

# Safer staff, better care

*RCN manual handling  
training guidance and  
competencies*





Royal College  
of Nursing

# Safer staff, better care

*RCN manual handling training guidance*

Lifts with care



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Liko UK Ltd develops, manufactures and markets patient lifts, placing safety and function first.

## Acknowledgements

Before producing the guidance, we held a series of focus group sessions throughout the UK in order to explore opinions about current training packages and ideas for the future. The groups included:

- ◆ back care advisers (BCAs) and manual handling experts
- ◆ RCN safety representatives
- ◆ nurses and nurse managers
- ◆ health care assistants
- ◆ disability support groups
- ◆ education and training providers
- ◆ equipment manufacturers representing a range of manual handling products
- ◆ health and safety inspectors and HSE policy officers.

The guidance is based on these sessions, evidence from the literature and consultation with other stakeholders. We would like to thank everyone who took part in the focus group sessions and interviews. Special thanks go to Liko UK Ltd, who funded the project, health ergonomist Emma Crumpton, who completed the research work, and the RCN Advisory Panel for Back Pain in Nurses.

# Safer staff, better care

## *RCN manual handling training guidance and competencies*

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## Introduction

The Royal College of Nursing gets lots of requests for information about manual handling training. The College's Back in Work project (RCN, 2000) shows that achieving real improvements in staff health calls for an integrated approach. Management issues, staff issues, problem solving, change management, equipment provision and training must all be taken into account.

Often, though, providing training is the first – and sometimes the only – action employers take in attempting to comply with the manual handling legislation. According to UK health and safety law, this is unacceptable. This guidance puts manual handling training in the context of a fully integrated risk management system that meets all the legal requirements.

## Policy

The RCN has worked alongside Liko (UK) Ltd to produce this guidance, which is underpinned by our Safer Handling Policy:

“The aim is to eliminate hazardous manual handling in all but the most exceptional of life-threatening situations. Patients should be encouraged to assist in their own transfers and handling aids must be used whenever they can reduce the risk of injury. Handling patients manually may continue only if it does not involve lifting most or all of a patient's weight. Care must also be taken when supporting a patient and pushing and pulling should be kept to a minimum. Staff should assess the capabilities and rehabilitation needs of a patient to decide on which, if any handling aids are suitable.”

RCN, 2000 (first published April 1996)

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## Why do we need more guidance?

There has long been a need for definitive standards in manual handling training, and many authorities have issued training guidance in the past. However, much of this focuses on the content, length and duration of training, and adopts a prescriptive, didactic approach.

This guidance aims to reflect the diverse opinions and working practices of a range of professionals in different areas. It draws on research-based evidence of what works, and seeks to promote excellence in practice by setting the guidance within the framework of clinical governance.

It therefore focuses on the competencies staff need to achieve safer patient handling. The guidance aims to bridge the gap between theory and practice by changing attitudes and behaviour to managing manual handling risks in a variety of workplace settings.

## Clinical governance

Clinical governance is “A framework (or system) through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish” (DH, 1998).

To make sure the guidance complies with the existing clinical governance framework, we used a practice development model which takes into account the fact that manual handling activities also take place in non-clinical or social care settings.

## Practice development

This guidance is set in the context of practice development: how health care professionals can continue to develop their knowledge and skills in order to provide better patient care.

Practice development must be enabled and supported by facilitators who are committed to systematic, rigorous and continuous processes of change. These processes will free practitioners to work in ways that better reflect the perspectives of both service users and providers. There are three essential elements for successful implementation.

1. The nature of the evidence
  2. The context or environment
  3. The method of facilitation
- (Manley, 1992).

### 1. The nature of the evidence

Evidence should be scientifically robust. It should reflect the professional consensus and meet patient needs. There is a large body of evidence around the area of manual handling. This guidance incorporates information from relevant literature, particularly on manual handling as a solution to the problem of musculo-skeletal pain and injury.

### 2. The context or environment

The work environment should be receptive to change, with a culture that prioritises health and safety. Organisations must identify who is responsible for manual handling and give them the resources, time and knowledge they need to carry out the necessary tasks (HSE, 1999).

### 3. Method of facilitation

Organisations should use skilled external clinical facilitators to bring about changes in the work

environment. Practice development theories identify two forms of facilitation.

1. **Task facilitation** – where facilitators enable individuals or groups to carry out a specific task.
2. **Holistic facilitation** – a complex, systemic process, enabling and empowering individuals or groups to analyse, reflect and change their own attitudes, behaviours and ways of working. Holistic facilitators help people use new theoretical insights to transform themselves and change the systems that hinder improvements in practice.

According to our focus groups, task facilitation is the most common type. However, the literature states that “holistic facilitation” is necessary to achieve excellence in practice. Clinical supervision is one potential model of a holistic facilitation style.

## Clinical supervision

Clinical supervision describes the formal process of professional support and learning which helps individual practitioners to develop knowledge and competence, assume responsibility for their own practice and safeguard patients in complex clinical situations. Clinical supervision can take place individually or in groups. The exact model to be followed will vary according to the organisational context (RCN, 1999).

## A new approach

The principles of change management and participative ergonomics underpin this guidance. The terminology used should reflect the move towards a new model. Instead of “training” we will use “education” when talking about formal updates and achieving core competencies, “supervision” when discussing line management and “facilitation” to refer to refresher or problem-solving sessions, and to co-ordinating supervision activities.

This guidance promotes a patient-centred approach and excellence in care. Staff health and patient care should no longer be viewed as two separate issues (RCN, 2001); excellence in manual handling is part of achieving excellence in care. The aim is to change practice and staff behaviour by creating a good manual handling culture based on a sound education process with adequate supervision.

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# The guidance – what to do

This guidance covers:

- ◆ creating the right context among both staff and clients for a successful manual handling culture, including an organisational flowchart and details of responsibility, accountability and delegation
- ◆ facilitating change, including the personnel needed
- ◆ practical steps towards achieving the competencies needed
- ◆ the documentation needed to audit and review the change process
- ◆ patient/client needs
- ◆ a list of competencies required for back care advisers (BCAs), supervisors and other staff.

## The right context

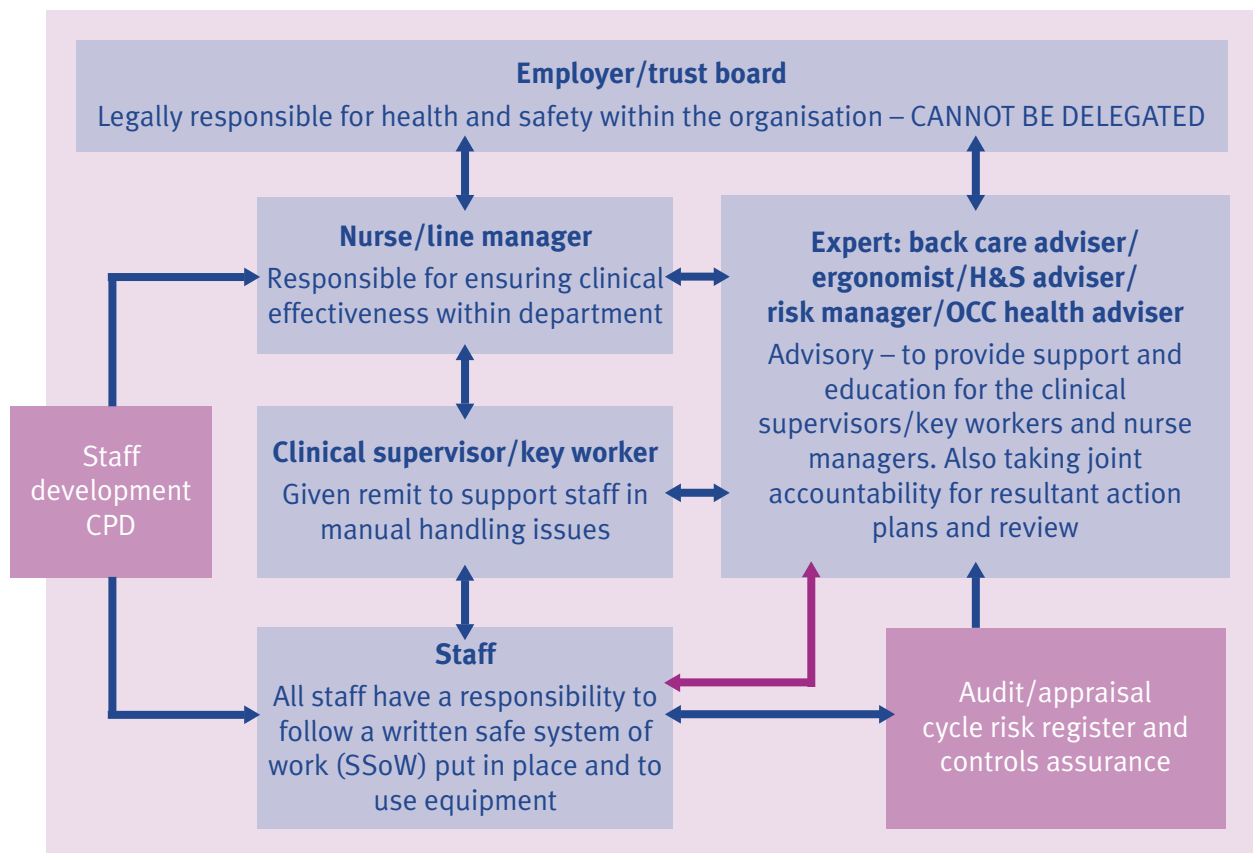
The right organisational context is one that helps staff achieve the competencies they need. It should include the following (see flow chart below).

### Responsibility

The employer/chief executive has ultimate responsibility under the law, which cannot be delegated. If the employer delegates the operational aspects of ensuring safer manual handling, they must ensure the person responsible has adequate time, resources and knowledge (see under “Delegation” below) (HSE, 1999).

### Accountability

In order to optimise staff health and patient care the “risk management” audit process should stipulate adherence to the manual handling policy. This will allow staff to give manual handling risk feedback to their employer, in turn helping employers to meet their statutory responsibilities.



FLOW CHART showing responsibilities and possible structure to ensure a good organisational context

## Delegation

Delegation must be handled through the line management chain, starting with a nominated board member with overall responsibility for managing manual handling risks. Roles and responsibilities should be clearly stated in job descriptions and monitored through regular appraisal. The first frontline level of management will be the clinical manager.

Good management practice within an agreed system of manual handling supervision is essential. Manual handling is a core competency for many staff caring for patients, and managers are responsible for assessing and assuring the clinical effectiveness and competence of their staff in this as well as all other clinical areas.

## Facilitating change

As well as the right organisational context, the right personnel are essential to facilitate change, ensure that staff get the training they need, and provide ongoing clinical support and supervision.

### Personnel

The manager is responsible for making sure good manual handling practice is followed in all care settings. Managers can delegate this task to any competent person, provided they have adequate time, resources, knowledge and competence (HSE, 1999) – a clinical supervision model (RCN, 1999) may help managers assess and enhance staff competence.

This person – the manual handling supervisor or key/link worker – is responsible for supervising manual handling in their work area. They must have all the necessary competencies to fulfil the role and meet the standards set by organisational policy and legislation (see below, under “The competencies”).

Whoever is responsible for managing manual handling should have access to competent advice and the expertise of a back care adviser (BCA)/manual handling expert, who should also provide the necessary education. Risk managers, ergonomists, occupational health advisers and health and safety advisers can also be education providers. Throughout the rest of this guidance we will use the abbreviation “BCA” to refer to all such experts/competent persons.

Employers also need competent help from a BCA to apply the provisions of health and safety law, including the law relating to manual handling (HSE, 1999). Employers should consider appointing one or more employees to provide this help. If there is no competent person within the organisation, employers will need to look outside.

The BCA should be given adequate information and support, and must have all the competencies outlined in this document. The role of the BCA is mainly advisory, and should include facilitating a holistic approach to safer patient handling and manual handling in the organisation. The BCA should also be involved in formulating strategy.

A safe manual handling system is a legal as well as a professional requirement. The BCA should set up systems to ensure that all staff have adequate knowledge of manual handling issues, and that they achieve the competencies set out in this guidance before handling patients. The BCA should also help whoever is managing manual handling to achieve effective clinical supervision and keep their knowledge up to date.

### Facilitation techniques

The BCA should help and enable, rather than tell or persuade. The content and duration of training or practice development should be tailored to the specific needs of the trainees and to the context in which they work.

For example, a one-on-one supervision session with a competent staff nurse working with patients who have complex needs may take the form of a detailed individual risk assessment for each patient. By contrast, a community-based nurse supervising a small group of carers with a stable group of clients may choose a more prescriptive documented manual handling plan based on the needs of individual clients. Carers will normally be asked to tell managers about any changes in patient/client needs, so that care plans can be reviewed. This may in turn trigger a review of the skills staff need.



## Achieving the necessary competencies

**BCAs** must update their knowledge regularly so that they can advise at both strategic and organisational levels as well as facilitating the educational needs of manual handling supervisors.

**Appointed manual handling supervisors** must achieve and build upon their competencies so that they can advise line managers and staff.

**Managers** are responsible for the clinical competence of their staff and for ensuring that competencies are kept up to date. Managers can delegate this responsibility to a manual handling supervisor (see above under “Delegation”).

**All staff** should achieve the competence requirements listed in this guidance before handling patients. They should be given adequate supervision and opportunity to update the skills needed for their particular work area. Updates should take the form of both formal and informal clinical problem-solving, supervision and feedback on the job.

**Students on placement** must achieve the required competencies before handling patients. There should be a clear agreement on who is responsible for the assessment, supervision and support of students or cadets working in clinical areas.

## Documentation

All education and supervision sessions, whether formal (usually a classroom-based planned session) or informal (planned or unplanned, often “on the job”) should be documented. This can be done in various ways.

Documentation for formal sessions should cover content and duration, and include a list of attendees. Informal problem-solving sessions will often be documented in patient notes. Individual competence and progress should be documented in a personal development plan, to be reviewed and discussed with the line manager on a regular basis. Individuals can choose how frequently these reviews take place, although managers remain responsible for ensuring that individual staff contribute to the clinical effectiveness of the whole department.

## Patient/client needs

Manual handling is often carried out by family members and social care staff, who do not have access to a full-time expert. Care in a client’s home, for example, can present particular difficulties. Clinical supervision models, though, will work in any context, and managers are responsible for ensuring good practice.

BCAs can be brought in to provide specialist advice, and will need to develop an understanding of the specific therapeutic, clinical, organisational and client needs in each case. As in any other situation, the BCA must take joint responsibility for following up and reviewing any actions taken as part of their service to the employer.

This guidance does not affect the relationship between a disabled person and their personal assistant, who is employed by the disabled person to provide support in personal, domestic, social and employment activities. Training/clinical supervision should be set up following discussion and negotiation between the disabled person and their PA: the disabled person is an expert on their own handling needs, but not necessarily on biomechanics and safer handling practices. Disabled people have a duty of care in common law to ensure the safety of their employees, and may need to get advice from a BCA.



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# Competencies for manual handling

In this section we look at the competencies needed by:

- ◆ BCAs
- ◆ manual handling supervisors
- ◆ anyone handling patients/clients.

The competencies:

- ◆ should be used to underpin education plans and supervision sessions, to identify educational needs or skills gaps and to assess competence
- ◆ can be used to establish the curriculum and learning outcomes for formal and informal education or training sessions.

Staff can use the competencies to record achievements and to reflect on their practice development needs. Competencies can also be turned into audit standards.

## The required competencies

In the next section we look in detail at the competencies required by people involved in handling patients or clients.

## The three domains

The competencies fit into three domains of practice development needs.

1. Management of risk.
2. Creating safe systems of work.
3. Professional effectiveness and maintaining standards.

Each domain contains written competencies to be achieved by the three staff groups. This guidance specifies both the competency to be achieved and the performance criteria necessary to demonstrate it.

### Domain 1: management of risk

#### Competencies for back care advisers

#### 1 Identify, assess and reduce risk at organisational and departmental level

##### Performance criteria

- A Evidence of the development and implementation of a system for monitoring and analysing safe systems of work, including the upkeep of detailed records.
- B Evidence of the development and implementation of a communications strategy throughout the organisation, including feedback to and liaison with clinical managers, the board and individuals.
- C Attendance at relevant strategic/operational organisational and departmental meetings. There should be evidence of written reports and feedback to appropriate staff.
- D Evidence of facilitating appointed manual handling supervisors and others where appropriate to ensure safer manual handling.
- E Evidence of a rigorous audit trail to demonstrate effectiveness.
- F Evidence that effective risk assessments have been completed – with review dates – and that they have been followed up.

### Competencies for line managers/appointed manual handling supervisors/key workers

#### 1 Identify, assess and reduce risk at departmental level

##### Performance criteria

- A Evidence of implementing an organisational system for monitoring and analysing safe systems of work in local areas.
- B Evidence of maintaining and supporting the communications strategy throughout the organisation.
- C Attendance at relevant organisational and departmental meetings and dissemination of information to staff. There should be evidence of effective communication among departmental staff, for example documentation showing effective handovers, care planning and problem-solving.
- D Evidence of facilitating staff to ensure safer manual handling within the department.
- E Evidence of compliance with and completion of the organisation’s audit trail to demonstrate effectiveness.
- F Evidence that effective departmental risk assessments have been completed – with review dates – and that these have been followed up.
- G Evidence of compliance with all manual handling policies and procedures by all staff within the department.
- H Evidence of supervision of all staff, including completion of records of competence in manual handling for each staff member.

### Competencies for all patient/client handlers

#### 1 Work within agreed framework to minimise risk to self and to patient

##### Performance criteria

- A Evidence of compliance with safer patient handling techniques and organisational and local safe systems of work. Recorded in competency record.
- B Evidence of the ability to select and use appropriate equipment for client needs and safer patient handling. Recorded in competency record.
- C Evidence of attendance at handover and contribution to care planning and problem-solving. Recorded in notes/minutes of meetings and personal development plan/competency record.
- D Evidence of implementation of care plans and understanding/reporting of problems or changes in risk assessment using the “Task, Individual, Load, Environment” (TILE) format. Recorded in competency record and personal development plan.
- E Evidence of taking up opportunities for formal and informal education and discussing manual handling training needs with line manager. Recorded in teaching session registers or notes/minutes of meetings.
- F Evidence of knowing when to stop and ask for help or guidance, including knowing the risk to self of unsafe manual handling practices. Recorded in competency record.
- G Evidence of understanding body dynamics and safer patient handling principles using reflective practice skills. Recorded in competency record and personal development plan.

## Domain 2: creating safe systems of work

### Competencies for back care advisers

#### 1 Enable individuals and groups within the organisation to carry out manual handling activities safely, with minimal threat to their musculo-skeletal health

##### Performance criteria

- A Evidence of facilitating others and supervising organisational success in the risk assessment process. Line managers should be able to understand and evaluate TILE assessments.
- B Evidence of the development and implementation of a strategy to ensure organisational success in equipment provision, selection and usage. This includes facilitating and supervising manual handling supervisors and line managers so they understand the needs of their departments and how to meet them.
- C Evidence of facilitation of manual handling supervisors and line managers to ensure that the organisation encourages staff to care for their own musculo-skeletal health. This involves formally and informally supervising the education of manual handling supervisors and line managers.
- D Evidence of the development and implementation of a strategy to ensure that the organisation evaluates client needs in the context of safer handling practice. This will involve care planning and facilitating and supervising the education of line managers to ensure that they understand the manual handling needs of their client group.
- E Evidence of advocacy between (a) staff and clients, (b) staff and the organisation, and (c) other staff.
- F Evidence of advice to the organisation on appropriate equipment purchase strategy based on proactive audit, evaluation (including user trials) and selection to enable each department to meet its clients' needs.

#### 2 Working with others to create and sustain a culture which promotes health in the workplace with respect to musculo-skeletal injury issues

##### Performance criteria

- A Evidence of influencing organisational change by providing evidence at strategic and operational levels of the implementation of actions identified following risk assessment, including review and evaluation of success.
- B Evidence of influencing and directing policy and practice including dynamic/changing (according to evidence) manual handling policy and procedures. This should be reviewed regularly.
- C Evidence of collaboration with all other key stakeholders, user groups and other staff. This includes networking links to groups within and without the organisation.

## Competencies for line managers/appointed manual handling supervisors/key workers

### 1 Enable individuals and groups within their local area to carry out manual handling activities safely, with minimal threat to their musculo-skeletal health

#### Performance criteria

- A Evidence of facilitating staff and supervising local performance in the risk assessment process. This includes ensuring that all staff can understand, evaluate and follow a basic TILE assessment.
- B Evidence of facilitating staff and supervising local performance in equipment provision, selection and usage. This involves documented discussion with staff about equipment problems and shortfalls in order to ensure that appropriate equipment provision is requested via the channels set out by the BCA.
- C Evidence of working with staff and the BCA to ensure that equipment meets the needs of the client group.
- D Evidence of facilitating staff and supervising local performance in encouraging staff to care for their own musculo-skeletal health. This involves giving all staff the opportunity to be educated in understanding musculo-skeletal risk and self help.
- E Evidence of facilitating staff and supervising local performance in evaluating client needs in the context of safer handling practice. This involves ensuring that care plans and individual client assessments are carried out and documented, that these are appropriate and that recommendations are implemented by all staff. This can be documented at staff meetings and handovers.
- F Evidence of advocacy between staff and clients, and other staff.
- G Evidence of supervision and problem-solving with individuals and groups within the department. This will include identifying needs and shortfalls with staff and providing supplementary input where necessary. Completion of staff competency records and informal training sessions, including patient notes and handovers, will provide this documentation.
- H Evidence that staff recognise their own limitations. Requests for help should be documented.

### 2 Working with others to create and sustain a culture which promotes health in the workplace with respect to musculo-skeletal injury issues

#### Performance criteria

- A Evidence that actions identified following risk assessment have been implemented, including review and evaluation of performance within the local area.
- B Evidence that organisational policy and practice has been implemented within the local area and that results are regularly reviewed.
- C Evidence of collaboration with other staff and clients in implementing policy and procedures.

### Competencies for all patient/client handlers – minimum requirements

#### 1 Comply with departmental and organisational policies and procedures to carry out manual handling activities safely, with minimal threat to their musculo-skeletal health

##### Performance criteria

- A Evidence of contributing to the risk assessment process within the local area including the ability to understand, evaluate, and follow a basic TILE assessment. Recorded in competency record and personal development plan.
- B Evidence of contributing to departmental decision-making in equipment provision, selection and usage to meet client needs. Recorded in meeting records and then in competency record and personal development plan.
- C Evidence of maintaining self-care in relation to musculo-skeletal health. Recorded in competency record and personal development plan, and attendance at the relevant education sessions where appropriate.
- D Evidence of ability to act as an advocate for clients; that is, of understanding client needs. This will be reflected in their contribution to problem-solving and care planning.
- F Evidence of participation in problem-solving sessions and care planning for safer patient handling. Recorded in competency record and personal development plan.
- G Evidence that they recognise their own limitations. All requests for help should be documented.
- H Evidence of supporting co-workers to ensure that policy, procedures and departmental risk assessments are followed. Recorded in competency record and personal development plan.

#### 2 Working with others to create and sustain a culture which promotes health in the workplace with respect to musculo-skeletal injury issues

##### Performance criteria

- A Evidence of collaboration with other staff and clients in implementing policy and procedures. Recorded in competency record and personal development plan.

## Domain 3: professional effectiveness and maintaining standards

### Competencies for back care advisers

#### 1 Maintain accurate records and documentation that comply with professional, legal and administrative requirements

##### Performance criteria

- A Evidence of a system for ensuring clear, legible, confidential records of risk assessment throughout the organisation, including evaluation dates, follow-up and outcome information.
- B Evidence of a comprehensive system for staff education which meets the legal standard and includes the achievement of competencies by managers or appointed manual handling supervisors. Both formal and informal teaching should be recorded.

#### 2 Promote improved standards of quality of care of clients/patients

##### Performance criteria

- A Evidence of evaluation of research, expert opinion and other evidence and the integration of new ideas into existing policies and procedures for continuous improvement in client/patient care.

#### 3 Practice and promote continuing professional development (CPD)

##### Performance criteria

- A Evidence of taking responsibility to enhance, update and develop appropriate knowledge and skills.

### Competencies for line managers/appointed manual handling supervisors/key workers

#### 1 Maintain accurate records and documentation which comply with professional, legal and administrative requirements

##### Performance criteria

- A Evidence of clear, legible, confidential records of risk assessments within the department, including evaluation dates, follow-up and outcome information.
- B Evidence of up-to-date care plans for all patients with risk assessment integrated into the process.
- C Evidence of both formal and informal teaching and problem-solving in order to achieve and build upon the minimum standard competencies for all staff.

#### 2 Promote improved quality of patient care

##### Performance criteria

- A Evidence of the integration of new, evidence-based ideas into existing departmental procedures for continuous improvement in patient/client care.



### 3 Practice and promote continuing professional development (CPD)

#### Performance criteria

A Evidence of taking responsibility to enhance, update and develop appropriate knowledge and skills.

### Competencies for all patient/client handlers – minimum requirements

#### 1 Maintain accurate records and documentation which comply with professional, legal and administrative requirements

#### Performance criteria

A Evidence of working with line manager to keep clear, legible, confidential records of risk assessments within the department. These should include evaluation dates, follow-up and outcome information. Recorded in competency record and personal development plan.

B Evidence of contributing to the maintenance of up-to-date care plans that reflect risk assessments. Recorded in competency record and personal development plan.

C Evidence of receipt of formal and informal education and problem-solving, including identification of education needs in collaboration with line manager.

#### 2 Promote improved standards of quality of care of clients/patients

#### Performance criteria

A Evidence of working with colleagues to ensure that all staff work within policies and procedures. Recorded in competency record and personal development plan.

B Evidence of feeding back on the effects of the integration of evidence-based new ideas into practice for continuous improvement in client care. Recorded in staff meeting minutes and handovers, and in competency records.

### 3 Practice and promote continuing professional development (CPD)

#### Performance criteria

A Evidence of taking responsibility to enhance, update and develop appropriate knowledge and skills.

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## Case studies

The evaluated projects outlined below provide two examples of how the competency approach to manual handling training works effectively in practice.

### Case study 1

When electric beds were introduced at Kings College Hospital, the hospital devised a comprehensive training programme for staff including:

- ◆ specific training sessions organised and held centrally
- ◆ provision of one bed on the receiving ward prior to full equipping to allow staff to familiarise themselves with the equipment
- ◆ on ward training during delivery and over the next three days
- ◆ repeat training during monitoring visits throughout the first month following installation.

Six months later, the effectiveness of the training was audited along with the staff's ability to use the beds. The audit showed that despite the training programme, 25 per cent of the staff still felt that their training had been inadequate. Tests showed that only 50 per cent of staff knew how to convert the bed into the chair position, while only 25 per cent knew about the lockout controls and how to locate and use the egress handle.

The company that supplied the beds has now built training into the service support it provides. Key performance targets, including the provision of direct local training and problem-solving, have been incorporated into nurse advisers' objectives. These targets are monitored quarterly and have financial penalties attached to them to ensure compliance.

Manual handling refresher training and ward-based problem-solving sessions have focused on helping staff understand the key functions of the electric beds and get the maximum benefit from them. As a result, over 65 per cent of staff now have the knowledge they need. This work-based approach has also led to improved standards of practice.

### Case study 2

Nottingham City Hospital is a 1,200-bed specialist teaching hospital. It employs approximately 5,000 staff, of whom 50 per cent are nurses. Since 1994 Dr Sue Hignett has been leading a project to incorporate ergonomic principles into the trust's strategies for managing manual handling risks.

The ergonomic strategy includes both top-down and bottom-up approaches. In the six years since the strategy was implemented, the number of manual handling incidents and days lost due to musculoskeletal sickness absence has consistently gone down. A simple calculation carried out by the HSE (based on the Wigan and Leigh model) suggests that the strategy has led to savings of more than £3,690,000 over the three-year period between 1996 and 1999.

The standard for back care training states that all staff should attend a back care session within a month of starting work. New starters should not be asked to carry out patient handling tasks until they have attended a training session. Updates are required every two years for patient handling staff and every three years for other staff. For more details about this case study see Hignett (2001).

## 6

## Getting RCN approval for your training programme

RCN accreditation assures the quality of a product, person or place, and means that it is fit for purpose and for practice. Our professional accreditation differs from academic validation in that it examines the impact that the person being accredited or the product being approved can have on nurses, nursing or the environment or culture of care.

Our purpose is to improve care for patients and clients, our ultimate beneficiaries. By approving educational initiatives such as moving and handling initiatives, both nurses and their employers can be assured of the quality of the training that nurses have undertaken and the care that they can deliver.

### How to gain accreditation

Contact the RCN Accreditation Unit (RCN AU) (see the bottom of this section for contact details). If your initiative is a study day, workshop, seminar, training course or similar initiative that lasts for between one and five days and does not lead to a formal award, please ask for an approval of events pack.

If your initiative includes a range of content and teaching strategies on a coherent theme and there will be a clinical assessment of the course material, possibly including the development of a personal portfolio which could be submitted for APL/APEL at a recognisable level, please request a pack for the approval of short professional courses. Initiatives in this category will normally last for over five days.

Once you have received your pack, please complete the application form and send it to the RCN AU with the appropriate fee and a rationale stating how your initiative addresses each of the competencies.

All applications are sent to a subject reviewer and educational reviewer whose job is to decide whether the application meets the standards for RCN approval. They will also write a report justifying their decision. If the reviewers have any concerns about your application we will help you address these, shaping your initiative so that it gets approval and meets the latest government recommendations, offering the best service to nurses and their employers.

### Certificates

All nurses attending RCN AU approved initiatives are issued with a certificate from the RCN AU showing either the number of hours attended or the number of CEPs awarded.

The RCN developed CEPs as a form of “professional currency” to help nurses keep track of their own CPD. CEPs are available wherever active learning can be demonstrated – this might mean asking nurses to complete a reflective practice profile, or developing an action plan for putting learning outcomes into practice.

If you would like your attendees to gain CEPs, this should be built into the original application for approval. You should also indicate who will be assessing this active learning, and explain why they are qualified to do this.

Certificates can be kept in the individual nurse’s portfolio, showing the number of hours of CPD undertaken. They can also help nurses meet PREP requirements for the Nursing and Midwifery Council (NMC).

## Competency and criteria achievement

The competencies in this document will enable your organisation to improve its manual handling systems. They can be achieved only in the context of a positive health and safety culture. If you would like to get your training programme approved by the RCN, please complete the grid below to show that you have met the initial criteria for approval and send it to the RCN AU along with your other application forms.

Criteria	Yes/No
A The programme meets the appropriate competency levels outlined in the guidance	
B The programme shows the link between training for manual handling and supervision of staff in the workplace and also shows how trainers manage this link	
C The assessment of practice is linked to environmental management, risk management and care planning in the workplace	
D The trainers used in the programme meet the competencies listed in this guidance for a BCA or key worker	
E The programme shows how supervision of practice in the workplace is used as part of the training process	
F The programme includes a communication strategy for promoting best practice in manual handling within the workplace	

## Contact details

If you have any enquiries about RCN approval please contact the RCN Accreditation Unit  
 20 Cavendish Square  
 London W1G 0RN  
 Tel: 020 7647 3824/3716/3647  
 Email: [accreditation@rcn.org.uk](mailto:accreditation@rcn.org.uk)

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