

Date of observation: _____ Room number: _____

Type of transfer: Gait belt / Total lift / Sit-to-stand lift / Lateral transfer / Boosting in bed / Repositioning – Bed/Chair

Other _____

Staff observed: _____

	Yes	No	Comments
Was the equipment inspected prior to the transfer?			
Did the caregiver greet the resident and assess any changes in ability?			
Did the caregiver ensure the room was free of trip/fall hazards?			
Was the care plan followed?			
Did the caregiver inform the resident of the transfer task to be conducted?			
Did the caregiver encourage the resident to participate in the transfer?			
If two caregivers were needed, did only one caregiver speak and give directions? Was only one set of hands on the gait belt?			
Was the caregiver observed using proper body mechanics?			
Was the method of transfer safe for everyone?			
Was the transfer conducted according to your policy?			

Did you observe any safety concerns not already documented above?

Is further training required? ☐ Yes ☐ No If yes, please specify.

Additional comments:

Review observation results with staff member performing the transfer.

Signature of person observing transfer: _____

Signature of person performing transfer: _____