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| --- |
| Individual Manual Handling Risk Assessment (MHRA-1) |
|  |
| Persons Name: |       |
| Mosaic No: |       | DOB: |       |
| Address / Location: |       |
|  |
| Does the person require assistance to move? | Yes | [ ]  | No | [ ]  |
| If yes to the above, please tick the assistance to be given; |
| Standing (e.g. from sitting) | [ ]  | Rolling | [ ]  |
| Walking | [ ]  | Turning | [ ]  |
| Sitting (e.g. from standing) | [ ]  | Lying to Sitting | [ ]  |
| Reposition in chair | [ ]  | Getting in/out of bed | [ ]  |
| Transfers | [ ]  | Personal care (Please specify)        | [ ]  |
| Getting up from floor | [ ]  |  |  |
| Position in bed | [ ]  | Other (please specify)       | [ ]  |
|  |
| A: Detailed assessment; |
| This section should be completed with the person and/or their carer’s. Identify if any of the following factors need to be taken into account when providing assistance to move, and make comments as appropriate. |
| ✓ | Factor | Comments |
| [ ]  | Height (please state if estimated) |       meters |
| [ ]  | Weight (please state if estimated) |       kg |
| [ ]  | Communication |       |
| [ ]  | Comprehension |       |
| [ ]  | Sight/hearing |       |
| [ ]  | Behaviour |       |
| [ ]  | History of falls/seizures |       |
| [ ]  | Medication |       |
| [ ]  | Balance |       |
| [ ]  | Weight bearing ability |       |
| [ ]  | Medical condition |       |
| [ ]  | Supports/attachments (e.g. walking aids, catheters) |       |
| [ ]  | Pain |       |
| [ ]  | Other (please specify) |       |
|  |
| Other problems to consider |
| Are there any other problems associated with the assistance to be given? If **YES** continue overleaf, if **NO** go to **Assessors name** and sign/date the form | YES | [ ]  | NO | [ ]  |
|  |
| B: Detailed assessment (continued) |
| **Problems to consider** | **Specify each activity to consider**(Make notes underneath of problems identified) | **Suggest possible changes to eliminate or reduce risk of injury** |
| **Task;**- Holding away from the trunk- Twisting/Stooping- Over stretching- Strenuous pushing/pulling- Unpredictable movement- Repetitive handling- Team handling**Individual Capability of staff/carer(s)**- Health/Fitness- Pregnancy- Lack of training**Environment;**- Lack of space- Lack of equipment- Variations in level- Poor flooring- To hot/cold- Poor lighting- Unsuitable equipment**Other Factors;**- Inappropriate work attire- poor work organisation- poor communication |       |       |
| **Examples of changes** |  |  |
| - rearrange area- change layout- provide equipment- re-schedule staff- staffing support levels- provide training- consult staff |  |  |
| C: Remedial action to be taken |
| Remedial steps that should be taken in order of priority: | Person responsible for implementing controls | Target implementation date: | CompletedYes/No |
| 1.       |       |       |  |
| 2.       |       |       |  |
| 3.       |       |       |  |
| 4.       |       |       |  |
| 5.       |       |       |  |
| 6.       |       |       |  |
| 7.       |       |       |  |
| Assessment discussed with (e.g. client, employees, informal carer’s):       |
| Assessors name:       | Signature: |  |
| Managers name:       | Signature: |  |
| Date of assessment:       | Target date for action: |       |
| Review Dates: |       |       |       |       |       |       |       |
|  |
| - Now complete the handling plan - |
|  |
| D: Safe system of work (Handling Plan) |
| Persons Name: |       |
| Mosaic No: |       | DOB: |       |
| Address / Location: |       |
| Persons height: |       meters | Persons weight: |       kg |
| Persons ability to support their own weight:       |
| Other factors to consider (e.g. pain, ability to cooperate):       |
|  |
| Tick when assistance to be given; |
| Standing (e.g. from sitting) | [ ]  | Rolling | [ ]  |
| Walking | [ ]  | Turning | [ ]  |
| Sitting (e.g. from standing) | [ ]  | Lying to Sitting | [ ]  |
| Reposition in chair | [ ]  | Getting in/out of bed | [ ]  |
| Transfers | [ ]  | Personal care (Please specify)       | [ ]  |
| Getting up from floor | [ ]  |  |  |
| Position in bed | [ ]  | Other (please specify)      | [ ]  |
|  |
| **Instructions for:**       |
| **Number of carers required:**  |
| **Equipment needed**:       |
| **Make and model of hoist:** |       |
| **Type of sling:** |       |
| **Size of sling/Serial No:** |       |
| **Leg configuration/fitting:** |       |
| **Loop fitting** | **Shoulder** |       |
|  | **Leg** |       |
|  | **(Other)**  |       |
| **Method to be used**:       |
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|  |
| **Instructions for:**       |
| **Number of carers required:**  |
| **Equipment needed**:       |
| **Make and model of hoist:** |       |
| **Type of sling:** |       |
| **Size of sling/Serial No:** |       |
| **Leg configuration/fitting:** |       |
| **Loop fitting** | **Shoulder** |       |
|  | **Leg** |       |
|  | **(Other)**  |       |
| **Method to be used**:       |
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|  |
| **Instructions for:**       |
| **Number of carers required:**  |
| **Equipment needed**:       |
| **Make and model of hoist:** |       |
| **Type of sling:** |       |
| **Size of sling/Serial No:** |       |
| **Leg configuration/fitting:** |       |
| **Loop fitting** | **Shoulder** |       |
|  | **Leg** |       |
|  | **(Other)**  |       |
| **Method to be used**:       |
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| **Instructions for:**       |
| **Number of carers required:**  |
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| **Size of sling/Serial No:** |       |
| **Leg configuration/fitting:** |       |
| **Loop fitting** | **Shoulder** |       |
|  | **Leg** |       |
|  | **(Other)**  |       |
| **Method to be used**:       |
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| **Instructions for:**       |
| **Number of carers required:**  |
| **Equipment needed**:       |
| **Make and model of hoist:** |       |
| **Type of sling:** |       |
| **Size of sling/Serial No:** |       |
| **Leg configuration/fitting:** |       |
| **Loop fitting** | **Shoulder** |       |
|  | **Leg** |       |
|  | **(Other)**  |       |
| **Method to be used**:       |
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| **Instructions for:**       |
| **Number of carers required:**  |
| **Equipment needed**:       |
| **Make and model of hoist:** |       |
| **Type of sling:** |       |
| **Size of sling/Serial No:** |       |
| **Leg configuration/fitting:** |       |
| **Loop fitting** | **Shoulder** |       |
|  | **Leg** |       |
|  | **(Other)**  |       |
| **Method to be used**:       |
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| **Instructions for:**       |
| **Number of carers required:**  |
| **Equipment needed**:       |
| **Make and model of hoist:** |       |
| **Type of sling:** |       |
| **Size of sling/Serial No:** |       |
| **Leg configuration/fitting:** |       |
| **Loop fitting** | **Shoulder** |       |
|  | **Leg** |       |
|  | **(Other)**  |       |
| **Method to be used**:       |
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| **Instructions for:**       |
| **Number of carers required:**  |
| **Equipment needed**:       |
| **Make and model of hoist:** |       |
| **Type of sling:** |       |
| **Size of sling/Serial No:** |       |
| **Leg configuration/fitting:** |       |
| **Loop fitting** | **Shoulder** |       |
|  | **Leg** |       |
|  | **(Other)**  |       |
| **Method to be used**:       |
|  |
| Equipment details |
| Name & contact no of organisation responsible for providing and maintaining equipment |       |
| Assessor:       | Signature: |       |
| Date of plan: |       | Review dates: |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
| Further information attached? | YES [ ]  NO [ ]  |
|  |  |
| E: Signatures |  |
| I have read and will comply with the Safe system of work within this document. If there are any changes to the service user, their handling needs and the working environment, or I am experiencing difficulties then I will inform my line manager immediately. |
| Print Name | Signature | Date |
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