Medical Device/Equipment **ALERT**

Ref. MDEA(NI)2007/34
Issued: 26th April 2007

For:

IMMEDIATE ACTION	
ACTION	✓
UPDATE	✓
INFORMATION	

	Section
Medical Device/Equipment: Patient hoists and slings.	► ①
Problem: Falls due to the poor compatibility of slings and hoists, inappropriate laundering of slings and inadequate maintenance of patient hoists used in hospitals and the community.	► ②
Action by: All those involved in the supply, maintenance or use of these devices, in particular nurses, care staff, laundry staff and maintenance staff or contractors.	► ③
Action: Ensure that: • All hoists and slings are used and maintained in accordance with the manufacturer's instructions. • See page 2 for further actions.	► ④
Distributed by NIAIC to: Chief Executive of each HSS Board Chief Executive of each HSS Trust Chief Executive of each Agency Hospices	► ⑤
Contacts Details of NIAIC contacts for technical aspects.	► ⑥
Feedback Requirements to NIAIC None required	► ⑦

This Alert is on our web site: http://www.dhsspsni.gov.uk/niaic

1. DEVICE/EQUIPMENT:

Patient hoists and slings.

2. PROBLEM:

Hoists and slings are used to transfer patients and this is usually achieved very successfully.

However, the NIAIC and MHRA continue to receive adverse incident reports involving patient hoists and slings used in hospitals and the community. Some of these incidents have resulted in serious patient injury or fatalities.

Some examples of these incidents are:

1. Whilst being hoisted a patient fell to the floor through an aperture in the patient sling. This aperture resulted from an incompatibility of the sling and the spreader bar. Also, the sling was an inappropriate size for the patient's weight and body size.
2. Carers have received electric shocks from contact with damaged leads and connectors when recharging hoist batteries. This damage should have been detected on visual inspection before use or during maintenance.
3. Slings being laundered/washed by methods not in accordance with the manufacturer's instructions have produced weaknesses in the slings and their mounting systems, leading to subsequent failure in use. (further guidance given in MDEA2007/16 Laundry damage to patient lifting slings with rigid plastic clips)
4. Single-use slings were laundered with reusable slings. Single-use slings are not manufactured to be laundered and reused. Patients being lifted in these slings could be put at increased risk.
5. A LOLER inspection revealed a hoist electric actuator had exceeded its manufacturer's cyclic design life. The hoist was kept in service following the inspection without the actuator being changed, which subsequently failed in use. (further guidance given in MDEA2005/29 Mobile electric patient hoists - Potential for electric actuators to fail without warning)

This Alert replaces earlier notices SAN(NI) 98/42 (July 1998) and SAN(NI)99/41 (September 1999), which are now withdrawn.

3. ACTION BY:

All those involved in the supply, maintenance or use of these devices, in particular nurses, care

4. ACTION:

Ensure that:

- All hoists and slings are used and maintained in accordance with the manufacturer's instructions.
- All sling and hoist combinations are compatible and appropriate for the patient and that risk assessments are repeated if the equipment combination or the patient's condition changes.
- All hoists and slings are visually inspected before use and are removed from service if defects are found.
- All slings are cleaned in accordance with the manufacturer's instructions.
- All hoists and slings are inspected by a competent person every six months as outlined in the Lifting Operations and Lifting Equipment Regulations (LOLER).

5. ONWARD DISTRIBUTION TO:

Please bring this notice to the attention of all who need to know or be aware of it. This will include distribution to:

- Liaison Officers
- Risk Managers
- Health & Safety Officers/Advisors
- Clinical Governance Leads
- Device Managers
- Estates Managers
- Occupational Therapists
- Physiotherapists
- Rehabilitation Engineers
- Medical Directors
- Clinical Directors
- Laundry managers or contractors
- Nurse Directors
- Medical, Nursing and Care Staff
- Ambulance Staff and Paramedics
- Maternity Wards
- Practice Nurses
- Directors of Public Health
- Social Care Staff
- Community Care Staff
- Independent Health and Social Care Providers – Private Clinics, Residential and Nursing Homes through RQIA
- Community Stores

6. CONTACTS:

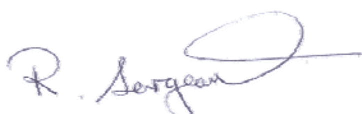
Enquires to NIAIC should quote reference number MDEA(NI)2007/34 and be addressed to:

Northern Ireland Adverse Incident Centre (NIAIC)
Health Estates
Estate Policy Directorate
Stoney Road
Dundonald
Belfast BT16 1US

Tel: 028 9052 3868
Fax: 028 9052 3900
Email: NIAIC@dhsspsni.gov.uk

7. FEEDBACK:

None Required



Robert Sergeant
NIAIC Operational Manager

HOW TO REPORT ADVERSE INCIDENTS

Adverse Incidents relating to medical devices, non-medical equipment, plant and buildings should be reported to NIAIC as soon as possible. Advice on how to report is given in MDEA(NI)2006/01. If you are in doubt about how to report incidents, please speak to your liaison officer or contact NIAIC using the telephone number provided. Adverse Incident reporting forms and an on-line reporting facility are available on the NIAIC website at www.dhsspsni.gov.uk/niaic

Heath Estates is an Executive Agency of the Department of Health, Social Services and Public Safety