Please complete the following survey during unit safe patient handling walk-thru to observe and coach staff or when you are performing a patient handling task.

**Instructions for Use for example:**

* Insert schedule for conducting audits
* Where to access audit forms
* Where to return completed audits

**Questions?** Contact XXXX at ext: or email

**Unit/Dept \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time\_\_\_\_\_\_\_\_\_\_\_\_\_**

**# of Caregivers Present \_\_\_\_\_\_\_ Role (circle): RN CNA PT Technician Other**

**Pt Gender M F Pt weight \_\_\_\_\_\_\_\_kg**

|  |  |  |
| --- | --- | --- |
| **Question (circle response):** |  | **Comments (Concerns, Problems,**  **Recommendations, Positive Feedback)** |
| 1. Did the task require equipment (per patient handling algorithm)?   1 = Yes  2 = No |  |  |
| 1. Type of task performed?   1 = Transfer e.g. bed to chair, chair to commode, etc.  2 = Lateral supine transfer (e.g. bed to gurney)  3 = Repositioning in bed  4 = Lifting/holding limbs  5= Ambulation from bed or chair  6 = Other, describe |  |  |
| 1. Was equipment used?   1 = Yes 3 = Equipment not needed.  2 = No 4 = Should have been used, but was not (describe why not in  comments) |  |  |
| 1. What equipment was used?   1 = Ceiling Lift 2 = Floor Lift  3 = Sit to Stand 4 = Friction Reducing sheet or Air Assist device e.g.  Hovermatt  5 = HoverJack 6 = Other (please note) 7 = Equipment not needed |  |  |
| 1. Was the equipment used properly?   1 = Yes  2 = No  3 = Equipment not needed.  ***If equipment not needed skip to question ‘I’*** |  |  |
| 1. Was a sling inspection conducted before performing the task?   1 = Yes  2 = No  3 = Sling not needed.  ***If sling not needed then skip to question ‘I’*** |  |  |
| 1. Was appropriate sling used?   1 = Yes  2 = No |  |  |
| 1. Was correct sling size used?   1 = Yes  2 = No |  |  |
| **Question (circle response):** |  | **Comments (Concerns, Problems,**  **Recommendations, Positives)** |
| 1. Correct work practices were performed? (circle Y or N) 2. Performed patient mobility check/assessment (e.g. before a vertical transfer to/from bed to chair, chair to chair, etc.)? **Y N** 3. Cleared work space of clutter? **Y N** 4. Assembled all equipment needed before starting lift/task? **Y N** 5. Explained task to patient? **Y N** 6. Placed bed at correct work height for task? **Y N** 7. Did not reach over raised bed rails? **Y N** 8. Did not reach over midline of patient’s body if logrolling? **Y N** |  |  |
| 1. Was equipment cleaned if used on another patient? (e.g. Sit to Stand device/Floor Lift/wipable belts or slings)   1 = Yes  2 = No  3 = Not applicable |  |  |
| 1. Was equipment working properly? (battery was charged; sling was not damaged etc)   1 = Yes  2 = No  3 = Equipment not needed. |  |  |

**Observer Feedback**

**1. Do you feel that the *SPM Program* is currently being accepted and used on this unit (primary staff involved)? Yes No**

**2. Since the last walk-through, have staff identified any problems or made any recommendations regarding the program?**

**Yes No If Yes, what have they identified?**

**3. Please offer any additional comments or concerns regarding the SPM Program or the interventions in space below.**

**Patient/Family Feedback (ask patient or family member following completion of lift, transfer or repositioning task)**

|  |  |  |
| --- | --- | --- |
| **Patient Feedback** |  | **Comments (Concerns, Problems, Recommendations, Positives)** |
| Were you moved using equipment?  1 = Yes  2 = No |  |  |
| Were you comfortable during the transfer?  1 = Yes  2 = No  3 = Unable to self report. |  |  |
| Did you feel safe during the transfer?  1 = Yes  2 = No |  |  |
| Did you receive education about the equipment prior to its use?  1 = Yes  2 = No |  |  |