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<tr>
<th><strong>Author / Title:</strong></th>
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<tr>
<td>Susan Westbury, Manual Handling Advisor</td>
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<td>Simon Lindsay, Manual Handling Trainer</td>
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<td>Version 2, Techniques for the Manual Handling of Patients, Corp/Proc/029</td>
<td>Anna Smith, Health &amp; Safety Manager</td>
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<td>Health &amp; Safety Committee</td>
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<td>24/07/2017</td>
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Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes

**Document for Public Display:** Yes

**Reference Check Completed by:** Joanne Phizacklea **Date:** 21/01/2017

To be completed by Library and Knowledge Services Staff
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BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioral Standards Framework – Expectations ‘at a glance’

<table>
<thead>
<tr>
<th>Introduce yourself with #hello my name is...</th>
<th>Value the contribution of everyone</th>
<th>Share learning with others</th>
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<tr>
<td>Be friendly and welcoming</td>
<td>Team working across all areas</td>
<td>Recognise diversity and celebrate this</td>
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<tr>
<td>Respect shown to everyone</td>
<td>Seek out and act on feedback</td>
<td>Ensure all our actions contribute to safe care and a safe working environment</td>
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<tr>
<td>Put patients at the centre of all we do</td>
<td>Be open and honest</td>
<td>For those who supervise / manage teams: ensure consistency and fairness in your approach</td>
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<tr>
<td>Show support to both staff and patients</td>
<td>Communicate effectively: listen to others and seek clarity when needed</td>
<td>Be proud of the role you do and how this contributes to patient care</td>
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PATIENT HANDLING Policy on a Page: For Managers and Manual Handling Champions

What do I need to know?

There are three policies relating to manual handling: Manual Handling of Inanimate Loads and Patients, Management of Bariatric Patients and Transferring Dependant Patients using a hoist.

There are standard Risk Assessments on the Health and Safety Intranet which deal with common handling activities. If these do not cover all activities in your area, contact Health and Safety to agree whether an additional one is required.

The approved techniques for handling patients are contained in the SOP (Techniques for the manual handling of patients) which is based on current national guidance. All staff who move patients are trained in these techniques. The SOP is found in the document library.

For In-Patients individual manual handling risk assessments must be completed within the care-bundles within 4 hours of admission and then weekly or when there are any changes to the patient’s ability. Ventilated/anaesthetised patients must have a trained member of staff to take control the airway during move. For Out-Patients arrangements must be made in advance to provide suitable and safe handling where required (e.g. provide a hoist).

A ward or department level assessment must be made to identify what and how much equipment is necessary as standard provision to ensure safe handling at all times. There must ALWAYS be sufficient slide sheets, transfer boards, handling belts and hoists.

Patient moving equipment MUST have a regular planned preventative maintenance schedule. If your dept has trolleys, theatre tables or other patient moving or positioning equipment, ensure it is recorded on the central equipment register held by Medical Engineering.

Contact

For more help please read the policies on Manual Handling in the document library.

Contact the Manual Handling Advisor or Health and Safety Team on Ext 45260

V2.1 August 2016

Why we need this guidance

Our staff are involved in manual handling activities constantly and manual handling incidents are our second most common type of incident. The potential for injury to our patients and staff is high.

This guidance describes:
- That we understand our risks
- How we assess and manage those risks
- How we provide and maintain equipment to ensure we comply with the law and give patients and staff the best experience

Bariatric Equipment

A bariatric patient weighs in excess of 159kg (25 stones) or has BMI of + 30 or whose dimensions exceed those of the equipment being used.

Contoura beds take 180kg/28 stones and Enterprise beds take 250kgs/39 stones in weight but Pentaflex mattresses take only 120kg/19 stones. Dynafoam Fire evacuation mattresses take 254kg/40 stones.

If a different mattress is required, hire it from:
- Huntleigh on 08457 34 2000

Details of patient’s weight, dimensions and mobility problems will be required so that the correct bed and mattress can be obtained.

SWLs for trolleys vary so check before transfer. A hyper-bariatric bed and bariatric wheelchair are available at RLI and FGH. White Clinell standard commodes take 190kg/30 stones.

Our Bariatric hoists are Liko Viking XL and take 300kg/47 stones. These are available on the 3 main sites. Gantry hoists can be hired in.

Additional equipment can be hired on a 4 hour delivery, 24 hours a day/7 days a week from:
- First Call Mobility on 01279 425 648

Hoists and Slings

These are covered by LOLER and MUST be made available for 6 monthly statutory checks and an annual service. Any hoist or sling not bearing a 6 month check label must be removed from service and reported to the Estates Department for action before being put back into use. Staff using hoists must be trained and competent. The make and model of hoist must be documented in the comments box of module F manual handling on ALL staffs T.M.S.

There is a separate Policy on a Page for Hoisting
1. SUMMARY

- UNSAFE / HIGH RISK MOVES
  There are a number of ‘traditional’ techniques which are now considered unsafe and which must no longer be used.
  Legally it is the Manual Handling Operations Regulations 1992\(^1\), - made under the Health and Safety at Work Act 1974\(^2\) - which govern all manual handling activities and to which reference should be made; the important publication here is Manual Handling; Manual Handling Operations Regulations 1992 Guidance on Regulations (as amended) L23 (Health and Safety Executive)\(^3\).
  All unsafe / high risk moves have either caused injuries to NHS and private sector patients, handlers, or both and as a consequence, have featured in court cases. They are no longer considered to be good practice AND MUST NOT BE USED.
  A handler injured when using any of these techniques would find it difficult to obtain compensation; a patient injured when being handled by any of these methods would find it easy to do so.
  Only moves approved by the Health & Safety Department are to be used by TRUST staff.
  Trainers should use this as a reference and/or contact health & safety department if they are in any doubt regarding the safety of any moves.
  IT IS TRUST POLICY THAT STAFF DO NOT USE NON-APPROVED MOVES.

2. PURPOSE

This document is designed to standardise patient handling procedures across the Trust.

- It is a reference for patient handler trainers, managers and staff.
- It is not intended to be a substitute for patient handling training.
- The techniques described in this guide should only be used when a full Moving and Handling Risk Assessment has been carried out on the patient.
- The technique chosen should be the one that reduces the risk of handling to its lowest level where reasonably practicable. Other techniques, for example those used for specific therapeutic reasons, are not included in this guide and should only be used under the explicit guidance of trainers, therapists and in all cases based on a risk assessment.
- None of the techniques are entirely risk free.
- The techniques described in this guide can be cross-referenced with care plans if desired.

3. SCOPE

These procedures apply to staff, students, volunteers employed by the trust involved in the handling and movement of patients.
4. PROCEDURE

4.1 Unsafe/High Risk moves

4.1.1 The Draglift
This includes any way of handling the patient in which the handler places a hand or an arm under the patient’s armpit (axilla), whether the patient is being moved up the bed, sat up in the bed, being assisted from sitting to standing, or being assisted to change from one seated position to another - and regardless of whether the handler is facing or behind the patient, or whether there is more than one handler.

An example of a draglift

An example of the worst kind of drag lift.
4.1.2 The Orthodox Lift
A two-person lift, in which the handlers place one arm around the patient’s back and the other under the patient’s thighs. The handler’s may clasp each other’s wrists, or they may hold the far side of the patient. Handling slings are sometimes used. In all cases these lifts are dangerous.

4.1.3 Two-Sling Lift (not shown)
With slings placed under the patient’s lower back and thighs, the handlers stand either side of the patient with one knee on the bed; this is a total body lift.

4.1.4 The Shoulder Lift (shown below)
Also known as the ‘Australian’ lift, regardless of whether the ‘Free arm’ is placed on the bed for ‘support’ or placed around the patient.

4.1.5 Front Transfer with One Nurse
This includes the pivot transfer, the elbow lift and the ‘Bear Hug’, regardless of whether a belt or sling is used.
4.1.6 When to not lift people
You must not lift people because:

- They weigh too much and are unpredictable
- It is difficult or impossible for staff to get into a safe position to lift
- Staff are at risk of injury in all manual handling techniques
- Most lifts include a risk of injuring the patient
- Manual lifts are not therapeutic; they do not improve the patient’s mobility.

4.2 Words of Command

The Trust command to be used when moving a patient is:

“READY
STEADY
GO”

An alternative is to substitute the word ‘GO’ with a description of the move that is being carried out, i.e. ‘Ready, Steady, Stand’; ‘Ready, Steady, Slide’ etc.

4.3 Procedures for seated patients

4.3.1 Sitting Back in a Chair

- Ensure the patient is sitting in the correct size of chair. The patient should be able to have their bottom at the back of the seat and still be able to have their feet flat on the floor, with their knees at hip height. If this is not possible; i.e. for very short patients, the patient should be given a footrest to rest their feet on.

Consider ways to prevent slipping:

- One way slide sheet
- Where appropriate, use a moulded or angled chair
Ways to sit back in the chair:

- Encourage the patient to move themselves back in the chair
- The patient stands and steps back before sitting down
- The patient stands up, the staff pushes the chair (if the chair is easily moveable) to the back of the patient’s legs, or the staff(s) stand the patient and a third staff pushes the chair to the back of the patient’s legs.
- If the patient is unable to move themselves, staff should reposition them using a stand aid or hoist.

**4.3.2 Cardiac Arrest in a Chair**

- **IF A PATIENT HAS A CARDIAC ARREST WHILST SITTING IN A CHAIR, DO NOT ATTEMPT TO LIFT THE PATIENT BACK INTO BED.**
- Call for assistance: a minimum of two staff is required
- SLIDE THE PATIENT ONTO THE FLOOR. Any manoeuvre involving a patient who has arrested is a high risk one.
- Two staff kneel on either side of the patient.
- The staff place their outside hands behind the patient’s bottom at the level of the seat cushion. Using their inside hands, they take hold of the patient’s legs, securing a hold at the back of the calves behind the patient’s knees. (See Figs 1 & 2)

![Fig 1](image1.png)  ![Fig 2](image2.png)

From this position, the staff perform a backwards weight transfer manoeuvre: on the command ‘GO’ they sit back from a high kneeling position onto their heels, keeping their outside arms as straight as possible and maintaining a good posture. (See Figs 3 & 4)
This manoeuvre will slide the patient forwards, their bottom moving clear of the chair cushion. Two staff can now release the patient; the momentum caused by the manoeuvre, combined with gravity and the patient’s weight will cause the patient to slide out of the chair and onto the floor. (See Fig 5)

To protect the patient’s head a third staff may place a pillow behind the patient’s head as the patient is sliding out of the chair. The pillow may be kept in place by the two kneeling staff until the patient is on the floor. (See fig 5)

The patient is now in a position to be resuscitated.

This manoeuvre can be made a little easier if the staff initially ‘sweep’ the patient’s feet forwards. This can be done by standing either side of the patient and placing a foot behind the patient’s ankles. On the command ‘GO’ the staff ‘sweep’ the patient’s feet forwards, this will make it easier to slide the patient to the floor.

4.3.3 Sitting to Standing

A patient should be assessed for their ability to stand with or without assistance and an appropriate height chair should be provided.

Where appropriate, the patient’s walking aid should be placed within easy reach of the operator.

To encourage independent standing ask the patient to:
- Move their bottom forward in the chair.
• Place their feet apart, one foot slightly in front of the other.
• Place their hands on the arm of the chair.
• Ask the patient to look forwards.
• Ask the patient to lean forward so that their head is over their toes.
• A rocking motion at this stage may help some patients; rocking forwards in time with the Commands “Ready, Steady..”
• The patient is instructed to push with their hands and stand up on the command ‘Stand’
• If the patient uses a walking aid, the staff gives it to them after the patient has stood up.

Where assistance is required:

• The staff should stand on one side of the patient, facing side on.
• The staff adopts a wide base, placing one foot level with the patient's feet.
• The staff places one arm around the patient’s waist or the flat of their hand in the small of the patient’s back; the other hand rests on the patient’s shoulder. To do this, the staff must bend their knees and not their back. (See fig 6)
• The same procedure as above can then be followed: On the command ‘GO’ the staff performs a sideways weight transfer manoeuvre from leg to leg in the direction of the move, their body weight going through the patient via their forearm thus assisting the patient to stand. (See Fig 7)

Alternatively, the staff stands close to the side of the patient, facing the same way as the patient. The staff places their outside foot level with the patient's feet and the other comfortably behind, adopting a wide base. Placing their hands on the patient as above, on the command ‘GO’ the staff performs a forward weight transfer manoeuvre from leg to leg assisting the patient to stand.
If two staff are required, one stands on each side of the patient and proceeds as above.

- Where a handling belt is assessed as appropriate, the same procedure is followed holding onto the handles of the belt instead of holding the patient directly.
- If the patient is not able to raise their bottom off the chair then a standing aid or hoist must be used.
- A patient must not be supported in standing if they are unable to take any weight through their legs.

4.3.4 Bed to Chair, Chair to Commode, Toilet to Wheelchair

It is essential that an assessment of the patient’s own capabilities is carried out and recorded in the individual patient Moving and Handling Risk Assessment form. This should be amended as the patient’s condition changes. From this assessment the correct transfer technique and the most appropriate equipment is identified.

Patients who are able to stand but have difficulty with turning or taking steps.

There are two methods that may be considered depending on the assessment of the patient.

1. Place the chair at 60° to the bed. Place one end of the transfer board under the patient’s thigh nearest the chair and the other end positioned onto the chair. The patient should reach across to the far arm of the chair. They should then slide their bottom along the board until safely positioned in the chair. A therapist should assess patients who use a transfer board.
2. A turning device with a handle or frame maybe used for patients who can stand and have good balance but are unable to take steps.

4.4 Procedure for falling/fallen patient

The patient should be risk assessed and recommendations/guidance for staff should be followed. If the patient does fall there is a significant risk of injury to the member of staff. If the patient becomes unsteady and is close to the chair/bed staff should guide them into the chair or onto the bed. Staff should not 'lower' the patient, as this will involve taking their weight.

If the patient is in close physical contact at the moment of collapse, the following steps are recommended.

- Release your hold on the patient
- Do not attempt to hold the patient up.
- When the patient is on the floor staff can then put them into the recovery position; check for injury, summon help etc.

If the patient is out of reach; it is unrealistic to try to rush to rescue them. In this situation there is no safe way of dealing with a falling patient, other than to allow them to fall. In the early stages of walking with a patient or if the risk assessment indicates a patient has a history of falls, two or three members of staff should walk with the patient, one of them following the patient pushing a wheelchair.

4.5 Procedure for walking with a patient

The patient’s ability to walk must be assessed.

- The patient must be able to weight bear bilaterally and take steps without manual assistance.
- The patient may wear a transfer belt and use an appropriate aid where necessary e.g. a walking frame, stick.
- If using a handling belt, hold one handle on the side of the patient. If using a hand hold for reassurance, the patient’s arm(s) should be straight, hand pressing down onto the staff’s flattened hand. Thumbs should not be interlocked, this enables staff to release their grip quickly and safely if the patient should fall.
• Face the direction you are going and ensure a clear path.
• Do not attempt to hold a patient up if they begin to fall.

4.6 Procedure for getting a patient off the floor

Always use a hoist /HoverJack if the patient is unable to get up independently.

• Assess the patient for any injuries and get medical assistance where necessary.
• Ascertain whether the patient can get off the floor independently and/or with verbal guidance. Do not offer the patient any physical assistance - the patient may grab hold of staff’s arm/hand/shoulder/neck and cause an injury.
• If the patient is unable to get off the floor, make them comfortable with pillows and blankets.
• When the patient is able to be moved safely, clear the area.
• If necessary, slide the patient into space that allows easier access for a hoist/HoverJack. A minimum of three staff will be required to perform this task.
• Place a pillow under the patient’s head and an evacuation sheet, blanket or bed sheet under the patient’s body by rolling using the standard procedure. One staff protects the patient’s head; two staff pull the blanket at the patient’s feet, if the feet are nearest the exit. This should be done with the staff standing with their knees bent and their backs straight, not twisted.
• If the patient’s head is nearest the exit, the blanket is pulled out headfirst. Once the patient is appropriately positioned, use a hoist/HoverJack to return the patient to their bed/chair.
• Insert the hoist sling or position on Hovermat by rolling the patient using the standard procedure.
• Position the hoist. The patient’s legs may have to be raised to enable the sling to be secured to the hoist. Raise the patient from the floor, ensuring that they are in a sitting position. Do not attempt to take the weight of the patient’s head; rely upon a high backed sling.
• Do not attempt to manually lift anyone off the floor, always use a hoist or HoverJack. Preferred method would always be a Hoverjack as you have to be entirely sure there are no injuries to use a hoist.

All slip, trip and fall incidents will be investigated and reported on in accordance with the Policy for Reporting and Management of Incidents including Serious Incidents which is found on Heritage. Moderate, major and catastrophic harms may be requested by the SIRI panel or where it is evident that a theme or pattern is emerging from scrutiny of investigations. Ref Slips, Trips
4.7 Moving and handling a patient with cardiac arrest collapsed to the floor

The patient should not be manually lifted from the floor. The patient should only be moved if not moving them would put the patient and/or the healthcare staff at risk of further harm. If the patient recovers, they should be placed into bed using a Hoverjack & mat. Using a conventional sling to do this will put pressure on the patient’s abdomen and put the patient at risk of re-arresting. If this is not possible, the patient should be made as comfortable as possible and not moved until the Paramedics arrive with a stretcher.

4.8 Procedures for moving patients on a bed

4.8.1 Rolling/turning a patient

This procedure can be used for all of the following moves:

- Rolling/Turning a patient
- Thirty degree tilt
- Insertion/removal of a slide sheet under a patient
- Insertion/removal of a hoist sling under a patient on a bed
- Insertion/removal of a hoist sling under a patient on the floor
- Insertion/removal of a transfer board under a patient
- Bed bathing a patient
- Application of/or changing the dressings of a patient whilst in bed
- Changing of bed linen whilst the patient is in bed
- If the patient is able to co-operate and move themselves, ask them to do so. If not:
  - Raise the bed to at least waist height. Turn the patient’s head in the direction of the turn i.e. away from staff.
  - A second member of staff must be on the other side of the bed to ensure the patient’s safety.
  - Raise/bend the patient’s leg nearest to staff so that their foot is as near to their bottom as possible. If this is not possible, cross their ankles.
  - The staff gently pushes against the patient’s shoulder and hip: the patient will easily turn over onto their side, assuming the recovery position. (See Fig 8)

![Fig 8](image-url)

The receiving staff maintains the patient’s position and safety by resting their hands on the patient’s shoulder and the uppermost side of the knee. (See Fig 9)
Alternative Procedure for rolling patients onto their side where the patient is either:

- On a trolley
- On an operating table
- On a treatment couch i.e. narrow surfaces
- On the floor
- On a divan bed

The staff follows the above ‘Standard Procedure’ but pulls the patient over and toward them (See Fig 9). This is because the staff does not have to compromise their posture by leaning across to reach the patient (due to the narrow surface) and to push roll the patient on a narrow surface constitutes an unnecessary risk.

4.8.1.1 Rolling/turning an anaesthetised/ventilated patient
1. A patient risk assessment will be carried out and any special measures required for the safe movement of the patient shall be documented.
2. Prior to the movement of the patient, a ROLL LEAD (RL) should be identified.
3. The RL should ensure that the correct numbers of competent staff are available for the move.
4. The RL will take responsibility for initiating and controlling the movement of the patient in its entirety.
5. The RL shall position themselves at the head end of the patient ensuring the airway and any tubes assisting with the air way are supported and not trapped, caught or tangled in any way.
6. The RL will initiate the roll of the patient by the call of READY. This is a question and the roll lead should await answer from the whole team involved in the move before continuing with the procedure.
7. Once the team has answered yes, the RL will continue onto the words BRACE and ROLL.
8. At this point any checks on the patient can be carried out, insertion of patslide or slide sheet can take place.
9. On the call of the RL again starting with the question READY? This needs to be responded to by the rest of the team; the patient can be lowered on the call Ready Brace Lower.
10. From this point, if the patient is being patslided, then the move can continue using the patslide technique guidelines 4.8.7. If the patient needs to be rolled in the other
direction, then repeat the above.

11. At no point should a patient with an assisted airway be moved without the presence and instructions from the Roll Lead.

4.8.2 Lying to Sitting on the edge of a Bed

Get the patient to do as much as possible for themselves, but where necessary and appropriate, use one or two staff to assist.

- The patient rolls onto their side and swings their legs over the side of the bed. The patient can then push up using their arms, into the sitting position.
- Where assistance is required, roll the patient as in the standard procedure, but with both legs raised/bent. The patient slides their feet over the side of the bed, the staff places one hand under the patient’s shoulder (between shoulder and bed) and one hand on the patient’s hip/thigh. (See Fig 10)
- The patient is moved into a sitting position by the staff transferring weight from leg to leg in the direction of the foot of the bed. At the same time the staff transfers their body weight through the patient’s hip/thigh. This manoeuvre will swing the patient’s legs around and down, their upper body following into a sitting position. (See Fig 11) The emphasis on the weight transfer should mean that almost all of the force exerted goes onto/through the patient’s hip/thigh and therefore minimal effort is required from the staff’s hand under the patient’s shoulder. I.e. The staff is NOT lifting the patient up by their shoulder.
- Always use a hoist if the patient is unable to assist.

Fig 10  

Fig 11

4.8.3 Lying to Sitting on a Bed/Trolley

If the patient has sitting balance but is unable to sit themselves up, use the following method:

- Ensure that the patient is on a draw sheet and that it is under their shoulders.
- Adjust the height of the trolley/bed to waist height, one staff standing each side of the patient, facing the patient’s face.
- Using their inside arms, they grasp and take up any slack in the draw sheet, positioning their hands close to the patient’s shoulders.
- The staff adopt a wide base, placing their inside foot at about a pace’s distance behind their outside foot. (See Fig 12)
- On the command ‘GO’ the staff, keeping their arms straight, step back onto their inside foot, performing a weight transfer manoeuvre in the standing position. (See Fig 13) Once the patient is sat up, one staff supports the patient, whilst the other raises the backrest of the trolley.
- If the patient is unable to assist, consider the use of a hoist.
4.8.4 Devices to Prevent Patients Slipping down the Bed

- Nurse the patient on a profiling bed use the knee break raised slightly.

4.8.5 Manoeuvres up the Bed

A patient should not be routinely moved up the bed. It should only be done if there is a medical reason for doing so, or at the patient’s specific request. These manoeuvres should only be carried out if assessed to be safe to do so. If in doubt, don’t do it.

- The patient should move themselves with or without the help of a slide sheet and/or hand blocks. (See Fig 14)

If the patient is able to walk, then stand the patient out of bed and walk them back to the top of the bed.

- If the patient can stand but has difficulty taking steps or is attached to equipment of any kind, stand them up and move the bed down until the correct position is reached.
- Where assessed to be appropriate, carry out a recognised manoeuvre with a slide sheet.
- Use a hoist to lift the patient clear of the bed. Move the bed down using two staff, until the patient is over the head end of the bed (it may be necessary to move the hoist backwards to do this) and then lower the patient back into bed. Push the bed back up
against the wall. This manoeuvre is easier than moving the hoist with the patient in situ.

To make space around the bed:
- Draw the curtains/screens.
- Move tables, chairs, and lockers out of the way.
- Move the bed into a central (more spacious) area.

4.8.5.1 Manoeuvres up the Bed: The Patient who cannot sit up
In order to minimise the risk to lowest reasonable level, such patients should be nursed in an electric profiling bed.
Prior to any manoeuvre, prepare the bed area, ie. brakes on, create as much space as possible.
- Always use a hoist / hovermat if there are no suitable alternatives.
- When the patient is not able to sit up unsupported, or is in a semi-recumbent position; a slide sheet can be used to slide the patient higher up the bed.
- To position a slide sheet under a patient with two staff
- Raise the bed to at least waist height. Turn the patient’s head in the direction of the turn, i.e. away from the staff.
- A second staff must be on the other side of the bed to ensure the patient’s safety and to foster their confidence. (See Fig 15)
- Roll the patient onto their side using the standard procedure.

Fig 15

- Ensure the slide sheet is facing the correct way and is ‘slippery’ in the desired direction. Position the half-rolled slide sheet as far as it will go under the rolled patient. Alternatively the slide sheet can be placed under the bed sheet. (See Fig 16)
If using large ‘open’ slide sheets, place two sheets on top of one another directly under the patient. (See Fig 17)

Repeat the manoeuvre from the other side of the bed to unroll the rest of the sheet. (See Fig 18)

Moving the patient up the bed with three staff:

1. One standing at the head end of the bed, facing the foot end with the backrest off. This staff grasps the upper slide sheet (or the top sheet if using two large “open” types) at either side of the patient’s head, just above their shoulders. The staff supports the patient’s head. Ensure that any slack in the slide sheet is taken up.
2. One standing each side of the patient each facing each other. These staff grasp the upper part of the slide sheet (or the top slide sheet if using two large ‘open’ types) at the points level with the patient’s shoulders and hips. Ensure any slack in the slide sheet is taken up. All staff hold the slide sheet close to the patient’s body; unless doing so means that any of the staff compromises their posture by over-stretching. In which case, grasp the slide sheet in a position most comfortable for the staff.
3. The staff at the end of the bed places one foot behind the other, adopting a wide base, ready to perform a backwards weight transfer manoeuvre in the direction of the move.
4. The staff at each side of the patient bend their knees and adopt a wide base, ready to
perform a sideways weight transfer manoeuvre in the direction of the move, avoiding twisting (See Fig 19)

Fig 19

- On the command ‘GO’ slide the patient up the bed in short stages, weight transferring from leg to leg in the direction of the manoeuvre.
- Remove the slide sheet as above, i.e. roll the patient from side to side. An alternative method is to grasp the lower surface of the slide sheet(s) at the patient’s ankle or knees and gently pull backwards (towards the patient’s head) until the slide sheet(s) are removed.

With two or four staff:
One staff on each side of the bed (two staff on each side of the bed if four staff are available) and now follow as above except that there is no staff at the head of the bed.

If it causes the patient discomfort to be rolled a slide sheet can be inserted using the rolling out method.

4.8.6 Inserting a Bed Pan (while the patient is in bed)
Get the patient to do as much as possible to help e.g. use a Hoskins pulley (sometimes referred to as a ‘monkey’ pole.), or ask the patient to ‘bridge’, i.e. the patient lies on their back, both knees flexed, feet flat on the bed, forearms and hands flat on the bed (palms down). The patient pushes down on their hands and feet to raise their hips. (See Fig 20)
- A patient may be rolled onto a bedpan. Bed pan to be inserted from staff side (roll away).
- Hand blocks.
- If this is not possible, a hoist must be used.

Fig 20
Do not attempt to lift the patient onto the bedpan.

4.8.7 Bed to Bed, Bed to Trolley, Trolley to Bed
Assess the patient and if fully co-operative and fully conscious encourage the patient to transfer independently. If not use the following procedure:-
- Obtain a transfer board.
- Use a minimum of four staff.
- Remove the head of the bed.
- If possible, the patient should be off centre in the bed, towards the side that they are going to transfer from.
- Place the transfer board under the patient by rolling, using the standard procedure i.e. push; do not pull the patient into the recovery position (See Fig 21). If the patient is lying on a narrow surface it may not be safe to use the standard procedure. In this case staff should use the alternative procedure.

![Fig 21](image1)

- Place the transfer board under the patient and sheet/draw sheet. Leave enough of the transfer board exposed so that a safe and effective ‘bridge’ is made between the bed and the trolley. (See Fig 22)

![Fig 22](image2)

Position the trolley parallel and close to the bed. Ensure that the trolley and bed brakes are on (see Fig 23).
In order to minimise staff effort, gravity and the patient’s weight can be utilised by raising the bed approximately 2” higher than the trolley. The manoeuvre will therefore involve pushing the patient downhill to approximately waist height. The staff stand at the head, feet and near side of the patient. (See Fig 24)

- The staff at the side places their hands on the patient’s hip and shoulder. The staff stands with one foot behind the other; ready to perform a forward weight transfer manoeuvre, which will push the patient in the direction of the transfer on the command ‘GO’.
- The staff at the head end takes up all the slack in the sheet, supporting the patient’s head and pillow. The staff at the foot end supports the patient’s feet in the same manner. The staff at the head and feet stand with their feet apart adopting a wide base. On the command ‘GO’ they transfer their weight from one leg to the other in the direction of the move, avoid twisting.
- On the command ‘GO’ move the patient mid-way.
- The pushing staff then moves around to the other (receiving) side and helps to manoeuvre the patient the remaining distance by moving the patient towards them: the staff grasps the draw sheet at the patient’s hip level and performs a weight transfer manoeuvre by stepping backwards on the command ‘GO’ with the other two staff moving as above. (See Fig 25)
A fourth member of staff stand at the receiving side of the bed and when the patient is in the mid position, they can grasp the sheet at the patient’s shoulder and hip level and weight transfer backwards, completing the manoeuvre.

If the transfer board is not immediately and easily removable, move the bed away from the trolley, roll the patient off the transfer board in the standard manner and the other staff pull out the transfer board.

4.8.8 30° TILT (Preston K.W. 1988)\(^4\)

If a patient needs to be turned regularly for relief of pressure areas, 30° tilting should be used.

- Three soft pillows are needed to support the trunk and lower limbs, plus a minimum of two are required for the head and neck.
- Place the patient centrally in the bed in the recumbent or semi-recumbent position.
- The assisting staff tilts the patient away from them, using the standard procedure for rolling (See Fig 26); the roll only needs to be to an angle of approximately 30°.
- The first pillow is placed length ways at an angle of approximately 45°, with a corner of the pillow positioned carefully to fill the small of the back, (See Fig 27).
- Do not overdo this - a pillow depth of 1.5 – 2” is usually adequate.

- Gently allow the patient to roll back onto the pillow.
- Check that the patient’s shoulders and thoracic spine are supported.
- The patient’s leg (on the same side as the inserted pillow) is supported next, using a pillow inserted under its entire length, the pillow being moulded around the limb with
the patient’s heel extending over the end to prevent heel pressure. (See Fig 28)
- The third pillow is inserted at an angle to support the other leg from the back of the knee to the ankle, leaving the heel unsupported. (See Fig 29)
- A staff can check that there is a clearance between the patient’s sacrum and the mattress with their flattened hand - it should be easy to put a hand in the slight gap created.
- Support for the feet may be necessary to prevent foot drop.

Fig 28                                                   Fig 29

4.9 Procedures for General Sling Hoisting

1. Patient’s risk assessment/care plan, use a minimum of two staff unless otherwise dictated by the staff when hoisting.
2. Storage / not in use.
   Ensure the brakes are on when the hoist is not in use. Ensure electric hoists are left on charge when not in use.
3. Safe Working Load (SWL)
   This should be clearly marked on every hoist. If in doubt, check with the manufacturer. Never use a hoist to lift a patient who exceeds the safe working load.
4. Service checks.
   Hoists and slings should be inspected twice a year.
5. Moving a hoist.
   Always push where possible and keep close to your body. Mobile hoists are designed to transfer patients; they are not designed to transport patients. Do not push or pull excessively. Protect the patient’s head from potential injury.
6. Use of hoist legs.
   Use handset controls to alter position of legs if the hoist is electric. Avoid kicking the hoists legs into position if the hoist is manual.
   Alter the hoists leg angles appropriately when positioning patient in a bed/chair etc.
7. Use of brakes.
   Brakes should be OFF except when in storage, being used on an incline, or when adjusting a hoisted patient’s clothing i.e. prior to toileting.
8. Explanation to user.
   Communicate with your patient and where possible obtain their consent and cooperation.
Use the appropriate sling for the hoist. Irrespective of manufacturer, ensure that the hoist/sling interface is compatible.
Use appropriate size sling for the patient. For general purpose slings this means that the sling should fit from the top of the patient’s head to the base of their spine.

All electric hoists have a manual override which can be operated in the event of a power failure. Staff should familiarise themselves with the override system on their hoists.

11. All staff to have received hoist training & information relating to hoist in their service.
12. All staff to carry out safety checks on hoist prior to use.

4.9.1 Safety Checks prior to each use
Read and follow the handling/hoisting plan

Handlers must do an ‘on the spot’ risk assessment to check there is no significant change from the handling/hoisting plan and do a visual check of all equipment prior to using it.

Prepare environment for hoisting, ensure there is sufficient space to use the hoist safely.

4.9.2 Hoist – mobile (electric & hydraulic), ceiling track systems, stand aid, bath
Ensure:

- Safe working Load (SWL) of the hoist and is clearly displayed
- The hoist is fully charged & the battery fitted correctly
- There are no obvious signs of damage
- Any leads are connected correctly
- There are no fluid leaks
- The emergency stop button is set correctly
- The lifting tape is intact and not frayed (applies to ceiling track, certain mobile hoists)
- The base adjustment moves freely i.e. free from carpet fibres/fluff etc. (mobile & standing hoists)
- The base adjustment moves freely (mobile & standing hoists)
- The raise/lowering mechanism works
- LOLER checks are in date

4.9.3 Slings
Ensure:

- It has been assessed for the client and is fit for purpose
- The sling is compatible with the person & the hoist
- All labels are legible and show SWL and unique identifier
- There are no signs of fraying, tears etc.
- All stitching is intact
- The fabric is not worn/ wearing
- Velcro (if applicable) is clean and free of fibres/fluff etc.
- The buckle (if applicable) has no signs of damage etc.
- The sling is clean
- LOLER checks are in date (single patient use slings are opened for the patient)
4.9.4 Environment
Ensure:

- There is sufficient space to use the hoist safely
- The floor is clear of obstacles
- There is sufficient access around and under furniture
- There is a suitable and safe area to store and charge (if applicable) the hoist
- The environment is prepared for the task

If a fault is identified with either the hoist or sling it should immediately be withdrawn from use and follow your reporting procedures.

4.9.5 General guidance - good practise for all hoisting tasks

- Do not use the hoist/sling unless you have had the necessary training
- Read the relevant handling/hoisting plan and ensure it is current and relevant
- Familiarise yourself with the hoists emergency lowering systems
- All hoisting tasks should be performed with 2 handlers
- Communicate with all involved in the task at all times
- Ensure safety and comfort of patient at all times
- Reassure the patient at all times
- Never use the hoist as a threat
- Brakes must not be applied during the hoisting procedure (unless otherwise risk assessed)
- Any concerns regarding the equipment, task, patient, environment etc., handlers must contact their manager or follow organisational procedures immediately.
- Apply sling first, bring hoist in last
- Double check the sling attachments and the sling and the person are in the correct position prior to raising
- Ensure the support surface is ready to receive the patient
- Hoist the person just above both support surfaces to obtain sufficient clearance.
- Avoid using the hoist to transport over distances, thresholds and different surfaces unless otherwise stated in the risk assessment.
- Follow local policies and procedures with regard to care and cleaning of the hoist.
- Place hoist on charge when not in use.
- Hoists and slings must not be adapted or misused.

Additional guidance for mobile hoists:

- Control the descent of the spreader bar and lower to the level of the patient’s chest or below for sling attachment.
- Store in safe place with the boom/jib in lowest position with brakes on when not in use.

If a patient is over 25 stone specialist advice may need to be sought.
This is down to departmental assessment.

Additional guidance may need to be sought for overhead/tracking, stand aid or bath hoists.

Please see National Back exchange & Manufacturing Guidelines.
4.10 Procedure for use of Hover jack & Hover mat

Hoverjack - SAFE WORKING LOAD (SWL) - 544Kg
Hovermatt – SAFE WORKING LOAD (SWL) - 544Kg

The hover jack can be obtained by contacting hotel services or collection by department staff. It must be signed/timed and dated on collection and return.

4.10.1 Personnel involved
Sufficient numbers of staff must be available during the task (MINIMUM TWO), with one as leader of the team. All staff should undertake an “on the spot risk assessment” assessing the need for further assistance for each individual patient.

All staff participating in the task must have had Manual Handling Training.

All staff must have had Training in the use of the Hoverjack and/or Hovermatt.

Pregnant Staff or those with health problems must be asked about their health status before starting the task.

4.10.2 Before commencement of the Task, the following checks are carried out
The environment must be clear and allow sufficient space and avoidance of obstacles for the Hoverjack and/or Hovermatt manoeuvre to ensure safety.

The Hoverjack and/or Hovermatt are appropriate for the patient.

The safe working load (SWL) is displayed on the Hoverjack and/or Hovermatt

The Hoverjack and/or Hovermatt are in a usable condition i.e. seams, fixing points and handles.

The Air Supply is in working order.

The mattress inflation valve and deflation valve are ‘closed’.

That all surfaces are free from sharp or abrasive objects.

Ensure all patient support systems e.g. catheters/ IV lines, oxygen lines etc., are free to move with the patient.

The route is planned.
The manoeuvre is fully explained / described to both the patient and staff.

The patient has given informed consent.

4.10.3 Procedure: HoverJack
Position the HoverJack underneath the Patient using the principals of manual handling so that the head and feet ends of the mattress correspond with the head and feet of the patient.

Ensure that the patient’s body is centred

The end with the valves should be positioned at the foot end of the bed, trolley or stretcher.

Make certain that red deflate valve is capped tightly.

Ensure that the patient safety straps are loosely fastened before inflating the mattress and tightened to make gentle contact with the patient once the mattress is fully inflated.

Plug in Air Supply to a suitable socket.

Hold hose against inlet Valve #1 of the HoverJack and turn on Air Supply to inflate.

Using the same process, move to Valve #2, Valve #3 and Valve #4 in succession. When all chambers are fully inflated, turn off Air Supply.

When fully inflated, remove hose. Valve will automatically close, keeping chamber inflated. CHAMBERS MUST BE FULLY INFLATED TO ENSURE STABILITY.

With the HoverJack positioned as close as possible to adjacent surface, transfer the patient using the principals of manual handling from HoverJack onto the bed, trolley or stretcher.

To stop the air supply in an emergency press the RED “RESET” button

For further information please refer to user instructions provided with this equipment.

4.10.3.1 Warnings
Move the HoverJack using the pull straps at the head and foot ends and/or the handles located along the top perimeter.

When moving a patient on the inflated Evacuation HoverJack, use caution and move slowly.
Never use the patient safety straps to pull the HoverJack, as they may tear.

Make certain that patient safety straps are secured before moving.

Someone should be with the patient at all times while inflating and using the HoverJack.

Do not lift the Air Supply by the air hose.

4.10.4 Procedure: Hovermatt
Position the Hovermatt underneath the Patient using the principals of manual handling so that the head and feet ends of the mattress correspond with the head and feet of the patient.

Ensure that the patient safety straps are loosely fastened before inflating the mattress and tightened to make gentle contact with the patient once the mattress is fully inflated.

Plug in Air Supply to a suitable socket.

To stop the air supply in an emergency press the RED “RESET” button

For further information please refer to user instructions provided with this equipment.

4.11 Technique for Log Rolling a Patient with Suspected Spinal Injury

The Log Roll technique can be described as ‘a manoeuvre used to roll a patient, from the supine position, onto the patients side or completely over without flexing the spinal column’

4.11.1
If there is any doubt that the patient has suffered a spinal injury, then no movement of the patient should occur, until the arrival of clinical staff. The clinical staff, on examining the patient, can then approve the following technique to commence.

4.11.2
There shall be a minimum number of 5 staff, one of whom will be clinically trained, in order to complete a safe Spinal Log Roll.

4.11.3
The clinically trained member of staff, who is competent, trained and signed off in carrying out the maneuver, shall be responsible for communicating all instructions throughout this technique. They shall be known as the Roll Lead (RL).

The RL will be positioned at the head of the patient and is responsible for ensuring that the patients head and neck are suitably immobilized and supported throughout the manoeuvre.

The RL is responsible for supporting the airway and any equipment involved in maintaining the airway and keeping the patient informed of all actions taking place. The RL will ensure the team involved in the move fully understands their role and asks the team to confirm this before the roll takes place.
4.11.4
The remaining 4 members of staff involved, with the tallest at the shoulder end of the patient and the remainder of the team working their way down the patient in order of height (tallest to shortest) are positioned as stated below.

1. 5th assistant passively positions patient’s arms across chest but above diaphragm. This is important as the arms are paralysed and may fall down causing injury to the shoulder joint.
2. 2nd assistant reaches over patient. First hand on shoulder and second hand on top of hip. 5th assistant supports patient’s arm during this action.
3. 3rd assistant positions hands. First hand at hip level alongside the 2nd assistant, and second hand underneath furthest thigh.
4. 4th assistant positions hands. First hand under the knee of the furthest leg, and second hand under the ankle of the same leg.

By following the above hand/arm positioning, the patient will have 3 arms over the body and waist, and 3 arms under the waist and legs (as shown in diagram 1)

Diagram 1. Arm possession for suspected spinal injury log roll.

4.11.5
Once all staff are in position and understand their duty during this technique, the RL can instigate the manoeuvre. The RL will state in the following order
1. ‘READY’- This is a question; everyone involved in the move is required to answer YES or NO depending. If anyone answers NO then the move is to be stopped immediately and any issues can be discussed, once the issue has been resolved, the process can start again. If everyone answers YES the manoeuvre can continue to step 2.
2. ‘BRACE’- The team involved in the manoeuvre PREPARE to roll the patient. All staff to ensure they have a firm hold/hand placement on the patient. Staff should also ensure they have the correct posture i.e. legs in correct position (lead leg slightly in front of the other) and their back straight.
3. ‘ROLL’- All staff to roll the patient in one smooth controlled technique, most importantly, staff MUST carry out their designated role simultaneously. The persons responsible for the leg should ensure it is supported and kept straight in order to prevent any movement that could affect the spine.
4. Once the patient has been rolled onto their side the person examining the patient, who should be prepared to start as soon as the roll has been completed, can complete all relevant observations and tests.
4.11.6
Once the test and observations are completed the patient is to be returned to the supine position. Again the RL is responsible for initiating the move and as 1.5 above the same call should be announced:
1. READY?
2. BRACE
3. DOWN

Everyone involved in the move shall work together and carry out their roles simultaneously. The staffs involved in the move are to ensure the leg and arms are supported to avoid movement which in turn could cause damage to the spine.

4.12. Ligature Rescue. (Ligature Cutter can be used left or right handed)

All complete or incomplete suspension incidents must be considered high risk with regard to manual handling, because of the loads involved and possible requirement to adopt awkward postures. The staff involved in this technique must be aware of their surrounding environment and any possible danger to themselves. Staff who have injuries or risk assessments in place that may affect their manual handling abilities must not attempt this technique.

Staff should carry out a dynamic risk assessment (T.I.L.E.) and also consider any other factors such as body fluids, contamination etc. Staff should apply safe handling principles to the best of their ability in the situations that they find themselves.

The weight taken by the staff will exceed the numerical guidelines, for lifting and lowering, (HSE1992), however in this emergency situation there is an acceptance that the guidelines cannot be fully followed.

DO NOT pull on the ligature to remove or unhook it

4.12.1 Complete Suspended Strangulation (hanging)

- On arrival at the scene, raise the alarm by shouting for help and dial 2222 if possible.
- Staff attending the scene, if possible, should approach the patient from the front. This will ensure the patient will fold towards the shoulder (i.e. towards the handler, and not away from them) after the ligature is cut.
- After raising the alarm, staff attending will hold the person’s thighs and raise them slightly, to reduce tension on the ligature. (see fig.1)
- If the person is at a height that the staff find difficult to reach, tension can be reduced by placing a table, chair, trolley (with breaks) or Hover Jack (if in the immediate vicinity) underneath the person.
- Before the ligature is cut staff must ensure either the weight of the person is fully supported (fig.2.) or if the dynamic risk assessment has stated an unhindered drop the staff must move clear of the danger area. One handler will cut the ligature from the point of suspension, preserving the knot. The knot must be preserved intact if possible; it may be used as evidence in any investigation.
- All strangulation attempts should be treated as a suspected spinal injury. Staff should support the neck, as far as is possible. No specific techniques exist to allow for support of the c-spine as the individual is lowered to the ground following hanging, so
staff should try to support the head to the best of their ability in the circumstances.

- Another handler will support the person’s head, while other staff lowers the person into a supine (lying face up) position onto the floor/ground, if it is risk assessed safe to do so.
- Remove the ligature from the neck, using a ligature cutter if required.
- Assess vital signs and commence resuscitation, if appropriate.
- When ready, raise the person from the floor, under clinical advice and using the HoverJack.

4.12.2 Incomplete Suspended Strangulation (semi seated or kneeling).

- On arrival at the scene, raise the alarm by shouting for help and dial 2222 if possible
- Staff attending the scene, after raising the alarm, will hold the person’s thighs, hips, or the person’s belt or clothes, and raise them slightly. Place pillows, seat cushions underneath the person to keep them raised in order to reduce the tension on the ligature.
- One handler will cut the ligature from the point of suspension, preserving the knot.
- One handler must support the person’s head as the person is lowered to the ground.
- Assess vital signs and commence resuscitation, if appropriate.

4.12.3 Lying Strangulation

- On arrival at the scene, raise the alarm by shouting for help and dial 2222 if possible
- Staff will slide (insert slide sheet if immediately available) the person up towards the point of suspension, to reduce the tension on the ligature before removal.
- All strangulation attempts should be treated as a suspected spinal injury. Staff should support the neck from moving from side to side (neck immobilisation should be performed by a medic)
- Remove the ligature from the neck, using a ligature cutter if required.
- Assess vital signs and commence resuscitation, if appropriate.

4.12.4 Community Working
All staff who work in the community must be aware that a ligature cutter will not be available for them to use. The rescue procedure will be:

- Upon discovery, DIAL 999 and raise the alarm immediately.
• Conduct the Dynamic T.I.L.E. Risk assessment.
• If able, support the client in order to relieve the pressure from the ligature.
• Use available furniture, if possible, to aid in supporting the patient.
• It is important to understand that a community worker should not carry out this action if it going to put them at serious risk of injury.

4.13 Clinical Incident

If an injury to staff or patient results from this procedure this must be inputted into the Trust incident reporting system on the intranet as per policy.

If staff exhibits symptoms for longer than 3 days then a referral to Occupational Health for advice re management should be made.

If a member of staff is off work for more than 7 days as a result of a work related accident/incident then this will then be reported onto RIDDOR from the clinical incident.

4.14 Maintenance and Infection Control

A Visual inspection is undertaken of all the equipment before use.

The HoverJack and Hovermatt are fully cleaned with hospital detergent and completely dry before returning it back to storage.

Contact medical engineering if any fault detected with the airflow.

4.15 Storage

A Trolley with the Hoverjack, Hovermat and air supply can be found at,

WGH - KEOSC
RLI Centenary – Cupboard SE 1.7 – (Next to children’s ward level 3)
RLI - Medical unit 2 – ward 20 training room.
RLI – Ward 5 Day surgery ward (4 bedded bay)
RLI – Women’s Unit Theatre department
FGH - Ward 2

4.16 Education & Training

Managers will ensure staff in their departments receive the appropriate training in line with the manual handling policy.

4.17 Monitoring & Audit

Health& Safety department will monitor & audit in line with Manual Handling of Inanimate and Patient Loads Policy.

Managers will ensure these standard procedures are adhered to within departments.

Key trainers in departments will provide training, advice and support for these procedures liaising with managers and keeping good records of training.
All staff have a duty to bring to the managers attention and not take part in any manual handling for which they have not received training. Staff have an opportunity to self assess their training requirements.

4.18 Review of procedure

These procedures will be reviewed 3 yearly by the Manual Handling Advisor or if significant changes are to be made.

5. ATTACHMENTS

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Guidance for Suspected Spinal/Head Injury</td>
</tr>
<tr>
<td>2</td>
<td>Equality &amp; Diversity Impact Assessment Tool</td>
</tr>
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6. OTHER RELEVANT / ASSOCIATED DOCUMENTS

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<tr>
<th>Unique Identifier</th>
<th>Title and web links from the document library</th>
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<tr>
<td>Corp/Proc/022</td>
<td>Reporting and management of incidents including serious incidents UHMB</td>
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<td><a href="http://uhmb/cs/tpdl/Documents/CORP-PROC-022.docx">http://uhmb/cs/tpdl/Documents/CORP-PROC-022.docx</a></td>
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<td>Slips, trips and falls policy UMBHT</td>
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<td>Corp/Pol/041</td>
<td>Manual Handling of Inanimate and Patient Loads</td>
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<td>Rescue Procedure for Patients, from Strangulation and Hanging</td>
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7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

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<td>21/07/2017)</td>
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<td></td>
<td>(accessed 21/07/2017)</td>
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<tr>
<td>5</td>
<td>Multidisciplinary Association Of Spinal Cord Injury Professionals.</td>
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<td><a href="https://www.mascip.co.uk/">https://www.mascip.co.uk/</a> (accessed 21/07/2017)</td>
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Bibliography


7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

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<th>References</th>
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8. DEFINITIONS / GLOSSARY OF TERMS

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<th>Definition</th>
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<tr>
<td>HSE</td>
<td>Health &amp; Safety Executive</td>
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<tr>
<td>SIRI Panel</td>
<td>Serious Incidents Requiring Investigation Panel</td>
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9. CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

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<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Date Consulted</th>
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<tbody>
<tr>
<td>Susan Westbury</td>
<td>Manual Handling Advisor</td>
<td></td>
</tr>
<tr>
<td>Anna Smith</td>
<td>Health and Safety Manager</td>
<td></td>
</tr>
<tr>
<td>Paula Witter</td>
<td>Practice Educator SCC Division</td>
<td></td>
</tr>
<tr>
<td>Simon Lindsay</td>
<td>Manual Handling Trainer</td>
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10. DISTRIBUTION PLAN

Dissemination lead: 

Previous document already being used? Yes

If yes, in what format and where? Electronic: Trust Procedural Documents Library

Proposed action to retrieve out-of-date copies of the document:

To be disseminated to:

Document Library

Proposed actions to communicate the document contents to staff: Include in the UHMB Friday Corporate Communications Roundup – New documents uploaded to the Document Library Communication to Key Trainers.
11. TRAINING

Is training required to be given due to the introduction of this policy? Yes

<table>
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<th>Action by</th>
<th>Action required</th>
<th>Implementation Date</th>
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<td>Trust’s Manual Handling Trainer</td>
<td>Pass on new technique through Manual Handling Champions and Practice Educators</td>
<td>Upon Ratification of Policy</td>
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12. AMENDMENT HISTORY

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<th>Version No.</th>
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<th>Page/Selection Changed</th>
<th>Description of Change</th>
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<td>1.1</td>
<td>07/09/2016</td>
<td>Page 4 Section 4.8.1.1</td>
<td>Added Policy on a Page New section</td>
<td>01/07/2018</td>
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<td>2</td>
<td>15/05/2017</td>
<td>Contents Page 3-33-35 Contents Page 3-4</td>
<td>Added Log roll for Spinal Injury/Addition of Ligature Rescue Technique. Insertion of Ligature Rescue Technique Re-numbered headings and page numbers to accommodate for new technique Insertion of new Log roll for spinal injuries technique Update to Evidence Insertion of new hyperlink Training Action added for Trust's Manual Handling Trainer Inserted location of new Hoverjack Equipment Insertion of Community Staff Rescue Technique Change of Job Title</td>
<td>01/05/2020</td>
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<tr>
<td>2.1</td>
<td>20/10/2017</td>
<td>Page 4</td>
<td>BSF page added</td>
<td>01/05/2020</td>
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</table>
GUIDANCE FOR SUSPECTED SPINAL INJURY

CONSIDER SPINAL INJURY IF ANY OF FOLLOWING ARE PRESENT:
- Fall from a height—more than 3 feet (e.g., out of bed)
- Fall where patient has hit head or neck
- Found on floor

IF PATIENT IS UNABLE TO VERBALISE EVENT OR GIVE AN ACCOUNT OF ANY INJURIES TREAT PATIENT AS A SUSPECTED SPINAL #

ON ASSESSMENT DOES THE PATIENT C/O:
- Weakness or Tingling in Arms/Legs
- Altered power, sensation or movement
- Neck Pain, if so is there any bony tenderness on gentle palpation of the vertebrae

E.g., no c/o neck pain, can verbalise the event, GCS 15 throughout, no signs of obvious #
Patient can then be returned to bed and await assessment by Dr if required

IF YES:
- IMMobilise C-SPINE—MEASURE FOR AND APPLY HARD COLLAR
- INFORM SENIOR NURSE ON DUTY (IF OUT OF HOURS CONTACT NIGHT SR)
- IMMEDIATE REVIEW FROM MEDIC
- COMPLETE NEUROLOGICAL OBSERVATIONS

GUIDANCE FOR SUSPECTED HEAD INJURY

SUSPECT A HEAD INJURY IN THE FOLLOWING CIRCUMSTANCES:
- Patient cannot verbalise how they fell and/or no witness to the fall
- Fall from a height (e.g., out of bed)
- Fall where patient or witness states has hit head and/or obvious head injury

If any of the above are present undertake GCS and request immediate review from medical staff.

Neurological observations to be repeated every 30 mins until reviewed by Doctor. Once reviewed continue observations as per Drs Instructions or as detailed below. This assumes patient had a GCS of 15 prior to the fall and is not subject of a head injury

IF GCS IS NOT 15 NEUROLOGICAL OBSERVATIONS TO BE RECORDED ON A HALF-HOURLY BASIS UNTIL GCS 15 REACHED. THEN AS FOLLOWS:
- HALF HOURLY FOR 2 HOURS
- THEN 1 HOURLY FOR 4 HOURS
- THEN 2-HOURLY FOR 4 HOURS OR UNTIL GCS 15 REACHED
- IF GCS 15 IS NOT REACHED WITHIN 24 HOURS THEN FURTHER CT SCAN TO BE CONSIDERED

WHILE UNDERTAKING GCS IF ANY OF THE FOLLOWING OCCUR PATIENT FOR IMMEDIATE MEDICAL REVIEW:
- Development of agitation or abnormal behaviour
- Sustained drop of 1 point in GCS over 30 mins
- Drop of 3 or more points in eye opening or verbal response scores or 2 or more in motor scores
- Development of severe or increasing headache or persistent vomiting
- New evolving neurological symptoms
Appendix 2: Equality & Diversity Impact Assessment Tool

Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Department/Function</th>
<th>Health &amp; Safety</th>
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<tbody>
<tr>
<td>Lead Assessor</td>
<td>Simon Lindsay</td>
</tr>
<tr>
<td>What is being assessed?</td>
<td>Techniques for the Manual Handling of Patients</td>
</tr>
<tr>
<td>Date of assessment</td>
<td>13/07/2017</td>
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<tr>
<td>What groups have you consulted with?</td>
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<tr>
<td></td>
<td>Equality of Access to Health Group</td>
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<td>Staff Side Colleagues</td>
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<td>Service Users</td>
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<tr>
<td></td>
<td>Staff Inclusion Network/s</td>
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<tr>
<td></td>
<td>Personal Fair Diverse Champions</td>
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<tr>
<td></td>
<td>Other (Inc. external orgs)</td>
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<td>Please give details:</td>
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1) What is the impact on the following equality groups?

<table>
<thead>
<tr>
<th>Equality Groups</th>
<th>Impact (Positive / Negative / Neutral)</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Race (All ethnic groups)</td>
<td>Neutral</td>
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<tr>
<td>Disability (Including physical and mental impairments)</td>
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<td></td>
</tr>
<tr>
<td>Sex</td>
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<tr>
<td>Gender reassignment</td>
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<tr>
<td>Religion or Belief</td>
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<td>Marriage and Civil Partnership</td>
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<td>Pregnancy and maternity</td>
<td>Neutral</td>
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</tr>
<tr>
<td>Other (e.g. caring, human rights)</td>
<td>Select</td>
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</tr>
</tbody>
</table>

| | | |
| Comments | Provide brief description of the positive / negative impact identified benefits to the equality group. |
|          | Is any impact identified intended or legal? |

2) In what ways does any impact
3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised**.
- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

### Action Plan Summary

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Timescale</th>
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*This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.*