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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL MOVING AND HANDLING PROFILE AND RISK ASSESSMENT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client Full Name:** | | | | | |  | | | | | | | **Assessors Full Name:** | | | | | | | | | |  | | | | | |
| **Date of Birth** | | | | | |  | | | | | | | **Organisation:** | | | | | | | | | |  | | | | | |
| **Address:** | | | | | | | | | | | | | **Contact Details:** | | | | | | | | | |  | | | | | |
| **Date of initial assessment** | | | | | | | | | |  | | | | | |
| **Suggested review date:** | | | | | | | | | |  | | | | | |
| **Personal Number:** | | | | | |  | | | | | | | **Date reviewed:** | | | | | | | | | |  | | | | | |
| **Carer's Full Name:** | | | | | |  | | | | | | | **Care provider name, contact details:** | | | | | | | | | | | | | | | |
| **Indicate the relationship with client if informal carer involved (e.g. partner, friend, privately arranged carer) :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **a)** | **Summary of client’s physical conditions and any relevant diagnosis: Highlight level of mobility and identified risk factors following assessment.** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | ***Caution: Care givers must review this assessment if there are any changes and at regular intervals to maintain its accuracy.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **b.** | **Approximate height, weight and build of client: When was the person last weighed? If weight possibly over 18 stones/ 114 kilos please also complete a Plus Size Checklist** | | | | | | | | | | | | | | | | | Height:  Weight:  Build: | | | | | | | | | | |
| **c)** | **Does this client have a recent history of falling?** | | | | | | | | | | | | | | | | | | | | | | | | ***YES*  *NO*** | | | |
| ***If Yes, give details (e.g. frequency and reason for the fall):*** *NB Follow your service procedure and refer to London Borough of Sutton Safer Manual Handling Policy for falls protocol* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **d.** | **Action to be taken following a fall (e.g. always use hoist for transfers, client uses safe call to call help)** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **e)** | **Does this client require any assistance with moving and handling?** | | | | | | | | | | | | | | | | | | | | | | | | ***Yes* No** | | | |
| ***If the answer is no, you do not need to complete the rest of this form but ensure there is a summary of the client’s ability in the above box (a).*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **f)** | **Is the assistance required only verbal encouragement?** | | | | | | | | | | | | | | | | | | | | | | | | ***Yes* No** | | | |
| ***If the answer is yes, please summarise in box (g) below the verbal prompts that are necessary.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **g)** | **The Task - Client ability rating and carer risk factors, please mark with an ‘X’ below** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **Client Ability Rating** | | | | | | | | | | | | | **Carer Risk Factors** | | | | | | | | | | | | | |
| **Task** | | **Independent** | **Independent with equipment** | | **Assisted by 1 person** | | | **Assisted by 2 people** | **Assisted by equipment & staff** | **Unable** | **Not Applicable** | ***FIM Score***  ***(refer to page 5)*** | | | **Awkward Position?** | **Stooping?** | **Reaching?** | | **Twisting?** | **Pushing / Pulling?** | | **Lifting a dependent weight?** | | **Holding Load away from body?** | | **Is the task repetitive** | **Lifting weight from below knees or above shoulders?** | **Any other:**  **Comments;** |
| **Standing** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **Taking steps** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **Moving in bed** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **Getting in /out of bed** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **On/off chair** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **On/off Commode** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **In / out of bath/ shower** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **Indoor mobility** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **Stair mobility** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **Outdoor mobility** | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
|  | |  |  | |  | | |  |  |  |  |  | | |  |  |  | |  |  | |  | |  | |  |  |  |
| **Is the client able to assist with any of the transfer (verbally/physically)?YES / NO**  ***If Yes, note how client is able to assist*** ***(e.g. Client is able to assist to roll on his side when fitting with the sling on the bed with prompts):*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Summary of client’s ability rating and risk factors above: How do these things affect risk to service user or carer:*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Assessor Signature** | | | |  | | | | | | | | | | ***Client has received and understood the Factsheet and accepts the care*** | | | | | | | | | | | | | | |
| **Manager signature** | | | |  | | | | | | | | | | **Client or Advocate’s Signature** | | | | | | |  | | | | | | | |
| **Manager Name** | | | | | | |  | | | | | | | **Date** | | | | | | |  | | | | | | | |

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| **RISK FACTORS – CLIENT DETAIL** | | | | | |
| * *Note any factors that may affect the handling of this service user.* * *Does the service user have any of the following problems: (put an X in the relevant boxes)* | | | | | |
| Pain? |  | Incontinence urine /faeces? |  | Attachments e.g. catheter/ colostomy? |  |
| Osteoporosis? |  | Inability to co-operate |  | Involuntary movements (e.g. Tremor/spasms)? |  |
| Weakness (Site)? |  | Loss of co-ordination? |  | Unpredictable behaviour? |  |
| Poor Balance (Sit / stand)? |  | Loss of feeling (site)?  Sensory sensitivity (eg.touch, noise) |  | Comprehension and cognitive problems/memory loss/learning impairment? |  |
| Impaired mobility? |  | Pressure sores/broken skin? |  | Visual/hearing/speech impairment? |  |
| Difficulty weight –bearing? |  | Anxiety/depression? |  | Cultural issues – service user family preferences |  |
| **Comments: (Indicate how the service user or carer is affected in detail):** | | | | | |
| **RISK FACTORS – THE STAFF** | | | | | |
| **Would any specific staff group be more at risk handling this service user? YES / NO**  ***(E.g. Very tall or short, history of knee or back problems, inexperienced, pregnant)?*** | | | | | |
| **Do the tasks require any special knowledge or skills? Identify below with “x” which skill level is required** | | | | | |
| ***Tier 1*** *– Basic skills, no knowledge of personal care handling* | | | | |  |
| ***Tier 2*** *– Has had training and is competent using hoists and common handling equipment and is able to follow instructions in risk assessments.* | | | | |  |
| ***Tier 3*** *– Experienced, able to problem solve, carry out on the spot or formal manual handling risk assessments at a basic level, and has experience of handling clients with cognitive / behavioural issues/communication.* | | | | |  |
| ***Tier 4*** *– A Senior Carer with very varied long term experience, confident, formal risk assessor and able to make decisions and solve and manage more complex problems and provide exceptionally skilled care for those with complex and multiple disabilities.* | | | | |  |
| **How many carers are required? :** | | | | | |
| **If requiring more than one handler,** **would both need to be of a higher tier level (3 or 4)? YES / NO** | | | | | |
| *If Yes, Details of skills required:* | | | | | |

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| **RISK FACTORS - ENVIRONMENT** | | | | | | | | | |
| **Locations in which the tasks are completed** | | **Location 1** | | | **Location 2** | **Location 3** | | | |
|  | | |  |  | | | |
| **Do any of the above have the following risk factors? (put an “X” in relevant boxes)** | | | | | | | | | |
|  | **Location** | | |  | | | **Location** | | |
| **1** | **2** | **3** | **1** | **2** | **3** |
| **Limited space?** |  |  |  | **Excessive furniture?** | | |  |  |  |
| **Stairs /slopes?** |  |  |  | **Difference in furniture height?** | | |  |  |  |
| **Poor lighting?** |  |  |  | **Lack of space under bed?** | | |  |  |  |
| **Clutter?** |  |  |  | **Low working surface?** | | |  |  |  |
| **Hazardous flooring?** |  |  |  | **Lack of space surrounding the bed** | | |  |  |  |
| **Trip/slip hazards?** |  |  |  | **Voyager hoist poles** | | |  |  |  |
| **Uncontrolled pets?** |  |  |  |  | | |  |  |  |
| **Electrical hazards?** |  |  |  |  | | |  |  |  |
| **Additional comments / Summary of Risk factors above and how they affect risks to service user or carer:** | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **RISK FACTORS - EQUIPMENT** | | | | |
| **Where equipment is used (e.g. wheelchair walking frame, Hoist, Stair Lift etc) provide details including service arrangements. If relevant note that the Working Load Limit (WLL) has been checked and is appropriate** | | | | |
| **Equipment** | **Supplied by** | **Serviced by** | **Date Serviced** | **Checked** |
|  |  |  |  | YES / NO |
|  |  |  |  | YES / NO |
|  |  |  |  | YES / NO |
|  |  |  |  | YES / NO |
|  |  |  |  | YES / NO |
|  |  |  |  | YES / NO |
| **Is the sling compatible for use with the hoist and in good condition?** | | | | YES / NO |
| **Is there any other equipment required to safely perform any of the tasks or any follow up work required?**  ***Give details and order from Equipment Stores (date equipment requested and by whom?)*** | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Functional Independence Measure Score (FIM)**  **(Granger CV Hamilton BB Am J Phys Med Rehabil 1993 72;84-89)** | | | | | | |
| **Complete Dependence** | | **Dependent** | | | **Independent** | |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **Total Assistance.** Subject expends less than 25% of the effort | **Maximal Assistance.** Subject expends between 25% and 50% of the effort | **Moderate Assistance.** Subject requires more help than touching, or expands 50% or more up to 75% if the effort | **Minimal contact assistance** **with physical contact.** The helper requires **no** more help than touching, subject expends 75% or more of the effort | **Supervision or set up.** Subject requires no more help than standby, coaxing or cuing without physical contact. Helper may apply **orthosis** or sets up items necessary. | **Modified Independence.** Activity requires anyone or more of the following; An assistive device more than reasonable time, and/ or are safety risks considerations. | **Complete Independence.** Another person is not required for the activity (no helper) |

|  |  |  |  |  |  |  |  |  |  |
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| **Risk Matrix Likelihood x Severity Chart (RML x S Chart)**  ***(Complete for each task after the control measure)*** | | | | | | | | | |
| **Step 1 – Likelihood**  **(Frequency or probability)** | | | | **Step 2 – Severity**  **(Consequence)** | | | | | |
| **Scores** | **Description** | | | **Scores** | | **Impact on individual** | | | **Impact on organisation** |
| **1 –**  **Rare** | Do not believe will happen, one off. Exceptional circumstances | | | **1**  **Insignificant** | | No injury  No apparent injury | | | No risk to the organisation, no impact on service no impact on environment |
| **2 –**  **Unlikely** | Not expected but possible. Could occur at sometime | | | **2**  **Minor** | | First Aid, Minor Injury or Minor illness up to 1 month | | | Minimal risk to organisation, Slight impact on service, Slight impact on environment |
| **3 –**  **Possible** | May occur at some time | | | **3**  **Moderate** | | Temporary incapacity. Short term monitoring. Additional Medical treatment required up to 1 year | | | Some service disruption. Potential for adverse publicity, avoidable with careful handling. Moderate impact on environment |
| **4 –**  **Likely** | Will probably occur | | | **4**  **Major** | | Major Injury (reportable) major clinical intervention | | | Service restriction Adverse publicity. Impact of reputation. Major impact on environment |
| **5 –**  **Almost Certain** | Likely to occur on many occasions. A persistent issue | | | **5 Catastrophic** | | Death | | | National Media Interest. Severe loss of confidence in organisation |
| **Step 3 - Risk Matrix Likelihood x Severity** | | | | | | | | | |
|  | | **Likelihood (Frequency or probability)** | | | | | | | |
| **Severity**  **(Consequences)** | | **5 Almost Certain** | **4 - Likely** | | **3**  **Possible** | **2**  **Unlikely** | **1**  **Rare** | **Key** | |
| **1 Insignificant** | | **5L** | **4L** | | **3L** | **2L** | **1L** | **Low Risk.** Local manager responsibility, manage by routine procedures. | |
| **2 Minor** | | **10M** | **8M** | | **6M** | **4L** | **2L** |
| **3 Moderate** | | **15H** | **12H** | | **9M** | **6M** | **3L** |
| **4 Major** | | **20H** | **16H** | | **12H** | **8M** | **4M** | **Medium Risk.** Senior manager attention required. Be alert. | |
| **5 Catastrophic** | | **25H** | **20H** | | **15H** | **10H** | **5H** | **High Risk.** Urgent Action Required. **SEEK EXPERT ADVICE NOW** | |

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| --- |
| **CONTROL MEASURES** |
| * Give details below as to moving and handling techniques to be used to complete each task with minimal risk. * State any short-term action if equipment is to be supplied and is not yet available. * If using equipment, for example, sliding sheet, specify size, name and technique to be used and clinical reasoning for use. * Ensure that if there is a hoist in place there is a detailed hoist plan including information regarding sling choice and a check that the sling is compatible with the hoist and spreader bar used.   *Include a description of what the service user is able to do to help the manoeuvre and how carers can promote service user participation. You may also refer to Sutton locality manual handling procedures to help you.* |

**\*RMLxS Chart = Risk Matrix Likelihood x Severity Chart**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Tasks/ Activities identified including No. of people required** | ***Equipment repairs and collection request please contact:-***  ***Croydon Equipment Solutions***  ***28 Boulogne Road, Croydon, CR0 2QT***  ***Tel: 0208 664 8860 Fax: 0208 683 0167***  ***e-mail:*** [***admin@croydon-equipment-solutions.com***](mailto:admin@croydon-equipment-solutions.com)  ***Out of*** *hour* ***contact : 0208 770 5000 (London Borough of Sutton)***  ***First Contact 0208 770 6080***  **Detail the methods to be used. Including the roles of client and care givers and preference of the person we support** | | | **Risk Level**  **refer to RMLxS Chart** | | **Change date with initials** | |
| **Client** | **Care giver** |
|  |  | | |  |  |  | |
| **ENSURE CARE GIVERS HAVE RECEIVED ADEQUATE TRAINING AND ARE COMPETENT IN TASKS AND THE EQUIPMENT USED. IF THERE ARE ANY CHANGES OR CONCERNS PLEASE CONTACT YOUR LINE MANAGER OR LBS OCCUPATIONAL THERAPY SERVICE ON 0208 770 6080** | | | | | | | |
| **PLEASE CHECK THAT YOU HAVE GIVEN DETAILS OF ACTION REQUIRED IN ABSENCE OF EQUIPMENT. ORGANISE ANY FOLLOW UP ACTION NOW!** | | | | | | | |
| *ALWAYS LEAVE ONE COPY WITH THE CLIENT AND CARE GIVERS* | | | | | | | |
| *ANY CHANGES MUST BE CONTINUED ON THE REVIEW SHEET AND THE DATE OF THE CHANGES / RE-ASSESSMENT ENTERED ON THE FIRST PAGE* | | | | | | | |
| **Assessor Signature** | | |  | **Date** |  | | |
| **Manager signature** | | |  | **Date** |  | | |

**✴*See Appendix A for continuation sheet if required.***

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| **PERSONAL MOVING AND HANDLING PROFILE AND RISK ASSESSMENT – REVIEW** | | | |
| **Client Full Name:** |  | **Assessors Full Name:** |  |
| **Date of Birth** |  | **Organisation:** |  |
| **Address:** | | **Contact Details:** |  |
| **Date of review :** |  |
| **Date of review :** |  |
| **Personal Number:** |  | **Care givers full Name:** |  |
| **Agency name, contact details:** | | | |

**\*RML x S Chart = Risk Matrix Likelihood x Severity Chart**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONTROL MEASURES** | | | | |
| **Tasks/ Activities identified including No. of people required** | **Detail the methods to be used. Including the roles of client and care givers and preference of the person we support** | **Risk Level**  **(refer to RMLxS Chart \*)** | | Change date with initials |
| **Client** | **Care giver** |
|  |  |  |  |  |

**\*Appendix A (continuation sheet)**

|  |
| --- |
| **CONTROL MEASURES** |
| * Give details below as to moving and handling techniques to be used to complete each task with minimal risk. * State any short-term action if equipment is to be supplied and is not yet available. * If using equipment, for example, sliding sheet, specify size, name and technique to be used. * Ensure that if there is a hoist in place there is a detailed hoist plan including information regarding sling choice and a check that the sling is compatible with the hoist and spreader bar used.   *Include a description of what the service user is able to do to help the manoeuvre and how carers can promote service user participation. You may also refer to Sutton locality manual handling procedures to help you.* |

**\*RML x S Chart = Risk Matrix Likelihood x Severity Chart**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Tasks/ Activities identified including No. of people required** | **Detail the methods to be used. Including the roles of client and care givers and preference of the person we support** | **Risk Level**  **(refer to RMLxS Chart \*)** | | **Change date with initials** |
| **Client** | **Care giver** |
|  |  |  |  |  |