

Appendix 2

Using bedrails safely and effectively

Falls from bed in hospital make up around 20% of all falls; in England and Wales, over a single year there were around 44,000 reports of patients falling from bed. This included eleven deaths and around 90 fractured neck of femur. Bedrails are not usually appropriate for an individual who could be independently mobile without them, or for a patient with capacity who does not want them, nor for a patient with severe confusion who is mobile enough to climb over them or a patient who may be at risk of self harm. For clients who are incapable of leaving their bed without help, bedrails are unlikely to act as restraint, or restrict independence, and may reduce the risk of injury from falls.

So organisations face the challenge of supporting good clinical decision making – ensuring bedrails are used where patients would benefit, but not where they would do more harm than good. To support them in this, a range of teaching materials, audit tools, draft policy, staff information posters, and bedside decision making tools can be found to support the NPSA

Safer Practice Notice *Using Bedrails Safely and Effectively* at:
<http://www.npsa.nhs.uk/nrls/alerts-and-directives/notices/bedrails/>

Bedrails need to be well designed, correctly fitted, and regularly maintained if they are not to cause harm through patient entrapment; deaths from bedrail entrapment in hospital settings in England and Wales around once in every two years, and could probably have been avoided if MHRA advice had been followed:

- MHRA Device Bulletin DB2006(06) *The safe use of bedrails* www.mhra.gov.uk
- MHRA Device Alert 2007/009 *Bed Rails and Grab Handles* www.mhra.gov.uk

It is particularly important that trusts take corporate action to identify and remove unsafe bedrails; some are still relying on formats that require staff to measure the gaps between bedrail bars each time they use the bedrail!

Further reading:

Healey F, Oliver D, Milne A (2008) The effect of bedrails on falls and injury: a systematic review of clinical studies. *Age Ageing*. 37 (4) 368-378.

Healey F, Oliver D (2009) Bedrails, falls, and injury: evidence or opinion? *Nursing Times*. 105 (26) 20-24.

Royal College of Nursing (2007) *Let's talk about restraint*. Available at:
http://www.rcn.org.uk/_data/assets/pdf_file/0007/157723/003208.pdf