working well initiative

Changing practice – improving health:

an integrated back injury prevention programme for nursing and care homes

A partnership project with the Royal College of Nursing, BackCare, Arjo Limited and three partner nursing homes

Royal College of Nursing

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Acknowledgements

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Contents

Introduction

This publication is a result of a project undertaken as part of the Department of Health's (England) *Back in Work* campaign 1999.

Previous projects about back injury prevention have focused mainly on moving and handling patients. The purpose of this project was to pilot and test a series of integrated interventions over a 10-month period in three nursing homes. The objective of these interventions was to reduce back injuries in staff working in nursing or care homes. Interventions were based on change management around three core concepts relating to preventing injury, identifying causes of musculo-skeletal ill health, and promoting good staff health and healthy backs.

The problem of back pain

Fifty million working days are lost each year as a result of back pain, and back pain costs over £5 billion per year in sickness absence costs (Clinical Standards Advisory Group, 1995). In a study for the Royal College of Nursing (RCN), the Institute of Employment Studies (IES) found that over 30% of nurses suffer work-related back pain each year (IES 1996, IES 1999).

In an RCN case (BBC News Online 2000), a nurse was awarded over £800,000 for a back injury sustained at work. It is not prudent to ignore this problem. Not only are the costs too high, both employees and employers have a legal responsibility under the Manual Handling Operations Regulations (1998) to manage and prevent back injury risk.

Meeting a legal standard

The Management of Health and Safety at Work Regulations (1999, 2000) and the Approved Code of Practice requires employers to undertake a risk assessment to determine the likely risk to health of any hazard in the workplace. More detailed requirements and guidance in the Manual Handling Operations Regulations (1998) complement other health and safety legislation. They require an employer to:

- assess the risk of back injury at work
- reduce the risk to the lowest level reasonably practicable
- provide training for staff on safe and healthy practice
- supervise staff to ensure compliance with the regulations.

Staff must comply with the arrangements that managers have made to protect staff health and safety. If managers or staff fail to meet the requirements of these regulations, the Health and Safety Executive (HSE) may issue an improvement notice. This requires an employer to take remedial action within a set timescale. Alternatively, HSE could issue a prohibition notice, which may result in closing down the nursing home until the required changes have been made. Breach of these regulations may result in a criminal conviction leading to a fine or prison sentence.

RCN guidance

The RCN publishes good practice guidance on professional nursing issues, and health and safety. RCN publications, and others used by the pilot project nursing homes, are listed as references in each section of the document.

The aims of this publication

The idea behind this publication is that it should act as a checklist for action. It should be used by managers to improve staff health and well-being as well as resident care.

The document is structured around the classic change management process of assess, plan, implement and evaluate. The central theme of staff health and resident care is the basic philosophy driving the whole process. To have healthy staff you must have excellence in resident care – and to provide good resident care, staff must

protect the health of staff and keep them well motivated.

This guidance is based upon interventions we used and found helpful while running the pilot project. Each section is titled according to the stage in the process and the intervention that was used. Each section is designed to stand alone. Together the guidance provides an integrated set of interventions that will lead to a successful back injury prevention programme.

Each section/part of section gives:

- the reasons why the intervention was seen as necessary
- action points, including a checklist or case study, to illustrate what the intervention entailed
- the benefits derived
- the risk factors or barriers which led to not implementing the intervention
- a reference list for each intervention, which provides background reading and more detailed information. You are encouraged to read and use all of these publications.

We hope you will find the guidance helpful in planning change within your workplace, and that you use it to enhance staff health and resident care.

References

BBC News Online (2000) Nurse wins £800,000 for back injury. Tuesday 15 February http://news.bbc.co.uk/hi/english/health/newsid_642000/642381.stm

Clinical Standards Advisory Group, CSAG (1995) *Report of a clinical standards advisory group committee on back pain.* Sudbury: HSE books.

Health and Safety Executive (NI) (2000) *The management of health and safety at work regulations, guidance on regulations.* Sudbury: HSE Books.

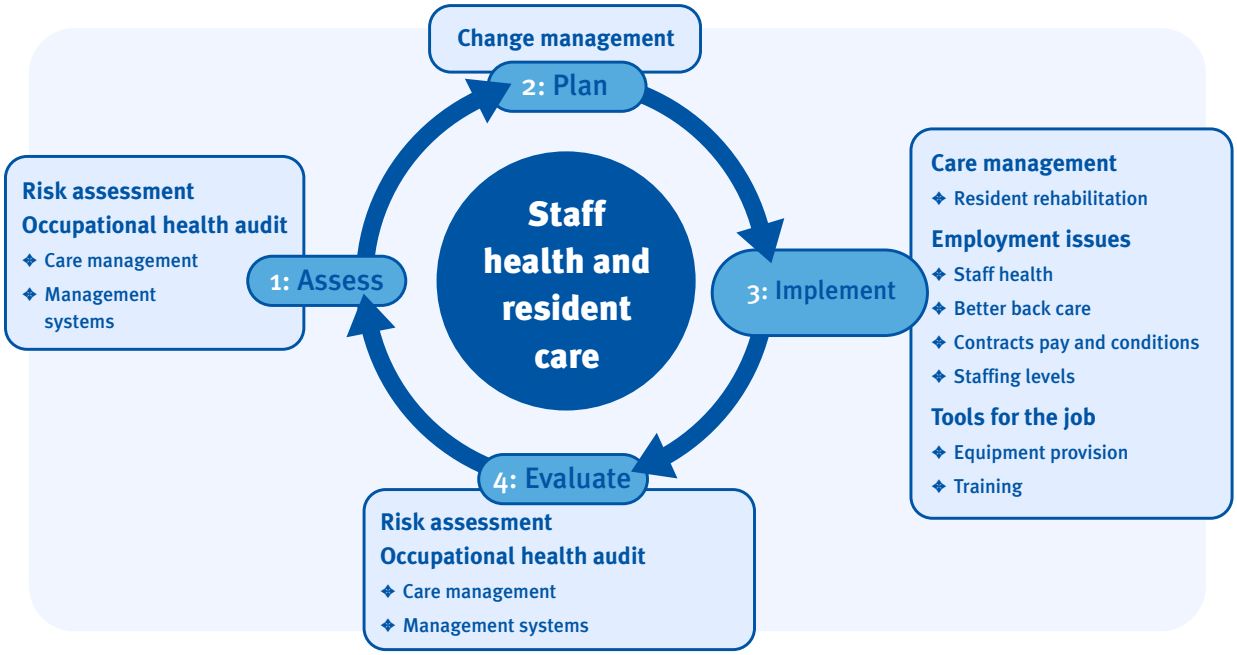
Health and Safety Executive (1999) *The management of health and safety at work regulations, guidance on regulations.* Sudbury: HSE Books.

Health and Safety Executive (1998) *Manual handling operations regulations, guidance on regulations.* Sudbury: HSE Books.

Institute of Employment Studies (IES) (1996) *Manual handling issues for nurses.* Brighton: University of Sussex.

Institute of Employment Studies (IES) (1999) RCN unpublished data from RCN Membership Survey.

Model for a successful integrated back injury prevention programme



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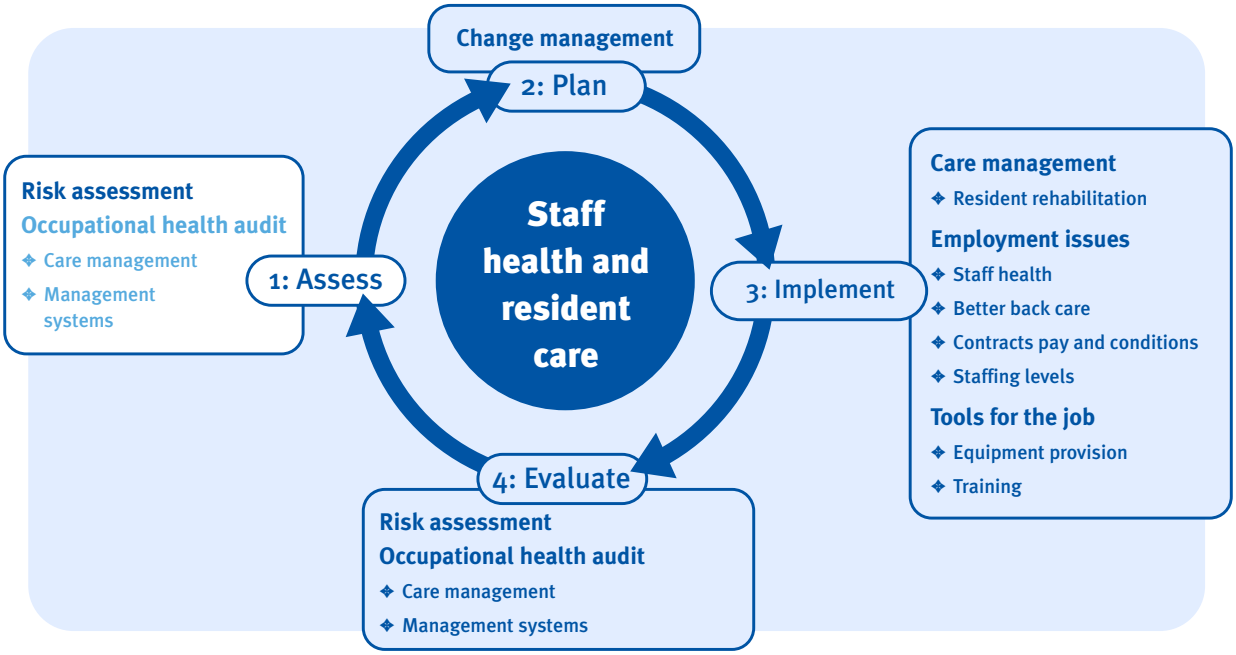
ASSESS – Risk assessment



Purpose of intervention

It is a legal requirement that risks must be identified by completing an appropriate risk assessment (HSE, 1998). The risk assessment process should cover all risks – from individual resident risks to risks arising from management systems.

As part of the risk assessment process, changes and risk reduction measures must be the result of consultation with staff. All changes must be reviewed and monitored by audit for effectiveness.

Actions

Checklist

- Assess problems – use an appropriate risk assessment form
- Plan with staff what needs to be changed and how
- Implement measures and supervise staff activity
- Evaluate, review, then if indicated change practice. Then review again. This is a process of continuous improvement.

Any systems put in place should form part of the health and safety audit checklist for continuous review. Time must be allocated to staff to ensure their participation in the process. Staff must also be trained in the skills needed to identify risks.

Case study

Moving a particularly heavy resident was identified as a risk by staff. Discussion and problem solving with staff led to a consensus that a profiling bed would allow safe transfers. Since no such beds were available, management submitted an application for funding with a copy of the risk assessment.

Staff used problem solving to devise a safer system of work as an interim measure. A date was set for review to follow up the funding application and ensure that the safer system of work was still appropriate.

The interim method of handling was reviewed daily at hand-over and this was documented.

A procedure for the handling of heavy residents was written up and communicated to staff for use with all heavy residents. Review of this procedure was then part of the general health and safety audit.

Benefits of action

- The risk assessment process identifies problems. This should include an occupational health audit of

all management and communication systems, as well as resident-based risk and needs assessment.

- Problem solving techniques such as critical incident analysis are helpful in improving health and safety systems. Discussion with staff and residents will help managers to find better working methods and to analyse adverse incidents when they occur. In this way staff will understand the problems, have ownership of the solutions and be committed to them. Time should be allocated for this process. Training in risk assessment must be provided to ensure that all staff have the skills needed to make adequate and appropriate risk assessments.
- Many key changes do not require direct expenditure – but spending on equipment should be planned for. Any work change affecting resident care should be discussed and negotiated with the residents. Residents must be involved in the change management process. This will also ensure that all creative solutions are considered.
- Resident care will improve as risks decrease.

Barriers to implementation

- Poor health and safety management may result in low staff morale, leaving staff uncommitted and unwilling to contribute to risk management processes.
- When determining staffing levels, resident dependency levels and needs must be analysed. Failing to do so may mean safe systems of work are ignored because of time shortages.
- Lack of training and low staffing levels mean that staff will not have the skills or time to recognise and document risks or solutions.
- Neglecting the views of residents may mean that changes made to systems of work will be unsuccessful.
- Lack of equipment and/or lack of funding may result in the inability to decrease risks effectively.

Further reading

BackCare and Royal College of Nursing (1998) *Guide to the handling of patients.* 4th edition, London: BackCare. Telephone 020 8977 5474.

Health and Safety Executive (1995) *6 Steps to successful risk assessment* (free leaflet). Suffolk: HSE Books.

Health and Safety Executive (1998) *Manual handling in the health services,* 2nd edition. Suffolk: HSE Books.

Royal College of Nursing (2000) *Manual handling risk assessment in the hospital and the community.* London: RCN. To order a copy contact RCN Direct 0845 772 6100, quoting publication code: 000 605.

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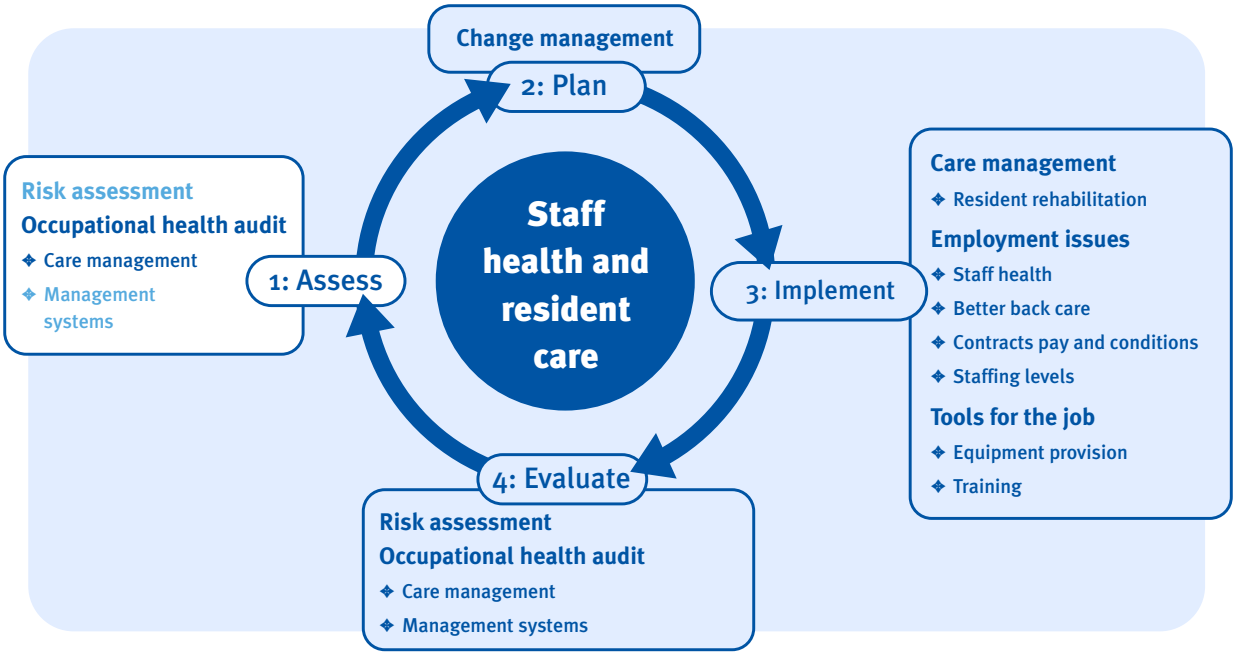
ASSESS – Occupational health audit – care management



Purpose of intervention

Effective organisations require good communication systems. Communicating change ensures the smooth running of an organisation. It is essential for care planning and high standards of resident care. Care must be based upon current best practice standards. Staff must be supported to integrate research evidence into their practice. Publications from the Care Standards Commission (Care Standards Act, 2000) are essential reading. Qualified nurses must see this as an important part of their UKCC re-registration requirements. Changes in practice must be communicated effectively to all staff. Clinical supervision must be in place for all qualified staff.

Actions

Checklist

Care plans

- Should be current and reviewed regularly.
- An identified person should be responsible for writing and changing care plans and allowed time for this.
- Care needs and risk assessments should be seen at a glance.
- In order for information to be communicated regularly, care plans should be used for staff hand-over.
- Review must take place whenever there is any change in resident needs or work environment.

Hand-over

- Should be at the start of each shift.
- Use care plans, do not assume that staff already know residents' needs.
- All staff must have a hand-over.
- This should be seen as essential and not missed.

Staffing levels

- Staffing levels should be linked to dependency levels of residents and staff roles.
- The ratio of qualified to unqualified care staff should reflect resident needs.

- There should be a named nurse/carer responsible for care plan entry.

Communication with other professionals

- GP/physiotherapist/occupational therapist – is the named nurse for the resident available to discuss changes in care?
- Where are details written?
- How are changes communicated? Changes must be clearly identified in the care plans so that information is communicated effectively.

Benefits of action

- Correct documentation and communication ensure that staff are able to identify when a resident's needs, rehabilitation plan, or health status have changed. Good communication systems are essential to ensure effective resident care and to minimise staff health risk.
- Prompt nursing, GP or physiotherapy assessment could be critical in ensuring that a resident needing a different care facility or further rehabilitation is seen as soon as possible. Communicating this effectively will ensure that resident health is maintained, and independence and dignity promoted.
- Involving residents in decisions about their care ensures that they are partners in care and their views are considered. Person-centred assessment is essential and the key is partnership.

Barriers to implementation

- Lack of communication and inadequate information at hand-over may be because residents are in long-term care and assumptions are made about their care needs. A person-centred assessment is essential. Residents must be seen as partners in care.
- Low staff morale and inadequate management systems can result in messages not being communicated. This in turn may lead to delays in implementing new programmes of care. This can increase the risk of detrimental health effects for both staff and residents.
- Low staffing levels and lack of time can result in poor written and verbal communication, leading to deteriorating standards of care.

Further reading

Arjo Limited (2000) *Arjo residents gallery.* Gloucester: Arjo (Ref 18.22.02) (See Appendix 1).

HMSO (2000) Care Standards Act. London: HMSO.

Royal College of Nursing (1998) *Caring for older people: an assessment tool.* London: RCN. To order a copy contact RCN Direct on 0845 772 6100, quoting publication code 000 797, free to members of an RCN older peoples forum (one copy), subsequent copies have a charge.

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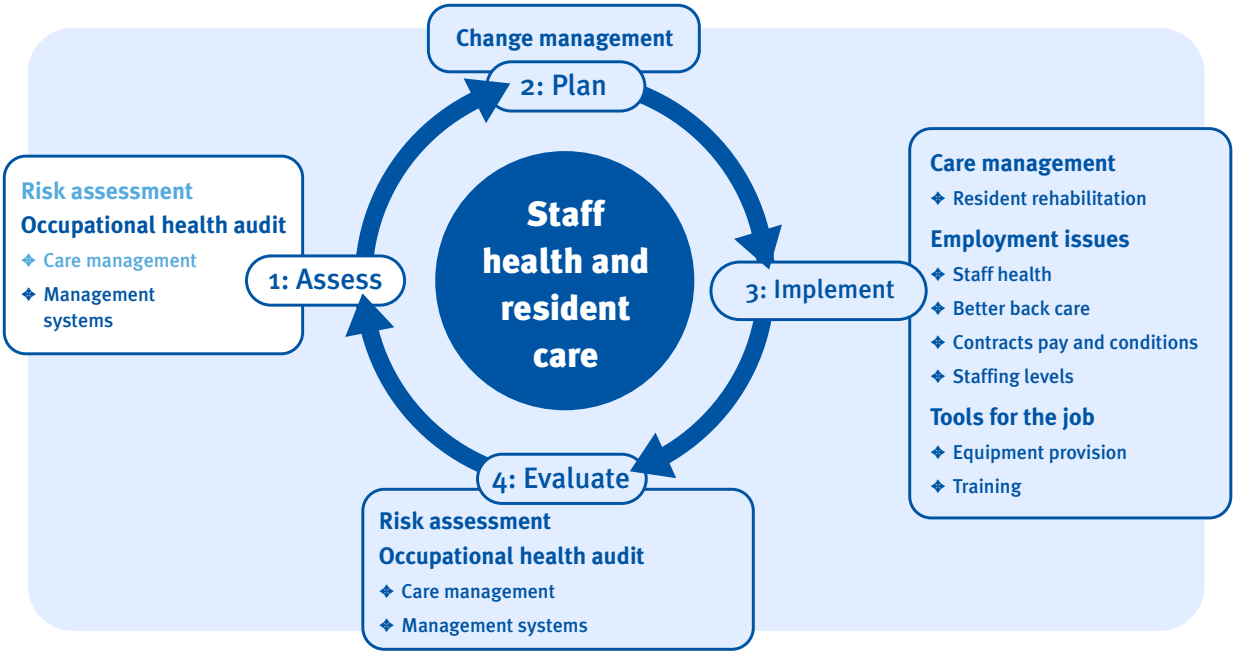
ASSESS – Occupational health audit – management systems



Purpose of intervention

Effective and efficient management systems ensure that health and safety procedures are carried out correctly and monitored. They show management commitment in meeting legal obligations, and provide a safer place of work and a caring environment for staff and residents.

Actions – Checklist

Risk management	Legal requirements	Recommended content
Health and safety policy	● produced and signed by person with H&S responsibility ● available to all staff ● consultation with staff	● statement of intent ● responsibilities ● organisational provision ● monitoring
Manual handling policy	● policy and procedure ● risk assessment – task, individual capabilities, load and environment ● training, supervision	● process for completion ● risk reduction strategies ● training for competence ● safe working systems ● detail of action if failures occur
Organisational systems Accident reporting	● report injuries, diseases and dangerous occurrences (it will soon be a requirement to investigate as well as to report to HSE)	● policy and procedure ● report forms for HSE ● accident investigation ● accident analysis, correction of procedures ● training
Sickness absence	● record, supervise and manage attendance	● analysis, rehabilitation, health surveillance and medical reports
Induction and Training	● training for competence	● content, evaluation and supervision, dates attended

Benefits of action

- All the policies and procedures listed in the checklist must be in place. A simple audit of the systems will show if they are being successfully implemented throughout the organisation, as well as highlighting where the system has the potential to break down.
- Monitoring and audit allows managers to observe any trends in accidents and sickness, which can then be acted upon. Implemented policies and training programmes ensure that staff understand the standard that they are required to achieve. Correct, documented procedures make following good practice possible.
- Implementation of an integrated back injury prevention programme will reduce many of the associated costs, for example, legal cases for back-injured staff and costs associated with high staff turnover and sickness absence.
- The references give examples of some policies mentioned, including accident investigation, sickness absence, and induction training for health and safety. You may wish to adapt them to your own needs.

Barriers to implementation

- Lack of staff time to undertake training to be able to audit effectively.
- Lack of management time to follow up accidents and sickness absence.
- Lack of time to monitor and audit systems and policies.
- Some changes in health and safety practice may not be completely effective in reducing identified risk. This will be apparent at review and remedial action should be taken.
- Staff must be given time to read and implement policies, and monitor and evaluate changes. It is essential to identify those elements of health and safety practice that do not work, and to change them.

Further reading

Health and Safety Commission (1992) *Provision and use of work equipment regulations.* London: HSE Books.

Health and Safety Executive (NI) (2000) *The management of health and safety at work regulations.* Sudbury: HSE Books.

Health and Safety Executive (1999) *The management of health and safety at work regulations.* Sudbury: HSE Books.

Royal College of Nursing (1999) *Occupational health audit.* London: RCN. To order a copy contact RCN Direct 0845 772 6100, quoting publication code 000 815.

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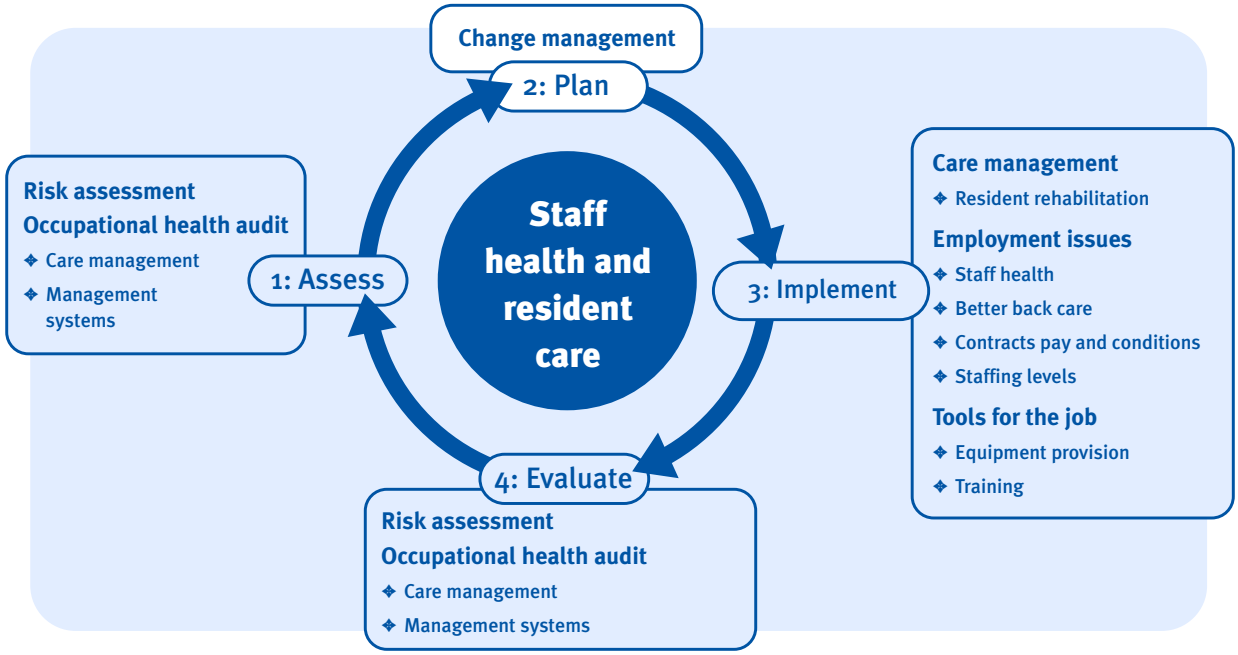
PLAN – Change management



Purpose of intervention

An important part of any intervention is to ensure that the changes will actually happen. Often, health and safety policies and procedures are not fully implemented for a variety of reasons. Staff must be committed to proposed changes for them to be successful. Changes and risk reduction measures should be the result of consultation with staff. All changes must be reviewed and monitored by audit for effectiveness. Managers must show leadership skills in order to motivate staff.

Actions

Checklist

- *Assess* problems with management support
- *Plan* with staff what needs to be changed and how. Get staff commitment, make them aware of any problems and their consequences.
- *Implement* measures and supervise staff activity
- *Review* actions taken.

Case study

In a nursing home the staff hand-over was carried out after residents had been given their breakfast. This meant that staff gave care for several hours without knowing the changes to residents' risk assessments and care plans since their last shift.

The risks associated with this practice were discussed with staff – for example deterioration in resident mobility required a change in equipment to transfer the resident safely. Barriers to change were discussed – such as time pressures associated with getting all residents ready for breakfast, and staff arriving late for their shift. Solutions to the barriers were found – such as delaying breakfast by 15 minutes, and putting management systems in place to monitor staff arrival times.

Staff found that a prompt hand-over allowed them to give better care, and reduced risks to themselves and the residents. This was reviewed by periodic checks on the timing of breakfast, and the timing and attendance of hand-overs.

Benefits of action

- Problem solving techniques, such as critical incident analysis, carried out with staff are helpful in improving health and safety systems, and making staff aware of problems.
- Discussions with staff and residents help managers to find better working methods and analyse adverse incidents when they occur. In this way staff will understand the problems, have ownership of the solutions and be committed to them. Time should be allocated for this process.

Barriers to implementation

- Poor health and safety management, ineffective leadership and the lack of a change management strategy may result in low staff morale. This can leave staff uncommitted and unwilling to contribute to changes. Staff will feel that they are not part of the process, and their views and experiences are not valued.
- Neglecting residents' views may mean that any changes made to work systems will be unsuccessful.
- Lack of time leads to the process being rushed, and staff and resident consultation can be missed out.
- Lack of training will lead to staff being unable to identify risks and suggest appropriate changes.
- Lack of equipment will lead to staff being unable to implement changes involving equipment provision.

Further reading

Health and Safety Executive (1995) *6 steps to successful risk assessment* (free leaflet). Suffolk: HSE Books.

Royal College of Nursing (1998) *Caring for older people: an assessment tool.* London: RCN. To order a copy contact RCN Direct on 0845 772 6100, quoting publication code 000 797, free to members of an RCN older peoples forum (one copy), subsequent copies have a charge.

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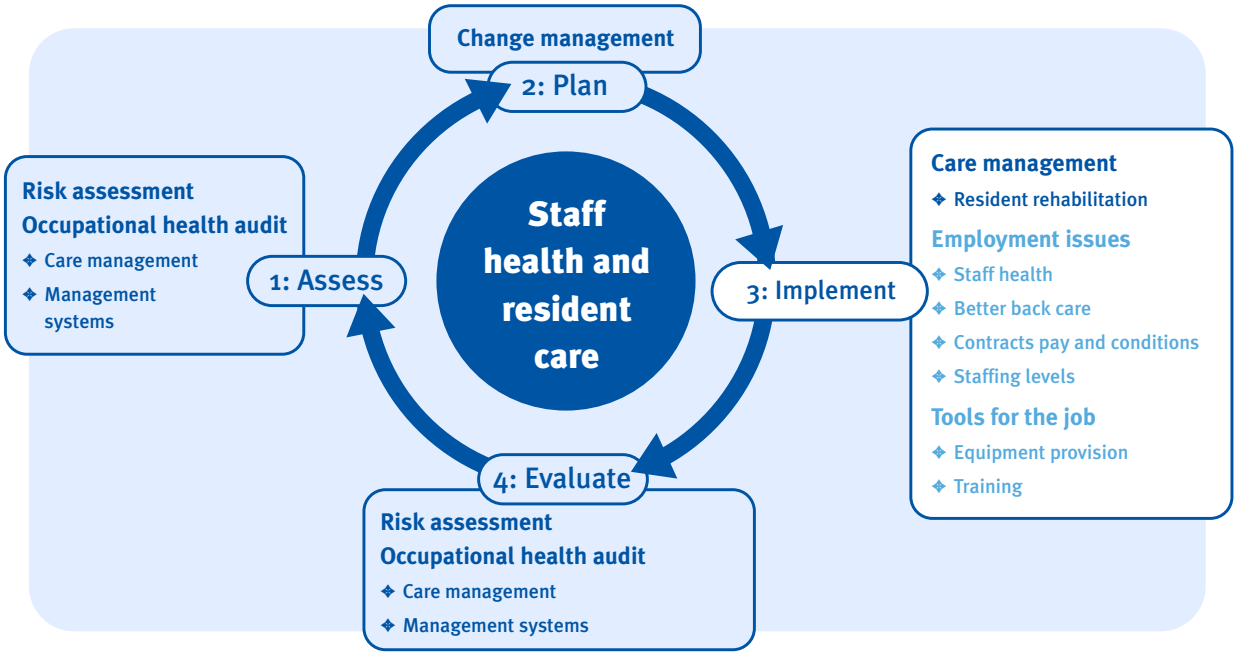
IMPLEMENT – Care management – resident rehabilitation



Purpose of intervention

Resident independence must be promoted. Residents should be involved in care planning and in decisions about their rehabilitation needs.

Good resident rehabilitation strategies depend upon minimising health and safety risks to staff, and supporting staff welfare initiatives. Achieving excellence in care is helped by ensuring that staff well-being is a high priority for employers. If staff become ill as a result of the work they do or the systems under which they work, standards of care for residents will suffer. The more independent the residents are, the less the physical and mental burden on staff.

Actions

Checklist

- Support residents in maintaining mobility and independence.
- Monitor each resident's levels of mobility and state of health. Note changes in mobility and complete a new assessment – then write into the care plan for communication to all staff.
- Liaise with other professionals, and communicate any care plan changes to all involved in the resident's care – including relatives, carers, therapists and the resident.

Case study

A resident was experiencing problems getting to the toilet at night. During the day she was fully independent. There was a problem-solving session with day and night staff and the resident. This led to repositioning the bed in the room to minimise the distance and to avoid the wall which posed an obstacle at night. Communication between night and day staff ensured that the written safe system for helping the resident out of bed was consistent between night and day. This helped the resident to remain independent and the staff to support continence. It also ensured that the bed stayed in the new position, as all staff were aware of the reason for the move.

Benefits of action

- Promoting independence and helping residents to remain active involve recognising that the health and mobility of residents may change over a 24-hour period. Nurses also need a good understanding of changing dependency levels. Effective communication, both written and verbal, ensures that changes to the care plan are carried out by all staff.
- Involving residents in problem solving is essential. If residents are unhappy about change, or staff are unsure about which equipment to use, then staff must carry out a full risk assessment and identify the best choice of equipment for individual resident needs. Staff may need to consult another specialist such as an occupational therapist, who may be able to suggest alternatives.
- The nurse needs good negotiating skills as well as skill and confidence in using the equipment. The nurse must explain the rationale for the health and safety policy to the resident, as well as involve the resident in the decision making and problem solving process.

Barriers to implementation

- Standards of resident care can suffer as a result of failures in communication, poor health and safety management, inadequate staff training and low levels of skill in the selection and use of manual handling equipment.
- A lack of confidence in negotiating the right solution for the resident's needs may mean failure to meet health and safety standards. Health and safety risk assessments must link in to the resident's needs assessment.

Further reading

Arjo Limited (2000) *Arjo residents gallery.* Gloucester: Arjo (Ref 18.22.02) (See Appendix 1).

BackCare & Royal College of Nursing (1998) *Guide to the handling of patients* 4th edition, London: BackCare. £25.00 plus £4.00 p&p from The National Back Pain Association, 16 Elmtree Road, Teddington, Middx. TW11 8ST. Tel: 020 8977 5474, Fax: 020 8943 5318, email: back_pain@compuserve.com

Royal College of Nursing (2000) *Rehabilitation: the role of the nurse.* London: RCN. To order a copy contact RCN Direct 0845 772 6100, quoting publication code 001 233.

Royal College of Nursing (2000) *Workability: Injured, ill and disabled nurses can return to work.* London: RCN. To order a copy contact RCN Direct 0845 772 6100, quoting publication code 001 159.

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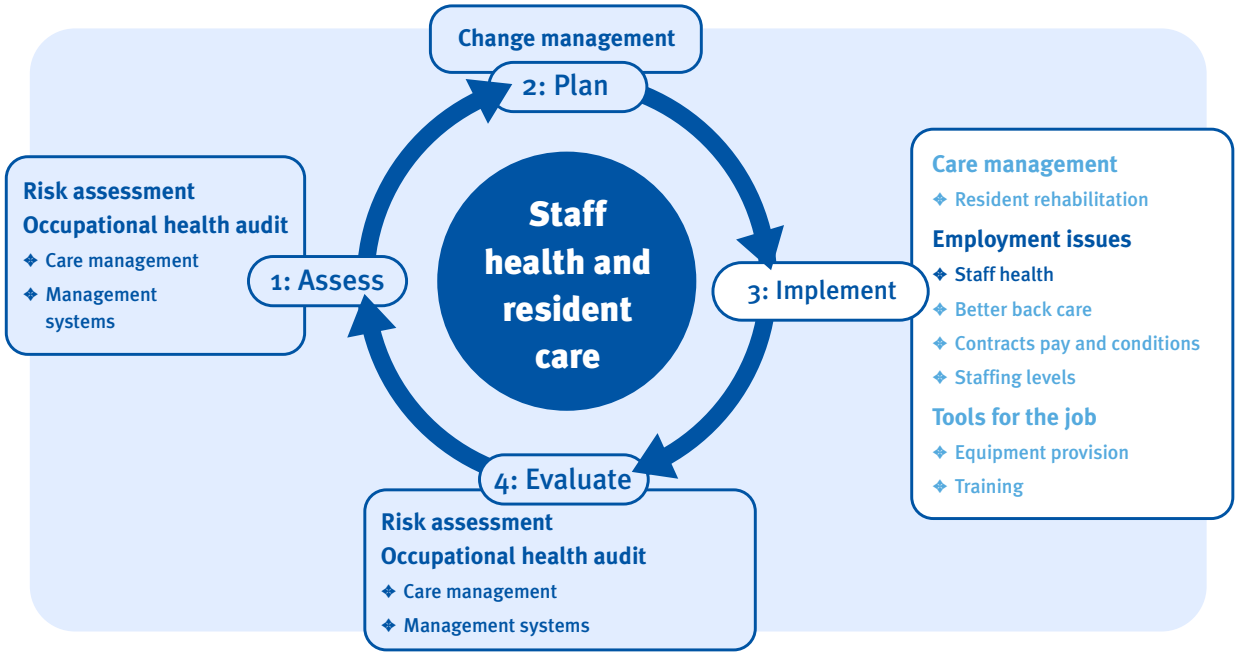
IMPLEMENT – Employment issues – staff health



Purpose of intervention

Employers have a legal responsibility to prevent injury and ill health occurring to staff as a result of their work. This includes undertaking a risk assessment to minimise health and safety risk. Some regulations may require staff to have access to health assessment. These include the Control of Substances Hazardous to Health Regulations (1999, 2000) and the Working Time Regulations (1998).

In 2000 the Government launched a new occupational health strategy called *Securing Health Together* (England, Wales and Scotland). This sets targets for reducing occupational ill health. Managers must show how they are meeting these targets.

Actions

Checklist

Health surveillance at work may be required under the following regulations (these are regulations relevant to nursing homes and not an exhaustive list):

- The Management of Health and Safety at Work Regulations (1999), Northern Ireland (2000).
- The Control of Substances Hazardous to Health Regulations (1999), Northern Ireland (2000).
- The Working Time Regulations (1998).
- The Display Screen Equipment Regulations (1992), Northern Ireland (1995).
- The Disability Discrimination Act (1995).

If the need for occupational health surveillance is identified from health and safety regulations, or because the manager or employee needs occupational health advice, the manager must be clear about what to ask the occupational health service to provide. The manager must determine that the occupational health service is "competent", under the Management of Health and Safety at Work Regulations (1999), to provide occupational health advice in a health care setting. (See Appendix 2 *Health of staff, referral criteria,* which suggests criteria for determining if you need advice from an occupational health service.)

Benefits of action

- Identify through risk assessment any health hazard which requires occupational health surveillance. Ask yourself whether there is a requirement under health and safety legislation – for example the eye testing requirements of the Display Screen Equipment Regulations (1992).
- When referring staff with a work-related health problem to their GP, inform the GP about exposure to the hazard and seek information about rehabilitation of the employee back to work.
- When referring staff to a GP or occupational health service following a back injury, include with your referral letter the patient information leaflet from the Royal College of General Practitioners or the Faculty of Occupational Medicine's guidelines on managing back pain at work.
- Develop criteria, which will trigger a referral to occupational health (see Appendix 2 *Health of staff, referral criteria*). Meet the targets set by the Health and Safety Commission document, *Securing Health Together.* Managers must monitor staff health and sickness absence, record the incidence of occupational ill health and devise strategies to reduce the future incidence. You can download *Securing Health Together* from HSE's web site on www.hse.gov.uk

Barriers to implementation

- Lack of knowledge of legal requirements and of staff occupational health needs.
- Locating and briefing a competent occupational health service.
- Determining when to refer a staff member for occupational health surveillance/rehabilitation.
- Determining when to refer a staff member for a GP assessment.

Further reading

Regulations listed are obtained through HSE books (Telephone: 01787 881165).

Faculty of Occupational Medicine (2000) *Guidelines on back pain at work.* London: Faculty of Occupational Medicine.

Health and Safety Commission (1999) *Health surveillance.* Sudbury: HSE Books.

Health and Safety Commission (2000) *Securing Health Together.* Sudbury: HSE Books.

Royal College of General Practitioners (1999) *Guidelines on the management of low back pain.* London: Royal College of General Practitioners.

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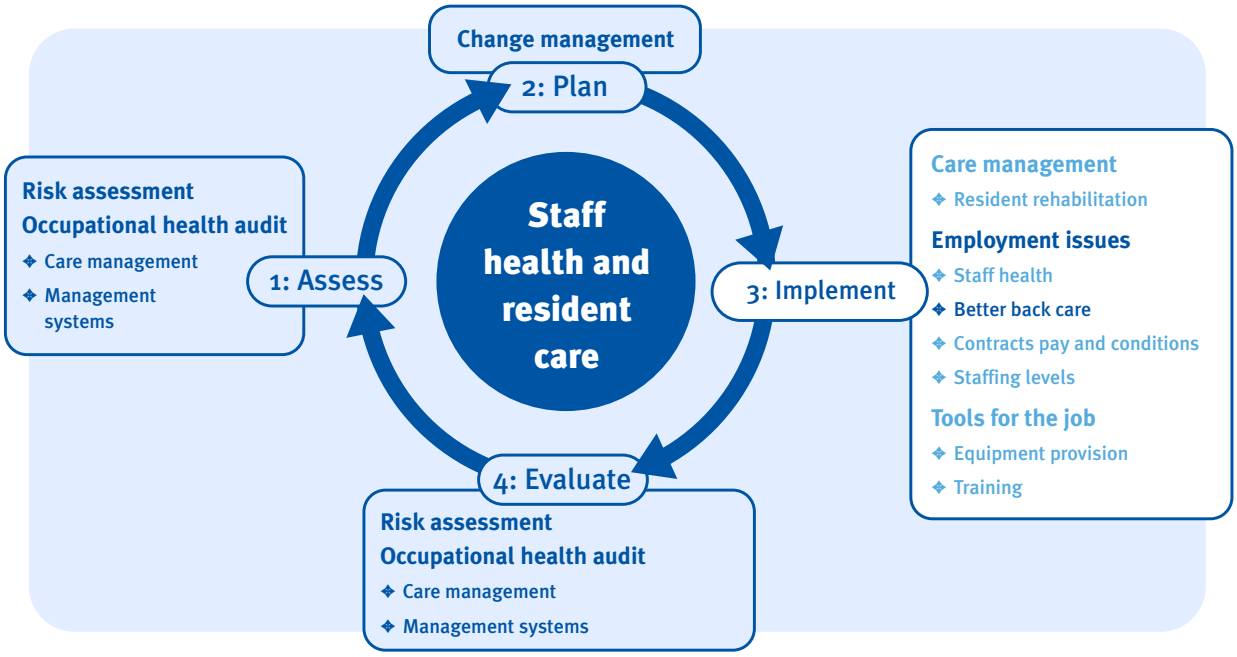
IMPLEMENT – Employment issues – better back care



Purpose of intervention

Back pain is very common. Most of us will get it at some time in our lives.

Managers should be aware of how they and their staff use their backs. Staff who experience back pain should be encouraged to remain as active as possible. Some simple adjustments in the workplace may be needed to help the individual remain in work or return to work quickly.

Actions

Checklist

- Ensure staff are aware of how to take care of their backs.
- Help staff identify particular movements and activities that seem to cause backache – can they be varied or adjusted?
- Encourage staff to do regular exercises, such as walking and swimming.
- Encourage staff to start and end the shift with warm up/warm down stretching exercises.

Benefits of action

- Caring for staff health may lead to a happier workforce and decreased staff turnover.
- Regular exercise is a great help in lifting the spirits, and improving fitness and well-being. Even relatively easy exercises, such as walking and swimming, can help lessen back pain.
- Activity and exercise may improve balance and posture, counter the effects of depression, help keep weight under control, lessen the risk of diseases such as heart disease, help reduce fear of movement, increase confidence, help sleep and mental alertness, and improve general level of fitness and stamina. A few minutes each day can make a big difference and may also be fun.

Barriers to implementation

- Staff may not recognise or understand the importance of maintaining their fitness levels for work.
- Employees who suffer from back pain at work may be depressed, less mobile and less agile and therefore not alert to the needs of the residents or themselves.
- Sickness absence from back injury results in loss of skilled staff in the work place and reduced time to deliver quality resident care and implement an integrated back injury prevention programme.

Further reading

BackCare (2000) *Basic back care.* London: BackCare.

BackCare (2000) *Back care for work and home.* London: BackCare.

BackCare (2000) *Active back care.* London: BackCare.

BackCare (2000) *Back in the office.* London: BackCare.

BackCare (2000) *Managing back pain.* London: BackCare.

To contact BackCare telephone: 020 8977 5474.

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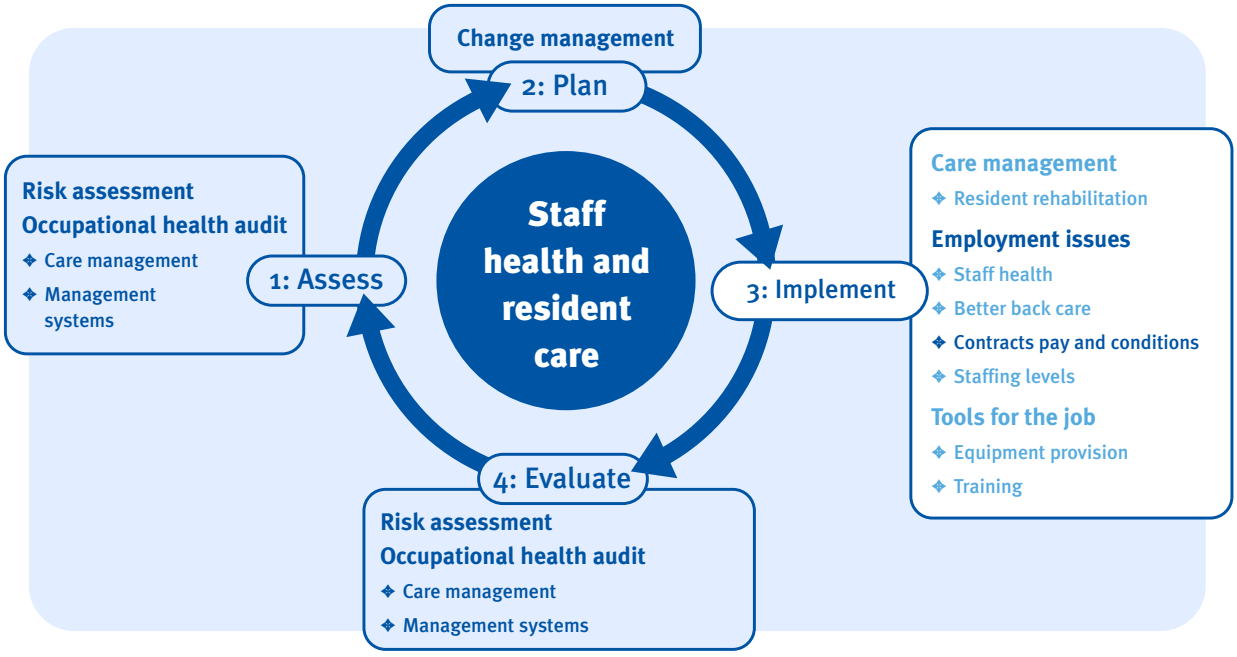
IMPLEMENT – Employment issues – contracts, pay and conditions



Purpose of intervention

A committed workforce is essential to achieving high quality patient care. Many aspects of employing staff are covered by employment legislation. Employers must ensure that employment rights are implemented. Good employment practices will help reduce staff turnover and lead to a good reputation as an employer. Disputes between employer and employee must be speedily resolved to avoid unnecessary costs in time and money.

Actions

Checklist

Every employee has a contract of employment which specifies:

- start date, job title, pay, how paid, hours of work, holiday entitlement, sick pay, pension, place of work, notice period, discipline and grievance procedures, and maternity benefits.

Statutory rights

The Employment Relations Act (1999) introduced a new package of employee-friendly conditions including:

- maternity leave: statutory maternity leave extended from 14 to 18 weeks and the right to take up to 40 weeks maternity leave reduced to one year's continuous employment. Rights already in existence include: paid time off for antenatal care; protection from dismissal; return to work after maternity leave.
- parental leave: all parents including adoptive parents are entitled to take up to three months unpaid parental leave during the first eight years of the child's life.
- time off for domestic emergencies: employees are able to take time off for domestic emergencies.

Other statutory rights in place before the Employment Rights Act include:

- redundancy payment
- unfair dismissal
- equal opportunities, and protection from discrimination on grounds of sex, race and disability

- statutory notice period (one week for each year of service up to a maximum of 12 weeks)
- Health and Safety at Work
- Working Time Regulations including rights to paid annual leave, maximum working week, length of night shifts and rest periods.

Benefits of action

- Good practice aims for a culture of fairness, understanding and co-operation between employer and employee. The Employment Relations Act includes new procedures for collective representation at work but good practice suggests that voluntary agreements to recognise a trade union are most appropriate.
- Employees are entitled to be accompanied by a trade union official or fellow employee of his or her choice at a disciplinary or grievance hearing.
- Good employment terms and conditions will attract and retain staff. Employers outside the NHS may develop their own pay structures but many will use the national pay scales agreed within the NHS structure.
- Many nurses have caring responsibilities in their home life so employee-friendly policies are important. This includes flexible working arrangements such as part-time working, self-rostering of shift patterns and job sharing.

Barriers to implementation

- Dissatisfied staff will not perform well at work and are likely to leave or be absent from work.
- Employment tribunal awards for unfair dismissal cases can be up to £50,000. Awards for other areas where rights have been denied or violated are unlimited – for example, racial discrimination.
- Costly management time can be wasted in resolving grievances or disputes with employees.

Further reading

HMSO (1999) Employment Relations Act. London: HMSO.

Royal College of Nursing (2000) *Tool for Joint Negotiating*. London: RCN.

Royal College of Nursing (2001) *Dealing with bullying and harassment*. London: RCN. To order a copy contact RCN Direct 0845 772 6100, quoting publication code 001 302.

Royal College of Nursing (2001) *Shifting patterns, a guide to employee-friendly working*. London: RCN. To order a copy contact RCN Direct 0845 772 6100, quoting publication code 001 500.

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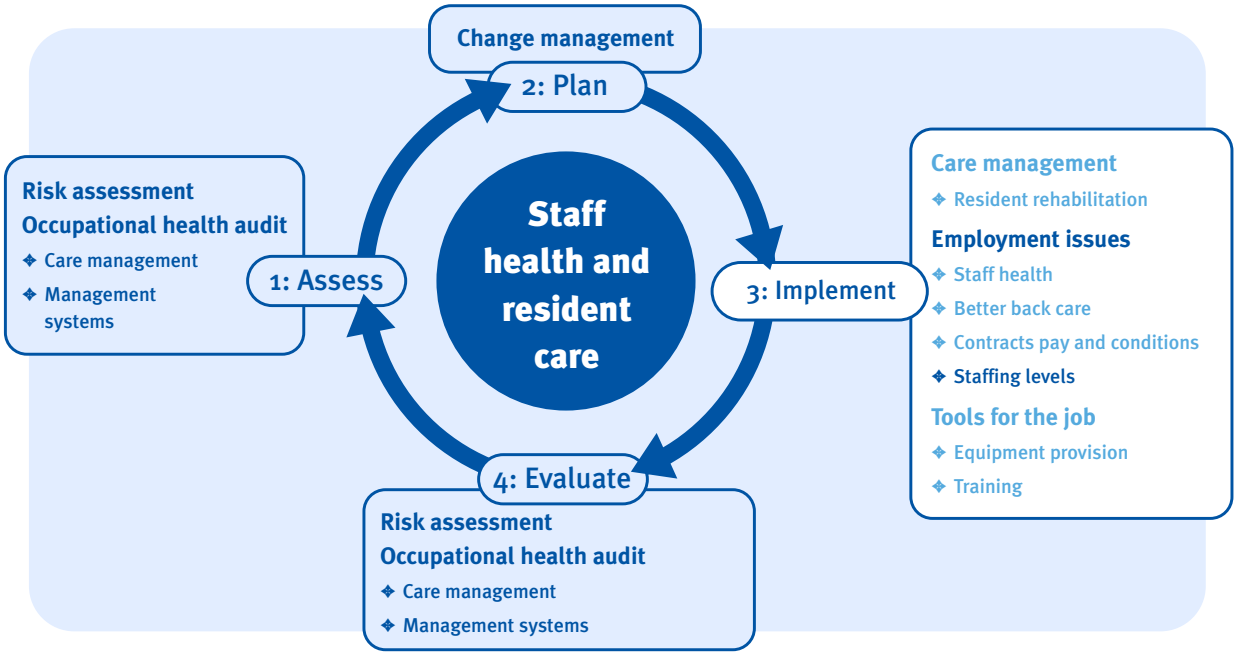
IMPLEMENT – Employment issues – staffing levels



Purpose of intervention

Inadequate staffing levels will affect staff performance. If staff are tired, they are more prone to accidents, injuries and making mistakes. The number of staff available at any time will directly affect the workload of each individual. Also the skill mix of the staff on each shift will determine the way in which individual needs are met, and the way resident care is allocated.

Actions

Checklist

- Are there sufficient numbers of staff on duty to give adequate and safe levels of care?
- Does the staff skill mix reflect the needs of the residents and the care that needs to be given?
- Have staff received adequate training to allow them to make decisions about care and apply them effectively?
- Does the ratio of qualified to non-qualified staff meet the Care Standards Act?
- Is there adequate provision for clinical supervision and staff development?

The Care Standards Commission has yet to set levels of acceptable staffing and skill mix, but the RCN recommends a minimum of five residents to one staff member for a morning shift.

Benefits of action

- Consult the RCN assessment tool for nursing older people. This is a very valuable tool for care planning and staffing level information. It helps staff to make a needs assessment so that appropriate care is given.
- Seek an appropriate skill mix. The ratio of qualified to unqualified staff should allow for clinical supervision, staff development and performance appraisal. Inadequate staffing levels contribute to poor standards of care, and compromise health and safety standards.
- Health care assistants should be encouraged to undertake S/NVQs in care (Care Standards Act, 2000).
- Audit the skills and competence of staff. Identify and implement training needs.

Barriers to implementation

- Shortages of time and resources may mean that clinical supervision, training and appraisal are not done.
- Too few staff and/or an inappropriate skill mix will result in an inadequate resident needs assessment, which may lead to inappropriate care.

Further reading

HMSO (2000) Care Standareds Act. London: HMSO.

Royal College of Nursing (1997) *Assessment tool for nursing older people.* London: RCN. To order a copy contact RCN Direct on 0845 772 6100, quoting publication code 000 797, free to members of an RCN older peoples forum (one copy), subsequent copies have a charge.

Royal College of Nursing (2000) *Clinical effectiveness.* London: RCN. For a copy please contact Jane Altun RCN Institute 20 Cavendish Square, London W1G 0RN, telephone 020 7647 3705 (£3.75), publication code 001 032.

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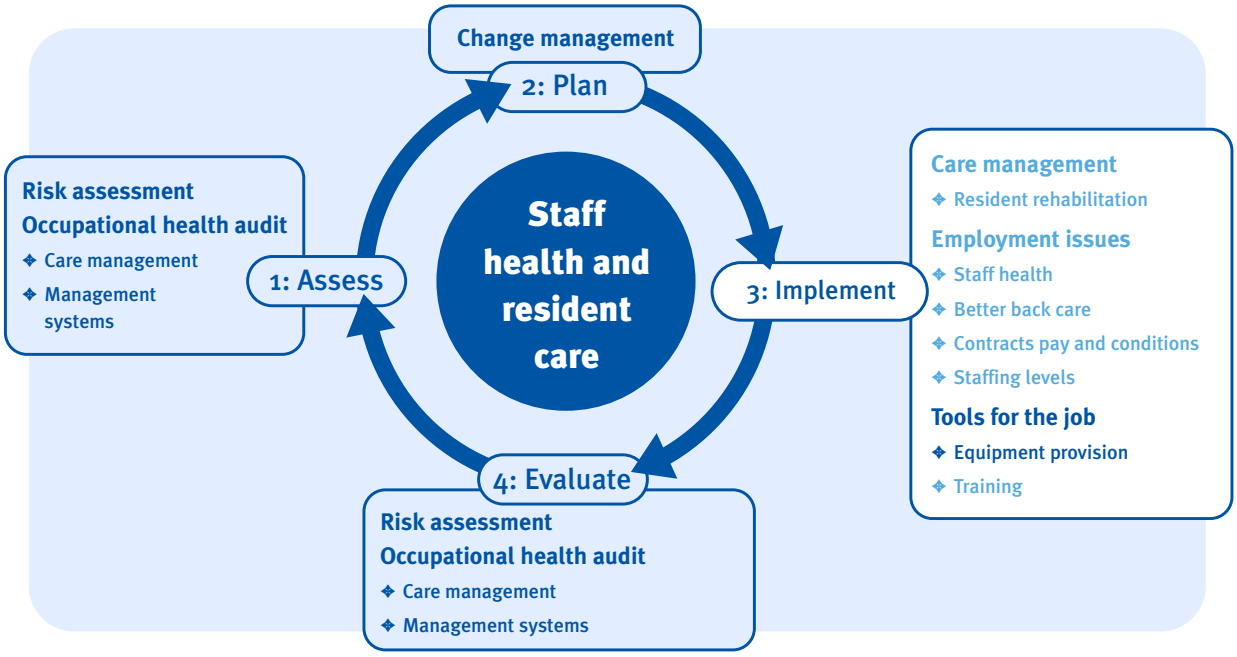
IMPLEMENT – Tools for the job – equipment provision



Purpose of intervention

Staff need the correct kind of equipment to help residents stay as independent as possible and to promote safer handling. Provision must include a choice of patient handling equipment, beds, bath and shower aids. Most manufacturers provide advice and data sheets which help staff to compare equipment options. The Medical Devices Agency produces technical reports on the performance of equipment. These may be helpful in choosing what to purchase.

(The dependency levels referred to below are based on the Arjo Residents Gallery in Appendix 1.)

Actions

Checklist

The flowchart in Appendix 3 is a guide to the range of equipment needed for problem solving residents' needs. Detailed guidance on equipment can be found in the RCN and BackCare *Guide to the handling of patients* (1998).

The amount of equipment will depend upon a full assessment of the whole workload, but generally one hoist/bath/standing aid is needed for every ten residents.

Case studies

Staff were observed using a mechanical stand and raise aid with a resident who had limited weight bearing ability. Staff complained that the equipment was unsuitable, as the resident felt uncomfortable and unsafe. Stand and raise aids should only be used with residents who can weight bear. The wrong equipment had been selected for the resident's needs.

Non-weight bearing residents must be transferred with appropriate equipment – for example a sling-lifting hoist.

Residents with no sitting balance or those with a tendency to be ridged and lean back, were found to slip off a low dependency bathing seat.

Bathing equipment must be of a suitable type to match dependency levels and meet residents' needs.

Staff were observed manually pushing and pulling beds without wheels away from walls to gain access to both sides of the bed in order to roll residents.

Beds must be on wheels and height adjustable (preferably profiling beds). Access to both sides is essential.

For safer care, all equipment must be maintained and kept in safe, good working order.

Benefits of action

- Inappropriate equipment can be dangerous, unsafe or unacceptable to residents. Equipment provision and solutions should be determined by and linked to the dependency levels and the needs of residents.
- Good communication ensures that both the staff and resident determine the best equipment solution. A written manual handling procedure should be in each care plan and regularly reviewed.
- If staff are unsure how to select equipment which best meets a resident's needs, they should consult the RCN's *Introducing a safer patient handling policy.*

Barriers to implementation

- Lack of adequate maintenance and/or availability results in equipment not being used.
- Lack of adequate training results in staff misusing equipment, or selecting the wrong equipment to meet residents' needs.
- Lack of adequate communication and record keeping results in staff not knowing safer procedures.
- If equipment provision is not linked to resident dependency levels, there may not be appropriate equipment available to meet residents' needs.

Further reading

BackCare and Royal College of Nursing (1998) *The guide to the handling of patients: introducing a safer handling policy* 4th edition. London: BackCare. Telephone: 020 8977 5474.

BackCare (1999) *Safer handling in the community.* London: BackCare. Telephone: 020 8977 5474

Royal College of Nursing (1999) *Introducing a safer patient handling policy.* London: RCN. Publication code 000 603. To order a copy contact RCN Direct on 0845 772 6100.

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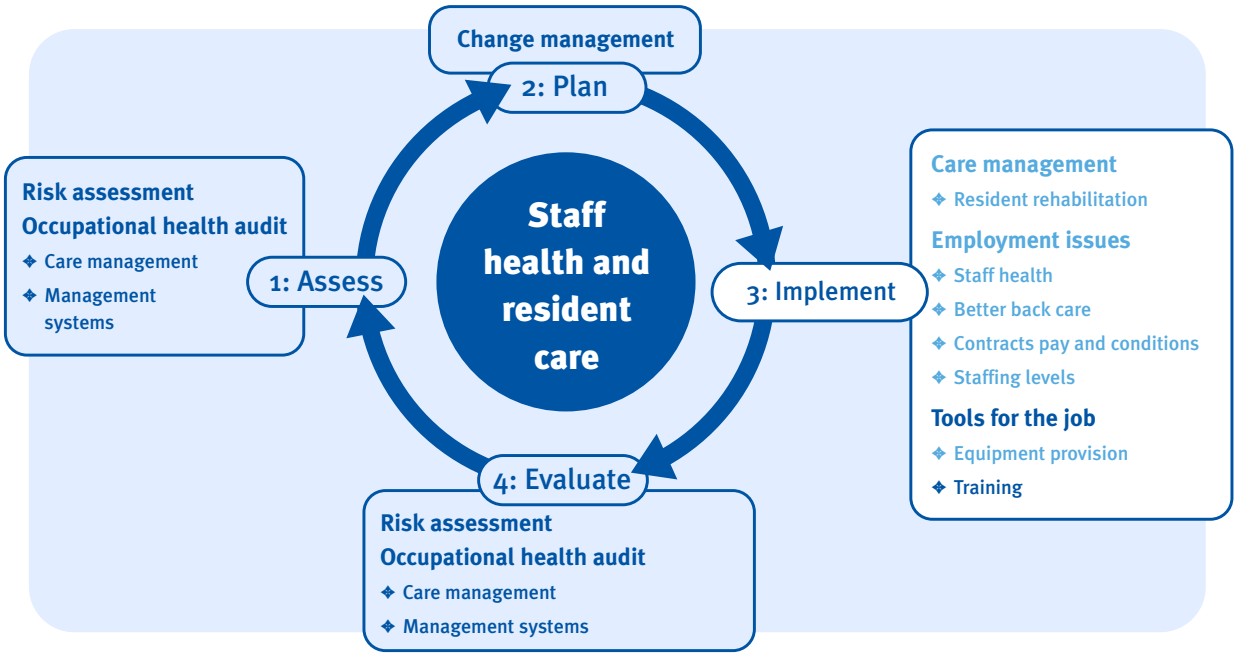
IMPLEMENT – Tools for the job, training provision



Purpose of intervention

Basic manual handling training ensures that all staff have a good knowledge and skill level of risk assessment, equipment selection, equipment usage and safer manual techniques. Staff must apply these skills to assessing resident needs. Staff need to learn problem-solving skills, and to know when to ask for help from another colleague or when to consult an expert in resident handling. Problem-solving sessions in the workplace ensure that good practice is understood and applied.

A leadership course for senior staff may help to develop the skills needed for motivating staff to improve their manual handling skills. Developing some staff to become manual handling trainers should be encouraged. This will support the regular supervision of staff manual handling skills. It also enables workplace-based problem solving sessions to be held. A 'Train the Trainers' course may support the development of staff who wish to undertake training roles.

Actions

For this project training comprised:

Manual handling skills training: Some classroom teaching was given but the emphasis was on problem-solving sessions in the workplace with small groups of staff, applied to the needs of actual residents. Initial manual handling training for new and untrained staff should be more comprehensive and longer than described below. The content of the three-hour manual handling update to enhance basic skills course included:

- outline of risk assessment and legal compliance principles
- basic handling principles
- practical manual techniques (bed and transfers)
- effective equipment usage – training must be focused on the use of available equipment and on the criteria for the use of available equipment.

The time allocated to skills training must reflect the learning needs of the staff and should be flexible. An adequately competent/trained member of staff should organise and lead the problem-solving sessions.

Train the Trainers course: One member of staff from each care home went on a four-day RCN accredited course to train people as manual handling trainers. This person was then able to act as a competent person, and train and run problem-solving sessions.

Leadership skills course: All managers and key staff were given two days of leadership skills training as part of the project. The content was determined by the results of the risk assessment and occupational health audit.

For new staff, induction training in manual handling, as well as health and safety policy and procedures, must be completed before they are asked to undertake any resident handling task. Their levels of knowledge, skill and competence must be assessed to ensure that they can meet the standards.

Training and problem solving should reflect and support the written policy. All staff must be supported and supervised in the practice environment by a 'competent' person as defined by the Manual Handling Operation Regulations (1992).

Benefits of action

- Staff must be made available for training. Staffing levels should allow for adequate time to be spent problem solving in the workplace.
- A leadership course for senior staff promotes the skills needed for motivating staff to maintain their practical and problem solving skills. It also ensures staff meet the health and safety objectives of the organisation.
- A 'Train the Trainers' course, for at least one member of staff, ensures that risk assessment and problem solving skills are present within the organisation. This may not be enough to ensure that you are providing a 'competent' person under the Manual Handling Operations Regulations (1992). Your staff member may require additional competence in teaching and training, and may need further training in ergonomics and risk management. The member of staff must also be supported in maintaining their competence. This may involve joining an appropriate professional body or support group, reading applicable journals and attending further training or education courses. Even with this person available, there may still be a need to seek advice from a competent back care adviser.

Barriers to implementation

- Too few staff in work areas leaving insufficient time for problem solving and care planning.
- Training sessions leave work areas understaffed.
- Training is unfocused and is not applied to the work environment, the available equipment or the needs of residents.
- The trainer is not competent to meet the requirements of the HSE regulations.

Further reading

Health and Safety Executive (1998) *Manual handling operations regulations, guidance on regulations.* Sudbury: HSE Books.

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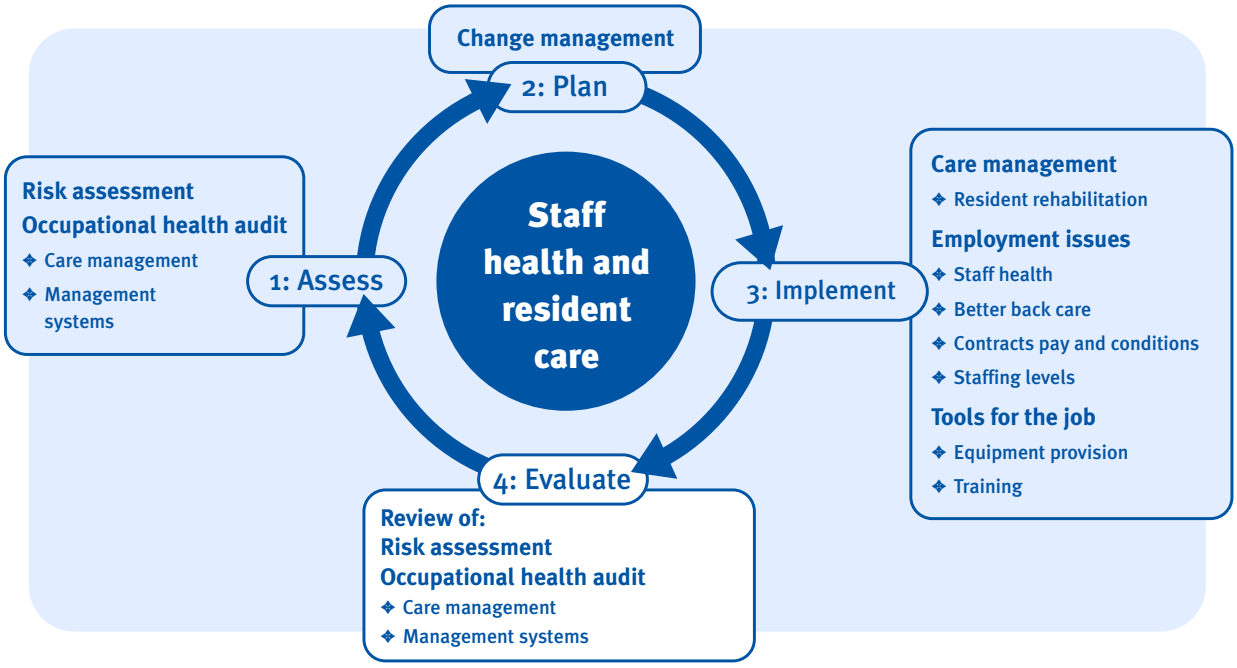
EVALUATE – Review



Purpose of intervention

A formal review process is essential for all changes that are made and will ensure continuous improvement. A full health and safety audit will evaluate the management systems and identify where problems are, including barriers to change. As well as this, a systematic review of all measures will ensure that they are monitored and updated as needed.

Please refer to Section 1 ASSESS, for details of risk assessment and occupational health audit.

Actions

Checklist

Setting of review dates.

- Setting of outcome measures and review questions.
- Allocating responsibility for the review to a senior member of staff.
- Allocating time to staff to ensure that reviews are carried out.
- Ensuring that proposed changes are achievable.

Case study

A 20-bedded unit has completed moving and handling assessments on all residents following problem-solving sessions including realistic and appropriate review dates. The review dates have been noted and all named nurses know that they are responsible for ensuring that the assessments are done.

Before the three-month review date, one very large and previously mobile resident suffers a cerebrovascular accident (CVA) and so deteriorates significantly. Immediately the named nurse recruits the help of other staff and they carry out a problem-solving session with the resident. The care plan is updated and all staff informed at hand-over.

Immediately task allocation is reviewed, and equipment availability assessed. Management is informed, and a new review date is set for a week's time to ensure that the following measures are taken.

- Is a hoist always used for transfers?
- Are two members of staff always available for manual handling?
- Are sliding sheets being used in the bed?

- Has the bed been moved so that it is away from the wall?
- Is the hi/lo mechanism of the bed being used?

These measures should be reviewed in a week. If there are any negative answers, reasons should be offered – for example not enough staff/equipment, or non-compliance with safe systems of work. Management should be informed and a new review date set to ensure problems have been addressed.

Benefits of action

- Changes and their effects are monitored. Reasons for inaction are addressed so that alternative action can be taken if the change has not been successful, or the reasons for the lack of success can be addressed. A proper risk assessment and audit system will ensure that this happens.
- Continuous improvement is ensured.

Barriers to implementation

- Changes may not happen.
- Reasons for problems may not be addressed.
- Continuous improvement may not happen.
- Lack of success may be due to:
  - lack of an appropriate change management strategy leading to low morale or lack of staff/resident participation
  - lack of adequate policies/procedures
  - lack of adequate management systems, including communication
  - employment issues such as low staffing levels or contract issues such as pay and conditions
  - lack of tools for the job such as equipment and training – also lack of finance to correct this
  - an inadequate review system to identify these problems.

Further reading

BackCare (1998) *The guide to the handling of patients: introducing a safer handling policy* 4th edition. London: BackCare. Telephone: 020 8977 5474.

Health and Safety Executive (1995) *6 steps to successful risk assessment* (free leaflet). Suffolk: HSE Books.

Royal College of Nursing (2000) *Manual handling risk assessment in the hospital and the community.* London: RCN. To order a copy contact RCN Direct on 0845 772 6100, quoting publication code 000 605.

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Date of review
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APPENDIX 1

Arjo Residents Gallery

ALBERT **Male, age 75, 82kg / 180lbs**

- Ambulatory, but uses a cane for support
- Independent, he can clean & dress himself
- Physically and mentally active
- Tires quickly
- Continent
- Requires careful monitoring

BARBARA **Female, age 82, 61kg / 134lbs**

- Uses a walker
- Can support herself to some degree
- Has a combination of medical conditions
- Incontinence problems are beginning
- Stiff and painful joints due to rheumatism
- Dependent on carer who is present in demanding situations
- Not physically demanding for carer
- Remaining capacity should be stimulated

CARL **Male, age 80, 95kg / 209lbs**

- Sits in wheelchair
- Left-side hemiplegic
- Some capacity to support himself
- Can stand for short periods
- Mentally capable of decision-making
- Urine incontinent
- Dependent on carer
- Physically demanding for carer
- Needs equipment to cope with loss of mobility & to protect carer from transfer-related injuries
- Important to stimulate remaining capacity and slow down deterioration of mobility

DORIS **Female, age 80, 90kg / 198lbs**

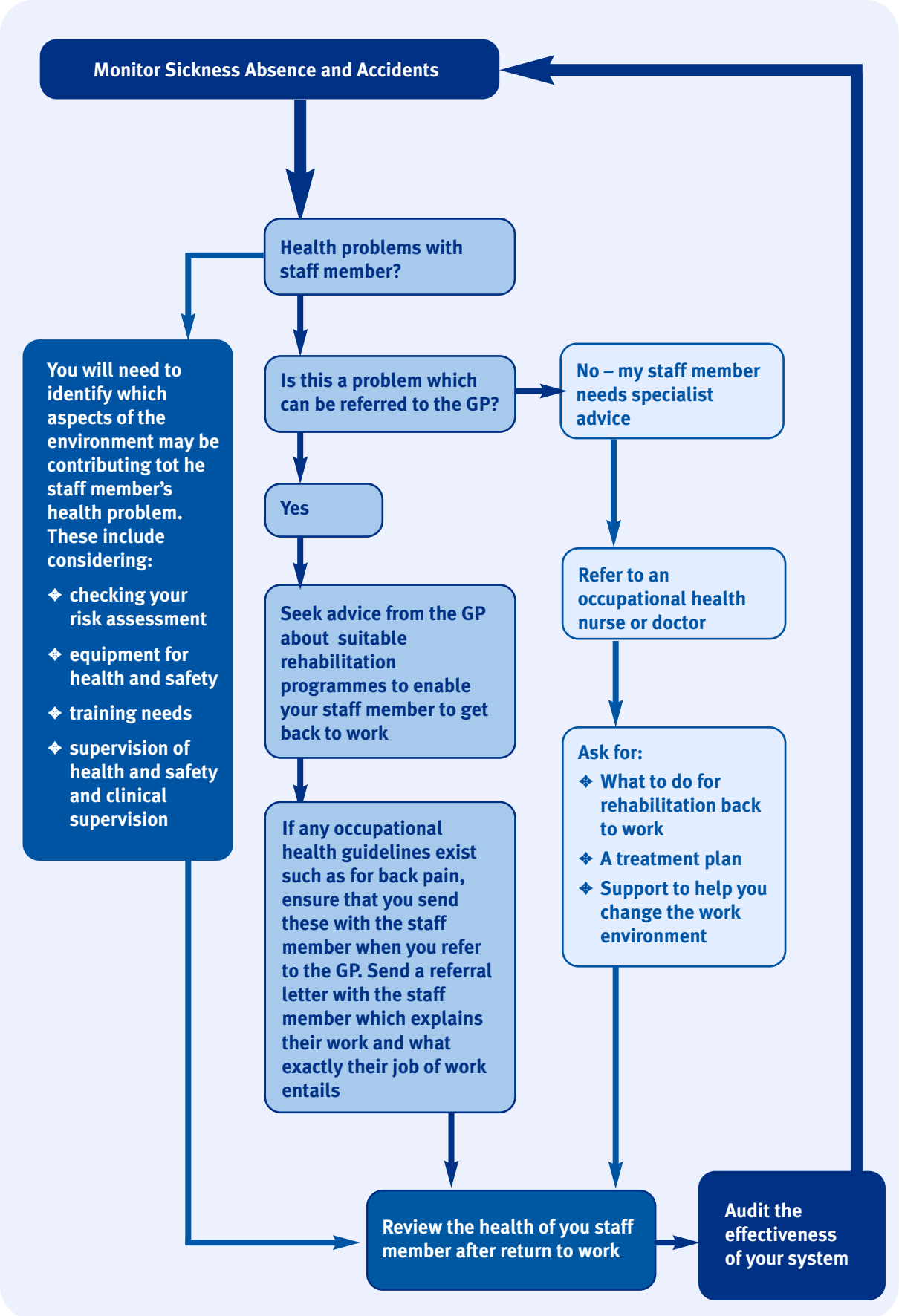
- Sits in wheelchair
- No capacity to support herself
- Cannot stand unsupported
- Increasing dementia
- Double incontinence
- Dependent on carer
- Needs equipment such as passive lift to cope with loss of function and to protect her carers
- Important to slow down deterioration of mobility

EMMA **Female, age 86, 42kg / 92lbs**

- Passive resident
- Almost completely bedridden
- In later stages of dementia
- Decreasing in weight
- Double incontinent
- Totally dependent
- Physically demanding for carer
- Mechanical aids should always be used to transfer
- Aim is to avoid complications caused by long-term confinement to bed and make her as comfortable as possible

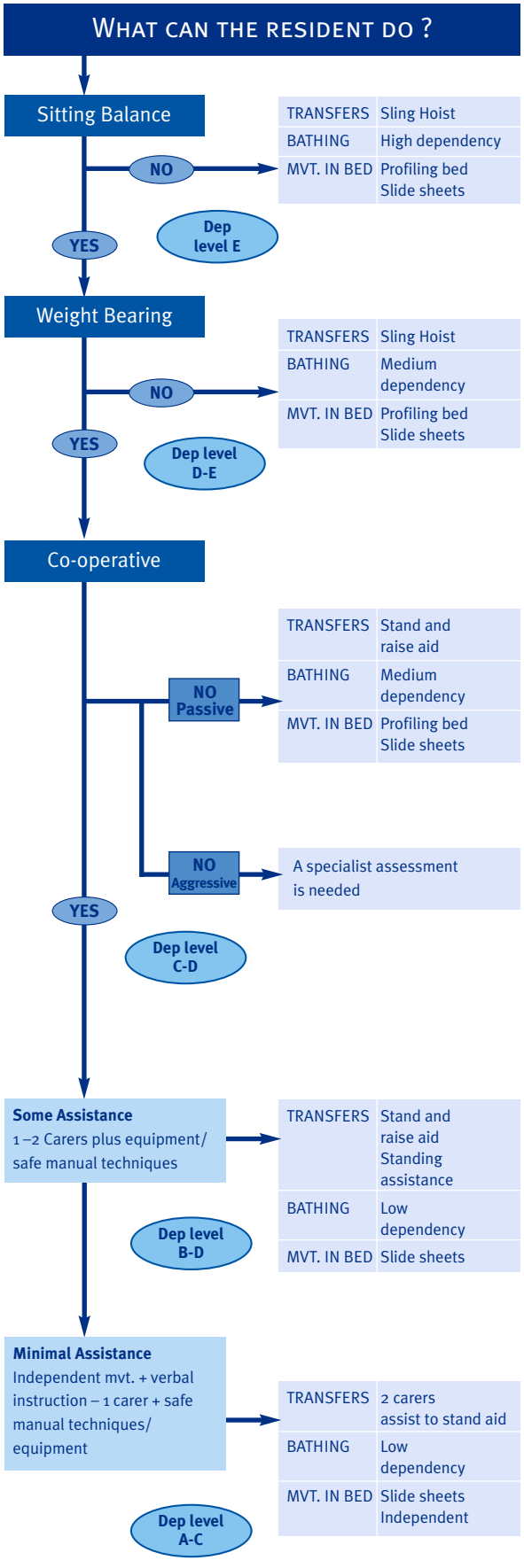
APPENDIX 2

Health of staff – Referral criteria flowchart



APPENDIX 3

Equipment provision flowchart



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