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The CSP is grateful for all the work that the key authors and contributors to chapter 3 have undertaken in the updating of this guidance.

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Executive summary

Professional and legal framework

• Physiotherapists owe a duty of care to their patients, colleagues and employers. This includes treatment involving manual handling, delegation of treatment, and the provision of manual handling guidance, advice and education.

• Health and safety legislation provides a framework that can assist the physiotherapist through the process of risk assessment and risk management. Recording the process and the outcome of patient-specific risk assessment is an essential part of the physiotherapist’s commitment to patient care, in the same way as their clinical assessment and treatment records.

• The law recognises that it would not be reasonably practicable to eliminate all potentially hazardous work. In considering the reasonable practicability of avoidance, the utility – or potential benefit – of the act (in this case, treatment involving manual handling) is one factor to be considered.

• However, the utility of the act alone is not a sufficient rationale to proceed with hazardous manual handling interventions with patients regardless of risk. If manual handling is to take place there is an absolute requirement to assess the risk arising, and to reduce the risk so far as it is reasonably practicable.

• Balancing the potential benefits (utility) to patients arising from physiotherapy interventions involving manual handling with the potential risks to themselves, the patient and colleagues, as well as family and other unqualified workers, is central to physiotherapy practice.

• Employers (including physiotherapist employers e.g. owners or directors of private physiotherapy practices) have a duty to provide physiotherapists with a safe system of work and to provide appropriate health and safety-related training.

Risk management in treatment handling

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

• Staff working in different specialisms will have differing skills. However, all physiotherapists will need relevant updating in manual handling throughout their career.

• Training must include relevant rehabilitation strategies, with especial reference to those to whom the rehabilitation process may be delegated.

• Physiotherapists must not use or condone unsafe systems of work. The use of additional suitably trained staff or equipment may need to be considered.

• Treatment goals must be realistic and achievable within available resources, or may need to be reconsidered.

Delegation, guidance and advice

• A physiotherapist may be an ideal person to contribute to the handling plan for a patient. Before acting to influence the handling of a patient by another, the physiotherapist must be clear in their mind whether their intention is to delegate or to offer guidance to assist in the decision-making process.

• All physiotherapists must be indemnified for their work and must be confident that they are working within their personal scope of practice.

• When undertaking handling, or delegating a handling task, the physiotherapist should ensure they are up-to-date with current good practice. They should understand that they remain accountable for their decision to delegate a task to another person, and should also consider who has managerial responsibility for that person.

Education and Continuing Professional Development (CPD)

• Undergraduate physiotherapists should experience discrete manual handling training as part of their studies, both within their Higher Education Institution and on therapeutic placement within a problem-solving environment.

• Chartered physiotherapists should be aware that their physiotherapeutic skills and knowledge only confer proficiency in manual handling and should not promote themselves as a manual handling expert prior to additional, specific training in manual handling.

• Graduate physiotherapists should continue to develop skills, knowledge and experience within manual handling situations as an integral part of their CPD.

• All manual handling courses provided to chartered physiotherapists shall be provided by competent persons and contain certain common core elements.

• Physiotherapy assistants and technical instructors should receive appropriate manual handling training before handling patients.

• All levels of staff should receive regular updates on manual handling from a competent person.

• Chartered physiotherapists who accept responsibility for training others in manual handling, for example as back care advisers, must understand the obligations and responsibilities of this role.

Key Issues with regards to purchasers, commissioners and service planners

• The role of the purchaser (or commissioner) is to ensure that health services are planned and delivered in a way that meets the interests of patients and taxpayers rather than health care providers. The role of the provider is to deliver the agreed health care services. From April 2012 the responsibility for commissioning NHS health care resources in England was transferred to the GP Clinical Commissioning Groups (CCGs). CCGs at present do not exist in
Executive summary

Scotland, Wales or Northern Ireland. For these countries, services are planned by health boards.

- Manual handling services are regarded as provider services. They may be purchased privately or commissioned as part of a service, for example, within an acute trust, one of the quality key performance indicators (KPIs) may relate to manual handling.
- It is important for physiotherapists and manual handling professionals to understand how their service is commissioned/or planned in order to be able to influence decision makers.
- Manual handling professionals and physiotherapists have specialist knowledge about the demands of manual handling. Therefore, it is important to work effectively with service planners to enable a two-way flow of information. This can be achieved through establishing effective relationships, providing information about the service, demonstrating evidence of effectiveness and gathering patient/user experience data.
Physiotherapists owe a duty of care to their patients, colleagues and employers. There is evidence that, despite their knowledge of biomechanics, the mechanism of spinal injury and the ability to treat back pain, physiotherapists are not immune to musculoskeletal injury. In a survey led by the Chartered Society of Physiotherapy (CSP), 67.5 per cent of physiotherapists reported a work-related musculoskeletal disorder (MSD), almost half of these (48 per cent) affecting the lower back. 40 per cent of physiotherapists reported hand, thumb and wrist problems, with neck problems coming third at 33 per cent.

A review of international studies on MSD within the profession identified a need for training undergraduates in MSD awareness, in particular low back pain risk awareness. In response to the survey results, the CSP produced a MSD resource pack, initially for CSP union stewards in the NHS, but applicable to all CSP members.

The CSP has long considered safer manual handling an essential core skill of the profession. In September 2013, a review of the 2008 version of the Guidance in manual handling in physiotherapy was approved. A committee of experts in the field was recruited, and the format of the revised guidance agreed. The revised draft was submitted to outside reviewers before the final version was agreed.

This 2014 4th edition has been updated to ensure its currency, to further inform and protect the membership on issues of manual handling. Physiotherapists have traditionally been associated with assisting people to move and teaching others methods of assisting mobility-impaired patients. This revised publication should enable physiotherapists to practise and delegate safely.

In Chapter 1, professional issues are identified, with standards of both professional conduct and practice from the Health and Care Professions Council (HCPC) and the CSP being discussed. It has been acknowledged that risk in manual handling cannot be eliminated, but physiotherapists are required to make assessments of unavoidable, potentially hazardous manual handling that occurs as part of their work and document strategies for reducing risks. Legal tests of reasonable practice are explained.

A simple algorithm is provided in Chapter 2 to guide physiotherapists through more complex treatment handling decisions. Further factors concerning the patient and person delivering the therapeutic handling will inform this iterative process. Physiotherapists must neither use nor condone unsafe practices. Emphasis is placed on the use of appropriate equipment and suitably trained staff, and the importance of management support is established.

Chapter 3 contains revised client/workplace specific information and case studies from the CSP’s professional networks, to provide relevant advice and examples to practitioners in a variety of fields.

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

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

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

Pat Alexander
Chair of Manual Handling Steering Group
Key messages

- Physiotherapists owe a duty of care to their patients, colleagues and employers. This includes treatment involving manual handling, delegation of treatment and the provision of manual handling guidance, advice and education.
- Physiotherapists are regulated by the Health and Care Professions Council (HCPC). HCPC, established as the Health Professions Council (HPC) in 2001, is the statutory regulator that works to protect patients by holding a register of members for each of 16 recognised health, psychological and social work professions.
- In order to practise under the protected title of ‘physiotherapist’ a person must be on the HCPC register of physiotherapists. HCPC physiotherapist registrants must meet the following HCPC standards:
  - Standards of conduct, performance and ethics\(^{(7)}\)
  - Standards of proficiency for physiotherapists\(^{(8)}\)
  - Continuing professional development and your registration\(^{(9)}\)
  - Standards of education and training\(^{(10)}\)
- Members of the CSP who are working as registered physiotherapists, physiotherapy assistants or support workers must comply with The CSP Code of members’ professional values and behaviour\(^{(11)}\) and Quality assurance standards.\(^{(12)}\)
- Further guidance is provided in the collaborative paper entitled Supervision, accountability and delegation of activities to support workers.\(^{(13)}\)
- Health and safety legislation provides a framework that can assist the physiotherapist through the process of manual handling risk assessment and risk management. Recording the process and the outcome of patient-specific risk assessment is an essential part of the physiotherapist’s commitment to patient care, in the same way as their clinical assessment and treatment records.
- The law appears to recognise that it would not be reasonably practicable to eliminate all potentially hazardous work. In considering the reasonable practicability of avoiding hazardous manual handling, the utility – or potential benefit – of the act (in this case, treatment / delegation of treatment / advice on care management involving manual handling) is one factor to be considered. The process of patient-specific manual handling risk assessment that takes account of the health, safety and wellbeing of the handler(s) and the enablement / rehabilitation / care / choice / dignity of the patient is referred to as ‘balanced decision-making’.
- Nevertheless, the utility of the act alone is not a sufficient rationale to proceed with hazardous manual handling interventions with patients regardless of risk. If potentially hazardous manual handling is to take place there is an absolute requirement to assess the risk arising, and to reduce the risk so far as it is reasonably practicable in the relevant circumstances.
- Employers have a duty to provide physiotherapists with a safe system of work, and to provide appropriate health and safety-related training, including in manual handling.
- Public bodies must not fetter the discretion of risk assessors, including physiotherapists, by applying any policy so rigidly that no consideration can be given to the individual circumstances of a case, such as by imposing ‘no lifting’ policies.
- Balancing the potential benefits (utility) to patients arising from physiotherapy interventions involving manual handling with the potential risks to themselves, the patient and colleagues, is central to physiotherapy practice.

Manual handling in physiotherapy

The purpose of this introductory chapter is to clarify and set in context the legal and professional duties relating to manual handling within the practice of physiotherapy. In order to do so, it is necessary to consider the requirements imposed by health and safety legislation including, but not limited to:

- the Health and Safety at Work Act (HSWA) 1974\(^{(14)}\)
- the Management of Health and Safety at Work Regulations (MHSWR) 1999\(^{(15)}\) and the Manual Handling Operations Regulations (MHOR) 1992 (as amended).\(^{(16, 17)}\)

Statutes relevant to decision-making in respect of the manual handling of people include:

- the Human Rights Act (1998)\(^{(18)}\)
- the Disability Discrimination Act, now part of the Equality Act 2010\(^{(19)}\)
- the Mental Capacity Act 2005\(^{(20)}\) – in Scotland, the Adults with Incapacity (Scotland) Act 2000\(^{(21)}\)
- the Children Act 1989\(^{(22)}\) and the Children Act 2004\(^{(23)}\)
- the Safeguarding Vulnerable Groups Act 2006\(^{(24)}\)
- the Care Standards Act 2000\(^{(25)}\)
- and other legislation relating to Social Care, the NHS and education.

Also relevant are:

- the CSP Code of members’ professional values and behaviour\(^{(11)}\)
- the CSP Quality assurance standards\(^{(12)}\)
- the CSP physiotherapy framework\(^{(26)}\)
- the Health and Care Professions Council standards of proficiency.\(^{(8)}\)

A definition of physiotherapy

A detailed definition of the evolving profession of physiotherapy is beyond the scope of this document. However, the World Confederation for Physical Therapy defines physiotherapy as a health care profession which:
The professional and legal framework

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

‘Physical therapy is concerned with identifying and maximising quality of life and movement potential within the spheres of promotion, prevention, treatment/intervention, habilitation and rehabilitation.’ (27)

The Health and Care Professions Council (HCPC) states that: ‘Physiotherapists deal with human function and movement and help people to achieve their full physical potential. They use physical approaches to promote, maintain and restore wellbeing.’ (28)

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

• massage and manual therapy
• therapeutic exercise which will include treatment handling (for example sitting to stand practice, assisted walking etc)
• electrophysical modalities
• kindred methods of intervention e.g. prescribing, injection therapy, acupuncture, etc.

Thus interventions/treatment involving manual handling, and the development of skills in order to carry out such interventions, are essential core elements of physiotherapy practice. In respect of all of the above, the physiotherapist must confine themselves to practice in which they have achieved and maintained the relevant competences. (29)

Standards of physiotherapy practice

HCPC is the UK-wide health regulator set up to protect the public. HCPC holds the register of those entitled to practise under one of the health professional protected titles. If a complaint is made to the HCPC with regard to a registrant’s fitness to practise, it may convene a full hearing and, if fitness to practise is deemed to be impaired, HCPC has the power to impose a range of sanctions on registrants.

CSP code of members’ professional values and behaviour (30)

The CSP introduced the code to replace and encompass the previous CSP Rules of Professional Conduct, and Code of Conduct for Associate Members. The principles of the code are focused towards:

• evidence-based practice (see Bolitho (30))
• communication
• documentation
• promotion of a safe working/treatment environment
• Continuing Professional Development (CPD).

All of the above have particular relevance both to the manual handling of patients and the handling of loads where the patient/client is the handler, as in the occupational health setting. Evidence based practice requires the physiotherapist to apply current best evidence when making decisions about the rehabilitation / enablement of individual patients that involve manual handling, in just the same way as any other aspect of practice. Documentation is the means by which the physiotherapist can provide evidence of their clinical reasoning, risk assessment and balanced decision-making process aimed at achieving agreed goals and functional performance outcomes.

The Quality Assurance Standards

The Quality Assurance Standards www.csp.org.uk/publications/quality-assurance-standards provide a method of determining service delivery by each CSP member and/or physiotherapy service in the UK achieves an acceptable and achievable level.

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

The standards are divided into 10 distinct areas of service;

1 Autonomy and accountability
2 Delivering a safe and effective service
3 Learning and development
4 Working in partnership
5 Consent
6 Record keeping and information governance
7 Communication
8 Evaluation of clinical care and services
9 Promoting, marketing and advertising physiotherapy services and products.

The CSP Quality Assurance Standards audit tool www.csp.org.uk/publications/quality-assurance-standards-audit-tool has been developed for use...
alongside the 10 standards and provide a clear process by which each standard is addressed locally, quality level identified and action for improvement recorded.

**Member Responsibilities**
Principle 1.2 of the CSP Code\(^{(11)}\) requires that a physiotherapist and associate perform only duties which they are safe and competent to deliver. The development of manual handling skills is based not only on knowledge and training but also on relevant and sometimes specific experience. When considering competence and safety in relation to the manual handling of patients, all physiotherapists must be as realistic and analytically self-critical as they would be in relation to any other aspect of their professional practice. All members are empowered by this rule to say ‘no’ since it provides a rational basis for not proceeding with any task, including manual handling, which they consider to be beyond their competence or ability to work safely. Similarly, the physiotherapist is responsible for appropriate delegation of duties in the field of manual handling.

Principles 3.2 and 3.3 of the code clearly state the responsibility of the physiotherapist in considering the safety of other personnel and their competence in manual handling, addressing the situation by carrying out an appropriate risk assessment and documenting the process, and explaining and engaging the patient in the risk and decision-making processes.

**Professional liability Insurance (PLI)**
Members of the CSP in practising, student and associate categories of membership benefit from medical malpractice and professional indemnity insurance, subject to the terms of the policy. See CSP Information paper PD027 Insurance and physiotherapy practice. [www.csp.org.uk/publications/insurance-physiotherapy-practice](http://www.csp.org.uk/publications/insurance-physiotherapy-practice)

The PLI scheme covers individual for all activities that are within the scope of physiotherapy practice and this will include manual handling activities.

For employed members, the employer stands vicariously liable for the acts and omissions of their employees that are performed as part of their employment. In some cases, the employer may subrogate liabilities for professional malpractice to employees and an employee may need to demonstrate that they have individual indemnity cover in place.

**The legal framework**

**Duty of care**

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

In summary, the key elements in relation to negligence in common law are:
- duty
- breach
- causation
- harm.

A physiotherapist, whether carrying out or delegating manual handling, giving advice or guidance about manual handling, or delivering training in manual handling, owes a duty of care to their patient and/or those whom they are educating.\(^{(30)}\)

**Standard of care**
One of the purposes of this manual handling guidance is to set out the expectations of practice for chartered physiotherapists within the specialism of manual handling. These expectations are what a member of the public, or a court would consider expect of a specialist in terms of:
- competence
- education / training
- physiotherapy interventions with patients
- delegation
- the giving of advice / guidance
- risk assessment and risk management
- the establishment and implementation of local policies / protocols.

In order to determine whether there has been a breach of the duty of care, it is necessary to judge the practice in question against the accepted standard of practice. This accepted practice is practice that is judged to be reasonable\(^{(31)}\) and responsible with a logical basis\(^{(29)}\) defined as:

‘…the standard of the ordinary skilled person exercising and professing to have that special skill’.

It is important to note, however, that if a physiotherapist professes to have greater than the ‘ordinary’ skill of a
physiotherapist, such as an extended scope practitioner, consultant or expert, then the required standard would be judged against that peer level of practice.

The Health and Safety at Work Act (HSWA) 1974
Occupational health and safety legislation falls within criminal law, and is enforced by the Health and Safety Executive (HSE). Whereas a breach of a duty of care may give rise to a civil claim for damages under the tort of negligence, a breach of health and safety law may give rise to a criminal prosecution. HSWA 1974\(^{(15)}\) was intended as the framework legislation upon which future regulatory control could be based. It now provides an enabling 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 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)\(^{(32)}\) 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 Management of Health and Safety at Work Regulations (MHSWR) 1999
The central provision of MHSWR 1999\(^{(15)}\) is Regulation 3, which states that:

‘Every employer shall make a suitable and sufficient assessment of:

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

The purpose of this general risk assessment process is to identify the measures that need to be taken to comply with the legal duties imposed on an employer with a view to managing risk. Employers also have a duty to implement systems that support staff in managing the coordination of risk control measures through planning, organisation, monitoring and review. Any adequate general risk assessment, taking place under MHSWR 1999 in a physiotherapy department or in relation to physiotherapy practice, would identify a range of different potential hazards. Where this general assessment indicates the possibility of risks to employees arising from manual handling, the requirements of MHOR 1992\(^{(16)}\) must be followed (see below).

The Manual Handling Operations Regulations (MHOR) 1992 (as amended)
These regulations\(^{(16, 17)}\) apply to the manual handling of loads by human effort. Manual handling, as defined in Regulation 2 of MHOR, means any transporting or supporting of a load (including lifting, putting down, pushing, pulling, supporting, carrying or moving it) by hand or bodily force.

The human effort may be applied directly to the load or indirectly, for example by hauling on a rope or pulling on a lever. Introducing mechanical assistance, such as a mobile hoist, may reduce but not eliminate manual handling since human effort may still be required to move, steady or position the load and/or the hoist.

The 2004 guidance on the regulations\(^{(33)}\) states that:

‘Manual handling includes both transporting a load and supporting a load in a static posture. The load may be moved or supported by the hands or any other part of the body, for example the shoulder. The application of human effort for a purpose other than transporting or supporting a load is not a manual handling operation.’

In the same guidance a load is defined as:

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

It is therefore arguable that, whilst facilitating the movement of a patient, say from sitting to standing, may well fall within MHOR 1992 (as amended), the physiotherapy treatment of a limb (such as offering resistance to movement) or the practice of mobilisation / manipulation may not. Nevertheless, any identified risk associated with such activities, including cumulative risk (see Chapter 2), would still have to be managed (under MHSWR 1999\(^{(15)}\)).

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

• Avoid hazardous manual handling so far as is reasonably practicable
• Make a suitable and sufficient assessment of any hazardous manual handling operations that cannot be avoided
• Reduce the risk of injury from those unavoidable manual handling operations so far as is reasonably practicable.
Thus the extent of the employer’s duty to avoid manual handling or to reduce the risk of injury is determined by reference to what is ‘reasonably practicable’. This duty can be satisfied if the employer can show that the cost of any further preventive steps would be grossly disproportionate to the further benefit from their introduction. However, this definition fails to address the manual handling considerations relating to physiotherapy interventions.

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

The consensus of the profession is very clearly that it is not. The 2004 guidance to MHor(33) now addresses these issues, albeit specifically in relation to the emergency services.

In the case of King v Sussex Ambulance NHS Trust(34), the Court of Appeal rejected an injured ambulance man’s appeal, partly on the basis that public service workers sometimes have to work at higher, though not unacceptable, levels of risk. The courts therefore seek to create a balance in which the utility of the task to be performed is one factor to be considered as part of the risk assessment process.

As an autonomous profession, we must take responsibility for setting the standards against which our practice as physiotherapists can be measured, including manual handling decision-making and practice (Bolam and Bolitho tests(29, 31)).

Children Act 1989 and Children Act 2004
These Acts(22, 23) set up a framework for the protection and care of children, and established clear principles with regard to decision-making in relation to their care and management. The overarching principle is that the child’s welfare is paramount. One of the main principles is that the views and opinions of the child should be sought wherever possible, and this includes decisions about their moving and handling assessment.

The manual handling risk assessment process
Step 1: Avoidance
Any general risk assessment taking place under MHSWR 1999(15) will identify, 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 or profession-specific risk management protocol.

It is worth reiterating here that, in relation to the manual handling of people, the utility of the act (the potential benefit of the treatment handling intervention) is an important consideration in deciding the reasonable practicability of avoidance.

Step 2: Risk assessment
On this point the law relating to manual handling is entirely clear. There is an absolute requirement to assess the risks arising from manual handling operations that cannot reasonably practicably be avoided.

In the health and social care sectors, such risk assessments may be:
- generic, i.e. pertaining to groups or classes of routinely undertaken or foreseeable but unavoidable tasks such as, for example: routine transfers from wheelchair to treatment table, or the transport of certain items of equipment
- patient-specific, where the generic protocol is not appropriate to a particular patient at a particular time.

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. To avoid any doubt:
- Hazard – something (e.g. a circumstance or behaviour) with the potential to cause harm
- Risk – a notional consideration of the likelihood that a 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 2004 Guidance on the Regulations(33) sets out at Schedule 1 the factors an employer must consider when making a risk assessment of a manual handling operation. These are summarised below, and reproduced in full with permission in Appendix 1 to this document.

The risk assessment filter and numerical load guidance for lifting and lowering, carrying, pushing and pulling are reproduced with permission in Appendix 2.

- Task related factors
- Individual (handler) related factors
- Load related factors
- Environment related factors
- Other factors (do not limit the risk assessment to the ergonomics factors listed above).
The acronym TILE is sometimes used as a mnemonic, and at other times ELITE is used, to include ‘equipment’ with the other 4 factors.

**The task**
It appears that the words ‘task’ and ‘operation’ are intended to have the same meaning within the interpretation of 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 that will vary depending upon the starting point (e.g. from a bed/easy chair/dining chair), the end point (i.e. the type of toilet/commode), the distance, the mode of transfer and so on. In this case, the risk arising from each sub-task must be considered separately and a strategy devised.

Similarly, in any physiotherapy intervention involving manual handling, each sub-task must also be considered separately; for example, assisting a person to initiate a transfer from a high bed may involve an entirely different order of risk compared to assisting the same patient to transfer back to bed from a low bedside chair.

**The individual**
The individuals referred to here are the handlers. Thus, in the case of treatment handling, any risk assessment must relate to the skills, competences and physical capabilities (relating to health status, gender, pregnancy, age, disability, anthropometrics, and so on) of the person carrying out the task, bearing in mind the Bolam and Bolitho tests and the physiotherapist’s duty of care.

This has particular implications in relation to the delegation of tasks to others of varying competence or the giving of advice and guidance (see Chapter 4).

**The load**
In the case of treatment handling, the load is the patient. A reference list of load factors relevant to person handling can be found in Appendix 3.

**The environment**
It is evident that environmental factors will impinge upon the manual handling of people, particularly space constraints imposed by the design of rooms or the placing of equipment.

When offering guidance or advice, physiotherapists must be aware of the environment in which a manual handling operation is to take place. If this is a person’s home it may pose an entirely different order of risk compared to the same operation taking place in the controlled environment of a physiotherapy department or hospital ward.

More detail on risk assessment in physiotherapy can be found in Chapter 2.

**Equipment or other factors**
This should include, for example, any lines attached to the patient or safety clothing/barrier garments worn by the handler and any other relevant factors.

**Step 3: Risk management**
Risk assessment is not an end in itself. It is the first part of a systematic process that should lead to the reduction of risk insofar as this can be achieved.

Risk management strategies or protocols that may be considered in relation to manual handling undertaken by physiotherapists include, but need not be limited to:

- the development of knowledge and skills in person handling and in the use and application of handling aids and equipment, and in the range of equipment available, through education and on-going professional development (see Chapter 5)
- the development of knowledge and skills in ergonomics and the application of ergonomics principles to work organisation and job design, task analysis, user trials (for handling aids/equipment) and the use of biomechanics (posture/force) assessment tools that can contribute to the analysis of risk
- working with manufacturers in the development of handling aids specifically designed to facilitate treatment interventions
- the provision of adequate resources such as appropriate staffing, equipment and adequate funding to facilitate the effective rehabilitation of patients, leading to increasing independence and thereby reducing the need for manual handling interventions in the longer term.

Where such resources are not provided, physiotherapists must not implicitly condone unsafe systems of work by ‘making do’, thus potentially placing themselves, carers and the patient at risk. In all such cases the issues should be documented and line managers advised.

- the implementation of generic protocols devised to manage risk arising from broadly similar manual handling operations
- the routine implementation of patient-specific risk assessment and risk management protocols following clinical assessment and the setting of realistic goals, as follows:
  - Assess the patient clinically.
  - Consider realistic clinical goals and functional outcomes in discussion with the patient, where the patient has capacity, or consult with relevant parties (family members, social worker etc)
  - Consider whether the proposed intervention involves hazardous manual handling.

- Can the hazardous manual handling operation be reasonably practicably avoided, when taking into consideration the utility of the intervention?

- If the operation cannot reasonably practicably be avoided, is there a generic protocol in place for managing the task-specific risk – and is it suitable for the specific patient and circumstances? If yes – work to agreed protocol.

- If it is not suitable, there is an absolute requirement to carry out a patient-specific risk assessment relating to the proposed manual handling intervention.

- Reduce the risk arising from the hazardous manual handling operation so far as is reasonably practicable by:
  i   adapting the technique
  ii   introducing equipment
  iii   seeking advice/assistance of appropriately skilled colleagues.

- If satisfied that the risks can be sufficiently reduced:
  i   record the risk assessment and risk management protocol
  ii  proceed with the manual handling intervention.

- If not satisfied that the risks have been sufficiently reduced:
  i  re-evaluate
  ii  consider competence to proceed
  iii  reconsider goals
  iv  seek more expert guidance.

The above is an iterative process, and the risk assessment must be revisited, together with the clinical review.

Physiotherapists must also be alert to short-term changes in performance and be sufficiently well trained and experienced (competent)\(^{(26)}\) to amend a treatment/risk management plan according to the presenting circumstances.

**Documentation**

Clinical record keeping is an integral and essential part of physiotherapy treatment, and must provide an effective means of communication between those involved in the provision of care in relation to any individual patient or client. (Standard 10 HCPC Standards of conduct, performance and ethics.\(^{(7)}\); CSP Code 2.1.2 and 3.4.1\(^{(11)}\). Documentation is therefore an essential element of the total care provided, and a tool that enables the physiotherapist to evidence that they have met their duty of care.

It is a requirement of MHSWR\(^{(15, 35)}\) and MHOR 1992 (as amended)\(^{(16, 17)}\) that the significant findings of any risk assessment should be recorded, dated, and the record be retained and readily accessible, as long as it remains relevant.

A system of clinical review and monitoring should ensure that risk assessments are updated regularly.

In the case of patient-specific risk assessments, these may need to be more detailed, breaking down manual handling operations into sub tasks where appropriate. They should also provide sufficient information for rehabilitation and care to be seamless and to provide evidence of the assessor’s reasoning in devising the risk management plan. Patient specific risk assessment documentation should be retained with the patient’s physiotherapy notes.

Documentation, including risk assessments, will also be required as evidence in the event of personal injury litigation or medical negligence claims. It is therefore essential that documentation does not fall short of the standard expected of a professional physiotherapist (Bolam and Bolitho tests).\(^{(29, 31)}\)

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

**Compliance with local policies**

Section 7(a) of HSWA\(^{(14)}\) 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 or omissions. What is required to discharge this duty may vary dependent upon professional qualification, management level and authority, and the extent of any relevant education/CPD provided by the employer.

Section 7(b) of HSWA imposes on the employee the duty to cooperate with his/her employer in meeting the duties and requirements placed upon the employer under health and safety legislation. This would include compliance with the employer’s health and safety policy, including manual handling policy and local generic protocols.

Given the role of physiotherapy in 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 physiotherapy staff are facilitated to develop their professional practice in this field.

All employers, including private physiotherapy practices employing five or more staff / physiotherapists, have...
a duty to have in place a health and safety policy that sets out the organisation’s general approach and commitment, together with the arrangements in place, for managing health and safety in the business. It is a unique document that says who does what, when and how, and it can only be effective if both the employer and their employees take ownership of it. It should include a policy specifically aimed at managing any risks associated with manual handling within the organisation in general, and specifically in relation to physiotherapy interventions / provision of advice / training delivery.

The Human Rights Act 1998
The Human Rights Act incorporated the European Convention on Human Rights into United Kingdom law. Since October 2000, public bodies such as NHS Trusts and local authorities (but not independent care providers) have been under a duty to act compatibly with the Convention rights of patients / service users and of disabled people not to be subjected to the consequences of overly restrictive interpretations of health and safety regulations in a health and social care context.

The Act sets out a number of wide ranging ‘rights’, and in respect of manual handling, the courts have now referred to three in particular. These are:
• Article 2: The right to life
• Article 3: The right not to be subjected to torture or to inhuman treatment or punishment
• Article 8: The right to respect for home, private and family life.

Public authorities must therefore be prepared to balance their responsibilities by adopting a more individual (person-centred) approach – for example, not allowing the blanket imposition of a ‘no lifting’ policy.

Some case examples relating to manual handling are included in Appendix 5.

Disability Discrimination Act 1995 (now subsumed within the Equality Act 2010)
The Equality Act defines disability, by requiring its effects to be substantial, adverse and long lasting or recurring.

It requires that people with disabilities are not treated less favourably than others, simply due to their disability, by those providing goods, facilities or services to the public (even if these are free).

However, in a booklet from the Minister for Disabled People 1996, it states:

‘This Act does not require you to do anything which would endanger the health and safety of any person, including that of a disabled person.’

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

The Mental Capacity Act 2005 (England and Wales)
The Mental Capacity Act came fully into force on 1 October 2007. It aims to protect people over 16 years of age who cannot make decisions for themselves due to a learning disability or a mental health condition, for example Alzheimer’s disease, or for any other reason. It provides clear guidelines for carers and professionals about who can take decisions in which situations.

There are five Section 1 principles:
• Assumption of capacity
• Practical help to person to make a decision
• Unwise decisions do not necessarily mean lack of capacity
• Best interests
• Least restrictive interventions.

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

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

The Adults with Incapacity (Scotland) Act 2000
The Adults with Incapacity (Scotland) Act 2000 provides a framework for regulating any interventions in the affairs of adults who have impaired capacity, including in relation to health care.

The Act recognises that an individual may be legally capable of making some decisions and actions, and not legally capable of making others. Incapacity is not an ‘all or nothing’ concept; it must be judged in relation to a particular decision.
The Act requires that, in circumstances where there may be doubt, the capacity of an individual to give consent to a medical treatment must be assessed, and a certificate of incapacity issued by a medical practitioner if appropriate in respect of a specific intervention. Present and past wishes of the adult also should be taken into account.

**Safeguarding Vulnerable Groups Act 2006**

The purpose of this legislation\(^{[24]}\) is to minimise the risk of harm posed to children and vulnerable adults by those who might seek to abuse them through their work (paid or unpaid). Abuse can take place in any setting, public or private, and can be perpetuated by anyone, including physiotherapists.

Particular examples of abuse in relation to moving and handling decisions include, but may not be limited to:

- Use of inappropriate manual techniques that can cause discomfort / harm and / or that limit enablement opportunities
- Provision of (or recommendations in respect of) inadequate / unsuitable moving and handling aids / equipment that can cause discomfort and / or harm and / or that limit enablement opportunities
- Use of moving and handling techniques / equipment in a way that is undignified for the vulnerable person
- Restraint imposed by the misuse of moving and handling aids / equipment / furniture etc

**Summary**

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

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

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

This chapter aims to ensure that physiotherapists are enabled to practise their profession. It includes a framework to ensure that rehabilitation handling can be undertaken as safely as possible for the physiotherapist, any person assisting, and the patient.

Manual handling tasks undertaken during rehabilitation and treatment can differ significantly from manual handling that takes place as part of a package of care. ‘Treatment handling’ (see p.18) may also be performed by other members of the health care team; however, this chapter is only concerned with what is performed as part of the delivery of physiotherapeutic intervention, which may include rehabilitation carried out by family members or unqualified workers as part of community reablement.

Musculoskeletal injuries in physiotherapists

Section 3.4.3 of the CSP code\(^{(38, 39)}\) states that physiotherapists must promote and maintain a safe, positive and healthy working environment.

There is an assumption that, due to their knowledge of biomechanics and the mechanism of spinal injury, and their ability to treat back pain, physiotherapists are less likely to suffer musculoskeletal injury.\(^{(31)}\)

Various studies have shown that physiotherapists’ perceptions of their training and knowledge lead them to believe that they are immune to injury, and it is only once an injury/episode occurs that they start to think about their own personal safety.\(^{(28, 30)}\) This situation is compounded by the lack of risk assessments undertaken.\(^{(39)}\)

In fact, studies completed in 2005 showed the reported career prevalence of work-related musculoskeletal disorders among members of the CSP is 67.5 per cent.\(^{(39)}\) Respondents ranked the following factors highest for contributing to musculoskeletal injury:

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

Key findings of the CSP member MSD report\(^{(33)}\)

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

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

It should be noted that the highest factor rated by physiotherapists as contributing to musculoskeletal injuries was task repetition. It is possible that a single manual handling task may not in itself pose a significant risk to the practitioner but, performed repeatedly, gives rise to a cumulative risk leading to injury. Research has been done into the cumulative risk faced by physiotherapists and a tool is in development that aims to help practitioners to quantify the risk in order to aid the risk management process.\(^{40}\)

More recent international studies have found a worryingly high prevalence of MSD injuries amongst physiotherapists, with reports of the incidence being:
- over 91 per cent in Nigeria\(^{41}\)
- 91 per cent in Australia\(^{39}\)
- 83 per cent in Israel\(^{42}\)
- 85 per cent in Turkey\(^{43}\)

**Definition of treatment handling**

The Health and Safety Executive (HSE) in its guidance on regulations, Manual Handling Operations Regulations 1992 (MHOR)\(^{43, 44}\) defines a manual handling operation as:

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

To the HSE definition may be added guiding, facilitating, manipulating, stretching or providing resistance. Thus, any treatment where force is applied through the patient’s body to or from any part of the therapist’s body constitutes manual handling.

Any manual handling involved in a physiotherapy treatment programme may be defined as treatment handling, whoever is involved in its delivery.

**General risk assessments**

- A general assessment under the Management of Health and Safety at Work Regulations 1992/1999\(^{15, 35}\) will identify manual handling that may be potentially hazardous. The requirements of MHOR 1992 will only apply to those tasks considered to be hazardous or potentially hazardous (see example below).
- When MHOR does apply, the hazards may include:
  - assisting patient transfers
  - unpredictable weight bearing
  - high force levels
  - providing manual resistance
  - compromised posture of physiotherapist, assistant or patient during treatment
  - lack of sufficient height-adjustable plinths
  - insufficient space and equipment for treatment, for example in community settings
  - the possible need to handle heavy limbs in awkward positions
  - inadequate equipment for carrying out rehabilitation, such as standing and walking hoists
  - insufficient/inadequate staffing levels
  - time constraints.

**Manual handling risk assessments**

**Generic manual handling risk assessments**

Generic manual handling assessments may suffice in some situations, taking into account the environment, the task, the individuals involved and the weight and type of handling involved. However, if any part of the assessment shows that there are risks specific to that manual handling situation – for example, co-operation of a patient being dependant on their mood – additional manual handling risk assessments must be made of that operation. This should be an integral part of the record of the patient to be handled.

If patients are able to walk into a treatment area, sit themselves down and undergo localised treatment, then the risks arising from any manual handling may be negligible and a manual handling risk assessment would not be required. However, a general assessment of the treatment area should have already identified any other potential hazards under the Management of Health and Safety at Work Regulations (1999).\(^{15}\)

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

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

**Individual manual handling risk assessments**

Those patients whose treatment may involve potentially risky manual handling will require an individual manual handling risk assessment (see example
Risk management in treatment handling

below). This should include an assessment of those factors included under TILE Step 2 (see: p.12.)

An amputee or stroke patient requiring assistance to transfer will require an in-depth assessment of his/her manual handling needs. However, a generic assessment and protocol should still be in place, such as ‘how to deal with a falling/fallen patient’. [46]

It is the physiotherapist’s responsibility to be familiar with the generic risk assessment for this task in the departmental area involved. Further information as to the risks of handling the particular patient should be recorded as appropriate.

All physiotherapists will need to assess any potentially hazardous manual handling involved in a treatment programme, as stated in the CSP Code (3.4.3). [11] A protocol follows that may assist this process.

Patient-specific assessment protocol

Physiotherapists must be able to assess the need to perform a potentially hazardous manual handling task. If it cannot reasonably practicably be avoided, then there is an absolute requirement to conduct a risk assessment (see Chapter 1).

The All Wales Treatment handling group document gives advice on treatment handling [47] and examples of methods of assessing and reducing the risks of treatment strategies that include manual handling.

In Chapter 1 of this document (47, Appendix 12) a patient-specific protocol was outlined.

Clearly, the risks must be re-assessed with each change in the situation. This may be a short-term change due to patient fatigue, or due to a reduction in ability following deterioration in a patient’s condition. Discussion with the patient must inform this process, and the clinical reasoning as well as the agreed strategy must be recorded.

If this treatment is to be delivered by another person on their behalf, the physiotherapist must ensure that specific guidance is given as to when the treatment should be altered or not provided, due to changes in the patient or situation.

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

- Following assessment can risks be reduced sufficiently using available means?
  - Yes
  - No – consider provision of extra, assistive equipment
    - No – consider extra staff
      - No – seek advice from Manual Handling Advisor
        - Does this reduce risks sufficiently?
          - Yes – acquire and continue
          - No – can aims be achieved using another treatment strategy?
            - Yes – acquire and continue
            - No – reconsider goals or relocation. Consult with manager for formal advice
              - Yes – continue to treat, using safe system agreed

For complex situations, further guidance may be required. The CSP professional networks provide a forum, through interactive CSP www.csp.org.uk/icsp, where discussions around common manual handling problems in specific fields can be aired.

Many professional networks produce guidance, based on evidence-based practice where available;
for example Guidance for physiotherapists: paediatric manual handling.\(^{(46)}\)

The All Wales Treatment Handling Group, 2011 has provided a comprehensive toolkit to support safe handling and delegation of handling of patients available on the CSP website: [www.csp.org.uk/documents/delegation-physiotherapy-treatment-handling-tasks-carers-non-clinical-personnel-toolkit](http://www.csp.org.uk/documents/delegation-physiotherapy-treatment-handling-tasks-carers-non-clinical-personnel-toolkit)

Chapter 3 includes input from the professional networks on manual handling risk management in special circumstances and settings.

Alternatively, health care professionals (including manual handling practitioners or back care advisors) with 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.

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

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

*Competency issues*
A senior physiotherapist specialising in neurology may possess greater treatment handling skill and experience in this clinical field than a newly qualified physiotherapist or a physiotherapist working in a different specialism. However, neither may necessarily be familiar with the biomechanical issues underlying safer manual handling.

Both pre-and post-graduate education must include safer treatment strategies (see Chapter 5).

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

The health status and physical ability of physiotherapists will, of course, be relevant to this assessment process and will include their abilities when returning to work following sickness or childbirth, as well as considering variations in their own physical abilities due to fatigue or ageing.

In some re-ablement schemes run on a social care model, there may be no direct therapy input in the contracted package of care, which would seem to assume (rightly or wrongly) that the care staff are highly trained in rehabilitation skills.

Cavendish, in her Review of health care assistants and support workers in NHS and social care,\(^{(49)}\) comments that ‘some employers and service users expect support workers to perform tasks for which they may not be trained’.

Should appropriate rehabilitation and accompanying manual handling training be delivered by physiotherapists, they must be up to date, confident in predicting the consistency or otherwise of certain conditions which may be encountered, and able to suggest alternative strategies when required.

Not only must the treating physiotherapist consider his/her own abilities at this point, but also the abilities of other people to whom he/she may delegate this treatment (see Chapter 4).

Unqualified staff must be aware that enthusiasm for enablement must be tempered with realistic goals.

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

*Patient participation (load)*
Handling patients will impose a load on the handler, as does the handling of inanimate loads. The term ‘load’, in a patient situation, could be seen as the amount of...
Risk management in treatment handling

musculoskeletal stress imposed on the physiotherapist arising from their contact/intervention with a patient.

The aim of the rehabilitation process is to encourage patients to move themselves or be allowed the opportunity to actively contribute to their own movement. Some patients may need equipment such as slide boards or walking harnesses only as a ‘safety net’ in case of unpredictable occurrences. Those with variable ability will need alternative treatment plans, with clear criteria to allow staff to decide which strategies they should employ.

For those patients who are unable to cooperate in their own movement, due to a physical/learning disability or a mental health problem, multi-disciplinary team discussions should enable safer acceptable strategies to be employed (see Mental Capacity Act 2005[16] and the Adults with Incapacity (Scotland) Act 2000[21]).

Factors to consider in manual handling of patients are:
- shape/size/weight of patient
- physical ability of patient and reasons this may fluctuate
- potential for rehabilitation/improvement
- clinical diagnosis and prognosis
- ability/motivation to co-operate
- complicating factors, for example pain, shape, skin condition, orthoses/prostheses
- lack of balance or coordination, involuntary movements or spasm
- instability or unpredictable movements
- risk of harm, for example challenging behaviour
- the requirement for staff to wear protective clothing, for example due to infection control measures
- medication
- social, psychological and cultural factors.

Moving towards intervention
Use of equipment
Having established their rehabilitation/treatment goals, physiotherapists will need to devise a treatment plan.

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

This does not mean that a hoist must be used for all transfers. Assessment and treatment should be part of a graded process, requiring less assistance to the patient as the treatment progresses. For example, a patient may require the use of a walking harness at the start of a rehabilitation programme, progressing to assistance from two members of staff with a third pushing a wheelchair behind, to eventually walking unaided. Equally the support offered may need to be increased if the patient deteriorates or is simply fatigued.

Shortages of staff should not be allowed to affect staff health and safety, and only those treatments in which the risk has been reduced as far as is reasonably practicable may be permitted to continue. Those making domiciliary assessments for rehabilitation must be aware of the skill of other staff involved in the programme.

In many instances, physiotherapists may feel obliged to supply treatment with insufficient resources; however, they should not collude in nor condone such unsafe practices (see CSP Code[11]). The lack of staff or equipment must be reported to a line manager, and perhaps the patient referred on to an alternative treatment facility where the required treatment may be provided safely. The cost/benefit implications of this will enter into the decision-making process, and the solution devised should enable the treatment to be delivered more safely. These costs will include the need for regular checks and maintenance of equipment, as specified in the Provision of Use of Work Equipment at Work Regulations (PUWER) 1998[30] and the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998.[51]

With an increase in community-based rehabilitation, particularly in the patient’s home, it is important to have the appropriate equipment to enable physiotherapists and others to carry out rehabilitation. Providing assistive equipment may well introduce the need for further training, whether for staff or family carers.[30]

Physiotherapists should play an active role in working groups that make decisions on equipment to be included in Community Equipment Stores. These should provide for both long-term equipment requirements, as may be needed for people with long-term conditions, and people requiring short-term loan of equipment, for example patients requiring intermediate care and rehabilitation.

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. There is a particular need for this when delegating a rehabilitation programme to others, to ensure that these others are sufficiently fit and trained to carry out the process.
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. Any modifications due to changes during treatment will need to be documented after the session.

Facilitated/assisted walking should only be performed where the risks to staff and patient have been reduced so far as is reasonably practicable, for example by reducing the possibility of a fall should the patient’s legs give way, thus eliminating the risk to the patient and to staff attempting to catch him.

_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 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.

Additionally, physiotherapists have a key role to play in rehabilitation and management of patients who have fallen. Goals may include improving balance and mobility and teaching patients how to get up from the floor.

Physiotherapists and supervisors must ensure that they have adequate training and equipment to be able to undertake this treatment in the appropriate treatment settings, for example using backward chaining methods to teach rising from the floor.

Consideration should be given to providing patients who remain at high risk of falls following rehabilitation with appropriate equipment so that they or their carers can safely help them up from the floor using, for example, hoists or electric lifting cushions, so long as no Injuries have occurred.

**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.

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

Managers should play an active role in equipment groups. There should be appropriate policies in place to support the role of physiotherapists within rehabilitation; for example, in the form of a rehabilitation policy.

Many health and social care organisations have manual handling policies in place that may be seen as ‘blanket bans’ on lifting. These are not acceptable, as the law does not require this, and they are also probably unlawful.

Rehabilitation requires skilled management of a degree of risk that is different to care handling. Managers should ensure there are appropriate rehabilitation policies in place to allow physiotherapists to work within their professional role and to use their clinical reasoning. In social care, management must ensure that their staff working in rehabilitation are sufficiently trained for their own and the clients’ safety.

Line managers must be prepared to support staff who report problems in relation to treatment handling, and assist in devising safer systems of work. When a decision is about to be made to withdraw treatment for safety reasons, line managers must be involved, and be able to demonstrate the clinical reasoning informing this decision when challenged. Records are an essential part of this process.

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

Management must ensure that emergency rescue plans (including patient evacuation and dealing with collapsed patients) incorporate staff safety and include protocols devised, practised and implemented following evaluation. Personal emergency evacuation plans (PEEPS) may be required for those patients with mobility impairments, following a Fire Safety Risk Assessment, in accordance with The Regulatory Reform (Fire Safety) Order 2005 for England and Wales The Fire (Scotland) Act 2005 or the Fire and Rescue Service (NI) Order 2006 for Northern Ireland and subsequent Regulations.

**Liaison with equipment manufacturers**

To develop and maintain competency, physiotherapists should be encouraged to visit relevant seminars and exhibitions, and liaise with manufacturers. In this way they will be able to ensure that future research and developments address 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 their own safety and the safety of others (see Chapter 5).
Special circumstances and settings

Manual handling in neurology

Special considerations
Safe handling is an integral part of the management of clients with neurological disability, and appropriate handling provides the basis for many neurological rehabilitation interventions. Facilitation of movement and posture underpins much of the work of the neurological physiotherapist, and the safety of both client and therapist is paramount throughout assessment and treatment.

Giving guidance to other professionals, care workers and relatives, which may include handling advice, is a routine and essential aspect of physiotherapy in neurology. Physiotherapists should work within their employer’s and national manual handling guidelines. However, in some circumstances it may be appropriate for the physiotherapist to question the validity of local manual handling policies if they seem inappropriate in relation to, and/or to the detriment of, the patient. Their clinical reasoning process should identify which part(s) of the manual handling policy is detrimental to the patient and this rationale should be clearly documented within the patient’s notes.

Factors that may need special consideration in this client group include:
- Importance of maintaining independence and dignity:
- Cognitive problems, including attention deficit
- Behavioural problems
- Variations in muscle tone, for example muscle spasms which can be influenced by a variety of factors including handling
- Communication problems, for example, receptive and expressive dysphasia
- Variable client ability related to:
  - medication, for example ‘on/off’ times in patients with Parkinson’s disease
  - changing presentation in patients with multiple sclerosis, traumatic brain injury or motor neuron disease
- Sensory deficits such as:
  - sensory and proprioceptive problems
  - neglect
- Pain and altered sensitivity
- Motor ability such as:
  - decreased balance and coordination
  - limb weakness
  - altered active and passive range of movement
- Visual disturbance e.g. diplopia; hemianopia
- Fatigue issues e.g. time of day; what the patient was doing beforehand
- Effects of medication
- The skill mix and experience of the team carrying out the manual handling procedure
- The presence of attachments to the patient such as a tracheostomy; chest and other drains; CVP line; IV lines; ICP bolts; catheter bag; stoma bag
  - Presence of pressure areas e.g. heels; sacrum
- Traumatic and non-traumatic spinal cord compression and the risk of spinal instability, including the use of braces

Clinical reasoning within risk assessment and changing performance requires regular review of decisions, clear documentation, and communication with all involved.

Case study: community/neurology
Scenario
Mr J had a stroke, causing left sided weakness, balance problems and spasticity in his left leg. When sitting over the edge of the bed, he tended to fall towards the left side, and had to hold on to the bed with his right hand while hooking his right leg onto the bed to try and stay as upright as possible. His left upper limb had some movement, but was very painful and his left shoulder joint was subluxed.

Mr J was keen to be as independent as possible to continue to improve and maintain his movement ability. He was resistant to the idea of a hoist being used, and wanted to continue working towards a more independent method of being able to transfer. This was what he was doing at the rehabilitation centre prior to his discharge home. There were times when he managed to convince the carers/ his family to help transfer him without the use of a hoist. His carers felt that the hoist was the safest way to transfer Mr J.

Goal
To transfer more independently and not use the hoist routinely

Task
Transferring from the bed to the wheelchair.

Individual
Some members of staff reported difficulty trying to manage the weakness and balance problems presented by Mr J’s trunk listing to the left, and his painful shoulder.

Load
Mr J was taller than some of his carers. His last weight was ascertained 9 months ago.

Environment
The bed was height adjustable. The space within his bedroom was adequate but there were some objects that needed moving. The carpet was smooth in some places.
Special circumstances and settings

Identified risks
• Risk of musculoskeletal injury to staff and family
• Pain in the affected arm.

Control measures
• A meeting was arranged with Mr J, the care manager, the physiotherapist, the two care staff and his family
• Mr J’s concerns and the clinical reasons for assisting Mr J rather than using the hoist were discussed
• An explanation of technique and a demonstration by the physiotherapist was followed by observation of the carers modifying the transfer to allow them to assist Mr J more easily e.g. adjusting the bed height, considering his foot placement, assisting his sitting balance
• The importance of asking Mr J to try by himself first was highlighted
• The physiotherapist prepared pictures of the transfer method including a written advice sheet, which included clinical reasons and cautions
• The names of all those present at the meeting were documented and a copy of the written advice sheet was kept in the notes with a brief record of the discussion
• A monitoring process was agreed.

Benefits (including details on costs and outcomes)
• Mr J has the choice to be more independent and continue to use and work on his physical function using the transfer procedure
• The risk of injury to staff and family is minimised with the suggested transfer method
• No additional cost for equipment is required.

Additional considerations
The hoist may need to be used in certain circumstances including if Mr J is unwell.

The plan will need to be reviewed if Mr J’s ability changes or any person involved experiences difficulties with the task.

New staff must be shown the adapted method by a competent person before they assist Mr J, and their competence training recorded.

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

Manual handling in oncology and palliative care
Special considerations
Physiotherapists working within the specialist area of oncology and palliative care may work in a number of settings; these include inpatient wards, the outpatient clinic, hospice settings, day hospital or the community. The role of the physiotherapist is therefore very varied and may present with a number of specific challenges due to the nature and variability of this patient group.

Working in the field of oncology and palliative care, the physiotherapist uses a patient-centred approach to discuss patients’ expectations, set realistic goals and provide rehabilitation so that patients can function at a minimum level of dependency, optimising their quality of life, regardless of life expectancy.

There are many significant factors particularly pertinent to oncology and palliative care which need to be considered in preparing manual handling care plans for patients in this client group. These include:
• Pain – pre-activity breakthrough analgesia may be required (other types of pain, including psychological pain may increase or reduce the safety of a manual handling technique)
• Cancer and anti-cancer treatment related side-effects including fatigue, poor skin integrity, steroid induced myopathy, along with chemotherapy induced peripheral neuropathy
• Cachexia – issues of comfort, skin integrity and profound muscle weakness
• Bone metastases – increase the risk of pathological fractures. The risk of metastatic spinal cord compression needs to be given consideration in those with known bony metastases
• Osteoporosis – increased risk post long term steroid use must be considered
• Fluctuations in cognitive ability associated with underlying brain disease or reversible changes in biochemistry (for example hypercalcaemia, infection)
• Post-surgery – the presence of tracheostomy, drains, IV lines etc. need to be considered
• Risk of bleeds – including those with thrombocytopenia and disease affecting vascular tissues must be considered in terms of ensuring safe manual handling. Risk assessments may require MDT discussion
• Shortness of breath due to lung pathology, anaemia or anxiety may be exacerbated by activity or disease, resulting in reduced exercise tolerance and limited performance of functional activities
• Lower and upper limb and/or pelvic oedema, including ascites and lymphoedema, may make transfers or mobility difficult, due to heavy limbs or shortness of breath
• Neutropaenia and the associated increased infection risk must be taken into account, especially when using manual handling equipment
• Neurological tumours – brain and spinal – may present with a wide spectrum of disability, including impaired balance, adverse muscle tone and associated reactions

Pain
– pre-activity breakthrough analgesia may be required (other types of pain, including psychological pain may increase or reduce the safety of a manual handling technique)
– issues of comfort, skin integrity and profound muscle weakness

Bone metastases – increase the risk of pathological fractures. The risk of metastatic spinal cord compression needs to be given consideration in those with known bony metastases

Osteoporosis – increased risk post long term steroid use must be considered

Fluctuations in cognitive ability associated with underlying brain disease or reversible changes in biochemistry (for example hypercalcaemia, infection)

Post-surgery – the presence of tracheostomy, drains, IV lines etc. need to be considered

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Shortness of breath due to lung pathology, anaemia or anxiety may be exacerbated by activity or disease, resulting in reduced exercise tolerance and limited performance of functional activities

Lower and upper limb and/or pelvic oedema, including ascites and lymphoedema, may make transfers or mobility difficult, due to heavy limbs or shortness of breath

Neutropaenia and the associated increased infection risk must be taken into account, especially when using manual handling equipment

Neurological tumours – brain and spinal – may present with a wide spectrum of disability, including impaired balance, adverse muscle tone and associated reactions
Special circumstances and settings

• **Psychological factors**, particularly overestimation of ability due to denial of deterioration, unrealistic goals and altered body image and sequelae

• **Importance of independence**, particularly among younger patients, and the significance of toileting with dignity.

It is important to use any assistive device available to reduce effort for patients and carers. These could include riser/recliner chairs, profiling beds, slide boards, stand aids and mobility aids.

The variability of function and motivation that often characterises this client group are important considerations for the physiotherapist as both physical and emotional presentation may vary widely throughout the pathway. Continual re-assessment and re-evaluation of a patient’s ability and ongoing adjustments to technique may be required to prepare for and adjust to the changing condition and irreversibility of the downward trajectory of the disease.

**Setting**

Working in patients’ own homes can present unpredictable and unique manual handling challenges that are likely to require individual risk assessment of the environment and adaptation of techniques accordingly.

This is particularly pertinent when making manual handling recommendations to formal and informal carers, and is likely to require an MDT approach, working closely with an occupational therapist.

This is important in ensuring that patients have the appropriate aids and support to allow them to stay in their chosen place of care, as they approach the end of life.

Safe manual handling is a foundation of quality care, as some element is involved in most tasks. ‘Safer handling often adds to the quality of care a patient receives. Encouraging self-help stimulates patients physically and mentally, it reduces side effects associated with immobility and contributes towards their rehabilitation’.[58]

**Further information**

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

**Manual handling in paediatrics**

**Special considerations**

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

The clinical areas covered by paediatric physiotherapists range from neonatal care to orthopaedics, respiratory care, neurodisability, palliative care, burns, and intensive care among others. The environments in which paediatric physiotherapists work can be varied and include inpatient and outpatient units, special schools and nurseries, mainstream schools, community (homes), hydrotherapy pools, sensory studios, soft play rooms, ball pools and hippotherapy centres.

The ergonomic mismatch of paediatric equipment, and in some instances the unfavourable environment, makes this a high-risk specialty to the handler. The need for the therapist/handler to engage with the pre-school-age child who spends most of its play time in floor based activity (play) requires additional consideration when assessing risk and delegating tasks.[59]

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

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

Paediatric physiotherapists must have a duty of care to the child and his/her carers and must demonstrate safe handling to all concerned.[50] The therapist must be aware of the differing skills and competences of those involved with the care of the child or young person and, following a risk assessment, adjust risk management strategies as appropriate to ensure the safety of all concerned at all times.

There should be clear clinical justification for the treatment approach and manual handling procedures, and in some instances this may result in adaptation or modification of the proposed management plan to minimise risks to all involved.[60]

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

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

Further information on manual handling for paediatric physiotherapists can be obtained from the Association of Paediatric Chartered Physiotherapists (APCP) publications officer via [http://apcp.csp.org.uk/contact-us](http://apcp.csp.org.uk/contact-us).

Case Study: paediatrics
Scenario
Manual handling case study: paediatrics
Specialty: paediatrics/neurology

Goal (including reference to clinical reasoning)
To assist a child with spastic quadriplegia to walk, maintaining weight-bearing ability.

Therapist stands behind child and supports from central point of control, for example pelvis.

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

Control measures
- The handler should sit on mobile stool to improve posture whilst handling.
- The area should be cleared of clutter.
- The distance to be walked should be reduced.

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

Additional considerations
Training for others if this task is delegated.

Further Information
More information on physiotherapy in paediatrics or details on how to access a copy of their manual handling guidance can be obtained from the Association of Paediatric Chartered Physiotherapists (APCP) at [www.csp.apcp.org.uk](http://www.csp.apcp.org.uk).

Manual handling in aquatic therapy (hydrotherapy)

Special considerations
Working in water is potentially hazardous for patients, physiotherapists and accompanying individuals. As outlined below, the main manual handling issues are at entry into and exit from the water, and while handling patients and equipment in the water.

Risk assessment for all activity in the pool is essential.

Specific to entry into the water
Entry into the water is affected by physical principles; that is, the upward force of buoyancy increases as a person is immersed in deeper water. This may have unexpected effects for physiotherapists inexperienced in hydrotherapy, for example:
- A patient not confident in descending steps on land will need decreasing manual support as buoyancy increasingly supports their weight
- A patient with osteoporosis will find standing in the water difficult as their legs (made buoyant by osteoporosis) tend to float; thus they need firmer than anticipated handling in the pool.

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

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

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

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

However, there are valid reasons for not using a hoist, for example:
- The pool does not have one
- The hoist is unavailable/broken
- The hoist’s chair attachment is unsuitable for this injured patient.

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

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

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

Note: There have been incidents where people have been under the weight limit for the board, but the straps would not fit around their body shape – weight/size issues are likely to become more frequent.

The safe weight limit of an emergency rescue board will vary depending on a number of factors:
- pool design, including:
  - the free board (that is, the height difference between the top of the water and the top of the pool wall or the pool side)
  - the presence of a hand rail at the evacuation point
  - a narrow pool wall for landing the board
  - a gap between the wall and the emergency trolley
- therapy staff, consideration of both:
  - the number of staff available both in the pool and at the poolside
  - their experience in hydrotherapy
- the patients, including:
  - the number in the pool
  - their individual age
  - ability
  - pathology
  - weight
  - water confidence
  - level of consciousness (that is, a patient may become unconscious as a result of a cardiac arrest in the pool).

For example, if the board is tested to a maximum weight of 150kg as for the Kiefer board:
- it may be safe for a 145kg unconscious patient to be safely evacuated from a deck level pool by a therapist experienced in hydrotherapy
- it may be unsafe for a conscious, non-water-confident, 63kg patient with acute back pain (or severe osteoporosis or spasticity) to be evacuated from a pool with a free board of 20cm by a newly qualified physiotherapist.

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

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

- they are inexperienced and have not achieved basic competences as demonstrated in the Aquatic Therapy Association of Chartered Physiotherapists (ATACP) training matrices
- the water is too deep or too shallow. The optimal depth of the water is to the therapist’s 11th thoracic vertebra, normally in the region of 1000-1350mm
• the tiles on the pool floor are non-specialist; tiles in a hydrotherapy pool should be non-slip
• patients are not water confident and, as a result, panic
• insufficient poolside support is given, that is, no poolside staff member within earshot of the therapist in the pool

Some specialist techniques, for example some Bad Ragaz ring patterns, require expert positioning from the physiotherapist to be performed safely.

Some patients, for example those with complex neurological conditions, require specialist therapeutic handling in the water.

Handling equipment
Some hydrotherapy techniques will require therapists to move equipment into and out of the pool and onto and off poolsides, for example:
• Aerobic exercise steps
• Pool plinths
• Pool exercise chairs.

This is made harder if the equipment:
• is awkward in shape
• is large in size and in surface area to move through the resistance of the water
• may need to be moved into and out of the water from shoulder height.

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

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

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

Poolside hoists
• Primary school children may be small and may not fit onto standard solid-chair hoists
• Following surgery (especially hip surgery) it may be difficult for patients to achieve a 90° position at the hip and knee to enable them to sit safely in a solid chair hoist
• It may not be possible to use adult-sized solid chair hoists safely with children who cannot bend their knees

• Many children find the solid plastic chair uncomfortable and are reluctant to use it, so parents and carers may choose to continue to lift them in and out of the pool
• Parents and carers get into the habit of lifting children in and out of the pool and continue to do so even after they become too heavy to manage safely
• In swimming lessons children are encouraged to enter the water independently from the poolside but may be unable to manage a safe exit
• A greater range of entry and exit can be supported if a sling hoist or trolley support is available
• Poolside hoists are designed to transfer one person at a time, and it is unsafe to use them in any other way.

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

Pool environment
• Due to their size, some young people may become cold more quickly than adults getting out of the pool, and are at greater risk from falls or injuries
• Parents or carers often use flotation aids such as armbands, which are designed for younger children, longer than appropriate due to the absence of knowledge of alternative ways to support older children in the water.

Schools
• Pressures of ‘timetables’ impact on time available for changing before and after swimming
• Training and support for staff varies between schools
• Provision of appropriate equipment varies between schools.

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

Case study: paediatric hydrotherapy
Scenario
Manual handling case study: hydrotherapy
Specialty: paediatric hydrotherapy

Goal (including reference to clinical reasoning)
To provide a safe and private changing environment for a powered wheelchair user in a mainstream school.
Identified risks
Task
Child B was able to access the pool successfully using a shower chair that attached to a poolside hoist. B was changed in the main boys’ changing room where there was a fixed height wide plinth at an appropriate height for a wheelchair transfer. The plinth provided sufficient space for B to roll so staff could assist him with dressing, but he was unable to transfer to and from his wheelchair or shower chair without a hoist. Maneuvering the mobile hoist to get B on and off the plinth was hazardous due to limited space in the changing room.

Patient
B is a 12-year-old boy with four-limb-involved cerebral palsy who used a powered wheelchair to get around school. He was unable to assist with transfers and needed a hoist to transfer him to and from the plinth and the shower chair or powered wheelchair. He was able to assist staff with removal of clothing, provided he was lying, as he could roll to either side. He was unable to assist staff when he was in a chair. He was unable to sit independently. There was also concern that as he grew older he would become more conscious of being hoisted in front of other children.

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

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

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

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

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

Further information
More information on physiotherapy in hydrotherapy can be obtained from the Aquatic Therapy Association of Chartered Physiotherapists (ATACP). See www.csp.org.uk/professional-networks/atacp

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

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

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

In view of the increasing emphasis on care in the community and the active encouragement for people with learning disabilities to access and benefit from the facilities enjoyed by the general population, it is essential that a holistic attitude is taken towards manual handling. A thorough risk assessment should be undertaken and documented where any new activity is contemplated, to ensure the safety of both the client and their carers in environments which are frequently not adapted to their needs.

It is important that the therapist works closely with all members of the team who are responsible for the welfare of the client to ensure their safety and enjoyment of the facilities available.

Following the Cavendish Review commissioned as a result of the findings at Mid Staffordshire NHS Foundation Trust and failings reported at Winterbourne View, 18 recommendations were made with regard to health care assistants (HCAs) and support workers in the NHS and social care. A number of these included adequate training for these staff and working as part of a team.

The responsibility may fall to the physiotherapist to ensure these staff are competent to carry out the manual handling techniques that make up part of the therapeutic package.

Special considerations
Factors that may need special consideration for this client group include:

- variations in tone
- fixed deformities
- sensory problems
- communication problems
- dementia – in people with Downs syndrome the onset of dementia may be from the age of 35 or earlier, and their health often deteriorates quite rapidly
- pain which cannot always be expressed and can present as alterations in behaviour
- epilepsy and its complications
- challenging behaviour
- the use of specialised seating and 24 hour postural management
- respiratory problems – people with a learning disability may have complicating factors such as deformed rib cages and spines
- impaired cognitive function, leading to an inability to understand the fundamentals of the treatment procedure
- osteoporosis, which can be exacerbated by reduced mobility and poor diet, leading to an increased susceptibility to fractures
- palliative care
- capacity to consent (Mental Capacity Act 2005 and Adults with Incapacity (Scotland) Act 2000).

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

- removal of clients from moulded wheelchair inserts in emergency situations, for example the need to administer rectal diazepam in the event of epileptic seizure
- mobilising clients where there is a likelihood of them dropping to the floor or lifting their feet; this can be complicated by added postural deformities and severe challenging and/or self-injurious behaviour.
- advising on safe hoist transfers where individuals exhibit severe challenging behaviour
- advising on accessing equipment in local community facilities such as gyms and leisure centres; this may include trampolines
- advising on accessing swimming pools in local leisure centres in order to continue rehabilitation programmes designed by the therapist.

Further information
More information on physiotherapy for people with learning disabilities can be obtained from the Association of Chartered Physiotherapists for People with Learning Disabilities (ACPPLD)

http://acppld.csp.org.uk/

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

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

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

In giving advice relevant to manual handling they should be aware of the current government laws and regulations applying (see Chapter 1) and be able to:
- Carry out a pre-riding/driving/vaulting/hippotherapy assessment of the client/patient to assess their capabilities and identify and record their specific problems
- Set realistic goals to be achieved from riding/driving/vaulting/hippotherapy and highlight the client/patient's moving and handling needs.
- Undertake an appropriate risk assessment of the unpredictable environment in which the riding/driving/vaulting/hippotherapy session will take place relevant to the client/patient's specific problems
- Assess the mounting facilities to select the safest and most appropriate method for the rider and helpers, depending on the facilities available, and document the procedure to be followed
- Communicate with instructors, volunteers/helpers and others and assist in training them in appropriate techniques for the safe moving and handling of the rider/driver and to minimise any identifiable risks to themselves
- Have knowledge of the appropriate selection, assessment and training of the equine, and understand the importance of matching the horse to the rider
- Document all advice given to riders/drivers or instructors/volunteers and set appropriate times to review that advice
- Undertake ongoing training on study days and courses to maintain CPD and keep a record of learning outcomes relevant to practice.

Details of the protocols involved are published in the Standards of Physiotherapy Practice in Therapeutic Riding published by the Association of Chartered Physiotherapists in Therapeutic Riding (ACPTR). The ACPTR runs study days and conferences and a recognised Hippotherapy Course, which is taught annually. Training can also be accessed by attending courses run within the Riding for the Disabled Association (RDA).

Manual handling in mental health
Physiotherapists work with people with mental health issues in many settings including hospitals, psychiatric units, community, secure services and patients’ homes.

People with mental health issues present physiotherapists with complex and often unique situations concerning manual handling. This may be due to cognitive impairment or a lack of capacity in relation to consent.

Special considerations
People with mental health issues are often vulnerable and can present with challenging behaviour which can impact on manual handling. They often have higher levels of fear due to lack of insight and a difficulty in communicating their concerns.

Older people often present with multiple pathologies as well as their mental health issues, which need to be taken into consideration when assessing manual handling needs. They may also require more time to process information and therefore consideration needs to be given to provide this. There is a need for ongoing evaluation due to the possible impact of fluctuating mental health and possibly variable physical health.

As with people with learning disabilities, physiotherapists will be involved with people who lack capacity or have an element of cognitive impairment and this must be considered when engaging in any manual handling situation.

The first principle of the Mental Capacity Act (2005) is to assume a person has capacity to make decisions until proven otherwise. Physiotherapists may need to consider options for maximising communication, for example pictorial, slower speech, short sentences and ensuring eye contact.

Those people who present with challenging behaviour may need more time to be reassured, and the physiotherapist may have to explain their actions before initiation of the task.

Where a service user is deemed to lack capacity or has barriers to communication, a therapist may have to carry out actions in their best interests. An important aspect of this is to include multi-disciplinary team members, family/carers, and most importantly the service user in the completion of a best interest task. Even if a service user is deemed to lack capacity, they should be made aware of the manual handling task before initiation to maximise safety for therapist and service user.

Sensitivity has to be given to the service user post-task as they may find the task distressing.
especially if consent has not been given, or if they have not comprehended the process. You may need to consider the following:

- Lack of verbal communication skills, whether this be a physical/cultural barrier or cognitive issue
- Fear and anxiety may present with agitation and challenging behaviour, so the patient may need more supportive slings or equipment
- Pain is often under-reported and undertreated in people with dementia and will have an impact on manual handling, with the risk of increasing challenging behaviour if not recognised. Consider a trial of analgesic cover, as it may have a positive effect
- Some service users may have paranoid beliefs and be resistant to new people
- Some older people may have longstanding contractures and stiff joints
- Situations where the person is resistant to interventions, e.g. personal-self-care
- People with dementia may have difficulty in recognising equipment and not know what it is used for; e.g. a frame may appear to be a cage around them, and they may require more explanation.

People with mental health issues may present with a variable level of mobility, requiring this to be assessed on each occasion, with a clear care plan that is individual and involves the person’s views in its writing. The care plan may need to include different options for manual handling dependent on the presenting situation. There are times when you may need to risk-assess adapting techniques dependent on variability and physical location.

A physiotherapist may be required to assess and advise on transfers and mobility in people with mental health issues when staff feel there may be a greater risk to harm both to the person and the staff, for example:

- people who present with challenging behaviour when being moved
- people who are variable in weight bearing
- those at risk of osteoporotic fracture; many people with dementia are at greater risk of this
- people in forensic units, who are often obese, requiring consideration of the use of bariatric equipment.

Physiotherapists working with people with mental health issues need to be competent in assessing the needs of this population, and require a comprehensive understanding of the mental health issues of people and how this may impact on their presentation.

Where people may be violent and aggressive, physiotherapists may be involved in the management of these situations.

Physiotherapists in contact with people living with mental health conditions need to be adequately trained, regularly updated, and familiar with the Mental Health Acts relevant to each country, The Human Rights Act and relevant NICE guidelines(CG25).[18, 65-71] They also require working knowledge of, and adherence to, their organisations’ policies and procedures. These may include advice on pre-restraint holds if a physical condition can make a service user vulnerable to injury e.g. recent fracture, longstanding conditions.

Physiotherapy can also be involved in after-care if an injury has been caused during a restraint, where staff have been trying to maintain the safety of the service user. This should be discussed with the service user post restraint, and the opportunity to access physiotherapy encouraged if any injury is noted.

Case study: manual handling in mental health

Scenario
Mrs W, an 85 year old lady with cognitive impairment is mobile with the support of two people, but at times and with some staff is non-weight-bearing. The physiotherapist was asked to advise care staff on manual handling and contribute to her care plan.

Goal
For the service user:

- To be transferred safely at all times while maximising her mobility and promoting independence.
- To be given the opportunity to maintain her mobility as she feels able in a safe and supported environment
- To reduce risk of injury to both service user and staff.

Identified risks
Mrs W can be unpredictable and variable in her mobility needs, which could lead to injury.

Different staff can support the service user in different ways.

One method will not meet the needs of the service user in her safe transfers.

Control measures
Staff will need to reassess mobility needs at each occasion for transfers and will need to agree on an individual basis.

A method for transfers when mobility is not an option i.e. use of appropriate and risk-assessed hoist and appropriate slings.
Special circumstances and settings

A method of supporting her mobility when she is able to weight bear; using the support of two staff, giving recommended hand positions and aids if necessary, also verbal or gestural prompts.

Benefits
Mrs W will be able to maintain her mobility levels and support her physical health.

Risks are considered on the occasions she is less mobile and that her mental health may be impacting on transfers.

Staff will be confident in supporting her transfers to reduce risk of injury to both staff and service user which will be clearly documented in her care records.

Additional considerations
Mrs W may not be able to verbalise her pain or fear of movement that may have an impact on her mobility levels.

She may need more time to process information and then execute the action. Staff will need to take into consideration these factors before deciding on actions and allow time and a clear explanation before commencing movements.

She may need adequate analgesic cover prior to transfers as this may be a factor in her variability.

Manual handling in bariatric rehabilitation
‘Bariatric’ (now sometimes called ‘plus sized person’) is often defined as exceeding a weight of 160kg, or a body mass index (BMI) of over 40. However, a more useful definition might be ‘a person whose mobility is impaired by their size’.

Although not all health and social care organisations have a bariatric policy, managers should be aware that, if no policy is in place, it could be time consuming to implement a patient-specific solution and costly delays to discharge may result.

There is advice for devising bariatric pathways in Hignett. Such guidance is invaluable when preparing for admission or discharge to/from a care setting, to ensure that all eventualities have been prepared for (see Chapter 6 on Commissioning with regard to obtaining finance).

As rehabilitation may be an important part of the plan, physiotherapists must be suitably trained and have adequate equipment to enable this process.

Special considerations
There are unique rehabilitation challenges when dealing with bariatric patients, especially with equipment provision.

• Mobilising a bariatric patient after a lengthy stay in bed following surgery or medical intervention has foreseeable risks. Their excess body weight restricts their mobility, hindering them from responding to the usual post-operative encouragement and medical intervention that can be achieved with patients with normal body weight.
• The bariatric patient with mobility problems will increase the risk of work related musculoskeletal disorders to physiotherapists, as they will exceed the guideline weights set by the HSE 1998.(72)
• It may not be easy to identify the exact weight of the person, especially in the community, but this is essential to establish that the equipment provided is sufficiently robust. Wheelchair scales can be obtained to assist in this process.
• Most of the challenge focuses on the daily movement and transfer techniques, and ensuring a sufficient number of staff are present at a given time – an optimum number being four or more following assessment.
• Their body weight will have increased the strain on the patient’s joints and cardiovascular system, resulting in extreme breathlessness and profuse sweating.
• Other co-morbidities will need to be taken into account, such as tissue viability issues, orthopaedic problems, Type 2 diabetes, continence problems and psychosocial problems. This last will include anxiety about falling, lack of balance, lack of confidence and embarrassment at their situation.
• Understanding the diversity of bariatric body shape is extremely important, and the rehabilitation programme should be patient-specific in order to provide safe and effective treatment.

Case study 1: Obesity and respiratory distress
Scenario
Mr D, a young man weighing 320kgs, walked into hospital with painful swollen legs and scrotum. He was admitted to a medical ward, where he became confined to bed with breathlessness resulting in oxygen dependency and increased fluid retention. Following nine weeks in bed Mr D needed to be rehabilitated to independence for discharge home.

Goal (including reference to clinical reasoning)
• To mobilise Mr D so he could be discharged back into the community independently
• To undertake this task in a reduced risk environment with equipment that is fit for purpose
• To reduce Mr D’s oxygen dependency and oedema.
Identified risks

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

Control measures

- A comprehensive risk and mobility assessment was undertaken from the outset, and a planned step-by-step intervention process implemented that included equipment provision by a professional versed in bariatric handling. Alternatively, a manual handling practitioner may be consulted to ensure the equipment is suitable and has a safe working load consistent with the needs of the patient.
- A bariatric process and handling plan was put in place specific to Mr D’s body shape and co-morbid condition. Special consideration was given to his respiratory and cardiac status and joint integrity.
- Precise monitoring of patient oxygen delivery through blood gases and pulse oximetry to ensure appropriate saturation and carbon dioxide levels.
- Appropriate equipment, which was fit for purpose, was sourced and procured before the task of rehabilitation was undertaken. This included a suitable mobile hoist and walking harness, to ensure the safety of all, should his legs give way.
- In-depth training and education was provided for all physiotherapy staff involved in the rehabilitation task. A manual handling practitioner may be able to provide this training onsite.
- Additional resources were made available to ensure that the rehabilitation was undertaken in a reduced risk environment. These resources include extra staff when required.
- Mr D was in a four-bedded ward, which gave the opportunity for two bed spaces to be cleared for his use. However, space was still at a premium and equipment was limited to bed and chair with a wheeled gantry. Care was taken to ensure that the walking aids provided had a suitable safe working load.

Benefits

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

Additional considerations

- Equipment that is fit for purpose is the key to providing effective, patient-specific rehabilitation within a reduced risk environment that is beneficial to both patient and physiotherapist.
- Training, appropriate equipment and sufficient staff must be provided.

Further information

More information on bariatric issues can be obtained from the Bariatric special interest group at National Back Exchange

www.nationalbackexchange.org

(see also Manual handling of Plus sized people)

Case study 2: Obesity and urinary incontinence

Scenario

Miss B, a 40 year old lady weighing 165.3kg, was admitted for gastric bypass surgery. Her BMI was 73.5kg/m²; however, a large proportion of her weight was carried in the form of a large abdominal apron. She had limited mobility, in the main due to the apron which extended down to below her knees. This apron and the lymphoedema in the legs and feet resulted in a slow, shuffling gait.

She suffered from severe stress and urge incontinence and overactive bladder disorder. The presence of the apron prevented her from wearing pads or incontinence garments, so she managed by sitting on incontinence pads and wearing no clothes on her lower body, unless she left the house.

Considerations

ContinenCe problems occur in the morbidly obese due to pressure on the pelvic floor muscles and connective tissue around the urethra. Obesity is the second most common cause of urinary incontinence.

Weight loss of 5% of excess body weight can improve continence. A 5-unit increase in BMI can be associated with a 60-100 per cent increase in the risk of urinary incontinence.

Identified risks

- Miss B’s decreased mobility increases her risk of DVT post-operatively.
- Any movement causes incontinence which puts the patient at risk of skin problems.
The abdominal apron affects the centre of gravity and can pre-dispose patient to falling, particularly forward. Lack of continence wear will compromise the patient’s dignity, as leaking occurs with movement.

Control measures:
- Potential catheterisation to assist handling and prevent embarrassment, wetness and risk of slipping.
- Handling of the apron needs particular care due to skin soreness underneath and the weight of lifting this out of the way to carry out any procedure.
- Unpredictability of the apron, the weight and its movement.
- Risk assessment.

As this patient’s body weight and BMI reduced, the apron also reduced in size so that she could be provided with specialised incontinence wear and she was able to get out of the house and become more mobile.

Conclusions:
- Manual handling of the bariatric patient can be affected by many issues relating to the patient’s weight and shape.
- Additional problems result from any co-morbidities or other medical problems that patients may have.

In this case it was important to seek input from a special physiotherapist in women’s health and continence to assist and advise on these areas and minimise risk to the patient and therapist.

Case study 3: Complications following bariatric surgery

Scenario
Mr. X, a 39 year old man weighing 200kg, was admitted for gastric bypass surgery. His BMI was 65kg/m².

Prior to admission he was referred via his GP to a weight management programme, which involved physiotherapy in the form of individual exercises and classes. These programmes can last up to 12 months on a weekly or monthly basis. Patients do not have to lose a large amount of weight or become considerably fitter during this time – the programmes are, in the main, to encourage commitment to a treatment programme post-surgery in the future.

Mr X carried his weight around his abdomen, but also had folds of skin and underlying fat around the groin and armpits. He had struggled with his weight since childhood but had steadily put on more weight following his marriage breakdown.

He had multiple co-morbidities – depression, hypertension, Type 2 diabetes and sleep apnoea.

He was mobile on admission with difficulty and he rarely set foot outside the house, as he suffered from agoraphobia and depression.

His personal hygiene was poor as he was unable to get into the shower and found it difficult to wash himself.

Following his gastric bypass surgery, Mr X suffered an anastamotic leak (the anastomosis between the small bowel and the new small stomach pouch) and was readmitted with signs of sepsis. This resulted in a second visit to theatre, for repair and lavage. Post-operatively, the wound was left open, packed, and had eight drains.

Considerations:
- Personal hygiene can be very poor in the morbidly obese, leading to poor healing and fungal infections.
- Poor diet has an impact on the post-operative healing process.
- Patients with diabetes can also have neuropathies and visual problems which should be considered prior to treatment.
- Depression often affects a patient’s motivation and compliance. Psychological input should be available as required. It is important to understand the cause of their depression prior to a treatment programme.
- Weight gain can be related to many emotional incidents that may have occurred in the past. Treatment must be approached so as not to touch on any difficult issues, or place a patient in a situation where they feel vulnerable e.g. a public place, in nightwear in an open ward.

Identified risks
Mr X used a Continuous Positive Airway Pressure (CPAP) machine for his sleep apnoea pre-operatively. Post-operatively, he was intubated and ventilated.

Due to pre-existing respiratory problems, initially it was impossible to extubate him. This required constant respiratory monitoring and input from the respiratory physiotherapists. Due to his weight he had a high risk of developing pressure sores. He had a Waterlow score of 30, putting him in the very high risk category.

This also related to multiple manual handling issues where tissue viability might be compromised e.g. in sliding, lifting, turning and moving in bed, as well as with transfers and use of the lifting and walking aids.

Control measures:
- Risk assessment.
- Assessment by specialist physiotherapist with regard to respiratory, cardiac and musculoskeletal problems.
- Bariatric bed – KCI Bariair bed that vibrates, rotates to 20 degrees and turns into a chair for rehabilitation and progression to walking.
Special circumstances and settings

- Urinary catheter and bowel system
- Turning every eight hours
- Assistance for turning from up to eight members of staff to prevent manual handling injuries
- Hoist for lifting/standing

Conclusions
- Manual handling of the bariatric patient can be affected by many issues relating to the patient’s weight and shape
- Multiple members of staff are required to prevent injury, even with correct and safe equipment. These patients are extremely labour intensive and staff involved in the moving and handling need to understand the complex handling issues that can occur
- Extra problems result from any co-morbidities or other medical problems that patients may have.

In this case it was important to have input from a physiotherapist specialising in bariatrics, manual handling and continence care to assist and advise in minimising risk to the patient and therapist.

Domiciliary care
In order to facilitate discharge home, planning must commence on admission.

- Home adaptations may require planning permission and obtaining finance from Social Services.
- Physiotherapists and occupational therapists will need to carry out home visits to formulate a practical discharge plan.
- Structural engineers may be required to assess the load bearing of the floors, to ensure that the weight of heavy equipment/furniture, as well as that of the client, can be safely carried.
- Many situations may require the provision of ground floor living for plus sized people. This could take several months to complete, and a lead practitioner/case manager should be identified to develop a project plan and keep key people informed of progress.

Communication between professionals is the key, remembering also to keep the patient informed, to ensure that their morale and motivation is maintained.

Whether patients are being cared for in their own home or in a residential unit, sufficient staff and time should be allocated for any treatment programme. Staff rosters should ensure that the same staff are not always providing the care, but creating a small team should ensure continuity of care while reducing the risks of cumulative loading to staff musculoskeletal systems.

If the programme of rehabilitation is delegated to non-therapy staff, the physiotherapist must ensure the staff are as safe as possible, and able to carry out the delegated tasks.

Rehabilitation of the plus size person will always present challenges, and physiotherapists are advised to seek advice from suitably experienced persons, and indeed many of the companies supplying the equipment required.

The Disabled Living Foundation has published a useful factsheet on Choosing equipment for the heavier person. (75)

Manual handling in private practice
Special considerations
Physiotherapists work in many different clinical areas as self-employed private practitioners. Private or independent practice is expanding in the changing health care environment and encompasses many clinical areas in addition to the more traditional MSK practice. These include neurology, paediatrics, rehabilitation, the occupational area of health promotion and ergonomics, and many others.

Some private practitioners own their own clinic areas, some lease or rent premises in which they practise. Private practitioners may also carry out domiciliary visits or work in private hospitals, care homes or schools. Some NHS services are subcontracted to private practitioners.

It is the responsibility of each physiotherapist to apply this guidance to their circumstances and carry out effective risk assessments which are appropriate to their area of work and scope of practice.

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

Private practitioners may employ staff for whom they hold a responsibility to provide a safe environment, and for many practitioners their own health is paramount to the success of their business.

Access to the clinic for people with disabilities must also be considered and documented.

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

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

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

Goal (including reference to clinical reasoning)
• To treat Ms E’s ankle on a plinth in the normal treatment area with access to electrical equipment if required
• To treat her in the gym area on a floor mat to assess and advise about continuing exercise
• To assist Ms E into a position where a therapeutic intervention can begin with minimal risk to both the assisting therapist and Mrs E.

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

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

Benefits
The benefits of investing in height-adjustable treatment couches are to both the patient and the therapist. Patients of all heights and abilities could sit comfortably and safely while getting on and off and therapists can work at a safer height for themselves.

Additional considerations
The risk of assisting the patient to the floor needs to be balanced against any measurable outcome from the exercise programme; does the risk outweigh the benefit, that is, ‘the utility of the act’?

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

Manual handling in occupational health
Physiotherapists operating in the field of occupational health (OH), ergonomics, or who are considering advancing their physiotherapy skills in this direction should be aware of manual handling issues in the context of OH. In addition to people moving and handling which has been extensively covered in this document, manual handling may involve managing, or advising on the management of, manual handling risk related to inanimate loads in the workplace.

OH practitioners invariably write reports which need to be robust enough to be contested in court and clear enough that advice offered cannot be misconstrued.

Appropriate training to achieve the knowledge and skills required in the field of manual handling risk management is essential in gaining and demonstrating competence. It is essential to have understanding and a working knowledge of legislation covering manual handling in the workplace in order to support safe delivery of services. The CSP PLI(76) covers members for adjuncts to physiotherapy, but it is worth clarifying specific work to be undertaken is covered within the policy.

For patient moving and handling the National Back Exchange is a good source for courses and further information www.nationalbackexchange.org ACPOHE provide a guidance document on Inanimate Object moving and handling risk management and offer a course on the same.

ACPOHE have, with the CSP, devised a competency framework, which lays out the levels of competency in OH.

ACPOHE have also published their Guidance on Manual Handling Risk Management for Physiotherapists Working in Occupational Health and Ergonomics for ACPOHE members.

For additional information on OH and physiotherapy, how to access ACPOHE courses, and join the professional network, see www.acpohe.org.uk
The aim of this chapter is to clarify the situation with regard to contemporary manual handling practice, including processes such as delegating or advising on activities.

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

The scope of physiotherapy generally extends much further than a 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 an important component of the delivery of physiotherapy services and it is often necessary to give advice on, or to delegate, this activity to others.

Professional bodies – for example, The Chartered Society of Physiotherapy, Royal College of Nursing or College of Occupational Therapists – have provided advice to their members on manual handling and associated practical problems which may arise in professional practice.\(^{7a, 7b}\)

In 2006, an intercollegiate information paper was published by the Chartered Society of Physiotherapy, the Royal College of Nursing, the Royal College of Speech and Language Therapists, and the British Dietetics Association to guide practitioners in delegation responsibilities.\(^{13}\)

It is important to remember that giving advice and delegating tasks is recognised by HCPC as a normal and essential part of physiotherapy (see Standard 9 of Standards of Proficiency – Physiotherapists, HCPC 2013).\(^{16}\) Being clear about this issue should not inhibit physiotherapists – it should actually facilitate balanced decision making.

The delegation of tasks involving manual handling to physiotherapy colleagues (including assistants, support workers and students) and the giving of advice and guidance on such tasks to other members of the care team or carers or support workers, including school staff, 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.

Delegation
Delegation implies the entrustment of a physiotherapy task to another person, who will perform that task in place of the treating or supervising physiotherapist, with the consent of the patient (section 7.3.2 of the CSP Quality Assurance Standards 2012\(^{12}\)).

Therefore delegation by a supervising physiotherapist, having performed a suitable and sufficient assessment, would normally be:
- person specific (patient and the person(s) undertaking the delegated task)
- task specific
- environment specific
- recorded and audited
- to a person who has the ability to undertake that delegated task.

Delegation of interventions involving manual handling would normally be to one of the following:
- another physiotherapist (e.g. supplemental private practitioner input)
- a less experienced physiotherapist
- a physiotherapy assistant
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- a student physiotherapist
- a technical instructor.

or to any other person providing a physiotherapy intervention, this could include:
- a member of the patient’s family
- a paid or unpaid carer of the patient
  (Note: in respect of carers paid by the family – in paediatrics, where the family has direct payment, these carers may well be introduced as a family member. It is important to establish if their care is volunteered, or funded by a care package managed by the family i.e. a paid carer)
- a school support worker
- a volunteer

Delegation of treatment handling
Prior to delegation to any other party, the following process applies:
- Explain what is proposed and gain consent from the patient, where possible. Inform the patient of the process for feeding back any compliment, comment or complaint should they wish
- Assess the patient clinically
- Know the limits of expertise of the person to whom you are delegating
- Consider realistic goals and functional outcomes, in discussion with the patient where possible
- Consider whether the proposed therapeutic intervention involves hazardous manual handling
- Consider whether the hazardous manual handling can reasonably practically 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 be made available.

Delegation to another physiotherapist
(e.g. a private practitioner)
Patients may access a physiotherapist via another department in the NHS or privately and may transfer between the two.

Recommended actions
- Gain consent from the patient to share relevant information and inform the patient on the audit process and complaints procedures
- Be aware of limitations and differences in working practices
- Share information following professional guidelines and ensure a suitable handover
- Maintain patient-centred care and be prepared to help
- Where there is concern, risk-assess the situation with the new physiotherapist, discussing remedial actions, and record the process and outcome in the notes

- Take account of difficulties relating to language or cultural differences and action these as appropriate
- Ensure that the patient understands the process and has access to the practitioners for raising concerns.

Delegation to a less experienced physiotherapist
Delegation to a less experienced member of staff will address the whole treatment of a patient, so that in this case the responsibility of the supervising therapist involves much more than just the manual handling element. However, for the purposes of this document, only the manual handling element is considered.

Each physiotherapist carries autonomy for their own assessment, treatment and handling of a patient. The purpose of this section is to assist those with a responsibility for other physiotherapists.

Further information on clinical supervision can be found in the CSP publication Clinical supervision: a brief overview: https://v3.pebblepad.co.uk/v3portfolio/csp/Asset/View/6jqbh3GzhGWrfMMd9zc4ts3Mkc

Recommended actions
- Gain consent and inform the patient on the audit process and complaints procedures
- Be aware of your own limitations and refer on as needed
- Be aware of the less experienced physiotherapist’s current handling experience and previous training
- Observe the less experienced physiotherapist’s overall handling skills
- Be aware of the possible difficulties presented by the patients in the care of the less experienced physiotherapist, and their clinical ability with respect to delegating tasks
- Be accessible to, and encourage expressions of concern from, the less experienced physiotherapist
- Where there is concern about the difficulty of handling a patient, observe the less experienced physiotherapist with the patient
- Be prepared to help. Consider use of equipment as appropriate
- Where there is concern, risk-assess the situation with the less experienced physiotherapist, encouraging them to consider remedial actions, and record the process and outcome in the notes
- Offer assistance in the form of extra physical help or further training as necessary
- Ensure that the less experienced physiotherapist has access to the procedure for raising concerns
- Ensure this intervention is recorded in the patient’s records
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- Ensure the less experienced physiotherapist always has access to advice or assistance from the supervising physiotherapist
- Ensure the learning from this intervention is recorded in the less experienced physiotherapist’s CPD portfolio.

Delegation to a physiotherapy support worker or technical instructor
Individual skills and knowledge of physiotherapy support workers vary widely. When delegating tasks to support workers, physiotherapists should bear in mind that they have a duty of care to the assistant as well as to their patient. Therefore the supervising physiotherapist should:
- treat the patient with the assistant initially
- demonstrate the method of handling required
- observe the assistant carrying out the chosen method
- record the above information.

Recommended actions
- Ensure the patient’s agreement to being treated by the support worker
- Take into account the individual capability and competence of the support worker
- Clarify the desired method of handling
- Ensure there are procedures in place so that the support worker can get further advice and support if they have concerns before they carry out the delegated task
- If the physiotherapist or the support worker has any concerns, consider either further training for the assistant or amending the chosen handling method
- Take account of difficulties related to language or cultural differences and action these as appropriate
- There should be a system in place for the support worker to access supervision and clinical advice as required, as support workers often work at times when a physiotherapist is not on duty
- Ensure that the support worker has access to the procedure for raising concerns
- Monitor the patient regularly, and record this in the patient’s notes, as a number of support workers may now be undertaking tasks with a patient. Ensure learning from this intervention is recorded in the support worker’s CPD portfolio.

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

Recommended actions
- Ask the student physiotherapist for confirmation of their manual handling training and experience
- Liaise with the clinical tutor from the student’s Higher Education Institution (HEI)
- to ascertain how much manual handling training the student has received so far
- Ensure placement- specific induction takes place
- Take into account the individual ability of the student
- Emphasise and demonstrate safer handling to the student as part of good clinical practice
- Obtain the patient’s agreement to be handled by the student
- Take account of difficulties related to language or cultural differences and action these as appropriate
- Observe the student’s handling skills before delegating tasks
- Observe the student carrying out delegated tasks with patient to your satisfaction, within current good practice, before leaving them to work alone
- Ensure the student knows how to access advice from you or an alternative supervisor at all times
- Ensure that the student has access to the procedure for raising concerns
- Record advice and assistance given
- Monitor the situation and record this
- Encourage the student to reflect on this experience in their learning log/CPD portfolio.

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

That being said, a family member, with the consent of the patient, may choose to carry out a procedure, for example a transfer from chair to commode, in a situation where the physiotherapist feels that it carries an unreasonable degree of risk. The physiotherapist should explain the risks involved, offer alternatives and make it clear that his/her advice is that the procedure should not be carried out. This should be recorded in the patient’s notes.

It may be appropriate to then refer to other professionals or give further advice to minimise the risk; but it should be remembered that the physiotherapist could be held responsible if any harm ensues as a result of their advice.

Recommended actions
- Ensure the patient has agreed to the therapeutic activity and is willing to involve the family
- Ensure the family is willing and capable to be involved. (Note that a risk assessment should always address individual capability)
- Keep the activity simple
- Leave clear written information.
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- Consider differences between a hospital environment and the patient’s home or the environment where the activity will be undertaken
- Observe family carrying out activity with the patient, modify and correct as necessary
- Take account of any difficulties related to language or cultural differences and action these as appropriate
- Ensure that the situation is, where necessary, monitored and the family are informed on how to get advice and to raise concerns if needed in the future. There are many situations, for example a working spouse who is unable to take much time off work, or where advice is given at the end of a course of treatment, where there could be difficulties arranging a review
- Consider how the delegated activity fits into other aspects of the patient’s daily life and modify if required
- Record all of the above.

Delegation to a support worker
Physiotherapists often train support workers in schools or supported living accommodation to carry out treatment programmes for individual children or vulnerable adults on their caseload. These staff may be employed by agencies other than the physiotherapist’s own employing organisation.

A support worker is eligible to join the CSP as an associate member if their delegating physiotherapist is a member of the CSP, empowering them to receive the same benefits package and to work to the CSP code of professional values and behaviour as physiotherapy assistants.

As a result of the Cavendish Review, in the longer term it is hoped that all support workers will have achieved a basic level of training.

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

The support worker is not permitted to contravene the local Children’s Services manual handling policy or the handling policy of the employer, and must be aware that the treatment requested is only applicable to the individual child/adult in this particular situation.

Similar situations could arise where physiotherapists are working with Community Health Partnership staff, health and social care staff, intermediate care teams, staff employed via the direct payment scheme and others from voluntary agencies.

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

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

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

Guidance or advice on manual handling may be given to any or all of the following:
- nursing staff
- other physiotherapists (e.g. a private practitioner)
- other members of the multidisciplinary team (manual handling practitioners, occupational therapists, speech therapists, radiographers, and so on)
- the family of the patient
- paid or unpaid carers of the patient
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- health and social care workers
- support workers
- any other parties involved in the care of the patient.

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

In all cases, the physiotherapist owes:
- a professional duty of care
- 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 patient and handler(s), as far as is reasonably practicable, and at the same time ensuring the best possible outcome for the patient.\(^{(30)}\)

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 will only be able to offer advice or guidance.

However, because of a generally acknowledged expertise in this area, physiotherapists are very frequently requested to offer guidance on the handling of a patient outside of direct physiotherapy treatment times. This may involve, for example, the 24-hour management of how a patient is handled in hospital, at home or in the community.

Here the therapist is extending their duty of care to those involved in following their guidance. Their responsibility is just as great as it is in the case of more direct delegation. The physiotherapist should be able to justify his/her recommendations and must document this information.

It is important for the physiotherapist to acknowledge that issues may arise that are multi-factorial, and that there may not be a right or wrong answer. It is advisable to choose a communication and decision-making system that helps all involved to reach an acceptable, balanced decision and fully document the clinical reasoning leading to the decision. A physiotherapist cannot dictate to others how they must handle a patient.

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

A physiotherapist may have significant expertise in handling patients that they can pass on to other people, but they may also find themselves caught between differing opinions, where the evidence for these handling skills is still in its infancy. It can be very difficult to balance what each interested party wants and believes to be the right course of action.

The physiotherapist needs to be aware of the limits of their role, but at the same time recognise the support they can provide in helping the patient, family and other professionals in reaching a good decision.

The physiotherapist should seek expert advice from other professionals, such as a manual handling practitioner/ back care advisor where appropriate.\(^{(81)}\)

The aim should always be to reach consensus and have an agreed system to deal with situations where consensus is not possible. Maintaining open channels of communication in the event of a failure to reach consensus may allow for subsequent agreement after a period of reflection. Legal action very occasionally may be required, but should not be seen as an option except where complete breakdown has occurred.

Advising other members of the multidisciplinary team

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

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

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

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

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

The physiotherapist:
- ensures staff are aware of the risks associated with walking with a person, and reminds them to consider the policy on handling the fallen and falling person and to receive additional training if necessary
- demonstrates first wherever possible, so that the staff can make their own assessment of their ability and whether they should proceed
- considers strategic placement of a chair/seating to minimise risk
- specifies the number of staff needed to walk with the patient
- indicates the technique to be used (for example, palm to palm contact with back support)
- indicates the extent of verbal prompting, if required
- demonstrates possible additional safety measures where staff are not confident or competent, or the patient's condition has deteriorated (for example, one member of staff wheeling a wheelchair behind the patient while they are assisted to walk)
- informs staff of the procedure for further discussion if needed
- documents all of the above, including the rationale for the handling plan.

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

**Recommended actions**
- Before discharge the physiotherapist should discuss any guidance given with the patient and family, considering the home setting. A home visit may help in the decision-making process
- Liaise with other engaged physiotherapy services e.g. private practitioner where possible
- Refer to community physiotherapy services if risks or additional factors are highlighted which mean that a handling plan could not be followed
- Ensure that there are good communication channels to avoid misunderstanding and confusion
- Document and circulate relevant information.

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

**Advising a patient's family in the patient's home**
By giving advice, the physiotherapist is extending their duty of care to the family, and his/her role may be to assist a number of parties to reach agreement on the best handling plan for all involved.

A patient and their family may choose a handling option that is considered less safe by the physiotherapist. The physiotherapist must decide whether he/she can support that decision, or offer additional advice.

If the physiotherapist considers the patient and family's chosen handling option carries an unreasonable degree of risk, the danger should be explained clearly, with suggested alternatives.

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

Case examples
Example 1: A patient has a deteriorating condition, but feels that maintaining the ability to stand improves his quality of life.

After trying different options, the family decides to undertake a front transfer for standing practice.

The risk factors are discussed and the physiotherapist suggests that a second person should be present to assist from behind.

Example 2: Due to the very variable weight-bearing ability of a patient, the physiotherapist advises that they should use a ceiling-tracking hoist at home. However, the patient and family want to use the standing hoist as they strongly believe it will help maintain independence.

The risks of falling are discussed, and a measurable rehabilitation programme is agreed by all.

The aim would be to move from using the ceiling-tracking hoist to using the standing hoist when the weight-bearing ability of the patient has improved.

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

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

A physiotherapist treating a patient who is purchasing care in this way does not have any obligation to provide formal manual handling training for the carer. If s/he agrees to do so, the physiotherapist should ensure that s/he has the appropriate experience and training (and insurance cover) to undertake this activity.

The patient must make their own arrangements to purchase adequate training for their employee. However, a domiciliary physiotherapist routinely assessing a patient might give advice on handling issues to both the patient and the carer. Any such advice should be documented.

Recommended actions
• Ensure own competence to advise and train; only do so if confident. Refer to the line manager if necessary
• Understand the physiotherapist’s role and the expectations of the family, and agree in advance the process for resolving differences
• Where able to advise, assess the patient within the home setting, considering their daily routine
• Take into account the relevant physical ability of the carer and psychosocial factors within the family that may affect the handling plan
• Have a realistic idea of the long-term aim for the patient. This may be continued improvement or simply maintenance of their condition
• Select the most appropriate methods of handling in consultation with the patient and family, estimating the competence of the carer(s) following the advice, including the possible use of equipment
• If agreement cannot be achieved, record this clearly and/or seek advice from the line manager on whether further action is required
• A number of people may have access to the information provided by the physiotherapist, whom the physiotherapist never meets. The aim should be to train and observe staff carrying out handling safely as appropriate, giving clear information on who the advice is intended for and who any new carers can contact
• Record the process, including clear description of the handling method and any considerations
Delegation, guidance and advice in manual handling

- Where continued responsibility exists, monitor the situation regularly.

**Carers paid by an outside agency**
Outside agencies could include:
- local authority social services
- community health partnerships
- intermediate care teams
- a charity
- a care agency.

If a carer is employed by Children’s Services/community health partnership/a charity, then the employer has the responsibility to ensure that there is a safe system of work within the patient’s domestic environment and that the carer is adequately trained by a competent manual handling trainer.

A carer provided by an agency may be considered to be self-employed for tax purposes. However, in the event of a personal injury claim in respect of a manual handling incident, the carer would almost certainly be treated by the court as an employee of the agency.

**Recommended actions**
- Ensure own competence to advise. Only do so if confident
- Understand the physiotherapist’s role and any family expectations of guidance, and ensure this is not in conflict with his/her own duties as a physiotherapist
- Where able to advise, assess the patient within the home setting, considering their daily routine
- Discuss a process for resolving any disagreements in advance
- Take into account the relevant physical ability and psychosocial factors
- Have a realistic idea of the long-term aim for the patient. This may be continued improvement or simply maintenance of their condition
- Select and demonstrate the most appropriate methods of handling in consultation with the patient, including the possible use of equipment
- If agreement cannot be achieved, record this clearly and/or seek advice from the line manager
- Train and observe staff to ensure they are carrying out handling in line with current good practice
- Provide further training as needed, or amend the method so that manual handling can be carried out as safely as possible
- Record the process, including clear description of the handling method and any considerations.
- A number of people may have access to the information provided by the physiotherapist, whom the physiotherapist never meets. The aim should be to train and observe staff carrying out handling safely as appropriate, giving clear information on who the advice is intended for and who any new carers can contact
- Where continued responsibility exists, monitor the situation regularly.

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

It is not the treating physiotherapist’s responsibility to provide training for volunteers, but he/she may give information of where to obtain further help. If the treating physiotherapist does provide advice then he/she should follow the recommendations as for paid carers.
Education and Continuing Professional Development (CPD)

Key messages

- All chartered physiotherapists require education and training in manual handling throughout their career pathways to allow them to perform within their designated scope in a professional, legal and ethical manner.
- All chartered physiotherapists, at whatever level of professional development, knowledge, skill and experience, should be able to identify the need for an individual assessment of any work situation where manual handling is indicated and be prepared to undertake, or at least contribute to, such an assessment.
- Chartered physiotherapists should be aware that their physiotherapeutic skills and knowledge only confer proficiency in manual handling, rather than expertise (see below).
- Physiotherapy undergraduates should experience discrete manual handling training as part of their studies, both within their Higher Education Institution and on therapeutic placement within a problem-solving environment.
- Graduate physiotherapists should continue to develop skills, knowledge and experience within manual handling situations as an integral part of their CPD.
- All manual handling courses provided to chartered physiotherapists must be provided by competent persons and contain certain common core elements.
- Every physiotherapist should be aware that their legal duties and professional responsibilities concerning manual handling cannot be delegated.
- Physiotherapy assistants and technical instructors should receive appropriate manual handling training before commencing employment.
- All levels of staff should receive regular updates on manual handling from a competent person.
- Chartered physiotherapists who accept responsibility for training others in manual handling, for example as back care advisers, must be aware of the higher standard expected of them as a result and must meet HCPC standards of proficiency after. The CSP Code of professional values and behaviours, ACPOHE standards, and other requirements consistent with National Back Exchange trainer guidelines offers a professional development framework which can be used by the individual, their manager and clinical educators to ensure that learning is relevant, integrated and continuous.

Acquisition of manual handling skills

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

For all chartered physiotherapists, the scope of their professional practice will involve certain levels of unavoidable risk inherent in the nature of physiotherapeutic treatment. These risks may be justifiable, and therefore reasonable, if offset by the ethical and professional responsibility of interpersonal physical treatment and management of risk.

The aim of the partnership of therapist and patient should be to include the safest possible working practices, which can only be determined by an ongoing assessment process resulting in balanced decision-making (see Chapter 2).

This chapter will offer recommendations regarding the structure and content of physiotherapist education in manual handling.

Dreyfus’ stages of skill acquisition

Dreyfus’ continuum of skill acquisition has already been interpreted to reflect nursing practice development, and, although it is one of many frameworks, it provides a realistic matrix against which to determine a physiotherapist’s progress towards the level of independent problem-solving required in manual handling.

The five-stage structure – novice, advanced beginner, competent, proficient and expert (see Appendix 7) – offers a professional development framework which can be used by the individual, their manager and clinical educators to ensure that learning is relevant, integrated and continuous.

By using this approach, students especially will have a measure of their progress from novice status through advanced beginner, both of which necessarily require adequate supervision and guidance.

Following qualification, staff will be expected to achieve at least competence in manual handling as proficiency is expected. Both these levels of skill carry accountability in decision making concomitant with professional responsibilities.

Physiotherapists who wish to progress to a strategic post in manual handling management and training (for example, as a back care adviser) should expect to undertake further specific postgraduate education to widen their skills, knowledge and experience beyond physiotherapeutic thinking. This would equip them to undertake responsibility for training and advising others outside the profession from an ‘expert’ status in manual handling.

In the following text, the terms ‘novice’, ‘advanced beginner’, ‘competent’, ‘proficient’ and ‘expert’ are only used in relation to Dreyfus’ criteria as applied to the acquisition of manual handling skills by physiotherapy practitioners.
education and continuing professional development (CPD)

physiotherapy students/undergraduates
Students are deemed ‘novices’ and ‘advanced beginners’ in manual handling skills and as such require discrete rules and guidance, as they have no holistic overview of patient handling. They require adequate supervision and advice in all areas from proficient practitioners, both in their HEIs and out on clinical placement, with expert resources where possible.

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

Physiotherapy graduates
Physiotherapy graduates are now expected to become at least competent in manual handling following graduation, allowing them to work with less supervision and less rigid adherence to rules and guidance, as they progress towards more problem-solving based on widening experience.

Graduates should therefore be encouraged to develop familiarity in all aspects of manual handling, including simulated situations in training, and expected to perform risk assessments for patients with supervision and guidance.

Manual handling skills should be clearly identified as part of an individual’s CPD.

Recommendations
- All graduates must attend mandatory manual handling updates provided by their employer/employing authority
- Graduates should liaise closely with proficient practitioners and back care advisers to identify specialised training and education opportunities reflecting physiotherapeutic practice and problems in manual handling
- Consideration should be given to the use of specific assessment tools for comparative and evaluative purposes (for example REBA, OWAS, DINO, RULA and to minor research projects within departments and specialisations to add to the knowledge base and evidence base for effective manual handling in physiotherapy
- Graduate physiotherapists should continue to acknowledge their own personal and professional limitations in manual handling and actively seek advice and guidance, for example from back care advisers/teams or CSP professional networks, to gain further experience and knowledge in discrete areas of patient care
- Graduates should make every effort to keep up to date with manual handling equipment being developed and should not hesitate to consult with BCAs regarding specialist equipment requirements for rehabilitation; consideration should be given to encouraging graduates to update knowledge and skills regarding manual handling equipment, for example by attendance at exhibitions
- Graduates working in private practice have a duty to comply with competency levels and to maintain their own skills and knowledge
- Where they are supervising students, graduates must be of proficient level in manual handling
- Graduate physiotherapists should be aware that ‘teaching’ or ‘training’ in manual handling automatically incurs a legal responsibility. They should ensure that their knowledge, skill and experience level is concomitant with this enhanced responsibility for insurance purposes (see also next section on BCAs).
Physiotherapists holding strategic manual handling management posts
Manual handling has risen in profile in the UK following the introduction of the Manual Handling Operations Regulations 1992.\(^{(16)}\)

Back care advisers (the generic term which covers back care coordinators, manual handling practitioners/ coordinators/advisers) are concerned with the implementation of manual handling policies and practices within an employing organisation, including training provision and management of manual handling aspects in line with legal responsibilities and effective patient care and safety.

Back care adviser posts are not exclusive to physiotherapists. They require specialist skills and knowledge in manual handling. The requirements for the title of ‘trainer’ and ‘BCA’ are outlined by National Back Exchange, a multidisciplinary association representing this specialised area. Other professional bodies have also set standards for staff working as BCAs; for example, the Royal College of Nursing\(^{(89)}\) and College of Occupational Therapists (COT),\(^{(79)}\) from whom further information should be sought.

Physiotherapists should be aware that to become a BCA requires further education that takes them beyond their traditional physiotherapeutic knowledge and skills. They should ensure for insurance purposes that their skills, knowledge and experience in manual handling are up to date and legally defensible in order to claim protection from the CSP under the Professional and Public Liability Insurance (PLI) scheme.\(^{(76)}\)

It is worth obtaining advice on whether you need extra indemnity cover, but there are circumstances when holding two concurrent insurance policies invalidates one policy. Therefore, bespoke insurance advice from a second broker or the CSP broker, LFC Graybrook www.lfcgraybrook.co.uk/ is strongly advised.

Postgraduate programmes within the specialist area of manual handling are based upon the Inter-Professional Curriculum (1997)\(^{(90)}\) which was jointly constructed by five professional organisations with direct input into manual handling development and practice:

- The Chartered Society of Physiotherapy
- National Back Exchange
- Royal College of Nursing
- College of Occupational Therapists
- Institute of Ergonomics and Human Factors.

**Recommendations**
- Physiotherapists who become BCAs may wish to consider registered membership of National Back Exchange www.nationalbackexchange.org
  - Membership confers a nationally recognised level of skill and experience in manual handling upon an individual
- BCAs working in health and social care provision should consult specialist physiotherapists regarding their areas of skill and knowledge and regarding specialised physiotherapeutic environments, for example hydrotherapy pools
- Physiotherapists who become BCAs have an enhanced responsibility regarding their CPD within the relevant professional codes of conduct to retain their position as ‘experts’.

Physiotherapy support workers
Physiotherapy support workers will require direction by proficient practitioners and supervision by competent or proficient practitioners.

They will generally be deemed to fit into the same skill categories as physiotherapy students i.e. ‘novice’ or ‘advanced beginner’, as they may not possess the holistic understanding of the patient’s overall rehabilitation plan nor have the knowledge to develop conceptual models of manual handling outcomes.

Some, however, may have developed further handling skills, and may have become competent or even proficient in the skills required in their own area of work. Their expertise will have been recognised by their supervising chartered physiotherapist, who will remain responsible, as always, for their work.

**Recommendations**
- Manual handling tasks must not be delegated to physiotherapy support workers without the delegating practitioner ensuring the support worker’s level of competence
- Physiotherapy support workers must attend regular training updates in manual handling provided by their employer, including training in equipment use and maintenance needs
- Physiotherapy support workers must have the opportunity to seek help and advice from proficient practitioners regarding manual handling problems.

Volunteers
All volunteers are deemed to be ‘novices’ in manual handling, for legal purposes.

**Recommendations**
- All volunteers will be supervised during manual handling of patients by a practitioner who is at least deemed competent in manual handling practice
- Volunteers should be given the opportunity to attend training in manual handling wherever possible.
Key issues with regard to purchasers, commissioners and service planners

What is commissioning?
In the early 1990s the purchaser/provider split was introduced into the NHS. The role of the purchaser (or commissioner) is to ensure that health services are planned and delivered in a way that meets the interests of patients and taxpayers rather than health care providers, whereas the role of the provider is to deliver health care services.¹¹

Current health care providers include: NHS acute hospitals; community services and mental health services, with a current drive to achieving Foundation Trust status; private health care providers, whether businesses or individuals; voluntary sector providers; and social enterprises.

Commissioning can be defined as a continuous process through which commissioners work in the field of health improvement and health care services to:

- identify need
- plan
- source
- deliver
- performance manage the activity of providers
- within a particular geographical area or for a defined group of individuals.

Commissioning should be carried out on behalf of the people who use or benefit from the service and independently of the organisation(s) providing it.¹¹ Commissioners should be seen as independent individuals/organisations responsible for ensuring that commissioned services meet identified needs and quality standards and provide value for money.

From April 2012 the responsibility for commissioning NHS health care resources in England was transferred to the GP Clinical Commissioning Groups (CCGs).

Commissioning processes and the commissioning cycle
Commissioning is undertaken on a cyclical process known as the “commissioning cycle” (see figure 1)

![Figure 1: Commissioning Cycle: From House of Commons Health Committee, Commissioning, Fourth Report of Session 2009-10, Volume 1](image)

There are three key areas in the commissioning cycle, each with component steps.

1. Plan
   - **Assessing needs**
     Through a systematic process, developing an understanding of the health and health care needs of the area’s population. Reviewing legal obligations, best practice guidance and evidence based guidelines.
   - **Describing services and gap analysis**
     Reviewing the services currently provided, determining whether they meet health needs, and defining gaps or any areas of over-provision or duplication.
   - **Deciding priorities**
     Given a list of desirable actions, using available evidence of cost effectiveness and based on a robust and defensible ethical framework, prioritising areas for purchase.
   - **Risk management**
     Understanding the key health and health care risks facing the commissioners and deciding on a strategy to manage them.
   - **Strategic options**
     Bringing together all the available information into a single strategic commissioning plan that outlines how the Commissioners will deliver their core objectives.

2. Execute
   - **Contract implementation**
     Putting strategic plans into action through contracting.
increased amount of community beds and equipment that should be allocated to the community equipment store to enable patients to be discharged home safely.

**Tips for working with commissioners**
Essentially commissioners are making decisions about what health care services should be bought, including manual handling services, so it is important to work effectively with commissioners to enable a two-way flow of information.

**Build a relationship**
Find out who your commissioner is and how you are able to communicate with them, whether through a formal meeting structure or through one-to-one communication.

Being able to communicate with your commissioner means that you can keep them informed on your service and support them to understand when and why there is a change in demands on your service.

**Provide information**
Provide your commissioner with the reports that are contractually required so that they are able to effectively monitor your service and any changes in demand.

Don’t just transmit bad news; tell them of achievements the service has made, even if these are not within KPIs.

Where problems are arising, for example an increasing demand on a service, let the commissioners know sooner rather than later so that investigation can start and plans made to try to solve the problem.

**Demonstrate evidence of effectiveness**
Make sure you fully understand your service: what does it cost? Can you prove that it makes a difference?

NHS finances are a limited resource and, with the increasing financial demands within the NHS, commissioners must ensure that services provide value for money while still meeting quality standards.

For example, demonstrate that the provision of manual handling equipment helps to reduce the staff or time required while providing the patient with a better experience.

**Gather evidence on patient/user experience**
It is important to measure and monitor patient experience. Particularly if there is an absence of evidence-based information, patient/user experience can be a useful tool to influence commissioners.
Key issues with regard to purchasers, commissioners and service planners

Commissioning in manual handling – specific issues to consider
Commissions and provider professionals often need to put business plans together quickly. Manual handling professionals and physiotherapists have specialist knowledge that is useful to contribute to these business plans. Without the evidence in place on which to build a business plan, services will not be commissioned effectively:

“Without providing the right level of information, e.g. activity data, within service specifications or contracts, etc. it is very likely that services will be inadequately funded. Without adequate funding inappropriate decisions relating to eligibility criteria can arise, which will ultimately be to the detriment of the client, and may even cause some services to fall into illegal practice.”

Welsh community equipment standards

Listed below are areas that should be remembered when developing business plans.

**Equipment costs**
The cost of equipment needs to be factored into any business plan. It is important to ensure that ALL equipment is identified, including requirements for specialist equipment such as bariatric or paediatric equipment. This is discussed in more detail below.

**Maintenance costs**
Where equipment is required, the cost of the maintenance of this equipment, and replacement of equipment as necessary, should be identified. This is particularly pertinent in the provision of specialist paediatric equipment which may require regular replacement as the child grows.

**Lead-in costs**
It is important that lead-in costs are identified. These may include the cost of training staff in the use of new manual handling equipment and techniques.

There are three possible strategies to deal with equipment needs:

- renting a package from an outside supplier
- using a company supplier to manage the equipment provision/equipment store
- purchasing and storing the equipment onsite.

However, the latter may not ensure that up to date equipment is available, and a total equipment management system may be the cheaper and more effective option. Maintenance will also be required for the equipment as an ongoing cost.

**Bariatrics**
Working with plus-size patients will need extra skills, training and equipment. These needs must be considered when planning, as the numbers of such patients are increasing, both in health care settings and in the community.

Timely provision of equipment for the plus-size patient is essential, as not only their comfort and dignity may be compromised, but also the health and safety of both patient and staff.

Training tailored to the needs of the therapy services will also be required, as some of this equipment may be unfamiliar to staff.

As rehabilitation for this client group is potentially hazardous, more staff may be required per patient, which will affect staffing ratios in other areas.

Physiotherapists must ensure that these extra needs are made clear to the commissioners upfront, as this will have financial implications for the service. The use of costings to demonstrate the effectiveness of such expensive rehabilitation would identify the savings that will result from a reduction in their continuing care needs.

**Re-ablement**
From March 2014 the Better Care Fund (formerly the Integration Transformation Fund) will require inter-agency discussions to decide how these funds are to be spent.

There is a £3.8 billion pooled budget to ensure that health and social care work together more closely. The skill mix required should allow for joint working, and encourage creative use of training for all involved.

Therapists must ensure that, as stakeholders in the re-ablement process, they communicate with the...
Key issues with regard to purchasers, commissioners and service planners

allocators of these funds and attempt to reduce the effects of any service change consequences.

Monitoring the cost/benefit of such initiatives will allow staff to demonstrate the utility of rehabilitation.
Appendices

Appendix 1: Problems to look for when making an assessment

The tasks
Do the tasks involve:
- holding loads away from the body?
- twisting, stooping or reaching upwards?
- large vertical movement?
- long carrying distances?
- strenuous pushing or pulling?
- repetitive handling?
- insufficient rest or recovery time?
- a work rate imposed by a process?

The loads: are they:
- heavy, bulky or unwieldy?
- difficult to grasp?
- unstable or likely to move unpredictably (like animals)?
- harmful, for example sharp or hot?
- awkwardly stacked?
- too large for the handler to see over?

The working environment: are there:
- constraints on posture?
- bumpy, obstructed or slippery floors?
- variations in levels?
- hot/cold/humid conditions?
- gusts of wind or other strong air movements?
- poor lighting conditions?
- restrictions on movements or posture from clothes or personal protective equipment (PPE)?

Individual capacity: does the job:
- require unusual capability, for example above-average strength or agility?
- endanger those with a health problem or learning/physical disability?
- endanger pregnant women?
- call for special information or training?

Ways of reducing the risk of injury
Can you:
- use a lifting aid?
- improve workplace layout to improve efficiency?
- reduce the amount of twisting and stooping?
- avoid lifting from floor level or above shoulder height, especially heavy loads?
- reduce carrying distances?
- avoid repetitive handling?
- vary the work, allowing one set of muscles to rest while another is used?
- push rather than pull?

Can you make the load:
- lighter or less bulky?
- easier to grasp?
- more stable?
- less damaging to hold?

If the load comes in from elsewhere:
- have you asked the supplier to help, for example provide handles or smaller packages?

Can you:
- remove obstructions to free movement?
- provide better flooring?
- avoid steps and steep ramps?
- prevent extremes of hot and cold?
- improve lighting?
- provide protective clothing or PPE that is less restrictive?
- ensure your employees’ clothing and footwear is suitable for their work?

Can you:
- pay particular attention to those who have a physical weakness?
- take extra care of pregnant workers?
- give your employees more information, for example about the range of tasks they are likely to face?
- provide more training (see ‘What about training?’)

Get advice from an occupational health advisor if you need to.

Factors affecting working practices
- Handling aids and equipment:
  - is the device the correct type for the job?
  - is it well maintained?
  - are the wheels on the device suited to the floor surface?
  - do the wheels run freely?
  - is the handle height between the waist and shoulders?
  - are the handle grips in good order and comfortable?
  - are there any brakes? If so, do they work?

Work organisation factors:
- is the work repetitive or boring?
- is the work machine or system-paced?
- do workers feel the demands of the work are excessive?
- have workers little control of the work and working methods?
- is there poor communication between managers and employees?

Ways of reducing the risk of injury
Can you:
- provide equipment that is more suitable for the task?
- carry out planned preventive maintenance to prevent problems?
Appendices

- change wheels, tyres and/or flooring so that equipment moves easily?
- provide better handles and handle grips?
- make brakes easier to use, reliable and effective?

Can you:
- change tasks to reduce the monotony?
- make more use of workers’ skills?
- make workloads and deadlines more achievable?
- encourage good communication and teamwork?
- involve workers in decisions?
- provide better training and information?
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Appendix 2: General risk assessment guidelines

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

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

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

Figure 1 Lifting and lowering

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

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Force to stop or start the load</td>
<td>15 kg</td>
<td>20 kg</td>
</tr>
<tr>
<td>Sustained force to keep the load in motion</td>
<td>7 kg</td>
<td>10 kg</td>
</tr>
</tbody>
</table>

Reproduced from HSE (29)
See ‘Good handling technique for pushing and pulling’ for some examples of forces required to push or pull loads.

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

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

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

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

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

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

HSE has also developed a tool called the Manual Handling Assessment Chart (MAC), to help you assess the most common risk factors in lifting, carrying and team handling. You may find the MAC useful to help identify high-risk manual handling operations and to help complete detailed risk assessments. It can be downloaded from www.hse.gov.uk/msd

Are you saying I mustn’t exceed the guidelines?

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

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

Appendix 3: Patient factors to consider when addressing the ‘load’ aspect of a manual handling risk assessment

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

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<th>Address:</th>
<th>Height:</th>
<th>Area seen:</th>
<th>ID No.:</th>
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<tbody>
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</tr>
<tr>
<td>Weight:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Therapist/s:</td>
<td></td>
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</tr>
</tbody>
</table>

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

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<thead>
<tr>
<th>Named task and Clinical Reasoning</th>
<th>Date/time Signature</th>
<th>Individual(s) assisting</th>
<th>Load (client)</th>
<th>Environment</th>
<th>Risk reducing measures</th>
<th>Date and reason no longer applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Record job title/grade, person/s assisting where relevant</td>
<td>Record details relevant to risk* and the Patient Ability Criteria, not just diagnosis</td>
<td>Record details relevant to risk* not just location of task undertaken</td>
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<td></td>
</tr>
</tbody>
</table>
### All Wales Treatment Handling Risk Assessment form – continuation sheet

<table>
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<table>
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<tr>
<th>Risk reducing measures</th>
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<table>
<thead>
<tr>
<th>Environment</th>
</tr>
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<tbody>
<tr>
<td>Record details relevant to risk* and the Patient Ability Criteria, not just location of task undertaken</td>
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<th>Load (client)</th>
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<td>Record details relevant to risk* and the Patient Ability Criteria, not just diagnosis</td>
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<tr>
<th>Individual(s) assisting</th>
</tr>
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<tbody>
<tr>
<td>Record job title/grade, person(s) assisting where relevant</td>
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### Appendixes

- All Wales Treatment Handling Risk Assessment form – continuation sheet

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Appendices

Notes on the All Wales Treatment Handling Risk Assessment form

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

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

This form only needs to be completed where there is a risk of injury from the task to be carried out.

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

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

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

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

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

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

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

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

Appendix 5: Human rights legislation

In October 2000, the Human Rights Act 1998 came into force. It acted as the vehicle for bringing into United Kingdom law the European Convention on Human Rights. The Act and Convention apply to public bodies, such as local authorities, NHS Trusts and central government departments – but not directly to independent care providers. This means that local authority decision making in respect of manual handling must comply not just with relevant domestic legislation, but also with the articles of the Convention. A number of Convention articles are relevant to local social services authorities in general. In respect of manual handling issues, the courts have to date referred to three in particular. These concern the right to life (article 2), the right not to be subjected to inhuman or degrading treatment (article 3) and the right to respect for home, private and family life (article 8).

On the courts’ current interpretation of ‘public body’, the Act and Convention do not apply directly, for example, to independent care providers of care homes or of domiciliary services. However, if a local authority knew, or should reasonably have known, that a care provider with whom it had contracted was acting contrary to human rights, the courts might find that authority to be in breach of the Act.

Manual handling

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

Perish

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

Disabled prisoner

A severely physically disabled person was sent to prison for contempt of court, for failing to disclose her assets in a debt case. In the police cell she was unable to use the bed and had to sleep in her wheelchair where she became very cold. When she reached the prison hospital, she could not use the toilet herself, the female duty officer could not manage to move her alone, and male prison officers had to assist. The European Court found that to detain a severely disabled person in conditions where she is dangerously cold, risks developing pressure sores because her bed is too hard or unreachable, and is unable to go to the toilet or keep clean without the greatest difficulty, constituted degrading treatment contrary to article 3. Damages of £4,500 were awarded (Price v United Kingdom).

Psychological integrity of a disabled person

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

Person dependent and humiliated

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

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Appendices

**Appendix 6: Private practitioner self-assessment pro forma**

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

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Y/N</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you regard the moving and handling of patients to be part of your current practice?</td>
<td></td>
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<tr>
<td>Have you attended a recent education course in handling skills and updated your CPD portfolio?</td>
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<tr>
<td>Does manual handling risk management form a regular part of your CPD and clinic organisation?</td>
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<tr>
<td>If you work alone do you have a risk management policy?</td>
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<tr>
<td>If you employ non-physiotherapy staff, have you carried out manual handling risk assessments of their tasks and individual capabilities?</td>
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<tr>
<td>Do manual handling assessments form a regular basis of your initial patient assessments?</td>
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<tr>
<td>Are these assessments ongoing and adequately documented?</td>
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<tr>
<td>Do you constantly consider the ‘Utility of the Act’, that is potential benefit to the patient, of any high risk treatment plans?</td>
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</table>
### Appendixes

<table>
<thead>
<tr>
<th>Question</th>
<th>Y/N</th>
<th>Action</th>
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<tbody>
<tr>
<td>Is your clinic accessible to patients with a disability? If not, have you considered the feasibility of reasonable adjustments to your clinic?</td>
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<tr>
<td>Is your clinic environment suitable for the moving and handling of patients as part of their clinical treatment?</td>
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<tr>
<td>Does your clinic have a policy for treating bariatric patients?</td>
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<tr>
<td>Is your equipment suitable for the range of handling tasks you undertake? For example, Do you know the safe working load of your treatment plinth? Is your treatment plinth height adjustable?</td>
<td></td>
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<tr>
<td>If you treat patients in a gym do you have transfer equipment available if required?</td>
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<tr>
<td>Do you constantly consider your own working patterns and postures with regard to the danger of work related Musculoskeletal disorders?</td>
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<tr>
<td>Do you prescribe treatment and manual handling plans for patients?</td>
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<td>Do you undertake the role of trainer of manual handling within your practice?</td>
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<tr>
<td>Have you considered your responsibilities as an employer in areas of education and supervision?</td>
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The section links indicated here are the key ones and do not replace reading the document.
## Appendices

### Appendix 7: The Dreyfus model of skill acquisition

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

<table>
<thead>
<tr>
<th>Level</th>
<th>Performance characteristics</th>
<th>Physiotherapy education level</th>
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<tbody>
<tr>
<td>A novice:</td>
<td>• Has little or no experience of the situations in which they are expected to perform</td>
<td>• Student physiotherapists are ‘observers’ where they observe manual handling practice of their tutors, clinical supervisors, and colleagues in simulated and controlled situations. They will learn basic manual handling manoeuvres of a generic type, for example ‘using a hoist’</td>
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<tr>
<td></td>
<td>• Rigidly adheres to rules, regulations and plans</td>
<td>• ‘getting a patient out of bed’</td>
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<td></td>
<td>• Has little situational perception</td>
<td>• with the outcome of ‘doing it correctly’ and ‘performing good practice’.</td>
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<td></td>
<td>• Doesn’t want to learn – wants to accomplish goal</td>
<td>• In common with other clinical skills at this level, students have little or no experience base in manual handling to analyse, argue or justify from. They require supervision at all times.</td>
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<td></td>
<td>• Applies rules universally as the situations they meet are context-free, generic and simple</td>
<td>• Advanced students now can be ‘assistants’ whereby they assist colleagues with predetermined manual handling procedures. They should now have experienced enough ‘real’ manual handling situations to begin to understand the recurring meaningful situational components, either alone or with the help of a mentor.</td>
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<td></td>
<td>• Displays behaviour that is necessarily extremely limited and inflexible</td>
<td>• However, they will be unable to apply principles alone and will still be producing rule-based behaviour and therefore rule-based performance errors. They will be supervised by proficient practitioners in specialist areas and may seek advice from competent colleagues.</td>
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<tr>
<td></td>
<td>• Doesn’t feel responsible for any action other than following the rule</td>
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<tr>
<td>An advanced beginner:</td>
<td>• Still has a limited perception of treatment outcomes</td>
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<td></td>
<td>• Finds ‘troubleshooting’ difficult</td>
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<td></td>
<td>• Wants information fast without analysis to achieve goal</td>
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<td></td>
<td>• Begins to formulate principles of responsive behaviour based on experience so far</td>
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<tr>
<td></td>
<td>• Should be able to identify new ‘situational’ elements and place advice in required context</td>
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<td></td>
<td>• Begins to apply rules to related conditions but still makes decisions by rule application</td>
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<td></td>
<td>• Does not experience personal responsibility</td>
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</table>
### Appendices

<table>
<thead>
<tr>
<th>Level</th>
<th>Performance characteristics</th>
<th>Physiotherapy education level</th>
</tr>
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</table>
| A competent practitioner: | • Begins to see actions in terms of long-range goals/plans  
• Begins to establish perspective based on abstract and analytical contemplation of the problem  
• Uses conscious deliberate planning to address specific aspects of the problem  
• Copes with previously-experienced situations well, but lacks speed and flexibility in decision making  
• Is beginning to cope with multiple clinical decision making  
• Utilises standardised procedures  
• Seeks out expert advice to assist with new situations and ‘troubleshooting’ | A graduate physiotherapist would be expected to be competent in manual handling – able to act safely within basic experienced situations but still requiring to perform procedures under direct (usually senior) supervision. Still building a ‘portfolio’ of experience across novel situations of different components. They should be actively seeking the directions/guidance of proficient and expert colleagues to extend their existing knowledge, reinforce practice and develop conceptual models. In novel situations they will seek direction and advice from proficient practitioners in their specialist areas or from experts in general problem-solving. They may offer basic advice and guidance within their own area of competence. |
| A proficient practitioner: | • Understands the situation as a whole due to perception of long-term goals  
• Learns from experience (including that of others) what typical events arise in a given situation and how plans need to be modified in response to those events  
• Can recognise when the anticipated outcomes do not materialise  
• Is able to use faster less laboured decision making due to prioritisation of situational aspects and attributes  
• Uses maxims that vary according to the requirements of the situation – reflecting the nuances of different situations  
• Is able to prioritise situation in terms of important actions  
• Perceives that deviation may be appropriate from ‘normal’ pattern of response  
• Can self-correct based on previous performance  
• Is frustrated by oversimplified information/instructions | A proficient practitioner in manual handling performs entire procedures without supervision. They refer constantly to conceptual models developed by themselves and others, using a balanced range of outcomes, including:  
• Therapist safety  
• Patient safety  
• Achieving treatment objectives  
• Patient satisfaction  
• Patient independence  
• External factors, for example funding, work system requirements  
• Psychosocial factors  

They will also be involved in generic and individual patient assessments incorporating manual handling recommendations as part of holistic patient management. They will be supervising and mentoring other physiotherapists, including students and assistants, and may train at a basic level. They may act as expert witnesses within their area of physiotherapeutic practice. In novel situations beyond their experience, they may seek peer or expert support. |
### Level  Performance characteristics  Physiotherapy education level

**An expert practitioner:**

- No longer uses an analytical approach to connect understanding of situation to appropriate action
- Instead uses an enormous experiential background to allow deep understanding and an intuitive grasp of situation
- ‘Homes in’ on accurate problem-solving without searching through a wasteful range of alternative solutions
- Possesses a range of highly-developed conceptual models
- Performs in a highly fluid, flexible and proficient capacity
- Is capable of advanced analytical problem solving in novel situations or when erroneous grasp of the holistic overview has been taken
- No longer dependent on structured algorithms
- Long-term vision of what alternatives are available and what is possible
- May use jargon expressions which may be unintelligible to non-proficient performers
- Produces a poor performance if forced to follow set rules

An expert practitioner in manual handling is truly independent. They plan, structure, implement and evaluate manual handling strategies using a consultative team approach to produce problem solving alternatives within an holistic approach. They use a manual handling experience base that is both deep (that is moving from simple to very complex problems/situations) and wide (that is across many physiotherapeutic specialities and into areas covered by other professions). They have an extended education in manual handling which empowers them to manage change (including behavioural change), and to research, evaluate and develop new practice in manual handling approaches. They will offer guidance and advice and will be structuring and developing educational pathways for other handlers, including other professionals. They may act as expert witnesses in manual handling litigation cases generally.

In novel situations they will create solutions using advanced analytical problem solving and they will also consult with expert peers, although in a group they will often have difficulty reaching consensus due to development of strongly individual conceptual models.
References


References

www.csp.org.uk/professional-union/practice/insurance/professional-public-liability-insurance


