Checklist for the Prescription of Electric Beds for APER Clients

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| **Client Name:** | | **DOB:** |
| **Address:** | | |
| **Current location of client:  Public Hospital**  **Private Hospital Est. discharge date:**  **Home** | | |
| **Client of End of Life Care (MRU):**  **No**  **Yes**  **AKPS:** **Phase:** **RUG-ADL:**  **Prognosis:**  1-2 weeks  less than 1 month  1-4 months  4-6 months  > 6 months | | |
| **Prescriber name:** | **Discipline:** | |

**What are the clinical indicators for a bed for your client? Complete the form below:**

**Mobility:**

How does the client mobilise?

Client mobilises independently  Client requires 1-2 assist

Client uses equipment to mobilise (e.g. MWC, 4WW)

Details:      .............................................................................................................................................................

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**Bed Mobility:** Client has difficulty with or is unable to reposition independently and carer is not available to assist or is at risk of serious injury when repositioning client

How does the client mobilise in bed?

Independent/supervision only  1 person (physical) assist

Two or more persons physical assist  Hoist transfer

Details (include any equipment used for transfers):      .........................................................................................

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**Bed Transfers:** The client or carer requires the bed height to be adjusted to enable transfers to be completed safely (e.g. sit to stand; bed to wheelchair)

How does the client transfer in and out of bed?

Independent/supervision only  1 person assist

Two or more persons physical assist  Hoist transfer

Details (include any equipment used for transfers):      .........................................................................................

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**Care Needs:** Multiple carers and/ or equipment items requiring various bed heights to enable access for care (e.g. bed requires adjustment to suitable height depending on the carer present at the time or the piece of equipment being used in the task)

Details:      ........................................................................................................................................................

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**Symptom** **Management/Clinical Needs:** Adjustable bed supports client to independently reposition to assist with symptom management

Pain Management: Details:      .....................................................................................................

Pressure Care Management: Details:      .....................................................................................................

Postural Drainage: Details:      .....................................................................................................

Assistance with Breathing: Details:      .....................................................................................................

What measures have been trialled in the first instance? Details:      …..............................................................

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| **Bed Requirements.** Note the standard bed option provided will have head raise, knee bend, and hi-lo feature | |
| **Size** | Single (900mm wide x 2070mm long, 180kg max user weight)  King Single (1070mm wide x 2030mm long, 250kg max user weight)  If king single requested, please complete the following:  Client weight -  Clinical/care need for wider bed –  Can a single bed be issued in the interim if a king single bed is not immediately available? -  Yes  No |
| **Accessories** state any accessories on equipment request form | Client height:      cm Consider bed extension for clients over 6’0” / 183 cm  (Note, generally the bed length should exceed the person’s height by 15cm)  Bed extension required:  Yes  No |
| Bed rails required:  Yes  No  Bed rail covers:  Yes  No  Mesh  Padded |
| Bed stick required:  Yes  No  I confirm that alternative options have been considered prior to requesting a bed stick. |
| **Risk of Entrapment**  **(Occupational Therapist or Physiotherapist only)** | Low  Medium  High  Very High  Refer to “Guide to Assessing Entrapment” on DHS Equipment Program website.  For medium risk and above, entrapment risk must be addressed – rails not recommended. |
| **Risk of Falls** | Low  Medium  High  Very High  For medium risk and above, bed sticks not recommended, or risks must be addressed. |
| **Pressure Injury Risk** | Braden Scale score:       Pressure Injury History:  Yes  No  Pressure Area Stage:  1 2  3  4 Pressure Injury Location: |
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|  | Type of mattress  Foam  Air overlay  Full air |
|  | Clinical reasoning if requesting air overlay/mattress: |
|  |
| **Other Information** |  |

**Additional Considerations to assist with delivery**

Consent gained from client/family/carer for bed to be supplied:  Yes  No   
Plan in place for where the bed will be placed in house and how room will be accessed  Yes  No   
Plan in place for who will make space ready for bed (ALTER) will not move/dismantle existing furniture)  Yes  No

Have you discussed with client and family the impact of electric bed (e.g. partners unable to sleep together / may not be able to sleep in same room) and do they accept this?  Yes  No

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| **Home Access** | | | |
| **Front** | Ramp | | Steps Number of Steps: |
| Rails:  Yes  No Pathways:  Safe  Unsafe | | |
| **Back** | Ramp | Steps Number of Steps: | |
| Rails:  Yes  No Pathways:  Safe  Unsafe | | |
| **Other Access Notes / Issues** | Please note any obstructions to access (e.g. clutter, supporting beams, garden bed): | | |
| **Bed Location** | Bedroom (consider room size, other equipment in room, safe work environment) | | |
| Lounge room Other: specify | | |
| **Power Point Access** | Power point within reasonable distance from bed:  Yes  No | | |
| 2 power points available (1 for bed & 1 for mattress):  Yes  No | | |
| **Internal Layout** | Passage width:  Narrow  Wide  Any obstacles Details: | | |
| Tight turn into bedroom:  Yes  No | | |
| Internal Step:  Yes  No Location:       Number of steps: | | |
| **Other Information** |  | | |