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| **Manual Handling Risk Assessment and Plan** |
| Date: |   | Reassessment due: |  | Consent to engage in assessment: Yes / No / Best Interest |
| AIS: |  | Assessor Name: |  |
| NHS No: |  | Assessor Signature: |  |  Client /representation Signature |
| Name: |  |
| DOB: |  | Job title:HCPC Registration no: |  |
| Address: |  | Demonstrated to: |  |
| Environmental assessment: | Home / School / Residential / Day Centre / Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Reason for assessment** |
| Please list :    |

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| --- | --- | --- |
| **Relevant Medical history / Social situation** | **Height:** | **Weight:** |
|  |
| **Weight bearing ability**Fully / Partially / None / Variable weight bearing | **Ability to use each limb** (F - Full, P - Partial, N - None):Right Left **Arm**  – F / P / N  **Arm** – F / P / N **Leg** – F / P / N **Leg**  – F / P / N |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Risks Factors** | Weight | [ ]  | Body shape | [ ]  | Fear | [ ]  | Behaviour | [ ]  |
|  | Cognitive | [ ]  | Pain | [ ]  | Skin/others | [ ]  | History of falls | [ ]  |
|  | Environment | [ ]  | Communication | [ ]  | Sensory | [ ]  |  |  |

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| **Risks identified** Please list |

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| **Agreed Recommendations:** |

**Moving & Handling Plan**

**KEY**: Level of assistance should be described as: Supervision, minimum or moderate assistance of one person/two people (*if deemed maximum consider alternatives*)

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| --- | --- | --- | --- | --- | --- |
| **Sling size & Type**  |   |   | **Sling size & Type**  |   |  |
| **Hoist Type**  |   | **Hoist Type**  |   |
| **Strap Positions** | **Strap Positions** |
| Shoulders  |   | Shoulders  |   |
| Hips  |   | Hips  |   |
| Legs |   | Legs |   |
|  |  |  |  |  |  |
| **Movement in Bed**  |   | **On / Off the Bed**  |   |
| No of Staff  |   | No of Staff  |   |
| Equipment  |   | Equipment  |   |
|
| Level of Assistance  |   | Level of Assistance  |   |
|
|  |  |  |  |  |  |
| **On / Off Chair**  |   | **Sit to Stand** |   |
| No of Staff  |   | No of Staff  |   |
| Equipment  |   | Equipment  |   |
|
| Level of Assistance  |   | Level of Assistance  |   |
|
|  |  |  |  |  |  |
| **Mobility** |   | **Toileting** |  |
| No of Staff  |   | No of Staff  |   |
| Equipment  |   | Equipment  |   |
|
| Level of Assistance  |   | Level of Assistance  |   |
|
|  |  |  |  |  |  |
| **Bathing / Personal Care**  |   | **Dressing** |   |
| No of Staff  |   | No of Staff  |   |
| Equipment  |   | Equipment  |   |
|
| Level of Assistance  |   | Level of Assistance  |   |
|
|  |  |  |  |  |  |
| **Raise from floor** |   |  |  |  |
| No of Staff  |   |  |  |  |
| Equipment  |   |  |  |  |
|  |  |  |
| Level of Assistance  |   |  |  |  |
|  |  |  |

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| **Any other relevant information** |
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I understand that information from this manual handling risk assessment will be shared with the relevant organisations providing my care. The following legal bases apply to this processing in order to deliver your care package:  GDPR Article 6 (1) (e) processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller;

GDPR Article 9 (2) (h) processing is necessary for the purposes of medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services or pursuant to contract with a health professional

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| **Agreed Recommendations:****I …………………………………… (client) or best interest advocate…………………………… have been made aware of my rights under the General Data Protection Regulation and agree that this document can be shared to support my care with:****List all parties and if permission is given to place this in the client's information folder at their home identify this.****NAME: REPRESENTATIVE OF (eg care agency):** |