

Preventing falls with bed rails in long term



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This essay will discuss the topic of preventing falls with regards to bed rails in long term care units. Firstly I will indicate the rationale for the chosen topic; I will then go onto to analyse government guidelines, polices and research and discuss the thoroughness of the underpinning evidence. This will be followed by reflection of the significance of this assignment for my future practice and patients that I will care for. Finally, I will conclude. To maintain confidentiality in accordance with the Nursing and midwifery council (NMC) code of professional conduct (2008) the name of the hospital will not be disclosed.

I chose this topic because I was in a placement on a long term care unit in a community hospital in East London which highlighted the ambiguity that surrounded the safe use of bed rails. I discovered that the wishes of patient's relative's conflicted with guidelines with regards to when to use or not use bed rails with patients that were confused. This particular area was chosen to enable me to provide patient's with care that is evidenced based. I will be able to clarify the rationale for the use or non use of bed rails to relatives In order to change their thinking on this matter.

Preventing falls is vital as they are the most frequent safety incident reported to the National Patient safety agency's (NPSA) National reporting Learning system (NRLS) (NPSA 2007a). Out of the 200, 000 falls that were reported from hospitals to NRLS in the period September 2005-August 2006 across England and Wales although most of which happened while patients are mobilising an estimated 44, 000 were from a bed in which 8% occurred while bed rails was in use 31% when they was not and 61% did not state either (Healey and scobie, 2007) although, this is likely to be an

underestimate due to falls going un-reported (Tideiskassar, 2002), (Bird, 2005). However, Bird (2005) indicates to make services safer, a consistent and accessible reporting system is a necessity so that past mistakes can be learnt from.

Preventing falls with any patient is necessary however, preventing these in long term care units is vital, due to there being a higher occurrence of falls in those aged 65 and over (Tideiskassar, 2002), with those in the community at higher risk of falls and entrapment from beds due to the diversity of beds and bedrails (MHRA 2006). This is set to continue to grow due to the aging population.

Falls are costly to the NHS. NSPA, (2007a) estimate this being 15 million pound for direct healthcare and 92 thousand pound for associated healthcare costs per annum.

More importantly falls are a major cause of morbidity and a leading cause of mortality in those over 75 years old (Scuffham & Chaplin 2002 cited by NICE, 2004) with 90 fractured neck of femur whilst approximately 1, 250 suffered injures from bedrails and 11 deaths largely due head injuries resulting from bed falls (NSPA 2007a). This further validates my choice of this topic.

In 1999 the Secretary of State for Health, Frank Dobson issued an action plan to save lives with one of the targets being that by 2010 the death rate is reduced by a fifth and serious injuries by a tenth from accidents such as falls, due to statistics indicating that deaths from falls are rising again to the same level as in 1989 (Saving Lives: Our Healthier Nation, 1999). This led to The Department of Health (DoH) launching The National Standards

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Framework (NSF) for older people, consisting of 8 standards. Standard 6 is related to falls the objective being to;

‘ Reduce to number of falls which result in serious injury and ensure effective treatment and rehabilitation for those that have fallen’ (NSF 2001).

To underpin the NSF for older people, in 2001 an managerial agency of the DoH whom HSE (2003) state, ‘ Has considerable expertise on bed rail use’, The Medicines and Healthcare products Regulatory Agency (MHRA) issued guidelines which, in 2006 were replaced by an updated version; The Safe Use of Bedrails; Device Bulletin 6. The recommendations of which are to inform local policy development and improve practice of the safe use of bedrails with regards to falls as well as entrapment. The guideline clarify’s that bedrails are solely intended to protect occupants from falling out of bed and being injured, and are not to be used to restrain those that are able and wish to leave their bed (MHRA 2006). RCN (2007) defines restraint as;

‘ The intentional restriction of a person’s voluntary movement or behaviour’.

Whilst the guideline states it;

‘ Applies mainly to ‘ third party’ bed rails’ (MHRA 2006),

it does identify intergal bedrails, which are common place in many NHS trust’s now due to the introduction of profiling beds. HSE (2007) discuss the huge benefit these have been for staff, patients and cost to the NHS but do go on and suggest that due to the readily availability on bedrails on this types of beds can cause bad practice. MHRA (2006) suggest that bedrail use is underpinned by a individualised risk assessment one that is documented as <https://assignbuster.com/preventing-falls-with-bed-rails-in-long-term/>

this will provide continuity of care (Holland et al 2003) and prevent duplication (Brooker and Nicol 2003) as duplication can take up nurses' valuable time. MHRA indicates that risk assessment should take place before use and repeated if any change occurs with the bed, mattress, bedrail or occupant's condition and at regular intervals throughout their use that starts with the occupant first (2007) that looks at the likelihood of the occupant falling and if bedrails are not suitable this prompts the need to assess an alternative such as special made low height beds or mesh or net sides (MHRA 2006), where the process would need to start again. MHRA (2006) indicate that the dimension of bedrails in relation to the mattress should be part of the assessment so that effectiveness of the bedrails is not compromised although; the guidelines did not discuss the dimensions for this. HSE (2003) confirm this being that the top of the bedrails are at least 22cm above the mattress, measuring this whilst the mattress is in a flat position and without any weight bearing on it will gain an accurate measurement. MHRA states that this will prevent the patient from rolling over the bedrails (2006) as the height of the fall will be increased thus the extent of the injury (Tideiksaar 2002). Furthermore, the bedrails in relation to the bed and mattress need to be assessed as MHRA (2006) indicates that some mattresses are too light to keep bedrails in place and if an occupant falls against these the bedrails could give way and the occupant could fall to the floor.

Concurring with the MHRA's (2006) guidelines as to the intentions of bedrails are the National Safety Patient Agency NSPA (2007b) who also state that bedrails are only to be used to prevent the occupant from accidentally falling, sliding, slipping, or rolling out of the bed and should not be used as a restraint.

The national safety patient agency (NPSA) issued guidelines; the Bedrail Safer Practice Notice (2007b) which refers to the MHRA device bulletin (2006) and the MHRA device alert bed rails and grab handles 09 (2007) and clarifies they should all be used together. This is vital in long term care due to higher use of third party bed rail use (MHRA 2006). The guidelines has been based on information gained from several different resources including accidents reported to themselves and the MHRA(NPSA 2007b) the intention's of which are also to improve practice of the safe use of bedrails in all NHS adult inpatient area's and recommend producing and implementing a policy based on the NPSA's draft policy or to make sure all crucial domains are covered in there current policy that is in place and admend where appopriate by Augest 2007. NPSA

Whist MHRA (2006) did not clearly state that bedrails should not be used for confused patients with regards to falls they did suggest the the occupants whom are they confused and have the power may be at risk of climbing over them but did affirm confusion being one of the clinical conditions that pose a greater risk of entrapment (MHRA 2006). The NPSA issued a Resources for Reviewing or Developing a Bedrail Policy NPSA (2007c), both the Safer Practice Notice and Resources for Reviewing or Developing a Bedrail Policy NPSA (2007c) indicate that patients that are confused and mobile should not have bedrails in use. Local policy also affirms that bedrails should not be used for patients whom are confused and are without clinical observation (Brady 2007). However, due to Brady stating confused patients without reference to their level of mobilty this could led staff whom access the local policy to believe bedrails are contraindiacted to all paitents that are

confused and therefore a patient that is confused but is unable to maintain a safe environment in bed could not have bedrails in place and fall, slip or roll from the bed even if they are being observed as a nurse trying to stop a patient from falling, slipping or rolling from a bed could cause injury to his/herself and the unlikelyhood of being able to stop them anyway.

Bedrails should not be used for patients that are confused and mobile enough incase they try to climb over the bedrails or become entangled in the bars in doing so. For confused patients that are immobile bedrails can be used if the patient have been identified at risk of falling but if the occupant has been identified of becoming entangled in the bedrails to, bedrails covers could be beneficial NPSA (2007b) whilst these should be air -permeable so as to prevent suffocation MHRA (2006).

Other areas bedrails are permitted to be used are when patients are transferred on trolleys between departments and the preliminary period when recovering from anaesthetic (NPSA 2007c, Brady 2007) or when sedated or have been admistered pre-medication as trolley's are high and narrow. Furthermore, bedrails are permitted to be raised such as patient preference as some patients feel more comfortable with them in place due to usually sleeping in a bigger bed although, when discussing bedrails with the occupant whom wishes to have them in place they should be informed that releasing the bedrails should only take place from outside of the bed as if the occupant tries to do this from being in the bed and lean over they may fall or become entrapped in doing so.

Sometimes relatives/carers ask for bedrails to be used or not used if the patient does not have the capacity. Capacity can be defined as the ability to understand and weigh up the risks and benefits of bedrails once it has been explained. If patients do not have the capacity to make this the decision nurses have a duty of care to act in their best interest unless the relative/carer holds the Lasting Power of Attorney that extends to healthcare decisions (Mental Capacity Act 2005). Brady (2007) affirms that the use or non-use of bedrails should be discussed with the patient and/or relatives/carers. NSPA (2007c) indicates this will allow the nurse to find out about the patient's likes/ dislikes whilst informing them about the risks and benefits. NPSA (2007b) recommend that bedrail policies provide clear guidance as to who is responsible for bedrails use or non use decision. Local policy on bedrails Brady (2007) has no link to the consent policy or the Mental Capacity Act (2005). Therefore, by not explicitly specifying who is responsible for making bedrail decisions for those with or without capacity the policy leaves it open to interpretation and those who sought this policy for the decision will still be left with the question unanswered.

In addition, from the time that the local policy Brady (2007) was approved this being February 2005 to when it was adopted July 2007 the NPSA (2007b), (2007c) and the MHRA (2006) guidance had been published but the policy had not and still has not been amended. Therefore, the trust has not complied with the guidance of the MHRA and the NPSA and the action recommended by them, so staff seeking guidance will come across a policy that is not all based on current best practice. As well as not having a link to consent policy and mental capacity act (2005) there is no guidance on

bedrail dimensions and although it indicates a risk assessment should be carried out before bedrail use but there is no guidance or tool to assist in the performance of this. Therefore, it is essential that the local policy is amended so a clear up to date policy is assessable for all staff so falls from bed are minimised as this will never be prevented as even with the nurses' knowledge and skill regarding bedrails patients' behaviour can not always be predicted.

Upon carrying out a search of bedrails policies on the World Wide Web through the search engine Google the policies that were assessed were hugely in line with the guidance of the MHRA and NPSA and the action recommend by them.

- A systematic review of clinical studies concerning bedrails and there effect on falls and injury was carried out by Healey et al (2008). For this review Healey and colleagues whittled it down to 24 suitable papers from 472 of a search between the years 1980-2007. These being 5 before and after bedrail reduction studies, 2 cohort studies, 1 case control study, 12 restrospective surveys and 2 case series and 2 case reports, Patient Uk (2008) categorises evidence into 4 strenghts. According to Patient UK (2008) the supporting evidence is of low strength due to containing controlled and uncontrolled observational studies, whilst a ramdomised controlled trial (RCT) would have higher strength, which Gray (2009) indicates should be first line choice for this kind of research. Healey et al (2008) affirms a RCT would be unethical as ramdomisation of bedrails would be needed to be used for patients whom has contraindiactions for there use and bedrails would not used for those

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whom have indications for their use. Therefore, in this case, studies are the highest possible level of evidence (Patient UK 2008). Healey et al (2008) identified there were remarkable increases in multiple falls or falls in three of the studies related to bedrail reduction. In the discontinue bedrail group, despite a substantial decrease in falls found by one paper, there were less falls in the continue bedrail group than in the discontinue bedrails group. According to one case control study there were substantially fewer falls amongst the patients with raised bedrails. The rate of the injury and head injury was substantially lower in falls with raised bedrails according to one retrospective survey carried out. Patients injured directly by bedrails were identified by twelve papers.

However, it is not easy to carry out formal clinical trials of an intervention which is already part of practice and all the papers included in this study were methodologically limited as none gained 10/10 in the quality criteria, the sample studies either involved females or gender was not stated and most were carried out outside the UK. However, it was concluded that it is usually the old fashion designs and incorrectly assembled bedrails that cause serious direct injuries and bedrails do not seem to play a part in increasing the risk of falls or bedrail related injury from falls (Healey et al 2008).

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It can clearly be seen that falls have a huge human and financial cost and as a nurse I believe it is our responsibility and duty to be up to date with current safe bed rail use guidance and policies but it is this is also required at organisational and management level. If bedrails policies are based on the guidance from the MHRA and the NPSA and the best available evidence this

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will enable nurses to not use or use the right equipment for the right patient in the right way and reduce falls, slips, rolls from beds.