PAPER D

EQUIPMENT MANAGEMENT BOARD – 24TH APRIL 2015

ISSUING OF BED RAILS – CORONERS INVESTIGATION - UPDATE

1. Purpose of Report

To update the EMB on the actions taken following the recent bed rails incident and Coroner's report.

2. Recommendations

EMB to:

(a) Note the contents of this report
(b) Comment on Section 5 – Transfer of responsibility arrangements and agree next steps

3. Background

The EMB received a report at its meeting on 27th February providing them with the full details of this case and the Coroner's findings. LPT, UHL and the ICES Commissioning Manager have been working together to address the concerns raised by the Coroner and to implement required actions.

A task and finish group was convened for the purposes of responding to the concerns raised by the Coroner with representatives from UHL Discharge, LPT Nursing and the ICES Commissioning Manager.

Both LPT and UHL have responded to the Coroner. LPT have supplied the Coroner with an action plan.

4. Action Taken

The following action has been taken:

(a) The bed rail risk assessment has been revised and updated and it is intended that this risk assessment will be used in both inpatient and community settings. LPT and UHL will use the risk assessment in the inpatient setting and LPT and Local Authority staff will use the risk assessment in the community setting, this may include residential homes.

The risk assessment has been circulated to Social Care Teams in the City, County and Rutland for comment. A copy of the revised risk assessment is attached as Appendix 1.

(b) The ICES and LPT ‘Safe use of bed rail Policy’ has been merged into one policy that will be used by UHL and LPT Inpatient and for staff accessing bed rails through the ICES.

This document has been circulated to members of the Task & Finish Group for comment and once a finalised version is agreed, this will be circulated through the ICES to Local Authorities for feedback.

Once all feedback has been received and updated as required, the Policy will need to be signed off by the UHL and LPT decision making groups and also by the ICES Contract Monitoring Group/EMB.

(c) Transfer of responsibility arrangements. The Policy now includes proposals for the transfer of responsibility for bed rails following discharge to the community or from a health or social care professional (their Organisation) within the community to another carer – this may be informal or formal care.

The transfer arrangements is a key area that needs to be addressed and agreement is required on who takes responsibility of point of discharge of the patient/service user, if bed rails are risk assessed as continuing to be required.

The arrangements included in the Policy at this stage, are those that can be put in place at this time. However further discussion and agreement on transfer arrangements is required by all organisations whose staff will be assessing for and prescribing bed rails. This is covered under Section 6 below.

5. Transfer of responsibility for bed rails

The current proposal is set out in Appendix 2 in the form of a flowchart.

Recommendations for length of time before bed rails should be reviewed is included within the risk assessment process. The recommendations are:

- Within hospital setting a minimum weekly
- Within community setting a minimum of six monthly; or
- Every time the patient/service user’s condition changes

The following issues need to be discussed and agreed:

(a) Should the responsibility for the bed rails be transferred from a health care professional, when there is no longer a health need, but the requirement for bed rails remains?

(b) What risks are associated with doing this?

(c) Should responsibility remain with the health care professional’s organisation? If so how will this be reviewed by that organisation?

(d) Should a dedicated review function be set up, which will take over responsibility for review of bed rails that remain in the community, six monthly or as notified in change of patient/service user condition. This option has been set up in Warwickshire, where the Community Health Service Provider has recruited two Band 4 posts to be responsible for reviewing bed rails. At point of patient/service user discharge, if the assessment identifies a need for the bed rails to remain in situ, then the responsibility for review is transferred to this review team.

This option would require additional funding for LPT to recruit staff for this role.

(e) What would be the position if the bed rails had been ordered for a social care need, e.g. by an NHS OT or Social Care OT and there had been no health care involvement. How would the review of rails that remained in situ be undertaken, as this would not be responsibility of LPT?

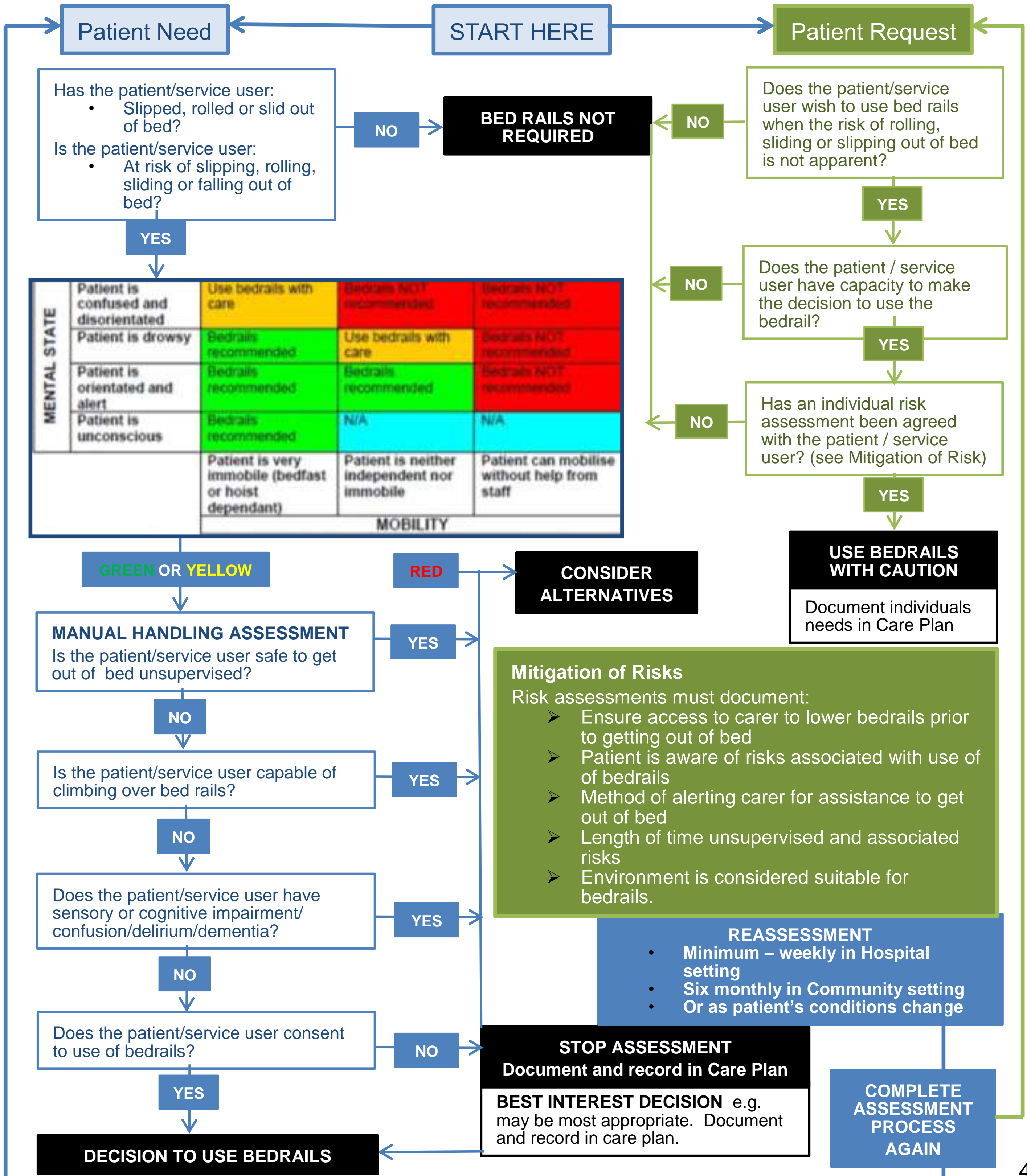
6. Report Author

Julie Morley, ICES Commissioning Manager

BED RAIL RISK ASSESSMENT FLOW CHART

APPENDIX 1

Complete on initial assessment
Review if condition changes
Review in preparation for discharge



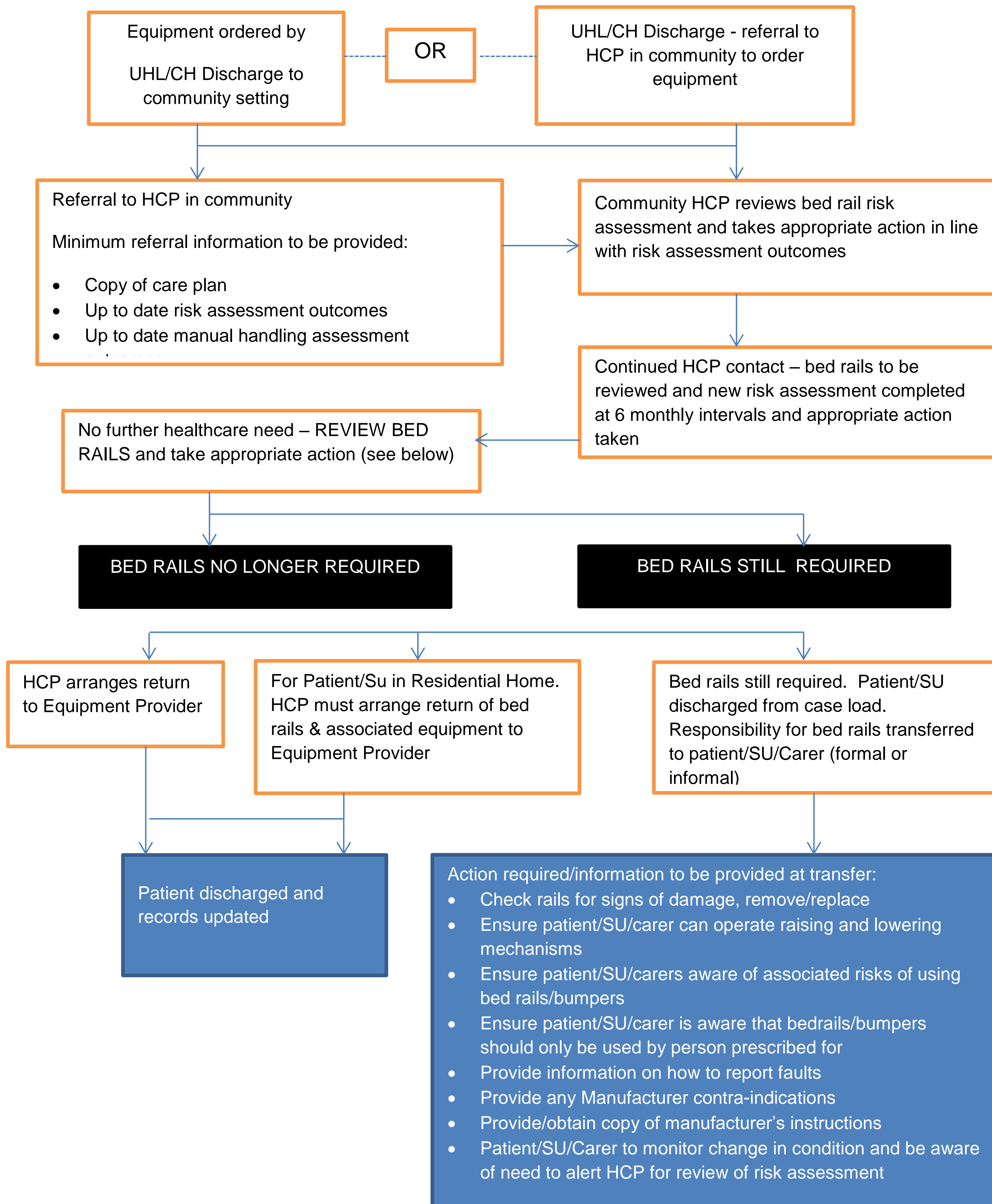
MENTAL STATE			
Patient is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
Patient is drowsy	Bedrails recommended	Use bedrails with care	Bedrails NOT recommended
Patient is orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails NOT recommended
Patient is unconscious	Bedrails recommended	N/A	N/A
MOBILITY	Patient is very immobile (bedfast or hoist dependant)	Patient is neither independent nor immobile	Patient can mobilise without help from staff

Must be printed in colour

V5 April 2015

APPENDIX 2

TRANSFER ARRANGEMENTS TO ANY PATIENT/SERVICE USER CARE SETTIN



The following has been included in the draft revised policy:

11. ARRANGEMENTS FOR TRANSFER OF CARE FROM HOSPITAL TO COMMUNITY AND WITHIN COMMUNITY

The arrangements for transferring responsibility for patient/service users with bed rails is set out in 'Transfer of arrangements flowchart' included as Appendix xx to this Policy.

Transfer from inpatient to community setting:

Minimum referral requirements are set out below which need to be in place and transferred at point of discharge from hospital to a health care professional in the community:

- Latest outcome of the bed rail risk assessment
- Latest outcome of moving and handling assessment
- Patient demographics
- Copy of care plan

For hospital discharge the information above will be contained in the ICE letter

Transfer within a community setting:

When the patient/service user care is being transferred within a community setting, e.g. transfer to a Care Agency, Residential Home, Informal Carer, the bed rails should be reviewed prior to discharging patient/service user.

If the bed rails are **NO LONGER** required then the healthcare professional should take the following action:

- If the bed rails are in the patient/service user's own home then the health care professional should arrange for these to be returned to the Equipment Provider
- If the bed rails have been provided for a patient/service user in a residential home, and no further nursing input is required, prior to discharging the patient/service user from caseload, the healthcare professional should arrange for the bed rails and other associated equipment, e.g. bed and pressure care equipment, to be returned to the Equipment Provider.
- **EQUIPMENT SHOULD NOT BE LEFT WITH THE RESIDENTIAL HOME**

If the bed rails are assessed as **still required** then the Health Care Professional should take the following action prior to discharge and as part of handover (hand over could be to Care Agency, Informal Carer :

- Check the rails to ensure that there are no signs of damage, faults or cracks on the bed rails. If any identified damage then the rails should be removed immediately and reported for repair. If the bed rails have been supplied through the ICES then the Health Care Professional should contact the Equipment Provider to arrange collection and replacement

- Ensure the patient/service user and/or organisation/person providing future care know how to report a fault

- If the manufacturer has provided advice on any contra indications for use then this information should be passed to patient/service user and/or organisation/person providing future care

- Check that the patient/service use operate any raising or lowering mechanism independently

- If the equipment has been provided through the ICES, ensure that a copy of the manufacturer's instructions are available, if not then please contact the Equipment Provide to obtain a copy for handover

- Ensure the patient/service user and /or organisation/person providing future care understand the risks associated with use of bed rails/bumpers

- Ensure that the patient service user and/or organisation/person providing future care understands that the bed rails/bumpers should only be used by the patient/service user prescribed for

- Ensure that the patient/service user and/or organisation/person providing future care monitors any changes in patient/service use condition and is aware of the need to alert a health care professional for review of risk assessment – do they have contact details?