Guidelines for Moving and Handling People in Home Care: New Zealand

Prepared for ACC

**Project coordinator**
*ResearchWorks NZ Ltd*
P.O. Box 65188 Mairangi Bay, Auckland

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Send comments to
ylthomas@xtra.co.nz
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1 Introduction

The purpose of these Guidelines is to provide information for home carers on how to reduce the risks of injury to themselves or the person being cared for, when moving or transferring people in home environments. These Guidelines are applicable to anyone moving and handling people in home care including paid staff working in homes, voluntary carers and family members.

The primary focus of these Guidelines is on the moving and handling of clients by support workers and family members who provide personal care to a disabled person or relative. Where necessary these Guidelines cover the broader context of providing home care services in order to show how moving and handling practices are integrated into the general delivery of home care services.

Several terms are used to describe home care services, the people who provide these services and the people receiving services. The terms ‘carers’ and ‘support workers’ are used in these Guidelines as they are commonly used in New Zealand, and we use the term ‘clients’ to refer to people receiving home care services. Standards New Zealand uses the term ‘service provider’ to refer to support workers and ‘consumer’ to refer to clients. Some organisations use the term ‘service user’ to refer to clients.

This document complements Moving and Handling People: The New Zealand Guidelines, published by ACC in March 2012. During the preparation of the NZ Guidelines in 2011, home carers in Auckland requested a resource that would address the specific concerns and issues they faced in moving and handling clients in home care. These guidelines describe strategies, advice and examples that are intended to reduce the risks of injury for carers and clients. We anticipate that the Guidelines will be updated from time to time as new information comes to hand.

1.1 Who should read the Guidelines?

If you are involved in home care services or your work requires the moving and handling clients in homecare, you should be familiar with most of the sections in this document. Table 1.1 shows the Sections that are particularly relevant for specific audiences.

The key audiences for the Guidelines are:
- Managers and service coordinators in home care service providers
- Support workers who provide personal care to clients (sometimes referred to in the Guidelines as ‘Carers’)
- Assessors who carry out needs assessments or risk assessments of clients receiving care in their homes. Assessors often have a background in physiotherapy or occupational therapy
- Trainers of support workers or carers
- Managers or coordinators in funding agencies responsible for approving or organising home care services. This includes agencies such as ACC, DHBs and Needs Assessment and Service Coordination (NASC) service organisations contracted by the Ministry of Health
- Individuals or families who employ their own support worker or may be a relative
- Family members who provide paid or unpaid personal care to a disabled relative.

The Guidelines will also be relevant to clients who may be involved in arranging care for themselves.
Table 1.1 Guidelines sections relevant to specific audiences

<table>
<thead>
<tr>
<th>Guidelines section</th>
<th>Managers of home care services, trainers</th>
<th>Support workers or carers, assessors, families</th>
<th>Managers in agencies funding home care services</th>
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<td>7 Transfer tasks and case studies in homecare</td>
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<td>8 Trends in home care in New Zealand</td>
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● = Very relevant  ○ = relevant

1.2 Homecare services in New Zealand

The New Zealand Home Health Association reported that about 110,000 people receive paid home support at some time each year at a total cost of around $592 million (2009-2010 figures). This includes:

- ACC funding of $140 million for 23,000 clients who require both short-term and long-term support following an accident
- Ministry of Health funding of $208 million for 10,500 people who require disability services, including intellectual disability
- DHB funding of $244 million for 77,000 clients for short-term support (post-hospitalisation, respite care or post-injury) and long-term support for people with chronic disease, serious injuries, young disabled people and frail elderly people.¹

Community support workers visit an estimated 25,000 people each day. Clients receiving home care services include; people needing assistance for injury-related rehabilitation following hospital discharge, long-term injury support, support for those living with short or long term medical conditions, palliative care, support for those living at home with dementia, and respite care for family carers.²

Clients of home care workers may include people of all ages requiring short term or lifelong disability support. Disabilities may be the result of brain injury, visual impairment, dementia, accidents or chronic illness. It also includes people recently discharged from hospital or medical care who require assistance with rehabilitation. The services provided by home carers can include household management (e.g., helping with domestic tasks such as cleaning), personal care (e.g., showering,

¹ New Zealand Home Health Association, 2011, p. 12
² New Zealand Home Health Association, 2011, p. 10
bathing and toileting), childcare, supervising or administering medication and advanced personal care. Support workers also help clients to continue participating in their community, such as using public transport and accessing day programmes and advocacy services. Box 1.1 lists examples of the tasks and activities commonly carried out by support workers.

**Box 1.1 Tasks and activities commonly carried out by support workers**

- Assisting with physical personal needs, such as personal hygiene (bathing, dressing, toileting), transferring, moving, eating and drinking
- Assisting with follow-up of medical plans and instructions, including management of prescribed medications, assisting with exercises, helping with aids to daily living, such as incontinence supplies, diabetic supplies, urological supplies, ostomy supplies, mobility equipment, nutrition and supplements, orthotics and transport to treatment.
- Assisting in the home environment and domestic duties: such as housework (vacuuming, cleaning, washing, laundry); preparing, serving and clearing away meals; providing help with childcare
- Assisting with the external needs of the person who requires care, such as shopping for groceries or clothes, using the telephone, managing money, going on scheduled outings (e.g. transporting clients to appointments and activities), arranging social activities, and accompanying people on outings
- Assisting in meeting psychosocial needs, for example by providing companionship, friendship and emotional support and managing problems related to dementia, brain injury or other challenging behaviours. Interacting with family members and other supports to ensure that care needs are identified and met

Adapted from: European Agency for Safety and Health at Work, 2007, p.2

Given the multiple tasks performed by home carers, moving and handling clients by carers may occur as part of providing personal care services for clients. These Guidelines are concerned primarily with identifying hazards and reducing risks associated with moving and handling clients that may lead to discomfort pain and injury for either the carer or client. However, we acknowledge the diverse contexts of providing home care, and the multiple types of tasks carried out by support workers, where they are relevant.

### 1.3 The home care workforce in New Zealand

Care and support services in New Zealand are provided by public and private organisations, including government agencies, private welfare organisations and, increasingly, commercial organisations. The following agencies provide funding for home support services:

- ACC funds social rehabilitation services for claimants eligible under the Injury prevention, Rehabilitation and Compensation Act 2001 (p.8, MOH, 2006)
- The Ministry of Health funds Disability Support Services (DSS) and DHBs for people requiring short-term or lifelong support, due to chronic or acute illness, hospitalization, age-related needs or disability
- District Health Boards (DHBs) fund services for older people
- Individuals and their families fund services in a private capacity.

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3 Health Workforce Advisory Committee, 2006, p. 10
A 2004 survey of New Zealand residential care and home care services estimated the total number of workers employed by support services to be around 40,000 to 50,000. From this total, it was estimated that between 18,000 to 25,000 are home support workers.\(^4\) Another estimate has come from the New Zealand Home Health Association. The service providers who are members employ around 21,000 support workers, about 450 nurses and 300 service coordinators. There were estimated to be around 2,000 or so additional staff outside of their membership, giving a total of about 23,750. Informal, unpaid caregivers such as spouses, relatives, and friends, are not included in these estimates as there is no accurate information on the numbers.\(^5\)

Research has indicated that carers who have poorer working conditions; such as little or no training, having little control over their work and having an unsupportive work environment, are more likely to experience back problems.\(^6\) Several reports have noted that New Zealand community support workers and home carers often have poor working conditions and earn little more than the minimum wage. They earn between 13–30 percent less than healthcare assistants or nurse aides working in a public hospital even though they often have higher qualifications than hospital aides and work mostly unsupervised. Work associated with home visits that does not involve contact with clients, such as writing reports, performance appraisals and training, is often not reimbursed. They do not receive penal rates or other benefits paid to DHB or other medical agency staff. As well, vehicle costs or travel time when visiting clients are usually not reimbursed.\(^7\)

1.4 Disability, policies and home care services

The 2006 national health and disability survey reported that 629,200 disabled people are living in households in New Zealand (90,000 children aged 0-14 years, and 539,200 adults aged 15 years and older), excluding people living in residential care. Among adults, 133,500 receive informal care (help or support provided by a family member, friend, or neighbour) and 90,400 receive formal/other home care which is provided by voluntary organisations, private organisations, other paid people or other people.\(^8\) Among the 90,400 adults receiving formal/other home care, 13.4% (12,200) receive personal care such as dressing, bathing, mobility assistance and medication.\(^9\)

The three main groups receiving state assistance for home care support in New Zealand are; people of any age who have had an accident leading to a short-term or long-term disability, people under 65 years who have a disability which was not the result of an accident and people over 65 years who have illnesses or age-related disabilities. For all age groups in New Zealand, there is a trend towards clients becoming heavier. This creates greater risks for carers involved in moving and handling clients.

Homecare can be seen as part of a continuum of services which range from community-based care through to residential care (e.g., aged care facilities, residential services for disabled children or adults) and then to full 24-hour acute care such as that provided by hospitals. Home-based support

\(^4\) Health Workforce Advisory Committee; 2006; Auckland UniServices, 2004a

\(^5\) Personal Communication, Betty Jenkins, Auckland, April 2012.

\(^6\) See Thomas et al, 2009, p. 17

\(^7\) New Zealand Home Health Association, 2011, p. 6

\(^8\) Office for Disability Issues and Statistics New Zealand, 2009, p. 17.

\(^9\) 2006 survey tables from Office for Disability Issues and Statistics New Zealand (Appendix Table 30, Disabled Adults Receiving Help with Different Types of Everyday Activities).
services such as household management and personal care are low intensity services (in terms of cost and resources required) and full managed care is high intensity. There is a general policy in health and disability services to provide home care where feasible for clients, relying on institutional care only when home care is not possible.

Among people over 65 years home care services are provided primarily by DHBs. As the population in New Zealand ages, there is increasing demand for health and disability support services such as community-based care, residential care and other managed care services. In many countries, including New Zealand, health and welfare policies are intended to provide support for people to remain in their usual residence for as long as feasible (‘ageing in place’) before moving into residential care or other organisations providing full managed care. The provision of home care services enables people to be cared for in their own homes for as long as possible. Homecare support can also enable people to return to their own homes following acute hospital care or temporary residential or nursing care. Such services can prevent or delay premature entry to aged residential care and the use of acute hospital services, such as emergency departments.

Many older people living in the community receiving home care services may move into residential care and possibly into hospital care (full managed care) if their health and physical competencies deteriorate. A national survey in New Zealand showed that while 74% of people aged 65 to 74 years were able to live at home without assistance, this dropped to 15% of those 85 and over. Older people requiring assistance to continue living home increased from 24% for those aged between 65 to 74 years to 57% in the 85 and over age group.10

Many people in residential care could remain in the community if they receive a sufficient level of community support. New Zealand research shows that functional decline; social isolation; a critical event such as a fall or hospital admission; negative mood (depression); inadequate meals; delirium; and high carer stress all increase the likelihood of entering residential care.11 People enter long-term residential care or managed care because they have;

- reduced ability to maintain activities of daily living (eating, bathing, dressing and toileting)
- health problems, such as continence problems cognitive impairment and dementia
- loneliness
- the absence of a carer available for the time needed
- mobility problems
- other non-health issues such as; death of spouse, not being able to maintain their residence, and lack of financial resources.

1.5 Safety, work hazards and risks for home carers

Safety concerns have been identified in both residential and home-based care in New Zealand, with higher risks noted in the home-based sector. Three key issues were:

- the existence of service gaps created by significant problems recruiting and retaining support workers
- inadequate training
- support workers in home-based services working in isolation with minimal orientation, training and ongoing supervision.12

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10 Ministry of Health, 2007, p.5
11 Auckland UniServices, 2006a
12 Health Workforce Advisory Committee, 2006, p. iv
While there is little systematic data available on injury rates in home care, the available evidence indicates a relatively high risk of back injuries and ‘strain’ injuries among home care workers (see Box 1.2). A 2004 survey of New Zealand home and residential care workers, reported that 55% of care workers felt at risk of being hurt or injured within the previous two years. Among home care workers, 43% felt at risk of, or had experienced a back injury. The main risks for back problems were reported to be poor transfer techniques, lack of hoists, and lifting clients, some of whom are larger than the carers.\(^{13}\)

An international report noted that the main causes of injuries among support workers are overexertion and repetitive movements while assisting clients; and slips, trips and falls inside and outside clients’ homes.\(^ {14}\)

There are a number of significant risks faced by home support workers. One risk that stands out is the lack of awareness of how a repeated series of tasks carried out in less than ideal conditions eventually culminate in discomfort, pain or injury.

\begin{quote}
I am greatly concerned that many (home support) workers are not aware of how a succession of events lead up to injuries. A worker who has vacuumed 3-4 houses or done similar housework for clients before helping Mrs B to shower suddenly finds she has pain in her back. But the signs were already there, a tired, aching back (Senior Clinical Supervisor).

Workers don’t recognise the incremental damage from incidents or accidents. It was after we showed our workers the ‘Moving and Handling People’ DVD that they started to recognise what some of them are experiencing [gradual onset injuries]. (Quality Manager).
\end{quote}

**1.6 Legislation relevant to workplaces in New Zealand**

Employees providing care for clients in a client’s home or other settings are covered by Health and Safety legislation in New Zealand. As a client’s home is a ‘workplace’ for paid carers or support workers, the law or Act that is applicable to workplace health and safety is the *Health and Safety in Employment Act 1992* (with 2002 amendments). Information in these guidelines is also relevant to family members who directly employ a support worker, who may be a relative. In this case, the family member employing the support worker is an employer.

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\^{13}\; Auckland Uniservices, 2004a, pp. 86-87

\^{14}\; European Agency for Safety and Health at Work, 2007
The Health and Safety Act requires employers to take all practicable steps to ensure the health and safety of employees and others at while they are working. In general, these responsibilities include:

- Proactively preventing harm to employees
- Identifying, assessing and controlling or eliminating significant hazards that can cause harm
- Continued monitoring and management of the situation and individuals affected, 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 clients).
- Encouraging a culture of timely and open disclosure of incidents and near-misses within the workforce and using these incident reports to continuously improve safety systems.

This Act makes it clear that employers have a duty to ensure people are not harmed while they are working. To do this they must establish a health and safety system with employees to:

- Identify hazards in the workplace, and then;
- Ensure those hazards are eliminated, isolated or minimised.

In providing a safe working environment employers must ensure that employees are properly trained and supervised, so they can work safely. This includes training for moving and handling clients. If a hazard in your workplace can reasonably be eliminated, then it should be. That decision depends on how much harm the hazard might cause, and how difficult and expensive it would be to eliminate the risk. In this respect, clients also have a role to play: that is to agree to be assisted in a manner which is safe for carers; to acquire and use appropriate moving and handling equipment where required; and ensure a safe working environment in consultation with the service provider and support worker, or an appropriate health professional.

When a hazard cannot be eliminated, employees have a right to know about the hazard, the level of risk, and what they need to do (or not do) in order to reduce the risk of harm and injury. The aim is to do things better in order to achieve a safe and healthy workplace, not just because that is what the law says, but because it’s better for everyone.

Employees can make their workplaces safer by:

- Being involved in processes to improve health and safety
- Complying with correct procedures and using the right equipment
- Wearing appropriate clothing
- Helping new employees, trainees and visitors to the workplace understand the right safety practices and why the practices exist
- Communicating incidents and concerns to your employer.

Further information is available in; Department of Labour, 2009
1.7 Standards for home care services

In 2012, Standards New Zealand updated the *Home and Community Support Sector Standard NZS 8158:2012*. This Standard covers services provided in a person’s home or in their community. It applies to organisations and service providers who are contracted to provide home and community support. The objectives of Standard NZ8158 2012 are to:

(a) Support achievement of good outcomes for those receiving services by ensuring that organisations are assessed principally on outcomes achieved, in addition to compliance with procedures;
(b) Support nationally consistent quality expectations across the health and disability sector by ensuring this Standard aligns with the Health and disability services Standards (NZS 8134) where this is appropriate;
(c) Enable training requirements to be better linked to the Standard.

The Standard sets out what people receiving support in a home or community setting can expect from the services they receive and the minimum requirements expected from service organisations. For home care services, the Standard provides information about the points that should be included in service agreements (see Section 4 of these Guidelines, details to be included in service delivery plans, training in use of equipment and supervision and support for support workers. Certification using the 8158 2012 Standard commenced in May 2012.

1.8 Government agencies

Five agencies have responsibilities and interests in preventing workplace injuries in healthcare services. These are:

- ACC – the Accident Compensation Corporation
- Department of Labour
- Ministry of Health
- District Health Boards
- Ministry of Social Development

ACC

ACC has a specific interest in home care services through its funding of support and rehabilitation services for people of all ages who require support because of an accident. More generally, ACC has lead the development of safety in moving and handling people in New Zealand through the publication of *Moving and Handling People: The New Zealand Guidelines*, and its emphasis on injury prevention within the healthcare industry. ACC has published nearly all the current information relating to moving and handling of clients in New Zealand. A recent initiative in the field has been the development of the *Prevention and Management of Discomfort Pain and Injury Programme* (DPI) for workplaces. Other initiatives have included providing tools relating to training programmes for DHBs and other training providers, and funding evaluations of new programmes, such as the piloted implementation in Guidelines in Auckland hospitals, and the evaluation of a pilot training programme at a district health board.

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16 Details on how to purchase the Standard are available from: www.standards.co.nz

17 Standards New Zealand, 2012, p.2
ACC funds needs assessment for injured people. This assessment determines the level of support that will be funded. A more complex needs assessment is conducted for clients classified as having a serious injury (such as moderate to severe brain or spinal cord injury, double amputees and those with severe burns). The needs of people with serious injuries are complex and lifelong and are likely to require long-term home care services.

**Department of Labour**

The Department of Labour administers the legislation relevant to health and safety in workplaces. It provides copies of legislation, guides, and health and safety pamphlets, many of which are available on its web pages. The Department implemented the Workplace Health and Safety Strategy (WHSS) in 2005. In 2001, ACC and the Department published the *Code of Practice for Manual Handling*. For moving and handling people purposes, ‘the load’ is a person and not an object. The Department of Labour also investigates serious workplace accidents.

**Ministry of Health**

The Ministry of Health through Disability Support Services (DSS) provides funding for home and community support services to help disabled people live at home. The services include both household management and personal care. People eligible for services need to be under 65 years old and meet the Disability Support Services definition of being disabled. This requires an assessment verifying the need for home-based support services. Household management is only available to people who have a Community Services Card or children (under 16 years) whose parents or caregivers have a Community Services Card. Needs Assessment and Service Coordination (NASC) service organisations based in the major DHB regions are contracted by the Ministry to work with disabled people to help identify their needs and outline what disability support services are available to them. NASC services allocate Ministry-funded support services and assist with accessing other support.

**District Health Boards (DHBs)**

The New Zealand DHBs, through funding provided by the Ministry of Health, provide a range of community-based health services. As DHBs are their own budget holders, their services are separate from the Ministry of Health. Many of these services provide short-term home support for people recently discharged from hospital and for elderly people who are at risk for being hospitalised due to poor health.

One concern for most DHBs is to reduce the high rates (and associated costs) of acute medical readmissions among people aged 65 years and over. Readmissions are a significant cost to the hospital sector and to the individuals who are readmitted. There are two groups that have unplanned readmissions to hospital following an episode of acute hospitalisation. The first is patients who are readmitted within four weeks following discharge, due to failure to receive adequate post-discharge care through community health care services. The second group is patients who are admitted several times during a 12-month period. In one estimate about half of all acute hospital admissions are older patients who have been admitted twice or more in the last 12 months.

Since publication of the original version of *The New Zealand Patient Handling Guidelines* in 2003, some of the 20 district health boards (DHBs) in New Zealand have implemented moving and handling initiatives. These include the appointment of moving and handling coordinators and facilitators; implementing moving and handling programmes; and providing training for carers. DHBs have an important role in providing models and training for moving and handling people in
community services and residential care. However, not all DHBs have training programmes. Those that do have training tend to focus on hospital settings that may have a better range of equipment and resources than home care services. There are challenges in providing access to DHB in-house moving and handling training programmes for external home care providers.

Ministry of Social Development

The Ministry provides information for carers; anyone who supports a person with ill health, a disability, mental illness, an addiction, or in their old age. The Ministry’s roles include ensuring access to income support for families with high and complex needs and providing information, training and raising awareness. In 2008, the Ministry published a five-year action plan covering carers.  

1.9 Overview of the Guidelines

Section 2 describes the two major components of risk assessment. These include risk assessment of clients and their mobility, information used in risk assessments such as hospital discharge forms and face to face assessments, identifying common risks in home care environments, conducting an environmental risk assessment.

Section 3 describes preparation of a care plan, and organising home modifications and review of care plans following changes in client health status.

Section 4 describes service agreements for home care, including topics relevant to moving and handling to include in service agreements, details regarding the content of service agreements. An Appendix at the end of this section provides a template for service agreements that can be adapted to suit the specific needs of service providers.

Section 5 covers accessing resources, including the types of resources available and agencies that can provide them, the types of equipment used in home care, training needed for support workers who moving clients in home care and how to access training.

Section 6 describes the importance of communication and how to establish effective communication with multiple stakeholders in the provision of home care. It also includes the client advocate role, managing client expectations and working with challenging clients.

Section 7 describes some common moving and handling tasks in home care and then presents a series of case studies to illustrate challenges faced by support workers and service providers.

Section 8 outlines current and future trends in home care in New Zealand.

Where possible, examples reported in these guidelines have drawn on the experiences of people providing home care services. These include examples illustrating issues arising in home care, and practical solutions and advice.

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18 See Ministry of Social Development, 2008
2 Risk assessment

Risk assessments need to cover both the home environment in which personal care will be provided for the client, and the client’s mobility and specific needs. This section covers two aspects of risk assessments related to moving and handling: client mobility and the client’s home environment. For families employing a home care provider directly (not through a home care service) a risk assessment is strongly recommended. In most areas, there are independent practitioners (e.g., physiotherapists, occupational therapists) who carry out risk assessments. For clients funded by ACC, the agency contracted to provide services will organise the assessment process.

The purpose the risk assessment is to identify hazards and minimise or eliminate risks of these hazards to the client. The risk assessment leads to development of a care plan that includes the assessment of client mobility and the suitability of the home environment for clients who need assistance with mobility and personal care. Care plans should be reviewed following changes in client mobility or health status.19

Figure 2.1 shows a summary of the typical steps needed when a new client is referred to a home care service. These steps emphasise that risk assessments need to occur early when setting up home care services for new clients.

![Figure 2.1 Steps needed for an effective home care service](image)

Adapted from: Worksafe Victoria, 2005, p. 10

One of the questions to consider during a risk assessment is whether it is realistic for a client to be cared for in their own home, compared to residential care, a hospital, or a hospice. For example if a

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client is very ill or dying and requires 24-hour care, their home may need to be set up with equipment (medical, moving and handling ones) and nursing care similar to a hospice. During the assessment, consider whether there is sufficient space in the house for equipment, and whether the required level of care can be provided.

Another issue to consider when a person is discharged from a hospital, is the need for continuity of care from hospital to home care. Overnight and weekend care may be required as hospitals sometimes discharge patients on Friday afternoon.

Some of the general challenges that may need to be addressed during a risk assessment are listed in Appendix 2.1.

2.1 Risk assessment process for clients

Before any moving and handling of a client in home care, there should be a systematic risk assessment to identify hazards and organise controls for risks identified. When a new client is referred to a home care service the initial risk assessment (the pre-service risk assessment), should be carried out by a specialist who has appropriate training and experience. The risk assessment process for clients should include any documents available (relating to the client’s health or mobility) and a face-to-face assessment at the client’s home.

When there are changes in a client’s mobility, or when a dispute arises as to whether moving and handling equipment is needed for client transfers, a more comprehensive risk or needs assessment may be required. All assessors should be competent in moving and handling people.

Details to cover in the risk assessment

Table 2.1 provides a guide for assessors carrying out a risk assessment related to moving and handling clients in home care. Relevant details for each topic listed should be included in the client’s profile. The level of assistance needed by the client is one of the most important

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**Box 2.1 Caring for clients in low beds:**

**Example of the risk assessment process**

**Task** – caring for clients in low beds and on double beds, including:
- turning in bed
- moving up or down the bed
- sitting patient to lying and vice-versa
- bed-bathing
- getting client in or out of bed.

**Identified risks for carers**

- prolonged stooped postures when attending to client
- awkward posture when moving client in bed

**Control measures** – the level of risk depends on the client and assessments should be carried out at the client’s home. For medium to high risks, consider using these options when working with the client:

- place knee(s) on bed or floor to reduce stooping when attending to a client (consider infection control issues)
- arrange a suitable bed such as an electric profiling bed
- arrange for hoists or transfer boards for transfers to or from bed
- keep the client in bed until equipment is available
- provide extra carers as required
- provide blocks to raise the bed

Assessments may result in recommendations to move furniture or provide equipment. These would need to be discussed with clients and their family. The environment should be managed appropriately, and if the client and family refuse assistive equipment, care may need to be scaled down to avoid risk to carers.

Adapted from: Royal College of Nursing, 2003.
criteria when considering transfer techniques and any equipment needed. Assess whether the client is fully dependent or partially dependent on the caregiver for transfers and the level of assistance needed. An example of a client mobility assessment form is shown in Appendix 2.2.

A newly injured client should be informed about the need for a risk assessment. In the early stages of recovery or rehabilitation it may be advisable not to overwhelm the person with too much information. Use language the client can understand to explain to the client what needs to happen and why. The risk assessment should also note any support provided by family members and people who visit the client’s house.

### Table 2.1: Information to cover in a client mobility assessment *

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
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<tbody>
<tr>
<td>Physical characteristics</td>
<td>Includes client’s details such as height, weight, pain, disability, spasm, cognition, vision, fatigue, tissue viability, risk of falling. Weight will be important to ensure any equipment used has an adequate safe working load (SWL) for the client. If using a hoist, the client’s shape and weight will determine the correct sling size and type.</td>
</tr>
<tr>
<td>Clinical conditions and special circumstances</td>
<td>Make note of pain level, fractures or joint limitations, upper/lower/onesided paralysis of the body, contracted limbs, effects of medication, balance issues relating to traumatic brain injury, recent surgery, muscle spasms, sensitive or fragile skin, ability to communicate, agitation, and comprehension and compliance with requests. Note if the client has any surgical dressings or other medical equipment (e.g., presence of drains, stomas, catheters, IV lines).</td>
</tr>
<tr>
<td>Weight bearing ability</td>
<td>The client’s ability to bear their own weight while they are moving from one location to another and being able to maintain their balance are important when planning transfers.</td>
</tr>
<tr>
<td>Client mobility</td>
<td>Describe what tasks or movements the client is able do themselves, and tasks for which the client needs assistance. Note also, the extent to which client is likely to cooperate with transfers.</td>
</tr>
<tr>
<td>Transfer tasks</td>
<td>List of transfers for the client needs supervision or assistance during their daily or weekly schedule of personal care. (e.g., bed to wheelchair, wheelchair to toilet, wheel chair to shower stool, wheelchair to vehicle). Note how the transfers be will be assisted (e.g. supervision and prompting by the carer, mobile hoist, electric profiling bed)</td>
</tr>
<tr>
<td>Equipment</td>
<td>Specify any equipment needed for the transfer tasks listed (e.g. type of chair, bed, hoist and sling). Note of the equipment is for large (bariatric) clients.</td>
</tr>
</tbody>
</table>

*An example of a client mobility assessment form is shown in Appendix 2.2

If a risk assessment was completed while the client was in hospital, it will be important to conduct a reassessment after the client returns home (see Box 2.2). The client’s home environment is likely to have features that have not been considered in the original hospital assessment. The risk assessment from the hospital, or the hospital discharge form, should be reviewed if available, prior to conducting a face-to-face assessment in the client’s home.

When completed, the risk assessment should clearly identify the transfer tasks the support worker needs to carry out for a client (e.g., transfer from bed to wheelchair, wheelchair to bath and toilet). The risk assessment should note any transfer tasks that require equipment or training (e.g. use of slide sheets and mobile hoists). The completed risk assessment then becomes part of the client’s record held by the service organisation.
One outcome of a risk assessment may be a recommendation that home care is not suitable for the client, that residential care or other managed care is necessary. Such a recommendation may be relevant for very large (bariatric) clients where suitable equipment cannot be used in the client’s home because of lack of space, or where three or more carers are needed to bath or provide other personal care for a client.

When the risk assessment has been completed, consult with staff at a district health board, ACC, or staff in other organisations who are familiar with moving and handling equipment to get advice on recommended equipment such as hoists, slings, beds and accessories. Occupational therapists or physiotherapists may be able to advice on access to Ministry of Health or ACC-funded equipment for moving and handling the client (See Section 5).

It may be necessary to make interim arrangements while waiting for equipment to be approved or before it arrives so that clients receive appropriate care, and that family members or support workers are put at risk through lifting a client.

2.2 Risk assessment of home care environment

Environmental risk assessment covers a range of different hazards, some of which are specific to moving and handling clients and other more general hazards. \(^{21}\) The type of environmental risk assessment carried out will depend, in part, on the specific tasks and responsibilities expected of the carer. The risk assessments described in this section are focused on moving and handling of clients during personal care.

It is also important to maintain the client’s mobility, health, comfort and dignity. The manner in which risk assessments are carried out is important. A simple request to the client to have less furniture in their bedroom or to have belongings such as children’s toys put away could be misconstrued as criticism. For the client it is their home. However, it is also the carer’s working environment. Effective consultation and communication between the assessor, client and their family (if relevant), carers and the service funder is needed, to ensure any modifications required for safety are carried out. This requires that the client and family members comply and cooperate with any plans and modifications. Communication processes are covered in Section 6.

Common hazards in home care environments

The design of most houses is not suitable for the needs of disabled or injured people in need of care. A ‘normal’ home can present support workers with hazards that create risks for both themselves and their clients (see Box 2.3). Assessment of the home environment should note any physical features

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\(^{21}\) Other types of hazards to which carers may be exposed include toxic household chemicals and hazardous waste, passive smoking, assaults and other violent behaviour. Home care workers may also be exposed to infectious diseases such as hepatitis, HIV, influenza (flu), tuberculosis (TB), measles, and chicken pox when providing direct client care, such as dressing, toileting and bathing.
or hazards that may increase risks to carers and clients. These include; cluttered rooms, carpets, and spaces that have no wheelchair access. Some of the common home environment features that present hazards while moving clients are described next.

**Furniture and appliances**
Carpets may be very thick, causing drag when manoeuvring equipment, or may have loose, ragged edges that can catch on equipment or cause trips. Hard flooring may be slippery when wet. There may be a range of electrical equipment wiring which are tripping hazards. Furniture may not be an ideal height or type for the client’s condition, or for safe lifting by the carer. Rooms may be cluttered, hallways narrow, and there may be inadequate space in bathrooms and toilets for carrying out client transfers. Hoarding can be a significant problem with some clients, adding to the problem of tight spaces in small cluttered rooms.

Household beds tend to be low and not appropriate for transferring people safely. Large mattresses can be extremely heavy and unwieldy to lift during changes of bedding. Chairs may not be suitable for clients and they may require continuous repositioning or the use of enablers.

**Other hazards**
The lack of space to carry out moving and handling tasks is a significant problem encountered regularly by support workers. Family members and friends who want to help but are not trained in safe moving and handling techniques can also present problems.

Clients have pets that can distract support workers, or endanger them (See Box 2.4). The risk assessment should note whether a dog or other pet needs to be restrained, or placed in another room during client transfers.

If a dependent client needs help to be get into a motor vehicle, check access from the house to the footpath, driveway or road. When using a

---

**Box 2.3 Examples of home environment hazards for moving and handling**

- Bed which is very low and not compatible with client or staff safety
- Pets running around, toys lying around
- Dog attacking staff providing care. Client refuses to lock dog in another room
- Cats climbing up support workers legs as they are moving client in hoist
- Chair no longer suits client’s size and they are falling out of it. Staff have to repeatedly reposition the client, who won’t get a chair that suits their build
- Thick carpets so can’t move hoist across rooms without dragging
- Tight spaces in small rooms full of clutter, restricts ability to bend appropriately
- Electrical equipment cluttering bedroom: fan, heater, TV, DVD player, gaming station, laptop, printer, wheelchair, battery charger, sleep apnoea machine, lamp, cables all over floor.

Source: Examples provided by New Zealand home care managers

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**Box 2.4 Dealing with pet problems**

Some clients may be reluctant to remove their pet from rooms where the support worker is present. In these cases, discussion with the client is needed to ensure everyone is aware of the risk posed by the pet and action needed from both the client and the support worker.

*Our support workers are told not to enter a home if the client’s dog is not secured. We had support workers who were attacked by clients’ dogs in the past. As a result, we now have a procedure in place to prevent the problem. Clients are informed about restraining their dogs before their workers arrive. If on arrival, it is clear to the worker that the dog is not tied up or locked away, the worker stays in their car and rings us. We then call the client and tell them to secure the dog otherwise ‘your worker won’t come into work’.*

Source: Quality manager
wheelchair to transfer a client from the house to a vehicle hazards such as uneven surfaces, steps and other physical impediments may be encountered.

If handrails (grab rails) are fitted check they are sufficiently robust to take the weight of the client. Often people buy a cheaper model that is not suitable to their weight. For example, some rails may take 60 kg but some clients are heavier than 60 kg.

There should be a section in service agreements noting that clients should not smoke while the support worker is in the house (See Section 4). If the client is using oxygen and oxygen cylinders are present, smoking can create a major hazard.

Cultural issues
As New Zealand has become a multicultural society, it is now common for some clients to request that support workers do not wear street shoes in their homes. Lack of footwear may put the support worker at risk of injury, for example if a mobile hoist rolls on their foot or when transferring clients on slippery floors. An alternative may be to keep a pair of clean ‘house shoes’ for the carer to use in the client’s home.

Violence
During the risk assessment, find out if the client has a history of aggressive or violent behaviour. Violence can be a significant risk and cause of injury to support workers. Violence is a leading cause of injury to support workers in some locations.\(^\text{22}\) Investigations of violent incidents usually indicate that the client involved had a history of violent behaviour that was not communicated to support workers through assessments or care plans. Violence may be physical, sexual or verbal abuse, harassment, bullying or discrimination.

People with traumatic brain injury, cognitive disability dementia or alcohol/drug addiction may be present challenging behaviours for support workers. The client may not be able to communicate their physical or emotional discomforts, so they express their feelings through behaviours that may include hitting, grabbing or swearing. Training support workers to keep safe when working with violent or challenging clients, and providing appropriate strategies for these workers is recommended.

2.3 Conducting a home environment risk assessment

The risk assessment should be conducted by an appropriate person or authority in the client’s home environment. The risk assessment process should be consistent with the health and safety policy of the employing organisation for support workers.

Table 2.2 lists common home environment areas or features that require assessment prior to developing a care plan for a client. If the support worker is to assist with household management in addition to personal care, the risk assessment should be more extensive. Appendix 2.3 shows an example of a home environment moving and handling assessment form.

\(^{22}\) See Worksafe BC, 2005.
Table 2.2 Areas to include in a home environment risk assessment

<table>
<thead>
<tr>
<th>Location of transfers</th>
<th>Specific details to note</th>
</tr>
</thead>
<tbody>
<tr>
<td>From vehicle to inside house</td>
<td>Type and condition of equipment needed (e.g., walking frame or wheelchair), access for wheeled equipment, steps or other obstacles, ramps (type of surface), presence of handrails, presence of any external lighting</td>
</tr>
<tr>
<td>Hallways and stairways</td>
<td>Type and suitability of flooring, furniture which may obstruct wheeled equipment, width of corridors and doorways, space for manoeuvring equipment, presence of handrails, quality of lighting, accessibility to other areas of house</td>
</tr>
<tr>
<td>Bedroom</td>
<td>Type and height of bed, space beside bed, type of chair (if any), type and quality of flooring, presence of handrails, quality of lighting</td>
</tr>
<tr>
<td>Bathroom and shower</td>
<td>Type and suitability of flooring, space for manoeuvring, drainage in wet areas, type of shower or bath, access for wheeled equipment, presence of handrails, quality of lighting, ventilation, handrails</td>
</tr>
<tr>
<td>Toilet</td>
<td>Presence of handrails, space for wheeled equipment or over-toilet frame, space for manoeuvring, type and quality of flooring, quality of lighting.</td>
</tr>
<tr>
<td>Dining area/lounge</td>
<td>Suitability of furniture for client, space for manoeuvring, type and quality of flooring, furniture which may obstruct wheeled equipment, presence of handrails, quality of lighting</td>
</tr>
<tr>
<td>Kitchen</td>
<td>Type and suitability of flooring, furniture which may obstruct wheeled equipment, height of work surfaces and accessibility of commonly used equipment, quality of lighting</td>
</tr>
<tr>
<td>General</td>
<td>Comment on home floor surfaces should include potential hazards such as loose carpets or rugs, steps or raised surfaces that might impede wheeled equipment, other slip or trip hazards. Note any electrical points which may be knocked by (or needed for) equipment and location and type of any heating appliances and whether heat guards are present or needed</td>
</tr>
<tr>
<td>Furniture</td>
<td>Suitability of beds, chairs and other furniture used by client and for client transfers</td>
</tr>
<tr>
<td>Other hazards</td>
<td>List of other specific features or circumstances which may be potential hazards that need changes or improvements</td>
</tr>
</tbody>
</table>

Generally, the home risk assessment will take place concurrently with the client risk assessment described earlier in this section so the outcomes from both types of risk assessment can be included in the client care plan. If any modifications to the home environment are needed following the home risk assessment, these should be agreed between the client, service provider and funding agency (where relevant) prior to finalisation of the care plan (see Section 3).

Providers of home care services should have a system of reviewing client risk assessments annually, or more frequently when there have been significant changes for the client and their support. Significant changes could include:

- the client moving to a different house
- after an incident or accident involving the client or the support worker
- changes in the client’s condition or level of function
- following alterations to the client’s home.
Support workers should be encouraged to report any relevant changes affecting the client or their home environment to their supervisor. A risk assessment should also be carried out if the support workers circumstances change. For example, if a support worker has had an accident, operation, or illness it may affect their ability to assist with client transfers.

Box 2.5 Example of items for a home safety checklist

- Access to the home: paths, steps, lighting, gates, pets
- Internal stairs
- Bedroom: height of bed, space, furniture
- Client aids and equipment: wheelchairs, shower seat, lifting equipment
- Bathroom and toilet: access, suitability, ventilation
- Interior facilities: floor surfaces, chairs, other furniture, power points
- Kitchen: electrical appliances, stove
- Laundry: space, bucket, mops, cleaning products
- Appliances: vacuum cleaner, iron, heating

Adapted from: Worksafe Victoria, 2005, p. 14
Appendix 2.1 Factors affecting hazards and risks in home care

The environment is not:
- under the direct control of the employer
- purpose built or designed for manual handling

Equipment:
- is not always readily available
- may be poorly maintained
- may not be readily accepted by the client and/or staff
- may not be compatible with furniture and environment

Clients:
- may have complex manual handling requirements
- may resist changes to the way care is provided
- have significant control of the workplace
- may not be willing to fund/purchase equipment or make changes to the environment

Staff:
- are working unsupervised
- do not have on the job support
- can be difficult to access with the knowledge and skill for completing specialised manual handling tasks
- can have a strong sense of loyalty to their clients

Tasks can:
- be repetitive over the shift and week
- be very specific to individual need and environment
- change gradually over time or overnight
- require risk management immediately
- require expert assessment and advice that may not be readily available

Appendices 2.2 and 2.3 Risk assessment forms

The two forms in these appendices provide examples of the types of items typically included in a client mobility assessment and home environment assessment. These forms were constructed specifically for the Guidelines after reviewing several examples of forms used by New Zealand service providers.

We recommend that service providers consider including the items below, or similar items, in their risk assessments. The forms can be adapted to suit the types of clients for whom agencies provide services; for example, by adding specific items for conditions that are regularly encountered among clients. Note that the items in the forms cover collection of information primarily relevant to moving and handling clients. Service providers may wish to collect additional information not included in these forms.
## Appendix 2.2 Example of a client mobility assessment form

<table>
<thead>
<tr>
<th>Name of client</th>
<th>Date completed</th>
<th>Time completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed by:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical characteristics and impairments</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>Kg</td>
</tr>
<tr>
<td>Height</td>
<td>cm</td>
</tr>
</tbody>
</table>

**Circle one**

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Hearing impairment?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision</th>
<th>Vision impairment?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other communication Impairment (e.g., confusion)</th>
<th>Communication impairment?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other physical impairments or disabilities</th>
<th>Other impairments?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioural problems (e.g., uncooperative, threatening, violence)</th>
<th>Has problem?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Conditions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin fragility</td>
<td>Has this condition?</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paralysis</th>
<th>Has this condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dressings</th>
<th>Has this condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Joint limitations or fractures</th>
<th>Has this condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pain when moving</th>
<th>Has this condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

| Tendency to faint, freeze, spasm or other changes in mobility | Has this condition? |
|                                                                | Yes | No  | If yes, describe condition |

<table>
<thead>
<tr>
<th>Incontinence</th>
<th>Has this condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other clinical conditions</th>
<th>Has other conditions?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Current medication that may affect mobility

<table>
<thead>
<tr>
<th>Takes medication?</th>
<th>If yes, describe how it affects mobility (e.g. pain or drowsiness)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

### Weight bearing and balance while standing

<table>
<thead>
<tr>
<th>Has problems with weight bearing</th>
<th>If yes, describe problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unable to stand unaided for 10 seconds</th>
<th>If Yes, describe balance difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

### Client mobility

<table>
<thead>
<tr>
<th>Type of movement or activity</th>
<th>Mobility assessment*</th>
<th>Describe specific help and any equipment needed (if not independent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Circle one**</td>
<td>Note whether any equipment needed is available in clients home, and the number of carers needed</td>
</tr>
<tr>
<td>Rolling in bed</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Sitting up in bed</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Sitting on bed to standing position</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Sitting on bed to chair</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Balance when sitting</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Getting dressed or undressed</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Using toilet</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Showering or bathing</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Getting into, or out of, a motor vehicle</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Other activity (specify)</td>
<td>I S A H</td>
<td></td>
</tr>
<tr>
<td>Other activity (specify)</td>
<td>I S A H</td>
<td></td>
</tr>
</tbody>
</table>

*I=Independent – Client can carry out activity on own, unsupervised
*S=Supervise – Can carry out activity, but requires supervision, encouragement and/or equipment
*A=Assist – Requires some physical assistance, unable to do activity unaided
*H=Hoist or major help needed – Requires major physical assistance, unable to do activity unaided

**Note: Some assessors prefer to put the response options in the order – H A S I
## Appendix 2.3 Example of a home environment moving and handling assessment form

<table>
<thead>
<tr>
<th>Household area</th>
<th>Describe relevant details and note which are hazards or potential hazards</th>
<th>Describe control measures needed, including equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outside house</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entry to house, any steps, pathway from vehicle parking area to house entry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedroom (e.g., bed type, bed height space, furniture)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shower or bath, any steps into shower, space for shower chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitchen, dining area, lounge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallways and stairways</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flooring (not covered previously)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrical appliances and cords (not covered previously)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other people in household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dogs or other pets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other hazards</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3 Preparing a client care plan

Following the risk assessment, the service provider should arrange to have the risk assessment information added to the client’s record. Records held on clients should provide sufficient information about the client’s capabilities and needs for development of a handling plan when needed. In each client record, there will generally be two parts related to moving and handling:

1. **The client risk assessment** covers the factors that affect client handling, such as mobility level, pain, cognitive state, medication, compliance, home environment and other relevant information. If the assessment shows specific risk factors for client mobility or transfers, a handling plan should be completed. Not all clients will need a handling plan.

2. **The client care plan** or service plan should, when needed, include a moving and handling plan that describes the techniques and equipment considered appropriate for each handling task and number of carers required. This may include support provided by household members or other people who visit the client’s house. The handling plan should be used by anyone carrying out client transfers. It should be reviewed if the client’s condition changes. For instance, a change in the client’s condition or medication may alter their strength, balance or ability to follow instructions.

The moving and handling plan, which is part of the client care plan, should provide carers with the information they need in a clear and consistent way. It provides a quick overview of the client’s condition and any handling needs. It sets out the techniques and equipment most suitable for each handling task, and provides a quick checklist of the factors carers need to consider before they carry out the task.

*The Home and Community Support Sector Standard NZS 8158:2012* provides information and guidance about details that should be included in client care plans, which are referred to in the Standard as ‘individual service plans.’ Section 4.4.1 states that:

An individual service plan is developed to reflect the consumer’s goals, support needs and requirements. This shall include, but is not limited to:

(a) Where more than one organisation is involved, the development of the individual service plan is coordinated;
(b) Where the organisation responsible for developing the individual service plan is different to the organisation responsible for, service delivery linkages exist between the two;
(c) The individual service plan reflects any natural supports/family/whanau;
(d) The individual service plan reflects the home environment;
(e) The individual service plan reflects the consumer’s support needs and goals;
(f) The individual service plan defines the use of equipment and enablers as part of service delivery and sets out service provider responsibilities. (p. 43)

Involving the client or a family/whanau member during the development of the client handling plan. It is important that the client understands what is necessary for reducing the risk of injury to both carers and the client. This will assist with planning any home modifications needed and introducing any specialist equipment required. Explain to the client how the equipment works and the benefits of using it.
3.1 The client care plan

Information from the risk assessment, recorded in the client record, is used to prepare the client care plan that is part of the service agreement between the service provider and the client. The care or support plan (sometimes called the ‘service plan’) should be based on the risk assessment reports and describe the services to be provided to the client. It would also note any identified hazards for the support worker or the client, how these hazards are to be controlled or minimised, and who is responsible for minimising specific hazards.

The client care plan will describe the specific areas and activities where the client needs help or assistance and details how assistance is to be provided. Table 3.1 shows an example of some of the specific areas and activities related to moving and handling transfers that a care plan might cover. Some of these activities, such as taking medication, might involve organising medications so they are accessible to the client, reducing the need for client movement.

Table 3.1: Examples of client moving and handling activities covered in a care plan

<table>
<thead>
<tr>
<th>Client activity</th>
<th>Goal for care</th>
<th>Care Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving around house</td>
<td>Client can move safely around house, maintaining independence where possible</td>
<td>Monitor client when moving around house, remove obstacles where feasible, provide physical assistance for client when requested or needed</td>
</tr>
<tr>
<td>Showering</td>
<td>Client is able to safely attend to personal hygiene needs and dignity is maintained</td>
<td>Provide assistance as needed before and after shower (undressing, drying, dressing), transferring from walking frame to shower stool, and monitoring during showering</td>
</tr>
<tr>
<td>Toileting</td>
<td>Client is able to attend toileting needs and dignity is maintained</td>
<td>Monitor client using walking frame to get to toilet. Assist client to transfer from walking frame to toilet and from toilet to walking frame, as needed.</td>
</tr>
<tr>
<td>Visits to GP</td>
<td>Client is able to attend necessary appointments</td>
<td>Provide assistance to client when exiting house using walking frame and when client is transferring from walking frame into vehicle and from vehicle to walking frame</td>
</tr>
<tr>
<td>Medication</td>
<td>Correct medications are taken at the appropriate time each day</td>
<td>Ensure medications are prepared ready for client and in a location where they are easily accessible to the client</td>
</tr>
</tbody>
</table>
Where the home care services is provided by more than one support worker (see Box 3.1), the care plan should describe the specific tasks of each worker, where they are expected to carry out different tasks.

Support workers should be provided with a list of tasks they are expected to carry out as part of the care plan. Where there is disagreement between the client and carer, or the client and the service provider, the care plan should describe the procedures needed to resolve any disagreements, or refer to the service agreement where relevant.

3.2 Controlling hazards and working with clients

Following a home assessment, where significant hazards are identified for carers (e.g., wet areas, no handrails, client and family or friends posing a risk to the support worker) a plan of action to remove or minimise the hazards should be developed. If a client does not agree to changes to reduce the identified hazards, support workers consult with their manager or supervisor to discuss options to keep themselves and the client safe. Any incidents should be reported to the support worker’s supervisor or manager as soon as possible for appropriate management. Any disagreements between the client and service provider should be negotiated and resolved as early as possible as part of the assessment and care planning process.

If the client does not agree or comply with the elimination or minimisation of hazards the service provider may need to consider suspending the service. It is acknowledged that this could leave the client isolated or make it impossible for the client to live at home. It may also result in potential loss of income for the service provider and support worker. The service provider has primary responsibility for ensuring the health and safety of their support workers and managing the risks associated with their work duties. It is important to notify the funding agency if continued non-compliance is likely to result in a serious compromise to client or carer safety, as alternative arrangements may be required.

Try to avoid getting caught out by unplanned events. Even the simplest request for assistance should always be accompanied by a risk assessment (see Box 3.2).

Box 3.1 Provision of help or backup for moving and handling clients

When a risk assessment shows it is not possible for client transfers to be conducted safely by a lone worker, address that risk by, for example, making arrangements to provide help or back-up. .... Where a risk assessment of the moving and handling needs for a particular client has highlighted a requirement for more than one person to be involved to ensure the safety of both client and staff, then this should be incorporated into the care plan for the client. With the increasing incidence of obesity in the population, the likelihood of visiting clients who fall into this category will also increase.

Source: Tofts, 2012 p. 54

Box 3.2 An unplanned request for assistance

We received a referral for temporary assistance for a disabled client who was at a motel in the area for the weekend. The client needed assistance with showering and dressing. When the support worker arrived at the motel, she found the client could only partially weight bear. There were no handrails to assist. The shower was very awkward and shower chair did not fit in easily. The client expected that the support worker would be willing to manually lift her. It was a very awkward situation. The support worker was on put on the spot. The problem lay with the lack of information on the referral, lack of preparation for a motel situation and unrealistic expectations from the client. It was a lesson for us. We need to get better information before accepting a referral like this in future.

Source: Quality Manager
3.3 Organising modifications to clients’ homes

Common features of homes that could compromise safety in moving and handling clients are insufficient space in toilets and bathrooms, slippery floors, poorly carpeted floors and narrow corridors. The following are five key features of homes relevant to reducing risks in moving and handling clients.

1. **Access**: Corridors and doors should be sufficiently wide to allow the client, the carer and equipment to pass through. Ramps should be available where steps exist.

2. **Space requirements**: There should be enough space around beds, toilets, showers and baths to allow the use of appropriate moving and handling techniques and equipment.

3. **Handrails and grab rails**: These help people who are partially mobile to move. They require careful placement so that they do not obstruct handling operations or the movement of equipment.

4. **Floor surfaces and friction**: Floors should have surfaces that enhance the safety of clients (from falls) and carers who push or pull wheeled equipment.

5. **Equipment storage**: There needs to be suitable storage for equipment close to handling areas, so that equipment is readily accessible for use and easy to put away after use.23

Following a mobility risk assessment, if a client’s home requires modification to make it safer for moving and handling the client, it is essential to establish whether this need has been assessed, is in the process of being assessed who will be responsible for organising the modifications and who will fund them. Section 5 covers accessing resources, including funding for home modifications. It is essential to consult with the client (or their family) and those completing the assessment, in planning any home modifications. In the event that home modifications are not completed prior to home care services commencing, interim arrangements should be made to provide a service for the client. These could include hygiene needs being met at a local rest home or provision of a stand-alone wet area bathroom.

3.4 Review of care plans

A care plan should be reviewed on a regular basis and modified where needed. The need for reviews will vary among clients. Service providers should request an assessment if they have concerns regarding changes in the client’s physical or mental state that may impact on the safety of support workers or clients.

Changes in a client’s physical or health status may be due to ageing, increasing or decreasing weight, and increasing cognitive difficulties. When cognitive decline becomes evident, there should be a process for triggering an assessment or a review of the care plan. Sometimes clients themselves do not perceive that these issues are creating difficulties in providing safe and adequate service. Frequently in the client’s view, they are the ‘same’ as when the disability first occurred and they do not see the need for

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**Box 3.3 Moving children**

One of our clients was a child. As he grew older, he became too big to be carried but his parents insisted that the child be carried by the support worker. We can’t allow our support workers to have lifetime injuries because clients want things done their way. The parents were told this [by the support worker’s employer]. Standing firm is important in these cases.

Source: Home services quality manager
change. This can create problems for safe moving and handling practices.

Sometimes a client will put on weight gradually and physical assistance by the carer without the use of equipment is no longer an option. In such cases, a hoist may be needed. Where there has been significant weight loss, equipment (e.g., slings for hoists) may no longer be the correct size to safely hold the client. Where changes in client weight or size affect moving and handling of the client, the support worker should request a client mobility assessment that includes updated recommendations for moving and handling techniques and equipment.

Palliative clients may require frequent reviews as their condition can change markedly within a short period such as overnight.
## Appendix 3.1 Example of a moving and handling plan for inclusion in a care plan

<table>
<thead>
<tr>
<th>Name of client</th>
<th>Date completed</th>
<th>Time completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed by:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Moving and Handling Plan

<table>
<thead>
<tr>
<th>Type of movement or activity</th>
<th>Type of assistance required</th>
<th>Specific help and equipment needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolling in bed</td>
<td>Independent</td>
<td></td>
</tr>
<tr>
<td>Sitting up in bed</td>
<td>Assist1*</td>
<td>Needs assistance when sitting up</td>
</tr>
<tr>
<td>Sitting on bed to standing position</td>
<td>Assist1</td>
<td>Provide physical support and use “ready, steady, stand”</td>
</tr>
<tr>
<td>Sitting on bed to chair</td>
<td>Assist1</td>
<td>Provide physical support and instruction</td>
</tr>
<tr>
<td>Balance when sitting</td>
<td>Independent</td>
<td></td>
</tr>
<tr>
<td>Getting dressed or undressed</td>
<td>Supervise</td>
<td>Sometime unsteady, needs watching and assistance of requested.</td>
</tr>
<tr>
<td>Walking</td>
<td>Supervise</td>
<td>Uses a walking frame. Needs assistance getting down the step outside front door</td>
</tr>
<tr>
<td>Using toilet</td>
<td>Assist1</td>
<td>Assist with sitting and standing when requested. Toilet has a handrail on both sides which client uses</td>
</tr>
<tr>
<td>Showering or bathing</td>
<td>Supervise</td>
<td>Shower has handrail on outside and shower stool. Client can shower self but needs supervision</td>
</tr>
<tr>
<td>Getting into, or out of, a motor vehicle</td>
<td>Assist1</td>
<td>Requires walker to get into position and instruction for getting into and out of vehicle</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td>Client has hearing aid and sometimes has difficulty hearing</td>
</tr>
</tbody>
</table>

*Number of carers needed can be indicated by Assist1 (one carer) or Assist2 ((assist with two carers) or Hoist1 or Hoist2.

**Equipment available in house:** Walking frame, walking belt, rails on pathway to front door, handrails in toilet and shower. Bed height is 500 mm to top of mattress. Height is not adjustable.
4 Service agreements for home care

This section outlines service agreements, describes why these are needed, and gives an example of a service agreement. It also outlines procedures for dispute resolution between service providers and clients and their families.

Service agreements are a contract between the service providers (and their employees) and the client. They are written documents that describe the types of services to be provided, the conditions under which the specified services will be provided, and any other information that is relevant to the delivery or cancellation of the services. Existing service providers will have a form that they use. However, it is useful to specify the types of information that one would expect to see in a service agreement and to make clients and support workers aware of the specific details that could or should be included in a service agreement.

For safety when transferring clients, it is important that the service agreement refers to or appends the care plan to the service agreement. The care plan will generally be developed following the risk assessment, and include any specific details needed from the risk assessment report.

The purpose of the service agreement is to make clear expectations for each of the client, the support worker and the service provider in relation to the delivery of an effective home care service. In the event of a dispute between the support worker or client, or the client and the service provider, the service agreement should provide guidance for settling the dispute. Service agreements should contain specific details that are relevant to the services provided for a particular client, as well as general details that are relevant to most or all clients.

The Home and Community Support Sector Standard NZS 8158:2012 lists a number of points to be included in service agreements under Standard 4.1 (see Box 4.1). These points in the Standards should be covered when preparing a service agreement.

Box 4.1 Service Agreement: NZ Standard

Standard 4.1 states that:
4.1.1 Each consumer shall have a written service agreement with the organisation providing the services. The written service agreement shall be in languages and formats suited to the needs of the consumer. It shall explain the services to be provided. The agreement shall include, but not be limited to:

... (c) Services provided as part of the agreement, including when or how frequently, by whom;
(d) Any fees payable for the service, including when or how frequently, by whom, and options for how payments can be made;
(e) Rights and responsibilities of both parties
(f) Obligations of the consumer for health and safety of the service provider;
(g) Any equipment and supplies to be made available by the consumer or organisation;
(h) The use of equipment and enablers as part of service delivery;
...
(k) Circumstances in which the service delivery may be cancelled by either party;
(l) That the client should be able to ask for a different service provider if the person assigned is not right for them. This may be particularly important if the service includes personal care;

Source: Home and Community Support Sector Standard NZS 8158:2012 p. 39 (Note: some items not relevant moving and handling are omitted)
Table 4.1 provides an overview of the topics and policies relevant to moving and handling that one would normally expect to be included in a service agreement for home care. Note that the list in the Table does not include other details, such as payment for services that would normally be part of a service agreement. These topics are elaborated with examples in the following text.

Table 4.1: Example of topics relevant to moving and handling to include in a service agreement

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obligations and responsibilities of the client</td>
<td>How the client should treat carers or support workers from whom they receive services</td>
</tr>
<tr>
<td>Obligations and responsibilities of the service provider</td>
<td>How the support worker and service provider organisation should treat the client</td>
</tr>
<tr>
<td>Types of services provided</td>
<td>Description of the services to be provided and by whom</td>
</tr>
<tr>
<td>Policies of the service provider</td>
<td>Reference to any policies and policy documents applicable to the service provided</td>
</tr>
<tr>
<td>Policies, standards and legislation relevant to the service</td>
<td>Reference to the Standards NZ document and other NZ legislation or policies which are relevant to the services provided</td>
</tr>
<tr>
<td>Personal information about the client</td>
<td>Information needed about the client by the service provider</td>
</tr>
<tr>
<td>Home modifications</td>
<td>Any modifications required to the house or property of the client</td>
</tr>
<tr>
<td>Equipment</td>
<td>Description of equipment needed for personal care, how equipment will be provided, and specific activities or transfers for which equipment shall be used</td>
</tr>
<tr>
<td>Equipment damage and maintenance</td>
<td>Responsibilities of the client and service provider in relation to any equipment damage and maintenance required</td>
</tr>
<tr>
<td>Reporting adverse events</td>
<td>Reporting of any events resulting in accidents, near-misses or other incidents of concern</td>
</tr>
<tr>
<td>Complaints procedures</td>
<td>Procedures to be followed in the event of a complaint from the client, their family/whanau or support worker relating to the services provided</td>
</tr>
<tr>
<td>Cancellation of service delivery</td>
<td>Circumstances in which the service delivery may be cancelled by either party</td>
</tr>
<tr>
<td>Review and ending of the service</td>
<td>How long the service will be provided (if known), the process by which services will be reviewed or ended, and notice to be given by either party to end the service (e.g., two weeks)</td>
</tr>
</tbody>
</table>

Includes obligations relating to the health and safety of the support worker.

Includes obligations relating to respect and dignity to be shown to client.

For personal care services requiring specific moving and handling assistance, reference to the care plan is needed.

Some organisations have service user handbooks or similar documents which set out details of their policies in relation to services provided.

These might include privacy, health and safety, health and disability, services, consumers’ rights.

The service provider needs clear protocols to maintain the confidentiality of clients’ personal information.

May need to specify modifications needed prior to, or following service commencement.

Equipment to be used for specific transfers would usually be included in the care plan, which should be part of the service agreement.

May need to itemise equipment items for which on-going maintenance is needed, and who is responsible.

E.g., client falls during a transfer, client declines use of equipment required for safety of the support worker.

Complaints may be about the client’s or support workers’ behaviour, standard of service or other circumstances that affect service delivery.

Should include notification time to be given by either party to cancel the service (e.g., two weeks).

The agreement should note if the services are for a defined period with a specified end date or are to continue until one party wishes to end the service.
4.1 Content for a service agreement

The following parts of this section provide further information relating to topics in the service agreement. A the end of the section Appendix 4.1 shows an example of a service agreement form that can be adapted to suit the specific needs of a service provider. Where a family employ a support worker, they may wish to adapt the service agreement shown in Appendix 4.1 to suit the requirements and expectations of the planned relationship between the family and support worker. In this case, the support worker is also the service provider.

(a) Obligations and responsibilities of the client
The obligations and responsibilities of the client to the support worker providing personal care, and other service provider staff, requires showing them dignity and respect. The support worker should feel they have a safe working environment when providing care for the client (See Box 4.2).

This section of the service agreement is essential to protect carers and support workers. It should include specific details such as; access to the client’s personal care plan held in the house and a smoke-free household when the support worker is present.

There may be a need to inform or remind some clients of their responsibilities, if there is information that clients are not providing a safe work environment.

Where a support worker feels at risk in relation to their rights, they should contact their supervisor or line manager to discuss options and what steps could be taken to protect the support workers rights.

(b) Obligations and responsibilities of the service provider
The obligations and responsibilities of the support worker and other service provider staff, require showing the client courtesy, dignity and respect. The client should be able to participate in decisions made about their care, have an advocate speak on their behalf if they wish, and the right to privacy and confidentiality regarding their personal information (See Box 4.3).

(c) Types of services provided
The service agreement will usually specify the types of service to be provided in relation to personal care and household duties. Where the support worker is expect assist with transferring the client, this should be noted in the service agreement and further details provided in the

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**Box 4.2 Example of rights of service provider staff**
- To be treated with courtesy, dignity and respect by clients and their families while carrying out their tasks
- To work without feeling any risk of physical harm, or physical or emotional harassment
- To be able to complete their work in the manner in which they have been trained
- To have access to the client’s care plan held in the clients home
- To advise clients when tasks requested of them are unsafe and to assist the client to find other solutions to resolve the problem
- To have any personal information and circumstances about the support worker, shared with the client, kept confidential

Adapted from: Worksafe Victoria, 2005, p. 15

**Box 4.3 Example of clients’ rights**
- The right to be treated with courtesy, dignity and respect
- The right to be part of decisions made about your care
- The right to pursue any complaint about service provision
- The right to involve an advocate of your choice
- The right to privacy and confidentiality of all personal information about the client and
- The right to access all personal information in the client’s record held by the service provider.

Adapted from: Worksafe Victoria, 2005, p. 16

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care plan. Normally the care plan should be an appendix in the service agreement, or referred to as a separate document. It is good practice to note in the service agreement that where there are any updates to the care plan, the service agreement refers to the latest version of the care plan.

(d) Policies, standards and legislation relevant to the service
Reference to organisational policies and policy documents that are applicable to the service being provided, should be mentioned in the service agreement. This might include the service provider’s health and safety policy. Some organisations have service user handbooks or similar documents that set out details of their policies in relation to services provided.

Include reference to the Standards New Zealand document and other New Zealand legislation or policies that are relevant to the services provided. These might include privacy, health and safety, health and disability services consumers’ rights. Where relevant, summarise key points from relevant legislation in the service user handbook.

(e) Holding personal information about the client
It is good practice to note that the service provider needs to hold personal information about the client in order to provide an effective service. The service agreement should note that only information relevant to home care services will be requested from client and that information on the client’s care plan, which is required by the support worker, should be available in the client’s home. The client’s personal information, including that received from any referral agency, will be confidential and not disclosed to any unauthorised person.

(f) Home modifications
Describe any modifications required to the house or property of the client that are related to service delivery, and moving and handling of the client. It may be relevant to specify whether the modifications are needed prior to, or following commencement of services.

(g) Equipment and equipment maintenance
Describe what equipment is needed for personal care, how the equipment will be provided, and specific activities or transfers for which equipment shall be used. Any equipment to be used for specific transfers should also be included in the care plan for the client.

Where relevant, note who is responsible for rectifying any equipment damage and maintenance required for equipment. For more complex equipment, such as mobile hoists and wheelchairs, it could be relevant to expectations regarding on-going maintenance, including who is responsible for maintenance.

(h) Reporting adverse events
As stated in Standard 8158, the support worker and the service provider should document and report any adverse, unplanned or untoward events including service delivery shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. The adverse event reporting system should be a planned and coordinated process that links to the service providers’ quality and risk management system.

An adverse event is an incident that resulted in, or could have resulted in, harm to a consumer. A serious event is one which has led to significant additional treatment and a sentinel event is life threatening or has led to an unexpected death or major loss of function. Falls were the most commonly reported serious and sentinel events in hospitals in 2009/10.
In March 2012, the New Zealand Health and Disability Services published a report on the National Reportable Events Policy. The report contains a form for reporting adverse events. Although the policy is primarily focused on services provided by DHBs, it also includes other health services. Relevant events for home care services include client accidents and client falls.

If any adverse events occur, inform clients, their family/whanau and supervisors about the event. Support workers record any incidents or events that concern them (date, time, place and description of the event) and discuss these events in the first instance with their supervisor or line manager. Following discussion, a record of the event and decisions should go on the client’s record and decisions about any further action required, such notifying other authorities.

National reporting of adverse events or incidents assists health services to manage and prevent risks when providing care. Incident management can help identify problems and failures in health care services that can help prevent similar events from happening in the future.

(i) Complaints procedures: managing conflict and disputes
Clients or family/whanau members should be free to make any complaints about the services provided to the client. Support workers should also be able to make complaints to their supervisor or manager about the client, other household members or any circumstances that affect the service delivery.

Service providers should have established procedures for dealing with any complaints. The procedures should provide an opportunity for all parties affected by the complaint to present their views. This should include the person making the complaint and any person being complained about (or their representative or advocate). Following consideration of the complaint and hearing the concerns of all parties there should be a recommended resolution or action that is communicated to all relevant parties.

(j) Cancellation of service delivery
The agreement should describe the circumstances in which the service delivery may be cancelled by either the client or the service provider, and the normal period of notice expected (e.g., two weeks).

In the event that the client dismisses the support worker or service provider on grounds of ‘incompatibility’ the service provider should have a suitable assessment procedure to find out why the client dismissed the support worker or the service provider. It should also consider the implications of any dismissal for its services and for the funding agency (where relevant).

There have been cases reported where a support worker (and the service provider) have been dismissed by clients on grounds of ‘incompatibility’ where the support worker has declined to manually lift the client because it was too risky (see case studies in Section 7). In such cases is may be useful for service providers receiving a new referral to enquire whether the client has received services from another service provider, and if so, what were the clients reasons for leaving that service provider.

(k) Review and ending of the service
The service agreement should note if the services are for a defined period with a specified end date or are to continue until circumstances change or one party wishes to end the service.

For clients receiving rehabilitation, for example following an illness or accident, the service might be expected to continue for a limited period, until the client becomes independent or able to be cared for by other household members. In such cases, the service agreement should note the conditions or circumstances in which the service will be expected to finish. This is likely to involve periodic reviews of the client’s mobility and wellbeing.

In cases involving long-term disabilities, there may be no clear end date expected for the services. Periodic reviews of the client’s mobility and service suitability will still be relevant in such cases.

In cases where physical decline by the client may occur, such as during palliative care or care for frail elderly people, the client’s mobility may decline over time and there may be an expectation that the client will eventually move into managed residential care. For these cases, regularly scheduled reviews will be important to assess the client’s mobility, the suitability of the services provided, and whether additional equipment or carers will be needed if the client’s mobility declines.

4.2 Finalising a service agreement

Once the service agreement is finalised is should be signed by both the client or their representative and the service provider. A copy of the service agreement should be given to the client or their representative, and a copy held on the clients file by the service provider.

If a representative for the client signs the service agreement, the client should be briefed by the representative on any specific requirements in the service agreement that they need to know. This might include the specific types of services included in the agreement, any equipment or home modifications agreed to, and any other relevant details such as having a smoke-free house when the support worker is present.

Support workers should be aware of the standard service agreement expectations for both clients and service providers. As well support workers informed of any specific conditions in a service agreement that may affect their work with a particular client.
Appendix 4.1 Example of a service agreement form

This Appendix shows an example of a service agreement form that can be adapted to suit the specific requirements of a service provider. The purpose of this form is to show the types of content that would normally be included in a service agreement. Service providers may wish to add or omit items depending on the types of clients they have, and their circumstances. If preferred some content could be placed in a service manual (e.g., a Client Handbook) which can be referred to in the service agreement.

Name of Client __________________________
(for whom services are to be provided)

Please read the following conditions and expectations regarding the home care services to be provided by the [name of service provider] and sign this agreement on the last page.

**A Client’s obligations and responsibilities**
The following are the obligations and responsibilities of the Client receiving the home care services.

- To treat the support worker or other staff employed as part of the service with courtesy, dignity and respect while carrying out their tasks
- To be at home for scheduled visits by support workers or other staff
- To provide support workers with access to the Client’s care plan when requested
- To allow the support worker to complete their work in the manner in which they have been trained
- To follow any requests from the support worker for procedures or use of moving and handling aids that are required to assist the safe transfer of the Client
- To keep confidential any personal information and circumstances shared by support workers with the Client
- To agree to the service provider contacting agencies who have previously provided home care services to the Client, to find out about the history of services provided to the Client.

The Client also agrees to make their home a safe workplace for the support worker or other staff by attending to the following, when needed.

**Outside your home**
- Keep driveway, paths, stairs and ramps free of moss, or clutter
- Make sure stairs have handrails
- Keep paths and entrances well lit
- Provide parking as close to your home as possible

**Inside your home**
- Keep hallways, stairs and other passageways clear of clutter
- Make sure floors are not slippery and loose rugs have a non-slip backing
- Make sure your support worker can walk around both sides of your bed
- Smoking: If anyone in the household smokes, they should stop smoking at least 1 hour before the support worker’s visit, and not smoke during the visit
- Do not drink alcohol or use non-medical drugs before or during the support worker’s visit
- Dogs and cats should be kept under control. Dogs should be on a short leash or locked in a separate room

*Guidelines for Moving and Handling People in Home Care – Draft 12 Sep 2012*
• Family and visitors: Let your care worker know if there is anyone else in your home
• Firearms: If there are any firearms in the household, they should be stored securely and not be visible during the support workers visit

B Service provider’s obligations and responsibilities
The following are the obligations and responsibilities of the service provider and support worker providing the home care services

• The Client shall be treated with courtesy, dignity and respect
• The Client and their family shall be part of decisions made about the Client’s care
• The Client has the right to pursue any complaint about the service provided
• The Client has the right to involve an advocate of their choice in any decisions or compliant about the service provided
• The Client has right of privacy and confidentiality of all personal information about the Client by the service provider
• The Client has the right to access all personal information in the Client’s record held by the service provider.

C. Services to be provided
The following services will be provided to the Client.
Personal care: (describe details here)

Household duties (describe details here)

D Policies and standards relevant to the services provided
The services provided to the Client shall be consistent with the following:
• Home and Community Support Sector Standard NZS 8158:2012
• Code of Health and Disability Services Consumers’ Rights 1996 (and subsequent reviews)
• Privacy Act 1993
• Health and Safety in Employment Act 1992 (with subsequent amendments)
• Treaty of Waitangi

The Client Handbook contains further details of the policies and standards for the services being provided to the Client.

E Client’s Personal Information
• Only information required to provide services will be requested from Client
• Information required by the Support Worker to provide safe care will be available on a Client’s Care
• Plan retained within the home. A copy will be securely retained on the Client’s record at the service providers office
• Client’s personal information, including that received from any referral agency, will be kept confidential and not disclosed to any unauthorised person
• The consent of the Client will be requested prior to any information being used for purposes other than the reason it was collected.

F Home modifications
The following modifications to the Client’s home or property shall be carried out within the date or time specified.
G Equipment
The following equipment shall be used for assisting Client transfers, as described in the Client’s care plan. (Describe equipment here)

The service provider or support worker is not responsible for maintaining equipment, or repairing any equipment, unless such responsibilities are included in the Client’s care plan.

H Reporting adverse events
The support worker will be responsible for reporting to the service provider any events resulting in accidents, near-misses or other any other incidents or concerns involving the support worker or Client.

I Complaints procedures
The Client has a right to make a complaint about any aspect of the services provided. Procedures for making a complaint are set out in the Client Handbook.

J Cancellation of service delivery
In the event that the home care services are no longer required by the Client, or the service provider is no longer able to provide the services, either party shall give two weeks notice in writing of the decision to discontinue or cancel the home care services.

K Review and ending of the service
Unless ended by prior cancellation of the service by either party, the need for the service will be reviewed periodically by both the service provider and the client. In the event that the service is no longer required, a mutually agreed finish date for the service shall be set.

L Confirmation of home services provided

- I have read and understood my rights responsibilities and obligations as stated in this agreement (as the Client or as the Client’s representative)
- I have received a copy of the Client Handbook
- I have been informed of and understand my rights to advocacy
- I have been informed and understand my rights to informed consent
- I have received a copy of this agreement

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client, or Client’s representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service provider representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Client (if not signed by Client above)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5 Accessing resources: Equipment and Training

This section describes the main funding agencies for home care in New Zealand, some of the types of equipment available for moving and handling people, and training for support workers.

5.1 Funding agencies

As described in the Introduction (Section 1), there are three main agencies that provide funding for home care services in New Zealand; ACC, Ministry of Health and District Health boards. Funding is usually paid to home care service provider organisations and these organisations then provide services to clients. Table 5.1 outlines the types of clients funded by each of the main funding agencies. In some cases, ACC provides funding directly to families who are providing support for a disabled person.

Table 5.1 Major funding agencies for home care services

<table>
<thead>
<tr>
<th>Types of clients provided with home care services</th>
<th>ACC</th>
<th>Ministry of Health</th>
<th>District Health Boards</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who have a need for either short-term assistance or long-term assistance as a result of an accident. Covers all ages.</td>
<td>People under 65 years who have disabilities and are living at home</td>
<td>People who need short-term assistance following discharge from hospital and elderly people who are at risk for being hospitalised</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
<th>ACC</th>
<th>Ministry of Health</th>
<th>District Health Boards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment process to determine injury related needs.</td>
<td>Administered through Disability Support Services section of the Ministry</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Locations and access</th>
<th>ACC</th>
<th>Ministry of Health</th>
<th>District Health Boards</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC has branches in all regions of NZ Ph 0800 101 996 <a href="http://www.acc.co.nz">www.acc.co.nz</a></td>
<td>Needs Assessment and Service Coordination (NASC) service organisations based in the major DHB regions carry out assessments assist with accessing other support</td>
<td>DHBs operate in each region of NZ</td>
<td></td>
</tr>
</tbody>
</table>

The pamphlet A Guide for Carers, produced by the Ministry of Social Development, lists the various agencies that provide funding, services and support for those in need of home care. It includes information about accessing multiple resources for carers including: equipment, housing and vehicle modifications.25

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5.2 Equipment for moving and handling

Equipment for moving and handling people is a rapidly developing area. There are many types of equipment available and new versions continue to become available. A risk assessment should be conducted before deciding on the type of equipment that is suitable for moving a client. The assessment should take into account the client’s physical and general health, living environment and lifestyle, and future changes in mobility to ensure the suitability of any equipment used.

Equipment may be used facilitate a client’s mobility and to reduce risks when transferring clients. In home care, transfers can be categorised into the four main groups. Examples of the types of equipment which are relevant to these groups of transfers are shown in Table 5.2.

- Sitting, standing and walking
- Bed mobility
- Lateral transfers
- Hoisting

### Table 5.2: Handling tasks for which equipment may be used*

<table>
<thead>
<tr>
<th>Types of movements or transfers</th>
<th>Examples of specific movements</th>
<th>Examples of equipment that could be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting, standing and walking</td>
<td>Sitting to standing from a chair</td>
<td>Transfer belt, standing hoist, mobile hoist, chair-lifter</td>
</tr>
<tr>
<td></td>
<td>Standing to sitting on bed</td>
<td>Transfer belt</td>
</tr>
<tr>
<td></td>
<td>Assisted walking</td>
<td>Transfer belt, walker, gutter frame, hoist with walking harness</td>
</tr>
<tr>
<td>Bed mobility</td>
<td>Turning in bed</td>
<td>Slide sheets, electric bed with turning function</td>
</tr>
<tr>
<td></td>
<td>Sliding client up in bed</td>
<td>Slide sheets, electric bed,</td>
</tr>
<tr>
<td></td>
<td>Sitting person up onto edge of bed</td>
<td>Slide sheets, electric beds, bed accessories</td>
</tr>
<tr>
<td>Lateral transfers</td>
<td>Lateral transfer from bed to stretcher</td>
<td>Slide sheets, transfer board, air mattress</td>
</tr>
<tr>
<td></td>
<td>Transfer from chair to commode</td>
<td>Ceiling hoist, mobile hoist, seated transfer board, framed turning platform</td>
</tr>
<tr>
<td></td>
<td>Transferring to toilet</td>
<td>Ceiling hoist, mobile hoist</td>
</tr>
<tr>
<td>Hoisting</td>
<td>Fitting a sling to client in bed</td>
<td>Sling</td>
</tr>
<tr>
<td></td>
<td>Hoisting from bed to chair</td>
<td>Ceiling hoist, mobile hoist, standing hoist</td>
</tr>
<tr>
<td></td>
<td>Hoisting client from floor</td>
<td>Ceiling hoist, mobile hoist, air jack</td>
</tr>
<tr>
<td></td>
<td>Transferring to toilet</td>
<td>Ceiling hoist, mobile hoist, standing hoist</td>
</tr>
</tbody>
</table>


Homecare equipment may come from a variety of sources such as DHBs, ACC or private ownership. For any home care equipment, it is essential to establish who is responsible for safety checks, maintenance and servicing the equipment.

For the safety of client and carers, both support workers and carers (where relevant) need to have appropriate training in using the equipment. Part of equipment training is doing visual and other basic checks before using it.
5.3 Main types of equipment relevant to home care

Some common types of equipment designed to assist with client mobility are shown in Table 5.3. There are many other specific devices, not listed in the table that may be useful for clients with specific types of disabilities.26

<table>
<thead>
<tr>
<th>Type of equipment</th>
<th>Description and common uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slide sheets (sliding sheets)</td>
<td>Sheets made of low friction material and used under clients to allow easy repositioning in bed, sling attachment and lateral transfers</td>
</tr>
<tr>
<td>Walkers (Walking frame, mobility walker)</td>
<td>A wheeled frame which the client holds onto for support while they walk</td>
</tr>
<tr>
<td>Chair raisers</td>
<td>Extensions placed on the underneath the legs of chairs and armchairs to raise the seating level. Use to assist client transfers such as sit to stand or transfer to a wheelchair</td>
</tr>
<tr>
<td>Transfer belts (handling belt, gait belt, walking belt)</td>
<td>Belts placed around the client’s waist during several types of transfers and for assisted walking for rehabilitation. There are multiple types of belts</td>
</tr>
<tr>
<td>Transfer boards (PAT slide, slide board, banana board)</td>
<td>A full-body length board used to bridge gaps for client transfers from one surface to another, such as from a stretcher to a bed. Smaller transfer boards can also be used for seated to seated transfers</td>
</tr>
<tr>
<td>Framed turning platform</td>
<td>A framed turning platform enables the client to stand during the move from seat to seat. It may have cushioned kneepads for the client to brace against during the move. Similar equipment includes pivot aids and turners.</td>
</tr>
<tr>
<td>Electric profiling beds (electric beds)</td>
<td>Electrically operated beds that have a mattress platform split into two, three or four sections, and which allow adjustment using a control handset or panel</td>
</tr>
<tr>
<td>Slings</td>
<td>A fabric support used for carrying clients while being moved with a hoist – there are multiple types of slings</td>
</tr>
<tr>
<td>Mobile hoists (floor hoist, floor lift, portable hoist)</td>
<td>A hoist with wheels that can be moved along the floor – used for lifting clients inside a sling or on a stretcher designed for use with hoists</td>
</tr>
<tr>
<td>Standing hoists (sit-to-stand hoist, standing lift, stand-aid hoist)</td>
<td>A specific type of mobile hoist designed to assist people between sitting and standing positions. Standing hoists are designed to fit under or around chairs</td>
</tr>
<tr>
<td>Ceiling hoists (overhead hoist, ceiling lift, mechanical lift, gantry hoist)</td>
<td>Hoists attached to permanently mounted ceiling tracking that move clients inside a sling. Gantry hoists have an overhead track mounted on wheeled frames</td>
</tr>
<tr>
<td>Toilet raiser (Toilet riser)</td>
<td>A device to lift the height of the toilet to make it easier for a disabled person to get on and off</td>
</tr>
<tr>
<td>Wheelchairs</td>
<td>A mobile chair used for transporting clients in a sitting or upright position. Bariatric wheelchairs must be powered or moved with a bed pusher</td>
</tr>
</tbody>
</table>

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26 For more detailed descriptions of moving and handling equipment, see Section 7 in ACC, 2012.
5.4 Selecting and purchasing equipment

ACC has its own needs assessment procedures, which include the selection of suitable equipment and home modifications. Other funding agencies may also have specific equipment selection procedures based on a needs assessment.

All ACC clients will be referred for an assessment which is completed by a trained and credentialed assessor. The assessor will recommend a range of strategies and responses to meet the client’s needs. This could include equipment. The assessor will consult with the client, family and carers regarding client needs and take into consideration the environment the client lives in. ACC can only approve equipment and or modifications identified through these assessment processes.

For clients not funded by ACC, Enable New Zealand provides a range of services including equipment maintenance, home modification services, equipment training, housing alterations and vehicle modifications on behalf of the Ministry of Health and DHBs for the lower North Island (South of Meremere) and South Island. Accessible Environmental Health Management Services provides similar services for the upper North Island (Auckland and Northland). These services are for people with long-term physical, sensory, intellectual or age-related disabilities. Their web sites have equipment lists and details of their services (www.accessable.co.nz; www.enable.co.nz).

For service providers and families not funded by ACC, who are responsible for equipment selection, the following advice is provided about the process of selecting equipment.

Consult an occupational therapist, physiotherapist or a person trained in moving and handling people before deciding on what equipment suits the client. Even with equipment as simple as grab rails and raised toilet seats it is important that the equipment selected is safe and appropriate for the client and their particular environment. Equipment use to lift or bear the weight of clients, such as hoists and handrails, should have a safe working load (SWL) stated. Check any equipment for large or heavy clients (e.g. over 100kg) has a suitable SWL.

Ensure clients are consulted, and are part of the discussions that take place before deciding on what equipment is to be purchased.

Equipment selection criteria

When selecting equipment for hire or purchase there are some general considerations to bear in mind. If the proposed equipment order is large or expensive, it is worth putting additional work into the initial consultation and assessment process to increase the likelihood that the equipment will be suitable for its intended purposes. Consider the general selection criteria below.

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Box 5.1 Check what is already available before ordering any equipment

A person who was sorting out their late mother’s house rang and said they had equipment that we could have for training or use with our clients. I went to the house, drove down this long driveway and I am not exaggerating, the driveway was lined with equipment! Every time their mother had a fall she would be assessed and given new equipment because nobody asked her if she needed it. There was equipment from over 30 years. We tracked down some of the owners and returned them but there were thousands of dollars just sitting there. It is very common to find equipment in people’s homes not used and often they belong to some organisation. There has to be a better way to use and manage resources.

Source: Senior Clinical Coordinator

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27 Enable New Zealand is an operating division of the MidCentral District Health Board.

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- ** Appropriateness**: Any equipment must be “fit for purpose” and be able to carry out the tasks for which the equipment is intended
- ** Accessibility and storage**: Where will the equipment be stored so it is accessible when needed?
- ** Infection control**: Equipment which gets soiled must be able to be cleaned as recommended by the infection control requirements, particularly when there is likelihood of direct exposure to skin or body fluids
- ** Value for money**: What is the expected useful life of the equipment before it will need replacing?
- ** Servicing**: Will the equipment require routine servicing? What is the cost of servicing and who will provide it?
- ** Training requirements**: Will the equipment require specific training for carers using it? Will the supplier provide training?

Where there is a changeover of funding source, equipment may need to be returned to the supplier or approval given by the supplier for the equipment to be retained. Most equipment is labelled with a number and identifying information regarding the supplier.

5.5 Specific equipment for moving and handling

**Hoists**

There are three general categories of hoists; mobile floor hoists, standing hoists and ceiling hoists (sometimes called overhead hoists). All hoists use slings to hold clients. All hoists, slings and any ceiling tracking should be clearly labelled with the SWL.

All carers using hoists should be trained in fitting slings and in proper use of the hoist prior to using it. Use of hoist by carers who have not been appropriately trained is a hazard. Carers also need to be familiar with the specific functions of particular types or models of hoists. Like other moving and handling equipment, hoist designs and features are continually evolving.

**Mobile Hoists**

Mobile hoists (sometimes called mobile floor hoists) are used to transfer clients who are not mobile between locations, such as from a bed to a chair or a bathroom. They can also assist with walking, and other specialised functions. The client is supported in a hoist sling that needs to be positioned prior to using the hoist.

Mobile hoists come in a multiple designs. All have a central lifting frame with a boom and sling bar (also known as a spreader bar or yoke) to which the sling is attached using the hooks or clips on the bar. The base or legs have wheels that allow the hoist to move along the floor. Some have bases that can expand or contract in width to fit around or under commodes, shower chairs, recliners, wheelchairs, and beds. Some hoists are foldable or collapsible.

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28 For detailed descriptions of hoists and slings, see Section 7 in ACC, 2012

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Some types of mobile hoists can be dismantled and carried in a carer’s vehicle. In some cases, carers ‘on call’ may consider routinely carrying a fold-up mobile hoist in their vehicle.

Mobile hoists can have some disadvantages. Carers may need a lot of strength to move a mobile hoist, in areas with carpet (especially if the hoist has small wheels), through doorways or on sloping corridors. There needs to be enough space in the room to use a mobile hoist and sometimes furniture can restrict movement. When using a mobile hoist over a bed, some cannot lift high enough to allow the client to clear the bed. Some beds may not have enough space beneath the bed to allow the hoist base underneath. Note that incorrect or unsafe use of mobile hoists, and the slings needed for them, can lead to injuries to clients. Carers must have training before using a mobile hoist.

**Ceiling hoists**

Ceiling hoists or ceiling lifts have tracking fastened along the ceiling and are generally a permanent feature built into either a single room (such as a bedroom or bathroom) or with tracking from a bedroom to other locations. Gantry hoists have the tracking mounted on a mobile frame and can provide a hoist for a single room where, for example, the main use is for transfers to and from a bed.

Ceiling hoists have four major advantages over other types of hoists:

- They require less force to move
- Because of their immediate availability, there is a higher likelihood of use when needed
- Floor coverings and uneven surfaces don’t affect use
- They have minimal storage space requirements.

However, there are some disadvantages; use of ceiling hoists is limited to areas with tracking installed, and hoists with fixed ceiling tracking may initially be more expensive to install than providing gantry hoists or mobile hoists. Ceiling hoists and tracking are generally installed for people with long-term disabilities.

**5.6 Common problems with furniture and equipment**

All equipment needs to be installed correctly. The person or agency responsible for supplying the equipment should be responsible for its installation. The support worker should be briefed to check any new equipment, prior to using the equipment. Specific equipment, such as mobile hoists and tilt tables for a bath, may need adjusting to specific settings for the client.

**Beds**

Beds in homes are often very low and not suitable for client transfers. Everyday tasks such as making beds can create risks from stooping and awkward postures. If a bed is low and is pushed against a wall, this

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**Box 5.2 The need for equipment training**

Often equipment gets dropped on people’s front door step and people don’t know what to do with it. The box sits there until the client falls for example and then someone realises that if the equipment had been used it could have prevented the fall.

Every piece of equipment, even something as simple as a toilet seat raiser, needs proper instructions for it to be installed effectively. Suppliers [and funders] have a responsibility to ensure this.

Source: Independent physiotherapist
restricts access and increases the risk of injury to the carer from over-reaching or stooping. The best bed height for client transfers is with the top of the mattress at the carer’s hip level so the carer’s knuckles can rest easily on the bed. If possible move the bed to provide access from both sides. Beds against walls create greater risks for carers through a reaching or stooping posture. It also means clients can only be moved from one side of the bed. This can be a problem if the client has a disability affecting one limb or side of their body.

A possible solution for low beds is to use bed raisers under the bed legs to lift the height of the bed and to move the bed away from the wall of a bedroom if feasible.

**Chairs**

Some chairs commonly used in houses can create problems for client transfer if the chairs are too low and the client reclines back into the chair. The preferred chair height and profile allows the client’s feet to just sit flat on the floor with the clients back nearly vertical. When leaning against the backrest. Chair with arms are preferred for supervised client transfers (e.g. sitting to standing). However, chair arms may obstruct lateral transfers between a chair and wheelchair.

**Hand rails and grab rails**

Handrails or grab rails are especially important for clients who are partially mobile. The fitting of rails requires specialist knowledge. Grab rails in toilets may not be suitable if they are too far from the toilet. Rails and other wall-mounted equipment can only fitted in areas where there are no pipes along the wall in a bathrooms or toilet.

### 5.7 Training for support workers

Training in the techniques for moving and handling clients, and training in the use of specialist equipment, are important for support workers, assessors and supervisors. Support workers need moving and handling training to carry out specific transfers of clients. Assessors need training so they can make suitable recommendations regarding transfer techniques to use following an assessment, the number of carers needed and the types of equipment needed.

Supervisors and coordinators need training so they can continually teach specific types of transfer to support workers when required and to arrange acquisition of specific equipment when needed for some types of transfers. Knowledge of effective moving and handling techniques is also required when advising staff or clients who may have a problem, or to reassure them that what is being done is correct. Another group for whom training may be needed are the spouses, partners or other family members who will be assisting a client with their personal care.

A typical training programme is usually a one-day workshop that covers the topics shown in Table 5.4.  

Training should be an ongoing activity for people working in home caring services. It should enable them to keep up with ongoing developments in moving and handling people including new equipment becoming available. Refresher training can help to maintain a consistent and safe approach to assisting clients with moving and handling. In addition to formal training workshops,

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mentoring new workers with experienced or competent support workers is another training method that can be used to teach the transfer techniques required for personal care.  

**Table 5.4 Example of content for a one-day moving and handling workshop**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background and context</td>
<td>Definitions of manual handling and client handling NZ legislation, and relevant organisation policies and procedures</td>
</tr>
<tr>
<td>Risk assessment</td>
<td>Risk assessment should include the risk to the carer, the client and the employer, and the costs of discomfort pain and injury</td>
</tr>
</tbody>
</table>
| Techniques             | Overview of moving and handling techniques  
                        Sit to stand—including verbal prompts, minimal assistance and transfer belts  
                        Lateral transfer such as wheel chair to chair transfer  
                        Use of slide sheets, repositioning using slide sheets, storage and washing  
                        Moving a fallen client  
                        Bed mobility, up and down, on and off the bed  
                        Using mobile and ceiling hoists, floor to bed, and bed to chair, sit to stand hoist. Moving bariatric clients |
| Equipment              | Main types of moving and handling equipment including slide sheets, transfer boards, transfer belts, mobile hoists, sit-to-stand hoists, ceiling hoists, and slings  
                        Slings and slide sheets – sizes and types, single and multiple use slings, laundering  
                        Safe working load (SWL), maintenance certificates, storage and servicing. |
| Demonstration of techniques | Demonstration of selected techniques by trainers  
                        Techniques covered should progress from supervision of mobile or partially mobile clients to transferring completely dependent clients and emergencies. |
| Practise of techniques | Participants (trainees) practise selected techniques across all levels of client mobility in both client and carer positions. |
| Problem solving        | Cases (scenarios) involving clients presented to trainees to select appropriate solution. Work in groups to problem-solve using skills and knowledge covered in earlier part of workshop. |


Service providers can provide training for staff through private trainers, occupational therapists and physiotherapists. Equipment suppliers are usually also willing to provide information and training on how to use their equipment. However, while suppliers may be competent at demonstrating the use of their equipment they are often not trained in moving and handling people.

There may be times when a service provider or the support worker identifies a gap in their work practice (e.g. client has been provided with new equipment) or after an incident (e.g. client and or support worker were injured or there was a near miss). Retraining should take place at an appropriate time after the event rather than wait for the scheduled training session.

**Training needed for moving and handling in home care**

The risk assessment process can be useful in determining what training in moving and handling support workers need. From the risk assessments, service providers can identify what common hazards support workers regularly face, the personal care tasks they carry out and the type of

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30 See further comments on training for home care in: Health and Safety Executive, 2001.
transfers that are required. Risk assessments should include the techniques needed to move and handle the client and the need for training in how to use any equipment or assistive devices.

Training should also take into consideration the home environment; such as the lack of space, clutter around transfer areas, carpeted areas, and any mobility equipment clients will be using. Support workers should also be trained to recognise hazards, the procedures to follow when a hazard is identified, and notification required in the event of an accident or incident during their work. They also need strategies to avoiding being coerced in to doing things that may compromise their safety and that of their client.

Workers need to be trained to recognise gradual changes with clients, such as when they get older they may be less weight bearing so workers need to be taught ‘when it starts to get uncomfortable report it,’ don’t wait until you (the support worker) get injured. Supervisor

I was tending to a terminally ill client who was surrounded by family including three of his daughters who were RNs (registered nurses). At one point the daughters asked me to sit him up which was contrary to what I had been instructed to do. It was very intimidating. You have to be strong to stand your ground when you know you are right even under these circumstances and know people back in the office (supervisor or manager) will back you up. Supervisor who was a support worker

Support workers should be encouraged to report discomfort and pain as soon as they are recognised (e.g. shoulder, neck and back pain) and ‘near misses’ so that remedial action can be taken.

Local physiotherapists or occupational therapists can provide advice on where to access training. There is a New Zealand Qualifications Authority Unit Standard relevant to moving and handling people, which is titled ‘Demonstrate musculoskeletal care and handle people safely in a health or disability setting’ (NZQA 5012). Anyone involved in training should be familiar with the competencies covered in this Unit Standard and be able to train people to the Standard.

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31 The NZQA 5012 Unit Standard was being updated in 2012 to include the ACC 2012 publication, Moving and Handling People: The New Zealand Guidelines.
6 Communication and consultation

Communication and consultation are key processes in effective home care. They assist with relationship building and have a significant role in keeping people safe. This section covers communication and consultation between service providers, support workers and clients and their families. It offers suggestions on how to establish effective communication, managing client expectations and working with challenging clients.

Communication can be formal and structured such as regular briefings, newsletters, bulletins and staff meetings. It can also be informal such as through conversations and discussions. Timely and open communication among three key groups; service providers, support workers and clients is one of the key elements in managing risks. Service providers, support workers and clients need to have a clear understanding of the specific services that are being provided.

Consultation is about discussing options for service delivery with all the interested parties involved. In the early stages, clients can be made aware of the hazards and risks during risk assessments. Clients should be consulted during the assessment and be part of the decision-making for care plans. Discussions at this time can enhance clients’ understanding of the situation and make them more likely to comply with the decisions in the care plan. Care is a collaborative process. Effective communication and consultation can break down barriers, fear of the unknown and bring about effective decisions and compliance by clients.

6.1 Setting the scene: Communication strategies and practices

Service providers have a key role in communicating and consulting with new and existing clients and their support workers on moving and handling issues. Effective communication and consultation early on in the relationship especially with new clients help to establish the ground rules, define the boundaries, tasks, responsibilities and expectations for the stakeholders.

Figure 6.1 summarises some of the key communication phases during the preparation and delivery of home care services to a client. Where relevant, the client’s whanau or family should be included, especially where the client needs advocacy or support to understand the specific aspect of the services to be delivered.

Interagency communication: New clients

When planning services for a new client, it can be important to find out whether the client had other previous home care providers, and the circumstances that led to the previous services being discontinued. Ask new clients if they have had previous service providers during the initial assessment. If the client has been disabled, and has needed care for a considerable time, it is likely they have had other service providers.

In these cases, it is recommended that the service provider contact the agencies previously providing services, to find out, or confirm the reasons why services to the client were discontinued. Such communication between organisations can assist the case manager in planning services for the new client. A protocol to enable communication between agencies where clients are transferring would be useful. Interagency communication can lead to collaboration to ensure continuity of service by identifying service gaps and giving service providers a better understanding of the client and their needs.
**Figure 6.1 Communication tasks during service preparation**

<table>
<thead>
<tr>
<th>Stage of home care service</th>
<th>Communication tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Client record set up</td>
<td>Check history of previous services provided for client (interagency communication)</td>
</tr>
<tr>
<td>Case manager appointed</td>
<td>Consult with client and family regarding care plan.</td>
</tr>
<tr>
<td>Risk assessment conducted</td>
<td>Note any concerns or special needs of client</td>
</tr>
<tr>
<td>Care plan developed</td>
<td></td>
</tr>
<tr>
<td>2. Assignment of support worker</td>
<td>Briefing of support worker on care plan and any special needs of client</td>
</tr>
<tr>
<td></td>
<td>Opportunities for support worker to get further information</td>
</tr>
<tr>
<td>3. Provide equipment and organise home modifications</td>
<td>Confirm with ACC, <em>Enable</em>, <em>Accessable</em> or other funding provider regarding supply of</td>
</tr>
<tr>
<td></td>
<td>any equipment needed.</td>
</tr>
<tr>
<td></td>
<td>Support worker updated regarding equipment</td>
</tr>
<tr>
<td></td>
<td>home modifications needed for client</td>
</tr>
<tr>
<td>4. Provide home care services</td>
<td>Regular communication among support worker</td>
</tr>
<tr>
<td></td>
<td>and case manager, support worker and client (and family)</td>
</tr>
<tr>
<td></td>
<td>and client and case manager when needed</td>
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</tbody>
</table>

While clients often have good reasons for changing their service provider, sometimes clients will terminate the services if the support worker declines to manually lift the client or the client refuses to allow the use of lifting equipment. Finding out the circumstances of discontinuation of a previous service, will alert the new service provider to the specific conditions that may need to go into the care plan and service agreement for a new client (see Box 6.1).

**Establishing ground rules early in relationship**

Ensure all support workers are familiar with the service provider’s health and safety policies, obligations and responsibilities for the client, and the tasks that are part of the client’s personal care plan. Arrange for the client to meet the support worker and discuss the roles of the support worker and client. During the meeting, establish clear expectations of client responsibilities and support worker responsibilities, by covering the following points.

- Explain to client the importance of sharing care plan with their support worker.
- Discuss the care to be provided
- Explain the service provider’s health and safety policies to the client and provide the client with a document which describes these policies
- Inform client of their rights and responsibilities and those of the support worker.
- Provide client with a written document covering service standards and expectations.
- Discuss how conflicts will be resolved if there is a problem, including whom can the client contact or seek advice from if they have concerns about their support worker.
Box 6.1 Finding out about a client’s previous service history

Dealing with clients who have been agency hopping is time consuming and it burns out our support workers. If the client cannot have things their way, they go to from one agency to another. I have had to front up to such clients and tell them ‘it’s the last time we are taking you on as a client’. Networking with agencies in the area, inter-agency communication and protocols around client confidentiality that allow us to share information in a constructive manner can help us manage these situations better.

We had a client who had been through several agencies before coming to us, but we did not know about this. He became unreasonable in his demands on our support worker like telling her to take him for appointments in the city, and not being around when the support worker came to work. He felt he was employing the staff and he could tell them what to do. We tried our best to work with him. In the end, he threatened to take us to the Health and Disability Commissioner. We started to go through the complaints procedure and then he disappeared. All this takes up a lot of our time.

Source: Senior Clinical Coordinator

Service provider’s role in communication

Service providers have a role in communicating and consulting with clients and support workers on moving and handling issues. The primary responsibility for communication will normally be through the case manager or supervisor of the support worker. Briefings to support workers and clients might include:

- Risk minimisation measures to be implemented, including equipment to be used
- Monitoring of client changes in mobility and communication which may lead to changes in moving and handling arrangements
- How any concerns or differences between the client and the support worker are to be resolved

Special attention should be given to clients with communication problems caused by a medical condition such as; stroke, cognitive impairment, hearing difficulties, medication, and dementia. Other communication challenges may arise where the client and their family (or the support worker) has English as a second language. For the safety of clients and support workers, support workers need to be made aware of such conditions and given appropriate training if necessary.

During the initial stages of providing home care services for a new client, it is good practice for the service provider to provide a handbook or brochure setting out information that is important for the client and their family regarding the home care services provided. This document, which would complement the service agreement, might include:

- The service providers health and safety policies
- The client’s rights and responsibilities
- Service standards and expectations
- Complaints and conflict resolution procedures, including who to contact
Box 6.2 Summary: Service provider’s responsibilities and tasks

- Ensure risk assessment findings are sent to the appropriate people
- Brief support worker on organisation’s health and safety policies, clients and their roles and tasks that are part of the care plan
- Introduce client to support worker and discuss the role of support worker.
- Establish clear expectations of client responsibility and that of support worker responsibility
- Explain to the client the importance of sharing the care plan with their support worker
- Discuss care to be provided.
- Provide a briefing on the organisation’s health and safety policies to the client
- Inform the client of their rights and responsibilities and those of support workers.
- Provide the client with brochure on service standards and expectations.
- Discussing how resolution conflict will take place if there is a problem; who the client can inform or seek advice if they have a concern about their support worker
- Termination of contract by client or service provider as a last resort

Communication among support workers and with clients

If a client has more than one support worker, communication and cooperation is essential to ensure moving and handling of the client is conducted in a safe manner. This is especially important when two or more support workers work with the client at different times of the day. One way to manage this communication is to have written records for each client, such as a communication sheet or log.

At the end of each visit, the support worker should write down what was done with the client, any problems or changes that may affect their mobility or transfers. This sheet could also include information on the client’s mood and wellbeing. Such information should be accessible to other support workers before assisting the client with personal care involving movements or transfers. Written information should be factual, dated and signed. Where a support worker has serious concerns for the client, they should contact their manager or supervisor.

Where changes have taken place within a client’s home that may affect moving and handling, they should be recorded in the written log. Such changes may include:

- Positioning of furniture
- Changes in flooring such as changes in the carpet
- Access to specific rooms or facilities obstructed
- Damage or deterioration to equipment
- Equipment not in working order
- New equipment installed
- Animals or pets present, that may affect moving and handling and or the worker’s safety.

Ensuring support workers have access to client care plans

An important source of information for the support worker is the client care plan that describes services provided for the client, and may including moving and handling instructions. Recent cases involving the Privacy Act (1993) present problems for support workers in relation to accessing care plans. In some agencies, support workers cannot carry a copy of the care plan with them because of concerns about the client’s privacy being breached.

The service provider will normally send a copy of the care plan to the client or the client’s family. The support worker usually cannot carry a copy of the care plan with them because any risk of someone
else accessing the care plan while it is in the client’s vehicle could lead to an infringement of the client’s right to privacy under the Privacy Act.

Despite the importance of conveying the care plan information to the support worker, the client may not share their care plan with the support worker. Some clients will not let their support worker see the plan because they feel it is confidential. Other clients may have dementia, some are in denial about their condition and do not even want family members to know they are receiving care. For a service provider with several hundred support workers, non-compliant clients who won’t share their care plans with support workers can be a big problem.

The support worker needs to know what is in the care plan to provide appropriate care for the client. Not being able to see the care plan can lead to risky situations for both support workers and clients.

The care plan should be available to the support worker at the service provider’s office and at the client’s home. Some agencies have developed specific strategies to make the care plan accessible at the client’s home (see Box 6.3). Ensure that the service agreement states that the client shall share their care plan with their support worker, when requested. If the client refuses to share their care plan, the support worker should report this to their supervisor so it can be noted on the client’s record and followed up by the service provider.

Box 6.3 Accessing the care plan in the client’s home

To address the problem of the support worker not being able to carry a copy of the care plan, one agency provides all clients with a fridge magnet. This magnet has the agency’s contact details on the front. On the back is a space to write the location of the care plan in the client’s home. This way, support workers visiting a client for the first time know where to find the care plan.

Source: Home care service provider

Box 6.4 Summary: Responsibilities of clients and support workers

Client’s responsibilities

- Inform and share information with service provider and support worker which can affect the care provided for them, such as the care plan and medical discharge report.
- Inform support worker of any changes which may affect their mobility, cognition and psychological state resulting from accidents, new medication, or rearrangement of furniture
- Discuss with support worker and or service provider if they are not comfortable with how they are transferred

Support workers’ responsibilities

- Inform client of the plan of action for the day
- Ask client if there were any new developments or changes which may affect their mobility
- Use verbal prompts (e.g. ‘ready, steady, roll’) to guide the client during a transfer or move.
- Record any follow-ups, concerns or changes (client is confused, agitated or uncooperative) which may affect the client’s moving and handling after finishing up with client.
- Record changes and daily tasks completed with client in communication sheet after each visit
- Consider whether anyone else be informed
- Report any accidents or near misses to supervisor or manager and put it on file in written form.

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6.2 Issues arising in communication

A number of issues may arise with clients while they are receiving home care services. These issues include; managing client expectations, working with challenging clients, and dealing with bullying and aggressive behaviour.

Managing client expectations

Managing the expectations of clients is an important part of maintaining safe working conditions. Stating both client rights and support workers rights in the service agreement and having these discussed early in the relationship can help establish a positive working relationship. Service providers should facilitate communication processes between the client and support worker.

As stated earlier developing an effective working relationship is best done by communicating expectations and boundaries with new clients. However, long-term clients can also present service providers with difficulties. Often these relate to their resistance to using equipment and unrealistic views about their mobility. The client may not acknowledge they have become heavier and less mobile over time; or they think that their home should not look like a hospital if moving and handling equipment is visible.

The story in Box 6.5 illustrates the importance of communication and consultation used to change a client’s expectations about his support workers and his attitude towards hoists. The meeting between the client and support workers was facilitated by an occupational health physiotherapist.

Working with challenging environments and clients

Challenging environments and clients are those that threaten the safety and wellbeing of support workers. This includes verbal abuse, bullying, harassment, threats or assault. Service providers and support workers may work home environments that may compromise the safety of the support workers. Situations involving unreasonable behaviours not directly related to moving and handling that require intervention are:

- Visitors in the client house drinking, taking drugs, making threatening comments or sexual advances to the support worker
- Clients with emotional problems calling their carer throughout the night. The support worker feels harassed and does not get enough sleep. Support workers who are not well rested may be less attentive while performing personal care and transfers for clients which could lead to an accident.

Other unreasonable client behaviours and expectations may require intervention by service providers or other health professionals. An example is that clients (or their family) have unrealistic views of the client’s mobility, following an increase in their weight and size, and refuse to use mobility aids. Some examples are:

- Clients using the ‘Incompatibility Clause’ as a threat to sack the support worker if they do not manually lift the client
- Clients refusing use a mobile hoist or install ceiling tracking hoist, refusing to install an electric bed or other equipment. (e.g., a client with no trunk control or functional arm use, who insisted on using a slide board to transfer while leaning on the support worker).
- Parents of growing children refusing to use more suitable methods of transfer and equipment as the child grows bigger
- Refusal to use a mobility vehicle and insisting on being manually lifted into and out of a car
- Family members refusing to assist when the care plan identifies them as being the ‘second person’ for moving and handling transfers
Box 6.5 Client expectations and the transition to using a hoist

I was asked by a home care agency to provide a risk assessment for the carers of a quadriplegic who had always resisted using a hoist. Since his injury 20 years ago, he had always been manually transferred and did not like the thought of having a hoist in his bedroom.

One of his carers had voiced her concern at having to use excessive force and awkward postures to transfer him from lying to sitting, and pivot transfer him from bed to wheelchair on a slide board. The others seemed reluctant to say anything about it to their coordinator and when asked said they could manage it fine.

His “ah hah” moment came after I watched the unsafe transfer, and I asked the carer if she felt strain on her body. She said only sometimes, but then another of the carers said that they often felt back when transferring him. I encouraged the carers to speak about the difficulty of the transfers. They also talked about the high risk of injury for him as well as for them.

There was one carer whom he (the client) said he wouldn’t let her transfer him as she was too little. He also said that he chose to spend more time in bed so that he did not have to ask his carers to transfer him more than necessary during the day, to avoid straining them further. I said that it looked like only younger fit carers could manage but they too would become older injured carers if they had to carry out all the heavy handling. Then I talked about how great ceiling track hoists were. We discussed all the advantages for him and the carers, of using a ceiling track hoist for him; how it wouldn’t look intrusive or take up space. We also discussed other positives for him in terms of facilitating his independence as friends could easily be shown how to hoist him. Having a hoist would also mean that he could spend more time up and about as it was easy to get him in and out of bed. He agreed then and there to have a ceiling track hoist installed.

Source: Occupational Health Physiotherapist

- Wife not getting out of bed when support workers come to turn client, resulting in the support workers have to climb over the wife in middle of night to turn the client

Other conditions reported, that are not conducive to a safe working environment, include:

- A client’s dog attacking staff providing care for client, and the client refused to lock dog in another room
- Toys and other household items lying around the floor

Service providers should discuss with clients and support workers the provider’s health and safety policy, and the client rights and responsibilities. Ideally, the funding provider should be part of the discussions to ensure the best outcome for all the parties involved, and to avoid one party playing off against another. For Maori clients it may be appropriate to liaise with a local runanga (health and community service section) or kaumatua for advice. If a client is noncompliant with any recommendations from an assessment there should be follow-up procedures to investigate further options. Procedures might include:

1. Meet with client and support worker to discuss the problems. Explain to the client the safety issues and the benefits of using the suggested transfer techniques or equipment. Bring in a health expert as an advocate if necessary.
2. Inform client of partial withdrawal of service for an agreed period.
3 If there is still no compliance by the end of the agreed period, the service provider withdraws its service or makes other arrangements in agreement with the client. The client might also terminate their contract with the service provider.

Investigating client or support worker complaints

Most clients and support workers get along with each other. The relationship between a client and support worker usually goes beyond providing a service. Their relationship is often a therapeutic one for the client, and they may form enduring friendships. However, there are occasions when the client may ask for a change of worker, or the support worker may request not to work with a particular client. Such requests should be treated seriously, as there are likely to be underlying reasons such as health and safety, bullying and harassment related to the request or complaint.

A 2004 survey of service users of home care services reported that clients many had concerns related to the home care services they were receiving (see Box 6.6).

Where a client is dissatisfied with the quality of the service, or has complaints about the support worker, these should be formally communicated to the home care service organisation and an investigation should be undertaken. Clients have a right to request a change in support worker because there may be occasions where despite their best efforts to resolve differences with the support worker they still ‘don’t get along.’

Most complaints are made by the client about a support worker. Although there are few complaints, they can take up large amount of service provider time and resources. The client may state a vague reason like ‘we are not getting along’, and ask the service provider to provide another support worker using the ‘incompatibility clause’. The ‘incompatibility clause’ creates an imbalance of power because the client has a right to use it to demand a change of support worker, or that the support worker uses a particular transfer procedure. If the client’s demands are unreasonable, they may compromise their own health and safety, and that of the support worker.

In the event a client requests a change of support worker, or makes a complaint, the service provider should initiate the review procedure. Where feasible, a review should also involve the funding provider. Having a joint investigation can address any power imbalance, and is consistent with a health and safety focus. The client’s history with other service providers should be available to prevent abuse of the system by clients who have unjustified demands. It is also a safeguard against unfair dismissal by the client of the support worker or service provider.

Support workers may request reassignment to another client or reasons of compatibility or for concerns about their safety. Service providers should investigate any case where the worker is concerned about their safety.

**Box 6.6 Concerns of clients receiving home care services**

A 2004 survey of users of home care services reported the following concerns.

- Many participants stated they did not feel sufficiently safe to raise concerns as they felt they might be labelled as ‘difficult.’
- Turnover and lack of continuity of support workers were a great concern for service users. Turnover was viewed by participants to be directly linked to poor pay and poor working conditions.
- Many service users felt that the needs assessors were too reliant on family members to either fill the gaps or supplement the services provided.

Source: Auckland Uniservices, 2004c, pp. 6-7.

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The following are some suggested procedures to use when investigating a complaint by either the client or support worker, or change of support worker by the client. This procedure assumes that there is a ‘third party’ carrying out the review, such as a supervisor or quality control person within the service provider organisation.

1. Ask both the client and the support worker to each tell their story (in separate meetings). Identify any underlying reasons behind statements such as ‘we are not getting along’. The grounds for a complaint need should have specific reasons why they want to change their support worker (or client). If necessary, ask for specific examples of unacceptable behaviour that make the client or support worker feel vulnerable or uncomfortable.

2. Identify what seem to be the key issues or concerns in each story and get another manager or practitioner to comment on these concerns.

3. Develop a recommended resolution to the request or complaint and show this to the client, support worker and another experienced person for comment. If the dispute involves a moving and handling issue, consider bringing in a health professional to explain and demonstrate the procedures needed for risk minimisation in moving and handling the client.

4. Following up any revisions, implement the recommended resolution.

In summary, early discussion of concerns of clients or support workers can help avoid these concerns escalating into a more serious. Supervisors and managers play a crucial role in facilitating the communications processes needed to avoid minor problems becoming major ones.
7 Transfer techniques and case studies in home care

Section 7 provides some examples of transfer tasks commonly used when moving and handling clients in home care, and some of the potential hazards. It then presents case studies that illustrate specific hazards and options for dealing with risks when transferring clients. While the case studies are not exhaustive, they illustrate actual experiences in home care services. They also show examples of problem solving. However, sometimes there are no readily available solutions. The examples reflect the complex and changing environment of home care workers.

7.1 Hazards when moving and handling clients in home care

Moving and handling clients in home care is potentially hazardous for support workers because of the risks of developing musculoskeletal disorders (MSD). In New Zealand, the Discomfort Pain and Injury Programme (DPI) is an ACC strategy for the prevention and management of workplace musculoskeletal conditions. Some musculoskeletal disorders, such as back pain, have a gradual onset. There may not be a single identifiable ‘accident’ event, but rather a sense of discomfort, followed later by pain and possibly an injury. Discomfort, pain and injury can be prevented or managed if the pain and its contributory factors are identified during the early stages and changes made in work patterns. Some hazards and risk factors when moving and handling clients in home care are described below.

**Load:** the effort or force put into moving or holding a client during transfers. Higher loads can stress muscles and ligaments and may lead to injury.

**Awkward postures:** An awkward posture occurs when any part of the body bends or twists excessively or an awkward posture is held for an extended period. Awkward postures increase the stress on muscles and ligaments.

**Repetitive movements:** These are movements occurring repeatedly using the same muscle groups. Performing the same or similar tasks without sufficient breaks or change of activity tires the muscles and increases the risk of injury.

![Figure 7.1 Awkward Postures](image)

7.2 Examples of moving and handling tasks

To prevent discomfort pain and injury during moving and handling clients in home care, some examples of common home care tasks are provided, and procedures that can be used to reduce the risks of injuries occurring.

**Task 1 Transferring or repositioning a client in bed**

**Risk factors:** Transferring or repositioning clients in bed without using equipment puts the carer at risk of injury because most people are too heavy for manual transfers. Such transfers may involve the carer reaching over, bending, twisting their upper body and carrying excessive load.

**Reducing risks:**
1. Prepare the area prior to the transfer such as removing any obstacles around bed or chairs. Have furniture or equipment in position prior to the transfer.

2. Use equipment when needed such as slide sheets, transfer boards and hoists.

3. Use appropriate techniques. If needed, the carer should request training on relevant moving and handling techniques such as; transfers in bed, bed to chair transfers and sitting to standing transfers. 32

**Task 2 Dressing clients in bed**

*Risk factors*: Dressing clients often involves reaching out, bending and supporting a client’s leg or arm in one position. The weight of the client’s leg or arm may create a heavy load for the carer.

*Reducing risks*: Ensure the client is close to the side of the bed. Remove any obstacles around the bed. Raise client’s leg using a pillow or other object to rest the leg on.

Clothing can be adapted to make it easier to dress clients. For example, use loose fitting clothing with elasticised waistbands, large buttons or Velcro fastenings.

**Task 3 Transfer from bed to chair**

Transferring clients from a lying position on a bed to a sitting position on a chair involves two separate moves. Both moves must be done appropriately to avoid injury risks.

*Lying on bed to sitting on edge of bed* 33

This technique is only suitable for clients with adequate upper limb strength and trunk stability. Before starting, lower bed to the appropriate height for the client if possible.

Ask the client to:

1. Bend at the knees
2. Roll onto their side by turning their head in the direction of the roll, placing their outside arm across their chest and rotating their flexed knees over in the direction of the roll
3. Get the client to push up into a side-sitting position by placing their outside hand flat on the bed to push and inside arm to push up using their elbow, putting their legs over the side of the bed at the same time
4. At this point the client can put their legs over the side of the bed and with feet flat on the floor move themselves sideways up the bed or stand up and walk with or without a walking aid.

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33 See Section 4, Technique 11 Supervised sitting to edge of bed in *Moving and Handling People, The New Zealand Guidelines*.
Sitting to sitting transfer using a walking frame34
In this technique, the carer assists the client to move from sitting on the edge of the bed to sitting in a chair or wheelchair with the client using a walking frame.

Make sure the bed is as close as possible to level of the seat to which the client is moving, and the seat is close to the bed and at right angles to the clients starting position on the edge of the bed. Position the walking frame directly in front of the client. Wheelchairs and chairs with movable armrests should have the closest armrest moved out of the client’s way to assist the manoeuvre.

1. Ask the client to position themselves with their hands flat on the bed and their feet flat on the floor, shoulder width apart
2. Lean forward on the bed and slide their bottom towards the edge of the bed
3. Carer helps them lean forward so their upper body is over their feet
4. Stand on “ready steady, stand”
5. Carer assists client to stand and client transfers hands to walking frame
6. Carer guides client while they use the walking frame to move into position with their bottom facing the chair to which they are moving
7. Client sits down.

Task 4 Bathing clients

Risk factors: Bathing clients may require bending over, supporting the client (heavy load), holding the clients leg or arm, and adopting an awkward posture because of confined space. Bathing clients in a bath may require kneeling and leaning against hard surfaces. This can put stress on the part of the carer’s body in contact with hard surfaces.

Reducing risks: Prepare all the things needed beforehand. If a wheelchair is needed, pull it from the front so that you do not have to climb around it.

Task 5 Supervised Standing from Toilet35

People who have problems standing up may have hip, knee, back or leg problems that affect their mobility. This makes everyday tasks such as getting on and off a toilet a difficult one. Where a client is able to get on and off the toilet with instruction, assisted them by talking them through the steps needed. If needed, arrange an assessment with an appropriate health care professional to discuss any difficulties standing or sitting on the toilet. The transfer assumes there are grab rails installed or another type of toilet rail available.

Ask the client to:
1. Place their hands firmly on the grab rails
2. Lean forward away from the back of the toilet
3. Move their bottom to the edge of the toilet seat by wriggling their bottom, transferring their weight from one buttock to the other
4. Check that their feet are shoulder width apart and below their knees
5. Lean forward so that the upper body is over their knees
6. Stand up as they use both arms to pull on grab rails as they stand up

34 See Section 4, Technique 18 Sitting to sitting transfer using walking frame in Moving and Handling People, The New Zealand Guidelines
Note: Never use a walking frame to hold onto whilst standing from a toilet. Walking frames are not designed for this purpose and could easily tip over.

7.3 Managing a falling client

Falls are the primary cause of hospitalisation for injury and one of the major causes of injury deaths in New Zealand. Slips, trips and falls account for about 40% of unintentional injury hospitalisations and 20% of unintentional injury deaths. The most common place for falls is at home. Caring for New Zealanders over 65 years who have been injured in falls costs around $60 million each year.\footnote{See ACC \url{www.acc.co.nz/about-acc/statistics/ABA00053} downloaded 20 July 2012.}

Try to prevent falls by identifying any risks, then eliminating, isolating or minimising those risks. This means having a system to identify clients who are at risk of falling, noting any situations or circumstances in which they at risk of falling and developing appropriate ways to prevent these clients from falling. Where relevant, these details should be included in the client’s care plan.

There may be times when falls happen without warning, such as when a client has a stroke or heart attack. Do not attempt to catch a falling person or try to hold the person up. This could result in injury to the person trying to stop the fall. Trying to ‘control’ a fall by holding onto or bearing the weight of the client is a high-risk activity.

Managing a fallen client

It is important that clients are aware of the moving and handling policy you use, so that they do not expect to be lifted by carers after a fall. If you find a fallen client, you need to assess the situation carefully to ensure that the client does not experience additional harm while you are trying to help them. This affects the method and choice of equipment you use. Give the client time to get calm, assess the situation, then either coach the client to get up or use equipment to get them up.

Assessing a fallen client

1. Assess the client’s airway, breathing and circulation. If necessary stabilise the client according to CPR guidelines and the client’s care plan
2. Call for help, especially if the client is unconscious, in great pain, or is lying in a small confined space
3. If you are able, make sure that the area around the client is safe and that no further harm can occur; for example, clear any spills or objects away
4. Continue the assessment as needed, using approved first aid procedures, and decide if the client can be moved
5. If the client is injured, make them comfortable on the floor and seek further medical advice
6. If they are uninjured, stay with the client and stay calm; do not hurry them to get up. This will help the client to stay calm and relaxed
7. Choose the right technique to help them up, explain the procedure and talk with them throughout the move to provide reassurance
8. Remember, moving them without assessing the situation carefully could cause injury to you and the client.

Supervising a fallen client who is conscious and uninjured

Firstly, do not panic; they cannot fall any further. Check the immediate environment for risks, such as a wet floor.

This section is adapted from ACC, 2012, pp.98-99.
1. Ask the client if they are hurt anywhere. Did they bang their head?
2. Do they remember falling? If they appear unhurt, ask staff not required to leave
3. Place a pillow under their head for comfort – remember touching the head can be taboo in some cultures, so always talk to the client and explain what you are doing
4. Cover them if required
5. Ask if they think they could stand themselves up with instruction
6. Ask client to roll on to their side then get on to hands and knees
7. When they have done this, ask if they are dizzy or feeling worse – if they are, get the client to lie down and hoist them instead
8. Once they are on their hands and knees, place a chair as close as possible to the client’s hip. Ask them to use the chair to lean on with their closest hand, and using their nearest leg get them to put their foot flat on the floor then push up into a sitting position using their leg and arm
9. Alternatively, the client may prefer to use their furthest leg and foot to provide extra balance, particularly if the client is large
10. If the client cannot get onto the chair, get them to lie down again and hoist them.

This technique can be taught to some clients who have a history of falling to reassure them that they can get up from the floor independently. They will need to crawl to a stable piece of furniture that they can use to push themselves up.

7.4 Case studies in moving and handling

This section presents some case studies events that were reported by home care managers and support workers. Many describe circumstances that present significant challenges for support workers. Following each of the case studies, there is a list of options for addressing the risks evident in the case details.

Case 1 Resistance to using moving and handling equipment
(Source: Homecare service manager)

Case details
The client is male, aged between 30 and 40 years. He has lost both legs and one arm. The family consist of a couple and their five children who live in a state-provided house. The wife is small, does not speak any English and does not assist with her husband’s care. An adult nephew of the client was employed as a support worker for the client, but injured his back lifting his uncle. Another nephew is currently providing support for the client.

Issues in the client’s home are:
1. There are large rugs on top of carpets throughout the home. These make it virtually impossible to use a mobile hoist in the home
2. The client and his wife are sleep in a double bed which is too low for a support worker to safely transfer the client from the bed to a chair
3. The client crawls around on the floor in the home to move around. The carer lifts him from the floor when being transferred to a chair.
4. The client is currently lifted from the bed and carried to the bathroom or toilet. He is then lifted from the toilet to the shower. After showering he is dressed while on the floor
5. There is no equipment for the shower. The shower has a lower edge above the floor that creates difficulties getting a chair into the shower. The bathroom needs to be renovated

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6. The client does not want any equipment (such as a hoist or wheelchair) in the home because the children play with equipment and damage the interior walls.

The service provider has a policy that support workers are not to lift anything over 14 kg. The client weighs more than 14 kg. The client is unwilling to have a mobile hoist or wheelchair in the home. In these circumstances, the service provider cannot arrange a support worker if the current carer is sick or away from home.

Possible options for the service provider
The circumstances described involve cultural issues, lack of understanding of safety, and other matters that require ongoing communication to educate the client and their family.

- Ensure all service agreements require the use of moving and handling equipment when needed and that the equipment be accessible in the client’s home
- Lifting the client is unsafe as shown by the injury to the nephew’s back. The only safe way of moving the client is using equipment such as a mobile hoist and wheelchair and that these require clear floor spaces without rugs
- Arrange a meeting with the client to discuss the conditions of service and requirements for the support worker to use equipment. Point out that the law does not allow the service provider to carry out tasks that are unsafe and are likely to lead to injury.
- Address any cultural or language barriers during meetings with the client and their family
- Point out that the support worker cannot assist the client by manually lifting them. Emphasise that unless a wheelchair and hoist are available for transfers, the client cannot be physically transferred by the support worker
- Discuss ways in which the children can be taught not to play with the equipment.

Case 2 Client deterioration and resistance to using moving and handling equipment
(Source: Quality Manager)

Case details
One of our clients was diagnosed with Motor Neurone disease. She was very independent and found it difficult to accept the diagnosis and resisted the need for assistance and equipment as much as she could. Our service was employed to assist Sandy with personal care and some community inclusion. Although very slow in her movements she could walk to the toilet and shower.

As her condition deteriorated, she began to have days where she would get stuck on the toilet or chair and was suddenly unable to weight bear. On the first occasion the support worker rang her coordinator to say her client was unable to get off the toilet, there was no moving and handling equipment at the house. An ambulance was called (This client lived in a remote rural location with no readily accessible help).

An urgent referral was made requesting an assessment for moving and handling solutions. Although a hoist and other equipment were recommended, the client insisted she had just had a bad day and refused to have any equipment installed.

We instruct our support workers not to manually lift under any circumstances. When the client asked the support worker to ‘lend her a shoulder’ from time to time our instruction was to call an ambulance. After the ambulance was called three or four times over a few weeks they advised the client that they would no longer be able to assist in this manner. At this point, she came to the realisation that she needed to use a hoist and other equipment. Equipment was installed and training was provided to the client and support worker soon after.
Commentary
Although calling the ambulance several times is not a recommended or ideal option, the service provider and support worker had limited choices. The client lived in a remote rural location and refused appropriate equipment, despite the risk assessment requiring equipment.

This case illustrates the importance of ensuring the service agreement requires the use of moving and handling equipment when recommended following an assessment and the need to document changes in the client’s mobility on the client record.

Case 3 Need for more than one carer  
(Source: Quality Manager)

Case details
One client we have lives rurally. She is a tetraplegic who lives alone with 24-hour care support. The client is on the larger side of average build and experiences spasms when being moved. She requires a hoist for all her moving and positioning, is unable to assist in any way. Her assessment for hours allocated by ACC allows for one carer at a time. This is fine for the simple transfers of the day.

In the morning when the client is manoeuvred a number of times to get the sling on, for toileting care, showering and then positioning into the wheelchair for the day. The job is very taxing for one carer. The house and bathroom is good but the flooring is not easy for moving the hoist. The spasms make the task tricky. The client’s family do not live close by. The support worker is a long distance from any additional help if it is required. A second support worker for one hour to assist with rolling from side to side, applying the sling, transferring to and from the bathroom, positioning into the wheelchair would be preferable.

Our service requested an additional assessment from the ACC requesting allocation of an additional hour each day for a second support worker during the morning period. The report from the second assessment said that one carer for this situation was within the spinal unit guidelines and no extra time would be allocated. The support worker is trained well for this case and so far we have not had any injuries from moving and handling. However, the work during this morning period is very taxing for one support worker and she feels very isolated working on her own.

The result is that we have a large turnover of staff. There are not a lot of potential support workers nearby to choose from in this rural location. The recruitment and training is a constant challenge and expense.

Possible option for the service provider
The service provider should request a meeting with ACC to discuss the carer allocation decision by ACC. It will help to have support from the client (or their family) for additional support. Put on record the situation faced by the support worker and the service provider.

Case 4 Disabled children get bigger and heavier  
(Source: Homecare quality manager)

Case details
One case involved a boy Tony, diagnosed with cerebral palsy with associated muscular spasms. Mum was unable to assist with personal care so our organisation provided assistance before and
after school. Tony was small for this age so up to the age of 6 years he was easily lifted in and out the bath in the family bathroom by support workers.

However as he grew our agency requested an allied service assessment so transfers could be made safe for Tony and his support workers. Tony’s mum was very resistant to large equipment, she felt Tony was still small and we were over reacting.

The assessing therapist agreed that lifting Tony for transfers was no longer safe. There were also problems with the narrowness of the passageway between the bedroom, the bathroom and the rest of the house. A hoist was only able to be used in the bedroom. Tony’s condition made it difficult to sit upright in the shower chair, alternatives were trialled and found unsuitable due to the shape of the bathroom and type of shower box.

Tony’s family were very upset when we decided that we could no longer bath or shower him safely in the family bathroom. Until there were modifications to the shower, our only safe option was to sponge bath Tony in his bedroom or shower him at school where there were suitable facilities. The family reluctantly agreed to the sponge bath option and were willing to consider bathroom renovations to enable Tony to safely access the bathroom. Sponge bathing continued for six months, until suitable renovations to the bathroom were completed.

Comments on case
In this case, the service provider made the correct decision in not allowing Tony to be assisted with showering when this was unsafe for the carers. Alternative arrangements were made for bathing and showering Tony, until the necessary bathroom modifications were completed.

Case 5 Harassment of care workers by client and visitors in household
(Source: Homecare service manager)

Case details
The client is male in his early 30’s and has a congenital condition that is causing him ongoing physical deterioration. The client cannot use his lower limbs; both legs are atrophied and have regular spasms causing them to fling out. The client maintains good upper body strength.

The client has allocated 14 hours personal care assistance each week, an hour each morning and an hour each evening to assist with showering and meal preparation. This has been assessed as essential care so the care will be provided seven days a week for 52 weeks of the year.

There are several issues affecting the support worker when visiting the client’s home.

Moving and handling issues:
- Client has a hoist but it is stored in the garage as client doesn’t feel that he needs to use it. He says it takes too long to get in and out. He feels that it is easier for him to lift his upper body to the chair and then for the support worker to bend down and lift the lower half of his body over on to the chair. Often this will trigger a spasm and the support workers have been kicked unintentionally during this transfer.
- Because client’s lower body is becoming smaller he has a tendency to slip through the seat of the shower chair. When this happens he yells at the support workers to lift him up. This poses a dangerous situation as he is often wet and soapy and slippery and the support workers try to seat him but he slips back quickly. We have tried to remedy this by applying some non-slip mat to the foot plates so that his feet stay on the plates and he can hold his body more upright, but this is not always successful and on the days when he is not in a good mood this situation can lead to him being abusive to the support workers.
Harassment of support workers

- Use of marijuana and alcohol by the client and his friends that are often in the home when the support workers are there, especially in the evenings
- Verbal abuse of support workers by the client
- Client treats support workers like slaves. He will have a bowel motion on the shower floor and tell the support workers to clean it up.
- Client makes sexual suggestions to the support workers.
- Support workers have been asked to prepare meals for the visitors in the home. This leads to a feeling of intimidation for the support workers because they are alone in a situation that make them feel unsafe so they will do what is being asked of them to remain safe and on good terms with the client.

Possible options for the service provider

A senior manager from the service provider needs to meet with the client and discuss both the moving and handling problems and the harassment of the support workers. The client behaviours that are not acceptable should be made clear to the client, and that the home care service will be withdrawn if the support workers feel unsafe or harassed.

A revised service agreement may be necessary which details the expectations for client behaviours and requires the use of specific equipment for client transfers. It would also need to include regular reviews of the client’s behaviour and close monitoring of the safety of the support workers.

7.5 Implications of case studies

The case studies presented in this section illustrate the complexity of the situation of some clients for whom home care services are provided. These cases show the need for effective consultation and communication with all the people involved with the clients. They also indicate that there will be times when support workers and home care service providers have to set boundaries for clients and their families if home care services are to continue. Setting boundaries that ensure the health and wellbeing of both support workers and clients requires ongoing consultation with managers and supervisors so that any decisions made regarding the setting of boundaries becomes a management decision on the part of the home care provider. This is essential to provide adequate support for carers who often work with clients in challenging circumstances.
8 Trends in home care in New Zealand

This section describes some of the current and emerging trends in New Zealand that are likely to affect home care services in the future. Some key trends that are considered likely to influence home care services in New Zealand are:

- Population changes: Ageing, cultural diversity and increasing weight
- Policies supporting high levels of home care for disabled people
- Improved training for support workers
- Equipment developments for moving and handling people in homecare
- Services for bariatric clients

8.1 Population changes: Ageing, cultural diversity and increasing weight

Three population trends in New Zealand have implications for home care services: a growing proportion of the population is over 65 years, there is increasing cultural diversity in New Zealand and the number of people who are overweight or obese is increasing.

As the population in New Zealand ages, there is increasing demand for health and disability support services such as community-based care, residential care and other managed care services. In many countries, including New Zealand, health and welfare policies are intended to provide support for people to remain in their homes for as long as feasible (‘ageing in place’) before moving into residential care or other organisations providing full managed care. Home care services enable people to be cared for in their own homes for as long as possible. The primary reasons are that it is more cost-effective to provide home-based health and personal care services and most people prefer to remain in their homes for as long as this is feasible.

Since 1996, census reports have noted the increasing ethnic and cultural diversity of people in New Zealand. While there has been migration from the Pacific Island countries to New Zealand for many years, more recently there have been increasing numbers of people migrating from Asia, Africa and the Middle East. This has two implications for home care service. An increasing number of clients and their families speak a first language other than English, and the cultural patterns of clients and families may be unfamiliar to service providers and support workers. For these reasons, there is an increasing need for service providers and support worker to be comfortable working with families from culture, and the need to ensure effective communication strategies during consultations and discussions related to care and the use moving and handling equipment.

In New Zealand obesity among adults (aged 18+ years), those having a BMI of 30 or more, was 26.5 percent in 2006/2007. This was the third highest measured obesity rate after the United States (33.8 percent in 2008) and Mexico (30.0 percent in 2006). Rates of obesity have been increasing in surveys conducted between 1997 and 2007. Given this trend home carers providing mobility assistance to clients can expect an increasing proportion of overweight or obese clients.

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8.2 Policies affecting home care for disabled people

Policies and decisions made by government agencies providing funding for home care services are evolving. This will affect how home care services will be delivered in future. For example, in 2012 ACC made a decision to contract with a smaller number of agencies providing care services to ensure more consistent, higher quality, more outcome-focussed services. This is leading to a consolation of home care agencies into a smaller number of larger agencies that operate regionally or nationally.

There are a number of specific initiatives under the general label of ‘ageing in place.’ These include prevention of injuries, especially falls, among older people, restorative care and assistance with house maintenance and repairs.

Restorative care
Restorative care is a multifaceted approach to improving home care services. It focuses on restoration and maintenance of older people’s physical function and mobility, using training to compensate for impairments. Restorative care is similar to ‘re-ablement’ services in the UK which aim to reduce the need for long-term support by helping service users to regain confidence and re-learn the skills necessary for daily living to enhance independence. In New Zealand, restorative care intervention requires an initial in-depth assessment and a support plan emphasising repetitive daily exercises for older people. The implication for home care services may be the addition of rehabilitation activities into ongoing moving and handling tasks when feasible.

House maintenance and repairs
Being unable to deal with the repairs and maintenance of their homes is a barrier to staying at home for many older people. In 2012 the ‘Good Homes’ programme made available three ‘tools’ or booklets to assist older people maintain their houses so people can choose to stay at home longer as they age. They have developed the three booklets to assist with house repairs and maintenance:

- A householder booklet
- A booklet for support service providers
- A booklet for providers owning or managing housing stock for older people or providers delivering repairs and maintenance services to older people.

The booklet for support service providers includes a checklist that may be useful to consider during home environment risk assessments carried out for home care services. The booklets include both assessment and solutions, and there are clear links between the problem identification sections and the solutions specific to each problem.

8.3 Improved training for support workers

The need for better training for support workers has been mentioned in several reviews of home and community support services. Given the need for multiple competencies, including those needed for using moving and handling equipment, there is a need for better training for and supervision of support workers. The New Zealand Home Health Association has recommended that funding

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39 See King, 2012

40 See www.goodhomes.co.nz

contracts recognise the cost of training of support workers and the cost of systematic supervision (clinical oversight) of support workers.\(^{42}\)

### 8.4 Equipment developments for moving and handling people in homecare

There is ongoing development of new moving and handling equipment. With the increasing complexity of equipment and technological development, information about specific equipment can quickly become outdated. People conducting needs assessment should be familiar with the range of new equipment becoming available so they can make suitable recommendations for clients. People providing training in equipment use, need to keep up-to-date with developments in equipment for moving and handling people.

### 8.5 Services for bariatric clients

One of the challenges that home care services are facing is the increasing number of bariatric or obese clients. A working definition of a bariatric client is someone who weighs 150kg or more, has a BMI of 40 or more, or who have large physical dimensions, lack of mobility and other conditions that make moving and handling very challenging.\(^{43}\)

Lifting any client can lead to musculoskeletal injuries, strains, sprains, and excessive spinal loading for carers. There are even greater risks associated with moving and handling bariatric clients when performing daily tasks. In home care, bariatric clients pose risks even when using equipment such as non-electric wheelchairs that may need pushing up ramps or controlling when going down ramps. Larger and heavier equipment for bariatric clients may present difficulties in homes. It is likely that home care services will need to develop specific training programmes for staff who move and handle bariatric clients.

\(^{42}\) New Zealand Home Health Association, 2011, p.4.

\(^{43}\) See Robertson, 2010.
References


*Guidelines for Moving and Handling People in Home Care – Draft 12 Sep 2012*