

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

## Equipment Needs Analysis

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

# Equipment Needs Evaluation Form

### Unit Characteristics

How many beds are there in this unit? \_\_\_\_\_

Is there adequate equipment storage space on this unit? \_\_\_\_\_

Does the available storage space have electrical outlets? \_\_\_\_\_

### Census

What is the average daily census in this unit? \_\_\_\_\_

How many RNs during day shift/night shift? \_\_\_\_\_ / \_\_\_\_\_

How many Nurse's Aids during day shift/night shift? \_\_\_\_\_ / \_\_\_\_\_

What percentage of your patients would be considered "No Lift"? \_\_\_\_\_

### Patient Population

On average., how many of your patients are considered "max assist"? \_\_\_\_\_

On average, how many bariatric patients are you caring for on a daily basis? \_\_\_\_\_

What percentage of your patients are on IV or ENT therapy? \_\_\_\_\_

What percentage of your patients are able to shower? \_\_\_\_\_

Please indicate what percentage of patients fall within each weight category.

< 100 lb. \_\_\_\_\_

100 -200 lb. \_\_\_\_\_

200-250 lb. \_\_\_\_\_

250-300 lb. \_\_\_\_\_

> 300 lb. \_\_\_\_\_

### Injuries

How many employee injuries were reported in this unit over the last calendar year? \_\_\_\_\_

How many employee injuries have been reported in this unit YTD this year? \_\_\_\_\_

What percentage of those injures are considered musculoskeletal in nature? \_\_\_\_\_

### Patient Handling - Type

How many patient transports are performed using a stretcher each day? \_\_\_\_\_

How many patient transports are performed using a wheelchair each day? \_\_\_\_\_

How many patient transports are performed using the patients bed each day? \_\_\_\_\_

Are patient transports performed using any other device? \_\_\_\_\_

If so, what type of device? \_\_\_\_\_

How many of the following patient assist maneuvers are performed each day?

Repositioning \_\_\_\_\_

Turning \_\_\_\_\_

Weighing \_\_\_\_\_

Dressing \_\_\_\_\_

Ambulation \_\_\_\_\_

Toileting \_\_\_\_\_

Personal Hygiene \_\_\_\_\_

Wound Care \_\_\_\_\_

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### Patient Handling - Vertical Lifts

How many **vertical** patient lifts are performed each day? \_\_\_\_\_

What percentage of vertical lifts are performed only to weight the patient? \_\_\_\_\_

What percentage of vertical lifts are performed for linen change or patient hygiene? \_\_\_\_\_

What percentage of vertical lifts are performed to put the patient on the commode or toilet? \_\_\_\_\_

What percentage of vertical lifts are performed to get the patient in to /out of a wheelchair? \_\_\_\_\_

### Patient Handling - Lateral Transfer

How many **lateral** patient transfers are performed each day? \_\_\_\_\_

What percentage of lateral transfers are bed to stretcher to bed? \_\_\_\_\_

What percentage of lateral transfers are bed to chair to bed? \_\_\_\_\_

### Patient Handling Equipment

Please indicate how many of each type of equipment is presently in use on this unit: \_\_\_\_\_

Vertical Lift \_\_\_\_\_

Lateral Transfer \_\_\_\_\_

Sit-to-Stand Lifts \_\_\_\_\_

Ceiling Track Lifts \_\_\_\_\_

Bath/Shower Lifts \_\_\_\_\_

Transfer Boards \_\_\_\_\_

Roller Boards \_\_\_\_\_

Slip Sheets \_\_\_\_\_

Air Mattress \_\_\_\_\_

Pivot Discs \_\_\_\_\_

Sheet Puller \_\_\_\_\_

Gait Belts \_\_\_\_\_

Other \_\_\_\_\_

None \_\_\_\_\_

Is the patient handling equipment in place on this unit used routinely? \_\_\_\_\_

If not used routinely, please indicate why \_\_\_\_\_

Space limitations in patient room \_\_\_\_\_

Dead or missing batteries \_\_\_\_\_

Slings - wrong size or not available \_\_\_\_\_

Patient complaint \_\_\_\_\_

Limited weight capability \_\_\_\_\_

Staff not comfortable with lift operation \_\_\_\_\_

Equipment is broken or not suitable for use on patient \_\_\_\_\_