Decision Making for Use of Bed Rails Procedure

1. Guiding Principles

The following procedure has been developed to assist WACHS staff to:

- Identify when the use of bed rails should be avoided
- Identify situations when the use of bed rails is the least restrictive and least harmful option for ensuring that a person and others are kept safe
- Implement risk control measures to minimise potential harm
- Identify unsafe or inappropriate use of two full length bedrails on hospital beds, trolleys and similar
- Identify when the use of bed rails is classified as a restraint, and therefore requires consent documented in the consumers' health record.

2. Procedure

Bed rails are considered to be a restraint or restrictive practice when they are used primarily with the intention of limiting a consumer's freedom of movement.
The application of any restrictive practice is an infringement of a person's right to free movement and decision-making. Use of any restrictive practices, including restraint, is potentially harmful, and is not therapeutic. The use of any restraint is always a last resort after other strategies have been unsuccessful.

Use of bed rails should be avoided if possible due to climbing/entrapment risk. However, if the risk to safety is immediate and serious, and alternative strategies have failed to maintain safety, bedrails may be the least restrictive way to maintain safety for the consumer and/or others. Bed rails may be a less restrictive form of restraint than using chemical restraint. Bed rails have more impact as a physical barrier or restraint for a person who has limited mobility; consider full length or half-length rail depending on the individual and the situation. For some people they are a visual and emotional barrier and may prevent the individual from attempting to get out of bed.

If decision is made to use bed rails, ensure consent is gained from individual and/or representative and documented in health record. Nursing staff must monitor and assess on a shift by shift basis to evaluate physical and mental status of individual.

2.1 Bed rail use that is not restraint

During transport, bedrails are a safety measure.

It is not restraint when a consumer who has decision making capacity has requested that the bed rails are used or has consented to their use. However, in these situations the consumer must be able to call for and receive assistance if needed.

2.2 Risk Assessment

The decision to use bed rails should be made as part of the consumer's assessment and based on the principles of safe care and restraint minimisation, or least restrictive care. Assessment by the consumer's health care team will identify:

- the presenting problem (why bed rails may be considered), and alternative strategies.
- the potential risk(s) of harm to the individual consumer if a bed rail is used.
- the care required to reduce harm if a decision is made to use bed rails.

Use the decision-making matrix below to assist with clinical reasoning where there are concerns for consumer safety.

2.3 Bed Rail Decision-Making Matrix

		Level of Mobility			
Decision-making capacity	Cognitive/mental state	Unable to mobilise or hoist dependent	Involuntary movement e.g. Huntington's, Epilepsy, Parkinson's Disease	Requires assistance to mobilise	Independent mobility
Uncertain	Drowsy, sedated, post-op, known diagnosis of dementia impaired consciousness	Consider bedrails with caution	Consider bedrails with caution	Consider bedrails with caution	Bedrails not recommended. Use alternative strategies
Uncertain	Confused. disorientated, Delirious, restless, poor memory, Agitated	Consider bedrails with caution	Bedrails not recommended.	Try alternative strategies, and only use bedrails as a last resort. Frequent monitoring required	Try alternative strategies, and only use bedrails as a last resort. Frequent monitoring required.
Uncertain	Cognitive Impairment/ behaviours of concern e.g. MMSE<26	Bedrails not recommended Use alternative strategies	Bedrails not recommended Use alternative strategies	Bedrails not recommended Use alternative strategies	Bedrails not recommended Use alternative strategies
Yes	Orientated and alert	Bedrails may be considered if the person consents or requests them. Ensure they can call for help if needed.	Consider bedrails with caution	Bedrails may be considered if the person consents or requests them. Ensure they can call for help if needed.	Bedrails not required. Can be requested by person.

Adapted from SA Health Resource – Tool 3: Safe use of bedrails (SA Health 2015) & Armadale Kalamunda Group – Safe use of bedrails guideline (2019)

2.4 Procedure Flowchart

Identify presenting safety problems that bed rails may help with and when the use of bed rails can be avoided.

You might you consider use of bed rails to:

- Minimise the risk of rolling off the bed
- To aid turning over or moving around the bed
- Minimise falls or injury when getting up from the bed

Identify potential risk or harm to the individual if bed rail used – consider alternative strategies. Consider care required to reduce any risk of harm if decision is made to use bed rails. Consider type of bedrail and availability i.e. full length or half length

Assess as relevant: falls risk, sedation, consciousness, dementia, delirium, behaviour, wandering or agitation, continence, sleep pattern

Discuss with resident/patient/representative. Provide information re potential harm and alternatives to using bed rails

Use bed rail decision matrix to identify risks of bed rails use for individuals.

Monitor individual while the bedrail is in situ; review need for bedrail in the context of the resident's/patient's mental and physical status.

Bed rails are considered a restraint or restrictive practice when they are used primarily with the intention of limiting freedom of movement.

If asked about using bedrails, staff should:

- Encourage individual or family to talk to staff to determine whether or not bedrails are indicated
- Reassure individual and family that in many cases the resident can sleep safely without bed rails.

Individuals can request bed rails to help turn in bed, or to hang call bell off etc.
Alternative bed mobility aids are available. Assessment by an OT or PTs recommended for those, where practicable.

Plan care with individual/representative and multidisciplinary team to minimise risk of harm and document care plan in the individual's health record.

2.5 Alternative strategies

Alternative strategies to address particular risks are also described in relevant guidelines such as:
For those at risk of falls, refer to:

- Falls Risk Assessment and Management Plan
- Falls and Fall Injury Prevention and Management Policy Directive and toolkit.
- For those at risk of behaviours of concern, refer to guidelines in the WACHS Cognitive Impairment Clinical Practice Standard and WACHS Restraint Minimisation Policy

For those at risk of challenging behaviour refer to:

- Preventing and Responding to Challenging Behaviour Policy Directive and toolkit.
- Delirium Guidelines.

2.6 Potential risks and care required to mitigate risk if bed rails are used.

Bed rail use can be harmful. If a decision is made to use bed rails, assessment and review will identify the potential risks of harm to the individual what strategies to put in place to mitigate risk. Consider:

- Risk of functional decline, falls, injury, entrapment and psychological harm in your decision making.
- For individuals with involuntary movement, bed rails, if used, may need to be padded; however, this may increase entrapment risk.
- Ongoing assessment and review of the individual's physical and mental status must occur.
- Regular visual monitoring of the individual.
- Teamwork and team communication - documentation in the care plan and medical record, and, included in handover
- Monitoring, review and safety of the bed rails if the consumer's mobility or cognitive status changes or they exhibit signs of distress, or their condition improves.

3. Definitions

Cognitive Impairment	It is acknowledged that the term cognitive impairment is inclusive of a broader range of genetic, medical and acquired conditions and that it can affect people from any age. For the purpose of this policy cognitive impairment will be used to refer to patients with dementia, delirium and depression.
Decision-making capacity	In the context of medical treatment, a person has capacity if he/she is capable of understanding the nature, purpose and consequences of the proposed treatment. Capacity must always be assessed in the context of the decision that is to be made. The *Mental Health Act 2014* (WA) (s15) defines a person has having capacity when they: • Understand the information or advice about the decision that is required. • Understand the matters involved in the decision. • Understand the effect of the decision. • Weigh up the above factors for the purpose of making a decision. • Communicate the decision in some way.
Restraint	The intentional restriction of an individual's voluntary movement or purposeful behaviour by physical, chemical. Mechanical or other means.

4. Roles and Responsibilities

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

5. Compliance

This procedure is a mandatory requirement under the *Aged Care Act 1997, Quality Care Principles 2014 and Health Services Act 2016*.

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

Required documentation in the medical record includes:

- alternative strategies attempted, but failed
- results of discussion with consumer and carer
- an agreed care plan to reduce harm while bed rails are used.

7. Evaluation

Monitoring of compliance with this document is to be carried out by individual Aged Care Facilities and inpatient areas through the evaluation of SAC events involving use of bed rails.

8. Standards

National Safety and Quality Health Service Standards – 1.30; 5.7; 5.25
Australian Aged Care Quality Agency Accreditation Standards – Standard 8
National Standards for Mental Health Services – 1, 2, 6, 8, 10

9. Legislation

Aged Care Act 1997
Quality Of Care Principles 2014
Health Services Act 2016
Mental Health Act 2014
Disability Services Act 1993

10. References

1. South Australian Health – tool 3: Safe use of bedrails (2015)
2. Armadale Kalamunda Group – Safe Use of Bedrails Guideline (2019)
3. Australian Best Practice Guidelines Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals, Residential Aged Care and Community Care (2009) Australian Commission on Safety and Quality in Health Care.
4. Prevalence and predictors of bedrail use in an acute hospital, 2014 Ó Flatharta T Age Ageing 43 (6): 801-805.
5. Safe use of bed rails. 2013. Medicines and Healthcare Products Regulatory Agency (UK). http://www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON2025348
6. A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: (revised April 2010) U.S. Food and Drug Administration, U.S. Department of Health and Human Services. http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/ucm123676.htm

11. Related Forms

RC13 Behaviour Assessment Form
RC29 High Risk Behaviour Consent Form
RC43 Restraint Assessment Form
RC44 Restraint Chart

12. Related Policy Documents

Restraint Minimisation Policy
Mental Health Restraint Policy
Mental Health Seclusion Policy
Falls Prevention and Management CPS
Cognitive Impairment CPS
Disturbed Behaviour Management CPS

13. Related WA Health System Policies

OD0657/16 WA Health Consent to Treatment Policy

14. Policy Framework

Clinical Governance Safety and Quality

15. Appendix 1: Safety Concerns and Alternative Strategies

This document can be made available in alternative formats on request for a person with a disability

Contact:	Senior Project Officer Aged Care		
Directorate:	Health Programs	**EDRMS Record #**	ED-CO-21-28462
Version:	1.00	**Date Published:**	24 February 2021

Appendix 1: Table 1 Safety Concerns and Alternative Strategies.

Type of risk	Who, and when is risk greatest?	Alternative strategies
Rolling off the bed	Intentional e.g. leaning or reaching	• Ensuring that personal items are within reach • Use of over-bed table for personal items.
	Unintentional, for example: • When turning/rolling over and sedated or drowsy • When there are uncontrolled movements or muscle spasms such as during a seizure (unless the risk of injury from hitting the rails is greater) • Being cared for on a narrow trolley • During transport or while wheeling bed from place to place.	• Use of foam bumpers or concave mattresses (as long as these are removed when the person is able to, and wanting to, get up from the bed). • Review of sedation; and medication. • Use beds that can be lowered to floor level or near. • Move onto hospital bed as soon as possible.
Difficulty turning or moving around in bed	People with limited physical mobility	Other bed mobility aids
Fall or injury when the patient is attempting to get up from or out of bed	Bedrails or any other forms of restraint are not recommended in either WA Health policy or national guidelines as a falls prevention strategy. There are many other strategies recommended to reduce the risk of falls and/or injury.	• Physiotherapy assessment of mobility, walking aids and/or correct bed height for the patient to safely get up. • Walking aids, footwear and glasses within reach. • Anticipate the reasons consumers get out of bed such as hunger, thirst, going to the bathroom, restlessness and pain. Meet these needs by regularly offering food and fluids, pain relief, toileting, and providing calming interventions, distractions or activities. • Hourly rounding. • Alarms to alert staff when a patient is moving e.g. Invisabeam™

Type of risk	Who, and when is risk greatest?	Alternative strategies
Unintentional self- harm	• Wandering means ambulation or mobility that appears to be lacking in purpose or intent, associated with cognitive impairment. • Patients with cognitive impairment who are restless, confused about where they are, and attempting to go home. • A patient is at risk if they are unable to find their way back, unable to recall where they are, or may go to a dangerous area.	• Effective strategies are documented in the Fall and Fall Injury Prevention and Management Guideline. • Anticipate the reasons patients wander such as boredom, need for social contact, hunger, thirst, going to the bathroom, restlessness and pain. • Meet these needs and provide reassurance, distraction and calming interventions.
Absconding, leaving care or leaving the area	Risk of leaving care: • contrary to a legal order, or • when there is risk to the person's health or safety	• Communication with patient and carer. • Patients with decision-making capacity can choose to leave care. Encourage them to complete forms as required. • Patients under legal orders (Mental Health, guardianship or other) can be prevented from leaving.
Protect staff and/or other people present	Risk of: • Intrusive or physically aggressive behaviour • In an emergency situation raising bed rails can create a temporary barrier between a violent or aggressive consumer and staff to allow planning of other strategies	• Reassess and provide alternative strategies to prevent challenging behaviours. • Strategies to minimise the use of restrictive practices. • Least restrictive practices, for example doorway barriers.