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**Bed Prescription Checklist:**

The following checklist must be used when undertaking a Bed Management Assessment.

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|  **Bed Prescription Checklist****TO BE USED IN CONJUNCTION WITH GUIDELINES** |
| **Name Address** |
| **Height Weight Hip Width****Do you need to consider bed extension or Bariatric equipment** |
|  | **Yes** | **No** | **Comments** |
|  |
| 1. What is your rationale for requesting a community bed |  |  |  |
| 2 Can the existing bed be adapted? What interventions have been tried? |  |  |  |
| 3 Is there sufficient room for the bed?**NB** a minimum area of 2.30m x2.30 m  (7ft 6in x 7ft 6in) is needed to facilitate access to bed and use of equipment e.g. turning circle for hoist Approx bed size: 2.0m x 0.92m (6ft 6in x 3ft) |  |  |  |
|  4 Is the bed to be placed downstairs?( Refer to Operational Protocol- Guidance on Beds Going Upstairs) |  |  | If no, risk assessment by Loan Stores required |
| 5 Is there an accessible power supply nearby? If no consider temporary extension lead. Consider permanent power supply for long term provision. |  |  |  |
| 6 Is there a gas fire in the room? (Refer to Operational Protocol) |  |  |  |
| 7 Is the floor even/level? |  |  |  |
| 8 Is the floor surface non-slip? Thick pile carpet /laminate floor |  |  |  |
| 9. Will the provision of a bed enable the person to be independent? |  |  |  |
| 10 Does the person require nursing interventions on the bed? Is the existing bed an appropriate height for nursing/carer intervention? NB must be minimum 56 cm (22 ins) with mattress depressed |  |  |  |
| 11 Is there sufficient room for carers to access both sides of the bed? Consider hazards such as radiators. |  |  |  |
|  | **Yes** | **No**  | **Comments** |
| 12 What assistance does the person require with mobility/personal care in and around the bed? |  |  |  |
| 13 Does the person have tissue damage? If so what grade?  |  |  |  |
| 14 What mattress is currently been used |  |  |  |
| 15 Is the person at risk of falling from the bed.?  If so what interventions have been tried? Have you considered Telecare equipment |  |  |  |
| 16 Are there any potential hazards at floor level, if the person rolled off the bed / crash mat? |  |  |  |
| 17 Is the person experiencing breathing difficulties when in bed? |  |  |  |
| 18 Can the person change their own position when in bed? |  |  |  |
| 19 Is there a danger of the handset being misused? |  |  |  |
| 20 Do you need to consider a ‘lock-out function’ on the handset? Need to specify if needed |  |  |  |
| 21 Is there sufficient safe access for delivery of a bed? Consult with stores for advice. |  |  |  |
| **DECISION: Is a Bed Required?** |  |  |  |
|  If yes, state choice of bed |  |  |  |
|  Are bed rails required? Please refer to Bed Rails Risk Assessment.(Appendix3) |  |  |  |
| Name of Prescriber |  | Date |  |
| Designation |  | Signature |  |

**N.B. This form is to inform and evidence your clinical reasoning for possible prescription of a community bed. Once completed please store in person’s**

**records and where appropriate share with other relevant Professionals If a bed is required please complete ILS referral form.**