Getting it right

Spotting poor practice and spreading good practice in moving and handling of people
Three focus areas

- Risk assessment
- Equipment
- Training
What does **GOOD** practice look like?
What does **POOR** practice look like?
NHS trust fined £1m following 53-year-old man's death in Lincolnshire

Date: 19 July 2017

United Lincolnshire Hospitals NHS Trust has been fined following the death of 53-year-old John Biggadice at Pilgrim Hospital in Boston.

Lincoln Crown Court heard that Mr Biggadice, who was a patient at the hospital, died on 16 April 2012 from internal injuries after falling onto an exposed metal post on the standing aid hoist that staff were using to support him.

The kneeless on the standing aid hoist had been incorrectly removed leaving the exposed metal post that caused the fatal injuries when he collapsed after standing up.

A Health and Safety Executive (HSE) investigation found the Trust did not have systems for training and monitoring how staff used the standing aid hoist and unsafe practices had developed.

United Lincolnshire Hospitals NHS Trust, of Trust Headquarters, Lincoln County Hospital, Greetwell Road, Lincoln, was found guilty of breaching Section 3(1) of the Health and Safety at Work Act 1974. It was fined £1 million and ordered to repay £160,080 in costs.

The trust has also been ordered to pay £30,000 to Mr Biggadice’s family to cover the costs of the funeral.

In his statement, John Biggadice’s brother Keith said: “John didn’t deserve to die.”

Media contacts

Journalists should approach HSE press office with any queries on regional press releases.

See also

- What’s new
- Campaigns
- Health and safety myths
- Events
Care home fined following death of elderly resident

Date: 30 August 2017

Chilton Care Homes Limited has today been fined following the death of an 89-year-old resident at its home in Sudbury, Suffolk.

Ipswich Crown Court heard how, on 14 November 2013, the elderly resident was being moved by two care workers with the aid of a hoist from her bed to a chair when she slipped through the slings and fell to the floor. She suffered a break to her right femur and fractured ribs but due to poor health could only be treated with palliative care until she died on 23 November 2013.

An investigation by the Health and Safety Executive (HSE) found Chilton Care Homes Limited did not have adequate health and safety arrangements in place to ensure users could be hoisted safely.

There was no manual handling policy setting out the arrangements for moving residents safely. Individual moving and handling risk assessments, and lifting plans, were inadequate because they failed to provide specific information about the equipment to be used. This resulted in some residents being hoisted with the wrong type or size of sling. Nurses and care workers had not received suitable training and several slings were found to be unsuitable to use. They had not been inspected prior to use and had not been thoroughly examined in the previous six months. HSE also found disposable slings were being washed and then reused.
Risk assessment and handling plans

✓ In place for every individual
✓ Meet regulations for TILEO
✓ Regularly updated
✓ Accessible
✓ Actually give information to reduce risk

✗ Cut and paste!!!
✗ What you read is not what you see
✗ Outdated
✗ Staff not aware
Training

✓ PASSPORT STANDARDS
✓ Training meets the needs of the staff and the needs of the work
✓ Regularly updated
✓ Includes practical work
✓ Evaluation taking place

✗ Poor training records
✗ Irrelevant training
✗ Theory only training
✗ Too brief
✗ Outdated
Equipment

✓ Fit for purpose - right person, right task
✓ Maintained
✓ Checked before use
✓ Meets PUWER & LOLER regulations
✓ Staff know how to use it

× poorly maintained
× Faults not reported/remedied
× Equipment has been modified
× Poor practices have become custom
× Dirty
How are you doing?
Releasing time to care

Introducing the single carer project
Why “releasing time to care”? 

• Increasing care hours available in community
• Reducing time individuals wait for care when a second person is needed
• Second person free to have other meaningful interaction, increased supervision of others
• Advances in equipment and techniques mean some of our beliefs about moving and handling are now outdated
What releasing time to care is NOT

• Changing one set of blanket rules for another
• All about big changes
mythbusters

• “It's all about money”

• “They are taking away carers jobs”

• “They are making us hoist with 1”

• “Now we can do it on our own if no one else is available”
Case study 1 - TOM

Arjo Sara Stedy
Profiling Bed
Wheeled Commode

CARE PROVISION
Initial Package – 2x carers  4 x daily
Renewed Package – 1 x carer  4 x daily

WEEKLY SAVINGS
• Care Hours -  15.75 (819 annually)
• Cost of Care £193.76 (£10,075.52 annually)
Diagram showing financial model around the break-even point for each service user

Cost profile for care providers' services before implementation of equipment

Cost profile for care providers' services after implementation of equipment

The break-even point. Currently an average of 48 days after the start of the new package

Financial benefit – the difference between the service providers' costs after implementation of equipment

* Initial investment in equipment is averaging £763 per SU
Playtime.............