



Patient Safety Alert

Stage One: Warning

Risk of death and serious harm by falling from hoists

28 October 2015

Alert reference number: NHS/PSA/W/2015/010

Alert stage: One - Warning

A National Reporting and Learning System (NRLS) search identified 15 occurrences in a recent four year period where a person has come to harm through falls from hoists, including one death and three severe injuries. Injuries included hip, leg and ankle fractures, head injuries, lacerations and haematomas. The incidents occurred in acute hospitals, care homes and individuals' own homes. The problems described potentially affect mechanical and electrical hoists, free-standing, ceiling or wall-mounted hoists, and hoists used as bathing aids and standing aids. An example incident reads:

'The patient was being moved from their bed when they fell out of the sling; an x-ray confirmed the patient had sustained two fractured ankles from the fall. On (date) it was confirmed by (hospital) that the patient had passed away. Staff hoisted the patient on their own. Noticed that the staff hadn't followed the correct moving and handling policies and procedure'.

The Medicines and Healthcare Products Regulatory Agency (MHRA) has received 78 reports including three deaths and nine incidents resulting in severe injury. A number of hoist-related incidents were also reported to the Health and Safety Executive (HSE) under Reporting Injuries, Diseases and Dangerous Occurrences (RIDDOR).

Analysis of the MHRA and NRLS data reveal similar themes:

- Failure to follow correct manual handling procedures including instructions on number of carers required to perform manoeuvre.
- Inadequate assessment of service user ability/disability and selection of equipment.
- Sling straps incorrectly fitted to hoist and/ or the person being lifted.
- Wrong size or type of sling used.
- Unclear responsibility for equipment maintenance.

The reports suggest existing advice on training and supporting staff to safely use hoists [1,2,3,4,5] issued by HSE had not always been reliably and systematically implemented. Key areas where opportunities to prevent harm through better implementation of existing guidance appeared not only to be around ensuring staff have completed initial moving and handling training and regular updates, but also that:

- training content is relevant to the types of hoists, patient groups and care settings where they are working;
- training takes into account how to check for changes in an individual's condition that may mean equipment that was previously used is no longer suitable for them; and
- training encompasses the importance of using only slings compatible with the specific design of the hoist.

Additionally, checks by frontline staff are not a substitute for systematic local programmes to provide routine maintenance checks plus the six-monthly thorough examination required by Lifting Operations and Lifting Equipment Regulations (LOLER). Staff should be trained to check the hoists for evidence that maintenance checks are in date (e.g. checking labels attached by maintenance staff with a clear date when maintenance will become overdue).

Actions

Who:

All providers of NHS funded care

When:

As soon as possible but no later than 9 December 2015



1 Identify if incidents involving falls from hoists have occurred or could occur in your organisation.



2 Consider any immediate action needs to be taken locally and ensure that an action plan is underway to reduce the risk of such incidents occurring.



3 Distribute this Alert to all relevant staff who care for children or adults in primary care, community care, emergency care, and inpatient care settings, including mental health and learning disability units.



4 Share any learning from local investigations or locally developed good practice resources by emailing: patient.safetyenquiries@nhs.net

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Technical notes

NRLS search dates and terms

The National Reporting and Learning System (NRLS) was searched on 10 February 2015 for incidents that had occurred between 1 January 2011 and 31 December 2014 using the free text search terms % hoist% and % sling%. The search generated a total of 7881 incidents. All incidents reported as death and severe harm were reviewed. In addition, two random samples of 100 moderate harm incidents and one random sample of 100 low harm incidents were reviewed. 15 incident reports were identified relevant to the patient safety question 'falls from hoists'. Because the moderate and low harm incidents reviewed were drawn from samples, we estimate around 20 further incidents, predominantly low harm, would have been identified if all incidents generated by the search had been reviewed.

MHRA search dates and terms

The Medicines and Healthcare Products Regulatory Agency (MHRA) database was searched using the codes BHSE 08/00 and 08/03 (fall, fell, drop, slip). 78 incidents were reported to the MHRA (Jan 2011— Dec 2014) including three deaths and nine incidents resulting in severe injury.

HSE search dates and terms

The Health and Safety Executive (HSE) (RIDDOR) database was searched (Jan—Dec 2014).

Both MHRA and HSE receive reports from a wider spectrum of organisations than the NRLS, which is focused on NHS funded care. It is not possible to rule out double-counting due to different reporting requirements to all agencies.

Stakeholder engagement

This alert has been developed with advice from the following, who fully support its publication:

- NHS England Medical Specialties Patient Safety Expert Group
- Medical Device Safety Officer Network
- Health and Safety Executive
- National Back Exchange (a professional association for moving and handling practitioners)

For details of the membership of the NHS England Patient Safety Expert Groups see <http://www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/>

References

1. Safe use of work equipment. Provision and Use of Work Equipment Regulations 1998. Approved Code of Practice and guidance L22 (Fourth edition) HSE Books 2014 ISBN 978 0 7176 6619 5 www.hse.gov.uk/pubns/books/l22.htm
2. Safe use of lifting equipment. Lifting Operations and Lifting Equipment Regulations 1998. Approved Code of Practice and guidance L113 HSE Books 1998 ISBN 978 0 7176 1628 2 www.hse.gov.uk/pubns/books/l113.htm
3. How the Lifting Operations and Lifting Equipment Regulations apply to health and social care Health Services Information Sheet HSIS4(rev1) HSE Books 2012 www.hse.gov.uk/pubns/hsis4.htm
4. Getting to grips with hoisting people Health Services Information Sheet HSIS3 HSE Books 2011 <http://www.hse.gov.uk/pubns/hsis3.pdf>
5. Reporting injuries, diseases and dangerous occurrences in health and social care: Guidance for employers Health Services Information Sheet HSIS1(rev3) HSE Books 2013 www.hse.gov.uk/pubns/hsis1.htm

Other useful information

- A number of Field Safety Notices regarding hoists have been issued: <https://www.gov.uk/search?q=hoists>
- MHRA Report a problem with a medicine or medical device: <https://www.gov.uk/report-problem-medicine-medical-device>
- Health and Safety Executive Frequently Asked Questions page: <http://www.hse.gov.uk/healthservices/faqs.htm>
- Donnelly B. Code of Practice for Community Equipment, A quality framework for procurement and provision of services. Buckinghamshire (UK): Community Equipment Solutions Ltd; 2011. ISBN: 978-0-9569095-0-3
- Love, J and Boulton, R. (2011) 'Core Hoisting Skills', in Smith, J.(ed) The Guide to the Handling of People. Middlesex (UK); Backcare. ISBN 978-0-9530582-1-1