SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Bedrails – Adult – for use in Acute and Subacute Care Settings
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/421
DATE OF PUBLICATION	November 2022
RISK RATING	High
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 1 - Governance for Safety and Quality in Health Service Organisations Standard 2 - Partnering with Consumers Standard 5 - Comprehensive Care Standard 8 - Recognising and Responding to Acute Deterioration
REVIEW DATE	November 2024
FORMER REFERENCE(S)	PD 249
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Clinical Stream Director, Aged Care and Rehabilitation
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FUNCTIONAL GROUP(S)	Aged Care and Rehabilitation
KEY TERMS	Bedrails, restraints, falls prevention, cognitive impairment, bedrail decision aid
SUMMARY	The purpose of this document is to give clinicians a guide to the appropriate use of bedrails for adults being cared for in acute and subacute care settings. The use of bedrails for patients with cognitive impairment can increase the risk of injury from falls but there are some circumstances when the use of bedrails is recommended. A Bedrail Decision Aid has been included to assist clinicians in using their clinical judgement to make the best decision for the individual needs of each patient.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Bedrails – Adult – for use in Acute and Subacute Care Settings

SESLHDPR/421

1. POLICY STATEMENT

Decisions about the use of bedrails will be made in the same way as decisions about other aspects of treatment and care. This means:

- The patient is entitled to decide whether or not to have bedrails used if they have the ability to understand and consider the risks and benefits of their decision once these have been explained to them.
- If there are concerns about the patient's cognitive ability and/or the presence of confusion, agitation, delirium or dementia, staff have a duty of care and must decide if bedrails are in the patient's best interests. In this circumstance, staff will discuss the decision with the identified person responsible. Bedrails are not to be used in SESLHD as a form of restraint.

Bedrails should generally not be used:

- If the patient can mobilise safely and independently
- To keep a patient in bed against their wishes, particularly those people who have the potential physical ability to attempt to either climb over the rails or out between the rails and at the end of the bed.

Bedrails generally should be used:

- If the patient specifically requests them
- If the patient is being transported on their bed
- When patients are recovering from anaesthetic, sedation or severely unwell and are under constant observation.

The Bedrail Decision Aid (Appendix 1) should be used as a guide to determine whether a patient would benefit or not from the use of bed rails. This procedure should also be read with reference to:

SESLHDPR/483 - Restrictive Practices with Adult Patients
SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older People in Acute and Sub Acute Care
SESLHDGL/054 - Falls Prevention and Management: Guideline for use of bed/chair alarm units (Adult Inpatient)
SESLHDGL/042 - Falls Prevention and Management: Guideline for Designated High Risk Observation Room (Adult Inpatient)
SESLHDGL/044 - Falls Prevention and Management of Non-Admitted Patients
SESLHDGL/099 - Falls Prevention and Management: A best practice guide for Allied Health Professionals
SESLHDPR/380 - Falls Prevention and Management for people admitted to acute and sub-acute care

2. BACKGROUND

Bedrails can be used safely (Safer Care, Victoria, 2019) but they should only be used in limited circumstances where the benefits outweigh the risks (Safer Care, Victoria, 2019).

Injuries and deaths have occurred in Australia and overseas due to the use of bed rails (Safer Care, Victoria, 2019). Studies have shown that raised bedrails do not deter older patients from getting out of bed unassisted and there are a number of reports each year of deaths and serious injuries resulting from the use of bedrails (Anderson et al., 2012). Bedrails can increase the risk of injury to patients through entrapment and falls from a height (Bellinger et al., 2017). Patients also have increased risk of injury when poorly designed or maintained bedrails are used, or if bedrails are incorrectly fitted to beds (Haugh et al., 2014).

Patients, particularly those who are agitated with an acute delirium, known cognitive impairment or dementia, are put at risk when bed rails are used as a means of keeping them in bed against their wishes.

Patients who are cognitively intact can request the use of bedrails, and the 'inappropriate non-use' of bedrails in these circumstances also puts the patient at risk of injury from falling (O'Flatharta et al., 2014).

Bed rails are not a substitute for supervision and appropriate use must always be in conjunction with other individualised falls prevention strategies.

The use of bedrails, as with all other care decisions, should be based on:

- Clinical judgement
- Risk assessment in consultation with the attending physician, patient/ carer (Shanahan, 2012).

In general, bedrails are intended to reduce the risk of accidentally falling out of bed and should not be used as a device to restrain and keep someone in bed against their wishes.

3. DEFINITIONS

Bed/chair alarm*:* Refers to an electronic monitoring system that alarms when a patient attempts to get up from their bed or chair. There are different types and brands of alarm units available. Please refer to SESLHDGL/054 - Falls Prevention and Management: Guideline for use of bed/chair alarm units (Adult Inpatient) for further information.

Bedrail: A device which is attached to either or both sides of a bed and forms a physical barrier.

Crash mat: a foam mat placed on the floor beside the bed to assist in preventing injuries to patients rolling out of bed, especially where side rails cannot be used. Ideally, the bed should be positioned on a low height setting to further minimise injury from a fall.

Lo-Lo bed: An electric height adjustable bed that can be lowered to a level below the standard minimum bed height, reducing the risk of injury to a patient who is impulsive or agitated and attempting to climb out of bed.

Patient: An adult patient, client, consumer or resident for whom the decision about bedrail use is being made.

Person responsible: Is someone who has the authority to consent to treatment for an adult who is unable to give a valid consent to their own medical or dental treatment. The person responsible is determined by the health practitioner according to the hierarchy of persons set out in section 33A of the NSW Guardianship Act 1987 (see NCAT Fact Sheet - Person Responsible for further information).

Hi-lo bed: An electric height adjustable bed that can be lowered for the patient to safely enter and exit the bed and raised to provide appropriate height for staff to deliver care (see Section 5.5).

Half-length bed rail: a half-length bed rail attaches to the head of the bed and allows someone who is independent to swing their legs over the edge and use the rail to assist themselves up to standing.

4. RESPONSIBILITIES

4.1 Chief Executive, General Managers, Clinical Stream Directors, Facility Directors of Nursing Managers and Supervisors will: provide overall governance for the implementation and monitoring of adherence to this procedure.

4.2 Line Managers will: ensure staff are aware of this procedure and that education resources are readily available in the clinical environment.

4.3 Staff involved in the clinical care of patients will: implement strategies identified in this procedure to reduce risk to patient through the correct use of bedrails.

5. PROCEDURE

5.1 Individual Patient Assessment

- Refer to the Bedrail Decision Aid (Appendix 1) when considering a patient's mobility, mental state and cognition
- Use clinical judgement in the consideration of risks and benefits for individual patients. 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
- Some examples of where bed rails may be used differently to the Bedrail Decision Aid are:
    - Immediate post-operative care where bed rails are used to protect patients from falling out of bed. Patients in these units are also closely supervised to prevent any risk of patients climbing over rails if in a confused or disorientated state
    - Padded bed rails are used where patients have epilepsy to prevent falling out of bed during seizures. Padding or covers over bed rails should be used with caution as they may create risk of asphyxiation (S.A. Health, 2015).
- Decisions regarding the use of bedrails should be frequently reviewed and adjusted in accordance with the patient's clinical needs and/ or condition

- In residential care facilities, bedrail covers may be used with caution, where the resident is frail and at risk of skin injury from the bedrail
- In acute care facilities, use of bedrails should be reviewed at the time of admission and whenever a patient's condition or wishes change, but as a minimum reviewed at least every shift
- In sub-acute and residential care facilities the review timeframe can be longer (up to one month) in line with local requirements
- Any other specific circumstances requiring the use of bedrails should be documented in the patient's medical record.

5.2 Communication and documentation

- Patients who have capacity to make decisions and who understand the risks involved in the use of bedrails are entitled to make their own choice regarding the use of bed rails
- Patients with cognitive impairment should have the use or non-use of bedrails discussed with their *person responsible*
- Discussions about the use or non-use of bedrails and decisions made by patients or persons responsible must be documented in the patient's medical record
- In residential care facilities, documentation must include the consent gained from the person responsible, including their understanding of the risks involved with the use of bed rails. If the resident is under Public Guardian, a Medical Officer must document that the clinical decision of the use of bed rails is recommended and appropriate.

5.3 When a decision to use bedrails is made

- Conduct a risk assessment and ensure that:
  - Bedrails are in good working order (see Appendix 2)
  - Bedrails are compatible with the bed and mattress they are to be used with, consider the additional height some overlay mattresses contribute and whether the height of the bed rail is sufficient to safely secure the patient
  - Bedrails are attached securely to the bed frame
  - Check the bedrails are doing what you intend them to do.
- Complete appropriate falls risk screen (Ontario Modified Stratify, Sydney scoring) and FRAMP (Falls Risk Assessment and Management Plan), document any actions/interventions that are required or have been implemented in the patient's medical record.

5.4. When bedrails are <u>not</u> used with a patient with cognitive impairment

- Complete the appropriate falls risk screen (Ontario Modified Stratify, Sydney scoring) and FRAMP (Falls Risk Assessment and Management Plan) in accordance with the SESLHD procedures and guidelines referenced in Section 1 - Policy Statement
- Document any actions/interventions that are required or have been implemented in the patient's medical record
- Consider what alternatives are available, such as designated high risk observation rooms, low level beds (see Section 5.5), bed/chair alarm devices, supervision by family/carers and the provision of volunteers and/or AINs/specials depending on specific site resources and approval processes.

If considering the use of a crash mat next to the lo-lo bed, will this be a trip hazard for staff and other patients/carers (Dept of Health, Victoria, 2020).

- Ensure that the decisions and interventions have been discussed with the patient's person responsible and documented in the medical record
- Ensure the patient is in a part of the ward/unit/facility where they can easily be observed
- Provide visual cues to assist the patient's orientation such as clock, day/ date and place on information board
- Ensure needs are met, for example: regular toileting, adequate pain management, provision of food and drinks etc.

5.5 Bed Height

- For patients who can mobilise independently, including those with a cognitive impairment, the bed height should be equal to the height of their knees when standing
- Patients with a cognitive impairment who are not independently mobile, but are capable of climbing over or around bed-rails, should have the bed-rails down and be cared for on a lo-lo bed or hi-lo bed (when available) that is positioned at its lowest possible height. Ideally, the maximum height of the bed is approximately 250mm and is raised only during patient care and transfers. This will help to reduce the risk of injury from a fall should the patient attempt to get out of bed without assistance.

5.6 Work Health and Safety

- Ensure that Manual Handling policies and procedures are adhered to: SESLHD Work Health and Safety Policies and Procedures
  This includes:
  - Re-positioning of bed to an appropriate height for patient care, transfers and mobility
  - Adequate assessment of patient mobility
  - Appropriate staffing and use of equipment.

6. DOCUMENTATION

- Bedrail Decision Aid (Appendix 1)
- Correct Fitting and Maintenance of Bedrails (Appendix 2)

7. AUDIT

Compliance with this policy will be monitored through the review of incident reports Incident Management System (IMS+) with particular focus on entrapment and falls related to the use of bed rails. Units/wards should also consider periodic bedside audits to monitor bedrail use in accordance with this guideline.

8. REFERENCES

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- SESLHDPR/483 - Restrictive Practices with Adult Patients
- SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older People in Acute and Sub Acute Care
- SESLHDGL/054 - Falls Prevention and Management: Guideline for use of bed/chair alarm units (Adult Inpatient)
- SESLHDGL/042 - Falls Prevention and Management: Guideline for Designated High Risk Observation Room (Adult Inpatient)
- SESLHDGL/044 - Falls Prevention and Management of Non-Admitted Patients
- SESLHDGL/099 - Falls Prevention and Management: A best practice guide for Allied Health Professionals
- SESLHDPR/380 - Falls Prevention and Management for people admitted to acute and sub-acute care
- NSW Ministry of Health Policy Directive PD2020 022 - Cleaning of the Healthcare Environment

9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
May 2009	0	Glenn Power, Clinical Stream Nurse Manager, Aged & Chronic Care/Community Care. Approved by Clinical Council 23 September 2009
June 2015	1	Kimberley Thomsett, Clinical Stream Nurse Manager, Aged Care and Rehabilitation.
July 2015	1	Changes endorsed by Peter, Gonski, Executive Sponsor
April 2018	2	Major review endorsed by Executive Sponsor
May 2018	2	Processed by Executive Services prior to submission to SESLHD Clinical and Quality Council
July 2018	2	Endorsed by SESLHD Clinical and Quality Council
October 2020	3	Minor review to update document title, reference policy updates, update hyperlinks and levels of evidence. Approved by Executive Sponsor. Published by Executive Services.
November 2022	4	Minor review to update reference policy updates, updated hyperlinks and levels of evidence. Approved by Executive Sponsor.

Appendix 1: Bedrail Decision Aid

In general, bedrails are intended to reduce the risk of accidentally falling out of bed and should not be used as a device for restraint.

This Decision Aid can assist the clinician in the identification of patients who may be vulnerable to injuries caused by entrapment and falls.

			MOBILITY		
			Patient is immobile - never leaves bed or is hoist dependent	***Patient mobilises with assistance***	***Patient can mobilise without help from staff***
	MENTAL STATE	***Patient is confused and disoriented***	**Conduct further risk assessment using table below**	**Bed-rails not recommended unless immediate post op with close supervision**	**Bed-rails not recommended**
		Patient is drowsy	**Bed-rails recommended**	**Conduct further risk assessment using guide below**	**Bed-rails not recommended**
		Patient is oriented and alert	**Bed-rails recommended with patient's consent**	**Bed-rails recommended with patient's consent**	**Bed-rails not recommended unless requested by patient**
		Patient is unconscious	**Bed-rails recommended**	**N/A**	**N/A**

If bedrails <u>are not used</u>, how likely is it that the patient will come to harm? Ask the following questions:

- How likely is it that the patient will **fall** out of bed? If likelihood of fall is increased – use bedrails
- Will the patient feel anxious if the bedrails are not in place?

If bedrails <u>are used</u>, how likely is it that the patient will come to harm? Ask the following questions:

- Will bedrails stop the patient from being independent?
- Could the patient climb over the bedrails? If yes, consider not using bedrails and implement alternatives to reduce risk of harm.

(NPSA 2007)

Appendix 2: Correct Fitting and Maintenance of Bedrails

- Bedrails in the raised position should be adjusted to have a maximum gap of 18cm between the head of the bed and the beginning of the bed rail.
- A head board should be in place.
- Gaps within the rail should be 18cms or less.
- Bedrails need to be stable when in place with minimum lateral movement.
- Latches fixing the bed rails to the bed frame should be stable to ensure bedrails are secure.
- All beds and bedrails should undergo routine checks and maintenance.
- All faults should be reported immediately and bed should be removed from use until repaired.
- Bedrails should be cleaned according to local protocol after each patient use and before being fitted to beds in line with NSW Ministry of Health Policy - PD2020_022 Cleaning of the Healthcare Environment.