G25	Standard	Moving and handling the fallen person (patient) with a fractured neck of femur (#NOF)

Systems are in place to cover the handling of the fallen **patient with fractured neck of femur (#NoF).**

Justification

Rationale

Falls resulting in such injuries are quite common, especially in the elderly. Incorrect handling can worsen the condition, so appropriate provision must be made to cover such eventualities.
Staff must be competent in the assessment of injury 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 et al (2010); Sturman (2011) HOP6

Cross reference to other standards in this document

A1-6,9-14; B1-4,7-9,12,13; C1,4-8,11-15; D1,4,6,8,14; E5; F (all); G1-3,10,11,15,17,18,20,22,23,31,32,34,40; 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 lifting from the floor – slide sheets, inflatable emergency lifting cushions including full body, hoist with a variety 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

G25 Protocol – Moving and handling of a patient collapsed with fractured neck of femur (#NOF).

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It is recommended that protocols G22, 23, (24) & 26 are considered collectively and read in conjunction with G25.

Terminology – for the sake of simplicity the person who has fallen will be referred to in this protocol as the 'patient', since their injury will necessitate surgical intervention. 'Person' may be used when describing those who have not yet fallen, but who may be vulnerable and require assessment and preventative measures.

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 1999, 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, 2011). The Cochrane report found older people living in residential and nursing homes are three times more likely to fall compared to those 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). In-patient falls account for one third of the patient injuries in the NHS (HSE 2006, NPSA 2011, NICE 2013) and are the most frequently reported incident in acute hospitals, (NPSA 2007).

Patients who sustain a fractured neck of femur (#NOF) have a high morbidity and high mortality rate, according to the NHS Institute for Innovation and Improvement (2006). The cost to the NHS is £348 million per annum. 90% of older people who fracture their NOF fail to recover their previous level of independence (Murrey et al, 2007).

Hignett and Sands (2009), NPSA (2007, 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).

Falls are a foreseeable event in any health and social care organisation and there should be systems in place to manage the fallen patient with a #NOF. The Management of Health and Safety at Work Regulations (1999), 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.

When an inpatient has a fall, safer manual handling, early diagnosis and treatment is essential to help the patient make the best recovery, (NPSA 2011, NICE 2013).

2. Management, organisation, supervision and support

Sturman and Hancock (2009) recommend that organisations need to start with an investigation of their current falls management processes in order to diagnose and manage problem areas. They should have a dedicated falls service (NICE, 2013), usually consisting of a falls advisor/ team.

Staff should be trained in how to manage the fallen patient who has sustained a #NOF. Moving and handling training should include specific training on how to manage the fallen patient with a #NOF, and the appropriate use of equipment.

All staff should be trained to the level of competence required, and will require supervision appropriate to their level of competence.

Support in the form of a de-brief, should be available after the event, 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 will require a higher ratio of staff to residents compared to other areas.

At least three-four staff will be required to assist with transferring a patient with a #NOF. Numbers of staff required will be based on a dynamic risk assessment and will vary depending on the size, behaviour, medical diagnosis and any other injury sustained by the patient.

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 patient, (Betts & Mowbray, 2005; Sturman, 2011).

Staff should be trained in how to manage the fallen patient who has sustained a #NOF.

4.1 Novice: New support workers, care assistants, family carers, personal assistants, students, therapists and nursing staff with limited experience of dealing with a #NOF. Their role would be to call for help; observe others

dealing with the fallen patient/ follow directions from a competent/ proficient member of staff.

4.2 Advanced beginner: Care assistants, support workers, 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 patient with a #NOF.

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 patient with a #NOF. 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 additional specialised training in safer management of the fallen patient with a #NOF, reached a high level of expertise and are able to assess the competence of others.

All healthcare professionals who deal with persons at risk of falling, and those who have fallen, should maintain normal basic professional competence in falls assessment and prevention (NICE, 2013), and in dealing with the fallen patient with a #NOF. Training should focus on multifactorial risk assessment and management strategies, including theoretical and practical scenarios of the fallen patient with a #NOF.

5. Environment

Falls where a patient sustains a #NOF 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, or be easily removable. 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 patients 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 patients aged 65 and over admitted to hospital, and those living in a residential or nursing home should be screened to determine whether they need a falls risk assessment completed as part of their care plan (NICE 2013; Sturman, 2011). Such organisations should have policies and systems in place setting out how they should be assisted should they fall and sustain a #NOF. All students and health and social care staff should receive specific training in techniques for assisting the fallen patient with a #NOF, including the use of equipment.

Management of a fallen patient with a #NOF will differ in community settings and acute environments. The NPSA Rapid Response Alert (2011) recommends that all organisations have clear systems in place to manage the person.

In an acute setting a senior member of staff should complete a dynamic "on the spot" risk assessment. A full medical examination of the patient should take place before any M&H is undertaken.

People who fall in the community (and community hospitals without 24/7 medical cover), who have a suspected #NOF, will require an assessment by the emergency services.

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 to use when a patient has fallen, and sustained a #NOF, to prevent further complications.

If the fall was unwitnessed, it will also be necessary to carry out neurological observations using the 15 point Glasgow coma scale (NPSA, 2011) prior to moving the person.

A full medical examination of the fallen patient will identify other potential injuries and the transfer method to be used.

Patients with a suspected #NOF should be transferred in supine from the floor.

8. Manual handling tasks

One task is involved – transfer of patients with suspected #NOF in supine. This can be carried out in four ways – see below. See section 10 for a full explanation of the method for each of the four ways.

All organisations must have the means (or be able to access the means) to transfer such patients.

There are, in broad terms, two kinds of settings where M&H tasks will be carried out – community and inpatient.

Community MH management of a #NOF

If a person falls at home and has a suspected #NOF the emergency services should be called immediately.

In a nursing or residential home and in some community hospitals and mental health hospitals, the safer moving of the patient will also be the responsibility of the emergency services, who should be called immediately. In such situations the staff should take care of the person until the emergency services attend and provide first aid as appropriate. In some other community hospitals, mental health hospitals the expertise and equipment may be available in-house and the person can be managed as with inpatients (see below).

Inpatient MH management of a #NOF in acute hospitals

The patient will require assessment prior to the transfer.

- HoverJack and HoverMat
- Scoop stretcher with mobile or ceiling track hoist
- Use of scoop stretcher
- Transfer with emergency lift sheet

9. Moving and handling assessment

Falls risks increase in people aged 65 and over (DTI, 1999). Patients from 50-64, admitted to hospital and judged by clinicians to be at higher risk of falling because of underlying conditions, should have a risk assessment (NICE, 2013). Also younger ones identified at risk of fractures from falls (Cryer & Patel, 2001), should be screened to determine whether a specific falls risk assessment needs to be completed.

Organisations should have a strategy and carry out a generic risk assessment for moving patients with suspected #NOF (Audit Commission, 2000; NPSA, 2011; NHS, 2006). The assessment should identify and document the best way that a fallen person with a #NOF should be managed.

Staff should be reminded to complete a dynamic risk assessment prior to moving and transferring a patient with a #NOF.

A reassessment post-fall will need to be carried out to: -

a) See how the fall could have been prevented

b) Ascertain the correct procedure to raise the fallen patient was carried out, with the correct equipment

c) Review the fallen patient and update the care plan.

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 the MHSWR (2000).

10. Methods, techniques and approaches

All organisations should be aware that falls are foreseeable and have strategies in place to manage and reduce the risk of a person sustaining a #NOF as a result of a fall.

Organisations should have clear pathways for managing transfers of the patient with a suspected #NOF.

It is essential to reassure the patient and to keep them informed. The transfer must be monitored throughout to ensure a smooth procedure and the best possible experience for the patient.

10i) HoverJack and HoverMat

Follow the manufacturer's instructions. (See Section 18 for manufacturers' web addresses).

10ii) Scoop stretcher with mobile or ceiling track hoist

- Two handlers separate the stretcher into its two halves.
- The stretcher is lengthened according to the patient's height and secured in position.
- One handler supports the patient's head throughout the insertion of the stretcher.
- The patient is asked to put his hands across his abdomen out of way of the stretcher.
- Two handlers then gently slide the scoop stretcher under the patient.
- The two halves of the stretcher are secured together. It is essential that it is checked to ensure that it is locked.
- The patient is secured on the stretcher with safety straps if required.
- The trolley/ bed is brought close to the patient.
- The lifting straps are connected to the stretcher, then to the hoist, following the manufacturer's guidance.
- The stretcher is raised to transfer the patient onto the bed/ trolley.
- The stretcher is disconnected from the hoist.
- One handler supports the patient's head whilst the other handlers remove the stretcher from under the patient.

10iii) Use of scoop stretcher

- The stretcher is positioned as above.
- The trolley/ bed is brought close to the patient.
- Two to four handlers are required to complete the manual lift of the stretcher.
- One handler coordinates the move and on a given signal the stretcher is lifted.
- Once the transfer has been completed, one handler supports the patient's head whilst two handlers remove the stretcher.

10iv) Transfer with emergency lift sheet

- Most organisations avoid rolling the patient with a suspected #NOF.
- Two handlers roll a pair of full length slide sheets into one roll.

- The roll is positioned with the roll towards the floor.
- It is then inserted under the patient at the head end, or under the lumbar spine.
- The top layer of slide sheet is held whilst unravelling the slide sheets. The technique should be started in high kneeling and ended in a low kneeling position.
- A third handler will be required to protect the patient's head.
- A fourth handler may be required to stabilise the patient's hip.
- Two handlers insert the emergency lift sheet in-between the 2 layers of the slide sheets.
- The lift sheet is slid gently down the patient's body until it is flat.
- The slide sheet closest to the patient is removed.
- The bed/ trolley is brought close to the patient.
- The number of handlers required to lift the patient will vary according to their size: 4-7 handlers may be necessary.
- All handlers grasp the handles of the lift sheet and follow safer manual handling principles.
- One handler co-ordinates the lift, by using the commands "Ready? – (Pause) – Steady – Lift!"
- On the word "Lift", the handlers will lift and transfer the patient onto a bed/ trolley.
- Where a trolley is used, another handler (not part of the lifting team) moves it under the raised patient.

11. Handling equipment

All areas should have access to several sets of full length slide sheets, a HoverJack and HoverMat, a scoop stretcher, ceiling/ mobile hoist and associated lift straps, and an emergency lift sheet.

12. Other equipment and furniture

Wherever possible areas should have items of furniture on castors or wheels so they can easily be moved out of the way and heavy chairs should have housekeeping wheels to facilitate easy movement, to create working space and enable access to the patient.

Organisations should have access to equipment, for example, bed/ or trolley, which can be moved to the patient.

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 patient with a #NOF.

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 = Med; 15 – 16 = High; 20 = V 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.

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).

Managing the fallen patient has been identified as high risk (Sturman, 2011). Risks are presented because the patient has fallen on the floor, sustaining a #NOF and some of the tasks may involve twisting, flexing, over reaching and working at floor level.

Risks can be reduced successfully through robust multifactorial risk assessment of intrinsic, extrinsic and behavioural risk factors and managing falls in the first place. High risk patients should be placed in areas with more space and accessibility.

14. Alerting the moving and handling team

Once a patient has fallen and sustained a #NOF, in the absence of a specialist falls advisors, the M&H team may be called for advice to investigate and advise on the management of falls e.g. for those who are difficult to assess, such as a

patient with a concomitant suspected or actual spinal cord injury (see G9). If it is not possible to contact the team directly, e.g. out of hours, a senior manager should be contacted for advice. The area/ ward M&H link worker should also be informed.

The M&H team has three roles:

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

i) To work with frontline staff to set up safe systems for recovering persons from the floor following a fall and #NOF. 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 safe recovery of the fallen person. Only in exceptional situations (e.g. suspected/ actual spinal cord injury) should it be necessary to bring in the team to help deal with the situation. NB: This service will not normally be available out of hours, in which case, a senior manager should be contacted for advice. (NB: This implies that such senior managers are competent to deal with such situations).

ii) 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 – which is in itself a serious untoward incident.

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 help 'design out' potential problems and hazards in the environment or systems by utilising an ergonomics approach.

15. Referral to and involvement of other specialists

Persons living in the community and identified at risk of falls are usually referred to a falls clinic for specialised investigations and assessments.

Once a patient 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 treatment of the patient.

For inpatients who fall the #NOF care pathway should be followed.

16. Transport (internal and external)

A patient attending A&E following a fall in the community will be transferred supine onto a trolley, using either an air slide or a full length sliding board.

A patient on a bed/ trolley will be transferred to other departments and wards, e.g. x-ray on this equipment. Beds and trolleys should be moved by 2 members of staff.

17. Discharge and transfer planning

When being discharged, transfer planning is essential.

Inpatients should follow the #NOF care pathway (NHS 2006; NPSA 2011).

The patients who were admitted from the residential/ care homes they will go back to their previous homes as soon as they are medically stable after surgery, but they should not be excluded from rehabilitation (NICE, 2011 CG124).

Some other patients identified at risk of falls or particularly following a fall which resulted in a #NOF may also have go into community hospital or residential care for rehabilitation. The discharge team should work closely with the residential home to support the provision of assistive technology and M&H equipment to reduce the incidence of further falls and aid rehabilitation after surgery.

18. References

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Web Addresses – for HoverJack & HoverMat

www.cjmedical.com/patienttransfer.html

www.patient-handling.com

www.poshchair.co.uk/Pressure-Relief/Inflatable-bed

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 G25 is:**

Systems are in place to cover the handling of the fallen patient with fractured neck of femur (#NoF).

- **Skilful M&H is key**

- **Special points for G25 are: -**
  - **Incorrect handling may increase the injury to the patient so all staff must be fully trained to manage this emergency safely**
  - **Generic M&H risk assessments must be carried out, and SOPs/ protocols formulated and made available for all staff**
  - **Sufficient numbers of trained staff must be available at all times**
  - **Specialist equipment must be available and staff trained in its use**
  - **Adverse events must be thoroughly investigated and learning outcomes and action plans relayed to all staff**