

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth
Address

DD / MM / YYYY

Postcode:

PATIENT HANDLING ASSESSMENT & SAFER HANDLING PLAN



TO BE COMPLETED IN BLACK INK

| Overall Mobility Classification | | | | | Fully Independent | | | | Risk of Falls | | | | |
|--|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|
| A B C D E | | | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | |
| Manual Handling Risk Factors / Constraints (tick if present) | | | | | | | | | | | | | |
| Hospital: | | Ward: | | | Lack of comprehension / understanding | | | | Disability | | | | |
| | | | | | Has confusion / agitation | | | | Weakness | | | | |
| Height: or ft, cms ins | | Weight: Kg Weighed <input type="checkbox"/> Estimated <input type="checkbox"/> Patient Reported <input type="checkbox"/> | | | Lack of co-operation / compliance | | | | Pain | | | | |
| | | | | | Skin lesions / wounds | | | | Infusion / catheter / drain etc. | | | | |
| Sensory Factors | | | | | Cultural considerations | | | | | | | | |
| Hearing deficit | | Hearing aid | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Other e.g. traction, limb oedema (state) | | | | | | | |
| Sight deficit | | Spectacles | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | (Consult patients notes for detail) | | | | | | | |

| Moving in bed (i.e. rolling, turning & up/down bed) | | | | | | Staff 1 2 3 other | | | | |
|---|--|-----------------------------|--|----------------------|--|---|--|--|--|--|
| Rolling/Turning | | Up/down bed | | Equipment (if reqd.) | | Additional information: e.g. method/manoeuvre, other equipment, day/night variation etc | | | | |
| Independent | | Independent | | Slide sheets | | | | | | |
| Supervision / verbal prompt | | Supervision / verbal prompt | | Grab handle | | | | | | |
| Assisted | | Assisted | | Other | | | | | | |
| N/A | | N/A | | | | | | | | |

| Supine ←→sitting on edge of bed | | | | Bed Rest | | Staff 1 2 3 other | | | | |
|----------------------------------|--|----------------------------------|--|----------------------|--|---|--|--|--|--|
| Supine to sitting on edge of bed | | Sitting on edge of bed to supine | | Equipment (if reqd.) | | Additional information: e.g. method/manoeuvre, other equipment, day/night variation etc | | | | |
| Independent | | Independent | | Slide sheets | | | | | | |
| Supervision / verbal prompt | | Supervision / verbal prompt | | Grab handle | | | | | | |
| Assisted | | Assisted | | Leg lifter | | | | | | |
| N/A | | N/A | | | | | | | | |

| Showering | | Equipment | | | | Staff 1 2 3 other | | | | |
|-----------------------------|--|---------------------------|--|--|--|---|--|--|--|--|
| Independent | | Hi-low hygiene chair | | | | Additional information: e.g. method/manoeuvre, other equipment, day/night variation etc | | | | |
| Supervision / verbal prompt | | Fixed Height Shower chair | | | | | | | | |
| Assisted | | Shower trolley | | | | | | | | |
| N/A | | | | | | | | | | |
| | | | | | | | | | | |

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| Bathing | | Equipment | | Staff 1 2 3 other |
|-----------------------------|----------------------|-----------|---------------------------------------|---|
| Independent | Bath / Hi-low bath | | | Additional information: e.g. method/manoeuvre, other equipment, day/night variation etc |
| Supervision / verbal prompt | Bath trolley / hoist | | | |
| Assisted | Hoist & sling | | Bathing sling size S M L LL XL | |
| N/A | | | | |

| Washing | | Equipment | | Staff 1 2 3 other |
|-----------------------------|-------------------|-----------|--|---|
| Independent | Bed/assisted wash | | | Additional information: e.g. method/manoeuvre, other equipment, day/night variation etc |
| Supervision / verbal prompt | Chair | | | |
| Assisted | | | | |
| N/A | | | | |

| Toileting | | Equipment | | Staff 1 2 3 other |
|-----------------------------|---------|-----------|--|---|
| Independent | Toilet | | | Additional information: e.g. method/manoeuvre, other equipment, day/night variation etc |
| Supervision / verbal prompt | Commode | | | |
| Assisted | Bedpan | | | |
| N/A | | | | |

| Walking | | Equipment | | Staff 1 2 3 other |
|-----------------------------|---------------|-----------|--|---|
| Independent | Walking stick | | | Additional information: e.g. method/manoeuvre, other equipment, day/night variation etc |
| Supervision / verbal prompt | Walking Frame | | | |
| Assisted | Walking Hoist | | | |
| N/A | | | | |

| All Transfers (i.e to/from bed, chair, commode, toilet etc.) | | | | Staff 1 2 3 other |
|--|--------------------|-------------------------------|--|---|
| Independent | Equipment | | | Additional information: e.g. method/manoeuvre, other equipment, day/night variation etc |
| Supervision / verbal prompt | Standing turntable | Standing Aid | | |
| Assisted | Bed assist, stand | Transfer Board | | |
| N/A | | | | |
| Active/Standing Hoist | Model: | Sling size S M L XL | | |
| Passive Hoist | Model: | Sling size S M L LL XL | | |

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| | | |
|--|--------------------------------|---|
| Other Specific Risks e.g. environmental, equipment or task-related etc. | | |
| Details | Risk Reduction Measures | |
| | | |
| | | |
| | | |
| | | |
| Assessor Name | Date | Mobility Classification Tool (LOCOmotor ©) |

| ADDITIONAL RESOURCES REQUIRED | | | | |
|-------------------------------|-----------------------|------------------|----------------|---------------|
| Resource Required | Reason/ Justification | Specification | Date Requested | Date Provided |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Manager Name | | Signature | Date | |


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SAFER HANDLING PLAN REVIEW

| Reason for Review | Routine | More assistance reqd | Less assistance reqd. | Following Incident |
|-------------------------------|------------------------------|----------------------|--|--------------------|
| Activity | Change(s) to Documented plan | | Overall Mobility Classification      A B C D E | |
| Moving in Bed | | | | |
| Getting in/out of bed | | | | |
| Showering / bathing / washing | | | | |
| Toileting | | | | |
| Transfers | | | | |
| Walking | | | | |
| Other relevant information: | | | | |
| Assessor Name | Signature | | Date | |

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Guidance Notes: Patient Handling Risk Assessment & Safer Handling Plan

Whom should complete this assessment: A Registered Healthcare Professional (RHP). If a suitably experienced person who is not an RHP completes the assessment form, then it must be checked and countersigned by an RHP.

Fix Patient Addressograph: Ensure correct addressograph is attached, if not available write patient's details in the box.

Functional Mobility Level: Consider the level of the patient's functional mobility i.e. what the patient is physically able to do in assisting with each task. Record this level using the Mobility classification tool (LOCOMotor ©) as detailed below **A,B,C,D or E** where indicated on the form.

| Mobility Classification Tool (LOCOMotor ©) | |
|--|---|
| | <u>A</u> Ambulatory, but may use a walking stick for support Independent, can clean and dress oneself. Usually no risk of dynamic or static overload to carer. Stimulation of functional mobility is very important |
| | <u>B</u> Can support oneself to some degree and uses walking frame or similar. Dependant on carer in some situations. Usually no risk of dynamic overload to carer. A risk of static overload to carer can occur if not using proper equipment. Stimulation of functional mobility is very important |
| | <u>C</u> Is able to partially weight bear on at least one leg. Often sits in a wheelchair and has some trunk stability. Dependant on carer in many situations. A risk of dynamic and static overload to carer when not using proper aids. Stimulation of functional mobility is very important |
| | <u>D</u> Cannot stand and is not able to weight bear. Is able to sit if well supported. Dependant on carer in most situations. A high risk of dynamic and static overload to carer when not using proper equipment. Stimulation of functional participation is very important |
| | <u>E</u> Might be almost completely bedridden, can sit out only in a special chair. Always dependent on carer. A high risk of dynamic and static overload to carer when not using proper equipment. Stimulation of functional participation is not a primary goal |

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Fully Independent: If **Yes**, sign the form, no further action required. If **No**, complete the remainder of the assessment form.

Risk of Falls: If **High**, ensure this is taken into account when prescribing techniques or equipment for the various manoeuvres with this patient.

Height and Weight It is important to ensure that the size, shape and safe working load (SWL) of any aid or equipment prescribed is suitable for the patient's weight, stature and height.

Manual Handling Risk Factors / Constraints: This is to identify any other factors that could affect the patient's mobility, and/or may impact on patient safety or safety of the carer. Please indicate any relevant clinical conditions. For the confidentiality of forms left at the bedside please only tick here, Staff must refer to patient notes for detail.

Sensory Factors: Sensory deficit(s) can impact on the patient's compliance. Ensure glasses and / or hearing aid are available, functioning and used.

Manoeuvres: In order to ensure that the patient is handled in a consistent and safe manner, these sections should prescribe the method, level of assistance, equipment including for example the manufacturer, type and size of hoist sling used, number of staff required, etc and any other relevant information as necessary.

Other Specialist Risk: Additional risks along with measures taken to reduce these should be documented to reduce the risk of incident / injury. Ensure usual specialist footwear or prosthetic appliances are fitted correctly and recorded under other specific risks.

Signature: The RHP must complete, or at least countersign this section.

Additional Resources: Are additional resources are required? For instance bariatric equipment hire? If so, what resource is needed, provide justification and specification for needing it and ensure the Manager is informed.

Reviews: in the paper version there is space to document two reviews, after which a new form should be completed to ensure legibility, instructions are clear and risks are highlighted.

Review of the assessment should be carried out a as minimum weekly or more frequently if there is a deterioration or change in the patient's condition or following an incident or a fall.

The Patient Handling Risk Assessment & Safer Handling Plan **MUST** be communicated/sent with the patient to other wards / departments: e.g., Radiology, Theatres, etc.