NYSIF® New York State Insurance Fund
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SAFETYPRINCIPLES

HEALTHCARE | EMPLOYER GUIDE

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 35lbs. 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

a.___ Full

b.___ Partial

c.___ None

III. 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 (patient whose behavior changes frequently should be considered unpredictable), not cooperative or unable to follow simple commands.

V. Weight: _________ Height: __________

Bass Mass Index (BMI) - <needed if patients weight is over 300lbs>
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 equipment and technique needed to move a patient/resident.

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

___Hip/Knee replacement
___ Fractures
___ Splints/Traction
___ Paralysis/paresis
___ Severe osteoporosis
___ Urinal/fecal stoma
___ Severe edema
___ Postural Hypotension
___ Tubes (IV, chest, etc.)
___ Respiratory/Cardiac compromise
___ History of Falls
___ Wounds affecting transfer/positioning
___ Amputation
___ Unstable spine
___ Severe Pain/discomfort
___ Contractures/spasms
___ Very fragile skin

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: __________________