Bed Rail Assessment

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BED RAIL ASSESSMENT

Resident/Patient _____ MR#_____
Room#_____ Date_____

☐ **Admission** ☐ **Readmission** ☐ **Quarterly** ☐ **Significant Change** ☐ **Other**

INSTRUCTIONS: Complete upon admission, readmission, quarterly, significant change, or other. Summarize findings, including a discussion of selected resident-specific interventions. Place a checkmark in the boxes pertaining to individual predisposing factors.

RATIONALE FOR POTENTIAL USE

☐ Resident request (specify reason)
☐ Family Request (specify reason)
☐ Medical Condition (specify)
☐ Positioning Assistance (specify)

DISCUSS MEDICAL SYMPTOM(S)

PREDISPOSING FACTORS	Date	1	2	3	4
Physical/Functional	☐ Weakness ☐ Pain ☐ Spontaneous body movements ☐ Balance deficit ☐ Orthostatic hypotension ☐ Limited truck strength; sitting position ☐ Limited truck or upper body strength; leans to side or forward (specify) ☐ Non-weight bearing or difficulty bearing weight				
Safety/Security	☐ History of rolling out of bed ☐ Fear of rolling out of bed ☐ History of sliding from bed to floor ☐ Other physical device in use (specify) ☐ Avoid rolling out of bed ☐ Provide sense of security				
Cognition	☐ Recent decline in cognitive status ☐ Poor short term memory (*Refer to BIMS summary score*) ☐ Delirium ☐ Poor safety awareness ☐ Agitation ☐ Other (specify)				

Bladder Continence	□ Continent □ Usually continent □ Frequently incontinent □ Always incontinent				
Bowel Continence	□ Continent □ Usually continent □ Frequently incontinent □ Always incontinent				
Bed Mobility	□ Turning side to side □ Moving self up and down in bed □ Pulling and holding self over □ Pulling self from laying to sitting position				
Transfer	□ Aid in supporting self □ Aid in safe entry into bed □ Aid in safe exiting from bed □ Use mechanical lift device for transfers to/from bed				

Will the bed rail enable the resident to achieve his/her highest level of functional independence in bed mobility?

Bed Mobility	□ Turning side to side □ Moving self up and down in bed □ Pulling and holding self over □ Pulling self from laying to sitting position	Comments
Transfer	□ Aid in supporting self □ Aide in safe entry into bed □ Aid in safe exiting from bed □ Use mechanical lift device for transfers to/from bed	Comments
Other	□ Device limits resident's freedom of movement □ Device limits sensory stimulation; obstructs resident's view	Comments
Recommendations	□ Side rail(s) are recommended due to: (specify) □ Side rails are not indicated, in lieu of alternatives □ Type ¼ ½ ¾ □ Left side: Upper Lower □ Right side: Upper Lower □ Both sides: Upper Lower □ Recommended whenever in bed □ Recommended only at night	Comments
Alternatives	Alternatives attempted prior to use of side rails: _____ _____ _____ Alternatives have been discussed with: Resident _____ Resident's Representative____	Comments

SUMMARY OF FINDINGS

NURSE SIGNATURE _____ **DATE** _____