

Standard Operating Procedure for managing Bariatric/Plus size patients

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Bariatric Patient Moving and Handling Procedure

1. Introduction

East Kent Hospitals University Foundation NHS Trust (hereafter referred to as EKHUFT) is committed to treating patients with appropriate non-discriminatory care, technical excellence, accessibility and acceptability, making sure dignity and respect is given during their stay in hospital, whilst ensuring the health and safety of employees involved in their care.

EKHUFT are proactive rather than reactive to the rise in obesity. 'Bariatrics' is the branch of medicine that deals with the causes, prevention and treatment of obesity and its associated diseases. American Dictionary (2000). The term is derived from 'baros' meaning weight and 'latros / latreia' meaning medical treatment (www.medicinenet.com)

A bariatric patient is defined within EKHUFT as a person who weighs over 127kgs (20stone) or who has a Body Mass Index (BMI)>30 or BMI 35 plus co-morbidities. ([Appendix 1](#)) The average Safe Working Load (SWL) for equipment is given as guidance only. Individual pieces of equipment must be checked for the precise SWL before using with a bariatric patient. The patient's weight must not exceed the SWL and consideration to the patient's shape has to be included.

This bariatric pathway has been developed to allow the multidisciplinary teams to provide care for the bariatric patient unique shape, size and body dynamics. ([Appendix 2](#))

2. Purpose

This is to be used alongside the Moving and Handling (M&H) Policy, available on the EKHUFT policy centre .

EKHUFT accepts that patients are individual in shape, size, dynamics and personality. The purpose of this guidance is:

- To provide employees with a clear understanding of the M&H issues / clinical risks ([Appendix 3](#)) connected with the provisions of care.
- To ensure each patient is handled in a comfortable and dignified manner
- To provide a bariatric patient pathway, to address the complex requirements (including equipment), safety and specialised care during their stay.

3. Definitions

- M&H= Moving & Handling
- MHSC=Moving and Handling Senior Co-ordinator
- MHFA=Moving and Handling Facilitator/Advisor
- MHBL= Manual Handling Bariatric Link
- MELS= Medical Equipment Libraries

- SWL =Safe Working Load
- BMI =Body Mass Index
- TVNS= Tissue Viability Nurse Specialist

4. Accountabilities and Responsibilities

4.1 Moving and Handling Senior Co-ordinator (MHSC)

EKHUFT has a MHSC who will assist on matters surrounding care of complex patients.

It is important that the wards / departments inform the MH team as soon as possible on any admissions, issues or difficulties arise with a complex / Bariatric patient. Either via internal mail, marked confidential, via phone on 721-2535 or via email to ekh-tr.manualhandling@nhs.net

The MHSC:

- Promotes safety for patients and employees.
- Provides appropriate training / study. (See M&H Training needs analysis)
- Provides appropriate reports, complex assessments, knowledge, advice, information and discussion re cases of needs, for all referring wards / departments, as far as is reasonably practicable.
- Reviews and discusses M&H with the relevant committees.
- Deals with M&H equipment issues, needs and requirements quickly and efficiently improving standards of quality and care, advising on any M&H equipment prior to purchase / loan /rent that may be required so that it is the most appropriate and safest option for the planned task.
- Investigates M&H accidents, incidents and near misses, of employees or patients, to prevent re-occurrence. In line with the Trust's incident reporting policy and to report all these investigation to the appropriate meeting and committees.
- Provides appropriate data for audits on the complex patients stay, including numbers referred, admitted and discharged on each pathway. Looking at the equipment required and assessing if it was from M&H or from outside companies / agencies. Report all these to the appropriate meeting and committees.

4.2 MHFA should:

- Deputise in the MHSC absence making decisions regarding equipment

- Ensure bariatric M&H equipment, is always locatable, in good working order and appropriate checks have been made, including condition, requirements, cleanliness, SWL etc. reporting any faults to EME or Estates

4.3 MHL should: Training programme [\(Appendix 15\)](#)

- Support the MHSC in providing appropriate care and support to wards and departments in relation to complex patient issues, safety, equipment, needs and requirements.
- Act as a resource in complex patient care, promoting and improving standards of quality in relation to M&H, completing complex patient assessments, if required.
- Ensure M&H equipment on their wards / departments are clean; in good working order and appropriate checks have been made reporting any faults to EME/ Estates.
- Attend a yearly specialist training session for bariatric patients with the M&H department

4.4 Care Group, Departmental Managers and Ward Managers

- Communicate the information to all employees within their area of responsibility, ensuring they are aware of the M&H Policy (including minimal lifting).
- Ensure that suitable, adequate M&H equipment is used, either from the Medical Equipment Library (MEL)
- Ensure that, **prior to purchase of** any M&H equipment; the M&H Advisers are consulted to ensure that the equipment is appropriate for the planned task. This includes any mechanical equipment, e.g. hoists, beds, trolleys.
- Develop and implement safe systems of work, investigate accidents, incidents and near misses regarding bariatric patients to prevent re-occurrence in line with the Trust's incident reporting policy and to report all these to the MHSC
- Ensure adequate employee levels for safe working practises. [\(Appendix 4\)](#)

5. Admission of a Bariatric Patient. [\(Appendix 5\)](#)

A bariatric generic M&H assessment form must be completed: -

- Bariatric Patient Mobility Assessment form [\(Appendix 6\)](#).
- 3rd Trimester Assessment for pregnant ladies with raised BMI [\(Appendix 7\)](#).

Information requested by the MH team must be e-mailed to ekh-tr.manualhandling@nhs.net or via internal post marked as **Confidential** to the M&H team at Buckland Hospital Dover

Management of bariatric patients in EKHUFT has been put in place to allow the multidisciplinary teams to provide care for the bariatric patient's unique shape, size and body dynamics.

- **Pathway 1- Over 127kgs / 20st or BMI Independent**
- **Pathway 2 – Over 191kgs / 30st Limited Assistance**
- **Pathway 3 – Over 222kgs / 35st Extensive Assistance**
- **Pathway 4 – Over 267kgs / 42st. Dependent**

Bariatric patients have specific M&H complex Clinical considerations ([Appendix 8](#)) around their environment or physical condition these assessments need to be carried daily or as/when necessary.

This needs to include:

- Baseline observation including weight ([Appendix 9](#)) height, BMI, body type, weight distribution, waist circumference, mobility status ([Appendix 10](#)) girth measurements
- Current diagnosis, expected examinations / diagnostic tests / prognosis / expected delivery date etc.
- M&H equipment needed, ([Appendix 11](#)) including bed, seating, hoist, commode etc.
- M&H assessments, including patient's ability to weight bear, transfer, movements in bed etc.
- Number of employees required for appropriate and safe M&H techniques to be used.
- Route for drug administration – IV, central line access etc.

Other considerations:

- Emergency situations of a bariatric patient ([Appendix 12](#))
- Personal care of the bariatric patient ([Appendix 13](#))

6. Designated Locations for the Admission and Care

The following locations have been identified as the preferred locations for delivery of care to a bariatric patient with complex needs as part of a planned admission. These wards are for extremely high-risk bariatric patients **purple score** these wards below will be stocked with XL hoist slings ready for their patients.

- **K&C** Orthopaedic Elective Bariatric patients only Invicta Ward, Marlowe Ward, Harvey

- **QEQM** AMUA AMUB Fordwich side room
- **WHH** Richard Stevens Unit, Kennington ward, Oxford ward

6.1 Wards That Have Restrictions for Bariatric Patients

- **WHH AMUA/Short Stay/Kings C2**, Floor restrictions
AMUA/Short Stay/Kings C2 can only take patients whose weight is no more than 150kg on a bariatric bed. This meets the needs of our patients with a low weight but high BMI.
- **K&C Mount/McMaster/Kingston/Treble/Harbledown/St Lawrence**, cannot take any patient above 150kg, this is due to evacuation risk and lift not being big enough to take bariatric bed in the 1937 building
- **QEQM (3 block) Deal/St Margaret's/Sandwich Bay** A structural assessment report completed by estates, This assessment has concluded that the existing structure is adequate and has identified that 3 block can take bariatric patients along with gantry and bariatric bed as long as the patient weight does not exceed 260kg this does not include bariatric bed and gantry. i.e. patient whose weight is 230kg and needs gantry and bariatric bed can go into these wards, However I would recommend one patient per bay only.

In the event that the preferred location is unsuitable for the patients care for example surgery, selection of an alternative location must be considered:

- Safe access and egress.
- Priority to clinical support services.
- Accessibility and availability of equipment and nursing care.

Physical environment including:

- Emergency evacuation.
- Safe working loads of equipment (inc. lifts) and floor surfaces.
- Availability of two bed spaces (if required).

7. Elective Admissions of a Bariatric Patient.

- If a planned admission meets the criteria of the process into the care of the bariatric patient then appropriate preparations can be made at this stage.
- Preferably a minimum of 5 days' notice and detailed information of a bariatric patient's

- M&H needs, weight, height and BMI should be obtained from the referring clinic/GP/ward and given to the admitting ward / department.
- Orthopaedic elective patients who are bariatric would be nursed on Invicta but no other speciality groups will be able to use this environment.
- This allows for the preparation of equipment such as a bed, hoist, and commode, wheelchair, walking frame and slide sheets. If the equipment is not available in the ward/ department, additional equipment can be booked through the 2gether Support Solutions Ltd (help desk) 722-5555
- If patient criteria are unknown, care of the bariatric patient' should to be initiated on arrival to the emergency admission ward.

7.1 Emergency Admissions of a Bariatric Patient.

- Emergency ambulance crews should use the Red flag system that they have in place, allowing the Emergency Department preparation time.
- If the emergency admission meets the criteria for the process into the care of the bariatric patient then appropriate preparations can be made at this stage by the Emergency Department or as soon as is reasonably practicable.
- In the event of an emergency admission, the Site Clinical Manager should refer the patient to the appropriate wards for K&C, QEQM, WHH, locations above. Two bed spaces might need to be considered to accommodate the patient.

7.2 If admission is not possible:

- Identify an alternative location suitable for the patient's needs. Remember to consider access in the event of an emergency, proximity to support services, equipment availability and minimal transfer distances.
- If the equipment is not available on the ward contact the Help desk giving them the bariatric patient assessment score. They will send this information to the 2gether Support Solutions Ltd Medical Equipment Library (MELS) so they can locate Trust bariatric equipment or hire in if necessary.

8. Inter-departmental discharge / transfers of a Bariatric Patient.

- When a bariatric patient requires treatment in another department, ideally 2 hours prior to movement, information on the patient's weight and handling needs must be given to that department and the porters who will move the patient.
- If equipment has been rented the ward must phone MELs to cancel, giving the patient name and new ward to the team Failing to do this will mean the ward will still be charged by the MELs

8.1 The receiving department must:

- Check the SWL of trolleys/ tables.
- Ensure appropriate employee numbers to carry out any M&H practises safely for both the patient and the employees.
- Ensuring that appropriate equipment, i.e. bed, trolley, hoist, sling, slide sheets etc. is within SWL of patient.

Access should be planned and the area made sure it is clear

- Where appropriate, the procedure should be carried out on the specialised bed or other suitable equipment to maintain patient and employee safety.
- Where this is not possible, and the patient's weight exceeds the SWL of the department's equipment, Contact MELs for appropriate equipment to be rented in. Advice and information are available via MHSC
- When a patient is transferred to another ward, a detailed report on the patient's weight and M&H needs must be given to the receiving ward as soon as possible.
- The ward must be given time to pre-plan and arrange for appropriate equipment, within SWL and where circumstances allow.
- Ambulance control must be given full details of the patient's weight and handling needs if transferred to another hospital.
- A full complex patient assessment must accompany the patient on transfer.

9. Discharge of a Bariatric Patient. [\(Appendix 14\)](#)

When a bariatric patient is discharged, detailed information on the patient's weight and handling needs must be given to:

- Community team so they have time to organise appropriate equipment/ aids such as wheelchairs, hoist, beds etc.
- Transport requirements and SWL of transportation
- All equipment must be cleaned, according to the Trust Infection Control Policy and manufacturer's instruction, before it is returned.
- If specialised equipment is borrowed from another ward / department, M&H department or hired from outside company, this will need to be returned as soon as is reasonably possible to the MELs after patient has been discharged. (as, the longer the equipment is around, the more the Trust will be charged.)

10. Care of the Deceased Bariatric Patient [Care after Death Guidelines](#)

Ward /Departmental Role: The on-call mortuary technician must be contacted if a bariatric death occurs between 1600 on a Friday and 1600 Sunday of any weekend.

Inform Mortuary, porter's service helpdesk, divisional managers/site team: ward MHL of the demise of the bariatric patient. A minimum of 1 hours' notices maybe needed

Ward staff to prepare all bariatric deceased in bariatric body bags. The bariatric body bags/shrouds can be located on:-

- WHH Oxford Ward
- QEQM Fordwich ward
- K&C Harvey ward

All other wards can be cross charged by the above wards if a bariatric body bag/shroud is needed for their ward.

- Lay a bed sheet over the deceased fully covering them to minimise exposure, tuck in under edges of deceased
- Contact porters and inform them of the deceased patient and request a mortuary green lift sheet
-

10.1 2gether support solutions Ltd Portering role:

- A minimum of 4 ward staff are to roll the deceased whilst the porter lays the green lift sheet in line with the deceased's spine.
- Ensure the green lift sheet is positioned to support the head with the label at the head end
- Roll the deceased in the other direction and unroll the green lift sheet under the deceased, ensuring the deceased is central on the sheet
- Tuck the edges of the bed sheet under the deceased.
- Laterally transfer deceased on to the concealment trolley following risk assessment
- Plan route from ward to mortuary

10.2 Mortuary Services Role:

- Assess the SWL and dimensions of the mortuary trolley, fridges and post mortem table.
- Ensure that suitable risk assessments, enough employee and transportation are available for the protection of the employee.
- Inform the coroner (where applicable) and funeral director of patient's size, dimensions etc.

Bariatric beds must not be stored in the mortuary fridges for prolonged period of time as this would affect the battery, patient & nurse handsets. A bariatric mortuary trolley should be hired from the MELs M&H would strongly advise that in all cases mattresses are removed from under the deceased patient in order that the outer cover and internal mechanism are not contaminated with body fluids. This can result in the mattress sustaining damage that cannot be reversed during the decontamination process and therefore resulting in it becoming condemned. In terms of a rental mattress the cost of replacement would be the responsibility of the hirer.

10.3 Measuring the bariatric patient for the appropriate equipment.

Ascertaining a Patients measurement for Seating

When ordering seating for a patient the help desk will ask you, what seat width is required, and the patient's weight. Along with patient bariatric score. It is important to note that it is the patient's hip / waist width that is needed to be measured and not the girth.

A quick and unobtrusive way of ascertaining this is to use the surface the patient is already on. Remember to consider the Pannus, also known as a pannus stomach or mother's apron, apron belly occurs when the belly and fat surrounding the internal organs expands due to weight gain or pregnancy, resulting in additional fat deposits in the omentum (an apron-like flap under your abdominal muscles and in front of your intestines.) This Pannus can hang down from the chair causing discomfort and pain to the patient. The patient would have difficulty in standing. This patient would need a tilt and space recliner chair, and not a standard patient chair.

For example

If the patient is on a 36" / 90cm width bed measure the distance from the side of the patient to the edge of the mattress on both sides and deduct this figure from the surface width and this will give you an indication of the seat width. This will be more representative if the patient is in an upright position [Back Rest Up] and the widest point is used.

Calculation

Distance from patients left hip / waist to edge of surface = 4 inches

Distance from patient's right hip / waist to edge of surface = 4 inches

Surface width 90cms – 8cms = Seat width of 82cms / 33"

11. Hiring of equipment

If you need bariatric equipment you must call the Help Desk 722-5555, giving them the name of the patient, along with the bariatric risk assessment score of the patient.

The Help desk will then book this through the MELs who will then use EKHUFT own bariatric equipment if available. If no equipment is available the MELs will hire the equipment in.

Same for the return of the equipment, phone the helpdesk and they will off hire and then return the equipment to the MEL.

12. References

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APPENDIX 1 CLASSIFICATION

Classification of Morbid Obesity and Co Morbidities		
<p>Morbid obesity is a chronic disease, meaning that its symptoms build slowly over an extended period of time. Obesity becomes “morbid” when it reached the point of significantly increasing the risk of one or more obesity related health conditions or serious diseases (also known as co-morbidities that can result either in significant physical disability or even death. McGillivray (2004)</p> <p>Co-Morbidities</p> <p>Obesity is a major risk factor associated with many chronic diseases, which reduce quality of life or lead to premature death.</p> <p>Chronic diseases linked to obesity are:</p>		
GREATLY INCREASED (>3)	MODERATELY INCREASED (2-3)	SLIGHTLY INCREASED (1-2)
<p>Diabetes</p> <p>Gallbladder Disease</p> <p>Dyslipidaemia</p> <p>Insulin Resistance</p> <p>Breathlessness</p> <p>Sleep Apnoea</p> <p>Impaired Circulation</p>	<p>Chronic Heart Disease</p> <p>Hypertension</p> <p>Osteoarthritis</p> <p>Hyperuricaemia</p> <p>Gout</p> <p>Impaired Fertility</p> <p>Soft Tissue Infection</p>	<p>Cancer:</p> <p>Breast (in post menopausal)</p> <p>Endometrial, colon</p> <p>Reproductive hormone abnormalities</p> <p>Polycystic ovary syndrome</p> <p>Foetal defects in maternal obesity</p> <p>Low Back Pain</p> <p>Anaesthesia complications</p> <p>Sleep disorders</p>

BODY MASS INDEX (BMI)

BMI is the most common internationally accepted standards used to measure weight and the height of a person

To Calculate BMI

Divide the Body Weight in Kilograms (kg) by the height in metres squared (M²)

BMI = Weight (KG) / Height (M ²)	
Underweight	Less than 20
Healthy Weight	20 – 24.9
Overweight	25 – 29.9
Obese (Class 1)	30 – 34.9
Obese (Class 2)	35 – 40
Morbid Obesity	More than 40

National Audit Office- Tackling Obesity in England 2001, World Health Organisation

APPENDIX 2

Guidelines Using Patients Weight/Size and BMI

INDEPENDENT



- Ambulatory may use a walking aid
- Independent, can clean and dress her/himself

Equipment- use EKHUFT- bariatric bed with normal bariatric mattress, static bariatric chair call Medical Equipment Library or porters

- If patient cannot get off the bed to mobilise due to bed not going low enough
- Rent in a lower bed from trust recommended rental company

LIMITED ASSISTANCE



- Uses walking aid
- Had trunk stability
- Can weight bear may need assistance in standing and walking
- Dependent on carer for some hygiene needs

Equipment- use EKHUFT- bariatric bed with normal bariatric mattress, static bariatric chair. Bariatric Zimmer frame refer to physio.

- If patient cannot get off the bed to mobilise due to bed not going low enough
- Rent in a lower bed from Trust recommended rental company

EXTENSIVE ASSISTANCE



- Sits in a wheelchair
- Has some trunk stability
- Is able to partially bear weight on at least one leg
- Able to shift weight from side to side
- Dependent on carer in most situations

Equipment – Commode /electric bariatric wheelchair form equipment Library

Rent bed/recliner chair from Trust recommended rental company

Assessment from the Physio or Manual Handling team if specialised equipment is needed

DEPENDENT



- Passive
- Might be almost completely bedridden
- Often stiff, contracted joints
- Totally dependent
- Physically demanding for carer

Equipment – from Trust recommended rental company

Rent bed, turning mattress, ultra twin hoist, and commode.

Assessment from the Physio or M&H team if specialised equipment is needed



BARIATRIC PATIENT PATHWAYS

Make sure suitable clear bed space is available, for all treatment, hygiene needs, equipment and access routes which includes the doorway width, thresholds, turning space, space around bed etc.

PATHWAY 1 (GREEN) UP TO 127KGS / 20ST OR BMI >30 OR >35 & CO-MORBIDITIES	PATHWAY 2 (AMBER) Up TO 191 KGS (30 ST)	PATHWAY 3 (RED) UP TO 222 KGS (35 ST)	PATHWAY 4 (PURPLE) AND ABOVE 267 KGS (42 ST)
EQUIPMENT Beds, Chairs / commodes and hoists within Trust SWL	EQUIPMENT Beds, Chairs / commodes and hoists within Trust SWL	EQUIPMENT Beds, Chairs / commodes and hoists - Trust Bariatric equipment from outside company.	EQUIPMENT Beds, Chairs / commodes and hoists From outside company only.
PATIENT ASSESSMENT Complete Bariatric Generic Assessment. Needs Referral to M&H Dept Might need complex assessment Via Physiotherapy	PATIENT ASSESSMENT Complete Bariatric Generic Assessment. Needs Referral to M&H Dept Might need complex assessment Via Physiotherapy	PATIENT ASSESSMENT Complete Bariatric Generic Assessment. Needs Referral to M&H Dept Might need complex assessment Via Physiotherapy Will need RISK assessment	PATIENT ASSESSMENT Complete Bariatric Generic Assessment. Needs Referral to M&H Dept Might need complex assessment Via Physiotherapy Will need RISK assessment

APPENDIX 3 CLINICAL RISK

CLINICAL RISK

Ventilation and circulatory problems arise as excess adipose tissue makes the insertion of catheters for central venous access and other invasive monitoring difficult. Non-invasive monitoring equipment can be inaccurate.

In an emergency e.g. an arrest, there is a potential increase of risk to the rescuer when leaning over the patient; a defibrillator charge may also be less effective as much may diffuse through tissue other than the heart:

Avoid Trendelenberg and supine position as it compromises breathing and risks the occurrence of gastric reflux, aspiration and positional asphyxiation. This can happen even when the patient is conscious and able to protect airway.

Drug doses are calculated differently with bariatric patients – they need to have pharmaceutical involvement as soon as possible.

- Loading drug doses have to be based on actual body weight and maintenance doses on ideal body weight.
- Many drugs are fat soluble, e.g. anaesthetic agents and need to be assessed by the appropriate physician.
- Certain medications that are moderately lipid soluble (e.g. Theophylline) distribute less into the excess body weight than into ideal body weight.
- Other drugs (e.g. Digoxin) are hydrophilic and the dose should be based on ideal body weight.

WOUND MANAGEMENT/SURGERY AND TISSUE VIABILITY RISKS

For wound management, deeper adipose layers may contribute to a reduced sensory perception at the skin structure.

During suturing of a wound the skin can be over stretched which become more friable. Assess the type of suture material as ultimately the weight falls on the suture.

Wound and fracture healing time will be delayed as a result of poor oxygenation, poor circulation and malnutrition.

Excess weight makes Bariatric Patients prone to lower limb fractures and, with the consequent weight addition of plaster of Paris, there is a real risk of skin breaking down in addition to the usual complications of bed rest.

Bariatric Patients often sweat more than most because of their larger surface area. Hygiene care and changing of sheets poses a problem because of the Patient's limited mobility.

Maintaining skin integrity is important, as well as the raised awareness of susceptibility to pressure ulcers, rashes, dermatitis, moisture and related lesions.

A risk assessment needs to be completed in main theatres prior to the patient arriving in the area; preferably prior to admission. Information needs to include if the equipment can support the patient.

This may require a transfer to another acute trust that has appropriate facilities, although transportation may be arranged

Equipment Risks - SWL and Space Constraints

All equipment to be used by the patient must be checked to ensure that the SWL will not be exceeded. This includes the vast majority of hospital beds, hoists, wheelchairs, commodes and walking aids.

Should the SWL not take the patients actual body weight then there is a severe risk that the hydraulics will fail; the patient could sustain severe injuries and the device will need to be taken out of service for repair or replacement.

Apart from the SWL of equipment, the patient's physical width needs to be considered. For example in order to do a lateral transfer the patient would need to be rolled onto their side to insert the PATSLIDE – in these cases this is not possible due to the risk factor to both Employee and the patient.

The SWL, shape and size of seating in waiting areas and in treatment rooms: including in imaging – X- ray tables, MRI table, CAT scan and trolleys.

If this is a problem where else can the diagnostic tools be provided (i.e. on the ward, other hospitals or other probabilities; large animal enclosures).

Moving and Handling Risks

It is very important to know the bariatric patients actual weight. The risk of injury, if the weight is unknown, increases.

Employee levels are important as inappropriate employee levels increase the risk of work related muscular- skeletal disorders when handling heavy loads that are highly dependent and unpredictable. This includes lack of time, clinical knowledge, space constraints etc.

Lack of appropriate training can cause unsafe practices and injury to employee and patients, so it is very important to attend mandatory M&H training (see M&H policy)

Environmental constraints cannot be an issue. The employee need to be able to move around the bed safely and cannot if the space is limited it could lead to unsafe posturing and practise, by not using appropriate and taught M&H techniques and equipment.

When undertaking M&H tasks there is a risk of shear / friction of the bariatric patient skin and they are at risk of developing tissue / wound issues.

These need to be assessed by the ward employee, TVNS and M&H Advisers.

When turning and repositioning a bariatric patient it requires a minimum of six to eight employees (depending on patient's weight, shape and ability). These all need to be fit and well and safe to practice and completed a mandatory M&H training session.

Assessment needs to be carried out on the positioning of the bariatric patient during anaesthesia and resuscitation.

It is essential to use the correct assessment and equipment for lateral transfer i.e. PATSLIDE, sliding sheets extension straps to prevent injury to employee or patients during all transfers.

Assessment needs to be carried out on the positioning of the bariatric patient during surgery including how the bariatric patient is moved / positioned during the operation and how they are positioned for wound care and ventilation.

Assessment needs to be carried out on the positioning of the Bariatric Patient after surgery including how the bariatric patient is moved / positioned for respiratory and wound care management, how they recover on the bed and how to position employee and patients during resuscitation.

APPENDIX 4 STAFF LEVELS OF SAFETY

SAFE EMPLOYEE LEVELS REQUIRED to care for the Bariatric Patient

Calculated on height, weight and body dynamics of the patient.
Carers should work within their own body space and safe limitations.
Extra Employees may be required to assist with patient M&H tasks.
Be aware of the other ward/department areas and patients when caring for the bariatric patient.
Special arrangements will be needed to cover night duty.
As identified by both the M&H and risk assessment policies, it is important that the manual handling standards techniques are used at all times.
Unsafe M&H techniques and procedures must not be used.
According to present perceived best practice relating to patient handling and lifting, these include the drag lift, the orthodox lift, the Australian lift and the bear hug.

The number of carers required changes according to patient's pathway.

PATHWAY 1	PATHWAY 2	PATHWAY 3	PATHWAY 4
OVER 127KGS / 20ST OR BMI >30 OR >35 & CO- MORBIDILITES	OVER 191kg (30st)	OVER 222 kg (35st)	OVER 267kg (42st)

EMPLOYEE: 2-5 Carers	EMPLOYEE: 4 Carers	EMPLOYEE: 4-8 Carers	EMPLOYEE: 6-8 CARERS
dependent on patient's ability, mobility and diagnosis / treatment etc.	dependent on patient's ability, mobility and diagnosis / treatment etc.	dependent on patient's ability, mobility and diagnosis / treatment etc	dependent on patient's ability, mobility and diagnosis / treatment etc.

APPENDIX 5 ADMISSION

ADMISSIONS need to have a Generic M&H Patient Assessment Form.

This includes: weight, height, BMI, ability, mobility and other factors.

This will be scored & depending on this leads to a referral to M&H department. If unknown weight, use Trust weighing equipment

Bed manager / site team need to be involved in ward location and to identify suitable clinical environment for admission.

Designated Locations of Admission

The following locations have been identified as the preferred locations for delivery of care to a bariatric patient with complex needs as part of a planned admission. These wards are for extremely high-risk bariatric patients **purple score**

- **K&C** Orthopaedic Elective Bariatric patients only Invicta Ward, Marlowe Ward, Harvey
- **QEQM** AMUA AMUB Fordwich side room
- **WHH** Richard Stevens Unit, Kennington ward, Oxford ward

Wards That Have Restrictions for Bariatric Patients

- **WHH** **AMUA/Short Stay/Kings C2**, Floor restrictions

AMUA/Short Stay/Kings C2 can only take patients whose weight is no more than 150kg on a bariatric bed. This meets the needs of our patients with a low weight but high BMI.

- **K&C** **Mount/McMaster/Kingston/Treble/Harbledown/St Lawrence**, cannot take any patient above 150kg, this is due to evacuation risk and lift not being big enough to take bariatric bed in the 1937 building

• **QEQM (3 block) Deal/St Margaret's/Sandwich Bay** A structural assessment report completed by estates, This assessment has concluded that the existing structure is adequate and has identified that 3 block can take bariatric patients along with gantry and bariatric bed as long as the patient weight does not exceed 260kg this does not include bariatric bed and gantry. i.e. patient whose weight is no more than 260kg and needs gantry and bariatric bed can go into these wards, However I would recommend one patient per bay only

- Safe access and egress.
- Priority to clinical support services.
- Accessibility and availability of equipment and nursing care.

Physical environment including: <ul style="list-style-type: none"> • Emergency evacuation. • Safe working loads of equipment (Inc. lifts) and floor surfaces. • Availability of two bed spaces (if required).
ELECTIVE ADMISSION of a Bariatric patient.
Via GP, Community Agencies, Midwife, consulting appointments in OPD, pre op assessment A minimum of <u>5 days</u> ' notice needs to be given to admitting ward / department including expected date of admission and time of arrival.
EMERGENCY ADMISSION of a Bariatric patient.
Via GP, Community Agencies, Midwife or ambulance In the event of an emergency admission, the Site Clinical Manager should refer the patient to the appropriate wards for KCH, QEQM, WHH, locations above.
Admitting Ward / department
Refer to your bariatric folder for information on equipment this information can also be found on the moving and handling web page and on SharePoint. Staff must adhere to agreed policies, protocols and guidelines. Complete (if not already done) a Bariatric M&H patient assessment form. Make sure suitable clear space available, including treatment, hygiene, equipment and access routes including doorway width, thresholds, turning space, space around bed etc.
INTER DEPARTMENTAL DISCHARGE / TRANSFER of the Bariatric patient
All of the bariatric patients' information is always required Copies of the entire patients' assessments have to accompany the bariatric patient at all times. Adhere to agreed policies, guidelines, protocols etc. Ward / Departmental Role Where applicable, a minimum of 2 hours' notice is required to transfer / discharge a patient to Ambulance Services, portering services, ITU, CCU, Delivery, OPD, Cardiology – ECG, Radiology / imaging, theatres, plaster room, physiotherapy / gym for preparation. Consider the following: Can the treatment / diagnostic tool be performed on ward / departmental area? That safe system of work and control measures has been communicated to all receiving wards / departments. That the transfer / discharge route is planned. including what happens in an emergency That equipment and employees are readily available.





Appendix 6

Ward Based
Bariatric Patient Mobility Assessment Form
Must be completed within 6 hours of being admitted to the ward

Patient Details	Use Label if Available	Ward	Admission Date:-	Time:-
		Height	Patient NHS number and risk score along with ward is to be sent via e-mail to ekh-tr.manualhandling@nhs.net Or via internal post marked as Confidential All techniques must comply with the moving and handling standards of practice which can be found on Manual Handling Web page.	
		Weight		
		BMI		

Complete Sections 1-5: Ring the scores. Add the TOTAL of all sections to find the Patients Assessment Score

1. Patient weight		4 Special Factors	
127kg (20st) to 152kg (24st)	1	Stoma/Catheter in situ	1
159kg (25st to 191kg (30st)	2	Peripheral/Central Line	2
197kg(31 st) to 222kg (35st)	3	Pain/Stiffness	3
229kg (36st) to 254kg (40st)	4	Diabetes risk of Hypo/Hypertension	4
260kg (41 st) or more	5	Paraplegia	5
2. Patient Body Mass Index (BMI)		Hemiplegia	6
BMI 30	1	Quadriplegia	7
BMI 35 +Co-morbidities	2	Muscular Spasm i.e. (multiple Sclerosis)	8
BMI 40 +Co-morbidities	3	Extened Pannus, chronic lymphoedema	9
BMI 45 +Co-morbidities	4	Major Surgery/Trauma (first 24 hours)	10
BMI 46 or more	5		
3 Ability		5.Mobility	
Conscious & Cooperative	0	Fully Mobile	0
Conscious & Confused	4	Minimal Assistance	1
Conscious &Uncooperative	5	Walks with aid/carers	2

Unconscious or Semi-conscious	6	Weight bears but unstable	4
Risk of Falls whilst Mobilising Including Vertigo	7	Unable to weight bear but transfers	5
Risk of falling out of bed *	8	Unable to Weight Bear Please tick hoist used <div>Gantry Hoist</div> <div>Viking XL</div>	6
Concerns regarding Risk of Pressure Ulcers Complete a Datix	8	Patients Moving and Handling total Assessment Score = Important information Bed Assessment- When using the Trust Standard (3ft 6 inches) bed the patient must have at least 4 inches each side of their widest point of their body (hips or abdomen) so they can roll. If they don't have this space then a bariatric bed is needed.	
*Hi Lo bed may be required see Falls Policy			
Score < 10 Independent Limited Risk	Score > 11-16 Limited Assistance AT Risk	Score >17-22 Extensive assistance High Risk	Score > 23 + Dependent Very High Risk
			
Some patient who may not recognise risks to their safety and may still need supervision when mobilising. For example, a patient may be confused but score as being independent Complete mobility assessment chart on reverse. Use appropriate bariatric walking aids. Inform manual handling team of admission, and liaise with nursing staff. If Required refer to Therapists	Complete mobility assessment chart on reverse. Use appropriate bariatric walking aids and slide sheets for use in bed. Inform manual handling team of admission. Debrief post assessment and raise any concerns. If Required refer to Therapists	A patient that requires more help, a minimum of two carers, specialist equipment is needed along with bariatric slide sheets Complete mobility assessment chart on reverse. Consider all equipment that may be required – eg: Viking XL or gantry hoist, bariatric slide sheets. Inform manual handling team of admission. Debrief post assessment and raise any concerns. refer to Therapists	Complete mobility assessment chart on reverse. Minimum of 4 staff when moving this patient Consider equipment that may be required: - eg: Gantry hoist, flat lift slings, lifting pants, bariatric tilt table, slide sheets, bariatric frames (if appropriate) Inform manual handling team of admission. Debrief post assessment and raise any concerns. refer to Therapists

Date of First Assessment:

Staff Name and Signature:

From your risk score please indicate what colour pathway your patient is following

***If the handling risk is Medium/High the patient must be assessed daily

Limited risk Less than 10 score	<input type="checkbox"/>	Limited Assistance 11- 16 Score	<input type="checkbox"/>	Extensive Assistance 17- 22 Score	<input type="checkbox"/>	Dependent 23 +	<input type="checkbox"/>
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Bariatric Mobility Assessment

This assessment **must** be made available to **all** staff who are required to undertake any M&H activities with the patient.

New to care staff must be adequately supervised until the appropriate skills levels and competencies have been achieved.

Task	No. of staff	Equipment to be used	Refer to risk assessments and safe systems of work) in your manual handling folder	Assessor signature
Sit to stand Ensure you complete a strength test to ensure patient can stand before undertaking this task			Bariatric Generic Risk Assessment GA01 Assessment of a patient to stand Refer to SSOW	
Walking / mobilising			Bariatric Generic risk assessment powered wheelchair BA15	

Bariatric mobility assessment continued				
Task	No of staff	Equipment to be used	Method (refer to risk assessments and safe systems of work)	Assessor signature
Transferring to and from bed /trolley			Bariatric Generic risk assessment BA02 lateral transfer	
Toileting /commode				
Hoist Transfer If using Gantry hoist ensure you have two bed spaces			Bariatric Generic risk assessment BA08 Using Liko Viking XL BA09 Gantry hoist BA11 Viking xl seated lift from floor. BA12 Viking XL Seated Transfer BA13 bariatric bed space	
Fallen			Generic Risk Assessment FloJac GA36a SSOW D2	
Repositioning and turning on a bed / trolley			Bariatric Generic risk assessment Moving back in bed BA03, inserting Repositioning sheets BA06	
Personal care needs				
Therapeutic support needs (OT / Physio consulted)				

Review date changes Yes/No Initials	1/	2/	3/	4/	5/	6/	7/	8/	9/	10/	11/	12/	13/	14/	15/	16/
Review date Changes Yes/No Initials	17/	18/	19/	20/	21/	22/	23/	24/	25/	26/	27/	27/	29/	30/	31/	

- Admission Date
- Hospital Site
- Hospital Number
- Date of Birth
- Weight
- Height
- BMI
- Complex Needs
- Total Score on Completed Bariatric Assessment Form

Scan a copy of this part of the form ONLY to the Moving and Handling Department BHD or

ekh-tr.manualhandling@nhs.net

Appendix 7

3rd trimester moving and handling Assessment-for pregnant women with a BMI of 40 or greater For Community Midwives Only

Woman's details			
(use label if available)		Weight and BMI at booking	
		Weight at 3 rd Trimester	
		Height	
		Ward/Department	
LEVEL OF HANDLING RISK (✓ relevant box)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> Independent ** Must be completed in all cases during 3 rd trimester		
Completed by: Signature		Date:	

HANDLING CONSTRAINTS (please ✓ all relevant boxes)		*delete as appropriate	
<input type="checkbox"/> upper / lower limb weakness*	<input type="checkbox"/> stiffness / rigidity*	<input type="checkbox"/> prone to falls	<input type="checkbox"/> anxious
<input type="checkbox"/> poor hearing / eyesight*	<input type="checkbox"/> poor communication	<input type="checkbox"/> unpredictable	<input type="checkbox"/> limited comprehension
<input type="checkbox"/> unconscious / drowsy* <input type="checkbox"/> pain	<input type="checkbox"/> attachments	<input type="checkbox"/> prosthesis / splints / POP*	
<input type="checkbox"/> spinal injury	<input type="checkbox"/> skin lesions	<input type="checkbox"/> Other....specify	

INITIAL ASSESSMENT Weight: Height: BMI: Mobility: Independent	METHODS / CONTROL MEASURES TO BE IMPLEMENTED (see examples listed below) If not independent on or during admission to hospital- Level of handling risk must be re-assessed and methods/control measures must be reviewed and implemented. If weight over 160 kgs or specialist handling needs are required, moving and handling department must be notified ext 721-2535 and site co-ordinator if out of hours.
Movement in bed <ul style="list-style-type: none"> up / down turning /sitting 	<i>Promote and encourage independent mobility</i> <i>Use of electric profiling bed according to safe working load/ including SWL of mattress</i> <i>Consider obtaining/Location of Bariatric bed when patient is admitted (see bariatric guidance pathway)</i> <i>Consider tissue viability-Tissue Viability Nurse ext 725-4561 mobile 07867906474</i>
Transfers to / from bed <ul style="list-style-type: none"> sitting / standing toileting internal transfers 	<i>Ensure safe working load of all equipment that might be needed i.e chair/commode</i> <i>Inform other departments if they are to be involved in a transfer as soon as possible/</i> <i>Moving and handling assessment form to accompany patient at all times.</i>
Mobilising	<i>Independent</i>
Bathing	<i>Use wet room for showering/personal hygiene</i>
Other please specify e.g. up from floor, in / out of car, stairs, moving / supporting limbs	<i>In the event of falls- Hover Jack/FloJac or hoist must be used unless patient able to get up independently Consider SWL of hoist.</i> <i>Location of Viking XL and sling SWL 300 kg equipment Library or porters</i>

Appendix 8 Clinical Considerations

Clinical considerations of a Bariatric Patient.

All Patients should expect appropriate care, technical excellence, accessibility and acceptability, with non-discriminatory and appropriate treatment, making sure dignity and respect is given during their hospital stay.

Airway, Breathing and Circulation Issues

Lungs and other organs do not increase significantly in size as the patient becomes obese although some bariatric patient's hearts are increased in size by the strain of supplying oxygenated blood to all the tissues.

It is very important that an anaesthetist is contacted when a bariatric patient is admitted. This allows preparation and awareness of the grade of the intubation required for the bariatric patient in an emergency situation; a longer length endotracheal may be required. It is recommended that for deep set trachea an adjustable flange tracheotomy tube should be used.

It is very hard to access the capillary refill times and SpO₂ (using pulse oximeter) due to peripheral perfusion, therefore Arterial Blood Gases (ABGs) will be more reliable.

Auscultation of breath sounds can be difficult due to displaced skin folds and adipose mass, it is recommended that using the bell or diaphragm of stethoscope may help.

The most effective way to auscultate heart sounds is over the left lateral chest wall. The bariatric patient should be turned towards the left side. If this is too difficult it is advised to auscultate over the aortic or pulmonary areas to the left of sternal borders at the second intercostal space. This depends on the patient weight, size and distribution of adipose tissue.

Airway restrictions, from excess adipose tissue and fatty deposits surrounding tongue and neck, are very common.

Due to the excessive amount of adipose tissue present in bariatric patients and deeper veins are seldom seen and very difficult to palpate, it is very difficult to obtain essential intravenous (IV) access.

If this occurs and IV access is inaccessible then a central Line can be the next option, this in itself can be difficult not only because of the excess adipose tissue but due to possible skin infections (yeast) in the skin folds.

A bariatric patient will often suffer from sleep apnoea.

They may require Continuous Positive Airway Pressure (CPAP).

Avoid Trendelenberg position (e.g. if sliding up the bed) as it compromises breathing and risk of gastric reflux / aspiration and positional asphyxiation.

Lung volumes are reduced and air resistance increased, mechanical ventilation should be initiated with a TV calculated according to **ideal body weight** rather than **actual body weight** to avoid high pressures, alveolar over distension and barotraumas. Mechanical ventilation may require higher PEEP and airway pressures.

Use reverse Trendelenberg position to reduce effect of abdomen restricting lung expansion and increased Tidal Volume (TV).

Hyperventilation is the typical respiratory pattern of many bariatric patients because the diaphragm is unable to fully descend because of adipose tissue and chest expansion is impaired; this results in decreased vital capacity and TV which compromises tissue oxygenation.

Abdominal size compresses chest expansion so position elevation of Patient head of at least 45°

Due to poor peripheral circulation bariatric patients can have venous hypertension. Observations can be inaccurate due to employees using inappropriate equipment i.e. cuff sizes and locations of cuff.

Follow 80/40 rule for cuff size (width of bladder 40%, length of bladder 80% of limb circumference). Too small a cuff will overestimate blood pressure (BP) observations

As there aren't any BP cuffs for bariatric patients at present, it is commonly agreed that using a regular size BP cuff may be used on forearm and the correct size or "thigh" cuff (dimensions 50cm/20cm) on upper arm, making sure that information re cuff size is recorded.

Alterations in blood pressure (BP) and heart rate (HR) of 20 % are a sign of physiological stress. Baseline observations and (PAR) scoring should be taken more frequently as potentially it is more difficult to treat a bariatric patient in an emergency. It is harder to wean and intubate the bariatric patient to NIV (BiPAP/CPAP) due to increased respiratory load and fatty deposits in the diaphragm and intercostal muscles. Make sure that adequate qualified multidisciplinary team members are available because re-intubation may be difficult and require experienced employee.

Renal Issues

Make sure that when estimating minimum urine output and hemofiltration parameters confirm which body weight is used (actual body weight versus ideal body weight)

Clinically it may be suggested that increased fluid may be required to balance increased insensible losses. Be aware of increased cellulites or oedema.

Abdominal / GI Issues

It is important to measure girth at widest point. This may be difficult to pass the tape measure under the Patient. Do not use the paper tape measures as they could break. When taking the tape measure out please be aware of friction / shearing of the skin.

Avoid supine and Trendelenberg position as there is a tendency for gastric reflux to happen in a Bariatric Patient, even when the Patient is conscious and protecting airway. It is important to know that bariatric patients have problems with the management systems of their bowels and often have diarrhoea.

An nasogastric (NG) tube may be required to decompress the stomach when assessment is needed for Assess Abdominal Perfusion Pressure (APP) and Intra-Abdominal Hypertension (IAH).

It is very difficult to accurately assess NG tube position due to the density of the adipose tissue on either X-ray imaging or abdominal ultrasound. Assessing bowel sounds can be difficult due to adipose tissues and skin folds. It could require assistant. It is recommended that the bell or diaphragm of stethoscope is used.

Nutritional care issues

Be aware that bariatric patients due to their excess adipose tissue are susceptible to altered metabolic profiles. This demands a more unique and unusual nutritional regimes. Therefore, it is essential that advice should be sought from a dietician.

Bariatric patients have increased nutritional requirements. Even though they have excess body fatty stores they are often protein malnourished during metabolic stress. This affects the cardiac and respiratory muscles.

Skin / Tissue viability issues (Refer to pressure ulcer prevention policy)

With decreased vascularity in adipose tissue, critically ill bariatric patients are at a high risk from pressure ulcers. Refer to the Tissue Viability Nurse Specialist (TVNS) as per tissue viability referral process

Adipose stores can mask hidden medical condition including oedema and ascites and cellulites.

It is often more difficult to assess the folds at the back of the neck, make sure the endotracheal tube ties are changed regularly and assessed for the development of occipital pressure ulcer.

The skin is also prone to breakdown resulting from impaired mobility, the increased pressure due to weight, shape and increased sheer / friction movement.

Make sure that intravenous lines, catheter tubing and medical devices / equipment are checked daily so they are not caught in the skin folds as this could cause breakdown of skin.

It is very important to make sure that the patient fits the bariatric equipment so that adipose tissue and skin folds are not pressing against or caught in safety sides of bed, chair, commode frames.

Bariatric patients may have poor peripheral circulation cannot always feel that issues are occurring.

Make sure that at least twice a day the skin folds are assessed for breakdown, rashes and eczematous lesions from perspiration and the friction of movement.

Managing and accessing skin folds under the breast, between the groin, around their neck, under abdominal masses and perineal areas are essential. These areas are very high risk for bacterial and fungal infections.

Moisture and urinary incontinence can exacerbate shear and skin problems by providing an environment in which bacterial and fungal infections can thrive.

Professionalism of employee surrounding how to care for a Bariatric Patient

It is very important to use a professional bedside demeanour. Do not discuss the bariatric patient within earshot of that or other patients, employees and relatives.

It is not acceptable to socially isolate the bariatric patient.

Assess and identify prejudice and bias amongst employees. This includes negative behaviour and non-verbal prejudices surrounding the patient's size, shapes and jokes about the patient. Acceptance needs to be demonstrated and empathy and sensitivity of body size is learnt.

Make sure that any procedures and tests during regular business hours to optimize manpower from other departments.

Include patients in any bedside discussion of their care; actively talk to the patient and their relatives about expected outcomes and bariatric equipment, treatments, surgery, professional visitors (i.e. dieticians) etc. and actively ask for their feedback.

Psychological needs of a Bariatric Patient

Professionals need to work together on the sensitive issues surrounding caring for a bariatric patient, this will ensure that the psychological needs are part of managing bariatric patients and that the individual is seen as a person not just someone who is bariatric and takes a lot of time, equipment, employee, expense and creates difficulties.

Bariatric patients not only have to deal with many complex clinical issues they also have to deal with the practicalities of overcoming environmental and equipment constraints.

Bariatric patients are subject to intense prejudice and discrimination. This is something that happens that not only happens in the community but also whilst they are in hospital.

They often have to listen to employee, patients and visitors discussing their size, shape and issues without discusses with them the difficulties.

Negative comments and action impacts and contribute to the poor wellbeing of the bariatric patient.

Bariatric patients often have increased feelings of isolation and humiliation. This often leads to low self-esteem.

APPENDIX 9

HOW TO WEIGH A BARIATRIC PATIENT

How to Weigh a Bariatric Patient

All Patients **must** be weighed on admission, or as soon as is reasonably practicable.

Average ward scales maximum weight varies from 150kg (23stone) to 200kg (31.5stone).

The Trust has the baros bed with scales built in on all main sites. The Maximum Patient weight of 470kg (74 stone) (located within the equipment library)

A detachable hoist weighing device is available on all wards with a Golvo Hoist

The Viking XL hoist has scales attached 340kg (54stone) on all main sites from (Equipment Library)

All Patients in excess of 127kg (20stone) will be classed as Bariatric, due to equipment limitations. Follow the Bariatric pathways.

APPENDIX 10

MOBILITY OF A BARIATRIC PATIENT

Mobility of a Bariatric Patient

The M&H safe techniques used on bariatric patient is based on already practised during M&H training and are advised of correct movements to use to prevent injury to employee or patients.

All patients must be assessed to ascertain whether they are able to mobilise independently.

Patients who cannot move independently in bed, or transfer from bed to chair or commode, must use a hoist within SWL.

Employee must not assist patients when walking. Patients must be independent.

Bariatric patients have different body types, each needing different treatment and techniques.

The body type can affect breathing and tolerance to movement as well as the risk to falls and sustaining unexpected injuries.

Pear-shaped patients have excessive adipose tissue in the gluteal-femoral region of the body.

Although they are often able to move around quite well and can get from sitting to standing as they can push their centre of mass over their legs. Generally these patients have a more stable disposition, although patients find that losing weight is more difficult with this body shape.

This is predominantly a weight concern of women.

The apple-shaped person has excessive adipose tissue in the viscera or abdominal area. Often this adipose tissue can press on the aorta, vena cava and small capillaries, causing increased stress on the cardiovascular and respiratory systems. The main risks are positional asphyxiation

(in supine Trendelenberg). They often have increased complications and more weight fluctuations and an increase chance of congestive heart failure.

APPENDIX 11

EQUIPMENT

EQUIPMENT Required for a Bariatric Patient

All equipment to be used by the patient must be checked to ensure that the Safe Working Load (SWL) will not be exceeded; If not there is a severe risk that the hydraulics fail on the bed.

The bariatric patient's physical width, size, shape of adipose tissue has also to be a consideration.

layout surrounding the bariatric patient is of equal importance, this includes; ward / department layout and the proximity of adjoining beds / trolleys to ensure adequate space for equipment and the employee movements to care for a bariatric patient.

PATHWAY1	PATHWAY 2	PATHWAY 3	PATHWAY 4
OVER 152KGS (24ST) OR BMI > 40 OR > 35 & CO-MORBILITIES	OVER 191KGS (30ST)	OVER 22KGS (35ST)	OVER 267 KGS (42ST)

EQUIPMENT	EQUIPMENT	EQUIPMENT	EQUIPMENT
Beds, Chairs/commodes and hoists all within EKHUFT SWL of generic equipment	Beds Chairs / Commodes and all hoists all within EKHUFT SWL of all generic equipment	Bariatric Beds, Chairs/Commodes and hoists-are available within EKHUFT. Contact the Help Desk who will ask for bariatric patient assessment score the Help Desk will then contact the MELs on main sites. However, if the MELs cannot locate EKHUFT equipment or if it is in use then Bariatric equipment has to be sourced from outside by MELs team Please note: that any equipment rented in will be subject to ward/department costs	Bariatric Beds, Chairs/Commodes and hoists-are available within EKHUFT. Contact the Help Desk who will ask for bariatric patient assessment score the Help Desk will then contact the MELs on main sites. However, if the MELs cannot locate EKHUFT equipment or if it is in use then Bariatric equipment has to be sourced from outside by MELs team Please note: that any equipment rented in will be subject to ward/department costs

All Bariatric equipment is audited every 6 months.

The correct equipment can help prevent injuries and makes the patient feel safe and comfortable with the care they receive.

It is very important to rely on bariatric equipment (including hoists, wheelchairs, chairs, sliding sheets and commodes), as it improves the care of the Patient and lowers risk of injury to both patients and employee.

As a Trust we have some bariatric equipment available via the equipment libraries

Bariatric equipment may need to be rented / loaned from outside agencies / companies, these will need to be agreed and the cost will be provided by the requesting ward / department.

SWL and Space Constraints

Consideration should be given to ward layout and the proximity of adjoining beds to ensure adequate space for equipment and the employees working with the patient to avoid injury due to cramped condition.

All equipment to be used by the Patient must be checked to ensure that the SWL will not be exceeded.

Beds, Mattresses and Manoeuvres

Having appropriate bed/trolley can make for greater manoeuvrability, Employee safety and skin care. They need to be wide enough so that the patients can turn independently.

Beds with low air-loss treatment may alleviate skin breakdown for those who have to stay in bed for more than a few days. Discuss this with the appropriate employee who may require input into patients care.

All bariatric patients must be nursed on a full electric 'Heavy duty' profiling bed or the ARJO 1080 Contoura bed purchased by EKHUFT. If the 1080 bed does not go low enough for the bariatric patient to get of safely for rehabilitation then outside companies may have to be used at a cost to the individual ward/department.

The SWL of the mattress must be checked to ensure that it is sufficient to accommodate the patients weight in order to maintain the integrity of pressure areas

Outside companies

Bariatric equipment is available from outside sources: funding is provided by ward. Please refer to the moving and handling bariatric folder

M&H do not hold a budget for any MH equipment or accessories.

Bariatric equipment Locations across sites

ALL SITES	SAFE WORKING LOAD	LOCATION
Huntleigh Enterprise 5000	39 stone (250kgs)	All sites -most areas
Huntleigh 560 Beds	42 stone (267kg)	All sites - most areas
Baros Bed	70 stone (445kgs)	All three main sites contact help desk
Heavy Duty Commodes	40 stone (254kg)	Medical Equipment Library
Heavy Duty Chairs	40 stone (254kg)	Medical Equipment Library
Shrouds - Extra Large		Designated areas below
Dignity Gowns	70 " chest	Linen Rooms
XL BP cuffs	35.5 – 46cms circumference	All sites -most areas
MRI / CT	Liaise directly with department for restrictions	

KCH		
Zimmer Frame Convaquip T100F	47 stone (299kg)	Physiotherapy
Heavy Duty Wheelchair	40 stone (254kg)	Medical Equipment Library
Trolley (Lifeguard)	39 stone (248kg)	ECC
Viking XL Hoist/slides	54 stone (343kg)	Medical Equipment library
Theatre Table	47 stone (299kg)	Main Theatres
General X-ray table	33-43 stone (210-270kg)	X-ray
FloJac/Hover Jack/Matt	No Outer Weight Limits	Medical Equipment Library
XXXL Eclipse Rehad Electric Wheelchair	39stone (248kg)	Medical Equipment Library
Bariatric Shrouds/Body Bags		invicta Ward
QEQM		
Viking XL Hoist/slides	54 stone (343kg)	Discharge Lounge
Zimmer Frame Convaquip T100F	47 stone (299kg)	Physiotherapy
Heavy Duty Wheelchair	40 stone (254kg)	A&E / OT
Trolley (Lifeguard)	39 stone (248kg)	A&E
Maquet Theatre Table	57 stone (362kg)	Main Theatres
General X-ray table	33-43 stone (210-270kg)	Medical Imaging
Crutches	30 stone (190kg)	Physiotherapy
Toilet Frame	30 stone (190kg)	OT
FloJac/Hover Jack/Matt	No Outer Weight Limits	Medical Equipment Library
XXXL Eclipse Rehad Electric Wheelchair	39stone (248kg)	Medical Equipment Library
Bariatric Shrouds/Body Bags		Minister Ward
WHH		
Viking XL Hoist/slides	54 stone (343kg)	Medical Equipment Library
Heavy Duty Commode	40 stone (254kg)	Medical Equipment Library
Heavy Duty Chair	40 stone (254kg)	Medical Equipment Library
Zimmer Frame Convaquip T100F	47 stone (299kg)	Kings B
Heavy Duty Wheelchair	40 stone (254kg)	Medical Equipment Library
Trolley (Lifeguard)	39 stone (248kg)	Theatre
Concealment cover for bed		Medical Equipment Library
Theatre Table	33-43 stone (210-270kg)	Main Theatres
General X-ray table	25 stone (159kgs)	X-Ray
Weighting Scales	54 stone (343kg)	Medical Equipment Library
FloJac/Hover Jack/Matt	No Outer Weight Limits	Medical Equipment Library
XXXL Eclipse Rehad Electric Wheelchair	39stone (248kg)	Medical Equipment Library
Bariatric Shrouds/Body Bags		Oxford Ward

BHD		
Heavy Duty Wheelchair	40 stone (254kg)	MH Training room
Viking XL Hoist/slings	54 stone (343kg)	Female changing room second floor opposite MH training room
Trolley (Lifeguard)	39 stone (248kg)	MIU
General X-ray Table	20 stone (127kg)	X-ray
FloJac/Hover Jack/ matt	No Outer Weight Limits	Female changing room second floor opposite MH training room
RVH		
Heavy Duty Wheelchair	40 stone (254kg)	Walk in Centre
General X-ray Table	32 stone (200kg)	X-ray
Hover Jack/Evacuation	No Outer Weight Limits	OPD

MATTRESSES AVAILABLE

DYNAMIC SUPPORT SERVICES	SAFE WORKING LOAD	LOCATION ALL HOSPITAL SITES
Bari-Breeze	455 kg (1000 lbs/71 stone) NB: ONLY TO BE USED WITH HUNTLEIGH 1080 BEDFRAME Contraindications: Unstable Fractures / Spinal Injuries	In Clean Mattress Store access via Equipment Libraries 8-4 Outside office hours contact help desk
Nimbus 3	250 kg/39 stone	As above Outside office hours contact help desk
Breeze	140 kg/22 stone	As above
Aura seating cushion	120 kg/19 stone	
STATIC FOAM MATTRESSES		
Pentaflex	150 kg or 23.5 stone	CHECK BASE OF MATTRESS
Pentaflex	250 kg/39 stone	CHECK BASE OF MATTRESS

APPENDIX 12

EMERGENCY SITUATIONS PATIENT

Resuscitation of a Bariatric patient.

(Use corrects Resuscitation Guidelines as issued by Resuscitation Officer.)

Identify any intubation, tracheotomy, cannulation, central line needed by the patient, preferably prior to admission.

Use Automated External Defibrillation to reduce the risk of contact with the bariatric patient during defibrillation. Identifying best position for defibrillation pads is essential but can be difficult.

Resuscitation is designed to maintain circulation of oxygenated blood to the vital organs, especially the heart, brain and kidney in an attempt to prevent degenerative processes associated with anoxia and tissue death until spontaneous cardiopulmonary function can be restored.

Due to the unique shape, size etc a bariatric patient presents a greater challenge and can make it very difficult to succeed. Bariatric Patients and their families need to be informed of this issue.

It is essential to provide airway protection as an airway compromise can lead to cardiac arrest in only 4-10 minutes and irreversible central nervous system damage occurs within 3-5 minutes of shut down.

Airway management of a bariatric patient is difficult. The adipose tissue can cause a "Bull Neck" (short, thick neck), increased soft tissue (double chins) and macroglossia (enlarged tongue).

Intubation can be difficult due to possible neck oedema or adipose emphysema. This can also result in ineffective head-tilt / chin-lift and challenging laryngoscope use.

Providing the appropriate mask is important when ventilating a patient and making sure of a close fit but it will likely require 3 people to ventilate a morbidly obese patient, (2 to hold the mask in place and 1 to ventilate).

Bariatric patients will de-saturate oxygen rapidly due to decreased functional reserve capacity.

When performing external chest compressions make sure bed height is correct. The minimal height of some specialist bariatric beds can be too high to perform effective CPR from standing and the patient's size and girth make it impossible to kneel on the bed. A taller person may need to reach the Trust, making sure they have no current injuries.

CPR can cause issues concerning the movements of the abdomen. It may be agreed to use synchronised abdominal and chest compressions.

Fallen Bariatric Patient

(Use alongside Trust Falls Policy)

If a bariatric patient has fallen encouragement should be used to allow the patient to get up from the floor independently. (See M&H policy). If the patient cannot get up from the floor please use the Hover Jack/Matt from the equipment libraries which can be located on all three main sites. This device enables patients to be lifted from the floor to a stretcher or bed as required. It is very easy to manoeuvre the patient onto this device using slide sheets or spinal boards allowing the patient to be moved comfortably and reducing the risk of injury to staff because of its ease of use. It can be used throughout the site as it is easily transferrable in its cart and can be used for any weight of patient including bariatric.

If the Hover Jack/Matt is not available use the Tenor bariatric hoist.

All the bariatric hoists have the ability to move a Patient from the floor, making sure an appropriate sling is used. This prevents injury to the employee. A bariatric hoist that takes the patient's weight is required to move the morbidly obese patient safely. This should be left on the ward / department until patient's discharge in case of an emergency. We have a minimum of three bariatric hoists within EKHUFT Contact the equipment libraries.

When a patient falls in an awkward area or away from the hoist the patient must be rolled onto extra-large slide sheets use of extension straps so the staff are not stooping, minimum of **six to eight** staff for this task. Move patient to a suitable spaced area so that the lifting equipment can be used.

APPENDIX 13

PERSONAL CARE

Personal Care of a Bariatric Patient
Bariatric patients sometimes feel as if they are being judged by others so their independence is very important. It is why it's best to pre plan Employee involvement, bariatric equipment and space if able to do so prior to admission.
Clothing
In hospital the dignity of a bariatric patient is diminished, in some cases individuals have to wear two gowns when moving around. To encourage independence and dignity, encourage patients to bring their own clothing into hospital.
Hygiene
<p>There is difficulty in controlling body temperature of a bariatric patient because of the increased perspiration. To maintain their independence they should be provided with washing facilities at a minimum twice a day. This may need to be assisted or a bed bath Areas to be aware of:</p> <ul style="list-style-type: none"> • Washing under skin folds it important to keep skin integrity, however, this may need more than one person as the weight of the folds is often too heavy to lift and wash underneath. • After the patient has been washed, including with the soap, make sure that drying under skin folds is a priority as the folds encourage fungal and bacterial growth. <p>It is recommended that where possible, bariatric patients should be showered and to use a Bariatric shower chair in the shower.</p>
Bed making
<p>It is very important to change the bariatric patient's sheets due to sweating and damp areas and linen folding under them, this can cause a lot of shearing / friction.</p> <p>If a bariatric patient is unable to get out of bed then they should be hoisted clear for bed making. This will require six to eight employees to make sure the sling is in place and prepare the patient and then changing the sheet, washing the patient, equipment etc.</p>

Urinary management

It is difficult for the bariatric patient to manage their urinary function. This is often due to their weight and shape with adipose tissue pressing on the bladder causing leakage or blockage.

A urinary bottle should be used for male patients or a slipper pan for female patients, for passing urine when they are unable to mobilise independently. Nurses should be ready to assist the morbidly obese patients who cannot reach their own perineal areas to position urinary containers.

Incontinence pads should be fit for the purpose and meet the needs of the individual. Giving inappropriate incontinence pads will affect their dignity. Refer to the incontinence advisor for assessment.

Moisture and urinary incontinence can exacerbate the environment in which micro-organisms that contribute to skin breakdown can thrive.

A wider commode makes toileting easier and is more comfortable a lot of wall-hung toilets have a weight limit of between 42stone (267kg) and 60stone (380kg) and the plastic toilet seat takes 25stone (160kg).

Patients must use the commode at the bedside. Employees must not push patients to the toilet on commodes as there is a high risk of back and shoulder injury to employee members.

Dependent patients should be hoisted on the bedside commode, or hoisted clear of the bed, then lowered over the bed pan so that they are suspended just clear of the pan during toileting.

The leg straps on the sling should not be crossed when using a bedpan as this will facilitate cleaning of the patient once the bedpan has been removed.

For bowel movement, the patient should be left in the sling as this will maintain the patient in a stable and natural position, as well as reducing the risk of injury to employees.

Inserting catheters in female bariatric patients involves difficulty in patient positioning; decreased visualisation of the urethral opening and it is likely extra help will be required to hold skin folds

Hoisting the patient just clear of the bed with the leg straps uncrossed will facilitate catheterisation, should it be required. This method will safeguard employee safety as regards M&H and will promote the adoption of an aseptic technique.

It is common for male bariatric patient's penises to be retracted due to oedema, cellulitis, ascites etc. Catheters are sometimes inserted under anaesthetic.

APPENDIX 14

DISCHARGE OF A BARIATRIC PATIENT

DISCHARGE of a Bariatric Patient to place of residence / other

Ward / departmental role prior to discharge:

Adhere to agreed discharge policies, guidelines, protocols etc.

Complete reports, assessments & plans of care regarding all equipment used and needs of patient prior to discharge. Include information from all multi-disciplinary employee involved in patient care, the complex discharge team and rehabilitation.

Book transport – allow 72 hours between booking discharge transport and actual discharge.

Inform transport services of individual needs, weight, mobility, equipment and employee required.

Discharge Team:

Assess and order equipment that maybe required for patient and employee comfort, safety and individual needs.

Assess the level of mobility, the available room space, adaptations that may be needed, the internal & external access to the property.

Assess the Care packages required or are in place and financial arrangements / resources.

Evaluate their social and personal needs.

Specialist 'Bariatric' ambulances may need to be used when the patient attends hospital either as an elective or emergency admission or for an outpatient appointment.

Ward / departmental role once patient is discharged.

All equipment provided by outside agency / company need to be returned.

Have a Team meeting (including multidisciplinary support) discussing Patient's stay and evaluating whether the needs of the employee or the Patient's safety, dignity and respect had been observed.

APPENDIX 15

TRAINING PROGRAMME MHL

TRAINING PROGRAMME for Moving and Handling Bariatric Links (MHL) Care Day.	
This is a one day course, which focuses on providing an appropriate service, information and advice into the safe care of the bariatric patient with dignity and respect, protecting the patient and employee health, safety and welfare, as far as is reasonably practicable.	
Course objectives	
<p>By the end of the course, participants will:</p> <ul style="list-style-type: none"> • Understand the meaning of the term bariatric and Body Mass Index (BMI) <p>Commit to the importance of employee and patient safety, including using appropriate support networks (i.e. M&H team), pathways, equipment, employee numbers, assessments and referrals to provide this object.</p> <ul style="list-style-type: none"> • Commit to overcome the prejudices and discriminations surrounding the bariatric patient from employee, colleagues and other visitors and patients. 	
PROGRAMME Will Cover	
<p>Introduction to Bariatric</p> <ul style="list-style-type: none"> - Body Types - Discussion and interaction around the terms <ul style="list-style-type: none"> a. Elephant in the Room b. Champions of change, Journey ahead c. Meaning of Bariatric, Bariatric Multidisciplinary team - Discussing patient with high BMI - Nutritional issues - Seating Issues - Tissue viability issues - Falls 	<p>Bariatric Care:-</p> <ul style="list-style-type: none"> - Admission - Pathway- employee levels-equipment-risk forms, referrals required - Risk management - Emergency situations - Dignity and respect, personal care - Equipment and mobility - Transfers, discharged/diseased - Making the change - Review of current bariatric equipment - Equipment trials /demonstrations

