Minimal Lifting in Nursing, Care Homes and by Domiciliary Care Providers (Care Agencies) Policy

<table>
<thead>
<tr>
<th>Version:</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Approved</td>
</tr>
<tr>
<td>Title of originator/author:</td>
<td>Clinical Development Manager - East Project Manager – Right Care</td>
</tr>
<tr>
<td>Name of responsible director:</td>
<td>Executive Medical Director</td>
</tr>
<tr>
<td>Developed/revised by group/committee and Date:</td>
<td>Version 1: Approved by Quality Committee: 16/04/2016 Staff Consultation: during January 2017 Internal Frailty Group: 05/01/2017 Clinical Effectiveness Group: 08/02/2017 Quality Committee: 18/05/2017</td>
</tr>
<tr>
<td>Approved by group/committee and Date:</td>
<td>Quality Committee 18/05/2017</td>
</tr>
<tr>
<td>Effective date of issue: (1 month after approval date)</td>
<td>18/06/2017</td>
</tr>
<tr>
<td>Next annual review date:</td>
<td>17/06/2018</td>
</tr>
<tr>
<td>Date Equality Impact Assessment Completed</td>
<td></td>
</tr>
</tbody>
</table>
Trust Policy Foreword

SWASFT has a number of specific corporate responsibilities relating to patient and staff safety and wellbeing which should be included within all Trust policy and strategy, as a foreword inside the front cover:

Code of Conduct and Conflict of Interest Policy - The Trust Code of Conduct for Staff and its Conflict of Interest and Anti-Bribery policies set out the expectations of the Trust in respect of staff behaviour. SWASFT employees are expected to observe the principles of the Code of Conduct and these policies by declaring any gifts received or potential conflicts of interest in a timely manner, and upholding the Trust zero-tolerance to bribery.

Compassion in Practice – SWASFT will promote the values and behaviours within the Compassion in Practice model which provide an easily understood way to explain our role as professionals and care staff and to hold ourselves to account for the care and services that we provide. These values and behaviours reflect the Trust’s commitment to developing an outstanding service through the conduct and actions of all staff. SWASFT will encourage staff to demonstrate how they apply the core competencies of Care, Compassion, Competence, Communication, Courage, and Commitment to ensure our patients experience compassionate care.

Duty of Candour – SWASFT will, as far as is reasonably practicable, apply the statutory Duty of Candour to all reported incidents where the Trust believes it has caused moderate or severe harm or death to a patient. This entails providing the affected patient or next of kin (within strict timescales) with: all information known to date; an apology; an explanation about any investigation; written follow-up; reasonable support; and the outcome fed back in person (unless they do not want it). The only exception is where making contact could have a negative impact upon the next of kin. SWASFT employees are expected to support this process by highlighting (early) any incident where they believe harm may have been caused.

Equality Act 2010 and the Public Sector Equality Duty - SWASFT will act in accordance with the Equality Act 2010, which bans unfair treatment and helps achieve equal opportunities in the workplace. The Equality Duty has three aims, requiring public bodies to have due regard to: eliminating unlawful discrimination, harassment, victimization and any other conduct prohibited by the Act; advancing equality of opportunity between people who share a protected characteristic and people who do not share it; and fostering good relations between people who share a protected characteristic and people who do not share it. SWASFT employees are expected to observe Trust policy and the maintenance of a fair and equitable workplace.

Fit and Proper Persons – SWASFT has a statutory duty not to appoint a person or allow a person to continue to be an executive director or equivalent or a non-executive director under given circumstances. They must be: of good character; have the necessary qualifications, skills and experience; able to perform the work they are employed for (with reasonable adjustments); able to provide information required under Schedule 3 (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The definition of good character is not the test of having no criminal convictions but instead rests upon judgement as to whether the person’s character is such that they can be relied upon to do the right thing under all circumstances. This implies discretion for boards in reaching a decision and allows that people can change over time.

Health and Safety - SWASFT will, so far as is reasonably practicable, act in accordance with the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations 1999 and associated legislation and approved codes of practice. It will provide and maintain, so far as is reasonable, a working environment for employees which is safe, without risks to health, with adequate facilities and arrangements for health at work. SWASFT employees are expected to observe Trust policy and support the maintenance of a safe and healthy workplace.

Information Governance - SWASFT recognises that its records and information must managed, handled and protected in accordance with the requirements of the Data Protection Act 1998 and other legislation, not only to serve its business needs, but also to support the provision of highest quality patient care and ensure individual’s rights in respect of their personal data are observed. SWASFT employees are expected to respect their contact with personal or sensitive information and protect it in line with Trust policy.

NHS Constitution - SWASFT will adhere to the principles within the NHS Constitution including: the rights to which patients, public and staff are entitled; the pledges which the NHS is committed to uphold; and the duties which public, patients and staff owe to one another to ensure the NHS operates fairly and effectively. SWASFT employees are expected to uphold the duties set out in the Constitution.

Risk Management - SWASFT will maintain good risk management arrangements by all managers and staff by encouraging the active identification of risks, and eliminating those risks or reducing them to the lowest level that is reasonably practicable through appropriate control mechanisms. This is to ensure harm, damage and potential losses are avoided or minimized, and the continuing provision of high quality services to patients, stakeholders, employees and the public. SWASFT employees are expected to support the identification of risk by reporting adverse incidents or near misses through the Trust web-based incident reporting system.
1. Purpose

1.1. South Western Ambulance Service NHS Foundation Trust (hereafter referred to as the Trust) is committed to providing the highest standards of care and treatment for service users and to their conveyance to an appropriate hospital where a need is identified.

1.2. This policy clarifies the roles and responsibilities of the Trust in respect of the moving and handling of patients who have fallen in a care home environment or one where domiciliary care is being provided.

1.3. The principles of this policy are supported by the local Clinical Commissioning Groups (CCGs), the Care Quality Commission (CQC) and follow guidance from the Health and Safety Executive (HSE) in the Management and Safety at Work Regulations 1992 (amended 1999). This policy will assist the Trust in:
   

   b) Avoiding manual handling operations that could give rise to injury, so far as is reasonably practicable.

1.4. It is a statutory requirement that staff employed by care agencies and in nursing and care homes should be suitably trained, equipped and of sufficient numbers at all times to carry out required manual handling operations, in a safe manner in compliance with their duty of care.

1.5. The Trust has produced and issued guidelines to care organisations to assist their staff in determining if the service user is in need of emergency ambulance attendance (Appendix E). This promotes patient dignity and ensures that the correct manual handling operation occurs as soon as practicable.

1.6. The Trust has also produced guidelines to assist operational staff in implementing this policy (Appendices A, B, C and F).

1.7. The Trust is not commissioned to provide a lifting or moving service for patients who are not injured in care homes or where domiciliary care is provided. There is an expectation that under their duty of care, suppliers of such services provide appropriate manual handling for patients in their care. This is a statutory obligation under the Health and Safety Act.
1.8. Staff feedback highlighted that a number of care agencies now have exceptionally tight timescales between visits and will often contact the Trust via a call to 999 and advise that a patient is on the floor, before leaving for their next visit. Often the caller will state that they cannot assess the patient for any injury, yet the patient can be heard in the background confirming they are not hurt.

1.9. Over 515 specific incidents from crews and clinical hubs across the Trust were reported to the Trust’s Right Care Team between 9 August 2015 and 31 December 2016 relating to patients who have fallen but have not required any clinical assessment or treatment in these settings. In addition to this, a number of Adverse Incident Reports have also been raised separately in this time frame.

1.10. Analysis of the feedback indicated that the most common issue relates to the application of no lifting policies by care providers. In these cases, none of the patients were conveyed.

2. **Scope**

2.1. The Trust recognises that there will always be elements of its work that will require some form of manual handling. Such work inevitably carries with it some risk.

2.2. The Trust’s aims to provide high quality, clinically effective patient care within a safe working environment, using resources both effectively and efficiently to achieve its goals.

2.3. Ambulance incidents that have no clinical input and only require simple lifting / moving of a service user who are not injured have a detrimental impact on the Trust’s ability to achieve its goals. The Trust is therefore determined to reduce these risks wherever possible and support staff in every way practicable.

2.4. The Trust is dedicated to designing safe systems of work so as to remove or diminish, as far as is reasonably practicable, this includes any unnecessary moving and handling activities that pose a risk of injury.

2.5. The Trust does not recognise “no-lifting” policies and protocols adopted by nursing and care providers in respect of manual handling operations involving service users not requiring face to face clinical assessment, treatment or conveyance by ambulance to hospital.

2.6. The Trust will continue to respond to 999 emergency calls to nursing and care providers where a clinical assessment is required.

2.7. On rare occasions, the fall may result in the need for a safeguarding referral being completed by either the care provider or the Trust. The Trust expects all
care providers to have robust safeguarding policies and procedures in place to support this.

2.8. This policy covers care providers regulated by the CQC for personal care:

2.8.1. The CQC regulations define personal care as:

(a) physical assistance given to a person in connection with:
   (i) eating or drinking (including the administration of parenteral nutrition),
   (ii) toileting (including in relation to the process of menstruation),
   (iii) washing or bathing,
   (iv) dressing,
   (v) oral care, or
   (vi) the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist);

Or

(b) the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision;"

3. Definitions

3.1. For the purposes of this policy the following definitions will apply:

3.1.1. Manual handling operation - the transporting or supporting of a load (including the lifting, set down, pushing, pulling, carrying or moving thereof) by hand or bodily force;

3.1.2. Minimal lifting - to avoid manual handling by reducing the risk to the lowest level possible. In exceptional or life threatening circumstances there may be no other alternative than to lift using manual handling techniques; however, the lift must be planned and a dynamic risk assessment undertaken, to ensure the activity is done as safely as possible.

3.1.3. Care providers – this term will be used to cover the following as a collective:
   • Care homes - which provides accommodation, personal care for older people or other persons as appropriate. This definition includes residential homes.
   • Nursing homes - which provides accommodation, 24/7 qualified nursing provision or personal care for older people or other persons as appropriate.
   • Domiciliary Care Providers (or Care Agencies) - providing care services in people’s own homes.
3.1.4. **Service user** - a person who may require emergency ambulance attendance.


4. **Duties**

4.1. **The Trust Board**

Board members are collectively responsible for providing leadership and direction on operational, clinical and health and safety matters. The Board is responsible for monitoring the effective implementation of this policy through the delegated tasks as detailed below.

4.2. **Chief Executive**

is responsible on behalf of the Trust Board for the effective implementation of this policy. The responsibility for ensuring the full implementation of this policy is delegated to the Executive Medical Director.

4.3. **Executive Medical Director**

has been nominated to have executive responsibility for ensuring the full implementation of this policy.

4.4. **Deputy Clinical Director**

as sponsor of the Right Care programme, is responsible for supporting the implementation of the policy through the Clinical Development team.

4.5. **Director of Operations**

is responsible for ensuring that the operational frontline and Clinical Hub functions detailed within this policy are fully supported.

4.6. **Head of Operations, Clinical Hubs**

is responsible for ensuring that all Clinical Hub staff are fully aware of the policy and that all incidents which fall under this policy are reported via the Trust incident reporting system in Appendix A.

4.7. **Operations Managers, Operations Officers and Hub Duty Managers**

Are responsible for ensuring that all staff within their area are fully aware of the policy and ensure that all incidents which fall under this policy are reported via the Trust incident reporting system.
4.8. **Operational Staff**

Are responsible for:
- maintaining professional standards at all times
- making themselves fully aware of the policy and the associated guidelines, to including the retrospective reporting of incidents.

4.9. **Head of Safeguarding**

is responsible for ensuring the triage and processing of safeguarding referrals generated through this policy and for making any referrals to external agencies such as the CQC, Police, Fire, Adult Social Care as appropriate.

4.10. **Health, Safety and Security Manager**

is responsible for providing appropriate advice and guidance regarding health and safety issues relating to the effective implementation of this policy.

4.11. **Incidents Manager**

is responsible for ensuring that all incidents reported to the Trust’s adverse incident procedures relating to this policy are recorded and investigated appropriately.

The post holder is also responsible for ensuring that the incidents team follows the agreed retrospective incident reporting process flow chart (Appendix A).

4.12. **Incidents Management team**

is responsible for:

a) Notifying the Administrator 999 Hub - Non-Injury Fallers (NIF Administrator) of any incident reported by staff in order for the process described in Appendix A sent to the nursing and care homes or care providers

b) Working with all parties involved to include the hub investigations and Right Care teams to collate the data of all incidents reported by staff.

4.13. **Administrator 999 Hub - Non-Injury Fallers (NIF Administrator)**

is responsible for working with all parties involved to include the incidents and Right Care teams to collate and process the data of all incidents reported by staff according to the retrospective incident reporting process flow chart (Appendix A).
4.14. **Right Care Project Manager**

is responsible for working with all parties involved to include the hub investigations and incidents teams to collate the data of all incidents reported by staff and the onward reporting to internal and external stakeholders.

4.15. **Clinical Development Team**

is responsible for managing the escalation process with specific care providers as directed by the Right Care Project Manager.

5. **Process**

5.1. **Reducing Incidents**

5.1.1. Care providers must conduct their own manual handling risk assessments on all their service users and have access to appropriate manual handling equipment.

5.1.2. The Trust deems it unacceptable for care providers to routinely make requests for an emergency ambulance response to lift uninjured patients (e.g. from the floor and return them to bed or sitting). In these cases the Trust feels it reasonable for care providers to call upon the services of their own staff. These instances will be recorded on the Trusts adverse incident reporting system, and an investigation will take place on the care providers’ management of the occurrence.

5.1.3. Care providers have a duty to ensure that their staff receive adequate manual handling and patient moving training together with training on the various items of equipment in situ on their premises. Providers of domiciliary care should also consider the provision of equipment which can be taken by their staff into Service Users’ homes.

5.1.4. Care providers must carry out suitable and sufficient risk assessments on the activities of the staff and their service users to ensure that there are suitable and sufficient control measures put in place to reduce the need to call for assistance where the service user is not injured.

5.2. **Escalation Process – Step by Step**

5.2.1. Hub 999 Calls from a care/nursing home or domiciliary care provider which appears to be requesting a response purely to lift a patient who is not injured will be managed by the Clinical Hub according the processes detailed within Appendices B and C.

5.2.2. Where Trust operational staff are aware of an incident, the reporting process detailed in Appendix A must be followed. The responsibilities and processes to be followed by each individual/department are detailed within. NB. Trust staff are...
not required to challenge the care staff on scene at the time of the incidents. Any concerns should be raised subsequent to the incident for further review.

5.2.3. Where the incident is the first one reported for an individual provider in the previous 12 months, the letter Appendix D will be sent to the care provider’s head office.

5.2.4. Where there recurring incidents are reported within a rolling 12 month period, the Trust will send a further letter to ask the care provider to contact the 999 NIF Administrator to arrange a telephone call or face to face meeting. The meeting will be attended by appropriate representatives from the provider and from the Trust. The purpose of the meeting will be to review the reported inappropriate incidents, and to determine the reason(s) as to why the care provider finds it necessary to use the emergency ambulance service as a basic lifting service. An action plan must be jointly agreed at the meeting with consideration to the environmental situation of the patient i.e. safeguarding and falls referrals.

5.2.5. Should subsequent incidents or no response received concerning the same care provider be reported within a rolling 12 month period, a further letter will be sent highlighting all the incidents that have been reported as inappropriate use of the emergency ambulance service and a reminder of what the agreements were at the meeting in step four. This letter will be copied in to the CQC, HSE and the local CCG.

5.2.6. Should further additional incidents occur following step five within a rolling 12 month period, the Trust’s Chief Executive Officer will formally write to the Chief Executive of the care provider to request a review the previously agreed action plan and to determine why further inappropriate calls are being received and to seek assurance of the actions that will be taken to address the continued inappropriate use of the service. The care provider’s failure to address the issue will be reported again to the CQC.
6. Monitoring

6.1. The Right Care Project Manager will supply a regular highlight report which will contain:

   a) a list of care providers who and have been sent a letter of reported breaches of this policy which will demonstrate the effectiveness of the Trust’s arrangements with regards the management and enforcement of this policy in nursing, care homes and care providers in service users’ own homes and include information on: escalation reports to respective local clinical commissioning groups (CCGs) and local authorities.

   b) a summary of the actions completed and ongoing relating to the enforcement of this policy the effectiveness of the reporting and corporate process and any developments to this.

7. Review

7.1. This policy will be reviewed after a further year and or following any significant operational, structural or legislative changes.

8. References

8.1. For this policy, the following references apply:

   - Health and Safety at Work etc. Act 1974;
   - Management of Health and Safety at Work Regulations 1992 (amended 1999);
   - Provision and Use of Work Equipment Regulations 1998
   - Lifting Operations and Lifting Equipment Regulations 1998
   - Reporting of Diseases and Dangerous Occurrences Regulations (RIDDOR)
   - The Care Act (2014)
9. Associated Documents

9.1. This policy links to:

- Appropriate Care Pathways Policy
- Health and Safety Policy
- Manual Handling and Moving Policy
- Lone Workers Policy
- Incident Reporting Policy
- Serious and Moderate Harm Incident Policy
- Risk Management Strategy
- Risk Assessment Policy
- Safeguarding Policy
- LOLER Policy.
- Care provider tool set available on the Trust website www.swast.nhs.uk/care
Appendix A

Retrospective Incident Reporting Process Flow

SWASFT updated (March 17, v2) process to manage demand around non-injury fallers who have not been conveyed, identifying nursing / care homes and domiciliary providers who implement a 'no lift' or 'not allowed to lift' policy and call 999 for an ambulance response to lift patients only

STEP 2: Initial validation by Data team upon receipt of incident submitted onto Data:
1. Review incident report and confirm activation of NIF process
2. Code incident as non-injury fall
3. Data team to refer to Administrator 999 Hub - Non-Injury Fallers (NIF Administrators)

STEP 3: In Review of CAD records and Yellow recording by NIF Administrator:
1. Confirm call to 999 or 111 by NIF Administrator
2. Reconfirm patient was not injured (not conveyed)
3. Search for tickets at same address to check contact of ambulance demand relating to a specific individual where this is possible
4. Check whether the caller stated the care company has a 'no lift policy' not allowed to lift
5. Access PCR and police incident meeting notes and to the Data Incident
6. Record all the required information on the Data Incident and master spreadsheet
7. NIF Administrator refers incident on to local operations team to clinically review PCR and review additional information provided to confirm whether corporate response is required

STEP 4: Operational and Clinical Validation
Local Operations Officer:
1. Reviews case and attachments
2. Performs clinical review of PCR to confirm the specific reported incident happened no clinical intervention and was therefore an injury fall
3. Validates requirement for trust response to care provider for requesting an ambulance to simply lift the patients by impacting their decision with the rationale into the Data Incident
4. Fails to NIF Administrator

STEP 5: Prepare Corporate Response: NIF Administrator:
1. Reviews and identifies any other incidents involving the same care provider
2. If escalation process appropriate:
   a. Prepares 1st or 2nd letter (as appropriate) and sends to Medical Director (usually the Trust's Medical Director/Assistant Director of Medical Director)
   b. RA points off letter, arranged signature, signs signed copy and sends forward to NIF Administrator, sends a signed original letter in post
3. If escalation process was not started, follow step 6 Escalation process
4. If escalation process previously triggered, follow step 6 Escalation process
5. NIF Administrator attaches all correspondence to the Data Incident, saves in the correspondence folder and e-mails back to Data team for closure. NIF Administrator updates master spreadsheet, escalation log

STEP 6: Escalation Process
A) NIF Administrator to flag care provider and provide summary to Right Care Project Manager to escalate / design care provider to a local Clinical Development Officer
B) Follow step-by-step escalation process as described in the Minimal Lifting Policy for Care and Nursing Home Care and Domiciliary Care Procedure
C) All locally around care providers who have triggered the escalation process will be informed on an action tracker

All correspondence passed to NIF administrator who reviews correspondence received and:
A) Repairs to Data Incident
B) Saves in Correspondence folder for the individual care provider
C) Alerts Right Care Project Manager
D) No further action
Appendix B
Clinical Hub Staff Call Handling Process (EMA/EMDs)

999 EMA / EMD FLOW

DO THE FOLLOWING ALL APPLY?
1. Call processed as non injury fail
2. You have reached the assistance needed at home due to inability to get off the floor disposition in NHSP or AMPOS code 17.404G (this confirms non injurious fall)

PLUS
Sa. Fore agency staff at scene at patient’s address (should be referee, they may have to ask)
Or
Sb. Formal care setting such as a nursing or care home (not ward controlled)

DO NOT MENTION ‘NO LIFT POLICY’

NO

COMPLETE CALL AS PER USUAL PROCESS

YES

‘Can I confirm the patient is not injured?’

NO (cannot be sure / is injured)

YES (not injured)

ACCEPT DISPOSITION IF REACH ASSISTANCE IS NEEDED AT LOCATION FOR A FALL and ask caller for care provider name

PASS CALL TO CLINICIN IN THE 999 HUB advising clinician the caller is a foreman or fore agency on scene at a non injury fall advising if first or subsequent call for same patient

IF CLINICIAN UNAVAILABLE

1. EMA and EMD highlights information in C2 notes if repeat call incident for same patient
2. EMA selects
a) Early Exit from NHS Pathways
b) transfer to a clinician
c) other (specify NON INJURY FALL, CARER ON SCENE)
3. EMD follows AMPOS which prompts CSD call script
4. EMA and EMD informs the caller that a clinical supervisor will call back as soon as they are available, if in the mean time the patient has any new symptoms or their condition gets worse, change. or you have any other concern call 111 or 999 (depending on which service they called)

Probe around
“are they complaining of pain?”
“are they saying there is a new inability to move a limb”
RE-TRIAGE INJURY USING RINGS PATHWAYS or AMPOS
Appendix C
Clinical Hub Staff Call Handling Process (Clinical Supervisor)

**South Western Ambulance Service NHS Foundation Trust**

### Appendix C

**Clinical Hub Staff Call Handling Process (Clinical Supervisor)**

---

**STEP 1: Clinical Triage of the call to establish or re-confirm EMA/EMD system triage no injury / symptoms** Establish whether the patient simply requires assistance to be moved (therefore re-confirming non injury faller status)

- **Answer could be:**
  1. We have a no lift policy (company policy)
  2. We always call 999 / 111 in these instances
  3. I am not allowed to lift on my own

### YES (injured)

- Re-assess and send ambulance

### NO (not injured)

- **FIRST CALL:** Close incident and do not send ambulance

---

**STEP 2: Clinician to consider verbally supporting carer over the telephone whilst they lift / move service user if safe and appropriate and as agreed by care(s).**

---

**STEP 3:**
1. Re-confirm care agency or care home name
2. Record details in OAD C3 Notepad
3. Advise caller as follows:
   A. To ask their manager to deploy additional carer / lifting equipment as necessary as there is no clinical need for an emergency ambulance to attend
   B. Give worsening advice, in case patient deteriorates
   C. Call 999 back if the patient is unable to be mobilised after assistance has been sought from care organisation / management

---

**STEP 4: FOR SECOND CALL: If the caller calls back or care home / agency manager calls in, establish or re-confirm with the caller**

- A. There is still no clinical need for an emergency ambulance and
- B. There is no way of lifting / mobilising the patient who has fallen / slipped ... etc

---

If care manager does not arrange to lift / move patient, advise that SWASFT will send an emergency ambulance for welfare reasons or consider referral to a community team (as appropriate) and supply the Trust web address as appropriate for care provider tools and support at www.swasft.nhs.uk/care (if appropriate).

---

For background information:

*Regulation 3 of the Management of Health and Safety at Work Regulations 1999 requires that all employers must assess the risk to the health and safety of their employees whilst they are at work and take into account those who may be affected by the actions and omissions of their staff.)*

*There is also a requirement in the Manual Handling Operations Regulations 1992 (as amended) to:
  * Carry out risk assessments
  * Provide adequate training on manual handling operations
  * Provide suitable lifting equipment which staff must be trained to use*
Appendix D

Example of template first letter from Trust to Care providers

[Letter content]

Our ref.
Your ref.
Private & Confidential
Date
Address

Dear [Insert name],

Ambulance attendance on [Insert date].
Ambulance incident number [Insert number].
Address ambulance called to [Location of incident patient's address or care home address].

South Western Ambulance Service NHS Foundation Trust (SWAST) recently received a 999 emergency call from a member of staff that you employ (enter CQC registered care provider name) requesting our attendance as a patient had fallen.

We have had a marked increase in 999 requests by care providers requesting paramedic attendance to lift patients who have fallen and require assistance to be picked up.

On [date] at [time] a care worker representing your organisation called 999. On review of this telephone call it appears the reason for this request was to [Enter reason for call].

Our emergency ambulance arrived on scene at [time] and the ambulance clinician carried out an assessment. It was discovered that the patient had not sustained any injuries, did not require any urgent treatment and required only manual handling. This should ideally have been undertaken by your organisation without the need for an emergency ambulance call out.

[Please delete if not applicable] Your employee stated on the telephone that they were not obliged to lift patient and stated that there was no 'no lift policy' in place.

To give you a little background to why we are raising this with you, Regulation 3 of the Management of Health and Safety at Work Regulations 1999 requires that all employers must assess the risk to the health and safety of their employees whilst they are works and take into account those who may be affected by their staff actions and omissions.

There is also a requirement in the Manual Handling Operations Regulations 1992 (as amended) to:

--- Carry out risk assessments.
--- Provide adequate training on manual handling operations.
--- Provide suitable lifting equipment which staff must be trained to use.

Ambulance employees are sometimes advised by carers on scene that the organisation they work for have a 'no lifting policy' and have been advised by their managers not to lift the patient but to dial 999 and wait for the arrival of the ambulance or for ambulance staff to transfer or lift the patient.

It is worth noting that in 2003 a High Court case A v East Sussex County Council looked at issues of manual handling in the context of providing care to disabled persons. The Court reviewed previous key cases and confirmed that there cannot be an absolute prohibition on hazardous lifting; although...
there can be a risk reduction or risk minimisation regime; there is no absolute requirement to make the situation absolutely safe for workers. Please see the Health and Safety in Care Homes guide HSE220.

In relation to the manual handling of people the court made it clear that an employee whose job is to move people may have to accept a greater degree of risk than one who is employed to move inanimate objects, while recognising that an employee cannot be exposed to unjustifiable risk. The court found that in some situations such as the provision of personal care and support some manual handling is inherent— and inescapable—features of the task that the employee is employed to do. Obviously the legislation applies to registered care companies in exactly the same way as it does to the ambulance service.

I am sure you are aware that care providers have a duty of care to their patients and this extends to the provision of care to foreseeable situations. Employers should undertake regular risk assessments and put provision in place when manual handling activities cannot be avoided. Appropriate risk management therefore should form an integral part of the care assessment, so that hazards are identified and dealt with before the care worker and the client are put at risk. Staff should be adequately trained and assistive equipment should be supplied as appropriate to reduce the risks to both the client and care worker. Care workers should know the procedures to be followed when the designated system of work cannot be applied; and how to secure additional assistance when it is required.

We would like to inform you that dialing 999 for assistance in cases where there is no clinical need is not appropriate use of the 999 emergency ambulance service. This increase of the use of emergency ambulances for lifting non-injured fallers means that this impacts on our ability to attend patients who are in most clinical need of the service.

We would encourage you to review your organisational policies relating to manual handling to address this issue to reduce the number of 999 calls made by your staff in these circumstances. Clearly, this does not affect the emergency requirements of patients who have fallen and are injured. However as an emergency 999 ambulance service we would not routinely be visiting patients simply to lift them from the floor.

If you would like to discuss any post falls care training needs please do not hesitate in contacting our training department as they are fully aware of issues faced by staff in care and domestic settings and would happily discuss any safe assistance and patient handling training requirements. You can contact our Commercial Training Team on 01392 453 842 or commercial.training@swast.nhs.uk.

In the meantime, it would be greatly appreciated if you could inform your staff that 999 should only be called for clinical emergencies and advise them of the correct procedure which should be followed when a person falls, as per the post-falls guidance issued on our website at www.swast.nhs.uk/care.

Please do get in touch should you wish to arrange a meeting or discuss this letter. In the first instance, please contact David Ham on 01392 453 829 or by email at david_ham2@swast.nhs.uk.

Yours faithfully

Dr Simon Scott-Hayward

SWASFT Medical Director (Primary Care)

Co Care Agency Head Office (if applicable)

Chairman: Tony Fox

Chief Executive: Jen Burnham

The Portal Patient User

[Logo]
Appendix E
Guidance for Care Providers

Guidelines, policy templates, training tools and checklists for use and implementation by care providers in relation to service users who could fall or have fallen are available at [www.swast.nhs.uk/care](http://www.swast.nhs.uk/care). This suite of documents have been developed in partnership local care providers the Trust has engaged with.

Indications for calling 999

1.1 The following list indicates the conditions or circumstances where it is likely that treatment and/or transport to hospital by the Trust is required following a fall:

- The patient is experiencing any 'new' or exacerbated chest pain or difficulty with their breathing either as a cause or result of the fall;
- The fall was associated with a loss of consciousness or resulted in a loss of consciousness or is associated with vomiting, dizziness or 'new' blurring of vision;
- There is thought or known to be a head injury,
- The patient suffers from a condition that impairs their ability to discern if they are injured;
- There is an attributable condition that has given rise to the patient’s fall (i.e. hypertensive, diabetic or cardiac patients);
- There is evidence of 'new' shortening/rotation/deformity or pain on movement of any limb or region of the body;
- There is an underlying condition that may result in an increased risk of deterioration from a fall (such as osteoporosis - fragile bone syndrome);
- There is believed to be an underlying injury, an existing wound or a pressure sore that has been worsened as a result of the fall;
- There is a 'soft tissue injury - the skin has been broken' with significant bleeding, particularly if it cannot be stopped quickly;
- There is evidence of recent deterioration in the patient's general condition or cognitive state;
- Staff did not witness the fall and the history obtained from the patient is not thought to be reliable;
- Where patient has spent excessive time on the floor >2 hours
- If the patient has a disability which impairs their ability to recognise that they have been injured.
2. Cases where calling 999 may not be necessary

2.1 The following list indicates conditions where there is not likely to be any injury or illness that is likely to require treatment and/or transport to hospital by the Trust following a fall:

- No chest pain or difficulty with breathing;
- Pain free and comfortable;
- No loss of consciousness before or after the fall;
- No bleeding, swelling or deformity;
- The patient freely moves all limbs within their normal range of movement, and has no diminished power and movement control and does not suffer any condition that may impair their ability to discern if they were injured;
- No evident worsening of any underlying condition.
- The patient insists that they require no clinical assistance, they have mental capacity but care staff remain concerned.
Appendix F

Guidance for ambulance staff relating to the manual handling of patients who have fallen and care staff have requested an emergency ambulance

1.1 In line with the Trust's commitment to avoid manual handling operations that could give rise to injury, so far as reasonably practicable, ambulance personnel will no longer lift or manually handle patients who need no other clinical assistance as a result of a fall whilst in a care setting.

1.2 The Trust has determined that staff employed by care providers should be suitably trained and equipped to carry out these manual handling operations themselves. This stance is supported by the Health and Safety Executive and Care Quality Commission.

1.3 The Trust will continue to respond to 999 emergency calls to carers on scene with service users in an appropriate manner.

1.4 Where an assessment made by the attending crew identifies that no clinical assistance is required then the responsibility for any further manual handling will rest with care home staff (paragraph 1.11).

1.5 As patient needs are paramount there may be occasions where the manual handling of a service user is unavoidable.

1.6 It is expected that guidelines Trust website available to care providers via the www.swast.nhs.uk/care will be adopted by such organisations to reduce the incidence of ambulances responding to obvious 'lift only' cases. It is reasonable to expect, however, that there may be circumstances where, unrelated to a clinical need, undertaking a manual handling operation is unavoidable. These incidents should be reported, as appropriate (paragraph 1.8)

1.7 In these situations ambulance staff should:

- Avoid conflict with care staff - particularly in the presence of patient or relatives;
- Ensure a risk assessment is undertaken in line with the principles of TILE - Task, Individual, Load and Environment;
- As part of this assessment consider alternatives to a manual handling and moving operation e.g. Is there appropriate lifting equipment available for use?
- Are there suitably qualified persons present to use such equipment?
- Advise care staff that this incident will be formally reported to the Trust for investigation and action, if appropriate.
- Report the incident via Datix.

1.8 Where operational ambulance staff have been called upon to carry out a manual handling operation for service users where the only requirement was to perform
this operation or where it was obvious that no clinical assistance was required then the incident should be reported as per process flow in Appendix A.

1.9 Guidance has been devised for care staff advising them of when they should or should not consider calling the 999 emergency services and of the standards they can expect from the Trust.

1.10 In addition to the above and existing protocols, the following guidelines have been produced to clarify the responsibilities of ambulance personnel when attending incidents at care homes.

- On attendance if an assessment identifies a clinical need or any doubt exists then treat the patient accordingly and convey to hospital, if appropriate.

- Document all clinical findings and observations in accordance with existing requirements.

- Where no clinical need or doubt exists then it is the responsibility of care staff to manually handle the patient. Refer them to guidelines issued to care providers by the Trust on www.swast.nhs.uk/care

- Ensure all relevant documentation is completed and advise the care staff accordingly.

- Where possible and in a polite and sensitive manner, operational ambulance personnel should ask for and record the names of care staff on duty.

- Where a request is refused, record appropriately. Any such information should be recorded via Datix.

- Remind care staff of the need to refer the patient to a GP or appropriate organisation to determine the cause of the fall.

- In some areas of the Trust ‘falls teams’ are operated. Where appropriate, care providers should be referred to these initiatives.

1.11 If there is doubt or uncertainty about the patient’s condition you must always assess and treat accordingly and convey to hospital if necessary.
### Appendix G
Version Control Sheet

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Draft</td>
<td>21/6/11</td>
<td>Clinical Development Manager East</td>
<td>New Policy</td>
</tr>
<tr>
<td>2 Draft</td>
<td>21/6/12</td>
<td>Clinical Development Manager East</td>
<td></td>
</tr>
<tr>
<td>3 Draft</td>
<td>12/05/15</td>
<td>Amendments made by Health and Safety Manager</td>
<td>Addition of HSE guidance</td>
</tr>
<tr>
<td>4 Draft</td>
<td>12/01/16</td>
<td>Charlotte Thomas</td>
<td>Inclusion of reference to nursing and care homes and domiciliary care providers Inclusion of formal trust response to care providers when an emergency ambulance has been requested to lift a patient who has fallen without injury</td>
</tr>
<tr>
<td>1</td>
<td>15/02/16</td>
<td>Charlotte Thomas</td>
<td>Update of escalation process and clinical hub process flows at time of incidents.</td>
</tr>
<tr>
<td>2</td>
<td>28/02/17</td>
<td>Charlotte Thomas</td>
<td>Revision of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a) Trust policy foreword</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) Appendix A – incident reporting process to reflect current process now dedicated Non Injury Faller administrator in post</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c) Appendix C – revised wording around step by step process for the clinicians in the 999 hubs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>d) Appendix D – updated care provider letter template</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e) Appendix G (now F) – updated language to include reference to care providers and care staff generally</td>
</tr>
</tbody>
</table>

Addition of
a) References in section to Care Act and
CCQ guidance for care providers
b) Reference to support materials available at www.swast.nhs.uk/care
c) Further information regarding expectations of trust staff
d) Further information as to what the policy covers in respect of care providers regulated by the CQC for personal care (see 2.8)

Removal of:

a) Appendix F (post falls guidance flow) as specific post falls guidance is available on the trust website for care agencies and care/nursing homes @ www.swast.nhs.uk/care