Single-handed care, what works: a discussion paper

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(Deborah Harrison, November 2020)

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Introduction

Matthew Box at Inclusion Me has invited me to write a paper about what works when implementing and successfully embedding single-handed care within a local authority. This paper will focus on the key elements essential for success, describing solutions to the common pitfalls; complexities of commissioning, strategies, engagement of the work force, and training, as well the legal pitfalls that were addressed in a recent paper by Mandelstam, 2020.

A pragmatic approach, will bring these elements to life to demonstrating the evidence with real case studies, recognising the commonalties in various projects that have successfully embedded the single-handed care approach across the UK. The paper will not only focus on the practicalities of implementing a single-handed care programme, but the importance of everyone's roles within the process.

Exploration of the commonly used term single-handed care is important to explain a shift by many councils and NHS organisations to usen the alternative 'Moving with Dignity using a single-handed care approach'.

This paper will address Moving with Dignity in the current Covid-19 pandemic, with examples from current practice. A section explores where we are with the use of robotics, what that actually means as well as current trends.

For the purpose of the paper it is recognised that different organisations, regions and practitioners will call the individuals being handled many different things, those being service users, clients, individual, person, citizen and patient. For the purpose of this paper they will be referred to as service users.

It's all in a name

The mere mention of the term single-handed care appears to produce a marmite response. Many councils that have implemented the programme have discovered the term single-handed care is not the best to use. The mere mention of single-handed care has historically, and to this day had negative connotations attached to it, causing resistance and hostility across care providers, service users, family members and raising concern with therapists and other healthcare professionals (HCP). The outcry of protest comes from a variety of sources for many different reasons, a study via the means of a survey explored the concerns from all major stakeholders (Harrison; 2017, 2018). Identification of specific barriers and stakeholders concerns can facilitate a better understanding to engage people involved and explore solutions collaboratively.

Technically, the introduction of a single-handed care approach is more than just reducing the care package down to one worker to save money, it is about carrying out a person-centred review of the whole package of care. This could include two or more workers that are required to carry out the manual handling elements of the task, a review could result in an increase of care, or it could mean reducing a care package from four to three, two to one (Harrison, 2020 and Mandelstam 2020).

Over two years ago, North Lincolnshire Council decided to call their programme 'Moving with Dignity' using a single-handed care approach and ethos. This name appeared to ring true to many as good practice should be Moving and Handling service users with Dignity and respect. The ethos behind Moving with Dignity is no matter how many people it takes to move and handle the service user, their needs and wishes are holistically assessed to provide the best outcome. Many other councils across the UK followed suit and called the projects by the same name.

A moving and handling assessment and subsequent plan of how to meet the service users' individual needs should be assessed using a holistic approach. Occupational therapists clearly felt guidance and tools were lacking that would facilitate a robust Care Act compliant assessment (Harrison 2017, 2018). They also felt ill equipped to carry out

assessments, without the right training, opportunity to practice their practical skills and confidently and competently facilitate a reduction in carers. The carer workforce was also of concern as they were often thought to be generally lacking in moving and handling skills. Many councils that adopted Moving with Dignity using a single-handed care approach came across resistance from the carer workforce at both an organisational and frontline level.

Therefore, it is crucial for the success and adoption of this approach that the local councils and NHS organisations work alongside the care providers in a consistent and supportive manner. Many examples of how this has been implemented are now available. Having worked across 53 councils, the author has seen in the main, several approaches, some more successful than others.

No one is suggesting that Moving and Handling using the single-handed care approach is suitable for everyone or all situations, all assessments should be person centred to meet their moving handling and rehabilitation needs.

Engagement is key

Due to the resistance from the care provider workforce and concerns from therapists and other healthcare professionals, engagement is vital from the onset and should be a part of the strategy and business plan.

Commissioners can assist the implementation and sustainability of this type of work by championing at an early stage and providing on-going support to the project lead and intervening when required. The commissioner needs to be aware of this uphill battle that the assessor faces, making themselves available to be called upon from time to time to lend support in many ways. Contractual arrangements are required to ensure that care providers can see what is required of them. Even if the care agency is on board and received free training, they still have to pay their staff for their time, as well as find time and resources to disseminate the new skills.

How and who you engage with is vital to the smoother implementation of your project Harrison and Webb (2020). The author has found the following routes to be of most benefit:

1. Start with a working party
2. A pilot, to establish does it work? Some skip this step
3. An engagement day, this would involve all stakeholders
4. An equipment evaluation, does it meet the needs, ideally involving all frontline staff?
5. Delivery of effective training across all organisations
6. Ongoing sustainability and support

A working party
This could involve several stakeholders with sub-groups and what stage individuals are brought in is debatable. For example, an authority who has one main care provider want them brought in near the beginning of discussion, most authorities leave bringing in the care providers until a decision has been made that the project is going to commence. Either way the care providers need to be involved from the beginning, whether it is the therapy lead going to visit on an individual basis, or inclusion within the meetings.

A pilot
Pilots are a great way to demonstrate that this approach works, any pilot project should however still involve the same engagement process, but on a much smaller scale. This may involve roll out just in one area, depending whether the authority has several providers of care in one area, the engagement process will have to involve all of those involved.

An engagement event
The author has found an engagement event is a simplistic and effective way of bringing together all stakeholders across health, social care and care providers. It delivers key messages of why Moving with Dignity is being introduced into the borough and is also beneficial to demonstrate how the authority will support the stakeholders during implementation. It addresses individual and organisational concerns during the session by means of an interactive survey and live demonstrations of the equipment in several scenarios.

At the end of the session feedback is actively encouraged and a subject expert and commissioner, or other, are available for a Q and A.

Equipment evaluation
Having already involved equipment stores with the initial engagement process and working party helps increase the realisation of the benefits of the change in process. A pathway between monies saved and the stores budget needs to be made transparent, without this the stores will not be able to fund continued purchases of additional equipment.
Involving all the stakeholders in the process of equipment evaluation as well as using a set format is fundamental. Different authorities use different approaches to this. Some authorities want a few select pieces of equipment and some want a wide range of equipment. What the author has found is having a smaller range of pieces of equipment as core stock is advantageous for the education of the care workforce. Different pieces of equipment will also work better in different setting for example a hospital and a home environment.

The main factors that should be considered when choosing equipment are; does it meet the individuals needs, is it compatible with the environment such as chairs beds etc, is it easy to use? How does it feel for the service user? Safety features, tissue viability, recyclability, does it come in different sizes and could it promote reablement and be used as part of a rehabilitation programme and encourage a natural pattern of movement? A scoring system is also recommended for evaluation purposes.

The typical types of equipment used are manual stand aids, mechanical/standing hoists, profiling beds, in-bed sheets with handles, gantry hoist systems normally followed by installation of ceiling track, wedges, slide sheets and slide sheets gloves. This is in addition to specialist equipment such as turning beds/mattresses for night time pressure relief.

Training

Section 5 of the Care Act (2014) underlines the importance of upskilling the carer workforce trainers, occupational therapists, physiotherapists and others who will be responsible for delivering assessments and care. Particular importance is placed upon the care provider and local authority working together to foster high quality Collaborative services.

How do they do that in the case of using the Moving with Dignity single-handed care approach?

A view expressed by Vivienne Aldred at Sefton Council; " Carers hours saved are reinvested into better equipment, training and releasing capacity with the care provider workforce for those who previously had nothing" Spreading the workforce further and therefore, meeting unmet demand.

Training has been shown to be highly beneficial to the outcome of the project using a variety of approaches to be used which are listed below:

1. Direct training to both the therapists and the care agency risk assessors and trainers. The training should involve both the change management and theory element as well as the practical skills. If the care provider assessors and the therapists are trained together, mutual respect of each other's issues is gained, barriers are overcome as well as fostering long term alliances for the referral process.

   The training should allow enough time for each delegate to practice all the techniques until confidence and competence is achieved. Several training suppliers provide training, ranging from a one-day awareness event to several days involving complex and diverse problem solving resulting in industry recognised qualifications.

2. Using the cascade model there is an expectation that the care providers trainers will now be able to provide training to their own staff, it is strongly advised this is written into a contract. Some struggle as they do not have the equipment that is being used on the project, or do not have a training venue. Many councils have resolved this issue by loaning equipment or even better, providing access to large equipment rooms with the correct equipment. Many councils have gone one step further and manned the training room so they can be on call to support the care provider trainer.

3. Training and assessing the care workforce on the front line. It is advised that during any assessment that the care provider assessor/trainer is present, so information can be cascaded down. It is expected that a review, or several reviews, need to be carried out depending on the complexity of the case. This is dependent on the current skills of the workforce; this is more so at the beginning of a project as opposed to when a project has become more main frame.

4. Short sessions off site in a training room, facilitated by therapists with the carers involved in specific case where practice is required and will be too invasive onsite.

5. A1 Risk Solutions created an evidence-based online system that demonstrates it's use significantly reduces risk and improves skill levels (Webb, Harrison and Szczepura, 2016). Therapists reported (Harrison, 2018) they felt they would quickly forget the new skills they learnt on training without an aid memoir. This comprises of over 345 Moving and Handling videos and safe systems of work, it supports therapists and councils as part of their single-handed care projects.

6. A1 Risk Solutions and the University of Salford (Webb and Harrison, 2019) developed an evidence-based competency assessment tool as part of a four-year longitudinal study. It breaks the task down to its core elements, gives structure and the ability to give feedback of how they can improve their practice and an action plan.

7. Some equipment suppliers offer product demonstrations and this can be a way of refreshing the therapy workforce in additional features and benefits of their equipment.

Ongoing sustainability and support

Once a programme is embedded it is imperative that the support of the care provider workforce is continued. A successful model used in Wales at Wrexham council is the provision of key worker support meetings, these are held throughout the year. Where issues that have been successfully addressed are shared within the group. They invite speakers as well as equipment suppliers to demonstrate products.

Therapists may get their support by training, addressing complex case studies in a problem solving creative and supportive environment. There is also support available online through the use of videos and safe systems of work.

Examples of where this has proven beneficial and why?

Dudley Council
Dudley council in 2017 followed the above model, gaining support from commissioners and engagement across the carer workforce. They used monies from the Better Care Funding to finance the initial equipment spend, formation of a team of Occupational therapists, social care assessors and therapy assistants. There lead therapist Christine Outhwaite reported it gave service users greater independence (2018).

They took a slightly different stance on dealing with hospital discharges and the team built into the plan to go out within hours of discharge and assess the service users and provide equipment required. The notion of a man with a van really took off, the van is equipped with folding gantry hoists, manual and mechanical stand aids, in-bed management sheets, slide sheets and a wedge.
Their project has been very successful, they reported 84% of total conversions from double to single-handed care.

North Lincolnshire Council
North Lincolnshire council in 2018 followed the above model, gaining support from commissioners and engagement across the carer workforce. The formation of a team comprised of a Moving and Handling lead, social care assessors, senior care staff and therapists.
They had two successful engagement events and ran joint training across social care and care providers.
The team was very successful, they reported an approximate figure of 80% of total conversions from double to single-handed care.

Sefton Council
Sefton council in 2018 followed the above model, gaining support from commissioners and engagement across the carer workforce. They used a mixture of locum staff with single-handed care assessment skills, as well as employed additional staff to form a team.
They had two successful engagement events and ran joint training across social care, health and care providers across a one and half year period (Sefton Council, 2019)
The team were very successful, they reported they had freed up care hours that met unmet need. The team continue to be successful during the Covid pandemic and changed working

practices carrying out virtual assessments and continuing with face to face assessments when required.

Lancashire County Council

Engagement early on at a commissioner level was one of the key elements with this council. This ensured the first meeting between the consultancy, Head Occupational Therapist, project lead, loan stores and consultancy/ training provider addressed seamlessly what was required from each party.

Commissioners were very responsive to meeting the needs of the service and service users in a safe and lawful manner. They also provided an early contact point to whom the team manager could go to and discuss issues and gain support. An equipment evaluation using a scored evaluation process was carried out using the views and opinions of over 100 people. An engagement event was held inviting key stakeholders to engage, this proved to be a resounding success to get the message across to a large number of people. The council held training using a cascade model in single-handed care to upskill the whole of the workforce, this engaged the care providers in a meaningful manner. Training of care provider assessors/trainers took place alongside the whole team of occupational therapists and hospital discharging therapists. A team was formed employing Occupational Therapists and support staff, this team support others when they have identified there is a capacity for reducing the package of care, but they lack the confidence.

As new therapists join the council, they are initially trained using the single-handed care approach as part of their induction training.

Pre Covid-19 they had successfully released hours in the community, creating capacity for new care packages and hospital discharges. In November 2019 Lancashire council presented their work at conference (Daley, 2019) up to date and initial results looked promising with conversions of double to single-handed carepackages estimated at around 87% Daley (2020).

Assessment tools

Harrison (2016) identified the need for a thorough assessment tool, this was clearly expressed by Occupational therapists and Moving and Handling Advisers. Some of the legal pitfalls have involved the assessor/ therapist not fully documenting the service user's needs and wishes, evidence of clinical reasoning including clear justification for their course of action and consideration of objections. A local authority will always have to justify that the needs will be met and the options considered. The importance of documentation and demonstrating that a process has been followed is vital.

Any new tool needs to assist the assessor to carry out a Care Act compliant assessment, shows clinical reasoning and justification for options considered and reported. It was felt it

this tool needs to take account of the service user's, families and care providers views, not just the clinicians.

The tool or a separate document would be essential to also include key performance indicators, then data can be centrally collated into a corresponding excel sheet which will self-calculate savings, predicted equipment spend, hours saved and concerns.

The evidence also identified that clinicians were concerned about advising single-handed care for more complex cases, examples give included those with distressed behaviour and plus size. A tool that could be used flexibly that would explore pathways was indicated.

Using a robust and evidence-based tool would help guide and enable an inexperienced assessor/ clinician through the process and reduce the need to default to two carers.

What is very clear is as emerging them from the clinicians were less nervous using a tool such as this, as it gave them guidance and a structured path to follow. A risk assessment tool and process such as this should not be used in isolation. There are other tools that have been developed for use in a community setting. One of these was a community equipment mobility assessment tool (CEMAT). This was developed initially in a collaborative approach with Dudley Council, Christine Outhwaite of Dudley Council, A1 Risk Solutions, and the care providers.

The purpose of the tool, it can assist people in different ways.

1. Assists the clinician to choose the right type of equipment.
2. If used by the care provider workforce, it can be used as a tool to notify the clinician of a change in mobility and therefore what equipment is possibly required.
3. It can identify trends, improvement and deterioration in mobility.
4. It can give rehabilitation and other services a way of measuring their success as people's mobility levels are measured at the beginning and end of a period.

Other tools that have been successfully used have been 'well-being' tools. Measuring how the service user felt about the interventions, the councils that have used these were Devon and Sheffield Council.

Hospital Discharges using the Moving with Dignity single-handed care approach

As single-handed care originated from the local authority sector, many of the benefits are directly related to councils, up until recently this was where the majority of the focus has been. Many NHS acute hospitals have been historically reluctant to actively engage with

this approach, despite the efforts of their associated councils to encourage them to explore discharging from the hospital into the community with one carer.

There are several reasons for this reluctance; the NHS view is that it is an issue with community care, the discharging clinician does not know how to move and handle using the equipment that facilitates using that approach. There is often a default position of two or more carers for the hoisting and other complex moving and handling tasks in acute settings. Quite simply, they do not have the equipment, skills, experience or received training to carry out a single-handed care assessment on a ward.

Therefore, they may genuinely feel it is unsafe and would prefer to discharge with two people and this then to be picked up and reassessed by the community Occupational Therapist. Apart from the duplication of assessment time, costs and the draining effect of double assessments on the service user. The crux of the issue is by the time the community therapist has been out to reassess, the processes and systems are engrained within the care package, family and care workforce. They often feel aggrieved when it is reduced several weeks or months after discharge.

There are solutions that have been explored across regions of Cheshire and Merseyside in 2019/2020 integrating social care, health and the care providers using the single-handed care approach. This involved 11 boroughs and the training of 256 staff across all three sectors. Previous evidence indicated that hospital patient flow significantly improved across 5 boroughs whose councils carried out single-handed care as opposed to other councils that did not. Thereby freeing up hospital beds in a timely and more efficient manner as care packages were less scarce.

This is of particular interest in the time of a Covid pandemic that required the rapid discharge of patients from a hospital setting into the community, it is reported that this had to be completed in 2 hours. Anecdotal evidence exists describing how community therapists went into the hospitals to assist with hospital discharges using the single-handed care approach.

Benefits of using a single-handed care approach

There are many benefits, they vary across the different stakeholder groups.

Service user/ patient

Due to the person-centred care that is carried out using the single-handed care approach there are numerous benefits, these include: improved relationship with care worker, treated with dignity, treated as an individual, reduced likelihood of being admitted to a care home, able to stay in own home longer, feel more in control, reduced isolation, less

invasive, feeling they were part of their own care and sometimes saving money. Due to an improved person-centred assessment process it is assumed better outcomes for the service user. Equipment used creatively for enablement and rehabilitation purposes using the single-handed care approach may result in improvement in the mobility of service users.

Family

Greater level of trust, as the family are dealing with less carers, the family are often happier if the service user is moved in a safe and dignified manner. If the package of care is privately funded, reducing the number of carers required is normally viewed positively by family and service users. The level of trust is built upon a one-to-one relationship with fewer carers, it is not incomprehensible that this approach will result in fewer complaints and reviews.

Carer Workforce

Upskilling of the workforce, often leads to an increase in job satisfaction, single-handed care fosters a good relationship with the service user and family and similar benefits that are associated with direct payments if a consistent workforce is used. Happier workforces stay longer.

Occupational Therapists

Occupational therapists improve their skills, knowledge and experience, resulting in improved assessments, the therapists often report feeling an increase in job satisfaction. Due to the level of resistance and conflict, the therapist needs a good level of support as this role can be both challenging and rewarding (Harrison, 2020).

The Council

The care workforce will be able to be redeployed to meet the current unmet need. There will be potential to take on more care packages, whether they are new care packages generated in the community or hospital discharges, the effects will be of benefit to the associated NHS. The workforce of the borough will be upskilled, an upskilled workforce that delivers high quality care ensures the local authority is compliant with the Care Act. There are monetary benefits that can be used to reinvest into better quality equipment, training and additional staff.

Hospital

The hospital that is situated in a borough whose council has been using the single-handed care approach should benefit as there will be more care packages available in the community.

Hospital discharges are less likely to be delayed when a transfer of care is required into the community, as there are more care packages available (Box and Agnew, 2019). The hospital

is less likely to be fined by the ambulance service, if the patient flow through the hospital is not blocked in accident and emergency.

If an acute hospital setting discharges using the single-handed care approach, where appropriate, the hospital will benefit by clearing more hospital beds and reducing the delayed transfer of care. This is of great benefit to the hospital and the community. The transition pathway between the hospital and community needs to be created, each pathway will be different and what is deemed appropriate for them.

Then of course there are the monetary savings, although some of this is reinvested in staff training, equipment processes and systems being put in place.

Hospital discharges and the discharge to assess model using the single-handed care approach

As the new 'discharge to assess' process has been announced (Department of Health, 2020), this advises that hospital Occupational Therapists will follow the patient through into the community and put everything in place, including equipment and set processes.

Although this technically is not much different to what has happened previously, however if the hospital therapists are not trained in single-handed care, the patient will still be discharged with unnecessary and costly care packages. This will also have a negative effect on any councils who have already established single-handed care within the community. As the community therapists will have to revisit the discharged patient and reassess the service user for the possibility of single-handed care.

This approach could add more work to the community services as well as add to the lack of care packages in the community and ultimately result in an increase in unwarranted admissions to step down beds and care homes.

The lack of skills and knowledge of the hospital discharging therapist in the field of single-handed care is not of their doing, there has been lack of opportunity combined with the fact it has never been viewed as part of their job.

There is a change in the air in a few hospitals, these are across Merseyside, Cheshire, Liverpool, Cumbria and Lancashire. These areas introduced the ethos of single-handed care in 2019/2020 and it was starting to have an effect, as Covid-19 hit the nation. It is reported that many of these areas have continued to embrace this new approach and have seen benefits of this in the first wave of Covid-19.

Other areas are doing discharge to assess using a community-based approach, where the community therapist will do one of two things. On receiving the initial brief referral, from the hospital therapist follow the patient home within two hours and carryout the full assessment within the person's home. This way the council who is using the single-handed care approach can easily continue with this process.
Other councils are sending in their community-based therapists to carryout the process fully, the approach of using community therapist will have some benefits at the moment as we enter the second wave of Covid-19. This will relieve the pressure on the hospital therapists as they are being diverted to assist with essential care across the hospital setting.

Many community services are already stretched, and would be unable to effectively offer this level of assistance. There are many services that are able to assist across the country, however not many have experience of the complexities of the single-handed care approach. In the authors opinion this could be approached in a few different ways:

1. Engage professional therapy services to carry out the day to day activities of Moving with Dignity assessments to enable your own staff to facilitate hospital discharge
2. Engage professional therapy services to carry out the 'discharge to assess' process whether it is health or community led.
3. Engage professional therapy services to carry out housing and adaptation assessments
4. Engage professional therapy services to carry out Moving with Dignity assessments using the single-handed care approach, these could be carried out in the community or in discharge to assess beds in a community setting.

If therapists wish to explore outside their normal scope of support, they may wish to consider using equipment suppliers. Would the suppliers be fully versed with single-handed care be of assistance in the assessment process either virtually, or in person, in a hospital, or community-based setting? Consider could they have a role to play as part of the discharge lounge process, either in person or virtually. However, with the discharge to assess process being such a quick turn around and so many hospitals that could call upon this as an option a simple process and assessment is required, that could then be followed up by the discharging health or community therapist.

At a time where the health and social care system is under extreme duress; we all need to rethink our processes and systems and how potential improvements could benefit the service user. Not just to empty beds. The process of 'discharge to assess' originally was intended to improve the patient transition and experience, not to be used as a vehicle to facilitate dumping of patients into any setting.

Rehabilitation and Enablement Services

It has been voiced by some therapists that single-handed care and the use of equipment does not support rehabilitation. The author would like to challenge that with the creative use of the equipment, rehabilitation services can use the equipment as a second set of hands. Rehabilitation goals can be achieved following a robust Care Act compliant assessment and by using the correct equipment and training. The improvement in mobility levels can be demonstrated and the transition from one level to another can be supported by the correct use of equipment and technique. Although not all therapeutic handling can be carried out single-handedly there are many instances where the introduction of equipment can improve the safety of the patient and the handler.

Examples of using equipment for a single-handed care approach to rehabilitation. Facilitating independence rehabilitation using:

1. A gantry and low back sling
   Sitting practice for a service user on the side of the bed typically requiring input of 2-4 of the therapy team. Using a low back sling attached to a gantry to hold the patient when they relax is a simple way to facilitate the same activity with one or two handlers.

2. Return
   The use of the Return with its flexible knee pads in a lowered position is a great way for a therapist to facilitate dorsiflexion. The use of the belt in a locked position is a safer way for the therapist to encourage the service user to stand independently. If the service user's legs give way in this circumstance, the correctly fitted belt will hold the person in position. The alternative viewpoint would be the therapists would support the service user's weight in a descent. This places the handlers and the service user at more risk of injury. This equipment could be used to practice seated exercises; trunk rotation, lateral trunk flexion and forward reaches can be achieved initially by using the Return for the service user to reach to and to act as something for them to hold onto. Practicing standing with minimal support can be achieved with one handler when using a standing aid. The patient can continue to push up from the arms of the chair, then hold the bar on standing, maintaining the ability to follow a natural pattern of movement. A seat or supportive belt just being used as a safety feature, just in case.

3. Walking vest and pant
   In walking this will often involve two or more handlers, if the patient is unable to continue, the handlers will often have to intervene. The handler in either of those circumstances is left no option but to decide whether or not to intervene. There are

the obvious risks of the patient becoming psychologically dependent on two or more handlers being present, plus, the risks of injury to the handler and patient should they fall. One alternative technique to consider would involve the use of a walking vest and a ceiling track. This technique will reduce actual and perceived risks for the patient and handlers if their legs give way, they will be caught by the equipment.

4. Standing hoists, although theses do not bring the patient up into standing using a natural pattern of movement, can provide a safer level of support when used, with the correct sling compared with two handlers (and reduce the level of risk for both the handlers and the service user.

It is the author's opinion and experience that therapeutic handling can in part be facilitated using equipment. This will sometimes result in a reduction in the number of handlers, or the reliance on their physical support.

The therapist, when discharging from a hospital setting is mindful that the care provider will not being carrying out therapeutic handling. The rationale for this is usually based on the assumption that carers do not have the skills or are afforded the time. When discharging the patient into a community setting, the therapist should consider Moving with Dignity using a single-handed care approach.

Complex care handling

There are instances where care handling for the individual who requires an increased in hours can be automated. Examples included the following:

- Repositioning with a turning bed or an in-bed management sheet with handles has several advantages.
- The service user can be easily moved with an automatic bed or mattress. This completely reduces the need for a carer to be present. On a cautionary note, I would expect with this type of intervention to include a monitoring call or a telecare of some description to alert the response service should an incident occur.
- A repositioning lifting sheet would reduce the need for multiple handlers to effectively roll an individual from side to side. The sheet and hoist will significantly reduce the effort required by the handlers.

Barriers and solutions using a single-handed care approach

The difficulties of implementing the single-handed care approach have been well documented by a variety of sources: The service user, the carer workforce, family and on occasion from healthcare professionals.

A national study in 2016 identified several reasons underlying the resistance to change to using a single-handed care approach. The main solutions were observed to be; engagement, education, training tools and the provision of the correct equipment as previously discussed. Several organisations have successfully adopted this process and systems approach. However, a change in culture is often a slow process that can feel like an uphill struggle. The key to the success is to encourage engagement at all levels and actively listen to all stakeholder's opinion.

One of the observations by therapists was the lack of in-depth training for themselves and the workforce, they did not feel confident or competent with jut an equipment demonstration. They felt if they were not confident themselves how could they confidently, competently assess, problem solve and persuade others. They expressed their concern about the opposition and conflict (Harrison 2017, 2018).

It has been recognised an engagement day is an ideal way to positively introduce the concept with practical demonstrations whilst addressing initial opposition.

The following councils have successfully completed engagement days:

- Kensington
- Westminster
- Sefton
- North Lincolnshire
- Lancashire
- Dudley
- Lanarkshire
- Whiston
- Cheshire East
- Cheshire West
- Denbighshire
- Wrexham

<u>Assessment tools and importance of recording data</u>

A key element that was identified as a concern/barrier to adaptation of the single-handed care approach was the lack of suitable assessment tools. Existing appropriate tools are currently very limited. One is a community mobility assessment tool. This was developed as a project looking at reablement and single-handed care (Outhwaite & Harrison, 2018).

A1 Risk Solutions has developed two tools, one intended to be used at the beginning of a project and the second one to be used to collect data throughout the project. Often, at the outset of introducing a single-handed care approach, project leader needs the support of

the commissioners to ensure they collect the correct data and have this analysed as a proof of concept. Then then allows the project to move on beyond the pilot phase.

The first tool outlines how savings can be made and this can be used as a cost benefit analysis and often aids the commissioners and project leads. It helps to build a business case and plan, demonstrate the hours saved, monetary savings, therapy staff extra time required as well as monetary spend on equipment and training.
The second tool will provide: the number of care hours saved and at what time of the day, so when analysed over a short period of time, it can indicate what time of the day extra hours will be required. This is invaluable for workforce planning. This tool self calculates monetary savings from the interventions, the time taken to recoup the spend on equipment and assessment time for each intervention. It allows analysis of the reasons for non-conversion, the type of equipment that is successfully used and this will facilitate budgeting for the equipment spend.

Research continues to gain consensus on this evidence-based Moving with Dignity tool from a range of therapists employing a single-handed care approach-watch this space for publication.

<u>If the plan is not followed</u>
If the handling plan indicates two carers are required using a single-handed care approach it is imperative that this is followed. There has been an incident where an individual fell, it was clearly written in the plan that the service user required the assistance of two people. This was not followed.

Similarly, if additional handlers were provided above and beyond what was required, it could be argued that these may compromise the task at hand. A common example is a person living within a supported living environment who easily triggered into distressed behaviour. The service user easily experiences sensory overloading and becomes distressed when two handlers are carrying out the moving and handling task. Often the reason is when one handler is present, the service user is the prime focus of their attention. Placing two handlers into this environment can be confusing for many service users, as the handlers talk between themselves, the service user is unsure of what is happening as the pace of dialogue is quicker than they can process.

<u>Care workforce lack of skills in single-handed care</u>
“The carers do not have the correct skills, confidence and attitude” this is one of the major concerns from the 2016 survey and is often cited in the implementation phase of a programme. It is often reported there is a high level of resistance from the carer workforce.

This may be reduced; different approaches have been tried by several councils. Some of the examples are below.

Sefton & Lancashire Councils:
Following a successful pilot project Sefton and Lancashire councils established a single-handed care team, consisting of occupational therapists. They offered onsite advice, guidance and demonstration to the existing care staff. This councils provided the same training and level of online support across all therapists and care provider trainers using a training room and offering drop-in sessions. The training room and equipment was offered as a resource to care providers to cascade training to their own staff. As a commissioner looking to engage this sector in this approach, this is the only way forward.

The author's experience is that commissioners buy into making their projects successful by deploying the strategies discussed. It is a definite 'spend to save' model that has been fully implemented across many councils. Dudley council and Sefton in 2017, North Lincolnshire in 2017, Lancashire in 2019, Cheshire West and Cheshire East in 2019, Denbighshire 2019/2020, Tameside 2019/2020.

In 2019/2020, a project was sponsored by NHS Education to explore the impact of having an integrated systems approach to hospital discharge. The project spanned across a total of 11 areas, including therapists from acute care, local authorities and care providers. If a project could be successfully and simultaneously rolled out to over 40 organisations, there is no reason why this systems approach to integrating health and social care should not be rolled out across the whole of the UK.

<u>Pressure to make saving</u>
Commissioners have always known that there is money to be saved using this approach. There is no evidence that pressure has been applied on health professionals to make savings, there is pressure to ensure that an assessment has been carried out in a Care Act compliant manner.

Occupational therapists and other healthcare professionals are aware of their responsibilities to carry out a robust risk assessment that carefully considers the person, the number, as well as skill of the handlers, the environment, equipment required, as well as taking into account needs and wishes of the service user. Therapists often within one case will have different numbers of staff required for specific times of the day. For example, an individual may require two people in the morning as they experience spasms during a shower that are difficult to control with one person. The rest of the visits are less complex and require one person. The authors experience is therapists are able to assess as they see fit.

Therapists more recently, have started to think in strategic terms and blend how they approach their practice. The realisation that they can meet the needs of the masses, that there is not an endless pot of money and if it is spent wisely, it can do so much more. Instead of solely focussing on the money saved, there is a shift to value the care hours saved that can now be invested to meet the vast demand of unmet need in the community. There is no need for any therapist to abandon their core principles in the desire to implement single-handed care.

Covid-19 Moving with Dignity using a single-handed care approach

During the time of the global pandemic has the assessment using a single-handed care approach continued? Some teams were immediately deployed such as North Lincolnshire and Sefton to facilitate effective and timely hospital discharges into the community to free up hospital beds. This involved the community assessors going into their local hospitals and facilitating discharges. Other teams have carried out assessments following discharge in the home environment. Many of these assessments were carried out remotely, unless they were particularly complex. It has been reported in the main that this was a successful model and effective way of working.

Remote assessments

During Covid-19 many family members at this time took over the complete care of the service users and discharged the care providers to reduce the risk of transmission by contact with care worker. Many family members also refused the therapists access to the service user for the same reason.

At the beginning of the first peak, there were lots of discussions within teams questioning whether a remote way of working could and should continue. Discussions raised concerns from a range of health professionals involved, including therapists missing something and lack of presence leading to, being unable to measure or feel if a person is sat correctly in the chair. There is also the impact of a reduction in the ability to establish a therapeutic relationship which an assessor builds with the service user during a face to face assessment.

The author has used technology to carry out remote assessments for many years and is aware of some of the pitfalls.

Some of the pitfalls; dependent upon the assessment first consider how to gain and demonstrate consent correctly as it may be required for evidence at a later date. The use of technology - who is going to facilitate that? Will it be the formal or informal carers, who is going to demonstrate the problem? Can the carer use the technology and it is a format that is used by your employing organisation, many organisations have put blanket bans on face time, zoom and Whatsapp. Therefore, bringing additional people into the equation at a potential cost and adding into the risk of more people working together in close proximity.

Ask the carer to measure the room, identify where windows, doors and radiators are in the room. Some of this information may be available from Zoopla. Sometimes we just have to be there in person, another great tip was advising through an open door or window.

A competent and experienced assessor will be able to foresee potential issues, direct the camera and assessment towards those issues. A lesser experienced or newly qualified assessor would struggle and require more prompts within the risk assessment process.

The assessor also has to give feedback when observing the competency of the handlers. This is normally adequate when dealing with experienced handlers. However, when dealing with inexperienced handlers such as family members or members of the care workforce, it can be very difficult to explain what they have done wrong and how they can rectify the issue.

Some authorities became creative to reduce the impact of this and help minimise risk by developing videos for the care workforce and families. This involved significant investment and time to develop. Many councils looed to existing support material and approached the author for the use of the evidenced-based online video system to use across the whole health and social care workforce. This enabled the carer workforce, family or paid care provider to watch the appropriate video and practice until they successfully completed the task, whether it was single or double-handed care.

The use of single-handed care and future technology

Single-handed care has been around for many years, in different forms such as direct payments and in the learning disability (LD) sectors. In the past, we did not have the variety of equipment, or realise its full potential.

As technology improves, the nations of Japan and Korea have invested billions of pounds into the development of robotics that will enable care tasks to be carried out with one or no carers. What appears to be in development phase were self-flushing toilets and care beds that automatically turned. All these countries are experiencing the lack of carers and increasing number of elderly, it is a global issue.

In New Zealand, a virtual doctor programme has been developed via an online web service. This programme asks questions and through a series of complex algorithms, will identify what course of action, treatment or if a referral is required. Patients are asked to upload images which can be sent to a specialist doctor in a different country by an online auction. The aim is to provide inexpensive healthcare to the difficult to reach communities.

The department of Business considered if care robotics have a place in care (2019). The development of exoskeletons are being piloted in a council in the UK. This technology has come from Japan and is currently being used within the car manufacturing. However, usability studies and protection of the individual requires ergonomic research as detailed by McGowan, B. and Beltzman, B. (2020). Although this is not considered main stream at the moment, it is expected to be here, sooner rather than later.

We need to look to other sectors and explore if their technologies are useful for care in the community. An example would be the automation of call systems far in advanced of telecare without the use of visible monitors. Consider how security systems operate by monitoring lights switching on and off, doors opening and the list goes on. This information generates an alert that will bump a manager's phone and with a push of a button they can decide whether to intervene or allow someone else to be deployed. None of this requires human intervention, reducing the risk of errors and significantly increasing the speed of transmission of the required data. Consider how this could be used in a care setting?

Artificial intelligence is a vision that is in the distance, however it is there.

The Law and single-handed care

Moving and Handling should always be based around avoiding or reducing the level of risk to the most reasonable level practicable (MHOR, 1992). The risk assessment should take into account the person's needs, the number of handlers, competency, the environment and any equipment or process required. As previously mentioned, the need for a robust risk assessment tool is at the top of everyone's wish list. Therefore, no matter how many carers are required, demonstrating you have followed a process and have a robust risk assessment is essential.

If single or double handed care is considered a default position, it is not consistent with legislation. What is clear is what we will be measured against. Is there a Care Act compliant robust assessment in place, was a process followed? (Mandelstam, 2018)

A briefing paper by Michael Mandelstam (2020) explores the legal side of the competence of the carer being asked to carry out the task. This is echoed by the findings in the survey 2016. To avoid this potential legal pitfall, the commissioners and assessors need to provide assistance, guidance, support and training to the care provider workforce.

I can hear many saying "it is the care provider's legal responsibility to provide training to their own workforce", which it is. However, it has to be remembered that the commissioners are introducing a different way of working that the care providers will not have been exposed to before. Who are the beneficiaries? The local authority and acute

hospital settings, ultimately not the care providers. It is a hard slog for care providers at the best of times, they are now being asked to do double the amount of administration work for the same money. The care providers have built their models of working and profitability margins around providing a certain number of carers into the work place.

The competence of the carer workforce needs to be addressed through realistic contracts and meaningful discussion.

Commissioners need to ensure; training is in a safe and structured environment, continued support of the care provider results in engagement, as well as upskilling a complete workforce. The author is aware of workforces such as Lancashire, Sefton, Halton, St Helens, North Lincs, Dudley and many more that have used this supportive approach. They now have the care providers who are not only less resistant, but actively highlight cases that they consider should be resolved.

The training is a meeting of minds and removal of barriers and where mutual respect is generated and biases are removed. The assessment outcome should be aimed at meeting the person's needs, ensuring it is compliant with the Care Act 2014. As using a single-handed care approach does not relegate itself solely to hoisting, but also to standing transfers and improving mobility, it can often, although not always, accommodate most people's needs.

Moving with Dignity using a single- handed care in practice

A Case Study:

A gentleman who was plus-size had taken himself to his bed. He was mentally struggling with the process that four carers were going to hoist him out of bed. He reported he had hands all over him, trying to roll him from side to side to change and position the sling. He felt he was being mauled. After an assessment by the community single-handed care project lead, his goals to make life easier for the carers, reduce his guilt, to be able to sit out of bed in his wheelchair and spend some time out of his house. The gentleman had been bed bound for several months.

The assessment took place with the care provider, with some support they were able to implement an action plan. The outcome was the gentleman was provided with equipment, including a gantry hoist and in-bed sheet system with handles. The care package was reduced to two people initially for the a.m. call to get him out of bed and dressed. This was to be reassessed after the workforce became familiar with the equipment to establish if the care package could be reduced any further. The calls that involved care on the bed were reduced from 4 to 1 person as the in-bed sheet system was taking the strain. The remaining

carer pressed a button to carry out the turn, changed bedding if required and carried out personal care. The author spoke to the gentleman, he spoke positively about the impact of the intervention on his life. This resulted in a potential saving of over 10 hours a day, 70 hours a week and also freeing up carers.

There would be enough hours released to meet the needs of an additional four other service users in the borough.

In this particular case, the reduction of core hours would have resulted in annual savings at over fifty thousand pounds. Not every case generates such savings, however, small amounts over a large number of cases have been demonstrated by numerous councils. The higher the conversion rate the council can achieve, the greater the freeing up of hours, some of which are highlighted in the table below:

	2018/2019 figures
North Lincolnshire	80%
Lancashire	87%
Dudley (total across professions)	84%
Cheshire West and Chester	80%

	2016 figures
Cambridgeshire	44%
Somerset	44%

Social Isolation

This has been aired as a cause for concern, technically, the length of the call may increase in time. If the call is complex, requires a shower and hoisting for all transfers a summary of one and two carers supporting the individual:

Task	With two carers	With one carer
Showering and getting dressed breakfast	1 hour	1 hour 30 minutes
Lunch call, use the commode and lunch	30 minutes	45 minutes
Tea call use the commode and tea	30 minutes	45 minutes
Evening call use the commode	30 minutes	45 minutes
Daily total care hours	5 hours	3 hours 45 minutes
Daily hours the service user is with carers	2 hours 30 minutes	3 hours 45 minutes

It may be that the call gets increased in time to account for the increase in duties that the carer is expected to carry out. As in the example above there is an increase in the time that the service user spends with a carer in attendance by 1 hour 15 minutes a day, resulting in an overall reduction in isolation.

It is good practice to revisit and review the assessment once the carers have become accustomed to working solo. This will establish whether there are any issues, adjustments, different equipment or whether timings need to be adjusted up or down. It is common for the care hours to be further reduced as the carer becomes accustomed to the process and use of equipment for the service user.

The care workforce is being asked to work more in isolation, this is not an uncommon occurrence, especially in enablement services and when the service user more commonly only needs one. The issue is when there is a complication and the theory that two heads are better than one is often misplaced. Simply put, the care provider organisation needs to ensure a support mechanism is in place such as a reliable and experienced on call service that can intervene when required.

Variation in condition and mobility

This is often cited as being a reason for the care package to be increased to two carers. If we look at the reasons for the increase, it could be a deterioration in health, it could be they have a clinical condition and their mobility varies enormously throughout the day.

So, as opposed to defaulting to hoisting, the service user's mobility could be recorded over a period of time, and the appropriate pieces of equipment are supplied. Alongside a variable handling plan and using the community mobility assessment tool, the carer would know which piece of equipment to use on each visit.

Case study

The author was asked to advise on, the service user preferred not to be hoisted. The local authority assessor had suggested that the lady was hoisted for all calls, as her mobility varied from mobilising independently, to not being able to sit upright independently.

A diary was kept, and the carers were advised to follow a plan that had three elements:

1. Independent mobilisation,
2. Using a manual stand aid with a belt for support,
3. Hoisting.

On average, the lady in question required hoisting once a week. The family were appreciative of the fact that the lady was able to maintain her mobility as long as possible. All of this was achieved with one carer, the service user and her family the majority of time were accepting of the need to carry out hoisting as a transfer when the time arose.

There were other times the service user and the family refused the use of the hoist, and physically lifted her in and out of bed. The risks were explained to all, this course of action was also included in the plan.

What was apparent with this case and many others that the author has advised on, previous discussions have been held were solely focussed around the health and safety of the worker, not a holistic assessment, where the person was at the centre of their focus and concerns.

“One of the main reasons we advise against physically lifting and carrying your loved one, they may get dropped and experience significant injury.

Reviewing assessments

A pitfall to avoid is reducing the amount of time required, should a person’s condition change and there is an increase in carers are required. There is a requirement to have documented the tasks can be completed in less time as there are now two carers there.

An example of this may simply be, the carers have transferred the service user out of bed, showered and dressed, as a double-handed technique. They then split off, taking the assigned tasks individually. As a typical example these could be; transfer downstairs, prepare breakfast, strip the bed, put the washing machine on, wash the pots, dry the service user’s hair, put makeup on, put shoes on and write in the care plan. The exact time taken to complete the tasks will not be half of the total time, but half of the time to complete the smaller necessary tasks.
Therefore, a summary of the tasks undertaken within the assessment to be determine the time taken.

When reviewing care packages, therapists and commissioners alike must be aware there is a probability that a care package may increase in the time required and number of carers. This is reasonable and demonstrates that the process is working and there is not a blanket approach to the number of carers required for moving and handling.

It is imperative for commissioners to review the assessment process to ensure it is working as intended, when commissioners are engaging with a therapy organisation. They need to accept that the reporting of the assessment in detail is vital and a one-page report will not suffice and be woefully inadequate if a case is disputed in court.

If an assessment outcome is contrary to the wishes of the service users, it is advisable for the therapist to be able to demonstrate they have carefully considered their needs and wishes. This may include the opinion of others involved within the process. If evidence and

reasoning is found to be lacking, the Judge may find the decision unlawful, as they are more concerned with whether a process has been followed. Therefore again, as previously mentioned, it comes back to documentation and having the correct assessment tools to assist the therapist through the process.

Informal carers and single-handed care

Many informal carers and direct payment recipients have carried out complex moving and handling, single-handedly for numerous years. Circumstances change in these instances, the informal carer realised the physical and mental burden, or may have health conditions of their own.

Frequent reviews of these cases would be advised to ascertain that the family is aware should support be required, they know the process and how to get a timely and urgent assessment. In the event of a breakdown in the interim, it is recommended that care is provided, preventing carer breakdown, distress to the individual and the family. Is that not the least we can do when families are playing such a vital and often unpaid role?

We have to recognise that the families have often been coping very well for years, and they often come to us when they are at the end of their tether. They are often upset as they are admitting to another person they can no longer cope, they feel guilty, in some ways as though they are letting their loved one down, as well as relinquishing a role they may have enjoyed for quite a while. They are trusting the well-being of their loved one to strangers. A range of emotions will be felt, is it any wonder that the informal carer can be less than welcoming when as an assessor, we come along and change their world and life? Such things need to be appreciated in a compassionate and empathetic manner.

Assistance may be offered to family members by simple things, such as a timely assessment, an easier technique or piece of equipment for them. Examples could be an insitu sling, this will reduce the amount of handling the informal carer has to do and also be easier for the individual to tolerate. Another example would be an automated turning device with a bed, the author has found the bed with the ability to cradle the service user useful, whilst being turned the service user does not get the feeling of falling as the turn initiates (Bartley and Webb, 2015).

As assessors, we may look at what families are carrying out and completely strip away the pride they have held in the work they have been doing. All too often a brusque approach saying “oh no, we cannot do that” does not foster therapeutic relations with the risk assessor.

A simple approach of saying to the family member "let's see if we can make it easier for you by doing it this way". This approach is easier for people to accept as you are inviting them to be involved in the assessment process as opposed to being dictated to. We should be inviting engagement, not hostility to the conversation. We should be advising families of risks and alternatives, whilst documenting this.

We need to be cautious about the over zealous use of the safeguarding process when there are alternatives. Albeit these can often be a slight increase in risk to the handler, however if the informal carer has consented to the higher level of risk, it can be a matter of negotiating advice and guidance. Having an open-door policy will ensure they come back to you with a request as and when needed, as opposed to avoiding you like the plague.

Conclusion

Individualised person-centred approaches, used to ensure service users are moved with dignity and respect should be the norm.

The assessment carried out should ultimately consider the needs and wishes of the service user. The competency of the carer workforce needs to be addressed through training, supervision, and instruction. Informal carers and family members to be applauded for the work they do, given the timely guidance and advice.

All of this is relevant, whether or not it is using a single-handed care approach.

As Moving with Dignity using a single-handed care approach can often come across resistance, teams and commissioners need to be mindful that assessments will take longer to ensure the legal pitfalls are avoided.

Commissioners and heads of service should actively engage and support the care provider workforce with a variety of strategies to ensure a successful programme. There will be training, guidance, online support, access to a training room and equipment. A necessity is for the contract to be written that single-handed care delivery is expected from the workforce and will be written in a supportive and meaningful manner.

In the current climate of a global pandemic and a reduced NHS and social care workforce can we afford not to implement Moving with Dignity using a single-handed care approach across all sectors?

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