Moving & Handling Strategy

An initiative of the London Group of National Back Exchange to provide

Standards for Handling People and Objects in Health and Social Care

Folder 5

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Appendix 9 – **"Person handling assessments and handling plans"**

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This appendix relates to Standard B7 - 'Person (patient/ service user) handling assessment (Straightforward)' **and Standard B8** – 'Person (patient/ service user) handling assessment (Complex)'

NB: Where equipment is mentioned, the purpose is to indicate the types of item that could prove useful. Generally, generic nomenclature is used, but occasionally specific items and manufacturers are named where an item may be unique. Other equipment firms may make or supply equivalent (or better) products. The inclusion of a manufacturer's name does not represent endorsement by the authors or the London group of National Back Exchange. Readers must apply their knowledge of products and their risk assessment skills to evaluate the efficacy and safety of equipment in order to determine the most suitable product for each situation.

Procedures for person handling risk assessment

Introduction

The overall purpose of conducting risk assessments is to reduce the likelihood of harm occurring, in this case to either staff or persons during handling procedures. The law requires that all potentially risky handling is assessed and that action is taken to reduce any identified risks to as low a level as is reasonably practicable. The assessment should be 'suitable and sufficient' and should be documented (Manual Handling Operations Regulations 1992). To aid compliance with our obligations a system has been devised to facilitate person handling assessments and it is essential that the process is undertaken for all persons.

This system was introduced in another organisation and has been used in that and other organisations for 6 – 12 years. It is the culmination of a good deal of development work and consultation and has evolved in the light of experience and feedback from clinicians and practitioners in the acute community, mental health and learning disability settings.

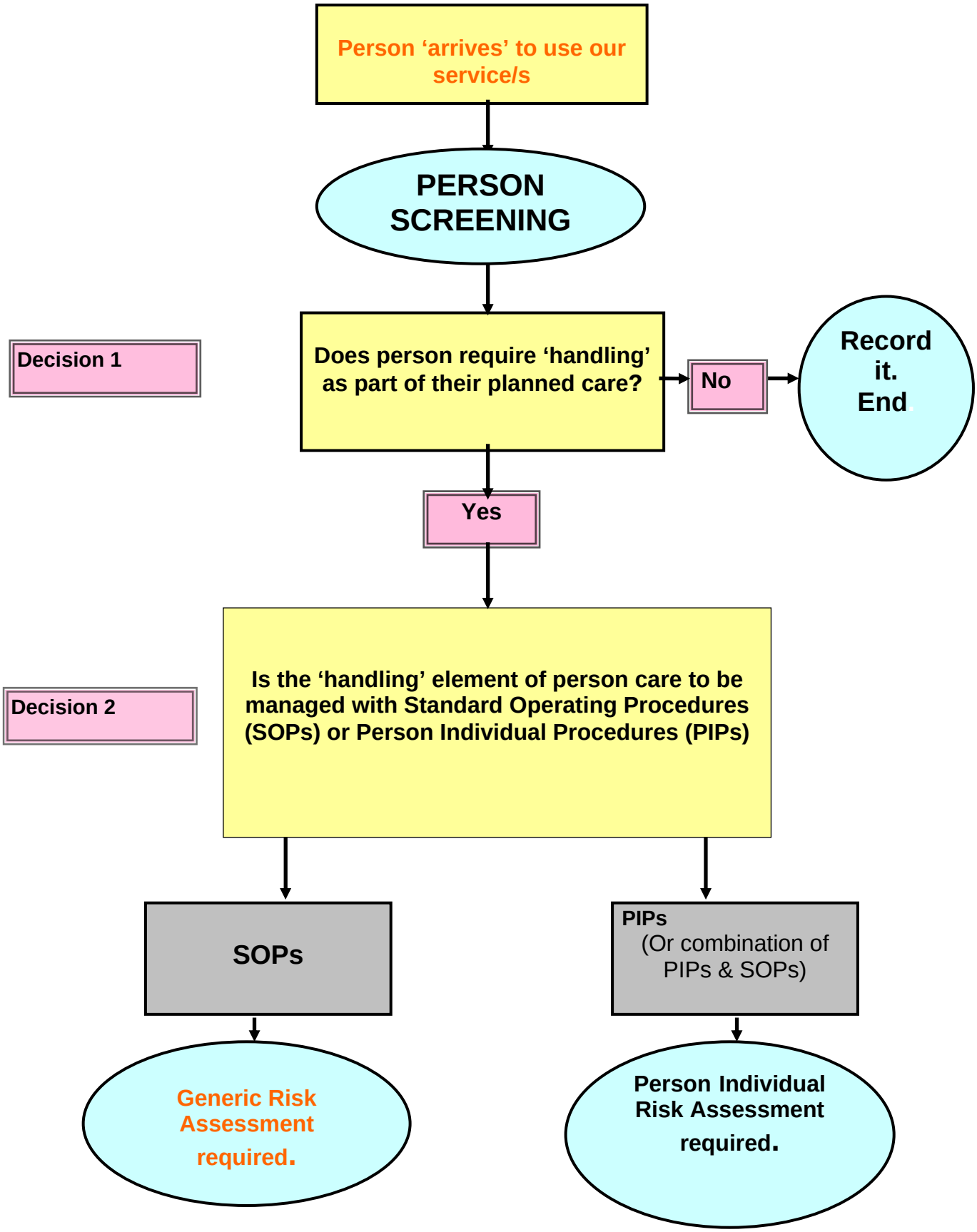
NB: These documents are legal records and could be produced in a court of law in the event of a prosecution or litigation. They will also be required in the event of an accident/incident investigation or a complaint and may be inspected by any one of the many inspection and audit bodies empowered to do so. As with other medical records they may be made available to the person concerned.

In day-to-day use these forms are to facilitate person care and improve safety for staff and persons, by identifying the handling needs and any associated risks.

Outline of the process

At the first point of contact with the person an initial assessment is carried out. Two questions have to be asked and two decisions made.
Firstly, does the person need assistance to move as part of his/ her care? If not continue no further. If the person does need help, continue.
Secondly, can the person's care be managed by means of 'Standard Operating Procedures' ('SOPs')? If yes, allocate the relevant procedures; if no, carry out a more detailed assessment, and design and implement 'Person Individual Procedures' ('PIPs').

Flowchart


Person 'arrives' to use our service/s
PERSON SCREENING
Does person require 'handling' as part of their planned care?
Decision 1
No
Record it. End.
Yes
Is the 'handling' element of person care to be managed with Standard Operating Procedures (SOPs) or Person Individual Procedures (PIPs)
Decision 2
SOPs
PIPs
(Or combination of PIPs & SOPs)
Generic Risk Assessment required.
Person Individual Risk Assessment required.

Purpose of the system

- To provide a clear, consistent, but flexible pathway for assessment, to an appropriate level of care and support for each person
- To facilitate the planning of care, linked to the control of risk
- To facilitate action planning
- To provide documentary evidence of the above
- To support communication

The system

Persons can be assessed at one of two broad levels; one for straightforward and a second for persons with complex and/ or unusual handling needs.

The system is based on the principle that persons are moved and handled according to their dependency level and that persons with a similar dependency level will be moved and handled in a similar way. To this accord we have developed 'Mobility Scores' (MS) which rank persons according to their dependency. Standard Operating Procedures (SOPs) for moving and handling detail how the handling needs of persons in each dependency level can be met whilst minimising the risks to both staff and person.

The aim of this approach is to enable time to be saved when assessing persons for their handling needs. The grouping together of persons who have straightforward needs into categories facilitates the assessment process so that it can be briefer than it would otherwise be, whilst still meeting legal, clinical and operational requirements.

Staff may decide that the standard methods of handling are not appropriate for the person they are assessing in which case **P**erson **I**ndividual **P**rocedures will need to be developed and this will require a more detailed assessment. This is the second level referred to above. Experience in hospitals has shown that less than 10 per cent of people are likely to require this level of assessment – in many departments this has reached as little as 1 – 2%.

The documentation

The documentation consists of two forms. **Form PH1** is required for **all persons** and records essential information about the person. It asks the assessor to judge the dependency level (MS) of the person and if Standard Operating Procedures are appropriate. Details about the person's physical shape and capabilities are recorded and an individual handling profile is built up.

Form PH2 is used only for persons for whom it is judged that Standard Operating Procedures do not apply. The form facilitates a detailed individual risk assessment of the person, the development of individual handling procedures (PIPs) and action planning.

In summary – straightforward persons are assessed using Form PH1 only. Complex persons (or situations) will need Form PH1 and Form PH2.

On the following pages you will find: -

- Mobility scores
- Brief guidance notes
- The assessment forms
- Detailed guidance notes
- Guidance on selecting handling methods and equipment for each mobility score and handling procedure

Mobility scores (MS)

At the initiation of the assessment process, each person is allocated a score that describes their level of mobility and therefore the amount of assistance that is likely to be necessary to help them move. The allocation of a mobility score should be based on the following criteria:

0: **"Fully independent"** – The person requires no handling assistance, nor any verbal guidance with movement.

1: **"Independent with equipment or aids"** – The person may require help with locating or positioning equipment or aids (e.g. wheelchair, walking frame, transfer board) after which they are able to move themselves. Approx. **0%** help required.

2: **"Requires supervision"** – The person will require guidance when mobilising and cannot be left alone to carry out mobility tasks. The supervision may take the form of verbal prompting and encouragement, and the handler may have to offer minimal assistance and use small handling aids. Approx. **20%** help required.
Examples include: - Person recovering from anaesthetic or a fit; someone under the influence of prescription or non-prescription drugs; a mildly confused person; someone with unstable blood pressure or feeling a bit dizzy; or a child.

3: **"Requires assistance"** – The person will be fully – partially weight bearing (at least 2/3) and will require minimal assistance, which is likely to involve some manual handling and the use of small handling aids and/or a turning frame (with handle). Approx. 40% help required.

4: **"Dependent *with* sitting balance and upper body strength"** – The person's weight-bearing ability will be significantly impaired (about ½ of normal). They will need assistance with most movement and will require significant input from the carers and the use of hoists, possibly standing and raising aids, as well as the smaller handling aids such as slide sheets. Approx. **60%** help required.

5: **"Dependent *without* sitting balance and upper body strength"** – The person's weight-bearing ability will be minimal, unreliable or absent, and the lack of sitting balance precludes some techniques and equipment. Approx. **80%** help required.

6: **"Totally dependent"** – The person will require total assistance with all movement. All care required. Examples include: - Person in theatres or ITU; quadriplegic; end stages of life. Approx. **100%** help required.

A brief mobility score flow chart is printed on **Form PH1** to assist staff.

The person is scored twice at this stage: first to record their *current* mobility score and then again to record a *predicted* mobility score during or after any planned intervention. This will allow, for example, a person who has a mobility score of 0 on admission to hospital but is due for surgery the following day, that will obviously increase their dependency level, to be entered into the assessment process.

If, ***but only if,*** the person's mobility score is 0 on admission or initiation of care and it is not anticipated that this will change at any stage during their stay or episode of care, then the assessment process can be halted here. Record this.

Brief Guidance Notes – Process and documentation

Step by step approach – steps 1 – 9 (All persons)

Step	Element	Detail	Use Form
1.	**Person's details**	Record: - Person's dimensions and weight- using Grid *or* BMI; Waterlow score (if necessary); Abilities to weight-bear and balance	PH1 (front)
2.	**Screening: Determining the person's level of mobility and dependency**	Persons presenting for investigation, treatment, rehabilitation or care must be screened. Record person's and assessor's details. Record: Mobility Score (MS) 0 – 6 (Current) Mobility Score (MS) 0 – 6 (Projected)	PH1 (front)

NB: If MS = 0 (both current and projected) → Process complete Stop here

If MS lies between 1 – 6, continue assessment process

3.	**Highlighting relevant medical factors $**		**PH1** (front)
4.	**Noting any behavioural problems ***		**PH1** (front)
5.	**Special protocols**		**PH1** (front)
6.	**Clinical considerations**	Treatment aims, etc.	**PH1** (front)
7.	**Environmental and other factors**	Hospital/community setting	**PH1** (front)
8.	**Determination of standard or individual provision**	SOPs only **Go to Form 1 Part 2** Mixture of SOPs and PIPs *or* PIPs only **Go to Form PH2**	**PH1** (front)
9.	**Building a person handling profile**	Detail the handling required and methods to be adopted as a safe system of work. Using the M&H prescription.	**Form 1 Part 2**

NB: For Straightforward persons → Initial assessment process Complete

On-going Assessment → The review columns of the person handling profile **PH1 Part 2** should be used to detail any changes to the person's handling needs.

The person should be reviewed periodically and whenever there is a significant change in their condition or other factors, e.g. when they are transferred to a new area.

Brief guidance notes process and documentation

Step by step approach – steps 10 – 15 (Complex persons)

After completing steps 1 – 9 of the assessment process using Form PH1

Step	Element	Detail	Use Form
10.	**Identification of person individual risk factors**	Use the scoring system to ascertain an individual risk rating for the person. Give details of any risk factors in the comments column.	**PH2** (Part 1)
11.	**Summarising the main risk factors**	List the main risk factors using the '**TILE'** format, or alternative.	**PH2** (Part 2)
12.	**Risk assessment and risk quantification**	Use the main guidance notes to help you determine the overall risk rating.	**PH2** (Part 2)
13.	**Care planning – developing Person Individual Procedures (PIPs)**	Develop individual procedures for person handling. Detail the method (**M**), the equipment (**Eq**) and the number of handlers (**N**). Highlight any warnings and risks and detail your clinical reasoning.	**PH2** (Part 3)
14.	**Action planning**	What is required to create a safer handling situation? Detail: - equipment required, staffing issues, environmental changes etc. The action plan should be agreed by the manager or budget holder, (or not, with reasons).	**PH2** (Part 4)
15.	**Building person handling profile**	Return to Form PH1 and complete the person handling profile indicating for which tasks (PIPs) apply.	**PH1** (Part 2)

NB: For Complex persons → Initial assessment process complete

On-going assessment → The review columns of the person handling profile **PH1 Part 2** should be used to detail any changes to the person's handling needs.

The person should be reviewed periodically and whenever there is a significant change in their condition or other factors, e.g. when they are transferred to a new area.

To enable the following forms to be printed 2-sided this page has been left deliberately blank

Handling needs assessment
Form PH1 part 1

Initial Assessor:	**Person's Name**
Name:……	**NHS Number**
Signature:……	**DOB / / M / F**
Designation:……...	**Date of initiation of care / /**
Date & time form completed / / am pm	**Name of clinical environment**

Step 1

Height	Waterlow ccore
Weight	BMI

Body shape

Tall			
Average			
Short			
	Light	Ave	Heavy

Weight bearing ability
Full / Partial / Unreliable / Non

Standing balance
Present / Unreliable / Absent

Sitting balance
Present / Unreliable / Absent

Upper body strength
Good / Variable / Poor

Step 2

No Handling needs	Independent with equipment	Supervision / verbal prompting required. Minimal Assistance required	Full / partial weight bearing. Moderate assistance. Use of small handling aids	Minimal / Non weight bearing Has sitting balance	Minimal / Non weight bearing No sitting balance	Total dependence; assistance required with all movement
0	1	2	3	4	5	6

Mobility score on admission or on initiation of care
Anticipated mobility score during/after intervention

If mobility score is **0** in **both** cases, **proceed no further** unless situation changes**,** Otherwise continue below.

Step 3 $ Any relevant medical factors or warnings:

Step 4 * Any behavioural problems or cognitive difficulties:

Step 5 Do any special protocols apply? Yes / No	**Details:**

Step 6 Clinical/ therapeutic considerations, e.g. reason for admission/ overall aims of treatment

Step 7 Environmental considerations (hazards/ risk factors/ problems)

Step 8 Are Standard Operating Procedures applicable to this person?
If Yes → PTO.
If No → Person Individual Procedures are required. Please complete **Form PH 2** and attach.

Person's Name _____ **NHS No.** _____ **Handling Profile** **Form PH 1 – Part 2**

	On admission / at first contact							1st Review							2nd Review							3rd Review						
Date →	/ /							/ /							/ /							/ /						
Mobility Score: →	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Step 9 **Care Task** (tick box if assistance required, or, insert MS for each task) ↓	Reason for Review →																											
	Method prescribed							Response to change							Response to change							Response to change						
Bed: Lying ←→sitting																												
Bed: Move up/down																												
Bed ← → trolley																												
Turn - change/wash																												
Turn - reposition																												
Lying ← → SOEB																												
Bed ← → chair																												
Sit ← →sit																												
Sit ← → stand																												
Walking/ mobilising																												
Toileting																												
Washing/ bathing																												
Multidisciplinary communication →																												
Signature/ Designation																												

Person Handling Risk Assessment

Form PH2 Parts 1 & 2

Assessor: Name Signature	**Date**	**Person's Name** _____ **DoB / / NHS No**

Part 1	**Person risk factors**	**Score**	**Comment - Please give details of Issues**
1	Weight: **Give 1 point** for every stone (or 6 Kg) up to **a maximum of 24**		
2	Fully weight bearing **0 pts** Partial (most 2/3 - 3/4) weight bearing **5 pts** Partial (minimal 1/4- 1/3) weight bearing **11 pts** Non weight bearing **16 pts**		
Score for items 3 - 14: 0=No Problem 1=Slight Problem 3=Moderate Problem 5=Severe Problem			
3	Dimensions, weight, height, build, extreme BMI, missing limbs (altered centre of gravity)		
4	Disability (joint and muscle) paralysis, weakness, stiff/ unstable joints		
5	Disability (neurological) balance, spasm/ spasticity, tendency to fit		
6	Circulatory/ respiratory problems		
7	Tissue viability/ skin problem		
8	Sensory deficit/ loss or altered sensation/ perception incl. visual/ hearing		
9	Communication and comprehension difficulties and/or cognitive issues		
10	Challenging behaviour/ aggressive, confused, unpredictable		
11	Handling history - history of falls etc		
12	Frailty, emaciation or dehydration		
13	Pain or fear		
14	Attachments (e.g. drips, drains, catheters)		
	Person Factors Total (of elements 1 - 14)		% (Divide this by 20 and enter in Person Risk Score)

Part 2 Other ("T-I-L-E") Risk Factors (See Guidance Notes for more detail)

Risk Score	**Environment**	**Inan. Loads** (Furn. & equip.)	**Tasks** (Mvt, post, force)	**Individual** (Comp. & fitness)
1 (Low)	Modern spacious uncluttered	Light compact load	Completed easily by the handler	Highly competent handler, confident, fit, healthy & aware
2 (Medium)	Problematic area or lack of equipment	Awkward to handle due to size, shape or weight	May involve discomfort / effort for handler	Competent handler, fairly confident, fit, healthy & aware
3 (High)	Problematic area + lack of equipment	Difficult to handle due to size, shape or weight	Involves a significant degree of discomfort	May not have all skills required, or has fitness issues
4 (V. High)	As 3 + Lack of space, clutter, poor lighting	Obviously hazardous to handle, excessive weight	Unacceptable degree of discomfort / effort	As for level 3 but to a greater degree
5 (Extreme)	Worst case scenario	Worst case scenario	Worst case scenario	Worst case scenario

Risk Scores			**Comments on risks and handling needs**
Risk Factor group	**on *Initial* assessment**	***if* Care Plan & SSW Followed**	
Person % /20			
Environment			
Inanimate loads			
Tasks			
Individual			
T-I-L-E Total			

Interpretation of Total Risk Score: 0 - 6 Low Risk 7-12 Medium Risk 13 - 18 High Risk 19 - 20 V. High Risk 21 – 25 Extreme

Person Handling Risk Assessment
Form PH 2 Part 3 & 4

Person's Name: _____ **NHS No.** _____

Part 3 **CARE PLAN** NB: Person Individual Procedures (PIPs) are required only for those handling tasks for which SOPs are not available or appropriate. Link this to Form PH 1 – PERSON HANDLING PROFILE		
Handling task (brief description)	**Person Individual Procedure**	
Task 1.	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
Task 2.	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
Task 3.	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
Task 4.	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
Task 5.	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
Legend: M = Method of handling **Eq** = Equipment required **N** = Number of handlers **RR** = Risk Rating **W** = Warnings **SP** = Special Precautions **CR** = Clinical Reasoning		

Part 4 **ACTION PLAN** Detail any particular action required (e.g. procurement of equipment)			
Current element or factor to be improved	Current Risk Rating	Means of improvement - Action points and target dates	Anticipated Risk Rating
Actions – Agreed / Not Agreed (Circle) by Manager / Budget Holder Signature		Clinical/ Managerial reasoning	

Form GPUA

General Purpose Assessment Update Form

This form will also serve as a continuation or review document. It is intended to be supplementary to other assessment documentation. It may be used as extra space for rough notes, sketch drawings, for the attachment of photographs, etc.

Assessment identification title, reference or cross reference		
Date (and time if relevant)	Update Information **-- Change in situation/ response to change/ action planned/ action taken/ progress/ requests for help**	**Name / Signature / Initials**

NB: Remember to reference or cross reference this page and/or attach to the main assessment and other relevant documents.

Detailed guidance notes

Step one (Person's details)

Prior to handling a person there is some basic information that it will be necessary to know and the form allows for this to be recorded:

- Weight and height – self-explanatory. Indicate if these are actual or estimated (e) measurements
- Waterlow score - The condition of a person's skin will have a strong bearing on how they are handled and a high Waterlow score may indicate the presence of pressure relieving equipment that may make mobility and handling more difficult.
- Body shape - Is relevant for sling sizing amongst other things and can be indicated by BMI or the body shape grid
- Weight bearing ability - self-explanatory.
- Standing balance - In your judgement is the person safe to leave standing alone and unsupported?
- Sitting balance - In your judgement is the person safe to leave sitting alone and unsupported, e.g. on the side of a bed?

Step two (Screening)

All persons will require the initial parts of the form to be completed. This will normally be at the first point of contact – on admission, or on the first visit in the community. The initial assessor details and person details are self-explanatory. A person label may be affixed if preferred rather than completing the person section.

Each person is then allocated a score that describes their level of mobility and therefore the amount of assistance that is likely to be necessary to help them move. The allocation of a mobility score should be based on the following criteria:

0: **"Fully independent"** – The person requires no handling assistance, nor any verbal guidance with movement.

1: **"Independent with equipment or aids"** – The person may require help with locating or positioning equipment or aids (e.g. wheelchair, walking frame, transfer board) after which they are able to move themselves. Approx. **0%** help required.

2: **"Requires supervision"** – The person will require guidance when mobilising and cannot be left alone to carry out mobility tasks. The supervision may take the form of verbal prompting and encouragement, and the handler may have to offer minimal assistance and use small handling aids. Approx. **20%** help required.
Examples include: - Person recovering from anaesthetic or a fit; someone under the influence of prescription or non-prescription drugs; a mildly confused person; someone with unstable blood pressure or feeling a bit dizzy; or a child.

3: **"Requires assistance"** – The person will be fully – partially weight bearing (at least 2/3) and will require minimal assistance, which is likely to involve some manual handling and the use of small handling aids and/or a turning frame (with handle). Approx. 40% help required.

4: **"Dependent *with* sitting balance and upper body strength"** – The person's weight-bearing ability will be significantly impaired (about ½ of normal). They will need assistance with most movement and will require significant input from the carers and the use of hoists, possibly standing and rising aids, as well as the smaller handling aids such as slide sheets. Approx. **60%** help required.

5: **"Dependent *without* sitting balance and upper body strength"** – The person's weight-bearing ability will be minimal, unreliable or absent, and the lack of sitting balance precludes some techniques and equipment. Approx. **80%** help required.

6: **"Totally dependent"** – The person will require total assistance with all movement. All care required. Examples include: - Person in theatres or ITU; quadriplegic; end stages of life. Approx. **100%** help required.

A brief mobility score flow chart is printed on **Form PH1** to assist staff.

The person is scored twice at this stage: first to record their *current* mobility score and then again to record a *predicted* mobility score during or after any planned intervention. This will allow, for example, a person who has a mobility score of 0 on admission to hospital but is due for surgery the following day, that will obviously increase their dependency level, to be entered into the assessment process.

If, ***but only if,*** the person's mobility score is 0 on admission or initiation of care and it is not anticipated that this will change at any stage during their stay or episode of care, then the assessment process can be halted here. Record this.

Step three $

Relevant medical factors or warnings - a detailed rundown of the persons condition is not necessary if it is documented elsewhere, but for the assessment of handling needs and risks, certain details will be relevant such as low blood pressure (increases likelihood of falls), epilepsy, fragile bones/osteoporosis. If these factors are thought to be significant add the symbol **$** to the mobility score in order to highlight the problem(s).

Step four *

Any confusion, aggression, challenging behaviour, whether due to mental illness, dementia, learning disability, temporary confused state, anoxia, head injury, infection, pain or fear, is likely to lead to problems of person co-operation and therefore increase the risks of moving and handling. If these issues are significant add the symbol ***** to the mobility score.

Step five (Special protocols)

Do any special protocols apply? e.g. bariatric, orthopaedic, etc. The question of special protocols being applicable is posed at this stage. Protocols are being developed for special handling situations such as very heavy persons or spinal injured persons and may be in place in some areas, and it should be indicated which, if any, of these protocols apply.

Step six (Clinical considerations)

Consider and take into account the overall aims of treatment intervention – therapeutic, rehabilitative, maintenance, palliative, etc. Clinical reasoning and rationale comes into play here.

Step seven (Environmental and other considerations)

Is there anything about the environment, or any other factor that is likely to impact on the handling required? Consider: staffing; organisational and management issues; availability of equipment; and interpersonal and psychosocial issues.

Step eight (Determination of standard or individual provision)

The next step is to determine whether this person can be managed by means of Standard Operating Procedures (SOPs), or whether they need to be assessed in more detail and managed by means of Person Individual Procedures (PIPs).

If the person's condition is a relatively straightforward case (for this particular clinical area) and there are no other complicating factors, they will probably be suitable for SOPs.

NB: The rapid assessment and care plan <u>cannot</u> be used in the absence of SOPs.

If the situation is more complex (possibly due to the person's medical condition, or if there are environmental or staffing issues) they may require a more detailed assessment. Some of their care at least may need to be delivered by PIPs – procedures designed specifically for them.

In the case of persons with complex needs or where there are complex handling situations, proceed directly to STEP TEN

Step nine (Building a person handling profile)

Part 2 of Form PH1 (at the back of Part 1) is for detailing the specifics of each individual Person's handling needs. Whilst SOPs may be applicable to a Person there may be slight variances and individual details which should be noted.

- The first column lists the main handling manoeuvres and offers a tick box for the assessor to indicate if the person needs help with this particular task.
- Column 2 (titled 'on admission') should be completed by the initial assessor. Circle the current mobility score of the person and give details such as:
- Variances to the SOP
- The number of handlers required
- The size of any equipment (slings, handling belts, slide sheets)
- Any issues involving the Task, the Load, the Individual or the Environment. Consider steps 10 – 15 if necessary (Form PH2).

If you require more space to detail these issues, use Form PH2 and/or the general purpose form (Form GPUA). (See p14)

Use the Moving & Handling Assistance and Equipment Required (see pages 18 - 21) to help you decide the best way of assessing the person and the equipment needed.

This is the end of the initial assessment process for straightforward persons. Monitoring, evaluation and review will still be necessary as required.

If the person has more complex needs or there are other complicating factors, proceed to steps 10 – 15, using Form PH2.

Below are charts that provide guidance on selecting handling methods and equipment, related to the person's mobility score.

Moving & Handling assistance and equipment required – Related to person's mobility and dependency

HPFT Mobility Score	Nearest equivalents in other systems		M&H assistance & equipment	Special bed & mattress	Personal care		Mobilising assistance & equipment
	Arjo Mobility Gallery (Mobility Degree)	Oxford/ FIM			Toileting method & equipment	Washing/ bathing/ showering equipment	
0: Fully independent – The person requires no handling assistance, nor any verbal guidance with movement.	**N/A**	7: **Complete independence** -- 'Another person is not required for the activity which is performed safely without modification or outside assistance within a reasonable time'.	None	N/A	N/A	N/A	N/A
1: Independent with equipment or aids – The person may require help with locating or positioning aids or equipment (e.g. wheelchair, walking frame, transfer board) after which they are able to move themselves. Approx. **0%** help required.	A (Albert): 'Ambulatory, but may use a walking stick for support. Independent, can clean and dress. Usually no risk [for the carer] of dynamic or static overload'.	6: **Modified independence** – ' Activity requires one or more of the following: - an assistive device, [more than reasonable time or safety (risk) considerations'.]	Assistance purely to locate and position equipment. Rope ladders, bed pulls, transfer boards, hand blocks and slide sheets may be used.	Electric profiling bed (EPB) could be considered if the person has difficulty in repositioning (moving and sitting-up e.g. due to weakness or stiffness). Tissue viability unlikely to be an issue and therefore a good base mattress should suffice.	May need adaptations.	May need adaptations.	Assistance purely to locate and position equipment. Walking aids (stick, crutches, mobility aid /walking frame) or wheelchair depending on the weight-bearing ability of the person.

2: **Requires supervision** – The person will require guidance when mobilising and cannot be left alone to carry out mobility tasks. The supervision may take the form of verbal prompting and encouragement, and the handler may have to offer minimal assistance and use small handling aids. Approx. **20%** help required. Examples include:- **person recovering from anaesthetic or a fit; someone under the influence of prescription or non-prescription drugs; a mildly confused person; someone with unstable blood pressure or feeling a bit dizzy; or a child.**	**N/A**	5: **Supervision or set up** – 'Someone required to help by observation or encouragement without contact'. **4:** **Minimal assistance (dependent)** – 'Someone required to help by touching – subject makes 75% or more of the effort'.	Supervision Supervision and minimal assistance	Electric profiling bed (EPB) could be considered if the person has difficulty in repositioning (moving and sitting-up e.g. due to weakness or stiffness). Tissue viability unlikely to be an issue and therefore a good base mattress should suffice. Electric profiling bed (EPB) could be considered if the person has difficulty in repositioning (moving and sitting-up e.g. due to weakness or stiffness). Tissue viability unlikely to be an issue and therefore a good base mattress should suffice.	Supervision using standard equipment. May need adaptations. Supervision and minimal assistance using standard equipment. May need adaptations.	Supervision using standard equipment. May need adaptations. Supervision and minimal assistance using standard equipment. May need adaptations.	Supervision plus assistance to locate and position equipment. Walking aids may be required. Supervision, assistance to locate and position equipment and minimal assistance to mobilise. Walking aids required.

3: **Requires assistance** – The person will be fully – partially weight bearing (at least 2/3) and will require minimal - moderate assistance, which is likely to involve some manual handling and the use of small handling aids. Approx. **30 - 40%** help required.	B (Barbara): 'Can support self to some degree and uses walking frame or similar. Dependent on carer in some situations. Usually no risk of dynamic overload [for the carer]. A risk of static overload can occur if not using proper equipment'.	3: **Moderate assistance (dependent)** – 'Someone required to help by more than touching – subject makes 50 – 75% of the effort'.	Manual assistance, with or without small handling aids, such as sliding sheets in bed and handling belts for transfers. A turning frame (with handle) may be used for some transfers if the person finds it difficult to 'step around'.	Electric profiling bed (EPB). Tissue viability ***may* be** an issue and therefore an appropriate mattress or overlay should be considered.	Assistance required, to access the WC and may be required for cleaning, using adapted equipment, such as raised toilet seats and handrails conveniently placed. Toilet needs to have space for carers on both sides.	Walk, or use shower chair to/from level access shower room. Bath, using bath hoist. May require assistance to wash lower body	Manual assistance, with or without small handling aids, (such as handling belts) for transfers and mobilising. Devices such as an 'Arjo Stedy' may be indicated where the person's exercise tolerance is low.
4: **Dependent *with* sitting balance and upper body strength"** – The person's weight-bearing ability will be significantly impaired (about ½ of normal). They will need assistance with most movement and will require significant input from the carers and the use of hoists, possibly standaids, as well as the smaller handling aids. Approx. **50 - 60%** help required.	**C (Carl):** 'Is able to partially weight bear on at least one leg. Often sits in a wheelchair and has some trunk stability. Dependent on carer in most situations. A risk [for the carer] of dynamic and static overload can occur if not using proper equipment'.	2: **Maximal assistance (complete dependence)** – 'Complete dependence. Subject makes less than 50% but at least 25% effort'.	Sliding sheets in bed, person contributing significantly to manoeuvres, using hand blocks. Transfer board or standing and raising aids for transfers. Hoisting (using a passive lifter) may be appropriate, in which case access/ toileting /hygiene sling can be used.	Electric profiling bed (EPB). Tissue viability **may be** an issue and therefore an appropriate mattress or overlay should be considered.	Commode chair to/from WC. Significant assistance required either using adapted equipment, such as raised toilet seats or using commode chair. Handrails to be conveniently placed. Toilet needs to have space for carers on both sides. Assistance in cleaning may be required.	Shower chair and level access shower room. Consider bathing, using variable-height bath. May require assistance to wash lower body.	It may be appropriate following assessment to use some manual assistance, with or without small handling aids, such as handling belts for transfers and mobilising. Devices such as an 'Arjo Stedy' may be indicated for indoors and wheelchairs for longer distances and outdoors.

5: **Dependent *<u>without</u>* sitting balance and upper body strength** – The person's weight-bearing ability will be minimal, unreliable or absent, and the lack of sitting balance precludes some techniques and equipment. <u>Approx. **80%** help required.</u>	D (Doris): 'Cannot stand and is not able to weight bear. Is able to sit <u>if well supported</u>. Dependent on carer in most situations. A high risk of dynamic and static overload [for the carers] when not using proper equipment'.	1: **Total assistance (complete dependence)** – 'Complete dependence. Subject makes <u>less than</u> 25% effort'.	Sliding sheets in bed, person will be unable to contribute significantly to manoeuvres, but can use suitable equipment to pull on. When hoisting is involved, (using a passive lifter) supportive slings will be necessary.	Electric profiling bed (EPB). Tissue viability **will be** an issue and therefore an appropriate mattress should be considered.	Hoisting, using a passive lifter and supportive slings onto and off commode chair, or the WC directly. Assistance in cleaning will be required. Ideally a lavatory incorporating automated cleaning and drying should be provided. Support will be necessary on toilet.	Shower trolley or bath. Variable-height bath. Assistance in washing will be required, especially of the lower body.	Wheelchair. Attention to the amount of trunk support required.
6: **Totally dependent** – The person will require total assistance with all movement. All care required. <u>Examples include:</u> - end stages of life; quadriplegic; person in theatres or ITU; <u>Approx. **100%** help required.</u>	E (Emma): 'Might be almost completely bedridden, can sit only in a special chair. Always dependent on carer. A high risk of dynamic and static overload [for the carers] when not using proper equipment'.	1: **Total assistance (complete dependence)** – 'Complete dependence. Subject makes <u>less than</u> 25% effort'.	Sliding sheets in bed, person will be unable to contribute to manoeuvres. When hoisting is involved, supportive slings will be necessary. Full length slide sheets in bed and slide sheets and full length transfer board for bed ← → trolley /theatre table transfers.	Electric profiling bed (EPB) or electric bed with turning facility. Tissue viability **will be** an issue and therefore an appropriate mattress should be considered.	Incontinence pads may be appropriate, with clothes that permit easy dressing and undressing. Cleaning will be carried out entirely by the carer.	Shower trolley or bath. Variable-height bath. All washing will need to be carried out by carers.	Wheelchair if well enough. Attention to the amount of trunk support required. Special tilted wheelchair. Trolley for ward ← → theatre transfers.

Steps Ten To Fifteen are for More Complex Cases only

Step ten (Identification of individual person risk factors)

This step moves the documentation to **Form PH2**, **Part 1** of this form is utilised to identify the risk factors for the 'Load', i.e. the person. There are many intrinsic factors which affect a Person's handling needs and the potential risks they may pose to the handler. The main ones are listed here.

Assign a score for their **weight** (item 1) as indicated (maximum score 24) and for their **weight-bearing ability** (item 2) (maximum score 16).

Make a judgement about the **other risk factors** (items 3—14) and give a score of 0—5 for each, with 0 indicating that this factor does not cause any problems and 5 indicating that the factor causes a severe problem.

If the risk factor is deemed to be a problem then please provide relevant details in the 'comments' column. This is to ensure that any subsequent handlers have all the relevant information to hand.

The maximum possible score for items 1—14 is 100; i.e. it provides a score percentage (%).

The interpretation of this score is given on the form and indicates the risk level due to the Person and their condition, in five levels of risk, from Low to Extreme.

If this percentage score is to be included in the total risk score with other elements or factors, using the "**T-I-L-E**" format, it must first be divided by 20, to provide a sore of 0 – 5.

Step eleven (Summarise the main risk factors)

In Form PH2, Part **2** set-out the full handling assessment, which must take an overall view of the risks that might exist for a handling operation. To do this we can utilise the "**T-I-L-E**" format and offer a summary of the main issues. NB: there are two sets of LOAD factors:

The **T**ask: What **manual handling operations** are being carried out and what exactly do they involve? Consider the handler's movements, postures and forces that need to be applied. Do certain procedures cause more risk than others?

The **I**ndividual: Who are the people who will be carrying out this task, are there any individual handlers or **staff members** who have particular risk factors?
Is the whole workforce properly trained and aware of safer handling.

The **L**oad (a): What is to be moved? In this case the **person** is the load and the main risk factors can be summarised from the detailed assessment carried out in Part 1.

The **L**oad(b): What has to be moved? In this case any **inanimate loads**, such as equipment and furniture.

The **E**nvironment **Where** are the handling tasks to be performed and does this pose any additional risks (e.g. if the Person is being nursed in a side room there may be additional space constraints)?

Step twelve (Risk assessment)

Risk assessment requires the identification and recording of all risks and the quantification of risks to give an overall level of risk. This is important for a number of reasons. An indication of the level of risk posed should be given in the risk rating column.
At this stage determine the level of risk to staff and Person. The risk should be quantified twice. The first risk score is for the situation at the time of the initial assessment and the second takes into account the reduction in risk that should have been achieved by means of the care plan and **the safe system of work** that is designed and fully implemented.
You will note that there are two different methods for determining risk level. One is the so-called 'T-I-L-E' method, where all of the factors are taken into account and the scores totalled, and the other is reached by using the now standard NHS 5 by 5 matrix system. In both cases the maximum score (highest risk) is 25. Either method may be used and they can be used to check each other. They should correspond fairly closely.

When using 'T-I-L-E' method, derive your scores by means of the criteria set-out in the tables provided in these notes, starting at the bottom of this page.

Quantifying the risk using criteria

The easiest and quickest way of determining the risk rating is to use the following guidelines (see pages 13 - 15) for each factor although previous assessment surveys may be utilised.
These guidelines are designed to take some of the subjectivity out of risk assessment. Each of the five sets of factors under "**T-I-L-E**" can be assessed, giving **possible scores of 0 – 5. The total possible score from the five sets of risk factors is 25.**

Task = Process/ manual handling operation/ job/ manoeuvre/ transfer

Movements, postures involved and forces required	**RISK**
L. Easy tasks that can be performed by a reasonably skilled operator with little or no difficulty and relatively little risk. This would mean an **absence/ minimum** of stooping, side bending, turning/ twisting or reaching; while pushing, pulling holding and carrying would be minimal or easy. (Almost ideal circumstances)*	**LOW (L) 1**
M. Intermediate between low and high	**MEDIUM (M) 2**
H. Tasks involve some degree of discomfort that is tolerable (for short periods at least) and low levels of general hazard that can be allowed for if care is taken. **However**, the hazards do exist and it is foreseeable that prolongation and/or repetition would lead to significant harm. *	**HIGH (H) 3**
VH. Tasks involve an unacceptably high degree of risk that will **inevitably** lead to injury or other negative outcomes. *	**VERY HIGH (VH) 4**
Ex. Worst case scenario	**EXTREME (Ex) 5**

* Consider the weight guidelines issued by the HSE

Individual = Worker/ carer/ operator/ handler/ member of staff

Capability (fitness and competence)	**RISK**
L. A competent and aware individual, who is up to date with respect to professional/ trade knowledge and skills. Such a person would be confident, healthy, fit and alert, with a good attitude towards health and safety. (Almost ideal handler)	**LOW (L) 1**
M. Intermediate between low and high	**MEDIUM (M) 2**
H. An individual who demonstrates all of the qualities listed in **L**, but to a lesser extent; or, someone exemplifying some of the qualities to a high degree, but with notable gaps.	**HIGH (H) 3**
VH. Someone with few or none of the qualities listed in **L**, requiring close supervision, by virtue of lack of experience, or other reason; or, someone with a serious health problem.	**VERY HIGH (VH) 4**
Ex. Worst case scenario	**EXTREME (Ex) 5**

When completing the Individual section on the individuals it may be appropriate to provide a summary of the general abilities of the staff.

Load **Inanimate** Loads relating to this particular person and situation

Equipment and furniture etc.	**RISK**
L. A light compact load that is easily held and handled	**LOW (L) 1**
M. Intermediate between Low and High	**MEDIUM (M) 2**
H. A load that is difficult to handle or move by virtue of its weight, bulk, shape weight distribution, labelling or packaging/lack of handles, etc. It may be hot, cold, dirty/contaminated, have sharp edges.	**HIGH (H) 3**
VH. A load that is obviously hazardous if handled, moved or lifted as it is excessively heavy or unwieldy or has any of the problems listed in **H** but to a greater degree so that injury or damage is very likely.	**VERY HIGH (VH) 4**
Ex. Worst case scenario	**EXTREME (E) 5**

Load **Person** as a 'Load'

It is recommended that the risk rating of the person load is determined by using the detailed Person risk assessment provided on Form PH2 Part 1, as this will provide all the necessary information. If however the precipitating reason for initiating Form 2 was not the Person load but instead was the environment or staffing issues for example then this rapid assessment may be appropriate.

General description of person	RISK
L. A person who is light, fairly able, stable and co-operative, with very few complications, requiring supervision or slight assistance only	**LOW (L) 1**
M. Intermediate between low and high	**MEDIUM (M) 2**
H. A person who is either heavy but fairly co-operative, alert, etc.; or is lighter but has other significant difficulties, rendering moving and handling hazardous. (Consider also challenging behaviour)	**HIGH (H) 3**
VH. A person who has a weight, disability level, frailty or instability that would render handling very likely to cause harm to operator and/ or Person. (Consider also medical, orthopaedic, surgical issues, tissue viability, pain and fear, non-compliance, challenging/ aggressive behaviour)	**VERY HIGH (VH) 4**
Ex. Worst case scenario	**EXTREME (Ex) 5**

Environment The working or clinical environment

	RISK
L. Modern, spacious, well-appointed and equipped area. No awkward places. Uncluttered well lit and clean with e.g. an electric profiling bed that can be raised and lowered and can be accessed from both sides without moving it (Almost ideal)	**LOW (L) 1**
M. Intermediate between low and high	**MEDIUM (M) 2**
H. Deficient or problematic area with some inconvenience and difficulty, plus a lack of adequate equipment and not up to a desirable standard.	**HIGH (H) 3**
VH. Obviously hazardous area due to lack of space, clutter, dirt, poor lighting, high levels of noise or vibration and/or lack of equipment.	**VERY HIGH (VH) 4**
Ex. Worst case scenario	**EXTREME (Ex) 5**

The final area in Form PH2 Part 2 is for comments on the risk score and risk factors and may be used for detailing any other potentially complicating factors which may be relevant, such as **compliance of the person** or their relatives to the procedures being proposed.

Risks Grading Matrix

Once a risk is identified within the organisation the following 5x5 Matrix will be applied giving a score potentially from 1 – 25.

Step 1: **The Consequence** of the identified Risk should it result in an adverse outcome is first estimate on a scale of 1 to 5. The following table assists in deciding the appropriate score for consequence depending on the type of risk.

Table 1 – Consequence Score

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury	Minor injury not requiring first aid	Minor injury or illness, first aid treatment needed	RIDDOR/ Agency reportable	Major injuries, or long term incapacity/ disability	Death or major permanent incapacity
Person experience	Unsatisfactory person experience not directly related to person care	Unsatisfactory person experience – readily resolvable	Mismanagement of person care	Serious mismanagement of person care	Totally unsatisfactory person outcome or experience
Complaints/ claims	Locally resolved complaint	Justified complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim
Objectives/ projects	Insignificant cost increase/ schedule slippage. Barely noticeable reduction in scope or quality	Less than 5% over budget/ schedule slippage. Minor reduction in quality/ scope	5-10% over budget/ schedule slippage. Reduction in scope or quality	10-25% over budget/ schedule slippage. Doesn't meet secondary objectives	More than 25% over budget/ schedule slippage. Doesn't meet primary objectives
Service/ business interruption	Loss/ interruption more than 1 hour	Loss/ interruption more than 8 hours	Loss/ interruption more than 1 day	Loss/ interruption more than 1 week	Permanent loss of service or facility
Staffing and competence	Short term low staffing level temporarily reduces service quality (less than 1 day)	On-going low staffing level reduces service quality	Late delivery of key objective/ service due to lack of staff. Minor error due to poor training. On-going unsafe staffing level	Uncertain delivery of key objective/ service due to lack of staff. Serious error due to poor training	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. Critical error due to insufficient training
Financial	Small loss (up to £100)	Minor loss (up to £1,000)	Moderate loss (up to £10,000)	Major loss (up to £100,000)	Catastrophic loss (in excess of £1 million)
Inspection/ audit	Minor recommendations Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Reduced rating. Challenging recommendations. Non-compliance with core standards	Enforcement action. Low rating. Critical report. Major non-compliance with core standards	Prosecution. Zero Rating. Severely critical report
Adverse publicity/ reputation	Rumours	Local media – Short term. Minor effect on staff morale	Local media – Long term. Significant effect on staff morale	National media less than 3 days	National media more than 3 days. MP Concern (Questions in House)

Step 2: The **likelihood** of this adverse outcome occurring is then estimated on a 1x 5 scale. If possible assign a predicted frequency of the adverse outcome occurring. If this is not possible assign a probability of it occurring in a given timeframe, either by the percentage figure or the probability description below.

Table 2 – Likelihood Score

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	Less than 1%	1 – 5%	6 – 20%	21 – 50%	Greater than 50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

Some organisations are experimenting with the use of 'modifiers' to increase or decrease the consequence likelihood scores in certain circumstances.

Step 3: Multiplying the consequence score by the likelihood score to obtain the Risk Rating.
re: Consequence x Likelihood = Risk Rating

Table 3 -Risk Rating Matrix

Likelihood	Consequence				
	1	2	3	4	5
1- Rare	1	2	3	4	5
2- Unlikely	2	4	6	8	10
3- Possible	3	6	9	12	15
4 - Likely	4	8	12	16	20 #
5 – Almost Certain	5	10	15	20 #	25 ##

Step 4: The Risk Rating determines the severity or priority of the risk, and the level at which the Risk should be managed.

Low Risk
Med Risk
High Risk # and ##

1 – 6 Needs to be resolved or accepted at Departmental level*

8 – 12 Needs to be resolved or accepted at Directorate level*

15+ Needs to be resolved or accepted at Organisation level. i.e. Assurance & Risk Committee and Board

 # 20 may be considered Very High and ## **25** Extreme

*If the risk is not acceptable and cannot be resolved at the appropriate level, it needs to be fed to the next level via the risk register and other appropriate channels.

Step thirteen (Care planning)
The care plan (**Part 3 of Form PH2**) is used for detailing the handling tasks for which SOPs do not apply and explaining how the person is to be moved.

Column 1 is used to explain which handling task is being looked at. A brief description is all that is required but do make sure that it is clear.

Column 2 is used to describe the method of handling (the 'Person Individual Procedure'). This has been broken down into 3 elements:

M (method): Exactly what is to be done, be clear but concise,
e.g. 'Moving up the bed'
Be careful about combining complicated tasks e.g. sitting up in bed and moving up the bed. These would be better treated separately.

Eq.(equipment): What equipment is required for the task

N (number of handlers): How many people are required to carry out the task safely

Column 3 is to give details of the risk rating (RR) of the task (refer to guidance offered in step 9). If there are any special precautions (SC) or particular warnings (W), these should be included. The assessor may also want to detail their rationale/ clinical reasoning (CR) for choosing a particular method of handling for this person.

The assessor should be aiming for a risk rating of low or at most medium. It may be that an Action Plan (step14) is required to put a safe system of work into place before this risk rating can be achieved but any higher risk than this will be putting the handlers at unreasonable and avoidable risk of injury.

If assessors require assistance in developing person individual procedures for any particular person they should seek help from their line manager, trained risk assessors or manual handling link worker in the first instance. The M&H department is here to help with advice and training and for assistance in difficult assessments.

Step fourteen (Action planning)

If necessary, draw up an **Action Plan** in **Part 4 of Form PH2**. This plan is for the management of this particular person as opposed to an action plan developed for a unit or service.

Record the element of care that you are trying to improve, for example, sitting the person up in bed. In this situation the current risk rating should be given, in this situation, if the person is very dependant (mobility score 5) the risk would probably be high to very high. The action that would need to be taken would be the procurement of an electronic profiling bed. This might for example, reduce the level of risk to low.

The action may not always involve procuring equipment, it may be having an extra member of staff on duty, providing extra training for staff or making an environmental alteration.

If the assessor does not have the authority to implement the action plan then agreement must be sought from the manager or budget holder. *They* must indicate their agreement or non-agreement by signing-off the form and they must give their rationale or reasoning if they disagree with the action recommended.

Step fifteen (Building a person handling profile – See Step nine)

Returning to **Part 2 of Form 1** the assessor should now complete the person handling profile as detailed in step 9. Under 'method prescribed' the assessor should indicate for which tasks individual procedures have been developed.

Ongoing assessment and reviews

Assessment is a continuous process and not a one off event so it is vital that the person's handling needs are reviewed regularly. There is not a definitive time scale for re-assessment and it will vary from person to person. Situations when the person should be reviewed include:

- Whenever there is a change in their condition that affects their dependency or mobility
- When they are transferred to another ward or department
- When there is a change in any of the influencing factors e.g. they were being nursed in a side room but have been moved onto the main ward
- If equipment provision is an issue
- Following the person's involvement in a handling related adverse event/ incident (e.g. a staff member is injured during the handling of the person, the person falls or the handling manoeuvre is unsuccessful for any reason)
- The review columns on the person handling profile (**Part 2 of Form 1**) should be used to detail any changes. If more than three reviews are required, use another form.

Multidisciplinary communication

Space is available in **Part 2 of Form 1** for input from and notes to all members of the multidisciplinary team – physiotherapists, occupational therapists, doctors, care workers, radiographers etc.

It is good practice to involve everyone who needs to be involved in the process of assessment and care planning, including the person and family/ informal carers. An assessment has not been fully carried out if the people who have to operate the system are not consulted and involved. The person's wishes should always be taken into account if at all possible. This does not mean that their wishes over-ride health and safety requirements.

Balanced decision making

It is important to take a balanced view. Conflicts can usually be resolved (and complaints / litigation avoided) if the process complies with the following principles: -

- Everyone involved is positively and genuinely seeking a good outcome
- Everyone's needs are taken into account
- Communication channels are kept open and there is transparency in all planning
- Appropriate equipment is made available at the time it is needed
- All relevant legislation (European and national), case law, approved codes of practice, official guidance and professional guidelines are taken into account in formulating organisational and locals policies, protocols and procedures
- Detailed records are kept

Interagency working

The system, process and documentation is ideally suited for the planning of provision in complex cases where there may be difficulty placing a person and funding is an issue. It will make a significant contribution to identifying care needs and the risks involved and this should help when there is negotiation between all the parties regarding the suitability of placement and also the issues of funding and the provision of equipment, training and care management / supervision.

NB: Risk assessments done properly to give meaningful scores require knowledge and skills in risk assessment and therefore, training. The rest of the assessment for straightforward persons, can

be carried out by any competent staff nurse or therapist, with little extra training apart from a 90 - 120 minutes briefing session.

Standard Operating Procedures explanation

The Person Handling Needs and Risk Assessment System requires the use of Standard Operating Procedures or (SOPs) for its effective functioning. Using SOPs will enable a rapid assessment to be made and appropriate procedures prescribed without compromising staff or Person safety, or the quality of care.

Writing SOPs

SOPs are the standard procedures used for moving and handling persons who meet certain criteria. They are generically assessed and should provide the best care at the lowest risk. The process is fairly straightforward for practitioners with experience and expertise in their speciality of nursing, therapy or imaging; however, SOPs are best developed as a team effort, where everyone in the multidisciplinary team who is likely to handle the person, or be affected in any way, is involved and consulted.

The alternative is to write specific procedures for each and every person. These Person Individual Procedures or (PIPs) are appropriate for certain Persons; typically those with complex handling needs and rare combinations of problems. It has been found that over 90% of Persons can be managed by means of SOPs. It has also been found that PIPs written for one particular Person become useful for others sooner or later and therefore become SOPs.

The process

a. Using the forms provided, write down how you currently carry out all of the regular care tasks in your area (ward / department / unit / team). Do this simply but systematically – the process can be quite revealing!
b. Decide if the methods used are acceptable from a clinical and health and safety point of view. If they are write them down in the prescribed format.
c. If they are not acceptable, write down how you think the care tasks should be done if they are to conform to best, evidence-based practice. You may find that you are not able to work to this standard for a number of reasons. This is an opportunity for you to examine your practice and work out what you need to bring practice up to the required level.
d. You may need -
    1. more equipment
    2. extra staff
    3. environmental modification.

The SOP Form

a. **'Scope'** means where, when and to whom this SOP is to apply; e.g., all stroke persons; persons with a # neck of femur; certain kinds of elderly persons; and the work area to which it applies.
b. **Unit/ Ward/ Team/ Dept.** Self-explanatory
c. Write a brief description of the **task**, manual handling operation (MHO), manoeuvre, transfer or procedure. (These will be standardised in time).
d. Give the task a unique **Reference No**. This will consist of an organisation code for location (directorate/ department/ unit) and task/ procedure – see below.
e. Write a procedure for each level of dependency or mobility – 'Mobility Score' (MS), **1 - 6.**
f. Using the code **M**, write a brief description of the **method** – e.g., manual handling, sliding, turning, rolling, hoisting, profiling, re-positioning.
g. Using the code **Eq**, specify the **equipment** (handling and other) to be used.
h. Using the code **N**, specify or indicate the **number** of handlers.

i. In the right hand column, enter the **Risk Rating (RR).** This should be determined using the tables set-out in the detailed guidance notes for assessment. If the risk is low that is fine, medium might be just about acceptable, but SOPs scoring high, very high or extreme must be avoided if at all possible; their use is only permissible if there is no other way of achieving the objective. In such cases the SOPs must be kept under constant review. Reducing the risk may require any or all of the following:

handling equipment
electric beds, chairs, standing frames
training
supervision
environmental modification
more staff
delivering care another way

j. Also in the right hand column, enter the following, as appropriate: -

W	**Warnings**
SP / SC	**Special Precautions / Special Considerations**
CR	**Clinical Reasoning** for choosing this particular method

k. Enter the **Date implemented** and the **names and signatures** of the devisor of the SOP (optional) and the officer or manager responsible, as well as that of the Manual Handling Practitioner.

l. **Once signed-off**, the SOP is available for use, provided of course, that the systems are in place – equipment, staff, training, supervision, etc.

m. The last thing to do is set a **Review date**, although each SOP must be constantly monitored for safety, efficiency, effectiveness and quality. Feedback must be actively sought and recorded as part of the evaluation process.

n. These SOPs may be audited as often as necessary.

Advantages of SOPs

1 The process of writing SOPs gives focus to the provision of care and to Clinical / Practice Governance.
2 Risks due to moving and handling, for staff and Persons, are significantly reduced.
3 SOPs facilitate rapid assessment without loss of thoroughness or legal compliance.
4 Practice is standardised or harmonised and therefore becomes more consistent, and easier to follow and apply.
5 Practice is improved.
6 It is easier for new staff, bank and agency staff, as well as students, doctors, therapists, radiographers, etc., to assimilate the practice(s) and work with the regular staff.
7 Quality control is facilitated – monitoring, evaluation, audit and investigation.
8 As part of the person assessment system, SOPs permit the use of a simpler means of documentation, without compromising standards of clinical practice and record keeping.

Referencing

It is suggested that a standard system is used, with each task being allocated a number that is used throughout an organisation. Thus **number one** could be used for **sitting a person up in bed,** for example. If this is used with a location (department) code, each task is uniquely identified and the risks of ambiguity are reduced. This system has been used to advantage in other organisations.

<u>Standard Operating Procedures</u> (SOPs) for Moving & Handling

Scope_____**Unit/ Ward/ Team/ Dept.**_____

Manual Handling Procedure

(Task/ Manoeuvre)_____SOP Ref. No**.**_____

(Brief Description) (Organisation Code)

MS	STANDARD OPERATING PROCEDURE (Write an SOP for each Mobility Score level (MS)	RISK RATING, WARNINGS, SPECIAL PRECAUTIONS & CLINICAL REASONING
1	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
2	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
3	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
4	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
5	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
6	**M:** **Eq:** **N:**	**RR:** Low/Med/High/ V.High/ Extreme **W/SP:** **CR:**
Comments		

Agreed by Manual Handling Practitioner _____ ____/____/____
Name & Signature

Responsible Manager_____ Date Implemented ____/____/____
Name & Signature

<u>Legend:</u> **M = Method, Eq = Equipment/ Aids, N = Number of Handlers -- (To go in <u>left</u> hand column)**
RR = Risk Rating, CR = Clinical Reasoning } (To go in <u>right</u> hand column)
W = Warnings, SP / SC = Special Precautions / Considerations }

Frequently Asked Questions with regards to Person Handling Risk Assessment

Why do we have to risk assess our persons?

- To determine if the handling needs of the person pose a risk of injury to the staff or the person
- To provide a clear and concise picture of what handling needs the person has
- To provide information regarding appropriate methods of handling the person, making sure that any potential risks are reduced to the lowest level that is reasonably practicable
- To assist with planning care for each individual person
- To comply with the legal responsibilities of the organisation and requirements of clinical governance.

Why do we have to write it all down?

- To assist with communication
- To comply with legal responsibilities
- To supply 'demonstrable evidence' that the assessment has been carried out and to provide a record of the findings and the action taken to reduce the risk of injury. (In legal circles it is often said that "If it isn't written down, it didn't happen")

What if the person does not need any help with handling?

Simply record the fact that the person's mobility score is 0 and your assessment is at an end. It is necessary to document this to provide proof that the handling needs of the Person were considered. (There may be local arrangements which render this unnecessary).

Why does it take so long?

The system of assessment and documentation we have developed is designed to speed the process up as much as possible. There is however a limit as to how speedily the task can be done if we are to provide a suitable and sufficient assessment that is of use to you and your colleagues and covers the legal responsibilities of the process. For a Person with straightforward handling needs for whom SOPs are applicable, the assessment process should not take much longer than 5 minutes.

A person with more complicated handling needs, requiring the use of both forms and the development of Person Individual Procedures, will take a reasonable amount of time to assess. However if the process is to be a meaningful one it, is not possible to make it any quicker. It is worth remembering that less than 10% of persons are likely to require the full process. In any case, Persons who require in-depth assessments usually receive care for relatively long periods, so there is time to assess them thoroughly for needs and risks.

What is a SOP?

A SOP is an abbreviation for a **Standard Operating Procedure**. The idea is that by having these ready prepared methods, or “Safe Systems of Work”, the time required to assess the person and plan for their for handling needs, will be greatly reduced. Another advantage is that methods will become standardised across the organisation, or at least, within departments.

Each department within the organisation should have their own SOPs which are relevant for their own 'standard' group of persons. Each staff member should familiarise themselves with the SOPs for their area so that they know how each person for whom SOPs are applicable should be handled.

Staff members should seek advice from their ward manager or handling co-ordinator or equivalent, if they are unfamiliar with any of the techniques detailed by the SOPs so that any training needs can be identified.

Who should be carrying out these assessments?

This is a matter for local managers who must satisfy themselves that anyone who is required to complete these forms is competent to do so and/ or the appropriate supervision is carried out. All person handlers need to be able to read the forms and apply their recommended or stipulated procedures

Where these forms should be kept?

Again this is a local matter, but our recommendation is that the forms are kept with the Person (i.e. at their bedside) so that anyone who is required to handle the person has easy access to the assessment. Confidentiality and person/ family involvement are two issues that will need to be considered.