



Adelaide Health Service

Starting from Scratch

Implementing a Manutention based manual handling program in a large metropolitan hospital

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Government
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SA Health

Royal Adelaide Hospital



- > 650 bed acute care hospital
- > Also Hampstead Rehabilitation Centre, a 150 bed sub-acute rehab facility
- > RAH employs about 6000 staff
- > In 2007-08 financial year:
 - 64,000 patients came through ED
 - More than 17,500 surgical procedures
 - Admitted approx. 75,000
 - Treated almost 500,000 outpatients



What happened previously?

- > Manual handling training provided by Staff Development Department (SDD) staff, who had limited time due to other training commitments
- > Short session at orientation
- > Other manual handling training occurred on request, usually a brief session in the ward or workplace



Search for solutions

- > The RAH looked around Australia for a successful manual handling risk management program



The model – adapted from a successful model at SCGH

- > The Sir Charles Gairdner Hospital (similar size to RAH) manual handling education program was considered best practice:
 - EA rating from the ACHS during EQuIP
 - Injury and incident statistics from SCGH were markedly better (about half the number occurring at the RAH)



Manual Handling Coordinators

- > 2.6 FTE Manual Handling Coordinators (MHC's) appointed
- > PT's or OT's with specific training and interest in Manual Handling
- > MHC's are externally accredited (AAMP)
- > MHC's have Cert IV in TAA (workplace training and assessment) which encompasses adult learning, managing groups, and assessing competence

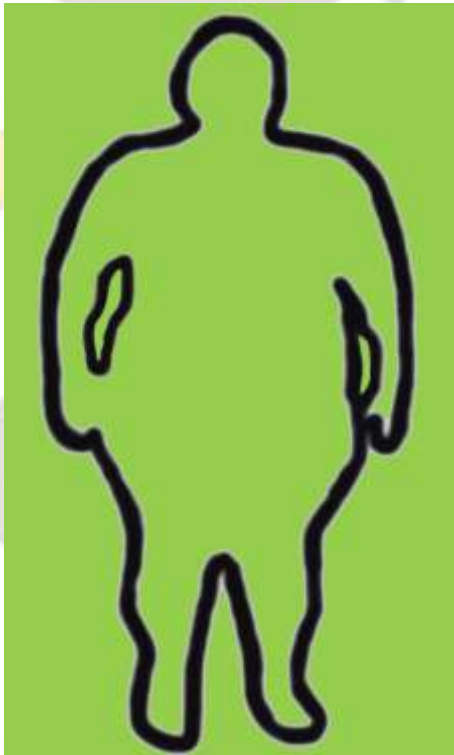


Training Needs Analysis

- > High risk areas: included Theatres, Critical Care (ED and ICU), Food & Nutrition (kitchen), DSS, Ortho, SSS, IMS
- > Non-clinical areas (e.g. Kitchens, DSS, stores, linen, medical records) highlighted the need for specific training tailored to risks in their work area

3 hour Patient Handling module

- > Nurses and other clinicians who assist patients with transfers (e.g. PT's, OT's, orderlies, RT's, AHA's, etc.)
- > Tailored to North Tce staff (acute) and HRC staff (rehab)
- > Tailored to specific work areas (e.g. lung function lab, sleep lab, BIRCH, etc.)



2 hour loads handling module

- > For non-clinical areas or clinicians who don't move patients much (e.g. psychologists, SW)
- > Focus on moving loads like crates, boxes, trolleys, office ergonomics, workstation set-up, etc.
- > Tailored to specific work areas (e.g. DSS, kitchens, E&BS, medical records, medical physics, utility services)





Assessor training (3-4 days)

- > Assessors – our title – could be called facilitators, back care coordinators, clinical champions link nurses, etc.
- > Key role in the manual handling program
- > Patient Handling Assessors or Loads Assessors – 2 different courses
- > Ongoing training, support, and resources from MHC's, not just trained and dumped



Assessors – role and function

- > Act as a resource in their work area – help with risk assessments, problem solving, complex clinical dilemmas, etc.
- > Reinforce behaviour change and safe manual handling practice in their ward or work area
- > Liaise with MHC's, HSR's, OHS, line managers
- > Our 'eyes and ears'



Assessors – role and function

- > Refresher/update training
- > Around 6000 RAH staff – no way the MHC's can train all of them every year
- > Assessors are primarily responsible for refresher/update training in their area – with support from MHC's as needed



Assessors – role and function

- > Use a standard workplace competency evaluation form provided by MHC's
- > Support and mentoring for at risk staff – e.g. new employees, overseas nurses, ESL staff



Difference between SCGH Assessors and RAH Assessors

- > SCGH Assessors are mostly SDN's – their primary role is education – they don't carry much of a clinical load
- > SCGH use annual skills days for nurses – provides a clear 2 hour window for refresher manual handling training
- > RAH Assessors are fitting their Assessor role around their usual jobs – e.g. full time clinical load

How many Assessors do you need?

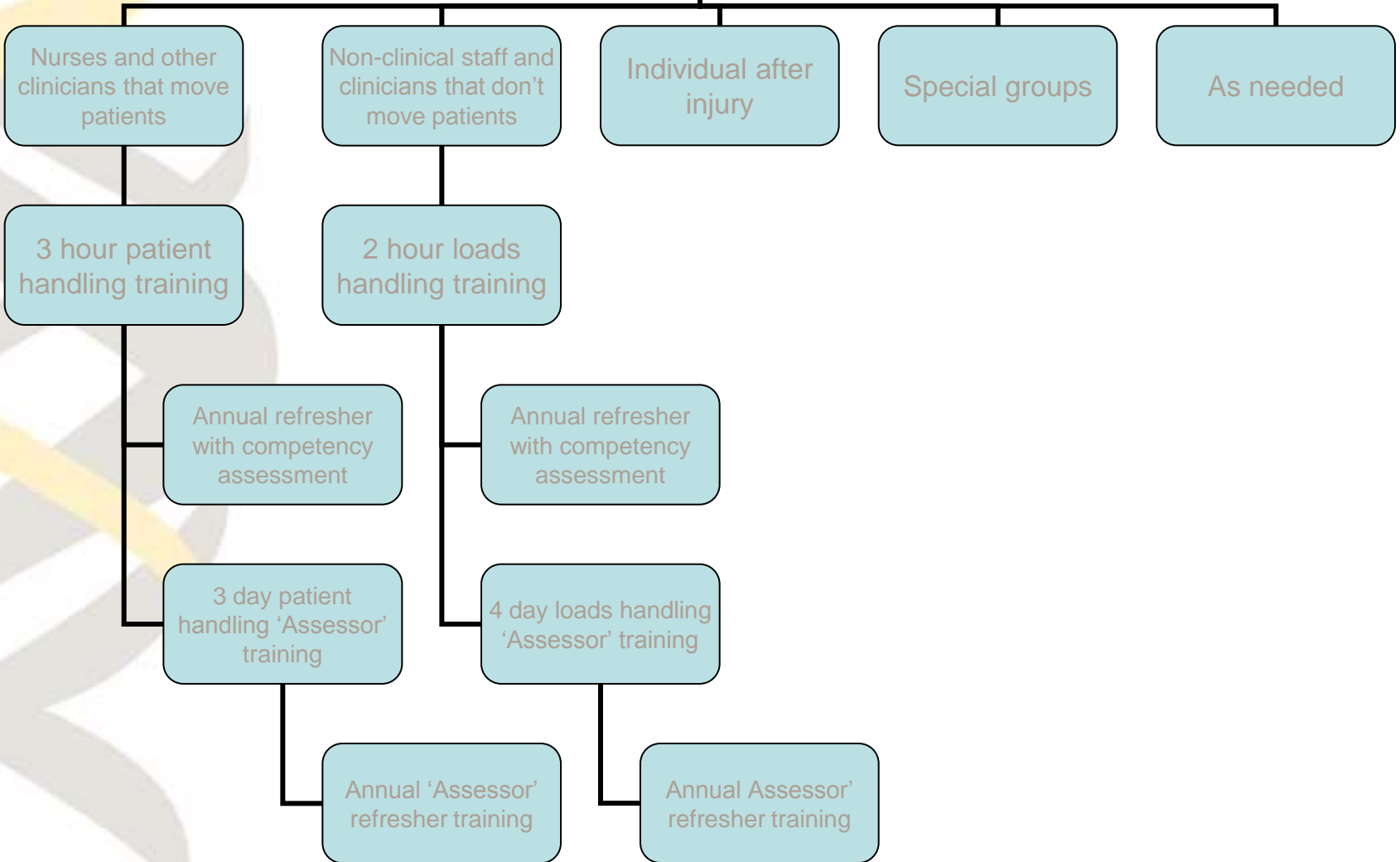
- > Currently we have about 80 Patient Assessors and 17 Loads Assessors, hard to keep track of them and support them
- > Depends on how much time they devote to their Assessor role
- > Be wary of 'putting all your eggs in one basket', there is significant attrition/turnover as Assessors leave for other jobs or personal reasons
- > Assessors often train and work in pairs, this has been successful and sustainable

How many Assessors do you need?

- > Attributes that make a good Assessor (initiative, flexibility, problem solving, clinical reasoning, time management, leadership, good with small groups, etc.) also increase the likelihood of that person finding another job that pays better!
- > It's hard work to build and maintain an Assessors skills, so ideally you want a smaller number of Assessors with time to do their role, who won't leave.
- > Find a balance, for the RAH currently that's about 100 Assessors in total

RAH Training Model

Training for all RAH employees



Other update modules run by the Manual Handling Coordinators

- > Focus for first 2 years was on getting staff through the initial module (3 hr patient or 2 hr loads)
- > MHC's now running updates for specific clinical challenges:
 - Lifters
 - Spinal
 - Bariatric
- > Assessors choose their update topics to suit their specific areas needs



What is Manutention?

- > **Manutention** describes an approach to manual handling which teaches people skills to protect the body from injury
- > It has a strong biomechanical basis enhanced by the study of human movement, martial arts, weightlifting, and abseiling.
- > **Manutention** helps participants develop safe movement behaviour by learning a system of postures and actions focusing on effective use of the big muscles in your thighs, maintaining a neutral spine, moving your feet, bracing or bracketing for support and using a shift of body weight. These postures and actions can be integrated into any activity whether it is moving a person, animal or thing



Type of training

- > Maintenance based
- > Participatory ergonomics
- > Focus on risk assessment, problem solving, hierarchy of control, etc.
- > Not 'recipe' based technique training
- > Large practical element – not a lecture based format or watching a video
- > Tailored to work area as much as practical
- > Competency based

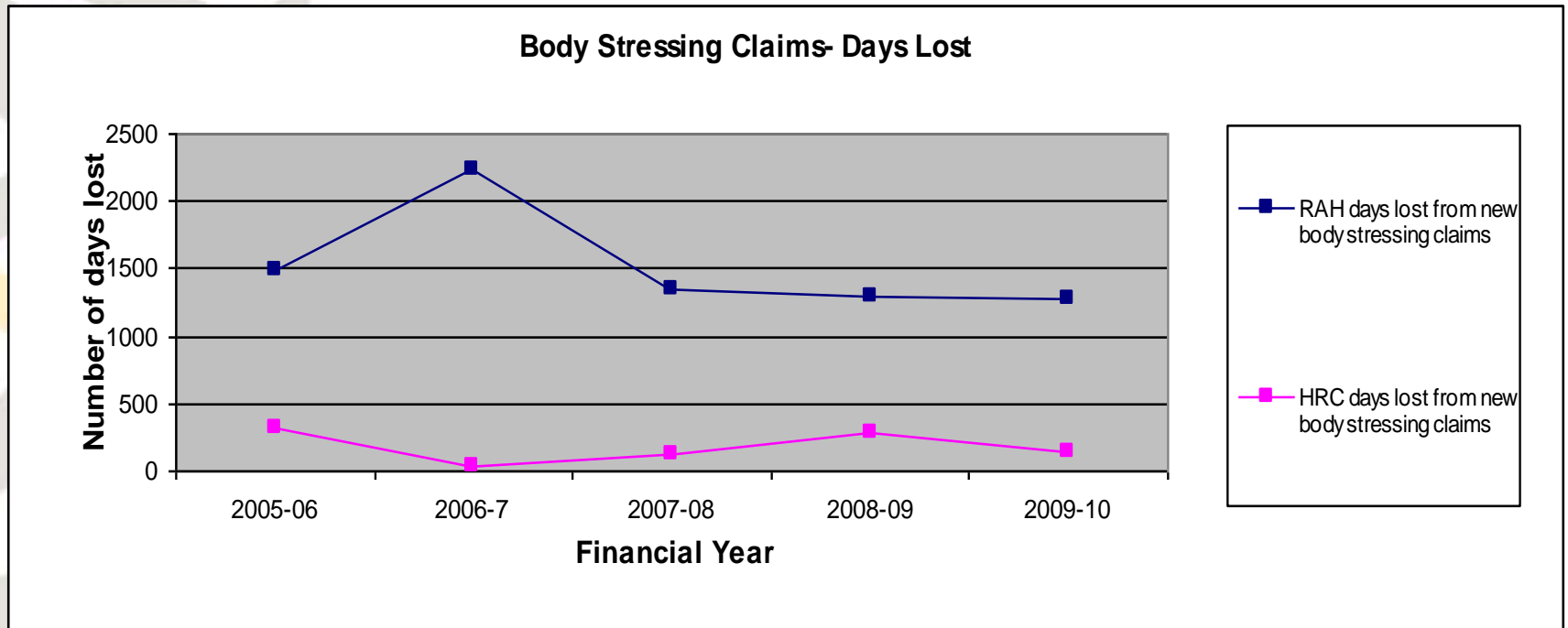


Other parties play a key role

- > Managers
- > Ergonomist
- > OHS facilitators
- > Other OHS staff
- > HSR's
- > RTW and rehab people
- > Assessors – the whole model collapses without them

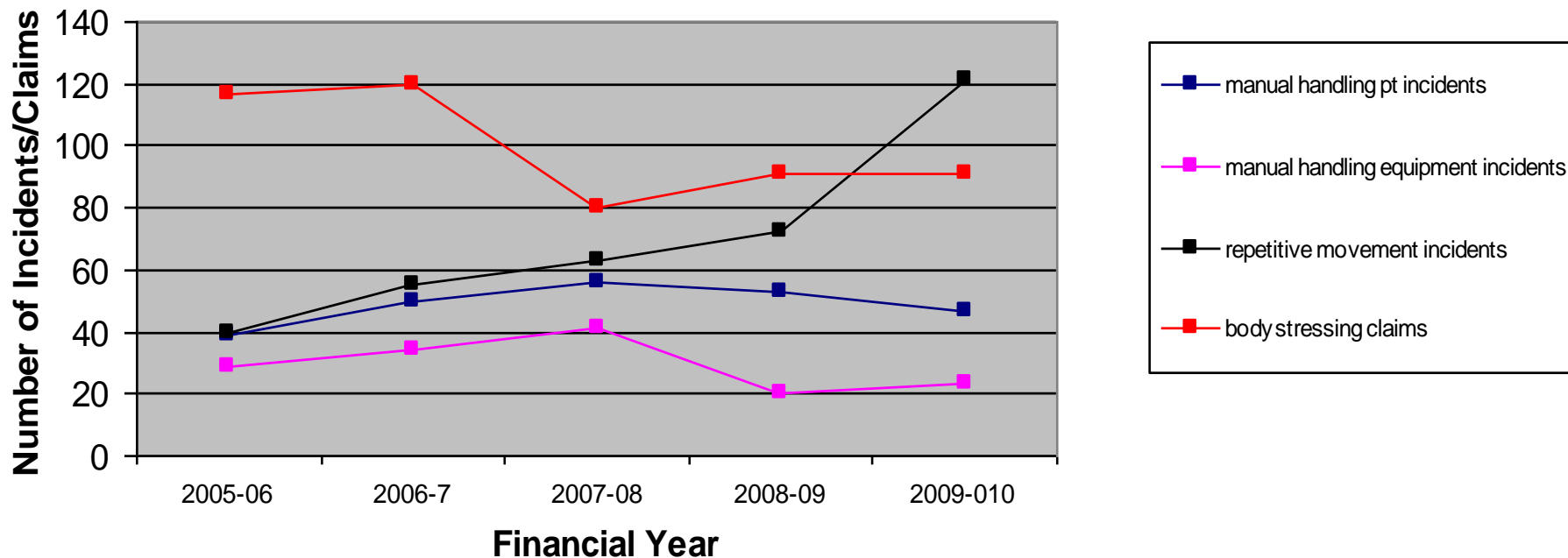
Statistics – is it making any difference?

Really too early to tell – but some promising trends



Trends in incidents and claims – what does it mean – how do we improve them?

Manual Handling Incident /Claim Trends- North Terrace





Things that have worked well

- > Dedicated manual handling resource – MHC's only do manual handling
- > MHC's work as a team
- > Commitment to skilling-up MHC's
 - AAMP training, accreditation, and professional development
 - Cert IV in TAA
 - OHS training
 - Membership of relevant groups (e.g. AAMHP, AAMP)



Things that have worked well

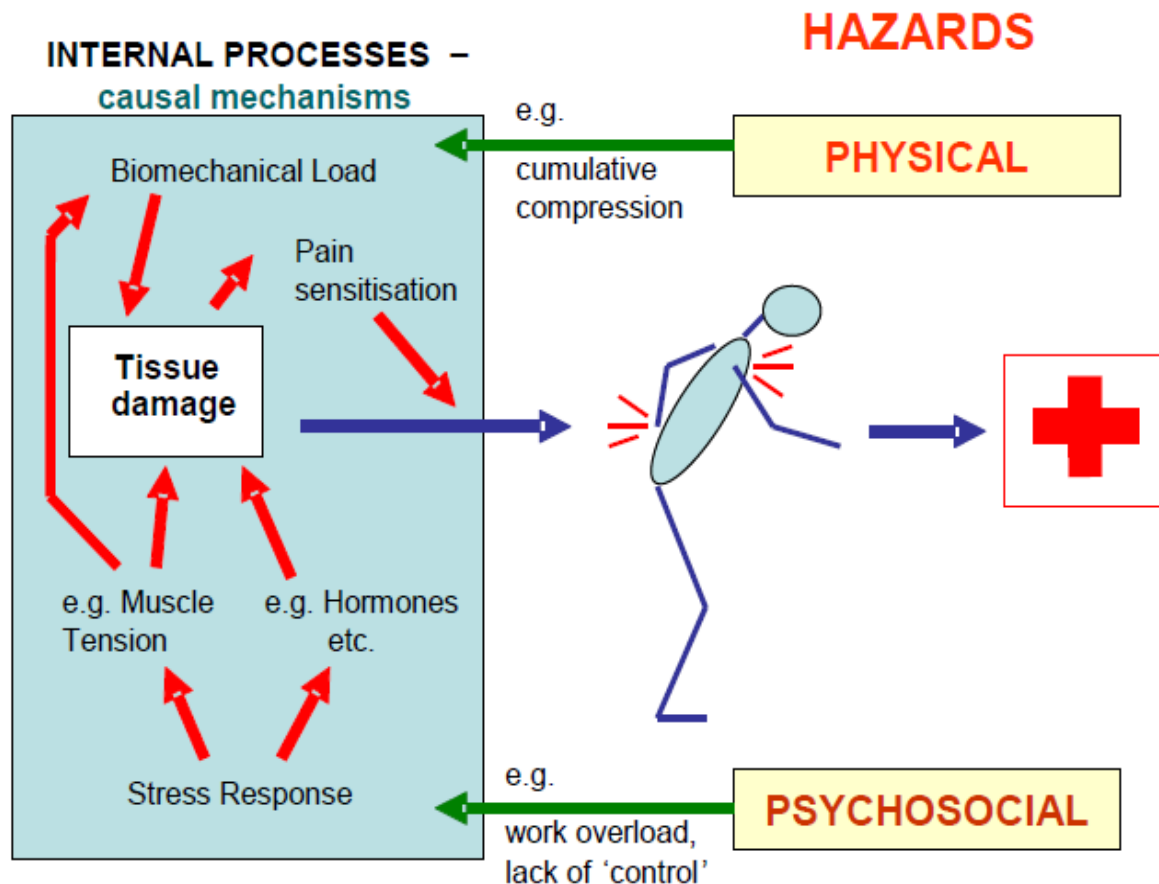
- > Support for 3 hours at Orientation – catch everyone when they start
- > Support for 3 hour module for existing nursing staff despite rostering challenge
- > Training venue – dedicated training venue essential
- > Support from OHS staff - ergonomist, OHS facilitators, etc.



Training isn't the panacea

- > Training is only one part of the overall risk management program
- > Many other things influence MSI (musculoskeletal injuries) – so a multi-factorial approach makes sense

Physical, organisational, and psychosocial hazards can increase MSI risk (From Macdonald & Evans, 2006, also Macdonald & Oakman 2009, pg. 10)





Literature review for MSI in the SA Health sector 2009

- > “...it is not possible to determine the proportion of MSI claims where the main cause was ‘manual handling’ as commonly understood, compared to the proportion of claims where other causes were equally or more influential.”

(Macdonald & Oakman, 2009, pg. 11)



What factors aren't we covering?

- > Different types of workplace hazards:
- > Task-specific hazards
- > Hazardous job demands
- > Inadequate Coping Resources
- > Psychosocial Hazards
- > High fatigue levels
- > Chronically high stress levels

(Macdonald & Oakman, 2009)

Psychometric testing – does it help?

(Lough & Ryan, 2005)

Tasmanian Police Force	Non-screened group	Screened group
Sick days	867	560
Stress claims	2	1
Physical injury claims	93	43
Stress claims - LTI	121	28
Physical injury claims - LTI	84	0
Public Complaints	6	5
MVA incidents	22	6
Drop outs	15	10



What about fatigue, sleepiness, and shift work?

- > Workers with excessive daytime sleepiness (EDS) have over two-fold higher risk of occupational injury

(Melamed & Oksenberg, 2002)

- > Shift workers have between a three-fold and five-fold risk of being injured in an occupational accident compared to daytime employees

(Swaen et al., 2003)



Crucial role of senior management

- > Appointment of MHC's – dedicated manual handling resource
- > Support for the 3 hour patient handling module – release of staff to attend
- > Training venue
- > Equipment procurement
- > Redesign of work environments
- > Rostering
- > Psychosocial stuff

Where to from here?





Areas for improvement

- > Training venue
- > Class sizes at orientation
- > Extra time for groups that take longer to 'get' things e.g. nurses from overseas, GNP's.
- > Assessor's given dedicated time by their managers to do their manual handling role
- > Decent database (CHRIS number)
- > Improve training delivered in undergraduate courses



Areas for improvement

- > Focus on employee wellbeing programs – fitness for work e.g.:
 - Subsidised gym membership
 - Free Pilates classes
 - Healthy food options cheaper in Cafe
 - Access to advice/services from Allied health – dietetics, physio triage, massage, psychology
 - Intervention/education for sleep deprived workers
- > Pre-employment screening
- > Management of injured workers and the RTW process

Areas for improvement – the big 3

- > Training of senior managers in MSI aetiology, prevention and management
- > Use of higher order controls e.g. redesign of work environments, systems, equipment to reduce exposure to risk
- > Viewing spending \$\$\$ on manual handling related equipment or other MSI prevention initiatives as an investment to save money in the long term, rather than just another drain on the budget





Any Questions?

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