NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

TRUST POLICY AND PROCEDURES FOR THE SAFE USE OF BED RAILS

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Version / Amendment History	Version	Date	Author	Reason
	1	March 2018	Hilary Sullivan	Merged and updated Policy for UHDB sites

Intended Recipients: All staff involved in the care and management of in-patients whilst under the care of UHDB – all sites

Training and Dissemination: Trust Induction, Mandatory Falls training programme and periodic updates, Intranet. There will be a communication launch via Flo as part of a communication plan.

- **To be read in conjunction with:** Trust Policy and Procedures for Managing the Risks Associated With Slips, Trips and Falls Including Work at Height for Staff and Others, Guidelines for the Management and prevention of Delirium, Maintaining a Safe Environment. Continence Pathway, Trust Policy for Prevention and Management of In Patient Falls,, Manual Handling Policy, Management of Head Injury after fall as inpatient guideline, Drugs contributing to falls in the elderly clinical guideline, Trust Incident Reporting Policy, Trust Policy for the Provision and Use of Walking Aids for Inpatients

In consultation with and Date: Chief Nurse meeting, Nursing & Midwifery group, JPAC, Trust Falls Group, Patient Safety Group, Trust Development Group

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Executive Lead Signature	Director of Patient Experience & Chief Nurse
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POLICY FOR THE SAFE USE OF BED RAILS

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UHDB NHS Foundation Trust

ADULT POLICY FOR THE SAFE USE OF BED RAILS

1. INTRODUCTION

The Trust aims to take all reasonable steps to ensure the safety and independence of patients and to respect the right of patients to make their own decisions about their care. This policy sets out a framework for the use of bed rails to reduce the risk of a patient slipping, sliding, falling or rolling out of a bed.

The Medicines and Healthcare products Regulatory Agency (MHRA) (2013) receives many reports of incidents relating to bed rails and associated equipment. These incidents are of concern as several result in patient harm or death, primarily from entrapment. Patients may be at increased risk of falling from bed for many reasons including poor mobility, dementia or delirium, visual impairment and the effects of their treatment or medication.

It is not appropriate to use bed rails for some patients, and the appropriate use of bedrails also involves risks. National data suggests around 1,250 patients injure themselves on bedrails each year, usually scrapes and bruises to their lower legs. Bed rails should not be used as a form of restraint or as an aid to moving and handling unless in exceptional circumstances which must be documented on the Bed Rail Risk assessment.

Based on reports to the MHRA, the HSE, and the NPSA deaths from bedrail entrapment in hospital settings in England and Wales occur less often than one in every two years, and could probably have been avoided if MHRA advice had been followed. Staff should continue to take great care to avoid bedrail entrapment, but need to be aware that in hospital settings there is a greater risk of harm to patients from falling from beds.

NHS 'Never events' are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. NHS 'Never events' frame work 2018 number 11 covers entrapment in bed rails [v]

2. SCOPE OF THE POLICY

This policy is relevant for all staff caring for adult patients in the Emergency Department, assessment units and inpatient areas within UHDB NHS Foundation Trust.

3. POLICY AIMS AND OBJECTIVES

This policy aims to:

- Reduce harm to patients caused by falling from beds or becoming trapped in bedrails
- Support patients and staff to assess the risks of using and of not using bedrails.
- Ensure compliance with Medicines and Healthcare Related products Agency (MHRA), Health and Safety Executive (HSE) and National Patient Safety Agency (NPSA) advice.

4. STAFF RESPONSIBILITIES

Decisions about the use of bedrails should be made in the same way as decisions about other aspects of treatment and care as outlined in the Trust's Consent Policy:

- If the patient has capacity to do so, they should be included in the discussions whether or not bedrails should be used. Capacity is the ability to understand and weigh up the risks and benefits of bedrails once these have been explained to them. Discussions about the risks of using bedrails, if requested by the patient, and decisions should be documented by staff.
- If the patient lacks capacity, a trained member of staff must decide if bedrails are in the patient's best interests. A capacity assessment must be carried out as part of the risk assessment. Staff can learn about the patient's likes dislikes and normal behaviour from relatives and carers and should discuss the benefits and risks of the use of rails with relatives or carers if possible. However the decision about the need for bed rails must be a clinical one using clinical judgement and the reasons for the decision to use bedrails must be recorded clearly on the bed rails assessment document.

5. BED RAILS AND FALLS PREVENTION

Decisions about bedrails are only one small part of preventing falls. Patients at risk of falling should be assessed to identify other steps that should be taken to reduce the patient's risk of falling not only from bed, but also when walking, sitting and using the toilet. If the patient is at risk of falling the Trust *Policy and Procedures for the Prevention and Management of Inpatient Falls* should be utilised.

6. INDIVIDUAL PATIENT RISK ASSESSMENT

Members of staff need to follow the manufacturer's instructions for use of the bed rails and any warnings about associated risks. The equipment should only be used and maintained in line with the manufacturer's instructions for use.

Risk assessments should be carried out before use and then reviewed and recorded every day and also if there is a significant change in the patient's condition or they are transferred to a different area in the trust.

Bedrails should not be used if the patient:

- is able to climb over them or around the end of the rails at the bottom of the bed.
- would be independent if the bedrails were not in place.

Bedrails should be used:

- if the patient is being transported on their bed
- in areas where patients are recovering from anaesthetic or sedation and are under constant observation.

However, most decisions about bedrails are a balance between competing risks. The risks for individual patients can be complex and relate to their physical and mental health needs i.e. cognitive impairment, the environment, and their treatment. Staff should use their professional judgement to consider the risks and benefits for individual patients.

Use bedrails if the benefits outweigh the risks in accordance with this policy.

There is an ethical decision regarding the utilisation of bed rails to prevent harm and their usage as restraint. To aid this decision the NPSA advise "*Restraint is the intentional restriction of a person's voluntary movement."*

Decisions about bedrails may need to be frequently reviewed and changed. For example, a patient admitted for surgery may move from being independent to semi-conscious and immobile whilst recovering from anaesthetic and then back to being independent in the course of a few hours. Therefore decisions about bedrails should be reviewed whenever a patient's condition changes. Reassessment should be carried out at least on a daily basis.

Increased Supervision

All patients receiving care and treatment on Trust premises are assessed with a view to monitoring their general safety and well-being. However, due to the disease process, unfamiliar surroundings, current medication therapy or the patient's mental health needs i.e. Dementia patients may require a temporary period of enhanced level of observation following a risk assessment, to maintain patient safety while the level of risk is managed. This should be considered especially for patients that have a cognitive impairment and are at risk of falls. Bed rails should not be used for patients requiring increased supervision.

7. DOCUMENTATION

The decision to use or not use bedrails should be recorded within the bed rails assessment documentation and any variances should be documented fully. All patients should be reassessed daily or if condition changes or the patient transfers to different area in the Trust.

8. USING BED RAILS

UHDB NHS Foundation Trust has taken steps to comply with MHRA advice through ensuring that;

- Types of bedrails, beds and mattresses used on each site within the organisation are of compatible size and design, and do not create entrapment gaps for adults within the range of normal body sizes

- When bedrails are used staff should carry out checks to ensure the bed rails are in good working order. If any issues are found the bed should be removed from service immediately.

- Where the patient is an unusual body size (for example, hydrocephalic, microcephalic, growth restricted, very emaciated or bariatric), staff should check for any bedrail gaps which would allow entrapment

- For patients who are assessed as requiring bedrails but who are at risk of striking their limbs on the bedrails, or getting their legs or arms trapped between bedrails, the ward staff should be aware of the availability and source of specialist equipment.

Hilo beds by design, do not require the use of bed rails.

9. REDUCING RISKS

If a patient is found in positions which could lead to bedrail entrapment, for example, feet or arms through rails, halfway off the side of their mattress or with legs through gaps between spilt rails, this should be taken as a clear indication that they are at risk of serious injury from entrapment. Urgent changes must be made to the plan of care and a risk assessment performed. The assessment findings could include changing to a special type of bedrail or deciding that the risks of using bedrails now outweigh the benefits.

If a patient is found attempting to climb over their bedrail, or does climb over their bedrail, this should be taken as a clear indication that bed rails should not be used. The risks of using bedrails outweigh the benefits, unless their condition changes.

The safety of patients with bedrails may be enhanced by frequently checking

that they are still in a safe and comfortable position in bed, and that they have everything they need, including toileting needs. However, the safety needs of patients without bedrails who are vulnerable to falls are very similar. All patients in hospital settings will need different aspects of their condition checked - for example, breathlessness, anxiety and pain. Consequently, observing patients with bedrails should not be treated as a separate issue but as an important part of general observation within each ward/department, it is important that vulnerable patients are placed in the area where they can be most easily observed within the Ward area.

10. EDUCATION AND TRAINING

UHDB NHS Foundation Trust ensures that:

- All staff who make decisions about bedrail use, or advise patients on bedrail use, have the appropriate knowledge to do so;
- All staff who have contact with patients, including students and temporary staff, understand how to safely lower and raise bedrails and know they should alert the nurse in charge if the patient is distressed by the bedrails, appears in an unsafe position, or is trying to climb over bedrails.

These points are achieved through:

- Mandatory Moving and Handling and falls prevention as part of the Trust standard update
- Clinical induction
- Specific training regarding the correct use of beds and mattresses and the correct selection of these to meet the patients' requirements.

11. BEDRAILS ON TROLLEYS

Rails on trolleys should be kept in an upright position at all times while the patient is on the trolley unless lowered to enable care to be delivered.

12. CLEANING BED RAILS

Bedrails should be cleaned as instructed as part of the routine bed cleaning list. Visible contamination of the rails should be cleaned with detergent and hot water ensuring that universal precautions are followed and should be undertaken in accordance with the Infection Control Policy.

13. ADVERSE INCIDENT REPORTING

Any member of staff discovering any variance or deviation from this policy must complete an Incident Form in line with the Trust Incident Reporting Policy.

Any untoward incidents should be dealt with by the appropriate management team. An Incident Form must be completed as per the Trust Incident Reporting Policy. If a serious injury occurs i.e. a fracture or head injury, this should be considered for being reported as a RIDDOR and the Divisional Governance Team advised of the incident as soon as possible. Any faulty beds must be removed from service, isolated and reported to Estates via the Helpdesk.

14. POLICY EFFECTIVENESS

The process for monitoring the effectiveness of the Adult Policy for Safe Use of Bed Rails is:

- Quality monitoring (ward assurance) and care planning audits will be used to monitor compliance. All critical incidents will evaluate the quality of initial and on-going assessment.
- The Clinical Risk Manager, Complaints and PALS Manager and Legal Services Manager will monitor Incidents, Complaints and Claims related to the Adult Policy for the Safe Use of Bed Rails.

15. REFERENCES

NPSA 2007 *Slips, trips and falls in hospital*

Department of Health. NHS Never Events. (2018)
http://www.dh.gov.uk/health/2012/01/never-events-update/

Mental Capacity Act 2005 The Stationary Office Limited: London

MHRA Device Bulletin DB2006(06) *The safe use of bedrails* and MHRA Device Alert 2007/009 *Bed Rails and Grab Handles* www.mhra.gov.uk

Health and Safety Executive Bed Rail Risk Management
http://www.hse.gov.uk/lau/lacs/79-8.htm

Health and Safety Executive Safe Use of Bedrails
http://www.hse.gov.uk?healthservices/bed-rails.htm