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| **MOVING AND HANDLING ASSESSMENT** |

**Manual Handling Assessment Must Be Completed:**

* **On Admission**
* **Reviewed Monthly**
* **Reviewed whenever there are any changes**

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| --- | --- | --- | --- |
| **Height** | **Weight** | **Age** | **Waterlow score** |

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| --- | --- | --- | --- | --- |
| **PHYSICAL HAZARDS** | **Yes** | **No** | **Comments** | **Action** |
| Could resident’s height cause a problem? |  |  |  |  |
| Could resident’s weight cause a problem? |  |  |  |  |
| Does the resident have swollen/fixed/flaccid limbs? |  |  |  |  |
| Does the resident have poor state of feet? i.e. swollen, painful, etc |  |  |  |  |
| Is Skin condition poor? i.e. frail, fragile, pain, broken, |  |  |  |  |
| Is resident difficult to hold? |  |  |  |  |
| Is the resident in pain when moving? |  |  |  |  |
| Is the resident’s hearing impaired? |  |  |  |  |
| Is the resident’s sight impaired? |  |  |  |  |
| Is the resident’s speech impaired? |  |  |  |  |
| Does the resident suffer from seizures/involuntary movements? |  |  |  |  |
| Is the resident unstable/ uncoordinated? |  |  |  |  |
| Are there any ‘attachments’ to consider e.g. IVI’s / catheters/oxygen cylinders? |  |  |  |  |
| Is the resident wearing appropriate clothing and footwear? |  |  |  |  |
| **PSYCHOLOGICAL HAZARDS** | **Yes** | **No** | **Comments** |  |
| Is the resident unpredictable? |  |  |  |  |
| Does the resident have difficulty following the instructions? |  |  |  |  |
| Is the Resident anxious or distressed? |  |  |  |  |
| Is the resident prone to mood swings? |  |  |  |  |
| **ENVIRONMENTAL HAZARDS** | **Yes** | **No** | **Comments** |  |
| Is the lighting adequate? |  |  |  |  |
| Are there any restrictions due to room layout? |  |  |  |  |
| Is the temperature comfortable/ventilation adequate? |  |  |  |  |

This assessment was done:

* in the best interest of
* with verbal consent given
* with non-verbal consent given

This was done in the presence of………………………………………………………………

**Comments:**

|  |  |
| --- | --- |
| **Other** |  |
|  |  |
|  |  |

**Assessment completed by: ………………………………………**

**Signed: ……………………………………………………………**

**Designation: ………………………………………………………**

**Date of Assessment: ………………………………………………**

**Review**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of review** | **Are there any changes in moving and handling care plan since the last assessment** | **Name and Signature** | **Designation** |
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