**APPENDIX F.1**

**LINCOLNSHIRE COUNTY COUNCIL**

**Hoist Information Pack**

**and**

**Adults**

**Moving and Handling**

**Assessment**

**Name:**

**DOB:**

**Address:**

**Date: dd.mm. 20yy**

**AIS No:**

**Copies sent to:**

This Moving and Handling Pack is to replace all previously implemented plans.

**In an emergency, (i.e. hoist breakdown) phone N.R.S. 0845 121 2031 (An “out of hours” number is given at the end of the answer phone message**

**ABOUT YOUR HOIST AND SLING**

**Servicing**

Your hoist and sling will be serviced every 6 months. The company responsible for organising the service is NRS, Lincolnshire Community Equipment Services, telephone 0845 121 2031. [Contract NRS if not carried out].

Please confirm that you have been shown how to use the equipment and are able to use it safely.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Signature:** |  | **Date:** |  |
| **OT:** |  | **Signature:** |  | **Date:** |  |
|  |  | **Signature:** |  | **Date:** |  |

**YOUR MOBILE HOIST**

|  |  |
| --- | --- |
| Make: |  |
| Model/Type: |  |
| Serial No: |  |
| Date of last service: |  |

**YOUR CEILING TRACK HOIST**

|  |  |
| --- | --- |
| Make: |  |
| Model/Type: |  |
| Serial No: |  | Location: |  |
| Service Dates: |  |

**HOIST BATTERY**

Remember to charge the battery as per manufacturer’s instructions – they do vary, (some need trickle charging). It is best to keep the battery on charge when not in use.

Most batteries will do 20 lifts before needing charging. (If the battery will only do a few lifts before needing charging, the battery needs replacing).

**Your Sling(s)**

**Number of Slings:**

|  |  |
| --- | --- |
| Make: |  |
| Model/Type: |  | Weight limit: |  |
| Size: |  |
| Date of Last Service: |  |

|  |  |
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| Make: |  |
| Model/Type: |  | Weight limit: |  |
| Size: |  |
| Date of Last Service: |  |

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| Make: |  |
| Model/Type: |  | Weight limit: |  |
| Size: |  |
| Date of Last Service: |  |

**SLING – WASHING INSTRUCTIONS**

Follow the manufacturer’s instructions.

The washing instructions are on the sling and the label must be readable. (If it is not; then phone the Customer Service Centre: 01522 782155 to request a new sling).

Your sling can be washed at a high temperature (see label) but do not tumble dry the sling.

**GENERAL POINTS FOR SAFE HOISTING**

GENERAL POINTS FOR HOISTING

1. Follow Moving and Handling Plan at all times.
2. Please check slings before each use.
3. When using the hoist – DO NOT RUSH.
4. Prepare – ensure all furniture/equipment is in place.
5. Watch the ‘boom’ – particularly when moving the hoist into position.
6. Before lifting up in sling ensure all correct loops are in place on the hoist bar.
7. As raising check arms/hands etc. are not going to become trapped.
8. Do not put brakes on hoist when hoisting – unless specifically advised to do so.
9. Hoisting is for transfers from bed to chair, etc., it is not for transporting.

If you are unsure – ask for help – ring the Customer Service Centre 01522 782111

**Photo/Picture (showing which loops to use)**



**SLING LOOP CONFIGURATION:**

Shoulder loops –

Leg loops –

Hip tapes –

Other –

**LINCOLNSHIRE INTER-AGENCY MOVING AND HANDLING GROUP**

**PERSON MOVING AND HANDLING ASSESSMENT (ADULTS)**

|  |  |
| --- | --- |
| **PERSON’S DETAILS** | **ASSESSOR DETAILS** |
| Name: | NHS No.: | D.O.B.: | Name:  |
| ICS No.:  |
| Location e.g. Home address//Day unit: | Designation: |
| Signature: |
| Height: | Weight: | Assessment date(s): | Review Date: |
| **Details of other people involved in the moving and handling assessment** |
| Name | Designation | Signature |
|  |  |  |
|  |  |  |
| **PART 1 - CHECKLIST OF HANDLING TASKS** |
| **TASK** | **CAN THE PERSON PERFORM THESE TASKS INDEPENDENTLY?** |
|  | **YES** | **NO** | **VARIABLE** | **N/A** | **COMMENTS** |
| **ROLLING IN BED** |  |  |  |  |  |
| **LYING TO SITTING IN BED** |  |  |  |  |  |
| **REPOSITIONING UP BED** |  |  |  |  |  |
| **GETTING INTO BED/OUT OF BED** |  |  |  |  |  |
| **GETTING ON/OFF A CHANGING BED** |  |  |  |  |  |
| **STANDING ⭤ SITTING (wheelchair)** |  |  |  |  |  |
| **STANDING ⭤ SITTING (chair)** |  |  |  |  |  |
| **STANDING ⭤ SITTING (bed)** |  |  |  |  |  |
| **STANDING** |  |  |  |  |  |
| **IN/OUT STANDER** |  |  |  |  |  |
| **WALKING** |  |  |  |  |  |
| **IN/OUT WALKER** |  |  |  |  |  |
| **LOWERING TO THE FLOOR** |  |  |  |  |  |
| **RAISING FROM THE FLOOR** |  |  |  |  |  |
| **STAIRS** |  |  |  |  |  |
| **STEPS** |  |  |  |  |  |
| **IN BATH/SHOWER** |  |  |  |  |  |
| **OUT BATH/SHOWER** |  |  |  |  |  |
| **ON TOILET/TOILETTING CHAIR** |  |  |  |  |  |
| **OFF TOILET/TOILETTING CHAIR** |  |  |  |  |  |
| **IN/OUT OF CAR** |  |  |  |  |  |
| **ON/OFF TRANSPORT**  |  |  |  |  |  |
| **IN/OUT OF SENSORY ROOM** |  |  |  |  |  |
| **REPOSITIONING SELF ON CHAIR**  |  |  |  |  |  |
| **MANOUEVERING WHEELCHAIR** |  |  |  |  |  |
| **OTHER TASKS – SPECIFY** |  |  |  |  |  |
| **IS THERE A HISTORY OF FALLS? YES/NO (PLEASE CIRCLE)****IF YES, PLEASE GIVE DETAILS BELOW INCLUDING CAUSATIVE FACTORS IF KNOWN.** |
| **PART 2 OF THE ASSESSMENT MUST NOW BE COMPLETED IF THE PERSON IS NOT INDEPENDENT IN ALL HANDLING TASKS** ***PART 2 COMPLETED ? ( Please tick )* *YES NO***  |
|  |

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| **PART 2** |
| **PERSON MOVING AND HANDLING ASSESSMENT**  |
| **Person’s Name:** **NHS No.:** |
| **D.O.B.: ICS No.:** |
| **Details of relevant medical condition/diagnosis:** |
|  |
| **Details of any moving and handling hazards in relation to the person’s physical condition e.g.****poor balance, pain in joints, muscle weakness:** |
| **Details of any mobility equipment, aids and appliances that the person uses e.g. walking aids,** **wheelchair etc.:** |
| **Details of other equipment, aids and adaptations that the person uses e.g. toilet/shower chair, profiling bed:** |
| **Details of any moving and handling hazards related to communication, comprehension or** **behaviour e.g. impaired hearing, poor vision, unpredictability**:  |
| **Person’s (or their representative) wishes and opinions:** |
| Do informal carers have physical limitations or medical problems which may affect their ability toperform moving and handling? YES/NO (PLEASE CIRCLE)  If YES please specify: *N.B. Staff with physical limitations or medical problems which may affect their ability to perform moving & handling safely must discuss the issues with their manager and action must be taken accordingly.* |
|  |
| **Assessment Date**: **Assessor’s Signature**: |
|  |

|  |
| --- |
| **Identify any problems relating to moving and handling and the environment:** |
|  |
| **Recommendations to improve the environment following the assessment:** |
|  |
| Is there any equipment required to safely perform any of the tasks? (please circle ) YES NO If **YES**, give details below: |
| **Equipment needed** | **Where to be obtained** | **Date requested & by whom** | **Equipment received****Sign and date** | **Any other actions required** |
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| **Additional comments / Action required:** |

**Assessor’s Signature:**

Assessment Review Date:

**Assessment Date:**

**MOVING AND HANDLING PLAN Sheet No.: 1 of**

**Person’s Name: D.O.B: NHS No.: ICS No.:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Task Description** | **Details of movement method to be used including equipment and techniques** | **No. of people (state designation)** | **Task duration & frequency** | **Assessors signature and date** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Information on this form should be used a guidance and each situation must still be assessed in case there are changes with the person or handling situation

**Handling Plan Review Date: ………………**

**PROBLEMS/DEFICIENCIESSHEET Sheet No. 1 of …**

**Person’s Name: D.O.B: NHS No.: ICS No.:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DETAILS OF REMAINING****PROBLEMS/DEFICIENCIES** | **ACTION/MEASURES NEEDED** | **PERSON REPORTED TO** | **REPORTED BY****(SIGN & DATE)** | **DATE RESOLVED****(SIGN & DATE)** |
|  |  |  |  |  |
|  |  |  |  |  |
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**REVIEW SHEET Sheet No.: 1 of**

**Person’s Name: D.O.B: NHS No.: ICS No.:**

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE OF REVIEW** | **REVIEWED BY** | **OUTCOME OF REVIEW****INCLUDING DETAILS OF ANY SIGNIFICANT CHANGES** | **ASSESSORS****SIGNATURE** |
|  |  |  |  |

IN SITUATIONS WHERE MAJOR CHANGES HAVE OCCURRED TO THE PERSON OR HANDLING SITUATION A NEW ASSESSMENT / HANDLING

PLAN MUST BE COMPLETED