

# Policy Directive

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## Manual Handling Incidents - NSW Public Health Services - Policy/Best Practice Guidelines Prevention

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**Functional Sub group** Personnel/Workforce - Occupational Health & Safety

**Summary** Policy and guidelines to assist staff etc prevent manual handling injuries and meet legislative requirements.

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**Director-General**

**Compliance with this policy directive is mandatory.**

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**CIRCULAR**

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**POLICY AND BEST PRACTICE GUIDELINES FOR THE PREVENTION OF MANUAL HANDLING INCIDENTS IN NSW PUBLIC HEALTH SERVICES.**

This circular replaces circular 97/35.

Manual handling is a major cause of workplace injury and disease in the health industry, yet many manual handling injuries are highly preventable. Injuries arising from manual handling include, for example, sprains and strains, cuts, bruises, fractures and injuries of gradual onset such as hernias, lower back pain, sciatica, and occupational overuse syndrome.

These Policy and Guidelines have been designed to assist managers, supervisors, staff and occupational health and safety committees and OHS Representatives within Health Services to prevent manual handling injuries, and to meet their legislative requirements.

Health Service includes public health organisations as defined under Section 7 of the Health Services Act 1997 (including Area Health Services), Corrections Health Service, the Children's Hospital at Westmead and the NSW Ambulance Service. Employees include permanent, casual, agency staff and contractors.

The objectives of this policy are to:

- ✓ Prevent/reduce the occurrence of manual handling incidents;
- ✓ Reduce the severity of injuries when they do occur;
- ✓ Satisfy legislative requirements;
- ✓ Contain costs;
- ✓ Reduce and eliminate manual handling where possible;
- ✓ Promote the supply and use of manual handling equipment.

NSW Health is committed to the development of Policy and Guidelines for the Prevention of Manual Handling Incidents in NSW Public Health Services. In light of the attached policy document Health Services should now develop or review existing Manual Handling Policies.

Robert McGregor  
**Acting**

**Director-General**

Distributed in accordance with circular list(s):

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In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health.



Policy and Best Practice Guidelines  
for the Prevention of  
Manual Handling Incidents  
in NSW Health

October 2001



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## 1.0 ABOUT THIS DOCUMENT

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<b>Responsibilities:</b>	This document was prepared under the direction of Employee Relations Division, NSW Department of Health.
<b>Version:</b>	October 2001
<b>Updates and Feedback:</b>	Feedback is welcome and should be provided to the Director, Employee Relations Division
<b>Rescinds:</b>	Policy and Guidelines for the Prevention of Manual Handling Incidents in NSW Public Health Care Facilities (Circular No:- 97/35)
<b>Authority:</b>	It is a condition of subsidy under the Accounts and Audit Determination that Health Services comply with all Department of Health Circulars and Policies.
<b>Related NSW Health Policies:</b>	<ul style="list-style-type: none"><li>• A Framework for Preventing and Managing Incidents in the Health Workplace (draft, July 2001)</li><li>• Employment Health Assessments – Policy and Guidelines (Circular 2000/89)</li><li>• Occupational Health and Safety Audit Profile (Circular 01/5)</li><li>• Policy for the Management of Rehabilitation in NSW Health, (Circular 97/98) under review.</li><li>• Security and Safety: Minimum Standards for Health Services, Sept. 98</li><li>• Workplace Health and Safety: a Better Practice Guide (Circular 2001/22)</li></ul>
<b>Additional References/ Resources</b>	See Section 12.1

## 2.0 INTRODUCTION

### 2.1 Introduction

Manual handling is a major cause of workplace injury and disease in the health industry, yet many manual handling injuries are highly preventable. Injuries arising from manual handling may be acute or chronic and may affect almost any part of the body. Acute injuries include sprains and strains, cuts, bruises, fractures and dislocations. Chronic injuries (gradual onset and developing over time) include hernias, low back pain, sciatica, capsulitis and occupational overuse syndrome.

Back injuries such as sprains and strains are the most common manual handling injuries, followed by injuries to the shoulders and arms. Most injuries tend to develop over time as a result of an accumulation of small incidents rather than one major accident.

As well as the significant workers compensation costs, there are other considerable unmeasured costs of manual handling injuries, which are often unrecognised. These include labour replacement, lost productivity, property and equipment damage, injuries to patients and administration costs.

Social or intangible costs can also be incurred by the Health Services and the employee. For the former, this includes lower employee morale, poor employee relations, lower standards of patient/client care and financial and organisational inefficiency; for the injured employee there can be loss of career and disruption to family and social life.

### 2.2 Purpose and Scope

This document outlines the NSW Health policy for the prevention of manual handling incidents in public health services in NSW, and provides guidelines on how policy requirements should be met. It applies to all Health Services including the Department of Health, public health organisations as defined under Section 7 of the Health Services Act 1997 (including Area Health Services), Corrections Health Service, the Children's Hospital at Westmead and the NSW Ambulance Service.

Manual handling is defined as any activity requiring the use of force exerted by a person to lift, lower, push, pull, carry or otherwise move, hold or restrain any object, animal or person. It therefore applies to the work of nurses, ward support staff, cleaners and storepersons, catering, laboratory, engineering and maintenance staff, gardeners, laundry workers and others.

The Policy and Guidelines have been designed to assist managers, supervisors, staff and occupational health and safety committees of Health Services to prevent manual handling injuries, and to meet their legislative requirements. Manual handling has been identified as a specific hazard requiring attention under the Incident Prevention Program of the NSW Health Workplace Health and Safety Model (Attachment 6).

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## 2.0 INTRODUCTION

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“Health Service“ includes the public health organisations as defined under Section 7 of the Health Services Act 1997 (including Area Health Services), Corrections Health Service, the Children’s Hospital at Westmead and the NSW Ambulance Service. For the purpose of this policy, employees are taken to be permanent, casual, agency staff and contractors.

### 2.3 Legislative Framework and Responsibilities

#### 2.3.1 *Occupational Health and Safety Act 2000*

The Occupational Health and Safety Act 2000 (OHS Act) prescribes general duties and legal obligations on occupational health and safety matters. It covers both employer and employee responsibilities.

An object of the OHS Act is to ensure that risks to health and safety at a place of work are identified, assessed and eliminated or controlled.

Section 8 of the Act requires *employers* to ensure the health, safety and welfare of employees, and of people visiting or working at their place of work who are not employees. This includes providing such things as a safe working environment, a safe system of work; safe plant, equipment and appliances; supervision; information, training and instruction to enable employees to safely carry out the organisation’s activities and meet OHS requirements.

Section 13 of the OHS Act contains a duty to consult with employees to contribute to the making of decisions affecting their health, safety and welfare.

Section 20 of the Act requires *employees* to co-operate with employers in maintaining health and safety at work by taking reasonable care for the health and safety their own safety and that of other persons who may be affected by their acts or omissions. This includes complying with health and safety instructions and safety procedures; correct use of safety devices and equipment; reporting to their supervisor any situation which could present a hazard; reporting any accident or injury which arises in the course of or in connection with their work.

Section 26 of the Act requires persons who are involved in the management of corporations to manage OHS within their areas of control and influence. For the purposes of the OHS Act, Area Health Services are corporations.

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## 2.0 INTRODUCTION

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### 2.3.2 *Occupational Health and Safety Regulation 2001*

The supporting Occupational Health and Safety Regulation 2001(OHS Regulation) expands on both the requirement for consultation and a risk management approach to occupational health and safety.

Section 86 of the OHS Act and Clause 341 of the OHS Regulation require employers to report/give notice of certain occurrences at the place of work. These include, for example, all work related deaths and work-related injuries and illnesses that cause a person to be unable to perform their normal duties or activities for seven or more continuous days. Such occurrences require a WorkCover Incident Report form to be completed.

### 2.3.3 *Part 4.4 of the OHS Regulation 2001*

Part 4.4 of the OHS Regulation sets out the responsibilities of employers to identify, assess, eliminate or control risks arising from all forms of manual handling tasks in workplaces. Under Part 4.4, and employer must, as far as reasonably practicable, achieve risk control **by means other than lifting**.

Specific *employer* responsibilities under the OHS Regulation include:

- i Ensuring that all objects (eg plant, equipment and containers) used in the workplace are designed, constructed and maintained, as far as is practicable, to eliminate manual handling risks;
- ii Ensuring that work practices carried out in the workplace are designed, as far as is practicable, to eliminate manual handling risks;
- iii Ensuring that the work environment is designed to be, as far as is practicable, consistent with safe manual handling activities;

If it is not practicable to eliminate manual handling risks, an employer must design the work activity to control the risk by:

1. modifying the design of the plant, equipment and containers to be handled or modifying the work environment, taking into account work design and work practices. (to the extent that the place of work is under their control).
2. Providing mechanical aids or, **where no other option exists**, making arrangements for team lifting, or both, and

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## 2.0 INTRODUCTION

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3. Ensuring that the persons carrying out the activity are trained in manual handling techniques, correct use of mechanical aids and team lifting procedures appropriate to the activity.
4. Ensure that as far as is practicable, the risks associated with manual handling are controlled;
5. Ensure that the processes of identification, assessment and control are done in consultation with the employees who are required to carry out the manual handling tasks and their representatives on health and safety issues;

Clause 81 of the Regulation outlines factors which must be taken into consideration when undertaking a manual handling risk assessment:

- (a) Actions and movements (including repetitive actions and movements)
- (b) Workplace and workstation layout
- (c) Working posture and position
- (d) Duration and frequency of manual handling
- (e) Location of loads and equipment
- (f) Weights and forces
- (g) Characteristics of loads and equipment
- (h) Work organisation
- (i) Work environment
- (j) Skills and experience
- (k) Age
- (l) Clothing
- (m) Special needs (temporary or permanent)
- (n) Any other relevant factors

*Employee responsibilities* in terms of the OHS Act include:

- i Participating in and using where possible the training provided in safe manual handling techniques;
- ii Cooperating in the risk identification, assessment and control process;
- iii Where possible, using mechanical aids, equipment and team lifting procedures in the manner in which they have been trained.

OHS legislation (including the OHS Regulation) applies to all places of work in NSW. A 'place of work' includes all Health Services and any other place where an employee carries out their duties including clinics, vehicles and patients' homes.

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## 2.0 INTRODUCTION

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### 2.3.4 *National Standard for Manual Handling*

The OHS Regulation references, as guidance material, the National Standard for Manual Handling [NOHSC: 1001 (1990)] and the National Code of Practice for Manual Handling [NOHSC:2005 (1990)] developed by NOHSC in 1990.

### 2.3.5 *National Code of Practice for Manual Handling*

The National Code of Practice for Manual Handling [NOHSC:2005(1990)] which was published in the same document as the National Standard, is the principal advisory document on how to meet the Standard. It is an approved code of practice under section 43 of the OHS Act, and failure to comply with the code of practice can be used as evidence in the event of a prosecution.

The National Code of Practice for the Prevention of Occupational Overuse Syndrome [NOHSC:2013(1994)] is also an approved code and should be used in conjunction with the assessment and control strategies outlined in the manual handling code. It is consistent with and complementary to the National Code of Practice for Manual Handling, and provides additional information and advice to employers and employees on meeting the National Standard for Manual Handling. In particular, it focuses on work where repetitive or forceful movements are involved, and/or where maintenance of constrained or awkward postures is required.

Both codes provide advice on conducting risk identification and assessment, and on implementing control measures, and should be the primary documents used when implementing this policy.

### 2.3.6 *Penalties*

An employer who has not taken adequate steps to reduce risks can be penalised for not complying with the legislation, even if no injury has occurred. The maximum fine for a breach of the Occupational Health and Safety Act is currently \$550,000 for a first offence and up to \$825,000 and 2 years jail for subsequent offences.

It should be noted that organisations are increasingly being held accountable under OHS legislation, and in particular, for failing to implement related policy.

Directors and Managers can be fined up to a maximum \$55,000 for a section 26 breach of the Act as they represent the employer.

Employees also have responsibilities under that Act and can also be prosecuted. They can be fined up to a maximum \$3,300 for a section 20 breach.

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## 2.0 INTRODUCTION

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<b>2.4</b>	<b>Key Definitions</b>	A number of terms will be regularly used in this document. For the purpose of this document, they are defined as follows:-
	<i>Awkward</i>	Where the posture or action required for the task creates some discomfort, or is difficult to maintain.
	<i>Constrained</i>	Where the posture is forced, cramped, restrained, unnatural, confined or restricted.
	<i>Consultation</i>	The sharing of information and exchange of views between managers, workers and/or their representative(s) on health and safety issues. It includes the opportunity to contribute to decision-making in a timely fashion to resolve manual handling risks.
	<i>External Services</i>	Health care services delivered away from major health treatment centres; ie ambulance or mobile van services, home or community health services, temporary disaster management sites etc.
	<i>Hazard</i>	Anything that has the potential to result in harm to a person.
	<i>Incident</i>	Any undesired event which could or does result in harm to people, loss of or damage to property, interruption to process, environmental impairment and/or loss of containment.
	<i>Job/Work</i>	Combination of all tasks that make-up the duties of the employment position.
	<i>Manual Handling</i>	Any activity requiring the use of force exerted by a person to lift, lower, push, pull, carry or otherwise move, hold or restrain any animate or inanimate object.
	<i>Patient</i>	For simplicity the term patient has been used in the place of the various other descriptors used such as 'client' or 'resident'.
	<i>Performance Indicator</i>	A measure of the performance of the particular activity or program. Should be related to the activity or program objective(s).
	<i>Plant</i>	Any machinery, equipment, appliance, implement and tool, and anything fitted or connected to them.
	<i>Risk</i>	The likelihood that harm will occur.
	<i>Static Loading</i>	Holding or supporting a load while in a fixed position; maintenance of constrained/awkward postures.
	<i>Task</i>	Group of related job parts done as a unit of work ie doing a dressing; bathing a patient/client, transporting equipment, preparing meals etc.

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## 2.0 INTRODUCTION

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<i>Transfer</i>	A 'transfer' is a term used in manual handling of patients relating to tasks where the patient is not lifted but instead is moved in some way.
<i>Working Environment</i>	Relates to the environment where tasks are conducted and includes temperature, air conditioning, humidity, ventilation, noise, lighting/glare, colour, space and layout etc.
<i>Workplace</i>	Any place where an employee works, or is likely to work, and includes any place that a person goes while at work ie hospitals, motor vehicles including ambulances, and patients' homes.
<i>Workplace Location</i>	The specific part of the workplace where the task is being conducted or work is being done ie laundry, laboratory, ward.
<i>Workstation</i>	The place from which the employee works, including equipment, furniture and fittings.

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## 3.0 NSW HEALTH POLICY

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### 3.1 Policy

Each Health Service shall develop and implement a manual handling incident prevention policy and program. A central feature of the implementation of this policy is to eliminate manual handling where possible or minimise the risk where it cannot be eliminated.

The objectives of this policy are to:

- i Prevent/reduce the occurrence of manual handling incidents;
- ii Reduce the severity of injuries when they do occur;
- iii Satisfy legislative requirements;
- iv Contain costs;
- v Reduce and eliminate manual handling where possible;
- vi Promote the supply and use of manual handling equipment.

The policy and program shall include, but not be limited to, the following key components:

- ***Timely, appropriate consultation with staff and their representatives throughout the development and implementation of the policy and program (Section 4)***
- ***Introduction of risk prevention strategies in the planning stages of: the work environment; task design and the determination of staffing levels; equipment design, purchase and maintenance; the design of transport systems (Section 5)***
- ***Identification of manual handling tasks likely to be a risk to health and safety, and assessment of the manual handling risks associated with these tasks (Section 6)***
- ***Implementation of control measures to reduce the risk including the provision of fit for purpose manual handling equipment or devices (Section 7)***
- ***Mandatory induction training and ongoing training of managers, supervisors and staff including assessment of the manual handling skills required of their position (Section 8)***
- ***Documentation at all stages of the process (Section 9)***
- ***Ongoing evaluation of the policy and program (Section 10)***

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## 3.0 NSW HEALTH POLICY

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## 3.0 NSW HEALTH POLICY

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- 3.2.5 *Occupational Health and Safety Committees and OHS Representatives* Occupational health and safety committees and OHS Representative are responsible for:
- i Providing a forum for joint consultation on manual handling issues;
  - ii Monitoring implementation of the manual handling policy and program.
- 3.2.6 *All Employees* All employees are responsible for:
- i Participating in the consultative process, and in manual handling training;
  - ii Following safe work practices as instructed, including taking rest breaks provided and using equipment when provided;
  - iii Reporting potential manual handling hazards or problems;
  - iv Not putting themselves or other workers or patients at risk by their actions or omissions.

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## 4.0 CONSULTATION

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**4.1 Policy** Each Health Service shall ensure timely, appropriate consultation with staff throughout the development and implementation of the policy and program.

**4.2 Guidelines** As reflected throughout this document, consultation is required during the design, implementation or purchase of new workplace layout, furniture, work processes and equipment, and at all stages of the identification, assessment and control process.

These activities should be undertaken in consultation with the employees who are required to carry out these tasks, and their representatives on health and safety issues where appropriate. Special attention should be given to including representatives of the various ethnic and other groups involved.

This consultation should occur when:

- i Planning new facilities, refurbishments or new services;
- ii Planning for the selection and introduction of new equipment or in the modification of equipment or manual handling tasks, or in the review of existing tasks;
- iii Identifying problem areas in order to establish priorities for assessment;
- iv Determining how tasks or patients will be assessed, and during the assessment process;
- v Various control measures are being developed;
- vi The effectiveness of any implemented control measure is being reviewed;
- vii Investigating incidents and hazard reports.

Consultation may occur through formal and/or informal processes, and involve direct and/or representational participation.

Such processes can include:

- i Formal and informal consultation with staff;
- ii Manual handling agenda items for staff and managers' meetings;
- iii OHS committee as a consultative forum for manual handling issues;

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## 4.0 CONSULTATION

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- iv Open communication systems that encourage hazard reporting and suggestions for improvements;
- v Staff surveys.

Consultation should occur with OHS committees in relation to the various aspects of manual handling risk management. Consultation should occur but not be limited to areas such as development of manual handling policies and programs; development of procedures for identification, assessment and control; determining training needs including the needs of special groups; investigation of incidents and hazard reports; involvement in assessment and control where necessary. The OHS committee should also monitor manual handling incidents and be involved in the evaluation of the manual handling program.

Where Health Services have established a separate manual handling consultative committee, this committee should maintain an appropriate relationship with the OHS committee, and keep the OHS committee up-to-date on its activities.

## 5.0 RISK PREVENTION STRATEGIES IN PLANNING AND DESIGN

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**5.1 Policy** Each Health Service shall ensure the introduction of risk prevention strategies in the planning stages of: the work environment; task design and the determination of staffing levels; equipment design, purchase and maintenance; the design of transport systems.

**5.2 Guidelines** Manual handling considerations should be applied when building new facilities or extending or refurbishing existing areas.

As stated in the National Code of Practice for Manual Handling, the most effective way to eliminate manual handling risk factors is at the design stage. Modifying or redesigning areas or processes for this purpose once they are in place is more difficult and incurs additional cost.

Work environment planning requires careful examination of the impact which the physical surroundings have on the ability of the end users to perform manual handling tasks. This should include examination of the working space layout, floor plan and floor coverings and surfaces, slopes of ramps and paths, positions and heights of working surfaces and storage areas, provision of lighting, and temperature regulation.

Design specifications should be developed after consultation between management, suitably qualified OHS personnel, architects, engineers, staff and their OHS representatives. Consideration should also be given to the working environment, tasks/work to be done and equipment to be used, in order to design the optimal conditions for the user and to meet their capacity to conduct the task.

The specifications should ensure that the ultimate environment or job/task change or equipment purchase achieves the 'best fit' with end users and optimises their ability to perform their tasks safely.

**5.2.1 Work Environment Planning and Design**

**i Working space, floor plan and layout**

There should be adequate working space to do the job safely and the floor plan and layout should support this.

For example, when designing bathrooms the possible dependency levels and disabilities of patients should be taken into account. The position of baths and the floor space in bathrooms should allow adequate access to the patients, and adequate room to manoeuvre manual handling appliances such as hoists, shower trolleys and shower chairs.

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## 5.0 RISK PREVENTION STRATEGIES IN PLANNING AND DESIGN

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The workplace should always be designed to accommodate the range of dimensions of the working population.

ii Floor surfaces and accessways

Floor surfaces should be even and non-slip and require minimal maintenance. Gradients of ramps and slopes should take into account pushing and pulling of equipment.

The use of carpet should be examined closely due to its effect of increasing forces required to move wheeled equipment, beds and trolleys. Tight corners at the top and bottom of slopes should be avoided. Ridges and crevices should be reduced or eliminated especially on entering and leaving lifts.

iii Work surfaces

Work surface dimensions should consider the work to be done at them and should take into account the range of dimensions of the working population. If the work is repetitive or performed for long periods then adjustability should be incorporated either into the work surface or the equipment used eg; laboratory and office workers and their chairs and linen handlers and their spring loaded trolleys.

iv Storage areas

Storage areas are extremely important and should be of a size, which will take into account future needs. They should where possible be close to the area of use, particularly for regularly required equipment or high demand products.

When designing shelving, consideration should be given to shelving depth and angles to reduce twisting, bending and stretching when under load. Shelving design should also allow the majority of items to be stored between knuckle and shoulder height, and, where high shelves are needed, steps or ladders should be provided. Storage of heavy items above chest height should be avoided.

In some cases trolleys can be used as storage areas to reduce double handling.

For further information refer to the Australian Entry in Section 11.1.

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## 5.0 RISK PREVENTION STRATEGIES IN PLANNING AND DESIGN

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When using steps and ladders, the object being handled should be able to be easily handled in one hand, as the other hand will be needed to hold onto the steps or ladder for support. Other more suitable equipment will need to be considered if the object is more awkward to handle.

v External environments

When the service is provided in the patient's home an assessment of the environment needs to be made before the service starts. Agreed changes should be made before service commencement. In the case of emergencies such as those attended by NSW Ambulance Service, there will be a very limited ability to negotiate and make changes.

5.2.2 *Work and Task Design and Determination of Staffing Levels*

When planning and organising work and task design, prior consultation should take place with employees through established consultative processes.

i Workloads and work procedures

Work organisation and mechanisation should reduce as much as possible, the need for regular or heavy manual handling, awkward or static postures, and double handling.

Consideration should be given to distributing the workload as evenly as possible throughout the day. Workloads should be planned to allow sufficient time for all tasks to be carried out effectively and safely. Tasks involving handling or continuous or awkward static postures should be alternated with light tasks. Job rotation should also be considered.

Workflow should be flexible enough so that staff can regulate some of the pressure related to their work. For example, showering of patients, a heavy manual task, should be spread throughout morning and afternoon shifts and not concentrated between 7.00 am - 9.30 am. It is important for adequate personnel to be available to maximise the opportunity for varying the workflow.

Jobs which involve repetitive work should be enlarged where possible to incorporate different activities. Repetitive tasks or tasks including static loading such as working on the stripping line of a dishwasher, should be rotated frequently if they cannot be modified to reduce the manual handling involved.

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## 5.0 RISK PREVENTION STRATEGIES IN PLANNING AND DESIGN

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Where manual handling of goods is unavoidable, consideration should be given to the tagging of heavy and/or hazardous items with their weight and safe handling methods developed.

Close attention should be given to load design so that loads are stable, compact, and can be moved on wheels rather than carried. Loads, if carried, should be easy to grip, held close to the body, of an optimum weight, and have handles where possible.

ii Number of personnel

Sufficient personnel should be provided so that tasks may be undertaken in safety and without imposing undue postural stress. A systematic method should be adopted when establishing staffing levels for new facilities and systems or reviewing existing levels. Historical methods are not suitable due to the changing service provision and dependency of patients. Cycles in the working week should also be considered when establishing staffing levels throughout the week.

The provision of manual handling devices can usually reduce the number of staff members required for moving patients and loads.

In emergency services it may be difficult to have appropriate staff readily available due to the unpredictable nature of the work. However, every effort should be made to obtain appropriate assistance once the extent of the manual handling task required has been determined.

If there is a shortage of staff, suitable strategies to overcome or minimise the problems should urgently be selected and implemented, eg, re-allocation of staff, establishment of staff pools to provide relief when permanent staff are on leave or unavailable. Services should not be extended unless they can be adequately and safely staffed. Requesting staff to work double shifts or overtime should be avoided.

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## 5.0 RISK PREVENTION STRATEGIES IN PLANNING AND DESIGN

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### 5.2.3 *Equipment Design, Purchase and Maintenance*

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#### Design and purchase of equipment

As it is often the manufacturer who designs the equipment, it is important that manufacturers and suppliers have a clear understanding of the buyer's requirements, including occupational health and safety considerations. Such market forces combined with the potential liability of manufacturers and suppliers should encourage the increasing availability of equipment that meets the specific needs of the task, or process, and satisfies occupational health and safety requirements.

When designing or ordering equipment, factors such as what the equipment is to be used for, the mechanics of its operation, any special features required, the degree of human involvement in the process, who will be using it, where it will be used/installed, who will maintain it and any storage requirements should be considered.

A specification document reflecting this should be completed for all major equipment purchased, and be developed by a team including representatives of those using the equipment, occupational health and safety practitioners, and other specialists, eg, engineers, mechanics, ergonomists, cleaners and maintenance staff, infection control specialists, manual handling practitioners, waste disposal staff, occupational therapists and physiotherapists.

Compatibility issues associated with both the working environment and other equipment need to be considered.

Data sheets should be obtained from suppliers, and demonstrations by the supplier or trialing of the equipment in the proposed work area should be considered to ensure it satisfies requirements. The same team should also coordinate the evaluation of equipment purchased.

At all times NSW Health purchasing procedures should be followed, as outlined in the NSW Health Purchasing and Supply Manual.

Training requirements should be considered during the purchasing process, and appropriately timed training arranged for users.

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## 5.0 RISK PREVENTION STRATEGIES IN PLANNING AND DESIGN

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### ii Manual handling devices

A range of equipment is available to assist with manual handling and transport of equipment/goods.

These include trolleys, tugs, loading devices, conveyors, rollers and cranes, and patient/client manual handling devices. Further examples are listed in Section 11. When purchasing such devices, reference should be made to the Australian Standards and NOHSC and WorkCover NSW recommendations where available.

Analysis should be made of the various tasks the device will be required to perform to determine the best quality product to meet those requirements. Involvement of those who will be using the item should be sought prior to the purchase of devices.

### iii Patient/client handling devices

Patient/client handling devices may include hoists, slide boards, slide sheets, straps and belts, turntables and other aids to assist with patient/client independence. Further examples are listed in Section 11.

Hoists should have a height adjustability range, which enables a patient to be lifted from the floor, and also raised to the highest surface. The choice of slings to accompany a hoist is also of utmost importance. Slings should be comfortable for the patient; easy to apply and uncomplicated.

Every facility should have access to a hoist capable of lifting obese patients and furniture capable of safely holding them, eg, wheelchair, chair, commode and bed. Hospital beds generally have a capacity of 200kgs and hoists of around 180kgs. Items of furniture with greater capacity are available from suppliers and hoists with a maximum capacity of 350kgs are also available.

### iv Maintenance

Maintenance requirements should be considered when purchasing equipment. The ability of an item to be repaired and maintained on site is important as well as the ability to provide maintenance in accordance with manufacturers' instructions.

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## 5.0 RISK PREVENTION STRATEGIES IN PLANNING AND DESIGN

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### 5.2.4 *Transport Systems*

Particular attention should be paid to design when purchasing vehicles required to transport both equipment, goods and patients. Equally, consideration should be made to portability when purchasing equipment that requires regular transport. Fleet managers as well as users should be involved in the development of criteria for purchasing of vehicles that will be used to transport patients or equipment.

Specific criteria addressing manual handling issues should be developed based on risk assessment and consultation with drivers and users. The interaction of the equipment with the vehicle should be considered. Examples include ambulances, service vans, delivery trucks and community health vehicles. Access at the Health Service, the patients' homes, and public places such as schools and halls needs to be considered.

The size of equipment and height of loading docks should allow easy access into and out of vehicles, vans or user premises. The bulk, awkwardness and manoeuvrability of the load, and the use of lifting platforms or hoists to load or unload, may need consideration.

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## 6.0 RISK IDENTIFICATION AND ASSESSMENT

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**6.1 Policy** Each Health Service policy and program shall include the identification of manual handling tasks likely to be a risk to health and safety, and assessment of the manual handling risks associated with these tasks.

**6.2 Guidelines** Management of manual handling risks is an ongoing process which should aim at continuous improvement. Managers and supervisors are generally responsible for ensuring that manual handling risks in their work area are identified, assessed and controlled. In order to do this effectively, managers and supervisors will need appropriate training and access to specialist advice. The first stage is to identify or find as many manual handling risks as you can. Prioritise them to decide which ones to start with. The task should then be closely analysed (assessed) so that control measures can be developed and implemented.

*6.2.1 Risk Identification* This can be done in three ways:

- i Examining hazard, incident reports and audit reports;
- ii Consulting the workers doing the job;
- iii Observing the work being done.

It is important to actually define the task accurately. For example, you could consider picking up the dirty linen as the task or you could break it down into several tasks, eg, taking linen bags out of linen trolleys, pushing large trolley to loading dock etc.

This list should be placed in a register which should include an action plan. (See Attachment 1). Risks should be added from time-to-time as identified either by hazard or incident reports or raised by staff members. Once an initial list has been collated the risks need to be prioritised in order to determine a starting point.

- i Examine hazard and incident reports

Specific things to use when prioritising include the type and severity (cost) of each injury; part of the body injured; the occupation of the injured person; the number of staff exposed; the likelihood of injury to patients; the frequency with which the task is carried out; the number of times the injury has occurred in that work area.

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## 6.0 RISK IDENTIFICATION AND ASSESSMENT

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ii Consultation

A quick and easy method of risk identification using consultation is to ask every worker in the area to write down three tasks which they find physically difficult or which they regard as hazardous. These can then be combined and ranked resulting in a list already prioritised for assessment. (Attachment 2)

iii Observe the task/s

Observation is best done by a small group consisting of a manager or supervisor, one or more employees involved in performing the task, and, if needed, an expert in the area of assessment.

Checklists, worksheets, photographs and videos of the task may assist in the risk identification process.

6.2.2 *Methods of  
Prioritising Risks*

Prioritising is best done after the risks have been identified. It can also be done after the assessment of the tasks. However, because the assessment process can be quite lengthy and can involve groups of people, it is more efficient to do the assessment once you have decided to do something about the risk and are also developing controls at the same time with the same group. The following methods are some ways this can be done:

i Giving the risk a score which is a combination of the likelihood of it happening and the damage if it does happen, eg, the Hazpak method (Attachment 3). The likelihood considers the number of staff involved in the task, and the frequency with which the task is done. This scoring method has the advantage of not needing to re-score the risks as more are added to the list.

ii Ranking the risks in order in relation to others on the list. The disadvantage of this method is that the order needs to be changed when other risks are added.

iii Prioritising after the assessment is done means that priority could be determined by the number of risk factors identified.

Additional information on the risk identification process is contained in the various publications listed in Section 11.0.

6.2.3 *Risk  
Assessment of a  
Task*

In health care there are two different types of risk assessments, that is, a risk assessment of a task and a risk assessment of a patient. When the loads being handled are people, the load is not constant or predictable and needs a different type of risk assessment.

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## 6.0 RISK IDENTIFICATION AND ASSESSMENT

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The risk assessment process determines the various risk factors which are present in the task and their relative contribution. It involves analysing information about the task to determine the level and nature of risk involved, and to gain an indication of the direction control measures may take. As a general rule, a number of specific risk factors contribute to the overall risk. Eliminating or modifying specific risk factors will reduce the overall risk associated with the task.

Generally, as supervisors are responsible for the conduct of work under their areas of supervision, they should therefore be responsible for ensuring that the risk assessment process is conducted in consultation with those performing the work, including those working on night shifts and weekends. Supervisors should be trained in the risk assessment process. In some instances, expert assistance for example, manual handling practitioners, may be required.

Risk assessment requires a systematic observation and analysis of the components of the task as it is being performed. A checklist appears at Attachment 4.

Risk assessment is best carried out once the decision has been made to do something to control the risks and the consultation to develop control measures can be done at the same time.

### 6.2.4 *Risk Assessment and Patient Handling*

A significant issue in the health industry is the handling of people. Patients are complex loads which vary in size and dependency and may be unpredictable or unco-operative. In addition, there will be variations in the tasks, equipment used and work environment during their handling. In this situation a patient handling assessment and plan is considered a risk assessment.

On admission, staff should assess the capabilities and limitations of the patient and determine a strategy including equipment needs for every handling task, eg, moving in the bed, moving out of the bed, ambulating, showering, transferring to theatres, etc. This plan should be done in consultation with those doing the work. Preferably nurses should determine methods to be used for nursing activities and document the results in the patient care plan. This assessment should be placed where everyone can read it including wardsmen and other non nursing handlers. Ideally it could be placed in front of the chart kept at the foot of the bed.

The patient-handling plan will require regular review, especially if the patient's condition changes rapidly eg, after surgery. The plan should state the equipment to be used and the number of staff required and any special considerations to be made.

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## 6.0 RISK IDENTIFICATION AND ASSESSMENT

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A different plan may be developed by rehabilitation staff and should only be used for therapeutic purposes. Different methods may be used by rehabilitation staff when attempting to restore a patient's independence. These methods often involve an element of risk and may require advanced skills.

### 6.2.5 *A Systematic Approach*

A systematic approach to assessment should be carried out using a standardised format. The majority of assessments may be completed by the supervisor or a local team who understands the work area and tasks. Complicated assessments may require more technical or expert advice.

Where the risk assessment takes place in the patient's home, as in community health, it should be done by community health staff who will be visiting the premises and providing the required service.

Procedures should incorporate safe manual handling procedures rather than having a separate safe operating procedure. Additional information on the risk assessment process is contained in the various publications listed in Section 12.0.

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## 7.0 RISK CONTROL

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**7.1 Policy** Each Health Service policy and program shall include the implementation of control measures to reduce the risk and include the provision of fit for purpose manual handling equipment or devices.

**7.2 Guidelines** Where the risks of individual manual handling tasks have been identified and assessed, specific risk control measures need to be developed and introduced as part of any overall risk control program.

*7.2.1 Developing Risk Control Measures*

The development of control measures is more efficiently carried out at the same time as the risk assessment process while the same groups of people are together. This process may involve further consultation with other employees who carry out the task as well as other in-house experts, eg, occupational health and safety practitioners, occupational therapists, physiotherapists, manual handling practitioners, engineers.

External advice may be required and may include other hospitals, share registers and consultants such as ergonomists or safety or design engineers. General and industry specific manual handling publications may provide relevant information, as may suppliers of materials handling equipment.

Options should be considered in terms of short, medium and long term solutions and the level of risk if it is not possible to implement the most desirable solutions immediately. A combination of controls will often be most effective. High risk tasks should be actioned immediately.

A common assumption is that men are more resistant to manual handling injuries than women are. Wardsmen have been employed specifically to lift and handle patients in hospitals. However manual handling injury rates in the health industry are similar for male and female employees but the incidence of major back injuries are considerably higher for males (12.1 per 1,000 workers) than for females (9.8 per 1,000 workers). (Industry Profile: Health, WorkCover NSW, 1995).

This serves as a reminder that equipment rather than men should be used for heavy manual handling tasks.

*7.2.2. Hierarchy of Controls*

When developing and evaluating risk control measures the hierarchy of controls should be followed. The hierarchy of control ranks strategies from the most effective to the least effective. Not all types of strategies will be practicable and more than one type of strategy may be needed to achieve the most effective result.

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## 7.0 RISK CONTROL

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- i Eliminate the manual handling task.

This is the most effective way of controlling risks associated with manual handling and should be the first option when developing control measures. The task should be reviewed in terms of why it is being done and why it is done so often. Elimination could consist of reducing the number of times a linen bag is handled for example, or attaching a monkey ring to the bed so the patients can move themselves around the bed.

- ii Eliminate or reduce the risk by modifying the work environment; supplying fit for purpose equipment and furniture; or modifying the object.

This includes the following:

- Modifying the lighting, flooring, space
- Changing the layout of furniture
- Improving housekeeping, clutter and tripping hazards
- Improving storage arrangements
- Changing work heights
- Modifying the load, eg, attaching handles, or decreasing its weight
- Providing an effective maintenance program
- Developing purchasing criteria for equipment

- iii Reduce the risk by modifying the work process and procedures.

Provision of adequate staff in peak periods, providing adequate rest breaks and recovery times, allowing job or task rotation and changing workflow may all reduce the manual handling risk factors.

Community health, or ambulance staff in an emergency situation may contact their immediate supervisor to request assistance or call upon the assistance of others at the treatment site, eg, relatives of the patient, or police or fire brigade staff at an accident scene.

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## 7.0 RISK CONTROL

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- iv Reduce the risk by providing mechanical aids.

The use of mechanical equipment and other manual handling devices is a most effective method of reducing risk of injury. Examples may include the use of patient hoists, or use of a trolley to reduce carrying.

- v Reduce the risk through provision of appropriate clothing and footwear.

Where specific uniforms are compulsory they should allow for unrestricted posture and movement. Examples include such items of clothing as action-back shirts, pleated trousers, pleated skirts and dresses, and culottes. A range of clothing options should be made available to staff to allow for personal preferences, modesty and special circumstances such as pregnancy.

Approximately twenty per cent of manual handling injuries are caused by slips and falls. Staff should be advised about suitable footwear which is slip resistant. Overshoes or boots should be provided where staff are required to work in wet areas, eg, showers, cold storage areas, laundries, roadsides, hydrotherapy pools. (See *WorkCover Guidance Note on Preventing Slips, Trips and Falls*).

Where gloves are provided, they should be a good fit as loose gloves can prevent a secure grip on the load. Further information can be obtained from Australian Standards, 2161 - Industrial Safety Gloves and Mittens, 4011 – Examination Gloves for Medical and Dental Use, 4179 - Single Use (Sterile) Rubber Surgical Gloves.

Provision of suitable personal protective equipment such as dust coats/overalls for handling dirty or dusty loads can help to reduce manual handling risk factors by ensuring the load is carried close to the body.

- vi Training

Training, while essential, should not be used as a sole control option. Training is the least effective option, as it does not control the actual hazard. Training should be specific to the tasks being performed and is useful if lack of skill or experience are risk factors or if new equipment is purchased.

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## 7.0 RISK CONTROL

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However, once control measures have been decided, their implementation should always include training of staff in the revised operating procedures. Further training considerations are discussed in Section 7.

### 7.2.3 *Preventive Maintenance Program*

All equipment including all wheeled equipment should be regularly inspected by competent persons and maintained in good working order.

Equipment should also be serviced according to the manufacturer's recommendations. A record detailing date of inspections, maintenance procedures undertaken and relevant comments regarding the use of the equipment should be kept in each work area for future reference.

Faulty equipment should be promptly removed from service, tagged and reported to whoever is responsible for instigating appropriate follow-up action.

Maintenance and repair services should be prompt and effective to maintain the confidence of staff in the equipment, and to prevent injury. Where lifting equipment is to be out of commission for any significant length of time, alternate arrangements should be in place. These may include arrangements for equipment loans by the supplier, or the availability of extra staff during this time.

Equipment on loan to patients also needs regular maintenance inspections. When the patient's own equipment is to be used, a contract needs to be made with the patient as to who will be responsible for servicing it.

### 7.2.4 *Provision of External Services*

The principles within this document equally apply to the delivery of services outside the hospital setting, eg, community health, ambulance and outreach services, where control of identified manual handling risks is also required.

However, there are special considerations when developing control options for workplaces over which the employer has little or no control, eg, patients' homes or, in the case of the Ambulance Service, places such as accident sites, doctors' surgeries and nursing homes. It should be noted that in these circumstances, although the employer may not be responsible for the working environment they are still responsible for ensuring a safe system of work.

In such situations control options include negotiating with the person/s in control of the workplace, or the patient (or their guardian) in their place of residence to modify the tasks and/or environment.

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## 7.0 RISK CONTROL

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Negotiations may include:

- Provision of equipment to do the task safely, eg, equipment loans;
- Provision of sufficient staff if team lifting is required;
- Attendance by the patient at a clinic;
- Maintenance of patient's equipment;
- Modification of the work area, eg, home alterations to reduce the risks associated with bathing/showering patients;
- Modification of the task to reduce the risks, eg, sponging a patient in bed instead of bathing.

In non-emergency situations, suspension of services or of high risk tasks may be considered until risks are appropriately controlled through negotiation, investigation of the options and task/environment modification.

Where difficulties are experienced, the use of an independent third party may be of assistance in the assessment and negotiation process.

### 7.2.5 *Action Plans for Implementing Control Measures*

Many tasks or systems of work will require a combination of control measures to reduce risk factors. An example may include re-arranging the workplace layout, providing manual handling equipment and training staff in its use and in the associated procedural changes.

Once control measures for the workplace have been determined, the next step is to implement these controls. A plan for implementing the control measures for each task or system should be developed. The plan should detail the control/solution, the activity required for the solution, the person responsible and estimated timeframe.

The responsibility for developing and implementing controls will depend on the type of control/solution required. This will often relate to the financial commitment and technical input required, and the time involved in introducing controls. These matters should be detailed in the control plan.

Additional information on the implementation of risk controls is contained in the various publications listed in Section 11.0

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## 7.0 RISK CONTROL

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### 7.2.6 *Evaluating Controls*

Any risk control measure which is implemented should be evaluated to ensure that it has reduced the risk. Evaluation methods include:

- Using the same checklist to assess the task again;
- Asking the employees about the acceptability of the new method and if it made a difference to the task. Particular attention should be paid to useability, productivity and patient satisfaction;
- Review injury/incident statistics.

On occasions, expert evaluations are required, especially if a control measure is expensive in time and money or if it has never been tried before.

Sometimes the first attempt at risk control fails. Instead of giving up, go through the consultation process again. Find out why it wasn't effective and make further improvements.

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## 8.0 TRAINING

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**8.1 Policy** Each Health Service shall ensure that all new staff undertake mandatory induction training: that all managers, supervisors and staff undertake ongoing training and are assessed on the manual handling skills required of their position.

**8.2 Guidelines** Manual handling training is as important as any other clinical or skills training. Manual handling is an important feature of patient and staff safety. Training is also a requirement of the Manual Handling Regulation and is an essential element in its implementation. The objectives of the overall manual handling training program should be to:

- i Prevent manual handling injuries from occurring by educating managers, supervisors and employees in risk identification, assessment and control principles and skills;
- ii Assist employees to understand the complex nature of manual handling and risk factors involved;
- iii Teach safe manual handling techniques and equipment use.

All training should be competency based and reference should be made to the following three documents when planning and designing training:

- Core Training Elements for the National Standard for Manual Handling, National Occupational Health and Safety Commission;
- National Guidelines for Integrating Occupational Health and Safety Competencies into National Industry Competency Standards [NOHSC: 7025 (1994)], National Occupational Health and Safety Commission 1994;
- Manual Handling Competencies for Nurses, NSW Nurses' Association 1998.

All employees will require manual handling training relevant to their responsibilities. Training should occur from the top down, that is, start with the training of managers and OHS committee members. This is essential to ensure that managers have knowledge of their responsibilities, roles, and the identification, assessment and control process in order to understand and adequately deal with manual handling issues raised by staff, and effectively implement the local manual handling policy and program in their areas of control.

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## 8.0 TRAINING

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The facility should ensure that all contractual arrangements with temporary staff, eg, contractors, agencies, volunteers' organisations, training institutions, include arrangements for manual handling training consistent with the requirements of the job.

The facility should consider the needs of part-time and casual staff, shift workers, and workers with disabilities when scheduling training. Training should also raise the awareness of supervisors to the issues of special groups in relation to manual handling.

### 8.2.1 *When to Train*

Appropriate training should be provided:

- i As part of induction before the employee commences duties, or at least within the first two weeks of employment;
- ii As part of an ongoing manual handling training and refresher program;
- iii At the time of procedural or equipment changes;
- iv Where manual handling performance evaluation indicates a need for further training.

### 8.2.2 *Core Training Elements*

The core training elements listed below are based on the training outcomes set-out in Core Training Elements for the National Standard for Manual Handling.

When designing manual handling training the following topics should be included for all groups:

- i Legislation, responsibilities and, policy and guidance material relating to manual handling;
- ii Health and safety effects of manual handling including anatomy, physiology, biomechanics, risk factors, principles of safe lifting and manual handling associated with occupational over-use syndrome;
- iii The identification, assessment and control of manual handling risks including risk factors, use of checklists, conducting assessments, the hierarchy of controls, risk reduction strategies, equipment, the role of individuals in the risk management process, and implementation of the local Health Service policy and program.

Training programs for managers, supervisors, and members of OHS Committees and OHS Representatives.

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## 8.0 TRAINING

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The following topics should be included in detail for training those individuals involved in the implementation of manual handling legislation and policy in Health Services:

- i Procedures for the identification of jobs, tasks, and systems likely to be of a risk and how to prioritise these for assessment. This includes tasks where there is a risk of development of occupational over-use syndrome;
- ii How to prepare for, undertake and record risk assessments relating to manual handling and occupational over-use syndrome;
- iii How to develop control options in consultation with employees, implement and evaluate control options for risks relating to manual handling and occupational over-use syndrome;
- iv Communication methods for manual handling risk management, including effective consultation, provision of information and training, and addressing the communication needs of special groups;
- v Designing a risk management program for manual handling and occupational overuse syndrome including:
  - Systems for identification, assessment and control of manual handling risks;
  - Procedures for prioritising and assessing manual handling risks and development, and implementation of control measures;
  - Development of procedures for record keeping;
  - Identification of training needs;
  - Development of performance indicators.

### 8.2.3 *Specific Task Training*

Specific task training needs to be carried out in addition to the core training described above. Specific task training should be developed in order to train employees in the safe operating procedures relevant to the tasks they carry out. This includes such skills as: the manual handling of people, keyboard work and pushing trolleys.

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## 8.0 TRAINING

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Similar training should also be provided to the supervisors of staff. It should be noted that training does not replace the need for appropriate supervision, staffing, equipment provision and monitoring of work practices and procedures for compliance. New and inexperienced employees may need additional supervision until full competence is achieved. Consider implementing a 'buddy' system for new or inexperienced employees.

Basic task training should incorporate all safety steps such as in safe operating procedures rather than being an add-on. There should be a practical component where techniques are practiced in the actual work situation or simulated. The training should be task specific and should aim to ensure that the employee:

- i Understands the manual handling risks associated with the job and the reasons for doing the job by the safest method;
- ii Can recognise the risks and decide on the best way of going ahead with the task;
- iii Understands the principles for safe manual handling;
- iv Demonstrates the ability to use manual handling aids correctly;
- v For the employee involved in the handling of people, understands the risks associated with handling of people and demonstrates how to choose the appropriate equipment or technique, or how to follow the care plan;
- vi Knows how to report any problems associated with manual handling.

### 8.2.4 *Principles for Safe Manual Handling*

Eliminating manual handling or reducing the number of times the load is handled, should be the first consideration in planning manual handling activities. The use of mechanical and other aids should be emphasised and recognised as the next option. There is a wide variety of environmental and task related factors, and mechanical aids cannot always be used. Rarely there is no choice but to manually handle the load.

Safe manual handling principles should be explained so that employees can adapt to a variety of situations. No specific weight can be identified as being safe to lift.

The principles for safe manual handling are outlined in the following process:

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## 8.0 TRAINING

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- i Plan the lift by assessing the situation: level of independence of the patient, weight of the object, pathway to follow, working environment, need for other employees or manual handling devices, and decide what is needed;
- ii Use mechanical aids for lifting and moving objects or people, where possible and appropriate;
- iii Manual lifting of the patient or load should be considered only when equipment is not available. Decide the best technique to complete the task by determining how the move will be best managed (maintain good balance, lift smoothly, bend the knees, avoid unnecessary twisting, bending, reaching etc), ensure there is enough space to allow for correct positions, postures and body movements, and ensure that there are no obstructions when moving objects;
- iv Take a secure grip (use the whole hand, not fingers only) since the ability to grip securely helps determine how safe the task will be;
- v Pull the load close to the body by holding it as close to the body as possible (a 10kg load that is carried 80cm away from the body places the same force on the spine as 50kg carried close to the body). It is important that the lift is achieved slowly and without jerking;
- vi Alternate heavy and light work to reduce fatigue and allow muscles to recover;
- vii Team lifting should not be considered an alternative to mechanical equipment. There are considerable risks involved in team lifting and if no other alternative is available then it should be co-ordinated with a standard count method.

### 8.2.5 *People as Loads*

Patients require a specific type of risk assessment.

Training of staff involved in moving patients should include:

- i How to assess the level of risk associated with individual patients;
- ii Incorporating patient/client specific aspects in the process;
- iii Principles of patient/client assessment, which addresses such issues as weight and medical condition, level of dependence, mental or emotional state and level of co-operation;

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## 8.0 TRAINING

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- iv Planning which methods and which equipment to use with each required transfer and including the involvement of the patient where possible;
- v The various handling, re-positioning, rolling and transferring methods that are available;
- vi Skills training in the use of available patient moving aids;
- vii Skills in deciding which method of handling is appropriate to the current circumstances and when re-assessment is required.

### 8.2.6 *Assessment*

An assessment of manual handling skills should be carried out in the following situations:

- After training
- On the job
- After a long absence
- After an accident or incident

### 8.2.7 *Training of NESB Employees*

Consideration should be given to non-English speaking staff when determining training techniques. Special emphasis or attention may be needed to ensure that the desirable skills transfer takes place. To assist these workers to obtain information consider the following:

- i The advantage of running workplace English language and literacy programs, including OHS aspects in these programs;
- ii Improving provision of and access to general OHS information in the workplace;
- iii Using simple, appropriate signs with graphics in the workplace;
- iv Providing, and informing staff of access to interpreter services;
- v Providing translated information;
- vi Assessing the language and literacy needs of participants prior to training.

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## 8.0 TRAINING

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### 8.2.8 *Training Records and Review of Training Programs*

Training records should be maintained for all staff who have attended manual handling training. Records of attendance, participation and successful completion of training should be also maintained on staff members' personnel records.

All training programs should be regularly reviewed and evaluated for ongoing relevance and effectiveness and linked to the program performance indicators. Employees and their representatives should be consulted as part of the evaluation process.

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## 9.0 DOCUMENTATION

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**9.1 Policy** Each Health Service shall ensure that suitable documentation is kept.

**9.2 Guidelines** Records associated with the implementation of the Manual Handling Regulation, should be maintained in a central location. Where appropriate, records should also be kept in local work areas for ready availability to employees on all shifts and their occupational health and safety representatives.

This information is also useful for future reference. Documentation is also evidence that the Health Service is working towards complying with the Manual Handling Regulation.

The following information should be recorded and retained:

- i Local policy and program;
- ii Those who were involved in identifying, assessing and controlling the manual handling risks;
- iii Risk identification and assessment reports and control plans, including patient assessment plans;
- iv Purchasing records related to manual handling including equipment trials and purchase;
- v Design modifications to, and specifications for, buildings, fixtures and fittings, plant and work processes;
- vi Risk control measures implemented and when, and action plans for the future;
- vii Procedure documentation;
- viii Hazard and incident reports including consultation and action taken;
- ix Evaluation results of manual handling injury prevention programs;
- x Training and education activities including attendance records;
- xi Minutes of staff and other meetings where manual handling issues are discussed;
- xii Managers' reports including manual handling program implementation in their areas.

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## 10.0 EVALUATION

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### 10.1 Policy

Each Health Service shall regularly monitor its manual handling policy and program for operational effectiveness.

### 10.2 Guidelines

#### 10.2.1 Monitoring

Monitoring of the manual handling prevention program should be an integral part of the program itself. In particular, newly introduced manual handling prevention activities should be closely monitored to ensure that they are successfully implemented and effective.

The CEO, senior executives and OHS committees should monitor the manual handling program. This will require the development of manual handling performance indicators as a basis for review and evaluation.

#### 10.2.2 Evaluation

It is important that evaluation plans or protocols be developed in the planning stage of any program, and not left until the end as an add on. This enables the collection of baseline data against which to measure performance. For evaluation to be meaningful, the aims and objectives of the Health Service's program should be clearly articulated, and both process and outcome performance measures or indicators developed.

Such indicators should be in significant program areas, relevant to key outcomes and limited to a number that can be regularly reviewed without undue strain on resources.

Consideration should be given to what is being measured, what data needs to be collected, or what can be measured from information collected. Any risk management program should ultimately have impact on categories such as sprains and strains, slips and falls, over exertion injuries and back injuries. Also consider direct and indirect costs of injuries, eg, replacement staff, administration of claims and rehabilitation of injured staff.

Factors other than prevention activities may impact on outcomes. For example, factors such as changes in services provided by the Health Service, or the contracting out of other services, eg, hotel services may all decrease the number of injury claims.

While Health Services should formally review and evaluate their programs annually, evaluation should be an ongoing process aimed at continual improvement. Individual components may need more frequent assessment, such as specific training programs, and the various steps of any implementation plan.

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## 10.0 EVALUATION

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### 10.2.3 Performance Indicators

The following are examples of what may be considered by Health Services when developing local manual handling performance indicators:

i Implementation indicators

These may include progress in the development and implementation of key areas of the manual handling injury prevention program; determining that the various steps in the identification, assessment and control process have been established and documented; determining the number of tasks identified and assessed, or documented control plans; the number of controls evaluated; checking that actions to rectify hazards have been implemented; determining whether ergonomic considerations were included in specifications for new or refurbished areas.

ii Training indicators

These may include numbers of general and specific training courses conducted and the percentage of managers and employees who have attended appropriate training; the percentage of new staff trained within two weeks of commencement; proportion of staff undergoing annual refresher training and an increase in staff able to demonstrate a level of competency in all aspects of manual handling risk management.

iii Indicators of commitment by senior staff

These may include the establishment of manual handling management committees or recruitment of a manual handling coordinator; the number of tasks identified, assessed and controlled; the inclusion of manual handling accountabilities in performance agreements; the number of position descriptions including occupational health and safety responsibilities; the number of senior staff attending appropriate manual handling training; and the allocation of resources to the manual handling program.

iv Use of manual handling aids

These may include number of staff who have attended training in their use; or staff surveys regarding the suitability and the use of manual handling equipment.

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## 10.0 EVALUATION

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v Staff consultation indicators

These may include numbers of staff consulted or involved in the various identification, assessment and control processes, the frequency that manual handling issues are discussed at staff meetings; and the overall views of employees including managers and supervisors regarding the risk control program. The latter information may be gathered through informal discussion, questionnaires and focus groups.

vi Outcomes or results indicators

As the ultimate goal of the activities being measured in the above points is the reduction of manual handling injuries, it is important that indicators are determined which will reflect this. Such indicators may include the reduction of incidence of reported accidents related to manual handling; the reduction of severity of injuries related to manual handling; numbers of manual handling claims, costs associated with manual handling claims, and average time away from work. The latter can be used as an indicator of severity of injury, and/or effectiveness of rehabilitation.

The size and/or number of staff of the Health Service will affect the outcomes indicators used. For example, small Health Services should not restrict themselves to number of manual handling related injury claims, or direct costs of these claims, as the size of the sample may not be statistically valid, or may be easily distorted by a single large claim.

At the Area Health level, two or three key result areas and related performance indicators should also be developed so that Area performance may be monitored and reviewed at the Area executive level.

10.2.4 *NSW Health  
System  
Performance*

In order for the Department to effectively review manual handling performance of both the NSW Health system in general and individual Area Health Services, aggregated, consistent information must be available.

The current standard benchmarking mechanisms are the Occupational Health, Safety and Rehabilitation Audit Profile, and workers compensation based statistics such as incidence of body stressing claims (number of claims per 100 employees) and body stressing claims cost (cost per employee). This workers compensation information is provided by the Treasury Managed Fund.

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## 10.0 EVALUATION

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The Manual Handling Audit Profile has been reviewed and incorporated into the revised Audit Profile which commenced use in July 2001.

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## 11.0 ISSUES IN PATIENT HANDLING

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### 11.1 Risks Associated with Patient Handling

Injuries can occur to anyone handling patients and can affect any area of the body. However, in the research literature, nurses are the main subjects and low back pain the main area of the body studied with patient handling. The literature shows that the main patient handling tasks associated with low back pain in nurses are:

- Manually moving patients in bed;
- Manually transferring patients between bed and chair;
- Manually lifting patients from the floor;
- Sustained postures such as stooping, eg, when taking observations or when supporting limbs in theatre.

### 11.2 Patient Risk Assessment

Handling people requires a specific type of risk assessment. Unlike inanimate objects, patients vary considerably and there are many different ways they need to be moved. An assessment needs to be done for each type of manual handling task (eg, moving up the bed, toileting, bed to chair).

A patient handling assessment should be carried out on admission and at regular intervals determined by the condition of the patient. For example, a surgical patient will change rapidly and require daily assessment whereas a rehabilitation patient may change quite slowly.

A patient handling assessment should include bed mobility, moving in and out of beds, to and from chairs, moving to and from toilets and commode chairs and walking the patient.

### 11.3 Risk Control Strategies

Initially the complete workflow should be examined with a view to eliminating manual handling or reducing the number of times patients are handled. This requires a systems approach and it may involve modifying traditional approaches, and may require the involvement of other work units.

Using the hierarchy of risk controls in patient handling also means that to eliminate or reduce manual handling, the patient should, as the first option, be encouraged to move themselves. This may require such appliances as self-help poles, electric beds, rope ladders and walking appliances.

For patients who require assistance, the following aids are available and should be used when carrying out planned and routine activities:

- Devices such as slides sheets and pat slides for any bed moving activities;
- Hoists or walk belts or similar devices for bed to chair

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## 11.0 ISSUES IN PATIENT HANDLING

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transfers;

- Hoists should always be used for any total body lifting including lifting patients from the floor.

Patient handling activities are often carried out in uncontrolled work environments and sometimes under emergency conditions. This may be in patients' homes, in the community or on the roadside. Ambulance officers are provided with other devices such as the scoop stretcher, carry sheet and mega lift, which can be used with team lifting if a hoist is not available.

Tasks which require awkward postures and may have cumulative effects should be assessed with the usual risk assessment procedures.

### 11.4 High Risk Techniques

The following lifting practices should not be used by employees:

- i Total body lifting should be avoided except in emergency situations. This includes the use of team lifting as there is no guarantee of eliminating or reducing the risk of manual handling injury;
- ii Dragging patients up the bed by holding them under their arms;
- iii The orthodox or cradle lift;
- iv Manually lifting patients from the floor or ground;
- v Top and tail lift.

All of these techniques can be eliminated by the use of currently available, fit for purpose equipment.

*NB: It is advisable that wards or units caring for babies and young children develop their own criteria for acceptable types of patient handling practices.*

The pivot transfer is also a moderately risky procedure especially if the patient has only one functioning leg, .eg, a stroke patient or an amputee. This type of transfer should be carried out using a hoist with suitable sling, except during rehabilitation procedures, when staff with special skills are available.

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## 11.0 ISSUES IN PATIENT HANDLING

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Research has indicated that when comparing traditional bed mobility techniques the draw sheet lift has a very low risk of back injury, less risk than the shoulder lift. However both of these techniques may present risks of injury to the upper limb especially in unskilled handlers. For this reason and the fact that they are team lifts, means that the use of these procedures in controlled situations should be reduced or eliminated. It is not possible to eliminate these techniques in uncontrolled environments or emergency situations.

### 11.5 Patient Cooperation and Carers' Rights

Where practical, the patient and their relatives should be informed on admission or the commencement of the service that mechanical appliances and other manual handling aids will be used to handle the patient for their own as well as staff safety. This information can be included in a brochure, including the rights and obligations of patients.

The type of lift to be used (whether manual or mechanical) should be explained to the patient. Where patients are being treated in the home, the patient and carer should understand their obligations in complying with the handling plan. A contract with the patient should be made at the initial (risk) assessment.

Patients or their relatives are sometimes initially unco-operative with the use of patient handling equipment. The Lamp, Dec/Jan 99 explores this issue.

In summary, while patients have rights they also have responsibilities. Every member of the community has the common law duty not to place others at risk by what they do or what they fail to do.

A health care worker has a professional responsibility towards the patient but it does not extend to putting themselves at risk of injury or death while carrying out these activities.

Another important consideration is the risk of injury to the patient during manual lifting, transferring and re-positioning when manual handling equipment and aids are not used.

To overcome ambiguity, organisations should have an explicit policy which is promoted to staff and patients. This can be in the form of a brochure. This policy should include:

A statement of the facility's commitment to the health and safety of everyone:

- A statement that the use of equipment may be necessary in the course of providing treatment and care;
- That staff must follow certain handling procedures which may include lifting equipment;

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## 11.0 ISSUES IN PATIENT HANDLING

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- That this equipment is used for both staff and patient safety;
- Procedures for staff to follow should the patient refuse to cooperate.

Good communication with patients and explanations of any equipment to be used should overcome any fear or resistance to use of appliances.

### 11.6 Pregnancy and Manual Handling

There are no recognised load limits specifically for pregnant workers. NIOSH (National Institute of Occupational Safety and Health, USA) (1977) in their *Guidelines on Pregnancy and Work* suggest that if a "woman can handle a load easily when not pregnant, chances are she will not be unduly stressed when pregnant. However if the load is lifted in front of the body the load may be more difficult in the last trimester due to the protruding abdomen. There is also an increased physiological load on the woman in the latter stages of pregnancy and for this reason loads should be decreased 20-25% during late pregnancy".

Some countries have adopted laws which entitle pregnant women to be re-assigned for at least part of their pregnancy if their health and ability does not match the task demands.

The Ambulance Service of NSW has specific requirements for pregnant officers. Ambulance officers must consult their doctor as soon as they are aware of their pregnancy. A job description is given to the doctor listing tasks, frequency, distance moved, type of load, weights of loads and postures required. Officers are encouraged to submit monthly certificates certifying their fitness to continue their normal duties.

The Service will attempt to find alternative similar employment for pregnant ambulance officers who, because of illness or risk, cannot carry out their normal duties. This alternative work is provided up until the commencement of maternity leave (9 weeks prior to the birth). Only employees who can demonstrate their ability to satisfactorily perform their normal duties can continue to work past the nine week period.

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## 12.0 APPENDICES

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### 12.1 Additional References And Resources

#### **Australian Nursing Federation (SA Branch)**

**(08) 8363 1948** - [www.sa.anf.org.au](http://www.sa.anf.org.au)

📖 Safer Manual Handling Policy, 1997

📖 No Lifting No Injury: Implementing a No Lift Policy in the Workplace

#### **Australian Nursing Federation (Victorian Branch)**

**(03) 9275.9333** - [www.vicnet.net.au/~anf/b](http://www.vicnet.net.au/~anf/b)

📖 No Lifting Implementation Guide and Checklist, 1998

#### **Auburn Health Promotion Unit Western Sydney Area Health Service**

**(02) 9646 2355** - [www.westmead.nsw.gov.au](http://www.westmead.nsw.gov.au)

📖 OHS in the Multilingual Workplace, Suzanne Baker

#### **Health and Research Employees Association**

**(02) 9264 4999** - [www.hrea.asn.au](http://www.hrea.asn.au)

#### **Independent Living Centre, 600 Victoria Road, Ryde NSW**

**(02) 9808 2233** - [www.ilcnsw.asn.au](http://www.ilcnsw.asn.au)

📖 Choosing a Mobile Hoist for the Home Situation (Guidelines)

#### **National Occupational Health and Safety Commission**

📖 Health Industry Back Pain Prevention Package

📖 Core Training Elements for the National Standard for Manual Handling (June 1995)

📖 National Guidelines for Integrating Occupational Health and Safety Competencies into National Industry Competency Standards, November 1998

📖 Research Report: Development of Ergonomic Guidelines for Manually-Handled Trolleys in the Health Industry, July 1994

📖 National Code of Practice for Prevention of Occupational Overuse Syndrome

#### **NSW Nurses' Association 1300 367 962 - [www.nswnurses.asn.au](http://www.nswnurses.asn.au)**

📖 Manual Handling Guide for Nurses, 1998

📖 Manual Handling Competencies for Nurses, 1998

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#### **NSW Treasury Managed Fund**

**(02) 9228 1109** - [www.gio.com.au](http://www.gio.com.au)

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## 12.0 APPENDICES

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### **Occupational Health & Safety Authority, Department of Business and Employment, Melbourne, Victoria**

**(03) 9628 8111 - [www.workcover.vic.gov.au](http://www.workcover.vic.gov.au)**

- 📖 Manual Handling in the Health Industry, Patient Care, Identification and Solutions, 1988
- 📖 Manual Handling in the Health Industry, Support Services, Identification and Solutions 1988
- 📖 healthSHARE Solutions Register
- 📖 Designing Workplaces for Safer Handling of Patients/Residents, December 1999
- 📖 Code of Practice for Manual Handling, April 2000

### **Standards Australia**

**(02) 8206 6009 – [www.standards.com.au](http://www.standards.com.au)**

- 📖 AS 2569 - Guide to the Lifting and Moving of Patients
- 📖 AS 2569.1 – 1982: Safe Manual Lifting and Moving of Patients
- 📖 AS 2569.2 – 1987: Selection and Use of Mechanical Aids for Patient Lifting and Moving
- 📖 AS 4034 - 1992: Motor Vehicle - Cargo Barriers for Occupant Protection
- 📖 AS HB10 - 1987: Occupational Overuse Syndrome - Preventative Guidelines
- 📖 AS 1680 - (Series): Interior Lighting
- 📖 AS 2161 - 1978: Industrial Safety Gloves and Mittens
- 📖 AS 4011 - 1992: Examination Gloves for Medical and Dental Use
- 📖 AS 4179 - 1994: Single Use (Sterile) Rubber Surgical Gloves
- 📖 AS 3590.2 - 1990: Workstation Furniture
- 📖 AS 1892 - (series): Portable Ladders
- 📖 AS 1657 - 1992: Fixed Platforms, Walkways, Stairways and Ladders - Design, Construction and Installation
- 📖 AS/NZ 4586:1999 Floor Surfaces

### **WorkCover NSW**

**13 1050 - [www.workcover.gov.nsw.au](http://www.workcover.gov.nsw.au)**

- 📖 OHS Manual Handling Training Course
- 📖 Manual Handling Resources: Guide to available information
- 📖 Manual Handling Legislative Requirements
- 📖 BackPak - a Guide to Manual Handling Regulations
- 📖 Six Steps to Occupational Health and Safety - Duty of Care in Occupational Health and Safety
- 📖
- 📖 National Standard and Code of Practice for Manual Handling 1990.
- 📖 Manual Handling Kit (includes all of the above plus three posters and stickers)
- 📖 What Managers Can Do: OHS and the Multicultural Workforce
- 📖 Manual Handling Injuries and Occupational Overuse Syndrome – Workers Compensation Statistics NSW
- 📖 BackWatch Collections

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## 12.0 APPENDICES

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- 📖 BackWatch Industry Profile: Health
- 📖 National Code of Practice for Prevention of Occupational Overuse Syndrome
- 📖 Lifting and Moving People: Choosing the Right Equipment, Publication Number 752
- 📖 Checklist for the Selection of Hospital Beds
- 📖 Checklist for the Selection of Patient Hoists
- 📖 Preventing Slips, Trips and Falls - Guidance Note Number 743
- 📖 Due Diligence at Work: A Checklist for Action on Workplace Health and Safety for Company Directors and Managers

### 12.1.1 *Other Resources*

- 📖 Abstracts: Manual Handling for Health and Aged Care, BackWatch Conference, September 1998
- 📖 Guide to the Handling of Patients; 4th Edition. National Back Pain Association, UK, 1998
- 📖 Kate Tuohy-Main's videos plus workbook developed under WorkCover Grants Scheme; available from Training Health and Educational Media Pty Ltd, (03) 54417673
- 📖 Proceedings: Ergonomics Society of Australia: "Coming to Grips with People", NSW Branch Conference, 1998
- 📖 [www.workcover.intime-online.net](http://www.workcover.intime-online.net) database of various manual handling appliances (non-nursing)

## 12.0 APPENDICES

### 12.2 List of Patient/Client Moving Aids

This list of equipment and possible uses is not exhaustive and does not include wheelchairs/ commodes/beds/trolleys.

EQUIPMENT	RANGE OF USES
<b>Hoists</b> <ul style="list-style-type: none"> <li>⊗ Overhead</li> <li>⊗ Electric</li> <li>⊗ Hydraulic</li> <li>⊗ General, stand-up, process</li> <li>⊗ Folding</li> <li>⊗ Car</li> </ul>	Moving in bed Moving in and out of wheelchairs Assisting patient to stand Bathing and dressing Toileting Into and out of the car
<b>Slideboards</b> <ul style="list-style-type: none"> <li>• Full size (PAT)</li> <li>• Wheelchair transfer board</li> <li>• Turntable disc</li> </ul>	Moving in bed Moving bed to trolley Moving in and out of car Moving in and out of wheelchair
<b>Slidesheets</b> <ul style="list-style-type: none"> <li>• Slidesheet</li> <li>• Roller tubes</li> <li>• Chair slider</li> <li>• Drawsheets</li> </ul>	Moving in bed Moving bed to trolley Moving back in chair or wheelchair Moving onto and off operating tables
<b>Stretchers</b> <ul style="list-style-type: none"> <li>• Scoop stretcher</li> <li>• Spine board</li> <li>• Mega lift</li> <li>• Jordan frame</li> <li>• Carry sheet</li> </ul>	Lifting people from the ground Carrying people Transferring patients between two different heights & two locations. Onto and off ambulance stretcher
<b>Straps and Belts</b> <ul style="list-style-type: none"> <li>• Buckle belts</li> <li>• Velcro belts</li> <li>• Carry seat</li> </ul>	Assisting patient in and out of chair or toilet Provides handles for holding patient during standing and walking Bed mobility
<b>Patient independence</b> <ul style="list-style-type: none"> <li>• Triangle</li> <li>• Bed rope or ladder</li> <li>• Walking frames</li> <li>• Grab rails</li> </ul>	Assist patient to move themselves in bed, toilet and standing

## 12.0 APPENDICES

### Non-Mechanical Aids Summary of Preferred Choices - Weight Bearing Patient

Transfer type	Buckle Belt	Velcro Belt	ME Sling	PAT slide	Slide sheet
Chair to bed	***	***	*		
Toiletting/commode	***	***	*		
Repositioning in bed	**	**	**		***
Helping up from floor	***				
Bed to trolley				***	*

- \*\*\* Best available choice  
 \*\* Can be done but involves some risk  
 \* Can be done but requires advanced skills

### Non-Mechanical Aids Summary of Preferred Choices - Non-Weight Bearing Patient

Work environments where hoists are not available.

Transfer type	Hoist	Buckle Belt	ME Sling	PAT slide	Slide sheet
Chair to bed	***	* 2 belts			
Toiletting/commode	***	* 2 belts			
Repositioning in bed		**	**		***
Helping up from the floor	***				
Bed to trolley				***	*

- \*\*\* Best available choice  
 \*\* Can be done but involves some risk  
 \* Can be done but requires advanced skills

Reproduced with permission from *Lifting and Moving People: Choosing the Right Equipment*, WorkCover NSW.

## 12.0 APPENDICES

### 12.3 List of General Aids

This list is not exhaustive. For more information visit the [WorkCover website](#).

EQUIPMENT	USE
<b>Trolleys</b> Fixed and mobile wheel combinations Flat bed Adjustable height Hand trucks Tub trolleys	Moving loads
<b>Tugs</b> Electric for moving beds/trolleys Sit on	Moving trolleys, beds, carts
<b>Loading Devices</b> Tailgate loaders Cargo drawers Vehicle cranes Hydraulic loading docks Hydraulic wheelchair loaders Mobile conveyors Forklifts	Loading vans, trucks and patient transport vehicles
<b>Conveyors and Rollers</b> Electric Roller	Foodlines Stores
<b>Other</b> Cleaning equipment mobile buckets	

## SAMPLE MANUAL HANDLING REGISTER

DATE	IDENTIFIED BY	DESCRIPTION	PRIORITY	TARGET DATE	BY WHO	ACTION TAKEN	COMPLETED (if not, why)
12/12/96	Carmel K	Pushing the hoist on carpet	3	30/1/97	ADON	new wheels purchased	

## SAMPLE RISK PRIORITISING METHOD

### PRIORITISING

This method combines risk identification, consultation and prioritising.

Ask workers this question: Write down the three tasks which you find the most physically demanding, or place you in awkward or fixed postures?. Collate the results and rank. eg:

Task	Rank Order
Dress/undress resident	1
Transfer resident to/from beanbag/mat	2
Transfer resident between chair & commode	3
Lift residents in/out spa	4
Transfer resident between bed & chair	5
Transfer resident between tub/change table	6
Reposition resident in tub/chair	7
Shower/bath resident	8
Change incontinence pads	9
Transfer resident to/from school bus/van	10
Change bed with resident in it	11
Feed resident	12
Make beds	13
Handle linen bags	14

### The HAZPAK METHOD OF RISK SCORING

After having identified all your risks or hazards, get together with your staff to prioritise.

#### HOW LIKELY IS IT TO HAPPEN?

HOW SEVERELY COULD IT HURT SOMEONE?  HOW ILL COULD IT MAKE SOMEONE?	<b>Very likely</b> Could happen any time	<b>Likely</b> Could happen sometime	<b>Unlikely</b> Could happen but very rarely	<b>Very unlikely</b> Could happen, but probably never will
<b>Kill or cause permanent disability or ill health</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>Long term illness or serious injury</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Medical attention and several days off work</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>First aid needed</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>

*Hazpak* is a WorkCover Publication



11. Is it difficult or unsafe to get adequate grip?  
*fractures, pain, delicate skin, wet skin, attached to equipment*

**E. Work Environment**

12. Is the task performed in a confined space?  
*patient's home, bathroom, hallway access,*
13. Is the lighting inadequate?
14. Is the climate hot or cold?
15. Are the work surfaces cluttered, uneven, slippery or otherwise unsafe?  
*obstacles electrical cords, rugs, ridges, carpeted making wheeling difficult*

**F. Individual Factors**

16. Is the employee new to the work or returning from extended absence?
17. Are there age related factors, disabilities, *pregnancy* factors?
18. Does the employees clothing, or *lack of waterproof clothing, footwear* or personal protective equipment interfere with manual handling performance?

**G. Equipment**

19. Is equipment:  
*Incompatible with furniture or other equipment?*   
*Unsuitable for the task it is being used for?*   
*Inefficient and slow to use?*   
*Poor quality?*   
*Difficult to use or understand how to use*   
*Poorly maintained?*

**H. Work Organisation**

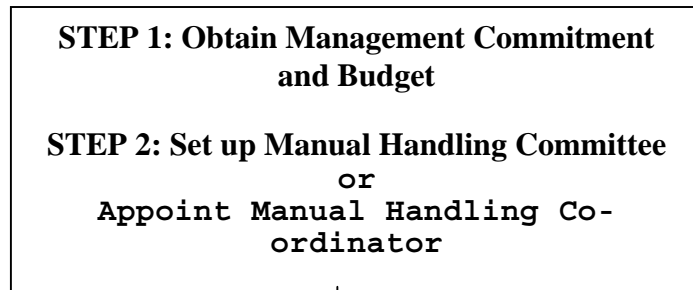
20. *Are there bottlenecks, deadlines or peak activities?*
21. *Is the work affected by insufficient staff numbers to complete tasks within deadline?*
22. *Are there inefficiencies in systems of work and or double handling?*

**I. Outcomes of consultation for risk control options**

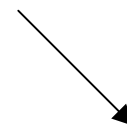
**J. Intervention details and action plan**

(Include date to be implemented and whose responsibility as in the manual handling register)

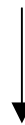
IMPLEMENTATION FLOW CHARTS  
1. PLANNING STAGE



Allocate responsibilities for program implementation  
Examine injury/incidents to patients and staff  
Undertake system audit (Audit Profile)  
Develop generic manual handling policy



Workers, contractors  
Management  
Supervisors  
Patients



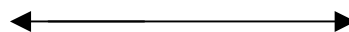
Determine – training needs  
Develop – training plan, materials  
Select trainers or book consultant



Publicise to staff

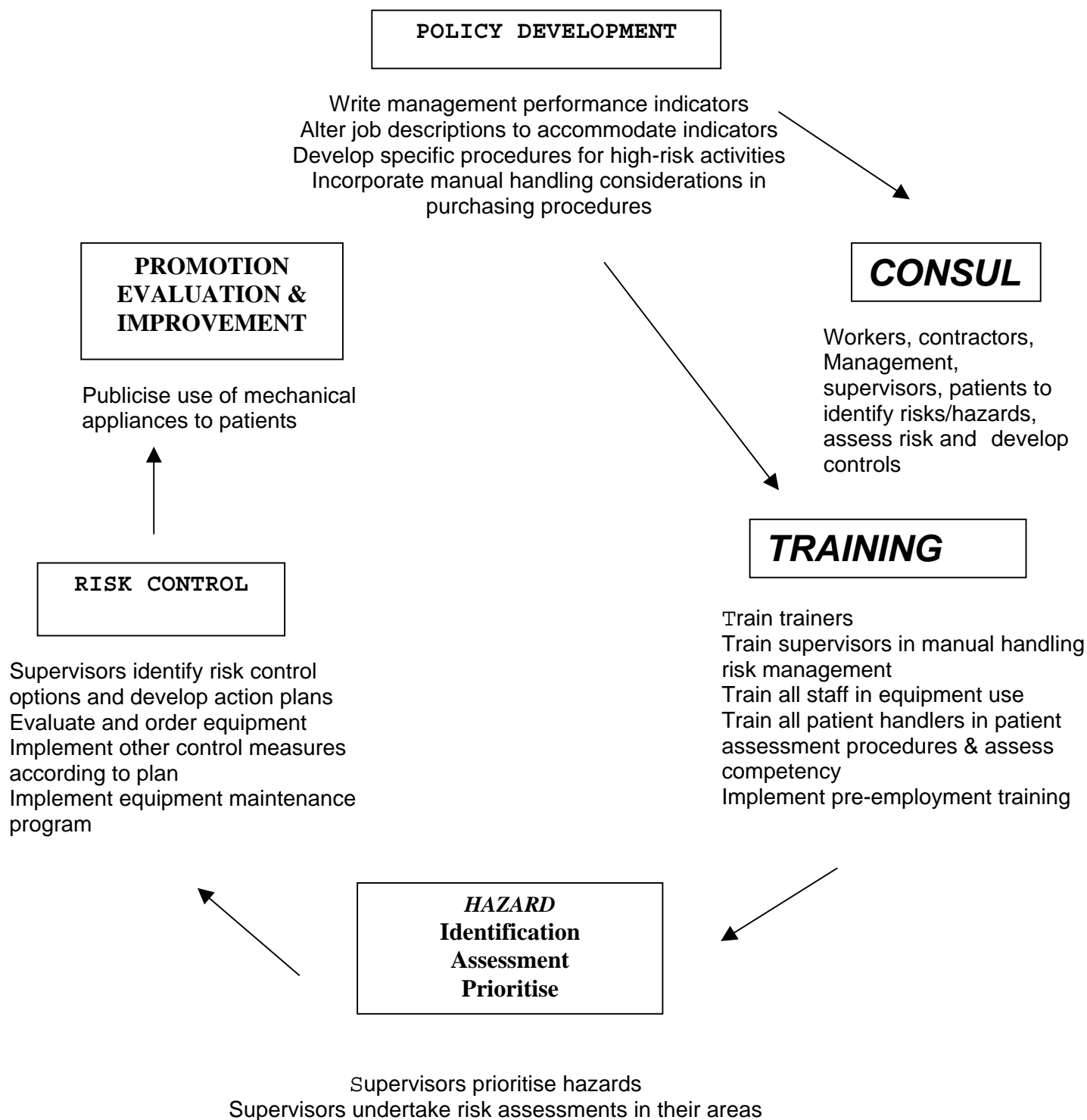


Develop assessment tools for patients, tasks and environment  
Use results of system audit to identify high risk wards/units and starting points



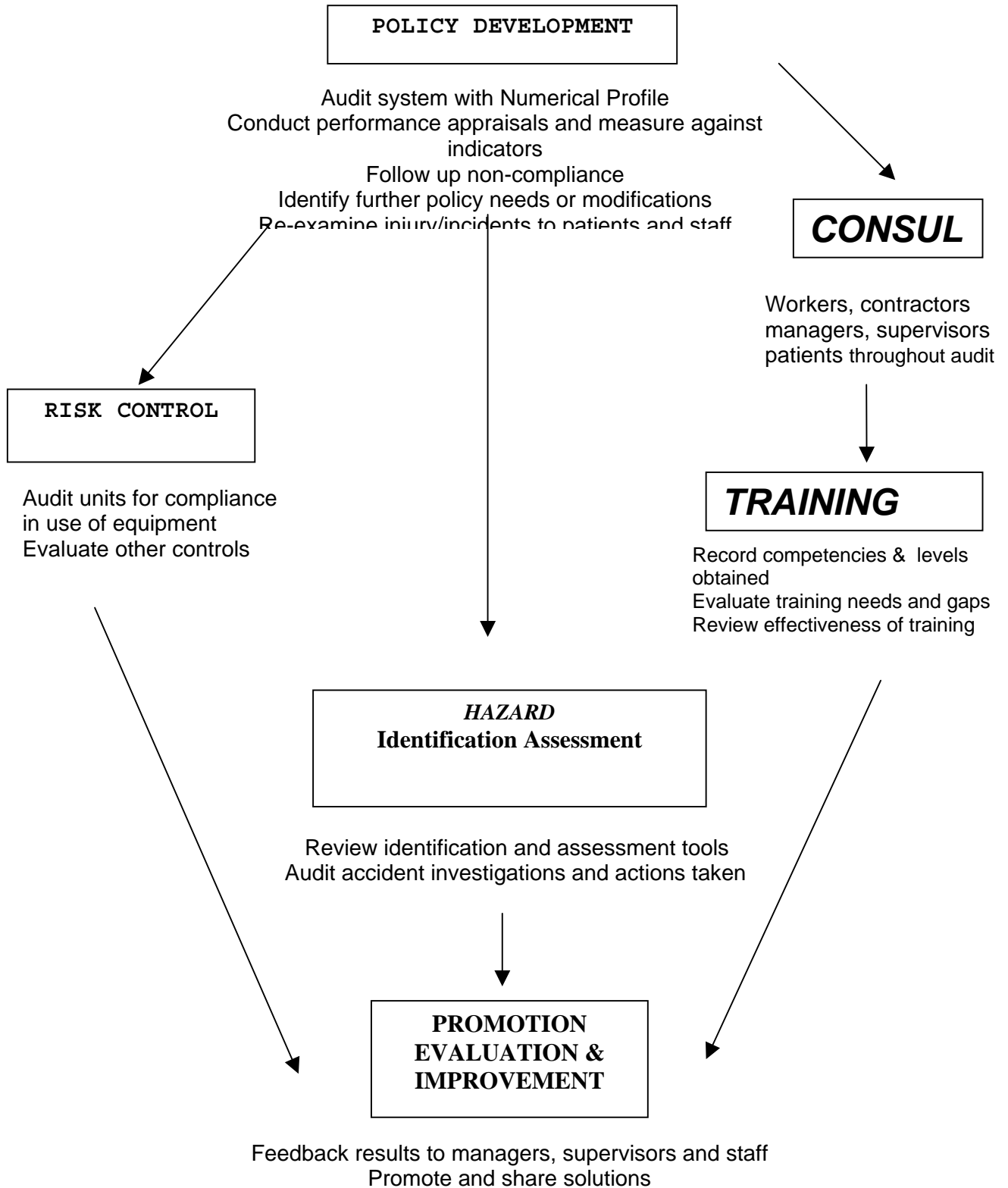
# MANUAL HANDLING PROGRAM

## 2. IMPLEMENTATION STAGE



# MANUAL HANDLING PROGRAM

## 3. EVALUATION STAGE



# Workplace Health and Safety Model

