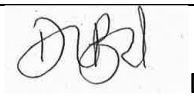
University Hospitals of Derby and Burton
NHS Foundation Trust

TRUST POLICY AND PROCEDURES FOR THE SAFE USE OF BEDRAILS WITH ADULTS

<table>
<tr><td>Reference Number:
POL-CL/2642/18</td><td>Version:
1.1</td><td>Status: Final</td><td colspan="2">Author:
Natalie Keightley

Job Title:
Senior falls practitioner – prevention and management</td></tr>
<tr><td rowspan="8">Version/Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td>Reason</td></tr>
<tr><td>1.0</td><td>March 2018</td><td>Hilary Sullivan</td><td>Merged and updated policy for UHDB sites</td></tr>
<tr><td>1.1</td><td>August 2024</td><td>Natalie Keightley</td><td>Updated with new guidance from MHRA</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Intended Recipients: All clinical and non-clinical staff involved in the care and management of adult patients including agency staff and students.</td></tr>
<tr><td colspan="5">Training and Dissemination: Dissemination via the Trust Intranet.
Guidance is included within:
Falls prevention and management training (induction and 2 yearly).
Mandatory Moving and Handling level 2 training (induction and 2 yearly).
Arjo bed and mattress training.</td></tr>
<tr><td colspan="5">To be read in conjunction with: Trust Policy and Procedure for the Prevention and Management of Patient Falls; Health and Safety - UHDB Trust Policy and Procedure; Trust Policy for Incident Reporting, Management and Learning; Joint Derby and Derbyshire Health & Social Care Policy for the Safe Use of Bed Rails and Bed Area Equipment in the Community; Infection Prevention and Control - UHDB Trust Policy and Procedure; Safety Management Standard Moving and Handling; Consent - Including the Mental Capacity Act (Lawful Authority for Providing Examination, Care or Treatment) - Trust Policy and Procedures.</td></tr>
</table>

In consultation with and Date: Falls Group (August 2024) Patient Safety Group (August 2024) Trust Delivery Group (September 2024)	
EIRA Stage One Completed: Yes **Stage Two Completed: N/A**	
Approving body and Date Approved	Trust Delivery Group 2 September 2024
Date of Issue	September 2024
Review Date and Frequency	(August 2027 then every 3 years)
Contact for Review	UHDB Falls Group
Executive Lead Signature	 Donna Bird Interim Executive Chief Nurse

CONTENTS

1 INTRODUCTION

Bed rails are 'medical devices', which fall under the authority of the Medicines and Healthcare Products Regulatory Agency (MHRA). Bed rails are used extensively in hospital settings, care homes and people's own homes to reduce the risk of bed occupants falling out of bed or trolleys and injuring themselves. For this document the term bed rail will be adopted, although other names are used for example, bed side rails, side rails, cot sides and safety sides.

Recent literature reports most falls from beds resulted in either no harm or minor injuries such as scrapes and bruises. People who fell from beds without bed rails were significantly more likely to be injured and to suffer head injuries (usually minor). Falls from beds with bed rails are usually associated with lower rates of injury, but these injuries are significantly more serious (Health and Safety Executive 2012).
From 1 January 2018 to 31 December 2022, the MHRA received 18 reports of deaths and 54 reports of serious injuries related to medical beds, bed rails, trolleys, bariatric beds, lateral turning devices and bed grab handles. The majority of these were due to entrapment or falls (NPSA Aug 2023).

2 PURPOSE AND OUTCOMES

The purpose of this policy is to:

- Reduce harm to patients caused by falling from beds or becoming entrapped in bed rails.

- Support patients and staff to make individual, evidenced based decisions around the risks of using and of not using bed rails.
- Ensure compliance with Medicines and Healthcare Related products Agency (MHRA) and National Patient Safety Agency (NPSA) advice.

The guidance within this policy reflects best, evidenced-based practice and should be adopted by all colleagues Trustwide, including agency staff, staff with honorary contracts and students on placement. This policy applies to all adult patient areas and wards within UHDB.

3 KEY RESPONSIBILITIES/DUTIES

3.1 Trust Board

The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively and updated accordingly.

3.2 Patient Safety Group (PSG)

Patient Safety Group meets regularly in accordance with the terms of reference. The Trust Falls Group reports to Patient Safety Group. Patient Safety Group provides advice, support and escalation of information or concerns as necessary in relation to these reports.

3.3 Trust Falls Group

The Falls Group is a formal group of multi-disciplinary colleagues accountable to the Patient Safety Group established to strengthen the delivery of the organisations vision, values, objectives and priorities. The purpose of the Falls Group in relation to bed rails is:

- To review policies and procedures in relation to the use of bed rails and latest national guidance to ensure ongoing updates and improvement.
- To seek assurance from Business Units and Divisions that best practice guidance is effectively implemented across the Trust.
- To collate and disseminate Trustwide learning from incidents involving ineffective or unsafe use of bed rails, particularly incidents where there has been harm.
- To develop and support education, quality improvement work across the Trust around the effective use of bed rails and share the learning Trustwide.

3.4 Medical Equipment Library, Procurement and Clinical Engineering

The Medical Equipment Library Team with support from Procurement and Clinical Engineering teams manage, regulate and support day to day equipment purchasing and standardisation. The key responsibilities of these teams in relation to bed rails are:

- Manage bed contracts/stock to ensure all beds comply with MHRA guidance.
- Maintain equipment to ensure this is safe for use.
- Monitor incidents involving bed rails and escalate any concerns to external companies where required.

3.5 Divisional Directors, Divisional Nurses, Director of AHPs and Divisional Medical Directors

In consultation with staff, Divisional Directors, Divisional Nurses, Director of AHPs and Divisional Medical Directors will ensure implementation of the policy by:

- Monitoring the attendance of staff at mandatory training.
- Providing assurance that staff are aware of the policy.
- Promoting all patient harm incidents involving bed rails are reported via DCIQ (this includes near miss incidents) and promoting a just culture.
- Providing oversight regarding incidents involving bed rails and feedback of relevant learning/information to staff.

3.6 Divisional Governance Teams – Clinical Governance Facilitators and Clinical Governance Advisors

In consultation with Line managers, Team Leads and clinical staff the divisional governance teams support the implementation of the policy by:

- Promoting all patient harm incidents involving bed rails are reported via DCIQ (this includes near miss incidents) and promoting a just culture.
- Having oversight of all incidents involving bed rail usage including ensuring where an incident has resulted in moderate harm or above that duty of candour has been undertaken.
- Supporting staff with investigations after incidents as required.
- Identifying themes from incidents involving bed rails and steering QI work alongside team leads and the patient safety team to address these themes.

3.7 Line Managers, Matrons and Team Leads

Line Managers, Matrons and Team Leads will ensure the implementation of the policy by ensuring:

- Staff are trained, educated and updated in the safe use of bed rails.
- All patient harm incidents involving bed rails are reported and ensure staff understand how and when to report.
- That all moderate/severe harm or death related to bed rails have an investigation/learning completed and actions implemented in line with the Trust Policy for Incident Reporting, Management and Learning.
- That staff participate in clinical audits and actions are taken following these audits.
- That quarterly reports are provided to Falls Group highlighting any concerns about the inappropriate and ineffective usage of bed rails, learning from incidents involving bed rails, ongoing quality improvement work and escalation of any concerns.

3.8 Patient Safety Team

The Patient Safety Team is based within Corporate Nursing and includes falls specialist staff who support clinical areas and staff. The role of the Patient Safety Team is to:

- Contribute to and support the Trust's Falls Group.
- Provide specialist education, training and advice to Trust staff around the safe and effective use of bed rails.
- Review reported incidents of patient harm from ineffective bed rail usage in hospital and work with matrons, governance team and ward managers to identify any themes and assist in steering local action plans.
- Undertake audits within the Trust to ensure compliance with safe use of bed rail policy and identify areas for improvement.
- Provide key visible leadership and to be the subject expert providing advice and support in relation to effective bed rail usage across the clinical/non-clinical workforce.

3.9 Ward Manager/Department Lead/Team Lead

Ward Managers, Department Leads, and Team Leaders will ensure the implementation of the policy by:

- Ensuring that this policy is adhered to in the clinical and non-clinical settings and that there is a clear process for dissemination.
- Ensuring that all patient harm incidents involving bed rail usage including near misses are reported via the Incident Reporting System (DCIQ) in line with the Trust Policy for Incident Reporting, Management and Learning.
- Ensuring that where an incident has resulted in moderate harm or above that Duty of candour is undertaken.
- Leading investigations/learning where a patient has come to harm due to ineffective bed rail usage including the completion of quality improvement work identified through investigation.
- Ensuring wards undertake monthly ward assurance audits across the Trust.
- Monitoring staff mandatory training compliance.
- Promoting accurate and contemporaneous completion of all patient documentation.
- Reporting any faults/concerns regarding beds or bed rails to the Medical Equipment Library.

3.10 All Staff Working with Patients

- Will undertake mandatory 2-yearly training as required, to maintain their awareness and skill concerning the effective use of bed rails.
- Will report all incidents where patient harm has occurred due to the ineffective use of bed rails via the Incident Reporting System (DCIQ) in line with the Trust Policy for Incident Reporting, Management and Learning.

- Will ensure that all patient documentation is completed accurately and contemporaneously.
- Will adhere to this policy in all clinical and non-clinical settings.
- Escalate any concerns regarding damaged or unsuitable beds or bed rails to the ward sister/department lead or team lead.

4 DEFINITIONS USED

4.1 Definitions/Abbreviations:

Fall	An event which results in a person coming to rest inadvertently on the ground or floor or other lower level (WHO 2012)
Bed Rail	Rails on the side of the bed incorporated into the design of the bed and supplied and fitted with the bed. Can be full length, three quarter length or split.
Nominated Clinician/ Reviewer	Person responsible for ensuring that a review of the bed rails in use in the community is completed after discharge. This could be from the Integrated Care Team, Specialist Health Services, Social Care (adults or children), or care home representative.
Atypical anatomy	Atypical anatomy is defined by the MHRA as individuals equal to or less than 1.46m (4ft 9"), body mass ≤40kg or BMI ≤17
The Trust/ Organisation	University Hospitals of Derby and Burton NHS Foundation Trust
Hazard	Something that has the potential to cause harm or loss
Risk	The likelihood of harm or loss occurring in defined circumstances
MHRA	Medicines and Healthcare Products Regulatory Agency
Ultra-Low bed	A bed designed to provide near floor level care with a height adjustable function
Patient Safety Group (PSG)	Clinical governance group used to review and escalate learning, issues and or concerns from trends and themes identified from Patient Safety, Reporting and Learning, Patient Experience. Reviews and escalates as required
PSIRF	Patient Safety Incident Response Framework
DCIQ	The Trust's system used to report and manage incidents, risks and complaints
NPSA	National Patient Safety Agency
HSE	Health and Safety Executive
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

4.2 Definitions of degrees of harm

NPSA has set out definitions for degrees of harm following a fall as below. The Trust has given examples to support with application of these terms.

Level of harm	Definition	Examples
0. Near miss	Any situation that had the potential to cause harm but was prevented, resulting in no harm	Water spill in a public place, cleaned up before adverse event occurred
1. No Harm	A situation occurred but no harm caused	Water spill in public place, individual falls, but does not injure themselves
2. Low Harm	Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons	Minor treatment is defined as first aid, additional therapy or additional medication. Minor financial loss / compensation claim. Minor environmental implications. Minor loss of reputation. Minor service interruption. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned. Nor does it include a return to surgery or readmission.
3. Moderate Harm	Any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling treatment or transfer to another area and which caused short term harm to one or more persons.	Moderate increase in treatment is defined as a return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment or transfer to another area such as intensive care as a result of the incident.

		Prolonged pain and/or prolonged psychological harm which the service user has or is likely to experience for a continuous period of at least 28 days.
4. Severe Harm	Any unexpected or unintended incident which caused permanent or long-term harm to one or more persons.	Excessive or permanent injuries (loss of body parts, misdiagnosis - poor progress etc). Short term negative impact on recruitment and retention. High environmental implications. Serious financial loss, loss of reputation/service interruption. Litigation / prosecution expected. A permanent lessening of bodily, sensory, motor, physiological or intellectual functions including removal of the wrong limb or organ or brain damage that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition. A patient/staff/visitor who has fractured a hip (including pathological fracture) from a fall is unlikely to regain the levels of mobility and independence they had prior to the fall. A patient/staff/visitor who has a sub-dural haematoma or subarachnoid haemorrhage from a fall, is unlikely to regain

		the levels of mobility an independence that had prior to the fall.
5. Death	Any unexpected or unintended incident which caused the death of one or more persons.	The death must relate to the incident rather than to the natural course of the patient's illness or underlying condition. Death, toxic-off site release with detrimental effect, national adverse publicity, affects large numbers of people (i.e. cervical screening disaster).

5 SAFE USE OF BED RAILS IN ADULT PATIENT SETTINGS

5.1 Safe use of bed rails in adult patient areas

Decisions about bed rails are only one small part in the prevention of falls. It is advisable to refer to the Trust Policy and Procedure for the Prevention and Management of Patient Falls to identify other steps that should be taken to reduce the patient's risk of falling not only from bed, but also, for example, whilst walking, sitting and using the toilet.

Bed rails **should be** in use:

- When the patient is being transported on their bed/trolley.
- When the patient is being cared for in a bariatric bed and using the rails for moving and handling purposes.
- In areas where the patient is recovering from anaesthetic or sedation and is under constant supervision.
- Where the patient has capacity and requests the use of bed rails after the risks of use have been explained to them.

Bed rails **should not be** in use if:

- The patient is agitated or confused and may climb over the bed rails.
- The patient is found attempting to climb over the bed rail. This should be taken as a clear indication that they are at risk of serious injury from falling from a greater height.
- The patient is independent enough to transfer or mobilise if the bed rails were not in place, as this could be deemed as restraint.
- The patient is found in positions which could lead to bed rail entrapment, for example, feet or arms through rails or halfway off the side of their mattress. This should be taken as a clear indication that they are at risk of serious injury from entrapment.
- There are signs of significant damage or faults to the bed rail.

The use of bed rails is a balance of risk. This risk will vary for individuals depending on their physical/mental health needs and the environment. Staff should use their clinical judgement alongside evidenced based best practice to weigh up the risks and benefits of using bed rails with each individual and only use bed rails where the benefits outweigh the risks. Additional consideration should be given to patients with:

- communication problems
- confusion, agitation or delirium
- learning disabilities
- dementia
- repetitive or involuntary movements
- larger or smaller than average body size (which may change entrapment risks)
- impaired or restricted mobility
- variable levels of consciousness, or those under sedation
- sensory impairment

Patients who require the use of bed rails but are at risk of striking their limbs on the bed rails should have bumpers applied to the bed. These should be purchased by the ward via NHS Supply Chain.

Every effort should be made to explain to the person being cared for and their relative / carer potential risks of using bed rails as well as measures taken to reduce their risk of falls and entrapment.
For patients who have been assessed as not having capacity to make decisions around the safe use of bed rails staff should make a decision in the best interest of the patient using guidance outlined in the Consent - Including the Mental Capacity Act (Lawful Authority for Providing Examination, Care or Treatment) - Trust Policy and Procedures.

5.1.1 Documentation

The decision to use or not use bed rails should be recorded within the UHDB bed rails risk assessment documentation (see Appendix 1) and any variances should be documented fully. All patients should be assessed on admission and thereafter reassessed weekly, if their condition changes or they are transferred to a different area in the Trust.

Patients who experience a fall from bed should have their bed rail assessment and bed height reviewed as part of the post falls care. This is outlined in the post falls documentation to minimise the risk of further harm and recurrent falls.

5.1.2 Bed rails and ultra-low beds

Guidance for use of ultra-low beds is outlined in the Trust Policy and Procedure for the Prevention and Management of Patient Falls. Ultra-low beds used at UHDB by design do not have bed rails available.

5.1.3 Use of bed rails with adults with atypical anatomy and bariatric patients

Adults with atypical anatomy are at increased risk of bed rails entrapment. Atypical anatomy is defined by MHRA (Aug 2023) as adults equal to or less than 146cm (4ft 9"), weight equal to or less than 40kgs or a BMI equal to or less than 17.

Any adults that meet these criteria should be cared for on a bed meeting standard BS EN 50637:2017 unless there is a reason for using a noncompliant bed, which should be documented. Currently the Trust has no beds that are compliant with this standard, therefore, these patients should have a risk assessment (see Appendix 1) completed as soon as reasonably practical and bed rails should only be used with clear clinical reasoning. Atypical anatomy adults who are assessed as requiring the use of bed rails need to be placed onto a bed with 5 bar bed rails or consider the use of an ultra-low bed to reduce the risk of entrapment.

Bariatric patients are also at increased risk of entrapment within bed rails. Any patient whose soft tissue fills the bed platform should be considered at increased risk of entrapment. The Bariatric Bed and Mattress Recommendations Flowchart (Appendix 4) should be followed in these cases to ensure the patient is on the most appropriate bed with compatible mattress as using the incorrect mattress size increases the risk of entrapment with wider beds.

The patient should be transferred to the most appropriate bed as soon as possible. Bariatric patients undergoing elective admissions should have bed suitability considered prior to admission.

5.2 Safe use of bed rails on trolleys in adult emergency departments

Across the emergency departments patients are cared for on a combination of trolleys and beds. ED departments have their own risk assessment (see Appendix 2) which should be completed for use of rails on beds or trolleys as appropriate.

For patients being cared for on trolleys:

- Rails should be always in place whenever the individual is being transported.
- Staff should use their clinical judgement and evidenced based practice to consider risks and benefits of using rails on stationary trolleys. However, due to the narrowness and height of trolleys, rails should be considered necessary for the majority of individuals.
- Individuals who have acute onset or existing confusion/agitation or frail patients who are being cared for on a trolley should be moved into an area where they can be easily observed.

- Patients who have confusion/agitation which requires enhanced supervision being transferred to other departments/wards, such as x-ray, will require an escort to reduce the risk of entrapment or falls over the rails.
- Adults with atypical anatomy are at increased risk of entrapment, therefore, should have a risk assessment completed as a priority as soon as reasonably practicable with mitigations to reduce the risk of entrapment clearly recorded within this.
- Any individual who is being cared for on a trolley where rails are deemed to be unsafe, and are therefore lowered, should have the clinical reasoning for this clearly documented as well as mitigating strategies that have been utilised to reduce the risk of the individual falling from the trolley.
- An individual should be transferred from a trolley to a bed within the emergency department if:
    - The person is awaiting admission to a ward.
    - The person is unsafe to care for on a trolley. For example, individuals who are trying to climb over/around the rails or individuals that display distressed behaviour despite attempts to manage this.
    - The person is at risk of developing pressure sores.
    - The person has atypical anatomy and is high risk of entrapment.

Once an individual is transferred to a bed within the emergency department the bed rail risk assessment must be completed as soon as possible. This assessment should be completed following the guidance outlined above in the safe use of bed rails in adult patient areas.

5.3 Safe use of rails on trolleys in adult clinical areas (excluding emergency departments)

Trolleys are used to care for patients in areas of the Trust outside of the emergency department, such as theatres, endoscopy and cath labs. Patients in these areas are continually supervised by staff, therefore, should have the rails in use as due to the narrowness and height of the trolley any fall is more likely to result in injury.

Patients who have confusion/agitation which requires enhanced supervision being transferred to other departments/wards, such as x-ray, will require an escort to reduce the risk of entrapment or falls over the rails.

6 PROVISION OF BED RAILS FOR SAFE DISCHARGE INTO THE COMMUNITY

6.1 Supplying bed rails to patients residing in Derbyshire

For hospital discharges where bed rails are recommended for use, the process outlined in the 'Joint Derby and Derbyshire Health & Social Care Policy for the Safe Use of Bed Rails and Bed Area Equipment in the Community' should be referred to and followed. This includes discharges where the patient already has bed rails in place at home and it is assessed that this remains appropriate. This policy can be found via KOHA.

In line with this policy prior to discharge a risk assessment must be completed within the inpatient setting and documented (see Appendix 7 and 8). Following supply of bed rails a 72-hour review should be undertaken in the community by a nominated clinician/reviewer (see Appendix 9). It is the responsibility of the health professional arranging discharge to communicate with the nominated clinician/reviewer who will be completing the 72-hour review assessment and record their details on the risk assessment form (see Appendix 7 and 8).

A copy of the risk assessment should be given to the individual/carer and another copy should be forwarded to the nominated clinician/reviewer for review. All information given to the individual/carer/agency must be documented.

Responsibility of equipment provision in care homes in Derby and Derbyshire can be checked in the Provision of Equipment to Care Homes document (see Appendix 11). Web Ordering www.tcesconnections.co.uk.

6.2 Supplying bed rails to patients residing in Staffordshire or out of area

For hospital discharges where bed rails are recommended for use, including discharges where the patient already has bed rails in place at home and it is assessed that this remains appropriate, a risk assessment should be completed (see Appendix 10). A copy of the risk assessment should be given to the individual/carer and another copy should be forwarded to the appropriate community service for ongoing review and support. After discharge the discharging clinician should complete a post installation review within 72 hours of discharge to ensure bed rails have been safely fitted and remain appropriate for the patient. This review can be completed via phone, video technology or face to face. The method of review should be clinically reasoned dependent on individual patient circumstances and outcome recorded in patient record.

In line with 'Bed Rails: Management and Safe Use Guidance' (MHRA 2023) beds rails should be regularly reviewed once issued to reduce the risk of entrapment. For individuals being discharged from hospital it is the responsibility of the health professional arranging discharge to refer to the most appropriate community service to ensure ongoing follow-ups.

7 INCIDENT/SAFEGUARDING REPORTING

Any incidents where there was potential for patient harm or patient harm occurred due to the use of bed rails should be reported via DCIQ in line with the Trust Policy for Incident Reporting, Management and Learning. If a moderate, severe harm or death incident occurs due to the use of bed rails this should be reported as a RIDDOR incident via DCIQ.

A safeguarding adult referral should be made when there is a concern that bed rails have been used with confused or disorientated patients and have caused actual or potential harm to a

patient whilst under the care of UHDB. Please refer to Appendix 4 for the falls and safeguarding assessment tool to support with decision making.

NHS 'Never Events' are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. NHS 'Never Events' number 11 (1) covers chest or neck entrapment in bed rails. Should a 'Never Event' occur due to bed rails this should be reported and immediately escalated in line with the Trust Policy for Incident Reporting, Management and Learning.

8 SUPPLY, MAINTENANCE AND CLEANING

MHRA (Aug 2023) recommend two international standards for medical beds which include requirement for acceptable gaps in order to reduce entrapment risks:

- BS EN 60601-2-52:2010+A1:2015 is the standard for adult beds (Appendix 5).
- BS EN 50637:2017 for medical beds and cots for children and adults with atypical anatomy (Appendix 6).

The Trust has taken steps to comply with MHRA advice through ensuring that:

- beds and their integral bed rails are regularly maintained.
- types of bed rails, beds and mattresses used on each site within the Trust are of compatible size and design, and do not create entrapment gaps for adults within the range of normal body sizes.
- the Trust's bariatric bed type has integral bed rails and is used with a compatible mattress.
- there is sufficient stock to ensure mitigations for atypical anatomy adults can be provided.
- scoping of new products that meet standard BS EN 50637:2017 will be completed regularly to ensure the Trust are considering purchase of compliant beds when appropriate products become available.

Any signs of damage, faults or cracks on the bed rails or bed rail release mechanism should be immediately reported to the medical equipment library and the bed should be taken out of use. Bed rails should not be adapted/altered by staff and any requested adaptations should be reviewed to ensure they are in line with the manufacturer's safe usage guidance.

Bed rails should be cleaned as instructed as part of the routine bed cleaning list. Visible contamination of the rails should be cleaned with detergent and hot water or detergent wipes ensuring that universal precautions are followed and should be undertaken in accordance with the Infection Prevention and Control - UHDB Trust Policy and Procedure.

9 MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring Requirement:	Compliance with policy
Monitoring Method:	Falls training compliance Audit and thematic analysis of incident data Business unit reports presented to falls group Ward assurance audits Essential to role training for prescription of bed equipment in the community
Report prepared by:	Senior Falls Practitioner
Monitoring report presented to:	Patient Safety Group
Frequency of report:	Patient Safety Group – bimonthly

10 REFERENCES

- Medicines and Healthcare Regulatory Agency (2023) Bed rails: management and safe use. Bed rails: management and safe use - GOV.UK (www.gov.uk)
- Medicines and Healthcare products Regulatory Agency. National Patient Safety Alert (Aug 2023) Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. NatPSA_bed_rails_30_8_23.pdf (publishing.service.gov.uk)
- Health and Safety Executive (2012) Safe use of bed rails. Health Services - Safe use of bed rails
- Health and Safety Executive (2012) Sector Information Minute (SIM 07/2012/06) Bed rail risk management. Sector Information Minute (SIM 07/2012/06)... (hse.gov.uk)
- Never Events List 2018. NHS England – (revised February 2021), NHS England » Never events

APPENDIX 1 - Inpatient Bed Rail Risk Assessment

Assessment for use of bed rails with adults

Complete this risk assessment for ALL patients.
This assessment should be completed on admission/weekly/change of condition/on transfer. This can be completed more frequently if required.

Bed rails must always be in place during transport. If not being transported followed the flow chart below.

Does the individual meet any of the high-risk criteria:

- ☐ BMI 17 or less
- ☐ Height 146cms or less
- ☐ Weight 40kgs or less
- ☐ The person is confused or agitated
- ☐ The person has previously attempted to climb over the bed rails or has been found with limbs between or over the bars

NO

YES

Patient is deemed high risk of entrapment.

DO NOT USE BED RAILS

DO NOT USE BED RAILS UNLESS:

A. The patient is using a bariatric bed and using rails for moving and handling purposes

B. The patient is recovering from sedation/anaesthetic and is under constant supervision

C. The patient has capacity and requests the use of bed rails after the risks of use have been explained to them

If there is clear clinical reasoning to use bed rails not covered by the risk assessment, please clearly document this below *(for example, the patient is hemiplegic and is leaning).*

If you are concerned there is a high risk of falls from bed and rails are not recommended consider the use of an ultra-low bed accessed via: QHB - Etrace, RDH - ring switchboard or ARJO.

Ward / Clinical Area	Date	Bed rails in use	If YES, reason as documented above. Document OTHER in care plan	Initials
		YES NO	A B C OTHER	
		YES NO	A B C OTHER	
		YES NO	A B C OTHER	
		YES NO	A B C OTHER	
		YES NO	A B C OTHER	
		YES NO	A B C OTHER	
		YES NO	A B C OTHER	
		YES NO	A B C OTHER	
		YES NO	A B C OTHER	
		YES NO	A B C OTHER	

Ward / Clinical Area	Date	Clinical reasoning for any variance	Initials

APPENDIX 2 - Assessment for use of bed/trolley rails in adult emergency department

UNIVERSITY HOSPITALS DERBY AND BURTON NHS FOUNDATION TRUST

Assessment for use of trolley rails in adult emergency department

Complete all appropriate sections of the risk assessment for ALL patients.
This assessment should be completed on change of condition / transfer. This can be completed more frequently if required.

Patient Demographic Sticker

Does the individual meet any of the high-risk criteria:

- ☐ BMI 17 or less
- ☐ Height 146cms or less
- ☐ Weight 40kgs or less
- ☐ The person is confused or agitated
- ☐ The person has previously attempted to climb over the rails or has been found with limbs between or over the bars

NO

Keep trolley rails in upright position but consider the following mitigations:

Tick appropriate mitigations used

- ☐ Trolley is set at the lowest setting
- ☐ Person / relative or carer has been advised to ask for support when moving from trolley
- ☐ Information has been given to person / relative or carer around safe use of trolley rails
- ☐ Person is fit to sit and has been moved to a chair

YES

Keep trolley rails in upright position but consider the following mitigations:

Tick appropriate mitigations used

- ☐ Person should be moved to a bed as soon as possible
- ☐ Person has been moved into an easily observable area
- ☐ Trolley is set at the lowest setting
- ☐ Person / relative or carer has been advised to ask for support before moving from trolley
- ☐ Information has been given to patient / relative or carer around safe use of trolley rails
- ☐ Person is fit to sit and has been moved to a chair

If there is clear clinical reasoning to use trolley rails not covered by the risk assessment, please clearly document. **Please note trolley rails must always be in use during transportation.**

.....
.....
.....

Ward / Department	Date	Name	Signature	Job role

1

Assessment for use of bed rails in adult emergency department

Complete this risk assessment for ALL patients.
This assessment should be completed on admission/weekly/change of condition/on transfer. This can be completed more frequently if required.

Bed rails must always be in place during transport. If not being transported followed the flow chart below.

Does the individual meet any of the high-risk criteria:

- ☐ BMI 17 or less
- ☐ Height 146cms or less
- ☐ Weight 40kgs or less
- ☐ The person is confused or agitated
- ☐ The person has previously attempted to climb over the bed rails or has been found with limbs between or over the bars

NO

YES

Patient is deemed high risk of entrapment.

DO NOT USE BED RAILS

DO NOT USE BED RAILS UNLESS:

A. The patient is using a bariatric bed and using rails for moving and handling purposes

B. The patient is recovering from sedation/anaesthetic and is under constant supervision

C. The patient has capacity and requests the use of bed rails after the risks of use have been explained to them

If there is clear clinical reasoning to use bed rails not covered by the risk assessment, please clearly document this below *(for example, the patient is hemiplegic and is leaning).*

If you are concerned there is a high risk of falls from bed and rails are not recommended consider the use of an ultra-low bed accessed via: QHB - Etrace, RDH - ring switchboard or ARJO.

Date	Bed rails in use	If YES, reason as documented above. Document OTHER below	Name	Signature	Job role
	YES NO	A B C OTHER:			

APPENDIX 3 - Safeguarding Assessment Tool

Circumstances	Yes	No	Rag rating	Possible category of abuse
Is there historical evidence that the patient was at risk of falls, but a) there was no falls risk assessment and/or b) no risk-reduction plan in place				Neglect/acts of omission
Is there evidence of assessment that the person required continuous supervision/1:1 care and the person fell while unattended?				Neglect / acts of omission
Did the fall likely result from failure to complete tests/observations/give appropriate medications e.g. because they have diabetes and their blood sugars hadn't been checked, they were post-operative or medication had been given incorrectly?				Neglect / acts of omission
Did the patient have a fall and staff failed or delayed seeking medical advice?				Neglect / acts of omission
Did the fall happened as the result of poor moving and handling activity?				Neglect / acts of omission
Were they known / assessed to be a falls risk and objects e.g. bell / drinks / glasses not in easy reach? Did they fall trying to reach to reach them ?				Neglect / acts of omission
Was the patient identified as confused or disorientated but bed rails were in use?				Neglect / acts of omission
Was the fall caused by the height of the bed being too high/too low?				Neglect / acts of omission
Was the patient assessed as requiring a mobility aid but was not issued this or this was left out of reach of the patient?				Neglect / acts of omission
Did the person have a fall because there was a loose carpet or an equipment maintenance issue?				Neglect / acts of omission
Was there an assault by a 3rd party involved e.g. patient or visitor?				Physical abuse / assault

If the answer is yes to any of the above a social care referral should be made and CQC informed. The Trust must notify CQC of all incidents that affect the health, safety and welfare of people who use services, as specified under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.In cases where a care provider has failed to take specific actions to identify, assess, address, and reduce risks, this could lead to enforcement action due to failure to have safe systems of work in place.

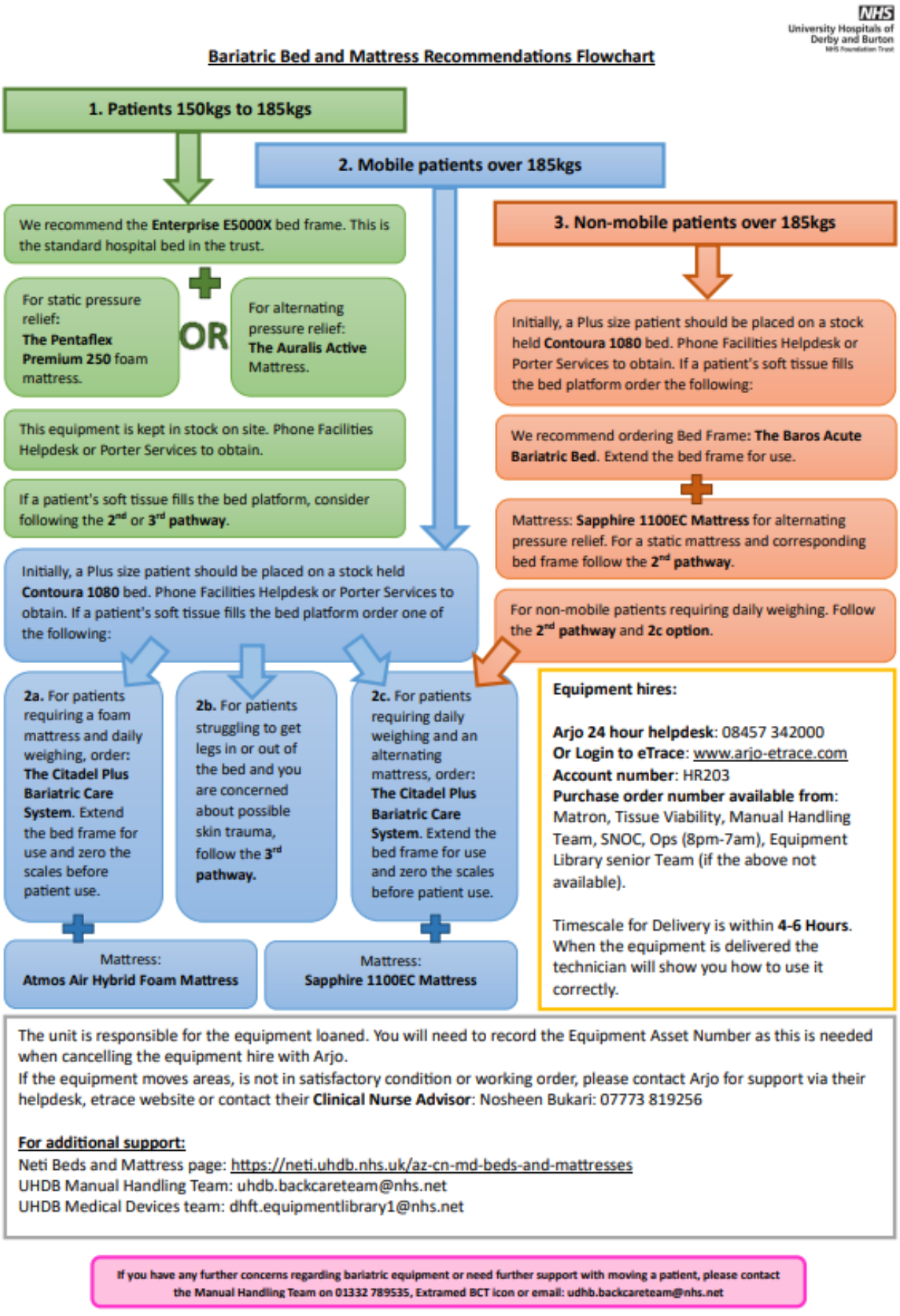
The Health and Safety Executive RIDDOR guidance is clear that accidents to members of the public (this is anyone not at work in the care setting) must be reported if they result in an injury and the person is taken directly from the scene of the accident to hospital for treatment to that injury.

- Examinations and diagnostic tests do not constitute 'treatment' in such circumstances.
- Incidents do not need to be reported where people are taken to hospital purely as a precaution when no injury is apparent.
- If the accident occurs in a hospital care setting, then it only needs to be reported to RIDDOR if the injury is a 'specified injury' as set out in the HSE guidance.

In both cases of safeguarding and incidents/accidents, report records should show:

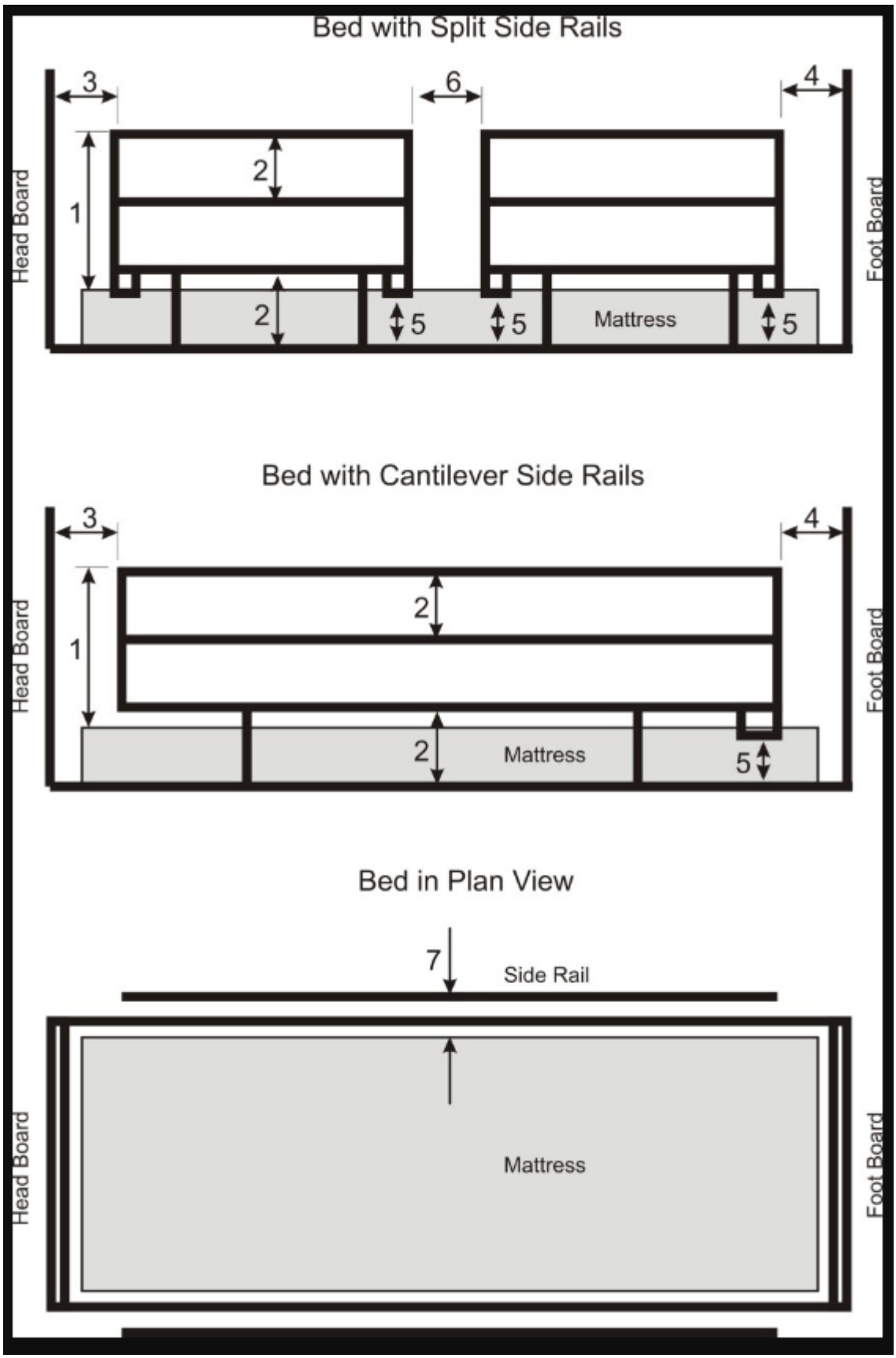
- What happened?
- How it happened?
- Who has been spoken to (including the resident and/or their family/advocate, witnesses, management, any health professionals, key social care worker, police etc.) and what have they said?
- What action has been taken (both immediate emergency action and longer term action such as management investigation or disciplinary etc.)?
- What has been put in place to stop/reduce it happening again (such as action plans, training, briefings, lessons learnt being shared across all services etc.)?
- How this will be monitored and review the actions?

APPENDIX 4 - Bariatric Bed and Mattress Recommendations Flowchart



APPENDIX 5 - Bed rail dimensions in BS EN 6061-2-52:2010+A1:2015

NPSA (Aug 2023)



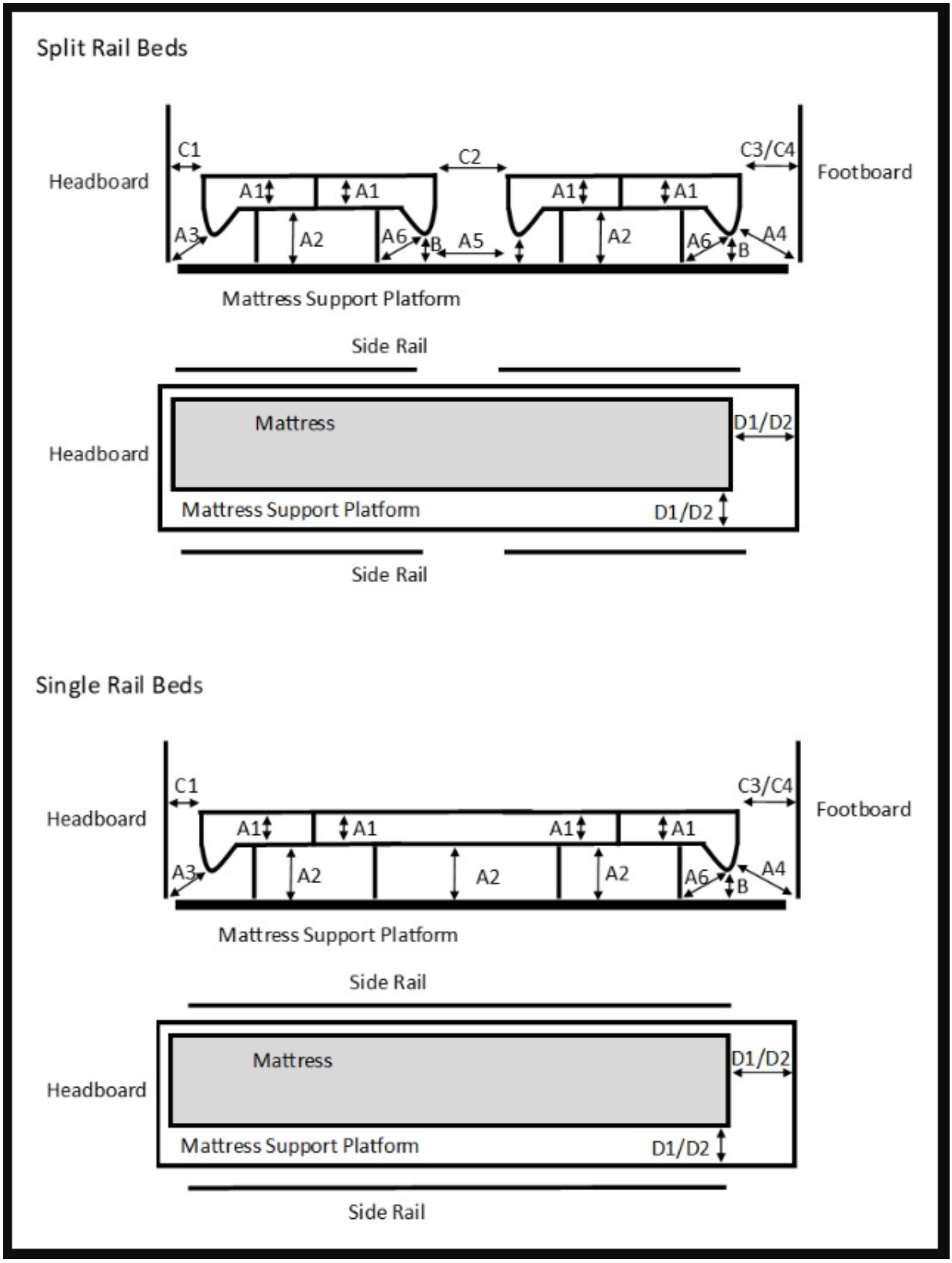
Description	Diagram Reference	BS EN 60601-2-52:2010	Notes
Height of the top edge of the side rail above the mattress without compression	1	≥ 220mm	Where a speciality mattress or mattress overlay is used and the side rail does not meet ≥ 220mm a risk assessment shall be performed to assure equivalent safety
Gaps between elements within the perimeter of the side rail and between the side rail and mattress platform	2	< 120mm	
Gap between headboard and end of side rail	3	< 60mm	Most disadvantageous angle between headboard and side rail
Gap between foot board and end of side rail	4	< 60mm OR > 318mm	Most disadvantageous angle between foot board and side rail
Distance between open end of side rail(s) and mattress platform	5	< 60mm	The gap between the open end of the side rail and headboard is not relevant to this position reference
Gap between split side rails	6	< 60mm OR > 318mm	When in most disadvantageous position

Gap between side rail and mattress in 'plan' elevation	7	Perform test	120mm aluminium cone is positioned between mattress and side rail to determine if gap is acceptable or not.

Note that compliance to this standard requires the use of specific measurement tools, rather than basic distance measurements alone. It is intended to be used by manufacturers. For this reason, it is recommended that end users do not use solely these measurements as the sole basis for evaluating suitability of a bed rail installation.

APPENDIX 6 - Bed Rails Dimensions BS EN 50637:2017

NPSA (Aug 2023)



Description	Diagram Reference	BS EN 50637:2017	Notes
Fully enclosed openings within a side rail, head/foot board, mattress support platform	A1	<60mm	
Fully enclosed opening defined by the side rail, its supports and the mattress support platform	A2	<60mm7	
Partially enclosed opening defined by the head board, mattress support platform and side rail	A3	<60mm	
Partially enclosed opening defined by the foot board, mattress support platform and side rail	A4	<60mm	Except when gap between side rail and foot board is >300mm
Partially enclosed opening between segmented or split side rail and the mattress support	A5	<60mm	Except when gap between side rails is >300mm
Partially enclosed opening defined by lowest point of a side rail, the adjacent side rail support and mattress support platform, to the outside of the side rail supports	A6	<60mm	

Other openings defined by accessories (e.g. IV poles, fracture frames) and side rails, head or foot boards and or mattress support platform. Not shown in figures.	A	<60mm	
Distance between mattress support platform and the lowest point of the side rail outside the side rail support AND The angle between the side rail and mattress support platform at the range of the mattress height defined by the manufacturer ± 2 cm	B	<40mm AND Angle between mattress support platform and side rail interface >75° over the entire range of mattress heights from minimum recommended height minus 2 cm to the maximum recommended mattress height plus 2 cm.	
Gap between head board and adjacent side rail	C1	<40mm	
Gap between segmented or split side rails with both side rails raised	C2	<40mm OR >300mm	For a gap >300mm: the gap shall be >300mm or <400mm for the entire vertical distance

For all medical beds except junior beds: gap between side rail and foot board. Other openings defined by accessories (e.g. IV poles, fracture frames etc.) and side rails, head board, foot board, and or mattress platform	C3	<40mm	
For junior beds: gap between side rail and foot board. Other openings defined by accessories (e.g. IV poles, fracture frames etc.) and side rails, head board, foot board, and or mattress platform	C4	<40mm OR >300mm	For a gap >300mm: the gap shall be >300mm or <400mm for the entire vertical distance
Region defined by side rail/head board/foot board and the mattress for cribs and cots	D1	Perform test	Cone tool does not sink below the mattress surface by 50% or more of its 60mm diameter.
Region defined by the side rail/head/foot board and the mattress for junior beds and oversize cots	D2	Perform test OR Gap between side rail/head/foot board and mattress <30mm	Cone tool does not sink below the mattress surface by 50% or more of its 60mm diameter.

APPENDIX 7 - Bed Rails Initial Assessment Form (Appendix within Joint Derby and Derbyshire Health & Social Care Policy).

BED RAILS INITIAL ASSESSMENT FORM – STAGE 1

SURNAME:	FORENAME:	DOB:
NHS NUMBER:	FRAMEWORK I NO:	GP:

A COPY MUST BE KEPT IN THE PERSON's RECORDS/CARE PLAN AND A COPY TO ACCOMPANY THE PERSON

INITIAL ASSESSMENT

Check and tick (✓) the following	**Yes**	**No**
1. Is the person at risk of falling out of bed? Rationale:		
2. Does the person independently transfer out of bed? Rationale:		
3. Does the person have the potential to climb over the top of the bed rails or out of the bottom of the bed? Rationale:		
4. Does the person's movement pose a risk, e.g. spasm, balance etc? Rationale:		
5. Does the person's current behaviour present a risk, e.g. confusion, agitation, challenging behaviour, self-injurious behaviour, lack of awareness of potential damage? Rationale:		
6. Does the person's physical size present a risk, e.g. entrapment of any part of the body? Rationale:		

7. Does the person have a complex medical condition, e.g. brittle bone syndrome, osteoporosis, epilepsy, dislocated hips, tracheotomy? Rationale:		
8. If provided is the person likely to use the bed rails for supporting, turning, sitting up? Rationale:		
Check and tick (✓) the following	**Yes**	**No**
9. Is the person left unsupervised and does this pose a risk? i.e. can they raise help? Rationale:		
10. Is there any other relevant information e.g. historical information, sensory needs etc. Rationale:		
11. Following this assessment are bed rails suitable for reducing the risk to the person? (Provide rationale if any answer is outside of the grey box) Rationale:		
12. Have alternative methods of bed management been considered? Rationale:		
13. Has the patient or family requested the provision of bed rails? Rationale:		
14. Does the patient require bed rail bumpers to reduce risk? Rationale:		
15. Are mattress infills required? Rationale:		

16. Where will the bed rails be used? (please tick)	Residential Home	Nursing Home	Own Home	Other
Type of bed:	Type of rail:			
Bed rails to be fitted? (please tick)	Yes		No	
If no please detail any alternative methods:				

Assessors Name:	Designation:
Signature:	Date /Time:
Remember to email a copy of the form to the Authoriser	
72 hour review to be completed by:	
Reviewer:	Team:
Tel. No	Base:
For any transfer of care, the prescriber must ensure that a nominated clinician accepts the referral for the 72 hour review.	

APPENDIX 8 - Guidance notes for completion of the bed rails and assessment tool - stage 1 (Appendix within Joint Derby and Derbyshire Health & Social Care Policy).

GUIDANCE NOTES FOR COMPLETION OF THE BED RAILS AND ASSESSMENT TOOL – STAGE 1

The following questions relate to the Assessment and Review Tools, Appendix 4.

Person Details

- Person details to be filled in fully and clearly.
- Those involved in the assessment, including verbally, should be recorded.

Question 1: Is the person at risk of falling out of bed?

- Has the person fallen out of bed recently or is anxious that they may fall out of bed if sleeping in a different bed e.g.' single bed?
- Is the person aware of their limitations and mobility including bed mobility?
- New condition affecting balance, e.g. amputee, etc.
- Can the person role / slide down the bed?

Question 2: Does the person transfer independently out of bed?

- Will the use of bed rails prevent independent transfers? Does the person require a bed lever or bed stick to assist with independent transfers?

Question 3: Does the person have the potential to climb over the top of the bed rails or out of the bottom of the bed?

- If the answer is "Yes" bed rails *must not* be used.

Question 4: Does the person's movement pose a risk?

For example, spasm, balance, epilepsy, involuntary movements, etc.

Question 5: Does the person's current behaviour present a risk, e.g. confusion, agitated and challenging behaviour?

- Could the use of bed rails or bed equipment impact on behaviour that could injure the person/carer, result in entrapment or cause stress or anxiety to the person?
- What needs to be taken into account considering behaviour?

Question 6: Does the person's physical size present a risk, e.g. entrapment of any part of the body in the rail or bed equipment?

- Bed safety sides are designed for use with all peoples over the age of 12. Therefore, they may not be suitable for use with children and adults with atypical anatomy (under 146cm in height **or** less than 40Kg in weight **or** BMI less than 17). A clinical judgement must be made as to whether the use of bedrails is appropriate and whether equipment meeting BS EN 50637:2017 is required. Please see the policy, with reference to appendix 16, for further information.

Question 7: Does the person have a complex medical Condition?

Detail any relevant medical history or diagnosis that will have an impact on the use of bedrails

Are there any issues posed by providing bed rails or bed equipment, e.g. rehabilitation, catheter, ventilator, gastrostomy, tubes, etc.?

- Are the other equipment / attachments / medical devices compatible with the chosen option?

Question 8: If bedrails are being considered, is the person likely to use them for supporting or turning / sitting up?

- Standard bed rails should not be provided for this purpose. However some manufacturers now produce bedrails that can be used to assist turning as well as safety. Seek guidance from the manufacturer
- Seek alternative equipment using manufacturer's guidance, e.g. bed levers

Question 9: What is the longest period the person is left unsupervised?

- Does this pose a risk?
- Is there adequate monitoring of the person whilst bed rails are in use?

Question 10: Is there any other relevant information re the use of bedrails or other bed area equipment, e.g. historical information, sensory needs, existing bed area equipment etc.

Question 11: Following this assessment are bed rails suitable for reducing the risk to the person? (Provide rationale if any answer is outside of the grey box)

Question 12: Have alternative methods of bed management been considered?

- Have alternative methods been considered, e.g. crash mats, low beds, sensory devices, etc.?
- Is this compatible with chosen method?

Question 13: Has the patient or family requested the provision of the bed rails?

- Consider the views of the patient and family.

Question14: Does the patient require bed rail bumpers to reduce risk?

Question 15: Are mattress infills required?

Question 16: Where will the bed rails be used?

- Tick the relevant box.

Complete type of bed and rail.

Confirm bed rails to be fitted.

Assessor to sign, date etc.

Complete responsible person for the 72 hour review. Ensure person accepts referral for the review if not the prescriber.

APPENDIX 9 - Bed rails post installation 72 hour assessment - stage 2 (Appendix Joint Derby and Derbyshire Health & Social Care Policy).

BED RAILS POST INSTALLATION 72 HOUR ASSESSMENT – STAGE 2

SURNAME:	FORENAME:	DOB:
NHS NUMBER:	FRAMEWORK I NO:	GP:
HEIGHT:	WEIGHT:	BMI:

To be completed on immediate initial review by the main carer, e.g. community nurse, therapist or social care.

BED RAIL TYPE: (Check and tick (✓) the following)					
	Yes	No		Yes	No
Integral	x		Split		
Mesh Sides			Inflatable		
Concertina			Bed Side Wedges		
Universal High Rail			Other (please state)		
Has safety issues been discussed with the person / carers?				x	
Please confirm what has been discussed: Risk of entrapment or rolling against the rails discussed. Risk of climbing over rails. Advised to contact Medequip if any concerns with bed rail use.					

ARE THE BED RAILS: (Check and tick (✓) the following)	Yes	No
A. Fitted securely, with no excessive movement?		
B. In good working condition, with no rust, loose fixings or cracks to joints?		
C. Suitable for the intended bed, according to supplier's instructions? Fitted by Medequip technician for Medequip provision bed.		
D. Are gaps avoided that could present an entrapment risk to the bed occupant? Consider are there no gaps that could present an entrapment risk: (reference MHRA guidance and pictures attached)		

1. Height of the top edge of the side rail above the mattress without compression should be greater than 220 mm. (240mm) 2. Gap between elements within the perimeter of the side rail and between the side rails and mattress platform must be less than 120 mm. Gap between mattress platform and bottom of side rail must be less than 120 mm. 3. Gap between the headboard and end of the side rail must be less than 60mm. 4. Gap between the footboard and end of side rail must be less than 60mm or greater than 318 mm. 5. Gap between the mattress platform and lowest part of the side rail must be less than 60 mm. 6. Gap between split side rails should be less than 60 mm or greater than 318 mm. 7. Visual check between mattress and side rail to determine if there is a gap that could pose an entrapment risk to head, limbs etc.		
E. Appropriate for the person?		
F. High enough to take into account any increased mattress thickness or additional overlay? Standard foam mattress provided. Air or hybrid mattress may affect bed rails meeting criteria.		
G. Compatible with other equipment? (e.g., lateral turning device, sleep system etc.)		
The desired outcome for all the questions above is 'Yes' if you answer "No" to any question there may be risks in using this equipment, review immediately and outline the planned action below:		
BUMPERS: (Check and tick (✓) the following)	**Yes**	**No**
H. Are bumpers required?		
If "No" go to next section, if "Yes" continue below:		
I. Compatible with the rails? Provided and fitted by medequip technician.		
J. Sufficiently padded?		
If you answer "No" to question I or J, outline the planned action below:		
If changes have been made to the initial installation, is a further post installation assessment needed?	Yes	No
If applicable who has accepted the referral to complete this? (Details):		

Assessment completed by:	
Name and Designation	Team
Tel. No.	Base

MHRA BEDRAIL GUIDANCE

Diagram of side view of bed with split rails

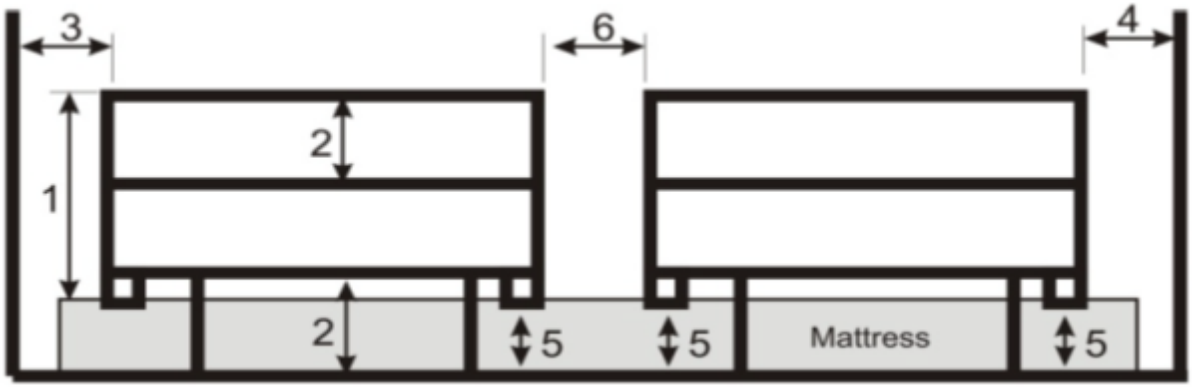


Diagram of side view of bed with cantilever side rails

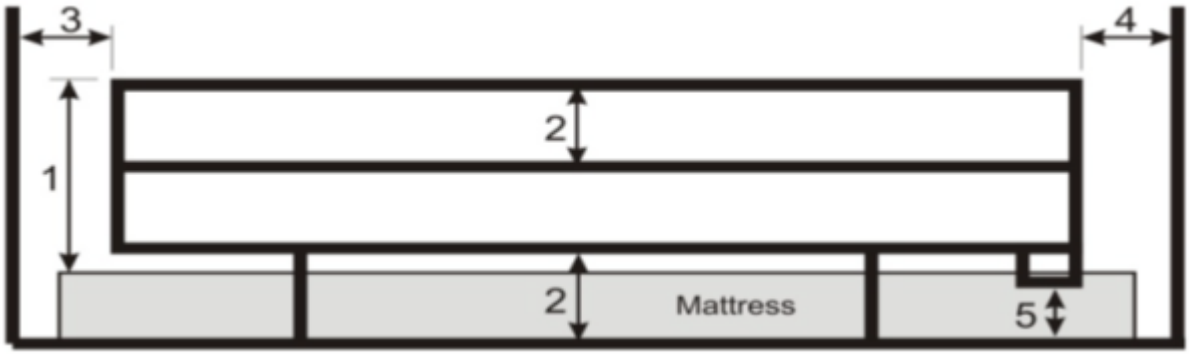
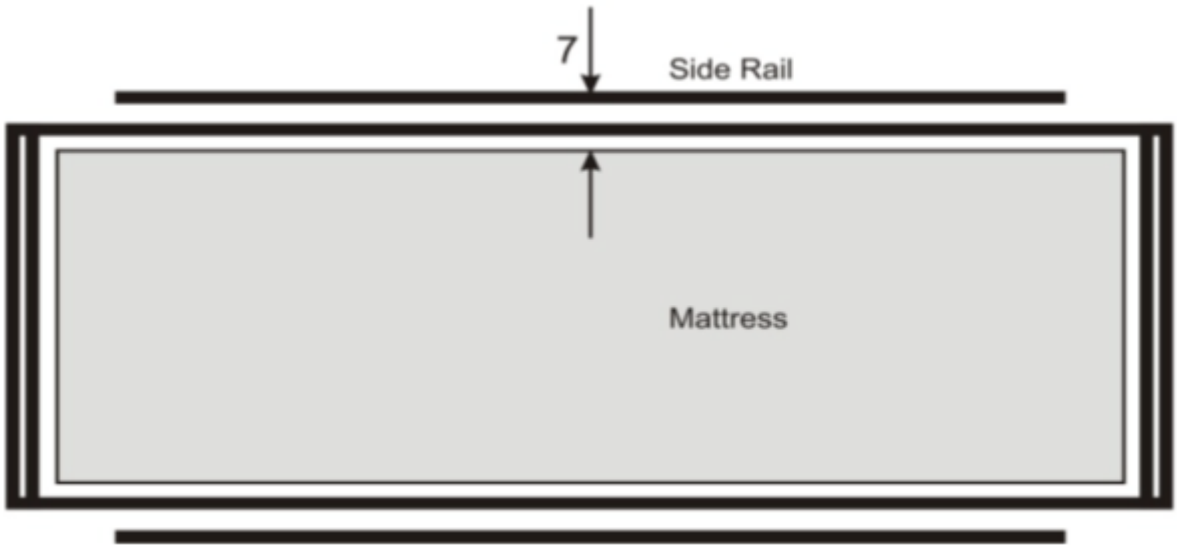


Diagram of bed aerial view


7
Side Rail
Mattress

APPENDIX 10 - Bed Rails Risk Assessment - Staffordshire or out of area

Bed Rails Risk Assessment – Staffordshire

Bed Rail Risk Assessment Checklist

1. This checklist must be completed by a trained member of staff from the relevant clinical team to decide if bed rails are actually required or if an alternative method should be used to reduce to reduce the risk of falls and potential injury.

2. This assessment should be used in conjunction with the Trust's Safe Use of Bed Rails Policy and with the nurses/therapists own professional/clinical judgement.

3. **Bed rails should only be used to prevent people from falling out of bed**, not to assist patient moving and handling or transfers.

4. It is important to determine if alternative equipment may be more suitable i.e., are bed rails actually required?

5. This assessment must be carried out before bed rails are used and once fitted, must then be followed up by the Bed Rail Review Checklist (Appendix 2).

6. The Bed Rail Review Checklist (Appendix 2) must also be completed after each significant change in the patient's condition, after alterations to any part of the equipment combinations or after any incident involving bed rails.

7. Beds should always be returned to the lowest possible height when carers/staff are not in attendance and where applicable, the bed height activator must be locked.

8. Bed rails must always be issued and fitted in pairs.

9. Bed rails will not be issued for divan beds.

10. Bed rail bumpers/pads will be supplied at the request of the referrer.

Bed Rail Risk Assessment

Patient Name: Date:
Address: Type of bed:
NHS Number:

1. Does the patient need to get out of bed unsupervised? e.g., to use the toilet. Yes No
The provision of bed rails may impede independence

2. Does the patient have any of the following: dementia, a learning disability, confusion, delusions, partial paralysis, abnormal or involuntary movement, unpredictable behaviour? Yes No
If 'Yes', please specify:

3. Is the patient currently at risk of falling from their bed? Yes No

4. Is the patient likely to climb over the bed rails?
An injury's severity could be increased if a person climbs over a bed rail and falls from a greater height. Patients who are confused and have enough strength and mobility to clamber over the bed rails are most at risk **Yes No**

5. Is the patient able to understand the purpose of bed rails? Yes No

6. Are the bed rails to be used with a typically sized adult patient? Yes No

7. Depending on mattress(es) being used, are standard height bed rails sufficient?
If 'No', consider the use of extra height bed rails or an alternative mattress. Yes No

8. Is the carer able to raise/lower the bed rails?
(Consider who would do this).
N.B. Not applicable to Community Hospitals.

9. Could the patient injure themselves on the bedrails?
Bed rails can cause injury if the patient knocks themselves on them or traps any body parts between them. The most vulnerable patients are those with uncontrolled limb movements, who are restless / confused or have fragile skin.
Bed rails even when fitted correctly carry the very rare risk of postural asphyxiation. Those who are frail, restless or confused are most at risk.
Would bed rail bumpers reduce the risk of entrapment / injury

10. Has the safe use and potential risks of bed rails been discussed with the patient/next of kin? Yes No

11. Has the assessment been discussed with the patient/next of kin? Yes No

12. Does the patient/next of kin agree with the assessment?

If 'Yes' to questions 1 or 2 then consider alternatives as the risk of entrapment is likely to be increased. If 'Yes' to questions 3 – 12 then the use of bed rails may be indicated. If a 'No' box has been ticked then alternatives should be considered as bed rails are possibly not required and there may be a potential entrapment risk. (**Note**: this does not apply to questions 1 and 2). Alternative solutions are discussed in the Safe use of Bed Rails Policy.

Bed rails to be used? Yes / No
Justification:

Name of Assessor:
Base:
(in full, printed)
Signature:
Tel No:
Designation:
Date:

KEEP WITH PATIENT'S NOTES
As required by the Clinical Record Keeping Policy

APPENDIX 11 - Provision of Community Equipment for Care Homes in Derbyshire and Derby City

CARE HOMES IN DERBYSHIRE AND DERBY CITY

Provision of Community Equipment for Care Homes in Derbyshire and Derby City

INTRODUCTION

This policy covers eligibility for Health and Social Care equipment for residents in registered care homes and community day care services, in line with the National Minimum Standards for Registered Care Homes and defines:

- The requirements on Care Homes to provide standard equipment in line with the National Minimum Standards which can be viewed on line at:

  http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4001911

- The statutory requirements of Primary Care Trusts who have responsibilities to provide certain equipment for people assessed as eligible for NHS Continuing Health Care in line with the National Framework for NHS Continuing Health Care and NHS Funded Nursing Care. (revised 2009)
- Bespoke equipment to be provided by ICES to their service users with an assessed need.

LEGISLATION

The relevant legislation can be found within outcome 11 on:

http://www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_March_2010_FINAL.pdf

The regulations ensure that service users have access to the adaptations and equipment they need and place responsibility for providing these services onto care homes. This expectation complies with not only their statement of purpose but also with the contract they have with the statutory agencies. Under this contract providers are required to meet the needs of their residents. This should include an assessment by the manager prior to placement and the need for equipment should be part of this assessment.

Care Homes should have sufficient adaptive equipment to meet a range of mobility needs. This should include items such as hoists, slings, parker baths, bath hoists, handrails etc.

Moving and Handling advice, training and the provision of equipment is strictly not within the remit of the statutory agencies as this is expected to be provided by the Care Home.

However, assistance/advice with an assessment may be requested of specialists from the statutory agencies, for example, in order to appropriately assess and identify suitable equipment to support tissue viability needs.

ABOUT THIS DOCUMENT

- This document demonstrates a wide range of equipment that **may be** required, either for a short or longer period of time, by a person within a Care Home setting.

- Equipment used to support persons in care homes is subject to management under Controls Assurance standards for the "Management of Medical Devices", all relevant legislation and guidance is available from the Medical Devices Agency.

- The Care Home Manager must ensure compliance with the requirements specified by the Care Quality Commission in order to comply with section 20 of the Health and Social Care Act 2008. In particular, with reference to equipment: Outcomes 4 – Care and welfare of people who use services, Outcome 7 – Safeguarding people who use services from abuse and Outcome 11 – Safety, availability and suitability of equipment.

ASSESSMENT

- Provision of equipment should be based on an assessment of need with the assessor utilising recognised accredited tools and scales, clinical guidance /agreed local protocols.

- All staff assessing for equipment must be competent and confident, having received appropriate training.

- Assessment should be undertaken by a relevant professional/discipline. This **may** mean requesting input from specialist practitioners from either primary or secondary care settings.

- All specialist equipment used for the care and management of named persons will be subject to review. The frequency of the review should be detailed in the person's care plan together with the name of the person responsible for the review.

PROVISION

- Specialist equipment should only be used for the person for whom it was originally prescribed.

- Where equipment has been provided to a care home and is no longer required by the person being cared for, it is the responsibility of the care home to notify the supplying agency immediately.

- Equipment should be maintained and returned in good working order and a charge will be made for wilful damage, for call out costs, replacement or repair

- The examples listed in the categories of equipment are not exhaustive and will be subject to review by the partner agencies.

- The classification of Adult Care Services Homes for Older People is the same as that for private Residential Homes.

- All equipment provided is subject to review and collection when no longer required by the patient it was prescribed for.

- The time standard for delivery of equipment is determined by the prescriber.

- The standard for collection is within 10 working days. Care Homes should contact the equipment provider with the service user details to arrange collections and any collection queries should be referred to the relevant Continuing Care Team

- For non commissioned equipment provision, referrals should be made to the PCT Commissioners.

- The principle of this document applies to any periods of respite required by the client.

ENQUIRIES AND COMPLAINTS

- If you have any queries you should contact your organisations Lead – see Appendix A

- Should you have a complaint, dependent upon its nature, you should refer to the relevant Complaints Process.

DEFINITIONS

Specialist equipment – for which there is a specific Department of Health provision under EL (95) 5 regulation, etc these are usually provided on prescription by medical staff e.g. PEG nutritional feeding, continuous ambulatory dialysis (CAPD), intravenous chemotherapy for cancer treatments. This equipment will not be provided by the community equipment services.

Bespoke equipment (tailor made) – designed or adapted or bio-engineered and manufactured for a specific individual. Equipment that is designed specially for an individual i.e. the product is not available directly from a manufacturer off the shelf.

Complex – this is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs.

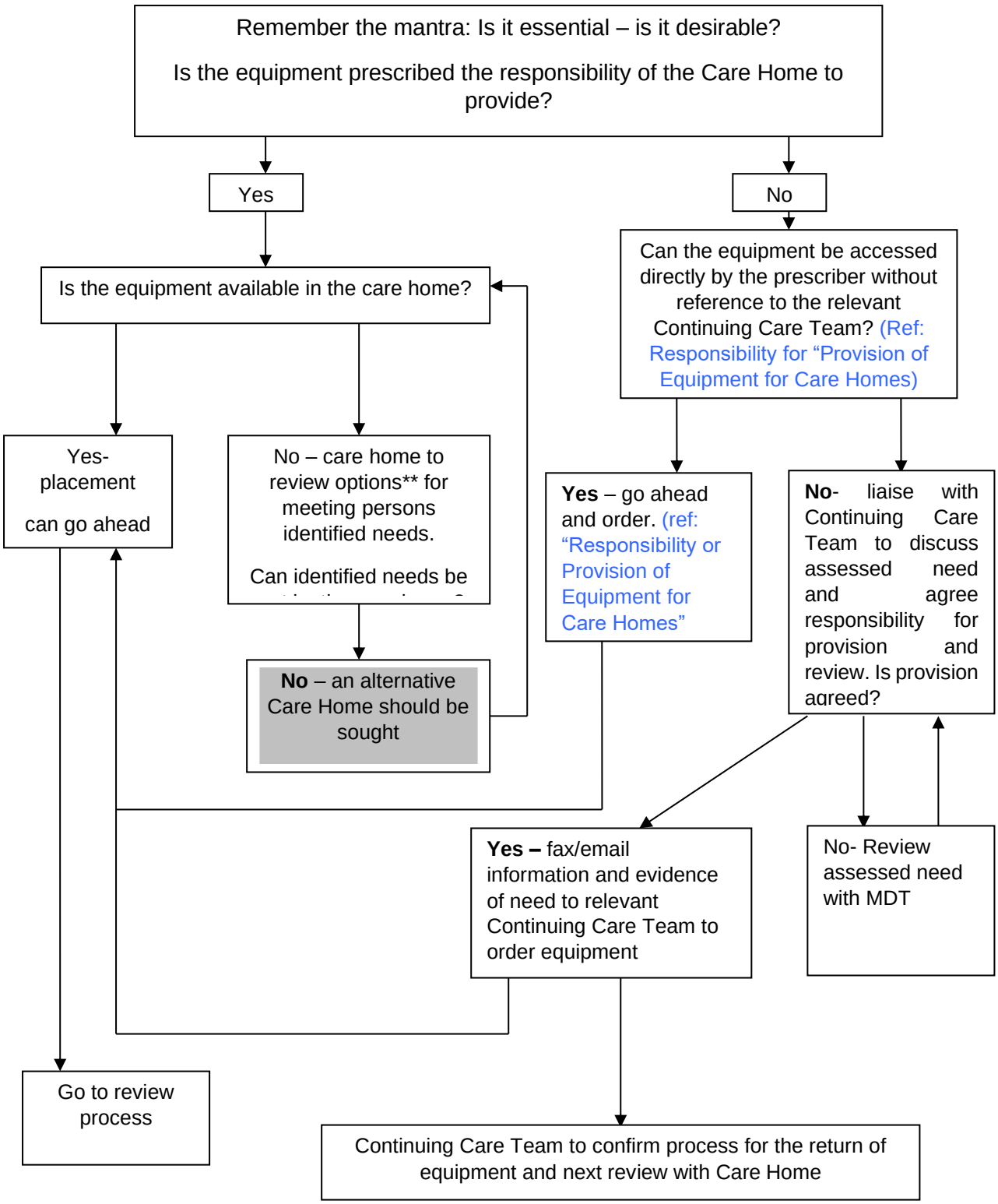
Bariatric – A bariatric patient is defined as anyone regardless of their age, who has limitations within health and social care due to their weight, physical size, shape, width, mobility, tissue viability or environmental access in one of the following areas:

- Has a Body Mass Index (BMI) greater than 40kg/m2 and or are 40kg above the ideal weight for their height (NICE 2004) or
- Exceeds the working load limit and dimensions of the support surface such as a bed, chair, wheelchair, toilet or mattress (Health and Safety Work Regulations 1999 and Manual Handling Operations amended 2007)

Bariatric Equipment – It therefore follows from the above definition, that bariatric equipment is equipment required to meet the above patient's needs in that different equipment is required to meet their size, shape, width etc

Non Commissioned Equipment – Not in an existing contract

No equipment should be prescribed prior to an assessment of need. The assessment should be undertaken by the most appropriate practitioner



**** Options for Care Homes are:**

1) Self Purchase 2) Hire, either short or long term, from Community Equipment providers.

Item of Equipment	Care Home Setting		Comments
	Nursing	Non-Nursing	
For Administration of Medicine			
For administration of oral medicine, e.g. measures, medication boxes	CH	CH	Medication via prescription/chemist packs
For administration of rectal medication, e.g. gloves	CH	PCT	Prescription via GP or Nurse Prescriber
For administration of medication by injection including plastics	CH	PCT	
Syringe drivers and disposables e.g. for epidurals	PCT	PCT	**Carry on with your present arrangements until new contracting agreements are in place**

Assistive Technology			
Telecare **Derby : 256062 FAX: 292165** **Minicom: 256000** **Derbyshire: 0845 058 058**	ACS	ACS	Contact Local Authority Telecare Lead for advice

Bathing Equipment			
Range of Bath Seats/Boards	CH	CH	
Electric/Manual Bath Lift	CH	CH	
Range of Shower Chairs/Stools	CH	CH	

Beds					
General Beds	CH		CH		
Manual and electric profiling beds	CH		CH/ CNS	**R**	CH for general use/CNS if required by Community Nursing staff to enable them to carry out nursing procedures following Risk Assessment and returned when not required
Specialist beds – for people with complex health care needs	PCT	**R**	PCT	**R**	Through continuing care route for equipment irrespective of care funding arrangements

Bed Attachments			
Range of Backrests	CH	CH	

Rope Ladder	CH	CH	
Range of Bed Raisers	CH	CH	
Over Bed Trolley Table	CH	CH	
Lifting Pole	CH	CH	
Bedrails for Divan/Standard/Electric Bed	CH	CH	

Chair Raising & Seating			
Range of Standard Chairs/Seating/Raisers of variable heights to include posture support, commercially available wedges and chairs	CH	CH	
Adult Seating e.g. bespoke (tailor made) for people with complex health care needs. Equipment that is designed specifically for an individual i.e. the product is not available directly off the shelf from a manufacturer	PCT	PCT/ACS	Through continuing care route for health **NB:** In a Derby residential home assessment and review will be undertaken by a Community Health or Intermediate Care Therapist.

CH -Care Home responsibility to provide
ACS - Adult Care Services/Derby Adults Health and Housing responsibility to provide
PCT – health provider responsibility to provider i.e. PCT, initiating trust, FP10 etc
PCT Continuing Care Team

Item of Equipment	Care Home setting Nursing Non Nursing	Comments

Dressing Aids			
Small Dressing Aids e.g. Stocking Aid/Tights Aid/Long Handles Shoe Horn	CH	CH	

Help with Feeding			
PEG Feeding Equipment (EL (95)5)	PCT	PCT	Commissioned contract initiated by discharging trust
PEG Feeding Consumables	PCT	PCT	Commissioned contract initiated by discharging trust

Subcutaneous Feeding Consumables	PCT	PCT	Via Community Nurse
Equipment e.g. Plate Accessories	CH	CH	
Range of Feeding Equipment	CH	CH	
Helping Hand	CH	CH	
Trolley	CH	CH	
Backrests to aid nutrition and hydration	CH	CH	

Mobility Equipment			
Walking Stick	PCT	PCT	
Walking Frames	PCT	PCT	
Walking Frame Alpha	PCT	PCT	
Walking Frame Gutter	PCT	PCT	
Crutches	PCT	PCT	
Gutter Crutches	PCT	PCT	
Delta-Type Walker	PCT	PCT	
Rollator-Type Walker	PCT	PCT	
Heavy-Duty Mobility Equipment e.g. for bariatric patients	PCT	PCT	Through continuing care route for equipment

Wheelchairs			
Basic porterng wheelchair (attendant push)	CH	CH	This is standard equipment for any care home
Other wheelchairs/Cushions and Specialist seating	PCT	PCT	Provided by Wheelchair Services for permanent/long term usage by the person for whom it is required.

Ramps			
Ramps	CH	CH	Safety issue/DDA

CH - Care Home responsibility to provide
ACS – Adult Care Services/Derby Adults Health and Housing responsibility to provide
PCT – health provider responsibility to provide i.e. PCT, initiating trust, FP10 etc
PCT Continuing Care Team

Item of Equipment	Care Home setting Nursing	Non Nursing	Comments
Nursing Procedures			
Venepuncture			
Vacutainer Bottles for Blood Test	PCT	PCT	Via GP practice
Syringes and Needle	CH	PCT	
Catheterisation			
For Management of Catheterisation	CH	PCT	
Catheters and Bags	PCT	PCT	Prescription
Routine Procedures			
Testing Urine	CH	PCT	Prescription
Aseptic Procedures			
Equipment used to support Aseptic technique e.g. probes, scissors, gloves etc	CH	PCT	
Dressings e.g. for procedures related to aseptic and clean dressings	FP10	FP10	Or as per Wound Care Formulary

Patient Repositioning			
For Moving and Handling under Health & Safety At Work Act, e.g. Hoists, Slings, Transfer Boards, Glide Sheets, Turntables	CH	CH	As per individual assessment
Hoists: Ceiling Tracks	CH	CH	
Hoists: Toileting	CH	CH	
Bariatric Hoist	PCT	PCT	Through continuing care route for equipment irrespective of funding arrangements
Bespoke Sling e.g. bespoke (tailor made) for people with complex health care needs. Equipment that is designed specifically for an individual	PCT	PCT/ACS	Through continuing care route for health **NB:** In a Derby residential home assessment and review

i.e. the product is not available directly off the shelf from a manufacturer			will be undertaken by a Community Health or Intermediate Care Therapist.

Respiration/Routine Vital Sign Monitoring			
For Maintenance of Respiration e.g. Suction Units	CH	PCT	Refer to HSE/LAC2001/17(2001)26
Oxygen Cylinders and Masks	PCT	PCT	NHS policy applies. Refer to local HOOF procedures
Oxygen – Consumables	PCT	PCT	Ordered via local Health Clinic
Simple Nebulisers	CH	PCT	Via Respiratory Team
Non-Standard and Complex Nebulisers (e.g. for ENT, CPAP BIPAP)	PCT	PCT	Via Specialist Team
Thermometer, sphygmomanometer and pulse oximeters	CH	CH/PCT	Routine investigations carried out by the care home, CHS staff as part of care plan.
Backrests to aid respiration	CH	CH	

CH - Care Home responsibility to provide
ACS/Adult Care Services /Derby Adults Health and Housing responsibility to provide
PCT – health provider responsibility to provide i.e. PCT, initiating trust , FP10 etc
PCT Continuing Care Team

Item of Equipment	**Care Home Setting**		**Comments**
	Nursing	**Non-Nursing**	
Prevention/Therapy and Management of Pressure Ulcers All prescriptions should be based on local and National Guidance e.g. NICE Guidelines 29, Guide to Product Selection for the Prevention and Treatment of Pressure Ulcers within Derbyshire ICES			
Foam mattress/cushion – up to high risk	CH	PCT	
Air Filled mattress/cushion – at risk	CH	PCT	
Alternating Overlay and Cushion – high risk	CH	PCT	

Dynamic Mattress/Cushion – very high risk	PCT	PCT	Derbyshire County Continuing Care – review as per clinical judgement and a maximum of 12 weekly, annually face to face.
Low Air Loss Replacement Mattress/Cushion – very high risk	PCT	PCT	NHS Derby City via Tissue Viability Team

Review: In a residential care home - Community Nurse working with the Home. TVN's will provide advice and support to DN as required for patients with Grade 4 pressure ulcers.

In a Care Home with Nursing – Continuing Care Assessment Nurse

Sensory/Hearing			
Vibrating clocks	ACS	ACS	
Flashing Fire Alarms	CH	CH	Standard provision for registration
Flashing Door Bells	CH	CH	As above
Mini Comms	CH	CH	As above
Hearing Loops	ACS	ACS	To meet individual needs
Sensory/Visual			
Range of Canes	ACS	ACS	
Liquid level indicators	ACS	ACS	
Magnifiers, glasses	PCT	PCT	Derby only - PCT fund DAB to provide Low Vision Aids

Toileting			
Urinals/bottles	CH	CH	
Urinals/bottles: non return valves	CH	CH	
Fracture pan (bed-pan)	CH	CH	
Range of commodes: standard	CH	CH	
Toilet seats: standard 2", 4", 6"	CH	CH	
Moulded toilet seat e.g. bespoke (tailor made) for people with complex health care needs. Equipment that is designed specifically for an individual i.e. the product is not available directly off the shelf from a manufacturer	PCT	PCT/ACS	Through Continuing Care route for health **NB**: In a Derby residential home assessment and review will be undertaken by a Community Health or Intermediate Care Therapist.
Continence products	PCT	PCT	Provided by Continence Service through continence delivery service (PCT)

Specialist toileting – for people with complex health care needs	PCT	PCT	Through Continuing Care route for equipment

CH - Care Home responsibility to provide
ACS –Adult Care Services/Derby Adults Health and Housing responsibility to provide
PCT – health provider responsibility to provide i.e. PCT, initiating trust, FP10 etc
PCT Continuing Care Team

Appendix A

Key Contacts

Carol Riley	Contracting and Compliance Manger	Derbyshire County Council
Carol Fox	Head of Enablement Services	Derby Adults Health and Housing
Sharon Cooper	Continuing Healthcare Lead	Derbyshire County PCT
Sue Meer	Continuing Healthcare Lead	NHS Derby City
Stephanie Marbrow	Community Care Co-ordinator	Derby Hospitals NHS Foundation Trust
Jo Hartley	Team Leader	Chesterfield and North Derbyshire Royal Hospital
Jeremy Marriot	Assistive Technology Advisor	Derby Adults Health and Housing
Sharon O'Hara	Assistive Technology Advisor	Derbyshire County Council