Safety Action Notice

Reference: SAN2307 **Issued:** 29 November 2023 **Review Date:** 29 November 2024

Ceiling-to-floor overhead track & hoist systems: risk of collapse during use

Summary

The systems affected by this alert utilise two or more posts that are locked into place between the floor and the ceiling. This safety alert highlights the risk of collapse associated with the use of ceiling-to-floor overhead track & hoist systems. Recommendations are given for the control of risk.

Action

1. This notice should be brought to the attention of all appropriate managers, staff and users.

2. Plan, install, use and maintain the ceiling-to-floor overhead track & hoist system in accordance with the manufacturer's instructions for use (IFU).

Planning (inc. pre-installation)

3. The most up to date instructions for use should always be followed, as these may change during the lifetime of the device. Contact the manufacturer for an up-to-date IFU and subscribe to receive update notifications if this facility is available.

4. Prior to installation a room survey should be carried out to ensure:

   a) the room meets all the ceiling and floor requirements including any other considerations stated in the manufacturer's IFU.
   b) advice is sought from an appropriate source, e.g. manufacturer and/or structural engineer
   c) the service user's pick-up point is within the transfer zone between the posts to ensure vertical lifting and lowering, and
   d) the open area for the transfer working space is within the specification outlined in the manufacturer's IFU.

Installation

5. When the equipment is loaned in the community, consideration should be given to managing it as a single unit, i.e. same components put into service, issued, assembled, dissembled, returned and reissued as a single unit. Do not allow sets to become separated and mixed. This is to ensure that the number of installations/assemblies can be counted.

6. During installation, the ceiling-to-floor overhead track & hoist system should be set up in accordance with the manufacturer's IFU.

Action (continued)

Use

7. Use the equipment according to the manufacturer's IFU. Pre-use checks should ensure all posts remain vertical as they may have become mis-aligned, e.g. accidentally knocked.

    a) Refer to the manufacturer's IFU for method and frequency of checks required to ensure that all posts are vertical before hoisting.
    b) If the manufacturer's IFU is inadequate on point a) above, report this as an incident to IRIC and consider alternative lifting equipment as an interim precaution.
    c) Record and document pre-use checks.
    d) Do not proceed with the lift if any of the posts are not vertical or if there are other safety concerns. Follow local procedures for assistance in maintaining safe lifting operations and resolving the equipment issue.
    e) Carers, service users/patients and family members should be informed of the risks if the posts are not vertical, e.g. accidentally knocked, and the action to be taken.

Inspection and Maintenance

8. Consider whether these hoist systems require more frequent thorough examinations or additional periodic checks to ensure compliance with LOLER (Lifting Operations and Lifting Equipment Regulations 1998).

9. Maintenance and servicing must be performed on the equipment as stated in the IFU and/or service manual to ensure that the product remains safe to use.

Ceiling-to-floor overhead track & hoist system (2-post version)

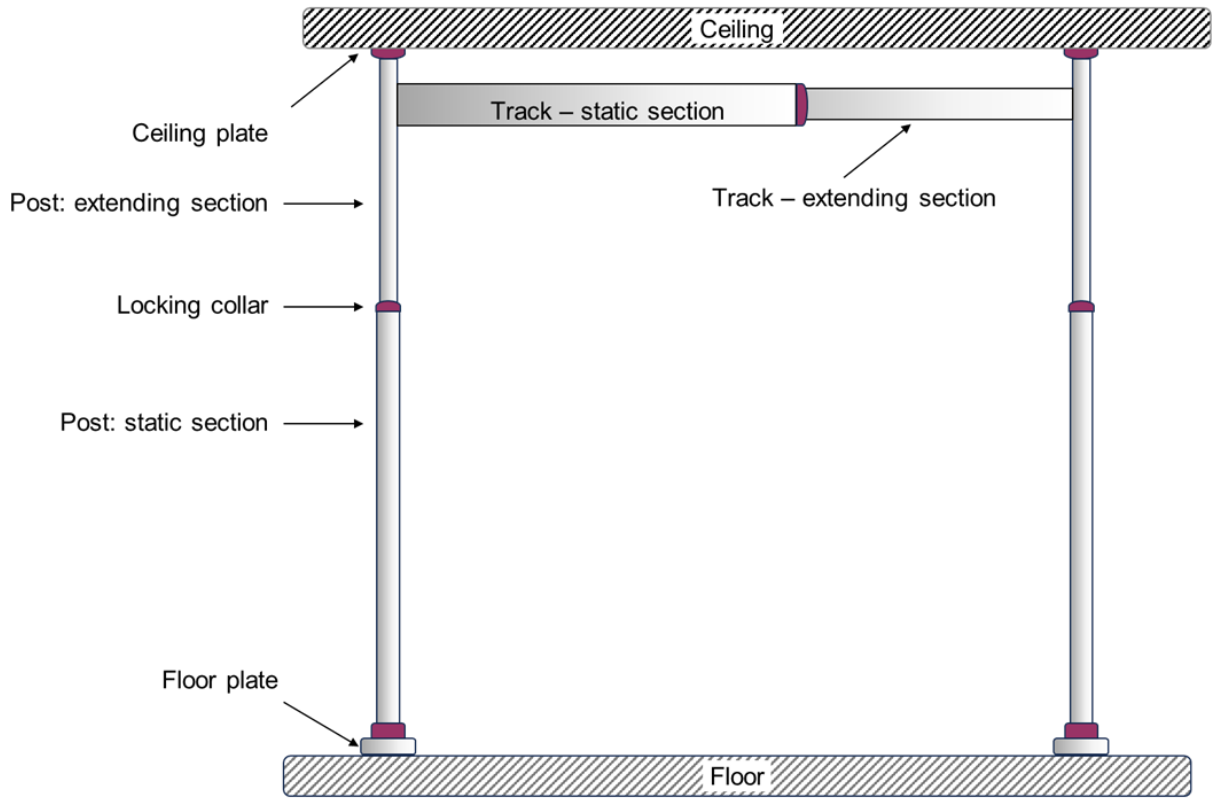

Figure 1. Illustration of posts fully extended to lock in position between ceiling and floor

Background

An incident occurred recently in which the support legs of a ceiling-to-floor overhead track & hoist system collapsed during use within the service user's home. This resulted in the service user sustaining an injury which may have contributed to their death.

This incident highlighted a risk of collapse leading to injury to the service user and operator when using a ceiling-to-floor overhead track & hoist system. The risk is higher due to the potential for the support legs to become misaligned, e.g. being accidentally knocked.

This alert highlights an under-recognised risk of collapse if the instructions for use are not followed and the pre-use check is not carried out.

Suggested onward distribution

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Adult Residential Services
Adult Social Work Services
Loaned Equipment Stores
Care Homes
Children's Services
Children's Social Work Service
Moving and Handling
Education services
Health, safety and wellbeing
Homecare services
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Enquiries

Enquiries and adverse incident reports should be addressed to:

Incident Reporting & Investigation Centre (IRIC)
NHS National Services Scotland
Tel: 0131 275 7575 Email: nss.iric@nhs.scot

Accessibility: Please contact us using the above details if you are blind or have a sight impairment and would like to request this alert in a more suitable format.

IRIC remit: general information about adverse incidents, safety alerts and IRIC's role can be found in CEL 43 (2009), *Safety of Health, Social Care, Estates and Facilities Equipment: NHS Board and Local Authority Responsibilities,* issued 30 October 2009.

Report an incident: Information on how to report an adverse incident

NHS National Services Scotland is the common name for the Common Services Agency for the Scottish Health Service https://www.nss.nhs.scot/