

Bed Rail Risk Data Collection Tool

LeadingAge®



**PATHWAY
HEALTH**
Insight | Expertise | Knowledge

*State logo added here. If not,
delete text box*

BED RAIL RISK DATA COLLECTION TOOL

Indicate the type and size of the bed rails to be used. Document the date the bed rails are initiated.

☐ **NO BED RAIL USED**

☐ Assist/Grab bar(s) L / R Date:

☐ Half bed rails L / R Date:

☐ Other (describe)

☐ Quarter top bed rails Date:

☐ Full bed rails L / R Date:

Date:

Functional Need for Bed Rail:

1. What is/are the symptom(s) or functional deficits that will be treated or managed with the use of bed rail(s)?

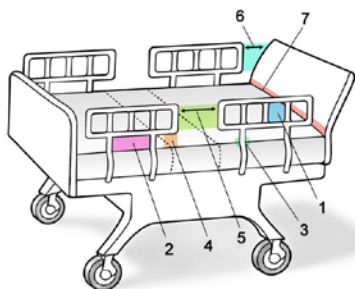
2. What alternatives have been used (i.e., verbal instructions, diversion activities, positioning with pillows, etc.) and what happened? Why did it not work?

3. When will the bed rail(s) be used?:

4. Is the resident able to show you how they safely use the rail(s)? ☐ Yes ☐ No ☐ N/A
5. How does the bed rail(s) benefit the resident? **Check Type:** ☐ Enabler for mobility ☐ Positioning ☐ Fall Prevention
Describe: _____
6. Does the bed rail attach firmly to the bed? ☐ Yes ☐ No → take rail out of service & contact maintenance to repair
7. Does the resident properly fit in the bed? ☐ Yes ☐ No → (Feet do not project beyond the end or touch the footboard, body does not extend beyond the sides of the mattress, resident does not "bottom out" on the mattress) **If NO, obtain a larger bed.**

Bed Rail Safety Assessment

Three key body parts at risk for life-threatening entrapment in the potential zones of bedrail are the head, neck, and chest.



There is a risk for a resident to trap their head, neck or limbs between the mattress and bed frame or mattress or bedrail.

When the resident is in the bed, the gap must be smaller than:

-4 ¾ inches (1) inside the rail, (2) under the rail, (4) between the rail and the mattress, or

-2 3/8 inches at (6) the end of the rail between the rail and the headboard or footboard.

Are there gaps of this size or larger when the resident is in the bed? ☐ Yes ☐ No

If Yes, the resident is at risk for being trapped.

Remove the rail and provide an alternative device or assistance.

Analysis(Assessment) _____

Nurse Signature: _____ **Date:** _____

RESIDENT NAME _____ **MR #** _____ **Room #** _____

This document is for general informational purposes only.

It does not represent legal advice nor relied upon as supporting documentation or advice with CMS or other regulatory entities.

© Pathway Health Services, Inc. – All Rights Reserved – Copy with Permission Only - Requirements of Participation P&P Manual 2017



**PATHWAY
HEALTH**
Insight | Expertise | Knowledge



Informed Consent for use of Bed Rails

☐ I give my approval with understanding of the risks vs. benefits as reviewed. ☐ I do not give my approval.

☐ I give approval as follows:

NAME OF INDIVIDUAL GIVING CONSENT:

☐ VERBAL CONSENT GIVEN VIA TELEPHONE DATE: _____ BY: _____

RELATIONSHIP TO RESIDENT: _____

Signature of Resident Representative: _____ Date: _____

Nurse Signature: _____ Date: _____

RESIDENT NAME _____ **MR #** _____ **Room #** _____

This document is for general informational purposes only.

It does not represent legal advice nor relied upon as supporting documentation or advice with CMS or other regulatory entities.

© Pathway Health Services, Inc. – All Rights Reserved – Copy with Permission Only - Requirements of Participation P&P Manual 2017