G16	Standard	Stroke units moving and handling (M&H)

The Standard

Systems are in place to cover all reasonably foreseeable situations in **managing the M&H of stroke patients**

Justification

Rationale

It is important to maximise function and minimise risk of complications and disability for patients. The provision of patient centred care is paramount with this group. The involvement of family and carers from an early stage is vital. Injury to patient, staff and family carers must be prevented. It is essential that care is taken when handling the affected shoulder and arm.

Authorising Evidence

HSWA (1974); MHOR 2004 (as amended); MHSWR (1999); DH (2001); DH (2007)

Links to other published standards & guidance

ACPIN (2001); CSP (2008); NICE (2008); CG 68; ISWP, RCP (2012); NPSA (2008); Ruszala et al (2010)

Cross reference to other standards in this document

B3-9, 12, 13; C; D1-4, 6-9, 11; F; G2, 8, 15, 17, 18, 21, 22, 23, 24, 31, 32, 39, 42

Appendices

4, 13-17, 20, 21, 26

Verification Evidence

- requirements for compliance to achieve and maintain this standard

- Arrangements within the organisation show that the national guidelines (ISWP, RCP 2012) are followed, e.g. MDT assessment and rehabilitation commences within 24 hours/ as soon as the clinical condition allows
- There is evidence that correct stroke positioning is observed
- Generic assessments are carried out and developed into protocols, which are implemented
- The environment is conducive to the handling of stroke patients
- All staff are trained to the level of competence required to handle stroke patients and there is suitable and sufficient local supervision
- Audits and incident reports identify equipment available and control measures are in place for high risk tasks
- There is evidence of the involvement of family and community carers

G16 Protocol - Stroke units (M&H)

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1. Introduction and background

Stroke affects between 174 – 216 people/ 100,000 population in the UK each year (Mant et al, 2004, cited in ISWP, 2012). Every five minutes, someone somewhere in the UK has a stroke (Stroke Association website). Whilst primarily affecting older people, a stroke can occur at any age from before birth onwards. In fact, one quarter of people who have a stroke are under 65 (DH, 2007). Stroke is the single largest cause of adult disability (DH, 2007). Stroke results in significant morbidity and survivors of stroke represent a substantial health and resource burden (NICE, 2008).

2. Management, organisation, supervision and support

Patients should be seen by at least one member of the MDT within 24hours for assessment, and by the rest of the team within 5 days (ISWP, 2012). Thereafter, weekly MDT meetings (ISWP, 2012, SIGN, 2010) should take place where problems are identified, meaningful and achievable rehabilitation goals are set, progress monitored and discharge is planned.

A common and potentially serious complication of stroke is dysphagia. This is associated with the development of pneumonia (Foley et al, 2008). Early multidisciplinary assessment should include swallow screening. Management may include feeding strategies, ideal positioning for patient and staff, appropriate seating, and liaison with family or care workers. It is paramount that all staff on the Stroke Unit are aware of patients with feeding difficulties to avoid clinical incidents such as offering inappropriate food and drink.

Rehabilitation should be patient centred (SIGN, 2004). Patients and family carers should have an early active involvement in the rehabilitation process. It is necessary to seek consent from the patient to involve family members. Patients should be mobilised as soon as safely possible.
Stroke handling management should be through a special training, supervision and assessment programme with the identified Manual Handling Key Worker and/ or Manual Handling Practitioner (MHP).

3. Staffing levels

To assess initially it is advisable to have two handlers. Post assessment the number will depend on stroke severity. Occasionally a third will also be required to position a wheelchair or chair, and to adjust clothing.

A typical staffing structure for a 10 bed unit providing good stroke care would be (SIGN, 2004);
Nurses - 10 WTE per 24 hour shift, in ratio of 2 registered:1 assistant
Physiotherapists – 1-2 WTE divided between qualified and assistant
Occupational therapists – 1-2 WTE divided between qualified and assistant
Speech and language therapist – 0.2-0.6
Social worker – 1 part time.
There is specific guidance within the London area for the level of staffing required to run a stroke unit. These vary from other guidance especially in nursing, where:
For Hyper stroke units; 2.9 WTE nurses are required per bed
For Acute stroke units: 1.3 WTE are required at a ratio of 65:35 registered: unqualified.

4. Staffing competencies (after Benner, as cited in Ruszala et al, 2010)

Novice – possible groups – all students, new staff (qualified and un-qualified) with little or no experience of working with stroke, and family members.

Advanced beginner - some students and new staff with some prior experience of stroke e.g. previous work on a stroke unit.

Competent - staff who have been working on the stroke unit, who have received additional stroke handling training, who have been supervised in the unit and assessed as such. New staff who have been assessed as such.

Proficient - the Manual Handling Key Worker who has received additional education, training, supervision and assessment.

5. Environment

It is particularly important that the space recommendations should be followed. The minimum bed space recommendation is 3600mm wide x 3700mm deep, (DH, 2008). However, research carried out by Hignett & Keen (2005) concluded that the minimum bed space requirement should be increased to 3600mm x 4700mm to accommodate mobile hoists and resuscitation tasks. However, adequate space is essential in all clinical areas such as bathrooms, toilets, dining room (see also point 12).

6. Communication and information systems regarding initial referral

Patients should be admitted to a dedicated stroke unit directly from the A & E department (ISWP, 2012). Where this is not possible due to bed availability, any outliers should be moved as soon as possible onto the unit. In the interim, staff on the host ward should be shown correct positioning, handling and ways of encouraging stroke patients to do as much as possible for themselves by a member of the stroke unit MDT, preferably the stroke unit Manual Handling Key Worker or a MHP. (See also G31 – 'Outliers').

7. Treatment planning

Recovery may take from a few days to years and both short and long-term support needs to be provided (DH, 2007). All aspects of care must be patient-centred, and where possible based on full discussion with the patient and/ or the family (NICE, 2008). Stroke unit care is the biggest factor that can improve outcomes following stroke (DH, 2007), built around a MDT. As each profession may consider the patient from a different perspective, co-operation and consultation between members of the MDT is essential (ISWP, 2012). Problems need to be identified, rehabilitation goals (outcomes) set (short and long-term), progress monitored, and discharge planned. All professionals should have a common understanding of the goals agreed for each patient (DH, 2001). Goals are often linked with the ADL, and these can be linked to the patient/ person manual handling risk assessment (PHRA). The team should promote the practice of skills gained in therapy into the patient's daily routine in a consistent manner, enabling the patient to practice as much as possible (ISWP, 2012), which should increase physical independence and ability. These goals and outcomes should be discussed with the patient and family regularly (ISWP, 2012). The ISWP recommend that;

- Healthcare workers (handlers) consider their knowledge, training, competence, health and physical capabilities before manual handling, taking into account the setting and available equipment
- All team members handling patients should be taught safe and appropriate ways of moving and handling and should be taught to adopt a consistent approach for any single patient
- Local teams should provide training opportunities for all staff in moving and handling to enhance the patients' rehabilitation
- The patient and/ or handler should be thoroughly trained in the safe and effective use of any equipment supplied
- The team should promote the practice of skills gained in therapy into the patient's daily routine in a consistent manner.

Rehabilitation should be started within 24hours of admission (DH, 2001), certainly once the patient's clinical condition has stabilised. There should be early mobilisation following assessment (National Collaborating Centre for Chronic Conditions, 2008; NICE, 2008).

8. Moving and handling tasks

These will be those associated with the activities of daily living (ADLs). Because the aim of all healthcare workers and handlers will be to maximise function and minimise risks of complications, and disability, the patient must be encouraged to do as much as possible for himself as soon as possible. In the initial stages, and particularly if the patient is unconscious, care must be taken in positioning and handling the patient to minimise complications due to immobility, such as abnormal tone, contractures, pain, respiratory problems and pressure ulcers (ISWP, 2012). Studies relating to patient positioning indicate that patients should be positioned on both the sound and affected sides, however, care must

be taken to ensure oxygen saturation levels and respiratory function remain satisfactory (NICE, 2008). Lying on alternate sides also aids functional recovery by providing appropriate sensory stimulation and increasing spatial awareness (SIGN, 2010). Patients should be placed in an upright sitting position as soon as their medical condition allows (ISWP, 2012; SIGN, 2010). This assists oxygen saturation, improves respiratory function and facilitates a better posture for drinking and eating/ feeding, reducing the risk of aspiration. (ISWP, 2012). Sitting upright stimulates postural and balance reactions. When first sitting up/ out of bed, the duration must be within the person's tolerance. Consider specialist seating to reduce tissue viability risks, increase safety, reduce fatigue and maintain a good posture. Employ forward planning for the return to bed. It is generally accepted that patients with reduced mobility need to be turned and positioned regularly, every 2-3hours initially, less as the patient becomes more independent. Lying supine has a tendency to increase the patient's tone and there is more risk of pressure ulcers developing on the sacrum and more commonly on the outside of the heel, hence it is better for the patient, whilst in bed, to lie on alternate sides (Johnstone, 1995). Supine lying may cause the affected leg to externally rotate, and the affected arm to retract and flex, unless pillows are used to help counteract this. Use of wedges and T–rolls may also be appropriate; this will be assessed by the therapists. Particular care must be given to handling and positioning the affected shoulder and arm to minimise shoulder pain and mechanical stress (ISWP, 2012). Incorrect handling is a major contributing factor in the development of shoulder pain.

Correct positioning and handling should also include the correct positioning of the patient in the room or ward, and correct positioning of the furniture. Ideally, the patient will be positioned in such a way that he has to look across his affected side to see what is going on around him, to try to avoid neglect of the affected side and increase spatial awareness (Johnstone, 1995; SIGN, 2010).

The most challenging activities for both patient and staff will be during rehabilitation. The patient will be re-educated in sitting in order to normalise tone and gain trunk control, and then in standing. Various transfers will also be part of the programme, and walking will follow.

9. Moving & handling assessment

Guidance in the MHORegs as amended (2004) requires a generic or task based assessment to be undertaken to ensure a unit is properly designed and equipped. In addition, an individual patient assessment (PHRA) will be required for all patients, especially those with significant mobility needs. It is paramount to inform handlers of the patient's capabilities and how much assistance is required. If handlers are unaware of this information a patient cannot be handled with correct rehabilitative technique. This assessment should identify what tasks of ADL will be necessary, who should carry them out (patient, handlers or a mix of both) and how the patient will be moved and handled. It is recommended (ISWP, 2012) that patients be assessed within 4 hours of admission for their MH needs, and should be mobilised as soon as safely possible. However, stroke patients may not be able to tolerate a full PHRA initially. This may be due to the fact that they tire easily, but a start can be made, particularly when the PHRA ties in with ADL activities such as bed bath,

toileting. The PHRA needs to be available to all staff that handle the patient, so needs to be kept with the patient. It needs to be monitored, reviewed and updated if; the condition of the patient changes, the environment/location changes, or the equipment needs change.

Staff also need to have available to them some supporting information about the patient, such as weight and height; side affected/ bilateral (for brain stem stroke with bilateral weakness); sensory loss; consciousness level; muscle tone; muscle strength; the presence of any pain or joint stiffness; any breathlessness; skin condition; attachments e.g. a catheter; ability to hear and see; capacity to understand and follow instructions; ability to communicate; swallowing difficulties; attention and concentration; varying ability over 24 hours (CSP, 2008); bladder and bowel continence, any undue anxiety; motivation – although this may be impossible to assess initially; spatial awareness; any behavioural issues; importance of maintaining independence and dignity (CSP, 2008); and as the patient progresses, their ability to sit and stand, balance and weight bear. These factors, coupled with the PHRA, will inform the handlers of the patient's capabilities and handling requirements when undertaking various tasks.

10. Methods, techniques and approaches

A holistic, multidisciplinary, 24hour approach using a shared philosophy and common goals, including family and friends supporting the patient, the encouragement of normal movement, and approach from the affected side will all help limit secondary complications.

In every instance, any handling technique used is as a result of the PHRA, where the clinical reasoning in general terms is to:

- Encourage/ increase patient involvement to maximise functional ability and independence.
- Give awareness of movement.
- Increase awareness of the affected side.
- Achieve functional goals.
- Increase ability to transfer weight and weight bear.
- Strengthen muscles.
- Improve postural control and increase confidence in balance.
- Improve exercise tolerance.
- Enable change of position.
- Promote confidence.
- Enable relief of pressure. (ACPIN, 2001).

11. Handling equipment

There should be a suitable and sufficient amount of equipment available. Patients may require equipment for extended periods. This will also depend on factors such as the size of the unit, and would include the following:

11.1 Electric profiling bed - fully profiling and height adjustable.

11.2 Mobile sling hoist (passive lifter), if there is no overhead tracking system, with the facility to enable a patient to carry out 'hoist assisted' walking using walking vests.

11.3 Active/ standing hoist - to assist in care handling tasks e.g. moving patients from one seated position to another to use the commode. Some standing hoists have a toilet seat attachment. This hoist can also be used therapeutically to give patients the opportunity to safely return to weight bearing. Some of these also allow for 'hoist assisted' walking. Some active/ standing hoists are better than others with regard to following a therapeutically good pattern of movement when rising from sitting.

11.4 Slide sheets/ roller sheets long enough and wide enough to protect *all* of the patient's pressure areas when being moved in bed i.e. head and heels as well as buttocks. These sheets should also be wide enough to protect all body parts when carrying out turning.

11.5 Repositioning sheets – are desirable when caring for a patient who has suffered a dense stroke or a bariatric patient who has suffered a stroke. Used in combination with a hoist, as well as moving the patient up/down the bed this system can reposition patients on their side, reducing the load for the handlers.

11.6 Other equipment that will sometimes be required is;

- small transfer/ sliding boards for seated (sit to sit) transfers.
- turntables to assist patients who have difficulty in moving feet round during a seated or half standing transfer.
- a turning device with a handle (e.g. a rotastand) for those who need the security of not reaching so far to the chair. (Please note the instructions for turning devices with handles suggest four working limbs are required. A risk assessment undertaken by the therapist would assess whether the turning device was appropriate and safe to use, prior to using it on a specific patient.)
- a one way glide for those who need assistance to move back and stay back in the chair.
- a soft padded turntable for assistance in swivelling the buttocks round.
- a patient handling belt to guide the patient/ give the patient a greater feeling of security.

12. Other equipment and furniture

It is vital that the unit has chairs, commodes and wheelchairs with drop down or removable arms to facilitate seated transfers.

12.1 If the wheelchairs have air filled tyres, there needs to be a pump on the unit. The tyre pressure also needs to be checked regularly – hence a tyre pressure gauge will be required - to ensure a smoother journey for the patient. There should also be working brake/s. The wheelchairs will also require swing round or removable foot rests. Since these wheelchairs will be used to take patients to other departments, it is necessary, particularly if going out into the grounds, that seat safety belts are used. The number of wheelchairs will vary, depending on the size of the unit, but there need to be sufficient for those

patients who are unable to walk yet need to be transported to other areas in the ward, and to departments. Wheelchairs need to have a service contract and be regularly maintained. Wheelchairs on a Stroke Unit are used excessively; risk of injury increases when parts go missing, sides become difficult/ stiff to remove, canvasses sag or tear. Wheelchairs also need to be regularly checked by the handlers and problems reported to the line manager.

12.2 It is important the unit has chairs in differing heights, as well as some with drop down arms as mentioned above, even some adjustable height chairs, to accommodate the various heights of stroke patients. It is also advisable that the chairs have housekeeping wheels on the back legs that can be utilised when moving them around the unit, as need dictates, to create a safer system of work for handlers. It is essential that specialist seating is available (see G39 – Moving and handling issues in persons requiring seating).

12.3 Some stroke units have a dining room which can help encourage stroke patients to carryover skills acquired in their rehabilitation sessions into this social situation (24 hour approach). Eating at a table helps facilitate a good eating posture and encourages communication with others. The dining table must be able to accommodate wheelchairs and allow the patient to get close to the table. Dining chairs should have arms for patient security, and ease of facilitating safe sitting and standing. These chair arms should be able to go under the tabletop. Dining chairs can be purchased with integral glides to facilitate pushing the chair in and pulling it out.

12.4 Toilets should have sufficient space for assistance to be given, by 2 staff if this level of assistance is required, sufficient turning space for a wheelchair, and correctly placed grab rails for stroke users. In order to encourage independence, yet allow access to the toilet in the event of an emergency, the entrance door should have the facility to open either way. At least 1 toilet should allow patient access from both sides of the toilet. The toilet roll should be accessible from either side.

12.5 Showers should be level access, and should have a shower chair to facilitate the less mobile, as well as a perching stool – this latter could be wall mounted. Controls should be accessible to a seated patient. Preferably the shower would have half height screens to assist in keeping any handler dry.

12.6 Leisure activities, e.g. Books, games, computer games, other leisure activities suitable for stroke patients, should be available since they play a part in rehabilitation. Anyone assisting with these activities needs to ensure good positioning of the patient is maintained during these. Leisure activities enjoyed by the patient prior to his/her stroke are usually documented in an individual risk assessment. Recreational need is part of the holistic approach on a stroke unit and also considered when the patient is discharged.
Any staff member or volunteer who assists the patient with these activities should be made aware of the importance of maintaining a good posture. Appropriate, height adjustable seating must be provided to avoid twisting and extended static muscle work.

13. Risk rating for each task

To carry out a 'suitable and sufficient' assessment, each task should be evaluated as part of the assessment process, so that the level of risk is quantified. Such assessments should be used, wherever possible, in the design of a safe system of work, and in highlighting any residual risks.

Various systems exist, but it is suggested that the NHS risk management 5x5 matrix, with 0-25 scale, is used for an overall evaluation of risk (NPSA, 2008) (see CD1, appendix 9 in folder 5). It is in common use, simple to use with 5 levels of risk, determined by a calculation of the likelihood or probability of an adverse event occurring multiplied by the severity of consequences or impact should it occur.

Likelihood/Probability (0-5) x Severity of Consequences or Impact (0-5) = 0-25

The values below are based on this system. Calculations lead to the following possible scores or ratings: -

1 – 6 = Low; 8 – 12 = Medium; 15 – 16 = High; 20 = Very High; 25 = Extreme

These ratings can then be used to alert staff and to justify any necessary expenditure to make the situation safer, on the basis of reasonably practicability. Actions to reduce the level of risk to the lowest level that is reasonably practicable can be demonstrated.

Risk analysis should be carried out on each individual and should start as early as possible during the hospital stay but this is difficult to quantify because the handler has to encourage and give guidance as much as possible, whilst expecting the patient to contribute maximally to the manoeuvre. The ability of the therapeutic staff constantly to assess the patient and the risks in a dynamic way is an essential skill. The risks could be quite high.

Extra care must be taken because rehabilitation handling is inherently more risky than care handling. This is due to 4 factors;

- Unpredictability of the patient
- Patient being near the limit of capability
- Uncertain cognitive ability
- Emotional lability

Judicious use of equipment should mitigate these risks.

14. Alerting the M & H team

If the patient is bariatric or presents with a dense stroke with consequent movement difficulties the MHP should be contacted without delay.

15. Referral to, and involvement of, other specialists

There needs to be close co-operation and liaison between all members of the MDT. The team usually consists of the consultant physician, nurses, OTs, PTs, SLTs, dieticians, clinical psychologists and social workers (ISWP, 2012). The family may be considered specialists in their own right.

16. Transport – internal & external

The patient may need to be moved to another department either on his bed, or in a wheelchair. If on a bed, the usual factors concerned with pushing and steering forces will need to be taken into account. If in a wheelchair, the above considerations for pushing and steering will need to be followed. All staff must pay specific attention to the maintenance of safe patient positioning, with specific attention to limbs i.e. both arms securely placed within the wheelchair and feet resting on the footplates.

17. Discharge and transfer planning

This should start from the day of admission. The primary goal is to return the patient home, so it is necessary to have factual information on the patient's home – steps to the front door; availability of grab rails; toilet facilities, type and height of bed, which side he is used to getting in and out from etc. A home visit is often carried out, often jointly by the occupational and physiotherapists to ascertain if any alterations or equipment are required, or even to prove a return home is not feasible. Where the latter happens, alternative accommodation will be required. Where possible, the patient should practice with any equipment required whilst in hospital in order to be familiar with its use back at home.

Follow up after discharge either in outpatients or at home is vital for both patients and carers. There should be a named telephone contact for any immediate post discharge problems (ISWP, 2012; SIGN, 2004).

Both patient and family must be fully involved (ISWP, 2012), and the primary care team, Social Services and allied health professionals as appropriate (SIGN, 2010). Where the patient lacks capacity to make decisions on discharge and there is no family or significant person to act in their interest, an advocate must be appointed.

Discharge documentation should be accurate and legible and sent to all relevant agencies and teams (SIGN, 2010).

Ideally a family support worker or volunteer stroke nurse should make contact with the patient and carer prior to discharge and follow up over the following 6-12 months through home visits or by telephone (SIGN, 2004).

Any equipment and support services necessary for a safe discharge must be in place (ISWP, 2012; SIGN, 2010), and the patient and family (if they will use the equipment) must know how to use it, and have a knowledge of safe manual handling where applicable.

Patients and families should be given information on appropriate statutory and voluntary agencies and community support groups, such as the Stroke Association (ISWP, 2012).

Patients with residual impairment after the end of initial rehabilitation should be offered a formal review at least every 6 months to consider whether further interventions are warranted by the specialist stroke rehabilitation service/ stroke care co-ordinator (DH, 2001). This is also in the profession specific concise guidelines for nurses, occupational therapists and physiotherapists (ISWP, 2012).

The offer of reviews, after 6 weeks, then 6 months then annually is one way to ensure people feel supported (DH, 2007).

18. References

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Other useful web sites

www.stroke.org.uk
www.chss.org.uk
www.nichsa.com

Summary/ Key Messages

- **The intention of the entire strategy and standards document is to contribute to the improvement of: -**
  - The quality of care - 'patient experience' (dignity, privacy and choice)
    - clinical outcomes
  - Patient/ person safety
  - Staff health, safety and wellbeing
  - Organisational performance – cost effectiveness and reputation, etc.

- **The standard for G16 is:**

Systems are in place to cover all reasonably foreseeable M&H situations in managing stroke patients

- **Skilful M&H is key**

- **Special points for G16 are: -**
  - **Provision of patient centred care**
  - **MDT assessment, and rehabilitation is started as soon as the clinical condition allows**
  - **Correct positioning of the patient**
  - **Care when handling the affected shoulder and arm**
  - **Minimising the risk of complications and disability**
  - **Maximising function by encouraging the patient to move themselves, where appropriate, taking care to avoid undue effort, which is likely to adversely affect tone**
  - **Involvement of family and carers from an early stage**