H&H Care SA Pty Ltd	**Form14.** Safe Mobility Manual Handling and Falls Prevention **Australian Government Support at Home Program**	
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Policy and procedure 14
H&H Care SA Pty Ltd | Support at Home services

This policy sets out how H&H Care SA supports safe movement and independence, controls hazardous manual tasks and reduces falls and injury. It explains assessment, individual transfer instructions, equipment checks, worker competence and immediate post-fall response.

Document control	Details
Policy number	HH SAH MOVE 014
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Prepared	24 October 2026
Policy owner	Director and Clinical Lead RN
Approved by	Director: Huy Le RN: Thi Ngoc Bich Tran
Effective date	24 October 2026
Next review	12 months after approval, or earlier following relevant change
Applies to	Managers, nurses, workers and approved contractors assisting mobility or undertaking manual tasks in homes and the community

1 Purpose and scope

Support the client to move and participate as independently as safely possible. Falls prevention should preserve activity and choice, not create unnecessary restriction or deconditioning. Protect clients and workers through assessment, suitable equipment, adequate staffing and safe task design; body mechanics training alone does not control hazardous lifting.

This policy applies to Support at Home delivery on behalf of The Fig Trees and other approved registered providers. It covers walking, transfers, repositioning, equipment and relevant domestic, transport and community tasks. It does not replace specialist assessment, manufacturer instructions, clinical plans or practical training. No generic instruction in this policy authorises a transfer for an individual client.

2 Responsibilities

The Coordinator obtains assessments, confirms resources and schedules the required staff. The Clinical Lead RN reviews clinical risks and arranges appropriate assessment. Occupational therapists, physiotherapists and other competent practitioners specify mobility, equipment and transfer recommendations within scope. The Director ensures hazard controls, equipment arrangements, training and worker consultation.

Workers check the current plan and actual situation before each task, seek consent, follow assessed methods and stop when conditions are unsafe. Agree with The Fig Trees who obtains assessment, funding approval, equipment, maintenance and plan updates. The registered provider retains its statutory duties; H&H Care retains its own service and WHS obligations. A client or family signature cannot waive those duties.

Assessment and individual planning

3 Assess before assistance begins

Obtain a client-specific assessment proportionate to the task before relevant assistance. Record ability, goals, preferences, pain, cognition, communication, fatigue, weight-bearing capacity, balance, falls history, equipment and environment. Identify relevant health risks such as fainting, seizures, dizziness, vision problems, foot conditions and medication effects. Do not infer safe mobility from diagnosis alone or a previous worker's confidence.

A competent practitioner must assess complex transfers and equipment needs. Use the current clinical and functional recommendations, with any staffing, supervision and stop criteria. Resolve conflicting hospital, family or provider instructions before the affected task. Review after discharge, falls, near misses, deterioration, weight or equipment changes and requests for a different method.

4 Individual mobility and transfer plan

- Describe what the person can do independently and the assistance they want, including communication, consent and cultural or intimate care preferences.
- Specify each relevant task separately: bed mobility, sit-to-stand, chair, toilet, shower, vehicle, walking, stairs and floor recovery if assessed.
- State the method, prescribed aids, exact equipment/sling compatibility where applicable, required worker numbers and competencies, supervision and environmental setup.
- Record restrictions, weight-bearing directions, pain or fatigue limits and signs requiring a pause, RN review or emergency assistance.
- Identify equipment maintenance and pre-use checks, contingency if equipment fails, emergency contacts and review triggers.
- Link the assessment author/date, clinical instructions, service authorisation and current plan version; confirm worker acknowledgement.

A two-worker roster does not make an unsafe manual lift acceptable. Do not use family members as substitutes for required trained staff unless their role has been assessed, voluntarily agreed and formally approved with the registered provider and relevant practitioner. Never reduce staffing below the assessed plan because another worker is late or funding is unclear.

5 Client choice and refusal

Explain risks and options, support informed decisions and document agreed controls. Offer less restrictive alternatives and referral where a person's preferred method creates risk. Do not force care, use bedrails, belts or furniture to confine the person, or substitute sedation for assistance. Equipment that restricts movement requires assessment of restrictive-practice implications and applicable safeguards; consent alone does not establish lawful use.

If required controls are declined, pause the affected unsafe task, notify management and the provider and arrange safe essential care alternatives. Do not abandon the person or require a risk waiver as permission for unsafe practice.

Safe tasks equipment and worker competence

6 Before every movement task

- Confirm identity, current plan and consent. Check whether the client's ability, alertness, pain or willingness has changed and whether prescribed conditions for the task are met.
- Explain the sequence and agree a simple communication signal. Give time and encourage safe independent participation; do not rush or pull the person.
- Check space, lighting, surfaces, footwear, furniture, equipment and any tubes or lines. Remove hazards with consent and protect privacy.
- Confirm the required trained workers and equipment are present. Allocate roles and follow the assessed task and manufacturer instructions.
- Stop if the client becomes unwell, loses expected weight-bearing, resists, develops pain, the device fails or the task differs from the plan. Reassess and obtain help rather than improvising.

7 Hoists slings aids and wheelchairs

Use only equipment prescribed or assessed as suitable and for which workers have demonstrated competence. Check the client/device safe working load, correct sling type/size/attachment and compatibility using reliable instructions, and inspect straps, stitching, attachment points, controls, batteries, brakes and other relevant components. A generic sling or similar-looking attachment is not evidence of compatibility.

Follow device-specific instructions, including brake use, setup, attachments, staff positioning and emergency lowering. Do not impose one universal brake rule across all hoists and transfer devices. Keep a person under continuous safe supervision during an assisted transfer; do not leave them suspended in a hoist. Stop use of damaged or unverified equipment, label or isolate it safely and arrange assessment or replacement.

Wheelchairs, walking frames, transfer boards, belts, slide sheets and standing aids each require an assessed role and safe method. A standing aid is not suitable merely because the person can stand once. Do not pull someone by their arms or clothing, lift under the armpits or improvise a belt from household items. Vehicle and stair assistance need specific assessment and training; never carry a person or occupied wheelchair on stairs as an ordinary workaround.

8 Other hazardous manual tasks

Assess lifting, pushing, pulling, carrying, sustained or awkward postures and repetitive tasks during cleaning, bed making, laundry, shopping and moving equipment. Eliminate unnecessary handling, use suitable aids, reduce loads, arrange work height and space and seek assistance where needed. Do not use a fixed weight limit as the only risk test. Consult workers and reassess when the load, environment or task changes.

Keep documented practical competency assessments, refresher needs and supervision. Generic training attendance alone is insufficient for a client-specific hoist or transfer. Maintain equipment registers and arrange servicing under manufacturer and relevant requirements; a pre-use check does not replace scheduled maintenance.

Falls prevention and safe participation

9 Individual falls prevention approach

Assess the person's falls and near-falls history, circumstances, concerns, mobility, environment and relevant clinical factors with the client. Use a multifactorial approach; a risk score alone must not determine care or deny mobility. Identify goals and controls suited to the person and refer for professional assessment where needed.

Factor	Actions within approved roles and plans
Strength balance and confidence	Support prescribed exercise and activity with required supervision. Do not independently prescribe or increase exercise intensity.
Medicines dizziness and health	Report dizziness, fainting, sedation, new weakness or medication-related concerns; arrange RN/GP/pharmacist review. Do not alter doses.
Vision feet and footwear	Encourage appropriate glasses and well-fitting footwear; refer vision, foot or podiatry concerns through agreed pathways.
Environment and equipment	Improve lighting, clear trip hazards with consent, keep prescribed aids accessible and seek OT review for rails, bathroom or furniture changes.
Toileting and routines	Offer planned assistance and timely access to the toilet; avoid rushing, unsafe night transfers and leaving required aids out of reach.
Nutrition hydration and bone health	Support the agreed intake plan and report concerns. Seek professional advice on bone health and fracture prevention rather than adding supplements independently.
Communication and cognition	Use clear cues, familiar routines, sensory aids and supported decisions; reassess sudden confusion or behaviour changes clinically.
Community activity	Plan routes, surfaces, weather, transport, resting points and communication. Maintain participation using assessed support rather than blanket restrictions.

Discuss alarm or monitoring devices with consent, privacy safeguards and an actual response plan. They do not replace required supervision or guarantee prevention. Do not use restraint or a blanket stay-in-bed instruction as routine falls prevention. Review fear of falling and the effect of over-restriction on function and wellbeing.

10 Daily checks and changes

At each visit, check new illness, dizziness, fatigue, medication changes reported, footwear, walking aids, surfaces and lighting. Report near misses as well as falls. If current assistance is no longer sufficient, pause the affected task and contact the Coordinator/RN. Obtain an updated assessment, service approval and clear instructions before increasing assistance or changing equipment.

After a fall and immediate response

11 First response after a fall

- Ensure the area is safe, stay calm and check responsiveness and normal breathing. Call 000 for an emergency and provide first aid under training and dispatcher advice.
- Do not automatically lift or encourage the person to stand. Check for pain, bleeding, possible head/neck/back injury, deformity, reduced movement or new confusion and seek appropriate clinical assessment. Avoid unnecessary movement where serious injury is possible unless needed for immediate safety or life-saving care.
- Call 000 for serious injury, loss of consciousness, abnormal breathing, severe pain, suspected fracture/spinal injury, uncontrolled bleeding, stroke-like signs or other emergency concerns. Note the event time and last known well if relevant.
- Notify the RN and Coordinator promptly even when no injury is obvious. Describe whether witnessed, possible head strike, time on the floor, symptoms, baseline and known anticoagulant use. An unwitnessed fall or inability to recall events increases concern; do not assume no head injury.
- Obtain urgent clinical advice for actual or possible head injury, especially with anticoagulants or concerning symptoms. If the person deteriorates or timely assessment cannot be arranged safely, call 000. Follow the clinician's advice on transfer and monitoring.
- Keep the client comfortable, warm, reassured and safely supervised while waiting. Do not offer food, drink or medicines where consciousness, swallowing or urgent treatment needs make this unsafe.
- Assist from the floor only after appropriate assessment establishes that it is safe, using a specifically assessed floor-recovery method, competent workers and suitable equipment. If those conditions are absent, obtain professional assistance rather than an improvised manual lift.

12 Reporting monitoring and reassessment

Record what happened, actual observations, injuries or symptoms, contacts, advice, recovery/transfer method and outcome. Complete the incident report and post-fall record, notify The Fig Trees and follow Policy 9 for reportability assessment. A fall alone is not automatically SIRS-reportable, but neglect, force or other qualifying circumstances may make it reportable.

The RN or treating clinician determines the monitoring and review needed, including any neurological or other observations. Workers must not invent a monitoring schedule or undertake assessments outside competence. Arrange a safe person to perform required checks, with escalation thresholds and documented handover; do not leave monitoring to an unavailable family member.

Before the next affected movement task, reassess the likely cause and current ability and confirm safe interim instructions. Review health, medicines, equipment, environment and care delivery. Seek multidisciplinary input and involve the client. Track corrective actions, revise the plan and confirm workers have received it. Offer open disclosure if something went wrong and support confidence to resume appropriate activity.

Individual mobility and transfer plan template

MOVE F01 | Complete by competent assessors and relevant clinicians. Attach task-specific instructions. This blank form does not authorise a transfer.

Client and identifier: _____
Assessor name role and date: _____
Plan version and assessment source: _____
Goals communication consent and preferences: _____
Usual function current restrictions and weight-bearing directions: _____
_____

Task	Method equipment and staffing	Stop criteria and referral
Bed/chair/toilet/shower	_____ _____	_____ _____
Walking/stairs/community	_____ _____	_____ _____
Repositioning/vehicle	_____ _____	_____ _____
Floor recovery if assessed	_____ _____	_____ _____

Exact hoist/sling/aids size compatibility and instructions if relevant: _____
_____
Required staff numbers competencies and roles: _____
Equipment safety checks and maintenance responsibility: _____
Environment setup and risks: _____
Falls prevention actions and prescribed exercise reference: _____
_____
What to do if ability changes or equipment/staff unavailable: _____
_____
Clinical contact and emergency plan reference: _____
Client involvement disagreement or declined controls: _____
Registered provider authorisation/arrangements: _____
Assessor/RN review as relevant and approval: _____
Workers briefed and practical competence verified: _____
Plan accessible at: _____
Review date and earlier triggers: _____

If task details are incomplete or conflict with clinical or manufacturer instructions, pause the affected task and obtain clarification. No generic two-worker instruction makes manual lifting safe.

Equipment checks and post fall record

Pre use equipment and task checklist

MOVE F02 | Client/task: _____ Worker/date: _____

- Current assessed method, client consent and unchanged ability confirmed.
- Required competent workers available and roles agreed.
- Correct equipment/sling, size, compatibility and working load verified.
- Inspection, maintenance status, attachments and device function checked.
- Space, surfaces, footwear, communication and safety controls ready.
- Client-specific and manufacturer instructions, including brakes, followed.

Item/device ID and instruction reference: _____
Defect or unsafe condition and isolation action: _____
Manager notified and safe alternative: _____
Task allowed/paused and author: _____

Post fall record

MOVE F03 | Link incident form; do not delay first aid or clinical contact.

Client/reference: _____ Date/time/location: _____
Witnessed/unwitnessed; account and information source: _____
_____
Activity and equipment at time of event: _____
Found position time on floor and last known well if relevant: _____
Symptoms responsiveness breathing and observed injuries: _____
_____
Head strike or uncertainty and anticoagulant information source: _____
Emergency call/first aid and times: _____
RN/clinician assessment advice and time: _____
Recovery/transfer method and receiving professional: _____
Manager/provider and chosen contact notifications: _____
Monitoring plan responsible person and confirmed handover: _____
_____
Interim transfer instructions before next visit: _____
Reassessment/referral owner and due time: _____
Corrective actions effectiveness review and client feedback: _____
_____
Author and entry date/time: _____

Record only observations actually made. Absence of visible injury does not establish that no injury occurred. Seek urgent assessment and emergency help according to symptoms, risk and professional advice.

Implementation oversight and references

13 Implementation and monitoring

Before approval, identify competent assessors, confirm RN and allied health referral pathways, agree equipment and staffing responsibilities with The Fig Trees and verify the post-fall escalation pathway. Complete client-specific plans and training before assigning movement tasks. Align scheduled staff numbers, time and funding approvals with the assessed care need; escalate gaps instead of diluting controls.

As internal controls, workers perform pre-task checks each time; the Coordinator tracks equipment defects and outstanding high-risk reviews each service day. Management reviews falls, near misses, worker injuries and unsafe-task reports monthly and audits a risk-based sample of mobility plans, equipment and competencies quarterly. Review practical competency at least annually and sooner for new devices, changed tasks, incidents or observed gaps. Follow shorter manufacturer, clinical or legal requirements where applicable.

Reassess plans at least annually as an internal minimum and promptly after changes, incidents or discharge. Monitor both falls and participation: fewer recorded falls caused by unnecessary immobility is not a good outcome. Involve clients and workers in reviewing controls and share lessons without unnecessary identification. Verify corrective actions and maintain safe care continuity during remediation.

14 Records and related documents

Retain current mobility plans, assessment sources, client participation, risk controls, equipment checks/servicing, practical competencies, incident/post-fall records, monitoring instructions and review evidence. Use controlled systems under Policy 8. Report staff injuries and equipment failures through incident/WHS processes and assess separate notification obligations; do not assume a client fall automatically meets every scheme.

Related documents: Policies 1 to 13; WHS and hazardous manual tasks; clinical governance; equipment management; prescribed exercise; worker training and supervision; transport; restrictive-practice safeguards where applicable; emergency and continuity procedures.

15 References

- Australian Commission on Safety and Quality in Health Care — Preventing Falls and Harm from Falls in Older People, Best Practice Guidelines for Community Care, current version. https://www.safetyandquality.gov.au/resources/falls-guidelines-community-care
- Safe Work Australia — Hazardous manual tasks in health care and social assistance. https://www.safeworkaustralia.gov.au/book/health-care-and-social-assistance/hazards-risks-and-controls/hazardous-manual-tasks
- Safe Work Australia — Lifting pushing and pulling. https://www.safeworkaustralia.gov.au/safety-topic/hazards/lifting-pushing-and-pulling-manual-tasks
- healthdirect — Falls and head injuries. https://www.healthdirect.gov.au/accidents-and-injuries/falls and https://www.healthdirect.gov.au/accidents-and-injuries/head-injuries
- Aged Care Act 2024 and Rules 2025; Work Health and Safety Act 2012 (SA) and Regulations; applicable professional and equipment requirements; The Fig Trees agreement and approved variations.

Official guidance checked 24 October 2026. National guidance supports practice; apply South Australian legal requirements and current client-specific clinical and equipment instructions. This policy does not replace practical training or specialist assessment.

Director approval: _____ Clinical Lead RN approval: _____
Effective date: _____ Next review: _____
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