

ASSESSMENT CRITERIA AND CARE PLAN FOR SAFE PATIENT HANDLING AND MOVEMENT

I. Patients Level of Assistance

- Independent—Patient performs task safely, with or without staff assistance, with or without assistive device.
- Partial Assist—Patient requires no more help than standby, cueing, or caregiver is required to lift no more than 35 lbs of a patient's weight.
- Dependent—Patient requires nurse or caregiver to lift more than 35 lbs of the patient's weight, or patient is unpredictable in the amount of assistance offered. In this case, devices must be used.

An assessment should be made prior to each task if the patient has varying level of ability due to medical reasons, fatigue, medications, etc. When in doubt, assume the patient cannot assist with the transfer/repositioning.

II. Weight Bearing

- Full
- Partial
- None

III. Bilateral Upper-Extremity Strength

- Yes
- No

IV. Patient's Level of Cooperation and Comprehension

- Cooperative—May need prompting, able to follow simple instructions.
- Unpredictable or varies—Not cooperative or unable to follow simple commands.
(patient whose behavior changes frequently should be considered unpredictable)

V. Weight: _____ Height: _____

Body Mass Index (BMI) is needed if patient's weight is over 300 lbs. If BMI exceeds 50, institute Bariatric Algorithms.



The presence of the following conditions is likely to affect the transfer/repositioning process and should be considered when identifying the equipment and techniques needed to move a patient or resident.

VI. Check applicable conditions likely to affect transfer/repositioning techniques.

- | | |
|--|--|
| <input type="checkbox"/> Hip/Knee Replacement | <input type="checkbox"/> Respiratory/Cardiac Compromise |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> History of Falls |
| <input type="checkbox"/> Splints/Traction | <input type="checkbox"/> Wounds Affecting Transfer/Positioning |
| <input type="checkbox"/> Paralysis/Paresis | <input type="checkbox"/> Amputation |
| <input type="checkbox"/> Severe Osteoporosis | <input type="checkbox"/> Unstable Spine |
| <input type="checkbox"/> Urinal/Fecal Stoma | <input type="checkbox"/> Severe Pain/Discomfort |
| <input type="checkbox"/> Severe Edema | <input type="checkbox"/> Contractures/Spasms |
| <input type="checkbox"/> Postural Hypotension | <input type="checkbox"/> Very Fragile Skin |
| <input type="checkbox"/> Tubes (IV, Chest, etc.) | |

Comments: _____

VII. Appropriate Lift/Transfer Devices Needed:

Vertical Lift: _____

Horizontal Lift: _____

Other Patient Handling Devices Needed: _____

Sling Type: Seated Seated (Amputee) Standing Ambulation

Limb Support Sling Size _____

Signature: _____

Date: _____