G31	Standard	'Outliers' – moving & handling (M&H)

Persons placed in inappropriate clinical settings, due to bed pressures, etc., must receive treatment and handling that is of equivalent quality and safety as that available to someone admitted to a specialist unit or 'centre of expertise' (COE). They should be treated according to the SOPs of the appropriate setting. Named specialist personnel should be available for guidance.

Justification

Rationale

Staff may not have the relevant skills and facilities may not be suitable for persons who are admitted or moved to inappropriate clinical areas (e.g. medical patients on surgical wards, orthopaedic patients on gynaecology wards) and this puts both the person and the staff at risk, and may seriously compromise the quality of care. In busy district general hospitals and other settings the risk of this occurring is reasonably foreseeable and therefore must be planned for.

Authorising Evidence

HSWA (1974); CQC (2010); MHOR (2004); MHSWR (2000)

Links to other published standards & guidance

NCGS (2008); NPSA (2008); Ruszala et al (2010)

Cross reference to other standards in this document

A10-12,14; B3,7,8; D4,6,7; G8-10,14-16,18,19,21,40

Appendices

4, 9, 10, 14-16, 20, 21, 25

Verification Evidence

- requirements for compliance to achieve and maintain this standard

- Generic assessments, which are developed into protocols in the COE, are made available to the inappropriate clinical settings
- Specialists from the COE are available for giving advice to staff in the inappropriate setting, and for monitoring the delivery of care
- Training for staff in the inappropriate setting will need to be reviewed to ensure the essential level of competence appropriate for the 'outlier'. Training can be proactive or reactive
- The incidence of outlying and the length of stay of each episode is monitored
- Assessments identify the provision of specialist handling equipment and the appropriate level of liaison, and this is included in regular audits
- All serious untoward incidents are reported and investigated

G31 Protocol - 'Outliers' (M&H)

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This protocol applies to persons (patients/ service users) who are admitted, transferred or accommodated inappropriately, in settings that are not intended for or suited to the person's condition.

1. Introduction and background

It is essential for quality, safety and cost-effectiveness that adequate provision is made for all specialist and unusual situations that may be encountered in a health or social care organisation. These situations are dealt with in G1 – G40.

For various reasons patients and service users ('persons') may be admitted or transferred to accommodation and specialist areas not designed for or suited to their needs. This generally occurs in acute hospital trusts where the appropriate beds are not available, due to for example 'winter pressures' and influenza epidemics. High occupation rates and the targets set for trusts not to exceed 4-hour waits in A&E make this increasingly likely.

Acutely ill patients (e.g. stroke patients, head injuries, spinal injuries) may sometimes be admitted or transferred to a setting that is not designed or equipped for their care. Other similar situations may arise that lead to persons not being housed appropriately, with for example a change in the condition of someone undergoing long-term care, who becomes temporarily or permanently more dependant. Other examples are mental health patients who develop acute conditions such as a fractured neck of femur (#NoF).

Therefore a patient with a medical condition or a fracture may be housed in a general surgical or gynaecology ward. This may cause problems even where the situation is temporary because the skill sets of the staff, the environment and the equipment are not geared up to the patient's particular needs. Other logistic and organisational issues may compound the problem, when such patients are removed from their centre of expertise*.

> *Centre of expertise (COE) = the area within the organisation (department, unit or ward), where specialist facilities are provided, e.g. orthopaedics.
> NB: In some cases, e.g. spinal injuries, the COE may be in another organisation, such as a regional unit.

Other examples of this phenomenon can be cited:

a) Stroke patients(see G16) (NCGS 2008)
b) Head injuries
c) Spinal injuries (see G9)
d) Service users in continuing care facilities or mental health and learning disability units may deteriorate physically over a period of time, and the

unit which was perfectly satisfactory for them at one stage may cease to become so.

Taking the example of an elderly patient requiring hoisting, admitted for a medical condition or a #NoF, but moved to a gynaecology ward; a hoist and suitable slings may not be readily available. Another example could be a service user with a learning disability receiving long-term care, who might become more dependant as s/he ages and experiences reduced mobility. Such a person may not be transferred to a more suitable unit because there may be some kind of commitment to the person (or their family), who has been encouraged to regard their accommodation as their home. It is essential in both cases that the correct equipment and necessary training is provided.

Generally, these situations are reasonably foreseeable, and so arrangements should be put into place to assure quality and minimise risk.

2. Management, organisation, supervision and support

The housing of persons in inappropriate clinical areas is obviously to be avoided wherever possible, but where it cannot be avoided, a high level of organisation will be required if quality and safety standards are to be maintained.

It is reasonably foreseeable that in the current NHS climate a bed may not be available in the appropriate area. It is therefore expected that there will be contingency planning by the organisation for this eventuality.

All areas need to be managed and organised appropriately, from a safety point of view (MHSW Regulations, 2nd ed, 2000, Reg 5), and from a clinical aspect according to recognised best practice for that speciality. Sufficient supervision and support is essential. Care must be taken to avoid hazardous manual handling (MHOR, 2004).

3. Staffing levels

Sufficient numbers of suitably qualified staff must be employed and rostered (CQC 2010). These levels should be pre-determined, with provision for peaks in demand. Staffing levels will need to be re-evaluated in the light of the increased demands stemming from the admission of a person into an inappropriate setting.

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

Novice (N); Advanced Beginner (AB); Competent (C); Proficient/Practitioner (P); Expert (Ex)

M&H will require various levels of competence. In some areas high levels (P or Ex) will be required, because of the complexity and/or difficulty of the task, or the consequences of making a mistake, as for example in the case of patients with actual or suspected spinal injuries. It is important therefore that competence is assured by means of training, assessment and supervision.

For acute hospitals some means will need to be arranged for the relevant knowledge and skills to be transferred from the centre of expertise to the outlying ward and for appropriate support to be put into place.

In the example of the service user with learning disabilities, suitable provision will need to be made and this may well change the character of the unit.

5. Environment

High quality, safe, efficient and effective practice is rendered difficult or impossible in settings that for the 'outlier', are inappropriate. This is often overlooked; therefore attention must be paid to: - space and layout (including storage), flooring, lighting, other ambient conditions, equipment and furniture, in order to ensure good ergonomics.

In the situations described above the working and clinical environment may be sub-optimal and if this is the case, other control measures will be required to compensate.

Bathing and toileting facilities may need special attention in order to meet the needs of the outlier.

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

Effective communication is vital, so that the correct information is relayed between the various teams and individuals involved in the 'patient journey', and this applies particularly to the outlier.

A means for transferring information, knowledge and skills from the COE to the ward hosting the outlier needs to be established. It will be necessary to assign a responsibility to nominated staff in both areas for the transmission of information and expertise, possibly utilising dedicated link workers. This must be overseen by senior medical and nursing staff, such as lead nurses and modern matrons. Bed managers will also be involved.

7. Treatment planning

At all stages of a person's journey through the system, treatment must be planned by the multidisciplinary team and goals agreed with all concerned. Care must be taken to ensure that steps in the process are not missed in these situations.

8. Moving & handling tasks

A full range of manoeuvres might be necessary to transfer or reposition persons in order to meet their needs safely – to assess, investigate, diagnose, care for,

treat, operate on, rehabilitate and transport this type of patient – and ensure excellent outcomes, as if they were in their own COE.

9. Moving and handling assessment

All moving & handling tasks must be assessed (MHOR, 2004). This can be done generically in connection with the drawing-up of SOPs, or individually. In emergency situations assessments will need to be made rapidly, but not so fast that safety is compromised. Forward planning for every reasonably foreseeable eventuality, such as falls and evacuation, will minimise the occurrence of true emergency handling.

With outliers SOPs should be 'imported' from the COE and adapted as necessary.

10. Methods, techniques and approaches

These should be appropriate to the person. Advice and support should be sought as required, from the COE or the M&H team.

The number of handlers should be determined on the basis of an individual risk assessment or SOP imported from the COE.

11. Handling equipment

Sufficient supplies of suitable handling equipment must be provided, according to the needs of the person. This may mean that equipment is provided temporarily – by internal loan, renting or lease. Sharing of such equipment between wards or units should only be contemplated where this is a feasible option – not compromising the quality and safety of care by involving delays or difficult transport of items, nor introducing infection control risks (G8).

12. Other equipment and furniture

Sufficient supplies of suitable other equipment must also be provided, such as trolleys, beds, couches, wheelchairs, commodes, walking aids, armchairs and specialist seating.

13. Risk rating for each task

To carry out a 'suitable and sufficient' assessment, each task should be evaluated as part of the assessment process, so that the level of risk is quantified. Such assessments should be used, wherever possible, in the design of a safe system of work, and in highlighting any residual risks.

Various systems exist, but it is suggested that the NHS risk management 5x5 matrix, with 0-25 scale, is used for an overall evaluation of risk (NPSA, 2008) (see CD1, appendix 9 in folder 5). It is in common use, simple to use with 5

levels of risk, determined by a calculation of the likelihood or probability of an adverse event occurring multiplied by the severity of consequences or impact should it occur.

Likelihood/Probability (0-5) x Severity of Consequences or Impact (0-5) = 0-25

The values below are based on this system. Calculations lead to the following possible scores or ratings: -

1 – 6 = Low; 8 – 12 = Medium; 15 – 16 = High; 20 = Very High; 25 = Extreme

These ratings can then be used to alert staff, 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.

14. Alerting the moving and handling team

This will depend on the speciality and the situation. Sometimes the M&H team will need to be summoned to help with a particular situation. In the case of 'outliers' there may not be the opportunity for prior planning but with link workers, SOPs, equipment and training it should be possible for each area to manage the outlier outside of their speciality

Reports of incidents and unusual circumstances should be passed routinely to the M&H team for monitoring purposes and to gain their advice in preventing a recurrence of a similar problem.

15. Referral to and involvement of other specialists

Involving relevant teams at the appropriate time will minimise the chances of harm occurring in a specific situation, and will also promote the provision of suitable measures for any future occurrences. M&H in these specialist, unusual or emergency situations will sometimes require the input of such specialist advisors as: - tissue viability, infection control, fire, prevention & management of violence & aggression (PMVA), security, general H&S, estates, facilities. Care must be taken to ensure that appropriate referrals are not missed in these situations.

16. Transport (internal and external)

Transport within the department, clinic, hospital etc., must be catered for, with variable height trolleys, wheelchairs etc. Transport to other units may require vehicles and these too should be suitable.

17. Discharge and transfer planning

It is essential that all such movements of persons from one care organisation to another are planned. This is particularly important when there are clinical complexities or complications, H&S issues, and where patients are bariatric.

Documentation regarding handling assessments, together with recommended approaches and methods for handling must accompany the person home as well as be incorporated in the discharge summary.

18. References

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) 3rd ed Standards in Manual Handling Towcester: NBE

Care Quality Commission (2010) *Essential Standards of Quality and Safety* Std 13

HSE (2000) *L21 Management of health and safety at work Management of Health and Safety at Work Regulations 1999 ACOP and guidance* Sudbury: HSE Books Regs 3, 5, 7, 10, 13

HSE (2004) *L23 Manual handling Manual Handling Operations Regulations 1992 (as amended) and guidance on regulations* Sudbury: HSE Books paras 48, 51

National Collaborating Centre for Chronic Conditions (2008) *Stroke national clinical guideline for diagnosis and initial management of acute stroke and transient ischaemic attacks (TIA) 2.2.1* London: RCP

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

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 G31 is:**

Persons placed in inappropriate clinical settings, due to bed pressures, etc., must receive treatment and handling that is of equivalent quality and safety as that available to someone admitted to a specialist unit or 'centre of expertise' (COE). They should be treated according to the SOPs of the appropriate setting. Named specialist personnel should be available for guidance.

- **Skilful M&H is key**

- **Special points for G31 are: -**
  - **Patients and service users (persons) should be treated and cared for in appropriate settings**
  - **Where this is not possible:**
    - **Expertise should be provided from the COE and additional training considered**
    - **Equipment appropriate to the person should be provided**
  - **The degree of 'outlying' in an organisation should be monitored, and adverse incidents related to this recorded, analysed, and where appropriate, investigated**