LINDSEY LODGE HOSPICE

SAFE USE OF BED RAILS (ADULT PATIENTS) POLICY

Contents

1.0 Policy Statement / Purpose
1.1 This policy seeks to reflect current best practice guidance as detailed in Device Bulletin DB2006 (06) 'Safe Use of Bed Rails', incorporate the requirements of NPSA Safer Practice Notice 17 ('Using Bedrails Safely and Effectively') and the Mental Capacity Act 2005 (the Act) and the accompanying Code of Practice (the Code), whilst detailing the factors to be considered and actions which must be taken when assessing the appropriateness of the use of bed rails for adult patients aged 18 years or over. The policy also seeks to ensure compliance with the relevant health & safety legislation, namely the Health & Safety at Work etc. Act 1974 and the Management of Health & Safety at Work Regulations 1999.

1.2 The purpose of this policy document is:

- To provide guidance on the making, documentation and review of decisions relating to the use of bed rails for adult patients aged 18 years or over
- To ensure that all relevant healthcare professionals are aware of the Hospice policy for the use of bed rails, are implementing the policy appropriately and effectively, and are aware of their obligations under the relevant health & safety legislation, the Mental Capacity Act 2005 and accompanying Code of Practice and the Mental Capacity Act Deprivation of Liberty Safeguards (MCA
- DOLS)
- To provide a baseline of good practice for clinical audit

1.3 Interpretation

1.3.1 For the purposes of this Policy, the term 'bed rail' will be used throughout, and this means bed side rails, cot sides, and safety sides. The term 'bed rail' is not to be confused with 'bed grab handle', which is a mobility aid to assist with a patient's transfer to and from a bed.

1.3.2 For the purposes of the Mental Capacity Act and accompanying Code of Practice, the use of bed rails where a person lacks capacity to consent to bed rails in place is an act of 'restraint' as defined in section 6(4) (b) of the Act, being an act which "restricts the patient's liberty of movement, whether or not the patient resists". Staff should follow the guidance in Section 8 of this Policy. Staff should also refer to the Hospice Policy on the Restraint of Patients (Adult).

2.0 Area
This policy applies to all adult patients (aged 18 and over) on the In Patient Unit and Day Care Unit at Lindsey Lodge Hospice.

3.0 Personnel / Duties
This policy is applicable to and outlines responsibilities for all Health Care Professionals employed by or seconded to Lindsey Lodge Hospice.

4.0 Introduction

4.1 The Hospice at all times aims to maintain the dignity of its patients, whilst taking all reasonable steps to ensure their safety. Bed rails are intended to be used only when necessary to prevent bed occupants from harm, e.g. falling from a bed or trolley and sustaining injury. They are not designed or intended to limit the freedom of people by preventing them from intentionally leaving their beds; nor are they intended to restrain people whose condition predisposes them to erratic, repetitive or violent movement. Bed rails should only be used for patients at risk of harm by **rolling/falling out of bed**, and are not to be used for those who have a tendency to climb out of bed.

4.2 Inappropriate use of bedrails may in itself be a serious hazard, leading to injuries caused for example from patients attempting to climb over, or slipping through the rails leading to entrapment and/or asphyxiation. In some patients, bed rails may also result in a feeling of isolation or unnecessary restriction and a loss of dignity. The inappropriate use of bed rails may also induce

agitated behaviour in patients who have not been properly risk assessed, and this in turn may result in further serious injuries. Appropriate use of bed rails however can result in significant benefit to patients, including minimising their risk of falling when being transported, promoting a sense of security, and aiding in turning and repositioning within the bed.

4.3 There are different types, designs and sizes of bed rails, as well as a range of bed types in use. All Electronic Profile beds within the Hospice have built in bed rails, the Bariatric beds have removable Bed Rails. All types of bed rail should be used with care and only after a full, documented risk assessment has been carried out for each bed occupant. When a patient has been risk assessed and requires bed rails an Electronic Profile Bed should be used unless the patient requires a Bariatric bed.

4.4 In all cases, raised bed rails will only be used if, following a full and comprehensive risk assessment, it is considered that they are the least restrictive option available to healthcare staff to ensure the safety of the patient and prevent harm. Patients or relatives should be asked to consent to the use of bed rails. When staff are acting in the 'best interests' of a patient who lacks capacity, any act done or decision made should be the least restrictive of a person's rights and freedoms of action (see section 8.0).

4.5 The use of bed rails does not replace the need for adequate and appropriate nursing and clinical observation, and the escorting of patients who have been assessed as being at a risk of falling.

5.0 Scenarios where the use of raised bed rails should have extra consideration

5.1 Extra consideration must be undertaken on utilising raised bed rails for patients who:

- are disorientated or confused for whatever reason (whether this is due to a long term condition such as dementia or a short term condition such as a head injury) and who may attempt to climb over the sides or the foot of the bed
- have impaired mobility
- are on medications which may alter conscious level and/or normal level of cognitive functioning (such as certain sedatives or strong analgesics) or medications which may result in drops in blood pressure
- are assessed as being at a minimal risk of falling
- are assessed as being at risk of becoming entrapped by the bed rails

5.2 Raised bed rails should only be used for patients at risk of harm – falling out of bed, and should never be used as a means of restraint, to prevent a patient leaving the ward/hospice/restricting movement, or as an alternative to adequate nursing care/support and observation.

6.0 Risk Assessment for the Use of Bed Rails

6.1 As part of the admission process, all patients identified as being at risk of falling (identified using the 'Falls Screening Tool' which should be completed for all inpatients) should have a fully documented risk assessment completed and appropriate management plan put in place (please refer to the Hospices' Falls Prevention Policy.

6.2 The bed rail risk assessment form should be completed for all patients in the community prior to the provision of bed rails.

6.3 The risk assessment should be reviewed at regular intervals during the admission, and at least every 7 days or sooner if there is any change in the patient's clinical condition, if there is any change or replacement of any part of the bed equipment combination.

6.4 The completed risk assessment documentation should be kept with the patient's clinical records.

6.5 The points to consider during a risk assessment include the following list.

6.5.1 Is the person likely to fall from their bed?
If yes, undertake a full Falls Risk Assessment. Consider whether the patient normally uses any aids at home, and how their clinical condition/mobility has changed on admission to the hospice . Consider whether the patient is more confused, disorientated or agitated than normal.

6.5.2 Could the use of a bed rail increase risk?

- Bed rails are most likely to be suitable for example, for a patient who is drowsy e.g. sedated or recovering from anaesthesia or for a patient who is being transferred in a bed from one clinical area to another. They are not suitable for a patient who is confused/agitated and who may attempt to climb over the rails or out of the bottom of the bed when the use of bed rails could lead to:
- Injury due to increased height of the fall
- Entrapment of the head/neck/limbs/body in between the bed rails
- Falling at the end of the bed
- Increased levels of frustration/agitation
- Some conditions may also be worsened by the patient pulling themselves up using bedrails e.g. increased tone in stroke
- Some adult patients have a higher risk of entrapment than others. These include older people and adults with:
    - Communication problems or confusion
    - Dementia
    - Cerebral palsy
    - Very small or very large heads
    - Repetitive or involuntary movements
    - Impaired or restricted mobility

6.5.3 Could the risk of falling from the bed be reduced by less restrictive means other than bed rails?

Alternatives may include:

- obtaining an Ultra-Low bed
- keeping the bed lowered to a minimum height (except for when carrying out direct clinical care)
- nursing the patient on a mattress on the floor. These options should be considered for confused or disorientated patients who repeatedly fall/attempt to climb out of bed, following discussion with the family to explain why this course of action is being taken
- placing the bed against the wall
- alarm systems which alert if the person has moved from their normal position or wants to get out of bed (N.B. need to ensure adequate staffing levels to respond)
- siting the patient's bed where they can be easily observed e.g. in view of the nurses' station
- close nursing observation
- regular offers of toileting
- relatives/carers or sitters staying with the patient
- medical re-assessment

7.0 Taking the decision of whether to use raised bed sides

7.1 The decision of whether or not it is appropriate to use raised bed sides is the responsibility of the staff member completing the Risk Assessment for the patient, and cannot be delegated. Wherever possible, this decision should be taken in conjunction with the patient if they have capacity or the family/carers if the patient does not have capacity and is being treated in their 'best interests' (see Section 8.0).

7.2 All risk assessments should be completed in full and kept in the patient's nursing records. All discussions with the patient/family/carers should be documented in the patient's healthcare record.

7.3 If the risk assessment indicates that the patient is at risk of falling from/climbing out of the bed, the Clinician (or member of team) must clearly document any specific factors that support a decision to use raised bed rails.

7.4 If the Registered clinician completing the risk assessment is in any doubt as to the appropriateness of the use of bed rails for a patient, the decision should be discussed with the multi-disciplinary team, and the discussion and final course of action clearly documented in the patient's healthcare record.

8.0 Patients who lack capacity

8.1 Capacity is the ability to make a decision, and the starting point must always be to assume that a person has capacity unless it is established that he/she lacks capacity. Difficulty communicating a decision is not the same as a lack of capacity to make the decision (see Section 20 'Definitions').

8.2 The Mental Capacity Act 2005 provides that healthcare professionals will not incur liability for any acts carried out in connection with the care or treatment of a person if, before doing the act, they have taken reasonable steps to establish that the person lacks capacity in relation to the matter in question, and it is in the person's best interests for the act to be done.

8.3 The effect of putting up bed rails can be construed as an act of restraint by a healthcare professional. Healthcare professionals will need to take 2 further steps to ensure that they do not incur liability in relation to their actions where the use of bed rails is being considered. The healthcare professional must ensure that:

- they reasonably believe that it is necessary to use bedrails in order to prevent harm to the person
  and
- that use of bed rails is a proportionate response to both the likelihood of the person suffering harm and the seriousness of that harm

8.3.1 For the purposes of the Act and this policy, a healthcare professional restrains an individual if he/she:

- uses, or threatens to use, force to secure the doing of an act which the individual resists or
- restricts the individual's liberty of movement, whether or not the individual resists

8.4 Some patients who lack capacity may, following a full risk assessment, require bed rails to prevent them rolling/falling out of bed – for example, after a stroke. It is important that an assessment of capacity has been carried out and a full risk assessment completed and documented in the patient's records before use of bed rails is implemented (for further information on 'best interests' and assessing capacity, see Section 19.0 'Definitions'). There must also have been due consideration given to any less restrictive options to prevent harm and ensure the safety of the patient (other than bed rails). Where bed rails are used they should be in place for the shortest possible time period. This requires regular re-assessment of the patient's risk of harm and whether use of bed rails are necessary and a proportionate response to the assessed risk.

8.5 Although 'restraint' of a person is permitted under the Mental Capacity Act (MCA) in certain circumstances in order to prevent harm to a patient, it is unlawful to deprive a person of their liberty without appropriate legal authorisation. Such authorisation can result from detention under the Mental Health Act, authorisation through the Deprivation of Liberty Safeguards (DOLS) process or an order of the Court of Protection. It is therefore very important that when taking a decision as to whether the use of bed rails is necessary and proportionate to prevent harm to a person, that the decision is never based upon a desire to prevent the patient leaving the ward or hospital, or a wish to exercise control over a person's movements or as a means of punishment. Staffing should not be a factor in deciding whether to use bed rails. Bed rails must never be used as a means of controlling difficult patients, or as an alternative to adequate clinical and nursing observation and care. They must only be used to prevent harm to the patient.

8.6 Consideration in all cases needs to be given as to whether or not the use of Bed rails constitutes a Deprivation of Liberty Safeguarding and whether a DOLS application needs to be submitted

9.0 Using bed rails

9.1 When bed rails are used, it is the responsibility of the Named Registered Clinician to ensure that:

- the purpose of the rails is explained to both the patient and relatives/carers
- the in-patient has a call bell within easy reach, and is made aware that this should be used when they need to get out of bed, rather than attempting to do so without assistance▫beds are always lowered with wheels locked when using bed rails
- when fitting the rails to the bed, the clinician ensures that the rails and bed are compatible, and that the rail is suitable for the intended bed
- the rails are always used as instructed by the bed manufacturer. If the manufacturer/supplier has provided any information on special considerations and/or contra-indications relating to the bed rails, this is adhered to
- the rails are complete and in good working order
- the rails are clean
- the rails are securely fixed, without excessive movement, and are raised whenever the patient is not being attended by staff/relative/carer
- whenever a bed rail is raised, it is the responsibility of the staff member/relative/carer raising it to ensure that it is securely locked into position
- gaps are avoided that could present an entrapment risk. The head or body should not be able to pass:
    - between the bars of the bed rails (Gaps between bars/rails should be less than 120mm)
    - through any gap between the bed rail and the side of the mattress ▫▫through the gap between the lower bed rail bar and the mattress, allowing for compression of the mattress at its edge
    - through any gap between the headboard/footboard and the end of the bed rail (Gap should be less than 60mm or more than 250mm)
- the bed rail is high enough to take into account any mattress overlay and so minimise the risk of the patient rolling over the top due to a reduction in the height of the bed rail relative to the top of the mattress (extra height bed rails are available from manufacturers for this situation)
- a bumper is considered if appropriate (for example if the patient is vulnerable because of thin skin) and if the patient does not have a specific objection, in order to prevent the patient from getting trapped between the bed-rail and the mattress
- the patient is regularly checked and all checks are documented

9.2 Assessments should be reviewed after any significant change in the bed occupant's physical and/or mental condition, or if there is a change in any of the bed, mattress or bed rail being used, and in any event at periods of not less than every 7 days during the period of bed rail use. Assessments should also be reviewed if the patient is transferred to a different ward or department. The outcome of any review and risk assessment should be fully documented and the care plan updated accordingly.

9.3 If a patient is re-assessed as no longer requiring bed rails and the bed rails can be removed they should be decontaminated and stored away.

10.0 Disputes regarding the Use of Bed Rails

10.1 Bed rails should only ever be used following a thorough risk assessment, and in situations where they are clinically indicated to prevent a patient rolling out of bed. It is the responsibility of the Named Registered clinician to undertake and document this assessment, and if there is any dispute as to whether bed rails are indicated, this should be discussed with the multi-disciplinary team (see section 7.4).

10.2 The issue of bed rails should be discussed with the patient and their carers/family if appropriate, and their consent sought and documented. If a patient who has been assessed as requiring bed rails refuses to consent to them, this should be fully documented in the healthcare records, and any suitable alternative options explored.

10.3 If a patient or relative specifically requests bed rails, when assessment has indicated that they are not required, the implications of both provision and non-provision should be discussed with the patient (and where appropriate, family and carers) and the multidisciplinary team. A full risk assessment must be carried out and documented, and all discussions and decisions reached should be fully documented in the patient's medical records.

11.0 Adverse Incident Reporting

11.1 An adverse incident is an event that causes, or has the potential to cause, unexpected or unwanted effects involving the safety of patients, users or other persons.

11.2 If any incident or accident occurs involving the use of bed rails, staff must follow the Guidance on incident reporting within the Risk Management Strategy and complete an Incident Report Form. If appropriate (and dependent on the severity), consideration should be given to the need to escalate the incident as a 'Serious Untoward Incident' and an appropriate internal investigation/root cause analysis carried out.

11.3 Any adverse incident involving a device should be reported to the MHRA (Medicines and Healthcare products Regulatory Agency – this can be done directly) especially if the incident has led to, or if it occurred again, could lead to:

- death, life threatening illness/injury, or the potential for death or injury in the future
- deterioration in health or permanent impairment of body structure or function
- the necessity for medical or surgical intervention
- prolonged hospitalisation

11.4 Further information on reporting adverse incidents to the MHRA is available from Hospice Chief Executive and found within the Risk Management Strategy.

12.0 Decontamination, Maintenance and Replacement of Bed Rails

12.1 Decontamination
Bed rails should be cleaned between patients and at any time when they are contaminated.

12.2 Maintenance

12.2.1 It is the responsibility of the Unit Manager to ensure that an annual review of the bed rails is undertaken, and to make appropriate arrangements for any maintenance required.

12.2.2 All inspections and maintenance records should be fully documented.

12.2.3 Equipment should only be used in and maintained in line with the manufacturer's instructions and recommendations.

12.2.4 Any defective equipment should be taken out of use immediately. It may need to be scrapped by physical destroying it to avoid it finding its way back into use with potentially disastrous consequences.

12.3 Replacement
It is the responsibility of the Unit Manager to ensure that there are sufficient supplies of compatible bed rails for any non-profile beds. All Electronic Profile beds have built in bed rails and bed rail bumpers available at all times, and to ensure that any defective bed rails that cannot be repaired are replaced as soon as practicable.

13.0 Audit / Monitoring Compliance and Effectiveness

13.1 Audit of the implementation and the application of the Hospice's Policy on the Use of Bed Rails for Adult Patients will be undertaken through the clinical audit route. This will aim to identify any areas where improvement is required, for example ensuring that decisions made on admission regarding the use of bed rails are properly and regularly reviewed by the clinical team. Audit will be informed by the information collected from the clinical notes, namely the Inpatient Falls Screening/Risk Assessment Tool/bed rail assessment tool, and the ongoing care plan documentation. Clinical audit outcomes will be reported to the Hospice Quality Assurance Group.

13.2 Analysis of incident data will also be used to understand the prevalence of falls – including the use or failure to use bed rails – and to identify any particular trends.

13.3 Any identified issues in respect of the use of bed rails and/or documentation will be monitored via the Quality Assurance Group.

14.0 Staff Training

14.1 It is the responsibility of the relevant Unit Managers to ensure that all relevant staff receive the necessary training in manual handling techniques, falls prevention, risk assessment and the safe use of bed rails in adult patients. It is the responsibility of individuals to ensure that they attend any relevant update training.

14.2 It is the responsibility of the individual staff member to ensure they access and receive their moving and handling training and then it is the responsibility of the unit manager to ensure that all employees who are responsible for selecting, fitting, maintaining and checking bed rails have received appropriate Moving and Handling training.

15.0 Review
This policy will be reviewed every 3 years or sooner should the need arise.

16.0 Associated Documents
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16.1 There are a number of local policies and guidelines which should be read in conjunction with this policy.

16.2 Hospice Policy for Consent to Treatment.

16.3 Manual Handling (Minimal Lift) Policy.

16.4 Hospice Policy on the Restraint of Patients (Adult).

16.5 Falls Prevention Policy.

16.6 Risk Management Strategy Including Incident Reporting Policy and Procedure.

16.7 Hospice Medical Devices Policy

16.8

17.0 Further Information
Further guidance and information on this policy can be obtained from the Chief Executive, or Unit Managers..

18.0 References

18.1 MHRA Device Bulletin 'Safe Use of Bed Rails. DB2006 (06). December 2006. MHRA website: www.mhra.gov.uk

18.2 Health & Safety at Work etc. Act 1974 (see sections 2 and 3).

18.3 SI 1999/3242 – Management of Health and Safety at Work Regulations 1999, (Regulation 3 'Risk Assessment').
18.4 The Mental Capacity Act 2005 and Code of Practice and the Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS) and Code of Practice.

18.5 The Human Rights Act 1998.

18.6 NPSA Safer Practice Notice 17 – 'Using Bedrails Safely and Effectively'. February 2007
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19.0 Definitions

19.1 Capacity
This is the ability to make a decision, and the starting point must always be to assume that an individual has capacity unless it is established that he lacks capacity. Difficulty communicating a decision is not the same as a lack of capacity to make the decision.

19.2 The test for capacity:
This is set out in the Mental Capacity Act, and is a 2 stage test which is decision specific. The test is:

- Does the patient have an impairment of, or a disturbance in the functioning of, their mind or brain?
- If yes, does this mean that the patient is unable to make a specific decision when they need to?
- A person is unable to make a decision if they are unable:
  - understand the information relevant to the decision
  - to retain that information
  - to use or weigh that information as part of the process of making the decision balancing risks and benefits
  - to communicate the decision
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19.3 Lack of capacity
A person lacks capacity in relation to the matter if at the material time he is unable to make a particular decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. This is a decision specific test, and so a person may lack capacity to make some decisions for themselves but may have capacity to make other decisions.

19.4 Best Interests
Anyone who is assessed as lacking capacity should be treated by healthcare professionals in their 'best interests' (unless there is a valid and applicable Advance Decision in existence, in which case this must be followed). The Mental Capacity Act does not actually define 'best interests' but is clear that in deciding what is in the best interests of a person lacking capacity, decision makers must take into account all relevant factors it would be reasonable to consider. As a starting point the Mental Capacity Act sets out a checklist of common factors that should always be considered, and these include:

- whether the person will regain capacity to make the decision and whether the decision can be delayed until then:
- Considering all relevant circumstances, and making every effort to encourage and enable the person lacking capacity to take part in making the decision
- Taking into account any evidence of the patient's current and previously expressed wishes and feelings, including any written statements made by the patient when he had capacity
- Considering the beliefs and values that would be likely to influence the individual's decision if he had capacity, and any other factors he would be likely to consider if able to do so
- If practicable and appropriate, taking into account the views of anyone named by the individual as someone to be consulted on matters of this kind, any carers or other people interested in the individual's welfare, any donee of a LPA appointed by the individual or any Deputy appointed by

- the Court, as to what would be in the individual's best interests

20.0 Consultation
Senior clinical management Team

21.0 Dissemination

21.1 A copy of the 'Policy on the Safe Use of Bed Rails for Adult Patients', once ratified, will be issued to all patient areas , will be made available to all new medical and nursing staff on induction and will be re-issued following each policy review. It is the responsibility of the Senior Nurses to ensure that all members of the nursing staff on their ward are aware of this policy.

21.2 Copies of the policy will be available in all departments, and a copy will be posted on the Hospice L drive- policies. Copies of this policy will be made available for patients/carers/relatives on request.

22.0 Equality Act (2010)

22.1 In accordance with the Equality Act (2010), the Hospice will make reasonable adjustments to the workplace so that an employee with a disability, as covered under the Act, should not be at any substantial disadvantage. The Hospice will endeavour to develop an environment within which individuals feel able to disclose any disability or condition which may have a long term and substantial effect on their ability to carry out their normal day to day activities.

22.2 The Hospice will wherever practical make adjustments as deemed reasonable in light of an employee's specific circumstances and the Hospices's available resources paying particular attention to the Disability Discrimination requirements and the Equality Act (2010).

Lead Author of Policy **Responsible Sub-group Quality Assurance** **RATIFICATION DATE BY TRUSTEES 13th April 2017** Review interval 3 year				
To Be reviewed	Review completed	By	Approved By	Circulation
April 2020				

Appendix 1

Bed Rails assessment form

Bed rail guide

Patient's mobility

Patient's mood	Immobile Reliant on others for all care needs. Cared for in bed/ hoist transfer	Assistance Requires help of others and/or equipment for care needs and mobility	Independent Able to move around the ward with no assistance from others
Unconscious	Bed rails recommended		
Drowsy/ semi-conscious	Bed rails may be used	Select bed rails with care	Bed rails NOT recommended
Confused/ agitated/ restless/ anxious/ disorientated	Select bed rails with care	Bed rails NOT recommended	Bed rails NOT recommended
Orientated and alert	Bed rails may be used	Bed rails may be used	Bed rails NOT recommended

Check your patient's mobility (column headings) and mood (row headings) and select the box that applies in the risk matrix.

After completing the matrix, consider the factors below prior to using bed rails. This is a guide – always use professional judgement.

Assessment of patient's behaviour	Actions
Might bed rails impede the patient's independence?	If YES - DO NOT use bed rails
Might the patient climb over the bed rails?	If YES - DO NOT use bed rails
Is the patient confused?	If YES - Bed rails may not be appropriate.
Could bed rails cause the patient distress?	If YES - DO NOT use bed rails
Might the patient injure themselves on bed rails?	If YES - DO NOT use bed rails
Do the bed rails need to be covered?	If YES - Cover the bed rails
Is a mattress overlay required?	If YES - Ensure bed rails are deep enough.
Might alternative options be requried in place of bed rails?	If YES - Use low bed/ floor mats/ position near nurses station

Risk assessment outcome - complete on admission and on change of condition

Date	Time	Mood	Mobility	RAG rating (red, amber or green?)	Bed rails indicated? (yes/no/with care)	Sign

The patient and/or carers must be involved in the assessment process. If this is not possible at the time of assessment the rationale for decision on bed rails must be communicated to relatives/carers within 24 hours