Equipment Program

Bed Assessment Clinical Considerations for Prescribers

# May 2015

| SECTION A: Information Gathering |
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| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Issues identified by the person, family, carers | * Ask the person/carer to identify and detail any entrapment incidents, falling out of bed, manual handling issues etc.
 | * Helps to identify any risks or areas where the bed may not be meeting the needs of the person and carers
 |
| Goals identified by the person, family and carers with the therapist | * What are the person, family and carers main goals in relation to the bed and bed set-up?
* Are these realistic? Are these safe?
 | * Helps to identify what the person, family and carers are aiming for, and what (if any) discussion / education is required around these goals
 |
| **Current Sleeping Equipment** |
| Bed make/model | * Check the bed and document brand, model, type, features and asset number
 | * Ensures there is an accurate record of the type of bed the person has and can later be determined if this is suitable for the person
 |
| Sleep dimensions of bed | * Measure the top surface of the bed (both length and width) on which the mattress will be placed.
 | * To determine the size of the mattress required. The mattress needs to cover as much of the bed surface as possible, to reduce entrapment risk by minimising the possibility of the mattress moving around on the bed surface, AND minimising any gap between the mattress and:
* rail (if being used)
* headboard
* footboard
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Mattress type and dimensions | * Check the mattress and document type, asset number and condition
 | * Ensures there is an accurate record of mattress type – can later be determined if this is suitable for the client
 |
| Pressure Redistribution Mattress (PRM) | * Check PRM condition, usage and pump settings if relevant
* Ensure person/carer has access to instruction manual if relevant
 | * Used to determine if pump settings match the needs of the person (e.g. weight, ensuring that mattress is not bottoming out)
 |
| Bed rails | * Check purpose of bed rails (i.e. is person falling out of bed, does client require them for comfort/security) and that person has provided consent for use of bed rails
* Check that bed rails are in good condition, operate smoothly and are fitted securely to the bed (i.e. minimal/no lateral shift)
* Check and document brand and length of bed rails, length of rail covers (if in use) and if bed rail struts are horizontal/vertical
* Refer to “***Bed Rails Clinical Considerations for Prescribers”*** if considering prescribing bed rails
 | * Used to ascertain condition and use of bed rails and safety in current bed rail set up. May indicate need for repairs
* Consent must be gained for use of bed rails as they are considered a restrictive practice
* Bed rails can place a person at risk of entrapment and proper use and setup of bed rails and bed rail covers is essential for persons at risk of entrapment
 |
| Bed Rail Covers | * Do the bed rail covers fit firmly and securely?
* What are they made of: mesh, vinyl, padded, reinforced?
* Are the bed rail covers ripped, torn or stretched?
* If secured by Velcro, does the Velcro still stick?
* Are there any young children who may undo the rail covers?
* Do the bed rail covers cover the span of the bed rails? Measure difference in length and note any discrepancy
* Ensure the dimensions of the covers fit the rail and meet entrapment measurement guidelines
* Refer to “***Bed Rails Clinical Considerations for Prescribers”*** if considering prescribing bed rail covers
 | * May indicate need for new bed rail covers or repair
* Ensure carers are aware of how to correctly position bed rail covers on the rails (if covers do not span length of rails)
* Full length rail padded covers may be required to prevent injury from contact with rails due to uncontrolled movements and entrapment but may pose suffocation risk
* Mesh or breathable covers may be required for clients who overheat in bed – these reduce suffocation risk
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Bed stick | * Note bed stick type/make/model/asset number
* Check that bed stick is secure and has been fitted appropriately
* Observe that bed stick being used safely and appropriately
* Refer to “***Bed Stick Clinical Considerations for Prescribers”*** if considering prescribing a bed stick
 | * A bed stick can pose risk of entrapment or impalement if not being used appropriately.
* Use clamp-on bed sticks only for electrically adjustable beds
 |
| Are bolsters required? | * Is the person at risk of entrapment? If yes, are there gaps larger than recommended?
* Are bolsters required/in use to fill any gaps?
* How securely do they fit the space?
* Where are the bolsters located?
* Does the person require bolsters for positioning?
* Note dimensions of existing bolsters and material used
 | * A well-fitting mattress is preferable to using bolsters to fill gaps (when possible)
* The sheet should be used over mattress and bolsters together to minimise gaps
* Wherever possible, bolsters should only be used as an interim solution to fill gaps in a bed system. Ideally, a well-fitting mattress should be prescribed to fit the sleep surface of the bed
 |
| Is a mattress surround required? | * Is the person at risk of entrapment? If yes, are there gaps larger than recommended?
* Does the person require a mattress surround to fill the space around the mattress to ensure it fits tight in the space?
* Is a mattress surround already in place?
* If so, how securely does it fill the space?
 | * A well-fitting mattress is preferable to using a mattress surround to fill space (when possible)
* An air mattress could be retained in a foam surround which could all be zipped into a cover if entrapment risk is evident
* Consider foam surrounds can affect ease of profiling the bed as surround will not be hinged to accommodate the movement of the bed sections
* A foam surround is not a viable option on a single bed
 |
| Does the mattress have firm or raised edges? | * Does the person require firm edges on a soft foam mattress to complete transfers?
* Could the mattress be compressed at the edges which may impact on entrapment risk between the mattress and rail?
* Does the person require raised edges to prevent them rolling out of bed?
 | * Firm edges may make transfers easier (sliding and standing)
* Soft edges increase risk of entrapment between the rail and mattress.
* Raised edges can be used instead of bed rails however these may compromise independent transfers
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Other equipment used on, in or around the bed | * Ask the person/carer and observe the environment around and in/on the bed, including the placement of the bed in the room, any additional furniture adjacent the bed, any additional equipment in or on the bed (e.g. bed cradle, bi-PAP machine, pressure care overlay, oxygen, suction, IV pole, etc.)
 | * Other equipment in and around the bed may pose an entrapment risk, particularly where gaps are created in and around the bed system
* Essential equipment may need to be accommodated safely within the bed system
 |
| ***Medical History*** |
| Diagnosis/Prognosis | * Is the person’s condition stable or deteriorating?
* Is there any other medical history of note?
 | * Provides information about the person and their current and future function, to assist with assessing risk of entrapment, and prescription needs
 |
| Seizures/Spasms | * Does the person have seizures or spasms? Ask the person/carer to describe the seizures and spasms
* How often do they occur (how many per day/ how many per night)?
* What impact do they have on sleep/sleep position?
 | * If the person has seizures or spasms, this uncontrolled movement can affect their position in bed and risk of entrapment
* Consider use of padded bed rail covers to prevent injury from contact with bed rails during seizures/spasms
* Persons may be more likely to fall out of bed, knock bed rails or become entrapped
 |
| Psychological/Behavioural factors | * Does the person experience anxiety?
* Ask the carers to identify any psychological or behavioural issues.
* How often do they occur?
* What is the severity?
* Take particular note of those that may impact sleep and position in bed
* Is a referral to a Psychologist required?
 | * Provides information about what may happen throughout the night that increases the person’s risk of entrapment
* A person who experiences anxiety may request bed rails to ease their anxiety of falling out of bed
* Persons may be more likely to fall out of bed if they are affected by alcohol or drugs
* Persons may be more likely to knock bed rails or may be at greater risk of entrapment if they are showing signs of agitation or confusion
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Medication | * Ask the person/carers to give details of any medications the person is on. Take particular note of side-effects that may impact on tone, seizures, levels of alertness, sleep and sleep patterns
 | * Provides information about what may happen throughout the night that increases the person’s risk of entrapment
* A person may be more likely to fall out of bed if they are sedated or drowsy
 |
| Height and Weight | * Is the person’s weight stable?
* Is a referral to a dietician required?
 | * A person may require an extra-long/wide bed if tall or obese
* Knowing the person’s weight will assist in completing an assessment of pressure risk i.e. considerations of low tissue bulk over bony prominences, choice of settings on Pressure Redistribution Mattress (PRM)
 |
| Smoking status | * Does the person smoke in bed?
 | * Persons are discouraged from smoking in bed due to the fire risk and damage this may cause to a mattress
 |
| Vision | * Does the person/carer report any problems with client vision?
* If so – what visual changes/condition are present?
 | * A person may be more likely to fall out of bed if they cannot see the perimeters of the bed and may require a mattress with raised/firm edges to help define bed borders
* A person may require tactile cues on an electrically operated bed controller
 |
| Hearing | * Does the person have any hearing loss?
 | * Hearing loss or limitation may affect a person’s ability to respond to auditory environmental cues. (e.g. a BPMD alarm)
 |
| Sensation | * Is the person’s body sensation normal or impaired?
* Note areas of sensory deficit/change
 | * Impaired sensation may influence positioning of body and limbs in bed, need for additional bed equipment (e.g. mattress with raised/firm edges, bed cradle, pressure management device, profiling of bed, bed positioning systems, etc.)
 |
| Body heat regulation | * Is the person significantly affected by changes in temperature?
* Does the person find it difficult to control their body temperature?
 | * Poor temperature regulation (e.g. in multiple sclerosis or motor neurone disease), may cause persons to experience greater fatigue, or decreased strength and coordination
* Consider whether temperature regulation can be improved e.g. by adjusting air-conditioning, using a cooling vest etc.
* Consider effect of mattress type and bed rail covers on body temperature
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Positioning requirements | * What ability does the person have to change position independently?
* Assess/ review any turning regimes
* Is special positioning required for breathing / swallowing /feeding regime / comfort / to accommodate deformities (e.g. scoliosis, kyphosis, arm contractures)?
* Is positioning equipment used (systems, wedges)?
 | * Additional positioning equipment in bed may pose entrapment risk
* Used to check that the features of the bed meet the person’s positioning needs and whether any additional bed equipment is required
 |
| Upper body (respiratory) | * Does the person use Bi-PAP or oxygen?
* Do they have regular/frequent colds or chest infections?
* Have they had pneumonia in the past/recently?
* Do they have sleep studies to monitor cardiorespiratory function?
* Do they need to sleep in a particular position to assist with breathing
 | * Helps to identify required bed features and profiling/positioning needs in bed
 |
| Upper body ( swallowing, gastrostomy) | * Does the person have a gastrostomy?
* Have they had issues with reflux in the past?
* Is this ongoing?
* Are they at risk of aspiration?
* Is a referral to a Speech Pathologist required?
 | * Used to check that the features of the bed meet the person’s needs, a person who has frequent chest infections or reflux may benefit from profiling features (back rest, knee break etc.). Consider profiling bed could create new entrapment zones. Need to determine priorities (i.e. need for positioning in bed to accommodate feeding regime may increase risk of entrapment)
* person s may benefit from a wedge back support, adjustable bed backrest, or an electrically operated bed with a profiling backrest. In some instances Trendelenburg may also be recommended
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Limbs | * Does the person have upper or lower limb contractures?
* Do they have spasticity? If so, how is this managed?
* Is there any altered/absent sensation in upper or lower limb?
* Is oedema an issue?
 | * Adds further information to help determine entrapment risk
* Provides information about comfort level and positioning needs. Used to check that the features of the bed meet the client’s needs
* Persons may benefit from a bed cradle, positioning bolster, or electrically operated bed with profiling knee break/raise. In some instances Trendelenburg may also be recommended.
 |
| History of pain | * Does the person have any ongoing/recurrent pain?
* What are the triggers for this pain?
* Is the person on any medication or other treatment for this?
* What impact does pain have on sleep and sleep position?
 | * Provides information about comfort level and potential positioning needs
* A person may be more likely to fall out of bed if they are sedated or drowsy
 |
| Bladder / Bowel management and toileting routine | * How is continence (bladder and bowel) managed while in bed?
* Do they use aids (catheters/drainage bags/absorbency sheets)?
* Do they have a timed toilet schedule or do they let the carer know when they require the toilet?
 | * Additional items in bed may affect pressure properties of the sleep surface
* Person may benefit from a urinal bottle, bed pan, absorbency and waterproof sheeting, bedside commode, night light, call bell and/or a toileting schedule
 |
| ***Communication*** |
| How does the person communicate? | * Are they verbal or non-verbal?
* Do they use keyword singing or a communication device?
* Do they communicate using vocalisations or facial expressions?
* Is the person able to call out at night?
* Ask the person/carer for examples of when they may call out (toilet, change, position change, sick etc.)?
 | * Used to ascertain entrapment risk, if they can’t call out when they need assistance then they may be at greater risk of entrapment
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| ***Cognition*** |
| Cognition | * Are they alert and/or orientated?
* Are they participating in the assessment?
* Does cognitive function change throughout the day/night?
* Does the person have insight regarding their needs and any risks to their safety in bed?
* Are they able to safely use a bed controller?
 | * Used to ascertain entrapment risk
* A person may be more likely to fall out of bed if confused
* A person may be more likely to climb over bed rails if significantly confused or agitated
* A person may be more likely to become entrapped if confused and they do not understand the risks and/or their limitations
* It is important that the person and carers are educated on the purpose and function of all equipment
* The person may require the controller to be locked so only the carer can adjust the settings
 |
| Is the person able to give informed consent? | * Does the person have a guardian?
* Are there any concerns about the person’s capacity to give informed consent?
* Check Consent Arrangement Profile
* Are bed rails in the person’s best interest?
 | * Use of bed rails and other bed positioning equipment may be considered a restrictive practice and consent must be provided accordingly
 |
| ***Behaviours of Concern*** |
| Unsafe habits or behaviours of concern | * Does the person have any unsafe behaviours in bed? E.g. smoking in bed
* Does the person have a behaviour support plan in relation to night time activities? E.g. wandering
 | * Behaviours of concern may impact on bed safety and inform support requirements
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| ***Pressure Injury Management*** |
| Pressure injury history | * Does the person have a history of pressure injury? Note location of injury and cause of injury
* Are there current pressure areas? Note location of injury and cause of injury.
* What is their current skin integrity?
* Can the person reposition independently?
* Refer to: **Pressure Mattresses- Clinical Considerations for Prescribers**  and **Guide to assessing pressure risk tool** if considering prescription of a Pressure Redistribution Mattress (PRM)
 | * Used to ensure the current mattress (or new mattress) meets the person’s pressure management needs
* A person with fragile skin is more prone to injury on bed rails
* **NOTE: air mattresses are excluded from the entrapment dimensional guidelines and bed safety may require careful consideration. Need to consider risk versus benefit.**
 |
| Routine skin inspections | * Is someone able to conduct routine skin inspections to monitor pressure injury risk / development?
* Can carers be compliant with carrying out regular skin inspections?
 | * Used to ensure the prescribed mattress will meet the person’s pressure management needs
* Prompts therapist to remind and educate the person/carer of the importance of monitoring for pressure injuries
 |
| **“Braden Pressure Ulcer Risk Assessment”** and Interpretation | * Will assist in determining if person is at risk of developing pressure sores? If so, how great is the risk?
* Identify potential risk factors such as limited mobility, sensory loss, chronic illness, poor skin hygiene, moisture, weight
 | * Used to ensure the prescribed mattress will meet the person’s pressure management needs
* Used to also identify other factors that may be impacting on pressure management
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Will the person/carer be able to monitor a Pressure Redistribution Mattress (PRM) | * Is the person or carer able and willing to monitor the PRM in terms of repairs issues, bottoming-out and entrapment risk?
 | * Monitoring the PRM is required to ensure it is meeting the client’s pressure needs **and**  is not bottoming out at any point (and has no repair issues needing to be attended to)
* A person who is in need of an air mattress **and** bed-rails may be at a greater risk of entrapment, therefore it is important that the person is monitored on the mattress
* In the case of a power failure, the person may need to switch the pump to mattress connections
 |
| Will the person tolerate the motion, noise and vibrations of air mattresses? | * Consider diagnosis, pain, sensory difficulties, behaviour concerns
 | * If the person is not able to tolerate an air mattress then an alternative pressure care option may be required
* The air mattress pump could be placed on the ground rather than on the end of the bed
 |
| Does the mattress bottom out when the backrest is raised? | * Does (or might) the person need to be positioned in bed with the backrest raised?
* If yes, does the mattress bottom out at this point?
 | * Helps to highlight risk of developing pressure areas
* Some air mattresses automatically increase the air pressure in the mattress cells to provide optimal pressure redistribution. Others need to be manually set
 |
| ***Environment*** |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Living arrangements | * Determine whether the person lives alone and if not, with whom they live
* If they live with a carer/family member, consider the capacity of involved persons to provide support e.g. their relevant medical conditions or physical capacities
* If in supported accommodation, is there active or passive overnight support?
* Determine whether the person receives support services e.g. carer support, day centre (including day options, supported accommodation), Meals on Wheels, RDNS etc.
* Record the name of the agency providing care, names of staff and contact details where appropriate
 | * Consider how often a person can be monitored and whether it is sufficient to ensure persons safety and comfort
 |
| Are carers able to hear the person if he/she calls out from bed? | * How far away is the carer’s room?
* Do they use/need an intercom or personal alarm system?
* Does the person require active or passive overnight care?
 | * Ensures that carer can hear person if they require assistance. If not then may need to recommend use of a room closer to the carers in a more observable area or intercom/personal alarm system
 |
| Living environment | * Bedroom set up: access to equipment, available space for hoist and transfers?
* Access to power points
 | * Bedroom environment can potentially exacerbate entrapment risk, i.e. a bed positioned against a wall, or a bed lowered to the ground can create a space in which person could become entrapped
 |
| ***Sleep Position and Routine*** |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Time spent in bed | * What time do they go to bed?
* What time do they wake up?
* Average hours of sleep per night?
 | * Gives an indication of any other potential issues related to sleep and sleep behaviour, may indicate need for referral for other sleep interventions such as psychology or medical review
 |
| Activities in bed | * List and give details including care provided – e.g. dressing, changing, eating, computer access, etc.
 | * Helps to ascertain features required as part of bed prescription, e.g. over bed table, hi-lo bed if dressing and changing occurs on the bed surface
 |
| Preferred sleeping position | * What position do they go to sleep in?
* Supine, side lying (which side), prone is not recommended
* Do they stay in this position all night?
* Does the person use any positioning equipment (e.g. sleep systems, wedges)? Does this need review?
 | * Helps to ascertain entrapment, pressure and asphyxiation risk
* Provides opportunity to review need for positioning equipment
 |
| Movement when awake | * When lying in bed awake (which may be whilst settling for sleep), do they move much, change position often?
* How many times do they wake up in the night?
 | * Helps to ascertain entrapment and pressure risk
 |
| Movement when asleep | * When asleep, do they change position often, move around in bed much?
* How often does the carer need to change the person’s position through the night?
 | * Helps to ascertain entrapment risk as a person who doesn’t/cannot move when asleep, has lower risk of entrapment. A client who moves a lot and gets themselves into positions they can’t get out of is at higher risk
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Current turning/repositioning regime | * Review current turning/repositioning regime
 | * Note that positional changes are still required after prescription of a Pressure Redistribution Mattress (PRM)
 |
| ***Entrapment*** |
| History of entrapment | * Determine if person has become entrapped before? Which part of their body became entrapped (head, left arm, right arm, left leg, right leg, trunk?)
* In which zone of the bed did they become entrapped?
* Time of day/night?
* How many times have they become entrapped?
* How frequently has entrapment occurred?
* When was the most recent incident?
* Similarities/differences of entrapment situations person has experienced?
 | * If the person has a history of entrapment, they are likely to be at continued risk
* Helps to ascertain specific issues/risks of entrapment for that individual which need to be reduced / monitored
 |
| ***Bed Transfers*** |
| Method and Aids | * How does the person transfer (stand/hoist)?
* Do they require assistance? Level of assistance?
* What type of equipment is used for transfers (e.g. bed stick, stand-aid hoist, mobile hoist, ceiling track hoist)?
* Refer to **“*Bed Sticks Clinical Considerations for Prescribers”*** if considering prescription of a bed stick
 | * Helps to ascertain features required
* If a person is independently mobile bed rails are inappropriate
* The person may benefit from changing their transfer technique, use of a bed stick or use of a hoist
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Working height required for carers  | * What personal care (bathing, dressing, continence management), wound dressings, repositioning, transfers are carers assisting the person with in or to/from bed?
* How tall are carers?
* Are there multiple carers?
 | * Helps to ascertain optimal bed height required by carers
 |
| Required transfer height for person | * How does the person get into bed - hoist, standing transfer, independently? Does the bed need to be raised?
* Measure the person’s heel to back of knee length. Measure the floor to top of mattress height (compressed and uncompressed)
* Measure the diameter of the feet of the bed if considering bed blocks
 | * Helps to ascertain features required e.g. ultra-low feature, bed blocks
 |
| History of falls during bed transfers | * Note any history of falls or difficulties with bed transfers
* Observe bed transfers, note any assistance required, note any difficulties
* Refer to **“*Bed Sticks Clinical Considerations for Prescribers”*** for further information if considering use of bed stick
 | * Helps to identify any issues with transfers
 |
| History of falling/rolling out of bed | * Note any history of falls from bed
* Observe bed mobility/behaviour if possible, identify bed setup, identify any carer support available
* Refer to **“*Bed Rails Clinical Considerations for Prescribers”*** if considering use of bed rails
 | * Helps to identify reasons for falls from bed
* May indicate need for bed equipment – explore all alternatives to bed rails prior to recommending them
 |
| ***Bed Mobility and Movement Control*** |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Moving to side of the bed/up the bed | * Is the person able to move to the sides of the bed and up and down the bed in a controlled manner?
 | * Used to ascertain level of independence in bed mobility
* Does the person need any assistive equipment to mobilise in bed or carer assistance?
* If the person can move around on the bed surface in a controlled and conscious manner, they are less likely to be at risk of entrapment
 |
| Lie to sit / sit to lie | * How does the person lie to sit and sit to lie?
* Does a carer provide assistance?
 | * Used to ascertain whether equipment or bed features may be of benefit (e.g. profiling back rest, bed stick)
 |
| Rolling  | * Is the person able to roll from side to side?
* Is this a controlled, voluntary movement?
* Can they roll both ways?
* Do they get stuck in any of these positions?
* If considering prescription of a bed stick, refer to **“*Bed Sticks Clinical Considerations for Prescribers”*** for further information if considering prescription of a bed stick
 | * Used to ascertain entrapment risk, if they can roll from side to side with ease and in a controlled manner then they may be at lesser risk of entrapment than if they cannot
* Consider that mattress type may influence bed mobility and transfers
* The person may benefit from a bed stick
 |
| **Question** | **Prompting Questions and Assessment Methods** | **Clinical Considerations** |
| Head control | * Does the person have good, moderate or poor head control? Can the person lift their head off the surface of the bed? Can they maintain that position?
* Describe what is observed of the person’s head control and head movement
 | * Used to ascertain entrapment risk, if the person has good head control then they may be at lesser risk of entrapment and asphyxiation than if they have minimal to no head control
 |
| Limb movement | * Is the person’s limb movement controlled?
* Is it fine, gross, involuntary, functional?
* How do they go with fine motor activities? Do they do any switching? How do they access the switch, if with arms, then what kind of movement?
* If they got their arm stuck through a bed rail or under themselves, could they get it out? Try to observe this if possible
* Refer to **“*Bed Rails Clinical Considerations for Prescribers”*** for further information if considering use of bed rails
 | * Person’s ability to control their limbs provides information about entrapment risk, particularly the risks involved if a bed

rail was used on the bed* Persons may be more likely to climb over bed rails if they have the strength and mobility to do so
* Persons may be more likely to knock the bed rails or become entrapped if they have involuntary movements
 |
|  |  |  |
| SECTION B: Interventions Considered |
| * Review the completed assessment and record any issues that have been identified
* Record identified issues and possible solutions
* If an equipment solution is being sought, refer to the **Bed Equipment Options** table below for further information on possible solutions

**Issue identified (For Example)*** Frequent seizures in bed and knocking against bed rails
* Stage 1 pressure area noted
* Difficulty with sitting up from lying

**Solution considered (For Example)*** Medical review required
* padded bed rail covers to be trialled
* Pressure Redistribution Mattress (PRM)
* Trial of bed stick
 |
|  |
| SECTION C: Risk Assessment |
| Use the **“*Risk Rating and Priority Scoring form”*** to determine risk of entrapment, impalement, falling from bed or during bed transfers and risk of any other injury to person or carer:* To help determine a person’s risk of bed **entrapment**, refer to the supporting document: **“Guide to Assessing Entrapment Risk”** NOTE: a person may also be placed at risk of entrapment if any component of the bed system is being changed (e.g. the mattress is being changed, a new/different Pressure Redistribution Mattress (PRM) is being prescribed, a bed stick is being added, bed rails are being added, etc.).If assessment of entrapment zones is indicated,refer to the “**Bed Entrapment Zone Measuring Tool”** and the **“Instructions for Measuring Entrapment Zones”**.
* If a person is at risk of **falls during bed transfers**, and implementation of equipment is being considered, refer to the appropriate clinical considerations or prescriber notes (e.g. **“*Bed Sticks Clinical Considerations for Prescribers”*** )
* If a person is at potential risk of falling onto a bed stick (**impalement**), a single point bed stick should **NOT** be considered/provided. Refer to **“*Bed Sticks Clinical Considerations for Prescribers”***
* If a person is at risk of **falls from bed/rolling out of bed**, and implementation of bed rails is being considered, refer to **“*Bed Rails Clinical Considerations for Prescribers”***
* If there is risk of injury to the carer(s) in assisting a person in managing bed transfers or bed activities, refer to appropriate clinical considerations and prescriber notes if considering an equipment solution (e.g. height adjustable bed, transfer equipment)
 |
| SECTION D: Recommendations |
| * Determine the most appropriate action or recommendation in consultation with the person and/or carer(s) for each issue identified
* Record agreed recommendations/actions on the assessment form (including any interim measures that have been discussed and agreed upon)
 |
| BED EQUIPMENT OPTIONS |
| The following table lists bed equipment that may be considered when working with persons who require prescription of beds, mattresses, or other bed equipment. For some persons, bed entrapment may be a risk. This document is not intended to eliminate clinical judgement and/or reasoning. When selecting appropriate bed equipment, individual personal requirements are to be assessed and this document is to be used as a guide only. To help determine risk of entrapment refer to the supporting document: “**Guide to Assessing Entrapment Risk”** |
| **Equipment**  | **Purpose** | **Clinical Considerations** |
| Alarm devices (proximity alarm) *Note: not in-scope of the DCSI Equipment Program* | * May be used to alert carers to when a person’s limbs or body parts fall outside of the sleep surface of the bed
 | * May be considered where constant direct supervision is not available
* Needs to be a support person who is able to attend quickly if alarm is activated
 |
| Alarm mats | * May be used to alert carers when a person has fallen from bed onto the sensor mat (if on the floor) or to alert of significant change in bed position (if used in bed)
 | * May be considered where constant direct supervision is not available
* Needs to be a support person who is able to attend quickly if alarm is activated
 |
| Bed blocks | * May be used to raise the height of the bed for person’s transfers or so equipment can be used under the bed, such as floor hoist.
 | * Consider stability of the bed if raising it.
* Consider all activities that need to occur on the bed
 |
| Bed end cover (padded, for bed head or footboard) | * Padded cover designed to go over the bed head and/or foot board May be indicated for persons who are at significant risk of strike injury and have significant uncontrolled movement and/or spasm
 | * Consider density of foam padding
 |
| **Equipment**  | **Purpose** | **Clinical Considerations** |
| Pressure Redistribution Mattress (PRM)* foam/air/gel
* static/dynamic
* overlay/full mattress replacement
 | * A PRM is a support surface (on a bed) that distributes load over the contact surfaces of the body of the person/client
* Use a pressure injury assessment scale e.g. the “**Braden Risk Assessment Scale”** in conjunction with a comprehensive clinical risk assessment to determine the client’s risk of pressure injury and inform selection of a support surface
 | * Consider impact of the mattress on overall bed mobility including transfers.
* Restriction of person’s movement within the bed can increase pressure risk if bed mobility is reduced by mattress design
* Compression of mattress edge will impact on entrapment concerns (particularly relevant for dynamic systems)
 |
| Bed rails | * Can be attached along the side of a bed. Used to help prevent a person falling/ rolling out of bed. Bed rails are available in a variety of sizes, shapes and lengths. There are bed rails for adjustable and non-adjustable beds.
 | * Refer to **“*Bed Rails Clinical Considerations for Prescribers”*** for further information
* Consideration of alternatives to bed rails is encouraged. Bed rails only to be used in exceptional circumstances
 |
| Bed rail covers * padded and non-padded
* full length or major proportion of bed rail length
* mesh, reflex, vinyl
 | * Bed rail covers can be used to eliminate gaps between the rails of a bed rail and / or to reduce risk of injury from bumping against the rail. Bed rail covers can be fabricated from a variety of materials..
 | * Refer to **“*Bed Rails Clinical Considerations for Prescribers”*** for further information
 |
| Bed sticks | * A metal tube, part of which usually sits under the mattress, or clamps to the bed frame, and part of the tubing extends vertically up the side of the mattress. Used to assist with rolling over in bed, sitting up from a lying position, getting in and out of bed and providing support when standing.
 | * Refer to **“*Bed Sticks Clinical Considerations for Prescribers”*** for further information
* Consideration of alternatives to bed sticks is encouraged.
 |
| **Equipment**  | **Purpose** | **Clinical Considerations** |
| Bed bolster  | * Bed bolsters may be indicated to reduce movement of a mattress that does not fit the bed frame and where there are gaps between the mattress and the bed rail/bed head/ bed end
 | * It is not ideal to use a bed bolster long-term as they are movable and may not be replaced/positioned correctly if multiple carers are involved
* Consider alternatives (e.g. better fitting mattress, mattress surround) prior to prescription of bed bolster
 |
| Bed cradle | * Holds blankets off client’s feet and legs providing pressure relief from blankets to lower limbs
 | * Consider entrapment risk prior to positioning bed cradles as they generally slide under the mattress and can easily move position.
 |
| Bed wedges or postural positioning devices | * Wedges and positioning devices used in bed to help position the person and/or keep them safely on the bed
 | * Consider whether restraint is an issue
 |
| Call bell/alarm systems to alert carers*Note: not in-scope of the DCSI Equipment Program* | * May be used to alert carers when client needs assistance
* May be used where person is unable to alert carer via voice alone
 | * Consider alternative access for those clients with minimal movement
 |
| Electric adjustable bed | A bed with electric adjustable features including some or all of the following features: high-low; head raise; knee bend and/or leg raise; and Trendelenburg. SIZES:* Single
* King single – wider and longer than single
* Length extensions are available for some single beds
 | * Choosing size of bed requires consideration of person’s body size, weight, position they sleep and ability to mobilise in bed (wider beds can give a client more space to roll in bed without falling out of the bed)
* Be aware of the environment in which the bed is to be located so that circulation space and access by the person and support people are taken into account. Wider beds require support people to reach further to assist bed user
 |
| **Equipment**  | **Purpose** | **Clinical Considerations** |
| Electric adjustable bed | FEATURES: |
| * Height adjustable – (Ultra-low or Floor-Line beds - may be required if person is likely to fall from bed).
 | * Consider good working height for carers and/or correct height for transfers (for low beds consideration of maximum height required as high range might be compromised)
 |
| * Head adjustment – top section of the bed can be raised and lowered. Assists client to sit up, raise chest and head (for respiration)
 | * Care to be used where the person has issues related to pressure. Mattress needs to be able to profile
 |
| * Knee bend – lower section of the bed rises in a scissor action allowing the knee to bend and have the calf supported, foot angled down. Assists person to support lower limbs, can assist to reduce pressure on the heels
 | * Care to be used where the person has issues related to pressure. Mattress needs to be able to profile
 |
| * Leg raise – lower section of the bed rises in a scissor action that flexes the hip and knee joints, supporting the calf. Assists client to support lower limbs
 | * Care to be used where the person has issues related to pressure. Mattress needs to be able to profile
 |
| * Trendelenburg function – provides flat positioning of the client so that their head is raised and feet lowered (reverse Trendelenburg) or vice-versa (Trendelenburg). May assist in positioning for respiratory issues, swallowing issues, positioning client and pressure care
 | * Care needs to be taken to instruct support staff adequately, to position person as directed and to ensure the client does not slide up/down the bed
 |
| Foam surround for mattress | * A custom made piece of foam, made to surround a mattress (usually an alternating air mattress). May be used to increase the overall size of the mattress to create a tight fit of the mattress to the bed system
 | * Where a mattress surround is prescribed for use with an alternating air mattress, consider providing a cover to enclose both mattress and surround and eliminate gaps between mattress and surround
* Consider alternating air mattress connections to pump and access to CPR deflation features in design of mattress surround
 |
| **Equipment**  | **Purpose** | **Clinical Considerations** |
| Floor Mat / Fall Out Mat (to help prevent injury from falls) SWEP | * Can be used on the floor beside a bed (without bed rails) for person who is at risk of falling out of bed
 | * Consider how person will be assisted off the floor and impact on carers
* Carers need to be aware of these mats as they can be a trip hazard.
 |
| IV Pole | * May be used to position bags/bottles for PEG feeds
 | * Entrapment risk may need to be considered when positioning IV poles on the bed
 |
| Mattress (basic – foam, innerspring, combination) ) | * Supporting surface for the person used on the bed
 | * Compression of mattress edge will impact on entrapment concerns
* Restriction of a person’s movement within the bed can increase pressure risk if bed mobility is reduced by the mattress design
* Ensure good fit of mattress to bed base/bed system
* Consider whether this type of mattress provides sufficient immersion and pressure management for the person.
 |
| Mattress on floor (no bed frame) | * May be used where person is at high risk of injuring themselves from falls or knocking against any component of the bed frame – i.e. where person has severe and uncontrolled movements e.g. Huntington’s
 | * Consider ease of transfers and impact on carers
* Carers need to be aware of these mats as they can be a trip hazard
* Consider as interim solution
 |
| Mattress with firm or raised edges (concave mattress) | * These mattresses have a customised edging which is higher and/or firmer than the middle of the mattress
* May be used to prevent the person from rolling out of bed
* May be used as an alternative to bed rails
 | * Consider restraint potential with raised edges on a mattress
* Consider impact on person’s transfers
* Restriction of a person’s movement within the bed can increase pressure risk if bed mobility is reduced by the mattress design
 |
| **Equipment**  | **Purpose** | **Clinical Considerations** |
| Monitoring system (auditory and/or visual)*Note: not in-scope of the DCSI Equipment Program* | * May be used to alert carers when client needs assistance
* May be used to amplify person’s attempts at alerting carers
* Could also be used to support monitoring of multiple person
 | * Consider care staff available to respond and monitor these systems
 |
| Self-help pole | * A bar that hangs over the person’s head and for the person to hang on to help mobilise up the bed.
* May be free-standing or attached to the bed frame
* Also known as over-head bar, monkey bar or goosenecks
 | * Consider ability of person to reach up and hold their own body weight so that they can re-position themselves in bed
* When free-standing, the self-help pole must be stable and positioned appropriately with consideration of load capacity and intended use
* Consider upper body strength and shoulder girdle stability of person
* Consider entrapment issues when positioning the upright pole
 |
| Specialised safety bed | * Manual or electric adjustable or non-adjustable bed with safety features to protect the occupant during use and to prevent the occupant from exiting the bed. May include extra high sides, padded surround and low stimulation features.
* This item may be prescribed for clients who are very mobile and may be at risk if they mobilise from bed unsupervised
 | * Consider mattress type, safety of person
 |
| **Equipment**  | **Purpose** | **Clinical Considerations** |
| Specialised safety bed (Huntington’s style) | * An electrically operated floor line bed with padded full length side rails and padded head and foot boards. Electric height, knee and back adjustment and Trendelenburg tilt as standard. Mattress may or may not be fully integrated
* This type of bed may be indicated for person s who are at significant risk of strike injury and have significant, uncontrolled movement and/or spasm
 | * Consider ease of raising and lowering rails, need to remove covers, etc. for care staff
 |
| 24 hour positioning system  | * A system that supports person s to improve posture in bed, increase comfort, and promote safety
 | * Incorrect use could increase risk of entrapment
* Review of the system needs to occur regularly to ensure correct use and positioning
 |
| **NON-EQUIPMENTCONSIDERATIONS** |
| * Ensure person’s needs whilst in bed are anticipated (e.g. drinks accessible, regular toileting, etc.)
* Ensure adequate supervision and carer support are available to ensure client safety
* Is a medical review required to optimise bed safety for the person?
* Would a strength and balance program assist the person to increase their independence in bed mobility and/or transfers?
 |

Equipment Program: Telephone:1300 295 786 Fax:1300 295 839 Email: equipment.feedback@dcsi.sa.gov.au