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| **SAFE HANDLING & MOBILITY AUDIT** |
| **Date & Time:**  | **Area Observed:** |
| **Audit Completed By:**  | **Staff Observed:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **(E) ENVIRONMENT** |  |  |  |
| **YES** | **PARTIAL** | **NO** |
| Clutter/Obstacles removed from workspace |  |  |  |
| Lighting levels are appropriate for the task(s) at hand |  |  |  |
| Bed is properly positioned (i.e. bed moved away from wall for access to both sides; bed height raised or lowered to staff’s/resident’s ideal position) |  |  |  |
| All appropriate equipment (for the task at hand) is assembled prior to starting activity |  |  |  |
| All equipment is properly secured. (i.e. bedrails are lowered, wheelchair locked activated, etc.) |  |  |  |
| Comments: |
| **(C) COMMUNICATION** |  |  |  |
| **YES** | **PARTIAL** | **NO** |
| Staff communicate presence and activity in a way appropriate for resident awareness and/or understanding.  |  |  |  |
| Staff communicate with one another if resident requires 2 person care |  |  |  |
| Comments: |
| **(A) AGGRESSION/AGITATION** |  |  |  |
| **YES** | **PARTIAL** | **NO** |
| Staff assess resident for signs of aggression/agitation.  |  |  |  |
| Based on assessment, and if required, staff adjust their work or STOP the activity.  |  |  |  |
| Comments: |
| **(P) PHYSICAL**What activity(s) are you observing?i.e. ceiling/Hoya lift; sit to stand lift; in bed repositioning; 1 or 2 person transfer; etc. |
| **Activity(s) Observed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **YES** | **PARTIAL** | **NO** |
| The movement activity being completed is appropriate, as per the resident’s current function |  |  |  |
| Equipment is prepared in accordance with the activity *(i.e. chair in proper location, brakes applied where necessary, armrests/footrests/headrests removed)* |  |  |  |
| All equipment used during the activity was pre-inspected before use.  |  |  |  |
| Appropriate number of staff is/are present for the activity.  |  |  |  |
| Staff are using appropriate body mechanics throughout the task. |  |  |  |
| Staff correctly followed organization’s safe work practices during the task. |  |  |  |
| Comments: |
|  |
| **AUDIT FOLLOW-UP** **Date *(if different)*:\_\_\_\_\_\_\_\_\_\_\_\_\_**  |  |
| **YES** | **PARTIAL** | **NO** |
| If adjustments to resident care were necessary, were all resident information documents updated?  |  |  |  |
| Were audit results shared with staff member(s)? |  |  |  |
| Were corrective actions recommended and documented? |  |  |  |
| Please list corrective actions implemented, or underway, as a result of the audit. |
| Additional Comments: |