National Patient Safety Alert

Medicines & Healthcare products Regulatory Agency

# Patient hoists and slings (all types): risk of death and serious harm from falls

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This alert is for action by: All those responsible for the use, purchase and/or maintenance of patient hoists, working within all acute and community healthcare organisations, care homes, nursing homes and care services supporting people in their own homes, and their equipment providers.

This is a safety critical and complex National Patient Safety Alert. Implementation should be coordinated by an executive leader (or equivalent senior accountable person, such as a registered manager or responsible induvial, in organisations without executive boards).

## Explanation of identified safety issue:

Fatal and serious harm continues to occur when patients fall from hoists or slings during transfers and repositioning. A review of recent incidents with a fatal outcome and wider surveillance data shows an average of two deaths per year since 2015. This is not confined to any manufacturer, model, or care setting. The most common causes of fatal and serious patient falls from hoists include:

- Detachment at critical load-bearing interfaces, including spreader bar hooks, clips, carabiners, fasteners, or other parts that are missing, worn, damaged or incorrectly assembled.
- Incompatible hoist and sling combinations, including use of third-party slings not validated for the specific hoist.
- Failure to identify damaged or incorrectly seated sling loops, or incorrect attachment to spreader bars during fitting and use.
- Failure to conduct effective pre-use checks that would identify unsafe equipment.
- Inadequate or overdue maintenance, servicing and examination under the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). This included continued use of a hoist or component parts beyond their indicated service life without risk assessment.
- Use of wrong size or type of sling for the patient.
- Insufficient staff training and competence assessment for the relevant hoist and sling types, including failure to follow correct manual handling procedures.
- Non-compliance with manufacturer's instructions for use (IFU)

## Actions required

**When:** Begin as soon as possible and be completed by **16th September 2027**

1. Ensure that standardised pre-use checks are in place and completed for all hoists and slings (aligned with manufacturer's IFU) to identify unsafe states. Pre-use checks should include a pause-and-check step after initial load take-up but before the patient is entirely lifted to verify that all sling attachment points are securely attached before proceeding.
2. Review and document the compatibility of all hoists and sling combinations in use across your organisation. In exceptional circumstances, where compatibility cannot be confirmed through the manufacturer's IFU, a risk assessment with supporting technical evidence must be completed by a qualified person. Maintain a local register of approved combinations and ensure this is accessible to all relevant staff.
3. Review the medical device management systems (inventory/database) for your organisation to ensure all patient hoists and slings, including those provided to a community setting, are identified and recorded. These must include maintenance, LOLER examination and device replacement plans.
4. Ensure all hoists are maintained, serviced and examined under LOLER and in accordance with manufacturer's IFU, with records kept up to date. Remove from service any hoist with overdue examinations or unresolved defects. Slings should be regularly checked in line with manufacturer instructions.
5. Ensure staff receive role-appropriate training with regular updates. Training should cover use in accordance with manufacturer's IFU, pre-use checks, hoist-sling compatibility, correct fitting and attachment, identification of unsafe states, and how to stop, escalate and report concerns. Training records must be maintained.

For further detail, resources and supporting materials see: alert on MHRA website



Failure to take the actions required under this National Patient Safety Alert may lead to CQC taking regulatory action

## Additional information:

Between 1 January 2015 to 31 December 2025, the MHRA received 22 reports of incidents with a fatal outcome during patient transfers. The incidents occurred in acute hospitals, care homes and in patient's own homes. The problems described may affect all hoists and slings. Investigations into incidents often found similar contributing factors, which are consistent with the themes raised in Medical Device Alert MDA/2014/054 and Patient Safety Alert NHS/PSA/W/2015/010, indicating that existing guidance has not been reliably and systematically implemented. For further information on incidents and case examples, please see supporting information page.

**Further details on the alert actions:**

**Action 1.** Pre-use checks should be capable of identifying missing components, worn or damaged carabiners and retaining features, damaged or incorrectly seated sling loops, and any other damage or degradation. The pause-and-check step is particularly important for loop-type sling attachments. Before fully lifting the patient, pause when the sling is taut and the patient's weight is partially supported to confirm all attachment points are secure. Any hoist or sling found to have missing, worn, damaged or incorrectly assembled components must be immediately removed from service, clearly marked as **DO NOT USE**, and reported through the relevant route in the organisation.

**Action 2.** Compatibility should be confirmed through the manufacturer's Instructions for Use (IFU). In exceptional circumstances, where third-party slings are used, compatibility must be verified by an appropriately qualified person, documented and supported by evidence. A documented, patient specific risk assessment must confirm that the hoist and sling combination is appropriate for the patient. Risk assessments must be repeated whenever the equipment combination or the resident's/patient's condition changes (e.g. weight, posture, tone, cognition, pain, sitting balance, ability to participate in transfers, tolerance of hoisting). This also applies to accessories and attachments such as weighing scales**;** all accessories must be compatible with the hoist and fitted in accordance with the IFU.

**Action 3.** For more information on a medical device management system (inventory/database), see guidance on Managing Medical Devices and Devices in practice: Checklists for Using Medical Devices. This should include as a minimum the manufacturer, make and model, lot number, location and date of last service, date of end of service life, date of last LOLER examination and next services and LOLER examination due dates for the device.

**Action 4.** Under LOLER, thorough examination by a competent person is required at intervals not exceeding 6 months. Pre-use checks are not a substitute for systemic maintenance programmes and statutory examinations. If maintenance or servicing is outsourced, compliance with the schedule should be monitored.

**Action 5.** Training for staff (and patients and their families or carers where applicable) should be relevant to their role and include the relevant hoist and sling types in use, correct attachment and fitting techniques, recognitions of unsafe equipment states, when to stop, escalate, and report incidents and near misses to the Yellow Card Scheme and via local reporting routes. Training content should be relevant to the types of hoists, patient groups and care settings where staff are working. Training should also cover safe handling and transportation of hoists, particularly in multistorey settings.

Other relevant guidance:

- Safety Action Notice – SAN2406: Hoist spreader bar and looped sling attachments| National Services Scotland
- Getting to grips with hoisting people Health Services Information Sheet No 3
- Issue 1: Falls from improper use of equipment - Care Quality Commission
- Moving and handling in health and social care - HSE

**Stakeholder engagement**

NHS England, Devolved Administrations, British Healthcare Trades Association, MDSO Editorial Board, Care Quality Commission, Care England