

G21	Standard	Therapeutic handling and rehabilitation
<p>Systems are in place for the rehabilitation process to enable the best clinical outcomes, whilst ensuring, so far as is reasonably practicable, the safety of the patient and the rehabilitation staff. Balanced decision making is essential. Therapeutic handling is an important part of this process.</p>		
<p>Justification</p>		
<p>Rationale</p>		
<p>Effective therapeutic handling, as used in rehabilitation, optimises clinical outcomes in terms of independence, function and quality of life. This should prove to be cost-effective as well as benefiting the patient. Skilled handling also impacts on safety for both patient and handlers, and this too is cost-effective. The importance of competence in this area cannot be overestimated.</p>		
<p>Authorising Evidence</p>		
<p>HSWA (1974); CQC (2010); LOLER (1998); MHOR (2004); MHSWR (2000); PUWER (1998); RAR (2010)</p>		
<p>Links to other published standards & guidance</p>		
<p>ACPIN (2001); All Wales (2010); CSP (2008); COT (2006); Crozier & Cozens (1998) HOP4; Betts & Mowbray (2005) HOP5; HOP6 (2011); NPSA (2008); RCN (2007 & 2010); Ruzala et al (2010)</p>		
<p>Cross reference to other standards in this document</p>		
<p>A4 - 7; B7 - 9; C1; D2 - 6; E5; F; G1,9,10,14 - 16,31,32,39,40; K; L1</p>		
<p>Appendices</p>		
<p>4, 9, 10, 14-16, 20, 21, 25; Attachments 21a, 21b & 21c</p>		
<p>Verification Evidence</p>		
<p>- requirements for compliance to achieve and maintain this standard</p>		
<p>Outcome measures demonstrate that all patients achieve their full potential following illness or injury.</p>		
<p>A multidisciplinary approach, which must include relevant staff in all services, and family carers, is made manifest in practice and documentation, by the following: -</p>		
<ul style="list-style-type: none"> • A therapeutic handling policy (as part of the general M&H policy) • Standards • A thorough and coherent assessment process, which identifies (amongst other things) the patient's level of mobility/independence • Multi-disciplinary team (MDT) meetings to discuss progress and set goals • A comprehensive rehabilitation plan to achieve the goals (including for example stairs) • On-going goal setting meetings to review and update the plan • Sharing information, through in-service training and team meetings 		
<p>Other essentials: -</p>		
<ul style="list-style-type: none"> • A person-centred approach • Access to expertise • Staff training and competency records • Staff working within their level of competence • Literature held in an accessible library or on-line • An environment conducive to rehabilitation therapy, with sufficient space for mobilising towards independence • An inventory of equipment • All equipment (handling, therapeutic and auxiliary), in hospital and at home suitable for the persons treated • Generic assessments are developed into protocols and SOPs. All patients/service users have adequate individual assessments and handling plans • All serious untoward incidents, including lack of appropriate staff and equipment, are reported and investigated, and learning from these is explicitly identified 		

G21 Protocol - Therapeutic handling and rehabilitation

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Note: In the context of rehabilitation and therapeutic handling the term 'patient' seems appropriate and is used in this protocol instead of 'person' or 'service user', except in direct quotes from referenced material.

1. Introduction and background

Rehabilitation is for patients who have suffered illness or injury, the aim of which is to restore them to their pre-morbid state, or if this is not possible, reach their optimal level of function. The risks associated with the moving & handling (M&H) of patients undergoing rehabilitation need to be prudently managed.

Therapeutic handling is employed in the treatment of patients undergoing rehabilitation. Systems must be in place to ensure that the best clinical outcomes are obtained, so that patients reach their full potential, whilst their safety and that of the staff are not unduly compromised. This implies clinical reasoning and 'balanced decision making' (A&B, X&Y v East Sussex, 2003) that takes all factors into account.

*"**Therapeutic handling** is manual handling in treatment, carried out by therapists but may be delegated to others, e.g. therapy assistants, students, family members, care staff. Therapeutic handling includes: - guiding, facilitating, manipulating or providing resistance. It may also be defined as any treatment where force is applied through any part of the therapist's body to any part of the patient's body" (CSP, 2008 a).*

*"**Rehabilitation** is a person-centred, active and creative process that may involve adaptation to changes in life circumstances. It is a shared activity between the person [patient, service user, etc.], people close to them, and the multi-professional teams who recognise the contribution of all concerned" (RCN, 2000).*

The RCN has produced an excellent workbook, *Role of the Rehabilitation Nurse*, providing comprehensive guidance on the topic (Hawkey and Williams, 2007). It contains several other definitions of rehabilitation and covers: - essential nursing skills; therapeutic practice; coordination; education; empowerment and advocacy; political awareness; advice and counselling; and clinical governance. This guidance is recommended for further reading.

In order to understand therapeutic handling it is necessary to appreciate the associated terms and context of manual handling.

Reablement (also known as Re-ablement) consist of “*Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living*” (Kent et al, 2000). It differs from conventional home care as it requires the active participation of the service user/patient and that of their family. Care must be taken when delegating tasks to family members to ensure they have been instructed in the process, are able to assess the improvement in their family member and adjust the support they give accordingly. Failure to do so can mean the family carer continues to offer more support than is necessary and unwittingly contributes to more dependency in the patient and increased manual handling for the carer. A fuller definition is provided in Attachment 21a at the end of this document.

Set out below is a more detailed consideration of the various types of manual handling.

Manual handling (MH). A manual handling operation (MHO) is defined as the transporting or supporting a **load** (including lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force. It includes both transporting a load and supporting a load in a static posture. The load may be moved or supported by the hands or any other part of the body, for example the shoulder. The application of human effort for a purpose other than transporting or supporting a load is not a manual handling operation (MHOR, 2004).

The **load** is a discrete moveable object, it may be inanimate (as in static or materials handling), or animate – an animal, a person or part of a person, e.g. a patient receiving medical attention and any part that needs to be manipulated as part of the assessment or treatment process.

Inanimate load handling

(In the context of rehabilitation this could be, for example: - positioning equipment or pushing wheelchairs).

For manual handling to be successful it requires that the handler has relevant knowledge and skills, a positive attitude and a measure of physical fitness (Regulated Activities Regulations, 2010).

It is suggested that the criteria of success will be: -

- Effectiveness – the operation is completed
- Efficiency – body mechanics are sound and a minimum of effort is expended
- Safety – no one gets injured and nothing is harmed. Risks are minimised. (Those at risk are the handlers.)

A number of methods or approaches have been developed, advocated or adopted in some areas. These seek to achieve effectiveness and safety by addressing efficiency. Handlers can be taught by a series of ‘rules’, or better still, learn about biomechanics and ergonomics and apply this theory in a principles-based approach.

Certain of these methods are said to focus on using the body *dynamically* through using ‘base movements’ (McClurg Anderson, 1951; Vasey & Crozier

1982), avoiding 'top heavy postures and movements' (McClurg Anderson, 1951; Vasey & Crozier 1982; Crozier & Cozens, 1998) throughout any handling and moving of the object/ person as may be required. These principles are incorporated in the Neuromuscular Approach to Human Movement (NMAHM)[®] (see section 10 and attachment 21b). This approach may be utilised in person handling and inanimate load handling.

Successful MH is easier to achieve where the ergonomics are good, whether this is brought about by systematic workplace design or improvisation in the home.

When the load is a person ~

This introduces another layer of complexity with many more factors to be taken into account. This and the possible vulnerability or fragility of a person who is a patient or service user, can add to the risks and necessitates a high level of skill. It is not only the handlers who may be at risk, but the person. It should be pointed out here that the person handling associated with control and restraint is not covered here.

~ (In this document the person referred to is a patient and 'patient' will be used in most cases, except where 'person' or service user' is more appropriate, as in the reablement situation, or in direct quotes from other sources.)

The handling of patients may be sub-divided into other categories (see table on p5), according to its purpose, although some suggest that there is no difference in practice; the proponents of the (NMAHM)[®] make this argument and this is included in Attachment 21b and quoted here:

"Although its concept, philosophy and methods can be tailored to focus on different areas of life activity, no single area is considered fully isolated from any other. Potential for differences may be perceived to exist between the areas of care handling and therapeutic handling, yet they are inherently linked. However in considering a potential continuum of knowledge and skills development, this is often weighted towards therapeutic handling. Experience directs that it may be care handling which may carry higher risk, and require a higher order of skills."

If distinctions are to be made to perhaps clarify terminology and practice, the various types are summarised as follows:

Care handling

The object is to support the activities of daily living (ADL) of the patient (Roper et al, 1980). Knowledge of the pathology of the patient group is essential in order to enhance quality of care and ensure patient safety, as the person is helped to re-position or transfer. Aids may be used and electrical/mechanical devices such as hoists and beds utilised to carry out the move.

"This is handling to facilitate a care need e.g. washing, eating and drinking. Whilst any handling requires the agreement of the patient, care handling does not necessarily require the active participation of the patient. It may be performed by less experienced staff in any care setting. Care handling should aim not to cause harm or delay the longer term goals of rehabilitation" (Williams, 2002).

Treatment handling

Any manual handling involved in a therapy programme may be defined as treatment handling. Under this heading can be included: - guiding, facilitating, manipulating or providing resistance; techniques that are not used or so well developed in care handling. Also, for OTs, the following: - *"guiding, facilitating, assisting, holding and positioning"* (COT, 2006 a).

Physiotherapists deal with human function and movement and help people achieve their full physical potential. They use physical approaches to promote, maintain and restore wellbeing (HPC, undated).

"This is handling which contributes to rehabilitation and ultimately the success of the rehabilitation programme. It does not necessarily require the active participation of the patient (e.g. passive movements, massage, positioning, de-escalation techniques). It must be performed by experienced staff who have specialist rehabilitation skills" (Williams, 2002).

Rehabilitation handling

Guidance from the College of Occupational Therapists (COT, 2006 b) is as follows:

"Lansdale et al (1995) suggest that rehabilitation handling is where the individual [person] is encouraged, guided and facilitated to move, in order to regain postural control and selective movement, and to learn functional motor skills. The CSP (2002), cited in Thomas (2005), also defines the aim of rehabilitation handling as encouraging people to move themselves, or being allowed the opportunity to contribute to their own movement."

"This is handling which actively pursues the person-centred short or long term goals. Rehabilitation handling aims to restore, or maintain, functional ability. It does require the consent and active participation of the patient. It needs to be performed by experienced staff who are conversant with the reasoning behind the goal-planning process within a programme of rehabilitation" (Williams, 2002).

Therapeutic handling

This term is usually associated with rehabilitation. It requires an even higher level of skill than care handling. This has to be based on a thorough understanding of neuro-physiology and neuro-development. Sophisticated techniques are employed to facilitate 'normal movement' (movement that follows physiological rather than pathological patterns). These techniques will attempt to normalise tone and inhibit abnormal movements or reactions.

Those involved in therapeutic handling should build on their knowledge of and skills in inanimate and care handling to develop a holistic approach that protects both the therapist as well as the patient. Whilst some approaches are holistic others are not. To focus purely on the patient, without considering the risks to the handlers, could be detrimental to those individuals.

Therapeutic handling is part of a patient's rehabilitation programme. It may be distinguished from care handling (and treatment handling) in that the patient actively participates at some level, by working with a skilled handler who guides, facilitates, manipulates or provides resistance to achieve a desired goal (CSP, 2008 b); whilst care handling is mainly concerned with supporting the basic

needs of the person (their twelve activities of daily life (ADL) (Roper et al, 1980). Another key difference is the aim of the activity – see table below for this and other distinguishing features.

Some comparisons between therapeutic handling and care handling		
Comparative factor	Therapeutic handling and rehabilitation	Care handling
Participation	Person actively participates	Person <i>may</i> be passive
Purpose/ aim/ objective	Rehabilitation – to improve or maintain function	Care – to support basic needs and ADL
Knowledge and skill level	Skilled → highly skilled in this area. Therapeutic programmes devised by therapists, some of which can be delegated.	<i>Can be</i> less skilled, but fully aware of the principles of safer moving and handling. All patient handlers receive relevant training and should be assessed as competent.
Methods, techniques and approaches	Therapeutic programmes individually tailored, goal orientated and structured in approach	Task orientated handling
Type of handlers	Generally therapists, from all specialities, plus other staff under supervision (and family carers)	Generally nurses, care staff (and family carers)
No. of handlers	May be higher	May be lower
Time required	Concentrated therapeutic sessions, e.g. duration 30mins – one hour	On-going throughout the day, variable duration for care tasks e.g. 5 – 30 minutes
M&H equipment	Use of therapeutic equipment such as – walking a person using a hoist with a walking harness or lift pants	M&H equipment such as a hoist or slide sheets, to move a person from a to b (transfer or re-position) often passively
Manoeuvres /MHOs	Some specialist approaches/ techniques, individually tailored, with elements of creativity	Relatively straightforward, using SOPs based on generic assessments, or when necessary, individual assessments
Levels of risk	May sometimes be higher than in care handling. Therapists sometimes take ‘calculated’ risks when handling therapeutically, to optimise the person’s rehabilitation, but this <u>always</u> has to be justified by clinical reasoning	Should be relatively low (as low as is reasonably practicable). Higher levels of risk cannot be justified, except in genuine emergency situations

As a simple example: a patient, in the early stages of recovery from a stroke, may be facilitated out of bed in the morning by a team of therapists who may

also be involved in combining this with dressing and toileting, etc. In the afternoon, evening or weekend, when staffing levels are probably lower and the patient urgently needs to use the commode, the nurses and care staff may hoist the same patient out of bed or chair. The first activity is rehabilitation involving therapeutic handling, whilst the second is a care procedure involving care handling. Both are perfectly acceptable at an appropriate time, provided that best practice and appropriate equipment are used and for example tone is not unduly altered, because the primary objective of the intervention is different.

All of the staff involved with persons undergoing rehabilitation will always have the foregoing in mind, and the division between the two types of handling may be somewhat arbitrary, but a patient-centred approach will call for the most suitable methods to be used according to the prevailing circumstances. Opportunities present themselves to the skilled handler during care handling to adopt a therapeutic approach with active participation by the person.

Most handlers who employ therapeutic handling base their practice on accepted approaches that are most suited to the person undergoing rehabilitation. Approaches are numerous and should be underpinned with research, evidence, knowledge, skills and understanding.

The guidance issued by the Chartered Society of Physiotherapy (CSP, 2008) and the College of Occupational Therapists (COT, 2006) is very comprehensive and readers are referred to these documents for further information.

2. Management, organisation, supervision and support

In rehabilitation units and other facilities where therapeutic handling takes place, there should be an appropriate organisational structure with all posts filled.

The culture should promote safety and learning, so that best practice is embedded in the unit and the whole organisation.

Equality and diversity should be catered for and form part of the organisation's/unit's policy.

"A rehabilitation policy may consider the following points:

- *The scope of the protocol – what rehabilitation includes*
- *Risk assessment procedures (generic and specific)*
- *Documentation guidelines*
- *The training, education and supervision requirements for staff at all levels*
- *Where the rehabilitation is to take place*
- *Who is able to undertake specific rehabilitation tasks*
- *The delegation of tasks to others"* (COT, 2006 c)

"The joint statement issued by the CSP, COT and RCN (1997) suggests that there may be conflicts between safer handling policies and the rehabilitation or maintenance needs of people. If people are to benefit from rehabilitation, then such conflicts need to be resolved by consultation and co-operation at policy and clinical levels. The joint statement suggests that assessment and understanding

of the roles of the multi-disciplinary team is key to rehabilitation handling being both effective and safe for all concerned" (COT, 2006 d).

All areas need to be managed and organised appropriately, from a safety point of view (MHSW Regulations, 2000), and from a clinical aspect according to recognised best practice for that speciality. Sufficient supervision and support is essential. Care must be taken to avoid hazardous manual handling (MHOR, 2004).

An excellent summary of the Professional and Legal Framework is provided by The Chartered Society of Physiotherapy in *Guidance on Manual Handling in Physiotherapy* (2008 c).

3. Staffing levels

Sufficient numbers of suitably qualified staff must be employed and rostered (CQC, 2010). These levels should be pre-determined, with provision for peaks in demand.

It is essential that the patient is given sufficient time for their rehabilitation. This is to allow for an approach that demonstrates that they are valued as well as permitting an unhurried therapeutic session. In many cases rushing a patient will lead to negative outcomes. Similarly the therapy and nursing staff must each have a case-load that enables therapy of the required quality. As with other aspects of therapeutic intervention, safety is paramount. Sub-optimal levels of staffing will impact on clinical outcomes and tend to lengthen inpatient stays and the duration of courses of treatment as an outpatient, all of which are costly. Staffing levels will need to be re-evaluated in the light of changes in demand.

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

Novice (N); Advanced Beginner (AB); Competent (C); Proficient/Practitioner (P); Expert (Ex)

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 patients with actual or suspected spinal injuries. 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.

Novice

New staff (registered and unregistered), including newly qualified nurses, therapists on their first rotation, new 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 person holistically. Typically they will be a senior therapist or nurse, but could be an experienced support worker or family carer.

Proficient

Handlers 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 person. 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. Handlers at this level can assess competence in others.

Expert

A handler 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 manual handling practitioners /back care advisors 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).

A robust system for assuring competence is required to ensure quality and safety in service delivery, whilst encouraging career progression.

5. Environment

High quality, safe, efficient and effective practice is rendered difficult or impossible in settings that are inappropriate. This is often overlooked; therefore attention must be paid to: - space and layout (including storage), flooring, lighting, other ambient conditions, equipment and furniture, in order to ensure good ergonomics (appropriate to fit the task of rehabilitation to the needs of the patient and the handler). If the working and clinical environment is sub-optimal (e.g. a lack of space) other control measures (from a recognised hierarchy) will be required to compensate. Two such hierarchies are to be found in Appendices 1 and 2 of the Guidance on Manual Handling Regulations (MHOR, 2004).

Settings may include; - the ward/ bedside; gym; PT/OT department; corridors and stairs; hydro pool; nursing/residential home; day centre and person's own home \$.

The clinical areas must be orderly and tidy and free from trip/slip hazards. They must also be scrupulously clean. Flooring needs to be fit for the purpose.

Bathing and toileting facilities may need special attention in order to meet the needs of the person.

It is important to maintain privacy for the person, with the appropriate use of screens and curtains.

Persons may be sensitive to certain environmental conditions and may respond well or adversely to a busy, stimulating scene. Ideally a quiet area, free from distractions, should be made available.

\$ Providing rehabilitation in the community is challenging and sometimes difficult to achieve in an environment that is less than ideal in terms of space, layout and available equipment. However, as predicted (DH, 2006) an increasing amount of interventions are likely to be carried out at home and this is likely to continue.

"Physiotherapists have a key role to play in delivering treatment in community settings, including the patient's home. Working in the community poses additional hazards that may be difficult to control" (CSP 2008 d). This must also be true of other professionals in this context.

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

Effective communication is vital, so that the correct information is relayed between the various teams and individuals involved in the 'patient journey' so as to ensure a smooth transition between each setting, e.g. when moving from an acute setting into the community where care may be taken over by NHS intermediate, primary or continuing care teams, social services or private agencies. (See also section 17 – Discharge and transfer planning).

Joint working between the various members of the MDT is vital and the person and his/her family should be involved in all key decisions. The following is a list of elements that should be put into place to ensure that this aspiration is achieved. (The list is not exhaustive): -

- Policies, procedures and protocols that emphasise multidisciplinary working to ensure a consistent approach based on best evidence-based practice
- Standard setting for rehabilitation activities
- Action plans that are designed to implement and embed the policies, procedures, protocols and standards
- Monitoring, auditing, review and reporting of the above
- Benchmarking against other similar units/organisations
- Assessment systems that link to care planning, where possible utilising integrated care pathways (ICP)

- Joint assessments (to include community staff as soon as possible before discharge)
- Notes accessible to all team members
- Goal setting meetings
- The whole team contributes to and updates the handling plan
- Joint therapeutic sessions #
- Joint teaching sessions as part of in-service training
- Joint learning by review of incidents/adverse events
- Joint home visits
- Liaison with other agencies (multiagency working)
- An outreach programme

Joint therapeutic sessions

Examples include: -

- PT working with the SLT to obtain and maintain an optimal position for swallowing or speech
- PT and OT working together on dressing practice

7. Treatment planning – goals, etc.

At all stages of a patient's journey through the healthcare (and in some cases, social care) system, in various settings, treatment must be planned by the multidisciplinary team and goals agreed with all concerned. Care must be taken to ensure that steps in the process are not missed in these situations.

Safety considerations for patient and handler/s need to be integrated with sound clinical reasoning when planning the most suitable approach and methods.

When balancing the risks involved in the numerous situations that can arise and the resources available at the time, it may be appropriate to utilise different methods according to the circumstances. So hoisting a person at one time where care handling is indicated and facilitating a more active transfer at another may not be incompatible. The person's condition is a main factor; so, a person may be taken by wheelchair to the toilet so that they are not distracted by the urgency to pass water or open their bowels, but assisted to walk back to their bed or sitting area when they are able to concentrate on their rehabilitation.

Therapeutic handling should be coordinated with medication when necessary to bring about an effective outcome. This is particularly important in fluctuating conditions, e.g. Parkinson's disease, and where pain is a factor, e.g. after surgery.

There should be a comprehensive rehabilitation plan, documented, showing clear progression by using outcome measures. In this way progression can be made whilst maintaining a high level of safety for both patient and staff. As an example, a patient progressing from bed mobility, through stages, to the use of stairs prior to discharge, should have a rehabilitation plan with milestones and a plot of progress against time. Appropriate equipment should be used and this may include overhead tracking (OHT) in conjunction with vest/harness when using a treadmill or stairs.

Rehabilitation plan

The plan could form a part of the record of treatment. The normal details of patient's name, date, therapeutic handler/s name/s and signature/s would of course also be included in the record.

A rehabilitation plan, following a thorough multidisciplinary assessment (see section 9), should include the following elements, probably in tabular form for ease of use.

There are two components that need to be linked – the treatment plan (with progress chart) and the handling plan.



Treatment Plan

- Problem list, showing clinical reasoning and detailing all of the issues that need to be addressed
- Mobility or independence level at present
- Goals in global terms – immediate, short-term and long-term, agreed with the MDT, patient (and family)
- Outcome measures, milestones and 'SMART' # goals
- Patient consent (informed and written)
- Planned activities – to address each item in the problem list, with transparent clinical reasoning
- Details of approach and methodology
- Setting or environment for treatment
- Treatment equipment (as opposed to handling equipment)
- Identification of M&H required (see Handling Plan)

Treatment Progress (this record should accompany the treatment plan)

- Response to treatment plotted against milestones
- Amended mobility or independence level
- Amendments to problem list
- Next planned activity
- Achievement of goals and outcomes

Handling Plan

- Identification of M&H tasks required

For each task: -

- Current level of mobility or independence (Mobility Score, Mobility Gallery or FIM)
- Activity (manual handling operation) e.g. sit ← → stand
- Purpose of activity, related to treatment plan
- Method for – e.g. manual, sliding, mechanical, hoisting
- Use of SOPs or patient individual procedures (PIPs)
- Number and roles of handlers
- Handling aids/ equipment
- Warnings and precautions
- Risk reduction measures (RRM)
- Risk level for patient and handlers (see section 13)

Each intervention should be recorded, detailing responses, variances, progress, etc. and this must be located so that it is accessible to all relevant staff.

Reviews should be conducted –

- a) Periodically
- b) When any significant change occurs in the TILEO risk factors

'SMART' goals, (Specific, measurable, achievable, realistic/relevant with a time-frame)
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Checklists are useful and may be used (with care and with supervision if necessary) by members of staff who may not be fully conversant with the considerations used by therapists. As an example the table below sets out the checks that should be made before attempting weight-bearing activities:

Checklist to be carried out before progressing to any weight-bearing activity	
Element	Check method
Ability to understand and follow instructions	Check records and discussion, including careful questioning
Informed consent	Verbally, possibly with written agreement (A protocol will need to be in place for patients unable to give consent)
Appropriate clothing and footwear	Clothing should be loose but fastened securely. Footwear should be firm and supportive with low heels and securely fastened.
Sitting balance	Able to sit unsupported and reach outside the base of support and recover – a patient that could safely be left sitting unsupported
Upper body strength	In unsupported sitting, able to resist gentle but firm displacement by the handler
Upper limb strength	In sitting: Able to push up from chair using upper limbs to raise bottom off chair. Also able to grasp and manipulate walking aids
Strength & function of lower limbs	Able to work against gravity – strength Oxford 3 (see below)
NB: Flexibility can be checked whilst assessing strength, as can	Able to work against gravity plus resistance provided by handler - strength

abnormalities of tone, response to touch and pain, also skin condition.	Oxford 4 Normal – strength Oxford 5
➤ Hip flexion/flexors	In sitting: raise knee (Oxford 3)
➤ Knee extension/ extensors (quads)	In sitting: raise foot to straighten knee (Oxford 3) and hold knee straight v. some resistance (Oxford 4)
➤ Knee flexion/hamstrings	In sitting: bend knee against resistance
➤ Ankle & foot joints and muscles	Move foot up and down and in and out
Other preparatory work RRM – If the patient is unsafe i.e. requires more than verbal instruction, then the method can range from: practise with harness + hoist/ suitable stand aid/ lift walker, to assistance of two or one handler	In sitting: <ul style="list-style-type: none"> - Moving to front of chair, by weight transfer and 'walking' on bottom ('shuffle'), or by lifting bottom - Placing hand/s at front of chair arms - Moving feet back (one foot may be a little further back than other) - Leaning forwards from the hips - Looking ahead - Pushing down on hands and feet - Raising bottom off chair - Able to move hand/s from chair to walking frame/ other
An explanation of the Oxford scale: Measurements of muscle strength and function – Oxford scale (Lee, 1978) 0 = no contraction 1 = flicker of contraction 2 = contraction when gravity eliminated 3 = muscle contraction against gravity 4 = muscle contraction against gravity and some resistance from handler (with care) or against a weight attached 5 = normal	

8. Moving & handling tasks

In order to meet a patient's needs safely, a full range of manoeuvres might be necessary, during their pathway from admission (or start of the episode of care) to discharge. They will require various transfers and repositioning to enable: - assessment, investigation, diagnosis, care, treatment, surgery, rehabilitation and transport – and to ensure excellent (i.e. the best possible) outcomes.

A list of these should be prepared for risk assessment, evaluation and development (where appropriate) into standard operating procedures (SOPs). These should be signed and dated at the time, with a date for review (important for audit and litigation). SOPs should be reviewed as necessary.

9. Moving & handling assessment

All the M&H tasks identified for the purposes listed above must be assessed (MHOR, 2004). This can be done generically in connection with the drawing-up of SOPs, or individually. In emergency situations assessments will need to be

made rapidly, but not so fast that safety is compromised. Forward planning for every reasonably foreseeable eventuality, such as falls and emergency evacuation, will minimise the occurrence of true emergency handling #.

Assessment in the context of rehabilitation is perhaps even more important than in some other types of patient handling, because of the activities and risks involved. The patient must make progress, but in a way that does not unduly put them or the handler/s at risk. Balanced decisions should be made based on thorough assessments that take these factors into account. In order to make such balanced decisions it will be necessary to evaluate and quantify all of the risks, so that they can be compared (see section 13).

The initial assessment must take all relevant risk factors into account using the '**TILEO**' format: -

Task

- The tasks involved (see Section 8)

Individual capabilities (of the therapeutic handler)

- Skills and competencies in M&H, and in organisation and communication
- Physical capabilities
- Health status
- Empathy

Load (the Patient)

This part of the assessment is made by following the normal methods of assessment, by taking a detailed history from the patient (and possibly the relatives) and by reference to their notes/ records. The symptoms the patient describes, or complains of, completes the **subjective** element of the assessment. After this a thorough examination will elicit the **objective** evidence, and the subjective and objective evidence together should enable the **analysis** of the patient's condition and point the way to formulating the treatment **plan**, by a process of clinical reasoning. The handling plan will link to the treatment plan.

- The person's medical condition and the effects of medication
- Handling history – history of falls
- Physiological risk factors
- Communication, comprehension and cognition difficulties
- Psychological/behavioural risk factors
- Sensory and perceptual deficits, including sight and hearing
- Challenging behaviour – aggressive, confused, unpredictable
- Frailty, emaciation or dehydration
- Pain or fear
- Circulatory and respiratory problems
- Attachments (e.g. drips, drains, catheters, external fixation)
- Tissue viability
- Size and weight
- Trunk stability and upper body strength

- Balance in sitting and standing
- Weight-bearing ability
- Musculoskeletal status – weakness, paralysis, stiff or unstable joints
- Neurological factors – spasms/spasticity, rigidity, epilepsy, athetosis (dystonia) or choreiform movement

The patient’s capability can be categorised so that they are grouped conveniently for care and treatment planning, utilising one of a number of systems, such as: -

- Mobility score (MS) (see Sections B and F of the main document)
- Arjo Mobility Gallery (Knibbe & Waaijer))
- Functional Independence Measure (FIM) } (Fray M, 2011)
(Granger et al, 1987))
- Oxford / Sunrise Medical system, based on FIM)

These systems are set out in outline in a comparative table in the main document (CD1), Appendix 9 in Folder 5, p19-22.

Load (Inanimate)

Inanimate loads used in connection with the treatment (equipment, furniture, etc.), will require assessment and the usual risk factors will need to be taken into account. All other loads that need M&H should be assessed as a separate exercise.

Environment

- The environment in which therapeutic handling is taking place (see Section 5).

Other factors

- Organisational and psychosocial factors may also need to be considered.

Further assessment tools

A range of assessment systems are available for more detailed assessments regarding handling. These are more sophisticated and are applicable in certain circumstances, for determining risks to handlers, person tolerance, etc. Systems include: -

- REBA and RULA
(Hignett & McAtamney, 2000 & 2006))
} (risks to the handler)
- OWAS (Karhu et al, 1977))
- Skill level of the handler (after Benner, 1984)-----)
- Perceived exertion for the handler } (Fray M, 2011)
- Comfort and dignity for the person)

Many other assessment tools are available for assessing the patient clinically and a small selection is mentioned here.

There are several validated assessment tools which can be used, such as the: -

- Tinetti Balance Assessment Tool (Tinetti et al, 1986)
- Berg Balance Test (Blum et al, 2013)
- Cannard Falls Risk Assessment Scoring Chart (undated)
- Timed Get Up And Go Test (Mathias et al, 1986)

Two further points about assessment should be made here:

Firstly, therapists as a matter of practice, continually assess whilst treating their patients and respond to the feedback they receive, so that assessment and treatment are part of a continuous process.

Secondly, all healthcare workers should respond to emergency or rapidly changing circumstances by carrying out a dynamic risk assessment (MHOR guidance 52). This 'informal' process is sometimes referred to as 'POSRA', (a Personal on the Spot Risk Assessment).

Both are informal and are recorded after the event.

10. Methods, techniques and approaches

The overall aim is the promotion of functional independence, however as the developers of the NMAHM ® continue to identify "*Variations in methods can make it difficult for personnel who are required to move and handle to discern which methods can pragmatically more assuredly assist professional and occupational practice*". Whatever the approach there must be discussion within the MDT to ensure team working throughout the 24-hours, seven days a week care. The use of more than one approach requires, for successful outcomes, that the team understand how they are likely to interact.

There are several different approaches used in therapy treatments. For example; physiotherapy for stroke could be based on the Neuro-Developmental Approach (NDA) or the Motor Relearning Approach (MRA). The developers of the NMAHM® also state that: "*The approach is applicable at any and all stages of the recovery-therapy- rehabilitation spectrum to deal with overcoming local issues and general movement-based function*".

Concepts and approaches

Therapeutic intervention is often a mix of components from different concepts and approaches to promote recovery of disability and independence. Evidence-based guidelines rather than therapist preference should serve as a framework from which therapists should derive the most effective treatment (Kollen et al, 2009).

The Bobath concept and Motor Relearning Programmes are popular approaches to neurological rehabilitation.

The Bobath Concept

The current definition of the Bobath Concept is; *"a problem-solving approach to the assessment and treatment of individuals with disturbances of function, movement and postural control due to a lesion of the central nervous system"*. (Institute of Bobath Instructors Training Association, IBITA). The IBITA also states that the Bobath Concept aims to identify and analyze problems within functional activities and participation in everyday life as well as the analysis of movement components and underlying impairments. The British Bobath Tutors' Association (BBTA) supports this view and adds that successful goal acquisition in a given task must be practiced to improve efficiency of movement and promote generalization in everyday life. (Kollen et al, 2009).

The Bobath Concept is also known as Neuro-developmental approach.

The Motor Relearning Approach

Motor Relearning is a task-orientated approach to improving motor control, focusing on the relearning of daily activities. Motor learning provides practice or experiences leading to change in the capability for producing skilled actions. (Jette et al, 2005)

Examples of other approaches

The BBTA advocates the use of evidence-based adjunctive treatments such as strength training, mental practice/mental imagery, treadmill training, modified constraint-induced movement therapy, electrical stimulation, orthotics and many others (Kollen et al, 2009). Patients often have multi-pathology and various therapeutic approaches can span across specialities and this may involve a multidisciplinary therapeutic approach. For example certain stroke patients may benefit from circuit training in the gym, (van de Port et al, 2012).

Supervised exercise programmes given to patients receiving treatment for cancer, reduce depression rates (Frontline, November 2012).

Motor relearning programmes can be applied when using robotics.

Proprioceptive Neuromuscular Facilitation (PNF) is a motor learning approach used in neuro motor development training to improve motor function and facilitate maximal muscular contraction.

Other, specific interventions could be used such as; musculoskeletal techniques, electrotherapy modalities such as: Transcutaneous Electrical Neurological Stimulation (TENS), Biofeedback, and Functional Electrical Stimulation (FES).

More complex strategies could be used such as the treadmill and un-weighting system (graduated weight-bearing) and robotic based interventions.

Methods, techniques and approaches should be appropriate to the patient and the handler's abilities. It is useful to have guidelines for the various techniques and procedures that are available, providing: -

- Indications
- Contraindications
- Alternatives and modifications

“Safe therapeutic handling is an integral part of the management of clients with neurological disability and good handling provides the basis for many neurological rehabilitation interventions. Facilitation of selective, automatic, more normal movement patterns and postures underpin much of the work of the neurological physiotherapist, and safety of both client and therapist is paramount throughout assessment and treatment” (CSP, 2008 e).

Advice and support should be sought as required, from the therapeutic handling experts or M&H team (see section 14).

The number of handlers should be determined on the basis of an individual risk assessment or SOP.

Great care must be taken when assigning tasks (whether by delegation or referral) to ensure that each handler is sufficiently competent and that adequate support and supervision is maintained (CSP, 2008 f).

The selection of techniques may be likened to the method employed in granting permission for pharmaceutical companies to release new drugs, the criteria being: -

- Safety
- Tolerance by the patient
- Efficacy
- Cost-effectiveness

A great many patient factors need to be taken into account with many considerations, precautions and contraindications to be aware of.

Patient factors: -

- Personal preferences
- Privacy/dignity/choice
- Personal space
- Aversion to touch
- Race/ethnicity
- Cultural differences
- Sex/gender
- Sex/gender orientation/identification
- Legal issues
- Mental status/capacity, due to e.g. mental illness, learning disability or dementia
- Communication issues

Helpful strategies include: -

- Agreed 24-hour approach with MDT

- Involving the person, explaining and gaining informed consent
- Involving the family and other informal carers (where appropriate)
- Empowering, giving back autonomy, using such language as "Let me know when you're ready"
- Acting in the person's best interest if informed consent cannot be achieved
- Not invading the person's personal space without permission
- Being professional
- Ensuring privacy and covering body parts that are not being treated
- Being empathetic
- Using chaperones
- Person's advanced statement of needs

Stairs

This topic is covered in Attachment 21c (see also G22)

11. Handling equipment – in a rehabilitation setting

"The judicious use of equipment during rehabilitation handling situations is advocated by Ruszala (2001) & Busse (2000). Both studies found that the use of hoists allowed therapists and carers to undertake rehabilitation, whilst reducing the burden of 'supporting' the person for long periods" (COT, 2006 e).

Sufficient supplies of suitable handling equipment must be provided, according to the needs of the person. This may mean that equipment is provided temporarily – by internal loan, renting or lease. Sharing of such equipment between wards or units should only be contemplated where this is a feasible option – i.e. not compromising the quality and safety of care by incurring delays or difficult transport of items, nor introducing infection control risks (see G8). Lack of equipment should be reported, as an adverse incident, to a line manager.

Equipment must be fit for purpose with appropriate SWL for the patients and service users served (LOLER, 1998; PUWER, 1998).

Appropriate handling equipment, properly used, allows the therapist, other healthcare professional, or family carer to work safely and significantly reduce risks (as far as is reasonably practicable) to both the patient being handled and the handler. For example: A patient can be facilitated to walk, at an earlier stage of the rehabilitation programme, using a walking harness or lift pants in conjunction with overhead tracking, a gantry or a mobile hoist.

Handling equipment is a complimentary adjunct to therapeutic handling and does not replace the handler's skilled input.

Therapeutic equipment can prove cost-effective as well as enhancing the quality of treatment. It can be used creatively to encourage normal movement, and to enhance mobility, strength, core-stability and balance. The person being treated can be motivated, stimulated, feel safer, and have fun when using equipment in the therapeutic setting.

Use of certain equipment may be more efficient, reducing the number of staff required for the activity and therefore reducing their collective time spent with the patient. For example: An obese patient who had suffered a stroke is assisted to stand by three staff, in the early stages of the rehabilitation programme. If this patient is assisted to stand using lift pants/walking harness and hoist, staff numbers might be reduced and costs therefore reduced.

The cost-effectiveness derives from the accelerated progress and better clinical outcomes that can be achieved, thus reducing: - length of inpatient stays (and avoids delayed discharges); duration of outpatient courses of treatment; and on-going morbidity and dependency.

Research provides the evidence-base to justify the rationale for use of certain equipment. The evidence-base underpins best practice, and provides a guide to making decisions in practice. Evidence-based research may be used to justify the cost of more expensive therapeutic equipment when applying for funding or planning expenditure.

Therapeutic handling covers a wide scope and therefore therapeutic equipment falls under many different categories, depending on the patient's condition and individual therapeutic needs. It is recommended that therapists keep up to date with the advancements in equipment technology, which brings many new products on the market. Attending trade shows, fairs, exhibitions, conferences, courses, arranging demonstrations of new equipment by company representatives, keeping equipment catalogues updated, reading equipment reviews in professional journals are examples of ways to maintain knowledge and competency.

The following table shows examples of types of equipment and the areas of rehabilitation where that may be used:

Category of equipment	Therapeutic equipment (Examples)	Area of rehabilitation
Hydrotherapy	<ul style="list-style-type: none"> • Hydrotherapy weights • Floats 	Neurological, Musculoskeletal, Paediatric, Orthopaedic
Paediatrics	<ul style="list-style-type: none"> • Upright-standers • Prone-standers • Supine-standers • Hoist/ gantry used with a walking harness or lift pants 	Paediatric
Standing equipment	<ul style="list-style-type: none"> • Tilt table • Standing bed • Adjustable standing table • Sit to stand hoist • Rota stand • Return 	Neurological, Musculoskeletal, Orthopaedic, Care of the elderly, Medical
Strengthening equipment	<ul style="list-style-type: none"> • Weights • Medicine ball • Theraband 	
Walking aids	<ul style="list-style-type: none"> • Sticks 	All

	<ul style="list-style-type: none"> • Crutches • Frames • Handling belts 	
Walking equipment	<ul style="list-style-type: none"> • Treadmill • Treadmill with an un-weighting system • Hoist/ gantry used with a walking harness or lift pants • Lift walker 	Neurological, Paediatric, Pulmonary, Bariatric (within SWL) , Orthopaedic, Musculoskeletal, Cardiac, Medical
Stair equipment	<ul style="list-style-type: none"> • Gym stairs • Hoist/ gantry used with a walking harness 	All
Balance equipment	<ul style="list-style-type: none"> • Wobble board • Pilates ball • Trampoline • Balance disc • Balance performance monitor 	Neurological, Musculoskeletal, Orthopaedic, Care of the elderly, Medical
Equipment for general fitness, cardiovascular and stamina	<ul style="list-style-type: none"> • Static bike • Rowing machine 	Neurological (specialised circuit training), Musculoskeletal, Cardiac, Medical, Pulmonary, Care of the elderly
Electrotherapy	<ul style="list-style-type: none"> • Functional electrical muscle stimulator • Transcutaneous electrical nerve stimulator (TENS) 	Musculoskeletal, Neurological

The division between handling and therapeutic equipment is somewhat arbitrary.

Equipment provision in the community may include that for – intermediate care, residential and nursing homes or within the patient’s own home. Community equipment loan stores are now joint stores providing equipment to meet both ‘health’ and ‘social care’ needs. (Hutfield et al, 2011)

When purchasing equipment the costs of regular checks, servicing, maintenance and repair as specified in PUWER (1998) and LOLER (1998) will need to be factored in. Replacement costs need also to be taken into account.

12. Other equipment and furniture – in a rehabilitation setting

Under this heading two categories are considered –

- a) Auxiliary equipment
- b) Therapeutic equipment

Sufficient supplies of suitable auxiliary equipment must be provided, such as trolleys, beds, couches, wheelchairs, commodes, armchairs and specialist seating (see G40). Equipment must be fit for purpose with appropriate SWL for the patients served.

The importance of suitable seating for patients undergoing rehabilitation, especially neuro-patients and those with poor postural control, cannot be over-estimated. In many cases seating will form part of the therapy by aiding in the management of posture and helping to prevent tissue viability problems. Similarly, postural control systems may be indicated for use in bed.

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.

In complex situations other more sophisticated systems of assessment may be employed to supplement the NHS matrix. These will pay particular attention to such elements as the loading on the handler, comfort for the patient and capability of the patient (see Sections 9 & 10).

14. Alerting the moving & handling team

This will depend on the speciality and the situation. Patients undergoing rehabilitation may present with issues or an unusual combination of factors that require a problem-solving approach, and sometimes the M&H team may be able to offer expertise and to look at issues from a different point of view.

In the case of new builds, upgrades and changes in premises use, it is essential that the M&H team is involved at the outset and consulted for their ergonomics advice.

Reports of incidents and unusual circumstances should be passed routinely to the M&H team for monitoring purposes and to gain their advice in preventing a recurrence of a similar problem.

15. Referral to and involvement of other specialists

Involving relevant teams at the appropriate time will minimise the chances of harm occurring in a specific situation, and will also promote the provision of suitable measures for any future occurrences. M&H in specialist, unusual or emergency situations will sometimes require the input of such specialist advisors as those involved in: - tissue viability, infection control, fire safety, prevention & management of violence & aggression (PMVA), security, general H&S, estates, facilities. Care must be taken to ensure that appropriate referrals are not missed in these situations.

16. Transport (internal and external)

Transport within the department, clinic, hospital etc., must be catered for, with variable height trolleys, wheelchairs etc. Transport to other units may require vehicles and these too should be suitable. For example, transportation of bariatric patients will require special vehicles.

17. Discharge and transfer planning

It is essential that all such movements of patients from one care organisation to another or to their home are planned. This is particularly important when there are clinical complexities or complications, H&S issues, and where patients are bariatric. Planning for discharge ideally should start before or on admission to identify any complex issues that could delay discharge, so action can be taken early to plan care. The community staff and relatives should be involved from the outset.

A discharge plan is unlikely to be successful unless the patient and family are involved.

Early discharge teams such as intermediate care/ rapid response/ reablement teams, continue rehabilitation in the person's home when they are discharged from hospital. The aim is that care between hospital and community is a seamless process. Such teams offer time limited, intensive, interventions by a multidisciplinary team to rehabilitate the person in their home environment. This would include therapeutic or treatment handling.

Documentation regarding handling assessments, 'SMART' goals#, together with recommended approaches and methods for handling, must accompany the person home and be incorporated in the discharge summary.

#'SMART' goals, (Specific, measurable, achievable, realistic/relevant with a time-frame), are set by the multidisciplinary team

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Attachment 21a Reablement (Re-ablement)

Definition – ‘Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living’ (Kent et al, 2000)

Reablement aims to maximise independence helping service users to regain practical skills and confidence. (Rabiee & Glendinning, 2011) It differs from conventional home care as it requires the active participation of the service user/patient and that of their family. Care must be taken when delegating tasks to family members to ensure they have been instructed in the process, are able to assess the improvement in their family member and adjust the support they give accordingly. Failure to do so can mean the family carer continues to offer more support than is necessary and unwittingly contributes to more dependency in the person and increased manual handling for the carer.

Skills delegated to family members, by members of the reablement team or professions working in collaboration with the reablement team, should be aware that a direct duty of care is owed to the person undertaking a delegated task. (Guidance of Manual Handling in Physiotherapy, CSP 2008). Family members should be monitored and assessed for competency in delegated skills to reduce risk of injury to both themselves and the service user.

A reablement home care service provides:

- Short term input, the duration is usually 6 – 12 weeks
- An assessment, which is undertaken in the service user’s home
- Goal setting with the service user and their family
- Provision of specialist equipment
- Activities of daily living focused on enabling service users to maximise independence and confidence

Activities are often focused upon are dressing, using the stairs, washing and preparing meals.

Apart from physical input, reablement also includes social, environmental and emotional factors.

Reablement teams are often strengthened by appointing occupational therapists and other specialist staff (Petch, 2008). The reablement team should have access to specialist skills, in particular the occupational therapist and physiotherapist (PSSRU, 2010). Occupational therapists and physiotherapists may be core team members or work collaboratively with a reablement service. They can be involved in assessment, goal planning, delivering therapy skills and equipment and providing training to care workers who are delivering reablement.

Attachment 21b The Neuromuscular Approach to Human Movement(NMAHM)®

The following information has been provided by Lesley Crozier and Sheila Cozens:

"Movement Education Services (MovES) Ltd's Neuromuscular Approach to Human Movement (NMAHM®) is a system designed to help people move as healthfully as they feasibly can when going about their daily activities whether as part of general living, at work, rest or play – or when recovering from illness, injury etc.

The Approach deals simultaneously with the full spectrum of requirements associated with personal and professional movement practices. The definition of Efficient Movement within the Approach takes account of the unique integration of developmental, physiological, anatomical and mechanical factors which directly support personal and tissue-based health, safety and wellbeing. (* as defined by MovES Ltd)*

Systematic and holistically oriented, the Approach has shown useful and beneficial application over decades in many areas of movement practice including the ability to fulfil people's immediate health and safety, as well as longer-term wellbeing requirements while supporting optimal movement performance.

Such a way of dealing with general movement or more specialised areas of movement practices including manual handling, posture, exercise etc additionally permits an on-going check of match and fitness to engage or proceed with activity within the given ergonomics of the presenting situation and environment.

Although its concept, philosophy and methods can be tailored to focus on different areas of life activity, no single area is considered fully isolated from any other. Potential for differences may be perceived to exist between the areas of care handling and therapeutic handling, yet they are inherently linked. However in considering a potential continuum of knowledge and skills development, this is often weighted towards therapeutic handling. Experience directs that it may be care handling which may carry higher risk, and require a higher order of skills.

Informed and balanced decision-making processes developed within the teaching and learning of the Approach take into account immediate effects and future consequences for all. Patients are supported to optimise their potential in moving towards meeting agreed clinical outcomes within the allocated resources as far as is feasible whilst any compromise of their safety and that of involved personnel is reduced so far as selected, or reasonably practicable.

To assist practitioners in the field in developing reliable criteria to guide, assess or monitor practice standards Efficient Movement is placed within the NMAHM® as critical to better supporting safety.*

Using effectiveness (i.e. the intended outcome of the manoeuvre being met) to be 'the' primary criterion is considered to have potential to mislead practitioners. For example, in technique-based systems which focus the handler towards

effectiveness may significantly reduce attention paid to immediate, and longer-term health, safety and wellbeing". (Lesley Crozier and Sheila Cozens)

MovES Ltd are the originators, developers and primary purveyors of:

The Neuromuscular Approach to Human Movement (NMAHM)®, which is a holistic and systematic approach to the science and art of movement.

*As a **principle-based process** a unique versatility to its scope and practice is enabled on a practical level, in turn supporting potential universal applicability wherever movement is appropriate as an intervention strategy.*

The Approach encompasses movement activity in general, and also specialised areas of movement practice such as exercise and manual handling where health, safety and well-being are necessary considerations.

The primary focus of the Approach concerns the relationship between movement and health, safety and well-being - and how each may influence the other (on a localised and/or generalised, direct or indirect, beneficial or negative basis).

Further details from:

www.moves.org.uk

e-mail info@moves.org.uk

"Birchcroft", Station Road, Brightons, Falkirk, Stirlingshire, FK2 0TY

Attachment 21c Stairs (see also G22)

Patients should only progress to a flight of stairs following successful preparatory work in the gym, including gym steps. In most cases patients are only taken on a flight of stairs if they require supervision and prompting only. However, in some therapeutic situations a therapist may take a patient on the stairs who requires a greater degree of 'hands-on' assistance, such as facilitation and guidance. In no case should therapists (or delegated handlers) physically lift or take the weight of a leg whilst assisting.

Stair activity spans many therapeutic specialities and patient conditions. In some areas of rehabilitation there are protocols to follow regarding ideal times for commencing stair activity, such as in orthopaedics, following surgery, and in cardiac rehabilitation.

Climbing steps and stairs is an essential activity for most patients but is often the activity that takes longer to achieve when rehabilitating. The Functional Independence Measure (FIM) (Granger et al, 1993) is a tool widely used within the field of rehabilitation and can be used to assess and monitor the level of independence on the stairs.

The normal pattern of movement to go up/down the stairs reciprocally, however, this may need to be modified and the person taught to go upstairs leading with the unaffected or stronger leg and downstairs leading with the affected/weaker leg.

Steps and training stairs are usually situated in the gym areas of the hospital. An appropriate public flight of stairs, within the hospital, can be utilised for stair climbing with a person. Stairs selected within the hospital ideally should: -

- have a banister on either side
- not be a busy site
- be accessible in case of an emergency

Steps and stairs can be selected for rehabilitation purposes within the hospital grounds or in the community, e.g. as encountered on an occupational therapy 'home visit'.

A risk assessment must be undertaken prior to climbing stairs to determine the patient's ability and level of assistance required. This must include a careful consideration of the possibility of a fall and a plan of the action to be taken in that event by the therapist.

The action in such an eventuality may be re-direction, or in the case of a very heavy or obese patient, it may be necessary not to intervene. This consideration will include a discussion with all parties and conclude with the patient's informed written consent. Stairs should not be undertaken without going through this essential process.

The following is an example of a suitable patient undertaking stair activity, as part of a rehabilitation programme with therapeutic support:

Preconditions - the patient: -

- is medically stable
- is able to walk with the supervision or prompting of one therapeutic handler, with or without a walking aid
- is cognitively aware, e.g. can follow instruction and understands
- is fully informed
- consents to climbing/ descending stairs
- has well cared for feet with short toenails
- wears appropriate footwear and clothing
- wears appropriate spectacles and functioning hearing aid as necessary

Preconditions - method and precautions: -

- there should always be two therapeutic handlers present when accompanying the patient on the stairs, even if the patient requires the assistance of one when walking; the other is on hand in case an emergency situation arises.
- there should be careful assessment, planning and communication on how the person is to be facilitated on the stairs, between the two therapeutic handlers
- both patient and handler/s should be able to hold the banister/s

Special points to consider

Therapeutic handlers should not stand immediately in front or behind the patient on the stairs as there is a risk of injury if the patient were to fall onto them. The handler positions slightly to the side of the patient. This requires sufficient space to accommodate both the patient and the handlers without compromising the optimal positioning. The Handling of People, 6th Edition, chapter 13, refers to redirecting a falling person on the stairs (Sturman, 2011).

There are added risks when undertaking stair activity with obese and, to a greater extent, morbidly obese patients, and contraindications and precautions should be considered. Effective management needs a systems approach. A manual handling risk assessment must be completed that is specific to the patient and handlers ('HOP 6' chapter 13) and the patient must be fully informed and must have given written consent.

Obese people should be able to weight-bear and ideally be able to undertake stair activity with supervision or prompting. It may pose considerable risk to the therapeutic handler to redirect an obese person who is falling on the stairs.

Particular environmental constraints should be assessed prior to stair activity with an obese person. Stairs should be accessible, (e.g. near a ward and crash trolley), ideally a short flight with a landing where a chair could be placed. The banister needs to be of a solid construction with space to allow a good coupling of the patient's hand grip. The width of the stairs needs to allow room for the girth of the patient.

If the patient is unable to manage stairs (assuming their home has stairs), arrangements should be made prior to discharge, to consider alternative

solutions and provide, as appropriate, one or more of the following: - stair lift; through floor lift; powered wheelchair climbers. Ramps may be necessary for front/ back steps, etc. Re-housing to single level living accommodation may be another option.

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 G21 is:**

Systems are in place for the rehabilitation process to enable the best clinical outcomes, whilst ensuring, so far as is reasonably practicable, the safety of the patient and the rehabilitation staff. Balanced decision making is essential. Therapeutic handling is an important part of this process.

➤ **Skilful M&H is key**

➤ **Special points for G21 are: -**

- **Rehabilitation is an essential element of most therapeutic interventions**
- **Assessments that are robust and balanced are necessary to facilitate the process**
- **Skilled therapeutic handling helps to ensure: -**
 - **The best possible clinical outcomes**
 - **The best patient experience**
 - **Safety of the patient and rehabilitation staff**
 - **Effective use of resources**