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Moments of speaking and silencing: Nurses share their experiences of manual handling in healthcare

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Summary Nursing care involves complex patient handling tasks, resulting in high musculoskeletal injury rates. Epidemiological studies from the 1980s estimated a lifetime prevalence of lower back injuries for nurses between 35 and 80%. National and international studies continue to mirror these findings. Despite the development of programs intended to reduce manual handling injuries, sustainable solutions remain elusive.

This paper reports on a study of nurses speaking about their perspectives on current manual handling practices. Qualitative research conducted in 2012 investigated nurses' perceptions and experiences relating to manual handling in the healthcare context and their participation in injury prevention programs. There were two research methods: semi-structured interviews and researcher reflective journaling. The research was framed in critical emancipatory methodology. Thirteen nurses from two Australian states participated in the study.

Thematic analysis revealed an overarching theme of 'power relations' with a subcategory of '(mis)power' that comprised two subthemes, these being 'how to practice' and 'voicing practice issues'.

Specifically, this paper explores nurses verbalising their views in the workplace and responses which left them feeling silenced, punished and disillusioned. The findings suggest that the sociopolitical context within which nurses practice impacts upon their ability to voice concerns or ideas related to manual handling. Inclusion of nurses in the manual handling dialogue may generate an expanded understanding of, and the potential to transform, manual handling practices in healthcare environments.

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Introduction

This paper presents a dataset from a recent qualitative study on manual handling in healthcare. The research was situated in the critical paradigm and the findings highlight the importance of including nurses' perspectives in the dialogue that informs approaches to manual handling injury prevention in the healthcare sector.

The paper begins with an overview of the context for manual handling, specifically noting the historical marginalisation of nurses in the management of manual handling issues. The major component of the paper follows, this being a discussion of the data associated with power relations and the challenges embedded within voicing practice issues.

Manual handling

Manual handling has been variously defined as actions that require the application of force to perform a particular task or task sequence. Whilst the precise definition varies according to national and international jurisdictions, the common thread is that of physical activity associated, but not confined to, lifting or moving objects or people in some manner (ASCC, 2007; Garg & Kapellusch, 2012; Hignett et al., 2007; HSE, 1992; Iakovou, 2008; WorkSafe Victoria, 2000). The provision of nursing care to patients in healthcare facilities necessarily entails manual handling and hence is an integral part of nursing practice (Holman, 2006; Retsas & Pinikahana, 2000). Research conducted over many years has yet to firmly resolve ongoing issues regarding injuries to clinicians consequent to manual handling activities. In particular, disproportionately high injury rates exist within the nursing and allied health professions (ASCC, 2009; Cromie, Robertson, & Best, 2000; D'Arcy, Sasai, & Stearns, 2012).

Injuries from manual handling

Musculoskeletal disorders (MSDs) comprise a broad range of injuries that arise from manual handling actions. The aetiology of MSDs is multifactorial thus potentially confounding the direct identification of causal links for MSDs and the recognition of actions required to prevent their development (Punnett & Wegman, 2004; Yassi & Lockhart, 2013). Despite the external validity threats arising from pre- and post-research designs, some case study findings suggest that a causal relationship between manual handling and MSDs is likely (Charney et al., 2010). Punnett and Wegman (2004) posited that ''an international near-consensus'' (p. 19) has been reached regarding the risks associated with repetitive movements, forceful exertions, non-neutral body positions and exposure to vibrations. On this basis, widespread development of guidelines and policies premised upon ergonomic principles for MSD prevention has ensued (ASCC, 2007; Hignett et al., 2007; HSE, 1992; WorkSafe Victoria, 2000).

An exception to the ''near-consensus'' (Punnett & Wegman, 2004, p. 19) was a review by a Canadian group of medical specialists and researchers that disputed associations between assisting patients and the development of low back pain (Roffey, Wai, Bishop, Kwon, & Dagenais, 2010). Their findings have been heavily criticised by other researchers due to contentious design issues (Yassi & Lockhart, 2013).

MSD prevalence in healthcare

MSDs occur in response to either a specific incident or alternatively as a result of cumulative damage over extended time periods. Musculoskeletal trauma that is not immediately apparent results in delayed recognition and treatment. The inability to link cumulative injuries directly to specific events further hinders an understanding of injury causality and therefore the development of effective injury prevention strategies (ASCC, 2006; Burdorf, Koppelaar, & Evanoff, 2013). Challenges in MSD detection and diagnosis, limitations on injury claims and cultural influences that discourage injury reporting, all contribute to inaccuracies in MSD prevalence data for the healthcare workforce (ASCC, 2006; Menzel, 2008; Safe Work Australia, 2009).

Despite potential underestimations, the prevalence and persistence of MSDs in healthcare has raised serious concerns internationally. An extensive and seminal review of the international literature by Buckle (1987) had a combined sample of 3912 nurses and suggested an annual low back injury rate of 40—50%. International studies consistently generate similar findings. Recent cross-sectional studies in Australia with high response rates have confirmed Buckle's findings and estimate that 95.5% of nurses will suffer an MSD during their professional lives (Mitchell, O'Sullivan, Burnett, Straker, & Rudd, 2008). Findings from other well-designed Australian studies endorse these estimates and have found comparable injury rates amongst student nurses (Mitchell et al., 2008; Retsas & Pinikahana, 2000; Smith & Leggat, 2004).

Marginalisation of nurses' manual handling experiences

Medical advances and the centralisation of healthcare have altered the structure of nursing work and increased the manual handling workload for nurses. However the potential impact of these developments received little attention until the emergence of MSD symptoms within the nursing workforce (Collins & Menzel, 2006). This prompted the education of nurses in 'good body mechanics', an approach devoid of empirical evidence, alongside judgements about the competency and integrity of injured nurses (Collins & Menzel, 2006; Garg & Kapellusch, 2012).

Medical and educational paradigms have continued to dominate manual handling injury prevention strategies (Charney et al., 2010; HSE, 2007; Koppelaar, Knibbe, Miedema, & Burdorf, 2013). Locally and globally, nurses have had minimal input into prevention programs and the contextual influences on nurses' manual handling practices have been largely overlooked (Kay, Glass, & Evans, 2012). The historical subordination of nurses' manual handling experiences demonstrates the need for an investigation of nurses' perspectives on manual handling, highlighting any sociopolitical factors that influence manual handling practice in the complex healthcare environment.