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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 positioned in necessary position (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 |  |  |  |
| Appropriate equipment is secured. (i.e. bedrails are lowed, wheelchair locked activated, etc.) |  |  |  |
| Comments: |
| **(C) COMMUNICATION** |  |  |  |
| **YES** | **PARTIAL** | **NO** |
| Staff initiates communication using appropriate means with the resident and they are aware staff are present |  |  |  |
| Staff communicate with one another if resident requires 2 person care? |  |  |  |
| Comments: |
| **(A) AGGRESION/AGITATION** |  |  |  |
| **YES** | **PARTIAL** | **NO** |
| Staff assesses resident for signs of aggression/agitation.  |  |  |  |
| \*If signs of aggression/agitation are present, staff make adjustments as required or STOP current activities. |  |  |  |
| Comments: |
| **(P) PHYSICAL**What task are you observing?i.e. ceiling/hoya lift; sit to stand lift; in bed repositioning; 1 or 2 person transfer; etc. |
| **Task Observed:** | **YES** | **PARTIAL** | **NO** |
| The movement task being completed is appropriate, as per the resident’s current function |  |  |  |
| Is the equipment 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 present for the activity.  |  |  |  |
| Staff are using appropriate body mechanics throughout the task. |  |  |  |
| For the task being observed, staff followed outlined safe work practices as detailed in the organization’s policies and procedures.  |  |  |  |
| Comments: |
|  |
| **AUDIT FOLLOW-UP** **Date *(if different)*:\_\_\_\_\_\_\_\_\_\_\_\_\_**  |  |
| **YES** | **PARTIAL** | **NO** |
| If adjustments to resident care were necessary, did staff take proper steps to update **ALL** resident information (i.e. care plan, assessment request, etc.) |  |  |  |
| Were audit results shared with staff member(s)? |  |  |  |
| Were corrective actions recommended *(please list)* and documented? |  |  |  |
| Additional Comments: |