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| <i>Bedrails procedure</i> | 1 of 16 | Approval Date: 21 Oct 2020 |
| Reference Number: UHB 239 | 239 | Next Review Date: 21 Oct 2023 |
| Version Number: 2 | 2 | Date of Publication: 17 Nov 2020 |
| Approved By: NMB | | |

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| Reference Number: Version Number: 2 | Date of Next Review: Previous Trust/LHB Reference Number: T/301, 239 |
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BEDRAILS PROCEDURE

Introduction and Aim

Healthcare professionals have a duty of care to minimise risks to their patients. Cardiff and Vale University Health Board (UHB) 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.

Patients in hospital or within the community setting may be at risk of falling from bed for many reasons including poor strength and coordination, cognitive impairment, sensory impairment, and the effects of their treatment or medication. Although most falls from beds result in no harm or minor injuries, falls from beds have resulted in significant injuries and death.

Bedrails should only be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of a bed. Bedrails will not prevent a patient leaving their bed and falling elsewhere, and should not be used for this purpose.

Bedrails are not appropriate for all patients, and using bedrails also involves risks, such as entrapment and falling from an increased height if climbed over.

The possible combinations of bedrails, beds and mattresses, together with the uniqueness of each bed occupant, means that a careful and thorough risk assessment is necessary if serious incidents are to be avoided (MHRA 2013: p.7).

This procedure aims to:

- Reduce harm to patients caused by falling from beds or becoming trapped in bedrails
- Support staff with regard to decision-making in the use of bedrails
- Ensure compliance with MHRA and NPSA advice
- Ensure compliance with the UHB [Consent to Examination or Treatment Policy](#)
- Ensure compliance with the UHB [Restraint in the Care Management of Adults with Impaired Mental Capacity Policy and Procedure](#)
- Ensure compliance with the UHB Health and Safety Policy
- Ensure compliance with the UHB Incident, Hazard and Near Miss Reporting Policy

Objectives

- To provide guidance to UHB staff in the safe, effective and lawful use of bedrails.

Scope

This procedure applies to all healthcare professionals employed by the UHB, including those

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on honorary contracts, who are involved in the care of adult patients. It also applies to academics, healthcare assistants, students and locums.

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| Equality and Health Impact Assessment | An Equality and Health Impact Assessment (EHIA) has not been undertaken as this is a procedure under the Restraint in The Care Management of Patients Aged 16 Years and Over with Impaired Mental Capacity- Policy and Procedure. |
| Documents to read alongside this Procedure | Mental Capacity Act 2005 Code of Practice Falls: Policy and Procedure for the Prevention and Management of Adult In-patient Falls Restraint in The Care Management of Patients Aged 16 Years and over with Impaired Mental Capacity- Policy and Procedure. |
| consultation | Clinical Standards and Innovation Group 6/2/20 UHB wide consultation February 2020 |
| Approved by | Falls Delivery Group (subcommittee of QSE) Nursing and Midwifery Board |

| | |
|---|---|
| Accountable Executive or Clinical Board Director | Executive Nurse Director |
| Author(s) | Consultant Nurse Older Vulnerable Adults Mental Capacity Act Manager |
| <u>Disclaimer</u> If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate . | |

| Summary of reviews/amendments | | | |
|--------------------------------------|--------------------------------|-----------------------|--|
| Version Number | Date of Review Approved | Date Published | Summary of Amendments |
| 1 | 7 August 2014 | 18 August 2014 | These procedures supersede the former Trust policy on the Safe and Effective Use of Bedrails |
| 2 | 21 Oct 2020 | 17 Nov 2020 | Re-formatted to comply with revised Corporate template. Reviewed and revised to reflect current hospital and community beds. Indications for numbered order changed. Community tool now incorporated. New falls patient information leaflet incorporated. Assessment tools amended. |

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BEDRAILS PROCEDURE

DO NOT ROUTINELY USE FULL BEDRAILS –

Indication 1. If their use is to prevent the patient from getting out of bed e.g. to try to stop the patient getting up and falling

Indication 2. If patient is agitated and has attempted/may attempt to climb over or around bedrails - use ultra-low bed and consider floor safety mats

Indication 3. If their use would reduce the patient's independence

Remember that the use of bedrails is a form of restraint, so they can only be used either with patient consent or in line with the Mental Capacity Act 2005, where it's in the patient's best interests, is to prevent harm to the patient and is a proportionate response to the likelihood and seriousness of harm (see Mental Capacity Act web page).

ISSUES TO CONSIDER WITH REGARD TO BEDRAIL USE

1.1 INDIVIDUAL PATIENT ASSESSMENT

There are different types of beds, mattresses and bedrails available, and each patient must be individually assessed. Always take into consideration appropriate combination and individual patient need.

1.2 INITIAL DECISION

If you are unfamiliar with the patient (e.g. he/she is newly admitted) and have little information about them, you will need to make an initial decision about whether or not to use bedrails.

Proceed with caution if –

The patient is an unusual body size - e.g. hydrocephalic, microcephalic, growth restricted, very emaciated or has other risk for entrapment.

1.3 WHEN TO USE BEDRAILS –

Indication 4. If patient is on a trolley (under normal circumstances)

Indication 5. To transport a patient on a bed/ trolley

Indication 6. To prevent the patient from slipping, sliding or rolling out of bed

Indication 7. To assist a patient to move themselves independently in and out of bed (commonly ½ rail top is recommended)

PRESENTING CONDITIONS TO CONSIDER FOR USE OF BEDRAILS –

Indication 8. Reduced levels of consciousness

Indication 9. Partial paralysis / poor trunk control

Indication 10. Seizures or spasms

Indication 11. Sedated, drowsy or recovering from anaesthesia

Indication 12. Patient decision

The reason for any deviation from this advice must be documented. 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 cognitive abilities, personality and lifestyle.

1.4 Consent and Mental Capacity Act 2005

Patient consent must be obtained for the use of bedrails. Where there is reason to doubt the patient's mental capacity to decide about bedrails, the Mental Capacity Act 2005 must be followed. Ensure the patient notes include details of consent or MCA compliance.

1.5 Bedrails and falls prevention

Decisions about bedrails are only one small part of preventing falls. The UHB's [Falls: Policy and Procedure for the Prevention and Management of Adult In-patient Falls](#) identifies 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.

1.6 Bedrails and community beds

Community beds do not have bedrails as standard, so staff need to consider whether bedrails are required at the time of ordering a community bed.

As there are several different models of community bed frames, ensure that the bedrails ordered are compatible with the bed frame and mattress.

The completed bedrail assessment must be scanned and uploaded into the individual Paris record.

1.7 Trolleys and bedrails

Patients on trolleys should have bedrails in use. If the decision is made not to use bedrails this must be recorded in the patient's notes, together with the reasons (appendix 5).

1.8 Bedrail checks

Whenever the decision to use bedrails is made, the following checks must be carried out:

- Check for any sign of damage, faults or cracks on the bedrails. If there is, then the bedrail must be removed and replaced. If the bedrails are integral to the bed then the bed must not be used and must be replaced.
- If the patient has an unusual body size or shape (e.g., hydrocephalic, microcephalic, growth restricted, very emaciated), check for any bedrail gaps which would allow head, body, limbs or neck to become entrapped.

1.9 Review of use of bedrails

Bedrail use must be reviewed regularly. See Use of Bedrails Decision Aid, Appendix 1

1.10 Problems with bedrails and incident reporting

Any incidents, accidents, near misses or situations where bedrails were implicated MUST be reported using eDatix. Report any equipment failures/difficulties/near miss to Medstrom and, if appropriate contact your Health and Safety Advisor.

1.11 High-sided $\frac{3}{4}$ length bedrails

If these are required and ward stock is unavailable please contact Medstrom.

1.12 Bedrail bumpers

If these are required and ward stock is unavailable please contact Medstrom.

2. Resources

No extra resources should be required to implement this procedure. Equipment such as floor safety mats, bedrail additions such as bumpers and safersides will be managed within the individual ward/department budget.

3. Training

The UHB manual handling training foundation programme provides instruction on the safety checks of bedrails. Ward/area based sessions may be provided by the Clinical Nurse Advisor for Medstrom (contractor for bed provision) on request.

4. Implementation

Directorates/Localities are responsible for implementing this procedure.

5. Audit

Adherence to this procedure will be monitored by a variety of processes, including structured and ad-hoc case note review. The use of bedrails should be considered as part of the Clinical Board/Directorate Clinical Audit plan.

6. Distribution

This procedure will be made available on the UHB intranet, clinical portal and internet sites.

7. Review

This procedure will be reviewed by the Nursing and Midwifery Board and the Falls Delivery Group every three years or sooner if appropriate.

8. References and further reading

Medicines and Healthcare products Regulatory Agency. (2007). Medical Device Alert MDA/2007/009, Bed rails and bed grab handles:
<http://www.mhra.gov.uk/Publications/Safetywarnings/MedicalDeviceAlerts/CON2025839>

Medicines and Healthcare products Regulatory Agency. (2013). Safe use of bed rails
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/422784/Safe_use_of_bed_rails.pdf

Medicines and Healthcare products Regulatory Agency. (2010). One Liner issue 75, March 2010: Beds:
<http://www.mhra.gov.uk/Publications/Safetyguidance/OneLiners/CON076295>

[Mental Capacity Act 2005](#)

[Mental Capacity Act 2005 Code of Practice](#)

Provision and Use of Work Equipment Regulations 1998. Statutory Instrument 1998 No. 2306. ISBN 0 11 079599 7:
<http://www.opsi.gov.uk/SI/si1998/19982306.htm>

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. SI 1995 No. 3163. London: HMSO, 1995. ISBN 0110537513:
http://www.opsi.gov.uk/SI/si1995/Uksi_19953163_en_1.htm

USE OF BEDRAILS DECISION AID

There are various types of beds, bedrails and mattresses. Always take into consideration appropriate combination and individual patient need.

INITIAL DECISION

If you are unfamiliar with the patient (e.g. he/she is newly admitted) and have little information about them, you will need to make an initial decision about whether or not to use bedrails.

DO NOT ROUTINELY USE FULL BEDRAILS –

Indication 1. If their use is to prevent the patient from getting out of bed e.g. to try to stop the patient getting up and falling

Indication 2. If patient is agitated and has attempted/may attempt to climb over or around bedrails- use ultra-low bed and consider floor safety mats

Indication 3. If their use would reduce the patient's independence

Remember that the use of bedrails is a form of restraint, so they can only be used either with patient consent or in line with the Mental Capacity Act 2005, where it's in the patient's best interests, is to prevent harm to the patient and is a proportionate response to the likelihood and seriousness of harm (see Mental Capacity Act web page).

PROCEED WITH CAUTION IF –

The patient is an unusual body size - e.g. hydrocephalic, microcephalic, growth restricted, very emaciated or has other risk for entrapment.

WHEN TO USE BEDRAILS –

Indication 4. If patient is on a trolley (under normal circumstances)

Indication 5. To transport a patient on a bed/ trolley

Indication 6. To prevent the patient from slipping, sliding or rolling out of bed

Indication 7. To assist a patient to move themselves independently in and out of bed (commonly ½ rail top is recommended)

PRESENTING CONDITIONS TO CONSIDER FOR USE OF BEDRAILS –

Indication 8. Reduced levels of consciousness

Indication 9. Partial paralysis / poor trunk control

Indication 10. Seizures or spasms

Indication 11. Sedated, drowsy or recovering from anaesthesia

Indication 12. Patient decision

IF YOU REQUIRE

- high-sided ¾ length bedrails or
- bedrail protection (bumpers)

please liaise with Medstrom.

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON FOR DECISION (INDICATION NUMBER): HOSPITAL USE**TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE**

| | | | | | | |
|------------|---------------------------|------------------|-----------|----------------------|---------------|----------------------|
| Left side | ½ rail top | ½ rail bottom | None | Reason for decision: | | |
| Right side | ½ rail top | ½ rail bottom | None | Reason for decision: | | |
| Other | Full or ¾ length bedrails | Floor safety mat | Left side | Right side | Ultra-low bed | Other (please state) |

If full or ¾ rails are used for both left and right sides the rationale must be made explicit as this may be overly restrictive and is not without risk. Record reason for decision of use (use indication numbers) and 'other' equipment.

Patient/Attorney/Deputy consent MCA Best interests (ensure patient notes reflect this)

Complete on admission/transfer to different clinical area

Review following any change in the patient's condition

Acute care – at least weekly

Long term care – if new patient or known to be at risk, at least weekly. Otherwise, at least monthly.

| | | |
|---------------|------|-------------|
| Date and time | Name | Designation |
|---------------|------|-------------|

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON FOR DECISION (INDICATION NUMBER): HOSPITAL USE**TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE**

| | | | | | | |
|------------|---------------------------|------------------|-----------|----------------------|---------------|----------------------|
| Left side | ½ rail top | ½ rail bottom | None | Reason for decision: | | |
| Right side | ½ rail top | ½ rail bottom | None | Reason for decision: | | |
| Other | Full or ¾ length bedrails | Floor safety mat | Left side | Right side | Ultra-low bed | Other (please state) |

If full or ¾ rails are used for both left and right sides the rationale must be made explicit as this may be overly restrictive and is not without risk. Record reason for decision of use (use indication numbers) and 'other' equipment.

Patient/Attorney/Deputy consent MCA Best interests (ensure patient notes reflect this)

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Acute care – at least weekly

Long term care – if new patient or known to be at risk, at least weekly. Otherwise, at least monthly.

| | | |
|---------------|------|-------------|
| Date and time | Name | Designation |
|---------------|------|-------------|

USE OF BEDRAILS RECORD AND DECISION: COMMUNITY USE

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON (INDICATION NUMBER) FOR DECISION

TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE

Bed model:

| | | | | | | | | | | | |
|------------------------|----------------------------------|--|----------------------------------|--|-----------------------------------|--|-------------------------|--|--------|--|----------------------|
| Left side | Universal bedrail ¾ length | | Full mesh side | | full length | | full length & bumper | | none | | Reason for decision: |
| Right side | Universal bedrail ¾ length | | Full mesh side | | full length | | full length & bumper | | none | | Reason for decision: |
| Other interventions | lower bed | | Floor safety mat left side | | Floor safety mat right side | | other bed type | | Other: | | |

Record reason for decision of use (use indication numbers) and 'other' equipment e.g. use of bedrail bumpers.

Patient/Attorney/Deputy consent

MCA Best interests (ensure patient notes reflect this)

Review following any change in the patient's condition

Short term use – at least weekly

Long term use – if new patient or known to be at risk, at least weekly. Otherwise, at least monthly.

| | | |
|---------------|------|-------------|
| Date and time | Name | Designation |
|---------------|------|-------------|

RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON (INDICATION NUMBER) FOR DECISION

TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE

Bed model:

| | | | | | | | | | | | |
|------------------------|----------------------------------|--|----------------------------------|--|-----------------------------------|--|-------------------------|--|--------|--|----------------------|
| Left side | Universal bedrail ¾ length | | Full mesh side | | full length | | full length & bumper | | none | | Reason for decision: |
| Right side | Universal bedrail ¾ length | | Full mesh side | | full length | | full length & bumper | | none | | Reason for decision: |
| Other interventions | lower bed | | Floor safety mat left side | | Floor safety mat right side | | other bed type | | Other: | | |

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RECORD OF USE OF BEDRAIL DECISION, EQUIPMENT & REASON (INDICATION NUMBER) FOR DECISION

TICK (✓) SHADED BOX TO INDICATE DECISION AND EQUIPMENT USE

Bed model:

| | | | | | | | | | | | |
|---------------------|-------------------------------|--|----------------------------|--|-----------------------------|--|----------------------|--|--------|--|----------------------|
| Left side | Universal bedrail ¾ length | | Full mesh side | | full length | | full length & bumper | | none | | Reason for decision: |
| Right side | Universal bedrail ¾ length | | Full mesh side | | full length | | full length & bumper | | none | | Reason for decision: |
| Other interventions | lower bed | | Floor safety mat left side | | Floor safety mat right side | | other bed type | | Other: | | |

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|---------------|------|-------------|
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Indication 9. Partial paralysis / poor trunk control

Indication 10. Seizures or spasms

Indication 11. Sedated, drowsy or recovering from anaesthesia

Indication 12. Patient decision

If you have any questions regarding this leaflet please talk to staff on the ward.

Further information about falls can be found on the Ageing Well in Wales website:

www.ageingwellinwales.com/en/themes/falls-prevention



This Leaflet is also available in Welsh and large print on request



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Moving safely in hospital: Information for patients and visitors



Hospitals can be busy unfamiliar places for many people, causing an increased risk of falls.

This leaflet will help you think about how to move around safely in hospital and reduce that risk.

Whilst you are in hospital it is important to think about ways to keep yourself safe whilst moving around. Staff may ask you questions such as:

- Have you had any falls at home? If so how many in the last year?
- What medication do you take? Do you take it regularly?
- Do you feel dizzy when you stand up or move around?
- Do you feel nervous about moving around?
- Do you use any walking aids inside or outside the house?
- Do you normally wear glasses and/or hearing aid(s)?

Top Tips

Bring your usual footwear from home. Ensure they fit well, have a closed back, fastenings and a good grip. Avoid walking in socks, as you may slip.



Use any walking aids recommended for you when moving around the ward. Don't lean on furniture as it may move.

Give yourself plenty of time when going from one place to another. If you need to go to the toilet try not to wait until you are desperate, to avoid rushing.

Ask staff to move obstacles out of your way so you are free to move safely.

If possible avoid sitting still for long periods. Aim to move / be active at least hourly as this will help you get better.

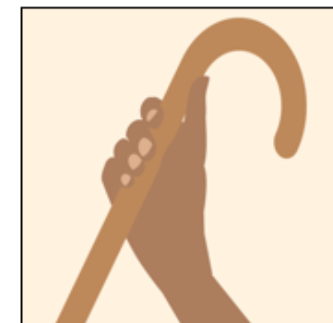
If you need help to walk make sure your call bell and any items you may need are close to hand. Ask staff to help if needed.

Bedrails are fitted to your bed and we need to decide with you whether to use them or not. Please ask staff for further information.

Items to bring in from home:

If you don't have the following, ask someone to bring it in for you. If no-one is able to do this, speak to a member of staff.

- Well fitting shoes and / or slippers
- Any indoor walking aids used at home
- Day Clothes
- Night Clothes
- Glasses / Hearing aids/ Dentures
- List of all medications



Os oes gennych unrhyw gwestiwnau ynglŷn â'r daflen hon siaradwch â staff ar y ward.

Gellir cael rhagor o wybodaeth am godymau ar wefan Heneiddio'n Dda yng Nghymru:

www.ageingwellinwales.com/en/themes/falls-prevention



Mae'r daflen hon i'w chael hefyd yn Saesneg ac mewn print bras ar gais.



GIG
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NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Symud yn ddiogel mewn ysbyty:

Gwybodaeth ar gyfer cleifion ac ymwelwyr



Gall ysbytai fod yn fannau prysur ac anghyfarwydd i lawer o bobl, gan gynyddu'r perygl o gael codwm.

Bydd y daflen hon yn eich helpu i feddwl am sut i symud o gwmpas yn ddiogel mewn ysbyty a lleihau'r perygl o gael codwm.

Pan fyddwch mewn ysbyty mae'n bwysig meddwl am ffyrdd i gadw eich hun yn ddiogel pan fyddwch yn symud o gwmpas. Efallai y bydd staff yn gofyn cwestiynau tebyg i:

- A ydych chi wedi cael unrhyw godwm gartref? Os do, faint yn ystod y flwyddyn ddiwethaf?
- Pa feddyginiaeth ydych chi'n ei chymryd? A ydych yn ei chymryd yn rheolaidd?
- A ydych chi'n teimlo'n benysgafn pan fyddwch yn codi ar eich traed neu'n symud o gwmpas?
- A ydych chi'n teimlo'n nerfus ynglŷn â symud o gwmpas?
- A ydych chi'n defnyddio unrhyw gymhorthion cerdded yn y tŷ neu pan fyddwch allan?
- A ydych chi fel arfer yn gwisgo sbectol a/neu gymorth (cymhorthion) clyw?

Cynghorion Da

Dewch â'ch esgidiau arferol o gartref. Gwnewch yn siŵr eu bod yn ffitio'n dda, bod cefn caeedig iddynt, bod dull i'w cau a bod gafael da ar y gwadnau. Osgowch gerdded mewn sanau, gan y gallech lithro.



Defnyddiwch unrhyw gymhorthion cerdded a argymhellir ar eich cyfer pan fyddwch yn symud o gwmpas y ward. Peidiwch â phwyso ar ddodrefn gan y gallant symud.

Rhowch ddigon o amser i'ch hun pan fyddwch yn mynd o un lle i'r llall. Os bydd angen i chi fynd i'r toiled ceisiwch beidio ag aros nes y funud olaf er mwyn osgoi gorfod brysio.

Gofynnwch i staff symud rhwystrau o'ch ffordd fel eich bod yn rhydd i symud yn ddiogel.

Os yn bosibl, osgowch eistedd am gyfnodau hir. Ceisiwch symud / bod yn gorfforol egniol o leiaf bob awr gan y bydd hyn yn eich helpu i wella.

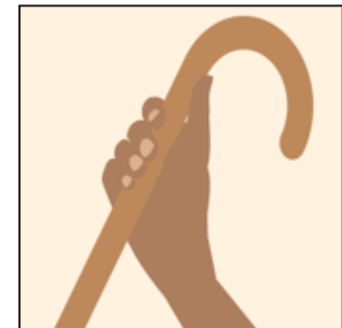
Os oes angen help arnoch i gerdded gwnewch yn siŵr bod eich cloch alw ac unrhyw eitemau allai fod eu hangen arnoch wrth law. Gofynnwch i staff helpu os bydd angen.

Gosodir rheiliau ar eich gwely a bydd angen i ni benderfynu gyda chi a oes angen eu defnyddio ai peidio. Gofynnwch i'r staff am ragor o wybodaeth.

Eitemau i ddod gyda chi o'ch cartref:

Os nad yw'r canlynol gennych, gofynnwch i rywun ddod â nhw o mewn i chi. Os na all unrhyw un wneud hyn, siaradwch ag aelod o staff.

- Esgidiau a / neu sliperi sy'n ffitio'n dda
- Unrhyw gymhorthion cerdded a ddefnyddir gartref
- Dillad dydd
- Dillad nos
- Sbectol / Cymhorthion clyw/ Dannedd gosod
- Rhestr o'ch holl feddyginiaethau.



Addressograph

Acute and Emergency Medical Directorate Falls Care Plan
 Under normal circumstances EU trolley rails should be used at all times

IS THE PATIENT AT RISK OF FALLS?

Example:
Underlying medical causes, on medications that lower BP or cause dizziness, unwell, history of falls, risk of seizures, hypotensive, cognitively impaired, disorientated, confused, sensory deficits, intoxicated, substance misuse

YES

| | |
|--|----------------------------------|
| If appropriate request a high priority bed in view of clinical risk | TICK <input type="checkbox"/> |
| Nursed in easily observed area | <input type="checkbox"/> |
| Ensure patients possessions and call bell within reach | <input type="checkbox"/> |
| Trolley/bed kept at lowest level whilst patient unattended | <input type="checkbox"/> |
| Is the patient agitated/confused and likely to try and get out of bed, climb | <input type="checkbox"/> |

- Provide 1:1 supervision or ensure relative/carer in attendance (refer to specialising guideline)
- Consider nursing patient in a chair
- Request ultra low bed from Medstrom (0844 811 3676)
- Consider manual handling issues if placing mattress on the floor
- Escalate request for ward bed
- Consider Nursing booklet B
- Inform NIC

NO

Monitor and re-assess if patients condition or environment changes

If patient falls complete post fall form

Sign :

Date :

Time :

Any actions or referrals required should be documented on the adjacent page.