

**POLICY FOR
 ASSESSMENT OF TRANSFERS AND WALKING, AND ISSUE OF
 APPROPRIATE WALKING AIDS TO PATIENTS**

(To be read in conjunction with the Slips, Trips and Falls Policy)

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DOCUMENT CONTROL

Reference OM/Jun15/WA	Version 2.0	Status Final	Author Clinical Specialist Physiotherapist (neurological) Clinical Lead Adult Rehabilitation
Amendments	Updated post acquisition and further amended to reflect ILT roll out across the county.		
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Intended recipients: Somerset Partnership Clinical Staff.			
Committee/Group Consulted: Rehabilitation Clinical Specialist Team Community hospital matrons and staff, inpatient mental health managers Community Hospitals Best Practice Group			
Monitoring arrangements and indicators: monitoring will be done within the Rehabilitation Best practice group and the Community Hospital best practice group.			
Training/resource implications: Clinical staff to be made aware of guidelines by their line managers. If local training needs are identified then the rehabilitation physiotherapist within the team locally will support the learning necessary to implement these guidelines.			
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Lead Director	Director of Nursing and Patient Safety		

CONTRIBUTION LIST Key individuals involved in developing the document

Name	Designation or Group
Ralph Hammond	Clinical Specialist Physiotherapist(Neurological)
Hannah Wass	Clinical Specialist Physiotherapist (Medical Conditions)
Fiona Grant	Clinical Specialist Physiotherapist (Orthopaedics & Amputees)
Lynne Merrett	Clinical Specialist Occupational Therapist (Stroke & Brain Injury)
Rob Kinder	Clinical Specialist Physiotherapist (Stoke & Brain Injury)
Andrew Sinclair	EIA / Head of Corporate Business

CONTENTS

Section	Summary of Section	Page
Doc	Document Control	2
Cont	Contents	3
1	Introduction	4
2	Purpose & Scope	4
3	Duties and Responsibilities	4
4	Explanations of Terms used	5
5	Guidelines To Support The Risk Assessment Process In The Mobilisation Of Patients	6
6	Training Requirements	11
7	Equality Impact Assessment	11
8	Monitoring Compliance and Effectiveness	12
9	Counter Fraud	12
10	Relevant Care Quality Commission (CQC) Registration Standards	12
11	References, Acknowledgements and Associated documents	13
12	Appendices	14
Appendix A	Decision Making Process	15
Appendix B	Walking Aids - A Quick Guide for Clinical staff	16

1. INTRODUCTION

- 1.1 This document has been compiled as guidelines to support clinical staff when they encounter a patient with mobility problems following assessments as part of the Understanding You (Mobility & transfer and patient handling risk assessments), so they can provide a patient with a suitable walking aid when their mobility status is not complex or while they are awaiting an assessment of their mobility from a member of the Independent Living Teams. This is to enable patients to be able to mobilise safely while awaiting this assessment and prevent patients remaining in bed unnecessarily. Patients who remain in bed unnecessarily can experience a very negative time, suffer more hospital acquired problems, and require more attention from clinical staff.
- 1.2 The Independent Living Team of occupational therapists, physiotherapists, and rehabilitation assistants now operate a seven day service and the assessment of new patients is a priority so this situation should rarely arise. However, clinical staff should be able to provide patients who do not have complex mobility needs with an appropriate walking aid (for example frame, wheeled frame [often called a rollator] or stick) to facilitate safe transfers and walking prior to full therapy assessment if necessary.

2. PURPOSE & SCOPE

2.1 The information within this document aims to:

- Help all clinical staff understand the expectation to assess mobility status
- Provide guidance to support the risk assessment process in the mobilisation of patients
- Provide simple, practical advice on how to provide newly referred patients (who do not have complex mobility needs) with an appropriate walking aid to facilitate safe transfers and mobility until a full therapy assessment has been undertaken.

3. DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has overall responsibility for procedural documents and delegates responsibility as appropriate
- 3.2 The **Lead Director who is the Director of Nursing and Patient Safety** with devolved responsibility for the implementation of this policy
- 3.3 The **Identified Lead** is the Rehabilitation Clinical Lead and she will be responsible for producing written drafts of the document and for consulting with others and amending the draft as appropriate.

- 3.4 **Service Managers/Heads of Service** Responsibility for implementing the guidance is devolved to Clinical Directors and Heads of Service.
- 3.5 The **Corporate Governance Manager** has responsibility for holding the central database of procedural documents including this guidance and for providing review reminders. The team also has responsibility for dissemination of the final document and archiving old versions.
- 3.6 **All inpatient clinical staff** including temporary staff are individually responsible for their actions including complying with this policy.
- 3.7 **Consultation and Communication with Stakeholders.** The process for consultation and communication with stakeholders is summarised in the Document control front sheet and the Contribution list.

4. EXPLANATIONS OF TERMS USED

- 4.1 The abbreviations commonly used by surgeons for post-op instructions are;
- FWB = Full Weight Bearing: Patient is allowed to fully weight bear through the limb. The patient may require a walking aid for balance or to limit pain but not specifically to limit weight bearing.
 - PWB = Partial Weight Bearing: Patient is NOT allowed to put all their weight through the limb and so will need aids such as a frame/wheeled frame or crutches to mobilise or a stand aid (such as an orbital seater or patient turner) to assist with transfer if patient is unable to limit weight bearing when stepping.
 - TWB = Touch Weight Bearing (also known as eggshell weight bearing or TTWB = toe touch weight bearing): Patient is only allowed to 'rest' the foot on the ground when stepping and is NOT allowed to put any significant weight through the limb when transferring or mobilising so will therefore need aids as above.
 - NWB = Non Weight Bearing: No weight is allowed through the limb at all. The patient will need aids such as a frame/wheeled frame or crutches to mobilise or a stand aid (such as an orbital seater or patient turner) to assist with transfers if patient is unable to avoid weight bearing when stepping (Davies: 2011).
 - Gait = Walking Pattern
 - Ferrule = A ferrule is a piece of metal or rubber that covers the end of a stick to protect it and stop it from slipping. Most walking aids will have these.
 - Understanding You = Multi-disciplinary assessment record this includes mobility assessment, patient handling assessment, risk assessments and therapy assessment.

5. **GUIDELINES TO SUPPORT THE RISK ASSESSMENT PROCESS IN ASSESSING MOBILITY STATUS AND PROVISION OF APPROPRIATE EQUIPMENT TO AID MOBILITY**

- 5.1 All newly referred patients should be assessed for their ability to transfer and walk. The clinical staff member is expected to undertake a basic mobility and transfer assessment (risk) as part of the MDAR and provide basic transfer aids/walking aids (frame/wheeled frame/stick) if necessary based on that assessment of need in accordance with Trust manual handling policy and guidance.
- 5.2 The following guidance is to support that risk assessment process. If the risk assessment indicates that the patient has complex mobility needs then a therapy assessment will be necessary prior to the issue of any transfer/walking aids.

5.3 **Information Gathering**

Information gathering is an important element of safe moving and handling practice. Prior to transferring/mobilising the patient, important knowledge about the patient which will impact on their ability to move and the assistance they are likely to require can be found from:

- Medical Notes: any previous rehabilitation input should be recorded with a transfer summary indicating the mobility status just prior to transfer
- care plans/handover sheets
- Talking to colleagues
- Talking to the patient

You will need to know;

- Why the patient has been referred
- Relevant past medical history
- Any information already gained about their mobility prior to referral
- Have they had recent falls? If 'yes', has a reason been identified?
- How have staff (e.g. in the acute sector) transferred / moved this patient so far and what problems have they had?
- What medication do they take? E.g. do they need painkillers before mobilisation / are they taking medications for conditions such as Parkinson's that will be most effective at particular times of the day?

- If they have a fracture / recent joint replacement / orthopaedic history, what are the instructions given by the surgeons regarding post-operative weight bearing status / mobilisation?

(This information is often written at the bottom of the pink operating notes in the medical notes if a patient has had an orthopaedic operation although weight bearing status may have been altered following surgery and will be documented in the medical record).

5.4 Meeting the patient

Ask the patient:

- Why they have been referred
- How they are feeling now
- Whether they suffer from dizzy spells / blackouts / balance problems
- Whether they have any pain? (N.B. if they have fallen they may have undiscovered fractures, e.g. hip, wrist).
- Whether they have any sensory problems? (e.g. numb feet will impair a patient's ability to balance).
- How they walked and transferred before referral-
? Aids used (including specially adapted footwear) / assistance Needed,? Problems,? Limiting factors
- What assistance they think they need to mobilise now (don't forget that some patients will have a very unreliable perception of their abilities)

5.5 Observation / Physical Assessment

- Look at the patient's posture – note any abnormality in symmetry.
- How 'active' do they look? That is, do they move themselves in the bed at all, or do they expect assistance to make any changes to their position?
- Upper limbs – can they lift their arms to shoulder height? – note any obvious weakness. Hand function – can they grip effectively?
- Lower limbs – can they lift their heel off the bed slightly whilst keeping knee straight? (this gives you a clue as to whether they are likely to be able to control their knee position in standing).
- Staff should ensure that they and the patient are aware of, and understand, any weight bearing or movement restrictions issued by an

orthopaedic/surgical team. Staff should clarify with the patient that the patient is able to adhere to these restrictions when transferring / walking.

5.6 Transferring / mobilising the patient

From your information gathering and observation/physical assessment of the patient you will be able to make a judgement on how to proceed.

The following could be considered;

- Ask for assistance from another member of staff unless the patient is obviously able to mobilise independently or with very minimal assistance.
- For those patients who do not have complex mobility limitations, clinical staff should provide a suitable walking aid (frame, wheeled frame or stick) if assessment indicates this is necessary. See instructions reference measuring for and use of walking aids. If you do not feel a patient will be able to step round safely, then consider the use of a *stand* aid (such as Patient Turner/ Orbital Seater or Arjo Steady) rather than provide a *walking* aid for transfers and await Physiotherapy or Occupational Therapy assessment for progression of mobility with appropriate walking aid. When using a stand aid, particular care must be taken to avoid damage to skin at the point of contact of shins on knee block pads. Ensure consideration is given to the integrity of the skin on the front of the lower legs as it may be inappropriate to use a stand aid or patient turner
- Ensure appropriate chair is available to transfer to.
- Allow patient to sit on edge of bed for a short while prior to standing.
- Following Trust patient handling guidelines, assist patient to standing. Ensure patient is not feeling dizzy prior to progressing to walking. If patient is dizzy, encourage patient to sit down again and then attempt again once recovered
- Hoist transfers may be necessary initially. N.B. A standard sling hoist manoeuvre should not be used with any person who has recently undergone total hip replacement or hemi-arthroplasty unless written notification is given by the consultant orthopaedic surgeon. This is because of the risk of dislocation of the prosthesis. A stand aid hoist (e.g. Sara) can be used as this does not increase the risk of the hip bending more than 90 degrees /adducting or internally rotating. If your community hospital does not have a stand aid hoist and the patient is unable to transfer with a mobility aid or patient turner following a hemi-arthroplasty/total hip replacement then the patient will need to be nursed in bed until the consultant's written agreement to proceed with sling-type hoist transfers is received.

5.7 **Please note that the referring hospital may state on the transfer form that the patient who has had a hemiarthroplasty or total hip replacement has been ‘hoisted’ in a sling, but some orthopaedic wards have hoists that have spreader bars which allow the patient to recline and do not bend the hip past 90 degrees during manoeuvre. Make sure you know what hoist manoeuvre is safe for the patient and what has been agreed by the orthopaedic team (Davies: 2011).**

- If you are unable, or feel unable to safely transfer your patient out of bed please contact a member of the Independent Living Team (Physiotherapist or Occupational Therapist) for their advice. Meanwhile ensure that you encourage regular changes of position of the patient in bed, or consider nursing the patient on a profiling bed that allows the position to be changed into a “chair” type position. Consider the Skin Bundle at all times.

See Appendix A for flow chart for decision making process.

5.8 **Walking Aids Information**

The term walking aids includes: Walking frames, wheeled walking frames (often called rollators), crutches and walking sticks. Walking aids for issue to in-patients are kept in a store at each community hospital. Make sure you know how to access this store at your place of work.

All walking aids must be checked to ensure they are fit for purpose before issuing the aid to the patient:

- Ferrules must be checked to ensure they are not worn or loose
- Locking mechanisms and spring buttons must be fully engaged and holes must not be worn.
- The frames’ metal joints should not be loose, struts should not be bent, screws should be firmly tightened.

5.9 **Walking Frames/ wheeled walking frames**

5.9.1 Maximum user weight: 160Kg (Somerset Community Equipment Service Catalogue: 2008)

5.9.2 These are the walking aids that give the most support and stability to patients when walking/transferring. Used when a patient needs to restrict weight bearing through a lower limb (either partial or non weight bearing) or when their balance is poor or when confidence is very low.

5.9.3 A wheeled walking frame (sometimes called a rollator) is created by replacing the front 2 legs of a frame with wheeled legs. When adjusting Coopers’ frames with wheels it is advisable to set the rear legs one position higher than the front wheels. This is to compensate for the increased height

of the wheels at the front which can adversely affect the stability of the frame and the slope of the handles (Sunrise Medical Limited).

5.9.4 Most patients manage a wheeled frame more easily than a frame as they do not have to lift it up and forwards but slide it gently along the floor. Some patients however fear that wheels will make the aid 'run away from them' and so a frame is more suitable in these cases.

5.9.4 The correct height of frame/wheeled frame is important. The height of the handgrips should be at the level of the wrist crease when the patient is standing upright and elbows are very slightly bent (approx. 15 degrees flexed) (Disabled Living Foundation: 2006). The user should be able to maintain an upright posture with the elbows slightly flexed (15 to 30 degrees) when standing or walking with the aid (Department for Families and Communities: 2011).

5.9.5 When assessing the correct height of frame/wheeled frame, ensure that the patient is wearing the footwear they are likely to use when mobilising. Encourage the user NOT to walk too far into the frame/wheeled frame otherwise they are more at risk of overbalancing backwards.

5.10 **Crutches**

5.10.1 Maximum user weight: 120Kg (Somerset Community Equipment Service Catalogue: 2008)

5.10.2 These can also be used when a patient needs to be non weight bearing or partial weight bearing. They are much more difficult to use than a frame or wheeled frame and demand reasonable balance and control. Unless a patient is already used to using crutches, a frame or wheeled frame is likely to be the safest walking aid option for initial transfers or mobilisation until a Physiotherapist or Occupational Therapist has assessed the patient and advised on appropriate walking aid and gait pattern.

5.10.3 The correct height of crutches handgrip is as per stick measurement below. The elbow cuff height can also be adjusted. The cuff should cradle the forearm just below the elbow joint so that movement of the elbow is not impeded (Disabled Living Foundation: 2006).

5.11 **Walking Sticks**

5.11.1 Maximum user weight of metal adjustable stick: 127Kg (Somerset Community Equipment Service Catalogue: 2008).

5.11.2 Patients may use one or two sticks to aid mobility. They do not give as much support as a frame/wheeled frame or crutches and so are not useful when a patient needs to restrict weight bearing significantly.

5.11.3 Walking sticks are a useful aid to balance and patients may progress from a frame/wheeled frame onto a stick or sticks as they are able to bear more weight or their balance improves and they become more confident. The

transition from one walking aid to another will be guided by the therapy team.

- 5.11.4 If one stick is to be used, it is normally held in the hand OPPOSITE the affected leg. When the patient walks, they generally place the stick on the ground at the same time as the affected leg.
- 5.11.5 If the patient is used to using a stick then, if possible, allow them to use the stick in the hand they usually use and the gait pattern they are familiar with.
- 5.11.6 To ensure correct stick length in standing, the base of the stick should be placed approximately 15cm from the outside of the foot and the handle height should be set at wrist crease height with patient standing upright.
- 5.11.7 The elbow should be bent slightly (generally between 15 and 30 degrees) when holding the stick and standing upright (Department for Families and Communities: 2011).
- 5.11.8 There are many other walking aids available to meet a variety of patient needs such as gutter frames for those patients who find it difficult to grip a standard aid. A physiotherapist will advise on the most appropriate aid for those patients with more complex mobility needs and liaise with staff on use of aid, suggested gait pattern and assistance needed.
- 5.11.9 If you need clarification on any of the information here or need further information then please contact the ward therapist who will be happy to help.

Please see Appendix B Walking Aids - 'Quick Guide' for Clinical staff

6. TRAINING REQUIREMENTS

- 6.1 There are no specific mandatory training requirements as part of the he Staff Training Matrix (Training Needs Analysis). However, training will be provided by the local rehabilitation staff in the community Hospitals as requested

7. EQUALITY IMPACT ASSESSMENT

- 7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1 Monitoring arrangements for compliance and effectiveness

This policy will be regularly reviewed and maintained by the rehabilitation service best practice group and the Community hospital best practice group.

8.2 Methodology to be used for monitoring

- complaints monitoring
- incident reporting and monitoring via DATIX
- safeguarding alerts

8.3 Frequency of monitoring

- frequency dependent on the number of incidents reported, the reports will be provided by Team Leaders and Rehab Independent Living Team Leaders

8.4 Process for reviewing results and ensuring improvements in performance occur.

Monitoring results will be presented to the Community Hospitals Best Practice group and the Rehabilitation Service Best Practice Group for consideration and identifying best practice, any shortfalls, action points and lessons learnt will be reviewed. These Groups will be responsible for ensuring improvements, where necessary, are implemented. Lessons learnt will be shared with the relevant Best Practice Group. A brief of any issues raised will be provided to staff to raise awareness through the SPICE newsletter.

9. COUNTER FRAUD

- 9.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

10. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

- 10.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 18:	Staffing

Regulation 19: Fit and proper persons employed
Regulation 20: Duty of candour
Regulation 20A: Requirement as to display of performance assessments.

10.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 18: Notification of other incidents

10.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

11.1 References

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Davies, S. (2011) *Weight Bearing Status and Use of Hoists Post Hip Replacement* [Telephone Conversation] (Personal Communication, October 6th, 2011).

11.2 Cross reference to other procedural documents

Mandatory Training Policy
Risk Management Policy and Procedure
Slips, Trips and Falls Policy
Staff Training Matrix (Training Needs Analysis)

Training Prospectus
Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

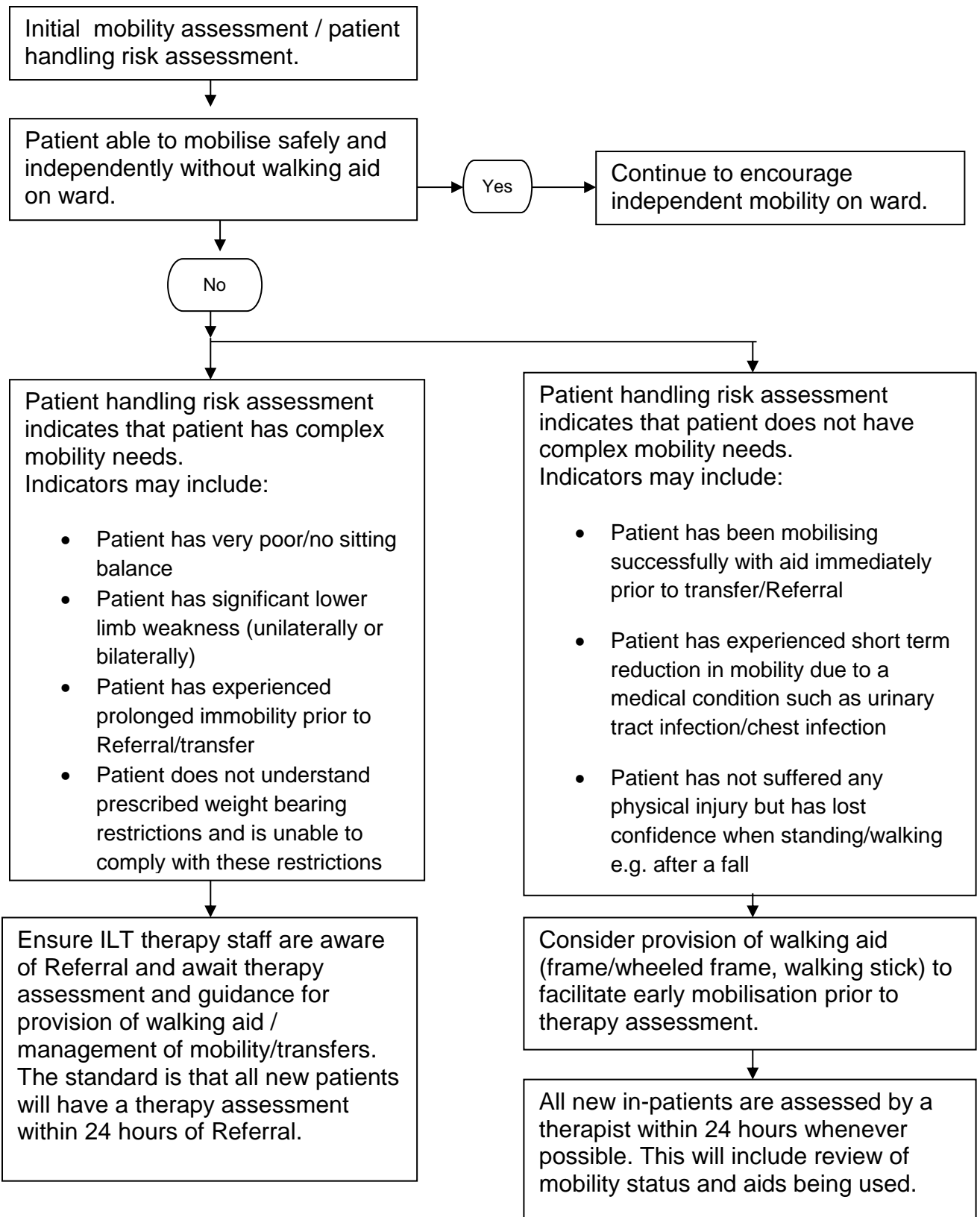
12. APPENDICES

12.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A Flow chart for decision making process

Appendix B Walking Aids a 'Quick Guide' For Clinical Staff

FLOW CHART FOR DECISION MAKING PROCESS FOR A WALKING AID



WALKING AIDS – ‘QUICK GUIDE’ FOR CLINICAL STAFF

Walking Frame / Wheeled Frame (standard frame with the two front legs replaced by wheels - sometimes called a rollator)

Maximum user weight – 160Kg

May be useful for patients with:

- Restricted weight bearing status (partial weight bearing, touch weight bearing, non weight bearing)
- Poor balance when walking
- Low confidence levels when mobilising
- Lower limb weakness

Correct height – Patient should be able to maintain upright posture with shoulders relaxed and elbows slightly bent (15 to 30 degrees) when standing or walking with the aid.

N.B. When adjusting frames made by Coopers with Coopers’ wheels, it is advisable to set the rear legs one position higher than the front wheels so that the handgrips are more level and the wheeled frame remains stable.

A wheeled frame tends to be easier to move forward than a frame without wheels and the majority of patients prefer this. Some patients prefer a frame without wheels as they fear that the wheels will make the aid ‘run away’ from them.

Crutches

Maximum user weight – 120Kg

May be useful for patients with:

- Restricted weight bearing status (partial weight bearing, touch weight bearing, non weight bearing)
- Lower limb weakness
- Use of crutches demands reasonable balance, control and coordination. They are much more difficult to use than a frame or wheeled frame. **Unless the patient has already been confidently using crutches on a regular basis then nursing staff should avoid issuing these to patients if possible.**
- Correct height - Patient should be able to maintain upright posture with shoulders relaxed and elbows slightly bent (15 to 30 degrees) when standing or walking with the crutches. The elbow cuff should cradle the forearm just below the elbow joint and should not impede elbow movement.

Walking stick

Maximum user weight – 127 KG

May be useful for patients with:

No lower limb weight bearing restrictions in place i.e. allowed to fully weight bear

Minimal confidence issues when walking / minimal support needs when walking

Correct height - Patient should be able to maintain upright posture with shoulders relaxed and elbows slightly bent (15 to 30 degrees) when standing or walking with the stick.

Patients may use one or two sticks. If one stick is to be used it is normally held in the hand opposite the affected leg. If being used as a balance aid the patient holds the stick in whichever hand they feel most comfortable.