Safe Bed Management for Adults Policy

This policy describes how we clinically reason the best solution to manage the patient's risk of falling or slipping out of bed. This is done through assessing the patient's individual presentation and any potential risks. It supports staff to make safe decisions regarding their management of patients who are at risk of falling out of bed.

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Contents

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Summary and aim

Patients /service users may be at risk of falling, sliding or slipping from a bed for many reasons. Management of patient safety in this scenario can be addressed through assessment of the individual patient presentation and clinically reasoning the most suitable solution to deliver safe patient centred care.

This policy describes how we clinically reason the best solution through assessing the patient's individual presentation and any potential risks. It aims to support staff to make safe decisions regarding their management of patients who are at risk of falling out of bed

Target audience

Clinical Staff in LPT inpatient and community settings who are considering and undertaking risk assessments related to a patient's safety in bed.

Training

There is a need for training identified within this policy to ensure staff are aware of risk and safe clinical decision making around managing a patient's risk of falling or slipping out of bed.

All clinical staff are expected to attend moving and handling mandatory training: awareness of this policy and importance of risk assessment will be iterated. Use of bedrails/low beds is also covered in the Falls awareness training

In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role essential training.

Key requirements

1. Staff member are to undertake falls risk assessment on admission to the ward or community caseload in line with NICE Guidance (all adult patients aged over 65 and those aged under 65 who are judged by a clinician to be at a higher risk of falling out of bed because of an underlying clinical presentation).

2. If it is indicated that there is risk of rolling out of bed or falling when getting out of bed then staff should complete a safe bed management risk assessment process to establish the best way to reduce or mitigate the level of risk.

3. Based on the mental and physical status of the patient the outcome of the risk assessment should be documented in the patient clinical record and the appropriate intervention included in the care / treatment planning process. Wherever possible the patient should be consulted and involved in the decision making process. Where the patient does not have capacity the decision should be taken in the patients best interest to ensure their safety.

4. The outcome of the assessment should be communicated to the appropriate members of the multidisciplinary team and reviewed according to local protocol.

Introduction and Purpose

1.0 Purpose of the Policy

Patients /service users may be at risk of falling, sliding or slipping from a bed for many reasons. Management of patient safety in this scenario can be addressed through assessment of the individual patient presentation and clinically reasoning the most suitable solution to deliver safe patient centred care.

The consequence of a patient falling out of their bed can be significant with the potential for fracture, head injury or even death thus it is essential that the organisation has clear process for managing and mitigating this risk.

Additionally, any equipment used in conjunction with the bed, but not for preventing falls out of bed e.g. bed levers, can also cause risk to patient safety in terms of entrapment or injury due to inappropriate use and appropriate risk assessments should be undertaken.

This policy describes how we clinically reason the best solution through assessing the patient's individual presentation and any potential risks. It supports staff to make safe decisions regarding their management of patients who are at risk of falling out of bed

Summary and scope of policy

The scope for this policy covers the safe management of any adult patients who are at risk of falling out of bed. This should be considered for all adult patients aged over 65 and those aged under 65 who are judged by a clinician to be at a higher risk of falling out of bed because of an underlying clinical presentation. This risk will have been identified through a multifactorial falls risk assessment and/or moving and handling assessment.

Risk factors affecting the management of a patient's bed safety will relate to their cognitive status and relative levels of mobility. Evaluation of these factors should form part of the patient assessment

The policy supports all LPT clinical staff in dealing with adults over 18 who are at risk of injury through falling out of bed or inappropriately getting out of bed whether in LPT premises or in the patients place of residence in the community

This policy sets out to

1. Ensure that all patients / service users within any care setting undergo a risk assessment prior to the decision to use equipment to reduce risk of falling out of bed
2. To reduce potential harm to patients / service users caused by falling from beds but also address the risk of using particular types of equipment in preventing the fall e.g., risk of becoming trapped in bed rails/bed levers.
3. Support patients / service users, carers and staff to make individual decisions

around the management of the potential risk of falling out of bed
4. Ensure compliance with Medicines and Healthcare Regulatory Agency (MHRA Bed rails: management and safe use, August 2023)

This Policy applies to health and social care professionals employed by Leicestershire Partnership Trust, students and trainees as well as any bank or agency staff working in our clinical services. It also references staff working with Integrated Community Equipment Loan Service (ICELS) who are involved with delivering equipment to individuals requiring and using bed rails, beds and bed levers in community settings.

Policy Requirements and Objectives

2.0 Introduction

Patients /service users may be at risk of falling, sliding or slipping from a bed or becoming entrapped in their equipment for a variety of reasons, whether in hospital or their normal place of residence. However through effective risk assessment and care planning, risks can be reduced and managed.

When a patient is identified as being at risk of falling out of bed a holistic patient centred evaluation should be undertaken to establish the reasons and risks which will determine the care planning needed to appropriately mitigate risks.

For example,

- If the patient has continence needs at night, then the continence care plan should reflect their need to access the toilet at night and the mitigating actions established to reduce the risk of them trying to access the toilet during the night and falling

- If the patient suffers with confusion or poor memory, they may not recall advice to seek help or ring the call bell if they wish to get out of bed

- Certain medications can make patients drowsy or lightheaded and contribute to the risk of falling out of bed. A medication review may identify medication changes to mitigate this risk

As part of the process of holistic care planning and identifying person centred solutions, there are also options to use equipment +/or supervision that may support staff to manage the risk of the patient falling out of bed

1. Bed Rails
2. Low beds and Falls mats
3. Increased Supervision

Risks associated with using any equipment should be assessed at this time as described in following sections

Process

3.0 Bedrails

Bed rails provide a physical barrier to falling, slipping or sliding out of bed, however the use of bed rails is not without risk. Each person who is at risk of falling, sliding or slipping out of bed should have a risk assessment completed to identify whether the benefits of using bed rails outweigh the risks**.**

3.1 Use of bed rails

NOTE: Bedrails are generally not used in mental health settings due to ligature risks. In these settings any use of bed rails and bed levers <u>MUST</u> be risk assessed considering clinical need to maintain safety against any self-harm risks. Bed rails are also not used with people with Huntington's disease due to the nature of their involuntary movements and entrapment risk

- Bed rails must only be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of a bed / trolley where alternative measures have been considered and risk assessments completed.
- Bed rails are not designed or intended to limit the freedom of a person and are not a form of restraint.
- Bed rails are not intended as a moving and handling aid. (Unless they are integral bed rails which are deemed by the manufacturer to be suitable for this purpose. In this case a manual handling risk assessment must be completed.) Note: ICELS do not currently supply beds with integral bedrails in the community.
- Bed levers must not be used to prevent patients falling / rolling out of bed. They should only be used where assessment shows the patient would benefit to change their position in bed and or move themselves from a lying to sitting position in or on the bed and where there is no risk of entrapment.
- Bed rail bumpers padded accessories or enveloping covers are primarily used to prevent impact injuries, but they can also reduce the potential for limb entrapment when securely affixed to the bed or rail, according to the instructions for use. However, bumpers that can move or compress and may themselves introduce entrapment or asphyxiation risks.

Minimum height of the top edge of the side rail above the standard foam mattress without compression should be <u>no less than 22cm</u>

3.2 Hazards and areas of risk in using Bedrails

3.2.1 Entrapment and entanglement

Bed rails present an entrapment and entanglement risk either within the gaps of the rails themselves, between the rails and the mattress or between the rails and the bed frame. In the most serious cases, this has led to death of bed users where they have

trapped their head and suffered postural asphyxiation. Severe limb damage has also been reported in cases where someone has become entangled in bed rails.

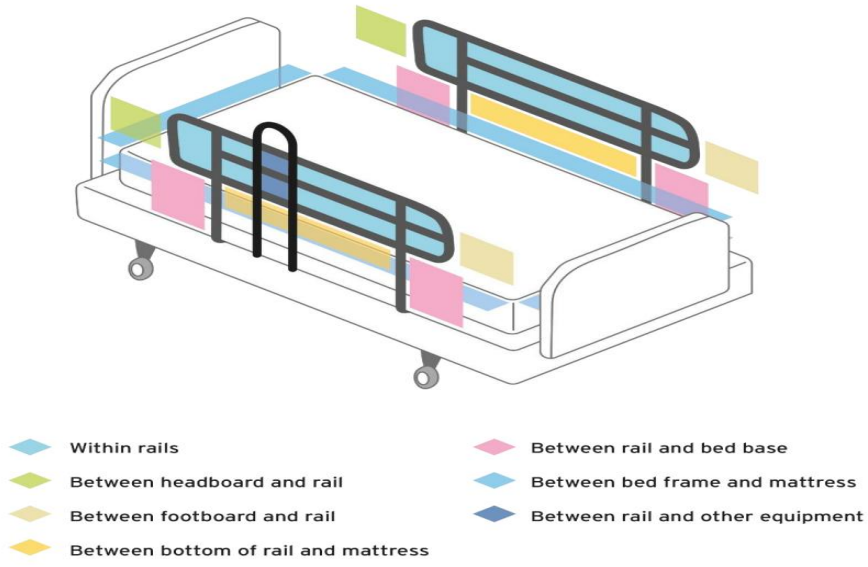
Risk areas are (See Figure 1)

- Between the top and end of the bed rail and the headboard / foot board if the gap is inappropriate.
- In the space between a poorly fitting mattress and side of the bed rail or if a bed rail is used that does not fit the bed base sufficiently snugly.
- Between the horizontal bars of the bed rails if the physical size of the bed occupant is not considered. Patients / service users who have an unusual body size, both large and small, amputees etc may be at greater risk of entrapment or harm
- In the space between the bed and the wall
- Where a mattress easily compresses at the edge
- Where a patient is at risk of striking their limbs on the bed rails through voluntary or involuntary movement
- Use of bedrails with specialist beds/mattresses checks should be made for any potential entrapment gaps

To reduce the risk of entrapment, staff must check safe measurements of gaps are within the safe parameters when using detachable bed rails or when bed rails are fitted: (See Appendix 6 for exact dimensions for safe product use)

- **The gap between the top end of the bed rail and the head of the bed must be less than 6 cm or more than 25 cm.**
- **The gap between the bottom end of the bed rail and the foot of the bed must be more than 25 cm.**
- **The fittings must all be in place and the attached rail must feel secure when raised**

Figure 1: The main areas of the bed-bed rail system where entrapment may occur.



(MHRA Safe Use of Bed Rails v3 March 2020)

3.2.2 Levels of cognition and confusion

Where a patient's levels of cognition is impaired or where they may be experiencing confusion or delirium, they may not be able to assess their own risk of falling or limb entrapment. Where users have been confused or disoriented and have tried to get out of the bed by climbing over the bed rails, they have then fallen from a greater height than would otherwise be the case, increasing the severity of injury.

Similarly, where they have tried to exit the bed between the headboard/footboard and the end of the rail, putting themselves at risk and suffering injury as a consequence.

Bed rails must not be used if:

•The patient is agile and/or confused enough to climb over them unless the service is providing one to one care to mitigate the risk.

•The patient would be independent if the bedrails were not in place. (See Safe Bed Management Tool Section 4)

3.2.3 Use of Split Bed Rails

In some circumstances it is appropriate to use split bed rails where there are agreed therapeutic benefits.

The need for split bed rails would be identified through MDT discussions, led by the Physiotherapists and/or Occupational Therapists, to support the practice of bed transfers where the patient has independent sitting balance.

The MDT, led by the therapists, should complete the Split Bed Rail risk assessment and scan onto Systmone. (See Appendix 12)

The request should then be made to the Bed contractor, Medstrom, who will provide a bed with split bed rails. Email ops@medstrom.co.uk or call 0843 506 0531 to request a bed with split bed rails. (Should be delivered within 4 hours of submission)

3.2.4 Equipment checks when using bedrails

Each time it is identified as safe for a patient to have bed rails the equipment should be checked before use and monitored regularly as below.

- Check the bedrail for signs of damage, faults or cracks before use
- Check all parts of the rails to ensure they are in working order
    - Defects:
        - Rusting or cracks in metal frame or joints
        - Flaking paintwork
        - Missing locking handles and fixing clamps, loose fixings, looseness in joints
        - Worn threads on clamps
        - Bent or distorted features

In an inpatient setting, if the bedrail is faulty, remove from use, label clearly, store safely and report for repair to Medstrom (Email ops@medstrom.co.uk or call 0843 506 0531)

In the community setting report to Medequip (contact details Medequip Leicester

Tel: 0116 216 8686 or email: LLRcommunityequipment@medequip-uk.com)

- Check for any gaps and spaces in the bed rail that may allow the patients head, body or neck to become entrapped.
- Check distance between top of mattress and top of bed rail – minimum 22 cm
- Consider the risk of larger patients rolling over the top of bed rail

4. Use and risks associated with Bed Levers

(also known as bed handles / bed sticks / bed loops)

- Bed rails should not be confused with bed levers , which are designed to aid mobility for the person in bed and help them transfer to and from bed, rather than to prevent falls from bed.
- Bed levers can pose the same hazards to users as bed rails, including entrapment and their use should be carefully considered, risk assessed and documented.
- Bed levers , which come in a variety of sizes and designs are not designed to prevent patients falling from their bed. They should not be used as an alternative to bed rails.
- Bed rails should not be used in the same way as bed levers unless indicated by the manufacture , this could result in the bed rail breaking and put the patient at risk.

Bed levers should be positioned at more than 318 mm away from wall / headboard / footboard so that any entrapment risk is reduced, as the gap would be large enough to pass through (unless patient is of extreme size) (<60mm or >318mm reduces risk of entrapment - Appendix 6). It must be fitted with a suitable stable and firm mattress that will not squash excessively and create a gap between the bed lever and mattress and further entrapment risks.

When prescribing or reviewing use of Bed Levers for use in the patient's home, staff should complete the **LPT Bed Lever Risk assessment** or **Review risk assessment** templates on SystmOne in line with the 'Equipment Safety in Patients Residence SOP'

5. Low beds

The use of the term 'Low bed' refers to an electronically operated bed that can be height adjusted to a level below that of a standard hospital bed, sometimes to floor level. All LPT inpatient beds have the capability of being used as low beds (21 cm or 19 cm depending on bed model). In the community, all Accora beds, available through Medequip, also have the capability to be used as a low bed.

Use of low beds can help to reduce harm from falls, for patients who are **at risk of rolling out of bed**, but for whom it is unsafe to use bedrails. A Falls mat (or mattress if clinically reasoned) should be used as injuries can still be sustained rolling from a low bed.

However, used inappropriately, low beds and falls mats can create further risks and their incorrect use can result in injury

Note: Within Mental Health Settings MMO 3000MH Ultra-Low mental health bed is used.
This is a four section electric profiling ultra-low hospital bed designed to be used in a mental health environment. The ultra-low height, additional unique features combined with selected adaptations for the mental health setting, provide a safer environment for both patients and staff.

Other specialist low beds and beds with adaptations may be in use that have been purchased with full MDT involvement alongside Medical Devices Team to meet the specialist needs of patients.

5.1 Risks associated with Low Beds

5.1.1 Environmental and entrapment risks

- Injuries from floor-level furniture or fittings such as radiators, pipes, or lockers
- Low beds placed close to a wall but not flush with it, creating potential for asphyxial entrapment if the patient slips between the side of the mattress and the wall (see MHRA bedrail guidance).
- Inappropriate use of mats beside low beds can create a trip hazard to patients and staff (Appendix 13)
- **NOTE**: In mental health settings the type of bed used **must ensure minimal ligature risks**

5.1.2 Risks related to impaired levels of cognition or confusion

- Where a patient's levels of cognition is impaired or where they may be experiencing confusion or delirium, they may not be able to assess risk to themselves.
- For a patient who is cognitively impaired, confused, agitated with the potential ability to try and get up, then the use of an ultra-low bed is NOT appropriate. This is due to the risk of the patient trying attempt to mobilise from a low height onto an unstable surface (mat), this could lead to a fall. Consider 1:1 supervision with the bed at normal height (i.e. knee height for patient).

5.2 Safe Use of Low beds

- The low bed must be returned to the lowest level to prevent a fall from height after being attended to by staff
- Ensure the low bed is positioned to the appropriate height for patients and staff when undertaking any care or manual handling activities e.g., hoisting.
- Ensure the low bed is either placed flush to a wall or with a large enough gap either side, to prevent asphyxial entrapment if the patient slipped between the side of the mattress and the wall.
- Ensure that the space under the low bed is clear and free from obstruction when the bed is lowered.
- Ensure the low bed is kept away from furniture and equipment, radiators and other

low level hazards to reduce the risk of patient injury or burns.

- Falls mats at the side of a low profiling bed should be used with caution. These can cause a trip hazard for patient, staff and others (See Appendix 13)
- Ensure that any wiring under the bed is kept tidy and does not present as a trip or electrical hazard. (See Appendix 14)

6. Increased Supervision (Inpatients)

Where use of bed rails or low beds present additional risk to a patient who is already at risk of falls then consideration should be given to providing increase levels of supervision.

- On the physical health wards (CHS) this is done by using the **Enhanced Observation Checklist** (See Appendix 11)
- On the mental health wards (DMH, MHSOP, LD) this is done by using the **Supportive Observation and Engagement of Inpatients policy** (SEE: https://www.leicspart.nhs.uk/wp-content/uploads/2021/05/Supportive-Observation-and-Engagement-of-Inpatients-Policy-exp-May-2023.pdf)

6.1 Enhanced Observation Checklist (CHS)

- In CHS the need for increased supervision can be assessed by using the Checklist for Enhanced Observations (Appendix 11) this can support decision making and options range from intermittent observation, within eyesight or continuous observation dependent on the patient's circumstances.
- A decision to provide enhanced observations is needed when a patient's clinical or behavioural risk exceeds the normal observation requirements of the allocated nurse and staffing levels of the ward.
- When a patient's condition changes and there is a demand for increased level of observation and care, the Enhanced Observation Checklist can be used in line with the professional judgement to support the decision to increase the level of support.
- Staff allocated to provide continuous observation or within eyesight should wear an identifiable lanyard to indicate that they cannot be called away on other duties.

6.2 Supportive Observation and Engagement of Inpatients policy (DMH, MHSOP, LD)

Observation can be defined as a nursing practice that aims to prevent patients from becoming a risk to themselves or others. It involves a named member of staff being allocated to observe the patient attentively whilst attempting to minimise the extent to which the patient feels they are under surveillance.

Where the risk of falling, sliding or slipping from a bed cannot be managed through use of individualised care planning or use of equipment, level 3 or 4 observations should be considered

Whilst on those levels staff need to ensure they are monitoring patient activity in

relation to movement/falls risks and log this as part of the level 3-4 hourly documentation.

7. Individual Patient Risk Assessment

Most decisions about use of bed rails/Low beds are a balance between competing risks. The risks for individual patients can be complex and relate to their physical, sensory and mental health needs; the environment; their treatment; their personality; their lifestyle; and the equipment available, inclusive of type of bed, bed rail and bed rail accessories. A comprehensive individualised assessment must be carried out to determine those factors that could influence the management of the patient.

Staff must use their professional judgment to consider the risks and benefits for individual patients / service users. Bed rails or low beds must be used only if the benefits outweigh the risks and this must be documented in the patient / service user records. The **Safe Bed Management tool** is available to **aid** decision making (see Section 4). If clinical reasoning determines an alternative solution to managing the risks, the assessment, the results of the assessment and the clinical reasoning must be clearly documented in the patient record

Within a hospital setting the continued use of bed rails/low beds must be reviewed by a health care professional each time there is a change in circumstances involving the patient or at a **minimum of weekly**. If the service is unable to achieve this it should be logged on the directorate risk register.

8. Patient involvement / Consent

The patient must consent to whether or not to have bed rails/low bed if they have capacity to make this decision. Consent must be voluntary and informed and can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand where appropriate, capacity should be determined by an assessment under the MCA (2005). The mental capacity of the patient to be able to make this particular decision must be assessed using the 2-stage test for mental capacity as outlined in the Mental Capacity Act (2005) and documented in the patients Electronic Patient Record (EPR).

> *(Capacity is the ability to understand, weigh up, retain and communicate the risks and benefits of bedrails once these have been explained to them and this will be recorded in the patient/service user care plan/records.)*

If the patient lacks capacity regarding the use of bed rails an MDT ‘Best Interests’ decision should be made, in consultation with the patient’s representatives and documented in the patient / service user records.

Every effort must be made to ensure that the patient is given the opportunity to be involved in the decision-making process. This may involve consideration for optimising communication for patients/service users (e.g., communication aids, time/place of assessment, interpreter).

Staff can learn about the patient's likes, dislikes and normal behaviour from relatives and carers, and must discuss the benefits and risks with relatives or carers. However, relatives or carers cannot make decisions for adult patients unless the patient has donated Lasting Power of Attorney (LPOA) for Health and Welfare, to a representative. If so, the views of the LPOA must be taken into account when having these discussions.

8.1 In the Community setting

All staff must ensure that the patients / service users and carers (formal or informal) are aware of their responsibility to.

- Ensure correct use of bed rails and bed rail accessories / low bed
- Alert the health care professional or equipment provider to a change in the circumstances that would affect the safe use of bed rails. (See Leaflet Appendix 10)

8.2 When the patient / service user has been assessed as requiring bed rails/low bed but then **refuses them** an alternative outcome of preventing injury from sliding, slipping and rolling out of bed must be considered. All decisions and information provided to the patient / service user must be documented and related to the Mental Capacity assessment and patient's best interests

8.3 When a patient / service user **requests bed rails/low bed** when there is no risk of rolling, sliding or slipping out of bed, staff should ensure that the appropriate strategies are in place to allow the patient / service user to get out of bed when necessary and limit the risks associated with the use of bed rails/low bed.

It is recognised that some of the safety options outlined above may not be acceptable to patients / service users, carers / relatives. Patient / service user safety must be balanced against the wishes of patients / services users, carers / relatives. These people need to be included in discussions to establish an acceptable level of risk. Any such discussions must be documented and kept with the patient's records.

9. Responsibilities in transferring care from inpatient to community settings

All patients / service users considered to have a continued need for bed rails/low bed on discharge from an LPT ward will have their risk assessment reviewed prior to the discharge that would inform the patient's needs in their discharge destination.

9.1 Where Patients are discharged to own home

All patients (and their informal/formal carers) with a continued need for bed rails/low bed will be involved with the decision and informed of the risks. Information relating to risks of bed rails are detailed within the **Safe Use of Bed Levers and Bed Rails Leaflet**. This leaflet also includes contract details of who to contact if there is an issue with the equipment (Appendix 10),

9.1.1 Where patients / service users have an **on-going health need on discharge and are referred to a community health care professional,** the referral must include.

- information regarding the use of bedrails/low beds/increased observation.
- Outcome of the **up to date risk assessment** (Appendix 7) prior to transfer.
- Details of care plan for the safe bed management.

The receiving health care professional will have a responsibility to review/reassess the patient's / needs for equipment whilst on the caseload in line with the LPT Equipment Safety in Patients Residence SOP.

Patients/Carers should be informed of any risks for the individual and also the triggers for them to alert a health care professional or equipment provider to a change in circumstances (Safe Use of Bed Rails and Bed Levers - Appendix 10)

On discharge from caseload, the need for the equipment should be reviewed and if the equipment is no longer needed the equipment provider should be contacted. If there is still a need for the equipment ensure that patient and / or carers are aware of any risks and when to alert a health care professional or equipment providers to a change in circumstances as above.

9.1.2 Patients / service users **without an on-going health need** on discharge but a continued need for bed rails will have carers (informal or formal) identified who will have been involved. The carer(s) must be provided (by Inpatient staff) with a '**Safe Use of Bed Levers and Bed Rails' leaflet** (Appendix 10); identifying any considerations for the individual and their need to alert a health care professional or equipment provider to a change in circumstances. Inpatient staff will undertake a review phone call with the patient or carer once home with the equipment is in situ to ensure its appropriateness within 5 days of the equipment delivery in line with 'Equipment Review in Patient's Residence SOP'.

9.2 Discharge to Care Home setting (residential / non-nursing care / nursing care)

Information must be given to the Care home prior to transfer

- information regarding the use of bedrails/low beds/increased observation.
- Outcome of the **up to date risk assessment** prior to transfer.
- Details of care plan for the safe bed management.

(Note: this information should also be supplied to any other healthcare setting, eg the acute setting, if the patient is admitted there.)

Patients / service users without an on-going health need transferring to residential / non-nursing care home **will not** have bed rails or bed rail accessories or low beds provided by the ICELS equipment provider. The care home provider should be involved with the decision making and must be informed of the needs of the patient to enable them to provide suitable equipment. (ICELS Policy for the Provision of Equipment into Registered Residential and Nursing Homes and Day Care Centres 2023)

Where Community Healthcare Professional is involved in the patient care then they should work with the care home provider to review the need for equipment to manage the risk of falling out of bed

9.3 Review following discharge from caseload

In line with the MHRA Alert (NatPSA/2023/010/MHRA), patients who are on record as having bed rails or bed lever prescribed by an LPT clinician will be offered by letter, on an annual basis, a reminder of when and how to escalate any issues and an offer of a review of their risk assessment.

9.4 New referrals into Community services where a patient is at risk of falling out of bed

If the community service receive a referral for a patient who is

- Already using bed rails / low bed to manage the risk of falling out of bed
- OR is identified as at risk of falling, slipping sliding out of bed

The same risk assessment processes should be followed considering appropriate individualised care planning, review risks of current use for bed rails/low bed or risks of new provision of bed rails/low bed and associated care needs.
For,

- New prescriptions of bedrails - complete **LPT Bed Rail Risk Assessment** (Appendix 7)
- Reviewing existing bed rails – complete **LPT Bed Rail Review Risk Assessment**.

On discharge from Caseload the need for the equipment should be reviewed and - identifying any considerations for the individual and their need to alert a health care professional to a change in circumstances. Ensure the patient and/or carer is clear how to escalate by supplying leaflet (Appendix 10)

Any equipment that is no longer deemed necessary should be returned to ICELS

(*Note: although Bed levers are not used to prevent falls from bed the same process is used to risk assess bed levers through use of the LPT Bed Lever risk assessment (Appendix 8) and review risk assessment tools on SystmOne*

10.0 SAFE BED MANAGEMENT TOOL

MOVING + HANDLING Ax + Falls Risk

- **Is the patient <u>at risk</u> of slipping or rolling out of bed?**

NO → **Use bed at normal height** (Knee height for patient)

YES

DETERMINE REASONING FOR SAFE MANAGEMENT IN BED

NOTE. Bedrails are not used in Mental Health Settings due to ligature risks

MENTAL STATUS	MOBILITY STATUS			
	* ¾ length bedrail only **NOT** split bed rails	Immobile e.g., bedbound / unable to sit up in bed	Some mobility not independent in getting out of bed e.g., rotunda +2	Mobile
	Patient is confused +/or disorientated Doesn't understand risk	Bedrail* or low bed indicated	Low bed *If able to stand consider appropriate monitored bed*	• Appropriate monitored bed + standard height. • Consider use of enhanced observations
	Patient is drowsy but not confused	Bedrail* or low bed indicated	Bed rail* with caution or low bed	• Appropriate monitored bed + standard height. • Consider use of enhanced observations
	Patient is alert + orientated + understands risk	Bedrail* indicated in discussion with patient (or low bed option)	Consider Bed rail* in discussion with patient (or low bed option)	Consider Bed rail* in discussion with patient
	Patient is unconscious	Bedrail indicated	n/a	n/a

CHECK QUESTIONS for bed rails / low bed

Is the patient known to be restless, able to sit themselves up and move around the bed at times? → YES

NO

Is the patient able to get out of bed unsupervised? → YES

NO

Is patient very small/large? Is there risk of entrapment in or around bedrail OR between low bed and wall? → YES

NO

ALTERNATIVES:

Consider using normal bed and..

- **Use Enhanced Observations / Therapeutic observations**

+/-

- **More appropriate bed space for monitoring**

+/-

- **Cohorting patients with supervision**

If Proceed with Low Bed
Consider whether crash mat or mattress is more appropriate beside bed?

If Proceed with Bed Rails
Ensure minimum **22cm** between top of rail and top of mattress

<u>DOCUMENT CLINICAL REASONING IN CARE PLAN</u>
Review a <u>minimum</u> of weekly OR following a fall OR as condition changes.

11. Roles and Responsibilities

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

11.2 The Trust Policy Committee is mandated on behalf of the Trust Board to adopt policies

11.3 The Patient Safety and Improvement Group and Falls Steering Group has responsibility for the Safe Bed Management policy

11.4 Divisional Directors and Heads of Service are responsible for ensuring that policy is embedded across their Division / Service.:

11.5 Managers and Team leaders are responsible for:

- Implementation of the policy within their clinical area.
- Managers and Team leaders will ensure by delegation that an individual patient risk assessment pertaining to safe bed management is carried out and acted upon.
- To manage and /or delegate the responsibility for ensuring staff have the knowledge base to evaluate the most appropriate way of managing bed safety and risks of falling out of bed.
- Investigating incidents where patients have sustained injury following the use of bedrails or low beds.
- Ensuring that action is taken to prevent recurrence of incident where bedrails or low beds and falls mats are implicated in a patient sustaining an injury.

11.6 Responsibility of Staff

- To maintain the standards and practice described in this policy and accept accountability for their own practice.
- Ensure equipment is in safe working order or in need of repair according to organisational or ICELS policy and report to the Equipment Provider if no longer needed (LLRcommunityequipment@medequip-uk.co)
- Report incidents and near misses relating to patient injury involving the use of bedrails, low beds or Falls mats.
- Undertaking/cooperating with audits of practice within the clinical setting.
- Complete risk assessments and documentation appropriate to the care settin

11.7 Policy Authors and Falls Steering Group

- Responsible for ensuring the policy remains in line with any national or local guidance and reflects key learning from incidents involving patients falling or rolling out of bed

12 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. **See section 8**

Appendix One: Definitions

Terminology: Descriptor

MFRAT	Multifactorial Falls Risk Assessment Tool
Bed rail	Bed rails are used to prevent or reduce the risk of bed occupants from falling and sustaining injury. Also known as bed side rails, side rails, cot sides, and safety sides
ICELS	Integrated Community Equipment Loan Service
MHRA	Medicines & Healthcare products Regulatory Agency
Low bed	An electronically operated bed that can be height adjusted to a level below that of a standard hospital bed, sometimes to floor level
Falls Mats	Also known as crash mats or impact mats. For use with low bed to reduce impact of the fall where patient is at risk of rolling out of bed
MDT	Multidisciplinary Team
MCA	Mental Capacity Act
EPR	Electronic Patient Record
LPOA	Lasting Power of Attourney
Bed Lever	Also known as grab handle/ grab rail/ bed stick / bed loops Used to facilitate patients with positioning themselves in bed and can help patients move themselves from a lying to sitting position in or on the bed. They can be attached to the bed frame or secured by the mattress They are not to be used to prevent falls from the bed

Appendix Two: Governance

Version control and summary of changes

Version number	Date	Description of key change
Version 3	27/08/25	Updated to reflect MHRA Alert (NatPSA/2023/010/MHRA) re bed rails/bed levers Updated to reflect risk assessment process as outlines in Equipment Safety in Patient's residence SOP Change from CHS Specialling Tool to CHS Enhanced Observations Amendments from review of policy by LPT Falls Steering Group

Responsibilities

Responsibility	Title
Executive Lead	*Head of Nursing*
Policy Author	*CHS AHP Lead*
Advisors	*LPT Moving and Handling Lead*
Policy Expert Group	*Falls Steering Group with Directorate reps from Nursing + Therapy, Moving and Handling Lead*

Governance

Governance Level	Name
Level 1 Assurance Oversight	*Quality + Safety Committee*
Level 2 Delivery Group for policy approval and compliance monitoring	*PSIG*
Level 3	*Falls Steering Group*

Compliance Measures

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
A 'Safe Bed Management' Risk assessment should be undertaken for all patients who are identified as at risk of falling / rolling out of bed	Through regular record keeping audits on inpatient sites and reporting into directorates
Risk assessments and care planning is appropriate and	Record Keeping and Clinical supervision Incident investigations reporting into Falls Steering Group

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
personalised. (Interventions should not create additional risks)	

Training Requirements

There is a need for training identified within this policy to ensure staff are aware of risk and safe clinical decision making around managing a patient's risk of falling or slipping out of bed.

All clinical staff are expected to attend moving and handling mandatory training: awareness of this policy and importance of risk assessment will be iterated. Use of bedrails/low beds is also covered in the Falls awareness training

In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role essential training.

References

9.0 References and Bibliography

The policy was drafted with reference to the following:

MHRA Bed rails: management and safe use
Guidance on managing and using bed rails safely.
Published 30 August 2023 Retrieved from
https://assets.publishing.service.gov.uk/media/64ede752da84510014632343/Bed_rails_guidance.pdf

NSPA The safe use of ultra-low beds | Signal Reference number1309, Issue date14 February 2011 Retrieved from:
https://www.rcplondon.ac.uk/file/932/download#:~:text=The%20safe%20use%20of%20ultra%20low%20beds%20%7C%20Signal&text=Ultra%20low%20beds%20can%20help,(see%20NPSA%20bedrail%20guidance).

HSE Safe use of bed rails 2021 Retrieved from:
https://www.hse.gov.uk/healthservices/bed-rails.htm

LPT Equipment Safety in Peoples Residences SOP

ICELS Policy for the Provision of Equipment into Registered Residential and Nursing Homes and Day Care Centres (updated 2023)

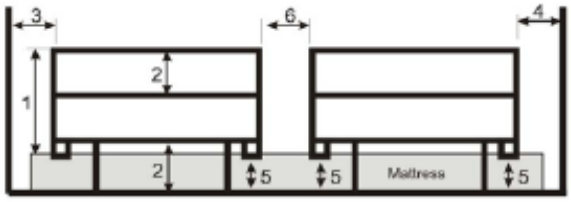
Hanger C, Willis K & Wilkinson T (2014) Classification of falls in stroke rehabilitation – not all falls are the same. Clinical Rehabilitation, 2014, Vol 28(2) 183–195

Highnett S, Griffiths P.(2005) Do Split side rails present increased risk to patient safety. Quality & Safety Healthcare, Vol 14, 113-116

Appendix 3: Safe Use of Bed Rails and Dimensions

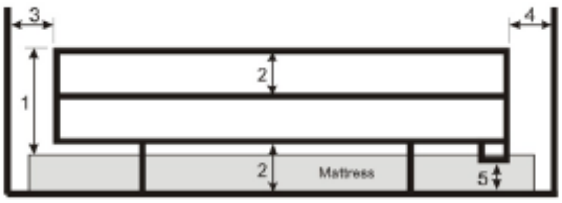
1. Side view of bed with Split Side Rails

Head Board Foot Board



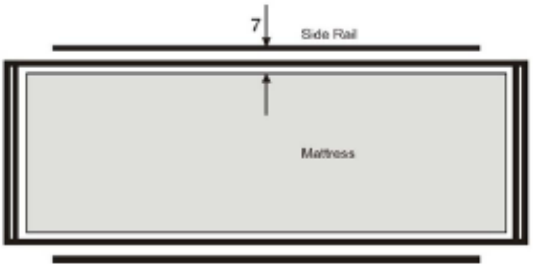
2. Side view of bed with Cantilever Bed Rails

Head Board Foot Board



3. Diagram of bed in plan view

Head Board Foot Board



Appendix Comparison of dimensions in product standards

Description	Ref on diagrams (see below)	Current standards (to be withdrawn in 2013)		New combined standard	Notes
		BS EN 1970:2000	BS EN 60601-2-38:1997	BS EN 60601-2-52:2010	
Height of the top edge of the side rail above the mattress without compression	1	≥ 220mm	≥ 220mm	≥ 220mm [a]	[a] 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	≤ 120mm	< 120mm	
Gap between head board and end of side rail	3	≤ 60mm or ≥ 250mm [b]	≤ 60mm or ≥ 235mm [b]	< 60mm [c]	[b] Side elevation between head board and side rail [c] Most disadvantageous angle between head board and side rail
Gap between foot board and end of side rail	4	≤ 60mm or ≥ 250mm [d]	≤ 60mm or ≥ 235mm [d]	< 60mm or > 318mm [e]	[d] Side elevation between foot board and side rail [e] Most disadvantageous angle between foot board and side rail
Distance between open end of side rail(s) and mattress platform [f]	5	If ID4 is ≥ 250mm then gap is ≤ 60mm If ID4 is ≤ 60mm then gap is ≤ 120mm	If ID4 is ≥ 235mm then gap is ≤60mm If ID4 is ≤ 60mm then gap is ≤ 120mm	< 60mm	[f] The gap between the open end of the side rail and head board is not relevant to this ID
Gap between split side rails	6	≤ 60mm or ≥ 250mm to ≤ 400mm [g]	≤ 60mm or ≥ 235mm [g]	< 60mm or > 318mm [h]	[g] When in flat position [h] When in most disadvantageous position
Gap between side rail and mattress in 'plan' elevation	7	Not specified	Not specified	Perform test [i]	[i] 120mm aluminium cone is positioned between mattress and side rail to determine if gap is acceptable or not

Appendix 4: LPT Bed Rails Assessment

Patient Surname:	Patient Forename:	Patient DOB:
NHS Number:	Height: Weight:	BMI:
Prescriber name:	Job title:	Date of Assessment:

THIS FORM MUST BE TRANSCRIBED INTO SYSTMONE BED LEVER RISK ASSESSMENT QUESTIONNAIRE OR SCANNED ONTO THE PATIENTS ELECTRONIC RECORD

IMPORTANT GUIDANCE NOTES

The below bed rail matrix can be used to assist in decision making:

MENTAL STATE	**Patient is confused and disorientated**	Bed rails may be considered with care	Bed rails **NOT** recommended	Bed rails **NOT** recommended
	Patient is drowsy	Bed rails can be considered	Bed rails **NOT** recommended	Bed rails **NOT** recommended
	Patient is orientated and alert	Bed rails can be considered	Bed rails can be considered	Bed rails **NOT** recommended
	Patient is unconscious	Bed rails can be considered		
		Patient is very immobile (bed bound or hoist dependent)	**Patient is neither independent nor immobile**	**Patient can mobilise without help from others**
	MOBILITY			

Section 1: Initial Assessment	**Yes**	**No**
Is the person at risk of falling out of bed? Rationale:		
Does the person independently transfer out of bed?		
Does the person have the potential to climb over the top of the bed rails or out of the bottom of the bed? Rationale:		
Does the person's movement pose a risk, e.g., spasm, balance etc.? Rationale:		
	Yes	**No**
Does the person's current behaviour present a risk, e.g., confusion, agitation, challenging behaviour, self-injurious behaviour, lack of awareness of potential damage?		

Does the person's physical size present a risk, e.g., entrapment of any part of the body? Check if they meet criteria for atypical anatomy (under 146cm in height **or** less than 40Kg in weight **or** BMI less than 17)		
Does the person have a complex medical condition, e.g., brittle bone syndrome, osteoporosis, epilepsy, dislocated hips, tracheotomy?		
If provided is the person likely to use the bed rails for supporting, turning, sitting up?		
Is the person left unsupervised and does this pose a risk? i.e. can they raise help?		
Is there any other relevant information e.g. historical information, sensory needs, existing bed area equipment which may affect risks? Rationale:		
Are bed rails suitable for reducing the risk to the person following this assessment? *Ensure that you provide rationale if any answer is outside of the grey box and continue with assessment if bed rails are suitable.* *Rationale:* ***If you are unsure on whether the provision of bed rails is suitable, seek further advise from supervisor.***		

Section 2: Provisioning	**Comments and Rationale**	**Yes**	**No**
Have alternative methods of bed management been considered? i.e. high low bed, crash mats, sensor mats			
Has the patient or family requested the provision of bed rails?			
Does the patient consent to the fitting of the bed rails?			
If the person lacks mental capacity, is the bed lever being provided following a best interest's decision?	*Add MCA and BI decision date*		
Would the fitting of the bed rail restrict personal care or transfers?			
Does the patient require bed rail bumpers to reduce the risk?			
Are mattress infills required?			
Bed Rails to be fitted	Yes		No

Section 3: Equipment ordered/recommended		
Details of equipment being ordered:	Type of Bed:	Type of Rail:

Where will the bed rails be used?	Residential/Nursing home	Own Home	Other
Date equipment ordered/recommended			
Who is installing the equipment	e.g. medequip/carehome		
Post installation review either face to face/remote (this must be completed following delivery and fitting)			
Date of review	Face to Face	Remote	
Confirmation that safety information leaflet has been provided to patient/carer/relative			
Completed by			

Appendix 5: LPT Bed Rails Assessment REVIEW

Patient Surname:	Patient Forename:	Patient DOB:
NHS Number:	Height:	Weight:
Reviewer name:	Job title:	Date of Review:

THIS FORM MUST BE TRANSCRIBED INTO SYSTMONE BED RAIL RISK ASSESSMENT REVIEW QUESTIONNAIRE OR SCANNED ONTO THE PATIENTS ELECTRONIC RECORD

Does the patient:	Live alone	Live alone with 24 hour care/family	Live alone with visiting care	
			Yes	**No**
Does the patient have bed rails				
Is the equipment still being used? *If no please alert medequip for collection*				
If yes to both of these questions continue with the review				
			Yes	**No**
Is the Person at increased risk of injury from entrapment, entanglement or falls due to: Medical conditions / Physical size / Cognitive or Behavioural impairment				
Does the patients environment pose any risks in using the equipment? *e.g does the equipment fit the bed properly*				
If yes, there is a patient safety risk and the patient's equipment needs to be reviewed and alternative options identified.				
			Yes	**No**
Does the patient understand the risks of injury if they should try to climb out over or around the bed rails? *Consider if an MCA needs to be completed*				
Is the person within the safe working weight of the bed lever? *Check the maximum user weight of the bed lever you are using, generally between 100 kg to 150 kg. Ensure this weight is not exceeded.*				
Is the equipment intact? *e.g. any breakages, rust, sharp areas*				
If no to any of the above questions there is a patient safety risk and the patients equipment needs must be reviewed and alternative options identified, or highlighted to Medequip.				
			Yes	**No**
Ensure and confirm that the patient has received a copy of the patient safety leaflet for this piece of equipment.				
Does this piece of equipment continue to be used safely and is appropriate?				

Appendix 6: LPT Bed Lever Risk Assessment Review

Patient Surname:	Patient Forename:	Patient DOB:
NHS Number:	Height:	Weight:
Reviewer Name:	Job title:	Date of Review:

THIS FORM MUST BE TRANSCRIBED INTO SYSTMONE BED LEVER RISK ASSESSMENT REVIEW QUESTIONNAIRE OR SCANNED ONTO THE PATIENTS ELECTRONIC RECORD

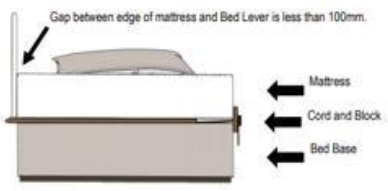
IMPORTANT GUIDANCE NOTES - Bed Lever Do's and Don'ts

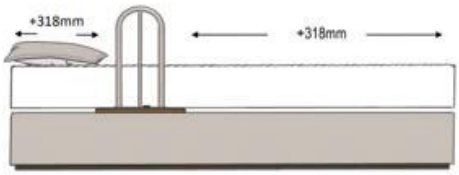
The bed lever must:

- Be fitted onto a suitable stable and firm mattress that will not squash excessively and create a gap between the bed lever and mattress.
- Be positioned at least 318 mm away from wall/headboard/footboard so that any entrapment risk is reduced as gap is large enough to pass through.
  n.b. There are 2 options only for fitting an Accora Bed lever due to the welding on the bed. The positions are: 570mm from headboard or 725mm from headboard.
- If using a bed lever with straps it must be securely fitted and regularly checked and tightened as needed i.e. Each time the bed is made. This is to prevent a gap forming between the lever and mattress of more than 100 mm.
- Between edge of mattress and bed lever or pillow – use forearm to push down on edge of mattress, it should be firm enough, so any gap created is less than 100 mm.

Bed levers (Bed rail 2 in 1 / Bed grab handle / Easy Fit bed rail with straps/ Parnel bed rail) must <u>NOT:</u>

- **Be fitted to a privately purchased powered profiling or hospital style bed.**
- **Be used to stop someone falling out of bed.**
- **Be used for a restless sleeper, or someone with erratic, repetitive or violent movements.**





Does the patient:	Live alone	Live alone with 24 hour care/family	Live alone with visiting care	
			Yes	**No**
Does the patient have bed lever(s)				
Is the equipment still being used? *If no please alert medequip for collection*				
If yes to both of these questions continue with the review				
Is the Person at increased risk of injury from entrapment, entanglement or falls due to: Medical conditions / Physical size / Cognitive or Behavioural impairment				
If yes, there is a patient safety risk and the patient's equipment needs to be reviewed and alternative options identified.				
			Yes	**No**
Is the person within the safe working weight of the bed lever? *Check the maximum user weight of the bed lever you are using, generally between 100 kg to 150 kg. Ensure this weight is not exceeded.*				
Is the position of the bed lever correct and fitted appropriately? e.g. positioned at least 318 mm away from wall/headboard/footboard (see guidance notes for reference and action as appropriate)				
Is the equipment intact? e.g. any breakages, rust, sharp areas				
If no to any of the above questions there is a patient safety risk and the patients equipment needs must be reviewed and alternative options identified, or highlighted to Medequip.				
			Yes	**No**
Ensure and confirm that the patient has received a copy of the patient safety leaflet for this piece of equipment.				
Does this piece of equipment continue to be used safely and is appropriate?				

Appendix 7: Safe use of Bed Levers and Bed Rails

Safe use of bed levers and bed rails

Information for patients, relatives, and carers

April 24

To contact the person that prescribed the equipment call:
SPA 0300 300 7777

www.leicpart.nhs.uk
Email: lpt.feedback@nhs.net

This leaflet has been produced for people who receive health care services and as a reminder on how to use and look after the bed lever or bed rails you have been supplied with.

Safe use of bed levers and bedrails

A risk assessment has been completed by a healthcare worker to check whether the use of either a Bed Lever or Bedrails is helpful to you and safe

You may have been prescribed a bed lever which is used to help you to roll or turn in the bed, or with getting in and out of bed. There are different types of bed levers depending on the type of bed you have and will be assessed for your individual needs.

or

You have been prescribed a Bedrail which is used to stop someone from rolling or falling out of bed and injuring themselves. They are not meant to stop you from getting out of bed if you wish. Sometimes the bed rails can have bumpers over the rails.

Instructions

The person fitting your bed levers or bedrails will be from Medequip who will provide you with a copy of the manufacturer's instruction.

Once fitted the bed lever/bedrail should not be moved or removed, if this is necessary you must seek help from a clinician to re-fit them.

The person who ordered the bed rails for you must make sure that they or another worker:

- Checks the bed lever/bedrails that have been fitted to ensure that they are safe.
- Shows you and your carers how to use them safely.
- Ensures you and your carer are aware of the risks associated with bed lever and bed rails
- Provides you with details of how to report problems or obtain assistance

You should check your bed lever/bedrails regularly to make sure that they are safe and fit for use.

Look at all parts of them to make sure they are working. Check for:

- Rusting or cracks in the metal.
- Flaking paintwork or plating.
- Missing locking handles and fixing clamps.
- Loose fixtures.
- Looseness in the joints.
- Worn threads on clamps.
- Bent or distorted parts.

If you find any damage, defects or problems with the bed lever/bedrail you must immediately call the telephone number below:

Medequip Leicester Tel: 0116 216 8686
Email: LLRcommunityequipment@medequip-uk.com

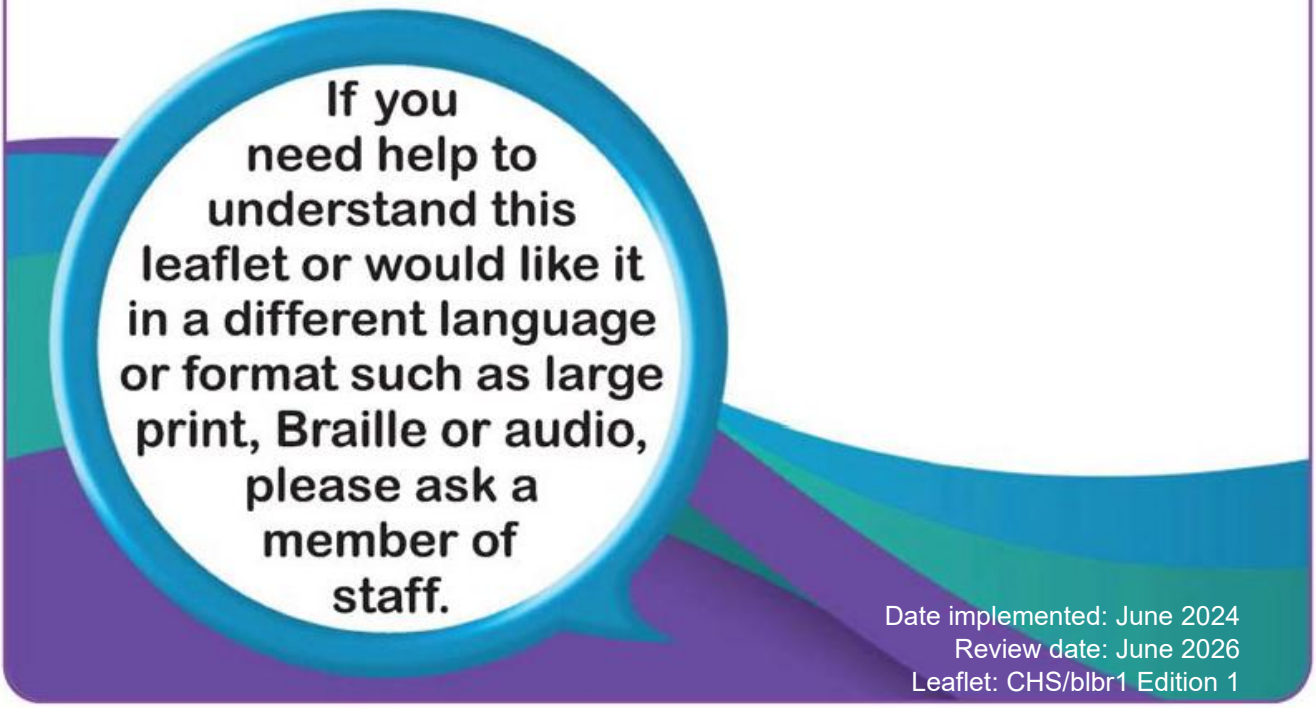
Cleaning

All parts of the bed lever/bedrails (including bedrail bumpers, if used) can be cleaned using a damp cloth and non-abrasive cleaning fluid. Don't let water run inside the tubes or bedrail bars via the holes.

Keeping you safe

You should contact the person who prescribed the bedrails if:

- The bed that the rails are fitted to is changed.
- The mattress is replaced.
- An extra mattress is put on top of the one on the bed.
- There are any changes in your physical or mental health, e.g. change of mobility or weight.
- The bedrails move out of position and a gap appears between the bedrail and the side of the mattress.
- The mattress becomes 'saggy' at the sides and there is a bigger gap between the bottom of the bed rail and squashed mattress when you sit on it.



Date implemented: June 2024
Review date: June 2026
Leaflet: CHS/blbr1 Edition 1

Appendix 8: CHS Community Hospitals Check list for Enhanced Observations

Patient No: Surname: Forename:	Hospital Site: Ward:

1.This tool should be used to support decision making for patients that are a falls risk, displaying self-harming behaviours, wandering and may need increased workforce to facilitate enhanced care.
2.This checklist should have an MDT review every 24 hours.

Checklist of Factors to be considered.	**Yes**	**No**	**Brief details of identified Factor**
Is the patient currently detained in hospital under the Mental Health Act (MHA) or the Deprivation of Liberty Safeguards (DoLs)?			
If the patient is attempting to leave the area – are there reasonable doubts (i.e., impaired memory/cognition) about their mental capacity to make an informed decision about leaving?			
Is there a history of the patient absconding? (Either recent or previous to admission)			
Is the patient currently at risk from others? e.g., exploitation, abuse/neglect?			
Is the patient currently a risk to self? (e.g., suicide, self-harm, fire hazard)			
Is the patient currently a risk to staff/patients/others? (e.g., verbal aggression/physical violence)			
Is the patient currently under the influence of alcohol/illicit substances or are they suspected/known to have a history of alcohol/substance abuse?			
Are there any possible physical causes of agitated/challenging behaviour(s)? (e.g., delirium, brain injury, sepsis, CVA, medication, dementia)			
Does the patient have a Learning Disability?			

Has the patient targeted their challenging behaviours towards a specific group of people? (e.g., based on sex/gender/race)			
Does the patient have a history of falls/ increased risk of falls/ demonstrating behaviour that increases risk of falls.			
Can the patient use a call bell?			
What is the bed location of the patient – would a move support enhanced care?			Location:
Have you considered alternative resources to support the patient e.g., family, friends, MAC?			
Based on the checklist does the patient require enhanced care			
Assessing Nurse's name:	Date: Time:		Signature.

If the decision is made that extra staff above the ward establishment is required to support a patient (e.g., 1.1 support), it must be discussed with Matron/ Operational Lead/ On Call Manager first. Then, please ensure that the extra shift is created on Healthroster, put out to bank/agency and consider opening up to mental health. If enhanced care requires staff in addition to planned staffing, then a Dynamic Risk Assessment (DRA) will need to be completed.

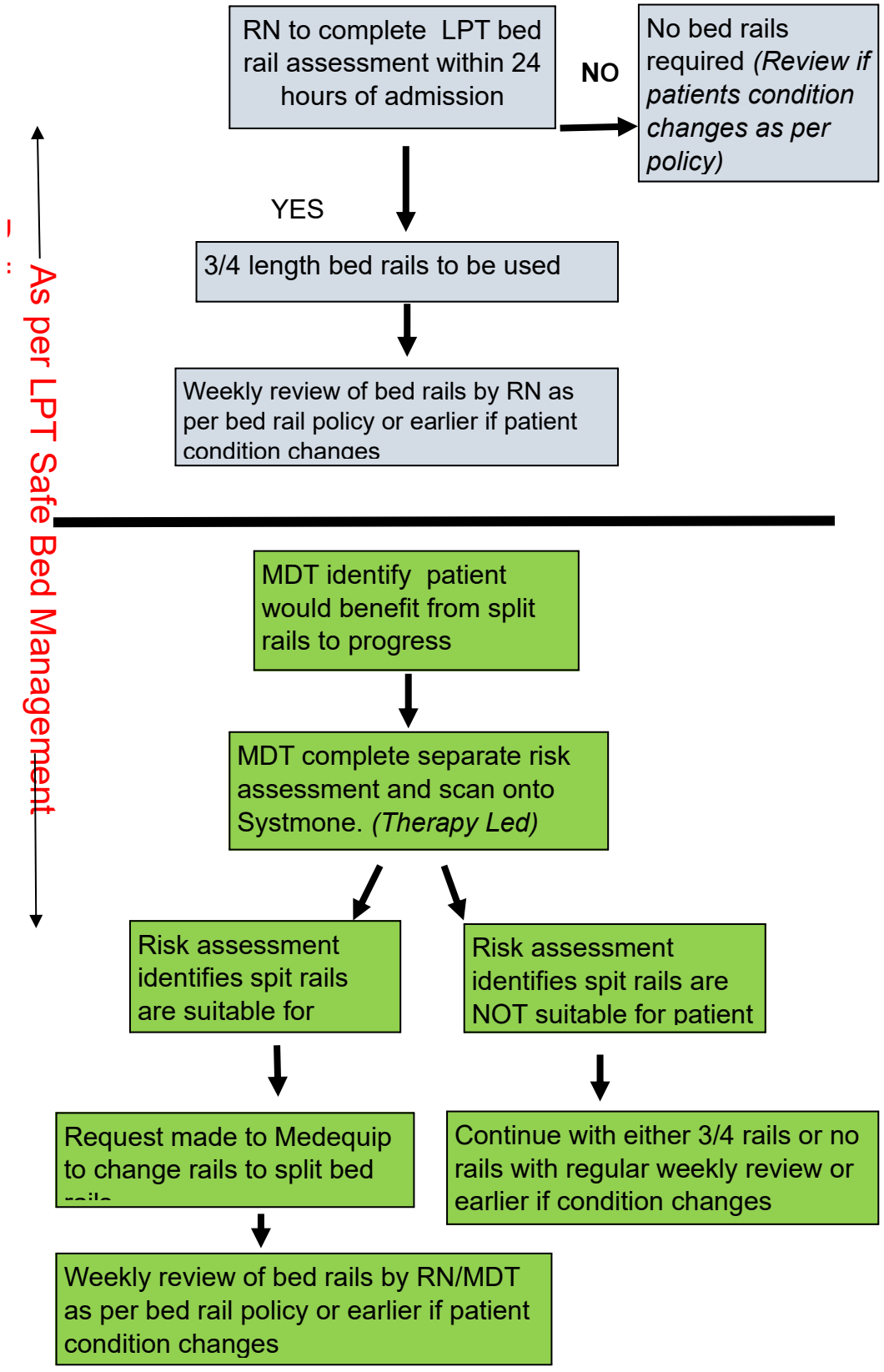
<u>If patient is to receive Enhanced care:</u>
Preferred Name:
What level of enhanced care does the patient require: 1;1 or cohort (delete as appropriate)
Level of interaction with patient: I.e., none, conversation only, puzzle/games, support to leave ward for short periods, and mobility issues i.e., NWB?
Proximity to Patient: i.e., inside/outside room/bay, next to patient, within watching distance.
Any known triggers which exacerbate Patient's behaviours: i.e., noise, medical investigations, time of day, specific individuals, uniforms, medications
Specific Risks to Staff Member (as identified from checklist overleaf)
Yellow lanyard Provided:

Assessing Nurse's name: Date/ Time of Initial Assessment:
Name of Matron/ Ops Lead/ On Call Manager Approving:
MDT Reviews of Checklist – every 24 hours:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:

Appendix 9: LPT Use of Split Bed Rails

Leicestershire Partnership NHS Trust Use of Split Bed Rails

Assessment Flow Chart and Assessment



*NB: - When patient is discharged—Request **MUST** be made to Medequip to return rails to 3/4 length rails so bed ready for new*

Example of assessment for split bed rails

Leicestershire Partnership NHS Trust Split Bed Rail Risk Assessment

Patient goal (related to need for split side rail)

Current sitting ability and seating recommendation:

Any sensory impairment?

Any cognitive impairment?

Current transfer ability:

Any nursing concerns re: night time?

Recommendation:

Date: _____ Therapist: _____ Nurse: _____

Board above bed updated: Y/N Patient Record updated: Y/N Patient care plan updated: Y/N

Appendix 10: How to use Falls Mats with Low Beds

DO NOT PLACE CRASH MAT DIRECTLY BENEATH BED SIDE RAILS

INCORRECT POSITIONING OF CRASH MAT

CORRECT POSITIONING OF CRASH MAT

Appendix 11: Cable Management Poster

Staff are responsible for good cable management. Before you move a bed you must make sure

Plugs are **removed** from the mains electric

Cables are not **trapped** in moving parts of the bed

Cables are **lifted** off the floor & are **not in front** of the bed castors

Please stop this from happening

Severed & damaged cables are dangerous and can cause harm!