

The National Patient Safety Agency

We recognise that healthcare will always involve risks, but that these risks can be reduced by analysing and tackling the root causes of patient safety incidents. We are working with NHS staff and organisations to promote an open and fair culture, and to encourage staff to inform their local organisations and the NPSA when things have gone wrong. In this way, we can build a better picture of the patient safety issues that need to be addressed.

Resources for reviewing or developing a bedrail policy



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Resources for reviewing or developing a bedrail policy

These resources are for NHS organisations that are developing or reviewing their bedrail policy, procedures or guidance for adult inpatients, as required by the NPSA's Safer practice notice 17: *Using bedrails safely and effectively*.

These resources are based on a range of NHS organisations' policy documents and tools. The resources include evidence from:

- Medicines and Healthcare products Regulatory Authority (MHRA), guidance;
- focus groups held with patients;
- a systematic review of the literature;
- a snapshot survey of current bedrail policies;
- an overnight survey of bedrail use;
- reports of patient safety incidents involving bedrails to the NPSA, MHRA, Health and Safety Executive (HSE) and NHS Litigation Authority (NHSLA).

Every NHS organisation has differing equipment, patients, staff and environment. Consequently, these resources should be adapted to suit local circumstances. Local systems for risk assessing the impact of any changes in practice should also be followed.

This resource pack includes:

	Page
Findings from a snapshot of existing bedrail policies	2
Findings from focus groups with patients	3
Findings from an overnight survey of bedrail use	4
Reports of falls from bed and injuries caused by bedrails	5
Optional model bedrail policy for local adaptation	6
Examples of bedrail decision aids	23
Examples of bedside documentation	27
Example of patient information on bedrails	29
Scenarios to test existing or newly developed policy	30
Systematic literature review of bedrails	31

Findings from a snapshot of existing bedrail policies

In 2006, the NPSA surveyed the bedrail policies of 42 NHS organisations that volunteered to have their policies reviewed. The survey was carried out via the Nurse Directors' Association in England and through Nurse Directors in Wales. The results should not be viewed as typical for all NHS organisations because the number of organisations reviewed is small. Nine of the 42 organisations (21 per cent) had no organisational guidance on bedrails, although some of these had draft versions or a bedrail policy within a speciality. Thirty-three organisations (79 per cent) had bedrail policies or sections covering bedrails within another policy (usually within a falls prevention policy).

The key points in the most effective policies were:

- balanced frameworks for decision making, with recognition that balancing risks and benefits is difficult, and that every patient's wishes should be taken into account;
- information for patients that emphasises they have a right to make their own decisions if they are able to;
- recognising that patients' behaviour can not always be predicted;
- providing special equipment for patients who could be harmed by standard bedrails.

Points that could lead to problems in some policies were:

- emphasising the potential harm of bedrails without advising on the risk of injury from falls;
- stating that the risk of fatal entrapment in bedrails can only be avoided by not using bedrails at all, rather than giving constructive advice based on MHRA guidance on how to reduce the risk of fatal entrapment;

- a lack of clarity about whether or not bedrails are a form of restraint. Very rarely, policies state that any use of bedrails constitutes restraint, equating this with abuse, and warning staff that they may be liable to civil or criminal prosecution;
- interpreting published literature wrongly, particularly applying American studies of body restraints (vest and belt devices) to bedrails;
- not linking the use of bedrails to other measures that can reduce patient falls and suggesting ineffective alternatives such as tucking sheets in;
- avoiding bedrails for a whole group of patients rather than looking at each patient individually. For example, policies which stated bedrails should never be used for any patients with dementia, or epilepsy, or a history of falls;
- decision-making tools that could lead to inappropriate outcomes for some patients;
- stating that relatives can take decisions about bedrails on behalf of adult patients;
- combining advice for adults, children and babies in hospitals, residential homes and patients' own homes. This can create inappropriate requirements, for example, hospital staff being asked to check for ornamental bed posts;
- frontline staff being made responsible for conforming to MHRA requirements rather than NHS organisations' taking steps to remove unsafe equipment, including requiring staff to measure gaps between bedrail bars each time they were used.

Suggestions for avoiding these problems are included in the optional model bedrail policy.

Findings from focus groups with patients

The NPSA held two focus groups with patients to find out how they view bedrails. One group included patients with dementia or depression and anxiety in the south of England. The other group was made up of black and minority ethnic older people recovering from strokes in the north of England. The groups were an opportunity sample, chosen because they had recent experience of hospital admission and now attended day services where we could meet them and listen to their views.

The discussions were unstructured although key themes were introduced to ensure all issues relating to bedrails were covered.

All patients felt that whether or not bedrails are used should depend on a patient's wishes and concerns about falling out of bed. However, they also recognised that they may be unable to make a decision if too ill or unconscious. In this case, they wanted staff to take care when making the decision on their behalf and to consider their safety. If a patient thought bedrails would make them secure, they thought they should be provided even if staff disagreed.

Patients were more familiar with the term 'cotsides' than 'bedrails' but preferred the term 'bedrails'. They thought the term 'cotsides' was undignified.

Some patients were used to a double bed at home and hospital beds made them feel insecure because they are narrower and higher. Patients with hemiplegia after a stroke who had electrically powered profiling beds were very positive about the increased comfort and independence these gave them, and had tended to have bedrails raised when using the controls to change their position. None of the patients said they had been given bedrails against their wishes.

Patients did not have particular anxieties about bedrails being in place: they saw them as a practical and temporary safety measure.

They did not view them as a measure that reduced their independence or dignity, and were slightly surprised that the NPSA wanted to know patients' views on bedrails.

The patients made suggestions that could improve the design of bedrails and hospital beds. These included softer finishes to bedrails and different sizes for very tall, large or small patients.

Findings from an overnight survey of bedrail use

The NPSA carried out an overnight survey of how bedrails are used in seven NHS acute hospitals. The hospitals were a random stratified sample. The mix of large, medium and small hospitals, geographic spread, and foundation and non-foundation status was broadly equivalent to the overall mix of NHS organisations in England and Wales.

The survey aimed to establish a picture of how bedrails are used, and to add context to the NPSA's findings on patient falls in hospitals. It looked at:

- which patients were given bedrails;
- the reasons nurses gave for decisions on whether or not a patient needs bedrails;
- whether or not patterns of bedrail use are consistent across the NHS.

The survey found that:

- twenty-six per cent of patients had a full set of bedrails raised at night;
- ninety-three per cent of patients with bedrails had limited mobility;
- eighty-six per cent of patients with bedrails were aged over 65 years;
- sixty-four per cent had no bedrails and, of these, 62 per cent were aged over 65 and 21 per cent had limited mobility;
- nine per cent of patients had partial bedrails (with bedrails raised on one side, or only the top section of split bedrails raised).

Where patients did not have bedrails, the most common reasons given by staff were:

- the patient was not at risk of falling out of bed (94 per cent);
- the patient did not want them (one per cent);
- the patient was likely to try climbing over them (one per cent).

Where patients did have bedrails, the most common reasons given by staff were:

- to prevent them falling out of bed (74 per cent);
- the patient used them to help turning in bed (seven per cent);
- the patient had requested them (five per cent);
- the patient's relatives had requested them (one per cent).

Some staff appeared worried that they would be criticised for using bedrails.

The survey found bedrail use varied between NHS organisations, with their use ranging from 11 per cent to 35 per cent of beds occupied at the time of the survey. The survey found that nurses were unlikely to use bedrails simply because they were available: 22 per cent of beds had bedrails attached but not in use.

Bedrail use might be expected to be highest in hospitals with a greater proportion of older patients, who are more vulnerable to falling, and lowest in hospitals with more independently mobile patients. The proportion of patients aged over 65 in the hospitals surveyed ranged from 57 per cent to 69 per cent. Patients who could mobilise without help from nurses ranged from 35 per cent to 50 per cent in the hospitals surveyed. However, there was no obvious link between the proportion of older and less mobile patients in the acute hospitals surveyed and the level of raised bedrails. More detailed analysis is needed, but these findings suggest that differences in bedrail use between NHS organisations may be influenced more by local equipment, policy, custom and practice than by differences in inpatient populations.

Reports of falls from bed and injury from bedrails

Reports to the NPSA's National Reporting and Learning System (NRLS) from acute hospitals, community hospitals and mental health units were reviewed to understand the circumstances in which patients fall from beds. A more detailed analysis of bedrail-related incidents reported to the NPSA, HSE and NHSLA, including tests of statistical significance where appropriate, can be found in Appendix 4 of *Slips, trips and falls in hospital*.¹

Between 1 September 2005 and 31 August 2006 there were around 44,000 reports to the NRLS of patients falling from bed in acute and community hospitals, mental health and learning disability units. Of these, around 90 patients fractured their neck of femur and eleven died. Not all reports said whether or not bedrails were in use, but eight per cent did say that bedrails had been in place, and 31 per cent said they were not in use. Falls from bed without bedrails, as well as being more frequent, were more likely to involve injuries (statistically significant). Head injuries, usually minor, were much more likely to occur in falls from beds without bedrails (highly statistically significant). No significant difference in moderate or severe injuries or fatalities was found between falls from beds with or without bedrails.

Patients who climbed over bedrails would be falling from a greater height and therefore at greater risk of injury. However, the free text in reports to the NRLS suggest staff generally avoid the use of bedrails when patients are both mobile and confused enough to attempt to climb over them. The difference in injuries, including head injury, may be because patients who fall from beds with bedrails often appear to have exited towards the foot of the bed whilst awake, feet first, whilst some patients who fall from bed without bedrails appear to have rolled or slid from a

lying-down position whilst asleep or semi-conscious, and knock their head on the floor or bedside furniture.

NHSLA data on litigation following falls from beds shows only three per cent (5 out of 147 cases) of these had bedrails in place. HSE data shows 22 per cent (15 out of 66 cases) of reported falls from bed occurred with bedrails in place. HSE reporting requirements² relating to environmental risks may mean that reports to the HSE are more likely to be made when equipment, such as bedrails, is implicated in a fall.

NRLS data suggests around 1,250 patients injure themselves on bedrails each year, usually scrapes and bruises to their lower legs. The HSE received reports of two fractures and one dislocation from bedrail entrapment in hospitals between 2001 and 2004. Deaths from bedrail entrapment in hospitals in England and Wales have been reported but these are extremely rare, and could probably have been avoided if advice from the MHRA had been followed. The NPSA has reviewed its own data going back to December 2003, HSE data from April 2000 and MHRA data from January 2000, and found three fatalities caused by a patient becoming trapped in a bedrail in a hospital.

The NPSA has one report of a patient's death caused by a bedrail failing in a hospital. This may be because it was inappropriately fitted or maintained and then broke or became detached causing the patient to fall to the floor. The HSE received six reports of major injury from bedrail failure in NHS hospitals between 2001 and 2004.

Optional model bedrail policy for local adaptation

With points to consider when reviewing or
developing bedrail policy

NHS organisations can adapt this model policy to suit their own circumstances, or use it to check whether their current policy includes the following content. Language and examples can also be adapted.

The points to consider are for use while the policy is being developed and they should be deleted before the local policy is published. This should reduce the size of the policy to **a cover sheet and four content pages**, with an appendix if specific tools and formats are included. Each organisation should have developed a standard policy format to comply with NHSLA or Welsh Risk Pool requirements, and may need to adapt this outline to match their local template.

A MSWord version of the following sample bedrail policy document is available for adaptation at local level from **www.npsa.nhs.uk/alerts**

Policy cover sheet		Points to consider
Policy title	Using bedrails safely and effectively	<p><i>This does not need to be a separate policy and should preferably be included in your organisation's falls prevention policy. It is not recommended that it is included in a policy that covers restraint (see the introduction below).</i></p> <p><i>The term 'cotsides' could be confusing when referring to adult beds and is disliked by patients.³ Consequently, the term 'bedrails' is preferred.</i></p>
Scope	This policy is relevant for all staff caring for adult patients in inpatient areas of NHS organisation	<p><i>The issues and risks relating to bedrail use in domestic settings are likely to be very different to those in hospital settings. Differences include: the roles and responsibilities of NHS staff and other carers, both informal and employed in residential care settings; the practicalities of obtaining and fitting bedrails for domestic beds; different patient groups; the environment; and the timing of reassessment. Consequently, organisations providing both inpatient and community care should have a separate policies for hospital inpatients and domestic or care home patients. This model policy is designed for inpatient settings.</i></p> <p><i>There should also be a separate policy for children. This outline is designed for use with adult patients.</i></p>
Linked policies		<i>Policies for community staff, children's wards and falls prevention could be highlighted.</i>
Date of issue		
Review date		<i>This should say when the policy is due to be reviewed and who will be responsible for doing this.</i>
Developed by		

Policy cover sheet		Points to consider
Consultation with		<i>The policy should be developed or revised by a group that includes as a minimum nursing staff, therapy staff, and staff responsible for buying and maintaining beds and bedrails, with appropriate patient representation or consultation. Tissue viability specialists and manual handling advisers may be able to offer useful advice on the design of beds and mattress types. Close links with the group responsible for the broader falls prevention policy are essential.</i>
Authorised by		
Policy terminology		<i>This document uses the word 'policy', but NHS organisations can use the term that is locally appropriate, for example, guidance, or procedures.</i>
Purpose	<p>This policy aims to:</p> <ul style="list-style-type: none"> • reduce harm to patients caused by falling from beds or becoming trapped in bedrails; • support patients and staff to make individual decisions around the risks of using and of not using bedrails • ensure compliance with Medicines and Healthcare Related products Agency (MHRA) and National Patient Safety Agency (NPSA) advice. 	
Evidence	<p>This policy has been based on:</p> <ul style="list-style-type: none"> • MHRA Device Bulletin 2006(06): Safe use of bed rails and Device Alert 2007/009: Bed rails and grab handles; ⁴ • NPSA safer practice notice: Using bedrails safely and effectively; ⁵ • NPSA bedrails literature review. ⁶ 	<i>Throughout this draft policy references to 'MHRA advice' means MHRA Device Bulletin 2006(06): Safe use of bed rails and Device Alert 2007/009: Bed rails and grab handles ⁴ which have superseded earlier advice and alerts from the MHRA and their predecessor organisations.</i>

Main sections of policy

Draft policy	Points to consider
<p>1. Introduction</p> <p>NHS organisation aims to take all reasonable steps to ensure the safety and independence of its patients, and respects the rights of patients to make their own decisions about their care.</p> <p>Bedrails should only be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of a bed. Bedrails used for this purpose are not a form of restraint. Restraint is defined as 'the intentional restriction of a person's voluntary movement or behaviour ...'.⁷ Bedrails will not prevent a patient leaving their bed and falling elsewhere, and should not be used for this purpose. Bedrails are not intended as a moving and handling aid.</p> <p>Patients in hospital may be at risk of falling from bed for many reasons including poor mobility, dementia or delirium, visual impairment, and the effects of their treatment or medication. In England and Wales, over a single year there were around 44,000 reports of patients falling from bed. This included eleven deaths and around 90 fractured neck of femurs, although most falls from beds resulted in no harm or minor injuries like scrapes and bruises. Patients who fell from beds without bedrails were significantly more likely to be injured, and to suffer head injuries (usually minor).¹ A systematic review of published bedrail studies suggests falls from beds with bedrails are usually associated with lower rates of injury, and initiatives aimed at substantially reducing bedrail use can increase falls.⁶</p> <p>Bedrails are not appropriate for all patients, and using 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.¹</p> <p>Based on reports to the MHRA, the HSE, and the NPSA⁵ 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 advice⁴ 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.</p>	<p>Some NHS organisations currently include in their policy a comment about dignity. However, patients tend not consider the use of bedrails to be undignified, and are less anxious about bedrail use than healthcare staff (see patient focus group summary in this resource pack).</p> <p>The NPSA suggests NHS organisations use this definition of restraint, or a similar definition that includes the intent of both patients and staff. A more basic definition such as 'anything that restricts freedom of movement' is confusing in a hospital setting where many medical interventions may restrict movement (for example, traction for a fracture). Such definitions do not help staff appreciate the ethical difference between helping a patient avoid doing something they do not want to do (fall out of bed) and stopping a patient doing something they want to do (get out of bed).</p> <p>You may wish to add figures on falls and injury taken from your organisation's local risk management system.</p> <p>Although bedrails are not intended or designed as a manual handling aid, the NPSA has found some patients with limited mobility like to have bedrails to help them roll or turn in bed (see overnight survey of bedrail use earlier in this resource pack).</p>

Points to consider	
<p>Organisations may wish to state who is responsible for making decisions about bedrails. This could be the registered nurse responsible for the patient, or other staff such as a physiotherapist.</p> <p>Whilst multi-disciplinary decision making is desirable for difficult decisions, many decisions about bedrails need to be made at night and in settings when nurses are the only professionals available.</p> <p>If bedrail use is rare in some settings, frontline staff could refer all decisions about bedrails to specific members of staff with particular expertise and training.</p> <p>Information for patients and relatives or carers is probably most useful when included with other information on preventing falls. A suggested insert that could be added to a falls prevention eaflet is in this resource pack.</p>	<p>Decisions about bedrails need to be made in the same way as decisions about other aspects of treatment and care as outlined in <i>NHS organisation's consent policy</i>. This means:</p> <ul style="list-style-type: none"> the patient should decide whether or not to have bedrails if they have capacity. Capacity is the ability to understand and weigh up the risks and benefits of bedrails once these have been explained to them; staff can learn about the patient's likes, dislikes and normal behaviour from relatives and carers, and should discuss the benefits and risks with relatives or carers. However, relatives or carers cannot make decisions for adult patients (except in certain circumstances where they hold a Lasting Power of Attorney extending to healthcare decisions under the Mental Capacity Act 2005 ⁸⁾; if the patient lacks capacity, staff have a duty of care and must decide if bedrails are in the patient's best interests. <p><i>NHS organisation</i> provides a leaflet for patients, relatives and carers giving information on bedrails and preventing falls.</p> <p><i>NHS organisation</i> does not require written consent for bedrail use, but discussions and decisions should be documented by staff (see section 5 below).</p>
<p>Many existing bedrail policies include some of the measures that can prevent falls or injuries from bed, such as special low beds, whilst not considering other issues such as reducing night sedation, or treating the cause of delirium. The <i>NPSA</i> recommends bedrail policies include either all the measures in their falls prevention policy or none and refer staff to the falls prevention policy.</p> <p>Organisations should note that nursing a patient on a mattress on the floor is seen as unacceptable by most patients and relatives.¹⁴ There are also manual handling issues.</p>	<p>Decisions about bedrails are only one small part of preventing falls. Use <i>NHS organisation's falls prevention policy</i> to identify other steps that should be taken to reduce the patient's risk of falling not only from bed, but also, for example, whilst walking, sitting and using the toilet.</p>
	<p>3. Bedrails and falls prevention</p>

<p>Points to consider</p>	<p><i>Policies should avoid saying that bedrails should never be used for patients with confusion or dementia. Confused patients and those with dementia will have cognitive impairment ranging from mild to severe, and a variety of co-existing illnesses. Patients with dementia have an increased risk of falls as well as an increased risk of injury from bedrails. Consequently, the decision-making process concerning these patients should be no different from the individual decision making used for other patients- consideration of the risks and benefits as they apply to the individual.</i></p> <p><i>Any absolute contraindications to bedrail use included in local policy must be justified by evidence that the risks of using bedrails will always outweigh any benefits.</i></p> <p><i>NHS organisations may wish to add other situations where bedrail use is standard. For example, they may have profiling beds where bedrails are recommended when immobile patients self-operate the controls to change their position in bed, or specific types of pressure relieving mattresses where bedrail use is recommended by the manufacturers. NHS organisations may also wish to recommend that using bedrails should be standard in certain settings such as intensive care units.</i></p> <p><i>This text on assessing individual patients is sufficient. However, there are other tools for making decisions about using bedrails included in this pack. A balance should be struck between offering staff tools that are too detailed and tools that, whilst easy to use, are not comprehensive enough when assessing unusual patients. There are not any published validated tools. The scenarios in the appendix and/or local patient case studies can be used to test whether the decision-making tools offered here, or the tool already in use in the NHS organisation, direct staff to the decisions that the NHS organisation considers appropriate.</i></p> <p><i>If tools are being introduced or piloted, review the reports of falls from bed and direct injuries from bedrails before and after the tools are implemented. Tools used should be clearly labelled as an aid to making professional judgements, and are not a substitute for them.</i></p> <p><i>Currently, a small number of NHS organisations use a numerical scoring system that adds together scores attributed to factors such as mobility and agitation. The total indicates whether or not bedrails should be used. The use of such tools does not appear to have an evidence base and cannot be recommended. Some existing policies use the word 'may' throughout. Whilst policies should leave scope for professional judgement, it needs to provide a framework for deciding when bedrails should normally be used, rather than only when they 'may' be used.</i></p> <p><i>The NPSA recommends that NHS organisations do not use statements that suggest bedrails should be used only as 'a last resort'. This appears to be interpreted as 'only after the patient has already fallen out of bed'. NHS organisations may wish to use different time frames for reassessment for different settings, for example, daily in surgical admission areas and weekly in community hospital and older people's mental health settings.</i></p>
<p>Draft policy</p>	<p>There are different types of beds, mattresses and bedrails available, and each patient is an individual with different needs.</p> <p>Bedrails should not usually be used:</p> <ul style="list-style-type: none"> • if the patient is agile enough, and confused enough, to climb over them; • if the patient would be independent if the bedrails were not in place. <p>Bedrails should usually be used:</p> <ul style="list-style-type: none"> • if the patient is being transported on their bed; • in areas where patients are recovering from anaesthetic or sedation and are under constant observation. <p>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, the environment, their treatment, their personality and their lifestyle. Staff should use their professional judgement to consider the risks and benefits for individual patients:</p> <p>If bedrails are not used, how likely is it that the patient will come to harm?</p> <p>Ask the following questions:</p> <ul style="list-style-type: none"> • How likely is it that the patient will fall out of bed? • How likely is it that the patient would be injured in a fall from bed? • Will the patient feel anxious if the bedrails are not in place? <p>If bedrails are used, how likely is it that the patient will come to harm?</p> <p>Ask the following questions:</p> <ul style="list-style-type: none"> • Will bedrails stop the patient from being independent? • Could the patient climb over the bedrails? • Could the patient injure themselves on the bedrails? • Could using bedrails cause the patient distress? <p>Use bedrails if the benefits outweigh the risks.</p> <p>The behaviour of individual patients can never be completely predicted, and NHS organisation will be supportive when decisions are made by frontline staff in accordance with this policy.</p> <p>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. Even stable patients in rehabilitation or mental health settings can have rapidly changing needs when physical illness intervenes. Therefore decisions about bedrails should be reviewed whenever a patient's condition or wishes change, but as a minimum reviewed every x days.</p>
<p>4. Individual patient assessment</p>	

Draft policy	Points to consider
<p>The decision to use or not use bedrails should be recorded as a standard part of NHS organisation's patient documentation and kept at the patient's bedside.</p> <p>Except in [ward/department/situation] where bedrail use is standard practice.</p> <p>and/or</p> <p>Except in [ward/department/situation] where bedrails are very rarely used.</p> <p>In these settings only exceptions to normal practice need be documented. [add different procedures for any situations where bedrails are used routinely e.g. recovery from anaesthetic, or very rarely used, e.g. adult mental health units].</p>	<p>Decisions about the use of bedrails should be reviewed and changed frequently in response to changes in a patient's condition. Documentation needs to be the minimum the NHS organisation considers necessary to:</p> <ul style="list-style-type: none"> • support decision making; • ensure safe use of equipment; • support continuity of care; • allow for repeated reassessment. <p>In settings where patient stays are longer, and their condition is usually stable, more detailed bedrail documentation may be feasible.</p> <p>Bedrail documentation can be built into falls documentation. For example, a patient assessed as having a minimal risk of falls might be assumed not to require bedrails. However, even normally independent and mobile patients may have a risk of falling from beds under some circumstances, for example, after sedation or anaesthetic.</p> <p>Documentation can be a useful way of bringing policy to the attention of frontline staff, but documentation which tries to include all the content of a policy can be overwhelming.</p> <p>Documentation formats will need to be consistent with the organisation's decision-making text or tool.</p> <p>If the policy sets out specific settings or situations in which bedrails are to be routinely used (see section five above), it may only be necessary to document exceptions.</p> <p>Some organisations currently require a 'bedrails risk assessment' to be completed on a separate sheet only if bedrails are used. However, decisions not to use bedrails need documenting just as much as decisions to use them. Most litigation associated with falls and bedrails relates to when bedrails were not used.⁹ Standard documentation formats should cover the initial assessment of whether or not bedrails are recommended, before moving onto the required safety checks (see section seven below) if bedrails are used.</p> <p>Some organisations have 'bedrail care plans'. They may wish to consider whether it is more appropriate to focus their care plan on the core problem – the patient's risk of falling out of bed – as bedrails should be considered one of several possible interventions.</p> <p>Many hospitals now have some or all beds with integral bedrails, so staff caring for the patient can no longer assume that bedrails are attached because a positive decision has been made to use them. Consequently, documentation on bedrails needs to be easily accessed, perhaps by being at the bedside or in handover sheets. NHS organisations may wish to consider other ways of indicating at the bedside whether bedrails are in use, but should remember that with separate signs there is a risk the sign is not always changed when the assessment is changed.</p> <p>In settings where bedrail use is very rare, it may be appropriate to use a separate sheet for documenting decisions about using bedrails. However, in most settings (including most acute hospital wards and community hospitals) any documentation on bedrail use should be part of standard documentation.</p>

5. Documentation

Draft policy	Points to consider
<p><i>[NHS organisation]</i> has taken steps to comply with MHRA advice¹⁶ through ensuring that:</p> <ul style="list-style-type: none"> all unsafe bedrails (e.g. two-bar bedrails, bedrails with internal spaces exceeding 120mm, bedrails not in matched pairs, and bedrails in poor condition or with missing parts – see MHRA advice) have been removed and destroyed; all bedrails or beds with integral rails have an asset identification number and are regularly maintained; 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 except for: <ul style="list-style-type: none"> [xxxxx] mattress overlay which should be used only with extra-height bedrails. The extra-height bedrails and [xxxxx] mattress overlay have fixed highly visible labels indicating this; [xxxxx] bariatric bed which must be used with a compatible extra-wide mattress. These are supplied by the equipment store as a unit and the mattress is attached to the bed with labelled plastic ties. <p>Whenever frontline staff use bedrails they should carry out the following checks:</p> <p>For all types of bedrail:</p> <ul style="list-style-type: none"> Are there any signs of damage, faults or cracks on the bedrails? If so, do not use and label clearly as faulty and have removed for repair; Is the patient an unusual body size? (for example, hydrocephalic, microcephalic, growth restricted, very emaciated). If so, check for any bedrail gaps which would allow head, body or neck to become entrapped by referring to MHRA advice at <i>[describe location on NHS organisation intranet or ward/departments]</i> <p>If using detachable bedrails:</p> <ul style="list-style-type: none"> the gap between the top end of the bedrail and the head of the bed should be less than 6cm or more than 25cm; the gap between the bottom end of the bedrail and the foot of the bed should be more than 25cm; the fittings should all be in place and the attached rail should feel secure when raised; 	<p>NHS organisations should tailor their safety checks to the equipment they use. For example, hospitals whose entire bed stock has integrated rails will not need to provide advice on detachable bedrails.</p> <p>NHS organisations need to ensure they have effective systems for complying with MHRA advice. If safe systems are in place, as far as possible, at an organisational level, frontline staff can focus more effectively on checks that can only be made at an individual patient's bedside.</p> <p>MHRA advice points out the risks of 'third party bedrails'. This is beds, mattresses and bedrails that are not the correct size to be used in combination, creating entrapment gaps or bedrails on inadequate height. Mattresses and detachable bedrails may be frequently swapped between beds as patients' needs change, and beds are moved between wards and departments. Some organisations' current policies require frontline staff to check bed, mattress and bedrail compatibility each time they use them, through compressing the mattress, measuring gaps, or through contacting the manufacturers (who will already have performed compatibility checks for the beds, mattresses and bedrails they supply with respect to adults within a normal ranges of body sizes). Placing this repeated responsibility on frontline staff is unlikely to be an efficient or effective way of complying with MHRA requirements. NHS organisations should check centrally all possible combinations of their existing bedrail models, bed models, and mattress types in line with MHRA advice. If combinations are identified that are unsafe for adults within a normal ranges of body sizes, they should be taken out of use or be clearly labelled so that unsafe combinations cannot be used together.</p> <p>NHS organisations should provide safe storage areas and equipment management systems for bedrails not in use, so they are less likely to have damaged or missing parts, and can be used as matching pairs.</p> <p>The checks are important not only to prevent bedrail entrapment but also bedrail failure (when a wrongly attached or poorly maintained bedrail detaches or breaks causing the patient to fall).</p> <p>Whilst MHRA advice on the foot-of-the-bed gap is either less than 6cm or more than 25cm to avoid neck entrapment in a patient who has moved upside-down in the bed, the NPSA recommends NHS organisations use the 'more than 25cm' dimension at the foot of the bed. The patient then has an exit route at the end of the bed, reducing the likelihood of them climbing over the rails.</p> <p>If NHS organisations are currently using bedrails with domestic or divan styles of bed (for example during terminal care in an older person's mental unit that generally has domestic rather than hospital-style furniture) we would suggest they carry out a risk assessment of whether in future it would be safer to substitute a hospital style bed with integral or compatible bedrails.</p>

Points to consider	Draft policy
<p><i>Insert local arrangements and local equipment, for example, padded bedrail covers or 'bumpers', mesh bedrails, integral bedrails with one-piece plastic covers and inflatable bedrails. Organisations should note that loose fitting padded bedrail covers cannot protect against limb entrapment.</i></p> <p><i>The main way of reducing the risk of fatal bedrail entrapment is to follow MHRA advice on risk assessment and on proper fitting and maintenance of equipment without gaps likely to trap heads, necks or trunks. Extra observation can in theory provide an additional safety barrier, but if NHS organisations include any requirements for special observation they need to ensure these are realistic and achievable. Some existing policies require all patients with bedrails to be checked every 15 minutes; this is likely to take up all the working time of one person every shift, on each ward, if seven or more patients have bedrails, and have an impact of other aspects of patient care, including less time for vulnerable patients not using bedrails. The limitations of moving a patient next to the nurses' station to increase observation should be understood; there are likely to be prolonged gaps in observation whilst staff are with other patients.</i></p> <p><i>Observation requirements may need to be changed for NHS organisations providing long term care or rehabilitation in home-like accommodation.</i></p>	<p>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 following equipment is available from [xxxxx].</p> <p>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 split 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. These could include changing to a special type of bedrail or deciding that the risks of using bedrails now outweigh the benefits.</p> <p>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 they are at risk of serious injury from falling from a greater height. The risks of using bedrails are likely to outweigh the benefits, unless their condition changes.</p> <p>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 [refer to ward practice on using more easily observed bays for most vulnerable patients, daytime/night-time routines of checks on all patients, etc.]</p> <p>Beds should usually be kept at the lowest possible height to reduce the likelihood of injury in the event of a fall, whether or not bedrails are used. The exception to this is independently mobile 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.</p> <p>Beds will need to be raised when direct care is being provided. Patients receiving frequent interventions may be more comfortable if their bed is left raised, rather than it being constantly raised and lowered.</p>
	<p>7. Reducing risks</p>

Draft policy	Points to consider
<p>NHS organisation ensures that:</p> <ul style="list-style-type: none"> • all staff who make decisions about bedrail use, or advise patients on bedrail use, have the appropriate knowledge to do so; • all staff who supply, maintain or fit bedrails have the appropriate knowledge to do so as safely as possible, tailored to the equipment used within NHS organisation; • 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. <p>These points are achieved through:</p> <ul style="list-style-type: none"> • [Examples for local adaptation] • ward induction packs; • corporate induction; • including the use of bedrails in annual training on falls prevention; • ward link nurses and cascade trainers. 	<p><i>Bedrails are only one aspect of preventing falls and any bedrail-related training should be part of wider falls prevention training.</i></p> <p><i>If bedrails are rarely used, it may be more appropriate to have systems in place that allow staff to call colleagues who have had both training and recent experience in making decisions about using and fitting bedrails.</i></p>
<p>8. Education and training</p>	<p>NHS organisations may wish to add local guidance on the use of rails on trolleys. Trolleys may involve a higher risk of falls and injury than beds because they are usually narrower, higher and used for patients who are newly admitted and whose condition may not yet have been fully assessed.</p> <p>If trolleys are used only in limited areas, for example in accident and emergency and for transfer for investigations, trolley use could be covered by departmental protocols rather than organisation-wide policy.</p>
<p>9. Rails on trolleys</p>	<p>NHS organisations may wish to add local guidance on the use of grab handles as a mobility aid, if they use them. These are normally recommended or prescribed by physiotherapists. MHRA advice shows there are potential entrapment risks associated with the use of grab handles.</p>
<p>10. Grab handles</p>	<p>NHS organisations may wish to add local guidance on the use of grab handles as a mobility aid, if they use them. These are normally recommended or prescribed by physiotherapists. MHRA advice shows there are potential entrapment risks associated with the use of grab handles.</p>

Draft policy	Points to consider
<p>NHS organisation aims to ensure bedrails, bedrail covers and special bedrails, can be made available for all patients assessed as needing them.</p> <p>Bedrails can be obtained from... Special bedrail covers/mesh rails etc. can be obtained from...</p> <p>[site/department manager] should be told of any shortfall. They will endeavour to release bedrails from patients who no longer need them. If bedrails cannot be obtained, staff should explore all possible alternatives to reduce the risk to the patient, and report the lack of equipment on local incident reporting form.</p> <p>Metal/plastic bedrails should be cleaned if visibly contaminated by ...</p> <p>They should be cleaned between patients by ...</p> <p>Bedrail covers/mesh rails/etc. should be cleaned by ...</p> <p>Detachable bedrails no longer needed should be removed from beds and stored in/returned to ...</p> <p>New beds, bedrails or mattresses can introduce new risks if they are not fully compatible with existing stock. To reduce this risk, all purchases orders for beds, bedrails, or mattresses of designs not already in use within NHS organisation will be forwarded by NHS organisation's stores/purchasing department for authorisation by [appropriate person e.g. falls co-ordinator, person with lead responsibility for bedrails policy] before NHS organisation's stores/purchasing department will process the order.</p> <p>When special mattresses are hired, the requisition form requires the make and model of bed/bedrail to be stated, and the company renting the mattress will be asked to confirm the mattress is compatible with the bed and bedrail.</p> <p>Bedrail maintenance is the responsibility of NHS organisation's maintenance department. All bedrails are asset identified (or are an integral part of beds which are asset identified).</p>	<p>NHS organisations should ensure enough bedrails are available for all patients who need them with a minimum of delay.</p> <p>If NHS organisations use a range of beds with integral rails, and beds with no rails attached or available, staff can find it difficult to give bedrails to new patients without inconveniencing existing patients by swapping them between beds; there should be sufficient flexibility as well as sufficient numbers of bedrails.</p> <p>The policy should outline any infection control issues related to bedrails or bedrail covers, for example, cleaning methods and laundry between patients.</p> <p>When bedrail covers are of types that need laundering, organisations need to ensure they have enough supplies to cover time spent in laundry.</p> <p>Manufacturers' instructions for use will cover recommended methods of cleaning and decontamination. See also MHRA Device Bulletin 2006(06) Managing Medical Devices¹⁰</p> <p>Mattress hire requests may already be directed through one member of staff, for example, the tissue viability nurse, and they can be the check point for ensuring new risks are not introduced. Alternatively, NHS organisations may choose to hire beds, mattresses and bedrails as an integral package.</p> <p>The detail of maintenance is likely to be best placed within the maintenance department's protocols or contracts. Maintenance programmes usually need to cover entire sites in acute hospitals since beds and bedrails will frequently be moved between departments, but ward or departmental level maintenance may be possible in community hospitals and mental health units.</p>
<p>11. Supply, cleaning, and purchase, and maintenance</p>	
<p>12. Reporting incidents</p>	<p>NHS organisations may wish to refer to a separate policy or describe local reporting arrangements relevant to falls, direct injury from bedrails, or equipment shortages, and responsibilities for ensuring reports are shared with NPSA, MHRA or HSE as appropriate.</p>

Draft policy	Points to consider
<p>13. Dissemination</p>	<p>Please note that the previous MHRA poster featuring a bed and pink/peach coloured mattress was intended for the social care sector. MHRA have replaced this poster with a more detailed poster with photos showing the risks of third party bedrails on domestic style beds in care homes and community settings, because these continue to feature in fatal entrapments.</p> <p>The NPSA has provided posters that are intended to direct staff to your local bedrail policy as well as MHRA and NPSA resources.</p>

NHS organisation has made staff aware of this policy through:

- ongoing training as outlined in section eight above;
- staff newsletter;
- staff meetings;
- posters.

[adapt to standard local policy dissemination procedures]

Examples of bedrail decision aids

A range of decision-making tools is presented below. These are composites drawn from several tools in use in NHS organisations. Most tools have been developed in acute settings but the principles and detail can be adapted for other settings.

NHS organisations should be aware that no tool is perfect. A balance needs to be struck between tools that are comprehensive but detailed, and tools that are easy to use but too brief and may not reflect the needs of more unusual patients. Using a tool is not essential and organisations can provide guidance as text in their bedrails policy. When deciding whether to use or adapt one of the formats below, or when reviewing an existing or proposed format, NHS organisations should use the scenarios provided by the NPSA and/or local patient case studies to test whether the outcomes that frontline staff are directed towards are appropriate. All tools need to be clearly labelled as being supports for professional judgement and that they are not a rigid substitute for professional judgement.

1. Brief risk balance tool	
<p><i>Risk balance tools are good at conveying the need to balance an individual patient's multiple risk factors. They also reflect the legal requirement that decisions are made in the patient's best interests when they lack capacity to make their own decisions. However, they rely on staff having a realistic picture of relative risks. Currently, many staff may over-estimate the risk of fatal entrapment and under-estimate the risk of injury from falls from bed.</i></p>	
THE RISK OF NOT USING BEDRAILS	THE RISK OF USING BEDRAILS
<p>How likely is it that the patient will fall out of bed? Patients may be more likely to slip, roll, slide or fall out of bed if they have mobility or eyesight problems or are confused or drowsy.</p> <p>How likely is it that the patient will be injured in a fall from bed? Injury from falls from bed may be more likely, and more serious, for patients who are elderly, have osteoporosis, are on anti-coagulants or are very ill.</p> <p>Will not using bedrails cause the patient anxiety? Some patients may be fearful even though their actual risk of falling out of bed is low.</p>	<p>Would bedrails stop the patient from being independent?</p> <p>Might the patient climb over the bedrails? An injury's severity can be increased if the patient climbs over a bedrail and falls from a greater height.</p> <p>Could the patient injure themselves on the bedrails? Bedrails can cause injury if the patient knocks themselves on them or trap their legs or arms between them. There is also a very rare risk of postural asphyxiation.</p> <p>Could using bedrails cause the patient distress? Bedrails may cause distress to some patients who feel trapped by them.</p>
BEDRAIL USE IS RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON THE RIGHT	BEDRAIL USE IS NOT RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON THE LEFT

2. Detailed risk balance tool	
<i>See comment under Alternative A about the advantages and disadvantages of this type of tool</i>	
THE RISK OF NOT USING BEDRAILS	THE RISK OF USING BEDRAILS
<p>How likely is it that the patient will fall out of bed?</p> <p>Patients may be more likely to slip, roll, slide or fall out of bed if they:</p> <ul style="list-style-type: none"> • have fallen from bed before; • have been assessed as having a high risk of falling; • are very overweight; • are semi-conscious; • have a visual impairment; • have a partial paralysis; • have seizures or spasms; • are sedated, drowsy from strong painkillers or are recovering from an anaesthetic; • are delirious or confused; • affected by alcohol or street drugs; • are on a pressure-relieving mattresses which 'gives' at the sides; • use bedrails at home; • have self-operated profiling beds. <p>How likely is it that the patient could be injured in a fall from bed?</p> <p>Injury from falls from bed may be more likely, and more serious for some patients than others, for example, if they:</p> <ul style="list-style-type: none"> • have osteoporosis; • are on anti-coagulants; • are older; • have fragile skin; • have a vascular disease; • are critically ill; • have long term health problems; • are malnourished. <p>Will not using bedrails cause the patient anxiety?</p> <p>Some patients may be afraid of falling out of bed even though their actual risk is low.</p>	<p>Would bedrails stop the patient from being independent?</p> <p>Bedrails can be a barrier to independence for patients who otherwise could leave their bed safely without help</p> <p>Is the patient likely to climb over their bedrails?</p> <p>An injury's severity can be increased if the patient climbs over a bedrail and falls from a greater height. It is patients who are significantly confused and have enough strength and mobility to clamber over bedrails that are most vulnerable.</p> <p>Could the patient injure themselves on their bedrails?</p> <p>Bedrails can cause injury if the patient knocks themselves on them or traps their legs or arms between them. The most vulnerable patients are those:</p> <ul style="list-style-type: none"> • with uncontrolled limb movements; • who are restless and significantly confused; • with fragile skin. <p>Bedrails, even when correctly fitted, carry a very rare risk of postural asphyxiation. Patients who are very confused, frail and restless are most likely to be at risk.</p> <p>Will using bedrails cause the patient distress?</p> <p>Bedrails may distress some patients who feel trapped by them.</p>
BEDRAIL USE IS RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON THE RIGHT	BEDRAIL USE IS NOT RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON THE LEFT

3. Risk matrix tool

Risk matrices provide a familiar format that is easy to understand but may over-simplify some decisions. For example, in the matrix below there are more relevant elements than the matrix suggests including vulnerability to injury and visual and spatial awareness.

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
	Patient is very immobile (bedfast or hoist dependant)	Patient is neither independent nor immobile	Patient can mobilise without help from staff	
	MOBILITY			

4. Group prescription tool

Group prescription tools are simple to use but can be problematic when a patient does not fit any of the predetermined groups, or when a patient fits more than one group with contradictory prescriptions. For example, a patient who is independently mobile but requests bedrails temporarily having lost confidence whilst recovering from an osteoporotic fracture.

Patients who are unconscious or completely immobile	Bedrails to be used
Patients who request bedrails or use bedrails at home	Bedrails to be used
Patients who are recovering from an anaesthetic	Bedrails to be used
Patients who have disruption to their spatial or visual awareness	Bedrails may be used
Patients who are not likely to attempt to get out of bed alone	Bedrails may be used
Patients who are likely to attempt to get out of bed alone	Bedrails not to be used
Patients who are independently mobile	Bedrails not to be used

5. Flow chart tool

Some NHS organisations use a flow chart to assist making decisions about using bedrails. A flow chart poses a series of questions which need to be answered yes or no and leads to either USE BEDRAILS or DO NOT USE BEDRAILS. The format can work well for contraindications for bedrail use, such as a risk of climbing over bedrails or being independent and not requiring bedrails. However, a flow chart means every question requires a yes or no response, which may not reflect the more difficult decisions about bedrails for complex patients, when the answer to questions can be 'maybe' rather than yes or no, and are also difficult because appropriate areas for bedrail use may fall into more than one place in a spectrum. For example, bedrail use is more likely to be safe in the fully orientated and alert patient and the completely unconscious patient than in patients somewhere between the two extremes. Consequently, flow charts can direct the user to options that may not be appropriate for every patient. If flow charts are used, the scenarios provided by the NPSA and/or case studies based on local patients should be tested to see if the outcomes are considered appropriate. Flow charts should not use negatively phrased questions as these are known to confuse users, for example, 'is the patient unable to...'

Examples of bedside documentation

Documentation should avoid only asking questions without indicating the subsequent action necessary to reduce risk.

<p>Option 1 Although this format is brief, even in more detailed formats decisions would ultimately have to be justified with reference to policy. If NHS organisations do not use detachable bedrails, the column requiring checks on head end and foot end gaps should be deleted.</p>							
Complete for all patients		Complete these columns only if bedrails recommended					Sign
Date/time	Bedrails recommended? (see bedrails policy)	Patient able to decide?	Bed, mattress and bedrail in good condition and safe to use together? (if not, do not use – see beds and mattresses chart)	Patient with unusual body size e.g. child-sized, very thin, very large or very small head? (if yes, special checks needed – see bedrails policy)	If detachable bedrail, is head of bed/end of bedrail gap less than 6cm or more than 25cm, and is foot of bed/end of bedrail gap more than 25cm? (if not, do not use until adjusted)	Are bedrail covers or special mesh rails required to reduce risk of limbs striking bedrails/limbs trapped in bedrails?	
13/9/06 14.00	Nr	Nr – consulted					B Nurse
15/9/06 22.15	Y	Nr	Y	Nr	n/a integral	Nr	A Nurse

Option 2

Although this option is also brief, it does record the rationale behind decisions. This format could be used to provide a visual bedside cue on whether bedrails should be raised by printing it on a double sided or folded sheet kept on the patient's bedside clipboard with a red flash or green flash visible according to the patient's current assessment. This format does not prompt checks on whether bedrails have been correctly fitted, so the NHS organisation would need to cover these checks through training or other documentation formats

Date/time	Bedrails to be used:	Bedrails NOT to be used:	Signed
	a) patient with capacity requests; b) risk of injury falling from bed outweighs the risks of bedrails; c) other – record in notes.	a) patient with capacity refuses; b) risk of climbing over and falling from a greater height; c) patient is independent; d) risk of entrapment in bedrails outweighs risks of falling; e) other – record in notes.	
12/9/06 22.00	B		A Nurse
13/9/06 14.00		C	B Nurse

Option 3

The MHRA provide a risk assessment checklist example.⁴ This focuses on the checks required if bedrail use appears indicated. The assessment of whether or not the benefits of bedrails outweigh the risks would need to be covered in supplementary documentation. The MHRA checklist was designed for use in a variety of settings, including small care homes, and some check points are not relevant for NHS organisations with safe systems in place (for example NHS staff should not need to measure gaps between the bars, since the NHS organisation will have removed all rails with gaps between the rails' elements of over 12cm). NHS organisations which use bedrails with domestic style or divan beds will need detailed and specific formats based on MHRA requirements.

Option 4

The decision-making aids in appendix one could be adapted for use as documentation, for example, by circling options on a risk matrix or drawing the route through a decision tree and adding the date and a signature. However, in this format repeated reassessment can require extra sheets which may not be practical in settings where patients' bedrail requirements would be expected to change rapidly.

Option 5

NHS organisations can include in core care plans or pathways for relevant conditions (e.g. falls prevention or post-operative recovery) an assessment of the risk of falling from bed, the risks of using bedrails, and the safety checks needed if bedrails are used.

Example of patient information on bedrails

Information for patients on bedrails should be provided as part of information on falls prevention. Written information on preventing falls should include what the NHS organisation is doing to reduce the risk of patients falling, as well as advice for patients, relatives and carers on what they can do to reduce the risk.

It is helpful if written information is available in accessible formats, such as large print, and in languages appropriate for the local population. It should be used as an aid when staff are discussing issues with patients, and not as a substitute for such discussions.

How bedrails are used

Bedrails are attached to the sides of hospital beds to reduce the risk of patients rolling, slipping, sliding or falling out of bed. They cannot be used to stop patients getting out of bed, even if they might be at risk of falling when they walk.

Who decides when to use bedrails

If patients are well enough, they can decide. If they are too ill to decide for themselves, hospital staff will decide after first talking to their relatives or carers. Bedrails are used if the benefits are greater than the risks.

The benefits

Some patients fall out of bed because their illness affects their balance, or their treatment makes them very drowsy. Some patients need special air-filled mattresses to reduce the risk of pressure sores, which can be easier to roll off accidentally. Some patients have electric beds with controls they use to move from lying down to sitting up. These beds can be very comfortable, but some patients are at risk of falling when they use the controls to change their position. Most patients who fall out of bed receive

only small bumps or bruises, but some patients are seriously injured. Bedrails can prevent such accidents.

The risks

Some illnesses can make patients so confused that they might try to climb over a bedrail and injure themselves. If there is a possibility that a patient will try to climb over a bedrail, it is safer not to use them.

If patients are independent, bedrails would get in their way.

If patients are very restless in bed, they can knock their legs on a bedrail or get their legs stuck between the bars. Padded covers and special soft bedrails can reduce this risk.

In this hospital, all bedrails have been checked to reduce the small risk of patients getting trapped between the bed and the bedrail.

Alternatives to bedrails

There are many ways to reduce the risk of patients falling [*refer to appropriate section in the leaflet on general falls prevention*].

If you have any questions about bedrails or preventing falls, please ask the staff.

Scenarios to test existing or newly developed policy

Or use patient case studies from your
own organisation

Mr Smith is very confused and not aware he is in hospital. He is fully mobile and spends long periods walking around the unit slightly unsteadily but without falling. However, he has twice fallen out of bed during the night. His family think he probably rolled over and fell out by accident, as he is used to sleeping in a double bed with one side against the wall, and his wife on the other side.

Mr Jones has vascular dementia but was living at home until he had a stroke that left him with severe hemiplegia. He can only stand with the help of two carers and balances poorly when sitting. Although he has spent some weeks on a stroke rehabilitation ward he has not taken in what has happened, and believes he can walk independently. His poor balance when sitting means he could fall out of bed. The team caring for him have decided to use bedrails. However Mr Brown thinks the bedrails have stopped him from walking and gets upset and tearful when they are raised.

Mr King has alcoholic liver disease and was unconscious following treatment for a series of seizures. He is now restless, agitated and semi-conscious. It seems very likely that he will fall out of bed. However, if bedrails were in place he would be striking his legs against them and might even try to climb over them.

Mrs Black is very frail, has poor hearing and eyesight, and limited mobility that means she can manage only a few steps with a walking frame. She was admitted to hospital following a

fall and hip fracture at home. She has been getting out of bed at night to use the commode without calling the nurses and her husband is desperately worried she will fall again. He asks the team to put bedrails on the bed. He knows she is unlikely to get around or over the bedrails because of her frailty so will have to call the nurses when wanting to get out of bed. Mrs Black agrees with her husband but the nurses are unsure if she has really understood.

Miss Patel has had major surgery and is recovering from the anaesthetic and being given strong pain relief. Her bed has an alternating pressure mattress. She is just conscious but not alert.

Miss Green has been admitted for investigations of weight loss and anaemia. She can walk independently but is weak, dizzy and very anxious. She asks the nurses to raise the bedrails on her first night in hospital, and says she wants staff to walk with her when she needs to use the toilet. She has been taking a high dose of sleeping tablets for many years.

Mrs Parker has a severe depression, osteoporosis and is very frail and underweight. She is dependant on nurses for getting out of bed. Her depression began after a hip fracture sustained when she fell out of bed at home. When asked her opinion about bedrails she says she does not want them because the sooner she has another fall and dies, the better.

Mr Hayes is extremely overweight and looks very unsafe when he tries to change his position in bed.

Mrs Clark is partially paralysed but changes her own position using the remote controls on her profiling bed. She has occasional leg spasms.

References

- 1 NPSA 2007 *Slips, trips and falls in hospitals* www.npsa.nhs.uk
- 2 HSE's specific requirements on the severity and circumstances in which a fall requires reporting to them can be found at <http://www.hse.gov.uk/pubns/hsis1.pdf>
- 3 NPSA 2007 Resources to support implementation of safer practice notice *Using bedrails safely and effectively* www.npsa.nhs.uk
- 4 MHRA Device Bulletin DB2006(06) The safe use of bedrails and MHRA Device Alert 2007/009 *Beds Rails and Grab Handles* www.mhra.gov.uk
- 5 NPSA Safer practice notice *Using bedrails safely and effectively* www.npsa.nhs.uk
- 6 NPSA 2007 *Bedrails - Reviewing the evidence: A systematic literature review* www.npsa.nhs.uk
- 7 Queensland Health (2003) *Falls prevention best practice guidelines for public hospitals* Queensland Government 2003 p37
- 8 *Mental Capacity Act 2005* The Stationary Office Limited: London
- 9 Healey F, Oliver D. Preventing falls and injury in hospitals: where are efforts best directed? *Healthcare Risk Report*. 2006; June: 15-17
- 10 MHRA Device Bulletin DB 2006(05) *Managing Medical Devices* www.mhra.gov.uk

