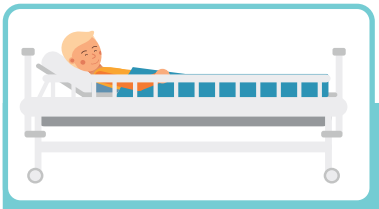
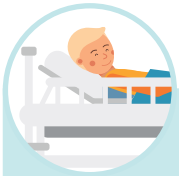
Guide for care home staff on the use of bed safety rails



This guide is designed to support care home staff to implement best practice in the use of bed safety rails.
This guide accompanies the "Bed Safety Rails - To use or not to use, that is the question?" poster resource which should be displayed within the care home as a quick reference guide for care home staff. Both resources have been produced by NHS GGC in collaboration with care home staff in response to latest MHRA guidance and NPSA.

For full details of the MHRA guidance scan the following QR code.



About Bed Safety Rails

Residents may be at risk of falling from bed for many reasons including impairments in physical, cognitive and functional abilities. Bed safety rails are designed to reduce the risk of residents accidentally slipping, sliding, falling or rolling out of bed.

Bed safety rails will not prevent a resident leaving their bed and falling elsewhere, and should not be used for this purpose.

Bed safety rails are not intended as an aid for a resident to manoeuvre him / herself e.g. sitting forwards in a bed, rolling over etc. There is some evidence to suggest that bed safety rails use may increase the risk of serious injury if residents attempt to climb over them to exit the bed, or become entrapped within the rails. The use of bed safety rails must be assessed and reviewed taking into account the benefits and risks for each individual resident.

There are two different types of bed safety rail:

- Integral types - these are incorporated into the bed design and supplied with / or offered as an optional accessory by the bed manufacturer, to be fitted later.
- Third party types - these are not specific to any particular bed model.
  They are attachable and detachable and intended to fit a wide variety of metal framed beds from different suppliers.

Risk Assessment

An assessment should be completed within 24 hours of admission to the care home.

When assessing the appropriateness of the use of bed safety rails, staff should consider the risks and benefits for individual residents. This should be documented in care home notes. An information leaflet is available to facilitate discussion with residents and their families.

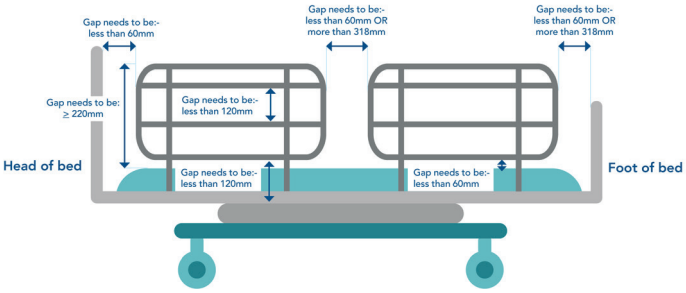
Things to consider when assessing the use of bed rails:

Resident safety may be compromised if bed safety rails are used improperly. As such, careful consideration must be given as to the need for their use in addition to the many other possible interventions available to reduce falls risk. Possible hazards include entrapment of a limb or body part, injury from falling over rails, or suffocation on padded accessories (eg. bumpers).

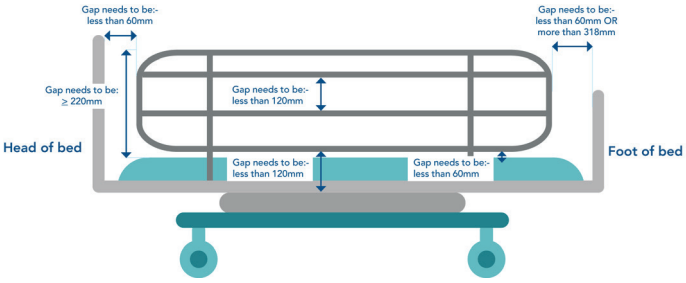
1. **Entrapment risk** - there is a risk of a resident becoming entrapped in a number of ways and in a number of places resulting in injury or death. Entrapment of the head, arms, legs and body are all possible. To prevent this there are a number of minimal measurements that require checked to reduce unsafe gaps from causing an entrapment.
   Please see below which illustrates these gaps.

Adult Sizes

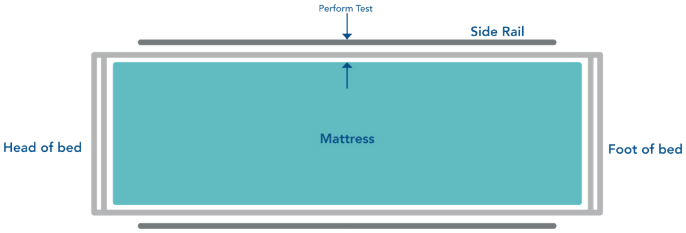
Bed with Split Side Rails



Bed with Cantilever Rails

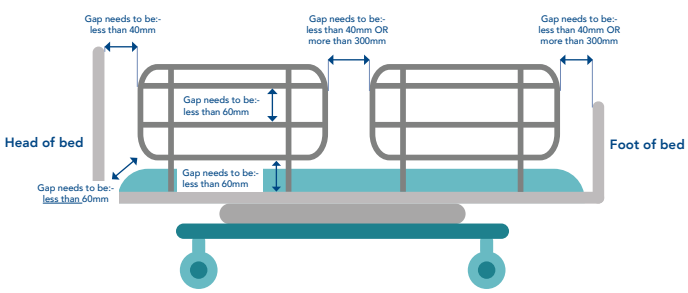


Bed in Plan View

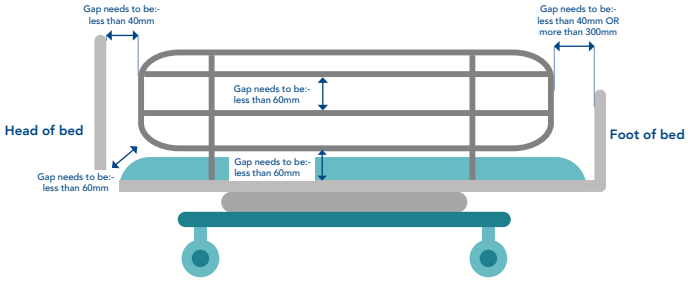


Adult with Atypical Anatomy

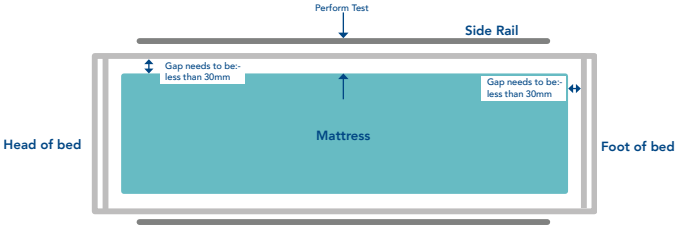
Bed with Split Side Rails



Bed with Cantilever Rails



Bed in Plan View



2. **BMI - body size shape** - if the resident is under 1.46m/4'11", less than 40KG or has a BMI of less than 17 they will be at increased risk of entrapment. To reduce this risk see illustration for adults with atypical anatomy for appropriate gaps.

3. **Dementia/delirium** - if the resident is showing signs of stress or distress or is unable to retain information then they may not be able to fully understand the use of the bedrail. They may be more likely to display risk taking behaviour e.g. trying to climb over the rail. The use of the rail may also add to their distress and agitation.
4. **Involuntary movements** - this may lead to the resident injuring themselves or potentially entrapping a limb - consideration should be given to whether bed rail bumpers may be of benefit.
5. **Consider risk of person climbing over** - If a resident climbs over the bed rail they are more likely to injure themselves more severely as they are falling from a greater height. If a resident is at risk of climbing over then alternatives to bed rails should be considered.
6. **Mattress type / height** - If the resident has been supplied with a new mattress such as a pressure relieving mattress or mattress topper then this may lead to it being easier for the resident to climb or roll over the top of the bed rails. There should be at least a 220mm distance between the top of the rail and the top of the mattress. Bed safety rail height extenders should be used if these measurements are not achieved.

Think Alternatives or Additions

There are other interventions including:

- **Low bed** - These beds can lower to approximately 14 inches off the floor (or lower) and can help to prevent serious injuries. They should be considered for use with residents who are at high risk of falls/sustaining injury when using a standard bed or residents of small stature whose independence is significantly impeded by the height of the bed. It is important to ensure that a compatible mattress is used and that the height of this does not negate the use of a lower height bed. You should also consider that if a resident requires a low-profiling bed they may need additional support to get in and out of bed. If this support is not available it may mean the resident's freedom to move is restricted and they could become less active or at greater risk of falling.
- **Bed rail bumpers** - These can be used to provide protection from impact injuries, this is more likely to occur if the person moves around a lot in bed or if there is some involuntary movement. The bumpers can help against entrapment issues, for example, of limbs. The bumpers must be used in accordance with the manufacturer's instructions. This includes fitting and washing. Depending on the type of bed and rails issued and the associated bumpers, the bumpers may move or compress. It is vital that they are secured appropriately in line with manufacturers' instructions. Bumpers can cause entrapment issues themselves and if there is involuntary movement, the person may end up in a fixed position with their face against the bumper, this may cause a risk of suffocation, so it is important that the risk factors are weighed up and the risk assessment completed in each case where a bed, bed (side) rails and bumpers are issued.
- **Crash mats** - These may be used to further reduce the risk of injury for a resident who is prone to falling out of bed. However it should be highlighted that these can cause an increased slip/trip risk for the resident and staff so should be used with caution.

- **Alarm systems** - If using falls alarm equipment ensure that this meets the resident's needs and is compatible with the nurse call system – some alarms can be used on a 'splitter' so the nurse calls buzzer can be in use with the resident, as well as the alarm. The alarm needs to be checked prior to every use. It needs to be positioned appropriately so it is triggered promptly. Alarms require to be regularly reviewed to ensure safety/ effectiveness.
- **Bed rail height extenders** - these allow the bed rail height to be adjusted and should be used whenever there is not a safe gap between the top of the mattress and the top of a rail to reduce the risk of the resident falling or rolling out of bed.

Review

The assessment of whether to use bedrails must be reviewed when the resident's:

- Physical condition changes and this change may affect risk of slipping, sliding, falling or rolling from the bed.
- Cognitive or safety awareness changes which may affect the safe use of bedrails (e.g. increased agitation and attempts to climb over the bed rails).
- Care environment and or care provision changes (e.g. the patient moves within the home or returns from another care environment such as hospital).

Care home staff should complete risk assessments as per local policies and procedures but as a guide it is suggested that the bed safety rail risk assessment should be reviewed:

- Monthly.
- After a resident falls.

Equipment Checks

Carry out regular checks of the bed rails to ensure they are in working order including:

- **Signs of wear and tear** - if you identify an issue with a piece of equipment then this should be reported through your local processes to facilitate a replacement/repair.
- **The bed rail moves up and down appropriately** - falling from a raised bed can increase the risk of residents injuring themselves so it is important that beds should be lowered to the safest height after staff complete any tasks.
- **The rail doesn't wobble when in place** - if there is excessive movement then there is a risk of entrapment between the mattress edge and rail and also it is possible for the bed rail to fail causing resident to fall.
- **There are no obvious gaps between bed/mattress** - as highlighted earlier in this guide it is important that there are no unsafe gaps to prevent the risk of the resident becoming entrapped.