GUIDANCE FOR THE MOVING AND HANDLING OF PATIENTS AND INANIMATE LOADS

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## Version Control and Summary of Changes

<table>
<thead>
<tr>
<th>Version number</th>
<th>Date</th>
<th>Comments (description change and amendments)</th>
</tr>
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<tbody>
<tr>
<td>Version 1</td>
<td>August 2007</td>
<td>Leicester City PCT Moving and Handling Policy and Guidance (August 2007 – August 2009).</td>
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</table>
| Version 2, Draft 1 | August 2009 | Reformatted into NHS Leicester City (NHS LC) template.  
This document accompanies NHS Leicester City Moving and Handling Policy.  
The document has had some changes made to reflect its adoption by the NHS Leicester City. |
| Version 3 Draft 1 | January 2010 | This is a revised draft received from LPT and the key changes are introduction of sketches of techniques being replaced by grey scale images.  
A number of images have been removed to streamline the document.  
New sections introduced include 19 and 20. |
| Version 3, Draft 2 | February 2010 | Comments received and incorporated from:  
• original author (Paul Hilton, Moving and Handling Advisor, Leicester County and Rutland Community Health Services),  
• some members of the Health and Safety Committee.  
This guidance has been adapted from Leicestershire Partnership NHS Trust, Moving and Handling Guidance, with whom the NHS LC and LCCHS have a Shared Service Level Agreement for Competent Moving and Handling advice and training.  
Title changed to reflect the handling of inanimate loads and a section has also been incorporated on inanimate handling.  
Guidance presented to and approved by LCCHS’s Clinical Governance Committee on 25th February 2010.  
Procedure disseminated across NHS Leicester City and Leicester City Community Health Services. |
Foreword

The authors of this document are aware that different descriptions are given to those entrusted to the care of NHS Leicester City (NHS LC) and Leicester City Community Health Service (LCCHS) staff. It is only to maintain consistency that the word “patient” is used throughout this guide to describe the person being moved by staff. For the same reason, the word “carer” is not intended to represent or exclude any particular staff group.

This procedure has been developed by the Moving and Handling Coordinator within Leicestershire Partnership Trust who provide this service to NHS LC, in consultation with the Pan Leicester Steering Group Members. NHS LC and LCCHS have representation on this group.

1.0 Scope of the Guidance

This document is designed to accompany the NHS Leicester City Moving and Handling Policy and the training provided to staff in handling patients and inanimate loads. The document describes a range of techniques involving use of handling aids that better facilitate handling of patients and inanimate loads. There is also a section on techniques that are considered unsafe and which should not be used to protect both staff and patients.

The section on inanimate handling provides some generic guidance to reflect key principles that may be applied in situations where inanimate handling of loads is to be carried out. Some of these principles also apply to handling patients. The nature of handling loads can vary considerably and this document provides general guidance to address a range of areas by empowering the individual staff member to ensure they undertake tasks after carefully assessing the situation.

2.0 Introduction

The NHS Leicester city, and its arms length Provider Leicester city community Health Services, endorses the statement of intent, contained in NHS Leicester City, Health and Safety Policy, that the greatest importance is attached to the health, safety and welfare of its employees and others affected by its undertaking and accepts fully its duties and responsibilities under the Health and Safety at Work Act 1974, and the Management of Health and Safety at Work Regulations 1999.

We aim to ensure that all services provided by the organisation conform to the requirements of the Human Rights Act and all equality legislation. As such, all organisational policies and procedures are periodically audited to ensure conformity.

As the procedures involve person-to-person contact, those persons handling patients should have regard for cultural views, opposite gender nursing,
considerations for mental capacity issues and safeguarding adults. These issues must be addressed in patient care plans.

This guide is designed to standardise handling procedures across NHS Leicester City.

- It is a reference document for moving and handling trainers, managers, and staff.
- It is not intended to be a substitute for moving and handling training.

The techniques described in this guide should only be used when a full Moving and Handling Risk Assessment has been carried out on the patient / load.

The technique chosen should be the one which reduces the risk of handling to its lowest level where reasonably practicable. Other techniques, for example those used for specific therapeutic reasons, are not included in this guide, and should only be used under the explicit guidance of trainers or therapists, and in all cases based on a risk assessment. The nature of moving and handling is such that none of the techniques are entirely risk free.

The techniques described in this procedure can be cross-referenced with care plans if desired; the relevant page number can be inserted at the appropriate entry in the care plan.

**Staff should always undertake a dynamic assessment, which is pre-task risk assessment at the time of the activity. All staff undertaking handling tasks should carry out a “mental” assessment using the Task, Environment, patient / load, and individual characteristics) prior to performing a handling task.**

### 3.0 Unsafe / High Risk Moves

There are a number of ‘traditional’ techniques which are now considered unsafe, and which must no longer be used.

Legally it is the Manual Handling Operations Regulations, 1992 – made under the Health and Safety at Work Act 1974 – which govern all manual handling activities, and to which reference should be made; the important publication here is Manual Handling; Manual Handling Operations Regulations 1992 Guidance on regulations L23 (Health and Safety Executive, 1992).

All unsafe / high risk moves have either caused injuries to NHS and Private sector patients, handlers, or both, and, as a consequence, have featured in court cases. They are no longer considered to be good practice and must not be used.
A handler injured when using any of these techniques would find it difficult to obtain compensation; a patient injured when being handled by any of these methods would find it easy to do so.

Only moves approved by the moving and handling team are to be used by staff.

Trainers should use this procedure as a reference source and any queries should be directed to NHS LC’s Health, Safety and Security Manager in the first instance.

**It is NHS Leicester City’s policy that staff do not use non-approved moves.**

### 3.1 The Drag Lift

The Drag Lift - This includes any way of handling the patient in which the handler places a hand or an arm under the patient’s axilla (armpit), whether the patient is being moved up the bed, sat up in the bed, being assisted from sitting to standing, or being assisted to change from one seated position to another – and regardless of whether the handler is facing or behind the patient, or whether there is more than one handler.

An example of a draglift.
An example of the worst kind of draglift.
3.2 The Orthodox Lift

**The Orthodox Lift** - a two-person lift, in which the handlers place one arm around the patient’s back, and the other under the patient’s thighs. The handlers may clasp each other’s wrists, or they may hold the far side of the patient. Handling slings are sometimes used. In all cases these lifts are dangerous.

3.3 Two Sling Lift

**Two sling lift** - With slings placed under the patient’s lower back and thighs, and the handlers standing either side of the patient with one knee on the bed; this is a total body lift.

3.4 The Shoulder Lift

**The shoulder lift** - Also known as the ‘Australian’ lift, regardless of whether the ‘free’ arm is placed on the bed for ‘support’ or placed around the patient:
3.5 Front Transfer with one Nurse

Front transfer with one nurse - This includes the pivot transfer, the elbow lift, and the ‘bear hug’, regardless of whether a belt or sling is used.

An example of the ‘bear-hug’ lift:

You must **not** lift people because:

- they weigh too much and are unpredictable.
- it is difficult or impossible for staff to get into a safe position to lift.
- staff are at risk of injury in all manual lifting techniques.
- most lifts include a risk of injuring the patient.
- manual lifts are not therapeutic, they do not improve the patient’s mobility.
4.0 Generic Guidance on Moving and Handling Loads

Manual handling is described as the lifting, lowering, carrying, pushing and pulling of a load requiring bodily effort.

The Manual Handling Operations Regulations set a clear hierarchy of measures to manage handling risks. They are to:

- **AVOID** – handling tasks where ever possible.
- **ASSESS** – those tasks that cannot be avoided
- **REDUCE** – the risk associated with those tasks that have been assessed
- **REVIEW** – the risk assessment

Furthermore, the Manual Handling Operations Regulations requires that all tasks take into account TILE, i.e. characteristics of Task, Individual, Load/Patient and Environment.

TILE can be used for carrying out risk assessments as required by the Manual Handling Operations Regulations and similarly the principles can also be applied by staff to undertake a Dynamic assessment.

4.1 Handling Inanimate Loads – Generic Guidance

**Plan Your Handling Task**

- Use aids where possible
- Clear area/route
- Consider resting load

**Guidelines on Handling Loads**

- **Avoid lifting** wherever possible.
- **Minimise**: bending (fore, back and side wards) and twisting.
- **Minimise**: supporting or applying a force to a load for prolonged periods.
- **Avoid** or **eliminate** handling activities at extremes of height/reach.
- **Minimise** cramped working spaces.
- **Use correct grasps** (two handed), with load/force evenly distributed and adopt correct upper body posture.
- Ensure **partner** is **similar in height and trained** in technique.
- **Avoid** jerky movements e.g. especially with big loads/force and poor postures.
- **Use trunk/arm muscles to stabilise** load/posture and **leg muscles to move** load.
- **Do Not** handle weights beyond your capacity, which are unpredictable. **Use aids.**
Generic Guidance on Techniques for Handling Loads:

1. Feet apart leading leg as far forward as comfortable.
2. Ensure stable base with feet “around” load.
3. Bend knees (don't kneel or hyperflex knee).
4. Lean slightly over the load - good grip.
5. Keep shoulders straight and facing same direction as hips.
6. Ensure spine is upright.
7. Utilise hook grip wherever possible.
8. Ensure heaviest side of load is closest to body.
9. Lift smoothly - Don’t be a jerk!
10. Keep load as close to body as possible.
11. If load is not easily reached slide it close to body before attempting to lift.
12. Don’t twist trunk when turning with load.
13. Don’t carry loads over any great distances - Use aids provided.

Above all before you lift - **Stop, Think then lift.**

4.2 Pushing and Pulling Loads

Where equipment is available this should be used to carry out handling tasks. For example using trolley, or lifting aids to enable the pushing and pulling of loads would be considered safer in some instances then physically carrying a load.

Where pushing and pulling a load occurs on a gradient a risk assessment should be carried out:

4.3 Commands Used When Moving and Handling Loads

The NHS LC command to be used when manoeuvring a patient is:

“**Ready, Steady** (where the word “Go” is used in this procedure, the operator should use an action word e.g. sit, roll, slide).

Using an action word helps the patient understand and also avoids any confusion.

5.0 Procedures for Seated Patients

5.1 Sitting Back In a Chair

Ensure the patient is sitting in the correct size of chair. The patient should be able to have their bottom at the back of the seat and still be able to have their feet flat on the floor, with their knees at hip height. If this is not possible; i.e. for very short patients, the patient should be given a footrest to rest their feet on.
Consider ways to prevent slipping:

- One-way slide sheet.
- Where appropriate, use a moulded or angled chair.

**Ways to sit back in the chair.**

- Encourage the patient to move themselves back in the chair.
- The patient stands and steps back before sitting down.
- The patient stands up, the carer pushes the chair (if the chair is easily moveable) to the back of the patient's legs, or the carer/carers stand the patient and a third carer pushes the chair to the back of the patient's legs.
- If the patient is unable to move themselves, staff should reposition them using a standard or hoist.

### 5.2 Cardiac Arrest in a Chair

**IF A PATIENT HAS A CARDIAC ARREST WHILST SITTING IN A CHAIR, DO NOT ATTEMPT TO LIFT THE PATIENT BACK INTO BED.**

Call for assistance - a minimum of two carers are required.

**SLIDE THE PATIENT ONTO THE FLOOR.**

Any manoeuvre involving a patient who has arrested is a high risk one.

- Two carers kneel in front of the patient.
- The carers place their outside hands behind the patient’s bottom at the level of the seat cushion. Using their inside hands, they take hold of the patient's legs, securing a hold at the back of the calves behind the patient's knees (see figures 1 and 2).

![Figure 1](image1.png)
![Figure 2](image2.png)
From this position, the carers perform a backwards weight transfer manoeuvre: on the command 'GO,' they sit back from a high kneeling position onto their heels, keeping their outside arms as straight as possible and maintaining a good posture (see figures 3 and 4).

This manoeuvre will slide the patient forwards, their bottom moving clear of the chair cushion. The two carers can now release the patient; the momentum caused by the manoeuvre, combined with gravity and the patient's weight will cause the patient to slide out of the chair and onto the floor (see figure 5).

To protect the patient's head, a third carer places a pillow behind the patient's head as the patient is sliding out of the chair (see figure 5). The pillow may be kept in place by the two kneeling carers until the patient is on the floor (see figure 6).
The patient is now in a position to be resuscitated.

This manoeuvre can be made a little easier if the carers initially ‘sweep’ the patient’s feet forwards. This can be done by standing either side of the patient and placing a foot behind the patient’s ankles. On the command ‘GO,’ the carers ‘sweep’ the patient’s feet forwards, which will move the patients bottom forward in the chair and so make the full move that much easier.

5.3 Sitting to Standing

A patient should be assessed for their ability to stand with or without assistance, and an appropriate height chair should be provided.

Where appropriate, the patients walking aid should be placed within easy reach of the operator.

To encourage independent standing, ask the patient to:
- Move their bottom forward in the chair.
- Place their feet apart, one foot slightly in front of the other.
- Place their hands on the arms of the chair.
- Ask the patient to look forward.
- Ask the patient to lean forward so that their head is over their toes.
- A rocking motion at this stage may help some patients; rocking forwards in time with the commands “Ready, Steady...”
- The patient is instructed to push with their hands and stand up on the command ‘Stand’.
- If the patient uses a walking aid, the carer gives it to them after the patient has stood up.
5.3.1 Where assistance is required:

- The carer should stand on one side of the patient, facing the patient side on.
- The carer adopts a wide base, placing one foot level with the patients feet.
- The carer places one arm around the patient’s waist or the flat of their hand in the small of the patients back, and the other hand resting on the patients shoulder. To do this, the carer must bend their knees not their back (See Figure 6).
- The same procedure as above can then be followed: On the command ‘GO’ the carer performs a sideways weight transfer manoeuvre from leg to leg in the direction of the move, their body weight going through the patient via their forearm thus assisting the patient to stand. (See Figure 7).
- Alternatively, the carer stands close to the side of the patient, facing the same way as the patient. The carer places their outside foot level with the patient’s feet and the other comfortably behind, adopting a wide base.
- Placing their hands on the patient as above, on the command ‘GO’ the carer performs a forward weight transfer manoeuvre from leg to leg assisting the patient to stand.

If two carers are required, one stands on each side of the patient and proceeds as above.

- Where a handling belt is assessed as appropriate, the same procedure can be followed holding onto the handles of the belt instead of holding the patient directly. The carers must not use the handling belt to lift patients.
- If the patient is not able to raise his bottom off the chair, then a standing aid or hoist must be used.
- A patient must not be supported in standing if they are unable to take any weight through their legs.

5.4 Bed to Chair, Chair to Commode, Toilet to Wheelchair

It is essential that an assessment of the patient's own capabilities is carried out and recorded on the individual patient Moving and Handling Risk Assessment form (see NHS LC’s Policy for Moving and Handling). This should be amended as the patient’s condition changes. From this assessment, the correct transfer technique and the most appropriate equipment is used.

5.5 Patients who can stand but have difficulty turning or taking steps

There are three methods that may be considered depending on the assessment of the patient:

1. Patients who use a transfer board should be assessed by a therapist.

   Place the chair at 60° to the bed. Place one end of a transfer board under the patient's thigh nearest the chair, and the other end position onto the
chair. The patient should reach across to the far arm of the chair, and slide their bottom along the board until safely positioned in the chair. These patients should have good sitting balance and upper body strength.

2. A turntable may be used for patients who can stand and have a good balance but are unable to take steps.

3. Stand Aid or Hoist.

5.6 Patients who are unable to weight bear

These patients must not be moved manually. There are only two methods to be considered:

- The use of a hoist / stand-aid.
- The use of a transfer board if assessed as safe to do so.

5.7 Toileting a patient

It is a very high risk activity to support a patient whilst attempting to attend to their hygiene and/or rearranging their clothing.

Carers must not ‘hold’ a patient up whilst performing this activity. To reduce the risk:

- Always refer to the patient's Moving and Handling Risk Assessment.
- If assessed as necessary, two carers may be required, one to assist the patient to stand, and another to attend to the patients hygiene and rearrange their clothing.
- Make appropriate use of available aids to assist the patient to safely stand e.g. toilet rails, zimmer frame, stick.
- Where a patient is unable to stand safely, use a stand-aid or a hoist.
6.0 Procedure for Walking with a Patient

- The patient’s ability to walk must be assessed.

- The patient must be able to weight bear bilaterally and take steps without manual assistance.

- The patient may wear a transfer belt and use an appropriate aid where necessary e.g. walking frame, stick.

- If using a handling belt, hold one handle on the side of the patient. If using a hand hold for reassurance, the patients arm/s should be straight, hand pressing down on to the carers flattened hand. Thumbs should not be interlocked, this enables carers to release their grip quickly and safely if the patient should fall. See figure below.

- Face the direction you are going and ensure a clear path.

Do not attempt to hold a patient up if they begin to fall.

7.0 Procedures for the Manual Handling of Falling / Fallen Patients

The patient should be risk assessed and recommendations / guidance for carers should be followed.

If a patient does fall, there is a significant risk of injury to the carer. If the patient becomes unsteady and is close to a chair / bed, then the carer should guide them into the chair or onto the bed. The carer should not 'lower' the patient as this will involve taking their weight.

If the patient is in close physical contact at the moment of collapse the following steps are recommended:
- Release your hold on the patient.
- Do not attempt to hold the patient up.
- When the patient is on the floor the carer can then put them into the recovery position; check for injury, summon help etc.

If the patient is out of the carer's reach, it is unrealistic to try to rush to rescue them. The carer will not be close enough to get into position in time.

**In this situation, there is no safe way of dealing with a falling patient, other than to allow them to fall. Where possible, carers should endeavour to remove items of furniture etc that may harm the patients fall.**

In the early stages of walking with a patient or if the risk assessment indicates a patient has a history of falls, two or three carers should walk with the patient, one of them following the patient pushing a wheelchair.

### 8.0 Procedure for Getting a Patient off the Floor

Always use a hoist if the patient is unable to get up independently by:

- Assess the patient for any injuries and get medical assistance where necessary.
- Ascertain whether the patient can get off the floor independently and/or with verbal guidance. Do not offer the patient any physical assistance - the patient may grab hold of the carer's hand/arm/shoulder/neck and cause an injury.
- If the patient is unable to get off the floor, make them comfortable with pillows and blankets.
- When the patient is able to be moved safely, clear the area.
- If necessary, slide the patient into a space that allows for easier access for the hoist. A minimum of three carers will be required to perform this task.
- Place a pillow under the patient's head, and an evacuation sheet, blanket or bed sheet under the patient's body by rolling using the standard procedure (See section 10.1). One carer protects the patient's head; two carers pull the blanket at the patient's feet, if the feet are nearest to the exit. This should be done with the carers standing with their knees bent and their backs straight, not twisted.
- If the patient's head is nearest the exit, the blanket is pulled out head end first. Once the patient is appropriately positioned, use a hoist to return the patient to their bed / chair.
• Insert the hoist sling by rolling the patient using the standard procedure (See section 10.1).

• Position the hoist. The patient’s legs may have to be raised to enable the sling to be secured to the hoist. Raise the patient from the floor, ensuring that they are in a sitting position. Do not attempt to take the weight of the patient’s head: rely upon a high backed sling.

**Do not attempt to manually lift any one off the floor. Always use a hoist.**

### 9.0 Cardiac Arrest - Patient Collapses to the Floor

The patient should not be manually lifted from the floor. The patient should only be moved if not moving them would put the patient and/or healthcare staff at risk of further harm.

If the patient recovers, they should be hoisted into bed. However, using a conventional sling to do this will put pressure on the patient’s abdomen and put the patient at risk of re-arresting; therefore a stretcher type sling should be used.

If a stretcher sling is not available, the patient may be placed in a conventional sling so long as it is possible to ensure that they are hoisted in the supine position. If this is not possible, the patient should be made as comfortable as possible and not moved until the Paramedics arrive with a stretcher.

### 10.0 Procedures for Moving and Handling of a Patient on a Bed

#### 10.1 Rolling / Turning A Patient

This procedure can be used for all of the following manoeuvres:

• Rolling / Turning a patient.

• 30° Tilt.

• Insertion/removal of a slide sheet under a patient.

• Insertion/removal of a hoist sling under a patient on a bed.

• Insertion/removal of a hoist sling under a patient on the floor.

• Insertion/removal of a transfer board under a patient.

• Bed bathing a patient.

• Application of or changing the dressings of a patient whilst in bed.
• Changing of bed linen whilst the patient is in the bed.

If the patient is able to co-operate and move themselves, ask them to do so. If not:

• Raise the bed to at least waist height. Turn the patients head in the direction of the turn, i.e. away from the carer.

• A second carer must be on the other side of the bed to ensure the patients safety.

• Cross the patient’s arms.

• Raise/bend the patients leg nearest to the carer so that their foot is as near to their bottom as possible. If this is not possible, cross their ankles.

• The carer gently pushes against the patient’s shoulder and hip so the patient will easily turn over onto their side, assuming the recovery position. (See Figure 8).

![Figure 8](image)

![Figure 9](image)

The ‘receiving’ carer maintains the patient’s position and safety by resting their hands on the patient’s shoulder and the uppermost side of the knee. (See Figure 9).
Alternative Procedure

For rolling patients onto their side where the patient is either:

- On a trolley
- On an operating table
- On a treatment couch
- On the floor
- On a divan bed

i.e. narrow surfaces

The carer follows the above ‘Standard Procedure’ but pulls the patient over and toward them (See Figure 9). This is because the carer does not have to compromise their posture by leaning across to reach the patient (due to the narrow surface) and to push roll the patient on a narrow surface constitutes an unnecessary risk.

In a domiciliary environment where the patient is on a fixed low bed with access on one side only, the carer may put one knee on the bed and use either of the above procedures, dependent upon their maintenance of good posture.

10.2 Lying to sitting on the edge of the bed

- Ask the patient to do as much as possible for themselves, but where necessary and appropriate, use one or two carers to assist.

- The patient rolls on to their side and swings their legs over the side of the bed. The patient can then push up, using their arms, into a sitting position.

- Where assistance is required, roll the patient as in the standard procedure, but with both of the patients legs raised / bent. The patient slides their feet over the side of the bed, the carer places one hand under the patients shoulder (between shoulder and bed) and one hand on the patient’s hip/thigh. (See Figure 10).

- The patient is moved into a sitting position by the carer transferring weight from leg to leg in the direction of the foot of the bed. At the same time the carer transfers their body weight through patient’s hip/thigh. This manoeuvre will swing the patient’s legs around and down, their upper body following into a sitting position. (See Figure 11). The emphasis on the weight transfer should mean that almost all the force exerted goes onto/through the patient’s hip/thigh, and therefore minimal effort is required from the carers hand under the patient's shoulder, i.e. The carer is NOT lifting the patient up by their shoulder.
- Always hoist if the patient is unable to assist.

**10.3 Lying to sitting in bed**

For the following manoeuvres, the patient must have sitting balance. If not, then they must either be hoisted and / or cared for in a profiling bed.

If the patient cannot sit up unassisted, they may be able to use a Jacob's ladder (See Figure 12) or bed lever to assist them.

If not, advise them to roll onto one side, and then push themselves up into a sitting position.
If the patient is unable to do any of the above, then use the following method:

- Adjust the height of the bed so that the carers can comfortably adopt an upright kneeling position either side of patient; facing the head of the bed, their inside knees on the bed at the patients' hip level.

- The patients' arms should be folded, and their chin on their chest. The carers outside hands go under the patients' shoulder.

- Prior to the manoeuvre, advise the patient to breathe out on the command 'GO' this will help to prevent them stiffening / resisting the manoeuvre.

- On the command 'GO' the patient is moved into a sitting position by the carers 'sitting' on their heels in a weight transfer manoeuvre.

If this has to be a regular occurrence for whatever reason, then consider nursing the patient on a sheet and use this to sit the patient forward:

- The carers take up position as above. Using their inside arms, they grasp and take up any slack in the sheet, positioning their hands close to the patients' shoulders. (See Figure 13). Keeping their arms straight, the carers perform the same weight transfer manoeuvre to sit the patient up. (See Figure 14). Ensure that the sheet is in good condition, i.e. not torn.

- Once the patient is sat up, one carer can support the patient.

To reduce the risk to its lowest level, patients who require assistance to sit up should be nursed on a profiling bed.
10.4 Lying to sitting on a trolley

This manoeuvre may also be used for a patient in bed where both carers can easily access the patient. If the patient has sitting balance but is unable to sit themselves up, use the following method:

- Ensure that the patient is on a draw sheet and that it is under their shoulders. As there is little or no room for the carers to place their knees on the trolley safely, this manoeuvre is carried out with the carers standing.

- Adjust the height of the trolley to waist height, one carer standing each side of the patient, facing the patients face.

- Using their inside arms, they grasp and take up any slack in the draw sheet, positioning their hands close to the patient's shoulders.

- The carers adopt a wide base, placing their inside foot at about a pace's distance behind their outside foot (See Figure 15).

- On the command 'GO' the carers, keeping their arms straight, step back onto their inside foot, performing a weight transfer manoeuvre in the standing position. (See Figure 16). Once the patient is sat up, one carer supports the patient, whilst the other raises the backrest of the trolley.

If the patient is unable to assist, consider the use of a hoist.
11.0 Devices to Prevent Patients Slipping Down the Bed

Nurse the patient in an electric profiling bed.

11.1 Manoeuvres up the Bed

A patient should not be routinely moved up the bed. It should only be done if there is a medical reason for doing so, or at the patient's specific request. These manoeuvres should only be carried out if assessed to be safe to do so. If in doubt, don't do it.

- The patient should move themselves with or without the help of a slide sheet and/or hand blocks. (See Figure 17).

Figure 17

If the patient is able to walk, then stand the patient out of bed and walk them back to the top of the bed.

- If the patient can stand but has difficulty taking steps or is attached to equipment of any kind, stand them up and move the bed down until the correct position is reached.

- Where assessed to be appropriate, carry out a recognized manoeuvre with a slide sheet.

- Use a hoist to lift the patient clear of the bed. Move the bed down using two carers, until the patient is over the head end of the bed (it may be necessary to move the hoist backwards to do this) and then lower the patient back into the bed. Push the bed back up against the wall. This manoeuvre is easier than manoeuvring the hoist with patient in situ.

To make more space around the bed:

- Draw curtains/screens around other patients.

- Move tables, chairs, lockers out of the way.
- Move the bed into a central (more spacious) area.

### 12.0 Moving up the Bed

#### 12.1 The Patient who cannot Sit-Up

In order to minimise risk to the lowest reasonable level, such patients should be nursed in an electric profiling bed.

Prior to doing any manoeuvre, prepare the bed area - i.e. brakes on, create as much space as possible.

- Always use the hoist if there are no suitable alternatives.

- When a patient is not able to sit unsupported, or is in a semi recumbent position; a slide sheet can be used to slide the patient higher up the bed.

#### 12.2 To position a Slide Sheet under a Patient with 2 Carers

- Raise the bed to at least waist height. Turn the patients head in the direction of the turn, i.e. away from the carer.

- A second carer must be on the other side of the bed to ensure the patients safety and to foster their confidence. (See Figure 18).

- Roll the patient onto their side using the standard procedure (see section 10.1).

![Figure 18](image)
Ensure the slide sheet is facing the correct way and is `slippery' in the desired direction. (See Figure 28). Position the half-rolled slide sheet as far as it will go under the rolled patient. Alternatively, the slide sheet can be placed under the bed sheet. (See Figure 19).

If using large "open' slide sheets, place two sheets on top of one another, directly under the patient. (See Figure 20).

Repeat manoeuvre from other side of bed to unroll the rest of the slide sheet. (See Figure 21).
12.3 To position a Slide Sheet under a Patient with Three Carers

- One standing at the head end of the bed, facing the foot end with the backrest off. This carer grasps the upper part of the slide sheet (or the top slide sheet if using two large ‘open’ types) at either side of the patient’s head, just above their shoulders. The carer supports the patient’s head. Ensure that any stack in the slide sheet is taken up.

- One on each side of the patient facing each other. These carers grasp the upper part of the slide sheet (or the top slide sheet if using two large ‘open’ types) at points level with the patient’s shoulders and hips. Ensure that any slack in the slide sheet is taken up. All carers hold the slide sheet close to the patient’s body, unless doing so means that any carer compromises their posture by over-stretching. In which case, grasp the slide sheet in a position most comfortable for the carer.

- The carer at the head end places one foot behind the other, adopting a wide base, ready to perform a backwards weight transfer manoeuvre in the direction of the move.

- The carers at each side of the patient bend their knees and adopt a wide base, ready to perform a sideways weight transfer manoeuvre in the direction of the move, avoiding twisting (See Figure 22).

- On the command ‘GO’, slide the patient up the bed in short stages, weight transferring from leg to leg in the direction of the manoeuvre.

- Remove the slide sheet as above, i.e. roll the patient from side to side. An alternative method is to grasp the lower surface of the slide sheet(s) at the patient’s ankles or knees, and gently but firmly pull backwards (towards the patient’s head) until the slide sheet(s) are removed.

- Where a patient presents carers with infection control issues, disposable (single patient use) slide sheets may be used if there are not enough normal slide sheets available to cover for the consequential laundry of infected equipment.
12.4 To position a Slide Sheet under a Patient with two or four carers

One carer on each side of the bed (two carers on each side of the bed if four staff are available) and now follow as above except that there is no carer at the head of the bed.

12.5 Bed Bathing / Sheet Changing

- Always get the patient to do as much as possible for themselves.
- A minimum of two carers are required if the patient is not able to assist in movement.
- Ensure that the bed is at least at waist height.
- When turning the patient use the standard procedure, i.e. push, do not pull the patient into the recovery position. If this is either impractical or unsafe, use the Alternative Procedures (See Section 10).
- Avoid bending and twisting.

12.6 Inserting a Bed Pan whilst the Patient is in Bed

- Ask the patient to do as much as possible to help e.g. use a monkey pole, or ask the patient to "bridge" - i.e. The patient lies on their back, both knees flexed, feet flat on bed, forearms and hands flat on bed (palms down). The patient pushes down on their hands and feet to raise their hips. (See Figure 23).
A patient can be rolled on to a bedpan.

Hand blocks.

If this is not possible the hoist must be used.

**Do not attempt to lift the patient onto the bedpan.**

### 13.0 Bed to Bed, Bed to Trolley, Trolley to Bed

Assess the patient, and if fully co-operative and fully conscious encourage them to transfer independently. If not, use the following procedure:

- Obtain a transfer board.
- Minimum of three carers.
- Remove the head of the bed.
- The patient should be off centre in the bed, towards the side that they are going to transfer from.
- Place the transfer board under the patient by rolling, using the standard procedure i.e. push; do not pull the patient into the recovery position. (See Figure 24). If the patient is lying on a narrow surface it may not be safe to use the standard procedure. In this case carers should use the Alternative Procedure.
- Place the transfer board under the patient and bed sheet/draw sheet. Leave enough of the transfer board exposed so that a safe and effective ‘bridge’ is made between the bed and the trolley. (See Figure 25).

- Position the trolley parallel and as close as possible to the bed. Ensure that the trolley and bed brakes are on. (See Figure 26).

If using three carers, ensure that the far cot-side on the trolley is raised for the patient’s safety.

In order to minimise carer effort, gravity and the patient's weight can be utilised by raising the bed approximately 2" higher than the trolley. The manoeuvre will therefore involve pushing the patient downhill to approximately waist height.
The carers stand at the head, feet, and near side of the patient. (See Figure 27).

- The carer at the side places their hands on the patient’s hip and shoulder. The carer stands with one foot behind the other; ready to perform a forward weight transfer manoeuvre which will push the patient in the direction of the transfer on the command ‘GO’.

- The carer at the head end takes up all the slack in the sheet, supporting the patient’s head and pillow. The carer at the foot end supports the patient's feet in the same manner. The carers at the head and feet ends stand with their feet apart adopting a wide base. On the command ‘GO’ they transfer weight from one leg to the other in the direction of the move, avoiding twisting.

- On the command ‘GO’ move the patient mid-way.
• The ‘pushing’ carer then walks round to the other (receiving) side and helps to manoeuvre the patient the remaining distance by moving the patient towards them. The carer grasps the draw sheet at the patient’s shoulder and hip level, and performs a weight transfer manoeuvre by stepping backwards on the command ‘GO;’ with the other two carers moving as above. (See Figure 28).

If a fourth carer is available, they stand at the receiving side of the bed and when the patient is in mid position, they can grasp the sheet at the patients shoulder and hip level and weight transfer backwards, completing the manoeuvre.

If the transfer board is not immediately and easily removable, move the bed away from trolley, roll the patient off the transfer board in the standard manner and the other carers pull out the transfer board.

Figure 28

14.0 30° Tilt (Preston K.W. 1988)

If a patient needs to be turned regularly for relief of pressure areas, 30° tilting should be used by the following:

• Three soft pillows are needed to support the trunk and lower limbs, plus a minimum of two are required for the head and neck.

• Place the patient centrally in the bed in the recumbent or semi recumbent position.
• The assisting carer tilts the patient away from them, using the standard procedure for rolling (see figure 29), the roll only requires to be approximately 30°.

• The first pillow is placed length ways at an angle of approximately 45°, with a comer of the pillow positioned carefully to fill the small of the back, (see figure 30).

• Do not over do this - a pillow depth of 1.5 - 2" is usually adequate.

• Gently allow the patient to roll back onto the pillow.

• Check that the patients' shoulders and thoracic spine are supported.

• The patients leg (on the same side as the inserted pillow) is supported next, using a pillow under its entire length, the pillow being moulded around the limb with the patients heel extending over the end to prevent heel pressure, (see figure 31).

• The third pillow is inserted at an angle to support the other leg from the back of the knee to the ankle, leaving the heel unsupported, (see figure 32).

• A carer can check that there is a clearance between the patient's sacrum and the mattress by checking with their flattened hand - it should be easy to put a hand in the slight gap created.

• Support for the feet may be necessary to prevent foot drop.
15.0 HOISTING PRINCIPLES

1. Unless otherwise dictated by the patient’s risk assessment/care plan, use a minimum of two carers when hoisting.

2. Storage / not in use. Ensure the brakes are on when the hoist is not in use. Ensure electric hoists are left on charge when not in use.

3. Safe Working Load (SWL) This should be clearly marked on every hoist. If in doubt, check with the manufacturer. Never use a hoist to lift a patient who exceeds the safe working load.

4. Service checks. Hoists and slings should be inspected twice a year.

5. Moving a hoist. Always push where possible and keep close to your body. Mobile hoists are designed to transfer patients; they are not designed to transport patients.

6. Use of hoist legs. Use handset controls to alter position of legs if the hoist is electric. Avoid kicking the hoists legs into position if the hoist is manual. Alter the hoists leg angles appropriately when positioning patient in a bed/chair etc.

7. Use of spreader bar. Do not push or pull excessively. Protect the patient’s head from potential injury.

8. Use of brakes. Brakes should be OFF except when in storage, being used on an incline, or when
9. Explanation to user. Communicate with your patient and where possible obtain their consent and cooperation.

10. Slings. Use the appropriate sling for the hoist. Irrespective of manufacturer, ensure that the hoist/sling interface is compatible. Use appropriate size sling for the patient. For general purpose slings this means that the sling should fit from the top of the patient’s head to the base of their spine.

11. Manual override. All electric hoists have a manual override which can be operated in the event of a power failure. Carers should familiarise themselves with the override system on their hoists.

For comprehensive guidance to the safe use of hoists, refer to the organisations document ‘Code of Practice for Using Hoists to Move Clients’.

16.0 Use of Wheelchairs to Move Patients

When using a wheelchair to move a patient, staff should follow the principles of safe handling and in particular the following:

- Keep the load close.
- Maintain good posture.
- Push rather than pull.
- Use your leg muscles to do the work.
- Avoid twisting.
- Do not lift.
- Plan ahead.
- Avoid unsuitable environments.

Wheelchairs should be treated as any other piece of moving and handling equipment; staff should consider the following points before using one to move a patient:
• Is the wheelchair suitable for the patient?
• Is the wheelchair well maintained?
• Does it need two people to push it?

Additional factors should be considered if the wheelchair is to be used outside of the clinical environment (e.g. visit to a shopping centre), a risk assessment should be made to determine whether or not any of the following would pose a potential risk:

• Has the vehicle been fitted with a suitable wheelchair access / security system?
• How far is the car park from your destination? Are the weather conditions going to make it difficult to manoeuvre the wheelchair? Will kerbs be a problem?
• Is there suitable access? Is it wide enough? Is there a threshold / doorsill?
• Are there any obstacles to negotiate?
• Are there suitable toileting facilities?
• Are there ramps; if so are they steep or slippery?
• Will there be crowds? Will it be noisy? Will the lighting be adequate?

It is the responsibility of the individual member of staff to decline to undertake a task if they consider it to be unsafe.

17.0 Moving Patients In And Out Of Cars

17.1 For Patients Who Are Able To Stand and Weight Bear

To get into a car:

1. If there is a kerb, move the car away from the kerb and gutter so that the patient can stand in the road and does not have so far to lower themselves into the car. Always place a person with restricted movement in the front seat of the car, as access is easier.

2. Prepare the car; set the door wide open and position the seat well back.

3. The patient should approach from the rear of the car so they can turn by the door and have their back to the car seat.

4. The patient should back up to the car until they can feel the sill against the backs of their legs.
5. The carer must hold the door open so that it does not swing closed.

6. The patient should hold onto the car frame on either side of them, lower themselves onto the car seat and lift their own legs into the car. If they have difficulty lifting their legs, the carer can assist using a leg lifter (often referred to as a ‘dog lead’).

7. If a patient has difficulty turning in the seat of the car, put a soft turntable on the seat before the patient sits down. The turntable can be left in place for the journey. Do not use a slide sheet or plastic bag instead of a turntable as the patient could slide off the seat.

8. The patient should shuffle themselves into a comfortable position and the seat belt applied.

**To get out of a car:**

1. Release the patient’s seat belt and hold the door open.

2. The patient turns and lifts their leg out of the car.

3. The patient pulls themselves into the standing position using the car frame.

**For patients who are non-weight bearing wheelchair users:**

This is a high-risk manoeuvre and non-weight bearing wheelchair using patients should only ever be transported in vehicles designed for this purpose. It must be stressed that it is neither safe practice nor in the best interests of the patient/carer to move patients in and out of vehicles not designed for this purpose.

**Placing a wheelchair into the boot of a car:**

Ideally the vehicle should have a level entry boot which is not too high off the ground and boot space cleared of obstructions.

1. The wheelchair should be stripped of its armrests and footplates and any other removable components to reduce weight and bulk.

2. The wheelchair should then be folded and the backrest folded down.

3. With the brakes on the carer should position the wheelchair so that the heaviest sides are on their strongest side i.e. right side if the carer is right-handed.

4. The carer grasps the wheelchair with one hand holding the wheel rim furthest from them and the other hand holding the seat frame nearest them.
5. The carer should then use their knee to pivot the wheelchair base away and up from him/herself so that the lower part of the wheelchair is supported on the boot rim.

6. The wheelchair can now be slid into the boot.

**Removing a wheelchair from the boot of a car**

1. The carer pulls the folded wheelchair towards them so that only the casters and lower part of the large wheels are resting on the boot rim.

2. The carer positions their feet so that one is forward and one behind.

3. As the weight of the wheelchair is pulled out, the front foot is pulled back so that the weight of the wheelchair falls between their feet.

4. The wheelchair can now be reassembled for use.

By using these procedures, it should be possible for the carer to maintain an erect posture. However, this procedure does involve a manual lift and most wheelchairs are heavy.

The carer must make an assessment whether this is within their capabilities.

### 18.0 Emergency Evacuation of Patients

It is a mandatory requirement under the Provisions of Policies and Principles, Section 3, Appendix 1 (Fire Code) that when healthcare premises are being used to accommodate patients of any kind, consideration must be given to how they can be evacuated in an emergency.

**STAFF SHOULD FAMILIARISE THEMSELVES WITH THEIR LOCAL PLANS FOR THE EVACUATION OF PATIENTS.**


There are three basic methods of emergency evacuation, which are (in order of priority):

- Walking
- Wheeled Transport
- Sliding along the Floor
18.1 Walking

Where patients are able to walk, they should be firmly told to walk to the assembly point. Some patients may have to be walked to the assembly point. This should then leave the staff to concentrate on those who cannot walk.

18.2 Wheeled Transport

Where a patient cannot walk, it is invariably safer and less physically exhausting to evacuate the patient on wheeled equipment. There are several items of equipment that should be considered.

18.3 Chairs

Chairs fitted with wheels make a good means of transport for many patients. Equipment such as wheelchairs, ambulance chairs, commodes on wheels, and even easy chairs on castors can be pressed into service.

**WARNING**: Chairs with castors can only be used on hard floors without obstructions. On soft or uneven surfaces they will require too much effort to move and may even get stuck.

Make sure that castors or wheels do not fall off when the chair is tilted.

Many wheels are not designed for this sort of journey; do not rely on something that won’t work when the real emergency happens.

18.4 Beds

The bed, provided it is on wheels, makes a useful means of transport to evacuate the patient out of the immediate area of risk. However, this method has its limitations:

- The bed can only travel over a relatively even floor. The bed or beds can create serious obstacles in corridors and at the top of stairs. Bed wheels need to be regularly maintained to ensure that they are free running.

- Nearly all hospital type beds have three position brakes. The positions are brake, free running and steer. In the steer position one pair of wheels is locked straight and the other pair will turn from side to side. This is the right position for pushing a bed along a corridor. Make sure that all staff know how to set the bed to this mode. A bed can be virtually uncontrollable in the free-running position with all four wheels free to turn in any direction.

If the plan involves the use of something with wheels to evacuate patients, checks must be made to ensure that the wheels will go over the ground. Try it out with a person in the chair or bed. Check the whole journey. Will it:

- Go across the carpet or other floor covering? Cross sills to rooms?
- Traverse the ground outside the building? (The patient will need to be taken to a safe distance away from the building).

Make sure that castors or wheels do not fall off when the bed is tilted.

As with chairs, many bed wheels are not designed for this sort of journey. Do not rely on something that won't work when the real emergency happens. These checks should be made before carrying out any training exercises.

18.5 Ski Pad

The ski pad has been developed from the ski sheet. It is a ski sheet with extra padding. Therefore, the patient's own mattress is not used. The main advantage of the ski pad is that it can negotiate narrow stairways, sharp bends, and narrow, twisting corridors with greater ease than a conventional bed mattress in a ski sheet.

The ski pad is usually wall-mounted in a ward in its own bag. The ski pad is laid on the floor and unfolded alongside the patient's bed. The patient is then transferred from the bed onto the ski pad and wrapped in a blanket. The straps are fastened and the patient can then be pulled along the floor on its vinyl base. This pad will protect the patient from some knocks and bruises.

The problem with this device is that there seems to be no way of safely moving and immobile patient on to it. It may be useful for a limited number of patients who are unable to move any distance or have difficulty controlling their limbs. Such patients may be persuaded to lay themselves on the pad so that they can be evacuated.

The ski pad may be of limited use. It should only be purchased where the risk assessment shows that it can be used safely.

18.6 Evacuation Chairs

These are chairs which can be used to push a seated person along on the flat and down stairs only. They have a special track mechanism that allows the chair to come down a flight of stairs in a controlled manner. Using the evacuation chair one person can safely steer a patient down a series of flights of stairs.

The evacuation chair folds flat and can be stored against the wall in a convenient place.

THE EVACUATION CHAIR MUST NOT BE CONFUSED WITH THE AMBULANCE CARRY CHAIRS.
19.0 Lowering a Patient from a Complete / Incomplete Strangulation

This is a high-risk activity. Principles of safe handling should be adhered to so far as is reasonably practicable, but this may not always be possible, particularly for the first person to arrive at the scene of the incident.

Where the risk to the handlers is considered too great, it may be appropriate to cut the ligature, preserving the knot, and allow the person to fall unhindered to the ground.

19.1 Suspended Strangulation

- Staff attending the scene will hold the person’s thighs and raise them slightly, to reduce tension on the ligature.

- If the person is at a height that the staff find difficult to reach, tension can be reduced by placing a table/chair underneath the person.

- One handler will cut the ligature from the point of suspension, preserving the knot. The knot must be preserved intact if possible; it may be used as evidence in any investigation.

- Another handler will support the person’s head, while other staff lower the person into a supine (lying face up) position onto the floor/ground.

- Remove the ligature from the neck, using a ligature cutter if required.

- Assess vital signs and commence resuscitation, if appropriate.

- When ready, raise the person from the floor, using an appropriate manoeuvre.

19.2 Incomplete Strangulation – Kneeling, Semi-seated, Lying

- Staff attending the scene will hold the person’s thighs, hips, or the person’s belt or clothes, and raise them slightly, to reduce the tension on the ligature.

- One handler will cut the ligature from the point of suspension, preserving the knot.

- One handler must support the person’s head as the person is lowered to the ground.

19.3 Lying Strangulation

- Staff will slide the person up towards the point of suspension, to reduce the tension on the ligature before removal.
20.0 Miscellaneous Procedures

20.1 Bathing A Patient In A Bath

- Unless the patient is fully independent, always use the ambulift or hoist.

- Transfer using equipment as per Care Plan/Manual Handling Risk Assessment.

- Never leave the patient alone on the ambulift or hoist.

- Remember to use safety arms and harness.

- Never leave the dependent patient alone in the bath.

Carers should not bend over the bath for a long period. Change position regularly; consider kneeling with use of kneeling pads, or changing tasks with another carer. If the bath is height adjustable ensure that it is at a suitable height to avoid bending over.

20.2 Moving Chairs

- Use a mechanical aid i.e. chair mover if available.

- Always move chairs with two carers.

- Decide who is going to co-ordinate the manoeuvre.

- Lift from either side of the chair and hold near to the backrest not from the ends.

- Do not attempt to lift or drag a chair with a patient in it.

- Ensure that there are no obstacles on the floor in the line of movement.

20.3 Moving Beds

- Do not attempt to move a bed on your own.

- Always have two carers, one at either end of the bed.

- Raise the bed to a height that will avoid the need for carers to bend their backs.

- Ensure that the brakes are off and that the bed is in the steer mode.

- Remove all potential obstacles in the line of movement.
Assess the need for bed rails/cot sides. Ensure that the bed rails/cot sides are securely fastened to the bed. When not in use, ensure that they do not stick out from the bottom or top ends of the bed.

For a comprehensive guide to the use of bed rails, refer to the Leicestershire Partnership NHS Trust document ‘Code of Practice for the Safe Use of Bed Rails.’

The carer at the foot of the bed steers the bed by standing at one corner, not pulling the bed behind them using both arms.

Consider a third carer to help with drips, feeds, monitors, etc. Remember the principles of safe handling i.e. keep the load close; maintain natural spinal curves; use legs to push; walk around comers, do not swing around.

- After repositioning, apply the brakes.
- Report any bed faults immediately.

21.0 Moving and Handling Children

Recognition has to be given to the potential risk of injury to employees and clients posed by the moving and handling of babies and children. The risks may arise from an ergonomic mismatch where employees stoop, lift, or squat, to work at awkward levels to reach the children, or where the child is ill, or has long term disabilities with complex needs. Children with disabilities may have unpredictable behaviour, be tearful and may feel insecure. They may find it difficult to understand what the carer is asking them to do.

21.1 Legislation

It is important to note that the same legislation for the moving and handling of adults applies to children. To be able to deliver seamless care to children some additional legislation applying to local authorities also needs to be taken into consideration.

Disabled children’s needs are in large part assessed under section 2 of the Chronically Sick and Disabled Persons Act 1970.

All children with a disability are ‘children in need’ and local authorities have an obligation under Section 17 of the Children Act 1989 to assess their needs and provide appropriate services. This act also covers other children whose health or development is at risk.

Looked after children are covered under Section 22 of the Children Act 1989 where the local authority have a duty to safeguard and promote the welfare of any child they are looking after.
The NHS Act 1977 underpins the health care provision of equipment and adaptations.

The legislation that applies to the provision for children include:

**Social Services Legislation: social care, equipment and adaptations**
- Chronically Sick and Disabled Act 1970
- Children Act 1989
- Carers (Recognition and Services) Act 1995
- Carers and Disabled Children Act 2000

**Housing legislation: home adaptations**
- Housing Grants, Construction and Regeneration Act 1996

**Education legislation: equipment and adaptations**
- Education Act 1996
- Code of practice on the Identification and Assessment of Special Educational Needs 2002

### 21.2 Risk Assessment

As with all manual-handling tasks, a suitable and sufficient formal risk assessment must be carried out by an appropriately trained person. In addition to this, informal risk assessments should be on going.

Working with children is never simply applying the principles of moving and handling on their own. Coordination and close liaison between a network of agencies is essential to ensure all are working together towards a common aim. Links are essential between health and all sectors including social services, housing, education, the voluntary sector, charities and families.

When assessing handling needs, those working with children need to consider all aspects of development, emotional growth, mobility, intellectual stimulation, recreation and assistance with personal care. When developing those activities there needs to be a clear definition of the aims of that activity and each carer who risk assesses the child must be able to justify and support their reasons for a particular approach. The continuing welfare and development of the child has to be balanced with the health and safety of their carers. Activities should be realistic, achievable and safe.

Remember all children have the right to opportunities; however, no one will ever be able to have access to all opportunities.

Carers working with children where they have to continually stoop, bend, or work in awkward postures to reach the children, have an ergonomic mismatch, so consideration should be given to:
- Good ergonomic planning of the workplace to reduce the need for hazardous actions.

- Careful selection of equipment and its suitability for both staff and children.
- Height adjustable equipment for staff to work at comfortable heights e.g. height adjustable changing tables, or height adjustable plinths to raise the child to a seat (cycling or riding) rather than lifting the child.

- Children should be encouraged to help move themselves around within the limits of their ability.

Even small children with disabilities may present handling problems may due to disorders of coordination and muscle tone. Children with disabilities present handling problems due to stiffness, floppiness, weakness, presence of splints and braces, or the need for specialist seating and other equipment.

When assessing for moving and handling equipment for disabled children consider what the Department of Health Integrating Community Equipment Services (2003) says about children’s equipment:

- Equipment is provided in order to develop their full potential, maintain their health, achieve independence as far as possible and be part of family life.

- Children’s equipment often needs replicating in a variety of different settings, or needs to be portable, e.g. home, school, respite care, play schemes, residential care. Equipment needs to be compatible so it can be used in different settings with minimal duplication.

- Children grow and develop and their needs change frequently. Equipment needs reviewing regularly.

21.3 Therapeutic Handling

Sometimes physical handling of children is undertaken as part of treatment programmes by therapists and is often referred to as therapeutic handling.

The Chartered Society of Physiotherapists 1999 says:

“Therapeutic handling is handling as an integral part of a patient physiotherapy management programme.”

“There can be distinguished from the need to handle patients just to move them from place to place, sometimes referred to as care handling.”

- There must be an individual risk assessment with documentation of treatment goals and the risk assessor able to justify and support their reasons for a particular approach. As with all manual handling, risks must be reduced. Equipment used as appropriate.
- Treatment goals must be realistic and achievable for both the person and those delivering the service.

- Requires additional skills, training and understanding above those needed for routine daily tasks.

- Should only be carried out by therapists, who have a professional duty to only perform tasks, which they are safe and competent to deliver, or persons specifically trained and judged to be competent to undertake the particular tasks in the particular circumstances.

- The same applies where handling techniques are delegated to family members. There has to be recognition that parents often do not perceive moving and handling a child as a cause of musculoskeletal injury and may be tempted to risk their own health and safety to give the child every opportunity to develop. The child’s continuing development depends on them providing consistent care. Therefore delegation to family members should be in accordance with agreed local protocols. There needs to be thorough risk assessment, adequate training, competency assessment and supervision.

- Remember under the Manual Handling Operation Regulations (1992) “care handling” or “therapeutic handling” still carries the same duty of care to ourselves and others.

21.4 Handling Babies and Children - some guidance on care handling

21.4.1 Lifting from the floor

The numerical guidelines for lifting and lowering (Health and Safety Executive (HSE) 2004) and the child’s risk assessment should be used as an indicator to determine when mechanical equipment should be used e.g. hoists, inflatable cushion seats.

Children may spend much of their waking time on the floor. Babies, small children and some disabled children will require assistance to get up.

A baby or small child may be manually lifted by one handler if assessed as safe to do so (The Guide to the Handling of People (2005) pages 261 - 262).

Some children can be encouraged to get up themselves from the floor, by turning themselves onto all fours and using secure furniture to push up on.

For an older child unable to get themselves up mechanical equipment such as hoists or inflatable cushions should be used.

21.4.2 Assisting children to walk

Many carers find that assisting a small child to walk can cause back strain. This may be due to the different height of the child to the carer, causing the
carer to maintain a stooped posture whilst also giving support to the child. With risk assessment, a stool on castors (wheeled therapy stool) that the carer can manoeuvre their feet while supporting the child may be considered. Care must be taken to ensure that this system of work does not pose other risks of slips, trips and falls by undertaking a risk assessment. There has to be awareness though, that handling whilst sitting presents other risks to the carer. Also, it is not advisable to support a child by holding their arms or hands above their head. For technique, see The Guide to the Handling of People 5th Edition Page 154.

If walking is part of a therapy programme for a child, consideration by therapists should be given to the use of a hoist with a walking harness, or an active hoist. For some children wheeled walkers may provide the support in walking they require.

For older and taller children assistance can be given as for an adult.

22.0 Monitoring / Auditing and Review

NHS Leicester City will monitor and audit this guidance in accordance with the arrangements as defined within the Policy for Moving and Handling (2010 – 2013).
23.0 References

- Backcare in collaboration with The Royal College of Nursing and The National Back Exchange.


- National Back Pain Association in collaboration with the Royal College of Nursing.


- Preston K.W. ‘Positioning for comfort and pressure relief: The 30 degree alternative’, Care-Science and Practice 6 (4); 116 - 119, 1998

- Graphics by Phil Allen
### APPENDIX 1: EQUALITY IMPACT ASSESSMENT TOOL / SUMMARY REPORT

Leicester City Community Health Service
Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration.

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<th>Yes/No</th>
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<tr>
<td><strong>1.</strong> Does the policy / guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
<td>Policy: Procedures for the Moving and Handling of Patients</td>
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<tr>
<td>• Age</td>
<td>No</td>
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<td>• Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
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<td>• Sexual orientation including lesbian, gay and bisexual people</td>
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<td><strong>2.</strong> Is there any evidence that some groups are affected differently?</td>
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</tr>
<tr>
<td><strong>3.</strong> If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>4.</strong> Is the impact of the policy/ guidance likely to be negative?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>5.</strong> If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>6.</strong> What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>7.</strong> Can we reduce the impact by taking different action?</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
FINDINGS

GENERAL

To promote best practice techniques when lifting or handling loads (people or inanimate objects) at work, maintaining the well-being of staff, patients and service users during manoeuvres.

Specific equality areas (age, disability, gender, race, religion or belief, sexual orientation)
No adverse impact found

EQUALITY OUTCOMES

Under the Human Rights Act 1998 the Trust is committed to ensuring that everyone’s rights are considered and that everyone is treated with respect

Safe handling techniques which protect staff and patients.

Further Actions

<table>
<thead>
<tr>
<th>Problem/barriers identified</th>
<th>Actions to overcome problem/barrier</th>
<th>Resources required</th>
<th>Responsibility</th>
<th>TARGET DATE</th>
</tr>
</thead>
</table>
