G13	Standard	Podiatry service moving and handling (M&H)

Systems are in place to cover all reasonably foreseeable manual handling situations when providing **podiatry services**

Justification

Rationale

It is important to identify the manual handling risks to staff in safely and effectively:

- assisting patients with mobility issues who require podiatry services
- using tools in potentially prolonged and difficult static postures
- transporting necessary equipment.

These will vary, dependent on the setting – clinic or domiciliary.

Authorising Evidence

HSWA (1974); MHOR (2004); MHSWR (2000)

Links to other published standards & guidance

HSE (2008); HSL (2004); HSL (2006); NPSA (2008); Ruszala et al (2010); Society of Chiropodists and Podiatrists (2001)

Cross reference to other standards in this document

B2-6,7,8,10,12,13; G8,10,14-16,18; H1,2

Appendices

11, 13, 14, 28

Verification Evidence

- requirements for compliance to achieve and maintain this standard

- An agreed approach, informed by evidence-based best practice, documented in the M&H policy, disseminated to all staff and embedded within the department/ service
- Risk assessments (for M&H) that are 'suitable and sufficient', robust and balanced
- Safe systems of work and standard operating procedures
- Individual person assessments where necessary – readily accessible and regularly reviewed
- Ergonomics is integral
- Information and communication systems – including documentation
- Competent, healthy staff, in sufficient numbers
- Training (theoretical and practical) and supervision
- An environment conducive to good care (space, layout, etc.)
- Handling and other equipment that is suitable (fit for purpose) and readily available
- Investigation of and learning from adverse events, using root cause analysis to locate the cause and prevent a recurrence SFAIRP
- Monitoring, audit and review of the verification evidence
- Points learnt from audit, and accident/ incident investigations and reports are disseminated and discussed with staff, with subsequent learning
- Reporting of the status (level of compliance) to the organisation
- Action plans to correct any lack of compliance
- The culture is one of learning rather than 'blame and shame'
- Staff work within protocols and record as necessary

G13 Protocol - Podiatry service moving and handling (M&H)

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NB: This protocol will be reviewed and re-issued later in 2014, as version 2, with two new elements that were not available at the time of publication, namely:

- Podiatric surgery
- New seating

1. Introduction and background

There has been an increasing awareness that podiatrists are exposed to risk factors leading to very high levels of musculoskeletal disorders. These are predominantly associated with poor working postures and static holding. Seventy-one per cent of podiatrists reported experiencing lower back trouble within the previous 3 months. On any given day, the data suggests that 45% of podiatrists experience low back problems, 31% experience shoulder problems and 26% experience wrist problems (Lee and Jones 2004/HSL, 2004).

Lee and Jones published other findings in their report related to the working postures and prolonged static muscular work, which are summarised here:

- General posture affected by environment, furniture and equipment/tools
- Repetition and duration inherent in the work
- Changes in work environment, between clinic and domestic settings
- Environmental issues related to lighting, temperature and reach to equipment
- Forces applied to the patient's foot
- Psychological issues

All of these issues were investigated and recommendations made to mitigate the adverse effects, under the following headings:

- Equipment design
- Podiatry tools
- Tools for
- Clinical layout and storage of equipment
- Training
- Patient management and education

Some of these are incorporated in the protocol, below, under the appropriate headings.

Tina Craggs, M&H Specialist at Lincolnshire NHS Shared services, conducted a study in her area which she presented at the NBE conference in 2004. This study built on the work of the Lee and Jones study and that of Edmundson (2000). She made detailed recommendations regarding working positions and furniture to make these safer. The recommendations were implemented and this resulted in a significant reduction in work-related sickness-absence and the achievement was recognised by the gaining of an NHS Back in Work Award.

2. Management, organisation, supervision and support

Health and Safety Laboratory (HSL) (2006) studies found there was the potential for increased postural and manual handling risk when making domiciliary visits. They identified that services must examine the case for clinic vs domiciliary treatment, also recognizing the impact on logistics, transport and access to treatment issues.

Service providers should pay attention to patient management and education.

3. Staffing levels

Treatments are usually given by podiatrists working alone, particularly in the domiciliary setting. They are therefore limited as to the assistance they can provide for those persons with more significant mobility problems. In large clinical areas assistance can be sought from other staff.

4. Staffing competencies (after Benner, cited in Ruszala et al, 2010)

Novice – all students and un-qualified podiatrists with little or no experience.

Advanced beginner - some students, qualified podiatrists and new staff with some prior experience of assisting persons with impaired mobility. There is some awareness of postural risks.

Competent - qualified podiatrists who have received additional training in postural/ back care awareness, moving & handling of persons and have been assessed as competent.

Proficient - qualified podiatrists who have received additional education and training to include supervisory and assessment skills.

Training should encompass: -

- The curriculum in college
- CPD
- Induction
- Product purchase information
- General awareness training (Lee and Jones, 2004/HSL, 2004)

5. Environment

With reference to the available HSL studies (2004, 2006, 2008), the environment is identified as one of the major contributory risk factors as regards postural strain for podiatrists/ chiropodists. Suitable access to the person's foot may be harder to achieve in the domiciliary setting and lack of control of the working layout will lead to increased flexion and reaching to treat the foot and also to access tools.

Clinic settings will allow more control of these factors and the use of specialised, height adjustable seating and support for both the podiatrist and person. The treatment room should be large enough to incorporate a mobile, wheeled podiatrist's/ chiropodist's chair that would be able to move around the whole of the foot end of the person's chair. This facilitates greater movement of the podiatrist's whole body thereby reducing the amount of bending, stretching, twisting and reaching. Sufficient space is required to permit safer transfers for the person who may need assistance with standing or getting onto/off of treatment couches.

6. Communication and information systems regarding initial referral

Referral systems should provide accurate information on the mobility level of the person and whether assistance, mobility aids and/ or equipment may be required, so that adequate preparations can be made, including assignment to a more suitable clinical setting. The need for transport can also be ascertained at this point.

7. Treatment planning

The main aim of any manual handling in podiatry services will be to facilitate and allow effective treatment of the person without undue risk to the podiatrist. Mobility of the person may be directly or indirectly affected by any necessary treatment. The overall aim is to improve the person's foot health which should positively impact on their mobility.

8. Moving and handling tasks

These will be associated with the positioning of persons receiving podiatric care. Tasks may include assisted walking, standing, transferring, sitting as well as adjustment of position on treatment chairs or plinths in order to enable ease of access to the part of the foot to be treated.

In addition it may be necessary for the podiatrist to manipulate the person's lower limbs or be involved in manually lifting an immobile person's feet from floor level. If the person has suffered leg oedema, and is relatively immobile, then the force required to lift the leg will be significant and potentially hazardous (HSE, 2004). Another aspect is the application of force when using tools such as clippers (HSL, 2006).

Risks associated with these tasks are potentially higher in the domiciliary setting than in the clinic.

9. Moving and handling assessment

Guidance in the Manual Handling Operations Regulations (MHOR) as amended (HSE, 2004) and Health and Safety in Podiatric Practice (SCP, 2001) requires a

generic or task based assessment to be undertaken to ensure that a clinic is properly designed and equipped.

The general risks can be assessed with a view to applying standard operating procedures (SOPs) for many of the regular handling tasks and standard transfers where the person's ability is predictable, and this approach can be applied to the handling of inanimate loads. This assessment should identify which handling tasks will be necessary, where assistance may be required, the number of staff required and any equipment to be used.

Postural assessments using Rapid Entire Body Assessment system (REBA; Hignett and McAtamney, 2000) have been used to attempt to quantify the level of exposure of podiatrists to the workplace MSD risk factors already mentioned above, especially relating to the posture.

10. Methods, techniques and approaches

In line with other care professions, there should be an emphasis on encouraging person involvement in his/her mobility to ensure as much independence as possible, with the necessary regard to person and staff safety.

11. Handling equipment

NB: In this section and the next references are made to items of equipment. Where possible generic terms have been used, but in some cases specific equipment that has been found to be effective is mentioned. The inclusion of a specific manufacturer or supplier does not represent an endorsement by the authors. Other companies may make similar or better products.

In the clinic setting, treatment couches should be fully adjustable for height and profile to ensure access to the areas of the foot to be treated.

The use of a correctly placed slide sheet can facilitate positioning on treatment chairs. Whilst there is always the option of treating a person in a wheelchair, it may be preferable to transfer the person to the treatment chair. For this, additional equipment may be required. This may include small sliding boards for seated (sit to sit) transfers; turntables to assist persons who have difficulty in moving feet round during a seated or half standing transfer; a turning device with a handle (e.g. a Rotastand) for those who need added security when transferring to the chair. There is a new item of equipment, the Arabian Stool (www.centrobed.com) that could prove to be useful for podiatry/ chiropody.

12. Other equipment and furniture

The seated podiatrist will also need appropriate support. Specialized seating such as the saddle seat, designed to alleviate neck, shoulder and lower back pain, or frontal support seating can reduce the degree of forward flexion.
In the domiciliary setting, portable leg supports for persons, use of kneeling mats (e.g. Zurich kneeling mat) and kneeling stools (e.g. Norwich Back Pal Kneeling

Stool) for the podiatrist/ chiropodist have proved beneficial. Both are available from Carbonlite Medical Technology. Transporting kit can be made easier by the use of wheeled kit bags, folding trolleys or back packs e.g. poc-kit bag available from www.biston.co.uk.

Bariatric treatment chairs or couches will need to be available for those patients exceeding the safe working loads of standard equipment available. Consideration will also need to be made for waiting room furniture (see also G15).

13. Risk rating for each task

To carry out a 'suitable and sufficient' assessment, each task should be evaluated as part of the assessment process, so that the level of risk is quantified. Such assessments should be used, wherever possible, in the design of a safe system of work, and in highlighting any residual risks.

Various systems exist, but it is suggested that the NHS risk management 5x5 matrix, with 0-25 scale, is used for an overall evaluation of risk (NPSA, 2008) (see CD1, appendix 9 in folder 5). It is in common use, simple to use with 5 levels of risk, determined by a calculation of the likelihood or probability of an adverse event occurring multiplied by the severity of consequences or impact should it occur.

Likelihood/Probability (0-5) x Severity of Consequences or Impact (0-5) = 0-25

The values below are based on this system. Calculations lead to the following possible scores or ratings: -

1– 6 = Low; 8 – 12 = Medium; 15 – 16 = High; 20 = Very High; 25 = Extreme

These ratings can then be used to alert staff, to prioritise action and justify any necessary expenditure to make the situation safer, on the basis of reasonable practicability. Options can be evaluated by considering risks, costs, and actions planned or taken, to reduce the level of risk to the lowest level that is reasonably practicable, which can thus be demonstrated.

For assessing postural risks and those associated with tasks other tools are more appropriate, such as RULA (Hignett S & McAtamney L, 2006), REBA (Hignett S & McAtamney L, 2000) and OWAS (Karhu et al, 1977). These not only look at postures but forces.

14. Alerting the moving and handling team

Access to M&H advice should be sought if any standard procedure is difficult to apply, or if any problems arise due to a specific mobility need (such as assisting a bariatric person with limited mobility) for either the person or member of staff.

The M&H team can help with more detailed assessments and problem-solving, giving advice on the suitability and availability of equipment.

15. Referral to, and involvement of, other specialists

Information on the level of mobility and assistance required together with any special considerations can be sought from nurses, specialists such as tissue viability nurses, occupational therapists, physiotherapists, or physicians involved in the person's care.

In cases where treatment to the person might affect his/her mobility, this information should be relayed appropriately.

16. Transport

Persons requiring wheelchairs may need assistance in movement within the clinic, therefore sound principles for moving a wheelchair should be adhered to.

In the domiciliary setting there is also the consideration of transporting equipment necessary to treat the person. Podiatrists will generally attend using a car and move their own tools to and from the car and the person's home when carrying out treatment. It is common practice, for hygiene reasons, to carry a full complement of tools for each individual person. As stated in HSL/2006/60, there is presently no specific guidance for podiatrists on the size and weight of their kit bags. However, there is guidance in the MHOR (2004), so that individuals could make informed decisions when deciding what to take with them on domiciliary visits. A suggested maximum weight for kit bags is 13 kg, which is considered relatively safe, if not comfortable, for 95% of the population to lift (HSE 2006). Risks from carrying can be reduced with the use of wheeled kit bags, folding trolleys or back packs as previously mentioned (section 12).

17. Discharge and transfer planning

N/A

18. References

Benner, P (1984) *From novice to expert: Excellence and power in clinical nursing practice* Boston: Addison-Wesley, pp 13 – 34 as cited in Ruszala S, Hall J and Alexander P (2010) 3rd ed Standards in Manual Handling Towcester: NBE

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Edmundson, J (2000) *The Epidemiology of Musculoskeletal Disorders within Yorkshire and North Lincolnshire* British Journal of Podiatry November 2000

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HSE (2004) *Manual handling Manual Handling Operations Regulations 1992 (as amended) Guidance on Regulations L23* 3rd edition Sudbury: HSE Books App 3

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Karhu O, Kansi P, Kuorinka I (1977) *Ovako Working-posture Analysis System* in Applied Ergonomics Vol 8 Issue 4 p199-201

Lee, D and Jones A (2004) *Musculoskeletal Disorders in Podiatry & Chiropody Professionals (preliminary report), ERG/04/07* as cited in HSE HSL (2008) RR 647 *Musculoskeletal Disorders in Podiatry & Chiropody* Professionals Authors: Leah C & Birtles M http://www.hse.gov.uk/research/rrpdf647.pdf Retrieved 14.04.12

NPSA (2008) National Patient Safety Agency *A Risk Matrix for Risk Managers* www.npsa.nhs.uk Retrieved 18.02.13

SCP (2001) *Health and Safety in Podiatric Practice* The Society of Chiropodists & Podiatrists Professional Practices Committee https://docs.google.com Retrieved 08.02.2012

Further reading

BackCare (2005) *The guide to the handling of people* 5th edition Smith J (Ed) London: BackCare

Other useful web sites

http://www.carbonlite-medical.com/acatalog/norwich-back-pal-kneeling-stool.html for kneeling stool

http://www.carbonlite-medical.com/acatalog/zurich-knee-mat.html for knee mat

http://www.biston.co.uk for poc-kit pack (point of care back pack)

http://www.centrobed.com for the Arabian Stool for bandaging & ? podiatry

Summary/ Key Messages

- **The intention of the entire strategy and standards document is to contribute to the improvement of: -**
  - The quality of care - 'patient experience' (dignity, privacy and choice)
    - clinical outcomes
  - Patient/ person safety
  - Staff health, safety and wellbeing
  - Organisational performance – cost effectiveness and reputation, etc.

- **The standard for G13 is:**

Systems are in place to cover all reasonably foreseeable manual handling situations when providing podiatry services

- **Skilful M&H is key**

- **Special points for G13 are: -**
  - **Staff working postures (increased flexion and reaching) and static holding particularly in the domiciliary setting to treat the foot or access tools**
  - **Transporting a person with mobility issues to a clinic vs treating the person at home**
  - **In clinic settings access to:**
    - **a fully adjustable couch for height and profile**
    - **special staff seating - saddle or front support seats**
    - **an environment conducive to good foot care**