**Clinical**

**Use of Bedrails**

<table>
<thead>
<tr>
<th>Policy Manager</th>
<th>Policy Group</th>
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<tr>
<td>Nursing and Midwifery Directorate</td>
<td>Short Life Working Group Bedrails</td>
</tr>
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<table>
<thead>
<tr>
<th>Policy Established</th>
<th>Policy Review Period/Expiry</th>
<th>Last Updated</th>
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<tbody>
<tr>
<td>January 2015</td>
<td>October 2022</td>
<td>October 2019</td>
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</table>

This policy does apply to Medical/Dental Staff

**UNCONTROLLED WHEN PRINTED**
# Use of Bedrails

(Previously part of the Bed and Mattress Policy)

## Version Control

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Purpose/Change</th>
<th>Author</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Previously a section within the Bed and Mattress Policy for in-patient beds</td>
<td>Sue Mackie</td>
<td>June 2009-2014</td>
</tr>
<tr>
<td>2.0</td>
<td>Updated in line with national policy changes</td>
<td>Sue Mackie</td>
<td>2014</td>
</tr>
<tr>
<td>3.0</td>
<td>Separate from Bed and Mattress Policy</td>
<td>Sue Mackie</td>
<td>January 2015</td>
</tr>
<tr>
<td>4.0</td>
<td>Reviewed against national standards and recommendations, no changes. Minor</td>
<td>Sue Mackie</td>
<td>March 2017</td>
</tr>
<tr>
<td></td>
<td>language and grammar amendments to some policy statements.</td>
<td>Audrey Fleming</td>
<td>May 2017</td>
</tr>
<tr>
<td>5.0</td>
<td>Updated, minor changes, now reflects use in children’s services</td>
<td>Honor MacGregor</td>
<td>October 2019</td>
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<td></td>
<td></td>
<td>Vicky Hampson</td>
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1. PURPOSE

The aim of this policy is to:

- Support patients, their families and healthcare professionals to have person-centred discussions and engage in shared decision making around the risks of using and of not using bedrails.
- Reduce harm to patients caused by falling from beds or becoming trapped in bedrails.
- Bed rails are medical devices and therefore practice must comply with the Medicines and Healthcare products Regulatory Agency (MHRA) guidance to ensure safe care. Further information can be found in the safe use of bed rails published by the Medicines and Healthcare products Regulatory Agency in 2013.

2. SCOPE

This policy has been informed by the following agencies/guidance and is relevant for all inpatient areas of NHS Tayside, links to these documents can be found in the reference list:

- Medicines and Health Products Regulatory Agency (2013) guidance 'Safe Use of Bedrails'
- National Patient Safety Agency (2007a) 'Slips, Trips and Falls in Hospital'
- Mental Welfare Commission Guidance (2017) 'Human Rights in Mental Health Services'

Definition – The term bed rails will be used throughout this policy and replaces other terms used such as: cot sides, side rails, safety sides and bed guards. Bed rails should not be confused with bed grab handles/bed levers which are designed to aid getting in and out of bed and movement in bed.

3. INTRODUCTION

NHS Tayside aims to take a person-centred approach to ensure the safety and independence of patients, and respects the rights of patients to make their own decisions about their care.

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.

Bedrails are designed as safety devices to protect vulnerable people from accidentally slipping, sliding, rolling or falling from bed (National Patient Safety Agency 2007b) and bedrails used for this purpose are not a form of restraint (Medicines and Health Products Regulatory Agency 2013).

In its broadest sense, restraint is taking place when the planned or unplanned, deliberate or unintentional actions of care staff prevent a person from doing what he or she wishes to do and as a result places limits on his or her freedom of movement (Mental Welfare Commission 2017). Any use of restraint should take into consideration the legislation from the Department of Health (Mental Health (Scotland) Act 2015).

There is evidence of indiscriminate bedrail use and some inadvertent use of bedrails as a form of restraint which can compromise individual patient safety, dignity and autonomy (O'Keefe 2013 and Shanahan 2012). When used in this way they are likely to be ineffective and increase the potential risk of harm i.e. climbing over the bed rails.
4. RESPONSIBILITY AND DECISION MAKING

Decisions about using bedrails are a balance between competing risks.

- If bedrails are used, how likely is it that patient will come to harm?
- If bedrails are not used, how likely is it that the patient will come to harm?

The decision to use or not use bedrails must be based on an individualised person-centred assessment (Medicines and Health Products Regulatory Agency 2007a). The risks for each patient can be complex and relate to their physical and mental health needs, the environment, their treatment, their personality and their lifestyle. Therefore, when planning, reviewing and evaluating patient care, the following must be considered:

4.1 Risk of Falling and Sustaining Injury

Published bedrail studies suggest falls from beds with bedrails are usually associated with lower rates of injury, and falls appear to increase when organisations try to substantially reduce the use of bedrails (Evans et al. 2003 and Shanahan 2012).

4.2 Risk of Entrapment

Bedrails are not appropriate for all patients. 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. There have been serious incidents reported to the Medicines and Health Products Regulatory Agency (see Appendix 1) the majority involved ‘third party’ bedrails – those not integral to the bed frame.

In NHS Tayside all beds within inpatient areas have integral bedrails (with the exception of Psychiatry of Old Age and General Adult Psychiatry areas. This is due to the ligature risk and entrapment associated with electric profiling beds and bedrails and the nature of the client group. In these areas, local risk assessments and risk management plans will be applied.

Based on evidence from the Medicines and Health Products Regulatory Agency and National Patient Safety Agency, colleagues need to be aware that in hospital settings there is a greater risk of harm to patients from falling out of bed than entrapment. However staff must bear in mind all factors that can cause entrapment (Appendix 1).

4.3 Guiding Principles to ensure a safe, effective and person-centred approach

- The patient (with capacity) should be involved in the decision making process. Capacity is the ability to understand and weigh up the risks and benefits of bedrails once these have been explained to them in a language/format they can understand. A language interpreter may be required. All adults are judged as having capacity unless they have been formally assessed as otherwise under the Adults with Incapacity (Scotland) Act 2000. If assessed as being incapable, please ascertain if there is a Welfare Power of Attorney or Guardian who needs to be included in any discussions. In this case colleagues should discuss the benefits and risks with relatives or carers.
- The NHS Tayside Patient Information leaflet 'How to reduce falls in hospital and the use of bedrails' (LN1019) must be given to the patient/carer or guardian and discussed to ensure both the patient where possible and the guardian/carer/relatives are fully aware of the risks of using or not using bedrails.
• If the patient lacks capacity, and there is a difference of opinion with the guardian; colleagues have a duty of care to decide if bedrails are in the patient’s best interests. The rationale for this decision and discussions with the carer or guardian must be fully documented in the nursing record.

• Disorientated or agitated patients may consider a raised bedrail a barrier to climbing over, may slide between raised, segmented bedrails, or may attempt to get around a raised bedrail via the top or bottom of the bed. When attempting to exit the bed by any of these routes, the patient is at risk of entrapment, entanglement, or falling from a greater height posed by the raised bedrail, with the possibility of sustaining injury or even death. In these circumstances bedrails should not be used.

• Specialist areas: Children and young people who attend Paediatric Complex Disability Service for respite will require bed rails for safety due to their complex needs and disability. All children that use profiling beds with bed rails are unable to climb but may be able to roll. Some children may have a therapeutic need for a sleep system to keep them in the one position. This is a therapeutic requirement and will support the individual in a symmetric posture while they are asleep and will reduce the build-up of pressure points, thus increasing comfort.

4.4 Considerations

• Bedrails must not be used as a form of restraint.

• Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bedrails and mattresses.

• Overlay mattresses that have an increased height more than a standard dynamic mattress which lessens the effect of the bedrail can leave the patient at risk of rolling over the bedrail and therefore should not be used.

• Bariatric beds must be used with a compatible extra-wide mattress and integral bedrails.

• When bedrails are in use, steps must be taken to ensure patients can communicate their needs with colleagues e.g. nurse call within reach.

• The decision to use or not use bedrail pads in patients at risk of injury due to restlessness must be documented in the nursing record; however bedrail pads that move or compress may in themselves introduce an entrapment risk.

• Restless children with excessive motor activity or children who can sit up by themselves and need nursing or therapy in bed may not be suitable for a profile bed with bed rails. They will be assessed for using a profiling platform cot that has cot doors that are designed with entrapment risks in mind. They are fully padded with visual windows and that there is no void for the child to fall into when the doors are partially opened.

• Within children’s services there are times when bed rails or an enclosure bed may be used in the interests of safety and observation. Use is based on age, consultation with parents/carer and with the safety of the child at the forefront.

5. ROLES AND RESPONSIBILITIES

5.1 Nurses/Midwives have a duty to:

• Ensure they comply with the safety of bedrails policy.

• Undertake full and individualised risk assessment to ensure use of bedrails and/or bumpers is necessary and appropriate.
• Ensure rationale and patient/carer discussions are documented accurately in the plan of care, (and use of interpreter if required) including ongoing review of patient’s continued need for bedrails.

Regularly monitor the patient to ensure identified needs are being met and documented in the nursing record.

• Inspect equipment regularly for signs of damage and/or incompatibility and report problems to Senior Nurse/Midwife and/or Estates.
• Senior Charge Nurses/Midwives incorporate this policy into the ward induction arrangements.

5.2 Estates Staff/Department have a duty to:

• Assess the integral bedrails (where fitted) to ensure they are in full safe working order during annual service as per local/site agreement.
• Maintain bed rails in accordance with the manufacturer’s recommendations in the instructions for use.
• Respond to requests for repair of removable bedrails, including condemning equipment which is no longer fit for purpose.
• Checking of following aspects during planned maintenance:
  ❖ presence of rust – this can affect the ease of adjustability of telescopic tubes
  ❖ welded joints are sound, not showing signs of cracking or failure
  ❖ cracking of paint or coating – can point to deeper structural failure
  ❖ flaking or peeling chrome plating – can cause lacerations
  ❖ missing locking handles and fixing clamps, clamp pads and other components
  ❖ loose fixings – these affect the rigidity of the assembly. Nuts should be of the self-locking type
  ❖ free play in joints – this can point towards loose, worn or incompatible components
  ❖ stripped threads on bed frame clamps – does not allow them to be tightened securely
  ❖ bent or distorted components
  ❖ damaged plastic components
  ❖ intact manufacturers labelling

6. NURSING AND MIDWIFERY ASSESSMENT

Assessments are usually carried out by nurses and midwives but it is recognised that any member of the healthcare team may contribute to initial and ongoing assessments and subsequent care delivery. The bedrails decision support tool (Fig 1) is on the falls treatment plan (THB 607), and should be used to guide the use of bedrails for in patients at risk of falls. Where the tool is not used the assessment and decision making process must be documented in the record of care.

Any tool is a support to decision making and is not a rigid substitute for professional judgement.
Nursing/midwifery colleagues must record the outcome of the assessment in the record of care/locally used documentation and where required, record specific interventions on the falls treatment.

6.1 Mitigation of Risks to Patients

The following are suggestions for consideration as alternatives to the use of bedrails for patients who are likely to climb over bedrails or are at risk of entrapment and where bedrails should not be used.

- Using the extra low height facility of the Enterprise beds at all times when the patient is not being attended to.
- Use of ultra-low beds may be considered appropriate for these patients.
- Position patient in an area which allows increased observation.
- Additional supervision may be required until other risk measure interventions can be put in place.
- Use of low beds which can be elevated electronically for transfer and activities of daily living care.
- Use of a padded mat which can be placed on the floor, adjacent to the variable height bed.
- Involve patient’s family and carers in developing visiting plans to prevent isolation and wandering behaviours.
- Placement of the patient’s call bell within easy reach and provision of visual and verbal reminders to use the call bell when necessary.
- Use of bed alarms to warn if patient attempts to exit from bed.
- Use of ‘perimeter reminders’ such as body pillow/cushions or mattresses with lipped/raised edges.
- Use environmental cues such as signs, clock, television, radio and photographs to assist in orienting the patient.
- Consider medication, symptoms and conditions which may be causing the patient to want to climb out of bed and possible responding interventions/treatments.
- Consider referral for specialist input e.g. dementia service and Psychiatry of Old Age Liaison Team.

In cases where bedrails are used ‘with care’, some of these interventions should be considered:

- Using the extra low height facility of the Enterprise beds at all times when the patient is not being attended to.
- Placement of the patient’s call bell within easy reach and provision of visual and verbal reminders to use the call bell when necessary.
- Position patient in an area which allows increased observation.

Please note: Following a falls risk assessment some patients might not be assessed as at risk of falling but require bedrails because of particular circumstances:

- In transit between areas – in which case no recording of the use of bedrails is required as this is standard safe practice.
• If the patient is unconscious, or patient uses bedrails to help move in bed, and again is not assessed as a falls risk, the decision support tool must be used to guide the patient’s care. The reason for use must be recorded in accordance with NHS Tayside Policy for Records and Record Keeping for Nursing and Midwifery Staff. A falls care plan does not require to be raised in this circumstance.

**Decision Support Tool Fig 1**

<table>
<thead>
<tr>
<th>Patient is unconscious or completely immobile</th>
<th>Bedrails may be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient requests bedrails or is used to bedrails at home</td>
<td>Bedrails may be used</td>
</tr>
<tr>
<td>Patients recovering from anaesthetic/sedation</td>
<td>Bedrails may be used</td>
</tr>
<tr>
<td>Patients who have disruption to their awareness of the surrounding environment or visual impairment</td>
<td>Use bedrails with care</td>
</tr>
<tr>
<td>Patients who are UNLIKELY to attempt to get out of bed alone, but may roll/fall out of bed or have uncontrolled movement</td>
<td>Use bedrails with care</td>
</tr>
<tr>
<td>This may include patients whose level of consciousness can rapidly change such as a person who has seizures</td>
<td></td>
</tr>
<tr>
<td>Patients who ARE LIKELY to attempt to get out of bed by climbing over or through bedrails or via the foot of the bed</td>
<td>Bedrails not to be used – use other methods – see mitigating of risk</td>
</tr>
<tr>
<td>Patients who are independently mobile</td>
<td>Bedrails not to be used unless requested as above</td>
</tr>
</tbody>
</table>

7. **CONSENT**

A person-centred approach to making decisions about using bedrails needs to be made in the same way as decisions about other aspects of treatment and care with regard to capacity and informed consent in accordance with NHS Tayside’s Informed Consent Policy. NHS Tayside does not require written consent for bedrail use but discussions and decisions must be documented by colleagues.

8. **AUTHORISED PROFESSIONALS**

All clinical colleagues accountable for the formulation of a plan of care must be registered with a professional clinical body and must at all times act in accordance with their respective professional code of practice.
9. EDUCATION AND TRAINING

- All colleagues that make decisions about bedrail use, or advise patients on bedrail use, must have the appropriate knowledge to do so.
- Estates colleagues, who supply, maintain or fit bedrails have the appropriate knowledge to do so as safely as possible, tailored to the equipment used within NHS Tayside.
- All colleagues who have contact with patients, including medical colleagues, students, Allied Health Professionals and temporary/bank/agency colleagues, should know if a patient should have bedrails up or not, should 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.
- These points are achieved through:
  - Ward induction arrangements.
  - Corporate induction and mandatory Moving and Handling updates.
  - Accessing training and information through the NHS Tayside Falls Awareness Learnpro module, the NHS Tayside Hospital Falls Resource Manual.

10. LEGAL LIABILITY

NHS Tayside as an employer will assume vicarious liability for the actions of all staff, including those on honorary contracts, providing that:

a. Staff have undergone any training identified as necessary for the process.
b. The member of staff is authorised by NHS Tayside to undertake the process.
c. The provision of this policy and the supporting procedure has been followed by the member of staff at all times.

Reporting Learning from Adverse Events and Near Misses

Following an episode of entrapment or near-entrapment, or if a patient climbs or attempts to climb over their bedrail, an immediate re-assessment of patient need and re-evaluation of equipment must be undertaken. **A Datix incident report must be completed in all cases where harm or entrapment occurs. A Datix should also be raised for an event that is a near miss.**
References


APPENDIX 1

Illustrated examples of entrapment (an excerpt from MHRA 2013)

- In this section we provide pictures of common problems that arise with bed rails and give some examples of the adverse incidents that have been reported to the MHRA.
- Incorrect or omitted risk assessment and consideration of the physical size of the bed occupant.
- A bed rail was supplied to the parents of a child being cared for in the community. No assessment of the child’s physical size was carried out to determine if an entrapment hazard existed. The gap between the horizontal bedrail bars was too large. The child slipped through the gap and was asphyxiated as a result of head entrapment between the bed rail bars.
- In another case, a bed rail with a bar spacing of 170 mm was being used for an older person being cared for in a nursing home. No risk assessment was carried out to determine if the device was suitable for use, or that it considered the space between the bars and the bed occupant’s size. The person asphyxiated as a result of head and neck entrapment when their body slipped between the bars.

Incompatibility or unsuitability of a bed rail for the bed

- A bed rail intended for use on a divan bed (i.e. having a flat base, the common domestic type of bed) was used on a hospital type bed. This produced a large gap between the bottom of the bed rail and the bed. A child slipped feet first between the bed rail and the bed. The gap was not large enough for the child to pass completely through and the child was trapped at chest level and died from postural asphyxiation (i.e. compression of the chest). The figure below shows a compressed mattress revealing the gap.
Entrapment in inappropriate gaps

- Entrapment can happen between the end of the bed rail and the headboard if the gap is inappropriate. Avoid gaps over 60 mm which could be sufficient to cause neck entrapment, as shown in Figures below.

- Entrapment can also occur in the space between a poorly fitting mattress and side of the bed rail or bed rail that does not fit the bed base snugly enough.

- The compressible nature of the edge of most mattresses can contribute towards the entrapment potential of existing gaps. This is further illustrated by the bed occupant’s weight compressing the mattress.

Bed occupants falling over the top of the bed rails

- This could occur if the bed rails are not high enough or are compromised by too high a mattress or mattress combination. Standards for adjustable and hospital beds require that the top surface of the bed rails is at least 220 mm from the top of the uncompressed mattress.
• For example, a pressure ulcer reduction overlay system was added to a bed that already had a bed rail fitted to it. The additional height of the overlay mattress was not taken into consideration and this compromised the effectiveness of the bed rail. The bed occupant fell over the rail sustaining a head injury, this illustrates that a combination of a large user and thick mattress or mattress combination may mean some beds rails are unsuitable and present a risk of injury.
### APPENDIX 2a

**NHS TAYSIDE – POLICY APPROVAL CHECKLIST**

This form must be completed by the Policy Manager and this checklist must be completed and forwarded with the policy to the Executive Team, Clinical Quality Forum or Area Partnership Forum for approval and to the appropriate Committee for adoption.

| POLICY AREA: | Nursing and Midwifery Directorate |
| POLICY TITLE: | Safe Use of Bedrails Policy |
| POLICY MANAGER: | Honor MacGregor |

**Why has this policy been developed?**

| To ensure the safe and appropriate use of bedrails |

**Has the policy been developed in accordance with or related to legislation? – Please give details of applicable legislation.**


**Has a risk control plan been developed and who is the owner of the risk? If not, why not?**

| No |

**Who has been involved/consulted in the development of the policy?**

| Nursing and Midwifery Directorate, SCNs, OHSAS Moving and Handling, Estates Falls Lead |

**Has the policy been Equality Impact Assessed in relation to:**

| Please indicate Yes/No for the following: |
| Please indicate Yes/No for the following: |

| Age | Yes |
| Disability | Yes |
| Gender Reassignment | Yes |
| Pregnancy/Maternity | Yes |
| Race/Ethnicity | Yes |
| Religion/Belief | Yes |
| Sex (men and women) | Yes |
| Sexual Orientation | Yes |
| People with Mental Health Problems | Yes |
| Homeless People | Yes |
| People involved in the Criminal Justice System | Yes |
| Staff | Yes |
| Socio Economic Deprivation Groups | Yes |
| Carers | Yes |
| Literacy | Yes |
| Rural | Yes |
| Language/Social Origins | Yes |

**Does the policy contain evidence of the Equality Impact Assessment Process?**

| Yes |
| **Is there an Implementation Plan?** | Yes |
| **Which officers are responsible for implementation?** | SCN/Heads of Department to ensure implementation at departmental level |
| **When will the policy take effect?** | January 2015 |
| **Who must comply with the policy/strategy?** | All staff who come into contact with inpatients or maintain beds |
|  | Managers to ensure sufficient equipment |
| **How will they be informed of their responsibilities?** | Email to notify of the policy and via Staffnet |
| **Is any training required?** | Yes, arranged locally |
| **If yes, attach a training plan.** | Teams require team based training plans and inclusion in ward induction |
|  | Training education supported via Moving and Handling updates |
| **Are there any cost implications?** | No |
| **If yes, please detail costs and note source of funding.** | N/A |
| **Who is responsible for auditing the implementation of the policy?** | Senior Charge Nurses |
| **What is the audit interval?** | Ongoing via nursing records audit |
| **Who will receive the audit reports?** | Lead Nurses |
| **When will the policy be reviewed and provide details of policy review period (up to 5 years)** | September 2022 |
### EQUALITY IMPACT ASSESSMENT

**Name of Policy, Service Improvement, Redesign or Strategy:**

| Safe Use of Bedrails |

**Lead Director of Manager:**

| Nursing and Midwifery Directorate |

**What are the main aims of the Policy, Service Improvement, Redesign or Strategy?**

| To ensure NHS Tayside staff use bedrails safely. |

**Description of the Policy, Service Improvement, Redesign or Strategy –
What is it? What does it do? Who does it? And who is it for?**

| Bedrails (sometimes known as cot sides) can be used to prevent patients accidentally falling out of bed; they can also be used by patients to help move themselves in bed. However the use of bedrails may cause significant risks and harm to patients. |

| This policy reflects current advice from MHRA and NPSA to assist Nursing and Midwifery staff in their clinical decision making on when to use or not use bedrails. |

**What are the intended outcomes from the proposed Policy, Service Improvement, Redesign or strategy? – What will happen as a result of it?? – Who benefits from it and how?**

| Healthcare staff will use tools within the policy to guide their decision making. Patients are involved in decisions when possible. |

**Name of the group responsible for assessing or considering the equality impact assessment? This should be the Policy Working Group or the Project team for Service Improvement, Redesign or Strategy.**

| Short Life Working Group |
**SECTION 1 Part B – Equality and Diversity Impacts**
Which equality group or Protected Characteristics do you think will be affected?

<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
</table>
| 1.1  | Will it impact on the whole population? Yes or No.  
If yes will it have a differential impact on any of the groups identified in 1.2.  
If no go to 1.2 to identify which groups. | No this policy is for all in-patients with the exception of Mental Health Inpatient areas. | In General Adult Psychiatry and Psychiatry of Old Age where there are risks of ligature injury from beds and bedrails, each area will have their own assessment of risk and risk management plan. | N/A |
| 1.2  | Which of the protected characteristic(s) or groups will be affected?  
- Minority ethnic population (including refugees, asylum seekers & gypsies/travellers)  
- Women and men  
- People in religious/faith groups  
- Disabled people  
- Older people, children and young people  
- Lesbian, gay, bisexual and transgender people  
- People with mental health problems  
- Homeless people  
- People involved in criminal justice system  
- Staff  
- Socio-economically deprived groups | All | All these groups may become Inpatients. | N/A |
<table>
<thead>
<tr>
<th>Item</th>
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<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
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</table>
| 1.3  | Will the development of the policy, strategy or service improvement/redesign lead to:  
• Discrimination  
• Unequal opportunities  
• Poor relations between equality groups and other groups  
• Other | No  
The Safe Use of Bedrails does not discriminate, provide an unequal opportunity or lead to poor relationships. | N/A | N/A |
### SECTION 2 – Human Rights and Health Impact

Which Human Rights could be affected in relation to article 2, 3, 5, 6, 9 and 11. (ECHR: European Convention on Human Rights)

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</table>
| 2.1  | On Life (Article 2, ECHR) | - Basic necessities such as adequate nutrition, and safe drinking water  
  - Suicide  
  - Risk to life of/from others  
  - Duties to protect life from risks by self/others  
  - End of life questions | If bedrails are in situ, a patient's freedom to move may be compromised and become unable to access food and drink.  
If bedrails are used appropriately they can protect a patient from harm due to a fall.  
Some patients may climb over the bedrails or entrap themselves in the bedrails, those known to be at high risk of either should not have bedrails activated.  
Some patients in mental health settings may be at risk of suicide and bedrails should not be used. | MHRA Safe Use of Bedrails.  
Nursing staff should ensure the patient is provided the opportunity to access adequate nutrition and hydration if bedrails prevent the patient reaching them. | N/A |
| 2.2  | On Freedom from ill-treatment (Article 3, ECHR) | - Fear, humiliation  
  - Intense physical or mental suffering or anguish  
  - Prevention of ill-treatment | Bedrails should not be used as a form of restraint to prevent someone wishing to get out of bed.  
Patients who request a bedrail for their own safety in | N/A | N/A |
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</table>
| • Investigation of reasonably substantiated allegations of serious ill-treatment  
• Dignified living conditions | bed should be allowed to use the bedrail. | | | |
| 2.3 | **On Liberty (Article 5, ECHR)**  
• Detention under mental health law  
• Review of continued justification of detention  
• Informing reasons for detention | Patients who are detained under mental health law in an acute hospital setting who may be a danger to themselves should not have bedrails unless they are under constant supervision. | N/A | N/A |
| 2.4 | **On a Fair Hearing (Article 6, ECHR)**  
• Staff disciplinary proceedings  
• Malpractice  
• Right to be heard  
• Procedural fairness  
• Effective participation in proceedings that determine rights such as employment, damages/compensation | Patients who have capacity and wish to have bedrails up to prevent them falling from bed should be supported in their request to use bedrails. | N/A | N/A |
| 2.5 | **On Private and family life (Article 6, ECHR)**  
• Private and Family life  
• Physical and moral integrity (e.g. freedom from non-consensual treatment, harassment or abuse  
• Personal data, privacy and confidentiality  
• Sexual identity  
• Autonomy and self-determination  
• Relations with family, community  
• Participation in decisions that affect rights | Patients who have capacity can have bedrails in situ if they request.  
For patients with incapacity the Registered Nurse should assess the risk of using bedrails against the risk of not using bedrails discussing this fully with the carers, relatives and those with Power of Attorney. | N/A | N/A |
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| 2.6  | - Legal capacity in decision making supported participation and decision making, accessible information and communication to support decision making  
       - Clean and healthy environment | No impact | N/A | N/A |
| 2.6  | **On Freedom of thought, conscience and religion (Article 9, ECHR)**  
       - To express opinions and receive and impart information and ideas without interference | No impact | N/A | N/A |
| 2.7  | **On Freedom of assembly and association (Article 11, ECHR)**  
       - Choosing whether to belong to a trade union | No impact | N/A | N/A |
| 2.8  | **On Marriage and founding a family**  
       - Capacity  
       - Age | No impact | N/A | N/A |
| 2.9  | **Protocol 1 (Article 1, 2, 3 ECHR)**  
       - Peaceful enjoyment of possessions | Bedrails should not be used as a form of constraint preventing someone accessing their possessions. | N/A | N/A |
## SECTION 3 – Health Inequalities Impact

Which health and lifestyle changes will be affected?

<table>
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</table>
| 3.1  | What impact will the function, policy/strategy or service change have on lifestyles?  
For example will the changes affect:  
• Diet & nutrition  
• Exercise & physical activity  
• Substance use: tobacco, alcohol or drugs  
• Risk taking behaviours  
• Education & learning or skills  
• Other | Bed rails must not be used as a form of constraint preventing patients from accessing food or fluid. Otherwise no impact | N/A | N/A |
| 3.2  | Does your function, policy or service change consider the impact on the communities?  
Things that might be affected include:  
• Social status  
• Employment (paid/unpaid)  
• Social/family support  
• Stress  
• Income | No impact | N/A | N/A |
| 3.3  | Will the function, policy or service change have an impact on the physical environment?  
For example will there be impacts on:  
• Living conditions  
• Working conditions  
• Pollution or climate change  
• Accidental injuries/public safety | No impact | N/A | N/A |
<table>
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</table>
|      | • Transmission of infectious diseases  
• Other |                                                      |                                                                              |                         |
| 3.4  | Will the function, policy or service change affect access to and experience of services?  
For example  
• Healthcare  
• Social services  
• Education  
• Transport  
• Housing | No impact | N/A | N/A |
| 3.5  | In relation to the protected characteristics and groups identified:  
• What are the potential impacts on health?  
• Will the function, policy or service change impact on access to health care? If yes - in what way?  
• Will the function or policy or service change impact on the experience of health care? If yes – in what way? | No impact | N/A | N/A |
## SECTION 4 – Financial Decisions Impact

How will it affect the financial decision or proposal?

<table>
<thead>
<tr>
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</table>
| 4.1  | • Is the purpose of the financial decision for service improvement/redesign clearly set out  
• Has the impact of your financial proposals on equality groups been thoroughly considered before any decisions are arrived at | No financial impact | N/A | N/A |
| 4.2  | • Is there sufficient information to show that "due regard" has been paid to the equality duties in the financial decision making  
• Have you identified methods for mitigating or avoiding any adverse impacts on equality groups  
• Have those likely to be affected by the financial proposal been consulted and involved | No financial impact  
There are no adverse impacts on equality groups  
No financial impact | N/A | N/A |
| 5.   | Involvement, Consultation and Engagement (IEC)  
(1) What existing IEC data do we have?  
• Existing IEC sources  
• Original IEC  
• Key learning  
(2) What further IEC, if any, do you need to undertake? | N/A | N/A | N/A |
<table>
<thead>
<tr>
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<th>Document any Evidence/Research/Data to support the consideration of impact</th>
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</thead>
</table>
| 6.   | Have any potential negative impacts been identified?  
      • If so, what action has been proposed to counteract the negative impacts? (if yes state how)  
      For example:  
      • Is there any unlawful discrimination?  
      • Could any community get an adverse outcome?  
      • Could any group be excluded from the benefits of the function/policy?  
      (consider groups outlined in 1.2)  
      • Does it reinforce negative stereotypes?  
      (For example, are any of the groups identified in 1.2 being disadvantaged due to perception rather than factual information?) | N/A | N/A | N/A |
| 7.   | Data & Research  
      • Is there need to gather further evidence/data?  
      • Are there any apparent gaps in knowledge/skills? | N/A | N/A | N/A |
| 8.   | Monitoring of outcomes  
      • How will the outcomes be monitored?  
      • Who will monitor?  
      • What criteria will you use to measure progress towards the outcomes? | N/A | N/A | N/A |
<table>
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</thead>
<tbody>
<tr>
<td>9.</td>
<td>Recommendations</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>State the conclusion of the Impact Assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Completed function/policy</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>• Who will sign this off?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Publication</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Conclusion Sheet for Equality Impact Assessment

<table>
<thead>
<tr>
<th>Positive Impacts</th>
<th>Negative Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Note the groups affected)</td>
<td>(Note the groups affected)</td>
</tr>
<tr>
<td>A bedrail assessment will provide healthcare staff with a tool to aid decision making on when to use or not use bedrails.</td>
<td>No negative impact if the policy is used.</td>
</tr>
</tbody>
</table>

### What if any additional information and evidence is required

None

### From the outcome of the Equality Impact Assessment what are your recommendations? (refer to questions 5 - 10)

None