Assignment Name(s):

Programme: QQI Level 6 Instructing People Handling

Module Code: 6N0234

Assignment Title: Risk Assessment

Submission Date:

Module Instructor:

**-------------- Declaration on Plagiarism Assignment Submission --------------**

I declare that this material, which Inow submit for assessment, is entirely my own work and has not been taken from the work of others, save and to the extent that such work has been cited and acknowledged within the text of my work. I understand that plagiarism, collusion, and copying are grave and serious offences in the university and accept the penalties that would be imposed should I engage in plagiarism, collusion or copying.

Any other source whatsoever are acknowledged, and the source cited are identified in the assignment references. This assignment, or any part of it, has not been previously submitted by meor any other person for assessment on this or any other course.

**I have read and understood the Assignment Brief.**

**I have read and understood the guidelines found at in the Learner Handbook.**

Name(s) PRINT:

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| --- |
|  |

Signature:

|  |
| --- |
| John  |

Date:

|  |
| --- |
| DD/MM/YYYY |

1. **Observe and Describe the Patient and their setting and circumstance**

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1. **Collect Data** (See section 1 & 2)
2. **Identify Risk Factors** (See section 3 to 10)

**People Handling Risk Assessment Form**

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| Is the service user able to mobilise independently? £ No £ Yes If *yes* please date and sign the form *here.* Date: Signature: Ward:  |

If *NO* please proceed with the assessment and sign below

|  |  |
| --- | --- |
| 2. Weight (kg)s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Specialist equipment may be required if the service users weight exceeds the safe working load of any equipment. Please detail.* | 3.Medication: is medication relevant to moving and handling? e.g. sedation/pain/anti spasmodic medication £ No £ Yes *If yes refer to Drug Kardex* |
| 4. Comprehension/Communication/Behaviour:Can the service user understand & participate in simple instructions? £ Yes £ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Will behaviour affect cooperation with moving and handling? £ No £ Yes  | 5. History of Falls: £ No £ Yes *If yes complete falls risk assessment* |
| 6. Environmental constraints: are confined space/non-adjustable equipment/floors/ramps/ service users’ attachments an issue? £ No £ Yes (*If yes please detail)* | 7. Carers Ability / Experience:Does handling this service user require any additional specialised training/instructions?  £ No £ Yes *( if yes report to Line Manager)* |
| 8. PPE Requirements: Is PPE Required? No£ Yes £ (*If yes please detail*) |
| 9. Current Mobility: Is assistance required to mobilise? £ No £ Yes If yes how many carers are required? \_\_\_\_\_\_\_\_\_\_\_\_\_\_Are mobility aids currently used? £ No £ Yes *please detail*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have these been brought with the service user? £ No £ Yes |
| 10. List main physical limitations: surgery, sedation, impaired sight or hearing, loss of use of limbs, general physical condition, stature, stroke, skin condition, bone density, pain etc. |
| 11. Is further assistance required to complete this assessment? £ No £ Yes Refer to: e.g. Line Manager, Physiotherapist, Manual Handling Instructor |
| People Handling Risk Level\* High – completely dependent, unpredictable, minimum of 2 carers & equipment required. More carers may be required for heavier / bariatric service users\* Medium– requires some assistance usually 1 carer & equipment, 2 carers may be needed for some activities.\* Low–requires no hands on assistance. May require verbal guidance/ equipmentIf the service users condition changes the moving and handling risk assessment will need to be reviewed. *The Handling Care Plan overleaf should now be completed* |
| Date:  | Assessor/s:  | Signature: |
| Assessment update/commentsDate: Signature: Ward:  |
| Assessment update / commentsDate: Signature: Ward:  |

**Handling Plan**

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| People Handling Risk Level: |
| Are there any special considerations about this service user? Note any i.e. poor eyesight, deaf etc. |

Activities : Note most common i.e. Lying to sitting etc.

|  |  |  |  |
| --- | --- | --- | --- |
| Activity  | Date | No of Carers / Equipment / service user action/ comments | Initials |
|  Re-positioning  |  |  |  |
| Consider use of • hoist • sliding sheets • monkey pole |
| Sitting forwards  |  |  |  |
| Consider use of • electric bed • hoist • rope ladder  |
| Sitting to standing  |  |  |  |
| Consider use of • hoist • standing hoist • handling belt  |
| Walking / Stairs |  |  |  |
| Consider use of · rollator • Zimmer frame • crutches • stick  |
| Toileting |  |  |  |
| Consider use of • standing hoist • commode • toilet riser  |
| Bath/Shower |  |  |  |
| Consider use of · hoist • shower chair  |
| Transport and Other Activities Advice |  |  |  |
| Re use of • wheelchair • Rollerboard • transfer board |
| Hoist Name: Type:  Sling Types: Name/s: Signature(s) :  |
| Reason for updating the handling plan: Date: Name/s: Signature(s) :  |