G14	Standard	Paediatric moving and handling (M & H)

Systems are in place to cover all reasonably foreseeable handling situations in managing children, in: - e.g. children's wards; A&E; outpatients; hospices; child development centres; nurseries; schools (special or mainstream); pools; horse-riding and activity/adventure centres; and in their own home. Non-routine paediatric handling is planned for and dynamic risk assessment (RA) is utilised.

Justification

Rationale

The need for the manual handling of children is self-evident; babies and small children need to be handled, e.g. picked-up, restrained, mobilised, in a variety of settings. Those with a mobility impairment will require assistance to move when they are older and heavier. Staff working with children (from neonates to 19 years old, and in some cases up to the age of 24) are exposed to various risks from the condition of the child or the variety of environments encountered. Particular care must be given to the need for floor work by staff, when carrying out care and therapeutic activities, to reduce the impact of MSD. Consent and child protection issues, and child advocacy may also be involved.

Authorising Evidence

HSWA (1974); Children Act (1989); Children Act (2004); Education Act 2011; Equality Act (2010); LOLER (1998); MHSWR (2000); MHOR (2004); PUWER (1998); Safeguarding Vulnerable Groups Act (2006)

Links to other published standards & guidance

Alexander and Johnson (2011); All Wales Passport (2010); APCP (2010); CSP (2008); DH (2000); NICE (2004) CG137; NPSA (2008); RCN (2007); Ruszala et al (2010); UN (1989)

Cross reference to other standards in this document

A4,5,13; B8,9; C1-4, 8-10, 13,14; D1-6, 8, 20-22; E5; F; G2-4,6,7,9-11,15,17, 19, 21,27,31,35,39; H; K1

Appendices

4,10,11,13,14,21,26

Verification Evidence

- requirements for compliance to achieve and maintain this standard

- Parents and family carers (and where possible the child) are involved in all decisions and there is a child-centred approach
- Policies reflect the organisation's commitment that the welfare of the child is paramount, consistent with its responsibilities under statutory law
- Strategies that offer the best safety, outcomes and quality of care have been implemented throughout the organisation to cover all paediatric manual handling situations
- All research-based practice and local guidelines have been consulted and are followed. Practice is audited
- Generic assessments are carried out and developed into SOPs/protocols, which are implemented, with staff trained to the required level of competence
- Paediatric handling plans are reviewed as required
- Staff are familiar with the process of dynamic risk assessment, and are able to alter strategies as needed
- Supervision, delegation and referral is appropriate
- Staff have specific manual handling training that is appropriate to their work
- All manual handling equipment deemed necessary, as a result of the RA, to assist staff and children in therapy, other treatment and care, has been provided
- Adverse events, including shortage of staff and lack of equipment are reported, investigated and appropriate action taken

G14 Protocol – Paediatric moving and handling (M&H)

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1. Introduction and background

This protocol gives outline guidance. More detailed guidance is to be found in *Manual Handling of Children* (Alexander and Johnson, 2011).

The most likely body parts to be injured in staff working in a paediatric setting are their wrists and knees (Crawford & Lane, 1998). Many lower limb problems result from working on the floor, and from crouching and kneeling which are frequently required in this setting (Haslegrove et al, 1997). Sitting on inappropriate chairs is also known to add to these risks (Crawford & Lane, 1998). Nursery workers are especially prone to musculoskeltal disorders (MSD) (Grant et al, 1995; Shimaoka et al, 1998).

There is an increased likelihood of MSDs for staff and parents as children get older and heavier. This is especially the case in children with degenerative diseases, e.g. Duchenne's Muscular Dystrophy, where their mobility tends to deteriorate as they become heavier.

Many staff visit children in a variety of locations, often under the responsibility of an employer other than their own. This can involve working in a setting over which they may seem to have little direct control of risks. However these situations are covered by the Management of Health & Safety at Work Regulations (2000), which state that employers sharing premises or delivering services jointly, must co-operate to ensure (SFAIRP) a safe environment.

Strategies must be developed to optimise the potential of the child – to provide the best clinical outcomes. This planning will usually be carried out by senior therapists in conjunction with the rest of the MDT and will involve the parents and the child. The strategy will take the form of a programme of activities and positioning. It is common practice to delegate the delivery of the programme to ensure that it is operational throughout 24hours, seven days a week. Essential elements are delegated to non-therapy staff or family members. This requires in-depth risk assessments, including both the child's and carer's ability and willingness to carry out these plans. All such strategies must be evidence-based, and staff planning, organising and delegating must show their clinical reasoning when selecting one method over others. Consent issues and child advocacy may also be involved in this process.

2. Management, organisation, supervision and support

There is a duty of care owed to staff to whom therapeutic tasks have been delegated. Condoning or ignoring hazardous situations must not occur, as healthcare staff owe a duty of care to others (APCP, 1999).

Staff must be supported by management, especially when multidisciplinary teams are involved. Sufficient time must be scheduled for peer-support, mentoring and staff meetings and this should be recorded.

The needs of parents and family carers must be considered.

3. Staffing levels

There must be sufficient staff available at the relevant time to carry out the required tasks. This should be identified on the recorded risk assessment (CQC, 2010).

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

The categories are: - Novice (N); Advanced Beginner (AB); Competent (C); Proficient/Practitioner (P); Expert (Ex)

Staff working in the field of paediatrics may be qualified therapists, nurses, therapy assistants, HCAs, teachers, or learning support staff. All those delivering a therapeutic programme should be seen to be competent in this work. If the staff available do not reach this level, then the programme may need to be adapted, or staff trained to the required level. A process for developing and assessing competence must be implemented, consisting of a systematic approach such as – 'explain, demonstrate, observe and record'. A robust system for assuring competence is required to ensure quality and safety, whilst encouraging career progression.

M&H requires various levels of competence. In some areas high levels (P or Ex) will be required, because of the complexity and/or difficulty of the task, or the consequences of making a mistake, as for example in the case of children with actual or suspected spinal cord injuries (see also G9). A great deal of damage can be done through incorrect handling, with long-lasting, sometimes irreversible consequences. The importance of competence in this area cannot be overestimated. It is important therefore that competence is assured by means of training, assessment and supervision. However a novice, under the guidance of a more experienced handler, can 'start the journey' through the levels of skill, and motivation for this will come naturally from small successes gained.

<u>Novice</u>
New staff (registered and unregistered), including newly qualified nurses, therapists on their first rotation, new teachers, support workers (learning support workers, HCAs, therapy assistants or family carers), students with little or no knowledge of therapeutic handling. They will require training support, close supervision and guidance.

Advanced Beginner
Someone who has been in post for several months, has undergone induction and foundation training and started to build their experience, and can transfer this into new situations. Close supervision is no longer required and they can carry out regimes of exercise, and treatment activities under some supervision. Typically they will be fairly junior substantive staff or more senior students.

Competent
Handlers in this category are more experienced. They have gained insight and see the picture as a whole, so that they can look at the child holistically. Typically they will be a senior therapist/nurse, but could be an experienced support worker or family carer.

Proficient
A handler at this level will have an in-depth knowledge of human development and movement, and a sensitivity of touch and a degree of empathy that helps them elicit optimal responses from the child. They naturally integrate an intuitive approach with developed clinical reasoning. Typically they will be an experienced senior therapist or nurse and may be a clinical specialist. They should also have a sound knowledge of good manual handling practice.

Expert
A practitioner at this level is likely to be a leader in their field, conducting research, innovating and developing the evidence-base. They will be a source of knowledge and inspiration, locally at least, for less experienced staff and exercise a nurturing role. They will be involved in strategic decisions. Typically they will be established clinical specialists and/or MHPs /BCAs in a strategic role. (NB: Not all MHPs will have this level of skill in therapeutic handling and they should liaise closely with therapeutic handling experts.)

5. Environment

Children are treated and cared for in a variety of settings, e.g. children's wards; A&E; outpatients; hospices; child development centres; family centres; nurseries; schools (special or mainstream); pools; horse-riding and activity/ adventure centres; and in their own home. Whatever the setting, every effort must be made to create a safe environment for the child and handler/s (MHSW Regs, 2000).

When working in children's own homes, staff must only attempt those treatments that can be achieved safely, bearing in mind any lack of staff, or equipment and space constraints.

Working in a school or nursery setting may involve the visiting worker in following local manual handling policies as well as their own (MHSWR, 2000).

6. Communication and information systems regarding initial referral and entry to the system

Initial referrals to the paediatric service must be dealt with in a timely manner, as with many mobility impaired children the time of intervention is of great importance. This would be determined by clinical assessment. Delays in referral are likely to put the child and its parents at risk from inappropriate M&H.

Virtually all work done with children involves multidisciplinary and multi-agency working and the key to success is communication between all stakeholders, including the family.

7. Treatment planning

There should be clear clinical justification for the treatment approach employed. The number of handlers for each treatment handling technique should be recommended or specified (All Wales Passport, 2010, treatment handling section 'Patient ability criteria' & 'elements of a treatment handling RA'; also paediatric guidance on MH from the CSP, 2008).

If delegation of treatment from qualified to less qualified staff is required, then the delegator must ensure that the staff to whom they are delegating have the appropriate skills. It is also natural for therapists to develop treatment programmes which involve other professionals and parents in carrying them out. This is not strictly speaking delegation, but guidance and advice on this topic has been published (CSP, 2008).

Detailed practical guidance is to be found in *Manual Handling of Children* (Alexander and Johnson, 2011).

8. Moving & handling tasks necessary

The M&H tasks that may be required will vary from child to child and setting to setting and are too numerous to list; but children at one time or another may need assisting for the purposes of assessment, investigation, surgery, treatment, postural care management *****, rehabilitation, education, entertainment, socialising and care. They may need help into and out of/ on and off postural care equipment, therapy equipment, and play equipment, such as rebound mats. In addition they may need to get on and off horses and into and out of pools. Transport will need to be considered (see section 16).

***** NB: Postural care management should be incorporated as part of a 24-hour programme. This applies to acute, education and community settings.

Fifty examples of handling tasks are to be found in *Manual Handling of Children* (Alexander and Johnson, 2011).

The responsibility of a therapist/nurse may be complex, as it requires them to consider the development of the child, alongside the health and safety of themselves and others involved in the task (CSP, 2008).

Training in moving inanimate loads and in the use of specialised therapy and lifting equipment will be necessary for this group of staff (HSAW Act, 1974). Large pieces of equipment may require moving around, and will increase the risk to staff of musculoskeletal injuries; as will working for long periods in stooped or crouching, squatting or kneeling postures.

9. Moving and handling assessment

An assessment should be carried out at the first contact and updated as required. This must consider the needs of the child and the risks to both the child and handlers (staff and family carers). The assessment will identify the M&H tasks and set out how they are to be carried out, detailing not only the method but the numbers of handlers and any equipment required. Special precautions will need to be included and the clinical reasoning for the choice of approaches and techniques should be given.

Formal assessments will need to be supplemented with 'dynamic assessments' in response to rapidly changing circumstances.

Other items to consider will be the tolerance of the child and the competence of the handlers. Quantified risk assessments may need to be carried out (see section 13).

Manual Handling of Children (Alexander and Johnson, 2011) provides a range of assessment tools to define or determine: -

- Child size
- Child ability
- Child comfort
- Handler effort
- Handler discomfort
- Skill required
- Equipment required
- Risk level

Adventurous activities
Due to the expectation that children may participate in adventurous activities, there must be rigorous risk assessment carried out and recorded beforehand, to ensure the safety of child and assistant.
Further guidance can be found from the Outdoor Education Advisors' Panel at www.oeap.info/.

10. Methods, techniques and approaches

There should be clear clinical justification for the treatment and handling approach and any associated therapeutic handling. If a particular skill is required e.g. working under the Bobath or Conductive Education (Peto) school of treatment, then therapists must ensure that the guidance given to those carrying

out the work is specific to that child, and that those handling/treating the child are competent in that skill (CSP, 2008).

It is sometimes difficult to assist/put a child into/onto, or take out of or off equipment that is deemed necessary for their development or maintenance. In such cases a specific RA should be carried out to determine the safest method and help prevent undue risk to both the child and the handler/s.

11. Handling equipment

All paediatric handling plans should indicate the use of appropriate equipment as necessary to facilitate outcomes, quality of care and safety. As children are often treated in a variety of settings, the appropriate equipment may need to be duplicated, and must be compatible with any other equipment and furniture used, and the space available.

Many mobility impaired children use standing frames, walkers and tricycles. A risk assessment must identify safe ways ~~must be~~ devised to allow staff to assist children to access this equipment. For example this may require the use of a standing jacket and hoist to get a mobility impaired child on and off an adopted tricycle. Appropriate equipment and sufficient numbers of staff must be available to ensure safety during this work (LOLER, 1998; PUWER, 1998; APCP, 1999).

12. Other equipment and furniture

Other equipment may be required, and qualified staff must ensure their knowledge of equipment currently available by attendance at relevant training sessions, exhibitions, seminars and conferences.

<u>Therapeutic equipment</u>
Pillows, wedges and other positioning equipment may be used, as well as upright, supine and prone standing frames; side-lyers; ball pools; gym balls; sensory rooms; etc.

<u>Other equipment</u>
Wheelchairs, commodes and shower chairs may be required, as may beds, treatment couches and changing beds. Where appropriate and possible these should be height-adjustable.

<u>Equipment to help staff</u>
Height-adjustable wheeled stools/chairs will be required for staff assisting small children to stand and walk, and must also be provided for those therapy and school staff to whom this task may be delegated or those working at low levels. Staff frequently find that the "meditation" type of stool, which fits over the calves in kneeling, will modify the impact of this position.

NB: The list is not exhaustive.

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.

Due to the variety of settings, this may vary from low to extreme. Healthcare staff must ensure that they are not asking other staff to perform tasks that are beyond the competence of that person and hazardous, either to themselves or the child/young person.

It will often be necessary to assess the postural risks to the handlers. Various systems are appropriate to use, including OWAS (Karhu et al, 1977), REBA (Hignett S & McAtamney L, 2000) and RULA (Hignett S & McAtamney L, 2006).

A risk-benefit analysis may be utilised when risks are high and unavoidable.

Manual Handling of Children (Alexander and Johnson, 2011) provides a range of assessment tools to cover the risk factors and other factors that need to be taken into consideration including a method for showing the overall level of risk (see section 9 above).

14. Alerting the moving and handling team

Any complex manual handling situations not able to be solved locally should be referred to the M & H team as required.

15. Referral to and involvement of other specialists

Involvement of the MDT is essential in complex cases, as their professional opinions may be required in order to inform decision making. Family involvement is generally essential too.

16. Transport (internal and external)

A manual handling risk assessment must be undertaken prior to transporting a child in a vehicle (See section 9). Also for further information see www.rospa.com/roadsafety/.

Risk assessment should involve the child, parents or carer in the decision making process. Consideration should be given to child comfort, dignity and child protection.

Parents using their own vehicles to transport their children may need to be advised regarding the safest way of positioning and securing the child in the vehicle. In wheelchair accessible vehicles it is recommended that a 'floor docking pod' is used to secure the wheelchair.

The safety and comfort of children must be ensured when being transported by minibus. Child passengers can be ambulant or in a wheelchair. Occupied wheelchairs must be restrained using the appropriate wheelchair clamps, tie-downs and occupant restraint systems for each type of chair. The occupant must also have a suitable seat belt, as well as appropriate postural support.

The risk assessment for vehicle loading should consider the mix of passengers and their needs to ensure that all passengers, including staff, can travel in safety and comfort. Also, the overall weight of occupants and equipment needs to be considered when loaded in the minibus to conform to the maximum authorised mass (MAM). If this is exceeded there can be severe penalties. For further information see the government websites www.direct.gov.uk/motoring and www.direct.gov.uk/en/TravelandTransport.

Other factors to consider during transportation of a child in a minibus: -

- Identification of appropriate transport to suit the child's needs
- Wheelchair numbers on board the minibus (room for staff to manoeuvre)
- Length of journey (deadlines for administration of medication)
- Environmental conditions outside (weather, road-works, parking space and accessibility of the vehicle)
- Appropriate safety equipment, such as wheel clamps and seat belt systems
- Weight of wheel clamps, combined weight of child and their wheelchair (force applied when tightening the wheel clamps or the positions staff are adopting for these tasks)
- Competency levels of the driver and escorts (training needs)

Competency based training should be given to staff using specialist equipment such as wheel clamps, harnesses and tail lifts.

Transportation tasks may include: -

- Pushing/pulling wheelchairs
- Manoeuvring a manual wheelchair on/off the tail lift
- Manoeuvring an electric wheelchair on/off the tail lift
- Attaching wheel clamps
- Securing seat belt systems
- Securing wheelchair supports/ straps (lap or groin straps, foot supports, harnesses)
- Assisting a child to ascend/descend the vehicle steps
- Assisting walking
- Assisting a child on/off booster seat

Transportation tasks can be moderate to high risk if manual handling principles are not applied. Risk can be reduced by: -

- Assessment of staff individual capacity and competence
- Assessment of the individual needs of the child
- Clear communication between all parties
- Using best practice and appropriate equipment (kneeling pad or knee protectors when kneeling on the hard floor of the vehicle)
- Appropriate vehicle equipment and safety checks
- Update training.

17. Discharge and transfer planning

It is essential that this is considered and planned for from the outset. Home visits will often be required.

This process can be quite challenging with staff working across organisational boundaries, within health, education, social services and housing organisations. If the family move house, for example, it is essential that all important details are forwarded, along with relevant information and/or equipment to meet the child's needs.

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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 G14 is:**

Systems are in place to cover all reasonably foreseeable handling situations in managing children, in: - e.g. children's wards; A&E; outpatients; hospices; child development centres; nurseries; schools (special or mainstream); pools; horse-riding and activity/adventure centres; and in their own home.
Non-routine paediatric handling is planned for and dynamic RA is utilised.

- **Skilful M&H is key**

- **Special points for G14 are: -**
  - **A child-centred agreed approach, informed by evidence-based best practice, documented in the M&H policy, is disseminated to all staff and family and embedded within the organisation**
  - **Parents and where possible their child are involved in the decision making and treatment**
  - **Consideration is given to staff/ parents' postures particularly with floor work, carrying out care or therapeutic activities**
  - **Careful consideration is given to any supervision, delegation and referral**
  - **Evidence of adoption of an ergonomics approach, the provision of suitable equipment and layout is conducive to safe and efficient practice**