G24	Standard	The moving and handling of a person, member of staff or visitor on the floor, with no apparent injury

Systems are in place to manage all reasonably foreseeable handling situations regarding a person on the floor (without apparent injury) in health or social care settings. Settings may include: -

- Clinical areas
- Public areas, including outside buildings (car parks, gardens, etc.)
- For community staff – anywhere their work takes them

Justification

Rationale

Slips or trips may result in a fall without injury in health or social care settings. There must be systems in place to manage this situation safely.

Staff must be competent in the assessment of injury and cardiac/ respiratory status.

Authorising Evidence

HSWA (1974); LOLER (1998); MHOR (as amended 2004); MHSWR (1999); PUWER (1998)

Links to other published standards & guidance

Betts & Mowbray (2005) HOP5; CQC (2010); DH (2001); NICE (2004) CG21; NICE (2013) CG161; NPSA (2007, 2008, 2010, 2011); Patient Safety First (2009); Ruszala (2010); Ruszala et al (2010); Sturman (2011) HOP6;

Cross reference to other standards in this document

A1-3,5,6,9-14; B1-4,7-9,12,13; C1,4-8,11-15; D1,6,8,14,16; E5; F (all); G1,22-27; J1-5; K (all)

Appendices

1, 4–10, 13–18, 21, 25, 27

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 that are 'suitable and sufficient', robust and balanced
- Safe systems of work and standard operating procedures
- Information and communication systems – including documentation
- Competent, healthy staff, in sufficient numbers
- Training and supervision
- An environment conducive to good care
- Handling equipment – for assisting up from the floor – slide sheets, inflatable emergency lifting cushions including full body, hoist with a variety and types of slings – type and size
- Other equipment and furniture - beds, trolleys, wheelchairs, stable chairs
- Investigation of and learning from adverse events, with de-briefing
- Monitoring , audit and review of verification evidence
- Reporting the status (compliance) to the organisation
- Action plans to correct any lack of compliance

G24 Protocol –Moving and handling (M&H) of a person, member of staff or visitor on the floor, no apparent injury

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It is recommended that protocols G22, 23, 25 & 26 are considered collectively and read in conjunction with G24.

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, persons 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, 2007 a). 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).

Persons of any age with neurological conditions will need special consideration. Some persons with mental health/ learning disability conditions may have behaviours that include putting themselves on the floor.

Hignett and Sands (2009), NPSA (2007 b, 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 (Hignett & Sands, 2009; HSE, 2010) or walking (NPSA, 2007 b).

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 and the appropriate use of equipment.

All staff should be trained to a level of competence and require supervision appropriate to their level of competence.

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

3. Staffing levels

Staffing levels will vary depending on the department and organisation. It is essential that sufficient numbers of staff are available (CQC, 2010). Residential and nursing homes specialising in dementia care may require a higher ratio of staff to residents compared to other areas.

In the majority of cases one-two handlers will be required to assist and supervise a fallen person without injury. More staff will be required in certain situations e.g. where the size, behaviour, 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. 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, for dealing with a person found on the floor.

4.3 Competent: All 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. They are able to assess for 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 and been assessed as competent.

All healthcare professionals who deal with persons at risk of falling should maintain normal 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 ensue. These should include different theoretical and practical scenarios.

5. Environment

Falls can occur in all environments within health and social care, including outside areas e.g. car parks and gardens, and the quality of the extrinsic factors can contribute to the incidence of falls (Sturman, 2011).

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 and are unable to reach the call alarm.

Where possible, furniture should have braked wheels to enable easier movement for access and getting up off the floor. 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 will provide adequate space to move a person. Alternatively with a smaller doorway (below 850mm) a wider corridor space will be required (HBN, 2013).

In the person's own home attention should be given to slip and trip hazards, such as rugs, cables, thresholds, clutter and pets.

Staff taking people on home visits/ outings must ensure a door to door risk assessment has been carried out in advance. Many visitor attractions have generic health and safety assessments which they will provide in advance.

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 be screened and have a falls risk assessment completed if necessary 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 screened/ assessed and supervised/ assisted should they fall. All students and health and social care staff should receive specific training in techniques on how to assist the fallen person, including the use of equipment.

If a falls risk assessment has been carried out, generic information at the time of this assessment regarding how to cope with a fallen person should be provided to relevant carer/ staff, their employer and family carers. Depending on the organisation's policy, if the person is unable to get up independently, the procedure may be to call an ambulance for the crew to deal with the situation.

Following a fall, a competent member of staff should carry out a dynamic "on the spot" risk assessment (MHOR, 2004; Love & Love, 2006) to determine whether the fallen person has any injury before any M&H is undertaken. This utilises a mental check list of factors to consider and should be in the local policy.

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

Mental health and learning disability patients may put themselves on the floor deliberately. The relevant behavioural management plan should be followed.

7. Treatment planning

The goal is to identify potential falls risks and implement strategies to reduce the likelihood and consequences should the person fall. There should be clear strategies in place, with specific techniques appropriate for use when a person has fallen, whether injured or uninjured.

Before undertaking any transfers a suitable and sufficient examination of the fallen person should be carried out to exclude injuries, and to ascertain the transfer method to be used. (If the person has sustained an injury in a hospital environment, the recommendations laid down by the NPSA (2011) should be

followed). 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) prior to moving the person.

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, Rehabilitation Plan onwards in Section 7 for further details of a comprehensive rehabilitation plan).

8. Manual handling tasks

Procedures relating to assisting a person with no injury up from the floor will include;

- Assessment of the general situation and a medical examination (NPSA, 2011) to exclude injury (see section 7)
- Administration of any necessary first aid treatment
- Locating and positioning relevant equipment
- Instructing a person to get up from the floor, using minimal assistance (section 10.1)
- Instructing a person to get up from the floor, using minimal supervision, verbal prompting and two chairs (can also use a chair either side, plus a third chair can be brought in behind)
- Use of an inflatable cushion with/ without integral backrest to assist a person up from the floor
- Use of a hoist
- Use of a full body inflatable cushion(e.g. HoverJack)

After the event

- 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 (where possible)

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 of falls (Patient Safety First, 2009) and fractures from falls (Cryer & Patel, 2001), should have a specific falls risk assessment and an action plan completed.

Organisations should have generic risk assessments and strategies for managing/ assisting the falling person with no injury up from the floor using:-

- one/ two/ three chairs
- inflatable lifting cushions (e.g. Mangar Elk or Camel)
- hoists
- full body inflatable lifting cushions.

These risk assessments must include an assessment for head injury, and also for spinal injury (NPSA, 2011).

Staff should be trained to carry out a dynamic risk assessment prior to assisting/ moving/transferring a fallen person with no injury up from the floor. Staff should be familiar with a routine mental checklist to follow (as identified in local falls policy).

Any member of staff 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 MHSWR (2000).

Once the person is up from the floor, a reassessment will need to be carried out for four reasons:-

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 review the fallen person to see whether the care plan is still valid (if a patient)

d) If the person is not currently a patient, but has fallen in hospital premises, and if it is thought appropriate, the person should be referred/ escorted to A&E or advised to visit the GP for investigation, according to organisational policy.

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 safe intervention of the fallen person.

Organisations should have clear pathways for managing transfers of the uninjured person up from the floor.

Before assisting/ moving the falling person a competent member of staff, personal assistant, or family carer should undertake a first aid observation to exclude any potential injury. Nothing sharp or heavy should be in the person's pockets.

Before the person is assisted, the environment should be prepared as much as possible, for example by moving light furniture and obstacles out of the way, ensuring sufficient suitable chairs or other equipment are to hand, to assist in the person getting up off the floor.

It is not advisable to get a person directly into a wheelchair as it will be too high for the majority. Instead, once the person is on a chair, and recovered from the fall, the transfer to a wheelchair can take place.

10.1 Instructing a person to get up from the floor, using minimal assistance

For simplicity the fallen person is taken to be male, and the handler female.

Criteria – a person being verbally instructed should have the physical and cognitive ability to be able to roll onto his side and onto hands and knees.

- Position a chair nearby in readiness.

The person is instructed as follows:

a. Bend his knees upwards keeping his feet flat on the floor – tap on his leg to initiate movement if necessary.
b. Bring one arm across his chest towards the direction of the roll and move the opposite arm away from his body. (If he has a preferred side to roll onto, this will be his direction of roll).
c. Turn his head to the preferred side.
d. Roll onto his side into side lying.
e. Once he is on his side, ask him to bring his upper arm over his body until his hand is flat on the floor, close to the opposite elbow.
f. Push up on his upper hand and at the same time push up on his forearm to sit up.
g. Carefully reposition the chair in front of him.
h. Keep pushing upwards and turn until on hands and knees, facing the chair.
i. Place his forearms onto the chair.
j. Bring his strongest leg forward and place the foot flat on the floor.

k. Push down on his forearms/ hands and foreward foot and turn to sit on the chair.

Taller persons

- Position a chair at the side of the fallen person.

The person is instructed as follows:

- As a. – f. above, then,
- Turn sideways on to the chair, stronger leg (if applicable) nearest the chair.
- Raise his nearest leg to the chair, so the foot is flat on the floor.
- Push on chair and at same time push down through his foot, raising himself up to *slide* onto the chair.
- Push down on his hands and feet and turn to sit on the chair.

10.2 Instructing a person to get up from the floor, using minimal supervision, verbal prompting and two chairs

- Position a chair nearby in readiness.

The person is instructed as follows:

- Bend his knees upwards keeping his feet flat on floor.
- Bring one arm across his chest and to move the opposite arm away from his body.
- Roll onto his side so he is in side lying.
- Once he is on his side, to bring his arm over his body until his hand is flat on the floor close to the opposite elbow.
- Push up on his hand and at the same time push up on his other forearm so he ends up in a half seated position.
- Reposition the chair in front of him.
- Keep pushing upwards and to turn until he is on all fours, facing the chair.
- Position his forearms onto the chair.
- Bring his strongest leg forward and place his foot flat on the floor.
- Push down on his forearms and feet.
- The handler can assist by placing a second chair behind the person under his hips.
- The handler prompts the person to sit backwards in the chair.

It is also possible to use a chair on either side of the person. As he stands up he sits onto one of the two chairs, OR a third chair is pushed in behind him by a handler.

10.3 Use of an inflatable cushion to assist a person up from the floor

Assess the person to see if they meet the criteria for being moved/ assisted with the use of an inflatable cushion a) without a back rest b) with a back rest
Instruct him to shuffle his hips onto the cushion, or partly roll (lift hip slightly), or lift his bottom up (bridge) to enable the handler to position the cushion.
If he is unable to shuffle or bridge, one handler should assist the person to turn onto his side, whilst a second handler positions the cushion.
Ask him if he can get himself from lying to sitting independently.

Without backrest
Criteria - Used for an uninjured person who may struggle to roll on the floor or who is

With backrest
Criteria - Used for a person who may have cognitive difficulties and may be

A chair could be positioned on one or both sides of the person so he can rest his arms on the chair(s). This will assist with support in sitting.
The cushion is inflated until he is in a position to transfer safely.
During cushion inflation he is verbally supported to bring his feet backwards towards it.

For more detailed guidance please refer to Ruszala (2010) and Starman (2011).

Use of a hoist

Staff/ carers must be trained and competent in how to position and use a hoist safely to raise a person from the floor. (See Sturman, 2011 for further information).

Use of a full body inflatable cushion
Staff/ carers must be trained and competent in how to position and use the above safely to raise a person from the floor. (Refer to the manufacturer's instructions for further information).

11. Handling equipment

All areas should have access to several sets of full length slide sheets, stable chairs, inflatable emergency lifting cushions, hoists with a variety of types and sizes of slings, and an inflatable full body lifting cushion. It is essential to know the SWL of hoists and slings (LOLER, 1998).

12. Other equipment and furniture

Wherever possible, areas should have furniture on braked castors or wheels and heavy chairs should have housekeeping wheels to facilitate easy movement to create working space and enable access to the person.

Organisations should have access to this equipment, for example, bed, chair, wheelchair or trolley, which can be moved to the 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 on the floor and some of the tasks may involve the handler/s twisting, flexing, over reaching and working at floor level.

Risk can be reduced successfully through robust multifactorial risk assessment of intrinsic, extrinsic and behavioural risk factors and managing falls in the first place.

14. Alerting the moving and handling team

The M&H team will work with the organisation's falls advisor/ team and has three roles:

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 the floor 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 the moving/ lifting of the fallen person. In exceptional situations e.g. suspected or actual spinal cord injury it may be considered appropriate to bring in the team to help deal with the situation. NB: This service will not normally be available out of hours. In this case, a senior manager should be contacted for advice.

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.

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 may fall in both community and hospital settings.

Those living in the community who have fallen should be advised to visit their GP for possible referral to a falls clinic for specialised investigation and assessment.

If a person in the community has fallen and is unable to get up independently, the person should not be moved, the emergency services should be contacted for assessment and possible treatment of the person. If a person has fallen in a care home, and following assessment by senior staff is found to be uninjured, the organisation's policy will identify how the person is to be encouraged/ assisted up from the floor.

If a patient has fallen in a hospital setting, a medical assessment will be required as identified by NPSA (2011). (See also G22, 23, 25, 26). Others who fall in hospital should be escorted/ referred to A&E to exclude injury and for possible referral to the community falls advisor/ team.

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

16. Transport (internal and external)

If a person has fallen, even though uninjured, he may require the use of a trolley, bed, flatlifter hoist/ scoop stretcher (NPSA, 2011), wheelchair or full body inflatable device.

Research shows (NPSA, 2011) that the use of a wheelchair is sometimes contraindicated. E.g. at the time of the fall it may not be apparent that an injury, such as a fractured neck of femur has occurred.

17. Discharge and transfer planning

When a patient who has fallen is being discharged, transfer planning is essential.

The person should be 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 discharge is from hospital, the person may need a referral to the GP, community social worker, community falls team, occupational therapist and/ or physiotherapist.

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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 G24 is:**

Systems are in place to manage all reasonably foreseeable handling situations regarding a person on the floor (without apparent injury) in health or social care settings.

- **Skilful M&H is key**

- **Special points for G24 are: -**
  - **Falls are reasonably foreseeable events so prior planning is essential to reduce the risk**
  - **Generic M&H risk assessments are carried out, SOPs/ protocols formulated and available for all staff**
  - **Careful planning is required to ensure adequate staffing levels**
  - **Suitable and sufficient equipment is required and all staff must be trained in its use**
  - **Adverse events must be thoroughly investigated and learning outcomes and action plans relayed to all staff**