SAFER HANDLING OF PEOPLE

FOUNDATION COURSE

All Wales Manual Handling Training Passport & Information Scheme

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MODULE A– MANUAL HANDLING THEORY

Module Aim

To provide underpinning knowledge necessary to reduce the risk of musculoskeletal injuries caused by poor manual handling in the workplace.

Module Objectives

By the end of the session the learner will be able to:

- Define the term manual handling
- Describe the causes and effects of musculoskeletal disorders (MSDs)
- Outline considerations for the prevention and management of musculoskeletal disorders
- Outline the legislation that applies to manual handling at work
- Describe the importance of ergonomics and risk assessment in reducing the risk of manual handling injury
- Describe the principles of safer handling
- Describe the effects of static loading
- Identify the risks involved in team handling
- Describe the importance of good communication in relation to manual handling
- Outline the management of safer handling within the organisation e.g. policy, organisation of training and occupational health.

QCF Criteria for this Module:

1.1, 1.2
2.1, 2.2
3.1, 3.2
6.2
Definitions

MANUAL HANDLING

Transporting a load by hand or bodily force or supporting a load in a static position. Actions include lifting, lowering, pushing, pulling, carrying. Manual handling also involves the intentional dropping or throwing a load.

ERGONOMICS

Ergonomics is the science of fitting environments to the people working in them and fitting tasks to the people performing them.

LOAD

A person, animal or discrete movable object.

Dynamic loading is when movement is apparent, e.g. when lifting, lowering, pushing, pulling, etc.

Static loading is when there is no apparent movement, such as when staying in one unstable posture for a period of time, e.g. putting on a person’s shoes and socks while stooping over.

HAZARD

An object, process or situation with the potential to cause harm.

RISK & RISK ASSESSMENT

A risk is a combination of the likelihood that the harm from a hazard will be realized and the severity of it.

Risk assessment analyses the task performed, the person’s capabilities for performing the task, the load being moved and the environment in which it occurs.

MUSCULOSKELETAL DISORDERS

Musculoskeletal disorders (MSDs) are conditions that affect the nerves, tendons, muscles and supporting structures, such as the discs in your back. They result from one or more of these tissues having to work harder than they’re designed to. MSDs most commonly occur in the back or upper limb.
Background and Injury Rates

Health and Safety Executive (HSE) figures show that in Great Britain:

- An estimated 553,000 workers in 2014/15 suffered from musculoskeletal disorders caused or made worse by their current or past work:
  - About 223,000 of these workers suffered from a bad back.
  - About 233,000 suffered from problems related to upper limbs and neck.
  - About 97,000 experienced lower limb problems.

- An estimated 9.5 million working days were lost in 2014/15 through work-related musculoskeletal disorders that were caused or made worse by work.

- On average, each person suffering took an estimated 17 days off in 2014/15.

Risk Factors for Developing MSDs

Various risk factors are thought to be associated with MSDs, including:

- Repetitive and/or heavy lifting.
- Bending and twisting.
- Repeating an action too frequently.
- Uncomfortable working position.
- Exerting too much force.
- Working too long without break.
- Adverse working environment (e.g. hot or cold).
- Psychosocial factors (e.g. high job demands, time pressures and lack of control).
- Not receiving and acting on reports of symptoms quickly enough.

Work related MSDs accounted for 44% of all work related illnesses and are the most commonly reported kind of accident. Fortunately, a manual handling accident is rarely fatal.

Costs of Musculoskeletal Disorders

Lost time from work is just one of the costs that employers have to deal with when an employee suffers an MSD:

- Sickness benefits to injured workers
- Overtime costs to other staff to fill in for their absent colleague
- Replacement staff costs, e.g. bringing in agency workers
- Bad publicity
- Lowered staff morale
- Health and safety inspections taking time and effort to prepare for and manage
- Correcting faults, defects and damage
- Purchasing new equipment
- Court and legal fees
Compensation costs
Increased insurance premiums.

Costs to employees include:

- Pain and suffering
- Buying non-prescription medication
- Payment for physical therapies or alternative treatments
- Decrease in earnings
- Restrictions on normal routines
- Emotional stress of being in pain and unable to work
- Strain on family relationships
- Possible legal costs of accident investigation.

**LAW AND MANUAL HANDLING**

**Health and Safety at Work Act 1974**

**EMPLOYER DUTIES**

Employer has a general duty to:

"...so far as is reasonably practicable, ensure the health, safety and welfare at work of all his employees."

"...provide information, instruction, training and supervision necessary to ensure, as far as reasonably practicable, the health and safety at work of their employees."

Specific employer duties under this law state that the employer must provide and maintain:

- Safe and suitable equipment
- Safe systems of work
- Safe working environments

**EMPLOYEE DUTIES**

- To take care of your own health and safety and that of others who may be affected by what you or what you fail to do.
- Co-operate with your employer to enable them to comply with their health and safety duties.
- Not to misuse or interfere with anything provided for the purposes of health and safety.
- Report accidents, incidents and near misses.

**Manual Handling Operations Regulations 1992 (As Amended)**

**EMPLOYER DUTIES**

- Avoid the need for employees to carry out hazardous handling if reasonably practicable.
- If it is impossible to avoid hazardous handling to assess such tasks to determine who could be harmed and to what extent.
- They must reduce handling risks to the lowest level reasonably practicable or eliminate them.
The employer must provide information on the load to be moved.
The employer must review the assessment when they think it is no longer valid, e.g. when things have changed or when an employee reports problems or an accident occurs.

EMPLOYEE DUTIES
- Use the safe system of works their employer has put in place for manual handling tasks.

Lifting Operations and Lifting Equipment Regulations 1998

EMPLOYER DUTIES
The employer must ensure the lifting equipment is:
- Sufficiently strong, stable and suitable for the proposed purpose.
- Positioned or installed to prevent the risk of injury.
- Visibly marked with any appropriate information, e.g. the safe working load. Accessories such as slings should also be marked with this information.
- If used for lifting people it is marked accordingly and safe for such a purpose.
- Thoroughly examined by a competent person and a report of this examination given to the employer.
- Examined yearly at least by a competent person. Equipment designed to lift people should be inspected every six months.

The employer must also ensure that lifting operations are planned, supervised and carried out in a safe manner by competent people.

Provision and Use of Workplace Equipment Regulations 1992

EMPLOYER DUTIES
The employer must ensure that:
- Equipment is maintained and serviced according to guidance in the regulations.
- Equipment is inspected before EVERY use.
- The equipment is suitable for its intended purpose and the area in which it is to be used.

Employees are given instruction, training and information to use the equipment correctly.

Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013

What are ‘reportable’ injuries?
The following injuries are reportable under RIDDOR when they result from a work-related accident:
- The death of any person (worker or non-worker).
- Specified Injuries to workers.
- Injuries to workers which result in their being unable to work for more than 7 days.
• Injuries to non-workers which result in them being taken directly to hospital for treatment, or specified injuries to non-workers which occur on hospital premises.

Risk Assessment in Manual Handling

The Manual Handling Operations Regulations require that, where avoidance of the hazardous manual handling tasks is not reasonably practicable, the employer should:

“…make a suitable and sufficient assessment of all such manual handling operations to be undertaken…”

Assessments might be GENERIC or SPECIFIC. A generic assessment groups together risks that are common to a number of broadly similar operations. This can be useful as a starting point to identify general principles, e.g. staffing levels, training needs, type and number of items of handling equipment a work area requires, preferred layout of furniture and equipment in rooms.

A specific assessment addresses risks presented in an individual circumstance: these assessments are required for most people handling tasks.

A risk assessment may be FORMAL or INFORMAL.

Formal – written down, signed with copies kept and communicated to all who need to comply with it. This usually has a formal review date.

Informal/Personal – a brief mental check done by anyone who is about to carry out a handling task. This is not recorded or communicated UNLESS a problem comes to light that will prompt the need for a new formal assessment.

However, the assessment need NOT be recorded if:

• The assessment could be repeated and explained at any time because it is so simple and obvious;
• The handling tasks are of low risk, only going to last a very short time and the time taken to record the assessment would be unreasonable.

There is no defined period in law when a review of an assessment should be conducted: however many organizations recommend that in people handling tasks, this should happen no less than yearly. Other triggers for reassessment include:

• Having reason to suspect it is no longer valid (perhaps the service user’s ability has changed)
• Significant change to the handling task to which it relates (for example, a new piece of equipment has altered the way the task is performed)
• Incident reports or complaints from employees of difficulties with the task
• An accident has occurred.
An Ergonomic Model

The Manual Handling Operations Regulations recommend an ergonomic approach to risk reduction:

"Ergonomics is the science of fitting the job to the worker and the product to the user."

We are all familiar with everyday examples of ergonomic design: think of a modern car seat, how it is shaped to the human body to give it support and cushion it from impact in a collision.

The goals of ergonomic design are to promote health and productivity in the workplace. As a major part of workplace activity, manual handling and its assessment should be subject to this ergonomic model.

The model offered in the Manual Handling Operations Regulations is often known as **T-I-L-E (or L-I-T-E)**

T-I-L-E is a prompt list: it offers questions in various categories that the assessor should consider. Not all categories will be relevant in all circumstances; however they are interrelated and cannot be considered in isolation.

T-I-L-E considers the load or person to be moved, the individual worker performing the actions, the requirements of the task and the environment in which it is happening.

The **T-I-L-E Model**

**TASK**

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<tr>
<th>RISK FACTORS</th>
<th>RISK REDUCTION MEASURES</th>
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<tr>
<td>Does the operation involve:</td>
<td>Change the task by:</td>
</tr>
<tr>
<td>▪ Holding loads away from the body?</td>
<td>▪ Improving the layout to eliminate postural constraints.</td>
</tr>
<tr>
<td>▪ Excessive lifting or lowering distances?</td>
<td>▪ Reducing effort by using body efficiently.</td>
</tr>
<tr>
<td>▪ Excessive pushing or pulling?</td>
<td>▪ Changing the work routine to allow recovery time.</td>
</tr>
<tr>
<td>▪ Excessive, frequent or prolonged physical effort?</td>
<td>▪ Introducing team handing to reduce effort.</td>
</tr>
<tr>
<td>▪ Unsatisfactory postures: bending, twisting, stretching, leaning, working at arm’s length?</td>
<td>▪ Eliminating lifting by using a hoist.</td>
</tr>
<tr>
<td>▪ Repetition of the task without a break?</td>
<td>▪ Minimising effort through use of aids.</td>
</tr>
<tr>
<td>▪ Ensuring equipment is maintained and accessible.</td>
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**INDIVIDUAL WORKER**

**RISK FACTORS**
- Does the task require unusual strength, height or capability to carry out?
- Would new or expectant mothers be at more risk?
- Would an employee with an existing health problem be at risk?
- Does the task need special information or training for its safe performance?

**RISK REDUCTION MEASURES**
- Change the task so it requires less strength, etc. (use equipment).
- Avoid allocating heavy manual handling tasks to new or expectant mothers.
- Avoid allocating heavy manual handling tasks to workers who are known to have an existing health problem.
- Ensure workers have all necessary training and information to carry out the task safely.
- Ensure workers are dressed appropriately to carry out manual handling tasks.
- Ensure workers are using good handling technique and posture.

**LOAD**

**RISK FACTORS**
Is the load:
- Heavy, large or difficult to grasp?
- Is it an awkward shape?
- Is it unstable or could its contents shift?
- Is it sharp, hot or otherwise potentially damaging?

**RISK REDUCTION MEASURES**
Change the load by:
- Reduce the weight or size of a load by splitting it into smaller parts.
- Use protective equipment, e.g. gloves, to help obtain a safer grip.
- Hold the load with heavier part nearest your body.
- Repackage contents to stop them shifting in transit.
- Attach handles to gain a better grip
ENVIRONMENT

<table>
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<th>RISK FACTORS</th>
<th>RISK REDUCTION MEASURES</th>
</tr>
</thead>
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<td>Are there:</td>
<td>Change the environment by:</td>
</tr>
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<td>▪ Space constraints preventing good posture?</td>
<td>▪ Removing (perhaps temporarily) items that constrain posture.</td>
</tr>
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<td>▪ Uneven, slippery or unstable floors?</td>
<td>▪ Changing the layout of the area for better access.</td>
</tr>
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<td>▪ Variations in floor levels (steps, stairs or ramps)?</td>
<td>▪ Adjusting the height of furniture if possible.</td>
</tr>
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<td>▪ Extremes of air movements, temperature or humidity (such as when working outdoors or in a steamy bathroom)?</td>
<td>▪Removing loose floor coverings, e.g. rugs.</td>
</tr>
<tr>
<td>▪ Lack of suitable equipment to carry out the task?</td>
<td>▪Removing distractions, e.g. turn off TV, ask visitor to wait in another room.</td>
</tr>
<tr>
<td>▪ Inappropriate or damaged equipment?</td>
<td>▪ Working at one level if possible (avoiding steps and stairs).</td>
</tr>
<tr>
<td>▪ Obstacles to free movement, e.g. humans, animals or furniture?</td>
<td>▪ Ensuring equipment is examined and serviced regularly.</td>
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<tr>
<td>▪ Inadequate lighting?</td>
<td>▪ Minimizing the distance to be moved.</td>
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Numerical Guidelines for Handling Objects

Purpose of the Guidelines

The Manual Handling Operations Regulations set no specific requirements on weight limits for moving objects. Instead a TILE assessment is used to determine the risk of injury, and to point out remedial actions. However a full assessment of every handling activity would be a major undertaking, very time consuming and possibly a wasted effort.

The numerical guidelines offer an initial filter to help an assessor decide whether a more detailed examination is required.

*It should be noted that there is no threshold below which manual handling may be regarded as ‘safe’. Even if operations fall within the boundaries of the guidelines, assessors should still make efforts to avoid the tasks or make them less demanding where it is reasonably practicable to do so.*
For Lifting and Lowering an Object:

Working in Teams to Move Loads or People

Working in a team to carry out a lift is not always better than using equipment as the guidelines note that **two people CANNOT lift twice as much as one person.** Lifting with three or more people is even more awkward.

To lift successfully as a team:

- People need to be roughly the same height and build
- All members of the team need to have roughly the same lifting ability
- Enough space is needed for the whole team (and the load) to be moved freely
- They all need to be able to get a secure grip on the load

For these reasons, the Manual Handling Operations Regulations 1992 recommend using equipment to lift wherever possible.

When handling as part of a team we also need to consider COMMUNICATION:

Good VERBAL communication: have a team leader who gives clear commands, plans the task and makes sure everyone is clear about what they are going to do.

Good commands for manual handling are, “READY, STEADY, LIFT”.

NON-VERBAL COMMUNICATION is also important: think for example about two people moving a long object while facing one another. Would it be better for the leader to say, “Go to your right” or for them to nod their head in the direction they want to turn?
Spinal Awareness and Injury

Structure and Function of the Spine

Musculoskeletal disorders (MSD’s) are common types of injury due to manual handling. Most of these are not one-off accidental injuries but tend to accumulate damage over time. Your spine is the strong core of your body, allowing your legs and arms to carry out activities. It does NOT work well if in awkward postures such as bend, twisted or stretched.

Functions of the Spine

- To provide support for our body
- Allow flexibility and body movement
- Act as a shock absorber
- Protect the spinal cord
- Attachment points for muscles and ligaments

The human spine is a column of 33 bones or VERTEBRAE, split into four areas. The bones form FACET JOINTS with each other to allow many different movements. The spinal column supports you and protects you spinal cord.

The spine is moved and supported by hundreds of MUSCLES, many of which are very small and can be STRAINED if they are over-used or over stretched. Your spine allows for great flexibility and a wide range of movement due to the interaction of its many joints.

The bones of the spine are supported and held together by LIGAMENTS. These are made of tough material with only a little stretch. Ligaments can be SPRAINED if over stretched.

Muscular or ligament damage is by far the most common injury due to manual handling.

The SPINAL CORD runs through a hollow channel in the vertebrae, from top to bottom, with SPINAL NERVES emerging from between each pair of bones. The spinal cord takes nerves messages to and from your body to control your body functions.

An INTERVERTEBRAL DISC lies between each pair of vertebrae as far as the tailbone. The disc act as shock absorbers, keep the bones apart and control movements.

The human spine consists of 33 bones or vertebrae, 24 of which are separate and distinct, connected to each other by intervertebral discs, muscles and ligaments and supplied with nerves.

Each vertebra has two joints called facet joints that enable them to move over one another, so giving the spine its flexibility.

The human spine has many functions:
- Protection of the spinal cord by enclosing it in a bony spinal canal.
- Mobility as the spinal components move over one another.
- Support to keep us upright and control of movement.
- It provides support for the skull, the shoulders and ribs.

The vertebrae are divided into four main groups as shown below:

**Spinal Curves**

The vertebrae form gentle curves and are held together by two ligaments running up the front and back of the spine. The natural “S” curves of the spine represent the best and most efficient working posture of the whole spinal structure as the joints, discs, ligaments and muscles are in neutral positions.

Changes from this posture place extra stress on all the spinal components. While bent or twisted postures may not be immediately harmful, staying in such positions for long periods – static postures – and repeating them frequently or while handling loads can lead to damage, possibly severe, over time.

You often hear people say that you should adopt a ‘straight back’ when lifting: not true! In a rigid, unnaturally flattened position, your spine is in a weaker position than if you maintain a relaxed, naturally curved spine. **Keeping the spine ‘naturally upright’ helps to protect all the structures in the spine.**
Causes of Back Pain

Degeneration (wear and tear)
Every person’s spine – along with the rest of their weight bearing joints – will experience wear and tear over time; it is a normal ageing process. However, this can made worse by a number of things such as repeated vibration, being very overweight, a disease processes (such as arthritis or osteoporosis) or continued bad postures.

Traumatic Injury
This is when a sudden, violent stress is placed on the spine, resulting in damage to ligaments, muscles and – in rare cases – the discs or vertebrae. Examples might be whiplash from a car accident or trying to move a load that is too heavy for you.

Psychological Attitudes
Being under stress makes the muscles tense and tight, leading to fatigue and inflexibility; this can make them more prone to injury. Being under stress, the person is more likely to be distracted and not fully concentrating on the job.

Chemical and Biological Factors
Things we take into our bodies, such as cigarette smoke, drugs and alcohol may have an effect on our wellbeing and safety in handling (and other) tasks. For women, the significant hormonal changes during menstruation, pregnancy and the menopause can have psychological and physical effects.

Cumulative Stress
This is the most common, but least recognized cause of back pain. Cumulative stress occurs gradually when minor stresses are placed on the back, causing twinges of back pain and ‘micro damage’. These tiny amounts of damage accumulate over time and may lead to a significant episode of back pain.

Holding muscles under tension for long periods of time – “static loading” - such as stooping over a low work surface, restricts the flow of blood to the muscles and so reduces the amount of oxygen they receive. This in turn creates a build up of waste products that leads to pain and maybe a strain when the muscle is next used.

Examples of situations causing static loading:
- Overhead and extended reaching
- Awkward posture forced by limited space
- Stooped, bent or twisted postures
- Prolonged lifting or carrying
- Kneeling, crouching or squatting
Keeping Your Back Healthy

EXERCISE
Research shows that a fit and healthy person becomes injured less often than a non-fit one and that they recover from injury more quickly too. Exercise should be something you enjoy doing that encourages your heart and lungs to work harder keeps you flexible and strong. About 4 or 5 half-hour sessions a week are good. One of the simplest ways of helping keep your back healthy is to take brisk walks, especially over rough or uneven ground.

DIET AND WEIGHT
A well-nourished body will feed essential nutrients and oxygen to your spinal structures. It is also important to ensure you don’t gain too much weight as this places undue strain on your joints, ligaments and discs and can lead to long-term problems with posture. (And after all, the heavier you are the harder your muscles have to work to move you, even before you move anyone else!)

DON’T SMOKE
There is some evidence to suggest that smoking is harmful for your spine: cigarette chemicals in your bloodstream displace oxygen and so lead to your muscles working less efficiently and over time, smoking tends to ‘fur up’ your arteries and lead to severe health problems and diseases.

GOOD HANDLING TECHNIQUE
Using your body effectively by recruiting strong muscles groups and adopting a balanced posture is more efficient and easy than using strength alone. Is your spine in a naturally upright “S” position, where it is under the least strain? Are your feet giving you a good stable base? Could you bend your legs instead of your back? Could you hold the load closer to your body to reduce strain on your arms and upper back?

GOOD POSTURE
Try to maintain good posture 24 hours a day, 7 days a week. The adult human spine is naturally curved into a double S-bend. This is the shape in which it works most efficiently and with least likelihood of harm. Moving the spine out of this posture applies pressure and strain to muscles, ligaments and discs. Poor posture is often a habit that you fall into without realising. Think of how you sit while watching TV, driving or while at work; think of how you stand, move and handle objects and people.

In manual handling we ALWAYS use good posture and consider our BASE OF SUPPORT. This is the space between our feet and needs to be large enough to maintain our stability as we move and handle loads: generally shoulder/ hip distance apart.
More Advice on Posture

SLEEPING
✓ Sleep on a mattress that is firm but not extremely hard.
✓ Roll onto one side when getting out of bed and sit up sideways, using your arms to help.
✗ Sleep on a sagging mattress as it puts your back in an unbalanced, stressful position.
✗ Sleep in one position for extended periods, e.g. more than 7 – 9 hours.

SITTING
✓ Sit close to your work.
✓ Ensure both feet are on the ground or a foot rest.
✓ Have a chair that supports your back.
✓ Maintain good posture while driving.
✗ Slump in your seat – your lower back should be supported.
✗ Lean forwards or downwards to reach for or look at your work.
✗ Sit for long periods without getting up.

STANDING
✓ Elevate or incline your work surface for precision work.
✓ Put one foot up on a block (or similar) and change position frequently if standing for a long time.
✓ Keep the work at a comfortable height.
✓ A padded surface, e.g. carpet is easier to stand on than an unpadded one, e.g. lino/wood.
✗ Don’t wear high heels or platform shoes for long periods, as they upset your balance.
✗ Don’t remain in one position for too long.
✗ Don’t stand with knees locked straight, tummy sticking out and back arched.
✗ Don’t stand bent forwards at the waist or neck.

AVOIDING STATIC LOADING
✓ Use handles and grips to make holding an object easier.
✓ Try to change your body position frequently.
✓ Keep a naturally upright spine during tasks.
✓ Avoid bending and twisting.
✗ Avoid kneeling, crouching or squatting for long periods.
✗ Avoid holding a static posture for more than a minute.

Getting Better From an Episode of Back Pain

Back pain is VERY common and though sometimes pain can be severe, for most people it’s rarely due to a serious cause and doesn’t result in long term disability; recovery happens in days or weeks.

Medical advice about back pain used to be about resting and lying down until the pain had gone. We now know this is NOT the best way to manage back pain! For the majority of people, its best to follow the points below


Bed rest is NOT GOOD for back pain in the long term: a couple of days, perhaps but no longer. KEEP MOVING.

Simple PAIN KILLERS for a few days can help you remain active and so help recovery: make sure you don’t go over the recommended dose.

STAYING ACTIVE and getting on with life, as best you can, is better than sitting still and avoiding normal activities.

ADVICE/treatment from a physiotherapist, osteopath or chiropractor may help speed your healing.

STAYING AT WORK or getting back to work as soon as possible, in spite of some pain, is better than staying on the sick.

The longer a person with back pain is off work, the lower their chance of returning to work.
MODULE B – INANIMATE LOAD HANDLING

Module Aim
To provide instruction in, and facilitate the application of, inanimate load risk assessment, including the safer handling of inanimate loads and application of ergonomic principles, to ensure the health and safety of employees.

Module Objectives
By the end of the session the learner will be able to:

- Demonstrate application of the principles of safer handling of loads including checking the weight of the load prior to handling.
- Demonstrate an understanding of formal and dynamic risk assessment.
- Demonstrate consideration of the four key areas, and other related factors such as guideline weights, to be considered when undertaking a manual handling risk assessment.
- Describe how the principles of safer handling can be applied to the movement of large or awkward loads.
- Describe considerations for safe storage of loads, including at low levels and above shoulder height.
- Outline the importance of good posture and safely demonstrate the following techniques:
  - Pushing and pulling; guidance in relation to wheelchair use may also be considered appropriate within this module.
  - Lifting and lowering load from the floor or low level / above shoulder height.
  - Carrying a load.
  - Correct posture whilst driving / sitting at an office desk (if appropriate).
- Demonstrate basic safety checks of equipment as appropriate.

During the training session the learner will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

QCF Criteria for this Module:
3.3, 3.4
5.1, 5.4
Principles for Safer Handling of Loads

Before Handling

- Check the load first – how heavy is it? Will it break when lifted? Is one side? Test it by tipping one edge or corner
- Do you have to lift or can you move it another way – such as sliding?
- Plan the move – remove obstacles from your path. Will you need a rest stop, somewhere to rest the load down?
- Ask for help if appropriate: either team handling or someone to hold doors open, etc.
- Prepare yourself – posture and position. Can you manage this?
- Move smoothly – don’t jerk or rush.
- Use your body weight to help move the item.
- Don’t twist your back – pivot on your feet instead.
- Put the item down carefully: don’t lean over or drop it suddenly

Good Posture for Safer Handling

These should be applied in any circumstance, with any load. If unable to achieve one or more of these principles prior to a handling operation, the worker should stop and reconsider: it may not be safe to proceed.

HEAD: Think it through! Keep your head up and in line with the rest of the spine.

ARMS: Keep them close to your body with elbows tucked in.

HANDS: A secure grip using your whole hand, not just the fingertips. Test it before lifting the load.

BODY: Keep your spine in its natural, upright position to minimise strain.

LEGS: Bend your knees and hips slightly to provide power to move and to keep you stable.

FEET: A stable base – they should be at least shoulder width apart with one foot further forwards than the other (the “Boxer’s” or “walk” stance).
Weightlifter Stance

Boxer Stance

The Diagonal Lift
**Practical Points for Pushing or Pulling**

- Pushing is better than pulling (in general).
- Keep your hands between waist and shoulder height when gripping the load.
- Where possible, push with hands HIGH, pull with hands LOW.
- Start the movement slowly to minimize forces on your body and don’t go faster than walking pace.
- Use two hands to push or pull wherever possible as using only one hand tends to make you twist.
Static and Dynamic Loading

Our bodies can experience two types of loading when performing manual handling tasks:

Dynamic Loading

This occurs when movement is evident in the manual handling task, i.e. pushing, pulling, lifting and lowering, carrying, throwing. The body has an opportunity to recover as these actions are usually done with ‘down’ time, even if only for a few seconds before they are repeated.

Dynamic loading becomes a more significant problem when actions are repeated very frequently (numerous times a minute) or involve heavy loads (exceeding those in the HSE guidelines).

Static Loading

This arises when we maintain our bodies, particularly the spine, in awkward postures that deviate from the naturally upright “S” curve that provides best stability and strength. The muscles and other structures have to work in a sustained way to resist the force of gravity pulling us over, so not having an opportunity to rest and recover.

- Static loading occurs when a posture is held for more than 3 – 4 seconds
- Such postures may present a risk of injury if held for 30 + seconds
- Common postures include bending, twisting and working at arm’s length
- Static loading also occurs in smaller joints, e.g. hand when sustained grips are required, shoulders when driving assisting a service user to eat.
- These need not involve active handling tasks.
Pushing Wheelchairs

General Points

- Go no faster than a walking pace.
- Take breaks if pushing the item over long distances.
- Consider the condition of the wheelchair – are the tyres pumped up and do the brakes work?
- Do a personal/ informal assessment using TILE – can you manage this service user in this wheelchair, in these environmental conditions?
- Ensure the service user has fastened the lap strap (safety belt).

Posture

- Keep your body in line with the wheelchair, don’t twist, instead move your feet.
- Keep close to the wheelchair, with your elbows slightly bent.
- Place your feet in the “boxer” stance.
- Have relaxed grip; pressure through the palms of your hands should be enough to move the wheelchair.
- To move forwards, lean your body weight onto your front foot.
- To move backwards, lean your body weight onto your rear foot.

Changing Direction

- Look at the castors, which way are they pointing? The wheelchair will most easily move in that direction, so it is worth moving it that way to start movement, then changing direction.

Castor facing BACKWARDS  
[Image of a wheelchair, castors facing backwards]

Castors facing FORWARDS  
[Image of a wheelchair, castors facing forwards]

- Turn the wheelchair in the direction you want to go WHEN THE CASTORS ARE MOVING.

Transporting a Wheelchair User in a Vehicle

Castors should face BACKWARDS as this gives the chair greater stability.
Managing a Step or Kerb – General Points.

- Find a dropped kerb if possible.
- Do a personal assessment using TILE.
- Check it is safe to cross at that point.
- Tell the service user what you are about to do.

Up a Kerb

- Approach the kerb forwards.
- Get as close as possible, until front castors touch the kerb.
- Place one foot on one of the tipping levers at the back of the wheelchair.
- Using your body weight, push down on the tipping lever.
- At the same time pull BACK on the handles. Take your foot off the tipping lever.
- Tilt the wheelchair slowly until it reaches a balance point (It no longer needs effort to hold it there).
- With the wheelchair tilted, push it forwards until the castors are on the pavement.
- Take a stable boxer stance with slightly bent knees.
- Change your grip on the handles so that your palms face upwards.
- Using your body weight, push the wheelchair’s rear wheels up onto the pavement.

![Image of wheelchair being pushed up a kerb]

Down a Kerb

- Turn the wheelchair so its rear wheels are closest to the edge of the pavement.
- Step down the kerb and adopt a stable boxer stance with slightly bent knees.
- Allow the rear wheels to roll down the kerb, using your body weight to control the movement.
- Place one foot on one of the tipping levers and draw the castors off the pavement, using your body weight on the tipping lever to control the movement.
MODULE C – SITTING, STANDING & WALKING

Module Aim
To provide instruction and training for the safe moving and handling of people during sitting, standing and walking.

Module Objectives
By the end of the session, the learner will be able to:

- Demonstrate application of the principles of safer handling of people.
- Demonstrate an understanding of formal and dynamic risk assessment specific to sitting, standing and walking.
- Demonstrate consideration of the four key areas, and other related factors such as guideline weights, to be considered when undertaking a manual handling risk assessment.
- Describe the importance of good posture and demonstrate through safe practice.
- Describe unsafe practices specific to sitting, standing and walking.
- Demonstrate the following manoeuvres, with the person moving independently / with instruction; being assisted by one carer; assisted by two carers; including, where appropriate, the use of relevant handling aids:
  - Assisting a person forward in a chair.
  - Assisting a person back in a chair.
  - Sitting to standing from chair.
  - Standing to sitting in chair.
  - Sitting to standing from edge of bed.
  - Standing to sitting on edge of bed.
  - Assisted walking.
  - The falling person (whether this is demonstrated and/or practised is at the discretion of the trainer and the organisation following a detailed risk assessment).
  - Raising the fallen person - instructing the person to raise him/herself (and with use of emergency lifting cushion if available).
  - Moving the fallen person out of a confined space (whether this is demonstrated and/or practised is at the discretion of the trainer and the organisation).
  - Bed-assisted stand.

During the training session the learner will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

Suggested equipment – flat and tubular slide sheets, handling sling, handling belt, one-way slide sheet, electric profiling bed.

QCF Criteria for this Module:
3.3, 3.4, 3.5, 3.6
4.1, 4.2
5.1, 5.2, 5.5, 5.6
Principles for Moving Service Users

- Check the care plan – and follow it.
- Make an informal assessment of the service user each and every time they need help to move – each time they may respond differently.
- Prepare the handling area: clear obstacles, have everything to hand, adjust height of furniture, apply brakes to wheelchairs or commodes.
- Check any equipment is safe and in position ready to use.
- Wear clothing that will not compromise safety or dignity. Footwear should be fully enclosed and supportive.
- Minimise jewellery to prevent harm to yourself and the service user.
- Plan the task with the service user and everyone else so each person knows what they should do.
- Facilitate and encourage the service user to be as independent as is safe.
- Identify a team leader to co-ordinate and give clear instructions, “ready, steady, go”.
- Sometimes gentle rocking with the “ready, steady, go” instructions can help all involved to prepare for and coordinate the movement.
- Ensure a gentle but secure grip on the service user doesn’t cause them discomfort or harm.
- Check everyone is ready and talk to the service user throughout the move.
- Use your body weight to help movement – transfer your weight from one foot to the other as the “go” instruction is given.
- Carry out the task smoothly and steadily: avoid fast or jerky movements.
- Avoid getting into or staying in awkward or static postures during the task.
- Make sure the service user is safe and comfortable before moving away or removing equipment.
- Store any equipment safely after checking it: does it need washing or charging?
Controversial and Unsafe Handling Techniques

A number of techniques for handling people have become recognised as hazardous. Techniques that were once thought acceptable may not be so any more. Check that your handling practices are up to date!

Unsafe and controversial techniques place YOU at risk and they place the SERVICE USER at risk of injury. Rough or inappropriate handling has been the subject of criminal court cases.

The 6TH Guide to the Handling of People (2011) integrates assessment of controversial practices within guidance on “core person handling skills” (pp. 121 – 169).

General principles apply when moving people: we generally do NOT do any of the following:

DO NOT: Lift the whole or majority of a person's weight unless there is a life threatening or emergency situation. Babies and children under 3 years old are excluded from this as it is normal and natural to lift them. It may also be acceptable to lift adult service users of very small stature.

There may be exceptional circumstances where a very careful risk assessment has identified that only a manual lift of a larger service user is appropriate and reasonably practicable after all other possibilities have been tried and eliminated.

DO NOT: Pull a service user by their hands or limbs or grasping around their limbs to move them.

DO NOT: Move a service user by holding on or under a joint, especially under the armpits.

DO NOT: Allow the service user to gain a hold on us that cannot be loosed when required.

If a care worker carries out any of these techniques when they are not specifically detailed in the care plan, they are breaking the law and could be liable for legal action.
The following are particular techniques that are identified as hazardous.

- **The Drag Lift**
  This means moving the person by holding under one or both of their armpits. It includes moving their buttocks forwards or backwards in a seat, leaning them forwards to insert or remove a sling, moving them up or own a bed, sitting to standing, or any other variation.

- **The "Top And Tail" Lift**
  A service user is lifted by two workers, one of whom grasps them from behind under their arms and around their forearms; the other worker grasps the service user around their knees or ankles.

- **The Front Standing Transfer**
  The worker stands in front of the service user and "hugs" them around their waist. The service user is allowed to grasp the worker around their waist or even their neck.

- **The Waistband Hold**
  By supporting a service user using their clothing, the worker is using an inappropriate grip that may cause discomfort. Also there is no guarantee that the clothing will not break and allow the service user to slip from their grasp.

- **“Towing” While Walking a Service user**
  This involves a worker walking backwards in front of the service user, encouraging and supporting them to walk while holding both their hands.

- **Grips Involving Use of the Worker’s Thumbs**
  The human hand is capable of powerful grips that can easily cause discomfort, pain and harm if the thumb is allowed to grip around the service user’s hand or limb.

The following are SAFER grips that may be used to facilitate a service user to move:

A flat or cupped hand:

- In the middle of their back to guide them to stand or walk
- At hips to support standing
- Under their hand or forearm to guide walking or transfers
- Under their knee to bend it while lying on a bed
- At their hips and shoulder to help turn or roll them on a bed
- Behind their shoulder blade to help them lean forwards.
Emergency vs Planned Manual Handling

What is an Emergency?

“A serious situation or occurrence that happens unexpectedly and demands immediate action.”

Emergency situations are those that could endanger the life of the service user or the health or life of the handler.

Examples often given of such emergencies are:
In danger from fire, drowning, collapse of a building or structure, fall from a height.

Some occurrences might be unexpected and certainly require immediate action, does that make them unforeseen?

Unexpected = Coming without warning.

Unforeseen = not seen or known about beforehand.

For example:

- You are caring for a service user who is known to have experienced frequent full body seizures. If they then had a seizure as you were assisting them, it wouldn’t be unforeseen.

In this situation, the emergency is known about (foreseen) and so can be planned for through a risk assessment, i.e. recording what action is required WHEN this person has a seizure.

A safer handling plan can be written and workers prepared accordingly.

- You are supervising an able-bodied person to walk when they collapse to the floor without warning: later medical tests show they have experienced a stroke.

This is unforeseen: no-one could know that this was about to happen. As such, a risk assessment could not have been written beforehand so the worker involved has to react to the best of their abilities in the circumstances.

- A fire breaks out in the main lounge of the premises where you work. Six elderly residents are sitting in the room as this happens.

This is unexpected, but not unforeseen: fire is a known risk therefore manual handling evacuation plans should have been written BEFORE any such occurrence.
Communication

We communicate with each other all the time and by many different means. It is important to include all methods of communication when we wish a service user to help themselves when we carry out a manual handling task as it increases the likelihood that they correctly receive our message and be able to cooperate and retain some independence.

We communicate through:

- **Using our voice**
  - Content, e.g. giving an instruction
  - Tone – positive and upbeat to encourage someone to move
  - Emphasis – stressing particular words that are important
  - Volume – again to stress what might be important in what we’re saying

- **Using eye contact**
  - To acknowledge someone and greet them
  - To signal we’re ready to move
  - To give feedback on how things are going

- **Gestures**
  - Useful where verbal communication is not easily understood
  - Backs up and strengthens verbal instructions

- **Demonstration**
  - Easier to understand than a complicated verbal instruction
  - Much quicker than describing a desired action
  - Creates a link between worker and person being assisted

- **Using touch**
  - To encourage movement in a particular direction
  - To reassure
  - To prompt and clarify intentions, e.g. “I want you to move this leg”.
  - To offer physical support

When a person has difficulty planning and performing a movement for themselves, it is useful to:

- Make sure you have eye contact with them.
- Give short, concise instructions, one at a time.
- Repeat these as necessary, but without adding too much extra detail.
- Use positive instructions, e.g. “stay standing” rather than negative ones, “don’t sit down”.
- Give the person time to respond and move independently.
- Use physical demonstration of the movement you would like them to make.
- Use physical touch to encourage movement in the direction wished.
When communicating with a person the sequence should be:

1. **Eye contact**

   This helps establish a link between the handler and the person. It indicates to them that the handler is about to do something and gives the handler a chance to assess their likely response.

2. **Verbal communication, gesture and demonstration**

   The handler can further assess the person’s response to the idea of being assisted. It also gives them a chance to assess the person’s level of understanding and potential cooperation with the task.

3. **Touch and physical help**

   This is the last stage of communication as it is the most personal and therefore has the highest risk of being poorly received. Only when the handler is satisfied that touch will be acceptable should they take this step.

   In other words, approach the service user gradually so they have time to register the worker’s presence and respond: beginning a communication with touch may startle them or lead to unwanted responses, e.g. aggression brought on by fear.

   **“Safe” Touch**

   Certain areas on the human body are (for the most part) regarded as “neutral” as far as touch is concerned. Other parts are no-go areas, unless the handler is giving personal care.

   Neutral areas include:
   - The back as far down as the waistband.
   - The arm, but rarely on top of the shoulder.
   - The hand.
   - The shin and lower part of the outside of the thigh.
   - The upper chest (in younger service users only).

**Normal Movement Patterns**

When we are born we are not capable of independent movement for a period of several weeks. The first movement a baby develops is head control via the “head on neck” reflexes. Once these are established, a baby is able to start body movement by using head movements as once the head moves the rest of the body follows.

The “head on body” reflex stays with us into adult life and it is the head that initiates movement of the rest of the body. Babies then learn trunk, arm and pelvic control in order to sit up and progress to standing and walking. They learn these complicated
manoeuvres in a stable position, lying down then progress to gradually less stable
positions: sitting up and standing.

Movement patterns are learned and retained by constant repetition, allowing the
nerve and muscular systems to practice the controlled movements required of the
muscles and joints in complex activities.

As human movement develops the body finds the most efficient way to move
according to the mechanics of the musculoskeletal system. This is why people all
move in the same way, with slight variation and use “normal” patterns of movement.

You will see these normal patterns in yourself and others:
- Rolling over to your side.
- Sitting up from lying down.
- Standing from sitting.
- Sitting from standing.
- Walking.
- Getting up from the floor.

The way a person breaks down these movements usually shows us the easiest way
of performing the action.

Moving Forwards and Backwards in a Chair

Before trying to stand up, it is easier to move your hips nearer the front of the seat.

- Encourage the service user to place their feet flat on the floor, hip width apart and
  under their knees.
- Instruct the service user to sit upright and hold the chair armrests.
- Ask them to lean forwards (chin over knees).
- Ask them to lean to one side, putting their weight on one buttock.
- Encourage them to hitch the other hip forwards or backwards, as needed.

Giving Assistance

- Half-kneel in front of the person facing them.
- Place a hand on their hip, opposite to the side they are leaning.
- The handler eases that hip across and forwards (or backwards) towards the front
  of the chair.
- Swap legs and do the same the other side.

Alternatively

The handler can place their open palm on the outside lower thigh of the leg they wish
to move forwards, and push gently away from them.
Sitting to Standing

- Encourage the service user to place their feet flat on the floor, hip width apart and under their knees.
- Instruct the service user to sit upright and hold the chair armrests.
- Encourage the service user to wriggle their bottom to the front of the seat.
- Instruct them to push up with their arms while leaning forwards.
- Instruct them to lift their head as they stand up to achieve a natural upright posture.

Giving Assistance

- *Stand at one side of the seat, facing in the direction of movement, the foot furthest from the chair is in line with the service user’s feet.*
- *The worker’s nearest hand is placed in the middle of the service user’s back*
- *Their furthest hand is placed in front of the service user’s shoulder*
- *As the service user pushes up to stand, the worker steps forwards with their back foot and places forwards pressure on their back.*
- *At the end of the movement, the worker is standing alongside the service user.*

Standing to Sitting

- Instruct the service user to feel for the edge of the seat with the back of their knees.
- Reach back with one or both hands to feel for the armrests (if any).
- Encourage them to lean forwards to aim their hips to the back of the seat.
- Once sitting, encourage them to remain leaning forwards, with feet flat on the ground and wriggle their bottom to the back of the seat.

Giving Assistance

- *Stand to one side, as for sitting to standing.*
- *Place their near hand across the service user’s shoulder blades to encourage them to lean forwards.*
- *Place their other hand in front of the service user’s shoulder or hip to provide a feeling of security.*
- *Step backwards with their near leg as the service user sits so as to maintain a stable working base.*

Walking with a Person

Preparation

- Clear the area of any trip hazards first.
- Have the destination seat ready (brakes on if it is a wheelchair or commode).
- Encourage them to move forwards by using constant encouragement and instruction.
- Placing your palm in the small of their back may help to guide them.
- Support the person’s hand or forearm that is nearest you, if this is appropriate.
To walk safely, the person has to be able to:

- Support ALMOST ALL their own body weight – a worker cannot hold them up.
- Understand and follow instructions from the worker.
- Sit upright unsupported and bear weight through both legs.
- Balance themselves when in a full standing position.
- Place one foot in front of the other and step with little assistance.

**Giving Assistance**

- Stand to one side of the person, facing the direction they wish to move.
- Place their near hand either in the centre of the person’s back or around to their opposite hip.
- If appropriate, support the person’s near hand or forearm or help to guide a walking aid.
- Move forwards in step with the person, i.e. right leg to their right leg, left to left, so that they remain balanced.

**Guiding a Person To or From the Floor**

The person must have a good degree of mobility to perform this task safely and almost independently, i.e. they must be able to fully weight bear and perhaps walk.

To the floor
- Person slides their hips forwards in a seat and turns slightly to one side.
- Holding the seat of the chair for support, they slide one, then both knees to the floor.

**Giving Assistance**

- Half-kneel to one side facing across the person.
- Place one hand on their near thigh and one on their furthest shoulder.
- Gently push to facilitate movement
  A version of this technique can be used in an emergency to lower an unconscious person to the ground.

Alternatively
Person leans forwards to place their hands on another surface in front of them, using this support to gently slide to the ground.

From the floor
- Encourage the person to roll onto one side with both knees bent.
- Prompt them to push their trunk up using the lower elbow and upper hand (called side sitting).
- Encourage them to roll onto all fours.
- Position a chair in front of them and encourage them to place both elbows on its seat.
- Instruct them to raise one foot and place it flat on the floor.
Pushing up with elbows and foot, the person raises their hips and turns to sit on the chair.

**Alternative - if the person cannot kneel**
- Encourage them to lean forward when sitting on the floor.
- Place a low stool or cushion behind their hips.
- Encourage them to bend their knees and dig heels into the ground while pushing up and back with their hands.
- Repeat this with gradually higher surfaces until they are in position from which they can stand.

This technique also works where the person is near a set of steps: they can use them to successively push themselves up each step to a position from which they can more easily stand.

**The Falling Person – Options**

Many organisations recognise that trying to catch a falling person, particularly a larger person, is very hazardous and can result in more injury to the falling person than might otherwise have happened if a worker had taken no action at all. The worker is also at significant risk of harm as the falling person may pull them to the floor or may even fall on them.

However, few care workers feel it acceptable to take no action at all if a person is falling. Risk assessment and a careful plan of action is required for each person who is at significant risk of falling.

The following actions might be considered should a person fall:

**Do Nothing**
- The worker(s) would put their own safety in severe danger if they were to intervene, e.g. a person falling down the stairs.
- It might not be feasible to reach them if they are out of arm’s reach.
- The person may be deliberately putting themselves on the floor in which case they are likely to resist any other intervention.
- The person might be of larger stature than the worker and it is not therefore safe or practical to consider stopping the fall.

**Minimise the Impact of the Fall**
- Try to move light-weight obstacles out of the line of the fall, e.g. small tables or chairs, so that the person falls onto a flat surface.
- Try to place / throw a soft object such as a cushion, beneath them as they fall.
- If the fall occurs as the person is rising from a sitting position, consider whether it is feasible to direct the fall so they return to sitting.
- If the person is walking and very close to a wall, consider whether it is possible to guide the fall so that they slide down the wall.

**Consider Using Your Own Body to Guide the Fall**
This is by far the most hazardous method and should only be used where a careful risk assessment shows it to be appropriate; if indicted, specific training will be given. For this to be feasible, the following criteria must be in place:

- The worker is of similar stature or slightly larger than the falling person.
- The person is not significantly heavier than the worker.
- The worker is very physically fit and skilled in this technique.
- The worker must be in physical contact with the person.
- The direction of the fall is backwards or directly down; if the person is falling away from the worker they will not be able to control it.
- The person is not resisting the actions of the worker.
- There are no obstructions in the environment.

**Equipment to Assist a Fallen Service User**

The Mangar Elk or Manger Camel are inflatable cushions that can be placed beneath a fallen person to mechanically lift them when they are unable to manage the above techniques.

Both require the service user to have some sitting balance and to cooperate with the process. They may be used by one worker but it is more common that two workers are required.
MODULE D – BED MOBILITY

Module Aim

To provide instruction and training for the safe moving and handling of people in and around a bed.

Module Objectives

By the end of the session, the learner will be able to:

- Describe the importance of good posture when working at a bed and demonstrate this through safe practice.
- Describe unsafe practices specific to movement into, out of and on a bed.
- Demonstrate safe use of electric profiling beds (where available) including appropriate bed height.
- Demonstrate the following manoeuvres, with the person moving independently / with instruction; being assisted by one carer; assisted by two carers; including, where appropriate, the use of relevant handling aids:
  - Fitting and removing tubular and / or flat slide sheets
  - Turning in bed
  - Moving the supine person up/ down the bed
  - Sitting a person from lying
  - Sitting a person up and onto the edge of the bed
  - Assisting a person to lie down from sitting on the edge of the bed

During the training session the learner will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

Suggested equipment – flat and tubular slide sheets, handling sling, turn disc, bed ladder, bed lever, hand blocks, leg raiser, electric profiling bed.

QCF Criteria for this Module:
3.2, 3.3, 3.6, 3.7
4.1
5.1 – 5.7 (All elements)
Many manual handling incidents happen when assisting a person to move in and on the bed. This is often due to the stooped postures and stretching that occur when the bed is not adjusted to the optimum position for the task. It is also due to the fact that many service users who are assisted are highly dependent and so cannot supply much, if any, power to move themselves.

**Suitable Equipment**

Electrically operated, four-section profiling beds are to be recommended wherever highly dependent people are cared for. These greatly reduce the physical loading on workers and also offer the dependent person opportunities for adjusting their own position without aid.

Where possible, the bed should be accessible from both sides and adjusted in height so that the top of the mattress falls at hip height on the workers. *If the bed is low and not height-adjustable, it may be advisable for the workers to kneel on one knee to improve their posture.* If in place, safety sides should be lowered while manual handling is occurring.

**Assisting Legs into Bed**

It is important to avoid two things in this activity: stooping while lifting the feet and twisting as the legs are moved onto the bed.

*Two workers may be required, depending on the person’s ability and risk assessment recommendations.*

- Ensure the person’s hips are as far onto the bed as possible.
- Encouraged the person to place both hands on the mattress to support themselves.
- The backrest on a profiling bed may be raised to offer side support.
- One worker supports their shoulders, either from the side or from behind (the other side of the bed).
- A second worker squats down to place a suitable item under the person’s heels (such as a handling sling).
- On a command, the worker holding the person’s feet, stands and, in doing so, lifts the person’s feet. The other worker supports their shoulders.
- The worker holding the feet walks towards the foot of the bed, so swinging the person’s legs gently onto the bed.
- A small tubular slide sheet may be placed on the bed before the person sits down to reduce the friction in this movement.

An alternative method is to use two long slide sheets in a cross shape on the bed, allowing the workers to adjust the service user’s position on the bed towards the centre and around, by using the top slide sheet to lift their legs.
Lying Down from Sitting Up

This may require one or two workers, depending on the assessed needs of the service user.

A choice of methods exists:

- Raise the backrest of a profiling bed before the person transfers onto it; use the backrest to lower them (or allow the person to do so themselves).
- A “Bed Leaver” rail, attached to the frame of the bed can assist the service user to control lying down independently.
- A bed rope ladder attached to the lower leg of the bed can offer the service user “rungs” they can hold to gradually lower their body to the mattress.
- The person sits in “long sitting” on the bed.
- Stand to one side of the bed in a boxer stance, placing the hand nearest the bed behind the service person’s nearest shoulder.
- Guide the person to place both hands on the bed, slightly behind the line of their shoulders.
- Encourage them to lean to one side, lowering their body onto that elbow.
- Encourage them to repeat this action to the other side.
- Repeat as necessary.
- The handler(s) may offer slight support behind the shoulder blades but will not hold the person up.

Rolling a person on a bed

It is often best for this to be performed by two workers, one standing at each side of the bed. It is then possible for one worker to start the roll and the other to perform the main part of it: this means that neither worker has to stretch too far across the bed.

- Encourage the person to bend the knee furthest from the worker they will roll towards.
  - If unable to do this the worker places their hands (flat palms) one under the knee and the other on the sole of the person’s foot. Worker then pushes upwards with both hands: the knee will bend.
- Encourage them to bring their furthest arm across their body and to turn their head to look at the worker (or a point beyond them).
  - If unable, worker uses a flat palm just above the person’s elbow to bring the arm across
- Using a boxer stance, worker places one hand behind the person’s shoulder, the other behind the hip and rolls the person by rocking their body weight backwards.
- If a person is to be rolled and turned frequently – such as when being bed bathed and changed, glide sheets can be inserted to reduce the effort required of the workers (see below).
Sitting Up from Lying Down

One of the hardest tasks to perform as workers are tempted to lift the person’s trunk in a bent and twisted posture.

Possible methods:

- Use the backrest of an electric profiling bed.
  - *N.B. Sitting a person up while at the same time trying to raise a manually-operated backrest is hazardous and should be avoided.*
- Use a passive hoist to reposition the service user.
- Bed rope ladder – the service person ‘climbs’ to a sitting position by pulling their trunk upright using its handles.
- The person is instructed to raise themselves to sitting by leaning to one side and pushing down on their elbows alternately. (Most people find this easier to do if they also lowering their legs over the edge of the bed at the same time).
- One worker, standing in a boxer stance at the bedside, facing the foot of the bed.
- The service user is guided to bend the knee furthest from the edge of the bed where the worker is standing and to reach across their body with the furthest hand.
- The worker offers the person their hand, but DOES NOT ALLOW THEM TO GRASP IT; the worker’s hand is a visual guide only.
- The worker can offer slight support behind the service user’s nearest shoulder blade as they begin to lift their trunk from the bed.
- Two workers use a suitable grip around the person’s shoulders (such as a handling sling) to sit them up without their active involvement.
  - The sling is placed beneath the person’s head and shoulders (by rolling them).
  - Workers stand either side of the bed, facing the headboard and holding the sling with their near hand.
  - Workers’ feet are in the boxer position, outside foot in front.
  - To sit the person up, workers step back with their front foot, supporting the person’s trunk with the sling.
  - A third worker may be required at this point if it is necessary to adjust pillows or perform another action.
  - To lie the person down, workers step forwards with the leg that is furthest from the bed.

Assisting a person to sit onto the edge of a bed from lying down

This may require one or two workers, depending on the ability of the person.

- Roll the person onto their side (see above).
- Encourage them to bring their feet towards the edge of the bed by tapping lightly behind their knees.
- Encourage them to push off the bed using the elbow of their lower arm and the hand of the uppermost arm.
Using a boxer stance, the worker places one hand under the person’s shoulder blade that is in contact with the bed.

On a command, the worker encourages them to sit up as they push gently on the person’s shoulder blade.

If necessary, a second worker can guide the person’s legs off the bed while standing the same side as the first worker OR the second worker could be the opposite side of the bed and support the person’s shoulders once they have reached a sitting position.

**Glide Sheets**

These may be flat sheets with handles or tube-shaped with or without handles. Helps the workers move a person on a bed with little effort and no friction on the person’s skin.

<table>
<thead>
<tr>
<th>Checks to make before using glide sheets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean and undamaged – particularly the seams and handles</td>
</tr>
<tr>
<td>Correct type for the task</td>
</tr>
<tr>
<td>Correct size – need to support the whole of the person’s body that will be in contact with the surface they are on</td>
</tr>
<tr>
<td>The right way out – some glide sheets only work one way</td>
</tr>
<tr>
<td>Always used as a double layer (either a tube sheet or two separate sheets together)</td>
</tr>
<tr>
<td>Positioned with a ‘safety gap’ between them and the edge of the surface the person is lying on</td>
</tr>
<tr>
<td>The person is moved using minimum force</td>
</tr>
<tr>
<td>They are removed after use and stored safely – do not allow them to drop on the floor</td>
</tr>
</tbody>
</table>
Inserting Glide Sheets

Various methods can be used, depending on the needs of the person established through risk assessment and the nature of the task:

- Place the sheets onto the bed before the person is moved onto it.
- Roll the person (see above) and push the glide sheets under them.
- Ask a more able person to “bridge”, i.e. lift their hips off the bed so the worker can place the glide sheet under their hips as they are lying down.
- Use the “unravelling method” to insert them beneath a person user who cannot roll onto their side.

Rolling Method – Flat Sheets or Tubular Sheets

Two workers are required, one each side of the bed. If possible, raise the bed to a suitable working height (hip height, approximately).

- Roll the person onto their side, as described above.
- The worker at the person’s back takes the glide sheets and lays them on the bed behind the person, ensuring a safety gap between the glide sheets and edge of the mattress. Also ensure the sheets will support the full length of the part of the person’s body they wish to move.
- The sheets are gently tucked under the person as they lie on their side, and smoothed out.
- The person is rolled to their back. The second worker should be able to see the edges of the glide sheets nearest them and can ease them out flat. The sheets should not overhang either side of the bed.

Unravelling method – Flat Sheets

Two workers are required, one each side of the bed. The bed is adjusted to a suitable working height.

- Sheets are placed together lengthwise. One worker holds each of the shorter ends.
- One worker rolls up the glide sheets, folding approximately 20 cm of fabric at a time. It is important to keep these folds neat and even.
- Once rolled, the folded sheets are placed under the service person’s pillow, with the loose ends on top, facing the head of the bed.
- Both workers face the head of the bed, holding the loose ends of the sheets with their outer hand.
- The hand nearest the bed goes, palm up, under the sheets to grasp the folded section.
- Moving smoothly and in time with each other, the workers pull along the bed to unravel each fold.
Removing Glide Sheets

Standard glide sheets (slippery both sides and of various colours), must be removed once movement of the person is complete as they present various hazards if left in place:

- If the person has any movement (voluntary or through muscle spasms), they may slide off the bed.
- The sheets are not breathable, so are hot and sticky to lie on.
- Due to their closely woven texture, glide sheets do not allow air through easily and may present a hazard to a person who turns face down on them.
- Glide sheets do not function properly when wet: if the person is incontinent, they will not be usable.

There are other versions of glide sheets that are designed to stay in place under the person.

Turning Inside-Out – Tubular Sheets

This can be done when the worker can see the sheet easily and can place their flat hand (without undue effort), beneath the person.

- Raise the bed to working height, waist level at least. If this is not possible, the worker may kneel at the bedside.
- The worker places their hands, palm down, between the two layers of the glide sheet to the far side.
- They grasp the BOTTOM layer of the sheet and pull it back through, using movement of their body weight to perform the action.

Pulling a Corner – Flat Sheets

- One worker turns a corner of the BOTTOM sheet under at the foot of the bed and passes it to their colleague on the other side of the bed.
- The second worker grasps this corner and, keeping the sheet flat, pulls it towards the top corner of the bed on their side, using their body weight to perform the movement.
- This is repeated with the top sheet, ensuring that its corner is turned UNDER, so that the handles of the glide sheet do not rub against the service user’s skin.

Using glide sheets to move a person up the bed

This task may be performed by one worker if:
- It is possible to stand behind the head of the bed and reach the glide sheets without over reaching.
- The service user concerned is assessed as being a suitable size and weight for the worker to manage alone.
- The service user’s posture or behaviour does not present a hazard of them sliding off the bed when the manoeuvre is performed in this way.
With two workers the procedure is as follows:

- Standing each side of the bed, workers face one another at the person’s waist.
- The bed is adjusted to their knuckle height and most of the pillows are removed.
- If possible, the knee rest of the bed should be raised.
- Turning to face the foot of the bed, they grasp the top glide sheet with the hand nearest the bed.
- They adopt the boxer stance, with the outside foot in front.
- On the command “ready, steady, slide”, they step back with the front foot, transferring their body weight backwards, so sliding the person up the bed.
- NOTE! No attempt should be made to pull with the arm; the move is achieved by transferring body weight from the front to the back leg.
- NOTE! Be aware that minimal effort is required to perform this movement.

Rolling and holding a person on their side: personal care

This two-person task can be useful when personal care is being performed, as it offers the supporting worker a much better posture and gives the person a feeling of support and safety.

- A worker stands at each side of the bed, at the person’s waist. The bed is adjusted to a good working height.
- With a boxer stance, one worker grasps the top sheet and on a command, pulls the person towards them across the bed by transferring their body weight from their front to their back foot.
- Both workers then prepare the person user to roll onto their side (moving their leg and arm).
- The worker who performed the first pull then turns the person onto their side to face their partner. The movement is achieved by rocking their body weight away from then towards the bed.
- Once on their side, the person can be supported there by the second worker, who takes over holding the handles of the glide sheet.
- The first worker can now peel the top glide sheet back to enable them to wash the person’ lower body.
- To complete the movement, the top glide sheet is replaced and the person is gently rocked onto their back.
- If necessary, the workers can slide them back to the centre of the bed.

Safe Use of Bed Rails

Why do we need to consider using bed rails for some service users?

To reduce the risk of falls from a bed. Bedrails are to prevent a person ACCIDENTALLY leaving the bed; just because a person user is agitated and gets up frequently when it is not appropriate to do so is NOT a reason for using bed rails.

They are NOT:
- For everyone – many other options should be considered before bed rails are considered.
- A limit to freedom – this is an abuse of Human Rights.
- A restraint.
- A grab rail – if the person requires support, appropriate equipment must be available.

**Hazards of Bed Rails**

- DEATH.
- Entrapment of a body part between rails.
- Entrapment between bedrails and mattress.
- Falling: trying to climb over them or around them.
- Hitting a part of the body against them.
- Detaching or loosening the rails by shaking.

**Reasons for Accidents**

- Rails not suitable for that person.
- Wrong rails for that bed.
- Rails not fitted as per supplier’s instructions.
- Poorly maintained bed rails (damaged, loose).
- Incorrectly fitted and adjusted rails.
- Poor design.


**ASSESSMENT AND MONITORING IS VITAL.**
MODULE E – LATERAL TRANSFERS

Course Aim

To provide instruction and training for the safe moving and handling of people during transfers from one position to another.

Course Objectives

By the end of the session the learner will be able to:

- Describe methods of maintaining personal hygiene and alternative techniques for toileting and clothing management.
- Describe unsafe practices specific to lateral transfers.
- Demonstrate the following manoeuvres, with the person moving independently / with instruction, being assisted by one carer, assisted by two carers, including, where appropriate, the use of relevant handling aids:
  - Standing transfer from bed to chair / chair to bed
  - Seated transfer from bed to chair / chair to bed
  - Transfer from chair to chair / commode / toilet

During the training session the trainee will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

Suggested equipment – straight and curved transfer board, flat and tubular slide sheets, stand aid, turntable, stand turner, handling belt.

QCF Criteria for this Module:
3.2, 3.3, 3.6, 3.7
4.1, 4.2
5.1 – 5.7 (all elements)
Transferring from One Seat to Another

This will be easier for the person if:

- The two surfaces are close together (at right angles is often useful).
- There are good supports along the way, e.g. armrests or grab rails.
- The two surfaces are of similar height.
- Both surfaces are secure, i.e. brakes are applied to any moveable item.
- The worker helping does not obstruct their view of where they are moving to.

Giving Assistance

- Stand to one side so as not to block the person’s view of the seat they are moving to.
- The worker places their near hand either in the centre of the person’s back or around to their opposite hip.
- If appropriate, support the person’s near hand or forearm or help to guide a walking aid.
- Maintain contact with the person by placing their hand in the middle of their back.
- Move with the person, side-stepping to finish the movement at the side of the new seat.

A number of pieces of equipment can be used, after a risk assessment, to help the person perform a safe transfer:

Handling Belt

Used to provide support and a safe grip on a person who is able to fully weight bear in standing or walk a few steps. It is NOT a lifting aid.

<table>
<thead>
<tr>
<th>Checks to make before using a handling belt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct size for the person: fitting snugly around their natural waist.</td>
</tr>
<tr>
<td>Clean and not damaged – particularly the fastening clasp.</td>
</tr>
<tr>
<td>Suitable for the task; check it can be adjusted properly.</td>
</tr>
<tr>
<td>The person has the ability required for the task and equipment.</td>
</tr>
<tr>
<td>The person finds it acceptable to wear.</td>
</tr>
<tr>
<td>The worker does not link their fingers or thumb through the belt handle when gripping it.</td>
</tr>
</tbody>
</table>
## Walking Frame or Rollator

This is NOT intended to help a person rise from sitting, but must be collected AFTER they have achieved a standing position.

### Checks to make before using a walking frame.

- It is in good working order – the ferrules (rubber feet) are not damaged, the handles are secure and the frame seems sturdy.
- The wheels run freely (if a Rollator).
- It is the correct frame for this service user (if in a residential home, for example).
- It is the right height for the person (the top rail should be at about wrist height).
- The service user is able to bear their weight and balance during movement.

## Stand-Turn Aid

For transferring a person who can weight bear, but cannot move their feet.

### Checks to make before using a stand-turn aid.

- It is in good working order – turns freely and the upright is securely fastened to the turning base.
- The knee pad and/or handle is adjusted to the appropriate height for the service user (shoulder high as they are sitting).
- There is sufficient space to place it in front of the service user and to turn it safely.
- The seat to which they are moving is at right angles to the seat they are in now and is very close to it.
- The worker applies the brake or places their foot on the steadying pad before the service user pulls themselves to stand or lowers themselves to sit.
Transfer or Glide Board
Straight or curved, many different materials. Assist a partially able person to perform a non or partial weight bearing transfer.

Checks to make before using a transfer board.
- The board is undamaged: if made of wood, particularly check for splinters.
- The transfer surfaces are very close together – the board must be supported for two-thirds its length.
- The transfer surfaces are the same or very similar in height.
- The service user has sufficient upper body physical strength and balance to use this equipment safely.
- They are wearing some clothing to allow them to slide along the board easily.
- They do not have broken skin on their buttocks or upper thighs.
- The service user understands how to use the item and can follow instructions.

Stand Transfer Aid
Used when a service user’s abilities are unreliable for weight bearing or they have other limitations that prevent them standing up fully.

Checks to make before using a stand transfer aid.
- Check for damage: tears to the padded portions, loose parts. Do the brakes work and the seat paddles raise and lower freely?
- Ensure the aid is clean and dry.
- Consider the person’s stature – are their legs long enough for them to sit securely on the seat paddles with knees resting against the shin pad?
- There is sufficient space to move the aid with the person on it.
- The legs of the aid can go around or under the furniture used during the transfer.
- The person has sitting balance, some upper body strength and a limited ability to bear weight through at least one leg.
- The service user understands and can follow instructions.
MODULE F – HOISTING

Course Aim

To provide instruction and training for the safe moving and handling of people who require hoisting equipment.

Course Objectives

By the end of the session the learner will be able to:

- Describe the principles of hoist use and the types of hoist available.
- Describe the type and use of slings.
- Demonstrate how to measure for correct fit of sling.
- State the main points of Lifting Operations and Lifting Equipment Regulations 1998.
- Describe unsafe practices specific to hoisting activities.
- Demonstrate the following techniques:
  - Fitting a sling with a person lying down.
  - Fitting a sling in lying using slide sheets.
  - Fitting a sling with a person in a sitting position.
  - Fitting a sling in a sitting position using slide sheets.
  - Hoisting a person from chair – bed – chair.
  - Hoisting a person to / from floor
  - Use of powered stand aid
  - Using an active hoist to transfer to/from the toilet
  - Using a passive hoist to transfer to/from the toilet

During the training session the trainee will be given the opportunity to practise all relevant manoeuvres specific to their individual needs.

Suggested equipment – sling lifting hoist (capable of lifting from floor if required); powered stand aid, flat and tubular slide sheets, selection of appropriate slings.

QCF Criteria for this Module:

3.2, 3.3, 3.6, 3.7
4.1, 4.2
5.1 – 5.7 (all elements)
Principles of Hoist and Sling Use

Hoists are generally large, bulky items of equipment that need to be used and moved with care; poor application of safer handling principles may result in injury to you and to the service user. Use your body weight to help move hoist rather than pulling/pushing with just your arms.

- Wear appropriate clothing and especially shoes: shoes should be sturdy and enclosed.
- Check the hoist and sling: they must both be working, clean and suitable for the task to be done
- Assess the person every time before hoisting them
- Use a sling appropriate to the person and the task to be carried out
- Check & prepare your environment – is there enough room to use the hoist?
- Explain the lift to the person and to your team mate before beginning the lift
- Explain to the person what they can do to help
- Apply the sling gently to avoid damaging their skin
- The sling, especially the leg straps, should be smooth and centred on the person: the bottom seam should be low on the person’s sacrum
- Open the legs of the hoist to increase stability and avoid furniture
- Position the hoist: lower the spreader bar to the person’s chest height and hold it steady to prevent it swinging
- Passive hoist operations are usually performed with the brakes OFF. This is to allow the hoist to take up the most stable position. Check the care plan for other instructions
- Choose the appropriate strap length for the transfer (if a looped sling) e.g. short at shoulders and longer at legs to place the person in a sitting position
- Attach all straps to the hoist correctly; ensure both sides are the same
- Check the hoist, straps and the person’s comfort before beginning to lift. Ensure they can see you at all times
- Raise the person smoothly – don’t stop and start as jerky movement can be unpleasant. Stop when their buttocks are JUST clear of the surface.

Many people – including care workers – dislike using hoists. So it is important that you:

- Appear CONFIDENT when operating one.
- Make sure the person feels SECURE and COMFORTABLE
- PLAN how you will use it.
- INCLUDE the person at all times.
Move the hoist as little distance as possible. One worker prevents the sling from swinging unduly as the person is hoisted.

During lowering: Position the person’s hips right to the back of a seat by pushing on their shins or the sling straps.

Stay in the person’s eye line to reassure them and note any problems.

Ensure person is correctly placed and comfortable before removing the sling.

Remove the sling carefully, turning leg straps away from their skin to prevent friction and damage.

Check the sling: does it need to be washed?

Store hoist appropriately to avoid trip hazards and put it on charge if necessary.

One NEVER, three MINIMUMS:

NEVER leave a person unattended when they have been raised in a hoist.

Move the hoist the MINIMUM DISTANCE possible.

Raise the person the MINIMUM HEIGHT above the transfer surface possible.

Keep the person raised the MINIMUM TIME possible.

What Can Go Wrong with Hoisting?

People can fall during hoisting for a variety of reasons. Problems include:

- Selection of the wrong size sling – resulting in discomfort if the sling is too small and a risk of the person slipping through the sling if it is too large.*

- Selection of the wrong type of hoist or sling for the person, or for the specific task – resulting in inadequate support and increased risk of falling from the sling. For example, access/toileting slings give a great degree of access but very little support and their use should therefore be restricted to toileting purposes, where appropriate.*

- Incompatibility of the hoist and sling – resulting in insecure attachment between the two. For example, incorrectly attaching a loop on a sling to a spreader bar designed for a clip attachment, or attaching a clip on a sling to a spreader bar designed to take a loop attachment. Follow the manufacturer’s advice and refer any concerns about sling/hoist design, supply, manufacturer’s instructions or compatibility claims to the MHRA, the regulator for medical devices (www.mhra.gov.uk).

- Failure of equipment due to poor maintenance, lack of inspection, inappropriate laundering processes or as a result of inadequate repair or modification.

- Leaving a vulnerable person unattended in a hoist, or in a position where they might be at risk of falling from the bed or chair.

- Hoist overturning when manoeuvring over difficult surfaces, transporting a person over a long distance on a hoist, or not following manufacturer’s instructions for use or safe systems of work.

- Not using the safety harness/attachment (if the sling specified for the service user has one).
Note:
Sling sizes and coding varies between manufacturers. There is a risk of using an inappropriately sized sling if you make assumptions without checking the suitability of a specific sling for the person. For example, two large slings from different manufacturers may be different sizes – the body of the sling may be a different length or the number of loop attachments may differ, resulting in a different lifting position.

Additionally, sling designs can alter over time, so a new sling from a manufacturer may differ in size or attachment strap length from one previously purchased. Some slings come with a range of different length loops for attachment to the hoist. These can be used to increase the comfort of the service user or put them in a more reclined or upright position. However, you should take great care to choose the correct loops for the person so that they are not at risk of slipping from the sling, and to use the same loop configuration on both sides to reduce the risk of the person falling from the sling sideways.

Two Main Types of Hoist

ACTIVE HOIST

Examples: MoLift Quickraiser (on left), ARJO Sara 3000 (on right), LIKO Sabina.

The person must be capable of co-operating. This type of hoist is used to bring a person from a sitting to a standing position (or vice versa).

People who are to use such a hoist must:

- Have the ability to support some of their body weight on at least one leg.
- Have reasonable trunk balance and shoulder function.
- Have some understanding of the situation and what they must do.
- Be able to co-operate – at least to some degree.
PASSIVE HOISTS

Examples: SUNRISE Oxford Major, LIKO Likorall, ARJO HUNTLEIGH Maximove.

The person raised in this hoist either cannot or does not need to have an active part in the process. These hoists will perform almost any type of transfer as they bodily lift the person clear of any surface.

These hoists may be mobile or ceiling mounted (tracking) or fixed (wall or floor mounted).
Checks on a Hoist Before Use

- It is within its LOLER legal inspection date (usually 6 months).
- Its SWL (Safe Working Load) is suitable for the person you wish to hoist.
- Charged up – check the indicator.
- Switched on – ensure the red “emergency stop” button is not pushed in.
- Emergency mechanical lowering and stop systems are functioning.
- Wiring is not damaged and is securely plugged into connections.
- Handset is undamaged and operating all hoist functions.
- Spreader bar is firmly attached to the lifting mechanism.
- Spreader bar turns and pivots freely.
- Sling retention clips in place and working correctly.
- No other visible damage, fault or missing part.

And on a MOBILE HOIST:

- Wheels run freely.
- Brakes operate securely.
- Leg/ chassis open and close correctly.
- The mast (upright) is securely attached to the hoist base.

Checks Before Using a Sling

- Clean and undamaged – particularly the attachment points (clips or loops).
- Sling label is legible.
- Assessed as suitable for the person to be lifted.
- The right size and type of sling for the person.
- All accessories are in place, e.g. some slings have stiffening rods in the back to support the person: these MUST be in place.
- Compatible with the hoist it is to be used with.
- Handler is trained in its use.

Is It The Right Size?

To fit a person correctly the sling must fulfill a number of checks. Too small and the person will be uncomfortably squashed; the sling may also rub against their skin and cause damage. If a sling is too large, there is a very real danger that the person will fall out of it.

For slings used with PASSIVE hoists:

- Wraps comfortably around their shoulders, i.e. the straps should not be in contact with their skin.
- Is of the appropriate body length:
  - Head support sling: from the crown of the person’s head to half-way down their buttocks.
  - Sling without head support: from the top of their shoulders to half way down their buttocks.
- The padded sections of the leg straps reach to their knee when the sling is centred on their spine.
For slings used with ACTIVE hoists:

- Stomach band should overlap slightly across the person’s abdomen.
- Back of sling should offer the person support from tailbone to shoulder blades.
- Padded sections of sides of sling should be centered under person’s arms.

**Good Technique when Fitting Slings**

- Work in partnership with your colleague, plan what actions you’ll take
- Avoid unsafe holds while moving the person to place the sling, e.g. drag lifting under their arm to lean them forwards
- Consider your own posture: use a wide base of support to improve your balance
- Avoid stooping: could you sit or squat or kneel instead?
- Check the picture on the sling label for correct fitting
- Ensure the sling fabric is smooth and even under the person before hoisting
- Encourage the person to do as much as they are capable of to assist this task
- Encourage the person to lean from side to side to help fit the sling beneath their buttocks.
- A slide sheet can help fit a sling behind a person’s back or under their legs if they are unable to move very much in a chair.

**Types of Sling**

### Toileting/Access

- Easy to fit.
- Allows good access to lower body for toileting, personal care and dressing.
- Offers little support to the person – might they be in danger of falling through it?
Specialist slings

Slings can be designed for many specific purposes and needs, some of which are shown here:

**General Purpose/ Universal/ Quickfit**

- Easy to insert in lying or sitting.
- Allows access for toileting, via a commode aperture but not to adjust clothing.
- Gives a good sitting position.
- Offers quite good support to trunk and perhaps the person’s head.

**Hammock**

- Harder to fit – best done with the service user in a lying position as there is no commode aperture or only a very small one.
- Gives a high level of support and comfort.
- Less versatile than other slings.

**Amputee**

This sling often has additional leg and groin straps to support the person and keep them secure in the sling.
**Walking harness**

This can be attached to a tracking hoist to allow a person to practice walking in safety.