SLEEP OBSERVATION STUDY FOR BED RAIL USE

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

This form will assist clients and caregivers to gather more detailed information regarding sleep and bed behaviors related to safety and the use of equipment such as bed rails. Observe and comment on three consecutive nights and return to your Therapist or Home Care Case Coordinator.

Date: _____ Time: _____a.m. / p.m. to _____ a.m. / p.m.

Night 1	Yes, No or N/A*	Comments
Did the client need help getting in or out of bed?		
Did the client use the existing bed rail or equipment safely and appropriately?		
Did the client try to climb out of bed or over an existing bed rail without asking for assistance?		
Did the client fall out or almost fall out of bed?		
Did you find the client close to the edge of the bed or parts of their body through the bed rail spaces?		
Did the client show signs of restlessness, agitation, or involuntary movements?		
Did the client get up to void/use the bathroom? If so, how many times?		
Other observations related to sleep behavior or equipment safety:		

*N/A = Not Applicable

Date: _____ Time: _____a.m. / p.m. to _____ a.m. / p.m.

Night 2	Yes, No or N/A*	Comments
Did the client need help getting in or out of bed?		
Did the client use the existing bed rail or equipment safely and appropriately?		
Did the client try to climb out of bed or over an existing bed rail without asking for assistance?		
Did the client fall out or almost fall out of bed?		
Did you find the client close to the edge of the bed or parts of their body through the bed rail spaces?		
Did the client show signs of restlessness, agitation, or involuntary movements?		
Did the client get up to void/use the bathroom? If so, how many times?		
Other observations related to sleep behavior or equipment safety:		

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Date: _____ Time: _____a.m. / p.m. to _____ a.m. / p.m.		
Night 3	Yes, No or N/A*	Comments
Did the client need help getting in or out of bed?		
Did the client use the existing bed rail or equipment safely and appropriately?		
Did the client try to climb out of bed or over an existing bed rail without asking for assistance?		
Did the client fall out or almost fall out of bed?		
Did you find the client close to the edge of the bed or parts of their body through the bed rail spaces?		
Did the client show signs of restlessness, agitation, or involuntary movements?		
Did the client get up to void/use the bathroom? If so, how many times?		
Other observations related to sleep behavior or equipment safety:		

*N/A = Not Applicable

_____ _____
HC Case Coordinator or Therapist Signature Date

_____ _____
HC Case Coordinator or Therapist Printed Name Phone Number