**Specific Client (Community) Moving and Handling Risk Assessment Form**

**Section A: Essential Information**

## A1

|  |  |  |  |
| --- | --- | --- | --- |
| **Personal Details** | **Review Details** | **Changes** | **No Changes** |
|  |  |  |  |
| Title: | Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Forename: | Assessor Signature: \_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Surname: |  |  |  |
| CHI No. | Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  | Assessor Signature \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Weight (Kg) \_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Actual  Estimated  | Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Height (metres) \_\_\_\_\_\_\_\_\_\_ | Assessor Signature \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Actual  Estimated  |  |  |  |
|  | Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **Assessor Details** | Assessor Signature \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |  |
| Name: | Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Designation: | Assessor Signature \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Details of other professionals involved  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature \_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |
|  | Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Assessor Signature \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |  |
| Date of Initial Assessment: \_\_\_\_\_\_\_\_\_ | Date of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  | Assessor Signature \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

With reference to the clents assessment of need and care plan, do any elements of the care tasks involve manual handling?

Yes  No 

If No, assessment need go no further.

If Yes, continue to Section B.

**NB If you (staff) have any concerns regarding your ability to participate in any moving**

**and handling activity, you must consult with your line manager.**

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**Section B: Client Handling Assessment**

**I** =Further Information **R**=Review Details

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Movement AbilityB1 | | | | | | | |
| B1.1 | Full | Partial | Variable | Unable | Details | **I** | **R** |
| Standing |  |  |  |  |  |  |  |
| B1.2 | | | | | |
| Walking |  |  |  |  |  |  |  |
| B1.3 | | | | | |
| Sitting Balance |  |  |  |  |  |  |  |
| B1.4 | | | | | |
| Head Control |  |  |  |  |  |  |  |
|  | | | | | |
| Upper Limb B1.5 Strength/Movement |  |  |  |  |  |  |  |
|  | | | | | |

#### B2

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| History/Risk of Falls (please refer to Management of Falls Guidelines and Policies) | Yes | No | Details | **I** | **R** |
|  | | | |  |  |

#### B3

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relevant Medical Conditions | Yes | No | Details | **I** | **R** |
|  | | | |  |  |

#### B4

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Communication | | | | | | | | |
| Any problems with: B4.1 | None | Slight | Moderate | | Severe | Details | **I** | **R** |
| Hearing |  |  |  | |  |  |  |  |
| B4.2 | | | | | | |
| Vision |  |  |  |  | |  |  |  |
| B4.3 | | | | | | |
| Communication |  |  |  |  | |  |  |  |
| B4.4 | | | | | | |
| Comprehension |  |  |  |  | |  |  |  |
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**I** =Further Information **R**=Review Details

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| **Handling Constraints** B5 | | | | | | | | |
|  | None | | Slight | Moderate | Severe | Details | **I** | **R** |
| Pain B5.1 |  | |  |  |  |  |  |  |
|  | | | | | | |
| Skin Lesions/ Vulnerability B5.2 |  | |  |  |  |  |  |  |
|  | | | | | | |
| Attachments B5.3 e.g. IV, plaster, PEG etc |  | |  |  |  |  |  |  |
| B5.4 | | | | | | |
| Involuntary Movements |  | |  |  |  |  |  |  |
|  | | | | | | |
| Difficulties with Muscle B5.5 Strength/Tone | |  |  |  |  |  |  |  |
|  | | | | | | |
| Behaviour B5.6 cooperation (potential for verbal/physical aggression) |  | |  |  |  |  |  |  |
| B5.7 | | | | | | |
| Stature |  | |  |  |  |  |  |  |
|  | | | | | | |

#### B6

|  |  |  |
| --- | --- | --- |
| Cultural Considerations | **I** | **R** |
|  |  |  |

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| --- | --- | --- |
| Personal Needs, have family been consultedB7 | **I** | **R** |
|  |  |  |

#### B8

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| --- | --- | --- |
| Existing Equipment | **I** | **R** |
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| --- | --- | --- |
| Existing Handling RisksB9 | I | R |
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| OtherB10 | I | R |
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SECTION C: WORKING ENVIRONMENT LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 3 (reverse)

**I** =Further Information **R**=Review Details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **The Working Environment Is/Are there;** | **Specify Hazards and Associated Risks** | **Remedial Action (Rough Notes)** | **I** | R |
| Sufficient space to carry out the tasks? C1 |  |  |  |  |
| Yes No |
| Any problems with furniture e.g. height/suitability/work surface?  **C2** |  |  |  |  |
| Yes No |
| Any problems with flooring? e.g. uneven / slippery / carpetingC3 |  |  |  |  |
| Yes No |
| Poor lighting?C4 |  |  |  |  |
| Yes No |
| Extreme temperaturesC5 |  |  |  |  |
| Yes No |
| Difficulties with access/ egressC6 |  |  |  |  |
| Yes No |
| Other: Specify (e.g. pets / hygiene)C7 |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Page 4

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#### D2

###### SECTION D ASSESSMENT SUMMARY / ACTION PLAN Page No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- |
| Date | Tasks (Risks) | Action To Be Taken | Person to Action and Date | Outcome | Date Actioned |
|  |  |  |  |  |  |

###### SECTION D: ASSESSMENT SUMMARY / ACTION PLAN - CONTINUATION Page No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 5

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| --- | --- | --- | --- | --- | --- |
| Date | Tasks (Risks) | Action To Be Taken | Person to Action and Date | Outcome | Date Actioned |
|  |  |  |  |  |  |

**NB Staff have a responsibility to follow the instructions within this handling plan, to use handling principles as per their training and to report any significant changes in the assessment.**

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reverse

###### Page No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### SECTION E: PERSON HANDLING PLAN I =Further Information R=Review Details

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| TASKS | | CLIENT’S/ABILITIES Using the rating scale below to assess the person abilities  Please tick in appropriate column | | | | | | | Handling Method/Instructions (please detail) | | | **No. of carers** | | | **Equipment To Be Used** | | **I** | **R** | | |
|  | | | | 1 | 2 | 3 |  | | |  | | |  | |  |  | | |
| No: | | Day | | | |  |  |  |
| Evening/ Night | | | |  |  |  |  | | |  | | |  | |  |  | | |
| No: | | Day | | | |  |  |  |  | | |  | | |  | |  |  | | |
| Evening/ Night | | | |  |  |  |  | | |  | | |  | |  |  | | |
| No: | | Day | | | |  |  |  |  | | |  | | |  | |  |  | | |
| Evening/ Night | | | |  |  |  |  | | |  | | |  | |  |  | | |
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| Evening/ Night | | | |  |  |  |  | | |  | | |  | |  |  | | |
| **RATING SCALE** | | | 1 | | ABLE WITH PROMPTING  (please detail **V** for Verbal or **P** for Physical) | | | | | 2  Page 6 | ABLE WITH ASSISTANCE  (please detail in method/ instruction column) | | 3 | FULL ASSISTANCE  DATE: --------------------------------- | | | | |
| **Task** | **Date** | | | Further Information | | | | | | | | | | | | **Signature** | | | |
|  |  | | |  | | | | | | | | | | | |  | | | |
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| Page 6 (reverse) |  | | |  | | | | | | | | | | | |  | | | |

**NB Staff have a responsibility to follow the instructions within this handling plan, to use handling principles as per their training and to report any significant changes in the assessment.**

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#### SECTION E: PERSON HANDLING PLAN: HOISTING / STANDING AID INSTRUCTIONS I =Further Information R=Review Details

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | 1 | 2 | 3 | 4 | **I** | **R** |
| Task Description | |  |  |  |  |  |  |
| No of Carers | |  |  |  |  |  |  |
| **Hoist / Standing Aid Details** | Make |  |  |  |  |  |  |
| Model |  |  |  |  |  |  |
| **Sling Details** | Type |  |  |  |  |  |  |
| Size |  |  |  |  |  |  |
| **Hoist Sling**  **Leg Fitting Details** | Under Legs |  |  |  |  |  |  |
| Between Legs |  |  |  |  |  |  |
| Between Legs and Crossed |  |  |  |  |  |  |
| **Sling Attachment**  **(e.g. Loop closest to client)** | Shoulder |  |  |  |  |  |  |
| Legs (N/A for a Standing  Aid, standing sling) |  |  |  |  |  |  |

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- |
| **TASK** | **DATE** | FURTHER INFORMATION | **SIGNATURE** |
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