Incident Report – SPHM Supplement

Follow Up for Incidents During Patient Assisting, Transferring and Repositioning

Name of Employee(s): ___________________________ Date of Incident: ___________________________

This report will be completed by the injured employee and supervisor providing detailed information as requested.

1. Have any other staff injuries, patient falls or patient injuries occurred in the last 24 months as a result of moving this patient? ☐ Yes ☐ No If so, how many: ___________________________

2. In the employee’s words, describe in detail how the patient was lifted, transferred or handled: ___________________________

3. Were correct transferring, handling techniques and good body mechanics used? ☐ Yes ☐ No If no, please explain: ___________________________

4. What transfer technique/level of assistance was identified on the patient’s care plan? ___________________________

5. Did employees communicate steps with each other prior to moving the patient? ☐ Yes ☐ No ☐ N/A (Check N/A only if one employee was involved in the move.) If no, please explain: ___________________________

6. Were the steps communicated with the patient involved, so patient was fully aware of what was occurring and was involved in the process? ☐ Yes ☐ No If no, please explain: ___________________________

7. Was the patient encouraged to help if possible (i.e. when moving patient in bed, patient was encouraged to bend their knees so patient could assist by pushing backwards when instructed to)? ☐ Yes ☐ No If no, please explain: ___________________________

Our safety evaluations, reports and recommendations are made solely to assist your organization in reducing hazards and the potential of hazards and accidents. These recommendations were developed from conditions observed and information provided at the time of our visit. They do not attempt to identify every possible loss potential, hazard or risk, nor do they guarantee that workplace accidents will be prevented. These safety evaluations, reports and recommendations are not a substitute for ongoing, well-researched internal safety and risk management programs. This report does not warrant that the property inspected and its operations are compliant with any law, rule or regulation.

United Heartland is the marketing name for United Wisconsin Insurance Company, a member of AF Group. All policies are underwritten by a licensed insurer subsidiary of AF Group.
8. Was the patient in the correct position prior to moving them (i.e. when transferring a patient from the bed to a chair once patient is sitting on edge of bed, patient’s feet are flat on the floor with one foot slightly in front of the other)?

☐ Yes  ☐ No  If no, please explain: ________________________________

9. Was the wheelchair, shower chair, height of bed, brakes, etc. in the correct position prior to moving the patient?

☐ Yes  ☐ No  If no, please explain: ________________________________

10. If repositioning in bed, were the side rails down, bed at appropriate height, transfer sheet used and employee on the appropriate side of the patient (not reaching across patient)?

☐ Yes  ☐ No

If no, please explain: ________________________________

11. What equipment was used to assist in the move, such as gait belt, transfer sheet, mechanical lift, etc.: __________

________________________________________________________________________

12. Was mandatory equipment used (i.e. mechanical lift, gait belt, transfer sheet, etc.)?  ☐ Yes  ☐ No  ☐ N/A

If no, please explain: ________________________________

13. If equipment was used, was it used correctly?  ☐ Yes  ☐ No  ☐ N/A

If no, please explain: ________________________________

14. If equipment was used, was it in good operating condition?  ☐ Yes  ☐ No  ☐ N/A

If no, please explain: ________________________________

15. If equipment was not used, could it have been helpful?  ☐ Yes  ☐ No

Please explain the yes or no answer: ________________________________
16. How many employees assisted in the transfer? ___________________________________________

17. Was the number of employees assisting in the transfer adequate to prevent injuries to patients and employees?  
☐ Yes  ☐ No  If yes, please explain: ______________________________________________________

18. Were there obstructions or other hazards that were injurious or in the way?  ☐ Yes  ☐ No  
If yes, please explain: ________________________________________________________________

19. Has patient’s abilities changed and patient needs to be re-evaluated for determination of appropriate use of 
assistive devices and moving techniques?  ☐ Yes  ☐ No  
If yes, please explain: ________________________________________________________________

20. Was patient combative or resistant to the transfer?  ☐ Yes  ☐ No  
If yes, please explain: ________________________________________________________________

21. What type of footwear was the employee wearing? ________________________________________

22. Was the footwear suitable for the task the employee was performing?  ☐ Yes  ☐ No  
If no, please explain: ________________________________________________________________

Signature of Employee: ________________________________________  Date: ________________

Signature of Supervisor: ________________________________________  Date: ________________