| G26 | Standard | The moving and handling of a collapsed person with a cardiac/ respiratory arrest |
|---|---|---|

Systems are in place to cover the moving and handling (M&H) of **a collapsed person with a cardiac/ respiratory arrest,** on the floor, in a chair or in a bed.

**Justification**

**Rationale**

A person undergoing resuscitation for cardiac/ respiratory arrest must be treated in the correct position. The person may not be in an optimal position for resuscitation and will need to be moved rapidly but safely into the correct position. Appropriate provision must be made to cover such eventualities.

**Authorising Evidence**

HSWA (1974); LOLER (1998); MHSWR (2000); MHOR (1992 as amended 2004); PUWER (1998)

**Links to other published standards & guidance**

Betts, M & Mowbray (2005); NPSA (2008); Resuscitation Council (UK) (2009); Ruszala et al (2010); Sturman (2011)

**Cross reference to other standards in this document**

B3, 7, 8, 9, 12, 13; C1-4, 11-13; G2, 4, 7, 10, 11, 13, 15, 16, 21, 22-25; I3-7; L6

**Appendices**

None

**Verification Evidence**

**-** requirements for compliance to achieve and maintain this standard

- The organisation has an up to date resuscitation policy, setting out procedures and defining responsibilities for all levels of management and staff
- Generic assessments are carried out, SOPs are written and developed into protocols, which are implemented with staff trained and supervised to the level of competence required with 'suitable and sufficient' local supervision
- Assessments are carried out on all persons considered at risk of cardiac/ respiratory arrest
- If a cardiac/ respiratory arrest does occur the person, staff and relatives are supported emotionally throughout and after their experience
- All collapses/ cardiac/ respiratory arrests are investigated to check whether clinical signs of deterioration were missed
- Audits and incident reports identify that suitable equipment for moving a collapsed person is available
- Points learnt from audits, and accident/ incident investigations and reports are disseminated and discussed with staff, with subsequent learning. The culture is one of learning rather than 'blame and shame'.

**G26 Protocol - Moving and handling (M&H) of a collapsed person – cardiac/ respiratory arrest, on floor, in bed or in chair**

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*Terminology* - for the sake of simplicity the 'collapsed person' who has suffered a cardiac arrest is called a 'person', unless a direct quotation is used from Resuscitation Council, 2009 where the word 'patient' is used.

## 1. Introduction and background

It is entirely predictable that a patient (person), or visitor may collapse in any setting in health or social care.

One in four nurses and carers are likely to take time off work as a result of a back injury sustained at work (Backcare, 2008; HSE, 2008; Sturman, 2011). Poor manual handling accounts for more than half of the reported incidents in the health and social care sector (MHOR, 1992 as amended 2004).

The Resuscitation Council (2009) view cardio-respiratory arrest as the most acute medical emergency faced by health and social care providers. A swift response is essential to ensure effective provision of cardio-pulmonary resuscitation (CPR) and survival.

The Resuscitation Council state that in around 80% of adults there are clinical signs of deterioration in health before the arrest appears, therefore cardio-respiratory arrest is a foreseeable event. Health and safety legislation and guidance recommends that any foreseeable events should be risk assessed and strategies to manage risks identified and implemented (MHOR, 1992 as amended 2004; MHSWR, 2000).

## 2. Management, organisation, supervision and support

All organisations should have an up to date resuscitation policy defining the duties of management as well as individuals. Procedures for resuscitation as well as how basic life support (BLS) is to be initiated need to be included in the policy. Acute hospitals will have their own 'crash' teams, which will arrive as a result of an emergency call (2222). In a home environment a 999 call will initiate the procedure.

As a cardio-respiratory arrest is a foreseeable event in health and social care establishments, organisations should have generic risk assessments in place to identify and manage risks (Resuscitation Council, 2009).
Any management and training strategy should be designed jointly and implemented with the resuscitation and M&H trainers to ensure balance between safer M&H and the need to respond quickly.

All clinical staff with direct contact with people (patients/ service users) must receive specific training in BLS as well as relevant M&H techniques. It is the individual's responsibility to attend the training provided, and managers must also ensure that all their staff are up to date with this training.

The nurse or manager on duty at the time of an arrest will take the lead in determining the way in which a collapsed person is to be moved.

## 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 a cardiac/ respiratory arrest are cared for. High risk areas such as acute medicine, coronary care, intensive care and dementia care homes will have higher ratio of staff to person.

In acute areas sufficient staff should be available when summoned by a 'crash call' and all staff should be aware of the way to initiate the call.

In a person's own home there may be only one other individual present and their first action should be to make a 999 call before starting any resuscitation.

## 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 collapsed person, (Betts and Mowbray, 2005; Sturman, 2011) and this will include all clinical/ other staff who have direct contact with people.

4.1 Novice: New support workers, care assistants, family carers, personal assistants, therapists and nursing staff with limited experience, who would not be expected to take part in moving a collapsed person. However, they should be able to initiate a call for help.

4.2 Advanced beginner: Care assistants, students familiar with care work, family carers, personal assistants with care experience, therapists and nursing staff who should be able to assist in the moving of a collapsed person under instruction and supervision.

4.3 Competent: All the above who have had further care experience and who have received specific training in the safe intervention of the collapsed person, and who have been assessed as competent in the RA and the safe intervention of the collapsed person. They are able to help with supervision of more junior staff.

4.4 Expert: Staff who take a lead in resuscitation and M&H training and policy writing in that context.

Training should focus on risk management strategies and include theoretical and practical scenarios of managing a patient requiring CPR on the floor, bed or chair (Resuscitation Council, 2009).

All clinical staff will require training in BLS and regular updates. However, novices/ advance beginners will require direction and supervision from a competent person. It would also be beneficial to carry out regular drills at the work place for moving a collapsed person.

## 5. Environment

A person can collapse and require CPR in any setting in health and social care environments including outside areas.

All risk assessments and strategies should include a review of the working environment, SCIE (2005).

Floors will generally have low slip potential so it is important that handlers create a sliding surface with the use of slide sheets, if required.

In the person's own home there may be insufficient space to access the collapsed person. Rugs, cables, thresholds, clutter and pets may also hinder moving a person on the floor.

Wherever possible, in acute/ residential areas furniture should be on castors or wheels so it can be moved easily out of the way to create working space and accessibility to the collapsed person.

It is preferable to have drop down grab rails that can be raised upright when trying to access a collapsed person in a bathroom or toilet area.

When designing the layout of a building, consideration should be given to the size of doorways and width of corridors. Larger doorways (850mm-1000mm) allow smaller corridors to provide adequate space to move a collapsed person on the floor. Alternatively if there is a small doorway (below 850mm), a larger corridor space will be required; unfortunately in a person's own home this is not usually the case.

Persons may collapse anywhere, but if in small bedrooms, wedged against a bed or in small bathrooms or toilets, they must be moved prior to resuscitation. Where possible persons at risk of collapse should be allocated larger rooms so that it is easier for staff to move them in order to perform resuscitation if required.

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

In the community, when a package of care is designed/ reviewed it is advisable to consider the possibility of the person collapsing. The initial M&H assessment will need to cover the action to be taken in this event and personal assistants, their employer and family carers should be informed on how to initiate an emergency call.

In acute hospitals, a 'crash call' will initiate the BLS action. All staff should be aware of how to call for help/ alert the 'crash team' and the delegation of key roles. A senior member of staff should complete a dynamic "on the spot" risk assessment prior moving the collapsed person.

## 7. Treatment planning

Speed is essential and a person requiring CPR needs to be moved quickly and safely. Any delay in treatment could significantly reduce the person's chance of survival. If a person is on the floor, CPR should be commenced there and the person should only be moved if there is no room to perform effective resuscitation. If on a bed - the person should be in supine. If on a chair/ toilet, the person should be moved to the floor.

## 8. Manual handling Tasks

The collapsed person should only be moved if there is inherent danger to the person or rescuers in that location (Resuscitation Council, 2009).
Otherwise the person is lowered/ repositioned into supine for BLS. If the person is on the floor, he should only be transferred into a bed/ trolley once his condition is stable or the resuscitation has been unsuccessful, using the relevant equipment (mentioned in section 11).

M&H tasks are as follows:
*Prior to resuscitation*
8i) Assisting a collapsed person on the floor
8ii) Repositioning the collapsed person into supine on an electric profiling bed

8iii) Repositioning the collapsed person into supine on a divan bed or bed with manual backrest
8iv) Lowering the collapsed person from a chair to the floor

*Post resuscitation*
8v) Transferring a person from the floor to a bed/ trolley following resuscitation.

## 9. Moving and handling assessment

Forward planning should ensure that strategies are devised to allow staff to act swiftly and reduce risk as much as possible.

The transfers listed in section 8, and described in section 10, should have generic risk assessments, and SOPs should be written on how to handle/ manage a collapsed person in a chair, bed, on the floor or trolley. All clinical staff should be conversant with, and competent to carry out, the tasks as described in the SOPs.

All staff physically unable to carry out these tasks require individual assessment of their capabilities in conjunction with Occupational Health.

Staff should be reminded to carry out a dynamic risk assessment prior moving and transferring a collapsed person.

## 10. Methods, techniques and approaches

All organisations should be aware that cardiac/ respiratory arrests are foreseeable and have strategies in place to manage them and reduce the risk of accidents and injuries.

There should be clear pathways for managing the handling of persons who need urgent resuscitation or who have been successfully, or unsuccessfully, resuscitated.

### 10i) Assisting a collapsed person on the floor

- *"Start CPR as quickly as possible*
- *Do not move patient unless there is inherent danger to the patient or rescuers in that location*
- *If the patient has collapsed in a public area, consider the use of screens to provide some privacy or ask other patients and members of public to leave the area*
- *If there is restricted access to the patient, move the furniture and obstacles out of the way*
- *If the access to the patient is restricted and the furniture cannot be moved quickly and safely it may be necessary to slide the patient*

*horizontally across the floor to a less restricted area. Use sliding sheets to achieve this"* (Resuscitation Council, 2009).

(See protocol G23 for more information about use of sliding sheets on the floor.)

**10ii) Repositioning the collapsed person into supine on an electric profiling bed**

- *"Clear the environment of any hazards*
- *Ensure that the brakes are on and, if applicable, bed rails are lowered*
- *With one hand to steady the raised part of the bed and the other to release the marked 'CPR' handle, the rescuers lower the bed slowly to a horizontal position. If available, the powered CPR button should be used*
- *Some electrically powered beds have 'controlled' release mechanisms; others may require the rescuer to release the bed while manually supporting the load. In these cases, be very careful to avoid bad posture, traumatic loadings and trapping hazards"* (Resuscitation Council, 2009).

**10iii) Repositioning the collapsed person into supine on a divan bed or bed with manual backrest**

- *"Clear the environment of any hazards*
- *Ensure the brakes are on and, if applicable, bedrails are lowered*
- *If sliding sheet(s)* or 'leave in bed positioning system, (e.g. Wendy Lett)' *is in position, with the bed at approximately hip-height, grasp the top layer of the sliding sheet and slide the patient down the bed away from the backrest until supine"*
- If slide sheet or 'leave in bed positioning system' is not under patient and "*if a slide sheet is readily available, it may be possible to insert this quickly underneath the patient's hips/buttocks by rolling the patient to one side*
- *If no sliding sheet is available do NOT use the bed sheet as a sliding aid*
- *Lower the bed to the lowest height*
- *Each rescuer faces the patient and positions themselves on either side of the bed*
- *The innermost knee rests on the bed whilst their outermost leg remains on the floor*
- *The patient's legs are flexed at both knees and hips*
- *Each rescuer grasps behind the back of the knee closest to them. One hand is placed in the crease of the knee and the other behind the calf*
- *On command, the rescuers transfer their body weight backwards towards their heels pulling the patient with them*
- *Re-position and repeat as necessary*

- *Readjust the height of the bed. The optimal height positions the patient between the knee and mid-thigh of the person performing chest compressions*
- *Consider the combined weight of the rescuers and the patient when using this approach; the total weight must not exceed the manufacturers' guidance or specified safe working load of the bed*
- *In the event that the resuscitation takes place on a trolley where there is a manual "pull up" backrest, two rescuers are required to lower the backrest using safer handling principles*
- *When resuscitating a patient on a pressure relieving bed or mattress, refer to the manufacturer's instructions. For resuscitation to be effective, a firm surface is required underneath the patient"* (Resuscitation Council, 2009).

On a divan bed,

- Pillow(s) should be removed from under the person's head, and the person may then be in supine
- If a person is lying on a divan bed particularly with a backrest, the handlers may need to kneel by the side of the bed and move from high kneeling into low kneeling
- Grasp the slide sheet/ 'in bed positioning system' and slide the ~~patient~~ person down the bed away from the backrest until supine.

## 10iv) Lowering the collapsed person from a chair to the floor

If a person collapses in a chair and requires CPR they must be lowered to the floor first before CPR can be commenced.

**Three handler transfer** (from a chair to the floor)

Area should be risk assessed and obstacles moved out of the way

- "*The chair must be secure, with any brakes in the ON position*
- *If a sliding sheet is available, place it under the patient's feet and extend the patients' legs to enable their feet and legs to slide away from the chair as they are lowered onto the floor*
- *One rescuer supports the head by standing at the side of the chair, level with the patient's head*
- *The two rescuers face the patient in the chair, and position themselves slightly in front and to the side of the chair*
- *These rescuers get into a half-kneeling position with their innermost knee on the floor and grasp hold of the patient at the back of the pelvis/ hip region with their outermost hand and behind the patient's knee with their innermost hand*
  *An alternative is to use the high-kneeling position which some rescuers may find more comfortable*
- *If the patient is dressed it may be helpful to grab hold of their clothing or belt*

- *On the command from one rescuer, each kneeling rescuer transfers their body weight back towards their heels. This pulls the patient forwards out of the chair into a sitting position on the floor with their back resting against the chair*
  (The movement may need to be repeated two or three times depending on size of patient and capabilities of handlers)
- *Once in this position, either move the chair or lower the patient's head and chest carefully to the floor, OR pull the patient's legs forwards away from the chair until the patient is supine"* (Resuscitation Council, 2009).

**Two handler transfer** (from a chair to the floor)
Area should be risk assessed and obstacles moved out of the way

- "*The chair must be secure, with any brakes in the ON position*
- *Both rescuers face the patient in the chair, and position themselves slightly in front and to the side of the chair*
- *If readily available place a sliding sheet under the patient's feet* (and extend the patient's legs to enable their feet and legs to slide away from the chair as they are lowered onto the floor)
- *Both rescuers get into a half-kneeling position with their innermost knee on the floor and grasp hold of the patient at the back of the pelvis/ hip region with their outermost hand and behind the patient's knee with their innermost hand. An alternative is to use the high-kneeling position which some rescuers may find more comfortable*
- *If the patient is dressed it may be helpful to grab hold of their clothing or belt*
- *On the command from one rescuer, each kneeling rescuer transfers their body weight back towards their heels. This pulls the patient forward out of the chair into a sitting position on the floor with their back resting against the chair*".
  (The movement may need to be repeated two or three times depending on size of patient and capabilities of handlers).
- *"Once the patient is in the sitting position on the floor, one rescuer takes responsibility for supporting their head , whilst the other pulls the patient's legs forwards and away from the chair, or if there is enough room, moves the chair. Alternatively, one rescuer gently pushes the patient sideways towards the other rescuer who lowers them to the floor"* (Resuscitation Council, 2009).

**One handler transfer** (from a chair to the floor)
*"Wherever possible one rescuer should not undertake this task and they should wait for assistance to arrive. However, it is recognised that in some situations a rescuer may decide to begin resuscitation and will need to transfer the patient to the floor.*

- *Kneel on the floor to one side of the patient*

- *Position the patient's arm that is closest to you across their chest*
- *Push against the patient's thigh which is nearest to you with both your hands to position the patient's hips at the front of the chair*
- *Place your hand around the patient's furthest hip. Place your other hand on the patient's thigh which is closed to you.*
- *Push/ pull the patient down to the floor"* (Resuscitation Council, 2009).

**Cardiac arrest on the toilet**

*"If a patient has a cardiac arrest on the toilet it is likely the patient will fall either sideways or forwards. Before transferring the patient onto the floor it is important that the door is kept open. This will ensure that the entrance is not blocked and will enable other rescuers to access the room. The patient needs to be transferred to the floor using a similar technique as described for a sitting position"* (Resuscitation Council, 2009).

**10v) Transferring a person from the floor to a bed/ trolley following resuscitation**

*"The safest method of transfer is to use a hoist with a stretcher attachment that enables direct lifting from the floor because it keeps the person horizontal".*

*"If this is not available, a hoist and a sling may be used as long as this enables direct lifting from the floor and the following criteria are met:*

- *The hoist sling must provide adequate support to the patient's head and trunk*
- *The hoist sling is inserted underneath the person using either a log-roll techniques or by using sliding sheets if the person is too unstable to be rolled*
- *During hoisting care is taken to ensure the person's trunk and head remain as horizontal as possible*
- *If the person re-arrests while in the hoist, either continue the transfer onto the bed or trolley or lower them back to the floor depending on which is the quickest or easiest"*

*"If a hoist is not available the person can be rolled onto a solid flat surface (e.g., a scoop stretcher) and raised with a mechanical lifting cushion"*

*"Manual lifts from the floor (*using a 'lifting sheet'*) are high risk and should only be used as a last resort if a hoist transfer cannot be achieved".*

- *"The transfer must be well planned and all rescuers briefed – in total 8 people*
  *will be required to assist.*
- *One rescuer co-ordinates the commands and lifting activity; this person is required to support the patient's head.*
- *Ensure that a designated lifting sheet (i.e., a sheet that has been designed for lifting) is available. A scoop stretcher may be used.*
- *Log roll the patient onto the lifting sheet.*
- *A minimum of three rescuers are positioned on each side of the patient.*

- *An additional rescuer will need to position the trolley under the patient*
- *Each rescuer faces the patient and drops down into the half-kneeling position*
  *(or into a position they feel comfortable in and are able to rise from)*
- *Each rescuer grasps the lifting sheet (or handles if present) with their wrists in a neutral position*
- *On the command the rescuers stand lifting the patient to approximately waist height*
- *The patient is transferred onto an appropriately positioned height-adjustable trolley"* (Resuscitation Council, 2009).

*Note: "Mechanical lifting device should always be used for a bariatric person"* (Resuscitation Council, 2009).

## 11. Handling Equipment

Slide sheets: *A*ll areas should have access to several sets of sliding sheets*. "These should be readily available and it is recommended that they are kept in strategic areas. If space permits these should be kept on or next to, the emergency resuscitation trolley, or at the nearest location to this which is easily identifiable"* (Resuscitation Council, 2009).

A hoist with stretcher attachment*:* Following resuscitation on the floor, "*the safest method to transfer the person is to use a hoist with a stretcher attachment as this keeps the person horizontal".*

"*Extra Caution: The use of a stretcher attachment on a hoist may lower the hoists overall safe working load"* (Resuscitation Council, 2009).

A hoist with a sling: If a stretcher hoist is not available a hoist with a sling can be used as long as the hoist sling provides adequate support to the person's head and trunk and during the hoisting the person's trunk and head can remain as horizontal as possible (Resuscitation Council, 2009).

A scoop stretcher with a mechanical lifting device: "*If a hoist is not available then the patient can be log rolled onto a solid flat surface (e.g. a scoop stretcher) and raised with a mechanical lifting cushion. The patient must be kept in a horizontal position, therefore sufficient staff must be available to ensure the surface is well balances on the cushion*" (Resuscitation Council, 2009).

Lifting sheets*:* Although manual lifts from the floor (especially those within confined areas) are high risks and should only be considered as a last resort if a hoist transfer cannot be achieved, for example, the person has collapsed in an area that is inaccessible to a hoist, a designated lifting sheet could be used to log roll the patient onto it. Total of 8 people will be required to assist. A scoop stretcher may also be used for this task instead of a lifting sheet (Resuscitation Council, 2009).

A full length slide board: This should be available for any lateral transfer of a collapsed person e.g. from an ambulance trolley to an A&E trolley.

Inflatable lifting aids: Using a full length inflatable lifting device (e.g., a HoverJack) would allow resuscitation to continue if the person rearrested during a transfer from the floor to the bed.

## 12. Other equipment and furniture

Organisations should have access to equipment that can be moved to the person, for example, a height adjustable bed or trolley in particular one that can be lowered close to the floor/ ground.

In hospitals/ nursing/ residential care environments beds and mattresses should be conducive to resuscitation procedures, for example beds should have a quick release CPR mechanism and mattresses should be ones that either inflate or deflate quickly to ensure a firm resuscitation surface.

In high risk areas bedside chairs should have the capacity to convert quickly to supine.

## 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.

Managing the collapsed person has been identified as high risk (Sturman, 2011; Resuscitation Council, 2009). Risks are presented because the person has collapsed and may require M&H either to be lowered to the floor or repositioned supine on the bed/ trolley. Some of the task may involve twisting, flexing, pulling, pushing, over reaching and working at floor level.

Risk can be reduced successfully through robust generic risk assessment, practical training and provision of appropriate equipment.

## 14. Alerting the moving and handling team

The M&H team should work jointly with the resuscitation team to agree transfers and their implementation during specific CPR and M&H training.

The M&H team would not be routinely called in these situations unless there were very special circumstances like a bariatric person who had collapsed straight after arrival.

## 15. Referral to and involvement of other specialists

Following CPR a person will be monitored in a coronary care/ intensive care unit and later on a medical ward.

The resuscitation officer/ team and the MHP should have devised SOPs. The implementation of these procedures may involve Estates/ Facilities e.g. to rehang toilet doors.

## 16. Transport (internal and external)

If a person collapses in a community setting, paramedic services will be involved. A full length slide board should be available for all lateral transfers in A&E.

A person who has collapsed will be transferred on a bed or trolley from A&E to a ward/ department.

## 17. Discharge and transfer planning

Persons will follow a cardiac discharge plan.

## 18. References


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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 G26 is:**

**Systems are in place to cover the moving and handling of a collapsed person with a cardiac/ respiratory arrest, on the floor, in a chair or in a bed.**

- **Skilful M&H is key**

- **Special points for G26 are: -**
  - **It is essential to try to identify and assess any person who is likely to suffer a cardiac or respiratory arrest although it should be noted this emergency may also occur to a visitor or contractor**
  - **Generic M&H risk assessments are carried out, SOPs/ protocols formulated and available for all staff**
  - **All staff must be trained to safely manage the MH of the collapsed person into a suitable position for resuscitation**
  - **Appropriate equipment is required and staff must be able to use it safely in an emergency situation**
  - **Adverse events must be thoroughly investigated and learning outcomes and action plans relayed to all staff**