G23	Standard	The moving & handling of a person on the floor in a confined space

Systems are in place to manage the **person who has fallen to the floor in a confined space.** The person may, or may not be, injured.
N.B. A confined space can be defined as a small area where there is not enough space to work freely in safety – work is cramped, body position for the handlers less than optimal. Some examples: - a small toilet, a small bathroom, a small space between the wall and the bed, under the bed, stuck in a small lift.

Justification

Rationale
Appropriate provision must be made to cover such eventualities to ensure that the person comes to no further harm, and the risk to the handlers is kept as low as is reasonably practicable.

Authorising Evidence
HSWAct (1974); LOLER (1998); MHSWR (1999); MHOR (1992) as amended 2004

Links to other published standards & guidance
Betts & Mowbray (2005) HOP5; CQC (2010); NHS Medway (2009); NICE (2004) CG21; NICE (2013) CG161; NPSA (2007, 2008, 2010, 2011); Resuscitation Council UK (2009); Ruszala et al (2010); Sturman (2011) HOP6

Cross reference to other standards in this document
A5; B1,4,9,12,13; C1,4,7,11-13; D1-4,6; E4; G1,2,5,15,16,21,22,24-26,33,34; K3

Appendices

Verification Evidence
– requirements for compliance to achieve and maintain this standard

- An agreed approach, informed by evidence-based best practice, documented in both M&H and falls policies, disseminated to all staff and embedded within the organisation
- Risk assessments (for falls and M&H) that are 'suitable and sufficient', robust and balanced, with 'screening' to focus attention on those most at risk
- Safe systems of work and standard operating procedures, including falls preventative measures, and decision support systems for allowing, redirecting or controlling the unavoidable fall
- Information and communication systems – including documentation
- Competent, healthy staff, in sufficient numbers
- Training (theoretical and practical) and supervision
- An environment conducive to good care
- If a fall does occur the person, staff and relatives are supported emotionally throughout and after their experience, with debriefing
- Investigation of and learning from, falls and adverse events, using root cause analysis to locate the cause and prevent a recurrence SFAIRP (Patient Safety First, 2009)
- Monitoring, audit and review of the verification evidence
- Points learnt from audit, and accident/ incident investigations and reports are disseminated and discussed with staff, with subsequent learning
- Reporting the status (compliance) to the organisation
- Action plans to correct any lack of compliance
  The culture is one of learning rather than 'blame and shame

G23 Protocol - Moving & handling (M&H) of a person on the floor in a confined space

Author: Melanie Sturman-Floyd

Other contributors: Liz Hughes; Carol Innerarity; Francine Mutuma

It is recommended that protocols G23-26 are considered collectively and read in conjunction with G22.

1. Introduction and background

Falls are a major problem for health and social care and affect a third of the population over the age of 65 (DTI, 2007; NICE, 2013). However, patients of any age can fall (NPSA, 2010). Inpatient falls account for one third of the patient injuries in the NHS (HSE, 2006; NPSA, 2011) and are the most frequently reported incidents in acute hospitals (NPSA, 2007a). The Cochrane report found older people living in residential and nursing homes are three times more likely to fall compared to individuals living in their own homes (Cochrane Review, 2010). It is likely residential and nursing homes specialising in dementia care will have a higher incidence of falls (NPSA, 2010).

Hignett and Sands (2009), NPSA (2007b, 2010) and Sturman (2008) emphasise that the majority of falls are not witnessed. Where falls are witnessed, they usually occur when the person is transferring from one surface to another, for example chair to chair, or during a M&H transfer (Hignett & Sands, 2009; HSE, 2010) or walking (NPSA, 2007b).

Falls are a foreseeable event in any health and social care organisation and there should be systems in place to manage the (falling and) fallen person. The Management of Health and Safety at Work Regulations (2000), and the Manual Handling Operations Regulations (1992, as amended 2004) place duties on employers to identify the risks and have systems in place to reduce the risks.

Any intervention needs to be tailored to the person concerned (NHS, 2009; NICE, 2013).

2. Management, organisation, supervision and support

Sturman and Hancock (2009) recommend that organisations investigate their current falls management processes in order to diagnose and manage problem areas. Organisations should have a dedicated falls service (NICE, 2013). This usually consists of a falls advisor/ team.

M&H training should include specific training on how to manage the fallen person in a confined space, and the appropriate use of equipment.

All staff should be trained to the level of competence. Supervision will be required for those below this level.

Support should be available, in the form of a debrief after the event, to include the person and relatives as appropriate.

3. Staffing levels

Staffing levels will vary depending on the department and organisation, but it is essential that sufficient numbers of staff are available (CQC, 2010) particularly where persons who have been identified as being at risk of falling are cared for. It is likely that residential and nursing homes specialising in dementia care will have a higher ratio of staff to residents compared to other areas.

Staffing levels for each M&H transfer will vary according to the person's size, medical diagnosis, behaviour and functional ability.

In the majority of cases a minimum of two staff will be required to assist with transferring the fallen person out of a confined space. More staff will be required in certain situations e.g. where the size, behaviour and medical diagnosis of the person indicates.

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

Organisations should have training systems in place to cover the management of the fallen person (Betts & Mowbray, 2005; Sturman, 2011).

4.1 Novice: New support workers, care assistants, family carers, personal assistants, students, therapists and nursing staff with limited experience of dealing with a person on the floor in a confined space. Their role would be to call for help; observe others dealing with the fallen person/ follow directions from a competent/ proficient member of staff.

4.2 Advanced beginner: Care assistants, students familiar with care work, family carers, personal assistants with care experience, therapists and nursing staff who have some experience, through observing others, of dealing with a person found on the floor.

4.3 Competent: All of the above who have had further care experience and who have received specific training and been assessed as competent in the safe management of the fallen person in a confined space. They are

able to assess for any injury and can use the Glasgow coma scale. They are able to provide supervision of more junior staff.

4.4 Proficient: M&H key workers, other key workers, trainers, therapists and nurses who have received specialised training in safe management of the fallen person in a confined space, building on the expertise achieved as a competent practitioner.

All healthcare professionals who deal with persons at risk of falling should maintain basic professional competence in falls assessment and prevention (NICE, 2013). Training should focus on multifactorial risk assessment of intrinsic, extrinsic and behavioural risk factors (Sturman, 2011) from which risk management strategies will emerge. These should include theoretical and practical scenarios including evacuation procedures of the fallen person from a confined space. It is essential that competency is maintained in the use of equipment such as sliding equipment, hoists and inflatable lifting devices (see Section 11).

5. Environment

Falls can occur in all environments within health and social care and the nature of these extrinsic factors (Sturman, 2011) can contribute to the incidence of falls.

All falls risk assessments and strategies should include a review of the working environment (SCIE, 2005; Cochrane Review, 2010). Falls can be reduced with simple adjustments to the working environment, (see G22 section 5 for more information).

There will be occasions when a person may fall in a small bedroom, wedged against a bed or in a small bathroom or toilet. In care settings all toilet doors should open both ways. Wherever possible a person assessed at high risk of falling should be allocated to a larger room so it is easier for staff to assist them should they fall. Persons identified at risk of falls are recommended to wear pendant or wrist alarms in case they fall in a confined area and are unable to reach the call alarm.

Where possible, furniture should have braked wheels to enable easier movement for access. Flooring should be level.

When designing the layout of a building consideration should be given to the size of doorways and width of corridors. A larger doorway (850mm-1000mm) means a smaller corridor may provide adequate space to slide/ move a person in. Alternatively with a smaller doorway (below 850mm) a wider corridor space will be required to slide the person out of a confined space (HBN, 2013).

6. Communication and information systems regarding initial referral and entry to the system

All older people aged 65 and over admitted to hospital, and those living in a residential or nursing home should have a falls risk assessment completed as part of their care plan (NICE, 2013; Sturman, 2011). This also applies to younger people identified as being at risk of falling (Patient Safety First, 2009). Systems must be in place with clear instructions as to how people should be assisted should they fall. All students and health and social care staff should receive specific training in techniques as to how to assist the fallen person, including the use of equipment.

At the time of the falls risk assessment generic information regarding how to deal with a fallen person in a confined space should be provided to relevant carers/ staff, their employer and family carers.

After finding a person on the floor in a confined space a competent member of staff should carry out a dynamic "on the spot" risk assessment to determine whether the fallen person has any injury before any M&H is undertaken. This utilises a mental checklist of risk factors and should be in the local policy.

After the person has been moved out of the confined space and raised from the floor, an incident form must be completed and staff debriefed. The patient and relevant relatives must also be debriefed. A further assessment should be undertaken to update the care plan and reduce the risk of further falls.

7. Treatment planning

The goal is to identify potential falls risks and implement strategies to reduce the likelihood of a fall and the consequences should the person fall in a confined space. There should be clear strategies in place with specific techniques appropriate for use when a person who has fallen in a confined space is injured or uninjured to exclude head injury. Before undertaking any transfers an examination of the fallen person will identify potential injuries, especially spinal cord injury, and will identify the transfer method to be used.

If the fall was un-witnessed, it will also be necessary to carry out neurological observations using the 15 point Glasgow coma scale (NPSA, 2011) to exclude a head injury, prior to moving the person.

If the person requires CPR, poor access to the confined space means that it may be necessary to move the person to a less confined area to enable effective CPR to take place (Resuscitation Council (UK), 2009). If the person has sustained an injury in a hospital environment, the recommendations laid down by the NPSA (2011) should be followed.

Any post-fall rehabilitation treatment should follow a detailed plan aimed at improving the person's strength, balance, flexibility, endurance and confidence, with appropriate risk control measures e.g. the person needs to regain confidence in walking by being mobilised in a standing aid, which allows stepping and walking training, or by using a forearm support walker with an integral sling to prevent falling until ready to progress to using a walking aid. (Please see G21, section 7 for further details of a comprehensive rehabilitation plan).

8. Manual handling tasks

Procedures related to moving a person out of a confined space will include: -

- Assessment of the general situation and medical examination of the person (see section 7)
- Administration of any necessary treatment (first aid)
- Evacuation of the person**#**

After the event

- A calm reassessment, treatment and reassurance of the person
- Debrief of staff, carers, person and relatives
- Completion of an incident form
- Investigation of the fall (see G22)
- Taking action to prevent a recurrence of the incident

The actual M&H tasks will involve some of the following: -

- (Locating equipment)
- Inserting and removing equipment
- Evacuating the person to a place of safety
- Transferring the person to a bed, trolley or chair
- Transporting the person

9. Moving and handling assessment

Falls risks increase in those aged 65 and over and it is therefore expected that this group of persons, as well as younger people identified at risk, e.g. from

fractures due to falls (Cryer & Patel, 2001), should have a specific screen, falls risk assessment and an action plan completed as necessary.

Organisations should complete a generic risk assessment and develop a strategy identifying appropriate systems to manage a fallen person in a confined space, assessing the M&H tasks identified in section 8 above and writing SOPs for each of these.

Assessment for head injury, and also for spinal injury must be included in the process (NPSA, 2011).

Staff should be trained to carry out a dynamic risk assessment prior to assisting/ moving/transferring a person out of a confined space. Staff should be familiar with a routine mental check list to follow (as identified in local falls policy).

Following the assessment a method will be identified to manage a fallen person in a confined space. This will also be in the local falls policy. An example of a risk assessment and prevention of patient falls policy can be found on the NHS Medway (2009) website.

Post evacuation, once the person is rescued/ recovered, a full review will need to be carried out:

a) To see how the fall could have been prevented

b) To ascertain that the correct procedure was carried out, with the correct equipment

c) To re-assess the fallen person to see whether the care plan is still valid.

Any changes required should be documented. If follow-up is required, e.g. if the person's mobility has deteriorated, referral to the MDT and falls team should be initiated.

10. Methods, techniques and approaches

All organisations should be aware that falls are foreseeable, and should have strategies in place to manage them and reduce the risk of accidents and injuries.

Staff working with persons who are unpredictable, have mental health/ learning disability diagnoses or variable mobility should be alerted and receive specific training on safer intervention when the person has fallen.

Organisations should have clear pathways for managing transfers out of a confined space of the injured, and uninjured person.

Staff should be trained in various ways of managing the fallen person in a confined space. Any member of staff with knee problems who is unable to kneel

will require an individual risk assessment (MHSWR, 2000). Such staff may not be able to undertake the task and should be replaced by staff who are able to kneel. For further information consult the local falls prevention policy, also MHSWRegs, (2000).

Prior to moving the fallen person a competent member of staff, personal assistant, or family carer should undertake first aid observation to check for potential injury.

Before undertaking the task, the environment should be prepared as much as possible, for example, by moving light-weight furniture and obstacles out of the way.

Once it has been established that the person has no injury, it should be further determined whether they are able to assist in, for example, rolling and/or bridging to facilitate the insertion of slide sheets. The procedure will be affected by the person's ability to assist.

After this assessment the actual evacuation will be as follows:

Organisations should have agreed pathways for managing transfers of the injured, and uninjured, person (NPSA, 2011).

<u>Preparation</u>

- The method will be by sliding the person out of the confined area with full length slide sheets and extension straps/ handles, ski sled or evacuation sliding equipment.
- A *minimum* of two handlers will be required.
- Handlers should position themselves appropriately in the confined space.
- If side sheets are to be used, handlers should use at least two placed on top of each other. The upper slide sheet should have integral long handles or extension straps attached to it. (If these are not available, the handlers hold the upper slide sheet, close to the fallen person when carrying out the move. This will necessitate the handlers working in a less than ideal position – squatting or kneeling.)
- The lower sheet can be a plain sliding sheet without handles or straps. Two or more of these can be used to create a pathway into the open area.
- One handler should co-ordinate the procedure.

<u>Insertion of equipment</u>

- If the person can bridge or roll they should be asked to do so.

- The person should be prepared for turning, by positioning the furthest arm across their chest and bringing the nearest arm away from the body to prevent entrapment during turning.
- One handler starts in a high kneeling position and holds the person's far shoulder and hip.
- The person is turned onto his side by the handler rolling the person towards them by sinking from a high into a low kneeling position.
- Once the person is on their side the second handler rolls the slide sheets lengthways and positions it lengthways behind the person.
- The person is lowered and the process repeated on the other side.
- If the person is in too much pain, too heavy or unable to be rolled, it may be possible to insert slide sheets from either the head end, foot end or under the lumbar spine. For inserting from the head or foot end, the two full length slide sheets should be folded into large folds into a roll, starting from one end. This roll should be positioned with the roll towards the floor and inserted at the head or foot end of the person. The upper slide sheet is held whilst unravelling the slide sheets. The technique is started in high kneeling with the handler/s ending in low kneeling with each unroll. If inserting under the lumbar spine, it is easier to concertina the slide sheets and pull on the top end up and under the person's head, and the bottom end down and under the person's buttocks and legs towards the feet.
- If no slide sheets are available, or the person is complaining of discomfort, a ski sled or evacuation slide can be used. The process for positioning will be similar to that described above, rolling the person from side to side.

<u>Evacuating the person to a place of safety</u>

- Depending on assessment the person can be moved/ slid out of the confined area by 1, 2, 3, 4 or more staff.
- The person's head should be supported throughout the transfer on a pillow.
- As stated above, in order to enable the move to be completed with the handlers in a standing position, the upper slide sheet should have integral long handles or extension straps attached to it. One foot should be in front of the other foot (in a 'walk-standing' position) and weight should be transferred from one foot to the other to achieve the move.
- If no extension straps are available/slide sheets have no handles, the handlers hold the upper slide sheet close to the person, at shoulder and pelvis level. The handlers should start in high kneeling and end the

transfer in low kneeling, in small stages, repeating as necessary, until the person has been moved into a larger area.

- If the handlers are unable to kneel, they can complete the task in a standing position. In this case, the use of extension straps/ handles is imperative. These should be attached to the upper slide sheet.
- It may be necessary to use several slide sheets to have a continuous trail of slide sheets until the person has been moved out of the confined space.
- Handlers must remember to remove slide sheets and not kneel/ step on them in order to prevent a trip/slip hazard.

Transferring the person to a bed/ trolley/ chair

- Once the person has been moved out of the confined space an assessment will be undertaken to identify which transfer method is required to assist the person up from the floor.

Transporting the person

- This will be as for any moving.

For further information, see Sturman (2011), chapter 13, pp 244-246.

11. Handling equipment

All areas should have access to several sets of full length slide sheets, including wider ones for the person who overlaps the edge of a regular one. Handles and extension straps that can be attached to the full length slide sheets are essential for safety and comfort.

The ski sled and evacuation mat are other alternatives that can be used to move a patient safely out of a confined space.

Once out, further assessment will need to be carried out regarding the means by which the person is to be raised from the floor. This will include relevant equipment, such as hoists and inflatable lifting devices. Competency should be maintained in the use of this equipment (see Section 4).

12. Other equipment and furniture

Wherever possible, furniture should be on castors or wheels so it can be moved easily out of the way to improve working space and accessibility to the person.

Floors will generally have non/ low slip potential, so it is important that handlers create a sliding surface with the use of slide sheets or ski sled.

It is preferable in a bathroom or toilet area to have drop-down grab rails that can be raised upright to facilitate access to a fallen person.

13. Risk rating

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, to prioritise action and justify any necessary expenditure to make the situation safer, on the basis of reasonable practicability. Options can be evaluated by considering risks, costs, and actions planned or taken, to reduce the level of risk to the lowest level that is reasonably practicable, which can thus be demonstrated.

Managing the fallen person has been identified as high risk Sturman, 2011). Risks arise because the person has fallen in a confined area and some of the tasks may involve the handler/s twisting, flexing, stooping and over reaching.

Risk can be reduced successfully through robust multifactorial risk assessment of intrinsic, extrinsic and behavioural risk factors and by having a management strategy in place. Persons who are at high risk should be accommodated in areas with more space and accessibility.

14. Alerting the moving and handling team

The team will work with the organisation's falls advisor/ advisory team and has three roles.

i. The main role of the M&H team is to work with frontline staff to set-up safe systems or procedures for recovering persons from confined spaces following a fall. If the correct systems are in place, with staff trained and

competent to deal with these contingencies, and appropriate equipment to hand, the M&H team will not normally need to be called. Senior staff and M&H link workers should be able to take the lead in organising removal of the fallen person to a place of safety. In exceptional situations, such as a suspected or actual spinal cord injury, it may be considered appropriate to bring in the team to help deal with the situation. NB: If out of hours, a senior manager should be contacted for advice.

ii. The second role, is to investigate falls as adverse incidents. This role will need to be extended to examination of the recovery/removal of the person if, for some reason, this was not achieved according to the agreed procedure.

iii. The M&H team should also be involved in the planning and commissioning of new builds, refurbishments/ adaptations/ changes of use of areas in order to 'design out' potential problems and hazards in the environment or systems by utilising an ergonomics approach.

15. Referral to and involvement of other specialists

People will fall in both community and hospital settings.

Those living in the community and identified at risk of falls should be referred to a falls clinic for specialised investigations and assessments. Those in hospital should be referred to the falls advisor/ team.

If a person has been injured as a result of a fall in the community the person should not be moved. The emergency services should be contacted for assessment and appropriate action.

If a person has fallen in a hospital setting, appropriate action, including a medical assessment, will be required (NPSA 2011). See also G22, 24, 25 and 26.

Other specialists will be contacted as necessary – e.g. the MDT as it may be that assessment is needed from a physiotherapist, occupational therapist, dietician, pharmacist or psychologist.

16. Transport (internal and external)

Once out of the confined space, consideration must be given as to how the person will be moved. If a person has been injured he may require the use of a trolley or bed following lifting on a flat-lifter/ scoop stretcher hoist attachment (NPSA, 2011) or inflatable lifting device.

Research shows (NPSA, 2011) that placing a fallen person in a seated position is contraindicated where there might be an undiagnosed fractured neck of femur.

Therefore the use of a wheelchair as a means of transportation should be avoided until this has been excluded.

17. Discharge and transfer planning

On discharge, transfer planning is essential.

It is important that the person is accommodated appropriately, bearing in mind the falls assessment. Any discharge or transfer should be planned and co-ordinated with the agreement of all parties, and fully documented. Assessments and care plans should accompany the person (MHOR, 2004, para 130).

Some persons identified at risk of falls or following a fall may be going into residential care. The discharge team should work closely with the residential home to ensure provision of assistive technology and M&H equipment to reduce the incidence of falls.

If being discharged from hospital, the person may need a referral to the GP, community social worker, community falls team, occupational therapist and/ or physiotherapist.

18. References

HSWA (1974) Health and Safety at Work etc Act (1974) Reprinted 1994 London: TSO Ch37 sec 2(1) & 2(2), sec 7

Benner P (1984) *From novice to expert. Excellence and power in clinical nursing practice* Boston: Addison-Wesley pp 13-34 as cited in Ruszala S, Hall J and Alexander P (2010) in Standards in Manual Handling Towcester: NBE

Betts M & Mowbray C (2005) *The falling and fallen person and emergency handling* in Smith J (ed) The guide to the Handling of People 5th ed Teddington: BackCare Ch 17, pp 260-261

CQC Care Quality Commission (2010) Care Quality Commission (2010) *Essential Standards of Quality and Safety* www.cqc.org.uk/_db/_downloads/Essential_standards_of_quality_and_safety_March_2010 Retrieved 18 September 2011 Outcome 13

Cochrane Review (2010) *Interventions for preventing falls in older people living in the community* Cochrane Database of Systematic Reviews, 2009 Issue 2

Cryer, C & Patel, S (2001) *Falls, fragility and fractures* Alliance for Better Bone Health cited in http://www.medwaycommunityhealthcare.nhs.uk/_uploads/documents/policies/clinical/mch16-c[1]-016-the-risk-asse-patient-falls-policy.pdf Retrieved 9.02.13

DTI Department of Trade and Industry (2007) *Research on the pattern and trends in home accidents* Government consumer safety research www.berr.gov.uk/files/file/21453.pdf Retrieved 2.04.13

Health Building Notes (2013) *Health Building Note 00-44 Circulation and communication spaces* www.gov.uk/Government/uploads/system/uploads/attachemnt_data/file/187026/Health_Building_Note_00-04_-_circulation_and_communication_spaces_-_updated_April_2013.pdf Retrieved 2.04.13

HSE (2006) *Patient Safety and Health: Two sides of the same coin* Health and Safety Minister addresses patient safety www.hse.gov.uk/press/2006/e06011.htm Retrieved 2.04.13

HSE (2000) *L21 Management of health and safety at work Management of Health and Safety at Work Regulations 1999 Approved Code of Practice & guidance 2nd ed* Sudbury: HSE Books Regs 3, 7 & 10

HSE (2004) *L23 Manual handling Manual Handling Operations Regulations 1992 (as amended) Guidance on regulations 3rd ed* Sudbury: HSE Books Regs 4 & 5

HSE (2010) *RIDDOR injuries in care homes 2008-2009* Unpublished statistics (in HOP6)

Hignett S and Sands G (2009) *Patient safety in moving and handling activities* Proceedings of the International Ergonomics Association Beijing China 9-14 August 2009

NHS Medway (2009) *The risk assessment and prevention of patient falling policy* www.medwaycommunityhealthcare.nhs.uk/uploads/documents/asse-patient-falls-policy.pdf Retrieved 08.02.13

NICE National Institute for Clinical Excellence (2004) *CG21 Falls The assessment and prevention of falls in older people* www.nice.org.uk/CG021NICEguideline Retrieved 23.04.13
NB: CG21 has been superseded by CG161(NICE 2013) since the writing of this document www.nice.org.uk Retrieved 23.06.13

NHS (2009) *How to Guide for harm from falls* www.patietsafetyfirst.nhs.uk Retrieved 8.02.13

National Patient Safety Agency (2007 a) *NPSA launches most comprehensive report on patient falls in hospitals* http://www.wales.nhs.uk/news/6290 Retrieved 14th January 2013

NPSA National Patient Safety Agency (2007 b) *Slips, trips and falls in hospital PSO/3* http://www.nrls.npsa.nhs.uk Retrieved 08.02.13

NPSA National Patient Safety Agency (2008) *A Risk Matrix for Risk Managers* www.npsa.nhs.uk Retrieved 18.02.13

NPSA National Patient Safety Agency (2010) *Slips, trips and falls data update* www.nrls.npsa.nhs.uk Retrieved 08.02.13

NPSA National Patient Safety Agency (2011) *Rapid Response Report NPSA/2011/RRR001 Essential Care after an In-patient Fall* http://www.nrls.npsa.nhs.uk/alerts/?entryid45=94033 Retrieved 14th January 2013

Patient Safety First (2009) *The 'How To' Guide for Reducing Harm from Falls* http://www.patientsafetyfirst.nhs.uk Retrieved 15.06.13

SCIE (2005) *Preventing falls in care homes* Social Care Institution for Excellence Research briefing 1http://www.scie.org.uk/publications/briefings Retrieved 14th January 2013

Sturman M (2008) *Are falls a problem for local authorities?* MSc Dissertation Unpublished Loughborough University

Sturman M & Hancock C (2009) *Analaysing falls management using failure mode effects analysis: Health Care Risk Report* February 2009 Pp17-19

Sturman M (2011) *A systems approach to the prevention and management of falls* in Smith J (ed) The guide to the Handling of People a systems approach 6th Ed (2011) Teddington: BackCare Chapter 13 Pp 244-246

Resuscitation Council UK (2009) Guidelines on Safer Handling during Resuscitation in Healthcare Settings 2009 www.resus.org.uk Retrieved 2.04.13 Page 10

Further reading

HSC (1998) *Safe use of lifting equipment Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) Approved Code of Practice and Guidance L113* Sudbury: HSE Books

HSC (1998) *Safe use of work equipment Provision and Use of Work Equipment Regulations (PUWER) 1998. Approved Code of Practice and Guidance L22* Sudbury: HSE books

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 G23 is:**

Systems are in place to manage the person who has fallen to the floor in a confined space. The person may, or may not be, injured.

- **Skilful M&H is key**

- **Special points for G23 are: -**
  - **Staff must be trained to identify if the fallen person is injured.**
  - **Organisations must have suitable falls management systems in place and plans to assist those who may fall in a confined space**
  - **Generic M&H risk assessments are carried out, SOPs/ protocols formulated and available for all staff**
  - **Suitable equipment for use in a confined space must be provided and all staff trained in its use**
  - **Where new buildings or adaptations are planned, consideration must be given to the space required for future users**