Leicestershire Partnership NHS
NHS Trust

Integrated Policy:
Safe Use of Bed Rails for Adults

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Name of originator/author:	LPT – Victoria Peach, Lead Nurse Community Services UHL – Mandy Gilhespie Mandy – Specialist Nurse for Discharge ICES – Julie Morley, Commissioning Manager
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NHSLA Risk Management Standards if applicable:	
State 00Relevant CQC Standards:	Regulation 15: Premises and Equipment. Regulation 12: Safe Care and Treatment. Regulation 9: Person Centred Care

This is a shared policy across Leicestershire Partnership NHS Trust, Integrated Community Equipment Services, and University Hospitals of Leicester. The document describes the standards for the safe use of bed rails.

University Hospitals of Leicester NHS
NHS Trust

Leicestershire Partnership NHS
NHS Trust

Leicester City Council

Leicestershire County Council

Rutland County Council

Date	Revision	By Whom	Version
13.04.15	Updates as agreed by Bed Rail Task & Finish Group to integrate LPT and ICES Bed Rail Policy	JEM	1
21.04.15	LPT considerations amended by Lead Nurse. Formatting and grammar changes made.	VP	2
24.04.15	Additions to appendices and associated changes within the text.	VP	3
1.5.15	Grammatical changes. Amended Fact sheet to Carers confirmation of information following feedback from LD.	VP	4
11.05.15	Additional circulation for ICES	JEM	5
14.05.15	LPT front page for LPT – amendment to LPT training section 12.2.2.	VP	6
04.06.15	UHL NME group comments 4.2.1 change director of nursing to chief nurse. 6.7. Risk assessment for bumpers added refer to 7.4 and 7.4.1. Updated distribution list, page numbers.	VP	7
08.06.15	Adult social care professional added to prescriber not just healthcare professional as OT's working in social care are not considered healthcare professionals.	VP	8
16.10.15	Amendment to transfer of care section to reflect EMB comments and collective care agreement.	VP	9

Key individuals involved in developing the document:

Name	Designation
Julie Morley	ICES Commissioning Manager
Victoria Peach	Lead Nurse Community Services, LPT
Linda Bull	Matron, Coalville Community Hospital, LPT
Maria Ward	Project Lead Documentation and Care Planning, LPT
Katie Crowfoot	Learning Disabilities Occupational Therapist, LPT
Tracey Charity	Learning Disabilities LPT
Mandy Gilhespie	UHL Specialist Discharge Lead
Andrew Lewitt	UHL Moving and Handling Co-ordinator

Circulated to the following for comments:

Name	Designation
Senior Clinical Team	LPT
Clinical Network – Community	LPT
Clinical Network – In patients	LPT
Clinical Network - MHSOP	LPT
Lead Nurses	LPT
Strategic Development Group	LPT
Professional Advisory Group Adults	ICES, LPT, Local Authority
Contract Monitoring Group	ICES
Equipment Management Board	ICES, LPT, Local Authority
Sue Deakin	LPT
NME group	UHL
CEG	LPT
Social Care Team Managers	Local Authority – City
Karen Walmsley	Local Authority
Jan Barton	Local Authority
Mark Goddin	Local Authority - County

Contents

Definitions that Apply to this Policy:

ICES	Integrated Community Equipment Service. A jointly funded service across Leicester City Council, Leicestershire County Council, Rutland County Council and the NHS Clinical Commissioning Groups for Leicester City, West Leicestershire, East Leicestershire & Rutland. This service provides equipment to eligible residents across Leicester, Leicestershire & Rutland following an assessment by a Health and/or Social Care Professional.
LLR	Leicester, Leicestershire & Rutland
Prescribers/professionals	Adult Social Care professionals employed by Leicester City Council, Leicestershire County Council, Rutland County Council and Healthcare professionals employed by Leicestershire NHS Partnerships Trust (LPT), University Hospitals of Leicester (UHL) with the ability to order equipment from ICES to meet patient need. Issued with a prescribing pin that enables them to order equipment from the ICES.
LPT	Leicestershire NHS Partnership Trust
UHL	University Hospitals of Leicester
MHRA	Medicines and Healthcare products Regulatory Agency.
HSE	Health and Safety Executive
NPSA	National Patient Safety Agency
NRS	Nottingham Rehab Services – provider of community equipment service to LLR ICES.
Restraint	Is defined as 'the intentional restriction of a person's voluntary movement or behaviour'.
NHS Never Events	Defined as serious largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
Capacity	Is the ability of an individual to understand and weigh up the risks and benefits of bedrail usage. The requirement is that the individual should have information provided in a way that will support their understanding and comprehension to reach a decision.
Bed rail(s)	Rails affixed to the sides of a bed to reduce the risk of an individual falling out of bed. May also be referred to as 'cot sides', 'side rails' or 'bed guards'. This includes specialist bed rail systems, for example inflatable or mesh safety systems.

Bed rail bumpers (padding)/cot side bumpers	These are a padded air- permeable accessory or enveloping cover in design that are primarily used to prevent impact injuries; they can also reduce the potential for limb entrapment when securely affixed to the bed or rail. In some instances these themselves can become a hazard and introduce entrapment risks if they are able to move or compress.
Entrapment	Where body parts, usually limbs, become trapped between rails or between the rails and the side of the mattress. It may be possible for the head to slip through the rails and may result in asphyxiation; although this risk is rare.
Adverse incident	An event that causes or has the potential to cause, unexpected or unwanted effects involving the safety of the device user(s);including patients, staff or other person.
Ultra Low profiling bed (high/low bed)	Refers to an electronically operated bed that can be height adjusted to a level below that of a standard hospital bed, sometimes to floor level.
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Equality Statement

The Leicester, Leicestershire and Rutland Integrated Community Equipment Service (ICES, Leicestershire Partnership NHS Trust and University Hospitals of Leicester aim to design and implement policy documents that meet the diverse needs of the services delivered, population and workforce, ensuring that none are placed at disadvantage over others. It takes into account the provisions of the Equality Act 2010 and advances equal opportunities for all. This document has been assessed to ensure that no-one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

1. Summary

The aim of this policy is to ensure the safety of all patients / service users using bed rails in all care settings, whilst promoting their independence and respecting their right to make their own decisions about their care.

The policy is a shared document across Leicester City Council, Leicestershire County Council, Rutland Council, University Hospitals of Leicester, and Leicestershire Partnership NHS Trust.

2. Introduction

Patients /service users may be at risk of falling, sliding or slipping from a bed or trolley for many reasons. Bedrails are one option available to help prevent persons' from falling, slipping or sliding out of bed. The use of bed rails is not without risk. Each person who is at risk of falling, sliding or slipping out of bed should have a risk assessment completed to identify that the benefits of using bed rails outweighs the risks.

Bed rails must only be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of a bed / trolley when alternative measures have been considered and risk assessments completed. Bed rails are not designed or intended to limit the freedom of a person and are not a form of restraint. Bed rails are not intended as a moving and handling aid.

This Policy applies to health and social care professionals employed by Leicester City Council, Leicestershire County Council, Rutland Council, University Hospitals of Leicester, and Leicestershire Partnership NHS Trust who are involved with individuals requiring and using bed rails.

3. Purpose of the Policy

The purpose of the policy is to:

3.1 Ensure that all patients / service users within any care setting undergo a risk assessment prior to the decision to use bed rails and that documentation must support the appropriate use of bed rails for any individual (refer to Bed Rail Risk Assessment Flow Chart Appendix 1).

3.2 Reduce potential harm to patients / service users caused by falling from beds or becoming trapped in bed rails.

3.3 Support patients / service users, carers and staff to make individual decisions around the risk of using and not using bed rails.

3.4 Ensure compliance with Medicines and Healthcare Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA) advice.

4. Duties within Organisations

4.1 Leicestershire Partnership Trust (LPT):

4.1.1 The LPT Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

4.1.2 Trust Board sub-committees have the responsibility for ratifying policies and protocols.

4.1.2 Divisional Directors and Heads of Service are responsible for ensuring that policy is embedded across their Division / Service.

4.1.3 Managers and Team leaders will be responsible for:

- Implementation of the policy within their clinical area.
- Managers and Team leaders will ensure by delegation that a risk assessment pertaining to the use of bed rails is carried out and acted upon.
- To manage and /or delegate the responsibility for ensuring staff have the knowledge base for the safe use of bed rails.
- Investigating incidents where patients have sustained injury following the use of bedrails.
- Ensuring that action is taken to prevent recurrence of any incident where bedrails have been implicated in a patient sustaining an injury.

4.1.4 Responsibility of Staff:

- Maintain the standards in this policy and accept accountability for their own practice.
- Report incidents and near misses relating to patient injury involving the use of bedrails.
- Undertaking/cooperating with audits of practice within the clinical setting.
- Complete documentation appropriate to the care setting.

4.2 University Hospital of Leicester (UHL):

4.2.1 The Medical Director and Chief Nurse have overall responsibility for the quality of medical and nursing intervention to support the policy.

4.2.2 It is the responsibility of the Consultant to ensure that a medical management plan is in place to treat and prevent causes of falling.

4.2.3 The Heads of Nursing and Matrons are responsible for ensuring compliance with this policy, supporting training, audit, reviewing results and implementing change where appropriate.

4.2.4 The Ward Sister/Charge Nurse has responsibility for ensuring adherence to policy are maintained and that staff report any examples of non-adherence to the policy through the hospital adverse events reporting system.

4.2.5 It is the responsibility of **all** members of the multi-disciplinary team to ensure they comply with the policy and to consult and update with the service user their families and carers regularly.

4.2.6 The Specialist Nurse for Discharge has responsibility for ensuring discharge teams working within UHL receive training to ensure compliance with policy when ordering hospital beds/bed rails for patients/service users for discharge, who are assessed as at risk of slipping, sliding or rolling out of bed.

4.2.7 The Discharge Team (discharge specialist sisters, discharge co-ordinators, acute care nurses, primary care co-ordinators) have responsibility for complying with policy when ordering equipment for patients/service users who are assessed as being at risk of slipping, sliding or rolling out of bed. The team will ensure that service users, their families and carers, are consulted regarding the assessment and care plan; and that a formal handover is provided to community health or social care services that are responsible for the patient / service user following transfer.

4.2.8 <u>UHL Legal Liability:</u>

- The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:
    - Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
    - Have been fully authorised by their line manager and their Directorate to undertake the activity.
    - Fully comply with the terms of any relevant Trust policies and / or procedures at all times.
    - Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable – such decision to be fully recorded in the patient notes.

- It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of these circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available: such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

- Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies. For further advice please contact Assistant Director (Head of Legal Services).

4. 3 Local Authority Social Care Teams:

4.3.1 Heads of Service, Locality Managers, Service/Operation Managers will be responsible for:

- Implementation of this policy within their clinical area.
- Managers and Team Leaders will ensure by delegation that a risk assessment pertaining to the use of bed rails is carried out and acted upon.
- To manage and/or delegate the responsibility for ensuring that staff are trained in the safe use of bed rails.
- Investigating incidents where patients have sustained injury following the use of bed rails.
- Ensuring that action is taken to prevent recurrence of any incident where bedrails have been implicated in a patient sustaining an injury.

4.3.2 Responsibilities of staff:

- Maintain the standards in this policy and accept accountability for their own practice.
- Report incidents and near misses relating to patient injury involving the use of bed rails.
- Undertaking/co-operating with audits of practice within the clinical setting.
- Complete documentation appropriate to care setting.

4.4 Integrated Community Equipment Service (ICES) Equipment Provider:

4.4.1 The ICES Equipment Provider will:

- Ensure that their staff are trained to install bed rails correctly and are complying with manufacturer's instructions.
- Provide manufacturer's instructions with delivery of all bed rails – for both new and recycled bed rails.
- Ensure recycled bed rails are inspected, stored and maintained in line with manufacturer's instructions and their own operating procedures.
- Ensure bed rails are supplied in good, clean working condition.

- Ensure that bed rails and bed rail bumpers meet product standards determined by up to date International, European and British health and safety requirements. Only supply bed rails when requested by an authorised prescriber.

5. Responsibility for Decision Making

5.1 Decisions about bed rails need to be made in the same way as decisions about other aspects of treatment and care, as outlined in the consent policies of the organisations signed up to this policy.

5.2 This means:

- The patient must decide whether or not to have bed rails if they have capacity to make this decision. (Capacity is the ability to understand and weigh up the risks and benefits of bedrails once these have been explained to them and this will be recorded in the patient/service user care plan/records.)
- Every effort must be made to ensure that the patient is given the opportunity to be involved in the decision-making process. This may involve providing interpreter services for patients/service users.
- Staff can learn about the patient's likes, dislikes and normal behaviour from relatives and carers, and must discuss the benefits and risks with relatives or carers. However, relatives or carers cannot make decisions for adult patients (except in exceptional circumstances where they hold a Lasting Power of Attorney extending to healthcare decisions under the Mental Capacity Act 2005).
- If the patient lacks capacity, staff have a duty of care to decide if bed rails are in the patient's best interests and this must be documented in the patient / service user records.

6. Individual Patient / Service User Assessment

6.1 Most decisions about bed rails are a balance between competing risks. The risks for individual patients can be complex and relate to: their physical, sensory and mental health needs; the environment; their treatment; their personality; their lifestyle; and the equipment available, inclusive of type of bed, bed rail and bed rail accessories. Staff must use their professional judgement to consider the risks and benefits for individual patients / service users. Bed rails must be used only if the benefits outweigh the risks and this must be documented in the patient / service user records. The Bed Rail Risk Assessment Flowchart (appendix 1) is available to aid decision making.

6.2 A comprehensive individual assessment must be carried out prior to the bed rail being used in the patient / service user's care setting that the bed rail is intended for use. The assessment must be clearly documented. .

6.2.1 Within a hospital setting the continued use of bed rails must be reviewed by a health care professional each time there is a change in circumstances involving the patient or at a minimum of weekly.

6.2.2 In the community setting the continued use of bed rails must be reviewed when there is a known change in the circumstances involving the patient or a

minimum of 6 monthly until the patient is discharged.

6.2.3 All staff must ensure that the patients / service users and carers (formal or informal) are aware of the their responsibility to;

- Ensure correct use of bed rails and bed rail accessories.
- Alert health care professional to a change in the circumstances that would affect the safe use of bed rails.

6.3 When the patient / service user has been assessed as requiring bed rails but then refuses them alternative outcome of preventing injury from sliding, slipping and rolling out of bed must be considered. All decisions and information provided to the patient / service user must be documented.

6.4 Bed rails must not be used if:

- The patient is agile enough or confused enough to climb over them.
- The patient would be independent if the bedrails were not in place.

6.5 When a patient / service user requests bed rails without having a determined risk of rolling, sliding or slipping out of bed, staff should ensure that the appropriate strategies are in place to allow the patient / service user to get out of bed when necessary and limit the risks associated with the use of bed rails (Follow the process for patient request set out in the Bed Rail Risk Assessment Flow Chart Appendix 1).

6.6 Within a hospital setting bed rails are used to transfer patients / service user between departments. Where a patient's risk assessment has identified that bed rails are not recommended or recommended with care for the patient, then the patient should receive continuous supervision throughout time of transfer.

6.7 Bed Rail Bumpers:

For patients / service users who are assessed as requiring bed rails and may need bed rail bumpers, then a risk assessment for use of bumpers must be carried out (refer to point 7.4 and 7.4.1).

7. Risk of Entrapment

7.1 Entrapment may occur:

- Between the end of the bed rail and the headboard if the gap is inappropriate.
- In the space between a poorly fitting mattress and side of the bed rail or if a bed rail is used that does not fit the bed base sufficiently snugly.
- Between the horizontal bars of the bed rails if the physical size of the bed occupant is not considered. This applies particularly to children and small adults.

7.2 Patients / service users who have an unusual body size, such as those with amputated limbs, very emaciated, hydrocephalic or microcephaly growth restriction, may be at increased risk of entrapment. Assessment and care planning must take an individual's risk into account; checks must be made to identify bed rail gaps which would allow head, body or neck to become

entrapped.

7.3 To reduce the risk of entrapment, staff must ensure that when using detachable bed rails:

- The gap between the top end of the bed rail and the head of the bed must be less than 6 cm or more than 25 cm.
- The gap between the bottom end of the bed rail and the foot of the bed must be more than 25 cm.
- The fittings must all be in place and the attached rail must feel secure when raised

(These dimensions comply with regulation BS EN 60601-2-52:2010.)

7.4 For patients / service users who are assessed as requiring bed rails but who are at risk of striking their limbs on the bed rails, or getting their legs or arms trapped between bed rails, bed rail bumpers must be used.

7.4.1 Bed rail bumpers, are padded accessories which are primarily used to prevent impact injuries but may in some instances reduce the potential for limb entrapment. However bumpers that can themselves be moved or compressed may introduce entrapment risks.

7.5 If a service user/patient is found in positions which could lead to bed rail entrapment, for example, feet or arms through rails, halfway off the side of their mattress or with legs through gaps between the horizontal bars of the bed rail, this must 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. These could include changing to a special type of bed rail, such as providing mesh bed rails, the use of 'cocoons', or deciding that the risks of using bed rails now outweigh the benefits.

7.6 Bariatric beds must be used with a compatible extra wide mattress and checks made for any potential entrapment gaps. If assessed for and required compatible bed rails and bumpers will be needed.

8. Safe Use of Bed Rails

8.1 All bed rails or beds with integral rails must have an asset identification number and be regularly maintained and serviced.

8.2 In exceptional circumstances when mattress overlays are required, these must be used with extra height bed rails and appropriate bumpers.

8.2.1 Mattress overlays are no longer used in UHL and are only available as a specialist item for use in LPT from the ICES subject to a discussion and authorisation by the Tissue Viability Team.

8.3 When using bed rails, staff must ensure that:

- The bed rails are not damaged, faulty or cracked. If so, label as faulty and remove from use.

- Equipment identified as unsafe should be reported for repair to the relevant organisation and in accordance with organisation's procedures.

- The patient / service user, and their carers, know how to report a fault.

- The bed rails are used in accordance with the manufacturer advice.

- The bed rail(s) is suitable for the bed to which it is be fitted.

- That equipment provided by ICES is supplied with manufacturer's instructions. If not, contact ICES for manufacturer's instructions to be supplied.

- The patient / service user, or carers / relatives, understand the risks associated with use of bed rails and bed rail accessories.

- The patient / service user, and carer / relatives, know that the bed rails / bed rail accessories should only be used by the patient / service user prescribed for.

- The patient / service user, or carers / relatives, know how to alert a health care professional if the condition of the patient / service user changes.

8.4 Avoid using bed rails designed for use with a divan bed on a wooden or metal bedstead. This creates gaps that present a risk of entrapment.

8.5 Ensure that the mattress does not easily compress at its edge. This presents a risk of entrapment.

8.6 If patient / service user is found attempting to climb over their bed rail, or does climb over their bed rail, this must be taken as a clear indication that they are at risk of serious injury from falling from a greater height. The risks of using bed rails most probably to outweigh the benefits and the use of bed rails must be reassessed.

8.7 Beds must usually be kept at the lowest possible height to reduce the likelihood of injury in the event of a fall, whether or not bed rails are used. The exception to this is independently mobile service users/patients who are likely to be safest if the bed is adjusted to the correct height for their feet to be flat on the floor whilst they are sitting on the side of the bed; bed rails are usually not recommended for those who are independently mobile.

8.9 Bed rails must not be used for moving and handling purposes, unless they are integrated bed rails which are deemed by the manufacturer to be suitable for this purpose. In this case a manual handling risk assessment must be completed.

8.10 The use of bed rails must be documented with the patient / service users do records and a plan of care reflecting their individual needs must be completed and available to inform care (refer to appendix 2).

9. Equipment Ordered through ICES

9.1 Any bed rails identified as being faulty / unsafe must be removed immediately and arrangements made for collection by the Leicester, Leicestershire and Rutland Community Equipment provider.

9.2 An urgent request must be raised to replace the faulty equipment. All concerns about specific bed rails and product compatibility issues must be reported to the ICES Commissioning Manager.

9.3 The ICES Equipment Provider will carry out service and maintenance of bed rails every time they are returned for reuse and prior to re-issue. Bed rails that remain in the community are part of the annual pre planned maintenance checks carried out to profiling beds. Bed rail inspection covers:

- Condition
- Mounting clamps/fixings
- Movement
- Rail gaps

10. Alternatives to Bed Rails

10.1 Alternatives to bed rails may be the most appropriate method of managing an individual patients / service users risk of falling, slipping or sliding out of bed. The Bed Rail Risk Assessment Flow Chart (appendix 1) should be used to aid the decision process.

10.2 Alternatives to bed rails are provided below, this is not an exhaustive list and not intended to identify the only options available which may be considered suitable for individual patients / service users:

- Move person to a more observable area to maximise supervision.
- Use of bed sensor and / or position device.
- Use of high low bed.
- Use of soft cushioning on the floor to break a patient / service user's fall, such as crash mat. Crash mats may introduce patient / service user handling risks.
- Ensure bed returned to lowest height after care delivery.
- Ensure patient / service user needs anticipated, such as accessible drinks, regular toileting, call bell to hand.
- Increased monitoring of patients / service users at high risk of falling.
- Use of mesh, netting or inflatable sides.
- Reducing night time sedation.
- Nursing person on mattress on floor. This should be a last resort and safety checks would be required to ensure risks from hot pipes, trailing wires, and electric sockets are minimised. Moving and handling risk assessment for staff must be completed.

10.3 It is recognised that some of the safety options outlined above may not be acceptable to patients / service users, carers / relatives. Patient / service user safety must be balanced against the wishes of patients / services users, carers / relatives. These people need to be included in discussions to

establish an acceptable level of risk. Any such discussions must be documented and kept with the patients records.

11. Arrangements on Transfer / Discharge

11.1 The arrangements for continued collective responsibility for patient / service users with bed rails are set out in 'Transfer / Discharge Arrangement Flowchart' (Appendix 3).

11.2 All patients / service users considered to have a continued need for bed rails on transfer / discharge from a health care provider will have a bed rail risk assessment completed prior to transfer / discharge that would inform the patients' / service user need, the bed the rails are to be used on, the type of bed rails and bed rail accessories required.

11.3 All patients / service users carers (informal or formal) with a continued need for bed rails will be involved with the decision and informed of the information detailed within the 'Carers' Confirmation Sheet for the Safe Use of Bedrails' (appendix 4), any special considerations for the individual, and their need to alert health care professional to a change in circumstances that would affect the safe use of bed rails prior to transfer.

11.2 Transfer from In-Patient to Patient's Own Home:

11.2.1 Patients / service users with an on-going health need will be referred to a community health care professional, the referral must include information regarding the use of bedrails;

- Outcome of the bed rail risk assessment prior to transfer.
- Outcome of moving and handling assessment.
- Details of care plan for the safe use of bed rails.

The receiving health care professional will continue to reassess the patient's / service users' needs for bed rails (refer to 6.2.2).

11.2.2 Patients / service users without an on-going health need will have carers (informal or formal) identified who will have been involved (refer to 11.3) and informed of the information detailed within the 'Carers' Confirmation Sheet for the Safe Use of Bedrails' (appendix 4); special individual considerations, and how to alert the most appropriate health care professional to a change in the circumstances that would affect the safe use of bed rails.

11.3 Transfers from In-Patient to Residential / Non-Nursing Care Home:

11.3.1 Patients / service users with an on-going health need will be referred to a health care professional; the referral must include information regarding the use of bedrails:

- Outcome of the bed rail risk assessment prior to transfer.

- Outcome of moving and handling assessment.

- Details of care plan for the safe use of bed rails.

The receiving health care professional will continue to reassess the patients / service users' needs for bed rails (refer to 6.2.2)

11.3.2 Patients / service users without an on-going health need transferring to a residential / non-nursing care home will not have bed rails or bed rail accessories provided by ICES equipment provider. The care home provider should be involved with the decision making and must be informed of the needs of the patient / service user to enable them to provide suitable equipment.

11.4 Transfers from In-Patient to Nursing Care Home:

11.4.1 Patients / service users transferring to a nursing care home will not have bed rails or bed rail accessories provided by ICES equipment provider. The care home provider should be involved with the decision making and must be informed of the needs of the patient / service user to enable them to provide suitable equipment.

11.5 Continued Use of Bed Rails in Patients Own Home's without Health Professional contact or in between Health Care contacts:

11.5.1 All patients / service users carers (informal or formal) with a continued need for bed rails will be involved with the decision and informed of the information detailed within 'Carers' Confirmation Sheet for the Safe Use of Bedrails' (appendix 4), any special considerations for the individual, and their need to alert health care professional to a change in circumstances that would affect the safe use of bed rails (refer to 6.2.3) prior to discharge.

11.5.3 If the patient / service user does not require continued use of bed rails then the health care professional will arrange for the bed rails and accessories to be returned to the Equipment Provider.

11.6 Transfer from Community Health Care Professional to Residential / Non-Nursing Care Home:

11.6.1 Patients / service users residing in a residential home being discharged from health care provision will not have continued provision of bed rails and bed rails accessories from ICES equipment provider. The health care professional should arrange for the bed rails and bed rail accessories to be returned to the ICES equipment provider. The care home should be provided with notification of the patients' / service users' discharge from health care provision, the return of equipment and must be informed of the needs of the patient / service user to enable them to provide suitable equipment.

11.7 Transfers from Community Health Care Professional to Nursing Care Home:

11.7.1 Patients / service users transferring to a nursing care home will not have bed

rails or bed rail accessories provided by ICES equipment provider. The care home provider should be involved with the decision making and must be informed of the needs of the patient / service user to enable them to provide suitable equipment.

12. Education and Training

12.1 The duties of roles and responsibilities within the organisations that are party to this policy are provided in section 4.

12.2 Leicestershire Partnership Trust:

12.2.1 All clinical staff are expected to attend moving and handling mandatory training: awareness of this policy and importance of risk assessment will be iterated.

12.2.1 The ICES will have a programme of training on beds and bed rails issued through the ICES which can be accessed to support and enhance the knowledge base of staff.

12.3 LLR ICES Equipment Provider staff:

12.3.1 The equipment provider will ensure that:

- All driver / technicians responsible for delivery and installation of bed rails receive familiarisation training, which includes how the equipment works, how it installed, how it is used;

- All driver / technicians will complete a competency based product training programme that is signed off by a designated trainer.

- On-site trainer will also carry out training with individual driver technicians in the community; ensuring that they are trained in how to fit rails to all types of beds and to be able to identify that they have the correct bed rails for the bed and to carry out checks to ensure safe installation.

- Driver technicians will also be responsible for demonstrating to the service user, their carer and/or relatives how to use the bed rails safely, e.g. lift up and down correctly.

13. Purchase and Disposal

13. 1 Each organisation will adhere to their own arrangements for the purchase and disposal of bed rails.

13.2 Bed rails supplied through the ICES will be subject to the purchase and disposal arrangements set out in the contractual requirements between the Equipment Provider and Leicester City Council, who host the service on behalf of Partners to the Pooled Arrangement for the ICES.

14. Cleaning and Infection Control

14.1 Each organisation will adhere to their own arrangements for cleaning and infection control and staff must comply with their own policies and procedures.

14.2 Bed rails supplied through the ICES will be subject to the cleaning, decontamination and refurbishment arrangements set out in the contractual requirements between the Equipment Provider and Leicester City Council, who host the service on behalf of Partners to the Pooled Arrangement for the ICES.

14.3 Staff prescribing bed rails into care settings must ensure they are aware of the importance of infection control and take appropriate action and that they do not use the bed rails for any other service user.

15. Reporting Incidents

15.1 All patient/service user incidents related to the use of bed rails and / or bed rail accessories and equipment shortages associated with bed rails must be reported via each organisation's incident reporting processes.

15.2 For equipment provided through the ICES, any incident must also be reported to the ICES Commissioning Manager

15.3 The Equipment Service Provider's staff should also report any concerns or adverse incidents that they become aware to their own organisation who will take action in accordance with their own Adverse Incident reporting policy.

16. Dissemination

16.1 Each organisation will be responsible for ensuring their own staff are made aware of this policy

17. Monitoring Performance and Effectiveness

17.1 Appropriate use of bed rails and the completion of bed rail risk assessment tools will be monitored as part of the falls audits across LPT on an annual basis.

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
No injury incurred by any patient as a direct result of the use of bed rails	Monitor incident reports
Correct completion of bed rail risk assessment tools and use of bed rails	Monitor as part of falls audit annually.

18. Link to Standards

18.1 This Policy links to Care Quality Commission (CQC):

- Regulation 15: Premises and Equipment.
- Regulation 12: Safe Care and Treatment.
- Regulation 9: Person Centred Care**.**

19. Due Regard

19.1 All organisations party to this policy are committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. They will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes.

19.2 This policy has been developed in context of paying due regard to the Public Sector Equality Duty (Equality Act 2010) to eliminate unlawful discrimination, harassment, victimisation; and advance equality of opportunity and foster good relations.

19.3 This policy sets out Leicestershire Partnership Trust's (LPT), University Hospitals of Leicester (UHL) and the Integrated Community Equipment Service (ICES) for Leicester, Leicestershire & Rutland policy for ensuring the safe and appropriate use of bed rails. Every effort has been made to ensure all equality groups (protected characteristics) are given equal access to service provision, especially in the context of disability. This is demonstrated through the provision of risk assessment and decision making tools to guide staff in the identification of risks associated with the use of bed rails.

20. Associated Documentation and Useful Reference Sites

Reference	Source
NPSA Safer Practice Notice: ***Using bed rails safely and effectively***	Available at: www.nrls.npsa.nhs.uk
Health and Safety Executive, Safe Use of Bed Rails	Available at www.hse.gov.uk/healthservices/bedrails/htm
MHRA Device Bulletin (Nov 2012) ***Safe use of bed rails***	Available at: www.mhra.gov.uk
MHRA Device Alert 2007/009: ***Bed rails and grab handles***	Available at: www.mhra.gov.uk
NPSA Safer Practice Notice: ***Using bed rails safely and effectively***	Available at: www.nrls.npsa.nhs.uk

APPENDIX 1

BED RAIL RISK ASSESSMENT FLOW CHART

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

Patient Need

Has the patient/service user:
- Slipped, rolled or slid out of bed?

Is the patient/service user:
- At risk of slipping, rolling, sliding or falling out of bed?

NO → **BED RAILS NOT REQUIRED**

YES

MENTAL STATE	Very immobile (bedfast or hoist dependant)	Neither independent nor immobile	Can mobilise without help from staff
Confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
Drowsy	Bedrails recommended	Use bedrails with care	Bedrails NOT recommended
Orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails NOT recommended
Unconscious	Bedrails recommended	N/A	N/A
	MOBILITY		

GREEN OR YELLOW

MANUAL HANDLING ASSESSMENT
Is the patient/service user safe to get out of bed unsupervised?

YES → **CONSIDER ALTERNATIVES**

NO

Is the patient/service user capable of climbing over bed rails?

YES → **CONSIDER ALTERNATIVES**

NO

Does the patient/service user have sensory or cognitive impairment/ confusion/delirium/dementia?

YES → **CONSIDER ALTERNATIVES**

NO

Does the patient/service user decline to consent to use of bedrails?

YES → **STOP ASSESSMENT**
Document and record in Care Plan

BEST INTEREST DECISION e.g. may be most appropriate. Document and record in care plan.

NO

DECISION TO USE BEDRAILS

Patient Request

Does the patient/service user wish to use bed rails when the risk of rolling, sliding or slipping out of bed is not apparent?

NO → **BED RAILS NOT REQUIRED**

YES

Does the patient / service user have capacity to make the decision to use the bedrail?

NO → **BED RAILS NOT REQUIRED**

YES

Has an individual risk assessment been agreed with the patient / service user? (see Mitigation of Risk)

NO → **BED RAILS NOT REQUIRED**

YES

USE BEDRAILS WITH CAUTION

Document individuals' needs in Care Plan

Mitigation of Risks

Risk assessments must document:
- Ensure access to carer to lower bedrails prior to getting out of bed
- Patient is aware of risks associated with use of bedrails
- Method of alerting carer for assistance to get out of bed
- Length of time unsupervised and associated risks
- Environment is considered suitable for bedrails.

REASSESSMENT
- **Minimum – weekly in Hospital setting**
- **Six monthly in Community setting**
- **Or as patient's conditions change**

COMPLETE ASSESSMENT PROCESS AGAIN

Must be printed in colour

V8 June 2015

Patient label Name: NHS/Hospital Number:	Bed Rail Risk Assessment (V1)	Leicestershire Partnership NHS Trust University Hospitals of Leicester NHS Trust

FIRST ASSESSMENT
- Complete as part of the initial assessment

REASSESSMENT
- Weekly as a minimum in a hospital setting
- Six monthly in a community setting
- Following transfer to another service/ward
- If the patient's condition changes or following a fall
- In preparation for discharge

MENTAL STATE	MOBILITY: Patient is very immobile (bedfast or hoist dependent)	MOBILITY: Patient is neither independent nor immobile	MOBILITY: Patient can mobilise without help from staff
Patient is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
Patient is drowsy	Bed rails 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

Date/Time/Signature ►						
Stage 1	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Has the patient/service user slipped, rolled or slid out of bed?						
Is the patient/service user at risk of slipping, rolling, sliding or falling out of bed?						
Does the patient/service user wish to use the bed rails when the risk of rolling, sliding or slipping out of bed is not apparent?						
DECISION (circle) ►	**Complete Bed Rail Matrix** (continue to Stage 2)	**Bed Rails NOT recommended Assessment complete**	**Complete Bed Rail Matrix** (continue to Stage 2)	**Bed Rails NOT recommended Assessment complete**	**Complete Bed Rail Matrix** (continue to Stage 2)	**Bed Rails NOT recommended Assessment complete**

Stage 2 Review patient risk using bed rail matrix (above) ►Apply the outcome of the manual handling risk assessment to aid decision making ► when complete proceed to stage 3	**Date completed:**	**Date completed:**	**Date completed:**

Stage 3 MATRIX OUTCOME: Consider outcome of Stage 2 & decide appropriate action required	Red / Yellow / Green (circle)		Red / Yellow / Green (circle)		Red / Yellow / Green (circle)	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Red – consider alternatives and complete care plan - where bed rails NOT recommended						
Green / Yellow – consider following: Is the patient/service user capable of climbing over bed rails?						
Does the patient / service user have sensory or cognitive impairment / confusion / delirium / dementia?						
Does the patient / service user **decline to consent** to use of bedrails?						
DECISION (circle) ►	If any answer is **YES** consider alternatives & complete Stage 4 care plan- where bed rails NOT recommended	If answer is **NO** to all questions - complete Stage 4 care plan where Bed rails recommended or use Bed rails with care	If any answer is **YES** consider alternatives & complete stage 4 care plan- where bed rails NOT recommended	If answer is **NO** to all questions - complete Stage 4 care plan where Bed rails recommended or use Bed rails with care	If any answer is **YES** consider alternatives & complete Stage 4 care plan- where bed rails NOT recommended	If answer is **NO** to all questions - complete Stage 4 care plan where Bed rails recommended or use Bed rails with care

Name: NHS Number: DOB: Ward:	University Hospitals of Leicester NHS NHS Trust

Stage 4 Bed Rail Care Plan 4a (Bed Rails NOT recommended) OR 4b (Bed rails recommended or use Bed rails with care) (V1)

Goal: To identify care required for patients who are at risk of slipping, rolling, sliding or falling out of bed who are assessed as requiring bed rails or where alternatives need to be considered where bed rails are not recommended

EXCEPTION: Within the hospital environment bed rails are used when transporting patients between departments.
Assess each patient on an individual basis as to whether an escort is required throughout their transfer and record this on the evaluation sheet

	Date/Time/Signature►								
Stage 4a Care Plan: Risk Assessment indicates that bed rails are NOT recommended – consider alternatives	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**
a. Does the patient/service user consent to use of bed rails?									
b. Ensure the patient/service user/carer are aware of risk assessment and how to summon help									
c. If the patient/service user is unable to consent apply best interest decision through the Mental Capacity assessment process. Record decision in the evaluation section									
d. Cross reference with Manual Handling Assessment and Falls Assessment and care plan to reduce risk of patient climbing out of bed without assistance (eg toileting/ continence needs)									
e. Ensure patient call bell is in close proximity to enable patient to call for help									
f. Specify level of observation required in the evaluation section overleaf									
g. Move bed to a high visibility area									
h. Does patient/service user require Hi Lo Bed with crash mat in-situ? (usually for patients who are not able to stand)									
i. Does patient/service user require Hi Lo Bed without crash mat in-situ? (usually when patients are likely to trip on crash mat)									
j. Leave bed at low level when left unattended									
k. Are Sensor mats in use?									
l. Where the patient is non-concordant identify why, record action taken in the evaluation and update the care plan									
m. Care plan to be reviewed: Weekly; if the patient's condition changes; on transfer between clinical areas / wards and following a fall. Record in the evaluation section									
n. Other specific person centred care interventions:									

Name: NHS Number: DOB: Ward:			Date/Time/Signature ▶									
Care Plan Stage 4b Risk Assessment indicates that bed rails are recommended	**OR**	**Use bed rails with care**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**
a. Does the patient/service user consent to use of bed rails?											
b. If patient/service user is unable to consent apply best interest decision through Mental Capacity Assessment process – record decision in the evaluation section											
c. Check risks of using bed rails – risk of entrapment of arms, legs or head between bed rail and mattress. If yes consider use of bed rail bumpers											
d. Are bed rail bumpers in place?											
e. Cross reference with Manual Handling Assessment and Falls Assessment and care plan to reduce risk of patient climbing out of bed without assistance (eg toileting/ continence needs)											
f. Ensure patient call bell is in close proximity to enable patient to call for help											
g. Specify level of observation required in the evaluation section below											
h. Leave bed at low level if left unattended											
i. Where the patient is non-concordant identify why, record action taken in the evaluation and update the care plan											
j. Care plan to be reviewed: Weekly; if the patient's condition changes; on transfer between clinical areas / wards and following a fall. Record in the evaluation section											
k. Other specific person centred care interventions:											

EVALUATION	**Date/Time/Signature ▼**

Name: NHS Number: Ward:	**Stage 4 BED RAIL CARE PLAN** (V1) **Care Plan 4a** Bed Rails NOT recommended **Care Plan 4b** Bed rails recommended or use with care	CONSIDER: Patient orientation / cognition. Confusion - Consider delirium. History of falls. Nurse Call system. Bedrail Assessment. Falls Risk and Prevention Care Plan. Safety Monitoring. Sensor equipment. Mental Capacity and DOLs assessment	Leicestershire Partnership NHS Trust G6

Problem / Need:

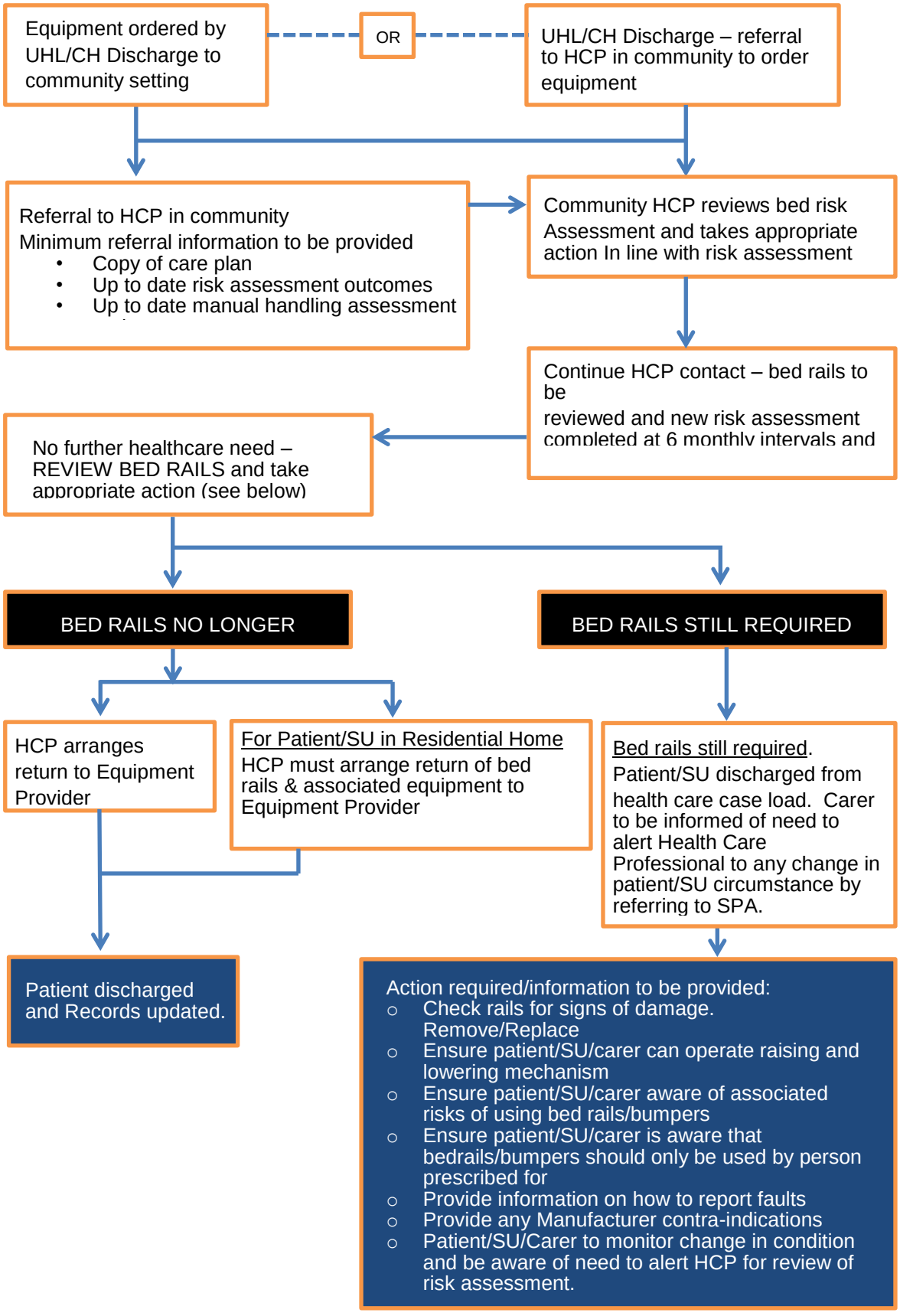
Goal: To identify care required for patients who are at risk of slipping, rolling, sliding or falling out of bed who are assessed as requiring bed rails or where alternatives need to be considered where bed rails are not recommended

EXCEPTION: Within the hospital environment bed rails are used when transporting patients between departments.
Assess each patient on an individual basis as to whether an escort is required throughout their transfer and record this on the evaluation sheet

	Date/Time/Signature►								
Stage 4a Care Plan: Risk Assessment indicates that bed rails are NOT recommended – consider alternatives	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**
a. Does the patient/service user consent to use of bed rails?									
b. Ensure the patient/service user/carer are aware of risk assessment and how to summon help									
c. If the patient/service user is unable to consent apply best interest decision through the Mental Capacity assessment process. Record decision in the evaluation section									
d. Cross reference with Manual Handling Assessment and Falls Assessment and care plan to reduce risk of patient climbing out of bed without assistance (eg toileting/ continence needs)									
e. Ensure patient call bell is in close proximity to enable patient to call for help									
f. Specify level of observation required on the Frequency of Intervention Record (FIR) chart									
g. Move bed to a high visibility area									
h. Does patient/service user require Hi Lo Bed with crash mat in-situ? (usually for patients who are not able to stand)									
i. Does patient/service user require Hi Lo Bed without crash mat in-situ? (usually when patients are likely to trip on crash mat)									
j. Leave bed at low level when left unattended									
k. Are Sensor mats in use?									
l. Where the patient is non-concordant identify why, record action taken in the evaluation and update the care plan									
m. Care plan to be reviewed: Weekly / if the patient's condition changes / on transfer between clinical areas and wards / following a fall. Record in evaluation section									
n. Other specific person centred care interventions:									

Name: NHS Number: Ward: Date/Time/Signature▶											
Care Plan Stage 4b Risk Assessment indicates that bed rails are recommended	**OR**	**Use bed rails with care**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**
a. Does the patient/service user consent to use of bed rails?											
b. If patient/service user is unable to consent apply best interest decision through Mental Capacity Assessment process – record decision in the evaluation section											
c. Check risks of using bed rails – risk of entrapment of arms, legs or head between bed rail and mattress. If yes consider use of bed rail bumpers											
d. Are bed rail bumpers in place?											
e. Cross reference with Manual Handling Assessment and Falls Assessment and care plan to reduce risk of patient climbing out of bed without assistance (eg toileting/ continence needs)											
f. Ensure patient call bell is in close proximity to enable patient to call for help											
g. Specify level of observation required and record bed rail use on the Frequency of Intervention Record (FIR) chart											
h. Leave bed at low level if left unattended											
i. Where the patient is non-concordant identify why, record action taken in the evaluation and update the care plan											
j. Care plan to be reviewed: Weekly; if the patient's condition changes; on transfer between clinical areas / wards and following a fall. Record in the evaluation section											
k. Other specific person centred care interventions:											

TRANSFER ARRANGEMENTS TO ANY PATIENT/SERVICE USER CARE



APPENDIX 4

Carers Confirmation Sheet for the Safe Use of Bed Rails

Healthcare Professional to ensure the appropriate carer(s) is:

- Able to operate the rise and lowering mechanism of the bed rail. (For bedrails provided by ICES driver technicians will be able to demonstrate to the service user, their carer and / or relatives how to use the bed rails safely, such as lift up and down correctly).
- Able to correctly use bed rail accessories.
- Aware of the risks associated with the use of bed rails and bed rail accessories.
- Understand what change in circumstances would alert the need for referral to a health care professional for a reassessment of need.
- Aware that the bedrails and bed rail accessories are only to be used for the person that it has been prescribed for.
- Provided with, or know to expect if being discharged from in-patient area with equipment provision from ICES, the manufacturer's instructions for use.

Carer(s) should:

- Be confident with the above.
- Check the bed rails weekly to ensure that there are no signs of damage, faults or cracks on the bed rails. If any identified damage then the bed rails should be removed immediately and reported for repair.
- Report a fault or repair contact to:
    - Name of Provider: _____
    - Contact Telephone: _____

EXTRACT FROM MHRA DEVICE BULLETIN DB 2006(06) V2.0 SAFE USE OF BED RAILS

Description	Ref on diagrams (see below)	Standards withdrawn in 2013		New combined standard	Notes
		BS EN 1970: 2000	**BS EN 60601-2-38: 1997**	**BS EN 60601-2-52:2010**	
Height of the top edge of the side rail above the mattress without compression*	**1**	≥220mm	≥220mm	≥220mm[a]	[a] Where a speciality mattress or mattress overlay is used and the side rail does not meet ≥220mm a risk assessment shall be performed to assure equivalent safety
Gaps between elements within the perimeter of the side rail and between the side rail and mattress platform	**2**	≤120mm	≤120mm	<120mm	
Gap between head board and end of side rail	**3**	≤60mm or ≥250mm[b]	≤60mm or ≥235mm[b]	<60mm[c]	[b] Side elevation between head board and side rail [c] Most disadvantageous angle between head board and side rail
Gap between foot board and end of side rail	**4**	≤60mm or ≥250mm[d]	≤60mm or ≥235mm[d]	<60mm or >318mm[e]	[d] Side Elevation between foot board and side rail [e] Most disadvantageous angle between foot board and side rail
Distance between open end of side rail(s) and mattress platform[f]	**5**	If ID4 is ≥250mm then gap is ≤60mm	If ID4 is ≥235mm then gap is ≤60mm	<60mm	[f] The gap between the open end of the side rail and head board is not relevant to this ID
		If ID4 is ≤60mm then gap is ≤120mm	If ID4 is ≤60mm then gap is ≤120mm	<60mm	
Gap between split side rails	**6**	≤60mm or ≥250mm to ≤400mm[g]	≤60mm or ≥235mm[g]	<60mm or >318mm[h]	[g] when in flat position [h] When in most disadvantageous position
Gap between side rail and mattress in 'plan' elevation	**7**	Not specified	Not specified	Perform Test[i]	[i] 120mm aluminium cone is position between mattress and side rail to determine if gap is acceptable or not
NB* The risk of entrapment will increase when the edge of the mattress can compression easily altering the measurement between the top edge of the mattress and the bed rail.					

Diagram of side view of bed with split side rails

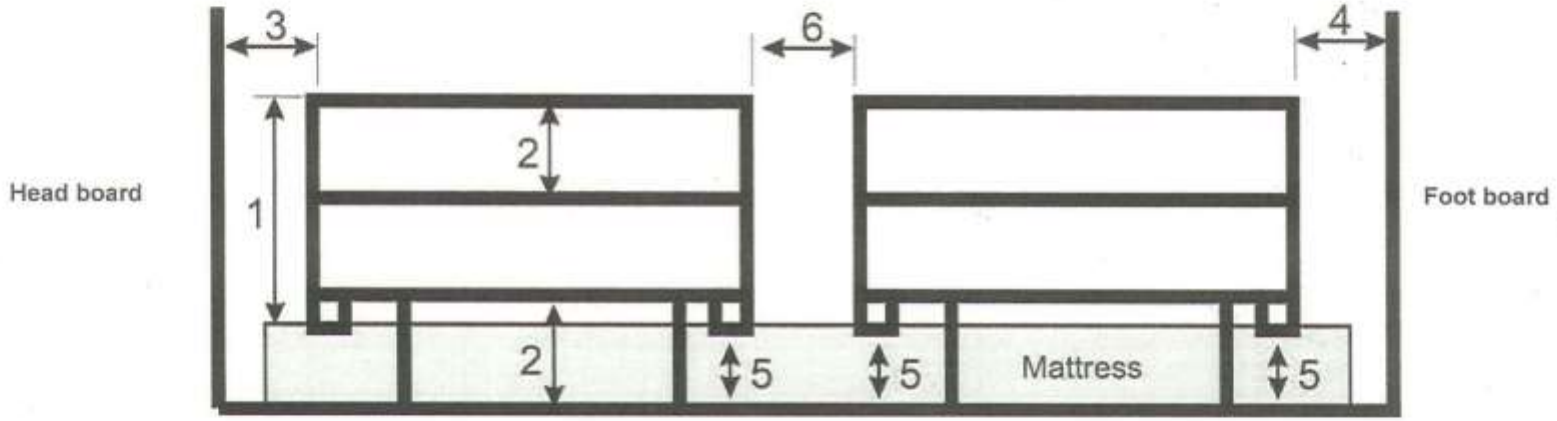
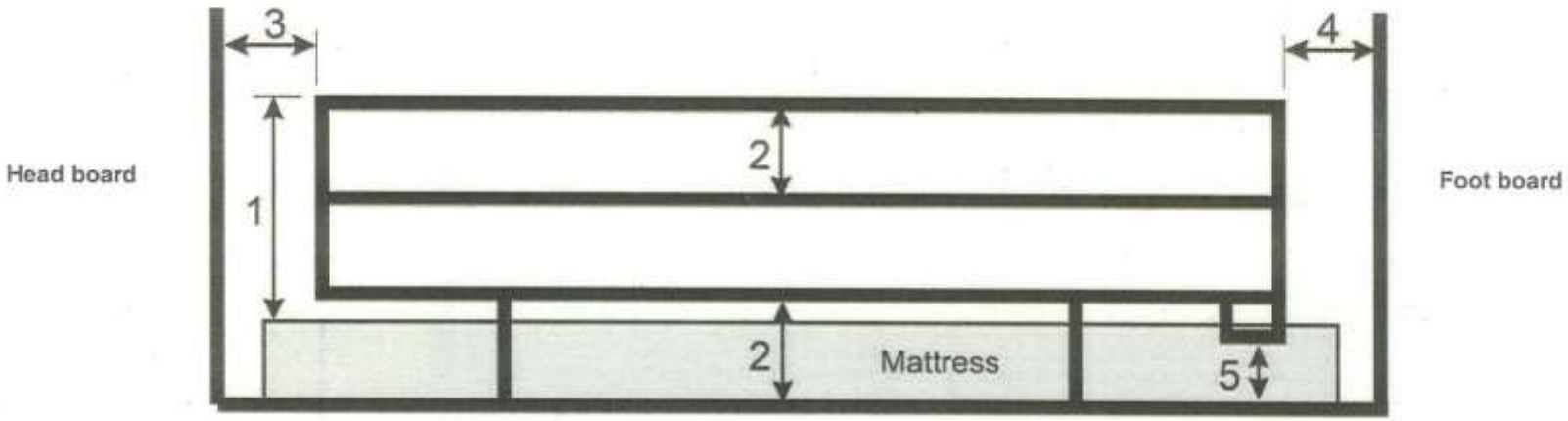
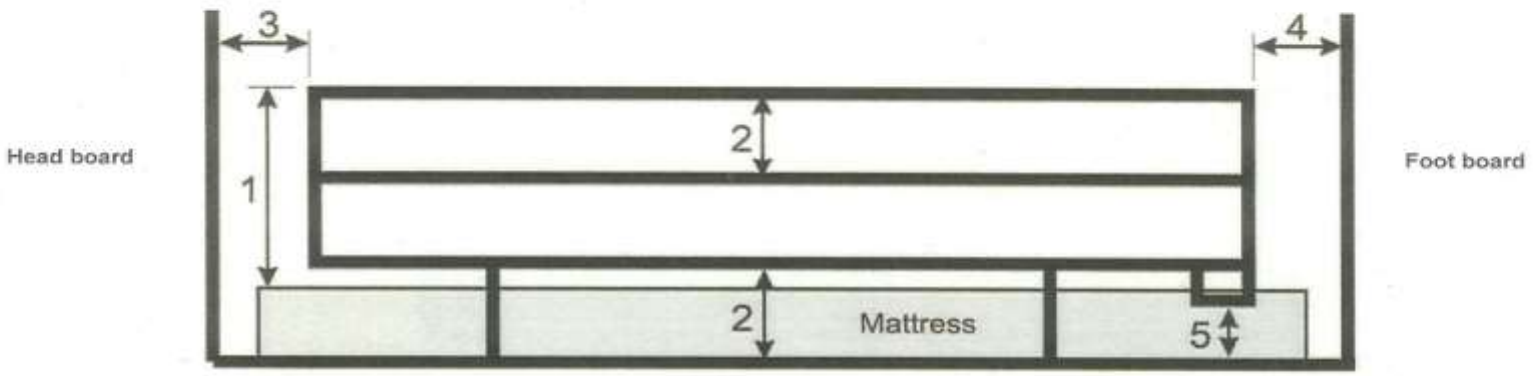


Diagram of side view of bed with cantilever side rails



Medicines and Healthcare products Regulatory Agency

Diagram of side view of bed with cantilever side rails



Safe use of bed rails DB 2006(06) v2.0 November 2012