

Bed-related Entrapment and Fall Report Form

Historically, incident reports for patient entrapments do not provide authorities with sufficient detail to allow a full assessment of the incident and a determination of whether any standards or guidelines that the bed conforms to are adequate.

This is where the reporter can play a very important role. For any entrapment incidents, please use this form to record important information, whether these incidents result in injuries or not. Please provide a copy of this form to the Health Products and Food Branch Inspectorate:

HEALTH CANADA
250 Lanark Avenue, 3rd Floor
Address Locator: 2003D
Ottawa, Ontario K1A 0K9
Tel: The Inspectorate Hotline 1-800-267-9675
Fax: (613) 954-0941
email MDCU_UCIM@hc-sc.gc.ca

As well, a copy of the form may be provided to the manufacturer to allow them to use this information to investigate the incident and improve their bed designs where applicable.

The purpose of the form is to report Entrapment incidents. The form can also be used to record falls data, but unless the fall resulted from a failure of components of the bed (i.e. side rail latch), fall data need not be communicated to Health Canada. In this context, please ensure that at a minimum, the following section be completed

An entrapment is defined as a patient being caught, trapped or entangled in the spaces in or about the bed rail, mattress or hospital bed frame.

A bed-related fall is defined as a fall that occurs from bed when a patient is getting out of bed, into bed or when a patient accidentally falls from the bed to the floor.

Date of incident / /
 Day / Month / Year

Time of incident : (24 hour clock)

1. Facility _____

2. Unit _____

3. Room/Bed Number _____

4. **Bed Barcode number**

5. **Bed Make** _____

6. **Bed Model** _____

7. **Patient Name** _____
 Last Name _____
 First Name _____
 and/or _____

Patient Identifier _____

(This information is optional but would help in further investigation by the authorities)

8. **Patient Age** (in years)

9. **Mental Status at time of incidence**

Alert & Oriented	Mildly Confused	Severely Confused	Comatose/Vegetative State	Baseline Intellectual Disability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. **Does patient have a seizure or movement disorder?** Yes No

11. **Gender** Male Female

12. **Height** _____

13. **Weight** _____

14. **Patient's admitting diagnosis:**

15. **Date of admission** / /
 Day / Month / Year

16. **Description of Incident, including events leading up to the incident:**

17. Type of incident	18. Was the patient injured?	19. What treatment was provided?
Entrapment <input type="checkbox"/>	Yes <input type="checkbox"/>	None <input type="checkbox"/>
Bed-related fall <input type="checkbox"/>	No <input type="checkbox"/>	First Aid <input type="checkbox"/>
If yes, describe condition:		Medical/Surgical Intervention <input type="checkbox"/>
<hr/> <hr/> <hr/> <hr/>		Other <input type="checkbox"/>

20. Was the incident reported?	21. Would this incident have normally been reported?	22. What was the patient's level of mobility at time of incident?
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Up ad lib <input type="checkbox"/>
No <input type="checkbox"/>	No <input type="checkbox"/>	Ambulate with Assistance <input type="checkbox"/>
		Ambulate with walker <input type="checkbox"/>
		Wheelchair/ chair bound <input type="checkbox"/>
		Bed bound <input type="checkbox"/>
		Missing limbs <input type="checkbox"/>

23. What was the patient's communication ability at time of incident?

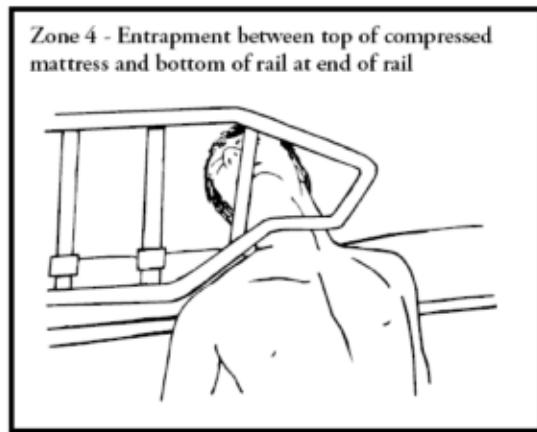
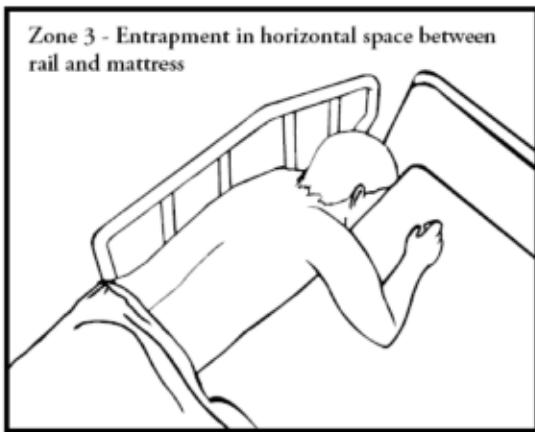
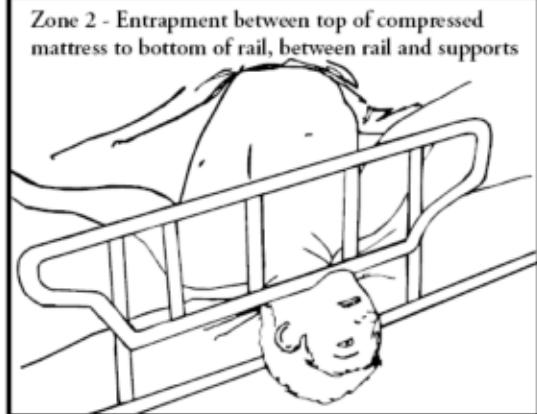
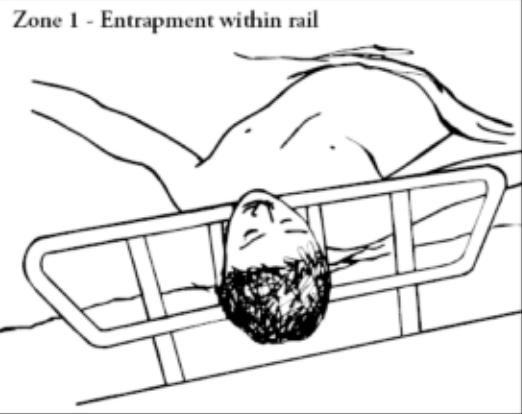
- Verbal
- Nonverbal only
- Sign language
- Foreign language

24. Accessories and Treatments in Use

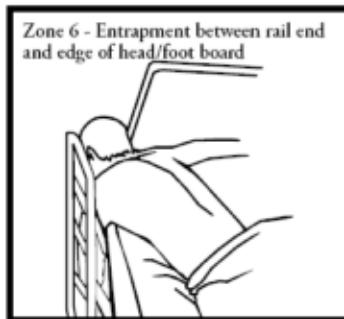
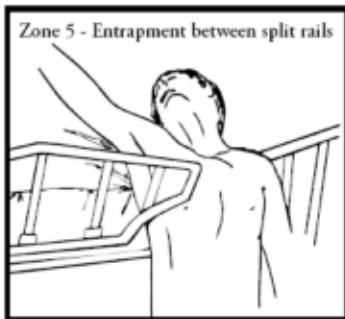
Rail bumper wedges	<input type="checkbox"/>	Rail pads	<input type="checkbox"/>	Rail covers	<input type="checkbox"/>	Entrapment shields	<input type="checkbox"/>
“Stuffer pads”	<input type="checkbox"/>	Bed rail extenders	<input type="checkbox"/>	Bed rail inserts	<input type="checkbox"/>	Positioning monitors	<input type="checkbox"/>
Bed exit alarm	<input type="checkbox"/>	Raised perimeter mattress	<input type="checkbox"/>	Positioning aid	<input type="checkbox"/>	Net enclosure	<input type="checkbox"/>
Nasal oxygen	<input type="checkbox"/>	IVs	<input type="checkbox"/>	Overbed table	<input type="checkbox"/>		
Other _____	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	Other _____	<input type="checkbox"/>

25. If an entrapment event occurred, indicate the location of entrapment by circling the appropriate Zone number.

Potential Entrapment (Zones 1, 2, 3 and 4 are the only zones assessed.)



Zones 5, 6 and 7 are not measured zones. These are shown here only for reference for future reporting of entrapment incidents.



26. **What body part was entrapped?** Neck Head Chest Other

27. **What was the size of the body part that was entrapped?** Neck diameter Head breadth (width), ear to ear Chest depth (thickness)
_____ _____ _____ _____

28. **Was patient in restraints?** Yes No

If yes, indicate type. Check all that apply.

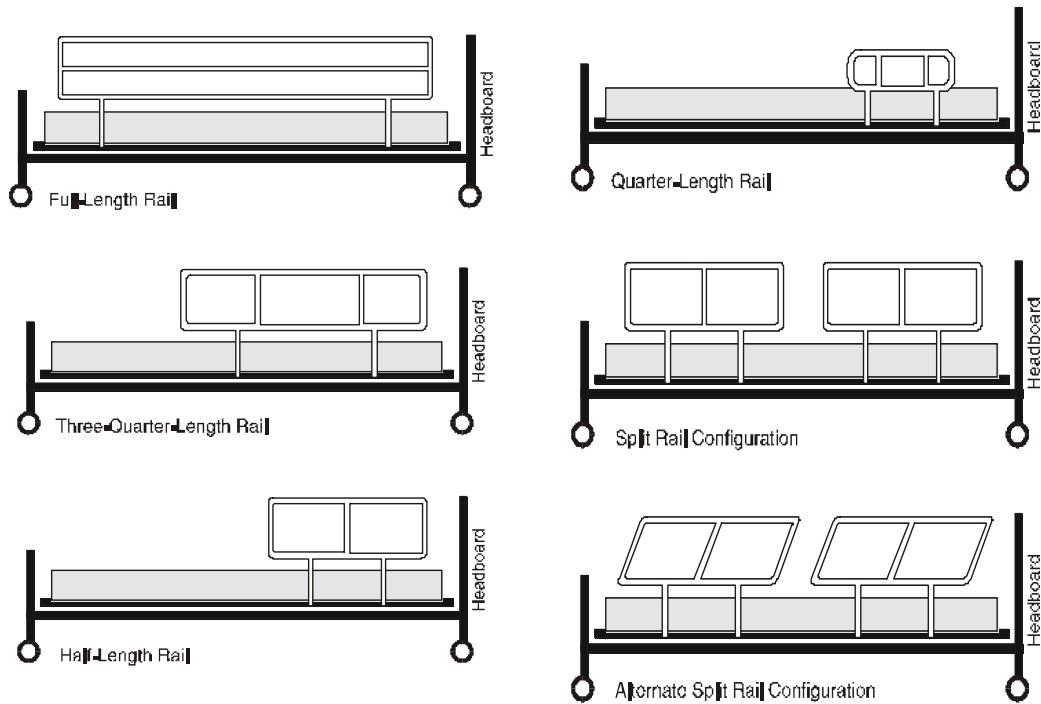
Vest/chest	<input type="checkbox"/>	Wrist soft--bilateral	<input type="checkbox"/>	Ankle soft--bilateral	<input type="checkbox"/>	Mitt--bilateral	<input type="checkbox"/>
Pelvic/crotch	<input type="checkbox"/>	Wrist soft--one	<input type="checkbox"/>	Ankle soft--one side	<input type="checkbox"/>	Mitt--one	<input type="checkbox"/>
Combination chest/pelvic	<input type="checkbox"/>	Wrist leather--bilateral	<input type="checkbox"/>	Ankle leather--bilateral	<input type="checkbox"/>	Other	<input type="checkbox"/>
Waist/Belt/roll belt	<input type="checkbox"/>	Wrist leather--one	<input type="checkbox"/>	Ankle leather--one side	<input type="checkbox"/>		

29. **Circle the appropriate diagram on the next page that best indicates the Rail Configuration on the bed involved in the entrapment.**

Also show where the entrapment occurred (drawing complete body is best).

Other, describe _____

Measure and report the size of the gap where the entrapment took place:



30. Were bed rails:

All up All down 1 up
 (Patient's Left ,
 Patient's Right) Top half up
 (Patient's Left ,
 Patient's Right) Bottom half up
 (Patient's Left ,
 Patient's Right)

Yes No Don't Know

31. Were the bed rails those recommended by the manufacturer?

32. What was the upper bed deck articulation?

<input type="checkbox"/>	Flat	<input type="checkbox"/>	46 to 89 degrees
<input type="checkbox"/>	15 to 30 degrees	<input type="checkbox"/>	90 degrees
<input type="checkbox"/>	31 to 45 degrees		

33. What was the lower deck articulation?

<input type="checkbox"/>	Flat	<input type="checkbox"/>	46 to 89 degrees
<input type="checkbox"/>	15 to 30 degrees	<input type="checkbox"/>	90 degrees
<input type="checkbox"/>	31 to 45 degrees		

34. Type of Mattress

<input type="checkbox"/>	Standard (Foam)	<input type="checkbox"/>	Other, specify
<input type="checkbox"/>	Water-filled		
<input type="checkbox"/>	Air-filled		

35. Mattress size:

As stated on label or other documentation:

_____ length _____ width _____ depth

As measured with measuring tape, no compression:

_____ length _____ width _____ depth

36. Mattress age (or production date) _____

37. Mattress condition (i.e. soft, firm, worn, torn, etc) _____

38. Was the mattress one of those recommended by the manufacturer?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't Know
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39. Was this bed assessed as per the Health Canada guidance on beds and if so what was the result?

	Yes	No	Don't Know
40. Did this bed meet the IEC 60601-2-52 international standard for medical beds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. Reporter contact information:

Name: _____

Facility Name: _____

Facility Address: _____

Phone number: _____

Fax Number: _____

Email: _____