

Toolbox Talk / Note – Safe Use of Bed Rails

Local Managers should communicate these key safety messages to their staff at handovers, staff meetings, huddles etc. They are developed in response to events that have occurred or identified hazards.

Introduction

Bedrails are safety devices used to reduce the risk of service users accidentally slipping, sliding or rolling out of bed. They are not intended to be used to limit the freedom of movement, as a method of restraint or as a moving and handling aid.

The aim of this briefing note is to inform staff that a bedrail assessment should be made before using bed rails.

There are two basic types of bed rails:

Integral - Incorporated into the bed design and are already fitted to the bed frame. Some are full length while others are split.

Third party - are not specific to any model. They are intended to fit a wide range of beds from different suppliers.

Currently four main pieces of legislation influence the correct use of bedrails and place legal duties on both the employer and employee. These are:

- The Health and Safety at Work Act (1974),
- Management of the Health and safety at work regulations 1999,
- The Provision and Use of Work Equipment Regulations 1998 (PUWER)
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

Responsibilities

A fully documented individual risk assessment must always be carried out before bed rails are used within hospitals and community settings. Decisions about their use (or not) must be made by applying professional clinical judgement and in collaboration with individual service users and their families or carers. Special consideration should be exercised when risk assessing bed rails for use with children and small adults.

Risk assessments must be repeated if there is a change in the service user's condition or if there is a change to any equipment such as the use of a different mattress or bed and this must be documented.

The Medicines and Healthcare Products Regulatory Agency (MHRA) Bed Rails Device Bulletin and the NHS Greater Glasgow & Clyde Bed Rails Risk Assessment provides guidance on risk of entrapment and assists with decision making.

Bed rails **SHOULD** be used:

- If an individual is being transported in their bed
- In areas where patients are recovering from anaesthetic or sedation and under constant observation

Toolbox Talk / Note – Safe Use of Bed Rails

Local Managers should communicate these key safety messages to their staff at handovers, staff meetings, huddles etc. They are developed in response to events that have occurred or identified hazards.

Bed rails **SHOULD NOT** be used:

- If an individual is confused and sufficiently agile to climb over the bed rail
- If the bed rail will prevent the person from being independent

Alternatives to bed rails include

- 'Adjustable' low height beds can be lowered to reduce the distance from bed to floor
- Bed movement monitoring systems
- Body positioning devices used to position patients with specific conditions e.g. cerebral palsy
- As a last resort, using a mattress on the floor where a fall from a bed is likely to occur and a low height bed is not immediately available

Extra consideration should be given when using different types of mattresses

- Compression of an overlay mattress may increase the risk of entrapment between the bed rail and the mattress.

The use of an extra height mattress will lead to a reduction in the effective height of the bedrail-extra height rails maybe required

Fitting, maintenance & care of bed rails

Bed rails should be cleaned routinely and if visibly contaminated

Bed rails should be in a safe working order. If not please report to:

- Estates Department Helpdesk (Hospitals),
- Equipment Loan Stores (Community)

In community, bed rails are fitted by the equipment and loan stores.

Staff should observe and report any damage such as rust, weld failures, missing parts, bent or distorted components, incompatibility of components and bed frame

Faulty bed rails should be removed from service

Incident reporting

All adverse events involving bed rails must be reported via the Datix Reporting System as per NHS Greater Glasgow and Clyde policy

Further information is available:

Health and Safety Executive

(<http://www.hse.gov.uk>)

Medicines and Healthcare Products Regulatory Agency – Safe Use of Bedrails, 2013

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/422784/Safe_use_of_bed_rails.pdf)

Further information and guidance is available on the Falls Service homepage on Staffnet.

Staffnet > Acute > Rehabilitation and Assessment > [Falls Service](#)