**Monthly bed rail audit**

To be completed monthly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Residents Initials** | **Room number** | **Type of bed.**  **Care home Profiling or NRS** | **Are bed rails securely fitted and bumpers in place, are they clean, stain free and no rips or tears (Yes/No)** | | **Bed rail risk Assessment completed and reviewed monthly or more often where required**  **(YES/NO)** | | | | **Extra height bed rails in situ if required**  **YES/NO** | | **comments** |
|  |  |  | **Yes** | **No** | **Risk assessment** | **Care plan** | **Consent or best interest** | **Yes** | | **No** |  |
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Completed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_