affected by those risks.

The Health and Safety Executive guidance on the *Manual Handling Operations Regulations 1992* (HSE 2004) advises that an employer's generic assessment would be considered 'suitable and sufficient' as long as they have considered 'all the types of manual handling operations their employees are required to carry out' (HSE 2004, Section 47(a)). Employers have a legal duty to consult their employees and health and safety representatives on health and safety matters. This is particularly important where the work undertaken is varied, or is peripatetic.

Hignett (2001) established generic 'themes' in order to assist with risk management within an occupational therapy department. Some of the themes decided upon by the occupational therapy team were:

- service user handling
- equipment loans
- storage of equipment
- changing rooms
- occupational therapy department access and room layout
- equipment in the community (delivery and fitting)
- moving equipment in and out of cars
- undertaking home visits.

The HSE (1998) advise that generic risk assessment is a multi-staged process. A generic risk assessment process and example forms are given in Appendix 2.

2.5 Specific manual handling assessments

Occupational therapists need to undertake specific manual handling assessments with the service user to whom they are providing treatment/intervention. Such an assessment should be part of the service user's overall plan of care and should involve the service user and their carers/family where appropriate. As with all intervention, occupational therapists should be able to demonstrate that they have gained the consent of the service user and/or carer to carry out the assessment. The service user/carer's signature can easily be incorporated into the form. In many cases the service user who requires assistance has expert knowledge of their own condition and needs. The role of the occupational therapist should then be one of advocate and advisor. The *College Of Occupational Therapists code of ethics and professional conduct* (COT 2005) Section 2.1, acknowledges a service user's right of refusal and right of choice. It places emphasis on working in partnership to promote the service user's dignity, privacy, safety and social inclusion. All these facets should be adhered to by occupational therapy personnel within any given situation and included within the risk assessment and resolution of manual handling situations. An example risk assessment format for the handling of people is given in Appendix 3. Such an assessment would need to be repeated for any change in the service user's condition or circumstances.

During complex manual handling situations a more detailed risk assessment will be required. The HSE (2004) guidance suggests the ergonomic TILE approach should be used. This incorporates 4 factors: TASK, INDVIDUAL CAPABILITY, LOAD and ENVIRONMENT and is shown in Appendix 1. The use of this approach is recognised by many professional organisations including the Royal College of Nursing (RCN 2003) and the Chartered Society of Physiotherapy (CSP 2002), as well as in national good practice documents such as the 5th Edition of *The guide to handling of people* (Smith 2005).

2.6 Reducing and managing the risks

Simply undertaking manual handling risk assessments will not result in the reduction of injuries associated with the manual handling of loads and people. It is, however, the precursory step in reducing the risk. Risk assessments can form the basis of subsequent departmental procedures and individual people handling protocols.

Appendix 1 of the Health and Safety Executive's guidance on the *Manual handling operations regulations 1992* (HSE 2004) identifies 7 steps that will assist in controlling risks from manual handling:

a) **Understand the issues and commit to action.** This involves the development of policies and departmental procedures to support staff.

b) **Create the right organisational environment.** It is essential to involve all staff during departmental risk assessments, selection of equipment and subsequent reviews. Additionally, the manager should allocate specific responsibilities related to manual handling and ensure the subsequent competence of staff.

c) **Assess the risks from manual handling in the workplace.** This involves doing generic risk assessments and ensuring that staff are competent to undertake individual specific assessments.

d) **Avoid, or where not possible, reduce the risks arising from manual handling.** Ergonomic principles should be applied to work organisation and job design. Using the ergonomic TILE approach will assist in the risk assessment and the identification of appropriate control measures (see Appendix 1). Managers should ensure that control measures have been implemented within a reasonable time frame. This may include the provision of adequate resources such as staffing and equipment, along with adequate funding to facilitate effective longer-term treatment/intervention programmes. The reviewing of such controls is essential.

   The *College of Occupational Therapists code of ethics and professional conduct* (COT 2005) Sections 3.2.6 and 3.2.7 clearly state the need for occupational therapists to make known their views regarding resource and service deficiencies to their manager. Subsequently, the manager has a duty to take appropriate action upon such notification.

e) **Educate, inform and consult with the team.** Managers should ensure that they have educated and informed the staff team with regards to risk assessment and management, so they may play an active part in risk management strategies. The development of skills and knowledge related to manual handling of people takes time, and formal education is greatly helped by experience (including supervision) within the workplace.

It should not be assumed that a qualified occupational therapist will possess all of the skills and knowledge to undertake complex manual handling assessments, or have complex manual handling skills. It is advised that manual handling forms part of continuing professional development (CPD) for all occupational therapy personnel. Occupational therapy team managers should ensure that they comply with the organisation's manual handling policy, allowing staff to undertake foundation training and also regular update training.

Managers and supervisory staff should ensure that all their staff are working safely, minimising any potential risks in manual handling, and not undertaking tasks in a manner that is contrary to the way they have been trained. If unsafe practice occurs, it should be stopped and corrected, with further education for staff if necessary.

f) **Manage manual handling injuries.** Managers should implement and support a system for early reporting of manual handling 'near misses' and injuries, and undertake accident investigations. Individual occupational therapists have a responsibility to report incidents and accidents using their organisation's agreed procedure. Reporting of 'near misses' will alert the manager to potential problems prior to actual injury being sustained. Accident and injury investigations should look at work activities that may have caused, or be linked with, the reported injury. During and/or following any investigation, relevant departments such as occupational health and physiotherapy may need to be informed and involved to assist with early return to work. The Royal College of Nursing and the Health and Safety Executive advise that organisations should have access to a manual handling advisor or a designated 'competent person' for manual handling (RCN 2002, HSE 2004). If such a person is employed within the organisation, then the manager is advised to liaise with this designated person who will be able to assist in detailed investigation of manual handling incidents.

Following the return to work of the injured worker, systems should be in place to ensure his/her safety. Risk assessment should be undertaken and control measures implemented, so as not to exacerbate the injury. An option may be to have a gradual return to work programme.

g) **Monitor risk management programme.** The manager should ensure that they monitor and review the risk management controls and should also ensure that they are up to date with new developments within the field of manual handling, aiming for continuous improvement.

The *Professional standards of occupational therapy practice* (COT 2003) provide safe working practice statements and corresponding service monitoring forms. These can assist managers to ensure that risk management strategies are maintained.

2.7 Recording risk assessments

It is a requirement of *the Management of Health and Safety at Work Regulations 1999*, and the *Manual Handling Operations Regulations 1992*, that the significant findings of any formal risk assessment should be recorded, dated and kept readily accessible to all staff, as long as it remains relevant. The Health and Safety Executive in its guidance and Approved Code of Practice for the *Management of Health and Safety at Work Regulations 1999* state that this should include:

- a record of the preventative and protective measures in place to control the risks;
- what further action, if any, needs to be taken to reduce risk sufficiently; and
- proof that a suitable and sufficient assessment has been made.

The *College of Occupational Therapists code of ethics and professional conduct* (COT 2005), Section 3.3, clearly states that all information related to professional activities should be accurately recorded. Such documentation provides evidence of the clinical reasoning behind devising a specific intervention. A risk assessment of the specific situation will identify how risks can be reduced to all concerned, to the lowest reasonably practicable level. The occupational therapists should also document changes in the person's condition and subsequent modifications to the treatment plan.

There are many formats in which risk assessments for the handling of individual people are recorded. Any assessment format that is used should allow sufficient detail, breaking down manual handling operations into sub-tasks where appropriate. These completed risk assessments should be kept with the individual's care records and retained to provide evidence that may be required in the event of personal injury litigation or medical negligence claims. The service user has the right of access to his/her health records. As the assessment has been done with the service user/carer's consent and has involved them throughout, it is good practice to provide them with a copy of the record for their information.

The Health and Safety Executive guidance on the *Manual Handling Operations Regulations 1992* (HSE 2004) provides examples of risk assessment checklists which can be copied freely, or used in the development of workplace specific assessment formats. Occupational therapists should use a format that best suits their needs and communicates clearly and concisely the risks of undertaking a specific task with a service user. Abbreviations and jargon should be avoided and the language used should be appropriate to any reader, which includes the service user. An example of a risk assessment

format has been included in Appendix 2. This may be adapted to suit the needs of departments if required.

2.8 Sharing assessment information.

Steed *et al* (2000) advise that written care plans and risk assessments should be made available for all staff involved in the care of a person in the community, with the informed consent of the service user. These care plans should include recommendations for the safer handling of a service user. For example, an occupational therapist may undertake a manual handling assessment in an acute hospital environment, prior to the service user's discharge home. Where there will be subsequent involvement of a community-based occupational therapist, the two therapists should communicate with each other and exchange information to allow ease of discharge from the hospital setting, following jointly established guidelines and protocols with regard to service user confidentiality and consent.

The *College of Occupational Therapists code of ethics and professional conduct* (2005) Section 5.3.6 explains that where more than one occupational therapist is involved in the treatment of the same service user, they should liaise with each other, agree who has overall responsibility, agree other areas of responsibility and communicate such agreements to the service user.

Such arrangements relating to documentation and communication should be formalised in interagency joint working policies. This is important to prevent miscommunication that may put service users and/or workers at unnecessary risk of injury. Ideally, such inter-agency working should be supported by joint training programmes, the use of similar risk assessment formats and also agreements on the provision of instruction and training to other care staff.

Further information on record keeping and the sharing of information is available from the College's 2006 publication *Record keeping. College of Occupational Therapists guidance 2'.*

3 Safer Handling Policies

3.1 Safer handling policies defined

The term 'safer handling policy' is currently used to indicate the aim of an organisation to work towards the safest possible solutions in manual handling, via a risk assessment process. When dealing with service users, manual handling can never be considered completely safe, hence the term 'safer'.

Despite the introduction of the manual handling legislation, a survey undertaken for the Royal College of Nursing estimated that 80,000 nurses were still injuring their backs (Gollancz 1996). As a result, the RCN launched a campaign to promote safer handling.

The campaign provided practical information on legislation, risk assessment, policies, procedures and training. Guidance to employers on their responsibility included:

- developing, implementing and communicating a safer handling policy and local codes of practice covering handling in the workplace;
- employing a competent person such as a Back Care Advisor (BCA);
- carrying out formal handling assessments; and
- monitoring policy and codes of practice, and taking action if they were not properly applied.

The guidance *Introducing a safer handling policy* (1996) explains that a safer handling policy is one that might state:
'…the manual lifting of patients is eliminated in all but exceptional or life threatening situations… patients are encouraged to assist in their own transfers and handling aids must be used wherever they can help to reduce risk, if this is not contrary to the patients needs.'

(Royal College of Nursing 1996, page 2)

Some confusion still seems to stem from the phrase 'exceptional or life threatening'. It is vital the policies that continue to use this statement clarify the meaning of the words.

An 'exceptional' situation is one where the particular needs of the service user or situation lead to the use of manual handling as the best management option. For example, a slight, elderly lady who has Alzheimer's and Parkinson's Disease who needs to sit out of bed once a day. An assessment has been done with hoists and slings, but due to her anxiety when having the sling fitted, she bites and hits out at the carers. It is decided that she should be manually lifted in and out of bed once a day, using a variable height bed and lifting blanket. Two members of staff are trained and supported in the lifting method to be used. The care staff are rotated regularly and supervised to ensure the method being used continues to be appropriate.

A 'life-threatening' situation is one where an unavoidable incident or need occurs that requires an immediate response. For example, a person who is

normally mobile and requires only minimal assistance who has a cardiac arrest whilst sitting in the bath. The carers present decide to pull the plug out of the water and manually lift the person out to a site where CPR can be given.

3.2 Safer handling policies in practice

Manual handling, when related to service users, is complex. Whilst organisations may issue guidelines, these need to be adaptable to meet the needs of each situation and the individual service users receiving assistance. The Health and Safety Executive (2001, Section 10), states that the *Manual Handling Operations Regulations 1992* should not be applied arbitrarily to care plans and that the correct approach would be one of proper risk assessment and risk management.

The guidance continues to recommend a balanced approach to ensure that:

- carers are not required to perform tasks that put them and service users at risk unreasonably;
- the service user's personal wishes on mobility assistance are respected wherever possible; and
- the service user's independence and autonomy is supported as fully as possible.

The blanket prohibition of the manual lifting of people may have a direct detrimental effect on the person needing assistance, as well as contravening duties under other legislation, such as the *Disability Discrimination Act 1995*, and the *Human Rights Act 1998*. The aim in service user handling situations is to achieve a balance between the safety of staff and/or carers and the quality of care provided to the individual.

It is also worth reconsidering the original definition of manual handling operations. The definition not only involves the lifting of objects, but is also concerned with aspects such as pushing, pulling and supporting. A policy that is too heavily focused merely on staff not 'lifting' is in danger of placing people at risk by ignoring the other tasks commonly and routinely undertaken.

When discussing a recent judicial review, Mandelstam reported how 'the court stated that blanket 'no lifting' policies would be likely to be unlawful; as would policies that necessarily prohibited lifting a) unless life and limb were at risk or b) if equipment could be used to effect a transfer' (Mandelstam 2005, Page 17).

The College of Occupational Therapists also presented a witness statement in the above case (COT 2002), as described in section 2.1. The College view does not suggest that people who so wish should be manually lifted without regard for their health and safety, or of those caring for them. The *Human Rights Act 1998* does not oblige any employer to provide exactly what a person wants in every case, but to treat people as individuals and in a humane and dignified manner. In reality, some individuals will be too heavy or too severely disabled

to be lifted or moved safely without the use of a hoist or other appropriate equipment. The College statement proposes that, in such circumstances, the implementation of the regulations must give priority to the safeguarding of employees (College of Occupational Therapists 2002, Section 11).

If the family/carers of a service user choose to use manual lifting when a hoist has been recommended, the occupational therapist cannot insist that the family/carers use the equipment, as they are outside of any employment relationship. He/she can only enable the family and carers to be as safe as possible through the provision of advice, guidance and support. The occupational therapist must fully document the input and advice given, recording the outcome of any assessments made, the recommendations given, the conversations held and the choice of the family/carers.

The Chartered Society of Physiotherapy provides a sample moving and handling policy and procedure for an NHS Trust within their *Guidance in manual handling for chartered physiotherapists* (2002). This is available as a PDF document from the CSP web site: www.csp.org.uk (Accessed 11/01/2006).

3.3 Safer handling policies and rehabilitation handling

This section aims to establish what is meant by rehabilitation handling and how the use of rehabilitation/treatment handling is able to co-exist with current legislation, professional guidance and evidence based publications, such as the 5th Edition of *The guide to the handling of people* (Smith 2005).

3.3.1 Rehabilitation handling

The *Manual Handling Operations Regulations 1992* define a manual handling operation as 'transporting or supporting of a load (including lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force' (Great Britain, Parliament 1992, 2(1)).

The Health and Safety Executive guidance on the Regulations defines it further. It states that 'manual handling includes both transporting a load and supporting a load in a static posture. The load may be moved or supported by the hands or any other art of the body, for example, the shoulder ' (Health and Safety Executive 2004, Section 25).

The Chartered Society of Physiotherapy guidelines (CSP 2002) suggest that treatment handling involves 'any force which is applied through the therapist's body to any part of the patient' (Chartered Society of Physiotherapy 2002, page 16).

Lansdale *et al* (1995) suggest that rehabilitation handling is where the individual is encouraged, guided and facilitated to move, in order to regain postural control and selective movement, and to learn functional motor skills. The CSP (2002), cited in Thomas (2005), also defines the aim of rehabilitation handling as encouraging people to move

themselves, or being allowed the opportunity to actively contribute to their own movement.

It is arguable that any manual handling undertaken as part of an occupational therapy intervention programme is done with the intention of improving or maintaining a person's physical state. If this is accepted, then any handling undertaken by an occupational therapist, or by a member of the occupational therapy team, could be considered 'rehabilitation' or 'treatment' handling. Thus, to the definition of manual handling operations may be added guiding, facilitating, assisting, holding and positioning.

For simplicity, the terms rehabilitation handling, treatment handling and therapeutic handling will be used synonymously throughout this section, but the umbrella term used will be rehabilitation handling.

3.3.2 Hazards of rehabilitation handling

There is no published research evidence at this time relating to the direct causes of musculoskeletal injuries to occupational therapists. Cromie *et al* (2000) undertook a study in 1999 of 20% of CSP members (2,283 respondents with a 46% response rate) to investigate work-related musculoskeletal disorders. The results of the study showed a 91% lifetime prevalence of musculoskeletal injuries in physiotherapists, with 1 in 6 therapists leaving the profession as a direct result of a musculoskeletal injury.

Whilst there are significant differences between the types of handling undertaken by the two main therapy professions, there are undeniable similarities. Due to the lack of current research within the field of occupational therapy, practitioners should heed these results when undertaking handling for rehabilitation or treatment purposes. The following 'treatment' handling situations are some examples that may cause practitioners reason for concern (the list is not exhaustive):

- supporting heavy limbs for the measurement and fitting of orthotic devices;
- compromised posture of the therapist whilst supporting, e.g. a child, sitting on the floor or on a trampoline;
- lack of sufficient space for treatment to occur;
- lack of adjustable height surfaces (plinths/chairs) leading to adoption of unfavorable postures, such as stooping and twisting;
- handling/assisting a service user in the community setting with limited space and/or environmental restrictions;
- handling/assisting a service user with their family/ unpaid carers; and
- providing resistance to a service user's limb or body during treatment of high or low tone.

The Health Services Advisory Committee (1998) in *Handling in the health services,* suggests that providing rehabilitation and maintaining

mobility are areas where staff work at a higher risk, as specified by the care or treatment process. The risks in such areas may not only involve manual lifting but also poor posture. The document suggests that techniques used should compliment the use of equipment, rather than act as an alternative method of treatment.

3.3.3 Rehabilitation and the use of equipment

The judicious use of equipment during rehabilitation handling situations is advocated by Ruszala (2001) and Busse (2000). Both studies found that the use of hoists allowed the therapists and carers to undertake rehabilitation, whilst reducing the burden of 'supporting' the person for long periods.

Management should consider financial planning to ensure the provision of appropriate equipment, to reduce any physical strain on their staff. Trials with specific pieces of equipment can often be arranged with various equipment companies. This will ascertain compatibility with potential treatment areas and other existing equipment.

3.3.4 Management considerations

There are also management considerations such as staff rotation, planning of the treatment programme to prevent many 'heavy' or 'dependent' people being seen at the end of the day (or all together), training and education of rehabilitation staff and regular supervision sessions. All of the above control measures should be considered following the undertaking of a detailed generic risk assessment, followed by individual assessments undertaken by each therapist on the specific person to be handled.

The Health Services Advisory Committee place much emphasis on the role of management and sound risk assessment in reducing risks associated with rehabilitation handling:
'If you are a manager responsible for staff who provide rehabilitation services, you should ensure that the rehabilitation programmes minimise the risk to staff or carers as far as possible. Manual handling policies will need to consider these situations, identifying groups of staff involved, the settings in which they take place and the training provision and treatment techniques. These should be considered as part of a risk assessment'.

(Health Services Advisory Committee 1998, Section 120)

When safer handling policies are developed for large organisations, such as NHS Trusts and local authorities, those responsible should consider all types of handling undertaken within the organisation, consulting with all appropriate employees, to reduce the associated risks. Individual departments may also wish to develop, with assistance from the organisation's manual handling/back care advisor, a separate policy looking at rehabilitation handling. Such policies should be in

keeping with the organisation's overall procedures and should consider wider research evidence, such as that provided in the 5th edition of *The guide to the handling of people* (Smith 2005).

A rehabilitation policy may consider the following points:

- the scope of the protocol – what rehabilitation includes;
- risk assessment procedures (generic and specific);
- documentation guidelines;
- the training, education and supervision requirements for staff at all levels;
- where the rehabilitation handling is to take place;
- when the rehabilitation handling takes place;
- who is able to undertake specific rehabilitation tasks; and
- the delegation of tasks to others.

The joint statement issued by the CSP, COT and RCN (1997) suggests that there may be conflicts between safer handling policies and the rehabilitation or maintenance needs of people. If people are to benefit from rehabilitation, then such conflicts need to be resolved by consultation and co-operation at policy and clinical levels. The joint statement suggests that assessment and understanding of the roles of the multi-disciplinary team is key to rehabilitation handling being both effective and safe for all concerned.

4 Delegation and guidance to others

4.1 Delegation and guidance defined

The Chartered Society of Physiotherapy make a useful distinction between delegation and guidance.

- Delegation – 'the entrustment of a (physiotherapy) task to another person, who will perform that task in the place of the treating (physio)therapist.'
- Guidance – 'professional verbal or written input given by the treating (physio)therapist in his/her role as a part of the care team, to the overall rehabilitation and/or management of a patient.'

(Chartered Society of Physiotherapy 2002, page 23)

Considering the role of the occupational therapist, another aspect may be the provision of instructions, possibly on the use of a piece of equipment provided to a person. This will be discussed further in Section 5.3.

4.1.1 Delegation – general principles

The *College of Occupational Therapists code of ethics and professional conduct for occupational therapists* (COT 2005) states that:
'Occupational therapists who delegate treatment or other procedures must be satisfied that the person to whom these are delegated is competent to carry them out. Such persons may include students, support workers or volunteers. In these circumstances, the occupational therapist will retain ultimate responsibility for the client.'

(College of Occupational Therapists 2005, Section 5.2)

It is important to note that occupational therapists, when providing any intervention, owe a duty of care under health and safety law and under common law, to any person or handler with whom they work or to whom they delegate authority. Prior to delegating a manual handling task, the occupational therapist must have assessed the health status, abilities and needs of the service user and must have made a risk assessment. The occupational therapist must aim to reduce the risk of harm or injury occurring to the handlers to the lowest reasonably practicable level. At the same time they should ensure the best possible outcome for the service user receiving treatment. There is no suggestion that this 'balance' is easy to strike.

4.1.2 Delegation within the line management structure

When delegating a manual task to another person within a line management structure, there are a number of considerations. The delegating occupational therapist should:

- ensure the service user has given consent (where possible) for treatment to be provided by another person;
- ensure the person is aware of the service user's condition, specific hazards related to the service user's health and also any contraindications of performing the task, for example, if the task should cause distress to the service user;

- be aware of the person's level of manual handling experience with the service user group;
- take into account the person's individual capability, including physical limitations, in relation to the delegated task;
- observe the person undertaking the delegated task, providing advice during and following the session;
- ensure that all equipment to be used is available and in good working order;
- provide advice on the setting and environmental concerns related directly to the delegated task;
- ensure he/she is available for immediate support and supervision during and following the treatment session (possibly in person or by phone);
- supervise and monitor the person and the service user's progress regularly; and
- ensure that the treatment sessions are recorded fully, with supervision and discussion if necessary.

There are further points to consider when delegating to occupational therapy or work experience students. The supervising occupational therapists should:

- be sure of the student's level of training/education and degree of clinical experience to date;
- ensure the student has received thorough departmental induction, including manual handling induction training from the host organisation. The higher education institution may provide generic manual handling training.

Students on work experience placements, who have no expertise or experience in occupational therapy, cannot be delegated occupational therapy tasks to be performed with service users. They should not be allowed to undertake any service user handling tasks. Their role whilst in the department is one of observation only.

4.1.3 Delegation outside of the line management structure

When delegating manual handling tasks to others outside of the line management structure, such as school support workers, local authority or voluntary staff, the considerations are the same, but with some additions.

It is vital that the delegating occupational therapist is aware of the manual handling policy of the other service or organisation, and the impact of the policy on the activities the other person is being asked to perform. Their line manager or employer should be made fully aware which manual handling task/s are being delegated.

It is important to note that when delegating tasks (or providing guidance) to others, whether within a line management structure or

not, the person is not 'obliged' to undertake the task if:
- they feel that undertaking the task is outside their area of expertise;
- they feel they do not have the physical capability to perform the task; or
- undertaking the task would mean they would contravene their own organisation's working policies.

Occupational therapists are not able to 'dictate' to other professions how a service user must be handled. For example, they cannot insist that a nurse use a manual transfer method to assist with the rehabilitative programme, rather than using a hoist. In such a case, a balance must be reached where rehabilitation is able to progress, even with the use of equipment.

4.1.4 Providing guidance – general principles

An occupational therapist may be asked to provide guidance in a number of different situations:
- to carers of a private agency who are providing care at the request of the local authority;
- to local authority home carers; or
- to a service user's family following an assessment for equipment.

When providing guidance or advice to a team or group of people it is not usually possible for the occupational therapist to know the knowledge, skills and experience of each individual who will handle the service user. Therefore, providing the right level of advice and communicating it to the right people is essential.

4.1.5 Providing guidance to formal/paid carers

Where guidance/advice is being provided by an occupational therapist to formal (paid) carers, such as agency carers or local authority carers, the occupational therapist should:
- be competent to instruct/provide guidance to others on manual handling;
- be aware of local manual handling policies;
- be aware of any generic risk assessments that have been previously undertaken;
- following the manual handling assessment, select the equipment needed and the optimum method for handling, considering the goal/s of intervention and involving the service user and/or family where possible;
- consider the skills, knowledge and level of expertise required to undertake the handling procedure;
- write a simple handling plan (pictorial if more appropriate) to guide staff on the specific method of handling. This may include general safety precautions specific to the individual situation, warnings etc;
- inform the line manager of the care team of the findings of the assessment and your advice regarding the equipment, the best

manual handling method and the required skill level;
- provide detailed guidance to delegated 'supervisor/s' of the care team to pass on to their staff. It would not be considered reasonably practicable to keep re-visiting the situation to guide each and every member of the team;
- be advised when equipment is delivered and the plan is initiated, and ensure that the situation is monitored regularly.

It is important to note that the occupational therapist is NOT responsible for the provision of formal training to care staff, unless this is recognised as part of his/her designated employment role. However, he/she may wish to feed back any training needs identified whilst working with care staff.

According to the *Managament of Health and Safety at Work Regulations 1999*, it is the responsibility of the employer (the agency, local authority, NHS Trust etc) to ensure that, 'in entrusting tasks to his employees, take into account their capabilities as regards health and safety'. Also to '…ensure that his employees are provided with adequate health and safety training' (Great Britain, Parliament 1999, Section 13). The occupational therapist should confirm that all care staff have received formal manual handling training on recruitment and then again on being exposed to any new risks.

When an agency is used to provide care workers, it is vital that the contracting organisation, when considering tenders for services, select an agency that can demonstrate it has complied with its employer duties under health and safety law. Training will be discussed further in Chapter 6.

4.1.6 Providing guidance and instruction to the service user's family or other voluntary (unpaid) carers

There may be times when the service user's family/voluntary carer wish, or need, to carry out manual handling tasks in the home. The service user must give his/her consent to this, if able.

Under the *Carers and Disabled Children Act 2000,* carers have the right to an assessment of their own needs. For the purposes of the Act the term 'carer' includes people (age 16 and over) who may or may not be a relative and who may or may not be living with the person for whom they are caring. The Act excludes from the definition of a carer paid care workers and volunteers from a voluntary organisation. The outcome of a carers' assessment must be taken in to account when considering their involvement in the manual handling of the service user.

It is recognised that some carers are young people. Parental consent should be sought before anyone under the age of 18 is given any

formal guidance or support. It is good practice to carry out a risk assessment specific to the situation, abilities and needs of the young person. Organisations should be aware that staff who provide training or supervision to children as part of their normal duties are in 'registered positions' under the *Criminal Justice and Court Services Act 2000*, and should meet its requirements.

The requirements in this situation are the same as those for providing instructions or guidance to a paid carer, in terms of their own competence. The same considerations, as identified above under delegation and guidance, apply concerning the family member/carer's awareness and ability. They may need greater and continuing support to ensure their confidence and safety, with amendments made to any tasks as required. The occupational therapist must stress to the family member/carer that they should only carry out activities as guided by the practitioner. Also that they should remain within their own abilities, as identified by the carer's assessment and/or the risk assessment. The manual handling task/s should be structured to meet the needs and capabilities of both the service user and the family member/carer, if possible, with instructions made available in a suitable format. The family should be provided with advice regarding their own posture/handling methods to help reduce the risk of any harm. A detailed record must be made of all information and advice given and any interventions carried out involving the family.

If the advice being given by an occupational therapist is within a hospital (acute) setting, the practitioner should, with the agreement of the service user, pass information on to community staff where follow-up may be provided. Such joint working arrangements should be clarified and formalised with joint working policies and procedures between community and health settings.

5 Providing manual handling equipment

5.1 The use of equipment

Following a service user functional assessment or a specific manual handling assessment, occupational therapists from all domains of practice are often involved with the provision of manual handling equipment. Practitioners should be aware of what manual handling equipment is available, the decision-making process involved in prescribing equipment, the provision of instructions to users, and the requirements in current law relating to the servicing and maintenance of equipment.

Mandelstam (2001) suggests that a better understanding of the law related to equipment is a positive step towards greater safety for service users; better professional practice; and greater immunity from potential litigation.

The appropriate use of equipment during manual handling tasks may:

- reduce risks and undue strain both to the handler and service user;
- enable transfers to be undertaken more efficiently, saving the service user's energy for other activities;
- assist in the rehabilitation of service users who would otherwise be too heavy for rehabilitation using manual assistance;
- assist with care being provided in a dignified manner; and
- assist a service user to be independent.

It is important to realise the limitations of providing equipment to assist with manual handling. The provision of a hoist does not eliminate manual handling risks. It may reduce or remove the risk associated with lifting the service user, but it may introduce new hazards associated with the maneuvering of the hoist. In such an instance, the design of the equipment, the layout of the environment and the knowledge and skills of the handler play an important part in reducing risks to a minimum.

5.2 Prescribing equipment

The *College of Occupational Therapists code of ethics and professional conduct* (COT 2005) informs occupational therapists that they should only provide services and use techniques for which they are qualified by education, training and/or experience, and are within their professional competence. Practitioners with little or no knowledge or experience of assessing for and providing manual handling equipment should seek expert advice.

Many occupational therapists may only select equipment from a limited and standardised stock, possibly due to its cost. Whilst it is acknowledged that organisations do not have a 'bottomless purse', this limitation may have a detrimental effect on the choice of equipment from both the practitioner's and the service users' perspective. The experienced therapist should be allowed to use clinical reasoning skills and any available evidence to decide the best equipment on an assessment of need, and not be constrained by what is immediately available.

Service users should be given the opportunity to have considerable input into the selection of equipment and should be given full information on the range of equipment that would meet their needs. The Health and Safety Executive (HSE 2001, Section 50) suggest that where a service user does not want a piece of equipment because it does not suit his or her lifestyle, efforts should be made to find alternative solutions.

Service users may also be able to purchase their own equipment through a direct payment scheme. In some cases the local authority will pay the service user the amount that it would have cost for the basic equipment, and the service user is able to 'top up' the funds to purchase the equipment they would prefer. Direct payments for equipment may also include staged payments for servicing costs, although this may only be for a certain period. The practitioner will need to take into consideration the local policy on direct payments.

When making an assessment for the prescription of equipment, the occupational therapist should ensure that it is comprehensive by using the TILE approach (see Section 2.4). The use of assessment tools such as the Functional Independence Measure (Granger, Hamilton 1987) and the Mobility Gallery (Crumpton *et al* 2005) can also help to establish the service user's functional level and indicate the type of equipment and physical assistance required. When prescribing equipment, occupational therapists need to balance risks of provision against the benefits for individual service users. Any limitations identified by the manufacturer must be adhered to, for example, weight restrictions. The clinical reasoning for the decisions made should be recorded in the service user's records.

5.3 Providing instructions

Occupational therapists will often be required to prescribe equipment that is to be used by others. This requires the occupational therapist to ensure that the people who are expected to use the equipment are competent to do so.

Providing instructions and information on the use of the equipment is crucial in establishing safe working systems. This is specified under the *Health and Safety at Work Act 1974*, the *Manual Handling Operations Regulations 1992,* the *Management of Health and Safety at Work Regulations 1999*, the *Provision and Use of Work Equipment Regulations 1998* and also in the common law of negligence. Failure to provide instructions has resulted in liability, for example Colclough v Staffordshire County Council 1998, cited in Mandelstam (2002).

The Medical Devices Agency bulletin *Medical device and equipment management for hospital and community-based organisations* (1998) considers practical management of equipment provision, provision of instructions, storage, prescribing, maintenance and repair. It advises that 'good clear instructions have a crucial role to play in the safe and effective use of medical devices' (Medical Devices Agency 1998).

Additionally the Medical Devices Agency (1998) advise that all service users and prescribers (professional users) have access to any manufacturers' instructions. They suggest that in some cases the instructions should be adapted to meet the service user's needs. Failure to pass on such information may compromise the service user's safety and also lay the provider open to litigation, specifically under the *Consumer Protection Act 1987* and the common law of negligence.

The provision of written instructions (supported with pictures if appropriate) is also supported by the Health and Safety Executive (HSE 2001, Section 52), who maintain that written instructions help to avoid confusion, especially in the use of hoists and slings. Such instructions can be incorporated into the care plan for reference by any carer. Any written instructions should:

- be clearly and simply phrased and formatted, without unnecessary jargon and/or detail;
- be accompanied by pictures/photographs if appropriate;
- include the contact details of the organisation of the prescribing occupational therapist;
- provided contact details in connection with broken/faulty equipment;
- indicate points of safe use and basic maintenance arrangements; and
- include the manufacturer's instructions.

In some situations occupational therapists have sought to protect themselves by the use of 'disclaimers' that have been signed by the service user. Disclaimers do not stop the occupational therapist from being responsible if there is harm resulting from negligence. For instance, if inadequate guidance or instructions are provided, or if the equipment prescribed is inappropriate.

If an accident occurs, the therapist is unlikely to be held responsible if it can be shown that the he/she has done everything that is reasonably practicable to ensure the safety of the service user and carer/s. For example, that a full risk assessment was made and recorded, that the recommended equipment is appropriate and in good order and that full guidance and instructions were provided, all with the service user/carers involvement. This highlights the importance of accurate and comprehensive record keeping.

5.4 Maintenance of equipment

Equipment such as hoists and slings must be maintained in good working order. The *Provision and Use of Work Equipment Regulations 1998* state that the employer has a duty to maintain equipment for use at work in an efficient state and good working order. The responsibility for maintenance generally lies with the owner of the equipment. When an item of equipment is loaned to a service user, long or short-term, it is the responsibility of the equipment loans service to set up an appropriate system for inspection and maintenance. The maintenance and repair of equipment is controlled by the *Provision and Use of Equipment at Work Regulations 1998* and the *Lifting Operations and Lifting Equipment Regulations 1998*. The Health and Safety Commission have

produced Approved Codes of Practice and guidance on both these regulations (HSC 1998a, HSC 1998b). Which regulation applies to what equipment will depend upon the primary purpose of the equipment and who is to use it.

When a service user privately owns a piece of equipment to be used by a paid carer, the employer of the carer cannot compel the service user to pay for its maintenance. It is up to the service provider to ensure the carer's safety and ensure all equipment is safe to use, possibly discussing with the service user any changes that need to be considered (HSE 2001, Section 53).

5.5 Mixing and matching hoists and slings

There may be an occasion where an occupational therapist is unable to meet a service user's particular needs with standardised hoists and slings. An option may be to use one manufacturer's sling with another manufacturer's hoist. A detailed risk assessment must be made, as this practice may introduce significant risks particularly where the designs of the hoist and sling differ. The occupational therapist must examine his/her reasoning for the choice of equipment, as 'ad hoc' prescriptions of incompatible slings and hoists can lead to accidents and legal liability. It is vital that the occupational therapist documents his/her professional reasons for 'mixing and matching' equipment.

Many companies now design and produce slings that can be attached to another manufacturer's hoists. On occasion, they are able to provide alternative equipment at lower cost than the original manufacturer. The respective manufacturers should be consulted as to the compatibility of the hoist and sling system. In a situation where the hoist manufacturer will not endorse compatibility, the therapist should assess the risk presented by the combination, and make a clinical judgement about whether or not to proceed using different slings to the manufacturer's recommendation. In this scenario a detailed record of the reasoning and the actions will need to be made. Practitioners must follow local policies for equipment provision in such circumstances.

6 Training

6.1 Current legislation and regulations on training

The provision of education and training in manual handling has long been considered an important control measure for the reduction of workplace associated musculoskeletal injuries (National Back Pain Association 1997, Health and Safety Commission 1998, Chartered Society of Physiotherapy 2002, College of Occupational Therapists 1995). However, current evidence suggests that the use of training as a single factorial intervention for risk management has no impact on working practices or injury rates (Hignett *et al* 2003).

The *Health and Safety at Work Act 1974* Section 2, requires employers to provide information, instruction, training and supervision. The *Management of Health and Safety at Work Regulations 1999,* Sections 10 and 13, clearly state that training should be provided (a) on being recruited, and (b) on the worker being exposed to new or increased risks. In addition, training should take place in the employee's working hours and employees are not required to pay for their own training.

The guidance to the *Manual handling operations regulations 1992* (HSE 2004) state that general health and safety training should be supplemented with more specific information and training on manual handling injury risks and prevention. This same document recognises that manual handling training has an important part to play in reducing the risks associated with manual handling, but that it is not a substitute for a safe system of work.

6.2 National guidelines for training

The current guidelines for the provision of manual handling training have been provided by the Chartered Society of Physiotherapy (CSP 2002), the Royal College of Nursing (RCN 2003) and the National Back Exchange (NBE 2002).

Much of the advice recommends that training is workplace specific and, where possible, to be undertaken within the area of work, with the equipment normally used (Hignett *et al* 2005, Royal College of Nursing 2002, Health and Safety Executive 2005). Effective training programmes should start with a baseline analysis of the needs of those carrying out manual handling. The most useful training programmes are those tailored to meet the needs of specific occupational groups (Health and Safety Executive 2005, Health and Safety Advisory Committee 1998, Health and Safety Executive 2001).

Previous guidelines from the Chartered Society of Physiotherapy (CSP 1997) and the 4th Edition of *The Guide to the handling of patients* (National Back Pain Association 1997) have suggested that induction training in the manual handling of service users lasts 3-5 days. The duration of the course is no indicator of the success or the usefulness of the training itself. If the training is generic, i.e. designed to meet the needs of many, the needs of specific occupational groups will not be met. This is not to suggest that there should be no classroom training. However, it could be used to compliment workplace

specific supervision, an element that the Royal College of Nursing reported was seriously lacking and a great cause for concern (RCN 2002).

The Health and Safety Executive does not publish prescriptive guidance on what 'good' manual handling training courses should include, or how long formal training should last. Simply that training should be suitable for the individual, the tasks and the environment involved, and should last long enough to cover all relevant information (HSE 2004). The need to update training on a regular basis is strongly advised.

The All-Wales NHS Manual Handling Advisors Group and the Health and Safety Executive have developed minimum standards for manual handling, which have included suggested training content and duration for the NHS across Wales (All Wales Manual Handling Advisors Group 2003). This suggests that training is a minimum of 2 days, and indicates a trainer to delegate ratio of 1 to 6 for practical sessions. It also provides an outline content for foundation courses. The document is in accordance with guidance issued by the National Back Exchange (2003) relating to trainers' competencies.

In keeping with the aforementioned standards, the outline content suggested for foundation training for occupational therapists may be as follows (the list is not exhaustive):

- current relevant legislation and professional guidelines (including how they effect everyday work practices);
- local policies (including arrangements for therapeutic handling);
- change management;
- risk assessment (generic and specific);
- the importance of the ergonomic approach;
- an awareness of workplace hazards and risks;
- the importance of good back care including static postures and other risk factors of back pain;
- the principles of normal human movement and promotion of service user independence;
- handling strategies for service users with impaired mobility;
- the assessment, prescription and use of manual handling equipment;
- dealing with unpredictable occurrences;
- the safe handling of loads (including the moving of equipment); and
- the use of problem solving scenarios.

6.3 Training others

Occupational therapists who are required to train others, must ensure that they have the necessary skills, knowledge and experience to perform this role. It is the duty of the employer to ensure that their staff have received sufficient formal training to fulfill their employment role.

Occupational therapists who are employed as Back Care (or Manual Handling) Advisors (BCAs and MHAs) must ensure that they attend and satisfactorily complete a course as validated or recognised by the *Interprofessional*

curriculum framework for back care advisors (CSP, COT, RCN, NBE, Ergonomic Society 1997). BCAs are advised to be a member of the National Back Exchange, to attend regular seminars and conferences and to keep up to date with current research, in order to maintain their competency.

Occupational therapists that have delegated 'trainer' tasks, in addition to their role as an occupational therapist, must also ensure they have received the suitable training from their employer. The required competencies can be found in the Royal College of Nursing training guidance (RCN 2003). Such occupational therapists should ensure that they have their additional duties formalised with their line manager and within the organisation's service specifications. In such a role they would be protected from litigation by the employer's vicarious liability. However, should the occupational therapist decide to train people not connected with the workplace or work role, they must ensure that they have their own suitable liability insurance, as their primary employer will not be responsible should litigation arise.

Appendix 1 The TILE approach

FACTOR	CONSIDERATIONS
Task	Does the task involve stooping or twisting; holding the load away from the body; repetitive handling; reaching above the head or to the floor, or considerable carrying distance; excessive pushing or pulling; precise positioning; risk of sudden movement or prolonged posture or physical effort; or handling with another person etc? It may be important to breakdown an overall task, such as 'assisting a person to transfer' into its component sub-tasks, to completely appreciate and recognise the hazards and risks associated with undertaking the overall task.
Individual Capability	Does the handler have the skills, competencies and physical capability to undertake the task? This may refer to the handler's age, gender, health status, anthropometrics, experience, knowledge and training. This is particularly important if tasks are to be delegated to another person (whether employee or informal carer). Occupational therapy personnel should also refer to the *College of Occupational Therapists code of ethics and professional conduct*, which states that they 'shall only provide services and use techniques for which they are qualified by education, training and/or experience', and are 'within their professional competence, relevant to their setting and terms of employment.' (College of Occupational Therapists 2005, Section 5.1) Additionally, where informal carers, such as family members, are to be involved with manual handling (on occasions link-working with formal carers), consideration needs to be given to the family members' capabilities. Also to the information and instruction provided which may enable all involved to work in a safe manner.
Load	This applies either to the object to be moved or to the client being assisted. The use of the word 'load' is in no way used to be derogatory to the service users who we assist. However, it is a term used by the *Manual Handling Operations Regulations 1992* and the HSE guidance to the *Manual Handling Operations Regulations 1992* (HSE 2004). These regulations are not focused specifically towards handling service users, rather towards manual handling across all areas of industry and care. For this reason this term will be used in this section, without forgetting the human factors involved.

	Factors such as the weight of the load, shape, size, resistance to movement, rigidity etc, all effect the level of risk to the handler/s. Additionally, the factors associated with the service user who is to be handled are numerous; such as communication, behaviour, mental state or pain and medical condition. Attention is often focused upon the weight of the person to be handled, but whilst this may play a part in increasing risks to the handler, a service user's functional mobility may play a much more vital role in reducing risks. Occupational therapy personnel may be at risk when handling awkward equipment into and out of their vehicles (a commonly performed task by community and acute care workers). It is vital that they are provided with information (e.g. such as the weight) pertaining to the loads they are expected to handle. The HSE (2004) provide a risk assessment filter related to weight, which may be used to ascertain the need to undertake a more detailed risk assessment of the handling task.
Environment	The environment will often play a determining role in the undertaking of a manual handling task. Such factors include the space constraints, type of flooring, design of the room, the main purpose of the room, the appropriateness of equipment used etc. For the occupational therapist who is peripatetic, or who may work in a person's home, the degree of risk is often increased due to environmental restrictions (compared to the same task undertaken within the controlled environment of the occupational therapy department). Difficulty may often lie with the need to adapt the environment; an issue often raising resistance by the home dweller or the family members. In such instances, a lower risk solution may need to be considered. For example, if a client refuses to have rugs moved to allow the movement of a hoist, then the movement of the hoist by the carers may need to be restricted to help avoid subsequent injury. The employer must consider the previously mentioned 'utility of the act' and balance the risk to employees against the need to undertake certain handling tasks. The decision may be to limit the manual handling tasks undertaken, still considering the needs and outcome for the person requiring assistance.

Appendix 2 Generic risk assessment process and example forms

This risk assessment process has been designed to be use by managers and their teams to assess GENERIC TASKS routinely undertaken within the occupational therapy department.

Step One

a) Identify risks of routinely undertaken tasks using:

- observation;
- team discussions; and
- injury and near miss records.

b) List tasks requiring further assessment using form MH1.

Step Two

Prioritise risks for action (1-25: Low – High) dependent upon the severity and likelihood, using form MH1.

LIKELIHOOD	SEVERITY					RISK LEVEL
	1 Insignifi -cant	2 Minor	3 Moderate	4 Major	5 Catastro -phic	
1 Rare	1	2	3	4	5	Low
2 Unlikely	2	4	6	8	10	Med
3 Possible	3	6	9	12	15	High
4 Likely	4	8	12	16	20	High
5 Almost certain	5	10	15	20	25	High

Step Three

Record assessment of manual handling risks using form MH2.

- Indicate any risk factors present for each task.
- Prioritise the tasks for action.
- Write a priority rating for each task.

Step Four

Control and monitor manual handling risks. Use form MH2 for recording of measures to be taken, for example:

- task redesign, eg modifying object, work process etc;
- mechanical equipment, eg hoists, variable height plinth etc;
- training on method/s or equipment to be used; or
- management, eg staffing, rest breaks, protective equipment.

MH1 Example preliminary record of tasks requiring generic risk assessment

Department: *Occupational Therapy Wheelchair Service*

Assessment Team: *Mary Smith (Team Manager), Jo Bloggs (Senior Occupational Therapist), Doris Jones (Occupational Therapy Assistant)*

LIKELIHOOD	SEVERITY					RISK LEVEL
	1 Insignifi -cant	2 Minor	3 Moderate	4 Major	5 Catastro -phic	
1 Rare	1	2	3	4	5	Low
2 Unlikely	2	4	6	8	10	Med
3 Possible	3	6	9	12	15	High
4 Likely	4	8	12	16	20	High
5 Almost certain	5	10	15	20	25	High

Ref. No.	Manual handling task	Initial assessment date	Priority/ risk level (1-25)	Full assessment needed?	Task assessment date (MH2)	Review date
1A	*Lifting a wheelchair into and out of a car*	*13/06/05*	*9 Medium*	*Yes*	*18/06/05*	*18/06/06*

MH2 Example generic risk assessment format for specific manual handling tasks

Task identified for manual handling assessment:
1A Lifting a wheelchair into and out a car

Date of Assessment: *18/06/05*

Assessment Team: *Jo Bloggs (Senior Occupational Therapist)*
Doris Jones (Occupational Therapy Assistant)

Risk Factors (Hazards) Present:
The following section assists to identify specific hazards present whilst undertaking the identified task. If a hazard exists, then the YES column should be marked, with comments added if required.

TASK Does it involve:	**YES**	**NO**	**COMMENTS**
• holding the person/object away from the body?	✔		*Depends upon type of car and if put into the boot or behind the seat* *No holding away from body if estate car used*
• twisting?		✔	
• stooping?	✔		*Related to type of car used and hold needed on chair*
• reaching upwards?		✔	
• repetitive handling?		✔	
• strenuous pushing?		✔	
• strenuous pulling?		✔	
• long carrying distance?		✔	
• lifting from the floor?	✔		*The grasp needed on the chair requires the hands to be close to the floor level*
• lifting of the floor to high level?		✔	
• more than one person to do the task?		✔	
• the use of specific protective clothing?		✔	
• the use of special equipment?		✔	
• time restrictions?		✔	
• other?			
INDIVIDUAL CAPBILITY Does the task require the handler to have:	**YES**	**NO**	**COMMENTS**
• unusual capability, such as strength?		✔	
• special training or instruction?	✔		*Handler needs to know how to take a wheelchair apart and put back together again*
• special knowledge or skills?		✔	

Does the task pose specific risks to people who:	**YES**	**NO**	**COMMENTS**
• have health problems?	✔		*Related to the need to lift wheelchair from the floor*
• are pregnant, or a new mother?	✔		*Will have difficulty holding the wheelchair close to her body*
LOAD (Person or object) Is the load:	**YES**	**NO**	**COMMENTS**
• heavy?	✔		*Weighs more than HSE guidelines for lifting off the floor*
• an awkward shape/size?	✔		*Particularly self-propelled wheelchairs*
• likely to move unexpectedly?		✔	
• difficult to grasp?	✔		*Due to moveable parts on the wheelchair it is difficult to get a grasp*
• intrinsically harmful		✔	
ENVIRONMENT Is there:	**YES**	**NO**	**COMMENTS**
• obstructed work space?		✔	
• Slippery or hazardous flooring?		✔	
• variations in working/floor levels?		✔	
• extreme hot or cold conditions?		✔	
• a situation of working outdoors?	✔		*Access into the car can be difficult depending on where parking available*
• poor lighting?		✔	
OTHER			

Control measures currently in place:

None. Therapists decide how to lift and move the wheelchair themselves.

LIKELIHOOD	**SEVERITY**					**RISK LEVEL**
	1 Insignifi -cant	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastro -phic**	
1 Rare	**1**	**2**	**3**	**4**	**5**	**Low**
2 Unlikely	**2**	**4**	**6**	**8**	**10**	**Med**
3 Possible	**3**	**6**	**9**	**12**	**15**	**High**
4 Likely	**4**	**8**	**12**	**16**	**20**	**High**
5 Almost certain	**5**	**10**	**15**	**20**	**25**	**High**

9

Assessment of risk considering current control measures

Further control measures required:			
Action required	**Who by**	**By when**	**Date completed**
Provide formal training on the use of wheelchairs	*Manager to liaise with Back Care Advisor to include in foundation manual handling training for OTs*	*21/06/05*	
Advise staff that wheelchair should be dismantled as far as possible prior to lifting and brakes applied	*Jo Bloggs (Senior OT)*	*21/06/05*	
Advise staff to assess their car as to access for a wheelchair	*All staff*	*30/06/05*	
Write protocol for the safe handling of wheelchairs into and out of different cars	*Jo Bloggs (Senior OT)*	*30/06/05*	

LIKELIHOOD	**SEVERITY**					**RISK LEVEL**
	1 Insignifi -cant	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastro -phic**	
1 Rare	**1**	**2**	**3**	**4**	**5**	**Low**
2 Unlikely	**2**	**4**	**6**	**8**	**10**	**Med**
3 Possible	**3**	**6**	**9**	**12**	**15**	**High**
4 Likely	**4**	**8**	**12**	**16**	**20**	**High**
5 Almost certain	**5**	**10**	**15**	**20**	**25**	**High**

Assessment of risk considering additional control measures **3**

Are control measures identified able to be implemented within desired timescale?

(Delete as necessary): YES ~~NO~~

Are short term/interim control measures required to manage levels of risk associated with the undertaking of this task? (Delete as necessary): ~~YES~~ NO			
Action required	**Who by**	**By when**	**Date completed**

Team Manager Signature: *J Bloggs* *Date: 18/06/05*

Appendix 3 Example risk assessment format for the handling of people

Primary Details

Service users name:	Date of birth:
Home address:	Location of assessment:
Name of assessor:	
Reason for assessment:	
Date of assessment:	Present:

Service user personal details

Height (cms):	Weight (Kgs):
Status	**Comments**
Pain	
Muscle tone/contractures	
Skin Condition	
Postural Stability (sitting balance, head control)	
Ability to bear weight in standing	
Ability to walk	
Motivation and behaviour	
Language and communication	
Any attachments, prosthesis etc	
Day and night variation	
Continence	
Religious and cultural considerations	
Other	

Considerations for the handler

Status	YES	NO	Comments
Is special training required? *i.e. in addition to foundation manual handling training*			
Is special equipment and/or clothing required? *i.e. gloves, apron etc*.			
Are special physical characteristics required? *i.e. strength, height etc.*			
Are there specific hazards to those with existing health problems (or pregnancy)?			
Other			

Environmental Considerations

Status	YES	NO	COMMENTS
Are there constraints on posture in the environment/s where handling is to take place? *i.e. space, furniture etc.*			
Is furniture appropriate to allow transfers to be undertaken with ease and in safety? *i.e. access under furniture by hoists etc.*			
Is there adequate space for easy access of equipment to be used? i.e. corridors, thresholds etc.			
Are the floor coverings appropriate to allow ease of movement of equipment? i.e. rugs, thick carpet etc.			
Are there extremes of temperature within the work area? i.e. heat and cold			
Other			

Remedial Action in order of priority

Concern/Difficulty	Action Required	By Whom	By When	Review date
1. *e.g. current height of bed does not allow hoist access*	*Order and deliver 4" bed raisers prior to discharge*	*Therapist's name and title*	*Discharge date*	*Inform community therapist of action (provide with copy of assessment)*
2.				
3.				
4.				
5.				

Signature of assessor: **Date:**

Signature of service user and/or carer: **Date:**

Handling Plan

Name of Service user:	**DOB:**	**Contact Address:**
Height (cms):		**Weight (Kgs):**
Assessor Name/s:		**Date of Assessment:** **Overall Review Date:**
Relevant Background Information:		

Transfer	**Method**	**Equipment and staff**	**Review Date**
Example: Bed to chair	*Service user to be hoisted out of bed to arm chair.* *Sling fitted under service user whilst in lying position and encouraged to roll herself side to side.* *Use flat slide sheets to fit sling if service user complains of pain prior to sling fitting. Fit slide sheets using 'unraveling' method*	*2 staff to assist* *Medium sling supplied and mobile hoist* *Flat slide sheets*	*04/07/05*

Assessor signature: **Date of initial assessment:**

Signature of service user and/or carer: **Date:**

References

All Wales NHS Manual Handling Advisors Group, Health and Safety Executive (2003) *All Wales NHS manual handling training, passport and information scheme.* Swansea: All Wales Manual Handling Advisors Group. (This document was revised in 2005)

Bolam v. Friern Hospital Management Committee 1957 Queens Bench Division. Available at: *http://oxcheps.new.ox.ac.uk/casebook/Resources/BOLAMV_1%20DOC.pdf* (Accessed on 24-01-06)

Busse M (2000) Access to appropriate hoisting equipment can be essential for effective rehabilitation: a case study*. Nursing and Residential Care, 83(7),* 168-173.

Chartered Society of Physiotherapy (2002) *Guidance in manual handling for chartered physiotherapists.* London: CSP.

Chartered Society of Physiotherapy (2001) *Work-Related Strain Injuries (Musculoskeletal Disorders).* (Health and Safety Briefing Pack no 11). London: CSP.

Chartered Society of Physiotherapy (1997) *Moving and handling for chartered physiotherapists.* London: CSP.

Chartered Society of Physiotherapy, College of Occupational Therapists, Royal College of Nursing (1997) *Joint statement on manual handling*. London: CSP, RCN and COT.

Chartered Society of Physiotherapy, College of Occupational Therapists, Royal College of Nursing, National Back Exchange, Ergonomic Society (1997) *The interprofessional curriculum framework for back care advisors*. Revised ed. London: College of Occupational Therapists.

College of Occupational Therapists (2006) *Record keeping. College of Occupational Therapists guidance 2.* London: COT.

College of Occupational Therapists (2005) *College of Occupational Therapists code of ethics and professional conduct.* London: COT.

College of Occupational Therapists (2004) *Definitions and core skills for occupational therapy*. (BAOT/COT Briefing 23). London: COT.

College of Occupational Therapists (2003) *Professional standards for occupational therapy practice*. London: COT.

College of Occupational Therapists (2002) *Witness statement from the College of Occupational Therapists for the Disability Rights Commission*. London: COT.

College of Occupational Therapists (1995) *Manual handling operations regulations 1992 and their application within occupational therapy.* London: COT.

Cromie JE, Robertson VJ, Best MO (2000) Work-related musculoskeletal disorders in physical therapists: prevalence, severity, risks and responses. *Physical Therapy, 80(4),* 336-351.

Crumpton E, Johnson C (2005) Introduction to practical chapters. In: Smith, J ed *The guide to the handling of people*. 5th ed. London: BackCare.

Dimond BC (1997) *Legal aspects of occupational therapy*. Oxford: Blackwell Science. (This document was revised in 2000)

Gollancz D. (1996) *Hazards of nursing. personal injuries at work.* London: Royal College of Nursing.

Great Britain, Parliament (2000) *Carers and Disabled Children Act 2000*. London: Stationery Office.

Great Britain, Parliament (2000) *Criminal Justice and Court Services Act 2000.* London: Stationery Office.

Great Britain, Parliament (1999) *Management of Health and Safety at Work Regulations 1999.* London: Stationery Office.

Great Britain, Parliament (1998) *Lifting Operations and Lifting Equipment Regulations 1998.* London: Stationery Office.

Great Britain, Parliament (1998) *Provision and Use of Work Equipment Regulations 1998.* London: Stationery Office.

Great Britain, Parliament (1998) *Human Rights Act 1998*. London: Stationery Office.

Great Britain, Parliament (1995) *Disability Discrimination Act 1995*. London: HMSO.

Great Britain, Parliament (1992) *Manual Handling Operations Regulations 1992.* London HMSO.

Great Britain, Parliament (1987) *Consumer Protection Act 1987*. London: HMSO.

Great Britain, Parliament (1974) *Health and Safety at Work Act 1974*. London: HMSO.

The Disability Rights Commission (2003) *A&B v East Sussex County Council Case* Available from: http://www.drc-gb.org/thelaw/judgementdetails.asp?id=5 (Accessed 10/01/06)

Health Services Advisory Committee (1998) *Manual handling in the health services*. London: Health and Safety Executive.

Hignett S (2001) Manual handling risk assessments in occupational therapy. *British Journal of Occupational Therapy, 64(2),* 81-86.

Hignett S, Crumpton E, Ruszala S, Alexander P, Fray M, Fletcher B (2003) *Evidence- based patient handling: tasks equipment and interventions*. London: Routledge.

Health and Safety Commission (1998a*) Safe use of lifting equipment: lifting operations and lifting equipment regulations 1998. Approved code of practice*. London: HSE.

Health and Safety Commission (1998b) *Safe use of work equipment: provision and use of equipment at work regulations 1998. Approved code of practice and guidance*. London: HSE.

Health and Safety Executive (2005) *Measuring the effectiveness of competency-based education and training programmes in changing the manual handling behaviour of healthcare staff.* (Research Report 315) London: Health and Safety Executive.

Health and Safety Executive (2004) *Manual handling: manual handling operations regulations 1992 (as amended). Guidance on regulations.* (L23). 3rd ed. London: HSE.

Health and Safety Executive (2003) *Health and safety regulation. A short guide.* London: HSE.

Health and Safety Executive (2001) *Handling homecare: achieving safe, efficient and positive outcomes for care workers and clients.* London: HSE.

Health and Safety Executive (2000) *Management of health and safety at work 1999 regulations. Approved code of practice and guidance*. (L21). London: HSE.

Keith RA, Granger CV, Hamilton BB, Sherwin FS. The functional independence measure: a new tool for rehabilitation. In: Eisenberg MG, Grzesiak RC (ed.). *Advances in clinical rehabilitation* volume 1. New York: Springer-Verlag; 1987. p. 6-18.

Lansdale P, Prosser L, Scurlock L (1995) Addressing the risks of risk assessment. *Physiotherapy, 81(11),* 662-664.

Mandelstam M (2005) Chapter 2 . In: Smith J ed. *The guide to the handling of people*. 5th ed. [BackCare in collaboration with the Royal College of Nursing and the National Back Exchange]. London: BackCare. 15-30.

Mandelstam M (2005) Manual handling in social care: law, practice and balanced decision making. In: Smith, J ed *The Guide to the Handling of People*. 5th ed. London: BackCare.

Mandelstam M (2002) *Manual handling in health and social care: an A-Z of law and practice.* London: Jessica Kingsley.

Mandelstam M (2001) Safe use of disability equipment and manual handling: legal aspects – part 1, disability equipment. *British Journal of Occupational Therapy, 64(1),* 9-16.

Medical Devices Agency (1998) *Medical device and equipment management for hospital and community-based organisations*. (DB9801). London: MDA.

National Back Exchange (2004) *Manual handling standards, interim document for healthcare providers.* Towcester: NBE.

National Back Exchange (2002) *Standards for training guidance*. Towcester: NBE.

National Back Pain Association (1997) *The handling of patients: introducing a safer handling policy*. 4th ed. London: Royal College of Nursing.

Restall M (2005) *Volunteers and the law.* London: Volunteering England.

Royal College of Nursing (2003) *Safer staff, better care: RCN training guidance and competencies*. London: RCN.

Royal College of Nursing (2002) *Survey to investigate NHS trusts compliance with the RCN Safer Patient Handling Policy 1996*. London: RCN.

Royal College of Nursing (1996) *Working well initiative -Introducing a safer handling policy*. London: RCN.
(This document was revised in 2000)

Royal College of Nursing (1981) *The handling of patients: a guide for nurse managers*. London: RCN.

Ruszala S (2001) *An evaluation of equipment to assist person sit-to-stand activities in physiotherapy*. University of Wales, School of Healthcare Studies, MSc.

Smith J ed (2005) *The guide to the handling of people*. 5th ed. [BackCare in collaboration with the Royal College of Nursing and the National Back Exchange]. London: BackCare.

Steed R, Wiltshire S, Cassar S, Field D (2000) Moving and handling: legislation and responsibilities. *British Journal of Therapy and Rehabilitation, 7(9),* 382-386.

Thomas S (2005) Assisted walking. In: Smith, J ed, *The guide to the handling of people*. 5th ed. London: BackCare.

Additional reading

Dimond BC (2004) Legal Aspects of Occupational Therapy. 2nd ed. Oxford: Blackwell Science.

Finnie NR (2000) Handling the Young Child with Cerebral Palsy at Home. 3rd ed. Oxford: Butterworth Heinmann.

Health and Safety Executive (2001) *Getting to grips with manual handling. A short guide*. London: HSE.

Mandelstam M (2005) Disable people, manual handling and human rights*. British Journal of Occupational Therapy, 66(11),* 529-530.

Pheasant S (2003) Ergonomics, Work and Health. Hampshire: Palgrave Macmillan.

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