BED RAIL SAFETY RISK ASSESSMENT TOOL

Client:_____
DOB:_____
MHSC: _____
PHIN#: _____

Assessment Date:_____ ☐ Occupational Therapist ☐ Physiotherapist ☐ Home Care Case Coordinator ☐ Palliative Care Nurse

Relevant Medical History: _____
_____

Legal/Alternate Decision Maker:_____

Living Environment (check all that apply)	☐ Alone ☐ Community ☐ Assisted Living ☐ With family/caregiver ☐ Group Home ☐ 24 hour care
Current Sleep System	☐ Standard bed: Size_____ Height _____ ☐ Electric bed: _____ ☐ Therapeutic sleep surface:_____ ☐ Existing rail(s):_____
Mobility Status	☐ Independent ☐ Gait aid_____ ☐ Assisted_____ ☐ Wheelchair (full time/part time) ☐ Dependent _____
Transfer Status	☐ Independent ☐ Equipment currently in use ☐ Assisted_____ _____ ☐ Dependent _____ _____
Bed Mobility	☐ Independent ☐ Equipment currently in use ☐ Assisted_____ _____ ☐ Dependent _____ _____
CLIENT RISK FACTOR	
☐ **History of injury or close call while in bed** ☐ N/A	☐ Entrapment _____ ☐ Fall _____ ☐ Other _____
☐ **Impaired cognition or judgement** ☐ N/A	☐ Confusion ☐ Agitation ☐ Impulsivity ☐ Other_____
☐ **Sedation or drowsiness due to medication** ☐ N/A	Drug/dose _____Time _____
☐ **Involuntary movements** ☐ N/A	☐ Seizures ☐ Tone/spasticity _____ ☐ Movement disorder _____ ☐ Other _____
☐ **Small physical stature** ☐ N/A	Sleep position in bed _____ Height _____ Weight _____ Comments: _____
☐ **Impaired ability to communicate needs** ☐ N/A	☐ Call system _____ ☐ Communication device _____
☐ **Acute illness affecting level of consciousness or cognition (e.g. dehydration, infection)** ☐ N/A	Diagnosis/onset _____ Symptoms _____
☐ **Incontinence or frequent need to void during the night** ☐ N/A	☐ Independent ☐ Assisted ☐ Dependent ☐ Equipment _____
☐ **Impaired Vision** ☐ N/A	Diagnosis _____ ☐ Visual aid_____

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Alternative/Supplemental Strategy	*Status	Recommendation/Comments
Bed alarm or motion-sensor alarm		
Use of a high/low bed		
Put bed into lowest position and use fall mat during sleep		
Put bed at optimal height and position for functional transfers (may need to mark on floor or move furniture)		
Ensure call system/bed controls are within reach		
Implement regular care routine (e.g., toileting, turning & positioning…)		
Increase level of caregiver observation or visual monitoring system		
Ensure personal or toileting items (e.g., phone, handheld urinal) are within reach		
Adequate lighting (e.g., night light)		
Implement exercise or activity program to maintain/build strength/ stay active during the day		
Request a medication review – drowsiness, pain		
Use of alternative equipment (e.g., helmet, positioning devices, gap fillers, trapeze…)		

Status: C – currently in place, R - recommended, U – unsuccessful, N/A – not applicable

Recommendations:

☐ **Bed Rails are not recommended** by clinician, however client/ADM/caregiver chooses to have bed rails in place. See below for rails ordered and alternative recommendations discussed.

☐ **Bed Rails are not recommended** by clinician, the following recommendations are made in lieu of bed rails.

_____

_____

_____

☐ **Bed Rails are being provided for the following reasons:**

☐ Feeling of comfort and security ☐ Assistance with bed mobility ☐ Minimize risk of falls from bed

☐ Assistance with transfers ☐ Access to bed/call system controls

☐ Other _____

☐ **Bed Rail recommendations**:

☐ ¼ ☐ fixed ☐ ½ ☐ folding ☐ ¾ ☐ rotating ☐ full ☐ Other: m-rail, trapeze, transfer pole… _____

☐ Right (client's right when lying in bed) ☐ Left (client's left when lying in bed) ☐ Bilateral

☐ Day and night ☐ During care in bed ☐ Night only ☐ Other:_____

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Informed Consent:

☐ Risk Versus Benefits of bed rail use reviewed with : ☐ Client ☐ Legal/ADM ☐ Staff _____
☐ *Safe Bed Rail Use Client Handout* provided to client, ADM/caregiver or staff
☐ Client/ADM/caregiver agree to use of bed rails
☐ Client/ADM/Caregiver choose to use bed rails despite clinician/HCCC recommendations of strategies alternative to Bed rails

_____ _____
Therapist/Home Care Case Coordinator Signature Date

_____ _____
Therapist/Home Care Case Coordinator Name Date

☐ Case and recommendations discussed with colleague/client team member/manager

Name and Designation: _____

Date discussed: _____