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Manual Handling for Chartered Physiotherapists

The issue of manual handling for Chartered physiotherapists has always been complex. Chartered physiotherapists routinely handle patients as part of the assessment and treatment process. They teach others how to handle patients as safely as possible as part of the ongoing rehabilitation programme for the patient. They formally teach other professions and act as back care advisers and tutors. Chartered physiotherapists also see the results of poor manual handling activities in the form of a range of musculo-skeletal injuries to various staff, including physiotherapy colleagues.

Following the introduction of Health and Safety Legislation in 1974, where the issue of manual handling was targetted, physiotherapists have been obliged by law to ensure that they undertake manual handling practices which are as safe as possible in order to ensure their own safety, as well as the safety of those they are instructing, delegating to or advising and also that of patients.

This document sets out to reassure many who are concerned regarding this area of practice and ensure that Chartered physiotherapists continue to treat and handle patients effectively and efficiently; also to provide the rationale to continue safe treatment handling practices in the best interests of patient care.

The purpose of this document is to enable and support chartered physiotherapists to treat and handle patients competently and as safely as possible.

Throughout this document the term "rehabilitation handling" is used. This term encompasses all the activities which involve handling as part of the patients rehabilitation programme. This includes the handling that is undertaken by the key treating physiotherapist themselves and staff, relatives or carers who are delegated to or advised on handling procedures.

The document sets out the legal framework in which rehabilitation handling takes place; sets rehabilitation handling in context and covers the range of people and circumstances where delegation and advice are appropriate and looks at the training requirements needed to accomplish this.

This document should be used by physiotherapists to inform themselves of the issues surrounding rehabilitation handling and to inform other professionals, patients and carers of the role of physiotherapists in this area. It can also be used to inform employers of their duties, in particular to support and facilitate physiotherapists to undertake rehabilitation handling as safely as possible and competently by the provision of appropriate training, equipment and protocols.

A limited amount of further information on manual handling is available from the Industrial Relations (IR) Department at the CSP; this guidance is incorporated into the Safety Representatives Information Manual, which is the Society's central resource for its 700 accredited workplace safety reps. It covers the law relating to moving and handling and also some more practical aspects of manual handling as a workplace hazard.

The IR information looks at manual handling from a slightly different perspective to the one taken in this publication; it addresses the manual handling legal responsibilities and duty of care that employers have towards CSP members who are their employees. It also explores the rights that employees have as a result of their employer's obligations to them and offers advice to members and representatives about good manual handling practice in the workplace and how to resolve any problems that may arise. This guidance does not address the professional duty of care between a physiotherapist and their patient.

The information places considerable emphasis on the necessity of comprehensive risk assessments and properly funded, appropriate risk reduction measures, as well as the importance of having agreed workplace manual handling policies. Members needing further advice in any of these areas should contact their local CSP steward or the Industrial Relations Department.

Physiotherapy is an autonomous profession concerned with the rehabilitation of patients

Manual Handling is integral to the practice of the profession of physiotherapy

It is not always reasonably practicable to avoid manual handling in physiotherapy without abandoning the goal of the rehabilitation of patients

A risk assessment must always be undertaken prior to handling any patient and appropriate steps taken to minimise any risk to the patient and to those delivering the physiotherapy intervention

1.1 Manual Handling in Physiotherapy: Legal and Professional Duties

The purpose of this introductory chapter is to clarify and set in context the legal duties relating to manual handling within the practice of physiotherapy. In order to do so it is necessary to consider the general requirements imposed by the Health and Safety at Work Act (HSWA) 1974, the Management of Health and Safety at Work Regulations (MHSWR) 1999 and the hierarchy of measures imposed by the Manual Handling Operations Regulations (MHOR) 1992. Some relevant aspects of common law will be discussed and reference will be made to the CSP Rules of Professional Conduct (RPC), Standards of Physiotherapy Practice (SPP – revised 2000) and The Human Rights Act (1998).

1.2 A Definition of Physiotherapy

A detailed definition of the evolving profession of physiotherapy is beyond the scope of this document. However, the 1996 Curriculum Framework defines physiotherapy as:

"…a health care profession which emphasises the use of physical approaches in the promotion and restoration of an individual's physical, psychological and social wellbeing, encompassing variations in health status".

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

- Manual therapy
- 'Therapeutic' handling (manual handling in treatment)
- Therapeutic exercise
- Electrophysical modalities

Thus interventions/treatment involving manual handling are an essential core element of the physiotherapy profession.

1.3 Standards of Physiotherapy Practice

The CSP has stressed the need for standards to be realistic, understandable, measurable and achievable. The revised core standards of physiotherapy practice are focused towards:

- Patient partnership
- Communication
- Documentation
- Promotion of a safe environment
- Assessment and treatment
- Continuing Professional Development (CPD)

All of the above have particular relevance to manual handling and the legal requirements placed upon us in occupational health and safety law, notably assessment, communication and negotiation, agreeing goals, treatment planning and review, patient and practitioner safety and, importantly, documentation. Documentation is the only tangible evidence of a critical link between the assessment, reasoning and goals of the treating physiotherapist and the patient's functional performance outcomes.

1.4 The Human Rights Act

At the time of writing this document, there is no body of law relating to judicial interpretation of The Human Rights Act. It must, however, be the case that public authorities are now under a duty to act compatibly with the Convention rights of patients 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. 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.

The English Legal System* is a Common Law System

Statutes and statutory instruments as well as previous cases are interpreted by Judges and their decisions become part of common law

Statute Law

EC Regulations

Acts of Parliament/Statutes

Made by House of Commons
House of Lords
Royal Assent

Statutory Instruments

Made by relevant ministry

Laid before Parliament

Common Law

EC Court rulings

House of Lords - cases on important points of law

Court of Appeal

High Court/Crown Court

decisions binding on basis of Precedent and hierarchy

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

1.5 Duty of Care

The law states that a duty 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. In the case of Donoghue v Stephenson (1932), 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 exist between a physiotherapist and his/her patient but 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 3).

Differences between criminal and civil law

	Criminal Law	Civil Law
Basis of action	criminal offence charge	an alleged wrong (a Tort) by one person against another
Action brought by	Crown Prosecution Service Health and Safety Executive	the person against whom the wrong (Tort) has been done
Standard of Proof	beyond reasonable doubt	balance of probabilities
Facts decided by	Magistrates Court - the magistrate(s) Crown Court - the jury	County Court - the judge High Court - the judge(s)
Law applied by	Magistrates Court - the magistrate(s) Crown Court - the judge	the judge(s)

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1.6 The Tort of Negligence

A breach of the duty of care may give rise to a claim for negligence in civil law. To succeed, a Claimant must show that:

- the Defendant owed the person harmed a duty of care;
- the Defendant was in breach of that duty. In respect of this point the person harmed must show that:
  - A the risk to which he/she was exposed was reasonably foreseeable
  - B it would have been reasonably practicable to circumvent the risk
- the harm was a direct consequence of the reasonably foreseeable risk;

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

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

Thus, a physiotherapist, whether performing or delegating manual handling or giving advice or guidance about it, may well owe a duty of care to those affected as a result.

1.7 Determining the Standard of Care

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

- education/training,
- physiotherapy interventions with patients,
- delegation,
- the giving of advice/guidance,
- 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 required 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) 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 a specialist or an expert, then the required standard would be of a different order. Further reference will be made to the Bolam test when considering the Guidance to the MHOR92/98.

In the more recent case of Bolitho v Hackney Health Authority (1997), 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. It remains unclear as to whether this actually modifies the Bolam test.

1.8 Rules of Professional Conduct

Rule 1 of the CSP Rules of Professional Conduct requires that a physiotherapist performs only duties which they are safe and competent to deliver. In relation to the manual handling of patients there appears to have been an assumption that all physiotherapists have a high level of skill in this area. Skill however, 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, physiotherapists must be as realistic and analytically self-critical as they would be in relation to any other aspect of their professional clinical practice. All physiotherapists are empowered by this rule to say 'no' since it provides a rational basis for not proceeding with a task which the physiotherapist considers beyond their competence or ability to work safely.

1.9 The Health and Safety at Work Act 1974

Firstly, it is important to recognise that Occupational Health and Safety Law is part of the Criminal Law, in this case, enforced by the Health and Safety Executive (HSE). Whereas breach of a duty of care may give rise to a civil claim for damages, breach of health and safety law may give rise to a criminal prosecution.

The HSWA'74 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. 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) 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. The legislation therefore attempts to create a balance in which the utility of the task to be performed, such as a physiotherapy intervention involving manual handling, is one factor to be considered.

1.10 The Management of Health and Safety at Work Regulations 1999

The central provision of the MHSWR'99 is Regulation 3:

Every employer shall make a suitable and sufficient assessment of:

- A the risks to the health and safety of his employees to which they are exposed while they are at work and:
- B the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking

The purpose of this general risk assessment is to identify the measures that need to be taken to comply with the legal requirements and prohibitions imposed on an employer with a view to managing risk.

Employers also have a duty to implement systems that support staff in managing the co-ordination of risk control measures through planning, organisation, monitoring and review.

Any adequate general risk assessment taking place under the MHSWR'99 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'92 must be followed.

1.11 The Manual Handling Operations Regulations 1992

The term manual handling is defined in the Regulations as the application of human effort using the hands or any other part of the body, either directly or indirectly, to transport, support, move, steady or position a load. Introducing mechanical assistance, such as a mobile hoist, may reduce the risk arising from a particular manual handling task but it may not eliminate all manual handling since human effort will still be required to manoeuvre, steady or position the human load.

These Regulations establish a clear hierarchy of measures that an employer must follow:

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

It is important to understand the different levels of duty which apply to the hierarchy of measures listed above. The words 'reasonably practicable' are much used in health and safety legislation and the requirement is very similar to the duty to take reasonable care in relation to the Tort of Negligence in civil law.

In law, the phrase 'reasonably practicable' has been defined as a narrower term than 'physically possible' and is said to imply that a computation must be made in which the quantum of risk is placed on one scale and the sacrifice, whether in money, time or trouble, involved in the measures necessary to avert the risk is placed on the other. If it can be shown that there is a gross disproportion between them, the risk being insignificant in relation to the sacrifice, the person upon whom the duty is laid discharges the burden of proving that compliance was not reasonably practicable. This computation must be made at a point in time prior to the incident or happening complained of. Note should be taken that the costs of any potential litigation which may arise is not a factor to be considered in the computation.

This definition fails however to address the manual handling considerations relating to physiotherapy interventions with patients. The issue is:

'is it reasonably practicable for the physiotherapy profession to abandon its core skills and the goal of patient rehabilitation?'

To date there has been no judicial opinion or guidance on this specific point. However, as an autonomous profession, we must take the responsibility for setting our own special core skills and standards against which our practice as individuals can be measured (Bolam and Bolitho tests). Until we do so in relation to physiotherapy interventions involving manual handling we are likely to continue to be measured against guidance published by the Royal College of Nursing who appear to have adopted a different philosophical response to the implementation of the MHOR'92.

1.12 Step 1: Avoidance

Any general risk assessment taking place under the MHSWR'99 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/professional risk management protocol. It is worth re-iterating here that, in relation to the manual handling of patients, the utility of the act (the potential benefit of the physiotherapy manual handling intervention) is an important consideration in deciding the reasonable practicability of avoidance.

1.13 Step 2: Risk Assessment

On this point the law relating to manual handling is entirely clear. The requirement to assess the risks arising from manual handling operations that cannot reasonably practicably be avoided is absolute.

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, if the generic protocol is not appropriate to a particular patient at a particular time then they may be patient-specific.

(For the avoidance of doubt - in the relevant legislation a *general* risk assessment will take place to identify a range of risks under the MHSWR'99. Under the MHOR'92 a *generic* risk assessment will draw together common threads from broadly similar manual handling operations.)

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 patient or anyone else associated with the task) and of the severity or extent of that harm.

The 1998 Guidance to the MHOR sets out at Schedule 1 those matters which must be considered when assessing the risk associated with a particular task (the acronym TILE is often used) as follows:

A Task factors

B Individual factors

C Load factors

D Environmental factors

(Schedule 1 to the Guidance is reproduced at Appendix 1)
(Numerical load guidelines taken from the 1998 Guidance to the MHOR'92 are summarised at Appendix 2)

Thus, even where a potential hazard exists, the extent of the risk arising from it can be mediated by manipulating the factors listed above.

1.13.1 The Task

It appears that the words task and operation are intended to have the same meaning within the interpretation of the MHOR. In health care, nursing staff may identify a task or operation as something like "take patient to toilet". In fact, taking a patient to the toilet will involve a series of sub-tasks which will vary depending upon the starting point i.e. from a bed/easy chair/ dining chair, the end point i.e. the type of toilet/commode, the distance, the mode of transfer etc. In this case the risk arising from each sub-task must be considered separately and a strategy devised. Similarly, in any physiotherapy intervention, each sub-task must also be considered separately i.e. assisting a patient to initiate a transfer from a high bed may involve an entirely different degree of risk compared to assisting the same patient to transfer back to bed from a low bedside chair.

1.13.2 The Individual

The individual referred to here is the handler and not the patient. Thus, in the case of manual handling in physiotherapy treatment, any risk assessment must relate to the skills, competencies and physical capabilities (relating to health status, gender, pregnancy, age, disability, anthropometrics etc) of the person carrying out the task, remembering Rule 1 of the Rules of Professional Conduct 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 3).

1.13.3 The Load

Not surprisingly, many patients and people with disabilities object to being referred to as a load and the HSE will accept that the language and structure of the Regulations and Guidance are not focused towards human load handling. A reference list of load factors relevant to patient handling is detailed at Appendix 3.

1.13.4 The Environment

It is self evident that environmental factors will impinge upon the manual handling of human loads, 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 the patient's home it may pose an entirely different degree of risk to the same operation taking place in the controlled environment of a physiotherapy department or hospital ward.

1.14 Step 3: Risk Management

Risk assessment is not an end in itself. It is the first part of a process which should lead to the reduction of risk. Risk management strategies or protocols that should be considered in relation to manual handling undertaken by physiotherapists may be:

- The implementation of generic protocols devised to manage risk arising from broadly similar manual handling operations;
- The routine implementation of patient-specific risk assessment and risk management protocols following clinical assessment and the setting of realistic clinical goals (see *'Patient-Specific Assessment Protocol'* reproduced at page 19, Chapter 2). This should be an iterative process and risk assessments should be updated, together with clinical review. In addition to the above physiotherapists must be alert to short term changes in patient performance and sufficiently well trained and experienced (competent) to amend a treatment/risk management plan according to the prevailing circumstances;
- The development of knowledge and skills in patient handling through training and experience. As earlier stated, physiotherapists must not automatically assume that they have such skills, particularly in the assessment and treatment of patients with complex movement disorders. Students must be given the opportunity to begin to develop the necessary skills (including self-awareness of posture and 'normal' movement) at an early stage and patient handling training must form a part of CPD. Physiotherapists should continue to attend routine manual handling refresher training provided by their employers but Trusts and physiotherapy managers must be aware that competence to handle patients with complex movement disorders can only be achieved through specialist training, experience and practice. This could only be provided by manual handling co-ordinators/back care advisers where they have the relevant expertise.
- The development of knowledge and skills in the use and application of handling aids and equipment and in the range of equipment available;
- The development of knowledge and skills in ergonomics applications;
- The application of ergonomics principles to work organisation and job design;
- Re-evaluation of the content, recommended frequency and duration of training courses;
- To work with manufacturers in the development of handling aids specifically designed to facilitate therapeutic interventions
- The provision of adequate resources such as appropriate staffing, equipment provision 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.

1.15 Documentation

Clinical record keeping is an integral part of patient care and 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. Documentation is therefore an essential element of the total care provided to a patient/client and a tool which enables physiotherapists to discharge their duty of care and to be able to show that they have done so.

It is a requirement of the MHSWR and the MHOR that the significant findings of any risk assessment should be recorded, dated and the record kept readily accessible, as long as it remains relevant. A system of monitoring and revue should ensure that risk assessments are updated as appropriate. In the case of patient specific risk assessments, these clearly should 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 clinical notes.

Documentation, including risk assessments, will also be required as evidence in 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).

Examples of manual handling risk assessment formats for therapeutic interventions, delegation and the giving of care handling guidance/advice are reproduced at Appendix 4.

1.16 Compliance with Local Policies

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

Section 7(b) of the HSWA imposes on the employee the duty to co-operate 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 etc.) 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 targets at the centre of their publication "Securing Health Together a long term occupational health strategy for England, Scotland and Wales" HSE 2000. Given the role of physiotherapy in patient rehabilitation and the 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 receive appropriate training.

1.17 Professional Liability Insurance

All members are covered by the Society for Professional Liability Insurance as one of the benefits of membership. This cover is available to all members paying a full annual subscription. Cover extends to the practice of the profession of physiotherapy and to members practicing within their own scope of this practice.

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 suing, alleging negligence on the part of a physiotherapist the suit will be handled by the employer, or solicitors acting on behalf of the employer.

An information paper (PA32) "Physiotherapists & Insurance" setting out further details of Professional Liability Insurance cover is available free of charge from the Professional Affairs Department of the CSP.

1.18 Key Messages

Duty of Care

Physiotherapists may well 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 and the provision of manual handling guidance or advice.

Professional Duty

Physiotherapists also have a professional duty to comply with the CSP Rules of Professional Conduct and Standards of Practice. Rule 1 of the RPC specifically requires a physiotherapist only to perform duties which they are safe and competent to deliver. This applies to the manual handling of patients just as much as to any other aspect of their professional practice.

Risk Assessment and Risk Management

Health and safety legislation provides a logical framework which can assist the physiotherapist through the process of risk assessment and risk management. Recording the process and the outcome of risk assessment is as much a part of the physiotherapist's commitment to patient care as their clinical assessment and treatment records.

The Utility of the Act

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 of the act is one factor to be considered.

Reducing Risk

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 the requirement to assess the risk arising and to reduce the risk so far as it is reasonably practicable to do so is absolute.

Employers' Duties

Employers have a duty to provide physiotherapists with a safe system of work, and to provide 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.

Competency

Balancing the potential benefits (utility) to patients arising from physiotherapy interventions involving manual handling with the potential risks to themselves, the patient and colleagues should therefore be nothing new to the competent physiotherapist.

2.1 Manual Handling in Physiotherapy assessment and Treatment

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 physiotherapist and patient. There has been much discussion concerning the manual handling undertaken during rehabilitation. This manual handling during treatment is performed by other members of the health care team as well, but this chapter is only concerned with that which is performed as part of physiotherapeutic intervention.

2.2 Definition of Treatment Handling

The Health and Safety Executive (HSE) in Guidance on Regulations, Manual Handling Operations Regulations 1992 (MHOR) 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.

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

A general assessment under the Management of Health and Safety at Work Regulations 1992/1999 will identify manual handling that may be potentially hazardous. If not hazardous, then the requirements of the MHOR will not apply, since these only apply to those tasks considered to be hazardous or potentially hazardous (see box below).

When the MHOR do apply the hazards may include:

- Compromised posture of physiotherapist or patient during treatment
- Lack of sufficient height-adjustable plinths
- Insufficient space for treatment
- The possible need to handle heavy limbs in awkward positions

> 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 potential hazards under the Management of Health and Safety at Work Regulations (1999).

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. This is an integral part of the patient records.

An amputee or stroke patient requiring assistance to transfer will require an in depth assessment of his manual handling needs. In either case, a generic assessment and protocol should still be in place, such as "how to deal with a falling/fallen patient" (see below). 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 may be recorded if appropriate.

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 staff.

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. (Hignett, Physiotherapy Sept 1995). The findings of recent research amongst physiotherapists concerning work related musculo-skeletal disorders (WRMSD) shows that as a profession we are highly susceptible. (Health and Safety Briefing no.11, CSP 2001). In fact, some studies (Cromie et al Australia 2000) show a lifetime prevalence of WRMSD of 91 % amongst physiotherapists.

Research quoted in the above CSP publication identifies the risk factors of working in physiotherapy as follows:

- Treatment requiring repetitive movements
- Continuous bending, twisting and lifting
- Awkward posture
- High force levels
- Manual resistance
- Patient's size, shape or condition
- Workload
- Staffing levels
- Age/gender of physiotherapist

Musculoskeletal Injuries in Physiotherapists – Key Findings

- Physiotherapist are susceptible to work related musculo-skeletal disorders (WRMSD) because of the nature of their work ie repetitive and labour intensive
- Younger physiotherapists ie below the age of 30, are more at risk, particularly during the first 4–5 years of practice
- Lifetime prevalence (ie have you ever had a work-related injury?) may be as high as 90%
- As many as 1 in 6 physiotherapists may move specialty or leave the profession as a result of a musculoskeletal injury
- The highest prevalence of injury is to the low back, followed by wrists and hands
- Lifting or transferring patients is the job task most likely to lead to injury
- Most physiotherapists sustaining a WRMSD either self treat or seek treatment from a colleague rather than from a doctor or from their occupational health service
- Physiotherapists who suffer a WRMSD respond to the injury by changing their working habits
- Failure to take rest breaks, inadequate staffing levels and a heavy caseload (work organisation factors) contribute to the risk of injury (ref. Health and Safety Briefing No.11 CSP 2001)

Source: International research studies, see CSP IR H&S briefing pack No. 11 "Work related strain injuries" Musculo-skeletal disorders.

2.3 Suggested Strategies – from risk assessment to risk reduction

All physiotherapists will need to assess any potentially hazardous manual handling involved in a rehabilitation programme. A protocol follows that may assist this process.

2.3.1 Patient specific assessment protocol

A Assess the patient clinically

B Consider immediate realistic clinical goals and functional outcomes in discussion with the patient

C Does the proposed treatment/therapeutic intervention involve hazardous manual handling?

D Can the hazardous manual handling operation reasonably practicably be avoided, when taking into consideration the utility of the intervention (see chapter 1) and the suitability of any aids or equipment that may be available?

E If not, then the requirement to assess the risk arising from the task or sub tasks (using TILE) is absolute

F Reduce the risk arising from the hazardous manual handling operation so far as is reasonably practicable by adapting the technique, the use of equipment or the assistance of appropriately trained colleagues

G If satisfied:
- i Record the risk assessment and risk management protocol
- ii Proceed with the treatment/therapeutic intervention

H If not satisfied:
- i Re-evaluate
- ii Consider competence to proceed
- iii Reconsider goals

The above is an iterative process and risk assessments should be updated together with clinical review. In addition to the above, physiotherapists must be alert to short term changes in patient performance which may be related to physical or psychological state. They must be sufficiently well trained and experienced to amend a treatment/risk management plan according to the prevailing circumstances.

For those complex situations further guidance may be required.

- Clinical Interest Groups should provide a forum for discussing common manual handling problems in their field, and produce guidance, based on evidence based practice where available. (ref Guidance on manual handling in treatment ACPIN working party 2001, Paediatric manual handling APCP 1999)
- Alternatively, those clinicians 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.

2.3.2 TILE Assessment

The model assessment protocol given above will ensure that physiotherapists are meeting their legal responsibilities under the MHOR. The TILE assessment is introduced in chapter 1 and relevant appendices, but the following information may also inform this process.

A 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. This factor should be covered by the individual capabilities part of the assessment as required by Schedule 1 in MHOR 1992. 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. Their own health status and physical ability 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.

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 3).

Does the task:

- require unusual capability eg strength or size
- present a hazard to those with a health problem eg previous musculo-skeletal disorders
- present a hazard to those who are pregnant
- call for special information or training, such as knowledge of different paradigms of treatment

B Patient participation (Load)

Handling patients will impose a load on the handler. The term ‘load’, in this situation, could be seen as the amount of musculo-skeletal stress on an individual 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 co-operate in their own movement, due to a learning disability or a mental health problem, multi-disciplinary team discussions should enable safer acceptable strategies to be employed.

Factors to include here are:

- shape/size/weight of patient
- physical ability of patient and reasons it may vary
- ability/motivation to co-operate
- difficult to grasp due to pain, shape, skin condition, orthoses/prostheses, lack of balance or co-ordination, involuntary movements or spasm
- unstable or unpredictable movement of load
- intrinsically harmful eg. challenging behaviour, or require wearing of protective clothing due to infection control measures
- medication

2.3.3 Methods of Risk Reduction

A 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 relevant 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, then the physiotherapist must use the equipment or alternative methods may need to be devised. Alternatively the provision of more staff might 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 2 members of staff and a third pushing a wheelchair behind, to eventually walking unaided.

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 feel obliged to supply treatment with insufficient resources, but they must not collude in such unsafe practices. 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, as specified in Provision of Use of Work Equipment at Work Regulations (PUWER) (1998) and, Lifting Operations and Lifting Equipment Regulations (LOLER) (1998).

B 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. Such modifications due to changes during the treatment session 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. eg. by reducing the possibility of a fall should the patient's legs give way, thus eliminating the risk of staff attempting to catch him.

C 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. All staff must be aware of these practices and adhere to the safe systems devised. [Chartered Society of Physiotherapy (2001) Audit pack for the guideline for the collaborative, rehabilitative management of elderly people who have fallen. CSP London].

2.4 Management Responsibilities

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

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 justify 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. Emergency rescue plans (including evacuation and collapsed patients) must address staff safety and include protocols devised, practised and implemented following evaluation.

2.5 Liaison with equipment manufacturers

To develop and maintain competency, physiotherapists should be encouraged to visit relevant exhibitions etc, 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 4)

2.6 Key Messages

- Physiotherapists manually handle patients as part of their professional role.
- When treatment programmes are devised that involve manual handling, that part of their work which is potentially hazardous must be assessed and the risks reduced so far as is reasonably practicable. This must be recorded.
- Staff working in different specialisms will have differing skills. However, all physiotherapists will need updating in manual handling throughout their career.
- Physiotherapists must not use unsafe systems of work and the use of extra suitably trained staff or equipment may need to be considered.
- Treatment goals must be realistic and achievable, 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.

3.1 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; or the physiotherapist is required to offer advice on the general management of the patient.

Manual handling is a vital component of physiotherapy treatment and as such it is often necessary to give advice on, or to delegate, this activity to others. Both the nursing and physiotherapy professions have done their best to advise their members on the practical problems arising from this, but many practicing physiotherapists are confused about what they should and should not do when delegating or advising activities involving manual handling. It is the aim of this chapter to clarify the situation as far as possible.

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 us - but should actually make it easier for us to continue.

The delegation of tasks involving manual handling to physiotherapist colleagues (including assistants 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.

A **Delegation** infers the entrustment of a Physiotherapy task to another person, who will perform that task in the place of the treating Physiotherapist.

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

- A more junior physiotherapist.
- A physiotherapy assistant.
- A student physiotherapist.

Also any other person providing a physiotherapy intervention which could include:

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

B **Guidance** 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:

- A qualified or unqualified nurse.
- Other members of the multidisciplinary team (occupational therapists; speech therapists; radiographers; etc)
- The family of the patient.
- Paid or unpaid carers of the patient.
- Social Services care workers.
- School 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 either 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

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; whilst at the same time ensuring the best possible outcome for the patient.

3.2 Delegation of Rehabiliation 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 individual undertaking the task.

3.2.1 Delegation to more junior Physiotherapists.

Delegation to a more junior 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 involved. However for the purposes of this document the manual handling element is considered.

Recommended actions:

- Be aware of the junior's current handling experience.
- Observe the junior's overall handling skills.
- Be aware of the difficulties presented by the patients in the care of the junior.
- Be accessible to and encourage expressions of concern from the junior therapist.
- Where there is concern about the difficulty of handling of a patient observe the junior with the patient. Be prepared to help. Consider use of equipment as appropriate.
- Risk assess the situation with the junior, encouraging them to consider remedial actions and record the process and outcome in the notes.
- Offer assistance in the form of extra physical help or further training as necessary.
- Monitor the situation regularly.
- Ensure this intervention is recorded in the junior's CPD file and the patients records.

3.2.2 Delegation to Physiotherapy Assistants.

Individual skills and knowledge of physiotherapy assistants vary widely. 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.

Recommended Actions:

- Ensure the patient's agreement to being treated by the assistant.
- Treat the patient with the assistant initially.
- Take into account the individual capability and competence of the assistant.
- Demonstrate the method of handling desired.
- Observe the assistant carrying out the chosen method.
- If the physiotherapist or the assistant has any concerns consider either further training for the assistant or amending the chosen method.
- When satisfied that the assistant can carry out the task safely allow them to do so.
- Ensure the assistant always has recourse to advice or assistance from the supervising physiotherapist.
- Monitor the assistant and the patient regularly, and record this.

Further information in PA6 'Criteria for the Delegation of Takes to Assistants' available from the PA Dpt CSP.

3.2.3 Delegation to Student Physiotherapists.

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

Recommended Actions:

- Liaise with clinical tutor from college/university to ascertain how much manual handling training the student has received so far.
- Ensure introduction includes placement specific induction, including (see "The Individual" manual handling, page 12, Chapter 1).
- Take into account the individual ability of the student.
- Emphasise safer handling to the student as part of good clinical practice.
- Observe the student's handling skills before delegating tasks.
- Ensure the patient's agreement to being handled by the student.
- Observe the student carrying out delegated tasks with patient satisfactorily before leaving them to work alone.
- Ensure student knows where to look for help from you or an alternative supervisor at all times.
- Record advice and assistance given.
- Monitor the situation and record this.

3.2.4 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. The family is with the patient all day and the possibility of extending some treatment into this period can be of great value. However, safety of the family is of paramount importance not just in terms of avoiding litigation, but also for the long-term care and well being of the patient.

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 guidelines.
- Observe family carrying out activity with the patient and correct as necessary.
- Alter activity if necessary to enable family to carry out safely.
- Ensure that the situation is regularly monitored.
- Record all of the above.

3.2.5 Delegation to school support workers.

Paediatric physiotherapists often train learning support assistants (LSA's) in schools to carry out treatment programmes for individual children on their caseload. These staff may be employed by agencies other than the physiotherapist's own Health Trust.

The physiotherapist must be aware of the local education 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.

A full risk assessment of the child and LSA 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 LSA is not permitted to contravene the Education Handling Policy and must be aware that the treatment requested is only applicable to the individual child in this particular situation.

Similar situations could arise where physiotherapists are working with Social Services staff and others from voluntary agencies. It is important to ensure the assistant or carer is carrying out instructions correctly and safely and has access to the physiotherapist should problems arise.

3.3 Giving Advice and Guidance

It is helpful to appreciate that 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.

> A physiotherapist cannot dictate to members of another profession how they must handle a patient.
>
> Physiotherapists on a neurological unit forbade the nurses on the unit to use hoists with their patients. They were not entitled to do this.

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 twenty-four hour management of how a patient is handled in hospital; or at home or in the community.

Where such advice is given, wherever possible it should be made specific to named individuals within an established time scale under specified circumstances. This should be documented.

The therapist may be 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.

3.3.1 Giving guidance to other members of the multidisciplinary team – In the hospital setting

The Physiotherapist may be requested to contribute to the multidisciplinary team management of a patient by offering guidance on the general manual handling of the patient.

It should be noted that in a ward situation it will not usually be possible for the physiotherapist to know each individual that will handle the patient. The difficulty communicating with night staff is one obvious example.

The variation in ability between trained and untrained members of the team must also be taken into account.

Recommended actions:

- Assess the patient and decide optimum method of handling for rehabilitation.
- Take into account local generic risk assessments.
- Take into account any local manual handling policy.
- 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 alternative to be used where staff do not feel competent to use chosen method; or condition of patient deteriorates. (e.g. night sedation).
- Communicate method(s) to nursing staff and other team members.
- Write clearly in patient care plan.
- Record assessment process and reasoning briefly but clearly in physiotherapy patient notes.
- Particularly record any warnings or negative instructions (i.e. what not to do) given.
- Monitor situation regularly.

Example

Walking with a patient who is just beginning to walk again.

- Ensure staff competent (trained) to deal with a falling patient.
- Consider strategic placement of chair.
- Indicate number of staff to walk with patient (one or two).
- Indicate technique, (e.g. palm to palm contact with back support.)
- Indicate extend of verbal prompting, if required.
- Suggest if concerned a wheelchair to be pushed behind.

  or

- Safest alternative of use of wheelchair or Sanichair where staff not confident or competent; or patient condition has deteriorated.

3.3.2 Giving guidance to patients family prior to discharge

Agencies responsible for providing ongoing care will need to ensure that they have undertaken a home manual handling risk assessment.

3.3.3 Giving guidance to the patient's family in the patients home environment

Advising a family on the handling of a patient within home, the setting can present different issues than those in the hospital setting, and it may be wise to refer to an appropriate professional with manual handling expertise. By giving advice the physiotherapist may be extending their duty of care to the family.

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.
- Take into account the relevant physical ability and psycho-social 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 most appropriate methods of handling including the possibility of use of equipment.
- Ensure the patient and the family are in agreement with the methods selected.
- If agreement cannot be achieved, record clearly 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 negative instructions or warnings given.
- Where continued responsibility exists, monitor situation regularly.

3.3.4 Giving guidance to carers other than the family in the home setting.

A 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 which 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 although they may agree to do so. The patient must make their own arrangements to purchase adequate training.

However, a domicillary physiotherapist routinely assessing a patient might give advice upon handling issues to both the patient and the carer. Any such advice should be documented.

B **Carers paid by an outside agency**

Outside agencies could include:

- Local authority social services
- A charity
- A care agency

If the carer is employed by Social Services 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.

Where the carer is provided by an agency, although they may be considered to be self-employed for tax purposes; 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 (Lane v. Shire Roofing (Oxford) Ltd. 1995).

C **Unpaid carers**

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 "master/servant 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 this training.

3.4 Key Messages

- 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.
- 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 their mind whether their intention is to delegate, or to offer guidance.
- The physiotherapist must be working within the remit of their employer in order to be covered by vicarious liability in the event of litigation.
- 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 profession how they must handle a patient.
- 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.
- It is important to remember that giving advice and delegating tasks is a normal and essential part of physiotherapy. Being clearer about what our position is should not inhibit us – but should actually make it easier for us to carry on giving advice and delegating tasks.

4.1 Education and Training

Physiotherapists are often seen, by themselves and others, as experts in human movement and in assisting people to move. If they claim this expertise then their curricular framework must reflect this. This chapter details the pre and post-graduate education necessary to enable physiotherapists to meet the demands of their profession and the expectations of others.

4.2 Physiotherapy Students

Physiotherapy students must be taught how to assess any risk arising in relation to treatment regimes during their training, and to be aware of postural risks for themselves as well as for patients. Familiarity with models of postural analysis such as OWAS (Ovako Working Posture Analysis, Karhu et al 1977), and REBA (Rapid Entire Body Analysis, McAtamney and Hignett 1995) may assist them in making objective judgements as to the risks involved, and in devising safer systems to replace those involving risk (see Chapter 1). The partnership of staff and patient must include safe working practices undertaken by well-educated practitioners: it is clearly advantageous to patients if skilled practitioners graduate.

Theoretical knowledge and practical skills must be acquired over the period of undergraduate education. This must then continue post-qualification as part of Continuing Professional Development (CPD). Formal assessment, including both theory and practical elements should take place at varying stages throughout their student career, and attendance at manual handling training should be seen as mandatory. Evidence of attendance and competencies achieved should be documented on student records. This training must include the following elements:

- Normal human movement and a familiarity with models of postural analysis to enable objective reflection of practice.
- Back Care – including anatomical structure and function of spine and its relationship with manual handling, biomechanics, posture and basic ergonomics
- Back injury – mechanisms and implications, accident/incident reporting (ref Curricular themes)
- Knowledge of the Standards of Physiotherapy Practice with regard to manual handling
- A working knowledge of the current legislation with regard to manual handling in physiotherapy
- A working knowledge of the risk assessment and risk management process
- Familiarity with a comprehensive variety of handling aids, including mechanical hoisting equipment
- Simulation of patient handling situations

Staff from the Higher Education Institutions and those providing placements must liaise to establish a written contractual agreement specifying the responsibilities of each party with regard to the student while on placement (See "Professional Liability Insurance", chapter 1). Discussion must take place regarding the induction process and what this may include; placement specific manual handling training by the clinical staff; and the relevant previous learning experience of the student prior to the placement.

- The responsibility for basic manual handling training must be that of the Higher Education Institution
- Practical skills must be acquired before students are required to handle patients
- At the appropriate stage during training, manual handling skills practice must be related to clinical placements and to the rehabilitation of patients under the supervision of the clinical tutor
- Manual handling must be an area that is specifically addressed in the induction programme of each student placement

- Students must not be permitted to participate in manual handling in clinical placements unless they have completed the relevant training
- There must be liaison between the higher Education Institution and clinical staff to ensure adequate levels of competent monitoring and supervision are available. (Refer to chapter 3)

  Note: Clinical supervisors/educators must maintain their own levels of competency with regard to manual handling through CPD. If sufficient competency is not available in-house, in academic institutions, then external manual handling educators should be sought.
- Specific learning outcomes should be set at the beginning of the placement. These should include manual handling issues related to the particular patient population of the placement
- Students must not teach carers or other staff manual handling whilst on clinical placements; however, as part of a rehabilitation programme students may give advice or guidance on treatment handling to carers whilst under direct supervision of a competent physiotherapist

4.3 Post-graduate Education

Employers have a duty under the professional development plan to identify training required to undertake a job competently. More often than not this will be given "in-house".

All Chartered physiotherapists have a legal duty to attend manual handling update sessions provided by their employers. This should revise previous knowledge as required, and include new research to inform practice. Practical problem solving, including use of equipment should be an important part of the learning process. Training should include all levels of staff, and be attended at least annually. (Manual Handling in the Health Services, 1998)

Clinical specialists will develop skills over time in their specialist area but they must use the clinical guidance provided by their specialist interest group and should be encouraged to attend training in delivery of skilled treatment handling geared towards their working situation. Employers may identify a need for additional training in a specialist area on top of general manual handling training and this may have to be arranged externally.

Physiotherapists working in private practice must comply with competency levels as stated in the Rules of Professional Conduct. They must be aware of their responsibilities towards others if they themselves are employers, under the Health and Safety at Work Act 1974. (See chapter 1 for Professional Liability Insurance)

4.4 Physiotherapy Assistants

All physiotherapists have a duty to ensure that physiotherapy assistants to whom manual handling tasks are delegated are enabled to work safely. This should be achieved at induction, by formal in-service training and education, monitoring and supervision in the workplace and provision of suitable equipment as required. They, as all other staff, should attend annual updates in manual handling. When delegating tasks to physiotherapy assistants, staff must ensure that they are familiar with the training and competence of the person to whom they are delegating. (See Chapter 3)

4.5 Volunteers

The employing authority has a duty of care to train volunteers as well as a duty under the Health and Safety at Work Act 1974.

4.6 Physiotherapist Back Care Advisers/Manual Handling Advisers

Physiotherapist Back Care Advisors (BCAs) are physiotherapists who may undertake, as part of their responsibilities, to run training sessions for groups of staff in the general areas of manual handling and this is not related to named patients on the physiotherapist's caseload.

Training for such BCAs should emphasise the need for attendance at a relevant post-graduate course, several of which are now offered at the PGC level at various universities around the country. Membership of relevant organisations will help ensure that physiotherapists working as BCAs have access to a forum dealing specifically with manual handling issues. [E.g. Association of Chartered Physiotherapists in Occupational Health and Ergonomics (ACPOHE), National Back Exchange (NBE)].

Such staff must consider their own CPD and be able to provide evidence of regular update by attending relevant conferences and seminars. Many BCAs may be involved in litigation, whether as witnesses of fact or expert witnesses and must appreciate the responsibilities of their specialism. (See Legal Pack, CSP 2002)

4.7 Standards for Training

Those physiotherapists acting as BCAs must ensure that their educational training packages comply with the CSP standards and keep abreast of nationally recognised standards currently available, such as those from National Back Exchange, which was drawn up using guidance available from a wide range of professional groups. Part of this guidance (Issue no. 1) is reproduced as Appendix 5, with the kind permission of the Executive Committee of National Back Exchange.

4.8 Key Messages

- All Chartered Physiotherapist should receive manual handling education and training on an ongoing basis to allow them to maintain competency levels and safely perform that which is essential to their work
- This education and training should be at undergraduate level and as part of CPD
- All physiotherapy assistants should receive manual handling education on induction and as a formal part of their ongoing in-service training programme
- Manual handling training should be updated on an annual basis for all levels of staff
- Management must support staff in resolving problems around manual handling issues
- Chartered Physiotherapists working as Back Care Advisers must meet the CSP Standards
- Physiotherapists working as BCA's must be familiar with recognised special interest groups such as ACPOHE and National Back Exchange.

Appendix 1

Factors to which the employer must have regard and questions he must consider when making an assessment of manual handling operations

Manual Handling Operations Regulations 1992 (MHOR)
Regulation L(l) (b) (i)

	Factors	**Questions**

Schedule	**1** The tasks	Do they involve:
		· holding or manipulating loads at distance from trunk?
		· unsatisfactory bodily movement or posture, especially:
		  · twisting the trunk?
		  · stooping?
		  · reaching upwards?
		· excessive movement of loads, especially:
		  · excessive lifting or lowering distances?
		  · excessive carrying distances?
		· excessive pushing or pulling of loads?
		· risk of sudden movement of loads?
		· frequent or prolonged physical effort?
		· insufficient rest or recovery periods?
		· a rate of work imposed by a process?

	2 The loads	Are they: · heavy? · bulky or unwieldy? · difficult to grasp? · unstable, or with contents likely to shift? · sharp, hot or otherwise potentially damaging?

	Factors	Questions
Schedule	**3** The working environment	· space constraints preventing good posture? · uneven, slippery or unstable floors? · variations in level of floors or work surfaces? · extremes of temperature of humidity? · conditions causing ventilation problems or gusts of wind? · poor lighting conditions?
	4 Individual capability	Does the job: · require unusual strength, height, etc? · create a hazard to those who might reasonably be considered to be pregnant or to have a health problem? · require special information or training for its safe performance?
	5 Other factors	Is movement or posture hindered by personal protective equipment or by clothing?

Appendix 2

Manual handling risk assessment detailed assessment guidelines filter

Introduction

1 The Manual Handling Regulations set no specific requirements such as weight limits. Instead, they focus on the needs of the individual and set out a hierarchy of measures for safety during manual handling operations:

A avoid hazardous manual handling operations so far as is reasonably practicable;

B make a suitable and sufficient assessment of any hazardous manual handling operations that cannot be avoided; and

C reduce the risk of injury from those operations so far as is reasonably practicable.

Risk assessment filter

2 Where manual handling operations cannot be avoided, employers have a duty to make a suitable and sufficient assessment of the risks to health. This assessment must take into account the range of relevant factors listed in Schedule 1 to the Regulations. A detailed assessment of every manual handling operation, however, could be a major undertaking and might involve wasted effort. Many handling operations, for example lifting a tea cup, will involve negligible handling risk. To help identify situations where a more detailed risk assessment is necessary, HSE has developed a filter to screen out straightforward cases.

3 The filter is based on a set of numerical guidelines developed from data in published scientific literature and on practical experience of assessing risks from manual handling. They are pragmatic, tried and tested; they are not based on any precise scientific formulae. The intention is to set out an approximate boundary within which the load is unlikely to create a risk of injury sufficient to warrant a detailed assessment.

4 The application of the guidelines will provide a reasonable level of protection to around 95% of working men and women. However, the guidelines should not be regarded as safe weight limits for lifting. There is no threshold below which manual handling operations may be regarded as 'safe'. Even operations lying within the boundary mapped out by the guidelines should be avoided or made less demanding wherever it is reasonably practicable to do so.

5 It is important to remember that the purpose of the guidelines is to avoid wasted time and effort. The use of the filter will only be worthwhile, therefore, where the relevance of the guideline figures can be determined quickly, say within 10 minutes. If it is not clear from the outset that this can be done, it is better to opt immediately for the more detailed risk assessment.

Guidelines for lifting and lowering

6 The guidelines for lifting and lowering operations assume that the load is easy to grasp with both hands and that the operation takes place in reasonable working conditions with the handler in a stable body position. They take into consideration the vertical and horizontal position of the hands as they move the load during the handling operations, as well as the height and reach of the individual handler. For example if a load is held at arm's length or the hands pass above shoulder height, the capability to lift or lower is reduced significantly.

7 The basic guideline figures for identifying when manual lifting and lowering operations may not need a detailed assessment are set out in Figure 22. If the handler's hands enter more than one of the box zones during the operation, the smallest weight figures apply. It is important to remember, however, that the transition from one box zone to another is not abrupt; an intermediate figure may be chosen where the handler's hands are close to a boundary. Where lifting or lowering with the hands beyond the box zones is unavoidable, a more detailed assessment should always be made.

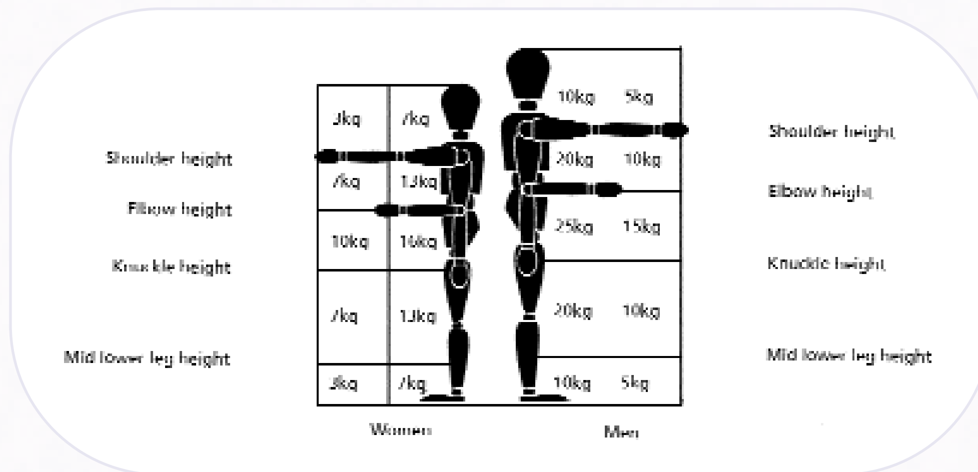

Figure 22 Lifting and lowering

8 These basic guideline figures for lifting and lowering are for relatively infrequent operations - up to approximately 30 operations per hour. The guideline figures will have to be reduced if the operation is repeated more often. As a rough guide, the figures should be reduce by 30% where the operation is repeated once or twice per minute, by 50% where the operation is repeated around five to eight times per minute and by 80% where the operation is repeated more than about 12 times per minute.

9 Even if the above conditions are satisfied, a more detailed risk assessment should be made where:

A the worker does not control the pace of work;

B pauses for rest are inadequate or there is no change of activity which provides an opportunity to use different muscles;

C the handler must support the load for any length of time.

Guidelines for carrying

10 Similar guideline figures apply to carrying operations where the load is held against the body and is carried no further than about 10 m without resting. If the load is carried over a longer distance without resting or the hands are below knuckle height then a more detailed risk assessment should be made.

11 Where the load can be carried securely on the shoulder without first having to be lifted (as for example when unloading sacks from a lorry) the guideline figures can be applied to carrying distances in excess of 10 m.

Guidelines for pushing and pulling

12 For pushing and pulling operations (whether the load is slid, rolled or supported on wheels) the guideline figures assume the force is applied with the hands between knuckle and shoulder height. The guideline figure for starting or stopping the load is a force of about 25 kg (ie about 250 Newtons) for men and about 16 kg (ie about 160 Newtons) for women. The guideline figure for keeping the load in motion is a force of about 10 kg (ie about 100 Newtons) for men and about 7 kg (ie about 70 Newtons) for women.

13 There is no specific limit to the distance over which the load is pushed or pulled provided there are adequate opportunities for rest or recovery.

Guidelines for handling while seated

14 The basic guideline figure for handling operations carried out while seated, shown in Figure 23, is 5 kg for men and 3 kg for women. These guidelines only apply when the hands are within the box zone indicated. If handling beyond the box zone is unavoidable, a more detailed assessment should be made.

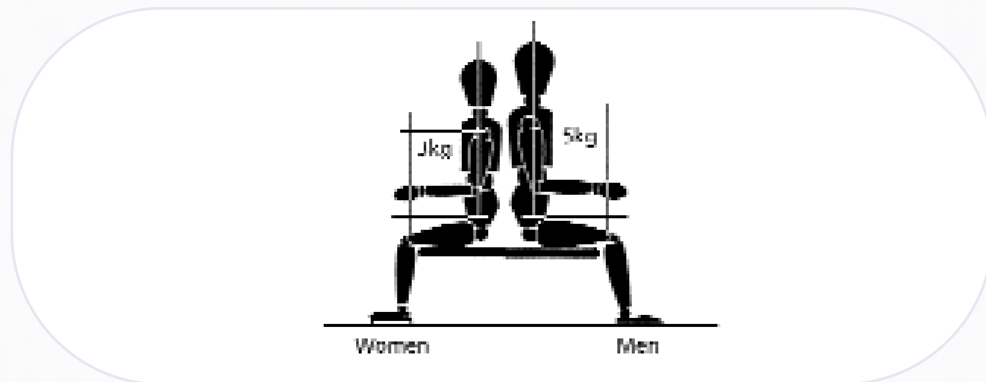

Figure 23 Handling while seated

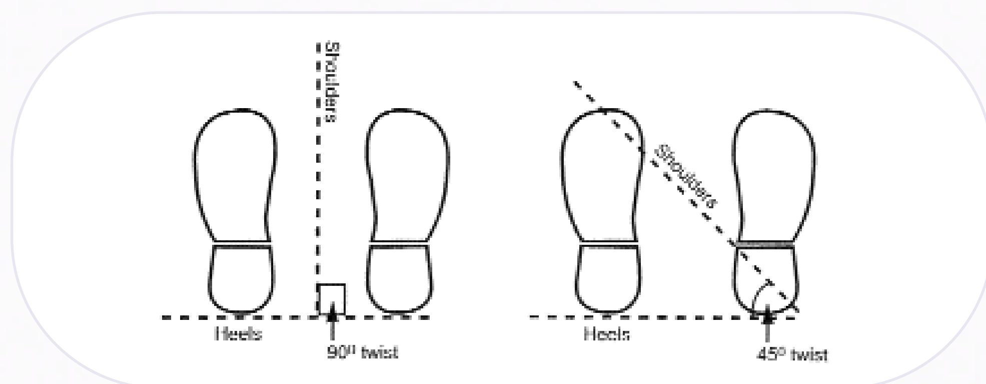

Figure 23 Assessing twist

Other considerations: Twisting

15 In many cases, manual handling operations will involve some twisting (see Figure 24) and this will increase the risk of injury. Where the handling task involves twisting and turning, therefore, a detailed risk assessment should normally be made. However, if the operation is relatively infrequent (see paragraph 8 of this Appendix) and there are no other posture problems then the filter can be used. In such cases, the basic guideline figures shown above should be reduced if the handler twists to the side during the operation. As a rough guide, the figures should be reduced by about 10% where the handler twists through 45° and by about 20% where the handler twists through 90°.

Remember:

The use of these guidelines does not affect the employer's duty to avoid or reduce risk of injury where this is reasonably practicable. The guideline figures, therefore, should not be regarded as weight limits for safe lifting. They are an aid to highlight where detailed risk assessments are most needed. Where doubt remains, a more detailed risk assessment should always be made. Even for a minority of fit, well-trained individuals working under favourable conditions, operations which exceed the guideline figures by more than a factor of about two may represent a serious risk of injury. Such operations should come under very close scrutiny.

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 co-operate
- Aggression
- Predictability
- Effort
- Time of day
- Tiredness

See also Page 20 [2.3.2. TILE Assessment. B Patient participation (Load)]

This list is not intended to be exclusive.

Appendix 4

A Sample Trust Moving and Handling Policy and Procedure

This is intended only as an example and would need to be tailored to local circumstances and need.

....NHS TRUST

The Scope of the policy and procedures

This policy and procedure applies to all staff employed by "..................................Trust" and voluntary workers who are involved in the manual handling of people and/or loads.

The regulations make the self-employed responsible for their own safety during handling. They should take the same steps to safeguard themselves as would be expected of an employer in protecting his/her employees in similar circumstances.

The Policy

The "Trust Board of ...." will work towards a "Safer Lifting Policy" over the next ....years, and as part of this process will ensure a current policy of minimal lifting.

The "Trust Board of ...." will ensure that the necessary arrangements are made to facilitate the information of the Policy and Procedures, for example by provision of appropriate and suitable training by professionally competent persons, for those who have duties under the policy and procedures.

While the Trust Board accepts its responsibility for compliance with the regulations it delegates the day to day management to Executive Directors, Clinical Directors/Locality Managers, Service Managers/Heads of Service employed within the Trust.

Responsibilies of "..."

The main objective is to achieve a significant reduction in the number of injuries and disablements caused by manual handling operations in the workplace. "...........................Health Trust" has a duty of care to ensure that:

- Minimum requirements for the "manual handling" of "loads" are followed where there is a particular, but not exclusive, risk of back injury to workers.
- The need for "manual handling" is avoided or, when it cannot be avoided, an assessment is made of the operation and where there is a risk of injury, appropriate steps taken to reduce or avoid that risk.
- Assessment of "manual handling" operations take into account factors which include characteristics of the load, the physical effort required, characteristics of the working environment and the requirements of the task.
- Information and training is provided to workers and managers on assessment and "manual handling" principles.

Responsibilies of the manager

The manager must:

- Be aware of manual handling operations within their area of responsibility.
- Avoid the need for employees to undertake any manual handling operations which involve a risk of injury, so far as is reasonably practicable.
- Make an assessment of any hazardous manual handling operations that cannot be avoided in order to reduce the risk of injury.
- Make clear record of the assessment and communicate its finding to all staff involved.
- Introduce appropriate measures to avoid or reduce risk by elimination of the risk, redesigning the operation or the use of mechanical aids.
- Provide information and ensure that all staff receive appropriate training in manual handling assessment principles, ensure that new staff received training BEFORE any manual handling tasks are undertaken.
- Ensure that mechanical aids provided are easily accessible and properly maintained.
- Ensure that manual handling requirements are clearly identified when recruiting staff so that appropriate advice can be given if pre-employment health screening is undertaken by Occupational Health Department (OHD) staff.
- Make allowance for any known health problems which might have a bearing on an existing employee's ability to carry out manual handling operations in safety.
- Refer to Occupational Health Advisers if there is any good reason to suspect that an individual's state of health might significantly increase the risk of injury from manual handling operations.
- Monitor and review manual handling assessments when there is reason to suppose that they are no longer valid due to a change in working conditions, personnel involved or a significant change in the manual handling operations effecting the nature of the task or of the load.
- Maintain records of accident and ill-health related to manual handling operations.

Responsibilies of the Employee

The employee must:

- Take reasonable care of their own health and safety and that of others who may be affected by their activities when involved in manual handling operations.
- Co-operate with their manager in the making of assessments of hazardous manual handling tasks.
- Observe safe systems of work and use of safety equipment, reporting any defects in mechanical aids to their managers.
- Participate in any training given in manual handling assessment principles.
- Report pregnancy or any medical conditions which might affect their ability to handle loads safely.
- Report any change in working conditions, personnel involved in manual handling risks or a significant change in the nature of the task or the load which may necessitate a review of the assessment.

Appendix 4

Responsibilies of Occupational Health Advisers

Occupational Health Advisers will:

- Carry out appropriate pre-employment screening when requested to identify those persons for whom manual handling tasks would present a particular risk and advise managers of any restrictions.
- Review initial assessments during the employee's period of employment.
- Provide early assessment by a qualified occupational health physician following injury as a result of manual handling.
- Arrange a final assessment by the occupational health physician regarding suitability for return to full duties.

Training

Awareness training should be provided for all staff with specific training for groups of workers involved in specific manual handling tasks.

The regulations state that the employer should:

- Provide training programmes for appropriate groups of staff BEFORE any manual handling tasks are undertaken.
- Provide training for all groups of staff at all levels which include skills involved in making ergonomic assessments and a problem solving approach to manual handling operations.
- Monitor and review training programmes to meet the needs of specific occupational groups and develop good practice based on assessment of current training status and the skills required to supervise and monitor established safe practice.
- Ensure that a minimum training programme includes the following elements:
- understanding of the assessment process
- back care
- manual handling techniques
- mechanical handling aids
- general fitness principle

} targeted to needs of individual and work process

- Establish a recall system which ensure that all staff, including part-time workers, have time set aside at least once a year for refresher training. Provide additional refresher training as appropriate after injury as part of the rehabilitation programme.
- Maintain accurate records of attendance for training events.

Implementation of the Procedure

Following their own briefing sessions, managers will ensure that staff are informed about the introduction of the procedure and are aware of its content.

Systems will be set up to enable assessment of manual handling operations to be carried out and subsequent recommendations for provision of mechanical aids; changes in the works process; changes in the environment; further staff training where and when appropriate.

Date of this Policy

………………………………………………………………

Monitoring of the Policy and Procedure

The Health & Safety Committee will monitor the overall effectiveness of the procedure within the Trust and review this and the policy as necessary.

Date of review ………………………….

NB The policy document also included a considerable amount of advice taken directly from the Guidance on the Manual Handling Operations regulations 1992 L23

Standards for Training Guidance Produced By National Back Exchange

Pre-training requisites

- There must be a training needs analysis to identify what is required. This may be informed by a health and safety audit process
- Adequate policies must be in place to promote best practice and staff fitness
- There must be management commitment and support for the training strategy and service delivery
- There must be allocation of sufficient resources by management to implement, develop and deliver the service

Training – planning and recording

- Training must be specific to group needs, and be job specific according to level required
- Length of training must be sufficient to encourage and develop a change in knowledge, attitude and skills. Demonstrations alone are not sufficient, but staff must have sufficient time to practise and develop practical skills under close supervision
- Feedback must be provided to management on attendance and ability of delegates to participate and any ongoing training needs
- A strategy for recall and update training on an annual basis must be in place
- Full records of all training must be kept, including:
  1. Names/signatures of trainer/trainee
  2. Date/place of training
  3. Duration
  4. Content
  5. Handouts
  6. Full/partial participation
  7. Refusal/inability to attend
  8. Equipment/aids used

Training delivery

- It should start with management and must include staff at all levels
- It must include risk management as appropriate
- Manual handling risk assessors must be trained to carry out and record suitable assessments for all appropriate clients/inanimate objects
- All staff must be able to recognise and report hazardous situations
- All staff must understand their own responsibility to report any physical problems e.g. pregnancy, back problems (past or current) which may affect their ability to participate
- Practical training must be safe and sufficiently supervised
- A suitable, equipped venue should be used
- An ergonomic approach to safer handling must be used

Appendix 5

The Standard Elements of Training should include:

- Spinal mechanics and function
- Importance of back care and posture, risk factors of back pain
- Current relevant legislation and professional guidelines where relevant
- Assessment of risks:
  1. Of tasks (including unexpected)
  2. Of loads (both inanimate and human)
  3. Of the environment and the importance of good housekeeping
  4. Of the limits of individual capability (self and others)
- Local policies
- Importance of ergonomic approach
- Principles of normal human movement and promotion of client independence
- Safe management of inanimate loads
- Handling strategies for clients with impaired mobility
- Dealing with unpredictable occurrences
- Use of equipment
- Problem solving

Sufficient follow up by management must ensure safe supervision and monitoring of handling practice. This may be supported by link workers who are competent practitioners and able to support staff who have received training.

Further Reading

Chartered physiotherapists should be conversant with certain pieces of legislation and the guidance documents relating to them and be aware of others. Some of this legislation and guidance is listed below.

C clinicians

M managers

T trainers

E essential

D desirable

A additional reading for interest.

E – CMT

National Back Pain Association, RCN. The Guide to the Handling of Patients. 4th edition 1997.

A comprehensive book covering all aspects of manual handling of patients, including legislation, techniques, equipment, etc.

National Back Pain Association, Grundy House, 32–33 Park Road, Teddington, Middlesex, TW11 0AB

E – CMT

HSAC 1988 Manual Handling in the Health Services

This booklet gives industry specific advice for the handling of patients in health services.

E – T

CSP, COT, RCN, National Back Exchange, Ergonomics Society 1997. The Interprofessional Curriculum Framework for Back Care Advisers.

A curriculum for those wishing to frame a course for trainers, describing a programme of study, competencies and accreditation.

National Back Exchange, Plantation House, The Bell Plantation, Towcester, Northants, MM12 6HN

E – MT, D – C

The Health and Safety at Work etc Act 1974. (Chapter 37)

This is the general enabling legislation of which the regulations below, which came out in 1992, form the more specific parts. HMSO/Book shops.

CMT – E

HSE 1992. Manual Handling – Guidance on Regulations. L23.

This legislation deals specifically with manual handling. It sets out a hierarchy of measures to be undertaken. It came into force in January 1993 and immediate compliance was required. All chartered physiotherapists involved in manual handling training should have a copy and be familiar with its contents. HMSO/Book shops.

CMT – D

HSE 1992. Management of Health and Safety at Work etc – Approved Code of Practice. Management of Health and Safety at Work Regulations 1992.

This overarching legislation sets out the principle of risk assessment. There is overlap with other legislations, which may give more detail of specific considerations in risk assessment. The Manual Handling Operations Regulations 1992 is good example of this. HMSO/Book shops.

CMT – D

HSE 1992. Workplace Health, Safety and Welfare – Approved Code of Practice. Workplace (Health, Safety and Welfare) Regulations 1992. L24.

This broad legislation does have relevance to those involved in manual handling training. Section 10 refers to room dimensions and space, while Regulation 12 refers to conditions of floors and traffic routes. Manual handling injuries can occur due to failure either to organise the workspace or to check the condition of the floors. HMSO/Book shops.

CMT – D

Disabled Living Foundation 1994. Handling people – Equipment, Advice and Information.

Source of information on equipment for handling people.

Disabled Living Foundation, 380–384 Harrow Road, London W9 2HU.

CMT – D

Disability Information Trust 1996. Hoists, Lifts and Transfers.

Source of information on equipment for handling people.

Disability Information Trust, Mary Marlborough Centre, Oxford.

CT – D, M – E

Medical Devices Agency Jan 1998. Medical Device and Equipment Management for Hospital and Community-based Organisations.

A comprehensive folder covering advice for managerial, technical and clinical staff responsible for purchasing, deploying, maintaining and repairing any medical device in hospital or the community. It sets the scene for the forthcoming legislation, Medical Device Regulation.

Medical Devices Agency publications – MDA-DTA orders, Business Services Level 9, Hannibal House, Elephant and Castle, London SE1 6TQ, Tel. 020 7972 8360

CMT – D

Medical Devices Agency 1996. Moving and Transferring Equipment.

CMT – D

Medical Devices Agency 1993. Mobile Domestic Hoists.

CMT – D

Medical Devices Agency 1994. Slings to Accompany Mobile Domestic Hoists.

CMT – D

Medical Devices Agency 1997. Handling Equipment for Moving Dependent People in Bed.

CMT – D

RCN 1996 Patient Handling Standards

RCN, 20 Cavendish Square, London W1M 0AB

CMT – D

RCN 1996 Code of Practice for Patient Handling Introducing a Safer Patient Handling Policy Manual Handling Assessments in Hospital and the Community

T – E, M – D, C – A

RCN 1996 Gollancz D and Thomas S. Hazards of Nursing. Personal Injuries at Work

TMC – D

RCN Institute for Employment Studies. 1996 Smith G and Seccombe I Manual Handling: Issues for Nurses.

E – TM

RCN Manual Handling Training Guidance 2002

T – D, MC – A

HSE 1992. Work Equipment – Guidance on Regulations. Provision and Use of Work Equipment Regulations 1992. L22.

Equipment can be used in manual handling operations to reduce risk of injury. If it is not suitable or poorly maintained it can contribute to an injury. Work equipment must comply with Regulations 1 to 10. There are other regulations within this document which may apply depending on the circumstances. HMSO/Book shops.

T – D, CM – A

HSE Control of Substances Hazardous to Health Regulations 1992 (COSHH).

This legislation requires assessment of substances which may be hazardous to health. Loads to be handled may contain toxic or corrosive substances. The manual handling of some loads may require special consideration because of the added risks associated with their contents.

T – D, CM – A

HSE 1995 A Guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). L73.

This legislation required the reporting of injuries and dangerous occurrences, which could be relevant to injuries or incidents related to manual handling. HMSO/Book shops.

T – D, CM – A

HSE 1992. Personal Protective Equipment at Work – Guidance on Regulations. Personal Protective Equipment at Work Regulations at Work 1992. L25.

Page 28 of the Manual Handling – Guidance on Regulations document refers to personal protective equipment and clothing. Information relating to hand and foot protection can be found on pages 31–37 of the Personal Protective Equipment at Work – Guidance on Regulations. HMSO/Book shops.

HSE Documents are available by mail order from:

HSE Books, PO Box 1999, Sudbury, Suffolk CO10 6FS.
Tel: 01787 881 165
Fax: 01787 313 995
www.hsebooks.co.uk or can be ordered through book shops.

HSE Information Centre, Broad Lane, Sheffield S3 YHQ
www.open.gov.uk/hse/hsehome.htm

Appendix 7

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Manual Handling in Physiotherapy: Legal and Professional Duties

Duty of Care

Physiotherapists may well 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 and the provision of manual handling guidance or advice.

Professional Duty

Physiotherapists also have a professional duty to comply with the CSP Rules of Professional Conduct and Standards of Practice. Rule 1 of the RPC specifically requires a physiotherapist only to perform duties which they are safe and competent to deliver. This applies to the manual handling of patients just as much as to any other aspect of their professional practice.

Risk Assessment and Risk Management

Health and safety legislation provides a logical framework which can assist the physiotherapist through the process of risk assessment and risk management. Recording the process and the outcome of risk assessment is as much a part of the physiotherapist's commitment to patient care as their clinical assessment and treatment records.

The Utility of the Act

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 of the act is one factor to be considered.

Reducing Risk

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 the requirement to assess the risk arising and to reduce the risk so far as it is reasonably practicable to do so is absolute.

Employers' Duties

Employers have a duty to provide physiotherapists with a safe system of work, and to provide 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.

Competency

Balancing the potential benefits (utility) to patients arising from physiotherapy interventions involving manual handling with the potential risks to themselves, the patient and colleagues should therefore be nothing new to the competent physiotherapist.

Manual Handling in Physiotherapy Assessment and Treatment

- Physiotherapists manually handle patients as part of their professional role.
- When treatment programmes are devised that involve manual handling, that part of their work which is potentially hazardous must be assessed and the risks reduced so far as is reasonably practicable. This must be recorded.
- Staff working in different specialisms will have differing skills. However, all physiotherapists will need updating in manual handling throughout their career.
- Physiotherapists must not use or condone unsafe systems of work and the use of extra suitably trained staff or equipment may need to be considered.
- Treatment goals must be realistic and achievable, 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.

Delegation, Guidance and Advice

- 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.
- 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 their mind whether their intention is to delegate, or to offer guidance.
- The physiotherapist must be working within the remit of their employer in order to be covered by vicarious liability in the event of litigation.
- 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 profession how they must handle a patient.
- 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.

It is important to remember that giving advice and delegating tasks is a normal and essential part of physiotherapy. Being clearer about what our position is should not inhibit us – but should actually make it easier for us to carry on giving advice and delegating tasks.

Education and Training

- All Chartered Physiotherapist should receive manual handling education and training on an ongoing basis to allow them to maintain competency levels and safely perform that which is essential to their work.
- This should be at undergraduate level and as part of CPD.
- Physiotherapy assistants should all receive manual handling education on Induction and as a formal part of their ongoing in-service training programme.
- Manual handling training should be updated on an annual basis for all level of staff.
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