

**SECTION 6:
MOVING &
HANDLING**

Moving & Handling in Low Resourced Settings

Definition of manual handling:

“Any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or by bodily force”.

Manual Handling Operations Regulations 1992 (as amended) (MHOR)

In the good old days (or bad old days) depending on your viewpoint; we bent down low, twisted, lifted, supported, carried and dragged any number of inanimate objects during the course of each day. As therapists, we did whatever we needed to do to rehabilitate our patients. We considered it important for everyone involved with our patients **‘to do as we do’** in order to maximise quality of movement and function.

The majority of therapists who train in UK/Europe are now steeped in European Health and Safety protocols. Moving & Handling is no exception. **Legislation underpins our professional practice.**

Since 1992 when the Moving & Handling Operations Regulations came into force, the majority of health care professionals have had to change the way they work when moving and handling their patients.

Regulation 4(1) of MHOR sets out a hierarchy of measures to reduce the risks of manual handling.

AVOID any handling procedures so far as is reasonably practicable.

ASSESS any procedures that cannot be avoided

REDUCE the risk of injury so far as is reasonably practicable.

<http://www.hse.gov.uk/> accessed 3.6.17

There has been a greater emphasis on considering not only the patient/client but also their family/carers as well as the health and safety of the treating therapist/s. This proved controversial at first, but over the two decades manual handling performance has improved

greatly; mainly due to the explosion of mandatory training and the availability of quality equipment to ensure that everyone involved is as safe as possible.

Unfortunately, this does not apply to the majority of low resourced settings where sometimes, outdated and frankly unsafe practices still occur. The harsh realities of poverty, overcrowding, local politics and corruption, customs and economics mean that some health care professionals who work hard to rehabilitate their patients are unlikely to have had the appropriate moving and handling training or have access to the equipment/resources required.

However, this does not mean that we can condone and accept 'poor handling' when working in low resourced settings. As therapists, we must endeavour to maintain standards but spend time sharing 'best practice' and **always** use 'safe 'principles of handling'. Assuming there is no equipment available, and no funding for larger pieces of equipment, wherever possible, encourage the use of 'low tech' equipment that can be made locally or transported easily (see low tech equipment)

The following information may be obvious to you; however, the colleagues you are working with may well have acquired the same theoretical knowledge as you, but may not have had the same practical training for many reasons (see working practices)

The TILE jigsaw

As health care professionals we are trained to **Risk Assess** any therapeutic intervention using **TILE** or **LITE**.

Task – what you plan to do

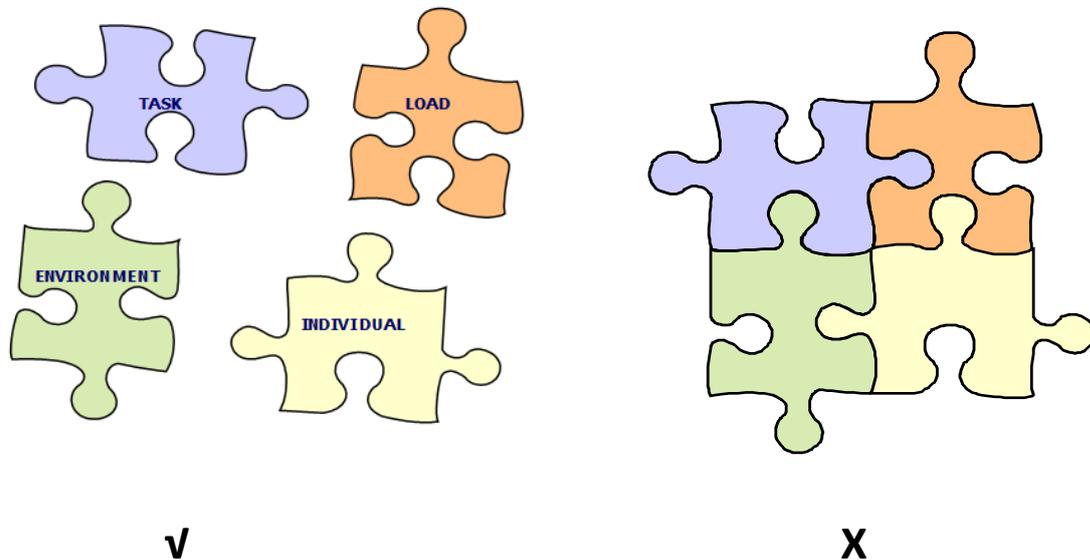
Individual – yourself or the people working with you

Load – the client/patient or inanimate object

Environment – how the environment you are working in affects your treatment, e.g. in a clinic or in someone's home.

During training sessions, TILE is often shown as a jigsaw of different pieces, each one representing one strand of Risk Assessment. Like a jigsaw, all aspects of risk assessment are interlinked and should not be seen in isolation. We need to make balanced decisions which

take account of safety for the client and staff but also enable us to meet the needs of the client. This is not always easy.



Principles of handling

Once you have looked at all the factors, you then need to **plan** the task (get equipment or help if needed), **communicate** so that everyone knows what is happening and finally make sure the client is **prepared** for the task.

Once this is done, always follow '**safe principles of moving & handling**'. This must apply whichever setting we are working in. Just because there is not a hoist available or a particular piece of equipment that you feel is necessary, as therapists we cannot abandon our patients, but we have to think of the 'best' possible alternative and that may include '**lifting**' a patient (something quite alien to us in UK). In some cases, you may need to get the help of several other people. Please remember if you are getting help from unqualified or untrained staff, it is important that you train them first in that particular manoeuvre and ensure they feel confident in helping.

If lifting is deemed appropriate, it is important that everyone knows 'how to lift'.

Know how to lift.

- **HANDHOLD** - secure comfortable grip, keeping as much of your hand and arms in contact with the load as appropriate for the load.
- **FOOT POSITION** - wide stable foot position (base) close to the load, leading foot forward in the direction of movement. Lift load between your knees if placed at a low level.
- **BACK IN LINE** - keep a naturally upright position wherever possible. Avoid twisting, bending, reaching or jerky movements. Look forwards when lifting and keep 'nose over toes'.
- **ARMS CLOSE** - keep the load close to your body, with elbows tucked in.
- **BODY WEIGHT**- use momentum to reduce lifting strain. Use your body weight and strong leg muscles to move a load e.g. pulling and pushing movements.
- **KNOW HOW TO CARRY**
 - keep the load close to your body
 - make sure you can see where you are going
 - plan rest pauses or use trolley. Do not carry for long.
 - do not twist; turn with your feet NOT your back
- **KNOW HOW TO SET DOWN THE LOAD**
 - stand close to where you plan to set down
 - split the lift if lifting above head height.
- **KNOW HOW TO PULL AND PUSH**
 - use your body weight and leg muscles.

LIFT SMOOTHLY, AVOID JERKY OR UNSUSPECTED MOVEMENTS.

Working Practices – how are they different?

- **Getting close to a patient.** In many countries, it is culturally unacceptable for a woman to get close to a man or vice versa. This immediately raises problems when moving or handling a patient as the therapist is unable to fulfil one of the basic principles, i.e. getting as close to the load (patient) as possible. You may need to get help from another member of staff who is the same gender as your patient.

- **Little or no equipment.** There is often little or no equipment at hand. Be prepared to be adaptable and use everyday objects to help, e.g. a plastic bin liner to help slide a patient.
- **Lifting patients is the norm** in many low resourced settings. Don't say 'you're not allowed to lift' a phrase I have heard many times in UK. Try to reduce the risk as far as is reasonably practicable and teach safe principles.
- **Room full of patients and carers.** It is usual in many low resourced settings for patients to arrive all at once and wait to be treated. They often wait in the same room as you are treating a patient. It can often be distracting and you can feel rushed. Don't compromise your standards. You are seen as a role model so ensure 'best practice' at all times when handling a patient.

Training

Moving and handling is integral to everyday life. If your mission is to train therapists, CBR workers, carers or patients themselves, training is much more effective when done practically. This way you have to work with the resources you are given (or have brought).

In my opinion, just teaching techniques to a group of people is not very effective. It is not personal enough. **Problem solving** everyday activities and therapeutic activities works much better. This way you can demonstrate safe principles of handling in real situations and with real people; this can sometimes be quite a challenge (as it can be in the UK too when visiting someone in their home)

When training, you are aiming to ensure that the person or people you are working with become '**competent**' at handling in a range of situations,

Competency is not just a 'tick box' exercise and cannot be achieved in a single training session. To be fully competent; one must be confident in their own ability, (not over confident) be able to explain, demonstrate and understand the different ways of moving and handling and have the ability to use the skills effectively. This requires practice as well as understanding the basic principles

Small handling aids

Small handling aids are extremely useful when working in less resourced settings. Not only can they put into your suitcase when going out on a mission (and left for therapists to use when you have gone), but they can often be made 'in country'. All equipment should be 'fit for use' and maintained properly.

Suggested equipment includes:

Handling belt

Essentially a handling belt has several handles sewn into a padded belt. It is attached around the client's waist and the handles provide a better grip when moving a person (rather than grabbing clothing) and helps maintain a better posture for the handlers. **It should NOT be used as a lifting device.** It is used to facilitate various transfers, including sit to stand, transfers from bed to chair, chair to chair or just for general positioning.

Handling belts come in all sizes and cost between £15 and £45 depending on the model



Slide sheets

Slide sheets are designed for **sliding** transfers and repositioning. They are made of very low friction material, which are placed underneath a person. This allows for an independent or assisted **sliding** movement in one or more directions across a level surface. Slide sheets come in various sizes and shapes and each of them serves different purposes.

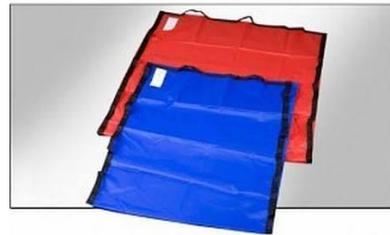
There are many slide sheets on the market and can be purchased for as little as £20.

Some sheets are tubular whilst others come in the form of 2 flat sheets (with or without handles). There are uni-directional slide sheets and there are also disposable slide sheets which are used for one person only and cannot be washed.

Tubular slide sheets



Flat slide sheets



Transfer board

A transfer board is usually made of laminated wood and facilitates day to day functional transfers such as bed to chair, wheelchair to commode and wheelchair to car. They are used for patients who are unable to do a standing transfer and they are most effective when the patient has some core stability and upper limb function. They can be used with or without a small slide sheet



Manual Transfer Sling

A manual transfer sling allows a child/young person to be lifted safely by two or more people. This type of sling has been designed for moving a client/patient in a difficult situation where a hoist is not accessible. However it should only be used if there is no other alternative. There are a couple of companies in UK that make these slings; they are much cheaper and much more portable than a hoist.



Silvalea Manual Transfer Sling

<http://www.silvalea.com/catalogsearch/result/?q=manual+transfer+sling>

(Thanks to Silvalea Ltd for allowing us to use their images)



Promove sling <https://www.promove.uk.com/>

(Thanks to Promove.co.uk for allowing us to use the images)

Self-lifting blocks

Bed blocks are used by people with enough upper limb strength who want to lift themselves up from the bed. They may be necessary to relieve pressure under the buttocks, assist in moving up and down the bed, or to help in positioning a bedpan. It may be possible to raise yourself several centimetres from the bed using these blocks



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All of the equipment described, will fit into an average suitcase and is easily transportable.

Key Messages:

- **Don't compromise standards just because you are in a setting where there are few resources.**
- **Competency is not just a 'tick box' exercise and cannot be achieved in a single training session.**