PRODUCT EVALUATION CHECKLIST

SW VICTORY SERIES

FACILITY: ______________________ **DATE:** ______________

EVALUATION BY: (INITIALS & STAFF POSITION) ______________________

DID THE PATIENT SAY THE MATTRESS WAS COMFORTABLE? ☐ **YES** ☐ **NO**
IF NO, PLEASE EXPLAIN: ______________________

DID THE MATTRESS HAVE A RAISED PERIMETER BORDER? ☐ **YES** ☐ **NO**
COMMENTS: ______________________

DID THE MATTRESS HAVE A ☐ **NYLON** OR ☐ **4 WAY STRETCH** FABRIC TOP COVER?

WAS THIS MATTRESS EFFECTIVE IN FACILITATING PATIENT POSITIONING AND MOBILITY? ☐ **YES** ☐ **NO**
IF NO, PLEASE EXPLAIN: ______________________

WAS THIS MATTRESS EFFECTIVE IN ASSISTING PATIENTS WHEN TRANSFERRING INTO AND OUT OF BED? ☐ **YES** ☐ **NO**
IF NO, PLEASE EXPLAIN: ______________________

DID THE PATIENT HAVE SKIN BREAKDOWN AT TIME OF ADMISSION? ☐ **YES** ☐ **NO**

WERE PRESSURE ULCER PREVENTION PROTOCOLS INITIATED FOR THIS PATIENT? ☐ **YES** ☐ **NO**

DID THE PATIENT'S SKIN REMAIN INTACT WHILE ON THIS MATTRESS? ☐ **YES** ☐ **NO**
IF NOT, WHAT TYPE OF BREAKDOWN OCCURRED? ______________________

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WHAT OTHER PROTOCOLS WERE IN PLACE FOR PRESSURE ULCER PREVENTION? ______________________

DID THE PATIENT EXPERIENCE EXCESSIVE MOISTURE ON THE MATTRESS? ☐ **YES** ☐ **NO**
COMMENTS: ______________________

WAS THE IN-SERVICE/TRAINING BENEFICIAL? ☐ **YES** ☐ **NO**
IF NO, PLEASE EXPLAIN: ______________________

WAS THIS MATTRESS EASY TO USE? ☐ **YES** ☐ **NO**
IF NO, PLEASE EXPLAIN: ______________________

ADDITIONAL COMMENTS? ______________________

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