

Guidance on Manual Handling

in Physiotherapy



THE CHARTERED SOCIETY OF PHYSIOTHERAPY

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process for the revision of the Guidance on Manual
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Statement from Liz Cavan, CSP Chair of Council



I welcome and support this updating of the Chartered Society of Physiotherapy's 2002 Manual Handling Guidance.

Almost all physiotherapy staff are involved in manual and therapeutic handling and it is vital that these potentially hazardous tasks are conducted safely to protect both the patient and the practitioner.

This is a complex area and we have drawn upon the expertise of a wide range of practitioners in the field to produce this guidance. The document demonstrates the career path of a physiotherapist from competent practitioner to expert in manual handling. The service examples included throughout this document demonstrate the ability of the physiotherapist to utilise their problem-solving skills to develop solutions for the individual in any particular setting.

The physiotherapy manual handling specialist is an ideal professional to be employed in both health and social care and industry to support development and implementation of health and safety policies and to educate the workforce in safe handling.

I believe that it will be essential reading for all physiotherapy practitioners and indeed for many other professions.

I extend my thanks to the working group and its Chair, Pat Alexander, on a timely and invaluable document.

Liz Cavan,
Chair of Council
The Chartered Society of Physiotherapy.

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The CSP is grateful for the invaluable contributions, expertise and experience of the Manual Handling Working Group, who gave their time and knowledge and without whom the revision of this document would not have achieved its depth and breadth:

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The development of Chapters 1, 2, 4 and 5 of this revised document was led by four experts in the field of Manual Handling. They are members of the National Back Exchange (NBE), all contributed to the Guide to the Handling of People (RCN/BackCare 5th edition 2005). Chapter 3 was compiled from submissions by Clinical Interest and Occupational Groups of the CSP and a bariatric specialist nurse by invitation.

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Executive Summary of Guidance on Manual Handling in Physiotherapy

Professional and Legal Framework

- Physiotherapists owe a duty of care at common law to their patients, colleagues and employers not to cause harm by their acts and omissions. This includes treatment involving manual handling, delegation of treatment and the provision of manual handling guidance, advice and education
- Health and safety legislation provides a logical framework that can assist the physiotherapist through the process of risk assessment and risk management. Recording the process and the outcome of patient-specific risk assessment is as much a part of the physiotherapist's commitment to patient care as their clinical assessment and treatment records
- Judicial interpretation of the law appears to recognise that it would not be reasonably practicable to eliminate all potentially hazardous work. In considering the reasonable practicability of avoidance, the utility – or potential benefit – of the act (in this case – treatment involving manual handling) is one factor to be considered
- However, the utility of the act alone is not a sufficient rationale to proceed with hazardous manual handling interventions with patients regardless of risk. If manual handling is to take place there is an absolute requirement to assess the risk arising, and to reduce the risk so far as it is reasonably practicable
- Balancing the potential benefits (utility) to patients arising from physiotherapy interventions involving manual handling with the potential risks to themselves, the patient and colleagues is central to physiotherapy practice
- Employers have a duty to provide physiotherapists with a safe system of work and to provide appropriate health and safety-related training to allow them to achieve sufficient competence to meet their professional duty of care to their patients as safely as possible.

Risk Management in Treatment Handling

- When treatment programmes are devised that involve manual handling, physiotherapists must assess that part of their work which is potentially hazardous and reduce the risks so far as is reasonably practicable. This must be recorded
- Staff working in different specialisms

will have differing skills. However, all physiotherapists will need relevant updating in manual handling throughout their career.

- Training must include relevant rehabilitation strategies
- Physiotherapists must not use or condone unsafe systems of work. The use of additional suitably trained staff or equipment may need to be considered
- Treatment goals must be realistic and achievable within available resources, or may need to be reconsidered.

Delegation, Guidance and Advice

- Before acting to influence the handling of a patient by another, the physiotherapist must be clear in their mind whether their intention is to delegate or to offer guidance to assist in the decision-making process.
- All physiotherapists must be insured and working within their professional scope in order to be covered by professional liability insurance
- No profession can dictate to another person how they must handle a patient. However, a physiotherapist may be an ideal person to contribute to the handling plan for a patient
- When undertaking handling, or delegating a handling task, the physiotherapist should ensure they are up-to-date with current good practice. They should be aware that a direct duty of care is owed to the person undertaking a delegated task, and should also consider who has managerial responsibility for that person.

Education and Continuing Professional Development (CPD)

- Undergraduate physiotherapists should experience discrete manual handling training as part of their studies, both within their Higher Education Institution and on therapeutic placement within a problem-solving environment
- Chartered physiotherapists should be aware that their physiotherapeutic skills and knowledge only confer proficiency in manual handling rather than expertise
- Graduate physiotherapists should continue to develop skills, knowledge and experience within manual handling situations as an integral part of their CPD
- All manual handling courses provided to Chartered physiotherapists shall be provided ►

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- ▶ by competent persons and contain certain common core elements.
- Physiotherapy assistants and technical instructors should receive appropriate manual handling training before commencing employment
- All levels of staff should receive regular updates on manual handling from a competent person
- Chartered physiotherapists who accept responsibility for training others in manual handling; for example as Back Care Advisers, must be aware of the higher standard expected of them as a result.



Introduction

Physiotherapists owe a duty of care to their patients, colleagues, employers and themselves not to cause harm. Despite the expertise possessed by many physiotherapists, 67.5 per cent report work-related musculoskeletal disorders, and almost half (48 per cent) of these affect the lower back. 40 per cent of physiotherapists report hand, thumb and wrist problems, with neck problems coming third at 33 per cent.⁽¹⁾ Either physiotherapists are not taking their own advice, or they are putting their patients' progress ahead of their own safety. This is clearly a short-sighted practice, preventing future patients from benefiting from their expertise in treatment.

The Chartered Society of Physiotherapy (CSP) has long considered safer manual handling an essential core skill of the profession. In July 2007, the editor was asked to chair a Steering Group in order to review the 2002 version of the *Guidance in Manual Handling for Chartered Physiotherapists*. A committee of experts in the field was recruited, and the format of the new guidance was decided. The new draft document was placed on interactiveCSP, to allow for further comment from the profession. Following amendment, a consensus conference was held for those with a specific interest, and further in-depth discussion ensured that a robust document was produced for the membership.

This 2008 publication has entirely new additional sections, with the former 1998 and 2002 versions revised to further inform and protect the membership in issues of manual handling. Physiotherapists have traditionally been associated with assisting people to move and teaching others methods of assisting mobility-impaired patients. This revised publication should enable them to practise and delegate safely.

Professional issues are identified, with standards of both professional conduct and practice from the CSP being discussed in Chapter 1. Legislation is shown to require physiotherapists to make assessments of unavoidable potentially hazardous manual handling that occurs as part of their work, and document strategies for reducing risks. Legal tests of competence are explained and set into context in physiotherapy practice.

A simple algorithm is provided in Chapter 2 to guide physiotherapists through more complex treatment handling decisions. Further factors

concerning the patient and person delivering the therapeutic handling will inform this iterative process. Physiotherapists must neither use nor condone unsafe practices. Emphasis is placed on the use of appropriate equipment and suitably trained staff, and the importance of management support is established.

Chapter 3 is an entirely new chapter, containing client/workplace specific information and case studies from the Clinical Interest and Occupational Groups, all of which were requested to contribute. This should provide relevant advice and examples to practitioners in a variety of fields.

Issues around delegating physiotherapy tasks to others, including assistants, support workers and families are discussed in Chapter 4. Clear guidelines are identified for physiotherapists when either asking others to perform physiotherapy tasks, or offering advice to others in the multi-disciplinary team. Although physiotherapists may delegate the carrying out of therapy tasks, they are reminded that they cannot delegate the responsibility for this.

Chapter 5, on education, has far-reaching messages for Higher Education Institutions and those professionals claiming an expertise as manual handling advisors. The author has adapted the Dreyfus model of skill acquisition, to define the physiotherapist novice in manual handling, through to an advanced practitioner. These categories cover undergraduate to graduate physiotherapists and Back Care Advisors from a physiotherapy background, and include technical instructors and assistants. Standards are set for educational programmes and those delivering them, emphasising the need for appropriate continuing professional development for all physiotherapists.

I commend this book to the membership, and all those healthcare professionals with an interest in manual handling. It will hopefully clarify those complex issues around handling in a rehabilitation setting, and contribute to patient safety and staff well-being, allowing for the continuing practice of physiotherapy to the benefit of all. I would like to thank all those whose hard work made this possible.

Pat Alexander

Chair of Manual Handling Steering Group.

The Professional and Legal Framework

1.1 Key Messages

- Physiotherapists owe a duty of care at common law to their patients, colleagues and employers not to cause harm by their acts and omissions. This includes treatment involving manual handling, delegation of treatment and the provision of manual handling guidance, advice and education
- Physiotherapists are regulated by the Health Professions Council (HPC). The HPC, established in 2001, is the statutory regulator that works to protect the health and well-being of patients by holding a register of members of 13 recognised allied health professions. In order to practise under the protected title of physiotherapist CSP members must meet the following HPC standards:
 - Standards of conduct, performance and ethics⁽²⁾
 - Standards of Proficiency for Physiotherapists (SoPP)⁽³⁾
 - Standards for Continuing Professional Development⁽⁴⁾
 - Standards of education and training⁽⁵⁾
- Chartered physiotherapists also have a professional duty to comply with the Chartered Society of Physiotherapy (CSP) Rules of Professional Conduct (RoPC) and Core Standards of Physiotherapy Practice (Core standards).^(6, 7) Physiotherapy assistants and generic health support workers who join the CSP as associate members are similarly bound by the CSP Physiotherapy Assistants Code of Conduct (Assistants Code)⁽⁸⁾
- Health and safety legislation provides a logical framework that can assist the physiotherapist through the process of risk assessment and risk management. Recording the process and the outcome of patient-specific risk assessment is as much a part of the physiotherapist's commitment to patient care as their clinical assessment and treatment records.
- Judicial interpretation of the law appears to recognise that it would not be reasonably practicable to eliminate all potentially hazardous work. In considering the reasonable practicability of avoidance, the utility – or potential benefit – of the act (in this case – treatment involving manual handling) is one factor to be considered.
- However, the utility of the act alone is not a sufficient rationale to proceed with hazardous manual handling interventions with patients regardless of risk. If manual handling is to take place there is an absolute requirement to assess the risk arising, and to reduce the risk so far as it is reasonably practicable
- Employers have a duty to provide physiotherapists with a safe system of work, and to provide appropriate health and safety-related training, including in manual handling, to allow them to achieve sufficient competence to meet their professional duty of care to their patients as safely as possible
- Public bodies must not fetter their discretion by applying any policy so rigidly that no consideration can be given to the individual circumstances of a case, such as by imposing blanket 'no lifting' policies
- Balancing the potential benefits (utility) to patients arising from physiotherapy interventions involving manual handling with the potential risks to themselves, the patient and colleagues, is central to physiotherapy practice.

1.2 Manual Handling in Physiotherapy

The purpose of this introductory chapter is to clarify and set in context the legal, common law and professional duties relating to manual handling within the practice of physiotherapy. In order to do so it is necessary to consider the requirements imposed by health and safety legislation including, but not limited to, the Health and Safety at Work Act (HSWA) 1974⁽⁹⁾, the Management of Health and Safety at Work Regulations (MHSWR) 1999⁽¹⁰⁾ and the Manual Handling Operations Regulations (MHOR) 1992 (as amended).^(11, 12) Also potentially relevant to decision making in respect of the manual handling of people may be the Human Rights Act (1998)⁽¹³⁾, the Disability Discrimination Act (1995)⁽¹⁴⁾, the Mental Capacity Act (2005)⁽¹⁵⁾ (in Scotland, the Adults with Incapacity (Scotland) Act 2000⁽¹⁶⁾), the Children Act (1989, 2004)^(17, 18), the Care Standards Act (2000)⁽¹⁹⁾ and a raft of legislation that relates to Social Care, the NHS and education. Some relevant aspects of common law will be discussed and reference will be made to the CSP Rules of Professional Conduct⁽⁶⁾ and Standards of Physiotherapy Practice,^(7, 20, 21) and the HPC Standards of Proficiency.⁽³⁾

However, in any given set of circumstances, there may be additional relevant legislation that must be considered by the physiotherapist.

The Professional and Legal Framework

1.2.1 A Definition of Physiotherapy

A detailed definition of the evolving profession of physiotherapy is beyond the scope of this document. However, the World Confederation for Physical Therapy defines physiotherapy as a healthcare profession which:

'... provides services to individuals and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan. This includes providing services in circumstances where movement and function are threatened by ageing, injury, disease or environmental factors. Functional movement is central to what it means to be healthy.'

Physical therapy is concerned with identifying and maximising quality of life and movement potential within the spheres of promotion, prevention, treatment/intervention, habilitation and rehabilitation.' ⁽²²⁾

The HPC states that:

'Physiotherapists deal with human function and movement and help people to achieve their full physical potential. They use physical approaches to promote, maintain and restore wellbeing.' ⁽²³⁾

Essentially then, physiotherapy is a profession concerned with rehabilitation and the core skills utilised by physiotherapists in facilitating the rehabilitation process include:

- Manual therapy
- Treatment handling
- Therapeutic exercise
- Electrophysical agents.

Thus interventions/treatment involving manual handling, and the developing of skills in order to carry out such interventions, are essential core elements of physiotherapy practice. In respect of all of the above the physiotherapist must confine themselves to practice in which they have achieved and maintained the relevant competencies, as specified in Rule 1 (Scope of Practice) of the CSP's RoPC.⁽⁶⁾

1.2.2 Health Professions Council Standards

The Health Professions Council is a UK-wide health regulator set up to protect the public. The HPC only registers people who meet its standards for their professional skills, behaviour and health, and will take action against people who do not, including in relation to manual handling.

The HPC has the power to impose Conditions of Practice orders on registrants and can compel a practitioner to address manual handling aspects of their practice where it considers a breach has occurred.

1.2.3 Standards of Physiotherapy Practice

The CSP has stressed the need for standards to be realistic, understandable, measurable and achievable. The revised Core Standards⁽⁷⁾ are focused towards:

- Patient partnership
- Evidence-based assessment and intervention (see Bolitho test at 1.3.4)
- Communication
- Documentation
- Promotion of a safe working/treatment environment
- Continuing Professional Development (CPD).

All of the above have particular relevance to the manual handling of people, and the legal requirements placed upon physiotherapists through occupational health and safety law. However, documentation is the only means by which the physiotherapist can provide tangible evidence of the application of a clinical reasoning process. The records must demonstrate the critical link to show how the clinical and risk assessments, and the reasoning of and communication by the treating physiotherapist lead to agreed goals and the patient's functional performance outcomes.

1.2.4 Service Standards

The CSP Service Standards⁽²¹⁾ have been developed by managers of physiotherapy services across the breadth of public and independent service provision to link the responsibilities of individual physiotherapists with those of organisations providing physiotherapy services. The standards are designed to ensure that individual physiotherapists are supported in carrying out their clinical practice as safely as possible. This is achieved through a process of appropriate risk management, in accordance with up to date national directives and local policies, with clinical governance and education processes in place. Further information on education can be found in Chapter 5.

1.2.5 Rules of Professional Conduct

Rule 1 of RoPC⁽⁶⁾ and of the Physiotherapy Assistants' Code⁽⁸⁾ requires that a physiotherapist and assistant perform only duties which they are safe and competent to deliver. The development >

The Professional and Legal Framework

- of manual handling skills is based not only on knowledge and training but also on relevant and sometimes specific experience. When considering competence and safety in relation to the manual handling of patients, all members must be as realistic and analytically self-critical as they would be in relation to any other aspect of their professional clinical practice. All members are empowered by this rule to say 'no' since it provides a rational basis for not proceeding with any task, including manual handling, which they consider to be beyond their competence or ability to work safely.

Rule 5 of RoPC clearly states the responsibility of the physiotherapist in considering the safety of other personnel in manual handling, addressing the situation by carrying out an appropriate risk assessment and documenting the process.⁽⁶⁾ This is reinforced in Rule 6 of the Assistants Code⁽⁸⁾, which adds that the calculated and assessed risks should be explained to the patient and the assistant, and subsequent activity undertaken by the assistant be supervised by the physiotherapist.

1.2.6 Professional Liability Insurance (PLI)

All fully subscribing CSP members obtain Professional Liability Insurance⁽²⁴⁾ as one of the benefits of membership. Cover extends to the practice of the profession of physiotherapy and to members practising within their own scope of this practice. Cover is also extended to persons acting on the member's behalf for whose acts the member is legally liable.

For employed members, the employer, as part of the employment contract, usually stands vicariously liable for their employee. That is, in the unlikely event of a patient or training delegate alleging negligence on the part of a physiotherapist the suit will be handled by the employer, or solicitors acting on behalf of the employer. Self-employed physiotherapists, or physiotherapists employing other physiotherapists, should contact the CSP as soon as any complaint or claim is received.

1.3 The Legal Framework

1.3.1 Common Law

The English* legal system is a common law system. Over the centuries English judges have unified and developed laws using a system of precedent and established practice in legal cases. Over the last century, statute law has become increasingly important although the

interpretation of statute law remains a matter for the Courts. Their decisions become part of common law, and may set a precedent for future cases.

Statute Law	Common Law
EC Regulations	EC Court rulings
Acts of Parliament/ Statutes	House of Lords – cases on important points of law
Made by: House of Commons Royal Assent House of Lords	Court of Appeal
Statutory Instruments	High Court/Crown Court
Made by relevant ministry Laid before Parliament	Decisions binding on basis of Precedent and hierarchy
Reproduced by kind permission: Legal Aspects of Physiotherapy, Bridgit Dimond; 1999.	

1.3.2 Duty of Care

The common law states that a duty exists where one person (organisation/legal entity) can reasonably foresee that his/her(its) actions and/or omissions could cause reasonably foreseeable harm to another person (organisation/legal entity). In the case of *Donoghue v Stephenson (1932)*⁽²⁵⁾, the House of Lords defined the duty of care owed at common law (i.e. judge-made law) as follows:

'you must take reasonable care to avoid the acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who then in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.'

Thus, a duty of care will generally be considered to exist between a physiotherapist and his/her patient. However, consideration must also be given to how far that duty of care may be extended in terms of the delegation of tasks to various others (see Chapter 4) or in respect of the delivery of programmes of education (see Chapter 5).

* There are some differences between the three common law systems in the United Kingdom (England and Wales, Scotland and Northern Ireland). However, these differences do not affect the principles in this chapter which apply to all physiotherapists practising in the UK.

The Professional and Legal Framework

1.3.3 The Law of Tort

A 'tort' is a civil wrong. Such wrongs include negligence, trespass, nuisance and defamation (libel and slander). The law of torts represents the means whereby those who suffer from the careless acts and omissions of others can obtain compensation, but only where it can be established that the defendant owed the claimant a duty of care. A breach of the duty of care may give rise to a claim for negligence (perhaps the most important tort in modern law, covering medical negligence and personal injury litigation) in civil law. To succeed, a claimant must show that:

1. The defendant owed the claimant a duty of care;
2. The defendant was in breach of that duty. In respect of this point the claimant must show that:
 - a. the risk to which he/she was exposed was reasonably foreseeable; and
 - b. that it would have been reasonably practicable to circumvent the risk;
3. The harm was a direct consequence of the reasonably foreseeable risk.

In summary the key elements in relation to negligence in common law are:

1. Duty.
2. Breach.
3. Causation.
4. Harm.

A physiotherapist, whether carrying out or delegating manual handling, giving advice or guidance about manual handling or delivering training in manual handling, may well owe a duty of care to those affected as a result (See Rule 5 of the RoPC).⁽⁶⁾

1.3.4 Determining the Standard of Care

In many ways the purpose of this publication is to set out the required standard for chartered physiotherapists in relation to manual handling in terms of:

- Competence
- Education/training
- Physiotherapy interventions with patients,
- Delegation
- The giving of advice/guidance
- Risk assessment and risk management
- The establishment and implementation of local protocols.

In order to determine whether there has been a breach of the duty of care it is necessary to establish a relevant standard. In common law the competence of a physiotherapist in relation to any particular aspect of their practice, including manual handling, would be measured against this required standard. The Court has, in the past, laid down the Bolam test (established in 1957 in the case of Bolam v Friern Hospital Management Committee⁽²⁶⁾) as the principle to be followed to determine the required standard:

'...the test is the standard of the ordinary skilled person exercising and professing to have that special skill'.

It is important to note however, that if a physiotherapist professes to have greater than the 'ordinary' skill of a physiotherapist, such as an extended scope practitioner, consultant or expert, then the required standard would be of a different order. Further reference will be made to the Bolam test when considering the MHOR 1992 (as amended).^(11, 12) In the more recent case of Bolitho v City and Hackney Health Authority (1997)⁽²⁷⁾, it was held that, where the Bolam test is applied, the practitioner must demonstrate that the body of professional opinion relied upon to defend a claim has a logical basis and that the professionals advocating its use had considered the relative risks and benefits in order to reach a defensible conclusion. This judgment reinforces the duty on the physiotherapist to adopt evidence-based practice since the above 'tests' would be applied in judging whether a physiotherapist had met their duty of care in any aspect of their practice.

1.3.5 The Health and Safety at Work Act (HSWA) 1974

Occupational health and safety legislation falls within the criminal law, and is enforced by the Health and Safety Executive (HSE). Whereas a breach of a duty of care may give rise to a civil claim for damages under the tort of negligence, a breach of health and safety law may give rise to a criminal prosecution. The HSWA 1974⁽⁹⁾ was intended as the framework legislation upon which future regulatory control could be based and now provides a vehicle through which European Community health and safety initiatives are incorporated into UK law. Section 2 of the HSWA makes it the duty of every employer:

'to ensure, so far as is reasonably practicable, the health, safety and welfare at work of his employees'.

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This duty is extended in Section 3 to persons not employed by them but who may be affected by their activities. An interpretation of the intentions of the HSWA was given by a High Court judge on appeal from an Industrial tribunal (*Canterbury City Council v Howletts and Port Lympne Estates Ltd 1997⁽²⁸⁾*) who held that the Act was not intended to outlaw work activities merely because they were dangerous, rather that its requirements related to the manner in which the work was undertaken. One could argue that if all potentially hazardous work were to be prohibited we would be deprived of firemen, paramedics and, arguably, physiotherapists.

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

The central provision of the MHSWR 1999⁽¹⁰⁾ is Regulation 3:

Every employer shall make a suitable and sufficient assessment of:

- The risks to the health and safety of his employees to which they are exposed while they are at work and
- 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.

The purpose of this general risk assessment process is to identify the measures that need to be taken to comply with the legal duties imposed on an employer with a view to managing risk. Employers also have a duty to implement systems that support staff in managing the coordination of risk control measures through planning, organisation, monitoring and review. Any adequate general risk assessment, taking place under the MHSWR 1999 in a physiotherapy department or in relation to physiotherapy practice, would identify a range of different potential hazards. Where this general assessment indicates the possibility of risks to employees arising from manual handling then the requirements of the MHOR 1992 (as amended)^(11, 12) must be followed.

1.3.7 The Manual Handling Operations Regulations (MHOR) 1992 (as amended)

These regulations^(11, 12) apply to the manual handling of loads by human effort. The human effort may be applied directly to the load, or indirectly for example, by hauling on a rope

or pulling on a lever. Introducing mechanical assistance, such as a mobile hoist, may reduce but not eliminate manual handling since human effort may still be required to move, steady or position the load and/or the hoist. The 2004 Guidance on the Regulations⁽²⁹⁾ 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 part of the body, for example the shoulder. The application of human effort for a purpose other than transporting or supporting a load is not a manual handling operation.'

In the same guidance a load is defined as:

'...a discrete moveable object. This includes, for example, not only packages and boxes but also a patient receiving medical attention....'

It is therefore arguable that, whilst facilitating the movement of a patient, say from sitting to standing, may well fall within the MHOR 1992 (as amended), the physiotherapy treatment of a limb (such as offering resistance to movement), or the practice of mobilisation/manipulation, may not. Nevertheless, any identified risk associated with such activities, including cumulative risk (see Chapter 2), would still have to be managed (under the MHSWR 1999⁽¹⁰⁾).

The MHOR establish a clear hierarchy of measures that an employer must follow to reduce the risks from manual handling. These are:

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

Thus the extent of the employer's duty to avoid manual handling or to reduce the risk of injury is determined by reference to what is 'reasonably practicable'. This duty can be satisfied if the employer can show that the cost of any further preventive steps would be grossly disproportionate to the further benefit from their introduction. This definition fails however to address the manual handling considerations relating to physiotherapy interventions.

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The issue is:

Is it reasonably practicable for the physiotherapy profession to abandon our core skills and our ambitions for patient rehabilitation?

The consensus of the profession is very clearly that it is not. The 2004 Guidance to the MHOR⁽²⁹⁾ now addresses these issues, albeit specifically in relation to the emergency services.

In the recent case of *King v Sussex Ambulance NHS Trust*⁽³⁰⁾, the Court of Appeal rejected an injured ambulance man's appeal, partly on the basis that public service workers sometimes have to work at higher, though not unacceptable, levels of risk. The courts therefore seek to create a balance in which the utility of the task to be performed is one factor to be considered when assessing a task.

As an autonomous profession, we must take the responsibility for setting the standards against which our practice as physiotherapists can be measured, including manual handling decision-making and practice (Bolam and Bolitho tests^(26, 27)).

1.3.8 The Manual Handling Risk Assessment Process

1.3.8.1 Step 1: Avoidance

Any general risk assessment taking place under the MHSWR 1999⁽¹⁰⁾ will or should already have identified the range of hazardous manual handling tasks taking place, or likely to take place, in a particular department/specialist setting. Many of these tasks will not be related directly to patient rehabilitation and every reasonably practicable step must be taken to avoid them. Management systems for the avoidance of hazardous manual handling should be devised and incorporated into a department/profession-specific risk management protocol. It is worth reiterating here that, in relation to the manual handling of people, the utility of the act (the potential benefit of the treatment handling intervention) is an important consideration in deciding the reasonable practicability of avoidance.

1.3.8.2 Step 2: Risk Assessment

On this point the law relating to manual

handling is entirely clear. There is an absolute requirement to assess the risks arising from manual handling operations that cannot reasonably practicably be avoided.

In the health and social care sectors, such risk assessments may be generic[†] (pertaining to groups or classes of routinely undertaken or foreseeable but unavoidable tasks such as routine transfers from wheelchair to treatment table or the transport of certain items of equipment) or, if the generic protocol is not appropriate to a particular patient at a particular time then they may be person-specific.

In arriving at Step 2 the physiotherapist has already taken the decision that it is not reasonably practicable to avoid the manual handling task and has moved on to consider the extent of the risk potentially associated with carrying out the task. For the avoidance of doubt:

- Hazard – something with the potential to cause harm
- Risk – a notional consideration of the likelihood that the hazard will result in harm (to the handler, the person or anyone else associated with the task) and of the severity or extent of that harm.

The 2004 Guidance on the Regulations⁽²⁹⁾ sets out at Schedule 1 the factors to which an employer must have regard when making an assessment of the manual handling operation. These are summarised below, and reproduced in full with permission at Appendix 1 to this document. The risk assessment filter and numerical load guidance for lifting and lowering, carrying, pushing and pulling are reproduced with permission at Appendix 2.

- Task related factors
 - Individual (handler) related factors
 - Load related factors
 - Environment related factors
 - Other factors (do not limit the risk assessment to the ergonomics factors listed above).
- (the acronym TILE is sometimes used as a mnemonic).

- **The Task**

It appears that the words 'task' and 'operation' are intended to have the same meaning within the interpretation of the MHOR. In healthcare, nursing staff may identify a task or operation as something like 'take patient to toilet'. In >

[†] For the avoidance of doubt - in the relevant legislation a general risk assessment will take place to identify a range of hazards and risks under the MHSWR 1999. Under the MHOR 1992 (as amended) a generic risk assessment will draw together common threads from broadly similar manual handling operations.

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- fact, taking a patient to the toilet will involve a series of sub-tasks that will vary depending upon the starting point, that is from a bed/easy chair/dining chair, the end point, that is the type of toilet /commode, the distance, the mode of transfer and so on. In this case the risk arising from each sub-task must be considered separately and a strategy devised. Similarly, in any physiotherapy intervention involving manual handling, each sub-task must also be considered separately, that is assisting a person to initiate a transfer from a high bed may involve an entirely different order of risk compared to assisting the same patient to transfer back to bed from a low bedside chair.

- **The Individual**

The individuals referred to here are the handlers. Thus, in the case of treatment handling, any risk assessment must relate to the skills, competencies and physical capabilities (relating to health status, gender, pregnancy, age, disability, anthropometrics, and so on.) of the person carrying out the task, remembering Rule 1 of the RoPC and the Bolam and Bolitho tests (the physiotherapist's duty of care). This has particular implications in relation to the delegation of tasks to others of varying competence or the giving of advice and guidance (see Chapter 4).

- **The Load**

In the case of treatment handling, the load is the patient. A reference list of load factors relevant to person handling is detailed at Appendix 3.

- **The Environment**

It is evident that environmental factors will impinge upon the manual handling of people, particularly space constraints imposed by the design of rooms or the placing of equipment. When offering guidance or advice physiotherapists must be aware of the environment in which a manual handling operation is to take place. If this is a person's home it may pose an entirely different order of risk compared to the same operation taking place in the controlled environment of a physiotherapy department or hospital ward. More detail on risk assessment in physiotherapy can be found in Chapter 2.

1.3.8.3 Step 3: Risk Management

Risk assessment is not an end in itself. It is the first part of a systematic process that should lead to the reduction of risk insofar as this can be achieved. Risk management strategies or protocols that may be considered in relation to manual handling undertaken by physiotherapists include, but need not be limited to:

- The development of knowledge and skills in person handling and in the use and application of handling aids and equipment, and in the range of equipment available, through education and on-going professional development (see Chapter 5)
- The development of knowledge and skills in ergonomics and the application of ergonomics principles to work organisation and job design, task analysis, user trials (for handling aids/equipment) and the use of posture/force assessment tools that can contribute to the analysis of risk
- Working with manufacturers in the development of handling aids specifically designed to facilitate treatment interventions;
- The provision of adequate resources such as appropriate staffing, equipment and adequate funding to facilitate the effective rehabilitation of patients leading to increasing independence and thereby reducing the need for manual handling interventions in the longer term. Where such resources are not provided, physiotherapists must not implicitly condone unsafe systems of work by 'making do', thus potentially placing themselves, carers and the patient at risk. In all such cases the issues should be documented and line managers advised
- The implementation of generic protocols devised to manage risk arising from broadly similar manual handling operations
- The routine implementation of person-specific risk assessment and risk management protocols following clinical assessment and the setting of realistic clinical goals:
 1. Assess the patient clinically.
 2. Consider realistic clinical goals and functional outcomes in discussion with the patient (patient partnership).
 3. Consider whether the proposed intervention involves hazardous manual handling.
 4. Can the hazardous manual handling operation be reasonably practicably avoided, when taking into consideration the utility of the intervention?

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5. If the operation cannot, is there a generic protocol in place for managing the task-specific risk – and is it suitable for the specific patient and circumstances? If yes – work to agreed protocol.
6. If it is not suitable, there is an absolute requirement to carry out a patient-specific risk assessment relating to the proposed manual handling intervention.
7. Reduce the risk arising from the hazardous manual handling operation so far as is reasonably practicable by:
 - i adapting the technique
 - ii introducing equipment
 - iii seeking advice/assistance of appropriately skilled colleagues.
8. If satisfied that the risks can be sufficiently reduced:
 - i record the risk assessment and risk management protocol
 - ii proceed with the manual handling intervention.
9. If not satisfied that the risks have been sufficiently reduced:
 - i re-evaluate
 - ii consider competence to proceed
 - iii reconsider goals
 - iv seek more expert guidance.

The above is an iterative process, and the risk assessment must be revisited, together with the clinical review. Physiotherapists must also be alert to short-term changes in performance and be sufficiently well trained and experienced (competent) to amend a treatment/risk management plan according to the presenting circumstances.

1.3.9 Documentation

Clinical record keeping is an integral and essential part of physiotherapy treatment, and must provide an effective means of communication between those involved in the provision of care in relation to any individual patient or client. (Standard 10 HPC Standards of Conduct, Performance and Ethics; Rule 2.3 Rules of Professional Conduct; Standards 14 and 15 Core Standards of Physiotherapy Practice and Standard 19 Service Standards)^(2, 6, 7, 21). Documentation is therefore an essential element of the total care provided and a tool that enables physiotherapists to discharge their duty of care and enable them to demonstrate that they have done so.

It is a requirement of the MHSWR^(10, 31) and the MHOR 1992 (as amended)^(11, 12) that the

significant findings of any risk assessment should be recorded, dated and the record be retained and readily accessible, as long as it remains relevant. A system of clinical review and monitoring should ensure that risk assessments are updated as appropriate.

In the case of patient specific risk assessments, these may need to be more detailed, breaking down manual handling operations into sub tasks where appropriate. They should also provide sufficient information for rehabilitation and care to be a seamless continuum and to provide evidence of the assessor's reasoning in devising the risk management plan. Patient specific risk assessment documentation should be retained with the patient's physiotherapy notes. Documentation, including risk assessments, will also be required as evidence in the event of personal injury litigation or medical negligence claims. It is therefore essential that documentation does not fall short of the standard expected of a professional physiotherapist (Bolam and Bolitho Tests).^(26, 27)

An example of a manual handling risk assessment format for treatment interventions is reproduced with permission at Appendix 4 along with guidance on the use of the form.

1.3.10 Compliance with Local Policies

Section 7(a) of the HSWA⁽⁹⁾ imposes a duty on each individual employee to take reasonable care while at work for the health and safety of him/her self and other persons who may be affected by his/her acts or omissions. What is required to discharge this duty may vary dependant upon professional qualification, management level and authority, and the extent of any relevant education/CPD provided by the employer.

Section 7(b) of the HSWA imposes on the employee the duty to cooperate with his/her employer in meeting the duties and requirements placed upon the employer under health and safety legislation. This would include compliance with the employer's (health service, social services, education) health and safety policy, with any manual handling policy that may be in place and with local generic protocols. The government has recognised the importance of rehabilitation and has placed rehabilitation at the centre of their occupational health and Pathways to Work strategies⁽³²⁾ for England, Scotland and Wales. Given the role of physiotherapy in rehabilitation and the >

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- restoration and maintenance of function, it is vital that physiotherapists contribute to the development of local policies and that employers understand the philosophical position of the CSP in relation to manual handling, and their duty to ensure that their physiotherapists are facilitated to develop their professional practice in this field.

1.3.11 The Human Rights Act 1998

The Human Rights Act⁽¹³⁾ incorporated the European Convention on Human Rights⁽³³⁾ into United Kingdom law. Since October 2000, public bodies such as NHS Trusts and local authorities (but not independent care providers) have been under a duty to act compatibly with the Convention rights of patients/service users and of disabled people not to be subjected to the consequences of overly restrictive interpretations of health and safety regulations in a health and social care context. The Act sets out a number of wide ranging 'rights', and in respect of manual handling, the courts have now referred to three in particular. These are:

- Article 2: The right to life
- Article 3: The right not to be subjected to torture or to inhuman treatment or punishment
- Article 8: The right to respect for home, private and family life.

An example could be the blanket imposition of a 'no lifting' policy. Public authorities must therefore be prepared to balance their responsibilities by adopting a more individual approach. Some case examples relating to manual handling are included in Appendix 5.

1.3.12 Disability Discrimination Act 1995

This Act⁽¹⁴⁾ defines disability, by requiring its effects to be substantial, adverse and long lasting or recurring. It requires that people with disabilities are not treated less favourably than others, simply due to their disability, by those providing goods, facilities or services to the public (even if these are free). However, in a booklet from the Minister for Disabled People 1996, it states:

'this Act does not require you to do anything which would endanger the health and safety of any person, including that of a disabled person'⁽³⁴⁾.

Thus the principles of balanced decision making are introduced into the equation.

1.3.13 The Mental Capacity Act 2005 (England and Wales)

The Mental Capacity Act⁽¹⁵⁾ came fully into force on 1 October 2007. It aims to protect people over 16 years of age who cannot make decisions for themselves due to a learning disability or a mental health condition, for example Alzheimer's disease, or for any other reason. It provides clear guidelines for carers and professionals about who can take decisions in which situations. There are five Section 1 principles:

- Assumption of capacity
- Practical help to person to make a decision
- Unwise decisions do not necessarily mean lack of capacity
- Best interests
- Least restrictive interventions.

The principles of Section 1 of the Mental Capacity Act must be applied to manual handling decisions where a person lacks capacity to consent or dissent to the manual handling.

The Act aims to enable people to make their own decisions for as long as they are capable of doing so and makes it possible for people to make an advance decision to refuse treatment should they lack capacity in the future. Treatment is defined in the Act as a 'diagnostic or other procedure'. If manual handling were part of treatment, an advance refusal could be made and, if valid and applicable, would be binding and have to be followed. If it were not part of treatment, such as manual handling involved in the provision of care, then an advance preference would be a mere advance statement (rather than decision) and would have to be taken into account, but not necessarily followed, as part of the best interests decision.

1.3.14 The Adults with Incapacity (Scotland) Act 2000

The Adults with Incapacity (Scotland) Act 2000⁽¹⁶⁾ provides a framework for regulating any interventions in the affairs of adults who have impaired capacity, including in relation to healthcare. The Act recognises that an individual may be legally capable in making some decisions and actions, and not legally capable in making others. Incapacity is not 'an all or nothing' concept, it must be judged in relation to particular decisions.

The Act requires that the capacity of an individual to give consent to a medical treatment

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must be assessed in circumstances where there may be doubt, and a certificate of incapacity issued by a medical practitioner if appropriate in respect of specific interventions. Present and past wishes of the adult should be taken into account (for more information see CSP Information paper PA 65 ⁽³⁵⁾).

1.3.15 Summary

Physiotherapists must work within the legal and professional framework briefly outlined in this chapter. This sometimes involves them in making difficult decisions in respect of patient treatment and care. The law does not seek to prevent practitioners from carrying out the potentially hazardous activities involved in physiotherapy practice, but does require that they are carried out as safely as possible, in line with current evidence-based best practice (the required standard). Physiotherapists must therefore carefully balance the risks and benefits in any patient intervention, and show that they have done so by documenting the process.

Employers also have duties in respect of balanced decision making, and must ensure that staff have the resources to facilitate rehabilitation. Where such resources are not provided, physiotherapists must not implicitly condone unsafe systems of work by 'making do', thus potentially placing themselves, colleagues, carers and the patient at risk.



Risk Management in Treatment Handling

2.1 Key Messages

- Physiotherapists routinely manually handle patients as part of their professional role
- When treatment programmes are devised that involve manual handling, physiotherapists must assess that part of their work which is potentially hazardous and reduce the risks so far as is reasonably practicable. This must be recorded
- Staff working in different specialisms will have differing skills. However, all physiotherapists will need relevant updating in manual handling throughout their career.
- Training must include relevant rehabilitation strategies
- Physiotherapists must not use or condone unsafe systems of work. The use of additional suitably trained staff or equipment may need to be considered
- Treatment goals must be realistic and achievable within available resources, or may need to be reconsidered
- Management must be aware of their responsibility to ensure staff safety is compatible with patient progress, and support staff in negotiations around rehabilitation issues.

This chapter aims to ensure that physiotherapists are enabled to practise their profession. It includes a framework to ensure that rehabilitation handling can be undertaken as safely as possible for the physiotherapist, any person assisting, and the patient. Manual handling tasks undertaken during rehabilitation and treatment can differ significantly from manual handling that takes place as part of a package of care. 'Treatment handling' (see Section 2.3) may also be performed by other members of the healthcare team, but this chapter is only concerned with that which is performed as part of the delivery of physiotherapeutic intervention.

2.2 Musculoskeletal Injuries in Physiotherapists

Standard 1a8 of the HPC SoPP⁽³⁾ states that physiotherapists must understand the importance of maintaining their own health. There is a dubious assumption that, due to their knowledge of biomechanics, the mechanism of spinal injury and ability to treat back pain, physiotherapists are less likely to suffer in this way.⁽³⁶⁾ Various studies have shown that

physiotherapists' perceptions of their training and knowledge lead them to believe that they are immune to injury, and it is only once an injury/episode occurs that they start to think about their own personal safety.^(37, 38) This situation is compounded by the lack of risk assessment undertaken.⁽¹⁾

In fact, studies completed in 2005 showed the reported career prevalence of work-related musculoskeletal disorders among members of the CSP is 67.5 per cent.⁽¹⁾ The top rating job risk factors quoted by respondents as contributive to musculoskeletal injury were:

- Performing the same task over and over
- Working in the same position for long periods
- Treating a large number of patients in one day
- Bending or twisting your back in an awkward way
- Lifting or transferring dependent patients
- Continuing to work when injured or hurt
- Reaching or working away from your body
- Performing manual therapy techniques
- Working in awkward or cramped conditions
- Working near to or at your physical limits.

2.2.1 Key Findings of the Report ⁽¹⁾

- The reported career prevalence of work-related musculoskeletal disorders among members of the CSP is 67.5%
- The lower back (48.8%), neck (33%), upper back (23.4%) and thumbs (23.3%) are the body areas with the highest rates of injury
- 43.2% reported more than one episode of work-related musculoskeletal injury
- The lower back was the body area identified by 44.2% of injured respondents as their most significant or serious injury
- Nearly a third (32%) of injured respondents first experienced their worst injury within five years of graduation
- A greater number of respondents (58.5%) were aged 30 or under when their most significant or most serious injury occurred
- 32.3% of respondents reporting injury took time off sick as a result
- 43.9% of respondents had not had a risk assessment in their current post
- Where risk assessments had been carried out 74% of respondents reported that changes had been made afterwards to reduce risks, with 78.6% saying the changes introduced were adequate to put them at less risk.

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From this it can be seen that manual handling related musculoskeletal injuries are a significant problem for physiotherapy staff – especially in the first years of their career. It can also be seen that where risk management strategies are implemented around the completion of risk assessments, and subsequent action taken to reduce risk, members perceive a reduction in the risks they face.

It should be noted that the highest factor rated by physiotherapists as being contributive to musculoskeletal injuries was the performance of the same task over and over. It is possible that a single manual handling task may not in itself pose a significant risk to the practitioner but performed repeatedly gives rise to a cumulative risk leading to injury. Research has been done into the cumulative risk faced by physiotherapists and a tool is in development that aims to help practitioners to quantify the risk in order to aid the risk management process.⁽³⁹⁾

More information on the personal safety culture and prevalence of work-related musculoskeletal injuries in physiotherapy can be found in the CSP's report 'Work-related musculoskeletal disorders affecting members of the Chartered Society of Physiotherapy'.⁽¹⁾

2.3 Definition of Treatment Handling

The Health and Safety Executive (HSE) in Guidance on Regulations, Manual Handling Operations Regulations 1992 (MHOR)⁽²⁹⁾ define a manual handling operation as:

'transporting or supporting a load (including lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force'.

To the HSE definition may be added guiding, facilitating, manipulating, stretching or providing resistance. Thus any treatment where force is applied through any part of the therapist's body to or from any part of the patient constitutes manual handling. Any manual handling involved in a physiotherapy treatment programme may be defined as treatment handling.

2.4 General Risk Assessments

A general assessment under the Management of Health and Safety at Work Regulations 1992/1999^(10, 31) will identify manual handling that may be potentially hazardous. The requirements of the MHOR 1992 will only apply to those tasks considered to be hazardous or potentially

hazardous (see example below). When the MHOR do apply the hazards may include:

- Assisting patient transfers
- Unpredictable weight bearing
- High force levels
- Providing manual resistance
- Compromised posture of physiotherapist or patient during treatment
- Lack of sufficient height-adjustable plinths
- Insufficient space and equipment for treatment, for example in community settings
- The possible need to handle heavy limbs in awkward positions
- Inadequate equipment for carrying out rehabilitation, such as standing and walking hoists
- Insufficient/inadequate staffing levels
- Time constraints.

2.5 Manual Handling Risk Assessments

2.5.1 Generic Manual Handling Risk Assessments

Generic manual handling assessments may suffice in some situations. However, if any part of the assessment shows that there are risks specific to that manual handling situation, in addition to those in the generic assessment already carried out, then an individual manual handling risk assessment must be made of that operation. This should be an integral part of the patient records.

If patients are able to walk into the outpatient treatment area, sit themselves down and undergo localised treatment, then the risks arising from any manual handling may be negligible, and a manual handling risk assessment would not be required. However, a general assessment of the treatment area should have already identified any other potential hazards under the Management of Health and Safety at Work Regulations (1999).⁽¹⁰⁾

In addition to working in accordance with legislation and professional guidance, physiotherapists need to be aware of government directives in terms of healthcare provision.⁽⁴⁰⁾ These emphasise the increase in healthcare to be provided within community-based settings. Physiotherapists have a key role to play in delivering treatment in community settings, including the patient's home. Working in the community poses additional hazards that may be more difficult to control. Physiotherapists need to be aware of risk assessment and risk reduction strategies to use within community >

Risk Management in Treatment Handling

- settings. If it is not reasonably practicable to avoid the manual handling tasks for the reasons set out in Chapter 1 then the physiotherapist must be prepared to assess the risks of the proposed handling tasks and reduce the risks so found. They must use their skills to the advantage of patients without endangering the patient, themselves or other people.

2.5.2 Individual Manual Handling Risk Assessments

Those patients whose treatment may involve potentially risky manual handling will require an individual manual handling risk assessment (see example below). This should include an assessment of those factors included under TILE (see Section 1.3.8.2).

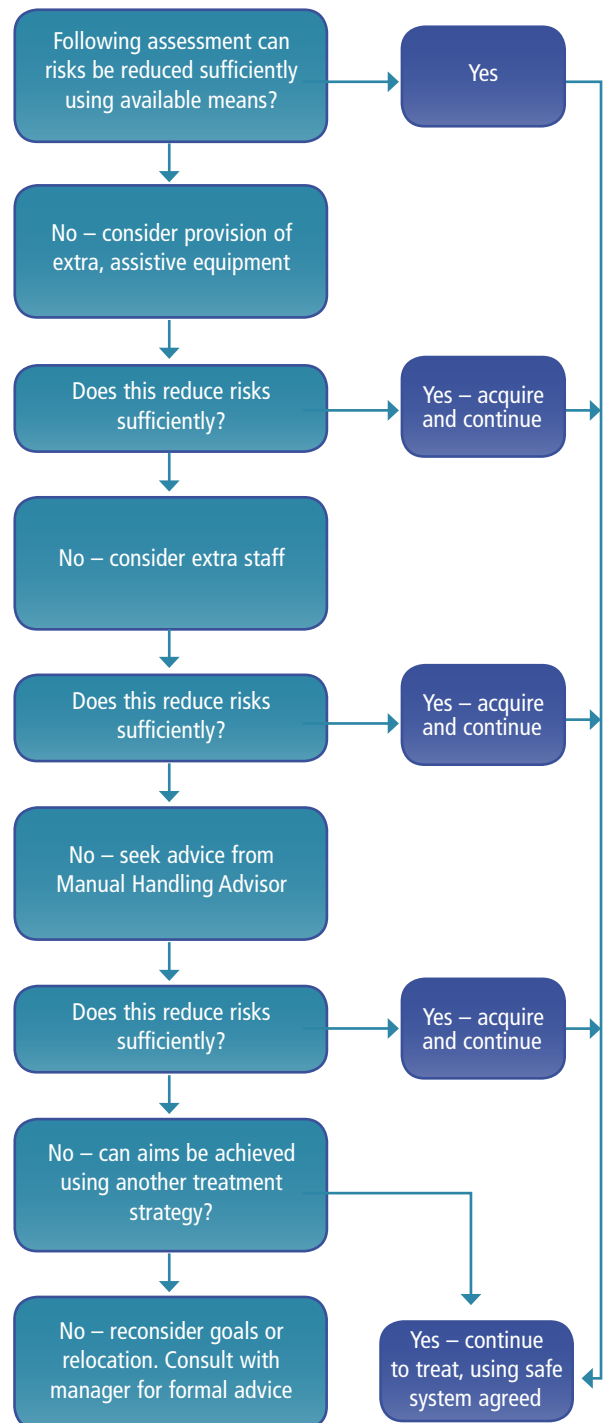
An amputee or stroke patient requiring assistance to transfer will require an in depth assessment of his/her manual handling needs. However, a generic assessment and protocol should still be in place, such as 'how to deal with a falling/fallen patient' (see Section 2.6.3). It is the physiotherapist's responsibility to be familiar with the generic risk assessment for this task in the departmental area involved. Further information as to the risks of handling the particular patient should be recorded as appropriate.

All physiotherapists will need to assess any potentially hazardous manual handling involved in a treatment programme, as stated in the CSP Core Standard 16.1.⁽⁷⁾ A protocol follows that may assist this process.

2.5.3 Patient Specific Assessment Protocol

Physiotherapists must be able to assess the need for potentially hazardous manual handling being performed. If this cannot reasonably practicably be avoided, then there is an absolute requirement to conduct a risk assessment (see Chapter 1). The All Wales Passport on Treatment Handling ⁽⁴¹⁾ gives examples of methods of assessing and reducing the risks of treatment strategies that include manual handling. In Chapter 1 (Section 1.3.8.3) a patient-specific protocol was outlined. Clearly, the risks must be re-assessed with each change in the situation. This may be a short-term change due to patient fatigue, or due to a reduction in ability due to deterioration in condition. Discussion with the patient must inform this process, and the clinical reasoning as well as the agreed strategy must be recorded.

Critical pathway for safer treatment handling in complex, high-risk situations



For those complex situations further guidance may be required. Clinical Interest and Occupational Groups (CI/OGs) provide a forum, through interactiveCSP, where discussions around common manual handling problems in specific fields can be aired. Many produce guidance, based on evidence-based practice where available for example Paediatric Manual Handling APCP 1999,⁽⁴²⁾ All Wales Treatment Handling Group, 2007.⁽⁴¹⁾

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Chapter 3 includes input from the CI/OGs on manual handling risk management in special circumstances and settings.

Alternatively, those relevant healthcare professionals who have experience in evaluating different approaches to safer systems of work should be consulted. This will enable a manual handling risk assessment to identify hazardous situations in all treatment situations. This can also be used to identify manual handling problems for individual patients.

2.5.4 TILE Assessment

The model assessment protocol given above will ensure that physiotherapists are meeting their legal responsibilities under the MHOR. The TILE assessment is based on ergonomic factors as introduced in Chapter 1 but the following information may also inform this process.

2.5.4.1 Individual capability of handler

Obviously, the risks to the person performing the task may differ, depending on the varying physical abilities and skill of the individuals involved. These factors should be covered by the individual capabilities part of the assessment as required by Schedule 1 in MHOR 1992.⁽¹¹⁾ This requires that hypothetical risks to a specific group of people must be recorded, rather than an individual assessment of each worker involved. The skills could be those possessed by different professions, as between nurses, physiotherapists and occupational therapists, or between members of the same profession.

A senior physiotherapist specialising in neurology may possess greater treatment handling skill and experience in this clinical field than a newly qualified physiotherapist or a physiotherapist working in a different specialism. However, neither may necessarily be familiar with the biomechanical issues underlying safer manual handling. Both pre- and post-graduate education must include safer treatment strategies (see example in box below and Chapter 5).

Prior to a placement, students could be taught methods of assisting a patient to sit over the side of the bed by commencing with the backrest raised. As their skill increases, and/or the patient improves, the backrest could be progressively lowered to encourage greater effort from the patient without putting the treating therapist at risk.

The health status and physical ability of physiotherapists will, of course, be relevant to this assessment process, and will include their abilities when returning to work following sickness or childbirth, as well as considering variations in their own physical abilities due to fatigue or ageing. Not only must the treating physiotherapist consider his/her own abilities at this point, but also the abilities of other people to whom he/she may delegate this treatment (see Chapter 4).

Does the task:

- require unusual capability, for example strength or height?
- present a hazard to those with a health problem e.g. previous/current musculoskeletal disorders?
- present a hazard to those who are pregnant?
- call for special information or training, such as knowledge of different paradigms of treatment, or highly specialised handling skills?

2.5.4.2 Patient participation (Load)

Handling patients will impose a load on the handler, as does the handling of inanimate loads. The term 'load', in a patient situation, could be seen as the amount of musculoskeletal stress imposed on the physiotherapist arising from their contact/intervention with a patient.

The aim of the rehabilitation process is to encourage patients to move themselves or be allowed the opportunity to actively contribute to their own movement. Some patients may need equipment, such as slide boards or walking harnesses, to facilitate their progress by being used only as a 'safety net' in case of unpredictable occurrences.

For those patients who are unable to cooperate in their own movement, due to a physical/ learning disability or a mental health problem, multi-disciplinary team discussions should enable safer acceptable strategies to be employed (see Mental Capacity Act 2007⁽⁴³⁾ and the Adults with Incapacity (Scotland) Act 2000⁽¹⁶⁾).

Factors to consider in manual handling of patients are:

- Shape/size/weight of patient
- Physical ability of patient and reasons this may fluctuate
- Clinical diagnosis and prognosis
- Ability/motivation to co-operate

Risk Management in Treatment Handling

- complicating factors, for example pain, shape, skin condition, orthoses/prostheses
- lack of balance or coordination, involuntary movements or spasm
- instability or unpredictable movements
- risk of harm, for example challenging behaviour
- the requirement to wear protective clothing, for example due to infection control measures
- medication
- social, psychological and cultural factors.

2.6 Moving Towards Intervention

2.6.1 Use of Equipment

Having established their rehabilitation/treatment goals, physiotherapists will need to devise a treatment plan. Technical skill can often be complemented by judicious use of appropriate equipment, in order to allow the physiotherapist's skill to be concentrated on those tasks that require their expertise. If the use of equipment can significantly reduce any risks as far as is reasonably practicable and still allow rehabilitation, then the physiotherapist must use the equipment, or alternative methods may need to be devised. The provision of more staff might also be indicated.

This does not mean that a hoist must be used for all transfers. Assessment and treatment should be part of a graded process, requiring less assistance to the patient as the treatment progresses. For example, a patient may require the use of a walking harness at the start of the rehabilitation programme, progressing to assistance from two members of staff and a third pushing a wheelchair behind, to eventually walking unaided. Equally the support offered may need to be increased if the patient deteriorates or is simply fatigued. Shortages of staff should not be allowed to affect staff health and safety, and only those treatments in which the risk has been reduced as far as is reasonably practicable may be permitted to continue.

In many instances, physiotherapists may feel obliged to supply treatment with insufficient resources, but they must not collude in nor condone such unsafe practices (see Standard 18 of the Core Standards.⁽⁷⁾) The lack of staff or equipment must be reported to a line manager, and perhaps the patient referred on to a treatment facility elsewhere, where the required treatment may be provided in safety. The cost/benefit implications of this will enter into the decision-making process, and the solution devised should enable the treatment to

be delivered more safely. These costs will include the need for regular checks and maintenance of equipment, as specified in Provision of Use of Work Equipment at Work Regulations (PUWER) 1998⁽⁴⁴⁾ and, Lifting Operations and Lifting Equipment Regulations (LOLER) 1998.⁽⁴⁵⁾

With an increase in community-based rehabilitation, particularly in the patient's home, it is important to have the appropriate equipment to enable physiotherapists to carry out rehabilitation. Physiotherapists should play an active role in working groups that decide on equipment to be included in Community Equipment Stores. This should consider both long-term equipment requirements, as may be needed for people with long-term conditions, as well as people requiring short-term loan of equipment, for example for patients requiring intermediate care and rehabilitation.

2.6.2 Importance of Documentation

Physiotherapists must record their clinical reasoning, and include a specific manual handling risk assessment where appropriate, when devising a treatment programme. Documentation may be required to support their clinical decision-making to justify their actions to management and even in court, should the need arise.

Any procedures considered to be potentially hazardous, such as assisting a patient to rise, may need to be modified to comply with safer practice, requiring equipment or another person to help (see Standards 8 and 16 of CSP Core Standards)⁽⁷⁾. Such modifications due to changes during treatment will need to be documented after the session. Facilitated/assisted walking should only be performed where the risks to staff and patient have been reduced so far as is reasonably practicable, for example by reducing the possibility of a fall should the patient's legs give way, thus eliminating the risk to the patient and to staff attempting to catch him.

2.6.3 Falling/Fallen Person

Patients with mobility problems may be susceptible to falls at any time. Generic risk assessments and protocols must be in place to deal with such foreseeable occurrences, such as falls and finding patients on the floor⁽⁴⁶⁾. All staff must be aware of these practices and adhere to the safe systems devised⁽⁴⁷⁾.

Additionally physiotherapists have a key role to play in rehabilitation and management of

Risk Management in Treatment Handling

patients who have fallen. Goals may include improving balance and mobility and teaching patients how to get up from the floor. Physiotherapists and supervisors must ensure that they have adequate training and equipment to be able to undertake this treatment in the appropriate treatment settings, for example using backward chaining methods to teach raising from the floor. Consideration should be given to providing patients who remain at a high risk of falls following rehabilitation with appropriate equipment so that they or their carers can safely help them up from the floor using, for example, hoists or electric lifting cushions.

2.7 Management Responsibilities

Under the Manual Handling Operations Regulations (MHOR) 1992⁽¹¹⁾, employers have a responsibility to ensure that manual handling risk assessment and management strategies are in place.

Management of manual handling risk in physiotherapy practice has already been discussed in Chapter 1 (see Section 1.3.8.3) and requires a strategic approach based on the implementation of a structured programme of activities. Appropriate training needs to be provided in both general moving and handling and in more specific rehabilitation handling and equipment selection and its use.

Managers should play an active role in equipment groups. There should be appropriate policies in place to support the role of physiotherapists within rehabilitation. This could take the form of a Rehabilitation Policy.

Many health and social care organisations have Manual Handling policies in place that may be seen as 'Blanket bans' on lifting. These are not acceptable, as the law does not require this, and are also probably unlawful.⁽⁴⁸⁾ Rehabilitation requires skilled management of a degree of risk that is different to care handling. Managers should ensure there are appropriate rehabilitation policies in place to allow physiotherapists to work within their professional role and to use their clinical reasoning.

Line managers must be prepared to support staff who report problems in relation to treatment handling, and assist in devising safer systems of work. When a decision is about to be made to withdraw treatment for safety reasons, line

managers must be involved, and be able to demonstrate the clinical reasoning informing this decision when challenged. Records are an essential part of this process.

Financial planning will be necessary to ensure the provision of appropriate equipment, and hoist access must be considered in all treatment areas. A source of funding such as the Health and Safety budget could be sought. Hoist-accessible plinths must be supplied, and gymnasium and pool areas must have hoist access and sufficient room to allow for safer working positions.

Management must ensure that emergency rescue plans (including patient evacuation and dealing with collapsed patients) include staff safety and include protocols devised, practised and implemented following evaluation.

2.8 Liaison with Equipment Manufacturers

To develop and maintain competency, physiotherapists should be encouraged to visit relevant seminars and exhibitions, and liaise with manufacturers. In this way they will be able to ensure that future research and development addresses staff safety as well as that of patients and that equipment design is appropriate for the task. Training must ensure that physiotherapists are familiar with, and able to use, appropriate equipment to ensure the safety of themselves and others (see Chapter 5).



Special Circumstances and Settings

3.1 Key Messages

- Manual handling risk can vary widely depending on the type of patients involved or the setting in which physiotherapy interventions are being delivered
- A number of CSP Clinical Interest/Occupational Groups have submitted sections for this chapter, focusing on the nature of manual handling risk faced by physiotherapists working in specific areas of practice
- Where possible, case studies have been provided to illustrate the points being made
- Members wishing to access further context-specific information can contact the relevant CI/OG using the contact details provided at the end of each section.

3.2 Manual Handling in Neurological Rehabilitation

3.2.1 Special Considerations

Safe therapeutic handling is an integral part of the management of clients with neurological disability and good handling provides the basis for many neurological rehabilitation interventions. Facilitation of selective, automatic, more normal movement patterns and postures underpin much of the work of the neurological physiotherapist and the safety of both client and therapist is paramount throughout assessment and treatment.

Giving guidance to other professionals, care workers and relatives, which may include therapeutic handling advice, is a routine and essential aspect of physiotherapy in neurology. Physiotherapists should work within national and local manual handling policies. However, in some circumstances it would be appropriate for the physiotherapist to question the validity of local manual handling policies if they are unreasonable and/or to the detriment of the patient.

Factors that may need special consideration in this client group include:

- Variations in tone, for example flaccidity or spasms, which can be influenced by a number of factors including handling
- Cognitive problems, including attention deficit.
- Behavioural problems
- Communication problems, for example, receptive problems and expressive dysphasia
- Variable client ability, for example 'on off' times in patients with Parkinson's disease and

changing presentation in patients with Multiple Sclerosis

- Sensory and proprioceptive problems and reduced mid-line awareness
- Pain and altered sensitivity
- Decreased balance and coordination
- Visual disturbance
- Varying ability over 24 hours, for example fatigue at the end of the day or during the night
- Effects of medication
- Varying capabilities of the patient related to the experience or skill mix of the handler/s
- Post surgery, presence of tracheotomy, chest and other drains, IV lines, ICP bolts and so on
- Traumatic and non-traumatic spinal cord compression and the risk of spinal instability
- Importance of maintaining independence and dignity.

Therapeutic handling and therapy input may optimise rehabilitation, which will influence manual handling advice/choices. Clinical reasoning within risk assessment and changing performance requires regular review of decisions.

3.2.2 Case Study: Neurological Rehabilitation

Manual Handling Case Study – Neurology Specialty:

Community/Neurology

Goal – including reference to Clinical Reasoning

Mrs A wanted to be as independent as possible and did not want a hoist to be used. She felt, and the physiotherapist agreed, that using the hoist would reduce her chances of progressing to be more independent.

Identified risks

Risk of musculoskeletal injury to staff through lifting Mrs A's legs and loss of potential for progress towards increased independence for Mrs A.

Task

Assisting Mrs A to lift her legs into bed.

Handler

Some members of staff reported difficulty in assisting Mrs A's legs on to and off the bed. The care agency manager considered changing the care plan to hoist transfers because she felt that assisting Mrs A to get into and out of bed was a hazardous manual handling operation.

Patient

Mrs A had a stroke causing right-sided weakness

Special Circumstances and Settings

and balance problems. Often her upper trunk rolled backwards as she moved herself into and out of a sitting position. If her upper trunk rolled back the activity became more effortful and high tone became more marked in her affected leg.

Environment

The bed was height adjustable. It had been used in a low position throughout the transfer. Increasing the height of the bed reduced the difficulty for the carers on the occasions they needed to assist Mrs A's legs on to the bed.

Control measures

1. A meeting was arranged with Mrs A, Care Manager, Physiotherapist and the two care staff.
2. The clinical reasons for assisting Mrs A rather than using the hoist were discussed.
3. Demonstration by the physiotherapist followed by observation of the slightly modified way in which the carers could assist Mrs A more easily at the times when Mrs A could not lift her own legs on to or off the bed. The bed was raised and slight assistance was given to prevent the trunk rolling backwards.
4. The physiotherapist prepared a written advice sheet, which included clinical reasons, and cautions.
5. The names of all those present at the meeting were documented and a copy of the written advice sheet was kept in the notes with a brief record of the discussion.
6. A monitoring process was agreed.

Benefits (including details on costs and outcomes)

- Mrs A could improve her strength and independence by lifting her own legs into bed when she was able
- Staff are less likely to be injured when help is required
- The importance of asking Mrs A to try herself first has been highlighted
- No additional cost for equipment is required.

Additional considerations

The hoist may need to be used in certain circumstances including if Mrs A is unwell. The plan will need to be reviewed if Mrs A's ability changes or any person involved experiences difficulties with the task.

New staff must be shown the adapted method by a competent person before they assist Mrs A.

3.2.3 Further Information

More information on physiotherapy in neurology can be obtained from the Association of Chartered Physiotherapists in Neurology (ACPIN) at www.acpin.net/

3.3 Manual Handling in Paediatrics

3.3.1 Special Considerations

Paediatric physiotherapy practice can present many manual handling challenges to those working in this field, due to the nature of the presenting child or the environment in which the physiotherapist works.

The clinical areas covered by paediatric physiotherapists can include those ranging from neo-natal care, orthopaedics, respiratory care, neuro-disability, palliative care, burns, and intensive care among others. The environments in which paediatric physiotherapists work can be equally as varied and include inpatient and outpatient units, special schools and nurseries, mainstream schools, community (homes), hydrotherapy pools, sensory studios, soft play rooms, ball pools and hippotherapy centres.

The ergonomic mismatch of paediatric equipment and in some instances the unfavourable environment, makes this a high-risk specialty to the handler.

It is the responsibility of every practising paediatric physiotherapist to adhere to the legislative framework related to children, that is the Children Act 1989, 2004.⁽¹⁸⁾ This may include manual handling regulations, and the obligation to carry out risk assessments.

Paediatric physiotherapists must also ensure that they adhere to the law regarding consent issues (competency) regarding children when undertaking any treatment intervention, including manual handling tasks, and act as advocates for the child or young person with whom they are working.

Paediatric physiotherapists must have a duty of care to the child and his/her carers and must demonstrate safe handling to all concerned. The therapist must be aware of the differing skills and competencies of those involved with the care of the child or young person, and following a risk assessment, adjust risk management strategies as appropriate to ensure the safety of all concerned at all times. There should be clear >

Special Circumstances and Settings

- clinical justification for the treatment approach, and manual handling procedures, and in some instances this may result in adaptation or modification of the proposed management plan to minimise risks to all those involved.

Many staff will work in Children's services establishments (education and social services). These staff must be aware of the manual handling policy for the area in which they are treating children. They must pay particular regard to this when delegating manual handling tasks to staff not employed by their own agency. The employer of these staff has a duty to undertake full risk assessments and to ensure safe practices are being used, working in partnership with and supported by the visiting physiotherapist.

- Manual handling is integral to paediatric physiotherapy practice
- Manual handling law applies to paediatric practice as much as to those working with adults
- Manual handling considerations should form part of the routine management planning of all children, irrespective of size, age or disability/condition
- If risks have been identified in the proposed therapy intervention, risk assessments should be carried out in accordance with health and safety legislation
- Assessments must be documented and reviewed regularly as the children change
- If delegating tasks, physiotherapists must be aware of their responsibilities and duty of care to others (see Chapter 4)
- Paediatric physiotherapists must ensure when delegating therapeutic tasks to others that carers have been trained and observed carrying out the task. The training and competency is task-specific to a named child and is not transferable to another child
- Delegated tasks must be detailed in the patient's notes and all staff trained in the task must be named and give a signed agreement as to the training they have received. This should be dated and a review date set. Carers should have a contact number for the physiotherapist in case of an emergency
- Physiotherapists must be aware of the effect of cumulative strain on a carer when handling children and young people
- Further information on manual handling for paediatric physiotherapists can be obtained from the ACPD publications officer (see Section 3.3.3).

3.3.2 Case Study: Paediatrics

Manual Handling Case Study – Paediatrics

Specialty:
Paediatrics/Neurology

Goal – including reference to Clinical Reasoning
To assist a child with spastic quadriplegia to walk, maintaining weight-bearing ability. Therapist stands behind child and supports from central point of control, for example pelvis.

Identified risks

- Task** – moderate-prolonged support of load, involves stooping.
- Handler** – moderate risk, may be pulled forwards by child.
- Patient** – moderate, weight-bearing may be unpredictable.
- Environment** – low risk if clear, moderate if cluttered or change in surface level.

Control measures

Handler to sit on mobile stool to improve posture whilst handling. Area to be cleared of clutter. Distance to be walked reduced.

Benefits

Child maintains ability to weight-bear for transfers. Mobile weight-bearing may reduce risk of deformities in spine and hips. May reduce the need for equipment in the home.

Additional considerations

Training for others if this task is delegated.

3.3.3 Further Information

More information on physiotherapy in paediatrics can be obtained from the Association of Paediatric Chartered Physiotherapists (APCP) at www.csp.org.uk/director/groupandnetworks/ciogs/clientgroups/paediatrics.cfm

3.4 Manual Handling in Hydrotherapy

3.4.1 Special Considerations

Working in water is potentially hazardous for both patients⁵ and physiotherapists.⁽⁴⁹⁾ As outlined below, the main manual handling issues are at entry into and exit from the water, and while handling patients and equipment in the water. Risk assessment for all activity in the pool is essential.

⁵ includes students, clients or anybody in the care of a physiotherapist in the hydrotherapy pool.

Special Circumstances and Settings

3.4.1.1 Specific to entry into the water

This is affected by physical principles, that is the upwards force of buoyancy increases as a person is immersed in deeper water. This may have unexpected effects for physiotherapists inexperienced in hydrotherapy, for example, a patient:

- Not confident in descending steps on land will need decreasing manual support as buoyancy increasingly supports their weight
- With osteoporosis will find standing in the water difficult as their legs (made buoyant by osteoporosis) tend to float, thus they need firmer than anticipated handling in the pool.

Risk assessment for all patients must include an understanding of the physical properties of water for example buoyancy, turbulence and hydrostatic pressure.

3.4.1.2 Specific to exit from the water

Examples of potential hazards:

- Transfers, for example from hoist chair to wheelchair may be hazardous as a wet patient will be difficult to support. To reduce this risk patients should not use massage oils or skin creams before treatment
- When using the steps patients (particularly those who have had recent surgery or are overweight) may be defeated as the full force of gravity returns on climbing the steps. This may necessitate extra manual support or evacuation via the hoist.

3.4.1.3 Emergency evacuation

Manual handling is a key issue in safe emergency evacuation from the pool. Pools differ in terms of evacuation equipment, pool design, building design, staff numbers and experience, patient pathology and numbers in the pool at any one time. For this reason each pool must have its own clear evacuation policy bearing in mind the general points below. Emergency evacuation should be regularly practised.

3.4.1.4 Using a hoist

In manual handling terms the safest way to evacuate a patient from the hydrotherapy pool is by a pool hoist. The hoist will have a weight limit. Where the hoist is the evacuation route then all pool users must be less than this weight.

However there are valid reasons for not using a hoist, for example:

- The pool does not have one

- The hoist is unavailable/broken
- The hoist's chair attachment is unsuitable for this injured patient.

In any of the above cases a safe alternative emergency evacuation route must be stated in the pool policy.

3.4.1.5 Using an emergency rescue board

This is an extremely skilled rescue because there are many potential hazards and anybody running a pool session needs training to ensure they are able to evacuate any patient from the pool in an emergency. Buoyancy assists in this evacuation thus, if it is performed competently, it can be a quick and safe method of evacuation.

Emergency rescue boards have a maximum tested weight limit and therapists must be aware of this. Where the board is the evacuation route then all pool users must be less than this weight. Therapists must practise evacuating persons of/near the maximum weight that they are required to evacuate in an emergency.

The safe weight limit will vary depending on a number of factors:

- Pool design, that is the free board^o, the presence of a hand rail at the evacuation point, a narrow pool wall for landing the board, a gap between the wall and the emergency trolley
- Therapy staff, that is the number of staff available both in the pool and at the poolside, their experience in hydrotherapy
- The patients, that is number in the pool, age and ability, pathology, weight, water confidence, level of consciousness (that is a patient may become unconscious as a result of a cardiac arrest in the pool).

For example, if the board is tested to a maximum weight of 150 kg as for the Kiefer board⁽⁵⁰⁾ then:

- It may be safe for a 145 kg unconscious patient to be safely evacuated from a deck level pool by a therapist experienced in hydrotherapy
- It may be unsafe for a conscious, non-water confident, 63 kg patient with acute back pain (or severe osteoporosis or spasticity) to be evacuated from a pool with a free board of 20cm by a newly qualified physiotherapist

^o the height difference between the top of the water and the top of the pool wall or the poolside.

Special Circumstances and Settings

- Individual risk assessment is needed for each patient in each situation.

3.4.2 In the Pool

3.4.2.1 Handling patients

Despite the effects of buoyancy, that is making patients relatively weightless, therapists engaged in 'hands on' techniques with patients will be at risk if:

- They are inexperienced and have not achieved basic competencies as demonstrated in the Hydrotherapy Association of Chartered Physiotherapists (HACP) training matrices⁽⁴⁹⁾ p.16 – 23
- The water is too deep or too shallow. The optimal depth of the water is to the therapist's 11th thoracic vertebrae, that is normally in the region of 1000-1350mm
- The tiles on the pool floor are non-specialist; tiles in a hydrotherapy pool should be non-slip
- Patients are not water confident and panic
- Insufficient poolside support is given, that is no poolside staff member within earshot of the therapist in the pool⁽⁵¹⁾
- Some specialist techniques, for example some Bad Ragaz ring patterns, require expert positioning from the physiotherapist to be performed safely
- Some patients, for example those with complex neurological conditions, require specialist therapeutic handling in the water.

3.4.2.2 Handling equipment

Some hydrotherapy techniques will require therapists to move equipment into and out of the pool, on to and off poolside, for example:

- Aerobic exercise steps
- Pool plinths
- Pool exercise chairs.

This is made harder because equipment:

- Is awkward in shape
- Is large in size and in surface area to move through the resistance of the water
- May need to be moved into and out of the water from shoulder height.

Again therapists must understand the physical properties of water to move equipment safely and risk analysis is essential.

3.4.3 Poolside

Although the handling issues for a poolside fall are as for dry land, extra vigilance is needed because slips are more likely on wet floors. People using sticks and crutches will be particularly at risk and should be accompanied.

3.4.4 Paediatric Hydrotherapy

There are special risks and considerations (in addition to general hydrotherapy) related to working with children in the hydrotherapy environment.

3.4.4.1 Poolside hoists

- Primary school children may be small and may not fit onto standard solid-chair hoists
- Following surgery (especially hip surgery) it may be difficult for patients to achieve a 90° position at the hip and knee so they can sit safely in a solid chair hoist
- It may not be possible to use adult-sized solid chair hoists safely with children who cannot bend their knees
- Many children find the solid plastic chair uncomfortable and are reluctant to use it so parents and carers may continue to lift them in and out of the pool
- Parents and carers get into the habit of lifting children in and out of the pool and continue to do so even after they become too heavy to manage safely
- In swimming lessons children are encouraged to enter the water independently from the poolside but may be unable to manage a safe exit
- A greater range of entry and exit can be supported if a sling hoist or trolley support is available
- Poolside hoists are designed to transfer one person at a time and it is unsafe to use them in any other way.

3.4.4.2 Changing rooms

- Space is often restricted especially when a whole class group is changing before and after swimming
- Plinths are seen as cumbersome and occupying space in school pool changing rooms
- Young people who require assistance may wish to have greater privacy than their peers
- Space for a hoist in the changing room may be restricted.

3.4.4.3 Pool environment

Due to their reduced size some young people may become cold more quickly than adults

Special Circumstances and Settings

getting out of the pool and are at greater risk from falls or injuries. Parents or carers often use flotation aids such as armbands, which are designed for younger children, longer than appropriate due to the absence of knowledge of alternative ways to support older children in the water.

3.4.4.4 Schools

- Pressures of 'timetables' impact on time available for changing before and after swimming
- Training and support for staff varies between schools
- Provision of appropriate equipment varies between schools.

3.4.4.5 Transfers

Unless overhead tracking is used children have to be transferred between their wheelchair and the pool using shower chairs that are designed for adults and are often a poor fit.

3.4.5 Case Study: Paediatric Hydrotherapy

Manual Handling Case Study – Hydrotherapy

Specialty:

Paediatric hydrotherapy

Goal – including reference to Clinical Reasoning

To provide a safe and private changing environment for a powered wheelchair user in a mainstream school.

Identified risks

Task – child B was able to access the pool successfully using a shower chair that attached to a poolside hoist. B was changed in the main boys changing room where there was a fixed height wide plinth at an appropriate height for a wheelchair transfer. The plinth provided sufficient space for B to roll so staff could assist him with dressing, but he was unable to transfer to and from his wheelchair or shower chair without a hoist. Manoeuvring the mobile hoist to get B on and off the plinth was hazardous due to limited space in the changing room.

Patient – B is a 12 year old boy with four-limb-involved cerebral palsy who used a powered wheelchair to get around school. He was unable to assist with transfers and needed a hoist to transfer him to and from the plinth and the shower chair or powered wheelchair. He was able to assist staff with removal of clothing provided he was lying as he could roll to either side. He was unable to assist staff when he was in a chair.

He was unable to sit independently. There was also concern that as he grew older he would become more conscious of being hoisted in front of other children.

Handler – the staff found the 'accessible plinth' was at a fixed height that was too low for them to maintain a safe back posture when assisting B. Since he could not transfer independently it was not a suitable height for him, but was regularly used by a number of other boys with special requirements. Staff felt that the lack of space affected the way they used the mobile hoist as it constrained their posture. Since staff assisted with changing after they had been in the pool they often found bare feet were trapped by the hoist when it moved.

Environment – the changing rooms contained fixed wall seats too narrow for B to sit on and were not designed to be occupied by a wheelchair and hoist. During group sessions the rest of the class had to wait for the girls changing room to empty so they could leave, because the hoist and B's wheelchair blocked the access door. A fire escape was available but only in emergencies.

Control measures

An accessible toilet located in the same complex just beside the entrance to the swimming pool changing rooms was identified as a suitable private space for B to change before and after swimming. A wall mounted adjustable height plinth was fitted which staff could then adjust to the correct height to assist B with changing. Staff of different heights could adjust the plinth to meet their needs. The mobile hoist was used to enable B to be transferred safely to and from the plinth and the shower chair or powered wheelchair. Staffing arrangements were changed to ensure staff assisting B were not in bare feet.

Benefits

- B was pleased that he had more privacy as he was becoming uncomfortable that his peers saw him in the hoist
- Staff were able to provide assistance and to think about their own posture while giving assistance
- The cost of the adjustable plinth was met by the Parent/Staff Association of the school and took all their funds for the year. It would not have been possible within the educational or health budgets to achieve this solution.

Additional considerations

In a couple of years the mobile hoist will become more hazardous and an overhead hoist will be needed.

3.4.6 Further Information

More information on physiotherapy in hydrotherapy can be obtained from the Hydrotherapy Association of Chartered Physiotherapists (HACP) at www.csp.org.uk/director/groupandnetworks/ciogs/skillsgroups/hydrotherapy.cfm

3.5 Manual Handling in Oncology and Palliative Care

3.5.1 Special Considerations

There are many significant factors particularly pertinent to oncology and palliative care which need to be given consideration in preparing manual handling care plans for patients in this client group including:

- Pain – pre-activity breakthrough analgesia may be required (other types of pain, including psychological pain may increase or reduce the safety of a manual handling technique)
- Effects of treatments, fatigue, neutropaenia (infection control risk), poor skin integrity, myopathy associated with chemotherapy, radiotherapy and steroid therapy
- Post-surgery, presence of tracheotomy, drains, IV lines, and so on
- Variable and unpredictable ability – this may be part of the normal diurnal cycle or due to medication, especially night sedation
- Cachexia – issues of comfort, skin integrity, and profound muscle weakness
- Bone secondaries – risk of pathological fractures, spinal instability and cord compression
- Shortness of breath due to lung pathology, anaemia or anxiety exacerbated by activity or disease
- Lower and upper limb and/or pelvic oedema, ascites and lymphodema
- Psychological factors particularly overestimation of ability due to denial of deterioration, unrealistic goals and altered body image and sequelae
- Fluctuations in cognitive ability associated with underlying brain disease or reversible changes in biochemistry (for example hypercalcaemia, infection)
- Importance of independence, particularly among younger patients, and the significance of toileting with dignity

- Irreversibility of the downward trajectory and continual assessment and re-evaluation of ability and ongoing adjustments to techniques and equipment required
- Neurological tumours – brain and spinal, resulting in a wide spectrum of disability, including impaired balance, adverse muscle tone and associated reactions
- If using a hoist – can position in sling be made more comfortable?
- Need to consider – spinal stability, frailty, lower limb oedema, hip replacements, sacral sores or other wounds, pathological fractures, issues of amputation, depending on levels
- It is important to use any assistive device available to reduce effort for patients and carers. These could include riser/recliner chairs, profiling beds, slide boards, stand aids and mobility aids.

One of the main purposes of physiotherapy in a hospice, the community or in any other oncology or palliative care setting is to provide rehabilitation to this client group. ⁽⁵²⁾ This involves a detailed assessment of the patient's goals and expectations. Many hospice policies acknowledge the uniqueness of every patient's fundamental approach to life and death, fostering independence for patients through the provision of appropriate rehabilitation services and skilled multi-disciplinary teamwork.

In modern healthcare, most professionals would claim to assess patients holistically, but in palliative care this underpins the rationale for the development of this particular specialism. The physical, emotional, social and psychological aspects of care must be addressed in a person-centred approach.

Safe manual handling is a foundation of quality care, as some element is involved in most tasks.

'Safer handling often adds to the quality of care a patient receives. Encouraging self-help stimulates patients physically and mentally, it reduces side effects associated with immobility and contributes towards their rehabilitation.' ⁽⁵³⁾

3.5.2 Further Information

More information on physiotherapy in oncology and palliative care can be obtained from the Association for Chartered Physiotherapists in Oncology and Palliative Care (ACPOPC) at www.acpopc.org.uk

Special Circumstances and Settings

3.6 Manual Handling in Learning Disabilities

3.6.1 Special Considerations

People with learning disabilities are among the most vulnerable and socially excluded in our society. Many people with learning disabilities have greater health needs than the rest of the population. They are more likely to experience mental illness and are more prone to chronic health problems, epilepsy and physical and sensory disabilities.⁽⁵⁴⁾ As a result of this, people with learning disabilities can often present difficulties for the physiotherapist when being moved or handled.

Physiotherapists can work with people with learning disabilities in a large number of environments, including private homes, day centres, community facilities, hydrotherapy pools and hospitals with the attendant problems caused when these environments are not appropriately adapted for people with disabilities.

People with learning disabilities can also present with challenging behaviours that can increase the already complex nature of the handling situation. The Mental Capacity Act 2005⁽¹⁵⁾ and Adults with Incapacity (Scotland) Act 2000⁽¹⁶⁾, provide statutory frameworks to protect and empower vulnerable people who are not always able to make their own decisions and this can impact on treatment planning by therapists when carrying out activities that involve manual handling. It must always be assumed that an individual has the capacity to make decisions however unreasonable these may seem, unless it is clearly established that this is not the case.

Factors that may need special consideration in this client group include:

- Variations in tone
- Fixed deformities
- Sensory problems
- Communication problems
- Dementia – in Downs syndrome the onset of dementia may be from the age of 35 or earlier and their health often deteriorates quite rapidly
- Pain which cannot always be expressed and can present as alterations in behaviour
- Epilepsy and its complications.
- Challenging behaviour
- The use of specialised seating and 24 hour postural management

- Respiratory problems. People with a learning disability may have complicating factors such as deformed rib cages and spines or an inability to understand the fundamentals of the treatment procedures
- Osteoporosis, often as a result of reduced mobility and poor diet in their early years leading to an increased susceptibility to fractures
- Palliative care
- Capacity to consent (Mental Capacity Act 2005⁽¹⁵⁾ and Adults with Incapacity (Scotland) Act 2000).⁽¹⁶⁾

As a result of these problems physiotherapists can be asked to advise on handling procedures in a variety of situations, including:

- Removal of clients from moulded wheelchair inserts in emergency situations, for example the need to administer rectal diazepam in the event of epileptic seizure
- Mobilising clients where there is a likelihood of them dropping to the floor or lifting their feet, this can be complicated by added postural deformities and severe challenging and/or self-injurious behaviour
- Advising on safe hoist transfers where individuals exhibit severe challenging behaviour
- Accessing trampolines, possibly in local gyms.

3.6.2 Case Study: Learning Disabilities

Manual Handling Case Study – Learning Disability

Specialty:

Learning disability/Community

Goal – including reference to Clinical Reasoning

The physiotherapist was asked to advise on safe transfers for Ms C, a young woman living in a residential home who presented with profound learning and physical disabilities.

Identified risks

The staff were using a hoist with a standard spreader bar, but owing to Ms C's increased tone and unpredictable flexor/extensor spasms it was found that she was in danger of hitting her head on the spreader bar when being hoisted.

Control measures

After careful assessment, it was recommended that extensor bars were used on the hoist. This changed the angle of the sling during hoisting and prevented Ms C's head coming into contact

with the spreader bar during any spasms. When inserting the sling, again the problem of flexor/ extensor spasm carried the risk of Ms. C slipping out of the wheelchair during the manoeuvre. It was therefore decided to insert the sling whilst the lap strap was still in situ and this was achieved using a sliding sheet. The staff reported no further problems.

Benefits

Ms C can continue to use the hoist for transfers without the risk of hitting her head. Additionally, the risk to Ms C and the staff when fitting the sling prior to transfer is alleviated.

Additional considerations

As with any manual handling manoeuvre the important issue is the carrying out of a full risk assessment before any handling is contemplated. In the case of clients with learning disabilities this may also require 'thinking outside the box' taking into account their multiple and complex problems.

3.6.3 Further Information

More information on physiotherapy in learning disability can be obtained from the Association of Chartered Physiotherapists for People with Learning Disability (ACPPLD) at www.acppld.org.uk

3.7 Manual Handling in Therapeutic Riding

3.7.1 Special Considerations

Physiotherapists working in the area of therapeutic riding may attend riding/driving/ vaulting and hippotherapy sessions with their patients/clients, from special schools, the community, or other centres, during their working hours. Others work within recognised Riding for the Disabled (RDA) Groups in a purely voluntary capacity in their own time. A small number may be employed in purpose-built centres for riders with a disability.

Physiotherapists working in this specialist area who are called upon to give professional advice should be aware that they will need to have specialist skills and knowledge, to ensure they are working within their scope of practice in the following:

- Basic horse knowledge
- Basic riding skills
- Assessment of the rider on the horse
- Effective use of helpers.

In giving advice relevant to manual handling they should be aware of the current government laws and regulations applying (see Chapter 1) and be able to:

- Carry out a pre-riding/driving/vaulting/ hippotherapy assessment of the client/patient to assess their capabilities and identify and record their specific problems
- Set realistic goals to be achieved from riding/ driving/vaulting/hippotherapy and highlight the client/patient's moving and handling needs.
- Undertake an appropriate risk assessment of the unpredictable environment in which the riding/driving/vaulting/hippotherapy session will take place relevant to the client/ patient's specific problems
- Assess the mounting facilities to select the safest and most appropriate method for the rider and helpers, depending on the facilities available, and document the procedure to be followed
- Communicate with instructors, volunteers/ helpers and others and assist in training them in appropriate techniques for the safe moving and handling of the rider/driver and to minimise any identifiable risks to themselves.
- Have knowledge of the appropriate selection, assessment and training of the equine, and understand the importance of matching the horse to the rider
- Document all advice given to riders/drivers or instructors/volunteers and set appropriate times to review that advice
- Undertake ongoing training on study days and courses to maintain CPD and keep a record of learning outcomes relevant to practice.

Details of the protocols involved are published in the Standards of Physiotherapy Practice in Therapeutic Riding published by Association of Chartered Physiotherapists in Therapeutic Riding (ACPTR).⁽⁵⁵⁾ The ACPTR runs a recognised course – The Horse in Rehabilitation Levels 1, 2 and 3 and organises study days and conferences. Further training can be acquired by attending courses run within the RDA.

3.7.2 Further Information

More information on physiotherapy in therapeutic riding can be obtained from the Association of Chartered Physiotherapists in Therapeutic Riding (ACPTR) at www.csp.org.uk/director/groupandnetworks/ciogs/neurologygroups/therapeuticriding.cfm, the ACPTR Members' Handbook⁽⁵⁶⁾ and RDA Membership Manual⁽⁵⁷⁾ (available from RDA National Office or www.rda.org.uk).

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3.8 Manual Handling in Bariatric Rehabilitation

3.8.1 Special Considerations

There are unique rehabilitation challenges when dealing with bariatric patients, especially with equipment provision. Mobilising a bariatric patient after a lengthy stay in bed following surgery, medical intervention has foreseeable risks. The bariatric patient with mobility problems will increase the risk of work related musculoskeletal disorders to physiotherapists, as they will exceed the guideline weights set by the HSE 1998.⁽⁵⁸⁾

Most of the challenge focuses on the daily movement and transfer techniques, and ensuring a sufficient number of staff are present at a given time – an optimum number being four or more following assessment. Mobility is especially difficult for bariatric patients after surgery/medical intervention. Their excess body weight restricts their mobility, hindering them from responding to the usual post-operative encouragement and medical intervention that can be achieved with patients with normal body weight. Their body weight will have increased the strain on the patients' joints and cardiovascular system, resulting in extreme breathlessness and profuse sweating.

Understanding the diversity of bariatric body shape is extremely important and the rehabilitation programme should be patient specific in order to provide safe and effective treatment.

3.8.2 Case Study: Bariatric Rehabilitation

Manual Handling Case Study – Bariatric rehabilitation

Specialty:

Bariatric rehabilitation

Goal – including reference to Clinical Reasoning

Mr D, a young man weighing 320kgs, walked into hospital with painful swollen legs and scrotum. He was admitted to a medical ward where he became confined to bed with breathlessness resulting in oxygen dependency and increased fluid retention. Following nine weeks in bed Mr D needed to be rehabilitated to independence for discharge home.

Goal

- To mobilise Mr D so he could be discharged back into the community independently
- To undertake this task in a reduced risk environment with equipment that is fit for purpose
- Reduce Mr D's oxygen dependency and oedema

Identified Risks

- Mr D's decreased mobility and increased dependency on oxygen increases the inherent risks to staff associated with handling heavy loads
- The unpredictability of Mr D's ability to weight bear and give assistance, combined with his lack of confidence, increases the risk of the patient falling during the rehabilitation process
- Mr D's body shape and co-morbid condition in relation to his body shape.
- The lack of suitable equipment and other resources
- Environmental constraints.

Control measures

- A comprehensive risk and mobility assessment was undertaken from the outset and a planned step-by-step intervention process implemented that included equipment provision by a professional versed in bariatric handling
- A bariatric process and handling plan was put in place specific to Mr D's body shape and co-morbid condition. Special consideration was given to his respiratory and cardiac status and joint integrity
- Precise monitoring of patient oxygen delivery through blood gases and pulse oximetry to ensure appropriate saturation and carbon dioxide levels
- Appropriate equipment sourced that was fit for purpose and procured before the task of rehabilitation was undertaken
- In-depth training and education was provided for all physiotherapy staff involved in the rehabilitation task
- Additional resources were made available to ensure that the rehabilitation was undertaken in a reduced risk environment
- Mr D was in a four-bedded ward, but space was still at a premium and equipment was limited to bed and chair with a wheeled gantry.

Benefits

- The benefit of training the physiotherapists enables them to understand the different body shapes and their effect on the patient co-morbidities. Training also reduces the inherent fear surrounding bariatric patients and gives confidence to the physiotherapists.

Additional considerations

Equipment fit for purpose is the key to providing effective, patient-specific rehabilitation within a reduced risk environment that is beneficial to both patient and physiotherapist.

3.8.3 Further Information

More information on bariatric issues can be obtained from the Bariatric Special Interest Group at National Back Exchange at www.nationalbackexchange.org

3.9 Manual Handling in Private Practice

3.9.1 Special Considerations

Physiotherapists work in many different clinical areas as self-employed private practitioners. These include the clinical areas of neurology, paediatrics, rehabilitation and the occupational area of health promotion and ergonomics. There are many others. Some private practitioners own their own clinic areas, some lease or rent premises in which they practise. Private practitioners may also carry out domiciliary visits or work in private hospitals, care homes or schools.

It is the responsibility of each physiotherapist to apply this guidance to their circumstances and carry out effective and appropriate risk assessments.

Access to regular CPD opportunities covering manual handling may be less straightforward for those in private practice than those employed by the NHS or independent providers.

Private practitioners may employ staff for whom they hold a responsibility to provide a safe environment, and for many practitioners their own health is paramount to the success of their business. Access to the clinic for people with disabilities must also be considered and documented.

Private practitioners are responsible for establishing their own policies and procedures to address the risks that are involved in their business.

Information and guidance on manual handling for the different specialist clinical areas is covered earlier in this chapter. Appendix 6 contains a self-assessment pro forma that will assist private practitioners to check their protocols.

3.9.2 Case Study: Private Practice

Manual Handling Case Study – Private Practice

Specialty:

Orthopaedic rehabilitation/private practice

Goal – including reference to Clinical Reasoning

Ms E, a patient with residual weakness following CVA two years ago requests treatment for a painful swollen ankle and also asks for exercises to improve her functional ability.

Goal

- To treat Ms E's ankle on a plinth in the normal treatment area with access to electrical equipment if required
- To treat her in the gym area on a floor mat to assess and advise about continuing exercise.

Identified Risks

- Ms E has poor balance and reduced proprioception on her affected side so movement onto the floor and other surfaces can be difficult and unpredictable at times. Therefore there is a risk of her falling during transfers
- The treatment plinth is of fixed height with a small stool available for patients to stand on if required. This is a risk to Ms E due to her poor balance and painful ankle
- In the gym area there are floor mats and full hoisting equipment available for transfers but there is a postural risk to the therapist from treating Ms E on the floor.

Control measures

- A full risk assessment of Ms E's manual handling requirements must be undertaken before commencing the treatment
- A height-adjustable plinth would be preferable for all patients, as well as for the therapist (bearing in mind that the safe working load for hydraulically operated plinths may be lower than that of traditional fixed-height plinths)
- In the gym area perhaps an inflatable lifting cushion would be an alternative to hoisting where a partially weight-bearing patient needed to access the floor. A more long-term solution would be to consider a low exercise plinth with reduced postural stress for the therapist.

Benefits

The benefits of investing in height-adjustable treatment couches are to both the patient and

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the therapist. Patients of all heights and abilities could sit comfortably and safely while getting on and off and therapists can work at a safer height for themselves.

Additional considerations

Would need to balance the risk of assisting the patient to the floor with any measurable outcome from their exercise programme. Does the risk outweigh the benefit, that is 'the utility of the act'.

3.9.3 Further Information

For more information on physiotherapy in private practice contact PhysioFirst at www.physiofirst.org.uk/



Delegation, Guidance and Advice

4.1 Key Messages

- It is important to remember that giving advice and delegating tasks is a normal and essential part of physiotherapy. Being clearer about this issue should not inhibit physiotherapists – it should actually facilitate balanced decision making
- The fundamental aim must always be to prevent harm or injury occurring to the handler(s) whilst at the same time ensuring the best possible outcome for the patient
- Whether the physiotherapist is delegating, offering advice or guidance, or carrying out the manual handling tasks themselves, the same principles of duty of care and risk assessment apply (see Chapter 1)
- Before acting to influence the handling of a patient by another, the physiotherapist must be clear in their mind whether their intention is to delegate or to offer guidance to assist in the decision making process
- All physiotherapists must be insured and working within their professional scope in order to be covered by PLI. (see Chapter 1).
- When delegating tasks to their assistants, physiotherapists should bear in mind that they have a duty of care to the assistant as well as to their patient
- No profession can dictate to another person how they must handle a patient. However, a physiotherapist may be an ideal person to contribute to the handling plan for a patient
- When undertaking handling, or delegating a handling task the physiotherapist should ensure they are up-to-date with current good practice. They should be aware that a direct duty of care is owed to the person undertaking a delegated task, and also consider who has managerial responsibility for that person.

The aim of this chapter is to clarify the situation with regard to contemporary manual handling practice, including processes such as delegating or advising on activities.

4.2 Delegation, Guidance and Advice

The scope of physiotherapy generally extends much further than the one to one relationship with a patient receiving treatment. Frequently some aspect of treatment is delegated to another person – Rule 1.7 RoPC⁽⁶⁾; or the physiotherapist is required to offer advice on the general management of the patient. Manual handling is an important component of the delivery of physiotherapy services and

it is often necessary to give advice on, or to delegate, this activity to others. Professional bodies, for example, the Chartered Society of Physiotherapy/ Royal College of Nursing/ College of Occupational Therapists, have each provided advice to their members on manual handling, and associated practical problems which may arise in professional practice.^(59, 60) In 2006, an intercollegiate information paper was published by the Chartered Society of Physiotherapy, the Royal College of Nursing, the Royal College of Speech and Language Therapists, and the British Dietetics Association to guide practitioners in delegation responsibilities.⁽⁶¹⁾

It is important to remember that giving advice and delegating tasks is recognised by the HPC as a normal and essential part of physiotherapy (see Standard 1b.3⁽³⁾). Being clearer about this issue should not inhibit physiotherapists – it should actually facilitate balanced decision making. The delegation of tasks involving manual handling to physiotherapy colleagues (including assistants, support workers and students) and the giving of advice and guidance on such tasks to other members of the care team or carers, are all routine aspects of physiotherapy practice. Whether the physiotherapist is delegating, offering advice or guidance, or carrying out the manual handling tasks themselves, the same principles of duty of care and risk assessment apply.

4.3 Delegation

Delegation infers the entrustment of a physiotherapy task to another person, who will perform that task in the place of the treating or supervising physiotherapist, with the consent of the patient (Standard 12.8 Core Standards).⁽⁷⁾

Therefore delegation by a supervising physiotherapist, having performed a suitable and sufficient assessment, would normally be:

- Person specific (patient and the person(s) undertaking the delegated task)
- Task specific
- Environment specific
- Recorded
- To a person who has the ability to undertake that delegated task.

Delegation of interventions involving manual handling would normally be to one of the following:

- A more junior physiotherapist

Delegation, Guidance and Advice

- A physiotherapy assistant
- A student physiotherapist
- A technical instructor.

Also to any other person providing a physiotherapy intervention, this could include:

- A member of the patient's family
- A paid or unpaid carer of the patient
- A school support worker
- A volunteer.

4.4 Delegation of Treatment Handling

Prior to delegation to any other party the following process applies:

1. Assess the patient clinically.
2. Consider realistic goals and functional outcomes, in discussion with the patient where possible.
3. Consider whether the proposed therapeutic intervention involves hazardous manual handling.
4. Consider whether the hazardous manual handling can reasonably practicably be avoided taking into account:
 - the purpose and possible benefits of the intervention
 - the suitability of any aids or equipment that might be available or made available.
5. If not, assess and reduce the risk as far as is reasonably practicable, taking into account the skill and ability of the individual undertaking the task.

4.4.1 Delegation to Less Experienced Physiotherapists

Delegation to a less experienced member of staff will address the whole treatment of a patient so that in this case the responsibility of the supervising therapist involves much more than just the manual handling element. However for the purposes of this document the manual handling element is considered. Each physiotherapist carries autonomy for their own assessment, treatment and handling of a patient. The purpose of this section is to assist those with a responsibility for other physiotherapists.

Recommended actions:

- Be aware of the less experienced physiotherapist's current handling experience
- Observe the less experienced physiotherapist's overall handling skills
- Be aware of the possible difficulties

presented by the patients in the care of the less experienced physiotherapist and their clinical ability in respect to delegating tasks

- Be accessible to and encourage expressions of concern from the less experienced physiotherapist
- Where there is concern about the difficulty of handling of a patient observe the less experienced physiotherapist with the patient. Be prepared to help. Consider use of equipment as appropriate
- Where there is concern, risk assess the situation with the less experienced physiotherapist, encouraging them to consider remedial actions and record the process and outcome in the notes
- Take account of difficulties related to language or cultural differences and action these as appropriate
- Offer assistance in the form of extra physical help or further training as necessary
- Ensure that the less experienced physiotherapist has access to the procedure for raising concerns
- Ensure this intervention is recorded in the patient's records
- Ensure the less experienced physiotherapist always has recourse to advice or assistance from the supervising physiotherapist
- Ensure the learning from this intervention is recorded in the less experienced physiotherapist's CPD portfolio.

4.4.2 Delegation to Physiotherapy Assistants and Technical Instructors

Individual skills and knowledge of physiotherapy assistants vary widely. When delegating tasks to support workers, physiotherapists should bear in mind that they have a duty of care to the assistant as well as to their patient. Therefore the supervising physiotherapist should:

- Treat the patient with the assistant initially
- Demonstrate the method of handling required
- Observe the assistant carrying out the chosen method
- Record the above information.

Recommended actions:

- Ensure the patient's agreement to being treated by the assistant
- Take into account the individual capability and competence of the assistants(s)
- Clarify the method of handling desired
- Ensure there are procedures in place so the assistant can get further advice and support ►

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- if they have concerns before they carry out the delegated task
- If the physiotherapist or the assistant has any concerns consider either further training for the assistant or amending the chosen method
- Take account of difficulties related to language or cultural differences and action these as appropriate
- There should be a system in place for the assistant to access supervision and clinical advice as required, as assistants often work at times when a physiotherapist is not on duty
- Ensure that the assistant has access to the procedure for raising concerns
- Monitor the patient regularly, and record this in the patient's notes, as a number of assistants may now be undertaking tasks with a patient⁽⁶¹⁾
- Ensure learning from this intervention is recorded in the assistant's CPD portfolio.

4.4.3 Delegation to Student Physiotherapists

The student physiotherapist lacks experience and may therefore be particularly vulnerable to manual handling injury.

Recommended actions:

- Ask the student physiotherapist for confirmation of their manual handling training and experience
- Liaise with clinical tutor from the student's HEI to ascertain how much manual handling training the student has received so far
- Ensure introduction includes placement-specific induction
- Take into account the individual ability of the student
- Emphasise and demonstrate safer handling to the student as part of good clinical practice.
- Ensure the patient's agreement to being handled by the student
- Take account of difficulties related to language or cultural differences and action these as appropriate
- Observe the student's handling skills before delegating tasks
- Observe the student carrying out delegated tasks with patient to your satisfaction, within current good practice before leaving them to work alone
- Ensure student knows how to access advice from you or an alternative supervisor at all times
- Ensure that the student has access to the procedure for raising concerns
- Record advice and assistance given
- Monitor the situation and record this

- Encourage the student to record the learning from this intervention in their learning log/CPD portfolio.

4.4.4 Delegation to the Patient's Family

There may be times when it could be appropriate to include the patient's family in the rehabilitation of the patient. However, safety of the family is of paramount importance not just in terms of avoiding litigation, but also for the long-term care and wellbeing of the patient.

However, a family member, with the consent of the patient, may choose to carry out a procedure, for example a transfer from chair to commode, in a situation where the physiotherapist feels that it carries an unreasonable degree of risk. The physiotherapist should explain the risks involved, offer alternatives and make it clear that his/her advice is that the procedure should not be carried out. This should be recorded in the patient's notes. It could be appropriate to then give further advice to minimise the risk, but it should be remembered that the physiotherapist could be held responsible if any harm ensues.

Recommended actions:

- Ensure the patient has agreed to the therapeutic activity and is willing to involve the family
- Ensure family is willing and capable to be involved. (Note that a risk assessment should always address individual capability)
- Keep the activity simple. Leave clear written information. Consider differences between a hospital environment and the patient's home or environment where the activity will be undertaken
- Observe family carrying out activity with the patient, modify and correct as necessary
- Take account of any difficulties related to language or cultural differences and action these as appropriate
- Ensure that the situation is, where necessary, monitored and the family are informed on how to get advice and to raise concerns if it is needed in the future. There are many situations, for example working spouse who can't take much time off work, or where advice is given at the end of a course of treatment where there could be a difficulties arranging a review
- Consider how the delegated activity fits into other aspects of the patient's daily life and modify if required
- Record all of the above.

Delegation, Guidance and Advice

4.4.5 Delegation to Support Workers

Physiotherapists often train support workers in schools or supported living accommodation to carry out treatment programmes for individual children or vulnerable adults on their caseload. These staff may be employed by agencies other than the physiotherapist's own employing organisation. Support workers are eligible to join the CSP as an associate member, if the delegating physiotherapist is a member of the CSP, empowering them to receive the same benefits package and to work to the Assistants Code⁽⁸⁾ as physiotherapy assistants.

The physiotherapist must be aware of the local Children's Services policy on manual handling of pupils in schools and the impact of this on the activities she/he is asking the assistant to carry out or liaise closely with the manager of the support worker. A full risk assessment should be carried out and instructions carefully documented with copies kept in physiotherapy notes, education files and care plans. A review date should be set at this stage.

The support worker is not permitted to contravene the Children's Services manual handling policy or the handling policy of the employer and must be aware that the treatment requested is only applicable to the individual child/adult in this particular situation. Similar situations could arise where physiotherapists are working with Community Health Partnership staff, Social Services staff, Intermediate Care teams, staff employed via the direct payment scheme and others from voluntary agencies.

Example: A paediatric physiotherapist may delegate the task of assisting a child to use a standing frame to a school support worker as part of a child's 24 hour postural management programme.

Recommended actions:

- Ensure the patient and/or parent/advocate/guardian has agreed to the therapeutic activity and is willing to involve the support worker
- Keep the activity simple. Leave clear written guidelines that include clinical reasoning and cautions
- Take into account the individual capability and competence of the support worker(s). It will be necessary to observe the person carrying out the activity with the patient and correct as necessary
- Take account of any difficulties related to language or cultural differences and action these as appropriate
- Alter activity if necessary to enable the support worker to carry it out safely
- Ensure that the situation is regularly monitored. The first link is likely to be by the line manager of the support worker
- Ensure that the support worker or their manager has contact details of the physiotherapist if an issue is raised
- Consider how the delegated activity fits into other aspects of the patient's daily life and modify if required
- Record all of the above.

4.5 Guidance and Advice

Guidance and advice is the professional verbal or written input given by the treating physiotherapist in his/her role as a part of the care team, to the overall rehabilitation and/or management of a patient. It may relate to tasks involving manual handling and may inform the risk assessment process.

Guidance or advice on manual handling may be given to any or all of the following:

- Nursing staff
- Other members of the multidisciplinary team (occupational therapists, speech therapists, radiographers, and so on)
- The family of the patient
- Paid or unpaid carers of the patient
- Social services care workers
- Support workers
- Any other parties involved in the care of the patient.

Before acting to influence the handling of a patient by another it would greatly assist the decision making process for the physiotherapist to be clear in his/her mind whether their intention is to delegate, or to offer guidance. This decision will inform the steps then to be taken.

In any case the physiotherapist owes:

- A professional duty
- Duties under occupational health and safety legislation
- A duty of care in common law to both the patient and any handlers of the patient.

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The fundamental aim must always be to reduce the risk of harm or injury occurring to the handler(s), as far as is reasonably practicable, while at the same time ensuring the best possible outcome for the patient.

In any situation where the physiotherapist is required to influence the manual handling of the patient in any way other than the direct delegation of physiotherapeutic intervention, they are only in a position to be able to offer advice or guidance.

However, because of a generally acknowledged expertise in this area, physiotherapists are very frequently required to offer guidance on the handling of a patient outside of direct physiotherapy treatment times. This may involve the 24 hour management of how a patient is handled in hospital, or at home or in the community. The physiotherapist should be able to justify his/her recommendations and must document this information. The therapist is extending their duty of care to those involved following their guidance.

The responsibility here is just as great as it is in the case of more direct delegation. It is important that the physiotherapist acknowledges that sometimes issues that arise are multi-factorial and that there may not be a right or wrong answer. It is advisable to choose a communication and decision-making system that helps all involved reach an acceptable balanced decision. A physiotherapist cannot dictate to others how they must handle a patient.

Example: Physiotherapists on a neurological unit forbid the nurses on the unit to use hoists with their patients. They are not entitled to do this. However, if the concerns about using hoists could be addressed within an agreed framework, it may be possible to come to a balanced decision that meets the needs of the patient, physiotherapy plans and staff requests.

The physiotherapist can be in the position of having significant areas of expertise in handling patients that they can pass onto other people, but they may also find themselves caught in a wave of differing opinions where the evidence for those handling skills is still in its infancy. It can be very difficult to balance what each interested party wants and believes is the right course of action.

The physiotherapist needs to be aware of the limits of their role, but at the same time recognise the amount of support they can provide in helping the patient, family and other professionals in reaching a good decision. The physiotherapist should seek expert advice from other professionals, such as a Back Care Advisor, where appropriate. The aim should always be to reach consensus and have an agreed system to deal with situations where consensus is not possible. Maintaining open channels of communication in the event of a failure to reach consensus may allow for subsequent agreement after a period of reflection. Legal action very occasionally may be required but should not be seen as an option except where complete breakdown has occurred.

4.5.1 Advising Other Members of the Multidisciplinary Team

The physiotherapist may be expected to contribute to the multidisciplinary team management of a patient by offering guidance on the general rehabilitation handling of the patient.

Physiotherapists should be aware that training and advice may be available and in place via a Back Care Adviser or Manual Handling Coordinator. There may be systems in place for shared training and assessment that can help when developing a patient focused handling plan. It should be noted that in a ward or community situation it will not usually be possible for the physiotherapist to know each individual that will handle the patient. The variation in ability between trained and untrained members of the team must also be taken into account.

Measures should be taken to ensure that good communication exists between all parties in order to demonstrate respect for individual professions and professionals, to prevent any professional misunderstandings, to avoid confusing or otherwise disrupting the quality of service offered to patients. The aim should be to promote collaborative working geared towards enhancing both safety and quality in service delivery.

Recommended actions:

- Assess the patient and decide optimum method of handling for rehabilitation. This may be in consultation with other professionals and appropriate parties
- Take into account local generic risk assessments where possible

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- Take into account any local manual handling policy where possible. In some circumstances it would be appropriate for the physiotherapist to question the validity of local manual handling policies if they are unreasonable and/or to the detriment of the patient
- Identify risk involved and wherever possible amend method so that risk is reduced as far as possible
- Estimate competence of team members to employ the recommended method safely
- Wherever possible identify safer alternatives to be used where staff do not feel competent to use chosen method; or condition of patient deteriorates (for example night sedation)
- Communicate method(s) to nursing staff and other team members
- Leave clear written notes, in accordance with CSP requirements for record keeping.
- Record assessment process and reasoning briefly but clearly in physiotherapy patient notes
- Particularly record any warnings or negative instructions (that is what not to do) given
- Where continued responsibility exists monitor situation regularly.

Specific case example

A patient who has had a knee replacement operation is just beginning to walk again. The physiotherapist has been asked to advise the nursing team on how to facilitate the patient to mobilise on the ward.

The physiotherapist:

- Ensures staff are aware of the risks associated with walking with a person and reminds them that they may need to consider the policy on handling the fallen and falling person and to have received additional training
- Demonstrates first wherever possible, so that the staff can make their own assessment in relation to their ability as to whether they proceed
- Considers strategic placement of chair/seating to minimise risk.
- Indicates number of staff to walk with patient (number to be specified)
- Indicates technique to be used (for example palm to palm contact with back support)
- Indicates extent of verbal prompting, if required
- Demonstrates possible additional safety measures where staff are not confident or competent; or the patient's condition has

deteriorated (for example one member of staff wheeling a wheelchair behind the patient while they are assisted to walk).

- Informs the staff of the procedure for further discussion if needed.
- Documents all of the above, including the rationale for the handling plan.

4.5.2 Advising a Patient's Family Prior to Discharge

The physiotherapist should consider constraints within a person's own home for any handling she/he has advised. For example, an exercise programme that the patient could carry out appropriately with family members, assistance in the hospital on a wide plinth may need to be adapted considerably if the only available surface at home is a low bed against a wall.

Recommended actions:

- Before discharge the physiotherapist should discuss with the patient and family guidance given considering the home setting. A home visit for example may help in the decision-making process
- Refer to community physiotherapy services if risks or additional factors are highlighted that mean that a handling plan could not be followed
- Ensure that there are good communication channels to avoid misunderstanding and confusion
- Document and circulate relevant information.

Agencies that provide ongoing care are responsible for undertaking their own home manual handling risk assessment.

4.5.3 Advising a Patient's Family in the Patient's Home

By giving advice the physiotherapist is extending their duty of care to the family and his/her role may be to assist a number of parties come to agreement on the best handling plan for all involved.

A patient and their family may choose a handling option that is considered less safe by the physiotherapist. The physiotherapist will need to decide whether he/she can support that decision or offer additional advice. If the physiotherapist considers the patient and family's chosen handling option carries an unreasonable degree of risk, the danger should be explained clearly, with alternatives suggested.

The physiotherapist may still support the family >

Delegation, Guidance and Advice

- ▶ in reducing the risk as far as possible, making it clear and recording that in his/her opinion the manoeuvre should not be carried out. The physiotherapist may need to take further action or seek additional advice, where they have concerns about the well-being of the patient or any other person involved, as they may be held responsible for any adverse effects resulting from their involvement.

Specific Case Examples

Example 1: a patient has a deteriorating condition, but feels that maintaining the ability to stand improves his quality of life. The family decides after trying different options to undertake a front transfer for standing practice. The risk factors are discussed and the physiotherapist suggests a second person is present to assist from behind.

Example 2: due to the very variable weight-bearing ability of a patient the physiotherapist advises that they should use a ceiling-tracking hoist at home. However, the patient and family want to use the standing hoist as they strongly believe it will help maintain independence. The risks of falling are discussed, and a measurable rehabilitation programme is agreed by all. The aim would be to move to using the standing hoist when the weight-bearing ability of the patient had improved.

Recommended actions:

- Ensure competence to advise. Only do so if confident
- Where able to advise, assess the patient within the home setting, considering their daily routine, wishes and expectations
- Take into account the relevant physical ability and psychosocial factors within the family
- Have a realistic idea of the long-term aims for the patient. This may be continued improvement or simply maintenance of their condition
- Select and demonstrate the most appropriate methods of handling in consultation with the patient and family including the possibility of use of equipment
- If agreement cannot be achieved, record clearly and/or seek advice from line manager
- Train and observe family carrying out handling safely. Provide further training or amend method so that manual handling can be carried out as safely as possible.

- Record process, including clear description of handling method and any considerations.
- Where continued responsibility exists, monitor situation regularly.

4.5.4 Advising Carers Other Than the Family in the Home Setting

4.5.4.1 Carers paid by the family

Where a family is paying the wages of a carer, regardless of the source of the funds with which they pay the carer, they have assumed the responsibilities of an employer. If the carer is employed to undertake tasks that involve manual handling, the employer has responsibilities regarding the health and safety of the carer. This is likely to include the provision of appropriate equipment and adequate manual handling training for the carer.

A physiotherapist who is treating a patient who is purchasing care in this way does not have any obligation to provide formal manual handling training for the carer. If he/she agrees to do so, the physiotherapist should ensure that he/she has the appropriate experience and training (and insurance cover) to undertake this activity, as previously described. The patient must make their own arrangements to purchase adequate training. However, a domiciliary physiotherapist routinely assessing a patient might give advice on handling issues to both the patient and the carer. Any such advice should be documented.

Recommended actions:

- Ensure competence to advise and train, only do so if confident. Refer to the line manager if necessary
- Understand the physiotherapist's role and the expectations of the family and agree in advance the process for resolving differences
- Where able to advise, assess the patient within the home setting, considering their daily routine
- Take into account the relevant physical ability of the carer and psychosocial factors within the family that may affect the handling plan
- Have a realistic idea of the long-term aims for the patient. This may be continued improvement or simply maintenance of their condition
- Select most appropriate methods of handling in consultation with the patient and family estimating the competence of the carers following the advice, including the possible use of equipment

Delegation, Guidance and Advice

- If agreement cannot be achieved, record clearly and/or seek advice from line manager and whether further action is required
- It is possible that a patient may have a number of people who have access to the information provided by the physiotherapist whom the physiotherapist never meets. The aim should be to train and observe staff carrying out handling safely as appropriate, giving clear information on whom the advice is intended for and whom new carers can contact
- Record process, including clear description of handling method and any considerations
- Where continued responsibility exists, monitor situation regularly.

4.5.4.2 Carers paid by an outside agency

Outside agencies could include:

- Local authority social services
- Community health partnerships
- Intermediate care teams
- A charity
- A care agency.

If the carer is employed by Children's Services/Community health partnership or a charity, then it is the employers who have the responsibility to ensure that there is a safe system of work within the patient's domestic environment and that the carer is adequately trained by a competent manual handling trainer. A carer provided by an agency may be considered to be self-employed for tax purposes. However, in the event of a personal injury claim in respect of a manual handling incident, the carer would almost certainly be treated by the court as an employee of the agency.⁽⁶²⁾

Recommended actions:

- Ensure competence to advise. Only do so if confident
- Understand the physiotherapist's role and the expectations by the family asking for guidance and ensure this is not in conflict with his/her own duties as a physiotherapist
- Where able to advise, assess the patient within the home setting, considering their daily routine
- Discuss a process for resolving any disagreements in advance
- Take into account the relevant physical ability and psychosocial factors
- Have a realistic idea of the long-term aims for the patient. This may be continued

improvement or simply maintenance of their condition

- Select and demonstrate the most appropriate methods of handling in consultation with the patient including the possibility of use of equipment
- If agreement cannot be achieved, record clearly and/or seek advice from line manager.
- Train and observe staff to ensure they are carrying out handling in line with current good practice
- Provide further training as needed or amend method so that manual handling can be carried out as safely as possible
- Record process, including clear description of handling method and considerations. It is possible that a patient may have a number of people who have access to the information provided by the physiotherapist that the physiotherapist never meets. The aim should be to train and observe staff carrying out handling safely as appropriate, giving clear information on whom the advice is intended for and whom new carers can contact
- Where continued responsibility exists, monitor situation regularly.

4.5.4.3 Unpaid carers/volunteers

Voluntary workers are the responsibility of the voluntary organisation. They fall into a 'grey' area in that not being paid they do not have a clear employer/employee relationship with the organisation. However, the organisation would almost certainly be considered to have a duty of care towards its volunteers and should ensure that its volunteers are adequately trained if they are expected to undertake manual handling tasks.

It is not the treating physiotherapist's responsibility to provide training for volunteers but he/she may give information of where to obtain further help. If the treating physiotherapist does provide advice then he/she should follow the recommendations as for paid carers.

5.1 Key Messages

- All chartered physiotherapists require education and training in manual handling throughout their career pathways to allow them to perform within their designated remit in a professional, legal and ethical manner
- All chartered physiotherapists, at whatever level of professional development, knowledge, skill and experience, should be able to identify the need for an individual assessment of each work situation where manual handling is indicated and be prepared to undertake or at least contribute to such assessment
- Chartered physiotherapists should be aware that their physiotherapeutic skills and knowledge only confer proficiency in manual handling rather than expertise (see below)
- Undergraduate physiotherapists should experience discrete manual handling training as part of their studies, both within their Higher Education Institution and on therapeutic placement within a problem-solving environment
- Graduate physiotherapists should continue to develop skills, knowledge and experience within manual handling situations as an integral part of their CPD
- All manual handling courses provided to chartered physiotherapists shall be provided by competent persons and contain certain common core elements.
- Every graduate physiotherapist should be aware that their legal duties and professional responsibilities concerning manual handling cannot be delegated
- Physiotherapy assistants and technical instructors should receive appropriate manual handling training before commencing employment
- All levels of staff should receive regular updates on manual handling from a competent person
- Chartered physiotherapists who accept responsibility for training others in manual handling, for example as Back Care Advisers must be aware of the higher standard expected of them as a result and must meet CSP Core Standards⁽⁷⁾, ACPOHE⁽⁶³⁾ standards and others consistent with National Back Exchange trainer guidelines.⁽⁶⁴⁾

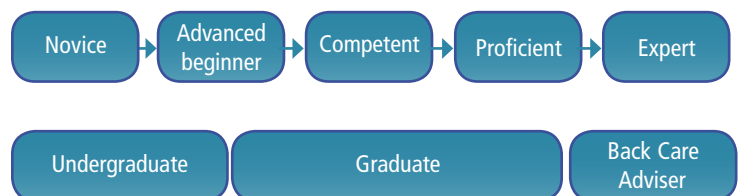
5.2 Acquisition of Manual Handling Skills

As with all clinical decision-making in physiotherapy, the progression of skill and knowledge acquisition in manual handling is not linear, but dynamic and cyclic, and this should be reflected in the educational pathway for students and graduates alike.

Dreyfus' continuum of skill acquisition⁽⁶⁵⁾ has already been interpreted to reflect nursing practice development⁽⁶⁶⁾, and it provides a realistic framework against which to determine physiotherapists' progress towards the level of independent problem-solving required in manual handling.

The five stages – novice, advanced beginner, competent, proficient and expert (see Appendix 7) – can be used to direct learning which is relevant, integrated and continuous, and this chapter will offer recommendations regarding the structure and content of physiotherapist education in manual handling.

Dreyfus' stages of skill acquisition



Physiotherapy career stages

By using this approach, students especially will have a measurement of progress from novice status through advanced beginner, both of which necessarily require adequate supervision and guidance. Following qualification, postgraduate staff will be expected to achieve at least competence in manual handling and at senior levels within a specialised area, proficiency would be expected to be the norm. Both of these levels of skill carry accountability in decision making, which is concomitant with professional responsibilities.

Physiotherapists who wish to progress to take up a strategic post in manual handling management and training (for example, as a Back Care Adviser) should be expected to undertake further specific postgraduate education to widen their skills, knowledge and experience beyond

Education and Continuing Professional Development

physiotherapeutic thinking. This would allow them to undertake the responsibility of training and advising others outwith the profession from an 'expert' standing in manual handling. (See Appendix 7 for further explanation of these categories.)

All chartered physiotherapists should appreciate that the scope of their professional practice will involve certain levels of unavoidable risk inherent in the nature of physiotherapeutic treatment. These risks may be justifiable and therefore reasonable in that they may be offset by the ethical and professional responsibility of interpersonal physical treatment and management of risk. It should be the aim of the partnership of staff and patient to include the safest possible working practices, which can only be determined by an ongoing assessment process which results in balanced decision making (see Chapter 2).

It should be noted that in the following text, the terms 'novice', 'advanced beginner', 'competent', 'proficient' and 'expert' are only used in relation to the criteria according to Dreyfus applied to the acquisition of manual handling skills by physiotherapy practitioners.

5.2.1 Physiotherapy Students/Undergraduates

Students are deemed 'novices' and 'advanced beginners' in manual handling skills and as such require discrete rules and guidance as they have no holistic overview of patient handling. They require adequate supervision and advice in all areas from proficient practitioners both in their Higher Education Institutions (HEIs) and out on clinical placement, with expert resources where possible.

Recommendations:

- During their initial year of education, all physiotherapy students will have achieved learning outcomes in the following manual handling topics:
 - Legal and professional responsibilities in manual handling
 - The epidemiology of musculoskeletal disorders (MSDs) in the physiotherapy profession
 - Principles of normal movement
 - Assessment of patients
 - Basic common techniques

- Following this, all manual handling education will be of a modular structure including key components and addressing agreed competence-markers (see Appendices 8 and 9 for suggestions)
- Students will also have achieved discrete learning outcomes in manual handling relevant to specific placements as appropriate, including use of equipment and simulated practical situations
- These outcomes are to be determined by consultation and discussion between proficient practitioners from the students' HEIs and clinical educators and Back Care Advisers (BCAs)
- Students will not be deemed to achieve practical learning outcomes without simulated situations having been overlaid by 'real-life' scenarios
- Students may not give advice regarding manual handling problems and situations without discussion and consultation with a proficient supervisor
- Clinical educators who are aware that their personal skills and knowledge in manual handling are not of proficient level must refer students to BCAs within employing organisations or seek further assistance
- Students must be closely supervised by at least a competent practitioner during all manual handling operations involving patients
- Students must be given the opportunity to participate in all relevant training and workshops, offered while on clinical placement
- Students should keep records of their manual handling activities to allow reproducible assessment by supervisors and the opportunity for reflective practice.

5.2.2 Physiotherapy Graduates

Physiotherapy graduates are now expected to become at least competent in manual handling following graduation, which will allow them to work with less supervision and less rigid adherence to rules and guidance, as they work towards more problem-solving based on widening experience. Graduates should therefore be encouraged to develop familiarity in all aspects of manual handling, including simulated situations in training, and would be expected to perform risk assessments for patients with supervision and guidance. Manual handling skills should be clearly identified as part of an individual's CPD.

Education and Continuing Professional Development

Recommendations:

- All graduates must attend mandatory manual handling updates provided by their employers/employing authority
- They should liaise closely with proficient practitioners and Back Care Advisers to identify specialised training and education reflecting physiotherapeutic practice and problems in manual handling
- Consideration should be given to the use of specific assessment tools for comparative and evaluative purposes (for example, REBA⁽⁶⁷⁾, OWAS⁽⁶⁸⁾, DINO⁽⁶⁹⁾, RULA⁽⁷⁰⁾) and to minor research projects within departments and specialisations to add to the knowledge base and evidence base for effective manual handling in physiotherapy
- Graduate physiotherapists should continue to acknowledge their own personal and professional limitations in manual handling and actively seek advice and guidance, for example Back Care Adviser/teams, clinical interest groups of CSP, to gain further experience and knowledge in discrete areas of patient care
- Graduates should make every effort to keep up to date with manual handling equipment being developed and should not hesitate to consult with BCAs regarding specialist equipment requirements for rehabilitation; consideration should be given to graduates updating knowledge and skills regarding manual handling equipment, for example by attendance at exhibitions
- Graduates working in private practice have a duty to comply with competency levels and to maintain their own skills and knowledge. Where they are supervising students, graduates must be of proficient level in manual handling
- Graduate physiotherapists should be aware that 'teaching' and 'training' in manual handling will automatically highlight their legal responsibility and should ensure that their knowledge skill and experience level is concomitant with the acceptance of this enhanced responsibility for insurance purposes (see also following section regarding BCAs).

5.2.3

Physiotherapists Holding Strategic Manual Handling Management Posts

Since the introduction of the Manual Handling Operations Regulations 1992⁽¹¹⁾ there has arisen a unique post within the UK – variously known

as a Back Care Adviser/Coordinator or Manual Handling Coordinator/Adviser (hereafter referred to generically as 'Back Care Adviser' or BCA). Back Care Advisers are concerned with the implementation of manual handling policies and practices within the employing organisation, including training provision and management of manual handling aspects in line with legal responsibilities and effective patient care and safety.

Back Care Adviser posts are not exclusive to physiotherapists. They carry the requirement to have developed specialist skills and knowledge in manual handling. The requirements for the title of 'trainer' and 'BCA' are outlined by National Back Exchange, a multidisciplinary association representing this specialised area. Other professional bodies have also set standards for staff working as BCAs, for example the Royal College of Nursing Competencies⁽⁷¹⁾ and College of Occupational Therapists (COT)⁽⁶⁰⁾, from whom further information should be sought.

Physiotherapists should be aware that to become a BCA requires further education that takes them beyond their physiotherapeutic remit. They should ensure for insurance purposes that their skills, knowledge and experience in manual handling are up to date and legally defensible in order to claim protection from the CSP under the Professional and Public Liability Insurance scheme.⁽⁷²⁾ Post-graduate programmes that award cohesion within this specialist area are based upon the Inter-Professional Curriculum (1997)⁽⁷³⁾ which was jointly constructed by five professional organisations with direct input into manual handling development and practice:

- Chartered Society of Physiotherapy
- National Back Exchange
- Royal College of Nursing
- College of Occupational Therapists
- Ergonomics Society.

Recommendations:

- Physiotherapists who become BCAs should consult the recommendations for a registered membership of National Back Exchange⁽⁷⁴⁾, the RCN Competencies⁽⁷¹⁾ and the requirements of the COT.⁽⁶⁰⁾ These confer a nationally recognised level of skill and experience in manual handling upon the individual and will eventually lead to enhanced professional protection and creation of standard evidence-based practice

Education and Continuing Professional Development

- Back Care Advisers working in health and social care provision should consult specialist physiotherapists regarding their areas of skill and knowledge, and regarding specialised physiotherapeutic environments, for example hydrotherapy pools
- Physiotherapists who become BCAs have an enhanced responsibility regarding their CPD within the relevant professional codes of conduct to retain their position as 'experts'.

5.2.4 Physiotherapy Assistants

Physiotherapy assistants will require direction by proficient practitioners and supervision by competent or proficient practitioners. They will be deemed to fit into the same skill categories as students i.e. 'novice' and 'advanced beginner' as they may not possess the holistic understanding of the patient's overall rehabilitation plan nor have the knowledge to develop conceptual models of manual handling outcomes.

Recommendations:

- Manual handling tasks must not be delegated to physiotherapy assistants without the delegating practitioner ensuring the assistant's level of competence
- Physiotherapy assistants must attend regular training updates in manual handling provided by their employers, including training in equipment use
- Physiotherapy assistants must have the opportunity to seek help and advice from proficient practitioners regarding manual handling problems.

5.2.5 Volunteers

All volunteers will be deemed to be 'novices' in manual handling, for legal purposes.

Recommendations:

- All volunteers will be supervised during manual handling of patients by a practitioner who is at least deemed competent in manual handling practice
- Volunteers should be given the opportunity to attend training in manual handling wherever possible.



Appendices – Appendix 1

Factors to consider when assessing manual handling risks and ways of reducing the risk

Reproduced with permission from HSE⁽²⁹⁾

Problems to look for when making an assessment	Ways of reducing the risk of injury
<p>The tasks, do they involve:</p> <ul style="list-style-type: none"> • holding loads away from the body? • twisting, stooping or reaching upwards? • large vertical movement? • long carrying distances? • strenuous pushing or pulling? • repetitive handling? • insufficient rest or recovery time? • a work rate imposed by a process? 	<p>Can you:</p> <ul style="list-style-type: none"> • use a lifting aid? • improve workplace layout to improve efficiency? • reduce the amount of twisting and stooping? • avoid lifting from floor level or above shoulder height, especially heavy loads? • reduce carrying distances? • avoid repetitive handling? • vary the work, allowing one set of muscles to rest while another is used? • push rather than pull?
<p>The loads, are they:</p> <ul style="list-style-type: none"> • heavy, bulky or unwieldy? • difficult to grasp? • unstable or likely to move unpredictably (like animals)? • harmful, for example sharp or hot? • awkwardly stacked? • too large for the handler to see over? 	<p>Can you make the load:</p> <ul style="list-style-type: none"> • lighter or less bulky? • easier to grasp? • more stable? • less damaging to hold? • If the load comes in from elsewhere, have you asked the supplier to help, for example provide handles or smaller packages?
<p>The working environment, are there:</p> <ul style="list-style-type: none"> • constraints on posture? • bumpy, obstructed or slippery floors? • variations in levels? • hot/cold/humid conditions? • gusts of wind or other strong air movements? • poor lighting conditions? • restrictions on movements or posture from clothes or personal protective equipment (PPE)? 	<p>Can you:</p> <ul style="list-style-type: none"> • remove obstructions to free movement? • provide better flooring? • avoid steps and steep ramps? • prevent extremes of hot and cold? • improve lighting? • provide protective clothing or PPE that is less restrictive? • ensure your employees' clothing and footwear is suitable for their work?
<p>Individual capacity, does the job:</p> <ul style="list-style-type: none"> • require unusual capability, for example above-average strength or agility? • endanger those with a health problem or learning/physical disability? • endanger pregnant women? • call for special information or training? 	<p>Can you:</p> <ul style="list-style-type: none"> • pay particular attention to those who have a physical weakness? • take extra care of pregnant workers? • give your employees more information, for example about the range of tasks they are likely to face? • provide more training (see 'What about training?') <p>Get advice from an occupational health advisor if you need to.</p>

Appendices – Appendix 1

Problems to look for when making an assessment	Ways of reducing the risk of injury
<p>Handling aids and equipment:</p> <ul style="list-style-type: none"> • is the device the correct type for the job? • is it well maintained? • are the wheels on the device suited to the floor surface? • do the wheels run freely? • is the handle height between the waist and shoulders? • are the handle grips in good order and comfortable? • are there any brakes? If so, do they work? 	<p>Can you:</p> <ul style="list-style-type: none"> • provide equipment that is more suitable for the task? • carry out planned preventive maintenance to prevent problems? • change the wheels, tyres and/or flooring so that equipment moves easily? • provide better handles and handle grips? • make the brakes easier to use, reliable and effective?
<p>Work organisation factors:</p> <ul style="list-style-type: none"> • is the work repetitive or boring? • is the work machine or system-paced? • do workers feel the demands of the work are excessive? • have workers little control of the work and working methods? • is there poor communication between managers and employees? 	<p>Can you:</p> <ul style="list-style-type: none"> • change tasks to reduce the monotony? • make more use of workers' skills? • make workloads and deadlines more achievable? • encourage good communication and teamwork? • involve workers in decisions? • provide better training and information?

Appendices – Appendix 2

General risk assessment guidelines

Reproduced with permission from HSE ⁽²⁹⁾

There is no such thing as a completely 'safe' manual handling operation. Working within the following guidelines will cut the risk and reduce the need for a more detailed assessment.

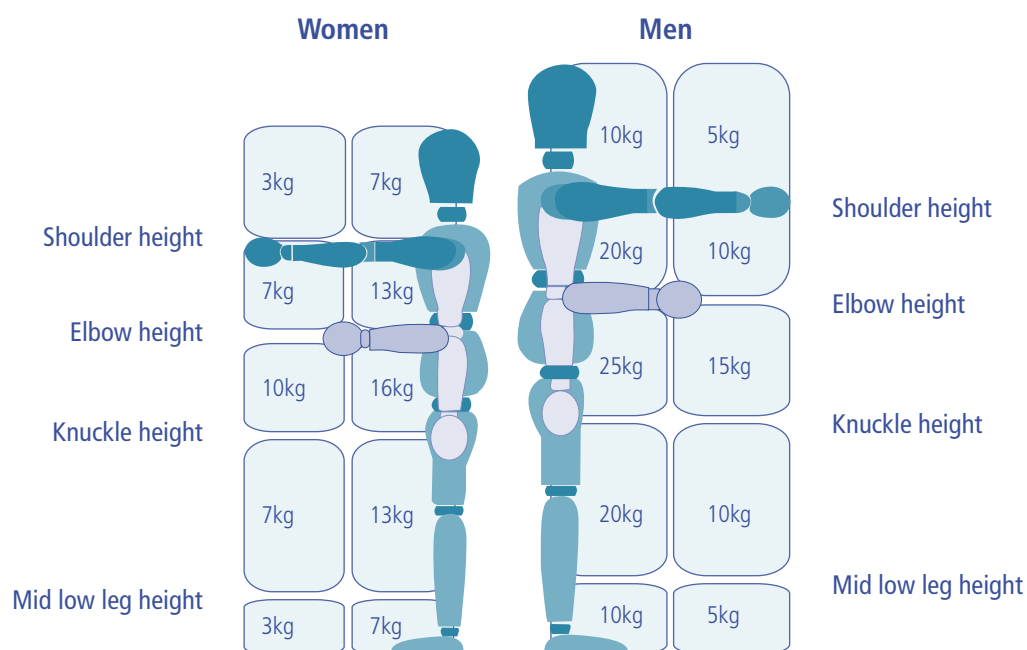


Figure 1 Lifting and lowering

- Use Figure 1 to make a quick and easy assessment. Each box contains a guideline weight for lifting and lowering in that zone. (As you can see, the guideline weights are reduced if handling is done with arms extended, or at high or low levels, as that is where injuries are most likely to occur)
- Observe the work activity you are assessing and compare it to the diagram. First, decide which box or boxes the lifter's hands pass through when moving the load. Then, assess the maximum weight being handled. If it is less than the figure given in the box, the operation is within the guidelines
- If the lifter's hands enter more than one box during the operation, use the smallest weight. Use an in-between weight if the hands are close to a boundary between boxes
- The guideline weights assume that the load is readily grasped with both hands and that the operation takes place in reasonable working conditions, with the lifter in a stable body position.

Twisting

Reduce the guideline weights if the handler twists to the side during the operation. As a rough guide, reduce them by 10 per cent if the handler twists beyond 45°, and by 20 per cent if the handler twists beyond 90°.

Frequent lifting and lowering

The guideline weights are for infrequent operations – up to about 30 operations per hour – where the pace of work is not forced, adequate pauses to rest or use different muscles are possible, and the load is not supported by the handler for any length of time. Reduce the weights if the operation is repeated more often. As a rough guide, reduce the weights by 30 per cent if the operation is repeated once or twice per minute, by 50 per cent if the operation is repeated five to eight times a minute, and by 80 per cent where the operation is repeated more than 12 times a minute.

Appendices – Appendix 2

Pushing and pulling

The task is within the guidelines if the following figures are not exceeded:

	Men	Women
Force to stop or start the load	20 kg	15 kg
Sustained force to keep the load in motion	10 kg	7 kg

See 'Good handling technique for pushing and pulling' for some examples of forces required to push or pull loads.

Using the results: do I need to make a more detailed assessment?

Using Figure 1 is a first step. If it shows the manual handling is within the guideline figures (bearing in mind the reduced limits for twisting and for frequent lifts) you need not do any more in most cases. But you will need to make a more detailed assessment if:

- the conditions given for using the guidelines (for example, that the load can be readily grasped with both hands) are not met
- the person doing the lifting has reduced capacity, for example through ill health or pregnancy
- the handling operation must take place with the hands beyond the boxes in the diagram; or
- the guideline figures in the diagram are exceeded.

For pushing and pulling, you should make a more detailed assessment if:

- there are extra risk factors like uneven floors or confined spaces
- the worker can't push or pull the load with their hands between knuckle and shoulder height
- the load has to be moved for more than about 20m without a break or
- the guideline figures in the table are likely to be exceeded.

More advice on how to make a more detailed assessment is given in our main guidance booklet *Manual handling*. Guidance on regulations (see 'Further reading' for details).

HSE has also developed a tool called the Manual Handling Assessment Chart (MAC), to help you assess the most common risk factors in lifting,

carrying and team handling. You may find the MAC useful to help identify high-risk manual handling operations and to help complete detailed risk assessments. It can be downloaded from www.hse.gov.uk/msd

Are you saying I mustn't exceed the guidelines?

No. The risk assessment guidelines are not 'safe limits' for lifting. But work outside the guidelines is likely to increase the risk of injury, so you should examine it closely for possible improvements. You should remember that you must make the work less demanding if it is reasonably practicable to do so.

Your main duty is to avoid lifting operations that involve a risk of injury. Where it is not practicable to do this you should assess each lifting operation and reduce the risk of injury to the lowest level reasonably practicable. As the risk of injury goes up you must look at the operation increasingly closely to make sure it has been properly assessed and the risk of injury has been reduced.

Appendices – Appendix 3

Patient factors to consider when addressing the 'load' aspect of a manual handling risk assessment

- Medical condition
- Medication effects
- Drips, tubes, lines, drains etc.
- Condition of the skin[†]
- State of the feet
- Pain
- Tremor
- Contracture
- Stiffness
- Tone
- Spasm
- Posture
- Balance
- Locus of control
- Height
- Weight
- Relationship between height and weight
- Cognition
- Perception
- Willingness to cooperate
- Aggression
- Predictability
- Effort
- Time of day
- Tiredness

See also Section 2.5.4.2 Patient participation (Load)

[†] therapists working with burns patients need to be particularly aware of the fragility and pain of the affected area. The skin substitute (or skin product) or graft must not be subjected to shearing forces in the early stages.

All Wales Treatment Handling Risk Assessment form

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

Record risks in appropriate column (* see document – elements of Treatment Handling Risk

Named task and Clinical Reasoning	Date/time Signature	Individual(s) assisting Record job title/grade, person/s assisting where relevant	Load (client) Record details relevant to risk* and the Patient Ability Criteria, not just diagnosis	Environment Record details relevant to risk* not just location of task undertaken	Risk reducing measures	Date and reason no longer applicable

All Wales Treatment Handling Risk Assessment form – continuation sheet

Name:		Address:				
DoB:						
Named task and Clinical Reasoning	Date/time Signature	Individual(s) assisting Record job title/grade, person/s assisting where relevant	Load (client) Record details relevant to risk* and the Patient Ability Criteria, not just diagnosis	Environment Record details relevant to risk* not just location of task undertaken	Risk reducing measures	Date and reason no longer applicable

Appendices – Appendix 4

Notes on the All Wales Treatment Handling Risk Assessment form

Rationale

The risk of injury from treatment handling is acknowledged by the CSP and COT. Many therapists still feel that if they do not have direct 'hands-on' contact with a patient/client, then they are not delivering appropriate therapy. However, patients/clients can be rehabilitated without the therapists putting themselves at risk of injury. This can be achieved by the appropriate use of equipment or sufficient foresight before beginning a treatment session as to safer positioning of patient, therapist or equipment.

In this litigious climate in which we live, we may soon have to justify why we carry out certain treatments should the client or therapist sustain an injury or even if the client fails to progress as expected following an injury or pathology.

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

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

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

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

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

Guidelines for Completion

- Each sheet number must be completed
- Patient/client details including name, address, date of birth, approximate height and weight (where accurate measurements are not available), location seen, hospital number and so on. Where patient information sticky labels are available, these can be used
- The name/s and signature/s of any therapists completing the form

- Named task – what the therapist is literally doing with the patient/client that is the treatment intervention. For example, assisted sit to stand, assisted walking, passive movements. If the form is used in conjunction with the 12 protocols, the clinical reasoning and patient ability criteria are already stated. It must be stated which protocol has been used
 - Clinical reasoning – why you are using that particular treatment intervention (perhaps over another) with the patient/client. What is your justification for the intervention? **This is NOT treatment goals or aims of treatment**
 - For example, assisting client into standing frame/tilt table as unable to stand independently. Passive movements as client unable to move limbs independently.
 - Assisted walking as client able to weight bear with minimal assistance, has voluntary stepping action with both feet and unable to walk independently.
 - Date/time/Signature – a risk assessment is only appropriate for that client, therapist or individual carrying out the intervention at that particular time and place. The therapist completing the risk assessment for the task must also sign in this column
 - Individual assisting – where relevant, the grade of therapist, level of experience of persons assisting should be documented. Personal details regarding the therapist's health should **not** be recorded
 - Load (this refers to the client) and environment – examples of risks associated with these areas of TILE are detailed on the Elements of Treatment Handling Risk Assessment document. These are examples only and in no way an exhaustive list. Risks relevant to the planned intervention should be documented. It is insufficient just to state the diagnosis
 - Risk Reducing Measures – detail here any measures that have been taken to reduce the risk of injury to any party involved in the intervention, to the lowest reasonably practicable level. For example use of adjustable height equipment, additional persons to carry out the intervention, use of glide sheets, small handling equipment and so on.
- A clear line must be put through the whole row of the risk assessment once a treatment intervention is:
- No longer relevant to the client.
 - Or the risk assessment is invalid either because the client has improved or sustained further pathological changes or simply deteriorated.

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

Appendices – Appendix 5

Human rights legislation

In October 2000, the Human Rights Act 1998 came into force. It acted as the vehicle for bringing into United Kingdom law the European Convention on Human Rights. The Act and Convention apply to public bodies, such as local authorities, NHS Trusts and central government departments – but not directly to independent care providers. This means that local authority decision making in respect of manual handling must comply not just with relevant domestic legislation, but also with the articles of the Convention. A number of Convention articles are relevant to local social services authorities in general. In respect of manual handling issues, the courts have to date referred to three in particular. These concern the right to life (article 2), the right not to be subjected to inhuman or degrading treatment (article 3) and the right to respect for home, private and family life (article 8). On the courts' current interpretation of 'public body', the Act and Convention do not apply directly, for example, to independent care providers of care homes or of domiciliary services. However, if a local authority knew, or should reasonably have known, that a care provider with whom it had contracted was acting contrary to human rights, the courts might find that authority to be in breach of the Act.

Manual handling

In relation to human rights, the courts have ruled that certain types of manual handling policy are likely to be unlawful in the context of community care. These were 'no lifting'; no lifting unless life or limb were at risk; and no lifting if equipment could physically effect the transfer (A&B, X&Y v East Sussex CC).

Perish

Leaving disabled people as a matter of manual handling related policy or protocol to drown in the bath or perish in a fire could engage article 2 and the right to life (A&B, X&Y v East Sussex CC).

Disabled prisoner

A severely physically disabled person was sent to prison for contempt of court, for failing to disclose her assets in a debt case. In the police cell she was unable to use the bed and had to sleep in her wheelchair where she became very cold. When she reached the prison hospital, she could not use the toilet herself, the female duty officer could not manage to move her alone, and male prison officers had to assist. The European Court found that to detain a severely disabled person in conditions where she is dangerously cold, risks developing pressure sores because her bed is too hard or unreachable, and is unable to go to the toilet or keep clean without

the greatest difficulty, constituted degrading treatment contrary to article 3. Damages of £4,500 were awarded (Price v United Kingdom).

Psychological integrity of a disabled person

Article 8 (right to respect for home, private and family life) has been held to include the physical and psychological integrity of disabled people, both within and without the home. Thus in a manual handling dispute, involving two women with severe physical and learning disabilities, it applied both to issues such as the dignity surrounding hoisting and transfers within the home – and to their participation in the life of the community, including recreational and cultural activities. However, the judge pointed out that paid carers, too, had rights relating to integrity and dignity under article 8. He also emphasised that hoisting was not inherently degrading, but that whether it was or not would depend on all the circumstances of the particular situation (A&B, X&Y v East Sussex County Council).

Person dependent and humiliated

A local authority social services department assessed a need of suitable accommodation and adaptations for a 48-year-old disabled woman (who had suffered a stroke) living with her family and six children. Two years later nothing had happened; the family was not eligible for assistance from the housing department, and social services had not acted. As a consequence, the woman could not reach the lavatory and soiled herself several times a day, had no privacy, could not go out of the house, could not go upstairs, and could not go anywhere without her husband's assistance. She had to share a cramped living room with her husband and two youngest children; the other children had to go through that room in order to go upstairs. Her husband's health was at risk; his back problem deteriorated from manual handling. She felt frustrated and humiliated because she was unable to do anything for her family and was totally dependent on them. The judge concluded that although some people would regard the above conditions as degrading, particularly in relation to the incontinence, he did not believe they crossed the threshold posed by article 3 of the Convention, although the matter was finely balanced. However, he did find a breach of article 8 (R v Enfield London Borough Council, ex p Bernard).

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Appendices – Appendix 6

Private practitioner self-assessment pro forma

The following questions are designed to assist private practitioners to access the parts of this guidance that are particularly pertinent to them, and to help them decide if they meet the guidance, comply with the law and whether they need to change their managerial or clinical processes.

Question	Y/N	Guidance section	Action
Do you regard the moving and handling of patients to be part of your current practice?		1.3.4 1.3.7 2.3	
Have you attended a recent education course in handling skills and updated your CPD portfolio?		1.2.5 5.1	
Does manual handling risk management form a regular part of your CPD and clinic organisation?		1.3.2 1.3.6 1.3.7 1.3.15 2.2.4 2.2.5 Appendices 1&2	
If you work alone do you have a risk management policy?		2.5.1	
If you employ non-physiotherapy staff, have you carried out manual handling risk assessments of their tasks and individual capabilities?		1.2.4 1.3.5 1.3.6 2.4	
Do manual handling assessments form a regular basis of your initial patient assessments?		1.2.5 1.3.4 2.5.1 2.5.2 Appendices 3 & 4	
Are these assessments ongoing and adequately documented?		1.3.6 1.3.8 1.3.9	
Do you constantly consider the 'Utility of the Act', that is potential benefit to the patient, of any high risk treatment plans?		1.1 1.3.8.2	

Appendices – Appendix 6

Question	Y/N	Guidance section	Action
Is your clinic accessible to patients with a disability? If not, have you considered the feasibility of reasonable adjustments to your clinic?		1.3.12	
Is your clinic environment suitable for the moving and handling of patients as part of their clinical treatment?		2.5.3 2.6.1	
Does your clinic have a policy for treating bariatric patients?		1.3.8.3 3.8.1	
Is your equipment suitable for the range of handling tasks you undertake? For example, Do you know the safe working load of your treatment plinth? Is your treatment plinth height adjustable?		1.3.5 1.3.6 1.3.7 1.3.8.1 1.3.8.2 2.7 2.8	
If you treat patients in a gym do you have transfer equipment available if required?		2.7	
Do you constantly consider your own working patterns and postures with regard to the danger of work related Musculoskeletal disorders?		2.2	
Do you prescribe treatment and manual handling plans for patients?		2.3	
Do you undertake the role of trainer of manual handling within your practice?		4.5 5.2	
Have you considered your responsibilities as an employer in areas of education and supervision?		1.1 1.2.4 5.2	

The section links indicated here are the key ones and do not replace reading the document.

Appendices – Appendix 7

The Dreyfus model of skill acquisition

The model⁽⁶⁵⁾ describes five stages of skill acquisition characterised by certain factors. Benner⁽⁶⁶⁾ has already used Dreyfus' model in application to nursing skills, and other sources have applied the same model variously to learner physicians and IT development. Here the model has been transcribed to apply to the acquisition of manual handling skills within the physiotherapeutic educational pathway, offering a structure that outlines both levels of responsibility and creates learning outcomes for physiotherapists' CPD.

Level	Performance characteristics	Physiotherapy education level
A novice:	<ul style="list-style-type: none"> • Has little or no experience of the situations in which they are expected to perform • Rigidly adheres to rules, regulations and plans • Has little situational perception • Doesn't want to learn – wants to accomplish goal • Applies rules universally as the situations they meet are context-free, generic and simple • Displays behaviour that is necessarily extremely limited and inflexible • Doesn't feel responsible for any action other than following the rule 	<p>Student physiotherapists are 'observers' where they observe manual handling practice of their tutors, clinical supervisors, and colleagues in simulated and controlled situations. They will learn basic manual handling manoeuvres of a generic type, for example 'using a hoist' 'getting a patient out of bed' with the outcome of 'doing it correctly' and 'performing good practice'. In common with other clinical skills at this level, students have little or no experience base in manual handling to analyse, argue or justify from. They require supervision at all times.</p>
An advanced beginner:	<ul style="list-style-type: none"> • Still has a limited perception of treatment outcomes • Finds 'troubleshooting' difficult • Wants information fast without analysis to achieve goal • Begins to formulate principles of responsive behaviour based on experience so far • Should be able to identify new 'situational' elements and place advice in required context • Begins to apply rules to related conditions but still makes decisions by rule application • Does not experience personal responsibility 	<p>Advanced students now can be 'assistants' whereby they assist colleagues with predetermined manual handling procedures. They should now have experienced enough 'real' manual handling situations to begin to understand the recurring meaningful situational components, either alone or with the help of a mentor. However, they will be unable to apply principles alone and will still be producing rule-based behaviour and therefore rule-based performance errors. They will be supervised by proficient practitioners in specialist areas and may seek advice from competent colleagues.</p>

Appendices – Appendix 7

Level	Performance characteristics	Physiotherapy education level
A competent practitioner:	<ul style="list-style-type: none"> • Begins to see actions in terms of long-range goals/plans • Begins to establish perspective based on abstract and analytical contemplation of the problem • Uses conscious deliberate planning to address specific aspects of the problem • Copes with previously-experienced situations well, but lacks speed and flexibility in decision making • Is beginning to cope with multiple clinical decision making • Utilises standardised procedures • Seeks out expert advice to assist with new situations and ‘troubleshooting’ 	<p>A graduate physiotherapist would be expected to be competent in manual handling – able to act safely within basic experienced situations but still requiring to perform procedures under direct (usually senior) supervision. Still building a ‘portfolio’ of experience across novel situations of different components. They should be actively seeking the directions/guidance of proficient and expert colleagues to extend their existing knowledge, reinforce practice and develop conceptual models. In novel situations they will seek direction and advice from proficient practitioners in their specialist areas or from experts in general problem-solving. They may offer basic advice and guidance within their own area of competence.</p>
A proficient practitioner:	<ul style="list-style-type: none"> • Understands the situation as a whole due to perception of long-term goals • Learns from experience (including that of others) what typical events arise in a given situation and how plans need to be modified in response to those events • Can recognise when the anticipated outcomes do not materialise • Is able to use faster less laboured decision making due to prioritisation of situational aspects and attributes • Uses maxims that vary according to the requirements of the situation – reflecting the nuances of different situations • Is able to prioritise situation in terms of important actions • Perceives that deviation may be appropriate from ‘normal’ pattern of response • Can self-correct based on previous performance • Is frustrated by oversimplified information/instructions 	<p>A proficient practitioner in manual handling performs entire procedures without supervision. They refer constantly to conceptual models developed by themselves and others, using a balanced range of outcomes, including:</p> <ul style="list-style-type: none"> • Therapist safety • Patient safety • Achieving treatment objectives • Patient satisfaction • Patient independence • External factors, for example funding, work system requirements • Psychosocial factors <p>They will also be involved in generic and individual patient assessments incorporating manual handling recommendations as part of holistic patient management. They will be supervising and mentoring other physiotherapists, including students and assistants, and may train at a basic level. They may act as expert witnesses within their area of physiotherapeutic practice. In novel situations beyond their experience, they may seek peer or expert support.</p>

Appendices – Appendix 7

Level	Performance characteristics	Physiotherapy education level
An expert practitioner:	<ul style="list-style-type: none"> • No longer uses an analytical approach to connect understanding of situation to appropriate action • Instead uses an enormous experiential background to allow deep understanding and an intuitive grasp of situation • ‘Homes in’ on accurate problem-solving without searching through a wasteful range of alternative solutions • Possesses a range of highly-developed conceptual models • Performs in a highly fluid, flexible and proficient capacity • Is capable of advanced analytical problem solving in novel situations or when erroneous grasp of the holistic overview has been taken • No longer dependent on structured algorithms • Long-term vision of what alternatives are available and what is possible • May use jargon expressions which may be unintelligible to non-proficient performers • Produces a poor performance if forced to follow set rules 	<p>An expert practitioner in manual handling is truly independent. They plan, structure, implement and evaluate manual handling strategies using a consultative team approach to produce problem solving alternatives within an holistic approach. They use a manual handling experience base that is both deep (that is moving from simple to very complex problems/ situations) and wide (that is across many physiotherapeutic specialities and into areas covered by other professions). They have an extended education in manual handling which empowers them to manage change (including behavioural change), and to research, evaluate and develop new practice in manual handling approaches.</p> <p>They will offer guidance and advice and will be structuring and developing educational pathways for other handlers, including other professionals. They may act as expert witnesses in manual handling litigation cases generally.</p> <p>In novel situations they will create solutions using advanced analytical problem solving and they will also consult with expert peers, although in a group they will often have difficulty reaching consensus due to development of strongly individual conceptual models.</p>

Appendices – Appendix 8

Suggested components of manual handling courses for physiotherapists to 'competence' level

- Principles of human movement, including principles of one person being moved by another⁽⁴⁶⁾
- Current manual handling legislation and how it impacts upon professional practice, including CSP standards of practice
- Risk factors associated with musculoskeletal problems and how tasks may be altered to lower the combination of these factors (ergonomics)
- Generic and individual risk assessment, including recording
- Musculoskeletal care, including the prevalence of injury to the profession
- Principles of problem solving in manual handling
- Working knowledge of the mechanical principles involved in equipment
- Working knowledge of commonly-met handling aids, including hoists and 'small' equipment, for example sliding sheets.

Appendices – Appendix 9

Evaluation of manual handling training-competences markers

It is suggested that further work is undertaken to clarify competence markers (or key performance indicators) within manual handling courses designed for physiotherapists. These markers would be suggested by the Dreyfus continuum as a useful approach. The following example is a suggestion for a competent level in manual handling. (It is expected that practical markers would need to be added per specialisation after consultation with specialised proficient practitioners.)

Decision making	<ul style="list-style-type: none"> • Locates and determines relevant manual handling information regarding patient, for example staff/pt. records/pt. interview, family, other professionals, care plan • Makes a reasoned judgement, taking all relevant risk factors into account.
Professionalism	<ul style="list-style-type: none"> • Shows respect, compassion, empathy, and establishes trust • Attends to patient's needs, their comfort and care while handling • Respects confidentiality • Behaves in an ethical manner with awareness of legal responsibilities • Is aware of personal and professional limitations in handling skills and knowledge.
Clinical judgement/reasoning	<ul style="list-style-type: none"> • Applies manual handling decisions within care plan and overall management of patient care • Selectively suggests recommendations considering appropriate outcomes, including the overall risk to carers and patient.
Communication skill	<ul style="list-style-type: none"> • Responds appropriately to verbal and non-verbal clues during assessment and handling performance • Explores patient perspective • Uses jargon-free, open and honest speech • Is empathetic in approach and agrees the management plan/therapy objectives with the patient before handling task commences.
Organisational	<ul style="list-style-type: none"> • Performs succinct professional clear record keeping • Works with and within a team • Is aware of financial responsibilities • Seeks further help and assistance from proficient and expert practitioners • Is aware of central and local manual handling policies, protocols and procedures.
Overall	<ul style="list-style-type: none"> • Uses appropriate clinical judgement • Uses synthesis and caring effectiveness • Makes appropriate use of manual handling resources including those offered, for example by a Back Care Adviser • Is aware of own limitations and responsibilities in manual handling.

Appendices – Appendix 9

Practical performance	<ul style="list-style-type: none">• Shows awareness of good posture and positioning wherever possible• Selects manoeuvre/techniques based on individual patient assessment (see above)• Uses only manoeuvres/techniques identified by evidence-based practice and/or• Uses alternative manoeuvres/techniques which are justifiable in terms of the above assessment and considered the safest possible in the circumstances• Uses efficient mechanical principles to effect movement, including:<ul style="list-style-type: none">• movement of shoulder girdle and pelvis• contact points on the trunk• use of low friction (sliding)• position of feet, head, shoulders, legs• using short lever distances• Uses effective communication as an assistive tool in moving patients• Achieves the determined therapeutic outcomes in the safest and most comfortable manner possible• Recognises when a particular manoeuvre/technique should be altered or abandoned and offers alternatives• Performs reactively to change in the patient's needs, requirements and capabilities• Chooses and uses appropriate manual handling equipment.
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Glossary

Advance refusal – the process whereby it is possible for people to make an advance decision to refuse treatment should they lack capacity in the future.

Common Law – the legal system employed by English courts.

Competence – general, overall capacity; holistic; rests on the consensus view of what forms good practice.⁽⁷⁵⁾

Conditions of Practice order – order placed by the Health Professions Council on a registrant who has been found guilty of a breach of the HPC Standards of Proficiency.

Delegation – the entrustment of a physiotherapy task to another person, who will perform that task in the place of the treating or supervising physiotherapist, with the consent of the patient.

Duty of care – in common law, a duty of care exists where one person (or organisation) can reasonably foresee that his/her (its) actions and/or omissions could cause reasonably foreseeable harm to another person.

Electrophysical agents – treatment interventions involving the use of electrophysical interventions (formerly known as electrotherapy).

Expertise – the ability to operate as a truly independent practitioner. Capacity to plan, structure, implement and evaluate strategies using a consultative team approach to produce problem-solving alternatives within an holistic approach.

Guidance and advice – the professional verbal or written input given by the treating physiotherapist in his/her role as a part of the care team, to the overall rehabilitation and/or management of a patient.

Hazard – something with the potential to cause harm.

Habilitation – the act of enabling.

Proficiency – the ability to perform entire procedures without supervision, referring constantly to conceptual models developed independently or by others, using a balanced range of outcomes.

Reasonably practicable – capable of being done and at a cost that is not grossly disproportionate to the benefit derived.

Rehabilitation strategies – the planned progression of manual handling intervention in response to a patient's increasing ability.

Risk – a notional consideration of the likelihood that a hazard will result in harm (to the handler, the person or anyone else associated with the task) and of the severity or extent of that harm.

Supervision – a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice.⁽⁷⁶⁾

Tort – a 'civil' wrong, for example negligence, trespass, nuisance and defamation (libel and slander).

Treatment handling – any treatment where force is applied through any part of the therapist's body to or from any part of the patient constitutes manual handling. Any manual handling involved in a physiotherapy treatment programme may be defined as treatment handling.

Utility – the potential benefits of an intervention

Vicarious liability – where the employer stands liable for an injury caused by an individual where they are acting in the course of their employment.⁽⁷⁷⁾

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