**Somerset Risk Assessment for use of beds and bed accessories for adults**

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| **This risk assessment must be completed with the individual and those involved in their care before use of any** **bed,** **bed side rails, bed grab rails, bed turning system or shower/changing table. A copy must be uploaded to TCES and stored within the person’s care plan and case records. It must be reviewed and recorded after each significant change in the individual’s health or condition or any changes or additions to the equipment, bed or mattress.** |
| **Person’s Name**  |  |
| **NHS no** |  | **DOB** |  |
| **Assessor’s name** |  | **Team** |  |
| **Role** |  | **Assessment Date** | Click or tap to enter a date. |
| **Those involved in the assessment** |  |
| **What equipment is being considered?** |
| **Item** | **Make and Model, description.** |
| [ ] Bed  |  |
| [ ] Bed side rails  |  |
| [ ] Bed grab rail/handle |  |
| [ ] Lateral turning device |  |
| [ ] Bed extension |  |
| [ ] Shower/changing table  |  |
| **Reason for considering this equipment** |
| [ ]  Assist with bed mobility [ ]  Prevent falling from bed [ ] Pressure care [ ]  Assist with care provision [ ]  Assist with bed transfers [ ]  Other (specify):  |
| **What other options have been considered?** |
|  |
| **Type of bed in use or being considered?** |
| [ ] Divan [ ] Wooden slatted [ ] Domestic style profiling [ ] Hospital profiling[ ] Other – specify:  |
| **Other equipment and accessories in situ or being considered?**e.g. Pressure care equipment, monitoring equipment, moving and handling, Other – specify below: |
|  |
| **Build e.g. is person larger or smaller than average, or have atypical anatomy?** |
|  |
| **How do they transfer in and out of bed?** |
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|  |  |  |  |
| --- | --- | --- | --- |
| **Height m:** |  | **Weight kg:** |  |

|  | **Y** | **N** | **Comment** |
| --- | --- | --- | --- |
| **Likely to gain or lose weight (due to age or medical condition)?** |[ ] [ ]   |
| **Able to communicate?** |[ ] [ ]   |
| **Able to move all limbs?** |[ ] [ ]   |
| **Erratic/repetitive/violent/involuntary movements?** |[ ] [ ]   |
| **Confusion/agitation/delirium?** |[ ] [ ]   |
| **Dementia?** |[ ] [ ]   |
| **Learning disability?** |[ ] [ ]   |
| **History of falls?** |[ ] [ ]   |
| **Likely to try to climb over rail?** |[ ] [ ]   |
| **Likely to fall from the bed?** |[ ] [ ]   |
| **Impaired/restricted mobility?** |[ ] [ ]   |
| **Likely/able to attempt to reposition themselves unaided in the bed?** | ☐ | ☐ |  |
| **Variable levels of consciousness /sedation?** |[ ] [ ]   |
| **Skin vulnerable to tearing or bruising?** |[ ] [ ]   |
| **Do they have a stoma, catheter or other feeding/medical tubes?** |[ ] [ ]   |
| **Do they have understanding (mental capacity) of how to use equipment and the risks regarding use of it?** |[ ] [ ]   |
| **Have they consented to the rails? If not, who has?** |[ ] [ ]   |
| **Does the person have the ability to use any controls safely?** |[ ] [ ]   |
| **Are they able to summon help reliably?** |[ ] [ ]   |
| **Do they share their home with children, vulnerable or elderly adults who may be impacted if there is a fall or injury?**  |[ ] [ ]   |
| **Is the equipment being considered suitable for the person’s circumstance and their physical and cognitive characteristics, including their height and weight?** |[ ] [ ]   |

**NB: non-registered staff (e.g. OTA, HCA) - If any concerns/risks have been identified above, please discuss with manager or supervisor before proceeding with equipment order.**

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|  | **Risks Highlighted During Assessment** | **Risk Rating** |
| **1** |  |  |
| **2** |  |  |
| **3** |  |  |
| **4.** |  |  |

|  |  |  |  |
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| **Recommendations to Reduce Outstanding Risk** | **By Whom** | **By When** | **Remaining Risk** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| **4** |  |  |  |  |

Examples of measures to mitigate risks (NB these measures could introduce further risk):

|  |  |
| --- | --- |
| * Netting/mesh bed sides
 | * Alarm system
 |
| * Inflatable bed side/bumpers
 | * Floor mats (crash mat)
 |
| * Ultra-low height bed
 | * Re-positioning of bed in the room
 |
| * Postural management system
 |  |
|  | Y | N | Comment |
| **Plan/Advice Verbally Agreed with person/carers?** |[ ] [ ]   |
| **Does the person and/or carer know when to request a re-assessment?** |[ ] [ ]   |
| **Is the person /carer aware of who to contact if circumstances change regarding medical condition or changes to equipment? e.g. bed or mattress** |[ ] [ ]   |
| **This document must be uploaded to TCES and to the person’s records. Please state where this has been saved e.g. Eclipse, Rio, LCS.**  |  |

|  |  |
| --- | --- |
| **Name** |  |
| **Role** |  |
| **Signature** |  | **Date** | Click or tap to enter a date. |

