To learn more about using this tool refer to the Section 8 in the Safe Patient Handling and Mobility: A Toolkit for Program Development 2025 at: https://www.nvha.net/safe-patient-handling-and-mobility-toolkit/

SPHM Post Implementation Audit Tool

Add Instructions for Use - include:

- Schedule for conducting audits
- Where to access audit forms
- Where to return completed audits
- How to use form e.g. 'Please complete the following survey when you observe and coach staff during unit safe patient handling & mobility walk-through or when you are performing a patient handling task.

Questions? Contact the SPHM Program Coordinator (name & email/phone) at

Unit/Dept: _____ ***Date:*** _____ ***Shift:*** _____

Audit completed by (name): _____ ***Role in SPHM program (e.g. unit champion/coach/ committee members/program coordinator/other)*** _____

RN/CNA/Therapist/Technician Other please specify: _____

Patient Room # _____ ***Patient weight*** _____***lbs***

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)	

Question (circle response):	Comments (Concerns, Problems, Recommendations, Positive Feedback)
D. What equipment was used? 1 = Ceiling Lift 2 = Floor Lift 3 = Sit to Stand 4 = Friction Reducing sheet or Air Assist device *(list devices available)* 5 = Other (please note) 6 = Equipment not needed	
E. Was the equipment used properly? 1 = Yes 2 = No 3 = Equipment not needed. ***If equipment is <u>not needed,</u> skip to question 'I'***	
F. Was a sling inspection conducted before performing the task? 1 = Yes 2 = No 3 = Sling not needed. ***If sling is <u>not needed,</u> then skip to question 'I'***	
G. Was appropriate sling used? 1 = Yes 2 = No	
H. Was correct sling size used? 1 = Yes 2 = No	
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 workspace 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/wipeable 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 *(circle response)*

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**		

Comments

_____

_____

_____