

**A-5**  
**Site Visit Unit Data Collection Tool**

*Type of Unit:* \_\_\_\_\_

*Facility:* \_\_\_\_\_

**Part I – SPACE/MAINTENANCE/STORAGE**

- a. Describe Unit, including # beds, room configurations (private, semi-private, 4-bed, etc.), and bathrooms:

# rooms w/ 2 beds: \_\_\_\_\_ w/ 3 beds: \_\_\_\_\_ w/ 4 beds: \_\_\_\_\_ private: \_\_\_\_\_

Bathrooms: In room?\_\_\_ Community?\_\_\_ Use Tub?\_\_\_ Bathing Chair? \_\_\_Other?\_\_\_

Draw/describe room configuration (on back, if needed).

- b. Describe current storage conditions and problems you have with storage. If new equipment were purchased, where would it be stored?
- c. Identify anticipated changes in the physical layout of your unit, such as planned unit renovations *in next 2 yrs.*
- d. Describe space constraints for patient care tasks & use of portable equipment; focus on patient rooms, bathrooms, shower/bathing areas. *Are typical room doorways narrow or wide?? Does the threshold uneven?*
- e. Describe any routine equipment maintenance program or process for fixing broken equipment. What is the Reporting Mechanism/ procedure for identifying, marking, and getting broken equipment to shop for repair? *Is equipment on a PM schedule?*
- f. If potential for installation of overhead lifting equipment exists, describe any structural factors that may influence this installation, such as structural load limits, presence of asbestos, etc.

**Part II - STAFFING**

a. List your existing FTEE, typical number of filled positions, & typical staffing.

FTEE Assigned Ceiling: \_\_\_\_ RN \_\_\_\_ LPN \_\_\_\_ NA  
\_\_\_\_ Transport \_\_\_\_ Other (list)

Typical positions filled: \_\_\_\_ RN \_\_\_\_ LPN \_\_\_\_ NA  
\_\_\_\_ Transport \_\_\_\_ Other (list)

Typical Staffing: M – F nights:\_\_\_\_ days:\_\_\_\_ eves:\_\_\_\_

Weekend nights:\_\_\_\_ days:\_\_\_\_ eves:\_\_\_\_

Odd schedules:\_\_\_\_\_

Shift: 8 hour? \_\_\_\_\_ 12 hour? \_\_\_\_\_ Other? \_\_\_\_\_

b. Peak Lift Load Times (Think about the time of day that's the busiest. What is the # of staff that would be lifting at same time):

c. What are the typical patient care assignments?

Single Staff Member?\_\_\_\_ Team\_\_\_\_ Shower/Lifting/Tech? \_\_\_\_\_

d. Discuss projected plans or upcoming changes in staffing, patient population, or bed closures in next two years.

**Part III - PATIENTS/RESIDENTS**

a. Describe the patients/residents on your unit.

b. Average Unit population characteristics (#hospice beds, Alzheimer beds, TBI beds, etc.) and variability in this.

c. Discuss proposed changes in the average daily census over the next two years.

- d. Identify typical distribution of patients by physical dependency level according to the definitions below. (**Base on PHYSICAL LIMITATIONS not on clinical acuity**)

*Note: This is not the same as patient acuity. The total for the 5 categories should equal your average daily census.*

- \_\_\_\_\_ **Total Dependence** – Cannot help at all with transfers, full staff assistance for activity during entire seven-day period. Requires total transfer at all times.
- \_\_\_\_\_ **Extensive Assistance** – Can perform part of activity, usually can follow simple directions, may require tactile cueing, can bear some weight, sit up with assistance, has some upper body strength, or may be able to pivot transfer. Over the last seven-day period, help provided three or more times for weight-bearing transfers or may have required a total transfer.
- \_\_\_\_\_ **Limited Assistance** – Highly involved in activity, able to pivot transfer and has considerable upper body strength and bears some weight on legs. Can sit up well, but may need some assistance. Guided maneuvering of limbs or other non-weight bearing assistance three or more times, or help provided one or two times during the last seven days.
- \_\_\_\_\_ **Supervision** – Oversight, encouragement, or cueing provided three or more times during the last seven days or physical assistance provided only one or two times during the last seven days.
- \_\_\_\_\_ **Independent** – Can ambulate normally without assistance in unusual situations may need some limited assistance. Help or oversight may have been provided only one or two times in the last seven days.

- e. Have ALL staff complete: **Tool for Prioritizing High-Risk Patient Handling Tasks**

#### Part IV - PATIENT HANDLING INJURIES

**Complete: Patient Care Incident/Injury Profile**

#### Part V - EQUIPMENT

- a. Provide inventory of all patient care equipment; describe working condition and how frequently equipment is used. **Complete: Unit Patient Handling Equipment Inventory**
- b. What percent of high-risk tasks are completed using proper equipment? Why?
- c. Perception of Problem Areas – what do you think are your problem areas?
- d. What equipment do you think you need?

Person Completing Report: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Contact #: \_\_\_\_\_

### Tool for Prioritizing High-Risk Patient Handling Tasks

**Directions:** Assign a rank (from 1 to 10) to the tasks you consider to be the highest risk tasks contributing to musculoskeletal injuries for persons providing direct patient care. A “1” should represent the highest risk, “2” for the second highest, etc. For each task, consider the frequency of the task (high, moderate, low) and musculoskeletal stress (high, moderate, low) of each task when assigning a rank. Delete tasks not typically performed on your unit. You can have each nursing staff member complete the form and summarize the data, or you can have staff work together by shift to develop the rank by consensus.

TASK FREQUENCY H= high M= moderate L= low	STRESS OF Task H= high M= moderate L= low	RANK 1= high-risk 10= low risk	PATIENT HANDLING TASKS
			Transferring patient from bathtub to chair
			Transferring patient from wheelchair or shower/commode chair to bed
			Transferring patient from wheelchair to toilet
			Transferring a patient from bed to stretcher
			Lifting a patient up from the floor
			Weighing a patient
			Bathing a patient in bed
			Bathing a patient in a shower chair
			Bathing a patient on a shower trolley or stretcher
			Undressing/dressing a patient
			Applying antiembolism stockings
			Lifting patient to the head of the bed
			Repositioning patient in bed from side to side
			Repositioning patient in geriatric chair or wheelchair
			Making an occupied bed
			Feeding bed-ridden patient
			Changing absorbent pad
			Transporting patient off unit
			Other Task:

Adapted from Owen, B.D. & Garg, A. (1991). *AAOHN Journal*, 39, (1).

## PATIENT CARE INCIDENT/INJURY PROFILE

**FACILITY:** \_\_\_\_\_

**UNIT:** \_\_\_\_\_

**DATES INCLUDED:** \_\_\_\_\_

**DATE COMPLETED:** \_\_\_\_\_

<b>Patient Care Activity</b> (reposition, bathe, transfer, etc.)	<b>Cause of Injury</b> (pull, push, reach, struck, etc.)	<b>Type of Injury</b> (strain/sprain, contusion, struck, etc.)	<b>Body Part/s</b> (upper/mid/lower back, legs, neck, etc.)	<b>Location</b> (pt. room, hall, sun-room, etc.)	<b>Lost Time</b> (# days)	<b>Modified Duty</b> (# days)
Ex: Repositioning (side to side)	Reaching, pulling residents all night – shoulder hurting	S/S	Shoulder	<u>Pt Room</u>	No	4 days

**#1 Cause:** \_\_\_\_\_ **#1 Activity:** \_\_\_\_\_ **Modified Duty Trend?** \_\_\_\_\_

**#2 Cause:** \_\_\_\_\_ **#2 Activity:** \_\_\_\_\_ **Lost Time Trend?** \_\_\_\_\_

**UNIT PATIENT CARE EQUIPMENT INVENTORY**

Unit: \_\_\_\_\_

Facility: \_\_\_\_\_

Date Completed: \_\_\_\_\_

<b>PATIENT CARE EQUIPMENT</b>	Manufacturer/Style/Name (Ex: Arjo Maxi Move)	Inventory (Total # you have now)	In working order?	Use (% being used now) Comment:	<u># Requested</u>
<p><u><i>FULL BODY SLING LIFTS</i></u> <i>Floor-based, Powered Lifts</i>  <i>Ex: Arjo Maxi Move</i></p>					
<p><i>Floor-based, Non-Powered Lifts</i>  <i>Ex: Hoyer</i></p>					
<p><u><i>Ceiling Mounted Lifts</i></u>  Ex: BHM Voyager</p>					
<p><i>Bathing Lifts</i></p>					
<p><u><b>LATERAL TRANSFER AIDS</b></u>  <b><i>Mechanical Lateral Transfer Aids</i></b>  Ex: Mobilizer, Totalift II, On-3</p>					
<p><i>Friction Reducing Lateral Sliding Aids</i>  Ex: Sliding/Surf Boards, RTA, Phili slide</p>					
<p><i>Air Assisted Lateral Transfer Aids</i>  <i>Ex: AirPal; Hovermat</i></p>					

<b>PATIENT CARE EQUIPMENT</b>	Manufacturer/Style/Name (Ex: Arjo Maxi Move)	Inventory (Total # you have now)	In working order?	Use (% being used now) Comment:	<u># Requested</u>
<u>TRANSFER CHAIRS</u> Ex: Transitchair					
<b>DEPENDENCY CHAIRS</b> Ex: Broad, Geri-chair					
<u>POWERED STANDING ASSIST &amp; REPOSITIONING LIFTS</u> Ex: Translift, Raisa Lift					
<u>STANDING ASSIST &amp; REPOSITIONING AIDS (Non- Powered)</u> Ex: Super/Pivot Pole, Bed-Bar					
<u>GAIT BELTS</u> <u>With Handles</u>					
<b>OTHER</b>					