Client Specific (Inpatient) Moving and Handling Intervention Plan

(For Clients with Complex Moving and Handling Requirements)

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient’s name:** |  | | | **Named Nurse:** | | | |  | | | Risk Level: | |
| Very High |  |
| High |  |
| Medium |  |
| Low |  |
| BODY BUILD | | | | | | | | Problems with comprehension, behaviour, co-operation (specify): | | | | |
| Obese | |  | Weight |  | | | |
| Above average | |  | Tall | | | |  |
| Average | |  | Average | | | |  |
| Below average | |  | Short | | | |  | Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify): | | | | |
| RISK OF FALLS | | | | | | | |
| High | |  | Low | | |  | |
| **Systems of Care to be Implemented**  This should include all activities likely to be undertaken with the client requiring assistance of staff including, personal hygiene, toileting, eating, and dressing | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Remaining Control Measures Required**  This may include the requirement to hire in equipment | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Date Assessed:** | | |  | |  | | | |  |  | | |
| **Assessor’s signature:** | | |  | |  | | | |  |  | | |
| **Proposed Review date:** | | |  | |  | | | |  |  | | |