G17	Standard	**Moving and handling (M&H) in Palliative / End of Life Care (EoLC)**

Systems are in place to cover all reasonably foreseeable moving & handling (M&H) situations in managing patients with **palliative/end of life care (EoLC)** needs.

Justification

Rationale

Palliative Care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is the achievement of the best quality of life for patients and their families. This kind of care is provided in a number of settings. Skilled handling is essential in order to assure a "good death" and reduce the risks to the staff and families. A patient with palliative care needs may present with very challenging and complex needs including physical and psychological. M&H will require highly skilled staff with a broad knowledge of the condition a range of approaches/skills/techniques and appropriate attitudes to provide high level care.

Authorising Evidence

HSWA (1974), Equality Act (2010), LOLER (1998), MHOR (2004), MHSWR (2000), PUWER (1998), W(HSW)R (1995)

Links to other published standards & guidance

DH (2008); DH (2013); Hansford & Meehan (2007); NCPC (2012); NICE (2004); NICE (2008); NPSA (2008); Ruszala et al (2010)

Cross reference to other standards in this document

A5,12-14; B2-4,7,8; C1-4,13,14; D1-6,9-11; E5; F All; G1-4, 7-10, 14-16, 18-26, 31-33, 35, 39-40; H2; J1; K All

Appendices

4,9,10,13,15-21,26

Verification Evidence

- requirements for compliance to achieve and maintain this standard

A multidisciplinary approach, which must include relevant staff in all services, and family carers, is made manifest in practice and documentation, by the following: -

- The M&H policy covers these aspects of palliative and EoLC
- Standards
- A thorough and coherent assessment process, which identifies (amongst other things) the patient's level of mobility/independence
- Generic assessments are developed into protocols and standard operating procedures (SOPs), which are implemented
- All patients have adequate individual risk assessments and handling plans.
- Multi-disciplinary team (MDT) meetings to share information, discuss progress and set goals
- Regular, comprehensive in-service training and team meetings

Other essentials: -

- A patient-centred approach – to meet the needs and wishes of the patient
- Access to expertise
- Staff training and competency records
- Staff working within their level of competence
- Up to date research literature held in an accessible library or on-line
- An environment conducive to palliative and EoLC, with sufficient space for care
- An inventory of equipment
- All equipment (handling, therapeutic and auxiliary), in hospital and at home suitable for the patient's needs
- Continuing Professional Development
- All serious untoward incidents, including lack of appropriate staff and equipment, are reported and investigated, and learning from these is explicitly identified

G17 Protocol - Moving and handling (M&H) in Palliative/ End of Life Care (EoLC)

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Whilst this document has been written with adults in mind, the principles may be applied to children.

Generally, the term 'patient' is used, rather than person or service user, except in direct quotes.

1. Introduction and background

Palliative care is the active holistic care for patients with an advanced, progressive illness, be it symptom control or end of life. EoLC is given to people at the end stage of life, with malignant or non-malignant disease.
Common symptoms in palliative/EoLC that need to be considered when moving and handling patients are: - pain, fear of pain, fatigue, dyspnoea, reduced mobility, general weakness and cachexia. Skin integrity needs to be taken into account (see G 40, Tissue viability protocol).

WHO Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

The goal of palliative care is the achievement of the best quality of life for patients and their families (The National Council for Palliative Care [NCPC], 2012).

Although everybody has their own idea of what a 'good death' is, for most people it would involve being without pain, in a familiar place with close family or friends

and being treated with respect. 75% of people say they would prefer to die at home. Recently, the number of people dying at home has increased (42% in 2011), but over half of deaths still occur in hospitals (DH, 2013).
A patient with palliative care needs may present with very challenging and complex needs including physical and psychological. M&H will require highly skilled staff with a broad knowledge of the condition, a range of approaches/skills/techniques, and appropriate attitudes to provide high level care. These needs may occur at various stages of their disease process from early diagnosis to EoLC. M&H will need to be tailored to ensure that the specific needs/ goals of the patient are identified and met, ensuring that the dignity, respect, choice and quality of life of the person are maintained throughout.

According to the EoLC strategy (DH, 2008), high quality EoLC *"should be available wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere"*.

The patient with palliative care needs may have an impaired level of cognitive function and may present with challenging behaviours; these may fluctuate on a daily basis, therefore continual re-assessment and communication is essential. They may also have other predisposing conditions such as a learning disability, dementia, arthritis, impaired vision or hearing.

There are other factors to consider; the patient's choice and dignity in relation to their safety, and the need to balance staff/carer safety in relation to the patient's quality of care and mental capacity.

2. Management, organisation, supervision and support

<u>2.1 Guidelines and Policies</u>

Providers of care need to ensure that current guidance about palliative care is adhered to (DH, 2008)

"*People approaching the end of life are offered social, practical and emotional support tailored to their needs and at the right time to help them feel supported, retain their independence and do things they enjoy, for as long as possible*" (NICE, 2004)

NCPC (2012) states that everyone approaching the end of life has the right to the highest quality care and support, wherever they live, and whatever their condition.

Organisations should have clear policies on risk management and safe systems of work in whichever environment the person wishes to be cared for. Employers must have access to 'competent persons' (Manual handling Practitioners [MHPs]) who can assist them with measures needed to comply with health and safety requirements (MHSWR, 2000).

There should be clear policies on managing risk. The Mental Capacity Act (2005), now included in the Equality Act (2010), has to be used as a guide when balancing the need to keep patients safe, against affording them the right to personal choice and dignity.

2.2 Responsibilities, resources and training

Management's responsibility is to provide sufficient resources, including provision of equipment and a sufficient number of staff (Care Quality Commission [CQC], 2010), who are trained in working within palliative care. This is in order to provide the highest level of care, whilst promoting quality of life and independence and ensuring the safety of the patient and handler/s.

2.3 Supervision and Support

Working with patients with palliative care needs can be challenging, both on a physical and psychological level. Regular supervision and psycho-social support is essential for all those working within the speciality of palliative care.

3. Staffing levels

A minimum of 2 registered nurses (RN) and 2 Health Care Assistants (HCA) should be working in a ward with about 8 beds. During staff breaks there are then a minimum of 2 members of staff in the ward. M&H with slide sheets or a hoist may require at least 2 members of staff, unless special in-situ slide sheet systems are provided (subject to risk assessment, see Section 11).

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

Novice: Nursing students and newly employed RNs/ HCAs.

Advanced beginner: The above having been supervised and coached in M&H relating to palliative/ EoLC by a competent person.

Competent: Experienced staff, having attended relevant M&H training in palliative/ EoLC and been assessed as competent.

Proficient: Staff fully understanding M&H situations, able to manage more complex situations and to assess competence in others.

Expert: Very experienced clinical practitioners and MHPs who can apply their knowledge and skills to palliative/ EoLC and be capable of taking the lead in organisations, in providing advice, developing policy and practice, etc.

5. Environment

The usual considerations apply: good lighting, adequate space and preparation of the area will allow safe working postures and easier movements (Ruszala, 2010).

Managers in charge of workplaces must make sure that floors and traffic routes are maintained in good condition and free from obstruction (W(HSW)R, 1995).

In private homes, supported housing or residential care homes, space and specialist equipment may be limited. Access into and around the room may prove difficult with minimal circulation space for staff and use of equipment. Staff

should take the conditions into account and safe systems of work need to be put into place to compensate for any inadequacies in the environment, in order to reduce the risks to the lowest reasonably practicable level.

6. Communication and information systems regarding referral and entry into the system

Patients in need of palliative care should have been identified by their local primary care team through the implementation of the Gold Standard Framework (Hansford & Meehan, 2007). In this a Supportive Care Register is compiled by each primary care team (GP & multi-disciplinary team)

This enables: -

- teams to work pro-actively in order to anticipate patient needs and reduce the number of EoLC crisis admissions to hospital
- patients to die in the place of their choice
- communication between patients, families and professionals to be better

Timely referral should be made, with adequate information supplied to the relevant practitioner/s. A more detailed risk assessment will be required for the most complex situations. A handling plan should be left with the patient. All assessments and care planning records should be readily available to all concerned.

7. Treatment planning

Treatment for patients must be discussed and evaluated by a multidisciplinary team, with an experienced MHP present. Medication such as analgesia, muscle relaxants or sedatives may be needed before M&H a patient. The use of steroids can have an impact upon muscle strength in the lower limbs, as well as affecting bone density and skin thickness. The care plan needs to take these aspects into account.

The team should set goals for patients where this is appropriate.

8. Moving & handling tasks – links to sections 9 and 10

Staff should be aware of any specific concerns in relation to the individual being moved (MHOR, 2004). Any move that is likely to cause pain or discomfort should be avoided wherever possible and an alternative method considered. Staff should also be aware of any medical equipment that the patient may have, such as syringe drivers, vac pumps, stoma bags, catheters, oxygen cylinders, etc., as this may require additional attention when the patient is assisted to move.

The following tasks are related to the 12 Activities of Daily Living (Roper et al, 1980) which are: - maintaining a safe environment, communicating, breathing, eating & drinking, eliminating, personal cleansing & dressing, controlling body temperature, mobilising, working & playing, expressing sexuality, sleeping, dying.

This list below is not an exhaustive one but may include the following: -

- Turning/ re-positioning in bed
- Lying ← → sitting in bed
- Sitting to sitting transfers
- Sitting ← → standing
- Assisted walking
- Dressing and undressing
- Assistance with hygiene to include toileting, bathing, showering and hair washing
- Assistance with eating and drinking
- Movement of limbs for wound dressings
- The falling and the fallen person and emergency handling (G22-26)

9. Moving and handling assessment

All the M&H tasks identified for the purposes listed above must be assessed (MHOR, 2004). Accurate and timely assessment is essential to ensure that the patient has the ability; physically, emotionally and cognitively to participate with the task.

A detailed risk assessment will be required for the most complex situations and a handling plan should be left with the patient. All assessments and care planning records should be readily available to all concerned. This can be done generically in connection with the drawing-up of SOPs, or individually. Most patients with EoLC needs should be individually assessed.

Prior to any M&H a dynamic ('on-the-spot') assessment in the context of palliative/ EoLC is perhaps even more important than in some other types of person handling, because of the activities and risks involved. Each dynamic assessment must consider the following: -

- The task - is it necessary? Is it still appropriate or is it to be changed?
- The current condition of the person including ability to assist, any pain/ discomfort, need for medication (analgesia, muscle relaxants or sedation), reassurance/ explanations etc
- The technique or equipment to be used
- The environment
- The handler/s.

In emergency situations assessments will need to be made rapidly, but not so fast that safety is compromised. Forward planning for every reasonably foreseeable eventuality, such as falls and emergency evacuation, will minimise the occurrence of true emergency handling.

Consideration must be given to working postures and the time required for each task (which may be prolonged because of the condition and tolerance of the patient) that they do not unduly put the patient or handlers at risk. In order to make such balanced decisions it will be necessary to evaluate and quantify all of the risks, so that they can be compared (see Section 13).

Continual re-assessment/review is essential as mentioned in section 1 to ensure that equipment provision continues to meet the often changing needs of the patient.

The following (additional) considerations should be taken into account:
If any rapid functional deterioration occurs, advice should be sought; similarly if spinal cord compression is suspected, the advice from NICE CG75 (2008) should be followed and the patient should be nursed flat with spine in neutral alignment. 'Log rolling' techniques or a turning bed and a 'slipper pan' for toilet purposes should be used until spinal and neurological stability has been achieved.
The site and extent of disease may affect decision making for example; bony metastases.

10. Moving & handling methods, techniques & approaches

Patients with palliative care needs may also have other pre disposing physical, physiological, psychological or medical conditions that staffs need to consider. Those handling the patient should have the knowledge and skills required to accommodate both the palliative care needs of the person and any co-existing conditions. Family carers should be enabled to provide as much care as they are able/ willing to undertake.

People with palliative care needs may resist the provision of equipment, wanting to stay independent for as long as possible. It is therefore important that the patient has a care plan with realistic and achievable goals and that they are involved as much as possible in all planning decisions, with good explanations, e.g. that equipment may prolong independence rather than curtail it (NICE, 2004).

Rehabilitation as an approach to palliative care challenges the way we care for patients with advanced conditions to promote and empower greater patient independence (Jennings, 2013).

Family carers are often extremely motivated to assist with the provision of care at the end of their relative's life and will need to be trained in the principles of safer handling and in the specific use of the MH equipment provided (if considered appropriate).

All manoeuvres should be carefully explained to both the patient and the carer. It is important to reassure them throughout the task to ensure the safety and comfort of both.

In accordance with the principles of M&H, the patient should be encouraged to participate as much as possible with each transfer. Due to the often fluctuating

functional abilities of a patient at EoLC, the patient and task will need to be carefully assessed before each moving and handling activity/ transfer as previously mentioned.

- Turning/ repositioning in bed

A person unable to turn by themselves must be repositioned frequently, every 2 to 3 hours, alternating between right side, back, and left side using 30° tilted side lying positions. This usually requires at least two staff, unless special equipment is in-situ; systems that can be left in-situ may be more appropriate than standard sliding sheets, particularly for EoLC (see also G40 Tissue viability).

Consideration needs to be given to the size and type of bed particularly when the patient is being cared for at home. Access to both sides of the bed will enable staff and family to care most effectively. The risk of injury to the carer is increased when there is access to one side of the bed only or when the patient is in a bed wider than a single bed. A height adjustable single bed will facilitate care but is not always possible or desired by the patient. Raising the height of a fixed height bed may offer a suitable compromise providing it does not interfere with the patient's ability to get out of and into bed safely.

Slide sheets of varying sizes can be useful; the use of in-situ slide sheet systems can prove very helpful as they reduce the handling required. The latter can also be used with turning slings where a hoist is provided; for some patients, it is preferable that they receive minimal physical handling and in-situ systems and turning sheets can be very effective. They will be required in sufficient quantity to allow for laundering. Bed levers may be useful for those who are able to participate in the turn.

Pressure care mattresses (where required) should have the facility to be programmed for M&H tasks – this facilitates handling and reduces risk. They should have either an automatic return to alternating pressure or a system should be in place to remind staff and family carers to return it to its standard function e.g. setting a kitchen alarm as a reminder.

Turning beds or turning system (i.e. TOTO) may be useful for a small number of people to reduce physical handling and to ensure that the risk of pressure ulcers is minimised.

- Lying ← → sitting

A profiling bed will facilitate sitting up in bed; where this is not possible, the use of a pillow lifter or mattress elevator may help. Some in-situ slide sheet systems can also facilitate sitting. Where the patient is able to participate, bed levers, bed blocks, non-slip mats for feet and rope ladders or their equivalent may be of assistance.

- Sitting to sitting transfers

The use of slide boards with or without slide sheets may facilitate transfers and reduce the effort required by the patient particularly if a turning disc is used under the patient's foot/ feet.
A handling belt may be of use for some patients who are able to weight-bear, but caution must be exercised to ensure it is not used to take the patient's weight and that it does not interfere with stoma bags, feeding tubes etc. Staff need to be

aware of the site and extent of the disease, as some patients may not be able to tolerate the position of the handling belt. When the patient is unable to fully participate in the transfer, additional equipment such as a standing (active) hoist or full (passive) hoist must be used.

- Sitting ← → standing transfers

Where the patient is able to weight-bear but requires assistance, the following devices should be considered for use: - handling belt; turning device with frame (e.g. Rota stand, Rotunda). Standing hoists, e.g. the Oxford Journey stand aid may be used for those requiring more assistance.

- Use of stand aids in palliative care

There are several types of stand aids available. Some, such as the Ross Return or Etac Molift Raiser, enable the person to be moved in a standing position and can eliminate some seated transfers. They have a belt/ chest sling that can help support the patient in standing for short periods. Choice of aid will also depend on the type of knee support required. For those who are able to stand for a very limited time, the Cricket 11, Stedy, or OpeBea may be useful as they promote sit to stand transfers but the person can sit down to be transferred, over a toilet for example.

If the stand aid/ standing hoist is suitable, continual re-assessment/review is essential to ensure that equipment provision continues to meet the often changing needs of the patient, as mentioned in section 1. Staff need to be aware of the site and extent of the disease, as some patients may not be able to tolerate the position of the chest sling or the pull of the chest sling. Therefore an alternative option/ manual handling technique will need to be considered, including the use of a sling hoist (passive lifter).

- Using a hoist

A hoist may be required at any stage during the disease process of a patient with palliative care needs. As mobility and physical function deteriorates, the patient's ability to weight-bear is often reduced. However, some patients and relatives may choose not to have equipment (such as a hoist) at the end of life, preferring to remain in bed. Staff need to discuss options to reduce risk to patient and handler/s and respect patient autonomy and choice.

If a patient is unable to cooperate during the positioning of a hoist sling, the task of hoisting will require extra handlers. Patients may present as being extremely weak with wasting of the body due to severe chronic disease and are often at high risk of developing pressure ulcers.

A risk assessment will be essential to ensure that pressure care is not compromised and consideration of the use of an in-situ sling is preferable. Where possible, ceiling track or gantry hoists should be used instead of a mobile hoist, as transfers require less space and carer/s find transferring easier to perform.

- Assisted walking

Palliative care patients will maintain their mobility longer if they are assisted to walk. As with any M&H tasks with this group of patients a 'dynamic' assessment of their ability to weight-bear/ walk should be carried out before the activity is

commenced (full guidance in G22- Attachment 22 - '*checklist to be carried out before progressing to any weight-bearing activity*'). The aim of the assessment should be to reduce the risk of the patient falling whilst they are assisted to walk as well as deciding if the equipment/ technique in use continues to be appropriate.

Safe hand holds should be used or walking can be facilitated with the judicious use of a handling belt where appropriate, whilst some patients could benefit from use of a walking aid such as a Zimmer frame.
All palliative care patients should have a falls screening/ risk assessment completed and their care plans should include actions to be taken if they were considered at risk of falling (see G22- 26).

- Dressing and undressing

This can be a difficult and time consuming activity for some palliative/ EoLC patients. The use of dressing aids can assist with clothing. Specialist clothing can look smart and reduce the need to struggle with tight clothing as it is adapted for ease of use.

- Assistance with hygiene needs to include toileting, bathing, showering and hair washing

The ability to continue to use the toilet and to have a bath or shower continues to be very important for many patients as their physical function deteriorates, towards the end of their life. Toilet aids, commodes, bath aids such as bath boards, steps or bath lifts and shower chairs may increase the patient's ability to maintain independence with these activities. Where hoisting is required, consideration must be given to the positioning and comfort of wet slings.
It may be preferable for some patients to be washed in bed. A specially shaped bowl is available for washing hair in bed. Carers need to maintain the best possible posture and a height adjustable bed is desirable.

- Assistance to eat and drink

This can take a long time for some people and should continue to be as enjoyable an activity as possible. Staff and family carers may need to be able to alter their postures and should have a height adjustable stool or chair and table provided to reduce the impact of static postures.

- Movement of limbs for wound dressings

Height adjustable equipment should be provided for staff and family carers. Leg lifters and leg slings may help to reduce the effort required to lift heavy limbs.

11. Handling equipment

A selection of different slide sheets are recommended – flat and roller sheets, in different sizes, with extension straps where necessary.
In-situ sliding sheet systems may prove to be useful especially for patients who have dementia or who have very fragile skin.
A range and variety of other aids and equipment, such as stand aids, transfer boards, turntables and leg lifters, should be considered, also handling/ transfer belts, non-slip mats, mattress variators, pillow lifts, bed levers, hand blocks, rope ladders and bath lifts.

Hoists may be needed; stand aid hoists (active lifters) for patients able to weight-bear, sling hoists (passive lifters) for patients who are unable to weight-bear. A bath hoist is useful for getting in and out of a bath. Overhead hoists may be fitted in patients' rooms. A selection of slings in different sizes and styles are needed if hoisting is to be carried out.

Slings used for turning/ changing patients are desirable in some cases; the Romedic Top Sheet is suitable for use in palliative care when the patient needs turning as part of their care, as the process is calm and gentle and the load is spread over the entire body area.

12. Other equipment and furniture.

Hospices, acute wards and nursing care homes should have sufficient supplies of equipment including profiling beds, adjustable height trolleys, mobile commodes, mobile shower chairs, wheelchairs, walking aids, armchairs and specialist seating systems. However, the above items may be limited within a residential care home and advice should be sought, particularly as more patients are choosing to remain in their "homes" for EoLC.

Home assessments should be completed for those patients living in their own/independent homes to ensure that the most relevant equipment is provided.

Equipment provision may be sourced from NHS equipment stores or social services (subject to their criteria) and may include: -

- Dressing aids
- Toilet raisers and toilet surrounds – padded seats may be required
- Chair/ bed raisers
- Mobile / static commodes
- Pressure mattress toppers
- Mattress replacement - alternating pressure mattresses
- Specialist seating systems with integrated pressure relief
- Ceiling track hoists/ gantry systems
- In-situ slings
- Specialist Beds

In the acute settings, hospitals or hospices, four section electric profiling beds should be available for all patients. This will enable staff to adjust the height when providing care. In some settings there may be access to beds which have lateral tilt facility e.g. the Baltic bed, or tilting devices for standard profiling beds.

In the home situation the usual range of beds will be encountered – single or double, divan based with a fixed height. Assessment will be required by an occupational therapist or MHP to provide necessary equipment to assist with M&H.

All work equipment must be routinely maintained and serviced including pre-use checks (PUWER, 1998). Additionally, equipment used for lifting people including hoists and slings must be inspected and thoroughly examined by a competent person at 6 monthly intervals (LOLER, 1998).

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 reasonable practicability. Options can be evaluated by considering risks, cost, and actions planned or taken, to reduce the level of risk to the lowest level that is reasonably practicable, which can be demonstrated.

In complex situations other more sophisticated systems of assessment may be employed to supplement the NHS matrix. These will pay particular attention to such elements as the loading on the handler, comfort for the patient and capability of the patient (see Sections 9 & 10).

14. Alerting the moving and handling team

The need to contact the M&H practitioners/advisors will depend on the difficulties experienced or anticipated, the environment and the equipment available.

M&H practitioners/advisors need to be able to promote a person-centred approach in order to improve the quality of care that these patients deserve.

15. Referral to other specialist advisors

At times the input of specialist advisors may be required: for example, hospice specialist nurses, Marie Curie nurses, Macmillan nurses, infection control, stoma

care nurses, tissue viability advisors, and occupational/physiotherapists may well be involved.

16. Transport

Services should be prioritised for the use of internal/external transport for patients who have rapidly changing needs. Transport should have appropriate equipment to meet the needs of the patients and escorts as required.

17. Discharge and transfer planning

It may be that a patient is discharged to enable him to die at home, if that is his choice. In this case all reasonable steps should be taken to ensure that resources are made available *prior* to discharge, as part of the planning process, to facilitate the best possible experience. M&H requirements need to be shared with staff involved, as well as any family carers. Equipment has to actually be in place (fully functional with essential instruction/ training) before the patient is discharged.

See also G33, Handling of the Deceased.

18. References and further reading

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Further reading and useful contacts

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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 G17 is:**

Systems are in place to cover all reasonably foreseeable handling situations in managing patients with palliative / end of life care.

- **Skilful M&H is key**

- **Special points for G17 are: -**
  - **Patients are cared for in a wide variety of settings and should receive expert M&H to minimise discomfort**
  - **On the spot risk assessments are vital as the ability of the patient can vary widely during the day and from day to day**
  - **Pain medication may be required before any MH is undertaken**
  - **A wide range of equipment should be provided and all staff need to be fully trained in its use**
  - **Family carers must be provided with appropriate training and suitable equipment to enable them to care safely**