

# Bed Rail Risk Data Collection Tool





## 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:

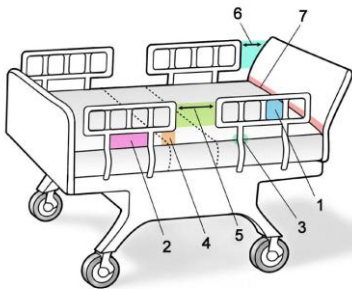
Date:

### 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 # \_\_\_\_\_



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**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 # \_\_\_\_\_