



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="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Entrapment ☐

Bed-related fall ☐

18. Was the patient injured?

Yes ☐

No ☐

If yes, describe condition:

19. What treatment was provided?

None ☐

First Aid ☐

Medical/Surgical Intervention ☐

Other ☐

20. Was the incident reported?

Yes ☐

No ☐

21. Would this incident have normally been reported?

Yes ☐

No ☐

22. What was the patient's level of mobility at time of incident?

Up ad lib ☐

Ambulate with Assistance ☐

Ambulate with walker ☐

Wheelchair/ chair bound ☐

Bed bound ☐

Missing limbs ☐

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

Verbal ☐

Nonverbal only ☐

Sign language ☐

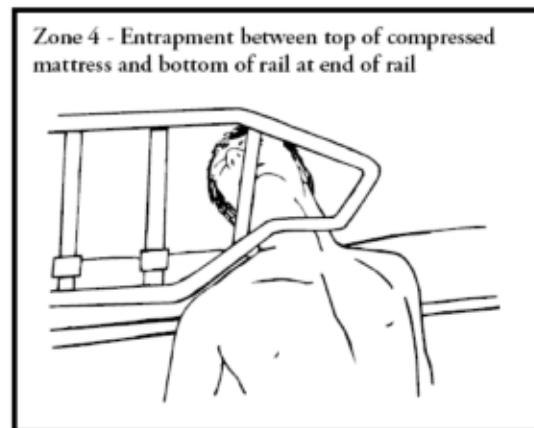
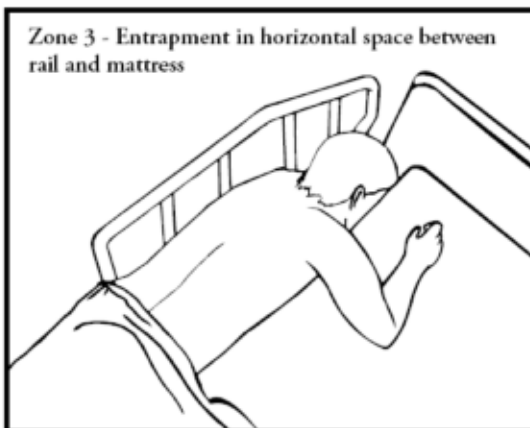
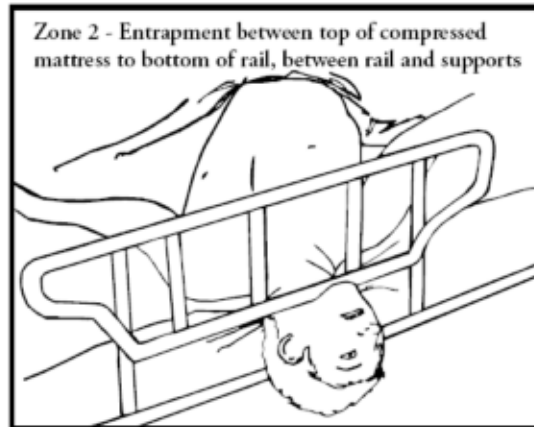
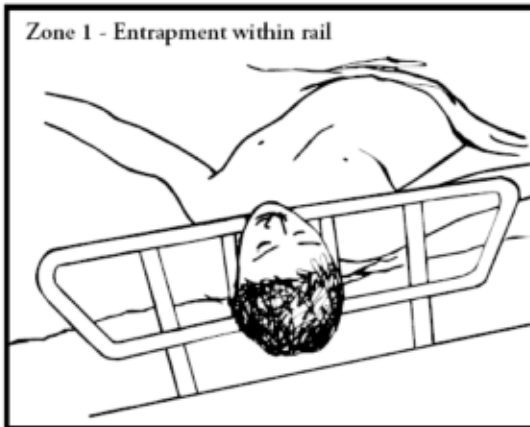
Foreign language ☐

24. Accessories and Treatments in Use

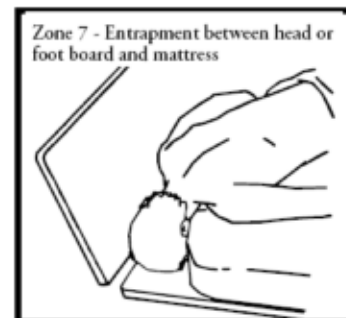
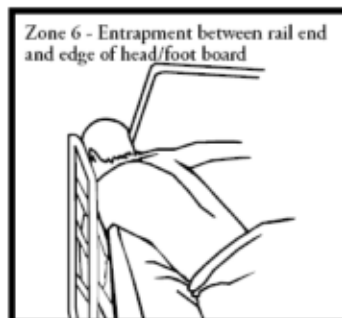
Rail bumper wedges	<input type="checkbox"/>	Rail pads	<input type="checkbox"/>	Rail covers	<input type="checkbox"/>	Entrapment shields	<input type="checkbox"/>
“Stuffer pads”	<input type="checkbox"/>	Bed rail extenders	<input type="checkbox"/>	Bed rail inserts	<input type="checkbox"/>	Positioning monitors	<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) Other:

28. Was patient in restraints? Yes No
☐ ☐

If yes, indicate type. Check all that apply.

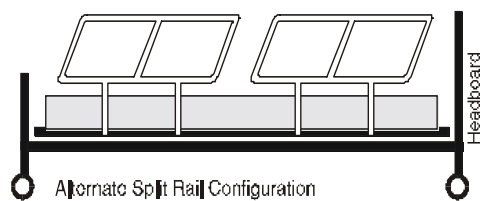
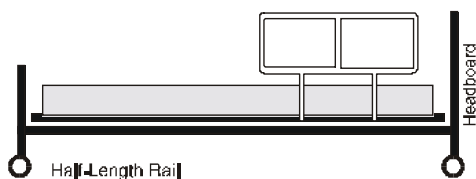
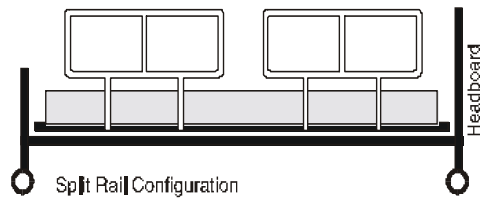
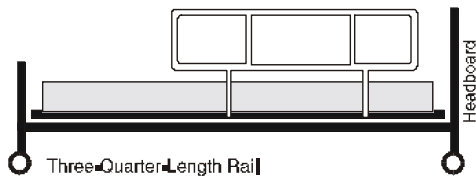
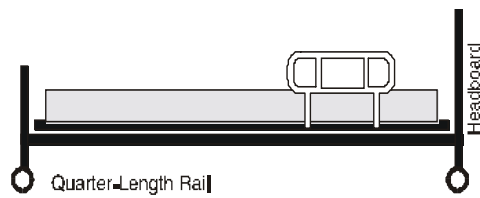
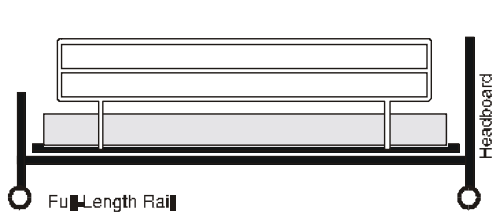
Vest/chest	<input type="checkbox"/>	Wrist soft--bilateral	<input type="checkbox"/>	Ankle soft--bilateral	<input type="checkbox"/>	Mitt--bilateral	<input type="checkbox"/>
Pelvic/crotch	<input type="checkbox"/>	Wrist soft--one	<input type="checkbox"/>	Ankle soft--one side	<input type="checkbox"/>	Mitt--one	<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 ☐)

☐
☐
☐
☐
☐

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

Yes

No

Don't Know

☐
☐
☐

32. What was the upper bed deck articulation?

☐

Flat

☐

46 to 89 degrees

☐

15 to 30 degrees

☐

90 degrees

☐

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) _____

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't Know |
| 38. Was the mattress one of those recommended by the manufacturer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

39. Was this bed assessed as per the Health Canada guidance on beds and if so what was the result?

40. Did this bed meet the IEC 60601-2-52 international standard for medical beds?

Yes

☐

No

☐

Don't Know

☐

41. Reporter contact information:

Name: _____

Facility Name: _____

Facility Address: _____

Phone number: _____

Fax Number: _____

Email: _____