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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.**