

Moving & Handling



Medical Solutions



**South African
Moving & Handling Project**

presents

**A Case for Legislative Change in
Safe Patient Handling
in South Africa**

Gavin Wright

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Introduction

Since people started caring for others, musculoskeletal problems, especially back injuries, have been among the most frequently experienced. The injuries received not only are expensive for the sufferer, but also the organisations who need to replace their staff concerned. Pain is par for the course, but often the sufferer cannot return to work, thus adding to the well-documented nursing shortage now and in the foreseeable future. Prior to 1992, the UK were losing 3600 nurses per year (10 every day of the week) to back pain. The current situation in the USA (where safe patient handling is just starting) is that 12% of nurses leave the profession annually due to back pain, however, it is noted that 98% of lifting patients is still done manually. Although there are no statistics for South Africa currently, the situation is comparable. Usually these injuries are resulting from cumulative stress rather than a specific one off incident. The USA figures show that 68% of disabling injuries to nurses are caused by manual lifting of patients.

This doesn't take into account the pain and discomfort experienced by the individuals being cared for. Imagine for instance, a patient with existing musculo-skeletal problems being manually lifted under the armpits and thighs by two nurses' who have been given no equipment and/or training to assist them.

Putting the patients to one side for the moment and taking just the nursing staff into consideration, the negative impact of this results in compensation payout's, nursing staff forced into early retirement, staff retention problems as they seek alternative employment or seek better working conditions overseas and of course, excessive governmental training costs as staff need to be replaced at a quicker than normal rate.

In the UK, as soon as the Health & Safety at Work Act (HASAWA) was published in 1974, safe patient moving and handling was debated. This Act of parliament was designed primarily as a means of accident prevention. However, it also provided a base line for which injured parties could seek compensation if the law was not upheld by an employer. This starting line is where we in South Africa are at present. This comes in the form of the Occupational Health and Safety Act (OHSA) 1993.

Although no specific safe patient handling law was in force, the very first time that a nurse successfully sued the UK's NHS, was 8 years later in the case of Williams v Gwent Health Authority (1982). Williams was a nurse in a ward where the "drag lift"* was used. The argument put forward was that this manner of moving someone was an "unsafe system of work" which put the employer in breach of section 2.2 of the HASAWA. The same legal demand is to be found in section 8 of OHSA. Williams' successful arguments in this case provided the means for many individuals to use it as a legal precedence of common law and pursue claims themselves. To date, no employer has managed to successfully defend it's use, firmly establishing it's legal classification of an unsafe system of work. Incidentally, the author of this document noted that during his research for this article, it was the most common method seen to be used within the hospitals visited. Each of the subsequent risk assessments involve in one form or another, the drag lift.

* The Drag Lift is any lift or movement of another individual where the carer uses the patients' axilla (arm pit) as a lever or handhold. For example, moving the patient up a bed, assisting them to stand, or even supporting them ready to catch via the axilla if they were to stumble while walking with them (see pictures E & H in this document).

The Williams case only served as identifying one method of patient handling as an unsafe system of work. Other cases brought further practices into question. Moore v Norfolk Health Authority (1982) highlighted that the orthodox lift was an unsafe system of work and Munro v Plymouth Health Authority (1991) did the same for the Australian lift which had been introduced as a means of combating the problems caused by the drag lift.

A flurry of activity in regard to patient handling occurred during the 1980's and 1990's. Starting in 1982, the Royal College of nursing published their guidance on the handling of patients which was revised in 1993 and again in 1996. In 1984 "The lifting of Patients in the

Health Services” was published by the Health Services Advisory Committee. This again was revised in 1992 and 1998. Although they were not legislation, they provided the courts with evidence to decide whether a breach of health and safety law had taken place. On their own a judge cannot decide if a breach has taken place, they must be drawn on and supported by an expert witness in each case.

The UK approach meant that each case individual case must be looked at on it's own merit. Further clarification was needed on identifying the unsafe practices as well as making the litigation channel more open for both employers and employees to see. By 1992 it was seen as necessary to prevent accidents by regulation and guidance of the HASAWA. So to be brought into force in January 1993 the Manual Handling Operations Regulations (MHOR) 1992 was published.

All of the above led to a swing from one extreme to another. The starting point being that nurses did all of the lifting, the end point being that “No Lift” policies were brought into existence. These no-lift policies were derived from the fact that MHOR had stipulated that any load over 25Kg (16Kg if a woman was the lifter) should be lifted without a risk assessment in place. Again, these weight limits were under ideal conditions, the limits drop according to the degree of flexion, stretching and knee bending needed to be done (see appendix 1). However, rather than simply conducting the risk assessments, health care establishments reasoned that if no-one is allowed to lift at all, then health and safety issues will be taken care of.

In 1996, some establishments started introducing moving and handling coordinators to be pro-active in combating these issues. This was accelerated in the 2000's to the point now where all NHS trusts have the role of Moving and Handling Coordinator (MHC) or Back Care Advisor (BCA) in a senior position with key workers in each ward. The latter being ward based staff who have the additional role of ensuring good practice is maintained in their area.

It appears that almost 30 years after this debate had been started by the introduction of the Health & Safety at Work Act in 1974 the pendulum started to settle as a result of the A&B, X&Y v East Sussex County Council case in 2003. In this case, the Judge decided that a “blanket ban” on lifting was unlawful. The two people concerned (A&B) were sisters with profound physical and learning disabilities. X&Y (mother and step-father) argued that to hoist them in a machine was making them afraid. Their argument was that Health and Safety laws should not only be a matter of physical, but also psychological safety. The Judge agreed and summarised his findings by implying that a balance where both parties make a degree of trade off is required. The ideal being that no nurses is put at risk by lifting patients but where there is disparity between opposing sides, the phrase “reasonably practicable” needs to be considered.

As a result of all of this, the UK now enjoys a situation where hardly anyone in a hospital or care home setting is ever lifted manually. In the rare cases where someone is lifted, it is always with the intention of assisting that individual to rehabilitation or acceptance of the nurses need for their health and safety to be considered in the long run. All nurses have the right to refuse to lift a patient where they feel they would be compromised. The Judge in the East Sussex case said that we should all remember the words of Jesus Christ, “do to others and you would have them do to you.” After all this is what nursing is about. Let us start putting the patient first while not neglecting our own self.

This rather messy and confusing evolution of safe patient handling legislation was being observed from overseas by the American Nurses Association (ANA). Wanting to avoid the lengthy protracted affair the UK put itself through, ANA have promoted specific Safe Patient Handling Legislation and not as exists in the UK, laws which are generic to all industries and interpreted to fit each situation. Texas became the first to agree with ANA in 2005 introducing their state legislation in this matter. Since then about half of all US states have introduced Safe Patient Handling legislation with others in the process of formulation. ANA and their supporters though, are still pushing for a national legislation to be brought into force. This is currently with the Senate in the USA and will likely be passed in the near future.

Other countries which have gone down the route of legislating safe patient handling laws are Australia, Canada, New Zealand, Japan and most European countries.

The current South African position

With the National Health Initiative (NHI) being upon us, not only is it time for South Africa to also consider this serious aspect of patient care, we also have the basis for it in law. We also have the potential of stumbling along as in the UK, being forced down legislative change through common law. Or we can get down to business and design a system of work which will protect the workforce and patients alike by legislating change.

As we all know, the brain drain that South Africa has been experiencing has the potential to cripple the economy. Skilled workers should be encouraged to return home. With regards to nursing staff, the conditions play a large part in the problem. The executive of the South African Moving & Handling Project (SAMHP) have met and discussed with many South African nurses overseas to ascertain what would encourage them to return to their homeland. The vast majority stated that they would love to return home to work and live. However, what is keeping them away is the working conditions they expect to encounter. Manually lifting quadriplegic patients for instance without any mechanical assistance to do so. Who is it that does most of the caring? It is the female population. According to BEE, women should be empowered into work. This can only go forward if improvements are made in their working conditions. However, women are expected to physically lift, very heavy patients, all day, every day of their working lives.

The lack of patient handling equipment, from the simple to the more detailed, is not only causing the injuries in the first place, but keeping the best nurses away from the country as they prefer to work in an environment where they feel they can make a difference.

This is closely linked to a lack of training resulting in unsafe techniques for patient handling being employed. For instance, in the UK they have a classification of lifting techniques which is termed as a "Controversial Technique". Any person found to be using these techniques must be able to justify why they employed it rather than an approved safer method.

In nursing heavy lifting is a major part of the job. It is very difficult to collate accurate work-related injury figures for South Africa, but according to most sources, as much as 50% can be put down to manual handling. Compare this with just 204 injuries using hoists in the whole of the UK during the 2006-7 year. This figure is accurate, as the UK has a very stringent reporting system.

Another consequence to consider resulting from unsafe lifting practices is "Work Instability" (WI). WI occurs where there is a mismatch between job function and individual capability. The majority of nurses train early on in working life, when they are relatively fit and can handle the pressures of nursing life. However, as time encroaches, and the ravages of advancing age take hold, coupled with the cumulative strain they have been exposing themselves to, WI begins to develop. The nurse becomes more susceptible to sickness absences, light duty requests, early retirement or even seeking employment overseas where the workload is easier. This takes place at a time when their experience is at a height and could be used productively.

There is an obvious link between the "lifting culture" that South African nurses experience and the incidence of back pain / injury. Sadly, it is a way of life and it must be stopped. Many people, nurses included, believe that back pain "goes with the job". This does not have to be the case. South African nurses working overseas are aware of this fact.

According to the Occupational Health and Safety Act (OHSA) of 1993, all health care establishments, shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of employees. Furthermore, the OHSA also demands that safe systems of work are introduced within the workplace. Further to this point, it also indicates that all employers must be pro-active in the assessment of hazards and not re-active.

1. OHSA goes on to explain that once hazards have been identified, information, instruction, training and supervision is required to ensure that the identified hazard has the lowest reasonably practicable level.
2. On another point, the recent discussions around the new NHI concept demand an increase in the quality of patient care and delivery to the end user.

It is with regard for these two points that Moving & Handling Medical Solutions (MHMS) propose to introduce safer patient handling practices throughout all government hospitals in South Africa.

A new post is required. One of Hospital Moving and Handling Coordinator

Safer patient handling is not simply a matter of learning some new techniques and training others in their use. It starts with changing mindsets of individuals to realise the importance of good practice, not only for their own sake, but also for the sake of those for whom they care. This cannot be achieved by introducing equipment or by the delivery of a few training sessions. A new post is required. One of Hospital Moving and Handling Coordinator (HMHC). In most hospitals, this could be an extension of the Occupational Health & Safety Officer's role. This person needs to be trained to an exceptionally high standard in identifying hazards and risk assessment relating to safer patient moving and handling. They should have authority to be able to implement the required changes to systems of work, but also the enthusiasm to be able to encourage and manage change without resorting to disciplinary procedures.

Anecdotal evidence suggests that a huge number of nurses are on light duties; i.e. underused or inactive as a result of poor lifting practices. Six theatre nurses are currently on the pay-role of just one hospital that fall into this group; that is just one department in one hospital. By eliminating the need for lifting patients and utilising the techniques and equipment introduced, there is no reason why each of these nurses cannot be used to their fullest potential.

Recognising the history of South Africa, the health care institutions have been disadvantaged and deprived of resources suitable for its patients, clients and employees. This led to the situation which exists today, that of physically lifting patients rather than empowering them to do the job in a more efficient way.

Employees have been using their physical strength to manually lift patients to facilitate Health care. The result? The government spending Billions of Rands in compensation, law suits and consequential loss of valuable staff as they seek employment overseas, especially the UK.

Therefore as stated in the BEE Charter, we need an *“adoption of a proactive strategy of change to foster and encourage transformation in the health care institutions at the tiers of Management, employment equity and rural development”*. As stated, these are the most disadvantaged i.e. our managers, employees and rural communities with their lack of manual handling skills and equipment. It is imperative to redress the historical imbalance of the past and serve our people fairly thus be able to compete with the international community.

Every ward, in every hospital where it is required, should have at least one patient hoist available at all times. Patient lifting hoists which are manufactured in South Africa, will create employment as they produce, service, repair and replace these, and other aids to mobility as well.

The positive effects of all this will be to enrich nursing knowledge and morale, making South Africa one of the places where nurses want to work. It will encourage the home coming revolution as these same nurses begin to take a national pride in what is happening here. As they return, they will bring with them the knowledge and experience they have gained overseas, giving us a globally competitive health care system.

Methodology for this document and pilot programme

This document has been compiled to highlight the difference between pre- and post-intervention assessment of patient handling procedures. Two methodologies have been utilised in each assessment;

1. MAC (Manual Handling Assessment Chart) tool (in part) and
2. REBA (Rapid Entire Body Assessment) postural analysis tool

MAC assessment tool

This method was introduced in 2003 by the Health & Safety Executive of the UK. It provides a quantitative analysis of the level of risk where an object is being handled. It also looks into the risks associated with team handling. However, while it is good for quick assessment of inanimate loads, it makes no allowance for the unpredictable nature of a person who is being handled or lifted. MAC allows for a quick assessment to see if further assessment is required. To gauge if further assessment is required, the Filter system (see appendix 1) can be used. Hence, it is partly used in this document as a precursor for the more detailed REBA postural analysis tool.

REBA postural analysis tool

This method was introduced in 2000 by Hignett & McAtamney of Loughborough University. It looks at key body parts and their degree of flexion or extension during a given procedure. It also takes into consideration additional factors such as the weight of the load, the ease of handling, the build up of force on the handler and the activity being carried out. It records outcomes based upon five levels of risk ranging from “Negligible” where no further action is required, to “Very High” where the task must cease until a safer solution can be found. For these reasons, it is currently the most appropriate ergonomic tool in patient handling assessment. The figures in the assessments are compiled from the REBA tables (see appendix 2).

Each nursing intervention is presented as a task, i.e. “*Task One: Turning a patient in bed.*” The first assessment is pre-intervention, while the second assessment of the same task, is post-intervention to make a direct comparison. The MAC assessment tool is used to quickly show that there is a need for a more detailed assessment. This detail comes through the REBA assessment. Video footage is taken (from where the still images are taken). The following page is the assessment itself completed by a qualified and experienced instructor with their rationale for the assessment on the subsequent page.

The term “Reasonably Practicable”

The process of risk assessment in order to comply with the OHS Act should be hinged around the term “reasonably practicable”. Before we can proceed we need to determine what is meant by the phrase “reasonably practicable”. The problem with the phrase lies in that which one person perceives as being “reasonable”, another will feel that the same solution is completely “unreasonable”. If there is a dispute between two parties, who is to say which one is correct? The answer to this question, sadly is often the presiding Judge. How does the Judge make a decision?

That which one person deems to be reasonable is likely to be considered unreasonable by another

Firstly, he recognises that the phrase “reasonably practicable” is different from “physically possible”. The prosecuting party may look at all possibilities and argue their case from their most favoured stand point. The Judge will also recognise that “reasonably practicable” is different from “profit and loss”. The defending side may present their case based upon everything depending upon profitability, arguing that it is not reasonably practicable to operate a company at a loss. However, the Judge is unlikely to agree that health and safety should be put to one side for the sake of profit. The days of operating businesses at the expense of the workers health and safety are firmly in the past.

He will make a balance with the “risk factor” on one side of the scales and the “time, effort and cost” on the other side. The greater the “risk factor”, the more “time, effort and cost” should be expended to reduce the risk.

Where a Hazard has been identified, the following is required:-

- Avoid** – wherever possible, all manual handling should be avoided
- Assess** – where this is not possible, the risk should be assessed
- Reduce** – if the assessment warrants, the risk should be reduced
- Review** – if circumstances change or new products are available

Cost / Benefit Analysis (Reasonably Practicable)

Not every situation or ward requires the use of machinery to produce a safer handling environment. For instance, some people simply need assistance with natural movement to achieve the goal of moving them. However, for the sake of this exercise and to demonstrate how to get a “reasonably practicable” outcome, we will consider the following example where a hoist is requested for an appropriate setting:-

Machines vary in cost depending upon manufacturer and function, however, a typical machine costs approximately R28,000. If this typical machine does approximately 10,000 lifts per year (based upon 28 lifts per day or 7 people hoisted 4 times a day), the following formula would apply.

$$**R28,000 / 10,000 lifts / 2 people = R1.28 per lift.**$$

As previously stated, and according to the OHS Act, we must be seen to be reducing risks as far as is “reasonably practicable”. It is the belief of MHMS that the cost of R1.28 per lift is a “reasonable” cost to take an individual from a “Very High” risk factor to a “Medium” or even in some cases “Low” risk factor.

However, the reality is that these machines will give much more than just one year service, reducing the cost per lift even further.

Other cost-saving benefits come in the form of reduced costs in other areas, i.e.,

- reduced number of catheterisations and associated complications thereof. Patients who were once catheterised simply because getting them to the toilet was a problem can now have their dignity restored as a result of the improved service delivery.
- reduced cost of disposable nappies as service users will be empowered to frequent the toilet more often.
- reduced number of injuries associated with poor handling techniques, that is, patients being dropped, subluxations of patient shoulder cuff muscles, bruising, clavicle fractures and of course nurses being injured while carrying out their duties.

The following pages provide the quantifiable evidence for the above claims based on pre- and post- intervention assessments.

Task One:
Turning patient in bed

Pre assessment

Initial Assessment

Task: Turning patient in bed

Date: 16/March/2010

Location: undisclosed

Moving & Handling Risk Assessment

Section A

Basic Task Description:

Rotating (turning) a patient in bed

Load/Weight:

Up to 200Kg

Frequency:

Several times an hour

Distance:

Less than 20m

Is assessment needed?
(if yes continue)

Yes

Section B

Detailed Task Description:

Two staff work together to turn a patient in bed. Standing either side of the bed, they place their arms under the patient and clasp wrists (see picture A). The patient is then lifted to one side of the bed (see picture B). The patient is then rolled back to the centre of the bed (see picture C).

The procedure took 34 seconds with both members of staff in flexion for 100% of the time. Excessive flexion and hyper flexion (REBA score of 3 or 4 respectively) was maintained for a period of 21 seconds often under excessive loading conditions.

Overall REBA score (assessed from picture B nurse A) was 12 indicating a "Very High" risk factor. The task should cease with immediate effect and safer alternatives introduced.

How many people required:

2

Section C

Remedial Steps in Order of Priority:

1. Training in back care for staff
2. Introduction of slide sheets for all dependent patients

Date of implementation:

The REBA score indicates that this task should stop with immediate effect and safer patient handling systems introduced at the earliest opportunity.

Review date:

One month from the date of initial assessment

Assessed by:

.....Gavin Wright.....



Picture A



Nurse A

Picture B



Picture C

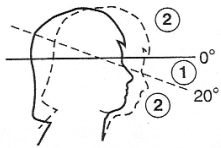
Rapid Entire Body Assessment

Task: Turning patient in bed

Date: 16/March/2010

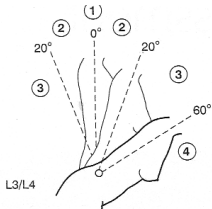
Location: undisclosed

Group A



+ 1 if twisted or side flexed

Neck score 2

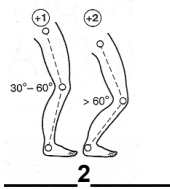


+ 1 if twisted or side flexed

Trunk score 4

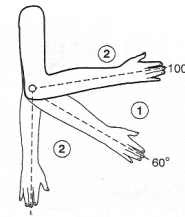
1 if bilaterally weight bearing/sitting

2 if unilaterally weight bearing or unstable base



2

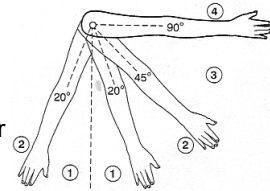
Group B



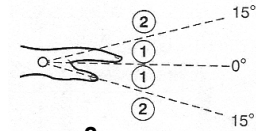
Lower arm score 1
(angle of the elbow)

+1 if ab/adducted or raised shoulder
-1 if supported

Upper arm score 5
(in relation to spine)



+1 if deviated or twisted



Wrist score 2

Table A = 6

+

Load/Force

3

+ 0 if < 5Kg
+ 1 if 5-10Kg
+ 2 if > 10Kg
+ 1 if sudden build up of force

Score A =

9

Use Table C

11

+

Activity score

1

=

REBA Score

12

7

= Table B

+

+ 0 if good
+ 1 if fair
+ 2 if poor
+ 3 if unacceptable

0

Coupling

=

= Score B

+1 if one or more body parts are static for longer than one minute
+1 if small range movements are repeated more than four times a minute
+1 if large rapid change in posture or you become unstable

Good = mid range power grip
Fair = fully closed or fingers slightly curled or using some other part of the body
Poor = flat hands
Unacceptable = dangerous

Score

1

2-3

4-7

8-10

11-15

Risk factor

Negligible

Low

Medium

High

Very High

Action

No need for any action

Action has probably already been taken to get to this level

Further consideration should be given as how risk can be lowered

Action needs to taken very soon

Work must cease until a safer solution can be found

Rationale for the above REBA Assessment

Group A

Neck: In extension as he communicates with colleague
Trunk: Hyper flexion
Legs: Bi-lateral weight bearing, straight legs with unstable base

Group B

Lower arm: Extended to between 60° and 100°
Upper arm: Greater than 90° in relation to the spine + utilisation of shoulder muscles
Wrist: Relatively flat over the dorsal aspect but deviated to take grasp of colleague

Load/Force: >10Kg load with sudden build up of force
Coupling: Mid range power grip

Activity: Large rapid change in posture + instability

Risks to staff:

Back pain and other musculo-skeletal disorders.

Risks to patients:

Discomfort and psychological injuries

Outcome:

As the REBA score suggests, this task must stop with immediate effect and safer solutions adopted. The consequences of failing to adopt a safer handling technique could be back injuries and other musculo-skeletal disorders to staff due to excessive flexion

Solution:

When moved around on the bed, the patient should have access to a slide sheet.

Task One:
Turning patient in bed

Post assessment

Initial Assessment

Task: Turning patient in bed

Date: 16/March/2010

Location: undisclosed

Moving & Handling Risk Assessment

Section A

Basic Task Description:

Rotating (turning) a patient in bed

Load/Weight:

Up to 200Kg

Frequency:

Several times an hour

Distance:

Less than 20m

Is assessment needed?
(if yes continue)

Unlikely if the following procedure is used.

Section B

Detailed Task
Description:

Two staff insert a tubular slide sheet under a patient without rolling (see picture J). One staff member turns the patient using the top part of the slide sheet by pulling at 45° (see picture L, nurse A). The other is there for safety only.

How many people
required:

2

Section C

Remedial Steps
in Order of Priority:

N/A

Date of
implementation:

If previous assessments have indicated a higher REBA score, this method should be considered at the earliest opportunity.

Review date:

One month from the date of initial assessment

Assessed by:

.....Gavin Wright.....



Picture J



Picture K



Nurse A

Picture L

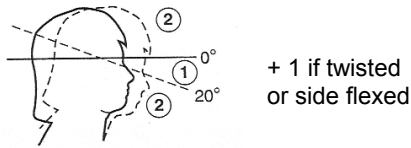
Rapid Entire Body Assessment

Task: Turning patient in bed

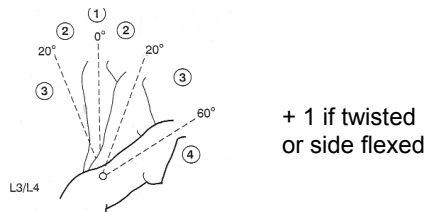
Date: 16/March/2010

Location: undisclosed

Group A



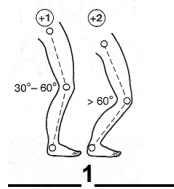
Neck score 2



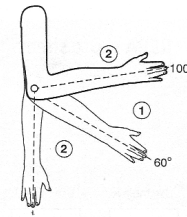
Trunk score 1

1 if bilaterally weight bearing/sitting

2 if unilaterally weight bearing or unstable base



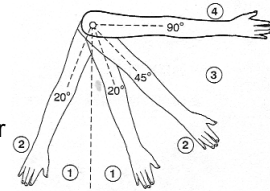
Group B



Lower arm score 2
(angle of the elbow)

+1 if ab/adducted or raised shoulder
-1 if supported

Upper arm score 3
(in relation to spine)



+1 if deviated or twisted

Wrist score 2

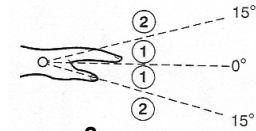


Table A =

1

+

Load/Force

2

+ 0 if < 5Kg
+ 1 if 5-10Kg
+ 2 if > 10Kg
+ 1 if sudden build up of force

Score A =

3

Use Table C

5

+

0

=

5

Activity score

REBA Score

5

= Table B

+

+ 0 if good
+ 1 if fair
+ 2 if poor
+ 3 if unacceptable

1

Coupling

6

= Score B

+1 if one or more body parts are static for longer than one minute
+1 if small range movements are repeated more than four times a minute
+1 if large rapid change in posture or you become unstable

Good = mid range power grip
Fair = fully closed or fingers slightly curled or using some other part of the body
Poor = flat hands
Unacceptable = dangerous

Score

1

2-3

4-7

8-10

11-15

Risk factor

Negligible

Low

Medium

High

Very High

Action

No need for any action

Action has probably already been taken to get to this level

Further consideration should be given as how risk can be lowered

Action needs to taken very soon

Work must cease until a safer solution can be found

Rationale for the above REBA Assessment

Group A

Neck: In flexion
Trunk: Erect
Legs: Bi-lateral weight bearing, straight legs with stable base

Group B

Lower arm: Flexed to beyond 100°
Upper arm: Slightly to the rear with utilisation of shoulder muscles
Wrist: Relatively flat over the dorsal aspect and rotated to palm down

Load/Force: >10Kg load
Coupling: Fair. Comfortable but beyond a Mid range power grip

Activity: No additional points required

Risks to staff:

"Medium" risk reduced from "Very High"

Risks to patients:

Minimal

Outcome:

As the REBA score suggests, this task is in the lower end of the medium risk category and therefore continued research for alternatives should be considered, but this may be the most "reasonably practicable" solution.

Task Two:
Transferring a patient from bed to chair

Pre assessment

Initial Assessment

Task: Transfer from bed to a chair Date: 16/March/2010

Location: undisclosed

Moving & Handling Risk Assessment

Section A

Basic Task Description:

Transferring a dependent patient from bed to a chair

Load/Weight:

Up to 200Kg

Frequency:

Several times an hour

Distance:

Less than 20m

Is assessment needed?
(if yes continue)

Yes

Section B

Detailed Task
Description:

Two staff work together to transfer a patient from bed to a chair. Standing either side of the bed, they first lowered the bed which placed them at greater postural risk for the remainder of the procedure. A further complication of this is that the patient would require more effort to attain a standing position if she had been able to assist. However, her level of dependency dictated the fact that the result was more effort exerted on the part of the staff.

Using the patients legs they swing her into a position suitable for standing (see picture D). This places nurse A into a REBA score of 13. To stand the patient they utilise the Drag Lift (see picture E). The patient could not weight bear and was held up throughout the procedure by the staff. If she collapsed at this moment the natural reaction would be to hold her up by her axillar increasing the risk of shoulder cuff injuries and causing pain to the patient while their already loaded spines would have been placed at geater risk with the increased unexpected weight and awkward posture.

How many people
required:

2

Section C

Remedial Steps
in Order of Priority:

1. Training in back care for staff
2. Introduction of & training in the use of mechanical hoisting equipent
2. Introduction of slide sheets for all dependent patients

Date of
implementation:

The REBA score indicates that this task should stop with immediate effect and safer patient handling systems introduced at the earliest opportunity.

Review date:

One month from the date of intial assessment

Assessed by:

.....Gavin Wright.....



Nurse A

Picture D



Picture E

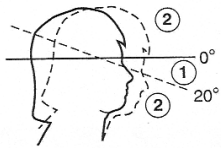


Picture F

Rapid Entire Body Assessment

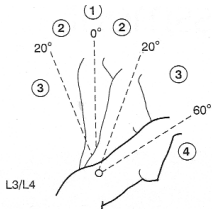
Task: Transfer from bed to a chair Date: 16/March/2010 Location: undisclosed

Group A



+ 1 if twisted or side flexed

Neck score 2

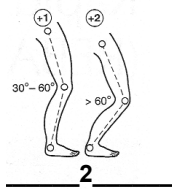


+ 1 if twisted or side flexed

Trunk score 5

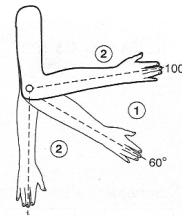
1 if bilaterally weight bearing/sitting

2 if unilaterally weight bearing or unstable base



2

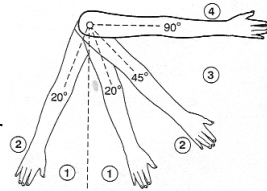
Group B



Lower arm score 2
(angle of the elbow)

+1 if ab/adducted or raised shoulder
-1 if supported

Upper arm score 5
(in relation to spine)



+1 if deviated or twisted

Wrist score 2

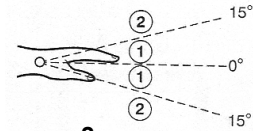


Table A =

7

+

Load/Force

3

+ 0 if < 5Kg
+ 1 if 5-10Kg
+ 2 if > 10Kg
+ 1 if sudden build up of force

Score A =

10

Use Table C

12

+

Activity score

1

=

REBA Score

13

+1 if one or more body parts are static for longer than one minute
+1 if small range movements are repeated more than four times a minute
+1 if large rapid change in posture or you become unstable

8 = Table B

+

+ 0 if good
+ 1 if fair
+ 2 if poor
+ 3 if unacceptable

2

Coupling

= 10 = Score B

Good = mid range power grip
Fair = fully closed or fingers slightly curled or using some other part of the body
Poor = flat hands
Unacceptable = dangerous

Score

1

2-3

4-7

8-10

11-15

Risk factor

Negligible

Low

Medium

High

Very High

Action

No need for any action

Action has probably already been taken to get to this level

Further consideration should be given as how risk can be lowered

Action needs to be taken very soon

Work must cease until a safer solution can be found

Rationale for the above REBA Assessment

Group A

Neck: In extension as she communicates with colleague
Trunk: Hyper flexion plus (as can be seen on video) rotation occurs during movement
Legs: Bi-lateral weight bearing, straight legs with unstable base.

Group B

Lower arm: Extended to below 60° of flexion
Upper arm: Greater than 90° in relation to the spine + utilisation of shoulder muscles
Wrist: Flat hands palm uppermost

Load/Force: Potential of >10Kg load with sudden build up of force
Coupling: Flat hands

Activity: Large rapid change in posture + instability

Risks to staff:

Back pain and other musculo-skeletal disorders.

Risks to patients:

Subluxation of shoulder, injuries associated with a fall, psychological injuries

Outcome:

As the REBA score suggests, this task must stop with immediate effect and safer solutions adopted. The consequences of failing to adopt a safer handling technique could be back injuries and other musculo-skeletal disorders to staff due to excessive flexion or attempting to rescue a fall if the patient slips. Utilising the drag lift brings with it, the risk of subluxation or even dislocation of the patient shoulder.

Solution:

This patient should be hoisted. When moved around on the bed, the patient should have access to a slide sheet.

Task Two:
Transferring a patient from bed to chair

Post assessment

Initial Assessment

Task: Transfer from bed to a chair Date: 16/March/2010

Location: undisclosed

Moving & Handling Risk Assessment

Section A

Basic Task Description:

Transferring a dependent patient from bed to a chair

Load/Weight:

Up to 200Kg

Frequency:

Several times an hour

Distance:

Less than 20m

Is assessment needed?
(if yes continue)

Yes

Section B

Detailed Task
Description:

In most cases, one staff member transfers a patient from bed to a chair using a hoist. The sling is placed under the patient by rolling the patient to one side and laying the sling on the bed. The patient is then rolled back onto the sling. The hoist is then placed in situ and the straps of the sling attached (see picture M). Using the hand control, the patient is then lifted (see picture N). The machine is then moved into position and placed onto chair, wheelchair or another bed (see picture O). The REBA assessment is done during the transfer (Picture O)

How many people
required:

1

Section C

Remedial Steps
in Order of Priority:

1. Training in back care for staff
2. Introduction of & training in the use of mechanical hoisting equipment
2. Introduction of slide sheets for all dependent patients

Date of
implementation:

The REBA score indicates that this task should stop with immediate effect and safer patient handling systems introduced at the earliest opportunity.

Review date:

One month from the date of initial assessment

Assessed by:

.....Gavin Wright.....



Picture M



Picture N

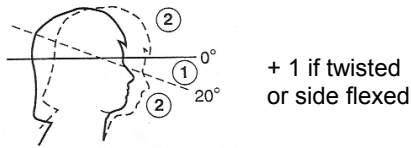


Picture O

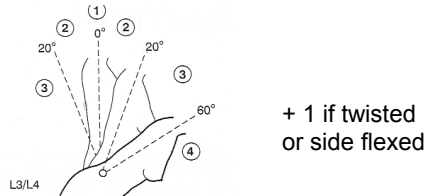
Rapid Entire Body Assessment

Task: Transfer from bed to a chair Date: 16/March/2010 Location: undisclosed

Group A



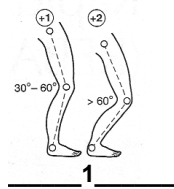
Neck score 2



Trunk score 1

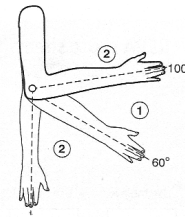
1 if bilaterally weight bearing/sitting

2 if unilaterally weight bearing or unstable base



Lower arm score 1

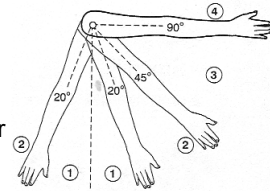
Group B



Upper arm score 1
(angle of the elbow)

+1 if ab/adducted or raised shoulder
-1 if supported

Lower arm score 1
(in relation to spine)



+1 if deviated or twisted

Wrist score 1

Table A =

1

+

Load/Force

2

+ 0 if < 5Kg
+ 1 if 5-10Kg
+ 2 if > 10Kg
+ 1 if sudden build up of force

Score A =

3

Use Table C

2

+

0

=

2

Activity score

REBA Score

1

= Table B

+

+ 0 if good
+ 1 if fair
+ 2 if poor
+ 3 if unacceptable

0

Coupling

1

= Score B

+1 if one or more body parts are static for longer than one minute
+1 if small range movements are repeated more than four times a minute
+1 if large rapid change in posture or you become unstable

Good = mid range power grip
Fair = fully closed or fingers slightly curled or using some other part of the body
Poor = flat hands
Unacceptable = dangerous

Score

1

2-3

4-7

8-10

11-15

Risk factor

Negligible

Low

Medium

High

Very High

Action

No need for any action

Action has probably already been taken to get to this level

Further consideration should be given as how risk can be lowered

Action needs to taken very soon

Work must cease until a safer solution can be found

Rationale for the above REBA Assessment

Group A

Neck: In flexion
Trunk: Straight spine
Legs: Bi-lateral weight bearing with stable base.

Group B

Lower arm: Extended between 60° and 100°
Upper arm: Less than 20° in relation to the spine
Wrist: Neutral

Load/Force: Greater than >10Kg load with no sudden build up of force
Coupling: Mid range power grip

Activity: No applicable risks apply

Risks to staff:

Very low

Risks to patients:

Very low

Outcome:

As the REBA score suggests, this task has taken away the high chance of subluxations of the shoulder. The risk of dropping the patient has been negated and back injuries have been dramatically reduced.

Task Three:
Moving a patient on the bed

Pre assessment

Initial Assessment

Task: Moving a patient on a bed

Date: 16/March/2010

Location: undisclosed

Moving & Handling Risk Assessment

Section A

Basic Task Description:

Moving a patient up the bed to place head on pillow

Load/Weight:

Up to 200Kg

Frequency:

Several times an hour

Distance:

Less than 20m

Is assessment needed?
(if yes continue)

Yes

Section B

Detailed Task Description:

Two staff work together to slide a patient up the bed for the purpose of placing her head on a pillow. Standing either side of the bed, they place their arms under the patients axilla (see picture G). Using the axilla as a leverage point they lift and drag the patient (see picture H) until the patients head is in line with the pillow.

To reorganise the sheet on the bed, one nurse pulls the sheet back to it's original position (see picture I). This could increase the likelihood of tissue viability problems.

REBA score (assessed from picture G Nurse A) was 12 indicating a "Very High" risk factor. The risk factor is easily placed into the low-medium risk category by the introduction of slide sheets. For the patient, the risk of shoulder injuries, discomfort and tissue viability issues indicate that a safer alternative is required with immediate effect.

How many people required:

2

Section C

Remedial Steps in Order of Priority:

1. Training in back care for staff
2. Introduction of slide sheets for all dependent patients

Date of implementation:

The REBA score indicates that this task must cease with immediate effect and a safer method should be introduced at the earliest opportunity.

Review date:

One month from the date of initial assessment

Assessed by:

.....Gavin Wright.....



Nurse A



Picture G



Picture H



Picture I

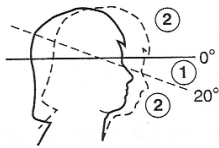
Rapid Entire Body Assessment

Task: Moving a patient on a bed

Date: 16/March/2010

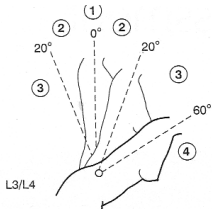
Location: undisclosed

Group A



+ 1 if twisted or side flexed

Neck score 3

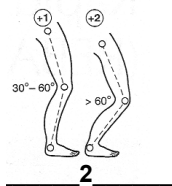


+ 1 if twisted or side flexed

Trunk score 5

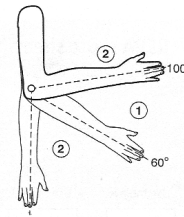
1 if bilaterally weight bearing/sitting

2 if unilaterally weight bearing or unstable base



2

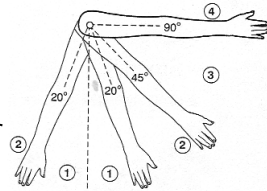
Group B



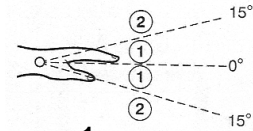
Lower arm score 1
(angle of the elbow)

+1 if ab/adducted or raised shoulder
-1 if supported

Upper arm score 2
(in relation to spine)



+1 if deviated or twisted



Wrist score 1

Table A =

8

+

Load/Force

3

+ 0 if < 5Kg
+ 1 if 5-10Kg
+ 2 if > 10Kg
+ 1 if sudden build up of force

Score A =

11

Use Table C

11

+

Activity score

1

=

REBA Score

12

+1 if one or more body parts are static for longer than one minute
+1 if small range movements are repeated more than four times a minute
+1 if large rapid change in posture or you become unstable

1

= Table B

+

+ 0 if good
+ 1 if fair
+ 2 if poor
+ 3 if unacceptable

0

Coupling

1

= Score B

Good = mid range power grip

Fair = fully closed or fingers slightly curled or using some other part of the body

Poor = flat hands

Unacceptable = dangerous

Score

1

2-3

4-7

8-10

11-15

Risk factor

Negligible

Low

Medium

High

Very High

Action

No need for any action

Action has probably already been taken to get to this level

Further consideration should be given as how risk can be lowered

Action needs to taken very soon

Work must cease until a safer solution can be found

Rationale for the above REBA Assessment

Group A

Neck: In extension and twisted towards the patients feet
Trunk: Hyper flexion and rotation occurs during movement
Legs: Bi-lateral weight bearing, straight legs with unstable base

Group B

Lower arm: Extended to between 60° and 100°
Upper arm: <20° in relation to the spine + utilisation of shoulder muscles
Wrist: Relatively flat over the dorsal aspect

Load/Force: >10Kg load with sudden build up of force
Coupling: Mid range grip

Activity: Large rapid change in posture + instability

Risks to staff:

Back pain and other musculo-skeletal disorders

Risks to patients:

Subluxation, dislocation, discomfort and psychological injuries

Outcome:

As the REBA score suggests, this task must stop with immediate effect and safer solutions adopted. The consequences of failing to adopt a safer handling technique could be back injuries and other musculo-skeletal disorders to staff due to excessive flexion

Solution:

When moved around on the bed, the patient should have access to a slide sheet with appropriately trained staff

Task Three:
Moving a patient on the bed

Post assessment

Initial Assessment

Task: Moving a patient on a bed

Date: 16/March/2010

Location: undisclosed

Moving & Handling Risk Assessment

Section A

Basic Task Description:

Intentionally Left Blank for Legal Reasons

Load/Weight:

Frequency:

Distance:

Is assessment needed?
(if yes continue)

Section B

Detailed Task
Description:

Intentionally Left Blank for Legal Reasons

How many people
required:

Section C
Remedial Steps
in Order of Priority:

Intentionally Left Blank for Legal Reasons

Date of
implementation:

Intentionally Left Blank for Legal Reasons

Review date:

Assessed by:

.....Gavin Wright.....

Picture X

Intentionally Left Blank for Legal Reasons

Picture X

Intentionally Left Blank for Legal Reasons

Picture X

Intentionally Left Blank for Legal Reasons

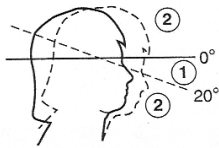
Rapid Entire Body Assessment

Task: Moving a patient on a bed

Date: 16/March/2010

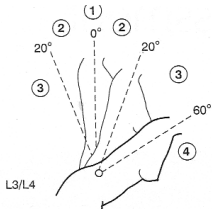
Location: undisclosed

Group A



+ 1 if twisted or side flexed

Neck score _____

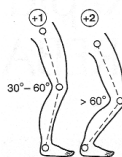


+ 1 if twisted or side flexed

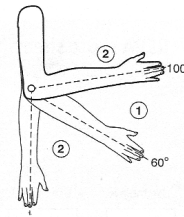
Trunk score _____

1 if bilaterally weight bearing/sitting

2 if unilaterally weight bearing or unstable base



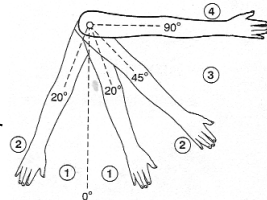
Group B



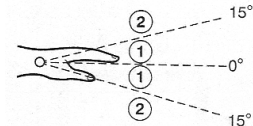
Lower arm score _____
(angle of the elbow)

+1 if ab/adducted or raised shoulder
-1 if supported

Upper arm score _____
(in relation to spine)



+1 if deviated or twisted



Wrist score _____

Table A =

+

Load/Force

+ 0 if < 5Kg
+ 1 if 5-10Kg
+ 2 if > 10Kg
+ 1 if sudden build up of force

Score A = _____

Use Table C

+

Activity score

=

REBA Score

= Table B

+

+ 0 if good
+ 1 if fair
+ 2 if poor
+ 3 if unacceptable

Coupling

= Score B

Good = mid range power grip

Fair = fully closed or fingers slightly curled or using some other part of the body

Poor = flat hands

Unacceptable = dangerous

+1 if one or more body parts are static for longer than one minute
+1 if small range movements are repeated more than four times a minute
+1 if large rapid change in posture or you become unstable

Score

1

2-3

4-7

8-10

11-15

Risk factor

Negligible

Low

Medium

High

Very High

Action

No need for any action

Action has probably already been taken to get to this level

Further consideration should be given as how risk can be lowered

Action needs to taken very soon

Work must cease until a safer solution can be found

Intentionally Left Blank for Legal Reasons

Rationale for the above REBA Assessment

Group A

Neck:

Trunk:

Legs:

Intentionally Left Blank for Legal Reasons

Group B

Lower arm:

Upper arm:

Wrist:

Load/Force:

Coupling:

Activity:

Intentionally Left Blank for Legal Reasons

Risks to staff:

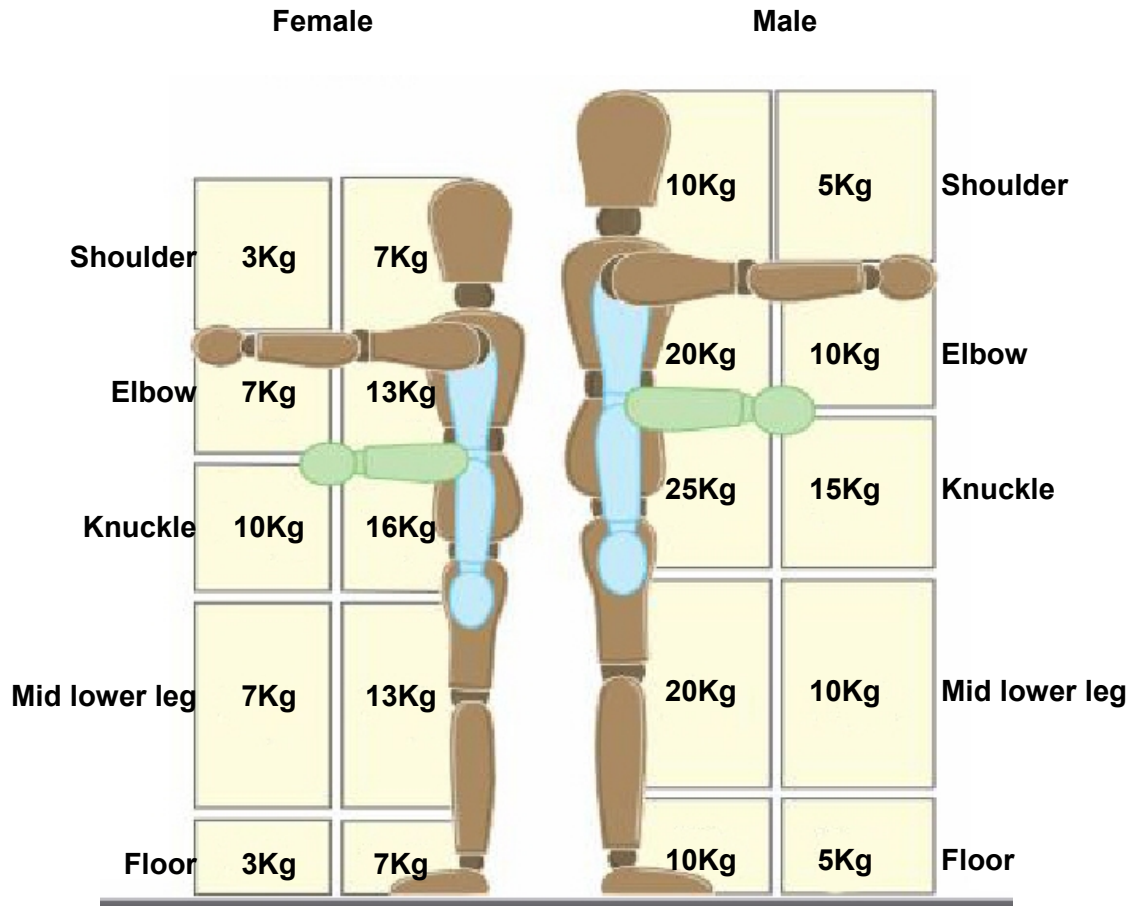
Risks to patients:

Outcome:

Solution:

Appendix 1

Filter System



The above weight limits are on the assumption that the person carrying out the lift has no fitness issues to deal with. It also is on the understanding that they have both feet firmly on the floor with a good base area. It also assumes that the person can take a firm and proper grasp of the object to be lifted and that they can release their grip in similar circumstances.

Team Lifting

Where two people carry out a lift, their combined weight lifting capacity should be reduced by two thirds. i.e. two females should not attempt 32Kg ($2 \times 16\text{Kg}$) max. but 21.3Kg. Where three or more people are involved in a lift, their combined weight lifting capacity should be reduced by half; i.e. three females should not attempt 48Kg ($3 \times 16\text{Kg}$) but 24Kg max.

This does not mean that these weight limits can not be exceeded at any time. Rather, it means that if they are to be surpassed, then a formal risk assessment should be carried out showing the most “*reasonably practicable*” way to perform the task *prior* to the task being completed. For instance, if a 17Kg paraplegic child fell from a bed, it would probably be reasonable for two members of staff to lift him back into bed even though they would be exceeding the guidelines. However, if it was a 90Kg paraplegic man, according to the system above, it would take 60 females to lift him back into bed from the floor (*more than 2 individuals reduces the weight capacity by half. $90\text{Kg} / 1.5\text{Kg} = 60$ females*). What sounds more reasonably practicable to you, 60 females or one, maybe two females using a hoist?

The way forward

It is clear from the evidence presented that a safer patient handling system is required. It is time now, with the advent of the new National Health Initiative (NHI), to legislate change. Doing so, will first and foremost, ensure a higher standard of service delivery. Additional benefits include increased professional and non professional nurse retention and reduced lost sickness time. Other cost savings will come in the form of less catheterisations and complications thereof and reduced cost in nappies.

We have the opportunity to either learn from the mistakes of the UK system, or to stumble along as they did, reacting to individual cases and take thirty years over achieving what could be done in five. Likewise, we have the USA model to compare. We could legislate in one province at a time. However, this would likely encourage disharmony amongst the masses and does not comply with the NHI concept of service delivery to all. Therefore, it is the proposal of MHMS, that the nation adopts a safer patient handling legislation, which, following a successful pilot, can be rolled out over a five year period.

In order to ensure implementation and accountability in line with the NHI, MHMS suggest that safe patient handling be structured in an organised fashion which is plain for all to see as follows (see organisational chart);

- Every person who handles patients^a should receive training in correct principles and techniques prior to placing their hands on the people they are required to move
- The same individuals should receive regular (at least annual) refresher training to ensure that employers are carrying out their responsibilities under section 8 of the Occupational Health and Safety Act 1993
- Each ward^b within each hospital should have a staff member who is trained as a ward based trainer (WBT). Their responsibilities would be to ensure that individuals are using their training in every day practice. They should actively encourage change to take place. They should also have completed a WBT trainers course. They should be able to handle most difficulties that arise but can refer to the MHC (see next bullet point) for assistance.
- Every hospital should have a Moving and Handling Coordinator (MHC). This ideally would be a post in its' own right but could be an extension of the Occupational Health and Safety Officers role. This individual should be trained to a high standard. It is their responsibility to ensure that safer patient handling practices are taught to every individual in the hospital/care establishment. In order to be credible, this person should be a medical or allied professional who can draw from their own experience. They also train and facilitate the WBT's. Where a WBT encounters a problem, the MHC may well have encountered a similar problem in another ward and can advise appropriately
- A new post of Provincial Moving and Handling Coordinator (PMHC) should be created. This individual should be someone with a large amount of experience in safer patient handling principles and techniques. They should at the very least be trained to the same standard as MHC but be actively pursuing professional advancement in a related subject. Their responsibilities include hosting quarterly network meetings with the MHC's in their province. A further role would be to facilitate any MHC's who encounter problems. Where one MHC has a problem, the probability is that the PMHC will have seen it elsewhere and can suggest possible solutions. A further responsibility would be to investigate any incidents/accidents arising from a patient handling operation
- A new post of National Moving & Handling Coordinator (NMHC) should be created. This individual should be someone with a large amount of experience in safer patient handling principles and techniques. They should be trained to a diploma or higher standard in safe patient handling and actively pursuing professional development. As with the previous role, they should be incident/accident investigators but predominantly the role is to unite the provinces to encourage national standardisation. They will facilitate any PMHC who encounters a problem. They should be a member of a body from whom they can seek advice in the event of encountering a problem they have not come across before. Other responsibilities including organisation of an annual National Moving & Handling Conference and Exhibition for the purpose of professional advancement of MHC's at all levels.

- a. This document has used the term “patients”, however, this term should be seen as referring to all individuals who require moving and handling assistance from a third party; i.e. service users of disability care organisations, and residents of nursing homes etc.
- b. This document has used the term ward but should equally be seen as referring to units within nursing homes and clinics etc.

National Moving & Handling Coordinator’s Role

Job Purpose

To coordinate the implementation of moving and handling training on a national basis. To set standards of safer handling practices for the protection of the work force and patients. To engender a spirit of pride in the development of safer handling practices in all of South African hospitals. To enforce standards of best practice.

Key Roles

1.0 Training Role

- 1.1 To establish, develop and run training programmes for selected "Provincial" coordinators.
- 1.2 To maintain a pool of "Provincial" coordinators who will be given the task of establishing a recommended programme in each of the hospitals under their jurisdiction.
- 1.3 To support “Provincial” coordinators in the selection of suitable “Hospital” coordinators to deliver these programmes to front-line staff.
- 1.4 To support the development of those members of staff who have undergone training.
- 1.5 To assess the competence of those members of staff who have undergone training.
- 1.6 To ensure all coordinators are familiar with moving and handling equipment used in patient transfers.
- 1.6 To increase the profile of safe patient handling on the national and international scene.

2.0 Policy and Review Role

- 2.1 To advise and assist in the formulation and review of policies and procedures in relation to moving and handling and the reduction of muscular skeletal problems experienced by employees.
- 2.2 To advise and assist in the formulation and review of policies and procedures in relation to moving and handling and the reduction of injuries received by patients during day to day transfers.

3.0 Advisory Role

- 3.1 To advise “Provincial” coordinators on general and specific moving and handling issues, assisting them with providing reports where required with recommendations for action.
- 3.2 To undertake on-site visits to advise on unusual or difficult moving and handling situations, within particular environments.
- 3.3 To investigate and report on any serious accidents and dangerous occurrences, relating to moving and handling and in order to reduce future risk.
- 3.4 To advise on health promotion in relation to back care.

4.0 Management Information Role

- 4.1 To develop, manage and monitor a database of training provision for the “Provincial” coordinators.
- 4.2 To ensure the “Provincial” coordinators manage & monitor their databases of training for the staff under their jurisdiction
- 4.3 To gather information for the purpose of developing statistical analysis of musculoskeletal and manual handling related injury, absence or ill health of employees working in South African hospitals.

5.0 Professional Role

- 5.1 To keep up to date with knowledge, developments and legislation concerning moving and handling and other relevant areas of work in both the national and international scene.
- 5.2 To advise at national as well as local level recommendations relating to the development of national moving and handling guidelines.
- 5.2 To undertake refresher and update training for “Provincial” coordinators.
- 5.3 To establish and maintain contact with the public, other Service Groupings, agencies and relevant national organisations, as necessary.
- 5.4 To carry out the duties of the post with due regard to Equal Opportunity & BEE Policies.

Legislative Proposal

The degree to which the task of avoidance and reduction of risk will be carried competently depends upon the degree to which an employer has a safe system of work. In order to achieve the above objective to ensure health and safety at work based on manual handling and lifting the following is suggested:

Legislation

Law is the starting point since it is legislation which underpins the very existence and the powers and duties of all government departments at local and national level. The law, on its' own, will not cure the problem, but it does provides a framework within which to think through manual handling policy and practice.

It is intended:

- To assist staff and their Managers working in the Health and Social Care field. i.e Nurses, Care assistants, Hospital porters, Occupational Therapists, Physiotherapists, Social Workers, All Hospital staff and Social Services staff, equipment stores staff and everybody delivering equipment.
- To assist Disabled people their parents or immediate families and significant others.
- To assist people working with children in schools i.e. Teachers.

Existing law (OHSA) will provide the framework, but further legislation is required to “fill in the gaps” or as a means of interpreting and applying existing law to the concept of safer patient handling. The term “Reasonably Practicable” for instance may need clarification or discussion in relation to moving and handling.

Training

Included in any legislation, needs to be the inclusion of adequate training which, should be provided to all employees relating to moving & handling skills with annual refresher training. This should be enforced in every health care institution. Training should be mandatory for every health care provider and strict rules should be legislated that employees will be restricted to take up their normal work if they don't refresh their manual handling skills annually. Courses specifically designed for moving and handling instructors should be implemented throughout the country especially in government institutions for senior personnel to train their subordinates. These instructors should in turn receive regular (annual) refresher and update training.

Supervision

As the system rolls out across the country, competent staff will undertake appropriate tasks such as drawing up manual handling care plans. Every institution should have its own coordinator (see Organisational Chart on page 45) who is responsible to an experienced provincial coordinator. In turn every institution coordinator will attend to the development of all staff in their institution via the means of an intensive training programme and one to one tuition, as well as regular "team" meetings of "link staff" for each ward or unit. As employees have duties to take care of themselves and others as legislated they have to follow safe systems of work and will be obliged to ensure they have kept themselves "up to date" with the clinical moving & handling skills.

Equipments

Using existing legislation until such time that more detailed instruction can be legislated, every institution must be provided with hoists and other handling equipment suitable to meet its needs. Almost every ward or department should be supplied with at least one hoist. Hoists must be thoroughly inspected and serviced where required, every six months for safe use.

How the pilots should be constructed

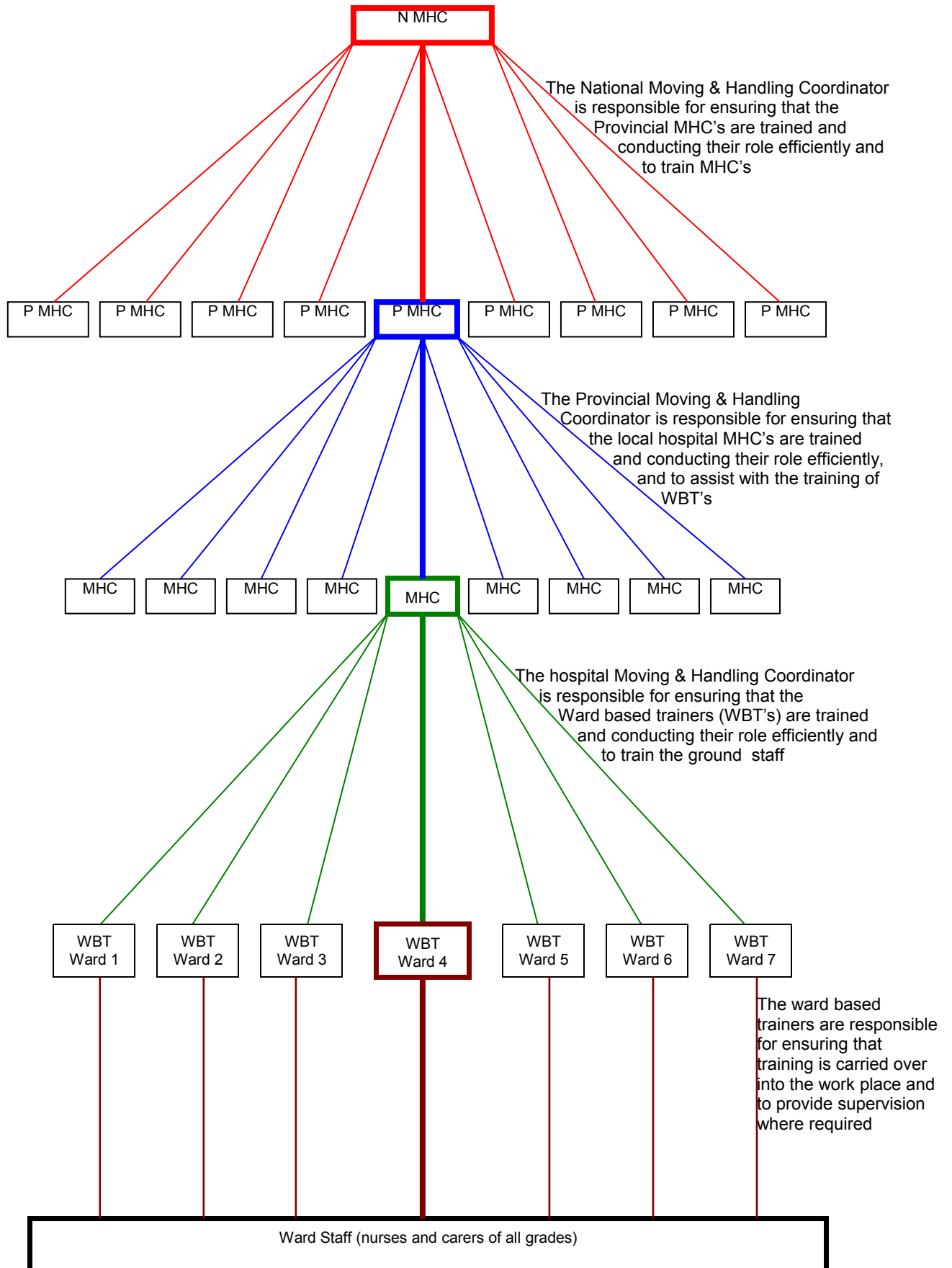
Week Event

- 1** Training needs analysis and meet with HOD's
- 2** Selection of candidates for roles of Provincial & Local moving and handling coordinators
- 3** Provincial & Local Coordinators course (part one) and interviews for WBT roles
- 4** Provincial & Local Coordinators course (part two) and WBT's course (part one)
- 5** WBT's course (part two)
- 6** Programme development for local needs
- 7** Training delivery & introduction of equipment by Local coordinator in Klerksdorp Ward 5 assisted by N & P MHC's if required
- 8 - 20** Week 7 repeated for each ward / dept where equipment is to be introduced
- 21-26** Data analysis, remedial training, evidence gathering and report writing

Regarding the roll out across the province, once the first example had been deemed successful, a new hospital can be added to the programme 6 weeks. Once the provincial coordinator is up to speed two new hospitals can be added every 6 weeks.

Again regarding the roll out: Each hospital wishing to join the project will pay an initial start up fee based upon the size and type of equipment required. A monthly management fee directly proportionate to the start-up fee will then be payable. These fees will cover the franchise to be able to deliver training to local nursing homes and private hospitals etc, training needs analysis, the lease of equipment and any training required. The initial start-up fee and the first 6 months management fee will be waived for K/T complex.

Organisational Chart



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