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 = Yes2 = 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 bed4 = Lifting/holding limbs5= Ambulation from bed or chair6 = 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.  Hovermatt5 = HoverJack 6 = Other (please note) 7 = Equipment not needed  |  |  |
| 1. Was the equipment used properly?

1 = Yes2 = No3 = Equipment not needed.***If equipment not needed skip to question ‘I’*** |  |  |
| 1. Was a sling inspection conducted before performing the task?

1 = Yes2 = No3 = Sling not needed.***If sling not needed then skip to question ‘I’*** |  |  |
| 1. Was appropriate sling used?

1 = Yes2 = No |  |  |
| 1. Was correct sling size used?

1 = Yes2 = 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 = Yes2 = No3 = Not applicable |  |  |
| 1. Was equipment working properly? (battery was charged; sling was not damaged etc)

1 = Yes2 = No3 = 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 = Yes2 = No |  |  |
| Were you comfortable during the transfer?1 = Yes2 = No3 = Unable to self report. |  |  |
| Did you feel safe during the transfer?1 = Yes2 = No |  |  |
| Did you receive education about the equipment prior to its use?1 = Yes2 = No |  |  |