SAMPLE - SAFE PATIENT HANDLING OBSERVATION SURVEY-AUDIT

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)
A. Did the task require equipment (per patient handling algorithm)? 1 = Yes 2 = No		
B. 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		
C. Was equipment used? 1 = Yes 3 = Equipment not needed. 2 = No 4 = Should have been used, but was not (describe why not in comments)		
D. 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		
E. Was the equipment used properly? 1 = Yes 2 = No 3 = Equipment not needed. ***If equipment not needed skip to question 'I'***		
F. 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'***		
G. Was appropriate sling used? 1 = Yes 2 = No		
H. Was correct sling size used? 1 = Yes 2 = No		

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Question (circle response):		Comments (Concerns, Problems, Recommendations, Positives)
I. Correct work practices were performed? (circle Y or N) i. Performed patient mobility check/assessment (e.g. before a vertical transfer to/from bed to chair, chair to chair, etc.)? **Y N** ii. Cleared work space of clutter? **Y N** iii. Assembled all equipment needed before starting lift/task? **Y N** iv. Explained task to patient? **Y N** v. Placed bed at correct work height for task? **Y N** vi. Did not reach over raised bed rails? **Y N** vii. Did not reach over midline of patient's body if logrolling? **Y N**		
J. 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		
K. 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		