Liten Up and Reduce The Risk

AN INTRODUCTION TO THE NEW ZEALAND PATIENT HANDLING GUIDELINES

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LITEN UP AND REDUCE THE RISK

A new approach to patient handling

Lifting patients is one of the most significant causes of injury to nurses and carers. It costs the industry and ACC many millions of dollars each year and causes a great deal of suffering.

Over recent years a new approach has been used overseas with outstanding results. It can cut injuries by up to 35%. But it requires an entirely new way of thinking.

We can eliminate thinking that a lift will be involved in patient handling. Instead we can take an integrated approach towards risk assessment, handling patients, use of equipment and facility design.

We call it the **LITE**N UP approach to patient handling. It sets a new best practice standard all employers need to work towards. Within five years it is expected to be an OSH required standard.

This introductory guide explains the main things you need to know – and the steps we're asking you to take now. The full guidelines will be released in the next few months.

It's a major change – but one that has huge benefits for everyone.
Please take a moment to read this information.
ACC and OSH are working together on the new patient handling guidelines.

THE HIGH COST OF INJURY

How many people in your organisation have been injured handling patients and how much is it costing each year? In 1999 ACC claims by nurses for injuries related to patient handling[1] cost over $30 million. And that's just a fraction of the total cost. The true cost, including lost time and productivity, increased premiums, high staff attrition rates and patient injuries, is likely to be at least four times higher[2]. This doesn't take into account the pain and loss suffered by those who are injured.

Is there a solution?

Yes there is a solution and it is effective. But it requires a wholesale change in the way we approach patient handling. First we need to recognise that lifting is unsafe. Any load over 16 kilos[3] represents a significant risk – and an avoidable occupational hazard. There is no lifting technique or training that can overcome this risk. The answer lies in a new way of doing things – and an integrated approach to risk assessment, handling patients, equipment use and ergonomic facility design.

We've developed **LITE**N UP patient handling guidelines and tools to help you introduce the change to your workplace. The name comes from **LITE** – the acronym for the risk assessment method used in the new approach, explained on page 5.

Over the last five to seven years the UK and European Union, and more recently Australia, have significantly reduced injuries with a 'no lift' approach to patient handling. It's now internationally accepted best practice.

Why change?

The cost in human and financial terms is huge. Reported injuries include back injuries, musculoskeletal disorders such as sprains and strains, OOS, and injuries to both patients and carers from slips and falls. The total cost may be $120 million[4] a year or more. At the same time, health care organisations are struggling to find and retain good staff. Some report attrition rates as high as 25% a year.

Creating a safer working environment makes financial sense and may help attract and retain staff. It is also a legal health and safety[5] obligation for employers to protect workers' safety – and this requires following a best practice approach.

The **LITE**N UP patient handling guidelines are based on internationally accepted best practice standards and OSH has set a five-year timeframe for their introduction to New Zealand. ACC and OSH are working together and in consultation with industry stakeholders[6] to bring about the change.

What are the benefits?

Based on overseas experience[7] you could expect up to a 35% reduction in injuries from a comprehensive patient handling programme, along with other benefits including:

- Better hazard control, less risk for carers
- Fewer and less severe injuries to staff and patients
- Reduced injury costs
- Improved performance and efficiency
- Improved morale and less absenteeism
- More people, such as older people, suitable for employment
- Better staff retention, fewer recruitment costs.

Change won't happen overnight – but we need to start now and we need to be committed to making it happen as quickly as we can.

1. *Patient handling is any task involved in moving a patient, including carrying, supporting, pushing, pulling, lifting and lowering. Refer to frequent question 1.*
2. *It is widely accepted that true costs are significantly higher than direct claim costs. The Australian Nursing Federation estimates true costs are four to eight times higher than direct costs.*
3. *This is not a safety limit, but a filter to screen out straightforward cases and set the boundary for when a risk assessment is needed. Refer to frequent question 2.*
4. *Based on 1999 ACC claims of $30 million and estimates that total costs are four to eight times more than direct costs. Refer to frequent question 5.*
5. *Employers have responsibilities to protect workers and to identify, assess and control hazards to prevent harm – this includes risks that could lead to musculoskeletal conditions. Refer to frequent question 10.*
6. *We've consulted with health boards and officials, private hospitals, employee and union groups, organisations for health professionals, as well as various teaching, advisory and service groups, and overseas advisers. Refer to frequent question 4.*
7. *The UK and Australia have significantly reduced claims with a 'no lift' approach. Refer to frequent question 8.*

Where do we start?

We've developed guidelines to help you plan and introduce a **LITE**N UP patient handling programme to your workplace. They provide a voluntary standard to help you meet your health and safety obligations. The guidelines will be delivered in stages.

STAGE ONE – GETTING READY – AN INTRODUCTION

In this introduction we're providing an overview and the information you need to develop your policies and prepare for change. This includes a short 'Are you ready?' checklist to help you assess what your organisation may need to do to introduce a **LITE**N UP patient handling programme.

STAGE TWO – OPERATIONAL TOOLS – MID 2003

In stage two we'll provide information and tools to support the introduction of **LITE**N UP practices to your workplace.

These include:[8]

- A patient risk profiling tool – this helps you complete patient risk assessments and produces handling plans based on the information you provide
- A cost-benefit tracker tool – which identifies and tracks costs involved with patient handling injuries
- Handling techniques and illustrations
- Information on training, equipment and facility design.

LATER STAGES

Development will continue, with resources for training, equipment and facility design being expanded in consultation with industry groups. We'll also be providing a comprehensive audit tool later in the year. The audit tool helps you assess your organisation's patient handling status and provides a baseline to measure progress.

8. Refer to frequent questions 14, 15 and 16 for more about the audit, profiling and tracker tools.

THE LITE WAY

The **LITE**N UP approach is about making patient handling safe for both staff and patients by reducing the risk. In the past the focus has been on how to lift. Now we need to eliminate thinking that a lift will be involved.

The new approach is centred on assessing the risk using **LITE** principles. This can be done using the profiling tool, which guides you through the assessment process and provides you with a detailed patient profile and handling plan based on the information entered.

What are the LITE principles?

LITE is a way to remember the key risk factors that must be considered when you are preparing a safe patient handling strategy. It is an acronym for:

Load	Load means patient characteristics that can affect the handling risk, such as age, gender, diagnosis, dependency, neurological status, size, weight, ability to co-operate, and fall risk.
Individual	Individual means the individual capabilities of staff, such as language, education, training, physical limitations, stress and fatigue which can affect their ability to do the job safely.
Task	Task means the nature of the task. Different tasks, such as toileting, bathing, ambulating, rehabilitation, postoperative care, counselling and full dependency care, have different requirements.
Environment	Environment means the working environment, and covers factors such as equipment, facilities, statistics, staffing levels, culture and resources, which all impact on how the task is done.

The risk factors are not necessarily assessed in this order – and not all risk factors need to be reassessed in every situation. In most wards or units high-level formal environment and individual assessments can be done by the supervisor and applied to the majority of patient handling situations. Generally the carer will only need to consider task and then load before selecting a handling technique, although obviously common sense is needed about other factors if something crops up. A full patient handling risk assessment may only be needed for about 20% of new admissions. In some situations, such as special needs units, full assessments may be required more frequently.

What else is required?

While assessing the risk and dealing with it appropriately are at the heart of the **LITE**N UP approach there are many other things that need to be addressed if the new approach is to work, including:

- Commitment to change at all levels of your organisation
- A sound framework of policy and procedures
- Training so everyone knows what to do
- Practical equipment and suitable facilities
- Good record keeping and regular reviews.

The LITE way is about reducing the risk. To succeed we need an integrated systems approach to the way we run our hospitals and rest homes.

THREE KEY STEPS

The **LITE**N UP patient handling guidelines are based around three key steps – review, plan and action. It's important to see these steps as part of a continuous cycle of improvement. By working through the cycle you can set up and support the systems needed to keep your workplace safe.

This model is based on the ACC WorkSafe review-plan-action cycle. WorkSafe provides a guide for building a comprehensive health and safety programme in your workplace. You can find out more about this on the ACC website.

REVIEW

The starting point for change is to assess your current position. What handling tasks are staff doing, how are they being done, what are the issues or risks for staff and patients, and what do you need to do to meet the new patient handling guidelines and standards?

It's also important to start tracking injuries and issues so that you can measure the cost of injury – and the savings made through change. A cost-benefit tracker tool will be available shortly to help you track injuries and costs. Later on we'll also be providing a comprehensive audit tool to help you find the gaps in your patient handling programme. These tools will help you measure the effectiveness of your approach. The information you record is confidential and for your own use only. It's not intended for reporting to ACC or OSH.

How will the audit and tracker tools help?

The audit and tracker tools will help you measure how effective your patient handling programme is.

Measures you can obtain include:

- Workplace injuries, measured in lost time
- Breakdowns to give insight into injury factors
- Claim costs and changes over time
- Premium costs and changes over time
- Staff absenteeism, turnover and stability rates
- Programme costs and return on investment
- Workplace satisfaction 'before and after'.

Why is doing an audit so important?

The aim is to create a baseline so you can:

- Measure the effectiveness of your current systems
- Identify injury factors and quantify the costs involved
- Determine the changes needed and resources required
- Measure the impact of the changes you make
- Calculate the return on your investment.

It's important to review progress regularly as part of the cycle of continual improvement. You might like to check ACC's WorkSafe guide for suggestions about reviews and what you need to consider. This information is available from the ACC website.

Introducing a significant change to the way people do their jobs requires strong commitment, clear communication and good planning.

Building commitment

Adopting a patient handling programme is a significant change that requires commitment at all levels of your organisation. Everyone needs to understand what the change is, why it is happening and what their role is. Management commitment needs to be visible. Staff need to be involved in decisions and feel a sense of ownership – and everyone needs to be clear about their roles and responsibilities.

COMMITMENT AND OWNERSHIP

Here are some vital signs that show an organisation is fully committed to the successful introduction of a **LITE**N UP approach:

- A policy and plan have been developed and agreed on
- Managers actively consult with employees from the start
- Everyone has responsibilities they are accountable for
- Policy, procedures and roles are clearly communicated
- Responsibilities are included in performance reviews
- Adequate resources are allocated to the programme
- There is a recognised patient handling adviser
- There is an active patient handling committee representing managers, staff and health and safety officers
- Patient handling is a permanent management agenda item
- There is ongoing monitoring, review and development
- Review outcomes are communicated to all staff levels.

Following these steps will help ensure staff at all levels are involved and gain a sense of ownership.

ROLES AND RESPONSIBILITIES

Everyone is responsible for protecting their own health and safety, and that of others in the workplace. Everyone has a role to play. There is a detailed chart of roles and responsibilities later on (appendix 5) but here's a quick overview.

- **The board of directors** decides how the health care facility is run and how resources are allocated, and is responsible for overall health and safety compliance.
- **Senior management** are responsible for the success of the programme in their operational areas and need to set a clear leadership example.
- **Unit or ward supervisors** are responsible for the programme in their units or wards and their duties cover all operational aspects.
- **The patient handling adviser** is the champion of best practice and co-ordinates aspects such as training, buying equipment and reporting to managers and staff.
- **Employees and contractors** must protect their own safety and that of others in the workplace, and are responsible for correctly carrying out patient handling procedures.
- **Employee organisations** are expected to work in partnership with management and staff to create safer workplaces.
- **Equipment suppliers** must ensure equipment is fit for the purpose and provide clear instructions on use and maintenance.

PATIENTS AND FAMILIES

Patients and their families also have an important role to play. Patients have the right to be treated with dignity and respect, and to be informed about and consent to procedures, but not to endanger the carer's health. Patients (and families) need to understand the new approach to patient handling and should be included in the risk assessment process. If every effort has been made to find acceptable handling solutions and the patient (or family) will not comply, the team needs to decide on the best course to take, which could include withdrawing care. Workers are not obliged to put their own health at risk. Ideally the explanation and consents should be incorporated into the admission process.

Planning communication

Introducing major change requires a well planned approach to communication. Encouraging two-way communication is also very important. It demonstrates commitment and ensures the voice of those who must use the new approach is heard.

THE PLANNED APPROACH

You need to decide what your key messages are for each of your audiences, and what channels you will use.

- **Key messages** include what the changes are, why they are being made, what the benefits are, when and how the changes will be made, what everyone's role is, what resources will be available, what evaluation will take place and so on. There will also be specific and detailed operational messages for each audience group.
- **Audiences** include management, staff, unions, patients and families, visitors, volunteers, suppliers, contractors, consultants, equipment designers and suppliers, facility designers, students and teachers, stakeholders, health and safety advisers, professional groups, disability managers, media and interest groups.
- **Channels** include things like memos, emails, newsletters, notice boards, wall charts, promotional activities, brochures, meetings and forums, training sessions, reports, manuals and suggestion boxes.

The other factors you need to consider are timing and frequency. It's important to keep up a steady flow of communication, and to repeat key messages several times, preferably using different channels.

ENCOURAGING TWO-WAY COMMUNICATION

Staff need to be involved and have a sense of ownership from the start. Effective two-way communication can help achieve this.

Here are some suggestions:

- Seek staff input before drafting policy and procedures – circulate drafts for comments and feedback
- Set up a formal feedback process, but also use informal means such as suggestion boxes and talking to staff on the job
- Include staff representatives in the review, plan and action cycle
- Seek 'grass roots' input before making big changes, such as buying equipment or altering facilities
- Keep up a regular stream of communication about what's happening and make sure results are communicated to everyone
- Encourage regular staff meetings to review progress, and use forums like training sessions to gain staff views and suggestions
- Actively seek comment on issues using means such as feedback forms in newsletters, questionnaires and email polls.

Developing policy and plans

Having a clear policy statement and a well thought out plan helps ensure everyone works towards a common goal in a consistent way. Changes in policy can have far-reaching effects so it's critical to have people affected by the change involved early on.

PATIENT HANDLING POLICY AND PLANNING

The aim of developing a patient handling policy statement and plan is to support the creation of an environment where staff are trained, equipped, supported and encouraged to manage patient handling in a way that reduces the risk of injury to themselves and their patients.

Your policy statement sets out the organisation's commitment to patient handling by defining the standards and approach required. It should encompass, at a high level, all the components required for success – such as guiding principles, roles and responsibilities, organisational review, patient risk assessments and handling procedures, training, equipment, facilities, monitoring and evaluation.

Your plan sets out in detail your objectives, strategies for achieving them, targets and timeframes, and the measures you will use to assess the results. You will also need to consider resources and budgets. This plan should be reviewed and updated each year.

Some things to consider in your policy and plan:

- Roles and responsibilities
- Admission procedures and forms
- Staff recruitment and employment contracts
- Staff training and supervision
- Appraisals and performance measures
- Contractors, suppliers, visitors, volunteers and others
- Timing and approach for programme introduction
- Staff participation and feedback
- Consultation and ongoing communication
- Organisational and unit reviews
- Patient risk assessments – using **LITE** and the 16 kilo limit
- Recording and reporting data
- Evaluating, reviewing and reporting progress
- Purchase, use and maintenance of equipment
- Facility design requirements
- Emergency readiness and dealing with exceptions
- Dealing with accidents, near misses and non-compliance
- Managing injuries, and conditions that affect staff potential.

We've included a sample policy (appendix 2) and a sample plan (appendix 3) with this resource. You might also like to check ACC WorkSafe for more suggestions about what you need to consider.

Managing change

Each organisation is different and there are many ways to approach change. We recommend a special project (or pilot) approach. But first, you may need to build a business case so your board has the facts it needs to be able to allocate resources to the programme.

BUILDING A BUSINESS CASE FOR CHANGE

In most organisations it will be necessary to build a business case to gain resources for the change. Here are some things to consider:

- The guidelines are a best practice resource and a practical step for employers to take to protect their workers' safety
- Overseas the return on investment has been substantial
- A comprehensive programme could theoretically reduce injuries by up to 35%
- You can use ACC levy calculators[9] to estimate potential savings.

A good starting point is to seek approval for the resources required to start tracking injury performance, using potential savings to support your case. Once you have collected cost-benefit data you will be able to build a sound business case for your patient handling programme. The tracker tool, which will be available soon, will help you collect comprehensive cost-benefit data.

A SPECIAL PROJECT APPROACH

Special project committees are very effective at a unit level for assessing requirements and organising training, equipment purchase and facility design. Here are some suggestions for getting started.

- **Choose a suitable target area** – this could be a unit that has shown interest in change and commitment to improvement, has existing resources or is undergoing redesign, or has a high injury rate.
- **Help them set up a project team** – this should include staff from each shift, team leaders, a union representative and if possible a physiotherapist or occupational therapist.
- **Help the team set their goals** – for instance "to develop and implement a patient handling programme" or "to control the personal and economic cost of workplace injury".

9. *Available at www.acc.co.nz/productslevies/calculatepay-levies*

- **Help the team define the process** – the main steps are to:
  – Collect baseline data to measure progress against
  – Do a unit or ward risk profile using **LITE** principles
  – Identify the gaps and develop strategies to reduce them
  – Implement and monitor the strategies
  – Measure their effectiveness and work out the return
  – Reassess the target area (a process of continuous improvement).

To complete these steps the unit will need the full patient handling guidelines.

Positive change – change can be difficult and you may meet with resistance. One of the resources included in this introduction is a paper called ***Patient Handling Guidelines: Managing the Implementation*** *(appendix 4). This paper outlines what you can do when conflict arises and suggests ways to build agreement amongst your staff.*

ACTION

The information and tools for the next stage – the action or implementation stage – will be provided over the next few months. But here's a quick overview of what's coming to help you plan ahead.

Patient handling

In stage two we'll supply you with full patient handling guidelines and a profiling tool that staff can use to create patient risk profiles and handling plans.

Staff training

All staff need to know how to carry out their work safely, including handling patients and using equipment. Your training will need to cover everything from legal requirements to handling techniques.

WHAT ARE YOUR RESPONSIBILITIES?

You have a legal responsibility to ensure staff have information about hazards and how to minimise them. They must have the knowledge and experience (or be appropriately supervised) to avoid harming themselves or others. And they must be trained in the safe use of equipment or anything else they use or handle in their jobs.

HOW WILL THE GUIDELINES HELP?

The patient handling guidelines will cover the key components of a comprehensive patient handling training programme (such as performing risk assessments, use of safe techniques, and selecting and using equipment). We'll also cover key competencies required by staff at each level of your organisation.

Equipment

The 16 kilo limit means there is more emphasis on using equipment to assist with patient handling – and on making it convenient and practical to use. It's important to have policies and systems in place to ensure the right equipment is bought and staff are trained to use it correctly.

WHAT ARE YOUR RESPONSIBILITIES?

Your organisation will be responsible for ensuring the right equipment is available to protect the safety of staff and patients, for keeping it in safe order and ensuring staff are trained to use it correctly. You'll need to allocate money for the purchase of equipment[10] so your patient handling programme can start as soon as possible.

HOW WILL THE GUIDELINES HELP?

The guidelines will provide you with information on equipment available in New Zealand, manufacturing and maintenance standards, and principles for safe use.

10. UK hospitals found equipment purchase costs accounted for 3% of their budget in the first year, and .03% in maintenance costs in subsequent years. (The Guide to the Handling of Patients – 4th edition, NBPA, UK).

Facility design

Facility design, and the way space is used, has a big impact on patient handling. It affects how people do their job and how practical it is to use the equipment needed.

WHAT ARE YOUR RESPONSIBILITIES?

Your organisation is responsible for providing a safe and functional workplace where patient handling tasks, including use of appropriate equipment, can take place without risk to staff or patients. The design of your spaces should encourage patient independence and reduce the need for patient handling – and of course it must meet legal requirements for access and mobility by patients and people with disabilities.

The right solution doesn't always require new structures. For instance it may mean redesignating some spaces, changing schedules to ease crowding, rearranging furniture to create room for equipment and careful selection of equipment suitable for the environment.

HOW WILL THE GUIDELINES HELP?

The guidelines will provide a process to help you assess your environment, with examples of how space and dimensions can be optimised to ensure safe handling.

Are you ready?

What are we asking you to do now?

We're asking you to kick-start your patient handling programme by:

- Making a commitment to the change
- Communicating this to staff
- Developing a patient handling policy
- Deciding on roles and responsibilities
- Deciding how and where you will start
- Allocating resources for the change.

How ready are you?

There's a short checklist of the main points we've covered in this introductory guide at the back (appendix 1) – so you can measure how ready you are and decide on the steps you need to take now.

TOOLS AND RESOURCES

Patient handling tools

We're providing practical tools and resources to help you introduce and manage a **LITE**N UP patient handling programme in your workplace.

The items available now are:

- **Are you ready?** (appendix 1) – a self-assessment checklist so you can measure how ready your organisation is and decide on the steps you need to take now.
- **Sample policy statement** (appendix 2) – a brief outline of the main points you'll need to include in your patient handling policy statement.
- **Sample plan** (appendix 3) – a simplified example of a health and safety plan for introducing a patient handling programme. You'll find other sample plans in the ACC WorkSafe materials.
- **Positive change** (appendix 4) – a change management resource. This paper, ***Patient Handling Guidelines: Managing the Implementation***, has been prepared to help you implement the new programme and overcome resistance to change in your workforce.
- **Roles and responsibilities chart** (appendix 5) – a one page overview of everyone's responsibilities to help you with your planning.

What's coming?

Over the next few months we'll be providing more items including:

- A cost-benefit tracker tool to record injuries, incidents and related costs
- A patient risk profiling tool for preparing risk assessments and handling plans
- A comprehensive audit tool to help you assess your progress
- Handling techniques and illustrations
- A staff questionnaire to gain feedback on your programme
- A ward or unit profile tool to identify where resources are needed
- Information on required training and staff competencies
- Information on assessing, buying and hiring equipment
- Information on the ergonomic facility design process.

The handling guidelines, and profiling and tracker tools, will be provided on CD with details on how to use them.

Other ACC resources

Here's a quick overview of other resources that can help you improve safety in your workplace and manage injuries more effectively. These materials are free to employers.

You can download them at www.acc.co.nz/acc-publications – or you can order online or by calling us on **0800 844 657.**

	Order code
Active and Working! Managing Acute Low Back Pain in the Workplace (employer guide) – the latest information for employers on managing acute low back pain in the workplace	ACC594
Acute Low Back Pain Management: Patient Guide – helpful advice for people with back pain	ACC526b
ACC WorkSafe: How to Set Up and Support Workplace Health and Safety – a planning framework, in two parts, to help you develop a comprehensive workplace health and safety plan	ACC365/366
ACC WorkSafe: How to Develop a Workplace Back Plan – describes how to set up a system to prevent and manage back problems in the workplace	ACC379
ACC WorkSafe: Manual Handling Equipment – details of New Zealand suppliers and equipment that can reduce the risk of injury from handling objects	ACC380
Code of Practice for Manual Handling – outlines your legal responsibilities and offers practical solutions for manual handling of objects	ACC532

Your local ACC Injury Prevention Consultant can also supply a CD listing all the common hazards in the health care sector and recommended controls (available from any ACC branch).

Useful links

www.acc.co.nz – for comprehensive information and advice on injury prevention and workplace programmes. If you'd prefer to go straight to the information you want, try:

FOR	TRY
Resources	Looking under Injury Prevention or Work Safety at: www.acc.co.nz/acc-publications
ACC branches	www.acc.co.nz/contact-us/branch-offices
Injury statistics	www.acc.co.nz/injury-prevention/acc-injury-statistics-2002
Levy calculators	Looking under Calculators and Tools at: www.acc.co.nz/productslevies/calculatepay-levies

www.osh.govt.nz – for information on health and safety laws, statistics and a range of publications. You can also find details of your nearest OSH office if you'd like to contact OSH field staff about health and safety planning.

Further reading

The Guide to the Handling of Patients: Introducing a Safer Handling Policy – revised 4th edition. Published by the NBPA (National Back Pain Association) in collaboration with the Royal College of Nursing, UK. ISBN 0-9530582-5-5.

Victorian Nurses Back Injury Prevention Project – evaluation report 2002. Published by the Policy and Strategic Project Division, Victorian Government Department of Human Sciences, available on www.nursing.vic.gov.au

Aftermath – The Social and Economic Consequences of Workplace Injury and Illness. Published jointly by ACC and the Department of Labour, ISBN 0-477-03669-4, available on www.dol.govt.nz

If you'd like to provide feedback on this patient handling resource, please contact your ACC injury consultant – or email patienthandling@acc.co.nz

FREQUENT QUESTIONS

You'll find the answers here to some of the questions you may have.

Q1: WHAT IS PATIENT HANDLING?

Patient handling is any task involved in moving or supporting a patient including carrying, pushing, pulling, lifting and lowering. Handling a person is more complex than handling an object. People are heavy, hard to grip, and must be treated with dignity, respect and consideration for their capabilities. Handling can be unpredictable because our centre of gravity shifts as we move and people have differing capabilities to assist. Safe handling means making it safe for both carer and patient.

There are limits to the load people can handle without risk of harm. When the load is another person it usually exceeds those limits, so we need to eliminate thinking that a lift will be involved. Team lifting is not the answer – it is difficult for carers to equally share the load of a handling task, and team lifting should only be used in an emergency.

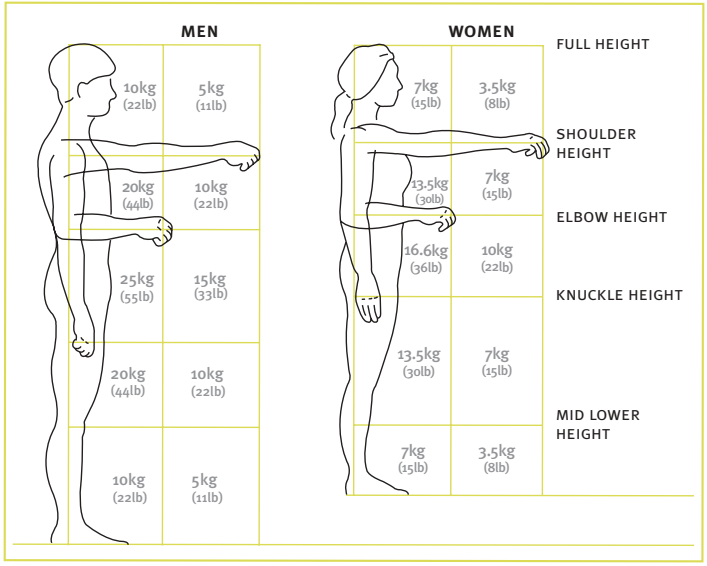
Q2: WHERE DOES THE 16 KILO LIMIT COME FROM?

The maximum load limits, shown on the chart, were developed by the UK as part of its manual handling regulations introduced in 1992 to meet EEC directives. The limits should not be regarded as a safety limit. Rather they provide a filter to screen out straightforward cases, and set a boundary within which patient handling is unlikely to create a risk of injury sufficient to require a detailed assessment. The limits are based on numerical guidelines developed from published scientific literature.

Australia bases its 'no lift' policy on a 16 kilo limit and New Zealand has also accepted this as a best practice standard. Adopting this standard will help employers meet their legal responsibilities.

MAXIMUM LIMITS

The maximum load limits are 25 kilos for men and 16.6 kilos for women – but only when the load is held close to the mid-body range between elbow and knuckle height. The load limits drop significantly in other positions. In most situations the task falls outside the limits and requires a risk assessment. These charts form part of the Manual Handling Operations Regulations 1992 in the UK and were reproduced with the permission of the Health and Safety Executive.



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1. ***Manual Handling Operations Regulations 1992***, UK. Published by HMSO, London.
2. ***The Guide to the Handling of Patients: Introducing a Safer Handling Policy*** – revised 4th edition. Published by the NBPA, UK.
3. ***Revised NIOSH equation for the design and evaluation of manual lifting tasks***, TR Waters, V Putz-Anderson, A Garg and JL Fine (1993). Ergonomics 36, (7) 749-776.
4. ***Force Limits in Manual Work***, Materials Handling Research Unit (1980). Published by IPC Science and Technology Press Ltd, England. ISBN 0-86103-034-6.
5. GC David, Robens Centre of Health Ergonomics, European Institute of Health and Medical Sciences, University of Surrey, UK.

Q3: WHAT IS THE ROLE OF ACC AND OSH?

ACC's mandate is to prevent injury. We have researched international best practice and developed the patient handling guidelines in consultation with industry groups and OSH.

These guidelines follow the work already done by ACC and OSH to develop the Code of Practice for Manual Handling (developed for handling inanimate objects).

OSH provides field resources and enforces health and safety standards. Their field officers can give practical guidance and advice on health and safety plans and procedures.

Q4: WHO HAVE WE CONSULTED WITH?

Active Rehab

Australian Nursing Federation

Council of Trade Unions

District Health Boards of New Zealand (12)

District Health Board Health and Safety Advisers

Ebos Group

IHC

Ministry of Health

National Back Pain Association, UK

National Safety Council of Australia

New Zealand Association of Occupational Therapists

New Zealand Fire Service

New Zealand Home Care Association

New Zealand Nurses Organisation

New Zealand Occupational Health Nurses Association

New Zealand Society of Physiotherapists

Nursing Council of New Zealand

Occupational Safety and Health Service

Private Hospitals Association

Public Service Association

Residential Care New Zealand

Salaried Medical Advisors

Service and Food Workers Union

St. John Ambulance

Waikato Polytechnic

We also acknowledge the support of Professor David Stubbs, Professor of Ergonomics, Robens Centre of Health Ergonomics, University of Surrey; and Louise O'Shea of NO Lift Systems Australia Pty Ltd.

Q5: WHAT DO PATIENT HANDLING INJURIES COST?

In New Zealand the cost in 1999 for ACC injury claims (new and ongoing) was over $30 million. The Australian Nursing Federation estimated that $26 million was spent on claims in 1996 and there were 1000 new injuries a year.

In the UK the Royal College of Nursing estimated in 1996 that £50 million was lost each year due to injury. And a 1992 study (Seccombe and Ball) found one in four nurses had time off for back injuries. Injury rates are similar in the USA and Canada.

REFERENCES:

1. ***The Guide to the Handling of Patients*** – 4th edition, NBPA, UK.
2. ***Preventing Low Back Pain Injuries: Literature Review (1998)***. Published by ACC, available at www.acc.co.nz/acc-publications under the injury prevention section.

Q6: WHAT'S BEEN TRIED IN THE PAST?

There have been many attempts internationally to reduce injuries in health care workers but success has been limited because the programmes tended to focus on single factors – and because the problem has been viewed in the past as a worker issue, rather than recognising it lies with the load. Past approaches include:

- **Back schools** – trying to teach people how to lift has failed because the problem is with the load, not the lifting technique.
- **Equipment** – success is limited when carers don't know how or when to use the items, don't have time, it's not part of standard procedures, or there is not enough space to use the equipment.
- **Lifting teams** – even strong people are injured lifting, and many teams have been cut because of funding shortfalls.
- **Health screening** – while screening people with previous injuries is helpful, it has been legally challenged. It's difficult to screen effectively and even people with no past history are at risk.

REFERENCES:

There are numerous studies on single factor intervention, including 20 studies (1998-2001) showing that education alone has little impact on outcomes and six concluding that equipment alone has limited effectiveness.

Q7: WHAT'S HAPPENING IN NEW ZEALAND?

New Zealand stakeholders have recognised the need to address patient handling issues. In the past many employers have developed patient handling programmes with varied degrees of success. The **LITE**N UP programme brings this work together, and uses information from successful programmes overseas, to provide a comprehensive and integrated patient handling programme. This initiative is supported by the New Zealand Nurses Federation, District Health Boards, residential care organisations and private hospitals.

ACC and OSH have already worked together to produce the Code of Practice for Manual Handling, which covers handling inanimate objects. We are now committed to working together, in consultation with health providers, to provide the health industry with an up-to-date and practical resource for handling patients.

Q8: WHAT'S HAPPENED OVERSEAS?

The UK and Australia have successfully reduced injuries by a combination of legislation and numerical guidelines (load thresholds). The **United Kingdom** introduced manual handling regulations in 1992, following EEC directives. Patient handling guidelines evolved over several years, with the latest Guide to the Handling of Patients (4th edition) released in 1999.

Australia introduced a 'no lift' policy in 1998. The Australian Nursing Federation's 'no lift' policy is based on the UK approach. The 2002 evaluation report of the Victorian Nurses Back Injury Prevention Project states that in the year following implementation of their patient handling programme, WorkCover claims reduced by 48%. The largest reduction was in sprains and strains, but back injuries were down 40%. A survey done at 18 months showed days lost due to injury had reduced by 74% and claim costs were down 54%.

REFERENCES:

1. ***Victorian Nurses Back Injury Prevention Project*** – evaluation report 2002, Victorian Government Department of Human Sciences, www.nursing.vic.gov.au
2. ***The Guide to the Handling of Patients*** – revised 4th edition, NBPA, UK.

Q9: WHAT DOES A SUCCESSFUL PROGRAMME INCLUDE?

The overseas experience shows us the most successful patient handling programmes use an integrated systems approach. They:

- Have a clear patient handling policy statement
- Define and communicate roles and responsibilities for everyone
- Are based on legal responsibilities
- Are based on biomechanical principles
- Use data collection tools for ongoing evaluation
- Use a risk assessment methodology
- Use handling equipment and safe techniques
- Describe and eliminate unsafe manoeuvres
- Differentiate between patient care and therapeutic handling
- Put theory into practice
- Have full support at all levels of the organisation.

The **LITE**N UP patient handling guidelines are built around these principles.

REFERENCES:

An extensive literature review by ACC concluded that programmes work well within a system but not in isolation. Refer ***Preventing Low Back Pain Injuries: Literature Review (1998)***. Published by ACC, available at www.acc.co.nz/acc-publications under the injury prevention section.

Q10: WHAT LEGAL RESPONSIBILITIES DO EMPLOYERS HAVE?

The Health and Safety in Employment Act 1992 and the Health and Safety in Employment Regulations 1995 require employers to take all practicable steps to ensure the health and safety of employees and others at work. Adopting the **LITE**N UP approach and the 16 kilo limit will help employers meet their legal responsibilities.

In very general terms those responsibilities include:

- Proactively preventing harm to employees
- Identifying, assessing and controlling or eliminating significant hazards which can cause harm, including harm later on
- Monitoring health if a significant hazard can't be eliminated
- Educating employees about the risks and how to avoid them
- Providing training and supervision to prevent employees from harming themselves or others (including patients).

It's important to note that musculoskeletal conditions are included in the list of serious harms detailed in the legislation.

Proactively preventing harm to your employees includes:

- Providing and maintaining a safe working environment
- Providing and maintaining facilities for staff health and safety
- Ensuring equipment is safe and well maintained
- Ensuring working arrangements are not hazardous (including the way things are organised, stored and transported)
- Providing procedures to deal with emergencies at work.

For more information visit www.osh.govt.nz to view the Act.

Q11: WHAT LEGAL RESPONSIBILITIES DO EMPLOYEES HAVE?

Employees must take all practicable steps at work to ensure their own safety and that of others. This includes identifying and reporting hazards, following safety procedures and attending training. For more information visit www.osh.govt.nz to view the Act.

Q12: WHAT LEGAL RESPONSIBILITIES DO SUPPLIERS HAVE?

The Health and Safety in Employment Regulations 1995 specify duties for designers, manufacturers and suppliers of plant. They must take all practicable steps to supply plant (and equipment) in accordance with ergonomic principles. Good design includes quality information on how equipment should be used and maintained. For more information visit www.osh.govt.nz to view the regulations.

Q13: WHAT DOES LITE MEAN?

LITE is an acronym for the risk assessment approach used. The key risk factors in patient handling are **L**oad, **I**ndividual, **T**ask and **E**nvironment.

- **Load** means patient characteristics that can affect the handling risk, such as age, gender, diagnosis, dependency, neurological status, size, weight, ability to co-operate, and fall risk.
- **Individual** means the individual capabilities of staff, such as language, education, training, physical limitations, stress and fatigue which can affect their ability to do the job safely.
- **Task** means the nature of the task. Different tasks, such as toileting, bathing, ambulating, rehabilitation, postoperative care, counselling, and full dependency care, have different requirements.
- **Environment** means the working environment and covers factors such as equipment, facilities, statistics, staffing levels, culture and resources, which all impact on how the task is done.

The risk factors are not necessarily assessed in this order – and not all risk factors will need to be reassessed in every situation.

In most wards or units high-level formal environment and individual assessments can be done by the supervisor and applied to the majority of patient handling situations. Generally the carer will only need to consider task and then load before selecting a handling technique, although obviously common sense is needed about other factors if something crops up.

A full patient handling risk assessment may only need to be done for about 20% of new admissions. In some situations, such as high needs units, full assessments may be required more frequently.

Q14: WHAT DOES THE AUDIT TOOL DO?

The audit tool allows you to review your organisation's position and measure the results against the **LITE**N UP guidelines. It will help you identify the gaps in your current practice – and set a baseline for measuring progress. The audit covers evaluation, policy and planning, patient risk assessment, training, equipment and facilities. Each section covers the core components essential for an effective patient handling programme. This tool will be available late 2003.

Q15: WHAT DOES THE TRACKER TOOL DO?

The tracker tool identifies and tracks costs involved with patient handling injuries. You will be able to measure things like:

- Workplace injuries, measured in lost time
- Various breakdowns to give insight into injury factors
- Claim costs and changes over time
- Premium costs and changes over time
- Staff absenteeism, turnover and stability rates
- Programme costs and return on investment
- Workplace satisfaction 'before and after'.

This tool will be available shortly.

Q16: WHAT DOES THE PROFILING TOOL DO?

The profiling tool helps staff complete patient handling risk assessments and produces individual patient handling plans based on the information provided. It asks questions based around **LITE** principles. The handling plans include techniques for each handling task, with diagrams and explanations. This tool will be available mid 2003.

ARE YOU READY?

APPENDIX 1

How ready are you to introduce a **LITE**N UP patient handling programme? This simple checklist is based on the information provided in this introductory guide. Score yourself on each question using a sliding scale – with 1 representing no action taken and 5 being completely ready. Your answers will help you determine where you have capacity and where you might need to build infrastructure before launching your programme.

	STEP 1: REVIEW	No action ← → Ready				
1	Have you set up systems to record injuries and costs?	1	2	3	4	5
2	Can you record data on:					
	a. Patient handling incidents (frequency and severity)	1	2	3	4	5
	b. Injury costs (direct and indirect)	1	2	3	4	5
	c. Programme costs	1	2	3	4	5
3	Have you planned for regular reviews? (at least annually)	1	2	3	4	5
4	Have you decided on your performance targets?	1	2	3	4	5
5	Have you set up systems to communicate results to staff?	1	2	3	4	5
	STEP 2: PLAN	No action ← → Ready				
6	Do you have a patient handling policy statement?	1	2	3	4	5
7	Have you defined everyone's roles and responsibilities?	1	2	3	4	5
8	Have you consulted with staff about your patient handling policy?	1	2	3	4	5
9	Does everyone know the policy and understand their role?	1	2	3	4	5
10	Have you got a communication and feedback plan?	1	2	3	4	5
11	Have you identified a target area to start your programme?	1	2	3	4	5
12	Have you made a patient handling plan with clear objectives?	1	2	3	4	5
13	Have you involved staff in the planning process?	1	2	3	4	5
14	Is someone designated as the programme co-ordinator?	1	2	3	4	5
15	Have you appointed a specialist patient handling adviser?	1	2	3	4	5
16	Have you allocated sufficient resources to carry out the plan?	1	2	3	4	5
17	Have you decided how you will measure your results?	1	2	3	4	5
18	Does your plan cover these key areas:					
	a. Patient admissions and records	1	2	3	4	5
	b. **LITE** risk assessments for all patients	1	2	3	4	5
	c. Patient handling and emergency procedures	1	2	3	4	5
	d. Staff induction, training, supervision and appraisals	1	2	3	4	5
	e. Purchase, use and maintenance of equipment	1	2	3	4	5
	f. Assessing and updating facility design and layout	1	2	3	4	5

	STEP 3: ACTION	No action ⟵ ⟶ Ready				
19	Patient handling training and staff performance:					
	a. Have you allowed time and budget for all staff to be trained?	1	2	3	4	5
	b. Have you allowed time and budget for refresher training?	1	2	3	4	5
	c. Can you provide modified work for staff with limiting conditions?	1	2	3	4	5
	d. Have you reviewed all employment and related contracts?	1	2	3	4	5
	e. Have you included patient handling performance measures in staff appraisals?	1	2	3	4	5
	f. Do you have procedures for non-compliance?	1	2	3	4	5
20	Patient handling equipment:					
	a. Have you reassessed your current equipment and needs?	1	2	3	4	5
	b. Do you regularly check, repair and replace equipment?	1	2	3	4	5
	c. Do you get staff input and arrange trials before acquiring new items?	1	2	3	4	5
	d. Have you allocated sufficient resources to buy or hire new items?	1	2	3	4	5
	e. Does your policy outline training and procedures for using equipment?	1	2	3	4	5
21	Facility design for patient handling:					
	a. Have you reviewed your facility requirements and constraints?	1	2	3	4	5
	b. Do you have a plan and timetable to make required changes?	1	2	3	4	5
	c. Have you allocated sufficient resources to make changes?	1	2	3	4	5
	d. Have you considered alternatives, such as new layouts and routines?	1	2	3	4	5
	e. Do you seek expert design and ergonomics advice on changes?	1	2	3	4	5
	f. Do you seek staff input before and after making changes?	1	2	3	4	5

SAMPLE PATIENT HANDLING POLICY STATEMENT

APPENDIX 2

The management of _____ is committed to providing and maintaining a **LITE**N UP patient handling programme to protect the health and safety of carers and patients. Our aim is to create an environment where staff are trained, equipped, supported and encouraged to manage patient handling tasks in a way that reduces the risk of injury to themselves and others.

Management will:

SET CLEAR OBJECTIVES AND MEASURES

- Set patient handling objectives and performance criteria for all managers and work areas
- Define and document roles and responsibilities for all management, staff and contractors
- Prepare an annual patient handling plan and carry out annual reviews
- Promote a system of continuous improvement.

CONSULT AND COMMUNICATE

- Encourage employee consultation and participation in all matters to do with patient handling
- Set up formal and informal ways to keep staff informed of progress and gain feedback
- Inform patients and families about patient handling and their rights and responsibilities.

PROVIDE THE RESOURCES NEEDED

- Allocate sufficient resources to implement and continuously improve the programme
- Contract a recognised patient handling adviser to provide advice to management and staff
- Provide the resources to record and report patient handling incidents
- Provide resources for training, acquisition of equipment and review of facilities in a timely manner for the implementation and maintenance of the patient handling programme.

ADOPT THE BEST PRACTICE STANDARD

- Follow a 'no lift' approach to patient handling – using the 16 kilo limit as a threshold
- Adopt the **LITE**N UP guidelines, or better, as the organisation's operating standard
- Require risk assessments and handling plans for all handling tasks over the threshold
- Ensure all risk assessments are carried out by trained and experienced staff
- Ensure staff carry out tasks in a manner that is safe for themselves and others
- Eliminate unsafe patient handling practices
- Promptly investigate all patient handling incidents and provide appropriate remedies.

TRAIN AND SUPPORT STAFF

- Ensure all staff are aware of the risks and how they can be reduced or eliminated
- Ensure all staff are trained and able to carry out patient handling tasks in a safe manner
- Provide comprehensive training by accredited trainers, and evaluate it for effectiveness
- Actively encourage staff to report and record any incidents and concerns
- Encourage staff to report changes in their capabilities, and provide safe work alternatives.

PROVIDE AND MAINTAIN THE EQUIPMENT NEEDED

- Provide the equipment needed for safe patient handling operations
- Establish processes to identify needs, and to trial and select appropriate equipment
- Ensure all equipment is repaired, maintained and replaced as required
- Ensure staff are trained in the safe use and maintenance of equipment
- Evaluate equipment needs annually.

REVIEW AND UPDATE FACILITIES

- Review facility design in relation to patient handling requirements and ergonomics principles, consulting with staff and expert advisers
- Establish a consultation group, including staff representatives, to oversee any changes.

Everyone has a role to play

Everyone in the workplace has a role to play and a responsibility to support the programme.

Every manager and supervisor has a responsibility for the health and safety of those working under their direction.

Each employee (or contractor) is expected to play a role in implementing and maintaining the patient handling programme by:

- Attending training and demonstrating competency
- Knowing the patient handling policy and procedures
- Following the policy and procedures in their work
- Demonstrating competency in patient handling operations
- Using **LITE** principles to identify, avoid and reduce risks
- Using safe handling techniques and avoiding unsafe practices
- Ensuring all equipment is safe before using it
- Reporting all incidents and concerns
- Reporting any change in their own capability to perform handling tasks
- Contributing to reviews and other processes to improve the programme.

SIGNED BY _____ **(CEO OR GENERAL MANAGER)**

DATE ___ /____ /_____

SAMPLE ORGANISATIONAL PATIENT HANDLING PLAN

APPENDIX 3

This is a high level plan, and obviously every organisation will have a different approach to planning. We've tried to include the key actions you'll need to cover in your first organisational patient handling plan.

PROCESS	PEOPLE	BUDGET	DATE
MANAGEMENT COMMITMENT			
Ensure all senior managers attend information sessions on patient handling	Chief executive		
Consider patient handling issues at all senior managers' meetings	Senior managers		
Prepare policy statement and consult with staff	Senior managers		
Define roles and responsibilities, build in to job descriptions and performance appraisals	Senior managers Supervisor		
Appoint patient handling adviser and contract extra expertise as required	Senior managers Supervisor		
REVIEW			
Undertake initial assessment of readiness	Supervisor		
Collect data – use tracker tool	Supervisor Staff		
Review plans and progress, and make recommendations, consulting with staff	Managers Supervisor Patient handling adviser		
PLAN			
Identify priority area to pilot programme, develop specific plans, targets and performance measures	Senior managers Supervisor Patient handling adviser		
Link patient handling plan to overarching health and safety plan	Patient handling adviser Health and safety adviser		
Link patient handling plan to other business planning	Managers		
Develop communication plan	Managers Supervisor		

PROCESS	PEOPLE	BUDGET	DATE
ACTION – HAZARD CONTROL			
Identify and assess all potential patient handling hazards	Supervisor Staff Patient handling adviser Specialist assessors		
Develop and implement specific action plans to eliminate or control hazards	Supervisor Staff Patient handling adviser		
Develop and implement process to ensure all accidents, incidents and near misses are reported and recorded	Supervisor Staff Patient handling adviser		
Investigate all incidents and implement remedy, report to senior management	Operations manager Supervisor Staff		
Review and update emergency plan, Hold regular drills – three monthly	Supervisor Staff		
ACTION – LITE PATIENT RISK ASSESSMENT			
Complete unit/ward profile (**LITE** environment assessment)	Supervisor Patient handling adviser Specialist assessors		
Complete unit/ward staff profiles (**LITE** individual capacity assessment)	Supervisor Patient handling adviser		
Develop and implement process to ensure **LITE** risk assessments and handling plans are done for all patients	Supervisor Staff Patient handling adviser		
ACTION – STAFF TRAINING AND PARTICIPATION			
Develop training for induction, ongoing training and annual refresher courses	Patient handling adviser Supervisor Staff		
Evaluate training effectiveness	Patient handling adviser Supervisor		
Develop and implement a process to involve staff in planning and reviews	Supervisor Staff		
Elect staff representatives for committees and patient handling issues/incidents	Supervisor Staff		
Ensure patient handling is part of all weekly staff meetings	Supervisor Staff		
Develop patient handling clause to be included in staff/contractor agreements	Managers Patient handling adviser		

PROCESS	PEOPLE	BUDGET	DATE
ACTION – PATIENT EDUCATION AND ADMISSIONS			
Develop patient handling information for patient and families – display publicly	Managers		
Review admission process and develop patient handling clause for admission forms	Managers		
Develop process for informing patients and dealing with non-consent	Supervisor Staff		
ACTION – EQUIPMENT			
Review current equipment and assess equipment needs	Supervisor Staff Patient handling adviser		
Trial and evaluate new equipment, ensure staff participation, make recommendations	Supervisor Staff Patient handling adviser		
Prepare and implement a process for regular equipment checks and maintenance	Operations manager Supervisor		
ACTION – FACILITIES			
Review facility requirements and constraints	Supervisor Staff Patient handling adviser		
Establish design consultation group	Operations manager Supervisor Patient handling adviser Specialist advisers Staff representatives		
Prepare plan, timetable and budget to implement changes	Operations manager Supervisor		
Inspect changes, regularly review needs	Supervisor		

PERFORMANCE MEASURES	TARGETS
Number of action points implemented	By __/__/__ all actions in current plan implemented
Patient handling injuries reduced	By __/__/__ patient handling injuries reduced by ___% compared with the previous year (note overseas hospitals report up to 50% reductions)
Number of accidents, incidents and near misses reported	By __/__/__ incident reporting increased by 50% compared with previous six months

PATIENT HANDLING GUIDELINES: MANAGING THE IMPLEMENTATION

1. Introduction

You now have new guidelines for safe patient handling and need staff to make a commitment to using them. Different personalities, viewpoints and values in the workplace may mean that you meet some resistance to the change – and getting consensus may not be easy. There may have been workplace issues in the past that left negative feelings, difficult relationships and parties with grudges against others – and you want to avoid those difficulties this time if possible.

What can you do to manage the implementation process constructively?

This paper outlines what to do when conflict arises and how to build agreement amongst your staff. It identifies how people typically approach change within an organisation – and sets out steps you can use for developing buy-in and commitment to safe patient handling.

1.1 APPROACHES TO CONFLICT

Conflict is an inevitable, and in fact necessary, part of any organisation. It can sharpen understanding of a problem, sort out what people value and why, help staff develop new skills, and broaden appreciation for a diversity of opinions. Conflict itself is seldom the real problem. The real problem is *unresolved conflict* that festers in an organisation – affecting perceptions, relationships, performance, credibility and the ability to achieve desired goals. It is important to approach and manage conflict so it is seen as a constructive part of organisational change.

There are many ways to approach conflict. The research of Kenneth Thomas and Ralph Kilman identified five very general approaches:

- Avoiding
- Coercing
- Yielding
- Compromising
- Collaborating.

Each one of these styles may be appropriate in certain circumstances. But collaboration is the style most likely to minimise the negative impacts of conflict, help maintain good relationships, enhance learning and ensure long-term results.

The diagram on the next page illustrates each approach.

Five approaches to conflict

Coercing means that you are totally focused on your own needs, with little or no attention to the needs of others. This is a power-oriented style where someone uses whatever power seems appropriate to win their position on the substantive issues.

Yielding means that you are totally focused on others' needs and do not attempt to satisfy, or even address, your own needs. There is an element of self-sacrifice in this mode, accommodating someone else totally in order to preserve the relationship.

Avoiding might take the form of diplomatically sidestepping an issue, postponing an issue until a better time, or simply withdrawing from a difficult or threatening situation.

Compromising falls in the middle ground between coercing and yielding. It addresses an issue more directly than avoiding, but doesn't explore it in as much depth as collaborating. Compromising might mean splitting the difference, exchanging concessions, or seeking a quick middle ground position.

Collaborating is both assertive and co-operative. It is focused on the needs of all parties. It involves an attempt to work with the other person to find some solution which fully satisfies everyone's underlying concerns.

Barbara Gray, in her book ***Collaborating: Finding common ground for multiparty problems***, outlines five features of a collaborative approach:

- Stakeholders are interdependent – the implementation process can produce solutions that none of them working independently could achieve
- Solutions arise by dealing constructively with different perspectives
- Decisions are jointly owned – stakeholders are directly responsible for the process and the outcome
- Collaborating often leads to increased efficiency through improved relationships
- Collaborating is an ongoing process rather than a one-off event prescribed by the organisation.

Collaborating is probably the hardest to implement because it is the least instinctive of the five approaches. People tend to coerce or yield rather than try to discover the underlying problem. The challenge is to understand what people really care about. Only then can a range of appropriate options be developed. External benchmarks (or standards) can then be used to select the fairest and most durable solution.

> ***The key to resolving conflict is to understand what people are really concerned about and to work on both the relationship and the substance.***

1.2 SEARCHING FOR WHAT PEOPLE ARE CONCERNED ABOUT

People often state their demands – what they want – rather than why they want it.

- **Positions** or demands are what people say they must have.
- **Interests** or concerns are the underlying reasons, needs or values that explain why they take the position they do.

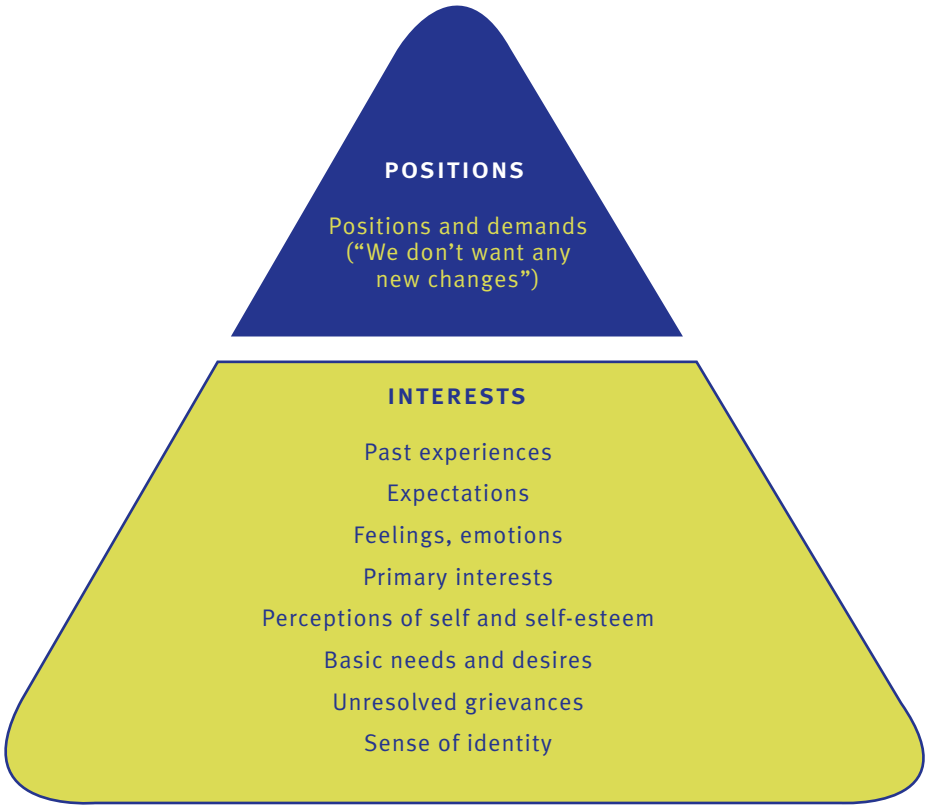
For example, someone may say, "I won't use these new safe handling techniques". Asking "why?" may reveal concerns such as "it is new and uncertain", or "it will create extra work", or "this is being imposed on me without consultation". All these could be underlying reasons for this person taking their initial position.

There are two primary reasons why understanding interests or concerns is so important. The first is that it is easier to have influence if you know what another person really cares about. The second is that, if you know each other's interests, you can potentially create better solutions that meet both your interests.

If trust is the interest, then work on how to build trust. If time is the interest, work on how to make new handling techniques more efficient. If being imposed on is the interest, work on how to develop more buy-in or ownership in the programme.

One way to understand the hidden layers of conflict is through the iceberg analogy illustrated over the page.

The conflict iceberg



This diagram does not imply that every process of collaboration needs to explore the basic sense of identity. What it does imply is that as we go further down the iceberg we begin to experience the interconnections between people, and the common goals that connect people in an organisation. The iceberg allows us to transform a demand into a set of reasons that can be constructively worked on. It is often not the surface layers that will aid resolution, it is the hidden layers that unlock the conflict and result in transforming situations and people.

One of the most obstructive assumptions in managing conflict is that people always have opposing interests. This immediately sets up a competitive scenario. If we always assume that conflict is about opposing interests then we will see resolution as a struggle or a win-lose process. But if we assume instead that people have largely co-operative goals, then conflict is a common problem to be solved.

1.3 GETTING BENEATH THE SURFACE

Kenneth Cloke and Joan Goldsmith, in their book ***Resolving Conflicts at Work***, have a set of guidelines for moving down the iceberg:

- Start by focusing on yourself and understanding more about your own approach to conflict
- Use curiosity (open ended questions and empathic listening) to discover the interests and concerns that lie beneath the surface
- Take a risk by bringing a deep level of honesty to what you see, hear and observe, recognising the more honest you are with yourself, often the deeper you can go with others
- Be willing to accept whatever you find beneath the surface without shame, anger or judgement.

Collaboration is working in partnership to understand and develop the underlying interests of all parties. The next section covers the key steps involved in building collaboration.

> ***The key to understanding interests is to ask "why?" – test your understanding of what is important.***

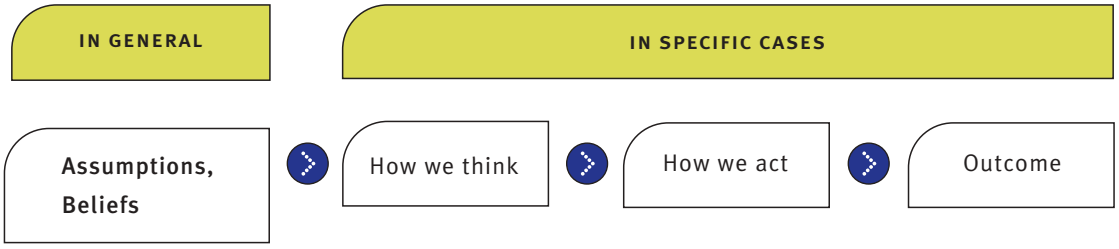
2. Steps and tools for effective collaboration

Before discussing the key steps in collaboration it is important to examine how assumptions influence outcomes. We make assumptions about people, the context or the issues all the time. The key question is whether we are open to test the assumptions we have made or those other people may hold.

If parties assume that conflict is always negative, a battle between people with irreconcilable views, a struggle over what is right and wrong, or who has more power, then they will generally end up with a win-lose result.

However if parties assume that conflict can be positive, that each has different but not incompatible interests, it can be an opportunity to explore what is important and even improve relationships – then the results are more likely to involve gains for everyone.

Our underlying assumptions and beliefs shape how we think. Our thinking dictates our choice of strategy, how we implement it and the outcomes that result – as shown in this diagram:



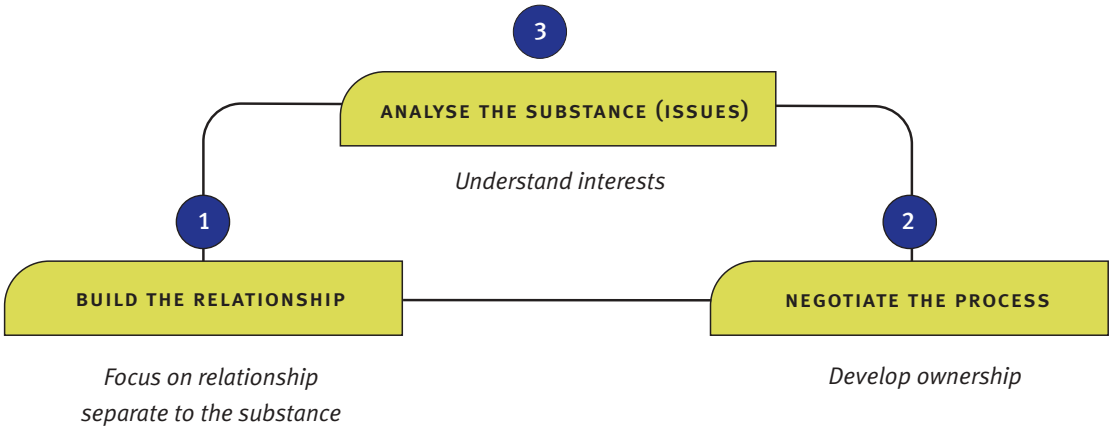
So if staff have an assumption that the level of patient care cannot be maintained with the new patient handling policy then they are likely to think that the policy won't work and will not commit to its implementation. The likely outcome of this is that the policy will have little effect on the level of musculoskeletal injury.

Key points for managing assumptions are:

- *Assumptions are necessary for efficient living. So the challenge is not to eliminate or avoid them – but to be aware of, and test, assumptions*
- *Just because someone has a conflicting or opposing position to your own, it does not mean their underlying interests are also opposed to yours. We need to test our assumptions about what people really care about as there is often much more common ground than we think.*

2.1 BUILDING THE RELATIONSHIP

The first step in collaboration, after testing the assumptions, is to build the relationship as outlined in this diagram:



Task (1) + (2) will influence any agreement in (3)

Relationships involve values such as mutual respect, understanding and trust. A good relationship is one where differences are well managed and help create more value between people. Conflict then becomes an asset – a source of innovation and learning – rather than a liability.

Experience has shown that building and maintaining good relationships has a real impact on results. If people trust, respect and understand each other, they are much more willing to openly share their real concerns and interests. They are more willing to think laterally about how to manage conflict, and have greater confidence that any commitments will be honoured.

A good relationship does not mean you need to agree with the other party. Trying to buy a good relationship with concessions is usually unsuccessful. This is because the substance (or issues) is different from the relationship itself. Having a good working relationship simply means we can deal with issues constructively, not that we must agree.

The relationship and the substance (or issues) are two different things and, when people do not agree on the substance, they may be tempted to see the other party as 'the problem'.

In collaboration it is important to separate the people from the problem, to maintain a good relationship while also being firm on the issues. This will increase the likelihood of achieving a durable agreement.

Key points for managing relationships are:

- *Separate the relationship and the substance*
- *Be gentle on the person and assertive on the problem*
- *Do only those things that will improve your ability to work with this person next time, even if they do not reciprocate*
- *Be unconditionally constructive on the relationship, without trading concessions on the substance.*

2.2 THE PROCESS

The second step in building collaboration is to negotiate and agree on the process with the parties. Process refers to *how* – how people talk with each other, how they identify and solve problems, how they make decisions, and how they resolve conflict. In contrast the substance (or issues) is what the conflict is about.

In managing the process one has to be conscious of five key elements:

- Purpose
- Product
- People
- Place
- Procedures

1. **Purpose** – what is the discussion or meeting trying to achieve? Is it for reaching agreement, achieving an understanding, exchanging information, or brainstorming ideas? It is essential parties define in advance what will constitute resolution and how they will know when it is accomplished. Being clear about the purpose will aid both the effectiveness and the efficiency of the process.
2. **Product** – what do stakeholders or participants want to finish up with? It is essential for all participants to be committed to this at the outset. Is it an action plan, a purchase decision, or suggestions for design changes?
3. **People** – who should be involved in addressing the substance? If the issue is significant to the organisation many people may want to be involved. But involving a large number of staff can make decision making difficult and inefficient. A simple method to decide who should be involved, and when, is required.
4. **Place or setting** – the first choice is should the setting for the meeting be formal or informal? An informal setting may be good for an open exchange of ideas, exploring interests, problem solving, brainstorming ideas or creating drafts of possible agreements. In an informal meeting it is useful to create a physical space that is consistent with its informal nature. A formal setting may be needed when parties are ready to make commitments or decisions around the process or the substance. The second choice is where the meeting should take place. Does it matter if it's held at either party's venue, or would a neutral venue be preferable?
5. **Procedures** – first there is a need to agree on ground rules for the meeting. These create certainty for participants, remove the likelihood of misunderstanding, and outline acceptable and unacceptable behaviour. How will discussions progress, decisions be made, and behaviours managed? Agreement on ground rules should involve all parties and should precede discussion of substantive issues. Second is the need to agree on an agenda and clarify the roles of participants, such as facilitator, timekeeper, recorder and so on.

Once you have built the relationship, and negotiated and agreed the process, you are ready to address the substance (or issues).

Key points on process are:

- *Make commitments on process before addressing the substance*
- *A shared commitment to the process can help participants manage the substance (issues)*
- *When participants are committed to the process, they are more likely to be committed to the outcome*
- *Separate the creating and exploring of ideas from the deciding and committing to solutions by being explicitly clear about the task at hand. Agree with participants when the task is to explore ideas – and agree when the task has changed to decision making. This will lead to more creative solutions and greater gains for participants.*

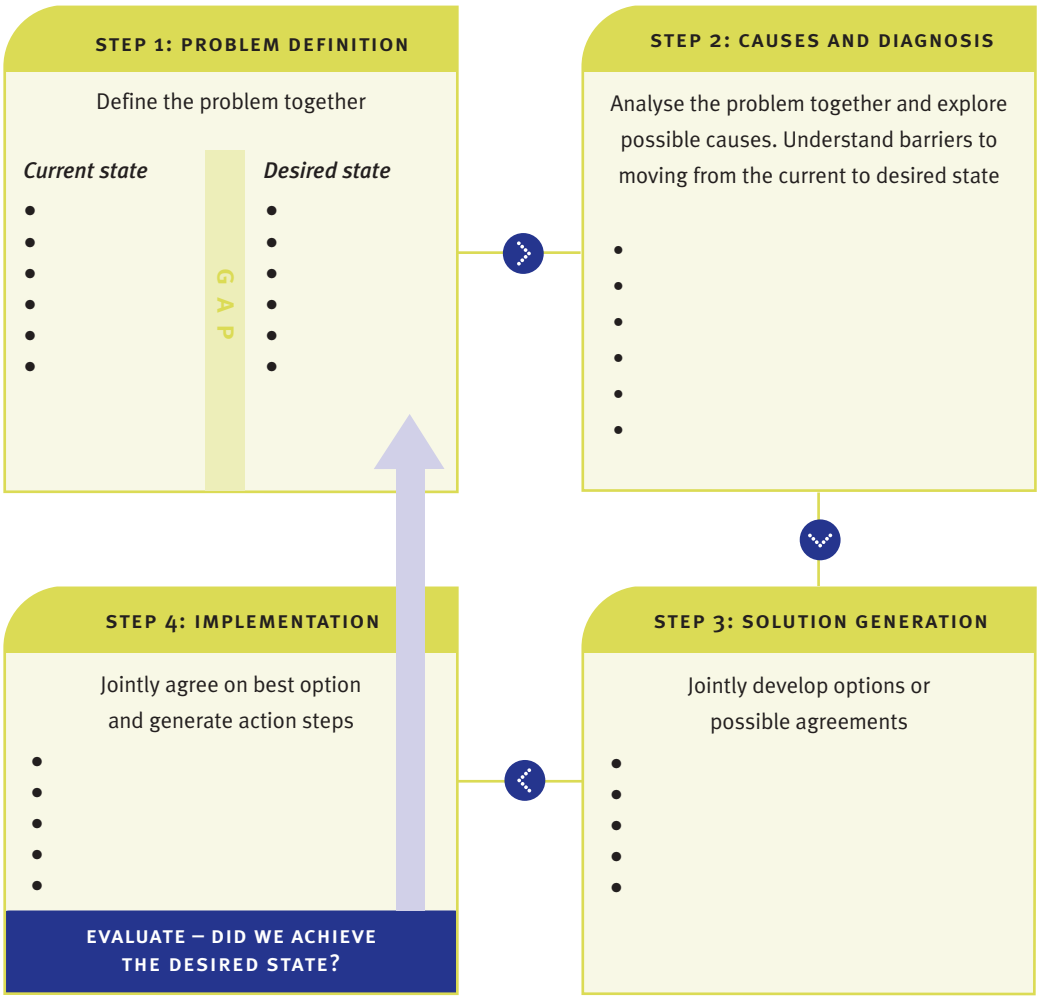
2.3 THE SUBSTANCE

In addressing the substance, often the greatest problem is not the issue, but how we go about resolving it. When faced with a difficult problem people often want to move as quickly as possible to potential solutions.

But without a clear and common understanding of the problem, a clear picture of the desired outcome, and a careful diagnosis of the causes, finding and agreeing on the right solution can be difficult.

The Four Quadrant tool provides a structured way to address substance by moving from problem definition, to the causes, solution generation and implementation as follows:

The Four Quadrant tool



THE STEPS IN THE FOUR QUADRANT TOOL

Step 1: Define the problem

- Think broadly about what is wrong.
- Identify the characteristics of the current situation that are undesirable (the symptoms of the problem).
- Define the characteristics of the desired state, being as specific and concrete as possible.

Step 2: Generate possible causes

- Analyse the gap between the current situation and the desired state.
- Hypothesise about possible causes for the gap.
- Consider any causes that could themselves be a problem in need of further analysis. Where appropriate, plug such causes back into Step 1.
- Be comprehensive – make sure you address all the symptoms of the problem.

Step 3: Brainstorm possible solutions

- Brainstorm many ways the problem could be addressed.
- Use your list of causes to focus efforts to generate solutions. Ensure you address each likely cause and generate specific solutions for each one. Don't waste time generating solutions that don't address the causes of the problem.

Step 4: Agree on best solution and decide on specific action

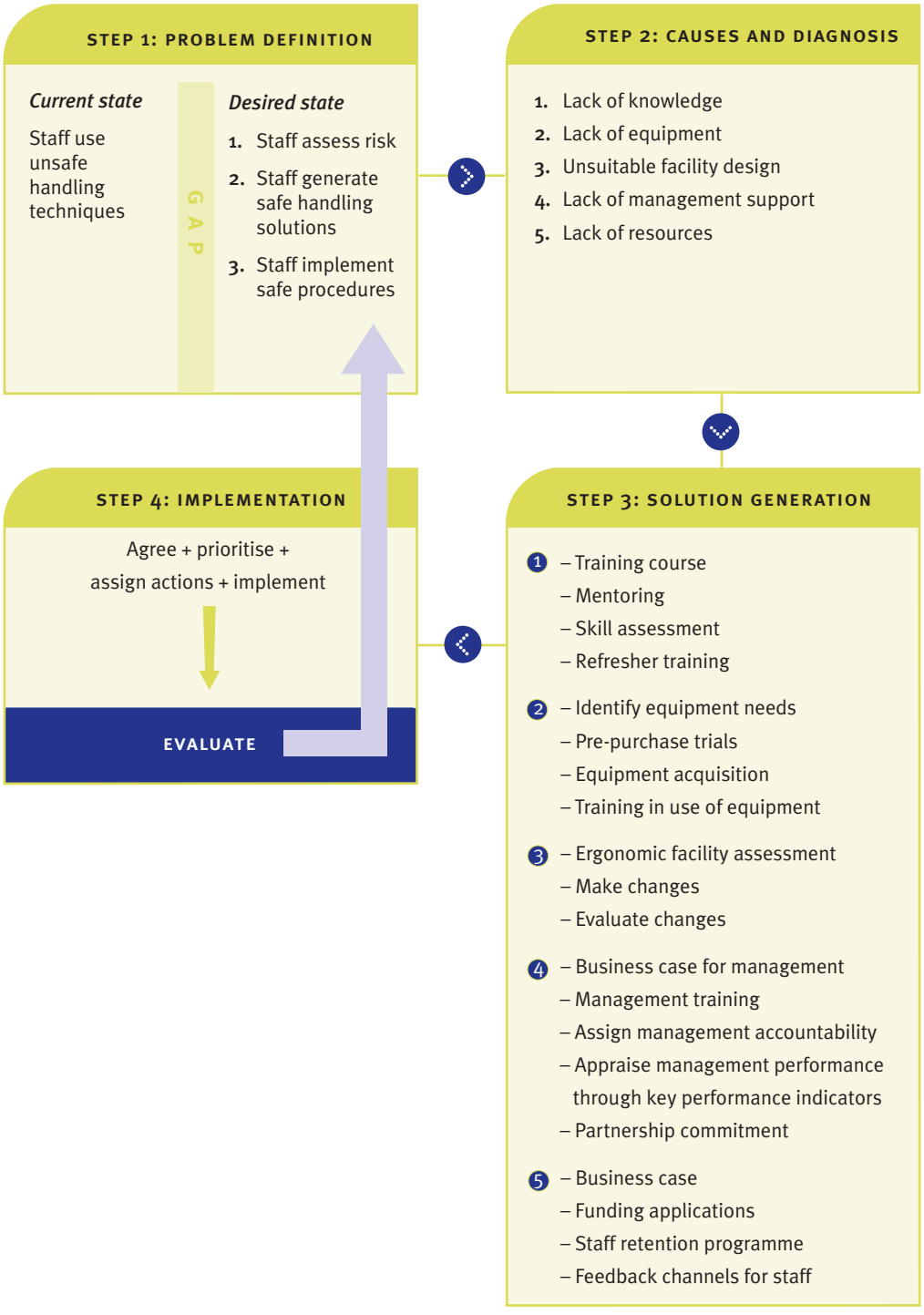
- Explore how the solutions generated in Step 3 might be implemented. Assess their feasibility in the real world and the costs and benefits associated with each.
- Convert possible solutions into specific action plans (who will do what by when).

Step 5: Evaluate results

- Evaluate whether solutions have achieved the desired state. If not, redefine the problem and repeat the problem solving process.
- As you work through the problem solving you keep revisiting the relationship and the process. If problem solving is getting stuck or bogged down, go back and test assumptions, do further work on the relationship, or rethink/renegotiate the process.

On the next page there is a simple example of problem solving using the Four Quadrant tool.

An example of collaborative problem solving on substance (or issues)



Key points on substance are:

- *Dig for interests rather than focusing on positions*
- *Develop a common understanding of the problem*
- *Explore the causes, or why the problem exists, before trying to fix it*
- *Separate inventing possible solutions from evaluating and deciding*
- *In a complex organisational environment a sound diagnosis will ensure action/s taken address the real problem/s.*

3. Seeking agreement in a complex organisation

In trying to implement new guidelines into your organisation you probably face a complex set of relationships, procedures and decision making systems. We have outlined two techniques from the work of Jeff Weiss and Jonathon Hughes, in their book ***Making Partnerships Work***, that may help you to get buy-in and support from essential parties in a relatively quick timeframe.

3.1 THE FIRST TECHNIQUE – THE I-C-N METHOD

The first technique allows you to determine which party to approach for what purpose. It's called the I-C-N Method. It can help you decide who needs to be *informed*, who needs to be *consulted* and who should *negotiate*. This method maximises inclusiveness and efficiency.

ISSUE/S DECISION/S	THE NEGOTIATE CATEGORY	THE CONSULT CATEGORY	THE INFORM CATEGORY

- In the *negotiation* category are those who need to sign-off on the decision or document.
- The *consultation* category should be broad enough to ensure that needed perspectives and expertise are included, and that necessary buy-in is obtained, particularly from those who could derail implementation. In this group are people who do not have the final authority to decide.
- In the *inform* category there is an attempt to keep people updated about the process, the need for the decision, and the reasoning behind the decision, rather than just informing them of the decision after the fact.

This technique allows people within the organisation to clarify different levels of involvement, and reduces the expectation from some that their input will be automatically incorporated.

3.2 THE SECOND TECHNIQUE – RELATIONSHIP MAPPING

In developing agreement it is often necessary to build alignment among multiple parties. This is even more difficult if you need the buy-in of people whose very support will create opposition in others. People often make unnecessary trade-offs between people as they lack an efficient method to get buy-in from multiple parties.

Relationship mapping is based on the work of Jim Sebenius who suggests that building support among multiple parties requires analysing the relationships they have with one another. These relationships can be categorised in three ways:

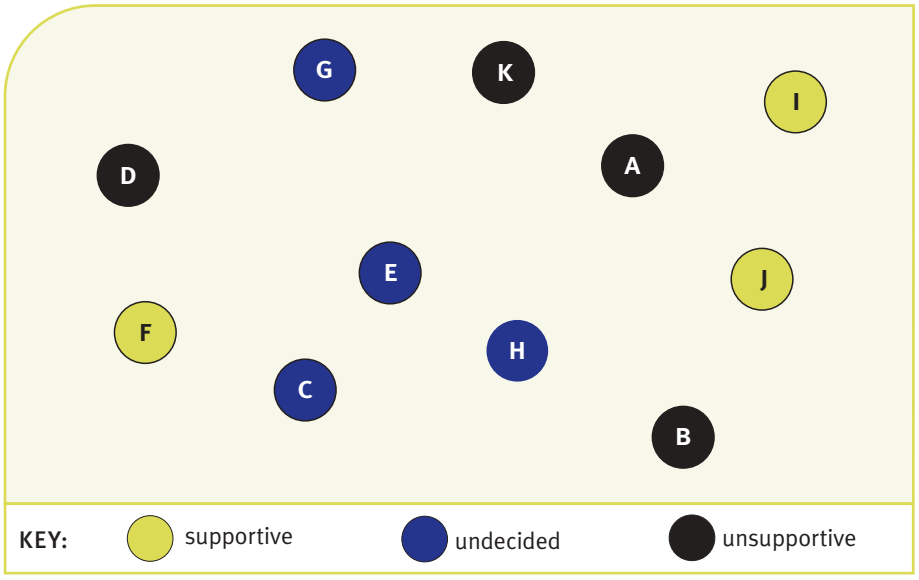
- **Antagonism** – if she agrees, he will not agree
- **Influence** – if she agrees, the chances of him agreeing is increased
- **Deference** – if she agrees, he will almost certainly follow suit.

Mapping out the key relationships within an organisation makes it possible to systematically build buy-in and support among multiple participants, rather than just acting in a random fashion. Know what the key relationships are, and systematically plan to gain buy-in by *minimising* the effects of antagonistic relationships and *maximising* the leverage of influential people.

STEPS IN RELATIONSHIP MAPPING

Step 1: Identify the parties

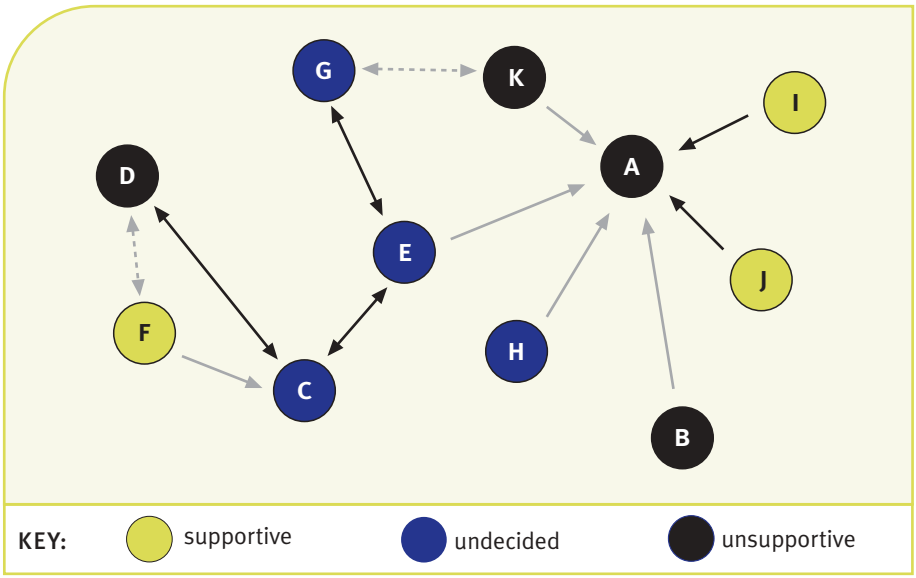
- Identify all people who need to buy in to a decision or course of action. Think especially about key decision makers or other influential parties who have the ability to either derail the decision, or expedite its approval or implementation.
- Estimate each party's biases – are they likely to be supportive or opposed?



Step 2: Map the relationships between the parties

- **Antagonism**
  If X supports an action or decision, then Y is likely to oppose it.
- **Influence**
  If X supports an action or decision, then Y will consider it carefully and the chances of his agreeing are increased.
- **Deference**
  If X supports an action or decision, then Y will almost certainly follow suit and agree as well.

Here is an example of a 'map' to decide on an effective strategy. Here I and J influence A's decisions, and K, E, H and B all defer to A. So it makes sense to approach I, J and A first.



Step 3: Determine a sequence for gaining buy-in

Consider each of the following criteria to come up with the most feasible and efficient sequence with the highest likelihood of success.

- **Efficiency** – whose buy-in do you need first to cause others to follow suit? Try to identify the sequence that will lead to the broadest support in the fewest consultations.
- **Biases** – who is likely to support or oppose your plan? Map out the influence of those who are inclined to be supportive, and look for a sequence that minimises the impact of antagonistic relationships.
- **Accessibility** – who do you realistically have access to? Who do you need to rely on to open doors for you?

The following strategy derives from the previous diagram and shows sequencing for efficient buy-in based on influence and leverage. This tool does not take away the need for people to be consulted – it provides a process for increasing the efficiency of buy-in.

1. *First go to:*
   - Party I
   - Party J
   - Party A
2. *Next go to:*
   - Party K
   - Party C
   - Party D
3. *Then approach:*
   - Party B
   - Party E
   - Party H
4. *Finally approach:*
   - Party G
   - Party F

The key to building agreement in a complex organisation is developing an inclusive decision making process.

4. Conclusions

- **Collaboration works best**
  Of the many styles of approaching conflict, collaboration is the only one that truly balances the needs of each party, works equally on the relationship and the substance, and develops solutions that typically provide more benefit to parties than they would otherwise obtain.
- **Assumptions affect results**
  Assumptions and beliefs about conflict and how to manage it often have a greater influence on results than strategies and actions. If in managing the conflict you are not getting the results you want, you need to test assumptions made about the situation, parties or methods of resolution.
- **Understanding builds co-operation**
  In managing conflict you need to focus first on exploring the underlying concerns or interests that create common goals and increase co-operation. A focus on interests will maximise the gains for all parties and lead to solutions that are more durable, less costly, and give participants greater control over process and outcome.
- **Relationships influence solutions**
  Relationships between people affect their ability to create durable solutions. Separate the relationship from the substance (issues) – and be unconditionally constructive on the relationship, whilst being firm and assertive on the issues.
- **Staff must be committed**
  Gaining people's commitment to the process will enhance their commitment to the outcome. If people believe their interests have been addressed fairly, they are more likely to be committed to the solution. Negotiate the process before trying to address the substance.
- **The approach outweighs the issue**
  When conflict exists it is often the way we approach the issues that is more of a problem than the issues themselves. Having a systematic method to understand the nature of the problem and the causes behind it will lead to more creative solutions and commitment to the action.
- **Complexity requires systematic thinking**
  Determining who needs to be involved and for what purpose is an essential step in developing an efficient and effective agreement. Mapping the relationships between key parties and being able to design the collaboration strategy will enhance commitment.

An integrated patient handling programme – roles and responsibilities

APPENDIX 5

	BOARD AND SENIOR MANAGEMENT	UNIT OR WARD SUPERVISORS	PATIENT HANDLING ADVISERS	STAFF AND CONTRACTORS
Review	• Prepare and review annual plan • Involve staff in review process • Incorporate recommendations and law changes into annual plan • Check policies and procedures • Review progress against objectives • Review staff performances	• Conduct audits and use tracker tool • Complete unit/ward reviews • Obtain staff feedback • Review findings and make recommendations • Consult with staff and ensure participation	• Work with the supervisor to collect and report statistics • Review objectives and performance indicators • Recommend improvements	• Take part in activities designed to evaluate the programme • Provide feedback and input
Plan	• Ensure policy and procedures are written and communicated to staff • Make a copy available to all staff, patients and visitors • Appoint and support a patient handling adviser and contract extra expertise as required • Delegate roles and responsibilities and set performance measures	• Know and follow policy and procedures • Communicate roles and responsibilities to staff • Monitor and evaluate staff	• Review policy and plans and make recommendations	• Know and follow policy and procedures • Contribute to development of policy and procedures
Action	• Allocate sufficient resources for the programme to operate • Ensure all handling risks are identified, assessed and controlled • Ensure policies and procedures are in use, with regular inspections and audits • Ensure everyone knows their role • Ensure unit/ward risk profiles are done and any issues addressed • Ensure patient risk profiling is done and safe handling plans used • Ensure all staff are properly trained and their performance monitored • Ensure training is done by accredited trainers and is evaluated • Ensure required equipment is supplied and well maintained • Ensure facility design issues are addressed in consultation with users • Ensure there is an emergency plan and regular drills • Ensure all incidents, issues and near misses are recorded, reported and prevention strategies put in place	• Lead and support staff • Complete unit/ward profiles and address any issues • Ensure risk profiles matching patient needs are done for all patients by trained staff • Ensure correct application of patient risk profiles, equipment and handling techniques • Ensure training, equipment and staffing levels support safe practices • Seek advice for challenging situations • Arrange special equipment and training if needed • Provide modified/alternative work for staff if required • Create emergency procedures and conduct drills • Conduct audits and inspections, take follow up action • Investigate and report on all incidents and take follow up action to eliminate risks • Co-ordinate, supervise and evaluate training, maintain a training register • Arrange and evaluate equipment trials, ensure staff participation and feedback, make recommendations • Ensure there is sufficient and appropriate equipment and that it is well maintained • Assess facilities, determine needs, ensure staff participation and feedback, recommend changes • Co-ordinate with design consultation group and inspect changes to ensure they meet needs • Periodically review facility needs	• Mentor staff • Provide, monitor and evaluate solutions for complex situations • Evaluate risk assessment process and recommend improvements • Train staff, keep training records and evaluate training effectiveness • Help determine equipment needs, participate in trials, assess equipment and make recommendations • Help determine facility design needs, work with designers and take part in consultation group • Inspect facility changes to ensure they meet needs	• Take part in training • Ensure risk profile is done for each patient • Follow safe patient handling plans • Report all incidents, issues and concerns • Report any medical or physical conditions which limit their capability to carry out handling tasks • Avoid patient handling risks and seek advice for challenging situations *Employee organisations are expected to support the creation of safer workplaces by understanding everyone's roles and actively working in partnership with management and staff.*

SUPPLIERS, DESIGNERS AND MANUFACTURERS HAVE A LEGAL RESPONSIBILITY TO ENSURE EQUIPMENT AND FACILITIES ARE FIT FOR THE PURPOSE – AND FOR SUPPLYING CLEAR INSTRUCTIONS ON USE AND MAINTENANCE.

Further resources

visit → www.acc.co.nz

or call → 0800 THINKSAFE (0800 844 657)