Bed Vacation Assessment Sheet

5. Appendix A – Prescription Guidance Summary

When considering the use of bed occupancy monitors, the choice of technology needs to be taken as part of a broader prescription (or tailoring) approach to the service set-up. This needs to be informed by a more complete assessment or profiling of the individual, looking both at their actual needs and risks and at their particular circumstances. The following sections summarise some of the key points to consider when prescribing bed occupancy monitors.

5.1 Alarm Monitoring Requirements

1	What types of alarm(s) are required?
a	Client has not gone to bed (Bed unoccupied alarm)
b	Client has not got out of bed (Bed occupied alarm)
c	Client has got out of bed (Bed exit alarm)
d	Client has got out of bed and not returned within a specified time-frame (Bed absence alarm)
e	Any combination of the above

2	When is the alarm monitoring to be active?
a	Always on
b	Manually configured (ON/Off switch)
c	During pre-determined time period or periods (timer-based)
d	Any combination of the above

5.2 Sensor Selection

3	How fast a response is required?
a	Person sits up in bed
b	Person rolls to edge of bed
c	Person steps onto floor/gets off bed
d	Person passes a particular point (such as the front of the bed or bedroom door)

4	Is there going to be a problem with the standard bed pad approach?
a	Service user likely to be disturbed by equipment installed on the bed
b	Service user likely to interfere with equipment installed on the bed
c	There may be an issue with carer having to re-install/align sensor on the bed after changing the sheets
d	Specialist bed – pressure relief mattress or profiling bed
e	Slatted base (need base board) or bed-frame/mattress in poor condition
f	Heavy mattress (e.g. pocket-sprung with very high spring count)
g	Service user does not weigh very much – especially in relation to the weight of the mattress
h	Single or double bed?
i	Single or double occupancy?
j	Exit on one or both sides?
k	Is bed against the wall?
l	Is service user suffering with or at risk of developing pressure sores?
m	Does service user use an electric blanket?

5.3 Alarm Notification Options

5	Where does the individual to be monitored reside?
a	In the community (their own house, bungalow, etc.)
b	In a sheltered scheme with a mobile warden
c	In an Extra-care scheme (with 24 hour staffing)
d	In a supported housing scheme with on-site support workers
e	In a residential care home
f	In a nursing home
g	In a community hospital or intermediate care facility

6	Who is going to accept and respond to the alarm call?
a	Their spouse/carer who sleeps in the same bed/room as them
b	A local responder who lives in the same property (but who sleeps in a different room to them)
c	A monitoring centre which can coordinate responses
d	A telecarer

7	Is the ability of the responder limited in any way?
a	Are they hard of hearing/deaf?
b	Do they take sleeping tablets or otherwise hard to wake up in the night?
c	Will they take longer than 30 minutes to arrive?
d	Are they physically capable of helping the service user back into bed?
e	Do they have other care responsibilities that could prevent them from being able to attend quickly?

5.4 Monitoring Parameters

8	Bedtime & Nocturnal Activity
a	What time does service user usually go to bed and get up in the morning?
b	How often do they usually get up in the night?
c	Where do they go – bathroom, kitchen? … and what do they do? (toilet, cup of tea, etc.)

9	Additional Factors
a	Is there a commode in the bedroom?
b	How far to the bathroom?
c	Is there a bedside light? Does user always switch lights on?
d	How far to the carer's room?
e	Is there a telephone in the room?
f	Bedside furniture

5.5 Home Automation

10	Lighting
a	Does low-level night-time lighting require linking to bed occupancy status at all or can they just be on all the time during the night?
b	Will a stand-alone lighting unit that illuminates the immediate vicinity of the bed suffice?
c	Which light(s) require switching and should there be a timed sequence?
d	Do any need to brighten gradually to avoid a shock to the user's eyes?
e	Do they need to be linked to the bed occupancy status?
f	When should the lights be extinguished?

11	Additional Support
a	Is a voice message prompt required when individual gets out of bed?
b	Is one prompt sufficient or are multiple prompts required?
c	What should trigger the prompt?
d	Where should the voice prompter be located?
e	What should the voice prompt say?
f	With who's voice should it be recorded?

6. Appendix B – Care Vignettes

The following 13 care vignettes provide some examples of the variability in needs and circumstances that can arise when considering the use of bed occupancy monitoring systems.

A	Mary lives alone in her own bungalow. She has Parkinson's disease and is considered to have poor mobility and is a significant fall risk. She weighs only 6 stone and sleeps in a single bed which has a controller for her electrically raising either the bed head or the foot of the bed. Her bed is in the corner of the bedroom. She has a commode that she sometimes uses instead of going to the bathroom in the middle of the night.
B	John lives alone in a sheltered housing scheme which has an ageing wardencall system but no other Telecare equipment. He has a history of Transient Ischemic Attacks. He now tends to lose temporal and spatial orientation at any time of the day or night, and is prone to get up during the hours of darkness and wonder around his flat or outside. He may start coking and risk a fire.
C	James has insulin-dependent diabetes and lives in a residential care home. He broke his wrist in a fall going into the garden and, at the moment, cannot use a walking aid and must rely on care staff to help him transfer and mobilise. He sometimes forgets about this and has suffered numerous falls trying to be independent.
D	Doris has lived with her daughter and son-in-law in a standard double bed in the spare room for 6 months since she had a serious fall and was left on the floor for 12 hours. She is unsteady on her feet and if she gets up during the night to visit the bathroom, she may try to go downstairs to the kitchen to make herself a cup of tea. Her daughter knows that this is dangerous because her mother's eyesight is poor and she never switches the lights on. Consequently, her daughter's sleep is fitful as she tries to listen for her mother getting up during the night so that she can help her.
E	Judith lives in supported housing with 3 other service users with learning disabilities. The wakeful night staff have been replaced by a sleep-in carer 5 nights a week and a telecarer for the other two nights. Staff intervention is needed if the service user break their routines with respect to sleep disturbance and the risk of wondering.

F	Robert has lung cancer and is receiving palliative care in order that he can die at home with his wife and family at his bedside. He remains a proud man and doesn't want to be a burden to his wife. Macmillan nurses care for him 4 nights a week, but his wife sleeps in an armchair in his room on the other nights so that she can help him reach the commode without falling off his hospital-style bed if he needs to use it during the night. She has very poor rest and her own health is failing.
G	Winnie is frail and sometimes incontinent. She fails to turn herself over in bed some nights so she has been provided with an alternating pressure mattress by the community equipment store. This has been fitted on her standard bed in an Extracare scheme which has night staff available in the event of an emergency.
H	Peter is physically disabled and has little strength or feeling in his legs. He lives alone in an adapted bungalow. During the day, he uses a wheelchair to get around. At night, he sleeps in a hospital bed with electronic controls which help him transfer to his wheelchair though he has in the past suffered accidents getting out of bed at night. He has Type 1 diabetes and is at risk of hypoglycaemia if he hasn't got out of bed for his breakfast by 8am.
I	Rose is in the early stages of Alzheimer's disease and is cared for by her husband, Alfie, who has an enlarged prostrate which causes him to visit the bathroom 3 or 4 times every night. He sleeps poorly because he worries that his wife might get up and suffer a fall. He is also at risk of falling if he tries to rush back to bed. They share a double bed.
J	Derek has suffered from depression and other mental health issues for a number of years. Since losing his wife, he has become increasingly dependent on alcohol which he drinks alone in the house. He has a history of stumbling on his way to bed at night and waking up on the floor or stairs bruised in the morning.
K	Elizabeth has received a hip replacement and is now in hospital intermediate care ward where they encourage her, and the other 15 patients, to walk around the bed space and the ward as much as possible during the day. At night, when the lights are down, they don't allow patients to get out of bed without help.
L	Margaret lost her sight on both eyes ten years ago and, since being confirmed with Alzheimer's disease, lives in a specialist nursing home for people with cognitive impairments. She remains mobile but has suffered numerous falls, especially during the night, when she tries to get up and go in search of her family.
M	Olive lives alone in a retirement housing complex which has no domiciliary care staff. She has suffered from constipation for many years and sometimes spends more than 50 minutes sitting on the toilet at any time of the day or night. She fell returning to bed from the toilet one night and wasn't found for 12 hours. She has been provided with a commode which is only about a metre from her bed but fears that she might fall transferring between the bed and the commode.