Editorial

The recent announcements on reform of Incapacity Benefits to replace “sickness” culture with work focus (Alan Johnson’s words not mine) may not immediately seem relevant to members of NBE. This is perhaps the biggest change in incapacity benefits since they were created and will supposedly provide enhanced financial security for the most severely sick and disabled as well as more money than is currently the case for all those claimants who take part in work focused activity. Those who completely refuse to engage – failing even to attend interviews – will receive (lower) Job Seekers Allowance rates.

I’ve always been a carrot rather than a stick person myself, but nevertheless welcome any efforts towards the rehabilitation, re-training and supported return to work of the very many people on this benefit who would dearly love the opportunity to do so, including many long term sick health and social care employees.

What concerns me more is why these people end up as passive recipients of benefits, with all its well known consequences including de-motivation, mental health problems, social isolation, relationship breakdown and financial hardship. Surely it’s better to prevent the problem in the first place, perhaps as part of a dual strategy. But this can only happen if there is a much bigger programme of change, which places real responsibilities on employers, in terms of both prevention and management, and GPs also have a pivotal role.

At least in relation to moving and handling, and postural load, prevention strategies based on a systems approach, fall entirely within our sphere of influence and practice, and hopefully are already being effective in reducing ‘working days lost’, as well as enhancing the quality of working life and patient experience. But there also has to be effective occupational health and safety management which includes systems for screening/early reporting, near miss investigation, early access to treatment and ergonomics interventions as appropriate. Which means we have to work in partnership to have the best possible chance of achieving our aims.

Which also brings me neatly to NBE Conference 2006 ‘Working in Partnership’. The move to Telford International Conference Centre is yet another great step forward in the progress of NBE, as is the new and expanded format of plenary and streamed sessions. The enclosed programme and booking form clearly demonstrate the wide range of topics and partners we are interested in, and working with. Please share your programme with your colleagues because it will have wide appeal… but book early to avoid disappointment!

Jacqui Smith
Chat from the chair

New Year is always designated as a time of change, as people look back to the old year and forward to the new. National Back Exchange has been and will continue to be a forum for people interested in the prevention of musculoskeletal problems; however, “forum” means both “meeting place” and “opportunity”, as in the capacity to speak. We can only have the opportunity to speak if we do it as recognised professionals, and our registration process is the beginning of this move. I say “beginning” because of course, it is not going to happen overnight—it has taken about four years of people’s hard work to get to this point with registration, and while we remain a voluntary association things will always take some time to come forward and take shape. However, registration is not the only change afoot in 2006. In this copy of the Column, you will receive your booking form for Conference 2006, which has not only moved to Telford International Centre, but has taken on a whole new and very exciting format. The whole aspect has broadened both in presentations and exhibition, and as a result, this change involves more choice in conference content for each member and a varied choice of hotel accommodation.

Other internal changes include the tendering of the Column out to professional publishing, and you will find a more structured and professional aspect appearing in many areas, including development days, affiliation and group guidelines. This move towards internal professionalism is becoming obvious to our external contacts, and we are now being approached by other bodies asking for our expertise, skill and knowledge. All five members of the All England Passport strategic group are provided by National Back Exchange, and NHS CLPU are asking us for our advice regarding their ongoing e-learning manual handling package. We are not just having an impact “at home”, either—we have contacts within the USA and elsewhere who are interested in sharing our experience and knowledge.

Exciting as all these developments are, it means that in order to gain external recognition and work towards being a professional set-up, we have to also address internal matters in a professional manner. Members will find that issues are more structured and clearer, especially with regard to finance, but that also they will be called upon to put their skill, knowledge and experience forward on behalf of national Back Exchange. What else would you expect of a professional organisation?

However, not all matters are professional, and it is with great sadness that I have to inform you that Michele Ali died at the end of January. Many of you will have known Michele as friend, colleague and staunch supporter of National Back Exchange, but please read more of her on page 10. A donation has been sent to the hospice as she requested, and the sound of her laughter (which was always near the surface) will be greatly missed by all those of us who knew her.

Philippa Leggett
National Chairman, National Back Exchange
Managing risk in therapeutic interventions

1 and 2 June 2006, Disabled Living, Manchester
10 and 11 October, Work Fit, Leeds

This two day highly interactive and practical course is aimed at moving and handling advisors working with therapy services as part of their role, and for physiotherapists/managers with a responsibility for risk assessment and/or the delivery of moving and handling training/update training to physiotherapists. Content will include:
- MSDs in physiotherapy
- Policy developments
- Generic risk management
- Clinical reasoning
- MH Protocols
- Documentation

Facilitators
- Jacqui Smith MSc MCSP Cert OH, Co-author of Guidance in Manual Handling for Chartered Physiotherapists 2002 and Editor of 5th edition of The Handling of Patients 2005
- Beth Hallows MCSP LPC (Back Care Management), Moving and Handling Advisor & Complex MH Risk Assessor

To book a place or for further information about this course, or our refresher training/training for physiotherapy trainers courses, please contact Jacqui Smith,
5 The Courtyard, 110 – 118 Church Street, South Leeds LS10 2JA
Tel 0113 2705444 Mob 07734 009661
email jacqui@work-fit.co.uk

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Introducing The Smart™, a lightweight, folding portable hoist. Made from lightweight aluminium, this hoist is ideal for taking with you wherever you go, but tough enough to cope with all lifting tasks. Oh, just like the whole Molift range it carries a 5 year parts and labour warranty!

The Column 18.1 February 2006

Report on Local Officers Workshop

Summary of Local Group Officers’ Workshop Held on 19 January 2006 at the Disabled Living Foundation, London

Fourteen local group officers and members of the Executive Committee attended this workshop. Nine affiliated groups were represented.

The discussion started with the format of Development Days, and those present felt that the current format should remain for the time being.

The May 2006 Development Day will be hosted by the East Midlands Group and held at Hill-Rom. It was proposed that the day would involve a presentation by a representative from Hill-Rom on Total Bed Management, followed by workshops and possibly an open forum discussing topical issues within National Back Exchange. It was also agreed that the cost of a place could be increased to £50.

Feedback on the Mailbox Memo system was requested, as local officers felt that this was a very useful resource, although some members were unsure of the process for requesting advice. It was explained that members need to email the administration office with any request for information. After being approved by the Membership Secretary, the memo is sent to all affiliated local groups for circulation to their members or for discussion at their next meeting.

The meeting was informed that the Group Guidelines are currently being updated and will include additional information, e.g. hosting Development Days, a sample local group constitution and specimen job descriptions of Local Officer posts.

Local Group Officers were asked to consider certain aspects of National Back Exchange’s future development within their groups and to report back at the next meeting, which will take place at the Development Day on Wednesday 17 May 2006. (see above)

Claire Mowbray
Regional Officer
Sara Jaskiewicz
National Membership Secretary

ADVERTISE HERE TO A FOCUSED GROUP OF PROFESSIONALS
For information and rates please contact the administration office – see page 3
Swansea & West Wales

September 2005 meeting

The Manual Handling Team from Swansea NHS Trust gave a presentation describing the history & processes behind the Trust arriving at the current training structure, its format & systems for recording, monitoring and reviewing the process. The presentation proved to be of great interest & value to the group & generated much discussion.

During lunch, David Bennett from Arjo gave a demonstration of new Bariatric equipment.

The AGM followed with the resignation of our secretary Ena Lymer & the election of Michael Jones to the position. Both the local officer job descriptions & local group constitution are in place. Discussion followed re poster competition for conference & contents of future meetings, & very importantly our Christmas luncheon arrangements!

The remainder of the afternoon was spent continuing the theme from the morning looking at how update training is provided. Length of time, content, format etc. To be continued at next meeting.

December 2005

Congratulations to the group on winning the poster competition at the national conference, well done!

Ann Morgan presented an overview of a small survey undertaken in the summer in relation to how other Trusts currently provide update training. (Many thanks to those participants) The results indicated, not surprising that a variety of methods are used but only a small percentage of those surveyed achieved an annual update for patient/client handlers. Discussion continued along this theme and work undertaken at the last meeting distributed. General consensus within the group was that whilst the content could be standardised/recommended for classroom-based update training, this and any other type of update needs to be based on an assessment of the individual/groups needs. It was also felt that any developments in this area also need to reflect the standards of the All Wales Passport Scheme. Competency assessments vary and the group was informed of work currently being undertaken by the All Wales Manual Handling Group.

A short “workshop” facilitated by Jeni Bryant followed, which explored the availability & accessibility of a range of Bariatric equipment for patients/clients in excess of 50 stone. This proved to be a very interesting & thought provoking session taking into account the needs of the patient/client in the home environment & within a hospital setting. The meeting was then concluded as lunch was waiting!

Contact Lorraine Dawson
email lorraine.dawson@pdt-tr.wales.nhs.uk tel 01437 773831

KENT

6 September at Buckland Hospital – ‘Equipment Play Day’ hosted by Kate Martin & Lynne Sharp. This gave the group an opportunity to trial and evaluate a range of fabric/patient specific slide sheets with some surprising results. Simon Saulis demonstrated the new Arjo Maxi Move hoist and Phil Neal from Pegasus showed the Ultra Low bed. Mike Murphy from Arro Medical demonstrated the Air Riser cushion & Burnet Bath Support.

19 October at Preston Hall Hospital – Community Handling was the topic, organised by Marcella Bennett & Susie Andrews (not a moment was lost!). A very thought provoking talk on postural stress in home delivery was given by Gill Hampshire. Gill and colleagues have produced for their Trust ‘Guidance Notes for Midwives Assisting with Births in the Home Environment’. This was followed by a session on practical handling in the community with Karen Bull. Jane Martin then gave a presentation on ICES (Integrated Community Equipment Stores), which created much discussion about the provision of equipment provided under a pooled budget agreement between 2 Social Services and 9 Primary Care Trusts. During lunch the Molift Smart Hoist was demonstrated. The afternoon addressed ‘Moving & Handling Risks with Informal Carers’ by Marcella & Susie. A very full day!

Congratulations to Kate, Lynne, Susie & Marcella for providing the group with such interesting subjects to contemplate and act upon.

The Group are hoping to organise a one-day seminar next year.

Unfortunately the December meeting had to be cancelled.

2006 meetings

16 March Falls / Falls prevention
28 April Bariatrics with Pegasus
05 June AGM
18 July Podiatry & Dentistry Issues
13 September Mental Health / Challenging Behaviour
09 November Legal Day
15 December Trip to Arjo (tbc)

If you are interested in attending any of the above please contact Joyce Cheney joyce.cheney@ekentmht.nhs.uk
Somerset, Avon & Gloucester

October 2005 meeting

Speakers

The speakers this evening meeting came to discuss the Personal Assistant scheme and also the management of the scheme by WECIL.

1. Teresa Sheppard came from the West of England Centre for Inclusive Living (WECIL).
2. Janet Scammell the chair of WECIL and a wheelchair user who uses the PA scheme very successfully.

WECIL.DP Services, Leinster Avenue, Knowle, Bristol BS4 1AR Telephone 0117 903 8900

This organisation has been in operation for 12 years and its primary role is to assist people wishing to use the Direct Payment scheme (DP). It is funded by Social Services and is for clients over the age of sixteen with a range of health problems/disabilities including hearing difficulties, HIV/AIDS, older people, parents with disabled children, and those with mental health issues. It currently covers four authorities – Bristol, BANES, South Gloucester and North Somerset. It has 203 people using the service and a budget of £50000.

The organisation

1. Advises on recruitment of staff
2. Using agency staff
3. Being an employer
4. Finance issues
5. Payroll
6. Provides advice and finance for short breaks, respite care, equipment or a combination of these needs.

Trusts can be set up and charged with managing the day to day care of the young adult 16-18.

Funding/payments through the scheme are not considered to be income and beneficiaries can get a one off payment or a combination for equipment as long as the social worker identifies that the need exists.

WECIL Staff

‘Independent Advisors’ who work with clients to assist them with making the decision about what type of care option – such as a PA scheme and can offer advice on legal aspects of being an employer, budgets etc.

Independent Living Support Worker – for clients who are in need of ‘high support’ or ‘low’ advocacy – undertaking payroll, rotas, agency etc.

Finance and Information Workers – assist with running payroll, Inland Revenue, processing wages etc. Currently reviewing the service offered to make it more competitive with high street financial management schemes.

Janet came to talk to us as a beneficiary of the DP scheme which she uses to employ a PA. She described to us what it was like to become disabled and become dependent on the ‘Home Care’ scheme. Sadly Janet had a poor experience of this scheme as it was ad hoc and unpredictable with an irregular service which was under pressure. She therefore decided to use the DP scheme and employ her own PA which has been a very successful method of maintaining her dignity, very active social life and independence. WECIL trained all of her PA’s and have provided support. Janet manages her PA’s independently and this has enabled her to have her individual needs met and a respectful working bond to be established between her PA and herself. If Janet wished to extend her PA’s role or to give her any training then she would use her DP scheme money to finance this.

The vulnerability of both parties was discussed with respect to PA’s and clients who were unable to articulate their needs. Teresa advised that WECIL could provide an advisor to help with this ongoing process. Therefore abuse etc, on both sides could be identified and dealt with accordingly.

The issue was raised of PA’s undertaking care in a NHS environment. Discussion was around whether the PA activity would be subject to the ‘sub-contractors’ legislation? Systems like the ‘Choose and Book’ will identify that a PA will be in attendance and will allow for additional arrangements.

November 2005 meeting

A Root Cause Analysis scenario session very well received by members. It was very thought provoking and generated a good deal of discussion. The National Patient Safety Agency produced STEPS on using this tool which are available via the Agency or SAG secretary.

2006 meetings

15 March 13.15 – 16.15 AGM
Followed by Handling Of People 5th edition discussion
‘How do we best use this guidance – its practical application’

11 May 17.00 – 19.00 St Monica’s Training Room

15 June One day workshop to be arranged.

16 October Venue (tbc)

28 November 17.00 – 19.00

East Anglian

Meeting held at West Suffolk College on October 14 2005

This was a productive day with a number of areas discussed. These included:

1. Update on the Passport Scheme; set up to raise the level of competence and to provide cost-effective training. Though it is currently restricted to the NHS, it may in the future link to Social Services. There was a discussion regarding nominations for the three representatives covering acute, mental health and the community. Some interest was shown in these positions.

2. Bariatric Special Interest Group – concerns were raised over some of the larger staff in relation to safer handling, as well as those with ‘awkward body dynamics’.


4. Kevin Barnard presented on the NHS Knowledge and Skills Framework. This was a clear and thorough presentation detailing how the Framework is applied.

Richard Handley, hoist and sling specialist delivered an interesting session in the afternoon on the selection of slings and legislation associated with moving and handling medical devices. Areas considered included:

– Definition of ‘competence’ under LOLER and how
examination of lifting equipment must be by a ‘competent’ person.
- Riser chairs are not under LOLER as they position, not lift.
- Compatibility of hoists and slings: request this in writing from the manufacturer.
- Anthropometrics and link to sling comfort and fit.
- Lifting client from reclined position to reduce tissue viability risk under thighs, however this can increase risk to staff when seating the client in an upright position.

2006/7 meetings
May (date to be confirmed)
13 July West Suffolk College, Bury St Edmunds
12 October Ipswich Hospital (tbc)
24 January 07 Trumpington, Cambridge
17 May 07 Ipswich

Contact Pippa Stanford
email pippa.stanford@westsuffolk.ac.uk

Lancashire & Greater Manchester
In October, the meeting was kindly hosted by David Lomas of Molift held at Stockport County Football Club. Molift provided a demonstration and practical trials of the Molift product range. Lynn Chivers has to step down as the chair of the group due to work relocation, and Teresa Twigg and Pam Sherliker have agreed to take on this role. The rest of the session was spent problem solving around problem risk assessments in different working areas.

In November, the meeting was kindly hosted by Bob Parsons of Liko, held at Stretton, Warrington. The day included a short introduction to Liko from Bob Parsons and a presentation to Jackie Warwick. Kay James, Freelance Manual Handling Adviser, and an Occupational Therapist, gave an extremely informative presentation on Therapeutic Handling titled ‘Reducing the Risks in Therapeutic Handling’. The afternoon was spent looking at Liko equipment in relation to the subject of Therapeutic Handling.

In December, the meeting was kindly hosted by Angela Vose and Philip Adamson, Wigan MBC. Some of the group attended the Aikaido 1 day workshop by Merrill Poole in November, and this session included feedback from the workshop and some of the techniques were demonstrated and practised.

The group is regularly having discussions re: the management of the fallen person in the community. Due to recurrence of this subject the group are considering hosting a 1-day workshop in July, with the aim of establishing clear guidelines and protocols to be used across the Lancashire and Greater Manchester Area.

2006 meetings
14 March Trafford MBC, Old Trafford – TBC
7 April Molift Stockport
17 May Westholme (Adele Finch)
12 June Chorley & South Ribble
18 July Proposed Management of the Fallen Person Workshop
8 September Centaur (tbc)
12 October Stockport (Judith Henry)

NENE
January: Full day session looking at the Passport Scheme which is in place in Wales. This has been taken up by Northampton General Hospital. The rest of the day was looking at the techniques used by the individual trainers in the group.
May: This session was spent looking at individual Chapters taken from The Handling of People 5th Edition.
July: This was a very well attended day spent looking at the management of falls and the fallen person. We had a talk from a falls co-ordinator and had demonstrations from different companies on equipment used to get people up from the floor. This included Cane & Able MK2 Elevator Recovery System, Williams Rehab Equip Limited lift and transport multi-purpose chair, and also the C-max Universal stair climber.
September: This was a review of our practical handling techniques with a visit from Nordic Services who demonstrated their small handling equipment.
November: This was to have been our AGM but this was postponed until December.
December: AGM Officers position remained the same this year. Elections will take place at the next AGM.

Chair Graham Wheeler
Vice-chair Ann Hancock
Treasurer Kristine Henderson
Secretary Donna Gristwood
Events Organiser Dave Downing

2006 meetings
March date and venue to be confirmed
5 June 11.00 – 16.00 Northampton General Hospital. Office ergonomics
4 September 11.00 – 16.00 Northampton General Hospital. Portable hoists
6 November 10.00 – 12.00 Northampton General Hospital AGM plus Handling in the catering business.

Contact
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Graham Wheele
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West Midlands

3 August – Walsgrave Hospital Coventry
A member of the group shared some work she had undertaken on evaluation of slide sheets for lateral transfers. The group then took part in a lively practical session trying out the slide sheets and sharing techniques used.

6 September – Heartlands Hospital Birmingham
There was discussion on Agenda for Change and the variations in banding amongst the membership, although many members were still waiting to hear. There was a demonstration of the Molift Smart. Unfortunately no money was available to buy!

5 October – Selly Oak Hospital, Birmingham
The discussion at this meeting centred round falls and the falling person.

3 November – Sunrise Medical, Stourbridge
This meeting was the AGM, which was well supported. The group continues to grow and discussion about how to meet the needs of members who have to travel long distances took place. It was decided to have 3 meetings a year that are longer and invite outside speakers. This decision will also help us to spend some of our money.

Sunrise Medical introduced their new range of hoists and various other tools that they have developed.

6 December – UCE, Birmingham
Another well attended meeting. Meetings for next year were discussed and dates set. The group were reminded about NBE conference call for papers, Registered Membership and the Development Day in January.

The discussion today was about the competency of student mentors in the workplace. The group felt that senior managers on some wards were not ensuring good practice and were in fact condoning poor practice and that change would only happened if this was addressed.

2006 meetings

The group meets monthly at various locations around the West Midlands. All meetings are from 2 – 4 p.m. unless otherwise stated. The following dates are planned for the rest of the year.

7 March Centromed turning device, Venue TBA
5 April Westholme day, 10am to 4 pm, Birmingham Centre Independent Living
11 May Topic TBA, Heartlands Hospital Birmingham
5 June TBA
4 July Carole Johnson, HOP 5 tools, Venue TBA
9 August TBA
7 Sept Topic TBA, Compton Hospice, Wolverhampton
5 October Michael Mandelstam Legal issues, venue TBA
7 November Topic TBA, Solihull PCT
6 December TBA

Contact Carol Croshaw, Chair
email carol.croshaw@solihull-pct.nhs.uk
tel 0121 712 8461

London

October 18 A full day was devoted to Tissue viability issues both in the community and Hospital setting. Stewart McGinn Clinical Nurse Advisor to Hertfordshire Equipment Services started the day by giving an overview of the problems between pressure relieving equipment and compatibility of moving and handling equipment necessary to carry out tasks. In the afternoon Krysztos Gebhardt led a discussion on hospital issues. In conclusion, working in partnership with all agencies and agreeing to a compromise became the obvious way forward.

9th November Contrasting Organisational Approaches to Manual Handling in the NHS. Led By Ian Kendall. This session looked at two approaches to training – one classroom-based (University College Hospitals) and the other ward-based (Gwent Healthcare). After various methods of obtaining information on how skills were transferred i.e. interviews, questionnaires, the conclusion/consensus drawn was that the ward-based training provided a better foundation for safer patient handling. There was evidence of more supervision, national and local backing, together with current local issues.

8th December Handling the spinal-injured person led by Derval Russell. This session was aimed at raising awareness of the complex issues involved in the movement of this type of patient/client. The emphasis being placed on teamwork and whoever is taking the lead for management of the individual would be consulted at every stage.

2006 meetings

15 February 6 – 8.30pm DLF Harrow Rd London
Agenda for Change, Knowledge and Skills Framework
16 March 6 – 8.30 pm DLF – How to write a business plan
11 April Full day, St Georges Hospital Tooting – Ergonomic assessments/Risk assessments back in the workplace.
17 May Full day, St Georges Hospital Tooting – Rehabilitation/therapeutic handing.

Contact Rosemarie Scrutton 01707 875172.

Southern

All meetings will be held from 10 am until 2.30 pm unless otherwise stated

London

18 April Guildford
21 June Portsmouth
24 August Guildford
16 October Portsmouth
12 December Guildford

Contact Corinne Winter
email cwinter@royalsurrey.nhs.uk
I first met Michele when she was a ward sister at the Royal National Orthopaedic Hospital, Stanmore shortly before the branch moved into the Middlesex Hospital. In January 1990 she undertook the first five day course, based on the Royal College of Nursing 1988 Syllabus for Training Instructor’s in Patient Handling, organised by Bloomsbury and Islington College of Nursing. From then on she played an important role in trying to reduce the potential risk of back injuries on the Orthopaedic Unit in particular as well as ancillary and nursing staff in general.

She ensured that all the staff nurses completed a 5 day course and liaised closely with the Patient Handling Co-ordinator and Director for Patient Handling Courses. At one point, convinced of the staff’s need for rest when assisting patients with complex orthopaedic problems, she took to blowing a whistle at hourly intervals to ensure that staff nurses and students took a 5 minute break. This was much appreciated by the students and the patients who were grateful for a rest in the proceedings. Her idea for Christmas work’s outings was tea at the Savoy, the Ritz or Browns. She became a member of Back Exchange on the 5th September 1992 and from then on played an important role in the London Group. In 1999 she became Vice Chair of London Group and Chair in 2001.

Michele became responsible for the management and much of the course content and delivery of patient and non patient handling courses at UCLH Trust from 1997. She continued to develop the various training courses for all the staff in the UCLH Trust in the years she was involved in training. Most staff in the Trust knew, and appreciated, Michele’s work. She played a vital role in ensuring that the new hospital was well equipped. There are ceiling hoists over most of the beds in the hospital. She was always ready to give advice, at the bedside, when her expertise was needed by staff.

Members of London Group visited Michele in October 2005 when they went for a walk, with Michele pushing her wheelchair, and her friend’s dog, who kept shepherding them if they fell too far behind. Michele had developed a fine taste in hats and was happy on that day. Michele confided to her friend, in the week before she died, that she was unlikely to live much longer. She died peacefully on Sunday, a few days later, with her friend and a niece with her. Michele had made her wishes known and her funeral will take place on Tuesday 7th February 2006 in a quiet, woodland setting in Hampshire surrounded by her close friends and immediate family. Michele, practical as always, requested no flowers but that donations should be made to Salisbury Hospice or any other Hospice. A Memorial Service will be held in London later. Michele will always be remembered by her colleagues and friends for the positive effect she had on their lives.

Died peacefully on Sunday 29th January 2005 will be remembered by her colleagues and friends for her enthusiasm for life, her spirit and the bravery she showed in the last months of her life. Those of us who knew her and had the privilege of working with her, will never forget her and the courage of her e-mail, which was an inspiration to us in August last year when she knew her diagnosis.

Fay Reid

The Complex Handling Interest Group and Social Care and Community Handling Advisors Special Interest Group have started collecting data and material for a joint project – Managing Falls in the Community. The plan will be to publish guidance that can be used to improve the lot of the fallen person as well as suggest potential improvements in a complex and difficult area.

Following a session held at the National Back Exchange Conference 2005 delegates put forward ideas and offered contact details to be further involved. If you have information on best practice that you are willing to share or have access to data that may contribute to identifying the size and nature of the problem, please contact Sue Green via e-mail at: Sue.Green@hwas-tr.wmids.nhs.uk

Thank you in advance for your support. All material or links used will be acknowledged.

Carole Johnson (Chairman CHIG)
The Principles and Practice of Moving & Handling …
Are you up to date?

A safer lifting environment cannot be maximised without the most profound clinical, legal and product knowledge, as well as practical expertise of the healthcare professional involved with moving and handling patients.

Sunrise Medical, one of the world’s leaders in homecare and extended care solutions, has developed its new ‘Principles & Practice of Moving and Handling’ training course to give all participants the knowledge, understanding and practical experience of safer moving and handling techniques.

Creating a Safer Environment

Validated by industry experts, this practical 3 day course will ensure that all participants:-

- Have a clearer understanding of the legislation relating to Moving & Handling, Health & Safety and Duty of Care
- Have the ability to identify areas of potential risk when handling people
- Have the confidence to demonstrate safer Moving & Handling techniques
- Are able to adapt Moving & Handling techniques according to individual client needs
- Will be able to identify the right equipment to carry out safer Moving & Handling

Dates and Locations:

Taunton:  
Day 1  28th March 2006  
Day 2 - 20th April 2006  
Day 3  23rd May 2006

Bromley:  
Day 1  19th April 2006  
Day 2 - 24th May 2006  
Day 3  15th June 2006

Oldham:  
Day 1  5th April 2006  
Day 2 - 3rd May 2006  
Day 3  7th June 2006

Course cost: £120 plus VAT per day (includes course materials and lunch)  
For details on how to reserve your place, please call 01384 44 65 76  
Alternatively, you can email us: steps@sunmed.co.uk
The integrity of electric actuators on mobile patient hoists

Background

The Medicines and Healthcare products Regulatory Agency (MHRA) issued Medical Device Alert (MDA) MDA/2005/024 on 18 April 2005. This ‘Alert’ drew attention to the potential for electric actuators to fail without warning, causing a sudden dropping of the hoist boom. Serious injury to patient and/or carer might result. On some occasions serious patient injury has occurred.

Suppliers and maintainers of such devices were prompted to identify mobile hoists with electric actuators to establish their usage rate and thus decide whether actuator replacement was necessary.

The MDA Alert documentation stated that all reported failures involved hoists with inclined electric actuators. Investigations showed that failures were influenced by usage (number of lifting cycles) rather than actuator age. The raising and lowering of a patient is one lifting cycle.

Inappropriate handling and lack of proper servicing presents a risk of damage and fatigue failures. Sudden failure of the actuator can result from excessive wear of the actuator mounting points.

Hoists do not have counters; therefore establishing ‘life’ from lifting cycles can be difficult. Although they are examined under the Lifting Operations and Lifting Equipment Regulations (LOLER), an internal examination of actuator components is prevented by their sealed design. This means that wear may go undetected until sudden failure occurs.

The action necessary, involved identifying mobile hoists with electric actuators and contacting the manufacturer with a model and serial number, its usage rate and age. With this information the manufacturer would be able to determine whether the actuator was due for replacement.

Actuators which have performed 10,000 cycles should be replaced, unless the manufacturer has advised that design/service life can exceed 10,000 cycles.

Should contact with the manufacturer be no longer possible, a risk assessment should take place to determine the need for actuator replacement. Refer to guidance in MHRA Medical Device Alert MDA/2005/024.

Future inspections and servicing should review the need for actuator replacement.

BSEN ISO 10535: 1998 is a standard that hoists should conform to in achieving a minimum of 10,000 lifting cycles.

Issues arising from MDA/2005/024

In response to the MHRA notice and subsequent discussion, Arjo invited moving and handling advisers and other health and social care professionals from NHS Trusts, Social Services and the private sector to a seminar which took place in Gloucester on Friday 23 September 2005. The day consisted of presentations from the MHRA and the HSE, and invitees took part in an open debate on the subject.

Questions had been raised about whether the Alert applied only to ‘inclined actuator type’ mobile hoists and also concerning the numbers of hoists involved with failures.

Arjo’s Marketing Director Steve Oldershaw facilitated the event. He was supported by Tony Hamer, Arjo’s Technical Compliance Manager.

Phil Papard, Principle Inspector from the Health and Safety Executive and John Ward, Senior Medical Device Specialist, also attended and gave explanatory presentations.

Key comments PHIL PAPARD (HSE)

UK health and safety legislation is largely ‘goal setting’. It is therefore up to manufacturers how they comply with legislation to achieve the risk reduction. The UK and the EU supply Directives prefer this approach as descriptive legislation can inhibit innovation.

A care worker has a duty of care to ensure that the equipment they use is safe to the extent that it is free from defects they can see or have been made aware of.

Key comments TONY HAMER (ARJO)

Arjo equipment is designed so that it does not compromise the safety of the patient and the operator. Their risk assessment approach involves research and design, quality management and service and maintenance.

The CE mark on equipment indicates conformity with the Medical Device Regulations encompassing ergonomics, safety and other technical requirements.

Arjo equipment has a ‘limiter’ which prevents it from being overloaded. An anti-crush device is also fitted.

Various tests are carried out on lifting equipment for fatigue and durability. Lifting equipment is also tested for stability; being tilted 10 degrees forwards and backwards and 5 degrees sideways under load (tilt test).

The new Arjo Maximove has a ‘minute meter’ that displays the total motor usage time. It is therefore a useful auditing tool and can be used as an accurate lift cycle counter.

Arjo report that there have not been any
Actuator failure incidents on their hoists as well as their baths.

Actuators for Arjo Lifts operate from a 24 volt motor which rotates a threaded shaft with a ball screw device that supports the load when the patient is lifted and lowered. Failure of this particular type of actuator will not result in sudden, rapid loss of height due to a specially designed ‘safety nut’. Should a failure occur, then it would be possible to lower the person to safety.

The reported failures have been exclusively on inclined actuators. Because actuators are sealed units, wear cannot be readily identified.

Arjo advocate good engineering control over the risks associated with actuator failures by establishing good maintenance procedures.

Key comments JOHN WARD (MHRA)

Whilst it is not possible to detect evidence of wear inside an actuator, it is possible to make observations to fixings which, when showing signs of wear can contribute to actuator failure.

John Ward made reference to eight incidents where electric actuators had failed on ‘inclined actuator type’ patient hoists. Five failures may have been preventable if observations had been made of actuator fulcrum points. Wear in this area can cause torsional movement of the actuator and as a consequence of this movement, internal damage can occur. Inspection and possible misuse may be a contributory factor in causing the actuator to have fractured in two.

Phil Papard (HSE) pointed out that good maintenance and appropriate use was the key to preventing actuator failure and that vertical lifts of the design type described by Arjo, were less of a concern because of the large numbers in use and the lack of failure evidence. Furthermore, their design seems more robust at preventing a sudden dropping of the lift arm provided appropriate action is taken if the actuator fails onto the safety nut; i.e. provided the operator does not continually try to raise/lower the unresponsive hoist.

Summary

Actuator failures have been reported to MHRA. Patient injury has resulted, eight hoists were involved. These had inclined actuators and maintenance was a major factor.

There has been some confusion on how best to act and which hoists required attention. This confusion may have arisen from the way the Medical Device Alert was read and interpreted.

Damage to electric actuators cannot be observed because they are sealed units. Fulcrum points however can be inspected for wear. This wear may cause movement of the actuator thus causing internal damage leading to sudden failure. When this happens on inclined actuators the hoist boom suddenly drops. No failures have been reported on Arjo hoists and baths.

Action

- Observe maintenance / service procedures
- Ensure LOLER inspections take place
- Carry out routine pre-use checks of equipment
- Receive training in the use of equipment
- Do not move or manoeuvre an ‘inclined actuator type’ hoist by pushing or pulling sideways on the boom
- Make sure equipment is appropriate for the job
- Use equipment with care and safety in mind
- Follow the MHRA instructions in order to establish the age, annual number of lift cycles and whether actuator replacement is necessary
- Follow manufacturers instructions for equipment use and product care
- Seek manufacturers advice whether your hoist is an ‘inclined actuator type’ or a vertical lifting device

Report compiled by:

Bill Varnam
Back Care Adviser
Rehabilitation, manual handling and changes to the NHS

Few readers of the Column could fail to be aware that the NHS is in the grip of major change. Some call it modernisation, others improvement, still others destruction – all depending on your point of view. At least four major issues have arisen during the financial year 2005-6.

First, on 28th July 2005, Sir Nigel Crisp at the Department of Health signalled – in a much discussed letter (Commissioning a patient-led NHS) to Primary Care Trusts (PCTs) – that central government wanted to see a move away from directly provided services and directly employed staff. Instead it wanted highly diversified provision with full use being made of the independent and private sectors.

Second, as 2005 progressed, central government became increasingly agitated about ‘overspending’ by NHS Trusts (of various types) which, by December 2005, was reported to be in the region of some £750 million and rising – across England (still less than 1% of the NHS budget). One reason for this agitation seems to be that NHS competition with the private sector – which Patricia Hewitt (Health Secretary) wants to implement – is not regarded as viable unless financial balance in Trusts is achieved (Carvel 2005).

Third, a White Paper is imminent in early 2006. It will be about ‘care outside hospital’. Fourth, the merry-go-round of organisational change – and the disruption it brings to frontline services – continues. Primary Care Trusts are due to be restructured during 2006. The consequence will be fewer PCTs and in some places an effective return to the old health authorities that PCTs replaced some five years ago.

So, how much does all this concern those working in the manual handling field? A great deal, it would appear. Rather than trace out the implications in vague policy talk, it might be helpful by way of example to consider what is happening in West Suffolk.

Faced with an annual overspend off over £20 million, Suffolk West Primary Care Trust is poised to implement a number of drastic proposals (Suffolk West PCT 2005).

These include the following: closure of all 16 rehabilitation beds at Newmarket Hospital, closure of 55 rehabilitation and elderly care beds at West Suffolk Hospital (Bury St Edmunds) – and closure of St Leonards and Walnuttree Hospitals in Sudbury, with the loss of 68 rehabilitation and elderly care beds. (West Suffolk is not an isolated example; readers may be aware that around the country some 90 community hospitals are under threat, with ward closures, often affecting older people, rehabilitation and manual handling, and staff redundancy imminent in acute hospitals as well).

The PCT seems to be arguing that, apart from acute rehabilitation (at West Suffolk Hospital), rehabilitation can be carried out in people’s own homes in the form of intermediate care (with its general six-week limit). In a small number of cases, it conceives that it might have to spot-purchase beds in care homes. It is this sort of approach that should concern those in the manual handling field and, in particular, those concerned with rehabilitation.

It is uncontroversial that rehabilitation in people’s homes, in the form of intermediate care, is both desirable and effective for some, perhaps, many people – if it is properly funded. In this latter respect, the reader may wish to consider that Suffolk West PCT proposes in the Sudbury area 1.5 physiotherapists, 1.5 occupational therapists and a shared therapy assistant – to provide intermediate care/rehabilitation for a local population of some 50,000 people and rising (Suffolk West PCT 2005a).

It is equally clear that rehabilitation in people’s own homes is neither possible nor practicable for everybody (Chamberlain et al 2005). For instance, there may be a lack of space for staff or equipment, an otherwise unsuitable environment, family dynamics, lack of able and willing informal carers, pets.

Heavy rehabilitation equipment may be required, which it is either simply not possible or practicable for peripatetic staff to transport in and out of people’s own homes. For instance, plinths, tilt tables, sit to stand hoists and parallel bars would come into this category. The equipment that is portable typically has significant limitations. For instance, some plinths may be portable, but are non-adjustable and not meant for constant carrying, assembly and disassembly. And portable parallel bars will be too unstable for use with many patients.

Equally, there may be no potential for rehabilitation within six weeks (a widespread criterion for intermediate care) for various reasons (pace of progress against amount of rehabilitation required, ‘slow starters’ due to weakness following an acute episode, malnourishment, recovery from acute episode etc).

Rehabilitation requirements may be intense, requiring intensive, expert input – which cannot be practically delivered in people’s geographically dispersed homes (particularly in a rural area). There may be a degree of medical instability (but insufficient for acute hospital bed occupancy), mental health complications (eg. dementia, depression), drug cocktails and toxicity to be managed, 24-hour re-education and reorientation to be managed etc – all of which, too, may be impractical or impossible to manage in people’s own homes (Walnuttree Hospital Action Committee, 2005).

Indeed, Suffolk West PCT’s own eligibility criteria anyway formally exclude people from intermediate care on a number of the above grounds – including an unsuitable home environment where staff or patients would be put at risk by rehabilitation activity (such as manual handling).

In addition, the alternative of increased rehabilitation apparently being proposed by Suffolk West PCT in acute hospitals is implausible. First, a significant number of older people requires slower stream, non-
acute rehabilitation in a quieter and more stable setting than is generally provided by acute hospitals. Second, readers of the Column will know that neither central government, nor NHS Trusts take kindly to older people with complex and multiple needs occupying acute hospital beds for any length of time. It is in any case contrary to government policy on intermediate care to increase the use of acute hospital beds in this way (HSC 2001/01).

Third, some recent studies show the efficacy of community hospital rehabilitation (Green J et al, *Effects of locality based community hospital care on independence in older people needing rehabilitation: randomised controlled trial*, BMJ, 6th August 2005, 317-322; Young et al, *Cost effectiveness: study on community hospitals, a randomised controlled trial*, publication pending, 2005). And a national study by the Commission for Social Care Inspection has shown the efficacy of focused use of community hospitals for recovery and rehabilitation closer to people’s homes (CSCI 2005).

Fourth, a local report commissioned by Suffolk West PCT and West Suffolk Hospitals Trust, published in late 2003, identified that therapy resources in West Suffolk (including at the acute hospital) were so stretched that a basic rehabilitation service was not being provided (Secta 2003). Notwithstanding this report, the West Suffolk Hospitals Trust is now implementing closure of a further 55 rehabilitation and elderly care beds at the acute hospital, together with the loss of some 260 jobs (including, potentially, therapists). All this seems to illustrate only too well the plight of rehabilitation in some acute hospitals.

The further alternative of rehabilitation in care homes is of course possible – for example, block purchase of beds in a specialist home – with dedicated rehabilitation space, facilities, equipment and staff as demanded by the national minimum standards for care homes (Department of Health 2003). But Suffolk West PCT proposes no such thing: it talks only of the spot purchasing of standard nursing home beds (which is likely to be clinically inappropriate, unreliable and expensive). Likewise day hospital attendance, for rehabilitation purposes, will be possible, practicable and effective only for some people.

In conclusion, why draw the Column reader’s attention to this local Suffolk example? First, it would be reassuring (except in Suffolk of course) if the Suffolk West PCT was acting in a maverick fashion. However, it appears that it is by no means an isolated case and may well be an unwelcome harbinger of things to come in some (and maybe many) other parts of the country. Second, manual handling and equipment are a crucial part of people’s rehabilitation. Yet the absence in people’s own homes of space for staff, equipment and safe manual handling may preclude the rehabilitation that would otherwise have been achievable through focused rehabilitation in a more appropriate setting.

It would seem inescapable that a balanced approach to rehabilitation would recognise that different people have different needs – which may need to be met in a variety of settings. However, the consequences of an over-simplistic, ‘one-size fits all’ approach proposed by some PCTs are likely to be highly detrimental. It is an approach that falls precisely into the trap warned against by the Audit Commission which recognised the need for ‘sufficient inpatient rehabilitation services for older people, complete with comprehensive multi-disciplinary assessment, specialist medical and nursing input and ‘intensive therapy’. In short, they (intermediate care services) should act as an extension to specialist clinical care and rehabilitation, and not as a substitute for it (Audit Commission 2000, italics added).

Manual handling advisers, therapists, district nurses and others may find themselves increasingly involved in risk assessments that preclude people receiving the rehabilitation they need – because of unsuitable home environments. If those professionals then ask what will become of those patients who require manual handling for rehabilitation, they may receive the glib answer apparently being provided by some risks managers within the NHS: “you shouldn’t be handling patients anyway”.

Michael Mandelstam is an independent consultant. He is author of various books including *Occupational therapy law and good practice* (2005), *Community Care Practice and the Law* (3rd edition, 2005), and *Manual Handling in Health and Social Care: an A-Z of law and practice* (2002). He is an active member of the Walnuttree Hospital Action Committee. He can be contacted at: michael.mandelstam@btinternet.com.


A new venue... and a new look

This three day Conference is a must attend event for our members and all those working in, or who have an interest in, the field of moving and handling. The theme is ‘Working in Partnership’ which reflects the need for those working in associated fields of practice e.g. tissue viability, infection control, pain management, risk management etcetera, to work together with NBE to deliver quality care.

Therefore, conference will consider the effect and impact of these multi-faceted issues on the safer handling of clients in a variety of settings and how working together can help deliver workable solutions.

Conference will feature strategic plenary, practical workshops and, new for 2006, streamed presentations which will allow delegates to attend sessions particularly pertinent to their sphere of work, and so makes the most effective use of their time to enhance their conference experience.

Featuring a wide range of presenters from different disciplines, reflecting the need for professionals to work together, the conference will be an educational and thought provoking experience to update both theoretical and practical knowledge and skills.
The International Centre, Telford is a purpose built exhibition and conference venue situated in the West Midlands, close to the heart of the motorway network. The centre’s numerous conference suites are all situated adjacent to the main exhibition hall, allowing ample space for seminars and related events. Add all this to the excellent registration and technical facilities, and an organiser’s office, and we will have the perfect venue for the forthcoming National Back Exchange 2006 Conference. In addition to the conference suites and exhibition halls, the centre has two on-site hotels, the Holiday Inn and International Hotel, providing 251 bedrooms a short walk from the exhibition halls and conference suites plus a range of other accommodation nearby.
A one day moving and handling conference focusing on the management of postural load in health and social care, based on the Dutch best practice guidelines, held at the NEC Hilton Metropole on 29 November 2005.

Conference opened with a presentation by Nico Knibbe, a physical therapist and international presenter, and also a director of LOCOmotion Ltd, based in Holland. After introducing us to a few simple words in Dutch, Nico first explained the ‘Arbeid en Gezondheid voor de verpleeg- en verzorgingshuizen’ [Work and Health for Nursing and Care Homes] collective labour agreement and the ‘Convenanten Arbeidsomstandigheden zorg’ [Covenant for Working Conditions in Care] which state that every care establishment in Holland must draw up a method statement in order to limit the physical load on carers. He went on to consider the extent to which static loading was a risk factor for work related musculoskeletal disorders. Nico reported that research into static loading requires a very labour intensive measuring tool, and has not yet been carried out in Holland to any great extent. However, in 1994, Engels et al carried out research into static loads on carers in...
used a great deal in Holland. Nico pointed out that this results in the carer standing in a flexed and / or rotated posture for nearly 70% of the time. The least hazardous postures were observed when using a manually-operated hydraulic highflow shower chair.

Nico stated that using the standard low and non-adjustable shower chair, the carer was observed to adopt a neutral upright position only 30% of the time, which increased to 58.8% with the use of a height-adjustable chair. This represented an increase of 28.8% in the time during which work was carried out in a ‘physically healthy way’. It was significant that not only was the amount of time spent in flexed / rotated postures reduced in respect of each task, but the overall time spent carrying out each task was also reduced.

Nico then quoted a separate study, *Gaining time & reducing physical strain by using height-adjustable hygiene chairs* which was carried out, again using OWAS.

Measurements, for washing/showering ten residents, five with a mobility level D and five with a mobility level C from long term elderly care wards of two hospitals.

For this research, five residents with mobility level D were washed on the bed, three of whom were washed by two carers. One carer washed the other two residents, though from a physical strain point of view, two carers should have washed them as well. When comparing the number of care minutes, washing residents with mobility level D on the bed takes an average of 36 minutes per resident, including the time needed by the second carer. In short:

**Washing on the bed**

**Mobility level D** 36 minutes

Of the residents with mobility level C, one was washed by two carers, two residents were washed by one carer and for the remaining two residents, a second carer was present for half of the time. When comparing the number of care minutes, washing residents with mobility level C on the bed takes an average of 31 minutes per resident, including the time needed by the second carer. In short:

**Washing on the bed**

**Mobility level C** 31 minutes

The research also looked at the benefits in terms of staff numbers and time taken in relation to specific individual chairs, some of which showed significant greater savings of up to 14 minutes per resident per wash / shower. In addition, the OWAS analysis showed that when washing on the bed, over 60% of the time was spent adopting ‘unhealthy postures’ compared to 90% of the time in ‘healthy postures’ when using the selected height adjustable hygiene chairs, even for relatively inexperienced carers, although Nico stressed the need for appropriate postural and product related education/training. He concluded that:

- The total number of care minutes when showering residents on an ergonomically sound height-adjustable hygiene chair is substantially lower than for washing residents on the bed. Carers gain up to 14 minutes per resident.
- For showering residents on one specific hygiene chair, only one carer is needed to complete the entire shower, while very often a second carer is needed for washing residents on the bed.
- Earlier studies have shown that carers spend significantly less time in unhealthy postures when washing residents on a height-adjustable hygiene chair instead of on a bed.
- Further research has shown that even inexperienced users can complete the entire daily care in a physically safer way when using ergonomically sound height-adjustable hygiene chairs.

**Other considerations**

- Quality difference between showering and washing on the bed: this study did not take into account the significant quality advantage of showering when it comes to personal hygiene.
- Showering is healthier for the patient’s skin because soap residue is better cleared.
- Patient comfort: this study did not take into account the significant quality advantage of seated showers in respect of patient experience.
- Active intervention programmes can reduce the physical strain on carers.

**Mobility gallery**

Hanneke Knibbe (Nico’s sister and co-director of LOCOMotion) and Nico then revisited the Mobility Gallery (we are probably all familiar with mobility classes of the basic elderly care series, represented by Albert, Barbara, Carl, Doris and Emma), a classification system which reflects fives notional stages of mobility between independence / dependence of those in receipt of care, although it is accepted that within each class.
there will be some variation so that person-specific risk assessment must always take place.

Hanneke explained that the Mobility Gallery series had been extended to cover home care, residential care, hospital care and bariatric care (the Bariatric Gallery can be viewed at www.arjo.co.uk), each based on the mobility classes A to E (see below), and she explained how careful analysis of the categories of patient/resident in a particular care environment can inform the equipment selection process.

A This person is able to perform daily activities independently. Special aids or appliances may be needed
- Ambulatory, but uses a cane for support
- Independent, he can clean and dress himself
- Physically and mentally active
- Tires quickly
- Continent
- Requires careful monitoring

B This person is not capable of performing daily activities without help.
- Uses a walking aid of some description
- Can support herself to some degree
- Dependent on handler who is present in demanding situations
- Not physically demanding for handler

C This person is not capable of performing daily activities without assistance, but is able to participate in the activity or perform part of the routine independently.
- Sits in wheelchair
- Is able to partially weight bear on at least one leg
- Has some trunk stability
- Dependent on handler(s) in most situations
- Physically demanding for handler
- Needs equipment to cope with loss of mobility and to protect his handler from transfer-related injuries
- Very important to stimulate remaining capacity and slow down deterioration of mobility

D This person is not capable of performing daily activities independently or to actively participate in these routines.
- Sits in wheelchair
- No capacity to support herself
- Cannot stand unsupported, no ability to weight bear
- Dependent on handler in most situations
- Physically demanding for handler
- Needs passive equipment to manage loss of function and to protect handlers

E This person is not capable of performing daily activities independently or to actively participate in these routines
- Passive
- Might be almost completely bedridden
- Often stiff contracted joints
- Totally dependant
- Physically demanding for handler
- Stimulation and activation is no longer a primary goal

The Care Thermometer
For the final presentation of the day, Hanneke introduced the Care Thermometer, an Excel based audit tool for providing a reliable overview of the current situation in a ward / facility in respect of residual physical care load and preventive policy. This is a tool that has been developed by LOComotion and published in 2005. Hanneke stated that one of the most important starting points for the design of a preventive policy is an assessment of the type and amount of assistance that patients require, which she summarised as ‘physical care load’. In order to calculate the physical care load, the updated Mobility Gallery is used to assess and classify all patients within the relevant facility.

The second fundamental issue for the policy design is to review the measures already in place in terms of equipment provision and managing handling risk. The Care Thermometer considers the availability of different types of equipment and relates this to the mobility level of the patients, and therefore to the physical care load. She added that, in addition to the provision of sufficient suitable equipment, the prevention and reduction of occupational risk also related to the maintenance / rehabilitation of the patient population.

Hanneke estimated that experienced users will require about 20 minutes to make a full ward assessment, but by covering all the wards within a particular facility it would be possible to gain an organisational overview. The process involves entering data in response to particular questions, but no calculation is necessary as the results are generated automatically, including the production of graphs and tables. By reviewing the graphs and analysing residual care load, it would be possible to produce an evidence base for the purchase of additional equipment, or redistribution of equipment, or the need for further training and instruction.
Many NBE members know the name “Christine Tarling” (Chris to her many friends), especially those of you in the Northern group. For those of you who don’t, here’s a bit of background, to help explain her influence in the manual handling field as well as in occupational therapy.

Chris trained as an occupational therapist on the sixties and soon “made her mark” setting up the first national equipment exhibition at the DLF in 1970.

Her career and private life since then encapsulate the wonderful woman we all know – quietly doing incredible things in every aspect of her life, and never seeking acknowledgement. These are just some of her achievements:

- Writing many influential publications over the years, including one of the first texts on hoisting, and contributing chapters to many editions of ‘The Guide to the Handling of Patients’
- Teaching in a variety of domains, such as setting up and teaching on an MSc and BSc course in Iran and a ‘train the trainers’ manual handling course at Northumbria University (a course she helped put together)
- A career devoted to clinical work with patients, which never lost its focus, even when managing services.
- Humanitarian work carried out over her lifetime and is ongoing in retirement. Examples of work she has been part of are 3 years VSO work in India, work looking at the rehabilitation needs of disabled men in the USA following the Vietnam War. Her allegiance remains ongoing with Soroptomist International, including work projects removing landmines, setting up a girls home for abused women in Israel (whatever their creed), and a project to support homeless women in Newcastle.
- Tirelessly working for her professional body – The College of Occupational Therapists.

These are only some of the reasons why Chris has been awarded the highest award possible within her Profession – “Fellow of the College of Occupational Therapists”.

Jan Spencer OT Professional Lead, Calderdale and Huddersfield NHS Trust

NBE would like to congratulate Christine on her very well deserved award, and to recognise her significant role in the development of Northern, and then National Back Exchange.

Christine Tarling
Fellow of College of Occupational Therapists

Congratulations

Christine Tarling
Fellow of College of Occupational Therapists
Increased mental ill-health may be down to diet changes

Changes to the human diet in the last 50 years could be an important factor behind the major rise of mental ill-health in the UK.

As new figures show mental ill-health is costing the UK almost £100 billion a year, The Mental Health Foundation and Sustain claim that dietary changes may hold the key to combating specific mental health problems including depression, schizophrenia, attention deficit hyperactivity disorder, and Alzheimer’s disease.

In recent decades, significant changes in the way food is produced and manufactured have reduced the amounts of essential fats, vitamins and minerals consumed and disturbed the balance of nutrients in the foods eaten. At the same time, the UK population is consuming less nutritious, fresh produce and more saturated fats and sugars. According to the Mental Health Foundation and Sustain, new substances, such as pesticides, additives and trans-fats, have also been introduced to the diet. These can prevent the brain from functioning effectively.

Dr Andrew McCulloch, Chief Executive of the Mental Health Foundation, says: “We are well aware of the effect of diet upon our physical health, but we are only just beginning to understand how the brain is influenced by the nutrients it derives from the foods we eat, and how our diets have an impact on our mental health.”

The Mental Health Foundation and Sustain are calling for a major shift in national policy and practice to make nutrition a mainstream factor in mental health care and promotion.

ELMS2 extends community support service for Red Cross

With the support of healthcare IT provider, Ethitec, and its equipment loan management system, ELMS2, the British Red Cross has secured two new contracts for its community equipment operations.

The extension of services means five integrated community equipment services managed by the British Red Cross has now benefited from ELMS2.

Matt Davis, national customer care manager for the British Red Cross, explains: “We’ve been using ELMS here in Leicester since 1990. The consistent performance of the system and Ethitec’s commitment to supporting us means we

PRODUCT REVIEWS

Products included in this section have been reviewed by a professional group of National Back Exchange members.

Inclusion of a product does not mean that the product is endorsed or recommended by National Back Exchange and no responsibility is assumed for any injury, loss or damage arising from any use of the equipment described. It is the responsibility of the purchaser to undertake adequate investigations regarding the suitability of equipment before purchase. The reviewers were Jean Bish (Product Review Editor), Julia Love, Linda Ward and Carol Foster

Ferno Compact 1
Carrying Chair

Type of product
Folding carrying chair

Manufacturer/Supplier
Ferno UK

Brief description
Compact carry chair for transferring clients, one piece back and seat panel

Ease of transport (without load)
Folds easily together for carrying (weight 9.5kg)

Manoeuvrability (with without load)
7” wheels for stability and ease of manoeuvring. Handler requires to tip client in chair to find point of balance on wheels for good manoeuvring

Comfort of client
Comfortable. When client tilted back for carrying downstairs, clients neck may go into flexion if too close to handler at back of chair

Dimensions
Height 93.5cm • Depth 42cm • Width 44.5cm • Weight – 9.5kg

Storage
Folds into compact size for storage (Height 77.5cm • Width 44.5kg)

Safety features
— Safety strap for use with client can also be used to keep chair in folded position
— Safety rings prevent collapse of chair if locking mechanism fails

Price
£331 + VAT

Additional comments
— Replacement covers available if damage occurs

Ferno Falcon Six
Stretcher

Type of product
Ambulance trolley

Manufacturer/Supplier
Ferno UK

Brief description
Ambulance trolley with hydraulic, height
adjustable raise/lower mechanism. It also has a gas assisted back rest for ease of positioning.

**Ease of transport (without load)**
Very easy to manoeuvre with 4 independently pivoting wheels

**Manoeuvrability (with without load)**
Easy to manoeuvre with 2 operators, Extendable push / pull handles, that fold down and clip underneath trolley

**Comfort of client**
Comfortable padded stretcher. Gas assisted back rest easily adjusted up to 75°. Knees can be brought into flexion using straps clearly indicated at both sides of trolley

**Dimensions**
Overall length 191.5cm • Folded length 145cm
Overall width 53.3cm • Minimum height 46cm
Weight (excluding mattress) 56kg
Max load 181kg

**Storage**
Remains in ambulance for storage

**Safety features**
- Removable 4 point body harness
- 3 safety belts
- 2 locking wheels at opposite corners of trolley
- Side rails (fold down)
- Digital tracker – records the number of raise lower cycle, measures use & advises servicing schedule

**Does this equipment achieve its purpose**
Yes – very effective

**How easy / difficult is the product to use**
Very easy to use, safety straps easy to apply and adjust. Positioning with knee flexion easily operated. Back rest very easy to adjust.

**Noise**
Very quiet

**Maintenance**
Each trolley has its own service history book (similar to a car service book) which details time of service either by number of cycles performed or by length of time since purchase

**Battery: charge times, life, No of lifts, etc**
Life of trolley approx 5 years – incentive given by Ferno for a full service history after this time

**Cleaning and washing instructions**
Full and comprehensive decontamination instructions included in service history book

**Accessories / options**
Paediatric accessories – specific harness attachments or children • Intravenous drip pole can be attached to trolley

**Compatibility with other equipment**
Ambulance – with locking device

**Price**
Trolley £5,249.78 • Mattress £213.71
Total £5,463.49 + VAT • Locking device (2 piece) for ambulance £1,889.47 + vat

**Additional comments**
- When client on the ground they need to be manually lifted onto the trolley using a scoop or spinal board. (height from ground to trolley bed at lowest level is 580mm)
- Full comprehensive user manual supplied with equipment
- Training and risk assessment essential prior to use

Ferno Pegasus Trolley

**Type of product**
Lift assist ambulance trolley

**Manufacturer/Supplier**
Ferno UK

**Brief description**
Light weight Ambulance Trolley with hydraulic, height adjustable dual action raise/lower mechanism. It also has a gas assisted back rest for ease of positioning.

**Ease of transport (without load)**
Very easy to manoeuvre with 4 independently lockable pivoting wheels

**Manoeuvrability (with without load)**
Easy to manoeuvre with 2 operators, Extendable push / pull handles, that unfold easily and can be folded down and clipped underneath trolley when not in use

**Comfort of client**
Comfortable full welded padded mattress stretcher. Gas assisted back rest easily adjusted up to 75°. Detachable contoured head support can be reversed to provide extension of trolley. Knees can be brought into flexion using straps clearly indicated at both sides of trolley

**Dimensions**
Overall length 192cm • Folded length 145cm
Overall width 59cm • Minimum height 47cm
Weight (excluding mattress) 60kg
Max load 200kg

**Storage**
Remains in ambulance for storage

**Safety features**
- Bi-lateral dual action foot pedal for raise/lower allows both operators to operate mechanism together for heavier clients
- Removable 4 point body harness
- 3 safety belts
- 4 pivoting & locking wheels
- Contoured Side rails (fold down)
- Digital tracker – records the number of raise lower cycle, measures use & advises servicing schedule

**Does this equipment achieve its purpose**
Yes – very effective

**How easy / difficult is the product to use**
Very easy to use, safety straps easy to apply and adjust. Positioning with knee flexion easily operated. Back rest very easy to adjust. Extending push/pull handles very easy to assemble and fold away under end of trolley

**Noise**
Very quiet

**Maintenance**
Each trolley has its own service history book (similar to a car service book) which details time of service either by number of cycles performed or by length of time since purchase

**Battery: charge times, life, No of lifts, etc**
Life of trolley approx 5 years – incentive given by Ferno for a full service history after this time

**Cleaning and washing instructions**
Full and comprehensive decontamination instructions included in service history book

**Mattress covering welded at each section for infection prevention**

**Accessories / options**
Paediatric accessories – specific harness attachments or children • Intravenous drip pole can be attached to trolley

**Compatibility with other equipment**
Ambulance – with locking device

**Price**
Trolley £5,262.32 • Mattress £207.48
Total £5,733.80 + VAT • Locking device (2 piece) for ambulance £1,889.47 + vat

**Additional comments**
- When a client is handled from the ground they need to be manually lifted onto the trolley using a scoop or spinal board. (height from ground to trolley bed at lowest level is 540mm)
- Full comprehensive user manual supplied with equipment
- Training and risk assessment essential prior to use
Slip, sliding away... you know the nearer your destination, the more you slip sliding away... the immortal words of Paul Simon.

In the moving and handling paradigm the introduction of glide sheets takes the professions by storm. We humbly hailed the nativity of such ingenious devices and started to train others in their uses. Thomas S. Kuhn (1922-1996) once postulated in his classical work “The structure of scientific revolutions” that the progress of science and technology is not a steady, cumulative acquisition of knowledge. In fact it was a series of peaceful interludes punctuated by intellectually violent revolutions.

He espoused that when knowledge grew, anomaly grew with it. When this anomaly had escalated to such a dimension that it could directly rival the ‘original’ knowledge and values, it would cause significant discomfort for the community who share these knowledge and values. If unchecked, the growth of the anomaly would manage to unsettle the very foundation of a paradigm, a violent shift might result. In Kuhn’s terms, a paradigm shift.

Without a doubt, just for the moment, the various glide sheets available to us serve us well. If used to transfer our patients horizontally it helps to lessen the risk of back injuries. If we take on a more searching view, is there any anomaly? It often is not the item itself but the way we use it? The following research papers aim to scientifically verify and evaluate the merits and efficacy of various glide sheets. Have we found any new answers? Enjoy…….

Gabriel Ip (literature review – sub editor)

TRANSFER OF THE HORIZONTAL PATIENT: THE EFFECT OF A FRICTION REDUCING ASSISTIVE DEVICE ON LOW BACK MECHANICS

McGill SM, Kavcic NS

Recognising that the transfer of bedridden patients is associated with a high rate of low back injuries, various devices have been developed to assist with sparing the patient handlers. The purpose of this study was to quantify the friction-reducing ability of three different ‘sliding’ patient transfer devices together with the subsequent consequences on the low back loads of people performing the transfers.

Coefficients of friction of the devices were determined by ‘transferring’ a standard object and a ‘patient’ over several surfaces common to a hospital setting. Then three participants performed controlled transfers with the various devices. Electromyography to measure muscle activation levels together with external forces and kinematic positional data were collected during push, pull and twist transfers. Spine loads were estimated with a three-dimensional biomechanical static link-segment model of the human body.

Simply sliding a patient on a cotton sheet (control condition) produced a coefficient of friction of 0.45. The assistive devices substantially reduced friction by well over one-half (coefficients of 0.18-0.21). However, when using the devices the subjects adopted a variety of postures and techniques, such that there were no consistent influences on trunk inclination, low back compression or muscle activation profiles. Direct measurement of reduced friction between the bed and the patient with a friction-reducing device together with measurement of the back loads when actually transferring a patient formed a proof of principle. Specifically, while the device lowers friction, the transfer technique adopted by the lifter must be proper to reduce low back loading and any subsequent risks of back troubles associated with patient transfers. The direction of hand forces and torso position remains important considerations.

DETERMINING WHAT SHOULD BE TAUGHT DURING LIFT-TRAINING INSTRUCTION

Lorenz EP, Lavender SA, Andersson GB

Every year many workers who perform manual materials handling tasks receive...
training on lifting techniques. The goal of these training programs is to reduce the biomechanical loads experienced by the spine, thereby reducing the potential for low back injury. The purpose of this article was to determine the effectiveness of specific lifting techniques used in the training of 955 material handling workers at 14 grocery, retail, and beverage distribution centres in controlling the three-dimensional spine moments experienced during simulated work tasks.

Each subject underwent up to 5 one-on-one training sessions with a coach over a 12 month period (time = 0, 1 month, 3 months, 6 months, and 9 months) while instrumented with the LiftTrainer TM biofeedback system. This PC-based system quantified the tri-axial moments at L5/S1 as trainees lifted and provided the coach with real-time audio feedback and post-lift charting to quantify progress.

The coach used the objective data in guiding the trainee towards behaviours that reduced one or more of the directional moments. Within each training session, the coach suggested several different techniques to be used.

At the completion of the session each trainee was rated on a 4-point scale as to how well each of the techniques was adopted. These scales became the independent variables in three multiple regression analyses used to determine which techniques account for the within session change in the moment values and which could best be used to predict performance at the end of a session.

Results indicated that trainees should be taught to slide boxes close prior to lifting, move the box and body together, initiate the lift by shifting the gaze upward, and think strategically about the lifting task in order to reduce the forward bending moments.

**REDUCED PUSH FORCES ACCOMPANY DEVICE USE DURING SLIDING TRANSFERS OF SEATED SUBJECTS**

Grevelding P, Bohannon RW


**Purpose** Research verifying the ability of various devices to reduce the forces required for transfers is virtually nonexistent.

Therefore, we compared the push forces required to move passive seated subjects across a horizontal surface when four different methods were employed.

**Subjects** 10 men and 14 women (weight 49.1-96.8 kg) served as subjects.

**Methods and materials** Passive subjects were moved horizontally across a treatment table that had a vinyl-covered foam mat on top. They sat either directly on the mat or on a vinyl sliding board (Ross Easy Glide), on a fabric tube (Ross Mini-Slide), or on a fabric tube on top of a sliding board on top of the mat. Subjects were pushed horizontally by each of the two authors via a hand-held dynamometer that was placed over their greater trochanter.

**Analyses** To examine interrater reliability of push forces, intra-class correlation coefficients (ICCs) were calculated for each transfer method using the two authors’ measurements. Validity was confirmed using Pearson correlations to test the relationship between subjects’ weights and the forces required to push them. A repeated measures analysis of variance (ANOVA) and pair-wise post hoc tests were used to compare the forces associated with the four methods.

**Results** The ICCs for push forces ranged from 0.77 to 0.91 depending on the transfer method. The push forces associated with the four transfer methods (no device = 200.7 +/- 40.8 N, sliding board = 120.5 +/- 27.7 N, fabric tube = 105.8 +/- 26.1 N, fabric tube and sliding board = 84.2 +/- 13.4 N) differed significantly (F = 273.9, p < 0.001).

**Conclusions** This study demonstrates that assistive devices can greatly reduce the forces required to move seated subjects horizontally. The sliding board and the fabric tube were most effective when used together.

**THE EXECUTION OF SPINE BOARD TRANSFER TECHNIQUES UNDER VARIOUS DEGREES OF SEGMENTAL INSTABILITY OF THE CERVICAL SPINE**

Del Rossi G.

(University of Florida) ** 2002; Ph.D. 104 p.

The purpose of this investigation was to assess the effectiveness of spine board transfer techniques using a cadaveric model. Four groups of qualified individuals (six per group) were required to execute the lift-and-slide (LS) technique and the log-roll (LR) manoeuvre on five cadavers. These techniques were tested under various degrees of spinal instability. The extent of spinal instability was dependent on the nature of the injury present within the spine. Initially, the effectiveness of transfer techniques was tested under normal conditions (i.e., a stable spine). After that, two different injury conditions were created surgically between the 5th and 6th cervical vertebrae to produce different levels of instability.

These were a 2-column injury (posterior ligamentous release) and a 3-column injury (complete segmental injury). The amount of linear and angular motion resulting from the execution of transfer techniques was measured using a three-dimensional, electromagnetic, motion analysis device (Polhemus Inc., Colchester, VT). This device assessed three-dimensional motion using tethered sensors that were fixed to the bodies of the aforementioned vertebrae using carbon-fibre rods. The measures of effectiveness that were recorded in this investigation were flexion-extension motion, anterior-posterior displacement, and vertebral distraction.

In general, the LR manoeuvre and the LS technique were equally effective in restricting the amount of flexion or extension motion that was generated within the lower cervical spine (mean for LR = 3.92 [degrees], mean for LS = 3.70 [degrees]; p > .05). This was not the case with either distraction or AP displacement motion. The results of this study revealed that groups generated significantly less distraction motion (mean for LR = 0.67 cm, mean for LS = 0.85 cm; p < .05) and AP displacement motion (mean for LR = 0.25 cm, mean for LS = 0.38 cm; p < .05) when using the LR manoeuvre.
Finally, the results of this study indicated that regardless of technique, the amount of motion generated across the C5-C6 segment increased almost always as the degree of instability increased. Overall, the LR manoeuvre emerged as the better technique for restricting motion of the lower segments of the cervical spine.

**SPINE-BOARD TRANSFER TECHNIQUES AND THE UNSTABLE CERVICAL SPINE**


Spine. 2004; 29(7): Online Exclusive: E134-8

**Study design** A repeated-measures design using a cadaveric model was used in this preliminary investigation on the effectiveness of spine-board transfer techniques.

**Objectives** To compare the amount of angulation (flexion-extension) motion that results at the cervical spine during the execution of the log-roll manoeuvre and the lift-and-slide technique; and to examine how changes to the integrity of the cervical spine impacts the amount of motion generated during the transfer process.

**Summary of background data** Very little research has been performed to establish the efficacy of spine-board transfer techniques. Early studies have indicated that the log-roll manoeuvre may not be appropriate for transferring victims with thoraco-lumbar injuries. Also, there has not been a single study that has reported the impact of transfer techniques on the unstable cervical spine. This lack of data necessitated the present study.

**Methods** Four groups (each with six participants) were asked to execute the log-roll manoeuvre and the lift-and-slide technique on five cadavers. An electromagnetic motion analysis device was used to assess the amount of angulation motion generated at the C5-C6 segment during the execution of these transfer techniques. To examine how changes to the integrity of the cervical spine impacts the amount of motion that is produced during the transfer process, flexion-extension motion was assessed under various conditions: across a stable C5-C6 segment, after the creation of a posterior ligamentous injury, and after a complete segmental injury.

**Results** No significant differences in angulation motion were noted between transfer techniques. However, significant differences were noted between all three injury conditions.

That is, as the severity of the injury increased, the average amount of angulation motion produced at the site of the lesion also increased, regardless of technique.

**Conclusion** The participants of this study were able to restrict flexion-extension motion equally well with the log-roll technique as with the lift-and-slide technique. However, more research is needed to fully ascertain the effectiveness of spine-board transfer techniques.

**A COMPARISON OF SPINE-BOARD TRANSFER TECHNIQUES AND THE EFFECT OF TRAINING ON PERFORMANCE**

Del Rossi G, Horodyski M, Powers ME.


**Objective** To compare the log-roll (LR) manoeuvre and the lift-and-slide (LS) technique and to investigate the effect of training on the performance of these transfer techniques.

**Design and setting** A repeated-measures design involving certified athletic trainers and athletic training students from a National Collegiate Athletic Association Division I college.

**Subjects** Certified athletic trainers and athletic training students were required to transfer healthy individuals onto a spine board. Testing was performed on 2 men of average size, whereas training sessions were performed on both men and women of different heights and weights.

**Results** Differences between transfer techniques were noted. The execution of the LR produced significantly greater lateral-flexion motion and greater axial rotation of the head as compared with the LS. Performance of spine-board transfer techniques did not improve with training.

**Conclusion** The LS technique was more effective in restricting motion of the head. To truly establish the safety of spine-board transfer techniques, researchers need to assess how individual segments move within the structurally unstable cervical spine.
The PMDC of Loughborough University is currently offering a Postgraduate Certificate/ Diploma/MSc programme in Back Care Management specifically for Health Service, Social Services, Community Care and Education.

The structure of the programmes has developed to include several stand alone modules which can be attended by both students on the programme and other interested parties wishing to further their learning in the back care field.

**Postgraduate Programme in Back Care Management**

<table>
<thead>
<tr>
<th>Modules</th>
<th>Module Title</th>
<th>June 06 Intake</th>
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<tbody>
<tr>
<td>1</td>
<td>The Scientific &amp; Organisational Bases of Back Care Management</td>
<td>26th - 30th Jun 2006</td>
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<td>2</td>
<td>Essential Applied Ergonomics</td>
<td>4th - 8th Sept 2006</td>
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<td>3</td>
<td>Suction Manual Handling</td>
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<td>4</td>
<td>Advanced Applied Ergonomics</td>
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<td>5</td>
<td>Behaviour Change</td>
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<td>6 (o)</td>
<td>The Role of the Back Care Advisor in The Peri-Operative Environment</td>
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<td>7 (o)</td>
<td>The Role of the Back Care Advisor in Paediatrics</td>
<td>1st - 3rd Aug 2007</td>
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<td>8 (o)</td>
<td>The Management of Handling issues in Bariatrics</td>
<td>18th - 20th Sep 2007</td>
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<td>9 (o)</td>
<td>Risk Management of Manual Handling issues in Transportation</td>
<td>5th - 7th Nov 2007</td>
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Students undertaking the Certificate programme will attend Modules 1, 2 & 3. Students continuing on to complete the Diploma programme will attend Modules 4 & 5 plus a choice of two of the optional modules. The Back Care programme will commence a further intake in January 2007.

**Continuing Education Programme**
For the first time we are able to offer a number of individual learning programmes for graduates and other Back Care Professionals.

**CPD update for Graduates**
A 2-day update programme has been devised to give both updates on existing information and new skills for the Back Care Advisor. The programme this year will include the application of the Mental Capacity Act, Audit Tools from European Research and examples of developing an effective management programme.

*These will run on:*
1st & 2nd June, 6th & 7th July, 27th & 28th July, 14th & 15th August, 17th & 18th August, 2006

**Postgraduate Short Courses**
In addition to the graduate updates, the following short courses are available for anyone in the Back Care field to develop their knowledge in the following four specific areas:

<table>
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<th>Course Title</th>
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<tr>
<td>The Role of the Back Care Advisor in The Peri-Operative Environment</td>
<td>3rd - 5th May 2006</td>
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<tr>
<td>The Role of the Back Care Advisor in Paediatrics</td>
<td>14th - 16th June 2006</td>
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<tr>
<td>Risk Management of Manual Handling issues in Transportation</td>
<td>3rd - 5th July 2006</td>
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<tr>
<td>The Management of Handling issues in Bariatrics</td>
<td>24th - 28th July 2006</td>
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Full details are available from:

Elaine Harris Programme Administrator or Charles Hancock Programme Director

The PMDC, Brockington Building, Loughborough University, Leicestershire, LE11 3TU

Tel: 01509 222158 Fax: 01509 223991 E-mail: E.R.Harris@lboro.ac.uk
**ABSENCE DATA**
Do you keep absence data and are you a Mental Health Care Trust? If so we need to hear from you. I work as a Manual Handling Advisor for a Mental Health NHS Trust with approximately 2,500 staff including inpatient staff, Community Mental Health Nurses and administrative staff of all grades. We need some comparable data as an audit tool. We have data that shows the number of staff off sick due to musculoskeletal injury (arms, body, neck, back and lower limb), the number of days taken and those incidents that are reported as work related. In particular we are concerned with those absences recorded under RIDDOR.

If you can help we would appreciate you reply to **Lynne Wyatt**, Manual Handling Advisor, Hellesdon Hospital, Drayton High Road

**LAUNDERING OF MOVING AND HANDLING EQUIPMENT WITHIN HOSPITAL LAUNDRY**
We have stumbled on a problem with the laundering of moving and handling equipment within our hospital laundry.

All articles washed within our laundry are tumble-dried; there are no facilities for air drying (for infection control reasons).

Our tumble driers operate by steam injected at 120c degrees. We have no facility for low temperature tumble drying.

Some of our equipment will not tolerate tumble drying, others can be tumble dried but not at that temperature, we realize that we could go down the disposable route for Hoist slings and some types of slide sheets but what about Standaid Slings, Handling belts, one-way slide sheets etc.

We thought that our equipment was washed as per its instructions.

- Do you know how your laundry deals with this issue?
- Have they low temperature tumble driers or air-drying rooms/areas?
- Do you use wipe clean equipment?

At present we are working alongside Infection Control, Laundry Management, and Health and Safety to try and rectify this problem. We would like advice. Have any of you had to solve this problem? Or does it exist in your area?

Please reply to **Trevor Stoker**
**email** trevor.stoker@chs.northy.nhs.uk

**LEG BANDAGING IN THE COMMUNITY**
As part of my MSc research project in Health Ergonomics, I am planning to assess the risks associated with kneeling on the floor and compare with the use of portable equipment such as a small stool and leg support for completing this task.

I would be grateful for:

- opinions/information from anyone who has previously looked at this either formally/informally
- used equipment/trialed equipment
- developed policies/protocols.

Please contact **Heather O’Neill**
Newcastle NHS Primary Care Trust, Spinal Awareness Team Leader, Newcastle General Hospital, Westgate Road
Newcastle upon Tyne, NE4 6BE
**Tel** 0191 273 6666 ext. 22556
**Fax** 0191 219 5079
**email** heather.oneill@newcastle-pct.nhs.uk

**MANUAL HANDLING ILLUSTRATION FOR POWER POINT PRESENTATIONS**
Does anyone have any information please of a good resource for manual handling illustrations for Power Point presentations?

Please reply to **Sue Olive**
**email** sue.olive@rochdale.gov.uk

**THERAPEUTIC HANDLING RISK ASSESSMENT AND THERAPEUTIC PLAN**
Please does anyone have a therapeutic risk assessment tool to share? How do your therapists document how the different levels of experience/competence/grade address the risks highlighted in the assessment? Any thoughts would be received gratefully.

Please contact **Lynn Chivers**, Manual Handling Advisor
Huddersfield Royal Infirmary, **email** lynn.chivers@cht.nhs.uk
IS CLIENT LIFTING MORE THAN YOU CAN BEAR? TRY THE NEW SOLUTION FROM MANGAR INTERNATIONAL

Designed to sit up and lift a fallen person from the floor, the Camel inflates to gently lift them ready to stand with or without assistance. The lightweight Camel is fully portable for use indoors or out and packs away into a compact case. Lifting up to 50 stone (320kg) this simple to use lifting device will provide an effective solution to a common moving and handling problem.

Don’t miss the Camel on Stand D at the Moving & Handling People Conference, 9th & 10th March 2006 at the Business Design Centre, Islington.

For further information about this innovative new product, telephone Mangar International on 01544 267674 or email: sales@mangar.co.uk

freedom through lightweight solutions
**Letter to the editor**

*Dear Editor*

I am a Back Care Trainer/Advisor in Northern Ireland and our Trust is currently job matching for Agenda for Change. I would be very interested to hear from anyone who has been through this process where a job match has been found for our role or otherwise. Thank you.

Sandra McGivern, Back Care Trainer/Advisor, Craigavon and Banbridge Community Trust
e-mail sandra.mcgivern@cbct.n-i.nhs.uk

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**TCR Limited** is a rapidly expanding training provider in health & social care in London and the Home Counties

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**Or call us on: 01992 815567**

We are interested even if you can only offer one day per month.

Trainers of other health & social care topics also required.

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**DIARY DATES**

**MARCH 2006**

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<td>9 &amp; 10</td>
<td>Moving &amp; Handling Conference: Handling The Challenge</td>
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<td>21 – 23</td>
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<td>Ergonomic Society Annual Conference</td>
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<td><a href="mailto:s.hull@ergonomics.org.uk">s.hull@ergonomics.org.uk</a></td>
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<td>College of Occupational Therapists 30th Annual Conference and Exhibition</td>
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**SEPTEMBER 2006**

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<td>18 – 20</td>
<td>National Back Exchange National Conference and Exhibition 2006</td>
<td>International Conference Centre, Telford</td>
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Contributors are reminded that the editorial team reserve the right to edit the materials supplied and to hold materials for publication at a later date. Submission of materials does not guarantee publication, articles will be reviewed prior to publication and the author/s notified of changes or amendments.

Author/contributor details required: name, qualification, contact details.

Copyright: If your material has graphics which are from copyrighted sources then source information must be provided and each graphic accordingly labelled. Copyright permission will need to be sought for any such material or it will not be published.

All materials to be submitted on disc or by email (ideally as a Word attachment). Hard copy will be accepted by prior arrangement with the Editor. Please supply a stamped addressed envelope if you require materials to be returned. Please note the editorial team and the National Back Exchange cannot be held responsible for the loss or damage of materials.

Submission for all sections of the journal are welcomed – even Diary Dates.

Content: Provide factual and verifiable details.

Style: Times New Roman, 12 point, 1.5 spacing. Avoid abbreviations – where they are necessary they must have been qualified in the article. Use the 24hr clock and write dates without the suffix e.g 1 not 1st.

Clearly specify any particular requirements that need to be considered by the editorial team.

All materials must be with the Editor by the copy date or they cannot be included.

Membership details

AIMS OF THE NATIONAL BACK EXCHANGE

The Association is established for the public benefit and for the following purposes:

1 To promote the exchange and dissemination of information and ideas on back care;
2 To develop and promote common standards of training in safer handling;
3 To promote initiatives and act as a forum for providing evaluation and audit of current practice in all matters associated with back care;
4 To lobby employers to provide back care advisory services to reduce work related back problems;
5 To provide support and advice to members.

Annual membership for National Back Exchange costs £45. Members receive a quarterly Journal and are eligible to vote at the AGM, held at the annual conference. Members have a preferential booking fee for the annual conference.

Members will be informed of their nearest local group which is affiliated to the National Association and which may charge you a small annual fee. They have regular meetings where you can exchange information and meet socially.

Affiliated groups can apply for funds (see local group guidelines). Individual members can apply for research funding through the National Executive committee.

To become a member, please phone the NBE Administration office for a membership form on 01327 358855.

Sara Jaskiewicz Membership Secretary, National Back Exchange, Linden Barns, Greens Norton Road, Towcester, Northants NN12 8AW
Contacts around the country

REGIONAL OFFICERS for contact details see page 3

EAST REGION Pat Alexander
East Midlands, West Midlands, Essex, East Anglia, Northern Home Counties, Nene

WEST REGION Mike Betts
Devon & Cornwall, Oxford, Somerset, Avon & Gloucester, Swansea & West Wales, South Wales, North West & North Wales

SOUTH REGION Claire Mowbray
London, South London, Sussex, Southern, Kent

NORTH REGION Heather Hetherington
Northern Ireland, Lancashire & Greater Manchester, Northern, Yorkshire

To ensure accurate information is published please can any changes in the above contact names and numbers be forwarded to the Editor and the Administration Office Tel 01327 358855 Fax 01327 353778

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