THE MANUAL HANDLING REVOLUTION

How health professionals can achieve creative solutions for people with disabilities and their caregivers

AIDEEN GALLAGHER

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About the author

Aideen Gallagher's vision is to revolutionise the manual handling industry and the process by which allied health professionals recommend manual handling equipment. She is passionate about the mental and physical wellbeing of people with complex physical disabilities and the care workers who assist them.

Aideen is a leader in her field, having published 10 articles in peer-reviewed academic journals. Through her company Risk Managed, she has developed courses in creative equipment prescription and manual handling, called HoistEd and MoveEd, and these are delivered in Australia and Europe.

Aideen is an energetic and engaging presenter. She is recognised for capturing her audience by drawing from her extensive clinical experience and being able to solve the trickiest of problems – and doing so in a way in which everyone wins.

Aideen provides simple insights that are changing the ways thousands of health professionals think about manual handling. Her ambition is that manual handling makes the lives of people with disabilities more comfortable and dignified and the care worker injury free. Aideen's further ambition is that every health professional prescribing manual handling equipment is able to do so with the confidence that they have ensured all parties are safe, while taking every opportunity to eliminate manual handling.

For more information, visit www.riskmanaged.com.au.

To Mum and Dad – for making me believe anything was possible.

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PART III: THE TEN PRINCIPLES

Introduction

About 12 years ago, I had to assess a client I will never forget. I was working within the Workplace Health and Safety (WHS) department of a care agency as a manual handling advisor. My role was to ensure the agency's care workers were safe when assisting people with disabilities with personal care tasks.

The client I had to assess was 27. He had cerebral palsy and his family was looking for help with his personal care. I noticed straightaway when I looked at the file that this client was born the same day as me. We both started our lives on the same day but, because of his cerebral palsy, his life and the lives of his parents were very different from my life and my parents' lives. How unfair was that.

At the assessment that day, I really wanted to give this family all the help they needed and deserved. However, as part of my role, I had to give the family some news they did not want to hear. The agency was not able to manually lift their son. This resulted in the client's father asking me to leave their home. While I needed to give

that message, because of the way I had delivered it I felt I had let them down at a time that they probably needed me most, and I was devastated.

How did this happen, when every bone in my body wanted to make this situation better for this family? I decided that day that I never wanted that to happen again; there must be another way. Manual handling involves moving a person from one position to another, but it is so much more than this. This experience sent me on a path of learning that would change the way I looked at manual handling and how I solved manual handling problems.

Seeing patterns and connections

In the 12 years since that incident, my career has meandered between mental health and manual handling, with a stint in academia along the way. This has allowed me to gain insight into some of the intricacies of the manual handling industry, while also giving me the ability to see the wood from the trees when I stepped out of the industry. I was able to view the situation from an academic perspective when I worked as a lecturer on an undergraduate occupational therapy program, and from a clinical perspective in my various clinical roles. In addition, I have also had the opportunity to work with some really clever professionals, both care workers and health professionals, who have taught me things that have really made a difference to my practice.

Throughout my 15 years in the industry, I have identified certain patterns in the way some allied health professionals address manual handling concerns. These patterns are limiting the extent to which many health professionals can achieve superior outcomes for the client and the care workers who support them, and limiting how confident they feel about the advice they are able to give.

Differing philosophies

I noticed some overarching philosophies in the WHS world that were very different from my practice in mental health. Risk assessment is a process used in both disciplines, yet in mental health it was used more creatively than in manual handling. I studied the literature to see if it was possible to take some lessons from the mental health area and apply them to manual handling. Could we be creative while still having safety as the overarching philosophy?

Focus on people first, then equipment

Allied health professionals I worked with seemed to have the philosophy of using people first and then equipment. I noticed many health professionals were still doing manual transfers when they didn't need to. Equipment was available that completely eliminated the need for manual transfers, and this equipment was easy to use. While many of these resources did cost money, they could be applied to a huge variety of manual handling problems if the clinician was willing to put on their creative hat. The cost of that equipment could eventually be dwarfed by the savings achieved by using the equipment to its fullest potential.

No systematic framework for equipment prescription

Seeing clients in the community with physical disabilities where health professionals were already involved, I started to see patterns in the mistakes some health professionals were making when prescribing equipment. These professionals were lacking a systematic framework, which made mistakes hard to avoid. These mistakes were not resulting in problems with safety, but they were making the carer work harder than they should have had to. In many instances, a second care worker was put in when they were not

needed. Watching the way in which the equipment was being used was akin to watching a Ferrari being driven in third gear. With a few minor adjustments to equipment, I knew I would be able to get them up to top gear – with all the benefits for efficiency that had to offer.

I saw that many health professionals weren't confident with equipment. They didn't seem to know what was available and what made one item of equipment different from the other, and what made it most suitable in solving a manual handling problem. Once they had an item of equipment to work with, many didn't know how to make it work for them. While manual handling innovators were coming up with solutions to solve problems, health professionals were becoming overwhelmed with choice.

Increased anxiety

Manual handling was not taught extensively in undergraduate programs, yet health professionals were coming out of university with the expectation that they would be experts in manual handling. Even if a health professional wanted to learn manual handling skills, few postgraduate training options were available to assist them with this upskilling. While improved equipment provided a significant opportunity to eliminate manual handling, no training was available in how to systematically prescribe equipment and ensure the most was made of what it had to offer.

As I started offering manual handling workshops, I noticed an air of anxiety among the health professionals I taught. Many health professionals disliked manual handling and were often fearful about making a wrong decision. Health professionals also felt they were responsible for the actions of a care worker they taught a manual handling routine to – so if a care worker was not following directions, they were to blame.

A manual handling routine aims to control the risk as far as reasonably practicable. The outcome of all risk assessment is that a certain part of the risk remains, no matter what control measures you put in place. Health professionals were becoming anxious about this remaining level of risk when they could not possibly be able to control all the risk, no matter how many skills or resources they had.

Lack of creative thinking

As a lecturer on an undergraduate occupational therapy program, I was aware of the massive emphasis on creative problem-solving in the education of health professionals. Experts in this area recognised this kind of problem-solving was needed for health professionals to be able to adapt to the growing health demands of contemporary practice. While I was confident health professionals had these skills, something appeared to happen when manual handling entered the mix. Some health professionals appeared paralysed and lacked the confidence to apply their demonstrated creative problem-solving skills in a manual handling setting.

Socially and emotionally challenging

As well as being challenging from a physical perspective, manual handling was also socially and emotionally challenging. So many people were involved in the manual handling process – including the client, the care worker and the family. Along with this, the needs for independence and autonomy for the client, and safety for the care worker were sometimes at odds with one another.

In terms of the client, I found that my mental health experience was invaluable to me in my role as a manual handling advisor. This experience gave me the skills to recognise the significant grief many

people with disabilities were experiencing when manual handling was involved. Manual handling always involved some kind of loss, where someone was unable to do something they might have been able to do before. I was able to identify this grief and, more importantly, I had the skills to be able to do something about it.

In terms of the care worker, in solving physical problems, I realised very quickly that a manual handling risk can very easily be replaced with a stress risk for the care worker if the way I dealt with the manual handling risk was insensitive towards the client. Care workers were in the client's home and they had to go into that home daily – unlike me, who came in once. I had to ensure my intervention did not add to the stress side of their job through damaging their relationship with their client.

For these reasons, some health professionals were finding manual handling interventions exceptionally challenging. They were the assessments that would take a long time and would involve some kind of conflict. Health professionals would have to manage the needs of multiple parties, without the advantage of some kind of framework for ensuring all needs were met.

The unfortunate result

Allied health professionals were telling me they dreaded the manual handling assessment because they didn't know how to achieve a solution where the client was happy, the care worker was safe and they themselves were confident that they had recommended the best routine possible to meet the needs of all parties.

Health professionals were finding themselves avoiding cases that involved manual handling because they were too challenging and massively complex. Manual handling was the bottom of the barrel in terms of areas to work in.

The manual handling revolution

In 2017, I made the decision to bring all my learning together in a book, and so I present to you 'the manual handling revolution'. This book is the product of my many years of observing, thinking, studying, researching and gaining experience in the care of people with complex disabilities who need a caregiver to move. As an industry, amazing manual handling advisors are out there who really get the big picture. Many gifted therapists come to workshops I run, and they get it and find amazing outcomes for their clients. However, all this is not always filtering down to the general therapist working in the community setting and I wanted to bring to these generalist health professionals a framework for navigating through the maze that is manual handling.

I wrote this book to guide allied health professionals working in the community sector through the process of recommending manual handling routines. My aim is to help these professionals ensure their clients are safe, care workers are resourced and they can leave the office with confidence that they have recommended the best routine they can.

This book explains the client experience of manual handling. It provides a process for meeting client needs with clear signposting so the client can remain in as much control as possible through the process. It discusses the challenges for care workers and why they are at high risk of physical injury and stress. Finally, the book outlines the health professional's experience and how some of their beliefs about manual handling are leading to significant anxiety. *The Manual Handling Revolution* provides a framework for clinicians to address this anxiety, start to be creative and get back to enjoying the job they have to do when assisting people with complex disabilities to move.

The book is divided into three main sections. The first section examines some of the needs of the client, the care worker and health professionals in solving these problems. The second section examines the current risk assessment process used to solve manual handling problems. The final section outlines the ten principles of successful interventions. These principles explain the resources that are at our fingertips and the shift in thinking we need to get to, to be able to get the best out of these resources. Not only will this help reduce injuries, but we will also create efficient and resourceful workers. The principles provide a framework for shifting our thinking to be able to access this process of working. At the end of each principle, I've provided a summary as well as some activities to help you start to implement some of these skills with your team.

10 principles to implement the manual handling revolution

This book explains the ten principles I think are critical to achieving the outcome of a well-resourced care worker, happy client and confident health professional:

1 *Understand it's a negotiation:* Health professionals can feel pulled in different directions, balancing the divergent needs of all parties in the manual handling process. Here I provide a framework for managing this process. This chapter presents the opportunity to create a win–win scenario for the client, family and their caregivers.

2 *Address the grief:* Grief is a significant issue in manual handling, with clients invariably losing something that results in them needing the assistance of a third party. This loss needs to be acknowledged and here I provide a framework for acknowledging this grief, without becoming a formal

counsellor (where this issue takes over the assessment process).

3 *Stop throwing care workers at the problem:* This principle examines the decision to increase care in the home from one care worker to two, and outlines some of the factors we need to consider in making these decisions. While we assume two care workers are better than one, a second care worker introduces many additional complexities that need to be part of the decision-making process.

4 *Manage the manual handling neurosis:* An air of anxiety exists among many health professionals in addressing the manual handling concerns of their clients. In this principle, I provide a framework for managing this anxiety by examining what is in your control and the real aim of risk assessment. I also provide a decision-making framework that compares decisions to the next best alternative to help you examine the best option available and why.

5 *Use systematic assessment:* In getting the best use out of available equipment, I advocate the use of a systematic framework for assessment and for prescribing equipment. Following the same formula for every assessment, you ensure you pick the best product for the problem, taking every opportunity to eliminate manual handling.

6 *Implement objective guidelines:* We need to be able to make objective decisions in the manual handling process, knowing what the client needs to be able to do for the care worker to assist them safely. We need to have a clear guide as to what 'safe' looks like and in turn, what 'unsafe' looks like. This chapter explains how this is as important for the management

of the expectations of parties in the negotiation process as it is for the assessment itself.

7 *Get creative:* In this principle I outline how you can get to intimately know the situation you are assessing. I also outline my framework for creative risk management to start to uncover all the resources and equipment that can help you eliminate manual handling for the care worker and get the best out of the equipment.

8 *Use equipment evaluation to separate the gem from the gimmick:* Here I provide an additional framework to enable clinicians to objectively assess the new manual handling equipment they come across. This framework allows them to take ownership of this assessment without being reliant on others to tell them. This framework forms a model I think we need to start using at conferences to objectively evaluate new equipment that comes on the market.

9 *Consider alternatives to get an outcome:* Manual handling is predominantly a physically orientated discipline and sometimes we think a physical intervention is the only way to solve the problem. This principle is about helping you explore some of the alternative ways to address manual handling concerns without completing any manual handling.

10 *Use the assessment guide:* Finally, I provide a framework for completing an assessment of manual handling need in the home environment. This is to assist you in managing the interests of the client, the family and the care worker, while addressing manual handling concerns in the home.

A note on terms used

Some variation exists in the terms used within the aged and disability section and within manual handling. For clarity, here's how I've used particular terms:

- *Manual handling:* I've used this to capture any task that requires a person to lift, lower, push, pull, carry or otherwise move, hold or restrain any person.[1]
- *Care worker:* While the challenges can be similar for family care givers, in this book I focus mainly on professional caregivers who are paid to provide professional care in the home, and I mostly use 'care worker' when referring to these people. When I use 'caregiver' or 'carer' in the book, I'm referring to the same role.
- *Health professional:* For simplicity, I mostly use 'health professional', 'clinician' or 'therapist' when referring to allied health professionals such as occupational therapists, physiotherapists and workplace health and safety professionals who provide advice on the manual handling of people.
- *Statistics:* This book has been written in the Australian context using statistics from this region. The figures outlined are, in many instances, comparable to those across the developed world.

So now let's get started on the needs of the client, the care worker and health professionals, and how we might look to solve some of the existing problems.

1 Workplace Health and Safety (2015). *Hazardous Manual Tasks Code of Practice*. Made under the *Work Health and Safety Act 2011*, section 274. Retrieved 8 August 2017 from www.legislation.gov.au/Details/F2016L00406/Explanatory%20Statement/Text.

Part I

The difficulties with manual handling

This part starts by asking why manual handling is so complicated. I break this question down by looking at all the stakeholders in the manual handling process, discuss the client and their needs, as well as the needs of the care worker and the risks manual handling presents to them. I also outline the changes in the aged and disabilities sectors that are leading to a manual handling 'perfect storm', and conclude by exploring the role of the allied health professional and the expertise expected from them in solving manual handling problems.

1 Why is manual handling so complicated?

In unpacking the reasons behind manual handling being so complicated, I have found a particular model of practice very useful – although it took me a little while to get there. I was never really a fan of models of practice while at university. I recall writing an essay comparing one model to another and I had no idea what I was writing about. I still didn't know when I left university either. It wasn't until I started working in Aboriginal Health in the Northern Territory of Australia that I really started to understand their application in identifying the source of problems – and, therefore, providing solutions to these problems.

Then, in 2008, I found myself having to teach models of practice to my first-year undergraduate OT students. At first, I was literally one lecture ahead of the students. The more I taught models of practice, however, the more I understood them, and I was determined that no student would leave my class without really getting to understand how a model of practice can help us unpack what might be really going on when we are presented with a mess.

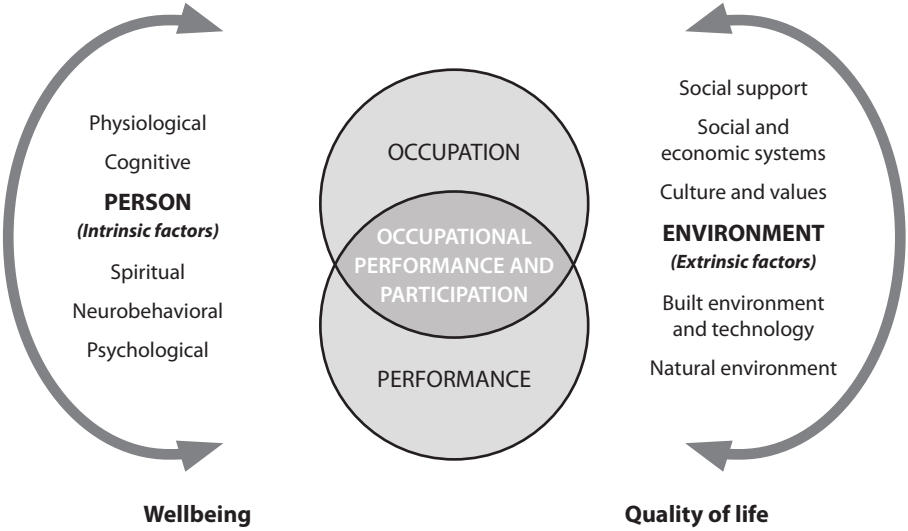
So, how are models of practice connected to manual handling? Since starting my workshops in 2007, I have always received feedback from allied health professionals about how they find manual handling interventions really challenging. These interventions were the ones that were most likely to end up with a complaint and that took so much more time. Most importantly, these situations were the ones therapists most often felt uneasy about – fearing they had let someone down. As a result, many therapists admitted avoiding manual handling cases if possible.

Manual handling interventions are clearly challenging. We all know that and feel it – but why, exactly, are they so hard? I found that the Person–Occupation–Environment (PEO) model[1], used to teach occupational therapy practice, explains really well exactly why manual handling is so hard.

The Person–Occupation–Environment model (the boring stuff)

Before I get stuck into how the PEO model (outlined in the following figure) relates to manual handling, explaining what is going on in this model is worthwhile. I will refer to this model throughout the book. The model has four main areas or circles, representing the person, their environment, their occupation and their performance. Ideally, they intersect in the middle to create an outcome of health and wellbeing in their occupational performance and participation. Through the arrangement of the circles, the model visually highlights that the person interacts with their environment through the things they do (occupations) and the way they do them (occupational performance) to lead to success or failure (occupational performance and participation).

1 Christiansen, CH, Baum, CM & Bass-Haugen, J. (2005). *Occupational therapy: performance, participation, and well-being* (3rd ed). Thorofare, NJ: SLACK.



Reproduced with permission from the Canadian Association of Occupational Therapists (CAOT).

Five main intrinsic elements of a person affect what they bring to this process. (This is not an academic text, so I only explain these areas in basic terms.) The five main areas of personal variables[2] are as follows:

- *Neurobehavioural:* These factors include how we physically move (our motor skills) and what we gain through our five senses (our sensory skills).
- *Physiological:* These involve our endurance, strength and coordination.
- *Psychological and emotion:* These cover our personality traits and our psychological disposition.
- *Spiritual:* What provides meaning to people.

2 *ibid.*

- *Cognitive:* These include our levels of attention and the memory aspects that are needed for a task.

The environment in which the occupation occurs brings five main extrinsic elements[3]. These variables are:

- *Built environment and technology:* This area includes buildings and all the physical things in them.
- *Natural environment:* This is the physical world outside the built environment, and the elements of climate that affect it.
- *Culture and values:* This covers cultural ethnicity, factors such as gender, age and socioeconomic background, along with the values that are incorporated into these cultural categories.
- *Social and economic systems:* This includes all public policy aspects and the economic system that has an impact on our lives.
- *Social support:* This covers the emotional and practical support, and the information offered in our environment.

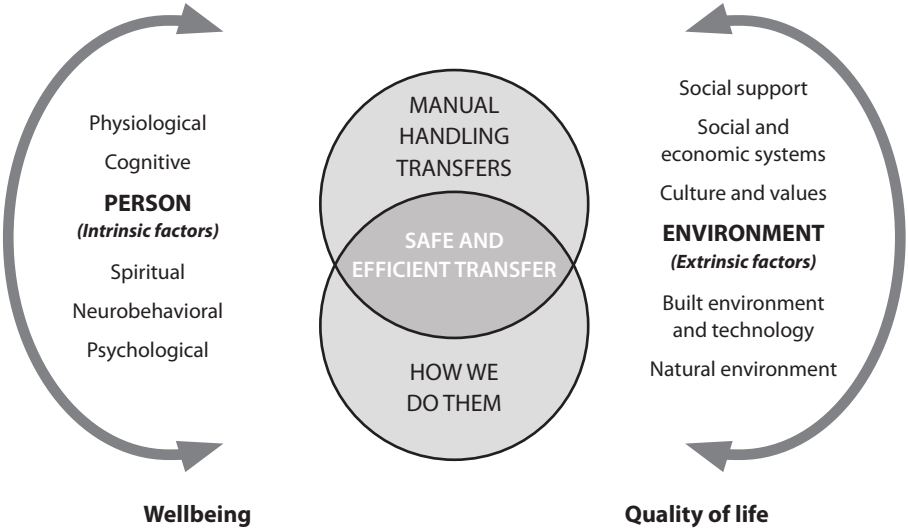
How does this look in manual handling?

If we were to make the PEO model specific to manual handling, we could say the person interacts with the environment through the manual handling tasks they have to do, and the way they do those tasks ideally leads to a safe and efficient transfer. The figure on the following page outlines what the PEO looks like when applied directly to manual handling.

While I was teaching this model of practice to my first-year students, one day it came to me that this model could very well explain why manual handling was so hard. I had grown very fond

3 *ibid.*

of this model because it was two-dimensional and it was neat. Essentially, one person interacts with their environment through the manual handling routines they do and the way they do them, to lead directly to a safe and efficient transfer.



However, manual handling is never a singular activity. The fact that manual handling is needed inherently means that this model completely changes – because someone does not do transfers by themselves. Importantly, *manual handling is always a 'we' activity*, and this makes things a whole lot more complicated. Together, a care worker and their client interact with the environment through the manual handling activities they do, and the way they do them to (ideally) lead to a safe and efficient transfer. A diagram showing this interaction would quickly go from neat to chaos (hence, I have not attempted to do it). The visual chaos in this imagined diagram translates into actual chaos in practice, with the health professional trying to manage all elements of this model – not only for the client but also (and always) for the care worker. In some instances, the

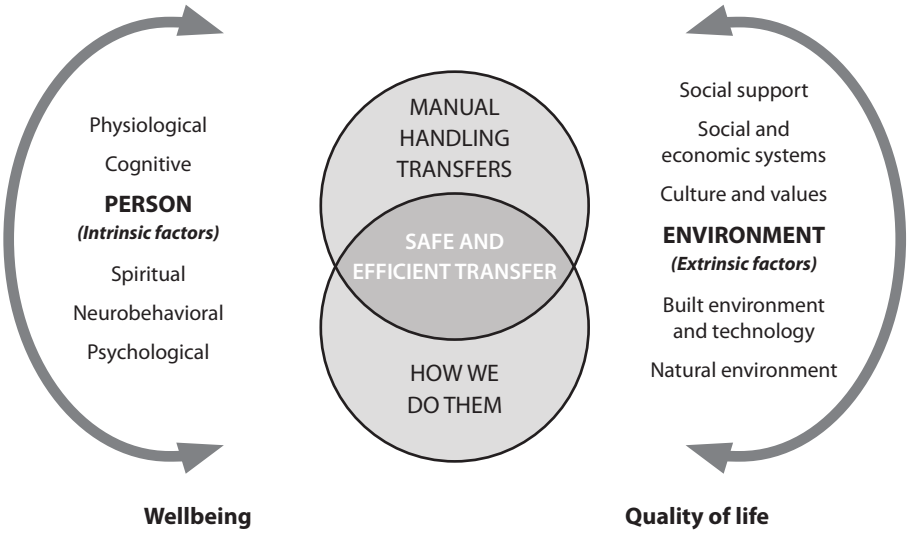
situation can involve two care workers and, many times, family as well. As a business leader once told me, once you add an extra person to a process, you haven't just doubled the complexity, but squared it. No wonder the process of manual handling is so hard.

In chapters 2 and 3, I look at each of the two main participants in manual handling (people with disability and care workers) individually, discussing the areas they commonly struggle with.

2 People with a disability want more

The manual handling PEO model I outline in chapter 1 (and shown again in the following figure) can describe the situation before a care worker ever gets involved. The client interacts with their environment in the task of moving themselves and how they do this leads to success or failure. If people succeed, they continue as normal. If they fail, allied health professionals get involved, complicating the PEO model.

In this chapter we highlight how grief and loss can be associated with this failure to be independent. At a time when the barriers to disability are diminishing, we also address the practical implications this change in function has on a person with a disability in their daily activities. Finally, we look at the person of size as a specific group and address some challenges they face if a disability becomes part of their daily life.



Manual handling can mean moving from ability to disability

As health professionals working in manual handling, we meet a person when they start failing at a fundamental task for them. Often, this task is the ability to move themselves independently, and this failure then influences all the choices that the ability to move independently involves.

Grief and loss

The ability to move yourself is an activity you don't really think about until you lose it. Sometimes this loss happens after an accident; sometimes it happens through a condition that gradually gets worse. But this loss means your movement is now in the hands of another person, so you don't get to have as much choice in

when certain activities happen. Sometimes, your care is based on someone else's schedule, with a resultant loss of spontaneity. The greater the loss the person experiences, the greater the assistance they need and the narrower the level of choice the person retains. A significant change occurs, for example, when a person moves from weight-bearing (standing) to non-weight-bearing (non-standing) transfers.

Needing assistance to move is not just about moving or choice, either; it is also about privacy. This movement happens in the context of often the most intimate routines of life – including showering, getting dressed and going to the toilet. The person is now required to invite people, often strangers, into the most intimate parts of their lives. Clients report that at times this can be very confronting.

A manual handling intervention involves some sort of acceptance that independence has not been achieved. In many situations, the client may not be ready to reach this level of acceptance. Sometimes, it is only through the assessments we complete that the person realises that independence may not be achievable and a greater level of external assistance is needed. Other times, they know this themselves but accepting this means addressing how they feel about the impact of their disability on their everyday lives.

Dealing with this loss of personal agency is a grieving process for a person with a disability. This grief can manifest itself in many different ways and, in my work as a manual handling advisor, I have seen a broad spectrum of emotion – from profound verbal outbursts through to complete apathy.

Disability is hard

On top of the grief and loss, living with a disability can be really hard. In Australia, according to the Australian Bureau of Statistics

(ABS), three out of five people with a disability need assistance with at least one activity of living[1]. As well as having implications on how they are moved, and their choice and privacy, an important factor here is also the time they are required to spend on basic activities.

To simply have a shower and get dressed, a person who is not able to stand has to go through the following:

- They have to be rolled to remove their night clothing.
- They have to be rolled to fit a hoist sling.
- They have to be moved in a hoist from their bed into a mobile shower chair.
- They need to be positioned over the toilet.
- They need to be moved into the shower.
- They need assistance with washing.
- They need assistance in drying.
- They have to be moved onto the bed via a hoist after their shower.
- They have to be rolled to get dressed on the bed.
- They have to be rolled to readjust the hoist sling.
- They have to be moved in the hoist off the bed to be transferred into their wheelchair for the day.

If you include activities such as going to the toilet during the day, the total time for personal care can take up to three hours a day.

1 Australian Bureau of Statistics (2012). *4430.0 – Disability, Ageing and Carers, Australia: Summary of Findings*. Retrieved 2 August 2017 from www.abs.gov.au/ausstats/abs@.nsf/lookup/3A5561E876CDAC73CA257C210011AB9B?opendocument.

People with disabilities want more

I get the opportunity to work with inspiring people weekly who are doing amazing things in their lives. The lives of people with disabilities are changing. They no longer focus on their disability but rather focus on their ability. Beyond their basic human right to be able to do so, people with disabilities want to achieve and they are succeeding. The physical barriers to disability are also changing. Better access means people with disabilities are able to get to more places. They can get to more workplaces, they can choose more leisure pursuits and they can engage with a larger part of their community.

According to 2015 figures from the Australian Bureau of Statistics (ABS), 53 per cent of people with disabilities aged between 15 and 64 in Australia now participate in the labour market[2]. While people with disabilities have always achieved and participated, the internet age and the advent of social media have broken down many of the remaining barriers to people with disabilities participating meaningfully in life.

Manual handling is the bridge to living

The process of being moved in the morning is the bridge a person with a disability has to cross every single day. They have to endure this transfer process because it is the gateway to them meeting their goals and working on what they want to achieve for the rest of the day.

Alongside this, people with disability also want the freedom from arduous personal care routines, and want to get on with activities that are important to them. Considering personal care is the bridge to achieving goals and aspirations for a person with a

2 Australian Bureau of Statistics (2012). *4433.0.55.006 – Disability and Labour Force Participation*. Retrieved 8 August 2017 from www.abs.gov.au/ausstats/abs@.nsf/mf/4433.0.55.006.

disability, we need to make this bridge as short as possible. We also need to ensure this bridge is robust.

People of size also need more

At the time of writing, 63 per cent of Australians are considered overweight or obese[3]. This means that we are seeing a greater proportion of people with a disability who are of size. The combination of disability and size can create added challenges for the manual handling process, especially for the person at the centre of that process.

The loss of function can have significant implications for a person of size, and the inability to weight bear can involve the introduction of equipment. This equipment needs to not only be suitable to the person in terms of their size and their weight, but also fit in and with their environment. For a client I assessed recently, her inability to weight-bear resulted in the home no longer being suitable to meet her needs, because the equipment to support her weight could not fit through the doorways of the home. Of course, not being able to move equipment around the house easily can result in people being confined to their home or even the room in the home in which they sleep.

People of size traditionally have not had a positive experience of the manual handling process, and a number of authors have outlined how people of size can be fearful[4] or unco-operative with the transfer process[5]. Many reports outline people feeling let down by

3 Australian Institute of Health and Welfare (2017). 'Overweight and obesity'. Retrieved 8 August 2017 from www.aihw.gov.au/overweight-and-obesity.

4 Cowley, SP, & Leggett, S. (2010). 'Manual handling risks associated with the care, treatment and transportation of bariatric patients and clients in Australia'. *International Journal of Nursing Practice*, (16), 262–267. doi:10.1111/j.1440-172X.2010.01839.x.

5 Kneafsey, R. (2009). 'The effect of occupational socialization on nurses' patient handling practices'. *Journal of Clinical Nursing*, 9(4), 585–593. doi 10.1046/j.1365-2702.2000.00391.x.

the professionals who are entrusted to care for them. They can even be the brunt of judgemental and discriminatory commentary from health professionals who feel overwhelmed in how to provide them with the care they need[6]. Providing allied health professionals with the resources they need to provide adequate care is a significant step in addressing this judgement and discrimination[7].

In a keynote address at the Australian Association for the Manual Handling of People (AAMHP), Chris Coliviti, a physiotherapist in Queensland Health in Australia, discussed the importance of movement patterns for people of size[8]. Coliviti outlined how people of size move differently from people who are not of size, meaning traditional movement patterns have not been successful in the rehabilitation and subsequent manual handling process for this population. She also discussed the simple omission of the step of 'asking' the person how they normally move and how they think they can assist and be assisted with the transfer process. Sometimes these simple communication strategies are the missing link in the problem-solving process.

The question of hygiene and skin care is of considerable importance to all clients but is even more so for people of size. The pressure on the skin from the increased adipose tissues means the skin is even more vulnerable during the moving process, and the caregiver needs to take extra care that the skin is not compromised as a result. People of size need greater assistance in personal care tasks to adequately clean under and dry skin folds (such as the pannus) because they can be more vulnerable to infection from excessive sweat and fluid leakage through the pores (known as *disaphoresis*).

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6 Gallagher, S. (2017). 'Taking the first steps in overcoming bias: Sensitivity, compassion and the obese patient'. Paper presented at the Bariatric Management Innovation Seminar Series, Concord Hospital, Sydney, Australia, 8 February 2017.

7 *ibid*.

8 Coliviti, C, & MacRae, J. (2016). 'Managing Bariatric Patients'. Paper presented at the Australian Association for the Manual Handling of People (AAMHP), Fremantle, Australia, 23 May 2016.

On many occasions that pannus itself can be a similar weight to a limb[9]. As a result of this, allied health professionals and care workers require specific education to be able to manage the needs of this group in an efficient, effective and empathetic manner.

Many equipment options are available to meet the needs of people with disabilities and of size in manual handling. A key component in the process of getting these equipment solutions to where they can be of benefit is the expertise of the health professional sourcing and prescribing them effectively. In chapter 5, I address some of the challenges for allied health professionals in advising on manual handling routines. Another key component of this team is the care worker, and in chapter 3, I discuss some of the difficulties care workers are experiencing while trying to provide quality care to their clients.

9 Gallagher, S. (2015). *A Practical Guide to Bariatric Safe Patient Handling and Mobility*. Visioning Publishing.